This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0002 Worksheet S Peri od: From 01/01/2022 Parts I-III AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: 5/25/2023 12:46 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/25/2023 Time: 12:46 pm] Manually prepared cost report use only If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

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

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by METHODIST HOSPITALS, INC (15-0002) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

			Title XVIII				
			II tie	XVIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	1, 592, 597	162, 416	0	-760, 401	1.00
2.00	SUBPROVIDER - IPF	0	1, 311	0		-58, 108	2.00
3.00	SUBPROVIDER - IRF	0	39, 506	0		9, 562	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	0		0	9. 00
200.00	TOTAL	0	1, 633, 414	162, 416	0	-808, 947	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

100 Street GO CRAY STREET PO Box	HOSPI T	HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 15-0002					
No. Street, 100 Standard Street Standard		1.00	0.00		2 00		5/25/2023 12:				
1.00 Street: 600 GMM/STREET FOR State: IN 210 Code 46/02 Control Code					3.00			4.00			
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if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost	23. 00		edicaid days on lines 24	and/or 2	5		3 N				23. 00
reporting period different from the method used in the prior cost											
					CUSI						
		reporting period? In column 2, ente	er "Y" for yes or "N" fo	r no.							

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

Health Financial Systems 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 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/25/2023 12: 46 pm XVIII XIX 1. 00 2.00 3.00 58.00 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. Ν 58.00 Pt. I 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see 60 00 Υ instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. If line 60 is yes, complete columns 2 and 3 for each program. (see 23.00 60.01 2 instructions) Y/N LME Direct GME IME Direct GME 1.00 2.00 3.00 4. 00 5. 00 61.00 Did your hospital receive FTE slots under ACA Ν 0 00 0.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)
61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary 61.05 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unwei ahted Unwei ahted IME FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0 00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 61.20 0.00 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 the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 62.00 your hospital received HRSA PCRE funding (see instructions) 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings

63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter

"Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

63.00

N

Health Financial Systems	METHODI	ST HOSPITALS, INC		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP				eriod: com 01/01/2022	Worksheet S-2 Part I Date/Time Pre 5/25/2023 12:	pared:
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Collins FEO.4 Collins AOA Brook V	ETE Dark lands to N		1.00	2. 00	3. 00	
Section 5504 of the ACA Base Year period that begins on or after a			-inis base year	r is your cost	reporting	
64.00 Enter in column 1, if line 63 is in the base year period, the numeresident FTEs attributable to resettings. Enter in column 2 the resident FTEs that trained in yof (column 1 divided by (column	ry trained residents n-primary care all nonprovider non-primary care column 3 the ratio	0.00	0.00		64. 00	
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
			FTEs Nonprovi der	FTEs in Hospital	3/ (col. 3 + col. 4))	
			Si te	Hospi tai	COI. 4))	
	1. 00	2. 00	3. 00	4. 00	5. 00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	55	2.55	0.00	0.00	0. 000000	65.00
			FTEs Nonprovi der	FTEs in Hospital	1/ (col . 1 + col . 2))	
			Site	nospi tui	001. 2))	
			1. 00	2. 00	3. 00	
Section 5504 of the ACA Current		n Nonprovider Setting	gsEffective f	or cost report	ing periods	
beginning on or after July 1, 20 66.00 Enter in column 1 the number of FTEs attributable to rotations or Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column	unweighted non-primar occurring in all nonpr unweighted non-primar cal. Enter in column 3	rovider settings. Ty care resident B the ratio of	0.00	0.00	0. 000000	66.00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1. 00	2. 00	3. 00	4. 00	5. 00	
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0. 000000	67. 00

Health Financial Systems METHODIST HOSPITALS, INC	In lie	eu of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0002 F	Peri od:	Worksheet S-2	
	From 01/01/2022 To 12/31/2022	Date/Time Pro	
		5/25/2023 12:	46 pm
		1. 00	
Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 1 68.00 For a cost reporting period beginning prior to October 1, 2022, did you obtain permissi		N	68.00
MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FI			00.00
(August 10, 2022)?			
	1.0	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 sul	pprovi der? 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 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for		N O	71.00
42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new team	chi ng		
program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for Column 3: If column 2 is Y, indicate which program year began during this cost reporting			
(see instructions)	ig perrod.		
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.			
76.00 If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes		N O	76. 00
no. Column 2: Did this facility train residents in a new teaching program in accordance	e with 42		
CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is indicate which program year began during this cost reporting period. (see instructions)			
Indicate which program year began during this cost reporting period. (See histractions,			
Long Term Care Hospital PPS		1. 00	_
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80.00
81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no.	g period? Enter	n N	81.00
TEFRA Provi ders			
85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section		. N	85. 00 86. 00
§413. 40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	ווע		00.00
87.00 Is this hospital an extended neoplastic disease care hospital classified under section		N	87. 00
1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	Approved for	Number of	
	Permanent Adjustment	Approved Permanent	
	(Y/N)	Adjustments	
00 00 Column 1. Lo this bearital approved for a permanent adjustment to the TFFDA target	1. 00	2. 00	0 88.00
88.00 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line	э		88.00
89. (see instructions)			
Column 2: Enter the number of approved permanent adjustments. Wkst. A Line	Effective	Approved	
No.	Date	Permanent	
		Adjustment Amount Per	
1.00	2.00	Di scharge	_
89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number 0.00	2. 00	3.00	89.00
on which the per discharge permanent adjustment approval was based.			
Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount			
per di scharge.			
Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.			
	V	XIX	
Title V and XIX Services	1. 00	2. 00	_
90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	N	Y	90.00
yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in	N	Y	91.00
full or in part? Enter "Y" for yes or "N" for no in the applicable column.			
92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter	N	N	93.00
"Y" for yes or "N" for no in the applicable column. 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	N	N	94.00
applicable column.			
95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the	0. 00 N	0. 00 N	95. 00 96. 00
applicable column.	1		
97.00 If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00

Health Financial Systems METHODIST HOSPITALS, INC		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CC		eriod: rom 01/01/2022	Worksheet S-2	
		o 12/31/2022	Date/Time Pro	
		V	5/25/2023 12: XI X	46 pm
98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and res	i donte nost	1. 00 Y	2. 00 Y	98.00
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" column 1 for title V, and in column 2 for title XIX.		Y	Y	98.00
98.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of ch C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in title XIX.		Y	Y	98. 01
98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no for title V, and in column 2 for title XIX.		Y	Y	98. 02
98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access h reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for for title V, and in column 2 for title XIX.		N	N	98. 03
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 10 outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for in column 2 for title XIX.		N	N	98. 04
98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE di Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for t column 2 for title XIX.		Y	Y	98. 05
98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed fo Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title column 2 for title XIX.		Y	Y	98. 06
Rural Providers 105.00 Does this hospital qualify as a CAH?		N		105. 00
106.00 If this facility qualifies as a CAH, has it elected the all-inclusive met	hod of payment	1		106.00
for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursem		N		107. 00
training programs? Enter "Y" for yes or "N" for no in column 1. (see ins Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&R approved medical education program in the CAH's excluded IPF and/or IRF	Rs in an			
Enter "Y" for yes or "N" for no in column 2. (see instructions) 108.00 s this a rural hospital qualifying for an exception to the CRNA fee sche CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108. 00
Physi cal 1. 00	Occupational 2.00	Speech 3.00	Respiratory 4.00	-
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N N	N N	N N	109. 00
			1.00	+
110.00 Did this hospital participate in the Rural Community Hospital Demonstrati Demonstration) for the current cost reporting period? Enter "Y" for yes or complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lapplicable.	"N" for no. I	f yes,	N	110.00
appri cubi c.				
111.00 f this facility qualifies as a CAH, did it participate in the Frontier C	Community	1. 00 N	2. 00	111.00
Health Integration Project (FCHIP) demonstration for this cost reporting "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds for tele-health services.	period? Enter enter the column 2.			
	1.00	2. 00	3. 00	
112.00 Did this hospital participate in the Pennsylvania Rural Health Model	N N	2.00	3.00	112.00
(PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the				
demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.				
113.00 Did this hospital participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no.				113. 00
Miscellaneous Cost Reporting Information 115.00 s this an all-inclusive rate provider? Enter "Y" for yes or "N" for no	l N] 0115. 00
in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on	N		`	5113.00
the definition in CMS Pub.15-1, chapter 22, §2208.1. 116.00 s this facility classified as a referral center? Enter "Y" for yes or	N N			116.00
"N" for no. 117.00 s this facility legally-required to carry malpractice insurance? Enter	Y			117. 00
"Y" for yes or "N" for no.				
118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.				118.00

Health Financial Systems	METHODI ST	HOSPI 7					In Lie	u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENIIFICATION DATA		Provider CC	CN: 15-0002			/01/2022 /31/2022	Worksheet S- Part I Date/Time Pr 5/25/2023 12	epared:
			'						
147.00 Was there a change in the statist	cal basis? Entor "V" i	for you	s or "N" for	no				1. 00 N	147. 0
148.00 Was there a change in the order of								N	148. 0
149.00Was there a change to the simplif					for r	าด.		N N	149. 0
· · · · · · · · · · · · · · · · · · ·			Part A	Part			tle V	Title XIX	
			1. 00	2. 00)	3	3. 00	4. 00	
Does this facility contain a prov or charges? Enter "Y" for yes or								3. 13)	
155. 00 Hospi tal			N	N			N	N	155. 0
156.00 Subprovider - IPF			N	N			N	N	156. 0
157.00 Subprovi der - I RF 158.00 SUBPROVI DER			N	N			N	N	157. 0
158. 00 SUBPROVI DER 159. 00 SNF			N	l N			N	N	158. 0 159. 0
160.00 HOME HEALTH AGENCY			N N	l N			N	N N	160. 0
161. OOCMHC			IV.	N N			N	N N	161. 0
								1.00	-
Multicampus									
65.00 s this hospital part of a Multic. Enter "Y" for yes or "N" for no.	ampus hospital that has	s one	or more camp	uses in d	i ffere	ent CB	SAs?	N	165. 0
	Name		County	State	Zip		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. 0
								1. 00	+
Health Information Technology (HI	T) incentive in the Amo	eri can	Recovery an	d Rei nves	tment	Act			
167.00 s this provider a meaningful use	under §1886(n)? Ente	er "Y"	for yes or	"N" for n	0.			Υ	167. 0
68.00 If this provider is a CAH (line 1	D5 is "Y") and is a mea	ani ngfi	ul user (lin			enter	the		168. 0
reasonable cost incurred for the									
68.01 If this provider is a CAH and is						a hard	shi p		168. 0
exception under §413.70(a)(6)(ii)(69.00) If this provider is a meaningful transition factor. (see instruction	user (line 167 is "Y")					N"), e	nter the	9. 9	9169. 0
Transition ractor. (See Histracti	5113)					Bea	i nni ng	Endi ng	
							1.00	2.00	1
70.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	peginning date and endi	i ng da	te for the r	eporti ng					170. 0
						1	1. 00	2. 00	
171.00 fline 167 is "Y", does this pro	vider have any days for	rindi	viduals enro	lledin			N		0171.0
section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2.	reported on Wkst. S-3, umn 1. If column 1 is y	Pt. I	, line 2, co	I. 6? Ent			.*		171.0

Heal th	Financial Systems METHODIST HOSE	DITAIS INC		In lie	u of Form CMS-	2552_10
	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0002	Peri od:	Worksheet S-2	
				From 01/01/2022 To 12/31/2022		narodi
				10 12/31/2022	5/25/2023 12:	
		<u> </u>		Y/N	Date	
				1. 00	2. 00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE General Instruction: Enter Y for all YES responses. Enter N			or all dates in	tho	_
	mm/dd/yyyy format.	i ioi aii no i	esponses. Ent	er arr dates in	trie	
	COMPLETED BY ALL HOSPITALS					1
	Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the			N		1.00
	reporting period? If yes, enter the date of the change in c	column 2. (see	instructions Y/N	Date	V/I	
			1.00	2.00	3.00	
2. 00	Has the provider terminated participation in the Medicare F	Program? If	N N	2.00	3.00	2.00
	yes, enter in column 2 the date of termination and in colum					
	voluntary or "I" for involuntary.					
3. 00	Is the provider involved in business transactions, including		N			3. 00
	contracts, with individuals or entities (e.g., chain home commedical supply companies) that are related to the provide					
	officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and other					
	relationships? (see instructions)			_	_	
			Y/N	Type	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
4. 00	Column 1: Were the financial statements prepared by a Cert	tified Public	ΙΥ	A		4.00
	Accountant? Column 2: If yes, enter "A" for Audited, "C" f	for Compiled,				
	or "R" for Reviewed. Submit complete copy or enter date ava	ailable in				
F 00	column 3. (see instructions) If no, see instructions.					F 00
5. 00	Are the cost report total expenses and total revenues differ those on the filed financial statements? If yes, submit rec		N			5. 00
	those on the fired financial statements: If yes, submit fee	conciliation.		Y/N	Legal Oper.	
				1. 00	2.00	
	Approved Educational Activities					
6. 00	Column 1: Are costs claimed for a nursing program? Column	2: If yes, i	s the provide	er N		6.00
7. 00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in	etructions		Υ		7.00
8. 00	Were nursing programs and/or allied health programs approve		wed during th			8.00
0.00	cost reporting period? If yes, see instructions.	sa ana, or rene	wed ddiring th			0.00
9. 00	Are costs claimed for Interns and Residents in an approved	graduate medi	cal education	ı Y		9. 00
	program in the current cost report? If yes, see instruction					
10. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.	or renewed in	the current	N		10.00
11. 00	Are GME cost directly assigned to cost centers other than I	& R in an An	proved	N		11.00
	Teaching Program on Worksheet A? If yes, see instructions.	a 1 a	p. 0.00G			
					Y/N	
					1. 00	
12 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	s coo instruc	ti onc		Y	12.00
	If line 12 is yes, did the provider's bad debt collection p			nst renorting	I I	13.00
10.00	period? If yes, submit copy.	or reg enange	ddi i iig tiii 5 c	lost reporting	.,,	10.00
14.00	If line 12 is yes, were patient deductibles and/or coinsura	ance amounts w	aived? If yes	s, see	N	14.00
	instructions.					
15 00	Bed Complement Did total beds available change from the prior cost reporti	na pori od2 lf	vos soo ins	tructions	N	15. 00
13.00	The total beds available change from the pirol cost reporti		_yes, see ms		t B	13.00
		Y/N	Date	Y/N	Date	
		1. 00	2.00	3. 00	4. 00	
4	PS&R Data		1			1,,,,,
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	N		N		16. 00
	date of the PS&R Report used in columns 2 and 4 (see					
	instructions)					
17. 00	Was the cost report prepared using the PS&R Report for	Υ	03/15/2023	Υ	03/15/2023	17. 00
	totals and the provider's records for allocation? If					
	leither column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)					
18. 00	· · · · · · · · · · · · · · · · · · ·	N		N		18.00
10.00	Report data for additional claims that have been billed			14		.0.00
	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
	Report data for corrections of other PS&R Report information? If yes, see instructions.					
	The standard of the good of the trade doctrolls.		1	I .	I	1

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 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Pre 5/25/2023 12:	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
					1.00	
	COMPLETED BY COCT DELMBURGED AND TEEDA HOCDITAL COMPY (FVC	1. 00				
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC Capital Related Cost	EPI CHILDRENS	HUSPI TALS)			+
22. 00	Have assets been relifed for Medicare purposes? If yes, se	o instructions			N	22.00
23. 00	Have changes occurred in the Medicare depreciation expense			sing the cost	IN	23.00
23.00	reporting period? If yes, see instructions.	due to apprai	sais illaue uu	ring the cost		23.00
24. 00	Were new leases and/or amendments to existing leases enter	ed into durino	this cost r	enorting period?		24.00
27.00	If yes, see instructions	Sa Thie duiling	, 5 6031 1	sporting periou!		27.00
25. 00	Have there been new capitalized leases entered into during	the cost reno	ortina period	? If ves. see		25.00
	instructions.	,	3 F200	J		
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost report	ing period?	lf yes, see		26.00
	instructions.	•	- ·	-		
27. 00	Has the provider's capitalization policy changed during th	e cost reporti	ng period? I	f yes, 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
00.00	period? If yes, see instructions.	L				00.00
29. 00	Did the provider have a funded depreciation account and/or		Debt Service	Reserve Fund)		29. 00
30. 00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat		u dob+2 l € vo			30.00
30.00	instructions.	unity with new	deptr ii ye	s, see		30.00
31.00	Has debt been recalled before scheduled maturity without i	ssuance of new	v deht? If ve	s see		31.00
01.00	instructions.	00441100 01 1101	. 4021 jo	3, 000		000
	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	uctions.	•			
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					4
34. 00	Were services furnished at the provider facility under an	arrangement wi	th provider-	pased physicians?	Y	34.00
25 00	If yes, see instructions.				N.	25 00
35.00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i		ents with the	provider-based	N	35.00
	physicians during the cost reporting period: if yes, see i	nstructions.		Y/N	Date	
				1.00	2. 00	
	Home Office Costs					
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
	If yes, see instructions.	· •				
38. 00	If line 36 is yes , was the fiscal year end of the home of			f N		38. 00
	the provider? If yes, enter in column 2 the fiscal year en					1
39. 00		er chain compo	onents? If ye	s, N		39.00
40.00	see instructions.	homo (661 - 0	1£ vo=	N.		10.00
40. 00	If line 36 is yes, did the provider render services to the instructions.	nome office?	ir yes, see	N		40.00
	THIS II UCTI UIIS.					
		1	. 00	2.	00	
	Cost Report Preparer Contact Information		. 55	2.		
41.00	Enter the first name, last name and the title/position	MI CHAEL	ALESSANDRI NI		41.00	
	held by the cost report preparer in columns 1, 2, and 3,			55		
	respecti vel y.					
42.00	Enter the employer/company name of the cost report	BLUE & CO., LI		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.	1				

Heal th Fi	inancial Systems	METHODIST H	OSPI T	ALS, INC		In Lieu	u of Form CMS-	2552-10
HOSPI TAL	. AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE		Provi der	CCN: 15-0002	eriod: fom 01/01/2022 o 12/31/2022	Worksheet S-2 Part II Date/Time Pre 5/25/2023 12:	epared:
					3. 00			
Co	ost Report Preparer Contact Information		_		3.00			
41. 00 En	nter the first name, last name and the t eld by the cost report preparer in colum espectively.			ECTOR				41. 00
42. 00 En	espectivery. nter the employer/company name of the co reparer.	st report						42.00
43. 00 En	nter the telephone number and email addr eport preparer in columns 1 and 2, respe							43. 00

Heal th Fi nancial SystemsMETHODIHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 15-0002

				To	12/31/2022	Date/Time Pre 5/25/2023 12:	
						1/P Days /	40 piii
						0/P Visits /	
						Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Li ne No.	2.00	Avai I abl e	4.00	F 00	
	PART I - STATISTICAL DATA	1. 00	2.00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	331	120, 815	0. 00	0	1.00
1.00	8 exclude Swing Bed, Observation Bed and	30.00	331	120,013	0.00	O	1.00
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		331	120, 815	0. 00	0	7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31.00	39	14, 235	0.00	0	8. 00
8. 01	NEONATAL ICU	31. 01	35	12, 775	0.00	0	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	43. 00				0	13.00
14. 00	Total (see instructions)		405	147, 825	0. 00	0	14. 00
15. 00	CAH visits					0	15. 00
16. 00	SUBPROVI DER - I PF	40. 00	12			0	16. 00
17. 00	SUBPROVI DER - I RF	41. 00	24	8, 760		0	17.00
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	101 00				0	21.00
22. 00	HOME HEALTH AGENCY	101. 00				0	22.00
23. 00 24. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE						23. 00 24. 00
24. 00	HOSPICE (non-distinct part)	30. 00					24. 00
25. 00	CMHC - CMHC	30.00					25. 00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)	07.00	441			O	27. 00
28. 00	Observation Bed Days		771			0	28.00
29. 00	Ambulance Trips					· ·	29.00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		C	ol			32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33. 01	LTCH site neutral days and discharges						33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30. 00	C	0		0	34.00

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part I | To 12/31/2022 | Date/Time Prepared: Provi der CCN: 15-0002

				1	0 12/31/2022	Date/Time Pre 5/25/2023 12:	
	·	I /P Days	/ O/P Visits	/ Trins	Full Time I	Equi val ents	40 piii
		171 Days	/ 0/1 1/3/13	/ 111 ps	Turi irille i	-qui vai ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	Component C			Patients	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	17, 859	2, 941	67, 757			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)	26, 008	21, 947				2.00
3.00	HMO IPF Subprovider	0	343				3.00
4.00	HMO IRF Subprovider	o	601				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	o	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation	17, 859	2, 941	67, 757			7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	2, 326	0	7, 946			8.00
8. 01	NEONATAL I CU	0	0	1, 775			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	2, 131			13.00
14.00	Total (see instructions)	20, 185	2, 941	79, 609	3. 00	1, 778. 79	
15. 00	CAH visits	0	0	0			15. 00
16.00	SUBPROVI DER - I PF	194	74	, , , , ,	0. 00	10. 43	ł
17. 00	SUBPROVI DER - I RF	1, 299	78	3, 527	0. 00	18. 63	1
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19.00
20.00	NURSI NG FACI LI TY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	4, 204	5, 727	18, 282	0. 00	24. 15	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE			405			24.00
24. 10	HOSPICE (non-distinct part)			105			24. 10
25.00	CMHC - CMHC						25.00
26. 00	RURAL HEALTH CLINIC				0.00	0.00	26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	
27. 00	Total (sum of lines 14-26)		2 5/0	11 500	3. 00	1, 832. 00	
28.00	Observation Bed Days	0	3, 569	11, 582			28.00
29.00	Ambulance Trips	٩		_			29.00
30. 00 31. 00	Employee discount days (see instruction) Employee discount days - LRF			0			30. 00 31. 00
32.00	Labor & delivery days (see instructions)	0	33				32.00
32.00	Total ancillary labor & delivery room	١	33] 35			32.00
32.01	outpatient days (see instructions)			l "			32.01
33. 00	LTCH non-covered days	0					33.00
33. 00	LTCH site neutral days and discharges	0					33.00
	Temporary Expansion COVID-19 PHE Acute Care	o	0	0			34.00
34.00	Tremporary Expansion Covid-17 The Acute Care	ı	U	1	1	1	1 34.00

Heal th Fi nancial SystemsMETHODIHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

					12/31/2022	5/25/2023 12:	
		Full Time		Di sch	arges		
		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	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	2, 654	391	10, 946	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, 859	3, 576		2. 00
3. 00	HMO IPF Subprovider				28		3. 00
4. 00	HMO I RF Subprovi der				45		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
	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 (54	204	40.047	13.00
14.00	Total (see instructions)	0. 00	0	2, 654	391	10, 946	
15.00	CAH visits	0.00	0	10	2	10/	15.00
16.00	SUBPROVIDER - I PF	0.00	0	13	3	106	16.00
17.00	SUBPROVI DER - I RF	0. 00	U	99	6	265	17.00
18.00	SUBPROVI DER						18. 00 19. 00
19. 00 20. 00	SKILLED NURSING FACILITY NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						20.00
21.00		0. 00					22.00
23. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.)	0.00					23. 00
24.00	HOSPICE						24.00
24. 00	HOSPICE (non-distinct part)						24. 00
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	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days (see Fristraetron)						31.00
32. 00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32.00
52. 01	outpatient days (see instructions)						52.01
33. 00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			o			33. 01
	Temporary Expansion COVID-19 PHE Acute Care						34.00

| Period: | Worksheet S-3 | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0002

						o 12/31/2022	Date/Time Pre 5/25/2023 12:	
		Wkst. A Line	Amount	Recl assi fi cat		Paid Hours	Average	40 pili
		Number	Reported	ion of Salaries	Salaries (col.2 ± col.	Related to Salaries in	Hourly Wage (col. 4 ÷	
				(from Wkst.	3)	col . 4	col . 5)	
		1. 00	2. 00	A-6) 3.00	4.00	5. 00	6. 00	
	PART II - WAGE DATA							
1. 00	SALARIES Total salaries (see	200.00	149, 270, 637	-553, 441	148, 717, 196	3, 817, 013. 00	38. 96	1. 00
2.00	instructions)							2 00
2. 00	Non-physician anesthetist Part A		0	0	C	0.00	0.00	2. 00
3. 00	Non-physician anesthetist Part		0	0	C	0.00	0. 00	3. 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		0 340, 527	0	1	0. 00 2, 064. 00	0.00	
5.00	Physician-Part B		340, 527	١	340, 527	2,004.00	164. 98	5.00
6. 00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	C	0. 00	0. 00	6. 00
7. 00	Interns & residents (in an	21. 00	0	О	c	0. 00	0. 00	7. 00
7. 01	approved program) Contracted interns and		245, 947	0	245, 947	5, 117. 00	48. 06	7. 01
	residents (in an approved programs)		_ , , , , , ,	_		2,		
8. 00	Home office and/or related organization personnel		0	0	C	0.00	0. 00	8. 00
9.00	SNF	44. 00	0	0	C	0.00	0.00	9.00
10. 00	Excluded area salaries (see instructions)		28, 763, 702	1, 110, 060	29, 873, 762	560, 850. 00	53. 27	10. 00
11 00	OTHER WAGES & RELATED COSTS		22 121 015		22 121 015	227 405 00	101 (2	11 00
11. 00	Contract Labor: Direct Patient Care		23, 121, 015	0	23, 121, 015	227, 495. 00	101. 63	11.00
12. 00	Contract Labor: Top Level management and other		0	0	C	0.00	0. 00	12.00
	management and administrative							
13. 00	services Contract Labor: Physician-Part		663, 442	0	663, 442	4, 883. 00	135. 87	13. 00
14. 00	A - Administrative Home office and/or related		0	0		0. 00	0. 00	14. 00
	organization salaries and			_				
14. 01	wage-related costs Home office salaries		0	0	C	0. 00	0. 00	14. 01
14. 02	Related organization salaries		0	0	C			14.02
15. 00	Home office: Physician Part A - Administrative		U			0.00	0.00	15. 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	О	c	0. 00	0. 00	16. 01
16. 02	- Teaching Home office contract		0	0		0. 00	0. 00	16. 02
	Physicians Part A - Teaching		-					
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		32, 460, 273	0	32, 460, 273			17. 00
18. 00	instructions) Wage-related costs (other)							18. 00
19. 00	(see instructions) Excluded areas		5, 950, 674	0	5, 950, 674			19. 00
20. 00	Non-physician anesthetist Part		0, 755, 67	Ö	G, 766, 67 i			20. 00
21. 00	Non-physician anesthetist Part		0	0	C			21. 00
22. 00	Physician Part A -		0	О	c			22.00
22. 01	Administrative Physician Part A - Teaching		0	0				22. 01
23. 00	Physician Part B		36, 017	0	36, 017			23.00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0					24. 00 25. 00
25. 50	approved program) Home office wage-related		0	0				25. 50
	(core)		0					
25. 51	Related organization wage-related (core)		Ü					25. 51
25. 52	Home office: Physician Part A - Administrative -		0	0	C			25. 52
	wage-related (core)							

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0002 Peri od: Worksheet S-3 From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/25/2023 12:46 pm 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) OVERHÉAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 2, 316, 627 -260, 151 2, 056, 476 28, 648. 00 71. 78 26.00 27.00 Administrative & General 5.00 22, 233, 418 -1, 466, 058 20, 767, 360 607, 440. 00 34. 19 27.00 28.00 2, 352, 028 2, 352, 028 11, 462. 00 205. 20 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 4, 936, 203 4, 902, 599 172, 704. 00 28. 39 30.00 -33, 604 . Laundry & Linen Service 8.00 0.00 31.00 31.00 0.00 247, 302. 00 Housekeepi ng 32.00 9.00 4, 490, 612 -18, 522 4, 472, 090 18. 08 32.00 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 34.00 Dietary 10.00 3, 492, 170 -1, 217, 068 2, 275, 102 84, 413. 00 26. 95 34.00 35.00 Dietary under contract (see 0.00 0.00 35.00 instructions) 36.00 Cafeteri a 11.00 291, 426 1, 207, 562 1, 498, 988 55, 301. 00 27. 11 36.00 37.00 Maintenance of Personnel 12.00 0.00 0.00 37.00 Nursing Administration 3, 728, 872 56. 27 38.00 38.00 13.00 3, 743, 490 -14, 618 66, 264. 00 39.00 Central Services and Supply 14.00 713, 429 5, 553 718, 982 35, 003. 00 20.54 39.00 40.00 Pharmacy 15.00 0.00 0.00 40.00 Medical Records & Medical Records Library 2, 103, 713 41.00 16.00 2, 103, 713 Ω 82, 829. 00 25. 40 41.00 42.00 Social Service 17.00 140 425, 415 425, 555 13, 604. 00 31. 28 42. 00

0.00

0.00 43.00

18.00

43.00 Other General Service

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10
HOSPITAL WAGE INDEX INFORMATION	Provi der CCN: 15-0002	Period: Worksheet S-3

					T	0 12/31/2022		
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Pai d Hours	Average	
		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		151, 036, 191	-553, 441	150, 482, 750	3, 821, 294. 00	39. 38	1.00
	instructions)							
2.00	Excluded area salaries (see		28, 763, 702	1, 110, 060	29, 873, 762	560, 850. 00	53. 27	2.00
	instructions)							
3.00	Subtotal salaries (line 1		122, 272, 489	-1, 663, 501	120, 608, 988	3, 260, 444. 00	36. 99	3.00
	minus line 2)							
4.00	Subtotal other wages & related		23, 784, 457	0	23, 784, 457	232, 378. 00	102. 35	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		32, 460, 273	0	32, 460, 273	0.00	26. 91	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		178, 517, 219	-1, 663, 501	176, 853, 718	3, 492, 822. 00	50. 63	6.00
7.00	Total overhead cost (see		46, 673, 256	-1, 371, 491	45, 301, 765	1, 404, 970. 00	32. 24	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: Worksheet S-3 From 01/01/2022 Part IV
		To 12/31/2022 Date/Time Prepared

	To 12/31/2022	Date/Time Pre 5/25/2023 12:	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	2, 260, 563	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	2, 133, 333	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)	17, 426, 164	
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	2, 982, 593	
10.00	Dental, Hearing and Vision Plan	689, 868	10.00
11. 00		775, 976	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)	553, 441	
14.00		0	
15.00		1, 276, 539	
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Noncumul ative portion)		
	TAXES		
17. 00		10, 251, 483	
18. 00		0	
19. 00		0	
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21. 00		e 0	21.00
	instructions))		
22. 00		0	22.00
		97, 004	
24. 00	Total Wage Related cost (Sum of lines 1 -23)	38, 446, 964	24.00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Peri od: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part V Date/Time Prepared: 5/25/2023 12:46 pm
Cost Center Description		Contract Labor	Benefit Cost

PART V - Contract Labor and Benefit Cost 1.00 2.00				5/25/2023 12:	46 pm
PART V - Contract Labor and Benefit Cost Hospital and Hospital-Based Component Identification:		Cost Center Description	Contract	Benefit Cost	
PART V - Contract Labor and Benefit Cost Hospital and Hospital -Based Component I dentification:			Labor		
Hospital and Hospital-Based Component I dentification: Total facility's contract labor and benefit cost 23, 121, 015 38, 446, 964 2.00 4.00 3.00 SUBPROVI DER - I PF 0 0 0.3.00 3.00 SUBPROVI DER - I RF 0 0 0.0			1. 00	2. 00	
1.00		PART V - Contract Labor and Benefit Cost			
2.00 Hospi tal 2.00 SUBPROVI DER - I PF 0 0 0 3.00 4.00 SUBPROVI DER - I RF 0 0 0 0 3.00 6.00 5.00 Subprovi der - (Other) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		Hospital and Hospital-Based Component Identification:			
3. 00 SUBPROVI DER - I PF 4. 00 SUBPROVI DER - I RF 5. 00 SUBPROVI DER - I RF 6. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.00	Total facility's contract labor and benefit cost	23, 121, 015	38, 446, 964	1.00
4.00 SUBPROVIDER - IRF 5.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7.00 Swing Beds - NF 8.00 SKILLED NURSING FACILITY 9.00 NURSING FACILITY 9.00 OTHER LONG TERM CARE I 11.00 Hospital -Based HHA 12.00 AMBULATORY SURGICAL CENTER (D.P.) I 13.00 Hospital -Based Health Clinic RHC 15.00 Hospital -Based Health Clinic RHC 16.00 Hospital -Based Health Clinic FOHC 17.00 RENAL DIALYSIS I 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00	Hospi tal	23, 121, 015	38, 446, 964	2.00
5.00 Subprovi der - (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 SKILLED NURSI NG FACILITY 8.00 9.00 NURSI NG FACILITY 9.00 10.00 OTHER LONG TERM CARE I 0 0 11.00 11.00 Hospital -Based HAA 0 0 11.00 12.00 AMBULATORY SURGI CAL CENTER (D. P.) I 12.00 12.00 13.00 Hospital -Based Heal th Clinic RHC 13.00 14.00 15.00 Hospital -Based Heal th Clinic FQHC 15.00 16.00 Hospital -Based-CMHC 16.00 17.00 RENAL DIALYSIS I 0 0 0 17.00	3.00	SUBPROVI DER - I PF	0	0	3.00
6.00 Swing Beds - SNF	4.00	SUBPROVI DER - I RF	0	0	4.00
7. 00 Swing Beds - NF	5.00	Subprovi der - (Other)	0	0	5.00
8.00 SKILLED NURSING FACILITY 9.00 NURSING FACILITY 9.00 OTHER LONG TERM CARE I 11.00 Hospital -Based HHA 12.00 AMBULATORY SURGICAL CENTER (D.P.) I 13.00 Hospital -Based Hospice 14.00 Hospital -Based Health Clinic RHC 15.00 Hospital -Based Health Clinic FQHC 16.00 Hospital -Based-CMHC 17.00 RENAL DIALYSIS I 8.00 9.00 10.00 11.00 9.00 11.00 12.00 12.00 12.00 13.00 14.00 15.00 16.00 17.00 17.00	6.00	Swing Beds - SNF	0	0	6.00
9.00 NURSING FACILITY 10.00 OTHER LONG TERM CARE I 11.00 Hospi tal - Based HHA 12.00 AMBULATORY SURGICAL CENTER (D.P.) I 13.00 Hospi tal - Based Hospi ce 14.00 Hospi tal - Based Heal th Clinic RHC 15.00 Hospi tal - Based Heal th Clinic FOHC 16.00 Hospi tal - Based - CMHC 17.00 RENAL DIALYSIS I 9.00 10.00 11.00 11.00 11.00 11.00 11.00 11.00	7.00	Swing Beds - NF	0	0	7.00
10.00 OTHER LONG TERM CARE I 11.00 Hospi tal -Based HHA 12.00 AMBULATORY SURGI CAL CENTER (D.P.) I 13.00 Hospi tal -Based Hospi ce 14.00 Hospi tal -Based Heal th Clinic RHC 15.00 Hospi tal -Based Heal th Clinic FQHC 16.00 Hospi tal -Based-CMHC 17.00 RENAL DIALYSIS I 10.00 0 0 11.00 11.00 0 0 0 17.00	8.00	SKILLED NURSING FACILITY			8.00
11. 00 Hospi tal -Based HHA 12. 00 AMBULATORY SURGI CAL CENTER (D. P.) I 13. 00 Hospi tal -Based Hospi ce 14. 00 Hospi tal -Based Heal th Clinic RHC 15. 00 Hospi tal -Based Heal th Clinic FOHC 16. 00 Hospi tal -Based-CMHC 17. 00 RENAL DIALYSIS I 0 0 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	9. 00	NURSING FACILITY			9.00
12. 00 AMBÜLATORY SURGICAL CENTER (D. P.) I 12. 00 13. 00 Hospi tal -Based Hospi ce 13. 00 14. 00 Hospi tal -Based Heal th Clinic RHC 14. 00 15. 00 Hospi tal -Based Heal th Clinic FQHC 15. 00 16. 00 Hospi tal -Based-CMHC 16. 00 17. 00 RENAL DIALYSIS I 0 0 0	10.00	OTHER LONG TERM CARE I			10.00
13. 00 Hospi tal -Based Hospi ce 13. 00 14. 00 Hospi tal -Based Heal th Clinic RHC 14. 00 15. 00 Hospi tal -Based Heal th Clinic FQHC 15. 00 16. 00 Hospi tal -Based-CMHC 16. 00 17. 00 RENAL DIALYSIS I 0 0 0	11.00	Hospi tal -Based HHA	0	0	11.00
14. 00 Hospital -Based Health Clinic RHC 14. 00 15. 00 Hospital -Based Health Clinic FQHC 15. 00 16. 00 Hospital -Based-CMHC 16. 00 17. 00 RENAL DIALYSIS I 0 0 0 17. 00	12.00	AMBULATORY SURGICAL CENTER (D. P.) I			12.00
15. 00 Hospital -Based Health Clinic FQHC 15. 00 16. 00 Hospital -Based-CMHC 16. 00 17. 00 RENAL DIALYSIS I 0 0 0	13.00	Hospi tal -Based Hospi ce			13.00
16. 00 Hospi tal -Based-CMHC 16. 00 17. 00 RENAL DIALYSIS I 0 0 17. 00	14.00	Hospital-Based Health Clinic RHC			14.00
17. 00 RENAL DIALYSIS I 0 0 17. 00	15.00	Hospital-Based Health Clinic FQHC			15.00
	16.00	Hospi tal -Based-CMHC			16.00
18.00 Other 0 0 18.00	17.00	RENAL DIALYSIS I	0	0	17.00
	18.00	0ther	0	0	18.00

Heal th	Financial Systems	METHODI ST HOSPI	ITALS. INC		In Lie	eu of Form CMS-2	2552-10
	IEALTH AGENCY STATISTICAL DATA		Provi der C		Period: From 01/01/2022	Worksheet S-4	
			Component		To 12/31/2022	Date/Time Pre	
					Home Health	5/25/2023 12: PPS	46 pm
					Agency I		
					1.	00	
0. 00	County	T: +1 - V	T: +1 - W/III	T: +1 - VIV	0+1	Tatal	0.00
		Title V 1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	Total 5. 00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1. 00 2. 00	Home Health Aide Hours Unduplicated Census Count (see instructions)	0.00	0 191. 00		0 0 0.00		
2.00	Tomage rearest comments (coo riner actions)	3. 33	171100		oloyees (Full Ti		2.00
		Enter the number your normal		Staff	Contract	Total	
		your norman	WOLK WEEK				
		0		1.00	2.00	3.00	
2 00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES		40.00		0 00	0.00	2 00
3. 00 4. 00	Administrator and Assistant Administrator(s) Director(s) and Assistant Director(s)		40. 00	0. C 0. C		l .	3. 00 4. 00
5.00	Other Administrative Personnel			7. 5	2 0.00	7. 52	5.00
6. 00 7. 00	Direct Nursing Service Nursing Supervisor			9. 5 0. 0			1
8. 00	Physical Therapy Service			3. 9		l .	8.00
9. 00 10. 00	Physical Therapy Supervisor Occupational Therapy Service			0. C 1. 3			
11. 00	Occupational Therapy Supervisor			0.0			1
12.00	Speech Pathology Service			0.0			
13. 00 14. 00	Speech Pathology Supervisor Medical Social Service			0. C 0. C			1
15. 00	Medical Social Service Supervisor			0.0			
16. 00 17. 00	Home Health Aide Home Health Aide Supervisor			1. <i>6</i>			
	Other (specify)			0. 0		0.00	
						CBSA Data 1.00	
	HOME HEALTH AGENCY CBSA CODES					1.00	
	Enter in column 1 the number of CBSAs where					1	
20.00	List those CBSA code(s) in column 1 serviced first code).	during this cos	st reporting	perioa (iine	20 contains the	23844	20.00
			sodes	LUDA Estanda	DED 0-1	T-+-1 (1-	
		Without WOUT Outliers	ith Outliers	LUPA Epi sode	PEP Only Epi sodes	Total (cols. 1-4)	
		1. 00	2. 00	3. 00	4.00	5. 00	
21. 00	PPS ACTIVITY DATA Skilled Nursing Visits	2, 153	192	3	6 22	2, 403	21.00
22. 00	Skilled Nursing Visit Charges	475, 369	41, 994	7, 92	1 4, 928	530, 212	22. 00
23. 00 24. 00	Physical Therapy Visits Physical Therapy Visit Charges	778 186, 606	162 38, 794		0 30 0 7, 105		
25. 00	Occupational Therapy Visits	265	104		4 3		1
26. 00 27. 00	Occupational Therapy Visit Charges	64, 139	25, 030	1			26. 00 27. 00
28. 00	Speech Pathology Visits Speech Pathology Visit Charges	0	0	•	0 0		28.00
29. 00	Medical Social Service Visits	5	2		0 0	•	29. 00
30. 00 31. 00	Medical Social Service Visit Charges Home Health Aide Visits	1, 769 385	695 38	l .	0 0 3		
32.00	Home Health Aide Visit Charges	38, 393	3, 742	20	2 303	42, 640	32.00
33. 00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3, 586	498	ϵ	2 58	4, 204	33.00
34.00	Other Charges	O	0		0 0	0	34.00
35. 00	Total Charges (sum of lines 22, 24, 26, 28,	766, 276	110, 255	13, 94	1 13, 077	903, 549	35. 00
36. 00	30, 32, and 34) Total Number of Episodes (standard/non	337		4	1 6	384	36.00
37. 00	outlier) Total Number of Outlier Episodes		20		0	20	37.00
	Total Non-Routine Medical Supply Charges	102, 604	2, 197	l .			

OSPI T	Financial Systems METHODIST HOSPITALS AL UNCOMPENSATED AND INDIGENT CARE DATA Pro		CN: 15-0002	Peri od:	u of Form CMS-2 Worksheet S-1	
	The stroom enough of the strong end end of the strong end of the strong end of the strong end of the strong end of the s	01.40. 0	10 0002	From 01/01/2022		
				To 12/31/2022	Date/Time Pre 5/25/2023 12:	pare
					372372023 12.	46 p
					1. 00	
00	Uncompensated and indigent care cost computation	1. 1. 1. 1.1	000		0.000504	
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid Medicaid (see instructions for each line)	ded by Li	ne 202 col u	mn 8)	0. 222534	1.
00	Net revenue from Medicaid				0	2.
00	Did you receive DSH or supplemental payments from Medicaid?				Y	3
00	If line 3 is yes, does line 2 include all DSH and/or supplemental	I payment	s from Medi	cai d?	N	4
00	If line 4 is no, then enter DSH and/or supplemental payments from	m Medicai	d		38, 157, 397	5
00	Medi cai d charges				499, 115, 740	
00	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program (li	ino 7 mir	nuc cum of I	ince 2 and E. if	111, 070, 222	
00	<pre> < zero then enter zero)</pre>	rne / mir	ius suili 01 1	rnes z and 5; ii	72, 912, 825	8.
	Children's Health Insurance Program (CHIP) (see instructions for	each lir	ne)			İ
00	Net revenue from stand-alone CHIP				0	
. 00	Stand-alone CHIP charges				0	1
. 00	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (li	i no. 11 mi	nuc line O	if a zoro thon	0	11
. 00	enter zero)	ine ii iii	nus ime 9,	ii < Zei o tileli	٥	12
	Other state or local government indigent care program (see instru	uctions f	or each line	e)		İ
. 00	Net revenue from state or local indigent care program (Not include				0	13
. 00	Charges for patients covered under state or local indigent care p	program	(Not include	d in lines 6 or	0	14
00	[10]					1
. 00	State or local indigent care program cost (line 1 times line 14) Difference between net revenue and costs for state or local indic	aent care	nrogram (I	ing 15 minus line	0	
). 00						
	I13: if < zero then enter zero)	9	, h 9 (.	10		
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP					
, 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)	and stat	ce/local ind		ams (see	
	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to fund	and stat	ce/local ind		ams (see	17.
3. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)	and stat ding char spital op	re/local ind	gent care progra	ams (see	17. 18.
3. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos	and stat ding char spital op	re/local ind rity care perations care progra	igent care progra	0 0 72,912,825	17. 18.
3. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i	and stat ding char spital op	re/local ind rity care perations care progra	ms (sum of lines	0 72,912,825	17. 18.
. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i	and stat ding char spital op	re/local ind rity care perations care progra Uninsured patients	ms (sum of lines Insured patients	0 0 72,912,825 Total (col. 1 + col. 2)	17. 18.
. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i	and stat ding char spital op	re/local ind rity care perations care progra	ms (sum of lines Insured patients 2.00	0 0 72,912,825 Total (col. 1 + col. 2) 3.00	17. 18.
3. 00 9. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil	and stat	re/local ind rity care perations care progra Uninsured patients	ms (sum of lines Insured patients 2.00	0 0 72,912,825 Total (col. 1 + col. 2) 3.00	17. 18. 19.
3. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions)	and stat ding chan spital op indigent	e/l ocal ind rity care perations care progra Uninsured patients 1.00	ms (sum of lines Insured patients 2.00 21 398,437	Total (col. 1 + col. 2) 3.00	17. 18. 19.
3. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discounts	and stat ding chan spital op indigent	re/local ind rity care perations care progra Uninsured patients 1.00	Insured patients 2.00	Total (col. 1 + col. 2) 3.00	17. 18. 19.
3. 00 9. 00 0. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions)	and stat ding char spital op indigent	e/l ocal ind rity care perations care progra Uninsured patients 1.00	ms (sum of lines Insured patients 2.00 21 398,437	Total (col. 1 + col. 2) 3.00 12,210,858 3,027,102	17. 18. 19. 20. 21.
3. 00 9. 00 0. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discounts	and stat ding char spital op indigent	e/l ocal ind rity care perations care progra Uninsured patients 1.00	ms (sum of lines Insured patients 2.00 21 398,437 65 398,437	Total (col. 1 + col. 2) 3.00 12,210,858 3,027,102	17. 18. 19. 20.
0.00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care	and stat ding char spital op indigent	e/l ocal ind rity care perations care progra Uninsured patients 1.00	Insured patients 2.00 21 398,437 0 0	Total (col. 1 + col. 2) 3.00 12,210,858 3,027,102	17 18 19 20 21 22
. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care	and stat ding char spital op indigent	e/l ocal ind rity care perations care prograi Uninsured patients 1.00	Insured patients 2.00 21 398,437 0 0	Total (col. 1 + col. 2) 3.00 12,210,858 3,027,102	17 18 19 20 21 22
. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22)	and stat ding char spital op indigent	Uni nsured patients 1.00 11,812,4 2,628,6	ms (sum of lines Insured patients 2.00 21 398, 437 65 398, 437 0 0 65 398, 437	Total (col. 1 + col. 2) 3.00 12,210,858 3,027,102 1.00	20 21 22 23
. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care	and stat ding char spital op indigent lity ts (see ff as	Uni nsured patients 1.00 11,812,4 2,628,6	ms (sum of lines Insured patients 2.00 21 398, 437 65 398, 437 0 0 65 398, 437	Total (col. 1 + col. 2) 3.00 12,210,858 3,027,102	20 21 22 23
. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local image is and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22)	and stat ding chan spital op indigent lity ts (see ff as days be rogram?	Uni nsured patients 1.00 11,812,4 2,628,6	Insured patients 2.00 21 398,437 0 0 65 398,437 h of stay limit	Total (col. 1 + col. 2) 3.00 12,210,858 3,027,102 0 3,027,102	20 21 22 23
3. 00 2. 00 3. 00 3. 00 4. 00 4. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care provided in the charges for patient days beyond the	and stated ing charspital opindigent indigent	Uni nsured patients 1.00 11,812,4 2,628,6 2,628,6 7ond a lengt	Insured patients 2.00 21 398,437 0 0 65 398,437 h of stay limit	Total (col. 1 + col. 2) 3.00 12,210,858 3,027,102 0 3,027,102	20 21 22 23 24 25
3. 00 0. 00 0. 00 0. 00 0. 00 0. 00 1. 00 1. 00 1. 00 1. 00 1. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care provided in the stay limit.	and stated ing charspital opindigent indigent in	Uni nsured patients 1.00 11,812,4 2,628,6 2,628,6	Insured patients 2.00 21 398,437 0 0 65 398,437 h of stay limit	Total (col. 1 + col. 2) 3.00 12,210,858 3,027,102 0 3,027,102 1.00 N 0 21,979,926 832,964	20 21 22 23 24 25 26 27
3. 00 2. 00 3. 00 3. 00 4. 00 5. 00 6. 00 7. 00 7. 01	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care pr If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see instructions) Medicare reimbursable bad debts for the entire hospital complex (see	and stated ing chars spital opin indigent indige	Uni nsured patients 1.00 11,812,4 2,628,6 2,628,6 vond a lengt	Insured patients 2.00 21 398,437 0 0 65 398,437 h of stay limit	Total (col. 1 + col. 2) 3.00 12,210,858 3,027,102 1.00 N 21,979,926 832,964 1,281,482	20. 21. 22. 23. 24. 25. 26. 27. 27.
3.3.00 9.00 0.00 1.00 1.00 2.00 3.00 4.00 7.00 7.00 7.00 7.00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local image is a supposed and in the suppose in the entire facility care charges and uninsured discounts for the entire facility care charges and uninsured discounts for the entire facility care of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care provided in the stay limit. Total bad debt expense for the entire hospital complex (see instructions) Medicare allowable bad debts for the entire hospital complex (see Medicare allowable bad debt expense (see instructions)	and stated ding chars spital opindigent lity and stated lity ts (see ff as days begrogram? indigent ructions) (see instructions)	Uni nsured patients 1.00 11,812,4 2,628,6 2,628,6 7ond a lengt care progra	Insured patients 2.00 21 398,437 0 0 65 398,437 h of stay limit	Total (col. 1 + col. 2) 3.00 12,210,858 3,027,102 0 3,027,102 1.00 N 0 21,979,926 832,964 1,281,482 20,698,444	20. 21. 22. 23. 24. 25. 26. 27. 27. 28.
9. 00 0. 00 1. 00 2. 00 3. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care pr If line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see instructions) Medicare reimbursable bad debts for the entire hospital complex (see	and stated ding chars spital opindigent lity and stated lity ts (see ff as days begrogram? indigent ructions) (see instructions)	Uni nsured patients 1.00 11,812,4 2,628,6 2,628,6 7ond a lengt care progra	Insured patients 2.00 21 398,437 0 0 65 398,437 h of stay limit	Total (col. 1 + col. 2) 3.00 12,210,858 3,027,102 1.00 N 21,979,926 832,964 1,281,482	20. 21. 22. 23. 24. 25. 26. 27. 27. 28. 29.

	Financial Systems SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	METHODIST HOSP F EXPENSES	Provider C	CN: 15-0002 P	In Lieu eriod:	u of Form CMS-2 Worksheet A	2552-10
NECLA	STITICATION AND ADJUSTMENTS OF THE BALANCE O	I EXI ENSES	l lovider co		rom 01/01/2022		narod:
						5/25/2023 12:	46 pm
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificat ions (See	Reclassified Trial Balance	
				1 001. 2)	A-6)	(col. 3 +-	
		1. 00	2. 00	3.00	4.00	col . 4) 5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
1. 00	00100 CAP REL COSTS-BLDG & FLXT		0	_	.,	20, 258, 510	1
4. 00 5. 01	00400 EMPLOYEE BENEFITS DEPARTMENT 00550 DATA PROCESSING	2, 316, 627	29, 342, 747			31, 948, 423 13, 869, 400	
5. 01	00560 PURCHASING RECEIVING AND STORES	4, 221, 843 968, 272	11, 371, 652 2, 568, 344			3, 374, 130	
5. 03	00570 ADMI TTI NG	4, 853, 859	1, 193, 342			6, 025, 222	
5. 04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	3, 239, 407	5, 276, 750			7, 200, 169	
5. 05 5. 06	O0590 OTHER A&G O0592 PATIENT TRANSPORTATION	8, 452, 934 497, 103	26, 007, 532 44, 732			18, 479, 506 534, 420	1
7. 00	00700 OPERATION OF PLANT	4, 936, 203	9, 864, 906			21, 100, 819	1
8.00	00800 LAUNDRY & LINEN SERVICE	0	1, 193, 219			1, 192, 566	1
9.00	00900 HOUSEKEEPI NG	4, 490, 612	1, 138, 364			5, 435, 358	1
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	3, 492, 170 291, 426	3, 330, 895 36, 087			4, 237, 652 2, 833, 362	
13. 00	01300 NURSI NG ADMI NI STRATI ON	3, 743, 490	1, 243, 774			4, 824, 807	
14.00	01400 CENTRAL SERVICES & SUPPLY	713, 429	2, 815, 626			3, 043, 349	1
15. 00 16. 00	O1500 PHARMACY O1600 MEDI CAL RECORDS & LI BRARY	0 2, 103, 713	15, 959, 459 729, 842			5, 566, 113 2, 831, 292	
17. 00	01700 SOCIAL SERVICE	2, 103, 713	724, 642			425, 415	
17. 01	01701 STAFF EDUCATION	О	0	0	0	0	17. 01
17. 02	01702 MEDI CAL EDUCATI ON	140	47, 657		-2, 082	45, 715	
21. 00 22. 00	02100 1 &R SERVICES-SALARY & FRINGES APPRVD 02200 1 &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	245, 947 31, 168	245, 947 31, 168	1
23. 00	02300 PARAMED ED PROGRAM	497, 735	102, 099	599, 834		808, 921	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	23, 031, 995 6, 646, 102	28, 887, 887 3, 890, 983			51, 257, 825 9, 793, 073	1
31. 00	03101 NEONATAL I CU	1, 482, 931	1, 279, 276			2, 719, 024	
40.00	04000 SUBPROVI DER - I PF	919, 088	86, 663		-22, 454	983, 297	
41.00	04100 SUBPROVI DER - I RF	1, 670, 419	309, 752		-50, 635	1, 929, 536	1
43. 00	04300 NURSERY ANCI LLARY SERVICE COST CENTERS	1, 404, 893	388, 023	1, 792, 916	-118, 125	1, 674, 791	43.00
50.00	05000 OPERATING ROOM	4, 730, 536	27, 934, 369	32, 664, 905	-14, 737, 534	17, 927, 371	50.00
50. 01	05001 ENDOSCOPY	685, 857	1, 034, 619			1, 177, 985	1
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	956, 655 3, 748, 173	184, 916 1, 159, 579			1, 138, 220 4, 620, 154	1
53.00	05300 ANESTHESI OLOGY	0, 710, 170	0			0	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 254, 330	2, 866, 888			4, 385, 322	1
54. 01 55. 00	O5401 RADI OLOGY - ULTRASOUND O5500 RADI OLOGY-THERAPEUTI C	1, 371, 957 427, 351	565, 833 2, 520, 723			1, 866, 688 2, 414, 142	
55. 01	05501 I NFUSI ON CENTER	365, 749	14, 868, 781			4, 164, 688	
	05600 RADI OI SOTOPE	658, 298	1, 302, 663	1, 960, 961	-65, 693	1, 895, 268	56.00
	05700 CT SCAN	1, 225, 272	1, 026, 870			2, 180, 243	1
59.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	507, 022 2, 502, 285	762, 138 6, 884, 877			1, 024, 350 3, 328, 108	
60.00	06000 LABORATORY	3, 905, 549	8, 645, 599			12, 409, 124	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 249, 606	387, 073		-17, 999	1, 618, 680	
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	2, 600, 925	0 2, 133, 201	_	-307, 046	0 4, 427, 080	
66. 00	06600 PHYSI CAL THERAPY	1, 343, 576	111, 434			1, 454, 305	1
67. 00	06700 OCCUPATI ONAL THERAPY	1, 081, 535	95, 515			1, 168, 768	67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY	445, 241	46, 033			491, 272	
69. 00	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	758, 338 418, 448	353, 916 402, 169		-181, 166 -214, 877	931, 088 605, 740	1
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 222, 923	12, 095, 520			1, 630, 391	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1	.,	14, 148, 528	
72. 00 73. 00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	386, 275	0 5, 085, 348	1	12, 212, 175 28, 458, 974	12, 212, 175 33, 930, 597	
74.00	07400 RENAL DIALYSIS	870	2, 287, 961		-9, 087	2, 279, 744	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	1
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	2, 979, 892	3, 099, 393	6, 079, 285	-289, 394	5, 789, 891	90.00
91.00	09100 EMERGENCY	7, 793, 123	9, 564, 325			16, 290, 435	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	, , ,		, , , , ,	, ,		92.00
101 00	OTHER REIMBURSABLE COST CENTERS	2 074 542	277 427	2 451 0/0	F2 F74	2 200 205	101 00
	0 10100 HOME HEALTH AGENCY 0 10200 OPIOID TREATMENT PROGRAM	2, 074, 543 0	377, 426 0			2, 399, 395 0	101.00
. 52. 00	SPECIAL PURPOSE COST CENTERS	٥			<u> </u>	0]
118.00		125, 668, 720	252, 906, 780	378, 575, 500	2, 004, 062	380, 579, 562	118.00
190 00	NONREIMBURSABLE COST CENTERS 1900 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
	19100 RESEARCH	ő	0				191.00
		,			,		

Health Financial Systems	METHODI ST HOSE	PITALS, INC		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provi der C		Period: From 01/01/2022	Worksheet A	
			l -	o 12/31/2022	Date/Time Pre 5/25/2023 12:	pared: 46 pm_
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
			+ col. 2)	ions (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	23, 511, 053	15, 445, 401	38, 956, 454	-185, 123	38, 771, 331	192.00
192. 01 19201 OTHER NON-REIMBURSABLE	0	2, 173, 934	2, 173, 934	-1, 818, 939	354, 995	192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	90, 864	101, 945	192, 809	0	192, 809	192. 02
193. 00 19300 NONPALD WORKERS	0	0		0	0	193. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	149, 270, 637	270, 628, 060	419, 898, 697	0	419, 898, 697	200. 00

Provi der CCN: 15-0002

Peri od: Worksheet A From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/25/2023 12:46 pm

				5/25/2023 12: 4	46 pm_
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For		
		4.00	Allocation 7.00		
	GENERAL SERVICE COST CENTERS	6. 00	7.00		
1.00	00100 CAP REL COSTS-BLDG & FLXT	-3, 049, 251	17, 209, 259		1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	-1, 876, 848	30, 071, 575		4. 00
5. 01	00550 DATA PROCESSING	-257, 949	13, 611, 451		5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES	0	3, 374, 130		5.02
5.03	00570 ADMI TTI NG	o	6, 025, 222		5.03
5.04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	-26, 231	7, 173, 938		5.04
5.05	00590 OTHER A&G	-148, 418	18, 331, 088		5.05
5. 06	00592 PATI ENT TRANSPORTATION	0	534, 420		5. 06
7. 00	00700 OPERATION OF PLANT	0	21, 100, 819	·	7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	1, 192, 566	·	8. 00
9.00	00900 HOUSEKEEPI NG	-5, 428	5, 429, 930		9.00
10.00	01000 DI ETARY	014 500	4, 237, 652		10.00
11. 00 13. 00	01100 CAFETERI A	-816, 582	2, 016, 780	l l	11. 00 13. 00
14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0 0	4, 824, 807 3, 043, 349	l l	14.00
15. 00	01500 PHARMACY		5, 566, 113	l l	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	-144, 814	2, 686, 478	l l	16. 00
17. 00	01700 SOCIAL SERVICE	0	425, 415		17. 00
17. 01	01701 STAFF EDUCATION	o	0	I I	17. 01
17. 02	01702 MEDI CAL EDUCATI ON	o	45, 715		17. 02
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	o	245, 947		21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	o	31, 168		22.00
23. 00	02300 PARAMED ED PROGRAM	-196, 701	612, 220		23.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDI ATRI CS	-3, 320, 396	47, 937, 429	·	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	9, 793, 073		31.00
31. 01	03101 NEONATAL I CU	-1, 088, 123	1, 630, 901		31. 01
40.00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	0 0	983, 297	·	40.00
41. 00 43. 00	04100 SUBPROVIDER - TRF		1, 929, 536 1, 674, 791		41. 00 43. 00
43.00	ANCI LLARY SERVICE COST CENTERS	l ol	1,074,771		43.00
50. 00	05000 OPERATI NG ROOM	-6, 914, 889	11, 012, 482		50.00
50. 01	05001 ENDOSCOPY	0	1, 177, 985		50. 01
51.00	05100 RECOVERY ROOM	o	1, 138, 220		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	4, 620, 154		52.00
53.00	05300 ANESTHESI OLOGY	0	0		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-2, 508	4, 382, 814		54.00
54. 01	05401 RADI OLOGY - ULTRASOUND	-6, 109	1, 860, 579	l l	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	-100, 192	2, 313, 950	l l	55.00
55. 01	05501 I NFUSI ON CENTER	-3, 522, 285	642, 403		55. 01
56. 00 57. 00	05600	0 -7, 689	1, 895, 268 2, 172, 554		56. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	-1, 492	1, 022, 858		58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 4,2	3, 328, 108		59.00
60.00	06000 LABORATORY	-59, 980	12, 349, 144		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	-41, 087	1, 577, 593		62.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	1	64.00
65.00	06500 RESPI RATORY THERAPY	0	4, 427, 080		65.00
66.00	06600 PHYSI CAL THERAPY	0	1, 454, 305		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	1, 168, 768	·	67.00
68. 00	06800 SPEECH PATHOLOGY	0	491, 272		68.00
69.00	06900 ELECTROCARDI OLOGY	115 242	931, 088	·	69.00
69. 01	06901 CARDI AC REHAB	-115, 243	490, 497		69. 01
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-6, 300 0	1, 624, 091 14, 148, 528		70. 00 71. 00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS		12, 212, 175		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	-157, 988	33, 772, 609	·	73.00
74.00	07400 RENAL DIALYSIS	-137, 700	2, 279, 744	·	74.00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	o o	2, 277, 744	·	77. 00
	OUTPATIENT SERVICE COST CENTERS	·			
90.00	09000 CLI NI C	-407, 529	5, 382, 362		90.00
91.00	09100 EMERGENCY	-2, 219, 532	14, 070, 903		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
	OTHER REIMBURSABLE COST CENTERS				
	10100 HOME HEALTH AGENCY	0	2, 399, 395	·	101.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0		102. 00
110 0	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	-24 402 E44	356 DOE DOD		118. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	-24, 493, 564	356, 085, 998		116.UU
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	ol	0		190. 00
	19100 RESEARCH	o o	0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES	-9, 095, 379	29, 675, 952		192.00
	•		-		

Health Financial Systems	METHODI ST HOS	PITALS, INC	In Lie	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TR	RIAL BALANCE OF EXPENSES	Provi der CCN: 15-000	From 01/01/2022	Worksheet A Date/Time Prepared: 5/25/2023 12:46 pm
Cost Center Description	Adjustments (See A-8)	Net Expenses For		

			5/25/2023 12: 46 pm
Cost Center Description	Adjustments	Net Expenses	
	(See A-8)	For	
		Allocation	
	6. 00	7.00	
192. 01 19201 OTHER NON-REI MBURSABLE	0	354, 995	192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	-100, 000	92, 809	192. 02
193.00 19300 NONPALD WORKERS	0	0	193. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	-33, 688, 943	386, 209, 754	200.00

Health Financial Systems RECLASSIFICATIONS | Peri od: | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: | 5/25/2023 12:46 pm Provider CCN: 15-0002

					5/25/2023 12:46 pm
		Increases			
	Cost Center	Li ne #	Sal ary	Other	
	2.00	3. 00	4. 00	5. 00	
1 00	A - CAFETERIA	11 00	1 200 110	1 200 242	1 00
1. 00	CAFETERI A	11.00	1, 208, 119 1, 208, 119	<u>1, 298, 342</u> 1, 298, 342	1.00
	B - CLINICAL TRAINING COST		1, 200, 119	1, 290, 342	
1. 00	PARAMED ED PROGRAM	23. 00	223, 506	0	1.00
2. 00	TANGEN ED TROOM III	0.00	0	Ö	2. 00
3. 00		0. 00	o	Ö	3.00
4.00		0.00	O	0	4. 00
5.00		0.00	O	0	5. 00
6.00		0.00	o	0	6.00
	0		223, 506	0	
	C - SOCIAL WORKERS				
1. 00	SOCI AL SERVI CE	<u>17.</u> 00	42 <u>5, 4</u> 15	0	1.00
	0		425, 415	0	
4 00	E - RESI DENTS	04.00		0.45 0.47	1.00
1. 00	I &R SERVI CES-SALARY &	21. 00	0	245, 947	1.00
2. 00	FRINGES APPRVD I&R SERVICES-OTHER PRGM	22. 00	0	31, 168	2.00
2.00	COSTS APPRVD	22.00	٥	31, 100	2.00
	0	+		277, 115	
	F - MED SUPPLY		-1	=::,:::=	
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	14, 148, 528	1.00
	PATIENTS				
2.00	IMPL. DEV. CHARGED TO	72. 00	O	12, 212, 175	2.00
	PATI ENTS				
3.00		0.00	0	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	o	o	9.00
10.00		0.00	Ö	0	10.00
11. 00		0.00	Ö	Ö	11.00
12. 00		0. 00	Ö	Ö	12.00
13. 00		0. 00	o	0	13.00
14.00		0.00	O	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	O	0	18. 00
19.00		0. 00	0	0	19.00
20.00		0. 00	0	0	20.00
21. 00		0. 00	0	0	21.00
22. 00		0. 00	0	0	22.00
23. 00		0.00	0	0	23.00
24. 00		0.00	0	0	24.00
25.00		0.00	0	0	25. 00
26. 00 27. 00		0. 00 0. 00	o	0	26. 00 27. 00
28.00		0.00	o	0	28.00
29. 00		0.00	0	o	29.00
30.00		0.00	o	Ö	30.00
31.00		0. 00	ő	ő	31.00
32. 00		0. 00	o	Ö	32.00
33. 00		0. 00	o	Ö	33.00
34. 00		0. 00	ő	Ö	34.00
35. 00		0. 00	o	Ö	35. 00
36.00		0.00	O	0	36.00
37.00		0.00	o	0	37.00
38.00		0.00	o	0	38.00
39. 00		0. 00	О	0	39.00
40.00		0. 00	o	0	40.00
41.00		0. 00	o	0	41.00
42.00		0. 00	O	0	42.00
43.00		0. 00	0	0	43.00
44.00		0. 00	0	0	44.00
45. 00		0. 00	0	0	45.00
46.00		0.00	0	0	46.00
47.00		0.00	0	0	47.00
48. 00		0.00	0	0 26, 360, 703	48. 00
	0		0	∠o, 36U, /U3	1

Provider CCN: 15-0002

In Lieu of Form CMS-2552-10
Worksheet A-6

Peri od: From 01/01/2022 To 12/31/2022 Date/Ti me Prepared: 5/25/2023 12: 46 pm

					5/25/2023 12	2: 46 piii
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4. 00	5. 00		
	G - LIGHT DUTY					
1 00		F 04	E01	0		1 00
1.00	PATI ENT TRANSPORTATI ON	5. 06	581			1.00
2.00	OPERATION OF PLANT	7. 00	199	0		2. 00
3.00	HOUSEKEEPI NG	9. 00	656	0		3.00
4.00	DI ETARY	10, 00	3, 050	0		4.00
5. 00	NURSING ADMINISTRATION	13. 00	8, 845	0		5. 00
						1
6. 00	CENTRAL SERVICES & SUPPLY	14. 00	6, 056	0		6. 00
7. 00	ADULTS & PEDIATRICS	30. 00	150, 569	0		7. 00
8.00	OPERATING ROOM	50.00	6, 504	0		8. 00
9.00	RECOVERY ROOM	51.00	14, 307	0		9. 00
10. 00	RADI OLOGY - ULTRASOUND	54. 01	7, 658	0		10.00
11. 00	RADI OI SOTOPE	56. 00	53, 741	0		11. 00
12.00	WHOLE BLOOD & PACKED RED	62. 00	2, 452	0		12.00
	BLOOD CELLS					
13.00	ELECTROCARDI OLOGY	69. 00	2, 585	0		13.00
	PHYSICIANS' PRIVATE OFFICES	192. 00	2, 948			14.00
14.00	FITTS CLANS FRIVALE OF LICES	172.00		0		14.00
	0		260, 151	0		
	H - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FLXT	1. 00	0	2, 404, 614		1.00
2.00		0.00	o	0		2.00
3. 00		0.00	o	0		3.00
3.00		<u> </u>				3.00
	U		0	2, 404, 614		_
	I - CORPORATE EXPENSE					
1.00	CAP REL COSTS-BLDG & FLXT	1. 00	0	7, 376, 630		1.00
2.00	OPERATION OF PLANT	7. 00	o	5, 588, 870		2.00
2.00	0	— — " "+	— — j	12, 965, 500		2.00
	0		U	12, 965, 500		
	J - DRUG EXPENSE					
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	28, 827, 774		1.00
2.00		0.00	ol	0		2.00
3. 00		0.00	o	0		3.00
3.00		<u> </u>	— — — 0			3.00
	0		U ₁	28, 827, 774		
	K - PHYSICIAN RECLASS					
1.00	OTHER A&G	5. 05	0	50, 750		1.00
2.00	CLINIC	90.00	ol	80, 800		2.00
		— — — 		131, 550		
	L DCTD DECLACE		o _l	131, 330		_
	L - PSTD RECLASS		ما	550 444		4 00
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	553, 441		1.00
2.00		0.00	0	0		2.00
3.00		0.00	ol	0		3.00
4.00		0.00	o	0		4.00
5. 00		0.00	o	0		5.00
		•	o o			1
6.00		0. 00	O	0		6. 00
7. 00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	o	0		9. 00
10. 00		0.00	o	0		10.00
			O O			
11. 00		0. 00	O	0		11. 00
12.00		0.00	0	0		12.00
13.00		0. 00	0	0		13.00
14.00		0.00	O	0		14.00
15. 00		0. 00	o	0		15. 00
16. 00		0. 00	0	0		16. 00
17.00		0.00	0	0		17. 00
18. 00		0.00	O	0		18. 00
19. 00		0.00	o	0		19.00
			-			
20.00		0. 00	0	0		20.00
21.00		0. 00	0	0		21. 00
22.00		0.00	0	0		22. 00
23.00		0.00	O	0		23.00
24. 00		0.00	o	0		24.00
			0			
25.00		0.00	-	0		25.00
26.00		0. 00	0	0		26. 00
27.00		0.00	O	0		27. 00
28. 00		0.00	o	0		28. 00
29. 00		0.00	U ₁	0		29. 00
30.00		0. 00	0	0		30.00
31.00		0.00	O	0		31.00
32.00		0. 00	O	0		32.00
33. 00		0.00	o	0		33.00
		0.00				
34. 00			•	0		34.00
	0		o	553, 441		

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10 | Peri od: | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: | 5/25/2023 12:46 pm Provider CCN: 15-0002

					5/25/202	23 12:46 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2.00	3. 00	4. 00	5. 00		
1 00	M - DEPRECIATION RECLASS CAP REL COSTS-BLDG & FIXT	1. 00	0	10, 477, 266		1.00
1. 00 2. 00	CAP REL CUSTS-BLUG & FIXT	0.00	0	10, 477, 200		2.00
3. 00		0.00	0	0		3.00
4. 00		0.00	0	0		4.00
5. 00		0.00	o	0		5.00
6. 00		0.00	0	0		6.00
7. 00		0. 00	ő	0		7. 00
8. 00		0. 00	o	0		8. 00
9. 00		0. 00	o	0		9. 00
10.00		0.00	o	0		10.00
11. 00		0.00	o	0		11.00
12. 00		0.00	o	0		12.00
13. 00		0.00	Ö	0		13.00
14. 00		0.00	Ö	0		14.00
15. 00		0.00	Ö	0		15. 00
16. 00		0.00	Ö	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	O	0		20.00
21.00		0.00	o	0		21.00
22.00		0.00	O	0		22.00
23. 00		0.00	0	0		23.00
24.00		0.00	O	0		24.00
25.00		0.00	O	0		25.00
26.00		0.00	O	0		26.00
27.00		0.00	O	0		27. 00
28.00		0.00	O	0		28. 00
29.00		0. 00	O	0		29. 00
30.00		0.00	O	0		30.00
31.00		0.00	O	0		31.00
32.00		0.00	0	0		32.00
33.00		0. 00	0	0		33.00
34.00		0.00	0	0		34.00
35.00		0. 00	0	0		35.00
36.00		0. 00	0	0		36.00
37.00		0. 00	0	0		37.00
38. 00		0. 00	0	0		38.00
39. 00		0. 00	0	0		39.00
40.00		0. 00	0	0		40.00
41.00		0.00	0	0		41.00
42.00		0. 00	0	0		42.00
43.00		0.00	0	0		43.00
44.00		0.00	0	0		44.00
45.00		0.00	0	0		45.00
46.00		0.00	0	0		46.00
47. 00		0.00	0	0		47. 00
	O N - DEPT 9101 RECLASS		0	10, 477, 266		
1 00		102 00	991, 437	275 252		1 00
1. 00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	991, 437 991, 437	27 <u>5, 3</u> 53 275, 353		1.00
	O - UTILITIES RECLASS		991, 437	215, 353		
1. 00	OPERATION OF PLANT	7. 00	ما	1, 230, 432		1 00
2. 00	OFENATION OF PLANT	0.00	0	1, 230, 432		1. 00 2. 00
2. 00 3. 00		0.00	0	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
0.00			0	<u> </u>	1	0.00
	P - C SECTION RECLASS		UU	1, 230, 432		
1. 00	OPERATING ROOM	50.00	60, 112	n		1.00
1.00	0		60, 112			1.00
500 00	Grand Total: Increases		3, 168, 740	84, 802, 090	4	500.00
3.00	1	1	2, 100, 10	2 ., 302, 070	ı	1 300. 00

RECLASSI FI CATI ONS

Provider CCN: 15-0002

Peri od: Worksheet A-6 From 01/01/2022 To 12/31/2022 Date/Time Prepared:

5/25/2023 12:46 pm Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 - CAFETERIA 1.00 DI ETARY 10.00 1, 208, 119 1, 298, 342 0 1.00 1, 208, 119 1, 298, 342 CLINICAL TRAINING COST 1.00 INTENSIVE CARE UNIT 31.00 10,851 0 1.00 0 0 2.00 OPERATING ROOM 50.00 9, 333 0 2.00 3.00 CARDIAC CATHETERIZATION 59.00 5.090 0 0 3.00 DELIVERY ROOM & LABOR ROOM 8,516 0 4.00 52.00 0 4.00 5.00 RESPIRATORY THERAPY 65.00 13, 455 0 0 5.00 6.00 EMERGENCY 91.00 176, 261 0 6.00 223, 506 0 SOCIAL WORKERS 1.00 OTHER A&G 5. 05 425, 415 0 1.00 425, 415 - RESIDENTS 1.00 **EMERGENCY** 91.00 277, 115 0 1.00 2.00 0.00 0 0 2.00 Ō 277, 115 F - MED SUPPLY 1.00 PURCHASING RECEIVING AND 5. 02 0 105, 764 0 1.00 **STORES** 2.00 ADMITTI NG 5.03 o 218 0 2.00 CASHI ERI NG/ACCOUNTS 3.00 5.04 0 0 3.00 RECEI VABLE 4.00 OTHER A&G 5.05 0 159 0 4.00 PATIENT TRANSPORTATION 5.00 5.06 0 13 0 5.00 0 6 00 OPERATION OF PLANT 7.00 0 6 00 LAUNDRY & LINEN SERVICE 0 7.00 8.00 0 653 7.00 8.00 HOUSEKEEPI NG 9.00 0 0 8.00 1,864 0 9.00 DI ETARY 10.00 ol 21 9.00 CAFETERLA 0 0 10.00 11.00 55 10.00 11.00 NURSING ADMINISTRATION 13.00 0 6, 218 0 11.00 CENTRAL SERVICES & SUPPLY 0 109, 959 12.00 14.00 0 12.00 0 13 00 PHARMACY 15 00 5, 589 13 00 MEDICAL RECORDS & LIBRARY 0 14.00 16.00 14.00 15.00 MEDICAL EDUCATION 17.02 0 2,082 0 15.00 0 0 16.00 PARAMED ED PROGRAM 23.00 501 16.00 0 0 ADULTS & PEDIATRICS 30 00 508 310 17 00 17 00 INTENSIVE CARE UNIT 0 18.00 31.00 0 167, 257 18.00 1, 125 19.00 NEONATAL ICU 31.01 0 0 19.00 20.00 SUBPROVIDER - IRF 41.00 0 26, 809 0 20.00 0 NURSERY 21 00 43.00 44.816 21 00 22.00 OPERATING ROOM 50.00 0 14, 065, 152 22.00 23.00 **ENDOSCOPY** 50.01 o 355, 159 0 23.00 0 RECOVERY ROOM 0 10, 188 24.00 51.00 24.00 25 00 DELIVERY ROOM & LABOR ROOM 52 00 66, 611 25.00 26.00 RADI OLOGY-DI AGNOSTI C 54.00 0 31, 564 0 26.00 27 00 RADIOLOGY - ULTRASOUND 54.01 o 66, 217 0 27.00 0 RADI OLOGY-THERAPEUTI C 0 8, 731 55.00 28.00 28.00 INFUSION CENTER 0 0 29 00 55.01 9, 168 29 00 30.00 RADI OI SOTOPE 56.00 0 578 0 30.00 o 0 31.00 CT SCAN 57.00 43, 450 31.00 MAGNETIC RESONANCE IMAGING 32.00 58.00 0 2,037 0 32.00 (MRI) 33.00 CARDIAC CATHETERIZATION 59.00 0 5, 905, 420 0 33.00 LABORATORY 34.00 60.00 0 1, 935 0 34.00 35 00 WHOLE BLOOD & PACKED RED 62 00 Ω 302 0 35.00 BLOOD CELLS 36.00 RESPIRATORY THERAPY 65.00 166, 342 0 36.00 PHYSICAL THERAPY o 0 37.00 37.00 66.00 373 0 OCCUPATIONAL THERAPY 67.00 0 38.00 38.00 442 SPEECH PATHOLOGY 0 39.00 68.00 39 00 40.00 ELECTROCARDI OLOGY 69.00 0 2,876 0 40.00 0 41.00 CARDI AC REHAB 69.01 0 1.323 41.00 ELECTROENCEPHALOGRAPHY 0 3, 738, 937 70.00 42.00 42.00 0 43.00 DRUGS CHARGED TO PATIENTS 73.00 0 336, 450 43.00 RENAL DIALYSIS 0 8, 798 0 44.00 74.00 44.00 0 45.00 CLINIC 90.00 0 171.443 45.00 46 00 EMERGENCY 91.00 0 320, 179 0 46.00 47.00 HOME HEALTH AGENCY 101.00 0 24, 614 0 47.00 48.00 PHYSICIANS' PRIVATE OFFICES 192.00 40, 982 0 48.00 26, 360, 703

Provider CCN: 15-0002

Peri od: Worksheet A-0 From 01/01/2022 To 12/31/2022 Date/Ti me Prepared: 5/25/2023 12:46 pm

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RECLASSI FI CATI ONS

Provider CCN: 15-0002

Peri od: Worksheet A-6 From 01/01/2022

1.00

500.00

12/31/2022 Date/Time Prepared: 5/25/2023 12:46 pm Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 M - DEPRECIATION RECLASS 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 4, 241 1.00 0 2.00 DATA PROCESSING 5.01 1, 556, 754 0 2.00 PURCHASING RECEIVING AND 0 0 3.00 5.02 48, 871 3.00 STORES. 4.00 ADMITTING 5.03 0 3, 182 0 4.00 CASHI ERI NG/ACCOUNTS 5.00 5.04 0 4, 374 0 5.00 RECEI VABLE OTHER A&G 0 6.00 5 05 242, 362 0 6.00 7.00 PATIENT TRANSPORTATION 5.06 0 4, 410 0 7.00 8.00 OPERATION OF PLANT 7.00 o 485, 981 0 8.00 0 0 HOUSEKEEPI NG 9.00 9.00 55, 513 9.00 10.00 DI FTARY 10.00 69, 982 10.00 11.00 NURSING ADMINISTRATION 13.00 0 141, 621 0 11.00 12.00 CENTRAL SERVICES & SUPPLY 14.00 o 381, 300 0 12.00 0 0 PHARMACY 278, 477 13.00 15.00 13.00 MEDICAL RECORDS & LIBRARY 0 14.00 16.00 2, 260 14.00 15.00 PARAMED ED PROGRAM 23.00 0 7, 155 0 15.00 0 16.00 ADULTS & PEDIATRICS 30.00 218, 863 16.00 0 0 INTENSIVE CARE UNIT 31.00 17 00 534.882 17 00 18.00 NEONATAL ICU 31.01 o 42,058 18.00 SUBPROVIDER - IPF 0 0 19.00 40.00 10, 350 19.00 SUBPROVIDER - IRF 0 8,083 20.00 41.00 20.00 0 0 60, 996 21.00 NURSERY 43.00 21.00 22.00 OPERATING ROOM 50.00 0 680, 846 0 22.00 0 0 23.00 **ENDOSCOPY** 50.01 187, 332 23.00 0 24 00 RECOVERY ROOM 51.00 24 00 1 003 0 DELIVERY ROOM & LABOR ROOM 0 25.00 52.00 138, 277 25.00 RADI OLOGY-DI AGNOSTI C 54.00 0 704, 090 0 26.00 26.00 0 27.00 RADIOLOGY - ULTRASOUND 54.01 ol 27.00 4.041 RADI OLOGY-THERAPEUTI C 55.00 0 0 28.00 524.447 28.00 29.00 INFUSION CENTER 55.01 0 80, 308 0 29.00 RADI OI SOTOPE 0 30.00 56.00 0 118, 856 30.00 31 00 CT SCAN 57 00 0 26 729 0 31 00 MAGNETIC RESONANCE IMAGING 0 32.00 58.00 0 242, 773 32.00 (MRI) CARDIAC CATHETERIZATION 0 33.00 59.00 0 141, 744 33.00 34.00 LABORATORY 60.00 0 135.857 0 34.00 WHOLE BLOOD & PACKED RED 35.00 62.00 0 11,093 0 35.00 BLOOD CELLS 36.00 RESPIRATORY THERAPY 65.00 0 115,686 0 36.00 37.00 PHYSICAL THERAPY 0 332 0 37.00 66.00 0 38 00 OCCUPATIONAL THERAPY 67.00 0 442 38.00 0 39.00 ELECTROCARDI OLOGY 69.00 0 171, 597 39.00 0 40.00 CARDI AC REHAB 69.01 o 160,025 40.00 ELECTROENCEPHALOGRAPHY 70.00 o 208, 510 41.00 41.00 0 DRUGS CHARGED TO PATIENTS 0 42.00 73.00 32, 350 42.00 43.00 RENAL DIALYSIS 74.00 0 289 0 43.00 0 44.00 CLI NI C 90.00 0 165, 607 44.00 **IEMERGENCY** 91 00 ol 270 161 0 45 00 45 00 PHYSICIANS' PRIVATE OFFICES 46.00 192.00 0 848, 869 0 46.00 47.00 OTHER NON-REIMBURSABLE 192. 01 1, 344, 287 0 47.00 0 10, 477, 266 N - DEPT 9101 RECLASS 1.00 CASHLERLNG/ACCOUNTS 5.04 991, 437 275, 353 0 1.00 RECEI VABLE 991, 437 275, 353 O - UTILITIES RECLASS 1 00 DATA PROCESSING 5.01 167, 341 0 1 00 CASHI ERI NG/ACCOUNTS 5.04 28, 992 0 2.00 2.00 RECEI VABLE 3.00 HOUSEKEEPI NG 9.00 117, 719 0 3.00 4.00 CARDI AC REHAB 69.01 53, 529 0 4.00 5.00 PHYSICIANS' PRIVATE OFFICES 192.00 388, 199 0 5.00 OTHER NON-REIMBURSABLE 6.00 192.01 474, 652 0 6.00 1, 230, 432 P - C SECTION RECLASS

DELIVERY ROOM & LABOR ROOM

500.00 Grand Total: Decreases

52.00

60, 112

60, 112

3, 722, 181

84, 248, 649

0

1.00

Provi der CCN: 15-0002

				Т	o 12/31/2022	Date/Time Pre 5/25/2023 12:	
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	5, 373, 674	427, 200	0	427, 200	0	1.00
2.00	Land Improvements	6, 958, 207	80, 932	0	80, 932	0	2.00
3.00	Buildings and Fixtures	309, 357, 738	5, 564, 655	0	5, 564, 655	0	3.00
4.00	Building Improvements	1, 230, 154	781, 684	0	781, 684	0	4. 00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	211, 798, 957	261, 239	0	261, 239	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	534, 718, 730	7, 115, 710	0	7, 115, 710	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	534, 718, 730	7, 115, 710	0	7, 115, 710	0	10.00
		Endi ng	Fully				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	5, 800, 874	0				1.00
2.00	Land Improvements	7, 039, 139	0				2.00
3.00	Buildings and Fixtures	314, 922, 393	0				3.00
4.00	Building Improvements	2, 011, 838	0				4. 00
5.00	Fi xed Equi pment	0	0				5. 00
6.00	Movable Equipment	212, 060, 196	0				6.00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	541, 834, 440	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	541, 834, 440	0				10.00

Heal th	Financial Systems	METHODI ST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 15-0002	Peri od: From 01/01/2022 To 12/31/2022		pared:
				SUMMARY OF CAP	PI TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9. 00	10. 00	11. 00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	MN 2, LINES 1	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	0	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	0ther	Total (1)				
		Capi tal -Rel at	(sum of cols	5.			
		ed Costs (see	9 through 14	ł)			
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	MN 2, LINES 1	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

Heal th	Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od:	Worksheet A-7	
					From 01/01/2022 o 12/31/2022		narod:
				'	0 12/31/2022	5/25/2023 12:	46 pm
		COMF	PUTATION OF RA	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 C		2.00	3.00	4.00	3.00	
1. 00	CAP REL COSTS-BLDG & FIXT	541, 834, 440	0	541, 834, 440	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	541, 834, 440		541, 834, 440		0	3.00
		ALLOCAT	TION OF OTHER (CAPI TAL	SUMMARY 0	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at				
		4 00	ed Costs	through 7)	0.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	6. 00	7. 00	8. 00	9. 00	10. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	ENTERS			17, 209, 259	0	1. 00
3. 00	Total (sum of lines 1-2)	0	0		17, 209, 259		3. 00
3.00	Total (Suil of Triles 1 2)	J	SI	JMMARY OF CAPI		J	3.00
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
			(see	instructions)	Capi tal -Rel at	(sum of cols.	
			instructions)		ed Costs (see	9 through 14)	
					instructions)		
	DADT III DECONOLITATION OF CARLEY COOTS	11. 00	12. 00	13. 00	14. 00	15. 00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS C					17 200 250	1 00
1. 00 3. 00	CAP REL COSTS-BLDG & FIXT Total (sum of lines 1-2)	0	ı	1			1. 00 3. 00
3.00	Total (Suiii of Titles 1-2)	ı V	0	(ار ار	17, 209, 259	3.00

Peri od: From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/25/2023 12: 46 pm

				Expense Classification on V		3/23/2023 12.	40 piii
				To/From Which the Amount is t	o be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	Sect content become per on	(2)				Ref.	
1 00	Investment income CAD DEL	1. 00 B	2.00	3. 00 CAP REL COSTS-BLDG & FLXT	4.00	5. 00	1. 00
1. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	В	-2, 404, 614	CAP REL CUSTS-BLDG & FIXT	1. 00	11	1.00
2. 00	Investment income - CAP REL		0	*** Cost Center Deleted ***	2. 00	0	2.00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0. 00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0		0. 00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0. 00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0. 00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0. 00	0	7. 00
7.00	stations excluded) (chapter 21)		, and the second		0.00	J	7.00
8. 00	Tel evi si on and radi o servi ce (chapter 21)		0		0. 00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21)	A-8-2	0 17 F00 F14		0. 00	0	9. 00 10. 00
	Provi der-based physician adjustment	A-8-2	-17, 589, 516				
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	
12. 00	Related organization transactions (chapter 10)	A-8-1	0			0	
13.00	Laundry and linen service Cafeteria-employees and guests	В	014 503	CAFETERI A	0. 00 11. 00	0	13. 00 14. 00
15. 00	Rental of quarters to employee		-810, 382 0	CALLIENTA	0.00	0	15. 00
16. 00	and others Sale of medical and surgical		0		0. 00	0	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than patients		0		0. 00	0	17. 00
18. 00	1.	В	-144, 814	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	Nursing and allied health education (tuition, fees,		0		0. 00	0	19. 00
	books, etc.)						
20.00	Vendi ng machi nes	В	0	DI ETARY	10. 00	0	20.00
21. 00	Income from imposition of interest, finance or penalty		0		0. 00	0	21. 00
	charges (chapter 21)						
22.00	Interest expense on Medicare overpayments and borrowings to		0		0. 00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
	therapy costs in excess of						
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
	(chapter 21)						
26. 00	Depreciation - CAP REL COSTS-BLDG & FIXT	А		CAP REL COSTS-BLDG & FLXT	1. 00	9	26. 00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2. 00	0	27. 00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00	_	28. 00
29. 00 30. 00		A-8-3	0) n	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
20.00	therapy costs in excess of limitation (chapter 14)	5 5		The state of the s	37.00		
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99
	instructions)		l	ı	Ţ	!	

Heal th	Financial Systems		METHODIST HOS	PITALS, INC	In Lie	u of Form CMS-:	2552-10
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 01/01/2022 To 12/31/2022	Date/Time Pre	nared:
					12/31/2022	5/25/2023 12:	46 pm
				Expense Classification on			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2)				Ref.	
	Tarana Sanata	1. 00	2. 00	3. 00	4. 00	5. 00	
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
	pathology costs in excess of						
22 00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32.00
32.00	Depreciation and Interest		١		0.00	0	32.00
33.00	DATA PROCESSING OTHER INCOME	В	-257 949	DATA PROCESSING	5. 01	0	33.00
33. 01	CASH, A/R, COLLECTIONS OTHER	B		CASHI ERI NG/ACCOUNTS	5. 04	Ö	33. 01
	INCOME			RECEI VABLE			
33. 02		В	-137, 751	OTHER A&G	5. 05	0	
33. 03		В	-5, 428	HOUSEKEEPI NG	9. 00	0	33. 03
	I NCOME			DADAMED ED DDOODAM			
33. 04	PARAMED ED PROGRAM OTHER	В	-63, 698	PARAMED ED PROGRAM	23. 00	0	33. 04
33. 05		В	_1 300	MAGNETIC RESONANCE IMAGING	58. 00	0	33. 05
33.03	(MRI)		,	(MRI)	30.00		33.03
33. 06	LAB OTHER INCOME	В		LABORATORY	60.00	О	33. 06
33. 07	BLOOD OTHER INCOME	В		WHOLE BLOOD & PACKED RED	62. 00	0	33. 07
				BLOOD CELLS			
33. 08		В		CARDI AC REHAB	69. 01	0	00.00
33. 09	ELECTROCEPHALOGRAPHY OTHER	В	-6, 300	ELECTROENCEPHALOGRAPHY	70. 00	0	33. 09
22 10	I NCOME	D	F07 2/0	DUVELCI ANCI DDI VATE OFFICES	102.00		22 10
33. 10 33. 11		B B		PHYSICIANS' PRIVATE OFFICES FAMILY HEALTH/GARY COMM	192. 00 192. 02	0	
JJ. 11	AWI ET HEALTH	L D		HEALTH	172.02		33.11
33, 12	EMT OFFSET	A	1	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 12
00 10	FUT OFFOFT		1 400 000	DADAMED ED DD00D444		1	1 00 40

-133, 003 PARAMED ED PROGRAM

-157, 988 DRUGS CHARGED TO PATIENTS

-1,853,062 EMPLOYEE BENEFITS DEPARTMENT

-8, 588, 010 PHYSICIANS' PRIVATE OFFICES

-10, 667 OTHER A&G

-33, 688, 943

23.00

5.05

73.00

192.00

4.00

33. 13

33.14

33. 15

33.16

33. 17

50.00

Α

Α

Α

Α

33. 13 EMT OFFSET

33. 15 RX PROGRAM

33. 17

33. 14 DUES/LOBBYI NG

33. 16 PENSION ADJUSTMENT

PHYSICIAN OFFSET

50.00 TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A,

column 6, line 200.) (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT | Peri od: | Worksheet A-8-2 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: Provi der CCN: 15-0002

					1	o 12/31/2022	Date/Time Pro 5/25/2023 12:	epared:
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	40 pili
	mkst. // Line #	I denti fi er	Remuneration	Component	Component	NOE AMOUNT	ider Component	
		. 46.11 6.	Tromarior a cr orr	00	ooportorre		Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00		EMPLOYEE BENEFITS DEPARTMENT	72	72		0		1.00
2.00		ADULTS & PEDIATRICS	3, 320, 396	3, 320, 396	0	0	0	2.00
3. 00		NEONATAL ICU	1, 088, 123			0	0	3.00
4. 00		OPERATING ROOM	6, 914, 889			0	0	4.00
5. 00	54.00	RADI OLOGY-DI AGNOSTI C	2, 508			0	0	5.00
6. 00		RADI OLOGY - ULTRASOUND	6, 109			0		6.00
7. 00		RADI OLOGY-THERAPEUTI C	114, 631	95, 781		211, 500	142	7. 00
8. 00		INFUSION CENTER	3, 522, 285			0	0	8.00
9. 00		CT SCAN	7, 689			0		9. 00
10.00		MAGNETIC RESONANCE IMAGING	192			0	0	10.00
		(MRI)				_	_	
11. 00		CLINIC	407, 529	407, 529	0	0	0	11. 00
12. 00		EMERGENCY	2, 219, 532			0	0	12.00
200.00			17, 603, 955			_	142	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Li mi t		Memberships &		of Malpractice	
				Li mi t	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2.00	8. 00	9. 00	12.00	13. 00	14.00	
1. 00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	0	(0	0	0	1.00
2.00	30. 00	ADULTS & PEDIATRICS	0		0	0	0	2.00
3.00	31. 01	NEONATAL ICU	0		0	0	0	3.00
4.00	50. 00	OPERATING ROOM	0		0	0	0	4.00
5.00		RADI OLOGY-DI AGNOSTI C	0		0	0	0	5. 00
6.00	54. 01	RADI OLOGY - ULTRASOUND	0		0	0	0	6. 00
7. 00	55. 00	RADI OLOGY-THERAPEUTI C	14, 439	722	0	0	0	7. 00
8. 00		INFUSION CENTER	0			0	0	8. 00
9. 00		CT SCAN	0		0	0	0	9. 00
10.00		MAGNETIC RESONANCE I MAGING	0		0	0	0	10.00
		(MRI)	_				_	
11. 00		ĈLI NÍ C	0		0	0	0	11.00
12.00		EMERGENCY	0		0	0	0	12.00
200.00			14, 439	722	0	0	0	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00		EMPLOYEE BENEFITS DEPARTMENT	0		0	72		1.00
2.00	30. 00	ADULTS & PEDIATRICS	0	(0	3, 320, 396		2.00
3.00	31. 01	NEONATAL ICU	0	(0	1, 088, 123		3.00
4.00	50. 00	OPERATING ROOM	0	(0	6, 914, 889		4.00
5.00	54.00	RADI OLOGY-DI AGNOSTI C	0	(0	2, 508		5. 00
6.00		RADI OLOGY - ULTRASOUND	0		,	6, 109		6. 00
7.00		RADI OLOGY-THERAPEUTI C	0	14, 439	4, 411	100, 192		7. 00
8.00	55. 01	INFUSION CENTER	0	(3, 522, 285		8.00
9. 00	57. 00	CT SCAN	0	(0	7, 689		9. 00
10.00	58. 00	MAGNETIC RESONANCE IMAGING	0	(0	192		10.00
		(MRI)						
11.00	90. 00	CLINIC	0	(0	407, 529		11. 00
12.00	91. 00	EMERGENCY	0		,	2, 219, 532		12.00
200.00			0	14, 439	4, 411	17, 589, 516		200.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: Provider CCN: 15-0002

					To	12/31/2022	Date/Time Pre 5/25/2023 12:	
				CAPI TAL			072072020 12.	ГО БІІІ
				RELATED COSTS	5454 0455	5.4.7.4	DUDOUA OLAIO	
		Cost Center Description	Net Expenses for Cost	BLDG & FIXT	EMPLOYEE BENEFITS	DATA PROCESSI NG	PURCHASING RECEIVING AND	
			Allocation		DEPARTMENT	FROCESSING	STORES	
			(from Wkst A					
			col. 7)	1.00			5.00	
	GENER	AL SERVICE COST CENTERS	0	1.00	4. 00	5. 01	5. 02	
1. 00		CAP REL COSTS-BLDG & FLXT	17, 209, 259	17, 209, 259				1. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	30, 071, 575	l .				4.00
5. 01	1	DATA PROCESSING	13, 611, 451	112, 155		14, 591, 334		5. 01
5. 02 5. 03		PURCHASING RECEIVING AND STORES ADMITTING	3, 374, 130 6, 025, 222	l .		0		5. 02 5. 03
5. 04		CASHI ERI NG/ACCOUNTS RECEI VABLE	7, 173, 938	l .		0	792	5. 04
5.05	1	OTHER A&G	18, 331, 088	1, 215, 262	1, 649, 106	14, 591, 334		5. 05
5.06		PATIENT TRANSPORTATION	534, 420	l e	,	0	272	5.06
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE	21, 100, 819 1, 192, 566	1		0	38, 235 0	7. 00 8. 00
9. 00		HOUSEKEEPI NG	5, 429, 930	1		0	32, 499	9. 00
10.00	01000	DI ETARY	4, 237, 652			0	58, 334	
11.00		CAFETERI A	2, 016, 780			0		11.00
13. 00 14. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	4, 824, 807 3, 043, 349	77, 495		0	39, 538 70, 929	13. 00 14. 00
15. 00		PHARMACY	5, 566, 113	l .		0	10, 342	15.00
16. 00		MEDICAL RECORDS & LIBRARY	2, 686, 478			0	514	16. 00
17. 00	1	SOCIAL SERVICE	425, 415	1		0	0	17. 00
17. 01		STAFF EDUCATION	0	136, 038		0	0	17. 01
17. 02 21. 00	1	MEDICAL EDUCATION I&R SERVICES-SALARY & FRINGES APPRVD	45, 715 245, 947	4, 564 0		0	346	17. 02 21. 00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRVD	31, 168			0		22. 00
23. 00	02300	PARAMED ED PROGRAM	612, 220	l .		0	262	23. 00
20.00		I ENT ROUTI NE SERVI CE COST CENTERS	47 027 420	2 022 501	4 747 210		100 1/2	20.00
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	47, 937, 429 9, 793, 073			0	190, 163 64, 596	30. 00 31. 00
31. 01		NEONATAL I CU	1, 630, 901	27, 557		0	1, 332	
40.00		SUBPROVI DER - I PF	983, 297	l .		0	40	
41.00		SUBPROVI DER – I RF	1, 929, 536	l .		0		41.00
43. 00		NURSERY LARY SERVICE COST CENTERS	1, 674, 791	298, 070	286, 221	0	12, 054	43. 00
50.00	05000	OPERATING ROOM	11, 012, 482	727, 932	975, 983	0	111, 678	50.00
50. 01		ENDOSCOPY	1, 177, 985	l e		0	21, 863	50. 01
51. 00 52. 00		RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	1, 138, 220 4, 620, 154	l .		0	0 13, 139	51. 00 52. 00
53.00	1	ANESTHESI OLOGY	4, 020, 134	05, 405		0	13, 137	53.00
54.00		RADI OLOGY-DI AGNOSTI C	4, 382, 814	647, 532	463, 289	0	9, 880	
54. 01		RADI OLOGY - ULTRASOUND	1, 860, 579			0		54. 01
55. 00 55. 01		RADIOLOGY-THERAPEUTIC INFUSION CENTER	2, 313, 950 642, 403	1		0	1, 779 11, 306	
56. 00		RADI OI SOTOPE	1, 895, 268			0		
57.00		CT SCAN	2, 172, 554			0		
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	1, 022, 858			0		
59.00		CARDI AC CATHETERI ZATI ON LABORATORY	3, 328, 108	1		0	26, 533	
60. 00 62. 00		WHOLE BLOOD & PACKED RED BLOOD CELLS	12, 349, 144 1, 577, 593			0	365, 077 20, 932	60. 00 62. 00
64.00		I NTRAVENOUS THERAPY	0			0		64.00
65. 00		RESPI RATORY THERAPY	4, 427, 080	l .		0	68, 211	65. 00
66.00		PHYSI CAL THERAPY	1, 454, 305			0	652	
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	1, 168, 768 491, 272			0	852 579	
69. 00	1	ELECTROCARDI OLOGY	931, 088	l .		0	1, 498	
69. 01	1	CARDI AC REHAB	490, 497	0		0	307	69. 01
70.00		ELECTROENCEPHALOGRAPHY	1, 624, 091	0		0	5, 225	70.00
71. 00 72. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS	14, 148, 528 12, 212, 175	l e	-	0	1, 117, 431 964, 505	
73. 00		DRUGS CHARGED TO PATIENTS	33, 772, 609			0	31, 784	
74.00		RENAL DIALYSIS	2, 279, 744	l .		0	1, 599	
77. 00		ALLOGENEIC HSCT ACQUISITION TIENT SERVICE COST CENTERS	0	0	0	0	0	77. 00
90.00		CLINIC	5, 382, 362	929, 713	605, 654	0	30, 239	90. 00
		EMERGENCY	14, 070, 903			0		
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)						92.00
101 00		REIMBURSABLE COST CENTERS HOME HEALTH AGENCY	2, 399, 395	0	420, 640	0	E E17	101. 00
		OPIOID TREATMENT PROGRAM	2, 399, 395	l .		0		101.00
	SPECI	AL PURPOSE COST CENTERS						
118.00)	SUBTOTALS (SUM OF LINES 1 through 117)	356, 085, 998	16, 709, 311	25, 097, 570	14, 591, 334	3, 627, 422	118. 00

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period: From 01/01/2022 To 12/31/2022		
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSI NG	PURCHASING RECEIVING AND STORES	
	0	1. 00	4. 00	5. 01	5. 02	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	21, 979		0	0	190. 00
191. 00 19100 RESEARCH	0	0		0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	29, 675, 952	325, 981	5, 027, 40	6 0	33, 572	192.00
192. 01 19201 OTHER NON-REIMBURSABLE	354, 995	42, 189		0	0	192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	92, 809	109, 799	18, 67	6 0	14	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	201. 00
202.00 TOTAL (sum lines 118 through 201)	386, 209, 754	17, 209, 259	30, 143, 65	2 14, 591, 334	3, 661, 008	202. 00

Peri od: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Ti me Prepared: 5/25/2023 12:46 pm

Description Description							5/25/2023 12:	
BRIEGIAL SERVICE COST CENTERS 5.03 5.04 54.04 5.05 5.06 1.00		Cost Center Description	ADMITTI NG	CASHI ERI NG/AC COUNTS	Subtotal	OTHER A&G	PATI ENT TRANSPORTATIO	
EMERIAL SERVICE COST CENTERS 1 00 MODIO CAPET CIRCLE NO A FIXTY 4 00 MODIO CAPET CIRCLE NO A FIXTY 5 00 MODIO CAPET CIRCLE NO A FIXTY 5 01 MODIO CAPET CIRCLE NO A FIXTY 5 02 MODIO CAPET CIRCLE NO A FIXTY 5 03 MODIO CAPET CIRCLE NO A FIXTY 5 04 MODIO CAPET CIRCLE NO A FIXTY 5 05 MODIO CAPET CIRCLE NO A FIXTY 5 06 MODIO CAPET CIRCLE NO A FIXTY 5 06 MODIO CAPET CIRCLE NO A FIXTY 5 06 MODIO CAPET CIRCLE NO A FIXTY 5 07 MODIO CAPET CIRCLE NO A FIXTY 5 07 MODIO CAPET CIRCLE NO A FIXTY 5 08 MODIO CAPET CIRCLE NO A FIXTY 6 08 MODIO CAPET CIRCLE NO A FIXTY 6 08 MODIO CAPET CIRCLE NO A FIXTY 6 08 MODIO CAPET CIRCLE NO A FIXTY 6 08 MODIO CAPET CIRCLE NO A FIXTY 6 08 MODIO CAPET CIRCLE NO A FIXTY 6 08 MODIO CAPET CIRCLE NO A FIXTY 6 08 MODIO CAPET CIRCLE NO A FIXTY 6 08 MODIO CAPET CIRCLE NO A FIXTY 6 08 MODIO CAPET CIRCLE NO A FIXTY 6 08 MODIO CAPET CIRCLE NO A FIXTY 6 08 MODIO CAPET CIRCLE NO A FIXTY 6 08 MODIO CAPET CIRCLE NO A FIXTY 6 08 MODIO CAPET CIRCLE NO A FIXTY 6 08 MODIO CAPET CIRCLE NO A FIXTY 6 08 MODIO CAPET CIRCLE NO A FIXTY 6 08 MODIO CAPET CIRCLE NO A FIXTY 7 08 MODIO CAPET CIRCLE NO A FIXTY CIRCLE NO A FIXTY 7 08 MODIO CAPET CIRCLE NO A FIXTY CIRCLE NO A FIXTY 7 08 MODIO CAPET CIRCLE NO A FIXTY C			F 00	RECEI VABLE	54.04	5.05	N	
0.000 COTON FILE DOSTS - BLIDS & FIRTY		GENERAL SERVICE COST CENTERS	5. 03	5. 04	5A. 04	5. 05	5.06	
5. 01 00560 PATA PROCESSI NG 00 00500 PATA PROCESSI NG 00 00 00500 PATA PROCESSI NG 00 00500 PAT	1. 00							1.00
5.02 0.0560 MIRCHASTING MICCEST MIGHT 0.00	4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
0.070 ADMITTING 7,142,077 8,007,013 35,787,145 5,034 5,055 5,0								
5.04 0.0580 CASH IERNIK JACOUNTS RECEIVABLE 0 8.007.513 35.787, 165 35.787, 165 5.06			7 140 077					
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0.0097 MITHINT TRANSPORTATION 0 0 6.36, 248 64, 977 701, 256 5, 06				1 1	35 787 165	35 787 165		
0.000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000				· ·				
0.00 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000	7.00		0	0				7.00
10.00 10.000 DETARY			0	0			_	
11.00 0 01100 (CAFFERIA) 0 0 0 2,485,779			0					
13.00 01300 NURSING ADMINISTRATION 0 0 5,708,246 582,900 0 10.00			0					
14. 00 01400 (FRITEAL, SERVICES & SUPPLY 0 0 3 . 6.99, 481 377, 813 0 14. 00			0					
15.00 01500 PIANAMACY 0 0 5 587, 806 599, 128 0 10 50							1	
17.00 01700 SOCIAL SERVICE 0								
17.0 01701 STAFF FOLICATION 0 0 136,038 13,893 0 17,01	16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	3, 257, 365	332, 662	0	16. 00
17.0 02100 MEDICAL EDUCATION 0 0 0 0 050, 654 5,173 0 17.0 22.0 02200 LAR SERVICES-SALARY & FRINGES APPRYD 0 0 0 245, 947 25,118 0 21.00 22.0 02200 LAR SERVICES-OTHER PROM COSTS APPRYD 0 0 0 880, 688 88.750 0 22.0 0 0 0 0 0 0 0 0 0								
21.00			-	l - 1				
22.00 02200 RAN SERVICES-OTHER PROM COSTS APPRVD 0 0 80, 835 81, 740 0 22.00 10 10 10 10 10 10 10								
23.00			•	·				
INPATI ENT ROUTH NE_SERVICE COST CENTERS		1						
31.00 03100 INTERSIVE CARE UNIT 99, 700 1111, 787 11, 668, 963 1, 191, 705 2, 160 31, 00 310 0310 1800 NEONATAL I CU 21, 990 24, 655 2, 011, 226 205, 388 0 31, 01 40, 00 04000 SUBPROVI DER - I FF 17, 889 20, 658 2, 644, 070 275, 135 2, 288 41, 00 4100 2410 04100 2410 04100 2410 04100 2410 248, 00 241 43, 00 241 44, 00 241 44, 00 241 44, 00 241 44, 00 241 44, 00 241 44, 00 241 44, 00 241 44, 00 241 44, 00 241 44, 00 241 44, 00 241 44, 00 241 44, 00 241 44, 00 241 4		INPATIENT ROUTINE SERVICE COST CENTERS						
31 01 03101								
40.00 0400								
41.00 O4100 SUBPROVI DER - 1 IRF								
ABOON OASON OASO								
ANCILLARY SERVICE COST CENTERS								
SOOI			·	·				
51.00								
S2.00 05200 DELIVERY ROOM & LABOR ROOM 25,766 28,890 5,526,788 564,429 8,760 22.00 53.00 05300 NESTHESED LOCY 0 0 0 0 0 0 0 0 0 53.00 05300 NESTHESED LOCY 0 0 0 0 0 0 0 0 0 0 0 0 0 53.00 05300 NESTHESED LOCY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 0 0								
54.00 05400 RADI OLOGY-DI AGNOSTIC 198, 482 222, 545 5, 924, 542 605, 050 43, 104 54. 01 54. 01 54. 01 55. 00 05500 RADI OLOGY-THERASOUND 114, 155 127, 994 2, 455, 543 25. 775 87, 071 54. 01 55. 00 05500 RADI OLOGY-THERAPEUTIC 120, 296 134, 880 2, 753, 943 281, 249 6, 624 55. 00 05500 INFUSION CENTER 87, 652 98, 278 984, 180 100, 510 0 55. 01 05500 INFUSION CENTER 87, 652 98, 278 984, 180 100, 510 0 55. 01 05500 INFUSION CENTER 87, 652 98, 278 984, 180 100, 510 0 55. 01 05500 INFUSION CENTER 87, 652 98, 278 984, 180 100, 510 0 55. 01 05500 INFUSION CENTER 87, 652 98, 278 984, 180 100, 510 0 55. 01 05500 INFUSION CENTER 87, 652 98, 278 984, 180 100, 510 0 55. 01 05500 INFUSION CENTER 87, 652 98, 278 984, 180 100, 510 0 0 55. 01 05500 INFUSION CENTER 87, 652 05000 RADIO CENTER 87, 777 748, 733 3, 967, 641 405, 199 166, 558 57. 00 05900 CARDITACTORY 145, 823 163, 494 1, 495, 497 152, 571 47, 592 58. 00 05900 CARDITACTORY 1, 34, 643 1, 159, 643 15, 997, 390 1, 633, 749 0 60. 00 60. 00 60000 LABORATORY 1, 344, 643 1, 159, 643 15, 997, 390 1, 633, 749 0 62. 00 64. 00 66. 00 66000 RESPIRATORY 146, 840 122, 001 2, 089, 513 213, 394 0 62. 00 66. 00 66000 RESPIRATORY 146, 840 122, 001 2, 089, 513 213, 394 0 62. 00 66. 00 66000 RESPIRATORY 146, 840 1								
54.01 05401 RADI OLOGY - JULTRASQUND			_	-1	~	•	_	
55.00 05500 RADIO LOCY-THERAPEUTIC 120, 296 134, 880 2, 753, 943 281, 249 6, 624 55.00 55.01 O5501 NFUSIO NO CENTER 87, 652 98, 278 984, 180 100, 510 0 0 55.01 56.00 05600 RADIO I SOTOPE 85, 782 96, 181 2, 401, 438 245, 249 39, 792 56.00 57.00 05700 CT SCAN 667, 777 748, 733 3, 967, 641 405, 199 166, 558 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 145, 820 163, 498 1, 493, 947 152, 571 47, 592 58.00 59.00 05900 CARRIJ AC CATHETERI ZATI ON 326, 407 365, 678 4, 661, 312 476, 041 26, 328 59.00 60.00 06000 LABORATORY 1, 034, 443 1, 159, 663 15, 997, 390 1, 633, 749 0 60.00 60.00 06000 LABORATORY 1, 034, 443 1, 159, 663 15, 997, 390 1, 633, 749 0 62, 200 62.00 06400 INTRAVENOUS THERAPY 206, 398 231, 420 5, 557, 319 567, 547 48 65.00 65.00 066500 RESPIR RATORY THERAPY 36, 767 41, 225 1, 988, 841 200, 049 0 66.00 66.00 06600 RESPIR ATORY THERAPY 26, 406 29, 607 1, 575, 095 160, 858 0 67.00 68.00 06600 06600 ELECTROCARDI I JOLGY 12, 992 14, 489 632, 692 64, 614 0 68.00 69.00 06600 ELECTROCARDI I JOLGY 12, 992 14, 489 632, 692 64, 614 0 68.00 69.00 06600 ELECTROCARDI I JOLGY 126, 990 142, 294 1, 356, 277 138, 511 3, 288 69, 00 69.00 06600 ELECTROCARDI I JOLGY 126, 990 142, 294 1, 356, 277 138, 511 3, 288 69, 00 69.00 06600 ELECTROCARDI I JOLGY 126, 990 142, 94 1, 356, 277 138, 511 3, 288 69, 00 69.00 06600 ELECTROCARDI I JOLGY 126, 990 142, 94 1, 356, 277 138, 511 3, 288 69, 00 69.00 07000 ELECTROCARDI I JOLGY 126, 991 1, 184, 138 206, 462 15, 656, 559 1, 598, 942 0 71, 00 70.00 07000 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 184, 138 206, 462 15, 656, 559 1, 598, 942 0 71, 00 70.00 07000 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 178, 631 194,								
56.00 05600 RADI OI SOTOPE 85, 782 96, 181 2, 401, 438 245, 249 39, 792 56. 00								
57. 00 05700 CT SCAN 667,777 748,733 3,967,641 405,199 166,558 57. 00 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 145,820 163,498 1,493,947 152,571 47,592 58. 00 05900 CARDI AC CATHETERI ZATI ON 326, 407 365,978 4,661,312 476, 041 26,328 59. 00 60. 00 06000 LABORATORY 1,034,643 1,159,663 15,997,390 1,633,749 0 60. 00 60. 00	55. 01	05501 INFUSION CENTER	87, 652	98, 278	984, 180	100, 510	0	55. 01
58.00 05800 MAGNETI C RESONANCE IMAGING (MRI) 145, 820 16.3, 498 1, 493, 947 152, 571 47, 592 58. 00 59. 00 05900 CARDI AC CATHETER ZATION 326, 407 365, 978 4, 661, 312 476, 041 26, 328 59. 00 60. 00 06000 LABORATORY 1, 034, 643 1, 159, 663 15, 997, 390 1, 633, 749 0 60. 00 62. 00 62. 00 06000 MOLE BLOOD & PACKED RED BLOOD CELLS 108, 810 122, 001 2, 089, 513 213, 394 0 62. 00 62. 00 0 0 0 0 0 0 0 0 0								
59.00								
60. 00 06000 LABORATORY 1, 034, 643 1, 159, 663 15, 997, 390 1, 633, 749 0 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 108, 810 122, 001 2, 089, 513 213, 394 0 62. 00 64. 00 06400 INTRAVENOUS THERAPY 206, 398 231, 420 5, 557, 319 567, 547 48 65. 00 66. 00 06500 RESPI RATORY THERAPY 206, 398 231, 420 5, 557, 319 567, 547 48 65. 00 67. 00 06700 OCCUPATI ONAL THERAPY 26, 406 29, 607 1, 575, 095 160, 858 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 12, 922 14, 489 632, 692 64, 614 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 126, 909 142, 294 1, 356, 277 138, 511 3, 288 69. 00 69. 01 06901 CARDI AC REHAB 7, 272 8, 154 592, 235 60, 483 2, 80 70. 00 70. 00 07000 LECTROCEPHALOGRAPHY 204, 834 229, 666 2, 314, 658 236, 387 2, 280 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 184, 138 206, 462 15, 656, 559 1, 598, 942 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 173, 631 194, 680 13, 544, 991 1, 383, 296 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 52, 866 59, 275 2, 447, 153 249, 918 24 74. 00 77. 00 0700 ALLOGENEI C HSCT ACQUISITION 0 0 0 0 0 77. 00 0700 CLI NI C COST CENTERS 79. 00 09000 CLI NI C COST CENTERS 79. 00 09000 CLI NI C COST CENTERS 79. 00 09000 OSERVATI ON BEDS (NON-DISTI NCT PART) 0 0 0 0 0 70 00 OTHER REI MBURSABLE COST CENTERS 79. 00 OSERVATI ON BEDS (NON-DISTI NCT PART) 0 0 0 0 0 70 OSERVATI ON BEDS (NON-DISTI NCT PART) 0 0 0 0 0 70 OSERVATI ON BEDS (NON-DISTI NCT PART) 0 0 0 0 0 0 70 OSERVATI ON BEDS (NON-DISTI NCT PART) 0 0 0 0 0 0 70 OSERVATI ON BEDS (NON-DISTI NCT PART) 0 0 0 0 0 0 0 70 OSERVATI ON BEDS (NON-DISTI NCT PART) 0 0 0 0 0 0 0 0 0 70 OSERVATI ON BEDS (NON-DISTI NCT PART) 0 0 0 0		` ,						
62.00 66200 WHOLE BLOOD & PACKED RED BLOOD CELLS 108,810 122,001 2,089,513 213,394 0 62.00 64.00 06400 INTRAVENOUS THERAPY 206,398 231,420 5,557,319 567,547 48 65.00 65.00 06500 RESPIRATORY THERAPY 26,406 29,607 1,575,095 160,858 0 67.00 67.00 06600 PHYSI CAL THERAPY 26,406 29,607 1,575,095 160,858 0 67.00 68.00 06800 SPEECH PATHOLOGY 12,922 14,489 632,692 64,614 0 68.00 69.00 06900 ELECTROCARDI OLOGY 126,909 142,294 1,356,277 138,511 3,288 69.00 69.01 06901 CARDI AC REHAB 7,272 8,154 592,235 60,483 0 69.01 69.01 07000 ELECTROCARDI OLOGY 204,834 229,666 2,314,658 236,387 2,280 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 184,138 206,462 15,656,559 1,598,942 0 71.00 72.00 07200 IMPLD DEV. CHARGED TO PATI ENTS 173,631 194,680 13,544,991 1,383,296 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 997,873 1,118,846 36,020,787 3,678,659 0 73.00 74.00 07400 RENAL DI ALYSI S 52,866 59,275 2,447,153 249,918 24 74.00 75.00 07700 ALDGENEIC HSCT ACQUI SI TI ON 0 0 0 0 0 77.00 0700 ALDGENEIC HSCT ACQUI SI TI ON 0 0 0 0 77.00 0700 CLERCENCY 516,883 579,545 17,239,126 1,760,563 10,104 91.00 79.00 09000 CLI NI C 99,921 112,035 7,159,924 731,214 216 90.00 79.00 09100 EMERGENCY 516,883 579,545 17,239,126 1,760,563 10,104 91.00 79.00 09100 EMERGENCY 516,883 579,545 17,239,126 1,760,563 10,104 91.00 70 0700 ALDGENEIC HSCLOTHERS 17,352 19,456 2,862,360 292,321 0 101.00 70 00 00 00 00 00 00								
64.00 06400 INTRAVENOUS THERAPY 206, 398 231, 420 5, 557, 319 567, 547 48 65.00 65.00 06500 RESPI RATORY THERAPY 206, 398 231, 420 5, 557, 319 567, 547 48 65.00 67.00 06600 PHYSI CAL THERAPY 36, 767 41, 225 1, 958, 841 200, 049 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 26, 406 29, 607 1, 575, 095 160, 858 0 67.00 68.00 06800 SPEECH PATHOLOGY 12, 922 14, 489 632, 692 64, 614 0 68.00 69.00 06900 ELECTROCARPI OLOGY 126, 909 142, 294 1, 356, 277 138, 511 3, 288 69.00 69.01 06901 CARDI AC REHAB 7, 272 8, 154 592, 235 60, 483 0 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 204, 834 229, 666 2, 314, 658 236, 387 2, 280 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATI ENTS 184, 138 206, 462 15, 656, 559 1, 598, 942 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 173, 631 194, 680 13, 544, 991 1, 383, 296 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 997, 873 1, 118, 846 36, 020, 787 3, 678, 659 0 73.00 74.00 07400 RENAL DI ALYSI S 52, 866 59, 275 2, 447, 153 249, 918 24 74, 00 77.00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 77.00 09000 CLI IN C 09000 CLI NIC CENTERS 101.00 09100 EMERGENCY 17, 352 19, 456 2, 862, 360 292, 321 0 101.00 102.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 0 102.00 00000 DI DI TREATMENT PROGRAM 0 0 0 0 0 102.00 00000 OI DI TREATMENT PROGRAM 0 0 0 0 0 191.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 191.00 191.00 19100 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 191.00 191.00 19100 0 0 0 0 0 191.00 19100 19100 19100 19100 0 0 0 0 191.00 19100			·					
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68.00 06800 SPEECH PATHOLOGY 12, 922 14, 489 632, 692 64, 614 0 68.00 69.00 06900 ELECTROCARDI OLOGY 126, 909 142, 294 1, 356, 277 138, 511 3, 288 69.00 69.01 06901 CARDI AC REHAB 7, 272 8, 154 592, 235 60, 483 0 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 204, 834 229, 666 2, 314, 658 236, 387 2, 280 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 184, 138 206, 462 15, 656, 559 1, 598, 942 0 71.00 72.00 07200 IMPL DEV. CHARGED TO PATIENTS 173, 631 194, 680 13, 544, 991 1, 383, 296 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 997, 873 1, 118, 846 36, 020, 787 3, 678, 659 0 73.00 74.00 07400 RENAL DI ALYSI S 52, 866 59, 275 2, 447, 153 249, 918 24 74.00 77.00 07700 ALLOGENEI C HSCT ACQUISITION 0 0 0 0 0 0000 09100 EMERGENCY 516, 883 579, 545 17, 239, 126 1, 760, 563 10, 104 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 00100 DITRATIMENT PROGRAM 0 0 0 0 0 00200 OP100 DI TREATMENT PROGRAM 0 0 0 0 0 00100 OP100 DITRATIMENT PROGRAM 0 0 0 0 0 0000 OP100 DITRATIMENT PROGRAM 0 0 0 0 0 0000 OP100 DITRATIMENT PROGRAM 0 0 0 0 0 0000 OP100 DITRATIMENT PROGRAM 0 0 0 0 0 0 0000 OP100 DITRATIMENT PROGRAM 0 0 0 0 0 0 0000 OP100 DITRATIMENT PROGRAM 0 0 0 0 0 0 0 0000 OP100 DITRATIMENT PROGRAM 0 0 0 0 0 0 0 0 0000 OP100 DITRATIMENT PROGRAM 0 0 0 0 0 0 0 0 0								
69. 00 06900 ELECTROCARDI OLOGY 126,909 142,294 1,356,277 138,511 3,288 69.00 69.01 06901 CARDI AC REHAB 7,272 8,154 592,235 60,483 0 69.01 07000 ELECTROENCEPHALOGRAPHY 204,834 229,666 2,314,658 2346,387 2,280 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 184,138 206,462 15,656,559 1,598,942 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 173,631 194,680 13,544,991 1,383,296 0 72.00 73.00 DRUGS CHARGED TO PATI ENTS 997,873 1,118,846 36,020,787 3,678,659 0 73.00 73.00 07400 RENAL DI ALYSI S 52,866 59,275 2,447,153 249,918 24 74.00 74.00 07400 RENAL DI ALYSI S 52,866 59,275 2,447,153 249,918 24 74.00 07400 RENAL DI ALYSI S 52,866 59,275 2,447,153 249,918 24 74.00 00 00 00 00 00 00 00								
69. 01 06901 CARDI AC REHAB 7, 272 8, 154 592, 235 60, 483 0 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 204, 834 229, 666 2, 314, 658 236, 387 2, 280 70. 00 71. 00 07000 MEDI CAL SUPPLIES CHARGED TO PATIENTS 184, 138 206, 462 15, 656, 559 1, 598, 942 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 173, 631 194, 680 13, 544, 991 1, 383, 296 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 997, 873 1, 118, 846 36, 020, 787 3, 678, 659 0 73. 00 07400 RENAL DI ALYSIS 52, 866 59, 275 2, 447, 153 249, 918 24 74. 00 07400 RENAL DI ALYSIS 52, 866 59, 275 2, 447, 153 249, 918 24 74. 00 07700 ALLOGENEIC HSCT ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						·		
70. 00 07000 ELECTROENCEPHALOGRAPHY 204, 834 229, 666 2, 314, 658 236, 387 2, 280 70. 00 71. 00 71. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 184, 138 206, 462 15, 656, 559 1, 598, 942 0 71. 00 72. 00 72. 00 1 MPL. DEV. CHARGED TO PATI ENTS 173, 631 194, 680 13, 544, 991 1, 383, 296 0 72. 00 73. 00 73. 00 073. 00 DRUGS CHARGED TO PATI ENTS 997, 873 1, 118, 846 36, 020, 787 3, 678, 659 0 73. 00 74. 00 07400 RENAL DI ALYSI S 52, 866 59, 275 2, 447, 153 249, 918 24 74. 00 074. 00 07400 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS				1 1				
73. 00 07300 DRUGS CHARGED TO PATIENTS 997, 873 1, 118, 846 36, 020, 787 3, 678, 659 0 73. 00 74. 00 07400 RENAL DI ALYSIS 52, 866 59, 275 2, 447, 153 249, 918 24 74. 00 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 0 0 0								
74. 00	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	173, 631	194, 680	13, 544, 991	1, 383, 296	0	72.00
77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 0 0 0								
OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 99, 921 112, 035 7, 159, 924 731, 214 216 90. 00 91. 00 09100 EMERGENCY 516, 883 579, 545 17, 239, 126 1, 760, 563 10, 104 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 92. 00 00				1		•		
90. 00 09000 CLINIC 99, 921 112, 035 7, 159, 924 731, 214 216 90. 00 91. 00 09100 EMERGENCY 516, 883 579, 545 17, 239, 126 1, 760, 563 10, 104 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0	77.00		0	0	0	0	1 0	//.00
91. 00 09100 EMERGENCY 516, 883 579, 545 17, 239, 126 1, 760, 563 10, 104 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 92. 00 0 0 0 0 0 0 0 0 0	90 00		99 921	112 035	7 159 924	731 214	216	90 00
OTHER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 17, 352 19, 456 2, 862, 360 292, 321 0 101. 00 102. 00 102.00 OTHER O						·		
101. 00 10100 HOME HEALTH AGENCY 17, 352 19, 456 2, 862, 360 292, 321 0 101. 00 102. 00 10200 OPI 0I D TREATMENT PROGRAM 0 0 0 0 0 102. 00 102. 00 SPECI AL PURPOSE COST CENTERS								
102. 00 10200 OPI 0I D TREATMENT PROGRAM O O O O 102. 00								
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 7,142,077 8,007,513 350,506,382 32,140,922 701,225 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 21,979 2,245 0 190.00 191.00 19100 RESEARCH 0 0 0 0 0 191.00 1								
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 7,142,077 8,007,513 350,506,382 32,140,922 701,225 118. 00	102. 00		0] 0	0	0	0	102.00
NONREI MBURSABLE COST CENTERS 0 21,979 2,245 0 190.00 191.00 19100 RESEARCH 0 0 0 0 0 191.00	118 00		7 142 077	8 007 512	350 506 392	32 140 022	701 225	118 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 21,979 2,245 0 190. 00 191. 00 191. 00 0 0 0 191. 00	110.00	9 /	7, 142, 077	0,007,515	330, 300, 302	32, 140, 722	701, 225	1110.00
191. 00 19100 RESEARCH 0 0 0 0 191. 00	190.00		0	0	21, 979	2, 245	0	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 35, 062, 911 3, 580, 835 0 192. 00	191. 00	19100 RESEARCH	0	0	0	0	0	191. 00
	192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	35, 062, 911	3, 580, 835	0	192.00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0002	Period: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared

						5/25/2023 12:	46 pm
Co	ost 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. 01 19201 0	THER NON-REIMBURSABLE	0	0	397, 184	40, 563	0	192. 01
192. 02 19202 F	AMILY HEALTH/GARY COMM HEALTH	0	0	221, 298	22, 600	0	192. 02
193. 00 19300 N	ONPALD WORKERS	0	0	0	0	0	193.00
200. 00 C	ross Foot Adjustments			0			200.00
201. 00 N	egative Cost Centers	0	0	0	0	0	201.00
202. 00 To	OTAL (sum lines 118 through 201)	7, 142, 077	8, 007, 513	386, 209, 754	35, 787, 165	701, 225	202. 00

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 01/01/2022 Part I | To 12/31/2022 Date/Time Prepared: 5/25/2023 12:46 pm

					12/51/2022	5/25/2023 12:	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		7. 00	LINEN SERVICE	9.00	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	00570 ADMITTING						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	20 424 521					5.06
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	28, 434, 531 534, 403	2 000 E12				7. 00 8. 00
9. 00	00900 HOUSEKEEPING	618, 648	2, 088, 513 0	1			9.00
10.00		565, 073	0		6, 232, 908		10.00
11. 00	1 I	395, 053	0		0, 202, 700		
13. 00	1 I	190, 376	0		0	101, 467	
14.00	1 I	1, 074, 591	2, 382		0	53, 598	
15.00	01500 PHARMACY	568, 340	0	165, 191	0	0	15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	338, 990	0	98, 529	0	126, 832	16.00
17. 00	l	48, 838	0		0	0	17. 00
17. 01	l	334, 193	0	,	0	0	
17. 02	l	11, 213	0		0	0	17. 02
21. 00	l	0	0	-	0	0	21.00
22. 00		133, 923	0		0	0	22.00
23. 00		100, 854	0	29, 314	0	41, 520	23.00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	9, 390, 403	960, 584	2, 729, 373	5, 032, 333	854, 186	30.00
31. 00		595, 533	147, 091	173, 095	224, 855	194, 637	
31. 00	1 I	67, 696	147, 091		224, 655 N	47, 473	
40. 00	1 I	119, 083	0		87, 231	33, 231	1
41. 00	1 I	936, 681	54, 872		251, 480		1
43. 00	1 I	732, 244	26, 806		201, 100		1
	ANCILLARY SERVICE COST CENTERS		==, ===			21,	1
50.00		1, 788, 247	214, 707	519, 764	0	187, 668	50.00
50. 01	05001 ENDOSCOPY	o	28, 841	0	0	23, 088	50. 01
51.00		436, 096	13, 381	126, 754	1, 857	28, 983	51.00
52.00	ł I	209, 953	51, 747		137, 787	128, 305	
53.00	ł I	0	0	0	0	0	53.00
54. 00		1, 590, 736	43, 901		0	108, 650	
54. 01		151, 521	22, 443		0	52, 061	
55.00	· · · · · · · · · · · · · · · · · · ·	233, 878	12, 166		0	16, 933	
55. 01	· · · · · · · · · · · · · · · · · · ·	170, 409	12 122	,	0		
56.00	ł ł	271, 114	13, 133		0	22, 627	1
57. 00 58. 00		256, 723 126, 068	26, 240 10, 935		0	49, 785 21, 309	1
59. 00		251, 626	46, 393		0	78, 118	
60.00	ł ł	705, 082	40, 373		0	177, 315	
62. 00	1	11, 542	0		0	86, 894	
64. 00		0	0		0		
65. 00	1	232, 829	0	67, 673	0		
66.00	1	367, 861	0		0	48, 920	
67.00	06700 OCCUPATI ONAL THERAPY	316, 144	0	91, 889	0	38, 477	67.00
68. 00	06800 SPEECH PATHOLOGY	53, 845	0	15, 650	0	15, 443	68.00
69. 00	06900 ELECTROCARDI OLOGY	o	3, 668	0	0	35, 911	69.00
69. 01		0	1, 105	0	0	17, 890	69. 01
70.00	1	0	21, 103	0	0	47, 115	1
71. 00		0	0	0	0	0	71.00
72. 00		0	0	0	0	0	72.00
73. 00	· · · · · · · · · · · · · · · · · · ·	49, 828	0	14, 483	0	12, 758	
74.00		131, 405	16, 419		0	49	
77. 00		0	0	0	0	0	77.00
00 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	2 202 045	E1 147	((2.041	0	10/ 00/	00 00
90. 00 91. 00		2, 283, 945	51, 147 319, 449		407 24E	106, 096	90.00
91.00	1 I	811, 362	319, 449	235, 827	497, 365	267, 014	91.00
7Z. UU	OTHER REIMBURSABLE COST CENTERS						72.00
101 0	0 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
	0 10200 OPI OI D TREATMENT PROGRAM	Ö	0	I I	0		102.00
. 52. 0	SPECIAL PURPOSE COST CENTERS		0		<u> </u>		1
118. 0		27, 206, 349	2, 088, 513	7, 572, 535	6, 232, 908	3, 249, 519	118.00
	NONREI MBURSABLE COST CENTERS						1
190. 0	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	53, 995	0	15, 694	0		190. 00
	0 19100 RESEARCH	0	0	0	0		191. 00
	0 19200 PHYSICIANS' PRIVATE OFFICES	800, 809	0		0		192. 00
192. 0	1 19201 OTHER NON-REIMBURSABLE	103, 643	0	30, 124	0	0	192. 01
				<u></u>			

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: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared: 5/25/2023 12:46 pm		

						5/25/2023 12:	46 pm
	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. 02 1920	FAMILY HEALTH/GARY COMM HEALTH	269, 735	0	78, 400	0	0	192.02
193. 00 1930	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)	28, 434, 531	2, 088, 513	7, 929, 513	6, 232, 908	3, 249, 519	202.00

| Peri od: | Worksheet B | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared:

			10	12/31/2022	Date/lime Pre 5/25/2023 12:	
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	
GENERAL SERVICE COST CENTERS 1. 00 00100 CAP REL COSTS-BLDG & FLXT						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						5. 03
5. 04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 04
5. 05 00590 OTHER A&G 5. 06 00592 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 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	4 420 202					11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	6, 638, 383	5, 520, 201				14.00
15. 00 01500 PHARMACY		0, 320, 201	7, 134, 465			15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	O	0	0	4, 154, 378		16.00
17.00 01700 SOCIAL SERVICE	0	0	0	0	650, 171	17.00
17. 01 01701 STAFF EDUCATION	0	0	0	0	0	17. 01
17. 02 01702 MEDICAL EDUCATION 21. 00 02100 L&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	O O	0	17. 02 21. 00
22. 00 02200 &R SERVICES-OTHER PRGM COSTS APPRVD		0	0	0	0	22.00
23. 00 02300 PARAMED ED PROGRAM	144, 000	Ö	Ö	Ö	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	2, 962, 521	0	0	291, 735	594, 442	30.00
31. 00 03100 INTENSIVE CARE UNIT 31. 01 03101 NEONATAL ICU	675, 047 164, 649	0	0	57, 991 12, 790	0	31. 00 31. 01
31. 01 03101 NEONATAL I CU 40. 00 04000 SUBPROVI DER	115, 254	0	0	6, 577	0	40.00
41. 00 04100 SUBPROVI DER - I RF	205, 791	Ö	Ö	10, 405	37, 153	41. 00
43. 00 04300 NURSERY	136, 921	0	0	5, 622	0	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	650, 878	0	0	461, 411	0	50.00
50. 01 05001 ENDOSCOPY 51. 00 05100 RECOVERY ROOM	80, 075 100, 522	0	0	30, 627 31, 567	0	50. 01 51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	444, 992	0	0	14, 987	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	Ö	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	0	115, 448	0	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	0	0	0	66, 398	0	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	69, 971	0	55.00
55. 01 05501 I NFUSI ON CENTER 56. 00 05600 RADI OI SOTOPE	0	0	0	50, 983 49, 895	0	55. 01 56. 00
57. 00 05700 CT SCAN		0	0	388, 414	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	Ö	0	Ō	84, 816	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	189, 856	0	59.00
60. 00 06000 LABORATORY	0	0	389, 046	601, 971	0	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	63, 290	0	62.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0	0	0	120, 052	0	64. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY		0	0	21, 386	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	Ö	0	Ō	15, 359	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0	0	0	7, 516	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	73, 817	0	69. 00
69. 01 06901 CARDI AC REHAB	0	0	0	4, 230	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		2, 962, 849	0	119, 142 107, 105	0	70. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		2, 557, 352	0	100, 993	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	Ö	0	6, 703, 217	580, 415	0	73. 00
74.00 07400 RENAL DIALYSIS	170	0	0	30, 750	0	74.00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS	21 402	0		EQ 120	0	00.00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	31, 493 926, 070	0	0	58, 120 300, 646	0 18, 576	90. 00 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	720,070	Ŭ	J	300, 040	10, 370	92. 00
OTHER REIMBURSABLE COST CENTERS						72.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	10, 093	0	101. 00
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS	4 420 202	E E20 201	7 000 070	A 1E4 070	/EO 171	110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117 NONREIMBURSABLE COST CENTERS) 6, 638, 383	5, 520, 201	7, 092, 263	4, 154, 378	650, 171	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	n	n	n	Ω	190. 00
191. 00 19100 RESEARCH	o o	ő	Ö	Ö	0	191. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	42, 202	o	0	192. 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 01/01/2022 To 12/31/2022	Worksheet B Part I Date/Time Prepared: 5/25/2023 12:46 pm		

						<u> 5/25/2023_12:</u>	46 pm
	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. 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)	6, 638, 383	5, 520, 201	7, 134, 465	4, 154, 378	650, 171	202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2022 | Part | | To 12/31/2022 | Date/Time Prepared: | 5/25/2023 12: 46 pm

			LAITEDNC 0	DECLIDENTS	5/25/2023 12:	46 pm
			INTERNS &	KESI DEN IS		
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	
GENERAL SERVICE COST CENTERS			T			1 00
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 00550 DATA PROCESSING 5. 02 00560 PURCHASING RECEIVING AND STORES						5. 01 5. 02
5. 03 00570 ADMITTING RECEIVING AND STOKES						5. 02
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 OO700 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 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON						11.00
14. 00 01400 CENTRAL SERVICES & SUPPLY						13. 00 14. 00
15. 00 01500 PHARMACY						15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY						16. 00
17. 00 01700 SOCIAL SERVICE						17. 00
17. 01 01701 STAFF EDUCATION	581, 259					17. 01
17.02 01702 MEDICAL EDUCATION	0	70, 299				17. 02
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	271, 065			21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0		267, 281		22. 00
23. 00 02300 PARAMED ED PROGRAM	947	0			1, 198, 760	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	450.004		1		40.077	00.00
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT	152, 901	0		0	49, 277	30.00
31. 00 03100 INTENSI VE CARE UNI T 31. 01 03101 NEONATAL CU	52, 476 13, 713	0		0	0	31. 00 31. 01
40. 00 04000 SUBPROVI DER - 1 PF	710	0		0	0	40.00
41. 00 04100 SUBPROVI DER - RF	11, 498	0		0	0	41.00
43. 00 04300 NURSERY	14, 922	0		· ·	0	43. 00
ANCILLARY SERVICE COST CENTERS				- 1		
50. 00 05000 OPERATING ROOM	72, 792	0	0	0	49, 277	50.00
50. 01 05001 ENDOSCOPY	8, 792	0	0	0	0	50. 01
51.00 05100 RECOVERY ROOM	6, 823	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	59, 527	0	0	0	49, 277	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	4, 083	0		_	0	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND 55. 00 05500 RADI OLOGY-THERAPEUTI C	4, 633	0		_	0	54. 01 55. 00
55. 00 05500 RADI OLOGI - THERAPEUTI C 55. 01 05501 INFUSI ON CENTER	837 8	0		0	0	55. 00
56. 00 05600 RADI 0I SOTOPE	169	0	0	0	0	56.00
57. 00 05700 CT SCAN	7, 761	0	0	Ö	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	110	0	Ö	O	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	20, 536	0	0	0	24, 639	59. 00
60. 00 06000 LABORATORY	423	0	0	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 649	0	0	0	0	62.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	11, 405	0	0	0	73, 916	65.00
66. 00 06600 PHYSI CAL THERAPY	761	0	0	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	575	0	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	364 2, 714	0		0	0	68. 00 69. 00
69. 01 06900 ELECTROCARDI OLOGI 69. 01 06901 CARDI AC REHAB	51	0	0	0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 249	0	0	o	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,217	0	0	Ö	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	7, 567	0	0	0	0	73. 00
74. 00 07400 RENAL DI ALYSI S	271	0	0	0	0	74.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	2, 832	0		_	0	90.00
91. 00 09100 EMERGENCY	90, 825	70, 299	271, 065	267, 281	952, 374	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY	10, 661	0	0	O	0	101. 00
102. 00 10200 OPI OI D TREATMENT PROGRAM	10, 001	0	•	l .		101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>	0		<u> </u>		. 52. 55
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	565, 585	70, 299	271, 065	267, 281	1, 198, 760	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	15, 649	0				190. 00
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002 | Period: From 01/01/2022 | Part I | To 12/31/2022 | To 12/31/2022 | Period: From 01/01/2022 | Period: From 0

					5/25/2023 12:	46 pm
			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	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	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	25	0	0	0	0	192. 02
193.00 19300 NONPALD WORKERS	o	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) 581, 259	70, 299	271, 065	267, 281	1, 198, 760	202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: Provider CCN: 15-0002

					Т	o 12/31/2022 Date/Time Pr 5/25/2023 12	
		Cost Center Description	Subtotal	Intern &	Total		
				Residents Cost & Post			
				Stepdown			
				Adjustments			
	GENER	AL 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		DATA PROCESSING					5. 01
5. 02 5. 03	1	PURCHASING RECEIVING AND STORES ADMITTING					5. 02 5. 03
5. 04		CASHI ERI NG/ACCOUNTS RECEI VABLE					5. 04
5. 05		OTHER A&G					5. 05
5. 06 7. 00	4	PATIENT TRANSPORTATION OPERATION OF PLANT					5. 06 7. 00
8. 00	1	LAUNDRY & LINEN SERVICE					8.00
9. 00		HOUSEKEEPI NG					9.00
10.00		DIETARY					10.00
11. 00 13. 00	1	CAFETERIA NURSING ADMINISTRATION					11. 00 13. 00
14. 00	1	CENTRAL SERVICES & SUPPLY					14.00
15.00		PHARMACY					15.00
16.00	1	MEDICAL RECORDS & LIBRARY					16.00
17. 00 17. 01		SOCIAL SERVICE STAFF EDUCATION					17. 00 17. 01
17. 01		MEDICAL EDUCATION					17. 01
21. 00	1	I&R SERVICES-SALARY & FRINGES APPRVD					21.00
22.00		I&R SERVICES-OTHER PRGM COSTS APPRVD					22.00
23. 00		PARAMED ED PROGRAM TENT ROUTINE SERVICE COST CENTERS					23. 00
30. 00		ADULTS & PEDIATRICS	86, 914, 608	0	86, 914, 608		30.00
31.00	1	INTENSIVE CARE UNIT	14, 983, 553	0	14, 983, 553		31.00
31. 01		NEONATAL I CU	2, 542, 621	0	2, 542, 621		31. 01
40. 00 41. 00	1	SUBPROVI DER - I PF SUBPROVI DER - I RF	1, 765, 771 4, 811, 601	0	1, 765, 771 4, 811, 601		40. 00 41. 00
43. 00	1	NURSERY	3, 694, 523	0			43.00
		LARY SERVICE COST CENTERS					
50. 00 50. 01	1	OPERATING ROOM ENDOSCOPY	19, 937, 495 1, 789, 789	0			50. 00 50. 01
51. 00		RECOVERY ROOM	2, 541, 453	0			51.00
52.00		DELIVERY ROOM & LABOR ROOM	7, 257, 576	0	7, 257, 576		52.00
53.00		ANESTHESI OLOGY	0	0	0		53.00
54. 00 54. 01		RADI OLOGY-DI AGNOSTI C RADI OLOGY - ULTRASOUND	8, 897, 870 3, 134, 486		8, 897, 870 3, 134, 486		54. 00 54. 01
55. 00		RADI OLOGY-THERAPEUTI C	3, 443, 579		3, 134, 480		55.00
55. 01	1	INFUSION CENTER	1, 374, 125	0			55. 01
56.00	1	RADI OI SOTOPE	3, 122, 218		3, 122, 218		56.00
57. 00 58. 00	1	CT SCAN MAGNETIC RESONANCE IMAGING (MRI)	5, 342, 939 1, 973, 990				57. 00 58. 00
59.00		CARDIAC CATHETERIZATION	5, 847, 986	0	5, 847, 986		59.00
60.00	06000	LABORATORY	19, 709, 912	0	19, 709, 912		60.00
62.00		WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 469, 637	0	2, 469, 637		62.00
64. 00 65. 00	1	I NTRAVENOUS THERAPY RESPI RATORY THERAPY	0 6, 738, 635	0	6, 738, 635		64. 00 65. 00
66.00		PHYSI CAL THERAPY	2, 704, 739		2, 704, 739		66.00
67.00		OCCUPATI ONAL THERAPY	2, 198, 397	0	2, 198, 397		67.00
68.00		SPEECH PATHOLOGY	790, 124		790, 124		68.00
69. 00 69. 01		ELECTROCARDI OLOGY CARDI AC REHAB	1, 614, 186 675, 994		1, 614, 186 675, 994		69. 00 69. 01
70. 00		ELECTROENCEPHALOGRAPHY	2, 742, 934	Ö	2, 742, 934		70.00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	20, 325, 455		20, 325, 455		71.00
72.00		IMPL. DEV. CHARGED TO PATIENTS	17, 586, 632		17, 586, 632		72.00
73. 00 74. 00		DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	47, 067, 714 2, 914, 352		47, 067, 714 2, 914, 352		73. 00 74. 00
		ALLOGENEIC HSCT ACQUISITION	0				77. 00
		TIENT SERVICE COST CENTERS	11 000 000		44 000 000		
90. 00 91. 00		CLINIC EMERGENCY	11, 088, 828 24, 037, 946				90. 00 91. 00
91.00		OBSERVATION BEDS (NON-DISTINCT PART)	24, 037, 940	-538, 346 0			91.00
		REIMBURSABLE COST CENTERS					
		HOME HEALTH AGENCY	3, 175, 435				101.00
102.00		OPIOID TREATMENT PROGRAM AL PURPOSE COST CENTERS	0	0	0		102.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	345, 217, 103	-538, 346	344, 678, 757		118.00
	NONRE	IMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	109, 562	0	109, 562		190. 00

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider Co	CN: 15-0002	Peri od: From 01/01/2022 To 12/31/2022	Worksheet B Part I Date/Time Prepared: 5/25/2023 12:46 pm
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown	Total		

	0001 000. 2000	oub to tu.			
	·		Resi dents		
			Cost & Post		
			Stepdown		
			Adjustments		
		24. 00	25. 00	26.00	
191.00 19100	RESEARCH	0	0	0	191. 00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	39, 719, 517	0	39, 719, 517	192. 00
192. 01 19201	OTHER NON-REIMBURSABLE	571, 514	0	571, 514	192. 01
192. 02 19202	FAMILY HEALTH/GARY COMM HEALTH	592, 058	0	592, 058	192. 02
193.00 19300	NONPALD WORKERS	0	0	0	193. 00
200.00	Cross Foot Adjustments	0	o	0	200.00
201.00	Negative Cost Centers	0	o	0	201.00
202.00	TOTAL (sum lines 118 through 201)	386, 209, 754	-538, 346	385, 671, 408	202.00
				•	·

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0002

					To	12/31/2022	Date/Time Pre 5/25/2023 12:	
				CAPI TAL			072072020 12.	ГО ріп
				RELATED COSTS				
		Cost Center Description	Directly	BLDG & FIXT	Subtotal	EMPLOYEE	DATA	
			Assigned New Capital			BENEFITS DEPARTMENT	PROCESSI NG	
			Related Costs			DEPARTMENT		
			0	1.00	2A	4. 00	5. 01	
	GENER	AL SERVICE COST CENTERS						
1.00		CAP REL COSTS-BLDG & FIXT						1. 00
4. 00		EMPLOYEE BENEFITS DEPARTMENT	0	72, 077		72, 077		4.00
5. 01	1	DATA PROCESSING	0	112, 155		2, 073	114, 228	5. 01
5. 02 5. 03		PURCHASING RECEIVING AND STORES ADMITTING	0	89, 480 118, 586		472 2, 374	0	5. 02 5. 03
5. 03		CASHI ERI NG/ACCOUNTS RECEI VABLE	0	374, 004		2, 374 1, 096	0	5.03
5. 05	1	OTHER A&G	0	1, 215, 262		3, 940	114, 228	5. 05
5.06	1	PATIENT TRANSPORTATION	0	0		243	0	5.06
7.00	00700	OPERATION OF PLANT	0	3, 653, 010	3, 653, 010	2, 407	0	7. 00
8.00	1	LAUNDRY & LINEN SERVICE	0	217, 536		0	0	8. 00
9.00		HOUSEKEEPI NG	0	251, 829		2, 196	0	9. 00
10.00		DIETARY	0	230, 021		1, 117	0	10.00
11. 00 13. 00		CAFETERIA NURSING ADMINISTRATION	0	160, 812 77, 495		736 1, 831	0	11. 00 13. 00
14. 00		CENTRAL SERVICES & SUPPLY	0	437, 428		353	0	14.00
15. 00		PHARMACY	0	231, 351		0	0	15. 00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	137, 991		1, 033	0	16.00
17. 00	01700	SOCIAL SERVICE	0	19, 880	19, 880	209	0	17.00
17. 01		STAFF EDUCATION	0	136, 038		0	0	17. 01
17. 02	1	MEDICAL EDUCATION	0	4, 564		0	0	17. 02
21. 00 22. 00		I &R SERVICES-SALARY & FRINGES APPRVD	0	0	-	0	0	21.00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PROGRAM	0	54, 515 41, 054		351	0	22. 00 23. 00
23.00		TENT ROUTINE SERVICE COST CENTERS	0	41,034	41,034	331	0	23.00
30.00		ADULTS & PEDIATRICS	0	3, 822, 501	3, 822, 501	11, 341	0	30. 00
31.00	03100	INTENSIVE CARE UNIT	0	242, 420	242, 420	3, 243	0	31.00
31. 01		NEONATAL I CU	0	27, 557		728	0	31. 01
40. 00	1	SUBPROVI DER - I PF	0	48, 474		445	0	40.00
41. 00 43. 00	1	SUBPROVI DER	0	381, 289 298, 070		812 684	0	41. 00 43. 00
43.00		LARY SERVICE COST CENTERS	0	290,070	290,070	004	0	43.00
50.00		OPERATING ROOM	0	727, 932	727, 932	2, 332	0	50.00
50. 01		ENDOSCOPY	0	0	0	337	0	50. 01
51.00		RECOVERY ROOM	0	177, 519		474	0	51.00
52.00		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	0	85, 465 0		1, 800 0	0	52. 00 53. 00
53. 00 54. 00		RADI OLOGY-DI AGNOSTI C	0	647, 532	-	1, 107	0	54.00
54. 01		RADI OLOGY - ULTRASOUND	0	61, 679		673	0	54. 01
55.00		RADI OLOGY-THERAPEUTI C	0	95, 203		210	0	55.00
55. 01		INFUSION CENTER	0	69, 368	69, 368	180	0	55. 01
56. 00	1	RADI OI SOTOPE	0	110, 361		350	0	56.00
57.00		CT SCAN	0	104, 503		601	0	57.00
58. 00 59. 00		MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION	0	51, 318 102, 428		249 1, 223	0	
60.00	1	LABORATORY	0	287, 014		1, 916	0	60.00
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELLS	0	4, 699		610	0	62.00
64.00	06400	I NTRAVENOUS THERAPY	0	0	0	o	0	64.00
65.00		RESPI RATORY THERAPY	0	94, 776		1, 265	0	65.00
66.00		PHYSI CAL THERAPY	0	149, 743		660	0	66.00
67. 00 68. 00	1	OCCUPATI ONAL THERAPY SPEECH PATHOLOGY	0	128, 691		527 219	0	67. 00 68. 00
69.00		ELECTROCARDI OLOGY	0	21, 918	21, 918	369	0	69.00
69. 01	1	CARDI AC REHAB	0	ĺ	0	205	0	69. 01
70. 00		ELECTROENCEPHALOGRAPHY	0	0	0	599	0	70.00
		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72. 00	1	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
		DRUGS CHARGED TO PATIENTS	0	20, 283		190	0	73.00
		RENAL DIALYSIS ALLOGENEIC HSCT ACQUISITION	0	53, 490 0		0	0	74. 00 77. 00
77.00		TIENT SERVICE COST CENTERS				U	0	, , , . 00
90.00		CLINIC	0	929, 713	929, 713	1, 447	0	90.00
91.00	09100	EMERGENCY	0	330, 277		3, 728	0	91.00
92.00		OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
101 00		REIMBURSABLE COST CENTERS	_	^		1 005	^	101 00
		HOME HEALTH AGENCY OPIOID TREATMENT PROGRAM	0			1, 005 0		101. 00 102. 00
. 52. 00	SPECI	AL PURPOSE COST CENTERS				<u> </u>		. 52. 50
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	16, 709, 311	16, 709, 311	59, 960	114, 228	118. 00

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider Co		Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Pre 5/25/2023 12:	
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	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	21, 979	21, 97	9 0	0	190.00
191. 00 19100 RESEARCH	0	0		0 0		191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	325, 981	325, 98	1 12, 072	0	192.00
192. 01 19201 OTHER NON-REIMBURSABLE	0	42, 189	42, 18	9 0	0	192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	0	109, 799	109, 79	9 45	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		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	17, 209, 259	17, 209, 25	9 72, 077	114, 228	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 01/01/2022 Part II
To 12/31/2022 Date/Time Prepared: 5/25/2023 12:46 pm

Control Property Control Pro						12,01,2022	5/25/2023 12:	
DITECT STORTS S		Cost Center Description		ADMITTI NG		OTHER A&G		
BIRDIAL STRUCT SET TIMPTERS 5.02 5.03 5.04 5.05 5.06								
CHINNEL SERVICE CREAT ENTITIES				5. 03		5. 05		
0.000 DEPLOYEE DEPLY ITS DEPAYMENT 0.000 0.00		GENERAL SERVICE COST CENTERS	2.02				2.22	
5. 01 DOSSIGNATA PROCESSING								1.00
5.02 0.0560 NIRCHARING RECEIVING AMD STORES 89,950		1						1
5.03 0.0570 ADMITTING		1	00.050					1
5.04 0.0580 CASH IERNIK JACOUNTS RECEIVABLE 19		1	1	101 070				1
0.000 0.07HER ABC 0.0000 0.0000 0.000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000		1	1					1
5.06 0.0502 ATT IENT TRANSPORTATION		1	1	-		1 333 430		1
0.00 00700 0.0700 0.0FEATT 0.00 0 0 0 0 0 0 0 0			1		1			ı
0.00 00000 LANDRIFY & LINEN SERVICE 0 0 0 5,365 0 8.00 0.00 00000 DOUGNEEKEP M 1,444 6 0 19,001 0.00		1	1 1	-	_			1
10.00 01000 DETARY		1	1	0	0			1
11.00 0 1100 (CAFTERIA	9.00	00900 HOUSEKEEPI NG	799	0	0	25, 240	0	9. 00
13.00 01300 MIRST NAT ADMINISTRATION 977 0 0 1.7.700 1.1.00			1, 434		-		1	1
14.00 01400 (FRITEAL SERVICES & SUPPLY 1.743 0 0 14,077 0 14.00 16.00 16.00 01400 PIRRAILCY 254 0 0 22.099 0 15.00 16.00 01400 PIRRAILCY 13 0 0 0 12.304 0 14.00 17.00 17.00 01700 SIZE SERVICES 0 0 0 0 0 12.304 0 14.00 17.00 17.00 01700 SIZE SIZE SERVICES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			2		- 1			
15.00 01500 PIANAMACY 254 0 0 22,099 0 15.00 17.00 01700 DETOLAL RECORDS & LIBRARY 13 3 0 0 12,094 0 16.00 17.00 01700 SOCIAL SERVICE 0 0 0 0 0 0 2,027 0 17.00 17.00 01701 STAFF EDUCATION 0 0 0 0 0 0 518 0 17.01 17.00 01701 STAFF EDUCATION 0 0 0 0 0 0 193 0 17.00 17.00 01701 STAFF EDUCATION 0 0 0 0 0 193 0 17.00 17.00 01701 STAFF EDUCATION 0 0 0 0 0 0 193 0 17.00 17.00 01701 STAFF EDUCATION 0 0 0 0 0 0 0 930 0 21.00 18.00 02300 PARAMED ED PROGRAM 0 0 0 0 0 0 3,045 0 22.00 18.00 03000 ADULTS & PEDIATRIC STAFF PROGRAM 0 0 0 0 0 0 3,045 0 22.00 18.00 03000 ADULTS & PEDIATRIC STAFF PROGRAM 0 0 0 0 0 0 3,045 0 29.00 18.00 03000 O18MENSIVE CASE UNIT 1 1,598 1 687 5,233 21,154 7,653 0 31.01 18.00 03000 O18MENSIVE CASE UNIT 1 1,598 1 687 5,233 21,154 7,653 0 31.01 18.00 03000 O18MENSIVE CASE UNIT 1 1,598 1 687 5,233 37.01 1 1,41 0 0 41.00 18.00 03000 O18MENSIVE CASE UNIT 1 1,598 1 687 7,633 0 31.01 18.00 03000 O18MENSIVE CASE UNIT 1 1,598 1 1,598 1 1,598 1 1,598 18.00 03000 O18MENSIVE CASE UNIT 1 1,598 1 1,598 1 1,598 1 1,598 1 1,598 18.00 03000 O18MENSIVE CASE UNIT 1 1,598			1				1	•
10.00 01-000 MEDICAL RECORDS & LIBRARY 13 0 0 12, 394 0 10 00 17.00 1700 0700 SIGAL EXERVICE 0 0 0 0 0 0 0 0 17.01 17.01 17.00 1700 0700 SIGAL EXERVICE 0 0 0 0 0 0 0 0 138 0 17.01 17.01 17.02 1702 MEDICAL RECORDS 0 0 0 0 0 0 0 0 0			1				1	1
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17.0 01701 STAFF EDUCATION 0 0 0 0 0 18 0 17.0 17.0 21.0 0 02.0 02.0 02200 02200 02800 087 SERVICES-SALARY & FRINGES APPRYD 0 0 0 0 0 32.6 022.0 02200 02800 087 SERVICES-SOLARY & FRINGES APPRYD 0 0 0 0 0 32.6 022.0 02200 02200 087 SERVICES-SOLARY & FRINGES APPRYD 0 0 0 0 0 32.6 022.0 022.0 02200 02800 087 SERVICES-SOLARY & FRINGES APPRYD 0 0 0 0 0 32.6 022.0		1	1		-		1	•
17.0 201700 MEDICAL EDUCATION S			1		-		-	•
21.00			1 1		1			•
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INPATI ENT ROUTH NE SERVICE COST CENTERS 4, 673	22. 00		o	0	0	326	0	22. 00
30.00	23.00	02300 PARAMED ED PROGRAM	6	0	0	3, 045	0	23. 00
33. 00 03100 INTERSIVE CARE UNIT 1,588 1,687 5,233 44,400 8 31.00 31.01 31.01 31.01 31.01 31.01 32.01 80.000 1,000								
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40.00 04000 04000 SUBPROVI DER - IPF 1 191 593 4 , 727 0 40.00 43.00 04300 04300 SUBPROVI DER - IRF 128 303 939 10, 251 11 41, 04 04.00 43			1				•	1
41.00 04100 SUBROVI DER - 1 IRF 128 303 939 10,251 11 41,00		1	33				•	1
ABOON DATESPENT COST CENTERS SOT B, 720 D 43, 00		1	120				1	1
ANCIL LARY SERVICE COST CENTERS		1						1
50.00 0500	43.00		270	100	307	0, 720		1 43.00
SOOI	50. 00		2, 745	13, 419	41, 634	55, 214	0	50.00
S2.00 05200 DELIVERY ROOM & LABOR ROOM 323 436 1, 352 21, 029 33 32 00 53.00 05300 NESTHESE DUCY 0 0 0 0 0 0 0 53.00 05300 NESTHESE DUCY 0 0 0 0 0 0 0 0 53.00 05300 NESTHESE DUCY 0 0 0 0 0 0 0 0 0 53.00 05300 NESTHESE DUCY 0 0 0 0 0 0 0 0 0 0 53.00 054.01 05401 RADIOLOGY - DI AGROSTIC 243 3,358 10,417 22,543 164 54.00 34.01 05401 RADIOLOGY - ULTRASOUND 229 1,931 5,991 9,343 332 54.01 05501 RADIOLOGY - THERAPEUTIC 44 2,035 6,314 10,479 25 55.01 05501 RADIOLOGY - THERAPEUTIC 44 2,035 6,314 10,479 25 55.01 05501 RADIOLOGY - THERAPEUTIC 44 2,035 6,314 10,479 25 55.01 05501 RADIOLOGY - THERAPEUTIC 44 2,035 6,314 10,479 25 55.01 10,5501	50. 01	1	1				67	50. 01
53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 0 0	51.00	05100 RECOVERY ROOM	0	918	2, 848	6, 199	0	51.00
54.00 05400 RADI OLOGY-DI ACNOSTIC 243 3,35E 10,417 22,543 164 54.00			323	436	1, 352	21, 029	33	•
54.01 05401 RADI OLOGY - JULTRASQUND 229 1, 931 5, 991 9, 343 332 54. 01 55. 00 05500 RADI DLOGY - THERAPEUTI C 44 2, 035 6, 314 10, 479 25 55. 00 55. 01 05501 INFUSION CENTER 278 1, 483 4, 600 3, 745 0 55. 01 56. 00 05500 RADI DLOGY - JULTRASQUARD 1, 659 1, 481 4, 502 9, 137 152 56. 00 57. 00 05700 CT SCAN 55. 01 55. 01 4, 502 9, 137 152 56. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 655 5, 522 17, 131 17, 736 100 59. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 652 5, 522 17, 131 17, 736 100 59. 00 60. 00 06000 LABORATORY 8, 972 17, 754 54, 580 60, 870 0 60. 00 60. 00 06000 LABORATORY 1, 676 3, 491 10, 832 21, 146 60. 62. 00 60. 00 06000 PHYSI CAL THERAPY 16 6622 1, 930 7, 453 0 66. 00 60. 00 06600 PHYSI CAL THERAPY 16 6622 1, 930 7, 453 0 67. 00 60. 00 06000 PHYSI CAL THERAPY 14 219 678 2, 407 0 68. 00 60. 00 06000 PHYSI CAL THERAPY 14 219 678 2, 407 0 68. 00 60. 00 06000 PHYSI CAL THERAPY 14 219 678 2, 407 0 68. 00 60. 00 06000 PHYSI CAL THERAPY 17 18 18 19 19 19 60. 00 06000 PHYSI CAL THERAPY 17 18 18 19 19 60. 00 06000 PHYSI CAL THERAPY 17 18 19 19 19 60. 00 06000 PHYSI CAL THERAPY 17 18 19 19 19 60. 00 06000 PHYSI CAL THERAPY 17 18 19 19 19 60. 00 06000 PHYSI CAL THERAPY 18 18 19 19 19 60. 00 06000 PHYSI CAL THERAPY 18 18 19 19 19 60. 00 06000 PHYSI CAL THERAPY 18 18 19 19 19 60. 00 06000 06000 06000 06000 06000 06000 06000 60. 00 06000 06000 06000 06000 06000 06000 07. 00 07000 07000 07000 07000 07000 07000 07000 07. 00 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07			1	-	_	O		ı
55.00 05500 RADIOLOCY-THERAPEUTIC 44 2,035 6,314 10,479 25 55.00 55.01 05501 NFUSION CENTER 278 1,483 4,600 3,745 0 55.01 56.00 05500 RADIOLOCY-THERAPEUTIC 1,659 1,451 4,502 9,137 152 56.00 57.00 05700 CT SCAN 555 11,296 35,047 15,097 634 57.00 58.00 05800 MAGNETIC RESONANCE MAGING (MRI) 153 2,467 7,653 5,684 181 58.00 59.00 05900 CARDIA C CATHETERI ZATI ON 652 5,522 17,131 17,736 100 59.00 60.00 06000 LABORATORY 8,972 17,754 54,580 60,870 0 60.00 60.00 06000 LABORATORY 0 0 0 0 0 0 0 0 0 0 0 62.00 06400 INTRAVENOUS THERAPY 1,676 3,491 10,832 21,146 0 65.00 65.00 06500 RESPIRATORY THERAPY 1,676 3,491 10,832 21,146 0 65.00 66.00 06600 RESPIRATORY THERAPY 1,676 3,491 10,832 21,146 0 65.00 66.00 06600 RESPIRATORY THERAPY 1,676 3,491 10,832 21,146 0 65.00 66.00 06600 RESPIRATORY THERAPY 1,676 3,491 10,832 21,146 0 65.00 68.00 06600 RESPIRATORY THERAPY 1,476 6 622 1,930 7,453 0 66.00 69.00 06600 RESPIRATORY THERAPY 1,476 6 622 1,930 7,453 0 66.00 69.00 06600 ELECTROCARDIOLOGY 14 219 678 2,407 0 68.00 69.00 06600 ELECTROCARDIOLOGY 37 2,147 6,61 5,161 13 69.00 69.01 06600 ELECTROCARDIOLOGY 37 2,147 6,61 5,161 13 69.00 69.01 06600 ELECTROCARDIOLOGY 37 2,147 6,61 5,161 13 69.00 69.01 06600 ELECTROCARDIOLOGY 37 3,115 9,644 59,573 0 71.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 23,704 2,937 9,113 51.539 0 72.00 72.00 07200 MEDICAL SUPPLIES CHARGED TO PATIENTS 39 894 2,775 9,311 0 74.00 72.00 07200 MEDICAL SUPPLIES CHARGED TO PATIENTS 39 894 2,775 9,311 0 74.00 72.00 07200 MEDICAL SUPPLIES CHARGED TO PATIENTS 39 894 2,775 9,311 0 0 0 0 0								1
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57. 00 05700 CT SCAN 5505 11, 296 35, 047 15, 097 634 57, 00 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 153 2, 467 7, 653 5, 684 181 58. 00 05900 CARDI AC CATHETERI ZATI ON 652 5, 522 17, 131 17, 736 100 59, 00 60. 00 06000 LABORATORY 8, 972 17, 754 54, 580 60, 870 0 60. 00 62. 00 06020 MIDLE BLOOD & PACKED RED BLOOD CELLS 514 1, 841 5, 711 7, 951 0 62. 00 62.00 06020 MIDLE BLOOD & PACKED RED BLOOD CELLS 514 1, 841 5, 711 7, 951 0 62. 00 66. 00		1	1					•
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64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 1,676 3,491 10,832 21,146 0 65.00 66.00 06600 PHYSI CAL THERAPY 16 622 1,930 7,453 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 21 447 1,386 5,993 0 67.00 68.00 06800 SPEECH PATHOLOGY 14 219 678 2,407 0 68.00 69.00 06900 ELECTROCARPIOLOGY 37 2,147 6,661 5,161 13 69.00 69.01 06901 CARDIAC REHAB 8 123 382 2,253 0 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 128 3,465 10,750 8,807 9,70.00 71.00 07100 MDIC CAL SUPPLIES CHARGED TO PATIENTS 27,442 3,115 9,664 59,573 0,71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 23,704 2,937 9,113 51,539 0,72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 781 16,880 52,372 137,059 0,73.00 74.00 07400 RENAL DI ALYSI S 39 894 2,775 9,311 0,74.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 77.00 09000 CLINIC CONTROL SUPPLIA CONTROL S	60.00	06000 LABORATORY	8, 972				0	60.00
65. 00 06500 RESPI RATORY THERAPY 1, 676 3, 491 10, 832 21, 146 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 16 622 1, 930 7, 453 0 66. 00 67. 00 06700 00CUPATI ONAL THERAPY 21 447 1, 386 5, 993 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 14 219 678 2, 407 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 37 2, 147 6, 661 5, 161 13 69. 00 69. 01 06901 CARDI AC REHAB 8 123 382 2, 253 0 69. 01 70. 00 07000 ELECTROCARDI PHALOGRAPHY 128 3, 465 10, 750 8, 807 9, 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 27, 442 3, 115 9, 664 59, 573 0, 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 23, 704 2, 937 9, 113 51, 539 0, 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 781 16, 880 52, 372 137, 059 0, 73. 00 74. 00 07400 RENAL DI ALYSI S 39 894 2, 775 9, 311 0, 74. 00 77. 00 07700 ALLOGENEI CHSCT ACQUI SI TI ON 0 0 0 0 0 77. 00 09100 EMERGENCY 4, 443 8, 744 27, 128 65, 595 38 91. 00 792. 00 09200 CLINIC 743 1, 690 5, 244 27, 244 1 90. 00 792. 00 09500 CLINIC 743 1, 690 5, 244 27, 244 1 90. 00 792. 00 09500 CLINIC 743 8, 744 27, 128 65, 595 38 91. 00 792. 00 09000 CLINIC 743 8, 744 27, 128 65, 595 38 91. 00 792. 00 01000 HOME HEALTH AGENCY 136 294 911 10, 891 0 101. 00 792. 00 01000 ONE HEALTH AGENCY 136 294 911 10, 891 0 792. 00 01000 ONE HEALTH AGENCY 136 294 911 10, 891 0 793. 00 10200 OPI OI DI TREATMENT PROGRAM 0 0 0 0 0 794. 00 00 00 00 00 00 00 795. 00 00 00 00 00 00 00 795. 00 00 00 00 00 00 00 796. 00 00 00 00 00 00 00 797. 00 00 00 00 00 00 00 00	62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	514	1, 841	5, 711	7, 951	0	62.00
66. 00 06600 PHYSI CAL THERAPY 16 622 1,930 7,453 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 21 447 1,386 5,993 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 14 219 678 2,407 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 37 2,147 6,661 5,161 13 69. 00 69. 01 06901 CARDI AC REHAB 8 123 382 2,253 0 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 128 3,465 10,750 8,807 9,70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 27,442 3,115 9,664 59,573 0,71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 23,704 2,937 9,113 51,539 0,72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 781 16,880 52,372 137,059 0,73. 00 74. 00 07400 RENAL DI ALYSI S 39 894 2,775 9,311 0,74. 00 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 90. 00 09000 CLETNIES 743 1,690 5,244 27,244 1 90.00 79. 00 09000 DEMERGENCY 4,443 8,744 27,128 65,595 38 91.00 79. 00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 0 0 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 0 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 109. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 191. 00 19100 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 191. 00 19100 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 191. 00 19100 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 191. 00 19100 19100 RESEARCH 0 0 0 0 0 191. 00 19100 19500 19500 19500 19500 19500 19500 19500 19500 191. 00 19100 195	64.00		0	0	0	0	0	64.00
67. 00 06700 0CCUPATI ONAL THERAPY 21 447 1, 386 5, 993 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 14 219 678 2, 407 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 37 2, 147 6, 661 5, 161 13 69. 00 69. 01 06901 CARDI AC REHAB 8 123 382 2, 253 0 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 128 3, 465 10, 750 8, 807 9 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 27, 442 3, 115 9, 664 59, 573 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 23, 704 2, 937 9, 113 51, 539 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 39 894 2, 775 9, 311 0 74. 00 74. 00 07400 RENAL DI ALYSIS 39 894 2, 775 9, 311 0 74. 00 77. 00 07700 ALLOGENEIC HSCT ACQUI SITI ON 0 0 0 0 0 77. 00 07000 EMERGENCY 4, 443 8, 744 27, 128 65, 595 38 91. 00 792. 00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 70 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 0 70 00 00 00			1					1
68.00 06800 SPEECH PATHOLOGY 14 219 678 2,407 0 68.00 69.00 69.00 61.00 69.00 61.00			1					1
69. 00 06900 ELECTROCARDI OLOGY 37 2, 147 6, 661 5, 161 13 69. 00 69. 01 06901 CARDI AC REHAB 8 123 382 2, 253 0 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 128 3, 465 10, 750 8, 807 9 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 27, 442 3, 115 9, 664 59, 573 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 23, 704 2, 937 9, 113 51, 539 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 781 16, 880 52, 372 137, 059 0 73. 00 74. 00 07400 RENAL DI ALYSI S 39 894 2, 775 9, 311 0 74. 00 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 77. 00 09700 CLI NI C 743 1, 690 5, 244 27, 244 1 90. 00 79. 00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 70 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 70 OTHER REI MBURSABLE COST CENTERS 710. 00 10100 HOME HEALTH AGENCY 136 294 911 10, 891 0 101. 00 710. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 710. 00 SPECI AL PURPOSE COST CENTERS 711. 00 1900 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 719. 00 19100 RESEARCH 0 0 0 0 0 710. 00 19100 RESEARCH 0 0 0 0 710. 00 19100 0 0 0 0 710. 00 19100 RESEARCH 0 0 0 0 710. 00 19100 0 0 0 0 0 710. 00 19100 RESEARCH 0 0 0 0 0 710. 00 19100 0 0 0 0 0 710. 00 19100 0 0 0 0 0 710. 00 19100 0 0 0 0 710. 00 19100 0 0 0 0 0 710. 00 19100 0 0 0 0 0 710. 00 19100 0 0 0 0 710. 00 19100 0 0 0 0 0 710. 00 19100 0 0 0 0 710. 00 19100 0 0 0 0 710. 00 19100 0								1
69. 01 06901 CARDI AC REHAB 8 123 382 2, 253 0 69. 01			1					1
70. 00 07000 ELECTROENCEPHALOGRAPHY 128 3, 465 10, 750 8, 807 9 70. 00 71. 00 7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 27, 442 3, 115 9, 664 59, 573 0 71. 00 72. 00 72. 00 1 MPL. DEV. CHARGED TO PATI ENTS 27, 442 2, 937 9, 113 51, 539 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 781 16, 880 52, 372 137, 059 0 73. 00 74. 00 07400 RENAL DI ALYSI S 39 894 2, 775 9, 311 0 74. 00 07400 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 0 77. 00 00 0000 CLI NI C 00 0000 CLI NI			1					1
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 27, 442 3, 115 9, 664 59, 573 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 23, 704 2, 937 9, 113 51, 539 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 781 16, 880 52, 372 137, 059 0 73. 00 74. 00 07400 RENAL DI ALYSI S 39 894 2, 775 9, 311 0 74. 00 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 743 1, 690 5, 244 27, 244 1 90. 00 91. 00 09100 EMERGENCY 4, 443 8, 744 27, 128 65, 595 38 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 OTHER REI MBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 136 294 911 10, 891 0 101. 00 TOTHER REI MBURSABLE COST CENTERS 118. 00 SUBTOTALS (SUM OF LI NES 1 through 117) 89, 127 121, 070 375, 119 1, 197, 588 2, 671 118. 00 SPECI AL PURPOSE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 84 0 190. 00 191. 00 19100 RESEARCH 0 0 0 0 0 0 191. 00			1		1		-	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS							•	
73. 00 07300 DRUGS CHARGED TO PATIENTS 781 16, 880 52, 372 137, 059 0 73. 00 74. 00 07400 RENAL DIALYSIS 39 894 2, 775 9, 311 0 74. 00 077. 00 07700 ALLOGENEI C HSCT ACQUI SITION 0 0 0 0 0 0 0 0 0			1 ' 1				0	
77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 0 0 0	73.00	07300 DRUGS CHARGED TO PATIENTS	781			137, 059	0	73.00
OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 743 1, 690 5, 244 27, 244 1 90. 00 91. 00 09100 EMERGENCY 4, 443 8, 744 27, 128 65, 595 38 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 OTHER REI MBURSABLE COST CENTERS 92. 00 OTHER REI MBURSABLE COST CENTERS 136 294 911 10, 891 0 101. 00 102. 00 ODE						9, 311	0	1
90. 00 09000 CLINIC 743 1, 690 5, 244 27, 244 1 90. 00 91. 00 09100 EMERGENCY 4, 443 8, 744 27, 128 65, 595 38 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 00 OTHER REIMBURSABLE COST CENTERS	77. 00		0	0	0	0	0	77. 00
91. 00 09100 EMERGENCY 4, 443 8, 744 27, 128 65, 595 38 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 OTHER REIMBURSABLE COST CENTERS	00		=1			0= -		00.5-
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 OTHER REIMBURSABLE COST CENTERS 92. 00 OTHER REIMBURSABLE COST CENTERS 93. 00 OTHER REIMBURSABLE COST CENTERS 94. 00 OTHER REIMBURSABLE COST CENTERS 95. 00 OT			1					1
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 136 294 911 10, 891 0 101.00 102.00 102.00 OTHER			4, 443	8, 744	27, 128	65, 595	38	1
101. 00 10100 HOME HEALTH AGENCY 136 294 911 10, 891 0 101. 00 102. 00 10200 OPI 0I D TREATMENT PROGRAM 0 0 0 0 0 102. 00 102. 00 SPECI AL PURPOSE COST CENTERS	72. UU							J 7∠. UU
102. 00 10200 OPI 0I D TREATMENT PROGRAM O O O O 102. 00	101 00		124	204	011	10 801	0	101 00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 89, 127 121,070 375, 119 1, 197, 588 2, 671 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 84 0 190.00 191.00 19100 RESEARCH 0 0 0 0 0 191.00			1					
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 89, 127 121, 070 375, 119 1, 197, 588 2, 671 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 84 0 190. 00 191. 00 19100 RESEARCH 0 0 0 0 0 191. 00 19	.02.00		, O	0	. 0	0		1.02.00
NONREI MBURSABLE COST CENTERS 0 0 84 0 190.00 191.00 19100 RESEARCH 0 0 0 0 0 191.00	118. 00		89, 127	121, 070	375, 119	1, 197, 588	2, 671	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 84 0 190. 00 191. 00 191. 00 0 0 0 0 191. 00								
						84		
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 825 0 0 133, 414 0 192. 00					- 1	0		
	192.00	19200 PHYSLCIANS' PRIVATE OFFICES	825	0	0	133, 414	0	192.00

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C	CCN: 15-0002	Peri od: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Pre 5/25/2023 12:	

						5/25/2023 12:	40 piii
	Cost Center Description	PURCHASI NG	ADMI TTI 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. 01 192	01 OTHER NON-REIMBURSABLE	0	0	0	1, 511	0	192. 01
192. 02 192	02 FAMILY HEALTH/GARY COMM HEALTH	0	0	0	842	0	192. 02
193. 00 193	OO 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)	89, 952	121, 070	375, 119	1, 333, 439	2, 671	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 01/01/2022 Part II
To 12/31/2022 Date/Time Prepared: 5/25/2023 12:46 pm

) 12/31/2022	5/25/2023 12:	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	0.00	10.00	44.00	
	CENEDAL CEDVICE COCT CENTEDS	7. 00	8. 00	9. 00	10.00	11. 00	
1. 00	GENERAL SERVICE COST CENTERS 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. 02	00570 ADMITTING						5. 02
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	3, 754, 525					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	70, 563	293, 464				8. 00
9.00	00900 HOUSEKEEPI NG	81, 687	0	361, 751			9. 00
10.00	01000 DI ETARY	74, 613	0	7, 493	333, 679		10.00
11.00	01100 CAFETERI A	52, 163	0	5, 238	0	228, 409	11.00
13.00	01300 NURSING ADMINISTRATION	25, 137	0	2, 524	0	7, 132	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	141, 890	335	14, 249	0	3, 767	14.00
15.00	01500 PHARMACY	75, 044	0	7, 536	0	0	15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	44, 761	0	4, 495	0	8, 915	16.00
17. 00	01700 SOCI AL SERVI CE	6, 449	0	648	0	0	17.00
17. 01	01701 STAFF EDUCATION	44, 127	0	4, 431	0	0	17. 01
17. 02	01702 MEDI CAL EDUCATI ON	1, 481	0	149	0	0	17. 02
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0	0		0	0	21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	17, 683	0	1, 776	0	0	22.00
23. 00	02300 PARAMED ED PROGRAM	13, 317	0	1, 337	0	2, 918	23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	1 220 010	124 07/	104 515	2/0 407	(0.041	20.00
30.00	03000 ADULTS & PEDIATRICS	1, 239, 919	134, 976	124, 515	269, 407	60, 041	30.00
31.00	03100 NTENSI VE CARE UNI T	78, 635	20, 668		12, 038	13, 681	31.00
31. 01	03101 NEONATAL I CU	8, 939	0	898	4 470	3, 337	31.01
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	15, 724 123, 680	-	1, 579 12, 420	4, 670	2, 336 4, 171	40. 00 41. 00
43.00	04300 NURSERY	96, 686	7, 710 3, 767	9, 710	13, 463	2, 775	43.00
43.00	ANCILLARY SERVICE COST CENTERS	70, 000	3, 707	7, 710	<u> </u>	2, 113	43.00
50.00	05000 OPERATING ROOM	236, 122	30, 169	23, 712	ol	13, 191	50. 00
50. 01	05001 ENDOSCOPY	0	4, 053		o	1, 623	50. 01
51. 00	05100 RECOVERY ROOM	57, 583	1, 880		99	2, 037	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	27, 722	7, 271	2, 784	7, 376	9, 019	52.00
53. 00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	210, 042	6, 169	21, 093	0	7, 637	54.00
54. 01	05401 RADI OLOGY - ULTRASOUND	20, 007	3, 153		0	3, 659	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	30, 881	1, 709		o	1, 190	55.00
55. 01	05501 I NFUSI ON CENTER	22, 501	0	2, 260	0	1, 301	55. 01
56.00	05600 RADI OI SOTOPE	35, 798	1, 845	3, 595	O	1, 590	56.00
57.00	05700 CT SCAN	33, 898	3, 687	3, 404	0	3, 499	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	16, 646	1, 537	1, 672	0	1, 498	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	33, 225	6, 519		0	5, 491	59.00
60.00	06000 LABORATORY	93, 100	0	9, 349	0	12, 464	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 524	0		0	6, 108	62.00
64. 00		0	0	-	0	0	64.00
65. 00	06500 RESPI RATORY THERAPY	30, 743	0	3, 087	0	7, 581	
66. 00	06600 PHYSI CAL THERAPY	48, 573	0	4, 878	0	3, 439	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	41, 744	0	4, 192	0	2, 705	67.00
68.00	06800 SPEECH PATHOLOGY	7, 110	0	714	0	1, 085	68.00
69.00	06900 ELECTROCARDI OLOGY	0	515	0	0	2, 524	69.00
69. 01	06901 CARDI AC REHAB	0	155		0	1, 257	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 965		U O	3, 312	70.00
71.00		0	0	0	0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	6, 579	0	441	0	897	72. 00 73. 00
74.00	07400 RENAL DIALYSIS	17, 351	2, 307	661 1, 742	0	3	74.00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	17, 331	2, 307	1, 742	0	0	77.00
77.00	OUTPATIENT SERVICE COST CENTERS	U U	0	U U	<u>U</u>	0	77.00
90. 00	09000 CLINIC	301, 574	7, 187	30, 285	n	7, 457	90. 00
91. 00	09100 EMERGENCY	107, 133	44, 887	10, 759	26, 626	18, 769	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	107, 133	44,007	10, 737	20, 020	10, 707	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
101 00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
	10200 OPIOID TREATMENT PROGRAM	0	0		0		101.00
. 52. 00	SPECIAL PURPOSE COST CENTERS	, o			٥		. 52. 55
118.00		3, 592, 354	293, 464	345, 465	333, 679	228, 409	118. 00
2.00	NONREI MBURSABLE COST CENTERS	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		2.2, .00	,,		
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	7, 130	0	716	0	0	190. 00
	19100 RESEARCH	0	0		0		191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	105, 740	0		0	0	192. 00
192.01	1 19201 OTHER NON-REIMBURSABLE	13, 685	0	1, 374	0	0	192. 01

Health Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0002	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Prepared:

						5/25/2023 12:	46 pm
	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. 02 19202	FAMILY HEALTH/GARY COMM HEALTH	35, 616	0	3, 577	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)	3, 754, 525	293, 464	361, 751	333, 679	228, 409	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0002

				IC	12/31/2022	Date/lime Pre 5/25/2023 12:	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
		ADMI NI STRATI O	SERVICES &		RECORDS &	SERVI CE	
		N 13. 00	14. 00	15. 00	16. 00	17. 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 5. 02	00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES						5. 01 5. 02
5. 03	00570 ADMITTING						5. 03
5.04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 04
5. 05	00590 OTHER A&G						5.05
5. 06 7. 00	00592 PATIENT TRANSPORTATION 00700 OPERATION OF PLANT						5. 06 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	01100 CAFETERI A	12/ 011					11.00
13. 00 14. 00	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY	136, 811	613, 842				13. 00 14. 00
15. 00	01500 PHARMACY	O	013, 042				15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	209, 602		16.00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	29, 213	
17. 01 17. 02	01701 STAFF EDUCATION 01702 MEDICAL EDUCATION	0	0	0	0	0	17. 01 17. 02
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	1
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	l o	0	Ö	Ö	0	
23.00	02300 PARAMED ED PROGRAM	2, 968	0	0	0	0	23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	(1.055			14 (05	27.700	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	61, 055 13, 912	0		14, 685 2, 919	26, 709 0	30.00
31. 01	03101 NEONATAL I CU	3, 393	0	0	644	0	31.00
40.00	04000 SUBPROVI DER - I PF	2, 375	0	0	331	0	40.00
41.00	04100 SUBPROVI DER – I RF	4, 241	0		524	1, 669	1
43. 00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	2, 822	0	0	283	0	43.00
50. 00	05000 OPERATING ROOM	13, 414	0	0	23, 225	0	50.00
50. 01	05001 ENDOSCOPY	1, 650	0		1, 542	0	50. 01
51.00	05100 RECOVERY ROOM	2, 072	0	0	1, 589	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	9, 171	0	0	754	0	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0 5, 811	0	
54. 01	05401 RADI OLOGY - ULTRASOUND		0	_	3, 342	0	1
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	3, 522	0	55.00
55. 01	05501 I NFUSI ON CENTER	0	0	0	2, 566	0	55. 01
56. 00 57. 00	05600	0	0	0	2, 512	0	56. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	19, 551 4, 269	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	9, 556	0	59.00
60.00	06000 LABORATORY	0	0	18, 338	30, 790	0	1
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	3, 186	0	02.00
65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0	0	0 6, 043	0	1
66.00		O	0	0	1, 076	0	1
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	773	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	378	0	68.00
69. 00 69. 01	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	0	0	0	3, 716 213	0	69. 00 69. 01
70.00	1	0	0	0	5, 997	0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	329, 469	0	5, 391	0	1
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	284, 373		5, 084	0	
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0		29, 216	0	
	07700 ALLOGENEIC HSCT ACQUISITION	4 0	0	_	1, 548 0	0	1
77.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>		<u> </u>			77.00
	09000 CLI NI C	649	0	0	2, 925	0	1
	09100 EMERGENCY	19, 085	0	0	15, 133	835	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
101 00	10100 HOME HEALTH AGENCY	0	0	0	508	0	101.00
	10200 OPIOID TREATMENT PROGRAM	0	0		0		102.00
	SPECIAL PURPOSE COST CENTERS						ļ
118.00	9 /	136, 811	613, 842	334, 295	209, 602	29, 213	118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	O	0	^	190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190.00
	19200 PHYSICIANS' PRIVATE OFFICES	o	0		o		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 Part II To 12/31/2022 Date/Time Prepared: 5/25/2023 12:46 pm			

					5/25/2023 12:	46 pm
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. 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)	136, 811	613, 842	336, 284	209, 602	29, 213	202. 00

					DECL DENTS	5/25/2023 12:	
				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	
	GENERAL SERVICE COST CENTERS	17. 01	17. 02	21.00	22. 00	23. 00	
	00100 CAP REL COSTS-BLDG & FLXT						1.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00550 DATA PROCESSING						5. 01
	00560 PURCHASING RECEIVING AND STORES						5. 02
4	00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 03 5. 04
	00590 OTHER A&G						5.05
	00592 PATIENT TRANSPORTATION						5. 06
1	00700 OPERATION OF PLANT						7. 00
1	00800 LAUNDRY & LI NEN SERVI CE						8.00
	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00
	01100 CAFETERI A						11.00
	01300 NURSING ADMINISTRATION						13.00
	01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY						15.00
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE						16. 00 17. 00
1	01700 SOCIAL SERVICE 01701 STAFF EDUCATION	185, 114					17.00
1	01702 MEDI CAL EDUCATI ON	0	6, 395				17. 02
	02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	936			21.00
1	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0		74, 300	/F 000	22.00
	02300 PARAMED ED PROGRAM INPATIENT ROUTINE SERVICE COST CENTERS	302	0			65, 298	23.00
	03000 ADULTS & PEDIATRICS	48, 695	0				30.00
	03100 NTENSI VE CARE UNI T	16, 712	0				31.00
31. 01	03101 NEONATAL I CU	4, 367	0				31. 01
1	04000 SUBPROVI DER - I PF	226	0				40.00
	04100 SUBPROVI DER - I RF 04300 NURSERY	3, 662	0				41. 00 43. 00
	ANCILLARY SERVICE COST CENTERS	4, 752	0				43.00
	05000 OPERATING ROOM	23, 182	0				50.00
1	05001 ENDOSCOPY	2, 800	0				50. 01
1	05100 RECOVERY ROOM	2, 173	0				51.00
1	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	18, 958 0	0				52. 00 53. 00
1	05400 RADI OLOGY-DI AGNOSTI C	1, 300	0				54.00
1	05401 RADI OLOGY - ULTRASOUND	1, 475	0				54. 01
	05500 RADI OLOGY-THERAPEUTI C	267	0				55.00
4	05501 NFUSION CENTER	3	0				55. 01
	05600 RADI 0I SOTOPE 05700 CT SCAN	54 2, 472	0				56. 00 57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	35	0				58.00
1	05900 CARDI AC CATHETERI ZATI ON	6, 540	0				59.00
1	06000 LABORATORY	135	0	•			60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	525	0				62.00
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0 3, 632	0				64. 00 65. 00
1	06600 PHYSI CAL THERAPY	242	0				66.00
	06700 OCCUPATI ONAL THERAPY	183	0				67.00
	06800 SPEECH PATHOLOGY	116	0				68. 00
	06900 ELECTROCARDI OLOGY	864	0				69.00
1	06901 CARDI AC REHAB 07000 ELECTROENCEPHALOGRAPHY	16 716	0				69. 01 70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	710	0				71.00
4	07200 I MPL. DEV. CHARGED TO PATIENTS	Ö	0				72.00
4	07300 DRUGS CHARGED TO PATIENTS	2, 410	0				73.00
	07400 RENAL DI ALYSI S	86	0				74.00
	07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0				77. 00
-	09000 CLINIC	902	0				90.00
1	09100 EMERGENCY	28, 925	6, 395				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS	0.005		Г	T		
	10100 HOME HEALTH AGENCY 10200 OPIOID TREATMENT PROGRAM	3, 395 0	0				101. 00 102. 00
	SPECIAL PURPOSE COST CENTERS	U _I	0				1,02.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	180, 122	6, 395	0	0	0	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH	4, 984 0	0				190. 00 191. 00
191.00	17 TOO NEGLAROIT	·	0	l	<u> </u>		1171.00

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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002 | Period: From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: 5/25/2023 12: 46 pm

					5/25/2023 12:	46 pm
			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	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				192.00
192.01 19201 OTHER NON-REIMBURSABLE	0	0				192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	8	0				192. 02
193. 00 19300 NONPALD WORKERS	0	0				193. 00
200.00 Cross Foot Adjustments			936	74, 300	65, 298	200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	185, 114	6, 395	936	74, 300	65, 298	202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0002

						To) 12/31/2022 Date/Time Pr 5/25/2023 12	
		Cost Center Description	Subtotal	Intern &	Total			,
				Residents Cost & Post				
				Stepdown				
			0.4.00	Adjustments	07.00			
	GENER	AL 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 5. 03	1	PURCHASING RECEIVING AND STORES ADMITTING						5. 02 5. 03
5. 04	1	CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 04
5. 05		OTHER A&G						5. 05
5.06	4	PATIENT TRANSPORTATION						5. 06 7. 00
7. 00 8. 00	1	OPERATION OF PLANT LAUNDRY & LINEN SERVICE						8.00
9. 00		HOUSEKEEPI NG						9. 00
10.00		DI ETARY						10.00
11.00		CAFETERI A						11.00
13. 00 14. 00	1	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY						13. 00 14. 00
15. 00		PHARMACY						15. 00
16.00	1	MEDICAL RECORDS & LIBRARY						16.00
17.00		SOCIAL SERVICE						17.00
17. 01 17. 02	1	STAFF EDUCATION MEDICAL EDUCATION						17. 01 17. 02
21. 00	1	I &R SERVICES-SALARY & FRINGES APPRVD						21.00
22. 00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD						22. 00
23. 00		PARAMED ED PROGRAM						23. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	6, 074, 091	0	6, 074	001		30.00
31.00		INTENSIVE CARE UNIT	465, 041	0		, 041		31.00
31. 01	1	NEONATAL I CU	59, 075	0		, 075		31. 01
40.00	1	SUBPROVIDER - I PF	81, 672	0		, 672		40.00
41. 00 43. 00		SUBPROVI DER – I RF NURSERY	565, 273 429, 235	0		, 273 , 235		41. 00 43. 00
43.00		LARY SERVICE COST CENTERS	427, 233	0	427	, 233		43.00
50.00	05000	OPERATING ROOM	1, 206, 291	0				50.00
50. 01		ENDOSCOPY	21, 790	0	ı	, 790		50.01
51. 00 52. 00		RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	261, 174 193, 493	0		, 174 , 493		51.00 52.00
53.00		ANESTHESI OLOGY	0	0	170	0		53.00
54.00		RADI OLOGY-DI AGNOSTI C	937, 416	0	937	, 416		54.00
54. 01		RADI OLOGY - ULTRASOUND	113, 823	0		, 823		54. 01
55. 00 55. 01	1	RADIOLOGY-THERAPEUTIC	154, 980 108, 285	0		, 980 , 285		55. 00 55. 01
56. 00		RADI OI SOTOPE	173, 006	0		, 006		56.00
57.00	05700	CT SCAN	234, 244	0	1	, 244		57.00
58.00		MAGNETIC RESONANCE IMAGING (MRI)	93, 362	0		, 362		58. 00
59. 00 60. 00		CARDI AC CATHETERI ZATI ON LABORATORY	209, 460 595, 282	0		, 460 , 282		59. 00 60. 00
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELLS	32, 822	0		, 822		62.00
64.00	06400	I NTRAVENOUS THERAPY	0	0		0		64.00
65.00	1	RESPI RATORY THERAPY	184, 272	0		, 272		65.00
66. 00 67. 00		PHYSICAL THERAPY OCCUPATIONAL THERAPY	218, 632 186, 662	0		, 632 , 662		66. 00 67. 00
68. 00		SPEECH PATHOLOGY	34, 858	0		, 858		68.00
69. 00		ELECTROCARDI OLOGY	22, 007	0		, 007		69. 00
69. 01		CARDI AC REHAB	4, 612	0		, 612		69. 01
70. 00 71. 00		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS	36, 748 434, 654	0		, 748 , 654		70.00 71.00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	376, 750	0		, 750		72.00
73.00		DRUGS CHARGED TO PATIENTS	583, 285	0		, 285		73. 00
		RENAL DIALYSIS ALLOGENEIC HSCT ACQUISITION	89, 550 0	0		, 550 0		74. 00 77. 00
77.00		TIENT SERVICE COST CENTERS	U	0		U		17.00
	09000	CLINIC	1, 317, 061	0				90.00
91.00		EMERGENCY	718, 500			, 500		91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS		0				92. 00
101.00		HOME HEALTH AGENCY	17, 140	0	17	, 140		101.00
	10200	OPIOID TREATMENT PROGRAM	0	0		0		102. 00
110 00		AL PURPOSE COST CENTERS	14 004 544	^	1/ 224	EAZ		110.00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117)	16, 234, 546	0	16, 234	, 546		118. 00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	34, 893	0	34	, 893		190. 00
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Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C		Peri od: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Prep 5/25/2023 12:4	
Cost Center Description	Subtotal	Intern & Residents Cost & Post	Total			

						111
(Cost Center Description	Subtotal	Intern &	Total		
			Resi dents			
			Cost & Post			
			Stepdown			
			Adjustments			
		24. 00	25. 00	26.00		
191. 00 19100 F	RESEARCH	0	0	0	191.	00
192. 00 19200 F	PHYSICIANS' PRIVATE OFFICES	590, 640	0	590, 640	192.	00
192. 01 19201 (OTHER NON-REIMBURSABLE	58, 759	0	58, 759	192.	01
192. 02 19202 F	FAMILY HEALTH/GARY COMM HEALTH	149, 887	0	149, 887	192.	02
193. 00 19300 N	NONPALD WORKERS	0	0	0	193.	00
200.00	Cross Foot Adjustments	140, 534	0	140, 534	200.	00
201.00	Negative Cost Centers	0	0	0	201.	00
202. 00	TOTAL (sum lines 118 through 201)	17, 209, 259	0	17, 209, 259	202.	00

	Financial Systems	METHODIST HOSE		ON 45 0000 D		u or form CMS-2	
COST A	ALLOCATION - STATISTICAL BASIS		Provi der C		eriod: rom 01/01/2022	Worksheet B-1	
					o 12/31/2022	Date/Time Pre	nared:
				'	0 12/31/2022	5/25/2023 12:	
		CAPI TAL				07 207 2020 121	, c p
		RELATED COSTS					
	Cost Center Description	BLDG & FIXT	EMPLOYEE	DATA	PURCHASI NG	ADMI TTI NG	
	oost contor bescription	(SQUARE FEET)	BENEFITS	PROCESSI NG	RECEIVING AND	(GROSS	
		(SQUARE TELT)	DEPARTMENT	(MACHI NE	STORES	CHARGES)	
				7		CHARGES)	
			(GROSS	TIME)	(PURCHASE		
		1.00	SALARI ES)	F 04	REQUISITIONS)	F 00	
	OFNEDAL CEDIUSE COCT OFNITEDO	1. 00	4. 00	5. 01	5. 02	5. 03	
	GENERAL SERVICE COST CENTERS	4 440 400					
1. 00	00100 CAP REL COSTS-BLDG & FIXT	1, 410, 133					1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	5, 906	146, 660, 720				4.00
5. 01	00550 DATA PROCESSING	9, 190	4, 221, 843				5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES	7, 332	960, 421	0			5. 02
5. 03	00570 ADMI TTI NG	9, 717	4, 835, 280	0	56, 460	1, 548, 882, 084	5. 03
5.04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	30, 646	2, 232, 145	0	10, 029	0	5. 04
5.05	00590 OTHER A&G	99, 579	8, 023, 560	100	4, 744	0	5. 05
5.06	00592 PATIENT TRANSPORTATION	0	494, 111	0	3, 449	0	5.06
7.00	00700 OPERATION OF PLANT	299, 329	4, 902, 599	1 0	484, 114	0	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	17, 825	0			0	8.00
9. 00	00900 HOUSEKEEPI NG	20, 635	4, 472, 090	0	411, 489	0	9.00
10.00	01000 DI ETARY	18, 848	2, 275, 102			0	10.00
11. 00	01100 CAFETERI A	13, 177	1, 498, 988			0	11.00
13. 00	01300 NURSING ADMINISTRATION	6, 350	3, 728, 872			0	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	35, 843				0	14.00
15. 00		1	718, 982				ı
	01500 PHARMACY	18, 957	0 400 740	0	,	0	15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	11, 307	2, 103, 713		-,	0	16.00
17. 00	01700 SOCIAL SERVICE	1, 629	425, 415		-	0	17. 00
17. 01	01701 STAFF EDUCATION	11, 147	0	0	-	0	17. 01
17. 02	01702 MEDI CAL EDUCATI ON	374	140	0	4, 375	0	17. 02
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	4, 467	0	0	0	0	22.00
23.00	02300 PARAMED ED PROGRAM	3, 364	714, 478	0	3, 314	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS			•			1
30.00	03000 ADULTS & PEDIATRICS	313, 217	23, 097, 111	0	2, 407, 762	108, 775, 154	30.00
31. 00	03100 INTENSIVE CARE UNIT	19, 864	6, 604, 229	l o		21, 622, 275	•
31. 01	03101 NEONATAL I CU	2, 258	1, 482, 931	0		4, 768, 938	31.00
40. 00	04000 SUBPROVI DER - I PF	3, 972	906, 984	1		2, 452, 257	40.00
		1 1					1
41. 00	04100 SUBPROVI DER – I RF	31, 243	1, 654, 676			3, 879, 700	41.00
43. 00	04300 NURSERY	24, 424	1, 392, 580	0	152, 622	2, 096, 145	43.00
	ANCI LLARY SERVI CE COST CENTERS	11		1 _			
50. 00	05000 OPERATING ROOM	59, 647	4, 748, 545		,	172, 039, 906	50.00
50. 01	05001 ENDOSCOPY	0	685, 857	0		11, 419, 398	50. 01
51. 00	05100 RECOVERY ROOM	14, 546	964, 495	0	0	11, 769, 949	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	7, 003	3, 665, 463	0	166, 364	5, 587, 972	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	53, 059	2, 254, 088	0	125, 095	43, 045, 376	54.00
54. 01	05401 RADI OLOGY - ULTRASOUND	5, 054	1, 371, 113	0	118, 092	24, 757, 047	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	7, 801	427, 351	0	22, 529	26, 088, 940	55.00
55. 01	05501 I NFUSI ON CENTER	5, 684	365, 749			19, 009, 274	
56.00	05600 RADI OI SOTOPE	9, 043	712, 039			18, 603, 735	
57. 00	05700 CT SCAN	8, 563	1, 223, 552			144, 822, 556	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	4, 205	507, 022			31, 624, 327	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	8, 393	2, 490, 395			70, 788, 792	59.00
	06000 LABORATORY						60.00
60.00	1 1	23, 518	3, 901, 317			224, 346, 171	•
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	385	1, 243, 002	1		23, 597, 930	62.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0 575 000	0		0	64.00
65.00	06500 RESPI RATORY THERAPY	7, 766	2, 575, 907			44, 762, 155	65.00
66. 00	06600 PHYSI CAL THERAPY	12, 270	1, 343, 576		-,	7, 973, 843	66.00
67.00	06700 OCCUPATI ONAL THERAPY	10, 545	1, 074, 137	1	10, 792	5, 726, 726	•
68. 00	06800 SPEECH PATHOLOGY	1, 796	445, 241	0	7, 333	2, 802, 466	
69. 00	06900 ELECTROCARDI OLOGY	0	751, 645	0	18, 967	27, 523, 086	69.00
69. 01	06901 CARDI AC REHAB	0	418, 448	0	3, 884	1, 577, 084	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	1, 220, 446			44, 422, 872	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			39, 934, 592	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		n	ĺ		37, 655, 721	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 662	386, 275			216, 411, 306	73.00
74.00	07400 RENAL DIALYSIS	4, 383	870			11, 465, 208	74.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	4, 363	0/0	•		11, 405, 206	77.00
77.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	0	1 0	ı U	0	, , , , , , , ,
00 00	09000 CLINIC	76, 181	2, 946, 748		202 071	21 470 210	00 00
90.00	1	1				21, 670, 219	90.00
91.00	09100 EMERGENCY	27, 063	7, 593, 565	0	2, 289, 091	112, 097, 741	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
	10100 HOME HEALTH AGENCY	0	2, 046, 583			3, 763, 223	
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 369, 167	122, 109, 679	100	45, 929, 002	1, 548, 882, 084	118. 00
							

Health Finan	ncial Systems	METHODI ST HOSI	DITAIS INC		In lie	u of Form CMS-2	2552_10
	TION - STATISTICAL BASIS	WETHODIST 11031	Provi der CO	`N: 15_0002 P	eri od:	Worksheet B-1	
	TION SINTISTICAL BASIS		Trovider of		rom 01/01/2022	Date/Time Pre 5/25/2023 12:	pared:
	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT	EMPLOYEE	DATA	PURCHASI NG	ADMI TTI NG	
	·	(SQUARE FEET)	BENEFITS DEPARTMENT (GROSS SALARIES)	PROCESSING (MACHINE TIME)	RECEIVING AND STORES (PURCHASE REQUISITIONS)	(GROSS CHARGES)	
		1. 00	4. 00	5. 01	5. 02	5. 03	
	IMBURSABLE COST CENTERS						
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 801	0	0	0	_	190. 00
191. 00 19100		0	0	0	0	_	191. 00
	PHYSICIANS' PRIVATE OFFICES	26, 711	24, 460, 177	0	425, 072		192.00
	OTHER NON-REIMBURSABLE	3, 457	0	0	0		192. 01
	FAMILY HEALTH/GARY COMM HEALTH	8, 997	90, 864	0	180		192. 02
	NONPALD WORKERS	0	O	0	0	0	193. 00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	47 000 050	00 440 450	44 504 004	0 //4 000		201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	17, 209, 259	30, 143, 652	14, 591, 334	3, 661, 008	7, 142, 077	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	12. 203997	0. 205533	145, 913. 34000 0	0. 078979	0. 004611	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)		72, 077	114, 228	89, 952	121, 070	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part		0. 000491	1, 142. 280000	0. 001941	0. 000078	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)		•				206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00
ı		ı I	'		ı I		1

	Financial Systems	METHODI ST HOSP		N 45 0000 5		u of Form CMS-	
COSTA	NLLOCATION - STATISTICAL BASIS		Provi der CC	F	eriod: rom 01/01/2022 o 12/31/2022	Worksheet B-1 Date/Time Pre 5/25/2023 12:	pared:
	Cost Center Description	CASHI ERI NG/AC F	Reconciliatio n		PATI ENT TRANSPORTATI O	OPERATION OF PLANT	40 piii
		RECEI VABLE (GROSS			N (NUMBER OF	(SQUARE FEET)	
		CHARGES)			TRI PS)		
	GENERAL SERVICE COST CENTERS	5. 04	5A. 05	5. 05	5. 06	7. 00	
1. 00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 5. 02	OO550 DATA PROCESSING OO560 PURCHASING RECEIVING AND STORES						5. 01 5. 02
5. 02	00570 ADMITTING						5. 02
5.04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	1, 548, 882, 084					5. 04
5. 05 5. 06	OO590 OTHER A&G OO592 PATIENT TRANSPORTATION	0	-35, 787, 165 0	350, 422, 589 636, 248			5. 05 5. 06
7. 00	00700 OPERATION OF PLANT	o	0	25, 799, 710			1
8. 00	00800 LAUNDRY & LINEN SERVICE	0	0	1, 410, 102		,	1
9. 00 10. 00	O0900 HOUSEKEEPI NG O1000 DI ETARY	0	0	6, 633, 420 4, 993, 616		20, 635 18, 848	1
11. 00	01100 CAFETERI A	o o	Ö	2, 485, 779			
13. 00	01300 NURSING ADMINISTRATION	0	0	5, 708, 246			
14. 00 15. 00	O1400 CENTRAL SERVI CES & SUPPLY O1500 PHARMACY	0	0	3, 699, 481 5, 807, 806			14. 00 15. 00
	01600 MEDICAL RECORDS & LIBRARY	o o	Ö	3, 257, 365			16.00
	01700 SOCIAL SERVICE	0	0	532, 732			1
17. 01 17. 02	O1701 STAFF EDUCATION O1702 MEDICAL EDUCATION	0	0	136, 038 50, 654			1
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	O	Ö	245, 947			21.00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	0	0	85, 683			
23.00	O2300 PARAMED ED PROGRAM INPATIENT ROUTINE SERVICE COST CENTERS	l ol	U	800, 385	0	3, 364	23.00
30.00	03000 ADULTS & PEDIATRICS	108, 775, 154	0	57, 761, 242			
31. 00 31. 01	03100 INTENSIVE CARE UNIT 03101 NEONATAL ICU	21, 622, 275 4, 768, 938	0	11, 668, 963 2, 011, 226			
40.00	04000 SUBPROVI DER - I PF	2, 452, 257	0	1, 242, 211		2, 238 3, 972	
41.00	04100 SUBPROVI DER - I RF	3, 879, 700	0	2, 694, 070			1
43. 00	04300 NURSERY ANCI LLARY SERVICE COST CENTERS	2, 096, 145	0	2, 291, 638	1	24, 424	43.00
50.00	05000 OPERATI NG ROOM	172, 039, 906	0	14, 510, 797	1	59, 647	50.00
50. 01	O5001 ENDOSCOPY O5100 RECOVERY ROOM	11, 419, 398	0	1, 452, 507			50. 01 51. 00
51. 00 52. 00	05200 DELIVERY ROOM & LABOR ROOM	11, 769, 949 5, 587, 972	0	1, 629, 097 5, 526, 788		14, 546 7, 003	
53.00	05300 ANESTHESI OLOGY	0	0	0		0	
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05401 RADI OLOGY - ULTRASOUND	43, 045, 376 24, 757, 047	0	5, 924, 542 2, 455, 543			1
55.00	05500 RADI OLOGY-THERAPEUTI C	26, 088, 940	0	2, 753, 943		7, 801	55.00
	05501 I NFUSI ON CENTER	19, 009, 274	0	984, 180			55. 01
	05600	18, 603, 735 144, 822, 556	0	2, 401, 438 3, 967, 641			56. 00 57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	31, 624, 327	0	1, 493, 947	1, 983	4, 205	58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	70, 788, 792 224, 346, 171	0	4, 661, 312 15, 997, 390	·	8, 393 23, 518	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	23, 597, 930	0	2, 089, 513		385	
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	_	. 0	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	44, 762, 155 7, 973, 843	0	5, 557, 319 1, 958, 841		7, 766 12, 270	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	5, 726, 726	Ö	1, 575, 095			
68.00	06800 SPEECH PATHOLOGY	2, 802, 466	0	632, 692		· ·	68.00
69. 00 69. 01	O6900 ELECTROCARDI OLOGY O6901 CARDI AC REHAB	27, 523, 086 1, 577, 084	0	1, 356, 277 592, 235		0	1
70.00	07000 ELECTROENCEPHALOGRAPHY	44, 422, 872	0	2, 314, 658		0	70.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	39, 934, 592 37, 655, 721	0	15, 656, 559 13, 544, 991		0	71. 00 72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	216, 411, 306	0	36, 020, 787		_	73.00
	07400 RENAL DI ALYSI S	11, 465, 208	0	2, 447, 153			74.00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	77.00
90.00	09000 CLI NI C	21, 670, 219	0	7, 159, 924	9	76, 181	90.00
91.00	09100 EMERGENCY	112, 097, 741	0	17, 239, 126	421	27, 063	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
	10100 HOME HEALTH AGENCY	3, 763, 223	0	2, 862, 360			101.00
102.00	10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	102.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 548, 882, 084	-35, 787, 165	314, 719, 217	29, 218	907, 468	118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	21, 979	0	1 201	190. 00
1 70.00	TILLED OF THE STOP OF THE STOP OF CONTILLING	1 9	<u> </u>	<u> </u>	1 0	1,001	1170.00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu	In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0002	Peri od:	Worksheet B-1		

From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/25/2023 12:46 pm Cost Center Description CASHIERING/AC Reconciliatio OTHER A&G PATI ENT OPERATION OF COUNTS (ACCUM. COST) TRANSPORTATIO PLANT n (SQUARE FEET) RECEI VABLE Ν (NUMBER OF (GROSS CHARGES) TRI PS) 5.04 5A. 05 5.05 5.06 7.00 191. 00 19100 RESEARCH 0 0 191.00 26, 711 192. 00 3, 457 192. 01 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 35, 062, 911 192. 01 19201 OTHER NON-REI MBURSABLE 0 397, 184 0 192.02 19202 FAMILY HEALTH/GARY COMM HEALTH 221, 298 0 8, 997 192. 02 193.00 19300 NONPALD WORKERS 0 o 0 193.00 Cross Foot Adjustments 200.00 200.00 201.00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, 8,007,513 35, 787, 165 701, 225 28, 434, 531 202. 00 Part I) 29. 980506 203. 00 3, 754, 525 204. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 0.005170 0.102126 23. 999760 204.00 Cost to be allocated (per Wkst. B, 375, 119 1, 333, 439 2,671 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000242 0.003805 0.091416 3. 958657 205. 00 11) 206.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

	ALLOCATION - STATISTICAL BASIS	WETHODIST HOS	Provi der CO	CN: 15-0002	Peri od:	Worksheet B-1	
					From 01/01/2022	Date/Time Pre 5/25/2023 12:	pared:
	Cost Center Description	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (PRODUCTI VE HOURS)	NURSI NG ADMI NI STRATI O N (DI RECT NURS. HRS.)	
	Ta	8. 00	9. 00	10.00	11. 00	13.00	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT				1	T	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. 00 17. 01	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 01700 SOCIAL SERVICE 01701 STAFF EDUCATION 01702 MEDICAL EDUCATION 02100 I &R SERVICES-SALARY & FRINGES APPRVD 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	1, 771, 781 0 0 0 0 2, 021 0 0 0 0 0	909, 974 18, 848 13, 177 6, 350 35, 843 18, 957 11, 307 1, 629 11, 147 374 0 4, 467	268, 520	2, 122, 138 66, 264 35, 003 0 82, 829 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 249, 994 0 0 0 0 0 0 0 0	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
30 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	814, 908	313, 217	216, 798	557, 837	557, 837	30.00
31.00		124, 784					
31. 01	03101 NEONATAL I CU	0	, , , , ,		31, 003		
40. 00 41. 00	04000 SUBPROVI DER	0 46, 550	-,				
43. 00	04300 NURSERY	22, 741			25, 782		1
F0 00	ANCILLARY SERVICE COST CENTERS	100 14/	F0 (47	Γ ,	122 550	122 550	
50.00	05000 OPERATI NG ROOM 05001 ENDOSCOPY	182, 146 24, 467			122, 559 15, 078		1
51. 00	05100 RECOVERY ROOM	11, 352					1
52.00	05200 DELIVERY ROOM & LABOR ROOM	43, 899					1
53.00	05300 ANESTHESI OLOGY	07.040	1		0		
54. 00 54. 01	05400 RADI OLOGY - DI AGNOSTI C 05401 RADI OLOGY - ULTRASOUND	37, 243 19, 039			70, 955 33, 999		54. 00 54. 01
55. 00		10, 321			11, 058		1
55. 01	05501 I NFUSI ON CENTER	0	-,		12, 085		
	05600 RADI OI SOTOPE	11, 141) 14, 777) 32, 513		
58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	22, 261 9, 277	8, 563 4, 205		32, 513 13, 916		
59.00	05900 CARDI AC CATHETERI ZATI ON	39, 357	8, 393	1	51, 016	0	59. 00
60.00	06000 LABORATORY	0	20,0.0		115, 798	l .	60.00
62. 00 64. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06400 INTRAVENOUS THERAPY	0	385		56, 747 0 0	0	62. 00 64. 00
65.00	06500 RESPIRATORY THERAPY	0	7, 766		70, 430	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	12, 270		31, 948	l .	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	10, 545 1, 796		25, 128 10, 085	l .	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	3, 112			23, 452		69.00
69. 01	06901 CARDI AC REHAB	937			11, 683	l .	
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17, 903	0		30, 769	0	70.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1, 662		8, 332	0	73. 00
74.00	07400 RENAL DI ALYSI S	13, 929			32		
77. 00	07700 ALLOGENEI C HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0		0	0	77.00
90.00	09000 CLI NI C	43, 390	76, 181	(69, 287	5, 930	90.00
91.00	I I	271, 003	27, 063	21, 42	7 174, 377	174, 377	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
101.00	10100 HOME HEALTH AGENCY	0	0	(0 0	0	101.00
	10200 OPIOID TREATMENT PROGRAM	0			0		102.00
110 00	SPECIAL PURPOSE COST CENTERS	1 771 704	0/0 000	2/0 52/	2 422 422	1 240 024	110 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	1, 771, 781	869, 008	268, 520	2, 122, 138	1, 249, 994	1118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1, 801	(0	0	190. 00
							

COST ALLOCATION - STATISTICAL BASIS	Provi der Co	CN: 15-0002	Peri od:	Worksheet B-1
			From 01/01/2022	
			To 12/31/2022	Date/Time Prepared:
				5/25/2023 12:46 pm

				11	0 12/31/2022	5/25/2023 12:	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	TO PIII
	·	LINEN SERVICE	(SQUARE FEET)	(MEALS	(PRODUCTI VE	ADMI NI STRATI O	
		(POUNDS OF		SERVED)	HOURS)	N	
		LAUNDRY)				(DI RECT NURS.	
						HRS.)	
		8. 00	9. 00	10.00	11. 00	13. 00	
	19100 RESEARCH	0	0	0	0		191. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	26, 711		0		192. 00
	19201 OTHER NON-REIMBURSABLE	0	3, 457		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, 088, 513	7, 929, 513	6, 232, 908	3, 249, 519	6, 638, 383	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	1. 178765	8. 714000	23. 212081	1. 531248	5. 310732	203. 00
204.00	Cost to be allocated (per Wkst. B,	293, 464	361, 751	333, 679	228, 409	136, 811	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 165632	0. 397540	1. 242660	0. 107632	0. 109449	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)						

COST ALLOCATION - STATISTICAL BAS	IS		Provi der CC	E	Period: From 01/01/2022 To 12/31/2022	Worksheet B-1 Date/Time Pre	pared:
Cost Center Descripti	on	CENTRAL SERVI CES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	STAFF EDUCATION (TIME SPENT)	46 pm
GENERAL SERVICE COST CENTER	RS	14. 00	15. 00	16. 00	17. 00	17.01	
1.00 00100 CAP REL COSTS-BLDG & 4.00 00400 EMPLOYEE BENEFITS DEF 5.01 00550 DATA PROCESSI NG 00560 PURCHASI NG RECEI VI NG 5.03 00570 ADMITTI NG 5.04 00580 CASHI ERI NG/ACCOUNTS R 5.05 00590 OTHER A&G 00592 PATIENT TRANSPORTATION 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVI 9.00 01000 DI ETARY 11.00 01100 CAFETERI A 13.00 01300 NURSI NG ADMINISTRATION 14.00 01400 CENTRAL SERVI CES & SU 15.00 01500 PHARMACY 16.00 01600 MEDICAL RECORDS & LIE 17.01 01700 SOCI AL SERVI CE 17.01 01700 SOCI AL SERVI CE 17.01 01700 MEDICAL EDUCATION 21.00 02100 I&R SERVI CES-SALARY & 22.00 02200 I&R SERVI CES-OTHER PR 23.00 02300 PARAMED ED PROGRAM	FIXT PARTMENT AND STORES ECEIVABLE IN CE IN IPPLY ERARY EFRINGES APPRVD EM COSTS APPRVD	26, 360, 703 0 0 0 0 0 0 0	22, 765, 671 0 0 0 0 0 0	1, 548, 882, 08 ⁴ C C C C C C C	700 0 0 0 0 0 0	68, 753 0 0 0 0 112	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 17. 01 17. 01 17. 02 21. 00 22. 00 23. 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 31. 01 03101 NEONATAL I CU 40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF 043. 00 04300 NURSERY		0 0 0 0 0	0 0 0 0 0	108, 775, 154 21, 622, 275 4, 768, 938 2, 452, 257 3, 879, 700 2, 096, 148	0 0 0 40	18, 086 6, 207 1, 622 84 1, 360 1, 765	30. 00 31. 00 31. 01 40. 00 41. 00 43. 00
ANCILLARY SERVICE COST CENT 50. 00 50.00 OPERATI NG ROOM 50. 01 O5000 OPERATI NG ROOM 52. 00 O5100 RECOVERY ROOM 52. 00 O5200 DELI VERY ROOM & LABOR 53. 00 O5300 ANESTHESI OLOGY 54. 00 O5400 RADI OLOGY - DI AGNOSTI C 54. 01 O5401 RADI OLOGY - DI AGNOSTI C 55. 00 O5500 RADI OLOGY - THERAPEUTI C 55. 01 O5501 INFUSI ON CENTER 56. 01 O5500 RADI OLOGY - THERAPEUTI C 57. 00 O5600 RADI OLOGY - THERAPEUTI C 58. 00 O5600 RADI OLOGY - THERAPEUTI C 59. 00 O5600 RADI OLOGY - THERAPEUTI C 59. 00 O5600 RADI OLOGY - THERAPEUTI C 60. 00 O6600 RADI OLOGY - THERAPY 61. 00 O6400 LABORATORY 62. 00 O6400 LABORATORY THERAPY 63. 00 O6400 INTRAVENOUS THERAPY 64. 00 O6400 PHYSI CAL THERAPY 65. 00 O6600 PHYSI CAL THERAPY 66. 00 O6600 PHYSI CAL THERAPY 67. 00 O6900 ELECTROCARDI OLOGY 69. 01 O6901 CARDI AC REHAB 70. 00 O7000 ELECTROENCEPHALOGRAPH 71. 00 O7100 MEDI CAL SUPPLI ES CHAR 72. 00 O7300 DRUGS CHARGED TO PATI 73. 00 O7300 DRUGS CHARGED TO PATI 74. 00 O7400 RENAL DI ALYSI S 77. 00 O7700 ALLOGENEI C HSCT ACQUI OUTPATI ENT SERVICE COST CEN	PATIENTS ENTS SITION	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 1, 241, 425 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	172, 039, 906 11, 419, 398 11, 769, 949 5, 587, 972 (43, 045, 376 24, 757, 047 26, 088, 940 19, 009, 274 18, 603, 735 144, 822, 556 31, 624, 327 70, 788, 792 224, 346, 171 23, 597, 930 44, 762, 155 7, 973, 843 5, 726, 726 2, 802, 466 27, 523, 086 1, 577, 084 44, 422, 872 39, 934, 592 37, 655, 721 216, 411, 306 11, 465, 208		8, 610 1, 040 807 7, 041 0 483 548 99 1 20 918 13 2, 429 50 195 0 1, 349 90 68 43 321 6 266 0 0 895 32	
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON OTHER REI MBURSABLE COST CEI	-DISTINCT PART)	0	0	21, 670, 219 112, 097, 741		335 10, 743	90. 00 91. 00 92. 00
101. 00 10100 HOME HEALTH AGENCY 102. 00 10200 OPI 0I D TREATMENT PROG SPECI AL PURPOSE COST CENTER	RAM	0	0	3, 763, 223 (101. 00 102. 00
118.00 SUBTOTALS (SUM OF LIN NONREIMBURSABLE COST CENTER	ES 1 through 117)	26, 360, 703	22, 631, 008	1, 548, 882, 084	700	66, 899	118. 00
190. 00 19000 GI FT, FLOWER, COFFEE		0	0	(0	1, 851	190. 00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0002	Period: Worksheet B-1 From 01/01/2022

				To	0 12/31/2022	Date/Time Pre 5/25/2023 12:	
	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		(GROSS			
		REQUIS.)		CHARGES)			
		14. 00	15. 00	16. 00	17. 00	17. 01	
191. 00 19100		0	0	0	0		191. 00
	PHYSICIANS' PRIVATE OFFICES	0	134, 663	0	0		192. 00
192. 01 1920	OTHER NON-REIMBURSABLE	0	0	0	0		192. 01
	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0		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, Part I)	5, 520, 201	7, 134, 465	4, 154, 378	650, 171	581, 259	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 209410	0. 313387	0. 002682	928. 815714	8. 454307	203. 00
204. 00	Cost to be allocated (per Wkst. B,	613, 842	336, 284				1
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 023286	0. 014772	0. 000135	41. 732857	2. 692450	205. 00
204 00	NAUE adjustment amount to be allegated						204 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS METHODIST HOSPITALS, INC In Lieu of Form CMS-2552-10 Peri od: From 01/01/2022 To 12/31/2022 Date/Ti me Prepared: 5/25/2023 12: 46 pm Provi der CCN: 15-0002 INTERNS & RESIDENTS

	Cost Center Description	MEDI CAL EDUCATI ON (ASSI GNED	SERVI CES-SALA RY & FRI NGES (ASSI GNED	SERVI CES-OTHE R PRGM COSTS (ASSI GNED	PARAMED ED PROGRAM (ASSI GNED	
		TI ME) 17. 02	TIME) 21.00	TI ME) 22. 00	TI ME) 23. 00	
4 00	GENERAL SERVICE COST CENTERS	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 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 11. 00	01000 DI ETARY 01100 CAFETERI A					10. 00 11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON					13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY					14.00
15.00	01500 PHARMACY					15.00
16. 00 17. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE					16. 00 17. 00
17. 00	01700 SOCIAL SERVICE					17.00
	01702 MEDI CAL EDUCATI ON	100				17. 02
21. 00	02100 &R SERVICES-SALARY & FRINGES APPRVD	0	100			21.00
22. 00		0		100	F 0/0	22.00
23.00	02300 PARAMED ED PROGRAM INPATIENT ROUTINE SERVICE COST CENTERS	0			5, 060	23. 00
30. 00		1 0	0	0	208	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0		0	31.00
31. 01	03101 NEONATAL I CU	0	0	0	0	31. 01
40.00	04000 SUBPROVI DER - I PF	0	0	0	0	40.00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	0		0	0	41. 00 43. 00
43.00	ANCILLARY SERVICE COST CENTERS			<u> </u>	<u> </u>	45.00
50.00	05000 OPERATING ROOM	0	0	0	208	50.00
50. 01	05001 ENDOSCOPY	0	0		0	50. 01
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	0	0	0	0 208	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY		0	0	208	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	Ö	Ö	ō	54.00
54. 01	05401 RADI OLOGY - ULTRASOUND	0	0	0	0	54. 01
55.00	O5500 RADI OLOGY-THERAPEUTI C	0	0	0	0	55.00
55. 01 56. 00	05501 I NFUSI ON CENTER 05600 RADI OI SOTOPE	0	0	0	0 0	55. 01 56. 00
57. 00	05700 CT SCAN	0	Ö	Ö	o	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	o	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	104	59.00
	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	60. 00 62. 00
64. 00					o	64.00
65.00		0	0	0	312	65.00
66. 00		0	0	0	0	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0	0	67. 00 68. 00
69.00	06900 ELECTROCARDI OLOGY		0	0	ol ol	69.00
69. 01	06901 CARDI AC REHAB	0	Ö	Ö	o	69. 01
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	o	70.00
71.00		0	0	0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	72. 00 73. 00
	07400 RENAL DIALYSIS	0	0	0	0	73.00
	07700 ALLOGENEIC HSCT ACQUISITION	0	Ö		Ö	77. 00
00 -	OUTPATIENT SERVICE COST CENTERS				.1	
	09000 CLI NI C 09100 EMERGENCY	100			0 4, 020	90. 00 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	100	100	100	4, 020	91.00
	OTHER REIMBURSABLE COST CENTERS	1				72.00
	10100 HOME HEALTH AGENCY	0			0	
102.00	10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	0	0	102.00
118. 00		100	100	100	5, 060	118. 00
	, , , , , , , , , , , , , , , , , , ,	100	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		3, 300	1

Health Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0002	Peri od:	Worksheet B-1

Cost Center Description	COST ALLOC	CATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-	-1
Cost Center Description								renared.
NONNEI MBURSABLE COST CENTERS TIME) TIME						10 12/31/2022		
EDUCATION (ASSI GNED TIME) TIME)				INTERNS &	RESI DENTS			
EDUCATION (ASSI GNED TIME) TIME)								
CASSIGNED TIME TI		Cost Center Description	MEDI CAL	SERVI CES-SALA	SERVI CES-0THE	PARAMED ED		
NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 191.00 191.00 191.00 191.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 0 192.00 192.01 19201 0 19201 0 19201 0 19201 0 19201 0 193.00						1 1		
17. 02 21. 00 22. 00 23. 00 23. 00 23. 00 20. 00 23. 00 2			(ASSI GNED	l ,	(ASSI GNED	(ASSI GNED		
NONREI MBURSABLE COST CENTERS 190.00 190000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190.00 191.00 191000 RESEARCH 0 0 0 0 0 0 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 0 192.01 19201 OTHER NON-REI MBURSABLE 0 0 0 0 0 192.02 19202 FAMILY HEALTH/GARY COMM HEALTH 0 0 0 0 0 192.03 19300 NONPAI D WORKERS 0 0 0 0 200.00 Cross Foot Adjustments 201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 702.990000 2,710.650000 2,672.810000 236.909091 203.00 203.00 Unit cost multiplier (Wkst. B, Part II) 702.990000 2,710.650000 2,672.810000 236.909091 203.00 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 63.950000 9.360000 743.000000 12.904743 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 0 206.00								
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 191.00 191.00 191.00 191.00 191.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.01 192.01 192.01 192.01 192.01 192.01 192.02 192.02 192.02 192.02 192.02 192.02 192.02 192.00 192.00 192.00 192.01 192.01 192.01 192.01 192.01 192.01 192.01 192.01 192.01 192.01 192.02 193.00 193.			17. 02	21. 00	22. 00	23. 00		
191.00								
192.00 19200 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192.00 192.01 19201 19201 OTHER NON-REIMBURSABLE 0 0 0 0 192.01 192.02 19202 FAMILY HEALTH/GARY COMM HEALTH 0 0 0 0 0 193.00 19300 NONPAID WORKERS 0 0 0 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 200.00 202.00 Cost to be allocated (per Wkst. B, Part I) 702.990000 2,710.650000 2,672.810000 236.909091 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 702.990000 2,710.650000 2,672.810000 236.909091 203.00 205.00 Unit cost multiplier (Wkst. B, Part II) 63.950000 9.360000 743.000000 12.904743 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 206.00 206.00			0	0		0		
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 NONPAID WORKERS 0 0 0 0 0 193.00 200.00 Cross Foot Adjustments Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 205.00 What is a part II of the pa			0	0		0		
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH 0 0 0 0 0 193.00 19300 NONPAID WORKERS 0 0 0 0 0 193.00 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 40 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0		0		
193.00 19300 NONPAID WORKERS 0 0 0 0 0 0 193.00 200.00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 702.990000 2,710.650000 236.90901 203.00 Unit cost multiplier (Wkst. B, Part II) 702.990000 2,710.650000 2,672.810000 236.909091 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 8,760 Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 63.950000 9.360000 743.000000 12.904743 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)		1	0	0		0		
200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, Part I) 702.990000 2,710.650000 2,672.810000 236.909091 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 702.990000 2,710.650000 2,672.810000 236.909091 203.00 204.00 205.00 Unit cost multiplier (Wkst. B, Part II) 63.950000 9.360000 743.000000 12.904743 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 206.00		1	0	0		0		
201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 702.990000 2,710.650000 2,672.810000 236.909091 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 702.990000 2,710.650000 2,672.810000 236.909091 203.00 204.00 205.00 Unit cost multiplier (Wkst. B, Part II) 63.950000 9.360000 743.000000 12.904743 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 206.00			0	0		0		
202.00 Cost to be allocated (per Wkst. B, Part I) 70,299 271,065 267,281 1,198,760 202.00 203.00 Unit cost multiplier (Wkst. B, Part I) 702.990000 2,710.650000 2,672.810000 236.909091 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 63.950000 9.360000 743.000000 12.904743 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 0 206.00 206.00								
Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part III) 205.00 Unit cost multiplier (Wkst. B, Part III) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) Part II) 207.090000 2,710.6500000 2,710.6500000 2,710.6500000 2,710.6500000000000000000000000000000000000	•							
203.00 Unit cost multiplier (Wkst. B, Part I) 702.990000 2,710.650000 2,672.810000 236.909091 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) 0.00 Unit cost multiplier (Wkst. B, Part II) 0.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 2,710.650000 2,710.650000 2,710.650000 236.909091 203.00 204.00 743.00000 12.904743 205.00 206.00	202. 00		70, 299	271, 065	267, 28	1, 198, 760		202. 00
204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 204.00 206.00 20								
Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) NAHE adjustment amount to be allocated (per Wkst. B-2) Part II) On Hand to be allocated (per Wkst. B-2) Part II) On Hand to be allocated (per Wkst. B-2) Part II) On Hand to be allocated (per Wkst. B-2)	•							
205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) Unit cost multiplier (Wkst. B, Part 63.950000 9.360000 743.000000 12.904743 205.00 206.00	204. 00		6, 395	936	74, 30	0 65, 298		204.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 206.00								
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 206.00	205. 00		63. 950000	9. 360000	743. 00000	0 12. 904743		205. 00
(per Wkst. B-2)		1 /						
	206. 00					0		206. 00
207.00 NAHE unit cost multiplier (Wkst. D, 0.000000 207.00	007.00					0.005		
	207.00					0.000000		207.00
Parts III and IV)		Parts III and IV)						1

Health Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0002		Worksheet C
		From 01/01/2022	

				أ	Го 12/31/2022	Date/Time Pre 5/25/2023 12:	pared:
			Title	XVIII	Hospi tal	PPS	то ріп
			11 21 0	7,,,,,	Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	5551 5511151 B5551 F11 611	(from Wkst.	Adj.	10141 00010	Di sal I owance	.014. 00010	
		B, Part I,	7.09.		Di dai i diidiido		
		col . 26)					
		1. 00	2. 00	3.00	4.00	5. 00	
1	NPATIENT ROUTINE SERVICE COST CENTERS		2.00	0.00		0.00	
	33000 ADULTS & PEDIATRICS	86, 914, 608		86, 914, 608	3 ol	86, 914, 608	30.00
	03100 INTENSIVE CARE UNIT	14, 983, 553		14, 983, 553		14, 983, 553	
	03100 INTENSIVE CARE UNIT	2, 542, 621		2, 542, 62		2, 542, 621	
	04000 SUBPROVIDER - IPF	1, 765, 771		1, 765, 77		1, 765, 771	1
	04100 SUBPROVIDER - IRF	4, 811, 601		4, 811, 60		4, 811, 601	
	l e e e e e e e e e e e e e e e e e e e						
	04300 NURSERY	3, 694, 523		3, 694, 523	<u> </u>	3, 694, 523	43.00
	NCILLARY SERVICE COST CENTERS	10 007 405		10 007 40	-1 -1	10 007 405	F0 00
	05000 OPERATING ROOM	19, 937, 495		19, 937, 495		19, 937, 495	
	D5001 ENDOSCOPY	1, 789, 789		1, 789, 789		1, 789, 789	
	D5100 RECOVERY ROOM	2, 541, 453		2, 541, 453		2, 541, 453	
	D5200 DELIVERY ROOM & LABOR ROOM	7, 257, 576		7, 257, 576		7, 257, 576	
	05300 ANESTHESI OLOGY	0		(-	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	8, 897, 870		8, 897, 870		8, 897, 870	
	05401 RADI OLOGY - ULTRASOUND	3, 134, 486		3, 134, 486		3, 134, 486	
	05500 RADI OLOGY-THERAPEUTI C	3, 443, 579		3, 443, 579		3, 447, 990	
	05501 INFUSION CENTER	1, 374, 125		1, 374, 125	5 0	1, 374, 125	55. 01
56.00 0	05600 RADI OI SOTOPE	3, 122, 218		3, 122, 218	3 0	3, 122, 218	56.00
	05700 CT SCAN	5, 342, 939		5, 342, 939	9 0	5, 342, 939	57.00
58.00 0	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 973, 990		1, 973, 990	0	1, 973, 990	58.00
59.00 0	05900 CARDI AC CATHETERI ZATI ON	5, 847, 986		5, 847, 986	6 0	5, 847, 986	59.00
60.00 0	06000 LABORATORY	19, 709, 912		19, 709, 912	<u>2</u> ol	19, 709, 912	60.00
62.00 0	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 469, 637		2, 469, 637	7 ol	2, 469, 637	62.00
64.00 0	06400 INTRAVENOUS THERAPY	0			ol ol	0	64.00
65.00 0	06500 RESPI RATORY THERAPY	6, 738, 635	0	6, 738, 635	sl ol	6, 738, 635	65.00
66.00 0	06600 PHYSI CAL THERAPY	2, 704, 739	0	2, 704, 739	el ol	2, 704, 739	66.00
	06700 OCCUPATI ONAL THERAPY	2, 198, 397	0			2, 198, 397	67.00
	06800 SPEECH PATHOLOGY	790, 124	0	790, 124		790, 124	68.00
	06900 ELECTROCARDI OLOGY	1, 614, 186	_	1, 614, 186		1, 614, 186	
	06901 CARDI AC REHAB	675, 994		675, 994		675, 994	
	07000 ELECTROENCEPHALOGRAPHY	2, 742, 934		2, 742, 934		2, 742, 934	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	20, 325, 455		20, 325, 455		20, 325, 455	
	07200 IMPL. DEV. CHARGED TO PATIENTS	17, 586, 632		17, 586, 632		17, 586, 632	
	07300 DRUGS CHARGED TO PATIENTS	47, 067, 714		47, 067, 714		47, 067, 714	
	07400 RENAL DIALYSIS	2, 914, 352		2, 914, 352		2, 914, 352	
	07700 ALLOGENEIC HSCT ACQUISITION	2, 714, 332		2, 914, 332		2, 914, 332	1
	DUTPATIENT SERVICE COST CENTERS	U)	U	77.00
	09000 CLINIC	11, 088, 828		11, 088, 828	ما ما	11 000 000	90.00
						11, 088, 828	
	09100 EMERGENCY	23, 499, 600		23, 499, 600		23, 499, 600	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	12, 687, 849		12, 687, 849	1	12, 687, 849	92.00
	THER REIMBURSABLE COST CENTERS	0 475 405		0 475 405	-1	0 475 405	
	0100 HOME HEALTH AGENCY	3, 175, 435		3, 175, 435		3, 175, 435	
	0200 OPI OI D TREATMENT PROGRAM	0	_	(1		102.00
200.00	Subtotal (see instructions)	357, 366, 606	0			357, 371, 017	
201.00	Less Observation Beds	12, 687, 849	_	12, 687, 849		12, 687, 849	
202.00	Total (see instructions)	344, 678, 757	0	344, 678, 757	7 4, 411	344, 683, 168	202.00

					rom 01/01/2022 o 12/31/2022	Part I Date/Time Pre 5/25/2023 12:	pared:
-			Title	xVIII	Hospi tal	PPS	40 piii
			Charges	AVIII	nospi tai	113	
	Cost Center Description	Inpati ent	Outpati ent	Total (col 6	Cost or Other	TEFRA	
	cost center bescription	Tripatrent	outpatrent	+ col . 7)	Ratio	Inpatient	
				1 001. 7)	Ratio	Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7. 00		
30.00	03000 ADULTS & PEDI ATRI CS	85, 749, 263		85, 749, 263			30.00
31.00	03100 INTENSIVE CARE UNIT	21, 622, 275		21, 622, 275	;		31.00
31. 01	03101 NEONATAL I CU	4, 768, 938		4, 768, 938			31.01
40.00	04000 SUBPROVI DER - I PF	2, 452, 257		2, 452, 257			40.00
41.00	04100 SUBPROVI DER - I RF	3, 879, 700		3, 879, 700			41.00
43.00	04300 NURSERY	2, 096, 145		2, 096, 145	i		43.00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	61, 213, 308	110, 826, 598	172, 039, 906	0. 115889	0. 000000	50.00
50. 01	05001 ENDOSCOPY	4, 650, 350	6, 769, 048	11, 419, 398	0. 156732	0.000000	50. 01
51.00	05100 RECOVERY ROOM	3, 537, 380	8, 232, 569	11, 769, 949	0. 215927	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 353, 656	3, 234, 316	5, 587, 972	1. 298785	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	0	0	C	0. 000000	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	9, 844, 413	33, 200, 963	43, 045, 376	0. 206709	0.000000	54.00
54.01	05401 RADI OLOGY - ULTRASOUND	6, 059, 772	18, 697, 275	24, 757, 047	0. 126610	0.000000	54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 039, 229	25, 049, 711	26, 088, 940	0. 131994	0.000000	55.00
55.01	05501 INFUSION CENTER	17, 469	18, 991, 805	19, 009, 274	0. 072287	0.000000	55. 01
56.00	05600 RADI OI SOTOPE	4, 673, 026	13, 930, 709	18, 603, 735	0. 167827	0.000000	56.00
57.00	05700 CT SCAN	52, 271, 434	92, 551, 122	144, 822, 556	0. 036893	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	11, 136, 164	20, 488, 163	31, 624, 327	0. 062420	0.000000	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	38, 933, 884	31, 854, 908	70, 788, 792	0. 082612	0.000000	59.00
60.00	06000 LABORATORY	95, 884, 577	128, 461, 594	224, 346, 171	0. 087855	0.000000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	11, 713, 765	11, 884, 165	23, 597, 930		0.000000	
64.00	06400 I NTRAVENOUS THERAPY	0	0	ı c	0. 000000	0.000000	
65.00	06500 RESPI RATORY THERAPY	41, 501, 855	3, 260, 300	44, 762, 155		0.000000	
66.00	06600 PHYSI CAL THERAPY	7, 122, 942	850, 901	7, 973, 843		0.000000	1
67. 00	06700 OCCUPATI ONAL THERAPY	5, 252, 101	474, 625			0. 000000	
68.00	06800 SPEECH PATHOLOGY	2, 527, 142	275, 324			0. 000000	1
69. 00	06900 ELECTROCARDI OLOGY	13, 660, 046	13, 863, 040			0. 000000	1
69. 01	06901 CARDI AC REHAB	474, 484	1, 102, 600			0. 000000	1
70.00	07000 ELECTROENCEPHALOGRAPHY	14, 856, 923	29, 565, 949			0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	21, 902, 573	18, 032, 019			0. 000000	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	20, 198, 414	17, 457, 307			0. 000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	99, 240, 576	117, 170, 730			0. 000000	1
74.00	07400 RENAL DIALYSIS	10, 492, 914	972, 294			0. 000000	1
77. 00	07700 ALLOGENEI C HSCT ACQUISITION	0	0	(C	0. 000000	0. 000000	77. 00
	OUTPATIENT SERVICE COST CENTERS			1			
90.00	09000 CLI NI C	133, 214	21, 537, 005			0. 000000	1
91.00	09100 EMERGENCY	23, 822, 067	88, 275, 674			0.000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 243, 466	17, 782, 425	23, 025, 891	0. 551025	0. 000000	92.00
101 00	OTHER REIMBURSABLE COST CENTERS		2 7/2 222	2 7/2 000	,		101 00
	10100 HOME HEALTH AGENCY	0	3, 763, 223	3, 763, 223			101.00
	10200 OPI OI D TREATMENT PROGRAM	(00 225 722	050 557 070	1 540 000 001	'		102.00
200.00		690, 325, 722	858, 556, 362	1, 548, 882, 084			200.00
201.00		400 335 733	050 554 343	1 540 000 004			201.00
202.00	Total (see instructions)	690, 325, 722	000, 000, 362	1, 548, 882, 084	ı I		202. 00

Heal th Financial Systems

METHODIST HOSPITALS, INC

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0002
From 01/01/2022
To 12/31/2022
To 12/31/2022
Date/Time Prepared: 5/25/2023 12: 46 pm

		Title XVIII	Hospi tal	PPS	40 pili
Cost Center Description	PPS Inpatient	TI LIE XVIII	nospi tai	FF3	
cost center bescription	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	11.00				
30. 00 03000 ADULTS & PEDIATRICS					30.00
31. 00 03100 NTENSI VE CARE UNIT					31.00
31. 01 03101 NEONATAL CU					31.01
40. 00 04000 SUBPROVI DER - PF					40.00
41. 00 04100 SUBPROVI DER - RF					41.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					1 43.00
50. 00 05000 OPERATING ROOM	0. 115889				50.00
50. 01 05001 ENDOSCOPY	0. 156732				50.00
51. 00 05100 RECOVERY ROOM	0. 215927				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1. 298785				52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 206709				54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	0. 126610				54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 132163				55.00
55. 01 05501 I NFUSI ON CENTER	0. 132103				55. 01
56. 00 05600 RADI 0I SOTOPE	0. 072287				56.00
57. 00 05700 CT SCAN	0. 036893				57.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 030843				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 082420				59.00
60. 00 06000 LABORATORY	0. 082812				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1				62.00
	0. 104655				64.00
	0.000000				1
65. 00 06500 RESPIRATORY THERAPY	0. 150543				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 339201				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 383884				67.00
68. 00 06800 SPEECH PATHOLOGY	0. 281939				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 058648				69.00
69. 01 06901 CARDI AC REHAB	0. 428635				69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 061746				70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 508969				71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 467037				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 217492				73.00
74. 00 07400 RENAL DI ALYSI S	0. 254191				74.00
77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON	0. 000000				77. 00
OUTPATIENT SERVICE COST CENTERS	0.544700				
90. 00 09000 CLI NI C	0. 511708				90.00
91. 00 09100 EMERGENCY	0. 209635				91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 551025				92.00
OTHER REIMBURSABLE COST CENTERS					101 00
101. 00 10100 HOME HEALTH AGENCY					101.00
102. 00 10200 OPI OI D TREATMENT PROGRAM					102.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

				o 12/31/2022	Date/Time Pre	pared:
		Ti +l	e XIX	Hospi tal	5/25/2023 12: Cost	46 PIII
		11 (1	e XIX	Costs	0031	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS	86, 914, 608		86, 914, 608	3 0	86, 914, 608	30.00
31. 00 03100 NTENSI VE CARE UNI T	14, 983, 553		14, 983, 553		14, 983, 553	31.00
31. 01 03101 NEONATAL I CU	2, 542, 621		2, 542, 621		2, 542, 621	31.00
40. 00 04000 SUBPROVI DER - 1 PF	1, 765, 771		1, 765, 771		1, 765, 771	40.00
41. 00 04100 SUBPROVI DER	4, 811, 601		4, 811, 601		4, 811, 601	41.00
43. 00 04300 NURSERY	3, 694, 523		3, 694, 523		3, 694, 523	
ANCILLARY SERVICE COST CENTERS	3,074,323		3, 074, 320	0	3, 074, 323	45.00
50. 00 05000 OPERATING ROOM	19, 937, 495		19, 937, 495	0	19, 937, 495	50.00
50. 01 05001 ENDOSCOPY	1, 789, 789		1, 789, 789		1, 789, 789	50.00
51. 00 05100 RECOVERY ROOM	2, 541, 453		2, 541, 453		2, 541, 453	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	7, 257, 576		7, 257, 576		7, 257, 576	
53. 00 05300 ANESTHESI OLOGY	7,207,070		(1	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	8, 897, 870		8, 897, 870	-	8, 897, 870	
54. 01 05401 RADI OLOGY - ULTRASOUND	3, 134, 486		3, 134, 486		3, 134, 486	1
55. 00 05500 RADI OLOGY-THERAPEUTI C	3, 443, 579		3, 443, 579		3, 447, 990	
55. 01 05501 NFUSI ON CENTER	1, 374, 125		1, 374, 125		1, 374, 125	55. 01
56. 00 05600 RADI 0I SOTOPE	3, 122, 218		3, 122, 218		3, 122, 218	1
57. 00 05700 CT SCAN	5, 342, 939		5, 342, 939		5, 342, 939	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 973, 990		1, 973, 990		1, 973, 990	
59. 00 05900 CARDI AC CATHETERI ZATI ON	5, 847, 986		5, 847, 986		5, 847, 986	
60. 00 06000 LABORATORY	19, 709, 912		19, 709, 912		19, 709, 912	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 469, 637		2, 469, 637		2, 469, 637	62.00
64. 00 06400 I NTRAVENOUS THERAPY	0				0	64.00
65. 00 06500 RESPIRATORY THERAPY	6, 738, 635	0	6, 738, 635	o o	6, 738, 635	65.00
66. 00 06600 PHYSI CAL THERAPY	2, 704, 739	0			2, 704, 739	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	2, 198, 397	0			2, 198, 397	67.00
68. 00 06800 SPEECH PATHOLOGY	790, 124	0	790, 124	ı o	790, 124	68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 614, 186		1, 614, 186	0	1, 614, 186	69.00
69. 01 06901 CARDI AC REHAB	675, 994		675, 994	ı o	675, 994	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 742, 934		2, 742, 934	0	2, 742, 934	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	20, 325, 455		20, 325, 455	0	20, 325, 455	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	17, 586, 632		17, 586, 632	<u> </u>	17, 586, 632	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	47, 067, 714		47, 067, 714	0	47, 067, 714	73.00
74.00 07400 RENAL DIALYSIS	2, 914, 352		2, 914, 352	2 o	2, 914, 352	74.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0		(0	77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	11, 088, 828		11, 088, 828	0	11, 088, 828	90.00
91. 00 09100 EMERGENCY	23, 499, 600		23, 499, 600	0	23, 499, 600	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	12, 687, 849		12, 687, 849)	12, 687, 849	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	3, 175, 435		3, 175, 435	5	3, 175, 435	
102.00 10200 OPIOID TREATMENT PROGRAM	0		C	1		102.00
200.00 Subtotal (see instructions)	357, 366, 606	0			357, 371, 017	
201.00 Less Observation Beds	12, 687, 849		12, 687, 849		12, 687, 849	
202.00 Total (see instructions)	344, 678, 757	0	344, 678, 757	4, 411	344, 683, 168	202. 00

From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/25/2023 12:46 pm 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 85, 749, 263 30.00 03000 ADULTS & PEDIATRICS 85, 749, 263 30.00 31.00 03100 INTENSIVE CARE UNIT 21, 622, 275 21, 622, 275 31.00 03101 NEONATAL ICU 4, 768, 938 4, 768, 938 31.01 31.01 40.00 04000 SUBPROVI DER - I PF 2, 452, 257 2, 452, 257 40.00 04100 SUBPROVI DER - I RF 3, 879, 700 41.00 3, 879, 700 41.00 43.00 04300 NURSERY 2, 096, 145 2, 096, 145 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0. 115889 50.00 61, 213, 308 110, 826, 598 172, 039, 906 0.000000 50.00 05001 ENDOSCOPY 50.01 4,650,350 6, 769, 048 11, 419, 398 0.156732 0.000000 50.01 51.00 05100 RECOVERY ROOM 3, 537, 380 8, 232, 569 11, 769, 949 0.215927 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 2, 353, 656 3, 234, 316 5, 587, 972 1. 298785 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 9, 844, 413 33, 200, 963 43, 045, 376 0.206709 0.000000 54.00 6, 059, 772 18, 697, 275 54.01 05401 RADI OLOGY - ULTRASOUND 24, 757, 047 0.126610 0.000000 54.01 26, 088, 940 05500 RADI OLOGY-THERAPEUTI C 25, 049, 711 55.00 1,039,229 0.131994 0.000000 55.00 05501 INFUSION CENTER 18, 991, 805 55.01 17, 469 19, 009, 274 0.072287 0.000000 55 01 05600 RADI OI SOTOPE 4, 673, 026 13, 930, 709 18, 603, 735 0.167827 0.000000 56.00 56.00 57.00 05700 CT SCAN 52, 271, 434 92, 551, 122 144, 822, 556 0.036893 0.000000 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 31, 624, 327 58.00 11, 136, 164 20, 488, 163 0.062420 0.000000 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 38, 933, 884 31, 854, 908 70, 788, 792 0.082612 0.000000 59.00 60.00 06000 LABORATORY 95, 884, 577 128, 461, 594 224, 346, 171 0.087855 0.000000 60.00 11, 884, 165 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 11, 713, 765 23, 597, 930 0.104655 0.000000 62.00 62.00 06400 I NTRAVENOUS THERAPY 64.00 0.000000 0.000000 64.00 65.00 06500 RESPIRATORY THERAPY 41, 501, 855 3, 260, 300 44, 762, 155 0.150543 0.000000 65.00 06600 PHYSI CAL THERAPY 7, 122, 942 850, 901 7, 973, 843 0. 339201 66.00 0.000000 66.00 06700 OCCUPATIONAL THERAPY 474, 625 5, 726, 726 0.383884 0.000000 67.00 5, 252, 101 67.00 06800 SPEECH PATHOLOGY 68.00 2, 527, 142 275, 324 2, 802, 466 0.281939 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 13, 660, 046 13, 863, 040 27, 523, 086 0.058648 0.000000 69.00 69.01 06901 CARDI AC REHAB 474, 484 1, 102, 600 1, 577, 084 0. 428635 0.000000 69.01 70 00 07000 ELECTROENCEPHALOGRAPHY 14, 856, 923 29 565 949 44, 422, 872 0.061746 0.000000 70 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.508969 0.000000 71.00 21, 902, 573 18, 032, 019 39, 934, 592 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 20, 198, 414 17, 457, 307 37, 655, 721 0.467037 0.000000 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 99, 240, 576 117, 170, 730 216, 411, 306 0.217492 0.000000 73.00 07400 RENAL DIALYSIS 10, 492, 914 972, 294 74 00 11, 465, 208 0 254191 0.000000 74 00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0.000000 77.00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLINIC 133 214 21, 537, 005 0.511708 0.000000 90 00 21, 670, 219 91.00 09100 EMERGENCY 23, 822, 067 88, 275, 674 112, 097, 741 0.209635 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 5, 243, 466 17, 782, 425 23, 025, 891 0.551025 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 101 00 10100 HOME HEALTH AGENCY 101 00 3, 763, 223 3, 763, 223

690, 325, 722

690, 325, 722

858, 556, 362

1, 548, 882, 084

858, 556, 362 1, 548, 882, 084

102.00

200.00

201.00

202.00

102.00 10200 OPI OID TREATMENT PROGRAM

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

200.00

201.00

202.00

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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0002 From 01/01/2022 To 12/31/2022 To 12/31/2022 To 12/5/25/2023 12: 46 pm

				5/25/2023 12: 46	pm
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS				30	0.00
31.00 03100 INTENSIVE CARE UNIT				31	1. 00
31. 01 03101 NEONATAL CU				31	1. 01
40. 00 04000 SUBPROVI DER - 1 PF				40	0. 00
41. 00 04100 SUBPROVI DER - I RF				41	1. 00
43. 00 04300 NURSERY				43	3.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM	0. 000000			50	0. 00
50. 01 05001 ENDOSCOPY	0. 000000			50	0. 01
51.00 05100 RECOVERY ROOM	0. 000000				1. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			•	2.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			•	3.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			•	4. 00
54. 01 05401 RADI OLOGY - ULTRASOUND	0. 000000				4. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000				5. 00
55. 01 05501 NFUSI ON CENTER	0. 000000				5. 01
56. 00 05600 RADI OI SOTOPE	0. 000000				6. 00
57. 00 05700 CT SCAN	0. 000000				7. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				8. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000				9. 00
60. 00 06000 LABORATORY	0. 000000				0.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000				2. 00
64. 00 06400 NTRAVENOUS THERAPY	0. 000000				4. 00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				5. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				6. 00
67. 00 06700 OCCUPATI ONAL THERAPY					7. 00
	0.000000			l l	
68. 00 06800 SPEECH PATHOLOGY	0.000000				8.00
69. 00 06900 ELECTROCARDI OLOGY	0.000000			• • • • • • • • • • • • • • • • • • •	9.00
69. 01 06901 CARDI AC REHAB	0.000000			• • • • • • • • • • • • • • • • • • •	9. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000				0.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			•	1.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			•	2.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			•	3.00
74. 00 07400 RENAL DI ALYSI S	0. 000000				4.00
77. 00 O7700 ALLOGENEIC HSCT ACQUISITION	0. 000000				7. 00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0. 000000			•	0.00
91. 00 09100 EMERGENCY	0. 000000				1.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92	2. 00
OTHER REIMBURSABLE COST CENTERS					
101.00 10100 HOME HEALTH AGENCY					1. 00
102.00 10200 OPI OI D TREATMENT PROGRAM					2.00
200.00 Subtotal (see instructions)					0.00
201.00 Less Observation Beds					1. 00
202.00 Total (see instructions)				202	2. 00

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 01/01/2022 To 12/31/2022		
		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				<u> </u>		
30.00 ADULTS & PEDIATRICS	6, 074, 091		0,0,1,0,			
31.00 INTENSIVE CARE UNIT	465, 041		465, 04			
31. 01 NEONATAL I CU	59, 075		59, 07			
40. 00 SUBPROVI DER - I PF	81, 672		81, 67			
41.00 SUBPROVIDER - IRF	565, 273		565, 27			41.00
43. 00 NURSERY	429, 235	l e	429, 23		201. 42	
200.00 Total (lines 30 through 199)	7, 674, 387		7, 674, 38	7 95, 963		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	17, 859				l	30.00
31. 00 INTENSIVE CARE UNIT	2, 326		•		l	31.00
31. 01 NEONATAL ICU	0	1			ļ	31. 01
40. 00 SUBPROVI DER - I PF	194				l	40.00
41. 00 SUBPROVI DER - I RF	1, 299	l .			ļ	41.00
43. 00 NURSERY	0	1			ļ	43.00
200.00 Total (lines 30 through 199)	21, 678	1, 724, 343	I			200. 00

Health Financial Systems	METHODIST HOS	SPITALS, INC		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider CO		Period: From 01/01/2022 To 12/31/2022	Worksheet D Part II Date/Time Pre 5/25/2023 12:	pared: 46 pm_
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	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, 206, 291		0. 00701		82, 788	50.00
50. 01 05001 ENDOSCOPY	21, 790	11, 419, 398			2, 708	50. 01
51.00 05100 RECOVERY ROOM	261, 174	11, 769, 949	0. 02219	0 612, 038	13, 581	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	193, 493	5, 587, 972	0. 03462	7 207, 260	7, 177	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0.00000	0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	937, 416	43, 045, 376	0. 02177	7 2, 786, 315	60, 678	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	113, 823	24, 757, 047	0. 00459	8 1, 484, 195	6, 824	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	154, 980	26, 088, 940	0. 00594	0 358, 979	2, 132	55.00
55. 01 05501 I NFUSI ON CENTER	108, 285	19, 009, 274	0. 00569	6 128	1	55. 01
56. 00 05600 RADI 01 SOTOPE	173, 006	18, 603, 735	0. 00930	0 1, 162, 264	10, 809	56.00
57. 00 05700 CT SCAN	234, 244	144, 822, 556	0. 00161	7 14, 597, 594	23, 604	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	93, 362		0. 00295		8, 487	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	209, 460	70, 788, 792	0. 00295	9 9, 851, 796	29, 151	59.00
60. 00 06000 LABORATORY	595, 282		0. 00265		71, 216	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	32, 822				1, 374	62.00
64. 00 06400 I NTRAVENOUS THERAPY	0		0. 00000		0	64.00
65. 00 06500 RESPIRATORY THERAPY	184, 272		0. 00411		45, 423	
66. 00 06600 PHYSI CAL THERAPY	218, 632		0. 02741		43, 337	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	186, 662		0. 03259		33, 008	
68. 00 06800 SPEECH PATHOLOGY	34, 858				9, 160	68.00
69. 00 06900 ELECTROCARDI OLOGY	22, 007				3, 058	
69. 01 06901 CARDI AC REHAB	4, 612				0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	36, 748				3, 469	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	434, 654				63, 671	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	376, 750				53, 427	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	583, 285				69, 043	73.00
74. 00 07400 RENAL DIALYSIS	89, 550				21, 368	74.00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	07,330		0. 00000		21, 300	77.00
OUTPATIENT SERVICE COST CENTERS	1 0	0	0.00000	0		77.00
90. 00 09000 CLI NI C	1, 317, 061	21, 670, 219	0. 06077	7 53, 364	3, 243	90.00
91. 00 09100 EMERGENCY	718, 500		0. 00641		43, 303	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	886, 703		0. 03850		54, 295	
200.00 Total (lines 50 through 199)		1, 424, 550, 283		145, 136, 916	· ·	
200. 00 Total (Tries 30 through 199)	7,427,122	1, 424, 330, 203	l	143, 130, 710	700, 333	1200.00

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS			Period: From 01/01/2022 To 12/31/2022	Worksheet D Part III Date/Time Pre 5/25/2023 12:	epared:
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		n Allied Health	All Other	
	Program	Program	Post-Stepdow	n Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 49, 277	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	1	0 0	0	31.00
31. 01 03101 NEONATAL I CU	0	0		0 0	0	31.01
40. 00 04000 SUBPROVI DER - 1 PF	0	0		0 0	0	40.00
41. 00 04100 SUBPROVI DER - RF	0	0		0	0	41.00
43. 00 04300 NURSERY	0	0	1	0 0	0	43.00
200.00 Total (lines 30 through 199)	0	0		0 49, 277	_	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien		I npati ent	200.00
oost denter bescription	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,	Days	col. 6)	l rogram bays	
	instructions)			(01. 0)		
	4. 00	5. 00	6, 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1. 00	0.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	0	49, 277	79, 33	9 0. 62	17, 859	30.00
31. 00 03100 I NTENSI VE CARE UNI T		0	1			
31. 01 03101 NEONATAL CU		0	1, 77		0	31.01
40. 00 04000 SUBPROVI DER - PF	0	0	1, 24		194	
41. 00 04100 SUBPROVI DER - 1 RF	0	0	3, 52		1, 299	
43. 00 04300 NURSERY		0	1			
200.00 Total (lines 30 through 199)		49, 277				200.00
Cost Center Description	Inpatient	49, 211	95, 90	<u>ی</u>	21,070	200.00
cost center bescription	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9.00					
INDATIENT DOUTINE CEDVICE COCT CENTEDS	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS	11, 073					30.00
						31.00
	0					
						31.01
40. 00 04000 SUBPROVI DER - PF	0					40.00
41. 00 04100 SUBPROVI DER - I RF						41.00
43. 00 04300 NURSERY	0					
43.00 04300 NURSERY 200.00 Total (Lines 30 through 199)	11, 073					43. 00 200. 00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-000	
THROUGH COSTS		From 01/01/2022 Part IV

				To 12/31/2022	Date/lime Pre 5/25/2023 12:	
		Title	XVIII	Hospi tal	PPS	40 piii
Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
3331 3311131 33331 1 211 311	Anesthetist	Program	Program	Post-Stepdown	/ I r od nod til	
		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	49, 277	50.00
50. 01 05001 ENDOSCOPY	0	0		0	0	50. 01
51.00 05100 RECOVERY ROOM	0	0		0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	49, 277	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	0	0		0	0	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	55.00
55. 01 05501 I NFUSI ON CENTER	0	0		0	0	55. 01
56. 00 05600 RADI 0I SOTOPE	0	0		0	0	56.00
57.00 05700 CT SCAN	0	0		0	0	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	24, 639	59.00
60. 00 06000 LABORATORY	0	0		0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	02.00
64.00 06400 I NTRAVENOUS THERAPY	0	0		0	0	
65. 00 06500 RESPIRATORY THERAPY	0	0		0	73, 916	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	
69. 01 06901 CARDI AC REHAB	0	0		0	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	1 /2.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0		0	0	74.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0		
91. 00 09100 EMERGENCY	0	0		0	952, 374	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	7, 194	
200.00 Total (lines 50 through 199)	0	0		0	1, 156, 677	200. 00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCI	LLARY SERVICE OTHER PASS Provider CCN: 15-0002	
		F 04 /04 /0000 D I IV

From 01/01/2022 | Part IV To 12/31/2022 | Date/Time Prepared: THROUGH COSTS 5/25/2023 12:46 pm 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 49, 277 49, 277 172, 039, 906 0.000286 50.00 05001 ENDOSCOPY 0 11, 419, 398 50.01 0.000000 50.01 0 05100 RECOVERY ROOM 11, 769, 949 51.00 0.000000 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 5, 587, 972 52.00 49, 277 49, 277 0.008818 52.00 05300 ANESTHESI OLOGY 0000000000000000000000000 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 43, 045, 376 0.000000 54.00 54.01 05401 RADI OLOGY - ULTRASOUND C 24, 757, 047 0.000000 54.01 05500 RADI OLOGY-THERAPEUTI C 55.00 C 26, 088, 940 0.000000 55.00 55.01 05501 INFUSION CENTER 19, 009, 274 0.000000 55.01 05600 RADI OI SOTOPE 0 18, 603, 735 0.000000 56.00 56.00 05700 CT SCAN 57.00 C 0 144, 822, 556 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 31, 624, 327 0.000000 58.00 05900 CARDI AC CATHETERI ZATI ON 0.000348 59.00 24, 639 24,639 70, 788, 792 59.00 06000 LABORATORY 224, 346, 171 60 00 0 000000 60 00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 23, 597, 930 0.000000 62.00 64.00 06400 I NTRAVENOUS THERAPY 0 0.000000 64.00 06500 RESPIRATORY THERAPY 65.00 73, 916 73, 916 44, 762, 155 0.001651 65.00 66.00 06600 PHYSI CAL THERAPY 7, 973, 843 0 000000 0 66 00 67.00 06700 OCCUPATI ONAL THERAPY C 0 5, 726, 726 0.000000 67.00 06800 SPEECH PATHOLOGY 2, 802, 466 0.000000 68.00 27, 523, 086 69.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 06901 CARDI AC REHAB 1, 577, 084 0.000000 69 01 69 01 70.00 07000 ELECTROENCEPHALOGRAPHY 44, 422, 872 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 39, 934, 592 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 37, 655, 721 72.00 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 C 216, 411, 306 0.000000 73.00 74.00 07400 RENAL DIALYSIS 0 11, 465, 208 0.000000 74.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0.000000 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 21, 670, 219 0.000000 90.00 09100 EMERGENCY 0 952, 374 952, 374 112, 097, 741 0.008496 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 7, 194 7, 194 23, 025, 891 0.000312 92.00

0

1, 156, 677

1, 156, 677 1, 424, 550, 283

200.00

200.00

Total (lines 50 through 199)

Health Financial Systems	TALS, INC	In Lieu	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0002	From 01/01/2022	Worksheet D Part IV Date/Time Prepared:	

111100011 00010			To	12/31/2022	Date/Time Pre 5/25/2023 12:	
		Title	XVIII	Hospi tal	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	Charges	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. 000286	11, 806, 567	3, 377	20, 030, 007	5, 729	50.00
50. 01 05001 ENDOSCOPY	0. 000000	1, 419, 155		1, 127, 980	0	50. 01
51.00 05100 RECOVERY ROOM	0. 000000	612, 038		1, 111, 594	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 008818	207, 260	1, 828	321, 750	2, 837	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	2, 786, 315	0	4, 012, 762	0	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	0. 000000	1, 484, 195	0	1, 214, 111	0	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	358, 979	0	5, 281, 986	0	55.00
55. 01 05501 I NFUSI ON CENTER	0. 000000	128	0	1, 937, 461	0	55. 01
56. 00 05600 RADI 0I SOTOPE	0. 000000	1, 162, 264	0	2, 553, 389	0	56.00
57.00 05700 CT SCAN	0. 000000	14, 597, 594	0	13, 702, 504	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	2, 875, 097	0	3, 395, 491	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000348	9, 851, 796	3, 428	5, 531, 570	1, 925	59.00
60. 00 06000 LABORATORY	0. 000000	26, 843, 537	0	7, 498, 130	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	988, 051	0	85, 455	0	62.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	0	0	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 001651	11, 033, 028	18, 216	455, 647	752	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 580, 547	0	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	1, 012, 678	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	736, 445	0	17, 619	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	3, 822, 883	0	2, 079, 172	0	69.00
69. 01 06901 CARDI AC REHAB	0. 000000	85	0	347, 331	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	4, 194, 674	0	4, 362, 497	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	5, 849, 986	0	3, 737, 615	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	5, 339, 995		3, 767, 107	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	25, 619, 087	0	35, 563, 347	0	73.00
74. 00 07400 RENAL DIALYSIS	0. 000000	2, 735, 664	o	239, 451	0	74.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	О	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS	<u>'</u>					
90. 00 09000 CLI NI C	0. 000000	53, 364	0	2, 974, 922	0	90.00
91. 00 09100 EMERGENCY	0. 008496	6, 755, 583	57, 395	9, 208, 660	78, 237	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000312	1, 409, 921		1, 957, 974	611	92.00
200.00 Total (lines 50 through 199)		145, 136, 916	84, 684	132, 515, 532	90, 091	200. 00

Worksheet D From 01/01/2022 Part V Date/Time Prepared: 12/31/2022 5/25/2023 12:46 pm Title XVIII Hospi tal Charges Costs PPS Services Cost Center Description Cost to PPS Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 2.00 5.00 1.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 115889 20, 030, 007 2, 321, 257 50.00 0 05001 ENDOSCOPY 1, 127, 980 50.01 0.156732 0 176, 791 50.01 05100 RECOVERY ROOM 0 51.00 0. 215927 1, 111, 594 240, 023 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 1. 298785 321, 750 0 0 417, 884 52.00 05300 ANESTHESI OLOGY 0.000000 0 0 53.00 53.00 4, 012, 762 0 0 829, 474 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.206709 54 00 0 0 54.01 05401 RADI OLOGY - ULTRASOUND 0. 126610 1, 214, 111 153, 719 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 0. 131994 5, 281, 986 0 697, 190 55.00 1, 937, 461 0 05501 INFUSION CENTER 0.072287 45 55.01 140,053 55.01 0 0 05600 RADI OI SOTOPE 56.00 0.167827 2, 553, 389 428, 528 56.00 57.00 05700 CT SCAN 0.036893 13, 702, 504 505, 526 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 0.062420 3, 395, 491 0 0 211, 947 58.00 05900 CARDI AC CATHETERI ZATI ON 0 456, 974 59 00 0.082612 5 531 570 59 00 0 60.00 06000 LABORATORY 0.087855 7, 498, 130 658, 748 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.104655 85, 455 0 0 8, 943 62.00 62.00 0 0 64.00 06400 I NTRAVENOUS THERAPY 0.000000 64.00 0 0 0 06500 RESPIRATORY THERAPY 0 150543 455, 647 68, 594 65 00 65 00 0 66.00 06600 PHYSI CAL THERAPY 0.339201 C 0 66.00 06700 OCCUPATI ONAL THERAPY 0. 383884 67.00 0 0 68.00 06800 SPEECH PATHOLOGY 0. 281939 17,619 4, 967 68.00 2, 079, 172 121, 939 06900 ELECTROCARDI OLOGY 0.058648 0 69 00 69 00 69. 01 06901 CARDI AC REHAB 0. 428635 347, 331 0 148, 878 69.01 07000 ELECTROENCEPHALOGRAPHY 0 12 269, 367 70.00 0.061746 4, 362, 497 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.508969 0 1, 902, 330 71.00 3, 737, 615 0 71.00 0 0. 467037 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 3, 767, 107 0 1, 759, 378 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 217492 35, 563, 347 4, 327 7, 734, 743 73.00 07400 RENAL DIALYSIS 74.00 0. 254191 239, 451 0 0 60.866 74.00 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 0.000000 77.00 0 OUTPATIENT SERVICE COST CENTERS 0. 511708 2, 974, 922 90.00 09000 CLI NI C 0 1, 522, 291 90.00 91.00 09100 EMERGENCY 0. 209635 9, 208, 660 0 85 1, 930, 457 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 0.551025 1, 957, 974 1, 078, 893 200.00 Subtotal (see instructions) 132, 515, 532 0 23, 849, 760 200. 00 4, 474 201.00 Less PBP Clinic Lab. Services-Program 0 201.00

132, 515, 532

0

4, 474

23, 849, 760 202. 00

Only Charges

Net Charges (line 200 - line 201)

202.00

12/31/2022 Date/Time Prepared: 5/25/2023 12:46 pm Title XVIII Hospi tal PPS Costs 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.) 7. 00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 05001 ENDOSCOPY 0 50.01 50.01 0 51. 00 | 05100 | RECOVERY ROOM 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 53. 00 05300 ANESTHESI OLOGY 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.01 05401 RADI OLOGY - ULTRASOUND 0 55.00 05500 RADI OLOGY-THERAPEUTI C 55.01 05501 INFUSION CENTER 3 0 05600 RADI OI SOTOPE 56.00 57. 00 | 05700 CT SCAN 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 05900 CARDI AC CATHETERI ZATI ON 0 59 00 60.00 06000 LABORATORY 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 06400 I NTRAVENOUS THERAPY 64.00 06500 RESPIRATORY THERAPY 0 65 00 06600 PHYSI CAL THERAPY 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 68.00 06800 SPEECH PATHOLOGY 69 00 06900 ELECTROCARDI OLOGY 0 69.01 06901 CARDI AC REHAB 0 07000 ELECTROENCEPHALOGRAPHY 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 73.00 07300 DRUGS CHARGED TO PATIENTS 941 07400 RENAL DIALYSIS 74.00 0

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provi der Co	CN: 15-0002	Peri od:	Worksheet D	
		C	20N 1F C002	From 01/01/2022	Part II	
		Component	CCN: 15-S002	To 12/31/2022	Date/Time Pre 5/25/2023 12:	pared: 46 pm
		Title	XVIII	Subprovi der -	PPS	
				I PF		
Cost Center Description	Capi tal	Total Charges			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				-1		
50. 00 05000 OPERATING ROOM	1, 206, 291	172, 039, 906			0	
50. 01 05001 ENDOSCOPY	21, 790				0	50. 01
51.00 05100 RECOVERY ROOM	261, 174				0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	193, 493				0	52.00
53. 00 05300 ANESTHESI OLOGY	0	1	0. 00000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	937, 416				21	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	113, 823		0. 00459	·	6	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	154, 980				0	55.00
55. 01 05501 I NFUSI ON CENTER	108, 285		0. 00569		0	55. 01
56. 00 05600 RADI 0I SOTOPE	173, 006				0	56.00
57. 00 05700 CT SCAN	234, 244		0. 00161	·	18	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	93, 362		0. 00295		13	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	209, 460				0	59.00
60. 00 06000 LABORATORY	595, 282		0. 00265	·	200	l
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	32, 822		0. 00139		0	62.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0. 00000		0	64.00
65. 00 06500 RESPI RATORY THERAPY	184, 272	44, 762, 155	0. 00411		25	65.00
66. 00 06600 PHYSI CAL THERAPY	218, 632		0. 02741		47	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	186, 662		0. 03259	·	50	67.00
68. 00 06800 SPEECH PATHOLOGY	34, 858		0. 01243		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	22, 007				5	69. 00
69. 01 06901 CARDI AC REHAB	4, 612		0. 00292		0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	36, 748		0. 00082	7 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	434, 654		0. 01088	4 704	8	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	376, 750	37, 655, 721	0. 01000		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	583, 285	216, 411, 306	0. 00269	5 95, 577	258	73.00
74. 00 07400 RENAL DI ALYSI S	89, 550	11, 465, 208	0. 00781	1 0	0	74.00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.00000	0 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	1, 317, 061				0	90.00
91. 00 09100 EMERGENCY	718, 500				0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0. 00000		0	92.00
200.00 Total (lines 50 through 199)	8, 543, 019	1, 424, 550, 283		205, 002	651	200. 00

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	METHODIST HOS RVICE OTHER PAS	S Provider Co	CN: 15-0002 CCN: 15-S002	Peri Fror To		u of Form CMS-2 Worksheet D Part IV Date/Time Pre 5/25/2023 12:	pared:
		Title	XVIII	Sul	bprovi der – I PF	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursi ng Program Post-Stepdown Adjustments	Nursi ng Program	Po	lied Health ost-Stepdown Adjustments	Allied Health	
	1. 00	2A	2.00		3A	3. 00	
ANCILLARY SERVICE COST CENTERS							
50. 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	49, 277 0 0 49, 277 0 0 0 0 0 0 0 24, 639 0	50. 00 50. 01 51. 00 52. 00 53. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 60. 00 62. 00
64. 00 06400 INTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB 70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS 74. 00 07400 RENAL DI ALYSI S 77. 00 07700 ALLOGENEI C HSCT ACQUI SITI ON	000000000000000000000000000000000000000	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 73, 916 0 0 0 0 0 0 0	64. 00 65. 00 66. 00 67. 00 68. 00 69. 01 70. 00 71. 00 72. 00 73. 00 74. 00 77. 00
OUTPATIENT SERVICE COST CENTERS		-			-		
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 200. 00 Total (lines 50 through 199)	0 0 0	0		0 0 0	0 0	0 952, 374 0 1, 149, 483	91. 00 92. 00

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	METHODIST HOS RVICE OTHER PAS	S Provider Component	CCN: 15-S002	Period: From 01/01/2022 To 12/31/2022	u of Form CMS-2 Worksheet D Part IV Date/Time Pre 5/25/2023 12:	
		Title	· XVIII	Subprovi der - I PF	PPS	
Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	col. 8)	to Charges (col. 5 ÷ col. 7) (see instructions)	
ANOLILIARY OFFICE COOT, OFFITFE	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS		40.077	40.03	172 020 007	0.000004	F0 00
50. 00 05000 OPERATING ROOM 50. 01 05001 ENDOSCOPY 51. 00 05100 RECOVERY ROOM	0	49, 277 0 0		7 172, 039, 906 0 11, 419, 398 0 11, 769, 949	0. 000286 0. 000000 0. 000000	50. 01
52. 00 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	49, 277 0		0 0	0. 008818 0. 000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 RADI OLOGY - ULTRASOUND 55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 43, 045, 376 0 24, 757, 047 0 26, 088, 940	0. 000000 0. 000000 0. 000000	54. 01
55. 01 05501 INFUSI ON CENTER 56. 00 05600 RADI OI SOTOPE	0	0		0 19, 009, 274 0 18, 603, 735	0. 000000 0. 000000	55. 01
57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	0	0	0.4.75	0 144, 822, 556 0 31, 624, 327	0. 000000 0. 000000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 060. 00 06000 LABORATORY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	24, 639 0 0	24, 63	70, 788, 792 0 224, 346, 171 0 23, 597, 930	0. 000348 0. 000000 0. 000000	60.00
64. 00 06400 INTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0	73, 916	1	0 6 44, 762, 155	0. 000000 0. 001651	64. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 7, 973, 843 0 5, 726, 726	0. 000000 0. 000000	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB	0	0		0 2, 802, 466 0 27, 523, 086 0 1, 577, 084	0. 000000 0. 000000 0. 000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 44, 422, 872 0 39, 934, 592	0. 000000 0. 000000	70. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DI ALYSI S	0	0 0 0		0 37, 655, 721 0 216, 411, 306 0 11, 465, 208	0. 000000 0. 000000 0. 000000	73.00
77.00 O7700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0. 000000	77. 00
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	952, 374 0		0 21, 670, 219 4 112, 097, 741 0 23, 025, 891	0. 000000 0. 008496 0. 000000	91.00
200.00 Total (lines 50 through 199)	0	1, 149, 483	1, 149, 48	3 1, 424, 550, 283	0.000000	200.00

Health Financial Contant	METHODI CT. HOCOL	TALC INC		1-11-	£ F CMC /	2552 10
Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	METHODIST HOSPI	Provi der C	CN: 15-0002	Period:	u of Form CMS-2 Worksheet D	2552-10
THROUGH COSTS	INVIOL OTHER TASS	Trovider o		From 01/01/2022	Part IV	
		· ·	CCN: 15-S002	To 12/31/2022	Date/Time Pre 5/25/2023 12:	
			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	3	Costs (col. 9	
	col . 7)		x col. 10)		x col . 12)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS	1		1	_1		
50. 00 05000 OPERATI NG ROOM	0. 000286	0		0	0	1
50. 01 05001 ENDOSCOPY	0. 000000	0	1	0	0	50. 01
51. 00 05100 RECOVERY ROOM	0. 000000	0	1	0	0	1
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 008818	0		0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	986		0	0	
54. 01 05401 RADI OLOGY - ULTRASOUND	0. 000000	1, 200		0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0	•	0	0	
55. 01 05501 I NFUSI ON CENTER	0. 000000	0		0	0	
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0	0	56. 00
57. 00 05700 CT SCAN	0. 000000	11, 086		0	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	4, 520		0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000348	0		0	0	59.00
60. 00 06000 LABORATORY	0. 000000	75, 342		0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0	0	62.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	0		0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 001651	5, 966	1	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 699		0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	1, 522		0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	6, 400		0 604	0	69. 00
69. 01 06901 CARDI AC REHAB	0. 000000	0		0	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	704		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	95, 577		0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	0		0	0	74.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	0. 000000	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 008496	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)		205, 002	1	0 604	0	200. 00

Health Financial Systems					In Lieu of Form CMS-2552-10			
APPORTIONMENT OF MEDICAL, OTHE	R HEALTH SERVICES AND	VACCINE COST	Provi der C	CN: 15-0002	Peri od:	Worksheet D		
			Component	CCN: 15-S002	From 01/01/2022 To 12/31/2022			
			Title	XVIII	Subprovi der -	PPS		
					I PF			
				Charges		Costs		
Cost Contor Doscri	ntion	Coct to	DDC	Cost	Coct	DDC Corvi coc		

	Title XVIII Subprovider -		PPS				
				Charges	IPF	Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	cost center bescription	Charge Ratio	Reimbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not	(366 11131.)	
		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	
Α.	NCILLARY SERVICE COST CENTERS	1.00	2.00	0.00		0.00	
	05000 OPERATING ROOM	0. 115889	0		0 0	0	50.00
50. 01	05001 ENDOSCOPY	0. 156732	0		0 0	0	50. 01
51.00	05100 RECOVERY ROOM	0. 215927	0		0 0	0	51.00
52.00	D5200 DELIVERY ROOM & LABOR ROOM	1. 298785	0		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 206709	0		0 0	0	54.00
	05401 RADI OLOGY - ULTRASOUND	0. 126610	0		0 0	0	54. 01
	05500 RADI OLOGY-THERAPEUTI C	0. 131994	0		0 0	0	55.00
1	05501 I NFUSI ON CENTER	0. 072287	0		0 0	0	55. 01
	05600 RADI OI SOTOPE	0. 167827	0		0 0	0	56.00
	05700 CT SCAN	0. 036893	0		0 0	0	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 062420	0		0 0	Ö	58.00
	05900 CARDI AC CATHETERI ZATI ON	0. 082612	0		0 0	o o	59.00
1	06000 LABORATORY	0. 087855	0		0 0		60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 104655	0		0 0	0	62.00
	06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	1	64.00
	06500 RESPIRATORY THERAPY	0. 150543	0		0 0	o o	65.00
	06600 PHYSI CAL THERAPY	0. 339201	0		0 0	0	66.00
	06700 OCCUPATI ONAL THERAPY	0. 383884	Ö		0 0	Ö	67.00
	06800 SPEECH PATHOLOGY	0. 281939	Ö		0 0	0	68.00
	06900 ELECTROCARDI OLOGY	0. 058648	604		0 0	· -	69.00
	06901 CARDI AC REHAB	0. 428635	0		0 0	0	69. 01
	07000 ELECTROENCEPHALOGRAPHY	0. 061746	0		0 0	1	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 508969	i n		0 0	o o	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 467037	i n		0 0	o o	72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 217492	0		0 0	l ő	73.00
	07400 RENAL DIALYSIS	0. 254191	0		0 0		74.00
	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0		77. 00
	OUTPATIENT SERVICE COST CENTERS	0. 000000			<u> </u>		77.00
	09000 CLI NI C	0. 511708	0		0 0	0	90.00
	09100 EMERGENCY	0. 209635			0 0	l	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 551025	Ö		0 0	o o	92.00
200.00	Subtotal (see instructions)	1.00.020	604		0 0		200.00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		604		0 0	35	202. 00
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Health Financial Systems	METHODI ST HOSI	PITALS, INC		In Lieu of Form CMS-2552-10			
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider Component	CN: 15-0002 CCN: 15-S002	Peri od: From 01/01/2022 To 12/31/2022		pared: 46 pm	
		Title	e XVIII	Subprovi der - I PF	PPS		
	Cos	its					
Cost Center Description	Cost Reimbursed	Cost Rei mbursed					

			IIIIe	: AVIII	I PF	PPS	
		Cos	sts				
	Cost Center Description	Cost	Cost	1			
	cost denter bescription	Rei mbursed	Rei mbursed				
		Servi ces	Servi ces Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00	1			
AN	NCILLARY SERVICE COST CENTERS	0.00	7.00	l			
	5000 OPERATING ROOM	0	0				50.00
	5001 ENDOSCOPY	0	0				50. 01
	5100 RECOVERY ROOM	0	o o	•			51.00
	5200 DELIVERY ROOM & LABOR ROOM	0	o o				52.00
	5300 ANESTHESI OLOGY	0	n				53.00
	5400 RADI OLOGY-DI AGNOSTI C	0	o n				54.00
	5401 RADI OLOGY - ULTRASOUND	0	o n				54. 01
	5500 RADI OLOGY-THERAPEUTI C	0	n				55. 00
1	5501 I NFUSI ON CENTER	0	0				55. 01
	5600 RADI OI SOTOPE	0	0				56.00
	5700 CT SCAN	0	0				57.00
	5800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	ł			58.00
	5900 CARDI AC CATHETERI ZATI ON	0	0				59.00
	6000 LABORATORY	0	0				60.00
	6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.00
	6400 INTRAVENOUS THERAPY	0	0				64.00
	5500 RESPIRATORY THERAPY	0	0				65.00
	6600 PHYSI CAL THERAPY	0	0				1
		0	0				66.00
	6700 OCCUPATIONAL THERAPY 6800 SPEECH PATHOLOGY	0	0				67. 00 68. 00
	1	0	0				69.00
	6900 ELECTROCARDI OLOGY	0	Ŭ	1			
	6901 CARDI AC REHAB	0	0				69. 01
	7000 ELECTROENCEPHALOGRAPHY	0	0				70.00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
	7200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72.00
	7300 DRUGS CHARGED TO PATIENTS	0	0				73.00
	7400 RENAL DI ALYSI S	0	0	1			74.00
	7700 ALLOGENEIC HSCT ACQUISITION	0	0				77. 00
	JTPATIENT SERVICE COST CENTERS			1			
	9000 CLINIC	0	_	1			90.00
	9100 EMERGENCY	0	0	ł			91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00	Subtotal (see instructions)	0	0				200. 00
201. 00	Less PBP Clinic Lab. Services-Program	0					201. 00
000 05	Only Charges	_	_				
202. 00	Net Charges (line 200 - line 201)	0	0				202. 00

Health Financial Systems	METHODIST HOS	SPITAIS INC		Inlie	u of Form CMS-2	2552_10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT		Provi der C	CN: 15-0002	Peri od:	Worksheet D	2332-10
THE PROPERTY OF THE PROPERTY O	7.2 000.0			From 01/01/2022	Part II	
			CCN: 15-T002	To 12/31/2022	Date/Time Pre 5/25/2023 12:	
			e XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Capi tal	Total Charges			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, 206, 291				313	
50. 01 05001 ENDOSCOPY	21, 790				6	50. 01
51.00 05100 RECOVERY ROOM	261, 174			· ·	28	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	193, 493				0	52.00
53. 00 05300 ANESTHESI OLOGY	0	_	0.0000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	937, 416			· ·	693	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	113, 823				48	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	154, 980				0	
55. 01 05501 I NFUSI ON CENTER	108, 285				0	55. 01
56. 00 05600 RADI 0I SOTOPE	173, 006		1	· ·	26	56. 00
57. 00 05700 CT SCAN	234, 244				115	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	93, 362				37	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	209, 460		1		0	59.00
60. 00 06000 LABORATORY	595, 282			· ·	1, 290	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	32, 822			· ·	12	62.00
64.00 06400 I NTRAVENOUS THERAPY	0		1 0.0000		0	64.00
65. 00 06500 RESPI RATORY THERAPY	184, 272			· ·	575	65.00
66. 00 06600 PHYSI CAL THERAPY	218, 632			· ·	19, 740	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	186, 662				20, 929	67.00
68. 00 06800 SPEECH PATHOLOGY	34, 858				1, 440	
69. 00 06900 ELECTROCARDI OLOGY	22, 007				14	69. 00
69. 01 06901 CARDI AC REHAB	4, 612				0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	36, 748				1	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	434, 654		1	· ·	51	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	376, 750		1	· ·	373	
73.00 07300 DRUGS CHARGED TO PATIENTS	583, 285		1		2, 420	
74. 00 07400 RENAL DI ALYSI S	89, 550				633	
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.00000	0 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS	T	1	T			
90. 00 09000 CLI NI C	1, 317, 061		1		0	90.00
91. 00 09100 EMERGENCY	718, 500				0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 540 040	,,	1		0	92.00
200.00 Total (lines 50 through 199)	8, 543, 019	1, 424, 550, 283	1	3, 329, 195	48, 744	J∠UU. UU

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	METHODIST HOS RVICE OTHER PAS	S Provider Component	CCN: 15-T002				pared:
		Title	XVIII		ovi der - I RF	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Allie Post-		Allied Health	
	1. 00	2A	2. 00		3A	3. 00	
ANCILLARY SERVICE COST CENTERS		,					
50. 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 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0	49, 277 0 0 49, 277 0 0 0 0 0 0 24, 639 0 0 73, 916	51. 00 52. 00 53. 00 54. 00 54. 01 55. 00 57. 00 58. 00 59. 00 60. 00 62. 00 64. 00 65. 00 66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB 70. 00 07100 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS 74. 00 07400 RENAL DI ALYSI S 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0UTPATI ENT SERVI CE COST CENTERS	000000000000000000000000000000000000000	Ö		0 0 0 0 0 0	0 0 0 0 0 0 0	0 0 0 0 0 0 0	69. 00 69. 01 70. 00 71. 00 72. 00 73. 00 74. 00
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 200. 00 Total (lines 50 through 199)	000000000000000000000000000000000000000	0		0 0 0	0 0	0	91. 00 92. 00

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	METHODIST HOS RVICE OTHER PAS	S Provider Component	CCN: 15-T002	Period: From 01/01/2022 To 12/31/2022	5/25/2023 12:	
		Title	· XVIII	Subprovi der - I RF	PPS	
Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	col . 8)	to Charges (col. 5 ÷ col. 7) (see instructions)	
ANOLI LADV CERVI OF COCT OFNITERS	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCI LLARY SERVI CE COST CENTERS 50, 00 05000 OPERATI NG ROOM	O	40 277	40.0	172 020 007	0.000004	E0 00
50. 00 05000 0PERATING ROOM 50. 01 05001 ENDOSCOPY 51. 00 05100 RECOVERY ROOM	0	49, 277 0 0		77 172, 039, 906 0 11, 419, 398 0 11, 769, 949	0. 000286 0. 000000 0. 000000	50. 01
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0	49, 277 0		0 0	0. 008818 0. 000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 RADI OLOGY - ULTRASOUND	0	0		0 43, 045, 376 0 24, 757, 047	0. 000000 0. 000000	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C 55. 01 05501 INFUSI ON CENTER	0	0		0 26, 088, 940 0 19, 009, 274	0. 000000 0. 000000	55. 01
56. 00 05600 RADI 0 SOTOPE 57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESONANCE MAGI NG (MRI)	0	0		0 18, 603, 735 0 144, 822, 556 0 31, 624, 327	0. 000000 0. 000000	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0	24, 639 0	24, 63		0. 000000 0. 000348 0. 000000	59.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 64. 00 06400 INTRAVENOUS THERAPY	0	0		0 23, 597, 930	0. 000000 0. 000000	62.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	73, 916 0		44, 762, 155 0 7, 973, 843	0. 001651 0. 000000	65.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	0		0 5, 726, 726 0 2, 802, 466	0. 000000 0. 000000	1
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB	0	0		0 27, 523, 086 0 1, 577, 084	0. 000000 0. 000000	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 44, 422, 872 0 39, 934, 592 0 37, 655, 721	0. 000000 0. 000000 0. 000000	71.00
73. 00 07300 DRUGS CHARGED TO PATTENTS 73. 00 07300 DRUGS CHARGED TO PATTENTS 74. 00 07400 RENAL DI ALYSI S	0	0		0 216, 411, 306 0 11, 465, 208	0. 000000 0. 000000 0. 000000	73. 00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	o	0		0 0	0.000000	•
90. 00	0	952, 374			0. 000000 0. 008496	91.00
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 200.00 Total (lines 50 through 199)	0	0 1, 149, 483	1, 149, 48	0 23, 025, 891 33 1, 424, 550, 283	0. 000000	92.00 200.00

We like Fire and A Control	METHODI CT. HOCOL	TALC INC		111	. C. F OMC	2550 40
Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SI	METHODIST HOSPI	Provi der C	CN: 15 0002	Period:	u of Form CMS-2 Worksheet D	2552-10
THROUGH COSTS	LAVICE UTILK FASS	Flovide	CIV. 15-0002	From 01/01/2022	Part IV	
		·	CCN: 15-T002	To 12/31/2022	Date/Time Pre 5/25/2023 12:	
		Title	· XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Outpati ent	Inpatient	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n Charges	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	<u>. </u>					
50. 00 05000 OPERATING ROOM	0. 000286	44, 635	1	13 0	0	50.00
50. 01 05001 ENDOSCOPY	0. 000000	3, 283		0 0	0	50. 01
51. 00 05100 RECOVERY ROOM	0. 000000	1, 248		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 008818	0		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. 000000	31, 825		0 0	0	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	0. 000000	10, 345		0 0	0	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0	1	0 0	0	55.00
55. 01 05501 NFUSI ON CENTER	0. 000000	0		0	0	55. 01
56. 00 05600 RADI OI SOTOPE	0. 000000	2, 814		0 0	0	56.00
57. 00 05700 CT SCAN	0. 000000	71, 274	l .	0 0	0	57.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	12, 703	•	0 0	Ö	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000348	0		0	0	59.00
60. 00 06000 LABORATORY	0. 000000	486, 332		0	0	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	8, 354		0	0	62.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	0,001		0 0	Ö	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 001651	139, 704		-	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	719, 930		0 0	ő	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	642, 102		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	115, 751			Ö	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	16, 906			Ö	69.00
69. 01 06901 CARDI AC REHAB	0. 000000	0,700			Ö	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	932		0 0	Ö	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	4, 655	l .	0 0	Ö	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	37, 287		0 0	Ö	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	898, 027			ő	73.00
74. 00 07400 RENAL DIALYSIS	0. 000000	81, 088			Ö	74.00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	01,000	•	0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS	0.000000			0	0	17.00
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 000000	0		0 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)	0.000000	3, 329, 195	24	-	_	200.00
200.00 10tal (111103 00 thi ough 177)	1	5, 527, 175	1 2-		,	1200.00

Health Financial Systems	METHODIST HOSPITALS	, INC	In Lie	u of Form CMS-2	552-10
COMPUTATION OF INPATIENT OPERATING COST	Pro	ovider CCN: 15-0002	Peri od: From 01/01/2022	Worksheet D-1	
				Date/Time Prep 5/25/2023 12:	oared: 46 pm
		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 roo	om days and swing-bed days,	excluding newborn)		79, 339	1.00
2 00 Inpatient days (including private rec	om dave oveluding ewing had	and nowborn days)		70 220	2 00

	IITIE XVIII HOSPITAI	PPS	
	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)	79, 339	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	79, 339 0	2. 00 3. 00
3.00	do not complete this line.	U	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	67, 757	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)	O	0.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
0.00	reporting period	0	0.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	U	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	17, 859	9. 00
40.00	newborn days) (see instructions)		40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	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) through December 31 of the cost reporting period	0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	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 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)	0	
10.00	SWING BED ADJUSTMENT		10.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17. 00
18. 00	reporting period 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	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20.00
20.00	reporting period	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	86, 914, 608	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5×1) 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 7 x line 19)	0	24.00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)		
26. 00	Total swing-bed cost (see instructions)	0 014 400	26. 00 27. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	86, 914, 608	27.00
28. 00		0	28. 00
	Private room charges (excluding swing-bed charges)	0	
	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)	0.00	•
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	•
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	
	Average per diem private room cost differential (line 34 x line 31)	0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	86, 914, 608	37.00
	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)	1, 095. 48	38. 00
	Program general inpatient routine service cost (line 9 x line 38)	19, 564, 177	
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, 564, 177	41.00

14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17.00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
	reporting period		
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0. 00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions)	86, 914, 608	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
25. 00	7×1 ine 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8)	0	25. 00
	x line 20)		
	Total swing-bed cost (see instructions)	0	
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	86, 914, 608	27. 00
20.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	0	20.00
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	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
	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)	0.000000	
	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	
	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
	Average per diem private room cost differential (line 34 x line 31)	0.00	
	Private room cost differential adjustment (line 3 x line 35)	0.00	36.00
36. 00 37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	- 1	
37.00	27 minus line 36)	00, 914, 000	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 095. 48	38. 00
	Program general inpatient routine service cost (line 9 x line 38)	19, 564, 177	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	19, 304, 177	
	Total Program general inpatient routine service cost (line 39 + line 40)	19, 564, 177	
41.00	Total Frogram general impatrent routine service cost (fine 37 + fine 40)	19, 304, 177	41.00

	Financial Systems ATION OF INPATIENT OPERATING COST	METHODIST HOSP	Provider C	CN: 15-0002	In Lie Period:	u of Form CMS-2 Worksheet D-1	
	ATTON OF THE ATTENT OF ENATING 6031		110VIGET C		From 01/01/2022		
					To 12/31/2022	Date/Time Pre 5/25/2023 12:	
	Cook Cooks Books at the	Tabal		XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient	Total Inpati ent	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
		Cost	Days	÷ col . 2)		col . 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
12.00	NURSERY (title V & XIX only)	0	0	0.0	0 0	0	42.
3. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	14, 983, 553	7, 946	1, 885. 6	7 2, 326	4, 386, 068	43.
3. 01	NEONATAL I CU	2, 542, 621	1, 775			0	43.
4. 00	CORONARY CARE UNIT						44.
5. 00	BURN INTENSIVE CARE UNIT						45.
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 47.
7.00	Cost Center Description						47.
						1. 00	
8.00	Program inpatient ancillary service cost (Wk			111 1: 10	1 1)	24, 227, 911	48.
8. 01 9. 00	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines				corumn 1)	0 48, 178, 156	48. 49.
7. 00	PASS THROUGH COST ADJUSTMENTS	+1 till ough +0.0	1) (300 111311 4	211 0113)		40, 170, 130	77.
0. 00	Pass through costs applicable to Program inp	atient routine :	servi ces (fro	m Wkst. D, sun	n of Parts I and	1, 514, 499	50.
					6.5	054 040	
1. 00	Pass through costs applicable to Program inp and IV)	atient ancillar	y services (fi	rom Wkst. D, s	sum of Parts II	851, 019	51.
2. 00	Total Program excludable cost (sum of lines	50 and 51)				2, 365, 518	52.
3. 00	Total Program inpatient operating cost exclu	ding capital re	lated, non-phy	ysician anesth	netist, and	45, 812, 638	
	medical education costs (line 49 minus line	52)					
4. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	 54.
5. 00	Target amount per discharge					0.00	
5. 01	Permanent adjustment amount per discharge					0.00	55.
5. 02	Adjustment amount per discharge (contractor					0.00	
00	Target amount (line 54 x sum of lines 55, 55				11 50)	0	56.
7. 00 8. 00	Difference between adjusted inpatient operat	ing cost and tai	rget amount (ine 56 minus	11ne 53)	0	57 58
9. 00							59
	updated and compounded by the market basket)						
0. 00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)						60.
1. 00							61.
	55.01, or line 59, or line 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)						
2. 00							62.
3. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	63.
4 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	+- +b				0	
4. 00	instructions)(title XVIII only)	ts through Decer	mber 31 of the	e cost reporti	ng period (See	0	64.
5. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the (cost reporting	period (See	0	65.
,	instructions)(title XVIII only)			(=\ ()			١
6. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line d	64 plus line (bb)(title XVII	i only); for	0	66.
7. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost re	eporting period	0	67.
	(line 12 x line 19)						
8. 00	Title V or XIX swing-bed NF inpatient routin	e costs after De	ecember 31 of	the cost repo	orting period	0	68.
	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (lino 67 : lin	e 68)		0	69.
9. NN				,		0	
9. 00	PART III - SKILLED NURSING FACILITY, OTHER N			ONLY			ĺ
0. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil	JRSING FACILITY, ity/ICF/IID rou	AND ICF/IID tine service	cost (line 37)			
). 00 I. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c	JRSING FACILITY, ity/ICF/IID rou ost per diem (Ii	AND ICF/IID tine service	cost (line 37)			71.
0.00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c Program routine service cost (line 9 x line	JRSING FACILITY, ity/ICF/IID rou ost per diem (Ii 71)	AND ICF/IID tine service (ine 70 ÷ line	cost (line 37) 2)			71. 72.
. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of Program routine service cost (line 9 x line Medically necessary private room cost applic	JRSING FACILITY, ity/ICF/IID rou ost per diem (li 71) able to Program	AND ICF/IID tine service ine 70 ÷ line (line 14 x li	cost (line 37) 2) ne 35)			71. 72. 73.
0. 00 . 00 2. 00 3. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c Program routine service cost (line 9 x line	JRSING FACILITY, ity/ICF/IID rou ost per diem (Ii 71) able to Program ice costs (Iine	tine service of tine 70 ÷ line (line 14 x line 72 + line 73)	cost (line 37) 2) ine 35)			71. 72. 73. 74.
. 00 . 00 . 00 . 00 . 00 . 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of Program routine service cost (line 9 x line Medically necessary private room cost application to the program general inpatient routine services (apital-related cost allocated to inpatient 26, line 45)	JRSING FACILITY, ity/ICF/IID rou ost per diem (li 71) able to Program ice costs (line routine service	tine service of tine 70 ÷ line (line 14 x line 72 + line 73)	cost (line 37) 2) ine 35)			71 72 73 74 75
. 00 . 00 . 00 . 00 . 00 . 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of Program routine service cost (line 9 x line Medically necessary private room cost applic Total Program general inpatient routine serv Capital-related cost allocated to inpatient 26, line 45) Per diem capital-related costs (line 75 ÷ li	JRSING FACILITY, ity/ICF/IID rou ost per diem (li 71) able to Program ice costs (line routine service ne 2)	tine service of tine 70 ÷ line (line 14 x line 72 + line 73)	cost (line 37) 2) ine 35)			71 72 73 74 75
0. 00 . 00 . 00 . 00 . 00 . 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of Program routine service cost (line 9 x line Medically necessary private room cost applic Total Program general inpatient routine serv Capital-related cost allocated to inpatient 26, line 45) Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	JRSING FACILITY, ity/ICF/IID rourost per diem (li 71) able to Program ice costs (line routine service ne 2) 76)	tine service of tine 70 ÷ line (line 14 x line 72 + line 73)	cost (line 37) 2) ine 35)			71 72 73 74 75 76 77
0. 00 . 00 . 00 . 00 . 00 . 00 . 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of Program routine service cost (line 9 x line Medically necessary private room cost applic Total Program general inpatient routine serv Capital-related cost allocated to inpatient 26, line 45) Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu	JRSING FACILITY, ity/ICF/IID rou ost per diem (li 71) able to Program ice costs (line routine service ne 2) 76) s line 77)	AND ICF/IID tine service ine 70 ÷ line (line 14 x li 72 + line 73 costs (from 1	cost (line 37) 2) ne 35) Norksheet B, F			71. 72. 73. 74. 75. 76. 77.
0. 00 . 00 2. 00 3. 00 3. 00 3. 00 4. 00 4. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of Program routine service cost (line 9 x line Medically necessary private room cost applic Total Program general inpatient routine serv Capital-related cost allocated to inpatient 26, line 45) Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	JRSING FACILITY, ity/ICF/IID rou ost per diem (li 71) able to Program ice costs (line routine service ne 2) 76) s line 77) s costs (from pi	AND ICF/IID tine service (ine 70 ÷ line (line 14 x li 72 + line 73) costs (from)	cost (line 37) 2) ine 35) Norksheet B, F	Part II, column		71. 72. 73. 74. 75. 76. 77. 78. 79.
0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 7. 00 8. 00 9. 00 9. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c Program routine service cost (line 9 x line Medically necessary private room cost applic Total Program general inpatient routine servicapital-related cost allocated to inpatient 26, line 45) Per diem capital-related costs (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 routine service cost per diem limi	JRSING FACILITY, ity/ICF/IID rourost per diem (li 71) able to Program ice costs (line routine service ne 2) 76) s line 77) s costs (from prarison to the cotation	AND ICF/IID tine service of ine 70 ÷ line (line 14 x l) 72 + line 73 costs (from) rovider record	cost (line 37) 2) ine 35) Norksheet B, F	Part II, column		71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81.
0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 3. 00 9. 00 9. 00 9. 00 9. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of Program routine service cost (line 9 x line Medically necessary private room cost application Total Program general inpatient routine service (apital-related cost allocated to inpatient 26, line 45) Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for excess Total Program routine service cost per diem limi Inpatient routine service cost limitation (l	JRSING FACILITY, ity/ICF/IID rourost per diem (li 71) able to Program ice costs (line routine service ne 2) 76) s line 77) s costs (from program arison to the cotation ine 9 x line 81)	AND ICF/IID tine service of ine 70 ÷ line (line 14 x li) 72 + line 73 costs (from) rovider record	cost (line 37) 2) ine 35) Norksheet B, F	Part II, column		71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82.
0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 3. 00 9. 00 0. 00 1. 00 2. 00 3. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of Program routine service cost (line 9 x line Medically necessary private room cost application Total Program general inpatient routine service (apital-related cost allocated to inpatient 26, line 45) Per diem capital-related costs (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 routine service cost per diem limi Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (JRSING FACILITY, ity/ICF/IID rourost per diem (li 71) able to Program ice costs (line routine service ne 2) 76) s line 77) s costs (from prairson to the cotation ine 9 x line 81 see instructions	AND ICF/IID tine service of ine 70 ÷ line (line 14 x li) 72 + line 73 costs (from) rovider record	cost (line 37) 2) ine 35) Norksheet B, F	Part II, column		71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83.
0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 3. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of Program routine service cost (line 9 x line Medically necessary private room cost application Total Program general inpatient routine service Capital -related cost allocated to inpatient 26, line 45) Per diem capital -related costs (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 routine service cost per diem limi Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I Reasonable inpatient routine services (see in	JRSING FACILITY, ity/ICF/IID rourost per diem (Ii 71) able to Program ice costs (Iine routine service ne 2) 76) s line 77) s costs (from prairison to the cotation ine 9 x line 81 see instructions)	AND ICF/IID tine service of ine 70 ÷ line (line 14 x li) 72 + line 73 costs (from note of the costs) rovider record ost limitation) s)	cost (line 37) 2) ine 35) Norksheet B, F	Part II, column		71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83.
0. 00 11. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 3. 00 9. 00 0. 00 11. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of Program routine service cost (line 9 x line Medically necessary private room cost application Total Program general inpatient routine service (apital-related cost allocated to inpatient 26, line 45) Per diem capital-related costs (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 routine service cost per diem limi Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (JRSING FACILITY, ity/ICF/IID rourost per diem (li 71) able to Program ice costs (line routine service ne 2) 76) s line 77) s costs (from parison to the cotation ine 9 x line 81) see instructions (see instruction)	AND ICF/IID tine service of time 70 ÷ line (line 14 x line) 72 + line 73; costs (from time) rovider record ost limitation s) s)	cost (line 37) 2) ine 35) Norksheet B, F	Part II, column		70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86.

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	
				From 01/01/2022 To 12/31/2022		pared: 46 pm_
		Title	XVIII	Hospi tal	PPS	
Cost Center Description						
					1. 00	
88.00 Adjusted general inpatient routine cost per	diem (line 27	÷ line 2)			1, 095. 48	88. 00
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			12, 687, 849	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	6, 074, 091	86, 914, 608	0. 06988	6 12, 687, 849	886, 703	90.00
91.00 Nursing Program cost	0	86, 914, 608	0.00000	0 12, 687, 849	0	91.00
92.00 Allied health cost	49, 277	86, 914, 608	0.00056	7 12, 687, 849	7, 194	92.00
93.00 All other Medical Education	0	86, 914, 608	0.00000	0 12, 687, 849	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 01/01/2022	Worksheet D-1
	Component CCN: 15-S002		
	Title XVIII	Subprovi der -	PPS
		I PF	

	. I PF		
Cost Center Description		1. 00	
PART I - ALL PROVIDER COMPONENTS		11 00	
I NPATI ENT DAYS			
1.00 Inpatient days (including private room days and swing-bed days, excluding newborn of the latter than the second days and swing bed and powborn of the latter than the second days are latter than the second days are latter to the second days a		1, 245 1, 245	
2.00 Inpatient days (including private room days, excluding swing-bed and newborn of 3.00 Private room days (excluding swing-bed and observation bed days). If you have of		1, 245	1
do not complete this line.	om y private room days,	· ·	0.0
4.00 Semi-private room days (excluding swing-bed and observation bed days)		1, 245	4.0
5.00 Total swing-bed SNF type inpatient days (including private room days) through D	December 31 of the cost	0	5.0
reporting period 6.00 Total swing-bed SNF type inpatient days (including private room days) after Dec	combon 21 of the cost	0	6.0
reporting period (if calendar year, enter 0 on this line)	celliber 31 of the cost	Ü	0.0
7.00 Total swing-bed NF type inpatient days (including private room days) through De	ecember 31 of the cost	0	7.0
reporting period			
8.00 Total swing-bed NF type inpatient days (including private room days) after Dece	ember 31 of the cost	0	8.0
reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (exc	cluding swing-bed and	194	9.0
newborn days) (see instructions)	cruaring swring-bed and	174	7.0
10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including pri	ivate room days)	0	10.0
through December 31 of the cost reporting period (see instructions)			
11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including pri		0	11.0
December 31 of the cost reporting period (if calendar year, enter 0 on this lir 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including		0	12.0
through December 31 of the cost reporting period	private room days)	O	12.0
13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including	private room days)	0	13.0
after December 31 of the cost reporting period (if calendar year, enter 0 on the			
14.00 Medically necessary private room days applicable to the Program (excluding swir	ng-bed days)	0	
15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only)		0	
SWING BED ADJUSTMENT	l	0	10.0
17.00 Medicare rate for swing-bed SNF services applicable to services through December	er 31 of the cost	0. 00	17.0
reporting period			
18.00 Medicare rate for swing-bed SNF services applicable to services after December	31 of the cost	0. 00	18.0
reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December	r 21 of the cost	0.00	19.0
reporting period	1 31 01 the cost	0.00	1 7. 0
20.00 Medicaid rate for swing-bed NF services applicable to services after December 3	31 of the cost	0.00	20.0
reporting period			
21.00 Total general inpatient routine service cost (see instructions)		1, 765, 771	•
22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost 5 x line 17)	reporting period (iine	0	22.0
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost re	eporting period (line 6	0	23.0
x line 18)			
24.00 Swing-bed cost applicable to NF type services through December 31 of the cost r	reporting period (line	0	24.0
7 x line 19)	norting poriod (line 0	0	25.0
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost rep	porting period (line 8	Ü	25.0
26.00 Total swing-bed cost (see instructions)		0	26.0
27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus lin	ne 26)	1, 765, 771	27.0
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) 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)		0.00	•
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)		0. 00	33.0
34.00 Average per diem private room charge differential (line 32 minus line 33)(see i	instructions)	0.00	•
35.00 Average per diem private room cost differential (line 34 x line 31)		0. 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 of	rost differential (lina	0 1, 765, 771	
27 minus line 36)	COST OFFICIAL (TILL	1, 700, 771	37.0
PART II - HOSPITAL AND SUBPROVIDERS ONLY]
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00 Adjusted general inpatient routine service cost per diem (see instructions)		1, 418. 29	
39.00 Program general inpatient routine service cost (line 9 x line 38)	o 3E)	275, 148	
40.00 Medically necessary private room cost applicable to the Program (line 14 x line	e 30)	0	
41.00 Total Program general inpatient routine service cost (line 39 + line 40)		275, 148	1 41 0

	Financial Systems	METHODIST HOSE				u of Form CMS-:	
COMPUT	ATION OF INPATIENT OPERATING COST			F	Period: From 01/01/2022 Fo 12/31/2022	Worksheet D-1 Date/Time Pre	
				e XVIII		5/25/2023 12: PPS	
					Subprovi der -		
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1. 00	2.00	3.00	4.00	5. 00	42.00
42.00	Intensive Care Type Inpatient Hospital Units	i d	(0.00	<u>J</u>	0	42.00
43. 00 43. 01	INTENSIVE CARE UNIT NEONATAL ICU	0	(0.00			
44.00	CORONARY CARE UNIT			0.00			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 1)	31, 244	
48. 01 49. 00	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS				corumn r)	306, 392	
50. 00	Pass through costs applicable to Program inp	atient routine	services (fro	om Wkst. D, sum	of Parts I and	12, 726	50. 00
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillar	y services (f	from Wkst. D, s	um of Parts II	661	51.00
52.00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		alatad nan nh	valaian anaa+h	atiot and	13, 387	52.00
53. 00	medical education costs (line 49 minus line	9 1	erated, non-pr	iysi ci ani anestri	etist, and	293, 005	53.00
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
55. 01 55. 02	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	use only)				0. 00 0. 00	1
56. 00	Target amount (line 54 x sum of lines 55, 55					0.00	1
57.00	Difference between adjusted inpatient operat	ing cost and ta	arget amount (line 56 minus	line 53)	0	57.00
58. 00 59. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	n the cost rec	ortina period	endi na 1996.	0.00	
60.00	updated and compounded by the market basket)						60.00
61. 00	market basket) 61.00 Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line					0	61.00
	53) are less than expected costs (lines 54 x enter zero. (see instructions)	60), or 1 % of	the target a	nmount (line 56), otherwise		
62.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ant (saa instru	ictions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)						64.00
65. 00	instructions)(title XVIII only)					0	
66. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions		•			0	
	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	J				0	
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)			·	rting period	0	
	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY	, AND ICF/IID	ONLY		0	
70.00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c						70. 00 71. 00
72.00	Program routine service cost (line 9 x line	71)		ŕ			72.00
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv						73. 00 74. 00
75. 00	Capital-related cost allocated to inpatient	•		•	art 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 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovi der recor	-de)			78. 00 79. 00
80.00	Total Program routine service costs for comp				us line 79)		80.00
81.00	Inpatient routine service cost per diem limi						81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (•				82. 00 83. 00
84.00	Program inpatient ancillary services (see in	structions)					84.00
	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
	, Far. a apar. act. ng 33363 (34m	00 11	3 7			ı	,

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-S002	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/25/2023 12:	pared: 46 pm
		Title	XVIII	Subprovi der - I PF	PPS	
Cost Center Description						
					1. 00	
PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST					
87.00 Total observation bed days (see instructions	s)				0	87.00
88.00 Adjusted general inpatient routine cost per	diem (line 27 -	÷ line 2)			0.00	88. 00
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			0	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	81, 672	1, 765, 771	0. 04625	3 0	0	90.00
91.00 Nursing Program cost	0	1, 765, 771	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	1, 765, 771	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	1, 765, 771	0. 00000	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 01/01/2022	Worksheet D-1
	Component CCN: 15-T002	To 12/31/2022	Date/Time Prepared: 5/25/2023 12:46 pm
	Title XVIII	Subprovi der -	PPS
		IRF	

		IRF		
	Cost Center Description		1.00	
	PART I - ALL PROVIDER COMPONENTS		1.00	
	I NPATI ENT DAYS			1
1.00	Inpatient days (including private room days and swing-bed day		3, 527	
2.00	Inpatient days (including private room days, excluding swing-		3, 527	
3. 00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ys). It you have only private room d	ays, 0	3. 00
4. 00	Semi-private room days (excluding swing-bed and observation b	ed days)	3, 527	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro	om days) through December 31 of the	cost 0	5. 00
4 00	reporting period Total swing-bed SNF type inpatient days (including private ro	om dovo) often December 21 of the co	o+ 0	4 00
6. 00	reporting period (if calendar year, enter 0 on this line)	on days) after becember 31 of the co	st 0	6.00
7. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December 31 of the c	ost 0	7. 00
0.00	reporting period	and the second s		0.00
8. 00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	m days) after December 31 of the cos	t 0	8. 00
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding swing-bed a	nd 1, 299	9. 00
	newborn days) (see instructions)		_	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc		0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		ter 0	11.00
	December 31 of the cost reporting period (if calendar year, e	nter 0 on this line)		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including 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 XI	X only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar y	ear, enter 0 on this line)		
14.00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed days)	0	
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)		0 0	1
10.00	SWING BED ADJUSTMENT			10.00
17. 00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 of the cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	on often December 21 of the cost	0.00	18. 00
16.00	reporting period	es al tel December 31 of the cost	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to service	s 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 service reporting period	s after December 31 of the cost	0.00	20.00
21. 00	Total general inpatient routine service cost (see instruction		4, 811, 601	21.00
22. 00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost reporting period (line 0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporting period (li	ne 6 0	23. 00
20.00	x line 18)	or or the cost reporting period (ii		20.00
24. 00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporting period (I	i ne 0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	21 of the cost reporting period (lin	e 8 0	25. 00
23.00	x line 20)	or the cost reporting perrou (irin	0	23.00
	Total swing-bed cost (see instructions)		0	
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)	4, 811, 601	27. 00
28 00	General inpatient routine service charges (excluding swing-be	d and observation bed charges)	0	28. 00
	Pri vate room charges (excluding swing-bed charges)	a ana ebeer vatron bea enargee,	Ö	
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 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)		0. 00 0. 00	
34. 00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instructions)	0.00	1
35. 00	Average per diem private room cost differential (line 34 x li	ne 31)	0.00	1
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 (0 Line 4, 811, 601	
57.00	27 minus Line 36)	ana private room cost differential (4,011,001	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		·]
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ		4.0/4.00	1 20 22
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	*	1, 364. 22 1, 772, 122	
40. 00	Medically necessary private room cost applicable to the Progr		0	1
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)	1, 772, 122	41.00

	Financial Systems	METHODI ST HOSE		ON 45 0000		eu of Form CMS-		
COMPUT	ATION OF INPATIENT OPERATING COST			CN: 15-0002	Period: From 01/01/2022			
				CCN: 15-T002	To 12/31/2022	5/25/2023 12:		
			Titl€	e XVIII	Subprovi der - I RF	PPS		
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1. 00	2.00	3.00	4.00	5. 00		
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	C	0.	00 0) 0	42.00	
43. 00	INTENSIVE CARE UNIT	0	C	0.	00 0	0	43.00	
43.01	4	0	C	0.	00 0	0		
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00	
46. 00	SURGICAL INTENSIVE CARE UNIT						46.00	
47. 00	OTHER SPECIAL CARE (SPECIFY)						47.00	
	Cost Center Description					1. 00		
48. 00	Program inpatient ancillary service cost (W	kst. D-3, col. 3	, line 200)			842, 461	48. 00 48. 01	
48. 01 49. 00								
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	patient routine	services (fro	m Wkst. D, sı	um of Parts I and	208, 191	50.00	
51. 00	III) Pass through costs applicable to Program in	oatient ancillar	y services (f	rom Wkst. D,	sum of Parts II	48, 988	51.00	
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				257, 179	52.00	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line	0 .	elated, non-ph	ysician anest	thetist, and	2, 357, 404	53. 00	
E 4 .00	TARGET AMOUNT AND LIMIT COMPUTATION	,						
54. 00 55. 00	Program discharges Target amount per discharge					0.00		
55. 01						0.00		
55. 02	, ,	J.				0.00		
56. 00 57. 00	Target amount (line 54 x sum of lines 55, 55) Difference between adjusted inpatient operations			lino 56 minus	s lino 52)	0 0		
58. 00	Bonus payment (see instructions)	ting cost and ta	inger amount (Title 50 millios	s i i ile 53)	0	•	
59. 00	Trended costs (lesser of line 53 ÷ line 54,		the cost rep	orting period	d ending 1996,	0.00		
60. 00								
61. 00	55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line						61.00	
	53) are less than expected costs (lines 54 > enter zero. (see instructions)	x 60), or 1 % of	the target a	mount (line S	56), otherwise			
62. 00 63. 00	Relief payment (see instructions)						62. 00 63. 00	
64 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	sts through Doco	umbor 21 of th	o cost ropor	ting pariod (Saa	0	64.00	
65. 00	instructions)(title XVIII only)					0		
	instructions)(title XVIII only)							
	Total Medicare swing-bed SNF inpatient routi CAH, see instructions		·		•	0		
67. 00	(line 12 x line 19)	o .						
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)			·	porting period	0		
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N	NURSING FACILITY	, AND ICF/IID	ONLY		0		
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of	•		•	<i>(</i>)		70.00 71.00	
72.00	Program routine service cost (line 9 x line		THE 70 - TIME	<i>-)</i>			72.00	
	Medically necessary private room cost applic	cable to Program					73.00	
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•		•	Part II, column		74. 00 75. 00	
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00	
77. 00	•						77.00	
78. 00	Inpatient routine service cost (line 74 minu						78.00	
	Aggregate charges to beneficiaries for excess				nue lino 70)		79.00	
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ost iimi tätiö	ıı (ııne /o Mi	nus iiile /9)		80. 00 81. 00	
82. 00	1 .)				82.00	
83. 00	•		ıs)				83.00	
							84.00	
84. 00 85. 00			ine)				85.00	

Health Financial Systems	METHODI ST HOSI	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 01/01/2022 To 12/31/2022	Date/Time Pre 5/25/2023 12:	pared: 46 pm_
Title XVIII Subprovider -					PPS	
Cost Center Description						
					1. 00	
PART IV - COMPUTATION OF OBSERVATION BED PAS						
87.00 Total observation bed days (see instructions)						87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88. 00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	565, 273	4, 811, 601	0. 11748	1 0	0	90.00
91.00 Nursing Program cost	0	4, 811, 601	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	4, 811, 601	0. 00000	0 0	0	92.00
93.00 All other Medical Education	o	4, 811, 601	0. 00000	0 0	0	93. 00

Health Financial Systems	METHODIST HOSPITALS, INC	In Li€	eu of Form CMS-2552-10	
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15	From 01/01/2022	Worksheet D-1	
		To 12/31/2022	Date/Time Pre 5/25/2023 12:	
	Title XIX	X Hospi tal	Cost	
Cost Center Description				
			1. 00	

-		Title XIX	Hospi tal	5/25/2023 12: Cost	46 pm		
	Cost Center Description	THE AIR	nospi tui	0031			
				1. 00			
	PART I - ALL PROVIDER COMPONENTS						
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days, excluding newborn) 79,339						
2. 00	Inpatient days (including private room days, excluding swing-			79, 339	1.00 2.00		
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,						
4 00	do not complete this line.			/7 757	4.00		
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		or 31 of the cost	67, 757 0	4. 00 5. 00		
3.00	reporting period	om days) trii ough beecimbe	7 31 01 the cost		3.00		
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00		
7 00	reporting period (if calendar year, enter 0 on this line)		04 0 11				
7. 00	Total swing-bed NF type inpatient days (including private roo reporting period	m days) through December	31 or the cost	0	7. 00		
8. 00	Total swing-bed NF type inpatient days (including private roo	m davs) after December 3	31 of the cost	0	8. 00		
	reporting period (if calendar year, enter 0 on this line)						
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	2, 941	9. 00		
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including privato r	coom days)	0	10.00		
10.00	through December 31 of the cost reporting period (see instruc		oolii days)	0	10.00		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11. 00		
	December 31 of the cost reporting period (if calendar year, e						
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	X only (including privat	e room days)	0	12. 00		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	13. 00		
.0.00	after December 31 of the cost reporting period (if calendar y			· ·	10.00		
14.00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	14. 00		
15.00	Total nursery days (title V or XIX only)			2, 131			
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16. 00		
17. 00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 c	of the cost	0.00	17. 00		
	reporting period	3					
18. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0. 00	18. 00		
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through Docombor 21 of	the cost	0.00	19. 00		
17.00	reporting period	s through becember 31 of	the cost	0.00	17.00		
20.00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	the cost	0. 00	20. 00		
21 00	reporting period	-1		0/ 014 /00	21 00		
21. 00 22. 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ing period (line	86, 914, 608 9	21. 00 22. 00		
22.00	5 x line 17)	5. 5. 5. the 555t rape.	ing portou (init	, and the second	22.00		
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportir	ng period (line 6	0	23. 00		
24. 00	x line 18) Swing-bed cost applicable to NF type services through Decembe	r 21 of the cost reporti	ng ported (line	0	24. 00		
24.00	7 x line 19)	1 31 of the cost reporti	ng perrou (irne	0	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		
04 00	x line 20)				04.00		
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 86, 914, 608	26. 00 27. 00		
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Trice 21 miles Trice 20)		00, 711, 000	27.00		
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	28. 00		
29. 00	Private room charges (excluding swing-bed charges)			0	29.00		
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	· lino 28)		0. 000000	30. 00 31. 00		
32. 00	Average private room per diem charge (line 29 ÷ line 3)	- 111le 20 <i>)</i>		0.00000			
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00			
34. 00	Average per diem private room charge differential (line 32 mi	, ,	ctions)	0.00			
35.00	Average per diem private room cost differential (line 34 x li	ne 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 di	fferential (line	0 86, 914, 608	36.00 37.00		
37.00	27 minus line 36)	ana private room cost ur	Troncinciai (TITIE	, 55, 714, 500	37.00		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY						
20.25	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			4 005 :=	00.00		
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	•		1, 095. 48 3, 221, 807	38. 00 39. 00		
40.00	Medically necessary private room cost applicable to the Progr	*		3, 221, 807	40.00		
	Total Program general inpatient routine service cost (line 39	•		3, 221, 807			
			'		-		

Intensive Care Type Inpatient Hospital Units	red: pm 22.00 3.00 3.01 4.00					
To 12/31/2022 Date/Time Prepare 5/25/2023 12: 46 Title XIX Hospital Cost	2. 00 3. 00 3. 01 4. 00					
Title XIX	2. 00 3. 00 3. 01 4. 00					
Inpati ent Di em (col. 1 + col. 2) Col. 3 x col. 4	3. 00 3. 01 4. 00					
Cost Days + col. 2 col. 4	3. 00 3. 01 4. 00					
42. 00 NURSERY (title V & XIX only) 3, 694, 523 2, 131 1, 733. 70 0 0 4 Intensive Care Type Inpatient Hospital Units 43. 00 INTENSIVE CARE UNIT 14, 983, 553 7, 946 1, 885. 67 0 0 4 43. 01 NEONATAL ICU 2, 542, 621 1, 775 1, 432. 46 0 0 4 44. 00 CORONARY CARE UNIT 45. 00 BURN INTENSIVE CARE UNIT 46. 00 SURGI CAL INTENSIVE CARE UNIT 47. 00 OTHER SPECIAL CARE (SPECIFY) 4 Cost Center Description	3. 00 3. 01 4. 00					
Intensive Care Type Inpatient Hospital Units	3. 00 3. 01 4. 00					
43. 01 NEONATAL I CU 2, 542, 621 1, 775 1, 432. 46 0 0 4 44. 00 CORONARY CARE UNIT 45. 00 BURN I NTENSI VE CARE UNIT 46. 00 SURGI CAL I NTENSI VE CARE UNIT 47. 00 OTHER SPECI AL CARE (SPECI FY) 4 Cost Center Description	3. 01 4. 00					
44. 00 CORONARY CARE UNIT 4. 45. 00 BURN INTENSIVE CARE UNIT 4. 46. 00 SURGICAL INTENSIVE CARE UNIT 4. 47. 00 OTHER SPECIAL CARE (SPECIFY) 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4.	4.00					
46. 00 SURGICAL INTENSIVE CARE UNIT 47. 00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description						
47.00 OTHER SPECIAL CARE (SPECIFY) 4 Cost Center Description	5. 00 6. 00					
	7. 00					
1.00						
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) 2,949,233 4	8. 00					
	8. 01 9. 00					
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and 0 50 1111)	0.00					
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II 0 5	1.00					
and IV) 52.00 Total Program excludable cost (sum of lines 50 and 51) 0 5.00 Total Program excludable cost (sum of lines 50 and 51)	2. 00					
	3.00					
medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION						
	4. 00 5. 00					
	5. 01					
O2 Adjustment amount per discharge (contractor use only) O3 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)						
	6. 00 7. 00					
	8. 00 9. 00					
updated and compounded by the market basket)	9.00					
60.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00					
	1. 00					
enter zero. (see instructions)	2. 00					
62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions)						
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See 0 6 instructions)(title XVIII only)	4. 00					
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	5. 00					
	6. 00					
CAH, see instructions 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period 0 6	7. 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 0 6	8. 00					
(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	9. 00					
	0. 00 1. 00					
	2. 00					
0 Medically necessary private room cost applicable to Program (line 14 x line 35)						
	4. 00 5. 00					
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 7						
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)	6.00					
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) 77.00 Program capital-related costs (line 9 x line 76)	76. 00 77. 00 78. 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) 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)	7. 00 8. 00 9. 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) 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)	7. 00 8. 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) 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)	77.00 88.00 99.00 80.00 81.00 82.00					
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) 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)	77.00 8.00 9.00 80.00 81.00					
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) 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) 70.00 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)	7. 00 78. 00 79. 00 80. 00 81. 00 82. 00 83. 00 84. 00 85. 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) 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) 70.00 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)	7. 00 8. 00 9. 00 60. 00 61. 00 62. 00 63. 00 64. 00					

Health Financial Systems	th Financial Systems METHODIST HOSPITALS, INC In Lieu				u of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT OPERATING COST			Worksheet D-1				
			From 01/01/2022 To 12/31/2022				
		Ti tl	e XIX	Hospi tal	Cost		
Cost Center Description							
					1. 00		
88.00 Adjusted general inpatient routine cost per	diem (line 27	÷ line 2)			1, 095. 48	88. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			12, 687, 849	89. 00	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation		
		(from line	column 2	Observati on	Bed Pass		
		21)		Bed Cost	Through Cost		
				(from line	(col. 3 x		
				89)	col. 4) (see		
					instructions)		
	1. 00	2.00	3.00	4. 00	5. 00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00 Capital -related cost	6, 074, 091	86, 914, 608	0. 06988	6 12, 687, 849	886, 703	90.00	
91.00 Nursing Program cost	0	86, 914, 608	0. 00000	0 12, 687, 849	0	91.00	
92.00 Allied health cost	0	86, 914, 608	0. 00000	0 12, 687, 849	0	92.00	
93.00 All other Medical Education	0	86, 914, 608	0. 00000	0 12, 687, 849	0	93.00	

Health Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Peri od: From 01/01/2022	Worksheet D-1
	Component CCN: 15-S002		
	Title XIX	Subprovi der -	Cost
		IPF	

PART 1 - ALL PROVIDER COMPONENTS	1.1 2.1 3.1 4.1 5.1 6.1 7.1 9.1 11.1 12.1
PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS 1.00 Inpatient days (including private room days and swing-bed days, excluding newborn) Inpatient days (including private room days, excluding swing-bed and newborn days) Inpatient days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line. Semi-private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line. Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total inpatient days including private room days after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 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)	2.1 3.1 5.1 6.1 7.1 8.1 10.1
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	15.
	16.
SWING BED ADJUSTMENT 17.00 Medicara rate for swing had SNE sarvices applicable to sarvices through December 21 of the cost	17
17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 0.00	17.
18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 0.00	18.
reporting period	
19.00 Medical rate for swing-bed NF services applicable to services through December 31 of the cost 0.00	19.
reporting period	20
20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 reporting period	20.
21.00 Total general inpatient routine service cost (see instructions) 1,765,771	21.
22.00 Swing-Ded cost applicable to SNF type services through December 31 of the cost reporting period (line 0	22.
5 x line 17)	
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 0)	23.
x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 0)	24.
7 x line 19)	2 1.
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	25.
x line 20)	
26.00 Total swing-bed cost (see instructions) O Congress inputient routing cost (see instructions)	26.
27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 1,765,771 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	21.
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)	28.
29.00 Private room charges (excluding swing-bed charges)	29.
30.00 Semi-private room charges (excluding swing-bed charges)	30.
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0.000000	31.
32.00 Average private room per diem charge (line 29 ÷ line 3) 0.00	32.
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 0.00	33.
34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 0.00	34.
35.00 Average per diem private room cost differential (line 34 x line 31)	35.
36.00 Private room cost differential adjustment (line 3 x line 35)	36.
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1,765,771)	37.
27 minus line 36)	
PART II - HOSPITAL AND SUBPROVIDERS ONLY	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 20 00 Adjusted general impatient routing cost for death particular cost instructions)	20
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,418.29	
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)	39. 40.
41.00 Total Program general inpatient routine service cost (line 39 + line 40)	
1 101/1001	

	Financial Systems	METHODI ST HOSI			In Lie	u of Form CMS-2	<u> 2552-10</u>
COMPUT	ATION OF INPATIENT OPERATING COST			F	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Pre	
				e XIX	Subprovi der -	5/25/2023 12: Cost	
	Cost Contar Description	Total	Total	Average Per	IPF Program Days	Program Cost	
	Cost Center Description	Inpatient Cost	I npati ent Days	Diem (col. 1 ÷ col. 2)	Program bays	(col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1. 00	2.00	3.00	4.00	5. 00	42.00
	Intensive Care Type Inpatient Hospital Units						
43. 00 43. 01	INTENSIVE CARE UNIT NEONATAL ICU	0	(0 0	
44.00	CORONARY CARE UNIT	_					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 1)	35, 165	1
48. 01 49. 00	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines				column I)	0 140, 118	
50.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (fro	om Wkst. D, sum	of Parts I and	0	50.00
51. 00		atient ancillar	ry services (f	rom Wkst. D, s	um of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53.00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line	ding capital re	elated, non-ph	ysician anesth	etist, and	0	1
	TARGET AMOUNT AND LIMIT COMPUTATION	<i>32)</i>				_	1
54. 00 55. 00	3					0 00	54.00 55.00
55. 01	Permanent adjustment amount per discharge					0.00	55. 01
55. 02 56. 00	Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 55					0.00	1
57. 00	Difference between adjusted inpatient operat			line 56 minus	line 53)	0	57.00
58. 00	Bonus payment (see instructions)	I' FF 6				0 0. 00	
59. 00	updated and compounded by the market basket)						59.00
60.00	market basket)						
61.00	61.00 Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 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						61.00
62. 00	lenter zero. (see instructions) Relief payment (see instructions)					0	62.00
	Allowable Inpatient cost plus incentive paym	ent (see instru	ıcti ons)			0	1
64. 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						64. 00
65. 00		ts after Decemb	per 31 of the	cost reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	l only); for	0	66. 00
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	e costs through	n December 31	of the cost re	porting period	0	67. 00
68. 00		e costs after [December 31 of	the cost repo	rting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00
	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	ıtine service	cost (line 37)			70. 00
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine 70 ÷ line	2)			71. 00 72. 00
73. 00			n (line 14 x l	ine 35)			73. 00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient			•	art II, column		74. 00 75. 00
76 NN	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 79. 00	,		rovider recor	·ds)			78. 00 79. 00
80. 00					us line 79)		80.00
81.00	i ·						81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (•				82. 00 83. 00
84. 00	Program inpatient ancillary services (see in	structions)					84.00
	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
	, , , , , , , , , , , , , , , , , , , ,		· /			•	

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0002 Peri od:				
		Component (CCN: 15-S002	From 01/01/2022 To 12/31/2022		pared: 46 pm
		Ti tl	e XIX	Subprovi der – I PF	Cost	
Cost Center Description						
					1. 00	
PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					
87.00 Total observation bed days (see instructions)				0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88. 00
89.00 Observation bed cost (line 87 x line 88) (se	ation bed cost (line 87 x line 88) (see instructions)					89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	81, 672	1, 765, 771	0. 04625	3 0	0	90.00
91.00 Nursing Program cost	0	1, 765, 771	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	1, 765, 771	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	1, 765, 771	0.00000	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 01/01/2022	Worksheet D-1
	Component CCN: 15-T002		
	Title XIX	Subprovi der -	Cost
		l IRF	

		TI LIE AIA	I RF	Cost	
	Cost Center Description			1 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			3, 527	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		ivato room days	3, 527 0	2. 00 3. 00
3.00	do not complete this line.	ys). It you have only pr	Tvate Toom days,	O	3.00
4.00	Semi-private room days (excluding swing-bed and observation b			3, 527	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro	om days) through Decembe	er 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6.00
0.00	reporting period (if calendar year, enter 0 on this line)	om days) arter becomber	or or the cost	· ·	0.00
7.00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roo	m days) after December 3	11 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	in days) area becomber a	or the cost	· ·	0.00
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	78	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	soom dayes)	0	10.00
10.00	through December 31 of the cost reporting period (see instruc		Oolii days)	U	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	oom days) after	0	11.00
10.00	December 31 of the cost reporting period (if calendar year, e				40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	x only (including privat	re room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar y				
14. 00 15. 00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	2 121	14. 00 15. 00
16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			2, 131 0	
	SWI NG BED ADJUSTMENT		l.		
17. 00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 c	of the cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	os after December 21 of	the cost	0.00	18. 00
10.00	reporting period	es al tel becember 51 01	the cost	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0.00	19.00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s after December 21 of t	ho cost	0.00	20.00
20.00	reporting period	s arter becember 31 or t	THE COST	0.00	20.00
21. 00	Total general inpatient routine service cost (see instruction			4, 811, 601	21.00
22. 00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost report	ing period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	na period (line 6	0	23. 00
20.00	x line 18)	or or the cost reportin	ig perrod (Trile d		20.00
24. 00	1 3 11 31	r 31 of the cost reporti	ng 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	neriod (line 8	0	25. 00
23.00	x line 20)	or the cost reporting	perrod (Trie o	O	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 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		4, 811, 601	27. 00
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	28. 00
	Pri vate room charges (excluding swing-bed charges)		9/	0	
30.00				0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	•
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	20) (0.00	•
34. 00 35. 00	Average per diem private room charge differential (line 32 mi		LLI ONS)	0.00	•
36.00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	35. 00 36. 00
36.00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line		36.00
37.00	27 minus line 36)	and private room cost ur	Transmittal (Trille	7,011,001	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		, , , , , , , , , , , , , , , , , , ,		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
38.00	Adjusted general inpatient routine service cost per diem (see	,		1, 364. 22	38.00
39.00	Program general inpatient routine service cost (line 9 x line	•		106, 409	1
40.00	Medically necessary private room cost applicable to the Progr Total Program general inpatient routine service cost (line 39			0 106, 409	40.00
- 1.00	Trotal Trogram general impatrent routine service cost (IIIIe 37		I	100, 409	71.00

	Financial Systems	METHODI ST HOS		15 0000 15		u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST				eriod: rom 01/01/2022 o 12/31/2022		pared:
			Ti ti	e XIX	Subprovi der -	5/25/2023 12: Cost	46 pm
	Cost Center Description	Total Inpatient	Total Inpati ent	Average Per Diem (col. 1	IRF Program Days	Program Cost (col. 3 x	
		Cost 1.00	Days 2.00	÷ col. 2) 3.00	4. 00	col . 4) 5.00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	(0.00	0	0	42.00
43.00	INTENSIVE CARE UNIT	0	(0.00	0	0	43.00
43. 01	NEONATAL ICU	0	(0.00	0	0	
	CORONARY CARE UNIT						44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
							47. 00
	Cost Center Description					1 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3. col. 3	3. Line 200)			1. 00 216, 764	48. 00
48. 01	Program inpatient cellular therapy acquisiti	on cost (Worksh	heet D-6, Part	III, line 10,	column 1)	0	48. 01
49. 00	Total Program inpatient costs (sum of lines	41 through 48.(01)(see instru	ıcti ons)		323, 173	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst D sum	of Parts I and	0	50.00
00.00		attent reatine	301 11 003 (11 0	mit with the big sain	or runts r une	Ü	00.00
51. 00	Pass through costs applicable to Program inp	atient ancilla	ry services (f	rom Wkst. D, su	ım of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53. 00	Total Program inpatient operating cost exclu		elated, non-ph	ysician anesth	etist, and	0	1
	medical education costs (line 49 minus line	52)	·				
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55. 00	, ,					0.00	
	Permanent adjustment amount per discharge					0. 00	1
55. 02	Adjustment amount per discharge (contractor					0.00	
56. 00 57. 00	Target amount (line 54 x sum of lines 55, 55			line 56 minus l	ine 53)	0	56. 00 57. 00
58. 00	, , , , , , , , , , , , , , , , , , , ,						58.00
59. 00							59. 00
60. 00	updated and compounded by the market basket) .00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)						60.00
61. 00	1.00 Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line						61.00
	53) are less than expected costs (lines 54 x enter zero. (see instructions)	60), or 1 % or	r the target a	imount (Tine 56,	, otnerwise		
62.00	Relief payment (see instructions)					0	
63.00	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST 4.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See						64.00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos					0	65. 00
	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line	64 plus line	65)(title XVIII	only); for	0	66. 00
67. 00							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	ting 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
	Skilled nursing facility/other nursing facil						70.00
	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		line /U ÷ line	2)			71. 00 72. 00
	Medically necessary private room cost applic		m (line 14 x l	ine 35)			73.00
	Total Program general inpatient routine serv						74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (from	Worksheet B, Pa	irt II, column		75. 00
76.00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
	Program capital-related costs (line 9 x line						77.00
	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		nrovider recor	rds)			78. 00 79. 00
	Total Program routine service costs for comp				ıs line 79)		80.00
81. 00	Inpatient routine service cost per diem limi	tati on			•		81.00
	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (•				82. 00 83. 00
	Program inpatient ancillary services (see in		113)				84.00
85.00	Utilization review - physician compensation	(see instruction					85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 th	hrough 85)				86.00

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0002 Peri od:				
		Component	CCN: 15-T002	From 01/01/2022 To 12/31/2022		pared: 46 pm
		Title XIX Subprovider -			Cost	
Cost Center Description						
					1. 00	
PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST					
87.00 Total observation bed days (see instructions)				0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88. 00
89.00 Observation bed cost (line 87 x line 88) (se	x line 88) (see instructions)					89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	565, 273	4, 811, 601	0. 11748	1 0	0	90.00
91.00 Nursing Program cost	0	4, 811, 601	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	4, 811, 601	0. 00000	0 0	0	92.00
93.00 All other Medical Education	o	4, 811, 601	0. 00000	0	0	93.00

Health Financial Systems METHODIST	HOSPITALS, INC		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Peri od:	Worksheet D-3	
			From 01/01/2022 To 12/31/2022	Date/Time Pre 5/25/2023 12:	pared: 46 pm
	Title	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	'	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col . 1 x	
		1.00	2. 00	col . 2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			22, 306, 041		30.00
31. 00 03100 NTENSI VE CARE UNI T			6, 284, 885		31.00
31. 01 03101 NEONATAL CU			0		31. 01
40. 00 04000 SUBPROVI DER - 1 PF			0		40.00
41. 00 04100 SUBPROVI DER - I RF			0		41.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM		0. 11588		1, 368, 251	50.00
50. 01 05001 ENDOSCOPY		0. 15673		222, 427	50. 01
51. 00 05100 RECOVERY ROOM		0. 21592		132, 156	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM		1. 29878		269, 186	52.00
53. 00 05300 ANESTHESI OLOGY		0.00000		0	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 20670		575, 956	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND 55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 12661 0. 13216		187, 914 47, 444	54. 01 55. 00
55. 01 05501 INFUSION CENTER		0. 13210		47, 444	55.00
56. 00 05600 RADI OI SOTOPE		0.07228		195, 059	56.00
57. 00 05700 CT SCAN		0. 03689		538, 549	57.00
58.00 O5800 MAGNETIC RESONANCE I MAGING (MRI)		0. 06242		179, 464	•
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 08261		813, 877	59.00
60. 00 06000 LABORATORY		0. 08785		2, 358, 339	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 10465		103, 404	62.00
64. 00 06400 I NTRAVENOUS THERAPY		0.00000	o o	0	64.00
65. 00 06500 RESPI RATORY THERAPY		0. 15054		1, 660, 945	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 33920	1, 580, 547	536, 123	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 38388		388, 751	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 28193		207, 633	
69. 00 06900 ELECTROCARDI OLOGY		0. 05864		224, 204	
69. 01 06901 CARDI AC REHAB		0. 42863		36	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.06174		259, 004	•
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 50896		2, 977, 462	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 46703	7 5, 339, 995	2, 493, 975	72.00

5, 571, 946 73.00

0

24, 227, 911 200. 00

74.00

77.00

90. 00 91. 00

92.00

201. 00 202. 00

695, 381

27, 307 1, 416, 207 776, 902

0. 217492

0. 254191

0.000000

0. 511708 0. 209635

0. 551025

25, 619, 087

2, 735, 664

53, 364 6, 755, 583 1, 409, 921

145, 136, 916

145, 136, 916

73. 00 07300 DRUGS CHARGED TO PATIENTS

07700 ALLOGENEIC HSCT ACQUISITION

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

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

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

OUTPATIENT SERVICE COST CENTERS

74. 00 07400 RENAL DIALYSIS

90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY

77.00

200.00

201.00

202.00

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0002 CCN: 15-S002	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Pre	
	'			5/25/2023 12:	
	Title	e XVIII	Subprovi der - I PF	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col . 1 x	
		1.00	2.00	col . 2) 3.00	\vdash
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	-
. 00 03000 ADULTS & PEDIATRICS					30
.00 03100 INTENSIVE CARE UNIT					31
O1 O3101 NEONATAL ICU					31
. 00 04000 SUBPROVI DER - I PF			380, 703		40
. 00 04100 SUBPROVI DER - RF					4
. 00 O4300 NURSERY					43
ANCILLARY SERVICE COST CENTERS OO 05000 OPERATING ROOM		0 11500	39 0	0	50
. 01 05000 OPERATING ROOM		0. 11588 0. 15673		0	
. 00 05100 RECOVERY ROOM		0. 15073		0	
. OO O5200 DELIVERY ROOM & LABOR ROOM		1. 29878		0	
. 00 05300 ANESTHESI OLOGY		0. 00000		0	1
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 20670		204	
. 01 05401 RADI OLOGY - ULTRASOUND		0. 12661		152	
. 00 05500 RADI OLOGY-THERAPEUTI C		0. 13216	0	0	5!
.01 05501 I NFUSION CENTER		0. 07228		0	
. 00 05600 RADI 0I SOTOPE		0. 16782		0	_
.00 05700 CT SCAN		0. 03689		409	
OO O5800 MAGNETIC RESONANCE IMAGING (MRI)		0.06242		282	
. 00 05900 CARDI AC CATHETERI ZATI ON . 00 06000 LABORATORY		0. 08261		0	-
.00 06000 LABORATORY .00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 08785 0. 10465		6, 619 0	
. 00 06400 NTRAVENOUS THERAPY		0. 00000		0	
. 00 06500 RESPI RATORY THERAPY		0. 15054		898	
. 00 06600 PHYSI CAL THERAPY		0. 33920		576	
. 00 06700 OCCUPATI ONAL THERAPY		0. 38388		584	6
.00 06800 SPEECH PATHOLOGY		0. 28193	0	0	68
. 00 06900 ELECTROCARDI OLOGY		0. 05864	6, 400	375	69
O1 06901 CARDI AC REHAB		0. 42863		0	
00 07000 ELECTROENCEPHALOGRAPHY		0. 06174		0	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 50896		358	
. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 46703		0	
.00 07300 DRUGS CHARGED TO PATIENTS .00 07400 RENAL DIALYSIS		0. 21749		20, 787 0	
.00 07400 RENAL DIALYSIS .00 07700 ALLOGENEIC HSCT ACQUISITION		0. 25419 0. 00000		0	1 '
OUTPATIENT SERVICE COST CENTERS		0.00000	,o ₁ 0	0	1
. 00 09000 CLI NI C		0. 51170	0 8	0	90
. 00 09100 EMERGENCY		0. 20963		0	
.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 55102	25 0	0	92
0.00 Total (sum of lines 50 through 94 and 96 through 98			205, 002	31, 244	
1.00 Less PBP Clinic Laboratory Services-Program only ch	arges (line 61)		0		201
2.00 Net charges (line 200 minus line 201)		1	205, 002		202

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	3
	Component		From 01/01/2022 To 12/31/2022	Date/Time Pre 5/25/2023 12:	
	Title	XVIII	Subprovi der -	PPS	чо рііі
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					İ
30. 00 03000 ADULTS & PEDIATRICS					30.00
31. 00 03100 I NTENSI VE CARE UNI T					31.00
31. 01 03101 NEONATAL I CU					31. 01
40. 00 04000 SUBPROVI DER - 1 PF			4 400 400		40.00
41. 00 04100 SUBPROVI DER - I RF			1, 430, 482		41.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00 O5000 OPERATING ROOM		0. 11588	9 44, 635	5, 173	50.00
50. 01 05001 ENDOSCOPY		0. 15673		515	
51.00 05100 RECOVERY ROOM		0. 21592		269	
52. 00 05200 DELIVERY ROOM & LABOR ROOM		1. 29878		0	
53. 00 05300 ANESTHESI OLOGY		0. 00000	0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 20670		6, 579	
54. 01 05401 RADI OLOGY - ULTRASOUND		0. 12661		1, 310	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 13216		0	
55. 01 05501 I NFUSI ON CENTER 56. 00 05600 RADI OI SOTOPE		0. 07228 0. 16782		0 472	
57. 00 05700 CT SCAN		0. 16762		2, 630	
58.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE MAGING (MRI)		0.06242		793	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 08261		0	•
60. 00 06000 LABORATORY		0. 08785		42, 727	•
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 10465	8, 354	874	62.00
64. 00 06400 INTRAVENOUS THERAPY		0. 00000		0	
65. 00 06500 RESPI RATORY THERAPY		0. 15054		21, 031	•
66. 00 06600 PHYSI CAL THERAPY		0. 33920		244, 201	•
67. 00 06700 0CCUPATIONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY		0. 38388		246, 493	
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY		0. 28193 0. 05864		32, 635 992	
69. 01 06901 CARDI AC REHAB		0. 42863		0	1
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 42003		58	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 50896		2, 369	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 46703		17, 414	•
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 21749		195, 314	73.00
74. 00 07400 RENAL DI ALYSI S		0. 25419		20, 612	
77. 00 07700 ALLOGENEIC HSCT ACQUISITION		0. 00000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS		0 51170	0		1 00 00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY		0.51170		0	1
91.00 09100 EMERGENCY 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART)		0. 20963 0. 55102		0	
200.00 Total (sum of lines 50 through 94 and 96 through	98)	0.55102	3, 329, 195	842, 461	
201.00 Less PBP Clinic Laboratory Services-Program only			0, 327, 173		201.00
			١		1

Health Financial Systems METHODIS	ST HOSPITALS, INC		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CC		Peri od:	Worksheet D-3	
			From 01/01/2022 To 12/31/2022	Doto/Time Dro	norod.
			To 12/31/2022	Date/Time Pre 5/25/2023 12:	
	Title	e XIX	Hospi tal	Cost	. с р
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col . 1 x	
	-	1.00	0.00	col . 2)	
INDATIENT DOUTINE CEDVICE COCT CENTERS		1. 00	2. 00	3. 00	
30.00 OOOOO ADULTS & PEDIATRICS			2.754.441		20.00
			2, 754, 441		30.00
31. 00 03100 INTENSIVE CARE UNIT 31. 01 03101 NEONATAL CU			632, 355		31.00
40. 00 04000 SUBPROVI DER - I PF			603, 131 100, 592		31. 01 40. 00
41. 00 04100 SUBPROVI DER - 1 PF			94, 620		41.00
43. 00 04300 NURSERY			254, 423		43.00
ANCILLARY SERVICE COST CENTERS			254, 425		43.00
50. 00 O5000 OPERATING ROOM		0. 11588	9 2, 377, 222	275, 494	50.00
50. 01 05001 ENDOSCOPY		0. 15673		23, 299	
51. 00 05100 RECOVERY ROOM		0. 21592	· ·	28, 817	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		1. 29878		479, 926	
53. 00 05300 ANESTHESI OLOGY		0.00000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 20670		59, 014	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND		0. 12661	0 213, 998	27, 094	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 13199	4 6, 579	868	55.00
55. 01 05501 I NFUSI ON CENTER		0. 07228	7 61	4	55. 01
56. 00 05600 RADI 0I SOTOPE		0. 16782	7 132, 071	22, 165	56.00
57. 00 05700 CT SCAN		0. 03689	3 1, 510, 130	55, 713	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 06242	0 298, 224	18, 615	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 08261		113, 062	
60. 00 06000 LABORATORY		0. 08785		312, 012	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 10465		8, 084	62.00
64. 00 06400 I NTRAVENOUS THERAPY		0.00000	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY		0. 15054		204, 252	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 33920	· ·	51, 825	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 38388		44, 979	1
68. 00 06800 SPEECH PATHOLOGY		0. 28193		15, 006	
69. 00 06900 ELECTROCARDI OLOGY		0. 05864		22, 513	
69. 01 06901 CARDI AC REHAB		0. 42863		5, 811	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 06174		15, 051	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0. 50896		132, 798	1
72.00 O7200 DRUCS CHARGED TO PATLENTS		0. 46703		121, 857	

260, 915 3, 162, 250

236, 511

5, 990

763, 353

17, 483, 748

17, 483, 748

687, 764

60, 119

3, 065

160, 026

0

0

2, 949, 233 200. 00

72.00 73.00

74.00

77.00

90.00 91.00

92.00

201.00

202.00

0. 217492

0. 254191

0.000000

0. 511708 0. 209635

0. 551025

73.00

77.00

200.00

201.00

202.00

07300 DRUGS CHARGED TO PATIENTS

07700 ALLOGENEIC HSCT ACQUISITION

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

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

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

OUTPATIENT SERVICE COST CENTERS

74.00 07400 RENAL DIALYSIS

90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0002	Peri od:	Worksheet D-3	;
	Component	CCN: 15-S002	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/25/2023 12:	
	Ti tl	e XIX	Subprovi der -	Cost	40 pi
Cost Center Description		Ratio of Cos	st Inpatient	I npati ent	
		To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1			
0. 00 03000 ADULTS & PEDI ATRI CS					30.
I. 00 03100 INTENSIVE CARE UNIT I. 01 03101 NEONATAL CU					31.
0. 00 04000 SUBPROVI DER - 1 PF			412, 516		40.
1. 00 04000 SUBPROVI DER - TPF			412, 310		41.
3. 00 04300 NURSERY					43.
ANCILLARY SERVICE COST CENTERS					1
0.00 O5000 OPERATING ROOM		0. 1158	89 0	0	50.
0. 01 05001 ENDOSCOPY		0. 1567	32 0	0	50.
I. 00 05100 RECOVERY ROOM		0. 2159		0	1 .
2.00 05200 DELIVERY ROOM & LABOR ROOM		1. 2987		0	
3. 00 05300 ANESTHESI OLOGY		0.0000		0	
I. 00 05400 RADI OLOGY-DI AGNOSTI C I. 01 05401 RADI OLOGY - ULTRASOUND		0. 2067 0. 1266		2, 998 177	
5. 00 05500 RADI OLOGY - THERAPEUTI C		0. 1200		0	
5. 01 05501 I NFUSI ON CENTER		0. 0722		0	1
5. 00 05600 RADI OI SOTOPE		0. 1678		0	
7. 00 05700 CT SCAN		0. 0368	93 0	0	57.
3.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 0624	20 0	0	58.
P. 00 05900 CARDI AC CATHETERI ZATI ON		0. 0826		0	1
0. 00 06000 LABORATORY		0. 0878		6, 519	
2. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 1046		537	1
1. 00 06400 INTRAVENOUS THERAPY 5. 00 06500 RESPIRATORY THERAPY		0. 0000 0. 1505		0	
6. 00 06600 PHYSI CAL THERAPY		0. 1303		0	
7. 00 06700 0CCUPATI ONAL THERAPY		0. 3838		0	
3. 00 06800 SPEECH PATHOLOGY		0. 2819		0	
9. 00 06900 ELECTROCARDI OLOGY		0. 0586		353	
9. 01 06901 CARDI AC REHAB		0. 4286	35 0	0	69.
D. 00 07000 ELECTROENCEPHALOGRAPHY		0. 0617	46 0	0	70.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 5089		0	1
2. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 4670		0	1
B. 00 07300 DRUGS CHARGED TO PATIENTS		0. 2174		23, 211	
1. 00 07400 RENAL DIALYSIS 7. 00 07700 ALLOGENEIC HSCT ACQUISITION		0. 2541 0. 0000		0	
OUTPATIENT SERVICE COST CENTERS		0.0000	00 0	0	┤ ′ ′ .
0.00 09000 CLINIC		0. 5117	08 52	27	90.
1. 00 09100 EMERGENCY		0. 2096		1, 343	
2. OO O9200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5510		0	1
70.00 Total (sum of lines 50 through 94 and 96 through 98)			214, 447	35, 165	200.
11.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.
02.00 Net charges (line 200 minus line 201)			214, 447		202.

Health Financial Systems METHOL INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	DIST HOSPITALS, INC Provider C		Peri od:	u of Form CMS-: Worksheet D-3	
	Component		From 01/01/2022 To 12/31/2022	Date/Time Pre 5/25/2023 12:	epared:
	Ti tl	e XIX	Subprovi der - I RF	Cost	40 piii
Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
INDATIENT DOUTINE SEDVICE COST CENTEDS		1.00	2.00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 31. 01 03101 NEONATAL ICU 40. 00 04000 SUBPROVIDER - IPF 41. 00 04100 SUBPROVIDER - IRF 43. 00 04300 NURSERY 04300 NU			357, 953		30. 00 31. 00 31. 01 40. 00 41. 00 43. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 50. 01 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 RADI OLOGY - ULTRASOUND 55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OLOGY-THERAPEUTI C 57. 01 05501 INFUSI ON CENTER 58. 00 05600 RADI OLOGY-THERAPEUTI C 59. 00 05800 MAGNETI C RESONANCE IMAGING (MRI) 59. 00 05800 MAGNETI C RESONANCE IMAGING (MRI) 59. 00 06900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 64. 00 06400 INTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06900 CARDI AC REHAB 70. 00 07000 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB 70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS 74. 00 07400 RENAL DI ALYSI S 77. 00 0000 CLINIC COST CENTERS 600 0000 CLINIC COST CENTERS 600 0000 CLINIC COST CENTERS 600 0000 CLINIC COST CENTERS 600 0000 CLINIC COST CENTERS 600 0000 CLINIC COST CENTERS 600 0000 CLINIC COST CENTERS 600 0000 CLINIC COST CENTERS 600 0000 CLINIC COST CENTERS 600 0000 CLINIC COST CENTERS 600 0000 CLINIC COST CENTERS 600 0000 CLINIC COST CENTERS 600 0000 CLINIC COST CENTERS 600 0000 CLINIC COST CENTERS 600 0000 CLINIC COST CENTERS 600 0000 CLINIC COST CENTERS 600 0000 CLINIC COST CENTERS 600 0000 CLINIC COST CENTERS 600 0000 CLINIC COST CENTERS 600 0000 CLINIC COST CENTERS 600 000		0. 11588 0. 15673 0. 21592 1. 29878 0. 00000 0. 20670 0. 12661 0. 13199 0. 07228 0. 16782 0. 03689 0. 06242 0. 08261 0. 08785 0. 10465 0. 00000 0. 15054 0. 33920 0. 38388 0. 28193 0. 05864 0. 42863 0. 06174 0. 50896 0. 46703 0. 21749 0. 25419 0. 00000	122 0 127 0 128 0 129 0 129 7, 172 120 2, 955 144 0 157 0 157 1, 337 157 25, 960 150 0 155 109, 789 155 5, 054 160 0 155 109, 789 155 5, 054 160 557 179, 249 160, 557 179, 249 160, 557 179, 249 179, 249 180, 557 199 26, 539 13, 468 15, 100 16, 100 17, 100 18, 100 19, 100 100 100 100 100 100 100 100	1, 291 0 0 0 0 1, 483 374 0 0 224 958 0 9, 646 529 0 5, 548 60, 801 61, 635 7, 482 790 0 17 6, 836 0 57, 006 2, 144	50. 01 51. 00 52. 00 53. 00 54. 01 55. 01 55. 01 56. 00 57. 00 59. 00 60. 00 62. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 01 70. 00 71. 00 72. 00 73. 00 74. 00
90.00 09000 CLINIC 09100 EMERGENCY 09200 09SERVATION BEDS (NON-DISTINCT PART) Total (sum of lines 50 through 94 and 96 through 201.00 Less PBP Clinic Laboratory Services-Program o		0. 51170 0. 20963 0. 55102	o o	0 0 0 216, 764	91.00 92.00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0002	From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 5/25/2023 12:46 pm

BARE A - IMPAILENT MODIFIEL SERVICES WHERE IPPS		Title XVIII	Hospi tal	5/25/2023 12: PPS	46 pm
ReAT A				1 00	
1.00 Disc amounts other than outlier payments for discharges occurring prior to October 1 (see 21,66,894 1.01 1.02 1.03 1.02 1.03 1.02 1.03 1.02 1.03 1.02 1.03 1.02 1.03 1		PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		1.00	
1.02 PRG arounts other than outlier payments for discharges occurring on or after october 1 (see 7,256,310 1.02		DRG amounts other than outlier payments for discharges occurring prior to October 1	(see	-	•
1,000 10	1. 02	DRG amounts other than outlier payments for discharges occurring on or after Octobe	r 1 (see	7, 256, 310	1. 02
Cotober 1 (see instructions) 2.00 Cotober 1 (see instructions) 2.00 Cotober 1 (see instructions) 2.00 Cotober 1 (see instructions) 2.00 Cotober 1 (see instructions) 2.00 Cotober 1 (see instructions) 2.00 Cotober 1 (see instructions) 2.00 Cotober 1 (see instructions) 2.00 Cotober 1 (see instructions) 2.00 Cotober 1 (see instructions) 2.00 Cotober 2 Cotober 2 Cotober 3 Cotober	1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurrin	g prior to October	0	1. 03
0.00		October 1 (see instructions)	g on or after	0	
2.01 Dutiliter payments for discharges occurring on or after October 1 (see Instructions) 1,444,936 2.03	2. 01	Outlier reconciliation amount		1	2. 01
Namaged Car'e Simulated Payments 32,777.406 3.00	2. 03	Outlier payments for discharges occurring prior to October 1 (see instructions)		1, 444, 936	2. 03
Indirect Medical Education Adjustment Section Programs for the most recent cost reporting period ending of or before 12/31/1996, (see instructions) 0.00 5.01	3.00	Managed Care Simulated Payments		32, 797, 406	3.00
or before 12/31/1996. (see Instructions) or before 12/31/1996. (see Instructions) 1. 0. 0 5.01 FTE count for all lopathic and osteopathic programs that meet the criteria for an add-on to the cap for 0.00 6.00 new programs in accordance with 42 CFR 413. 79(e) 6.20 Rural track program FTE cap I initiation adjustment after the cap-building window closed under \$127 of 0.00 6.20 new programs in accordance with 42 CFR 413. 79(e) 7. 01 MA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(8)(1) 0.00 7.00 new programs in the surface propriation of the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(8)(2) If the 0.00 7.01 new programs with a rural track for Medicare (BE affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions) 8. 00 Adjustment (increase or decrease) to the hospital's rural track program FTE I limitation(s) for rural track programs with a rural track for Medicare (BE affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions) 8. 01 The amount of increase or decrease) to the FTE count for all opathic and osteopathic programs for 0.00 8.00 new programs with a rural track for Medicare (BE affiliated) programs in accordance with 413.75(b) and 87 FR 50069 (August 1, 2002) 8. 01 The amount of increase if the hospital was awarded FTE cap slots under § 5508 of the ACA If the cost 1998) and 67 FR 50069 (August 1, 2001) 8. 02 The amount of increase if the hospital was awarded FTE cap slots under § 126 of the CAA 2021 (see 0.00 8.21 Instructions) 8. 03 The amount of increase if the hospital was awarded FTE cap slots under § 126 of the CAA 2021 (see 0.00 8.21 Instructions) 8. 01 The amount of increase if the hospital was awarded FTE cap slots under § 126 of the CAA 2021 (see 0.00 8.21 Instructions) 8. 02 The amount of increase if the hospital was awarded FTE cap slots under § 126 of the CAA 2021 (see 0.00 8.21 Instructions) 9. 01 The count for all opathic and osteopathic prog		Indirect Medical Education Adjustment			
FTE count for all opathic and ostopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		or before 12/31/1996. (see instructions)			
the CAA 2021 (see Instructions) 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) ff the cost cost report stradies July 1, 2011 then see instructions 7.02 Adjustment (increase or decrease) to the hospital 's rural track programs in accordance with 413.75(b) and 87 FR 49076 (August 10, 2022) (see instructions) 8.00 Adjustment (increase or decrease) to the hospital 's rural track programs in accordance with 413.75(b) and 87 FR 49076 (August 10, 2022) (see instructions) 8.01 Adjustment (increase or decrease) to the FIE count for all opathic and osteopathic programs for and 87 FR 49076 (August 10, 2022) (see instructions) 8.02 The amount of increase if the hospital was awarded FTE cap slots under \$5080 of the ACA. If the cost report straddle s July 1, 2011, see instructions. 8.17 The amount of increase if the hospital was awarded FTE cap slots under \$5050 of ACA. (see instructions) 8.21 The amount of increase if the hospital was awarded FTE cap slots under \$120 of the CAA 2021 (see instructions) 8.22 The amount of increase if the hospital was awarded FTE cap slots under \$120 of the CAA 2021 (see instructions) 8.23 The amount of increase if the hospital was awarded FTE cap slots under \$120 of the CAA 2021 (see instructions) 8.24 The amount of increase if the hospital was awarded FTE cap slots under \$120 of the CAA 2021 (see instructions) 8.25 The amount of increase if the hospital was awarded FTE cap slots under \$120 of the CAA 2021 (see instructions) 8.26 The count for all opathic and osteopathic programs in the current year from year records 8.27 The amount of increase if the hospital was awarded FTE cap slots under \$120 of the CAA 2021 (see instructions) 8.28 The amount of increase if the programs in the current year from year records 8.29 The count for the program see the current year from year records 8.20 The count for the program see the current year from year records 8.20 The count for the program see the current year from year records 8.20 The count for		FTE count for allopathic and osteopathic programs that meet the criteria for an add		l e	•
	6. 26		sed under §127 of	0.00	6. 26
7.02 Adjustment (increase or decrease) to the hospital's rural track program FIE limitation(s) for rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions) 8.00 Adjustment (increase or decrease) to the FIE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50060 (August 1, 2002). 8.01 The amount of increase if the hospital was awarded FIE cap slots under § 5503 of the ACA. If the cost report stradide July 1, 2011, see instructions. 8.02 The amount of increase if the hospital was awarded FIE cap slots under § 5503 of ACA. (See instructions) 8.21 The amount of increase if the hospital was awarded FIE cap slots under § 126 of the CAA 2021 (see instructions) 8.22 In The amount of increase if the hospital was awarded FIE cap slots under § 126 of the CAA 2021 (see instructions) 8.23 Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions) 9.00 FIE count for allopathic and osteopathic programs in the current year from your records 9.00 Current year all owable FIE (see instructions) 10.00 FIE count for allopathic and osteopathic programs in the current year from your records 10.00 FIE and all lomable FIE (see instructions) 10.00 FIE and all lomable FIE (see instructions) 10.00 FIE and all lomable FIE (see instructions) 10.00 FIE and all lomable FIE (see instructions) 10.00 FIE and all lomable FIE (see instructions) 10.00 FIE and all lomable FIE (see instructions) 10.00 FIE and FIE and for the prior year program (see instructions) 10.00 FIE and		ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)	, , , , , , , , , ,	l	
Adjustment (Increase or decrease) to the FTE count for al lopathic and osteopathic programs for affiliated programs in accordance with 14 cZ FR 413.79(c) (2) (1v), 64 F82040 (May 12, 1998), and 67 FR 50009 (August 1, 2002).	7. 02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitat track programs with a rural track for Medicare GME affiliated programs in accordance		0.00	7. 02
8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic p affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26		0.00	8. 00
8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5506 of ACA. (see instructions)	8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of th	e ACA. If the cost	0.00	8. 01
The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teac	hing hospital	0.00	8. 02
Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	8. 21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the	CAA 2021 (see	0.00	8. 21
11. 00 TE count for residents in dental and podiatric programs. 0.00 11. 00 12. 00 12. 00 13. 00 14. 00 13. 00 14. 00 14. 00 15. 00 14. 00 15. 00 15. 00 15. 00 16. 00	9. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 a	nd 7.01, plus or	8. 53	9. 00
13.00 Total allowable FTE count for the prior year. 3.00 13.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero. 3.00 14.00 14.00 15.00			ords		
14.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero. 15.00 Sum of lines 12 through 14 divided by 3. 3.00 15.00 16.00 Adjustment for residents in initial years of the program (see instructions) 0.00 16.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 18.00 0.00 19.00 0.00 19.00 0.00 19.00 0.00 19.00 0.00 19.00 0.00 19.00 0.00 19.00 0.000 19.00 0.000 19.00 0.000 19.00 0.000 19.00 0.0000 0.0000 0.00000 0.000000 0.00000000		, , , , , , , , , , , , , , , , , , , ,		•	
15.00 Sum of lines 12 through 14 divided by 3. 3.00 15.00 16.00 Adjustment for residents in initial years of the program (see instructions) 0.00 16.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 17.00 Adjustment to hed ratio (line 18 divided by line 4). 0.0088043 19.00 0.008103 0.		Total allowable FTE count for the penultimate year if that year ended on or after S	eptember 30, 1997,	l	ł
17. 00		Sum of lines 12 through 14 divided by 3.		l	ı
19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.008043 19.00 20.00 Prior year resident to bed ratio (see instructions) 0.008123 20.00 0.008123 20.00 20.00 Enter the lesser of lines 19 or 20 (see instructions) 0.008043 21.00 22.00 IME payment adjustment (see instructions) 126,871 22.00 IME payment adjustment - Managed Care (see instructions) 143,915 22.01 Indirect Medical Education Adjustment for the Add-on for \$ 422 of the MMA 143,915 22.00 Indirect Medical Education Adjustment for the Add-on for \$ 422 of the MMA 143,915 22.00 140 150	17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.008043 21.00 22.00 IME payment adjustment (see instructions) 126,871 22.00 1ME payment adjustment - Managed Care (see instructions) 143,915 22.01 1MI 1 1 1 1 1 1 1 1 1				l	ı
22.00 IME payment adjustment (see instructions) 126,871 22.00 22.01 IME payment adjustment - Managed Care (see instructions) 143,915 22.01 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 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 lower of line 23 or line 24 (see instructions) 0.00 25.00 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.01 IME add-on adjustment amount (see instructions) 0.28.00 28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.000000 28.00 29.01 Total IME payment (sum of lines 22 and 28) 126,871 29.00 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 143,915 29.01 Disproportionate Share Adjustment 30.00 30.00 Percentage of SSI recipient patient days (see instructions) 8.53 30.00 31.00 Percentage of				l	
22. 01 IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412. 105 (f) (1) (iv) (C). 24. 00 IME FTE Resident Count Over Cap (see instructions) 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0. 00 Instructions) 26. 00 Resident to bed ratio (divide line 25 by line 4) 0. 000000 26. 00 0. 1ME payments adjustment factor. (see instructions) 0. 1ME add-on adjustment amount (see instructions) 0. 1ME add-on adjustment amount (see instructions) 0. 28. 00 0. 1ME add-on adjustment amount - Managed Care (see instructions) 0. 28. 01 0. 1ME payment (sum of lines 22 and 28) 0. 10 Total IME payment (sum of lines 22 and 28) 0. 10 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0. 10 Disproportionate Share Adjustment 0. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 0. 00 Sum of lines 30 and 31 0. 00 Sum of lines 30 and 31				l	
23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 23.00 (f)(1)(iv)(C). 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 lower of line 23 or line 24 (see 0.00 25.00 instructions) Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.00 IME add-on adjustment amount (see instructions) 0.28.00 29.01 IME add-on adjustment amount - Managed Care (see instructions) 0.28.01 29.01 Total IME payment (sum of lines 22 and 28) 126,871 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 8.53 30.00 Sum of lines 30 and 31 39.82 32.00		IME payment adjustment - Managed Care (see instructions)		143, 915	
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 lower of line 23 or line 24 (see instructions) 0.00 25.00 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.01 IME add-on adjustment amount (see instructions) 0.28.00 28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.28.01 29.00 Total IME payment (sum of lines 22 and 28) 126,871 29.00 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 143,915 29.01 Disproportionate Share Adjustment 9ercentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 8.53 30.00 31.00 Percentage of Medicaid patient days (see instructions) 31.29 31.00 32.00 Sum of lines 30 and 31 39.82 32.00	23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42	CFR 412. 105	0.00	23. 00
instructions Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.00 IME add-on adjustment amount (see instructions) 0.28.00 IME add-on adjustment amount - Managed Care (see instructions) 0.28.01 29.00 Total IME payment (sum of lines 22 and 28) 126,871 29.00 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 143,915 29.01 29		IME FTE Resident Count Over Cap (see instructions)	ne 24 (see	l	1
28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.01 Total IME payment (sum of lines 22 and 28) 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Sum of lines 30 and 31 28.00 28.01 126,871 29.00 129.00 143,915 29.01 29.01 30.00 31.00 Percentage of Medicaid patient days to Medicare Part A patient days (see instructions) 31.00 Sum of lines 30 and 31	26. 00	instructions)			
28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 31.00 Sum of lines 30 and 31 28.01 29.00 126,871 29.00 143,915 29.01 30.00 31.00 31.00 31.00 31.00				l	1
29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 29.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Percentage of Medicaid patient days (see instructions) 31.00 Sum of lines 30 and 31 29.00 30.00 31.00 Percentage of Medicaid patient days (see instructions) 31.00 Sum of lines 30 and 31					
Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 39.82 32.00	29.00	Total IME payment (sum of lines 22 and 28)		126, 871	29. 00
31.00 Percentage of Medicaid patient days (see instructions) 31.00 Sum of lines 30 and 31 31.00 Sum of lines 30 and 31	30 00	Di sproporti onate Share Adjustment	uctions)	0.53	20.00
32.00 Sum of lines 30 and 31 39.82 32.00			ucti ons)	l e	
22 00 IAI lowable disproporti opate share percentage (see instructions)	32.00	Sum of lines 30 and 31		39. 82	32.00
33.00 Allowable disproportionate share percentage (see instructions) 22.07 33.00	33. 00	Allowable disproportionate share percentage (see instructions)		22. 07	33.00

Heal th	Financial Systems METHODIST HOSPI	TALS, INC	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0002	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Pre	pared:
		Title XVIII	Hospi tal	5/25/2023 12: PPS	
		TITLE AVIII	поѕрі таі	PPS	
				1. 00	
34. 00	Disproportionate share adjustment (see instructions)		Prior to 10/1	1, 595, 284	34.00
			1.00	2. 00	
	Uncompensated Care Payment Adjustment				
35.00	Total uncompensated care amount (see instructions)			6, 874, 403, 459	
35. 01 35. 02		enter zero on this line	0. 000486183 3, 496, 630	0. 000494220 3, 397, 293	
3E 03	(see instructions)	CD (see instructions)	2 415 207	054 205	3E 03
35. 03 36. 00	Pro rata share of the hospital UCP, including supplemental UCT Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	CP (See Tristructions)	2, 615, 287 3, 471, 592	856, 305	35. 03 36. 00
00.00	Additional payment for high percentage of ESRD beneficiary di	scharges (lines 40 throu			00.00
40.00	Total Medicare discharges (see instructions)		5, 262		40.00
41. 00 41. 01	Total ESRD Medicare discharges (see instructions) Total ESRD Medicare covered and paid discharges (see instruc	tions)	530 530		41. 00 41. 01
42.00	Divide line 41 by line 40 (if less than 10%, you do not quali		10. 07		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	,	5, 037		43.00
44. 00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	1. 357682		44.00
45. 00	days) Average weekly cost for dialysis treatments (see instructions	5)	435. 60		45. 00
46. 00	Total additional payment (line 45 times line 44 times line 4	•	313, 447		46.00
47. 00	Subtotal (see instructions)		36, 045, 508		47.00
48. 00	Hospital specific payments (to be completed by SCH and MDH, sonly, (see instructions)	small rural hospitals	0		48. 00
	on y. (see matructrons)			Amount	
40.00	T-t-1	->		1.00	40.00
49. 00 50. 00	Total payment for inpatient operating costs (see instructions Payment for inpatient program capital (from Wkst. L, Pt. I a	•		36, 189, 423 2, 427, 924	
51. 00	Exception payment for inpatient program capital (Wkst. L, Pt.			2, 127, 721	
52.00		. III, see instructions)		0	51.00
	Direct graduate medical education payment (from Wkst. E-4, I			97, 930	52.00
53.00	Nursing and Allied Health Managed Care payment			97, 930 49, 544	52. 00 53. 00
53. 00 54. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies			97, 930	52. 00 53. 00 54. 00
53.00	Nursing and Allied Health Managed Care payment	ine 49 see instructions).		97, 930 49, 544 473, 475	52. 00 53. 00
53. 00 54. 00 54. 01 55. 00 55. 01	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cellular therapy acquisition cost (see instructions)	ine 49 see instructions).		97, 930 49, 544 473, 475 0 0 0	52. 00 53. 00 54. 00 54. 01 55. 00 55. 01
53. 00 54. 00 54. 01 55. 00 55. 01 56. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see into	ine 49 see instructions). 69) ructions)	brough 35)	97, 930 49, 544 473, 475 0 0 0 0	52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00
53. 00 54. 00 54. 01 55. 00 55. 01	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see interpretable) Routine service other pass through costs (from Wkst. D, Pt.	ine 49 see instructions). 59) ructions) III, column 9, lines 30 t	hrough 35).	97, 930 49, 544 473, 475 0 0 0 11, 073	52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00
53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see into	ine 49 see instructions). 59) ructions) III, column 9, lines 30 t	hrough 35).	97, 930 49, 544 473, 475 0 0 0 0	52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00
53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see interesting service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments	ine 49 see instructions). 69) ructions) III, column 9, lines 30 t IV, col. 11 line 200)	hrough 35).	97, 930 49, 544 473, 475 0 0 0 11, 073 84, 684 39, 334, 053	52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00
53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see interesting service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus	ine 49 see instructions). 69) ructions) III, column 9, lines 30 t IV, col. 11 line 200)	hrough 35).	97, 930 49, 544 473, 475 0 0 0 11, 073 84, 684 39, 334, 053 44 39, 334, 009	52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00
53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see into Routine service other pass through costs (from Wkst. D, Pt. Tatal (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries	ine 49 see instructions). 69) ructions) III, column 9, lines 30 t IV, col. 11 line 200)	hrough 35).	97, 930 49, 544 473, 475 0 0 0 11, 073 84, 684 39, 334, 053	52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00
53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see into Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)	ine 49 see instructions). 69) ructions) III, column 9, lines 30 t IV, col. 11 line 200)	hrough 35).	97, 930 49, 544 473, 475 0 0 0 11, 073 84, 684 39, 334, 053 44 39, 334, 009 2, 644, 928 791, 916 518, 132	52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 60. 00 61. 00 62. 00 63. 00 64. 00
53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see interest Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)	ine 49 see instructions). 69) ructions) III, column 9, lines 30 t IV, col. 11 line 200) s line 60)	hrough 35).	97, 930 49, 544 473, 475 0 0 0 11, 073 84, 684 39, 334, 053 44 39, 334, 009 2, 644, 928 791, 916 518, 132 336, 786	52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00
53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 63. 00 64. 00 65. 00 66. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see interest Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions)	ine 49 see instructions). 69) ructions) III, column 9, lines 30 t IV, col. 11 line 200) s line 60)	hrough 35).	97, 930 49, 544 473, 475 0 0 0 11, 073 84, 684 39, 334, 053 44 39, 334, 009 2, 644, 928 791, 916 518, 132 336, 786 314, 274	52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00
53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see interest Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)	ine 49 see instructions). 69) ructions) III, column 9, lines 30 t IV, col. 11 line 200) s line 60)		97, 930 49, 544 473, 475 0 0 0 11, 073 84, 684 39, 334, 053 44 39, 334, 009 2, 644, 928 791, 916 518, 132 336, 786	52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00
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53. 00 54. 00 54. 01 55. 01 56. 00 57. 00 58. 00 59. 00 61. 00 62. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 87 70. 87 70. 89 70. 90	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see introutine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instoutal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons: N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration OSCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions)	ine 49 see instructions). 59) ructions) III, column 9, lines 30 t IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (s. (For SCH see instruction) tration) adjustment (see	ee instructions) s)	97, 930 49, 544 473, 475 0 0 0 11, 073 84, 684 39, 334, 0053 44 39, 334, 009 2, 644, 928 791, 916 518, 132 336, 786 314, 274 36, 233, 951 0 0 0	52. 00 53. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 50 70. 75 70. 87 70. 88 70. 89 70. 90
53. 00 54. 00 54. 01 55. 01 56. 00 57. 00 58. 00 59. 00 61. 00 62. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 75 70. 88 70. 89	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see introutine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs (from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) (Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons: N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions)	ine 49 see instructions). 59) ructions) III, column 9, lines 30 t IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (s. (For SCH see instruction) tration) adjustment (see	ee instructions) s)	97, 930 49, 544 473, 475 0 0 0 11, 073 84, 684 39, 334, 053 44 39, 334, 009 2, 644, 928 791, 916 518, 132 336, 786 314, 274 36, 233, 951 0 0 0 0	52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 55. 00 57. 00 58. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 70. 70. 75 70. 87 70. 87 70. 89 70. 90 70. 91
53. 00 54. 00 54. 01 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 70. 75 70. 87 70. 88 70. 90 70. 91 70. 92 70. 93	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line of Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see introutine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus) Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons: N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount (see instructions) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	ine 49 see instructions). 59) ructions) III, column 9, lines 30 t IV, col. 11 line 200) s line 60) tructions) applicable to MS-DRGs (s. (For SCH see instruction) tration) adjustment (see	ee instructions) s)	97, 930 49, 544 473, 475 0 0 0 11, 073 84, 684 39, 334, 053 44 39, 334, 009 2, 644, 928 791, 916 518, 132 336, 786 314, 274 36, 233, 951 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	52. 00 53. 00 54. 00 55. 01 55. 00 57. 00 58. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 50 70. 75 70. 87 70. 88 70. 89 70. 90 70. 91 70. 92 70. 93
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Health Financial Systems	METHODIST HOSPITALS, INC		In Lieu	u of Form CMS-:	2552 10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der		Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Pre 5/25/2023 12:	pared:
	Ti tl	e XVIII	Hospi tal	PPS	
		FFY	(уууу)	Amount	
			0	1. 00	
70.96 Low volume adjustment for federal fiscal		'	0	0	70. 96
the corresponding federal year for the personal formula of the personal first federal fiscal the corresponding federal year for the personal first federal f	year (yyyy) (Enter in column 0	1	0	0	70. 97
the corresponding federal year for the performance of the performance	errod endring on or arter 10/1)			0	70. 98
70.99 HAC adjustment amount (see instructions)				0	70. 98
71.00 Amount due provider (line 67 minus lines	68 nlus/minus lines 60 & 70)			35, 990, 582	1
71.01 Seguestration adjustment (see instruction				453, 481	1
71. 02 Demonstration payment adjustment amount a				433, 401	1
71. 03 Sequestration adjustment-PARHM or CHART p	•			O	71.02
72. 00 Interim payments	ass throughs			33, 944, 504	1
72.01 Interim payments-PARHM or CHART				00, 711, 001	72.01
73.00 Tentative settlement (for contractor use	onl v)			0	1
73. 01 Tentative settlement-PARHM or CHART (for				· ·	73. 01
74.00 Balance due provider/program (line 71 mir 73)		1		1, 592, 597	74. 00
74.01 Balance due provider/program-PARHM or CHA	ART (see instructions)				74. 01
75.00 Protested amounts (nonallowable cost repo				858, 958	1
TO BE COMPLETED BY CONTRACTOR (lines 90 t					
90.00 Operating outlier amount from Wkst. E, Pt plus 2.04 (see instructions)				0	90.00
91.00 Capital outlier from Wkst. L, Pt. I, line				0	91.00
92.00 Operating outlier reconciliation adjustme				0	92.00
93.00 Capital outlier reconciliation adjustment				0	93. 00
94.00 The rate used to calculate the time value				0. 00	1
95.00 Time value of money for operating expense	,			0	95. 00
96.00 Time value of money for capital related e	expenses (see instructions)			0	96.00
luon o			Prior to 10/1 1.00	0n/After 10/1 2.00	
HSP Bonus Payment Amount			l ol	^	100 00
100.00 HSP bonus amount (see instructions)			U U	0	100.00
HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions)			0. 0000000000	0. 0000000000	101 00
102.00 HVBP adjustment amount for HSP bonus payr			0.0000000000		101.00
HRR Adjustment for HSP Bonus Payment	ient (see mistractions)		ı o		102.00
103.00 HRR adjustment factor (see instructions)			0.0000	0. 0000	103 00
104.00 HRR adjustment amount for HSP bonus payme	ent (see instructions)		0.0000		104.00
Rural Community Hospital Demonstration Pr		iustment	<u> </u>		1104.00
200.00 Is this the first year of the current 5-y					200. 00
Century Cures Act? Enter "Y" for yes or " Cost Reimbursement		1110 2131			200.00
201.00 Medicare inpatient service costs (from Wk	st D-1 Pt II line 49)				201. 00
202. 00 Medicare discharges (see instructions)	(3t. b 1, 1t. 11, 11116 47)				202.00
203.00 Case-mix adjustment factor (see instructi	ons)				203.00
Computation of Demonstration Target Amoun		r of the currer	nt 5-year demons		
204.00 Medicare target amount					204. 00
205.00 Case-mix adjusted target amount (line 203	times line 204)				205. 00
206 00 Medicare innatient routine cost can (line			1		206 00

206.00

207. 00

208.00

209.00

210.00

211. 00

212. 00 213. 00 218. 00

210.00 Reserved for future use

206.00 Medicare inpatient routine cost cap (line 202 times line 205)

211.00 Total adjustment to Medicare IPPS payments (see instructions)

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

207.00 Program reimbursement under the §410A Demonstration (see instructions)

208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)

218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)

Adjustment to Medicare Part A Inpatient Reimbursement

209.00 Adjustment to Medicare IPPS payments (see instructions)

Comparision of PPS versus Cost Reimbursement

(line 212 minus line 213) (see instructions)

213.00 Low-volume adjustment (see instructions)

| Peri od: | Worksheet E | From 01/01/2022 | Part A Exhibit 4 | To 12/31/2022 | Date/Time Prepared: | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Exhibit 4 | Part A Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0002

					To	12/31/2022	Date/Time Pre 5/25/2023 12:	
					XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from 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	1. 00	0	0	0	0	0	1.00
1. 01	payments DRG amounts other than outlier payments for discharges	1. 01	21, 656, 859	0	21, 656, 859		21, 656, 859	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	7, 256, 310	0		7, 256, 310	7, 256, 310	1. 02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1. 03	0	0	0		0	1. 03
1.04	October 1 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, 444, 936	0	1, 444, 936		1, 444, 936	2. 02
2. 03	October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see	2. 04	180, 209	0		180, 209	180, 209	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	32, 797, 406	0	24, 136, 277	8, 661, 129	32, 797, 406	4. 00
	Indirect Medical Education Adj	ustment						
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 008043	0. 008043	0. 008043	0. 008043		5. 00
6. 00	IME payment adjustment (see instructions)	22. 00	126, 871	0	95, 030	31, 841	126, 871	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	143, 915	0	105, 910	38, 005	143, 915	6. 01
	instructions) Indirect Medical Education Adj	L ustment for the	a Add-on for Se	ection 422 of 1	he MMA			
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	О	0	0	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	126, 871	0	95, 030	31, 841	126, 871	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and	29. 01	143, 915	0	105, 910	38, 005	143, 915	9. 01
	8.01) Disproportionate Share Adjustm	ent						l
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 2207	0. 2207	0. 2207	0. 2207		10.00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	1, 595, 284	0	1, 194, 917	400, 367	1, 595, 284	11.00
11. 01	Uncompensated care payments	36.00	3, 471, 592		2, 615, 287	856, 305	3, 471, 592	11. 01
12. 00	Additional payment for high pe Total ESRD additional payment	46.00	313, 447	discharges 0	234, 441	79, 006	313, 447	12. 00
13. 00 14. 00	(see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH,	47. 00 48. 00	36, 045, 508 0	0	27, 241, 470 0	8, 804, 038 0	36, 045, 508 0	13. 00 14. 00
15. 00	small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions)	49. 00	36, 189, 423	0	27, 347, 380	8, 842, 043	36, 189, 423	15. 00

LOW VO	LUME CALCULATION EXHIBIT 4			Provi der C		Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Exhibi Date/Time Pre 5/25/2023 12:	pared:
					XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from 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	
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2, 427, 924	O			2, 427, 924	16.00
17. 00	Special add-on payments for new technologies	54. 00	473, 475	0	409, 72	63, 748	473, 474	
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	О	18. 00
19.00	SUBTOTAL			0	29, 591, 69	7 9, 499, 124	39, 090, 821	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	1. 00 1. 01	2, 173, 207 0	0	1,,	3 541, 204 0 0	2, 173, 207 0	20. 00
21. 00 21. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments	2. 00 2. 01	63, 692 0	0	59, 13	5 4, 557 0 0	63, 692 0	21. 00 21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0040	0. 0040	0. 004	0. 0040		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	8, 693	0	6, 52	8 2, 165	8, 693	23.00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0839	0. 0839	0. 083	9 0. 0839		24.00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	182, 332	0	136, 92	5 45, 407	182, 332	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	2, 427, 924	0	1, 834, 59	1 593, 333	2, 427, 924	26. 00
		W/S E, Part A	(Amounts to					
		line	E, Part A)			1.00	5 00	
27.00	I am and and add a feet and	0	1. 00	2. 00	3.00	4.00	5. 00	27.00
27. 00 28. 00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			0.00000	0. 000000	0	27. 00 28. 00
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	o	29. 00
100. 00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

Provider CCN: 15-0002

Peri od:

Worksheet E

From 01/01/2022 Part A Exhibit 5 Date/Time Prepared: 5/25/2023 12:46 pm 12/31/2022 Hospi tal Title XVIII Period to Total (cols. Wkst. E, Pt. Amt. from Period on Wkst. E, Pt. 10/01 after 10/01 A. line 2 and 3) A) 0 1.00 2.00 3.00 4.00 1.00 DRG amounts other than outlier payments 1. 00 1.00 DRG amounts other than outlier payments for 1.01 1.01 21, 656, 859 21, 656, 859 21, 656, 859 1.01 discharges occurring prior to October 1 1 02 DRG amounts other than outlier payments for 1 02 7, 256, 310 7, 256, 310 7, 256, 310 1.02 discharges occurring on or after October 1 DRG for Federal specific operating payment 1.03 1.03 0 1.03 for Model 4 BPCI occurring prior to October 1 04 DRG for Federal specific operating payment 1 04 0 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 0 2.01 **BPCI** 2.02 1, 444, 936 1, 444, 936 2.02 Outlier payments for discharges occurring 2.03 1, 444, 936 prior to October 1 (see instructions) Outlier payments for discharges occurring on 2.03 2.04 180, 209 180, 209 180, 209 2.03 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 3.00 Managed care simulated payments 32, 797, 406 24, 136, 278 8, 661, 129 32, 797, 407 4.00 3.00 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.008043 0.008043 0.008043 5.00 (see instructions) 6.00 IME payment adjustment (see instructions) 22.00 126, 871 95,030 31,841 126, 871 6.00 6.01 IME payment adjustment for managed care (see 22.01 143, 915 105, 910 38,005 143, 915 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 0.000000 7.00 IME payment adjustment factor (see 27. 00 0.000000 0.000000 7.00 instructions) 8.00 IME adjustment (see instructions) 28.00 0 8.00 0 0 IME payment adjustment add on for managed O 28 01 0 8 01 8 01 Ω care (see instructions) 9.00 Total IME payment (sum of lines 6 and 8) 29.00 126, 871 95,030 31,841 126, 871 9.00 Total IME payment for managed care (sum of 105, 910 38, 005 143, 915 9.01 29.01 143, 915 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0. 2207 0. 2207 0.2207 10.00 (see instructions) 11.00 Di sproporti onate share adjustment (see 34.00 1, 595, 284 1, 194, 917 400, 367 1, 595, 284 11.00 instructions) 3, 471, 592 11.01 36 00 2, 615, 287 856, 305 3, 471, 592 Uncompensated care payments 11.01 Additional payment for high percentage of ESRD beneficiary discharges 313, 447 313, 447 12.00 Total ESRD additional payment (see 46.00 234, 441 79,006 12.00 instructions) 47.00 13.00 Subtotal (see instructions) 36, 045, 508 27, 241, 470 8, 804, 038 36, 045, 508 13.00 14.00 Hospital specific payments (completed by SCH 48.00 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 15 00 49 00 36 189 423 27 347 380 8 842 043 36 189 423 15 00 (see instructions) 16.00 Payment for inpatient program capital (from 50.00 2, 427, 924 1, 834, 591 593, 333 2, 427, 924 16.00 Wkst. L, Pt. I, if applicable)

54.00

68.00

93.00

473, 475

r

409, 727

29, 591, 698

0

63, 748

9, 499, 124

0

473, 475

Λ 17.02

0 18.00

39, 090, 822 19. 00

17.00

17.01

17.00

17.01

17.02

18.00

19.00 SUBTOTAL

Special add-on payments for new technologies

Credits received from manufacturers for

replaced devices for applicable MS-DRGs

Capital outlier reconciliation adjustment

Net organ acquisition cost

amount (see instructions)

Health Financial Systems

Health Financial Systems		METHODI ST HOS				u of Form CMS-2	2552-10
HOSPITAL ACQUIRED CONDITI	ON (HAC) REDUCTION CALCULA	ATION EXHIBIT 5		F	Period: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/25/2023 12:	pared:
				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		1. 00	2, 173, 207	1, 632, 003	541, 204	2, 173, 207	20.00
	al DRG other than outlier	1. 01	0	(0	0	20. 01
21.00 Capital DRG outlie		2. 00	63, 692	59, 135	4, 557	63, 692	
21.01 Model 4 BPCI Capit	al DRG outlier payments	2. 01	0	C	0	0	21. 01
22.00 Indirect medical e instructions)	ducation percentage (see	5. 00	0. 0040	0. 0040	0. 0040		22. 00
23.00 Indirect medical e instructions)	ducation adjustment (see	6. 00	8, 693	6, 528	2, 165	8, 693	23.00
24.00 Allowable dispropo (see instructions)	rtionate share percentage	10. 00	0. 0839	0. 0839	0. 0839		24.00
25.00 Di sproporti onate s	hare adjustment (see	11. 00	182, 332	136, 925	45, 407	182, 332	25.00
26.00 Total prospective instructions)	capital payments (see	12. 00	2, 427, 924	1, 834, 591	593, 333	2, 427, 924	26. 00
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
		0	1.00	2.00	3. 00	4. 00	
27. 00							27.00
28.00 Low volume adjustm	ent prior to October 1	70. 96	0	(0	28. 00
29.00 Low volume adjustm	ent on or after October 1	70. 97	0		0	0	29. 00
30.00 HVBP payment adjus	tment (see instructions)	70. 93	0	l c	0	0	30.00
30.01 HVBP payment adjus payment (see instr	tment for HSP bonus (uctions)	70. 90	0	C	0	0	30. 01
31.00 HRR adjustment (se		70. 94	-243, 369	-222, 873	-20, 496	-243, 369	31.00
	HSP bonus payment (see	70. 91	0	(0	0	31. 01
						(Am+ +a	

0 70. 99

32.00 HAC Reduction Program adjustment (see instructions)
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.

1.00

Ν

2.00

3.00

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

32. 00 100. 00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0002	From 01/01/2022	Worksheet E Part B Date/Time Prepared: 5/25/2023 12:46 pm

		Title XVIII	Hospi tal	5/25/2023 12: PPS	40 piii
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1. 00	Medical and other services (see instructions)			966	1.00
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instruction OPPS payments	ons)		23, 759, 669 22, 572, 835	2. 00 3. 00
4. 00	Outlier payment (see instructions)			254, 891	4.00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instructi	ons)		0. 000	5.00
6.00	Line 2 times line 5			0	6.00
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	7. 00 8. 00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV,	col. 13, line 200		90, 091	9. 00
10.00	Organ acqui si ti ons	,		0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			966	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
12. 00	Ancillary service charges			4, 474	12. 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	e 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			4, 474	14.00
15 00	Customary charges	mont for condince on	a abanga basi s	0	15 00
15. 00 16. 00	Aggregate amount actually collected from patients liable for pay Amounts that would have been realized from patients liable for pay		0	0	15. 00 16. 00
10.00	had such payment been made in accordance with 42 CFR §413.13(e)	aymone for solvices o	ir a chargebasi's		10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18.00	Total customary charges (see instructions)	16.11	44) (4, 474	
19. 00	Excess of customary charges over reasonable cost (complete only instructions)	IT line 18 exceeds II	ne II) (see	3, 508	19. 00
20.00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20. 00
	instructions)		, ,		
21. 00	Lesser of cost or charges (see instructions)			966	21.00
22. 00 23. 00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instruc	rti one)		0	22. 00 23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	, (1 0113)		22, 917, 817	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)			0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 2	•		3, 602, 279	26.00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plu instructions)	is the suill of fittes 22	and 23] (See	19, 316, 504	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line	e 50)		45, 717	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)			19, 362, 221	
31. 00 32. 00	Primary payer payments Subtotal (line 30 minus line 31)			4, 668 19, 357, 553	31. 00 32. 00
02.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES	5)		17/007/000	02.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
34.00	Allowable bad debts (see instructions)			735, 523	34.00
35. 00 36. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instruc	rtions)		478, 090 671, 366	35. 00 36. 00
37. 00	Subtotal (see instructions)	, (1 0113)		19, 835, 643	
38.00				11	
39. 00	OTHER			14	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions) N95 respirator payment adjustment amount (see instructions)			0	39. 50 39. 75
39. 75 39. 97	Demonstration payment adjustment amount (see instructions)			0	39. 75 39. 97
39. 98	Partial or full credits received from manufacturers for replaced	devices (see instruc	ti ons)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00	Subtotal (see instructions)			19, 835, 646	40.00
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			249, 929 0	40. 01 40. 02
40. 02	Sequestration adjustment-PARHM or CHART pass-throughs			U	40. 02
41. 00	Interim payments			19, 423, 301	41.00
41. 01	Interim payments-PARHM or CHART				41.01
42.00	Tentative settlement (for contractors use only)			0	42.00
42. 01 43. 00	Tentative settlement-PARHM or CHART (for contractor use only) Balance due provider/program (see instructions)			162, 416	42. 01 43. 00
43. 00	Balance due provider/program-PARHM (see instructions)			102, 410	43. 00
44. 00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	chapter 1,	0	44.00
	§115. 2		-		
00 00	TO BE COMPLETED BY CONTRACTOR			0	00 00
90. 00 91. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	90. 00 91. 00
92.00	The rate used to calculate the Time Value of Money			0.00	92.00
93. 00	Time Value of Money (see instructions)			0	93.00
94. 00	Total (sum of lines 91 and 93)			0	94.00

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:	Worksheet E	
		From 01/01/2022		
		To 12/31/2022		
			5/25/2023 12	: 46 pm_
	Title XVIII	Hospi tal	PPS	
			1. 00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days				0 200. 00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			Worksheet E
	Component CCN: 15-S002	From 01/01/2022 To 12/31/2022	
	compenent con. 10 3002	10 12/01/2022	5/25/2023 12: 46 pm
	Title XVIII	Subprovi der -	PPS

	If the XVIII Subprovider	- 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 instructions)	35	2.00
3. 00 4. 00	OPPS payments Outlier payment (see instructions)	55	3. 00 4. 00
4. 00	Outlier reconciliation amount (see instructions)		4. 00
5. 00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6. 00	Line 2 times line 5	0	6. 00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7. 00 8. 00
8. 00 9. 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		9.00
10. 00	Organ acqui si ti ons	Ö	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, line 69)	o o	
	Total reasonable charges (sum of lines 12 and 13)	0	14.00
45.00	Customary charges		45.00
15. 00 16. 00	Aggregate amount actually collected from patients liable for payment for services on a charge basi Amounts that would have been realized from patients liable for payment for services on a chargebas	1	15. 00 16. 00
10.00	had such payment been made in accordance with 42 CFR §413.13(e)		10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0. 000000	
	Total customary charges (see instructions)	0	18.00
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19. 00
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20.00
	instructions)		
21.00	Lesser of cost or charges (see instructions)	0	21.00
	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instructions)	0	22. 00 23. 00
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	55	
	COMPUTATION OF REIMBÜRSEMENT SETTLEMENT		
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26. 00 27. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	11	26. 00 27. 00
27.00	instructions)	44	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28. 00
	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
	Subtotal (sum of lines 27 through 29) Primary payer payments	44	30. 00 31. 00
	Subtotal (line 30 minus line 31)	44	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
	Composite rate ESRD (from Wkst. I-5, line 11)	0	
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)	0	34. 00 35. 00
	Allowable bad debts for dual eligible beneficiaries (see instructions)	Ö	36.00
37.00	Subtotal (see instructions)	44	
	MSP-LCC reconciliation amount from PS&R	0	
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)	0	39. 00 39. 50
39. 75	N95 respirator payment adjustment (see instructions)	0	39. 75
39. 97	Demonstration payment adjustment amount before sequestration	0	39. 97
39. 98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)	0 44	39. 99 40. 00
40. 01	Sequestration adjustment (see instructions)	0	40.00
	Demonstration payment adjustment amount after sequestration	0	40. 02
40. 03	Sequestration adjustment-PARHM or CHART pass-throughs		40. 03
	Interim payments Interim payments-PARHM or CHART	44	41. 00 41. 01
	Tentative settlement (for contractors use only)	0	41.01
42.01	Tentative settlement-PARHM or CHART (for contractor use only)		42. 01
43.00	Balance due provider/program (see instructions)	0	
43. 01	Balance due provider/program-PARHM (see instructions)		43.01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
	Original outlier amount (see instructions)	0	
	Outlier reconciliation adjustment amount (see instructions)	0 00	91.00
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)	0.00	
	Total (sum of lines 91 and 93)		94.00
		<u> </u>	

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:	Worksheet E	
		From 01/01/2022		
	Component CCN: 15-S002	To 12/31/2022		
	·		5/25/2023 12:	46 pm
	Title XVIII	Subprovi der -	PPS	
		I PF		
			1. 00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days				200.00

In Lieu of Form CMS-2552-10 Health Financial Systems METHODIST HOSPITALS, INC ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0002 Peri od: Worksheet E-1 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/25/2023 12:46 pm Title XVIII Hospi tal PPS Part B Inpatient Part A mm/dd/yyyy Amount mm/dd/yyyy Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 33, 252, 166 18, 948, 458 1.00 Interim payments payable on individual bills, either 2 00 2 00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. write "NONE" or enter a zero List separately each retroactive lump sum adjustment 3.00 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 12/31/2022 692, 338 12/31/2022 474, 843 3.01 3.02 3.02 0 3 03 0 0 3 03 3.04 0 0 3.04 3.05 3.05 0 0 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 0 0 3.51 3.51 0 0 3.52 3.52 3 53 0 0 3 53 3.54 3.54 0 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 692, 338 474, 843 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 33, 944, 504 19, 423, 301 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after 5.00 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 0 0 5.02 0 5.02 5.03 0 5.03

Health Financial Systems	METHODIST HOSPIT	ALS, INC	In Lieu	ı of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR	R SERVICES RENDERED	Provider CCN: 15-0002	Peri od: From 01/01/2022	Worksheet E-1 Part I
		Component CCN: 15-S002	To 12/31/2022	Date/Time Prepared: 5/25/2023 12:46 pm

					5/25/2023 12:	46 PM
		Titl∈	× XVIII	Subprovi der - I PF	PPS	
	· · · · · · · · · · · · · · · · · · ·	Innatier	nt 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		158, 00	7	44	1.00
2. 00	Interim payments payable on individual bills, either		1	0	0	
	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			O	0	
3. 02				O	0	
3. 03			1	O	0	
3. 04				O	0	
3. 05				O	0	3.05
	Provi der to Program					
3. 50	ADJUSTMENTS TO PROGRAM		l .	O O	0	
3. 51					0	
3. 52			1			
3. 53 3. 54			1			
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		l .)		
3. 99	3. 50-3. 98)		'	J	0	3.99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		158, 00	7	44	4.00
1. 00	(transfer to Wkst. E or Wkst. E-3, line and column as		100,00	,		1.00
	appropri ate)					
	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	TENTATI VE TO PROVI DER			O	0	
5. 02				O	0	
5. 03				O	0	5.03
	Provi der to Program				1 -	
5. 50	TENTATI VE TO PROGRAM		1)	0	
5. 51			1)	0	
5. 52	Cultural (0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		· '	J	0	5. 99
6. 00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		1, 31	1	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			O	0	6. 02
7. 00	Total Medicare program liability (see instructions)		159, 31	8	44	7.00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
	In the second		0	1. 00	2.00	
8. 00	Name of Contractor					8.00

Health Financial Systems	METHODIST HOSPIT	ALS, INC		In Lieu	ı of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR	SERVI CES RENDERED	Provi der CO		Peri od: From 01/01/2022	Worksheet E-1 Part I
		Component (CCN: 15-T002	To 12/31/2022	Date/Time Prepared: 5/25/2023 12:46 pm
		Title	· XVIII	Subprovi der -	PPS

		Title	e XVIII	Subprovi der - I RF	PPS	10 p
		I npati en	nt 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		2, 421, 88		0	
2. 00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3.00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	L	l .		1	
3. 01	ADJUSTMENTS TO PROVIDER			ol	0	3. 01
3. 02			1	0	0	
3. 03				0	0	
3. 04				0	0	
3. 05				O	0	
	Provider to Program		•	<u>'</u>	•	
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			0	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 421, 88	2	0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					-
F 00	TO BE COMPLETED BY CONTRACTOR	Γ	I	T	I	- 00
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			ol	0	5. 01
5. 02	TENTATI VE TO TROVIDER			Ö		
5. 03				o		
	Provider to Program				_	1
5. 50	TENTATI VE TO PROGRAM			o	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			0	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		39, 50	6	0	
6. 02	SETTLEMENT TO PROGRAM			0	0	
7. 00	Total Medicare program liability (see instructions)		2, 461, 38		0	7.00
				Contractor	NPR Date	
		,	0	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		J	1.00	2.00	8.00
0.00	Indine of Cotti actor	I		Ţ	I	1 0.00

Heal th	Financial Systems METH	HODIST HOSPITALS, INC	In Lieu	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-0002	Peri od: From 01/01/2022	Worksheet E-	1
			To 12/31/2022	Date/Time Pro	
-		Title XVIII	Hospi tal	5/25/2023 12: PPS	46 piii
		11 11 0 1111	noopi tui		
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COS	T REPORTS			
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND	CALCULATI ON			
1.00	Total hospital discharges as defined in AARA §410	2 from Wkst. S-3, Pt. I col. 15 line	e 14		1.00
2.00	Medicare days (see instructions)				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6.	line 2			3.00
4.00	Total inpatient days (see instructions)				4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8				5. 00
6.00	Total hospital charity care charges from Wkst. S-				6. 00
7. 00	CAH only - The reasonable cost incurred for the p	ourchase of certified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168				
8. 00	Calculation of the HIT incentive payment (see ins				8. 00
9. 00	Sequestration adjustment amount (see instructions				9. 00 10. 00
10. 00	10.00 Calculation of the HIT incentive payment after sequestration (see instructions)				
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
	Initial/interim HIT payment adjustment (see instr	ructions)			30.00
	Other Adjustment (specify)				31.00
32. 00	Balance due provider (line 8 (or line 10) minus l	ine 30 and line 31) (see instruction	ns)		32.00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMEN	Provi der CCN: 15-0002		Worksheet E-3
	Component CCN: 15-S002	From 01/01/2022	Part II Date/Time Prepared:
	Component Con. 13-3002	10 12/31/2022	5/25/2023 12: 46 pm
	Title XVIII	Subprovi der -	PPS
		LDE	

	. I PF		
		1. 00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
0	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	177, 448	1
0	Net IPF PPS Outlier Payments	0	
С	Net IPF PPS ECT Payments	0	
0	Unweighted intern and resident FTE count in the most recent cost report filed on or before November	0. 00	
	15, 2004. (see instructions)		
1	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0. 00	
	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)		
)	New Teaching program adjustment. (see instructions)	0. 00	
)	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0. 00	
,	teaching program" (see instuctions)	0.00	
)	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new tracking program" (see instructions)	0. 00	
0	teaching program" (see instuctions) Intern and resident count for IPF PPS medical education adjustment (see instructions)	0. 00	
0	Average Daily Census (see instructions)	3. 410959	
00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0. 000000	
00	Teaching Adjustment (line 1 multiplied by line 10).	0.000000	1
00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	177, 448	
00	Nursing and Allied Health Managed Care payment (see instruction)	0	1
00	Organ acqui si ti on (DO NOT USE THIS LINE)	J.	1
00	Cost of physicians' services in a teaching hospital (see instructions)	0	
00	Subtotal (see instructions)	177, 448	
00	Primary payer payments	0	
00	Subtotal (line 16 less line 17).	177, 448	-
00	Deductibles	17, 116	1
00	Subtotal (line 18 minus line 19)	160, 332	2
00	Coi nsurance	0	2
00	Subtotal (line 20 minus line 21)	160, 332	2
00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	1, 552	2
00	Adjusted reimbursable bad debts (see instructions)	1, 009	2
00	Allowable bad debts for dual eligible beneficiaries (see instructions)	164	2
00	Subtotal (sum of lines 22 and 24)	161, 341	
00	Direct graduate medical education payments (see instructions)	0	2
00	Other pass through costs (see instructions)	10	
00	Outlier payments reconciliation	0	
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	
50	Pioneer ACO demonstration payment adjustment (see instructions)	0	
98	Recovery of accelerated depreciation.	0	3
99	Demonstration payment adjustment amount before sequestration	0	1 ~
00	Total amount payable to the provider (see instructions)	161, 351	
01	Sequestration adjustment (see instructions)	2, 033	
02	Demonstration payment adjustment amount after sequestration	150,007	3
00	Interim payments	158, 007	
00	Tentative settlement (for contractor use only)	0	3
00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	1, 311	3
JU	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	٦
	TO BE COMPLETED BY CONTRACTOR		
20	Original outlier amount from Worksheet E-3, Part II, line 2	0	5
	Outlier reconciliation adjustment amount (see instructions)	0	5
00	The rate used to calculate the Time Value of Money	0. 00	
00	Time Value of Money (see instructions)	0.00	5
55	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-1		`
00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	g
	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0. 000000	

Health Financial Systems METHODIST	HOSPITALS, INC	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0002	Peri od:	Worksheet E-3	
		From 01/01/2022	Part III	
	Component CCN: 15-T002	To 12/31/2022	Date/Time Pre	pared:
	'		5/25/2023 12:	46 pm
	Title XVIII	Subprovi der -	PPS	
		IRF		
			1. 00	
PART III - MEDICARE PART A SERVICES - IRF PPS				
1 00 Net Federal PPS Payment (see instructions)			2 244 594	1 00

	1171		
	-	1 00	
	DADT LLL MEDICADE DADT A CEDIMICEC LDE DDC	1. 00	
1 00	PART III - MEDICARE PART A SERVICES - IRF PPS Net Federal PPS Payment (see instructions)	2 244 504	1.00
1. 00 2. 00	Medicare SSI ratio (IRF PPS only) (see instructions)	2, 244, 594 0. 1009	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	191, 239	3.00
4. 00	Outlier Payments	191, 239	
5. 00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior	0. 00	5.00
5.00	to November 15, 2004 (see instructions)	0.00	3.00
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0. 00	5. 01
5. 01	program or hospital closure, that would not be counted without a temporary cap adjustment under 42	0.00	3.01
	CFR \$412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)		
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0. 00	
	teaching program" (see instructions)		
8. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0. 00	8.00
	teaching program" (see instructions)		
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	9. 663014	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	2, 541, 693	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	2, 541, 693	17.00
18.00	Primary payer payments	19, 150	18.00
19.00	Subtotal (line 17 less line 18).	2, 522, 543	19. 00
20.00	Deducti bl es	14, 004	
21.00	Subtotal (line 19 minus line 20)	2, 508, 539	
22. 00	Coinsurance	33, 065	22.00
23.00	Subtotal (line 21 minus line 22)	2, 475, 474	
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	26, 275	
25.00	Adjusted reimbursable bad debts (see instructions)	17, 079	
26. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	26, 275	
27. 00	Subtotal (sum of lines 23 and 25)	2, 492, 553	
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28. 00
29. 00	Other pass through costs (see instructions)	244	
30.00	Outlier payments reconciliation	0	30.00
31. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	
31. 98	Recovery of accelerated depreciation.	0	
31. 99	Demonstration payment adjustment amount before sequestration	0	
32.00	Total amount payable to the provider (see instructions)	2, 492, 797	
32. 01	Sequestration adjustment (see instructions)	31, 409	
32. 02	Demonstration payment adjustment amount after sequestration	0	
33.00	Interim payments	2, 421, 882	
34.00	Tentative settlement (for contractor use only)	0	
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	39, 506	
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	36. 00
	§115. 2		
EO 00	TO BE COMPLETED BY CONTRACTOR	10E 0/0	EO 00
	Original outlier amount from Wkst. E-3, Pt. III, line 4	105, 860	
51. 00 52. 00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money	0.00	
52.00	Time Value of Money (see instructions)	0.00	
55.00	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-1		55.00
99. 00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0. 000000	99 00
	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0. 000000	
, , . U I	paradicated readining may determine rate of the eartern year. (see that detroits)	0.000000	, , , , , , ,

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 01/01/2022 To 12/31/2022	Worksheet E-3 Part VII Date/Time Prepared: 5/25/2023 12:46 pm

			10 12/31/2022	5/25/2023 12:	
		Title XIX	Hospi tal	Cost	
			Inpatient	Outpati ent	
			1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	RVICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		6, 171, 040		1.00
2.00	Medical and other services			0	2.00
	Organ acquisition (certified transplant programs only)		0		3.00
	Subtotal (sum of lines 1, 2 and 3)		6, 171, 040	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)		6, 171, 040	0	7.00
İ	COMPUTATION OF LESSER OF COST OR CHARGES				
ļ	Reasonable Charges				
8.00	Routine service charges		4, 439, 563		8.00
9.00	Ancillary service charges		17, 483, 748	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, 923, 311	0	12.00
İ	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment fo	r services on a charge	0	0	13.00
	basis				
	Amounts that would have been realized from patients liable fo		0	0	14.00
	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			
	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	
	Total customary charges (see instructions)		21, 923, 311	0	
17.00	Excess of customary charges over reasonable cost (complete on	ly if line 16 exceeds	15, 752, 271	0	17.00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete on	ly if line 4 exceeds line	9 0	0	18. 00
	16) (see instructions)				
	Interns and Residents (see instructions)		0	0	
	Cost of physicians' services in a teaching hospital (see inst		0	0	
	Cost of covered services (enter the lesser of line 4 or line		6, 171, 040	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provid			1 22 00
	Other than outlier payments		0	0	
	Outlier payments		0	0	
	Program capital payments		0		24. 00 25. 00
	Capital exception payments (see instructions)		0	0	
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	-	
	Customary charges (title V or XIX PPS covered services only) Titles V or XIX (sum of lines 21 and 27)		4 171 040	0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		6, 171, 040	0	29.00
	Excess of reasonable cost (from line 18)			0	30.00
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	6, 171, 040	0	
	Deductibles)	0, 171, 040	0	
	Coi nsurance			0	02.00
	Allowable bad debts (see instructions)			0	
	Utilization review			U	35.00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 an	4 33)	6, 171, 040	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	u 33)	0, 171, 040	0	
			6, 171, 040	0	
	Subtotal (line 36 ± line 37) Direct graduate medical education payments (from Wkst. E-4)		0, 171, 040	U	39.00
	Total amount payable to the provider (sum of lines 38 and 39)		6, 171, 040	0	
	Interim payments		6, 931, 441	0	
	Balance due provider/program (line 40 minus line 41)		-760, 401	0	
	parance due provider/program (Title 40 millus Title 41)		- / 00, 401	-	
	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15_2	_ ∩I	Λ	1 43 UU
43. 00	Protested amounts (nonallowable cost report items) in accorda chapter 1, §115.2	nce with CMS Pub 15-2,	0	0	43.00

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 01/01/2022	Worksheet E-3
	Component CCN: 15-S002		
	Title XIX	Subprovi der -	Cost
		IDF	

	TI LI E	e XIX	I PF	COST	
			Inpatient	Outpati ent	
			1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR T	ITLES V OD VI		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES COMPUTATION OF NET COST OF COVERED SERVICES	IILES V UK AI	A SERVICES		
1. 00	Inpatient hospital/SNF/NF services		140, 118		1.00
2. 00	Medical and other services		140, 118	0	2.00
			0	Ü	3.00
3. 00 4. 00	Organ acquisition (certified transplant programs only) Subtotal (sum of lines 1, 2 and 3)			0	4.00
			140, 118	Ü	5.00
5. 00	Inpati ent pri mary payer payments		U	0	
6.00	Outpatient primary payer payments		140 110	0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		140, 118	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
0.00	Reasonable Charges		440 544		0.00
8.00	Routine service charges		412, 516	0	8.00
9.00	Ancillary service charges		214, 447	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)		626, 963	0	12.00
40.00	CUSTOMARY CHARGES				40.00
13. 00	Amount actually collected from patients liable for payment for services o	n a charge	0	0	13.00
4.4.00	basis				
14. 00	Amounts that would have been realized from patients liable for payment fo		0	0	14.00
45.00	a charge basis had such payment been made in accordance with 42 CFR §413.	13(e)			45.00
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)		626, 963	0	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only if line 1	6 exceeds	486, 845	0	17. 00
	line 4) (see instructions)		_	_	
18. 00	Excess of reasonable cost over customary charges (complete only if line 4	exceeds line	0	0	18. 00
	16) (see instructions)		_	_	
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	Cost of covered services (enter the lesser of line 4 or line 16)		140, 118	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for	or PPS provid			
	Other than outlier payments		0	0	22. 00
23. 00			0	0	23. 00
	Program capital payments		0		24. 00
25. 00			0		25.00
26. 00	Routine and Ancillary service other pass through costs		0	0	26. 00
27.00			0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		140, 118	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)		140, 118	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		o		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		140, 118	0	36.00
37. 00			0	0	37. 00
38. 00	Subtotal (line 36 ± line 37)		140, 118	0	38. 00
39. 00	· · · · · · · · · · · · · · · · · · ·		0	Ü	39. 00
40. 00			140, 118	0	40. 00
41. 00			198, 226	0	41. 00
42. 00	Balance due provider/program (line 40 minus line 41)		-58, 108	0	42.00
43. 00	Protested amounts (nonallowable cost report items) in accordance with CMS	Pub 15-2	0	0	43.00
10.00	chapter 1, §115.2	. 45 10 2,		O	10.00
	Tompton 1, 3.10.2		1		1

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 01/01/2022	Worksheet E-3
	Component CCN: 15-T002		
	Title XIX	Subprovi der -	Cost
		I RF	

	""	e xi x	I RF	COST	
			Inpatient	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
1.00	Inpatient hospital/SNF/NF services		323, 173		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant programs only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		323, 173	0	
5.00	Inpatient primary payer payments		0		5.00
6. 00	Outpatient primary payer payments			0	
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		323, 173	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonable Charges		1		
8.00	Routine service charges		357, 953		8.00
9.00	Ancillary service charges		864, 315	0	
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		1 222 270	0	11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		1, 222, 268	0	12.00
13. 00	CUSTOMARY CHARGES Amount actually collected from patients liable for payment for services	on a charge	0	0	13.00
13.00	basis	on a charge	U	U	13.00
14. 00	Amounts that would have been realized from patients liable for payment f	or services or		0	14.00
14.00	a charge basis had such payment been made in accordance with 42 CFR §413			O	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	. 13(0)	0. 000000	0. 000000	15.00
16. 00	Total customary charges (see instructions)		1, 222, 268	0.000000	16.00
17. 00	Excess of customary charges over reasonable cost (complete only if line	16 exceeds	899, 095	0	
17.00	line 4) (see instructions)	το εκεεεασ	077,070	Ü	17.00
18. 00	Excess of reasonable cost over customary charges (complete only if line	4 exceeds line	. 0	0	18.00
	16) (see instructions)			_	
19.00	Interns and Residents (see instructions)		o	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		323, 173	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed	for PPS provid	lers.		
22.00	Other than outlier payments		0	0	22. 00
	Outlier payments		0	0	
	Program capital payments		0		24.00
	Capital exception payments (see instructions)		0		25.00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27. 00			0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		323, 173	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
			0	0	
31.00			323, 173	0	
32.00	Deducti bl es		0	0	
	Coinsurance		0	0	
34. 00			0	0	
35.00	Utilization review		000 470		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		323, 173	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		222 172	0	
	Subtotal (line 36 ± line 37)		323, 173	U	
	Direct graduate medical education payments (from Wkst. E-4)		222 172	0	39.00
	Total amount payable to the provider (sum of lines 38 and 39)		323, 173	0	
41.00	Interim payments Release due provider (program (Line 40 minus Line 41)		313, 611	0	
42.00	Balance due provider/program (line 40 minus line 41) Protested amounts (nonallowable cost report items) in accordance with CM	IS Dub 15 2	9, 562	0	
43.00	chapter 1, §115.2	13 FUD 13-Z,	١	U	43.00
	Chapter 1, 3110.2		1		I

EDI CA	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der Co	CN: 15-0002	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E-4 Date/Time Prep	naron
				10 12/31/2022	5/25/2023 12:4	
		Title	XVIII	Hospi tal	PPS	
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
00	Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.	programs fo	r cost report	ing periods	10. 83	1. (
01	FTE cap adjustment under §131 of the CAA 2021 (see instruction				0. 00	1. (
00 26	Unweighted FTE resident cap add-on for new programs per 42 C Rural track program FTE cap limitation adjustment after the the CAA 2021 (see instructions)				0. 00	2. 2.
00 01	Amount of reduction to Direct GME cap under section 422 of M Direct GME cap reduction amount under ACA §5503 in accordance	e with 42 CFI	R §413.79 (m)	. (see	0. 00 0. 00	3. 3.
02	instructions for cost reporting periods straddling 7/1/2011) Adjustment (increase or decrease) to the hospital's rural traprograms with a rural track Medicare GME affiliation agreement	ack FTE limi			:	3.
00	49075 (August 10, 2022) (see instructions) Adjustment (plus or minus) to the FTE cap for allopathic and GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)		programs due	e to a Medicare	0. 00	4.
01	ACA Section 5503 increase to the Direct GME FTE Cap (see ins straddling 7/1/2011)		r cost report	ing periods	0. 00	4.
02	ACA Section 5506 number of additional direct GME FTE cap slo periods straddling 7/1/2011)	ts (see ins	tructions for	cost reporting	0. 00	4.
21	The amount of increase if the hospital was awarded FTE cap s instructions)				40.00	4.
00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lin 3.01, plus or minus line 3.02, plus or minus line 4, plus lin Unweighted resident FTE count for allopathic and osteopathic	nes 4.01 thro	ough 4.27		10. 83 3. 00	5. 6.
	records (see instructions)	programs ro	the current	. year 110m your		
00_	Enter the lesser of line 5 or line 6		Primary Car	e Other	3.00 Total	7.
			1.00	2.00	3. 00	
00	Weighted FTE count for physicians in an allopathic and osteo program for the current year.	pathi c	0. (2. 50	2. 50	8.
00		wise	0. (2. 50	2 50	9.
-	If line 6 is less than 5 enter the amount from line 8, other multiply line 8 times the result of line 5 divided by the am 6. For cost reporting periods beginning on or after October if Workshot 5.2. Part I line 68 is "V" see instructions	ount on line		2. 30	2. 50	
00	multiply line 8 times the result of line 5 divided by the am 6. For cost reporting periods beginning on or after October if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the cur	ount on line 1, 2022, or rent year		0.00	2. 50	
00 01	multiply line 8 times the result of line 5 divided by the am 6. For cost reporting periods beginning on or after October if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the cur Unweighted dental and podiatric resident FTE count for the contract of the	ount on line 1, 2022, or rent year		0. 00 0. 00	2. 50	10
00 01 00	multiply line 8 times the result of line 5 divided by the am 6. For cost reporting periods beginning on or after October if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the cur Unweighted dental and podiatric resident FTE count for the count are gighted to the count weighted FTE count Total weighted resident FTE count for the prior cost reportions.	ount on line 1, 2022, or rent year urrent year	0.1	0. 00 0. 00 0. 00 2. 50	2. 50	10. 10. 11. 12.
00 01 00 00	multiply line 8 times the result of line 5 divided by the am 6. For cost reporting periods beginning on or after October if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the curulnweighted dental and podiatric resident FTE count for the curulnweighted FTE count Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions)	ount on line 1, 2022, or rent year urrent year ng year (see	0.1	0. 00 0. 00 00 2. 50 00 2. 50	2. 50	10 11 12
00 01 00 00 00	multiply line 8 times the result of line 5 divided by the am 6. For cost reporting periods beginning on or after October if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the cur Unweighted dental and podiatric resident FTE count for the circular weighted FTE count Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reyear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided	ount on line 1, 2022, or rent year urrent year ng year (see eporting	0. (0. (0. (0. 00 0. 00 2. 50 2. 50 00 2. 50	2. 50	10 11 12 13
00 01 00 00 00 00	multiply line 8 times the result of line 5 divided by the am 6. For cost reporting periods beginning on or after October if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the curulnweighted dental and podiatric resident FTE count for the curulnweighted FTE count Total weighted FTE count Total weighted resident FTE count for the prior cost reportionstructions) Total weighted resident FTE count for the penultimate cost reveal (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs	ount on line 1, 2022, or rent year urrent year ng year (see eporting d by 3).	0. 0 0. 0 0. 0	0. 00 0. 00 2. 50 00 2. 50 00 2. 50 00 2. 50 00 0. 00	2. 50	10 11 12 13 14 15
00 01 00 00 00 00 00	multiply line 8 times the result of line 5 divided by the am 6. For cost reporting periods beginning on or after October if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the curulnweighted dental and podiatric resident FTE count for the curulnweighted FTE count Total weighted FTE count Total weighted resident FTE count for the prior cost reportionstructions) Total weighted resident FTE count for the penultimate cost reyear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new programs.	ount on line 1, 2022, or rent year urrent year ng year (see eporting d by 3). programs	0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0	0. 00 0. 00 2. 50 00 2. 50 00 2. 50 00 2. 50 00 0. 00 00 0. 00	2. 50	10 11 12 13 14 15 15
00 01 00 00 00 00 00 01 00	multiply line 8 times the result of line 5 divided by the am 6. For cost reporting periods beginning on or after October if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the curulnweighted dental and podiatric resident FTE count for the curulnweighted FTE count Total weighted FTE count Total weighted resident FTE count for the prior cost reportionstructions) Total weighted resident FTE count for the penultimate cost reyear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divider Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new Adjustment for residents displaced by program or hospital classes.	ount on line 1, 2022, or rent year urrent year ng year (see eporting d by 3). programs osure	0. 0 0. 0 0. 0	0. 00 0. 00 2. 50 00 2. 50 00 2. 50 00 2. 50 00 0. 00 00 0. 00	2. 50	10 11 12 13 14 15 15 16
00 01 00 00 00 00 01 00 01 00 00	multiply line 8 times the result of line 5 divided by the am 6. For cost reporting periods beginning on or after October if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the curulnweighted dental and podiatric resident FTE count for the curulnweighted FTE count for the prior cost reportions weighted resident FTE count for the prior cost reportions linestructions) Total weighted resident FTE count for the penultimate cost revear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs. Unweighted adjustment for residents in initial years of new Adjustment for residents displaced by program or hospital clunweighted adjustment for residents displaced by program or closure Adjusted rolling average FTE count Per resident amount	ount on line 1, 2022, or rent year urrent year ng year (see eporting d by 3). programs osure	0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0	0. 00 0. 00 2. 50 00 2. 50 00 2. 50 00 0. 00 00 00 00 00 00 00 00 00 00	2. 50	10 11 12 13 14 15 16 16 17 18
00 01 00 00 00 00 01 00 01 00 01	multiply line 8 times the result of line 5 divided by the am 6. For cost reporting periods beginning on or after October if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the cur Unweighted dental and podiatric resident FTE count for the crotal weighted FTE count Total weighted resident FTE count for the prior cost reportions instructions) Total weighted resident FTE count for the penultimate cost revear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divide Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new Adjustment for residents displaced by program or hospital clouwere Adjusted rolling average FTE count	ount on line 1, 2022, or rent year urrent year ng year (see eporting d by 3). programs osure	0. (0. (0. (0. (0. (0. (0. (0. 00 0. 00 2. 50 00 2. 50 00 2. 50 00 2. 50 00 0. 00 00 0. 00 00 0. 00 00 0. 00	2. 50 252, 358	10. 11. 12. 13. 14. 15. 16. 16. 17. 18.
00 01 00 00 00 00 01 00 01 00 01	multiply line 8 times the result of line 5 divided by the am 6. For cost reporting periods beginning on or after October if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the curulnweighted dental and podiatric resident FTE count for the curulnweighted fTE count Total weighted FTE count for the prior cost reportionstructions) Total weighted resident FTE count for the penultimate cost reyear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new Adjustment for residents displaced by program or losure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021	ount on line 1, 2022, or rent year urrent year ng year (see eporting d by 3). programs osure	0. (0. (0. (0. (0. (0. (0. (0. 00 0. 00 2. 50 00 2. 50 00 2. 50 00 0. 00 0. 00 00 00 00 00 00 00 00 00 00	252, 358	10 11
00 01 00 00 00 01 00 01 00 01 00	multiply line 8 times the result of line 5 divided by the am 6. For cost reporting periods beginning on or after October if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the curulnweighted dental and podiatric resident FTE count for the curulnweighted fTE count Total weighted FTE count for the prior cost reportionstructions) Total weighted resident FTE count for the penultimate cost reyear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new Adjustment for residents displaced by program or losure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021	ount on line 1, 2022, or rent year urrent year ng year (see eporting d by 3). programs osure hospital	0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0	0. 00 0. 00 0. 00 2. 50 00 2. 50 00 2. 50 00 0. 00 0. 0		10 11 12 13 14 15 16 16 16 17 18 18 19
00 01 00 00 00 00 01 00 01 00 01 00 00	multiply line 8 times the result of line 5 divided by the am 6. For cost reporting periods beginning on or after October if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the curulnweighted dental and podiatric resident FTE count for the curulnweighted fTE count Total weighted FTE count for the prior cost reportions weighted resident FTE count for the prior cost reportions (see instructions) Total weighted resident FTE count for the penultimate cost rever (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs unweighted adjustment for residents in initial years of new Adjustment for residents displaced by program or hospital clubweighted adjustment for residents displaced by program or closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instructions)	ount on line 1, 2022, or rent year urrent year ng year (see eporting d by 3). programs osure hospital FTE resident uctions)	0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0	0. 00 0. 00 0. 00 2. 50 00 2. 50 00 2. 50 00 0. 00 0. 0	252, 358 1. 00 0. 00 0. 00	10 11 12 13 14 15 16 16 17 18 18 19 20 21
00 01 00 00 00 00 01 00 01 00 00 00 00	multiply line 8 times the result of line 5 divided by the am 6. For cost reporting periods beginning on or after October if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the curulnweighted dental and podiatric resident FTE count for the curulnweighted FTE count Total weighted FTE count for the prior cost reportions weighted resident FTE count for the prior cost reportions (see instructions) Total weighted resident FTE count for the penultimate cost reyear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new Adjustment for residents displaced by program or hospital clumeighted adjustment for residents displaced by program or closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instruAllowable additional direct GME FTE Resident Count (see instructions).	ount on line 1, 2022, or rent year urrent year ng year (see eporting d by 3). programs osure hospital FTE resident uctions) ructions)	0.0 0.1 0.1 0.0 0.1 0.1 cap slots re	0. 00 0. 00 2. 50 00 2. 50 00 2. 50 00 0. 00 0. 00 00 00 00 00 00 00 00 00 00	252, 358 1. 00 0. 00 0. 00 0. 00	10 11 12 13 14 15 15 16 16 17 18 18 19
00 01 00 00 00 00 01 00 01 00 01 00 00	multiply line 8 times the result of line 5 divided by the am 6. For cost reporting periods beginning on or after October if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the curulnweighted dental and podiatric resident FTE count for the curulnweighted FTE count Total weighted FTE count for the prior cost reportions weighted resident FTE count for the prior cost reportions (see instructions) Total weighted resident FTE count for the penultimate cost reyear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divide Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new Adjustment for residents displaced by program or hospital clumweighted adjustment for residents displaced by program or closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instructions) Enter the locality adjustment national average per resident set.	ount on line 1, 2022, or rent year urrent year ng year (see eporting d by 3). programs osure hospital FTE resident uctions) ructions)	0.0 0.1 0.1 0.0 0.1 0.1 cap slots re	0. 00 0. 00 2. 50 00 2. 50 00 2. 50 00 0. 00 0. 00 00 00 00 00 00 00 00 00 00	252, 358 1. 00 0. 00 0. 00	10 11 12 13 14 15 16 16 17 18 18 19 20 21 22

	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der C	CN: 15-0002	Peri od:	Worksheet E-4	
DICA	L EDUCATION COSTS			From 01/01/2022 To 12/31/2022	Date/Time Pre 5/25/2023 12:	
		Title	XVIII	Hospi tal	PPS	
			I npati ent	Managed Care	Total	
			Part A	0.00	2 22	
	COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2. 00	3. 00	
. 00	Inpatient Days (see instructions) (Title XIX - see S-2 Part I	V Lino	21, 67	78 26, 008		26.00
0. 00	3.02, column 2)	A, TITIE	21,07	20,000		20.00
. 00	Total Inpatient Days (see instructions)		82, 28	82, 285		27.00
3. 00	Ratio of inpatient days to total inpatient days		0. 26345			28.00
	Program direct GME amount		66, 48		146, 247	
0. 01	Percent reduction for MA DGME			3. 26	. 10/ 21/	29.0
	Reduction for direct GME payments for Medicare Advantage			2, 600	2, 600	
	Net Program direct GME amount			,	143, 647	
					1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITL EDUCATION COSTS)	E XVIII ONL'	Y (NURSING PR	OGRAM AND PARAME	DI CAL	
2. 00	Renal dialysis direct medical education costs (from Wkst. B,	Pt. I, sum	of col. 20 an	d 23, lines 74	0	32.0
. 00	and 94) Renal dialysis and home dialysis total charges (Wkst. C, Pt.	I col 8	sum of lines	74 and 94)	11, 465, 208	33.0
	Ratio of direct medical education costs to total charges (lin			, , and , , ,	0. 000000	
	Medicare outpatient ESRD charges (see instructions)		/		0	
	Medicare outpatient ESRD direct medical education costs (line	34 x line	35)		0	36.0
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY				
	Part A Reasonable Cost				54 000 404	
	Reasonable cost (see instructions)	->			51, 099, 131	
. 00	Organ acquisition and HSCT acquisition costs (see instruction Cost of physicians' services in a teaching hospital (see inst				0	
. 00	Primary payer payments (see instructions)	i uctions)			19, 194	ı
	Total Part A reasonable cost (sum of lines 37 through 39 minu	s line 40)			51, 079, 937	
. 00	Part B Reasonable Cost	3 11116 40)			31,077,737	1 41.00
. 00	Reasonable cost (see instructions)				23, 850, 761	42.00
	Primary payer payments (see instructions)				4, 668	
	Total Part B reasonable cost (line 42 minus line 43)				23, 846, 093	
	Total reasonable cost (sum of lines 41 and 44)				74, 926, 030	45.0
. 00	Ratio of Part A reasonable cost to total reasonable cost (lin	e 41 ÷ line	45)		0. 681738	
. 00	Ratio of Part B reasonable cost to total reasonable cost (lin		45)		0. 318262	47.0
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA	RT B				
	Total program GME payment (line 31)				143, 647	48.00
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)				97, 930	
	Part B Medicare GME payment (line 47 x 48) (title XVIII only)				45, 717	

Health Financial Systems METHODIST HOSPITALS, INC In Lieu				u of Form CMS-2	552-10
OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT Provider CCN: 15-0002 Period: From 01/01/2022				Worksheet E-5	
			To 12/31/2022	Date/Time Prep 5/25/2023 12:4	oared: 46 pm_
		Title XVIII		PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or su	m of 2.03 plus 2.04 (see	instructions)	0	1.00
2.00 Capital outlier from Wkst. L, Pt. I, line 2				0	2.00
3.00 Operating outlier reconciliation adjustment amount (see instructions)				0	3.00
4.00 Capital outlier reconciliation adjustment amount (see instructions)				0	4.00
5.00 The rate used to calculate the time value of money (see instructions)				0.00	5.00
6.00	Time value of money for operating expenses (see instruction	s)		0	6.00
7.00	Time value of money for capital related expenses (see instr	uctions)		0	7.00

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 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/25/2023 12:46 pm

UIII y)					5/25/2023 12:	46 pm
		General Fund	Specific	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	0.00	11.00	
1.00	Cash on hand in banks	62, 791, 549		0	0	1.00
2. 00	Temporary investments	613, 661		0		2.00
3.00	Notes recei vabl e	0	0	0	0	3.00
4. 00 5. 00	Accounts recei vabl e Other recei vabl e	51, 673, 429		0	0	4. 00 5. 00
6. 00	Allowances for uncollectible notes and accounts receivable			0	0	6.00
7. 00	Inventory	14, 807, 322		0	0	7.00
8.00	Prepai d expenses	4, 998, 937		0	0	8.00
9.00	Other current assets	6, 508, 559	0	0	0	9. 00
10.00	Due from other funds	71, 750		0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	141, 465, 207	0	0	0	11.00
12 00	FIXED ASSETS Land	E 000 074	. 0	0	0	12.00
12. 00 13. 00	Land improvements	5, 800, 874 7, 039, 139		0	0	12. 00 13. 00
14. 00	Accumul ated depreciation	-407, 368, 667		0	0	14.00
15. 00	Bui I di ngs	314, 922, 393		0	Ő	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17. 00	Leasehold improvements	2, 011, 838	0	0	0	17.00
18. 00	Accumulated depreciation	0	0	0	0	18. 00
19. 00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation Automobiles and trucks	0	0	0	0	20.00
21. 00 22. 00	Accumulated depreciation	0		0	0	21. 00 22. 00
23. 00	Major movable equipment	212, 060, 196	-	0	0	23.00
24. 00	Accumulated depreciation	0		0	0	24.00
25. 00	Minor equipment depreciable	0	o o	0	Ö	25. 00
26.00	Accumulated depreciation	0	0	0	0	26.00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	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) OTHER ASSETS	134, 465, 773	0	0	0	30.00
31. 00	Investments	110, 713, 364	. 0	0	0	31.00
32. 00	Deposits on Leases	0		0	0	32.00
33. 00	Due from owners/officers	Ö	o	0	Ō	33.00
34.00	Other assets	346, 503	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	111, 059, 867		0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	386, 990, 847	0	0	0	36.00
27.00	CURRENT LI ABI LI TI ES	20 270 212	J	0		1 27 00
37. 00 38. 00	Accounts payable Salaries, wages, and fees payable	28, 278, 312	0	0	0	37. 00 38. 00
39. 00	Payrol I taxes payable			0	0	39.00
40.00	Notes and Loans payable (short term)	2, 815, 000	o o	0	Ő	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0)			42.00
43.00	Due to other funds	0	0	0	0	43.00
44. 00	Other current liabilities	23, 047, 026		0	0	44.00
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	54, 140, 338	0	0	0	45.00
46. 00	Mortgage payable	1	ol	0	0	46.00
47. 00	Notes payable	28, 660, 564		0	0	47.00
48. 00	Unsecured Loans	0	Ö	0		48. 00
49.00	Other long term liabilities	43, 578, 676	0	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	72, 239, 240	0	0		50.00
51.00	Total liabilities (sum of lines 45 and 50)	126, 379, 578	0	0	0	51.00
F0 00	CAPITAL ACCOUNTS	0/0/44 0/0				
52. 00 53. 00	General fund balance Specific purpose fund	260, 611, 269				52. 00 53. 00
54. 00	Donor created - endowment fund balance - restricted		J	0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
FO 00	replacement, and expansion	2/0 /44 0/0			_	F0 00
59. 00 60. 00	Total fund balances (sum of lines 52 thru 58)	260, 611, 269		0	0	59. 00 60. 00
00.00	Total liabilities and fund balances (sum of lines 51 and 59)	386, 990, 847		U		00.00
	15.1	I	1		ı	I

Provi der CCN: 15-0002

					To 12/31/2022	Date/Time Pre 5/25/2023 12:	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1. 00	2. 00	3.00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	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 0	287, 981, 063 -27, 369, 794 260, 611, 269		0 0 0 0 0 0	0 0 0 0 0	5. 00 6. 00 7. 00 8. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0 0	0 260, 611, 269 0 260, 611, 269		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	10.00 11.00 12.00 13.00 14.00 15.00 16.00
		Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8. 00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	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	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0	0 0 0 0 0		0 0 0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

Health Financial Systems NSTATEMENT OF PATLENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0002

			7	o 12/31/2022	Date/Time Pre 5/25/2023 12:	
	Cost Center Description		Inpati ent	Outpati ent	Total	40 pili
	oust defices bescription		1.00	2.00	3. 00	
	PART I - PATIENT REVENUES				9. 9.9	
	General Inpatient Routine Services					
1.00	Hospi tal		85, 800, 853	3	85, 800, 853	1.00
2.00	SUBPROVI DER - I PF	İ	2, 452, 404	1	2, 452, 404	2.00
3.00	SUBPROVI DER - I RF		3, 880, 129		3, 880, 129	3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF		(0	5.00
6.00	Swing bed - NF		(0	6.00
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		92, 133, 386		92, 133, 386	10.00
	Intensive Care Type Inpatient Hospital Services					
11. 00	INTENSIVE CARE UNIT		26, 683, 143	3	26, 683, 143	11.00
11. 01	NEONATAL I CU		()	0	11. 01
12. 00	CORONARY CARE UNIT					12.00
13. 00	BURN INTENSIVE CARE UNIT					13.00
14. 00	SURGICAL INTENSIVE CARE UNIT					14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16. 00	Total intensive care type inpatient hospital services (sum of	lines	26, 683, 143	3	26, 683, 143	16. 00
47.00	11-15)		440 047 507		440 047 500	47.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	'	118, 816, 529		118, 816, 529	17.00
18.00	Ancillary services		543, 136, 819		1, 291, 110, 773	
19.00	Outpati ent servi ces		23, 958, 296		135, 191, 559	19.00
20.00	RURAL HEALTH CLINIC		(-	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		(0	21.00
22. 00	HOME HEALTH AGENCY			3, 763, 223	3, 763, 223	22.00
23. 00	AMBULANCE SERVICES					23. 00
24. 00	CMHC					24.00
25. 00 26. 00	AMBULATORY SURGI CAL CENTER (D. P.) HOSPI CE					25. 00 26. 00
27. 00	PROFESSIONAL FEES		484, 120	60, 383, 620	60, 867, 740	27.00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst	686, 395, 764	· · ·		28. 00
20.00	G-3, line 1)	to wkst.	000, 373, 70	723, 334, 000	1,007,747,024	20.00
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			419, 898, 697		29. 00
30.00	ADD (SPECIFY)		(· · ·		30.00
31.00			(31.00
32.00			(32.00
33.00		İ	(33.00
34.00			(34.00
35.00			()		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECIFY)		()		37.00
38. 00			()		38.00
39. 00			(39.00
40.00			()		40.00
41. 00			()		41.00
42. 00	Total deductions (sum of lines 37-41)			0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42	2)(transfer		419, 898, 697		43.00
	to Wkst. G-3, line 4)					

Heal	th Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-2	2552-10
STAT	EMENT OF REVENUES AND EXPENSES	Provi der CCN: 15	From 01/01/2022	Worksheet G-3 Date/Time Pre	
				5/25/2023 12:	46 pm_
				1. 00	
1. 00				1, 609, 749, 824	1.00
2.00		n patients' accounts		1, 218, 849, 934	2.00
3.00	,			390, 899, 890	
4.00	3 1 1 1 1			419, 898, 697	ł
5.00		minus line 4)		-28, 998, 807	5.00
	OTHER I NCOME				
6.00				0	
7.00				4, 202, 856	
8.00	•	eous communication services		0	
9.00				0	9. 00
10.0				0	
11. 0	•			0	
12.0				0	12.00
13. 0				0	13.00
	O Revenue from meals sold to employees and gu	ests		0	14.00
	O Revenue from rental of living quarters			0	15.00
	O Revenue from sale of medical and surgical s			0	16.00
	O Revenue from sale of drugs to other than pa			0	17.00
	O Revenue from sale of medical records and ab			0	18.00
19. 0	O Tuition (fees, sale of textbooks, uniforms,	etc.)		0	19.00
20.0	O Revenue from gifts, flowers, coffee shops,	and canteen		0	20.00
21. 0	O Rental of vending machines			0	21.00
22.0	O Rental of hospital space			0	22. 00
23.0	O Governmental appropriations			0	23. 00
24. 0	O OTHER OPERATING INCOME			12, 151, 434	24. 00
24. 0	1 NON OPERATING INCOME			397, 700	24. 01
24. 0	2 CHANGE IN UNREALIZED GAIN/LOSS			-17, 502, 903	24. 02
24. 0	3 REALIZED GAIN/LOSS ON INVESTMENT SAL			971, 504	24. 03
24. 0				193, 582	
04 5	0 00000 40 000 5 0			4 400 044	1 04 -0

193, 582 24. 04
1, 433, 246 24. 50
1, 847, 419 25. 00
-27, 151, 388 26. 00
202, 915 27. 00
15, 491 27. 01
218, 406 28. 00
-27, 369, 794 29. 00

24.50 COVID-19 PHE Funding
25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)

27.01 FOUNDATION OTHER

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 SALARIES

	Financial Systems		METHODIST HOSE				eu of Form CMS-	
COST A	LLOCATION - HHA GENERAL SERVICE	E COST		Provi der C		Period: From 01/01/2022	Worksheet H-1 Part I	
				HHA CCN:	15-7536	To 12/31/2022	Date/Time Pre 5/25/2023 12:	
						Home Health	PPS	то р
			Capital Rel	ated Costs		Agency I		
			·					
		Net Expenses for Cost	Bl dgs & Fi xtures	Movable Equipment	Plant Operation	Transportatio % n	Subtotal (cols. 0-4)	
		Allocation	TTAtures	Equi pilierri	Mai ntenance		(0013. 0-4)	
		(from Wkst.						
		H, col . 10)	1. 00	2. 00	3.00	4. 00	4A. 00	
	GENERAL SERVICE COST CENTERS			2.00	0.00			
1. 00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2. 00	Capital Related - Movable	0		0			0	2.00
2 00	Equi pment			0				2 00
3. 00 4. 00	Plant Operation & Maintenance Transportation	0	0	0	1	0 0	O	3.00
5.00	Administrative and General	874, 684	0	0		0 0	874, 684	
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	891, 161	O	0	1	0 0	891, 161	6.00
7. 00	Physical Therapy	423, 016	1	0	•	0 0		1
8.00	Occupational Therapy	141, 413	0	0		0 0		1
9. 00 10. 00	Speech Pathology Medical Social Services	0 3, 607	0	0			_	
11.00	Home Health Aide	65, 514		0		o c		
12.00	Supplies (see instructions)	0	l l	0	•	0 0	_	
13. 00 14. 00	Drugs DME	0	1	0		0 0	0	
	HHA NONREIMBURSABLE SERVICES							
15. 00 16. 00	Home Dialysis Aide Services Respiratory Therapy	0	1	0		0 0		
17. 00	Private Duty Nursing	0	0	0	•			1
18.00	Clinic	0	0	0		0 0		1
19. 00 20. 00	Health Promotion Activities Day Care Program	0	0	0			0	
21.00	Home Delivered Meals Program	0	0	0		0 0	Ö	
	Homemaker Service	0	0	0		0 0	0	
	All Others (specify) Telemedicine	0	0	0	1	0 0	_	
	Total (sum of lines 1-23)	2, 399, 395	0	0	1	0 0	_	1
		Administrativ e & General	Total (cols. 4A + 5)					
		5. 00	6.00					1
	GENERAL SERVICE COST CENTERS							1.00
1. 00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable							2.00
3. 00	Equipment Plant Operation & Maintenance							3.00
4. 00	Transportation							4.00
5. 00	Administrative and General	874, 684						5.00
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	511, 234	1, 402, 395					6.00
7.00	Physi cal Therapy	242, 672	665, 688					7.00
8. 00 9. 00	Occupational Therapy Speech Pathology	81, 125 0	1					8. 00 9. 00
9. 00 10. 00	Medical Social Services	2, 069						10.00
11.00	Home Heal th Ai de	37, 584	103, 098					11.00
12. 00 13. 00	Supplies (see instructions) Drugs	0	1					12. 00 13. 00
	DME	0						14.00
15 00	HHA NONREI MBURSABLE SERVI CES							15 00
15. 00 16. 00	Home Dialysis Aide Services Respiratory Therapy	0	1					15. 00 16. 00
17.00	Private Duty Nursing	0	O					17.00
	Clinic	0	0					18.00
17. UU	Health Promotion Activities Day Care Program	0	0					19. 00 20. 00
			l ol					21.00
20. 00 21. 00	Home Delivered Meals Program	0						
20. 00 21. 00 22. 00	Homemaker Service	Ō	O					22. 00
20. 00 21. 00 22. 00 23. 00		1	0					

	51		METHODI OT 1100	CDITALC INC		111	. C. F OHC .	0550 40
	Financial Systems LLOCATION - HHA STATISTICAL BAS	SIS	METHODI ST HOS			Period: From 01/01/2022 To 12/31/2022		pared:
						Home Health	PPS	40 piii
						Agency I		
		Capital Rel	ated Costs					
		BI dgs & Fi xtures (SQUARE FEET)	Movabl e Equi pment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	n (MI LEAGE)	Reconciliatio n	e & General (ACCUM. COST)	
	T	1. 00	2. 00	3. 00	4. 00	5A. 00	5. 00	
4 00	GENERAL SERVICE COST CENTERS	1 5				1	1	1
1. 00	Capital Related - Bldg. & Fixtures	0				0		1.00
2. 00	Capital Related - Movable Equipment		C			0		2.00
3.00	Plant Operation & Maintenance	O	C			0		3.00
4.00	Transportation (see	0	C) c		0		4.00
	instructions)							
5. 00	Administrative and General	0	C) <u> </u>)	0 -874, 684	1, 524, 711	5.00
/ 00	HHA REIMBURSABLE SERVICES		C) C		ol o	001 1/1	/ 00
6. 00 7. 00	Skilled Nursing Care Physical Therapy	0	(0 0		6. 00 7. 00
8. 00	Occupational Therapy					0 0	141, 413	1
9. 00	Speech Pathology					0 0	141, 413	9.00
10.00	Medical Social Services		(0 0	3, 607	
11. 00	Home Heal th Aide		Č	ól ő		0 0	65, 514	1
12. 00	Supplies (see instructions)	l o	C			0 0	0	12.00
13.00	Drugs	o	C			0	0	13.00
14.00	DME	0	C) c)	0 0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15. 00	Home Dialysis Aide Services	0	C) c		0	0	1
16. 00	Respiratory Therapy	0	C) C)	0	0	16. 00
17. 00	Private Duty Nursing	0	C	0)	0	0	17. 00
18. 00	Clinic	0	C	0)	0	0	18.00
19.00	Health Promotion Activities	0	C)	0	0	19.00
20.00	Day Care Program	0	C)	0	0	20.00
21.00	Home Delivered Meals Program	0	C		2	0	0	21.00
22. 00 23. 00	Homemaker Service All Others (specify)					0		22. 00 23. 00
23. 50	Telemedicine					0		23.00
24. 00	Total (sum of lines 1-23)		(0 -874, 684	1, 524, 711	1
25. 00	Cost To Be Allocated (per		(0	874, 684	
20.00	Wester and II 1 Deset I)	ı		1	1	~	1 0, 4, 504	1 20.00

0.000000

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0. 573672 26. 00

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24.00 Total (sum of lines 1-23)
25.00 Cost To Be Allocated (per Worksheet H-1, Part I)
26.00 Unit Cost Multiplier

5/25/2023 12:46 pm

Home Health PPS 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 0 17, 352 1.00 420, 640 5, 517 1, 402, 395 2.00 Skilled Nursing Care 0 2.00 Physical Therapy 665, 688 0 0 3.00 000000000000000000 0 3.00 Occupational Therapy 222, 538 0 0 o 4.00 4.00 Speech Pathology 0 0 5.00 C 5.00 0 6.00 Medical Social Services 5,676 0 0 6.00 7.00 Home Heal th Aide 103, 098 o 7.00 0 0 0 0 8 00 Supplies (see instructions) 0 8 00 0 0 9.00 Drugs C 9.00 10.00 DMF 10.00 11.00 Home Dialysis Aide Services 0 0 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 C 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 Total (sum of lines 1-19) (2) 2, 399, 395 420, 640 5, 517 17, 352 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 N 5.05 5.06 7. 00 8.00 5. 04 5A. 04 462, 965 1.00 Administrative and General 19, 456 47, 281 1.00 2.00 Skilled Nursing Care 0 1, 402, 395 143, 220 0 0 2.00 0 0 Physical Therapy 3.00 0 665, 688 67, 984 0 3 00 0 0 4.00 Occupational Therapy 222, 538 22, 727 4.00 5.00 Speech Pathology 0 0 0 0 0 0 0 0 0 0 0 0 5.00 0 6.00 Medical Social Services 5, 676 580 0 6.00 0 7.00 Home Health Aide 103, 098 10, 529 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 0 11.00 12.00 Respiratory Therapy 0 12.00 13.00 Private Duty Nursing 0 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 C 19.50 Tel emedi ci ne 0 19.50 0 0 20.00 20 00 Total (sum of lines 1-19) (2) 19, 456 2 862 360 292, 321 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.

⁽¹⁾ 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.

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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

21.00

Home Health Aide

Respiratory Therapy

Private Duty Nursing

Day Care Program

Homemaker Service

6 decimal places.

Tel emedi ci ne

All Others (specify)

Drugs

Clinic

DMF

Supplies (see instructions)

Home Dialysis Aide Services

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

⁽¹⁾ 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.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Provider CCN: 15-0002 Peri od: Worksheet H-2 From 01/01/2022 Part I HHA CCN: 15-7536 12/31/2022 Date/Time Prepared: To 5/25/2023 12:46 pm Home Health PPS Agency I PARAMED ED Allocated HHA Total HHA Cost Center Description Subtotal Intern & Subtotal A&G (see Part PROGRAM Resi dents Costs Cost & Post II) Stepdown Adjustments 23. 00 24. 00 25. 00 26.00 27. 00 28. 00 Administrative and General 1.00 0 531,000 1.00 531,000 2.00 Skilled Nursing Care 1, 545, 615 1, 545, 615 310, 358 1, 855, 973 2.00 3.00 Physical Therapy 0 733, 672 733, 672 147, 321 880, 993 3.00 Occupational Therapy 0 245, 265 49, 249 294, 514 4.00 245, 265 4.00 0 Speech Pathology 5.00 5.00 6.00 Medical Social Services 6, 256 0 6, 256 1, 256 7, 512 6.00 7.00 Home Health Aide 113, 627 113, 627 22, 816 136, 443 7.00 Supplies (see instructions) 0 0 8.00 8 00 O 0 0 0 0 0 9.00 Drugs 0 9.00 10.00 DME 0 10.00 11.00 Home Dialysis Aide Services 0 0 0 0 0 0 0000000 0 0 0 11.00 0 Respiratory Therapy 0 0 12.00 12.00 Private Duty Nursing 13.00 0 0 13.00 14.00 Clinic 0 14.00 Health Promotion Activities 15.00 0 0 0 15.00 0 0 16.00 16.00 Day Care Program 17.00 Home Delivered Meals Program 0 0 17.00 Homemaker Service 0 0 o 18.00 0 0 0 0 18.00 All Others (specify) 0 0 0 o 19.00 19 00 19.50 Tel emedi ci ne 0 0 0 19.50 20.00 Total (sum of lines 1-19) (2) 3, 175, 435 3, 175, 435 531, 000 3, 175, 435 20.00 21.00 Unit Cost Multiplier: column 0.200799 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.

⁽¹⁾ 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 01/01/2022 Part II To 12/31/2022 Date/Time Prepared: 5/25/2023 12: 46 pm BASIS HHA CCN: 15-7536 Home Health PPS

						Home Health	PPS	
		CAPI TAL				Agency I		
		RELATED COSTS						
	Cost Center Description	BLDG & FIXT	EMPLOYEE	DATA	PURCHASI NG	ADMITTING	CASHI ERI NG/AC	
	5651 5611161 Beseit Pt. 611	(SQUARE FEET)	BENEFITS	PROCESSI NG	RECEIVING AND	(GROSS	COUNTS	
		(SQUINC TEET)	DEPARTMENT	(MACHI NE	STORES	CHARGES)	RECEI VABLE	
			(GROSS	TIME)	(PURCHASE	OTHEROES)	(GROSS	
			SALARI ES)	111112)	REQUISITIONS)		CHARGES)	
		1.00	4. 00	5. 01	5. 02	5. 03	5. 04	
1. 00	Administrative and General	0		0		3, 763, 223		1. 00
2. 00	Skilled Nursing Care	0	0	0		0,700,220	0,700,220	2. 00
3. 00	Physical Therapy	l ő	0	0	1	0	ő	3. 00
4. 00	Occupational Therapy	l ő	0	0	1	0	ő	4. 00
5. 00	Speech Pathology	l o	0	Ö	1	0	o	5. 00
6. 00	Medical Social Services	l o	0	1		_	o	6. 00
7. 00	Home Heal th Ai de	l ő	0	0	1	_	Ö	7. 00
8. 00	Supplies (see instructions)	l o	0	0	1	_	0	8. 00
9. 00	Drugs	l o	0	0	1	0	Ö	9. 00
10.00	DME	l o	Ö	Ö	1	0	o	10.00
11. 00	Home Dialysis Aide Services	l o	0	0		0	Ö	11. 00
12. 00	Respiratory Therapy	l o	Ö	1	-	0	Ö	12. 00
13. 00	Private Duty Nursing	0	0				0	13. 00
14. 00	Clinic	0	Ö	1	1	_	Ö	14. 00
15. 00	Health Promotion Activities	0	0	0		0	Ö	15. 00
16. 00	Day Care Program	0	0	0	0	0	Ö	16. 00
17. 00	Home Delivered Meals Program	0	0	0	0	0	Ö	17. 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	l o	0	0	0	0	0	19. 50
20. 00	Total (sum of lines 1-19)	0	2, 046, 583	0	69, 851	3, 763, 223	3, 763, 223	20. 00
21. 00	Total cost to be allocated	0	420, 640		5, 517	17, 352		21. 00
		_						
22. 00	Unit cost multiplier	0. 000000	0. 205533	0. 000000	0. 078982	0.004611	0.005170	22.00
22. 00		0.000000 Reconciliatio						22. 00
22. 00	Unit cost multiplier Cost Center Description	0.000000 Reconciliatio n	O. 205533 OTHER A&G (ACCUM. COST)	0. 000000 PATI ENT TRANSPORTATI 0	0. 078982 OPERATI ON OF PLANT	O. 004611 LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	22.00
22.00		Reconciliatio	OTHER A&G	PATI ENT	OPERATION OF	LAUNDRY &		22.00
22.00		Reconciliatio	OTHER A&G	PATI ENT TRANSPORTATI O	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	22.00
22. 00		Reconciliatio	OTHER A&G	PATI ENT TRANSPORTATI O N	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG	22.00
22. 00		Reconciliatio	OTHER A&G	PATIENT TRANSPORTATIO N (NUMBER OF	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG	22.00
1.00		Reconciliatio n	OTHER A&G (ACCUM. COST)	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00	HOUSEKEEPI NG (SQUARE FEET) 9.00	1.00
	Cost Center Description	Reconciliatio n 5A. 05	OTHER A&G (ACCUM. COST)	PATIENT TRANSPORTATIO N (NUMBER OF TRIPS) 5.06	OPERATION OF PLANT (SQUARE FEET) 7.00	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00	HOUSEKEEPI NG (SQUARE FEET) 9.00	
1.00	Cost Center Description Administrative and General	Reconciliatio n 5A. 05	OTHER A&G (ACCUM. COST) 5. 05 462, 965	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06	OPERATION OF PLANT (SQUARE FEET) 7.00 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00	HOUSEKEEPI NG (SQUARE FEET) 9.00	1.00
1. 00 2. 00	Cost Center Description Administrative and General Skilled Nursing Care	Reconciliatio n 5A. 05	OTHER A&G (ACCUM. COST) 5. 05 462, 965 1, 402, 395	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06	OPERATION OF PLANT (SQUARE FEET) 7.00 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0	HOUSEKEEPI NG (SQUARE FEET) 9.00 0	1.00
1. 00 2. 00 3. 00	Cost Center Description Administrative and General Skilled Nursing Care Physical Therapy	Reconciliatio n 5A. 05	OTHER A&G (ACCUM. COST) 5. 05 462, 965 1, 402, 395 665, 688	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06	OPERATION OF PLANT (SQUARE FEET) 7.00 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0	HOUSEKEEPI NG (SQUARE FEET) 9.00 0 0	1. 00 2. 00 3. 00
1. 00 2. 00 3. 00 4. 00	Cost Center Description Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy	Reconciliatio n 5A. 05	OTHER A&G (ACCUM. COST) 5. 05 462, 965 1, 402, 395 665, 688 222, 538	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06	OPERATION OF PLANT (SQUARE FEET) 7.00 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 0 0	9. 00 9. 00 0 0 0	1. 00 2. 00 3. 00 4. 00
1. 00 2. 00 3. 00 4. 00 5. 00	Cost Center Description Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	Reconciliatio n 5A. 05	OTHER A&G (ACCUM. COST) 5. 05 462, 965 1, 402, 395 665, 688 222, 538	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5.06	OPERATION OF 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 0	9.00 9.00 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	Cost Center Description Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	Reconciliatio n 5A. 05	OTHER A&G (ACCUM. COST) 5. 05 462, 965 1, 402, 395 665, 688 222, 530 5, 676	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5.06	OPERATION OF PLANT (SQUARE FEET) 7.00 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 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
1. 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 Medical Social Services Home Health Aide	Reconciliatio n 5A. 05	OTHER A&G (ACCUM. COST) 5. 05 462, 965 1, 402, 395 665, 688 222, 530 5, 676	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06	OPERATION OF PLANT (SQUARE FEET) 7.00 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	9.00 9.00 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
1. 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)	Reconciliatio n 5A. 05	OTHER A&G (ACCUM. COST) 5. 05 462, 965 1, 402, 395 665, 688 222, 530 5, 676	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06	OPERATION OF PLANT (SQUARE FEET) 7.00 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	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
1. 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	Reconciliatio n 5A. 05	OTHER A&G (ACCUM. COST) 5. 05 462, 965 1, 402, 395 665, 688 222, 530 5, 676	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06	OPERATION OF 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	9.00 9.00 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
1. 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	Reconciliatio n 5A. 05	OTHER A&G (ACCUM. COST) 5. 05 462, 965 1, 402, 395 665, 688 222, 530 5, 676	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06	OPERATION OF 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	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
1. 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	Reconciliatio n 5A. 05	OTHER A&G (ACCUM. COST) 5. 05 462, 965 1, 402, 395 665, 688 222, 530 5, 676	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06	OPERATION OF 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	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
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	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	Reconciliatio n 5A. 05	OTHER A&G (ACCUM. COST) 5. 05 462, 965 1, 402, 395 665, 688 222, 530 5, 676	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5.06	OPERATION OF 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	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
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	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	Reconciliatio n 5A. 05	OTHER A&G (ACCUM. COST) 5. 05 462, 965 1, 402, 395 665, 688 222, 530 5, 676	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5.06	OPERATION OF 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
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	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	Reconciliatio n 5A. 05	5. 05 462, 965 1, 402, 395 665, 688 222, 538 0 5, 676 103, 098 0 0	PATI ENT TRANSPORTATI 0 N (NUMBER OF TRI PS) 5. 06	OPERATION OF 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	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
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	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	Reconciliatio n 5A. 05	0THER A&G (ACCUM. COST) 5. 05 462, 965 1, 402, 395 665, 688 222, 538 0 5, 676 103, 098 0 0 0 0 0 0 0 0 0 0	PATI ENT TRANSPORTATI 0 N (NUMBER OF TRI PS) 5. 06	OPERATION OF 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	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00
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	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	Reconciliatio n 5A. 05	0THER A&G (ACCUM. COST) 5. 05 462, 965 1, 402, 395 665, 688 222, 538 0 5, 676 103, 098 0 0 0 0 0 0 0 0 0 0	PATI ENT TRANSPORTATI 0 N (NUMBER OF TRI PS) 5. 06	OPERATION OF 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	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
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	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)	Reconciliatio n 5A. 05	0THER A&G (ACCUM. COST) 5. 05 462, 965 1, 402, 395 665, 688 222, 538 0 5, 676 103, 098 0 0 0 0 0 0 0 0 0 0	PATI ENT TRANSPORTATI 0 N (NUMBER OF TRI PS) 5. 06	OPERATION OF 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	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
1. 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 19. 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	Reconciliatio n 5A. 05	5. 05 462, 965 1, 402, 395 665, 688 222, 538 0 5, 676 103, 098 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	PATI ENT TRANSPORTATI 0 N (NUMBER OF TRI PS) 5. 06	OPERATION OF 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	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
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 16. 00 17. 00 18. 00 19. 00 19. 50 20. 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)	Reconciliatio n 5A. 05	0THER A&G (ACCUM. COST) 5. 05 462, 965 1, 402, 395 665, 688 222, 538 0 5, 676 103, 098 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	PATI ENT TRANSPORTATI 0 N (NUMBER OF TRI PS) 5. 06	OPERATION OF 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	1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 11. 00 12. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00
1. 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 19. 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 Total (sum of lines 1-19) Total cost to be allocated	Reconciliatio n 5A. 05	5. 05 462, 965 1, 402, 395 665, 688 222, 538 0 5, 676 103, 098 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	PATI ENT TRANSPORTATI 0 N (NUMBER OF TRI PS) 5. 06	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	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

Worksheet H-2
Part II
Date/Time Prepared:
5/25/2023 12: 46 pm Peri od: From 01/01/2022 To 12/31/2022 BASIS HHA CCN: 15-7536

						Home Health Agency I	PPS	то ріп
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(MEALS SERVED)	(PRODUCTI VE HOURS)	ADMI NI STRATI O N	SERVICES & SUPPLY	(COSTED REQUIS.)	RECORDS & LI BRARY	
		JERVED)	11001(3)	(DI RECT NURS.	(COSTED	KEQUI 3.)	(GROSS	
				HRS.)	REQUIS.)		CHARGES)	
1. 00	Administrative and General	10. 00	11. 00	13. 00	14.00	15. 00 0	16. 00 3, 763, 223	1. 00
2.00	Skilled Nursing Care	0	0	0	•		3, 703, 223	2.00
3.00	Physi cal Therapy	0	0	0	0	0	0	3. 00
4.00	Occupational Therapy	0	0	0	_	0	0	4.00
5. 00 6. 00	Speech Pathology Medical Social Services		0	0			0	5. 00 6. 00
7. 00	Home Health Aide	O	0	Ö	•		0	7. 00
8.00	Supplies (see instructions)	0	0	0	_ ~	0	0	8.00
9. 00 10. 00	Drugs DME	0	0	0	0	0	0	9. 00 10. 00
11. 00	Home Dialysis Aide Services	Ö	0	Ö	Ö		Ö	11.00
12.00	Respiratory Therapy	0	0	0			0	12.00
13. 00 14. 00	Private Duty Nursing	0	0	0			0	13. 00 14. 00
15. 00	Health Promotion Activities		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 19. 00	Homemaker Service All Others (specify)	0	0	0	0	0	0	18. 00 19. 00
19. 50	Tel emedi ci ne	Ö	0	Ö	Ö	0	Ö	19. 50
20.00	Total (sum of lines 1-19)	0	0	0	0	0	3, 763, 223	
21. 00 22. 00	Total cost to be allocated Unit cost multiplier	0. 000000	0. 000000	0. 000000	_	0. 000000	10, 093 0. 002682	
22.00	on t cost martipire	0.00000	0. 000000	0.00000		RESI DENTS	0.002002	22.00
	01.01	600141	CTAFF	MEDICAL	CEDVILOES CALA	CEDW OFC OTHE	DADAMED ED	
	Cost Center Description	SOCI AL SERVI CE	STAFF EDUCATI ON	MEDI CAL EDUCATI ON	RY & FRINGES	SERVICES-OTHE R PRGM COSTS	PARAMED ED PROGRAM	
		(TIME SPENT)	(TIME SPENT)	(ASSI GNED	(ASSI GNED	(ASSI GNED	(ASSI GNED	
		17.00	17.01	TIME)	TIME)	TIME)	TIME)	
1. 00	Administrative and General	17. 00	17. 01 1, 261	17. 02	21.00	22. 00	23. 00	1. 00
2.00	Skilled Nursing Care	0	0				0	2. 00
3.00	Physi cal Therapy	0	0	0		0	0	3.00
4. 00 5. 00	Occupational Therapy Speech Pathology	0	0	0		0	0	4. 00 5. 00
6. 00	Medical Social Services	Ö	0	Ö			Ö	6. 00
7. 00	Home Heal th Ai de	0	0	0	0		0	7. 00
8. 00 9. 00	Supplies (see instructions) Drugs	0	0	0	0	0	0	8. 00 9. 00
10.00	DME		0	Ö		0	0	10.00
11. 00	Home Dialysis Aide Services	O	0	0	0	0	0	11. 00
12. 00 13. 00	Respiratory Therapy	0	0	0			0	12.00
14. 00	Private Duty Nursing Clinic		0	0			0 0	13. 00 14. 00
15. 00	Health Promotion Activities	0	0				0	
16.00	Day Care Program	0	0	0			0	16.00
17. 00 18. 00	Home Delivered Meals Program Homemaker Service	0	0	0	0	0	0	17. 00 18. 00
19. 00	All Others (specify)	l ő	0	ő	ő	0	0	19.00
19. 50	Tel emedi ci ne	0	0	0	0	_	0	19.50
20. 00 21. 00	Total (sum of lines 1-19) Total cost to be allocated	0	1, 261 10, 661			0	0	20. 00 21. 00
	Unit cost multiplier	0. 000000	8. 454401			0. 000000	_	

Hool +h	Financial Systems		METHODIST HOS	DITALS INC		In Lio	u of Form CMS 1	DEE2 10
	Financial Systems TIONMENT OF PATIENT SERVICE COST	rs .	METHODIST HOS	Provi der C	CN: 15-0002	Peri od:	u of Form CMS-2 Worksheet H-3	
711 1 0101	TONNENT OF TATTENT SERVICE GOST	. 3		HHA CCN:	15-7536	From 01/01/2022 To 12/31/2022	Part I Date/Time Pre	pared:
				Title	XVIII	Home Health Agency I	5/25/2023 12: PPS	40 piii
	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2,	Shared Ancillary Costs (from	Total HHA Costs (cols 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷	
			Part I)	Part II)			col . 4)	
	DART I COMPUTATION OF LEGGER	0	1.00	2.00	3.00	4.00	5. 00	
	PART I - COMPUTATION OF LESSER COST LIMITATION	OF AGGREGATE	PROGRAM COST, A	AGGREGATE OF II	HE PROGRAM LI	MITATION COST, C	OR BENEFICIARY	
	Cost Per Visit Computation			Г				
1. 00	Skilled Nursing Care	2. 00		l .	1, 855, 9			
2.00	Physi cal Therapy	3. 00		l .			196. 34	
3. 00	Occupational Therapy	4. 00		l .	294, 5°	·		
4. 00	Speech Pathology	5.00				0	0. 00	
5. 00	Medical Social Services	6. 00		l .	7, 5			
6.00	Home Health Aide	7.00	l '	l	136, 4		87. 80	
7. 00	Total (sum of lines 1-6)		3, 175, 435	0	-,,			7. 00
					Program Visi	ts		
					P.	art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject	Subject to		
	•		, ,		to	Deducti bl es		
					Deducti bl es	&		
					Coi nsurance	•		
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		23844	0				8. 00
9.00	Physi cal Therapy		23844	0		90		9. 00
10.00	Occupational Therapy		23844	0	3.	76		10.00
11. 00	Speech Pathology		23844	0		0		11.00
12.00	Medical Social Services		23844	0		7		12.00
13.00	Home Health Aide		23844	0		28		13.00
14. 00				0	4, 20			14.00
	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols 1 + 2)		Ratio (col. 3 ÷ col. 4)	
		0	1. 00	2.00	3.00	4.00	5. 00	
	Supplies and Drugs Cost Comput						5. 52	
15.00	Cost of Medical Supplies	8.00	0	0		0 0	0. 000000	15. 00
16.00	Cost of Drugs	9. 00				0 0	0. 000000	16.00
			Program Visits		Cost of Services			
			Par	t B		Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
	•		to	Deductibles &		to	Deductibles &	
			Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
			Coi nsurance			Coi nsurance		
		6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
	PART I - COMPUTATION OF LESSER COST LIMITATION	OF AGGREGATE	PROGRAM COST, A	AGGREGATE OF TI	HE PROGRAM LI	MITATION COST, C	OR BENEFICIARY	
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	2, 403			0 419, 828		1.00
2.00	Physi cal Therapy	0	990			0 194, 377		2.00
3.00	Occupational Therapy	0	376			0 70, 624		3.00
4.00	Speech Pathology	0	0			0 0		4.00
5.00	Medical Social Services	0	7			0 1, 052		5.00
, 00	Home Heal th Aide	l o	428	I	I	0 37, 578		6.00
6.00			420			0 37, 370		0.00
6. 00 7. 00	Total (sum of lines 1-6)	Ö		ł		0 723, 459		7.00

Heal th	ı Financial Systems		METHODIST HOS	SPITALS. INC		In Lie	u of Form CMS-:	2552-10
	FIONMENT OF PATIENT SERVICE COST	ΓS		Provider Co	CN: 15-0002 15-7536	Peri od: From 01/01/2022 To 12/31/2022	Worksheet H-3 Part I Date/Time Pre	epared:
				Title	XVIII	Home Health	5/25/2023 12: PPS	46 pm
						Agency I		
	Cost Center Description		7 00			10.00		
	Limitation Cost Computation	6. 00	7. 00	8. 00	9. 00	10.00	11.00	
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							8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
		Progi	ram Covered Cha	arges	Cost of Services	Part B		
	Cost Center Description	Part A 6.00	Not Subject to Deductibles & Coinsurance 7.00	Subject to Deductibles &	Part A 9.00	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	Supplies and Drugs Cost Comput							
	Cost of Medical Supplies Cost of Drugs	0	107, 363 0	1		0 0	0	
	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00						
	PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation	OF AGGREGATE	PROGRAM COST,	AGGREGATE OF TI	HE PROGRAM L	IMITATION COST, O	R BENEFICIARY	
1. 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 Total (sum of lines 1-6)	419, 828 194, 377 70, 624 0 1, 052 37, 578 723, 459						1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
	Cost Center Description	12. 00						
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00								8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 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		Provi der C		Peri od:	Worksheet H-3		
				HHA CCN:	15-7536	From 01/01/2022 To 12/31/2022	Date/Time Pre	
							5/25/2023 12:	46 pm_
						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 I	BY SHARED HOSP	TAL DEPARTME	NTS		
1.00	Physi cal Therapy	66.00	0. 339201	0		0 col. 2, line 2	. 00	1.00
2.00	Occupational Therapy	67.00	0. 383884	0		0 col. 2, line 3	. 00	2.00
3.00	Speech Pathology	68.00	0. 281939	0		0 col. 2, line 4	. 00	3.00
4.00	Cost of Medical Supplies	71.00	0. 508969	0		0 col. 2, line 1	5. 00	4.00
5.00	Cost of Drugs	73.00	0. 217492	0		0 col. 2, line 1	6. 00	5.00

	Financial Systems METHODIST H TION OF HHA REIMBURSEMENT SETTLEMENT	IOSPITALS, INC Provider C	CN: 15-0002	In Lieu of Form CMS-255 Period: Worksheet H-4		
LOOLA	TON OF THE RET INDURSEMENT SETTEEMENT	HHA CCN:	15-7536	From 01/01/2022 To 12/31/2022	Part I-II	
		T: +1 o	XVIII	Home Health	5/25/2023 12: PPS	
		n tre	XVIII	Agency I		
			Part A	Not Subject	t B Subject to	
			rai t A	to Deductibles &	Deductibles & Coinsurance	
			1.00	Coi nsurance	3.00	
P.	ART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR	CUSTOMARY CHARGE	1.00 ES	2. 00	3. 00	
	Reasonable Cost of Part A & Part B Services				_	
	Reasonable cost of services (see instructions)			0 0	0	
	Total charges Customary Charges			0 0	0	2
	Amount actually collected from patients liable for payme	nt for services		0 0	0	3
c	on a charge basis (from your records)					
f	Amount that would have been realized from patients liable for services on a charge basis had such payment been mad			0 0	0	4
0 %	with 42 CFR §413.13(b) Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 0000	0. 00000	0. 000000	5
	Total customary charges (see instructions)		0.0000	0 0.00000	0.000000	1
0 E	Excess of total customary charges over total reasonable only if line 6 exceeds line 1)			0 0	0	7
	Excess of reasonable cost over customary charges (comple 1 exceeds line 6)	te only if line		0 0	0	8
	Primary payer amounts			0 0	0	
				Part A	Part B Servi ces	
				Servi ces 1.00	2. 00	
P.	ART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
	Total reasonable cost (see instructions)			0	0	
	Total PPS Reimbursement - Full Episodes without Outliers			0	716, 263 41, 974	
	Fotal PPS Reimbursement - Full Episodes with Outliers Fotal PPS Reimbursement - LUPA Episodes			0	11, 044	
	Total PPS Reimbursement – PEP Episodes			0	8, 612	
	Fotal PPS Outlier Reimbursement - Full Episodes with Out	liers		0	10, 285	
	Total PPS Outlier Reimbursement - PEP Episodes	11613		0	0, 203	1
				0	0	
	Total Other Payments			0	_	
	DME Payments			0	0	
	Oxygen Payments			0	0	1
	Prosthetic and Orthotic Payments			0	0	
	Part B deductibles billed to Medicare patients (exclude	coi nsurance)			0	
	Subtotal (sum of lines 10 thru 20 minus line 21)			0	788, 178	
	Excess reasonable cost (from line 8)			0	0	
	Subtotal (line 22 minus line 23)			0	788, 178	
	Coinsurance billed to program patients (from your record	S)			0	
	Net cost (line 24 minus line 25)			0	788, 178	
	Allowable bad debts (from your records)				0	
	Adjusted reimbursable bad debts (see instructions)				0	
	Allowable bad debts for dual eligible (see instructions)				0	
	Total costs - current cost reporting period (see instruc	tions)		0	788, 178	
00 C	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	0	30
50 F	Pioneer ACO demonstration payment adjustment (see instru	ctions)		0	0	30
99 🛭	Demonstration payment adjustment amount before sequestra	ti on		0	0	30
00 5	Subtotal (see instructions)			0	788, 178	31
	Sequestration adjustment (see instructions)			0	9, 901	
- 1	Demonstration payment adjustment amount after sequestrat	i on		0	1	1
1	Sequestration adjustment for non-claims based amounts (s			0	0	
	Interim payments (see instructions)			0	778, 276	
00 1	1 9 (0	770, 270	1
	lentative settlement (for contractor use only)					
00 T	Tentative settlement (for contractor use only)	31 02 31 75 2	3 and 33)			
00 T	lentative settlement (for contractor use only) Balance due provider/program (line 31 minus lines 31.01, Protested amounts (nonallowable cost report items) in ac			0	0	34

Health Financial Systems	METHODIST HOSPIT	TALS, INC		In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED TO PROGRAM BENEFICIARIES	HHAS FOR SERVICES RENDERED	Provi der C	CCN: 15-0002	Peri od: From 01/01/2022	Worksheet H-5
TO PROGRAM DENEFTCTARTES		HHA CCN:	15-7536		Date/Time Prepared:

12/31/2022 Date/Time Prepared: 5/25/2023 12:46 pm Home Health PPS 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 778, 276 1.00 2.00 0 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. 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 0 3.01 0 3.02 3.02 0 3.03 0 3.03 3.04 0 0 3.04 0 3.05 0 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 0 778, 276 4.00 (transfer to Wkst. H-4, Part II, column as appropriate, line 32) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after 5.00 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 0 Total Medicare program liability (see instructions) n 778, 276 7.00 7.00 NPR Date Contractor Number (Mo/Day/Yr) 0 1.00 2.00

8. 00

8.00 Name of Contractor

METHODIST HOSDITALS, LND					
Health Financial Systems METHODIST HOSPIT CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0002	Peri od: From 01/01/2022 To 12/31/2022		
				5/25/2023 12:	
Title XVIII Hospital				PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
1. 00	Capital DRG other than outlier			2, 173, 207	1. 00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			63, 692	2.00
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)			212. 36	3.00
4.00	Number of interns & residents (see instructions)			3. 00	4.00
5. 00	, , , , , , , , , , , , , , , , , , , ,			0. 40 8, 693	5.00
6. 00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)				6. 00
7. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line			8. 53	7. 00
0.00	30) (see instructions)			21 20	0.00
8. 00 9. 00				31. 29 39. 82	8. 00 9. 00
10.00				8. 39	
11. 00				182, 332	
	00 Total prospective capital payments (see instructions)			2, 427, 924	
				=, :=:, :=:	
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1. 00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)			0	2.00
3. 00 4. 00				0	3. 00 4. 00
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
3.00	The and the program capital cost (Time 3 x Time 4)				3.00
	DADT LLL COUNTATION OF EVOCETION DAYMENTS			1. 00	
1 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS				1 00
1. 00 2. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstar	neae (coo instructions)		0	1. 00 2. 00
3. 00	Net program inpatient capital costs for extraordinary circumstar	ices (see Ilisti uctions)		0	3.00
4. 00	Applicable exception percentage (see instructions)		0.00	4. 00	
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0	5. 00
6.00	Percentage adjustment for extraordinary circumstances (see i	nstructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinar	ry circumstances (line 2	x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)			0	8. 00
9. 00	Current year capital payments (from Part I, line 12, as appl	,		0	9. 00
10.00	Current year comparison of capital minimum payment level to			0	10.00
11. 00	Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	capital payment (from pr	ior year	0	11. 00
12. 00	Net comparison of capital minimum payment level to capital p	navments (line 10 nlus li	ne 11)	o	12.00
13. 00	Current year exception payment (if line 12 is positive, enter			0	13.00
14. 00	Carryover of accumulated capital minimum payment level over		′	0	14. 00
	(if line 12 is negative, enter the amount on this line)			١	
15.00	OU Current year allowable operating and capital payment (see instructions)			0	15.00
	Current year operating and capital costs (see instructions)			0	16. 00
17. 00	Current year exception offset amount (see instructions)		l	, 0	17. 00