ioai tii i i iiaiioi	a. cycrome		71201 1110	2.00	. 01 101111 01110 20	30 2
This report is	required by law (42 USC 1395	g; 42 CFR 413.20(b)). Fai	lure to report can re	sult in all interim	FORM APPROVED	
payments made	since the beginning of the co	st reporting period being	deemed overpayments	(42 USC 1395g).	OMB NO. 0938-0	050
					EXPIRES 05-31-	2019
HOSPITAL AND H	OSPITAL HEALTH CARE COMPLEX (OST REPORT CERTIFICATION	Provider CCN: 15-0002		Worksheet S	
AND SETTLEMENT	SUMMARY			From 01/01/2016		
				To 12/31/2016	Date/Time Preparent	
					5/26/2017 1:16	pm
PART I - COST	REPORT STATUS					
Provi der	1. [X] Electronically filed	cost report		Date: 5/26/20	17 Time: 1:	16 pm
use only	2. [] Manually submitted co	st report				
	3. [0] If this is an amended	I report enter the number	of times the provider	resubmitted this o	ost report	
	4. [F] Medicare Utilization.	Enter "F" for full or "l	_" for low.		·	
Contractor	5. [1]Cost Report Status	6. Date Received:	10). NPR Date:		
use only	(1) Ås Submitted	7. Contractor No.	11	I. Contractor's Vendo	or Code:	4
	(2) Settled without Audit	8. [N] Initial Report for	or this Provider CCN 12	2.[0]If line 5, co	lumn 1 is 4: En	nter
	(3) Settled with Audit	9. N Final Report for	this Provider CCN		es reopened = 0	
	(4) Reopened				•	

PART II - CERTIFICATION

(5) Amended

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by METHODIST HOSPITALS, INC (15-0002) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 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.

(Si gned)

Officer or Administrator of Provider(s)

Title

Date

			Ti tle XVIII				
	Cost Center Description	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	756, 665	-114, 329	0	-693, 763	1.00
2.00	Subprovi der - IPF	0	6, 516	292		110, 629	2.00
3.00	Subprovi der - IRF	0	98, 528	-1		10, 209	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
200.0	0 Total	0	861, 709	-114, 038	0	-572, 925	200. 00
T1		The second of the selection	C				

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

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

	III-State	III-State	out-or	001-01	Wedi Cai u	Other	
	Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
	pai d days	el i gi bl e	Medi cai d	Medi cai d		days	
		unpai d	pai d days	el i gi bl e			
		days		unpai d			
	1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
24.00 If this provider is an IPPS hospital, enter the	3, 217	12, 169	463	594	11, 768	0	24.00
in-state Medicaid paid days in column 1, in-state							
Medicaid eligible unpaid days in column 2,							
out-of-state Medicaid paid days in column 3,							
out-of-state Medicaid eligible unpaid days in column	ı						
4, Medicaid HMO paid and eligible but unpaid days ir	ı						
column 5, and other Medicaid days in column 6.							
25.00 If this provider is an IRF, enter the in-state	94	667	0	24	737		25.00
Medicaid paid days in column 1, the in-state							
Medicaid eligible unpaid days in column 2,							
out-of-state Medicaid days in column 3, out-of-state							
Medicaid eligible unpaid days in column 4, Medicaid							
HMO paid and eligible but unpaid days in column 5.							

OSPITAL AND HOSPITAL HEALTH CARE CO	MPLEX IDENTIFICATION DA	ATA	Provi der CC		eriod: com 01/01/2016	Worksheet S-2 Part I	
				To	12/31/2016	5/26/2017 1:1	pared: 4 pm
		Y/N	I ME	Direct GME	I ME	Direct GME	
1.06 Enter the amount of ACA §5503 used for cap relief and/or FTE care or general surgery. (see	s that are nonprimary	1.00	2.00	3. 00 0. 00	4. 00	5. 00	61.0
	·	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
1.10 Of the FTEs in line 61.05, spe	cify each now program		1. 00	2. 00	3. 00	4. 00	61. 1
specialty, if any, and the num for each new program. (see ins column 1, the program name, er program code, enter in column unweighted count and enter in FTE unweighted count. 1.20 Of the FTEs in line 61.05, spe program specialty, if any, and	ber of FTE residents tructions) Enter in ter in column 2, the 3, the IME FTE column 4, direct GME cify each expanded				0. 00		61. 2
residents for each expanded pr instructions) Enter in column enter in column 2, the program 3, the IME FTE unweighted cour 4, direct GME FTE unweighted c	1, the program name, code, enter in column t and enter in column						
						1. 00	
ACA Provisions Affecting the F 2.00 Enter the number of FTE reside your hospital received HRSA PC	nts that your hospital	trai ne			od for which	0.00	62.0
2.01 Enter the number of FTE reside during in this cost reporting Teaching Hospitals that Claim	nts that rotated from a period of HRSA THC pro	a Teachi gram. (:	<u>see instructio</u>		your hospital	0.00	62.0
3.00 Has your facility trained resi	dents in nonprovider se	ettings	during this c		oeriod? Enter	N	63.0
				Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				Si te			
Section 5504 of the ACA Base Y				1.00 This base year	2.00 is your cost	3.00 reporting	
period that begins on or after 4.00 Enter in column 1, if line 63 in the base year period, the r resident FTEs attributable to settings. Enter in column 2 t resident FTEs that trained in of (column 1 divided by (column	is yes, or your faciliumber of unweighted non rotations occurring in he number of unweighted your hospital. Enter in	ty train n-priman all non d non-pr n column	ned residents ry care nprovider rimary care n 3 the ratio	0.00	0.00	0. 000000	64.0
	Program Name		ogram Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
5.00 Enter in column 1, if line 63	1. 00		2. 00	3. 00 0. 00	4. 00 0. 00	5. 00 0. 000000	65.0
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 i column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column	n			3. 30	3. 50	0.00000	. 33. 0

Health Financial Systems METHODIST HOSPI				Li eu	of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der C	Fr	eriod: com 01/01/		Worksheet S- Part I	_
		To		2016	Date/Time Pr 5/26/2017 1:	
			V 1. 00		XI X 2. 00	_
95.00 If line 94 is "Y", enter the reduction percentage in the appl 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes			0. 00 N		0. 00 N	95. 00 96. 00
applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the appl Rural Providers	licable colum	nn.	0. 00		0. 00	97. 00
105.00 Does this hospital qualify as a critical access hospital (CAI 106.00 of this facility qualifies as a CAH, has it elected the all-ifor outpatient services? (see instructions)		thod of payment	N N			105. 00 106. 00
107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.	1. (see inst	tructions) If	N			107. 00
108.00 Is this a rural hospital qualifying for an exception to the (CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N			108.00
_	Physi cal 1. 00	0ccupati onal 2.00	Speech 3. 00	1	Respi ratory 4.00	<u>'</u>
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 N	109. 00
					1. 00	
110.00 Did this hospital participate in the Rural Community Hospital the current cost reporting period? Enter "Y" for yes or "N"		on project (41	OA Demo)fo	r	N	110.00
				1. 00	2.00 3.00)
Miscellaneous Cost Reporting Information 115.00 s this an all-inclusive rate provider? Enter "Y" for yes or	"N" for no i	n column 1 lf	column 1	N	0	115. 00
is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers Pub. 15-1, chapter 22, §2208.1.	If column 2 t for long te	is "E", enter erm care (inclu	in column des	IN		115.00
116.00 s this facility classified as a referral center? Enter "Y" 1117.00 s this facility legally-required to carry malpractice insura			"N" for	N Y		116. 00 117. 00
no. 118.00 Is the malpractice insurance a claims-made or occurrence policlaim-made. Enter 2 if the policy is occurrence.	icy? Enter 1	if the policy	is	1		118.00
		Premi ums	Losses	6	Insurance	
		1.00	2.00		2.00	
118.01 List amounts of malpractice premiums and paid losses:		1, 830, 012	2. 00	0	3. 00 228, 1 ⁴	13 118. 01
			1. 00		2. 00	_
118.02 Are mal practice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting scheduland amounts contained therein.			N		2.00	118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified Harmless provision in ACA §3121 and applicable amendments	column 1, ̈"۱ alifies for t	/" for yes or the Outpatient	N		N	119. 00 120. 00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implaid patients? Enter "Y" for yes or "N" for no.	ntable device	es charged to	Y			121.00
122.00 Does the cost report contain state health or similar taxes? I for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included.			N			122. 00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	r yes and "N"	for no. If	N			125. 00
126.00 If this is a Medicare certified kidney transplant center, enlin column 1 and termination date, if applicable, in column 2.		fication date				126. 00
127.00 If this is a Medicare certified heart transplant center, ento in column 1 and termination date, if applicable, in column 2.	er the certif					127. 00
128.00 If this is a Medicare certified liver transplant center, ento	er the certif	cation date				128.00
in column 1 and termination date, if applicable, in column 2.		cation date in				
in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, or	r the certifi					129. 00 130. 00
129.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.	r the certifi enter the cer umn 2. , enter the c	rti fi cati on				

ealth Financial Systems METHODIS OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT	TA Provi dei	r CCN: 15-0002	Peri od		Worksheet S-	-2
				1/01/2016 2/31/2016	Date/Time Pr	
					5/26/2017 1:	14 pm
				1. 00	2. 00	
33.00 If this is a Medicare certified other transplant center in column 1 and termination date, if applicable, in column 1	olumn 2.					133. 0
34.00 of this is an organ procurement organization (0PO), en and termination date, if applicable, in column 2.	nter the OPO numb	per in column 1				134. 0
All Providers 40.00Are there any related organization or home office cos	ts as defined in	CMS Pub. 15-1,		N		140.0
chapter 10? Enter "Y" for yes or "N" for no in column are claimed, enter in column 2 the home office chain i	number. (see inst		sts			
1.00 If this facility is part of a chain organization, ent	2.00	 		3.00	-6 +1	
office and enter the home office contractor name and			e name ar	iu auui ess	or the nome	
41.00 Name: Contractor's Na	ame:	Contrac	ctor's Nu	umber:		141. (
42.00 Street: PO Box: 43.00 City: State:		Zip Cod	10.			142. (
+3. OO O ty. State.		ZI P COO	ic.			143. (
					1.00	
44.00 Are provider based physicians' costs included in Work	sheet A?				Y	144. (
				1. 00	2. 00	
45.00 If costs for renal services are claimed on Wkst. A, I				Υ		145. (
inpatient services only? Enter "Y" for yes or "N" for no, does the dialysis facility include Medicare utili:			5			
period? Enter "Y" for yes or "N" for no in column 2.	2011011101 11113	ost reporting				
46.00 Has the cost allocation methodology changed from the p	previously filed	cost report?		N		146. (
Enter "Y" for yes or "N" for no in column 1. (See CMS yes, enter the approval date (mm/dd/yyyy) in column 2		er 40, §4020)	If			
yes, enter the approval date (min/da/yyyy) in cordini 2	•					
47 00 Was there a shares in the statistical hasing Fator IIV	"	£			1.00	1.47
47.00Was there a change in the statistical basis? Enter "Y' 48.00Was there a change in the order of allocation? Enter '					N N	147. (148. (
49.00 Was there a change to the simplified cost finding met	hod? Enter "Y" fo	or yes or "N" f			N	149. (
	Part A		Т	itle V	Title XIX 4.00	
Does this facility contain a provider that qualifies	for an exemption	from the appl	cation o	3.00 of the low		
or charges? Enter "Y" for yes or "N" for no for each				12 CFR §41	3. 13)	
55.00 Hospital 56.00 Subprovider - IPF	N	N		N	N N	155.0
55. 00 Subprovider - TPF 57. 00 Subprovider - TRF	N N	N N		N N	N N	156. (157. (
58. 00 SUBPROVI DER						158. 0
59. 00 SNF	N	N		N	N	159. (
60.00 HOME HEALTH AGENCY 61.00 CMHC	N	l N N		N N	N N	160. (161. (
or. oo cwire		IV.		IN	14	101.0
Multicampus					1. 00	
65.00 s this hospital part of a Multicampus hospital that Enter "Y" for yes or "N" for no.	has one or more o	campuses in dif	ferent C	BSAs?	N	165. (
Name	County		Zip Code	CBSA	FTE/Campus	
0	1. 00	2. 00	3. 00	4. 00	5. 00	201444
66.00 If line 165 is yes, for each campus enter the name in column					0.0	00 166. (
O, county in column 1, state in						
column 2, zip code in column 3,						
CBSA in column 4, FTE/Campus in column 5 (see instructions)						
co. a.m. o (coo mott dott one)	1	1			1 00	
Health Information Technology (HIT) incentive in the	American Recovery	and Reinvesti	ment Act		1.00	
		or "N" for no.			Y	167. (
			/11.5		I	d168. (
67.00 s this provider a meaningful user under §1886(n)? Ei 68.00 olf this provider is a CAH (line 105 is "Y") and is a i		(line 167 is "\	m), ente	er the		
68.00 If this provider is a CAH (line 105 is "Y") and is a more asonable cost incurred for the HIT assets (see instructions).	ructions)	•				168 (
68.00 If this provider is a CAH (line 105 is "Y") and is a \circ	ructions) r, does this prov or "N" for no. (s	vider qualify f see instruction	for a har ns)	dshi p		168. (99169. (

Health Financial Systems	METHODIST HOSPIT	TALS, INC	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTI	FICATION DATA		Peri od:	Worksheet S-2	2
			From 01/01/2016		
		To 12/31/2016			
			5/26/2017 1:1	4 pm	
			Begi nni ng	Endi ng	
			1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beginning	10/02/2016	12/30/2016	170.00		
period respectively (mm/dd/yyyy)	-				
			1. 00	2.00	
171.00 If line 167 is "Y", does this provider ha	N	C	171. 00		
section 1876 Medicare cost plans reported					
"Y" for yes and "N" for no in column 1. I	f column 1 is ves. ei	nter the number of section	on		
1876 Medicare days in column 2. (see inst					
1070 moundar of days 111 oor dimit 21 (600 11161)	40110110)		The state of the s	I	1

Heal th	Financial Systems METHODIST HOS	SPITALS, INC		In Lie	u of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Peri od:	Worksheet S-2	
				From 01/01/2016 To 12/31/2016		epared:
				\/ (N	5/26/2017 1: 1	
				Y/N 1. 00	2.00	
	General Instruction: Enter Y for all YES responses. Enter	N for all NO re	esponses. Ente			
	mm/dd/yyyy format.					-
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					+
1.00	Has the provider changed ownership immediately prior to th	e beginning of	the cost	N		1.00
	reporting period? If yes, enter the date of the change in	column 2. (see		D. L.	\/ /I	
			1. 00	Date 2.00	V/I 3. 00	
2. 00	Has the provider terminated participation in the Medicare		N N	2.00	0.00	2.00
	yes, enter in column 2 the date of termination and in colu	mn 3, "V" for				
3. 00	voluntary or "I" for involuntary. Is the provider involved in business transactions, includi	na management	l N			3.00
0.00	contracts, with individuals or entities (e.g., chain home					0.00
	or medical supply companies) that are related to the provi					
	officers, medical staff, management personnel, or members of directors through ownership, control, or family and oth					
	relationships? (see instructions)	er simirai				
			Y/N	Type	Date	
	Einancial Data and Deports		1.00	2. 00	3. 00	
4. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cer	tified Public	Υ	Α	04/07/2017	4.00
	Accountant? Column 2: If yes, enter "A" for Audited, "C"					
	or "R" for Reviewed. Submit complete copy or enter date av	ailable in				
5. 00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diff	erent from	l N			5.00
	those on the filed financial statements? If yes, submit re					0.00
				Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
6.00	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is t	he provider is	N		6.00
	the legal operator of the program?					
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see i Were nursing school and/or allied health programs approved		d during the	Y		7. 00 8. 00
8.00	cost reporting period? If yes, see instructions.	and/or renewer	a durring the	'		8.00
9. 00	Are costs claimed for Interns and Residents in an approved		cal education	Υ		9. 00
10. 00	program in the current cost report? If yes, see instructio Was an approved Intern and Resident GME program initiated		the current	N		10.00
10.00	cost reporting period? If yes, see instructions.	or renewed in	the current	IN		10.00
11. 00	Are GME cost directly assigned to cost centers other than	I & R in an Ap	proved	N		11.00
	Teaching Program on Worksheet A? If yes, see instructions.				Y/N	
					1.00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If ye			st roporting	Y N	12.00 13.00
13. 00	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.	porrey change	during this co	st reporting	IN IN	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-paym	ents waived? I	fyes, see ins	tructi ons.	N	14. 00
15 00	Bed Complement				N.	15 00
15.00	Did total beds available change from the prior cost report		<u>yes, see rnst</u> t A		t B	15.00
		Y/N	Date	Y/N	Date	
	DOAD D. J.	1.00	2. 00	3. 00	4. 00	
16. 00	PS&R Data Was the cost report prepared using the PS&R Report only?	l N		N		16.00
10.00	If either column 1 or 3 is yes, enter the paid-through					10.00
	date of the PS&R Report used in columns 2 and 4 (see					
17. 00	instructions) Was the cost report prepared using the PS&R Report for	Y	03/23/2017	Υ	03/23/2017	17. 00
17.00	totals and the provider's records for allocation? If	'	03/23/2017	'	03/23/2017	17.00
	either column 1 or 3 is yes, enter the paid-through date					
18 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18.00
10.00	Report data for additional claims that have been billed	IN IN		I V		13.00
	but are not included on the PS&R Report used to file this					
19. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19.00
17.00	Report data for corrections of other PS&R Report	IN IN		IN.		17.00
	information? If yes, see instructions.					

Heal th	Financial Systems METHODIST HO	SPITALS, INC		In Lie	u of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0002	Peri od: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II	epared:
		Descr	iption	Y/N	Y/N	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R		0	1. 00 N	3. 00 N	20.00
20.00	Report data for Other? Describe the other adjustments:			IN.	IV	20.00
		Y/N	Date	Y/N	Date	
21. 00	Was the cost report prepared only using the provider's	1.00 N	2.00	3. 00 N	4. 00	21.00
21.00	records? If yes, see instructions.	IN IN		14		21.00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	CEPT CHILDRENS	HOSPI TALS)			
22. 00	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, se	aa instructions		-	N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.			ing the cost	IV	23. 00
24. 00	Were new leases and/or amendments to existing leases enter If yes, see instructions	eporting period?		24. 00		
25. 00	Have there been new capitalized leases entered into during instructions.	? If yes, see		25. 00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during tinstructions.	f yes, see		26. 00		
27. 00	Has the provider's capitalization policy changed during the copy.	ne cost reporti	ng period? If	f yes, submit		27. 00
28. 00	Interest Expense Were new loans, mortgage agreements or letters of credit e	t reporting		28. 00		
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		29. 00			
30. 00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat instructions.	s, see		30.00		
31. 00	Has debt been recalled before scheduled maturity without instructions.		31.00			
32. 00	Purchased Services Have changes or new agreements occurred in patient care se		ed through co	ontractual	N	32.00
33. 00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.		ng to competi	tive bidding? If	N	33.00
	Provi der-Based Physi ci ans					
34. 00	Are services furnished at the provider facility under an a lf yes, see instructions.	arrangement wit	h provi der-ba	ased physicians?	Υ	34.00
35. 00	If line 34 is yes, were there new agreements or amended exphysicians during the cost reporting period? If yes, see i		nts with the	provi der-based	N	35. 00
	This contains during the occur reporting portion in year occur.	1.51. 451. 61.6.		Y/N	Date	
	Home Office Costs			1. 00	2. 00	
36 00	Home Office Costs 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 If yes, see instructions.	prepared by the	home office?			37. 00
38. 00	If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year er			N		38. 00
39. 00				s, N		39. 00
40. 00	If line 36 is yes, did the provider render services to the instructions.		40. 00			
		00				
	Cost Report Preparer Contact Information		00			
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MI CHAEL		ALESSANDRI NI		41.00
42. 00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LL	_C			42.00
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7959		MALESSANDRI NI @	BLUEANDCO. COM	43.00

Health Financial Systems METH	HODIST HOS	SPITALS, INC		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTION	NNAI RE	Provi der CCI		Peri od: From 01/01/2016	Worksheet S-2 Part II	
					Date/Time Pre	pared:
					5/26/2017 1:1	4 pm
		3.0	0			
Cost Report Preparer Contact Information						
41.00 Enter the first name, last name and the title/pos	sition	DI RECTOR				41.00
held by the cost report preparer in columns 1, 2,	, and 3,					
respectively.						
42.00 Enter the employer/company name of the cost repor	rt					42.00
preparer.						
43.00 Enter the telephone number and email address of t	the cost					43.00
report preparer in columns 1 and 2, respectively.						
· · · · · · · · · · · · · · · · · · ·						-

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

					Τ	o 12/31/2016	Date/Time Pre 5/26/2017 1:1	
							I/P Days /	T PIII
							0/P Visits /	
							Trips	
	Component	Worksheet A	No.	. of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1. 00		2. 00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		370	135, 420	0. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
2. 00	for the portion of LDP room available beds) 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						Ö	6.00
7. 00	Total Adults and Peds. (exclude observation			370	135, 420	0. 00	0	7. 00
7.00	beds) (see instructions)			0,0	100, 120	0.00	o l	7.00
8.00	INTENSIVE CARE UNIT	31. 00		33	12, 078	0.00	0	8. 00
8. 01	NEONATAL ICU	31. 01		35			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)			438	160, 308	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		39	14, 274		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						_	21.00
22. 00	HOME HEALTH AGENCY	101. 00					0	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23.00
24. 00	HOSPI CE	20.00						24.00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
26.00	RURAL HEALTH CLINIC	89. 00					0	26. 00 26. 25
26. 25 27. 00	FEDERALLY QUALIFIED HEALTH CENTER	89.00		489			U	26. 25
28. 00	Total (sum of lines 14-26) Observation Bed Days			409			0	28.00
29.00	Ambulance Trips						U	29.00
30.00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days (see Fristraction)							31.00
32. 00	Labor & delivery days (see instructions)			0	(,		32.00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33.00	LTCH non-covered days							33.00

| Period: | Worksheet S-3 | From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared: Provi der CCN: 15-0002

				Т	o 12/31/2016	Date/Time Pre 5/26/2017 1:1	
		I/P Davs	/ O/P Visits	/ Trips	Full Time Equivalents		4 pili
						1	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
		6. 00	7. 00	Patients 8.00	& Residents 9.00	Payrol I 10. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		3, 213	75, 634	7.00	10.00	1.00
1.00	8 exclude Swing Bed, Observation Bed and	30, 07 1	3, 213	75,054			1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	3, 593	24, 919				2.00
3.00	HMO IPF Subprovider	0	o				3.00
4.00	HMO IRF Subprovider	0	1, 428				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	O	o	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		o	0			6.00
7.00	Total Adults and Peds. (exclude observation	30, 671	3, 213	75, 634			7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	3, 562	0	8, 305			8.00
8. 01	NEONATAL I CU	0	0	3, 489			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, 802			13.00
14. 00	Total (see instructions)	34, 233	3, 213	90, 230	2. 93	2, 079. 51	14. 00
15. 00	CAH visits	0	0	0			15.00
16. 00	SUBPROVI DER - I PF	1, 614	525	2, 967	0.00	13. 54	1
17. 00	SUBPROVIDER - IRF	6, 219	94	10, 240	0. 00	47. 35	1
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	7 401	4 2/2	10 250	0.00	24.72	21.00
22.00	HOME HEALTH AGENCY	7, 431	4, 362	19, 359	0. 00	24. 62	1
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24. 00 24. 10	HOSPICE	0	0	0			24. 00 24. 10
25. 00	HOSPICE (non-distinct part) CMHC - CMHC	U	٩	Ü			25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	
27. 00	Total (sum of lines 14-26)	o _l	٩	Ü	2. 93	2, 165. 02	
28. 00	Observation Bed Days		0	19, 384	2. 73	2, 103. 02	28.00
29.00	Ambulance Trips	0	٩	17, 304			29.00
30.00	Employee discount days (see instruction)	١		0			30.00
31. 00	Employee discount days (see Fristraction)			0			31.00
32. 00	Labor & delivery days (see instructions)	0	79	85			32.00
32. 01	Total ancillary labor & delivery room		′′	0			32.00
02.01	outpatient days (see instructions)			O			32.0.
33.00	LTCH non-covered days	o					33.00
	·		'			•	•

Provider CCN: 15-0002

Full Time					To	12/31/2016	Date/Time Pre 5/26/2017 1:1	
Nonpail Workers Title V Title XIV Patients					Di sch	arges		
Norters								
11.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 4493 4,097 2.00 40		Component	· ·	Title V	Title XVIII	Title XIX		
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 HM0 and other (see instructions) 3.00 HM0 IPF Subprovider 4.00 0.00 HM0 IPF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed SNF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.01 INTENSIVE CARE UNIT 8.00								
Hospi ce days) (see instructions for col. 2 7	1. 00			0	5, 926	418	15, 584	1. 00
For the portion of LDP room available beds) 2.00 Mol and other (see instructions) 4.007 2.00 3.00 4.00 Mol per Subprovider 9.00 3.00 4.00 Mol per Subprovider 9.00 6.00 Mospital Adults & Peds. Swing Bed SNF 6.00 7.00								
2.00 HM0 and other (see instructions)								
MMO IPF Subprovi der								
HMO IRF Subprovider					493			
5.00						٧,		
6.00 Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 8.00 10 10 10 10 10 10 10						99		
7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 NTENSIVE CARE UNIT 8.00 NTENSIVE CARE UNIT 9.00 0.00								
BedS (See instructions) 8.00 1NTENSIVE CARE UNIT 8.01 1NTENSIVE CARE UNIT 9.00 1.00 10.00 11.00 1								
8. 00 NTENSIVE CARE UNIT	7. 00	`						7. 00
8. 01 NEONATAL ICU CORONARY CARE UNIT 9. 00 11. 00 SURRI (ALL INTENSIVE CARE UNIT 10. 00 11. 00		, ,						
9.00 CORONARY CARE UNIT								
10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 12.00 13.00 14.00 15.00 15.926 418 15.584 15.584 15.00 15.00 15.00 16.00 1								
11. 00 SURGICAL INTENSIVE CARE UNIT 11. 00 12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 13. 00 NURSERY 15. 00 CAH visits 15. 0								
12. 00 13. 00 13. 00 14. 00 15. 00 15. 00 15. 00 16. 00 15. 00 16. 00 18. 00 18. 00 18. 00 19								
13. 00 14. 00 14. 00 15, 926 18 15, 594 14. 00 16. 00 16. 00 17. 00 18. 00 18. 00 19.								
14. 00 Total (see instructions) 0. 00 0 5, 926 418 15, 584 14. 00 15. 00 CAH visits 0. 00 0 92 0 242 16. 00 17. 00 SUBPROVI DER - IPF 0. 00 0 0 449 8 723 17. 00 18. 00 SUBPROVI DER - IRF 0. 00 0 0 449 8 723 17. 00 18. 00 SUBPROVI DER 0. 00 0 0 0 0 19. 00 SKILLED NURSING FACILITY 0. 00 19. 00 NURSING FACILITY 0. 00 19. 00 OTHER LONG TERM CARE 0. 00 22. 00 HOME HEALTH AGENCY 0. 00 23. 00 AMBULATORY SURGI CAL CENTER (D. P.) 22. 00 24. 10 HOSPI CE 0. 00 0 24. 10 HOSPI CE 0. 00 25. 00 CMHC - CMHC 24. 10 26. 00 RURAL HEALTH CLINIC 26. 25 27. 00 Observation Bed Days 0. 00 29. 00 Ambulance Trips 0. 00 20. 00 Cmpl oyee discount days (see instruction) 32. 00 32. 00 Total (sum of lines 14-26) 0. 00 32. 00 Total (sum of lines 14-26) 0. 00 33. 00 Empl oyee discount days (see instructions) 32. 00 30. 00 Empl oyee discount days (see instructions) 32. 01 33. 00 Total (sum of lines 14-26) 0. 00 33. 00 Total (sum of lines 14-26) 0. 00 34. 00 0. 00 0. 00 35. 00 0. 00 0. 00 36. 00 0. 00 0. 00 37. 00 0. 00 0. 00 38. 00 0. 00 0. 00 39. 00 0		` ′						
15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER 19. 00 SKILLED NURSING FACILITY 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 24. 10 HOSPICE 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 00 Observation Bed Days 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trip ps 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01		1						
16.00 SUBPROVIDER - IPF 0.00 0 92 0 242 16.00 17.00 SUBPROVIDER - IRF 0.00 0 449 8 723 17.00 18.00 SUBPROVIDER SKILLED NURSING FACILITY 19.00 19.00 SKILLED NURSING FACILITY 20.00 19.00 HOME HEALTH AGENCY 21.00 22.00 HOME HEALTH AGENCY 0.00 23.00 AMBULATORY SURGICAL CENTER (D.P.) 23.00 24.10 HOSPICE 24.10 25.00 CMHC - CMHC 25.00 26.00 RURAL HEALTH CLINIC 25.00 26.00 RURAL HEALTH CLINIC 26.00 27.00 Total (sum of lines 14-26) 0.00 28.00 Observation Bed Days 28.00 29.00 Ambul ance Trips 30.00 30.00 Employee discount days (see instruction) 31.00 31.00 Employee discount days (see instructions) 32.01 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 32.01			0. 00	0	5, 926	418	15, 584	
17. 00 SUBPROVIDER - IRF								
18.00 SUBPROVI DER 18.00 19.00 SKI LLED NURSI NG FACI LI TY 19.00 20.00 NURSI NG FACI LI TY 20.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 0.00 23.00 AMBULATORY SURGI CAL CENTER (D. P.) 23.00 24.00 HOSPI CE (non-distinct part) 24.10 HOSPI CE (non-distinct part) 24.10 25.00 CMHC - CMHC 25.00 CMHC - CMHC 26.00 26.25 FEDERALLY QUALIFIED HEALTH CENTER 0.00 27.00 28.00 Observation Bed Days 29.00 Ambul ance Trips 29.00 28.00 29.00 Ambul ance Trips 29.00 29.00 Ambul ance Trips 29.00		1		-		0		
19. 00 20. 00 19			0. 00	0	449	8	723	
20.00 NURSING FACILITY 20.00 21.00 21.00 22.								
21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 44.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 26.25 Total (sum of lines 14-26) 27.00 Observation Bed Days 29.00 Ambul ance Trips 29.00 Labor & delivery days (see instruction) Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 31.00 Total ancillary labor & delivery room outpatient days (see instructions) 32.01								
22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 26. 25 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 29. 00 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)								
23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 Total (sum of lines 14-26) 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01								
24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 26. 25 FEDERALLY OUALIFIED HEALTH CENTER 26. 25 FOO Total (sum of lines 14-26) 27. 00 Observation Bed Days 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01			0.00					
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 Total (sum of lines 14-26) 27. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 Total ancillary labor & see instructions)								
25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 26. 25 27. 00 Total (sum of lines 14-26) 27. 00 28. 00 Observation Bed Days 29. 00 Ambulance Trips 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)								
26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)								
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0. 00 27. 00 28. 00 Observation Bed Days 28. 00 Ambul ance Trips 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)								
27. 00 Total (sum of lines 14-26)		1	0.00					
28.00 Observation Bed Days 29.00 Ambulance Trips 29.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 32.01								
29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)			0.00					
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 31.00 agr. 32.01								
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 31.00 32.01								
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 32.00								
32.01 Total ancillary labor & delivery room outpatient days (see instructions) 32.01								
outpati ent days (see instructions)								
	32.01							32. U I
	33 00	,				1		33 00
	33.00	Eron non covered days	ļ	l	I	I	l	33.00

HOSPI T	AL WAGE INDEX INFORMATION			Provi der C		Peri od:	Worksheet S-3	
						rom 01/01/2016 o 12/31/2016	Part II Date/Time Pre 5/26/2017 1:1	pared: 4 pm
		Worksheet A Line Number	Amount Reported	Reclassificat ion of Salaries (from Worksheet	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (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	147, 977, 382	-386, 884	147, 590, 498	4, 503, 234. 00	32. 77	1.00
2. 00	instructions) Non-physician anesthetist Part		0	0	C	0.00	0. 00	2. 00
3. 00	A Non-physician anesthetist Part		0	0	C	0.00	0. 00	3. 00
4. 00	B Physician-Part A -		0	0	C	0.00	0. 00	4. 00
4. 01	Administrative Physicians - Part A - Teaching		0	0	(0.00	0.00	
5. 00 6. 00	Physician and Non Physician-Part B Non-physician-Part B for		0	0		0.00	0. 00 0. 00	
0.00	hospi tal -based RHC and FQHC services		J	O		0.00	0.00	0.00
7. 00	Interns & residents (in an approved program)	21. 00	0	0	C	0.00	0. 00	7. 00
7. 01	Contracted interns and residents (in an approved		227, 722	0	227, 722	6, 240. 00	36. 49	7. 01
8. 00	programs) Home office and/or related		0	O	C	0.00	0. 00	8. 00
9. 00	organization personnel SNF	44.00	0	О	C	0.00	0. 00	9. 00
10. 00	Excluded area salaries (see instructions)		28, 777, 108	230, 732	29, 007, 840	554, 465. 00	52. 32	10.00
11. 00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		4, 435, 085	0	4, 435, 085	95, 781. 00	46.30	11.00
12. 00	Care Contract labor: Top level		4, 433, 003	0				12. 00
	management and other management and administrative							
13. 00	services Contract Labor: Physician-Part		855, 310	0	855, 310	7, 030. 00	121. 67	13. 00
14. 00	A - Administrative Home office and/or related orgainzation salaries and		0	О	C	0.00	0. 00	14. 00
	wage-related costs							
14. 01 14. 02	Home office salaries Related organization salaries		0	0		0.00		14. 01 14. 02
15. 00	Home office: Physician Part A		0	0		0.00		15. 00
	- Administrative Home office and Contract		0	0		0.00	0. 00	
	Physicians Part A - Teaching WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see instructions)		35, 171, 451	0	35, 171, 451			17. 00
18. 00	Wage-related costs (other) (see instructions)		0	O	C			18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		5, 977, 234 0	0	5, 977, 234 C	1		19. 00 20. 00
21. 00	A Non-physician anesthetist Part		0	0	C			21. 00
22. 00	Physician Part A - Administrative		0	0	C			22. 00
22. 01	Physician Part A - Teaching		o	o	C			22. 01
23. 00		1	o	0	C			23. 00
24. 00 25. 00	Interns & residents (in an		0 0	0	(24. 00 25. 00
25. 50	approved program) Home office wage-related			0	,			25. 50
25. 51	Related orgainzation wage-related		0	0				25. 51
25. 52	Home office: Physician Part A - Administrative -		0	О	C			25. 52
25. 53	wage-related Home office & Contract Physicians Part A - Teaching -		0	0	C			25. 53
	wage-related							

	Titlancial Systems		WETHODIST HOS			THI LIC	d of Torin civio 2	
HOSPI T	HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 15-0002 Period:			Worksheet S-3	
						From 01/01/2016		
						To 12/31/2016	Date/Time Pre 5/26/2017 1:1	
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Pai d Hours	Average	4 piii
		Line Number	Reported	i on of	Sal ari es	Related to	Hourly Wage	
		Li ile ivallibei	Reported	Sal ari es	(col. 2 ± col.		(col. 4 ÷	
				(from	3)	col . 4	col . 5)	
				Worksheet		COI. 4	COI. 3)	
				A-6)				
		1. 00	2. 00	3. 00	4.00	5. 00	6. 00	
	OVERHEAD COSTS - DIRECT SALARI	ES						
26.00	Employee Benefits Department	4. 00	1, 625, 177	-110, 309	1, 514, 86	8 34, 918. 00	43. 38	26.00
27.00	Administrative & General	5. 00	21, 040, 088	-536, 946	20, 503, 14	2 668, 907. 00	30. 65	27.00
28.00	Administrative & General under		1, 210, 499	0	1, 210, 49	9 4, 802. 00	252. 08	28. 00
	contract (see inst.)							
29.00	Maintenance & Repairs	6. 00	0	0		0.00	0. 00	29.00
30.00	Operation of Plant	7. 00	3, 599, 819	-8, 518	3, 591, 30	1 158, 847. 00	22. 61	30.00
31.00	Laundry & Linen Service	8. 00	0	0		0.00	0. 00	31.00
32.00	Housekeepi ng	9. 00	4, 738, 469	-29, 136	4, 709, 33	303, 696. 00	15. 51	32.00
33.00	Housekeeping under contract		0	0		0.00	0.00	33.00
	(see instructions)							
34.00	Dietary	10.00	3, 077, 411	-939, 899	2, 137, 51	2 122, 058. 00	17. 51	34.00
35.00	Di etary under contract (see		0	0		0.00	0. 00	35.00
	instructions)							
36.00	Cafeteri a	11. 00	331, 313	929, 933	1, 261, 24	6 71, 687. 00	17. 59	36.00
37.00	Maintenance of Personnel	12.00	0	0		0.00	0. 00	37.00
38.00	Nursing Administration	13. 00	2, 705, 196	-14, 954	2, 690, 24	2 62, 159. 00	43. 28	38. 00
39.00	Central Services and Supply	14. 00	561, 047	-5, 187	555, 86	0 30, 532. 00	18. 21	39. 00
40.00	Pharmacy	15. 00	0	0		0.00		40.00
41.00	Medical Records & Medical	16. 00	2, 037, 106	-184	2, 036, 92	2 85, 022. 00	23. 96	41.00
	Records Library							
42.00	Social Service	17. 00	75, 566	492, 378	567, 94	4 18, 728. 00	30. 33	42.00
43.00	Other General Service	18. 00	. 0			0.00	0.00	43.00
	1			•	•			

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10
HOSPITAL WAGE INDEX INFORMATION	Provi der CCN: 15-0002	Peri od: Worksheet S-3 From 01/01/2016 Part III To 12/31/2016 Date/Time Prepared: 5/26/2017 1:14 pm

					T	o 12/31/2016	Date/Time Pre 5/26/2017 1:1	
		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		148, 960, 159	-386, 884	148, 573, 275	4, 501, 796. 00	33. 00	1.00
	instructions)							
2.00	Excluded area salaries (see		28, 777, 108	230, 732	29, 007, 840	554, 465. 00	52. 32	2.00
	instructions)							
3. 00	Subtotal salaries (line 1		120, 183, 051	-617, 616	119, 565, 435	3, 947, 331. 00	30. 29	3.00
	minus line 2)							
4. 00	Subtotal other wages & related		5, 290, 395	0	5, 290, 395	102, 811. 00	51. 46	4.00
	costs (see inst.)			_				
5. 00	Subtotal wage-related costs		35, 171, 451	0	35, 171, 451	0. 00	29. 42	5. 00
	(see inst.)							
6. 00	Total (sum of lines 3 thru 5)		160, 644, 897					
7. 00	Total overhead cost (see		41, 001, 691	-222, 822	40, 778, 869	1, 561, 356. 00	26. 12	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	Peri od: Worksheet S-3
		From 01/01/2016 Part IV

	To 12/31/2016	Date/Time Pre 5/26/2017 1:1	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		1
1.00	401K Employer Contributions	2, 132, 187	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	6, 684, 027	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7. 00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		1
8. 00	Health Insurance (Purchased or Self Funded)	16, 160, 645	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)	0	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	2, 776, 442	9.00
10.00	Dental, Hearing and Vision Plan	1, 105, 426	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	506, 635	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
	Disability Insurance (If employee is owner or beneficiary)	0	13.00
	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00		1, 166, 470	15.00
16.00	· ·	0	1
	Non cumulative portion)		1
	TAXES		1
17.00	FICA-Employers Portion Only	10, 153, 082	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
	Unemployment Insurance	175, 328	19.00
20.00	State or Federal Unemployment Taxes		20.00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21.00
	instructions))		
22. 00	Day Care Cost and Allowances	l ol	22.00
	Tuition Reimbursement	288, 443	23.00
	Total Wage Related cost (Sum of lines 1 -23)	41, 148, 685	
	Part B - Other than Core Related Cost	, , , , , , , , , , , , , , , , , , , ,	
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00
			•

11 1.11.	Floor tal Contain	METHODI CT HOCDI	FALC. INC.	1 . 11	C. E OHC. (2550 40
	Financial Systems	METHODIST HOSPIT			u of Form CMS-2	
HOSPLI	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0002	Peri od: From 01/01/2016	Worksheet S-3 Part V	
					Date/Time Pre	narod:
				10 12/31/2010	5/26/2017 1: 1	4 pm
	Cost Center Description			Contract	Benefit Cost	
				Labor		
				1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost					
	Hospital and Hospital-Based Component Identi					
1.00	Total facility's contract labor and benefit	cost		0	41, 148, 685	1.00
2.00	Hospi tal			0	41, 148, 685	2.00
3.00	Subprovi der - IPF			0	0	3.00
4.00	Subprovider - IRF			0	0	4.00
5.00	Subprovider - (Other)			0	0	5.00
6.00	Swing Beds - SNF			0	0	6.00
7.00	Swing Beds - NF			0	0	7. 00
8.00	Hospi tal -Based SNF					8. 00
9.00	Hospi tal -Based NF					9. 00
10.00	Hospi tal -Based OLTC					10.00
11.00	Hospi tal -Based HHA			0	0	11.00
12.00	Separately Certified ASC					12.00
13.00	Hospi tal -Based Hospi ce					13.00
14.00	Hospital-Based Health Clinic RHC					14.00
15.00	Hospital-Based Health Clinic FQHC					15. 00
16.00	Hospi tal -Based-CMHC					16.00
17. 00	Renal Dialysis			0	0	17.00
18.00	Other			0	0	18. 00

Heal th	Financial Systems	METHODIST HOS	SPITALS, INC		In Lie	u of Form CMS-2	2552-10
HOME H	EALTH AGENCY STATISTICAL DATA			F	eriod: rom 01/01/2016		
			Component	CCN: 15-7536 To	o 12/31/2016	5/26/2017 1:1	
					Home Health Agency I	PPS	
					1.	00	
0. 00	County	Title V	Title XVIII	Title XIX	Other	Total	0.00
	LIOME LIEALTH ACENCY STATISTICAL DATA	1.00	2.00	3.00	4. 00	5. 00	
1. 00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	0	_				1. 00
2. 00	Unduplicated Census Count (see instructions)	0.00	349.00	0.00 Number of Empl			2. 00
				·		•	
		Entor the numb	on of bound in	Ctoff	Contract	Total	
			er of hours in I work week	Staff	Contract	Total	
		(0	1.00	2. 00	3. 00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						0.00
3. 00 4. 00	Administrator and Assistant Administrator(s) Director(s) and Assistant Director(s)		40. 00	0. 00 0. 00			3. 00 4. 00
5. 00 6. 00	Other Administrative Personnel Direct Nursing Service			6. 41 10. 11			5. 00 6. 00
7. 00	Nursing Supervisor			0.00			7. 00
8. 00 9. 00	Physical Therapy Service Physical Therapy Supervisor			4. 29 0. 00			8. 00 9. 00
10.00	Occupational Therapy Service			1. 05			10.00
11. 00 12. 00	Occupational Therapy Supervisor Speech Pathology Service			0. 00 0. 46			11. 00 12. 00
13. 00	Speech Pathology Supervisor			0.46			
14. 00 15. 00	Medical Social Service Medical Social Service Supervisor			0. 00 0. 00			
16.00	Home Health Aide			2. 24			16.00
17. 00 18. 00	Home Health Aide Supervisor Other (specify)			0. 00 0. 00			
	HOME HEALTH AGENCY CBSA CODES			0.00	0.00	0.00	
19. 00	Enter in column 1 the number of CBSAs where you provided services during the cost			1			19. 00
20.00	reporting period.			23844			20.00
20. 00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20			23844			20. 00
	contains the first code).	Full Fr	pi sodes				
		Wi thout Outliers		LUPA Epi sodes	PEP Only Episodes	Total (cols. 1-4)	
	PDC ACTIVITY DATA	1.00	2.00	3.00	4. 00	5. 00	
21. 00	PPS ACTIVITY DATA Skilled Nursing Visits	3, 000	239	144	172	3, 555	21. 00
22.00	Skilled Nursing Visit Charges Physical Therapy Visits	472, 059					22.00
23. 00 24. 00	Physical Therapy Visit Charges	2, 079 357, 976	l .				23. 00 24. 00
25. 00 26. 00	Occupational Therapy Visits Occupational Therapy Visit Charges	407 70, 195	l .		31 5, 345	458 79, 000	25. 00 26. 00
27. 00	Speech Pathology Visits	126		1 1	3, 343	132	27.00
28. 00 29. 00	Speech Pathology Visit Charges Medical Social Service Visits	23, 446	188	1		24, 574 7	28. 00 29. 00
30.00	Medical Social Service Visit Charges	998					30.00
31. 00 32. 00	Home Health Aide Visits Home Health Aide Visit Charges	871 61, 169					31. 00 32. 00
33. 00	Total visits (sum of lines 21, 23, 25, 27,	6, 487	1				33. 00
34. 00	29, and 31) Other Charges	0	0	О	0	0	34.00
35. 00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	985, 843	55, 040				
36. 00	Total Number of Episodes (standard/non outlier)	360		62	24	446	36. 00
37. 00 38. 00	1	48, 311	9 22, 638	1, 813	3 600		37. 00 38. 00

HOSPI TA	Financial Systems METHODIST F L UNCOMPENSATED AND INDIGENT CARE DATA	HOSPITALS, INC Provider CO	CN: 15-0002	Peri od:	u of Form CMS-2 Worksheet S-1		
	LE CHOCKE ENGLISE THIS THIS CELL CAME STATE	1.00.40.		From 01/01/2016			
				To 12/31/2016	Date/Time Pre 5/26/2017 1:1		
	Incompanded and indigent care cost computation				1. 00		
	Jncompensated and indigent care cost computation Cost to charge ratio (Worksheet C, Part I line 202 colum	n 2 dividad by Li	ino 202 colum	n 0)	0. 239875	1.0	
	Medicaid (see instructions for each line)	iii s divided by ii	THE 202 COT UIII	11 0)	0. 239073	1.0	
-	Net revenue from Medicaid				29, 407, 208	2.0	
	Did you receive DSH or supplemental payments from Medica	i d?			Υ	3.0	
	If line 3 is "yes", does line 2 include all DSH or suppl		from Medicai	d?	Ϋ́	4.0	
	If line 4 is "no", then enter DSH or supplemental paymen	1 2			0	5.0	
4	Medicaid charges				148, 074, 424	6.0	
. 00	Medicaid cost (line 1 times line 6)				35, 519, 352	7.0	
8. 00 I	Difference between net revenue and costs for Medicaid pr	ogram (line 7 min	nus sum of li	nes 2 and 5; if	6, 112, 144	8.0	
	< zero then enter zero)]	
	Children's Health Insurance Program (CHIP) (see instruct	ions for each lir	ne)				
	Net revenue from stand-alone CHIP				0		
	Stand-alone CHIP charges				0	10.0	
	Stand-alone CHIP cost (line 1 times line 10)	01115 (11 44 1			0	11. (
	Difference between net revenue and costs for stand-alone	CHIP (line 11 mi	nus line 9;	if < zero then	0	12.0	
	enter zero)	oo imatruatiana t	For cook line			-	
	Other state or local government indigent care program (s				0	13.0	
3.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 4.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or							
	charges for patrents covered under state or focal findingen. 100	int care program	(NOT THE dued	THE THES O OF	0	14.0	
1	State or local indigent care program cost (line 1 times	line 14)			0	15.0	
6.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0							
	13; if < zero then enter zero)	· · · · · · · · · · · · · · · · · ·	- h3 (_		
	Uncompensated care (see instructions for each line)			,		1	
	Private grants, donations, or endowment income restricte				0	17. C	
8.00	Government grants, appropriations or transfers for suppo	rt of hospital o	oerati ons		0	18.0	
	Total unreimbursed cost for Medicaid , CHIP and state an	d Local indigent	care program	s (sum of lines	6, 112, 144	19.0	
	8, 12 and 16)						
			Uni nsured	Insured	Total (col. 1		
			patients	pati ents	+ col . 2)		
0 00 1	Charity care charges for the entire facility (see instru	ctions)	1. 00 34, 239, 17	2.00	3. 00 34, 239, 170	20.0	
	Cost of patients approved for charity care (line 1 times		8, 213, 12		8, 213, 121		
- 1	Partial payment by patients approved for charity care	1111e 20)		0	0, 213, 121	1	
	Cost of charity care (line 21 minus line 22)		8, 213, 12		8, 213, 121		
0.00	oost of chartty care (fine 21 minus fine 22)		0,210,12		0,210,121	20.0	
					1. 00		
4. 00 I	Does the amount in line 20 column 2 include charges for	patient days beyo	ond a Length	of stay limit	N	24.0	
li	imposed on patients covered by Medicaid or other indigen	t care program?	3	j			
5. 00	If line 24 is "yes," charges for patient days beyond an	indigent care p	rogram's Leng	th of stay limit	0	25.0	
6.00	Total bad debt expense for the entire hospital complex (see instructions		-	16, 098, 324	26.0	
	Medicare bad debts for the entire hospital complex (see				1, 751, 942		
		,					
30.00	Cost of uncompensated care (line 23 column 3 plus line 2 Total unreimbursed and uncompensated care cost (line 19	9)			11, 654, 459 17, 766, 603	1	

	Financial Systems	METHODIST HOSP		N 45 0000		of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der CC	N: 15-0002 F	Period: From 01/01/2016	Worksheet A	
					Го 12/31/2016	Date/Time Pre	pared:
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	5/26/2017 1: 1 Recl assi fi ed	4 pm
	cost center bescription	Sararres	other	+ col . 2)		Trial Balance	
					A-6)	(col. 3 +-	
					·	col. 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		ol	(9, 297, 778	9, 297, 778	1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 625, 177	31, 094, 652	32, 719, 829		32, 996, 390	
5. 01	00550 DATA PROCESSING	4, 325, 491	9, 717, 309	14, 042, 800		14, 039, 394	5. 01
5.02	00560 PURCHASING RECEIVING AND STORES	975, 987	2, 673, 049	3, 649, 036		3, 603, 842	5. 02
5. 03	00570 ADMI TTI NG	2, 018, 641	465, 239	2, 483, 880		2, 475, 590	
5. 04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	2, 102, 892	2, 672, 939	4, 775, 831		4, 770, 844	
5. 05 5. 06	OO590 OTHER A&G OO592 PATIENT TRANSPORTATION	11, 064, 638 552, 439	22, 872, 036 65, 533	33, 936, 674 617, 972		21, 298, 902 626, 414	
7. 00	00700 OPERATION OF PLANT	3, 599, 819	8, 154, 468	11, 754, 287		16, 132, 730	
8. 00	00800 LAUNDRY & LINEN SERVICE	0	1, 435, 714	1, 435, 714		1, 435, 714	
9.00	00900 HOUSEKEEPI NG	4, 738, 469	1, 304, 211	6, 042, 680	-32, 522	6, 010, 158	9. 00
10.00	01000 DI ETARY	3, 077, 411	3, 688, 748	6, 766, 159		4, 489, 699	
11.00	01100 CAFETERI A	331, 313	44, 914	376, 227		2, 642, 721	
13. 00 14. 00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	2, 705, 196 561, 047	737, 672 1, 948, 524	3, 442, 868 2, 509, 57		3, 427, 109 2, 263, 775	
15. 00	01500 PHARMACY	0	16, 077, 333	16, 077, 333		5, 458, 297	
16.00	01600 MEDICAL RECORDS & LIBRARY	2, 037, 106	1, 109, 552	3, 146, 658		3, 146, 474	
17. 00	01700 SOCI AL SERVI CE	0	o	(492, 378	492, 378	
17. 01	01701 STAFF EDUCATION	0	0	(0	0	17. 01
	01702 MEDI CAL EDUCATI ON	75, 566	28, 641	104, 207		104, 065	
21. 00 22. 00	02100 &R SERVICES-SALARY & FRINGES APPRVD 02200 &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	(,	197, 546 30, 176	1
23. 00		400, 509	99, 966	500, 475		711, 867	1
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	100,007	7,7,700	0007 170	211/072	7.1.7007	20.00
30.00	03000 ADULTS & PEDIATRICS	30, 784, 678	7, 203, 703	37, 988, 38	-824, 700	37, 163, 681	
31.00	03100 INTENSIVE CARE UNIT	6, 378, 761	1, 739, 131	8, 117, 892		7, 899, 702	
31. 01	03101 NEONATAL I CU	2, 248, 575	794, 944	3, 043, 519		3, 029, 146	1
40. 00 41. 00	04000 SUBPROVI DER	1, 019, 784 3, 098, 258	94, 765 495, 056	1, 114, 549 3, 593, 314		1, 148, 835 3, 532, 243	
43.00	04300 NURSERY	712, 350	295, 046	1, 007, 396		968, 452	1
10.00	ANCILLARY SERVICE COST CENTERS	712,000	270,010	1,007,070	5, 50, 711	700, 102	10.00
50.00	05000 OPERATING ROOM	4, 174, 101	18, 346, 218	22, 520, 319	-13, 807, 610	8, 712, 709	50.00
50. 01	05001 ENDOSCOPY	1, 195, 062	2, 231, 167	3, 426, 229		3, 069, 264	
51.00	05100 RECOVERY ROOM	1, 060, 523	140, 125	1, 200, 648		1, 181, 990	
52. 00 53. 00	O5200 DELI VERY ROOM & LABOR ROOM O5300 ANESTHESI OLOGY	2, 430, 655	520, 401 0	2, 951, 05 <i>6</i>	1	2, 936, 051 0	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 410, 257	2, 248, 378	4, 658, 635	-	4, 540, 263	
54. 01	05401 RADI OLOGY - ULTRASOUND	1, 390, 914	673, 487	2, 064, 40		1, 973, 792	
55.00	05500 RADI OLOGY-THERAPEUTI C	491, 118	1, 298, 484	1, 789, 602		1, 778, 005	
56. 00	05600 RADI OI SOTOPE	564, 644	968, 102	1, 532, 746		1, 531, 980	
	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 068, 157	1, 293, 362 459, 979	2, 361, 519		2, 274, 135	
	05900 CARDI AC CATHETERI ZATI ON	463, 519 2, 004, 530	7, 791, 576	923, 498 9, 796, 106		863, 723 3, 910, 410	
60.00	06000 LABORATORY	3, 547, 102	6, 730, 143	10, 277, 245		10, 274, 065	
60. 01	06001 BLOOD LABORATORY	0	0	(0	0	1
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0	(0	0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 162, 738	371, 692	1, 534, 430	-20, 047	1, 514, 383	
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0	(0	
65.00	06500 RESPIRATORY THERAPY	2, 404, 010	1, 098, 683	3, 502, 693	-	3, 305, 538	
66.00	06600 PHYSI CAL THERAPY	1, 477, 774	127, 318	1, 605, 092		1, 611, 907	1
67.00	06700 OCCUPATI ONAL THERAPY	1, 146, 195	133, 207	1, 279, 402		1, 279, 213	
68.00	06800 SPEECH PATHOLOGY	402, 925	48, 764	451, 689	9 0	451, 689	
69. 00	06900 ELECTROCARDI OLOGY	625, 735	251, 119	876, 854		871, 952	
69. 01	06901 CARDI AC REHAB	393, 941	277, 059	671, 000		669, 960	
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	958, 324 0	5, 909, 836	6, 868, 160 (2, 892, 586 12, 096, 772	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0	(13, 957, 025	
73. 00		427, 527	972, 462	1, 399, 989		11, 897, 093	
74.00		0	1, 952, 756	1, 952, 756	-146	1, 952, 610	74.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	2, 553, 028	2, 132, 447	4, 685, 475		4, 565, 211	
91.00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 931, 939	2, 982, 908	9, 914, 847	-582, 353	9, 332, 494	91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
101.00	10100 HOME HEALTH AGENCY	1, 843, 483	313, 069	2, 156, 552	-4, 815	2, 151, 737	101.00
	SPECIAL PURPOSE COST CENTERS						
118.00		125, 562, 308	174, 085, 887	299, 648, 195	1, 342, 284	300, 990, 479	118.00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	E7 210	178, 810	224 020		236, 028	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	57, 218 0	178, 810	236, 028 (190.00
	1 2 2 2	1 91			<u>, 91</u>		

Health Financial Systems	METHODIST HOSE	PITALS, INC		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provi der Co		eri od:	Worksheet A	
			_	rom 01/01/2016 o 12/31/2016		
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
			+ col. 2)	ions (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	19, 000, 031	18, 274, 945	37, 274, 976	-65, 493	37, 209, 483	192.00
192. 01 19201 OTHER NON-REIMBURSABLE	3, 196, 831	2, 962, 922	6, 159, 753	-1, 276, 791	4, 882, 962	192. 01
192. 02 19202 FAMILY HEALTH/GARY COMM HEALTH	160, 994	55, 652	216, 646	0	216, 646	192. 02
193. 00 19300 NONPALD WORKERS	O	0	C	0	0	193.00
200.00 TOTAL (SUM OF LINES 118-199)	147, 977, 382	195, 558, 216	343, 535, 598	0	343, 535, 598	200. 00

Health FinancialSystemsMETHODISTRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Peri od: Worksheet A From 01/01/2016 Date/Time Prepared: 5/26/2017 1:14 pm Provi der CCN: 15-0002

				5/26/2017 1	
	Cost Center Description	Adjustments	Net Expenses	072072017	
	·	(See A-8)	For		
			Allocation		
	OFNEDAL CERVILOE COCT OFNITERS	6. 00	7. 00		
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FLXT	-2, 525, 391	6, 772, 387	1	1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	858, 686		·	4.00
5. 01	00550 DATA PROCESSING	-230, 000		•	5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES	0		·	5. 02
5. 03	00570 ADMITTING	0	2, 475, 590	·	5. 03
5.04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	-17, 188	4, 753, 656		5. 04
5.05	00590 OTHER A&G	-456, 637	20, 842, 265		5. 05
5. 06	00592 PATI ENT TRANSPORTATI ON	0	1,	l control of the cont	5. 06
7.00	00700 OPERATION OF PLANT	0		l control of the cont	7.00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	2 210	1, 435, 714		8.00
10.00	01000 DI ETARY	-3, 310 -28, 888			9.00
11. 00	01100 CAFETERI A	-984, 635			11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	-6, 724			13.00
14. 00		0	2, 263, 775		14.00
15. 00	01500 PHARMACY	-367, 899	1		15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	-10, 421	3, 136, 053		16. 00
17. 00		0	492, 378		17. 00
17. 01	01701 STAFF EDUCATION	0	0	•	17. 01
	01702 MEDICAL EDUCATION	0	104, 065		17. 02
21.00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	0	197, 546	·	21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PROGRAM	-388, 460	30, 176	•	22. 00 23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	-300, 400	323, 407		23.00
30. 00		-279, 140	36, 884, 541		30.00
31. 00	03100 INTENSIVE CARE UNIT	0	7, 899, 702	•	31.00
31. 01	03101 NEONATAL I CU	-602, 000	1		31. 01
40.00	04000 SUBPROVI DER - I PF	0	1, 148, 835		40.00
41.00	04100 SUBPROVI DER - I RF	0	3, 532, 243		41.00
43.00	04300 NURSERY	0	968, 452		43. 00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0, , , 2, , 0,	l control of the cont	50.00
50. 01	05001 ENDOSCOPY	0	3, 069, 264		50.01
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	1, 181, 990 2, 936, 051		51.00 52.00
53. 00	05300 ANESTHESI OLOGY	0	2, 930, 031		53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-1, 240	_		54.00
54. 01	05401 RADI OLOGY - ULTRASOUND	0	1, 973, 792		54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	-267, 507	1, 510, 498		55.00
56.00	05600 RADI OI SOTOPE	0	1, 531, 980		56.00
57.00	05700 CT SCAN	-231	2, 273, 904		57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	863, 723	·	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	3, 910, 410		59. 00
60.00	06000 LABORATORY	-97, 802			60.00
	06001 BLOOD LABORATORY	0		l control of the cont	60.01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	ľ	1	61. 00 62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	-65, 340	1, 449, 043		63.00
64. 00		0	0		64.00
65. 00	1	0	3, 305, 538		65. 00
66. 00		0	1, 611, 907		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	1, 279, 213	·	67.00
68.00	06800 SPEECH PATHOLOGY	0	451, 689		68. 00
69. 00		0	871, 952	l control of the cont	69. 00
69. 01	06901 CARDI AC REHAB	-178, 092		l e e e e e e e e e e e e e e e e e e e	69. 01
	07000 ELECTROENCEPHALOGRAPHY	-80, 651	2, 811, 935	l e e e e e e e e e e e e e e e e e e e	70.00
71.00		0			71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0		l control of the cont	72.00
	07400 RENAL DIALYSIS		11, 897, 093 1, 952, 610	l control of the cont	73. 00 74. 00
, 4. 00	OUTPATIENT SERVICE COST CENTERS		1, 732, 010	1	74.00
90. 00	09000 CLINIC	7, 159	4, 572, 370		90.00
	09100 EMERGENCY	0			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		<u> </u>		92.00
	OTHER REIMBURSABLE COST CENTERS	,			
101.00	10100 HOME HEALTH AGENCY	0	2, 151, 737		101. 00
440 -	SPECIAL PURPOSE COST CENTERS		005 04 : = :	J	140
118. 00		-5, 725, 711	295, 264, 768	<u> </u>	118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		224 020		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH	0			190. 00 191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	·		191.00
			1 2:,207,700	I	1

Health Financial Systems	METHODI ST HOS	PITALS, INC		In Lie	u of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	OF EXPENSES	Provi der CC	CN: 15-0002	Peri od: From 01/01/2016	Worksheet A	
				To 12/31/2016	Date/Time Pre 5/26/2017 1:1	
Cost Center Description	Adjustments	Net Expenses				
	(See A-8)	For				
		Allocation				
	6. 00	7. 00				
192. 01 19201 OTHER NON-REI MBURSABLE	0	4, 882, 962				192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	0	216, 646				192. 02
193.00 19300 NONPALD WORKERS	0	0				193.00
200.00 TOTAL (SUM OF LINES 118-199)	-5, 725, 711	337, 809, 887				200. 00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0002

COUNT COUNTY COUN						5/26/2017 1:	
1.00		Coot Conton	Increases	Calassi	Othor		
1.00 A CAPTERIA	-						
APPLIED APPLIES CHARGED TO 72,00 13,057,722 1.00 2.00			3.00	4.00	5.00		
S - CLINICAL TRAN IN COST	1.00		11. 00	929, 933	1, 336, 561		1.00
1.00 MANAGE ED PIRICIGIAM 23.00 211,554 0 2.00 3.00		0		929, 933	1, 336, 561		
2.00 0.	4 00		22.20	044 554			4 00
3 00		PARAMED ED PROGRAM					1
4.00			· · · · · · · · · · · · · · · · · · ·	- 1			1
5.00			· · · · · · · · · · · · · · · · · · ·	Ö			1
7.00 1.00				ō			
C - SOCIAL MORKERS				O			
C - SOCIAL MORKERS	7.00		0.00		0		7. 00
1.00		0		211, 554	0		
Company	1 00		17 00	102 270	0		1 00
E - RESIDENTS 1.00 1 RS SERVICES-SALAY & 21.00 1 RS SERVICES-ADRED 2.00 1 RS SERVICES-ADRED 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.0	1.00	0			0		1.00
FRINCES APPRIOR		E - RESIDENTS		1727070	<u> </u>		
LAR SERVI CES-OTHER PROM	1.00	I &R SERVI CES-SALARY &	21. 00	0	197, 546		1.00
COSTS APPRVD							
NED SUPPLY	2. 00		22. 00	0	30, 176		2.00
The Display		O STS APPRVD	+				
1.00 NEDICAL SUPPLIES CHARGED TO		F - MED SUPPLY		<u> </u>	221, 122		
PATI ENTS	1.00		71. 00	0	12, 096, 772		1.00
ATIENTS 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0		PATI ENTS					
3.00 4.00 5.00 6.00 6.00 7.00 0.00 0.00 0.00 0.00 0	2. 00		72. 00	0	13, 957, 025		2.00
4. 00 6. 00 6. 00 6. 00 6. 00 6. 00 6. 00 6. 00 6. 00 6. 00 6. 00 7. 00 8. 00 9. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 11. 00 11. 00 12. 00 13. 00 14. 00 15. 00 15. 00 16. 00 17. 00 18. 00 19. 00 11	2 00	PATTENTS	0.00		0		2 00
5.00				- 1			1
6. 00 7. 00 8. 00 9. 00 9. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 11. 00				- 1			
7. 00 8. 00 9. 00 10. 00 10. 00 10. 00 10. 00 10. 00 11. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 11. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 11. 00 11. 00 11. 00 11. 00 11. 00 12. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 18. 00 19. 00 19. 00 19. 00 10. 00 1				-1			1
9.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 11.00 1				O	0		1
10.00	8.00		0. 00	0	0		8. 00
11.00	9.00		0. 00	0	0		9. 00
12.00			l	0			10.00
13.00				- 1			
14. 00 14. 00 14. 00 14. 00 15. 00 16. 00 16. 00 16. 00 16. 00 17. 00 18. 00 17. 00 18. 00				-			
15.00			l l				
16. 00			I	- 1			
17.00							
18. 00				- 1			
19.00 0.00 0.00 0 0 0 0 20.00 20.00 21.00 22.00 22.00 0.00 0 0 0 0 22.00 22.00 23.00 0.00 0 0 0 0 22.00 24.00 24.00 0.00 0 0 0 0 0 24.00 24.00 25.00 0.00 0 0 0 0 25.00 26.00 0.00 0 0 0 25.00 26.00 0.00 0 0 0 0 27.00 28.00 0.00 0 0 0 0 0 27.00 28.00 0.00 0 0 0 0 0 27.00 28.00 0.00 0 0 0 0 0 27.00 28.00 0.00 0 0 0 0 0 0 0				- 1			
20.00			l .	- 1			
21.00 22.00 20.00 0.00 0.00 0.00 0.00 0.			l .	- 1			1
22.00 23.00 23.00 23.00 0.00 0.00 0.00 0				- 1			
23.00				-1			
24. 00				- 1			
25. 00				- 1			
26. 00 27. 00 28. 00 0. 00 0. 00 0. 00 0. 00 0. 00 28. 00 29. 00 30. 00 31. 00 31. 00 32. 00 33. 00 33. 00 34. 00 0. 00							
27. 00							4
28. 00 29. 00 30. 00 30. 00 31. 00 31. 00 32. 00 33. 00 33. 00 33. 00 34. 00 35. 00 36. 00 37. 00 36. 00 37. 00 38. 00 38. 00 39. 00 40. 00 42. 00 42. 00 6 - Light duty 1. 00 9 ATIENT TRANSPORTATION 2. 00 1. 00 1. 00 2. 00 3. 00					Ö		
29. 00 30. 00 30. 00 30. 00 31. 00 32. 00 32. 00 33. 00 33. 00 33. 00 34. 00 35. 00 36. 00 37. 00 36. 00 37. 00 38. 00 38. 00 39. 00 30. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				•			
31.00							
32. 00 33. 00 33. 00 34. 00 35. 00 36. 00 36. 00 37. 00 38. 00 39. 00 39. 00 39. 00 39. 00 39. 00 40. 00 40. 00 41. 00 42. 00 PATIENT TRANSPORTATION 5. 06 8, 442 0 0. 00 10				0			
33.00	31.00			0	0		31.00
34.00 35.00 36.00 0.00 0 0 0 0 35.00 36.00 36.00 37.00 36.00 37.00 38.00 39.00 39.00 39.00 39.00 40.00 41.00 42.00 0 0 0 0 0 0 0 0 0	32.00		0. 00	o	0		32.00
35.00 36.00 36.00 36.00 36.00 36.00 37.00 38.00 37.00 37.00 37.00 38.00 37.00 38.00 38.00 39.00 39.00 39.00 39.00 40.0			0. 00				
36.00 37.00 36.00 36.00 37.00 37.00 38.00 37.00 38.00 38.00 38.00 38.00 38.00 39.00 39.00 39.00 39.00 40.00 41.00 42.00				- 1			
37.00				- 1			
38.00 39.00 40.00 40.00 41.00 42.00 O				- 1			
39.00				- 1			
40.00 41.00 42.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				-			
41. 00 42. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				- 1			
42.00 0 0 0 0 0 0 26,053,797 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
O C C C C C C C C C				•			
G - LIGHT DUTY 1. 00 PATI ENT TRANSPORTATI ON 5. 06 8, 442 0 1. 00 2. 00 HOUSEKEEPI NG 9. 00 4, 100 0 2. 00 3. 00 DI ETARY 10. 00 7, 049 0 3. 00 4. 00 ADULTS & PEDI ATRI CS 30. 00 7, 779 0 4. 00 5. 00 I NTENSI VE CARE UNI T 31. 00 11, 457 0 5. 00	72. UU						72.00
1. 00 PATI ENT TRANSPORTATION 5. 06 8, 442 0 1. 00 2. 00 HOUSEKEEPI NG 9. 00 4, 100 0 2. 00 3. 00 DI ETARY 10. 00 7, 049 0 3. 00 4. 00 ADULTS & PEDI ATRI CS 30. 00 7, 779 0 4. 00 5. 00 I NTENSI VE CARE UNI T 31. 00 11, 457 0 5. 00		G - LIGHT DUTY		٧	,, , , , ,		1
2. 00 HOUSEKEEPI NG 9. 00 4, 100 0 3. 00 DI ETARY 10. 00 7, 049 0 4. 00 ADULTS & PEDI ATRI CS 30. 00 7, 779 0 5. 00 I NTENSI VE CARE UNI T 31. 00 11, 457 0	1.00		5. 06	8, 442	0		1.00
4. 00 ADULTS & PEDIATRICS 30. 00 7, 779 0 4. 00 5. 00 INTENSIVE CARE UNIT 31. 00 11, 457 0 5. 00			9. 00	4, 100	0		
4. 00 ADULTS & PEDIATRICS 30. 00 7, 779 0 4. 00 5. 00 INTENSIVE CARE UNIT 31. 00 11, 457 0 5. 00	3.00	DI ETARY	10. 00	7, 049	0		3.00
6. 00 SUBPROVI DER - 1 PF 40. 00 34, 509 0 6. 00							
	6.00	DORKKONI DEK - 1 LF	40. 00	34, 509	U		6.00

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2016 | To 12/31/2016 | Date/Time Prepared: Provider CCN: 15-0002

					To 12/31/2016 Date/Time Pi 5/26/2017 1:	repared: :14 pm
		Increases			0,20,2011	, , , _D ,,,
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
7.00	SUBPROVI DER - I RF	41.00	552	0		7. 00
8.00	OPERATING ROOM	50. 00	14, 595	0		8. 00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	2, 837	0		9. 00
10.00	RADI OLOGY-DI AGNOSTI C	54.00	9, 385	0		10.00
11.00	PHYSICAL THERAPY	66. 00	9, 604	0		11.00
	0		110, 309	0		
	H - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	3, 532, 692		1.00
2.00		0. 00	0	0		2. 00
3.00		0. 00	0	0		3.00
4.00		0. 00	0	0		4. 00
5.00		0. 00	0	0		5. 00
6.00			0	0		6. 00
	0		0	3, 532, 692		
	I - CORPORATE EXPENSE					4
1. 00	CAP REL COSTS-BLDG & FIXT	1. 00	0	5, 765, 086		1. 00
2.00	OPERATION OF PLANT			<u>4, 387, 0</u> 00		2. 00
	0		0	10, 152, 086		_
	J - DRUG EXPENSE					
1. 00	DRUGS CHARGED TO PATIENTS	7300		<u>10, 590, 1</u> 36		1.00
	0		0	10, 590, 136		_
	L - PSTD RECLASS					
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	386, 884		1.00
2. 00		0. 00	0	0		2. 00
3. 00		0. 00	0	0		3. 00
4. 00		0. 00	0	0		4. 00
5. 00		0.00	0	0		5. 00
6. 00		0. 00	0	0		6. 00
7. 00		0.00	0	0		7. 00
8. 00		0.00	0	0		8. 00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17. 00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00		0		19.00
20. 00 21. 00		0. 00 0. 00	0	0		20. 00 21. 00
			ol Ol	0		1
22. 00 23. 00		0. 00 0. 00	0	0		22. 00 23. 00
24. 00		0.00	o O	0		24.00
25. 00		0.00	0	0		25. 00
26. 00		0.00	0	0		26.00
26. 00 27. 00		0.00	0	0		26.00
28.00		0.00	0	0		27.00
28.00		0.00	0	0		29.00
30.00		0.00	o o	0		30.00
30.00			— — — ;	386, 884		30.00
500 00	Grand Total: Increases		1, 744, 174	52, 279, 878		500.00
500.00	prana rotar. Hici cases	l	1, 744, 174	JZ, Z17, U10		1 300.00

Provider CCN: 15-0002

Peri od: Worksheet A-6 From 01/01/2016 To 12/31/2016 Date/Time Prepared:

Cord Dentity 1 ms Settary 0 ther 0 mst 5.7 Rpr						'	o 12/31/2016 Date/lime Pro 5/26/2017 1:	
Color Colo								
A. CARETERIA								
1.00			7.00	8.00	9.00	10.00		
1.00	1.00		10. 00	929, 933	1, 336, 561	0		1.00
ADDITION APPENDIX CAMPE WITH		0 — — — —						
MITERS NY CARE DINT 31.00 10,420 0 0 3.100						1		
0 0 0 0 0 0 0 0 0 0								1
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5,00 CARDIAC CATHETER ZATION 50,00 2,798 0 0 6,00 6,00 6,00 6,00 6,00 6,00 6,00 6,00 6,00 6,00 6,00 6,00 6,00 6,00 7,00<		1			-	_		1
0.00 0.00		1			0	0		1
DERECENCY		1			0	0		1
C - SOCI AL MORKERS					0	0		1
1.00		0						
1.00								
E - RESIDENTS 1.00 MED SUPPLY	1. 00	OTHER A&G						1.00
1.00 CAMPRICENCY		U E DESIDENTS		492, 378	0			-
2.00	1 00		91 00	0	227 722	0		1 00
1.00 CANTES BENEFITS DEPARTMENT		Emerica :						1
DOC MAPLOYEE BENEFITS DEPARTMENT 4, 00		0			227, 722			j
2.00 URCHUSIN IN RECELVING AND 5.02 0 43,742 0 2.00 3.00 ADMITTIN 5.03 0 38 0 3.30 5.00 OPERATION OF PLANT 7.00 0 3.96 0 6.00 OPERATION OF PLANT 7.00 0 0								
STORES		1		-				1
3.00 ADMITTING 5.03 0 38 0 3.00 6.00 CONTRA RAG 5.05 0 29 0 4.400 7.00 NURSING ADMINISTRATION 7.00 0 3.39 0 5.00 7.00 NURSING ADMINISTRATION 13.00 0 8.05 0 7.00 8.00 CONTRAT. SERVICES & SUPPLY 14.00 0 240.609 0 8.00 9.00 HARRAGY 15.00 0 220.609 0 9.00 9.00 HARRAGY 15.00 0 220.609 0 9.00 9.00 HARRAGY 15.00 0 128.900 0 9.00 9.00 ADMITTING 15.00 0 9.00 9.	2.00		5. 02	O	43, 742	0		2.00
4.00 OTHER AAG	3 00		5 03	0	38	0		3 00
5.00 OPERATION OF PLANT		1						1
7. 00 MURSING ADMINISTRATION 13. 00 0 20,609 0 3.00 9. 00 PHARMACY 15. 00 0 24,609 0 9.00 9. 00 PHARMACY 15. 00 0 28,900 0 9.00 11. 00 PARAMED ED PROGRAM 23. 00 0 162 0 111. 00 12. 00 ADLITS & PEDIATRIC S 30. 00 0 665, 552 0 12. 00 13. 00 INTERISIVE CARE LINI T 31. 00 0 211, 089 0 13. 00 15. 00 SUBPROVI DER - I PF 40. 00 0 223 0 15. 00 16. 00 SUBPROVI DER - I RF 41. 00 0 51. 670 0 16. 00 17. 00 NURSERY 43. 00 0 33. 944 0 17. 00 18. 00 DERATTING ROOM 50. 00 0 35. 118 0 17. 00 19. 00 PERMOVIDER - I RF 41. 00 0 35. 118 0 17. 00		1		0				1
8. 00 CENTRAL SERVICES & SUPPLY 14. 00 0 240, 609 0 9. 00 10. 00 MEDICAL EDUCATION 17. 02 0 142 0 10. 00 11. 00 MEDICAL EDUCATION 17. 02 0 142 0 10. 00 12. 00 ADULTS & PEDIATRICS 30. 00 0 666, 353 0 12. 00 14. 00 ADULTS & PEDIATRICS 31. 00 0 21. 089 0 12. 00 14. 00 NEONATAL ICU 31. 01 0 83 0 14. 00 15. 00 SUBPROVI DER - IPF 40. 00 0 223 0 15. 00 16. 00 SUBPROVI DER - IFF 41. 00 0 51. 670 0 16. 00 17. 00 NUSERY 43. 00 0 38. 944 0 17. 00 18. 00 OPERATING ROOM 50. 00 0 13. 803, 874 0 18. 00 19. 00 PEDOSCOPY 50. 01 0 352. 118 0 19. 00 20. 00 RECOVERY ROOM 51. 00 0 18. 120 0 22. 00 22. 00 RADIOLOGY - UITARSOUND 54. 01 0 28. 135 0 22. 00 24. 00 RADIOLOGY - UITARSOUND 54. 01 0 28. 135 0 22. 00 24. 00 RADIOLOGY - UITARSOUND 54. 01 0 28. 135 0 22. 00 26. 00 CT SCAN 57. 00 0 0 2.665 0 22. 00 27. 00 ARADIOLOGY - UITARSOUND 54. 01 0 28. 135 0 22. 00 28. 00 CT SCAN 57. 00 0 0 2.665 0 22. 00 29. 00 CT SCAN 57. 00 0 0 2.665 0 22. 00 29. 00 CT SCAN 57. 00 0 0 2.665 0 22. 00 29. 00 CT SCAN 57. 00 0 0 2.665 0 22. 00 29. 00 LABORATORY 60. 00 0 2.665 0 22. 00 29. 00 LABORATORY 60. 00 0 0 2.665 0 22. 00 29. 00 LABORATORY 60. 00 0 0 2.665 0 22. 00 29. 00 LABORATORY 167RAPY 65. 00 0 0 2.665 0 2.605 29. 00 LABORATORY 167RAPY 65. 00 0 0 1.496 0 33. 00 29. 00 LABORATORY 167RAPY 65. 00 0 0 1.496 0 33. 00 29. 00 LABORATORY 167RAPY 65. 00 0 0 1.496 0 33. 00 20. 00 POLICATION 16. 00 0 0 0 0 0 0 0 20. 00 0 0 0 0 0 0 0 0	6.00	HOUSEKEEPI NG		0	3, 386	0		6. 00
9.00 PHARMACY	7.00		13. 00					7. 00
10.00 MEDICAL EDUCATION 17.02 0 142 0 11.00 11.00 PARMED ED PROGRAM 23.00 0 162 0 11.00 12.00 ADULTS & PEDIATRICS 30.00 0 665,553 0 12.00 14.00 NEONATAL I.CU 31.01 0 211,089 0 14.00 15.00 NEONATAL I.CU 31.01 0 223 0 15.00 16.00 SUBPROVI) DER - I.PF 40.00 0 223 0 15.00 16.00 SUBPROVI) DER - I.PF 41.00 0 51,670 0 16.00 18.00 SUBPROVI) DER - I.PF 41.00 0 51,670 0 16.00 18.00 SUBPROVI) DER - I.PF 41.00 0 51,670 0 16.00 18.00 OPERATING ROON 50.00 0 13.803,874 0 18.00 19.00 ADULTS & PEDIATRIC ROON 50.00 0 13.803,874 0 18.00 19.00 ADULTS & PEDIATRIC ROON 51.00 0 18.20 0 20.00 20.00 RECOVERY ROOM 51.00 0 18.120 0 20.00 21.00 DELIVERY ROOM & LABOR ROOM 52.00 0 11.337 0 21.00 22.00 RADIOLOGY - ULTRASOUND 54.00 0 2.665 0 22.00 23.00 RADIOLOGY - ULTRASOUND 54.00 0 2.665 0 22.00 24.00 RADIOLOGY - ULTRASOUND 54.00 0 27.877 0 25.00 25.00 RADIOLOGY - ULTRASOUND 54.00 0 27.877 0 25.00 27.00 MAGNETIC RESONANCE I MAGING 58.00 0 27.877 0 26.00 27.00 MAGNETIC RESONANCE I MAGING 58.00 0 27.877 0 28.00 28.00 CARDIAC CATHETERIZATION 59.00 0 5.882,025 0 28.00 29.00 LABORATORY HEERAPY 66.00 0 1.496 0 33.00 MIDLE BLOOD & PACKED RED 62.00 0 1.496 0 33.00 MIDLE BLOOD & PACKED RED 62.00 0 1.496 0 33.00 MIDLE BLOOD & PACKED RED 62.00 0 1.496 0 33.00 MIDLE BLOOD & PACKED RED 65.00 0 1.496 0 33.00 RESPIRATORY HEERAPY 66.00 0 0 0 0 0 0 0 ADULTS ENTRY HEERAPY 67.00 0 1.496 0 33.00 RESPIRATORY HEERAPY 67.00 0 1.496 0 33.00 RESPIRATORY HEERAPY 67.00 0 0 0 0 0 0 0 DRUGS CHARGED TO PATIENTS 73.00 0 97.032 0 0 0 0 0 ADULT HEARD HEARD 73.00 0 0 0 0 0								1
11. 00 PARAMED ED PROGRAM 23. 00 0 16.2 0 11. 00 12. 00 12. 00 12. 00 12. 00 12. 00 12. 00 12. 00 12. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 13. 00 14. 00 14. 00 14. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 16. 00 1		1						1
12.00 ADULTS & PEDIATRICS 30.00 0 665, 353 0 12.00 17.01 13.00 17.01 13.00 17.01 13.00 17.01 13.00 17.01 13.00 17.01 13.00 17.01 13.00 17.01 13.00 17.01 13.00 17.01 13.00 17.01 13.00 17.01 13.00 17.01 13.00 17.01 13.00 17.01 13.00 17.01 13.00 17.00 15.								1
13. 00 INTENSIVE CARE UNIT 31. 00 0 211,089 0 13. 00 14. 00 14. 00 15. 00 SUBPROVI DER - I PF 40. 00 0 223 0 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 17. 00		1						1
14. 00 NEONATAL I CU 31. 01 0 83 0 14. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 15. 00 16. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 18. 00 17. 00 18. 00 17. 00 18. 00 19. 00 18. 00 19. 00 18. 00 19. 00				•				1
15.00 SUBPROVIDER - IPF								1
17. 00 NURSERY		1		•				4
18. 00 OPERATING ROOM 50. 00 0 13,803,874 0 19. 00	16.00	SUBPROVI DER - I RF	41. 00	0	51, 670	0		16.00
19.00 ENDOSCOPY 50.01 0 352.118 0 19.00 20.00 RECOVERY ROOM 51.00 0 11.337 0 22.00	17.00	NURSERY	43. 00	•	38, 944	0		17. 00
20.00 RECOVERY ROOM S1.00 S1.00 S1.100 C.0.00 C.0.000 C.0.00 C.0.0		1						1
21. 00 DELIVERY ROOM & LABOR ROOM 52. 00 0 11. 337 0 22. 00 RADI OLOGY-DI AGNOSTIC 54. 00 0 2, 665 0 22. 00 23. 00 RADI OLOGY-DI AGNOSTIC 55. 00 0 2, 665 0 22. 00 24. 00 RADI OLOGY-THERAPEUTIC 55. 00 0 6. 960 0 24. 00 25. 00 26. 00 RADI OLOGY-THERAPEUTIC 55. 00 0 6. 960 0 24. 00 25. 00 26. 00 CT SCAN 57. 00 0 27. 877 0 26. 00 27. 00 2						_		1
22.00 RADI OLOGY - DI AGNOSTI C 54.00 0 2.665 0 22.00 RADI OLOGY - ULTRASOUND 54.01 0 28.135 0 23.00 24.00 RADI OLOGY - HERAPEUTI C 55.00 0 6.960 0 24.00 25.00 RADI OLOGY - HERAPEUTI C 55.00 0 6.960 0 24.00 25.00 RADI OLOGY - HERAPEUTI C 55.00 0 421 0 25.00 26.00 0 70.00 26.00 0 27.00 26.00 0 27.00 26.00 0 27.00 26.00 0 27.00 26.00 0 27.00 26.00 0 27.00 26.00 0 27.00 26.00 0 27.00 27.00 28.00 27.00 28.00 27.00 28.00 27.00 28.00 27.00 28.00 27.00 28.00 27.00 28.00 29								1
23.00 RADI OLOGY - ULTRASOUND 54.01 0 28.135 0 23.00 24.00 RADI OLOGY-THERAPEUTI C 55.00 0 6.960 0 0 24.00 0 25.00 0 24.00 0 25.00 0 24.00 0 25.00 0 24.00 0 25.00 25.00								1
24. 00 RADI OLOGY-THERAPEUTI C 55. 00 0 6, 960 0 25. 00 RADI OLSOTOPE 56. 00 0 421 0 0 25. 00 26. 00 27. 00 RADI OLSOTOPE 56. 00 0 421 0 0 25. 00 26. 00 27. 00 MGNETI C RESONANCE I MAGI NG 57. 00 0 26. 00 27. 877 0 26. 00 27. 00 MGNETI C RESONANCE I MAGI NG 58. 00 0 288 0 0 27. 00 MGNETI C RESONANCE I MAGI NG 58. 00 0 288 0 0 27. 00 28. 00 27. 00 27. 00 28. 00 27. 00 28. 00 27. 00 28. 00 27. 00 27. 00 28. 00 27.				-				
25.00 RADI OI SOTOPE				-				
27. 00 MAGNETI C RESONANCE I MAGI NG (MRI) 28. 00 CARDI AC CATHETERI ZATI ON 59. 00 0 5, 882, 025 0 28. 00 29. 00 LABORATORY 60. 00 0 296 0 29. 00 30. 00 WHOLE BLOOD & PACKED RED 62. 00 820 0 820 0 30. 00 BLOOD CELLS 31. 00 RESPI RATORY THERAPY 65. 00 0 182, 624 0 31. 00 32. 00 PHYSI CAL THERAPY 66. 00 0 189 0 32. 00 33. 00 OCCUPATI ONAL THERAPY 67. 00 189 0 33. 00 34. 00 ELECTROCARDI OLOGY 69. 00 0 4, 902 0 34. 00 35. 00 CARDI AC REHAB 69. 01 0 1, 040 0 35. 00 36. 00 ELECTROCARDI OLOGY 70. 00 0 3, 975, 574 0 36. 00 37. 00 DRUGS CHARGED TO PATI ENTS 73. 00 0 93, 032 0 37. 00 38. 00 REMAL DI ALYSI S 74. 00 0 146 0 38. 00 39. 00 CLI NI C 90. 00 0 195, 053 0 40. 00 40. 00 EMERGENCY 91. 00 0 195, 053 0 40. 00 41. 00 HOME HEALTH AGENCY 101. 00 0 4, 815 0 41. 00 42. 00 PHYSI CLANS' PRI VATE OFFI CES 192. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25.00	RADI OI SOTOPE		0		0		25. 00
MRI	26.00	CT SCAN		0	27, 877	0		26.00
28. 00	27. 00		58. 00	0	268	0		27. 00
29. 00 LABORATORY 60. 00 0 296 0 0 30. 00 WHOLE BLOOD & PACKED RED 62. 00 0 820 0 30. 00 BLOOD CELLS 3. 00 BLOOD CELLS 3. 00 BLOOD CELLS 3. 00 PHYSI CAL THERAPY 65. 00 0 182, 624 0 31. 00 32. 00 PHYSI CAL THERAPY 66. 00 0 1, 496 0 32. 00 33. 00 CCUPATI ONAL THERAPY 67. 00 0 189 0 33. 00 34. 00 53. 00 CARDI AC REHAB 69. 01 0 1, 040 0 34. 00 54. 00 0 0 180 0 0 0 0 0 0 0 0 0 0 0 0 0 0	20.00		F0.00		F 000 00F	0		20.00
30.00 WHOLE BLOOD & PACKED RED 62.00 0 820 0 30.00								
BLOOD CELLS				0				
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32. 00 PHYSI CAL THERAPY 66. 00 0 1, 496 0 32. 00 33. 00 OCCUPATI ONAL THERAPY 67. 00 0 189 0 33. 00 34. 00 ELECTROCARDI OLOGY 69. 00 0 4, 902 0 35. 00 CARDI AC REHAB 69. 01 0 1, 040 0 35. 00 36. 00 ELECTROENCEPHALOGRAPHY 70. 00 0 3, 975, 574 0 36. 00 37. 00 DRUGS CHARGED TO PATIENTS 73. 00 0 93, 032 0 37. 00 38. 00 REMAL DI ALYSI S 74. 00 0 146 0 38. 00 39. 00 CLI NI C 90. 00 115, 219 0 39. 00 41. 00 EMERGENCY 91. 00 0 195, 053 0 40. 00 42. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 59, 563 0 42. 00 3. 00 3. 00 CLI GHT DUTY EMPLOYEE BENEFI TS DEPARTMENT 4. 00 110, 309 0 0 0 2. 00 3. 00 0. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31.00		65. 00	o	182, 624	0		31.00
34. 00 ELECTROCARDI OLOGY 69. 00 0 4, 902 0 34. 00 35. 00 CARDI AC REHAB 69. 01 0 1,040 0 35. 00 36. 00 ELECTROENCEPHALOGRAPHY 70. 00 0 3, 975, 574 0 36. 00 37. 00 0 0 0 0 0 0 0 0 0				0	1, 496	0		
35.00 CARDI AC REHAB 69.01 0 1,040 0 35.00 36.00 ELECTROENCEPHALOGRAPHY 70.00 0 3,975,574 0 36.00 37.00 DRUGS CHARGED TO PATIENTS 73.00 0 93,032 0 37.00 38.00 RENAL DI ALYSI S 74.00 0 146 0 38.00 39.00 CLI NI C 90.00 0 115,219 0 39.00 40.00 EMERGENCY 91.00 0 195,053 0 40.00 41.00 HOME HEALTH AGENCY 101.00 0 4,815 0 41.00 42.00 PHYSI CI ANS' PRI VATE OFFI CES 192.00 0 26,053,797 G - LI GHT DUTY				0				1
36. 00 ELECTROENCEPHALOGRAPHY 70. 00 0 3, 975, 574 0 36. 00 37. 00 37. 00 38. 00 37. 00 38. 00 37. 00 38. 00 37. 00 38. 00 38. 00 37. 00 38. 00 38. 00 38. 00 38. 00 38. 00 38. 00 38. 00 38. 00 38. 00 38. 00 38. 00 38. 00 39. 00				0				
37. 00 DRUGS CHARGED TO PATIENTS 73. 00 0 93, 032 0 37. 00 38. 00 RENAL DI ALYSIS 74. 00 0 146 0 38. 00 39. 00 CLI NI C 90. 00 0 115, 219 0 39. 00 40. 00 4				0				1
38. 00 RENAL DI ALYSIS 74. 00 0 146 0 38. 00 39. 00 CLI NI C 90. 00 0 115, 219 0 40. 00 40. 00 EMERGENCY 91. 00 0 195, 053 0 40. 00 41. 00 HOME HEALTH AGENCY 101. 00 4, 815 0 41. 00 42. 00 PHYSICI ANS' PRI VATE OFFICES 192. 00 0 59, 563 0 42. 00 G - LI GHT DUTY 1. 00 EMPLOYEE BENEFITS DEPARTMENT 4. 00 110, 309 0 0 2. 00 2. 00 3. 00 4. 00 4. 00 4. 00 5. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0				
39. 00 CLINIC 90. 00 0 115, 219 0 39. 00 40. 00 40. 00 40. 00 41. 00 40. 00 41. 00 42. 00 42. 00 42. 00 43. 00 44				0				1
40. 00 EMERGENCY 91. 00 0 195, 053 0 40. 00 41. 00 42. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 26, 053, 797				0				
41. 00 HOME HEALTH AGENCY 101. 00 0 4, 815 0 41. 00 42. 00 PHYSICIANS' PRIVATE OFFICES 192. 00 0 59, 563 0 42. 00 G - LIGHT DUTY 1. 00 EMPLOYEE BENEFITS DEPARTMENT 4. 00 110, 309 0 0 1. 00 2. 00 3. 00 0 0 0 0 0 3. 00 4. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0				
A2.00 PHYSICIANS' PRIVATE OFFICES 192.00 0 59,563 0 0 26,053,797				-				
C - LIGHT DUTY				+	5 <u>9, 5</u> 63	0		42.00
1. 00 EMPLOYEE BENEFITS DEPARTMENT 4. 00 110, 309 0 0 0 2. 00 3. 00 0. 00 0. 00 0 0 0 0 2. 00 3. 00 0. 00 0 0 0 0 3. 00 4. 00 0. 00 0 0 0 0 4. 00 5. 00 0. 00 0 0 0 0 5. 00 6. 00 0. 00 0 0 0 0 6. 00		0		0	26, 053, 797			1
2. 00 0.00 0 0 0 0 2. 00 3. 00 0.00 0 0 0 0 3. 00 4. 00 0.00 0 0 0 0 4. 00 5. 00 0.00 0 0 0 0 5. 00 6. 00 0.00 0 0 0 0 6. 00	1 00		4 00	110 200	^			1 00
3. 00 0.00 0 0 0 0 3. 00 4. 00 0.00 0 0 0 0 4. 00 5. 00 0.00 0 0 0 0 5. 00 6. 00 0.00 0 0 0 0 6. 00		EMPLUTEE BENEFITS DEPARTMENT		1				1
4.00 0.00 0 0 0 4.00 5.00 0.00 0 0 0 5.00 6.00 0.00 0 0 0 0								1
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6.00 0.00 0 0 6.00				-	0	Ö		1
7.00 0.00 7.00				•	0	0		1
	7. 00		0.00	0	0	0		7.00

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2016 | To 12/31/2016 | Date/Time Prepared: Provider CCN: 15-0002

						5/26/2017 1	
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
8.00		0. 00	0	0	0		8. 00
9. 00		0. 00	0	0	0		9. 00
10. 00		0. 00	0	0	0		10.00
11. 00		0.00	0_	0	0		11. 00
	0		110, 309	0			
4 00	H - INTEREST EXPENSE	5 05		1 050 077			
1.00	OTHER A&G	5. 05	0	1, 958, 366	11		1.00
2.00	RADI OLOGY - DI AGNOSTI C	54.00	0	119, 014	11		2.00
3.00	RADI OLOGY - ULTRASOUND	54. 01	0	59, 507	11		3.00
4. 00	CT SCAN	57. 00	0	59, 507	11		4.00
5. 00	MAGNETIC RESONANCE I MAGING	58. 00	0	59, 507	11		5. 00
6. 00	(MRI) OTHER NON-REIMBURSABLE	192. 01	o	1, 276, 791	11		6.00
0.00	O IIILK NON-KET WBOKSABLE	192.01	— — 	3, 532, 692	 		0.00
	I - CORPORATE EXPENSE		<u> </u>	3, 332, 072			
1. 00	OTHER A&G	5. 05	0	10, 152, 086	9		1.00
2. 00	o men nao	0. 00	o	0 10, 102, 000	ó		2.00
2.00			— — ŏ	10, 152, 086	<u> </u>		2.00
	J - DRUG EXPENSE		-1		<u>'</u>		
1.00	PHARMACY	15. 00	0	10, 590, 136	0		1.00
	0 — — — — —			10, 590, 136			
	L - PSTD RECLASS						
1.00	DATA PROCESSING	5. 01	3, 406	0	0		1.00
2.00	PURCHASING RECEIVING AND	5. 02	1, 452	0	0		2.00
	STORES						
3. 00	ADMI TTI NG	5. 03	8, 252	0	0		3.00
4. 00	CASHI ERI NG/ACCOUNTS	5. 04	4, 987	0	0		4.00
	RECEI VABLE	5 05	0.4.04.0				
5.00	OTHER A&G	5. 05	34, 913	0	0		5.00
6. 00	OPERATION OF PLANT	7. 00	8, 518	0	0		6.00
7. 00	HOUSEKEEPI NG	9. 00	33, 236	0	0		7.00
8. 00	DI ETARY	10.00	17, 015	0	0		8.00
9.00	NURSI NG ADMI NI STRATI ON	13. 00	14, 954	0	0		9.00
10.00	CENTRAL SERVICES & SUPPLY	14.00	5, 187	0	0		10.00
11. 00	MEDICAL RECORDS & LIBRARY	16. 00	184	0	0		11.00
12.00	ADULTS & PEDIATRICS	30. 00	148, 695	0	0		12.00
13.00	INTENSIVE CARE UNIT	31.00	8, 138	0	0		13.00
14.00	NEONATAL I CU	31. 01	14, 290	0	0		14.00
15.00	SUBPROVI DER - I RF	41.00	9, 953	0	0		15.00
16.00	OPERATING ROOM	50.00	4, 928	0	0		16.00
17. 00	RECOVERY ROOM	51.00	538	0	0		17.00
18.00	DELIVERY ROOM & LABOR ROOM	52.00	6, 505	0	0		18.00
19.00	RADI OLOGY - DI AGNOSTI C	54.00	6, 078	0	0		19.00
20.00	RADI OLOGY - ULTRASOUND	54. 01	2, 967	0	0		20.00
21. 00	RADI OLOGY-THERAPEUTI C	55. 00	4, 637	0	0		21.00
22. 00	RADI OI SOTOPE	56.00	345	0	0		22.00
23. 00	CARDI AC CATHETERI ZATI ON	59.00	873	0	0		23.00
24. 00	LABORATORY	60.00	2, 884	0	-		24. 00
25. 00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62. 00	19, 227	0	0		25. 00
26. 00	RESPIRATORY THERAPY	65. 00	5, 762	0	o		26. 00
27. 00	PHYSI CAL THERAPY	66. 00	1, 293	0	0		27.00
28. 00	CLINIC	90.00	5, 045	0			28.00
29. 00	EMERGENCY	91.00	6, 692	0			29.00
30. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	5, 930	0			30.00
55. 55	0		386, 884	— — <u> </u>	$ -$		33.00
500.00	Grand Total: Decreases		2, 131, 058	51, 892, 994			500.00
	1	ı			' '		

Acqui si ti ons Beginning Bal ances Donati on Total Di sposal s and Reti rements
Beginning Balances Donation Total Disposals and Retirements
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 2.00 3.00 4.00 5.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 3,745,499 700,000 0 700,000 0 1.00 2.00 Land Improvements 6,370,152 89,527 0 89,527 0 2.00 3.00 Buildings and Fixtures 253,262,319 11,933,286 0 11,933,286 0 3.00 4.00 Building Improvements 0 0 0 0 0 0 0 0 5.00 5.00 Fixed Equipment 0 0 0 0 0 0 5.00 6.00 Movable Equipment 176,332,654 22,914,219 0 22,914,219 1,540,279 6.00
1.00 Land 3,745,499 700,000 0 700,000 0 1.00 2.00 Land Improvements 6,370,152 89,527 0 89,527 0 2.00 3.00 Buildings and Fixtures 253,262,319 11,933,286 0 11,933,286 0 3.00 4.00 Building Improvements 0 0 0 0 0 4.00 5.00 Fixed Equipment 0 0 0 0 0 5.00 6.00 Movable Equipment 176,332,654 22,914,219 0 22,914,219 1,540,279 6.00
2.00 Land Improvements 6,370,152 89,527 0 89,527 0 2.00 3.00 Buildings and Fixtures 253,262,319 11,933,286 0 11,933,286 0 3.00 4.00 Building Improvements 0 0 0 0 0 0 4.00 5.00 Fixed Equipment 0 0 0 0 0 5.00 6.00 Movable Equipment 176,332,654 22,914,219 0 22,914,219 1,540,279 6.00
3.00 Buildings and Fixtures 253, 262, 319 11, 933, 286 0 11, 933, 286 0 3.00 4.00 Building Improvements 0 0 0 0 0 0 4.00 5.00 Fixed Equipment 0 176, 332, 654 22, 914, 219 0 22, 914, 219 1, 540, 279 6.00
4.00 Building Improvements 0 0 0 0 4.00 5.00 Fixed Equipment 0 0 0 0 0 5.00 6.00 Movable Equipment 176,332,654 22,914,219 0 22,914,219 1,540,279 6.00
5.00 Fi xed Equi pment 0 0 0 0 0 0 5.00 6.00 Movable Equi pment 176,332,654 22,914,219 0 22,914,219 1,540,279 6.00
6. 00 Movable Equi pment 176, 332, 654 22, 914, 219 0 22, 914, 219 1, 540, 279 6. 00
7 00 ULT decignated Accets
7.00 HIT designated Assets 3,857,110 0 0 0 7.00
8.00 Subtotal (sum of lines 1-7) 443,567,734 35,637,032 0 35,637,032 1,540,279 8.00
9.00 Reconciling Items 20,950 0 0 0 9.00
10. 00 Total (line 8 minus line 9) 443, 546, 784 35, 637, 032 0 35, 637, 032 1, 540, 279 10. 00
Ending Fully
Bal ance Depreciated
Assets
6.00 7.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES
1.00 Land 4, 445, 499 0 1.00
2.00 Land Improvements 6, 459, 679 0 2.00
3.00 Buildings and Fixtures 265, 195, 605 0 3.00
4.00 Building Improvements 0 0 4.00
5.00 Fi xed Equi pment 0 0 5.00
6.00 Movable Equipment 197, 706, 594 0 6.00
7. 00 HIT designated Assets 3,857,110 0 7. 00
8.00 Subtotal (sum of lines 1-7) 477,664,487 0 8.00
9.00 Reconciling Items 20,950 0 9.00
10.00 Total (line 8 minus line 9) 477,643,537 0 10.00

Health Financial Systems	METHODIST HOS	SPITALS, INC		In Lieu of Form CMS-2552-10			
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2016	Worksheet A-7	'	
					Date/Time Pre	pared:	
					5/26/2017 1:1		
		Sl	JMMARY OF CAPI	TAL			
Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see		
				(see	instructions)		
				instructions)			
	9. 00	10. 00	11.00	12. 00	13. 00		
PART II - RECONCILIATION OF AMOUNTS FROM WOR	RKSHEET A, COLUI	MN 2, LINES 1		1		1	
1.00 CAP REL COSTS-BLDG & FLXT	0	0)	0	0	1.00	
3.00 Total (sum of lines 1-2)	0	0)	0	0	3.00	
	SUMMARY 0	F CAPITAL					
Cost Center Description	0ther	Total (1)					
	Capi tal -Rel at	(sum of cols.					
	ed Costs (see	9 through 14)					
	instructions)						
	14. 00	15. 00					
PART II - RECONCILIATION OF AMOUNTS FROM WOR	RKSHEET A, COLUI	MN 2, LINES 1	and 2				
1.00 CAP REL COSTS-BLDG & FLXT	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 Lieu of Form CMS-2552-10		
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od:	Worksheet A-7	
				1 -	From 01/01/2016 To 12/31/2016		narod:
				'	12/31/2010	5/26/2017 1: 14	
		COMF	COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITA				
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 -			
		1. 00	2.00	col. 2) 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	477, 643, 537	0	477, 643, 537	1. 000000	0	1.00
3. 00	Total (sum of lines 1-2)	477, 643, 537	l .	477, 643, 537			3. 00
		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at				
			ed Costs	through 7)	0.00	10.00	
	DART III DECONOLILATION OF CARLTAL COCTO	6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS C CAP REL COSTS-BLDG & FIXT	ENTERS		1	F F04 F77	0	1. 00
3. 00	Total (sum of lines 1-2)	0	0		5, 504, 577 5, 504, 577		3. 00
3.00	Total (Suil of Titles 1-2)	U	SI SI	JMMARY OF CAPI		U	3.00
			30	JWW/AICT OF CALL	IAL		
	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)		
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C			1			
1.00	CAP REL COSTS-BLDG & FIXT	1, 267, 810	l e	(-	6, 772, 387	1.00
3.00	Total (sum of lines 1-2)	1, 267, 810	0		0	6, 772, 387	3.00

ADJUST	MENTS TO EXPENSES			Provi der CCN: 15-0002	Peri od:	Worksheet A-8	
					From 01/01/2016 To 12/31/2016	Date/Time Pre	
				Expense Classification o	n Worksheet A	5/26/2017 1:1	4 pm
			To	/From Which the Amount is	to be Adjusted		
					1		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1 00		1. 00	2.00	3.00	4.00	5. 00	4 00
1. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	В	-2, 264, 882 CA	P REL COSTS-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)		0		0.00	0	4.00
4.00	Trade, quantity, and time discounts (chapter 8)				0.00		4.00
5. 00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5. 00
6. 00	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		Ğ		0.00		7.00
8. 00	21) Television and radio service		0		0.00	0	8. 00
	(chapter 21)						
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-1, 131, 796		0.00	0	9.00
	adj ustment	-			0.00		
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13. 00	Laundry and linen service		О		0.00	0	13.00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee	В	-984, 635 CA	FETERI A	11. 00 0. 00		1
15.00	and others				0.00		15.00
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16.00
	patients						
17. 00	Sale of drugs to other than patients		0		0.00	0	17. 00
18. 00	Sale of medical records and	В	-10, 421 ME	DICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing school (tuition, fees,		О		0.00	0	19.00
20. 00	books, etc.) Vending machines	В	-28, 888 DI	ETADV	10.00	0	20.00
	Income from imposition of	ь	-26, 666 DI	LIAKI	0.00	0	
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		О		0.00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	ORE	SPI RATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	O PH	YSI CAL THERAPY	66. 00		24.00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review -		0 * *	* Cost Center Deleted ***	114.00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL	А	-260, 509 CA	P REL COSTS-BLDG & FLXT	1. 00	9	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL		0 * *	* Cost Center Deleted ***	2.00	0	27. 00
28. 00	COSTS-MVBLE EQUIP		0 **	* Cost Center Deleted ***	19.00		28. 00
29.00	Non-physician Anesthetist Physicians' assistant		0		0.00		
30.00	Adjustment for occupational therapy costs in excess of	A-8-3	oloc	CUPATI ONAL THERAPY	67. 00		30.00
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see instructions)		OAD	ULTS & PEDIATRICS	30.00		30. 99
31.00	Adjustment for speech	A-8-3	0 SP	EECH PATHOLOGY	68. 00		31.00
	pathology costs in excess of limitation (chapter 14)						
	(5.66 5.5. 17)	ļ	ļ		ļ	1	·

	Financial Systems		METHODIST HOS			u of Form CMS-2	
ADJUST	MENTS TO EXPENSES				eri od:	Worksheet A-8	
					rom 01/01/2016 o 12/31/2016	Date/Time Pre	nared.
					0 12/31/2010	5/26/2017 1: 1	4 pm
				Expense Classification on	Worksheet A		
				To/From Which the Amount is			
					,		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2)				Ref.	
	Tarana da mara	1. 00	2. 00	3. 00	4. 00	5. 00	
32.00	CAH HIT Adjustment for		0		0. 00	0	32.00
	Depreciation and Interest	_				_	
	BENEFITS	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	00.00
33. 01	DATA PROCESSING OTHER INCOME	В		DATA PROCESSING	5. 01	0	
33. 02	CASH, A/R, COLLECTIONS OTHER	В		CASHI ERI NG/ACCOUNTS	5. 04	0	33. 02
	I NCOME			RECEI VABLE			
34.00	A&G OTHER INCOME	В		OTHER A&G	5. 05	0	1 0 00
35. 00	ENVI RONMENTAL SERVI CES OTHER	В	-3, 310	HOUSEKEEPI NG	9. 00	0	35.00
27 00	I NCOME		(704	NUDCI NO ADMINI CEDATI ON	12.00	0	27.00
36. 00 37. 00	NURSING ADMIN OTHER INCOME RX PROGRAM	В		NURSING ADMINISTRATION PHARMACY	13. 00 15. 00	0	36.00 37.00
38.00	PARAMED ED PROGRAM OTHER	A B		PHARMACY PARAMED ED PROGRAM	23. 00	0	
38.00	I NCOME	В	-388, 400	PARAMED ED PROGRAM	23.00	Ü	38.00
39. 00	ADULTS & PEDS OTHER INCOME	В	_86_425	ADULTS & PEDIATRICS	30. 00	0	39. 00
40. 00	RADI OLOGY	В		RADI OLOGY-DI AGNOSTI C	54. 00	0	40.00
41. 00	LAB OTHER INCOME	В		LABORATORY	60.00	0	
42. 00	BLOOD OTHER INCOME	В		WHOLE BLOOD & PACKED RED	62. 00	0	
42.00	BEOOD OTHER TROOME			BLOOD CELLS	02.00	O	72.00
43.00	CARDIAC REHAB OTHER INCOME	В		CARDI AC REHAB	69. 01	0	43.00
44. 00	ELECTROCEPHALOGRAPHY OTHER	В		ELECTROENCEPHALOGRAPHY	70. 00	0	
50	I NCOME		2, 200		. 5. 66	· ·	55
45.00	CLINIC OTHER INCOME	В	-1, 991	CLINIC	90. 00	0	45.00
	LOBBYI NG EXPENSE	A		OTHER A&G	5. 05	0	1
46. 01	DUES/LOBBYI NG	Α		OTHER A&G	5. 05	0	46. 01
46. 02	PENSION ADJUSTMENT	Α		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	46. 02
	TOTAL (6 1: 1 +b 10)		F 70F 711	1			FO 00

-5, 725, 711

50.00

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 01/01/2016 To 12/31/2016 Date/Time Prepared: Provi der CCN: 15-0002

					-	To 12/31/2016	Date/Time Pre 5/26/2017 1:1	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	•
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2.00	3. 00	4. 00	5. 00	6.00	7. 00	
1.00	30.00	ADULTS & PEDIATRICS	185, 000	185, 000	0	237, 100	0	1. 00
2.00	30.00	ADULTS & PEDIATRICS	18, 900	4, 050	14, 850	211, 500	110	2.00
3.00	31. 01	NEONATAL ICU	348, 950	348, 950	0	169, 700	0	3.00
4.00	31. 01	NEONATAL ICU	253, 050	253, 050	0	169, 700	0	4. 00
5.00	54.00	RADI OLOGY-DI AGNOSTI C	48	48	0	197, 500	0	5.00
6.00	57. 00	CT SCAN	231	231	0	179, 000	0	6.00
7.00	70.00	ELECTROENCEPHALOGRAPHY	90, 863	67, 078	23, 785	271, 900	95	7. 00
8. 00	90.00	CLINIC	-9, 150	-9, 150	0	197, 500	0	8. 00
9. 00	55. 00	RADI OLOGY-THERAPEUTI C	323, 978	259, 178	64, 800	271, 900	432	9. 00
10.00	0.00		0	0	0	0	0	10.00
200.00			1, 211, 870	1, 108, 435	103, 435		637	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Malpractice	
				Limit	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		ADULTS & PEDIATRICS	0	1	_	_	· -	1.00
2.00		ADULTS & PEDIATRICS	11, 185	l .				2.00
3.00		NEONATAL ICU	0	0	_			3.00
4.00		NEONATAL ICU	0	0	0	_	0	4.00
5.00		RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	5. 00
6.00		CT SCAN	0	0	0	0	0	6. 00
7.00		ELECTROENCEPHALOGRAPHY	12, 418	621	0	0	0	7. 00
8.00		CLINIC	0	0	0	0	0	8. 00
9. 00		RADI OLOGY-THERAPEUTI C	56, 471	2, 824	0	0	0	9. 00
10.00	0. 00		0	0	0	0	0	10.00
200.00			80, 074		0	0	0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	14 15. 00	16. 00	17. 00	18. 00		
1. 00	30.00	ADULTS & PEDIATRICS	0	0		185, 000		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	11, 185	3, 665	7, 715		2.00
3.00	31. 01	NEONATAL ICU	l o	0	0	348, 950		3.00
4.00	31.01	NEONATAL ICU	0	0	0	253, 050		4.00
5.00	54.00	RADI OLOGY-DI AGNOSTI C	l o	0	0	48		5. 00
6.00		CT SCAN	0	o	0	231		6.00
7.00	70.00	ELECTROENCEPHALOGRAPHY	l o	12, 418	11, 367	78, 445		7. 00
8.00		CLINIC	0	0	0	-9, 150		8. 00
9. 00		RADI OLOGY-THERAPEUTI C	1 0	56, 471	8, 329			9. 00
10.00	0.00	4	0	0	0	0		10.00
200.00			0	80, 074	23, 361	1, 131, 796		200.00
	•	•	•	•		•		•

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared: Provider CCN: 15-0002

					To	12/31/2016	Date/Time Pre 5/26/2017 1:1	
				CAPI TAL			372072017 1.1	T PIII
				RELATED COSTS	5454 0455	5.474	DUDOUA OLAIO	
	Cost C	Center Description	Net Expenses for Cost	BLDG & FIXT	EMPLOYEE BENEFITS	DATA PROCESSI NG	PURCHASING RECEIVING AND	
			Allocation		DEPARTMENT	FROCESSING	STORES	
			(from Wkst A		DEI 7 II CI III EI CI		0.020	
			col. 7)					
	CENEDAL SEDV	VICE COST CENTERS	0	1.00	4. 00	5. 01	5. 02	
1. 00		EL COSTS-BLDG & FLXT	6, 772, 387	6, 772, 387				1. 00
4.00		EE BENEFITS DEPARTMENT	33, 855, 076					4.00
5. 01	00550 DATA F		13, 809, 394			14, 856, 072		5. 01
5. 02 5. 03	00560 PURCHA	ASING RECEIVING AND STORES	3, 603, 842			0		5. 02
5. 03		ERING/ACCOUNTS RECEIVABLE	2, 475, 590 4, 753, 656			0	4, 916 2, 237	5. 03 5. 04
5. 05	00590 OTHER	A&G	20, 842, 265			14, 856, 072		5. 05
5.06		IT TRANSPORTATION	626, 414			0	147	5. 06
7. 00 8. 00		TION OF PLANT	16, 132, 730			0	35, 996	7.00
9. 00	00900 HOUSEK	RY & LINEN SERVICE	1, 435, 714 6, 006, 848			0	20 40, 456	8. 00 9. 00
10.00	01000 DI ETAF		4, 460, 811	90, 520		0	42, 823	
11.00	01100 CAFETE		1, 658, 086			0		11.00
13.00		NG ADMINISTRATION	3, 420, 385			0	3, 243	
14. 00 15. 00	01400 CENTRA	AL SERVICES & SUPPLY	2, 263, 775 5, 090, 398			0	55, 375 11, 123	14. 00 15. 00
16. 00	1	AL RECORDS & LIBRARY	3, 136, 053			0	906	16.00
17. 00	01700 SOCI AL		492, 378			0	0	17.00
17. 01	01701 STAFF		0	53, 535		0	0	17. 01
17. 02 21. 00	01702 MEDI CA	AL EDUCATION ERVICES-SALARY & FRINGES APPRVD	104, 065			0	25 0	17. 02 21. 00
21.00		ERVICES-SALARY & FRINGES APPROD	197, 546 30, 176		-	0		21.00
23. 00		ED ED PROGRAM	323, 407			0		23. 00
		DUTINE SERVICE COST CENTERS	1					
30. 00 31. 00		S & PEDIATRICS SIVE CARE UNIT	36, 884, 541 7, 899, 702	1, 504, 277 95, 400		0		30. 00 31. 00
31.00	03100 TNTENS		2, 427, 146			0	65, 182 957	31.00
40.00	04000 SUBPRO		1, 148, 835			0	128	
41. 00	04100 SUBPRO		3, 532, 243			0		
43. 00	04300 NURSER	RY ERVICE COST CENTERS	968, 452	117, 300	165, 235	0	12, 492	43.00
50.00	05000 OPERAT	TING ROOM	8, 712, 709	286, 464	967, 350	0	124, 397	50. 00
50. 01	05001 ENDOSC	COPY	3, 069, 264	0	276, 080	0	61, 224	50. 01
51.00	05100 RECOVE		1, 181, 990			0	3, 473	51.00
52. 00 53. 00	05200 DELT VE 05300 ANESTH	ERY ROOM & LABOR ROOM	2, 936, 051	33, 633		0	9, 948	52. 00 53. 00
54. 00		LOGY-DI AGNOSTI C	4, 539, 023		-	0	1	54.00
54. 01		LOGY - ULTRASOUND	1, 973, 792			0		
55.00		LOGY-THERAPEUTI C	1, 510, 498			0	2, 089	
56. 00 57. 00	05600 RADI 0I 05700 CT SCA		1, 531, 980 2, 273, 904	·		0	77, 122 28, 228	
58.00		TIC RESONANCE IMAGING (MRI)	863, 723			0		58.00
59.00		AC CATHETERI ZATI ON	3, 910, 410			0		
60.00	06000 LABORA		10, 176, 263			0	256, 569	
60. 01 61. 00	06001 BL00D	LABORATORY INICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	60. 01 61. 00
62.00		BLOOD & PACKED RED BLOOD CELLS	1, 449, 043	1, 849	265, 247	0	24, 301	
63.00		STORING, PROCESSING & TRANS.	0	0		0	0	63.00
64.00		/ENOUS THERAPY	0	0	-	0	0	64.00
65.00		RATORY THERAPY	3, 305, 538			0	51, 788	
66. 00 67. 00	06600 PHYSI 0	ATIONAL THERAPY	1, 611, 907 1, 279, 213			0	1, 278	66. 00 67. 00
68. 00	06800 SPEECH		451, 689			0		68. 00
69. 00	06900 ELECTR		871, 952			0		69. 00
69. 01	06901 CARDI A		491, 868		,	0	246	
70. 00 71. 00		ROENCEPHALOGRAPHY AL SUPPLIES CHARGED TO PATIENTS	2, 811, 935 12, 096, 772			0	0 1, 096, 367	
72. 00		DEV. CHARGED TO PATIENTS	13, 957, 025		-	0	1, 264, 983	
73.00	07300 DRUGS	CHARGED TO PATIENTS	11, 897, 093	7, 982		0	68, 862	73.00
74. 00	07400 RENAL		1, 952, 610	21, 050	0	0	1, 205	74. 00
90. 00	09000 CLINIC	SERVICE COST CENTERS	4, 572, 370	365, 871	591, 025	0	9, 269	90. 00
			9, 332, 494			0		
92. 00		/ATION BEDS (NON-DISTINCT PART)						92.00
101 00		JRSABLE COST CENTERS JEALTH AGENCY	2, 151, 737	0	427, 611	0	4 020	101. 00
101.00		POSE COST CENTERS	2, 101, 737		427,011	0	0, 620	101.00
118.00		TALS (SUM OF LINES 1-117)	295, 264, 768	6, 575, 640	28, 685, 459	14, 856, 072	3, 810, 652	118. 00

Health Financial Systems	METHODI ST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CC		Period: From 01/01/2016	Worksheet B Part I	
				To 12/31/2016		pared:
		CAPI TAL			3/20/2017 1.1	4 pili
		RELATED COSTS				
Cost Center Description	Net Expenses	BLDG & FIXT	EMPLOYEE	DATA	PURCHASI NG	
	for Cost		BENEFI TS	PROCESSI NG	RECEIVING AND	
	Allocation		DEPARTMENT		STORES	
	(from Wkst A					
	col . 7)					
	0	1. 00	4. 00	5. 01	5. 02	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTER	EN 236, 028	8, 650	13, 272	2 0	14, 995	190. 00
191. 00 19100 RESEARCH	0	0	(0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	37, 209, 483	128, 284	4, 405, 834	4 0	39, 123	192.00
192. 01 19201 OTHER NON-REIMBURSABLE	4, 882, 962	16, 603	741, 531	1 0	336	192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	216, 646	43, 210	37, 344	4 0	0	192. 02
193.00 19300 NONPALD WORKERS	O	0	(0	0	193.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		o	(0	0	201.00
202.00 TOTAL (sum lines 118-201)	337, 809, 887	6, 772, 387	33, 883, 440	14, 856, 072	3, 865, 106	202. 00

Provider CCN: 15-0002

Peri od: Worksheet B From 01/01/2016 Part I To 12/31/2016 Date/Ti me Prepared: 5/26/2017 1:14 pm

Cost Center Description
CENTRAL SERVICE COST CENTERS
ENERAL SERVICE COST CENTERS
1.00
0.0400 DM-DUTE EBRETTS DEPARTMENT
0.050 0.050 DATA PROCESSING
5.02 00500 PURCHASI ING RECEL YING AND STORES 2,993,499 5.03 00570 2ABH TITING 0 0 0.38,627,143 38,627,143 38,627,143 5.04 5.04 5.05 00590 CASH IERI ING/ACCOUNTS RECEI VABLE 0 0 0 76,6662 07,6692 684,384 5.06 5.07 6.00 6.
5.03 00550 ADMITTING 2, 993, 499 5 5 38 5 31 5
5.05 0.0590 OTHER MAG 0 0 0 38,627,143 38,627,143 5.05 6.050 0.0500 PATIENT TRANSPORTATION 0 0 0 7.506,622 97,692 894,394 0 7.00 0.00 0.00 0.00 0.000
5.06 0.0592 PATIENT TRANSPORTATION 0 0 756, 662 97, 692 854, 354 5.06
7.00 007000 (DERDATION OF PLANT) 0 0 18, 439, 332 2, 386, 684 0 7.00 9.00 00900 (LAUNDRY & LIENEY SERVICE) 0 0 1, 521, 341 196, 619 0 8.00 9.00 00900 (HOLSKEREPI NG) 0 0 7, 238, 774 633, 691 0 0 10.00 1000 (DETARY) 0 0 5, 899, 967 657, 616 0 10.00 1000 (DETARY) 0 0 2, 014, 036 260, 030 0 11.00 10.00 1000 (DETARY) 0 0 2, 014, 036 260, 030 0 11.00
0.0000 LANDRY & LINEN SERVICE
0,000 009000 HOUSEKEEPI NG 0 0 0 7, 238, 774 934, 591 0 0 0 0 1.00 0 0 0 0 0 0 0 0 0
11.00 01100 CAFETERIA 0
13. 00 01300 NURSI NC ADMINI STRATION 0 0 4, 078, 148 526, 526 0 13. 00 15. 00 15. 00 01500 PARMINCY 0 0 0 5, 192, 565 670, 407 0 15. 00 15. 00 01500 PARMINCY 0 0 0 5, 192, 565 670, 407 0 15. 00 17. 00 01700 SOCIAL SERVI CE 0 0 0 0 614, 413 79, 326 0 17. 00 17. 00 17. 01 01701 STAFF EDUCATION 0 0 0 614, 413 79, 326 0 17. 00 17. 00 17. 01 01701 STAFF EDUCATION 0 0 0 0 614, 413 79, 326 0 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 18 ESRVI CES-SAI ARY & FRI NGES APPRVD 0 0 0 123, 414 15, 934 0 17. 02 17. 02 17. 00 17. 00 18 ESRVI CES-SAI ARY & FRI NGES APPRVD 0 0 17. 546 25, 505 0 21. 00 22. 00 02200 18R SERVI CES-SAI ARY & FRI NGES APPRVD 0 0 482, 4034 62, 235 0 23. 00 23.00 23.00 PARAMED ED PROGRAM 0 0 0 482, 4034 62, 235 0 23. 00 23.00 23.00 PARAMED ED PROGRAM 0 0 0 482, 4034 62, 235 0 23. 00 23.00 23.00 0
14. 00 01400 CHATRAL SERVICES & SUPPLY 0 0 2, 620, 228 338, 295 0 14. 00 16. 00 01600 PHADRIACY 0 0 0 5, 19, 2565 670, 407 0 15. 00 10500 PHADRIACY 0 0 0 0 3, 663, 743 473, 022 0 16. 00 17. 00 10700 SOCIAL SERVICE 0 0 0 0 0 53, 535 6, 912 0 17. 01 17. 01 17.01 STAFF EDUCATI ON 0 0 0 53, 535 6, 912 0 17. 01 17. 02 01702 MEDICAL EDUCATI ON 0 0 0 53, 535 6, 912 0 17. 01 17. 02 01702 MEDICAL EDUCATI ON 0 0 0 197, 546 25, 505 0 21. 00 22. 00 02200 RAS SERVICES-SALARY & FRI NGES APPRVD 0 0 0 197, 546 25, 505 0 22. 00 02200 RAS SERVICES-OHLER PREMO 0 0 0 51, 629 6, 666 0 22. 00 18. PERVICES-OHLER PREMO 0 0 5482, 034 62, 235 0 23. 00 18. PERVICES-OHLER PREMO 0 0 5482, 034 62, 235 0 23. 00 18. PERVICES-OHLER PREMO 0 0 5482, 034 62, 235 0 23. 00 18. PERVICES-OHLER PREMO 0 0 0 5482, 034 62, 235 0 23. 00 18. PERVICES-OHLER SERVICE COST CENTERS 0 0. 0 0. 0 0 0 0 0 0
15. 00 01500 PHARMACY 0 0 0 5, 192, 565 670, 407 0 16. 00 17. 00 01700 SOLIAL SERVICE 0 0 0 0 614, 413 73, 322 0 16. 00 17. 00 1
16. 00 01-600 MEDICAL RECORDS & LI BRARY 0 0 3, 663, 743 473, 022 0 16. 00 17. 00 17070 SOICAL SERVICE 0 0 0 0 53, 535 6, 912 0 17. 01 1702 1702 MEDICAL EDIOLATION 0 0 0 53, 535 6, 912 0 17. 01 17. 02 1702 MEDICAL EDIOLATION 0 0 0 197, 546 25, 505 0 21. 00 22. 00 02200 IAS SERVICES. SALARY & FRI NCES APPRVD 0 0 0 197, 546 25, 505 0 21. 00 23. 00 02300 IAS SERVICES. SOILARY & FRI NCES APPRVD 0 0 0 197, 546 25, 505 0 21. 00 23. 00 02300 PARAMED ED PROGNOSTS APPRVD 0 0 0 482, 034 62, 235 0 23. 00 23. 00 02300 PARAMED ED PROGNOSTS APPRVD 0 0 0 482, 034 62, 235 0 23. 00
17.00 01700 SOCIAL SERVICE 0 0 614, 413 79, 326 0 17.00 17.01 01701 STAFF EDUCATION 0 0 0 123, 414 15, 934 0 17.01 17.02 01702 MEDICAL EDUCATION 0 0 0 123, 414 15, 934 0 17.01 17.02 01702 MEDICAL EDUCATION 0 0 0 123, 414 15, 934 0 17.01 17.01 01700 RS SERVICES-OTHER PROM COSTS APPRVD 0 0 0 51, 629 6, 666 0 0 22.00 18.00 02000 PARAMED ED PROGRAM 0 0 482, 034 62, 235 0 23.00 18.00 03000 ADULTS & PEDIATRICS 249, 775 449, 674 46, 394, 922 5, 989, 961 359, 095 18.00 03000 ADULTS & PEDIATRICS 249, 775 449, 674 46, 394, 922 5, 989, 961 359, 095 18.00 03100 INTENSI WE CARE UNIT 41, 135 74, 056 9, 653, 433 1, 246, 345 6, 154 31 00 10.00 03100 INTENSI WE CARE UNIT 41, 135 74, 056 9, 653, 433 1, 246, 345 6, 154 31 00 10.00 04000 SUBPROVI DER - 1 PF 10, 543 18, 981 1, 42, 115 186, 190 826 40, 00 10.00 04000 SUBPROVI DER - 1 PF 20, 449 674 8, 355 1, 276, 475 164, 804 40, 00 10.00 04000 SUBPROVI DER - 1 PF 20, 449 36, 814 47, 606 576, 808 10, 834 41, 00 10.00 04000 SUBPROVI DER - 1 PF 20, 449 36, 814 47, 606 576, 808 10, 834 41, 00 10.00 04000 SUBPROVI DER - 1 PF 20, 449 36, 814 47, 606 576, 808 10, 834 41, 00 10.00 04000 SUBPROVI DER - 1 PF 20, 449 36, 814 47, 606 576, 808 10, 834 41, 00 10.00 04000 SUBPROVI DER - 1 PF 20, 449 36, 814 47, 606 676, 808 10, 834 41, 00 10.00 04000 SUBPROVI DER - 1 PF 20, 449, 671 8, 355 1, 276, 475 164, 804 41, 00 10.00 05000 DERPOVI PER - 1 PF 20, 449, 671 8, 355 1, 276, 475 164, 804 41, 00 10.00 05000 DERPOVI PER - 1 PF 20, 449, 671 8, 355 1, 276, 475 164, 804 41, 00 10.00 05000 DERPOVI PER - 1 PF 20, 449, 671 20, 449, 671 20, 449, 671 20, 449, 671 20, 449, 671 20, 449, 671 2
17. 0 1070 STAFF EDUCATION 0 0 53, 555 6, 912 0 17. 02 1702 2100 0 0 0 0 0 0 0 132, 414 15, 934 0 17. 02 1702 210 0 0 0 0 0 0 0 0 0
21.00 02100 Lar SERVICES-SALARY & FRINGES APPRVD 0 0 197, 546 25, 505 0 21.00 22.00 02300 RA SERVICES-OTHER PROKI COSTS APPRVD 0 0 482, 034 62, 235 0 23.00 1 1 1 1 1 1 1 1 1
22.00 02200 Lar SERVICES-OTHER PRGM COSTS APPRVD 0 0 482,034 62,235 0 23.00
23.00
INPATIENT ROUTINE SERVICE COST CENTERS 249, 775
30.00 03000 ADULTS & PEDIATRICS 249,775 449,674 46,394,922 5,989,961 359,095 30.00 30.00 30.00 ADULTS & PEDIATRIC S 449,674 46,394,922 5,989,961 359,095 30.00 30.00 30.00 ADULTS & PEDIATRIC S 449,674 46,394,922 5,989,961 359,095 30.00 30.00 30.00 ADULTS & PEDIATRIC S 449,674 46,394,922 5,989,961 359,095 30.00 30.01 ADULTS & PEDIATRIC S 449,674 46,394,922 5,989,961 359,095 30.00 30.01 ADULTS & PEDIATRIC S 449,674 46,394,922 5,989,961 359,095 30.00 30.01 ADULTS & PEDIATRIC S 449,674 46,595 44,676 46,595 47,693 47,693 47,693 47,694 47,795 47,995 47,795
33.00 03100 INTENSIVE CARE UNIT
40.00 04000 04000 04000 04000 04000 04000 0410
41.00 04100 SUBPROVI DER - IRF 20, 449 36, 814 4, 467, 606 576, 808 10, 834 41.00 04300 NURSERY 4, 641 8, 355 1, 276, 475 164, 804 0 43.00 NURSERY 20, 00 05000 DEPRATI ING ROOM 396, 297 713, 925 11, 201, 142 1, 446, 168 0 50.00 05001 ENDOSCOPY 47, 780 86, 019 3, 540, 367 457, 093 22, 641 50.01 50.0001 ENDOSCOPY 47, 780 86, 019 3, 540, 367 457, 093 22, 641 50.01 50.0001 ENDOSCOPY 47, 780 86, 019 3, 577, 793 461, 925 5927 52.00 05200 DELI VERP ROOM LABOR ROOM 12, 571 22, 631 3, 577, 793 461, 925 5927 52.00 52.00 05200 DELI VERP ROOM LABOR ROOM 12, 571 22, 631 3, 577, 793 461, 925 5927 52.00 54.00 05400 RADI OLOGY - DI AGNOSTI C 90, 122 162, 248 55, 619, 459 725, 523 87, 081 54.00 54.01 05401 RADI OLOGY - DI L'RRASOUND 40, 782 73, 421 2, 448, 345 316, 103 91, 777 54.01 55.00 05500 RADI OLOGY - DI L'RRASOUND 40, 782 73, 421 2, 448, 345 316, 103 91, 777 54.01 55.00 05600 RADI OLOGY - DI L'RRASOUND 40, 782 73, 421 2, 448, 345 316, 103 91, 777 54.01 55.00 05600 RADI OLOGY - DI L'RRASOUND 46, 347 83, 440 1, 819, 981 234, 976 4, 729 55.00 56.00 05600 RADI OLOGY - DI L'RRASOUND 272, 016 489, 714 3, 352, 755 432, 871 129, 441 57.00 59.00 05600 RADIO LAGORATORY 343, 852 619, 042 12, 330, 785 1, 592, 015 32 60.00
43.00
NACILLARY SERVICE COST CENTERS Service Centers
50.00
50.01 05001 ENDOSCOPY 47, 780 86, 019 3, 540, 367 457, 093 22, 641 50, 01 51.00 05100 RECOVERY ROOM 26, 544 47, 787 1, 575, 525 203, 414 49 51. 00 52.00 05200 DELIVERY ROOM & LABOR ROOM 12, 571 22, 631 3, 577, 793 461, 925 5, 927 52. 00 53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 53. 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 90, 122 162, 248 5, 619, 459 725, 523 87, 081 54. 00 54.01 05401 RADI OLOGY-THERASOUND 40, 782 73, 421 2, 448, 345 316, 103 91, 777 54. 01 55.00 05500 RADI OLOGY-THERAPEUTI C 46, 347 83, 440 1, 819, 981 234, 976 4, 729 55. 00 56.00 05500 RADI OLOGY-THERAPEUTI C 46, 347 83, 440 1, 819, 981 234, 976 4, 729 55. 00 57.00 05700 CT SCAN 272, 016 489, 714 3, 352, 755 432, 871 129, 641 57. 00 58.00 05800 MAGRETI C RESONANCE I MAGI NG (MRI) 70, 223 126, 423 1, 196, 154 154, 434 43, 338 58. 00 60.00 06000 LABORATORY 343, 852 619, 042 12, 330, 785 1, 592, 015 32 60. 00 60.01 06001 BLOOD LABORATORY 343, 852 619, 042 12, 330, 785 1, 592, 015 32 60. 00 60.01 06001 BLOOD LABORATORY 0 0 0 0 0 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 20, 037 36, 073 1, 796, 550 231, 951 0 62. 00 63.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 0 64.00 06400 NTRAVENOUS THERAPY 99, 167 178, 531 4, 226, 880 545, 690 1, 263 65. 00 65.00 06500 RESPI RATORY THERAPY 99, 167 178, 531 4, 226, 880 545, 690 1, 263 65. 00 66.00 06600 PECCI PATIONAL THERAPY 99, 167 178, 531 4, 226, 880 545, 690 1, 263 65. 00 66.00 06600 SPEECH PATHOLOGY 5, 086 9, 156 568, 739 73, 429 0 68. 00 69.01 06901 CARDIAC REHAB 2, 237 3, 847 599, 476 76, 107 0 69. 01 70.00 07000 CELECTROCARDI OLOGY 50, 086 91, 262 3, 308, 145 427, 111 9, 247 70. 00
52.00 DELIVERY ROOM & LABOR ROOM 12, 571 22, 631 3, 577, 793 461, 925 5, 927 52. 00 53.00 OS300 ANESTHESI OLOGY 0 0 0 0 53. 00 54.00 OS400 RADI OLOGY-JI AGNOSTI C 90, 122 162, 248 5, 619, 459 725, 523 87, 811 54. 00 54.01 OS401 RADI OLOGY-THERASOUND 40, 782 73, 421 2, 448, 345 316, 103 91, 777 54. 01 55.00 OS500 RADI OLOGY-THERAPEUTI C 46, 347 83, 440 1, 819, 981 234, 976 4, 729 55. 00 57.00 OS500 RADI OLOGY-THERAPEUTI C 46, 347 83, 440 1, 819, 981 234, 976 4, 729 55. 00 57.00 OS500 CT SCAN 272, 016 489, 714 3, 352, 755 432, 871 129, 641 57. 00 59.00 OS900 CARDI AC CATHETERI ZATI ON 171, 130 308, 087 4, 932, 292 636, 803 29, 345 59. 00 60.01 O6001 BLOD LABORATORY 343, 852 619, 042 12, 330, 785 1, 592, 015<
53. 00 05300 ANESTHESI OLOGY 0 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 90, 122 162, 248 5, 619, 459 725, 523 87, 081 54. 00 54. 01 05401 RADI OLOGY - ULTRASOUND 40, 782 73, 421 2, 448, 345 316, 103 91, 777 54. 01 55. 00 05500 RADI OLOGY-THERAPEUTI C 46, 347 83, 440 1, 819, 981 234, 976 4, 729 55. 00 56. 00 05500 RADI OLOGY-THERAPEUTI C 46, 347 83, 440 1, 819, 981 234, 976 4, 729 55. 00 57. 00 05700 CT SCAN 272, 016 489, 714 3, 352, 755 432, 871 129, 641 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 70, 223 126, 423 1, 196, 154 154, 434 43, 338 58. 00 59. 00 CAPDI AC CATHETERI ZATI ON 171, 130 308, 087 4, 932, 292 636, 803 29, 345 59. 00 60. 01 060001 BLOOD LABORATORY 0 0
54. 00 05400 RADI OLOGY - DI AGNOSTI C 90, 122 H62, 248 S, 619, 459 725, 523 R7, 081 S4. 00 54. 01 05401 RADI OLOGY - ULTRASOUND 40, 782 T3, 421 2, 448, 345 R40 S, 619, 459 R40
54. 01 05401 RADI OLOGY - ULTRASOUND 40,782 73,421 2,448,345 316,103 91,777 54. 01 55. 00 05500 RADI OLOGY-THERAPEUTI C 46,347 83,440 1,819,981 234,976 4,729 55. 00 05600 RADI OLOGY-THERAPEUTI C 34,048 61,298 1,878,772 242,566 46,253 56. 00 05700 CT SCAN 272,016 489,714 3,352,755 432,871 129,641 57. 00 58.00 MAGNETI C RESONANCE I MAGI NG (MRI) 70,223 126,423 1,196,154 154,434 43,338 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 70,223 126,423 1,196,154 154,434 43,338 58. 00 06000 CARDI AC CATHETRI ZATI ON 171,130 308,087 4,932,292 636,803 29,345 59. 00 06000 LABORATORY 343,852 619,042 12,330,785 1,592,015 32 60. 00 60. 01 61. 00 6000 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 61. 00 62000 Whole BLOOD & PACKED RED BLOOD CELLS 20,037 36,073 1,796,550 231,951 0 62. 00 63. 00 64. 00 6400 INTRAVENOUS THERAPY 0 0 0 0 0 64. 00 65. 00 66500 RESPI RATORY THERAPY 99,167 178,531 4,226,580 545,690 1,263 65. 00 66. 00 66600 6600 6700 0 0 0 6700 0 0 0 6700 0 0 0 0 0 0 0 0 0
55. 00 05500 RADI OLOGY-THERAPEUTI C 46, 347 B3, 440 B6, 347 B3, 440 B7, 2016 B7, 00 1, 819, 981 B7, 224, 566 B7, 00 4, 729 B7, 00 55. 00 65. 00 B7, 00 B7, 00 1, 819, 981 B7, 72 B7, 224, 566 B7, 00 4, 729 B7, 00 55. 00 65. 00 B7, 00 1, 819, 981 B7, 772 B7, 224, 566 B7, 00 4, 729 B7, 00 55. 00 65. 00 67. 00 B7, 00 1, 819, 981 B7, 772 B7, 224, 566 B7, 00 46, 253 B7, 00 56. 00 67. 00 B7, 00 67. 00 B7, 00 67. 00 67. 00 B7, 00 67. 00
56. 00 05600 RADI OI SOTOPE 34, 048 61, 298 1, 878, 772 242, 566 40, 253 56. 00 57. 00 05700 CT SCAN 272, 016 489, 714 3, 352, 755 432, 871 129, 641 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 70, 223 126, 423 1, 196, 154 154, 434 43, 338 58. 00 60. 00 OS900 CARDI AC CATHETERI ZATI ON 171, 130 308, 087 4, 932, 292 636, 803 29, 345 59. 00 60. 01 06001 LABORATORY 343, 852 619, 042 12, 330, 785 1, 592, 015 32 60. 00 60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 60. 01 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 0 0 0 0 0 60. 01 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 20, 037 36, 073 1, 796, 550 231, 951 0 62. 00
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 70, 223 120, 423 1, 190, 154 154, 434 43, 338 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 171, 130 308, 087 4, 932, 292 636, 803 29, 345 59. 00 60. 00 06000 LABORATORY 343, 852 619, 042 12, 330, 785 1, 592, 015 32 60. 00 61. 00 06100 DABORATORY 0 <td< td=""></td<>
59. 00 05900 CARDI AC CATHETERI ZATI ON 171, 130 308, 087 4, 932, 292 636, 803 29, 345 59. 00 60. 00 06000 LABORATORY 343, 852 619, 042 12, 330, 785 1, 592, 015 32 60. 00 60. 01 06001 BLOOD LABORATORY 0
60. 00
60. 01
61. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 20,037 36,073 1,796,550 231,951 0 62.00 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 65. 00 06500 RESPIRATORY THERAPY 99,167 178,531 4,226,580 545,690 1,263 65.00 66. 00 06600 PHYSI CAL THERAPY 19,488 35,084 2,071,395 267,436 0 66.00 67. 00 06700 0CCUPATI ONAL THERAPY 14,955 26,923 1,638,886 211,595 16 67.00 68. 00 06800 SPEECH PATHOLOGY 5,086 9,156 568,739 73,429 0 68.00 69. 00 06900 ELECTROCARDI OLOGY 50,659 91,202 1,160,617 149,846 4,049 69.00 69. 01 06901 CARDI AC REHAB 2,137 3,847 589,476 76,107 0 69.01 70. 00 07000 ELECTROENCEPHALOGRAPHY 97,817 176,102 3,308,145 427,111 9,247 70.00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 85,937 154,714 15,462,659 1,996,368 0 72.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 0 0 63. 00 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 64. 00 65. 00 06500 RESPIRATORY THERAPY 99, 167 178, 531 4, 226, 580 545, 690 1, 263 65. 00 66. 00 06600 PHYSI CAL THERAPY 19, 488 35, 084 2, 071, 395 267, 436 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 14, 955 26, 923 1, 638, 886 211, 595 16 67. 00 68. 00 06800 SPEECH PATHOLOGY 5, 086 9, 156 568, 739 73, 429 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 50, 659 91, 202 1, 160, 617 149, 846 4, 049 69. 00 69. 01 06901 CARDI AC REHAB 2, 137 3, 847 589, 476 76, 107 0 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 97, 817 176, 102 3, 308, 145 427, 111 9, 247 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 126, 917 228, 490 13, 548, 546 1, 749, 239 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 85, 937 154, 714 15, 462, 659 1, 996, 368 0 72. 00
65. 00 06500 RESPI RATORY THERAPY 99, 167 178, 531 4, 226, 580 545, 690 1, 263 65. 00 66. 00 06600 PHYSI CAL THERAPY 19, 488 35, 084 2, 071, 395 267, 436 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 14, 955 26, 923 1, 638, 886 211, 595 16 67. 00 68. 00 06800 SPEECH PATHOLOGY 5, 086 9, 156 568, 739 73, 429 0 68. 00 69. 00 69. 00 ELECTROCARDI OLOGY 50, 659 91, 202 1, 160, 617 149, 846 4, 049 69. 00 69. 01 06901 CARDI AC REHAB 2, 137 3, 847 589, 476 76, 107 0 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 97, 817 176, 102 3, 308, 145 427, 111 9, 247 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 126, 917 228, 490 13, 548, 546 1, 749, 239 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 85, 937 154, 714 15, 462, 659 1, 996, 368 0 72. 00 072. 00
66. 00 06600 PHYSI CAL THERAPY 19, 488 35, 084 2, 071, 395 267, 436 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 14, 955 26, 923 1, 638, 886 211, 595 16 67. 00 68. 00 06800 SPEECH PATHOLOGY 5, 086 9, 156 568, 739 73, 429 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 50, 659 91, 202 1, 160, 617 149, 846 4, 049 69. 00 69. 01 06901 CARDI AC REHAB 2, 137 3, 847 589, 476 76, 107 0 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 97, 817 176, 102 3, 308, 145 427, 111 9, 247 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 126, 917 228, 490 13, 548, 546 1, 749, 239 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 85, 937 154, 714 15, 462, 659 1, 996, 368 0 72. 00 072.
67. 00 06700 0CCUPATI ONAL THERAPY 14, 955 26, 923 1, 638, 886 211, 595 16 67. 00 68. 00 06800 SPEECH PATHOLOGY 5, 086 9, 156 568, 739 73, 429 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 50, 659 91, 202 1, 160, 617 149, 846 4, 049 69. 00 69. 01 06901 CARDI AC REHAB 2, 137 3, 847 589, 476 76, 107 0 69. 01 70. 00 69. 01 71. 00 07100 ELECTROENCEPHALOGRAPHY 97, 817 176, 102 3, 308, 145 427, 111 9, 247 70. 00 71. 00 71. 00 07200 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 126, 917 228, 490 13, 548, 546 1, 749, 239 0 71. 00 72. 00 72. 00 72. 00 72. 00 73.
68. 00 06800 SPEECH PATHOLOGY 5,086 9,156 568,739 73,429 0 68. 00 69. 00 69. 00 69. 01
69. 00 06900 ELECTROCARDI OLOGY 50, 659 91, 202 1, 160, 617 149, 846 4, 049 69. 00 69. 01 6
69. 01 06901 CARDI AC REHAB 2, 137 3, 847 589, 476 76, 107 0 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 97, 817 176, 102 3, 308, 145 427, 111 9, 247 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 126, 917 228, 490 13, 548, 546 1, 749, 239 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 85, 937 154, 714 15, 462, 659 1, 996, 368 0 72. 00 07200 0
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 126, 917 228, 490 13, 548, 546 1, 749, 239 0 71. 00 72. 00 07200 MPL. DEV. CHARGED TO PATIENTS 85, 937 154, 714 15, 462, 659 1, 996, 368 0 72. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 85, 937 154, 714 15, 462, 659 1, 996, 368 0 72. 00
73.00 07300 DRUGS CHARGED TO FATTENTS 324, 071 304, 343 12, 702, 341 1, 070, 137 0 73.00
74. 00 07400 RENAL DI ALYSI S 17, 613 31, 709 2, 024, 187 261, 341 0 74. 00
OUTPATIENT SERVICE COST CENTERS
90. 00
91. 00 09100 EMERGENCY 167, 255 301, 111 11, 649, 340 1, 504, 035 1, 620 91. 00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 92. 00
OTHER REI MBURSABLE COST CENTERS 101 00 10100 HOME HEALTH ACENCY 7 954 14 140 2 609 162 236 737 0 101 00
101. 00 10100 HOME HEALTH AGENCY 7, 854 14, 140 2, 608, 162 336, 737 0 101. 00 SPECI AL PURPOSE COST CENTERS
118. 00 SUBTOTALS (SUM OF LINES 1-117) 2, 993, 499 5, 389, 701 289, 815, 586 32, 430, 646 854, 354 118. 00
NONREI MBURSABLE COST CENTERS
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 272, 945 35, 240 0 190.00
191. 00 19100 RESEARCH 0 0 0 191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 41, 782, 724 5, 394, 526 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	Peri od: Worksheet B From 01/01/2016 Part I To 12/31/2016 Date/Time Prepared:

						5/26/2017 1:1	4 pm
	Cost Center Description	ADMITTI NG	CASHI ERI NG/AC	Subtotal	OTHER A&G	PATI ENT	
			COUNTS			TRANSPORTATIO	
			RECEI VABLE			N	
		5. 03	5. 04	5A. 04	5. 05	5. 06	
192. 01 19201	OTHER NON-REIMBURSABLE	0	0	5, 641, 432	728, 360	0	192. 01
192. 02 19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	297, 200	38, 371	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	0	201.00
202. 00	TOTAL (sum lines 118-201)	2, 993, 499	5, 389, 701	337, 809, 887	38, 627, 143	854, 354	202. 00

Provider CCN: 15-0002

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2016 | Part I | To 12/31/2016 | Date/Time Prepared: | 5/26/2017 1:14 pm

							5/26/2017 1: 1	4 pm
		Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
			PLANT	LINEN SERVICE		10.00	11 00	
	CENER	PAL SERVICE COST CENTERS	7. 00	8. 00	9. 00	10. 00	11.00	
1. 00		CAP REL COSTS-BLDG & FLXT						1. 00
4. 00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01		DATA PROCESSING						5. 01
5. 02	1	PURCHASING RECEIVING AND STORES						5. 02
5. 03		ADMITTING						5. 03
5.04		CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 04
5. 05	00590	OTHER A&G					l	5. 05
5.06	00592	PATIENT TRANSPORTATION					l	5.06
7.00		OPERATION OF PLANT	20, 820, 016					7.00
8.00		LAUNDRY & LINEN SERVICE	391, 294	2, 109, 054				8.00
9. 00		HOUSEKEEPI NG	452, 979	0				9. 00
10.00		DIETARY	413, 751	0		6, 339, 554		10.00
11.00		CAFETERIA	289, 261	0		0	2, 688, 242	11.00
13.00		NURSING ADMINISTRATION	139, 395	0	,	0	61, 214	
14.00		CENTRAL SERVICES & SUPPLY	786, 825	23, 392		0	30, 068	14.00
15. 00 16. 00		PHARMACY MEDICAL RECORDS & LIBRARY	416, 144 248, 211	13 0		0	0 83, 730	15. 00 16. 00
17. 00		SOCIAL SERVICE	35, 760	0		0	16, 362	17.00
17. 00		STAFF EDUCATION	244, 699	0		0	10, 302	17.00
17. 01		MEDICAL EDUCATION	8, 210	0		0	2, 081	17. 02
21. 00		I &R SERVICES-SALARY & FRINGES APPRVD	0, 210	0		0	0	21.00
22. 00		I &R SERVICES-OTHER PRGM COSTS APPRVD	98, 060	0	- 1	o	ő	22. 00
23. 00	1	PARAMED ED PROGRAM	73, 847	0		0	22, 230	23.00
	I NPAT	TENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6, 875, 736	1, 003, 917	2, 969, 224	4, 352, 238	974, 891	30.00
31.00		INTENSIVE CARE UNIT	436, 054	53, 146	188, 306	839, 683	160, 841	31.00
31. 01	1	NEONATAL ICU	49, 568	46, 912		0	51, 854	31.01
40.00		SUBPROVIDER - IPF	87, 193	0		0	28, 558	
41. 00		SUBPROVI DER - I RF	685, 846	0		580, 578	97, 032	
43.00		NURSERY	536, 155	43, 609	231, 534	0	18, 170	43.00
FO 00		LARY SERVICE COST CENTERS	1 200 270	211 200	F/F 440	ام	107.05/	FO 00
50.00		OPERATING ROOM	1, 309, 370	211, 399		0	127, 256	50.00
50. 01 51. 00		ENDOSCOPY RECOVERY ROOM	210 214	25, 745		103	34, 053	50.01
52.00	1	DELIVERY ROOM & LABOR ROOM	319, 314 153, 730	55, 337 47, 277		241, 443	25, 271 65, 294	51. 00 52. 00
53. 00		ANESTHESI OLOGY	155, 750	47,277		241, 443	03, 294	53.00
54. 00	1	RADI OLOGY-DI AGNOSTI C	1, 164, 751	70, 293	- 1	0	79, 239	54.00
54. 01		RADI OLOGY - ULTRASOUND	110, 945	11, 927		0	31, 445	
55. 00		RADI OLOGY-THERAPEUTI C	296, 023	3, 187		o	12, 026	
56. 00		RADI OI SOTOPE	198, 512	25, 789		o	12, 539	56.00
57.00		CT SCAN	187, 975	16, 201		0	29, 156	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	92, 308	6, 477	39, 862	0	11, 447	58.00
59.00	05900	CARDIAC CATHETERIZATION	184, 243	46, 275	79, 564	62, 848	47, 916	59.00
60.00	06000	LABORATORY	516, 267	0	222, 945	0	111, 680	60.00
60. 01	06001	BLOOD LABORATORY	0	0	0	0	0	60. 01
61. 00		PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00		WHOLE BLOOD & PACKED RED BLOOD CELLS	8, 452	0		0	60, 563	
63.00		BLOOD STORING, PROCESSING & TRANS.	0	0	- 1	0	0	
64.00		I NTRAVENOUS THERAPY	0	0	- 1	0	0	
65.00		RESPI RATORY THERAPY	170, 479	3, 113		0	73, 163	65.00
66.00	1	PHYSI CAL THERAPY	269, 351	25, 534		O O	39, 394	66.00
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	231, 484 39, 426	0		19, 500	28, 675 9, 016	67. 00 68. 00
69.00	1	ELECTROCARDI OLOGY	37, 420	12, 138	,	19, 500	21, 852	
69. 01		CARDI AC REHAB	0	3, 671	1	0	11, 720	
70.00		ELECTROENCEPHALOGRAPHY	0	0,071		584	25, 650	
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	0	Ö	0	o	ő	72.00
73. 00	1	DRUGS CHARGED TO PATIENTS	36, 484	0	15, 755	o	9, 924	73. 00
74.00		RENAL DIALYSIS	96, 216	97, 407		0	0	74.00
	OUTPA	TIENT SERVICE COST CENTERS						
90.00		CLINIC	1, 672, 325	39, 667	722, 178	0	68, 883	90.00
91. 00		EMERGENCY	594, 087	225, 885	256, 551	242, 577	200, 945	91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)						92.00
101 00		R REIMBURSABLE COST CENTERS		0		ما	0	101 00
101.00		HOME HEALTH AGENCY	0	0	0	0	0	101. 00
118. 00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	19, 920, 730	2, 098, 311	8, 237, 996	6, 339, 554	2, 684, 138	118 00
110.00		IMBURSABLE COST CENTERS	17, 720, 730	2,070,311	0, 231, 790	0, 337, 334	2,004,130	110.00
190 00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	39, 536	0	17, 073	o	4 104	190. 00
		RESEARCH	37, 330 0	0		0		190.00
		PHYSICIANS' PRIVATE OFFICES	586, 360	10, 743		o		192.00
		OTHER NON-REIMBURSABLE	75, 888	0		Ō		192. 01

Health Financial Systems	METHODIST HOSPI	TALS, INC	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS			Peri od: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Prepared: 5/26/2017 1:14 pm
Cost Center Description	OPERATION OF	LAUNDRY & HOUSEKEEPING	DIFTARY	CAFETERIA

						5/20/201/ 1:1	4 piii
	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	197, 502	0	85, 289	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 118-201)	20, 820, 016	2, 109, 054	8, 626, 344	6, 339, 554	2, 688, 242	202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2016 | Part I | To 12/31/2016 | Date/Time Prepared: Provider CCN: 15-0002

					Ic	12/31/2010	Date/lime Pre 5/26/2017 1:1	
		Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
			ADMI NI STRATI O	SERVICES &		RECORDS &	SERVI CE	
			N 13. 00	SUPPLY 14. 00	15. 00	16. 00	17. 00	
	GENER	AL SERVICE COST CENTERS	10.00		10100	10.00	171.00	
1.00		CAP REL COSTS-BLDG & FLXT						1.00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 5. 02	1	DATA PROCESSING PURCHASING RECEIVING AND STORES						5. 01 5. 02
5. 02	1	ADMITTING						5. 02
5. 04	1	CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 04
5.05		OTHER A&G						5. 05
5.06		PATIENT TRANSPORTATION						5.06
7.00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE						7.00
8. 00 9. 00		HOUSEKEEPING						8. 00 9. 00
10.00	1	DI ETARY						10.00
11.00	1	CAFETERI A						11.00
13.00		NURSING ADMINISTRATION	4, 865, 480					13.00
14.00		CENTRAL SERVICES & SUPPLY	0	4, 138, 591	, 450 007			14.00
15. 00 16. 00		PHARMACY MEDICAL RECORDS & LIBRARY	0	0	'''''	4 575 904		15. 00 16. 00
17. 00	1	SOCIAL SERVICE	43, 676	0	0	4, 575, 894	804, 980	17.00
17. 01		STAFF EDUCATION	0	0	0	Ö	0	17. 01
17. 02		MEDICAL EDUCATION	0	0	0	0	0	17. 02
21. 00	1	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22. 00		I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0		0	0	22.00
23. 00		PARAMED ED PROGRAM I ENT ROUTINE SERVICE COST CENTERS	59, 338	0	0	0	0	23. 00
30.00		ADULTS & PEDIATRICS	2, 602, 270	0	0	381, 767	621, 070	30. 00
31. 00	1	INTENSIVE CARE UNIT	429, 332	0		62, 873	0	31.00
31. 01	03101	NEONATAL I CU	138, 413	0	0	25, 916	0	31.01
40.00	1	SUBPROVI DER - I PF	76, 231	0		16, 115	0	40.00
41.00		SUBPROVI DER - I RF	259, 009	0		31, 254	137, 681	41.00
43. 00		NURSERY LARY SERVICE COST CENTERS	48, 500	0	0	7, 093	0	43. 00
50.00		OPERATING ROOM	339, 684	0	0	606, 223	0	50.00
50. 01	1	ENDOSCOPY	90, 899	0		73, 029	0	50. 01
51.00	1	RECOVERY ROOM	67, 456	0	0	40, 571	0	51.00
52.00	1	DELIVERY ROOM & LABOR ROOM	174, 290	0	0	19, 213	0	52.00
53. 00 54. 00	1	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	0	0	0	127 744	0	53. 00 54. 00
54. 00	1	RADI OLOGY - DI AGNOSTI C RADI OLOGY - ULTRASOUND		0		137, 746 62, 334	0	54. 00
55. 00	1	RADI OLOGY-THERAPEUTI C	l o	0	0	70, 839	0	55. 00
56.00	05600	RADI OI SOTOPE	0	0	0	52, 041	0	56.00
57.00		CT SCAN	0	0	· ·	415, 760	0	57.00
58.00	1	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	107, 332	0	58.00
59. 00 60. 00		CARDI AC CATHETERI ZATI ON LABORATORY	0	0	0 789, 531	261, 562 525, 558	0	59. 00 60. 00
60. 00		BLOOD LABORATORY		0	769, 551	0	0	60.00
61. 00		PBP CLINICAL LAB SERVICES-PRGM ONLY		· ·		Ĭ	o .	61. 00
	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	30, 626	0	62.00
63.00		BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00		I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	0	0	0	151, 571 29, 786	0	65. 00 66. 00
67.00		OCCUPATIONAL THERAPY		0	0	22, 857	0	67.00
68. 00	1	SPEECH PATHOLOGY	0	0	0	7, 773	0	68. 00
69.00		ELECTROCARDI OLOGY	0	0	0	77, 429	0	69.00
69. 01		CARDI AC REHAB	0	0	0	3, 266	0	69. 01
70.00		ELECTROENCEPHALOGRAPHY	0	1 001 540	,	149, 508	0	70.00
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS		1, 921, 548 2, 217, 043		193, 985 131, 350	0	71. 00 72. 00
73.00		DRUGS CHARGED TO PATIENTS		2, 217, 043		496, 271	0	73.00
74. 00		RENAL DI ALYSI S	0	0		26, 921	0	74.00
	OUTPA	TIENT SERVICE COST CENTERS						
		CLINIC	0	0		89, 682	0	90.00
		EMERGENCY	536, 382	0	0	255, 639	46, 229	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS						92.00
101.00		HOME HEALTH AGENCY	0	0	6, 327	12, 004	0	101. 00
250		AL PURPOSE COST CENTERS			. 3,327	, 551		
118.00		SUBTOTALS (SUM OF LINES 1-117)	4, 865, 480	4, 138, 591	6, 313, 957	4, 575, 894	804, 980	118. 00
100 0		I MBURSABLE COST CENTERS	_1	_		_1		100.00
		GIFT, FLOWER, COFFEE SHOP & CANTEEN RESEARCH	0	0		0		190. 00 191. 00
		PHYSICIANS' PRIVATE OFFICES		0		0		191.00
	,		· "		, 200	٥١		

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 01/01/2016 Part I To 12/31/2016 Date/Time Prepared:

						5/26/2017 1:	14 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	o	0	0	0		0 201. 00
202 00	TOTAL (sum Lines 118-201)	4, 865, 480	4, 138, 591	6, 458, 837	4, 575, 894	804.98	0 202.00

Provider CCN: 15-0002

Peri od: Worksheet B From 01/01/2016 Part I To 12/31/2016 Date/Time Prepared:

					0 12/31/2016	5/26/2017 1:1	
				INTERNS &	RESI DENTS		
	Cost Center Description	STAFF	MEDI CAL	SERVI CES-SALA	SERVI CES-OTHE	PARAMED ED	
	oost conten beschiptron	EDUCATI ON	EDUCATI ON	RY & FRINGES	R PRGM COSTS	PROGRAM	
	January 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	17. 01	17. 02	21. 00	22. 00	23. 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. 03	00570 ADMITTING						5. 03
5. 04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.04
5. 05 5. 06	00590 OTHER A&G 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 13. 00	O1100 CAFETERI A O1300 NURSI NG ADMI NI STRATI ON						11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00	01500 PHARMACY						15.00
16.00	01600 MEDICAL RECORDS & LIBRARY						16.00
17. 00 17. 01	01700 SOCIAL SERVICE 01701 STAFF EDUCATION	410 017					17.00
17. 01	01701 STAFF EDUCATION 01702 MEDICAL EDUCATION	410, 817 18	153, 202				17. 01 17. 02
21. 00	02100 I & SERVICES-SALARY & FRINGES APPRVD	0	0				21.00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	o	0		198, 701		22.00
23. 00	02300 PARAMED ED PROGRAM	338	0			731, 912	23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	245 505		1		0	1 20 00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	215, 585 37, 847	0		_	0	30. 00 31. 00
31. 01	03101 NEONATAL I CU	8, 693	0			0	31.00
40. 00	04000 SUBPROVI DER - I PF	4, 845	0		Ö	0	40.00
41.00	04100 SUBPROVI DER - I RF	20, 805	0	0	o	0	41.00
43.00	04300 NURSERY	5, 695	0	0	0	0	43.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	14, 769	0	0	ol	0	50.00
50. 00	05000 PERATTING ROOM	2, 099	0		· ·	0	50.00
51. 00	05100 RECOVERY ROOM	7, 779	0		· ·	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	9, 110	0	0	o	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	1	0	0	53.00
54. 00 54. 01	05400 RADI OLOGY - III TRASOLIND	8, 384 5, 030	0		0	0	54. 00 54. 01
55. 00	05401 RADI OLOGY - ULTRASOUND 05500 RADI OLOGY-THERAPEUTI C	3, 052	0		0	0	55.00
56. 00	05600 RADI OI SOTOPE	1, 430	0		o	0	56.00
57.00	05700 CT SCAN	1, 227	0	0	o	0	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	861	0		- I	0	58.00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	3, 614 1, 195	0	0		0	59. 00 60. 00
60. 00	06001 BLOOD LABORATORY	1, 195	0		· ·	0	60.00
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		· ·	Ĭ	١	· ·	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	142	0	0	o	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	3, 280	0	0	0	0	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	157	0	0		0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	637	0	0	l ol	0	67.00
68.00	06800 SPEECH PATHOLOGY	206	0	0	o	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	2, 408	0	0	0	0	69.00
69. 01	06901 CARDI AC REHAB	21	0	0	0	0	69.01
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 205	0	0	0	0	70. 00 71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0			0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	28	0	Ö	ō	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
00.00	OUTPATIENT SERVICE COST CENTERS	4 70:1		_			00.00
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY	1, 796 37, 157	0 153, 202	0 223, 051	0 198, 701	0 731, 912	90. 00 91. 00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	37, 137	100, 202	223,051	170, /01	131,712	91.00
00	OTHER REIMBURSABLE COST CENTERS	<u>. </u>			I		1
101.00	10100 HOME HEALTH AGENCY	4, 514	0	0	0	0	101.00
110 0	SPECIAL PURPOSE COST CENTERS	404 007	450.000	000 051	400 704	704 010	110 00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	404, 927	153, 202	223, 051	198, 701	731, 912	J118.00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	0	ol	0	190. 00
	19100 RESEARCH	o o	0		l .		191.00
					· '		

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002 | Period: From 01/01/2016 | Form 01/01/2016 | Part I |
To 12/31/2016 | Date/Time Prepared: 5/26/2017 1: 14 pm

_							5/26/2017 I: I	4 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	
1	192. 00 19200	PHYSICIANS' PRIVATE OFFICES	5, 890	0	C	0	0	192.00
1	192. 01 19201	OTHER NON-REIMBURSABLE	0	0	0	0	0	192. 01
1	192. 02 19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0	0	192. 02
1	193. 00 19300	NONPALD WORKERS	0	0	0	0	0	193. 00
2	200.00	Cross Foot Adjustments			0	0	0	200.00
2	201. 00	Negative Cost Centers	0	0	0	0	0	201. 00
2	202.00	TOTAL (sum lines 118-201)	410, 817	153, 202	223, 051	198, 701	731, 912	202.00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0002 Peri od: Worksheet B From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 5/26/2017 1:14 pm Cost Center Description Subtotal Intern & Total Resi dents Cost & Post Stepdown Adj ustments 24. 00 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 4 00 5.01 00550 DATA PROCESSING 5.01 00560 PURCHASING RECEIVING AND STORES 5.02 5.02 00570 ADMITTING 5.03 5.03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.04 5.04 5.05 00590 OTHER A&G 5.05 00592 PATIENT TRANSPORTATION 5.06 5.06 7 00 00700 OPERATION OF PLANT 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 01701 STAFF EDUCATION 17.01 17.01 01702 MEDICAL EDUCATION 17.02 17.02 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 22.00 23 00 02300 PARAMED ED PROGRAM 23 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 72, 740, 676 72, 740, 676 30.00 03100 INTENSIVE CARE UNIT 31.00 13, 114, 014 0 13, 114, 014 31.00 03101 NEONATAL ICU 31 01 3 735 381 0 3, 735, 381 31 01 04000 SUBPROVI DER - I PF 40.00 1, 879, 727 0 1, 879, 727 40.00 04100 SUBPROVI DER - I RF 0 7, 163, 629 41.00 7, 163, 629 41.00 43.00 04300 NURSERY 2, 332, 035 0 2, 332, 035 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 15, 821, 451 15, 821, 451 50.00 05001 ENDOSCOPY 4, 246, 029 4, 246, 029 50.01 50.01 51.00 05100 RECOVERY ROOM 2, 432, 609 0 2, 432, 609 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 4, 822, 389 4, 822, 389 52.00 53.00 05300 ANESTHESI OLOGY 53.00 54 00 05400 RADI OLOGY-DI AGNOSTI C 8, 395, 463 8, 395, 463 54.00 05401 RADI OLOGY - ULTRASOUND 3, 125, 817 0 3, 125, 817 54.01 54.01 05500 RADI OLOGY-THERAPEUTI C 0 55.00 2, 572, 648 2, 572, 648 55.00 56.00 05600 RADI OI SOTOPE 2, 543, 628 2, 543, 628 56.00 05700 CT SCAN 4, 646, 761 57.00 4, 646, 761 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58 00 1, 652, 213 0 1, 652, 213 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 6, 284, 462 6, 284, 462 59.00 60 00 06000 LABORATORY 16, 090, 008 16, 090, 008 60.00 06001 BLOOD LABORATORY 0 60.01 0 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 Λ 0 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 2, 131, 934 62.00 62.00 2, 131, 934 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 0 0 63.00 06400 INTRAVENOUS THERAPY 64.00 0 64.00 65.00 06500 RESPIRATORY THERAPY 5, 248, 759 0 5, 248, 759 65.00 66, 00 06600 PHYSI CAL THERAPY 2, 819, 370 2, 819, 370 66.00 06700 OCCUPATI ONAL THERAPY 2, 234, 114 67.00 2, 234, 114 67.00 06800 SPEECH PATHOLOGY 68.00 735, 115 735, 115 68.00 69.00 06900 ELECTROCARDI OLOGY 1, 428, 339 1, 428, 339 69.00 06901 CARDI AC REHAB 69.01 684, 261 684, 261 69.01 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70.00 4, 564, 613 4, 564, 613 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 17, 413, 318 17, 413, 318 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 19, 807, 420 0 19, 807, 420 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 20, 092, 876 0 20, 092, 876 73.00 74 00 07400 RENAL DIALYSIS 2, 547, 622 2, 547, 622 74 00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 9, 034, 100 9, 034, 100 90.00 91.00 09100 EMERGENCY 16, 857, 313 -421, 752 16, 435, 561 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 2, 967, 744 0 2, 967, 744 101.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 282, 165, 838 -421, 752 281, 744, 086 118.00 NONREIMBURSABLE COST CENTERS

368, 898

0

368, 898

190.00

190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CC	N: 15-0002	Period: From 01/01/2016 To 12/31/2016	
Cost Center Description	Subtotal	Intern & Residents	Total		
		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	48, 178, 337	0	48, 178, 33	37	192. 00
192. 01 19201 OTHER NON-REIMBURSABLE	6, 478, 452	0	6, 478, 45	52	192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	618, 362	0	618, 36	52	192. 02
193. 00 19300 NONPALD WORKERS	0	0		0	193. 00
200.00 Cross Foot Adjustments	o	O		0	200.00
201.00 Negative Cost Centers	o	O		0	201.00
202.00 TOTAL (sum lines 118-201)	337, 809, 887	-421, 752	337, 388, 13	35	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2016 | Part II | To 12/31/2016 | Date/Time Prepared: | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2017 | 14/2 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0002

				'	0 12/31/2016	Date/lime Pre 5/26/2017 1:1	
	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	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT				00.044		1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	28, 364			44 074	4.00
5. 01 5. 02	00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES	0	44, 136			44, 974 0	5. 01 5. 02
5. 02	00570 ADMITTING	0	35, 213 46, 667	1		0	5. 02
5. 04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	147, 182	1		0	5. 04
5. 05	00590 OTHER A&G	0	478, 244	1		44, 974	5. 05
5.06	00592 PATIENT TRANSPORTATION	0	C) c	109	0	5.06
7.00	00700 OPERATION OF PLANT	0	.,,	1		0	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0		1		0	8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	99, 103	1		0	9.00
11. 00	1 I		90, 520 63, 285	1		0	11.00
13. 00	1 1	0	30, 497	1		0	13. 00
14.00	1 I	0	172, 142	1		0	14.00
15. 00	1 1	0	91, 044	91, 044		0	15. 00
16. 00		0		1		0	16. 00
17.00		0	7, 824	1		0	17.00
17. 01 17. 02	1	0	53, 535 1, 796	1		0	17. 01 17. 02
21. 00			1, 730) 1, 7, 70		0	21.00
22. 00	1	0	21, 453	1	-	0	22.00
23. 00	1 1	0				0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	_					
30.00		0	,			0	
31. 00 31. 01		0 0		1		0	31.00
40. 00			19, 076			0	40.00
41. 00		0	150, 049			0	41.00
43.00	04300 NURSERY	0		1		0	43.00
	ANCILLARY SERVICE COST CENTERS	1			1		
50. 00 50. 01	1	0 0	286, 464	286, 464		0	50. 00 50. 01
51. 00	1		69, 859	1		0	51.00
52. 00	1	0		1		0	52.00
53.00	1 1	0	C			0	53.00
54.00		0	254, 824	1		0	54.00
54. 01		0	24, 273	1		0	54.01
55. 00 56. 00		0	64, 764 43, 430	1		0	55. 00 56. 00
57. 00	1 I		41, 125			0	57.00
58. 00	1 1	0	l ·	1		0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	40, 309	40, 309	388	0	59.00
60.00	1 1	0	112, 949	112, 949	688	0	
60. 01		0	C)	0	0	60.01
61. 00 62. 00		0	1 040	1 040	222	0	61. 00 62. 00
63. 00	1 1	0	1, 849	1, 849	222	0	63.00
64. 00		0	Ö		o o	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	37, 297	37, 297	464	0	65.00
66. 00		0	58, 929			0	66. 00
67.00		0	50, 644			0	67.00
68. 00 69. 00		0	8, 626	8, 626		0	68.00
69. 00		0			121 76	0	69. 00 69. 01
70. 00		0			186	0	70.00
71.00		0	C		0	0	71.00
72. 00		0	[c) c	0	0	72.00
73.00		0	7, 982	1		0	73.00
74. 00	07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS	0	21, 050	21, 050	0	0	74.00
90.00		0	365, 871	365, 871	494	0	90.00
91.00		Ö	129, 974	1		0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			c			92.00
101 0	OTHER REIMBURSABLE COST CENTERS	1 -		J -	0=0		101 00
101.0	O 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	C) C	358	0	101.00
118. 0		0	6, 575, 640	6, 575, 640	24, 017	44, 974	118.00
			•	•			•

Health Finar	ncial Systems	METHODIST HOS	SPITALS, INC		In Lie	u of Form CMS-2	2552-10
ALLOCATI ON	OF CAPITAL RELATED COSTS		Provi der CO		Peri od:	Worksheet B	
					From 01/01/2016 o 12/31/2016		
			CAPI TAL				
	Cost Center Description	Directly Assigned New Capital	RELATED COSTS BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSI NG	
		Related Costs			DELAKTIMENT		
		0	1.00	2A	4.00	5. 01	
	I MBURSABLE COST CENTERS						
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8, 650	8, 650	11		190. 00
191. 00 19100		0	0	(0		191. 00
	PHYSICIANS' PRIVATE OFFICES	0	128, 284	128, 284	3, 685	0	192.00
192. 01 19201	OTHER NON-REI MBURSABLE	0	16, 603	16, 603		0	192. 01
192. 02 19202	FAMILY HEALTH/GARY COMM HEALTH	0	43, 210	43, 210	31	0	192. 02
193.00 19300	NONPALD WORKERS	0	0	(0	0	193. 00
200.00	Cross Foot Adjustments			()		200.00
201.00	Negative Cost Centers		0	(0	0	201.00
202. 00	TOTAL (sum lines 118-201)	0	6, 772, 387	6, 772, 387	28, 364	44, 974	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2016 Part II
To 12/31/2016 Date/Time Prepared: 5/26/2017 1:14 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0002

				10	12/31/2010	5/26/2017 1:1	
	Cost Center Description	PURCHASI NG	ADMITTI NG	CASHI ERI NG/AC	OTHER A&G	PATI ENT	
		RECEIVING AND STORES		COUNTS RECEI VABLE		TRANSPORTATIO N	
		5. 02	5. 03	5. 04	5. 05	5. 06	
	GENERAL SERVICE COST CENTERS					2.22	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00550 DATA PROCESSING	05 400					5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES	35, 402	47 100				5.02
5. 03 5. 04	00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE	45 20	47, 102 0				5. 03 5. 04
5. 05	00590 OTHER A&G	58	0		525, 320		5.04
5. 06	00592 PATIENT TRANSPORTATION	1	0		1, 329	l	5.06
7. 00	00700 OPERATION OF PLANT	330	0	Ö	32, 379	1	7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	0	0	2, 671	0	8.00
9.00	00900 HOUSEKEEPI NG	370	0	0	12, 711	0	9. 00
10.00	01000 DI ETARY	392	0	_	8, 938	l	10.00
11. 00	01100 CAFETERI A	1	0	0	3, 537	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	30	0	0	7, 161	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	507	0	0	4, 601	0	14.00
15.00	01500 PHARMACY	102	0	_	9, 118	0	15.00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	8	0	_	6, 434 1, 079		16. 00 17. 00
17. 00	01700 SOCIAL SERVICE		0	0	94		17.00
17. 01	01702 MEDICAL EDUCATION		0		217	ĺ	17. 02
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	l o	347	Ö	21.00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	91	Ō	22. 00
23.00	1	5	0	0	846	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	1, 858	3, 920		81, 429	605	30. 00
31. 00	03100 INTENSIVE CARE UNIT	597	646		16, 951	10	31.00
31. 01	03101 NEONATAL I CU	9	266		5, 276	0	31. 01
40.00	04000 SUBPROVI DER - I PF	1 10/	165		2, 532	1	40.00
41.00	04100 SUBPROVI DER - I RF	106	321 73		7, 845	18 0	41.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	114	/3	229	2, 241	0	43.00
50. 00	05000 OPERATING ROOM	1, 139	6, 344	19, 228	19, 669	0	50.00
50. 01	05001 ENDOSCOPY	561	750		6, 217	38	50. 01
51. 00	05100 RECOVERY ROOM	32	417		2, 767	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	91	197	621	6, 283	10	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	123	1, 414		9, 868	l .	54.00
54. 01	05401 RADI OLOGY - ULTRASOUND	129	640		4, 299	l e	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	19	727		3, 196	8	55.00
56.00	05600 RADI OI SOTOPE	706	534		3, 299	l	56.00
57.00	05700 CT SCAN	259	4, 269		5, 887	218	57.00
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	74 350	1, 102 2, 685		2, 100 8, 661	73 49	58. 00 59. 00
60.00	06000 LABORATORY	2, 350	5, 396		21, 653	0	60.00
60. 01	06001 BLOOD LABORATORY	2, 330	0, 370		21,033	ĺ	60.01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		· ·	Ĭ	· ·		61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	223	314	990	3, 155	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	l	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00	06500 RESPI RATORY THERAPY	474	1, 556		7, 422	2	65.00
66. 00	06600 PHYSI CAL THERAPY	12	306		3, 637	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	12	235		2, 878		67.00
68.00	06800 SPEECH PATHOLOGY	7	80		999	l e	68.00
69. 00 69. 01	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	15	795		2, 038	7 0	69. 00 69. 01
70.00		2	34 1, 535		1, 035 5, 809		70.00
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 040	1, 992		23, 791	0	70.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	11, 591	1, 349		27, 152	l e	72.00
73. 00		631	5, 095		22, 797	Ö	73.00
74.00		11	276		3, 554	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
90.00		85	921		10, 014	1	90.00
91.00		1, 352	2, 625	8, 268	20, 456	3	91.00
92.00							92.00
104 6	OTHER REIMBURSABLE COST CENTERS		100	22-1	. ===	-	101 00
101.00	10100 HOME HEALTH AGENCY	62	123	388	4, 580	0	101. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	34, 904	47, 102	147, 609	441, 043	1 420	118. 00
110.00	NONREIMBURSABLE COST CENTERS	34, 904	47, 102	147,009	441, U43	1, 439	ji 10. 00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	137	0	0	479	n	190. 00
	19100 RESEARCH	0	0		0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES	358	0		73, 370		192.00
	·	· · · · · · · · · · · · · · · · · · ·					

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0002	Peri od: Worksheet B From 01/01/2016 Part II Date/Time Prepared: 5/24/2017 1:14 pm

					5/26/2017 1:1	4 pm
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 19201 OTHER NON-REIMBURSABLE	3	0	0	9, 906	0	192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	0	0	0	522	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 118-201)	35, 402	47, 102	147, 609	525, 320	1, 439	202.00

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

				10) 12/31/2010	Date/lime Pre 5/26/2017 1:1	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT 7,00	LI NEN SERVI CE	0.00	10.00	11 00	
	GENERAL SERVICE COST CENTERS	7. 00	8. 00	9. 00	10. 00	11. 00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00550 DATA PROCESSING						5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES						5. 02
5. 03 5. 04	00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 03 5. 04
5. 05	00590 OTHER A&G						5. 05
5.06	00592 PATIENT TRANSPORTATION						5.06
7. 00	00700 OPERATION OF PLANT	1, 470, 981					7. 00
8. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	27, 646	115, 924				8.00
9. 00 10. 00	01000 DI ETARY	32, 004 29, 232	0		132, 502		9. 00 10. 00
11. 00	01100 CAFETERI A	20, 437	0		132, 302	89, 606	1
13.00	01300 NURSING ADMINISTRATION	9, 849	0		0	2, 040	1
14.00	01400 CENTRAL SERVICES & SUPPLY	55, 591	1, 286		0	1, 002	1
15.00	01500 PHARMACY	29, 402	1	3, 023	0	0	
16. 00 17. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	17, 537	0	,	0	2, 791	16. 00 17. 00
17. 00	01700 SOCIAL SERVICE	2, 527 17, 289	0	260 1, 777	0	545 0	17.00
17. 02	01702 MEDI CAL EDUCATI ON	580	0	60	Ö	69	1
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	6, 928		–	0	0	
23. 00	02300 PARAMED ED PROGRAM	5, 217	0	536	0	741	23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	485, 783	55, 176	49, 948	90, 965	32, 496	30.00
31. 00	03100 INTENSIVE CARE UNIT	30, 808	2, 921		17, 550	5, 361	
31. 01	03101 NEONATAL I CU	3, 502	2, 579		0	1, 728	1
40.00	04000 SUBPROVI DER - I PF	6, 160	0		0	952	1
41.00	04100 SUBPROVI DER - I RF	48, 457	0		12, 135	3, 234	1
43. 00	04300 NURSERY	37, 881	2, 397	3, 895	0	606	43.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	92, 510	11, 620	9, 511	0	4, 242	50.00
50. 01	05001 ENDOSCOPY	0	1, 415		2	1, 135	1
51.00	05100 RECOVERY ROOM	22, 560	3, 042		0	842	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	10, 861	2, 599	1, 117	5, 046	2, 176	1
53.00	05300 ANESTHESI OLOGY	0	0	-	0	0	53.00
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05401 RADI OLOGY - ULTRASOUND	82, 292 7, 839	3, 864		0	2, 641 1, 048	54. 00 54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	20, 915	656 175		0	401	55.00
56.00	05600 RADI OI SOTOPE	14, 025	1, 418		Ö	418	1
57.00	05700 CT SCAN	13, 281	890	1, 365	0	972	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	6, 522	356		0	382	1
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON	13, 017	2, 544		1, 314	1, 597	1
60.00	06000 LABORATORY 06001 BLOOD LABORATORY	36, 475 0	0	-,	0	3, 723 0	1
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				Ŭ	0	61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	597	0	61	0	2, 019	62.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	-		0	0	1
64.00		0	0		0	0	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	12, 045 19, 030			0	2, 439	1
67.00		16, 355			0	1, 313 956	
68. 00	06800 SPEECH PATHOLOGY	2, 786			408	301	1
69. 00		0	667	0	0	728	
69. 01	06901 CARDI AC REHAB	0	202		0	391	1
	07000 ELECTROENCEPHALOGRAPHY	0	0	1	12	855	
71. 00 72. 00		0	0	0	0	0	
	07300 DRUGS CHARGED TO PATIENTS	2, 578	0	265	0	331	
	07400 RENAL DIALYSIS	6, 798			0	0	1
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	118, 154			0	2, 296	1
	09100 EMERGENCY	41, 974	12, 416	4, 315	5, 070	6, 698	1
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
	SPECIAL PURPOSE COST CENTERS				<u> </u>]
118.00	SUBTOTALS (SUM OF LINES 1-117)	1, 407, 444	115, 333	138, 570	132, 502	89, 469	118. 00
100.00	NONREI MBURSABLE COST CENTERS	0.700		1 00-1	51	407	100.00
) 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN) 19100 RESEARCH	2, 793		287 0	0		190. 00 191. 00
	19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES	41, 428	_		0		191.00
	19201 OTHER NON-REI MBURSABLE	5, 362			Ö		192. 01

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: From 01/01/2016 Part II To 12/31/2016 Date/Time Prepared: 5/26/2017 1:14 pm

						5/26/2017 1:1	4 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	2 FAMILY HEALTH/GARY COMM HEALTH	13, 954	0	1, 435	0	0	192.02
193. 00 1930	O 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 118-201)	1, 470, 981	115, 924	145, 102	132, 502	89, 606	202.00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2016 Part II
To 12/31/2016 Date/Time Prepared: 5/26/2017 1:14 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0002

		Cost Conton Decemintion	NURSI NG	CENTRAL	DHADMACY		5/26/2017 1:1	
		Cost Center Description	ADMI NI STRATI O	CENTRAL SERVICES &	PHARMACY	MEDICAL RECORDS &	SOCI AL SERVI CE	
			N 13. 00	SUPPLY 14. 00	15. 00	LI BRARY 16. 00	17. 00	
		AL SERVICE COST CENTERS	10.00	11.00	10.00	10.00	17.00	
1. 00 4. 00	1	CAP REL COSTS-BLDG & FIXT EMPLOYEE BENEFITS DEPARTMENT						1.00 4.00
5. 01		DATA PROCESSING						5. 01
5. 02	1	PURCHASING RECEIVING AND STORES						5. 02
5. 03 5. 04		ADMITTING CASHIERING/ACCOUNTS RECEIVABLE				•		5. 03 5. 04
5. 05	1	OTHER A&G						5. 05
5.06		PATIENT TRANSPORTATION						5.06
7. 00 8. 00	1	OPERATION OF PLANT LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	1	HOUSEKEEPI NG						9.00
10.00		DIETARY						10.00
11. 00 13. 00		CAFETERIA NURSING ADMINISTRATION	51, 112					11. 00 13. 00
14. 00		CENTRAL SERVICES & SUPPLY	0	240, 952				14.00
15.00	01500	PHARMACY	o	0	132, 690			15. 00
16. 00 17. 00	1	MEDICAL RECORDS & LIBRARY	0 459	0	0	83, 272	12 700	16. 00 17. 00
17.00		SOCIAL SERVICE STAFF EDUCATION	459	0	0	0	12, 790 0	17.00
17. 02	01702	MEDICAL EDUCATION	o	0		0	0	17. 02
21. 00 22. 00		I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	1	0	0	21. 00 22. 00
22.00		PARAMED ED PROGRAM	623	0		0	0	22.00
	I NPAT	IENT ROUTINE SERVICE COST CENTERS				- 1		
30.00		ADULTS & PEDIATRICS	27, 337	0		6, 957	9, 867	30.00
31. 00 31. 01		INTENSIVE CARE UNIT NEONATAL ICU	4, 510 1, 454	0		1, 146 472	0	31. 00 31. 01
40.00	04000	SUBPROVI DER - I PF	801	0		294	0	40. 00
41.00		SUBPROVI DER – I RF	2, 721	0		570	2, 188	
43. 00		NURSERY LARY SERVICE COST CENTERS	509	0	0	129	0	43.00
50.00		OPERATING ROOM	3, 568	0	0	10, 927	0	50. 00
50. 01		ENDOSCOPY	955	0		1, 331	0	50.01
51. 00 52. 00	1	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	709 1, 831	0		739 350	0	51. 00 52. 00
53.00		ANESTHESI OLOGY	0	Ō	1	0	0	53.00
54.00		RADI OLOGY-DI AGNOSTI C	0	0	I - 1	2, 510	0	54.00
54. 01 55. 00	1	RADI OLOGY - ULTRASOUND RADI OLOGY-THERAPEUTI C	0	0	0	1, 136 1, 291	0	54. 01 55. 00
56.00	1	RADI OI SOTOPE	0	0	0	948	0	56.00
57.00	1	CT SCAN	0	0	0	7, 577	0	57. 00
58. 00 59. 00		MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION	0	0	0	1, 956 4, 767	0	58. 00 59. 00
60.00	1	LABORATORY		0		9, 578	0	60.00
60. 01		BLOOD LABORATORY	0	0	0	0	0	60. 01
61. 00 62. 00		PBP CLINICAL LAB SERVICES-PRGM ONLY WHOLE BLOOD & PACKED RED BLOOD CELLS		0		558	0	61. 00 62. 00
63.00		BLOOD STORING, PROCESSING & TRANS.		0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	o	0	0	О	0	64.00
65.00		RESPI RATORY THERAPY PHYSI CAL THERAPY	0	0	0	2, 762 543	0	65. 00 66. 00
66. 00 67. 00		OCCUPATIONAL THERAPY		0	0	417	0	67.00
68.00	06800	SPEECH PATHOLOGY	O	0	0	142	0	68. 00
69.00		ELECTROCARDI OLOGY	0	0	0	1, 411	0	69.00
69. 01 70. 00		CARDI AC REHAB ELECTROENCEPHALOGRAPHY		0	13, 193	60 2, 725	0	69. 01 70. 00
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	o	111, 871	0	3, 535	0	71. 00
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	129, 081	0	2, 394	0	72.00
73. 00 74. 00		DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	0	0		9, 044 491	0	73. 00 74. 00
71.00		TIENT SERVICE COST CENTERS	<u> </u>			171		71.00
90.00		CLINIC	0	0		1, 634	0	90.00
91. 00 92. 00	1	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	5, 635	0	0	4, 659	735	91. 00 92. 00
72.00		REIMBURSABLE COST CENTERS						72.00
101.00	10100	HOME HEALTH AGENCY	0	0	130	219	0	101. 00
118. 00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	51, 112	240, 952	129, 713	83, 272	12, 790	118 00
	NONRE	IMBURSABLE COST CENTERS		270, 732	127, / 13	03, 272	12, 130	
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1	0		190.00
		RESEARCH PHYSI CI ANS' PRI VATE OFFI CES	0	0		0		191. 00 192. 00
. , 2. 00	.,.,200	1	<u>, </u>	0	2, 7, 1	<u> </u>	0	1. 72. 00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0002	Period: Worksheet B From 01/01/2016 Part II To 12/31/2016 Date/Time Prepared:

						5/26/2017 1:1	4 pm
Cost Cent	er 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 NO	I-REI MBURSABLE	0	0	0	0	0	192. 01
192. 02 19202 FAMI LY HE	ALTH/GARY COMM HEALTH	0	0	0	0	0	192.02
193. 00 19300 NONPALD V	/ORKERS	0	0	0	0	0	193.00
200.00 Cross Foo	ot Adjustments						200.00
201.00 Negative	Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (su	m lines 118-201)	51, 112	240, 952	132, 690	83, 272	12, 790	202.00

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

				T		Date/Time Pre 5/26/2017 1:1	
				I NTERNS &	RESI DENTS		
	Cost Center Description	STAFF EDUCATION	MEDI CAL EDUCATI ON	SERVI CES-SALA RY & FRI NGES	SERVICES-OTHE R PRGM COSTS	PARAMED ED PROGRAM	
		17. 01	17. 02	21.00	22. 00	23. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT			I			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. 02	00570 ADMITTING						5. 02
5. 04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 04
5. 05 5. 06	00590 OTHER A&G 00592 PATIENT TRANSPORTATION						5. 05 5. 06
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8. 00 9. 00
10.00	01000 DI ETARY						10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON						11. 00 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. 01	01701 STAFF EDUCATION	72, 695					17. 01
17. 02 21. 00	01702 MEDICAL EDUCATION 02100 I&R SERVICES-SALARY & FRINGES APPRVD	3	2, 740 0				17. 02 21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	O	Ö		29, 184		22. 00
23. 00	02300 PARAMED ED PROGRAM INPATIENT ROUTINE SERVICE COST CENTERS	60	0			24, 303	23. 00
30. 00	03000 ADULTS & PEDIATRICS	38, 150	0				30.00
31.00	03100 INTENSIVE CARE UNIT	6, 697	0				31.00
31. 01 40. 00	03101 NEONATAL I CU 04000 SUBPROVI DER - I PF	1, 538 857	0				31. 01 40. 00
41.00	04100 SUBPROVI DER - I RF	3, 681	0				41.00
43. 00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	1, 008	0				43.00
50.00	05000 OPERATI NG ROOM	2, 613	0	1			50.00
50. 01 51. 00	05001 ENDOSCOPY 05100 RECOVERY ROOM	371 1, 377	0				50. 01 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 612	0	1			52.00
53.00	05300 ANESTHESI OLOGY	0	0				53.00
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05401 RADI OLOGY - ULTRASOUND	1, 484 890	0				54. 00 54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	540	0				55.00
56. 00 57. 00	05600	253 217	0				56. 00 57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	152	0				58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	639 211	0				59. 00 60. 00
60. 01	06001 BLOOD LABORATORY	0	Ö				60. 01
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	25	0				61. 00 62. 00
63.00		0	0				63.00
	06400 I NTRAVENOUS THERAPY	0	0				64.00
65. 00 66. 00		580 28	0				65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	113	0				67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	37 426	0				68. 00 69. 00
69. 01	06901 CARDI AC REHAB	4	Ö				69. 01
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	390	0				70. 00 71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72.00
	07300 DRUGS CHARGED TO PATIENTS	5	0				73.00
74.00	07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS	l 0	0				74.00
	09000 CLI NI C	318	0 740				90.00
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 575	2, 740				91.00 92.00
	OTHER REIMBURSABLE COST CENTERS			1			
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	799	0				101.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	71, 653	2, 740	0	0	0	118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	l ol	0				190. 00
	19100 RESEARCH	Ö	0	1			191.00

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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002 | Period: From 01/01/2016 | Part II To 12/31/2016 | Date/Time Prepared: 5/26/2017 1:14 pm

						5/20/201/ 1:1	4 piii
				INTERNS &	RESI DENTS		
	October Description	CTAFF	MEDICAL	CEDVILOEC CALA	CEDVI OFC. OTHE	DADAMED ED	
	Cost Center Description	STAFF	MEDI CAL	SERVICES-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	
192.0019	200 PHYSICIANS' PRIVATE OFFICES	1, 042	0				192.00
192. 01 19	201 OTHER NON-REIMBURSABLE	0	0				192. 01
192. 02 19	202 FAMILY HEALTH/GARY COMM HEALTH	0	0				192. 02
193. 00 19	300 NONPALD WORKERS	0	0				193.00
200.00	Cross Foot Adjustments			347	29, 184	24, 303	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	72, 695	2.740	347	29. 184	24, 303	202.00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0002 Peri od: Worksheet B From 01/01/2016 Part II Date/Time Prepared: 12/31/2016 5/26/2017 1:14 pm Cost Center Description Subtotal Intern & Total Resi dents Cost & Post Stepdown Adj ustments 24. 00 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 4 00 5.01 00550 DATA PROCESSING 5.01 00560 PURCHASING RECEIVING AND STORES 5.02 5.02 00570 ADMITTING 5.03 5.03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.04 5.04 5.05 00590 OTHER A&G 5.05 5.06 00592 PATIENT TRANSPORTATION 5.06 00700 OPERATION OF PLANT 7 00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 01701 STAFF EDUCATION 17.01 17.01 01702 MEDICAL EDUCATION 17.02 17.02 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 22.00 23 00 02300 PARAMED ED PROGRAM 23 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2, 407, 082 2, 407, 082 30.00 03100 INTENSIVE CARE UNIT 31.00 189, 033 0 189, 033 31.00 03101 NEONATAL ICU 29, 299 31 01 0 29 299 31 01 04000 SUBPROVI DER - I PF 40.00 32, 198 0 32, 198 40.00 04100 SUBPROVI DER - I RF 237, 917 0 237, 917 41.00 41.00 43.00 04300 NURSERY 166, 520 0 166, 520 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 468, 644 0 468, 644 50.00 05001 ENDOSCOPY 50.01 15, 368 15, 368 50.01 51.00 05100 RECOVERY ROOM 106, 181 0 106, 181 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 66, 898 66, 898 52.00 53.00 05300 ANESTHESI OLOGY 0 53.00 54 00 05400 RADI OLOGY-DI AGNOSTI C 372, 551 0 372, 551 54.00 05401 RADI OLOGY - ULTRASOUND 44.156 0 44. 156 54.01 54.01 05500 RADI OLOGY-THERAPEUTI C 0 55.00 96.571 96.571 55.00 68, 343 56.00 05600 RADI OI SOTOPE 68, 343 0 56.00 05700 CT SCAN 89, 713 0 89, 713 57.00 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 37, 144 58 00 37.144 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 86, 117 0 86, 117 59.00 60 00 06000 LABORATORY 229, 991 229, 991 60.00 06001 BLOOD LABORATORY 60.01 0 0 60.01 0 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 10,013 62.00 62.00 10,013 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 63.00 0 0 06400 INTRAVENOUS THERAPY 64.00 0 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 71, 352 0 71, 352 65.00 66, 00 06600 PHYSI CAL THERAPY 88, 410 88, 410 66.00 06700 OCCUPATI ONAL THERAPY 74, 252 0 74, 252 67.00 67.00 14, 001 06800 SPEECH PATHOLOGY 68.00 0 14,001 68.00 69.00 06900 ELECTROCARDI OLOGY 8,712 0 8,712 69.00 06901 CARDI AC REHAB 1, 910 1, 910 69.01 69.01 07000 ELECTROENCEPHALOGRAPHY 29, 556 0 29, 556 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 157, 503 0 71.00 157, 503 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 175, 815 0 175, 815 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 165,030 0 165, 030 73.00 07400 RENAL DIALYSIS 74 00 39, 104 0 39, 104 74 00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 517, 016 0 517, 016 90.00 91.00 09100 EMERGENCY 254, 809 0 254, 809 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 Ω OTHER REIMBURSABLE COST CENTERS 6, 659 101.00 10100 HOME HEALTH AGENCY 6, 659 0 101.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 6, 357, 868 0 6, 357, 868 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 12, 494 0 12, 494 190.00

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider Co	CN: 15-0002	Peri od: From 01/01/2016 To 12/31/2016		epared:
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total			
	24. 00	25. 00	26.00			
191. 00 19100 RESEARCH	0	0		0		191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	255, 994	0	255, 9	94		192. 00
192. 01 19201 OTHER NON-REIMBURSABLE	33, 045	0	33, 0	45		192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	59, 152	0	59, 1	52		192. 02
193. 00 19300 NONPALD WORKERS	0	0		0		193. 00
200.00 Cross Foot Adjustments	53, 834	0	53, 8	34		200.00
201.00 Negative Cost Centers	0	0		0		201.00
202.00 TOTAL (sum lines 118-201)	6, 772, 387	0	6, 772, 3	87		202. 00

31.00 03100 INTENSIVE CARE UNIT	19, 864	6, 371, 660	0	719, 182	16, 137, 742	31.00
31. 01 03101 NEONATAL CU	2, 258	2, 234, 285	0	10, 558	6, 651, 844	31.01
40. 00 04000 SUBPROVI DER - I PF	3, 972	1, 054, 293	0	1, 407	4, 136, 239	40.00
41. 00 04100 SUBPROVI DER - I RF	31, 243	3, 088, 857	0	127, 615	8, 022, 185	41.00
43. 00 04300 NURSERY	24, 424	712, 350	0	137, 831	1, 820, 698	43.00
ANCILLARY SERVICE COST CENTERS						1
50.00 05000 OPERATING ROOM	59, 647	4, 170, 365	0	1, 372, 538	155, 635, 066	50.00
50. 01 05001 ENDOSCOPY	0	1, 190, 215	0	675, 519	18, 744, 590	50. 01
51.00 05100 RECOVERY ROOM	14, 546	1, 059, 985	0	38, 319	10, 413, 420	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	7, 003	2, 426, 987	0	109, 756	4, 931, 560	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, 413, 564	0	147, 816	35, 355, 787	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	5, 054	1, 387, 947	0	155, 926	15, 999, 392	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	13, 485	486, 481	0	23, 051	18, 182, 554	55.00
56. 00 05600 RADI 0I SOTOPE	9, 043	564, 299	0	850, 921	13, 357, 538	56.00
57. 00 05700 CT SCAN	8, 563	1, 068, 157	0	311, 452	106, 714, 673	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	4, 205	463, 519	0	89, 072	27, 549, 154	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	8, 393	2,000,859	0	421, 937	67, 136, 072	59.00
60. 00 06000 LABORATORY	23, 518	3, 544, 218	0	2, 830, 853	134, 896, 832	60.00
60. 01 06001 BLOOD LABORATORY	0	o	0	0	0	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	385	1, 143, 511	0	268, 128	7, 860, 813	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	o	o	0	0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	o	0	o	0	64.00
65. 00 06500 RESPIRATORY THERAPY	7, 766	2, 389, 479	0	571, 408	38, 904, 211	65.00
66. 00 06600 PHYSI CAL THERAPY	12, 270	1, 486, 085	0	14, 106	7, 645, 259	
67. 00 06700 OCCUPATI ONAL THERAPY	10, 545	1, 146, 195	0	14, 146	5, 866, 867	67.00
68.00 06800 SPEECH PATHOLOGY	1, 796	402, 925	0	7, 943	1, 995, 180	
69. 00 06900 ELECTROCARDI OLOGY	0	625, 735	0	18, 321	19, 874, 004	
69. 01 06901 CARDI AC REHAB	0	393, 941	0	2, 716	838, 401	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	958, 324	0	0	38, 374, 743	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	o	0	12, 096, 770	49, 790, 787	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	o	0	13, 957, 023	33, 714, 164	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 662	427, 527	0	759, 790	127, 379, 561	73.00
74. 00 07400 RENAL DI ALYSI S	4, 383	o	0	13, 296	6, 909, 817	74.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	76, 181	2, 547, 983	0	102, 265	23, 018, 952	90.00
91. 00 09100 EMERGENCY	27, 063	6, 772, 361	0	1, 628, 583	65, 615, 853	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						1
101. 00 10100 HOME HEALTH AGENCY	0	1, 843, 483	0	75, 251	3, 081, 207	101.00
SPECIAL PURPOSE COST CENTERS						1
118.00 SUBTOTALS (SUM OF LINES 1-117)	1, 369, 167	123, 666, 486	100	42, 044, 692	1, 174, 544, 724	118.00
MCRI F32 - 10. 5. 160. 2						

Health Financial Systems	METHODI ST HOSI	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
				From 01/01/2016 To 12/31/2016	Date/Time Pre 5/26/2017 1:1	
Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (MACHINE TIME)	PURCHASI NG RECEI VI NG AND STORES (PURCHASE REQUI SI TI ONS)	ADMI TTI NG (GROSS CHARGES)	
	1. 00	4. 00	5. 01	5. 02	5. 03	
NONREI MBURSABLE COST CENTERS	1.00	4.00	3.01	5. 02	3.03	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 801	57, 218		165, 449	0	190.00
191. 00 19100 RESEARCH	0	0	(0	191.00
192. 00 19200 PHYSICIANS' PRIVATE OFFICES	26, 711	18, 994, 101	(431, 659	0	192.00
192. 01 19201 OTHER NON-REIMBURSABLE	3, 457	3, 196, 831	(3, 705	0	192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	8, 997	160, 994	(o	0	192. 02
193. 00 19300 NONPALD WORKERS	0	0	(0	0	193.00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	6, 772, 387	33, 883, 440	14, 856, 07	3, 865, 106	2, 993, 499	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	4. 802658	0. 231958	148, 560. 7200	0. 090633	0. 002549	203. 00
204.00 Cost to be allocated (per Wkst. B, Part II)		28, 364	44, 97	35, 402	47, 102	204. 00
205.00 Unit cost multiplier (Wkst. B, Part		0. 000194	449. 74000	0. 000830	0. 000040	205. 00

Cost Center Description		n Financial Systems	METHODIST HOSP		N. 15 0000 D		u of Form CMS-2	
County C	COST	ALLOCATION - STATISTICAL BASIS		Provider Co	F	rom 01/01/2016	Date/Time Pre	pared:
COLUMBS COMBAS CONTROL CONTROL COLUMBS COLUMB		Cost Center Description					OPERATION OF	4 pm
CAMPAGES				n	(ACCUM. CUST)			
			(GROSS			(NUMBER OF	(,	
CREATER SERVICE COST CENTERS				EA OF	F 0F		7.00	
1.00		GENERAL SERVICE COST CENTERS	5. 04	5A. U5	5.05	5.06	7.00	
5.01 000500 DATA PROCESSING 5.02 000500 AURICHASHON RECEIVABLE 5.03 000500 AURICHASHON RECEIVABLE 5.04 000500 AURICHASHON RECEIVABLE 5.05 000500 AURICHASHON RECEIVABLE 5.06 000500 AURICHASHON RECEIVABLE 5.06 000500 AURICHASHON RECEIVABLE 5.07 000500 AURICHASHON RECEIVABLE 5.08 000500 AURICHASHON RECEIVABLE 5.09 000500 AURICHASHON RECEIVABLE 6.00 000500 AURI		00100 CAP REL COSTS-BLDG & FIXT						1.00
Decomposition Decompositio								4.00
5.03 ODSTON JAWAIN TITURG								
5. 05 00 00599 OTHER AGG 0. 00590 OTHER AGG								5. 03
5.00 00902 PATLENT TRANSPORTATION 0 0 756, 662 92, 754 5.00			1, 174, 544, 724					5. 04
0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.000000 0.000000 0.00000000								
8.00 0.0000 LAURDRY & LINEN SERVICE 0 0 1, 521, 341 0 17, 825 8.00 10.00 10.000 DIETARY 0 0 0 5, 699, 967 0 18, 448 10.00 10.01 10.000 CAFETER AMINI STRATION 0 0 2, 141, 336 0 13, 771 10.01 10.000 CAFETER AMINI STRATION 0 0 2, 141, 336 0 13, 771 10.01 10.000 CAFETER AMINI STRATION 0 0 2, 202, 228 0 35, 843 10.00 10.000 CAFETER AMINI STRATION 0 0 0 5, 699, 967 0 18, 967 10.00 10.000 CAFETER AMINI STRATION 0 0 0 5, 699, 473 0 18, 977 10.00 10.000 CAFETER AMINI STRATION 0 0 0 5, 699, 473 0 18, 977 10.00 10.000 CAFETER AMINI STRATION 0 0 0 5, 699, 473 0 18, 977 10.00 10.000 CAFETER AMINI STRATION 0 0 0 5, 699, 473 0 18, 977 10.00 10.000 CAFETER AMINI STRATION 0 0 0 5, 699, 473 0 18, 977 10.00 10.000 CAFETER AMINI STRATION 0 0 0 5, 699, 473 0 18, 977 10.00 10.000 CAFETER AMINI STRATION 0 0 0 5, 699, 473 0 18, 977 10.00 10.000 CAFETER AMINI STRATION 0 0 0 5, 699, 473 0 11, 1477 17, 0 10.00 10.000 CAFETER AMINI STRATION 0 0 0 5, 699, 473 0 11, 1477 17, 0 10.00 10.000 CAFETER AMINI STRATION 0 0 0 5, 699, 473 0 11, 1477 17, 0 10.00 10.000 CAFETER AMINI STRATION 0 0 0 5, 699, 473 0 0 11, 1477 17, 0 10.00 10.000 CAFETER AMINI STRATION 0 0 0 5, 699, 473 0 0 11, 1477 17, 0 10.00 10.000 CAFETER AMINI STRATION 0 0 0 0 0 0 0 0 0			-	-			948. 434	
10.00 010000 DETARY				-				1
11.00 01100 CAFETERIA 0 0 2, 2014, 036 0 13, 177 11.00 11.00 01100 CAFETERIA 0 0 4, 678, 148 0 6, 550 13.00 11.00 01100 CHNIRAL SERVICES & SUPPLY 0 0 0 2, 202, 228 0 39, 443 14.00 11.00 01100 CARRIAGO 0 0 3, 663, 743 0 11.30 11.00 11.00 CARRIAGO 0 0 3, 663, 743 0 11.30 11.00 11.00 CARRIAGO 0 0 3, 663, 743 0 11.30 11.00 11.00 CARRIAGO 0 0 3, 663, 743 0 11.30 11.00 11.00 CARRIAGO 0 0 3, 663, 743 0 11.30 11.00 11.00 CARRIAGO 0 0 3, 663, 743 0 11.30 11.00 11.00 CARRIAGO 0 0 0			0	-				1
13.00 01300 MURSING ADMINISTRATION 0 0 4,079,148 0 0,590 13.00			0	-				1
14.00 01400 CENTRAL SERVICES & SUPPLY			0	-				
16.00 01-600 MEDICAL, RECORDS & LIBRARY 0 0 3,663,743 0 11,307 16.00 17.00 1710 01701 STAFF EDUCATION 0 0 0 53,555 0 11,147 17.00 1710 01701 STAFF EDUCATION 0 0 0 53,555 0 11,147 17.00 1710 01701 STAFF EDUCATION 0 0 0 123,414 0 374 17.00 0210 188 SERVICES-SALARY & FRINGES APPRIVO 0 0 1797,544 0 0 21.00 22.00 02200 188 SERVICES-SALARY & FRINGES APPRIVO 0 0 1797,544 0 0 4.467 22.00 22.00 22.00 188 SERVICES-SALARY & FRINGES APPRIVO 0 0 51,629 0 4.467 22.00 22.00 22.00 02200 188 SERVICES-SALARY & FRINGES APPRIVO 0 0 51,629 0 4.467 22.00 22.00 22.00 02200 02001 188 SERVICES-SALARY & FRINGES APPRIVO 0 0 51,629 0 4.467 22.00 22.0								
17.00 01700 SOCIAL SERVICE 0 0 614,413 0 1,629 17.00 17.01			1					1
17.0 01702 STAFF EDUCATION 0 0 53,535 0 11,147 17.0 1702 1702 1702 1702 1702 1702 1702 1702 1702 1702 1702 1702 1702 1702 1702 1702 1702 18 SERVICES-SALARY & FRINCES APPRYD 0 0 0 170, 546 0 0 4,467 22.0 22.0 02200 18 SERVICES-SALARY & FRINCES APPRYD 0 0 0 51,629 0 4,467 22.0 22.0 02200 18 SERVICES-SALARY & FRINCES APPRYD 0 0 0 462,034 0 3,364 23.0 23			-1	-				1
17.00 0.700 IRS PERVICES-SALARY & FRINCES APPRVD 0 0 197, 546 0 0 21.00				-				1
22.00 02000 LAR SERVICES_OTHER PROM COSTS APPROD 0 43.07 22.00 23.00 2	17. 02	01702 MEDICAL EDUCATION	0	-				
23.0 00 02300 PARAMED ED PROCRAM 0 0 482,034 0 5.364 23,000			-	-				21.00
INPATI ENT ROUTINE SERVICE COST CENTERS 97, 989, 559 0 46, 394, 922 22, 173 313, 277 30. 00 30.00 AULTS & PEDIATRICS 97, 989, 559 0 46, 394, 922 22, 173 313, 277 30. 00 31. 00 310 10 310 10 3010 10		1	1	-				
30.00	23.00	<u> </u>	J O	U	462, 034	<u> </u>	3, 304	23.00
31.01 03101 NEOMATAL ICU 6.651, 844 0 3.004, 688 0 2.288 31.01 01.00 04000 SUBPROVI DER - I PF 4.136, 239 0 1, 442, 115 51 3, 972 40.00 141.00 SUBPROVI DER - I PF 8.022, 185 0 4.467, 606 669 31.243 41.00 41.00 04100 SUBPROVI DER - I RF 8.022, 185 0 4.467, 606 669 31.243 41.00 41.00 04100 SUBPROVI DER - I RF 8.022, 185 0 4.467, 606 669 31.243 41.00 41.00 04100 SUBPROVI DER - I RF 8.022, 185 0 4.467, 606 669 31.243 41.00 41.00 04100 SUBPROVI DER - I RF 8.022, 185 0 4.467, 606 669 31.243 41.00 41.00 04100 SUBPROVI DER - I RF 8.022, 185 0 4.467, 606 669 31.243 41.00 41.00 04100 SUBPROVI DER - I RF 8.022, 185 0 4.467, 606 669 31.243 41.00 41.00 04100 SUBPROVI DER - I RF 8.022, 185 0 4.40 12.245 14.00 12	30.00		97, 989, 559	0	46, 394, 922	22, 173	313, 217	30.00
40.00 04000 SUBPROVI DER - I PF 4. 136, 239 0 1, 442, 115 51 3, 972 40.00 43.00 50.00 SUBPROVI DER - I RF 8. 022, 185 0 4, 467, 606 669 31. 243 43.00 34.00				-				
41.00 04100 SUBPROVIDER - IRF		· · · · · · · · · · · · · · · · · · ·		-			,	
ANCILLARY SERVICE COST CENTERS 50. 00 GOSQO OPERATINE ROOM 10. 015, 635, 066 11. 201, 142 10. 59, 647 50. 01 05000 OPERATINE ROOM 10. 413, 420 13. 540, 367 13. 98 0 50. 01 50. 00 05000 RECOVERY ROOM 10. 413, 420 0 1, 575, 525 3 14, 546 51. 00 52. 00 05200 DELLYERY ROOM 4, 931, 560 0 0 0 0 0 0 0 0 0 3, 577, 793 366 7, 003 52. 00 53. 00 53.00				-				1
50. 00 05000 0FEATING ROOM 155, 635, 066 0 11, 201, 142 0 59, 647 50. 00	43.00		1, 820, 698	0	1, 276, 475	0	24, 424	43.00
50. 01 GSOO1 ENDOSCOPY 18, 744, 590 0 3, 540, 367 1, 398 0 50. 01	50 00		155 635 066	0	11 201 142		59 647] 50 00
10, 10 05100 05100 05100 05100 052								50.00
53.00 OS300 ANESTHESI OLOGY 0 0 0 0 53.05				-				
54. 00 05400 RADIO LOGY-DI ACNOSTI C 35, 355, 787 0 5, 619, 459 5, 377 53, 059 54, 05 054, 01 05401 RADIO LOGY - ULTRASOUND 15, 999, 392 0 2, 448, 345 5, 667 5, 054 54, 01 55. 00 05600 RADIO LOGY-THERAPEUTI C 18, 182, 554 0 1, 819, 981 292 13, 485 55. 00 05600 RADIO LOGY-THERAPEUTI C 18, 182, 554 0 1, 819, 981 292 13, 485 55. 00 05600 RADIO LOGY-THERAPEUTI C 18, 182, 554 0 1, 878, 772 2, 856 9, 043 55. 00 05600 RADIO LOGY-THERAPEUTI C 18, 182, 554 0 1, 878, 772 2, 856 9, 043 55. 00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 27, 549, 154 0 1, 196, 154 2, 676 4, 205 58. 005 8, 563 57. 00 05900 CARDIAC CATHETERI ZATI ON 67, 136, 072 0 4, 932, 292 1, 812 8, 393 59. 00 05900 CARDIAC CATHETERI ZATI ON 67, 136, 072 0 4, 932, 292 1, 812 8, 393 59. 00 05900 CARDIAC CATHETERI ZATI ON 67, 136, 072 0 12, 330, 785 2 23, 518 60. 00 06001 BLOOD LABORATORY 134, 896, 832 0 12, 330, 785 2 23, 518 60. 00 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0				-				
54.01 OS401 RADIOLOGY - ULTRASOUND 15,999,392 0 2,448,345 5,667 5.054 54.01			١	-	J			
56.00 0500				0				
57. 00 05700 CT SCAN 106, 714, 673 0 3, 352, 755 8, 005 8, 563 57. 00								
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 27, 549, 154 0 1, 196, 154 2, 676 4, 205 58. 00 05900 05900 CARDIAC CATHETERIZATION 67, 136, 072 0 4, 932, 292 1, 812 8, 393 59. 00 06.00 06000 LABORATORY 134, 896, 832 0 12, 330, 785 2 23, 518 60. 00 06.01 06001 BLOOD LABORATORY 0 0 0 0 0 06.02 08000 MHOLE BLOOD & PACKED RED BLOOD CELLS 7, 860, 813 0 1, 796, 550 0 385 62. 00 03.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 7, 860, 813 0 1, 796, 550 0 385 62. 00 03.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 065.00 06500 RESPIRATORY THERAPY 38, 904, 211 0 4, 226, 580 78 7, 766 65. 00 066.00 06600 PRYSI CAL THERAPY 7, 645, 259 0 2, 071, 395 0 12, 270 66. 00 069.00 06900 ELECTROCARDIOLOGY 19, 874, 004 0 1, 160, 617 250 0 1, 796 68. 00 069.01 06900 CARDIAC REHAB 838, 401 0 589, 476 0 0 69. 01 069.01 06900 CARDIAC REHAB 838, 401 0 589, 476 0 0 69. 01 070.00 07000 MELECTROCARDIOLOGY 19, 874, 004 0 1, 160, 617 250 0 69. 01 070.00 07000 CARDIAC REHAB 838, 401 0 589, 476 0 0 69. 01 070.00 07000 MELECTROCARDIOLOGY 19, 874, 004 0 1, 160, 617 250 0 69. 01 070.00 07000 MILLE SCHARGED TO PATIENTS 33, 714, 164 0 15, 462, 659 0 0 71. 00 071.00 07000 MILLE DEV. CHARGED TO PATIENTS 33, 714, 164 0 15, 462, 659 0 0 72. 00 072.00 07000 MILLE DEV. CHARGED TO PATIENTS 127, 379, 561 0 12, 982, 341 0 1, 662 73. 00 073.00 07000 MILLE DEV. CHARGED TO PATIENTS 27, 379, 561 0 2, 024, 187 0 70. 04, 283 74. 00 070.00 07000 MILLES CHARGED TO PATIENTS 27, 379, 561 0 2, 024, 187 0 70. 04, 283 74. 00 070.00 07000 MILLES COST CENTERS 0 0 0 0 0 0 0 0 070.00 07000 MILLES COST CENTERS 0 0 0 0 0 0 0 0 0								
59.00 05900 CARDI AC CATHETERI ZATI ON			1 1	-		.,		1
60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0				0		·		
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 1,796,550 0 385 62.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 7,860,813 0 1,796,550 0 0 0 0 63.00 06300 STORING, PROCESSING & TRANS. 0 0 0 0 0 0 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 65.00 06500 RESPI RATORY THERAPY 38,904,211 0 4,226,580 78 7,766 65.00 66.00 06600 PHYSI CAL THERAPY 7,645,259 0 2,071,395 0 12,270 66.00 67.00 06700 0CCUPATI ONAL THERAPY 5,866,867 0 1,638,886 1 10,545 68.00 06800 SPEECH PATHOLOGY 1,995,180 0 568,739 0 1,796 68.00 69.00 06900 ELECTROCARDIOLOGY 19,874,004 0 1,160,617 250 0 69.00 69.01 06901 CARDIAC REHAB 838,401 0 589,476 0 0 69.01 70.00 07000 ELECTROCARDIOLOGY 38,374,743 0 3,308,145 571 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 49,790,787 0 13,548,546 0 0 71.00 72.00 07200 IMPLE DEV. CHARGED TO PATI ENTS 127,379,561 0 12,982,341 0 1,662 73.00 74.00 07400 RENAL DI ALYSI S 6,909,817 0 2,024,187 0 4,383 74.00 74.00 09000 CLINI C 23,018,952 0 5,702,844 27 76,181 90.00 74.00 09000 CLINI C 23,018,952 0 5,702,844 27 76,181 90.00 74.00 09000 CLINI C 23,018,952 0 5,702,844 27 76,181 90.00 75.00 09000 CLINI C 23,018,952 0 5,702,844 27 76,181 90.00 75.00 09000 CLINI C 23,018,952 0 5,702,844 27 76,181 90.00 75.00 09000 CLINI C 23,018,952 0 5,702,844 27 76,181 90.00 75.00 09000 CLINI C 23,018,952 0 5,702,844 27 76,181 90.00 75.00 09000 CLINI C 23,018,952 0 5,702,844 27 76,181 90.00 75.00 09000 CLINI C 09000			1	-		2		
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 7,860,813 0 1,796,550 0 385 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 64.00 06400 INTRAVENIOUS THERAPY 38,904,211 0 4,226,580 78 7,766 65.00 06500 RESPIRATORY THERAPY 7,645,259 0 2,071,395 0 12,270 66.00 06600 PHYSI CAL THERAPY 7,645,259 0 2,071,395 0 12,270 66.00 06600 PHYSI CAL THERAPY 7,645,259 0 2,071,395 0 12,270 68.00 06800 SPECH PATHOLOGY 1,995,180 0 568,739 0 1,796 68.00 06800 SPECH PATHOLOGY 1,995,180 0 568,739 0 1,796 69.00 06900 ELECTROCARDI OLOGY 19,874,004 0 1,160,617 250 0 69.00 69.01 06901 CARDI AC REHAB 838,401 0 589,476 0 0 69.01 70.00 07000 ELECTROCARDI OLOGY 33,371,743 0 3,308,145 571 0 70.00 71.00 07000 ELECTROCARDI OLOGY 33,714,743 0 3,308,145 571 0 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 33,714,764 0 15,462,659 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 33,714,764 0 12,982,341 0 1,662 73.00 74.00 07300 DRUGS CHARGED TO PATI ENTS 33,714,764 0 12,982,341 0 1,662 73.00 74.00 07400 RENAL DI ALYSIS 6,909,817 0 2,024,187 0 4,383 74.00 74.00 09000 CLINIC 23,018,952 0 5,702,844 27 76,181 75.00 09000 DRERGENCY 65,615,853 0 11,649,340 100 27,063 91.00 75.00 09000 DRERGENCY 3,081,207 0 2,608,162 0 0 75.00 09000 DRERGENCY 3,081,207 0			O	-	0	0	0	
64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 0 0 65.00 06			7, 860, 813	0	1, 796, 550	0	385	62.00
65. 00	63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0		0	63.00
66. 00 06600 PHYSI CAL THERAPY 7, 645, 259 0 2, 071, 395 0 12, 270 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 5, 866, 867 0 1, 638, 886 1 10, 545 67. 00 68. 00 06800 SPECH PATHOLOGY 1, 995, 180 0 568, 739 0 1, 796 68. 00 69. 00 06900 ELECTROCARDI OLOGY 19, 874, 004 0 1, 160, 617 250 0 69. 01 06901 CARDI AC REHAB 838, 401 0 589, 476 0 0 69. 01 07. 00 07. 00 07. 00 ELECTROENCEPHALOGRAPHY 38, 374, 743 0 3, 308, 145 571 0 70. 00 07. 00 07. 00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 49, 790, 787 0 13, 548, 546 0 0 71. 00 07. 00 07. 00 IMPL. DEV. CHARGED TO PATIENTS 33, 714, 164 0 15, 462, 659 0 0 72. 00 07.			0	0	4 334 500	0		64.00
67. 00 06700 0CCUPATI ONAL THERAPY 5, 866, 867 0 1, 638, 886 1 10, 545 67. 00 68. 00 06800 SPEECH PATHOLOGY 1, 995, 180 0 568, 739 0 1, 796 68. 00 69. 00 6990 ELECTROCARDI OLOGY 19, 874, 004 0 1, 160, 617 250 0 69. 01 69. 01 06901 CARDI AC REHAB 838, 401 0 589, 476 0 0 69. 01 07. 00 07. 00 ELECTROEREPHALOGRAPHY 38, 374, 743 0 3, 308, 145 571 0 70. 00 07. 00 ELECTROEREPHALOGRAPHY 38, 374, 743 0 3, 308, 145 571 0 70. 00 07. 00 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 49, 790, 787 0 13, 548, 546 0 0 71. 00 07. 00				0				
68. 00 06800 SPEECH PATHOLOGY 1, 995, 180 0 568, 739 0 1, 796 68. 00 69.			1	0				
69. 01 06901 CARDI AC REHAB 838, 401 0 589, 476 0 0 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 38, 374, 743 0 3, 308, 145 571 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 49, 790, 787 0 13, 548, 546 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 33, 714, 164 0 15, 462, 659 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 127, 379, 561 0 12, 982, 341 0 1, 662 73. 00 74. 00 07400 RENAL DI ALYSI S 6, 909, 817 0 2, 024, 187 0 4, 383 74. 00 00 07400 RENAL DI ALYSI S 6, 909, 817 0 2, 024, 187 0 4, 383 74. 00 00 09000 CLI NI C 23, 018, 952 0 5, 702, 844 27 76, 181 90. 00 91. 00 09100 EMERGENCY 65, 615, 853 0 11, 649, 340 100 27, 063 91. 00 92. 00 09200 DSSERVATI ON BEDS (NON-DI STI NCT PART) 01 00 09100 HOME HEALTH AGENCY 3, 081, 207 0 2, 608, 162 0 0 101. 00 07HER REI MBURSABLE COST CENTERS 101. 00 SUBTOTALS (SUM OF LI NES 1-117) 1, 174, 544, 724 -38, 627, 143 251, 188, 443 52, 754 907, 468 118. 00 000 NONREI MBURSABLE COST CENTERS	68. 00	06800 SPEECH PATHOLOGY	1, 995, 180		568, 739	0	1, 796	68.00
70. 00			1 ' ' 1	0				69.00
71. 00				0			-	70.00
73. 00		07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		Ö				71.00
74. 00				ŭ,				72.00
90. 00 O9000 CLI NI C CLI NI CLI NI C CLI NI CLI NI C				-				
90. 00	, 4. 00		0, 707, 017	0	2,024,107	. 0	4, 303	, 4. 00
92. 00		09000 CLI NI C						90.00
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 3, 081, 207 0 2, 608, 162 0 0 101.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 1, 174, 544, 724 -38, 627, 143 251, 188, 443 52, 754 907, 468 118.00 NONREIMBURSABLE COST CENTERS			65, 615, 853	0	11, 649, 340	100	27, 063	
101.00 10100 HOME HEALTH AGENCY 3, 081, 207 0 2, 608, 162 0 0 101.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 1, 174, 544, 724 -38, 627, 143 251, 188, 443 52, 754 907, 468 118.00 NONREIMBURSABLE COST CENTERS	92.00	,						j 92.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 1,174,544,724 -38,627,143 251,188,443 52,754 907,468 118.00 NONREIMBURSABLE COST CENTERS 118.00 118.0	101. 0		3, 081, 207	0	2, 608, 162	ol	0	101.00
NONREI MBURSABLE COST CENTERS		SPECIAL PURPOSE COST CENTERS						
	118. 0		1, 174, 544, 724	-38, 627, 143	251, 188, 443	52, 754	907, 468	J118. 00
	190. 0		O	0	272, 945	ol	1, 801	190. 00
				- 1				

Health Financial Systems	METHODI ST HOS	PITALS, INC		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
				From 01/01/2016		
				To 12/31/2016	Date/Time Pre	
					5/26/2017 1:1	4 pm
Cost Center Description	CASHI ERI NG/AC	Reconciliatio	OTHER A&G	PATI ENT	OPERATION OF	
	COUNTS	n	(ACCUM. COST)	TRANSPORTATI 0	PLANT	
	RECEI VABLE			N	(SQUARE FEET)	
	(GROSS			(NUMBER OF		
	CHARGES)			TRI PS)		
	5. 04	5A. 05	5. 05	5. 06	7. 00	
191. 00 19100 RESEARCH	0	0		0	0	191.00

	Cost Center Description	CASHI ERI NG/AC	Reconciliatio	OTHER A&G	PATI ENT	OPERATION OF	
		COUNTS	n	(ACCUM. COST)	TRANSPORTATI O	PLANT	
		RECEI VABLE			N	(SQUARE FEET)	
		(GROSS			(NUMBER OF		
		CHARGES)			TRI PS)		
		5. 04	5A. 05	5. 05	5. 06	7. 00	
191. 00 1910	RESEARCH	0	0	0	0	0	191.00
192.00 1920	PHYSICIANS' PRIVATE OFFICES	0	0	41, 782, 724	0	26, 711	192.00
192. 01 1920	1 OTHER NON-REIMBURSABLE	0	0	5, 641, 432	0	3, 457	192. 01
192. 02 1920	2 FAMILY HEALTH/GARY COMM HEALTH	0	0	297, 200	0	8, 997	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						201.00
202.00	Cost to be allocated (per Wkst. B,	5, 389, 701		38, 627, 143	854, 354	20, 820, 016	202.00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 004589		0. 129109	16. 195056	21. 951992	203.00
204. 00	Cost to be allocated (per Wkst. B,	147, 609		525, 320	1, 439	1, 470, 981	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 000126		0. 001756	0. 027278	1. 550958	205.00
	[1]						

	ALLOCATION - STATISTICAL BASIS	WETHODIST HOS	Provi der Co	CN: 15-0002 F	Peri od:	Worksheet B-1	
				F	rom 01/01/2016	Date/Time Pre 5/26/2017 1:1	pared:
	Cost Center Description	LAUNDRY & LI NEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (PRODUCTI VE HOURS)	NURSI NG ADMI NI STRATI O N (DI RECT NURS. HRS.)	
		8. 00	9.00	10.00	11.00	13.00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT			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 16. 00 17. 00 17. 01 17. 02 21. 00 22. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER A&G 00592 PATIENT TRANSPORTATION 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01701 SOCIAL SERVICE 01701 STAFF EDUCATION 01702 MEDICAL EDUCATION 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	2, 448, 825 0 0 0 0 27, 160 15 0 0	909, 974 18, 848 13, 177 6, 350 35, 843 18, 957 11, 307 1, 629 11, 147 374 0	368, 988	2, 729, 730 62, 159 30, 532 0 85, 022 16, 615 0 2, 113 0	1, 850, 886 0 0 0 16, 615 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. 01 17. 02 21. 00 22. 00
23. 00	02300 PARAMED ED PROGRAM INPATIENT ROUTINE SERVICE COST CENTERS	0	3, 364		22, 573	22, 573	23.00
30.00	03000 ADULTS & PEDIATRICS	1, 165, 650	313, 217	253, 318	989, 934	989, 934	30.00
	03100 NTENSIVE CARE UNIT	61, 708					
31. 01 40. 00	03101 NEONATAL I CU 04000 SUBPROVI DER - I PF	54, 470	•				
41. 00	04100 SUBPROVI DER - I RF	0					
43.00	04300 NURSERY	50, 635	24, 424		18, 450	18, 450	43.00
50.00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	245, 456	59, 647		129, 220	129, 220	50.00
50. 00	05001 ENDOSCOPY	29, 892					1
51.00	05100 RECOVERY ROOM	64, 252	14, 546		25, 661	25, 661	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	54, 893				1	
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	81, 617	_		_		
54. 01	05401 RADI OLOGY - ULTRASOUND	13, 848				l	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	3, 700				l	
56.00	05600 RADI OI SOTOPE	29, 944			,	l e	
57.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	18, 811 7, 520			29, 606 11, 624	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	53, 730	8, 393	3, 658	48, 656	0	59.00
60.00	06000 LABORATORY	0			113, 404	0	
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0	0	60. 01 61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	385	C	61, 498	0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	C	0	0	
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	3, 615	0 7, 766		0 74, 292	0	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	29, 648				· -	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	10, 545	C	29, 118	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	1, 796			i e	68.00
69. 00 69. 01	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	14, 093 4, 262			,	0	69. 00 69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	0		34			70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	_		
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0 1, 662		_	0	
74.00		113, 099	.,			l	
	OUTPATIENT SERVICE COST CENTERS						
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY	46, 057		14 110		l .	
91.00	O9200 OBSERVATION BEDS (NON-DISTINCT PART)	262, 276	27, 063	14, 119	204, 046	204, 046	91. 00 92. 00
	OTHER REIMBURSABLE COST CENTERS						1
101.00	10100 HOME HEALTH AGENCY	0	0	C	0	0	101. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	2, 436, 351	869, 008	368, 988	2, 725, 563	1, 850, 886	118 00
	NONREI MBURSABLE COST CENTERS	2, 730, 331			2,720,000	1, 000, 000]
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1, 801	C	4, 167	0	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 01/01/2016

				To	12/31/2016	Date/Time Pre 5/26/2017 1:1	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
	·	LINEN SERVICE	(SQUARE FEET)	(MEALS	(PRODUCTI VE	ADMINISTRATIO	
		(POUNDS OF		SERVED)	HOURS)	N	
		LAUNDRY)				(DI RECT NURS.	
						HRS.)	
		8. 00	9. 00	10.00	11. 00	13.00	
191. 00 19100	RESEARCH	0	0	0	0	0	191. 00
192. 00 19200	PHYSICIANS' PRIVATE OFFICES	12, 474	26, 711	0	0	0	192.00
192. 01 19201	OTHER NON-REIMBURSABLE	0	3, 457	0	0	0	192. 01
192. 02 19202	FAMILY HEALTH/GARY COMM HEALTH	0	8, 997	0	0	0	192. 02
193. 00 19300	NONPALD WORKERS	0	0	0	0	0	193. 00
200.00	Cross Foot Adjustments						200. 00
201.00	Negati ve Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	2, 109, 054	8, 626, 344	6, 339, 554	2, 688, 242	4, 865, 480	202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 861251	9. 479770	17. 180922	0. 984801	2. 628730	203. 00
204.00	Cost to be allocated (per Wkst. B,	115, 924	145, 102	132, 502	89, 606	51, 112	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 047339	0. 159457	0. 359096	0. 032826	0. 027615	205. 00
	11)						

		REQUIS.)		CHARGES)		
		14. 00	15. 00	16.00	17. 00	17. 01
	GENERAL SERVICE COST CENTERS					
00	00100 CAP REL COSTS-BLDG & FLXT					
00	00400 EMPLOYEE BENEFITS DEPARTMENT					
01	00550 DATA PROCESSING					
02	00560 PURCHASING RECEIVING AND STORES					
03	00570 ADMITTING					
04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE					
05	00590 OTHER A&G					
06	00592 PATIENT TRANSPORTATION					
00	00700 OPERATION OF PLANT					
00	00800 LAUNDRY & LINEN SERVICE					
00	00900 HOUSEKEEPI NG					
. 00	01000 DI ETARY					
. 00	01100 CAFETERI A					
. 00	01300 NURSI NG ADMI NI STRATI ON					
. 00	01400 CENTRAL SERVI CES & SUPPLY	24 052 702				
		26, 053, 793	44 440 740			
. 00	01500 PHARMACY	0	14, 418, 749			
. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	1, 174, 544, 724		
. 00	01700 SOCIAL SERVICE	0	0	0	801	
01	01701 STAFF EDUCATION	o	ol	0	o	115, 495
	01702 MEDI CAL EDUCATI ON	ol	ol	0	ol	5
. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD		ő	0	0	ő
. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD		0	0	0	0
		-1	0	0	0	
. 00	02300 PARAMED ED PROGRAM	0	0	0	0	95
	INPATIENT ROUTINE SERVICE COST CENTERS					
00	03000 ADULTS & PEDI ATRI CS	0	0	97, 989, 559	618	60, 609
. 00	03100 INTENSIVE CARE UNIT	0	0	16, 137, 742	0	10, 640
. 01	03101 NEONATAL I CU	o	ol	6, 651, 844	ol	2, 444
. 00	04000 SUBPROVI DER - I PF	o	o	4, 136, 239	0	1, 362
. 00	04100 SUBPROVI DER – I RF	o	ol	8, 022, 185	137	5, 849
. 00	04300 NURSERY		Ö		0	
UU		l Ol	U	1, 820, 698	U	1, 601
~~	ANCILLARY SERVICE COST CENTERS		ما	455 (05 0//	ما	4.450
00	05000 OPERATING ROOM	0	0	155, 635, 066	0	4, 152
01	05001 ENDOSCOPY	0	0	18, 744, 590	0	590
. 00	05100 RECOVERY ROOM	0	0	10, 413, 420	0	2, 187
. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	4, 931, 560	0	2, 561
. 00	05300 ANESTHESI OLOGY	ol	ol	0	اه	0
. 00	05400 RADI OLOGY-DI AGNOSTI C	o	ő	35, 355, 787	0	2, 357
. 01	05401 RADI OLOGY - ULTRASOUND		0	15, 999, 392		1, 414
		0	o o		0	
. 00	05500 RADI OLOGY-THERAPEUTI C	0	O	18, 182, 554	0	858
. 00	05600 RADI OI SOTOPE	0	0	13, 357, 538	0	402
. 00	05700 CT SCAN	0	0	106, 714, 673	0	345
. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	o	ol	27, 549, 154	o	242
. 00	05900 CARDI AC CATHETERI ZATI ON	o	0	67, 136, 072	0	1, 016
00	06000 LABORATORY	Ö	1, 762, 554	134, 896, 832	Ö	336
		0	1, 702, 554		0	
01	06001 BLOOD LABORATORY	U	٩	0	٩	0
00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					
.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	7, 860, 813	0	40
00	06300 BLOOD STORING, PROCESSING & TRANS.	0	ol	0	O	0
00	06400 I NTRAVENOUS THERAPY	o	ol	0	o	o
00	06500 RESPIRATORY THERAPY	Ö	ol	38, 904, 211	Ö	922
00	06600 PHYSI CAL THERAPY		٥	7, 645, 259		44
			Ŏ		S)	
00	06700 OCCUPATI ONAL THERAPY		0	5, 866, 867	0	179
00	06800 SPEECH PATHOLOGY	0	0	1, 995, 180	0	58
00	06900 ELECTROCARDI OLOGY	0	0	19, 874, 004	0	677
01	06901 CARDI AC REHAB	o	ol	838, 401	ol	6
00	07000 ELECTROENCEPHALOGRAPHY	o	1, 433, 569	38, 374, 743	ام	620
00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12, 096, 770	., .55, 557	49, 790, 787	٥	0
	1	13, 957, 023	٥			
00	07200 IMPL. DEV. CHARGED TO PATIENTS	l ' '	0	33, 714, 164	0	0
00	07300 DRUGS CHARGED TO PATIENTS	0	10, 885, 070	127, 379, 561	0	8
00	07400 RENAL DI ALYSI S	0	0	6, 909, 817	0	0
	OUTPATIENT SERVICE COST CENTERS					
00	09000 CLI NI C	0	0	23, 018, 952	0	505
00	09100 EMERGENCY	o	ol	65, 615, 853	46	10, 446
00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		٩	33, 313, 333	40	10, 440
UU						
	OTHER REIMBURSABLE COST CENTERS				-	
. 00	10100 HOME HEALTH AGENCY	0	14, 124	3, 081, 207	0	1, 269
	SPECIAL PURPOSE COST CENTERS					
3. 00		26, 053, 793	14, 095, 317	1, 174, 544, 724	801	113, 839
-	NONREI MBURSABLE COST CENTERS	.,,	.,	, ,	23.1	,
			0	0	0	0
1 0	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0				

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CO		eri od:	Worksheet B-1	
				rom 01/01/2016 o 12/31/2016		nared:
			'	. 12/31/2010	5/26/2017 1: 1	
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 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	323, 432	0	0	1, 656	192. 00
192. 01 19201 OTHER NON-REIMBURSABLE	0	0	0	0	0	192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0	0	192. 02
193.00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	4, 138, 591	6, 458, 837	4, 575, 894	804, 980	410, 817	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 158848	0. 447947	0. 003896	1, 004. 968789	3. 557011	203 00
204.00 Cost to be allocated (per Wkst. B,	240, 952	132, 690		·		
Part II)	210, 702	102, 070	00,272	12,770	, 2, 0,0	
205.00 Unit cost multiplier (Wkst. B, Part	0. 009248	0. 009203	0. 000071	15. 967541	0. 629421	205. 00
)				1		I

From 01/01/2016 12/31/2016 Date/Time Prepared: 5/26/2017 1:14 pm INTERNS & RESIDENTS PARAMED ED MEDI CAL SERVI CES-SALA SERVI CES-0THE Cost Center Description **FDUCATION** RY & FRINGES R PRGM COSTS **PROGRAM** (ASSI GNED (ASSI GNED (ASSI GNED (ASSI GNED TIME) TIME) TIME) TIME) 17.02 21.00 22.00 23.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00550 DATA PROCESSING 5.01 5.01 00560 PURCHASING RECEIVING AND STORES 5.02 5.02 00570 ADMITTING 5.03 5.03 5.04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.04 5.05 00590 OTHER A&G 5.05 5.06 00592 PATIENT TRANSPORTATION 5.06 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 01701 STAFF EDUCATION 17 01 17 01 01702 MEDICAL EDUCATION 17.02 100 17.02 02100 I&R SERVICES-SALARY & FRINGES APPRVD 100 21.00 21.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 100 22.00 02300 PARAMED ED PROGRAM 100 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 0 03000 ADULTS & PEDIATRICS C 30.00 0 03100 INTENSIVE CARE UNIT 0 31.00 0 0 31.00 0 31 01 03101 NEONATAL I CU 0 0 31.01 40.00 04000 SUBPROVI DER - I PF 0 0 0 0 40.00 0 41.00 04100 SUBPROVI DER - I RF 0 0 0 41.00 0 04300 NURSERY 0 43.00 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0 50.00 50.01 05001 ENDOSCOPY 0000000000000 0 0 0 50.01 0 51.00 05100 RECOVERY ROOM 0 0 51 00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 52.00 53 00 05300 ANESTHESI OLOGY 0 0 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0 54.00 0 54.01 05401 RADI OLOGY - ULTRASOUND 0 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 55.00 56.00 05600 RADI OI SOTOPE 0 0 56.00 0 05700 CT SCAN 0 57.00 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 C 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 0 60.00 06000 LABORATORY 0 0 60.00 0 06001 BLOOD LABORATORY C 0 60.01 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 000000000000 0 62.00 0 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 0 63.00 64.00 06400 INTRAVENOUS THERAPY 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 0 0 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 66.00 0 67 00 06700 OCCUPATIONAL THERAPY 0 0 67 00 0 68.00 06800 SPEECH PATHOLOGY C 68.00 06900 ELECTROCARDI OLOGY 69.00 0 0 69.00 06901 CARDI AC REHAB 0 69.01 0 69.01 07000 ELECTROENCEPHALOGRAPHY 0 70.00 C 70.00 71.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 Ω 0 0 73 00 07400 RENAL DIALYSIS 74.00 0 0 0 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C C 0 90.00 09100 EMERGENCY 100 100 100 91 00 100 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 100 100 100 100 118.00

	METHODI OT 1100	DI TALO 1110			6.5. 0110.0550.40
Health Financial Systems	METHODIST HOS				u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1
				From 01/01/2016 To 12/31/2016	Data/Time Drangrad
				To 12/31/2016	Date/Time Prepared: 5/26/2017 1:14 pm
		INTERNS &	RESI DENTS		37 207 2017 1. 14 piii
		TIVILINIO Q	RESIDENTS		
Cost Center Description	MEDI CAL	SERVI CES-SALA	SERVI CES-OTHE	PARAMED ED	
oost conten beschiptron	EDUCATI ON	RY & FRINGES	R PRGM COSTS		
	(ASSI GNED	(ASSI GNED	(ASSI GNED	(ASSI GNED	
	TIME)	TIME)	TIME)	TIME)	
	17. 02	21. 00	22.00	23. 00	
NONREI MBURSABLE COST CENTERS	17.02	21.00	22.00	20.00	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			190.00
191. 00 19100 RESEARCH	0	0			191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0			192.00
192. 01 19201 OTHER NON-REI MBURSABLE	0	0			192.01
192. 02 19202 FAMILY HEALTH/GARY COMM HEALTH	0	0			192.02
193.00 19300 NONPALD WORKERS	0	0			193. 00
	U	U	'	Y Y	200.00
1 1					
201.00 Negative Cost Centers	450.000	000 054	100 70	704 040	201.00
202.00 Cost to be allocated (per Wkst. B,	153, 202	223, 051	198, 70	731, 912	202. 00
Part I)	4 500 000000	0 000 54000	4 007 04000	7 040 400000	202 22
203.00 Unit cost multiplier (Wkst. B, Part I)				7, 319. 120000	203. 00
204.00 Cost to be allocated (per Wkst. B,	2, 740	347	29, 18	4 24, 303	204. 00
Part II)					

27. 400000

3. 470000

291. 840000

243. 030000

205. 00

Unit cost multiplier (Wkst. B, Part

205.00

				o 12/31/2016	Date/Time Pre 5/26/2017 1:1	pared:
		Title	XVIII	Hospi tal	PPS	4 рііі
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst.	Adj .		Di sal I owance		
	B, Part I,					
	col . 26)		0.00	4.00		
INDATIONE DOUTING CODY OF COCT CONTEDC	1. 00	2.00	3. 00	4. 00	5. 00	
I NPATIENT ROUTINE SERVICE COST CENTERS	70 740 (7/		70 740 (7)	2 (/[70 744 041	20.00
30. 00 03000 ADULTS & PEDI ATRI CS	72, 740, 676		72, 740, 676		72, 744, 341	30.00
31. 00 03100 NTENSI VE CARE UNI T 31. 01 03101 NEONATAL CU	13, 114, 014		13, 114, 014	0	13, 114, 014	31.00
40. 00 04000 SUBPROVI DER - 1 PF	3, 735, 381 1, 879, 727		3, 735, 381 1, 879, 727	0	3, 735, 381 1, 879, 727	31. 01 40. 00
41. 00 04000 SUBPROVI DER - 1 PF	7, 163, 629			-	7, 163, 629	41.00
43. 00 04300 NURSERY	2, 332, 035		7, 163, 629 2, 332, 035		2, 332, 035	
ANCI LLARY SERVI CE COST CENTERS	2, 332, 033		2, 332, 033	<u> </u>	2, 332, 033	43.00
50. 00 05000 OPERATING ROOM	15, 821, 451		15, 821, 451	O	15, 821, 451	50.00
50. 01 05001 ENDOSCOPY	4, 246, 029		4, 246, 029		4, 246, 029	
51. 00 05100 RECOVERY ROOM	2, 432, 609		2, 432, 609		2, 432, 609	
52.00 05200 DELIVERY ROOM & LABOR ROOM	4, 822, 389		4, 822, 389		4, 822, 389	
53. 00 05300 ANESTHESI OLOGY	0		0		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	8, 395, 463		8, 395, 463	o	8, 395, 463	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	3, 125, 817		3, 125, 817		3, 125, 817	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	2, 572, 648		2, 572, 648		2, 580, 977	55.00
56. 00 05600 RADI OI SOTOPE	2, 543, 628		2, 543, 628		2, 543, 628	1
57. 00 05700 CT SCAN	4, 646, 761		4, 646, 761	o	4, 646, 761	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 652, 213		1, 652, 213	o	1, 652, 213	
59. 00 05900 CARDI AC CATHETERI ZATI ON	6, 284, 462		6, 284, 462	o	6, 284, 462	59.00
60. 00 06000 LABORATORY	16, 090, 008		16, 090, 008	o	16, 090, 008	60.00
60. 01 06001 BLOOD LABORATORY	0		0	0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 131, 934		2, 131, 934	0	2, 131, 934	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0		0	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	5, 248, 759	0	5, 248, 759	0	5, 248, 759	65.00
66. 00 06600 PHYSI CAL THERAPY	2, 819, 370	0	2, 819, 370	0	2, 819, 370	66. 00
67.00 06700 OCCUPATIONAL THERAPY	2, 234, 114	0	2, 234, 114	0	2, 234, 114	67.00
68. 00 06800 SPEECH PATHOLOGY	735, 115	0	, , , , , , ,		735, 115	
69. 00 06900 ELECTROCARDI OLOGY	1, 428, 339		1, 428, 339		1, 428, 339	69. 00
69. 01 06901 CARDI AC REHAB	684, 261		684, 261	0	684, 261	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	4, 564, 613		4, 564, 613		4, 575, 980	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17, 413, 318		17, 413, 318		17, 413, 318	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	19, 807, 420		19, 807, 420		19, 807, 420	
73. 00 07300 DRUGS CHARGED TO PATIENTS	20, 092, 876		20, 092, 876		20, 092, 876	
74. 00 07400 RENAL DIALYSIS	2, 547, 622		2, 547, 622	0	2, 547, 622	74.00
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC	9, 034, 100	I	9, 034, 100	ol	9, 034, 100	90.00
91. 00 09100 EMERGENCY	16, 435, 561		16, 435, 561	0	16, 435, 561	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	14, 840, 003		14, 840, 003	ا ا	14, 840, 003	
OTHER REIMBURSABLE COST CENTERS	14, 640, 603		14, 640, 003		14, 640, 003	72.00
101. 00 10100 HOME HEALTH AGENCY	2, 967, 744		2, 967, 744		2, 967, 744	101 00
200.00 Subtotal (see instructions)	296, 584, 089	0			296, 607, 450	
201.00 Less Observation Beds	14, 840, 003		14, 840, 003		14, 840, 003	
202.00 Total (see instructions)	281, 744, 086	0			281, 767, 447	
		'				

Date/Time Prepared: 12/31/2016 5/26/2017 1:14 pm Title XVIII Hospi tal PPS Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent TEFRA I npati ent + col. 7) Ratio Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 68, 765, 356 30.00 03000 ADULTS & PEDIATRICS 68, 765, 356 30.00 31.00 03100 INTENSIVE CARE UNIT 16, 137, 742 16, 137, 742 31.00 03101 NEONATAL ICU 6, 651, 844 6, 651, 844 31.01 31.01 40.00 04000 SUBPROVI DER - I PF 4, 136, 239 4, 136, 239 40.00 04100 SUBPROVI DER - I RF 8, 022, 185 41.00 8, 022, 185 41.00 43.00 04300 NURSERY 1, 820, 698 1,820,698 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 95, 055, 211 0.000000 50.00 60, 579, 855 155, 635, 066 0. 101657 50.00 05001 ENDOSCOPY 50.01 4, 682, 415 14, 062, 175 18, 744, 590 0. 226520 0.000000 50.01 51.00 05100 RECOVERY ROOM 5, 199, 562 5, 213, 858 10, 413, 420 0. 233603 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 2, 821, 595 2, 109, 965 4, 931, 560 0. 977863 0.000000 52.00 05300 ANESTHESI OLOGY 53.00 0.000000 0.000000 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 9, 500, 620 25, 855, 167 35, 355, 787 0.237457 0.000000 54.00 05401 RADI OLOGY - ULTRASOUND 5, 145, 968 10, 853, 424 15, 999, 392 0.195371 54.01 0.000000 54.01 05500 RADI OLOGY-THERAPEUTI C 17, 049, 452 18, 182, 554 0.000000 55.00 1, 133, 102 0.141490 55.00 05600 RADI OI SOTOPE 0. 190426 56.00 5, 616, 532 7, 741, 006 13, 357, 538 0.000000 56.00 05700 CT SCAN 38, 732, 759 67, 981, 914 106, 714, 673 0.043544 0.000000 57.00 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 10, 062, 748 17, 486, 406 27, 549, 154 0.059973 0.000000 58.00 05900 CARDI AC CATHETERI ZATI ON 32, 092, 844 0.093608 35, 043, 228 59.00 67, 136, 072 0.000000 59.00 60.00 06000 LABORATORY 58, 956, 959 75, 939, 873 134, 896, 832 0. 119276 0.000000 60.00 60.01 06001 BLOOD LABORATORY 0.000000 0.000000 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 0.000000 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 1, 835, 509 62.00 6, 025, 304 7, 860, 813 0.271210 0.000000 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0.000000 63.00 0 06400 INTRAVENOUS THERAPY 0.000000 64.00 0.000000 64.00 65.00 06500 RESPIRATORY THERAPY 34, 013, 151 4, 891, 060 38, 904, 211 0.134915 0.000000 65.00 06600 PHYSI CAL THERAPY 7, 327, 942 7, 645, 259 66.00 317, 317 0.368774 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 5, 683, 347 183, 520 5, 866, 867 0.380802 0.000000 67.00 06800 SPEECH PATHOLOGY 1, 811, 514 1, 995, 180 68.00 183, 666 0.368445 0.000000 68.00 19, 874, 004 69 00 06900 ELECTROCARDI OLOGY 10, 656, 552 9, 217, 452 0 071870 0.000000 69 00 838, 401 06901 CARDI AC REHAB 0.000000 69.01 218, 786 619, 615 0.816150 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 12, 229, 782 26, 144, 961 38, 374, 743 0.118948 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 26, 854, 053 22, 936, 734 49, 790, 787 0.349730 0.000000 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 33, 714, 164 21, 648, 625 12, 065, 539 0. 587510 0.000000 72 00 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 105, 479, 475 21, 900, 086 127, 379, 561 0.157740 0.000000 73.00 07400 RENAL DIALYSIS 6, 414, 615 495, 202 6, 909, 817 0.368696 0.000000 74.00 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 0.392464 0.000000 09000 CLI NI C 442,069 22, 576, 883 23, 018, 952 90.00 91.00 09100 EMERGENCY 16, 489, 661 49, 126, 192 65, 615, 853 0. 250482 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 7, 289, 168 21, 935, 035 29, 224, 203 0.507798 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 3, 081, 207 3, 081, 207 101.00 200.00 Subtotal (see instructions) 637, 118, 423 537, 426, 301 1, 174, 544, 724 200.00 201.00 Less Observation Beds 201.00

637, 118, 423

537, 426, 301 1, 174, 544, 724

202.00

202.00

Total (see instructions)

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0002	Period: Worksheet C From 01/01/2016 Part I To 12/31/2016 Date/Time Prepared: 5/26/2017 1:14 pm

				5/26/2017 1:14 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
0. 00 03000 ADULTS & PEDI ATRI CS				30.00
1.00 03100 INTENSIVE CARE UNIT				31.00
1. 01 03101 NEONATAL CU				31.0
0. 00 04000 SUBPROVI DER - 1 PF				40.00
1. 00 04100 SUBPROVI DER - I RF				41. 00
3. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
0.00 05000 OPERATING ROOM	0. 101657			50.00
0. 01 05001 ENDOSCOPY	0. 226520			50. 0
1.00 05100 RECOVERY ROOM	0. 233603			51.00
2.00 05200 DELIVERY ROOM & LABOR ROOM	0. 977863			52.00
3. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 237457			54.00
4. 01 05401 RADI OLOGY - ULTRASOUND	0. 195371			54.0
5. 00 05500 RADI OLOGY-THERAPEUTI C	0. 141948			55.00
6. 00 05600 RADI 0I SOTOPE	0. 190426			56.00
7.00 05700 CT SCAN	0. 043544			57. 0
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 059973			58.00
9. 00 05900 CARDI AC CATHETERI ZATI ON	0. 093608			59.00
0. 00 06000 LABORATORY	0. 119276			60.00
O. 01 06001 BLOOD LABORATORY	0. 000000			60. 0
1.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			61.00
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 271210			62.00
3.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.00
4.00 06400 I NTRAVENOUS THERAPY	0. 000000			64. 0
5. 00 06500 RESPIRATORY THERAPY	0. 134915			65. 00
6. 00 06600 PHYSI CAL THERAPY	0. 368774			66. 00
7. 00 06700 OCCUPATI ONAL THERAPY	0. 380802			67. 00
8.00 06800 SPEECH PATHOLOGY	0. 368445			68. 00
9. 00 06900 ELECTROCARDI OLOGY	0. 071870			69. 00
9. 01 06901 CARDI AC REHAB	0. 816150			69. 0°
0.00 07000 ELECTROENCEPHALOGRAPHY	0. 119245			70.00
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 349730			71. 00
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 587510			72.00
3.00 07300 DRUGS CHARGED TO PATLENTS	0. 157740			73.00
4.00 07400 RENAL DIALYSIS	0. 368696			74.00
OUTPATIENT SERVICE COST CENTERS				
0. 00 09000 CLI NI C	0. 392464			90.00
1.00 09100 EMERGENCY	0. 250482			91.00
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 507798			92.00
OTHER REIMBURSABLE COST CENTERS				
01.00 10100 HOME HEALTH AGENCY				101. 00
00.00 Subtotal (see instructions)				200. 00
01.00 Less Observation Beds				201. 00
02.00 Total (see instructions)				202. 00

				o 12/31/2016	Date/Time Pre 5/26/2017 1:1	pared:
		Ti +I	e XIX	Hospi tal	Cost	4 pm
		11 (1	e xix	Costs	COST	
Cost Center Description	Total Cost (from Wkst. B, Part I,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	col . 26) 1.00	2. 00	3. 00	4.00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS	72, 740, 676		72, 740, 676	3, 665	72, 744, 341	30.00
31. 00 03100 NTENSI VE CARE UNI T	13, 114, 014		13, 114, 014		13, 114, 014	31.00
31. 01 03101 NEONATAL CU	3, 735, 381		3, 735, 38		3, 735, 381	31. 01
40. 00 04000 SUBPROVI DER - 1 PF	1, 879, 727		1, 879, 727		1, 879, 727	40.00
41. 00 04100 SUBPROVI DER - RF	7, 163, 629		7, 163, 629		7, 163, 629	1
43. 00 04300 NURSERY	2, 332, 035		2, 332, 035		2, 332, 035	
ANCI LLARY SERVI CE COST CENTERS	2,002,000		2,002,000	,1	2, 662, 666	10.00
50. 00 05000 OPERATING ROOM	15, 821, 451		15, 821, 451	0	15, 821, 451	50.00
50. 01 05001 ENDOSCOPY	4, 246, 029		4, 246, 029		4, 246, 029	50. 01
51. 00 05100 RECOVERY ROOM	2, 432, 609		2, 432, 609		2, 432, 609	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	4, 822, 389		4, 822, 389		4, 822, 389	
53. 00 05300 ANESTHESI OLOGY	0				0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	8, 395, 463		8, 395, 463	o o	8, 395, 463	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	3, 125, 817		3, 125, 817	0	3, 125, 817	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	2, 572, 648		2, 572, 648	8, 329	2, 580, 977	55.00
56. 00 05600 RADI 0I SOTOPE	2, 543, 628		2, 543, 628	o o	2, 543, 628	56.00
57.00 05700 CT SCAN	4, 646, 761		4, 646, 76	0	4, 646, 761	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 652, 213		1, 652, 213	0	1, 652, 213	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	6, 284, 462		6, 284, 462	0	6, 284, 462	59.00
60. 00 06000 LABORATORY	16, 090, 008		16, 090, 008	0	16, 090, 008	60.00
60. 01 06001 BL00D LABORATORY	0		(0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		(0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 131, 934		2, 131, 934	0	2, 131, 934	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0		(0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0		(0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	5, 248, 759	0	5, 248, 759	0	5, 248, 759	65.00
66. 00 06600 PHYSI CAL THERAPY	2, 819, 370	0			2, 819, 370	66. 00
67.00 06700 OCCUPATIONAL THERAPY	2, 234, 114	0	_, _,		2, 234, 114	67. 00
68. 00 06800 SPEECH PATHOLOGY	735, 115	0	735, 115		735, 115	
69. 00 06900 ELECTROCARDI OLOGY	1, 428, 339		1, 428, 339		1, 428, 339	69.00
69. 01 06901 CARDI AC REHAB	684, 261		684, 26		684, 261	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	4, 564, 613		4, 564, 613		4, 575, 980	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17, 413, 318		17, 413, 318		17, 413, 318	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	19, 807, 420		19, 807, 420		19, 807, 420	
73. 00 07300 DRUGS CHARGED TO PATIENTS	20, 092, 876		20, 092, 876		20, 092, 876	
74. 00 O7400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS	2, 547, 622		2, 547, 622	2 0	2, 547, 622	74.00
90. 00 O9000 CLINIC	9, 034, 100		9, 034, 100) 0	9, 034, 100	90.00
91. 00 09100 EMERGENCY	16, 435, 561		16, 435, 56		16, 435, 561	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	14, 840, 003		14, 840, 003		14, 840, 003	
OTHER REIMBURSABLE COST CENTERS	17,040,003		14, 040, 000	'I	14, 040, 003	, /2.00
101. 00 10100 HOME HEALTH AGENCY	2, 967, 744		2, 967, 744		2, 967, 744	101.00
200.00 Subtotal (see instructions)	296, 584, 089	0			296, 607, 450	
201.00 Less Observation Beds	14, 840, 003		14, 840, 003		14, 840, 003	
202.00 Total (see instructions)	281, 744, 086	0			281, 767, 447	
	•	•	•			

From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 5/26/2017 1:14 pm Title XIX Hospi tal Cost Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent TEFRA I npati ent + col. 7) Ratio Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 68, 765, 356 30.00 03000 ADULTS & PEDIATRICS 68, 765, 356 30.00 31.00 03100 INTENSIVE CARE UNIT 16, 137, 742 16, 137, 742 31.00 03101 NEONATAL ICU 6, 651, 844 6, 651, 844 31.01 31.01 40.00 04000 SUBPROVI DER - I PF 4, 136, 239 4, 136, 239 40.00 04100 SUBPROVI DER - I RF 8, 022, 185 41.00 8, 022, 185 41.00 43.00 04300 NURSERY 1, 820, 698 1,820,698 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 95, 055, 211 0.000000 50.00 60, 579, 855 155, 635, 066 0. 101657 50.00 05001 ENDOSCOPY 50.01 4, 682, 415 14, 062, 175 18, 744, 590 0. 226520 0.000000 50.01 51.00 05100 RECOVERY ROOM 5, 199, 562 5, 213, 858 10, 413, 420 0. 233603 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 2, 821, 595 2, 109, 965 4, 931, 560 0. 977863 0.000000 52.00 05300 ANESTHESI OLOGY 53.00 0.000000 0.000000 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 9, 500, 620 25, 855, 167 35, 355, 787 0.237457 0.000000 54.00 05401 RADI OLOGY - ULTRASOUND 5, 145, 968 10, 853, 424 15, 999, 392 0.195371 54.01 0.000000 54.01 05500 RADI OLOGY-THERAPEUTI C 17, 049, 452 18, 182, 554 0.000000 55.00 1, 133, 102 0.141490 55.00 05600 RADI OI SOTOPE 0. 190426 56.00 5, 616, 532 7, 741, 006 13, 357, 538 0.000000 56.00 05700 CT SCAN 38, 732, 759 67, 981, 914 106, 714, 673 0.043544 0.000000 57.00 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 10, 062, 748 17, 486, 406 27, 549, 154 0.059973 0.000000 58.00 05900 CARDI AC CATHETERI ZATI ON 32, 092, 844 0.093608 35, 043, 228 59.00 67, 136, 072 0.000000 59.00 60.00 06000 LABORATORY 58, 956, 959 75, 939, 873 134, 896, 832 0. 119276 0.000000 60.00 60.01 06001 BLOOD LABORATORY 0.000000 0.000000 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 0.000000 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 1, 835, 509 62.00 6, 025, 304 7, 860, 813 0.271210 0.000000 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0.000000 63.00 C 06400 INTRAVENOUS THERAPY 0.000000 64.00 0.000000 64.00 65.00 06500 RESPIRATORY THERAPY 34, 013, 151 4, 891, 060 38, 904, 211 0.134915 0.000000 65.00 06600 PHYSI CAL THERAPY 7, 327, 942 7, 645, 259 66.00 317, 317 0.368774 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 5, 683, 347 183, 520 5, 866, 867 0.380802 0.000000 67.00 06800 SPEECH PATHOLOGY 1, 811, 514 1, 995, 180 68.00 183, 666 0.368445 0.000000 68.00 19, 874, 004 69 00 06900 ELECTROCARDI OLOGY 10, 656, 552 9, 217, 452 0 071870 0.000000 69 00 838, 401 06901 CARDI AC REHAB 0.000000 69.01 218, 786 619, 615 0.816150 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 12, 229, 782 26, 144, 961 38, 374, 743 0.118948 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 26, 854, 053 22, 936, 734 49, 790, 787 0.349730 0.000000 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 33, 714, 164 21, 648, 625 12, 065, 539 0. 587510 0.000000 72 00 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 105, 479, 475 21, 900, 086 127, 379, 561 0.157740 0.000000 73.00 07400 RENAL DIALYSIS 6, 414, 615 495, 202 6, 909, 817 0.368696 0.000000 74.00 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 0.000000 09000 CLI NI C 442,069 22, 576, 883 23, 018, 952 0.392464 90.00 09100 EMERGENCY 16, 489, 661 49, 126, 192 65, 615, 853 0. 250482 0.000000 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 7, 289, 168 21, 935, 035 29, 224, 203 0.507798 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 3, 081, 207 3, 081, 207 101.00 200.00 Subtotal (see instructions) 637, 118, 423 537, 426, 301 1, 174, 544, 724 200.00 201.00 Less Observation Beds 201.00

637, 118, 423

537, 426, 301 1, 174, 544, 724

202.00

202.00

Total (see instructions)

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0002	From 01/01/2016	Worksheet C Part I Date/Time Prepared:

					5/26/2017 1:14 pm
			Title XIX	Hospi tal	Cost
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
I NP	PATIENT ROUTINE SERVICE COST CENTERS				
30.00 030	000 ADULTS & PEDIATRICS				30.00
31.00 031	100 INTENSIVE CARE UNIT				31.00
31. 01 031	IO1 NEONATAL ICU				31.01
40.00 040	000 SUBPROVI DER - I PF				40.00
41.00 041	100 SUBPROVI DER - I RF				41.00
	BOO NURSERY				43.00
ANC	CILLARY SERVICE COST CENTERS				
	000 OPERATING ROOM	0. 000000			50.00
50. 01 050	001 ENDOSCOPY	0. 000000			50. 01
51.00 051	100 RECOVERY ROOM	0. 000000			51.00
52.00 052	200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
53.00 053	BOO ANESTHESI OLOGY	0. 000000			53.00
	100 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
54. 01 054	101 RADI OLOGY - ULTRASOUND	0. 000000			54. 01
	500 RADI OLOGY-THERAPEUTI C	0. 000000			55.00
1	600 RADI OI SOTOPE	0. 000000			56.00
	700 CT SCAN	0. 000000			57.00
	MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58.00
	900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
	DOO LABORATORY	0. 000000			60.00
	001 BLOOD LABORATORY	0. 000000			60. 01
	100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			61.00
	200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62.00
	300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.00
	100 INTRAVENOUS THERAPY	0. 000000			64.00
1	000 RESPI RATORY THERAPY	0. 000000			65.00
1	500 PHYSI CAL THERAPY	0. 000000			66.00
	700 OCCUPATI ONAL THERAPY	0. 000000			67.00
	300 SPEECH PATHOLOGY	0. 000000			68.00
	900 ELECTROCARDI OLOGY	0. 000000			69.00
	PO1 CARDI AC REHAB	0. 000000			69. 01
1	000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
1	200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
	BOO DRUGS CHARGED TO PATTENTS	0. 000000			73.00
	100 RENAL DIALYSIS	0. 000000			74.00
74.00 074	PATIENT SERVICE COST CENTERS	0.000000			74.00
	DOO CLINIC	0. 000000			00.00
1					90.00
1	100 EMERGENCY	0.000000			91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
	HER REIMBURSABLE COST CENTERS				101 00
-	HOME HEALTH AGENCY				101.00
200.00	Subtotal (see instructions)				200.00
201. 00	Less Observation Beds				201. 00
202. 00	Total (see instructions)				202. 00

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 01/01/2016 To 12/31/2016		pared: 4 pm
		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						
30. 00 ADULTS & PEDIATRICS	2, 407, 082		2, 10, 100	· ·		
31.00 INTENSIVE CARE UNIT	189, 033		189, 03			
31. 01 NEONATAL I CU	29, 299		29, 29			
40. 00 SUBPROVI DER - I PF	32, 198	0	32, 19		l	
41. 00 SUBPROVI DER - I RF	237, 917	0	237, 91			
43. 00 NURSERY	166, 520		166, 52			
200.00 Total (lines 30-199)	3, 062, 049		3, 062, 04	9 122, 821		200.00
Cost Center Description	I npati ent	Inpatient				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 ADULTS & PEDIATRICS	30, 671	776, 896				30.00
31. 00 INTENSIVE CARE UNIT	3, 562	81, 071				31.00
31. 01 NEONATAL I CU	0	0	1			31. 01
40. 00 SUBPROVI DER - I PF	1, 614	· ·	•			40.00
41. 00 SUBPROVI DER - I RF	6, 219		1			41.00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30-199)	42, 066	1, 019, 946				200. 00

Health Financial Systems	METHODI ST HOS	SPITALS, INC		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Period: From 01/01/2016	Worksheet D Part II	
				To 12/31/2016	Date/Time Pre 5/26/2017 1:1	pared: 4 nm
		Title	e XVIII	Hospi tal	PPS	т рііі
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		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)					
ANOLULARY OFFICE COST OFFITTED	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	4/0 /44	155 (25 0//	0.00201	1 2/ 2/0 020	100, 400	
50. 00 05000 OPERATING ROOM	468, 644		•		109, 480	50.00
50. 01 05001 ENDOSCOPY	15, 368				1, 806	50.01
51. 00 05100 RECOVERY ROOM	106, 181				16, 542	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	66, 898				785	52.00
53. 00 05300 ANESTHESI OLOGY	0		1 0.0000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	372, 551		•		44, 482	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	44, 156				6, 306	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	96, 571					
56. 00 05600 RADI 0I SOTOPE	68, 343					
57. 00 05700 CT SCAN	89, 713					
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	37, 144					•
59. 00 05900 CARDI AC CATHETERI ZATI ON	86, 117				18, 405	
60. 00 06000 LABORATORY	229, 991				41, 540	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0. 00000	0	0	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	40.040	7 0/0 040			0.544	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	10, 013				2, 541	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	1	1 0.0000		0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0		0.00000		0	64.00
65. 00 06500 RESPIRATORY THERAPY	71, 352				24, 782	65.00
66. 00 06600 PHYSI CAL THERAPY	88, 410		•		20, 129	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	74, 252				12, 770	
68. 00 06800 SPEECH PATHOLOGY	14, 001	1, 995, 180			4, 638	
69. 00 06900 ELECTROCARDI OLOGY	8, 712				2, 267	69.00
69. 01 06901 CARDI AC REHAB	1, 910		•		1	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	29, 556				841	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	157, 503				30, 188	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	175, 815				46, 212	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	165, 030					73.00
74. 00 07400 RENAL DIALYSIS	39, 104	6, 909, 817	0. 00565	9 3, 752, 176	21, 234	74.00
OUTPATIENT SERVICE COST CENTERS	E17.01/	22 010 052	0.00044	0 170 507	4 000	00.00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	517, 016				4, 009	90.00
	254, 809				37, 875	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	491, 056		l		54, 297	
200.00 Total (lines 50-199)	3, 180, 216	1, 065, 929, 453	1	210, 893, 380	589, 701	J∠UU. UU

Harlin Florest d. Cartana	METHODI CT. HOC	DITALC INC		1 . 11 .	6.5	0550 40
Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	METHODIST HOS SS THROUGH COS		CN: 15-0002	Period: From 01/01/2016 To 12/31/2016		
					5/26/2017 1:1	4 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Allied Health	All Other	Swi ng-Bed	Total Costs	
	School	Cost	Medi cal	Adjustment	(sum of cols.	
			Educati on	Amount (see	1 through 3,	
			Cost		minus col. 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
31. 01 03101 NEONATAL CU	0	0		0	0	31.01
40. 00 04000 SUBPROVI DER - I PF	0	0		0 0	0	40.00
41. 00 04100 SUBPROVI DER - I RF	0	0		0	0	41.00
43. 00 04300 NURSERY	0	0		0	0	43.00
200.00 Total (lines 30-199)	0	0		0	0	200.00
Cost Center Description	Total Patient	Per Diem	I npati ent	I npati ent		
	Days	(col. 5 ÷	Program Days	Program		
		col. 6)		Pass-Through		
				Cost (col. 7		
				x col. 8)		
	6. 00	7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	95, 018					30.00
31.00 03100 INTENSIVE CARE UNIT	8, 305	0.00	3, 56	0 0		31.00
31. 01 03101 NEONATAL CU	3, 489	0.00		0 0		31.01
40. 00 04000 SUBPROVI DER - 1 PF	2, 967	0.00	1, 61	4 0		40.00
41. 00 04100 SUBPROVI DER - I RF	10, 240	0.00	6, 21	9 0		41.00
43. 00 04300 NURSERY	2, 802	0.00		0 0		43.00
200.00 Total (lines 30-199)	122, 821		42, 06	0	ĺ	200. 00

Health Financial Systems	METHODIST HOSPIT	ALS, INC	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0002	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2016	Part IV

THROUGH COSTS 12/31/2016 Date/Time Prepared: To 5/26/2017 1:14 pm Title XVIII Hospi tal PPS Cost Center Description Non Physician Nursi ng Total Cost Allied Health All Other Anestheti st Medi cal (sum of col 1 School Cost Educati on through col. Cost 1. 00 2.00 3.00 4. 00 5.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50 00 50 00 000000000000000 0 0 50.01 05001 ENDOSCOPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 50.01 51.00 05100 RECOVERY ROOM 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 0 52.00 0 05300 ANESTHESI OLOGY 0 53.00 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 05401 RADI OLOGY - ULTRASOUND 05500 RADI OLOGY-THERAPEUTI C 54.01 0 0 0 54.01 0 55.00 0 0 55.00 05600 RADI OI SOTOPE 0 56.00 56.00 0 0 57.00 05700 CT SCAN 0 0 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 05900 CARDIAC CATHETERIZATION 0 59.00 0 59.00 0 0 60.00 06000 LABORATORY 0 0 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0000000000000 0 0 0 62.00 62.00 0 0 0 0 0 0 0 0 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 63.00 06400 INTRAVENOUS THERAPY 0 64.00 64.00 0 06500 RESPIRATORY THERAPY 0 0 65.00 65.00 0 06600 PHYSI CAL THERAPY 0 66.00 0 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 67.00 06800 SPEECH PATHOLOGY 68.00 0 68.00 0 69 00 06900 ELECTROCARDI OLOGY 0 Ω 69.00 06901 CARDI AC REHAB 0 69.01 69.01 0 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 0 0 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 0 73.00 07400 RENAL DIALYSIS
OUTPATIENT SERVICE COST CENTERS 0 0 74.00 74.00 0 0 0 90.00 0 90.00 09000 CLI NI C 0 0 0 0 91.00 09100 EMERGENCY 0 731, 912 731, 912 91.00 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) ol 0 0 92.00 731, 912 200. 00 Total (lines 50-199) 0 731, 912 o 200.00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0002	Peri od: Worksheet D
THROUGH COSTS		From 01/01/2016 Part IV

THROUGH COSTS				o 12/31/2016	Date/Time Pre 5/26/2017 1:1	
			XVIII	Hospi tal	PPS	
Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	I npati ent	
	Outpati ent	(from Wkst.	to Charges	Ratio of Cost	Program	
	Cost (sum of	C, Part I,	(col. 5 ÷	to Charges	Charges	
	col. 2, 3 and	col. 8)	col. 7)	(col. 6 ÷		
	4)			col. 7)		
	6. 00	7. 00	8. 00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS			,			
50. 00 05000 OPERATI NG ROOM	0	155, 635, 066			36, 360, 029	
50. 01 05001 ENDOSCOPY	0	18, 744, 590			2, 202, 786	50. 01
51.00 05100 RECOVERY ROOM	0	10, 413, 420			1, 622, 274	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	4, 931, 560			57, 879	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0. 000000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	35, 355, 787			4, 221, 488	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	0	15, 999, 392			2, 284, 815	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	18, 182, 554			298, 306	
56. 00 05600 RADI 0I SOTOPE	0	13, 357, 538	0. 000000	0.000000	2, 649, 460	56.00
57. 00 05700 CT SCAN	0	106, 714, 673	0. 000000	0. 000000	15, 588, 338	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	27, 549, 154	0. 000000	0. 000000	3, 782, 848	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	67, 136, 072	0. 000000	0. 000000	14, 345, 345	59.00
60. 00 06000 LABORATORY	0	134, 896, 832	0. 000000	0. 000000	24, 363, 362	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0. 000000	0. 000000	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	7, 860, 813	0. 000000	0. 000000	1, 994, 126	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0. 000000	0. 000000	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0. 000000	0. 000000	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0	38, 904, 211	0. 000000	0. 000000	13, 512, 342	65.00
66. 00 06600 PHYSI CAL THERAPY	0	7, 645, 259	0.000000	0.000000	1, 740, 631	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	5, 866, 867	0. 000000	0. 000000	1, 009, 035	67.00
68. 00 06800 SPEECH PATHOLOGY	0	1, 995, 180	0. 000000	0. 000000	660, 922	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	19, 874, 004	0. 000000	0. 000000	5, 175, 640	69.00
69. 01 06901 CARDI AC REHAB	0	838, 401	0. 000000	0. 000000	479	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	38, 374, 743	0. 000000	0. 000000	1, 091, 754	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	49, 790, 787	0. 000000	0. 000000	9, 544, 058	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	33, 714, 164	0. 000000	0. 000000	8, 861, 416	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	127, 379, 561	0. 000000	0. 000000	42, 609, 998	73.00
74.00 07400 RENAL DIALYSIS	0	6, 909, 817	0. 000000	0. 000000	3, 752, 176	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	23, 018, 952	0.000000	0. 000000	178, 507	90.00
91. 00 09100 EMERGENCY	731, 912	65, 615, 853	0. 011154	0. 011154	9, 753, 992	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	29, 224, 203	0. 000000	0. 000000	3, 231, 374	92.00
200.00 Total (lines 50-199)	731, 912	1, 065, 929, 453			210, 893, 380	200. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet D | From 01/01/2016 | Part IV | To 12/31/2016 | Date/Time Prepared: | 5/26/2017 1:14 pm | THROUGH COSTS

		Title	XVIII	Hospi tal	PPS	<u> </u>
Cost Center Description	Inpati ent	Outpati ent	Outpati ent	,		
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8	Ü	Costs (col. 9			
	x col. 10)		x col. 12)			
	11. 00	12. 00	13. 00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	15, 475, 716	C			50.00
50. 01 05001 ENDOSCOPY	o	4, 701, 464	l			50. 01
51.00 05100 RECOVERY ROOM	o	1, 987, 901		1		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	o	22, 513		1		52.00
53. 00 05300 ANESTHESI OLOGY	o	0		1		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	o	7, 666, 407		1		54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	o	2, 052, 813		1		54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	o	6, 531, 433				55.00
56. 00 05600 RADI OI SOTOPE	o	2, 474, 057				56.00
57. 00 05700 CT SCAN	o	16, 218, 354				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	o	4, 205, 426		ı		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	o	15, 367, 223		ı		59.00
60. 00 06000 LABORATORY	o	7, 914, 479		1		60.00
60. 01 06001 BLOOD LABORATORY	0	0				60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	346, 813	1			62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	l d			64.00
65. 00 06500 RESPIRATORY THERAPY	0	623, 175	l d			65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	1			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	17, 492	l d			67.00
68. 00 06800 SPEECH PATHOLOGY	0	13, 608				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	2, 654, 760				69.00
69. 01 06901 CARDI AC REHAB	0	231, 726				69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	4, 964, 605				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5, 788, 307				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	4, 843, 684				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	4, 704, 575				73.00
74. 00 07400 RENAL DI ALYSI S	0	290, 476				74.00
OUTPATIENT SERVICE COST CENTERS	<u>۱</u>	2,3,170				1
90. 00 09000 CLINIC	O	7, 225, 952	С			90.00
91. 00 09100 EMERGENCY	108, 796	8, 943, 477				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1 0	3, 499, 571				92.00
200.00 Total (lines 50-199)	108, 796	128, 766, 007				200.00
		.20, .00, 007	,,,,,,,,	1		1-30.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0002 Peri od: Worksheet D From 01/01/2016 Part V Date/Time Prepared: 12/31/2016 5/26/2017 1:14 pm Title XVIII Hospi tal PPS Charges Costs PPS Services Cost Center Description Cost to PPS Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) Services (see From 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. 101657 15, 475, 716 1, 573, 215 50.00 05001 ENDOSCOPY 0 4.701.464 50.01 0. 226520 0 1,064,976 50.01 05100 RECOVERY ROOM 51.00 0. 233603 1, 987, 901 0 464, 380 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.977863 22, 513 0 0 22,015 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0 0 53.00 0 0. 237457 1, 820, 442 54.00 05400 RADI OLOGY-DI AGNOSTI C 7, 666, 407 0 54 00 315 0 54.01 05401 RADI OLOGY - ULTRASOUND 0. 195371 2, 052, 813 0 401,060 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 0.141490 6, 531, 433 0 924, 132 55.00 05600 RADI OI SOTOPE 0. 190426 2, 474, 057 0 470 56.00 471, 125 56.00 0 05700 CT SCAN 0.043544 7, 998 57.00 16, 218, 354 706, 212 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.059973 4, 205, 426 617 252, 212 58.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 0.093608 15, 367, 223 1, 112 1, 438, 495 59.00 06000 LABORATORY 7, 914, 479 0 944, 007 60 00 0 119276 0 60 00 0 60.01 06001 BLOOD LABORATORY 0.000000 0 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 0 0 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0. 271210 346, 813 0 0 94,059 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0.000000 63 00 C 0 63 00 0 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0 0 64.00 06500 RESPIRATORY THERAPY 0. 134915 84,076 623, 175 65.00 0 0 66.00 06600 PHYSI CAL THERAPY 0.368774 66,00 0 06700 OCCUPATI ONAL THERAPY 0 0.380802 17, 492 67 00 6,661 67.00 0 0 68.00 06800 SPEECH PATHOLOGY 0.368445 13, 608 5,014 68.00 06900 ELECTROCARDI OLOGY 0.071870 0 0 190, 798 69.00 2, 654, 760 69.00 06901 CARDI AC REHAB 69.01 0.816150 231.726 0 0 189, 123 69.01 07000 ELECTROENCEPHALOGRAPHY 4, 964, 605 0 28.981 70.00 0.118948 590, 530 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.349730 5, 788, 307 0 2, 024, 345 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.587510 4, 843, 684 2.644 2, 845, 713 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 73 00 0.157740 4, 704, 575 0 20, 561 742, 100 74.00 07400 RENAL DIALYSIS 0.368696 290, 476 0 107, 097 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0.392464 7, 225, 952 0 2, 835, 926 90.00 09100 EMERGENCY 0 105 91.00 91.00 0. 250482 8, 943, 477 2, 240, 180 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.507798 3, 499, 571 0 1, 777, 075 92.00 200.00 Subtotal (see instructions) 128, 766, 007 2,644 60, 159 23, 814, 968 200. 00 Less PBP Clinic Lab. Services-Program 201. 00 201.00 Only Charges

128, 766, 007

2, 644

60, 159

23, 814, 968 202. 00

202.00

Net Charges (line 200 +/- line 201)

Health Financial Systems	METHODIST HOSPITALS,	, INC	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST Pro	ovider CCN: 15-0002		Worksheet D
			From 01/01/2016	Part V

					To 12/31/2016	Part V Date/Time Pre 5/26/2017 1:1	
			Ti tl	e XVIII	Hospi tal	PPS	ı pııı
		Cos	sts				
	Cost Center Description	Cost	Cost	1			
	, , , , , , , , , , , , , , , , , , ,	Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0)				50.00
50. 01	05001 ENDOSCOPY	0)				50. 01
51.00	05100 RECOVERY ROOM	0)				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0)				52.00
53.00	05300 ANESTHESI OLOGY	0)				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	75	5			54.00
54.01	05401 RADI OLOGY - ULTRASOUND	0) (54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0) (55.00
56.00	05600 RADI OI SOTOPE	0	9(56.00
57.00	05700 CT SCAN	0	348	3			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	37	7			58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	104	1			59. 00
60.00	06000 LABORATORY	0) (60.00
60. 01	06001 BLOOD LABORATORY	0) (60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0)				61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0) (62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0) (63.00
64.00	06400 I NTRAVENOUS THERAPY	0)				64.00
65.00	06500 RESPI RATORY THERAPY	0)				65.00
66.00	06600 PHYSI CAL THERAPY	0)				66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0))			67.00
68. 00	06800 SPEECH PATHOLOGY	0))			68. 00
69. 00	06900 ELECTROCARDI OLOGY	0))			69. 00
69. 01	06901 CARDI AC REHAB	0))			69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	3, 44	7			70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0))			71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	1, 553	(72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	3, 243	3			73.00
74.00	07400 RENAL DIALYSIS	0)				74.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	1				90.00
91.00	09100 EMERGENCY	0		1			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1	- 1			92.00
200.00		1, 553	7, 370)			200.00
201.00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	0)				201.00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)	1, 553	7, 370	O			202. 00

Cost Center Description Capital Related Cost (from Wkst. (from Wkst. (from Wkst. B, Part II, col. 26) Capital Related Cost (from Wkst. Col. 8) Capital Total Charges Ratio of Cost Inpatient (column Column Colum	eet D I ime Prep 017 1:14 PPS Costs	pared:
Component CCN: 15-S002 To 12/31/2016 Date/T 5/26/2 Title XVIII Subprovider - IPF Cost Center Description Capital Related Cost (from Wkst. (from Wkst. (from Wkst. (From Wkst. B, Part II, col. 26) Col. 8) Col. 2) Component CCN: 15-S002 To 12/31/2016 Date/T 5/26/2 Subprovider - IPF Capital (from Wkst. to Charges (col. 1 ÷ Charges (col. 1) col. 2)	ime Prep 017 1:14 PPS Costs In 3 x	pared: 1 pm
Cost Center Description Capital Related Cost (from Wkst. (from Wkst. (From Wkst. R. Part II, col. 26) Related Cost (from Wkst. Col. 8) Capital Ratio of Cost Inpatient (Column Column	017 1:14 PPS Costs	pared:
Cost Center Description Capital Related Cost (from Wkst. (from Wkst. B, Part II, col. 26) Title XVIII Subprovider - IPF Cost Center Description Capital Total Charges (from Wkst. to Charges (col. 1 ÷ Charges Charges col. 2) Capital (from Wkst. col. 8) Capital (col. 1 ÷ Charges Charges col. 2)	PPS Costs	
Cost Center Description Capital Related Cost (from Wkst. to Charges (column (from Wkst. B, Part II, col. 8) col. 2) Capital Total Charges (from Wkst. to Charges (column (column (from Wkst. B, Part II, col. 8) col. 2)	ın 3 x	
Related Cost (from Wkst. to Charges Program (column (from Wkst. C, Part I, col. 1 ÷ Charges column col. 26)	ın 3 x	
(from Wkst. C, Part I, (col. 1 ÷ Charges columbia col. 2) col. 26)		
B, Part II, col. 8) col. 2)	111 4)	
col . 26)		
1.00 2.00 3.00 4.00 5.	00	
ANCILLARY SERVICE COST CENTERS		
50. 00 05000 0PERATI NG ROOM 468, 644 155, 635, 066 0. 003011 3, 756	11	50.00
50. 01 05001 ENDOSCOPY 15, 368 18, 744, 590 0. 000820 2, 431		50. 01
51. 00 05100 RECOVERY ROOM 106, 181 10, 413, 420 0. 010197 1, 567	•	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 66, 898 4, 931, 560 0. 013565 660	9	52.00
53. 00 05300 ANESTHESI OLOGY 0 0 0 0 0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 372, 551 35, 355, 787 0. 010537 10, 189	107	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND 44, 156 15, 999, 392 0. 002760 5, 177	14	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C 96, 571 18, 182, 554 0. 005311 0	0	55.00
56. 00 05600 RADI 0I SOTOPE 68, 343 13, 357, 538 0. 005116 0	0	56.00
57. 00 05700 CT SCAN 89, 713 106, 714, 673 0. 000841 40, 596		57.00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 37, 144 27, 549, 154 0.001348 11, 269	-	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 86, 117 67, 136, 072 0. 001283 1, 802		59.00
60. 00 06000 LABORATORY 229, 991 134, 896, 832 0. 001705 251, 452		60.00
60. 01 06001 BLOOD LABORATORY 0 0. 000000 0	0	60. 01
61. 00 O6100 PBP CLINICAL LAB SERVICES-PRGM ONLY		61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 10, 013 7, 860, 813 0. 001274 1, 372	•	62.00
63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0.000000 0		63.00
64. 00 06400 I NTRAVENOUS THERAPY		64.00
65. 00 06500 RESPI RATORY THERAPY 71, 352 38, 904, 211 0. 001834 64, 835		65.00
66. 00 06600 PHYSI CAL THERAPY		66. 00 67. 00
68. 00 06700 05700		68.00
69. 00 06900 ELECTROCARDI OLOGY 14, 001 1, 993, 160 0.007017 1, 908 69. 00 06900 ELECTROCARDI OLOGY 8, 712 19, 874, 004 0.000438 7, 200		69.00
69. 01 06901 CARDI AC REHAB 1, 910 838, 401 0. 002278 0		69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY 29, 556 38, 374, 743 0. 000770 1, 767	1	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 157, 503 49, 790, 787 0. 003163 2, 559		71.00
72. 00 07200 MPL. DEV. CHARGED TO PATI ENTS 175, 815 33, 714, 164 0. 005215 0		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 165, 030 127, 379, 561 0. 001296 627, 045		73.00
74. 00 07400 RENAL DI ALYSIS 39, 104 6, 909, 817 0. 005659 12, 839		74.00
OUTPATIENT SERVICE COST CENTERS		
90. 00 09000 CLINIC 517, 016 23, 018, 952 0. 022460 13, 623	306	90.00
91. 00 09100 EMERGENCY 254, 809 65, 615, 853 0. 003883 75, 504	293	91.00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 29, 224, 203 0.000000 286		92.00
200. 00 Total (Lines 50-199) 3, 289, 160 1, 065, 929, 453 1, 164, 616	2, 590 2	200. 00

Health Financial Systems	METHODIST HOSPI	· · · · · · · · · · · · · · · · · · ·	CCN 15 0000		u of Form CMS-1	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEITHROUGH COSTS	RVICE UTHER PASS	Provi der	CCN: 15-0002	Peri od: From 01/01/2016	Worksheet D Part IV	
INCOUGH COSTS		Componen-	t CCN: 15-S002	To 12/31/2016		epared: 4 pm
		Ti t	le XVIII	Subprovi der - I PF	PPS	
Cost Center Description	Non Physician	Nursi ng	Allied Heal	th All Other	Total Cost	
	Anesthetist	School		Medi cal	(sum of col 1	
	Cost			Educati on	through col.	
				Cost	4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS					_	
50. 00 05000 OPERATING ROOM	0		0	0 0	0	
50. 01 05001 ENDOSCOPY	0		0	0 0	0	
51. 00 05100 RECOVERY ROOM	0		0	0 0	0	1
52.00 05200 DELIVERY ROOM & LABOR ROOM	0		0	0 0	0	
53. 00 05300 ANESTHESI OLOGY	0		0	0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0		0	0 0	0	
54. 01 05401 RADI OLOGY - ULTRASOUND	0		0	0 0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		0	0 0	0	
56. 00 05600 RADI OI SOTOPE	0		0	0 0	0	
57. 00 05700 CT SCAN	0		0	0 0	0	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0		0	0 0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		0	0 0	0	
60. 00 06000 LABORATORY	0		0	0 0	0	
60. 01 06001 BLOOD LABORATORY	0		0	0 0	0	
61.00 O6100 PBP CLINICAL LAB SERVICES-PRGM ONLY					_	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0 0	0	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0		0	0 0	0	1
64. 00 06400 I NTRAVENOUS THERAPY	0		0	0 0	0	
65. 00 06500 RESPIRATORY THERAPY	0		0	0 0	0	
66. 00 06600 PHYSI CAL THERAPY	0		0	0 0	0	
67. 00 06700 OCCUPATI ONAL THERAPY	0		0	0 0	0	
68. 00 06800 SPEECH PATHOLOGY	0		0	0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0		0	0 0	0	
69. 01 06901 CARDI AC REHAB	0		0	0	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		0	0	0	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0		0	0	0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0 0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0		0	0 0	0	
74. 00 07400 RENAL DIALYSIS	0		0	0 0	0	74. 00
90.00 O9000 CLINIC					^	00.00
	0		0 721 0	0 0	0 731, 912	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0 731, 9	0 0	731, 912	1
200.00 Total (lines 50-199)	0		0 731, 9	-	731, 912	
200.00 [10tal (11163 30-177)	١		O ₁ /31, 9	12 0	131, 712	₁ 200.00

Health Financial Systems	METHODIST HOS	SPITAIS INC		Inlie	u of Form CMS-2	2552_10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE			CN: 15-0002	Peri od:	Worksheet D	2332-10
THROUGH COSTS	KVI OL OTTLK TAC			From 01/01/2016	Part IV	
		'		To 12/31/2016	Date/Time Pre 5/26/2017 1:1	
		Title	· XVIII	Subprovi der - I PF	PPS	
Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	I npati ent	
	Outpati ent	(from Wkst.	to Charges	Ratio of Cost	Program	
	Cost (sum of	C, Part I,	(col. 5 ÷	to Charges	Charges	
	col. 2, 3 and	col. 8)	col. 7)	(col. 6 ÷		
	4)			col . 7)		
	6. 00	7. 00	8. 00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0				3, 756	
50. 01 05001 ENDOSCOPY	0				2, 431	50. 01
51. 00 05100 RECOVERY ROOM	0	10, 413, 420			1, 567	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	4, 931, 560	0.00000	0. 000000	660	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0.00000	0. 000000	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	35, 355, 787			10, 189	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	0	15, 999, 392			5, 177	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0			0. 000000	0	55.00
56. 00 05600 RADI 0I SOTOPE	0			0. 000000	0	56.00
57. 00 05700 CT SCAN	0	106, 714, 673	0.00000	0. 000000	40, 596	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	27, 549, 154	0.00000	0. 000000	11, 269	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	67, 136, 072	0.00000	0. 000000	1, 802	59.00
60. 00 06000 LABORATORY	0	134, 896, 832	0.00000	0. 000000	251, 452	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0.00000	0. 000000	0	60.01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	7, 860, 813	0.00000	0. 000000	1, 372	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0. 00000	0. 000000	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	l o	0. 00000	0. 000000	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0	38, 904, 211	0.00000		64, 835	65.00
66. 00 06600 PHYSI CAL THERAPY	0				17, 445	1
67. 00 06700 OCCUPATI ONAL THERAPY	0	5, 866, 867	0.00000	0. 000000	9, 274	67.00
68. 00 06800 SPEECH PATHOLOGY	0				1, 968	
69. 00 06900 ELECTROCARDI OLOGY	0				7, 200	
69. 01 06901 CARDI AC REHAB	0				0	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	o o		•		1, 767	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o o	,,	•		2, 559	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	o o				0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	Ö		0. 00000		627, 045	
74. 00 07400 RENAL DIALYSIS	0		0. 00000		12, 839	
OUTPATIENT SERVICE COST CENTERS		5,757,617	2. 23000	-, 3. 333000	.2,007	1 50
90. 00 09000 CLI NI C	1 0	23, 018, 952	0.00000	0. 000000	13, 623	90.00
91. 00 09100 EMERGENCY	731, 912				75, 504	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	731, 712				286	
200.00 Total (lines 50-199)	1	1, 065, 929, 453		0.000000	1, 164, 616	
[1014] [11103 00 177]	751,712	1 ., 500, 727, 400	ı	1	1, 101, 010	1-00.00

Health Financial Systems	METHODIST HOSPIT	ALS, INC	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0002	Peri od: From 01/01/2016	Worksheet D
THROUGH COSTS		Component CCN: 15-S002		
		Title XVIII	Subprovi der -	PPS

			Title	XVIII	Subprovi der -	PPS	
Cost Center Des	crintion	Inpatient	Outpati ent	Outpati ent	I PF		
cost center bes	ici i pti on	Program	Program	Program			
		Pass-Through	Charges	Pass-Through			
		Costs (col. 8	charges	Costs (col. 9			
		x col . 10)		x col. 12)			
		11. 00	12. 00	13.00	-		
ANCILLARY SERVICE COS	ST CENTERS	11.00	12.00	15.00			
50. 00 05000 OPERATING ROOM		0	0	С			50.00
50. 01 05001 ENDOSCOPY		o	0	C			50. 01
51.00 05100 RECOVERY ROOM		O	0	C			51.00
52.00 05200 DELIVERY ROOM &	LABOR ROOM	O	0	C			52.00
53. 00 05300 ANESTHESI OLOGY		O	0	C			53.00
54. 00 05400 RADI OLOGY-DI AGN	IOSTI C	0	342	C			54.00
54. 01 05401 RADI OLOGY - ULT	RASOUND	0	0	C	1		54. 01
55. 00 05500 RADI OLOGY-THERA		0	0	C	1		55.00
56. 00 05600 RADI 0I SOTOPE		0	3	C	ı		56.00
57.00 05700 CT SCAN		0	54	C	ı		57.00
58.00 05800 MAGNETIC RESONA	NCE IMAGING (MRI)	0	4	C	ı		58. 00
59. 00 05900 CARDI AC CATHETE		0	8	C	1		59.00
60. 00 06000 LABORATORY		0	1, 796	C	1		60.00
60. 01 06001 BLOOD LABORATOR	Y	0	0	C	1		60. 01
61.00 06100 PBP CLINICAL LA	B SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & F	ACKED RED BLOOD CELLS	0	0	C	1		62.00
63.00 06300 BLOOD STORING,	PROCESSING & TRANS.	0	0	C	1		63.00
64.00 06400 I NTRAVENOUS THE	RAPY	0	0	C	1		64.00
65. 00 06500 RESPIRATORY THE	RAPY	0	0	C			65.00
66. 00 06600 PHYSI CAL THERAF	Υ	0	0	C			66.00
67. 00 06700 OCCUPATI ONAL TH	ERAPY	0	0	C			67.00
68.00 06800 SPEECH PATHOLOG	Υ	0	0	C			68.00
69. 00 06900 ELECTROCARDI OLO	GY	0	0	C			69.00
69. 01 06901 CARDI AC REHAB		0	0	C			69. 01
70. 00 07000 ELECTROENCEPHAL	OGRAPHY	0	196	C			70.00
71.00 07100 MEDICAL SUPPLIE	S CHARGED TO PATIENTS	0	0	C			71.00
72.00 07200 I MPL. DEV. CHAR	GED TO PATIENTS	0	0	C			72.00
73.00 07300 DRUGS CHARGED T	O PATIENTS	0	139	C			73.00
74.00 07400 RENAL DIALYSIS		0	0	C			74.00
OUTPATIENT SERVICE CO	OST CENTERS						
90. 00 09000 CLI NI C		0	0	C			90.00
91. 00 09100 EMERGENCY		842	1, 871	21			91.00
92.00 09200 OBSERVATION BED	,	0	1, 145				92.00
200.00 Total (lines 50	1-199)	842	5, 558	21			200.00

Health Financial Systems	METHODI ST HOS	SPITALS, INC		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provi der C		Period: From 01/01/2016	Worksheet D Part V	
		Component	CCN: 15-S002	To 12/31/2016		
		Title	XVIII	Subprovi der -	PPS	
				I PF		
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins	. Ded. & Coins.		
	9		(see inst.)	(see inst.)		

Cost Center Description					charges		00313	
From North-New C. Part 1, col.		Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
Norksheet C. Part I, col. Ded. & Colins. Subject To Ded. & Colins. Colins. Part I, col. Ded. & Colins. Colin			Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
Part I, col. Ded. & Colins. Ded. & Ded. & Colins. Ded. & Ded. & Colins. Ded. & Ded. & Ded. & Colins. Ded. & Ded. & Ded. & Ded. Ded. & Ded. & Ded. Ded. & Ded. Ded. & Ded. & Ded. Ded. & Ded. Ded. & Ded. & Ded. & Ded. Ded. & Ded. & Ded. Ded. & Ded. Ded. & Ded. Ded. & Ded. & Ded. Ded. Ded. & Ded. & Ded. & Ded. Ded. & Ded. Ded. De			From	Services (see	Servi ces	Services Not		
ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00				inst.)				
ANCILLARY SERVICE COST CENTERS			Part I, col.		Ded. & Coins.	Ded. & Coins.		
ANCILLARY SERVICE COST CENTERS					(see inst.)	(see inst.)		
50.00 05000 OPERATING ROOM 0.101657 0 0 0 0 0 50.00			1. 00	2. 00	3. 00	4. 00	5. 00	
50.01 05001 ENDOSCOPY 0.226520 0 0 0 0 0 50.01								
51.00 05.100 RECOVERY ROOM 0.233603 0 0 0 0 51.00			0. 101657	0	0	0	0	50.00
52.00 05200 05200 05200 0 0 0 0 0 0 0 0 0			0. 226520	0	0	0	0	50. 01
53.00 05300 AMESTHESI OLOGY 0.000000 0 0 0 5.3.00					0	0	0	51.00
54. 00 05400 RADI OLOGY - ULTRASOUND 0.195371 0.0 0.0 0.54.01 0.54.01 0.54.01 0.54.01 0.54.01 0.54.01 0.54.01 0.54.01 0.54.01 0.54.01 0.55.00	52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 977863	0	0	0	0	52.00
54. 01 05401 RADI OLOGY - ULTRASOUND 0. 195371 0. 0 0 0 0 54. 01	53.00	05300 ANESTHESI OLOGY	0. 000000	0	0	0	0	53.00
55.00 05500 RADI OLOGY-THERAPEUTIC 0. 141490 0 0 0 0 55.00	54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 237457	342	0	0	81	54.00
56, 00 05600 RADI OI SOTOPE 0, 190426 3 0 0 1 56, 00	54.01	05401 RADI OLOGY - ULTRASOUND	0. 195371	0	0	0	0	54.01
57, 00 05700 CT SCAN 0.043544 54 0 0 2 57, 00 58, 00 05800 Magnetic Resonance I Maging (MRI) 0.059973 4 0 0 0 58, 00 59, 00 05900 CARDIAC CATHETERI ZATI ON 0.059973 4 0 0 0 58, 00 60, 01 06000 LaBoratory 0.019276 1,796 0	55.00	05500 RADI OLOGY-THERAPEUTI C	0. 141490	0	0	0	0	55.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.059973 4 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERIZATION 0.093608 8 0 0 1 59. 00 60. 00 06000 LABORATORY 0.119276 1,796 0 0 0 0 0 60. 01 60. 01 6000 1 59. 00 0	56.00	05600 RADI 0I S0T0PE	0. 190426	3	0	0	1	56.00
59.00 05900 CARDI AC CATHETERI ZATI ON 0.093608 8 0 0 1 59.00	57.00	05700 CT SCAN	0. 043544	54	0	0	2	57.00
60. 00 06000 LABORATORY 0. 119276 1, 796 0 0 214 60. 00 60. 01 06001 BLOOD LABORATORY 0. 000000 0 0 0 0 0 0 0 60. 01 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0. 0000000 0 0 0 0 0 0 61. 00 00 62. 00 62. 00 6200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0. 271210 0 0 0 0 0 0 0 62. 00 63. 00 6300 BLOOD STORING, PROCESSING & TRANS. 0. 000000 0 0 0 0 0 0 63. 00 64. 00 06400 INTRAVENOUS THERAPY 0. 0. 000000 0 0 0 0 0 0 65. 00 65. 00 665. 00 665. 00 665. 00 66600 PHYSI CAI THERAPY 0. 380802 0 0 0 0 0 0 67. 00 66. 00 66600 PHYSI CAI THERAPY 0. 380802 0 0 0 0 0 67. 00 68. 00 69700 CCUPATI ONAL THERAPY 0. 380802 0 0 0 0 0 67. 00 68. 00 69900 ELECTROCARDI OLOGY 0. 071870 0 0 0 0 69. 01 69. 01 69. 01 69901 CARDI AC REHAB 0. 816150 0 0 0 0 0 69. 01 70. 00 7100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 349730 0 0 0 0 0 0 72. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 349730 0 0 0 0 0 0 72. 00 0 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0. 349730 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 059973	4	0	0	0	58.00
60. 01 06001 BLOOD LABORATORY 0.000000 0 0 0 60. 01 61. 00 06100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY 0.000000 0 0 0 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.271210 0 0 0 0 0 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0.000000 0 0 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 0.000000 0 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0.134915 0 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0.348415 0 0 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 0.380802 0 0 0 0 0 68. 00 06800 SPECH PATHOLOGY 0.380842 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0.071870 0 0 0 0 69. 01 06901 CARDI AC REHAB 0.816150 0 0 0 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.118948 196 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.349730 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.349730 0 0 0 0 71. 00 07300 DRUGS CHARGED TO PATI ENTS 0.349730 0 0 0 0 71. 00 07400 RENAGED TO PATI ENTS 0.368696 0 0 0 0 71. 00 07400 RENAGED TO PATI ENTS 0.368696 0 0 0 71. 00 09000 CLI NI C 0.392464 0 0 0 71. 00 09000 CLI NI C 0.392464 0 0 0 0 71. 00 09000 CLI NI C 0.392464 0 0 0 0 71. 00 09000 CLI NI C 0.392464 0 0 0 0 71. 00 09000 CLI REGENCY 0.250482 1,871 0 0 0 71. 00 09000 CLI REGENCY 0.250482 1,871 0 0 0 71. 00 09000 CLI RESERVATI ON BEDS (NON-DI STI NCT PART) 0.507798 1,145 0 0 70. 00 00100 Lees PBP Cli ni c Lab. Services-Program 0.0100 0 0 70. 00 00100 Charges	59.00	05900 CARDI AC CATHETERI ZATI ON	0. 093608	8	0	0	1	59.00
60. 01 06001 BLOOD LABORATORY 0.000000 0 0 0 60. 01 61. 00 06100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY 0.000000 0 0 0 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.271210 0 0 0 0 0 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0.000000 0 0 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 0.000000 0 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0.134915 0 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0.348415 0 0 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 0.380802 0 0 0 0 0 68. 00 06800 SPECH PATHOLOGY 0.380842 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0.071870 0 0 0 0 69. 01 06901 CARDI AC REHAB 0.816150 0 0 0 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.118948 196 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.349730 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.349730 0 0 0 0 71. 00 07300 DRUGS CHARGED TO PATI ENTS 0.349730 0 0 0 0 71. 00 07400 RENAGED TO PATI ENTS 0.368696 0 0 0 0 71. 00 07400 RENAGED TO PATI ENTS 0.368696 0 0 0 71. 00 09000 CLI NI C 0.392464 0 0 0 71. 00 09000 CLI NI C 0.392464 0 0 0 0 71. 00 09000 CLI NI C 0.392464 0 0 0 0 71. 00 09000 CLI NI C 0.392464 0 0 0 0 71. 00 09000 CLI REGENCY 0.250482 1,871 0 0 0 71. 00 09000 CLI REGENCY 0.250482 1,871 0 0 0 71. 00 09000 CLI RESERVATI ON BEDS (NON-DI STI NCT PART) 0.507798 1,145 0 0 70. 00 00100 Lees PBP Cli ni c Lab. Services-Program 0.0100 0 0 70. 00 00100 Charges	60.00	06000 LABORATORY	0. 119276	1, 796	0	0	214	60.00
61. 00	60. 01	06001 BLOOD LABORATORY	0. 000000			0	0	60. 01
63. 00	61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000		l o	0		1
63. 00	62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 271210	l o	l o	0	0	62.00
64. 00 06400 INTRAVENOUS THERAPY 0.000000 0 0 0 0 64. 00 65. 00 06500 RESPI RATORY THERAPY 0.134915 0 0 0 0 0 65. 00 06600 PHYSI CAL THERAPY 0.348975 0 0 0 0 0 0 65. 00 06700 OCCUPATI ONAL THERAPY 0.380802 0 0 0 0 0 0 0 0 0	63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0	l o	0	0	63.00
65. 00 06500 RESPIRATORY THERAPY 0.134915 0 0 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.3688774 0 0 0 0 0 0 66. 00 06700 0CCUPATI ONAL THERAPY 0.380802 0 0 0 0 0 0 0 67. 00 06800 SPEECH PATHOLOGY 0.368445 0 0 0 0 0 0 0 68. 00 06900 ELECTROCARDI OLOGY 0.071870 0 0 0 0 0 0 0 0 69. 00 06901 CARDI AC REHAB 0.816150 0 0 0 0 0 0 0 0 0			1		0	0	0	1
66. 00 06600 PHYSI CAL THERAPY 0. 368774 0 0 0 0 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0. 380802 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 368445 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 071870 0 0 0 0 0 69. 01 06901 CARDI AC REHAB 0. 816150 0 0 0 0 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 118948 196 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 349730 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 587510 0 0 0 0 0 74. 00 07300 RUGS CHARGED TO PATIENTS 0. 157740 139 0 0 22 73. 00 74. 00 07400 RENAL DI ALYSIS 0. 368696 0 0 0 0 00007471 DI TERVICE COST CENTERS 0. 392464 0 0 0 0 90. 00 09000 CLI NI C 0. 392464 0 0 0 0 469 91. 00 91. 00 09200 DSERVATION BEDS (NON-DISTINCT PART) 0. 507798 1, 145 0 0 581 92. 00 201. 00 Less PBP Clinic Lab. Services-Program 0 0 0 0 001 Only Charges 0 0 0 0 001 0 0 0 0 002 003 003 003 003 003 003 003 003 003 004 005 005 005 005 001 001 005 005 005 001 001 005 005 005 001 001 005 005 005 001 005 005 005 001 005 005 005 001 005 005 005 001 005 005 001 005 005 005 001 005 005 005 001 005 005 005 001 005 005 005 001 005 005 005 001 005 005 005 001 005 005 005 001 005 005 005 001 005 005 005 001 005 005 005 001 005 005 001 005 005 005 001 005 005 005 001 005 005 001 005 005 001 005 005 005 001 005 005 001 005 005 005 001 005 005 001 005 005 001 005 005 001 005 005 001 005 005 001 005 005 002 005 005 005 003 005 005 005 005 005 005 005 005 005 005 005 005 005 005 005 005			1		0	0	0	1
67. 00 06700 0CCUPATI ONAL THERAPY 0.380802 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.368445 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.071870 0 0 0 0 0 0 0 69. 01 06901 CARDI AC REHAB 0.816150 0 0 0 0 0 0 0 0 0		l	1		0	0	0	1
68. 00 06800 SPEECH PATHOLOGY 0. 368445 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 071870 0 0 0 0 69. 00 69. 01 06901 CARDI AC REHAB 0. 816150 0 0 0 0 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 118948 196 0 0 0 23 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 349730 0 0 0 0 0 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0. 587510 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 157740 139 0 0 0 22 73. 00 74. 00 07400 RENAL DI ALYSI S 0. 368696 0 0 0 0 0 001794TI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0. 392464 0 0 0 0 469 91. 00 91. 00 09200 DESERVATI ON BEDS (NON-DI STI NCT PART) 0. 507798 1, 145 0 0 581 92. 00 200. 00 Subtotal (see instructions) 0. 10 0 0 0 001 V Charges					0	0	0	1
69. 00 06900 ELECTROCARDI OLOGY 0. 071870 0 0 0 0 69. 00 69. 01 06901 CARDI AC REHAB 0. 816150 0 0 0 0 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 118948 196 0 0 23 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 349730 0 0 0 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0. 587510 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 157740 139 0 0 0 74. 00 07400 RENAL DI ALYSI S 0. 368696 0 0 0 0 74. 00 00100 EMERGENCY 0. 392464 0 0 0 0 75. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0. 507798 1, 145 0 0 76. 00 00100 Less PBP Clinic Lab. Services-Program 0 0 0 76. 00 00100 Less PBP Clinic Lab. Services-Program 0 0 77. 00 00100 CLINIC 0. 392464 0 0 0 78. 00 00100 00100 00100 00100 79. 00 00100 00100 00100 00100 79. 00 00100 00100 00100 00100 79. 00 00100 00100 00100 79. 00 00100 00100 00100 79. 00 00100 00100 79. 00 00100 00100 00100 79. 00 00100 00100 79. 00 00100 00100 79. 00 00100 00100 79. 00 00100 00100 79. 00 00100 00100 79. 00 00100 00100 79. 00 00100 00100 79. 00 00100 00100 79. 00 00100 00100 79. 00 00100 00100 79. 00 00100 00100 79. 00 00100 00100 79. 00 00100 00100 79. 00 00100 00100 79. 00 00100 00100 79. 00 00100 00100 79. 00 00100 00100 79. 00 79. 00 79. 00 79. 00 79. 0				0	0	0	0	
69. 01 06901 CARDI AC REHAB 0.816150 0 0 0 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.118948 196 0 0 23 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.349730 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.587510 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.157740 139 0 0 0 74. 00 07400 RENAL DI ALYSI S 0.368696 0 0 0 0 74. 00 00100 TATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0.392464 0 0 0 0 91. 00 09100 EMERGENCY 0.250482 1,871 0 0 469 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.507798 1,145 0 0 200. 00 Subtotal (see instructions) 5,558 0 0 1,394 001. 00 CLI STI CE Lab. Servi ces-Program 0 0 0 001. 00 001. 00 001. 001. 001. 001.					0	0	0	1
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 118948 196 0 0 23 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 349730 0 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 587510 0 0 0 0 0 0 72. 00 07300 DRUGS CHARGED TO PATIENTS 0. 157740 139 0 0 0 22 73. 00 07400 RENAL DI ALYSI S 0. 368696 0 0 0 0 0 0 0 0 0			1		0	0	0	1
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 349730 0 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 587510 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 157740 139 0 0 0 22 73. 00 74. 00 07400 RENAL DI ALYSI S 0. 368696 0 0 0 0 0 00179ATI ENT SERVI CE COST CENTERS 90. 00 09100 CLI NI C 0. 392464 0 0 0 0 0 91. 00 09100 CBERGENCY 0. 250482 1, 871 0 0 469 91. 00 92. 00 09200 DRSERVATI ON BEDS (NON-DI STI NCT PART) 0. 507798 1, 145 0 0 5,558 200. 00 Subtotal (see instructions) 1, 394 200. 00 201. 00 Unity Charges 0 0 0 00 0 0 0 0 00 0					0	0	23	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 587510 0 0 0 0 72. 00 07300 DRUGS CHARGED TO PATIENTS 0. 157740 139 0 0 0 22 73. 00 07400 RENAL DIALYSIS 0. 368696 0 0 0 0 0 0 0 0 0			1			0		1
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 157740 139 0 0 0 0 74. 00 07400 RENAL DIALYSIS 0. 368696 0 0 0 0 0 0 0 0 0			1		0	0	0	1
74. 00 07400 RENAL DI ALYSI S 0. 368696 0 0 0 0 0 74. 00					0	0	22	
90. 00 0900 CLINIC 0. 392464 0 0 0 0 0 90. 00 91. 00 09100 EMERGENCY 0. 250482 1,871 0 0 469 91. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0. 507798 1,145 0 0 581 92. 00 200. 00 Subtotal (see instructions) 5,558 0 0 1,394 200. 00 201. 00 Less PBP Clinic Lab. Services-Program 0 0 0 201. 00 1								1
90. 00 09000 CLINIC 0. 392464 0 0 0 0 90. 00 91. 00 91. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0. 507798 1, 145 0 0 469 91. 00 92. 00 09200 0 0 0 0 0 0 0 0 0			0.000.0	_	_	_		1
91. 00 09100 EMERGENCY 0. 250482 1, 871 0 0 469 91. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0. 507798 1, 145 0 0 581 92. 00 200. 00 Subtotal (see instructions) 5, 558 0 0 1, 394 200. 00 201. 00 0 201. 00 0 0 201. 00 0 0 0 0 0 0 0 0 0	90 00		0.392464	0	0	0	0	90.00
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0. 507798 1, 145 0 0 581 92. 00 200. 00 Subtotal (see instructions) 5, 558 0 0 0 201. 00 201. 00 0 0 0 201. 00 0 0 0 0 0 0 0 0 0								1
200.00 Subtotal (see instructions) 5,558 0 0 1,394 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 201.00 0 0 0 0 0 0 0 0 0				,		_		
201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 Only Charges			0.007770			0		
Only Charges				3,000	l	0	., 0, 1	1
	_000				Ĭ			
	202.00			5, 558	0	0	1, 394	202.00

Health Financial Systems	METHODIST HOS	·			u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Component	CCN: 15-0002 CCN: 15-S002	Peri od: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/26/2017 1:1	
		Title	e XVIII	Subprovi der - I PF	PPS	
Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00	_			
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	O	(50.00
50. 01 05001 ENDOSCOPY 51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 01 05401 RADI OLOGY - ULTRASOUND 55. 00 05500 RADI OLOGY - ULTRASOUND 56. 00 05500 RADI OLOGY - ULTRASOUND 57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06900 CABORATORY 61. 00 06100 PBP CLI NI CAL LAB SERVI CES - PRGM ONLY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 63. 00 06300 BLOOD STORI NG PROCESSI NG & TRANS 64. 00 06400 INTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY 66. 00 066700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					50. 01 51. 00 52. 00 53. 00 54. 01 55. 00 56. 00 57. 00 58. 00 60. 00 60. 01 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 68. 00 69. 00
69. 01 06901 CARDI AC REHAB 70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS 74. 00 07400 RENAL DI ALYSI S	0 0 0 0	(69. 01 70. 00 71. 00 72. 00 73. 00 74. 00

0

0

0

0

90.00

91.00

92.00

200.00

201.00

202.00

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

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program
Only Charges

Net Charges (line 200 +/- line 201)

91. 00 09100 EMERGENCY

OUTPATIENT SERVICE COST CENTERS
90. 00 09000 CLINIC

200.00

201.00

202.00

Health Financial Systems APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	METHODIST HOS	Provi der C	CN. 1E 0000	Peri od:	u of Form CMS-2 Worksheet D	2002 10
APPORTIONMENT OF INPATTENT ANCILLARY SERVICE CAPITA	AL CUSTS	Provider C	CN: 15-0002	From 01/01/2016		
		Component	CCN: 15-T002	To 12/31/2016	Date/Time Pre 5/26/2017 1:1	pared: 4 pm
		Titl∈	: 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)	2. 00	3.00	4.00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	468, 644	155, 635, 066	0.0030	11 64, 722	195	50.00
50. 01 05001 ENDOSCOPY	15, 368		l .		43	
51. 00 05100 RECOVERY ROOM	106, 181		•		68	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	66, 898				9	
53. 00 05300 ANESTHESI OLOGY	0		1		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	372, 551	35, 355, 787	l .		1, 698	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	44, 156	15, 999, 392	0.00276	49, 445	136	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	96, 571	18, 182, 554	0.00531	11 19, 057	101	55.00
56. 00 05600 RADI 0I SOTOPE	68, 343	13, 357, 538	0.00511	16 24, 588	126	56.00
57. 00 05700 CT SCAN	89, 713	106, 714, 673	0. 00084	41 239, 574	201	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	37, 144		0. 00134	48 128, 319	173	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	86, 117				247	
60. 00 06000 LABORATORY	229, 991				1, 677	
60. 01 06001 BLOOD LABORATORY	0	0	0. 00000	00	0	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	10, 013				60	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	_			0	
64. 00 06400 I NTRAVENOUS THERAPY	0				0	
65. 00 06500 RESPIRATORY THERAPY	71, 352		0.00183		775	
66. 00 06600 PHYSI CAL THERAPY	88, 410				27, 293	
67. 00 06700 OCCUPATI ONAL THERAPY	74, 252				27, 708	
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	14, 001 8, 712				1, 597 15	•
69. 01 06901 CARDI AC REHAB	1, 910		1		0	•
70. 00 07000 ELECTROENCEPHALOGRAPHY	29, 556		•		6	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	157, 503		l .		591	
72. 00 07100 MEDICAL SOFTEILS CHARGED TO PATIENTS	175, 815		•		65	
73. 00 07300 DRUGS CHARGED TO PATIENTS	165, 030		l .		4, 656	
74. 00 07400 RENAL DI ALYSI S	39, 104		•		2, 325	
OUTPATIENT SERVICE COST CENTERS	077.01	0,707,017	0.0000	1107007	2,020	1 55
90. 00 09000 CLINIC	517, 016	23, 018, 952	0. 02246	5, 676	127	90.00
91. 00 09100 EMERGENCY	254, 809		l .		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	29, 224, 203	0. 00000	0	0	92.00
200.00 Total (lines 50-199)	3 280 160	1, 065, 929, 453		11, 419, 131	69, 892	lann nn

Health Financial Systems	METHODIST HOSPI	, 			u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provi der	CCN: 15-0002	Period: From 01/01/2016	Worksheet D Part IV	
THROUGH COSTS		Component	CCN: 15-T002	To 12/31/2016	Date/Time Pre 5/26/2017 1:1	
		Ti tl	e XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description	Non Physician	Nursi ng	Allied Heal		Total Cost	
	Anesthetist	School		Medi cal	(sum of col 1	
	Cost			Education	through col.	
				Cost	4)	
ANOLILIA DIVI OFDIVI OF COOT OFFITEDO	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0		0	0 0	0	50.00
50. 01 05001 ENDOSCOPY	0		0	0 0	0	50. 01
51. 00 05100 RECOVERY ROOM	0		0	0 0	0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0		0	0 0	0	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	0	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		0	0 0	0	55. 00
56. 00 05600 RADI 01 SOTOPE	0		0	0	0	56.00
57. 00 05700 CT SCAN	0		0	0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0		0	0 0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		0	0 0	0	59. 00
60. 00 06000 LABORATORY	0		O	0 0	0	60.00
60. 01 06001 BL00D LABORATORY	0		O	0 0	0	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0		0	0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0		0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0		0	0 0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0		0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0		0	0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0		0	0 0	0	69. 00
69. 01 06901 CARDI AC REHAB	0		0	0	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		O	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0 0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0		0	0 0	0	73. 00
74. 00 07400 RENAL DIALYSIS	0		0	0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS			-1	.1		
90. 00 09000 CLI NI C	0		0	0 0	0	90.00
91. 00 09100 EMERGENCY	0		0 731, 9		731, 912	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0	0 0	0	92.00
200.00 Total (lines 50-199)	0		0 731, 9	12 0	731, 912	1200.00

Weel the Figure in L. Contains	METHODI CT. HOC	SDITALC INC		1-11-		2552 40
Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SI	METHODIST HOS		CN: 15 0002	Period:	u of Form CMS-2 Worksheet D	2552-10
THROUGH COSTS	ERVICE UINER PAS	53 Provider C		From 01/01/2016		
THROUGH COSTS		· ·	CCN: 15-T002	To 12/31/2016		
		Title	XVIII	Subprovi der – I RF	PPS	
Cost Center Description	Total	Total Charges	Ratio of Cos		I npati ent	
	Outpati ent	(from Wkst.	to Charges	Ratio of Cost	Program	
	Cost (sum of	C, Part I,	(col. 5 ÷	to Charges	Charges	
	col. 2, 3 and	col. 8)	col. 7)	(col. 6 ÷		
	4)			col. 7)		
	6. 00	7. 00	8. 00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	C				64, 722	
50. 01 05001 ENDOSCOPY	C				52, 532	
51. 00 05100 RECOVERY ROOM	C				6, 632	
52.00 05200 DELIVERY ROOM & LABOR ROOM	C				660	
53. 00 05300 ANESTHESI OLOGY	C		0.00000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	C		0.00000		161, 120	
54. 01 05401 RADI OLOGY - ULTRASOUND	C	15, 999, 392			49, 445	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	C				19, 057	55. 00
56. 00 05600 RADI 0I SOTOPE	C	13, 357, 538	0. 00000	0. 000000	24, 588	56.00
57. 00 05700 CT SCAN	C	106, 714, 673	0.00000	0. 000000	239, 574	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	C	27, 549, 154	0.00000	0. 000000	128, 319	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	C	67, 136, 072	0.00000	0. 000000	192, 442	59.00
60. 00 06000 LABORATORY	C	134, 896, 832	0.00000	0. 000000	983, 637	60.00
60. 01 06001 BLOOD LABORATORY	C	0	0.00000	0. 000000	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	C	7, 860, 813	0.00000	0. 000000	47, 006	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	C	0	0.00000	0. 000000	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0.00000	0. 000000	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0	38, 904, 211	0.00000	0. 000000	422, 399	65.00
66. 00 06600 PHYSI CAL THERAPY	0	7, 645, 259	0.00000	0. 000000	2, 360, 144	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	C	5, 866, 867	0.00000	0. 000000	2, 189, 330	67.00
68. 00 06800 SPEECH PATHOLOGY	C	1, 995, 180	0.00000	0. 000000	227, 609	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	19, 874, 004	0. 00000	0. 000000	34, 034	
69. 01 06901 CARDI AC REHAB		838, 401	0. 00000	0. 000000	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	C				7, 251	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	49, 790, 787	0. 00000	0. 000000	186, 967	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS					12, 397	
73. 00 07300 DRUGS CHARGED TO PATIENTS					3, 592, 751	
74. 00 07400 RENAL DI ALYSI S	i c				410, 839	
OUTPATIENT SERVICE COST CENTERS		,,		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	1
90. 00 09000 CLI NI C	C	23, 018, 952	0.00000	0. 000000	5, 676	90.00
91. 00 09100 EMERGENCY	731, 912				0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	70.77.2	1			Ö	
200.00 Total (lines 50-199)	1	1, 065, 929, 453			11, 419, 131	
	. ,	1	'	1	, , , , , , , , , , , , , , , , , , , ,	

Health Financial Systems	METHODIST HOSP	TALS, INC	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0002	Peri od: From 01/01/2016	Worksheet D
THROUGH COSTS		Component CCN: 15-T002		
		Title XVIII	Subprovi der -	PPS
			I RF	

		litie	XVIII	Subprovider -	PPS	
Cost Center Description	Inpati ent	Outpati ent	Outpati ent	IKF		
555t 5511tol 5555t pti 611	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8	g	Costs (col.			
	x col . 10)		x col. 12)			
	11.00	12. 00	13.00			
ANCILLARY SERVICE COST CENTERS	1					
50.00 05000 OPERATING ROOM	0	0		0	5	50.00
50. 01 05001 ENDOSCOPY	0	0		0	5	50. 01
51.00 05100 RECOVERY ROOM	0	0		0	5	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	5	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0	5	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	5	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	0	379		0	5	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	5	55.00
56. 00 05600 RADI 0I SOTOPE	0	0		0	5	56. 00
57. 00 05700 CT SCAN	0	0		0	5	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	5	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	5	59. 00
60. 00 06000 LABORATORY	0	376		0	6	60.00
60. 01 06001 BLOOD LABORATORY	0	0		0	6	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					6	61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	6	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	1 6	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0	1 6	64. 00
65. 00 06500 RESPIRATORY THERAPY	0	0		0	1 6	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	6	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	1 6	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0		0	1 6	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	6	69. 00
69. 01 06901 CARDI AC REHAB	0	0		0	6	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	7	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 283		0	7	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	7	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	7	73. 00
74. 00 07400 RENAL DI ALYSI S	0	0		0	7	74. 00
OUTPATIENT SERVICE COST CENTERS			•	•		
90. 00 09000 CLI NI C	0	0		0	9	90.00
91. 00 09100 EMERGENCY	o	0		0	9	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	o	0		0	9	92.00
200.00 Total (lines 50-199)	0	2, 038		0	20	00.00
			•	•	•	

Health Financial Systems	METHODIST HOS	SPITALS, INC		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	ND VACCINE COST	Provi der C		Peri od: From 01/01/2016	Worksheet D Part V	
		Component	CCN: 15-T002	To 12/31/2016	Date/Time Pre 5/26/2017 1:1	
		Title	XVIII	Subprovi der -	PPS	•
		_		I RF		
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
	From	Services (see	Servi ces	Servi ces Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins	Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1. 00	2.00	3.00	4. 00	5. 00	
ANCLLLARY SERVICE COST CENTERS						

Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not	(, , , , , , , , , , , , , , , , , , ,	
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins.	Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1. 00	2. 00	3.00	4.00	5. 00	
ANCILLARY SERVICE COST CENTERS		<u> </u>				
50. 00 05000 OPERATING ROOM	0. 101657	0	0	0	0	50.00
50. 01 05001 ENDOSCOPY	0. 226520	0	0	0	0	50. 01
51. 00 05100 RECOVERY ROOM	0. 233603	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 977863	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. 237457	0	0	0	Ō	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	0. 195371	379	0	0	74	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 141490	0.7	0	0	0	55.00
56. 00 05600 RADI 0I SOTOPE	0. 190426	0	0	_	Ö	56.00
57. 00 05700 CT SCAN	0. 043544	0	0	0	o o	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 059973		0	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 093608	ĺ	1	_	Ö	59.00
60. 00 06000 LABORATORY	0. 119276	376			45	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	3/0	0	_	0	60.00
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000	0		_	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 271210	0			0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0	0	_	0	63.00
64. 00 06400 INTRAVENOUS THERAPY	0. 000000	0	0	0	0	64.00
i i		0] 0]	0	0	65.00
	0. 134915	0	1	_		
66. 00 06600 PHYSI CAL THERAPY	0. 368774	0	0	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 380802	0	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 368445	0	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 071870	0	0	_	0	69.00
69. 01 06901 CARDI AC REHAB	0. 816150	0	0	0	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 118948	0	0	0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 349730	1, 283	0	0	449	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 587510	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 157740	0	0			73. 00
74. 00 07400 RENAL DIALYSIS	0. 368696	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS		_	_	_	_	
90. 00 09000 CLI NI C	0. 392464	0				
91. 00 09100 EMERGENCY	0. 250482	0	0	0	1	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 507798	0	0	0	0	92.00
200.00 Subtotal (see instructions)		2, 038	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)	1	2, 038	0	0	J 568	202. 00

	Figure 1 at Control	METUODI CT. 1100	DITALO INO			. C. F OHC	0550 40
	Financial Systems IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	METHODIST HOS		CN: 15-0002	Period:	u of Form CMS- Worksheet D	2552-10
ALLOKI	TOTAL OF WEDT CAL, OTHER HEALTH SERVICES AND	VACCINE COST		CCN: 15-T002	From 01/01/2016	Part V Date/Time Pre 5/26/2017 1:1	epared:
			Title	e XVIII	Subprovi der - I RF	PPS	
		Cos					
	Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
		6. 00	7. 00				
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	Ιο		N.			50.00
51. 00 52. 00 53. 00 54. 00 54. 01 55. 00 57. 00 58. 00 59. 00 60. 01 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00	05001 ENDOSCOPY 05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY - DI LARASOUND 05500 RADI OLOGY - ULTRASOUND 05500 RADI OLOGY - HERAPEUTI C 05600 RADI OLOGY - THERAPEUTI C 05600 RADI OLOGY - THERAPEUTI C 05600 RADI OLOGY - THERAPEUTI C 05600 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					50. 01 51. 00 52. 00 53. 00 54. 01 55. 00 56. 00 57. 00 58. 00 59. 00 60. 01 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 66. 00 67. 00
68. 00 69. 00 69. 01 70. 00 71. 00 72. 00 73. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S	0 0 0 0 0 0 0					68. 00 69. 00 69. 01 70. 00 71. 00 72. 00 73. 00 74. 00

0

0

0

0

90.00

91.00

92.00

200.00

201.00

202.00

91. 00 09100 EMERGENCY

200.00

201.00

202.00

OUTPATIENT SERVICE COST CENTERS
90. 00 09000 CLINIC

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

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program
Only Charges

Net Charges (line 200 +/- line 201)

Heal th	Financial Systems	METHODIST HOSPIT	ALS, INC	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002	Peri od:	Worksheet D-1	
				From 01/01/2016		
				To 12/31/2016	Date/Time Pre 5/26/2017 1:1	
			Title XVIII	Hospi tal	PPS	
	Cost Center Description					
					1. 00	
	PART I - ALL PROVIDER COMPONENTS					
	I NPATI ENT DAYS					
1.00	Inpatient days (including private room days	and swing-bed days	s, excluding newborn)		95, 018	1.00
2.00	Inpatient days (including private room days,	excluding swing-	bed and newborn days)		95, 018	2.00
3.00	3.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days					
	do not complete this line.					
4.00	Semi-private room days (excluding swing-bed	and observation be	ed days)		75, 634	4.00
5.00	Total swing-bed SNF type inpatient days (inc	cluding private ro	om days) through Decemb	er 31 of the cost	0	5. 00

	Cost Center Description		
	PART I - ALL PROVIDER COMPONENTS	1. 00	
	INPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	95, 018	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	95, 018	
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3. 00
4. 00	Semi-private room days (excluding swing-bed and observation bed days)	75, 634	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost		5.00
0.00	report in g peri od	ĭ	0.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)		
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	١	0.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	30, 671	9. 00
	newborn days)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
11 00	through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	o	11. 00
11. 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	١	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period	1	
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
44.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		44.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days) Total nursery days (title V or XIX only)	0	
15. 00 16. 00	Nursery days (title V or XIX only)	0	
10.00	SWING BED ADJUSTMENT	J	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
19.00	reporting period	0.00	19.00
20. 00	Medicald rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
	reporting period		
21. 00	Total general inpatient routine service cost (see instructions)	72, 744, 341	
22. 00	Swing-bed cost applicable to SNF type services through December 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 (line 6	ol	23. 00
23.00	Swing bed east approache to swing period (The east reporting period (The ea	Ĭ	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
	7 x line 19)		
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	72, 744, 341	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
	Private room charges (excluding swing-bed charges)	0	
30.00	Semi-private room charges (excluding swing-bed charges)	0	
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3)	0. 000000 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	
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	1
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	72, 744, 341	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00		765. 58	38. 00
39.00	Program general inpatient routine service cost (line 9 x line 38)	23, 481, 104	•
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)	23, 481, 104	41.00

Provider COL 15.000		Financial Systems	METHODIST HOSE				u of Form CMS-2	
Cost Center Description	COMPU	FATION OF INPATIENT OPERATING COST		From 01/01/2016				
Design D						To 12/31/2016		
			Tabal				PPS	
Cost Devs Cost		Cost Center Description						
MINESTER (FITTE V & XIX COTY)			Cost	Days	÷ col . 2)		col . 4)	
Internsive Care Type Input on thospital Bin 19 13,114,014 8,305 1,579,05 3,562 56,624,576 43,00 MINERSIVE CARE BUILT 3,735,381 3,489 1,070,62 0 45,00 45	42 00	NURSERY (title V & XIX only)						42 00
43.01		Intensive Care Type Inpatient Hospital Units						
44.00 GORDMARY CARE UNIT								
64.00 SURGICAL INTERSIVE CARE UNIT			3, 733, 361	3, 407	1,070.0	2		1
47.00 Program Inpatient ancillary service cost (Wist. D.3. col. 3, Tine 200) 36, 719,184 48, 00 1018 1709 1								
Cost Centre Description								
Program Inpatient and CILIATY Service cost (West. D-3, col. 3, 11ne 200) Program Inpatient costs (come of lines 4, 11ne 200) Ale 200 Total Program Inpatient costs (come of lines 4, 11ne 200) Ale 200 Program Inpatient costs (come of lines 4, 11ne 200) Ale 200 A	17.00							171.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions) 65.825,521 49.00	49.00	Program inpatient ancillary convice cost (Wk	st D2 col 3	2 Lino 200)				49.00
50.00 Pass through costs applicable to Program inpatient routine services (from West. D. sum of Parts I and 1971.00 115. 10.		Total Program inpatient costs (sum of lines			ons)			
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II 698, 497 51.00 201 Total Program excludable cost (sum of lines 50 and 51) 1,556, 464 52.00 1,000	50. 00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sur	n of Parts I and	857, 967	50.00
1,556, 464 52.00 53.00 Total Program excludable cost (sum of lines 50 and 51) 53.00 Total Program injustient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52) 53.00 64, 269, 057 53.00 64, 269, 057 53.00 64, 269, 057 53.00 64, 269, 057 53.00 64, 269, 057 53.00 64, 269, 057	51. 00	Pass through costs applicable to Program inp	atient ancillar	ry services (f	rom Wkst. D,	sum of Parts II	698, 497	51.00
medical education costs (line 49 in nusline 52)		Total Program excludable cost (sum of lines						
54.00 Program discharges 0.0 55.00 55.00 Target amount per discharge 0.0 55.00 56.00 Target amount per discharge 0.0 55.00 56.00 Target amount (line 54 x line 55) 0.56.00 57.00 0.58.00 0.58.00 0.59.	53. 00	medical education costs (line 49 minus line		elated, non-ph	ysician anestl	netist, and	64, 269, 057	53.00
55.00 Target amount per discharge 65.00 Target amount per discharge 65.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 65.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 65.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 65.00 Difference between adjusted inpatient operating cost and target amount (line 56) 65.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions) 63.00 All loweble inpatient cost by Six Incentive payment (see instructions) 64.00 Instructions (line 12 x VIII and 19) 65.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (lite I x VIII and 19) 66.00 Total Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (Intervitions) (lite 12 x III ne 19) 67.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (Inte 12 x III ne 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (Inte 13 x III ne 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (Iine 67 + Iine 68) 69.00 PaxFITI - SXILLEUS DMISSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 69.00 Program routine service cost (Iine 97 x Iine 71) 69.00 Program routine service cost (Iine 97 x Iine 72) 69.00 Program routine	54 00						0]] 54 00
57. 00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 57. 00 0 58. 00 58. 00 Esser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 0.00 59. 00 0 0 0 0 0 0 0 0 0								
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85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 70tal observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)	83. 00	Reasonable inpatient routine service costs (see instruction	*				83. 00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				nns)				
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 765.58 88.00								
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 765.58 88.00	07.00						10.004	07.00
		,	•	· line 2)				
	89. 00	Observation bed cost (line 87 x line 88) (se	e instructions))			14, 840, 003	89.00

Health Financial Systems	METHODI ST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	2, 407, 082	72, 744, 341	0. 03309	0 14, 840, 003	491, 056	90.00
91.00 Nursing School cost	0	72, 744, 341	0.00000	0 14, 840, 003	0	91.00
92.00 Allied health cost	0	72, 744, 341	0.00000	0 14, 840, 003	0	92.00
93.00 All other Medical Education	0	72, 744, 341	0.00000	0 14, 840, 003	0	93.00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0002	Peri od:	Worksheet D-1
		From 01/01/2016	
	Component CCN: 15-S002	To 12/31/2016	
	·		5/26/2017 1:14 pm
	Title XVIII	Subprovi der -	PPS
		IPF	

	I PF	
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 days, excluding newborn)		967 1. 967 2.
2.00 Inpatient days (including private room days, excluding swing-bed and newborn days) 3.00 Private room days (excluding swing-bed and observation bed days). If you have only private		0 3
do not complete this line.	room days,	
4.00 Semi-private room days (excluding swing-bed and observation bed days)	2,	967 4
5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of	of the cost	0 5
reporting period 6.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of	the cost	0 6
reporting period (if calendar year, enter 0 on this line)	the cost	0 0
7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 o	f the cost	0 7
reporting period		
8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of	the cost	0 8
reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swind	g_hed_and 1	614 9.
newborn days)	g-bed and	014 7
10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	ays)	0 10
through December 31 of the cost reporting period (see instructions)		
11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	ays) after	0 11
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	m days)	0 12
through December 31 of the cost reporting period	iii days)	ا ا
13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room	m days)	0 13
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
15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only)		0 15 0 16
SWING BED ADJUSTMENT		0 10
17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the	cost	0. 00 17.
reporting period		
18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the co	ost (). 00 18.
reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the	cost	0. 00 19.
reporting period	6031	,, 00 17
20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the co	st (0. 00 20.
reporting period		
21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting po	1,879,	1
5 x line 17)	errou (Triie	0 22
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting peri	iod (line 6	0 23
x line 18)	,	
24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting per	riod (line	0 24
7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting periods.	od (line 9	0 25
x line 20)	ou (Title 6	0 23
26.00 Total swing-bed cost (see instructions)		0 26
27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1, 879,	727 27.
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	\ \ \ \	
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges))	0 28
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges)		0 29
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000	
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) 36.00 Private room cost differential adjustment (line 3 x line 35)		0. 00 35. 0 36.
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differen	ntial (line 1,879,	
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)	•	3. 54 38.
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	1, 022,	534 39
41.00 Total Program general inpatient routine service cost (line 39 + line 40)	1. 022	534 41
1 3 3 3 3 3 4 4 4 4 4 4 4 4 4 4 4 4 4 4	1 ., 522,	

Heal th	Financial Systems	METHODIST HOS	SPITALS, INC		In Lie	u of Form CMS-2	2552-10
COMPUT	TATION OF INPATIENT OPERATING COST		Provi der C		Period: From 01/01/2016	Worksheet D-1	
			Component		Γο 12/31/2016	Date/Time Pre 5/26/2017 1:1	
			Title	e XVIII	Subprovi der -	PPS	4 piii
	Cost Contar Deceription	Total	Total	Average Per	IPF Program Days	Dragram Coot	
	Cost Center Description	Total Inpatient	Total Inpatient	Di em (col. 1	Program bays	Program Cost (col. 3 x	
		Cost	Days	÷ col . 2)		col . 4)	
42. 00	NURSERY (title V & XIX only)	1. 00 0	2.00	3.00	4.00	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	0		, 0. 0.	<u> </u>		72.00
43.00	INTENSIVE CARE UNIT	0	(0	43.00
43. 01 44. 00	NEONATAL ICU CORONARY CARE UNIT	0	(0.00	0	0	43. 01 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46.00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	cost center bescription					1. 00	
	Program inpatient ancillary service cost (Wk					187, 459	•
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)	(see instructi	ons)		1, 209, 993	49. 00
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	17, 512	50.00
F1 00		-+!	/ /	W+ D -	£ Dt- 11	2 422	F1 00
51. 00	Pass through costs applicable to Program inpland IV)	atient ancilla	ry services (T	rom WKST. D, S	um of Parts II	3, 432	51.00
52.00	Total Program excludable cost (sum of lines	50 and 51)				20, 944	52.00
53.00	Total Program inpatient operating cost exclu		elated, non-ph	ysician anesth	etist, and	1, 189, 049	53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54.00	Program di scharges					0	54.00
55.00	Target amount per discharge					0.00	1
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and t	arget amount (line 56 minus	line 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	ing cost and t	arget amount (Time of minds	11110 00)	0	58.00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and co	mpounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report u	ndated by the	market basket		0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by							61.00
	which operating costs (line 53) are less tha		ts (lines 54 x	60), or 1% of	the target		
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62.00
63.00	Allowable Inpatient cost plus incentive paym	ent (see instr	ucti ons)			0	
(4.00	PROGRAM INPATIENT ROUTINE SWING BED COST	+- +b D	21 +		(6	-	
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through bec	eliber 31 OF th	e cost reporti	ng perrod (see	0	64.00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decem	ber 31 of the	cost reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	no costs (lino	44 plus line	4E) (+i +l o V/// I	Lonly) For	0	66. 00
00.00	CAH (see instructions)	ne costs (Title	04 prus rine	05)(11116 XVII	1 Only). To	O	00.00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs throug	h December 31	of the cost re	porting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after	December 31 of	the cost reno	rting period	0	68. 00
00.00	(line 13 x line 20)	c costs arter	becember 51 or	the cost repe	in tring period	Ü	00.00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NI Skilled nursing facility/other nursing facil						70. 00
71. 00	Adjusted general inpatient routine service c	ost per diem (71.00
72.00	Program routine service cost (line 9 x line		(I : 14 ·· I	: 25)			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	no 2)					76. 00
77.00	Program capital-related costs (line 9 x line						77.00
78.00	Inpatient routine service cost (line 74 minu	s line 77)					78. 00
79.00	Aggregate charges to beneficiaries for exces	-	•	*.	us line 70)		79. 00 80. 00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		cost iimi tätiö	n (iiie /8 mir	ius IIIR <i>19)</i>		80.00
82.00	Inpatient routine service cost limitation (ine 9 x line 8					82.00
83.00	Reasonable inpatient routine service costs (ns)				83. 00 84. 00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ons)				84.00
86. 00	Total Program inpatient operating costs (sum	of lines 83 t					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					0	87. 00
88.00	Adjusted general inpatient routine cost per		÷ line 2)				88.00
89. 00	Observation bed cost (line 87 x line 88) (se	•	•				89. 00

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2016		
		Component (CCN: 15-S002	To 12/31/2016	Date/Time Pre 5/26/2017 1:1	
		Titlo	XVIII	Subprovi der -	PPS	4 pili
		11116	AVIII	I PF	113	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
oost denter beschiption	0031	(from line	column 2	Observati on	Bed Pass	
		21)	001 411111 2	Bed Cost	Through Cost	
		2.7		(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	32, 198	1, 879, 727	0. 01712	29 0	0	90.00
91.00 Nursing School cost	0	1, 879, 727	0. 00000	00	0	91.00
92.00 Allied health cost	0	1, 879, 727	0. 00000	00	0	92.00
93.00 All other Medical Education	0	1, 879, 727	0. 00000	00	0	93.00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0002	Peri od: From 01/01/2016	Worksheet D-1
	Component CCN: 15-T002		
	Title XVIII	Subprovi der -	PPS
		I RF	

			IRF		
	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			10, 240	
2.00	Inpatient days (including private room days, excluding swing-			10, 240	2.00
3. 00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ys). IT you have only pri	ivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation b	ed days)		10, 240	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro	om days) through Decembe	r 31 of the cost	0	5.00
	reporting period		24 . 6 . 1	0	, 00
6. 00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	om days) after becember .	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7. 00
	reporting period	3 , 3			
8. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3°	1 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	o the Program (eveluding	swing bod and	6, 219	9. 00
9.00	newborn days)	o the Frogram (excluding	Swifig-bed and	0, 219	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private ro	oom days)	0	10.00
	through December 31 of the cost reporting period (see instruc				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11.00
12. 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12.00
12.00	through December 31 of the cost reporting period	x only (merading private	s room days)	· ·	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13.00
44.00	after December 31 of the cost reporting period (if calendar y				
14. 00 15. 00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	am (excluding swing-bed o	days)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	16.00
10.00	SWING BED ADJUSTMENT		I		10.00
17. 00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 of	f the cost	0. 00	17. 00
10 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	oo often December 21 of	the cost	0.00	18. 00
16.00	reporting period	es al tel December 31 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
	reporting period				
20.00	Medicald rate for swing-bed NF services applicable to service reporting period	s after December 31 of th	ne cost	0.00	20.00
21. 00	Total general inpatient routine service cost (see instruction	s)		7, 163, 629	21.00
22. 00	Swing-bed cost applicable to SNF type services through Decemb		ing period (line		1
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reportin	ng period (line	0	24.00
	7 x line 19)	·			
25. 00		31 of the cost reporting	period (line 8	0	25. 00
26 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		7, 163, 629	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-be	d and observation bed cha	arges)	0	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	23)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 mi	, ,	ti ons)	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 di	fferential (line		36. 00 37. 00
57.00	27 minus line 36)	and private room cost ur		7, 103, 027	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
00.05	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			/00 ==	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	,		699. 57 4, 350, 626	1
	Medically necessary private room cost applicable to the Progr	*		4, 350, 626	1
	Total Program general inpatient routine service cost (line 39			4, 350, 626	

Heal th	Financial Systems	METHODIST HOS	SPITALS, INC		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C		Period: From 01/01/2016	Worksheet D-1	
			Component		Γο 12/31/2016	Date/Time Pre 5/26/2017 1:1	
-			Title	e XVIII	Subprovi der -	PPS	4 piii
	Cost Contar Doscription	Total	Total	Average Per	I RF	Drogram Cost	
	Cost Center Description	Total Inpatient	Total Inpatient	Di em (col. 1	Program Days	Program Cost (col. 3 x	
		Cost	Days	÷ col . 2)		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	0		0. 00	5]	0	42.00
43.00	INTENSIVE CARE UNIT	0	(0	43.00
43. 01 44. 00	NEONATAL ICU CORONARY CARE UNIT	0	(0.00	0	0	43. 01 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46.00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	cost center bescription					1. 00	
	Program inpatient ancillary service cost (Wk					2, 883, 509	1
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)	(see instructi	ons)		7, 234, 135	49. 00
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	144, 467	50.00
F1 00		-+!+!!!-	/ /	W+ D -	£ Dt- II	/0.000	F1 00
51. 00	Pass through costs applicable to Program inpland IV)	atient ancilia	ry services (T	rom WKST. D, S	um of Parts II	69, 892	51.00
52.00	Total Program excludable cost (sum of lines	50 and 51)				214, 359	52.00
53.00	Total Program inpatient operating cost exclu		elated, non-ph	ysician anesth	etist, and	7, 019, 776	53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54.00	Program di scharges					0	54.00
55.00	Target amount per discharge					0.00	1
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and t	arget amount (line 56 minus	line 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	ing cost and th	arget amount (Time oo iii nas	11116 00)	0	58.00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and co	mpounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report w	ndated by the	market basket		0. 00	60.00
61. 00	If line 53/54 is less than the lower of line				the amount by	0	61.00
	which operating costs (line 53) are less tha		ts (lines 54 x	: 60), or 1% of	the target		
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62.00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instr	uctions)			0	
(4.00	PROGRAM INPATIENT ROUTINE SWING BED COST	+- +b	21 +	+		-	
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through beco	eliber 31 OF th	le cost reporti	ng perrod (see	0	64.00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	ber 31 of the	cost reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	no costs (lino	44 plus line	4E) (+i +l o V////	Lonly) For	0	66. 00
00.00	CAH (see instructions)	ne costs (Title	04 prus rine	os)(title xvii	i only). To	O	00.00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	h December 31	of the cost re	porting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after l	December 31 of	the cost reno	rting period	0	68. 00
00.00	(line 13 x line 20)	c costs arter i	becember 51 or	the cost repe	in tring period	O	00.00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NI Skilled nursing facility/other nursing facil						70.00
71. 00	Adjusted general inpatient routine service c						71.00
72.00	Program routine service cost (line 9 x line		(I : 14 ·· I	: 25)			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
74 00	26, line 45)	no 2)					74 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu	s line 77)					78. 00
79.00							79.00
80. 00 81. 00	, , , , , , , , , , , , , , , , , , ,						80. 00 81. 00
82.00	22.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00							83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ons)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 t					86. 00
07 00	PART IV - COMPUTATION OF OBSERVATION BED PASS					^	07.00
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		÷ line 2)			0 0. 00	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (se	•	•				89. 00

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (CCN: 15-T002	From 01/01/2016 To 12/31/2016		
		Title	XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	237, 917	7, 163, 629	0. 03321	12 0	0	90.00
91.00 Nursing School cost	0	7, 163, 629	0. 00000	00	0	91.00
92.00 Allied health cost	0	7, 163, 629	0. 00000	00	0	92.00
93.00 All other Medical Education	0	7, 163, 629	0. 00000	00	0	93. 00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0002	Peri od: From 01/01/2016	Worksheet D-1	
		To 12/31/2016		
	Title XIX	Hospi tal	Cost	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00 Inpatient days (including private room days a	and swing-bed days, excluding newborn)		95, 018	1.00
2.00 Inpatient days (including private room days,	95, 018	2.00		
3.00 Private room days (excluding swing-bed and of	oservation bed days). If you have only p	rivate room days,	0	3.00

	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)	95, 018	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	95, 018	
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3.00
	do not complete this line.		
4.00	Semi-private room days (excluding swing-bed and observation bed days)	75, 634	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5.00
	reporting period	_	
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
7.00	reporting period	U	7.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	J	0.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	3, 213	9.00
	newborn days)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
13.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	U	13.00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
	Total nursery days (title V or XIX only)		15. 00
	Nursery days (title V or XIX only)	0	
	SWING BED ADJUSTMENT	_	
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
	reporting period		
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
	reporting period		
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	0.00	20.00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0. 00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	72, 740, 676	21. 00
	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		22.00
22.00	5 x line 17)	Ü	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line	0	23.00
	x line 18)		
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
	7 x line 19)		
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)	_	
	Total swing-bed cost (see instructions)	0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	72, 740, 676	27.00
20 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
	Pri vate room charges (excluding swing-bed charges)	0	
	Semi -pri vate 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	32.00
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	1
35.00	Average per diem private room cost differential (line 34 x line 31)	0. 00	1
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	72, 740, 676	
	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)	765. 55	
39. 00	Program general inpatient routine service cost (line 9 x line 38)	2, 459, 712	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0 450 710	
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2, 459, 712	41.00

8.00	Total Swing-bed we type impatrent days (including private room days) after becember 31 of the cost	۰Į	8.00
	reporting period (if calendar year, enter 0 on this line)		
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	3, 213	9. 00
	newborn days)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	ol	12.00
	through December 31 of the cost reporting period		
13.00	Swing-bed NF type inpatient days applicable to titles V or XLX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	Ĭ	
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)	-	15. 00
16. 00		2, 002	
16.00	Nursery days (title V or XIX only)	- 0	16.00
47.00	SWING BED ADJUSTMENT	0.00	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18.00
	reporting period		
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19.00
	reporting period		
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
	reporting period		
21.00	Total general inpatient routine service cost (see instructions)	72, 740, 676	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)		
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line	ol	23.00
20.00	In line 18)	,	20.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
24.00	7 x line 19)	Ĭ	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
25.00	x line 20)	۰	25.00
24 00	,	0	26. 00
26. 00	Total swing-bed cost (see instructions)	-	
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	72, 740, 676	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	_	
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
29. 00	Private room charges (excluding swing-bed charges)	0	
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	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35. 00	Average per diem private room cost differential (line 34 x line 31)	0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	-	
37.00		12, 140, 070	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
00.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	7/5 ==	00.00
	Adjusted general inpatient routine service cost per diem (see instructions)	765. 55	
39. 00	Program general inpatient routine service cost (line 9 x line 38)	2, 459, 712	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2, 459, 712	41.00

	Financial Systems	METHODI ST HOSI				u of Form CMS-2	
COMPUT	TATION OF INPATIENT OPERATING COST		Provi der Co	F	Period: From 01/01/2016		
				Т	o 12/31/2016	Date/Time Pre 5/26/2017 1:1	
	Out Out of Developing	Tabal		e XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient	Total Inpatient	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
		Cost	Days	÷ col . 2)		col . 4)	
42 00	NURSERY (title V & XIX only)	1. 00 2, 332, 035	2. 00 2, 802	3. 00 832. 28	4. 00 0	5. 00	42.00
	Intensive Care Type Inpatient Hospital Units						
43. 00 43. 01	INTENSIVE CARE UNIT NEONATAL ICU	13, 114, 014 3, 735, 381	8, 305 3, 489	· ·		0	
44. 00	CORONARY CARE UNIT	3, 733, 361	3, 409	1,070.02	. 0		44. 00
45.00	BURN I NTENSI VE CARE UNIT						45.00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
	Cost Center Description					4.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3. line 200)			1. 00 2, 104, 661	48. 00
49. 00				ons)		4, 564, 373	
50.00	Pass through costs applicable to Program inp	atient routine	services (from	m Wkst. D, sum	of Parts I and	0	50.00
51.00	<pre> Pass through costs applicable to Program inp</pre>	atient ancillar	y services (fi	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 exclu	ding capital re	elated, non-phy	ysician anesth	etist, and	0	
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					l I
	Program di scharges					0	54.00
	Target amount per discharge Target amount (line 54 x line 55)					0.00	1
57. 00	Difference between adjusted inpatient operat	ing cost and ta	nrget amount (I	line 56 minus	line 53)	0	
58.00	Bonus payment (see instructions)					0	
59. 00	DO Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	1
61.00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					0	61.00
42.00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)			-	0	62.00
62. 00 63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ıcti ons)			0	1
(4.00	PROGRAM INPATIENT ROUTINE SWING BED COST	+- +h				0	64.00
64. 00	instructions)(title XVIII only)	Ü		•			
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the o	cost reporting	peri od (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line o	65)(title XVII	l only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31 o	of the cost re	porting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after [ecember 31 of	the cost repo	rting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NI Skilled nursing facility/other nursing facil		•				70.00
71.00	Adjusted general inpatient routine service c	ost per diem (I		•			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		ı (line 14 x li	ine 35)			72. 00 73. 00
74.00	Total Program general inpatient routine serv	ice costs (line	e 72 + line 73))			74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from N	Norksheet B, P	art II, column		75. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu						78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp			,	uc Line 70)		79. 00 80. 00
81.00	Inpatient routine service costs for comp		ost IIIII tatioi	i (i i ile 76 iii ii	us Title 74)	-	81.00
82.00	Inpatient routine service cost limitation (I		* .				82.00
83. 00 84. 00							83. 00 84. 00
85.00	Utilization review - physician compensation	(see instruction					85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rough 85)				86.00
87. 00	Total observation bed days (see instructions)				19, 384	
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	,				765. 55 14, 839, 421	
57.00	(3e)					. 1, 557, 721	, 57. 50

Health Financial Systems	METHODI ST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016		
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	2, 407, 082	72, 740, 676	0. 03309	1 14, 839, 421	491, 051	90.00
91.00 Nursing School cost	0	72, 740, 676	0.00000	0 14, 839, 421	0	91.00
92.00 Allied health cost	0	72, 740, 676	0.00000	0 14, 839, 421	0	92.00
93.00 All other Medical Education	0	72, 740, 676	0.00000	0 14, 839, 421	0	93.00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0002	Peri od: From 01/01/2016	Worksheet D-1
	Component CCN: 15-S002		
	Ti tle XIX	Subprovi der -	Cost
		IPF	

		IPF		
	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		2, 967	
2. 00 3. 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		2, 967 ays, 0	
3.00	do not complete this line.	ys). It you have only private room u	ays, 0	3.00
4.00	Semi-private room days (excluding swing-bed and observation b	ed days)	2, 967	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
6. 00	reporting period Total swing-bed SNF type inpatient days (including private ro	om days) after December 31 of the co	st 0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	om days) arter becomber 51 or the co	51	0.00
7.00	Total swing-bed NF type inpatient days (including private roo	m days) through December 31 of the c	ost 0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roo	m days) after December 21 of the cos	t 0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	ill days) after beceiliber 31 of the cos	0	0.00
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding swing-bed a	nd 525	9. 00
40.00	newborn days)			40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc		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			
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 O 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)		2, 802	15. 00 16. 00
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
10.00	reporting period		0.00	10.00
18. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es after becember 31 of the cost	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of the cost	0.00	19. 00
00.00	reporting period	St. Bereiter 24 - S. Herrert	0.00	00.00
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	s)	1, 879, 727	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	21 of the cost reporting period (Li	ne 6 0	23. 00
23.00	x line 18)	31 of the cost reporting period (11		23.00
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)	21 -	e 8 0	25.00
25. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting period (iin	e 8 0	25. 00
26.00	Total swing-bed cost (see instructions)		0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)	1, 879, 727	27. 00
20 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation had charges)		28. 00
29. 00	Private room charges (excluding swing-bed charges)	d and observation bed charges)	0	1
30. 00	Semi -pri vate room charges (excluding swing-bed charges)		0	1
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)	0. 000000	1
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	1
34. 00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instructions)	0.00	ı
35.00	Average per diem private room cost differential (line 34 x li		0.00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)	and private room and differently /	0	
37. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost differential (line 1, 879, 727	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	· ·	633. 54	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	•	332, 609	1
	Total Program general inpatient routine service cost (line 39	·	332, 609	
			•	

Heal th	Financial Systems	METHODIST HOSE	PITALS, INC		In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST				Period: From 01/01/2016 Fo 12/31/2016	Worksheet D-1	pared:
			Ti t	le XIX	Subprovi der -	Cost	4 piii
	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)	
40.00	INUDGEDY (II II I IV A VIV II I	1. 00	2.00	3.00	4.00	5. 00	40.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0		0.00	0	0	42.00
43.00	INTENSIVE CARE UNIT	0		0.00	0 0	0	43.00
43. 01	NEONATAL I CU	0		0.00	0	0	43. 01
44.00	CORONARY CARE UNIT						44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description						
48. 00	Program inpatient ancillary service cost (Wk	ct D 2 col 2	2 Line 200)			1. 00 10, 185	48. 00
49. 00	Total Program inpatient costs (sum of lines			ons)		342, 794	1
	PASS THROUGH COST ADJUSTMENTS	··· ···· ·····························				J.=/	
50.00	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	rv services (1	from Wkst D s	um of Parts II	0	51.00
31.00	and IV)	atrent anerria	y services (TOIL WKSt. D, 3	diii or rarts rr	J	31.00
52.00	Total Program excludable cost (sum of lines					0	
53. 00	Total Program inpatient operating cost exclu		elated, non-pl	nysician anesth	etist, and	0	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54.00	Program di scharges					0	54.00
55.00	Target amount per discharge					0. 00	1
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and to	ract amount	(lino E4 minus	Lino E2)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	ing cost and ta	inget allibuitt	(Title 56 IIITius	111le 55)	0	58.00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and co	mpounded by the	0.00	
40.00	market basket	anat manamt um	dotod by the	markat baakat		0.00	40.00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0.00	60. 00 61. 00
	which operating costs (line 53) are less tha					_	
	amount (line 56), otherwise enter zero (see	instructions)					
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ant (saa instru	ictions)			0	62. 00 63. 00
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mstru	10113)			0	03.00
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	ne cost reporti	ng period (See	0	64.00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	or 21 of the	cost roporting	ported (See	0	65. 00
03.00	instructions)(title XVIII only)	ts arter beceilib	bei 31 of the	cost reporting	perrou (See	0	05.00
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	I only). For	0	66. 00
67 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	a costs through	December 31	of the cost re	norting period	0	67. 00
07.00	(line 12 x line 19)	e costs through	i becember 31	of the cost re	por tring period	0	07.00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	December 31 of	f the cost repo	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 ± lir	ne 68)		0	69. 00
07.00	PART III - SKILLED NURSING FACILITY, OTHER N					J	07.00
70.00	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	e 2)			71. 00 72. 00
73.00	Medically necessary private room cost applic		n (line 14 x l	ine 35)			73.00
74.00	Total Program general inpatient routine serv						74.00
75. 00	Capital-related cost allocated to inpatient	routine service	costs (from	Worksheet B, F	Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital -related costs (line 9 x line						77. 00
78. 00	Inpatient routine service cost (line 74 minu						78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exces	,		*.	us Lino 70)		79. 00 80. 00
81.00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ost riiii tall(or (TITIE 70 IIII)	ius IIIIc /7)		81.00
82.00	Inpatient routine service cost limitation (1)				82. 00
83.00	Reasonable inpatient routine service costs (ns)				83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		nns)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum						86.00
0=	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		- line 2)			0 00	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (se						89.00
		- /					•

Health Financial Systems	METHODIST HOSPITALS, INC In L				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 01/01/2016 To 12/31/2016		
		Ti tl	e XIX	Subprovi der -	Cost	
		D 0		I PF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	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	32, 198	1, 879, 727	0. 01712	29 0	0	90.00
91.00 Nursing School cost	0	1, 879, 727	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	1, 879, 727	0. 00000	00	0	92.00
93.00 All other Medical Education	0	1, 879, 727	0. 00000	00	0	93.00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0002	Peri od: From 01/01/2016	Worksheet D-1	
	Component CCN: 15-T002			
	Ti tle XIX	Subprovi der -	Cost	
Cost Contar Description		I RF		

		I RF		
	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 days, excluding newborn)		10, 240	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days		10, 240	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only	private room days,	0	3. 00
4 00	do not complete this line.		10 240	4 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) through Dece	umbar 31 of the cost	10, 240	4. 00 5. 00
3.00	reporting period	illiber 31 of the cost	O	3.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after Decemb	er 31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)			
7. 00	Total swing-bed NF type inpatient days (including private room days) through Decem	ber 31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room days) after Decembe	or 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	i or or the cost	O	0.00
9.00	Total inpatient days including private room days applicable to the Program (excluding	ling swing-bed and	94	9. 00
	newborn days)		_	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private through December 21 of the continuous applicable to title XVIII only (including private through December 21 of the continuous applicable to title XVIII only (including private through December 21 of the continuous applicable to title XVIII only (including private through December 21 of the continuous applicable to title XVIII only (including private through December 21 of the continuous applicable to title XVIII only (including private through December 21 of the continuous applicable to title XVIII only (including private through December 21 of the continuous applicable to title XVIII only (including private through December 21 of the continuous applicable to title XVIII only (including private through December 21 of through December 22 of through December	e room days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private	e room days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	e room days) arter	G	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including pri	vate room days)	0	12.00
	through December 31 of the cost reporting period		_	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including priafter December 31 of the cost reporting period (if calendar year, enter 0 on this		0	13. 00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-t		0	14. 00
15. 00		ou uujo)	2, 802	
16.00	Nursery days (title V or XIX only)		0	16.00
	SWING BED ADJUSTMENT			
17. 00		11 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. 1.10 0001	0.00	10.00
19. 00	Medicald rate for swing-bed NF services applicable to services through December 31	of the cost	0.00	19. 00
20.00	reporting period	£ 11	0.00	20.00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of reporting period	i the cost	0. 00	20. 00
21. 00			7, 163, 629	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost rep	orting period (line	0	22.00
	5 x line 17)			
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost report x line 18)	ting period (line 6	0	23. 00
24. 00		orting period (line	0	24. 00
	7 x line 19)		_	
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost report	ing period (line 8	0	25. 00
24 00	X line 20)		0	24 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 2	(6)	0 7, 163, 629	26. 00 27. 00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	.0)	7, 103, 027	27.00
28.00	General inpatient routine service charges (excluding swing-bed and observation bed	l charges)	0	28. 00
	Private room charges (excluding swing-bed charges)		0	29. 00
30.00	Semi -pri vate room charges (excluding swing-bed charges)		0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3)		0. 000000 0. 00	31. 00 32. 00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see inst	ructions)	0. 00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	,	0. 00	35.00
36.00			0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost	differential (line	7, 163, 629	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)		699. 57	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)		65, 760	39. 00
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0 (F 7(0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		65, 760	41.00

Heal th	Financial Systems	METHODIST HOS	SPITALS, INC		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der 0		Period: From 01/01/2016	Worksheet D-1	
			Component		Γο 12/31/2016	Date/Time Pre 5/26/2017 1:1	
			Ti ti	e XIX	Subprovi der -	Cost	4 piii
	Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
	Cost Center Description	Inpatient	Inpati ent	Di em (col. 1	Pi Ogi alli Days	(col. 3 x	
		Cost	Days	÷ col . 2)		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	0		η	5]	0	42.00
43.00	INTENSIVE CARE UNIT	0	(0	43.00
43. 01 44. 00	NEONATAL ICU CORONARY CARE UNIT	0	(0.00	0	0	43. 01 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
	Program inpatient ancillary service cost (Wk					68, 952	
49. 00	Total Program inpatient costs (sum of lines	41 through 48)	(see instructi	ons)		134, 712	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program input	atient routine	services (fro	m Wkst D sum	of Parts I and	1 0	50.00
30.00	[111]	atrent routine	services (iic	ili WK3t. D, Suli	i or raits i and	0	30.00
51.00	Pass through costs applicable to Program inp	atient ancilla	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 exclu		elated, non-ph	vsician anesth	etist, and	0	53.00
	medical education costs (line 49 minus line	9 1					
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION					0	 E4 00
54. 00 55. 00	Program di scharges Target amount per di scharge					0. 00	54.00 55.00
56. 00	Target amount (line 54 x line 55)					0	56.00
57. 00	Difference between adjusted inpatient operat	ing cost and t	arget amount (line 56 minus	line 53)	0	57.00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	norting period	ending 1006	undated and co	mnounded by the	0.00	58. 00 59. 00
37.00	market basket	portring perrou	ending 1990,	upuateu anu cc	illipourlaed by the	0.00	39.00
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	60.00
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					0	61.00
	amount (line 56), otherwise enter zero (see		t3 (1111e3 54 A	00), 01 1% 01	the target		
62.00	Relief payment (see instructions)					0	62.00
63. 00	Allowable Inpatient cost plus incentive paymer PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instr	uctions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dec	ember 31 of th	e cost reporti	ng period (See	0	64.00
	instructions)(title XVIII only)			•			
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decem	ber 31 of the	cost reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routing	ne costs (line	64 plus line	65)(title XVII	I only). For	0	66. 00
	CAH (see instructions)						
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs throug	h December 31	of the cost re	porting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after	December 31 of	the cost repo	rting period	0	68. 00
	(line 13 x line 20)				5 .	_	
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70.00	Skilled nursing facility/other nursing facil						70.00
71. 00	Adjusted general inpatient routine service c		line 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)		m (line 1/ v l	ine 35)			72. 00 73. 00
74.00	Total Program general inpatient routine serv		•				74.00
75.00	Capital-related cost allocated to inpatient				art II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	no 2)					76. 00
77.00	Program capital-related costs (line 73 = 11)						77.00
78. 00	Inpatient routine service cost (line 74 minus	s line 77)					78. 00
79.00	Aggregate charges to beneficiaries for excess	-	•	*.	us line 70)		79.00
80. 00 81. 00	Total Program routine service costs for comp. Inpatient routine service cost per diem limi		cost iiiiii tätit	m (iiile /8 Mir	ius IIIIe /9)		80. 00 81. 00
82.00	Inpatient routine service cost limitation (ine 9 x line 8					82. 00
83.00	Reasonable inpatient routine service costs (ns)				83.00
84. 00 85. 00	Program inpatient ancillary services (see in: Utilization review - physician compensation		ons)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum						86.00
0	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	<u>, , , , , , , , , , , , , , , , , , , </u>				
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		÷ line 2)			0 00	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (see						89.00
	, ,	•			'		

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (CCN: 15-T002	From 01/01/2016 To 12/31/2016		
		Ti tl	e XIX	Subprovi der -	Cost	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	237, 917	7, 163, 629	0. 03321	12 0	0	90.00
91.00 Nursing School cost	0	7, 163, 629	0. 00000	00	0	91.00
92.00 Allied health cost	0	7, 163, 629	0. 00000	00	0	92.00
93.00 All other Medical Education	0	7, 163, 629	0. 00000	00	0	93.00

I NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der (CCN: 15-0002	Peri od: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Pre 5/26/2017 1:1	pared:
		Title	e 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)	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
30. 00	03000 ADULTS & PEDIATRICS		1	26, 960, 516		30.00
31.00	03100 INTENSIVE CARE UNIT			6, 855, 813		31.00
31. 00	03101 NEONATAL I CU			0, 055, 015		31.00
40.00	04000 SUBPROVI DER - I PF			Ö		40.00
41. 00	04100 SUBPROVI DER – I RF			0		41.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS		•			1
50.00	05000 OPERATING ROOM		0. 10165	36, 360, 029	3, 696, 251	50.00
50.01	05001 ENDOSCOPY		0. 22652	2, 202, 786	498, 975	50.01
51.00	05100 RECOVERY ROOM		0. 23360	1, 622, 274	378, 968	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 97786	57, 879	56, 598	52.00
53.00	05300 ANESTHESI OLOGY		0.00000		0	
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 23745		1, 002, 422	1
54. 01	05401 RADI OLOGY - ULTRASOUND		0. 19537		446, 387	
55.00	05500 RADI OLOGY-THERAPEUTI C		0. 14194		42, 344	
56. 00 57. 00	05600 RADI OI SOTOPE		0. 19042		504, 526	
58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE MAGING (MRI)		0. 04354 0. 05997		678, 779 226, 869	
59.00	05900 CARDIAC CATHETERIZATION		0. 03997		1, 342, 839	
60.00	06000 LABORATORY		0. 11927		2, 905, 964	
60. 01	06001 BLOOD LABORATORY		0. 00000		2, 703, 704	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000		0	61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 27121		540, 827	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		0.00000		0	63.00
64.00	06400 I NTRAVENOUS THERAPY		0.00000	0 0	0	64.00
65.00	06500 RESPI RATORY THERAPY		0. 13491	5 13, 512, 342	1, 823, 018	65.00
66.00	06600 PHYSI CAL THERAPY		0. 36877	1, 740, 631	641, 899	66.00
67.00	06700 OCCUPATI ONAL THERAPY		0. 38080		384, 243	
68. 00	06800 SPEECH PATHOLOGY		0. 36844		243, 513	
69. 00	06900 ELECTROCARDI OLOGY		0. 07187		371, 973	
69. 01	06901 CARDI AC REHAB		0. 81615		391	
70.00	07000 ELECTROENCEPHALOGRAPHY		0. 11924		130, 186	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0. 34973		3, 337, 843	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 58751		5, 206, 171	72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS		0. 15774 0. 36869		6, 721, 301 1, 383, 412	
74.00	OUTDATIENT SERVICE COST CENTERS		U. 30809	τυ 3, /32, 1/6	1, 303, 412	J /4.00

0. 392464

0. 250482

0. 507798

178, 507

9, 753, 992 3, 231, 374

210, 893, 380

210, 893, 380

70, 058

36, 719, 841 200. 00

2, 443, 199

1, 640, 885

90.00

91.00

92.00

201.00

202.00

OUTPATIENT SERVICE COST CENTERS

90. 00 09000 CLINIC

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

Net Charges (line 200 minus line 201)

Total (sum of lines 50-94 and 96-98) Less PBP Clinic Laboratory Services-Program only charges (line 61)

91. 00 09100 EMERGENCY

200.00

201.00

202.00

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0002	Peri od:	(2017	Worksheet D-3	3
	Component	CCN: 15-S002	From 01/01/ To 12/31/		Date/Time Pre 5/26/2017 1:1	
	Title	XVIII	Subprovi de I PF	er -	PPS	, p
Cost Center Description	'	Ratio of Cos		nt	I npati ent	
		To Charges	Progra Charge		Program Costs (col. 1 x col. 2)	
		1.00	2. 00		3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						4
. 00 03000 ADULTS & PEDI ATRI CS				0		30.
. 00 03100 INTENSIVE CARE UNIT				0		31.
. 01 03101 NEONATAL CU			2 250	0		31.
. 00 04000 SUBPROVI DER - 1 PF . 00 04100 SUBPROVI DER - 1 RF			2, 250), 159 0		40.
. 00 04100 SUBPROVI DER - I RF . 00 04300 NURSERY				٩		43.
ANCILLARY SERVICE COST CENTERS						43.
. OO O5000 OPERATING ROOM		0. 1016	57 3	3, 756	382	50.
. 01 05001 ENDOSCOPY		0. 2265		2, 431	551	
.00 05100 RECOVERY ROOM		0. 2336		, 567	366	
.00 05200 DELIVERY ROOM & LABOR ROOM		0. 9778		660	645	52
. 00 05300 ANESTHESI OLOGY		0.0000	00	0	0	53
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2374	57 10), 189	2, 419	54
. 01 05401 RADIOLOGY - ULTRASOUND		0. 1953	71 5	5, 177	1, 011	54
. 00 05500 RADI OLOGY-THERAPEUTI C		0. 1419	48	0	0	
. 00 05600 RADI 0I SOTOPE		0. 1904	· ·	0	0	
. 00 05700 CT SCAN		0. 0435), 596	1, 768	
.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 0599		, 269	676	
. 00 05900 CARDI AC CATHETERI ZATI ON		0. 0936		, 802	169	
. 00 06000 LABORATORY		0. 1192		, 452	29, 992	
. 01 06001 BLOOD LABORATORY		0.0000		0	0	
.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY .00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 0000 0. 2712		٩	0 372	
. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0.2712		7, 372 0	0	
. 00 06400 I NTRAVENOUS THERAPY		0.0000		0	0	
. 00 06500 RESPI RATORY THERAPY		0. 1349		1, 835	8, 747	
. 00 06600 PHYSI CAL THERAPY		0. 3687		7, 445	6, 433	
. 00 06700 OCCUPATI ONAL THERAPY		0. 3808		274	3, 532	
. 00 06800 SPEECH PATHOLOGY		0. 3684		, 968	725	
. 00 06900 ELECTROCARDI OLOGY		0. 0718		, 200	517	
. 01 06901 CARDI AC REHAB		0. 8161		0	0	69
. 00 07000 ELECTROENCEPHALOGRAPHY		0. 1192	45 1	, 767	211	70
.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3497	30 2	2, 559	895	71
.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 5875	10	0	0	72
.00 07300 DRUGS CHARGED TO PATIENTS		0. 1577	· ·	7, 045	98, 910	
. 00 07400 RENAL DIALYSIS		0. 3686	96 12	2, 839	4, 734	74
OUTPATIENT SERVICE COST CENTERS						4
. 00 09000 CLI NI C		0. 3924		3, 623	5, 347	
. 00 09100 EMERGENCY		0. 2504	-	5, 504	18, 912	
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5077		286		92
0.00 Total (sum of lines 50-94 and 96-98) 1.00 Less PBP Clinic Laboratory Services-Program only of	harges (1: (4)		1, 164		187, 459	200
I DULL LLESS PRE CLINIC LANGRATORY SERVICES-PROGRAM ONLY C	marmes (LIDE 61)	1	1	0		コノロー

	eri od:	Worksheet D-3	,
-T002 Fr	rom 01/01/2016 o 12/31/2016		
S	Subprovi der - I RF	PPS	
of Cost	I npati ent	I npati ent	
harges	Program Charges	Program Costs (col. 1 x col. 2)	
. 00	2. 00	3.00	
	_		١
	C		30
	C		31
	C	1	31
	4 040 355	1	40
	4, 868, 355		41
			43
0. 101657	64, 722	6, 579	50
0. 226520			
0. 233603	1		
0. 977863			
0. 000000		1	
0. 237457	161, 120	38, 259	54
0. 195371	49, 445	9, 660	54
0. 141948	19, 057	2, 705	55
0. 190426	24, 588	4, 682	56
0. 043544			
0. 059973			
0. 093608			
0. 119276	1		
0. 000000		1	
0.000000		0	
0. 271210			
0.000000		1	
0. 000000 0. 134915		1	
0. 134913			
0. 380802			
0. 368445			
0. 071870	1		
0. 816150			
0. 119245		1	
0. 349730	1		
0. 587510			
0. 157740	3, 592, 751	566, 721	73
0. 368696	410, 839	151, 475	74
0. 392464		2, 228	
0. 250482		1	
0. 507798	_	1 -	
	11, 419, 131	i ·	
	C	Ί	201
			0 11, 419, 131

Health Financial Systems	ETHODIST HOSPITALS, INC		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CO		Peri od:	Worksheet D-3	
			From 01/01/2016		
			To 12/31/2016	Date/Time Pre 5/26/2017 1:1	
	Ti +I	e XIX	Hospi tal	Cost	4 piii
Cost Center Description	11 (1	Ratio of Cos		I npati ent	
cost center bescription		To Charges	Program	Program Costs	
		To onal ges	Charges	(col . 1 x	
			onal goo	col . 2)	
		1.00	2, 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			1, 970, 519		30.00
31.00 03100 INTENSIVE CARE UNIT			371, 303		31.00
31. 01 03101 NEONATAL CU			683, 096		31. 01
40. 00 04000 SUBPROVI DER - 1 PF			0		40.00
41. 00 04100 SUBPROVI DER - RF			0		41.00
43. 00 04300 NURSERY			186, 171		43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 10165	7 3, 153, 793	320, 605	50.00
50. 01 05001 ENDOSCOPY		0. 22652	0 102, 757	23, 277	50. 01
51.00 05100 RECOVERY ROOM		0. 23360	3 185, 913	43, 430	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 97786	3 351, 998	344, 206	52.00
53. 00 05300 ANESTHESI OLOGY		0.00000	0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 23745	7 226, 138	53, 698	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND		0. 19537	1 150, 623	29, 427	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 14149	0 25, 666	3, 631	55.00
56. 00 05600 RADI 0I SOTOPE		0. 19042	6 117, 460	22, 367	56.00
57. 00 05700 CT SCAN		0. 04354	4 916, 450	39, 906	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 05997	3 245, 395	14, 717	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 09360	8 728, 929	68, 234	59.00
60. 00 06000 LABORATORY		0. 11927	6 1, 745, 974	208, 253	60.00
60. 01 06001 BL00D LABORATORY		0.00000	0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 27121	0 30, 818	8, 358	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0.00000	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY		0.00000	0 0	0	64.00
65. 00 06500 RESPIRATORY THERAPY		0. 13491	5 976, 207	131, 705	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 36877		46, 940	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 38080		35, 602	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 36844		12, 136	
69. 00 06900 ELECTROCARDI OLOGY		0. 07187		16, 476	1
69. 01 06901 CARDI AC REHAB		0. 81615		3, 523	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 11894		40, 444	1
71 00 07100 MEDICAL SUBDILLES CHARCED TO DATIENTS		0.24072		,	

0. 349730

0. 587510

0. 157740

0.368696

0. 392464

0. 250482

0.507798

0

2, 786, 576

106, 848

10, 096

618, 074

13, 306, 999

13, 306, 999

0 71.00

72.00

73.00

74.00

90.00

91.00

92.00

201. 00 202. 00

O

439, 554

39, 394

3, 962

0

2, 104, 661 200. 00

154, 816

71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS

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

Net Charges (line 200 minus line 201)

Total (sum of lines 50-94 and 96-98) Less PBP Clinic Laboratory Services-Program only charges (line 61)

OUTPATIENT SERVICE COST CENTERS

73.00 07300 DRUGS CHARGED TO PATIENTS

74.00 07400 RENAL DIALYSIS

90. 00 09000 CLINIC

200.00

201.00

202.00

91. 00 09100 EMERGENCY

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0002	Peri od: From 01/01/2016	Worksheet D-3	•
	Component	CCN: 15-S002	To 12/31/2016		
	Ti tl	e XIX	Subprovi der - I PF	Cost	_ i _ pii
Cost Center Description		Ratio of Cos		I npati ent	
'		To Charges		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	
00 03000 ADULTS & PEDIATRICS			C		30
00 03100 INTENSIVE CARE UNIT			C		31
01 03101 NEONATAL I CU			C		31
00 04000 SUBPROVI DER - I PF			101, 895		40
00 04100 SUBPROVI DER - I RF			C		41
00 04300 NURSERY			C		43
ANCILLARY SERVICE COST CENTERS				1	١
00 05000 OPERATING ROOM		0. 1016			
01 05001 ENDOSCOPY		0. 2265			
00 05100 RECOVERY ROOM 00 05200 DELIVERY ROOM & LABOR ROOM		0. 2336 0. 9778			
00 05300 ANESTHESI OLOGY		0.9778		l .	1
00 05400 RADI OLOGY-DI AGNOSTI C		0.0000		_	
01 05401 RADI OLOGY - ULTRASOUND		0. 1953		l .	
00 05500 RADI OLOGY-THERAPEUTI C		0. 1414		l .	
00 05600 RADI 0I SOTOPE		0. 1904		l .	
00 05700 CT SCAN		0. 0435		93	57
00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 0599	73 698	42	58
00 05900 CARDI AC CATHETERI ZATI ON		0. 0936	08	0	59
00 06000 LABORATORY		0. 1192			
01 06001 BL00D LABORATORY		0.0000			
00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000			
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 2712			
00 06300 BLOOD STORING, PROCESSING & TRANS. 00 06400 INTRAVENOUS THERAPY		0.0000 0.0000			
00 06500 RESPI RATORY THERAPY		0. 0000			
00 06600 PHYSI CAL THERAPY		0. 3687			
00 06700 OCCUPATI ONAL THERAPY		0. 3808			
00 06800 SPEECH PATHOLOGY		0. 3684			
00 06900 ELECTROCARDI OLOGY		0. 0718			
01 06901 CARDI AC REHAB		0. 8161			
00 07000 ELECTROENCEPHALOGRAPHY		0. 1189	48 C	0	70
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3497	30 7	2	71
00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 5875		0	1
00 07300 DRUGS CHARGED TO PATIENTS		0. 1577			
00 07400 RENAL DI ALYSI S		0. 3686	96 3, 801	1, 401	74
OUTPATIENT SERVICE COST CENTERS OO 09000 CLINIC		0. 3924	64 C	0	90
00 09100 EMERGENCY		0. 3924			
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 2504		1,031	1
0.00 Total (sum of lines 50-94 and 96-98)		0.3077	60, 396		
1.00 Less PBP Clinic Laboratory Services-Program only ch	arges (line 61)	1	00, 370	10, 100	201
2.00 Net Charges (line 200 minus line 201)	. 3 (01)	1	60, 396	1	202

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0002	Peri od: From 01/01/2016	Worksheet D-3	3
	Component	CCN: 15-T002	To 12/31/2016	Date/Time Pre 5/26/2017 1:1	
	Ti tl	e XIX	Subprovi der - I RF	Cost	т рш
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
INDATI ENT. DOUTLING CEDIUSE COCT. CENTERS		1. 00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS . 00 03000 ADULTS & PEDI ATRI CS			0		30.
. 00 03100 I NTENSI VE CARE UNI T			0		31.
. 01 03101 NEONATAL CU			0		31.
00 04000 SUBPROVI DER - I PF			0		40.
. 00 04100 SUBPROVI DER - I RF			127, 609		41.
. 00 04300 NURSERY			0		43.
ANCILLARY SERVICE COST CENTERS					
. 00 05000 OPERATING ROOM		0. 1016	57 1, 221	124	50.
. 01 05001 ENDOSCOPY		0. 2265	20 0	0	50.
. 00 05100 RECOVERY ROOM		0. 2336	03 212	50	51.
.00 05200 DELIVERY ROOM & LABOR ROOM		0. 9778	63 462	452	52.
. 00 05300 ANESTHESI OLOGY		0.0000	00 0	0	53.
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2374		668	
. 01 05401 RADI OLOGY - ULTRASOUND		0. 1953		158	
. 00 05500 RADI OLOGY-THERAPEUTI C		0. 1414		0	
. 00 05600 RADI 0I SOTOPE		0. 1904		0	1
. 00 05700 CT SCAN		0. 0435			57.
00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0599	· ·	88	
. 00 05900 CARDI AC CATHETERI ZATI ON		0. 0936		0	
. 00 06000 LABORATORY . 01 06001 BL00D LABORATORY		0. 1192	·	2, 206	
		0.0000		0	1
.00 O6100 PBP CLINICAL LAB SERVICES-PRGM ONLY .00 O6200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 0000 0. 2712		42	
. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 2712		0	1
. 00 06400 I NTRAVENOUS THERAPY		0.0000		0	
. 00 06500 RESPI RATORY THERAPY		0. 1349		1, 364	
. 00 06600 PHYSI CAL THERAPY		0. 3687	·	23, 298	
. 00 06700 OCCUPATI ONAL THERAPY		0. 3808		21, 769	1
. 00 06800 SPEECH PATHOLOGY		0. 3684		3, 256	
. 00 06900 ELECTROCARDI OLOGY		0. 0718		55	1
. 01 06901 CARDI AC REHAB		0. 8161		0	
. 00 07000 ELECTROENCEPHALOGRAPHY		0. 1189		89	1
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3497		721	71.
.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 5875	10 0	0	72.
. 00 07300 DRUGS CHARGED TO PATIENTS		0. 1577	40 88, 122	13, 900	73.
. 00 07400 RENAL DIALYSIS		0. 3686	96 1, 267	467	74.
OUTPATIENT SERVICE COST CENTERS					
. 00 09000 CLI NI C		0. 3924		0	
. 00 09100 EMERGENCY		0. 2504		0	
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5077		0	1
0.00 Total (sum of lines 50-94 and 96-98)			263, 511	68, 952	1
1.00 Less PBP Clinic Laboratory Services-Program only c	horace (line 41)		0		201.

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552		
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0002		Worksheet E Part A Date/Time Prepared: 5/26/2017 1:14 pm	

			10 12,01,2010	5/26/2017 1:1	4 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring instructions)	ing prior to October 1 ((see	0 37, 850, 541	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring instructions)	1 (see	12, 616, 847	1. 02	
1. 03	DRG for federal specific operating payment for Model 4 BPCI for 1 (see instructions)	or discharges occurring	prior to October	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for October 1 (see instructions)	or di scharges occurri ng	on or after	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			2, 086, 037 0	2. 00 2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instruct	i ons)		0	2. 02
3.00	Managed Care Simulated Payments			4, 434, 585	3.00
4. 00	Bed days available divided by number of days in the cost report Indirect Medical Education Adjustment	rting period (see instru	uctions)	385. 04	4. 00
5. 00	FTE count for allopathic and osteopathic programs for the mosor before 12/31/1996. (see instructions)	t recent cost reporting	period ending on	8. 53	5. 00
6. 00	FTE count for allopathic and osteopathic programs which meet for new programs in accordance with 42 CFR 413.79(e)	the criteria for an add-	on to the cap	0. 00	6. 00
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified ACA Section 5503 reduction amount to the IME cap as specified			0. 00 0. 00	7. 00 7. 01
8. 00	If the cost report straddles July 1, 2011 then see instruction Adjustment (increase or decrease) to the FTE count for allopar affiliated programs in accordance with 42 CFR 413.75(b), 413.	ns. thic and osteopathic pro	ograms for	0.00	8. 00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slo	0. 00	8. 01		
8. 02	the cost report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slo	0. 00	8. 02		
9. 00	under section 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line	8. 53	9. 00		
10. 00	instructions)				10.00
	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)				11.00
	Total allowable FTE count for the prior year.			3. 00	•
14. 00	Total allowable FTE count for the penultimate year if that yes otherwise enter zero.	ar ended on or after Sep	otember 30, 1997,	3. 00	1
15.00	Sum of lines 12 through 14 divided by 3.			2. 98	15.00
	Adjustment for residents in initial years of the program				16.00
	Adjustment for residents displaced by program or hospital clos	sure			17. 00
	Adjusted rolling average FTE count			2. 98	1
	Current year resident to bed ratio (line 18 divided by line 4)).		0.007739	1
	Prior year resident to bed ratio (see instructions)			0.007680	1
	Enter the lesser of lines 19 or 20 (see instructions) IME payment adjustment (see instructions)			0. 007680 211, 408	1
22. 00	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)			18, 576	1
	Indirect Medical Education Adjustment for the Add-on for Secti Number of additional allopathic and osteopathic IME FTE resid		Sec. 412 105		23. 00
24. 00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)	one dap stors under 12 c	766. 112. 166		24.00
	If the amount on line 24 is greater than -0-, then enter the instructions)	lower of line 23 or line	e 24 (see		25. 00
	Resident to bed ratio (divide line 25 by line 4)			0. 000000	1
	IME payments adjustment factor. (see instructions)			0. 000000	1
	IME add-on adjustment amount (see instructions)			0	ł
			0 211, 408		
29. 00 29. 01					29. 00 29. 01
20.00	Disproportionate Share Adjustment	ationt days (!!)+i ono)	0.00	20.00
	Percentage of SSI recipient patient days to Medicare Part A pa Percentage of Medicaid patient days (see instructions)	atrent days (see instruc	. (1 0115)	9. 83	•
	Sum of lines 30 and 31			31. 24 41. 07	1
	Allowable disproportionate share percentage (see instructions))			33.00
	Disproportionate share adjustment (see instructions)	,		2, 914, 492	1
2 00			I	=, , , , , , , , , , , , , , , , , , ,	,

	The state of the s	T. 1. 0. 1. 10.		6.5. 040.4	
	Financial Systems METHODIST HOSPI ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0002	Period:	u of Form CMS-2 Worksheet E	2552-10
ONLOGE	ATTON OF RETWINDORSEMENT SETTLEMENT	11 0V1 de1 00N. 13 0002	From 01/01/2016	Part A	
			To 12/31/2016	Date/Time Pre 5/26/2017 1:1	pared: 4 pm
		Title XVIII	Hospi tal	PPS	<u> </u>
			Prior to 10/1		
	Uncompensated Care Adjustment		1. 00	2. 00	
35. 00	Total uncompensated care amount (see instructions)		6, 406, 145, 534	5, 977, 483, 147	35. 00
35. 01	Factor 3 (see instructions)		0. 000869767	0. 000846433	35. 01
35. 02	Hospital uncompensated care payment (If line 34 is zero, ent (see instructions)	ter zero on this line)	5, 571, 856	5, 059, 538	35. 02
35. 03	Pro rata share of the hospital uncompensated care payment amo		4, 171, 281	1, 275, 282	
36. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.0 Additional payment for high percentage of ESRD beneficiary di		5, 446, 563		36. 00
40. 00	Total Medicare discharges on Worksheet S-3, Part I excluding		0		40. 00
41. 00	652, 682, 683, 684 and 685 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6	583, 684 an 685. (see	0		41. 00
41. 01	instructions) Total ESRD Medicare covered and paid discharges excluding MS-	-DPCs 650 680 683 684	0		41. 01
	an 685. (see instructions)				
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not qualitated Medicare ESRD inpatient days excluding MS-DRGs 652, 68		0.00		42. 00 43. 00
43.00	instructions)	52, 003, 004 dii 003. (See	0		43.00
44. 00	Ratio of average length of stay to one week (line 43 divided days)	by line 41 divided by 7	0. 000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41	1.01)	(1 135 000		46.00
47. 00 48. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH, s	small rural hospitals	61, 125, 888		47. 00 48. 00
	only. (see instructions)	mari rarar nospitars			40.00
				Amount	
49. 00	Total payment for inpatient operating costs (see instructions	<u> </u>		1. 00 61, 144, 464	49. 00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I ar			4, 439, 583	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, li	ne 49 see instructions).		68, 306	52.00
53. 00 54. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies			14, 167 33, 732	53. 00 54. 00
54. 01	Islet isolation add-on payment			0	54. 01
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	59)		Ö	55. 00
56.00	Cost of physicians' services in a teaching hospital (see intr			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. I	II, column 9, lines 30 t	hrough 35).	0	57.00
58. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		108, 796	
59.00	Total (sum of amounts on lines 49 through 58)			65, 809, 048	
60.00	Primary payer payments	. 1: (0)		53, 250	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus	s line 60)		65, 755, 798 4, 861, 836	
62. 00 63. 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			818, 384	
	Allowable bad debts (see instructions)			1, 417, 258	
65. 00	Adjusted reimbursable bad debts (see instructions)			921, 218	
66. 00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		714, 330	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	,		60, 996, 796	67.00
68.00	Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (s	ee instructions)	0	68.00
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).	(For SCH see instruction	s)	0	69. 00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70. 50	RURAL DEMONSTRATION PROJECT			0	70. 50
70. 88	SCH or MDH volume decrease adjustment			0	70. 88
70. 89	Pioneer ACO demonstration payment adjustment amount (see inst	tructions)		0	70. 89
70. 90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70. 90
70. 91 70. 92	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0	70. 91 70. 92
70. 92	1			225, 006	
70. 93	, , , , , , , , , , , , , , , , , , , ,			-1, 100, 379	
	Recovery of accelerated depreciation				70. 95
	•				

Health Financial Systems METHODIST HOSPI	TALS, INC		In Lieu	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider Co	CN: 15-0002	Peri od: From 01/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Pre 5/26/2017 1:1	pared: 4 pm
	Title	XVIII	Hospi tal	PPS	
		FFY	(yyyy)	Amount	
			0	1. 00	
70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter the corresponding federal year for the period prior to 10/1)	in column 0		0	0	70. 96
70.97 Low volume adjustment for federal fiscal year (yyyy) (Enter the corresponding federal year for the period ending on or a			0	0	70. 97
70.98 Low Volume Payment-3	ŕ			0	70. 98
70.99 HAC adjustment amount (see instructions)				486, 432	70. 99
71.00 Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			59, 634, 991	71.00
71.01 Sequestration adjustment (see instructions)				1, 192, 700	71. 01
72.00 Interim payments				57, 685, 626	72.00
73.00 Tentative settlement (for contractor use only)				0	73.00
74.00 Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)				756, 665	74.00
75.00 Protested amounts (nonallowable cost report items) in accordance with				116, 839	75.00
CMS Pub. 15-2, chapter 1, §115.2					
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see in	structions)			0	
91.00 Capital outlier from Wkst. L, Pt. I, line 2				0	, , , , , ,
92.00 Operating outlier reconciliation adjustment amount (see inst				0	92.00
93.00 Capital outlier reconciliation adjustment amount (see instru				0	93.00
94.00 The rate used to calculate the time value of money (see inst				0.00	
95.00 Time value of money for operating expenses (see instructions				0	
96.00 Time value of money for capital related expenses (see instru	ctions)		Prior to 10/1	0 /After 10/1	96.00
			1.00	2.00	
HSP Bonus Payment Amount			1.00	2.00	
100.00 HSP bonus amount (see instructions)			ol	0	100.00
HVBP Adjustment for HSP Bonus Payment			<u> </u>	0	100.00
101. 00 HVBP adjustment factor (see instructions)			0. 0000000000	0. 0000000000	101 00
102.00 HVBP adjustment amount for HSP bonus payment (see instruction	ns)		0.000000000		102.00
HRR Adjustment for HSP Bonus Payment	/		- 9		1.52.00
103.00 HRR adjustment factor (see instructions)			0.0000	0.0000	103.00
104.00 HRR adjustment amount for HSP bonus payment (see instruction	s)		0		104.00
	•		'		'

∐oal ±h	Financial Systems		METHODIST HOS	DITALS INC		In Lie	u of Form CMS-2	2552 10
Health Financial Systems METHODIST HOSE LOW VOLUME CALCULATION EXHIBIT 4			Provider Co		Period: From 01/01/2016 To 12/31/2016	Worksheet E Part A Exhibi	t 4 pared:	
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After	through 4)	
						10/01		
		0	1. 00	2.00	3. 00	4. 00	5. 00	
1. 00	DRG amounts other than outlier payments	1. 00	0	0		0 0	0	1.00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 01	37, 850, 541	0	37, 850, 54	1	37, 850, 541	1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	12, 616, 847	0		50, 467, 388	50, 467, 388	1. 02

Heal th	Financial Systems		METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
	OLUME CALCULATION EXHIBIT 4			Provi der Co		Peri od: From 01/01/2016 To 12/31/2016	Worksheet E Part A Exhibi Date/Time Pre 5/26/2017 1:1	t 4 pared:
					XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prion 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	
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0		0 0	0	18. 00
19.00	SUBTOTAL			0	44, 384, 82	23 21, 232, 956	65, 617, 779	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		4, 057, 627 0	0		0 4, 057, 627 0 0	4, 057, 627 0	1
21. 00 21. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG	2. 00 2. 01	15, 552 0	0		0 15, 552 0 0	15, 552 0	21. 00 21. 01
22. 00	outlier payments Indirect medical education percentage (see instructions)	5. 00	0. 0035	0. 0035	0. 003	0. 0035		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	14, 202	0		0 14, 202	14, 202	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0868	0. 0868	0. 086	0. 0868		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	352, 202	0		0 352, 202	352, 202	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	4, 439, 583	0		0 4, 439, 583	4, 439, 583	26. 00
		W/S E, Part A	(Amounts to					
		line 0	E, Part A) 1.00	2.00	3.00	4.00	5. 00	
27. 00	Low volume adjustment factor	U	1.00	2.00	0. 00000		5.00	27. 00
28. 00	1	70. 96			0.00000	0.00000	0	1
29. 00	Low volume adjustment (transfer amount to Wkst. E,	70. 97				0	0	29. 00
100.00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

HOSPI I	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5			Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/26/2017 1:1	pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3. 00	4. 00	
1. 00 1. 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for	1. 00 1. 01	37, 850, 541			37, 850, 541	1. 00 1. 01
1. 02	discharges occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	12, 616, 847		12, 616, 847	12, 616, 847	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	0		0	0	1.03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00	2, 086, 037	1, 564, 52	521, 509	2, 086, 037	2.00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0		0	0	2. 01
3.00	Operating outlier reconciliation	2. 01	0	0.005.00	0 0	0	3.00
4. 00	Managed care simulated payments Indirect Medical Education Adjustment	3. 00	4, 434, 585	3, 325, 93	3 1, 108, 647	4, 434, 585	4.00
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 007680	0. 00768	0. 007680		5. 00
6.00	IME payment adjustment (see instructions)	22. 00	211, 408			211, 408	6. 00
6. 01	IME payment adjustment for managed care (see instructions) Indirect Medical Education Adjustment for the		18, 576		2 4, 644	18, 576	6. 01
7. 00	IME payment adjustment factor (see	27. 00	0. 000000		0. 000000		7.00
	instructions)						
8. 00 8. 01	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions)	28. 00 28. 01	0		0 0	0	8. 00 8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	211, 408	158, 55	52, 852	211, 408	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	18, 576			18, 576	1
10.00	Di sproporti onate Share Adjustment	22.00	0.0040	0.004	0 0040		10.00
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 2310	0. 231	0. 2310		10.00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	2, 914, 492	2, 185, 86	728, 623	2, 914, 492	11.00
11. 01	Uncompensated care payments	36. 00	5, 446, 563	4, 171, 28	1 1, 275, 282	5, 446, 563	11. 01
40.00	Additional payment for high percentage of ESI		di scharges	Г	ما ما		
12. 00	Total ESRD additional payment (see instructions)	46. 00	0		0	0	12.00
13. 00	Subtotal (see instructions)	47. 00	61, 125, 888	45, 930, 77	5 15, 195, 113		
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48. 00	0		0	0	14.00
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	61, 144, 464	45, 944, 70	7 15, 199, 757	61, 144, 464	15. 00
16. 00	Payment for inpatient program capital	50. 00	4, 439, 583			4, 439, 583	
17.00	Special add-on payments for new technologies	54. 00	33, 732	25, 29	9 8, 433	33, 732	17.00
17. 01 17. 02	Net organ acquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0		0	0	17. 01 17. 02
18. 00	Capital outlier reconciliation adjustment	93. 00	0		0	0	18. 00
19. 00	amount (see instructions) SUBTOTAL			49, 299, 69	16, 318, 086	65, 617, 779	19. 00

Health Financial Systems HOSPITAL ACQUIRED CONDITION (HAC) RED	DUCTION CALCULA	METHODIST HOS ATION EXHIBIT 5		F	In Lie Period: From 01/01/2016 To 12/31/2016		t 5 pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1. 00	2. 00	3. 00	4. 00	
20.00 Capital DRG other than outlier		1. 00	4, 057, 627	3, 043, 220	1, 014, 407	4, 057, 627	20.00
20.01 Model 4 BPCI Capital DRG other	than outlier	1. 01	0	(0	0	20. 01
21.00 Capital DRG outlier payments		2. 00	15, 552	11, 664	3, 888	15, 552	21.00
21.01 Model 4 BPCI Capital DRG outli	er payments	2. 01	0	(0	0	21.01
22.00 Indirect medical education per instructions)	centage (see	5. 00	0. 0035	0. 0035	0. 0035		22. 00
23.00 Indirect medical education adj	ustment (see	6. 00	14, 202	10, 652	3, 550	14, 202	23. 00
24.00 Allowable disproportionate sha (see instructions)	re percentage	10. 00	0. 0868	0. 0868	0. 0868		24.00
25.00 Disproportionate share adjustm	ent (see	11. 00	352, 202	264, 151	88, 051	352, 202	25. 00
26.00 Total prospective capital paym instructions)	ents (see	12. 00	4, 439, 583	3, 329, 687	1, 109, 896	4, 439, 583	26. 00
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt. A)				
		0	1. 00	2.00	3.00	4. 00	
27. 00							27. 00
28.00 Low volume adjustment prior to	October 1	70. 96	0	(0	28. 00
29.00 Low volume adjustment on or af	ter October 1	70. 97	0		0	0	29.00
30.00 HVBP payment adjustment (see i	nstructions)	70. 93	225, 006	168, 754	56, 252	225, 006	30.00
30.01 HVBP payment adjustment for HS payment (see instructions)	P bonus	70. 90	0		0	0	30. 01
31.00 HRR adjustment (see instruction	ns)	70. 94	-1, 100, 379	-825, 284	-275, 095	-1, 100, 379	31.00
31.01 HRR adjustment for HSP bonus p		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

Υ

2.00

486, 432

3.00

0

(Amt. to Wkst. E, Pt.

A) 4.00 486, 432

32.00

100.00

Health Financial	Systems	METHODIST HOSPIT	ALS, INC		In Lieu	u of Form CMS-2552-10
CALCULATION OF F	REIMBURSEMENT SETTLEMENT		Provi der C	CCN: 15-0002	From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/26/2017 1:14 pm
			Titl∈	e XVIII	Hospi tal	PPS

PART B. IMPLICAL AND CHING HEATH INTROLETS 1.00				To 12/31/2016	Date/Time Pre 5/26/2017 1:1	
NATE 5 - MEDICAL AND OTHER HEALTH SERVICES 1.00 Medical and other services (see instructions) 23.115, 212, 2.00 2.00			Title XVIII	Hospi tal		трііі
NATE 5 - MEDICAL AND OTHER HEALTH SERVICES 1.00 Medical and other services (see instructions) 23.115, 212, 2.00 2.00						
		DADT D. MEDICAL AND OTHER HEALTH CERVICES			1. 00	
Medical and other services reinfluresed under OPPS (see instructions) 23,715,212 2.00	1 00				8 023	1 00
3.00 DPS payments 20,756.715 3.00 250.562 4.00 5.00 1.00 200.00 200.00 5.00 1.00 200.00 5.00 1.00 5.00 1.00 5.00 1.00 5.00 1.00 5.00 1.00 5.00 5.00 1.00 5.00 5.00 5.00 1.00 5.00		1	tions)			
Finder the hospit fall specific payment to cost ratio (see instructions)		,	,			1
Line 2 times line 5 0 0 0 0 0 0 0 0 0	4.00	Outlier payment (see instructions)			252, 582	4.00
Sum of line 3 plus line 4 divided by line 6 0,00 7,00			ictions)			1
Transitional Corridor payment (see instructions) 0 8 00						1
Ancillary service other pass through costs from Wist. D. Pt. IV, col. 13, line 200 99,756 900 11.00 Organ acquisitions 8,933 11.00		, , , , , , , , , , , , , , , , , , , ,				1
10.00 Organ acquisitions 0 10.00 10.			IV col 13 line 200			1
2.00 Ancillary service charges 62,803 12.00 13.00			,			
Reasonable charges	11. 00				8, 923	11.00
12.00 Ancil lary service charges 62,803 12.00 13.00 1076 angeujstition charges (from West. D-4, Pt. III, col. 4, line 69) 0 13.00 13.00 1076 angeujstition charges (sum of lines 12 and 13) 0 0767 angeujstition charges (sum of lines 12 and 13) 15.00 0768 angeujstition charges (sum of lines 12 and 13) 15.00 0768 angeujstition charges (sum of lines 12 and 13) 15.00 0768 angeujstition charges (sum of lines 12 and 13) 15.00 0768 angeujstition charges (sum of lines 12 and 13) 15.00 0768 angeujstition charges (sum of lines 12 angeujstition charges) 15.00 0768 angeujstition charges (sum of lines 12 angeujstition charges) 15.00 0768 angeujstition charges (sum of lines 12 angeujstition charges) 15.00 0768 angeujstition charges (sum of lines 12 angeujstition charges) 15.00 0768 angeujstition charges (sum of lines 12 angeujstition charges) 15.00 0768 angeujstition charges (sum of lines 12 angeujstition charges) 15.00 0768 angeujstition charges (sum of lines 12 angeujstition charges) 15.00 0768 angeujstition charges (sum of lines 12 angeujstition charges) 15.00 0768 angeujstition charges (sum of lines 12 angeujstition charges) 15.00 0768 angeujstition charges (sum of lines 12 angeujstition charges) 15.00 0768 angeujstition charges (sum of lines 12 angeujstition charges) 15.00 0768 angeujstition charges (sum of lines 12 angeujstition charges) 15.00 0768 angeujstition charges (sum of lines 12 angeujstition charges) 15.00 0768 angeujstition charges (sum of lines 12 angeujstition charges) 15.00 0768 angeujstition charges (sum of lines 12 angeujstition charges) 15.00 0768 angeujstition charges (sum of lines 12 angeujstition charges) 15.00 0768 angeujstition charges (sum of lines 12 angeujstition charges) 15.00 0768 angeujstition charges (sum of lines 12 angeujstition charges) 15.00 0768 angeujstition charges (sum of lines 12 angeujstition charges) 15.00 0768 angeujstition charges (sum of lines 12 angeujstition c						
13.00 Organ acquisition charges (from Wist. D-4, Pt. III, col. 4, line 69)	12 00				42 902	12.00
14.00 Total reasonable charges (sum of lines 12 and 13)			ine 69)			
Customary charges			1116 07)			1
16.00 Amounts that would have been realized from patients iable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 9413.13(e)						
had such payment been made in accordance with 42 CFR \$413.13(e)						1
17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 17.00 18.00 17.00 19.00	16.00			on a chargebasis	0	16.00
18.00 Total customary charges (see instructions) 62,803 18.00	17 00	1 3	e)		0.000000	17 00
19.00						1
20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 0.00			ly if line 18 exceeds li	ne 11) (see		
Instructions						
21.00 Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions) 0 22.00 23.00 20.00 2	20. 00		ly if line 11 exceeds li	ne 18) (see	0	20.00
22.00 Interns and residents (see instructions) 0 22.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 24.00 0 23.00 0 23.00 24.00 0 23.00 24.00 0 24.00 0 24.00 0 24.00 0 24.00 0 24.00 0 24.00 0 24.00 0 24.00 0 25.00 0 24.00 0 25.00 0 25.00 0 0 0 0 0 0 0 0 0	21 00		e instructions)		8 923	21 00
24. 00 Total prospective payment (sum of lines 3, 4, 8 and 9) 21,109,053 24,00						
COMPUTATION OF REIMBURSEMENT SETTLEMENT 0 25.00 0 0 0 0 0 0 0 0 0	23. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	23. 00
25. 00 Deductibles and coinsurance (for CAH, see instructions) 0 25. 00 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) 4,058,107 26. 00 27. 00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 17,091,796,869 27. 00 28. 00 Direct graduate medical education payments (from Wkst. E-4, line 50) 21,897 28. 00 29. 00 ESRD direct medical education costs (from Wkst. E-4, line 36) 29. 00 29.	24. 00				21, 109, 053	24.00
26. 00 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) 4,058,107 26. 00 27. 00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 17,059,869 27. 00 1 1 1 1 1 1 1 1 1	25 00					25 00
27. 00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 17, 059, 869 27. 00 28. 00 Direct graduate medical education payments (from Wkst. E-4, line 50) 21, 897 28. 00 29. 00 ESRD direct medical education costs (from Wkst. E-4, line 36) 29. 00 29. 00 29. 00 29. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00			ur CAH see instructions)			1
28. 00 Direct graduate medical education payments (from Wkst. E-4, line 50) 21, 897 28. 00 29. 00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0 29. 00 31. 00 Subtotal (sum of lines 27 through 29) 17, 081, 766 30. 00 31. 00 Primary payer payments 33, 374 31. 00 32. 00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 17, 084, 392 33. 00 Composite rate ESRD (from Wkst. I-5, line 11) 0 33. 00 35. 00 Adjusted reimbursable bad debts (see instructions) 1, 236, 606 34. 00 36. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 964, 081 36. 00 38. 00 MSP-LCC reconciliation amount from PS&R -416 38. 00 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 00 39. 99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 90 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 35. 00 40. 01 Sequestration adjustment (see instructions) 17, 852, 602 40. 00 Sequestration adjustment (see instructions) 17, 609, 879 <td></td> <td>, ·</td> <td></td> <td></td> <td></td> <td>1</td>		, ·				1
29, 00 SSRD direct medical education costs (from Wkst. E-4, line 36) 0 29, 00 30, 00 Subtotal (sum of lines 27 through 29) 17, 081, 766 30, 00 31, 00 Primary payer payments 33, 374 31, 00 32, 00 Autotal (line 30 minus line 31) 17, 048, 392 20 33, 00 Composite rate ESRD (from Wkst. I-5, line 11) 0 33, 00 34, 00 Allowable bad debts (see instructions) 1, 236, 606 34, 00 36, 00 Allowable bad debts (see instructions) 964, 081 36, 00 37, 00 Subtotal (see instructions) 964, 081 36, 00 38, 00 MSP-LCC reconciliation amount from PS&R -416 38, 00 39, 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39, 00 39, 50 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39, 90 39, 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39, 99 40, 00 Subtotal (see instructions) 17, 852, 60 40, 01 41, 00 Tentative settlement (for contractors use only) 17, 695, 60 4				·		
30. 00 Subtotal (sum of lines 27 through 29) 17,081,766 30. 00 31. 00 Primary payer payments 33,374 31. 00 33. 374 31. 00 33. 374 31. 00 33. 374 31. 00 33. 374 31. 00 33. 374 31. 00 33. 00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33. 00 33. 00 34. 00 All lowable bad debts (see instructions) 1, 236, 606 34. 00 35. 00 Adjusted reimbursable bad debts (see instructions) 803, 794 35. 00 36. 00 All lowable bad debts for dual eligible beneficiaries (see instructions) 964, 081 36. 00 37. 00 Subtotal (see instructions) 17, 852, 186 37. 00 37. 00 38. 00 MSP-LCC reconciliation amount from PS&R -416 38. 00 39. 00 07HER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39. 90 Poincer ACO demonstration payment adjustment (see instructions) 39. 90 98. Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 99. 90 99						1
31.00 Note						1
Subtotal (line 30 minus line 31)						1
33.00 Composite rate ESRD (from Wkst. I - 5, line 11) 0 34.00 All lowable bad debts (see instructions) 1,236,606 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 964,081 36.00 All lowable bad debts for dual eligible beneficiaries (see instructions) 964,081 36.00 37.00 Subtotal (see instructions) 17,852,186 37.00 38.00 MSP-LCC reconciliation amount from PS&R -416 38.00 39.00 THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.50 97.00 97.						
34.00		· ·	CES)			
35.00 Adjusted reimbursable bad debts (see instructions) 803,794 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 964,081 36.00 37.00 Subtotal (see instructions) 17,852,186 37.00 38.00 MSP-LCC reconciliation amount from PS&R -416 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.50 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 17,852,602 40.00 40.01 Sequestration adjustment (see instructions) 357,052 40.01 41.00 42.00		1				
36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 964,081 36.00 37.00 Subtotal (see instructions) 17,852,186 37.00 38.00 MSP-LCC reconciliation amount from PS&R -416 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.50 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.01 Sequestration adjustment (see instructions) 17,852,602 40.00 40.01 Sequestration adjustment (see instructions) 357,052 40.01 41.00 Interim payments 17,609,879 41.00 42.00 Tentative settlement (for contractors use only) 0 42.00 44.00 Portested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 90.00 92.00 The rate used to calculate the Time Value of Money		1				
37. 00 Subtotal (see instructions) 17, 852, 186 37. 00 38. 00 MSP-LCC reconciliation amount from PS&R -416 38. 00 39. 00 THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 50 39. 98 39. 99 Poincer ACO demonstration payment adjustment (see instructions) 0 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Sequestration adjustment (see instructions) 17, 852, 602 40. 00 41. 00 Interim payments 17, 609, 879 41. 00 42. 00 43. 00 Bal ance due provider/program (see instructions) 24. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115. 2 TO BE COMPLETED BY CONTRACTOR 90. 00 Time Value of Money (see instructions) 0 93. 00 93. 00 Time Value of Money (see instructions) 0 93. 00 93. 00 10 10 10 10 10 10 10		` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` `	ructions)			
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00		,	, , , , , , , , , , , , , , , , , , , ,			
39.50 Pi oneer ACO demonstration payment adjustment (see instructions) 0 39.50	38. 00	MSP-LCC reconciliation amount from PS&R			-416	38. 00
39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98						
39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 17,852,602 40.00 40.01 Sequestration adjustment (see instructions) 357,052 40.01 41.00 Interim payments 17,609,879 41.00 42.00 Tentative settlement (for contractors use only) 17,609,879 41.00 43.00 Balance due provider/program (see instructions) -114,329 43.00 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,		, , ,	•			
40.00 Subtotal (see instructions) 17,852,602 40.00 40.01 Sequestration adjustment (see instructions) 357,052 40.01 41.00 Interim payments 17,609,879 41.00 42.00 Tentative settlement (for contractors use only) 0 42.00 43.00 Bal ance due provider/program (see instructions) -114,329 43.00 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2 0 44.00 90.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 93.00 Time Value of Money (see instructions) 0 93.00			iced devices (see instruc	CTI ONS)		
40.01 Sequestration adjustment (see instructions) 357,052 40.01 41.00 Interim payments 17,609,879 41.00 42.00 Tentative settlement (for contractors use only) 0 42.00 43.00 Bal ance due provider/program (see instructions) -114,329 43.00 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 90.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 93.00 Time Value of Money (see instructions) 0 93.00						
41.00 Interim payments 17,609,879 41.00 42.00 Tentative settlement (for contractors use only) 0 42.00 43.00 Bal ance due provider/program (see instructions) -114,329 43.00 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 90.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 93.00 Time Value of Money (see instructions) 0 93.00						
43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 \$\frac{\$115.2}{\$10.80}\$ COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 O 93.00						
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{9115.2}{10.80}\$ TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 O 93.00						
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 vollier reconciliation adjustment amount (see instructions)			! +L ONC D L 45 0	-1		
TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 98.00 Outlier reconciliation adjustment amount (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions)	44.00		ince with CMS Pub. 15-2,	cnapter 1,	0	44.00
90. 00Original outlier amount (see instructions)090. 0091. 00Outlier reconciliation adjustment amount (see instructions)091. 0092. 00The rate used to calculate the Time Value of Money0. 0092. 0093. 00Time Value of Money (see instructions)093. 00						1
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00 93.00	90.00				0	90.00
93.00 Time Value of Money (see instructions) 0 93.00						
74.00 10tal (3uii 01 111165 71 aliu 73)						
	74.00	Total (Sail of Fillos /Falla 70)			O	1 /4.00

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 01/01/2016	Worksheet E Part B
	Component CCN: 15-S002		
	Title XVIII	Subprovi der -	PPS
		IDF	

		Title XVIII	Subprovi der - I PF	PPS	
	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 instruc	tions)		1, 373	
3.00	PPS payments			2, 492	3. 00
4. 00	Outlier payment (see instructions)			0	4.00
5. 00 6. 00	Enter the hospital specific payment to cost ratio (see instru Line 2 times line 5	ictions)		0.000	5. 00 6. 00
7. 00	Sum of line 3 plus line 4 divided by line 6			0. 00	
8. 00	Transitional corridor payment (see instructions)			0	
9.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		21	9. 00
10.00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			0	11. 00
	Reasonable charges				
12.00	Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	
14. 00	Total reasonable charges (sum of lines 12 and 13)			0	14. 00
15. 00	Customary charges Aggregate amount actually collected from patients liable for	navment for services on	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for			0	16.00
	had such payment been made in accordance with 42 CFR §413.13(
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	
18. 00 19. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete or	ly if line 10 eyeseds l	ino 11) (000	0	
19.00	instructions)	if y if fille to exceeds i	THE IT) (See	Ü	19.00
20.00	Excess of reasonable cost over customary charges (complete or	ly if line 11 exceeds I	ine 18) (see	0	20.00
	instructions)				
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH se	e instructions)		0	
22. 00 23. 00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see inst	ructions)		0	22. 00 23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)	ructions)			24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			0	
26. 00 27. 00	Deductibles and Coinsurance relating to amount on line 24 (for Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			498 2, 015	
27.00	instructions)	prus the sum of filles 2	z anu zsj (see	2,015	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30.00	Subtotal (sum of lines 27 through 29)			2, 015	
31. 00 32. 00	Primary payer payments Subtotal (line 30 minus line 31)			0 2, 015	31. 00 32. 00
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)		2,013	32.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	· · · · ·		0	33. 00
34.00	Allowable bad debts (see instructions)			426	
35.00	1 7	rusti ana)		277	
36. 00 37. 00	Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (see instructions)	ructions)		426 2, 292	
38. 00	MSP-LCC reconciliation amount from PS&R			0	38.00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instruction			0	
39. 98 39. 99	Partial or full credits received from manufacturers for repla RECOVERY OF ACCELERATED DEPRECIATION	ced devices (see instru	ctions)	0	39. 98 39. 99
40.00	Subtotal (see instructions)			2, 292	
40. 01	Sequestration adjustment (see instructions)			46	
41.00	Interim payments			1, 954	
42.00	, , , , , , , , , , , , , , , , , , , ,				42.00
43. 00 44. 00				292 0	
44.00	§115. 2	ince with cms rub. 13-2,	Chapter 1,	U	44.00
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	90.00
	, , ,				91.00
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92.00 93.00
	Total (sum of lines 91 and 93)				94.00
			'		-

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 01/01/2016	Worksheet E Part B
	Component CCN: 15-T002	To 12/31/2016	Date/Time Prepared: 5/26/2017 1:14 pm
	Title XVIII	Subprovi der -	PPS
		IRF	

		Title XVIII	Subprovi der - I RF	PPS	
			110		
	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 instruc	tions)		568	
3. 00	PPS payments			164	3.00
4.00	Outlier payment (see instructions)	ctions)		0. 000	4.00
5. 00 6. 00	Enter the hospital specific payment to cost ratio (see instru Line 2 times line 5	Ctions)		0.000	5. 00 6. 00
7. 00	Sum of line 3 plus line 4 divided by line 6			0. 00	
8.00	Transitional corridor payment (see instructions)			0	8. 00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	
10. 00 11. 00	Organ acquisitions Total cost (sum of Lines 1 and 10) (see instructions)			0	10. 00 11. 00
11.00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			U	11.00
	Reasonable charges				
12.00	Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	
14. 00	Total reasonable charges (sum of lines 12 and 13) Customary charges			0	14. 00
15. 00	Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for			0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	
18. 00 19. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete or	Ly if line 19 eveneds L	ino 11) (soo	0	
17.00	instructions)	Ty IT TITLE TO EXCEEUS T	The TT) (see	U	17.00
20.00	Excess of reasonable cost over customary charges (complete or	ly if line 11 exceeds l	ine 18) (see	0	20.00
	instructions)				
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH se	e instructions)		0	
22. 00 23. 00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see inst	ructions)		0	22. 00 23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)	ruetrons)		164	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			0	
26.00	Deductibles and Coinsurance relating to amount on line 24 (fo			33	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	plus the sum of lines 2	2 and 23] (see	131	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30.00	Subtotal (sum of lines 27 through 29)			131	
31. 00 32. 00	Primary payer payments Subtotal (line 30 minus line 31)			0 131	31. 00 32. 00
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)		131	32.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	/		0	33.00
34.00	Allowable bad debts (see instructions)			0	
35.00	Adjusted reimbursable bad debts (see instructions)			0	
36. 00 37. 00	Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (see instructions)	ructions)		0 131	
38. 00	MSP-LCC reconciliation amount from PS&R			0	38.00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instruction			0	
39. 98	Partial or full credits received from manufacturers for repla	ced devices (see instru	ictions)	0	39. 98
39. 99 40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 131	39. 99 40. 00
40. 01	Sequestration adjustment (see instructions)			3	40. 01
41.00	Interim payments			129	41.00
42.00	Tentative settlement (for contractors use only)				42.00
43. 00 44. 00					43.00
44.00	§115. 2	nce with cms Pub. 15-2,	chapter i,	0	44.00
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)				90. 00
	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92.00 93.00
	Total (sum of lines 91 and 93)				94.00
				٥١	

Health Financial Systems METH ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared: Provi der CCN: 15-0002

				10 12/31/2010	5/26/2017 1:14	
-		Ti tl e	e XVIII	Hospi tal	PPS	
		Inpatient Part A P		Par	rt 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		56, 610, 33		16, 582, 475	1. 00
2. 00	Interim payments payable on individual bills, either	•	1		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	12/31/2016	814, 09		861, 804	3. 01
3. 02		12/31/2016	261, 20		165, 600	3. 02
3. 03				0	0	3. 03
3. 04				O	0	3. 04
3. 05				O	0	3. 05
0 50	Provi der to Program					0 50
3. 50	ADJUSTMENTS TO PROGRAM		•)	0	3. 50
3. 51				0		3. 51
3. 52 3. 53						3. 52 3. 53
3. 53 3. 54			•)		3. 53
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		1, 075, 29		1, 027, 404	3. 99
3. 77	3. 50-3. 98)		1,075,29	3	1,027,404	3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		57, 685, 62	4	17, 609, 879	4. 00
1. 00	(transfer to Wkst. E or Wkst. E-3, line and column as		07,000,02		17,007,077	1.00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR		1		•	
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		1	O	0	5. 01
5.02				O	0	5. 02
5. 03				O	0	5. 03
	Provider to Program			-1		
5. 50	TENTATI VE TO PROGRAM			O	0	5. 50
5. 51				O O	0	5. 51
5. 52	6 1 1 1 1 1 (6 1 1		1)	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		'	O	0	5. 99
4 00	Determined net settlement amount (balance due) based on					4 00
6. 00	the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		756, 66	5	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			O	114, 329	6. 02
7. 00	Total Medicare program liability (see instructions)		58, 442, 29		17, 495, 550	7.00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00	In a Contract of		0	1. 00	2. 00	0.66
8.00	Name of Contractor					8. 00

Health Financial Systems	METHODIST HOSPI	TALS, INC		In Lie	u of Form CMS-2	552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDER	RED	Provi der Co	CN: 15-0002	Peri od:	Worksheet E-1	
		Component (From 01/01/2016 To 12/31/2016		
		Title	XVIII	Subprovi der - I PF	PPS	
		I npati en	t Part A	Par	t B	
	г	nm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00 Total interim payments paid to provider			1, 111, 13	35	1, 954	1. 00
	- ! - !		i	0		2 00

		I npati en	it Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4. 00	
1. 00	Total interim payments paid to provider	1.00	1, 111, 135	3.00	1, 954	1.00
2.00	Interim payments payable on individual bills, either		1, 111, 133		1, 734	2. 00
2.00	submitted or to be submitted to the contractor for		U		١	2.00
	services rendered in the cost reporting period. If none,					
3. 00	write "NONE" or enter a zero					3. 00
3.00	List separately each retroactive lump sum adjustment 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					
2 01	ADJUSTMENTS TO PROVIDER	T			1 0	2 01
3. 01	ADJUSTMENTS TO PROVIDER		0			3. 01
3. 02			0		0	3. 02
3. 03			0		0	3. 03
3. 04			0		0	3.04
3. 05			0		0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3. 53			0		0	3.53
3.54			0		0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 111, 135		1, 954	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	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		0		0	5. 01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	5.50
5. 51			0		0	5. 51
5. 52			0		0	5.52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		l ol	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, 516		292	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6.02
7. 00	Total Medicare program liability (see instructions)		1, 117, 651		2, 246	7.00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
)	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	! 	'	'		'	

Health Financial Systems	METHODI ST HOSI	PITALS, INC		In Lie	u of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES I	RENDERED	Provi der C		Period: From 01/01/2016	Worksheet E-1 Part I	
		Component	CCN: 15-T002	To 12/31/2016	Date/Time Pre 5/26/2017 1:1	
		Title	e XVIII	Subprovi der – I RF	PPS	
		Inpatien	it Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1 00	2 00	3 00	4 00	

				I RF		
		Inpatien	nt Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider	1.00	8, 455, 288	3.00	129	1. 00
2.00	Interim payments payable on individual bills, either		0, 433, 200		127	2.00
2.00	submitted or to be submitted to the contractor for					2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		•			
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02			0		ol	3. 02
3. 03			0		ol	3. 03
3.04			0		ol	3. 04
3.05			0		ol	3.05
	Provider to Program		•			
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3. 51
3.52			0		0	3. 52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		8, 455, 288		129	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	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		0		0	5. 01
5. 02			0		0	5. 02
5. 03			0		0	5. 03
F F0	Provi der to Program					
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52	6		0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
4 00	5. 50-5. 98)					4 00
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6. 01	SETTLEMENT TO PROVIDER		98, 528		0	6. 01
6. 01	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		98, 528		1	6. 01
	·				128	
			8, 553, 816			7. 00
7. 00	Total Medicare program liability (see instructions)			Contractor	NDD Doto	
7. 00	lotal Medicare program Hiability (see Instructions)			Contractor	NPR Date	
7. 00		(,	Number	(Mo/Day/Yr)	
8. 00	Name of Contractor	(0			8. 00

Heal th	Financial Systems METHODIST HOSPI	TALS, INC	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-0002	Peri od:	Worksheet E-1	
			From 01/01/2016 To 12/31/2016		pared:
				5/26/2017 1: 1	4 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst		e 14	15, 584 34, 233	1. 00
2.00	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				2. 00
3.00	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12		87, 428	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			1, 174, 544, 724	5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20		34, 239, 170	6. 00
7.00	CAH only - The reasonable cost incurred for the purchase of	certified HIT technology	Wkst. S-2, Pt. I	0	7. 00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)			0	8. 00
9.00	Sequestration adjustment amount (see instructions)			0	9. 00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)		0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30.00
31.00	Other Adjustment (specify)			0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instructio	ns)	0	32.00

Health Financial Systems M	ETHODIST HOSPITALS, INC	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0002	Peri od:	Worksheet E-3	
		From 01/01/2016		
	Component CCN: 15-S002	To 12/31/2016	Date/Time Pre	pared:
	· '		5/26/2017 1:1	4 pm
	Title XVIII	Subprovi der -	PPS	
		I PF		
			1. 00	
PART II - MEDICARE PART A SERVICES - IPE PPS		-		

		1. 00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1, 278, 117	1.00
2.00	Net IPF PPS Outlier Payments	65, 960	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November	0. 00	4.00
	15, 2004. (see instructions)		
4. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0. 00	4. 01
	program or hospital closure, that would not be counted without a temporary cap adjustment under 42		
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		
5.00	New Teaching program adjustment. (see instructions)	0. 00	5.00
6. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0. 00	6. 00
0.00	teaching program" (see instuctions)	0.00	0.00
7. 00	Current year's unweighted L&R FTE count for residents within the new program growth period of a "new	0. 00	7. 00
7.00	teaching program" (see instuctions)	0.00	7.00
8. 00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0. 00	8. 00
9. 00	Average Daily Census (see instructions)	8. 106557	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0. 000000	
11. 00	Teaching Adjustment (line 1 multiplied by line 10).	0.000000	11.00
12. 00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1, 344, 077	12.00
13. 00	Nursing and Allied Health Managed Care payment (see instruction)	1, 344, 077	13.00
14. 00		١	14.00
	Organ acquisition (DO NOT USE THIS LINE)	ا	
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	
16.00		1, 344, 077	
17.00		0	
18. 00	,	1, 344, 077	
19. 00		55, 384	
20.00	Subtotal (line 18 minus line 19)	1, 288, 693	
	Coi nsurance	154, 882	
22. 00	Subtotal (line 20 minus line 21)	1, 133, 811	22.00
23. 00		8, 934	
24.00	Adjusted reimbursable bad debts (see instructions)	5, 807	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1, 462	25.00
26.00	Subtotal (sum of lines 22 and 24)	1, 139, 618	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27. 00
28.00	Other pass through costs (see instructions)	842	28. 00
29.00	Outlier payments reconciliation	0	29. 00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30. 50
30. 99	Recovery of Accelerated Depreciation	0	30. 99
31. 00		1, 140, 460	
31. 01	Sequestration adjustment (see instructions)	22, 809	
32. 00	, ,	1, 111, 135	
33. 00	Tentative settlement (for contractor use only)	0	33. 00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	6, 516	34.00
35. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0, 010	35.00
33.00	\$115. 2	,	33.00
	TO BE COMPLETED BY CONTRACTOR		
50 00	Original outlier amount from Worksheet E-3, Part II, line 2	65, 960	50.00
	Outlier reconciliation adjustment amount (see instructions)	05, 400	51.00
	The rate used to calculate the Time Value of Money	0.00	
	Time Value of Money (see instructions)		53.00
33.00	Time value of money (see first detroits)	υĮ	1 33.00

Heal th	Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0002	Peri od:	Worksheet E-3	
			From 01/01/2016		
		Component CCN: 15-T002	To 12/31/2016		
				5/26/2017 1: 1	4 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)			8, 130, 194	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instru	uctions)		0. 0561	2.00
3.00	Inpatient Rehabilitation LIP Payments (see ir	nstructions)		495, 942	3.00
4.00	Outlier Payments			169, 602	4.00
E 00	Unweighted intern and recident FTF count in t	the meet recent each reporting period o		0 00	E 00

		1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	8, 130, 194	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0561	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	495, 942	3.00
4.00	Outlier Payments	169, 602	4.00
5. 00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior	·	5.00
	to November 15, 2004 (see instructions)		
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0.00	5. 01
	program or hospital closure, that would not be counted without a temporary cap adjustment under 42		
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		
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	7.00
	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)	27. 978142	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)	8, 795, 738	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)	8, 795, 738	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	8, 795, 738	19.00
20.00	Deducti bl es	28, 308	20.00
21.00	Subtotal (line 19 minus line 20)	8, 767, 430	21.00
22.00	Coi nsurance	59, 892	22.00
23.00	Subtotal (line 21 minus line 22)	8, 707, 538	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	32, 071	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	20, 846	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	22, 515	26.00
27.00	Subtotal (sum of lines 23 and 25)	8, 728, 384	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31. 99	Recovery of Accelerated Depreciation	0	31. 99
32.00	Total amount payable to the provider (see instructions)	8, 728, 384	32.00
32. 01	Sequestration adjustment (see instructions)	174, 568	32. 01
33.00	Interim payments	8, 455, 288	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)	98, 528	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	3, 819	36.00
	§115. 2		
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	169, 602	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

MCRI F32 - 10. 5. 160. 2

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0002	Peri od: From 01/01/2016 To 12/31/2016 Worksheet E-3 Part VII Date/Time Prepared: 5/26/2017 1:14 pm
	Ti +I o VI V	Hospital Cost

		'	0 12/31/2016	5/26/2017 1: 1	
		Title XIX	Hospi tal	Cost	
			I npati ent	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		4, 564, 373		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		o		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		4, 564, 373	0	4.00
5.00	Inpatient primary payer payments		o		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		4, 564, 373	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonabl e Charges]
8.00	Routi ne servi ce charges		3, 211, 089		8.00
9.00	Ancillary service charges		13, 306, 999	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)		16, 518, 088	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment fo	r services on a charge	0	0	13.00
	basi s				
14. 00	Amounts that would have been realized from patients liable fo	1 3	0	0	14. 00
	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0. 000000	1
16.00	Total customary charges (see instructions)		16, 518, 088	0	
17. 00	Excess of customary charges over reasonable cost (complete on	Ty if line 16 exceeds	11, 953, 715	0	17. 00
10 00	line 4) (see instructions)	ly if lime 4 avecade lime	0	0	10 00
18. 00	Excess of reasonable cost over customary charges (complete on 16) (see instructions)	Ty IT TIME 4 exceeds Time	٩	U	18. 00
19. 00	Interns and Residents (see instructions)		0	0	19.00
	Cost of physicians' services in a teaching hospital (see inst	ructions)	0	0	
	Cost of covered services (enter the lesser of line 4 or line		4, 564, 373	0	
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			0	21.00
22 00	Other than outlier payments	compreted for 113 provid	0	0	22. 00
	Outlier payments		o o	0	
	Program capital payments		o o	Ü	24.00
	Capital exception payments (see instructions)		0		25.00
	Routine and Ancillary service other pass through costs		o	0	
	Subtotal (sum of lines 22 through 26)		o	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	1
29. 00	Titles V or XIX (sum of lines 21 and 27)		4, 564, 373	0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	4, 564, 373	0	31.00
32.00	Deducti bl es		0	0	32.00
33.00	Coi nsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 an	d 33)	4, 564, 373	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38. 00	Subtotal (line 36 ± line 37)		4, 564, 373	0	
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
	Total amount payable to the provider (sum of lines 38 and 39)		4, 564, 373	0	
41.00	Interim payments		5, 258, 136	0	
42.00	Balance due provider/program (line 40 minus line 41)		-693, 763	0	
43.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2		1		I

Health Financial Systems	METHODIST HOSPITALS. INC	In Lio	u of Form CMS-2	DEE2 10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Peri od:	Worksheet E-3	
	Component CCN: 15-S002	From 01/01/2016 To 12/31/2016	Date/Time Pre	
-	Title XIX	Subprovi der -	5/26/2017 1: 12 Cost	4 pm
		Inpati ent	Outpati ent	

Input int			' I PF		
DORPUTATION OF NET CONTROL SERVICES 1.00			Inpatient	Outpati ent	
COMPUTATION OF NET COST OF COVERED SERVICES 342,794 0.2.00				2. 00	
Inpati ent hospit all /SNF/MF services			X SERVICES		
Medical and other services					
0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 0.00 0 0 0 0 0 0			342, 794		1.00
Subtotal (sum of lines 1, 2 and 3)	2.00	Medical and other services		0	2.00
Inpatient primary payer payments 0 0 0.00	3.00	Organ acquisition (certified transplant centers only)	0		3.00
Outpatient primary payer payments 0	4.00	Subtotal (sum of lines 1, 2 and 3)	342, 794	0	4.00
Subtotal (line 4 less sum of lines 5 and 6)	5.00	Inpatient primary payer payments	0		5.00
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges Routine service charges 101,895 8.00 8.00 8.00 10,000 10,000 10,000 10,000 10,000 10,000 11,000	6.00	Outpatient primary payer payments		0	6.00
Reasonable Charges 0	7.00		342, 794	0	7.00
Routine service charges 101,895 8.00 10.00 00.00 Ancillary service charges, ent of revenue 0.0 10.00		COMPUTATION OF LESSER OF COST OR CHARGES			
9.00 Ancil lary service charges 60.396 0 9.00					
10.00 Organ acquisition charges, net of revenue 0 10.0					
1.00 Incentive from target amount computation 11.00 0 11.00 12.00	9.00		60, 396	0	
12.00 Total reasonable charges (sum of lines 8 through 11) 10.20 20.00 10.	10.00		0		10.00
CUSTOMARY CHARGES 0 0 13.00	11. 00		-		
13.00	12.00	Total reasonable charges (sum of lines 8 through 11)	162, 291	0	12.00
basis					
14. 00 Amounts that would have been realized from patients Liable for payment for services on a rarge basis had such payment been made in accordance with 42 CFR §413. 13(e) 0.000000 0.000000 15. 00 16. 00 17. 00 18. 00	13.00	Amount actually collected from patients liable for payment for services on a charge	0	0	13.00
a charge basis had such payment been made in accordance with 42 CFR §413.13(e)					
15.00	14. 00		0	0	14.00
16. 00 Total customary charges (see instructions) 162, 291 0 16. 00					
17. 00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 0 17. 00 10					
Line 4) (see instructions) Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 180, 503					
18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 180, 503 0 18.00 16) (see instructions) 0 0 19.00 10.	17. 00		0	0	17. 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) 162, 291 0 21, 00 10 ther than outlier payments 0 0 22, 00 24, 00 Program capital payments 0 23, 00 24, 00 Program capital payments (see instructions) 0 25, 00 26, 00 Routine and Ancillary service other pass through costs 0 0 26, 00 27, 00 Subtotal (sum of lines 22 through 26) 0 0 28, 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) 0 0 28, 00 20, 00 Titles V or XIX (sum of lines 18) 180, 503 0 30, 00 31, 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 162, 291 0 31, 00 32, 00 Deductible s 0 0 32, 00 0 32, 00	18.00		180, 503	0	18.00
20. 00 Cost of physicians' services in a teaching hospital (see instructions) 0 162,291 0 21.00				_	
21.00			_	_	
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22. 00 Other than outlier payments 0 0 22. 00 23. 00 Outlier payments 0 0 23. 00 24. 00 Program capital payments 0 24. 00 25. 00 Capital exception payments (see instructions) 0 25. 00 26. 00 Routine and Ancillary service other pass through costs 0 0 25. 00 27. 00 Subtotal (sum of lines 22 through 26) 0 0 27. 00 0 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) 162, 291 0 29. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30. 00 Excess of reasonable cost (from line 18) 180, 503 0 30. 00 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 162, 291 0 31. 00 32. 00 Deductibles 0 0 33. 00 33. 00 Coinsurance 0 0 33. 00 34. 00 Allowable bad debts (see instructions) 0 0 33. 00 <td>21.00</td> <td></td> <td></td> <td>0</td> <td>21.00</td>	21.00			0	21.00
23.00 Outlier payments 0 0 23.00 24.00 Program capit tal payments 0 24.00 25.00 Capit tal exception payments (see instructions) 0 25.00 26.00 Routine and Ancillary service other pass through costs 0 0 26.00 27.00 Subtotal (sum of lines 22 through 26) 0 0 27.00 28.00 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) 162,291 0 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 180,503 0 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 162,291 0 31.00 32.00 Deductibles 0 0 32.00 33.00 Coinsurance 0 0 33.00 34.00 Allowable bad debts (see instructions) 0 0 34.00 35.00 Utilization review 0 0 35.00 36.00 Subtotal (sum of lines 31, 34 and		9 7 1			
24.00 Program capital payments 0 24.00 25.00 Capital exception payments (see instructions) 0 25.00 26.00 Routine and Ancillary service other pass through costs 0 0 26.00 27.00 Subtotal (sum of lines 22 through 26) 0 0 27.00 28.00 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) 0 162,291 0 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 180,503 0 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 162,291 0 31.00 32.00 Deductible s 0 0 32.00 33.00 Coinsurance 0 0 33.00 34.00 Allowable bad debts (see instructions) 0 34.00 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 162,291 0 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 <td></td> <td>1 3</td> <td></td> <td></td> <td></td>		1 3			
25.00 Capital exception payments (see instructions) 25.00 26.00 Routine and Ancillary service other pass through costs 0 0 26.00 27.00 28.00 Customary charges (title V or XIX PPS covered services only) 0 0 28.00 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) 0 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT			-	0	
26.00 Routi ne and Ancillary service other pass through costs 0 0 26.00 27.00 Subtotal (sum of lines 22 through 26) 0 0 27.00 28.00 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) 0 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 180,503 0 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 162,291 0 31.00 32.00 Deductibles 0 0 32.00 33.00 Coi nsurance 0 0 33.00 34.00 Allowable bad debts (see instructions) 0 0 34.00 35.00 Utilization review 0 35.00 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 162,291 0 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 162,291 0 3			_		
27.00 Subtotal (sum of lines 22 through 26) 0 0 27.00 28.00 Customary charges (title V or XIX PPS covered services only) 0 0 28.00 162, 291 0 29.00 29.00 20.00			_		
28.00 Customary charges (title V or XIX PPS covered services only) Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 33.00 Coinsurance 34.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 40.00 Interim payments 41.00 Balance due provider/program (line 40 minus line 41) 42.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 28.00 Consurance 30.00 180, 291 0 162, 291 0 170, 201 0 170			-	_	
29.00 Titles V or XIX (sum of lines 21 and 27) 0 29.00			_		
COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 180,503 0 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 162,291 0 31.00 32.00 Deductibles 0 0 0 32.00 33.00 Coinsurance 0 0 0 32.00 34.00 Allowable bad debts (see instructions) 0 0 0 34.00 35.00 Utilization review 0 35.00 Utilization review 0 35.00 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 162,291 0 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 162,291 0 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 162,291 0 40.00 Interim payments 51,662 0 41.00 42.00 Bal ance due provider/program (line 40 minus line 41) 110,629 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00			-		
30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 33.00 Coinsurance 34.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 36.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 40.00 Interim payments 41.00 Balance due provider/program (line 40 minus line 41) 42.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 10 31.00 30.00 31.00 32.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	29.00		162, 291	0	29.00
31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 33.00 Coi nsurance 34.00 Allowable bad debts (see instructions) 35.00 Utilization review 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 162,291	20.00		400 500	0	00.00
32.00 Deductibles 0 32.00 33.00 33.00 34.00 34.00 34.00 34.00 34.00 35.00 Utilization review 0 35.00 35.00 Utilization review 0 35.00 35					
33.00 Coinsurance 0 0 33.00 34.00 Allowable bad debts (see instructions) 0 0 34.00 35.00 Utilization review 0 35.00 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 162,291 0 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 162,291 0 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 162,291 0 40.00 41.00 Interim payments 51,662 0 41.00 42.00 Bal ance due provider/program (line 40 minus line 41) 110,629 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00					
34.00 Allowable bad debts (see instructions) 34.00 Utilization review 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 162,291 163,662 170,662 171,662 171,662 171,662 171,662			_		
35.00 Utilization review 0 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 162,291 0 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 162,291 0 38.00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 Total amount payable to the provider (sum of lines 38 and 39) 162,291 0 40.00 Interim payments 51,662 0 41.00 Balance due provider/program (line 40 minus line 41) 110,629 0 42.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00			_		
36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 162, 291 0 36.00 38.00 39.00 162, 291 0 39.00 162, 291 0 40.00 110, 291 0 40.00 110, 291 0 41.00 110, 629		· · · · · · · · · · · · · · · · · · ·	١	0	
37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 162,291 0 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 162,291 0 40.00 41.00 Interim payments 51,662 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) 110,629 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00				0	
38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 162, 291 0 38.00 39.00 162, 291 0 40.00 41.00 41.00 41.00 42.00 43.00			162, 291		
39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 39.00 40.00 41.00 41.00 41.00 42.00 43.00		, , , , ,	0		
40.00Total amount payable to the provider (sum of lines 38 and 39)162,291040.0041.00Interim payments51,662041.0042.00Balance due provider/program (line 40 minus line 41)110,629042.0043.00Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,043.00			162, 291	0	
41.00 Interim payments 51,662 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) 110,629 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00			0	_	
42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 42.00					
43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00					
		,			
cnapter 1, §115.2	43.00		0	0	43.00
		junapter 1, §115.2	1 1		

Health Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0002	Peri od:	Worksheet E-3	
		From 01/01/2016		
	Component CCN: 15-T002	To 12/31/2016		
			5/26/2017 1:1	4 pm
	Title XIX	Subprovi der -	Cost	
		IRF		
		I npati ent	Outpati ent	
		1. 00	2. 00	

		INI	0	
		I npati ent	Outpati ent	
		1. 00	2. 00	
	<u> PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX</u>	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	134, 712		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	134, 712	0	4.00
5.00	Inpatient primary payer payments	0		5.00
	Outpatient primary payer payments		0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)	134, 712	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES	1017712	J	,,,,,
	Reasonable Charges			
	Routine service charges	127, 609		8.0
	Ancillary service charges	263, 511	0	9.00
	Organ acquisition charges, net of revenue	200, 011	J	10.00
	Incentive from target amount computation	0		11.00
1	Total reasonable charges (sum of lines 8 through 11)	391, 120	0	
12.00	CUSTOMARY CHARGES	371, 120	U	12.00
13. 00	Amount actually collected from patients liable for payment for services on a charge	ol	0	13.00
13.00	basis	U	O	13.00
14. 00	Amounts that would have been realized from patients liable for payment for services on	0	0	14.00
14.00	a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	o o	O	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0. 000000	0. 000000	15. 0
16. 00	Total customary charges (see instructions)	391, 120	0.000000	16.00
			0	17.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds	256, 408	U	17.00
18. 00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete only if line 4 exceeds line	o	0	18.00
16.00	16) (see instructions)	٥	U	10.0
19. 00	Interns and Residents (see instructions)	0	0	19.0
	· · · · · · · · · · · · · · · · · · ·	ol Ol	0	20.00
	Cost of physicians' services in a teaching hospital (see instructions)	134, 712	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)	· · · · · · · · · · · · · · · · · · ·	U	21.0
22.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS provide	0	0	22.00
	Other than outlier payments	0	-	
	Outlier payments	-	0	23.00
	Program capital payments	0		24.00
	Capital exception payments (see instructions)	0		25.00
	Routine and Ancillary service other pass through costs	0	0	26. 0
	Subtotal (sum of lines 22 through 26)	0	0	27.00
	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
	Titles V or XIX (sum of lines 21 and 27)	134, 712	0	29.0
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
	Excess of reasonable cost (from line 18)	0	0	30.00
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	134, 712	0	31.0
32.00	Deducti bl es	0	0	32.00
33. 00	Coi nsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.0
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	134, 712	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	o	0	37.0
	Subtotal (line 36 ± line 37)	134, 712	0	38.00
	Direct graduate medical education payments (from Wkst. E-4)	0	-	39.0
	Total amount payable to the provider (sum of lines 38 and 39)	134, 712	0	40.0
40.00			0	41.00
40. 00	Interim payments	124 5031		
40. 00 41. 00	Interim payments Balance due provider/program (Line 40 minus Line 41)	124, 503 10, 209		
40. 00 41. 00 42. 00	Interim payments Balance due provider/program (line 40 minus line 41) Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	124, 503 10, 209 0	0	42. 00 43. 00

	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT L EDUCATION COSTS	Provi der Co	CN: 15-0002	Period: From 01/01/2016	Worksheet E-4	
				To 12/31/2016	5/26/2017 1: 1	
		litle	xVIII	Hospi tal	PPS	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				1. 00	
. 00	Unweighted resident FTE count for allopathic and osteopathic	programs fo	r cost report	ing periods	10. 83	1.0
. 00	ending on or before December 31, 1996. Unweighted FTE resident cap add-on for new programs per 42 CF	R 413.79(e)	(1) (see inst	ructions)	0.00	2.0
. 00	Amount of reduction to Direct GME cap under section 422 of MM	MΑ	. , .	ŕ	0.00	
. 01	Direct GME cap reduction amount under ACA §5503 in accordance instructions for cost reporting periods straddling 7/1/2011)	e With 42 CF	K 9413.79 (M)	. (See	0. 00	3.0
. 00	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	4.0
. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see inst		r cost report	ing periods	0.00	4.0
. 02	straddling 7/1/2011) ACA Section 5506 number of additional direct GME FTE cap slot	ts (see ins	tructions for	cost reporting	0. 00	4.0
. 00	periods straddling 7/1/2011) FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl	ue or minue	line / nlus	lines 4 01 and	10. 83	5.0
	4.02 plus applicable subscripts		·			
. 00	Unweighted resident FTE count for allopathic and osteopathic records (see instructions)	programs for	r the current	year from your	2. 93	6.0
. 00	Enter the lesser of line 5 or line 6			011	2. 93	7.0
			Primary Card	e Other 2.00	Total 3. 00	
. 00	Weighted FTE count for physicians in an allopathic and osteop	oathi c	0. (2. 53	8.0
. 00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherw	vi se	0. (2. 53	2. 53	9. 0
	multiply line 8 times the result of line 5 divided by the amo	ount on line				
0. 00	Weighted dental and podiatric resident FTE count for the curr			0.00		10.0
0. 01 1. 00	Unweighted dental and podiatric resident FTE count for the cu Total weighted FTE count	ırrent year	0.0	0. 00 2. 53		10.0
2. 00	Total weighted resident FTE count for the prior cost reportir	ng year (see		1		12.0
3. 00	instructions) Total weighted resident FTE count for the penultimate cost re	eporti ng	0.0	2. 50		13.0
4. 00	year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided	1 by 2)	0.0	2. 48		14. C
5. 00	Adjustment for residents in initial years of new programs	1 by 3).	0.0	1		15. (
5. 01	Unweighted adjustment for residents in initial years of new p		0. (1		15.0
6. 00 6. 01	Adjustment for residents displaced by program or hospital clo Unweighted adjustment for residents displaced by program or h		0.0	1		16. (16. (
0. 01	closure	iospi tai	0. (0.00		10.0
7. 00			0. (1		17. (
8. 00 9. 00	Per resident amount Approved amount for resident costs		0.0	0 81, 136. 49 0 201, 218	201, 218	18. (19. (
					1. 00	
0.00	Additional unweighted allopathic and osteopathic direct GME F	TE resident	cap slots re	eceived under 42		20.0
1. 00	Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instru	uctions)			0. 00	21. (
2. 00	Allowable additional direct GME FTE Resident Count (see instr				0.00	22.
3. 00	, , ,	mount (see i	nstructions)		0. 00	
	Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24)				0 201, 218	1
, oo	Total arroad one amount (oam of fried fr and Er)		I npati ent	Managed care	201/210	20.
			Part A 1.00	2.00	3. 00	
	COMPUTATION OF PROGRAM PATIENT LOAD		ı			
5.00	Inpatient Days (see instructions)		42, 0			26.0
7. 00 3. 00	Total Inpatient Days (see instructions) Ratio of inpatient days to total inpatient days		100, 7: 0. 4176!			27.0
9. 00	Program direct GME amount		84, 0	I I		29. (
0. 00	Reduction for direct GME payments for Medicare Advantage			1, 014		30.0
$\cap \cap$	Net Program di rect GME amount				90, 203	1 31

	NET LOCATION OF LIGHT	TALO 1110		6.5. 0110.4	
	Financial Systems METHODIST HOSPI GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 15-0002	Period:	u of Form CMS-2 Worksheet E-4	
	L EDUCATION COSTS	Provider CCN: 15-0002	From 01/01/2016		
WILDI CA	L EDUCATION COSTS		To 12/31/2016		
		Title XVIII	Hospi tal	PPS	
	DUDGOT MEDICAL EDUCATION COOTS FOR FORD COMPOSITE DATE. TITLE	5 10 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	OLIGOT AND DADAMED	1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITL EDUCATION COSTS)	·		OI CAL	
32. 00	Renal dialysis direct medical education costs (from Wkst. B, and 94)	Pt. I, sum of col. 20 a	nd 23, lines 74	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.	I, col. 8, sum of lines	74 and 94)	6, 909, 817	33.00
34.00	Ratio of direct medical education costs to total charges (lir	ne 32 ÷ line 33)		0.000000	34.00
	Medicare outpatient ESRD charges (see instructions)			0	
36.00	Medicare outpatient ESRD direct medical education costs (line			0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY			
	Part A Reasonable Cost				
	Reasonable cost (see instructions)			74, 269, 649	ł
	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
	Primary payer payments (see instructions)	. 11		53, 250	1
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minu Part B Reasonable Cost	is line 40)		74, 216, 399	41.00
42 00	Reasonable cost (see instructions)			23, 825, 853	12 00
43. 00				34, 167	1
	Total Part B reasonable cost (line 42 minus line 43)			23, 791, 686	1
	Total reasonable cost (sum of lines 41 and 44)			98, 008, 085	1
	Ratio of Part A reasonable cost to total reasonable cost (lin	ne 41 ÷ line 45)		0. 757248	1
	Ratio of Part B reasonable cost to total reasonable cost (lin			0. 242752	1
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA			<u> </u>	
48.00	Total program GME payment (line 31)			90, 203	48. 00
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instructions)		68, 306	49. 00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(see instructions)		21, 897	50.00
			·		

Health Financial Systems

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

Provider CCN: 15-0002

Period: Worksheet G From 01/01/2016 To 12/31/2016 Date/Time Prepared: 5/26/2017 1:14 pm

J 37		General Fund	Specific	Endowment Fund	5/26/2017 1:1 Plant Fund	4 pm
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-542	I	0	0	1.00
2. 00 3. 00	Temporary investments Notes receivable	3, 003, 725	0	0	0	2. 00 3. 00
4. 00	Accounts receivable	65, 935, 710	-	0	0	4.00
5. 00	Other recei vable	00,700,710	Ö	o	0	5.00
6. 00	Allowances for uncollectible notes and accounts receivable	-21, 824, 891	0	ō	0	6.00
7.00	Inventory	11, 126, 425	0	o	0	7.00
8.00	Prepai d expenses	3, 423, 143	•	0	0	8. 00
9.00	Other current assets	36, 208, 565		0	0	9.00
10. 00 11. 00	Due from other funds	418, 689 98, 290, 824	•	0	0	10.00 11.00
11.00	Total current assets (sum of lines 1-10) FIXED ASSETS	90, 290, 024	l o	<u>U</u>	0	11.00
12. 00	Land	4, 445, 499	0	O	0	12.00
13. 00	Land improvements	6, 459, 678		Ö	0	13.00
14.00	Accumulated depreciation	-336, 406, 001	0	o	0	14.00
15. 00	Bui I di ngs	259, 822, 331	0	0	0	15.00
16. 00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	2, 639, 796		0	0	17.00
18. 00 19. 00	Accumulated depreciation Fixed equipment	0	0	0	0	18. 00 19. 00
20.00	Accumulated depreciation	0	0	0	0	20.00
21. 00	Automobiles and trucks		0	0	0	21.00
22. 00	Accumulated depreciation	ĺ	0	ol	0	22.00
23. 00	Maj or movable equipment	204, 276, 234	0	o	0	23.00
24.00	Accumulated depreciation	0	0	o	0	24.00
25. 00	Mi nor equi pment depreci abl e	0	0	0	0	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 29. 00	Accumulated depreciation	0	0	0	0	28. 00 29. 00
30.00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	141, 237, 537	0	0	0	30.00
30.00	OTHER ASSETS	141, 237, 337	0			30.00
31.00	Investments	138, 457, 735	0	0	0	31.00
32.00	Deposits on Leases	0	0	o	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35. 00	Total other assets (sum of lines 31-34)	138, 457, 735		0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	377, 986, 096	U U	0	0	36.00
37. 00	Accounts payable	18, 519, 562	0	ol	0	37.00
38. 00	Salaries, wages, and fees payable	0	O	o	0	38.00
39.00	Payrol I taxes payable	0	0	o	0	39.00
40.00	Notes and Loans payable (short term)	2, 317, 017	0	0	0	40.00
41. 00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0				42.00
43. 00 44. 00	Due to other funds Other current liabilities	154, 562 25, 605, 472		0	0	43. 00 44. 00
45.00	Total current liabilities (sum of lines 37 thru 44)	46, 596, 613		0		45.00
43.00	LONG TERM LIABILITIES	40, 370, 013	0	O		1 43.00
46.00	Mortgage payable	0	0	0	0	46. 00
47.00	Notes payable	64, 234, 151	0	o	0	47. 00
48.00	Unsecured Loans	0	0	0	0	48. 00
49. 00	Other long term liabilities	30, 986, 827		0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	95, 220, 978		0	0	50.00
51. 00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	141, 817, 591	0	0	0	51.00
52.00	General fund balance	236, 168, 505				52.00
53. 00	Specific purpose fund	200, 100, 000	0			53.00
54.00	Donor created - endowment fund balance - restricted			o		54.00
55.00	Donor created - endowment fund balance - unrestricted			o		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
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	236, 168, 505	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	377, 986, 096	1	ol	0	60.00
	[59]			Ĭ	Ü	
			,	'		

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 15-0002

					From 01/01/2016 To 12/31/2016		
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2. 00	3.00	4.00	5. 00	
1. 00 2. 00 3. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		231, 852, 464 4, 316, 041 236, 168, 505		(1. 00 2. 00 3. 00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Additions (credit adjustments) (specify)	0 0 0 0 0			0 0 0 0 0		5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0 0 0 0	0 236, 168, 505				13. 00 14. 00 15. 00 16. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)		0 236, 168, 505)	18. 00 19. 00
		Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8.00	_		
1. 00 2. 00 3. 00 4. 00 5. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0	0.00	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	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0 0 0 0 0		0 0		5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
17. 00 18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	0		0		17. 00 18. 00 19. 00

| Peri od: | Worksheet G-2 | From 01/01/2016 | Parts | & II | To 12/31/2016 | Date/Time Prepared: Health Financial Systems NSTATEMENT OF PATLENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0002

		Т	o 12/31/2016	Date/Time Pre 5/26/2017 1:1	
	Cost Center Description	I npati ent	Outpati ent	Total	, p
		1, 00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	70, 586, 054		70, 586, 054	1.00
2.00	SUBPROVI DER - I PF	4, 136, 239		4, 136, 239	2.00
3.00	SUBPROVI DER - I RF	8, 022, 185		8, 022, 185	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	İ			7. 00
8.00	NURSING FACILITY	İ			8.00
9.00	OTHER LONG TERM CARE	İ			9.00
10.00	Total general inpatient care services (sum of lines 1-9)	82, 744, 478		82, 744, 478	10.00
	Intensive Care Type Inpatient Hospital Services	<u> </u>			
11.00	INTENSIVE CARE UNIT	22, 789, 586		22, 789, 586	11.00
11. 01	NEONATAL I CU	0		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	22, 789, 586		22, 789, 586	16.00
	11-15)				
17.00	Total inpatient routine care services (sum of lines 10 and 16)	105, 534, 064		105, 534, 064	17. 00
18.00	Ancillary services	507, 363, 460	440, 706, 985	948, 070, 445	18. 00
19. 00	Outpati ent servi ces	24, 220, 897	93, 638, 111	117, 859, 008	19. 00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22. 00	HOME HEALTH AGENCY		3, 081, 205	3, 081, 205	22. 00
23.00	AMBULANCE SERVICES				23. 00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)				25.00
26. 00	HOSPI CE				26. 00
27. 00	PHYSI CI AN	0	,	7, 363, 292	27. 00
27. 01	PRO FEES	0	44, 143, 494	44, 143, 494	27. 01
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wks	st. 637, 118, 421	588, 933, 087	1, 226, 051, 508	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES		0.40 505 500		
29. 00	Operating expenses (per Wkst. A, column 3, line 200)	44 070 5/5	343, 535, 598		29. 00
30.00	HAF	11, 970, 565			30.00
31.00	OTHER	156, 332			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35. 00	Total additions (average lines 20.25)	0			35.00
36.00	Total additions (sum of lines 30-35)		12, 126, 897		36.00
37. 00	DEDUCT (SPECIFY)	0			37.00
38. 00		0			38.00
39. 00		0			39.00
40.00		0			40.00
41.00	Total deductions (sum of lines 27 41)	0			41.00
42. 00 43. 00	Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transport	efor	355, 662, 495		42. 00 43. 00
43.00	to Wkst. G-3, line 4)	121 01	300, 002, 495		43.00
	10 WK31. 0-3, 11116 4)	I	ı		I

llool +b	Financial Cystems METHODIST HOSDI	TALC INC	la li o	. of Form CMC 1	DEED 10
	Financial Systems METHODIST HOSPI METHODIST HOSPI METHODIST HOSPI METHODIST HOSPI	Provi der CCN: 15-0002	Peri od:	u of Form CMS-2 Worksheet G-3	
SIAIL	IENT OF REVENUES AND EXTENSES	11 0 VI del Celv. 13 0002	From 01/01/2016	WOT RSTICET O 5	
			To 12/31/2016	Date/Time Pre 5/26/2017 1:1	pared: 4 pm
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, li			1, 226, 051, 508	1.00
2.00	Less contractual allowances and discounts on patients' accounts on patients accounts on patients accounts and discounts on patients accounts accounts and discounts on patients.	nts		930, 097, 502	1
3.00	Net patient revenues (line 1 minus line 2)	40)		295, 954, 006	•
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		355, 662, 495	4.00
5. 00	Net income from service to patients (line 3 minus line 4) OTHER INCOME			-59, 708, 489	5.00
6. 00	Contributions, donations, bequests, etc		1	0	6.00
7. 00	Income from investments			0	
8. 00	Revenues from telephone and other miscellaneous communication	n sarvicas		0	
9. 00	Revenue from television and radio service	ii sei vi ces		0	1
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	•
12. 00	Parking lot receipts			0	
13. 00	Revenue from Laundry and Linen service			0	•
14.00	Revenue from meals sold to employees and guests			0	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other	than patients		0	16.00
17.00	Revenue from sale of drugs to other than patients	•		0	17. 00
18.00	Revenue from sale of medical records and abstracts			0	18.00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	
21.00	Rental of vending machines			0	
22. 00	Rental of hospital space			0	
23. 00	Governmental appropriations			0	
24. 00	OTHER OPERATING INCOME			4, 783, 459	1
24. 01	NON-OPERATING INCOME			35, 000	1
24. 02	UNREALI ZED GAI N/LOSS			2, 019, 894	
24. 03	REALIZED GAIN/LOSS ON INVESTMENT			1, 842, 397	
24. 04	GAIN/LOSS ON ASSET DI SPOSAL			0	
24. 05	I NVESTMENT I NCOME			3, 399, 262	
24. 06	MEDICALD DSH			51, 899, 485	•
24. 07 25. 00	OTHER ENTITIES Total other income (sum of lines 6-24)			259, 484 64, 238, 981	
	Total (line 5 plus line 25)			4, 530, 492	•
27. 00	FOUNDATION			4, 530, 492 214, 451	•
28. 00	Total other expenses (sum of line 27 and subscripts)			214, 451	1
	Net income (or loss) for the period (line 26 minus line 28)			4, 316, 041	
27. 30	1 (2. 1.000) 10. 11.0 por 100 (1.1.10 20 millios 11110 20)		I	., 5.5, 511	

	Financial Systems		METHODIST HOSE	PITALS, INC		In Lie	eu of Form CMS-	2552-10
COST A	LLOCATION - HHA GENERAL SERVICE	E COST		Provi der C	CN: 15-0002	Peri od: From 01/01/2016	Worksheet H-1 Part I	
				HHA CCN:	15-7536	To 12/31/2016	Date/Time Pre	
						Home Health	5/26/2017 1: 1 PPS	14 pm
			0			Agency I		
			Capital Rela	ated Costs				
		Net Expenses	BI dgs &	Movabl e	PI ant	Transportatio	Subtotal	
		for Cost Allocation	Fi xtures	Equi pment	Operation Maintenance		(cols. 0-4)	
		(from Wkst.			warrichane			
		H, col . 10)	1 00	2.00	2.00	4.00	44.00	
	GENERAL SERVICE COST CENTERS	0	1. 00	2. 00	3. 00	4. 00	4A. 00	
1. 00	Capital Related - Bldg. &	0	0				C	1.00
2. 00	Fixtures Capital Related - Movable	0		C				2.00
	Equi pment							
3. 00 4. 00	Plant Operation & Maintenance Transportation	0	0	C		0 0	C	3. 00 4. 00
5. 00	Administrative and General	700, 352	0	C		0 0		•
	HHA REIMBURSABLE SERVICES	011.010	ا				011.016	
6. 00 7. 00	Skilled Nursing Care Physical Therapy	814, 919 418, 770	0	C	1	0 0	814, 919 418, 770	1
8.00	Occupational Therapy	104, 431	o	C		0 0	104, 431	8. 00
9.00	Speech Pathology	44, 680	0	C		0 0	44, 680	
10. 00 11. 00	Medical Social Services Home Health Aide	2, 931 65, 654	0	C		0 0	2, 931 65, 654	1
12.00	Supplies (see instructions)	0	0	C		0 0	C	12.00
13. 00 14. 00	Drugs DME	0	0	C		0 0	C	
14.00	HHA NONREI MBURSABLE SERVI CES	0	O _I		4	0 0		14.00
15. 00	Home Dialysis Aide Services	0	0	C	1	0 0	_	
16. 00 17. 00	Respiratory Therapy Private Duty Nursing	0	0	C		0 0	C	
18. 00	Clinic	0	Ö	C	ó	0 0	Č	1
19.00	Health Promotion Activities	0	0	C		0 0	C	
20. 00 21. 00	Day Care Program Home Delivered Meals Program	0	0	C)	0 0	C	
22. 00	Homemaker Service	0	O	C		0 0	d	1
23.00	All Others (specify) Telemedicine	0	0	C		0 0	C	
23. 50 24. 00	Total (sum of lines 1-23)	2, 151, 737	0	C		0 0	2, 151, 737	
		Admi ni strati v	Total (col s.		•	'		
		e & General 5.00	4A + 5) 6.00					-
	GENERAL SERVICE COST CENTERS	0.00	0.00				l	
1. 00	Capital Related - Bldg. & Fixtures							1.00
2. 00	Capital Related - Movable							2.00
2 00	Equi pment							0.00
3. 00 4. 00	Plant Operation & Maintenance Transportation							3. 00 4. 00
5. 00	Administrative and General	700, 352						5.00
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	393, 232	1, 208, 151					6.00
7. 00	Physi cal Therapy	202, 073	620, 843					7.00
8. 00	Occupational Therapy	50, 392	154, 823					8.00
9. 00 10. 00	Speech Pathology Medical Social Services	21, 560 1, 414	66, 240 4, 345					9. 00 10. 00
11. 00	Home Heal th Ai de	31, 681	97, 335					11.00
12.00	Supplies (see instructions)	0	0					12.00
13. 00 14. 00	Drugs DME	0	0					13. 00 14. 00
00	HHA NONREIMBURSABLE SERVICES		Ψ ₁					1 55
15.00	Home Dialysis Aide Services	0	0					15. 00 16. 00
16. 00 17. 00	Respiratory Therapy Private Duty Nursing	0	0					17. 00
18.00	Clinic	O	0					18.00
19. 00 20. 00	Health Promotion Activities Day Care Program	0	0					19. 00 20. 00
21. 00	Home Delivered Meals Program		0					21.00
22.00	Homemaker Service	0	0					22.00
23. 00 23. 50	All Others (specify) Telemedicine	0	0					23. 00 23. 50
	Total (sum of lines 1-23)		2, 151, 737					24. 00

	Financial Systems		METHODIST HOS				u of Form CMS-2	
COST A	LLOCATION - HHA STATISTICAL BAS	SIS		Provi der C	CN: 15-0002	Peri od: From 01/01/2016	Worksheet H-1 Part II	
				HHA CCN:		To 12/31/2016	Date/Time Pre 5/26/2017 1:1	pared:
						Home Health	PPS	т рііі
						Agency I		
		Capital Rel	ated Costs					
		BI dgs &	Movabl e	Plant	Transportatio	Reconciliatio	Administrativ	
		Fi xtures	Equi pment	Operation &	n (MI LEAGE)	n	e & General	
		(SQUARE FEET)	(DOLLAR	Mai ntenance			(ACCUM. COST)	
			VALUE)	(SQUARE FEET)				
	T	1. 00	2. 00	3. 00	4. 00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS			I	-			
1. 00	Capital Related - Bldg. &	0				0		1.00
2 00	Fixtures		0					2 00
2. 00	Capital Related - Movable Equipment		0			0		2.00
3. 00	Plant Operation & Maintenance	0	0	_		0		3.00
4. 00	Transportation (see	0	0	0		0		4.00
4.00	instructions)		O					7.00
5.00	Administrative and General	o	0	0		0 -700, 352	1, 451, 385	5. 00
	HHA REIMBURSABLE SERVICES						, , , , , , , , , , , , , , , , , , , ,	
6.00	Skilled Nursing Care	0	0	0		0 0	814, 919	6.00
7.00	Physi cal Therapy	0	0	0		0 0	418, 770	7.00
8.00	Occupational Therapy	0	0	0		0 0	104, 431	8. 00
9. 00	Speech Pathology	0	0	0		0	44, 680	
10.00	Medical Social Services	0	0	0		0	2, 931	
11. 00	Home Health Aide	0	0	0		0	65, 654	
12.00	Supplies (see instructions)	0	0	0		0	0	
13.00	Drugs	0	0			0	0	
14. 00	DME HHA NONREI MBURSABLE SERVI CES	0	0	0		0 0	0	14.00
15. 00	Home Dialysis Aide Services	O	0	0		ol o	0	15.00
16. 00	Respiratory Therapy	0	0				0	10.00
17. 00	Private Duty Nursing	0	0			0 0	0	1
18. 00	Clinic	0	0	1		0 0	o o	
19. 00	Health Promotion Activities	0	0			0 0	0	
20.00	Day Care Program	o	0	l o		o o	o	
21.00	Home Delivered Meals Program	0	0	0		0 0	0	21.00
22.00	Homemaker Service	0	0	0		0 0	0	22. 00
	All Others (specify)	0	0	0		0 0	0	23. 00
23. 50	Tel emedi ci ne	0	0	0		0 0	0	23. 50
24. 00	Total (sum of lines 1-23)	0	0	0		0 -700, 352	1, 451, 385	
25.00	Cost To Be Allocated (per	0	0	0		0	700, 352	25. 00
0/ 00	Worksheet H-1, Part I)	0.00000	0.000000	0.00000	0 00000		0 4005 10	2/ 22
76 ()()	Unit Cost Multiplier	0. 000000	0. 000000	0.000000	0.00000	UI	0. 482540	1 26.00

							5/26/2017 1: 1	4 pm
						Home Health	PPS	
			CAPI TAL			Agency I		
			RELATED COSTS					
	Cost Center Description	HHA Trial	BLDG & FLXT	EMPLOYEE	DATA	PURCHASI NG	ADMI TTI NG	
	oost deriter beserretron	Bal ance (1)	DEDG & TTAT	BENEFITS	PROCESSI NG	RECEIVING AND	7.Diiii 111110	
		Bur unce (1)		DEPARTMENT	1 KOOLOOT NO	STORES		
		0	1. 00	4. 00	5. 01	5. 02	5. 03	
1. 00	Administrative and General	0	0	427, 611	C	6, 820	7, 854	1.00
2.00	Skilled Nursing Care	1, 208, 151	0	0	C	0	0	2.00
3.00	Physi cal Therapy	620, 843	0	0	(0	0	3.00
4.00	Occupational Therapy	154, 823	0	0	C	0	0	4.00
5.00	Speech Pathology	66, 240	0	0	(0	0	5.00
6. 00	Medical Social Services	4, 345	0	0	(0	0	6.00
7. 00	Home Heal th Ai de	97, 335	0	0	C	1	0	7.00
8.00	Supplies (see instructions)	0	0	0	C	1	0	8.00
9.00	Drugs	0	0	0		1	0	9.00
10. 00 11. 00	DME Home Dialysis Aide Services	0	0	0		-	0	10. 00 11. 00
12. 00	Respiratory Therapy	0	0	0		1	0	12.00
13. 00	Pri vate Duty Nursing	0	0	0		,	0	13.00
14. 00	Clinic	0	0	0		1	0	14. 00
15. 00	Health Promotion Activities	0	o O	0		-	ő	15. 00
16. 00	Day Care Program	l o	o	0	d	o o	o	16.00
17.00	Home Delivered Meals Program	0	0	0	C	0	0	17.00
18.00	Homemaker Service	0	0	0	C	0	0	18.00
19.00	All Others (specify)	0	0	0	C	0	0	19.00
19. 50	Tel emedi ci ne	0	0	0	C	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	2, 151, 737	0	427, 611	C	6, 820	7, 854	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.							
	Cost Center Description	CASHI ERI NG/AC	Subtotal	OTHER A&G	PATI ENT	OPERATION OF	LAUNDRY &	
	oost conten beschiptron	COUNTS	Subtotal	OTHER AGO	TRANSPORTATIO		LINEN SERVICE	
		RECEI VABLE			N			
		5. 04	5A. 04	5. 05	5. 06	7. 00	8. 00	
1.00	Administrative and General	14, 140	456, 425	58, 929	C	0	0	1.00
2.00	Skilled Nursing Care	0	1, 208, 151	155, 983	C	0	0	2.00
3.00	Physical Therapy	0	620, 843	80, 156	C	0	0	3.00
4.00	Occupational Therapy	0	154, 823	19, 989	(0	0	4.00
5. 00	Speech Pathology	0	66, 240	8, 552	C	-	0	5.00
6.00	Medical Social Services	0	4, 345	561	C	1	0	6.00
7. 00	Home Heal th Ai de	0	97, 335	12, 567		1	0	7.00
8. 00 9. 00	Supplies (see instructions)	0	U	0			0	8.00
10.00	Drugs DME	0	0	0			0	9. 00 10. 00
11. 00	Home Dialysis Aide Services	0	0	0			0	11.00
12. 00	Respiratory Therapy	0	0	0			0	12.00
13. 00	Pri vate Duty Nursing	0	0	0		o o	0	13.00
14. 00		l o	0	0		o o	ő	14. 00
15. 00	Health Promotion Activities	0	0	0	Ċ	0	0	15.00
16.00	Day Care Program	0	0	0	C	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	(0	0	17.00
18.00	Homemaker Service	0	0	0	C	0	0	18.00
19. 00	All Others (specify)	0	0	0	C	0	0	19.00
			_	Λ) 0	0	19. 50
19. 50	Tel emedi ci ne	0	이	o _l	١	,	l o	
20.00	Total (sum of lines 1-19) (2)	0 14, 140		336, 737	(o o	0	20.00
	Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	0 14, 140	2, 608, 162 0. 000000	336, 737	C	0	0	
20.00	Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	0 14, 140		336, 737	C	0	0	20.00
20.00	Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus	0 14, 140		336, 737 336, 737	C	0	0	20.00
20.00	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	0 14, 140		336, 737	C	0	0	20.00
20.00	Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus	0 14, 140		336, 737	C	0	0	20.00

⁽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.

0

0

0

0

0

0

0 0

0

14.00

15.00

16.00

17.00

18.00

19.00

19.50 20.00

21.00

0

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C

C

4, 514

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0

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0

0

12,004

14.00

15.00

16.00

17.00

18.00

19.00

19.50

20 00

21.00

Clinic

Day Care Program

Homemaker Service

6 decimal places.

Tel emedi ci ne

All Others (specify)

Health Promotion Activities

Home Delivered Meals Program

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

Unit Cost Multiplier: column

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

⁽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 01/01/2016 Part I
To 12/31/2016 Date/Time Prepared: 5/26/2017 1:14 pm Provider CCN: 15-0002 HHA CCN: 15-7536 Home Health PPS

						nome near th	PPS	
	Cost Center Description	PARAMED ED	Cubtotal	Intorn 0	Subtotal	Agency I Allocated HHA	Total HHA	
	cost center bescription		Subtotal	Intern &	Subtotai			
		PROGRAM		Residents		A&G (see Part	Costs	
				Cost & Post		11)		
				Stepdown Adjustments				
		23. 00	24. 00	25. 00	26.00	27. 00	28. 00	
1. 00	Administrative and General	23.00	538, 199	25.00	538, 199		20.00	1.00
2. 00	Skilled Nursing Care	0	1, 364, 134	0	1, 364, 134	1	1, 666, 320	
3.00	Physical Therapy	0	700, 999	0	700, 999		856, 286	
4. 00	Occupational Therapy	0	174, 812	0	174, 812		213, 537	
5. 00	Speech Pathology	0	74, 792	0	74, 792		91, 360	
		0	4, 792 4, 906		4, 906		·	
6. 00 7. 00	Medical Social Services Home Health Aide	0	4, 906 109, 902	0			5, 993	
		0	109, 902	0	109, 902	24, 346	134, 248	
8.00	Supplies (see instructions)	0	0	0			0	8.00
9.00	Drugs	0	0	0		0	0	9.00
10.00	DME	0	0	0		0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15. 00
16. 00	Day Care Program	0	0	0	0	0	0	16. 00
17. 00	Home Delivered Meals Program	0	0	0	0	0	0	17. 00
18.00	Homemaker Service	0	0	0	0	0	0	18. 00
19. 00	All Others (specify)	0	0	0	0	0	0	19. 00
19. 50	Tel emedi ci ne	0	0	0	0	0	0	19. 50
20.00	Total (sum of lines 1-19) (2)	0	2, 967, 744	0	2, 967, 744		2, 967, 744	
21. 00	Unit Cost Multiplier: column					0. 221523		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.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provi der CCN: 15-0002 HHA CCN: 15-7536	From 01/01/2016 To 12/31/2016	Worksheet H-2 Part II Date/Time Prepared: 5/26/2017 1:14 pm
		Home Health	PPS

						Home Health Agency I	PPS	
		CAPI TAL				Agency		
		RELATED COSTS						
	Cost Center Description	BLDG & FIXT	EMPLOYEE	DATA	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/AC	
		(SQUARE FEET)	BENEFITS	PROCESSI NG	RECEIVING AND	(GROSS	COUNTS	
			DEPARTMENT	(MACHINE	STORES	CHARGES)	RECEI VABLE	
			(GROSS	TIME)	(PURCHASE		(GROSS	
		1.00	SALARI ES)	F 04	REQUISITIONS)	F 00	CHARGES)	
1 00	Administrative and Conoral	1.00	4. 00	5. 01 0	5. 02	5. 03	5. 04	1 00
1. 00 2. 00	Administrative and General Skilled Nursing Care	0	1, 843, 483	0	75, 251 0		3, 081, 207	1. 00 2. 00
3. 00	Physical Therapy	0	0	0	0	_	1	3. 00
4. 00	Occupational Therapy	0	0	0		0	0	4. 00
5. 00	Speech Pathology	o o	0	0	ĺ	0	l o	5. 00
6. 00	Medical Social Services	0	0	0	Ö	0	o	6. 00
7. 00	Home Health Aide	0	0	0	0	0	o	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	o	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0		0	10.00
11. 00	Home Dialysis Aide Services	0	0	0	0	_	0	11. 00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0		1	13.00
14. 00 15. 00	Clinic	0	0	0	0	0	0	14. 00 15. 00
16. 00	Health Promotion Activities Day Care Program		0	0		0	0	16. 00
17. 00	Home Delivered Meals Program	0	0	0		0	0	17. 00
18. 00	Homemaker Service	0	0	0		0	0	18. 00
19. 00	All Others (specify)	0	0	0	١	0	o o	19. 00
19. 50	1	0	0	0	l o	0	l o	19. 50
20.00	Total (sum of lines 1-19)	0	1, 843, 483	0	75, 251	3, 081, 207	3, 081, 207	20.00
21.00	Total cost to be allocated	0	427, 611	0	6, 820	7, 854	14, 140	21.00
22. 00		0. 000000	0. 231958	0.000000	0. 090630	0.002549	0. 004589	22.00
	Cost Center Description	Reconciliatio	OTHER A&G	PATI ENT	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	22.00
	Cost Center Description	Reconciliatio n		TRANSPORTATI 0	PLANT	LINEN SERVICE		22.00
	Cost Center Description		OTHER A&G	TRANSPORTATION		LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG	22.00
	Cost Center Description		OTHER A&G	TRANSPORTATIO N (NUMBER OF	PLANT	LINEN SERVICE	HOUSEKEEPI NG	22.00
	Cost Center Description		OTHER A&G	TRANSPORTATION	PLANT	LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG	22.00
1.00	Cost Center Description	n	OTHER A&G (ACCUM. COST)	TRANSPORTATIO N (NUMBER OF TRIPS)	PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET) 9.00	1.00
1. 00 2. 00	·	n 5A. 05	OTHER A&G (ACCUM. COST)	TRANSPORTATION N (NUMBER OF TRIPS) 5.06	PLANT (SQUARE FEET) 7.00	LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00	HOUSEKEEPI NG (SQUARE FEET) 9.00	
2. 00 3. 00	Administrative and General Skilled Nursing Care Physical Therapy	5A. 05	OTHER A&G (ACCUM. COST) 5. 05 456, 425 1, 208, 151 620, 843	TRANSPORTATION N (NUMBER OF TRIPS) 5.06	PLANT (SQUARE FEET) 7.00 0 0 0	LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0	HOUSEKEEPI NG (SQUARE FEET) 9.00 0 0 0	1. 00 2. 00 3. 00
2. 00 3. 00 4. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy	5A. 05	OTHER A&G (ACCUM. COST) 5. 05 456, 425 1, 208, 151 620, 843 154, 823	TRANSPORTATION N (NUMBER OF TRIPS) 5.06	PLANT (SQUARE FEET) 7.00 0 0 0 0	LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0	9. 00 9. 00 0 0 0	1. 00 2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	5A. 05	OTHER A&G (ACCUM. COST) 5. 05 456, 425 1, 208, 151 620, 843 154, 823 66, 240	TRANSPORTATIONN (NUMBER OF TRIPS) 5.06 0 0 0 0	PLANT (SQUARE FEET) 7.00 0 0 0 0 0 0	LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 0	9.00 9.00 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00 6. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	5A. 05	OTHER A&G (ACCUM. COST) 5. 05 456, 425 1, 208, 151 620, 843 154, 823 66, 240 4, 345	TRANSPORTATION N (NUMBER OF TRIPS) 5.06	PLANT (SQUARE FEET) 7.00 0 0 0 0 0 0 0	LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 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
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	5A. 05	OTHER A&G (ACCUM. COST) 5. 05 456, 425 1, 208, 151 620, 843 154, 823 66, 240	TRANSPORTATIONN (NUMBER OF TRIPS) 5.06 0 0 0 0	PLANT (SQUARE FEET) 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 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 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	5A. 05	OTHER A&G (ACCUM. COST) 5. 05 456, 425 1, 208, 151 620, 843 154, 823 66, 240 4, 345	TRANSPORTATIONN (NUMBER OF TRIPS) 5.06 0 0 0 0	7.00 7.00 0 0 0 0 0 0	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	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	5A. 05	OTHER A&G (ACCUM. COST) 5. 05 456, 425 1, 208, 151 620, 843 154, 823 66, 240 4, 345	TRANSPORTATIONN (NUMBER OF TRIPS) 5.06 0 0 0 0	PLANT (SQUARE FEET) 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 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 7.00 8.00 9.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	5A. 05	OTHER A&G (ACCUM. COST) 5. 05 456, 425 1, 208, 151 620, 843 154, 823 66, 240 4, 345	TRANSPORTATIONN (NUMBER OF TRIPS) 5.06 0 0 0 0	7.00 7.00 0 0 0 0 0 0	B. 00 8. 00 0 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	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	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	5A. 05	OTHER A&G (ACCUM. COST) 5. 05 456, 425 1, 208, 151 620, 843 154, 823 66, 240 4, 345	TRANSPORTATIONN (NUMBER OF TRIPS) 5.06 0 0 0 0	7.00 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	B. 00 8. 00 0 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	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	5A. 05	OTHER A&G (ACCUM. COST) 5. 05 456, 425 1, 208, 151 620, 843 154, 823 66, 240 4, 345	TRANSPORTATIONN (NUMBER OF TRIPS) 5.06 0 0 0 0	7.00 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	B. 00 8. 00 0 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	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy	5A. 05	OTHER A&G (ACCUM. COST) 5. 05 456, 425 1, 208, 151 620, 843 154, 823 66, 240 4, 345	TRANSPORTATIONN (NUMBER OF TRIPS) 5.06 0 0 0 0	7.00 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	B. 00 8. 00 0 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	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 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	5A. 05	OTHER A&G (ACCUM. COST) 5. 05 456, 425 1, 208, 151 620, 843 154, 823 66, 240 4, 345	TRANSPORTATIONN (NUMBER OF TRIPS) 5.06 0 0 0 0	7.00 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	B. 00 8. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 9.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 14.00 15.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	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	5A. 05	OTHER A&G (ACCUM. COST) 5. 05 456, 425 1, 208, 151 620, 843 154, 823 66, 240 4, 345	TRANSPORTATIONN (NUMBER OF TRIPS) 5.06 0 0 0 0	7.00 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	B. 00 8. 00 0 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
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	5A. 05	OTHER A&G (ACCUM. COST) 5. 05 456, 425 1, 208, 151 620, 843 154, 823 66, 240 4, 345	TRANSPORTATIONN (NUMBER OF TRIPS) 5.06 0 0 0 0	7.00 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	B. 00 8. 00 0 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
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	5A. 05	OTHER A&G (ACCUM. COST) 5. 05 456, 425 1, 208, 151 620, 843 154, 823 66, 240 4, 345	TRANSPORTATIONN (NUMBER OF TRIPS) 5.06 0 0 0 0	7.00 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	B. 00 8. 00 0 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
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00	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)	5A. 05	OTHER A&G (ACCUM. COST) 5. 05 456, 425 1, 208, 151 620, 843 154, 823 66, 240 4, 345	TRANSPORTATIONN (NUMBER OF TRIPS) 5.06 0 0 0 0	7.00 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	B. 00 8. 00 0 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
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	5A. 05	0THER A&G (ACCUM. COST) 5. 05 456, 425 1, 208, 151 620, 843 154, 823 66, 240 4, 345 97, 335 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	TRANSPORTATIONN (NUMBER OF TRIPS) 5.06 0 0 0 0	7.00 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	B. 00 8. 00 0 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
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00 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)	5A. 05	5. 05 456, 425 1, 208, 151 620, 843 154, 823 66, 240 4, 345 97, 335 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	TRANSPORTATIONN (NUMBER OF TRIPS) 5.06 0 0 0 0	7.00 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	B. 00 8. 00 0 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 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) Total cost to be allocated	5A. 05	0THER A&G (ACCUM. COST) 5. 05 456, 425 1, 208, 151 620, 843 154, 823 66, 240 4, 345 97, 335 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	TRANSPORTATION N (NUMBER OF TRIPS) 5.06 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	PLANT (SQUARE FEET) 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8. 00 8. 00 0 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 15.00 16.00 17.00 18.00 19.00 19.50 20.00 21.00

Peri od: Worksheet H-2
From 01/01/2016 Part II
To 12/31/2016 Date/Time Prepared: 5/26/2017 1:14 pm BASIS HHA CCN: 15-7536

						Home Health Agency I	PPS	<u> </u>
	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	
		SERVED)	11001(3)	(DI RECT NURS.	(COSTED	REGUIS.)	(GROSS	
				HRS.)	REQUIS.)		CHARGES)	
1. 00	Administrative and General	10. 00	11. 00	13. 00	14.00	15. 00 14, 124	16. 00 3, 081, 207	1. 00
2. 00	Skilled Nursing Care		0			14, 124	3,001,207	2.00
3.00	Physical Therapy	O	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			0	5. 00 6. 00
7. 00	Home Heal th Aide		0		_		0	7. 00
8. 00	Supplies (see instructions)	O	0	0	l .		0	8. 00
9.00	Drugs	0	0	0	0	0	0	9.00
10. 00 11. 00	DME Home Dialysis Aide Services	0	0	0	0		0	10. 00 11. 00
12. 00	Respiratory Therapy		0				0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	1		0	14.00
15. 00 16. 00	Health Promotion Activities Day Care Program	0	0	0	0	0	0	15. 00 16. 00
17. 00	Home Delivered Meals Program	Ö	0	Ö	ő	o	0	17. 00
18.00	Homemaker Service	О	0	0	0	0	0	18. 00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19. 50 20. 00	Telemedicine Total (sum of lines 1-19)	0	0	0	0	14, 124	3, 081, 207	19. 50 20. 00
21. 00	Total cost to be allocated	Ö	0	Ö	Ö		12, 004	
22. 00	Unit cost multiplier	0. 000000	0. 000000	0. 000000			0. 003896	22.00
					INTERNS &	RESI DENTS		
	Cost Center Description	SOCI AL	STAFF	MEDI CAL	SERVI CES-SALA	SERVI CES-OTHE	PARAMED ED	
		SERVI CE	EDUCATION	EDUCATI ON	RY & FRINGES	R PRGM COSTS	PROGRAM	
		(TIME SPENT)	(TIME SPENT)	(ASSI GNED TIME)	(ASSIGNED TIME)	(ASSI GNED TIME)	(ASSIGNED TIME)	
		17. 00	17. 01	17. 02	21.00	22. 00	23. 00	
1. 00	Administrative and General	0	1, 269				0	1.00
2. 00 3. 00	Skilled Nursing Care Physical Therapy	0	0	0		0	0	2. 00 3. 00
4. 00	Occupational Therapy		0		_	0	0	4.00
5.00	Speech Pathology	O	0	0	0	0	0	5. 00
6.00	Medical Social Services	0	0	0	_		0	6.00
7. 00 8. 00	Home Health Aide Supplies (see instructions)	0	0	0	0		0	7. 00 8. 00
9. 00	Drugs	Ö	0	Ö	ő	o	0	9. 00
10.00	DME	O	0	0	_	0	0	10. 00
11. 00 12. 00	Home Dialysis Aide Services	0	0	0	0	0	0	11. 00 12. 00
13.00	Respiratory Therapy Private Duty Nursing		0		1		0	13.00
14. 00	Clinic	Ö	0	Ö			0	14.00
15.00	Health Promotion Activities	0	0	0			0	
16. 00 17. 00	Day Care Program Home Delivered Meals Program	0	0	0			0	16. 00 17. 00
18. 00	Homemaker Service		0		ő	o	0	18.00
19. 00	All Others (specify)	0	0	0	_		0	19. 00
19. 50	Telemedicine	0	0	0	0	_	0	19.50
20. 00 21. 00	Total (sum of lines 1-19) Total cost to be allocated		1, 269 4, 514			0	0	20. 00 21. 00
	Unit cost multiplier	0. 000000	3. 557132			0. 000000	-	

llool +b	Financial Cyatama		METHODI CT. HOC	DITALC INC		la lia	u of Form CMC 1	DEED 10
	<u>Financial Systems</u> TONMENT OF PATIENT SERVICE COST	rs .	METHODIST HOS	Provi der C	CN: 15-0002	Peri od:	u of Form CMS-2 Worksheet H-3	
74 1 0101	TOWNERT OF TATTENT SERVICE 6031	. 3		HHA CCN:	15-7536	From 01/01/2016 To 12/31/2016	Part I Date/Time Pre	pared:
				Titl∈	· XVIII	Home Health Agency I	5/26/2017 1:1 PPS	4 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 ÷	
		0	Part I)	Part II)	2.00	4.00	col . 4) 5.00	
	PART I - COMPUTATION OF LESSER		1.00	2.00	3.00			
	COST LIMITATION	OI AGGREGATE	FROGRAM COST, I	AGGREGATE OF T	IL FROGRAM LI	WITATION COST, C	N DENETTOTAKT	
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	1, 666, 320		1, 666, 32	20 10, 582	157. 47	1.00
2.00	Physi cal Therapy	3.00	856, 286	0	856, 28	5, 040	169. 90	2.00
3.00	Occupational Therapy	4.00	213, 537	0	213, 5	37 1, 142	186. 99	3.00
4.00	Speech Pathology	5.00			91, 30	50 303	301. 52	4.00
5.00	Medical Social Services	6.00			5, 9	93 14	428. 07	5.00
6.00	Home Health Aide	7.00			134, 2			
7. 00	Total (sum of lines 1-6)		2, 967, 744					7. 00
	(2000)				Program Visi			
					g			
					P	art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject	Subject to		
					to	Deducti bl es		
					Deductibles	&		
					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	_, _,			9. 00
10.00	Occupational Therapy		23844	0	1	58		10.00
11. 00	Speech Pathology		23844	0	•	32		11.00
12.00	Medical Social Services		23844	0		7		12.00
13.00	Home Heal th Aide		23844	0	., -			13.00
14. 00			E	0	- 1		Dalla (all 0	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	ati ons						
	Cost of Medical Supplies Cost of Drugs	8. 00 9. 00	0	0		0 0		•
			Program Visits		Cost of Services			
				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	
		/ 00	Coi nsurance	0.00	0.00	Coi nsurance	44.00	
	DART I COMPUTATION OF LESSER	6. 00	7. 00	8.00	9. 00	10. 00	11.00	
	PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation	OF AGGREGATE	PRUGRAM CUSI, A	AGGREGATE OF T	HE PRUGRAW LI	MITATION COST, C	JR BENEFICIARY	
1. 00	Skilled Nursing Care	0	3, 555			0 559, 806		1.00
2.00	Physical Therapy		2, 268			0 385, 333		2.00
3. 00	Occupational Therapy		458			0 85, 641		3.00
4. 00	Speech Pathology		132			0 39, 801		4.00
5. 00	Medical Social Services		7			0 2, 996		5.00
6. 00	Home Heal th Ai de		1, 011			0 59, 578		6.00
7. 00	Total (sum of lines 1-6)	Ö				0 1, 133, 155		7. 00
				•	•	,	•	

Heal th	Financial Systems		METHODIST HOS	SPITALS. INC		In Lie	u of Form CMS-:	2552-10
	TIONMENT OF PATIENT SERVICE COST	ΓS		Provi der C		Peri od: From 01/01/2016	Worksheet H-3 Part I	3
				HHA CCN:	15-7536	To 12/31/2016	Date/Time Pre 5/26/2017 1:1	
				Title	XVIII	Home Health	PPS	ТРШ
						Agency I		
	Cost Center Description							
	The second second	6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
0.00	Limitation Cost Computation							
8. 00 9. 00	Skilled Nursing Care Physical Therapy							8. 00 9. 00
9. 00 10. 00	Occupational Therapy							10.00
11. 00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13. 00	Home Heal th Aide							13.00
	Total (sum of lines 8-13)							14.00
		Progr	ram Covered Ch	arges	Cost of			
				· ·	Servi ces			
				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	
		6. 00	Coi nsurance 7.00	8.00	9. 00	Coi nsurance 10.00	11. 00	
	Supplies and Drugs Cost Comput		7.00	0.00	7.00	10.00	11.00	
15. 00	Cost of Medical Supplies	0	C	0		0 0	0	15.00
	Cost of Drugs	_		l .		0	0	
	Cost Center Description	Total Program		'	•	•		
		Cost (sum of						
		col s. 9-10)						
		12. 00						
	PART I - COMPUTATION OF LESSER	OF AGGREGATE	PROGRAM COSI,	AGGREGATE OF TH	HE PROGRAM L	IMITATION COST, C	R BENEFICIARY	
	COST LIMITATION Cost Per Visit Computation							-
1. 00	Skilled Nursing Care	559, 806						1.00
2. 00	Physical Therapy	385, 333						2.00
3. 00	Occupational Therapy	85, 641						3.00
4. 00	Speech Pathology	39, 801						4.00
5.00	Medical Social Services	2, 996						5.00
6.00	Home Health Aide	59, 578						6.00
7.00	Total (sum of lines 1-6)	1, 133, 155						7.00
	Cost Center Description							
	To a contract of the contract	12. 00						
	Limitation Cost Computation	Γ	T					
8. 00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10. 00 11. 00	Occupational Therapy Speech Pathology							10.00
12.00	Medical Social Services							12.00
13. 00	Home Health Aide							13.00
	Total (sum of lines 8-13)							14.00
	(Sum 81 11.168 8 10)	I	I					,

Heal th	Financial Systems		METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
APPORT	TIONMENT OF PATIENT SERVICE COST	ΓS		Provi der C	CN: 15-0002	Peri od: From 01/01/2016	Worksheet H-3 Part II	
				HHA CCN:	15-7536	To 12/31/2016	Date/Time Pre 5/26/2017 1:1	
				Title	XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Charge Ratio	Charge (from	Ancillary	Part I as		1
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1. 00	2. 00	3.00	4. 00		
	PART II - APPORTIONMENT OF COS	T OF HHA SERVI	CES FURNISHED E	BY SHARED HOSP	ITAL DEPARTME	NTS		
1.00	Physi cal Therapy	66.00	0. 368774	0		0 col. 2, line 2	. 00	1.00
2.00	Occupational Therapy	67.00	0. 380802	0		Ocol. 2, line 3	. 00	2.00
3.00	Speech Pathology	68.00	0. 368445	0		Ocol. 2, line 4	. 00	3.00
4.00	Cost of Medical Supplies	71.00	0. 349730	0)	0 col. 2, line 1	5. 00	4.00
5.00	Cost of Drugs	73.00	0. 157740	0		0 col. 2, line 1	6. 00	5.00

	Financial Systems METHODIST HOSPIT ATION OF HHA REIMBURSEMENT SETTLEMENT	ALS, INC Provider C	CN: 15_0002	Por	<u>In Lie</u> i iod:	u of Form CMS-2 Worksheet H-4	
LCUL	ATION OF HEA REIMBURSEMENT SETTLEMENT			Fro	m 01/01/2016	Part I-II	
		HHA CCN:	15-7536	То	12/31/2016	Date/Time Pre 5/26/2017 1:1	
		Title	XVIII	Н	ome Health	PPS	т рп
				4	Agency I	+ D	
			Part A		Par Not Subject	Subject to	
			1 4 4 7 7	'	to	Deductibles &	
					eductibles &	Coi nsurance	
			1.00	(Coi nsurance 2. 00	3. 00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTO	OMARY CHARGI			2.00	3.00	
	Reasonable Cost of Part A & Part B Services						
00	Reasonable cost of services (see instructions)			0	0	0	1
00	Total charges Customary Charges			0	0	0	2
00	Amount actually collected from patients liable for payment fo	r servi ces		0	0	0	3
	on a charge basis (from your records)						
00	Amount that would have been realized from patients liable for for services on a charge basis had such payment been made in			0	0	0	4
	with 42 CFR §413.13(b)	accoi dance					
00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	000	0. 000000	0.000000	5
00	Total customary charges (see instructions)			0	0	0	6
00	Excess of total customary charges over total reasonable cost only if line 6 exceeds line 1)	(complete		0	0	0	7
00	Excess of reasonable cost over customary charges (complete on 1 exceeds line 6)	lyifline		0	0	0	8
00	Primary payer amounts			0	793	0	9
					Part A	Part B	
					Servi ces	Servi ces	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				1.00	2. 00	
	Total reasonable cost (see instructions)				1.00	2. 00	
00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers				1.00	2. 00 -793 1, 102, 245	11
00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers				1.00	2.00 -793 1,102,245 30,998	11 12
00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers				1.00 0 0	2. 00 -793 1, 102, 245	11 12 13
00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers				1.00 0 0 0	2. 00 -793 1, 102, 245 30, 998 26, 157 27, 456 2, 186	11 12 13 14 15
00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes				1.00 0 0 0	2. 00 -793 1, 102, 245 30, 998 26, 157 27, 456 2, 186 3, 385	11 12 13 14 15 16
00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments				1.00 0 0 0	2.00 -793 1,102,245 30,998 26,157 27,456 2,186 3,385 0	11 12 13 14 15 16
00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments				1.00 0 0 0	2.00 -793 1,102,245 30,998 26,157 27,456 2,186 3,385 0 0	11 12 13 14 15 16 17
00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments				1.00 0 0 0	2.00 -793 1,102,245 30,998 26,157 27,456 2,186 3,385 0	11 12 13 14 15 16 17 18
00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments				1.00 0 0 0 0 0 0 0 0	2.00 -793 1,102,245 30,998 26,157 27,456 2,186 3,385 0 0	11 12 13 14 15 16 17 18 19 20
00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments				1.00 0 0 0 0 0 0 0 0	2.00 -793 1,102,245 30,998 26,157 27,456 2,186 3,385 0 0 0	11 12 13 14 15 16 17 18 19 20 21
00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins				1.00 0 0 0 0 0 0 0 0	2.00 -793 1,102,245 30,998 26,157 27,456 2,186 3,385 0 0 0 0	11 12 13 14 15 16 17 18 19 20 21
00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23)				1.00 0 0 0 0 0 0 0 0 0	2. 00 -793 1, 102, 245 30, 998 26, 157 27, 456 2, 186 3, 385 0 0 0 0 1, 191, 634	11 12 13 14 15 16 17 18 19 20 21 22 23
00 00 00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records)				1.00 0 0 0 0 0 0 0 0 0 0	2.00 -793 1,102,245 30,998 26,157 27,456 2,186 3,385 0 0 0 1,191,634 0 1,191,634	111 12 13 14 15 16 17 18 19 20 21 22 23 24 25
00 00 00 00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25)				1.00 0 0 0 0 0 0 0 0 0	2.00 -793 1,102,245 30,998 26,157 27,456 2,186 3,385 0 0 0 1,191,634 0 1,191,634	111 122 13 144 15 16 17 18 19 20 21 22 23 24 25 26
00 00 00 00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records)	urance)			1.00 0 0 0 0 0 0 0 0 0 0	2.00 -793 1,102,245 30,998 26,157 27,456 2,186 3,385 0 0 0 1,191,634 0 1,191,634	111 122 133 144 155 166 177 188 199 20 21 22 23 24 25 26 27
00 00 00 00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records)	urance) nstructi ons)		1.00 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 -793 1, 102, 245 30, 998 26, 157 27, 456 2, 186 3, 385 0 0 0 0 1, 191, 634 0 1, 191, 634 0 1, 191, 634	111 122 133 144 155 166 177 188 199 20 21 22 23 24 25 26 27 28
00 00 00 00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin	urance) nstructi ons)		1.00 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 -793 1, 102, 245 30, 998 26, 157 27, 456 2, 186 3, 385 0 0 0 1, 191, 634 0 1, 191, 634 1, 191, 634	111 122 133 144 155 166 177 188 199 200 211 222 233 244 255 266 277 28 29
00 00 00 00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin OTHER	urance) nstructi ons e 27))		1.00 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 -793 1, 102, 245 30, 998 26, 157 27, 456 2, 186 3, 385 0 0 0 1, 191, 634 0 1, 191, 634 1, 191, 634 -3, 055	111 122 133 144 155 166 177 188 199 200 211 222 233 244 255 266 277 288 299 300
00 00 00 00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin OTHER	urance) nstructi ons e 27))		1.00 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 -793 1,102,245 30,998 26,157 27,456 2,186 3,385 0 0 0 1,191,634 0 1,191,634 0 1,191,634 -3,055 0	111 122 133 144 155 166 177 188 199 200 211 222 233 244 255 266 277 288 299 300 300 300 300 300 300 300 300 300 3
00 00 00 00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin OTHER Pioneer ACO demonstration payment adjustment (see instruction Subtotal (see instructions)	urance) nstructi ons e 27))		1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 -793 1, 102, 245 30, 948 26, 157 27, 456 2, 186 3, 385 0 0 0 1, 191, 634 0 1, 191, 634 -3, 055 0 1, 188, 579	111 122 133 144 155 166 177 188 199 200 211 222 233 244 255 266 277 288 299 300 300 311
00 00 00 00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin OTHER Pioneer ACO demonstration payment adjustment (see instruction Subtotal (see instructions) Sequestration adjustment (see instructions)	urance) nstructi ons e 27))		1.00 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 -793 1,102,245 30,998 26,157 27,456 2,186 3,385 0 0 0 1,191,634 0 1,191,634 -3,055 0 1,188,579 23,772	111 122 133 144 155 166 177 188 199 200 211 222 233 244 255 266 277 288 299 300 310 311 311
00 00 00 00 00 00 00 00 00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin OTHER Pioneer ACO demonstration payment adjustment (see instruction Subtotal (see instructions) Sequestration adjustment (see instructions) Interim payments (see instructions)	urance) nstructi ons e 27))		1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 -793 1, 102, 245 30, 948 26, 157 27, 456 2, 186 3, 385 0 0 0 1, 191, 634 0 1, 191, 634 -3, 055 0 1, 188, 579	111 122 133 144 155 166 177 188 199 200 211 222 233 244 255 266 277 288 299 300 311 313 313 313
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin OTHER Pioneer ACO demonstration payment adjustment (see instruction Subtotal (see instructions) Sequestration adjustment (see instructions)	urance) nstructi ons; e 27) s))		1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 -793 1, 102, 245 30, 998 26, 157 27, 456 2, 186 3, 385 0 0 0 1, 191, 634 0 1, 191, 634 -3, 055 0 1, 188, 579 23, 772 1, 164, 807	111 122 133 144 155 166 177 188 199 200 211 222 233 244 255 266 277 288 299 300 311 311

Health Financial Systems	METHODI ST HOSI	PITALS, INC		In Lie	u of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED H TO PROGRAM BENEFICIARIES	IHAS FOR SERVICES RENDERED	Provi der	CCN: 15-0002	Peri od: From 01/01/2016	Worksheet H-5	
TO TROOM BENEFICIANTES		HHA CCN:	15-7536	To 12/31/2016	Date/Time Pre 5/26/2017 1:1	
				Home Health	PPS	
				Agency I		
		1	+ D + A	D	+ D	

				Home Health	PPS	. р
				Agency I	113	
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3.00	4. 00	
1. 00	Total interim payments paid to provider	11.00		0	1, 164, 807	1.00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for			0	0	2. 00
2 00	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					2 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each					3. 00
	payment. If none, write "NONE" or enter a zero. (1)					
2 01	Program to Provider					2 01
3. 01 3. 02				0	0	3. 01 3. 02
3. 02				0		3. 02
3. 04				Ö	0	3. 04
3. 05				Ö	l ol	3. 05
	Provider to Program					
3.50	•			0	0	3. 50
3. 51				0	0	3. 51
3. 52				0	0	3. 52
3. 53				0	0	3. 53
3. 54				0	0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0	1, 164, 807	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider					
5. 01	- rogram to rrottad.			0	0	5. 01
5. 02				O	l ol	5. 02
5.03				0	0	5. 03
	Provider to Program					
5. 50				0	0	5. 50
5. 51				0	0	5. 51
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 52 5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER			0	ol	6. 01
6. 02	SETTLEMENT TO PROGRAM			Ö	ا ا	6. 02
7. 00	Total Medicare program liability (see instructions)			0	1, 164, 807	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		C)	1. 00	2. 00	
8.00	Name of Contractor	I		1	ı	8.00

11 1. 11.	Financial Systems METHODIST HOS	DITALO INO		. C. E OHC. /	2550 40			
	u of Form CMS-2	2552-10						
CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0002	Peri od:	Worksheet L				
			From 01/01/2016 To 12/31/2016		narod:			
			10 12/31/2010	5/26/2017 1:1				
	PPS	. р						
				1. 00				
	PART I - FULLY PROSPECTIVE METHOD							
	CAPITAL FEDERAL AMOUNT							
1. 00	Capital DRG other than outlier	4, 057, 627	1.00					
1. 01	Model 4 BPCI Capital DRG other than outlier	0						
2.00	Capital DRG outlier payments		15, 552					
2. 01	Model 4 BPCI Capital DRG outlier payments	0						
3.00	Total inpatient days divided by number of days in the cost	239. 11						
4.00	Number of interns & residents (see instructions)	2. 98						
5.00	Indirect medical education percentage (see instructions)	0. 35	5. 00					
6.00	Indirect medical education adjustment (multiply line 5 by 1	1, columns 1 and	14, 202	6. 00				
	1.01)(see instructions)							
7. 00	Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions)	E, part A line	9. 83	7. 00				
8. 00	Percentage of Medicaid patient days to total days (see inst	tructions)		31. 24	8.00			
9. 00					9.00			
10.00	Allowable disproportionate share percentage (see instruction	ons)		41. 07 8 68	10.00			
11. 00	- · · · · · · · · · · · · · · · · · ·				11.00			
	Total prospective capital payments (see instructions)							
12.00	Total prospective capital payments (see Thisti detrons)			4, 439, 583	12.00			
			1. 00					
	PART II - PAYMENT UNDER REASONABLE COST							
1.00	Program inpatient routine capital cost (see instructions)				1.00			
2.00	Program inpatient ancillary capital cost (see instructions)				2.00			
3.00	Total inpatient program capital cost (line 1 plus line 2)				3.00			
4.00	Capital cost payment factor (see instructions)				4.00			
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5.00			
				1. 00				
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			11.00				
1.00	Program inpatient capital costs (see instructions)			0	1.00			
2.00	Program inpatient capital costs for extraordinary circumsta	ances (see instructions)		0	2.00			
3.00	Net program inpatient capital costs (line 1 minus line 2)			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 instructions)				6.00			
7.00	Adjustment to capital minimum payment level for extraordinary 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 applicable)				9.00			
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)				10.00			
11. 00	Carryover of accumulated capital minimum payment level over capital payment (from prior year				11. 00			
12. 00	Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)				12.00			
13. 00					13.00			
14. 00								
14.00	(if line 12 is negative, enter the amount on this line)	capital payment for the	ioi iowing periou	0	14.00			
15. 00	,	0	15.00					
16. 00	, , , , , , , , , , , , , , , , , , , ,							
	Current year operating and capital costs (see instructions)			0	17. 00			
	122 2 Joan onosperon or our amount (500 mort dott ons)		I	٥١				