	required by law (42 USC 1395				FORM APPROVE	D
payments made	since the beginning of the co	ost reporting period being	g deemed overpayments	(42 USC 1395g).	OMB NO. 0938	
					EXPIRES 05-3	1-2019
HOSPITAL AND H	OSPITAL HEALTH CARE COMPLEX (	COST REPORT CERTIFICATION	Provider CCN: 15-000		Worksheet S	
AND SETTLEMENT	SUMMARY			From 01/01/2017		
				To 12/31/2017	Date/Time Pr	
					5/30/2018 8:	23 am
PART I - COST	REPORT STATUS					
Provi der	1. [ X ] Electronically filed	cost report		Date: 5/30/20	18 Ti me:	8:23 am
use only	2. [ ] Manually submitted co	ost report				
	3. [ 0 ] If this is an amende	d report enter the number	of times the provide	er resubmitted this o	cost report	
	4. [ F ] Medicare Utilization	Enter "F" for full or "L	_" for low. '		'	
Contractor	5. [ 1 ]Cost Report Status	6. Date Received:	1	O. NPR Date:		
use only	(1) Ås Submitted	7. Contractor No.	1	1. Contractor's Vendo	or Code:	4
u	(2) Settled without Audit	8. [ N ] Initial Report fo	or this Provider CCN1	2. [ 0 ] If line 5, co	olumn 1 is 4:	Enter
	(3) Settled with Audit	9. N Final Report for	this Provider CCN	number of tim	nes reopened =	= 0-9.
	(4) Reopened					
	. , .					
	(5) Amended					

## PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by METHODIST HOSPITALS, INC (15-0002) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Si gned)	
	Officer or Administrator of Provider(s)
Title	
Title	
<del></del>	
Date	

	·		Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	1, 149, 911	138, 123	0	-479, 582	1.00
2.00	Subprovi der - IPF	0	43, 184	0		95, 493	2.00
3.00	Subprovi der - IRF	0	68, 365	0		33, 140	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	1		0	9. 00
200.00	Total	0	1, 261, 460	138, 124	0	-350, 949	200.00

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

	In-State	In-State	Out-of	Out-of	Medicaid	Other	
	Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
	pai d days	eligible	Medi cai d	Medi cai d		days	
		unpai d	pai d days	eligible			
		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, 171	13, 621	0	1, 331	9, 149	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	ו						
4, Medicaid HMO paid and eligible but unpaid days ir	ו						
column 5, and other Medicaid days in column 6.							
25.00 If this provider is an IRF, enter the in-state	88	533	0	0	303		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	<del>)</del>						
Medicaid eligible unpaid days in column 4, Medicaid							
HMO paid and eligible but unpaid days in column 5.							

Health Financial Systems METHODI	ST HOSE	PITALS, INC		1	n Lie	u of For	m CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider CC		Peri od:		Workshe		
				From 01/01. Γο 12/31.		Part I Date/Ti		
				Urban/Ru	ral C	5/30/20		2 am
				1. 00		2. (		
26.00 Enter your standard geographic classification (not wa			ginning of th	е	1			26. 00
cost reporting period. Enter "1" for urban or "2" for 27.00 Enter your standard geographic classification (not was			d of the cost		1			27. 00
reporting period. Enter in column 1, "1" for urban or	~ "2" f	or rural. If a						
enter the effective date of the geographic reclassifi 35.00 If this is a sole community hospital (SCH), enter the			CH status in		0			35. 00
effect in the cost reporting period.	- Hambe							
				Begi nni 1. 00		Endi 2. (		
36.00 Enter applicable beginning and ending dates of SCH st	atus.	Subscript line	36 for numbe		<u>'</u>	2. (	,,,	36. 00
of periods in excess of one and enter subsequent date			I. MDII I I					07.00
37.00 If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	the n	umber or perio	as MDH Status		0			37.00
37.01 Is this hospital a former MDH that is eligible for th	ne MDH	transitional p	ayment in	N				37. 01
accordance with FY 2016 OPPS final rule? Enter "Y" fo	or yes	or "N" for no.	(see					
38.00 If line 37 is 1, enter the beginning and ending dates								38. 00
greater than 1, subscript this line for the number of enter subsequent dates.	peri o	ds in excess o	f one and					
enter subsequent dates.				Y/N		Υ/	N	
				1.00	)	2. (		00.00
39.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i)				e N		N		39. 00
for yes or "N" for no. Does the facility meet the mil	eage r	equirements in	accordance					
with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column instructions)	1 2 "Y"	for yes or "N	" for no. (se	е				
40.00 Is this hospital subject to the HAC program reduction	adj us	tment? Enter "	Y" for yes or	N		N		40. 00
"N" for no in column 1, for discharges prior to Octob			yes or "N" fo	r				
no in column 2, for discharges on or after October 1.	(See	instructions)			V	XVIII	XIX	
					1.00	2.00	3. 00	
Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment	nt for	di sproporti ona	te share in a	ccordance	l N	Y	N	45. 00
with 42 CFR Section §412.320? (see instructions)					"	'	'`	43.00
46.00 Is this facility eligible for additional payment exce					N	N	N	46. 00
pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.	L, P	t. III and wks	t. L-1, Pt. 1	thi ough				
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.						N	N	47.00
48.00 Is the facility electing full federal capital payment Teaching Hospitals	: Ent	er "Y" Tor yes	or "N" Tor n	0.	N	N	N	48. 00
56.00 Is this a hospital involved in training residents in	approv	ed GME program	s? Enter "Y"	for yes	Y			56.00
or "N" for no. 57.00 If line 56 is yes, is this the first cost reporting p	neriod (	during which r	esidents in a	nnroved	N			57. 00
GME programs trained at this facility? Enter "Y" for					"			37.00
is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "\								
"N", complete Wkst. D, Parts III & IV and D-2, Pt. II			t E-4. II COI	ullin 2 15				
58.00 If line 56 is yes, did this facility elect cost reimb	ourseme	nt for physici	ans' servi ces	as	N			58. 00
defined in CMS Pub. 15-1, chapter 21, §2148? If yes, 59.00 Are costs claimed on line 100 of Worksheet A? If yes			. Pt. I.		N			59. 00
	,		NAHE 413.85	Workshee	et A	Pass-Th		
			Y/N	Li ne	#	Qualifi Crite		
						Cod		
40.00 Are you claiming pursing and allied health advertices	(NIALIE)	costs for	1. 00 Y	2. 00	)	3. (	00	60.00
60.00 Are you claiming nursing and allied health education any programs that meet the criteria under §413.85? (			,					60.00
60.01 If line 60 is yes, complete columns 2 and 3 for each	progra	m. (see			23. 00	2		60. 01
i nstructi ons)	Y/N	I ME	Direct GME	IME		Di rect	GME	
61.00 Did your hospital receive FTE slots under ACA	1. 00 N	2. 00	3. 00	4.00	0.00	5. (		61.00
section 5503? Enter "Y" for yes or "N" for no in					0.00		5. 00	51.00
column 1. (see instructions)								61 01
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports								61. 01
ending and submitted before March 23, 2010. (see								
instructions) 61.02 Enter the current year total unweighted primary care								61. 02
FTE count (excluding OB/GYN, general surgery FTEs,								
and primary care FTEs added under section 5503 of ACA). (see instructions)								
1 - 1 - 1 - 1 - 2 - 2 - 2 - 2 - 2 - 2 -	. 1		'	1		1	'	

HOSPITAL AND H	OSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	ATA	Provi der Co		Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Pre 5/30/2018 8:2	pared:
			Y/N	IME	Direct GME	I ME	Direct GME	
			1.00	2. 00	3.00	4. 00	5. 00	(1.0)
and/or g	ne base line FTE count for general surgery residents wing compliance with the cions)	s, which is used for						61.03
surgery	ne number of unweighted pallopathic and/or osteop cost reporting period.(s	pathic FTEs in the						61.04
and/or g pri mary	ne difference between the general surgery FTEs and care and/or general surg nus line 61.03). (see in	the current year's pery FTE counts (line						61.05
61.06 Enter th used for	ne amount of ACA §5503 av cap relief and/or FTEs general surgery. (see in	vard that is being that are nonprimary						61.06
			Pro	gram Name	Program Code	IME FTE Count	Unweighted Direct GME FTE Count	
61 10 Of the E	TEs in line 61.05, speci	fy each now program		1. 00	2.00	3. 00	4.00	61.10
for each column 1 program unweight FTE unwe	ry, if any, and the number new program. (see instr , the program name. Ente code. Enter in column 3, red count. Enter in colum eighted count.	ructions) Enter in er in column 2, the the IME FTE nn 4, the direct GME				0.00	0.00	(1.20
program resident instruct Enter in 3, the I	TEs in line 61.05, speci specialty, if any, and t as for each expanded prog- ions) Enter in column 1, a column 2, the program of ME FTE unweighted count.	the number of FTE gram. (see the program name. code. Enter in column Enter in column 4,				0.00	0.00	61. 20
							1. 00	
62.00 Enter th	risions Affecting the Hea ne number of FTE resident pital received HRSA PCRE	s that your hospital	trai nec			eriod for which	0.00	62.00
duri ng i Teachi ng	ne number of FTE resident n this cost reporting pe g Hospitals that Claim Re	eriod of HRSA THC procesidents in Nonprovid	gram. (s er Setti	see instruction	ons)	,	0.00	62.01
	facility trained residences yes or "N" for no in col						N	63.00
					Unwei ghted FTEs Nonprovi der Si te	FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
Section	5504 of the ACA Base Yea	ar FTF Residents in M	onnrovia	der Settings	1.00	2.00	3.00	
period t	hat begins on or after .	July 1, 2009 and befo	re June	30, 2010.				
in the b resident settings resident	ocolumn 1, if line 63 is nase year period, the num FTEs attributable to ro Enter in column 2 the FTEs that trained in you mum 1 divided by (column	nber of unweighted nor etations occurring in e number of unweighted our hospital. Enter in	n-primar all nor d non-pr n columr	ny care nprovider imary care n 3 the ratio	0. (	0.00	0. 000000	64.00
(23.9		Program Name		gram Code	Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1. 00		2. 00	Si te 3.00	4. 00	5. 00	-

2.00

3. 00

4. 00

5. 00

1. 00

	1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS				
70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovide	? Y			70.00
Enter "Y" for yes or "N" for no.				
71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the mos	: N		0	71.00
recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (se				
42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching				
program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no.				
Column 3: If column 2 is Y, indicate which program year began during this cost reporting perio	l.			
(see instructions)				
Inpatient Rehabilitation Facility PPS				
75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF	Y			75.00
subprovider? Enter "Y" for yes and "N" for no.				

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0002	Period: From 01/01/ To 12/31/	′2017 ′2017	Workshe Part I Date/Ti 5/30/20	me Pre	pared:
			1. 00	2. 00	3. 00	1
n.00 If line 75 is yes: Column 1: Did the facility have an approved recent cost reporting period ending on or before November 15, 2 no. Column 2: Did this facility train residents in a new teachi CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column indicate which program year began during this cost reporting periods.	004? Enter "Y" for yes ng program in accordan Jumn 3: If column 2 is	or "N" for ace with 42 ; Y,	N N	2.00	0	76. 0
				1. 0	0	
Long Term Care Hospital PPS  1.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes an old is this a LTCH co-located within another hospital for part or a second secon		ng period? [	Enter	N N		80. 0 81. 0
TEFRA Providers  1.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TE  1.00 Did this facility establish a new Other subprovider (excluded u §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			no.	N		85. 0 86. 0
0.00 Is this hospital an extended neoplastic disease care hospital c	lassified under section	n		N		87.0
1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		V		XLX		
Title V and XIX Services		1.00		2. 0	0	
Does this facility have title V and/or XIX inpatient hospital syes or "N" for no in the applicable column.	ervices? Enter "Y" for	· N		Υ		90.0
yes of N 10 His the applicable column.  100 Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the application.		N		N		91.0
.00 Are title XIX NF patients occupying title XVIII SNF beds (dual instructions) Enter "Y" for yes or "N" for no in the applicable	certification)? (see		ŀ	N		92.0
Does this facility operate an ICF/IID facility for purposes of "Y" for yes or "N" for no in the applicable column.		- N	ŀ	N		93.0
00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and applicable column.	"N" for no in the	N		N		94. (
5.00 If line 94 is "Y", enter the reduction percentage in the applic 5.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or applicable column.		0. 00 N		O. 0 N		95. 0 96. 0
7.00 If line 96 is "Y", enter the reduction percentage in the applic 8.00 Does title V or XIX follow Medicare (title XVIII) for the inter stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for column 1 for title V, and in column 2 for title XIX.	ns and residents post	0. 00 Y		0. 0 Y		97. 0 98. 0
B.01 Does title V or XIX follow Medicare (title XVIII) for the report C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title title XIX.				Υ		98.0
B.02 Does title V or XIX follow Medicare (title XVIII) for the calcubed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "for title V, and in column 2 for title XIX.		Y		Υ		98.0
3.03 Does title V or XIX follow Medicare (title XVIII) for a critical reimbursed 101% of inpatient services cost? Enter "Y" for yes of for title V, and in column 2 for title XIX.				N		98. (
8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH rei outpatient services cost? Enter "Y" for yes or "N" for no in co in column 2 for title XIX.	mbursed 101% of lumn 1 for title V, an	N nd		N		98. (
B.05 Does title V or XIX follow Medicare (title XVIII) and add back Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in colucolumn 2 for title XIX.				Υ		98.
8.06 Does title V or XIX follow Medicare (title XVIII) when cost rei Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 column 2 for title XIX.  Rural Providers		Y		Y		98.
ns.00 Does this hospital qualify as a CAH? n6.00 If this facility qualifies as a CAH, has it elected the all-inc	lusive method of payme	nt N				105. ( 106. (
for outpatient services? (see instructions) 17.00 If this facility qualifies as a CAH, is it eligible for cost retraining programs? Enter "Y" for yes or "N" for no in column 1. yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25	imbursement for I&R (see instructions) It	N				107. (
reimbursed. If yes complete Wkst. D-2, Pt. II. 8.00 s this a rural hospital qualifying for an exception to the CRN	M foo oobodul oo Coo	.2 N				108.

	Provi der C	F	Period: From 01/01/2 To 12/31/2	2017	Worksheet S- Part I Date/Time Pr 5/30/2018 8:	-2 repared
	Physi cal	Occupati onal	Speech	1	Respi ratory	
09.00   of this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"	1. 00 N	2. 00 N	3. 00 N		4. 00 N	109.0
for yes or "N" for no for each therapy.					1. 00	
10.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	"Y" for yes or	r "N" for no.	lf yes,		N	110. C
			1.00		2. 00	_
11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services.	cost reporting column 1 is Y, articipating in	period? Enter enter the n column 2.	N		2.00	111. C
Microllopeous Cost Deporting Information				1. 00	2.00 3.00	0
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes o is yes, enter the method used (A, B, or E only) in column 2 3 either "93" percent for short term hospital or "98" perce psychiatric, rehabilitation and long term hospitals provide Pub. 15-1, chapter 22, §2208.1.	2. If column 2 ent for long te ers) based on t	is "E", enter erm care (incl the definition	in column udes	N	0	115. C
16.00 s this facility classified as a referral center? Enter "Y" 17.00 s this facility legally-required to carry malpractice insuno.			"N" for	N Y		116. 0 117. 0
18.00 Is the malpractice insurance a claims-made or occurrence po claim-made. Enter 2 if the policy is occurrence.	olicy? Enter 1	. ,		1		118.
		Premi ums	Losses		Insurance	
		1.00	2.00		3. 00	
18.01 List amounts of malpractice premiums and paid losses:		1, 879, 08		0		11 118. (
			1.00		2. 00	_
18.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche and amounts contained therein. 19.00 DO NOT USE THIS LINE			N			118.
20.00 s this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no.	n column 1, "\ qualifies for	Y" for yes or the Outpatient			N	120.
21.00 Did this facility incur and report costs for high cost imple patients? Enter "Y" for yes or "N" for no.	antable device	es charged to	Y			121.
22.00 Does the cost report contain healthcare related taxes as de Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included.	1 is "Y", ente		N			122.
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" f	or yes and "N'	' for no. If	N			125.
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 f this is a Medicare certified kidney transplant center, e		fication date				126.
in column 1 and termination date, if applicable, in column 27.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column	nter the certi	fication date				127.
in column i and termination date, if applicable, in column 28.00 f this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column	nter the certi	fication date				128.
in column I and termination date, if applicable, in column 29.00 f this is a Medicare certified lung transplant center, ent   column 1 and termination date, if applicable, in column 2.		cation date i	n			129.
		rti fi cati on				130.
	n unii z.		i	İ		131.
30.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in co 31.00 If this is a Medicare certified intestinal transplant cente date in column 1 and termination date, if applicable, in co	er, enter the d Dlumn 2.					
30.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in co 31.00 If this is a Medicare certified intestinal transplant cente	er, enter the d blumn 2. nter the certif 2.	fication date				132. 133.

OSPITAL AND HOSPITAL HEALTH CARE COMPLE	EX IDENTIFICATION DATA	Provi der CCI	N: 15-0002	Period: From O To 1:	1/01/2017 2/31/2017	Worksheet S- Part I Date/Time Pr 5/30/2018 8:	epared:
					1. 00	2. 00	_
40.00 Are there any related organization chapter 10? Enter "Y" for yes or 'are claimed, enter in column 2 the	"N" for no in column 1. I	f yes, and home	office co	ı	N N	2.00	140.00
1.00	2.	00			3. 00	L	
If this facility is part of a cha			ugh 143 th	ne name ar	nd address	of the home	
office and enter the home office	<u>contractor name and contr</u>   Contractor's Name:	ractor number.	Contro	ctor's Nu	mbor.		141 00
41. 00 Name: 42. 00 Street:	PO Box:		Contra	ictor s nu	iliber:		141. 00 142. 00
43. 00 Ci ty:	State:		Zip Co	de:			143. 00
	•		' '				
		•				1.00	
44.00 Are provider based physicians' co	sts included in Worksheet	: A?				Y	144. 00
					1. 00	2.00	
45.00   f costs for renal services are clinpatient services only? Enter "Y' no, does the dialysis facility in period? Enter "Y" for yes or "N" 46.00   Has the cost allocation methodolog	" for yes or "N" for no i clude Medicare utilizatio for no in column 2. gy changed from the previ n column 1. (See CMS Pub.	n column 1. If con for this cost ously filed cost	column 1 i reporting t report?		Y N		145. 00
47 OOW than a share in the statistic	:!: -2 F-+   \/	"NI"				1.00	147.0
47.00 Was there a change in the statisti 48.00 Was there a change in the order o						N N	147. 0 148. 0
49.00Was there a change to the simplifi				for no.		N N	149. 0
	<i>J</i>	Part A	Part E		itle V	Title XIX	
-		1.00	2. 00		3. 00	4. 00	
Does this facility contain a prov or charges? Enter "Y" for yes or							
55. 00 Hospi tal	N TOT HO TOT EACH COMPC	N N	N	b. (See 4	N N	3. 13) N	— 155. 0
56. 00 Subprovi der – IPF		N N	N		N	N	156. 0
57.00 Subprovi der – IRF		N	N		N	N	157.0
58. 00 SUBPROVI DER							158. 0
59. 00 SNF		N N	N		N	N	159.0
60.00HOME HEALTH AGENCY 61.00CMHC		N	N N		N N	N N	160. 0 161. 0
вт. ображите			IV		IN	IN	101.0
						1. 00	
Mul ti campus							
65.00 Is this hospital part of a Multica	ampus hospital that has c	one or more campu	uses in di	fferent C	BSAs?	N	165. 0
Enter "Y" for yes or "N" for no.	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2.00	3. 00	4.00	5. 00	-
66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0. (	00 166. 0
						1.00	
Health Information Technology (HI	T) incentive in the Ameri	can Recovery and	d Reinvest	ment Act		1. 00	
67.00 <mark>ls this provider a meaningful use</mark> 68.00 <mark>lf this provider is a CAH (line 10</mark>	r under §1886(n)? Enter O5 is "Y") and is a meani	"Y" for yes or " ngful user (line	'N" for no		r the	Y	167. 0 0168. 0
reasonable cost incurred for the l 68.01 If this provider is a CAH and is a			onalify	for a har	dshi n		168. 0
exception under §413.70(a)(6)(ii) 69.00   f this provider is a meaningful	? Enter "Y" for yes or "N user (line 167 is "Y") an	l" for no. (see i	nstructio	ns)		9. (	99169.0
	nne)						1
transition factor. (see instruction	ons)			Bei	ai nni na	Endi na	
	ons)				gi nni ng 1. 00	Endi ng 2. 00	

Health Financial Systems METHODIST HOSPI	In Lie	In Lieu of Form CMS-2552-10				
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Worksheet S-2	)			
		From 01/01/2017 To 12/31/2017	Date/Time Pre	narod.		
		10 12/31/2017	5/30/2018 8: 2			
		1. 00	2. 00			
171.00 If line 167 is "Y", does this provider have any days for indi	viduals enrolled in	N	C	171.00		
section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I						
"Y" for yes and "N" for no in column 1. If column 1 is yes, e	on					
1876 Medicare days in column 2. (see instructions)						

Heal th	Financial Systems METHODIST HOS	SPITALS, INC		In Lie	eu of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Peri od:	Worksheet S-2	
				rom 01/01/2017 o 12/31/2017		epared:
				\/ /NI	5/30/2018 8: 2	22 am
				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					_
1. 00	Provider Organization and Operation  Has the provider changed ownership immediately prior to the	e heainning of	the cost	N		1.00
1.00	reporting period? If yes, enter the date of the change in			14		1.00
			Y/N	Date	V/I	
2. 00	Has the provider terminated participation in the Medicare	Drogram2 If	1. 00 N	2. 00	3. 00	2.00
2.00	yes, enter in column 2 the date of termination and in colu		IN IN			2.00
	voluntary or "I" for involuntary.					
3. 00	Is the provider involved in business transactions, includi		N			3. 00
	contracts, with individuals or entities (e.g., chain home 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	er similar				
	relationships? (see instructions)		Y/N	Type	Date	
			1.00	2. 00	3. 00	
	Financial Data and Reports					
4. 00	Column 1: Were the financial statements prepared by a Cer		Y	А	04/12/2018	4. 00
	Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date av					
	column 3. (see instructions) If no, see instructions.	arrabre in				
5. 00	Are the cost report total expenses and total revenues diff		N			5. 00
	those on the filed financial statements? If yes, submit re	conciliation.		Y/N	Legal Oper.	
				1.00	2. 00	
	Approved Educational Activities					
6. 00	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is t	he provider is	N		6. 00
7. 00	the legal operator of the program?  Are costs claimed for Allied Health Programs? If "Y" see i	nstructions		Υ		7. 00
8. 00	Were nursing school and/or allied health programs approved		d during the	Ϋ́		8.00
	cost reporting period? If yes, see instructions.					
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	Y		9. 00
10.00	Was an approved Intern and Resident GME program initiated		the current	N		10.00
	cost reporting period? If yes, see instructions.					
11. 00	Are GME cost directly assigned to cost centers other than		proved	N		11. 00
	Teaching Program on Worksheet A? If yes, see instructions.		,		Y/N	
					1. 00	
	Bad Debts					
12. 00 13. 00	Is the provider seeking reimbursement for bad debts? If ye If line 12 is yes, did the provider's bad debt collection			st roporting	Y N	12. 00 13. 00
13.00	period? If yes, submit copy.	porrey change	durring 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				T N	15.00
15.00	Did total beds available change from the prior cost report		yes, see inst t A		N N T B	15. 00
		Y/N	Date	Y/N	Date	
		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	I	N	I	16.00
10.00	If either column 1 or 3 is yes, enter the paid-through	IN		IN		10.00
	date of the PS&R Report used in columns 2 and 4 (see					
17.00	instructions)		04/20/2010	V	04 (20 (2010	17.00
17. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	Y	04/20/2018	Υ	04/20/2018	17. 00
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	N		N		18. 00
	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
	Report data for corrections of other PS&R Report information? If yes, see instructions.					
	1	ı	1	ı	ı	I

Heal th	Financial Systems METHODIST HO	SPITALS, INC		In Lie	u of Form CMS-	2552-10	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0002	Peri od: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Pre 5/30/2018 8:2	epared:	
		Descr	iption	Y/N	Y/N	L GIII	
20.00	16 11 at 47		0	1.00	3.00	00.00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00	
	Thopas is dutie for other 1 books as the other day dother to	Y/N	Date	Y/N	Date		
		1.00	2. 00	3. 00	4. 00		
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00	
					1. 00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	CEPT CHILDRENS	HOSPI TALS)				
22.00	Capital Related Cost	a i natruati ana			N	22.00	
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, so Have changes occurred in the Medicare depreciation expense			ing the cost	N	22. 00 23. 00	
20.00	reporting period? If yes, see instructions.	s add to apprai	Sar S made dar	Ting the cost		20.00	
24. 00	Were new leases and/or amendments to existing leases enter If yes, see instructions	red into during	this cost re	eporting period?		24. 00	
25. 00	Have there been new capitalized leases entered into during	g the cost repo	rting period?	olf yes, see		25. 00	
26. 00	instructions.  Were assets subject to Sec. 2314 of DEFRA acquired during tinstructions.	the cost report	ing period? I	f yes, see		26. 00	
27. 00	Has the provider's capitalization policy changed during th	ne cost reporti	ng period? If	yes, submit		27. 00	
20.00	copy. Interest Expense	ntored into du	ring the cost	ronortina		20.00	
28. 00	Were new loans, mortgage agreements or letters of credit eperiod? If yes, see instructions.	enterea into au	ring the cost	. reporting		28. 00	
29. 00	Did the provider have a funded depreciation account and/or	bond funds (D	ebt Service R	Reserve Fund)		29. 00	
	treated as a funded depreciation account? If yes, see inst						
30. 00	Has existing debt been replaced prior to its scheduled mat		30. 00				
31. 00	instructions. Has debt been recalled before scheduled maturity without instructions.		31.00				
	Purchased Services						
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		ng to competi	tive bidding? If	N	33. 00	
	no, see instructions. Provider-Based Physicians						
34.00		arrangement wit	h provi der-ba	sed physicians?	Υ	34.00	
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex	kisting agreeme	nts with the	provi der-based	N	35. 00	
	physicians during the cost reporting period? If yes, see i	nstructions.					
				Y/N	Date		
	Home Office Costs			1. 00	2. 00		
	Were home office costs claimed on the cost report?			N		36. 00	
37. 00	If line 36 is yes, has a home office cost statement been p	orepared by the	home office?	P N		37. 00	
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of			- N		38. 00	
39. 00				s, N		39. 00	
40. 00	see instructions. If line 36 is yes, did the provider render services to the	e home office?	If yes, see	N		40. 00	
	i nstructi ons.						
	1.00 2.						
	Cost Report Preparer Contact Information						
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MI CHAEL		ALESSANDRI NI		41.00	
42. 00	respectively. Enter the employer/company name of the cost report	BLUE & CO., LL	_C			42.00	
43. 00	preparer. 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 METHODIST H	OSPITALS, INC	In Lie	u of Form CMS-25	552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CCN: 15-0002	Peri od: From 01/01/2017 To 12/31/2017		ared:
	3. 00			
Cost Report Preparer Contact Information				
41.00 Enter the first name, last name and the title/position	DI RECTOR			41.00
held by the cost report preparer in columns 1, 2, and 3,				
respecti vel y.				
42.00 Enter the employer/company name of the cost report				42.00
preparer.				
43.00 Enter the telephone number and email address of the cost				43.00
report preparer in columns 1 and 2, respectively.				

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: Heal th Fi nancial SystemsMETHODIHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0002

					To	12/31/2017	Date/Time Pre 5/30/2018 8:2	
							1/P Days /	.2 (1111
							0/P Visits /	
							Tri ps	
	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		377	137, 605	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)							2.00
2. 00 3. 00	HMO and other (see instructions)							2.00
4. 00	HMO IPF Subprovider HMO IRF Subprovider							4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						0	
6. 00	Hospital Adults & Peds. Swing Bed NF						0	
7. 00	Total Adults and Peds. (exclude observation			377	137, 605	0. 00	0	
7.00	beds) (see instructions)			377	137,003	0.00	0	7.00
8. 00	INTENSIVE CARE UNIT	31.00		33	12, 045	0. 00	0	8.00
8. 01	NEONATAL ICU	31. 01		35	12, 775	0.00	0	
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)			445	162, 425	0.00	0	14.00
15.00	CAH visits						0	
16. 00	SUBPROVI DER - I PF	40. 00		14	5, 110		0	
17. 00	SUBPROVI DER - I RF	41. 00		39	14, 235		0	1
18.00	SUBPROVI DER							18.00
19.00	SKILLED NURSING FACILITY							19.00
20.00	NURSING FACILITY							20.00
21. 00 22. 00	OTHER LONG TERM CARE HOME HEALTH AGENCY	101. 00					0	21. 00 22. 00
22. 00	AMBULATORY SURGICAL CENTER (D. P. )	101.00					0	23.00
24. 00	HOSPICE							24.00
24. 00	HOSPICE (non-distinct part)	30. 00						24. 00
25. 00	CMHC - CMHC	30.00						25. 00
26. 00	RURAL HEALTH CLINIC							26.00
	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	
	Total (sum of lines 14-26)	07.00		498			Ŭ	27. 00
	Observation Bed Days						0	
29. 00	Ambulance Trips							29. 00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31.00
32.00	Labor & delivery days (see instructions)			0	0			32.00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33.00	LTCH non-covered days							33.00
33. 01	LTCH site neutral days and discharges		l	l				33. 01

Heal th Fi nancial SystemsMETHODIHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Peri od: | Worksheet S-3 | From 01/01/2017 | Part I | To 12/31/2017 | Date/Time Prepared: Provi der CCN: 15-0002

				1	0 12/31/2017	5/30/2018 8: 2	
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	2 4111
		.,,-					
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	·			Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	27, 937	3, 165	72, 236			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)	15, 196	24, 014				2.00
3. 00	HMO IPF Subprovi der	36	0				3.00
4. 00	HMO IRF Subprovider	0	836				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	0	0				5.00
6. 00	Hospital Adults & Peds. Swing Bed NF		0	_			6. 00
7. 00	Total Adults and Peds. (exclude observation	27, 937	3, 165	72, 236			7. 00
	beds) (see instructions)	0 570					
8.00	INTENSIVE CARE UNIT	3, 570	0				8.00
8. 01	NEONATAL ICU	O .	0	2, 820			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)		0	2 040			12.00
13. 00 14. 00	NURSERY	31, 507	0 3, 165	2, 849 86, 441	2. 94	2, 063. 06	13. 00 14. 00
15. 00	Total (see instructions) CAH visits	31, 307	3, 103	00, 441	2. 94	2,003.00	15.00
16. 00	SUBPROVI DER - I PF	925	619	2, 343	0. 00	12. 87	•
17. 00	SUBPROVIDER - I RF	5, 800	88			•	•
18. 00	SUBPROVI DER	3, 000	00	7, 323	0.00	43.02	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	7, 434	0	21, 066	0.00	25. 93	
23. 00	AMBULATORY SURGICAL CENTER (D. P. )	7, 101	J	21,000	0.00	20.70	23. 00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)	0	0	0			24. 10
25. 00	CMHC - CMHC	1		_			25.00
26. 00	RURAL HEALTH CLINIC						26, 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	o	0	0	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				2. 94	2, 144. 88	27. 00
28.00	Observation Bed Days		0	18, 479			28. 00
29.00	Ambul ance Trips	0					29. 00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	93	106			32.00
32.01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days	0					33.00
33. 01	LTCH site neutral days and discharges	0					33. 01

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part I | Date/Time | Prepared: | Date/Time | Prepared: | Part | Part | Prepared: | Part Provi der CCN: 15-0002

				To	12/31/2017	Date/Time Pre 5/30/2018 8:2	
		Full Time	_	Di scha	arges	7 07 007 20 10 0.2	
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	5, 264	396	14, 473	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
0.00	for the portion of LDP room available beds)			4 070	2 0/0		0.00
2.00	HMO and other (see instructions)			1, 870	3, 862		2.00
3.00	HMO I PF Subprovi der				0		3.00
4. 00	HMO I RF Subprovi der				53		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00 7. 00
7. 00	Total Adults and Peds. (exclude observation						7.00
8. 00	beds) (see instructions)   INTENSIVE CARE UNIT						8.00
8. 01	NEONATAL I CU						8.00
9. 00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	0.00	0	5, 264	396	14, 473	
15. 00	CAH visits	0.00	Ü	3, 204	370	14, 475	15.00
16. 00	SUBPROVIDER - I PF	0.00	0	65	0	202	16.00
17. 00	SUBPROVIDER - I RF	0.00	0	377	4	591	17. 00
18. 00	SUBPROVI DER	0.00	, and the second	0		07.	18.00
19. 00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28. 00
29. 00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30. 00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
00.55	outpatient days (see instructions)			_			
33.00	LTCH non-covered days			0			33.00
33. 01	LTCH site neutral days and discharges			0			33. 01

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

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0002 Period: From 01/01/2017 To 12/31/2017 Part II Date/Time Prepared: 5/30/2018 8: 22 am

Wkst. A Line Number Reported Reported Salaries (col. 2 ± col. Salaries in col. 4 ÷ col. 5)

West. A Line Number Reclassificat i on of Salaries (from Wkst. A-6)

Amount Reclassificat in Col. 4 ÷ col. 5)

						12/31/201/	5/30/2018 8: 2	
		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst.	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	151, 936, 992	-350, 875	151, 586, 117	4, 461, 361. 00	33. 98	1. 00
	instructions)	200.00						
2. 00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2. 00
3. 00	Non-physician anesthetist Part B		0	0	0	0. 00	0. 00	3.00
4. 00	Physician-Part A -		0	0	0	0. 00	0. 00	4.00
4. 01	Administrative Physicians - Part A - Teaching		0	0	0	0. 00	0. 00	4. 01
5. 00	Physician and Non Physician-Part B		0	0	0	0. 00	0. 00	5. 00
6. 00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0. 00	0. 00	6. 00
7. 00	Interns & residents (in an approved program)	21. 00	0	0	0	0. 00	0. 00	7. 00
7. 01	Contracted interns and residents (in an approved programs)		210, 061	0	210, 061	6, 240. 00	33. 66	7. 01
8. 00	Home office and/or related organization personnel		0	0	0	0. 00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 30, 995, 412	0 131, 352	~	0. 00 582, 979. 00	0. 00 53. 39	9. 00 10. 00
	instructions) OTHER WAGES & RELATED COSTS							
11. 00	Contract labor: Direct Patient		0	0	0	0. 00	0. 00	11.00
12. 00	Care Contract Labor: Top Level		0	0	0	0. 00	0.00	12. 00
12.00	management and other management and administrative		O	O	J	0.00	0.00	12.00
13. 00	services Contract Labor: Physician-Part		865, 624	0	865, 624	6, 445. 00	134. 31	13.00
14. 00	A - Administrative Home office and/or related		0	0	0	0. 00	0. 00	14. 00
	orgainzation salaries and wage-related costs							
14. 01	Home office salaries		0	0	0	0.00		14.01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	0	0	0. 00 0. 00	0.00	14. 02 15. 00
	- Administrative							
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	0	0. 00	0. 00	16. 00
	WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see instructions)		36, 684, 329	0	36, 684, 329			17. 00
18. 00	Wage-related costs (other) (see instructions)		0	0	0			18. 00
19.00	Excluded areas		7, 241, 789	0	7, 241, 789			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21. 00	Non-physician anesthetist Part B		0	0	0		•	21.00
22. 00	Physician Part A - Administrative		U	0	U			22. 00
22. 01	Physician Part A - Teaching		0	0	0			22. 01
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		0	)   0	0			23. 00 24. 00
25. 00	Interns & residents (in an		0	0	0			25. 00
25. 50	approved program) Home office wage-related		0	0	0			25. 50
25. 51	(core) Rel ated organi zati on		0	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A		Ω	n	0			25. 52
	- Administrative -		G					
25. 53	wage-related (core) Home office & Contract		Ω	0	0			25. 53
00	Physicians Part A - Teaching - wage-related (core)		· ·					
	1235 1014104 (0010)	l l		I	ı	I	l	

Provider CCN: 15-0002

| Peri od: | Worksheet S-3 | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared:

					1	0 12/31/2017	5/30/2018 8:2	
		Wkst. A Line	Amount	Recl assi fi cat	Adjusted	Pai d Hours	Average	
		Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
			·	Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from Wkst.	3)	col. 4	col. 5)	
				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, 774, 019	-121, 305	1, 652, 714	35, 729. 00	46. 26	26.00
27.00	Administrative & General	5. 00	21, 320, 696	-510, 954	20, 809, 742	659, 216. 00	31. 57	27.00
28. 00	Administrative & General under		1, 579, 643	0	1, 579, 643	7, 232. 00	218. 42	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0. 00		29. 00
30.00	Operation of Plant	7. 00	3, 869, 603	0	3, 869, 603	163, 718. 00	23. 64	30.00
31.00	Laundry & Linen Service	8. 00	0	0	0	0.00	0. 00	31.00
32.00	Housekeepi ng	9. 00	4, 557, 455	-12, 988	4, 544, 467	292, 874. 00	15. 52	32.00
33.00	Housekeeping under contract		0	0	0	0.00	0. 00	33.00
	(see instructions)							
34.00		10. 00	2, 943, 449	-867, 346	2, 076, 103	122, 482. 00		34.00
35.00	Dietary under contract (see		0	0	0	0. 00	0. 00	35.00
	instructions)							
36.00	Cafeteri a	11. 00	323, 846	850, 662	1, 174, 508			36.00
37.00	Maintenance of Personnel	12. 00	0	0	0	0. 00		37.00
38.00	Nursing Administration	13. 00	2, 931, 939	-20, 209	2, 911, 730	63, 165. 00	46. 10	38. 00
39. 00	Central Services and Supply	14. 00	524, 233	-1, 165	523, 068	27, 026. 00	19. 35	
40.00	Pharmacy	15. 00	0	0	0	0.00	0. 00	40.00
41.00	Medical Records & Medical	16. 00	2, 026, 695	0	2, 026, 695	83, 117. 00	24. 38	41.00
	Records Library							
42.00		17. 00	17, 205	465, 581	482, 786	15, 285. 00		42.00
43.00	Other General Service	18. 00	0	0	0	0. 00	0. 00	43.00

HOSPI T	AL WAGE INDEX INFORMATION			Provi der Co		Period: From 01/01/2017 To 12/31/2017		
		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		153, 306, 574	-350, 875	152, 955, 69	9 4, 462, 353. 00	34. 28	1.00
	instructions)							
2.00	Excluded area salaries (see		30, 995, 412	131, 352	31, 126, 76	4 582, 979. 00	53. 39	2.00
	instructions)							
3. 00	Subtotal salaries (line 1		122, 311, 162	-482, 227	121, 828, 93	5 3, 879, 374. 00	31. 40	3.00
	minus line 2)							
4. 00	Subtotal other wages & related		865, 624	0	865, 62	4 6, 445. 00	134. 31	4.00
	costs (see inst.)							
5. 00	Subtotal wage-related costs		36, 684, 329	0	36, 684, 32	9 0.00	30. 11	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		159, 861, 115					
7. 00	Total overhead cost (see		41, 868, 783	-217, 724	41, 651, 05	9 1, 538, 505. 00	27. 07	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 01/01/2017   Part IV

	To 12/31/2017	Date/Time Pre 5/30/2018 8: 2	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		l
1.00	401K Employer Contributions	1, 952, 275	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	7, 217, 360	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7. 00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8. 00	Health Insurance (Purchased or Self Funded)	18, 147, 555	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	3, 006, 535	9. 00
10.00	Dental, Hearing and Vision Plan	1, 012, 377	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	523, 976	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, 207, 995	15.00
16.00	· ·	0	16.00
	Non cumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	10, 419, 991	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
	Unemployment Insurance	118, 311	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21.00
	instructions))		
22. 00	Day Care Cost and Allowances	l ol	22.00
	Tuition Reimbursement	319, 743	23.00
	Total Wage Related cost (Sum of lines 1 -23)	43, 926, 118	
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-1			
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part V Date/Time Pre 5/30/2018 8:2	pared:	
Cost Center Description		Contract Labor 1.00	Benefit Cost		
PART V - Contract Labor and Benefit Cost		1.00	2.00		

	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	43, 926, 118	1.00
2.00	Hospi tal	0	43, 926, 118	2.00
3.00	Subprovi der - IPF	0	0	3.00
4.00	Subprovi der - I RF	0	0	4.00
5.00	Subprovi der - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	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	0ther	0	0	18. 00

HOME F	IEALTH AGENCY STATISTICAL DATA		TALS, INC		III LI C	u of Form CMS-2	2552-10
				CN: 15-0002 CCN: 15-7536	Peri od: From 01/01/2017 To 12/31/2017	Worksheet S-4 Date/Time Pre 5/30/2018 8:2	pared:
					Home Health	PPS	<u> 2 aiii                                </u>
					Agency I		
0.00	In the second				1.	00	0.00
0. 00	County	Title V	Title XVIII	Title XIX	Other	Total	0.00
		1.00	2.00	3. 00	4. 00	5. 00	
1. 00	HOME HEALTH AGENCY STATISTICAL DATA  Home Health Aide Hours	0	0		0 0	0	1.00
2. 00	Unduplicated Census Count (see instructions)	0.00	349. 00				
				Number of Em	ployees (Full Ti	me Equivalent)	
		Enter the numbe your normal		Staff	Contract	Total	
		your norman	work week				
		0		1.00	2.00	3. 00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES				2.00	0.00	
3.00	Administrator and Assistant Administrator(s)		40. 00				
4. 00 5. 00	Director(s) and Assistant Director(s) Other Administrative Personnel			0.0		0. 00 6. 41	4. 00 5. 00
6.00	Direct Nursing Service			10. 1	0. 00	10. 11	6.00
7.00	Nursi ng Supervi sor			0.0		0.00	
8. 00 9. 00	Physical Therapy Service Physical Therapy Supervisor			4. 2		4. 29 0. 00	
10.00	Occupational Therapy Service			1. (		1. 05	
11.00	Occupational Therapy Supervisor			0.0		0.00	
12. 00 13. 00	Speech Pathology Service Speech Pathology Supervisor			0. 4		0. 46 0. 00	
14. 00	Medical Social Service			0. 0		0.05	
15.00	Medical Social Service Supervisor			0.0		0. 00	
16.00	Home Health Aide			2. 2			
17. 00 18. 00	Home Health Aide Supervisor Other (specify)			0. (			
	HOME HEALTH AGENCY CBSA CODES						
19. 00	Enter in column 1 the number of CBSAs where you provided services during the cost				1		19.00
	reporting period.						
20. 00	List those CBSA code(s) in column 1 serviced			23844			20.00
	during this cost reporting period (line 20 contains the first code).						
	contains the first code).	Ful l Epi					
			With Outliers	LUPA Epi sode		Total (cols.	
		Outliers 1.00	2.00	3.00	Epi sodes 4.00	1-4) 5. 00	
	PPS ACTIVITY DATA						
21. 00 22. 00	Skilled Nursing Visits Skilled Nursing Visit Charges	2, 936 487, 974	533 88, 867		158 37 26, 192		1
23. 00	Physical Therapy Visits	1, 944	54		33 78	2, 109	1
24.00	Physical Therapy Visit Charges	350, 658	9, 716	6, 04	13, 972	380, 388	24.00
25. 00	Occupational Therapy Visits	458	38	1	0 21	517	25.00
26. 00 27. 00	Occupational Therapy Visit Charges Speech Pathology Visits	83, 681	6, 837 14	1	0 3, 796 0 5	94, 314 89	26. 00 27. 00
28. 00	Speech Pathology Visit Charges	13, 567	2, 632	1	0 940	17, 139	
29.00	Medical Social Service Visits	12	1		2 1	16	
30.00	Medical Social Service Visit Charges Home Health Aide Visits	3, 201 743	268 153	1	36 253 3 34	4, 258 933	
32. 00	Home Health Aide Visit Charges	54, 877	11, 299	22	25 2, 498	68, 899	
33. 00	Total visits (sum of lines 21, 23, 25, 27,	6, 163	793	18	31 297	7, 434	33.00
	29, and 31) Other Charges	o	0		0 0	0	34.00
34.00	Total Charges (sum of lines 22, 24, 26, 28,	993, 958	119, 619	1		1, 191, 968	
34. 00 35. 00		ı l		I			I
35. 00	30, 32, and 34)	20-				4	2/ 22
	Total Number of Episodes (standard/non	331		6	59 17	417	36. 00
35. 00 36. 00 37. 00	Total Number of Episodes (standard/non outlier)	331 32, 093	17 12, 908		2	19	37.00

Heal th	Financial Systems METH	HODIST HOSPITALS, INC		In Lie	u of Form CMS-:	2552-10
HOSPI 7	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der C	CN: 15-0002	Peri od:	Worksheet S-1	0
				From 01/01/2017 To 12/31/2017	Date/Time Pre	nared.
				12, 01, 201,	5/30/2018 8: 2	
					1.00	
	Uncompensated and indigent care cost computation					
1. 00	Cost to charge ratio (Worksheet C, Part I line 20 Medicaid (see instructions for each line)	2 column 3 divided by I	ine 202 colum	n 8)	0. 234617	1.00
2. 00	Net revenue from Medicaid				89, 148, 443	2.00
3. 00	Did you receive DSH or supplemental payments from	n Medicaid?			Υ Υ	3.00
4.00	If line 3 is yes, does line 2 include all DSH and			ai d?	Y	4.00
5. 00	If line 4 is no, then enter DSH and/or supplement	al payments from Medica	i d		0	
6.00	Medical d charges				273, 092, 506	
7. 00 8. 00	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medi	cald program (Lipo 7 mi)	nue eum of Li	nos 2 and 5: if	64, 072, 144 0	1
8.00	<pre>&lt; zero then enter zero)</pre>	card program (Trie 7 mm)	nus sum or ri	nes 2 and 5, 11	0	0.00
	Children's Health Insurance Program (CHIP) (see i	nstructions for each li	ne)			1
9.00	Net revenue from stand-alone CHIP				0	
	Stand-alone CHIP charges				0	
11. 00 12. 00	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for star	nd alone CHIP (line 11 m	inus lino 0:	if < zoro thon	0	
12.00	enter zero)	id-arone chir (title ti li	illus Illie 4,	II < Zero then	0	12.00
	Other state or local government indigent care pro	gram (see instructions	for each line	e)		1
13.00	Net revenue from state or local indigent care pro				0	13.00
14. 00	Charges for patients covered under state or local	indigent care program	(Not included	lin lines 6 or	0	14.00
15. 00	10)  State or Local indigent care program cost (line 1	times line 14)			0	15.00
16. 00	Difference between net revenue and costs for state		e program (Li	ne 15 minus line		1
10.00	13; if < zero then enter zero)	e or rodar rhangeme dan	e program (ri	no ro minuo rine	ĺ	10.00
	Grants, donations and total unreimbursed cost for instructions for each line)	Medicaid, CHIP and sta	te/local indi	gent care progra	ams (see	
17. 00	Private grants, donations, or endowment income re	estricted to funding cha	rity care		0	17. 00
18.00	Government grants, appropriations or transfers for	or support of hospital o	perati ons		0	18. 00
19. 00	The state of the s	state and local indigent	care program	ns (sum of lines	0	19.00
	8, 12 and 16)		Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col . 2)	
			1.00	2.00	3. 00	
	Uncompensated Care (see instructions for each lin					
20. 00	Charity care charges and uninsured discounts for (see instructions)	the entire facility	17, 097, 3	19, 786, 960	36, 884, 344	20.00
21. 00	Cost of patients approved for charity care and ur	ni nsured di scounts (see	4, 011, 3	19, 786, 960	23, 798, 297	21.00
	instructions)				_	
22. 00		ously written off as		0 0	0	22.00
23 00	charity care Cost of charity care (line 21 minus line 22)		4, 011, 3	19, 786, 960	23, 798, 297	23 00
20.00	cost of charty date (Time 21 million 17116 22)		1,011,0	17, 700, 700	20, 170, 271	20.00
					1. 00	
24. 00	Does the amount on line 20 column 2, include char		yond a Length	n of stay limit	N	24.00
25. 00	imposed on patients covered by Medicaid or other If line 24 is yes, enter the charges for patient		t care progra	m's length of	0	25. 00
26. 00	stay limit Total bad debt expense for the entire hospital co	mmlex (see instructions	)		23, 417, 425	26.00
27. 00	Medicare reimbursable bad debts for the entire ho		•		2, 056, 467	1
27. 01	Medicare allowable bad debts for the entire hospi		,		3, 163, 794	1
28. 00	Non-Medicare bad debt expense (see instructions)	, ,	-		20, 253, 631	1
29. 00	Cost of non-Medicare and non-reimbursable Medicar		instructions	5)	5, 859, 173	
30.00	Cost of uncompensated care (line 23 column 3 plus	*			29, 657, 470	1
31.00	Total unreimbursed and uncompensated care cost (I	ine 19 plus line 30)			29, 657, 470	31.00

RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC	CN: 15-0002   P	eriod: rom 01/01/2017 o 12/31/2017	Worksheet A	narod:
						5/30/2018 8: 2	2 am
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificat ions (See	Reclassified Trial Balance	
				+ (01. 2)	A-6)	(col. 3 +-	
					,	col . 4)	
	OFNEDAL CERVICE COST OFNEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FLXT		ol	C	22, 121, 550	22, 121, 550	1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 774, 019	25, 480, 056	27, 254, 075		27, 472, 947	1
5. 01	00550 DATA PROCESSING	4, 041, 195	9, 177, 998	13, 219, 193		10, 811, 546	
5. 02	00560 PURCHASING RECEIVING AND STORES	1, 005, 062	2, 420, 728	3, 425, 790		3, 351, 236	
5. 03 5. 04	00570 ADMITTING   00580 CASHIERING/ACCOUNTS RECEIVABLE	1, 972, 452 2, 123, 372	447, 428 2, 358, 328	2, 419, 880 4, 481, 700		2, 418, 852 4, 469, 739	1
5. 05	00590 OTHER A&G	11, 590, 657	20, 551, 371	32, 142, 028		19, 480, 020	
5.06	00592 PATIENT TRANSPORTATION	587, 958	70, 692	658, 650		627, 975	1
7. 00	00700 OPERATION OF PLANT	3, 869, 603	10, 753, 190	14, 622, 793		18, 862, 772	
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE	4 557 455	1, 353, 425	1, 353, 425		1, 353, 425	
10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	4, 557, 455 2, 943, 449	1, 299, 539 2, 697, 718	5, 856, 994 5, 641, 167		5, 808, 858 3, 747, 821	
11. 00	01100 CAFETERI A	323, 846	39, 549	363, 395		2, 159, 398	1
13.00	01300 NURSING ADMINISTRATION	2, 931, 939	627, 215	3, 559, 154		3, 510, 498	
14.00	01400 CENTRAL SERVICES & SUPPLY	524, 233	1, 844, 110	2, 368, 343		1, 955, 916	
15. 00 16. 00	01500   PHARMACY   01600   MEDI CAL   RECORDS & LI BRARY	0 2, 026, 695	15, 347, 018 807, 801	15, 347, 018 2, 834, 496		5, 489, 306 2, 831, 212	1
17. 00	01700 SOCIAL SERVICE	0	0	2,001,170		465, 581	
17. 01	01701 STAFF EDUCATION	0	O	O	- 1	0	
17. 02	01702 MEDI CAL EDUCATI ON	17, 205	38, 034	55, 239		54, 990	
21. 00 22. 00	02100   L&R SERVICES-SALARY & FRINGES APPRVD   02200   L&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0		210, 423 46, 752	
	02300 PARAMED ED PROGRAM	398, 549	73, 360	471, 909		630, 736	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	30, 300, 035	7, 450, 050	37, 750, 085		35, 733, 551	
31. 00 31. 01	03100   INTENSIVE CARE UNIT   03101   NEONATAL   CU	6, 703, 231	2, 107, 085 900, 152	8, 810, 316		8, 061, 452 2, 919, 071	
40.00	04000 SUBPROVI DER - I PF	2, 047, 370 1, 019, 387	98, 895	2, 947, 522 1, 118, 282		1, 112, 915	1
41. 00	04100 SUBPROVI DER - I RF	2, 976, 855	514, 111	3, 490, 966		3, 421, 365	
43.00	04300 NURSERY	694, 855	290, 348	985, 203	-86, 927	898, 276	43.00
50. 00	ANCILLARY SERVICE COST CENTERS    05000   OPERATING ROOM	4, 427, 978	18, 944, 201	23, 372, 179	-16, 514, 432	6, 857, 747	]   50. 00
50. 00	05000 OPERATING ROOM	1, 234, 820	2, 366, 985	3, 601, 805		2, 873, 344	
51.00	05100 RECOVERY ROOM	1, 168, 467	155, 245	1, 323, 712		1, 306, 587	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 829, 485	553, 841	3, 383, 326		3, 167, 714	
53. 00 54. 00	05300 ANESTHESI OLOGY	0	0 422 170	4 040 105		4 140 054	
54. 00	05400   RADI OLOGY-DI AGNOSTI C   05401   RADI OLOGY - ULTRASOUND	2, 427, 006 1, 402, 719	2, 433, 179 891, 261	4, 860, 185 2, 293, 980		4, 140, 956 1, 786, 898	
55.00	05500 RADI OLOGY-THERAPEUTI C	463, 510	1, 302, 295	1, 765, 805		1, 381, 435	
56.00	05600 RADI OI SOTOPE	598, 750	1, 214, 610	1, 813, 360		1, 687, 630	
57. 00 58. 00	05700 CT SCAN	1, 095, 282	1, 173, 826	2, 269, 108		1, 735, 162	
59.00	05800 MAGNETIC RESONANCE IMAGING (MRI)   05900 CARDIAC CATHETERIZATION	442, 254 2, 060, 816	788, 660 6, 513, 465	1, 230, 914 8, 574, 281		647, 719 2, 863, 881	1
60.00	06000 LABORATORY	3, 541, 429	6, 714, 584	10, 256, 013		10, 203, 722	
60. 01	06001 BLOOD LABORATORY	0	o	O	0	0	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1 100 E00	202 470	1 572 052	0	1 540 303	
62. 00 63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	1, 180, 582	392, 470 0	1, 573, 052	-4, 670 0	1, 568, 382 0	1
64.00	06400 I NTRAVENOUS THERAPY	Ö	Ö	0	Ö	0	
65.00	06500 RESPI RATORY THERAPY	2, 420, 938	1, 093, 270	3, 514, 208		3, 171, 714	1
66.00	06600 PHYSI CAL THERAPY	1, 544, 468	130, 708	1, 675, 176		1, 672, 961	1
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	1, 228, 704 419, 301	107, 045 80, 885	1, 335, 749 500, 186		1, 335, 285 495, 514	
69. 00	06900 ELECTROCARDI OLOGY	644, 586	234, 761	879, 347		760, 892	
69. 01	06901 CARDI AC REHAB	395, 078	338, 434	733, 512		616, 255	
70.00	07000 ELECTROENCEPHALOGRAPHY	883, 233	6, 628, 914	7, 512, 147		1, 126, 728	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	,	12, 044, 990 13, 726, 555	•
73.00	07300 DRUGS CHARGED TO PATIENTS	384, 721	855, 934	1, 240, 655		13, 766, 090	1
74. 00	07400 RENAL DIALYSIS	0	2, 108, 726	2, 108, 726		2, 106, 463	
	OUTPATIENT SERVICE COST CENTERS						
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY	2, 884, 665	2, 369, 506	5, 254, 171		4, 997, 236	
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 228, 157	3, 453, 285	10, 681, 442	-974, 106	9, 707, 336	91.00
00	OTHER REIMBURSABLE COST CENTERS						1 .2.00
101.00	10100 HOME HEALTH AGENCY	2, 012, 787	348, 334	2, 361, 121	-6, 829	2, 354, 292	101. 00
110 00	SPECIAL PURPOSE COST CENTERS	107 240 450	1/7 0/0 /05	205 204 702	2 020 020	200 424 /74	110 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)     NONREIMBURSABLE COST CENTERS	127, 349, 158	167, 942, 625	295, 291, 783	2, 839, 888	298, 131, 671	1118.00
					1		H
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	45, 589	180, 112	225, 701	-11, 234	214, 467	190.00

Health Financial Systems	METHODIST HOSE	PITALS, INC		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der C		eri od:	Worksheet A	
			rom 01/01/2017 o 12/31/2017	Date/Time Pre 5/30/2018 8:2	pared: 2 am	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
			+ col . 2)	i ons (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1. 00	2.00	3. 00	4. 00	5. 00	
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	21, 804, 728	19, 422, 591	41, 227, 319	-886, 999	40, 340, 320	192.00
192. 01 19201 OTHER NON-REIMBURSABLE	2, 575, 181	3, 441, 571	6, 016, 752	-1, 941, 653	4, 075, 099	192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	162, 336	52, 960	215, 296	-2	215, 294	192. 02
193. 00 19300 NONPALD WORKERS	0	0	C	0	0	193. 00
200.00   TOTAL (SUM OF LINES 118 through 199)	151, 936, 992	191, 039, 859	342, 976, 851	0	342, 976, 851	200. 00

Health FinancialSystemsMETHODISTRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0002 | Period:

Peri od: Worksheet A From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/30/2018 8: 22 am

					5/30/2018 8: 22 am
Cost Center Description			let Expenses		
	(See A-		For		
	6.00		Allocation 7.00		
GENERAL SERVICE COST CENTER			7.00		
1. 00 00100 CAP REL COSTS-BLDG & I		5. 855	20, 254, 695		1.00
4.00 00400 EMPLOYEE BENEFITS DEP			35, 881, 867		4.00
5. 01 00550 DATA PROCESSING	-177	7, 723	10, 633, 823		5. 01
5. 02 00560 PURCHASING RECEIVING	AND STORES	0	3, 351, 236		5. 02
5. 03   00570 ADMITTING		0	2, 418, 852		5. 03
5. 04 00580 CASHI ERI NG/ACCOUNTS RI		1, 481	4, 408, 258		5. 04
5. 05   00590   OTHER A&G	l l	1, 224	18, 975, 796		5. 05
5. 06 00592 PATIENT TRANSPORTATION	N	0	627, 975		5.06
7. 00   00700   OPERATION OF PLANT 8. 00   00800   LAUNDRY & LINEN SERVIO	CE.	0	18, 862, 772		7. 00 8. 00
9. 00   00900   HOUSEKEEPI NG	l l	3, 018	1, 353, 425 5, 800, 840		9.00
10. 00   01000 DI ETARY		0	3, 747, 821		10.00
11. 00 01100 CAFETERI A	-965	5, 614	1, 193, 784		11.00
13.00 01300 NURSING ADMINISTRATIO	l l	1, 325	3, 509, 173		13.00
14.00 01400 CENTRAL SERVICES & SUI		0	1, 955, 916		14.00
15.00 01500 PHARMACY	-319	9, 290	5, 170, 016		15. 00
16.00 01600 MEDICAL RECORDS & LIBI	RARY -105	5, 456	2, 725, 756		16.00
17. 00  01700   SOCIAL SERVICE		0	465, 581		17. 00
17. 01   01701   STAFF EDUCATION		0	0		17. 01
17. 02   01702   MEDI CAL   EDUCATI ON	EDINOEC ADDDUD	0	54, 990		17. 02
21. 00   02100   1 &R SERVICES-SALARY & 22. 00   02200   1 &R SERVICES-OTHER PRO		0	210, 423		21.00
22. 00   02200   1 &R SERVICES-OTHER PRO 23. 00   02300   PARAMED ED PROGRAM		1, 084	46, 752 309, 652		23.00
I NPATIENT ROUTINE SERVICE C		1,004	307, 032		23.00
30. 00 03000 ADULTS & PEDIATRICS		3, 640	35, 524, 911		30.00
31. 00 03100 I NTENSI VE CARE UNI T	200	0	8, 061, 452		31.00
31. 01   03101   NEONATAL   CU	-704	1, 900	2, 214, 171		31.01
40. 00   04000   SUBPROVI DER - 1 PF		0	1, 112, 915		40.00
41. 00   04100   SUBPROVI DER - I RF		0	3, 421, 365		41.00
43. 00 04300 NURSERY		0	898, 276		43.00
ANCILLARY SERVICE COST CENT	ERS				
50. 00   05000   OPERATI NG ROOM		0	6, 857, 747		50.00
50. 01   05001 ENDOSCOPY		0	2, 873, 344		50. 01
51. 00   05100   RECOVERY ROOM 52. 00   05200   DELI VERY ROOM & LABOR	POOM	0	1, 306, 587		51. 00 52. 00
53. 00   05200   DELT VERT   ROOM & LABOR   53. 00   05300   ANESTHESI OLOGY	ROOM	o	3, 167, 714		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		o	4, 140, 956		54.00
54. 01   05401 RADI OLOGY - ULTRASOUNI	D	-709	1, 786, 189		54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C		9, 447	1, 251, 988		55.00
56. 00 05600 RADI OI SOTOPE		0	1, 687, 630		56.00
57.00 05700 CT SCAN		-396	1, 734, 766		57.00
58.00 05800 MAGNETIC RESONANCE IM		0	647, 719		58.00
59. 00  05900 CARDI AC CATHETERI ZATI (	1	0	2, 863, 881		59.00
60. 00   06000   LABORATORY	-46	5, 925	10, 156, 797		60.00
60. 01   06001   BLOOD LABORATORY	LOEC BROW ONLY	0	0		60. 01
61. 00   06100   PBP   CLI NI CAL   LAB   SERV   62. 00   06200   WHOLE   BLOOD & PACKED   I		0	1 475 415	ı	61.00
62.00   06200   WHOLE BLOOD & PACKED I 63.00   06300   BLOOD STORING, PROCES		2, 967	1, 475, 415 0	I	62. 00 63. 00
64. 00   06400   I NTRAVENOUS THERAPY	SING & IRANS.	o	0		64.00
65. 00 06500 RESPIRATORY THERAPY		0	3, 171, 714		65.00
66. 00 06600 PHYSI CAL THERAPY		ol	1, 672, 961		66.00
67. 00 06700 OCCUPATI ONAL THERAPY		o	1, 335, 285		67.00
68.00 06800 SPEECH PATHOLOGY		o	495, 514		68.00
69. 00 06900 ELECTROCARDI OLOGY		0	760, 892		69.00
69. 01  06901   CARDI AC REHAB		3, 859	507, 396		69. 01
70. 00 07000 ELECTROENCEPHALOGRAPH	l l	-714	1, 126, 014		70.00
71. 00 07100 MEDICAL SUPPLIES CHAR		0	12, 044, 990	1	71.00
72. 00 07200 IMPL. DEV. CHARGED TO		0	13, 726, 555		72.00
73. 00   07300   DRUGS CHARGED TO PATI   74. 00   07400   RENAL DI ALYSI S	ENIS	0	13, 766, 090		73. 00 74. 00
74.00 O7400 RENAL DIALYSIS OUTPATIENT SERVICE COST CEN	TEDS	23	2, 106, 486		74.00
90. 00   09000   CLINIC		7, 656	4, 949, 580		90.00
91. 00   09100   EMERGENCY	l l	2, 844	9, 674, 492		91.00
92. 00 09200 OBSERVATION BEDS (NON-	l l	-, 011	7, 07 1, 172		92.00
OTHER REIMBURSABLE COST CEN					72.00
101. 00 10100 HOME HEALTH AGENCY		0	2, 354, 292		101.00
SPECIAL PURPOSE COST CENTER					
118.00 SUBTOTALS (SUM OF LIN		3, 816	300, 835, 487		118. 00
NONREI MBURSABLE COST CENTER					
190. 00 19000 GIFT, FLOWER, COFFEE S	SHOP & CANTEEN	0	214, 467		190.00
191. 00 19100 RESEARCH	EELCES	0	40 340 330		191.00
192.00 19200 PHYSI CLANS' PRI VATE OF	IIIUES	0	40, 340, 320	I	192.00

Health Financial Systems	METHODIST HOS	SPITALS, INC		In Lie	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	OF EXPENSES	Provi der C	CN: 15-0002	Peri od:	Worksheet A
				From 01/01/2017	
				To 12/31/2017	Date/Time Prepared:
					5/30/2018 8: 22 am
Cost Center Description	Adjustments	Net Expenses			
	(See A-8)	For			
		Allocation			
	6. 00	7. 00			

0

2, 703, 816

4, 075, 099 215, 294

345, 680, 667

192. 01 192. 02 193. 00 200. 00

192. 01 19201 OTHER NON-REIMBURSABLE
192. 02 19202 FAMILY HEALTH/GARY COMM HEALTH
193. 00 19300 NONPALD WORKERS
200. 00 TOTAL (SUM OF LINES 118 through 199)

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0002

Cost Center   Line #   Salary   Other						5/30/2018 8	
2.00   3.00   4.00   5.00		Cost Contor	Increases	Calary	Othor		
1.00 A_CASETERIA							
0			0.00		0.00		
B	1.00	CAFETERI A	1100				1.00
1.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00		0		854, 514	947, 655		
2 00	1 00		22.00	1/5 700			1 00
3.00 4.00 5.00 0.00 0.00 0.00 0.00 0.00 0		PARAMED ED PROGRAM					4
4.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00			•	- 1			1
6.00				Ö			4. 00
1.00				0	0		5. 00
C	6.00		0. 00	0	0		6. 00
C - SOCIAL MORKERS	7. 00		0.00	•	0		7. 00
1.00		0		165, 783	0		_
O	1 00		17 00	16E E01	0		1 00
C	1.00	0			— — <u> </u>		1.00
1.00   IAR SERVICES SALARY &   21.00   0   210.423		E - RESIDENTS		100,001	<u> </u>		
LAR SERVICES-OTHER PROM	1.00		21. 00	0	210, 423		1.00
COSTS APPROD		FRI NGES APPRVD					
1.00	2.00		22. 00	0	46, 752		2. 00
F - MED SUPPLY		COSTS APPRVD	+	+			
1.00   PATIENTS   1.00   1.		F _ MED SUPPLY		UU	257, 175		
PATIENTS	1. 00		71. 00	O	12, 044, 990		1.00
2.00   MPL DEV. CHARGED TO   72.00   0   13.726.555   2.00   3.00	50		50	Ĭ	, , , , , , ,		
3.00 4.00 5.00 6.00 6.00 6.00 6.00 6.00 6.00 6	2.00	IMPL. DEV. CHARGED TO	72. 00	О	13, 726, 555		2.00
4.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00		PATI ENTS					
5.00 6.00 7.00 8.00 9.00 9.00 9.00 9.00 9.00 9.00 11.00 10.00 11.0				1			3.00
6.00 7.00 8.00 9.00 10.0			•	- 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  18. 00  19. 00  11. 00  11. 00  11. 00  12. 00  13. 00  14. 00  15. 00  16. 00  17. 00  18. 00  18. 00  19. 00  11. 00  11. 00  11. 00  11. 00  11. 00  12. 00  13. 00  14. 00  15. 00  16. 00  17. 00  18. 00  18. 00  19. 00  19. 00  11. 00  11. 00  11. 00  11. 00  11. 00  11. 00  12. 00  13. 00  14. 00  15. 00  16. 00  17. 00  18. 00  18. 00  19. 00  19. 00  11. 00  1				- 1			1
8. 00			•	-			1
9.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 11.00 1				-			1
11.00 12.00 13.00 13.00 14.00 15.00 16.00 16.00 16.00 17.00 18.00 18.00 18.00 19.00							9. 00
12.00	10.00		0.00	О	0		10.00
13.00			0. 00	0	0		11. 00
14. 00							12. 00
15.00				-			
16.00							1
17.00     0.00   0   0   0   17.00   18.00   19.00   19.00   19.00   0.00   0   0   0   0   19.00							
18.00			•				1
19,00   0,00   0,00   0,00   0,00   0,00   21,00   22,00   2							
20.00   0.00   0.00   0   0   22.00			•				4
22.00				О			20.00
23. 00 24. 00 24. 00 24. 00 25. 00 0. 00 0 0 0 0 25. 00 26. 00 27. 00 28. 00 0. 00 0 0 0 0 0 0 0 0 27. 00 28. 00 0. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	21.00		0. 00	0	0		21.00
24.00			•	- 1			
25. 00							1
26. 00 27. 00 28. 00 0.							
27. 00							
28.00   0.00   0.00   0   0   28.00   29.00   30.00   0.00   0   0   31.00   31.00   32.00   32.00   33.00   32.00   33.00   3							
29. 00 30. 00 30. 00 30. 00 31. 00 32. 00 32. 00 33. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 43. 00 43. 00 44. 00 45. 00  6 - LIGHT DUTY  6 - LIGHT DUTY  1. 00 PATIENT TRANSPORTATION 5. 06 558 0. 00							
31. 00 32. 00 32. 00 33. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 38. 00 39. 00 30. 00 00 00 00 00 00 00 00 00 00 00 00 00	29.00		0. 00		0		29. 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 40. 00 40. 00 41. 00 42. 00 43. 00 44. 00 45. 00  0				1			30.00
33. 00 34. 00 35. 00 36. 00 36. 00 37. 00 38. 00 38. 00 39. 00 40. 00 41. 00 42. 00 43. 00 44. 00 45. 00  PATIENT TRANSPORTATION 5. 06 0. 00 0.				1			31.00
34. 00 35. 00 35. 00 36. 00 37. 00 38. 00 39. 00 39. 00 40. 00 41. 00 42. 00 44. 00 45. 00  G - LI GHT DUTY  1. 00 PATI ENT TRANSPORTATI ON 2. 00 HOUSEKEEPI NG  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
35. 00 36. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 44. 00 45. 00  G - LI GHT DUTY  1. 00 PATI ENT TRANSPORTATI ON 2. 00 HOUSEKEEPI NG 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
36. 00   0.00   0.00   0   0   36. 00   37. 00   38. 00   37. 00   0.00   0.00   0.00   0.00   38. 00   39. 00   0.00   0							
37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 43. 00 44. 00 44. 00 45. 00  G - LI GHT DUTY  1. 00 PATI ENT TRANSPORTATI ON 2. 00 HOUSEKEEPI NG 9. 00 9, 542 9, 00 9, 542 9 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
38. 00 39. 00 40. 00 41. 00 41. 00 42. 00 43. 00 44. 00 44. 00 45. 00							37.00
40. 00							38. 00
41. 00				О	0		39. 00
42. 00							40.00
43. 00							
44. 00 45. 00 0 0 0 0 0 0 0 0 0 0 0 0							
45. 00							
0 0 25, 771, 545 G - LIGHT DUTY  1. 00 PATIENT TRANSPORTATION 5. 06 558 0 1. 00 2. 00 HOUSEKEEPING 9. 00 9, 542 0 2. 00							
G - LIGHT DUTY  1. 00 PATIENT TRANSPORTATION 5. 06 558 0 1. 00 2. 00 HOUSEKEEPING 9. 00 9, 542 0 2. 00	15.00						75.00
1. 00     PATI ENT TRANSPORTATI ON     5. 06     558     0     1. 00       2. 00     HOUSEKEEPI NG     9. 00     9, 542     0     2. 00		G - LIGHT DUTY		<u> </u>	.,,		
		PATIENT TRANSPORTATION					1.00
3. 00  ULETARY   10. 00  11, 507  0  3. 00							2.00
	3. 00	DI ETARY	10. 00	11, 507	0		3.00

Health Financial Systems RECLASSIFICATIONS | Peri od: | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: | 5/30/2018 8: 22 am Provider CCN: 15-0002

					5/30/2018 8:	
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
4.00	2. 00 ADULTS & PEDIATRICS	3. 00	4. 00	5. 00		4.00
4. 00 5. 00	INTENSIVE CARE UNIT	31. 00	32, 732 255	0		5.00
6. 00	SUBPROVI DER - I PF	40. 00	20, 442	O		6. 00
7. 00	SUBPROVI DER - I RF	41. 00	6, 213	0		7. 00
8.00	OPERATING ROOM	50.00	23, 315	0		8. 00
9.00	DELIVERY ROOM & LABOR ROOM	52. 00	185	0		9. 00
10.00	EMERGENCY	91.00	215	0		10.00
11. 00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	<u> </u>	0		11.00
	H - INTEREST EXPENSE		119, 735			_
1. 00	CAP REL COSTS-BLDG & FIXT	1. 00	O	3, 439, 235		1.00
2. 00	CAF REE COSTS-BEDG & TTAT	0. 00	0	0		2. 00
3. 00		0. 00	o	0		3. 00
4.00		0.00	O	0		4.00
5.00		0.00	O	0		5. 00
6.00		0.00	•_	0		6. 00
	0		0	3, 439, 235		4
1 00	I - CORPORATE EXPENSE CAP REL COSTS-BLDG & FLXT	1.00	0	5, 439, 957		1 00
1. 00 2. 00	OPERATION OF PLANT	7. 00	0	4, 672, 851		1. 00 2. 00
2.00	0	— — <del>/.</del> 00	<del> </del> _	10, 112, 808		2.00
	J - DRUG EXPENSE		<u> </u>	107 1127 000		
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	12, 740, 019		1.00
2.00		0.00	0_	0		2. 00
	0		0	12, 740, 019		_
	K - PHYSICIAN RECLASS					
1.00	OTHER A&G	5. 05	0	43, 900		1.00
2. 00	TOTALS	9000	0	4 <u>8, 945</u> 92, 845		2. 00
	L - PSTD RECLASS		O <sub>1</sub>	72, 045		+
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	350, 875		1.00
2.00		0.00	o	0		2.00
3.00		0.00	O	0		3.00
4.00		0. 00	0	0		4. 00
5. 00		0. 00	0	0		5. 00
6. 00		0.00	0	0		6.00
7. 00 8. 00		0. 00 0. 00	0	0		7. 00 8. 00
9. 00		0.00	0	0		9.00
10.00		0.00	ő	Ö		10.00
11.00		0.00	O	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13. 00
14. 00		0. 00	0	0		14.00
15.00		0.00	0	0		15.00
16. 00 17. 00		0. 00 0. 00	0	0		16. 00 17. 00
18. 00		0.00	0	0		18.00
19. 00		0.00	ő	Ö		19. 00
20.00		0. 00	Ö	0		20. 00
21.00		0.00	O	0		21.00
22. 00		0.00	0	0		22. 00
23. 00		0. 00	0	0		23. 00
24.00		0.00	0	0		24.00
25. 00		0.00	0	0		25. 00
26. 00 27. 00		0. 00 0. 00	0	0		26. 00 27. 00
28. 00		0.00	o	0		28.00
20.00	<u> </u>	<u> </u>	<del> </del>	350, 875		20.00
	M - DEPRECIATION RECLASS		<u> </u>			1
1. 00	CAP REL COSTS-BLDG & FLXT	1. 00	0	13, 242, 358		1.00
2.00		0.00	0	0		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4.00
5. 00 6. 00		0. 00 0. 00	0	0		5. 00 6. 00
7. 00		0.00	0	0		7.00
8. 00		0.00	Ö	0		8. 00
9. 00		0. 00	Ö	Ö		9. 00
10.00		0. 00	O	0		10.00
11.00		0. 00	О	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

METHODIST HOSPITALS, INC

In Lieu of Form CMS-2552-10

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0002

Health Financial Systems		METHODI ST HOS	SPITALS, INC	In Lieu of Form CMS-2552-10		
RECLASS	I FI CATI ONS			Provider CCN: 15-0002	Peri od:	Worksheet A-6
					From 01/01/2017	
					To 12/31/2017	Date/Time Prepared:
		Lnorocco				5/30/2018 8: 22 am
	Cost Center	Increases Line #	Sal ary	Other		
	2.00	3.00	4. 00	5. 00		
15. 00	2.00	0.00	4.00	0		15. 00
16. 00		0.00	0	0		16.00
17. 00		0.00	0	0		17. 00
18. 00		0.00	0	0		18.00
19. 00		0.00	0	0		19.00
20. 00		0.00	0	0		20.00
21. 00		0.00	0	0		21.00
22. 00		0.00	0	0		22.00
23. 00			0	0		23.00
		0.00		0		
24. 00		0.00	0			24.00
25. 00		0.00	0	0		25.00
26. 00		0.00	0	0		26.00
27. 00		0.00	0	0		27.00
28. 00		0.00	0	0		28.00
29. 00		0.00	0	0		29. 00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32. 00		0.00	0	0		32.00
33. 00		0.00	0	0		33.00
34. 00		0.00	0	0		34.00
35. 00		0.00	0	0		35.00
36. 00		0.00	0	0		36.00
37. 00		0.00	0	0		37.00
38. 00		0.00	0	0		38.00
39. 00		0.00	0	0		39.00
40. 00		0.00	0	0		40.00
41. 00		0.00	0	0		41.00
42. 00		0.00	0	0		42.00
43. 00		0.00	0	0		43.00
44. 00		0.00	0	0		44.00
45. 00		0.00	0	0		45.00
46. 00		0.00	0	0		46.00
47.00		0.00	0	0		47.00
48. 00		0.00	0	0		48. 00
49. 00		0.00	0	O		49.00
	TOTALS		0	13, 242, 358		
500.00	Grand Total: Increases		1, 605, 613	66, 954, 515		500.00

Health Financial Systems M RECLASSIFICATIONS

Provider CCN: 15-0002 Period: From 01/01/20

Peri od: Worksheet A-6 From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/30/2018 8: 22 am

						5/30/2018 8:	
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - CAFETERIA	, ,					4
1. 00	DI ETARY	10.00	85 <u>4, 5</u> 14	94 <u>7, 6</u> 55			1.00
	0		854, 514	947, 655			_
	B - CLINICAL TRAINING COST	, ,					4
1. 00	ADULTS & PEDIATRICS	30.00	11, 926	0	0		1.00
2.00	INTENSIVE CARE UNIT	31. 00	6, 743	0	0		2.00
3.00	OPERATING ROOM	50.00	8, 672	0	0		3. 00
4.00	ENDOSCOPY	50. 01	3, 136	0	0		4.00
5.00	CARDI AC CATHETERI ZATI ON	59. 00	1, 810	0	0		5.00
6.00	RESPI RATORY THERAPY	65.00	5, 674	0	0		6.00
7.00	EMERGENCY	91.00	127, 822	0	0		7. 00
	0 — — — — —		165, 783				1
	C - SOCIAL WORKERS						1
1.00	OTHER A&G	5. 05	465, 581	0	0		1.00
			465, 581	<sub>0</sub>			
	E - RESIDENTS			-			1
1.00	EMERGENCY	91, 00	0	257, 175	0		1.00
2. 00	E.M.E.R.G.E.N.G.	0.00	o	0			2.00
2.00			— — <del>ŏ</del>	257, 175			1 2.00
	F - MED SUPPLY		O <sub>I</sub>	207, 170			1
1. 00	PURCHASING RECEIVING AND	5. 02	0	70, 662	0		1.00
50	STORES	0.02	9	.0,002			
2. 00	ADMITTING	5. 03	0	7	0		2.00
3. 00	OTHER A&G	5. 05	ő	517	o		3.00
4. 00	OPERATION OF PLANT	7.00	ő	14			4.00
5. 00	HOUSEKEEPI NG	9.00	0	2, 519	1		5. 00
6. 00	DI ETARY	10.00	o	2, 317	l !		6. 00
7. 00	CAFETERI A	11.00	0	28	0		7. 00
8. 00	NURSING ADMINISTRATION	13.00	0		-		8.00
				1, 236	l t		4
9.00	CENTRAL SERVICES & SUPPLY	14.00	0	187, 398	l t		9.00
10.00	PHARMACY	15.00	0	30, 705	l t		10.00
11.00	MEDICAL EDUCATION	17. 02	0	249	l .		11.00
12. 00	PARAMED ED PROGRAM	23. 00	0	340	0		12.00
13. 00	ADULTS & PEDIATRICS	30.00	0	656, 975			13.00
14. 00	INTENSIVE CARE UNIT	31.00	0	226, 633	0		14.00
15. 00	NEONATAL ICU	31. 01	0	145			15. 00
16.00	SUBPROVI DER - I PF	40. 00	0	5	0		16. 00
17. 00	SUBPROVI DER - I RF	41. 00	0	56, 117	0		17. 00
18. 00	NURSERY	43. 00	0	29, 581	0		18. 00
19. 00	OPERATING ROOM	50.00	0	15, 129, 728	0		19.00
20.00	ENDOSCOPY	50. 01	0	343, 766	0		20.00
21.00	RECOVERY ROOM	51.00	0	14, 406	0		21.00
22.00	DELIVERY ROOM & LABOR ROOM	52.00	0	15, 632	0		22. 00
23.00	RADI OLOGY-DI AGNOSTI C	54.00	0	2, 438	0		23. 00
24.00	RADI OLOGY - ULTRASOUND	54. 01	0	36, 289	0		24.00
25.00	RADI OLOGY-THERAPEUTI C	55. 00	O	10, 943	0		25. 00
26.00	RADI OI SOTOPE	56.00	O	329	0		26.00
27.00	CT SCAN	57. 00	O	36, 582	0		27. 00
28.00	MAGNETIC RESONANCE IMAGING	58.00	O	274	l 1		28. 00
	(MRI)						
29.00	CARDÍ AC CATHETERI ZATI ON	59.00	ol	4, 824, 111	0		29. 00
30.00	LABORATORY	60.00	o	1, 135	1		30.00
31. 00	WHOLE BLOOD & PACKED RED	62. 00	o	572			31.00
	BLOOD CELLS		٦				
32.00	RESPIRATORY THERAPY	65. 00	o	214, 747	0		32.00
33.00	PHYSI CAL THERAPY	66.00	o	814			33.00
34. 00	OCCUPATIONAL THERAPY	67.00	0	40	l .		34.00
35. 00	SPEECH PATHOLOGY	68. 00	0	199	1		35. 00
36. 00	ELECTROCARDI OLOGY	69.00	0	6, 238	1		36.00
36.00	CARDI AC REHAB	69. 00	0	6, 238 1, 247	0		37.00
38.00			0				38.00
	ELECTROENCEPHALOGRAPHY	70.00	-	3, 286, 474	l t		1
39.00	DRUGS CHARGED TO PATIENTS	73.00	0	201, 709	l t		39.00
40.00	RENAL DI ALYSI S	74.00	0	2, 263	l t		40.00
41. 00	CLINIC	90.00	0	139, 243	l t		41.00
42.00	EMERGENCY	91.00	0	174, 971	l t		42.00
43.00	HOME HEALTH AGENCY	101.00	0	6, 262			43.00
44.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	57, 975	l t		44. 00
45.00	FAMILY HEALTH/GARY COMM	192. 02	0	2	0		45. 00
	HEALTH	<u> </u>			<u> </u>		
	0		0	25, 771, 545			_
	G - LIGHT DUTY						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	119, 735	0	1		1.00
2.00		0.00	0	0	l .		2. 00
3.00		0.00	O	0	0		3.00
					·		

RECLASSI FI CATI ONS

Provider CCN: 15-0002

Peri od: Worksheet A-6

From 01/01/2017 12/31/2017 Date/Time Prepared: 5/30/2018 8: 22 am Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 4.00 0.00 0 0 4.00 5.00 0.00 5.00 0 0 6.00 0.00 0 6.00 7.00 0.00 0 0 0 7.00 0 8.00 0.00 0 0 8.00 9.00 0 0 9.00 0.00 0 10.00 0.00 ol 0 0 10.00 11.00 0. 00 0 11.00 119, 735 H - INTEREST EXPENSE 1.00 OTHER A&G 5. 05 1, 867, 996 11 1 00 0 2.00 RADI OLOGY-DI AGNOSTI C 54.00 0 118,024 11 2.00 3.00 RADIOLOGY - ULTRASOUND 54.01 0 59, 012 11 3.00 4.00 CT SCAN 57.00 0 59,012 4.00 11 MAGNETIC RESONANCE IMAGING 0 59,012 5.00 5.00 58.00 11 (MRI) 6.00 OTHER NON-REIMBURSABLE 1<u>92.</u> 01 1, 27<u>6, 1</u>79 11 6.00 3, 439, 235 I - CORPORATE EXPENSE 1 00 OTHER A&G 5.05 0 10, 112, 808 1.00 2.00 0.00 0 2.00 ō 10, 112, 808 J - DRUG EXPENSE 1.00 PHARMACY 15.00 0 9, 692, 963 0 1.00 2.00 ELECTROENCEPHALOGRAPHY 70.00 0 3, 047, 056 0 2.00 12, 740, 019 K - PHYSICIAN RECLASS 1.00 PHYSICIANS' PRIVATE OFFICES 192.00 0 0 1.00 92,845 2.00 0 0.00 0 2.00 92, 845 TOTALS - PSTD RECLASS 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 1,570 1.00 2.00 DATA PROCESSING 5.01 1,832 0 0 2.00 ADMITTING 0 3.00 5.03 957 0 3.00 CASHI ERI NG/ACCOUNTS 4.00 5.04 7, 170 0 0 4.00 RECEI VABLE 5.00 OTHER A&G 5.05 25, 728 0 0 5.00 6.00 PATIENT TRANSPORTATION 0 5 06 10.244 0 6.00 7.00 HOUSEKEEPI NG 9.00 22,530 0 0 7.00 8.00 10.00 24, 339 0 DI ETARY 8.00 9.00 CAFETERI A 11.00 3, 852 0 0 9.00 0 NURSING ADMINISTRATION 10.00 0 10.00 13.00 20, 209 11.00 CENTRAL SERVICES & SUPPLY 14.00 1, 165 0 11.00 12.00 ADULTS & PEDIATRICS 30.00 58, 129 0 0 12.00 0 INTENSIVE CARE UNIT 31.00 0 13.00 13.00 11.542 14.00 NEONATAL ICU 31.01 6, 252 0 14.00 0 15.00 SUBPROVIDER - IPF 40.00 13, 148 0 15.00 16.00 SUBPROVIDER - IRF 41.00 9, 361 0 16.00 0 OPERATING ROOM 50.00 13, 137 0 17.00 17.00 DELIVERY ROOM & LABOR ROOM 18.00 52.00 5, 500 0 18.00 19.00 RADI OLOGY-DI AGNOSTI C 54.00 10, 495 19.00 0 0 0 20.00 CT SCAN 57.00 6,080 0 20.00 CARDIAC CATHETERIZATION 21.00 59.00 16, 136 0 21.00 22.00 LABORATORY 60.00 11,503 0 22.00 23.00 RESPIRATORY THERAPY 65.00 2, 981 0 0 23.00 0 SPEECH PATHOLOGY 24.00 68.00 463 0 24.00 25.00 ICLI NI C 90.00 740 0 25.00 26.00 **EMERGENCY** 91.00 12, 464 0 0 26.00 GIFT, FLOWER, COFFEE SHOP & 190.00 5,858 27.00 27.00 CANTEEN

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**STORES** 

ADMITTING

RECEI VABLE OTHER A&G

HOUSEKEEPI NG

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PHYSICIANS' PRIVATE OFFICES

EMPLOYEE BENEFITS DEPARTMENT

M - DEPRECIATION RECLASS

PURCHASING RECEIVING AND

DATA PROCESSING

CASHI ERI NG/ACCOUNTS

OPERATION OF PLANT

PATIENT TRANSPORTATION

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 01/01/2017 Date/Time Prepared: F/20/2018 9:23 om Provider CCN: 15-0002

Cost Center								5/30/2018 8: 22 a	am
6.00			Decreases						
10.00   DIETARY   10.00		Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.			
11.00   CAFETERIA   11.00   0   2,286   0   11.00   12		6. 00	7. 00	8. 00	9. 00	10.00			
12. 00 NURSING ADMINISTRATION   13. 00   27, 211   0   12. 00   13. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 00   14. 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   16. 00   15	10.00	DI ETARY	10. 00	0	78, 320	0		10	0.00
13.00   CENTRAL SERVICES & SUPPLY   14.00   0   223,864   0   13.00   14.00   14.00   14.00   14.00   14.00   15.00   0   134,044   0   15.00   0   15.00   0   134,044   0   15.00   15.00   0   134,044   0   15.00   15.00   0   15.00   0   15.00   0   15.00   0   15.00   0   15.00   17.00	11.00	CAFETERI A	11. 00	0	2, 286	0		11	1.00
14 OD   PHARMACY   15 OD   134 O44   0   14.00   15.00   16.00   17.00   18.00   17.00   17.00   18.00   17.	12.00	NURSING ADMINISTRATION	13. 00	0	27, 211	0		12	2. 00
15.00   MEDICAL RECORDS & LIBRARY   16.00   0   3.284   0   15.00   16.00   17.00	13.00	CENTRAL SERVICES & SUPPLY	14. 00	0	223, 864	0		13	3. 00
16. 00   PARAMED ED PROGRAM   23. 00   0   6. 616   0   116. 00   17. 00   ADULTS & PEDI ATRICS   30. 00   0   1.322, 236   0   17. 00   18. 00   17. 00   18. 00   17. 00   18. 00   17. 00   18. 00   17. 00   18. 00   17. 00   18. 00   17. 00   18. 00   17. 00   18. 00   19. 00	14.00	PHARMACY	15. 00	0	134, 044	0		14	4. 00
17. 00   ADULTS & PEDIATRICS   30. 00   0   1,322,236   0   17. 00   18. 00   17. 17. 00   18. 00   17. 17. 00   18. 00   17. 17. 00   18. 00   17. 17. 00   18. 00   17. 17. 00   18. 00   17. 17. 00   18. 00   17. 00   18. 00   17. 00   18. 00   17. 00   18. 00   17. 00   18. 00   17. 00   18. 00   17. 00   18. 00   17. 00   18. 00   17. 00   18. 00   17. 00   18. 00   17. 00   18. 00   17. 00   18. 00   17. 00   18. 00   17. 00   18. 00   17. 00   18. 00   17. 00   18. 00   17. 00   18. 00   17. 00   17. 00   18. 00   17. 00	15.00	MEDICAL RECORDS & LIBRARY	16. 00	0	3, 284	0		15	5. 00
18. 00   INTENSIVE CARE UNIT   31. 00   0   504. 201   0   18. 00   19. 00   NEONATAL I CU   31. 01   0   22. 054   0   19. 00   19. 00   NEONATAL I CU   31. 01   0   22. 054   0   19. 00   20. 00   21. 656   0   20. 00   21. 00   SUBPROVI DER - I RF   41. 00   0   10. 336   0   21. 00   22. 00   22. 00   22. 00   22. 00   23. 00   24. 00   22. 00   23. 00   24. 00   22. 00   23. 00   24. 00   25. 00   25. 00   0   336. 210   0   23. 00   24. 00   25. 00   25. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   26. 00   27. 79   0   25. 00   26. 00	16.00	PARAMED ED PROGRAM	23. 00	0	6, 616	0		16	5. 00
19, 00   NEONATAL   CU	17.00	ADULTS & PEDIATRICS	30. 00	0	1, 322, 236	0		17	7.00
20. 00   SUBPROVI DER - IPF   40. 00   0   12. 656   0   22. 00	18.00	INTENSIVE CARE UNIT	31. 00	o	504, 201	0		18	3. 00
21. 00   SUBPROVI DER - IRF	19.00	NEONATAL I CU	31. 01	o	22, 054	0		19	9. 00
22. 00   NURSERY	20.00	SUBPROVI DER - I PF	40.00	o	12, 656	0		20	0.00
23. 00   OPERATING ROOM   SO. 00   C   1, 386, 210   O   223. 00   ENDOSCOPY   SO. 01   O   381, 559   O   24, 00   25. 00   RECOVERY ROOM   ST. 00   O   D   194, 665   O   26. 00   DELIVERY ROOM & LABOR ROOM   ST. 00   O   194, 665   O   27. 00   ADDI OLOGY - ULTRASOUND   ST. 00   O   28. 00   RADI OLOGY - ULTRASOUND   ST. 00   O   29. 00   RADI OLOGY - ULTRASOUN	21.00	SUBPROVI DER - I RF	41.00	o	10, 336	0		21	1.00
23. 00   OPERATING ROOM   SO. 00   1, 386, 210   0   223. 00   24. 00   ENDOSCOPY   SO. 01   0   381, 559   0   25. 00   RECOVERY ROOM   ST. 00   0   25. 00   26. 00   DELI VERY ROOM & LABOR ROOM   ST. 00   0   194, 665   0   26. 00   DELI VERY ROOM & LABOR ROOM   ST. 00   0   194, 665   0   28. 00   RADI OLOGY - ULTRASQUIND   ST. 00   0   194, 665   0   29. 00   RADI OLOGY - ULTRASQUIND   ST. 01   0   411, 781   0   29. 00   RADI OLOGY - ULTRASQUIND   ST. 00   0   373, 427   0   29. 00   RADI OLOGY - ULTRASQUIND   ST. 00   0   373, 427   0   29. 00   RADI OLOGY - ULTRASQUIND   ST. 00   0   373, 427   0   29. 00   RADI OLOGY - ULTRASQUIND   ST. 00   0   373, 427   0   29. 00   RADI OLOGY - ULTRASQUIND   ST. 00   0   373, 427   0   29. 00   RADI OLOGY - ULTRASQUIND   ST. 00   0   432, 272   0   31. 00   CT SCAN   ST. 00   0   432, 272   0   31. 00   CT SCAN   ST. 00   0   432, 272   0   31. 00   CT SCAN   ST. 00   0   432, 272   0   31. 00   CARDI AC CATHETERI ZATI ON   ST. 00   0   39, 653   0   31. 00   CARDI AC CATHETERI ZATI ON   ST. 00   0   39, 653   0   31. 00   WHOLE BLOOD & PACKED RED   G2. 00   0   4, 098   0   31. 00   BLOOD CELLS   ST. 00   0   4, 098   0   31. 00   RESPIRATORY THERAPY   65. 00   0   1, 401   0   37. 00   31. 00   ST. 00   31. 00   CLUPATI ONAL THERAPY   67. 00   0   424   0   38. 00   31. 00   CUPATI ONAL THERAPY   67. 00   0   424   0   39. 00   31. 00   CARDI AC REHAB   69. 01   0   116, 010   0   31. 00   CARDI AC REHAB   69. 01   0   116, 010   0   31. 00   CARDI AC REHAB   69. 01   0   116, 010   0   31. 00   CARDI AC REHAB   69. 01   0   116, 897   0   31. 00   CARDI AC REHAB   69. 01   0   165, 897   0   31. 00   CARDI AC REHAB   69. 01   0   165, 897   0   31. 00   CARDI AC REHAB   69. 01   0   165, 897   0   31. 00   CARDI AC REHAB   69. 01   0   165, 897   0   31. 00   CARDI AC REHAB   69. 01   0   165, 897   0   31. 00   CARDI AC REHAB   69. 01   0   165, 897   0   31. 00   CARDI AC REHAB   69. 01   0   165, 897   0	22.00	NURSERY	43.00	o	57, 346	0		22	2. 00
24. 00   ENDOSCOPY   50. 01   0   381,559   0   224. 00	23.00	OPERATING ROOM		o	1, 386, 210	0		23	3. 00
26. 00 DELIVERY ROOM & LABOR ROOM 52. 00 0 194, 665 0 26. 00 27. 00 RADI OLOGY - DI AGNOSTI C 54. 00 0 588, 272 0 27. 00 27. 00 28. 00 RADI OLOGY - ULTRASOUND 54. 01 0 411, 781 0 28. 00 RADI OLOGY - ULTRASOUND 54. 01 0 411, 781 0 28. 00 RADI OLOGY - THERAPEUTI C 55. 00 0 373, 427 0 29. 00 RADI OLOGY - THERAPEUTI C 55. 00 0 125, 401 0 30. 00 RADI OLOGY - THERAPEUTI C 55. 00 0 125, 401 0 30. 00 RADI OLOGY - THERAPEUTI C 55. 00 0 125, 401 0 30. 00 RADI OLOGY - THERAPEUTI C 55. 00 0 125, 401 0 30. 00 31.	24.00	ENDOSCOPY	50. 01	o				24	4. 00
26. 00 DELIVERY ROOM & LABOR ROOM 52. 00 0 194, 665 0 26. 00 27. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 588, 2772 0 27. 00 27. 00 28. 00 RADI OLOGY- ULTRASOUND 54. 01 0 411, 7811 0 28. 00 RADI OLOGY-THERAPEUTI C 55. 00 0 373, 427 0 29. 00 RADI OLOGY-THERAPEUTI C 55. 00 0 125, 401 0 30. 00 RADI OLOGY-THERAPEUTI C 55. 00 0 125, 401 0 30. 00 RADI OLOGY-THERAPEUTI C 55. 00 0 125, 401 0 30. 00 RADI OLOGY-THERAPEUTI C 55. 00 0 125, 401 0 30. 00 31. 00 CT SCAN 57. 00 0 432, 272 0 31. 00 31. 00 CT SCAN 57. 00 0 432, 272 0 31. 00 31. 00 RAGNETI C RESONANCE I MAGI NG 58. 00 0 523, 909 0 7. 00 7	25. 00	RECOVERY ROOM		o				25	5. 00
27.00   RADI OLOGY - DI AGNOSTI C   54.00   0   588,272   0   27.00   28.00   RADI OLOGY - ULTRASOUND   54.01   0   411,781   0   28.00   29.00   RADI OLOGY - HERAPEUTI C   55.00   0   373,427   0   29.00   31.00   RADI OLOGY - HERAPEUTI C   55.00   0   125,401   0   30.00   31.00   CT SCAN   57.00   0   432,272   0   31.00   32.00   MAGNETI C RESONANCE I MAGI NG   58.00   0   523,909   0   32.00   (MRI)   33.00   CARDI AC CATHETERI ZATI ON   59.00   0   868,343   0   33.00   34.00   35.00   WHOLE BLOOD & PACKED RED   62.00   0   4.098   0   35.00   34.00   35.00   WHOLE BLOOD & PACKED RED   62.00   0   4.098   0   35.00   37.00   0	26.00	DELIVERY ROOM & LABOR ROOM	52.00	o	194, 665	0		26	5. 00
28. 00 RADI OLOGY - ULTRASOUND 54. 01 0 411, 781 0 29. 00 RADI OLOGY - HERAPEUTI C 55. 00 0 373, 427 0 30. 00 RADI OLOGY - HERAPEUTI C 55. 00 0 373, 427 0 30. 00 RADI OLOGY - HERAPEUTI C 55. 00 0 125, 401 0 30. 00 RADI OLOGY - HERAPEUTI C 55. 00 0 125, 401 0 30. 00 RADI OLOGY - HERAPEUTI C RESONANCE I MAGI NG 57. 00 0 432, 272 0 31. 00 32. 00 MAGNETI C RESONANCE I MAGI NG 58. 00 0 523, 909 0 32. 00 32. 00 MAGNETI C RESONANCE I MAGI NG 58. 00 0 523, 909 0 32. 00 32. 00 33. 00 CARDI AC CATHETERI ZATI ON 59. 00 0 868, 343 0 33. 00 34. 00 LABORATORY 60. 00 0 39, 653 0 34. 00 35. 00 WHOLE BLOOD & PACKED RED 62. 00 0 4. 098 0 35. 00 BLOOD CELLS 80. 00 0 119, 092 0 35. 00 80. 00 CELLS 80. 00 0 119, 092 0 36. 00 RESPI RATORY THERAPY 66. 00 0 1, 401 0 37. 00 9HYSI CAL THERAPY 67. 00 0 424 0 38. 00 0 CCUPATI ONAL THERAPY 67. 00 0 4. 010 0 39. 00 SPECECH PATHOLOGY 68. 00 0 4. 010 0 39. 00 SPECECH PATHOLOGY 69. 00 0 112, 217 0 40. 00 41. 00 CARDI AC REHAB 69. 01 0 116, 010 0 39. 00 SPECECH PATHOLOGY 69. 00 0 112, 217 0 40. 00 41. 00 CARDI AC REHAB 69. 01 0 116, 010 0 41. 00 42. 00 ELECTROSCREPHALOGRAPHY 70. 00 0 51, 889 0 41. 00 42. 00 ELECTROSCREPHALOGRAPHY 70. 00 0 51, 889 0 42. 00 64. 00 44. 00 45. 00 64. 00 45. 00 64. 00 45. 00 64. 00 45. 00 64. 00 45. 00 64. 00 45. 00 64. 00 45. 00 64. 00 45. 00 64. 00 45. 00 64. 00 45. 00 64. 00 45. 00 64. 00 66. 67. 00 6				o					
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32. 00   MAGNETI C RESONANCE I MAGI NG (MRI)  33. 00   CARDI AC CATHETERI ZATI ON   59. 00   0   868, 343   0   33. 00    34. 00   LABORATORY   60. 00   0   39, 653   0   34. 00    35. 00   WHOLE BLOOD & PACKED RED   62. 00   0   4, 098   0    BLOOD CELLS   0   0   119, 092   0   36. 00    37. 00   RESPI RATORY THERAPY   65. 00   0   119, 092   0   36. 00    38. 00   OCCUPATI ONAL THERAPY   67. 00   0   424   0   38. 00    39. 00   SPEECH PATHOLOGY   68. 00   0   41, 010   0    40. 00   ELECTROCARDI OLOGY   69. 00   0   112, 217   0   40. 00    41. 00   CARDI AC REHAB   69. 01   0   116, 010   0    42. 00   ELECTROENCEPHALOGRAPHY   70. 00   0   51, 889   0    44. 00   CLINIC   99. 00   0   12, 875   0    44. 00   CLINIC   99. 00   0   165, 897   0    45. 00   EMERGENCY   91. 00   0   401, 889   0    46. 00   HOME HEALTH AGENCY   101. 00   0    47. 00   CARDI AC REI MBURSABLE   192. 01   0   665, 474   0    49. 00   OTHER NON-REI MBURSABLE   192. 01   0   665, 474   0    103. 00   0   10, 442, 358   0    49. 00   OTHER NON-REI MBURSABLE   192. 01   0   665, 474   0    103. 00   0   10, 442, 358   0    40. 00   10, 10, 10, 10, 10, 10, 10, 10, 10, 10,				0		-			
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34. 00	33.00	1` ′	59. 00	ol	868. 343	0		33	3. 00
35. 00		1		0					
BLOOD CELLS   36.00   RESPIRATORY THERAPY   65.00   0   119,092   0   36.00   37.00   PHYSI CAL THERAPY   66.00   0   1,401   0   37.00   38.00   OCCUPATI ONAL THERAPY   67.00   0   424   0   38.00   39.00   SPEECH PATHOLOGY   68.00   0   4,010   0   39.00   40.00   ELECTROCARDI OLOGY   69.00   0   112,217   0   40.00   41.00   CARDI AC REHAB   69.01   0   116,010   0   41.00   42.00   ELECTROENCEPHALOGRAPHY   70.00   0   51,889   0   42.00   43.00   DRUGS CHARGED TO PATIENTS   73.00   0   12,875   0   43.00   45.00   EMERGENCY   91.00   0   401,889   0   45.00   45.00   EMERGENCY   91.00   0   401,889   0   45.00   46.00   HOME HEALTH AGENCY   101.00   0   567   0   46.00   47.00   GIFT, FLOWER, COFFEE SHOP & 190.00   0   5,376   0   47.00   CANTEEN   48.00   PHYSI CI ANS' PRI VATE OFFI CES   192.00   0   703,460   0   48.00   49.00   OTHER NON-REI MBURSABLE   192.01   0   665,474   0   0   49.00   TOTALS   0   13,242,358   0				0		-			
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44. 00 CLINI C 90. 00 0 165, 897 0 44. 00 45. 00 EMERGENCY 91. 00 0 401, 889 0 45. 00 46. 00 HOME HEALTH AGENCY 101. 00 567 0 46. 00 47. 00 GIFT, FLOWER, COFFEE SHOP & 190. 00 5, 376 0 CANTEEN CANTEEN 192. 00 0 703, 460 0 48. 00 49. 00 OTHER NON-REI MBURSABLE 192. 01 0 665, 474 0 107 ALS		·		0				1	
45. 00 EMERGENCY 91. 00 0 401, 889 0 45. 00 46. 00 HOME HEALTH AGENCY 101. 00 0 567 0 46. 00 47. 00 GFT, FLOWER, COFFEE SHOP & 190. 00 0 5, 376 0 47. 00 CANTEEN CANTEEN 192. 00 0 703, 460 0 48. 00 49. 00 OTHER NON-REI MBURSABLE 192. 01 0 665, 474 0 0 13, 242, 358		1		0				1	
46. 00 HOME HEALTH AGENCY 101. 00 0 567 0 46. 00 47. 00 GI FT, FLOWER, COFFEE SHOP & 190. 00 0 5, 376 0 48. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 703, 460 0 49. 00 OTHER NON-REI MBURSABLE 192. 01 0 665, 474 0 49. 00 TOTALS 0 13, 242, 358		1		0		_			
47. 00 GI FT, FLOWER, COFFEE SHOP & 190. 00 0 5, 376 0 47. 00  48. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 703, 460 0 48. 00  49. 00 OTHER NON-REI MBURSABLE 192. 01 0 665, 474 0 49. 00  TOTALS 0 13, 242, 358		1		0		_		1	
48. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 703, 460 0 48. 00 49. 00 OTHER NON-REI MBURSABLE 192. 01 0 665, 474 0 0 49. 00 TOTALS 0 13, 242, 358		1		0					
48. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 703, 460 0 48. 00 49. 00 OTHER NON-REI MBURSABLE 192. 01 0 665, 474 0 0 49. 00 TOTALS 0 13, 242, 358	77.00		1 70.00	٩	3, 370			47	
49. 00 OTHER NON-REIMBURSABLE 192. 01 0 665, 474 0 0 13, 242, 358	48 00	1	192 00	0	703 460	n		1/18	3 00
TOTALS 0 13, 242, 358		1		0				1	
	17.00			— — — <del>}</del>			-	47	,. 00
	500 00			1, 956, 488	66, 603, 640		-	500	00 0

Provider CCN: 15-0002

				To	12/31/2017	Date/Time Pre 5/30/2018 8: 2	
				Acqui si ti ons		7 37 307 2010 0. 2	Z dili
		Beginning	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	4, 445, 499	928, 175	0	928, 175	0	1.00
2.00	Land Improvements	6, 459, 679	192, 448	0	192, 448	0	2.00
3.00	Buildings and Fixtures	274, 400, 272	7, 197, 192	0	7, 197, 192	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	192, 338, 088	7, 792, 023	0	7, 792, 023	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	477, 643, 538	16, 109, 838	0	16, 109, 838	0	8.00
9.00	Reconciling Items	0	0	0	0	0	,
10.00	Total (line 8 minus line 9)	477, 643, 538	16, 109, 838	0	16, 109, 838	0	10.00
		Endi ng	Fully				
		Bal ance	Depreciated				
			Assets				
	DART 1 ANALYSIS OF SUANSES IN SARITAL ASSE	6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	5, 373, 674	0				1.00
2.00	Land Improvements	6, 652, 127	0				2.00
3.00	Buildings and Fixtures	281, 597, 464	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	200, 130, 111	0				6.00
7. 00	HIT designated Assets	400 750 074	0				7.00
8. 00	Subtotal (sum of lines 1-7)	493, 753, 376	0				8.00
9.00	Reconciling Items	402 752 274	0				9.00
10. 00	Total (line 8 minus line 9)	493, 753, 376	0				10.00

Health Financial Systems		METHODIST HOSPITALS, INC			In Lieu of Form CMS-2552-10			
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 15-0002	Peri od: From 01/01/2017 To 12/31/2017		pared:	
		SUMMARY OF CAPITAL						
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)		
		9. 00	10. 00	11.00	12.00	13.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FLXT	0		0	0	0	1.00	
3.00	Total (sum of lines 1-2)	0		0	0 0	0	3.00	
	SUMMARY OF CAPITAL							
	Cost Center Description	0ther	Total (1)					
		Capi tal -Rel at	(sum of cols	5.				
		ed Costs (see	9 through 14	ł)				
		instructions)						
		14. 00	15. 00					
•	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0		0	·	·	1.00	
3.00	Total (sum of lines 1-2)	0		0			3.00	

Health Financial Systems		METHODIST HOSPITALS, INC			In Lieu of Form CMS-2552-10		
RECONCILIATION OF CAPITAL COSTS CENTERS			Provi der C		Peri od:	Worksheet A-7	
					From 01/01/2017 o 12/31/2017	Part III Date/Time Pre	narod:
				'	0 12/31/2017	5/30/2018 8: 2	
		COMP	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 -			
		1, 00	2. 00	col . 2) 3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS					5.00		
1. 00	CAP REL COSTS-BLDG & FLXT	493, 753, 376	0	493, 753, 376	1. 000000	0	1.00
3. 00	Total (sum of lines 1-2)	493, 753, 376		493, 753, 376			3.00
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					F CAPITAL		
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at				
			ed Costs	through 7)	0.00	10.00	
6.00   7.00   8.00   9.					9. 00	10. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	ENTERS	0		18, 978, 515	0	1. 00
3. 00	Total (sum of lines 1-2)	0	0		18, 978, 515		3. 00
0.00	Total (Sam of Fries 1 2)	SUMMARY OF CAPITAL					0.00
		Somma art of Statistics					
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
			(see	instructions)			
			instructions)		ed Costs (see	9 through 14)	
		11.00	10.00	10.00	instructions)	15.00	
	DART III DECONOLILIATION OF CARLTAL COCTO C	11. 00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS  1. 00 CAP REL COSTS-BLDG & FIXT						1 00	
1. 00 3. 00	Total (sum of lines 1-2)	1, 276, 180 1, 276, 180				20, 254, 695 20, 254, 695	1. 00 3. 00
3.00	10 tal (Suii 01 111165 1-2)	1, 270, 100	ı	1	رار ا	20, 254, 095	3.00

Health Financial Systems
ADJUSTMENTS TO EXPENSES METHODIST HOSPITALS, INC In Lieu of Form CMS-2552-10 Provider CCN: 15-0002 Peri od: From 01/01/2017 To 12/31/2017 Worksheet A-8 Date/Time Prepared: 5/30/2018 8:22 am Expense Classification on Worksheet A

				To/From Which the Amount is t			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1 00	J	1. 00	2.00	3.00	4.00	5. 00	1 00
1. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	В		CAP REL COSTS-BLDG & FIXT	1.00	11	1. 00
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2. 00	0	2. 00
3. 00	Investment income - other (chapter 2)		0		0. 00	0	3. 00
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0. 00	0	4. 00
5. 00	Refunds and rebates of		0		0. 00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0. 00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0. 00	0	7. 00
	stations excluded) (chapter 21)						
8. 00	Television and radio service (chapter 21)		0		0. 00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -1, 105, 262		0. 00	0	9. 00 10. 00
11. 00	adjustment Sale of scrap, waste, etc.		0		0. 00	0	
12. 00	(chapter 23) Rel ated organi zati on	A-8-1	0		0.00	0	
	transactions (chapter 10)	A-0-1	0		0.00		
13. 00 14. 00	1	В	-965, 614	CAFETERI A	0. 00 11. 00	0	13. 00 14. 00
15. 00	Rental of quarters to employee and others		0		0. 00	0	15. 00
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16.00
17. 00	patients Sale of drugs to other than		0		0. 00	0	17. 00
18. 00		В	-105, 456	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing and allied health		0		0. 00	0	19. 00
	education (tuition, fees, books, etc.)						
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00	0	20. 00 21. 00
21.00	interest, finance or penalty charges (chapter 21)				0.00	Ö	21.00
22. 00	Interest expense on Medicare		0		0. 00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23.00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00		А	296, 200	CAP REL COSTS-BLDG & FIXT	1. 00	9	26. 00
27. 00			0	*** Cost Center Deleted ***	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00 30. 00	,	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
50.00	therapy costs in excess of limitation (chapter 14)	N-0-2		OCCUPATIONAL INLINACT	37.00		50.00
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99
	,	ı		·	1	'	

0

-342, 713 OTHER A&G

-319, 290 PHARMACY

-46, 925 LABORATORY

-108, 859 CARDI AC REHAB

-725 CLI NI C

-68, 940 OTHER A&G

-92, 571 OTHER A&G

2, 703, 816

-177, 723 DATA PROCESSING

-8, 018 HOUSEKEEPI NG

-61, 481 CASHI ERI NG/ACCOUNTS

-1, 325 NURSING ADMINISTRATION

RECEI VABLE

-321, 084 PARAMED ED PROGRAM

-16, 890 ADULTS & PEDIATRICS

BLOOD CELLS

23 RENAL DIALYSIS

-1, 715 RADI OLOGY-THERAPEUTI C

-92, 967 WHOLE BLOOD & PACKED RED

-714 ELECTROENCEPHALOGRAPHY

8, 408, 920 EMPLOYEE BENEFITS DEPARTMENT

32.00

33.00

33.01

33.02

34.00

35.00

37.00

40.00

40.01

41.00

42.00

43.00

44.00

45.00

46.00

46.01

50.00

0 36.00

0 38.00

0 44.01

0.00

5.01

5.04

5.05

9.00

13.00

15.00

23.00

30.00

55.00

60.00

62.00

69. 01

70.00

74.00

90.00

5.05

5.05

4.00

	(Transfer	to Wo	orksheet	Α,								
	column 6,	line	200.)									
(1)	Description	- all	chapter	referen	ces ir	this	col umn	pertai n	to	CMS	Pub.	15-1.

В

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38.00

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43.00

44.00

44.01

45.00

46.00

46.01

50.00

LNCOME

LNCOME

I NCOME

I NCOME

RX PROGRAM

CAH HIT Adjustment for

A&G OTHER INCOME

LAB OTHER INCOME

RENAL DIALYSIS

DUES/LOBBYI NG

LOBBYING EXPENSE

CLINIC OTHER INCOME

PENSION ADJUSTMENT

BLOOD OTHER INCOME

Depreciation and Interest DATA PROCESSING OTHER INCOME

CASH. A/R. COLLECTIONS OTHER

ENVIRONMENTAL SERVICES OTHER

NURSING ADMIN OTHER INCOME

ADULTS & PEDS OTHER INCOME

CARDIAC REHAB OTHER INCOME

ELECTROCEPHALOGRAPHY OTHER

TOTAL (sum of lines 1 thru 49)

(2) Basis for adjustment (see instructions).

PARAMED ED PROGRAM OTHER

RADI OLOGY - THERAPUETI C

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

B. Amount Received - if cost cannot be determined.

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

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Peri od: Worksheet A-8-2 From 01/01/2017 Provi der CCN: 15-0002

						Γο 12/31/2017		epared: 22 am
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		l 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		ADULTS & PEDIATRICS	191, 750			0	0	1.00
2. 00		NEONATAL ICU	704, 900			-	0	2.00
3. 00		RADI OLOGY - ULTRASOUND	709			0	0	3.00
4. 00		CT SCAN	396			0	0	4.00
5. 00		CLINIC	99, 250					5. 00
6. 00		EMERGENCY	89, 350					6.00
7. 00		RADI OLOGY-THERAPEUTI C	190, 478	118, 478	72, 000	271, 900	480	7. 00
8. 00	0. 00		0	0	0	0	0	8. 00
9. 00	0. 00		0	0	0	0	0	9. 00
10.00	0. 00		0	0	0	0	0	10.00
200.00		0 1 0 1 (5)	1, 276, 833					200.00
	Wkst. A Line #	,	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Continuing Education	Share of col. 12	Insurance	
	1. 00	2.00	8. 00	9. 00	12. 00	13. 00	14. 00	
1. 00		ADULTS & PEDIATRICS	0.00	7.00	12.00		0	1. 00
2.00		NEONATAL ICU	0	0			0	2.00
3. 00		RADI OLOGY - ULTRASOUND	0	0	0	-	Ö	3.00
4. 00		CT SCAN	0	0		0	Ö	4. 00
5. 00		CLINIC	52, 319	2, 616	0	0	o o	5. 00
6. 00		EMERGENCY	56, 506			0	0	6. 00
7. 00		RADI OLOGY-THERAPEUTI C	62, 746			0	o o	7. 00
8. 00	0. 00		0	0	0	0	0	8. 00
9. 00	0. 00		l o	0	0	0	o	9. 00
10.00	0. 00		0	0	0	0	0	10.00
200.00			171, 571	8, 578	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1.00		ADULTS & PEDIATRICS	0		0			1.00
2.00		NEONATAL ICU	0	0	0			2.00
3.00		RADI OLOGY - ULTRASOUND	0	0	0			3.00
4. 00		CT SCAN	0	0	0	1 0,0		4.00
5.00		CLI NI C	0	52, 319				5.00
6.00		EMERGENCY	0	56, 506				6.00
7.00		RADI OLOGY-THERAPEUTI C		62, 746				7.00
8. 00	0.00			0	_			8.00
9. 00	0.00			0		· -		9.00
10. 00 200. 00	0. 00			171, 571	E4 420			10. 00 200. 00
200.00		I	ı	1/1,5/1	54, 629	1, 105, 262		∠∪∪. ∪∪

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2017 | Part I | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-0002

					To	12/31/2017	Date/Time Pre 5/30/2018 8: 2	
				CAPI TAL			37 307 2010 0. 2	2 4111
				RELATED COSTS				
		Cost Center Description	Net Expenses	BLDG & FIXT	EMPLOYEE	DATA	PURCHASI NG	
			for Cost Allocation		BENEFITS DEPARTMENT	PROCESSI NG	RECEIVING AND STORES	
			(from Wkst A		DEFARTMENT		STORES	
			col. 7)					
			0	1. 00	4. 00	5. 01	5. 02	
4 00		AL SERVICE COST CENTERS	00.054.405	20 254 (25			ı	4 00
1. 00 4. 00		CAP REL COSTS-BLDG & FLXT EMPLOYEE BENEFITS DEPARTMENT	20, 254, 695 35, 881, 867					1.00 4.00
5. 01		DATA PROCESSING	10, 633, 823			11, 734, 804		5. 01
5. 02		PURCHASING RECEIVING AND STORES	3, 351, 236			0		5. 02
5.03		ADMI TTI NG	2, 418, 852		472, 930	0	4, 669	5. 03
5.04		CASHI ERI NG/ACCOUNTS RECEI VABLE	4, 408, 258			0	1, 985	
5. 05		OTHER A&G	18, 975, 796		2, 662, 556	11, 734, 804		5. 05
5. 06 7. 00		PATIENT TRANSPORTATION OPERATION OF PLANT	627, 975 18, 862, 772		,	0	347 49, 190	5. 06 7. 00
8. 00		LAUNDRY & LINEN SERVICE	1, 353, 425			0	19	8.00
9. 00	1 1	HOUSEKEEPI NG	5, 800, 840			0	39, 701	9. 00
10.00	01000	DI ETARY	3, 747, 821	270, 727	498, 024	0	34, 267	10.00
11.00		CAFETERI A	1, 193, 784			0		11.00
13.00		NURSI NG ADMI NI STRATI ON	3, 509, 173			0	2, 754	
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	1, 955, 916 5, 170, 016			0	33, 081 14, 305	14. 00 15. 00
16. 00		MEDICAL RECORDS & LIBRARY	2, 725, 756			0	758	16.00
17. 00		SOCIAL SERVICE	465, 581	23, 398		0	0	17.00
17. 01	01701	STAFF EDUCATION	0	160, 112	0	0	0	17. 01
17. 02		MEDICAL EDUCATION	54, 990			0	52	17. 02
21.00		I &R SERVICES-SALARY & FRINGES APPRVD	210, 423		- 1	0	0	21. 00 22. 00
22. 00 23. 00		I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PROGRAM	46, 752 309, 652			0		23.00
20.00		ENT ROUTINE SERVICE COST CENTERS	007,002	10, 017	100, 07 1		027	20.00
30.00		ADULTS & PEDIATRICS	35, 524, 911			0		
31.00		INTENSIVE CARE UNIT	8, 061, 452			0	70, 722	•
31. 01 40. 00		NEONATAL ICU SUBPROVIDER - IPF	2, 214, 171 1, 112, 915	32, 433 57, 053		0	500 244	
41. 00		SUBPROVI DER - I RF	3, 421, 365			0	l .	
43.00		NURSERY	898, 276		166, 685	0	11, 640	43.00
	ANCI LL	ARY SERVICE COST CENTERS		05/ 750			10.700	
50. 00 50. 01		OPERATING ROOM ENDOSCOPY	6, 857, 747 2, 873, 344	856, 750 0		0	68, 728 65, 421	50. 00 50. 01
51. 00		RECOVERY ROOM	1, 306, 587	208, 934		0	3, 731	51.00
52.00		DELIVERY ROOM & LABOR ROOM	3, 167, 714			0	10, 589	
53.00		ANESTHESI OLOGY	0	0	- 1	0	0	53.00
54.00		RADI OLOGY-DI AGNOSTI C RADI OLOGY - ULTRASOUND	4, 140, 956			0		
54. 01 55. 00		RADI OLOGY - ULTRASOUND RADI OLOGY-THERAPEUTI C	1, 786, 189 1, 251, 988			0	13, 865 2, 677	
56. 00		RADI OI SOTOPE	1, 687, 630			0	86, 797	
57.00	05700	CT SCAN	1, 734, 766			0	25, 579	57.00
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	647, 719			0		58. 00
59.00		CARDI AC CATHETERI ZATI ON	2, 863, 881	120, 554		0		1
60. 00 60. 01		LABORATORY BLOOD LABORATORY	10, 156, 797	337, 805 0		0	265, 975 0	60. 00 60. 01
61. 00		PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0		61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 475, 415	5, 530	283, 203	0	25, 194	62.00
63.00		BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64. 00 65. 00		I NTRAVENOUS THERAPY RESPI RATORY THERAPY	0 2 171 714	111 540	0 E70 440	0	0 46, 964	64. 00 65. 00
66.00		PHYSI CAL THERAPY	3, 171, 714 1, 672, 961	111, 548 176, 242		0	1, 081	•
67. 00	1 1	OCCUPATI ONAL THERAPY	1, 335, 285			0	1, 219	•
68. 00		SPEECH PATHOLOGY	495, 514			0	454	
69. 00		ELECTROCARDI OLOGY	760, 892		154, 626	0	1, 509	•
69. 01		CARDI AC REHAB ELECTROENCEPHALOGRAPHY	507, 396		94, 773	0	387	69. 01
70. 00 71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 126, 014 12, 044, 990		211, 873 0	0	0 1, 049, 817	
72.00		IMPL. DEV. CHARGED TO PATIENTS	13, 726, 555			0	1, 196, 362	
73.00		DRUGS CHARGED TO PATIENTS	13, 766, 090		92, 288	0		
74.00		RENAL DIALYSIS	2, 106, 486	62, 956	0	0	2, 408	74.00
00 00	001PA1	CLINIC	4 040 500	1 004 220	691, 807	0	0 050	90.00
		EMERGENCY	4, 949, 580 9, 674, 492			0		
		OBSERVATION BEDS (NON-DISTINCT PART)	1, 2, ., 2		., ,		120,011	92.00
	OTHER	REIMBURSABLE COST CENTERS						
101.00		HOME HEALTH AGENCY AL PURPOSE COST CENTERS	2, 354, 292	0	482, 835	0	7, 491	101. 00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117)	300, 835, 487	19, 666, 273	30, 077, 724	11, 734, 804	3, 648, 397	118. 00
			*					

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		Peri od: From 01/01/2017	Worksheet B Part I	
				To 12/31/2017		
		CAPI TAL RELATED COSTS				
Cost Center Description	Net Expenses	BLDG & FIXT	EMPLOYEE	DATA	PURCHASI NG	
	for Cost		BENEFITS	PROCESSI NG	RECEIVING AND	
	Allocation		DEPARTMENT		STORES	
	(from Wkst A					
	0	1. 00	4. 00	5. 01	5. 02	
NONREI MBURSABLE COST CENTERS		1.00	1. 00	0.01	0.02	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	214, 467	25, 869	9, 53	1 0	14, 583	190. 00
191. 00 19100 RESEARCH	0	0		0 0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	40, 340, 320	383, 668	5, 222, 75	7 0	33, 912	192. 00
192. 01 19201 OTHER NON-REIMBURSABLE	4, 075, 099	49, 655	617, 74	5 0		192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	215, 294	129, 230	38, 94	2 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	0.45 (00 (/7	0 054 (05	25 0// /0	0		201.00
202.00   TOTAL (sum lines 118 through 201)	345, 680, 667	20, 254, 695	35, 966, 69	9 11, 734, 804	3, 697, 648	1202.00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2017 Part I
To 12/31/2017 Date/Time Prepared: 5/30/2018 8:22 am

					5/30/2018 8: 2	
Cost Center Description	ADMITTI NG	CASHI ERI NG/AC COUNTS	Subtotal	OTHER A&G	PATI ENT TRANSPORTATI O	
		RECEI VABLE			N N	
	5. 03	5. 04	5A. 04	5. 05	5. 06	
GENERAL SERVICE COST CENTERS  1.00 O0100 CAP REL COSTS-BLDG & FLXT					Γ	1. 00
4.00   OO4OO EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 00550 DATA PROCESSING						5. 01
5. 02 00560 PURCHASING RECEIVING AND STORES						5. 02
5. 03   00570   ADMI TTI NG	3, 036, 023					5.03
5. 04   00580   CASHI ERI NG/ACCOUNTS   RECEI VABLE	0	5, 358, 075				5.04
5. 05   00590   OTHER A&G	0	0	34, 808, 999	34, 808, 999	l	5. 05
5. 06   00592 PATIENT TRANSPORTATION	0	0	767, 040	85, 887	852, 927	5.06
7. 00   00700   OPERATION OF PLANT 8. 00   00800   LAUNDRY & LINEN SERVICE	0	0	24, 139, 683 1, 609, 477	2, 702, 969 180, 216	0	7. 00 8. 00
9. 00   00900   HOUSEKEEPI NG	0	0	7, 227, 080	809, 231	0	9. 00
10. 00 01000 DI ETARY	0	o	4, 550, 839	509, 567	Ö	10.00
11. 00   01100   CAFETERI A	0	0	1, 664, 835	186, 415	0	11.00
13.00 01300 NURSING ADMINISTRATION	0	0	4, 301, 613	481, 660	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	2, 629, 310	294, 409	0	14.00
15. 00   01500   PHARMACY	0	0	5, 456, 613	610, 988	0	15.00
16. 00   01600   MEDI CAL RECORDS & LI BRARY	0	0	3, 375, 096	377, 916	l e	16.00
17. 00   01700   SOCI AL SERVI CE 17. 01   01701   STAFF EDUCATI ON	0	0	600, 664	67, 258		17.00
17. 01   01701   STAFF EDUCATION 17. 02   01702   MEDICAL EDUCATION	0		160, 112 64, 541	17, 928 7, 227	0	17. 01 17. 02
21. 00   02100   &R SERVICES-SALARY & FRINGES APPRVD	0	0	210, 423	23, 561	0	21. 00
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	Ö	o	110, 915	12, 419		22. 00
23.00 02300 PARAMED ED PROGRAM	0	0	494, 174	55, 334	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	246, 872		48, 149, 026	5, 391, 418	i .	30.00
31. 00   03100   INTENSIVE CARE UNIT	43, 638		10, 141, 821	1, 135, 600	l .	31.00
31. 01   03101   NEONATAL   CU	14, 119		2, 775, 773	310, 809	l e	31.01
40. 00   04000   SUBPROVI DER -   PF 41. 00   04100   SUBPROVI DER -   RF	8, 615 19, 680		1, 440, 316 4, 647, 948	161, 275 520, 440	l e	40. 00 41. 00
43. 00   04300   NURSERY	5, 184	9, 149	1, 441, 752	161, 436		43.00
ANCI LLARY SERVICE COST CENTERS	3, 104	7, 147	1, 441, 732	101, 430		43.00
50. 00 05000 OPERATING ROOM	414, 492	731, 412	9, 991, 691	1, 118, 790	70	50.00
50. 01   05001   ENDOSCOPY	48, 455	85, 516	3, 368, 197	377, 144	21, 154	50. 01
51.00   05100   RECOVERY ROOM	26, 638	47, 012	1, 873, 199	209, 746	18	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	13, 346	23, 554	3, 993, 265	447, 134	6, 607	52.00
53. 00   05300   ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	91, 930	162, 244	5, 750, 685	643, 916	l .	54.00
54. 01   05401   RADI OLOGY - ULTRASOUND 55. 00   05500   RADI OLOGY-THERAPEUTI C	41, 210 34, 106	72, 730 60, 193	2, 323, 078 1, 653, 847	260, 120 185, 185		54. 01 55. 00
56. 00   05600 RADI 0L0GT-THERAPEUTI C	37, 856	66, 811	2, 152, 616	241, 033	1	56.00
57. 00   05700 CT   SCAN	273, 901	483, 401	2, 901, 925	324, 934		57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	70, 449	124, 333	1, 017, 275	113, 906		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	180, 426	318, 428	4, 044, 716	452, 895		59. 00
60. 00   06000   LABORATORY	357, 209	630, 428	12, 594, 987	1, 410, 286		60.00
60. 01   06001   BL00D   LABORATORY	0	0	0	0	0	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	00 440	20.000	0	007.004		61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	22, 119	39, 038	1, 850, 499	207, 204	0	62.00
63. 00   06300   BLOOD STORING, PROCESSING & TRANS. 64. 00   06400   NTRAVENOUS THERAPY	0	0	0	0	0	63. 00 64. 00
65. 00   06500   RESPI RATORY   THERAPY	100, 592	177, 532	4, 187, 018	468, 829	736	65.00
66. 00 06600 PHYSI CAL THERAPY	18, 964	33, 469	2, 273, 210	254, 536	l e	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	15, 427	27, 227	1, 825, 369	204, 390	l .	67. 00
68.00 06800 SPEECH PATHOLOGY	5, 490	9, 690	637, 418	71, 373	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	51, 086	90, 159	1, 058, 272	118, 497	3, 593	69. 00
69. 01   06901   CARDI AC   REHAB	2, 297	4, 054	608, 907	68, 181	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	57, 824	102, 051	1, 497, 762	167, 707	7, 045	70.00
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS	123, 621 88, 363	218, 175 155, 950	13, 436, 603 15, 167, 230	1, 504, 523	0	71. 00 72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	380, 580		15, 167, 230	1, 698, 305 1, 677, 835	l	72.00
74. 00 07400 RENAL DI ALYSI S	21, 076		2, 230, 123	249, 711	Ö	74.00
OUTPATIENT SERVICE COST CENTERS		2.,				
90. 00 09000 CLI NI C	55, 427	97, 821	6, 897, 724	772, 352		90.00
91. 00   09100   EMERGENCY	156, 715	276, 582	12, 353, 145	1, 383, 206	5, 696	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
OTHER REIMBURSABLE COST CENTERS	0.01/	4. (22	0.017.111	224 222		
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	8, 316	14, 677	2, 867, 611	321, 092	0	101. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	3, 036, 023	5, 358, 075	294, 308, 839	29, 056, 793	852, 909	118 00
NONREI MBURSABLE COST CENTERS	3, 030, 023	5, 556, 675	277, 300, 037	27,000,170	002, 707	. 10.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0	264, 450	29, 611		190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	45, 980, 657	5, 148, 546	0	192. 00

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002
From 01/01/2017
To 12/31/2017
Date/Time Prepared:

					5/30/2018 8: 2	2 am
Cost Center Description	ADMI TTI 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	4, 743, 255	531, 112	18	192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALT	-H 0	0	383, 466	42, 937	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 through :	201) 3, 036, 023	5, 358, 075	345, 680, 667	34, 808, 999	852, 927	202. 00

| Peri od: | Worksheet B | From 01/01/2017 | Part I | To 12/31/2017 | Date/Time Prepared:

					Ic	12/31/2017	Date/lime Pre   5/30/2018 8:2	
		Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
			PLANT	LINEN SERVICE	2.22	10.00	11.00	
	CENED	AL SERVICE COST CENTERS	7. 00	8. 00	9. 00	10. 00	11. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FLXT						1.00
4. 00	1	EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01		DATA PROCESSING						5. 01
5.02	00560	PURCHASING RECEIVING AND STORES						5. 02
5.03	1	ADMI TTI NG						5. 03
5. 04		CASHI ERI NG/ACCOUNTS RECEI VABLE						5.04
5. 05 E. 04	1	OTHER A&G PATIENT TRANSPORTATION						5. 05 5. 06
5. 06 7. 00		OPERATION OF PLANT	26, 842, 652					7.00
8. 00		LAUNDRY & LINEN SERVICE	504, 485	l e				8.00
9. 00	1	HOUSEKEEPI NG	584, 013	l '				9.00
10.00	01000	DIETARY	533, 438	0	178, 550	5, 772, 394		10.00
11.00	1	CAFETERI A	372, 936	l e		0	2, 349, 014	1
13.00		NURSI NG ADMI NI STRATI ON	179, 718	l e	,	0	55, 615	1
14.00		CENTRAL SERVICES & SUPPLY PHARMACY	1, 014, 431	25, 006		0	23, 795	1
15. 00 16. 00	1	MEDICAL RECORDS & LIBRARY	536, 522 320, 012	14 0		0	0 73, 182	
17. 00		SOCIAL SERVICE	46, 104	0		0	13, 188	1
17. 01		STAFF EDUCATION	315, 483	Ö		Ö	0	17. 01
17. 02	01702	MEDICAL EDUCATION	10, 585	0	3, 543	0	269	17. 02
21. 00		I&R SERVICES-SALARY & FRINGES APPRVD	0	0		0	0	21.00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRVD	126, 425			0	0	22.00
23. 00		PARAMED ED PROGRAM TENT ROUTINE SERVICE COST CENTERS	95, 208	0	31, 868	0	17, 961	23. 00
30. 00		ADULTS & PEDIATRICS	8, 864, 693	1, 073, 201	2, 967, 153	4, 027, 977	833, 273	30.00
31. 00		INTENSIVE CARE UNIT	562, 192			712, 357	148, 002	•
31. 01	1	NEONATAL I CU	63, 906			0	40, 347	1
40.00		SUBPROVI DER - I PF	112, 416			О	24, 008	1
41.00	04100	SUBPROVI DER - I RF	884, 242	0	295, 970	514, 481	79, 075	41.00
43.00		NURSERY	691, 250	46, 619	231, 372	0	15, 542	43.00
FO 00		LARY SERVICE COST CENTERS	1 (00 104	225 000	F/F 04F	ام	114 21/	 
50. 00 50. 01	1	OPERATING ROOM ENDOSCOPY	1, 688, 134 0			0 33	114, 316 29, 096	1
51.00	1	RECOVERY ROOM	411, 682	l ·		0	23, 823	•
52.00		DELIVERY ROOM & LABOR ROOM	198, 199	l '		204, 727	66, 444	1
53.00	05300	ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00		RADI OLOGY-DI AGNOSTI C	1, 501, 680	l '		0	69, 453	•
54. 01		RADI OLOGY - ULTRASOUND	143, 039	l '		0	29, 092	1
55. 00 56. 00		RADI OLOGY-THERAPEUTI C RADI OI SOTOPE	381, 654	l '		0	10, 513	1
57.00		CT SCAN	255, 936 242, 351	17, 319		0	12, 010 27, 352	1
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	119, 010			0	10, 220	1
59.00		CARDI AC CATHETERI ZATI ON	237, 539			62, 790	42, 032	1
60.00	06000	LABORATORY	665, 608	0	222, 790	O	96, 889	60.00
60. 01		BLOOD LABORATORY	0	0	0	0	0	
61.00		PBP CLINICAL LAB SERVICES-PRGM ONLY	10.007		0 (47		F0 F04	61.00
		WHOLE BLOOD & PACKED RED BLOOD CELLS BLOOD STORING, PROCESSING & TRANS.	10, 896 0	l	0,0	0		62. 00 63. 00
64. 00		INTRAVENOUS THERAPY	0	0		0	0	1
65. 00	1	RESPI RATORY THERAPY	219, 794		· ·	o	63, 130	•
66.00		PHYSI CAL THERAPY	347, 266			O	35, 152	
67.00		OCCUPATI ONAL THERAPY	298, 445	0		0	26, 213	67.00
68. 00		SPEECH PATHOLOGY	50, 831	0		17, 078	8, 225	1
69.00	1	ELECTROCARDI OLOGY	0	12, 975		0	18, 589	•
69. 01 70. 00		CARDI AC REHAB ELECTROENCEPHALOGRAPHY	0	7, 669 0		279	10, 323 20, 488	•
71.00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		2/9	20, 488	1
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	Ö	0	o	7, 907	
		DRUGS CHARGED TO PATIENTS	47, 038	0	15, 744	O	0	1
74.00		RENAL DIALYSIS	124, 048	104, 129	41, 521	0	0	74.00
		TIENT SERVICE COST CENTERS						
90.00		CLINIC	2, 156, 081			0	63, 290	•
	1	EMERGENCY   OBSERVATION BEDS (NON-DISTINCT PART)	765, 939	241, 475	256, 372	232, 672	184, 282	91.00 92.00
72.00		REIMBURSABLE COST CENTERS						72.00
101.00		HOME HEALTH AGENCY	0	0	0	0	0	101.00
		AL PURPOSE COST CENTERS	05 15 1					
118. 00		SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	25, 683, 229	2, 275, 992	8, 232, 247	5, 772, 394	2, 346, 600	118. 00 
190. 00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	50, 972	0	17, 061	ol	2.414	190. 00
		RESEARCH	0	l	· ·	Ö		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	755, 977			О	0	192. 00
192. 01	19201	OTHER NON-REIMBURSABLE	97, 840	0	32, 749	0	0	192. 01

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 01/01/2017 Part I To 12/31/2017 Date/Time Prepared:

						5/30/2018 8: 2	<u> 2 am</u>
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE				
		7. 00	8. 00	9. 00	10.00	11. 00	
192. 02 19202	FAMILY HEALTH/GARY COMM HEALTH	254, 634	0	85, 230	0	0	192.02
193.00 19300	NONPALD WORKERS	0	0	0	0	0	193.00
200. 00	Cross Foot Adjustments						200.00
201. 00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	26, 842, 652	2, 294, 178	8, 620, 324	5, 772, 394	2, 349, 014	202.00

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 01/01/2017 | Part I | To 12/31/2017 | Date/Time Prepared: 5/30/2018 8:22 am

						, 12/31/2017	5/30/2018 8: 2	
		Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL	
			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	11.00	10.00	10.00	17.00	
1.00		CAP REL COSTS-BLDG & FLXT						1.00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	1	DATA PROCESSING						5. 01
5. 02		PURCHASING RECEIVING AND STORES						5.02
5. 03 5. 04	1	ADMITTING CASHIERING/ACCOUNTS RECEIVABLE						5. 03 5. 04
5. 05		OTHER A&G						5. 05
5. 06		PATIENT TRANSPORTATION						5. 06
7.00		OPERATION OF PLANT						7. 00
8.00	1	LAUNDRY & LINEN SERVICE						8. 00
9.00	1	HOUSEKEEPI NG						9.00
10. 00 11. 00		DI ETARY CAFETERI A						10. 00 11. 00
13.00		NURSING ADMINISTRATION	5, 078, 761					13.00
14. 00		CENTRAL SERVICES & SUPPLY	3,070,701	4, 326, 497				14.00
15. 00		PHARMACY	o	0				15. 00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	4, 253, 319		16. 00
17. 00		SOCIAL SERVICE	42, 058	0	0	0	784, 704	17. 00
17. 01	1	STAFF EDUCATION	0	0	0	0	0	17. 01
17. 02		MEDICAL EDUCATION	0	0	0	0	0	17. 02
21. 00 22. 00	1	I&R SERVICES-SALARY & FRINGES APPRVD   I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	-	0	0	21. 00 22. 00
23. 00		PARAMED ED PROGRAM	57, 276	0		0	0	23.00
20.00		IENT ROUTINE SERVICE COST CENTERS	0,,2,0		<u> </u>	<u>~</u> 1		20.00
30.00	03000	ADULTS & PEDIATRICS	2, 657, 298	0	92	345, 799	605, 427	30.00
31.00		INTENSIVE CARE UNIT	471, 980	0		61, 125	0	31.00
31. 01		NEONATAL I CU	128, 667	0		19, 777	0	31.01
40.00		SUBPROVIDER - I PF	76, 563	0	- 1	12, 067	124 212	40.00
41. 00 43. 00	1	SUBPROVIDER - IRF  NURSERY	252, 171 49, 563	0	- 1	27, 566 7, 261	134, 213 0	
43.00		LARY SERVICE COST CENTERS	47, 303	0	١	7, 201	0	43.00
50.00		OPERATING ROOM	364, 553	0	0	581, 283	0	50.00
50. 01		ENDOSCOPY	92, 786	0	- 1	67, 871	0	50. 01
51.00	1	RECOVERY ROOM	75, 971	0		37, 312	0	51.00
52.00	1	DELIVERY ROOM & LABOR ROOM	211, 890	0	0	18, 694 0	0	52.00
53. 00 54. 00	1	ANESTHESI OLOGY   RADI OLOGY-DI AGNOSTI C	0	0	0	128, 768	0	53. 00 54. 00
54. 01	1	RADI OLOGY - ULTRASOUND	0	0	0	57, 723	0	54. 01
55. 00		RADI OLOGY-THERAPEUTI C	0	0	0	47, 773	0	55. 00
56.00	05600	RADI OI SOTOPE	0	0	0	53, 026	0	56.00
57.00	1	CT SCAN	0	0	0	383, 660	0	57.00
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	98, 679	0	58.00
59. 00 60. 00	1	CARDI AC CATHETERI ZATI ON LABORATORY	0	0	0 749, 470	252, 726 500, 351	0	59. 00 60. 00
60. 00	1	BLOOD LABORATORY	0	0	749, 470	500, 551	0	60.00
61.00		PBP CLINICAL LAB SERVICES-PRGM ONLY	Ĭ	Ü		Š	· ·	61.00
62.00	1	WHOLE BLOOD & PACKED RED BLOOD CELLS	o	0	0	30, 983	0	
63.00		BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64. 00	1	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00		RESPI RATORY THERAPY	0	0	0	140, 902	0	65.00
66. 00 67. 00	1	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	0	0	0	26, 563 21, 609	0	66. 00 67. 00
68. 00	1	SPEECH PATHOLOGY	0	0	0	7, 690	0	68.00
69. 00	1	ELECTROCARDI OLOGY	0	0	Ö	71, 557	0	69. 00
69. 01	06901	CARDI AC REHAB	0	0	0	3, 218	0	69. 01
70.00		ELECTROENCEPHALOGRAPHY	0	0	0	80, 995	0	70. 00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 022, 101		173, 159	0	71.00
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	2, 304, 396		123, 772	0	72.00
73. 00 74. 00		DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	0	0		533, 087 29, 522	0	73. 00 74. 00
74.00		TIENT SERVICE COST CENTERS	<u> </u>	0	١	27, 322		74.00
90.00		CLINIC	0	0	0	77, 638	0	90.00
91.00	09100	EMERGENCY	597, 985	0	0	219, 514	45, 064	91.00
92.00		OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		REI MBURSABLE COST CENTERS		_				
101.00		HOME HEALTH AGENCY	0	0	4, 984	11, 649	0	101. 00
118. 00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	5, 078, 761	4, 326, 497	6, 631, 485	4, 253, 319	784, 704	118. 00
		IMBURSABLE COST CENTERS	3, 3, 3, 7, 01	., 525, 777	5,001,100	., 200, 017	701,704	
	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1	0		190. 00
		RESEARCH	0	0		0		191.00
192.00	ı <sub> </sub> 19200	PHYSICIANS' PRIVATE OFFICES	<u> </u> 0	0	152, 235	0	0	192. 00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0002	Period: Worksheet B From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared:

						5/30/2018 8: 2	22 am
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
		ADMI NI STRATI O	SERVICES &		RECORDS &	SERVI CE	
		N	SUPPLY		LI BRARY		
		13. 00	14. 00	15. 00	16.00	17. 00	
192. 01 19201	OTHER NON-REIMBURSABLE	0	0	0	0	C	192.01
192. 02 19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0	C	192.02
193.00 19300	NONPALD WORKERS	0	0	0	0	C	193.00
200. 00	Cross Foot Adjustments						200.00
201. 00	Negative Cost Centers	0	0	0	0	C	201.00
202 00	TOTAL (sum Lines 118 through 201)	5, 078, 761	4, 326, 497	6, 783, 720	4, 253, 319	784. 704	202.00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2017 Part I
To 12/31/2017 Date/Time Prepared: 5/30/2018 8:22 am

5.00   0.0992   PATENT TRANSPORTATION					'	0 12/31/2017	5/30/2018 8: 2	
SEREBLE SERVICE COST CENTERS					INTERNS &	RESI DENTS		
SEREBLE SERVICE COST CENTERS		Cost Center Description	STAFF	MEDI CAI	SERVICES_SALA	SERVI CES_OTHE	PARAMED ED	
DEMINISTRATION CONTINUES   17.01   17.02   21.00   22.00   23.00		cost denter bescription						
1.00   000000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   000000								
4.00   00-000   EMPLOYEE ERREFITS DEPARTMENT   5.00								
5.01 000500 JATA PROCESSING 5.02 000500 JAMENTHING 5.03 000500 JAMENTHING 5.03 000500 JAMENTHING 5.04 000500 JAMENTHING 5.05 000500 JAMENTHING 5.06 000500 JAMENTHING 5.07 000500 JAMENTHING 5.08 000500 JAMENTHING 5.09 000500 JAMENTHING 5.00 000500 JAMEN								1
5 00 00560 PURCHASING RECEIVING AND STORES 5 00 00560 CASH ERIN RAZACOUNTS RECEIVABLE 6 00 00660 CASH ERIN RAZACOUNTS RECEIVABLE 7 00 00660 CASH ERIN RAZACOUNTS RAZACOUNTS RECEIVABLE 7 00 00660 CASH ERIN RAZACOUNTS		1 1						1
5.00   COSTO ARMITTING		l l						1
0.00680   CASHI EMIN CACCOUNTS RECEI VABLE		1 1						1
5.05 (0.0000) OTHER AGO (0.0000) DITEM AGO (0.00000) DITEM AGO (0.0000) DITEM AGO (0.0000		1 1						1
5.06   00992 PATIENT TRANSPORTATION   5.00		1 1						5. 05
8.00 000000 (AUNDRY & LINEN SERVICE 9.00 00000 (DISTREP) 9.00 00000 (DISTREP) 9.00 00000 (DISTREP) 9.00 0000 (DISTREP) 9.00 0000 (DISTREP) 9.00 00000  (DISTREP) 9.00 00000 (DISTREP) 9.00 000000 (DISTREP) 9.00 000000000 (DISTREP) 9.00 000000000000000000000000000000000	5.06	1 1						5.06
9.00   0.0900   MUSICAREP NO	7.00	00700 OPERATION OF PLANT						7.00
10.00   01000   ETARY		i i						8.00
11.00   01100   CAFETERIA								1
13.00   01300   MURSH NG AMM IN STRATION   14.00   01400   01500   PHARMACY   15.00		i i						1
14.00   01400   CENTRAL SERVICES & SUPPLY     14.00   1050   01600   MEDICAL RECORDS & LIBRARY     16.00   1070   1070   1070   1070   0170		1 1						1
15.00   01500   PHASMACY     16.00   17.00		1 1						1
16.00   1000   MEDICAL RECORDS & LIBRARY     16.00   17.00		1 1						1
17.01   01701   STAFF EDUCATION   599, 120   17.01   17.02   17		1 1						16.00
17. 02   O1702   MEDICAL EDUCATION   0   86, 165   223, 984   292, 076   217, 02   22. 00   220   187 SERVICES-SEALARY & FRINGES APPRVD   0   0   0   233, 984   292, 076   275, 2011   22. 00   2000   187 SERVICES-COTIE PROM COSTS APPRVD   0   0   0   0   0   0   0   20. 00   2000   2000   187 SERVICES COST CENTERS   380   0   0   0   0   0   0   0   0   0	17.00	01700 SOCIAL SERVICE						17.00
21.00   02100   IAS SERVICES-SALARY & FINNES APPRVD   0   0   233, 994   221,000   220,000   220,000   220,000   220,000   220,000   220,000   220,000   220,000   220,000   220,000   220,000   220,000   220,000   220,000   220,000   220,000   220,000   230,000   220,000   220,000   230,000   220,000   230	17. 01	01701 STAFF EDUCATION	599, 120					17. 01
22.00   02200   LAR SERVICES-OTHER PROM COSTS APPRVD   0   0   292,076   752,201   22.00   100,0000   100,0000   100,0000   100,0000   100,0000   100,0000   100,0000   100,0000   100,0000   100,0000   100,0000   100,00000		1 1	١					17. 02
23.0   0   2020  PARAMED ED PROCRAM   390   0   752, 201   23.0		1 1	1					21.00
INPATT   ENT ROUTINE SERVICE COST CENTERS   293, 304		1 1	١			292, 076	750 004	1
30.00	23. 00		380	0			/52, 201	23.00
31.00 03100   INTENSIVE CARE UNIT   56, 663   0   0   0   31.00   0   0   31.00   0   0   0   0   0   0   0   0   0	20.00		202 204		1		<u> </u>	20 00
31.01   33101 NEONATAL ICU						_		
40.00   04000   SUBPROVI DER - I PF   6. 245   0   0   0   0   0   0   0   0   0		1 1						1
A1 .00   04100   SUBPROVI DER - I RF   33, 667   0   0   0   0   41.00		l l				o	-	
ANCIL LLARY SERVICE COST CENTERS		1 1	1			Ö		1
50.00   05000   0FEATI NG ROOM   31,098   0 0 0 0 0 50.01   50.00   50.01   50.00   ENDOSCOPY   1,718   0 0 0 0 0 50.01   51.00   51.00   65	43.00	1 1		0	0	0	0	43.00
50.00     050001   ENDOSCOPY		ANCILLARY SERVICE COST CENTERS						
51.00   05100   DECOVERY ROOM & LABOR ROOM   5.907   0 0 0 0 0 0 51.00						· ·		
52 00   05200   DELIVERY ROOM & LABOR ROOM   21,514   0   0   0   0   52,00		1 1				· ·		1
53.00   05300   ANESTHESI OLOGY   0   0   0   53.00		1 1				- I	-	
54. 01 05400 RADIOLOGY-DIAGNOSTIC		1 1	1					1
54.01   CADI		1 1	١	-	1	0	-	1
55.00   05500   RADI OLOGY-THERAPEUTI C   2, 125   0   0   0   0   0   55.00		1 1				0		1
57.00   05700   CT SCAN   2,333   0   0   0   0   57.00						Ö		1
S8. 00   05900   MAGNETIC RESONANCE IMAGING (MRI)   6.48   0   0   0   0   0   59. 00	56.00	05600 RADI OI SOTOPE		0	0	o	0	56.00
59.00   05900   CARDI AC CATHETERI ZATI ON   8,074   0   0   0   0   0   59.00	57.00	05700 CT SCAN	2, 333	0	0	0	0	57.00
60.00   06.000   LABORATORY   1, 431   0   0   0   0   0   60.00		1 1			•	0	0	
60.01   06001   BLOOD LABORATORY   0   0   0   0   0   0   0   61.00						0	ŭ	1
61.00   06100   PBP CLI NI CAL LAB SERVI CES-PRGM ONLY						· ·		1
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   139   0   0   0   0   62. 00   63. 00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   0   0   0   63. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   65. 00   06500   RESPI RATORY THERAPY   7, 130   0   0   0   0   66. 00   06600   PHYSI CAL THERAPY   167   0   0   0   0   67. 00   06700   OCCUPATIONAL THERAPY   389   0   0   0   0   68. 00   06800   SPEECH PATHOLOGY   245   0   0   0   0   69. 00   06900   ELECTROCARDIOLOGY   1, 819   0   0   0   0   69. 01   06901   CARDIA CREHAB   102   0   0   0   0   69. 01   06901   CARDIA CREHAB   102   0   0   0   0   69. 01   07000   ELECTROCARDIOLOGY   2, 425   0   0   0   0   69. 01   07000   ELECTROCARDIOLOGY   1, 819   0   0   0   0   69. 01   07000   ELECTROCARDIOLOGY   1, 819   0   0   0   69. 01   07000   DIELECTROENCEPHALOGRAPHY   2, 042   0   0   0   0   69. 01   07000   DIELECTROENCEPHALOGRAPHY   2, 042   0   0   0   0   69. 01   07000   DIELECTROENCEPHALOGRAPHY   2, 042   0   0   0   0   69. 01   071, 00   69. 01   071, 00   69. 01   072, 00   69. 00   07200   INIBEL DEV. CHARGED TO PATIENTS   0   0   0   0   69. 01   072, 00   69. 00   07200   DRUGS CHARGED TO PATIENTS   1, 991   0   0   0   0   69. 00   07400   RENAL DIALYSIS   0   0   0   0   69. 00   07400   RENAL DIALYSIS   0   0   0   69. 00   09000   CLI NI C   0   69. 00   09000   08ERGRENCY   09000   0   69. 00   09000   08ERGRENCY   09000   09000   09000   69. 00   09000   09000   09000   09000   09000   69. 00   09000   09000   09000   09000   69. 00   09000   09000   09000   09000   09000   69. 00   09000   09000   09000   09000   09000   69. 00   09000   09000   09000   09000   09000   69. 00   09000   09000   09000   09000   09000   09000   69. 00   09000   09000   09000   09000   09000   09000   69. 00   09000   09000   09000   09000   09000   09000   09000   09000   69. 00   09000   09000   09000   09000   09000   09000   090			٥	Ü	0	U	Ü	
63.00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   0   0   0   63.00   64.00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   0   64.00   65.00   06500   RESPI RATORY THERAPY   7,130   0   0   0   0   0   65.00   66.00   06600   PHYSI CAL THERAPY   167   0   0   0   0   0   66.00   67.00   06700   0CCUPATI ONAL THERAPY   389   0   0   0   0   0   67.00   68.00   06800   SPECCH PATHOLOGY   245   0   0   0   0   0   68.00   69.01   06901   ELECTROCARDI OLOGY   1,819   0   0   0   0   0   69.01   70.00   07000   ELECTROCHEDI OLOGY   1,819   0   0   0   0   0   0   71.00   07000   ELECTROENCEPHALOGRAPHY   2,042   0   0   0   0   0   0   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   0   72.00   07200   IMPL DEV. CHARGED TO PATI ENTS   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   74.00   07400   RENAL DI ALYSIS   0   0   0   0   0   74.00   07400   RENAL DI ALYSIS   0   0   0   0   0   74.00   07400   RENAL DI ALYSIS   0   0   0   0   792.00   0900   CLINIC   C   2,019   0   0   0   792.00   0900   CLINIC   C   2,019   0   0   0   792.00   0900   DISERVATI ON BEDS (NON-DI STI NCT PART)   0   0   0   0   70.00   O100   HERGENCY   8,005   0   0   0   0   70.00   O100   HERGENCY   8,005   0   0   0   70.00   ONE IMBURSABLE COST CENTERS   70.00   O100   O100   HERALTH AGENCY   8,005   0   0   0   0   70.00   O100   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   70.00   0100   O100   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   70.00   0100   O100   O100   COPFEE SHOP & CANTEEN   0   0   0   0   0   70.00   0100   O100   COPFEE SHOP & CANTEEN   0   0   0   0   0   0   70.00   0100   O100   COPFEE SHOP & CANTEEN   0   0   0   0   0   0   70.00   0100   O100   COPFEE SHOP & CANTEEN   0   0   0   0   0   0   70.00   0100   COPFEE SHOP & CANTEEN   0   0   0   0   0   0   0   70.00   0100   O100   COPFEE SHOP & CANTEEN   0   0   0   0   0   0   0   70.00   0100   O100   COPFEE SHOP & CANTEEN   0   0   0   0   0			130	0	0	0	0	1
64. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   0   64. 00   65. 00   06500   RESPIRATORY THERAPY   7, 130   0   0   0   0   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   167   0   0   0   0   0   0   67. 00   06700   0CCUPATI ONAL THERAPY   389   0   0   0   0   0   0   68. 00   06800   SPEECH PATHOLOGY   245   0   0   0   0   0   68. 00   69. 00   06900   SELECTROCARDI OLOGY   1, 819   0   0   0   0   0   69. 01   06901   CARDI AC REHAB   102   0   0   0   0   0   70. 00   07000   ELECTROENCEPHALOGRAPHY   2, 042   0   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   1, 991   0   0   0   0   74. 00   07400   RENAL DI ALYSI S   0   0   0   0   74. 00   07400   RENAL DI ALYSI S   0   0   0   0   75. 00   09000   CLI IN C   0   75. 00   09000   CLI NI C   0   75. 00   09000   DESERVATI ON BEDS (NON-DI STI NCT PART)   0   0   0   0   75. 00   0100   HORE HEALTH AGENCY   8, 005   0   0   0   0   75. 201   118. 00   75. 201   190. 00   190. 00   190. 00   75. 201   190. 00   190. 00   190. 00   75. 201   190. 00   190. 00   75. 201   190. 00   190. 00   190. 00   75. 201   190. 00   190. 00   75. 201   190. 00   190. 00   75. 201   190. 00   75. 201   190. 00   75. 201   190. 00   75. 201   190. 00   75. 201   190. 00   75. 201   190. 00   75. 201   190. 00   75. 201   190. 00   75. 201   190. 00   75. 201   190. 00   75. 201						0	-	
65. 00   06500   RESPI RATORY THERAPY   7, 130   0   0   0   0   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   167   0   0   0   0   0   66. 00   67. 00   06700   0CUPATI ONAL THERAPY   339   0   0   0   0   0   0   68. 00   06800   SPEECH PATHOLOGY   245   0   0   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   1, 819   0   0   0   0   0   69. 01   06901   CARDI AC REHAB   102   0   0   0   0   0   70. 00   07000   ELECTROENCEPHALOGRAPHY   2, 042   0   0   0   0   0   71. 00   07000   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0   0   0   0   0   72. 00   07200   IMPL DEV. CHARGED TO PATI ENTS   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   74. 00   07400   RENAL DI ALYSI S   0   0   0   0   74. 00   07400   RENAL DI ALYSI S   0   0   0   0   74. 00   09100   CLI NI C   09200   DSERVATI ON BEDS (NON-DI STI NCT PART)   79. 00   09200   DSERVATI ON BEDS (NON-DI STI NCT PART)   0   0   0   0   70   010100   HOME HEALTH AGENCY   8, 005   0   0   0   0   70   00000   0100   MORREI MBURSABLE COST CENTERS    101. 00   10100   HOME HEALTH AGENCY   8, 005   0   0   0   0   70   00000   0100   00000   0   0   70   00000   0100   00000   0   70   00000   0100   00000   0   70   00000   0100   00000   0   70   00000   0100   00000   0   70   00000   0100   00000   00000   70   00000   0100   00000   00000   70   00000   00000   00000   70   00000   00000   00000   70   00000   00000   00000   70   00000   00000   00000   70   00000   00000   00000   70   00000   00000   00000   70   00000   00000   00000   70   00000   00000   00000   70   00000   00000   00000   70   00000   00000   00000   70   000000   00000   00000   70   00000   00000   00000   70   00000   00000   00000   70   00000   00000   00000   70   00000   00000   00000   70   00000   000000   000000   70   00000   000000   000000   70   000000   0000000000			-1	-	1	o	-	
66. 00   06600   PHYSI CAL THERAPY   167   0   0   0   0   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   389   0   0   0   0   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   245   0   0   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   1, 819   0   0   0   0   0   69. 01   06901   CARDI AC REHAB   102   0   0   0   0   0   70. 00   07000   ELECTROCEPHALOGRAPHY   2, 042   0   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   1, 991   0   0   0   0   74. 00   07400   RENAL DI ALYSIS   0   0   0   0   0   74. 00   07400   RENAL DI ALYSIS   0   0   0   0   75. 00   09000   CLI NI C   2, 019   0   0   0   76. 00   09100   EMERGENCY   67, 140   86, 165   233, 984   292, 076   752, 201   75. 201   101. 00   SPECI AL PURPOSE COST CENTERS    101. 00   SPECI AL PURPOSE COST CENTERS    102. 00   1000   1000   1000   1000   1000   1000   1000    103. 00   1000   1000   1000   1000   1000   1000    104. 00   1000   1000   1000   1000   1000   1000    105. 00   1000   1000   1000   1000   1000   1000    106. 00   1000   1000   1000   1000   1000   1000    107. 00   1000   1000   1000   1000   1000   1000    108. 00   109. 00   1000   1000   1000   1000    109. 00   109. 00   1000   1000   1000   1000    109. 00   1000   1000   1000   1000   1000   1000    1000   1000   1000   1000   1000   1000   1000    1000   1000   1000   1000   1000   1000   1000    1000   1000   1000   1000   1000   1000   1000   1000    1000   1000   1000   1000   1000   1000   1000   1000    1000   1000   1000   1000   1000   1000   1000   1000    1000   1000   1000   1000   1000   1000   1000   1000    1000   1000   1000   1000   1000   1000   1000    1000   1000   1000   1000   1000   1000   1000    1000   1000   1000   1000   1000   1000   1000    1000   1000   1000   1000   1000   1000   1000    1000   1000   1000   1000   1000   1000   1000    1000   1000   1000   1000   1000			-1			ol		1
68. 00				0	0	o	0	66.00
69. 00	67. 00	06700 OCCUPATI ONAL THERAPY	389	0	0	o	0	67.00
69. 01 06901 CARDI AC REHAB 102 0 0 0 0 0 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 2, 042 0 0 0 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 1, 991 0 0 0 0 0 73. 00 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 73. 00 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 74. 00 00TPATIENT SERVICE COST CENTERS  90. 00 09000 CLINIC 2, 019 0 0 0 0 0 90. 00 91. 00 09100 EMERGENCY 67, 140 86, 165 233, 984 292, 076 752, 201 91. 00 92. 00 09200 DBSERVATION BEDS (NON-DISTINCT PART) 92. 00 00THER REIMBURSABLE COST CENTERS  101. 00 10100 HOME HEALTH AGENCY 8, 005 0 0 0 0 0 101. 00 SPECIAL PURPOSE COST CENTERS  118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 591, 245 86, 165 233, 984 292, 076 752, 201 118. 00 NONREI MBURSABLE COST CENTERS				-	0	0	0	68.00
70. 00				0	0	0	-	69.00
71. 00		1 1		0	0	0		69.01
72. 00			2, 042	0	] 0	0		1
73. 00   07300   DRUGS CHARGED TO PATIENTS   1, 991   0   0   0   0   0   73. 00   74. 00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   74. 00    00TPATIENT SERVICE COST CENTERS  90. 00   09000   CLI NI C   2, 019   0   0   0   0   0   0    91. 00   09100   EMERGENCY   67, 140   86, 165   233, 984   292, 076   752, 201   91. 00    92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   92. 00    00THER REI MBURSABLE COST CENTERS  101. 00   10100   HOME HEALTH AGENCY   8, 005   0   0   0   0   101. 00    SPECI AL PURPOSE COST CENTERS  118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   591, 245   86, 165   233, 984   292, 076   752, 201   118. 00    NONREI MBURSABLE COST CENTERS  190. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   190. 00				0		0	-	
74. 00			1 001					1
OUTPATIENT SERVICE COST CENTERS   OUTP			1, 771					
90. 00	00				,	<u> </u>	0	1 55
91. 00	90.00		2, 019	0	0	O	0	90.00
OTHER REIMBURSABLE COST CENTERS  101. 00		09100 EMERGENCY	67, 140	86, 165	233, 984	292, 076	752, 201	91.00
101.00   10100   HOME HEALTH AGENCY   8,005   0   0   0   101.00	92.00							92.00
SPECIAL PURPOSE COST CENTERS					T	-		
118. 00     SUBTOTALS (SUM OF LINES 1 through 117)     591, 245     86, 165     233, 984     292, 076     752, 201       190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN     0     0     0     0     0     190. 00	101.00		8, 005	0	0	0	0	101.00
NONREI MBURSABLE COST CENTERS           190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         0         0         190. 00	110 00		E01 04E	0/ 1/5	222.004	202 07/	750 001	110 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190.00	118.00		591, 245	86, 165	233, 984	292, 076	752, 201	1118.00
	190 00		nl	Λ	n	nl	Ω	190.00
						l .		

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002 | Period: From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: 5/30/2018 8: 22 am

						5/30/2018 8:2	<u> </u>
				INTERNS &	RESI DENTS		
	Cost Center Description	STAFF	MEDI CAL	SERVI CES-SALA	SERVI CES-OTHE	PARAMED ED	
	oost denter bescription	EDUCATI ON	EDUCATI ON	RY & FRINGES		PROGRAM	
		17. 01	17. 02	21. 00	22. 00	23. 00	
192.00 19200	PHYSICIANS' PRIVATE OFFICES	7, 875	0	0	0	0	192.00
192. 01 19201	OTHER NON-REIMBURSABLE	0	0	0	0	0	192. 01
192. 02 19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0	0	192. 02
193.00 19300	NONPALD WORKERS	0	0	0	0	0	193.00
200. 00	Cross Foot Adjustments			0	0	0	200.00
201. 00	Negative Cost Centers	0	0	0	0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	599, 120	86, 165	233, 984	292, 076	752, 201	202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2017 | Part I | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-0002

					Т	o 12/31/2017   Date/Time Pr 5/30/2018 8:	
		Cost Center Description	Subtotal	Intern &	Total	, , , , , , , , , , , , , , , , , , , ,	
				Residents Cost & Post			
				Stepdown			
				Adjustments			
	GENER	AL SERVICE COST CENTERS	24. 00	25. 00	26. 00		
1.00		CAP REL COSTS-BLDG & FIXT					1.00
4. 00		EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 01		DATA PROCESSING PURCHASING RECEIVING AND STORES					5. 01
5. 02 5. 03	1	ADMITTING					5. 02 5. 03
5. 04		CASHI ERI NG/ACCOUNTS RECEI VABLE					5. 04
5. 05		OTHER A&G					5. 05
5. 06 7. 00	1	PATIENT TRANSPORTATION OPERATION OF PLANT					5. 06 7. 00
8. 00		LAUNDRY & LINEN SERVICE					8.00
9. 00	00900	HOUSEKEEPI NG					9. 00
10.00		DI ETARY					10.00
11. 00 13. 00	1	CAFETERIA NURSI NG ADMI NI STRATI ON					11. 00 13. 00
14. 00	1	CENTRAL SERVICES & SUPPLY					14.00
15.00		PHARMACY					15. 00
16.00		MEDICAL RECORDS & LIBRARY					16.00
17. 00 17. 01		SOCIAL SERVICE STAFF EDUCATION					17. 00 17. 01
17. 01		MEDICAL EDUCATION					17. 01
21. 00	1	I&R SERVICES-SALARY & FRINGES APPRVD					21.00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRVD	•				22.00
23. 00		PARAMED ED PROGRAM   ENT ROUTINE SERVICE COST CENTERS					23. 00
30.00		ADULTS & PEDIATRICS	75, 558, 456	0	75, 558, 456		30.00
31.00	1	INTENSIVE CARE UNIT	13, 539, 584	0	13, 539, 584		31.00
31. 01		NEONATAL I CU	3, 429, 065	0	3, 429, 065		31.01
40. 00 41. 00	1	SUBPROVI DER - I PF SUBPROVI DER - I RF	1, 870, 885 7, 399, 465	0	1, 870, 885 7, 399, 465		40. 00 41. 00
43. 00	1	NURSERY	2, 646, 170	0			43.00
		LARY SERVICE COST CENTERS					
50. 00 50. 01	1	OPERATING ROOM ENDOSCOPY	14, 680, 969 3, 983, 335	0	.,		50. 00 50. 01
51.00		RECOVERY ROOM	2, 834, 610	0			51.00
52.00		DELIVERY ROOM & LABOR ROOM	5, 285, 353	0	5, 285, 353		52.00
53.00		ANESTHESI OLOGY	0	0	0		53.00
54. 00 54. 01		RADI OLOGY - DI AGNOSTI C RADI OLOGY - ULTRASOUND	8, 766, 192 2, 968, 685	0	8, 766, 192 2, 968, 685		54. 00 54. 01
55. 00		RADI OLOGY-THERAPEUTI C	2, 418, 103	0	2, 418, 103		55. 00
56.00	1	RADI OI SOTOPE	2, 874, 182	0			56.00
57.00		CT SCAN	4, 116, 450	0	4, 116, 450		57.00
58. 00 59. 00		MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION	1, 456, 778 5, 260, 821	0			58. 00 59. 00
		LABORATORY	16, 241, 830	0	16, 241, 830		60.00
60. 01		BLOOD LABORATORY	0	0	0		60. 01
61.00	1	PBP CLINICAL LAB SERVICES-PRGM ONLY	0 154 073	0	0 154 073		61.00
62. 00 63. 00	1	WHOLE BLOOD & PACKED RED BLOOD CELLS BLOOD STORING, PROCESSING & TRANS.	2, 156, 872 0	0	2, 156, 872 0		62. 00 63. 00
64. 00		I NTRAVENOUS THERAPY	0	0	Ō		64.00
65.00		RESPI RATORY THERAPY	5, 164, 436	0	5, 164, 436		65.00
66. 00 67. 00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	3, 080, 426 2, 476, 309	0	3, 080, 426		66. 00 67. 00
68. 00		SPEECH PATHOLOGY	2, 476, 309 809, 874	0	2, 476, 309 809, 874		68.00
69. 00		ELECTROCARDI OLOGY	1, 285, 302	0	1, 285, 302		69.00
69. 01	1	CARDI AC REHAB	698, 400	0	698, 400		69. 01
70. 00 71. 00		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 776, 318 17, 136, 386	0	1, 776, 318 17, 136, 386		70.00 71.00
71.00		IMPL. DEV. CHARGED TO PATIENTS	19, 301, 610	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23, 137, 051	0	23, 137, 051		73. 00
74. 00		RENAL DIALYSIS	2, 779, 054	0	2, 779, 054		74. 00
90. 00		TIENT SERVICE COST CENTERS	10, 765, 177	0	10, 765, 177		90.00
91.00	1	EMERGENCY	17, 716, 916	-526, 060			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92. 00
101 00		REIMBURSABLE COST CENTERS	2 040 044		2 242 244		101 00
101.00		HOME HEALTH AGENCY   AL PURPOSE COST CENTERS	3, 213, 341	0	3, 213, 341		101.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	286, 828, 405	-526, 060	286, 302, 345		118. 00
400.5		IMBURSABLE COST CENTERS			2// 5		100.00
190.00	J 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	364, 508	0	364, 508	1	190. 00

Health Financial Systems METHODIST HOSPITA				In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0002	Peri od: From 01/01/2017 To 12/31/2017	Worksheet B Part I Date/Time Prepared:
Cook Cooker Doored at lon	Culatatal	1 = 4 = == 0	Tatal		5/30/2018 8: 22 am
Cost Center Description	Subtotal	Intern &	Total		
		Residents			
		Cost & Post			
		Stepdown			
		Adjustments			
	24. 00	25. 00	26. 00		
191. 00 19100 RESEARCH	0	0		0	191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	52, 316, 513	0	52, 316, 5	13	192. 00
192. 01 19201 OTHER NON-REIMBURSABLE	5, 404, 974	0	5, 404, 97	74	192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	766, 267	o	766, 26	57	192. 02
193. 00 19300 NONPALD WORKERS	0	o		0	193. 00
200.00 Cross Foot Adjustments	0	o		0	200.00
201.00 Negative Cost Centers	0	o		0	201.00
202.00 TOTAL (sum lines 118 through 201)	345, 680, 667	-526, 060	345, 154, 60	07	202. 00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2017 | Part II |
| To | 12/31/2017 | Date/Time | Prepared: | 5/30/2018 8: 22 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0002

					12/31/2017	5/30/2018 8: 2	
	Cost Center Description	Directly Assigned New Capital	CAPITAL RELATED COSTS BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSI NG	
		Related Costs 0	1.00	2A	4. 00	5. 01	
	GENERAL SERVICE COST CENTERS		1.00	2.5	4.00	3.01	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	84, 832		84, 832		4. 00
5. 01	00550 DATA PROCESSING	0	132, 002		2, 286	134, 288	5. 01
5. 02 5. 03	00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING	0	105, 314		569	0	5. 02
5. 03 5. 04	00570 ADMITTING 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	139, 572 440, 189		1, 116 1, 198	0	5. 03 5. 04
5. 05	00590 OTHER A&G	0	1, 430, 321		6, 282	134, 288	5.05
5.06	00592 PATIENT TRANSPORTATION	0	0		327	0	5.06
7. 00	00700 OPERATION OF PLANT	0	4, 299, 465		2, 190	0	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	256, 033	1	0	0	8.00
9.00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	296, 394	1	2, 572	0	9.00
10. 00 11. 00	01100 CAFETERI A	0	270, 727 189, 270	1	1, 175 665	0	10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION	0	91, 209	1	1, 648	0	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	514, 837	1	296	0	14. 00
15.00	01500 PHARMACY	0	272, 292	272, 292	0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	162, 410	1	1, 147	0	16.00
17.00	01700 SOCIAL SERVICE	0	23, 398		264	0	17.00
17. 01 17. 02	01701 STAFF EDUCATION 01702 MEDICAL EDUCATION	0	160, 112 5, 372		0 10	0	17. 01 17. 02
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	5, 3/2		0	0	21.00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	o o	64, 163		ő	Ö	22.00
23.00	02300 PARAMED ED PROGRAM	0	48, 319		319	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	.,,		17, 102	0	30.00
31. 00 31. 01	03100 INTENSIVE CARE UNIT	0	285, 320		3, 784	0	31. 00 31. 01
40.00	03101   NEONATAL   I CU   04000   SUBPROVI DER -   I PF	0	32, 433 57, 053		1, 155 581	0	40.00
41. 00	04100 SUBPROVI DER - I RF	0	448, 764		1, 683	0	41.00
43. 00	04300 NURSERY	0	1		393	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	1	1	2, 507	0	50.00
50. 01	05001 ENDOSCOPY 05100 RECOVERY ROOM	0	0 208, 934		697	0	50. 01
51. 00 52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	100, 589		661 1, 598	0	51.00 52.00
53. 00	05300 ANESTHESI OLOGY	0	100, 307	1	1, 370	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	762, 122	762, 122	1, 368	0	54.00
54. 01	05401 RADI OLOGY - ULTRASOUND	0	72, 594	1	794	0	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	193, 694		262	0	55.00
56.00	05600 RADI OI SOTOPE	0	129, 891		339	0	56.00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	122, 996 60, 399		616 250	0	57. 00 58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	l .		1, 156		59.00
60.00	06000 LABORATORY	Ö			1, 998	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	_		0		_	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	5, 530		668	0	62.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0	0	0	0	63. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	0	111, 548	111, 548	1, 365	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0	176, 242		874	Ö	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	151, 465	1	695	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	25, 797	25, 797	237	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	0	365	0	69.00
69. 01	06901 CARDI AC REHAB 07000 ELECTROENCEPHALOGRAPHY	0	0	0	224	0	69. 01
70. 00 71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	500 0	0	70. 00 71. 00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	23, 872	23, 872	218	0	73.00
74.00	07400 RENAL DIALYSIS	0	62, 956		0	0	74. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	,		1, 632	0	90.00
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	388, 724	388, 724 0	4, 012	0	91.00 92.00
7Z. UU	OTHER REIMBURSABLE COST CENTERS		L	. 0			72.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	1, 139	0	101. 00
	SPECIAL PURPOSE COST CENTERS	_					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	19, 666, 273	19, 666, 273	70, 937	134, 288	118. 00

Health Financial Systems	METHODIST HOS	SPITALS, INC		In Lie	eu of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C		Peri od:	Worksheet B	
				From 01/01/2017		
				To 12/31/2017	Date/Time Pre	epared:
					5/30/2018 8: 2	22 am
		CAPI TAL				
		RELATED COSTS				
Cost Center Description	Di rectly	BLDG & FIXT	Subtotal	EMPLOYEE	DATA	
'	Assigned New			BENEFLTS	PROCESSI NG	
	Capi tal			DEPARTMENT		
	•			DEI ARTIMENT		
	Related Costs					
	0	1.00	2A	4. 00	5. 01	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	25, 869	25, 86	9 22	0	190.00
191. 00 19100 RESEARCH	0	(		0	0	191.00
	1				1	1

383, 668

129, 230

20, 254, 695

49, 655

383, 668

49, 655 129, 230

20, 254, 695

0

0

12, 323

84, 832

1, 458

92

0

0 192.00 0 192. 01 0 192. 02

0 193.00

0 201. 00 134, 288 202. 00

200.00

192.00 19100 RESEARCH 192.00 19200 PHYSICI ANS' PRIVATE OFFICES 192.01 19201 OTHER NON-REI MBURSABLE 192.02 19202 FAMI LY HEALTH/GARY COMM HEALTH 193.00 19300 NONPAI D WORKERS

Cross Foot Adjustments

Negative Cost Centers TOTAL (sum lines 118 through 201)

200.00

201.00 202.00 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-0002

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2017 Part II
To 12/31/2017 Date/Time Prepared: 5/30/2018 8:22 am

					) 12/31/201/	5/30/2018 8: 2	
	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	2.02		9.9.		2.22	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00550 DATA PROCESSING	405 000					5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES	105, 883	140 000				5. 02
5. 03 5. 04	00570   ADMITTING   00580   CASHIERING/ACCOUNTS   RECEIVABLE	134 57	140, 822 0	441, 444			5. 03 5. 04
5. 05	00590 OTHER A&G	158	0	441, 444	1, 571, 049		5. 05
5. 06	00592 PATIENT TRANSPORTATION	10	0		3, 877	l	5.06
7. 00	00700 OPERATION OF PLANT	1, 409	0	o	122, 002		1
8.00	00800 LAUNDRY & LINEN SERVICE	1	0	0	8, 134	0	8. 00
9.00	00900 HOUSEKEEPI NG	1, 137	0	0	36, 526	0	9. 00
10.00	01000 DI ETARY	981	0	_	23, 000	0	10.00
11. 00	01100 CAFETERI A	1	0		8, 414	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	79	0		21, 740	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	947	0		13, 289	0	14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	410 22	0		27, 578 17, 058	1	15. 00 16. 00
	01700 SOCIAL SERVICE	0	0		3, 036	0	1
	01701 STAFF EDUCATION	l ol	0		809	o o	17. 01
	01702 MEDI CAL EDUCATI ON	2	0	0	326	0	17. 02
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	1, 063	0	21.00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	561	0	22. 00
23. 00		24	0	0	2, 498	0	23.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	5 040	44.4	05.040	0.40 0.47	1 700	00.00
30.00	03000 ADULTS & PEDIATRICS	5, 240	11, 411	35, 919	243, 247	1, 728	
31. 00 31. 01	03100 INTENSIVE CARE UNIT	2, 025 14	2, 017 653	6, 349 2, 054	51, 257 14, 029	24	31. 00 31. 01
40. 00	04000 SUBPROVI DER - I PF	7	398		7, 279	l .	40.00
41. 00	04100 SUBPROVI DER – I RF	288	910		23, 491	48	ı
43. 00	04300 NURSERY	333	240		7, 287	0	1
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 968	19, 649		50, 498	l e	
50. 01	05001 ENDOSCOPY	1, 874	2, 240		17, 023	105	1
51.00	05100 RECOVERY ROOM	107	1, 231	3, 876	9, 467	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	303	617 0	1, 942 0	20, 182 0	33	1
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 394	4, 249	_	29, 064	0 421	
54. 00	05401 RADI OLOGY - ULTRASOUND	397	1, 905		11, 741	439	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	77	1, 576		8, 359	29	55.00
56. 00	05600 RADI OI SOTOPE	2, 486	1, 750		10, 879	l	1
57.00	05700 CT SCAN	733	12, 660	39, 852	14, 666	669	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	237	3, 256	10, 250	5, 141	248	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	2, 044	8, 340		20, 442	l	59. 00
60.00	06000 LABORATORY	7, 617	16, 511	51, 973	63, 655	0	60.00
60. 01 61. 00	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	721	1, 022	3, 218	9, 352	0	61. 00 62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	1, 022	3, 218	9, 332	0	63.00
64. 00	06400 I NTRAVENOUS THERAPY		0	0	0	Ö	64.00
65.00	06500 RESPI RATORY THERAPY	1, 345	4, 650	14, 636	21, 161	4	65.00
66.00	06600 PHYSI CAL THERAPY	31	877	2, 759	11, 489	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	35	713	2, 245	9, 225	0	67.00
68. 00	06800 SPEECH PATHOLOGY	13	254	799	3, 222	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	43	2, 361	7, 433	5, 349	l	
69. 01	06901 CARDI AC REHAB	11	106		3, 077	0	69. 01
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	30, 064	2, 673 5, 714	8, 413 17, 987	7, 570 67, 909	l e	70. 00 71. 00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	34, 251	4, 084		76, 655	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	1, 429	17, 591	55, 374	75, 731	Ö	
	07400 RENAL DI ALYSI S	69	974	3, 067	11, 271	Ō	1
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	253	2, 562		34, 861	3	90.00
	09100 EMERGENCY	4, 476	7, 244	22, 802	62, 433	28	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
101 00	OTHER REIMBURSABLE COST CENTERS	04-1	00.	4 040	11 100	_	101 00
101.00	10100   HOME HEALTH AGENCY   SPECIAL PURPOSE COST CENTERS	215	384	1, 210	14, 493	<u> </u>	101.00
118.00		104, 472	140, 822	441, 444	1, 311, 416	A 21A	118. 00
	NONREI MBURSABLE COST CENTERS	104, 472	170, 022	1	7, 511, 410	1 7,214	1 . 5. 50
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	418	0	0	1, 337	0	190. 00
191.00	19100 RESEARCH	O	0		0	0	191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	971	0	0	232, 386	0	192. 00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0002	Peri od: Worksheet B From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/30/2018 8:22 am

						5/30/2018 8: 2	2 am
	Cost Center Description	PURCHASI NG	ADMITTI NG	CASHI ERI NG/AC	OTHER A&G	PATI ENT	
		RECEIVING AND		COUNTS		TRANSPORTATIO	
		STORES		RECEI VABLE		N	
		5. 02	5. 03	5. 04	5. 05	5. 06	
192. 01 19201	OTHER NON-REIMBURSABLE	22	0	0	23, 972	0	192. 01
192. 02 19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	1, 938	0	192. 02
193. 00 19300	NONPALD WORKERS	0	0	0	0	0	193.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	105, 883	140, 822	441, 444	1, 571, 049	4, 214	202.00

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ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0002

					12/31/201/	5/30/2018 8: 2	
	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		7. 00	8.00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 5. 02	00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES						5. 01 5. 02
5. 03	00570 ADMITTING						5. 03
5. 04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 04
5. 05	00590 OTHER A&G						5. 05
5. 06	00592 PATI ENT TRANSPORTATI ON						5. 06
7. 00 8. 00	00700 OPERATION OF PLANT	4, 425, 066 83, 165	l e				7.00
9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	96, 276	1				8. 00 9. 00
10. 00	01000 DI ETARY	87, 938	ł		392, 788		10.00
11. 00	01100 CAFETERI A	61, 479	ł .		0	266, 098	11.00
13.00	01300 NURSING ADMINISTRATION	29, 627	0	-,	0	6, 300	1
14.00	01400 CENTRAL SERVICES & SUPPLY	167, 231	3, 786		0	2, 696	1
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	88, 447	2	, , , , , , , , , , , , , , , , , , , ,	O  O	9 200	
17. 00	01700 SOCIAL SERVICE	52, 755 7, 600	l e	-,	0	8, 290 1, 494	1
17. 00	01701 STAFF EDUCATION	52, 008	l e		Ö	0	I
17. 02	01702 MEDI CAL EDUCATI ON	1, 745	0		0	31	1
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	_	0	0	21.00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	20, 841	0	_,	0	0	
23. 00	02300 PARAMED ED PROGRAM INPATIENT ROUTINE SERVICE COST CENTERS	15, 695	0	1, 600	0	2, 035	23. 00
30. 00	03000 ADULTS & PEDIATRICS	1, 461, 363	162, 480	149, 008	274, 088	94, 388	30.00
31. 00	03100   NTENSI VE CARE UNI T	92, 679	1		48, 473	16, 766	1
31. 01	03101 NEONATAL I CU	10, 535	1		0	4, 571	1
40. 00	04000 SUBPROVI DER - I PF	18, 532	l e	,	0	2, 720	1
41.00	04100 SUBPROVI DER - I RF	145, 769	l e		35, 008	8, 958	1
43. 00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	113, 954	7, 058	11, 619	0	1, 761	43. 00
50. 00	05000 OPERATING ROOM	278, 292	34, 214	28, 376	ol	12, 950	50.00
50. 01	05001 ENDOSCOPY	0	1		2	3, 296	1
51.00	05100 RECOVERY ROOM	67, 867	8, 956	6, 920	0	2, 699	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	32, 674	7, 652		13, 931	7, 527	1
53.00	05300 ANESTHESI OLOGY	0	0	_	0	0	
54. 00 54. 01	05400  RADI OLOGY-DI AGNOSTI C   05401  RADI OLOGY - ULTRASOUND	247, 555 23, 580	l		0	7, 868 3, 296	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	62, 916	l		0	1, 191	1
56. 00	05600 RADI OI SOTOPE	42, 192	l e		o	1, 361	1
57.00	05700 CT SCAN	39, 952	l		0	3, 099	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	19, 619	l		0	1, 158	1
59.00	05900 CARDI AC CATHETERI ZATI ON	39, 159			4, 273	4, 761	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	109, 727 0	0	,	0	10, 976 0	1
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	U	0		o o	U	61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 796	0	183	0	6, 061	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	36, 233			0	7, 151	1
66.00	06600 PHYSI CAL THERAPY	57, 248			0	3, 982	1
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	49, 199 8, 380	l e	-,	1, 162	2, 969 932	
69. 00	06900 ELECTROCARDI OLOGY	0, 300	1, 964		1, 102	2, 106	1
69. 01	06901 CARDI AC REHAB	0	1, 161	1	Ō	1, 169	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	19	2, 321	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	7 754	0	0	0	896	1
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	7, 754 20, 450	ł	791 2, 085	0	0	1
74.00	OUTPATIENT SERVICE COST CENTERS	20, 430	15, 705	2,003	<u> </u>		74.00
90.00		355, 434	11, 160	36, 242	0	7, 170	90.00
91.00	09100 EMERGENCY	126, 267	36, 559	12, 875	15, 832	20, 876	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
101 00	OTHER REIMBURSABLE COST CENTERS	0		. I	ما		101 00
101.00	10100   HOME HEALTH AGENCY   SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	101.00
118.00		4, 233, 933	344, 580	413, 416	392, 788	265, 825	118.00
	NONREI MBURSABLE COST CENTERS	., 200, 700		,	3,2,,00		]
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	8, 403	0		0		190. 00
	19100 RESEARCH	0	0	0	0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES   19201 OTHER NON-REIMBURSABLE	124, 624 16, 129		1	0		192. 00 192. 01
172.0	I 1/20 I OTHER NON-REINBURGABLE	10, 129	1 0	1, 045	Ч	0	1172.01

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: Worksheet B From 01/01/2017 Part II To 12/31/2017 Date/Time Prepared:

							5/30/2018 8: 2	22 am
		Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
			PLANT	LINEN SERVICE				
			7. 00	8. 00	9. 00	10.00	11. 00	
192	. 02 19202	FAMILY HEALTH/GARY COMM HEALTH	41, 977	0	4, 280	0	0	192.02
193	. 00 19300	NONPALD WORKERS	0	0	0	0	0	193.00
200	. 00	Cross Foot Adjustments						200.00
201	. 00	Negative Cost Centers	0	0	0	0	0	201.00
202	. 00	TOTAL (sum lines 118 through 201)	4, 425, 066	347, 333	432, 905	392, 788	266, 098	202.00

In Lieu of Form CMS-2552-10

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ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0002

						5/30/2018 8: 2	
	Cost Center Description	NURSI NG ADMI NI STRATI O	CENTRAL SERVICES &	PHARMACY	MEDI CAL RECORDS &	SOCI AL SERVI CE	
		N N	SUPPLY		LI BRARY	SERVICE	
	T	13. 00	14. 00	15. 00	16. 00	17. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FLXT						1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00550 DATA PROCESSING						5. 01
5.02	00560 PURCHASING RECEIVING AND STORES						5. 02
5. 03	00570 ADMI TTI NG						5. 03
5. 04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.04
5. 05 5. 06	O0590   OTHER A&G   O0592   PATI ENT TRANSPORTATI ON						5. 05 5. 06
7. 00	00700 OPERATION OF PLANT						7.00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	152 424					11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	153, 624	720, 134				14.00
15. 00	01500 PHARMACY		720, 134				15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		247, 061		16.00
17. 00	01700 SOCI AL SERVI CE	1, 272	0	0	0	37, 839	17. 00
17. 01	01701 STAFF EDUCATION	0	0	0	0	0	17. 01
17. 02	01702 MEDI CAL EDUCATI ON	0	0	0	0	0	17. 02
21. 00 22. 00	02100   &R SERVICES-SALARY & FRINGES APPRVD 02200   &R SERVICES-OTHER PRGM COSTS APPRVD		0	0	0	0	21.00 22.00
23. 00	1	1, 733	0		o	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS	,,		-	-		
30. 00	03000 ADULTS & PEDIATRICS	80, 378	0		20, 043	29, 194	30. 00
31.00	03100 INTENSIVE CARE UNIT	14, 277	0		3, 543	0	31.00
31. 01 40. 00	03101   NEONATAL   I CU   04000   SUBPROVI DER -   I PF	3, 892 2, 316	0	0	1, 146 699	0	31. 01 40. 00
41. 00	04100 SUBPROVI DER – TPF	7, 628	0		1, 598	6, 472	40.00
43. 00	04300 NURSERY	1, 499	0	1	421	0, 172	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	11, 027	0		34, 216	0	50.00
50. 01	05001 ENDOSCOPY	2, 807	0		3, 934	0	50.01
51. 00 52. 00	O5100   RECOVERY ROOM   O5200   DELI VERY ROOM & LABOR ROOM	2, 298 6, 409	0		2, 163 1, 084	0	51.00 52.00
53. 00	05300 ANESTHESI OLOGY	0, 409	0	-1	1, 084	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	o o	0	0	7, 464	0	54.00
54. 01	05401 RADI OLOGY - ULTRASOUND	0	0	0	3, 346	0	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	2, 769	0	55.00
56.00	05600 RADI OI SOTOPE	0	0	0	3, 074	0	56.00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	22, 238 5, 720	0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON		0	0	14, 649	0	59.00
60.00	06000 LABORATORY	o o	0	43, 943	29, 002	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	1, 796	0	62.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0	0	0	0	63. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY		0	0	8, 167	0	65.00
66. 00	06600 PHYSI CAL THERAPY	Ö	0	Ö	1, 540	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	1, 253	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	446	0	68.00
69.00	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	0	0	0	4, 148	0	69.00
69. 01 70. 00			0		187 4, 695	0	69. 01 70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		336, 573	0	10, 037	0	70.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	383, 561	0	7, 174	0	72.00
73. 00		0	0	,	30, 899	0	73. 00
74. 00		0	0	0	1, 711	0	74.00
90. 00	OUTPATIENT SERVICE COST CENTERS  O9000 CLINIC	l ol	0	0	4 500	0	90.00
	09100 EMERGENCY	18, 088	0		4, 500 12, 724	2, 173	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	10,000	0		12, 124	2, 173	92.00
00	OTHER REIMBURSABLE COST CENTERS						1
101.00	10100 HOME HEALTH AGENCY	0	0	292	675	0	101. 00
140 0	SPECIAL PURPOSE COST CENTERS	450 (0.1	700 15:	200 00:	047.04.1	07.05	110 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS	153, 624	720, 134	388, 821	247, 061	37, 839	Ji 18. 00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	l ol	0	0	0	n	190. 00
	19100 RESEARCH	0	0		o		191.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	8, 926	0		192. 00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10
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						5/30/2018 8: 2	22 am
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
		ADMI NI STRATI O	SERVICES &		RECORDS &	SERVI CE	
		N	SUPPLY		LI BRARY		
		13. 00	14. 00	15. 00	16. 00	17. 00	
192. 01 1920	1 OTHER NON-REIMBURSABLE	0	0	0	0	0	192. 01
192. 02 19202	2 FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0	0	192.02
193. 00 19300	NONPALD WORKERS	0	0	0	0	0	193.00
200. 00	Cross Foot Adjustments						200.00
201. 00	Negative Cost Centers	0	0	0	0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	153, 624	720, 134	397, 747	247, 061	37, 839	202.00

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				LUTERNO	DECL DENTS	5/30/2018 8: 2	2 am
				INTERNS &	RESI DENTS		
	Cost Center Description	STAFF	MEDI CAL	SERVI CES-SALA	SERVI CES-OTHE	PARAMED ED	
		EDUCATI ON	EDUCATI ON	RY & FRINGES	R PRGM COSTS	PROGRAM	
	GENERAL SERVICE COST CENTERS	17. 01	17. 02	21.00	22. 00	23. 00	
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						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
11. 00	01100 CAFETERI A						11.00
	01300 NURSI NG ADMI NI STRATI ON						13.00
	01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY						15.00
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE						16. 00 17. 00
	01700 SOCIAL SERVICE	218, 232					17. 00
	01702 MEDI CAL EDUCATI ON	0	7, 664				17. 02
	02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0				21.00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0		87, 690	70.044	22.00
23. 00	02300 PARAMED ED PROGRAM	138	0			72, 361	23. 00
30. 00	O3000 ADULTS & PEDIATRICS	106, 837	0				30.00
	03100   NTENSI VE CARE UNI T	20, 640	0				31.00
31. 01	03101 NEONATAL I CU	6, 646	0				31. 01
40.00	04000 SUBPROVI DER - I PF	2, 275	0				40.00
41.00	04100 SUBPROVI DER – I RF	12, 263	0				41.00
43. 00	04300   NURSERY   ANCILLARY SERVICE COST CENTERS	501	0				43.00
50.00	05000 OPERATING ROOM	11, 327	0				50.00
50. 01	05001 ENDOSCOPY	626	0				50. 01
51.00	05100 RECOVERY ROOM	2, 152	0				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	7, 837	0				52.00
53. 00 54. 00	05300   ANESTHESI OLOGY   05400   RADI OLOGY-DI AGNOSTI C	3, 143	0				53. 00 54. 00
54. 01	05401 RADI OLOGY - ULTRASOUND	2, 253	0				54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	774	0				55.00
56. 00	05600 RADI OI SOTOPE	187	0				56.00
57. 00 58. 00	05700 CT SCAN	850 236	0				57. 00 58. 00
59. 00	05800   MAGNETIC RESONANCE I MAGING (MRI)   05900   CARDIAC CATHETERIZATION	2, 941	0				59.00
60. 00	06000 LABORATORY	521	0				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	51	0				62.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0				63. 00 64. 00
65. 00	06500 RESPI RATORY THERAPY	2, 597	0				65.00
66.00	06600 PHYSI CAL THERAPY	61	0				66.00
67.00	06700 OCCUPATI ONAL THERAPY	142	0				67.00
68. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	89	0				68.00
69. 00 69. 01	06901 CARDI AC REHAB	663 37	0				69. 00 69. 01
	07000 ELECTROENCEPHALOGRAPHY	744	0	ł			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	725	0				73.00
74. 00	07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS	0	0				74.00
90.00	09000 CLINIC	735	0				90.00
	09100 EMERGENCY	24, 456	7, 664				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
101 00	OTHER REIMBURSABLE COST CENTERS	0.041	_				101 00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	2, 916	0				]101. 00
118.00		215, 363	7, 664	0	0	0	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
191.00	19100  RESEARCH	0	0	l			191. 00

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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002 | Period: From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: 5/30/2018 8: 22 am

						5/30/2018 8: 2	2 am
				INTERNS &	RESI DENTS		
Cost Co	enter Description	STAFF	MEDI CAL	SERVI CES-SALA	SERVI CES-OTHE	PARAMED ED	
		EDUCATI ON	EDUCATI ON	RY & FRINGES	R PRGM COSTS	PROGRAM	
		17. 01	17. 02	21. 00	22. 00	23. 00	
192. 00 19200 PHYSI C	ANS' PRIVATE OFFICES	2, 869	0				192.00
192. 01 19201 OTHER I	NON-REI MBURSABLE	0	0				192. 01
192. 02 19202 FAMI LY	HEALTH/GARY COMM HEALTH	0	0				192. 02
193. 00 19300 NONPALI	) WORKERS	0	0				193.00
200.00 Cross I	Foot Adjustments			1, 063	87, 690	72, 361	200. 00
201.00 Negativ	ve Cost Centers	0	0	0	0	0	201.00
202. 00 TOTAL	(sum lines 118 through 201)	218, 232	7, 664	1, 063	87, 690	72, 361	202.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | From 01/2010 | Prepared: | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0002

				10	o 12/31/2017 Date/lime Pr   5/30/2018 8:	
	Cost Center Description	Subtotal	Intern &	Total	1 67 667 26.6 6.	
			Resi dents			
			Cost & Post			
			Stepdown			
		24. 00	Adjustments 25.00	26. 00		
	GENERAL SERVICE COST CENTERS	21.00	20.00	20.00		
1.00	00100 CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 01	00550 DATA PROCESSING					5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES					5. 02
5. 03	00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE					5. 03
5. 04 5. 05	00590 OTHER A&G					5. 04 5. 05
5. 06	00592 PATIENT TRANSPORTATION					5.06
7. 00	00700 OPERATION OF PLANT					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00	00900 HOUSEKEEPI NG					9. 00
10.00	01000 DI ETARY					10.00
11.00	01100 CAFETERI A					11.00
13. 00 14. 00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY					13. 00 14. 00
15. 00	01500 PHARMACY					15.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY					16.00
17. 00	01700 SOCIAL SERVICE					17. 00
17. 01	01701 STAFF EDUCATION					17. 01
17. 02	1					17. 02
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD					21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD					22.00
23. 00	02300 PARAMED ED PROGRAM INPATIENT ROUTINE SERVICE COST CENTERS					23. 00
30. 00	03000 ADULTS & PEDIATRICS	7, 191, 384	0	7, 191, 384		30.00
31.00	03100 INTENSIVE CARE UNIT	565, 205	0			31.00
31. 01	03101 NEONATAL I CU	85, 795	0			31. 01
40.00	04000 SUBPROVI DER - I PF	95, 005	0	95, 005		40.00
41.00	04100 SUBPROVI DER - I RF	710, 606	0			41.00
43.00	04300 NURSERY	496, 638	0	496, 638		43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	1, 401, 790	0	1, 401, 790		50.00
50. 00	05001 ENDOSCOPY	43, 490	0			50.00
51. 00	05100 RECOVERY ROOM	317, 331	0			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	205, 710	0			52.00
53.00	05300 ANESTHESI OLOGY	0	0	0		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 113, 643	0			54.00
54. 01	05401 RADI OLOGY - ULTRASOUND	130, 675	0			54. 01
55. 00 56. 00	05500  RADI OLOGY-THERAPEUTI C   05600  RADI OI SOTOPE	283, 540	0			55. 00 56. 00
57. 00	05700 CT SCAN	206, 369 265, 027	0			57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	109, 562	0			58.00
59.00		256, 207	0			59.00
	06000 LABORATORY	684, 916	0	684, 916		60.00
	06001 BLOOD LABORATORY	0	0	0		60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	20.000		20.200		61.00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	30, 398	0	30, 398		62. 00 63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500 RESPIRATORY THERAPY	213, 056	0	213, 056		65. 00
66.00	06600 PHYSI CAL THERAPY	265, 073	0	265, 073		66.00
67.00	06700 OCCUPATI ONAL THERAPY	222, 958	0	222, 958		67.00
68.00	06800 SPEECH PATHOLOGY	42, 185	0	42, 185		68. 00
69. 00	06900 ELECTROCARDI OLOGY	24, 450	0	24, 450		69. 00
69. 01	06901 CARDI AC REHAB	6, 306	0	6, 306		69. 01
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	26, 970 468, 284	0	26, 970 468, 284		70. 00 71. 00
71.00	07200 I MPL. DEV. CHARGED TO PATTENTS	519, 478	0	519, 478		72.00
73.00		558, 965	0			73.00
74. 00		118, 348	0			74.00
	OUTPATIENT SERVICE COST CENTERS					
90.00		1, 556, 856	0			90.00
91.00		767, 233	0			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS		0			92.00
101. 00	10100 HOME HEALTH AGENCY	21, 324	0	21, 324		101.00
	SPECIAL PURPOSE COST CENTERS					
118.00		19, 004, 777	0	19, 004, 777		118. 00
100.00	NONREI MBURSABLE COST CENTERS	27 470	^	27 470		100.00
190.00	D 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	37, 179	0	37, 179		190. 00

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CO		Peri od:	Worksheet B	
				From 01/01/2017		
				To 12/31/2017	Date/Time Prep 5/30/2018 8: 22	
Cost Center Description	Subtotal	Intern &	Total		37 307 2010 0. 22	. aiii
Coor Conton Docon per on	oub to tu.	Resi dents				
		Cost & Post				
		Stepdown				
		Adjustments				
	24. 00	25. 00	26.00			
191. 00 19100 RESEARCH	0	0		0	1	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	781, 227	0	781, 22	27	1	192.00
192. 01 19201 OTHER NON-REIMBURSABLE	92, 881	0	92, 88	31	1	192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	177, 517	0	177, 51	7	1	192. 02
193. 00 19300 NONPALD WORKERS	o	0		0	1	193.00
200.00 Cross Foot Adjustments	161, 114	0	161, 11	4	[2	200.00
201.00 Negative Cost Centers	o	0		0	2	201.00
202 00 TOTAL (sum Lines 119 through 201)	20 254 605	o	20 254 60	5	-	202 00

20, 254, 695

20, 254, 695

202.00

202.00

TOTAL (sum lines 118 through 201)

	ALLOCATION - STATISTICAL BASIS	WETHODIST HOSE	Provi der Co	CN: 15-0002 F	eri od:	Worksheet B-1	
				F	rom 01/01/2017 o 12/31/2017	Doto/Time Doo	norod.
				'	0 12/31/201/	5/30/2018 8: 2	epareu: 22 am
		CAPI TAL	<u>'</u>				
		RELATED COSTS					
	Cost Center Description	BLDG & FIXT	EMPLOYEE	DATA	PURCHASI NG	ADMI TTI NG	
		(SQUARE FEET)	BENEFITS	PROCESSI NG	RECEIVING AND	(GROSS	
			DEPARTMENT	(MACHI NE	STORES	CHARGES)	
			(GROSS	TIME)	(PURCHASE		
		1. 00	4. 00	5. 01	REQUISITIONS) 5. 02	5. 03	
	GENERAL SERVICE COST CENTERS	1.00	4.00	3.01	5.02	5.03	
1.00	00100 CAP REL COSTS-BLDG & FLXT	1, 410, 133					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	5, 906	149, 933, 403				4.00
5. 01	00550 DATA PROCESSING	9, 190	4, 039, 363	100	j		5. 01
5.02	00560 PURCHASING RECEIVING AND STORES	7, 332	1, 005, 062	C	42, 424, 880		5. 02
5. 03	00570 ADMI TTI NG	9, 717	1, 971, 495			1, 220, 297, 021	
5. 04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	30, 646	2, 116, 202			0	
5. 05	00590 OTHER A&G	99, 579	11, 099, 348			0	
5.06	00592 PATIENT TRANSPORTATION	0	578, 272			0	
7.00	00700 OPERATION OF PLANT	299, 329	3, 869, 603			0	7.00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	17, 825 20, 635	0 4, 544, 467			0	
10.00	01000 DI ETARY	18, 848	2, 076, 103			0	
11. 00	01100 CAFETERI A	13, 177	1, 174, 508			0	1
13. 00	01300 NURSING ADMINISTRATION	6, 350	2, 911, 730			0	13.00
14. 00		35, 843	523, 068			0	1
15. 00	01500 PHARMACY	18, 957	0			0	15.00
16.00		11, 307	2, 026, 695			0	16.00
17. 00	01700 SOCI AL SERVI CE	1, 629	465, 581			0	17. 00
	01701 STAFF EDUCATION	11, 147	0		o	0	17. 01
17. 02	01702 MEDICAL EDUCATION	374	17, 205	(	601	0	17. 02
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	C	0	0	21.00
22.00		4, 467	0	C	0	0	22.00
23.00	02300 PARAMED ED PROGRAM	3, 364	564, 332	(	9, 509	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1					
30.00		313, 217	30, 262, 712			99, 224, 902	
	03100 INTENSIVE CARE UNIT	19, 864	6, 685, 201				
31. 01	l l	2, 258	2, 041, 118			5, 674, 848	
	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	3, 972	1, 026, 681			3, 462, 684	
41. 00 43. 00	04300 NURSERY	31, 243 24, 424	2, 973, 707 694, 855				1
43.00	ANCILLARY SERVICE COST CENTERS	24, 424	074, 033		133, 330	2,003,301	43.00
50.00		59, 647	4, 429, 484		788, 548	166, 627, 825	50.00
50. 01	05001 ENDOSCOPY	0	1, 231, 684			19, 475, 289	
51.00	05100 RECOVERY ROOM	14, 546	1, 168, 467			10, 706, 556	
52.00	05200 DELIVERY ROOM & LABOR ROOM	7, 003	2, 824, 170	C	121, 495	5, 364, 077	
53.00	05300 ANESTHESI OLOGY	0	0	C	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	53, 059	2, 416, 511	(	157, 768	36, 949, 293	54.00
54. 01	05401 RADI OLOGY - ULTRASOUND	5, 054	1, 402, 719				
	05500 RADI OLOGY-THERAPEUTI C	13, 485	463, 510				
	05600 RADI OI SOTOPE	9, 043	598, 750			15, 215, 385	1
57. 00		8, 563	1, 089, 202			110, 088, 963	1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	4, 205	442, 254			28, 315, 443	
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	8, 393	2, 042, 870			72, 518, 351	
60.00	06000 LABORATORY	23, 518	3, 529, 926			143, 572, 843 0	1
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		U	1	,	U	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	385	1, 180, 582		289, 056	8, 890, 399	1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	1, 100, 302			0, 0,0,0,377	1
64. 00	06400 I NTRAVENOUS THERAPY	0	0			0	1
65. 00	06500 RESPI RATORY THERAPY	7, 766	2, 412, 283			40, 430, 889	
66.00	06600 PHYSI CAL THERAPY	12, 270	1, 544, 468	l c		7, 622, 213	
67.00	06700 OCCUPATI ONAL THERAPY	10, 545	1, 228, 704	(	13, 986	6, 200, 644	67.00
68.00	06800 SPEECH PATHOLOGY	1, 796	418, 838	C	5, 208	2, 206, 688	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	644, 586	[ c	17, 316	20, 532, 765	69.00
69. 01	06901 CARDI AC REHAB	0	395, 078			923, 324	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	883, 233			23, 240, 973	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1		49, 686, 879	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0			35, 515, 731	1
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 662	384, 721			152, 966, 052	
74. 00	07400 RENAL DIALYSIS	4, 383	0	C	27, 628	8, 471, 203	74.00
90. 00	OUTPATIENT SERVICE COST CENTERS  09000 CLINIC	76, 181	2, 883, 925		101, 536	22, 277, 687	90.00
91.00	09100 EMERGENCY	27, 063	2, 883, 925 7, 088, 086				1
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	27,003	7,000,000		1, 773, 439	02, 700, 270	92.00
, 2. 00	OTHER REIMBURSABLE COST CENTERS						72.00
101.00	10100 HOME HEALTH AGENCY	0	2, 012, 787	C	85, 950	3, 342, 486	101.00
	SPECIAL PURPOSE COST CENTERS						1
118.00		1, 369, 167	125, 384, 146	100	41, 859, 797	1, 220, 297, 021	118. 00

Health Finar	ncial Systems	METHODI ST HOSI	DITAIS INC		In lie	u of Form CMS-2	2552_10
	TION - STATISTICAL BASIS	WETHODIST 11031	Provi der CO	N: 15-0002 P	eri od:	Worksheet B-1	
	TION SINTISTICAL BASIS		Trovider of		rom 01/01/2017	Date/Time Pre 5/30/2018 8: 2	pared:
	Cook Cooker Doors' atten	CAPITAL RELATED COSTS BLDG & FLXT	EMDLOVEE	DATA	DIDONACINO	ADMITTI NO	
	Cost Center Description	(SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	DATA PROCESSING (MACHINE TIME)	PURCHASI NG RECEI VI NG AND STORES (PURCHASE	ADMI TTI NG (GROSS CHARGES)	
			SALARI ES)		REQUISITIONS)		
NONE	LUDURARI E AGOT AFRITERO	1. 00	4. 00	5. 01	5. 02	5. 03	
	I MBURSABLE COST CENTERS	1 004	20 724		4/7 04/		100.00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 801	39, 731	0	167, 316	-	190. 00 191. 00
191. 00 19100	PHYSICIANS' PRIVATE OFFICES	0/ 711	01 770 000	0	200 000	-	191.00
	OTHER NON-REIMBURSABLE	26, 711	21, 772, 009 2, 575, 181	0	389, 088		192.00
	FAMILY HEALTH/GARY COMM HEALTH	3, 457 8, 997	162, 336	0	8, 679		192.01
	NONPALD WORKERS	0, 997	102, 330	0	0		192.02
200.00	Cross Foot Adjustments	٩	۷	U	٩	U	200.00
200.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	20, 254, 695	35, 966, 699	11, 734, 804	3, 697, 648		
202.00	Part I)	20, 254, 075	33, 700, 077	11, 754, 004	3, 077, 040	3, 030, 023	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	14. 363677	0. 239884	117, 348. 04000	0. 087158	0. 002488	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)		84, 832	134, 288	105, 883	140, 822	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part		0. 000566	1, 342. 880000	0. 002496	0. 000115	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)		•				206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00
ı	,	ı I			! I		ı

	Financial Systems ALLOCATION – STATISTICAL BASIS	METHODIST HOSP	Provider C	ON: 1E 0002 D		u of Form CMS-	
CUST	ALLUCATION - STATISTICAL BASIS		Provider Co	F	eriod: rom 01/01/2017 o 12/31/2017	Worksheet B-1 Date/Time Pre	
						5/30/2018 8: 2	2 am
	Cost Center Description	CASHI ERI NG/AC F	Reconciliatio n		PATI ENT TRANSPORTATIO	OPERATION OF PLANT	
		RECEI VABLE		(	N	(SQUARE FEET)	
		(GROSS			(NUMBER OF		
		CHARGES) 5. 04	5A. 05	5. 05	TRI PS) 5. 06	7. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 4. 00	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT						1. 00 4. 00
4. 00 5. 01	00550 DATA PROCESSING						5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES						5. 02
5. 03	00570 ADMITTING	1 220 207 021					5. 03
5. 04 5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER A&G	1, 220, 297, 021	-34, 808, 999	310, 871, 668			5. 04 5. 05
5. 06	00592 PATIENT TRANSPORTATION	0	0	767, 040			5.06
7.00	00700 OPERATION OF PLANT	0	0	24, 139, 683			1
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	0	1, 609, 477 7, 227, 080		,	•
10.00	01000 DI ETARY	0	0	4, 550, 839		•	1
11.00	01100 CAFETERI A	0	0	1, 664, 835			
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	0	4, 301, 613 2, 629, 310			13. 00 14. 00
15. 00	01500 PHARMACY	0	0	5, 456, 613			15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	3, 375, 096		,	16.00
17. 00 17. 01	01700 SOCIAL SERVICE 01701 STAFF EDUCATION	0	0	600, 664 160, 112			1
	01702 MEDICAL EDUCATION	0	0	64, 541			1
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	210, 423		l	21.00
22.00	02200   1&R SERVICES-OTHER PRGM COSTS APPRVD 02300   PARAMED ED PROGRAM	0	0	110, 915 494, 174			1
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		474, 174		3, 304	25.00
30.00	03000 ADULTS & PEDIATRICS	99, 224, 902	0	48, 149, 026			1
31. 00 31. 01	03100   NTENSI VE CARE UNI T 03101   NEONATAL   CU	17, 539, 425 5, 674, 848	0	10, 141, 821 2, 775, 773		1	1
40.00	04000 SUBPROVI DER - I PF	3, 462, 684	0	1, 440, 316			1
41.00	04100 SUBPROVI DER - I RF	7, 909, 819	0	4, 647, 948			1
43. 00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	2, 083, 501	0	1, 441, 752	0	24, 424	43.00
50.00	05000 OPERATING ROOM	166, 627, 825	0	9, 991, 691	4	59, 647	50.00
50. 01	05001 ENDOSCOPY	19, 475, 289	0	3, 368, 197		l	
51. 00 52. 00	O5100   RECOVERY ROOM   O5200   DELIVERY ROOM & LABOR ROOM	10, 706, 556 5, 364, 077	0	1, 873, 199 3, 993, 265		14, 546 7, 003	•
53. 00	05300 ANESTHESI OLOGY	0	0	0, 773, 203		1	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	36, 949, 293	0	5, 750, 685			•
54. 01 55. 00	05401   RADI OLOGY - ULTRASOUND   05500   RADI OLOGY-THERAPEUTI C	16, 563, 335 13, 708, 271	0	2, 323, 078 1, 653, 847			
	05600 RADI OI SOTOPE	15, 215, 385	0	2, 152, 616			56.00
	05700 CT SCAN	110, 088, 963	0	2, 901, 925		•	57.00
58. 00 59. 00	05800   MAGNETI C RESONANCE I MAGING (MRI)   05900   CARDI AC CATHETERI ZATI ON	28, 315, 443 72, 518, 351	0	1, 017, 275 4, 044, 716			58. 00 59. 00
60.00	06000 LABORATORY	143, 572, 843	0	12, 594, 987		23, 518	
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	1
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	8, 890, 399	0	1, 850, 499	0	385	61.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	Ö	l	1
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	· ·		
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	40, 430, 889 7, 622, 213	0	4, 187, 018 2, 273, 210			65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	6, 200, 644	0	1, 825, 369		i .	
68. 00	06800 SPEECH PATHOLOGY	2, 206, 688	0	637, 418		, , , ,	1
69. 00 69. 01	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	20, 532, 765 923, 324	0	1, 058, 272 608, 907		0	1
70.00	1	23, 240, 973	0	1, 497, 762			
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	49, 686, 879	0	13, 436, 603			
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	35, 515, 731 152, 966, 052	0	15, 167, 230 14, 984, 417		l	
74.00	07400 RENAL DIALYSIS	8, 471, 203	0	2, 230, 123			•
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C 09100 EMERGENCY	22, 277, 687 62, 988, 278	0				90.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	02, 700, 270	O	12, 333, 143	323	27,003	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY   SPECIAL PURPOSE COST CENTERS	3, 342, 486	0	2, 867, 611	0	0	101.00
118.00		1, 220, 297, 021	-34, 808, 999	259, 499, 840	48, 666	907, 468	118.00
	NONREI MBURSABLE COST CENTERS						1
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	264, 450	0	1, 801	190. 00

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

	Cost Center Description	CASHI ERI NG/AC COUNTS RECEI VABLE (GROSS	Reconciliatio n	Т	N (NUMBER OF	5/30/2018 8: 2 OPERATION OF	
		CHARGES) 5. 04	5A. 05	5. 05	TRI PS) 5. 06	7. 00	
191. 00 1910	O RESEARCH	0.01	0	0.00	0.00		191. 00
192. 00 1920	O PHYSICIANS' PRIVATE OFFICES	O	0	45, 980, 657	0		192.00
192. 01 1920	1 OTHER NON-REIMBURSABLE	0	0	4, 743, 255	1	3, 457	192. 01
192. 02 1920	2 FAMILY HEALTH/GARY COMM HEALTH	0	0	383, 466	0	8, 997	192. 02
193. 00 1930	O NONPALD WORKERS	0	0	C	0	0	193. 00
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	5, 358, 075		34, 808, 999	852, 927	26, 842, 652	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 004391		0. 111972	17. 525777	28. 302077	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	441, 444		1, 571, 049	4, 214	4, 425, 066	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000362		0. 005054	0. 086588	4. 665655	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

COST ALLOCATION - STATISTICAL BASIS			Provi der Co		eriod: com 01/01/2017	Worksheet B-1	
				To			pared:
Cost Center Descri	ption	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	5/30/2018 8: 2 NURSI NG	2 am
		LINEN SERVICE	(SQUARE FEET)	(MEALS	(PRODUCTI VE	ADMI NI STRATI O	
		(POUNDS OF LAUNDRY)		SERVED)	HOURS)	N (DI RECT NURS.	
		EnonDitty				HRS. )	
GENERAL SERVICE COST CEN	ITEDS	8. 00	9. 00	10.00	11. 00	13. 00	
1. 00 O0100 CAP REL COSTS-BLDG							1.00
4. 00 00400 EMPLOYEE BENEFITS	DEPARTMENT						4. 00
5. 01 00550 DATA PROCESSING 5. 02 00560 PURCHASING RECEIVI	NG AND STORES						5. 01 5. 02
5. 03   00570   ADMI TTI NG	NO TIND STORES						5. 03
5. 04 00580 CASHI ERI NG/ACCOUNT	S RECEIVABLE						5. 04
5. 05   00590 OTHER A&G 5. 06   00592 PATIENT TRANSPORTA	TION						5. 05 5. 06
7.00 00700 OPERATION OF PLANT							7. 00
8.00   00800 LAUNDRY & LINEN SE	RVI CE	2, 251, 221	000 074				8. 00 9. 00
9. 00   00900   HOUSEKEEPI NG 10. 00   01000   DI ETARY		0	909, 974 18, 848				10.00
11. 00   01100   CAFETERI A		0	13, 177	0	2, 667, 928		11. 00
13. 00   01300   NURSI NG   ADMI NI STRA		0	6, 350		63, 165	1, 808, 806	13.00
14. 00   01400   CENTRAL SERVICES & 15. 00   01500   PHARMACY	SUPPLY	24, 538 14	35, 843 18, 957		27, 026 0	0	14. 00 15. 00
16.00 01600 MEDICAL RECORDS &	LI BRARY	O	11, 307		83, 117	0	16.00
17. 00   01700   SOCIAL SERVICE		0	1, 629	0	14, 979	14, 979	
17. 01   01701   STAFF EDUCATION 17. 02   01702   MEDICAL EDUCATION		ol Ol	11, 147 374	0	306	0	17. 01 17. 02
21.00   02100   1 &R SERVICES-SALAR		Ō	0		0	0	21.00
22. 00   02200   1 &R SERVI CES-OTHER		0	4, 467		20, 200	0	22.00
23.00 O2300 PARAMED ED PROGRAM INPATIENT ROUTINE SERVICE		U	3, 364	0	20, 399	20, 399	23. 00
30. 00 03000 ADULTS & PEDIATRIC	S	1, 053, 107	313, 217		946, 399	· ·	30. 00
31. 00   03100   I NTENSI VE CARE UNI 31. 01   03101   NEONATAL   I CU	T	55, 750	19, 864		168, 096	168, 096	
31. 01   03101   NEONATAL   I CU 40. 00   04000   SUBPROVI DER -   I PF		49, 211 0	2, 258 3, 972		45, 825 27, 268	45, 825 27, 268	
41. 00   04100   SUBPROVI DER - I RF		O	31, 243	31, 390	89, 811	89, 811	41.00
43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST O	PENTEDS	45, 746	24, 424	0	17, 652	17, 652	43. 00
50. 00 05000 OPERATING ROOM	DENTERS	221, 757	59, 647	0	129, 836	129, 836	50. 00
50. 01 05001 ENDOSCOPY		24, 862	0	_	33, 046	33, 046	
51.00   05100   RECOVERY ROOM 52.00   05200   DELIVERY ROOM & LA	BOR ROOM	58, 048 49, 593	14, 546 7, 003		27, 057 75, 465	27, 057 75, 465	51. 00 52. 00
53. 00   05300   ANESTHESI OLOGY	BOIL ILOUM	0	0	0	0	0	53.00
54. 00   05400   RADI OLOGY - DI AGNOST		73, 737	53, 059		78, 882	0	54.00
54. 01   05401   RADI OLOGY - ULTRAS 55. 00   05500   RADI OLOGY-THERAPEU		12, 511 3, 343	5, 054 13, 485		33, 042 11, 940	0	54. 01 55. 00
56. 00   05600 RADI OI SOTOPE		27, 053	9, 043		13, 641	0	56.00
57. 00 05700 CT SCAN		16, 995	8, 563		31, 066	0	57.00
58. 00 05800 MAGNETI C RESONANCE 59. 00 05900 CARDI AC CATHETERI Z		6, 794 48, 542	4, 205 8, 393		11, 608 47, 739	0	
60. 00   06000   LABORATORY		0	23, 518		110, 043	0	60.00
60. 01   06001   BLOOD   LABORATORY	EDVI CEC DDOM ONLY	0	0	0	0	0	60.01
61.00   06100   PBP CLINICAL LAB S 62.00   06200   WHOLE BLOOD & PACK		0	385	0	60, 768	0	61. 00 62. 00
63. 00 06300 BLOOD STORING, PRO		Ō	0		0	0	63.00
64. 00   06400   I NTRAVENOUS THERAP 65. 00   06500   RESPI RATORY THERAP		0	0		71 701	0	64.00
65. 00   06500   RESPI RATORY THERAP 66. 00   06600   PHYSI CAL THERAPY	T	3, 266 26, 785	7, 766 12, 270		71, 701 39, 924	0	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERA	PY	0	10, 545	0	29, 772	0	67. 00
68. 00 06800 SPEECH PATHOLOGY		12 722	1, 796		9, 342	0	68. 00 69. 00
69. 00   06900   ELECTROCARDI OLOGY 69. 01   06901   CARDI AC   REHAB		12, 732 7, 525	0	0	21, 113 11, 725	0	69.00
70. 00 07000 ELECTROENCEPHALOGR	1	0	0	17	23, 269	0	70. 00
71.00   07100   MEDICAL SUPPLIES C 72.00   07200   IMPL. DEV. CHARGED		0	0	0	0 8, 981	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO P		0	1, 662	١	0, 901	0	73.00
74.00 07400 RENAL DIALYSIS		102, 179	4, 383		0	0	74.00
90. 00 O9000 CLINIC	CENTERS	72, 335	76, 181	O	71, 882	0	90.00
91.00 09100 EMERGENCY		236, 953	27, 063		209, 301	212, 973	91.00
92. 00 09200 OBSERVATION BEDS (							92.00
OTHER REIMBURSABLE COST 101.00 10100 HOME HEALTH AGENCY		0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CEN		2, 233, 376	869, 008		2, 665, 186		110 00
NONREIMBURSABLE COST CEN	ITERS						
190. 00 19000 GLFT, FLOWER, COFF	EE SHOP & CANTEEN	0	1, 801	0	2, 742	0	190. 00

| Peri od: | Worksheet B-1 | From 01/01/2017 | To 12/31/2017 | Date/Ti me Prepared:

				10	0 12/31/2017	5/30/2018 8:2	pared: 2 am
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
		LINEN SERVICE	(SQUARE FEET)	(MEALS	(PRODUCTI VE	ADMI NI STRATI O	
		(POUNDS OF		SERVED)	HOURS)	N	
		LAUNDRY)				(DI RECT NURS.	
						HRS. )	
		8. 00	9. 00	10.00	11. 00	13. 00	
	19100 RESEARCH	0	0	0	0		191. 00
4	19200 PHYSICIANS' PRIVATE OFFICES	17, 845			0		192. 00
4	19201 OTHER NON-REIMBURSABLE	0	3, 457		0		192. 01
	19202 FAMILY HEALTH/GARY COMM HEALTH	0	8, 997	0	0		192. 02
	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,	2, 294, 178	8, 620, 324	5, 772, 394	2, 349, 014	5, 078, 761	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	1. 019082					
204.00	Cost to be allocated (per Wkst. B,	347, 333	432, 905	392, 788	266, 098	153, 624	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 154286	0. 475733	1. 115270	0. 099740	0. 084931	205. 00
	[11]						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

				FI	rom 01/01/2017 o 12/31/2017		
	Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S. )	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	STAFF EDUCATION (TIME SPENT)	Zum
	CENEDAL SERVICE COST CENTERS	14. 00	15. 00	16. 00	17. 00	17. 01	
17. 01 17. 02 21. 00	02200   &R SERVICES-OTHER PRGM COSTS APPRVD 02300   PARAMED ED PROGRAM	25, 771, 546 0 0 0 0 0 0 0	15, 032, 603 0 0 0 0 0 0	0	801 0 0 0 0	1	17. 02 21. 00 22. 00
30. 00 31. 00 31. 01 40. 00 41. 00 43. 00	NPATIENT ROUTINE SERVICE COST CENTERS  03000 ADULTS & PEDIATRICS  03100 INTENSIVE CARE UNIT  03101 NEONATAL ICU  04000 SUBPROVI DER - I PF  04100 SUBPROVI DER - I RF  04300 NURSERY	0 0 0 0 0	204 0 0 0 0 0	17, 539, 425 5, 674, 848 3, 462, 684 7, 909, 819	618 0 0 0 137 0	12, 239 3, 941 1, 349 7, 272	31. 00 31. 01 40. 00 41. 00
60. 01 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 01 70. 00 71. 00 72. 00 73. 00	06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 06901 CARDIAC REHAB 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 1, 660, 813 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	19, 475, 289 10, 706, 556 5, 364, 077 0 36, 949, 293 16, 563, 335 13, 708, 271 15, 215, 385 110, 088, 963 28, 315, 443 72, 518, 351 143, 572, 843 0 8, 890, 399 0 40, 430, 889 7, 622, 213 6, 200, 644 2, 206, 688 20, 532, 765 923, 224 23, 240, 973 49, 686, 879 35, 515, 731 152, 966, 052	0 0 0 0	371 1, 276 4, 647 0 1, 864 1, 336 459 111 504 140 1, 744 309 0 30 0 1, 540 36 84 53 393 22 441 0 0	50. 01 51. 00 52. 00 53. 00 54. 01 55. 00 56. 00 57. 00 58. 00 60. 01 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 01 70. 00 71. 00 72. 00 73. 00
	OUTPATIENT SERVICE COST CENTERS  09000 CLINIC  09100 EMERGENCY  09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 46		1
	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	11, 044	3, 342, 486	0	1, 729	101.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	25, 771, 546		1, 220, 297, 021		·	
190.00	) 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	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

				Fi To	rom 01/01/2017 o 12/31/2017	Date/Time Pre 5/30/2018 8:2	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	STAFF	2 4111
		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 1910	00 RESEARCH	0	0	0	0	0	191. 00
192. 00 1920	OO PHYSICIANS' PRIVATE OFFICES	0	337, 351	0	0	1, 701	192.00
	OTHER NON-REIMBURSABLE	0	0	0	0		192. 01
192. 02 1920	2 FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0	0	192. 02
	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,	4, 326, 497	6, 783, 720	4, 253, 319	784, 704	599, 120	202.00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 167879	0. 451267	0. 003485	979. 655431	4. 629698	203. 00
204.00	Cost to be allocated (per Wkst. B,	720, 134	397, 747	247, 061	37, 839	218, 232	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 027943	0. 026459	0. 000202	47. 239700	1. 686387	205. 00
	[11]						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0002 Peri od: Worksheet B-1 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/30/2018 8: 22 am 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 through 117) 100 100 100 100 118.00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0002	Period: Worksheet B-1 From 01/01/2017
		To 12/31/2017 Date/Time Prepared:

				Ť.	o 12/31/2017	Date/Time Pre 5/30/2018 8: 2	
			INTERNS &	RESI DENTS			
	Cost Center Description	MEDI CAL		SERVI CES-OTHE			
		EDUCATI ON	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		
	IMBURSABLE COST CENTERS		_	_			
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
191. 00 19100		0	0	0	0		191. 00
	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
	OTHER NON-REI MBURSABLE	0	0	0	0		192. 01
	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0		192. 02
	NONPALD WORKERS	0	0	0	0		193. 00
200. 00	Cross Foot Adjustments						200.00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	86, 165	233, 984	292, 076	752, 201		202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	861. 650000	2, 339. 840000	2, 920. 760000	7, 522. 010000		203. 00
204.00	Cost to be allocated (per Wkst. B, Part II)	7, 664	1, 063	87, 690	72, 361		204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	76. 640000	10. 630000	876. 900000	723. 610000		205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206. 00
207. 00	NAHE unit cost multiplier (Wkst. D,				0. 000000		207. 00
	Parts III and IV)						

			T	o 12/31/2017	Date/Time Pre 5/30/2018 8:2	pared:
		Title	xVIII	Hospi tal	PPS	Z alli
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst.	Adj.		Di sal I owance		
	B, Part I,					
	col . 26)					
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	75, 558, 456		75, 558, 456	0	75, 558, 456	30.00
31.00 03100 INTENSIVE CARE UNIT	13, 539, 584		13, 539, 584	0	13, 539, 584	31.00
31. 01   03101   NEONATAL   CU	3, 429, 065		3, 429, 065	0	3, 429, 065	31.01
40. 00   04000   SUBPROVI DER - 1 PF	1, 870, 885		1, 870, 885	0	1, 870, 885	40.00
41. 00   04100   SUBPROVI DER -   RF	7, 399, 465		7, 399, 465	0	7, 399, 465	41.00
43. 00 04300 NURSERY	2, 646, 170		2, 646, 170	0	2, 646, 170	43.00
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	14, 680, 969		14, 680, 969	0	14, 680, 969	50.00
50. 01   05001   ENDOSCOPY	3, 983, 335		3, 983, 335	0	3, 983, 335	50. 01
51.00   05100   RECOVERY ROOM	2, 834, 610		2, 834, 610	0	2, 834, 610	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	5, 285, 353		5, 285, 353	0	5, 285, 353	52.00
53. 00   05300   ANESTHESI OLOGY	0		0	0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	8, 766, 192		8, 766, 192	0	8, 766, 192	54.00
54. 01  05401 RADI OLOGY - ULTRASOUND	2, 968, 685		2, 968, 685	0	2, 968, 685	54. 01
55. 00   05500   RADI OLOGY-THERAPEUTI C	2, 418, 103		2, 418, 103	9, 254	2, 427, 357	55.00
56. 00   05600   RADI 01 SOTOPE	2, 874, 182		2, 874, 182	0	2, 874, 182	56.00
57.00  05700 CT SCAN	4, 116, 450		4, 116, 450	0	4, 116, 450	57.00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	1, 456, 778		1, 456, 778	0	1, 456, 778	
59. 00   05900   CARDI AC CATHETERI ZATI ON	5, 260, 821		5, 260, 821	0	5, 260, 821	59.00
60. 00   06000   LABORATORY	16, 241, 830		16, 241, 830	0	16, 241, 830	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, 156, 872		2, 156, 872	0	2, 156, 872	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, 164, 436			0	5, 164, 436	65.00
66. 00   06600   PHYSI CAL THERAPY	3, 080, 426			0	3, 080, 426	1
67. 00 06700 OCCUPATI ONAL THERAPY	2, 476, 309		_,,	0	2, 476, 309	67.00
68. 00 06800 SPEECH PATHOLOGY	809, 874	0		0	809, 874	68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 285, 302		1, 285, 302	0	1, 285, 302	
69. 01   06901   CARDI AC   REHAB	698, 400		698, 400	0	698, 400	
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 776, 318		1, 776, 318	0	1, 776, 318	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17, 136, 386		17, 136, 386	0	17, 136, 386	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	19, 301, 610		19, 301, 610	0	19, 301, 610	
73. 00 07300 DRUGS CHARGED TO PATIENTS	23, 137, 051		23, 137, 051	0	23, 137, 051	73.00
74. 00 O7400 RENAL DIALYSIS	2, 779, 054		2, 779, 054	0	2, 779, 054	74.00
OUTPATIENT SERVICE COST CENTERS	10 7/5 477	ı	107/5477	00.004	10 705 500	
90. 00   09000   CLI NI C	10, 765, 177		10, 765, 177	30, 331	10, 795, 508	1
91. 00   09100   EMERGENCY	17, 190, 856		17, 190, 856	15, 044	17, 205, 900	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	15, 391, 529		15, 391, 529		15, 391, 529	92.00
OTHER REIMBURSABLE COST CENTERS	2 212 244	1	2 212 244		2 212 244	101 00
101.00 10100 HOME HEALTH AGENCY	3, 213, 341	_	3, 213, 341	F4 (00	3, 213, 341	
200.00 Subtotal (see instructions)	301, 693, 874	0		54, 629	301, 748, 503	1
201.00 Less Observation Beds	15, 391, 529		15, 391, 529	l	15, 391, 529	
202.00   Total (see instructions)	286, 302, 345	1	286, 302, 345	54, 629	286, 356, 974	1202. UU

Peri od: Worksheet C From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared: 5/30/2018 8: 22 am Provider CCN: 15-0002

					.0 12,01,201,	5/30/2018 8: 2	2 am
			Title	XVIII	Hospi tal	PPS	_
			Charges		·		
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	•	,	·	+ col. 7)	Rati o	Inpati ent	
						Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
I NPAT	TIENT ROUTINE SERVICE COST CENTERS	<u> </u>					
30.00 03000	ADULTS & PEDIATRICS	69, 277, 711		69, 277, 71	1		30.00
31.00 03100	INTENSIVE CARE UNIT	17, 539, 425		17, 539, 425	5		31.00
31. 01   03101	NEONATAL ICU	5, 674, 848		5, 674, 848	3		31. 01
40.00 04000	SUBPROVI DER - I PF	3, 462, 684		3, 462, 684			40.00
	SUBPROVI DER - I RF	7, 909, 819		7, 909, 819			41.00
	NURSERY	2, 083, 501		2, 083, 50			43.00
	LARY SERVICE COST CENTERS	, , , , , , , , ,		, , , , , , ,			
50.00 05000	OPERATING ROOM	98, 778, 524	67, 849, 301	166, 627, 825	0. 088106	0.000000	50.00
50. 01 05001	ENDOSCOPY	4, 045, 767	15, 429, 522			0.000000	50. 01
51.00 05100	RECOVERY ROOM	5, 058, 324	5, 648, 232	10, 706, 556	0. 264755	0.000000	51.00
	DELIVERY ROOM & LABOR ROOM	3, 063, 071	2, 301, 006			0. 000000	52.00
	ANESTHESI OLOGY	0	0		0. 000000	0. 000000	53.00
	RADI OLOGY-DI AGNOSTI C	9, 742, 397	27, 206, 896	36, 949, 293		0. 000000	
	RADI OLOGY - ULTRASOUND	4, 856, 159	11, 707, 176			0. 000000	
	RADI OLOGY-THERAPEUTI C	1, 279, 338	12, 428, 933			0. 000000	
	RADI OI SOTOPE	5, 433, 492	9, 781, 893			0. 000000	56.00
	CT SCAN	40, 625, 643	69, 463, 320			0. 000000	57.00
	MAGNETIC RESONANCE IMAGING (MRI)	10, 276, 983	18, 038, 460			0. 000000	
	CARDI AC CATHETERI ZATI ON	34, 860, 415	37, 657, 936			0. 000000	59.00
	LABORATORY	59, 310, 157	84, 262, 686			0. 000000	
	BLOOD LABORATORY	0	04, 202, 000			0. 000000	60.01
	PBP CLINICAL LAB SERVICES-PRGM ONLY		0		0.000000	0. 000000	61.00
	WHOLE BLOOD & PACKED RED BLOOD CELLS	7, 047, 945	1, 842, 454	8, 890, 39		0. 000000	
1	BLOOD STORING, PROCESSING & TRANS.	7,047,745	1, 042, 434			0. 000000	63.00
	INTRAVENOUS THERAPY		0		0.000000	0. 000000	
	RESPIRATORY THERAPY	35, 292, 134	5, 138, 755			0. 000000	65.00
	PHYSI CAL THERAPY	7, 240, 714	381, 499	7, 622, 213		0. 000000	66.00
	OCCUPATIONAL THERAPY	5, 939, 855	260, 789			0. 000000	67.00
	SPEECH PATHOLOGY	1, 987, 691	218, 997			0.000000	68.00
	ELECTROCARDI OLOGY	11, 222, 375	9, 310, 390			0.000000	
	CARDI AC REHAB	191, 541	731, 783			0.000000	
	ELECTROENCEPHALOGRAPHY	9, 556, 277	13, 684, 696			0.000000	70.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	26, 048, 252	23, 638, 627			0.000000	
	IMPL. DEV. CHARGED TO PATIENTS	22, 576, 222	12, 939, 509			0.000000	71.00
	I and the second						
	DRUGS CHARGED TO PATIENTS	108, 789, 051	44, 177, 001			0.000000	74.00
	RENAL DIALYSIS	7, 866, 810	604, 393	8, 471, 203	0. 328059	0. 000000	74.00
	ATIENT SERVICE COST CENTERS	E00 ((E	21, 697, 022	22 277 40	0 402227	0.000000	90.00
	EMERGENCY	580, 665 15, 807, 961	47, 180, 317			0. 000000 0. 000000	91.00
	OBSERVATION BEDS (NON-DISTINCT PART)	6, 942, 034	23, 005, 157			0.000000	
	R REIMBURSABLE COST CENTERS	0, 942, 034	23,003,137	29, 947, 19	0.013930	0.000000	92.00
	HOME HEALTH AGENCY	ol	3, 342, 486	3, 342, 486			101. 00
200.00	Subtotal (see instructions)	650, 367, 785		1, 220, 297, 02°			200.00
201.00	Less Observation Beds	030, 307, 763	507, 727, 230	1,220,271,02	'		200.00
202.00	Total (see instructions)	650, 367, 785	560 020 226	1, 220, 297, 02 <sup>-</sup>	1		201.00
202.00	Tiotal (See Histiactions)	000, 307, 760	507, 727, 230	1,220,271,02	'(		202.00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0002	From 01/01/2017	Worksheet C Part I Date/Time Prepared:

					5/30/2018 8: 22 am
			Title XVIII	Hospi tal	PPS
	Cost Center Description	PPS Inpatient			
		Rati o			
		11. 00			
	IPATIENT ROUTINE SERVICE COST CENTERS				
	3000 ADULTS & PEDIATRICS				30.00
1	3100 INTENSIVE CARE UNIT				31.00
	3101 NEONATAL I CU				31. 01
1	1000 SUBPROVI DER – I PF				40.00
4	100 SUBPROVI DER – I RF				41.00
	300 NURSERY				43.00
	CILLARY SERVICE COST CENTERS				
	5000 OPERATING ROOM	0. 088106			50.00
	5001 ENDOSCOPY	0. 204533			50. 01
51.00 05	100 RECOVERY ROOM	0. 264755			51.00
52. 00 05:	5200 DELIVERY ROOM & LABOR ROOM	0. 985324			52.00
53.00 05	300 ANESTHESI OLOGY	0. 000000			53.00
54.00 05	6400 RADI OLOGY-DI AGNOSTI C	0. 237249			54.00
54. 01 05	6401 RADI OLOGY - ULTRASOUND	0. 179232			54. 01
55. 00 05	5500 RADI OLOGY-THERAPEUTI C	0. 177072			55.00
56.00 05	6600 RADI 0I SOTOPE	0. 188900			56.00
57. 00 05	5700 CT SCAN	0. 037392			57.00
	800 MAGNETIC RESONANCE IMAGING (MRI)	0. 051448			58.00
	5900 CARDI AC CATHETERI ZATI ON	0. 072545			59. 00
	5000 LABORATORY	0. 113126			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. 242607			62.00
1	3300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.00
1	4400 I NTRAVENOUS THERAPY	0. 000000			64.00
1	5500 RESPIRATORY THERAPY	0. 127735			65.00
4	6600 PHYSI CAL THERAPY	0. 404138			66.00
	5700 OCCUPATI ONAL THERAPY	0. 399363			67.00
	8800 SPEECH PATHOLOGY	0. 367009			68.00
	900 ELECTROCARDI OLOGY	0. 062598			69.00
1	9901 CARDI AC REHAB	0. 756398			69. 01
1	7000 ELECTROENCEPHALOGRAPHY	0. 736348			70.00
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 076430			70.00
4	7200 IMPL. DEV. CHARGED TO PATIENTS	0. 543466			71.00
	7300 DRUGS CHARGED TO PATIENTS	0. 151256			73.00
		1			73.00
74.00 07	7400 RENAL DI ALYSI S ITPATI ENT SERVI CE COST CENTERS	0. 328059			74.00
		0.404500			00.00
4	2000 CLINIC	0. 484588			90.00
	2100 EMERGENCY	0. 273160			91.00
	0200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 513956			92. 00
	HER REIMBURSABLE COST CENTERS				101 00
	0100 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

				o 12/31/2017	Date/Time Pre 5/30/2018 8:2	pared:
		Ti tl	e XIX	Hospi tal	Cost	Z dIII
		11.61	, x	Costs	0001	
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						
30. 00   03000   ADULTS & PEDI ATRI CS	75, 558, 456		75, 558, 456		75, 558, 456	
31.00 03100 INTENSIVE CARE UNIT	13, 539, 584		13, 539, 584		13, 539, 584	31.00
31. 01   03101   NEONATAL   I CU	3, 429, 065		3, 429, 065		3, 429, 065	31. 01
40. 00   04000   SUBPROVI DER -   PF	1, 870, 885		1, 870, 885		1, 870, 885	40.00
41. 00   04100   SUBPROVI DER -   RF	7, 399, 465		7, 399, 465		7, 399, 465	41.00
43. 00   04300   NURSERY	2, 646, 170		2, 646, 170	0	2, 646, 170	43.00
ANCILLARY SERVICE COST CENTERS  50.00 OPERATING ROOM	14, 680, 969		14, 680, 969	ol	14, 680, 969	50.00
50. 00   05000   OPERATTING ROOM 50. 01   05001   ENDOSCOPY						
51. 00   05100   RECOVERY   ROOM	3, 983, 335 2, 834, 610		3, 983, 335		3, 983, 335 2, 834, 610	50. 01 51. 00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	5, 285, 353		2, 834, 610 5, 285, 353		5, 285, 353	
53. 00   05300   ANESTHESI OLOGY	3, 265, 353 N		5, 265, 353		o, 260, 303 0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	8, 766, 192		8, 766, 192	-	8, 766, 192	54.00
54. 01   05401   RADI OLOGY - ULTRASOUND	2, 968, 685		2, 968, 685		2, 968, 685	54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C	2, 418, 103		2, 418, 103	1	2, 427, 357	55. 00
56. 00   05600 RADI OI SOTOPE	2, 874, 182		2, 874, 182		2, 874, 182	56.00
57. 00   05700 CT SCAN	4, 116, 450		4, 116, 450		4, 116, 450	
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 456, 778		1, 456, 778		1, 456, 778	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	5, 260, 821		5, 260, 821		5, 260, 821	59.00
60. 00   06000   LABORATORY	16, 241, 830		16, 241, 830		16, 241, 830	1
60. 01   06001   BLOOD LABORATORY	0		(		0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		Ċ	o	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 156, 872		2, 156, 872	0	2, 156, 872	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0				0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0			o	0	64.00
65. 00 06500 RESPIRATORY THERAPY	5, 164, 436	0	5, 164, 436	0	5, 164, 436	65.00
66. 00 06600 PHYSI CAL THERAPY	3, 080, 426	0	3, 080, 426	0	3, 080, 426	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	2, 476, 309	0	2, 476, 309	o	2, 476, 309	67.00
68.00 06800 SPEECH PATHOLOGY	809, 874	0	809, 874	0	809, 874	68.00
69. 00  06900 ELECTROCARDI OLOGY	1, 285, 302		1, 285, 302	0	1, 285, 302	69. 00
69. 01   06901   CARDI AC REHAB	698, 400		698, 400		698, 400	
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 776, 318		1, 776, 318		1, 776, 318	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17, 136, 386		17, 136, 386		17, 136, 386	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	19, 301, 610		19, 301, 610		19, 301, 610	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	23, 137, 051		23, 137, 051		23, 137, 051	73.00
74. 00 07400 RENAL DI ALYSI S	2, 779, 054		2, 779, 054	0	2, 779, 054	74.00
OUTPATIENT SERVICE COST CENTERS	40 7/5 477		40.7/5.47		40 705 500	00.00
90. 00   09000   CLI NI C 91. 00   09100   EMERGENCY	10, 765, 177		10, 765, 177		10, 795, 508	
91. 00   09100   EMERGENCY 92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)	17, 190, 856 15, 391, 529		17, 190, 856 15, 391, 529		17, 205, 900 15, 391, 529	1
OTHER REIMBURSABLE COST CENTERS	15, 391, 329		10, 391, 325	<b>'</b>	10, 391, 329	92.00
101. 00 10100 HOME HEALTH AGENCY	3, 213, 341		3, 213, 341		3, 213, 341	101 00
200.00 Subtotal (see instructions)	301, 693, 874	0			301, 748, 503	
201.00 Less Observation Beds	15, 391, 529		15, 391, 529		15, 391, 529	1
202.00 Total (see instructions)	286, 302, 345	0				
		'				

From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/30/2018 8: 22 am Title XIX Hospi tal Cost Charges Total (col. 6 Cost or Other TEFRA Cost Center Description Inpati ent Outpati ent I npati ent + col. 7) Ratio Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 69, 277, 711 30.00 03000 ADULTS & PEDIATRICS 69, 277, 711 30.00 31.00 03100 INTENSIVE CARE UNIT 17, 539, 425 17, 539, 425 31.00 03101 NEONATAL ICU 5, 674, 848 5, 674, 848 31.01 31.01 40.00 04000 SUBPROVI DER - I PF 3, 462, 684 3, 462, 684 40.00 04100 SUBPROVI DER - I RF 7, 909, 819 7, 909, 819 41.00 41.00 43.00 04300 NURSERY 2, 083, 501 2, 083, 501 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 98, 778, 524 0.088106 0.000000 50.00 67, 849, 301 166, 627, 825 50.00 05001 ENDOSCOPY 15, 429, 522 50.01 4, 045, 767 19, 475, 289 0 204533 0.000000 50.01 51.00 05100 RECOVERY ROOM 5, 058, 324 5, 648, 232 10, 706, 556 0.264755 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 3, 063, 071 2, 301, 006 5, 364, 077 0. 985324 0.000000 52.00 05300 ANESTHESI OLOGY 53.00 0.000000 0.000000 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 9, 742, 397 27, 206, 896 36, 949, 293 0. 237249 0.000000 54.00 05401 RADI OLOGY - ULTRASOUND 0.179232 54.01 4, 856, 159 11, 707, 176 16, 563, 335 0.000000 54.01 1, 279, 338 12, 428, 933 05500 RADI OLOGY-THERAPEUTI C 13, 708, 271 0.000000 55.00 0.176397 55.00 05600 RADI OI SOTOPE 56.00 5, 433, 492 9, 781, 893 15, 215, 385 0.188900 0.000000 56.00 05700 CT SCAN 40, 625, 643 69, 463, 320 110, 088, 963 0.037392 0.000000 57.00 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 10, 276, 983 18, 038, 460 28, 315, 443 0.051448 0.000000 58.00 05900 CARDI AC CATHETERI ZATI ON 37, 657, 936 34, 860, 415 72, 518, 351 59.00 0.072545 0.000000 59.00 60.00 06000 LABORATORY 59, 310, 157 84, 262, 686 143, 572, 843 0. 113126 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 8, 890, 399 62.00 7.047.945 1,842,454 0.242607 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 35, 292, 134 5, 138, 755 40, 430, 889 0. 127735 0.000000 65.00 06600 PHYSI CAL THERAPY 7, 622, 213 66.00 7, 240, 714 381, 499 0.404138 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 5, 939, 855 260, 789 6, 200, 644 0.399363 0.000000 67.00 06800 SPEECH PATHOLOGY 68.00 1, 987, 691 218, 997 2, 206, 688 0.367009 0.000000 68.00 20, 532, 765 69 00 06900 ELECTROCARDI OLOGY 11, 222, 375 9, 310, 390 0.062598 0.000000 69 00 06901 CARDI AC REHAB 0.000000 69.01 191, 541 731, 783 923, 324 0.756398 69.01 13, 684, 696 70.00 07000 ELECTROENCEPHALOGRAPHY 9, 556, 277 23, 240, 973 0.076430 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 26, 048, 252 23, 638, 627 49, 686, 879 0.344888 0.000000 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 22, 576, 222 12, 939, 509 35, 515, 731 0.543466 0.000000 72 00 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 108, 789, 051 44, 177, 001 152, 966, 052 0.151256 0.000000 73.00 07400 RENAL DIALYSIS 7, 866, 810 604, 393 8, 471, 203 0.328059 0.000000 74.00 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 0.000000 09000 CLI NI C 580, 665 21, 697, 022 22, 277, 687 0.483227 90.00 09100 EMERGENCY 15, 807, 961 47, 180, 317 62, 988, 278 0. 272922 0.000000 91.00 91.00

6, 942, 034

650, 367, 785

650, 367, 785

23, 005, 157

3, 342, 486

569, 929, 236

29, 947, 191

3, 342, 486

1, 220, 297, 021

569, 929, 236 1, 220, 297, 021

0.513956

0.000000

92.00

101.00

200.00

201.00

202.00

92.00

200.00

201.00

202.00

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Subtotal (see instructions)

OTHER REIMBURSABLE COST CENTERS

Less Observation Beds

Total (see instructions)

101.00 10100 HOME HEALTH AGENCY

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

INPATIENT ROUTINE SERVICE COST CENTERS   11.00						5/30/2018 8: 22 am
INPATI ENT ROUTINE SERVICE COST CENTERS				Title XIX	Hospi tal	Cost
INPATI ENT ROUTINE SERVICE COST CENTERS   30.00   30.00   ADULTS & PEDI ATRICS   31.00   31.		Cost Center Description	PPS Inpatient			
INPATI ENT ROUTI NE SERVI CE COST CENTERS   30.00   30.00   30.00   30.00   30.00   30.00   30.00   30.00   30.00   30.00   30.00   30.00   30.00   30.00   30.00   30.00   30.00   30.00   30.00   31.00						
30.00     3000   ADULTS & PEDIATRICS     31.00   31.01   31.			11. 00			
31.00   3310   INTERSIVE CARE UNIT   31.01   31.01   31.01   31.01   31.01   31.01   31.01   31.01   31.01   31.01   31.01   31.01   31.01   31.00   34.00	I NP	PATIENT ROUTINE SERVICE COST CENTERS				
31.01   03101   NEONATAL   CU	30.00 030	DOO ADULTS & PEDIATRICS				30.00
40.00   04000   SUBPROVI DER - I PF	31.00 031	100 INTENSIVE CARE UNIT				31.00
41.00   0.4100   SUBPROVI DER - 1 IRF	31. 01   031	101 NEONATAL ICU				31.01
43.00   A300   NURSERY   A0.00   A000000   A0000000   A00000000	40.00 040	000 SUBPROVI DER - I PF				40.00
ANCIL LARY SERVICE COST CENTERS   50.00   50.00   50.00   650.00   676.00   676.00   670.00   50.00	41.00 041	100 SUBPROVI DER - I RF				41.00
50. 00   05000   0FEATI NG ROUM   0. 0000000   50. 00						43.00
50.01   GS001   ENIDOSCOPY   0.000000   51.00   51.00   51.00   61.00   RECOVERY ROOM   0.000000   52.00   62.00   RECOVERY ROOM   0.000000   52.00   52.00   53.00   62.00   RESURVERY ROOM   0.000000   52.00   53.00   63	ANC	CILLARY SERVICE COST CENTERS				
51.00   05100   RECOVERY ROOM   0.000000   52.00   05200   0ELIVERY ROOM   1.600000   52.00   05200   0ELIVERY ROOM   1.6000000   52.00   05200   0ELIVERY ROOM   1.6000000   53.00   05400   RADIO LOGY-DI AGNOSTI C   0.000000   54.00   0.000000   54.00   0.000000   54.00   0.000000   54.00   0.000000   54.00   0.000000   54.00   0.000000   54.00   0.000000   54.00   0.000000   55.00   0.000000   55.00   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.000000   0.0000000   0.0000000   0.0000000   0.00000000			0. 000000			50.00
52.00   05200   DELI VERY ROOM & LABOR ROOM   0.000000   52.00   053.00   053.00   053.00   053.00   053.00   053.00   053.00   053.00   053.00   053.00   053.00   053.00   053.00   053.00   053.00   053.00   053.00   055.00	50. 01 050	DO1 ENDOSCOPY	0. 000000			50. 01
53.00   0s300   Anesthesiology   0.00000   0s400   0s400   RaDiology-Diagnostic   0.00000   54.00   0s400   RaDiology-Diagnostic   0.000000   54.00   55.00   0s500   RaDiology-Diagnostic   0.000000   55.00   0s500   RaDiology-Tierrapeuric   0.000000   0s600   LaBoratory   0.000000   0s600   LaBoratory   0.000000   65.00   0s600   HUDE BLODO LABORATORY   0.000000   65.00   0s600   WHOLE BLODO & PACKED RED BLODO CELLS   0.000000   65.00   0s600   WHOLE BLODO & PACKED RED BLODO CELLS   0.000000   65.00   0s600   WHOLE BLODO & PACKED RED BLODO CELLS   0.000000   65.00   0s600   HUDE BLODO & PACKED RED BLODO CELLS   0.000000   65.00   0s600   HUDE BLODO & PACKED RED BLODO CELLS   0.000000   65.00   0s600   HUDE BLODO & PACKED RED BLODO & PA	51.00 051	100 RECOVERY ROOM	0. 000000			51.00
54, 00   05400   RADI OLOGY-DI LARNOSTI C   0,0000000   0,0000000   0,0000000   0,0000000   0,0000000   0,000000   0,000000   0,0000000   0,0000000   0,00000000	52.00 052	200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
S4. 01   05401   RADI OLOGY - ULTRASQUND   0.000000   55. 00   05500   RADI OLOGY - THERAPEUTI C   0.000000   55. 00   05500   RADI OLOGY-THERAPEUTI C   0.000000   55. 00   05500   RADI OLOGY-THERAPEUTI C   0.000000   55. 00   05500   CT SCAN   0.000000   57. 00   05700   CT SCAN   0.000000   57. 00   05900   CARDIA C CATHETERI ZATI ON   0.000000   59. 00   05900   CARDIA C CATHETERI ZATI ON   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000	53.00 053	300 ANESTHESI OLOGY	0. 000000			53.00
55. 00   05500   RADI OLOGY-THERAPEUTI C   0.000000   55. 00   05600   RADI OLOGY-THERAPEUTI C   0.000000   55. 00   05600   RADIO I SOTOPE   0.000000   55. 00   05700   CT SCAN   0.000000   55. 00   05900   CARS I CATHETERI ZATI ON   0.000000   55. 00   05900   CARDI AC CATHETERI ZATI ON   0.000000   59. 00   05900   CARDI AC CATHETERI ZATI ON   0.000000   59. 00   05900   CARDI AC CATHETERI ZATI ON   0.000000   59. 00   05900   CARDI AC CATHETERI ZATI ON   0.000000   60. 00   06.	54.00 054	400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
56.00   0500	54. 01 054	401 RADI OLOGY - ULTRASOUND	0. 000000			54. 01
57.00   05700   CT SCAN   05800   MAGNETIC RESONANCE IMAGING (MRI )   0.000000   55.00   05900   CARDIAC CATHETERI ZATI ON   0.000000   0.000000   0.00000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000	55.00 055	500 RADI OLOGY-THERAPEUTI C	0. 000000			55.00
58. 00       05800 MAGNETI C RESONANCE IMAGING (MRI )       0.0000000       59. 00         00       05900 CARDIAC CATHETERIZATION       0.000000       59. 00         60. 00       06000 LABORATORY       0.000000       60. 01         61. 00       06100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY       0.000000       61. 00         62. 00       06200 WHOLE BLOOD & PACKED RED BLOOD CELLS       0.000000       62. 00         63. 00       06300 BLOOD STORI NG , PROCESSI NG & TRANS.       0.000000       63. 00         64. 00       06400 INTRAVENOUS THERAPY       0.000000       64. 00         65. 00       06500 RESPI RATORY THERAPY       0.000000       65. 00         66. 00       06600 PHYSI CAL THERAPY       0.000000       65. 00         66. 00       06700 OCCUPATI ONAL THERAPY       0.000000       67. 00         68. 00       06900 ELECTROCARDI OLOGY       0.000000       68. 00         69. 01       06900 ELECTROCARDI OLOGY       0.000000       69. 01         70. 00       07000 ELLCAL SUPPLIES CHARGED TO PATI ENTS       0.000000       71. 00         71. 00       07400 MEDICAL SUPPLIES CHARGED TO PATI ENTS       0.000000       72. 00         73. 00       07400 MEDICAL SUPPLIES CHARGED TO PATI ENTS       0.000000       73. 00	56. 00 056	600 RADI OI SOTOPE	0. 000000			56.00
58. 00       05800 MAGNETI C RESONANCE I IMAGI NG (MRI )       0.000000       59. 00         60. 00       05900 CARDI AC CATHETERI ZATI ON       0.000000       59. 00         60. 00       06000 LABORATORY       0.000000       60. 01         61. 00       061.00 PBP CLINI CAL LAB SERVI CES-PRGM ONLY       0.000000       60. 01         62. 00       06200 WHOLE BLOOD & PACKED RED BLOOD CELLS       0.000000       62. 00         63. 00       06300 BLOOD STORI NG , PROCESSI NG & TRANS.       0.000000       63. 00         64. 00       06400 I INTRAVENOUS THERAPY       0.000000       64. 00         65. 00       06500 RESPI RATORY THERAPY       0.000000       65. 00         66. 00       06600 PHYSI CAL THERAPY       0.000000       65. 00         66. 00       06700 OCCUPATI ONAL THERAPY       0.000000       67. 00         68. 00       06900 ELECTROCARDI OLOGY       0.000000       68. 00         69. 01       06900 ELECTROCARDI OLOGY       0.000000       69. 01         70. 00       07000 ELLCA SUPPLIES CHARGED TO PATI ENTS       0.000000       71. 00         71. 00       07100 MEDICAL SUPPLIES CHARGED TO PATI ENTS       0.000000       72. 00         73. 00       07300 DRUGS CHARGED TO PATI ENTS       0.000000       73. 00	57. 00 057	700 CT SCAN	0. 000000			57.00
59. 00   05900   CARDI AC CATHETERI ZATI ON   0.000000   06000   LABORATORY   0.0000000   0.0000000   0.0000000   0.00000000			0. 000000			58.00
60. 01   0601   0601   0601   0601   0601   0601   0610   0701   0610   0701   0610   0701   0610   0701   0610   0701   0610   0701   0610   0701   0610   0701			0. 000000			59.00
61. 00   06100   PBP CLINICAL LAB SERVICES-PRGM ONLY   0.000000   62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0.000000   62.00   63.00   06300   08.000 STORING, PROCESSING & TRANS.   0.000000   64.00   64.00   64.00   64.00   65.00   66.00   6	60.00 060	DOO LABORATORY	0. 000000			60.00
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0.000000   63. 00   63. 00   63.00   63.00   64.00   64.00   64.00   64.00   64.00   65.00   6	60. 01 060	DO1 BLOOD LABORATORY	0. 000000			60. 01
63. 00	61.00 061	100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			61.00
64. 00	62.00 062	200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62. 00
64. 00	63.00 063	300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.00
66. 00 06600 PHYSI CAL THERAPY 0. 0.000000 67. 00 0CCUPATI ONAL THERAPY 0. 0.000000 67. 00 06700 0CCUPATI ONAL THERAPY 0. 0.000000 67. 00 06800 SPEECH PATHOLOGY 0. 0.000000 68. 00 06900 ELECTROCARDI OLOGY 0. 0.000000 69. 01 06901 CARDI AC REHAB 0. 0.000000 69. 01 07000 ELECTROENCEPHALOGRAPHY 0. 0.000000 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 0.000000 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 0.000000 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 0.000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 0.000000 74. 00 07400 RENAL DI ALYSI S 0. 0.000000 74. 00 07400 RENAL DI ALYSI S 0. 0.000000 74. 00 09100 EMERGENCY 0. 0.000000 99. 00 09100 EMERGENCY 0. 0.000000 99. 00 09200 OSSERVATI ON BEDS (NON-DI STI NCT PART) 0. 0.000000 992. 00 09200 OSSERVATI ON BEDS (NON-DI STI NCT PART) 0. 0.000000 10 10100 HOME HEALTH AGENCY 0. 0.000000 10100 HOME HEALTH AGENCY 0.000000 10100 HOME HEALTH AGENCY 0.000000 10100 HOME HEALTH AGENCY 0.000000 10100 Less Observati on Beds 200. 00			0. 000000			64.00
66. 00 06600 PHYSI CAL THERAPY 0. 000000 67: 00 06700 0CCUPATI ONAL THERAPY 0. 000000 67: 00 06800 SPEECH PATHOLOGY 0. 000000 68: 00 06800 SPEECH PATHOLOGY 0. 000000 68: 00 06900 ELECTROCARDI OLOGY 0. 000000 69: 01 06901 CARDI AC REHAB 0. 000000 69: 01 07: 00 0	65.00 065	500 RESPI RATORY THERAPY	0. 000000			65. 00
68. 00						66.00
68. 00	67. 00 067	700 OCCUPATI ONAL THERAPY	0. 000000			67.00
69. 00		BOO SPEECH PATHOLOGY				68. 00
70. 00						
70. 00	69. 01 069	901 CARDI AC REHAB	0. 000000			69. 01
71. 00	1	l e e e e e e e e e e e e e e e e e e e	1			
72. 00	4	· ·	1			
73. 00 74. 00 07400 RENAL DI ALYSIS 0. 000000 00TPATIENT SERVICE COST CENTERS 90. 00 91. 00 92. 00 00THER REI MBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 200. 00 201. 00 Less Observation Beds 73. 00 0. 0000000 0. 0000000 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000						
74. 00   07400   RENAL DI ALYSI S   0.000000   74. 00	73. 00 073	300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
OUTPATIENT SERVICE COST CENTERS   90.00   91.00   90.00   91.00   91.00   91.00   92.00   95			1			
90. 00 91. 00 91. 00 92. 00 09100   GLINIC 09100   GMERGENCY 09200   OBSERVATION BEDS (NON-DISTINCT PART) 0. 000000  092. 00 093. 00 093. 00 094. 00 094. 00 095. 00 0						
91. 00   09100   EMERGENCY   0. 000000   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0. 000000   92. 00   0THER REIMBURSABLE COST CENTERS   101. 00   10100   HOME   HEALTH   AGENCY   101. 00   200. 00   Subtotal (see instructions)   200. 00   201. 00   Less Observation   Beds   201. 00   201.			0. 000000			90.00
92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0.000000   92.00   0THER REIMBURSABLE COST CENTERS   101.00   10100   HOME HEALTH AGENCY   101.00   200.00   Subtotal (see instructions)   200.00   201.00   Less Observation Beds   201.00						
0THER REIMBURSABLE COST CENTERS           101.00 10100 HOME HEALTH AGENCY         101.00           200.00 Subtotal (see instructions)         200.00           201.00 Less Observation Beds         201.00						
101.00						
200.00         Subtotal (see instructions)         200.00           201.00         Less Observation Beds         201.00						101.00
201.00 Less Observation Beds 201.00		l .				
	1					

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co		Period: From 01/01/2017 To 12/31/2017		
			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	7, 191, 384		,,.,,,		79. 27	30.00
31.00   INTENSIVE CARE UNIT	565, 205		565, 20			31.00
31. 01 NEONATAL I CU	85, 795		85, 79			
40. 00   SUBPROVI DER - I PF	95, 005		95, 00		40. 55	
41.00 SUBPROVIDER - IRF	710, 606	l e	710, 60		74. 60	
43. 00 NURSERY	496, 638	l e	496, 63		174. 32	1
200.00 Total (lines 30 through 199)	9, 144, 633		9, 144, 63	3 116, 788		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	27, 937				l	30.00
31. 00   I NTENSI VE CARE UNI T	3, 570		•		ļ	31.00
31. 01 NEONATAL ICU	0				ļ	31. 01
40. 00 SUBPROVI DER - I PF	925				l	40.00
41. 00 SUBPROVI DER - I RF	5, 800		•		ļ	41.00
43. 00 NURSERY	0				ļ	43.00
200.00 Total (lines 30 through 199)	38, 232	2, 921, 125			ļ	200. 00

Health Financial Systems	METHODIST 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 01/01/2017	Worksheet D Part II	
				To 12/31/2017	Date/Time Pre 5/30/2018 8: 2	parea: 2 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col. 26)	0.00	0.00			
ANOLILIADY OFFICE OCCUPANTED	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1 401 700	1// /27 025	0.00041	24 172 020	207 504	FO 00
50. 00 O5000 OPERATING ROOM	1, 401, 790					
50. 01   05001   ENDOSCOPY 51. 00   05100   RECOVERY ROOM	43, 490					
51.00   05100   RECOVERY ROOM 52.00   05200   DELIVERY ROOM & LABOR ROOM	317, 331 205, 710				47, 170 4, 603	
53. 00   05200   DELI VERY ROOM & LABOR ROOM 53. 00   05300   ANESTHESI OLOGY	205, 710				4,603	52.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	1, 113, 643	1				54.00
54. 01   05401   RADI OLOGY - ULTRASOUND	130, 675					54.00
55. 00   05500   RADI OLOGY - THERAPEUTI C	283, 540		0. 02068			55.00
56. 00   05600   RADI 01 SOTOPE	206, 369					
57. 00   05700   CT   SCAN	265, 027	110, 088, 963			l .	57.00
58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI)	109, 562					
59. 00 05900 CARDI AC CATHETERI ZATI ON	256, 207					59.00
60. 00   06000   LABORATORY	684, 916					60.00
60. 01 06001 BLOOD LABORATORY	001,710				0	60.01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		Ĭ	0.0000		Ĭ	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	30, 398	8, 890, 399	0. 00341	9 3, 065, 508	10, 481	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0. 00000		0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0			0	64.00
65. 00 06500 RESPIRATORY THERAPY	213, 056	40, 430, 889			69, 397	65.00
66. 00 06600 PHYSI CAL THERAPY	265, 073					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	222, 958					67.00
68.00 06800 SPEECH PATHOLOGY	42, 185					68. 00
69. 00 06900 ELECTROCARDI OLOGY	24, 450					69.00
69. 01   06901   CARDI AC   REHAB	6, 306	923, 324	0. 00683	0 0	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	26, 970	23, 240, 973	0. 00116	0 3, 024, 434	3, 508	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	468, 284	49, 686, 879	0. 00942	5 8, 337, 826	78, 584	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	519, 478	35, 515, 731	0. 01462	7 8, 528, 874	124, 752	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	558, 965	152, 966, 052	0. 00365	4 41, 222, 169	150, 626	73.00
74.00 07400 RENAL DIALYSIS	118, 348	8, 471, 203	0. 01397	1 3, 611, 201	50, 452	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	1, 556, 856	22, 277, 687				90.00
91. 00 09100 EMERGENCY	767, 233				1	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 464, 904					
200.00   Total (lines 50 through 199)	11, 303, 724	1, 111, 006, 547		206, 245, 767	1, 622, 529	200. 00

Health Financial Systems	METHODIST HOS	PITALS. INC		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA		TS Provi der C		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part III Date/Time Pre 5/30/2018 8:2	pared:
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	School	School	Post-Stepdowr	Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments		1		Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0		l	0	0	31.00
31. 01   03101   NEONATAL   I CU		١		n 0	ő	31.01
40. 00   04000   SUBPROVI DER -   PF		١			Ö	40.00
41. 00   04100   SUBPROVI DER -   1 FF					0	
43. 00   04300   NURSERY					0	
	0					200.00
200. 00   Total (lines 30 through 199)	Cool as a Dard	Total Costs	Total Patient	Per Diem		200.00
Cost Center Description	Swing-Bed Adjustment	(sum of cols.		(col. 5 ÷	Inpatient Program Days	
			Days	,	Program bays	
	Amount (see	1 through 3,		col . 6)		
		minus col. 4)	/ 00	7.00	0.00	
INPATIENT ROUTINE SERVICE COST CENTERS	4. 00	5. 00	6.00	7. 00	8. 00	
30. 00 03000 ADULTS & PEDIATRICS	0	0	90, 71	5 0.00	27, 937	30.00
31. 00   03100   NTENSI VE CARE UNI T					3, 570	1
31. 01   03100   NTENSTVE CARE UNIT			2, 82			31.00
		0			0	
	0	U	2, 34		925	
41. 00   04100   SUBPROVI DER -   I RF	0	1	1 .,		5, 800	
43. 00   04300   NURSERY		0			0	
200.00 Total (lines 30 through 199)		0	116, 78	3	38, 232	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						1
30. 00 03000 ADULTS & PEDIATRICS	0	l .				30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
31. 01   03101   NEONATAL   CU	0					31. 01
40. 00   04000   SUBPROVI DER - 1 PF	0					40.00
41. 00   04100   SUBPROVI DER - I RF	0					41.00
43. 00   04300   NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00
	•	-				•

In Lieu of Form CMS-2552-10

Period: Worksheet D
From 01/01/2017 Part IV
To 12/31/2017 Date/Time Prepared: 5/30/2018 8:22 am THROUGH COSTS

						5/30/2018 8: 2	2 am
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	School	School	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 0	0	50.00
50.01	05001 ENDOSCOPY	0	0		0	0	50. 01
51.00	05100 RECOVERY ROOM	0	0		0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	1	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 OI SOTOPE	0	0	)	0 0	0	56.00
57.00	05700 CT SCAN	0	0	)	0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	l		0 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	l		0 0	0	59.00
60.00	06000 LABORATORY	0	l		0 0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	,	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		-				61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	,	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	l	)	0 0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
69. 01	06901 CARDI AC REHAB	0	0		0 0	0	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	1
74.00	07400 RENAL DI ALYSI S	0	0		0	0	74.00
	OUTPATIENT SERVICE COST CENTERS			•			
90.00	09000 CLI NI C	0	0		0 0	0	90.00
91. 00	09100 EMERGENCY	0	l		0	752, 201	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	1
200.00		0	o		0 0	752, 201	

| Peri od: | Worksheet D | From 01/01/2017 | Part IV | To 12/31/2017 | Date/Time Prepared: | Part IV | Par THROUGH COSTS

			11	0 12/31/2017	5/30/2018 8: 2	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
· ·	Medi cal	(sum of col 1	Outpati ent	(from Wkst.	to Charges	
	Educati on	through col.	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col. 2, 3 and	col. 8)	col. 7)	
			4)			
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0	_	166, 627, 825	0. 000000	1
50. 01  05001  ENDOSCOPY	0	0	_		0.000000	
51.00 05100 RECOVERY ROOM	0	0	0	10, 706, 556	0. 000000	1
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	5, 364, 077	0. 000000	1
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	0	· ·	0. 000000	
54. 01  05401  RADI OLOGY - ULTRASOUND	0	0	0	16, 563, 335	0. 000000	1
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	0	0	13, 708, 271	0. 000000	
56. 00   05600   RADI 0I SOTOPE	0	0	0	15, 215, 385	0. 000000	
57. 00   05700   CT   SCAN	0	0	0	110, 088, 963	0. 000000	
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	28, 315, 443		
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0	0	0	72, 518, 351	0. 000000	
60. 00   06000   LABORATORY	0	0	0	143, 572, 843	0. 000000	1
60. 01   06001   BLOOD LABORATORY	0	0	0	0	0. 000000	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	8, 890, 399	0. 000000	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0. 000000	1
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0. 000000	1
65. 00 06500 RESPI RATORY THERAPY	0	0	0	40, 430, 889	0. 000000	
66. 00 06600 PHYSI CAL THERAPY	0	0	0	7, 622, 213	0. 000000	1
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	6, 200, 644	0. 000000	
68. 00 06800 SPEECH PATHOLOGY	0	0	0	2, 206, 688	0. 000000	
69. 00   06900   ELECTROCARDI OLOGY	0	0	0	20, 532, 765	0. 000000	
69. 01   06901   CARDI AC REHAB	0	0	0	923, 324	0. 000000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	23, 240, 973		1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	49, 686, 879	0.000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	35, 515, 731	0. 000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	152, 966, 052	0. 000000	1
74. 00 07400 RENAL DIALYSIS	0	0	0	8, 471, 203	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS	1 .1					
90. 00 09000 CLINIC	0	0		· ·		1
91. 00   09100   EMERGENCY	0	752, 201		62, 988, 278		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	750 001	750 001	29, 947, 191	0. 000000	
200.00   Total (lines 50 through 199)	0	752, 201	/52, 201	1, 111, 006, 547		200. 00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS   Provider (		Worksheet D
TUDOUCH COSTS		From 01/01/2017	Part IV

THROUGH COSTS 12/31/2017 Date/Time Prepared: 5/30/2018 8: 22 am Title XVIII Hospi tal PPS Outpati ent Cost Center Description Outpati ent I npati ent I npati ent Outpati ent Program Ratio of Cost Program Program Program to Charges Charges Pass-Through Charges Pass-Through (col. 6 ÷ col. 7) Costs (col. 8 Costs (col. x col. 12) 13.00 x col. 10) 9. 00 10.00 11.00 12.00 ANCILLARY SERVICE COST CENTERS 50 00 0.000000 17, 458, 962 50 00 05000 OPERATING ROOM 34, 173, 838 0 05001 ENDOSCOPY 0.000000 1, 781, 266 4, 496, 631 0 50.01 50.01 05100 RECOVERY ROOM 1, 591, 470 0 1, 869, 268 51.00 0.000000 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 52.00 120, 037 354, 772 0 52.00 0 53.00 05300 ANESTHESI OLOGY 0.000000 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 4, 413, 398 5, 387, 445 0 54.00 05401 RADI OLOGY - ULTRASOUND 0.000000 2, 308, 505 2, 042, 320 0 54.01 54.01 05500 RADI OLOGY-THERAPEUTI C 519, 463 3, 926, 304 55.00 0.000000 0 0 55.00 56.00 05600 RADI OI SOTOPE 0.000000 2, 290, 286 3, 078, 956 0 56.00 57.00 05700 CT SCAN 0.000000 15, 483, 864 16, 369, 174 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 4, 182, 906 0 4, 401, 904 0 58.00 05900 CARDI AC CATHETERI ZATI ON 0 0.000000 13, 496, 360 59.00 59.00 14, 826, 580 0 60.00 06000 LABORATORY 0.000000 22, 886, 860 7, 244, 093 0 60.00 06001 BLOOD LABORATORY 60.01 0.000000 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 3,065,508 228, 670 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 63.00 63.00 0 0 0 06400 I NTRAVENOUS THERAPY 0.000000 64.00 0 64.00 0 06500 RESPIRATORY THERAPY 65.00 0.000000 13, 168, 276 572, 600 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 1,627,744 0 66.00 06700 OCCUPATI ONAL THERAPY 1, 123, 450 67.00 0.000000 20,036 0 67.00 68 00 06800 SPEECH PATHOLOGY 0.000000 735, 368 0 26, 299 Ω 68 00 0.000000 0 69.00 06900 ELECTROCARDI OLOGY 5, 113, 000 2, 406, 031 0 69.00 69.01 06901 CARDI AC REHAB 0.000000 230, 991 0 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 3,024,434 0 2, 909, 673 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71 00 0.000000 8, 337, 826 5, 308, 103 0 71 00 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0.000000 8, 528, 874 4, 218, 870 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 41, 222, 169 10, 794, 351 0 73.00 07400 RENAL DIALYSIS 74.00 0.000000 3, 611, 201 226, 250 0 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 207, 360 3, 995, 129 0 90.00 09100 EMERGENCY 0.011942 8, 995, 177 107, 420 8, 062, 780 96, 286 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 2, 906, 907 2, 814, 605 0 92.00 C

107, 420

121, 940, 577

206, 245, 767

96, 286 200. 00

200.00

Total (lines 50 through 199)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0002 Peri od: Worksheet D From 01/01/2017 Part V Date/Time Prepared: 12/31/2017 5/30/2018 8: 22 am Title XVIII Hospi tal Charges Costs PPS Services Cost Center Description Cost to PPS Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) 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 05000 OPERATING ROOM 50.00 0.088106 17, 458, 962 60 1, 538, 239 50.00 05001 ENDOSCOPY 4, 496, 631 0 919, 709 50.01 0. 204533 0 50.01 05100 RECOVERY ROOM 51.00 0. 264755 1,869,268 0 494, 898 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.985324 354, 772 0 0 349, 565 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0 0 53.00 1, 278, 166 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 237249 5, 387, 445 1 471 54 00 54.01 05401 RADI OLOGY - ULTRASOUND 0. 179232 2,042,320 0 0 366, 049 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 0. 176397 3, 926, 304 0 6 692, 588 55.00 05600 RADI OI SOTOPE 0.188900 3, 078, 956 0 581, 615 56.00 117 56.00 05700 CT SCAN 20 612,076 57.00 0.037392 16, 369, 174 6, 473 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.051448 4, 401, 904 939 226, 469 58.00 05900 CARDI AC CATHETERI ZATI ON 3 59.00 0.072545 13, 496, 360 1, 109 979, 093 59.00 06000 LABORATORY 0 60 00 0 113126 7, 244, 093 0 819, 495 60 00 60.01 06001 BLOOD LABORATORY 0.000000 0 0 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 0 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0. 242607 228, 670 0 71 55, 477 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0.000000 63 00 C 0 0 63 00 0 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0 0 64.00 06500 RESPIRATORY THERAPY 0. 127735 572,600 73, 141 65.00 0 0 66.00 06600 PHYSI CAL THERAPY 0.404138 66,00 0 0 06700 OCCUPATI ONAL THERAPY 0.399363 20,036 8,002 67 00 67 00 o 68.00 06800 SPEECH PATHOLOGY 0.367009 26, 299 9,652 68.00 06900 ELECTROCARDI OLOGY 0.062598 2, 406, 031 0 0 150, 613 69.00 69.00 0 06901 CARDI AC REHAB 69.01 0.756398 230, 991 0 174, 721 69.01 2, 909, 673 0 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0.076430 222, 386 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.344888 5, 308, 103 0 0 1,830,701 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.543466 4, 218, 870 10,020 0 2, 292, 812 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 0.151256 10, 794, 351 62, 045 1, 632, 710 73 00 187 74.00 07400 RENAL DIALYSIS 0. 328059 226, 250 74, 223 74.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0.483227 3, 995, 129 391 1. 930. 554 90.00 09100 EMERGENCY 91.00 91.00 0.272922 8,062,780 0 111 2, 200, 510 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.513956 2, 814, 605 1, 446, 583 92.00 0 200.00 Subtotal (see instructions) 121, 940, 577 10, 235 71, 793 20, 960, 047 200.00 Less PBP Clinic Lab. Services-Program 201. 00 201.00 Only Charges

121, 940, 577

10, 235

71, 793

20, 960, 047 202. 00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	METHODIST HOSPIT	ALS, INC	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0002	Peri od:	Worksheet D

To 12/31/2017 Date/Time Prepared: 5/30/2018 8: 22 am Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 7. 00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 05001 ENDOSCOPY 000000010000000000000000 50.01 0 50.01 05100 RECOVERY ROOM 0 51.00 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 54.00 112 54.01 05401 RADI OLOGY - ULTRASOUND C 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 55.00 22 56.00 05600 RADI OI SOTOPE 56.00 05700 CT SCAN 57.00 242 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 48 58.00 59.00 05900 CARDIAC CATHETERIZATION 80 59.00 06000 LABORATORY 60.00 60 00 0 60.01 06001 BLOOD LABORATORY 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 17 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63 00 0 63 00 06400 I NTRAVENOUS THERAPY 64.00 0 64.00 65.00 06500 RESPIRATORY THERAPY 65.00 06600 PHYSI CAL THERAPY 0 66.00 66.00 06700 OCCUPATI ONAL THERAPY 67 00 0 67 00 06800 SPEECH PATHOLOGY 68.00 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 69. 01 06901 CARDI AC REHAB 0 69.01 07000 ELECTROENCEPHALOGRAPHY 70.00 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 5.446 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 28 9, 385 73.00 74.00 07400 RENAL DIALYSIS 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 189 90.00 91.00 09100 EMERGENCY 91.00 0 30 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 200.00 Subtotal (see instructions) 5, 475 10, 131 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges

5, 475

10, 131

202.00

202.00

Net Charges (line 200 - line 201)

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 Co		Peri od:	Worksheet D	
		Component		From 01/01/2017 To 12/31/2017	Part II Date/Time Pre	pared:
					5/30/2018 8: 2	2 am
			XVIII	Subprovi der - I PF	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost		Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1. 00	2.00	3.00	4.00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	1, 401, 790	166, 627, 825	0. 00841	3 0	0	50.00
50. 01   05001   ENDOSCOPY	43, 490				Ö	
51. 00   05100   RECOVERY   ROOM	317, 331				ő	
52. 00   05200   DELIVERY ROOM & LABOR ROOM	205, 710				0	
53. 00   05300   ANESTHESI OLOGY	203,710				0	
	_	1			_	
	1, 113, 643				214	
54. 01   05401   RADI OLOGY - ULTRASOUND	130, 675				55	
55. 00   05500   RADI OLOGY-THERAPEUTI C	283, 540		0. 02068		0	
56. 00   05600   RADI 0I SOTOPE	206, 369				176	
57.00  05700   CT SCAN	265, 027				64	
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	109, 562		0. 00386	9 3, 212	12	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	256, 207		0. 00353	3 0	0	59.00
60. 00   06000   LABORATORY	684, 916	143, 572, 843	0.00477	1 140, 395	670	60.00
60. 01   06001   BLOOD   LABORATORY	0	0	0.00000	0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	30, 398	8, 890, 399	0. 00341	9 13, 093	45	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0				0	
64. 00 06400 I NTRAVENOUS THERAPY	0				Ö	
65. 00 06500 RESPIRATORY THERAPY	213, 056	1			2	65.00
66. 00 06600 PHYSI CAL THERAPY	265, 073				212	
67. 00   06700   OCCUPATI ONAL THERAPY	222, 958				119	
68. 00   06800   SPEECH PATHOLOGY				-, -	0	
	42, 185					
69. 00 06900 ELECTROCARDI OLOGY	24, 450				24	
69. 01   06901   CARDI AC   REHAB	6, 306				0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	26, 970				0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	468, 284				1	71.00
72.00 07200 MPL. DEV. CHARGED TO PATIENTS	519, 478		0. 01462		0	
73.00 07300 DRUGS CHARGED TO PATIENTS	558, 965			4 323, 642	1, 183	73.00
74. 00 07400 RENAL DIALYSIS	118, 348	8, 471, 203	0. 01397	1 0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	1, 556, 856	22, 277, 687	0. 06988	4 0	0	90.00
91. 00  09100 EMERGENCY	767, 233			1 60, 922	742	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0. 00000	0 1, 335	0	92.00
200.00 Total (lines 50 through 199)	9, 838, 820	1, 111, 006, 547		626, 612	3, 519	200.00
	•				•	•

Health Financial Systems	METHODIST HOS				eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PAS		CN: 15-0002 CCN: 15-S002	Peri od: From 01/01/201 To 12/31/201	Worksheet D Part IV Date/Time Pre 5/30/2018 8:2	epared:
		Title	XVIII	Subprovi der -	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	School	School	Post-Stepdowr	۱	
	Cost	Post-Stepdown		Adjustments		
	1.00	Adjustments	0.00	0.4	2 00	
ANCILLARY CERVICE COCT CENTERS	1. 00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS 50. 00   O5000   OPERATING ROOM	0	0	Γ		ol o	50.00
50. 00   05000   0FERATTING ROOM 50. 01   05001   ENDOSCOPY						
51. 00   05100   RECOVERY ROOM		0		-		
52.00   05200   DELIVERY ROOM & LABOR ROOM		0		0		
53. 00   05300   DEET VERT   ROOM & LABOR ROOM		0		0		
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0		0		
54. 01   05401   RADI OLOGY - ULTRASOUND		0		0		
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	ol ö	
56. 00   05600   RADI OI SOTOPE	0	0		0	ol o	
57. 00 05700 CT SCAN	0	0		-	ol o	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	Ö		O	ol o	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	ol o	59.00
60. 00 06000 LABORATORY	0	0		0	ol o	60.00
60. 01   06001   BLOOD LABORATORY	0	0		0	o o	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0 0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0 0	63.00
64.00  06400   I NTRAVENOUS THERAPY	0	0		0	0 0	1
55. 00  06500 RESPIRATORY THERAPY	0	0		0	0 0	65.00
66. 00  06600 PHYSI CAL THERAPY	0	0		9	0 0	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0 0	
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0	
69. 00 06900 ELECTROCARDI OLOGY	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 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	
72.00   07200   IMPL. DEV. CHARGED TO PATIENTS 73.00   07300   DRUGS CHARGED TO PATIENTS	0			0	0 0	1
	0					
74. 00 O7400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS		<u> </u>		U	<u>U</u>	1 /4.00
90. 00   09000   CLINIC	0	0		0	0 0	90.00
91. 00   09100   EMERGENCY		l			0 752, 201	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			Ö	0 732, 201	1
(Non District TAKT)	1	i .	1	-1	1	1 ,2.0

0 90.00 752, 201 91.00 0 92.00 752, 201 200.00

0 0 0

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

Heal th	Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
APP0R1	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS		S Provider C Component	CCN: 15-S002	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV	epared:
			Title	e XVIII	Subprovi der  - I PF	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medical Education	(sum of col 1	Outpatient Cost (sum of	(from Wkst. C, Part I,	to Charges (col. 5 ÷	
		Cost	through col.				
		COST	4)	col . 2, 3 and 4)	COI. 8)	col. 7)	
		4. 00	5. 00	6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
50.00	05000 OPERATING ROOM	0	0		0 166, 627, 825	0.000000	50.00
50. 01	05001 ENDOSCOPY	0	0		0 19, 475, 289		
51.00	05100 RECOVERY ROOM	0	O		0 10, 706, 556		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 5, 364, 077		52.00
53.00	05300 ANESTHESI OLOGY	0	0		0	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 36, 949, 293	0.000000	54.00
54.01	05401 RADI OLOGY - ULTRASOUND	0	0		0 16, 563, 335	0.000000	54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 13, 708, 271	0.000000	
56.00	05600  RADI 0I S0T0PE	0	0	1	0 15, 215, 385		
57.00	05700  CT SCAN	0	0	1	0 110, 088, 963		
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 28, 315, 443		
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	l .	0 72, 518, 351		
60.00	06000 LABORATORY	0	0		0 143, 572, 843		
60. 01	06001 BLOOD LABORATORY	0	0	1	0	0. 000000	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 8, 890, 399	l	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0.000000	
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0			0 0 40, 430, 889	0. 000000 0. 000000	
66.00	06600 PHYSI CAL THERAPY	0		1	0 7, 622, 213		
67.00	06700 OCCUPATI ONAL THERAPY	0			0 6, 200, 644		
68. 00	06800 SPEECH PATHOLOGY	0			0 2, 206, 688		1
69.00	06900 ELECTROCARDI OLOGY	0			0 20, 532, 765		
69. 01	06901 CARDI AC REHAB				0 923, 324		
70.00	07000 ELECTROENCEPHALOGRAPHY	l 0	n	1	0 23, 240, 973		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	ĺ	l .	0 49, 686, 879		
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	Ö	,	0 35, 515, 731		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	1	0 152, 966, 052		
74.00	07400 RENAL DI ALYSI S	0	1 0	1	0 8, 471, 203		74.00

752, 201

752, 201

0 752, 201 1, 111, 006, 547

752, 201

22, 277, 687

62, 988, 278 29, 947, 191

90.00

91.00 92. 00 200. 00

0.000000

0.011942

0.000000

07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50 through 199)

200.00

90. 00 09000 CLINIC

91. 00 09100 EMERGENCY

Hoal th	Financial Systems	METHODI ST HOSPI	ITALS INC		In Lio	u of Form CMS-2	2552 10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE		Provider C	CN: 15-0002	Peri od:	Worksheet D	2332-10
	H COSTS	KVICE OTTER PASS	FI OVI dei C	CN. 15-0002	From 01/01/2017	Part IV	
			·	CCN: 15-S002	To 12/31/2017	Date/Time Pre 5/30/2018 8:2	
			Titl∈	e XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷		Costs (col.	8	Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	C		0	0	
50. 01	05001 ENDOSCOPY	0. 000000	C	)	0	0	50. 01
51.00	05100 RECOVERY ROOM	0. 000000	C	)	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	C	)	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	C	)	0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	7, 114		0	0	54.00
54.01	05401 RADI OLOGY - ULTRASOUND	0. 000000	6, 998	3	0 0	0	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	C		0 0	0	55.00
56.00	05600 RADI OI SOTOPE	0. 000000	12, 998	3	0 0	0	56.00
57.00	05700 CT SCAN	0. 000000	26, 524		0 0	0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	3, 212	1	0 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000			0 0	0	59.00
60.00	06000 LABORATORY	0. 000000	140, 395		0 0	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	C		0 0	Ō	
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		_				61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	13, 093		0 0	0	1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	.0,070	1	0 0	0	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	C	1	0 0	0	1
65. 00	06500 RESPIRATORY THERAPY	0. 000000	445	1	0 0	Ö	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	6, 091	l	0 0	Ö	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	3, 316	•	0 0	Ö	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	3, 310		0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	20, 435	1	0 0	0	69.00
69. 01	06901 CARDI AC REHAB	0. 000000	20, 433	1	0 0	0	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	C	I .	0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	92	1	0 0	0	
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	72	•	0 0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 000000	323, 642	1	0 0	0	73.00
74.00	07400 RENAL DI ALYSIS	0. 000000	323, 042 C	•	0 0	0	
74.00	OUTPATIENT SERVICE COST CENTERS	0.000000		'	0 0	U	74.00
90. 00	09000 CLINIC	0. 000000	C	\	0 0	0	90.00
90.00	09100 EMERGENCY	0. 000000	60, 922			0	
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 011942		1	0 0	0	
200.00	· · · · · · · · · · · · · · · · · · ·	0.000000	1, 335 626, 612	1		_	200.00
∠00.00	Total (lines 50 through 199)		020, 012	.  /2	ان.	ı	<sub>1</sub> 200.00

Health Financial Systems	METHODIST HOS	·	1		u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provi der C		Peri od: From 01/01/2017	Worksheet D Part II	
		Component	CCN: 15-T002	To 12/31/2017	Date/Time Pre 5/30/2018 8:2	epared:
		Title	xVIII	Subprovi der - I RF	PPS	.z um
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
oost center bescription	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)	3	.,	
	col . 26)					
	1. 00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	1, 401, 790	166, 627, 825	0. 00841	3 205, 472	1, 729	50.00
50. 01 05001 ENDOSCOPY	43, 490	19, 475, 289	0. 00223	3 24, 135	54	50. 01
51.00 05100 RECOVERY ROOM	317, 331	10, 706, 556	0. 02963	9, 308	276	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	205, 710			0 1, 398	54	52.00
53. 00   05300   ANESTHESI OLOGY	0	1	1		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 113, 643	36, 949, 293	l .		4, 240	54.00
54. 01   05401 RADI OLOGY - ULTRASOUND	130, 675		•		313	1
55. 00 05500 RADI OLOGY-THERAPEUTI C	283, 540				660	
56. 00   05600   RADI OI SOTOPE	206, 369				150	1
57. 00   05700   CT   SCAN	265, 027				669	1
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	109, 562				363	
59. 00 05900 CARDI AC CATHETERI ZATI ON	256, 207				479	
60. 00   06000   LABORATORY	684, 916				4, 167	60.00
60. 01   06001   BLOOD   LABORATORY	0		1		0	1
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	30, 398	8, 890, 399	0. 00341	9 56, 685	194	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0				0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0.00000		0	
65. 00 06500 RESPIRATORY THERAPY	213, 056	40, 430, 889			2, 115	
66. 00 06600 PHYSI CAL THERAPY	265, 073			· ·	79, 795	
67. 00 06700 OCCUPATI ONAL THERAPY	222, 958				76, 441	67.00
68. 00 06800 SPEECH PATHOLOGY	42, 185				3, 909	
69. 00 06900 ELECTROCARDI OLOGY	24, 450				31	69.00
69. 01   06901   CARDI AC   REHAB	6, 306		•		0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	26, 970				23	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	468, 284				1, 829	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	519, 478		•	· ·	125	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	558, 965		•	· ·	14, 134	
74. 00   07400   RENAL DI ALYSI S	118, 348				6, 117	74.00
OUTPATIENT SERVICE COST CENTERS	,					1
90. 00 09000 CLINIC	1, 556, 856	22, 277, 687	0. 06988	22, 108	1, 545	90.00
91. 00   09100   EMERGENCY	767, 233	1			0	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		l .		Ō	92.00
200.00 Total (lines 50 through 199)	9, 838, 820	1, 111, 006, 547		11, 504, 274	199, 412	
, ,	•	•	•	•	•	

Health Financial Systems	METHODIST HOS				eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY THROUGH COSTS	SERVICE OTHER PAS		CN: 15-0002 CCN: 15-T002	Period: From 01/01/201 To 12/31/201	Worksheet D Part IV Date/Time Pre 5/30/2018 8:2	
		Title	× XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursi ng School Post-Stepdown Adjustments	Nursi ng School	Post-Stepdowr Adjustments		
	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS			1			
50. 00   05000   OPERATING ROOM	0	1	1	-	0	
50. 01   05001   ENDOSCOPY 51. 00   05100   RECOVERY   ROOM	0	0	1	-		
52. 00 05200 DELIVERY ROOM & LABOR ROOM				0		
53. 00 05300 ANESTHESI OLOGY	0					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	o o	ĺ	,	o o		1
54. 01   05401 RADI OLOGY - ULTRASOUND	0	O		0	0	1
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	)	0	0	55.00
56. 00   05600   RADI OI SOTOPE	0	0	1	٠	0	
57.00 05700 CT SCAN	0	0		-	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		٠	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		٠	0	
60. 00   06000   LABORATORY	0	0		٠	0	
50.01  06001 BLOOD LABORATORY 51.00  06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	1	0	0	
61.00  06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 62.00  06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0		0	o	61.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	,   0			٠		63.00
64. 00 06400 I NTRAVENOUS THERAPY	0			-		
65. 00 06500 RESPIRATORY THERAPY	0	Ö	,	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	1	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	)	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	1	0	0	
69. 01   06901   CARDI AC REHAB	0	0		٠	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	1	0	0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	1	0	0	71.00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0	1	0	0	
· · · · · · · · · · · · · · · · · · ·	0	0	1			
74.00 O7400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS	0		1	U	0	74.00
90. 00   09000   CLINIC	0	0		0	o lo	90.00
91. 00   09100   EMERGENCY	0		1		752, 201	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			1	0	0	1

0 92.00 752, 201 200.00

0 0 0

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

Heal th	ı Financial Systems	METHODIST HOS	SPITALS INC		In lie	eu of Form CMS-2	2552-10
APPOR	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF GH COSTS		S Provider C Component	CCN: 15-T002	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV	epared:
			Title	e XVIII	Subprovi der – I RF	PPS	
	Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I,	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
	1	4. 00	5.00	6. 00	7. 00	8. 00	
50. 00 50. 01 51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 01 61. 00	05001 ENDOSCOPY 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05401 RADI OLOGY-DI AGNOSTI C 05401 RADI OLOGY - ULTRASOUND 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OL OGY-THERAPEUTI C 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI ) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 060100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY	0 0 0 0 0 0 0 0 0 0 0			166, 627, 825 0 19, 475, 289 0 10, 706, 556 0 5, 364, 077 0 36, 949, 293 0 16, 563, 335 0 13, 708, 271 0 15, 215, 385 0 10, 088, 963 0 28, 315, 443 72, 518, 351 143, 572, 843 0 0	0.000000 0.000000 0.000000 0.000000 0.000000	50. 01 51. 00 52. 00 53. 00 54. 00 54. 01 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00
62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 01 70. 00 71. 00 72. 00 73. 00 74. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 06901 CARDIAC REHAB 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0 0 0 0 0 0 0 0 0 0			0 8, 890, 399 0 0 0 40, 430, 889 0 7, 622, 213 0 6, 200, 644 0 2, 206, 688 0 20, 532, 765 0 923, 324 0 23, 240, 973 49, 686, 879 0 35, 515, 731 0 152, 966, 052 0 8, 471, 203	0.000000 0.000000 0.000000 0.000000 0.000000	62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 01 70. 00 71. 00 72. 00 73. 00

752, 201

752, 201

22, 277, 687 62, 988, 278 29, 947, 191

0

752, 201 1, 111, 006, 547

752, 201

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90.00

91.00 92.00

07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50 through 199)

200.00

90. 00 09000 CLINIC

91. 00 09100 EMERGENCY

Health Financial Systems	METHODIST HOSPI	TALS. INC		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE		Provi der C	CN: 15-0002	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2017	Part IV	
		Component	CCN: 15-T002	To 12/31/2017	Date/Time Pre 5/30/2018 8:2	
		Title	XVIII	Subprovi der  - I RF	PPS	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12. 00	13.00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	0. 000000	205, 472		0	0	
50. 01  05001  ENDOSCOPY	0. 000000	24, 135		0	0	
51. 00  05100   RECOVERY ROOM	0. 000000	9, 308		0	0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 000000	1, 398		0	0	52.00
53. 00   05300   ANESTHESI OLOGY	0. 000000	0		0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000	140, 676		0 1, 761	0	54.00
54. 01   05401 RADI OLOGY - ULTRASOUND	0. 000000	39, 707		0 0	0	54.01
55. 00   05500   RADI OLOGY-THERAPEUTI C	0. 000000	31, 901		0	0	55.00
56. 00   05600   RADI OI SOTOPE	0. 000000	11, 025		0	0	56.00
57. 00   05700   CT   SCAN	0. 000000	277, 902		0	0	57.00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	93, 736		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	135, 507		0 0	0	59.00
60. 00   06000   LABORATORY	0. 000000	873, 335		0 0	0	60.00
60. 01   06001   BLOOD   LABORATORY	0. 000000	0		0 0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	56, 685		0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	401, 410		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	2, 294, 548		0 0	0	66, 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	2, 125, 913		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	204, 492		o o	Ō	
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	26, 226		o o	Ō	
69. 01   06901   CARDI AC   REHAB	0. 000000	0		o o	Ō	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	20, 171		0 0	Ö	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	194, 059			Ö	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	8, 574			Ö	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	3, 868, 095			0	
74. 00 07400 RENAL DIALYSIS	0. 000000	437, 855		0 0	0	
OUTPATIENT SERVICE COST CENTERS	3. 000000	737, 000		<u> </u>		1 , ,, 50
90. 00 09000 CLINIC	0. 000000	22, 108		0 0	0	90.00
91. 00   09100   EMERGENCY	0. 011942	36		0 0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	
200.00 Total (lines 50 through 199)	0. 000000	11, 504, 274		0 1, 761	_	200.00
200.00   10tal (111103 30 till ough 177)	1	11, 504, 214	ı	1, 701	0	1200.00

Health Financial Systems METHODIST HOSPITALS, INC				In Lieu of Form CMS-2552-10		
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A			Period: From 01/01/2017			
	Component	CCN: 15-T002	To 12/31/2017	Date/Time Pre 5/30/2018 8:2		
		Title	· XVIII	Subprovi der – I RF	PPS	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Servi ces	
	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
	From	Services (see		Servi ces Not		
	Worksheet C	inst)	Subject To	Subject To		

			Charges		Costs	
		200				
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	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 088106	0	0	0	0	50.00
50. 01   05001 ENDOSCOPY	0. 204533				0	50. 01
51. 00   05100   RECOVERY   ROOM	0. 264755		0		Ö	51.00
52.00   05200   DELI VERY   ROOM & LABOR   ROOM	0. 985324		ľ		0	52.00
		1	· -	0	_	
53. 00   05300   ANESTHESI OLOGY	0. 000000		1	0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 237249		0		418	54.00
54. 01   05401   RADI OLOGY - ULTRASOUND	0. 179232		-		0	54. 01
55. 00   05500   RADI OLOGY-THERAPEUTI C	0. 176397	0	0	0	0	55.00
56. 00   05600   RADI OI SOTOPE	0. 188900	0	0	0	0	56.00
57. 00   05700   CT   SCAN	0. 037392	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 051448	0	0	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 072545	0	1 0	0	0	59.00
60. 00   06000   LABORATORY	0. 113126		0	0	0	60.00
60. 01   06001   BLOOD   LABORATORY	0. 000000			_	0	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			0	· ·	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 242607	0		0	0	62.00
			1	0	_	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000		0	0	0	63.00
64. 00   06400   I NTRAVENOUS THERAPY	0. 000000	ł .	0	_	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 127735		0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 404138	ł .	0	0	0	66. 00
67. 00  06700 OCCUPATI ONAL THERAPY	0. 399363		0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 367009	0	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 062598	0	0	0	0	69.00
69. 01   06901   CARDI AC   REHAB	0. 756398	0	0	0	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 076430	l o	l o	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 344888		0	0	0	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 543466		0	0	Ö	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 151256		l	0	Ö	73.00
	0. 131230					74.00
	0. 328059			U	U	74.00
OUTPATIENT SERVICE COST CENTERS		_	_	_	_	
90. 00 09000 CLI NI C	0. 483227		-		0	90.00
91. 00   09100   EMERGENCY	0. 272922		1		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 513956		0	0	0	92.00
200.00 Subtotal (see instructions)		1, 761	0	0	418	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, 761	0	0	418	202.00
	'	•	'	'		•

PPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST  Provider CCN: 15-0002 Component CCN: 15-1002  Title XVIII  Cost Center Description  Cost Rei mbursed Services Subject To Ded. & Coins. (see inst.) 6.00  Provider CCN: 15-0002 From 01/01/2017 To 12/31/2017 Subprovider - IRF  Worksheet D Part V Date/Time Prepared 5/30/2018 8: 22 am  Vaccine Cost From 01/01/2017 To 12/31/2017 Ded: & Cost Subprovider - IRF  Cost Rei mbursed Services Not Subject To Ded: & Coins. (see inst.) Cost inst.) Cost (see inst.) Cost Rei mbursed Services Not Subject To Ded: & Coins. (see inst.) Cost inst.) Cost Rei mbursed Services Not Subject To Ded: & Coins. (see inst.) Cost inst.) Cost Rei mbursed Services Not Subject To Ded: & Coins. (see inst.) Cost Rei mbursed Services Not Subject To Ded: & Coins. (see inst.) Cost Rei mbursed Services Not Subject To Ded: & Coins. (see inst.)	ealth Financial Systems	METHODIST HOS	SPITALS, INC		In Lieu	u of Form CMS-	2552-1
Cost Center Description  Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)			Provi der Co		Peri od: From 01/01/2017	Worksheet D Part V Date/Time Pre	pared
Cost Center Description  Cost Rei mbursed Services Subject To Ded. & Coins. (see inst.)  Cost Rei mbursed Services Not Subject To Ded. & Coins. (see inst.)			Title	XVIII		PPS	
	Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				

Cost Center Description	Cost	Cost	
	Rei mbursed	Rei mbursed	
	Servi ces	Services Not	
	Subject To	Subject To	
	Ded. & Coins.	Ded. & Coins.	
	(see inst.)	(see inst.)	
	6. 00	7. 00	
ANCILLARY SERVICE COST CENTERS			
50.00   05000   OPERATING ROOM	C	0	50.00
50. 01   05001   ENDOSCOPY	C	0	50. 01
51.00   05100   RECOVERY ROOM	C	0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	C	0	52.00
53. 00   05300   ANESTHESI OLOGY	C	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	C	0	54.00
54. 01   05401   RADI OLOGY - ULTRASOUND	C	0	54. 01
55. 00   05500   RADI OLOGY-THERAPEUTI C	C	0	55.00
56. 00   05600   RADI 0I SOTOPE	C	0	56.00
57. 00  05700 CT SCAN	C	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	C	0	58.00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	C	0	59.00
60. 00   06000   LABORATORY	C	0	60.00
60. 01   06001   BLOOD   LABORATORY	C	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	C		61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	C	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	C	0	63.00
64.00 06400 INTRAVENOUS THERAPY	C	0	64.00
65. 00 06500 RESPIRATORY THERAPY	C	0	65.00
66. 00 06600 PHYSI CAL THERAPY	C	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	C	0	67.00
68.00 06800 SPEECH PATHOLOGY	C	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	C	0	69.00
69. 01   06901   CARDI AC REHAB	C	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	C	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	C	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	C	1	73.00
74. 00 07400 RENAL DIALYSIS	C	0	74.00
OUTPATIENT SERVICE COST CENTERS			
90. 00  09000  CLI NI C	C	0	90.00
91. 00   09100   EMERGENCY	C		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	C	0	92.00
200.00 Subtotal (see instructions)	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program	0		201. 00
Only Charges			
202.00   Net Charges (line 200 - line 201)	0	0	202.00

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 01/01/2017	Worksheet D-1	
		To 12/31/2017	Date/Time Pre 5/30/2018 8: 2	pared: 2 am
	Title XVIII	Hospi tal	PPS	
Cost Center Description	_			
			1. 00	

		Title XVIII	Hospi tal	5/30/2018 8: 2 PPS	2 alli
	Cost Center Description		•		
	DADT I ALL DROWLDED COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day	s, excluding newborn)		90, 715	1.00
2.00	Inpatient days (including private room days, excluding swing-			90, 715	2.00
3. 00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ys). If you have only pr	rivate room days,	0	3. 00
4. 00	Semi-private room days (excluding swing-bed and observation b	ed days)		72, 236	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost		5. 00
	reporting period			_	
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 December	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private roo	m davs) 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	31 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 (excluding	swing-bed and	27, 937	9. 00
7. 00	newborn days)	o the regram (exertation)	, om ng bou and	27,707	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10.00
11. 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII o		nom days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, e		days) arter		11.00
12.00	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	V anly (including privat	o noom dovo)	0	12 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13.00
14.00	Medically necessary private room days applicable to the Progr			0	14.00
15. 00	Total nursery days (title V or XIX only)		-	0	15.00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 c	of the cost	0.00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0. 00	19. 00
17.00	reporting period	3 th ough becomber 31 of	the cost	0.00	17.00
20.00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	the cost	0.00	20.00
21. 00	reporting period Total general inpatient routine service cost (see instruction	e)		75, 558, 456	21. 00
22. 00	Swing-bed cost applicable to SNF type services through Decemb		ina period (line		22.00
	5 x line 17)		3   1		
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportir	ng period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	na period (line	0	24. 00
21.00	7 x line 19)	. Or or the cost report.	ng perrou (Trie	o l	21.00
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
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		75, 558, 456	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	28.00
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)			0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li		cu ons)	0. 00 0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	iic 31 <i>)</i>		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line		37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			832. 92	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	38)		23, 269, 286	39. 00
40.00	Medically necessary private room cost applicable to the Progr	•		0	40.00
41.00	Total Program general inpatient routine service cost (line 39	+ II ne 40)		23, 269, 286	41.00

	Financial Systems	METHODI ST HOSI				u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	F	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Pre	pared:
			Ti +Lo	e XVIII	Hospi tal	5/30/2018 8: 2 PPS	2 am
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NUDCEDY (+: +1 - V 0 VIV1.)	1. 00	2.00	3. 00	4.00	5. 00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.00	0	U	42.00
43.00	INTENSIVE CARE UNIT	13, 539, 584	8, 536	1, 586. 17	3, 570	5, 662, 627	43.00
43. 01	NEONATAL ICU	3, 429, 065	2, 820	1, 215. 98	0	0	
44. 00	CORONARY CARE UNIT						44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description						
40.00	Drogram impationt and Harry convice and (WK	a+ D 2 aal 2	) Line 200)			1.00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			ons)		33, 694, 744 62, 626, 657	
50.00	Pass through costs applicable to Program inp	atient routine	servi ces (fro	m Wkst. D, sum	of Parts I and	2, 450, 936	50. 00
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillar	ry services (f	rom Wkst. D, s	um of Parts II	1, 729, 949	51.00
52.00	Total Program excludable cost (sum of lines					4, 180, 885	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		elated, non-phy	ysician anesth	etist, and	58, 445, 772	53. 00
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge					0.00	
	Target amount (line 54 x line 55)					0	56.00
57. 00	Difference between adjusted inpatient operat	ing cost and ta	arget amount (	line 56 minus	line 53)	0	57. 00
58.00	Bonus payment (see instructions)	norting noried	anding 1004	undated and ac	mnounded by the	0	58.00
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	ending 1996, 1	updated and co	mpounaea by the	0.00	59. 00
60.00		cost report, up	dated by the i	market basket		0. 00	60.00
61. 00	.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						61.00
	amount (line 56), otherwise enter zero (see	instructions)					,,,,,,
62.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ıcti ons)			0	
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST	cit (see mistre	ictrons)			0	03.00
64. 00	instructions)(title XVIII only)	Ü		·		0	64.00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	per 31 of the (	cost reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)		•		•	0	
	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)					0	
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)			·	rting period	0	
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70. 00	Skilled nursing facility/other nursing facil		•				70. 00
71. 00	Adjusted general inpatient routine service c	ost per diem (I		, ,			71. 00
72.00	Program routine service cost (line 9 x line		. (lim- 14 li	ino 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 26, line 45)	•		,	art II, column		75. 00
76.00	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 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces	,	rovider rocer	de)			78. 00 79. 00
80.00	Total Program routine service costs for comp				us line 79)		80.00
81.00	Inpatient routine service cost per diem limi	tati on		,	,		81.00
82.00	Inpatient routine service cost limitation (I		* .				82.00
83. 00 84. 00	Reasonable inpatient routine service costs (		ıs)				83. 00 84. 00
	Program inpatient ancillary services (see in Utilization review - physician compensation		ons)				85.00
	Total Program inpatient operating costs (sum						86.00
07	PART IV - COMPUTATION OF OBSERVATION BED PASS					4= :=:	07.55
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	- line 2)			18, 479 832. 92	
	Observation bed cost (line 87 x line 88) (se					15, 391, 529	
	, , , , , , , , , , , , , , , , , , , ,						

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 8:2	
		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	7, 191, 384	75, 558, 456	0. 09517	6 15, 391, 529	1, 464, 904	90.00
91.00 Nursing School cost	0	75, 558, 456	0.00000	0 15, 391, 529	0	91.00
92.00 Allied health cost	0	75, 558, 456	0.00000	0 15, 391, 529	0	92.00
93.00 All other Medical Education	o	75, 558, 456	0.00000	0 15, 391, 529	0	93.00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu	of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0002	Peri od: From 01/01/2017	Worksheet D-1
	Component CCN: 15-S002		
	Title XVIII	Subprovi der -	PPS
		IPF	

		I PF		
	Cost Center Description		4 00	
	PART I - ALL PROVIDER COMPONENTS		1. 00	
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newbor	rn)	2, 343	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn da	iys)	2, 343	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have on	nly private room days,	0	3. 00
	do not complete this line.		0.040	
4. 00	Semi-private room days (excluding swing-bed and observation bed days)		2, 343	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through De reporting period	ecember 31 of the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after Dece	ember 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 Dec	cember 31 of the cost	0	7. 00
0.00	reporting period		0	0.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after Decem reporting period (if calendar year, enter 0 on this line)	nber 31 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excl	uding swing-bed and	925	9.00
7. 00	newborn days)	aarrig siirrig soa arra	,20	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including priv	ate 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 priv		0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line Swing-bed NF type inpatient days applicable to titles V or XIX only (including p		0	12. 00
12.00	through December 31 of the cost reporting period	in vate 100m days)	O	12.00
13.00		orivate room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on thi			
14.00	Medically necessary private room days applicable to the Program (excluding swing	j-bed days)	0	14.00
15.00	1 3 3 3 3 3 3		0	15.00
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT		0	16. 00
17. 00		31 of the cost	0.00	17. 00
00	reporting period	0. 0. 1 0001	0.00	177.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 3	31 of the cost	0.00	18. 00
40.00	reporting period			40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December reporting period	31 of the cost	0.00	19. 00
20. 00		of the cost	0.00	20.00
	reporting period			
21. 00			1, 870, 885	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost r	eporting 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 rep	porting ported (line A	0	23. 00
23.00	x line 18)	or tring period (Trine of	0	23.00
24.00		eporting 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 repo	orting 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)	1, 870, 885	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		, , , , , , , , , , , , , , , , , , , ,	
	General inpatient routine service charges (excluding swing-bed and observation b	ed 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 in	structions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line 31)	,	0.00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room co	st differential (line	1, 870, 885	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)		798. 50	38, 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)		738, 613	
	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)		738, 613	41.00

Heal th	Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C		Period: From 01/01/2017	Worksheet D-1	
			Component		Γο 12/31/2017	Date/Time Pre 5/30/2018 8: 2	
			Title	e XVIII	Subprovi der -	PPS	<u> 2 aiii                                </u>
	Cost Contor Description	Total	Total	Average Per	IPF Program Days	Drogram Cost	
	Cost Center Description	Inpati ent	Inpatient	Diem (col. 1	Program bays	Program Cost (col. 3 x	
		Cost	Days	÷ col . 2)		col. 4)	
42. 00	NURSERY (title V & XIX only)	1. 00 0	2.00	3.00	4.00	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	0		η	<i>γ</i>	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 (Wks					97, 046	1
49. 00	Total Program inpatient costs (sum of lines a PASS THROUGH COST ADJUSTMENTS	41 through 48)	(see instructi	ons)		835, 659	49. 00
50.00	Pass through costs applicable to Program inpa	atient routine	services (fro	m Wkst. D, sum	of Parts I and	37, 509	50.00
F1 00		-+!+!!!-		W D	£ Dt- 11	4 0 4 7	F1 00
51. 00	Pass through costs applicable to Program inpand IV)	attent ancilia	ry services (i	rom wkst. D, S	um or Parts II	4, 247	51.00
52.00	Total Program excludable cost (sum of lines!	,				41, 756	52.00
53.00	Total Program inpatient operating cost exclude		elated, non-ph	ysician anesth	etist, and	793, 903	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 operati	ing cost and ta	arget amount (	line 56 minus	line 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)		g (			0	58.00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and co	mpounded by the	0.00	59. 00
60.00	market basket Lesser of lines 53/54 or 55 from prior year	cost report. u	ndated by the	market basket		0. 00	60.00
61. 00	If line 53/54 is less than the lower of lines	s 55, 59 or 60	enter the les	ser of 50% of		0	61.00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		ts (lines 54 x	60), or 1% of	the target		
62. 00	Relief payment (see instructions)	ilisti ucti olis)				0	62. 00
63.00	Allowable Inpatient cost plus incentive payme	ent (see instr	uctions)			0	63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST  Medicare swing-bed SNF inpatient routine cost	ts through Doc	ombor 21 of th	o cost roporti	ng poriod (Soc	0	64.00
04.00	instructions)(title XVIII only)	ts through beco	elliber 31 of th	e cost reporti	ing period (see	O	04.00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	ber 31 of the	cost reporting	period (See	0	65.00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 nlus line	65)(title XVII	Lonly) For	0	66. 00
00.00	CAH (see instructions)	ne costs (Time	or prus rine	00)((11110 XVII	1 om y). 1 or	· ·	00.00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	h December 31	of the cost re	porting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after	December 31 of	the cost repo	rting period	0	68. 00
	(line 13 x line 20)					_	
69. 00	Total title V or XIX swing-bed NF inpatient   PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.00
70.00	Skilled nursing facility/other nursing facili						70.00
71.00	Adjusted general inpatient routine service co		line 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)		m (line 14 x l	ine 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine servi		•				74.00
75. 00	Capital-related cost allocated to inpatient	routine servic	e costs (from	Worksheet B, F	art II, column		75. 00
76. 00	26, line 45)  Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line	76)					77. 00
78. 00	Inpatient routine service cost (line 74 minus		nravi dan nagan	do)			78.00
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa	,			us line 79)		79. 00 80. 00
81.00	Inpatient routine service cost per diem limi	tati on		,	<i>,</i>		81.00
82.00	Inpatient routine service cost limitation (I						82.00
83. 00 84. 00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in:		113)				83. 00 84. 00
85.00	Utilization review - physician compensation	(see instructi					85. 00
86. 00	Total Program inpatient operating costs (sum		hrough 85)				86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					0	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27				0.00	88. 00
89. 00	Observation bed cost (line 87 x line 88) (see	e instructions	)		l	0	89. 00

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (	CCN: 15-S002	From 01/01/2017 To 12/31/2017		
		Title	XVIII	Subprovi der -	PPS	
				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	95, 005	1, 870, 885	0. 05078	31 0	0	90.00
91.00 Nursing School cost	0	1, 870, 885	0. 00000	00	0	91.00
92.00 Allied health cost	0	1, 870, 885	0. 00000	00	0	92.00
93.00 All other Medical Education	0	1, 870, 885	0. 00000	00	0	93. 00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0002	Peri od:	Worksheet D-1
		From 01/01/2017	
	Component CCN: 15-T002	To 12/31/2017	Date/Time Prepared:
	·		5/30/2018 8: 22 am
	Title XVIII	Subprovi der -	PPS
		I RF	

		TI LIE XVIII	I RF	113	
	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			9, 525	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-l Private room days (excluding swing-bed and observation bed day		ivate room days	9, 525 0	2. 00 3. 00
0.00	do not complete this line.	(3). IT you have only pr	rvate room days,		0.00
4. 00	Semi-private room days (excluding swing-bed and observation be			9, 525	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private rooreporting period	om days) through Decembe	r 31 of the cost	0	5.00
6. 00	Total swing-bed SNF type inpatient days (including private roo	om 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 roor reporting period	n days) through December	31 of the cost	0	7.00
8.00	Total swing-bed NF type inpatient days (including private roor	n days) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)			5 000	
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	5, 800	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days)	0	10.00
	through December 31 of the cost reporting period (see instruct			_	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, en		oom days) after	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		e 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 XI) after December 31 of the cost reporting period (if calendar ye			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra			0	14.00
15.00	Total nursery days (title V or XIX only)	( Jan 19 Jan Jan 19 Jan		0	15.00
16. 00	Nursery days (title V or XIX only)			0	16.00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
.,. 00	reporting period	3			
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00
	reporting period	G			
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of t	he cost	0. 00	20.00
21. 00	Total general inpatient routine service cost (see instructions	s)		7, 399, 465	21.00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	a period (line A	0	23. 00
23.00	x line 18)	or or the cost reportin	g perrou (rine u		25.00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24.00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	R1 of the cost reporting	neriod (line 8	0	25. 00
20.00	x line 20)	or the cost reporting	perred (rine e		20.00
26.00	Total swing-bed cost (see instructions)	(1) 04		0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost   PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(IINE 21 MINUS IINE 26)		7, 399, 465	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28.00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30. 00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	- IIne 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	nue lino 22)/coo i not	tions)	0.00	•
34. 00 35. 00	Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x lin		11 0115)	0. 00 0. 00	34.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	ic 31 <i>)</i>		0.00	36.00
37.00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line		37.00
57.00	27 minus line 36)	pri vato room cost ur		7, 377, 405	07.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	MOTHENTO.			
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU		T	77/ 05	20.00
38.00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			776. 85 4 505 720	
39. 00 40. 00	Medically necessary private room cost applicable to the Progra	,		4, 505, 730 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39			4, 505, 730	
		•	'		

Heal th	Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	<u> 2552-10</u>
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C		Period: From 01/01/2017	Worksheet D-1	
			Component		To 12/31/2017	Date/Time Pre 5/30/2018 8: 2	
			Title	e XVIII	Subprovi der -	PPS	<u> 2 aiii                                </u>
	Cost Contar Doscription	Total	Total	Average Per	IRF Program Days	Drogram Cost	
	Cost Center Description	Inpati ent	Inpatient	Diem (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		0.00	γ <sub>1</sub>	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, 929, 557	1
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)	(see instructi	ons)		7, 435, 287	49. 00
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	432, 680	50.00
F1 00		-+!+!!!-		W D	£ Dt- II	100 410	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	199, 412	51.00
52.00	Total Program excludable cost (sum of lines					632, 092	52.00
53. 00	Total Program inpatient operating cost exclu	9 1	elated, non-ph	ysician anesth	etist, and	6, 803, 195	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 (	Title 66 illi ildə	11110 00)	0	58.00
59. 00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the						
60. 00	market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by						0. 00 0	61.00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	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 +			0	
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)							64.00
65.00	Medicare swing-bed SNF inpatient routine 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) (+; +  o V)/	Loply) For	0	66. 00
00.00	CAH (see instructions)	ne costs (Title	04 prus rine	os)(ti ti e xvii	i only). For	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 repo	Ting 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		. (11 44 1	05)			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
7/ 00	26, line 45)	2)					77, 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	Aggregate charges to beneficiaries for exces	,		*.	70)		79.00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		cost fimitatio	ıı (ııne /8 min	us rine 79)		80. 00 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		ons)				84. 00 85. 00
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 HOSPIT			ALS, INC In Lieu		u of Form CMS-2552-10	
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0002			Period: From 01/01/2017	Worksheet D-1	
		Component (	Component CCN: 15-T002		Date/Time Pre 5/30/2018 8:2	
		Title	XVIII	Subprovi der -	PPS	
				I RF		
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	710, 606	7, 399, 465	0. 09603	35 0	0	90.00
91.00 Nursing School cost	0	7, 399, 465	0.00000	0 0	0	91.00
92.00 Allied health cost	0	7, 399, 465	0. 00000	00	0	92.00
93.00 All other Medical Education	0	7, 399, 465	0. 00000	00	0	93.00

Health Financial Systems	Financial Systems METHODIST HOSPITALS, INC			
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0002	Period: From 01/01/2017	Worksheet D-1	
			Date/Time Pre 5/30/2018 8:2	pared: 2 am
	Title XIX	Hospi tal	Cost	
Cost Center Description				
			1 00	

		Title XIX	Hospi tal	Cost	
	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 day			90, 715	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		ivate room days	90, 715 0	2. 00 3. 00
0.00	do not complete this line.	ys). It you have omly pr	Tvate room days,	· ·	0.00
4. 00	Semi-private room days (excluding swing-bed and observation b			72, 236	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roreporting period	om days) through Decembe	er 31 of the cost	0	5. 00
6. 00	Teporting period  Total swing-bed SNF type inpatient days (including private ro	om 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 roo reporting period	m days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private roo	m davs) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	3 ,			
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	3, 165	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	nlv (includina private r	room davs)	0	10.00
	through December 31 of the cost reporting period (see instruc	tions)	,	_	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room 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
.2.00	through December 31 of the cost reporting period	( aa p	augo)	· ·	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr	ear, enter 0 on this lin am (excluding swing-bed	le)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	am (exertaining swring bea	udy3)	2, 849	
16.00	Nursery days (title V or XIX only)			0	16. 00
17 00	SWING BED ADJUSTMENT	as through Dagambar 21 a	f the cost	0.00	17. 00
17.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es through becember 31 c	i the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	c through Docombon 21 of	the cost	0.00	19. 00
19.00	reporting period	s through becember 31 or	the cost	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instruction	6)		75, 558, 456	21. 00
22. 00	Swing-bed cost applicable to SNF type services through Decemb		ing period (line		22.00
	5 x line 17)			_	
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	ig period (line 6	0	23. 00
24.00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	0	24.00
25 00	7 x line 19)	21 -6		0	25 00
25. 00	Swing-bed cost applicable to NF type services after December x line 20)	3) or the cost reporting	period (line 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)		75, 558, 456	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation bed ch	arges)	0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)		9/	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	
34.00	Average per diem private room charge differential (line 32 mi	, ,	tions)	0.00	
35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	75, 558, 456	37.00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			832. 92	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			2, 636, 192	39. 00
40.00	Medically necessary private room cost applicable to the Progr			0	40.00
41.00	Total Program general inpatient routine service cost (line 39	+ IIIIe 4U)		2, 636, 192	41.00

37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (lir	ne 75, 558, 456	37.0
	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)	832. 92	38.0
39.00	Program general inpatient routine service cost (line 9 x line 38)	2, 636, 192	39.0
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.0
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2, 636, 192	41.0
		•	

	Financial Systems	METHODIST HOSE				u of Form CMS-2		
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0002   Peri od:   From 01/01/2017   To 12/31/2017		Worksheet D-1 Date/Time Pre	pared:		
			T: +1	Title XIX Hospital		5/30/2018 8: 2 Cost	2 am	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Total Average Per Program Days Inpatient Diem (col. 1		Program Cost (col. 3 x col. 4)		
10.00	Indiportory (1111 May May 11)	1.00	2. 00	3.00	4. 00	5. 00	10.00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	2, 646, 170	2, 849	928. 81	0	0	42.00	
43. 00	INTENSIVE CARE UNIT	13, 539, 584	8, 536	1, 586. 17	0	0	43.00	
43. 01	NEONATAL I CU	3, 429, 065	2, 820			0		
44.00	CORONARY CARE UNIT						44.00	
45.00	BURN INTENSIVE CARE UNIT						45.00	
46.00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00	
47.00	Cost Center Description						47.00	
	·					1. 00		
	Program inpatient ancillary service cost (Wk					1, 944, 423	1	
49. 00	PASS THROUGH COST ADJUSTMENTS	, i		,		4, 580, 615		
50. 00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	0	50. 00	
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillar	ry services (f	rom Wkst. D, s	um of Parts II	0	51.00	
52.00	Total Program excludable cost (sum of lines	50 and 51)				0	52.00	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		elated, non-phy	ysician anesth	etist, and	0	53. 00	
	TARGET AMOUNT AND LIMIT COMPUTATION	,						
	Program di scharges					0	•	
	Target amount per discharge Target amount (line 54 x line 55)					0.00	•	
57.00	Difference between adjusted inpatient operat	ing cost and ta	arget amount (	line 56 minus	line 53)	0		
58.00	Bonus payment (see instructions)	ring cost and to	inger amount (	Trie oo iii nas	1110 00)	0		
59.00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, i	updated and co	mpounded by the	0.00	59. 00	
	market basket					0.00	,,,,,,	
60.00	1				the amount by	0.00	60. 00 61. 00	
01.00	61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						01.00	
	amount (line 56), otherwise enter zero (see instructions)							
62.00		0						
03.00	00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST							
64. 00							64.00	
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	per 31 of the o	cost reporting	period (See	0	65. 00	
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line	65)(title XVII	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	of the cost re	porting period	0	67. 00	
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	December 31 of	the cost repo	rting period	0	68. 00	
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient					0	69. 00	
70.00	PART III - SKILLED NURSING FACILITY, OTHER N		•				70.00	
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c	,		, ,			70. 00 71. 00	
72. 00	Program routine service cost (line 9 x line			-/			72.00	
73.00	Medically necessary private room cost applic	abĺe to Program					73. 00	
74.00	Total Program general inpatient routine serv	•		,			74.00	
75. 00	Capital-related cost allocated to inpatient 26, line 45)		e costs (from )	worksneet B, P	art II, Column		75. 00	
76.00	Per diem capital related costs (line 75 ÷ li						76.00	
77. 00 78. 00	Program capital -related costs (line 9 x line   Inpatient routine service cost (line 74 minu						77. 00 78. 00	
79.00	Aggregate charges to beneficiaries for exces		rovi der recor	ds)			79.00	
80.00	Total Program routine service costs for comp	arison to the c			us line 79)		80.00	
81.00	Inpatient routine service cost per diem limi						81. 00 82. 00	
82. 00 83. 00								
84. 00								
85.00	00 Utilization review - physician compensation (see instructions) 85							
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)  86.							
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bad days (see instructions)							
88.00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	- line 2)			18, 479 832. 92	1	
	Observation bed cost (line 87 x line 88) (se	•				15, 391, 529		

Health Financial Systems	METHODIST HOSPITALS, INC			In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO	Provi der CCN: 15-0002		Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 8:2	
		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	7, 191, 384	75, 558, 456	0. 09517	6 15, 391, 529	1, 464, 904	90.00
91.00 Nursing School cost	0	75, 558, 456	0.00000	0 15, 391, 529	0	91.00
92.00 Allied health cost	0	75, 558, 456	0.00000	0 15, 391, 529	0	92.00
93.00 All other Medical Education	0	75, 558, 456	0. 00000	0 15, 391, 529	0	93. 00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0002	Peri od: From 01/01/2017	Worksheet D-1	
	Component CCN: 15-S002			
	Title XIX	Subprovi der -	Cost	
		I PF		

		II ti o ni n	I PF		
	Cost Center Description		-	1. 00	
	PART I - ALL PROVIDER COMPONENTS		I	1.00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			2, 343	
2. 00 3. 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		ivate room days	2, 343 0	1
3. 00	do not complete this line.	ys). If you have only pr	Tvate Toom days,	O	3.0
4.00	Semi-private room days (excluding swing-bed and observation b	ed days)		2, 343	4.0
5.00	Total swing-bed SNF type inpatient days (including private ro	om days) through Decembe	er 31 of the cost	0	5.0
6. 00	reporting period Total swing-bed SNF type inpatient days (including private ro	om days) after December	21 of the cost	0	6.0
6.00	reporting period (if calendar year, enter 0 on this line)	olli days) ai tei beceilibei	31 OF THE COST	U	0.0
7. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7.0
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	11 of the cost	0	8.0
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	619	9.0
7. 00	newborn days)	o the rrogram (excruding	3wi ng-bed and	017	7.0
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	oom days)	0	10.0
	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	11.0
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	12.0
12.00	through December 31 of the cost reporting period	A only (Therauring privat	le room days)	O	12.0
13.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	13.0
	after December 31 of the cost reporting period (if calendar y				
14.00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	14.0
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			2, 849	ı
16.00	SWING BED ADJUSTMENT			0	10.0
17. 00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 c	of the cost	0.00	17.0
	reporting period				
18.00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0. 00	18.0
10.00	reporting period	a through Dacambar 21 of	the cost	0.00	10.0
19. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s through becember 31 of	the cost	0.00	19.0
20. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0. 00	20.0
	reporting period				
21.00	Total general inpatient routine service cost (see instruction			1, 870, 885	
22. 00	Swing-bed cost applicable to SNF type services through Decemb $5 \times 1$ ine 17)	er 31 of the cost report	ing period (line	0	22.0
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	na neriod (line A	0	23.0
20.00	x line 18)	or or the cost reportin	ig perrod (Trile d	0	20.0
24.00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	0	24.0
05 00	7 x line 19)				0- 0
25. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	period (line 8	0	25.0
26 00	Total swing-bed cost (see instructions)			0	26.0
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		1, 870, 885	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				1
	General inpatient routine service charges (excluding swing-be	d and observation bed ch	arges)	0	
	Private room charges (excluding swing-bed charges)			0	
30.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	: line 20)		0. 000000	30. 0 31. 0
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00000	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	
34.00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0. 00	1
35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	ı
36.00	Private room cost differential adjustment (line 3 x line 35)	and naturate! "	fforonti-l (li	1 070 005	36.0
37. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	Trerential (IIne	1, 870, 885	37.0
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			1
38. 00	Adjusted general inpatient routine service cost per diem (see	instructions)		798. 50	38.0
39. 00	Program general inpatient routine service cost (line 9 x line	*		494, 272	
40.00	Medically necessary private room cost applicable to the Progr	am (line 14 x line 35)		0	40.0
	Total Program general inpatient routine service cost (line 39		1	494, 272	ı

	ATION OF INPATIENT OPERATING COST			CCN: 15-0002	Period: From 01/01/2017	Worksheet D-1	
			· ·	CCN: 15-S002	To 12/31/2017	Date/Time Pre 5/30/2018 8: 2	
			11 t	le XIX	Subprovi der – I PF	Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)		Program Cost (col. 3 x col. 4)	
		1. 00	2.00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	(	0.	00 0	0	42.00
43. 00	INTENSIVE CARE UNIT	0		0.	00 0	0	43.00
43. 01	NEONATAL ICU	0	(	0.		0	1
44. 00	CORONARY CARE UNIT						44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description						
18. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	R line 200)			1. 00 7. 519	48.00
49. 00	Total Program inpatient costs (sum of lines			ons)		501, 791	
	PASS THROUGH COST ADJUSTMENTS						
50. 00	Pass through costs applicable to Program inpulli)	atient routine	services (fro	om Wkst. D, si	um of Parts I and	0	50.00
51. 00	Pass through costs applicable to Program inp	atient ancillar	y services (1	rom Wkst. D,	sum of Parts II	0	51.00
	and IV)						
52. 00 53. 00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclu		lated non ph	weician anost	thatist and	0	
13.00	medical education costs (line 49 minus line		erateu, non-pi	iysi ci aii ailesi	inetist, and	0	33.00
	TARGET AMOUNT AND LIMIT COMPUTATION	·					
	Program di scharges Target amount per di scharge					0 0. 00	
55. 00 66. 00	Target amount (line 54 x line 55)					0.00	
7. 00	Difference between adjusted inpatient operat	ing cost and ta	rget amount (	line 56 minus	s line 53)	0	
8.00	Bonus payment (see instructions)					0	
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period	ending 1996,	updated and d	compounded by the	0.00	59.00
50.00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the	market basket	t	0. 00	60.00
51. 00	If line 53/54 is less than the lower of line					0	61.00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		S (Tines 54 )	( 60), Or 1% (	or the target		
52. 00	Relief payment (see instructions)					0	
53.00	Allowable Inpatient cost plus incentive paym	ent (see instru	ıcti ons)			0	63.00
54. 00	PROGRAM INPATIENT ROUTINE SWING BED COST  Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	ne cost report	ting period (See	0	64.00
	instructions)(title XVIII only)	Ü		•		_	
55.00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decemb	er 31 of the	cost reportir	ng period (See	0	65.00
56. 00	Total Medicare swing-bed SNF inpatient routing	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66.00
	CAH (see instructions)		•		•		
57. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31	of the cost r	reporting period	0	67.00
58. 00	Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost rep	oorting period	0	68.00
,	(line 13 x line 20)			(0)			,,,
59. 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	ity/ICF/IID rou	ıtine service	cost (line 37	7)		70.00
71.00	Adjusted general inpatient routine service of		ine 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)		ı (line 14 x l	ine 35)			72.00
74. 00	Total Program general inpatient routine serv						74.00
75. 00	Capital-related cost allocated to inpatient	routine service	costs (from	Worksheet B,	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						77.0
78.00	Inpatient routine service cost (line 74 minus		unavil el	ado)			78.00
79. 00 30. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa				nus line 79)		79.0
31. 00	Inpatient routine service cost per diem limi			( 70 IIII			81.00
32.00	Inpatient routine service cost limitation (I						82. 0
33. 00 34. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in:		is)				83.00
35. 00	Utilization review - physician compensation		ons)				85.0
36. 00	Total Program inpatient operating costs (sum	of lines 83 th					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					0	87. O
37. 00							, 0/.0

Health Financial Systems	METHODI ST HOS	PITALS, INC	In Lie	In Lieu of Form CMS-2!		
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
			CCN: 15-S002	From 01/01/2017 To 12/31/2017		
		Ti tl	e XIX	Subprovi der -	Cost	
01. 01 D	01	D. 11		I PF	01	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		ŕ		(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	95, 005	1, 870, 885	0. 05078	31 0	0	90.00
91.00 Nursing School cost	0	1, 870, 885	0. 00000	00	0	91.00
92.00 Allied health cost	0	1, 870, 885	0. 00000	00	0	92.00
93.00 All other Medical Education	0	1, 870, 885	0. 00000	00	0	93.00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0002	Peri od:	Worksheet D-1
		From 01/01/2017	
	Component CCN: 15-T002	To 12/31/2017	Date/Time Prepared:
			5/30/2018 8: 22 am
	Title XIX	Subprovi der -	Cost
		IRF	

			I RF		
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,	excluding newborn)		9, 525	1.00
2.00	Inpatient days (including private room days, excluding swing-bed			9, 525	2.00
3. 00	Private room days (excluding swing-bed and observation bed days)	. If you have only pr	ivate room days,	0	3.00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed	days)		9, 525	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	9, 329	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 o	lava) +bravab Dagambar	21 of the cost	0	7. 00
7.00	reporting period	lays) thi ough becember	31 Of the Cost	U	7.00
8.00	Total swing-bed NF type inpatient days (including private room o	lays) after December 3	1 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable to t	the Program (excluding	swing-bed and	88	9. 00
10. 00	newborn days)   Swing-bed SNF type inpatient days applicable to title XVIII only	/ (including private r	nom days)	0	10.00
10.00	through December 31 of the cost reporting period (see instruction		Join days)	G	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days) after	0	11.00
10.00	December 31 of the cost reporting period (if calendar year, enter			0	10.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX of through December 31 of the cost reporting period	only (Including privat	e room days)	0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX o	only (including privat	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year	, enter O on this lin	e)		
14.00	Medically necessary private room days applicable to the Program	(excl udi ng swi ng-bed	days)	0	14.00
15.00	Total nursery days (title V or XIX only)			2, 849	
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost	0.00	17. 00
	reporting period	3			
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services t	hrough December 31 of	the cost	0.00	19. 00
17.00	reporting period	. Til odgir becember 31 or	the cost	0.00	17.00
20.00	Medicaid rate for swing-bed NF services applicable to services a	after December 31 of t	he cost	0. 00	20.00
04.00	reporting period			7 000 4/5	04.00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December	21 of the cost report	ing ported (line	7, 399, 465 0	21. 00 22. 00
22.00	5 x line 17)	31 of the cost report	ing period (iine	U	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31	of the cost reportin	g period (line 🛭	0	23.00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December $3 \times 1$ ine 19)	31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
	x line 20)		F	_	
26. 00	Total swing-bed cost (see instructions)			0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost (li	ne 21 minus line 26)		7, 399, 465	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed a	and observation hed ch	arnes)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	ma obcervation boa on	an gooy	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ l	ine 28)		0. 000000	31.00
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	32. 00 33. 00
34.00	Average per diem private room charge differential (line 32 minus	: line 33)(see instruc	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line			0.00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)	•		0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and	l private room cost di	fferential (line	7, 399, 465	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	MENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see in			776. 85	38.00
39. 00	Program general inpatient routine service cost (line 9 x line 38	,		68, 363	39. 00
40.00	Medically necessary private room cost applicable to the Program	,		0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 +	1111e 40)		68, 363	41.00

Heal th	Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C		Period: From 01/01/2017	Worksheet D-1	
			Component		Γο 12/31/2017	Date/Time Pre 5/30/2018 8: 2	
			Ti tl	e XIX	Subprovi der -	Cost	<u> 2 aiii                                </u>
	Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
	Cost Center Description	Inpatient	Inpatient	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 0	2.00	3.00	4.00	5. 00	42.00
.2. 00	Intensive Care Type Inpatient Hospital Units					<u> </u>	12.00
43. 00 43. 01	INTENSIVE CARE UNIT NEONATAL ICU	0				0	43.00
44. 00	CORONARY CARE UNIT	U		0.00	J	Ü	43. 01 44. 00
45.00	BURN INTENSIVE CARE UNIT						45. 00
46.00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
						1. 00	
	Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines			one)		50, 397 118, 760	•
47.00	PASS THROUGH COST ADJUSTMENTS	41 thi ough 40)	(see mstructi	0113)		110, 700	47.00
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	0	50.00
51. 00		atient ancilla	rv services (f	rom Wkst D s	um of Parts II	0	51.00
	and IV)		. ,				
52. 00 53. 00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclu		olated non nh	veieian anoeth	estict and	0	52. 00 53. 00
33.00	medical education costs (line 49 minus line	9 1	erateu, non-pr	ysi ci aii ailesti	letist, and	U	33.00
<b>54.00</b>	TARGET AMOUNT AND LIMIT COMPUTATION						
54. 00 55. 00	Program di scharges Target amount per di scharge					0 0. 00	54. 00 55. 00
56. 00	Target amount (line 54 x line 55)					0.00	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	endi na 1996	undated and co	mnounded by the	0.00	58. 00 59. 00
07.00	market basket			•	pouriuou 25 tirio	0. 00	
60. 00 61. 00							60. 00 61. 00
61.00	which operating costs (line 53) are less that					0	61.00
	amount (line 56), otherwise enter zero (see	instructions)			Ü		,,,,,,
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instr	uctions)			0	62. 00 63. 00
	PROGRAM INPATIENT ROUTINE SWING BED COST	•	ļ				
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Dec	ember 31 of th	e cost reporti	ng period (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
// 00	instructions)(title XVIII only)	+- (1:	(4 -1 1:	/E) /±: ±1 = \\\/\/\	l ambal Fam	0	// 00
66. 00	Total Medicare swing-bed SNF inpatient routil CAH (see instructions)	ne costs (iine	64 prus rine	65)(title XVII	i only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	h December 31	of the cost re	porting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after l	December 31 of	the cost reno	rting period	0	68. 00
00.00	(line 13 x line 20)	c costs arter i	becember of or	the cost rope	a tring period	o o	00.00
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 14 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	routine servic	e costs (from	Worksheet B, F	art II, column		75. 00
76. 00	26, line 45)  Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line	76)					77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu: Aggregate charges to beneficiaries for excess		nrovi dor rocor	de)			78. 00 79. 00
80.00	Total Program routine service costs for compa	,		*.	us line 79)		80.00
81.00	Inpatient routine service cost per diem limi	tati on		•	ĺ		81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (						82. 00 83. 00
83.00	Program inpatient ancillary services (see in:		113)				83.00
85.00	Utilization review - physician compensation	(see instructi					85. 00
86. 00	Total Program inpatient operating costs (sum		hrough 85)				86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					0	87. 00
88.00	Adjusted general inpatient routine cost per	diem (line 27					88. 00
89. UU	Observation bed cost (line 87 x line 88) (see	e instructions	J			0	89. 00

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (		From 01/01/2017 To 12/31/2017		
		Ti tl	e XIX	Subprovi der -	Cost	
				I RF		
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	710, 606	7, 399, 465	0. 09603	5 0	0	90.00
91.00 Nursing School cost	0	7, 399, 465	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	7, 399, 465	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	7, 399, 465	0. 00000	0	0	93.00

	Financial Systems	METHODIST HOSPITAL				u of Form CMS-2	
I NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	P	rovider C		Peri od: From 01/01/2017 To 12/31/2017	Worksheet D-3 Date/Time Pre	
					10 12/31/2017	5/30/2018 8: 2	2 am
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description			Ratio of Cos		I npati ent	
				To Charges	Program	Program Costs	
					Charges	(col . 1 x	
				1.00	2.00	col. 2) 3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			1.00	2.00	3.00	
30.00	03000 ADULTS & PEDIATRICS				25, 819, 562		30.00
31. 00	03100   NTENSI VE CARE UNIT				7, 279, 675		31.00
31. 01	03101 NEONATAL I CU				0		31.01
40.00	04000 SUBPROVI DER - I PF				0		40.00
41.00	04100 SUBPROVI DER - I RF				0		41.00
43.00	04300 NURSERY						43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM			0. 08810		3, 010, 920	
50. 01	05001 ENDOSCOPY			0. 20453		364, 328	
51. 00 52. 00	05100   RECOVERY ROOM   05200   DELIVERY ROOM & LABOR ROOM			0. 26475 0. 98532		421, 350 118, 275	
53.00	05300 ANESTHESI OLOGY			0. 00000		118, 275	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C			0. 23724		1, 047, 074	
54. 01	05401 RADI OLOGY - ULTRASOUND			0. 17923		413, 758	
55. 00	05500 RADI OLOGY-THERAPEUTI C			0. 17707		91, 982	
56.00	05600 RADI 0I SOTOPE			0. 18890		432, 635	1
57.00	05700 CT SCAN			0. 03739	15, 483, 864	578, 973	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)			0. 05144		215, 202	
59.00	05900 CARDI AC CATHETERI ZATI ON			0. 07254		1, 075, 594	
60.00	06000 LABORATORY			0. 11312		2, 589, 099	
60. 01	06001 BLOOD LABORATORY			0.00000		0	
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS			0. 00000 0. 24260		0 743, 714	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.			0. 00000		743, 714	1
64. 00	06400 I NTRAVENOUS THERAPY			0. 00000		0	
65. 00	06500 RESPIRATORY THERAPY			0. 12773		1, 682, 050	
66.00	06600 PHYSI CAL THERAPY			0. 40413		657, 833	1
67.00	06700 OCCUPATI ONAL THERAPY			0. 39936		448, 664	•
68.00	06800 SPEECH PATHOLOGY			0. 36700		269, 887	68.00
69.00	06900 ELECTROCARDI OLOGY			0. 06259	5, 113, 000	320, 064	69.00
69. 01	06901 CARDI AC REHAB			0. 75639		0	69. 01
	07000 ELECTROENCEPHALOGRAPHY			0. 07643		231, 157	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0. 34488		2, 875, 616	1
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS			0. 5434 <i>6</i> 0. 15125	8, 528, 874	4, 635, 153	72.00

0. 151256

0. 328059

0. 484588

0. 273160

0.513956

41, 222, 169

3, 611, 201

8, 995, 177

2, 906, 907

206, 245, 767

206, 245, 767

207, 360

73.00

74.00

90.00

91.00

92.00

201.00

202.00

6, 235, 100

1, 184, 687

100, 484

33, 694, 744 200. 00

2, 457, 123

1, 494, 022

73. 00 07300 DRUGS CHARGED TO PATIENTS

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 through 94 and 96 through 98) Less PBP Clinic Laboratory Services-Program only charges (line 61)

74.00 07400 RENAL DIALYSIS

91. 00 09100 EMERGENCY

200.00

201.00

202.00

		CN: 15-0002	Perio		Worksheet D-3	,
	Component	CCN: 15-S002	To	01/01/2017 12/31/2017	Date/Time Pre 5/30/2018 8:2	
	Ti tl e	e XVIII	Subj	provider - IPF	PPS	
Cost Center Description		Ratio of Cos	st I	npati ent	I npati ent	
		To Charges		Program Charges	Program Costs (col. 1 x col. 2)	
		1.00		2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
0. 00   03000   ADULTS & PEDI ATRI CS				0		30.
1. 00 03100 I NTENSI VE CARE UNI T				0		31.
I. 01   03101   NEONATAL   CU				0		31.
0. 00   04000   SUBPROVI DER -   PF				1, 368, 929		40.
1. 00   04100  SUBPROVI DER - 1 RF 3. 00   04300  NURSERY				0		41.
B. 00   04300   NURSERY   ANCI LLARY SERVI CE COST CENTERS						43.
0. 00 05000 OPERATI NG ROOM		0. 0881	06	ol	0	50.
0. 01   05001   ENDOSCOPY		0. 2045		Ö	0	
1. 00 05100 RECOVERY ROOM		0. 2647		ő	0	
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 9853		o	0	
B. 00 05300 ANESTHESI OLOGY		0.0000		o	0	53.
I. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 2372	49	7, 114	1, 688	54
I. 01   05401   RADI OLOGY - ULTRASOUND		0. 1792	32	6, 998	1, 254	54.
5. 00   05500   RADI OLOGY-THERAPEUTI C		0. 1770	72	0	0	55.
5. 00   05600   RADI 0I SOTOPE		0. 1889		12, 998	2, 455	
7. 00  05700 CT SCAN		0. 0373		26, 524	992	
B. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0514		3, 212	165	
O. OO O5900 CARDI AC CATHETERI ZATI ON		0. 0725		0	0	
0. 00   06000   LABORATORY		0. 1131		140, 395	15, 882	
0. 01   06001   BLOOD LABORATORY		0.0000		0	0	
1. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000		10.000	0	
2. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 2426		13, 093	3, 176	
B. 00   06300  BL00D STORING, PROCESSING & TRANS. H. 00   06400  INTRAVENOUS THERAPY		0. 0000 0. 0000		0	0	
5. 00   06500   RESPI RATORY   THERAPY		0. 0000	1	445	57	
5. 00   06600   PHYSI CAL THERAPY		0. 1277		6, 091	2, 462	
7. 00   06700   0CCUPATI ONAL THERAPY		0. 3993		3, 316	1, 324	
B. 00   06800  SPEECH PATHOLOGY		0.3670	1	3, 310	0	1
P. 00 06900 ELECTROCARDI OLOGY		0. 0625		20, 435	1, 279	
P. 01 06901 CARDI AC REHAB		0. 7563		0	0	1
0. 00 07000 ELECTROENCEPHALOGRAPHY		0. 0764		ő	0	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3448		92	32	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 5434		o	0	72.
B. 00 07300 DRUGS CHARGED TO PATIENTS		0. 1512	56	323, 642	48, 953	73.
1. 00 07400 RENAL DIALYSIS		0. 3280		0	0	74.
OUTPATIENT SERVICE COST CENTERS						
0. 00   09000   CLI NI C		0. 4845		0	0	
. 00   09100   EMERGENCY		0. 2731		60, 922	16, 641	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5139	56	1, 335		92
00.00 Total (sum of lines 50 through 94 and 96 through 98) 11.00 Less PBP Clinic Laboratory Services-Program only charg				626, 612	97, 046	
01.00 Less PBP Clinic Laboratory Services-Program only charc				O		201

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0002	Peri od:	Worksheet D-3	3
	Component	CCN: 15-T002	From 01/01/2017 To 12/31/2017		
	Title	: XVIII	Subprovi der -	5/30/2018 8: 2 PPS	<u>.2 a</u>
Cost Center Description		Ratio of Cos	IRF st Inpatient	Inpati ent	
oust deliter bescription		To Charges		Program Costs	
			Charges	(col . 1 x	
				col . 2)	
LANDATI ENT. DOUTI NE. OEDIN OF OCCT. OFFITEDO		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS  OO 03000 ADULTS & PEDIATRICS		I	44		30
00 03100 INTENSIVE CARE UNIT			0		31
01 03101 NEONATAL I CU			0		31
00 04000 SUBPROVI DER - I PF			0		40
00 04100 SUBPROVI DER - I RF			4, 808, 076		41
00   04300   NURSERY					43
ANCILLARY SERVICE COST CENTERS					
00   05000   OPERATING ROOM		0. 0881		18, 103	
01   05001   ENDOSCOPY		0. 2045	·	4, 936	
00   05100   RECOVERY ROOM 00   05200   DELI VERY ROOM & LABOR ROOM		0. 2647 0. 9853		2, 464 1, 377	
00   05300   ANESTHESI OLOGY		0. 9833		1, 3//	
00 05400 RADI OLOGY-DI AGNOSTI C		0. 2372		33, 375	
01   05401 RADI OLOGY - ULTRASOUND		0. 1792		7, 117	
00 05500 RADI OLOGY-THERAPEUTI C		0. 1770		5, 649	
00   05600   RADI 0I SOTOPE		0. 1889		2, 083	
00   05700   CT   SCAN		0. 0373		10, 391	
00   05800   MAGNETIC RESONANCE I MAGING (MRI)		0.0514		4, 823	
00   05900   CARDI AC   CATHETERI ZATI ON 00   06000   LABORATORY		0. 0725 0. 1131		9, 830 98, 797	
01   06001   BLOOD LABORATORY		0. 0000	·	90, 797	
00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000		0	
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 2426		13, 752	
00 06300 BLOOD STORING, PROCESSING & TRANS.		0.0000		0	
00 06400 I NTRAVENOUS THERAPY		0.0000		0	
00 06500 RESPI RATORY THERAPY		0. 1277		51, 274	
00   06600   PHYSI CAL THERAPY		0. 4041		927, 314	
00   06700   OCCUPATI ONAL THERAPY 00   06800   SPEECH PATHOLOGY		0. 3993 0. 3670		849, 011 75, 050	
00   06900   ELECTROCARDI OLOGY		0. 3670	·	75, 050 1, 642	
01   06901 CARDI AC REHAB		0. 7563		1, 042	1
00 07000 ELECTROENCEPHALOGRAPHY		0. 0764		1, 542	
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3448		66, 929	
00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 5434		4, 660	
00 07300 DRUGS CHARGED TO PATIENTS		0. 1512		585, 073	
00 07400 RENAL DIALYSIS		0. 3280	59 437, 855	143, 642	74
OUTPATIENT SERVICE COST CENTERS  OO   O9000   CLINIC		0. 4845	88 22, 108	10, 713	٥٢
00   09100   EMERGENCY		0. 4845		10, 713	
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5139		0	
0.00 Total (sum of lines 50 through 94 and 96 through 9	98)		11, 504, 274	2, 929, 557	
1.00 Less PBP Clinic Laboratory Services-Program only of			0		201
2.00 Net charges (line 200 minus line 201)			11, 504, 274		202

Health Financial Systems	METHODIST HOSPITA	ALS, INC		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider C		Peri od:	Worksheet D-3	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 8:2	pared: 2 am
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description			Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col . 2)	
			1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS				1, 891, 793		30.00
31.00 03100 INTENSIVE CARE UNIT				392, 077		31.00
31. 01   03101   NEONATAL   CU				500, 784		31. 01

	Title	XIX	Hospi tal	Cost	
Cost Center Description	F	Ratio of Cost	I npati ent	I npati ent	
·		To Charges	Program	Program Costs	
		3	Charges	(col . 1 x	
			onal goo	col . 2)	
	-	1.00	2. 00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00   03000   ADULTS & PEDI ATRI CS			1, 891, 793		30.00
31. 00   03100   NTENSI VE CARE UNIT			392, 077		31.00
31. 01   03101   NEONATAL   CU			500, 784		31. 01
40. 00   04000   SUBPROVI DER - I PF			0		40.00
41. 00   04100   SUBPROVI DER - I RF			0		41.00
43. 00   04300   NURSERY			185, 315		43.00
ANCILLARY SERVICE COST CENTERS					
50. 00   05000   OPERATING ROOM		0. 088106	3, 228, 210	284, 425	50.00
50. 01   05001   ENDOSCOPY		0. 204533	83, 238	17, 025	50. 01
51. 00   05100   RECOVERY ROOM		0. 264755	163, 559	43, 303	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM		0. 985324	340, 975	335, 971	52.00
53. 00   05300   ANESTHESI OLOGY		0. 000000	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 237249	212, 609	50, 441	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND		0. 179232	131, 216	23, 518	54.01
55. 00   05500 RADI OLOGY-THERAPEUTI C		0. 176397	35, 187	6, 207	55.00
56. 00   05600 RADI 0I SOTOPE		0. 188900	103, 907	19, 628	56.00
57. 00   05700   CT   SCAN		0. 037392	909, 413	34, 005	57. 00
58. 00   05800   MAGNETI C RESONANCE I MAGING (MRI)		0. 051448	208, 793	10, 742	58.00
59. 00   05900 CARDI AC CATHETERI ZATI ON		0. 072545	986, 414	71, 559	59.00
60. 00   06000 LABORATORY		0. 072343	1, 668, 979	188, 805	60.00
			1,000,979		
60. 01   06001   BLOOD LABORATORY		0.000000	0	0	60.01
61.00   06100   PBP CLINICAL LAB SERVICES-PRGM ONLY		0. 000000	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 242607	31, 289	7, 591	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 000000	0	0	63.00
64. 00   06400   I NTRAVENOUS THERAPY		0. 000000	0	0	64.00
65. 00  06500  RESPI RATORY THERAPY		0. 127735	965, 648	123, 347	65.00
66. 00  06600  PHYSI CAL THERAPY		0. 404138	100, 369	40, 563	66.00
67. 00  06700  OCCUPATI ONAL THERAPY		0. 399363	75, 878	30, 303	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 367009	30, 991	11, 374	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 062598	228, 643	14, 313	69.00
69. 01   06901   CARDI AC REHAB		0. 756398	3, 519	2, 662	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 076430	200, 148	15, 297	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 344888	0	0	71.00
72. 00 O7200 I MPL. DEV. CHARGED TO PATIENTS		0. 543466	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 151256	2, 685, 751	406, 236	73.00
74. 00 07400 RENAL DI ALYSI S			152, 590	50, 059	74.00
OUTPATIENT SERVICE COST CENTERS		0. 328059	152, 590	30, 039	74.00
90. 00 09000 CLINIC		0. 483227	12, 472	6, 027	90. 00
91. 00   09100   EMERGENCY					
		0. 272922	553, 352	151, 022	91.00
		0. 513956	10 110 150	0	92.00
Total (sum of lines 50 through 94 and 96 through 98)	(1)		13, 113, 150	1, 944, 423	
201. 00 Less PBP Clinic Laboratory Services-Program only charge:	s (line 61)		0		201.00
202.00   Net charges (line 200 minus line 201)			13, 113, 150		202. 00

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0002	Peri od:	Worksheet D-3	3
	Component	CCN: 15-S002	From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 8:2	
	Ti tl	e XIX	Subprovi der -	Cost	2 411
Cost Center Description	- 1	Ratio of Cos To Charges	st Inpatient	Inpatient Program Costs	
			Charges	(col. 1 x col. 2)	
UNDATUENT POUTLNE CERVICE COCT CENTERS		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS  00   03000   ADULTS & PEDIATRICS		I	0		30.
00 03100 INTENSIVE CARE UNIT			0		31.
01 03101 NEONATAL I CU			0		31.
00   04000   SUBPROVI DER - 1 PF			88, 557		40.
00   04100   SUBPROVI DER - I RF			00, 337		41.
00   04300   NURSERY			0		43.
ANCILLARY SERVICE COST CENTERS					1
00 05000 OPERATING ROOM		0. 0881	06 0	0	50.
01   05001   ENDOSCOPY		0. 2045	33 0	0	50.
00 05100 RECOVERY ROOM		0. 2647	55 0	0	51.
00 05200 DELIVERY ROOM & LABOR ROOM		0. 9853	24 0	0	52
00 05300 ANESTHESI OLOGY		0.0000	00	0	53
00 05400 RADI OLOGY-DI AGNOSTI C		0. 2372	49 1, 056	251	54
01 05401 RADI OLOGY - ULTRASOUND		0. 1792	1, 016	182	54
00 05500 RADI OLOGY-THERAPEUTI C		0. 1763	97 0	0	55
00   05600   RADI 0I SOTOPE		0. 1889	00	0	56
00  05700 CT SCAN		0. 0373	92 2, 312	86	57
00   05800   MAGNETIC RESONANCE I MAGING (MRI)		0. 0514	48 353	18	58
00   05900   CARDI AC CATHETERI ZATI ON		0. 0725	45 0	0	59
00   06000   LABORATORY		0. 1131		1, 353	
01   06001   BL00D LABORATORY		0. 0000	00	0	60
00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0. 0000	00	0	61
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 2426		0	1
00 06300 BLOOD STORING, PROCESSING & TRANS.		0.0000		0	
00 06400 INTRAVENOUS THERAPY		0.0000		0	
00 06500 RESPI RATORY THERAPY		0. 1277		215	
00 06600 PHYSI CAL THERAPY		0. 4041		96	
00 06700 OCCUPATI ONAL THERAPY		0. 3993		56	
00 06800 SPEECH PATHOLOGY		0. 3670		15	
00 06900 ELECTROCARDI OLOGY		0. 0625		67	
01   06901   CARDI AC REHAB		0. 7563		0	
00 07000 ELECTROENCEPHALOGRAPHY		0. 0764		0	1
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3448		14	
00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 5434		0	
00 07300 DRUGS CHARGED TO PATIENTS		0. 1512		4, 050	
00 07400 RENAL DI ALYSI S		0. 3280	59 0	0	74
OUTPATIENT SERVICE COST CENTERS OO 09000 CLINIC		0.4022	27		90
		0. 4832		0	
		0. 2729			
.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	10)	0. 5139		0 7 510	
7.00 Total (sum of lines 50 through 94 and 96 through 94 and 96 through 94 and 96 through 95 through 96 through 96 through 96 through 96 through 96 through 97 through 98 throug			50, 773	7, 519	
1.00 Less PBP Clinic Laboratory Services-Program only o	nardes (line 61)	I .	0	1	201

AITH FINANCIAL SYSTEMS METHODIST HOS  IPATIENT ANCILLARY SERVICE COST APPORTIONMENT	PITALS, INC Provider Co	CN: 15-0002	Peri od:	u of Form CMS-2 Worksheet D-3	
	Component	CCN: 15-T002	From 01/01/2017 To 12/31/2017		pared
	Ti tl	e XIX	Subprovi der -	5/30/2018 8: 2 Cost	22 am
Coot Contar Decement on		Datio of Coo	I RF	I nnati ont	
Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x	
		1.00	2.00	col. 2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			2.00	0.00	
0. 00   03000   ADULTS & PEDI ATRI CS			0		30.0
I.00   03100   INTENSIVE CARE UNIT			0		31.0
I. 01  03101 NEONATAL ICU			0		31.0
0. 00   04000   SUBPROVI DER - 1 PF			0		40.0
I. 00   04100   SUBPROVI DER - I RF			80, 551		41.0
3. 00 04300 NURSERY			0		43.0
ANCILLARY SERVICE COST CENTERS					
0.00   05000   OPERATING ROOM		0. 08810	· ·	123	
0. 01   05001   ENDOSCOPY		0. 20453		107	
I. 00   05100   RECOVERY ROOM		0. 26475		121	
2. 00   05200   DELI VERY ROOM & LABOR ROOM		0. 98532		984	
3. 00   05300   ANESTHESI OLOGY		0.00000		0	
4. 00   05400   RADI OLOGY - DI AGNOSTI C		0. 23724		454	
4. 01   05401   RADI OLOGY - ULTRASOUND		0. 17923		86	
5. 00   05500   RADI OLOGY-THERAPEUTI C		0. 17639		0	
5. 00   05600   RADI 0 I SOTOPE 7. 00   05700   CT   SCAN		0. 18890		48	
		0. 03739	· ·	65 95	
		0. 05144		95	1
P. 00   05900   CARDI AC   CATHETERI ZATI ON D. 00   06000   LABORATORY		0. 07254 0. 11312		1, 402	1
D. 01   06000   LABORATORY		0. 00000		1, 402	1
1.00   06100   BBOOD LABORATORY		0.00000		0	1
2. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 24260		37	1
3. 00   06300   BLOOD STORING, PROCESSING & TRANS.		0. 00000		0	1
1. 00   06400   I NTRAVENOUS THERAPY		0. 00000		0	1
5. 00 06500 RESPIRATORY THERAPY		0. 12773		1, 031	
5. 00 06600 PHYSI CAL THERAPY		0. 40413		16, 277	1
7. 00 06700 OCCUPATI ONAL THERAPY		0. 39936		14, 201	1
3. 00 06800 SPEECH PATHOLOGY		0. 36700	· ·	1, 948	1
P. 00 06900 ELECTROCARDI OLOGY		0. 06259	· ·	49	
P. 01   06901   CARDI AC REHAB		0. 75639		0	1
0. 00 07000 ELECTROENCEPHALOGRAPHY		0. 07643		26	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 34488		642	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 54346		93	1
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 15125		10, 841	73.0
1. 00 07400 RENAL DIALYSIS		0. 32805	5, 386	1, 767	74.0
OUTPATIENT SERVICE COST CENTERS					
0. 00 09000 CLI NI C		0. 48322	27 0	0	90.0
I. 00   09100   EMERGENCY		0. 27292	22 0	0	91.0
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 51395		0	92.0
Total (sum of lines 50 through 94 and 96 through 98)			191, 578	50, 397	200.0
D1.00 Less PBP Clinic Laboratory Services-Program only char	ges (line 61)		0		201.0
02.00 Net charges (line 200 minus line 201)			191, 578		202. (

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0002	Peri od: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/30/2018 8:22 am

				5/30/2018 8: 2	2 am
	<u> </u>	Title XVIII	Hospi tal	PPS	
				1 00	
	DADT A LADATIENT HOCDITAL CEDVICEC HADED LDDC			1. 00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			0	1 00
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurr instructions)	35, 049, 700	1. 00 1. 01		
1. 02	DRG amounts other than outlier payments for discharges occurrinstructions)	ing on or after October	1 (see	11, 235, 752	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI f 1 (see instructions)	or discharges occurring	prior to October	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCl f 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			1, 725, 159 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			18, 375, 817	3.00
4. 00	Bed days available divided by number of days in the cost repo Indirect Medical Education Adjustment	rting period (see instru	ctions)	394. 37	4. 00
5. 00	FTE count for allopathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)	t recent cost reporting	period ending on	8. 53	5. 00
6. 00	FTE count for allopathic and osteopathic programs 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 $\S$ 5503 reduction amount to the IME cap as specified under			0. 00 0. 00	7. 00 7. 01
8. 00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413.			0. 00	8. 00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost				8. 01
8. 02	report straddles July 1, 2011, see instructions.  The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital				8. 02
9. 00	under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see				9. 00
10. 00 11. 00	instructions) FTE count for allopathic and osteopathic programs in the curr FTE count for residents in dental and podiatric programs.	ent year from your recor	ds	2. 93	10. 00 11. 00
12. 00	Current year allowable FTE (see instructions)			2. 93	
	Total allowable FTE count for the prior year.			2. 93	
14. 00	Total allowable FTE count for the penultimate year if that ye otherwise enter zero.	ar ended on or after Sep	tember 30, 1997,	3. 00	•
15. 00	Sum of lines 12 through 14 divided by 3.			2. 95	15.00
16.00	Adjustment for residents in initial years of the program			0.00	16.00
17.00	Adjustment for residents displaced by program or hospital clo	sure		0.00	17.00
18. 00	Adjusted rolling average FTE count			2. 95	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4	).		0.007480	19.00
20.00	Prior year resident to bed ratio (see instructions)			0. 007610	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.007480	21.00
22. 00	IME payment adjustment (see instructions)			188, 891	22.00
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 42			74, 992	22. 01
23. 00	Number of additional allopathic and osteopathic IME FTE resid $(f)(1)(iv)(C)$ .	ent cap slots under 42 0	FR 412. 105	0. 00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)				24.00
25. 00	If the amount on line 24 is greater than -0-, then enter the instructions)	lower of line 23 or line	24 (see		25. 00
	Resident to bed ratio (divide line 25 by line 4)			0.000000	1
27. 00	IME payments adjustment factor. (see instructions)			0.000000	27. 00
28. 00	IME add-on adjustment amount (see instructions)			0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions	)		0	28. 01
29. 00	Total IME payment ( sum of lines 22 and 28)			188, 891	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.0 Disproportionate Share Adjustment	1)		74, 992	29. 01
30.00	Percentage of SSI recipient patient days to Medicare Part A p	atient days (see instruc	tions)	10. 92	30.00
31.00	Percentage of Medicaid patient days (see instructions)			31. 51	31.00
	Sum of lines 30 and 31			42. 43	1
	Allowable disproportionate share percentage (see instructions	)		24. 22	1
	Disproportionate share adjustment (see instructions)			2, 802, 584	1
			'		•

Heal th	Financial Systems METHODIST HOSPI	ITALS, INC	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0002	Peri od: From 01/01/2017		
			To 12/31/2017	Date/Time Pre 5/30/2018 8: 2	
		Title XVIII	Hospi tal	PPS	
			Pri or to 10/1 1.00	0n/After 10/1 2.00	
	Uncompensated Care Adjustment				
35. 00 35. 01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		5, 977, 483, 147 0. 000846433	6, 766, 695, 163 0. 000831454	
35. 02		ter zero on this line) (s		l e	
35. 03 36. 00	Pro rata share of the hospital uncompensated care payment am Total uncompensated care (sum of columns 1 and 2 on line 35.		3, 784, 256 5, 202, 367		35. 03 36. 00
40.00	Additional payment for high percentage of ESRD beneficiary d				10.00
40. 00	Total Medicare discharges on Worksheet S-3, Part I excluding 652, 682, 683, 684 and 685 (see instructions)	g discharges for MS-DRGS	6, 856		40.00
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, instructions)		672		41.00
41. 01	an 685. (see instructions)				41.01
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not qual Total Medicare ESRD inpatient days excluding MS-DRGs 652, 6 instructions)		9. 80 e 4, 755	l e	42. 00 43. 00
44. 00	Ratio of average length of stay to one week (line 43 divided days)	by line 41 divided by 7	1. 010842		44.00
45.00	Average weekly cost for dialysis treatments (see instruction		447. 81		45.00
46. 00 47. 00	Total additional payment (line 45 times line 44 times line 4 Subtotal (see instructions)	11. 01)	56, 204, 453		46. 00 47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH, only. (see instructions)	small rural hospitals	0		48. 00
			<u> </u>	Amount	
49. 00	Total payment for inpatient operating costs (see instruction	15)		1. 00 56, 279, 445	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I a		)	4, 108, 515	1
51.00				04 405	51.00
52. 00 53. 00	Direct graduate medical education payment (from Wkst. E-4, I Nursing and Allied Health Managed Care payment	The 49 see Instructions)		84, 695 18, 229	
54.00	Special add-on payments for new technologies			14, 194	
54.01	Islet isolation add-on payment			0	54. 01
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see int		through 2E)	0	56.00
57. 00 58. 00	Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt.		through 35).	0 107, 420	57. 00 58. 00
59. 00	Total (sum of amounts on lines 49 through 58)	17, 661. 11 11116 200)		60, 612, 498	
60.00	Primary payer payments			4, 613	1
61.00	Total amount payable for program beneficiaries (line 59 minu	ıs line 60)		60, 607, 885	61.00
62.00	Deductibles billed to program beneficiaries			4, 444, 888	
63. 00	Coinsurance billed to program beneficiaries			620, 165	
	Allowable bad debts (see instructions)			1, 594, 781	
65. 00 66. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins	structions)		1, 036, 608 574, 875	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	structrons)		56, 579, 440	
07.00	Credits received from manufacturers for replaced devices for	annlicable to MS-DRGs (	see instructions)		
68 00	Outlier payments reconciliation (sum of lines 93, 95 and 96)			Ö	
68. 00 69. 00		(	,	0	70.00
68. 00 69. 00 70. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	stration) adjustment (see	instructions)	Ō	70. 50
69.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   Rural Community Hospital Demonstration Project (§410A Demons	stration, aujustillent (see		1 0	70.87
69. 00 70. 00 70. 50 70. 87	Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration	, ,		0	
69. 00 70. 00 70. 50 70. 87 70. 88	Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)			0	70. 88
69. 00 70. 00 70. 50 70. 87 70. 88 70. 89	Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see ins			0	70. 88 70. 89
69. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 90	Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70. 88 70. 89 70. 90
69. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 90 70. 91	Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions)			0	70. 88 70. 89 70. 90 70. 91
69. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 90 70. 91 70. 92	Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0 0 0 0	70. 88 70. 89 70. 90 70. 91 70. 92
69. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 90 70. 91	Rural Community Hospital Demonstration Project (§410A Demons Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions)			0	70. 88 70. 89 70. 90 70. 91 70. 92 70. 93

	Financial Systems METHODIST HOSPI				u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der C		Peri od: From 01/01/2017 To 12/31/2017		
		Title	xVIII	Hospi tal	PPS	
		-	FFY	(уууу)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		0	0	70. 96
	the corresponding federal year for the period prior to 10/1)					70.0-
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter i			0	0	70. 97
70. 98	the corresponding federal year for the period ending on or af Low Volume Payment-3	ter 10/1)			0	70. 98
70. 96 70. 99	HAC adjustment amount (see instructions)				0	
	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			55, 755, 411	
71. 01	Sequestration adjustment (see instructions)	07 & 70)			1, 115, 108	
	Demonstration payment adjustment amount after sequestration				1, 110, 100	1
72.00	Interim payments				53, 490, 392	
73. 00	Tentative settlement (for contractor use only)				0	73.00
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.073)	02, 72, and			1, 149, 911	74.00
75. 00	Protested amounts (nonallowable cost report items) in accorda CMS Pub. 15-2, chapter 1, §115.2	ance with			967, 832	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					ł
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see ins	structions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2	) (1 do (1 di 3)			ő	•
	Operating outlier reconciliation adjustment amount (see instr	ructions)			Ö	
	Capital outlier reconciliation adjustment amount (see instruc				0	93.00
	The rate used to calculate the time value of money (see instr				0.00	94.00
95. 00	Time value of money for operating expenses (see instructions)	)			0	95.00
96. 00	Time value of money for capital related expenses (see instruc	ctions)			0	96.00
					On/After 10/1	
				1. 00	2. 00	
	HSP Bonus Payment Amount			1		
100.00	HSP bonus amount (see instructions)			0	0	100.00
101 00	HVBP Adjustment for HSP Bonus Payment			0.000000000	0.000000000	101 00
	HVBP adjustment factor (see instructions)	20)		0. 0000000000		101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment	15)		0	U	1102.00
102 00	HRR adjustment factor (see instructions)			0.0000	0.0000	102 00
	HRR adjustment amount for HSP bonus payment (see instructions)	=)		0.0000		104.00
104.00	Rural Community Hospital Demonstration Project (§410A Demonst		ustment	0	0	1104.00
200 00	Is this the first year of the current 5-year demonstration pe					200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.	or roa ando.	2.00			
	Cost Reimbursement					
	Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir	ne 49)				201.00
	Medicare discharges (see instructions)					202.00
203.00	Case-mix adjustment factor (see instructions)					203.00
	Computation of Demonstration Target Amount Limitation (N/A in period)	n first year	of the curre	nt 5-year demons	strati on	
204.00	Medicare target amount					204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)					205.00
206. 00	Medicare inpatient routine cost cap (line 202 times line 205)	)				206. 00
	Adjustment to Medicare Part A Innationt Deimburgement					1

207. 00

Adjustment to Medicare Part A Inpatient Reimbursement
207.00 Program reimbursement under the §410A Demonstration (see instructions)

| Peri od: | Worksheet E | From 01/01/2017 | Part A Exhibit 4 | To 12/31/2017 | Date/Time Prepared: | From 01/01/2017 | Part A Exhibit 4 | Part A Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0002

					To	12/31/2017	Date/Time Pre 5/30/2018 8: 2	
					XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1. 00	2. 00	3.00	4. 00	5. 00	
1.00	DRG amounts other than outlier	1. 00	0	0	0	0	0	1.00
1. 01	payments DRG amounts other than outlier payments for discharges	1. 01	35, 049, 700	0	35, 049, 700		35, 049, 700	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	11, 235, 752	0		11, 235, 752	11, 235, 752	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1. 03	0	0	0		0	1. 03
1. 04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1. 04
2.00	Outlier payments for	2. 00	1, 725, 159	0	1, 308, 014	417, 145	1, 725, 159	2. 00
2. 01	discharges (see instructions) Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2. 01
3.00	Operating outlier	2. 01	0	0	0	0	0	3. 00
4. 00	reconciliation Managed care simulated payments	3. 00	18, 375, 817	0	14, 352, 230	4, 023, 587	18, 375, 817	4. 00
5. 00	Amount from Worksheet E, Part	ustment 21.00	0. 007480	0. 007480	0. 007480	0. 007480		5.00
6. 00	A, line 21 (see instructions)  IME payment adjustment (see	21.00	188, 891	0.007480	143, 038	45, 853	188, 891	6.00
6. 01	instructions) IME payment adjustment for	22. 01	74, 992	0	74, 992	0	74, 992	6. 01
	managed care (see instructions) Indirect Medical Education Adj	ustment for the	e Add-on for Se	ection 422 of 1	the MMA			
7. 00	IME payment adjustment factor	27. 00	0. 000000		0. 000000	0. 000000		7. 00
8. 00	(see instructions) IME adjustment (see instructions)	28. 00	0	0	0	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see	28. 01	0	0	0	0	0	8. 01
9. 00	instructions) Total IME payment (sum of lines 6 and 8)	29. 00	188, 891	0	143, 038	45, 853	188, 891	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	74, 992	0	74, 992	0	74, 992	9. 01
	Disproportionate Share Adjustm	ent						
10. 00	Allowable disproportionate share percentage (see	33. 00	0. 2422	0. 2422	0. 2422	0. 2422		10. 00
11. 00	<pre>instructions) Disproportionate share adjustment (see instructions)</pre>	34. 00	2, 802, 584	0	2, 122, 259	680, 325	2, 802, 584	11. 00
11. 01	Uncompensated care payments	36.00	5, 202, 367	0	3, 784, 256	1, 418, 111	5, 202, 367	11. 01
12. 00	Additional payment for high pe Total ESRD additional payment (see instructions)	rcentage of ESI 46.00	RD beneficiary 0	di scharges 0	0	0	0	12.00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47. 00 48. 00	56, 204, 453 0	0	42, 407, 267 0	13, 797, 186 0	56, 204, 453 0	13. 00 14. 00
15. 00	(see instructions) Total payment for inpatient operating costs (see	49. 00	56, 279, 445	0	42, 482, 259	13, 797, 186	56, 279, 445	15. 00
16. 00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I,	50. 00	4, 108, 515	0	3, 105, 838	1, 002, 677	4, 108, 515	16. 00
17. 00	if applicable) Special add-on payments for new technologies	54. 00	14, 194	0	14, 194	0	14, 194	17. 00
17. 01 17. 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	0	0	0	17. 01 17. 02

Heal th	Financial Systems		METHODIST HOS				u of Form CMS-2	2552-10
LOW VO	DLUME CALCULATION EXHIBIT 4			Provider Co		Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Exhibi Date/Time Pre 5/30/2018 8:2	pared:
				Title	XVIII	Hospi tal	PPS	_
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After 10/01	Total (Col 2 through 4)	
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0		0 0	0	18. 00
19.00	SUBTOTAL			0	45, 602, 29	14, 799, 863	60, 402, 154	19.00
		W/S L, line	(Amounts from L)					
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
20. 00	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier		3, 752, 656 0	0	_, _,	915, 259 0 0	3, 752, 656 0	20. 00 20. 01
21. 00 21. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments	2. 00 2. 01	5, 736 0	0 0	3, 71	2,024	5, 736 0	21. 00 21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0036	0. 0036	0. 003	0. 0036		22. 00
	Indirect medical education adjustment (see instructions)	6. 00	13, 510	0	,		13, 510	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0897	0. 0897	0. 089	0. 0897		24.00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	336, 613	0	254, 51	4 82, 099	336, 613	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	4, 108, 515	0	3, 105, 83	1, 002, 677	4, 108, 515	26. 00
		W/S E, Part A	(Amounts to					
		line	E, Part A)					
	T	0	1. 00	2. 00	3.00	4. 00	5. 00	
27. 00 28. 00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E,	70. 96			0.00000	0.000000	0	27. 00 28. 00
29. 00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	0	29. 00

100.00

Pt. A, line)
100.00 Transfer low volume adjustments to Wkst. E, Pt. A.

From 01/01/2017 Part A Exhibit 5 Date/Time Prepared: 12/31/2017 5/30/2018 8:22 am Hospi tal Title XVIII Period to Total (cols. Wkst. E, Pt. Amt. from Period on Wkst. E, Pt. 10/01 after 10/01 A. line 2 and 3) A) 0 1.00 2.00 3.00 4.00 1.00 DRG amounts other than outlier payments 1. 00 1.00 DRG amounts other than outlier payments for 1.01 1.01 35, 049, 700 35, 049, 700 35, 049, 700 1.01 discharges occurring prior to October 1 1 02 DRG amounts other than outlier payments for 1 02 11, 235, 752 11, 235, 752 11, 235, 752 1.02 discharges occurring on or after October 1 DRG for Federal specific operating payment 1.03 1.03 0 1.03 for Model 4 BPCI occurring prior to October 1 04 DRG for Federal specific operating payment 1 04 0 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 1, 725, 159 1, 308, 014 417, 145 1, 725, 159 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 0 0 0 2.01 **BPCI** 3.00 2.01 3.00 Operating outlier reconciliation Managed care simulated payments 18, 375, 817 14, 352, 230 4, 023, 587 18, 375, 817 4.00 4.00 3.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21. 00 0.007480 0.007480 0.007480 5.00 (see instructions) 6.00 IME payment adjustment (see instructions) 22. 00 188, 891 143, 038 45, 853 188, 891 6.00 16, 420 74, 992 IME payment adjustment for managed care (see 74, 992 6.01 22.01 58, 572 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 27.00 0.000000 0.000000 0.000000 7.00 instructions) 28 00 8 00 8 00 IME adjustment (see instructions) 0 0 8.01 IME payment adjustment add on for managed 28. 01 0 0 0 8.01 care (see instructions) 9 00 Total IME payment (sum of lines 6 and 8) 29. 00 188, 891 143, 038 45, 853 188, 891 9.00 Total IME payment for managed care (sum of 16, 420 74, 992 9.01 29.01 74, 992 58, 572 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0. 2422 0.2422 0.2422 10.00 (see instructions) Di sproporti onate share adjustment (see 2, 802, 584 11.00 34.00 2.802.584 2, 122, 259 680. 325 11.00 instructions) 11.01 Uncompensated care payments 36.00 5, 202, 367 3, 784, 256 1, 418, 111 5, 202, 367 11.01 Additional payment for high percentage of ESRD beneficiary discharges Total ESRD additional payment (see 12.00 12.00 46.00 instructions) 13.00 Subtotal (see instructions) 47.00 56, 204, 453 42, 407, 267 13, 797, 186 56, 204, 453 13.00 Hospital specific payments (completed by SCH 48.00 14.00 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 56, 279, 445 56, 279, 445 15.00 49.00 42, 465, 839 13, 813, 606 15.00 (see instructions) 16,00 Payment for inpatient program capital (from 50.00 4, 108, 515 3, 105, 838 1.002.677 4, 108, 515 16.00 Wkst. L, Pt. I, if applicable) Special add-on payments for new technologies 17.00 17.00 54 00 14 194 14 194 0 14 194 17.01 Net organ acquisition cost 17.01 17.02 Credits received from manufacturers for 68. 00 0 0 17.02 replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment 93.00 18.00 0 amount (see instructions) 19. 00 | SUBTOTAL 45, 585, 871 14, 816, 283 60, 402, 154 19.00

Health Financial Systems	METHODIST HOS	SPITALS INC		In lie	u of Form CMS-:	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCUL		Provider CO	!	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Exhibi Date/Time Pre 5/30/2018 8:2	t 5 pared:
			XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1.00	2.00	3. 00	4.00	
20.00 Capital DRG other than outlier	1. 00	3, 752, 656	2, 837, 39	7 915, 259	3, 752, 656	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	5, 736	3, 71:	2, 024	5, 736	21.00
21.01 Model 4 BPCI Capital DRG outlier payments	2. 01	0		o o	0	21. 01
22.00 Indirect medical education percentage (see instructions)	5. 00	0. 0036	0. 003	0. 0036		22. 00
23.00 Indirect medical education adjustment (see instructions)	6. 00	13, 510	10, 21!	3, 295	13, 510	23. 00
24.00 Allowable disproportionate share percentage (see instructions)	10. 00	0. 0897	0. 089 <sup>-</sup>	0. 0897		24.00
25.00 Disproportionate share adjustment (see	11. 00	336, 613	254, 51	82, 099	336, 613	25. 00
26.00 Total prospective capital payments (see instructions)	12. 00	4, 108, 515	3, 105, 83	1, 002, 677	4, 108, 515	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 after October 1	70. 97	0		o	0	29.00
30.00 HVBP payment adjustment (see instructions)	70. 93	255, 837	253, 64 <sup>-</sup>	7 2, 190	255, 837	30.00
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	(		0	30. 01
31.00 HRR adjustment (see instructions)	70. 94	-1, 079, 866	-845, 038	-234, 828	-1, 079, 866	31.00
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0	(	0	0	31.01
,					(Δmt to	

0 70. 99 1.00

2.00

0

3.00

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

32.00

100.00

0

32.00 HAC Reduction Program adjustment (see

instructions)

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

Health Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0002	From 01/01/2017	Worksheet E Part B Date/Time Prepared: 5/30/2018 8:22 am

Next II			10 12/31	5/30/2018 8: 2	
Note 5			Title XVIII Hospita		2 4111
New Teach and other services (see Instructions)   15,606   1.00   Medical and other services (see Instructions)   20,863,701   2.00   Medical and other services (reinforraed under OPS (see Instructions)   20,863,701   2.00			THE ATTENDED TO		
New Teach and other services (see Instructions)   15,606   1.00   Medical and other services (see Instructions)   20,863,701   2.00   Medical and other services (reinforraed under OPS (see Instructions)   20,863,701   2.00				1. 00	
Medical and other services (see Instructions)		PART B - MEDICAL AND OTHER HEALTH SERVICES			
Medical and other services rie fiburised under OPPS (see Instructions)   19,078,028   3,00   OPPS promitists   19,078,028   3,00   OPPS promitists   19,078,028   3,00   OPPS promitists   19,078,028   3,00   OPPS promitists   19,078,028   3,00   OPPS	1.00			15, 606	1.00
1.00   OPEN payment   See instructions    19,7781,0781   3.00   OUT   19	2.00	1	tions)		
0.00   1.00   0.00		,	,		
0.00		, ,			
Enter the hospital specific payment to cost ratio (see instructions)   0.000   5.00					
Line 2 times line 5		,	ctions)		
	6.00		,	ı	
1.00   Content				0.00	
Ancillary service other pass through costs from Wist. 0, Pt. IV, col. 13, line 200   96, 286   9.00				•	
0. 00   0   0   0   0   0   0   0   0		,	IV col 13 line 200		1
11.00   Total cost (sum of lines 1 and 10) (see instructions)   15.00   11.00			,		
COMPUTATION OF LESSER OF COST OR CHARGES   Reasonable charges (from Wast. D-4, Pt. 111, col. 4, line 69)   Reasonable charges (sum of lines 12 and 13)   Reasonable charges (sum of lines 14)   Reasonable charges (sum of lines 14)   Reasonable (sum of lines 15 to line 16 (not to exceed 1,000000)   Reasonable cost lines (sum of lines 15 to line 16 (not to exceed 1,000000)   Reasonable cost lines (sum of lines 14)   Reasonable cost (complete only if line 18 exceeds line 11) (see   Reasonable cost over customary charges (complete only if line 18 exceeds line 11) (see   Reasonable cost over customary charges (complete only if line 18 exceeds line 11) (see   Reasonable cost over customary charges (complete only if line 18 exceeds line 18) (see   Reasonable cost over customary charges (complete only if line 18 exceeds line 18) (see   Reasonable cost over customary charges (complete only if line 18 exceeds line 18) (see   Reasonable cost over customary charges (complete only if line 18 exceeds line 18) (see   Reasonable cost over customary charges over reasonable cost (complete only if line 18 exceeds line 18) (see   Reasonable cost over customary charges over reasonable cost (complete only if line 18 exceeds line 18) (see   Reasonable cost over customary charges over reasonable cost (complete only if lines 18 exceeds line 18) (see   Reasonable cost over customary charges over reas		9		-	1
Reasonable charges   82,028   12.00   20.00	11.00			10,000	11.00
2.00   Anciliary service charges   92.028   12.00   13.00   101					1
13.00   organ acquisition charges (from Wist. D-4, Pt. III., col. 4, line 69)   0   13.00	12 00			82 028	12 00
14. 00   Total reasonable chargies (sum of lines 12 and 13)   13. 00   15. 00   15. 00   Aggregate amount actually collected from patients liable for payment for services on a charge basis   0   16. 00   16. 00   17. 00   18.			ine 69)		
Customery charges			1110 07)		1
15.00   Aggregate amount actually collected from patients liable for payment for services on a chargebasis   0   16.00	14.00	,		02,020	14.00
16. 00   Amounts that would have been realized from patients   Iable for payment for services on a chargebasis   0   16. 00   Nation of   Iine   15 to   Iine   16 (Inct to exceed   1.000000)   17. 00   18. 00   Toll   18. 00   Toll   19. 00   Toll   19	15 00		navment for services on a charge ha	nsis 0	15 00
had such payment been made in accordance with 42 CFR \$413.13(e)		, ,		1	1
17. 00	10.00			0	10.00
18. 00   Total customary charges (see instructions)   82,028   18. 00	17 00	,	6)	0.000000	17 00
9. 00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see   66, 422   9. 00				•	1
Instructions		,	Ly if line 19 exceeds line 11) (see	1	
20. 00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see   0   20. 00	19.00		Ty IT TITLE TO EXCEEUS TITLE IT) (See	, 00, 422	19.00
instructions	20 00		Ly if line 11 exceeds line 19) (see	.	20.00
15,606   21.00   22.00   23.00   20.	20.00		Ty IT TITLE IT EXCEEDS TITLE 10) (See	9	20.00
22.00   Interns and residents (see Instructions)   0   22.00   23.00   Cots of physic lands services in a teaching hospital (see instructions)   1,954,527   24.00   Computation No fee Bim Burks Burks StritLewin   25.00   Deductible sand coin surance (for CAH, see Instructions)   3,632,655   26.00   27.00   Deductible sand coin surance (for CAH, see Instructions)   3,632,655   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)   16,337,468   27.00   Instructions)   25.00   28.00   Direct graduate medical education payments (from Wkst. E-4, line 50)   25.00   28.00   ESRB direct medical education costs (from Wkst. E-4, line 36)   25.00   29	21 00			15 606	21 00
23. 00   Cost of physicians' services in a teaching hospital (see instructions)   19,954,527   24. 00   24. 00   24. 00   25. 0					
24.00   Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)   19,954,527   24.00		,	ructions)		1
COMPUTATION OF REINBURSEMENT SETTLEMENT   25.00			ructions)		1
25.00   Deductible sand coin surance (for CAH, see instructions)   0.00   25.00   26.00   Deductible sand Coinsurance relating to amount on line 24 (for CAH, see instructions)   3.632,665   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)   16.337,468   27.00   28.00   29.00   ESRD direct medical education payments (from Wkst. E-4, line 50)   25.049   28.00   29	24.00			19, 954, 527	24.00
26.00   Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)   3,632,665   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)   16,337,468   27.00     27.00   Direct graduate medical education payments (from Wkst. E-4, line 50)   29.00     28.00   Direct graduate medical education payments (from Wkst. E-4, line 50)   29.00     30.00   Subtotal (sum of lines 27 through 29)   16,362,517   30.00     30.00   Subtotal (sum of lines 27 through 29)   16,353,057     31.00   Composite rate ESRD (From Wkst. I-5, line 11)   16,353,057     31.00   Composite rate ESRD (From Wkst. I-5, line 11)   0   14,383,488   34.00     32.00   Allowable BAD DBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   17,438,348   34.00     33.00   Allowable bad debts (see instructions)   934,926   35.00     36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   855,814   36.00     38.00   MSP-LCC reconciliation amount from PSR   1,115   38.00     39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   1,115   38.00     39.90   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.90     39.90   RECOVERY OF ACCELERATED DEPRECIATION   0   39.90     39.90   RECOVERY OF ACCELERATED DEPRECIATION   0   39.90     39.90   RECOVERY OF ACCELERATED DEPRECIATION   0   39.90     30.00   The trian payment adjustment amount before sequestration   0   345,737     30.00   0   0   0   0   0   0     30.00   0   0   0   0   0   0   0   0   0	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)   25.049   28.00		1	r CAH coo instructions)		1
Instructions		, ·	The state of the s		1
28.00	27.00		prus the sum of filles 22 and 23] (s	see 16, 337, 468	27.00
29.00   ESRD diffect medical education costs (from Wkst. E-4, line 36)   29.00   30.	20 00		ino EO)	3E 040	20 00
30.00   Subtotal (sum of lines 27 through 29)   16, 362, 517   30.00   31.00   Primary payer payments   9, 460   31.00   32.00   Subtotal (line 30 minus line 31)   16, 353, 057   32.00					1
31.00   Primary payer payments   9, 460   31.00   32.00   Subtotal (line 30 minus line 31)   16, 353, 057   32.00   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. I - 5, line 11)   0   33.00   33.00   34.00   Allowable bad debts (see instructions)   1, 438, 348   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   934, 926   35.00   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   855, 814   36.00   37.00   Subtotal (see instructions)   17, 287, 983   37.00   39.00		· · · · · · · · · · · · · · · · · · ·			1
32.00   Subtotal (ine 30 minus line 31)   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. I-5, line 11)   0   33.00   34.00   Allowable bad debts (see instructions)   1, 438, 348   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   855, 814   36.00   37.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   855, 814   36.00   37.00   Subtotal (see instructions)   17, 287, 983   37.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS)   17, 287, 983   37.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS)   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS)   39.50   Partial or full credits received from manufacturers for replaced devices (see instructions)   39.50   39.90   Partial or full credits received from manufacturers for replaced devices (see instructions)   39.90   39.90   Partial or full credits received from manufacturers for replaced devices (see instructions)   39.90   39.90   Partial or full credits received from manufacturers for replaced devices (see instructions)   39.90   39.90   Partial or full credits received from manufacturers for replaced devices (see instructions)   39.90   39.90   Partial or full credits received from manufacturers for replaced devices (see instructions)   39.90   39.90   Partial or full credits received from manufacturers for replaced devices (see instructions)   39.90   39.9		,			1
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33. 00   Composite rate ESRD (from Wkst. I - 5, line 11)   0   33. 00     35. 00   All owable bad debts (see instructions)   1, 438, 348   34. 00     35. 00   All owable bad debts (see instructions)   934, 926   35. 00     36. 00   All owable bad debts for dual eligible beneficiaries (see instructions)   17, 287, 983   37. 00     37. 00   Subtotal (see instructions)   17, 287, 983   37. 00     38. 00   MSP-LCC reconciliation amount from PS&R   1, 115   38. 00     39. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39. 00     39. 50   Pioneer ACO demonstration payment adjustment (see instructions)   99. 97     39. 98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39. 99     40. 00   Subtotal (see instructions)   17, 286, 868   40. 00     40. 01   Sequestration adjustment (see instructions)   345, 737   40. 01     40. 02   Demonstration payment adjustment amount after sequestration   0   42. 00     41. 00   Interim payments   16, 803, 008   41. 00     42. 00   Tentative settlement (for contractors use only)   138, 123     43. 00   44. 00   Frotested amounts (see instructions)   138, 123     40. 00   Original outlier amount (see instructions)   0   91. 00     90. 00   Original outlier amount (see instructions)   0   91. 00     90. 00   Original outlier amount (see instructions)   0   91. 00     90. 00   Time Value of Money (see instructions)   0   93. 00					1
33.00   Composite rate ESRD (from Wkst. I - 5, line 11)	32.00		CEC)	16, 333, 037	32.00
34.00	33 00	·	CE3)	1 0	33 00
35.00   Adjusted reimbursable bad debts (see instructions)   934,926   35.00   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   855,814   36.00   37.00   Subtotal (see instructions)   17,287,983   37.00   38.00   MSP-LCC reconciliation amount from PS&R   1,115   38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0 39.00   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   29.97   29.98   29.99   Partial or full credits received from manufacturers for replaced devices (see instructions)   0 39.97   29.99   29.99   29.90   29.90   29.90   29.90   29.90   29.90   29.00   20.00   29.00   20.00   29.00					
36.00		, , , , , , , , , , , , , , , , , , , ,			
37. 00   Subtotal (see instructions)   17, 287, 983   37. 00   38. 00   MSP-LCC reconciliation amount from PS&R   1, 115   38. 00   39. 00			ructions)		
38.00       MSP-LCC reconciliation amount from PS&R       1, 115       38.00         39.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0 39.00         39.50       Demonstration payment adjustment (see instructions)       39.50         39.97       Demonstration payment adjustment amount before sequestration       0 39.97         39.98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0 39.98         39.99       RECOVERY OF ACCELERATED DEPRECIATION       0 39.99         40.01       Subtotal (see instructions)       17, 286, 868       40.00         40.01       Sequestration adjustment (see instructions)       345, 737       40.01         40.02       Demonstration payment adjustment amount after sequestration       0 40.02         41.00       Interim payments       16, 803, 008       41.00         42.00       Interim payments       16, 803, 008       41.00         43.00       Bal ance due provider/program (see instructions)       138, 123       43.00         44.00       Frotested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2       44.00         90.00       Original outlier amount (see instructions)       0 90.00         91.00       The rate used to calculate the Time Value of Money       0 0.00 </td <td></td> <td></td> <td>r de tr ons)</td> <td></td> <td></td>			r de tr ons)		
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 Pomonstration payment adjustment amount before sequestration 39.50 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.99 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Bal ance due provider/program (see instructions) 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  \$\frac{				1 ' '	1
39.50 39.97 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.99 40.00 39.99 40.00 40.01 Demonstration payment adjustment amount after sequestration 40.02 Demonstration payment adjustment amount after sequestration 41.00 Demonstration payment adjustment (see instructions) 42.00 Asiance due provider/program (see instructions) 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 91.00 91.00 91.00 91.00 Outlier reconciliation adjustment amount (see instructions) Time Value of Money (see instructions) 0 39.97 39.97 39.98 Asiance devices (see instructions) 17,286,868 40.00 17,286,868 40.0					
39.97 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 50 Sequestration adjustment (see instructions) 60 Subtotal (see instructions) 60 Sequestration adjustment (see instructions) 61 Sequestration adjustment (see instructions) 62 Subtotal (see instructions) 63 Sequestration adjustment (see instructions) 63 Sequestration adjustment (see instructions) 64 Subtotal (see instructions) 75 Sequestration adjustment (see instructions) 75 Sequestration adjustment (see instructions) 75 Sequestration payment adjustment amount after sequestration 75 Sequestration payment adjustment amount after sequestration 75 Sequestration payment (see instructions) 75 Sequestration adjustment (for contractors use only) 75 Sequestration adjustment (for contractors use only) 77 Sequestration adjustment amount (see instructions) 77 Sequestration adjustment amount (see instructions) 78 Sequestration adjustment amount (see instructions) 79 Sequestration adjustment amount after sequestration 79 Sequestration adjustment amount after sequestration 70 Sequestration adjustment amount after sequestration 70 Sequestration adjustment amount after sequestration 70 Seques		1	c)		1
39.98 Partial or full credits received from manufacturers for replaced devices (see instructions)  39.98 RECOVERY OF ACCELERATED DEPRECIATION  40.00 Subtotal (see instructions)  50 Sequestration adjustment (see instructions)  40.01 Demonstration payment adjustment amount after sequestration  40.02 Demonstration payment adjustment amount after sequestration  41.00 Interim payments  42.00 Tentative settlement (for contractors use only)  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, payments  44.00 Original outlier amount (see instructions)  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  139.98  39.98  39.99  39.99  30.90  39.99  37.28  40.00  345,737  40.01  40.02  41.00  42.00  42.00  42.00  43.00  44.00  90.00  91.00  91.00  92.00  93.00  Time Value of Money (see instructions)  93.99		, , , , , , , , , , , , , , , , , , , ,	3)		
39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   40.00   Subtotal (see instructions)   17,286,868   40.00   40.01   Sequestration adjustment (see instructions)   345,737   40.01   40.02   41.00   Interim payment adjustment amount after sequestration   0   40.02   41.00   Interim payments   16,803,008   41.00   42.00   43.00   Balance due provider/program (see instructions)   138,123   43.00   44.00   47.00			cod dovices (see instructions)	•	1
40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.02 Interim payments 42.00 Tentative settlement (for contractors use only) 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, \$\frac{1}{5}15.2\$ 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 Time Value of Money (see instructions) 94.00 O 93.00			ced devices (see mistructions)		
40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.02 Interim payments 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 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,  \$\frac{\sqrt{115.2}}{\sqrt{10 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 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 O Q Q Q Q Q Q Q Q Q Q Q Q Q Q Q Q Q Q					1
40.02 Demonstration payment adjustment amount after sequestration  10, 803,008 41.00  11, 100 Interim payments  11, 100 Interim payments  12, 100 Interim payments  13, 100 Entative settlement (for contractors use only)  13, 100 Entative settlement (for contractors use only)  13, 100 Entative settlement (for contractors use only)  138, 123 43.00  14, 00 Entative settlement (for contractors use only)  138, 123 43.00  14, 00 Entative settlement (for contractors use only)  138, 123 43.00  15, 115, 2  10 Entative settlement (for contractors use only)  10 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, only 44.00  10 Entative settlement (for contractors use only)  10 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, only 44.00  10 Entative settlement (for contractors use only)  10 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, only 44.00  10 Entative settlement (for contractors use only)  10 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, only 44.00  11 Entative settlement (for contractors use only)  12 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, only 44.00  13 Entative settlement (for contractors use only)  14 Entative settlement (for contractors use only)  15 Entative settlement (for contractors use only)  16 Entative settlement (for contractors use only)  16 Entative settlement (for contractors use only)  18 Entative settlement (for contractors use only)  19 Entative settlement (for contractors use only)  19 Entative settlement (for contractors use only)  10 Entative set					
41.00		, ,			
42.00 Tentative settlement (for contractors use only) 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, §115.2  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 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Time Value of Money (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (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)					
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    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)					
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\ \frac{\text{\$115.2}}{\text{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 Time Value of Money (see instructions) 94.00 Ogs.				•	
\$115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 0 outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 93.00 Time Value of Money (see instructions) 0 93.00		, , , , , , , , , , , , , , , , , , , ,	noo with CMC Dub 1E 2 about on 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)  90.00 Outlier reconciliation adjustment amount (see instructions)  90.00 Outlier reconciliation adjustment amount (see instructions)  90.00 Outlier reconciliation adjustment amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 Outlier reconciliation adjustment amount (see instructions)  93.00 Outlier reconciliation adjustment amount (see instructions)  93.00 Outlier reconciliation adjustment amount (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)	44.00		nce with CMS Pub. 15-2, chapter 1,		44.00
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) 90.00 91.00 92.00 93.00					-
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)  0 91.00  92.00  93.00	90 00			^	90 00
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		, ,		•	1
93.00 Time Value of Money (see instructions) 0 93.00		•		•	1
				1	1
74. 00   10 tai (Suiii 01 11 lies 71 aliu 73)		,		•	
	74. UU	Total (Sail Of Titles 71 and 75)		ı	74.00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0002	Peri od: From 01/01/2017	Worksheet E
	Component CCN: 15-T002		
	Title XVIII	Subprovi der -	PPS

DATE     Model call and other services (ace instructions)			Title XVIII	Subprovi der – I RF	PPS	
Next   Street   Next				IKF		
1.00		DART R MEDICAL AND OTHER HEALTH SERVICES			1. 00	
Medical and other services relaburated under oPPS (see Instructions)	1. 00				0	1. 00
4.00   Duttler payment (see instructions)   0   4.00			tions)		418	
0.01   cr   reconciliation amount (see instructions)   0.00   5						
Enter the hospit fall specific payment to cost ratio (see instructions)		, , ,			-	
Line 2 Lines   Line 5   0.00   0.00		l ,	ctions)		-	
Transitional corridor payment (see instructions)   0 8 8 00   0			,			
Ancillary service other pass through costs from West. D. Pt. IV, col. 13, line 200   9, 90   0   100   00   00   00   00   100   00   00   00   100   00   00   100   00   00   100   00   100   00   00   100   00   00   100   00   00   100   00   00   100   00   00   100   0						
0.00   07-gurn acquisitions   0.10.00   0.			11/ 12 11 200		-	
11.00		, ,	IV, col. 13, line 200		-	
COMPUTATION OF LESSER OF COST OR CHARGES   Computation						
12.00   Ancillary service charges   0   12.00   12.00   10   10   10   10   10   10   10						
13.00   Organ acquisition charges (From Wist. D-4, Pt. III., col. 4, line 69)   0   13.00	40.00			T		40.00
14.00			ino 60)			
Customary_charges			The 09)		-	
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 \$413.13(e)					-	
had such payment been made in accordance with 42 CFR \$413.13(e)					-	
17.00   Ratio of Line 15 to line 16 (not to exceed 1.000000)   17.00   0.000000   17.00   19.00   Excess of customary charges (see instructions)   0.18.00   0.00	16. 00			on a chargebasis	0	16. 00
18.00   Total customary charges (see instructions)   0   18.00   18.	17. 00		e)		0. 000000	17. 00
Instructions    20.00						
20.00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see   0   20.00	19. 00		ly if line 18 exceeds li	ne 11) (see	0	19. 00
Instructions    0	20.00		ly if line 11 evenede li	no 10) (coo	0	20.00
1.00   Lesser of cost or charges (see instructions)   0   21.00	20.00		Ty IT TITLE IT exceeds IT	ne 18) (See	U	20.00
23.00	21. 00				0	21.00
24. 00   Total prospective payment (sum of lines 3, 4, 4, 01, 8 and 9)   116   24. 00   25.	22. 00	Interns and residents (see instructions)			-	
COMPUTATION OF RELIMBURSEMENT SETTLEMENT			ructions)		-	
25.00   Deductibles and Coinsurance (for CAH, see instructions)   23   25.00	24.00				116	24.00
27. 00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   0   28. 00   1   1   1   1   1   1   1   1   1	25. 00				0	25. 00
Instructions	26. 00				23	26.00
28. 00   Direct graduate medical education payments (from Wkst. E-4, line 50)   28. 00   ESRD direct medical education costs (from Wkst. E-4, line 36)   0   29. 00   03. 00   03. 00   Subtotal (sum of lines 27 through 29)   93   30. 00   03. 00   03. 00   04. 00   05. 00	27. 00		plus the sum of lines 22	2 and 23] (see	93	27. 00
29. 00       ESRD direct medical education costs (from Wkst. E-4, line 36)       29. 00         30. 00       Subtotal (sum of lines 27 through 29)       33. 00         31. 00       Primary payer payments       93         32. 00       Subtotal (line 30 minus line 31)       93         ALOWABLE BAD DERIS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)       93         33. 00       Composite rate ESRD (from Wkst. I-5, line 11)       0         34. 00       Allowable bad debts (see instructions)       0         35. 00       Allowable bad debts (see instructions)       0         36. 00       Allowable bad debts for dual eligible beneficiaries (see instructions)       0         36. 00       Allowable bad debts for dual eligible beneficiaries (see instructions)       0         37. 00       Subtotal (see instructions)       0         38. 00       MSP-LCC reconciliation amount from PS&R       0         39. 00       OTHER ADJUSTIMENTS (SEE INSTRUCTIONS) (SPECIFY)       0         39. 50       Pancial or full credits received from manufacturers for replaced devices (see instructions)       0         39. 99       Partial or full icredits received from manufacturers for replaced devices (see instructions)       0         40. 01       Sequestration adjustment disee instructions)       0         40. 02       D	28 00		ine 50)		0	28 00
30.00   Subtotal (sum of lines 27 through 29)   30.00   Primary payer payments   0.31.00   Primary payer payments   31.00   31.00   32.00			THE 30)		-	
Subtoral (ine 30 minus line 31)   93   32.00					93	30.00
ALLOWABLE   BAD   DEBTS   (EXCLUDE   BAD   DEBTS   FOR   PROFESSIONAL   SERVICES)   33. 00   Composite rate   ESRD   (from   Wkst.   1-5,   line   11)   0. 34. 00   34. 00   35. 00   34. 00   35. 00   36. 00   Adjusted reimbursable   bad   debts   (see   instructions)   0. 36. 00   36. 00   36. 00   Allowable   bad   debts   for   dual   eligible   beneficiaries   (see   instructions)   0. 36. 00   36. 00   37. 00   Subtotal   (see   instructions)   93. 37. 00   38. 00   MSP-LCC   reconciliation   amount   from   PS&R   0. 38. 00   MSP-LCC   reconciliation   amount   from   PS&R   0. 39. 00   THER   ADJUSTMENTS   (SEE   INSTRUCTIONS)   (SPECIFY)   0. 39. 00   39. 00		1 3 . 3 . 3			-	
33.00   Composite rate ESRD (from Wkst. I-5, line 11)	32.00		CES)		93	32.00
34.00	33. 00	`	013)		0	33. 00
36.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       0       36.00         37.00       Subtotal (see instructions)       93       37.00         38.00       MSP-LCC reconciliation amount from PS&R       0       38.00         39.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       39.00         39.50       Pioneer ACO demonstration payment adjustment (see instructions)       39.50         39.97       Demonstration payment adjustment amount before sequestration       0       39.97         39.98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39.98         39.99       RECOVERY OF ACCELERATED DEPRECIATION       0       39.99         40.01       Sequestration adjustment (see instructions)       93       40.00         40.01       Sequestration adjustment (see instructions)       2       24.00         40.02       Demonstration payment adjustment amount after sequestration       0       40.02         41.00       Interim payments       91       41.00         42.00       Tentative settlement (for contractors use only)       0       42.00         43.00       Bal ance due provider/program (see instructions)       0       42.00         44.00       Prot						
37.00   Subtotal (see instructions)   93   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   39.50   39.97   Demonstration payment adjustment amount before sequestration   0   39.97   39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.98   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   40.00   Subtotal (see instructions)   93   40.00   40.01   Sequestration adjustment (see instructions)   2   40.01   40.02   Demonstration payment adjustment amount after sequestration   91   41.00   41.00   1nterim payments   91   41.00   42.00   Tentative settlement (for contractors use only)   0   42.00   43.00   44.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 15.15.2   10   BE COMPLETED BY CONTRACTOR   90.00   Original outlier amount (see instructions)   0   91.00   91.00   Outlier reconciliation adjustment amount (see instructions)   0   91.00   92.00   The rate used to calculate the Time Value of Money   93.00   0		````			-	
38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.97 Demonstration payment adjustment amount before sequestration 39.97 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 RECOVERY OF ACCELERATED DEPRECIATION 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.99 Subtotal (see instructions) 39.90 Outlotal (see instructions) 39.90 Demonstration payment adjustment (see instructions) 39.91 AU.00 Demonstration payment adjustment amount after sequestration 39.97 AU.00 Demonstration payment adjustment amount after sequestration 39.99 AU.00 Demonstration adjustment amount after sequestration 39.99 AU.00 Demonstration adjustment amount after sequestration 39.99 AU.00 AU.00 Demonstration amount (see instructions) 39.99 AU.00			ructions)		-	
39. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       39. 00         39. 50       Pioneer ACO demonstration payment adjustment (see instructions)       39. 50         39. 97       Demonstration payment adjustment amount before sequestration       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)       93       40. 00         40. 01       Sequestration adjustment (see instructions)       2       40. 01         40. 02       Demonstration payment adjustment amount after sequestration       0       40. 02         41. 00       Interim payments       91       41. 00         42. 00       Tentative settlement (for contractors use only)       0       42. 00         43. 00       Bal ance due provider/program (see instructions)       0       43. 00         44. 00       Fills. 2       10       45. 00         70. 00       Original outlier amount (see instructions)       0       90. 00         91. 00       Outlier reconciliation adjustment amount (see instructions)       0       90. 00         92. 00       The rate used to c		l				
39. 97 39. 98 39. 99 Recovery of Accelerated Deprectation 39. 99 40. 00 Subtotal (see instructions) 39. 99 40. 01 Sequestration adjustment amount after sequestration 40. 02 Demonstration payment adjustment amount after sequestration 40. 02 Interim payments 42. 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, 515. 2 TO BE COMPLETED BY CONTRACTOR  90. 00 Original outlier amount (see instructions) 0 49. 00 91. 00 Outlier reconciliation adjustment amount (see instructions) 0 90. 00 91. 00 The rate used to calculate the Time Value of Money Time Value of Money (see instructions) 0 39. 99 39. 99 39. 99 40. 00 39. 99 40. 00 39. 99 40. 00 39. 99 40. 00 39. 99 40. 00 40. 01 40. 00 40. 01 40. 01 40. 01 40. 01 41. 00 42. 00 42. 00 43. 00 44. 00 44. 00 6						
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)       93       40. 00         40. 01       Sequestration adjustment (see instructions)       2       40. 01         40. 02       Demonstration payment adjustment amount after sequestration       0       40. 02         41. 00       Interim payments       91       41. 00         42. 00       Tentative settlement (for contractors use only)       0       42. 00         43. 00       Balance due provider/program (see instructions)       0       43. 00         44. 00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, spitch of the complex of t			s)			
39. 99   RECOVERY OF ACCELERATED DEPRECIATION   0   39. 99				-+:>		
40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.02 Interim payments 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Bal ance due provider/program (see instructions) 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  \$\frac{1}{5}\$ 115.2  \$\frac{1}{10}\$ BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 90.00 Outlier reconciliation adjustment amount (see instructions) 90.00 The rate used to calculate the Time Value of Money 91.00 Time Value of Money (see instructions) 93.00 Value of Money (see instructions) 93.00 Value of Money (see instructions) 94.00 Value of Money (see instructions) 95.00 Value of Money (see instructions) 96.00 Value of Money (see instructions) 97.00 Value of Money (see instructions) 98.00 Value of Money (see instructions) 99.00 Value of Money (see instructions) 90.00 Value of Money (see instructions) 90.00 Value of Money (see instructions) 90.00 Value of Money (see instructions)		· ·	ced devices (see instruc	ctions)		
40. 01 Sequestration adjustment (see instructions)  2					-	
41.00   Interim payments	40. 01	· · · · · · · · · · · · · · · · · · ·				40. 01
42.00 Tentative settlement (for contractors use only)  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,  5115.2  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 To settlement (for contractors use only)  42.00 42.00  43.00  44.00  45.00  45.00  46.00  47.00  47.00  48.00  49.00  90.00  90.00  90.00  90.00  90.00  90.00  90.00  90.00		, , , ,			-	
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 Fils. 2  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						
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{9}{5115.2}\$ 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 Time Value of Money (see instructions)		,				
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)		, , , , , , , , , , , , , , , , , , , ,	nce with CMS Pub. 15-2,	chapter 1,		
90.00 Original outlier amount (see instructions) 0 Utlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0 93.00 Time Value of Money (see instructions) 0 90.00 91.00 92.00 93.00						
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)  0 91.00  92.00  93.00 Time Value of Money (see instructions)	00.00				0	00.00
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 0.00 93.00		, ,				
93.00 Time Value of Money (see instructions) 0 93.00		,				
94.00   Total (sum of lines 91 and 93) 0   94.00	93.00	Time Value of Money (see instructions)			0	93.00
	94. 00	lotal (sum of lines 91 and 93)			0	94.00

Health Financial Systems METHO	ODIST HOSPI	TALS, INC		In Lie	u of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider Co		Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part I Date/Time Pre 5/30/2018 8:2	
		Title	XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00 Total interim payments paid to provider			52, 406, 51	6	15, 893, 138	1.00
2.00 Interim payments payable on individual bills, eith	ner			0	0	2.00

1.00   Total interim payments paid to provider   1.00   2.00   3.00   4.00   1.00   2.00   3.00   4.00   1.00   2.00   3.00   4.00   1.00   2.00   1.00   3.00   4.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00			I npati en	t Part A	Par	rt B	
1.00			mm/dd/vvvv	Amount	mm/dd/vvvv	Amount	
Total interlim payments paid to provider   15,993,138   1.00   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	1.00	Total interim payments paid to provider					1. 00
Services rendered in the cost reporting period. If none, write "NoNE" or enter a zero the interim rate for the Cost reporting period. Also show date of each payment. If none, write "NoNE" or enter a zero (1)	2.00	Interim payments payable on individual bills, either		0		0	2.00
write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 12/31/2017 1, 083, 876 12/31/2017 909, 870 3.01 3.02 3.03 3.04 3.05 3.04 3.05 3.04 3.05 3.04 3.05 3.06 3.08 3.09 3.09 3.09 3.09 3.09 3.09 3.09 3.09		submitted or to be submitted to the contractor for					
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider							
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)							
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	3.00						3.00
payment. If none, write "NONE" or enter a zero. (1)							
Program to Provi der							
ADJUSTMENTS TO PROVIDER							
3.02   0	2 01		12/21/2017	1 002 074	12/21/2017	000 970	2 01
3. 03 3. 04 3. 05 3. 05 3. 06 3. 07 3. 08 3. 09 3. 09 3. 09 3. 00		ADJUSTMENTS TO PROVIDER	12/31/2017		12/31/2017		
3.04   0				· · · · · · · · · · · · · · · · · · ·			
3.05   Provider to Program				· ·		-	
Provider to Program							
3. 50   ADJUSTMENTS TO PROGRAM	0.00	Provider to Program		<u> </u>		Ü	0.00
3.52   3.53   3.54   3.54   3.59   3.53   3.54   3.59   3.50   3.53   3.50   3.50   3.53   3.50   3.50   3.53   3.50   3.50   3.53   3.50	3.50			0		0	3.50
3.53   3.54   3.54   3.54   3.54   3.54   3.54   3.54   3.54   3.55   3.54   3.55   3.56   3.59   3.50   3.99   3.50   3.50   3.99   3.50	3. 51			0		0	3.51
3.54   3.99   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   1,083,876   909,870   3.99   3.50-3.98)   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   53,490,392   16,803,008   4.00   4	3. 52			0		0	3.52
3. 99   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   3. 50-3.98)   4. 00   Total interim payments (sum of lines 1, 2, and 3.99)   53, 490, 392   16, 803, 008   4. 00   (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR	3.53			0		0	3.53
3.50-3.98   Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   To BE COMPLETED BY CONTRACTOR				"		0	
Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR	3. 99			1, 083, 876		909, 870	3. 99
Contractor   Con							
appropriate   TO BE COMPLETED BY CONTRACTOR	4. 00			53, 490, 392		16, 803, 008	4. 00
TO BE COMPLÉTED 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)   Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider	5 00						5 00
Write "NONE" or enter a zero. (1)   Program to Provider	5. 00						3.00
Program to Provider							
TENTATI VE TO PROVI DER							
Solution   Separation   Solution   Solutio	5. 01			0		0	5. 01
Provider to Program	5. 02			0		0	5.02
TENTATI VE TO PROGRAM   0   0   5.50	5.03			0		0	5.03
5.51   0							
5. 52 5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions)  Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr)  Number (Mo/Day/Yr)  0 1. 00 2. 00		TENTATI VE TO PROGRAM					
5. 99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 1,149,911 138,123 6.01 6. 02 SETTLEMENT TO PROGRAM 0 0 0 6.02 7. 00 Total Medicare program liability (see instructions) 54,640,303 16,941,131 7.00  Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00							
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr)  0 1.00 2.00							
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr)  Number (Mo/Day/Yr)  0 1.00 2.00	5. 99			0		0	5. 99
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  1,149,911 138,123 6.01 6.02 7.00 Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr) Number 0 1.00 2.00		,					
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  1,149,911 0 0 6.02  54,640,303 16,941,131 7.00  Contractor Number (Mo/Day/Yr)  0 1.00 2.00	6.00	,					6.00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)  0 1.00 2.00	6 01			1 149 011		138 123	6 01
7.00 Total Medicare program liability (see instructions)    Contractor Number (Mo/Day/Yr)   0   1.00   2.00						130, 123	
Contractor         NPR Date           Number         (Mo/Day/Yr)           0         1.00         2.00				l ĭ		16, 941, 131	
Number         (Mo/Day/Yr)           0         1.00         2.00		1		2., 2.2, 000	Contractor		
0 1.00 2.00							
8.00   Name of Contractor     8.00			(	)	1. 00	2. 00	
	8.00	Name of Contractor		ļ			8.00

Health Financial Systems	METHODIST HOSPI	TALS, INC	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR	SERVI CES RENDERED	Provi der CCN: 15-0002	Peri od: From 01/01/2017	Worksheet E-1 Part I
		Component CCN: 15-S002	To 12/31/2017	Date/Time Prepared: 5/30/2018 8:22 am
		Title YVIII	Subprovi der -	DDC

		Title	XVIII	Subprovi der - I PF	PPS	
		I npati en	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		660, 270	)	0	
2.00	Interim payments payable on individual bills, either		0	)	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		l		l	
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02					0	3. 02
3.03			C		0	3.03
3.04			0	1	0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	
3. 51			0		0	
3. 52			0		0	3. 52
3. 53			0		0	3.53
3. 54 3. 99	Subtatal (sum of lines 2 01 2 40 minus sum of lines		0		0	3. 54 3. 99
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		660, 270		0	4.00
1. 00	(transfer to Wkst. E or Wkst. E-3, line and column as		000, 270			1.00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					ļ
F 01	Program to Provider			1		  1
5. 01 5. 02	TENTATIVE TO PROVIDER				0	5. 01 5. 02
5. 02						
5. 05	Provider to Program			1		3.03
5. 50	TENTATI VE TO PROGRAM		С		0	5.50
5. 51			O		0	
5. 52			O		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
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		43, 184		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7.00	Total Medicare program liability (see instructions)		703, 454		0	7.00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00	Name of Contractor	(	)	1. 00	2. 00	0.00
8. 00	Name of Contractor			1	I	8.00

Health Financial Systems	METHODIST HOSPIT	ΓALS, INC	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SE	ERVI CES RENDERED	Provi der CCN: 15-0002 Component CCN: 15-T002	From 01/01/2017	

Title XVIII Subprovi der -**IRF** Inpatient Part A Part B mm/dd/yyyy mm/dd/yyyy Amount Amount 1. 00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 7, 705, 194 1.00 2.00 Interim payments payable on individual bills, either 2.00 0 submitted or to be submitted to the contractor for services rendered in the cost reporting period. write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider ADJUSTMENTS TO PROVIDER 3.01 3.01 0 3.02 0 3.02 3.03 0 3.03 3.04 0 0 3.04 0 3.05 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 3. 51 0 0 3.51 0 3.52 0 3.52 3.53 0 3.53 3.54 0 0 3.54 0 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 3.99 3. 50-3. 98) Total interim payments (sum of lines 1, 2, and 3.99) 4.00 91 7, 705, 194 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 PROVIDER 0 n 5.01 0 0 5.02 5.02 5.03 0 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 5.50 O n 5. 51 0 0 5.51 5. 52 0 0 5. 52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 0 5.99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.01 68, 365 0 6.02 SETTLEMENT TO PROGRAM 0 6.02 Total Medicare program liability (see instructions) 7, 773, 559 91 7.00 7.00 NPR Date Contractor Number (Mo/Day/Yr) 0 1.00 2.00 8.00 Name of Contractor 8. 00

Heal th	Financial Systems METHOD	IST HOSPITALS, INC	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-0002	Peri od:	Worksheet E-1	1
			From 01/01/2017 To 12/31/2017		epared:
				5/30/2018 8: 2	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST R				4
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CA				4
1.00	Total hospital discharges as defined in AARA §4102 f		e 14		1.00
2. 00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of I				2.00
3. 00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. lir				3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of I	·			4.00
5. 00	Total hospital charges from Wkst C, Pt. I, col. 8 li				5. 00
6. 00	Total hospital charity care charges from Wkst. S-10,				6.00
7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I			7. 00		
0.00	line 168	t!)			0.00
8. 00	Calculation of the HIT incentive payment (see instru	ictions)			8. 00
9.00	Sequestration adjustment amount (see instructions)				9.00
10. 00	Calculation of the HIT incentive payment after seque	estration (see instructions)			10.00
20.00	I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH	LI \	T		1 20 00
	Initial/interim HIT payment adjustment (see instruct	trons)			30.00
	Other Adjustment (specify)	20 1: 21) ( :			31.00
32.00	Balance due provider (line 8 (or line 10) minus line	e 30 and line 31) (see instruction	ns)		32.00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Peri od:	Worksheet E-3
		From 01/01/2017	
	Component CCN: 15-S002	To 12/31/2017	Date/Time Prepared:
	·		5/30/2018 8: 22 am
	Title XVIII	Subprovi der -	PPS
		I PF	

	I PF		
		4 00	
	PART II - MEDICARE PART A SERVICES - IPF PPS	1. 00	
1. 00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	762, 498	1. 00
2. 00	Net IPF PPS Outlier Payments	0	2. 00
3.00	Net IPF PPS ECT Payments	0	3. 00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November	0. 00	4.00
	15, 2004. (see instructions)		
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0. 00	4. 01
	program or hospital closure, that would not be counted without a temporary cap adjustment under 42		
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)		
5. 00	New Teaching program adjustment. (see instructions)	0. 00	5. 00
6. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0. 00	6. 00
7 00	teaching program" (see instuctions)	0.00	7 00
7. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new 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)	6. 419178	9. 00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0. 000000	10.00
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)	762, 498	12. 00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	762, 498	16.00
17. 00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	762, 498	
19. 00	Deducti bl es	51, 324	
20. 00	Subtotal (line 18 minus line 19)	711, 174	
21. 00	Coi nsurance	37, 422	
22. 00	Subtotal (line 20 minus line 21)	673, 752	
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	66, 661	
24.00	Adjusted reimbursable bad debts (see instructions)	43, 330	
25. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	9, 212	
26. 00 27. 00	Subtotal (sum of lines 22 and 24)	717, 082 0	26. 00 27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49) Other pass through costs (see instructions)	728	28.00
29.00	Outlier payments reconciliation	728	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30. 50	Pioneer ACO demonstration payment adjustment (see instructions)	Ö	30. 50
30. 99	Demonstration payment adjustment amount before sequestration	0	30. 99
31. 00	Total amount payable to the provider (see instructions)	717, 810	31.00
31. 01	Sequestration adjustment (see instructions)	14, 356	31.01
31. 02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	660, 270	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	43, 184	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	35.00
	§115. 2		
F0 0-	TO BE COMPLETED BY CONTRACTOR	_	F0 05
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0 0. 00	51.00
52.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)	0.00	52. 00 53. 00
55.00	Time value of money (see flistructions)	υĮ	33.00

Health Financial Systems METHODIST	HOSPITALS, INC	In Lie	u of Form CMS-2	552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0002	Peri od:	Worksheet E-3	
		From 01/01/2017	Part III	
	Component CCN: 15-T002	To 12/31/2017	Date/Time Pre	oared:
	'		5/30/2018 8: 2	
	Title XVIII	Subprovi der -	PPS	
		IRF		
			1. 00	
PART III - MEDICARE PART A SERVICES - IRF PPS				
1 00 Net Federal PDS Dayment (see instructions)			7 212 007	1 00

		1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	7, 212, 887	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0956	•
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	415, 462	3.00
4.00	Outlier Payments	361, 280	4. 00
5. 00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5. 00
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5. 01
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 teaching program" (see instructions)	0.00	7. 00
8. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8. 00
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)	26. 095890	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)	7, 989, 629	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00			15.00
16. 00		l ol	16.00
17. 00	J	7, 989, 629	
18. 00	· · · · · · · · · · · · · · · · · · ·	0	1
19. 00		7, 989, 629	
20.00		23, 688	1
21. 00		7, 965, 941	
22. 00		75, 341	
23. 00		7, 890, 600	•
24. 00		64, 004	•
25. 00		41, 603	•
26. 00		48, 437	
			•
27. 00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	7, 932, 203	
28. 00		0	28.00
29. 00		0	
30.00	1 1.3	0	30.00
31.00		0	31.00
31. 50		0	31.50
31. 99	Demonstration payment adjustment amount before sequestration	0	
32. 00		7, 932, 203	1
32. 01	Sequestration adjustment (see instructions)	158, 644	1
32. 02		0	
33.00		7, 705, 194	1
34.00	1 · · · · · · · · · · · · · · · · · · ·	0	34.00
35. 00		68, 365	1
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	202, 683	36. 00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	361, 280	50.00
	Outlier reconciliation adjustment amount (see instructions)	0	51.00
	The rate used to calculate the Time Value of Money	0.00	52.00
	Time Value of Money (see instructions)		53. 00

Health Financial Systems METHODIST HOSPITALS, INC		In Lieu of Form CMS-2552		
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0002	Peri od: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2018 8:22 am	

			10 12/31/2017	5/30/2018 8: 2	
		Title XIX	Hospi tal	Cost	
		2 12	Inpatient	Outpati ent	
			1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		4, 580, 615		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, 580, 615	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		4, 580, 615	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routi ne servi ce charges		2, 969, 968		8.00
9.00	Ancillary service charges		13, 113, 150	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, 083, 118	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	r services on a charge	0	0	13.00
	basis				
14.00	Amounts that would have been realized from patients liable for	r payment for services or	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	
16.00	Total customary charges (see instructions)		16, 083, 118	0	
17. 00	Excess of customary charges over reasonable cost (complete on	ly if line 16 exceeds	11, 502, 503	0	17.00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete onl	ly if line 4 exceeds line	0	0	18. 00
40.00	16) (see instructions)				40.00
19.00	Interns and Residents (see instructions)		0	0	
20.00	Cost of physicians' services in a teaching hospital (see insti		4 500 (15	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line		4, 580, 615	0	21.00
22 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be Other than outlier payments	compreted for PPS provid	0	0	22. 00
	Outlier payments		0	0	
	Program capital payments		0	U	24.00
	Capital exception payments (see instructions)		0		25.00
	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29.00	Titles V or XIX (sum of lines 21 and 27)		4, 580, 615	0	
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		4, 300, 013		27.00
30.00	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)	)	4, 580, 615	0	
	Deductibles	,	0	0	
33.00	Coinsurance		0	0	
34.00	Allowable bad debts (see instructions)		0	0	
	Utilization review		0	· ·	35.00
	O Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		4, 580, 615	0	
	O OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Subtotal (line 36 ± line 37)		4, 580, 615	0	
			0	ū	39.00
	0 Total amount payable to the provider (sum of lines 38 and 39)		4, 580, 615	0	
41.00			5, 060, 197	0	
42.00	Balance due provider/program (line 40 minus line 41)		-479, 582	0	
43.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				
					-

Health Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0002	Peri od:	Worksheet E-3
	Component CCN: 15-S002	From 01/01/2017 To 12/31/2017	
	Title XIX	Subprovi der -	Cost

	"	tie xix	I PF	COST	
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR	TITIES V OR XI		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	C TITLES V OR AL	X OLIVIOLO		
1.00	Inpatient hospital/SNF/NF services		501, 791		1.00
2. 00	Medical and other services		301,771	0	2.00
3. 00	Organ acquisition (certified transplant centers only)		0	O	3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		501, 791	0	4.00
5. 00	Inpatient primary payer payments		001,771	o ,	5.00
6. 00	Outpatient primary payer payments			0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		501, 791	0	7.00
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		001,771	0	7.00
	Reasonable Charges				
8. 00	Routine service charges		88, 557		8. 00
9. 00	Ancillary service charges		50, 773	0	9. 00
10.00	Organ acquisition charges, net of revenue		0	<u> </u>	10.00
11. 00	Incentive from target amount computation		0		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)		139, 330	0	
	CUSTOMARY CHARGES		,	-	
13.00	Amount actually collected from patients liable for payment for services	s on a charge	0	0	13.00
	basis	g-		_	
14.00	Amounts that would have been realized from patients liable for payment	for services on	o	0	14.00
	a charge basis had such payment been made in accordance with 42 CFR §4				
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	. ,	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		139, 330	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line	e 16 exceeds	0	0	17. 00
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete only if line	e 4 exceeds line	362, 461	0	18.00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		139, 330	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed	d for PPS provid			
	Other than outlier payments		0	0	22. 00
23. 00	Outlier payments		0	0	23.00
	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)		139, 330	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			_	
	Excess of reasonable cost (from line 18)		362, 461	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		139, 330	0	31.00
32.00	Deducti bl es		0	0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		100 000	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		139, 330	0	36.00
37. 00	, , , ,		120 220	0	37.00
38.00	Subtotal (line 36 ± line 37)		139, 330	0	38.00
39. 00 40. 00			139, 330	0	39. 00 40. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39) Interim payments		43, 837	0	40.00
41.00	Balance due provider/program (line 40 minus line 41)		95, 493	0	41.00
42.00	Protested amounts (nonallowable cost report items) in accordance with	MS Dub 15 2	95, 493	0	42.00
43.00	chapter 1, §115.2	JWIJ FUD 13-2,	١	U	43.00
	Onaptor 1, \$110.2		1	ļ	ı

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 01/01/2017	Worksheet E-3
	Component CCN: 15-T002		
	Title XIX	Subprovi der -	Cost
		I RF	

		litle XIX	Subprovi der -	Cost	
			I RF	0 1	
			Inpati ent	Outpati ent	
	DART WALL CALLOW ATLANT OF RELABURATION AND OTHER WEATTH OF	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES		440.740		4 00
1.00	Inpatient hospital/SNF/NF services		118, 760		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)		118, 760	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments		440 740	0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		118, 760	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
0.00	Reasonable Charges		00 551		0 00
8.00	Routine service charges		80, 551	0	8.00
9.00	Ancillary service charges		191, 578	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0	0	11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		272, 129	0	12.00
12 00	CUSTOMARY CHARGES	condina an a charge	O	0	12 00
13. 00	Amount actually collected from patients liable for payment for	services on a charge	١	0	13. 00
14. 00	basis Amounts that would have been realized from patients liable for	normant for convices on	o	0	14. 00
14.00	a charge basis had such payment been made in accordance with 4		'l '	U	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	12 CFR 9413. 13(e)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		272, 129	0.000000	16.00
17. 00	Excess of customary charges over reasonable cost (complete onl	vifling 16 overeds	153, 369	0	17. 00
17.00	line 4) (see instructions)	y II IIIle To exceeds	155, 509	U	17.00
18. 00	Excess of reasonable cost over customary charges (complete onl	v if line 1 exceeds line	el ol	0	18. 00
10.00	16) (see instructions)	y II IIIle 4 exceeds IIIle	il	O	10.00
19. 00	Interns and Residents (see instructions)		o	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instr	cuctions)	0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		118, 760	0	21.00
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
23. 00	Outlier payments		o o	0	23. 00
	Program capital payments		o o	o .	24. 00
25. 00	Capital exception payments (see instructions)		o o		25. 00
26. 00	Routine and Ancillary service other pass through costs		o o	0	26.00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		118, 760	0	29. 00
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		1.107.700	5	27.00
30.00			0	0	30.00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		118, 760	0	31. 00
32. 00	Deducti bl es		0	0	32.00
33. 00	Coinsurance		o	0	33.00
34.00	Allowable bad debts (see instructions)		o	0	34.00
35. 00	Utilization review		o	_	35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1 33)	118, 760	0	36.00
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,	0	0	37. 00
38. 00	Subtotal (line 36 ± line 37)		118, 760	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)		118, 760	0	40.00
41. 00	Interim payments		85, 620	0	41.00
42. 00	Balance due provider/program (line 40 minus line 41)		33, 140	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2.	0	0	43.00
	chapter 1, §115.2	•	]		
			•	'	

I RECT	Financial Systems METHODIST HOSPI GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider Co	CN: 15-0002	Peri od:	u of Form CMS-2 Worksheet E-4	
	L EDUCATION COSTS			From 01/01/2017 To 12/31/2017	Date/Time Pre	pare
		T: +1 o	VVI I I	Hooni tol	5/30/2018 8: 2 PPS	2 am
		II ti e	XVIII	Hospi tal	PPS	
					1. 00	
00	COMPUTATION OF TOTAL DIRECT GME AMOUNT Unweighted resident FTE count for allopathic and osteopathic	programs for	r cost report	ing periods	10. 93	1.
	ending on or before December 31, 1996.	. 0	·			
00 00	Unweighted FTE resident cap add-on for new programs per 42 C Amount of reduction to Direct GME cap under section 422 of M		(I) (see Inst	ructions)	0. 00 0. 00	
01	Direct GME cap reduction amount under ACA §5503 in accordance instructions for cost reporting periods straddling 7/1/2011)		R §413.79 (m)	. (see	0. 00	
00	Adjustment (plus or minus) to the FTE cap for allopathic and		programs due	to a Medicare	0.00	4.
01	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f) ACA Section 5503 increase to the Direct GME FTE Cap (see ins		r cost report	ing periods	0. 00	4
02	straddling 7/1/2011) ACA Section 5506 number of additional direct GME FTE cap slo	ts (see ins	tructions for	cost reporting	0. 00	4
00	periods straddling 7/1/2011) FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 p	lus or minus	line 4 plus	lines 4.01 and	10. 93	5
00	4.02 plus applicable subscripts Unweighted resident FTE count for allopathic and osteopathic	programs for	r the current	year from your	2. 93	6
00	records (see instructions) Enter the lesser of line 5 or line 6				2. 93	7
			Primary Care		Total	
00	Weighted FTE count for physicians in an allopathic and osteo	nathi c	1.00	2.00	3. 00	8
00	program for the current year.	•			2. 43	
)()	If line 6 is less than 5 enter the amount from line 8, other multiply line 8 times the result of line 5 divided by the am		0.0	2. 43	2. 43	9
00	<ol><li>Weighted dental and podiatric resident FTE count for the cur</li></ol>	rent year		0.00		10
01	Unweighted dental and podiatric resident FTE count for the co	urrent year		0.00		10
.00	Total weighted FTE count Total weighted resident FTE count for the prior cost reportion	na voor (coo	0. 0 0. 0	1		11
	instructions)					
00	Total weighted resident FTE count for the penultimate cost reyear (see instructions)		0.0			13
. 00	Rolling average FTE count (sum of lines 11 through 13 divide	d by 3).	0.0			14
. 00 . 01	Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new	nrograme	0. 0 0. 0			15 15
. 00	Adjustment for residents displaced by program or hospital cla		0. 0	1		16
01	Unweighted adjustment for residents displaced by program or closure		0. 0			16
. 00	Adjusted rolling average FTE count		0.0	2. 46		17
. 00	Per resident amount		0.0			18
. 00	Approved amount for resident costs			0 204, 393	204, 393	19
					1. 00	
00	Additional unweighted allopathic and osteopathic direct GME Sec. 413.79(c)(4)		cap slots re	celved under 42	0. 00	
. 00	Direct GME FTE unweighted resident count over cap (see instru				0.00	
.00	Allowable additional direct GME FTE Resident Count (see inst Enter the locally adjustment national average per resident a		nstructions)		0. 00 0. 00	
	Multiply line 22 time line 23	mount (see in	nstructions)		0.00	
	Total direct GME amount (sum of lines 19 and 24)				204, 393	
			Inpatient Part A	Managed care		
			1.00	2.00	3. 00	
	COMPUTATION OF PROGRAM PATIENT LOAD			, d		
. 00	Inpatient Days (see instructions)		38, 23			26
. 00	Total Inpatient Days (see instructions) Ratio of inpatient days to total inpatient days		95, 56			27
. 00	Program direct GME amount		0. 40005 81, 7 <i>6</i>	1		28
			01, 70	4, 603		30
. 00	Reduction for direct GME payments for Medicare Advantage			4. 00.51		1 .71.

Heal th	Financial Systems METHODIST HOSPI	TALS, INC	In Lie	u of Form CMS-2	2552-10
DI RECT	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 15-0002	Peri od:	Worksheet E-4	
MEDI CA	L EDUCATION COSTS		From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 8: 2:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITL EDUCATION COSTS)	E XVIII ONLY (NURSING S	CHOOL AND PARAMED	I CAL	
32. 00	Renal dialysis direct medical education costs (from Wkst. B, and 94)	Pt. I, sum of col. 20 a	nd 23, lines 74	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.	I, col. 8, sum of lines	74 and 94)	8, 471, 203	33.00
	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	35. 00
36.00	Medicare outpatient ESRD direct medical education costs (line			0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY			
	Part A Reasonable Cost				
37. 00				70, 897, 603	
38. 00				0	
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
	Primary payer payments (see instructions)				40.00
41. 00	Total Part A reasonable cost (sum of lines 37 through 39 minu	is line 40)		70, 892, 990	41.00
42.00	Part B Reasonable Cost			20, 07/, 071	40.00
42.00	Reasonable cost (see instructions) Primary payer payments (see instructions)			20, 976, 071	42.00
43.00	Total Part B reasonable cost (line 42 minus line 43)			20, 966, 611	1
	Total reasonable cost (sum of lines 41 and 44)			91, 859, 601	1
	Ratio of Part A reasonable cost to total reasonable cost (lir	ne 41 ÷ line 45)		0. 771754	1
	Ratio of Part B reasonable cost to total reasonable cost (III			0. 771734	1
47.00	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA			0. 220240	17.00
48 00	Total program GME payment (line 31)			109, 744	48 00
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instructions)		84, 695	1
	Part B Medicare GME payment (line 47 x 48) (title XVIII only)			25, 049	1
			'		

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: From 01/01/

Period: Worksheet G From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/30/2018 8:22 am

oni y)				1270172017	5/30/2018 8: 2	2 am
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	1, 374, 997	0	0	0	1.00
2.00	Temporary investments	576, 070	0	0	0	
3. 00	Notes receivable	0	1	0	0	
4.00	Accounts receivable	73, 771, 381	0	0	0	1
5.00	Other receivable	0 0 0 10 0		0	0	
6. 00 7. 00	Allowances for uncollectible notes and accounts receivable Inventory	-25, 130, 009 11, 403, 205		0	0	
8. 00	Prepaid expenses	3, 616, 215		0	0	
9. 00	Other current assets	23, 882, 494		0	Ö	1
10.00	Due from other funds	0	Ö	0	0	1
11.00	Total current assets (sum of lines 1-10)	89, 494, 353	0	0	0	11.00
	FIXED ASSETS	T	,			
12. 00	Land	5, 373, 674		0	0	1
13.00	Land improvements	6, 652, 126		0	0	
14. 00 15. 00	Accumulated depreciation Buildings	-347, 669, 702 273, 095, 783		0	0	1
16. 00	Accumulated depreciation	273,043,763		0	0	
17. 00	Leasehold improvements	2, 606, 826		0	0	1
18. 00	Accumulated depreciation	0	Ö	0	0	
19.00	Fi xed equi pment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	
21. 00	Automobiles and trucks	0	0	0	0	
22. 00	Accumulated depreciation	0	0	0	0	
23. 00	Major movable equipment	204, 660, 944		0	0	1
24. 00 25. 00	Accumulated depreciation Minor equipment depreciable	0	0	0	0	
26. 00	Accumulated depreciation			0	0	1
27. 00	HIT designated Assets			0	ő	1
28. 00	Accumulated depreciation	0	Ö	0	0	1
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	144, 719, 651	0	0	0	30.00
	OTHER ASSETS		1 -1	_		
31.00	Investments	129, 402, 882		0	0	1
32.00	Deposits on leases	0	0	0	0	
33. 00 34. 00	Due from owners/officers Other assets			0	0	
35. 00	Total other assets (sum of lines 31-34)	129, 402, 882		0	0	
36. 00	Total assets (sum of lines 11, 30, and 35)	363, 616, 886		0	Ö	1
	CURRENT LIABILITIES		,			1
37. 00	Accounts payable	11, 309, 117	0	0	0	37.00
38. 00	Salaries, wages, and fees payable	0	0	0	0	
39. 00	Payroll taxes payable	0	0	0	0	1
40. 00 41. 00	Notes and Loans payable (short term) Deferred income	2, 436, 521		0	0	
41.00	Accel erated payments			U	U	42.00
43. 00	Due to other funds		Ó	0	0	1
	Other current liabilities	25, 015, 358		0	Ō	
45.00	Total current liabilities (sum of lines 37 thru 44)	38, 760, 996	0	0	0	45.00
	LONG TERM LIABILITIES					1
46. 00	Mortgage payable	0	0	0	0	
47. 00	Notes payable	61, 519, 536		0	0	
48. 00	Unsecured Loans Other Long term Liabilities	20, 995, 639	0	0	0	
49. 00 50. 00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	82, 515, 175		0	0	1
51. 00	Total liabilities (sum of lines 45 and 50)	121, 276, 171		0	0	
01.00	CAPITAL ACCOUNTS	121/2/0/1/1	<u> </u>	<u> </u>		1
52.00	General fund balance	242, 340, 715	i			52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			O		56.00
57. 00 58. 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	1
50.00	replacement, and expansion					30.00
59. 00	Total fund balances (sum of lines 52 thru 58)	242, 340, 715	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	363, 616, 886		0	0	
	59)					

Provi der CCN: 15-0002

				Т	o 12/31/2017	Date/Time Pre 5/30/2018 8: 2	epared:
		General	Fund	Special Pu	rpose Fund	Endowment Fund	
		1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	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	243, 458, 347 8, 435, 424 251, 893, 771	000000000000000000000000000000000000000	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	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) RECONCILING ENTITIES	9, 553, 056 0 0 0 0	0 251, 893, 771	0 0 0 0 0 0	0	0 0 0 0 0 0	9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
17. 00 18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	9, 553, 056 242, 340, 715	0	0	0	17. 00 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 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0	0			1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) RECONCILING ENTITIES  Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0	0 0 0 0 0	0000			10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

| Peri od: | Worksheet G-2 | From 01/01/2017 | Parts | & II | To 12/31/2017 | Date/Time Prepared: Health Financial Systems NSTATEMENT OF PATLENT REVENUES AND OPERATING EXPENSES Provi der CCN: 15-0002

Cost Center Description   1.00   1.00   1.00   2.00   3.00			Т	o 12/31/2017	Date/Time Pre 5/30/2018 8: 2	
PART I - PATIENT REVENUES		Cost Center Description	Inpatient	Outpati ent		2 4111
General Inpatient Routine Services   1,00   1,361,211   1,00   2,00   3UBPROVIDER   1PF   3,462,684   3,462,684   2,00   3,00   3UBPROVIDER   7,909,819   7,909,819   3,00   3,00   3UBPROVIDER   7,909,819   7,909,819   3,00   4,00   5,00						
1.00   Hospital		PART I - PATIENT REVENUES	<u> </u>			
2.00   SUBPROVIDER - IPF   7,999,819   7,999,819   4,00   4,00   5,00		General Inpatient Routine Services				
3. 00   SUBPROVIDER - IRF	1.00	Hospi tal	71, 361, 211		71, 361, 211	1.00
3.00   SUBPROVIDER	2.00	SUBPROVIDER - IPF	3, 462, 684		3, 462, 684	2.00
5.00   Swing bed - SNF	3.00	SUBPROVI DER - I RF	7, 909, 819		7, 909, 819	3.00
Swing bed = NF   0   0   0   0   0   0   0   0   0	4.00	SUBPROVI DER				4.00
7. 00   SKILLED NURSING FACILITY   8   8.00   9.00   OTHER LONG TERM CARE   9.00   OTHER LONG TERM CARE   9.00   OTHER LONG TERM CARE   9.00   0.00   OTHER CARE (SPECIFY)   0.00   OTHER SPECIAL CARE (SPECIAL CARE (SPECIAL CARE (SPECIAL CARE (SPECIAL CARE (SPECIAL	5.00	Swing bed - SNF	0		0	5.00
8. 00 NURSI NG FACILITY 9. 00 Total general inpatient care services (sum of lines 1-9) 11-00 Total general inpatient care services (sum of lines 1-9) 11-00 Total general inpatient hospital Services 11-100 COROMARY CARE UNIT 12-00 COROMARY CARE UNIT 13-00 COROMARY CARE UNIT 14-00 SURGICAL INTENSIVE CARE UNIT 15-00 Total inpatient routine care services (sum of lines 10 and 16) 16-00 Total inpatient routine care services (sum of lines 10 and 16) 17-00 Total inpatient routine care services (sum of lines 10 and 16) 18-00 Total inpatient routine care services (sum of lines 10 and 16) 19-00 OUTPAIL INTENSIVE CARE UNIT 19-00 OUTPAIL INTENSIVE CARE UNIT 19-00 OUTPAIL INTENSIVE CARE (SPECIFY) 10-00 Total inpatient routine care services (sum of lines 10 and 16) 19-00 OUTPAIL INTENSIVE CARE (SPECIFY) 19-00 OUTPAIL INTENSIVE CARE UNIT 19-00 OUTPAIL INTENS	6.00	Swing bed - NF	0		0	6.00
9.00 OTHER LONG TERM CARE 10.00 Total general inpatient care services (sum of lines 1-9) 10.00 Total general inpatient care services (sum of lines 1-9) 11.00 Intensive Care Type inpatient Hospital Services 11.00 Intensive Care Unit 1 12.00 CORONARY CARE UNIT 1 13.00 BURN INTENSIVE CARE UNIT 1 14.00 SURGICAL INTENSIVE CARE UNIT 1 15.00 Total intensive care type inpatient hospital services (sum of lines 10 and 16) 15.00 OTHER PSECIAL CARE (SPECIFY) 16.00 Total intensive care type inpatient hospital services (sum of lines 10 and 16) 17.00 Total inpatient routine care services (sum of lines 10 and 16) 18.00 Angular type inpatient routine care services (sum of lines 10 and 16) 19.00 Outpatient services 19.00 Outpati	7.00	SKILLED NURSING FACILITY				7.00
10, 0	8.00	NURSING FACILITY				8.00
Intensive Care Type Inpatient Hospital Services	9.00	OTHER LONG TERM CARE				9.00
11.00   NTENSIVE CARE UNIT   23, 214, 273   23, 214, 273   11.00   10.10   10.00   10.10   10.00   10.10   10.00   10.10   10.	10.00	Total general inpatient care services (sum of lines 1-9)	82, 733, 714		82, 733, 714	10.00
11. 01   NEONATAL ICU   12. 00   11. 01   12. 00   13. 00   13. 00   14. 00   13. 00   14.		Intensive Care Type Inpatient Hospital Services				
12.00 CORONARY CARE UNIT 13.00 BURN INTENSIVE CARE UNIT 13.00 OTHER SPECIAL CARE (SPECIFY) 15.00 OTHER SPECIAL CARE (SPECIFY) 16.00 Total intensive care type inpatient hospital services (sum of lines 10.5, 947, 987 11.05) 17.00 Total intensive care type inpatient hospital services (sum of lines 10.5, 947, 987 11.15) 18.00 Ancillary services 18.00 Ancillary services 19.00 Outpatient services 19.00 Outpatie	11.00	INTENSIVE CARE UNIT	23, 214, 273		23, 214, 273	11.00
13.00   BURN INTENSIVE CARE UNIT	11. 01	NEONATAL I CU	0		0	11.01
14. 00   SURGICAL INTENSIVE CARE UNIT   14. 00   15. 00   OTHER SPECIAL CARE (SPECIFY)   15. 00   Total intensive care type inpatient hospital services (sum of lines   23, 214, 273   23, 214, 273   16. 00   17. 00   Total inpatient routine care services (sum of lines 10 and 16)   105, 947, 987   17. 00   Total inpatient routine care services (sum of lines 10 and 16)   105, 947, 987   105, 947, 987   17. 00   Total inpatient routine care services (sum of lines 10 and 16)   105, 947, 987   17. 00   100,	12.00	CORONARY CARE UNIT				12.00
15. 00 OTHER SPECIAL CARE (SPECIFY) 16. 00 Total intensive care type inpatient hospital services (sum of lines 17.00 Total inpatient routine care services (sum of lines 10 and 16) 11-15) 17. 00 Total inpatient routine care services (sum of lines 10 and 16) 18. 00 Ancillary services 19. 00 Outpatient services 19. 00 Outpatient services 23, 330, 660 24, 300 ORBAL HEALTH CLINIC 22. 00 HOME HEALTH AGENCY 23. 00 HOME HEALTH AGENCY 24. 00 CMHC 25. 00 HOSPICE 27. 00 PHYSICIAN PROFESSIONAL FEES 27. 00 PHYSICIAN PROFESSIONAL FEES 28. 00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 650, 900, 496 625, 758, 021 1, 276, 658, 517 28.00 13.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	13.00	BURN INTENSIVE CARE UNIT				13.00
16.00 Total intensive care type inpatient hospital services (sum of lines 10 and 16) 11-15) 17-15 17-1	14.00	SURGICAL INTENSIVE CARE UNIT				14.00
11-15   105, 947, 987   17. 00   105, 947, 987   17. 00   105, 947, 987   17. 00   105, 947, 987   17. 00   105, 947, 987   17. 00   105, 947, 987   18. 00   19. 00   19. 00   105, 947, 987   18. 00   19. 00	15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
17. 00 Total inpatient routine care services (sum of lines 10 and 16) 105, 947, 987 521, 089, 136 474, 704, 253 995, 793, 389 18. 00 0 Unitary services 23, 330, 660 91, 882, 497 115, 213, 157 19. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	16.00	Total intensive care type inpatient hospital services (sum of lines	23, 214, 273		23, 214, 273	16.00
18.00   Ancillary services   521,089,136   474,704,253   995,793,389   18.00   19.00   Outpatient services   23,330,660   91,882,497   115,213,157   10.00   20.00   RURAL HEALTH CLINIC   0 0 0 0 0 21.00   20.00   21.00   22.00   HOME HEALTH AGENCY   3,342,486   3,342,486   22.00   23.00   AMBULANCE SERVICES   22.00   24.00   25.00   AMBULANCE SERVICES   25.00   AMBULANCE SERVICES   25.00   AMBULANCE SERVICES   25.00   26.00   26.00   27.00   Physician revenues (sum of lines 17-27)(transfer column 3 to Wkst.   650,900,496   625,758,021   1,276,658,517   27.00		11-15)				
19,00   Outpatient services   23,330,660   91,882,497   115,213,157   19,00   20.00   RURAL HEALTH CLINIC   0   0   0   0   0   21.00   22.00   22.00   23.00   AMBULANCE SERVICES   3,342,486   3,342,486   22.00   24.00   24.00   25.00   AMBULATORY SURGICAL CENTER (D.P.)   25.00   AMBULATORY SURGICAL CENTER (D.P.)   25.00   26.00   0   27.00   27.	17.00	Total inpatient routine care services (sum of lines 10 and 16)	105, 947, 987		105, 947, 987	17.00
20.00   RURÂL HEALTH CLINIC   0   0   0   0   20.00   21.00   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   21.00   22.00   HOME HEALTH AGENCY   3,342,486   3,342,486   22.00   23.00   AMBULANCE SERVICES   24.00   24.00   CMHC   24.00   25.00   AMBULATORY SURGICAL CENTER (D.P.)   25.00   26.00   HOSPICE   532,713   55,828,785   56,361,498   27.00   PHYSICIAN PROFESSIONAL FEES   532,713   55,828,785   56,361,498   28.00   Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst.   650,900,496   625,758,021   1,276,658,517   29.00   Operating expenses (per Wkst. A, column 3, line 200)   34,00   0   31.00   31.00   32.00   33.00   34.00   0   33.00   34.00   34.00   0   34.00   35.00   36.00   Total additions (sum of lines 30-35)   0   36.00   37.00   DEDUCT (SPECIFY)   0   0   37.00   38.00   39.00   40.00   0   40.00   41.00   42.00   Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer   342,976,851   43.00   42.00   Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer   342,976,851   43.00   42.00   Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer   342,976,851   43.00   42.00   Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer   342,976,851   43.00   43.00   Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer   342,976,851   43.00   44.00   Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer   342,976,851   43.00   44.00   Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer   342,976,851   43.00   44.00   Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer   342,976,851   43.00   44.00   Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer   342,976,851   43.00   44.00   Total operating expenses (sum of lines 30 and sum of lines 30 and	18.00	Ancillary services	521, 089, 136	474, 704, 253	995, 793, 389	18.00
21. 00   FEDERALLY QUALIFIED HEALTH CENTER   0 0 0 0 21. 00   22. 00   22. 00   40ME HEALTH AGENCY   3, 342, 486   3, 342, 486   22. 00   22. 00   24. 00   24. 00   24. 00   24. 00   24. 00   24. 00   24. 00   25. 00   26. 00   40SPL CENTER (D.P.)   26. 00   40SPL CENTER (D.P.)   26. 00   27. 00   28. 00   28. 00   29. 00   28. 00   29. 00   2	19. 00	Outpatient services	23, 330, 660	91, 882, 497	115, 213, 157	19.00
22.00 HOME HEALTH AGENCY 23.00 AMBULANCE SERVICES  CMHC 24.00 CMHC 25.00 AMBULATORY SURGICAL CENTER (D.P.)  26.00 HOSPICE  PHYSICIAN PROFESSIONAL FEES  Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 6-3, line 1)  PART II - OPERATING EXPENSES  29.00 ADD (SPECIFY)  29.00 ADD (SPECIFY)  3, 342, 486 22.00 23.00 24.00 25.00 26.00 25.00 26.00 25.00 26.00 27.00 28.00 28.00 28.00 29.00 30.00 30.00 30.00 31.00 31.00 32.00 33.00 33.00 34.00 35.00 36.00 37.00 38.00 38.00 39.00 40.00 40.00 41.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 37-41) Total operating expenses (sum of lines 39-36) minus line 42) (transfer  3, 342, 486 3, 342, 486 22.00 23.00 24.00 25.00 25.00 26.00 27.00 25.00 26.00 27.00 28.00 342, 976, 851 342, 976, 851 342, 976, 851 342, 976, 851	20.00	RURAL HEALTH CLINIC	0	0	0	20.00
23. 00 24. 00 24. 00 25. 00 26. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 31. 00 32. 00 33. 00 34. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 37. 00 38. 00 39. 00 39. 00 39. 00 39. 00 40. 00 41. 00 41. 00 42. 00 42. 00 43. 00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer column for a fine and column for a fine	21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
24. 00 25. 00 26. 00 26. 00 26. 00 27. 00 28. 00 29. 00 29. 00 29. 00 20	22. 00	HOME HEALTH AGENCY		3, 342, 486	3, 342, 486	22.00
25. 00 26. 00 26. 00 27. 00 29. 00 29. 00 30. 00 31. 00 33. 00 33. 00 33. 00 34. 00 35. 00 35. 00 36. 00 37. 00 38. 00 37. 00 38. 00 39. 00 39. 00 39. 00 39. 00 30. 00 31. 00 31. 00 32. 00 33. 00 34. 00 35. 00 35. 00 36. 00 37. 00 38. 00 39. 00 39. 00 39. 00 39. 00 39. 00 30	23.00	AMBULANCE SERVICES				23.00
26. 00 27. 00	24.00	CMHC				24.00
27. 00	25.00	AMBULATORY SURGICAL CENTER (D. P. )				25.00
28. 00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 650, 900, 496 625, 758, 021 1, 276, 658, 517 6-38, line 1)  PART II - OPERATING EXPENSES  Operating expenses (per Wkst. A, column 3, line 200)  30. 00 30. 00 31. 00 32. 00 33. 00 34. 00 33. 00 34. 00 35. 00  34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 41. 00 42. 00 Total adductions (sum of lines 37-41)  Total apatient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 650, 900, 496 625, 758, 021 1, 276, 658, 517 28. 00 342, 976, 851 28. 00 342, 976, 851 29. 00 342, 976, 851 29. 00 32. 00 33. 00 32. 00 32. 00 32. 00 33. 00 32. 00 33. 00	26.00	HOSPI CE				26.00
G-3, line 1) PART II - OPERATING EXPENSES  29. 00 30. 00 31. 00 31. 00 32. 00 33. 00 33. 00 34. 00 35. 00 36. 00 37. 00 36. 00 37. 00 38. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer  29. 00 342, 976, 851 29. 00 342, 976, 851 29. 00 342, 976, 851 29. 00 30. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer	27.00	PHYSICIAN PROFESSIONAL FEES			56, 361, 498	27.00
PART II - OPERATING EXPENSES  29.00	28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wks	t. 650, 900, 496	625, 758, 021	1, 276, 658, 517	28. 00
29. 00   Operating expenses (per Wkst. A, column 3, line 200)   342, 976, 851   29. 00   30. 00   31. 00   31. 00   32. 00   33. 00   32. 00   33.						
30.00   ADD (SPECIFY)   0   30.00   31.00   32.00   33.00   32.00   33						
31.00 32.00 33.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY)  0 38.00 39.00 40.00 41.00 42.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer)  0 31.00 0 32.00 33.00 33.00 0 33.00 0 34.00 0 35.00 0 0 36.00 0 0 0 0 0 0 0 0 0 40.00 0 41.00 0 0 42.00 0 342.00 0 342.00 342.976,851						
32.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35)  DEDUCT (SPECIFY)  DEDUCT (SPECIFY)  DEDUCT (SPECIFY)  O  38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer  O  32.00 33.00 33.00 34.00 35.00 35.00 36.00 37.00 38.00 0 0 0 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer  342,976,851 43.00		ADD (SPECIFY)				
33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) 0 35.00 37.00 DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 33.00 0 34.00 0 35.00 0 35.00 0 37.00 0 37.00 0 38.00 0 49.00 0 41.00 0 42.00 1 50.00			-			
34.00 35.00 36.00 Total additions (sum of lines 30-35) 37.00 DEDUCT (SPECIFY) 0 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer  34.00 0 35.00 0 36.00 37.00 38.00 0 0 39.00 40.00 0 41.00 42.00 342.976,851			-			
35.00 36.00 Total additions (sum of lines 30-35) 37.00 DEDUCT (SPECIFY)  0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer)  35.00 0 36.00 37.00 0 37.00 0 38.00 0 39.00 0 40.00 0 41.00 0 42.00 35.00 37.00 37.00 38.00 39.00 0 40.00 0 40.00 0 41.00 0 42.00						
36.00 Total additions (sum of lines 30-35) 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 342, 976, 851 33.00			-			
37. 00   DEDUCT (SPECIFY)			0			
38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 342, 976, 851 33.00						
39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 342, 976, 851 39.00 39.00 0 41.00 42.00 342, 976, 851 43.00		DEDUCT (SPECIFY)	-			
40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 342, 976, 851 43.00			-			
41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 342, 976, 851 43.00						
42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 342, 976, 851 43.00						
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 342,976,851 43.00			0			
				_		
to Wkst. G-3, line 4)	43. 00		sfer	342, 976, 851		43.00
		TO WKST. 6-3, TINE 4)	I			

Heal th	Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0002	Peri od:	Worksheet G-3	
			From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 8:2	
4.00	T. I. I. I. O. O. D.			1.00	1 00
1.00	Total patient revenues (from Wkst. G-2, Par			1, 276, 658, 517	1.00
2.00	Less contractual allowances and discounts of	n patrents' accounts		986, 304, 338	2.00
3.00	Net patient revenues (line 1 minus line 2)	2 Deat II Iii 42)		290, 354, 179	3.00
4. 00	Less total operating expenses (from Wkst. G			342, 976, 851	4.00
5. 00	Net income from service to patients (line 3	minus iine 4)		-52, 622, 672	5. 00
6. 00	OTHER INCOME Contributions, donations, bequests, etc			0	6. 00
7. 00	Income from investments			0	7.00
8. 00	Revenues from telephone and other miscelland	nous communication sorvices		0	
9. 00	Revenue from television and radio service	eous communication services		0	
	Purchase di scounts			0	10.00
	Rebates and refunds of expenses			0	11.00
	Parking Lot receipts			0	12.00
	Revenue from Laundry and Linen service			0	13. 00
	Revenue from meals sold to employees and gu	ests		0	14. 00
	Revenue from rental of living quarters			0	15. 00
	Revenue from sale of medical and surgical sa	upplies to other than patients		0	16. 00
	Revenue from sale of drugs to other than par			0	17. 00
	Revenue from sale of medical records and ab			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	20.00
	Rental of vending machines			0	21.00
	Rental of hospital space			0	22.00
	Governmental appropriations			0	23.00
	INVESTMENT INCOME			6, 470, 253	24.00
24. 01	NON OPERATING INCOME			32, 083	24. 01
24. 02	CHANGE IN UNREALIZED GAIN/LOSS			2, 620, 238	24. 02
24. 03	REALIZED GAIN/LOSS ON INVESTMENT SAL			9, 475, 491	24.03
24.04	GAIN/LOSS ON ASSET DISPOSAL			158, 516	24.04
04.05	OTHER INCOME				04.05

4, 118, 796 24. 05 38, 395, 879 24. 06

38, 395, 879 24, 06
61, 271, 256 25, 00
8, 648, 584 26, 00
213, 160 27, 00
213, 160 28, 00
8, 435, 424 29, 00

24.05 OTHER INCOME

25.00 Total other income (sum of lines 6-24) 26.00 Total (line 5 plus line 25)

27.00 LOSS ON SALE OF EQUIPMENT
28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

24. 06 DSH

Heal th	Financial Systems		METHODIST HOSE	PITALS, INC			In Lieu	u of Form CMS-2	2552-10
COST A	LLOCATION - HHA GENERAL SERVICE	E COST		Provi der C	CN: 15-0002		riod: om 01/01/2017	Worksheet H-1 Part I	
				HHA CCN:	15-7536	То		Date/Time Pre	
							Home Health	5/30/2018 8: 2 PPS	2 am
							Agency I		
			Capital Rela	ated Costs					
		Net Expenses	BI dgs &	Movabl e	Plant	Т	ransportatio	Subtotal	
		for Cost	Fi xtures	Equi pment	Operation		n	(col s. 0-4)	
		Allocation (from Wkst.			Mai ntenano	е			
		H, col . 10)							
	GENERAL SERVICE COST CENTERS	0	1. 00	2. 00	3.00		4. 00	4A. 00	
1.00	Capital Related - Bldg. &	0	0					0	1.00
	Fixtures			_				_	
2. 00	Capital Related - Movable Equipment	0		(	)			0	2.00
3. 00	Plant Operation & Maintenance	0	0	(		0		0	3.00
4.00	Transportation	0	0	(	1	0	0	7/0 /10	4.00
5. 00	Administrative and General HHA REIMBURSABLE SERVICES	769, 613	0	(	)[	0	0	769, 613	5.00
6.00	Skilled Nursing Care	889, 760	0	(		0	0	889, 760	6.00
7.00	Physical Therapy	457, 230	0	(	1	0	0	457, 230	•
8. 00 9. 00	Occupational Therapy Speech Pathology	114, 021 48, 784	0	(	1	0	0	114, 021 48, 784	1
10.00	Medical Social Services	3, 200	0	(	1	O	o	3, 200	
11.00	Home Heal th Ai de	71, 684	0	(	1	0	o	71, 684	11.00
12. 00 13. 00	Supplies (see instructions) Drugs	0	0	(	•	0	0	0	
14. 00	DME	Ö	0	(	1	Ö	O	0	1
45.00	HHA NONREI MBURSABLE SERVI CES				,			0	45.00
15. 00 16. 00	Home Dialysis Aide Services Respiratory Therapy	0	0	(	1	0	0	0	
17. 00	Private Duty Nursing	Ö	o	(	1	O	Ö	0	
18.00	Clinic	0	0	(	•	0	0	0	
19. 00 20. 00	Health Promotion Activities Day Care Program	0	0	(	•	0	0	0	
21. 00	Home Delivered Meals Program	Ö	Ö	(	•	Ö	Ö	0	
22.00	Homemaker Service	0	0	(		0	0	0	
23. 00 23. 50	All Others (specify) Telemedicine	0	0	(	1	0	0	0	23. 00 23. 50
	Total (sum of lines 1-23)	2, 354, 292	0	(	1	Ö	Ö	2, 354, 292	•
		Administrativ e & General	Total (cols.						
		5. 00	4A + 5) 6.00						
	GENERAL SERVICE COST CENTERS								
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	769, 613							5.00
4 00	HHA REIMBURSABLE SERVICES	420, 400	1 221 000						6.00
6. 00 7. 00	Skilled Nursing Care Physical Therapy	432, 120 222, 058							6. 00 7. 00
8.00	Occupational Therapy	55, 375	169, 396						8. 00
9.00	Speech Pathology Medical Social Services	23, 692	72, 476						9.00
10. 00 11. 00	Home Health Aide	1, 554 34, 814	4, 754 106, 498						10.00 11.00
12.00	Supplies (see instructions)	0	0						12.00
13. 00 14. 00	Drugs DME	0	0						13. 00 14. 00
14.00	HHA NONREI MBURSABLE SERVI CES	1 0	U						14.00
15.00	Home Dialysis Aide Services	0	· ·						15.00
16. 00 17. 00	Respiratory Therapy Private Duty Nursing	0	0						16. 00 17. 00
18. 00	Clinic	0	0						18.00
19. 00	Health Promotion Activities	0	0						19.00
20.00	Day Care Program Home Delivered Meals Program	0	0						20. 00 21. 00
21.00	Homemaker Service	0	0						21.00
23. 00	All Others (specify)	0	0						23. 00
	Telemedicine Total (sum of lines 1-23)	0	0 2, 354, 292						23. 50 24. 00
27.00	110tar (30m 01 111163 1-20)	I	2,334,272						27.00

Heal th	Financial Systems		METHODIST HOS	SPITALS, INC		In Lie	u of Form CMS-2	2552-10
COST A	ALLOCATION - HHA STATISTICAL BAS	SIS		Provi der C	CN: 15-0002	Peri od: From 01/01/2017	Worksheet H-1 Part II	
				HHA CCN:	15-7536	To 12/31/2017		
						Home Health	PPS	
						Agency I		
		Capital Rel	ated Costs					
		BI dgs &	Movabl e	PI ant	Transportati	o Reconciliatio	Administrativ	
		Fi xtures	Equi pment	Operation &	n (MI LEAGE)	n	e & General	
		(SQUARE FEET)	(DOLLAR	Mai ntenance			(ACCUM. COST)	
		1.00	2. 00	(SQUARE FEET) 3.00	4. 00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	JA. 00	5.00	
1. 00	Capital Related - Bldg. &	0				0		1.00
	Fixtures							
2. 00	Capital Related - Movable		0			0		2.00
3. 00	Equipment Plant Operation & Maintenance	0	0					3.00
4. 00	Transportation (see		0					4.00
4.00	instructions)		O					4.00
5.00	Administrative and General	О	0	0		0 -769, 613	1, 584, 679	5.00
	HHA REIMBURSABLE SERVICES							
6. 00	Skilled Nursing Care	0	0			0 0	1	
7.00	Physical Therapy Occupational Therapy	0	0	0		0 0	457, 230	
8. 00 9. 00	Speech Pathology	0	0				114, 021 48, 784	1
10.00	Medical Social Services		0				3, 200	
11. 00	Home Heal th Ai de	O	0	O		0 0	71, 684	
12.00	Supplies (see instructions)	0	0	0		0	0	12.00
13. 00	Drugs	0	0			0	0	13.00
14. 00	DME	0	0	0		0 0	0	14.00
15. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0			0 0	0	15. 00
16. 00	Respiratory Therapy	0	0				0	16.00
17. 00	Pri vate Duty Nursing	l o	0			0 0	0	17. 00
18. 00	Clinic	O	0	0		0 0	0	18.00
19. 00	Health Promotion Activities	0	0	0		0	0	19. 00
20.00		0	0	0		0 0	0	20.00
21. 00	3	0	0	0		0	0	21.00
22.00	Homemaker Service All Others (specify)		0					22. 00 23. 00
23. 50	Tel emedi ci ne		0				1 0	23. 50
24. 00	Total (sum of lines 1-23)	l ő	0			0 -769, 613	1, 584, 679	1
25. 00	Cost To Be Allocated (per	0	0	0		0	769, 613	
	Warkahaat II 1 Dant I)	1		I	I	1	I	I

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

Home Health

Agency I CAPI TAL RELATED COSTS DATA ADMITTI NG HHA Trial BLDG & FIXT **EMPLOYEE PURCHASI NG** Cost Center Description Bal ance (1) **BENEFITS** PROCESSI NG RECEIVING AND DEPARTMENT **STORES** 0 1. 00 4.00 5. 01 5. 02 5. 03 1.00 Administrative and General 00 482.835 0 7, 491 8, 316 1.00 2.00 Skilled Nursing Care 1, 321, 880 0 2.00 Physical Therapy 679, 288 0 0 3.00 000000000000000000 0 3.00 Occupational Therapy 169, 396 0 0 o 4.00 4.00 0 Speech Pathology 72, 476 0 5.00 0 5.00 0 6.00 Medical Social Services 4,754 0 0 6.00 7.00 Home Heal th Aide 106, 498 o 7.00 0 0 0 0 0 8 00 Supplies (see instructions) 8 00 0 0 9.00 Drugs C 9.00 10.00 DMF 10.00 11.00 Home Dialysis Aide Services 0 0 0 0 0 11.00 Respiratory Therapy 0 12 00 12 00 13.00 Private Duty Nursing 0 13.00 14.00 0 14.00 Clinic Health Promotion Activities 0 0 15.00 15.00 0 0 0 Day Care Program 16.00 16.00 Ω 17.00 Home Delivered Meals Program 0 0 0 17.00 Homemaker Service 0 18.00 0 0 18.00 All Others (specify) 0 0 19 00 0 19 00 C 0 19.50 Tel emedi ci ne 0 0 0 19.50 Total (sum of lines 1-19) (2) 2, 354, 292 482, 835 7, 491 8, 316 20.00 20.00 21.00 Unit Cost Multiplier: column 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places CASHI ERI NG/AC OPERATION OF LAUNDRY & Cost Center Description Subtotal OTHER A&G PATI ENT COUNTS TRANSPORTATI O PLANT LINEN SERVICE RECEI VABLE 5.05 5.06 7. 00 8.00 5. 04 5A. 04 1.00 Administrative and General 14, 677 513, 319 57, 477 1.00 2.00 Skilled Nursing Care 0 1, 321, 880 148, 014 0 0 2.00 0 0 0 0 0 0 0 0 0 0 0 0 0 Physical Therapy 3.00 0 679, 288 76,061 0 3 00 0 4.00 Occupational Therapy 169, 396 18, 968 4.00 5.00 Speech Pathology 0 72, 476 8, 115 0 5.00 0 6.00 Medical Social Services 0 4, 754 532 0 6.00 0 7.00 Home Health Aide 106, 498 11, 925 7.00 8.00 0 Supplies (see instructions) 8.00 9.00 0 9.00 Drugs 0 0 0 10.00 DMF 0 0 10.00 11.00 Home Dialysis Aide Services 0 C 0 11.00 12.00 Respiratory Therapy 0 12.00 0 13.00 Private Duty Nursing 0 0 0 13.00 0 0 14.00 Clinic C 14.00 15.00 Health Promotion Activities C 15.00 0 0 0 16.00 Day Care Program 0 0 0 16.00 0 Home Delivered Meals Program 17.00 0 17.00 0 0 18.00 Homemaker Service C 18.00 19.00 All Others (specify) 0 0 0 0 19.00 19.50 Tel emedi ci ne 0 19.50 20.00 20 00 Total (sum of lines 1-19) (2) 14.677 2 867 611 321, 092 0 21.00 Unit Cost Multiplier: column 0.000000 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.

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

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20 00

21.00

Drugs

Clinic

Home Dialysis Aide Services

Health Promotion Activities

Home Delivered Meals Program

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

Unit Cost Multiplier: column

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

Respiratory Therapy

Private Duty Nursing

Day Care Program

Homemaker Service

6 decimal places.

Tel emedi ci ne

All Others (specify)

DMF

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

Provider CCN: 15-0002 Worksheet H-2 From 01/01/2017 Part I Date/Time Prepared: HHA CCN: 15-7536 12/31/2017 To 5/30/2018 8: 22 am Home Health PPS Agency I PARAMED ED Allocated HHA Total HHA Cost Center Description Subtotal Intern & Subtotal A&G (see Part PROGRAM Resi dents Costs Cost & Post II) Stepdown Adjustments 23. 00 24. 00 25. 00 26.00 27. 00 28. 00 Administrative and General 1.00 0 595, 434 595, 434 1.00 1, 804, 216 2.00 Skilled Nursing Care 1, 469, 894 1, 469, 894 334, 322 2.00 3.00 Physical Therapy 0 755, 349 755, 349 171, 802 927, 151 3.00 Occupational Therapy 0 188, 364 0 188, 364 42, 843 231, 207 4.00 4.00 0 Speech Pathology 80, 591 98, 921 5.00 5.00 80, 591 18, 330 6.00 Medical Social Services 5, 286 0 5, 286 1, 202 6, 488 6.00 26, 935 7.00 Home Health Aide 118, 423 118, 423 145, 358 7.00 Supplies (see instructions) 0 0 0 8.00 8 00 0 0 0 0 0 9.00 Drugs 0 9.00 10.00 DMF 0 10.00 0 0 11.00 Home Dialysis Aide Services 0 0 0 0 0 0 0000000 0 11.00 0 Respiratory Therapy 0 0 12.00 12.00 Private Duty Nursing 13.00 0 0 13.00 14.00 Clinic 0 14.00 Health Promotion Activities 15.00 0 0 0 15.00 0 0 16.00 Day Care Program 16.00 17.00 Home Delivered Meals Program 0 0 17.00 Homemaker Service 0 0 o 18.00 0 0 0 0 18.00 All Others (specify) 0 0 0 o 19.00 19 00 19.50 Tel emedi ci ne 0 0 0 0 19.50 20.00 Total (sum of lines 1-19) (2) 3, 213, 341 3, 213, 341 595, 434 3, 213, 341 20.00 21.00 Unit Cost Multiplier: column 0.227447 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.

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

Peri od: Worksheet H-2
From 01/01/2017
To 12/31/2017 Date/Time Prepared: 5/30/2018 8: 22 am BASIS HHA CCN: 15-7536 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 01	REQUISITIONS)	F 00	CHARGES)	
1. 00	Administrative and General	1.00	4. 00 2, 012, 787	5. 01 0	5. 02 85, 950	5. 03 3, 342, 486	5. 04 3, 342, 486	1.00
2. 00	Skilled Nursing Care	0	2,012,787	0	05, 750	3, 342, 460	3, 342, 460	2.00
3. 00	Physical Therapy	0	0	0	0	0		3.00
4. 00	Occupational Therapy	, o	0	0	0	0		4. 00
5. 00	Speech Pathology	0	Ö	Ö	Ö	Ö	l ol	5. 00
6.00	Medical Social Services	0	0	O	O	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	0	10.00
11. 00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0		_	_	0	12.00
13.00	Private Duty Nursing	0	0	1	1	_	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15. 00 16. 00	Health Promotion Activities Day Care Program	0	0	0		0	0	15. 00 16. 00
17. 00	Home Delivered Meals Program		0	0		0		17.00
18. 00	Homemaker Service	0	0	0		0		18. 00
19. 00	All Others (specify)	0	0	0	0	0		19. 00
19. 50	Tel emedi ci ne	0	0	0	Ö	0		19. 50
20. 00	Total (sum of lines 1-19)	o o	2, 012, 787	Ö	85, 950	3, 342, 486	3, 342, 486	20.00
21. 00	Total cost to be allocated	0	482, 835	O	7, 491			21.00
22. 00	Unit cost multiplier	0. 000000	0. 239884	0. 000000	0. 087155	0. 002488	0. 004391	22.00
			0. 207001		0.007133	0.002400	0.004371	22.00
	Cost Center Description	Reconciliatio	OTHER A&G	PATI ENT	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	22.00
	Cost Center Description			PATI ENT TRANSPORTATI O	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	22.00
	Cost Center Description	Reconciliatio	OTHER A&G	PATI ENT TRANSPORTATI O N	OPERATION OF	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG	22.00
	Cost Center Description	Reconciliatio	OTHER A&G	PATIENT TRANSPORTATIO N (NUMBER OF	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	22.00
	Cost Center Description	Reconciliatio n	OTHER A&G (ACCUM. COST)	PATIENT TRANSPORTATIO N (NUMBER OF TRIPS)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	22.00
1.00	Cost Center Description  Administrative and General	Reconciliatio	OTHER A&G	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06	OPERATION OF PLANT (SQUARE FEET) 7.00	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG	1.00
1. 00 2. 00	·	Reconciliatio n 5A. 05	OTHER A&G (ACCUM. COST)	PATIENT TRANSPORTATIO N (NUMBER OF TRIPS) 5.06	OPERATION OF PLANT (SQUARE FEET)  7.00	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET) 9.00	
	Administrative and General	Reconciliatio n 5A. 05	OTHER A&G (ACCUM. COST) 5. 05 513, 319	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06	OPERATION OF PLANT (SQUARE FEET)  7.00	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)  9.00	1.00
2. 00 3. 00 4. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy	Reconciliatio n 5A. 05	OTHER A&G (ACCUM. COST)  5. 05  513, 319  1, 321, 880  679, 288  169, 396	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06	OPERATION OF PLANT (SQUARE FEET)  7.00  0 0 0 0	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	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	Reconciliatio n 5A. 05	OTHER A&G (ACCUM. COST)  5. 05  513, 319 1, 321, 880 679, 288 169, 396 72, 476	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06  0 0 0 0	OPERATION OF PLANT (SQUARE FEET)  7.00  0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0 0 0 0 0 0	9.00  9.00  0 0 0 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	Reconciliatio n 5A. 05	5. 05 513, 319 1, 321, 880 679, 288 169, 396 72, 476 4, 754	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06	OPERATION OF PLANT (SQUARE FEET)  7.00  0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0 0 0 0 0 0	9.00  9.00  0 0 0 0 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	Reconciliatio n 5A. 05	OTHER A&G (ACCUM. COST)  5. 05  513, 319 1, 321, 880 679, 288 169, 396 72, 476	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06  0 0 0 0	OPERATION OF PLANT (SQUARE FEET)  7.00  0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0 0 0 0 0 0	9.00  9.00  0 0 0 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)	Reconciliatio n 5A. 05	5. 05 513, 319 1, 321, 880 679, 288 169, 396 72, 476 4, 754	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06  0 0 0 0	OPERATION OF PLANT (SQUARE FEET)  7.00  0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0 0 0 0 0 0	9.00  9.00  0 0 0 0 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	Reconciliatio n 5A. 05	5. 05 513, 319 1, 321, 880 679, 288 169, 396 72, 476 4, 754	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06  0 0 0 0	OPERATION OF PLANT (SQUARE FEET)  7.00  0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0 0 0 0 0 0	9.00  9.00  0 0 0 0 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	Reconciliatio n 5A. 05	5. 05 513, 319 1, 321, 880 679, 288 169, 396 72, 476 4, 754	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06  0 0 0 0	OPERATION OF PLANT (SQUARE FEET)  7.00  0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0 0 0 0 0 0	9.00  9.00  0 0 0 0 0 0 0 0 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services	Reconciliatio n 5A. 05	5. 05 513, 319 1, 321, 880 679, 288 169, 396 72, 476 4, 754	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06  0 0 0 0	OPERATION OF PLANT (SQUARE FEET)  7.00  0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0 0 0 0 0 0	9.00  9.00  0 0 0 0 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
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Heal th Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy	Reconciliatio n 5A. 05	5. 05 513, 319 1, 321, 880 679, 288 169, 396 72, 476 4, 754	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06  0 0 0 0	OPERATION OF PLANT (SQUARE FEET)  7.00  0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0 0 0 0 0 0	9.00  9.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	Reconciliatio n 5A. 05	5. 05 513, 319 1, 321, 880 679, 288 169, 396 72, 476 4, 754	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06  0 0 0 0	OPERATION OF PLANT (SQUARE FEET)  7.00  0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0 0 0 0 0 0	9.00  9.00  0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	Reconciliatio n 5A. 05	5. 05 513, 319 1, 321, 880 679, 288 169, 396 72, 476 4, 754	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06  0 0 0 0	OPERATION OF PLANT (SQUARE FEET)  7.00  0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0 0 0 0 0 0	9.00  9.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	Reconciliatio n 5A. 05	0THER A&G (ACCUM. COST)  5. 05 513, 319 1, 321, 880 679, 288 169, 396 72, 476 4, 754 106, 498 0 0 0 0 0 0 0 0	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06  0 0 0 0	OPERATION OF PLANT (SQUARE FEET)  7.00  0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0 0 0 0 0 0	9.00  9.00  0 0 0 0 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
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	Reconciliatio n 5A. 05	0THER A&G (ACCUM. COST)  5. 05 513, 319 1, 321, 880 679, 288 169, 396 72, 476 4, 754 106, 498 0 0 0 0 0 0 0 0	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06  0 0 0 0	OPERATION OF PLANT (SQUARE FEET)  7.00  0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0 0 0 0 0 0	9.00  9.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	Reconciliatio n 5A. 05	0THER A&G (ACCUM. COST)  5. 05 513, 319 1, 321, 880 679, 288 169, 396 72, 476 4, 754 106, 498 0 0 0 0 0 0 0 0	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06  0 0 0 0	OPERATION OF PLANT (SQUARE FEET)  7.00  0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0 0 0 0 0 0	9.00  9.00  0 0 0 0 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
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	Reconciliatio n 5A. 05	0THER A&G (ACCUM. COST)  5. 05 513, 319 1, 321, 880 679, 288 169, 396 72, 476 4, 754 106, 498 0 0 0 0 0 0 0 0	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06  0 0 0 0	OPERATION OF PLANT (SQUARE FEET)  7.00  0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0 0 0 0 0 0	9.00  9.00  0 0 0 0 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 19. 50	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	Reconciliatio n 5A. 05	0THER A&G (ACCUM. COST)  5. 05 513, 319 1, 321, 880 679, 288 169, 396 72, 476 4, 754 106, 498 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06  0 0 0 0	OPERATION OF PLANT (SQUARE FEET)  7.00  0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0 0 0 0 0 0	9.00  9.00  0 0 0 0 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 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19)	Reconciliatio n 5A. 05	5. 05 513, 319 1, 321, 880 679, 288 169, 396 72, 476 4, 754 106, 498 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	PATI ENT TRANSPORTATI 0 N (NUMBER OF TRI PS) 5. 06	OPERATION OF PLANT (SQUARE FEET)  7.00  0 0 0 0 0 0 0	LAUNDRY & 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 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 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	Reconciliatio n 5A. 05	0THER A&G (ACCUM. COST)  5. 05 513, 319 1, 321, 880 679, 288 169, 396 72, 476 4, 754 106, 498 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	PATI ENT TRANSPORTATI 0 N (NUMBER OF TRI PS) 5. 06	7.00  7.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)  8.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00  9.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00

| In Lieu of Form CMS-2552-10 | Worksheet H-2 | Part II | Date/Time Prepared: | 5/30/2018 8:22 am Peri od: From 01/01/2017 To 12/31/2017 BASIS HHA CCN: 15-7536

						Home Health Agency I	PPS	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(MEALS	(PRODUCTI VE	ADMI NI STRATI O	SERVICES &	(COSTED	RECORDS &	
		SERVED)	HOURS)	N N	SUPPLY	REQUIS.)	LI BRARY	
				(DI RECT NURS.	(COSTED		(GROSS	
		10. 00	11. 00	HRS. ) 13. 00	REQUI S. ) 14. 00	15. 00	CHARGES) 16.00	
1. 00	Administrative and General	0	0			11, 044	3, 342, 486	1. 00
2. 00	Skilled Nursing Care	o	0	0		0	0	2.00
3.00	Physi cal Therapy	O	0	0	0	0	o	3.00
4.00	Occupational Therapy	0	0	0	0	0	O	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6. 00	Medical Social Services	0	0	0		0	0	6.00
7. 00	Home Health Aide	0	0	0		0	0	7.00
8. 00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9. 00 10. 00	Drugs DME	0	0	0	0	0	0	9. 00 10. 00
11. 00	Home Dialysis Aide Services	0	0	0	0	0	0	11. 00
12. 00	Respiratory Therapy		0	0		0	Ö	12. 00
13. 00	Private Duty Nursing	o	0	0		0	Ö	13. 00
14.00	Clinic	0	0	0	0	0	О	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 20. 00	Telemedicine Total (sum of lines 1-19)	0	0	0	0	11, 044	3, 342, 486	19. 50 20. 00
21. 00	Total (sum of filles 1-17) Total cost to be allocated	0	0	0	0	4, 984	11, 649	
22. 00	Unit cost multiplier	0. 000000	0. 000000	-			0. 003485	
					INTERNS &			
	Cost Center Description	SOCI AL	STAFF	MEDI CAL	SERVI CES-SALA		PARAMED ED	
		SERVI CE	EDUCATION	EDUCATION	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, 729			0	0	1. 00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0		0	0	3.00
4. 00	Occupational Therapy	0	0	0		0	0	4. 00
5.00	Speech Pathology	0	0	0		0	0	5.00
6. 00 7. 00	Medical Social Services Home Health Aide	0	0	0	· ·	0	0	6. 00 7. 00
8. 00	Supplies (see instructions)	0	0	0		0	0	8. 00
9. 00	Drugs		0	0	0	0	Ö	9. 00
10.00	DME	o	0	Ö	· ·	0	o	10.00
11. 00	Home Dialysis Aide Services	o	0	0	0	0	o	11.00
12.00	Respi ratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
	Clinic	0	0	0		_	0	
	Health Promotion Activities	0	0	0		0	0	
16. 00 17. 00	Day Care Program Home Delivered Meals Program	0	0	0	· ·	0	0	16. 00 17. 00
	Homemaker Service	0	0	0	0	0	0	18.00
19. 00	All Others (specify)		0	0	0		o	19. 00
19. 50	Tel emedicine	ا	0	ا م	0	o o	o	19. 50
	rerelledici ile	l Oi	U	0				
20.00	Total (sum of lines 1-19)	0	1, 729	Ö	· ·	0	0	20.00
21. 00		0.000000	1, 729 8, 005 4. 629844	0	0	0	0 0 0. 000000	21.00

	Financial Systems		METHODIST HOS		1-		u of Form CMS-2	
APPORT	TIONMENT OF PATIENT SERVICE COS	ΓS		Provi der C		Period: From 01/01/2017	Worksheet H-3 Part I	
				HHA CCN:		Γο 12/31/2017		pared:
-				Title	xVIII	Home Health Agency I	PPS	<u> 2 alii                                 </u>
	Cost Center Description	From, Wkst.	Facility	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I,	Costs (from	Ancillary	Costs (cols.		Per Visit	
		col. 28, line	Wkst. H-2,	Costs (from	1 + 2)		(col. 3 ÷	
			Part I)	Part II)	2.00	4.00	col . 4)	
	PART I - COMPUTATION OF LESSER	0	1. 00	2.00	3.00	4.00	5. 00	
	COST LIMITATION	UF AGGREGATE	PRUGRAM CUST, A	AGGREGATE OF TI	HE PRUGRAW LIW	II IAITUN COSI, C	JR BENEFICIARY	
	Cost Per Visit Computation							İ
1.00	Skilled Nursing Care	2.00	1, 804, 216		1, 804, 210	12, 057	149. 64	1.00
2.00	Physical Therapy	3.00	927, 151	0	927, 15°	5, 082	182. 44	2.00
3.00	Occupational Therapy	4.00	231, 207	0	231, 20	1, 148	201. 40	3.00
4.00	Speech Pathology	5.00			, 0, , 2			
5.00	Medical Social Services	6.00			6, 488			
6.00	Home Health Aide	7.00			145, 358			6.00
7. 00	Total (sum of lines 1-6)		3, 213, 341		0/2:0/0:			7.00
					Program Visits	6		
			I		Pa	rt B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject	Subject to		
	cost center bescription	COST LIMITS	CDSA NO. (1)	l lait A	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				10.00
11. 00	Speech Pathology		23844	0	89			11.00
12.00	Medical Social Services		23844	0	10			12.00
13.00	Home Heal th Ai de		23844	0	, , ,			13.00
14.00	Total (sum of lines 8-13)  Cost Center Description	From Wkst.	Facility	Shared	7,434 Total HHA		Ratio (col. 3	14.00
	cost center bescription	H-2 Part I,	Costs (from	Ancillary	Costs (cols.	(from HHA	÷ col. 4)	
		col. 28, line	Wkst. H-2,	Costs (from	1 + 2)	Records)	- (01. 4)	
		20, 11116	Part I)	Part II)	1 + 2)	Records)		
		0	1. 00	2.00	3. 00	4. 00	5. 00	
	Supplies and Drugs Cost Comput	ati ons						
	Cost of Medical Supplies	8. 00				0		
16. 00	Cost of Drugs	9. 00				0	0. 000000	16.00
			Program Visits		Cost of			
			Don	t B	Servi ces	Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
	cost center bescription	rait A	to	Deductibles &	rait A	to	Deductibles &	
						Deductibles &		
			Coi nsurance	COI IISUI UIICC		Coi nsurance	COI IISUI UIICC	
		6. 00	7. 00	8.00	9. 00	10. 00	11.00	
	PART I - COMPUTATION OF LESSER							
	COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0				564, 143		1.00
2.00	Physi cal Therapy	0	_,			384, 766		2.00
3.00	Occupational Therapy	0	517			104, 124		3.00
4.00	Speech Pathology	0	89			33, 223		4.00
5.00	Medical Social Services	0	16	l .	1	1, 996		5.00
6.00	Home Heal th Ai de	0	933		•	55, 084		6.00
7. 00	Total (sum of lines 1-6)	0	7, 434	1	Ι (	1, 143, 336	l l	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	CN: 15-0002	Peri od:	Worksheet H-3	
				HHA CCN:	15-7536	From 01/01/2017 To 12/31/2017	Part I Date/Time Pre 5/30/2018 8:2	epared: 22 am
				Title	XVIII	Home Health	PPS	
	Cost Center Description					Agency I		
	cost center bescription	6. 00	7. 00	8.00	9. 00	10.00	11.00	
	Limitation Cost Computation	0.00	7.00	0.00	7.00	10.00	11.00	
8.00	Skilled Nursing Care							8.00
9.00	Physi cal Therapy							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
14.00	Total (sum of lines 8-13)	_			2			14.00
		Progi	ram Covered Ch	arges	Cost of			
					Servi ces			
			Par	t B		Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
	5551 551151 55551 Pt. 51.	'''	to	Deductibles &		to	Deductibles &	
			Deductibles &			Deductibles &	Coi nsurance	
			Coi nsurance			Coi nsurance		
		6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
	Supplies and Drugs Cost Comput							1
	Cost of Medical Supplies	0				0 0		
16. 00	Cost of Drugs	<b>+</b>	C	0		0	C	16.00
	Cost Center Description	Total Program						
		Cost (sum of cols. 9-10)						
		12. 00						1
	PART I - COMPUTATION OF LESSER		PROGRAM COST	AGGREGATE OF TH	HE PROGRAM I	IMITATION COST (	DR BENEFICIARY	
	COST LIMITATION	01 710011207112						
	Cost Per Visit Computation							1
1.00	Skilled Nursing Care	564, 143						1.00
2.00	Physi cal Therapy	384, 766						2.00
3.00	Occupational Therapy	104, 124						3.00
4.00	Speech Pathology	33, 223						4.00
5.00	Medical Social Services	1, 996						5. 00
6. 00	Home Heal th Ai de	55, 084						6.00
7. 00	Total (sum of lines 1-6)	1, 143, 336						7.00
	Cost Center Description	12.00						-
	Limitation Cost Computation	12. 00						
8. 00	Skilled Nursing Care							8.00
9. 00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11. 00	Speech Pathology							11.00
12. 00	Medical Social Services							12.00
13. 00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00
								-

Heal th	Financial Systems		METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
APP0R1	TIONMENT OF PATIENT SERVICE COST	ΓS		Provi der C	CN: 15-0002	Peri od:	Worksheet H-3	
				HHA CCN:	15-7536	From 01/01/2017 To 12/31/2017	Part II Date/Time Pre	
				T1.11	\0.41.1.		5/30/2018 8: 2	<u>2 am</u>
				litle	: XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Charge Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1. 00	2. 00	3.00	4. 00		
	PART II - APPORTIONMENT OF COS	T OF HHA SERVI	CES FURNISHED E	BY SHARED HOSP	TAL DEPARTME	ENTS		
1.00	Physi cal Therapy	66.00	0. 404138	0		0 col. 2, line 2	. 00	1.00
2.00	Occupational Therapy	67.00	0. 399363	0		0 col. 2, line 3	. 00	2.00
3.00	Speech Pathology	68. 00	0. 367009	0		0 col. 2, line 4	. 00	3.00
4.00	Cost of Medical Supplies	71.00	0. 344888	0		0 col. 2, line 1	5. 00	4.00
5.00	Cost of Drugs	73.00	0. 151256	0		0 col. 2, line 1	6. 00	5.00

	Financial Systems METHODIST  ATION OF HHA REIMBURSEMENT SETTLEMENT	HOSPITALS, INC Provider CO	CN: 15-0002	Pc	eri od:	u of Form CMS-2 Worksheet H-4	
LOOL	STITUTE OF THE REPORT OF THE PROPERTY OF THE P	HHA CCN:	15-7536		om 01/01/2017	Part I-II Date/Time Pre	pare
		Title	XVIII		Home Health Agency I	5/30/2018 8: 2 PPS	2 am
				<u> </u>	Par		
			Part A		Not Subject to Deductibles &	Subject to Deductibles & Coinsurance	
			1. 00		Coi nsurance 2. 00	3. 00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OF	R CUSTOMARY CHARGE			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 payments	ent for services		0	0	0	3.
	on a charge basis (from your records)						
.00	Amount that would have been realized from patients liab for services on a charge basis had such payment been may with 42 CFR §413.13(b)			0	0	0	4
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 only if line 6 exceeds line 1)	cost (complete		0	0	0	7
00	Excess of reasonable cost over customary charges (complet exceeds line 6)	ete only if line		0	0	0	8
00	Primary payer amounts			0	0	0	9
				_	Part A Services 1.00	Part B Services 2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT						
. 00	Total reasonable cost (see instructions)	-			0	000 007	
. 00	Total PPS Reimbursement - Full Episodes without Outlier: Total PPS Reimbursement - Full Episodes with Outliers	5			0	999, 887 52, 945	
. 00	Total PPS Reimbursement - LUPA Episodes				Ö	28, 936	
. 00	Total PPS Reimbursement - PEP Epi sodes				o	23, 226	
. 00	Total PPS Outlier Reimbursement - Full Episodes with Ou	tliers			0	16, 829	
. 00	Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments				0	645	
. 00	DME Payments				Ö	0	18
. 00	Oxygen Payments				0	0	19
. 00	Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude	coi neuranco)			0	0	20
. 00		corrisur ance)			o	1, 122, 468	
. 00	Excess reasonable cost (from line 8)				Ö	0	
. 00	Subtotal (line 22 minus line 23)				0	1, 122, 468	24
. 00	Coinsurance billed to program patients (from your record	ds)				0	
. 00	Net cost (line 24 minus line 25) Reimbursable bad debts (from your records)				0	1, 122, 468	26
. 00	, , ,	(see instructions	)				28
. 00	Total costs - current cost reporting period (line 26 pl				О	1, 122, 468	
. 00	OTHER				0	83	
. 50	Pioneer ACO demonstration payment adjustment (see instru				0	0	
. 99	Demonstration payment adjustment amount before sequestral Subtotal (see instructions)	ati UII			0	0 1, 122, 551	
. 01	Sequestration adjustment (see instructions)				o	22, 451	
1. 02	Demonstration payment adjustment amount after sequestra	ti on			0	0	31
2. 00	Interim payments (see instructions)				0	1, 100, 099	
3. 00	Tentative settlement (for contractor use only)	22 and 22)			0	0	33
	Balance due provider/program (line 31 minus lines 31.01	, 32, and 33)			0	1	34
1. 00 5. 00	Protested amounts (nonallowable cost report items) in a	ccordance with CMS	S Pub 15_2	J	Λl	0	35

Health Financial Systems	METHODIST HOSPIT	TALS, INC		In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED TO PROGRAM BENEFICIARIES	HHAS FOR SERVICES RENDERED	Provider (	CCN: 15-0002 15-7536	Peri od: From 01/01/2017 To 12/31/2017	Worksheet H-5 Date/Time Prepared: 5/30/2018 8:22 am
					07 007 20 10 0. 22 dill

				5/30/2018 8: 2	2 am
			Home Health	PPS	
	1	. 5	Agency I	1 5	
	Inpatien	t Part A	Par	rt B	
	mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	1.00	2.00	3. 00	4. 00	
.00 Total interim payments paid to provider	1.00	2.00	0	1, 100, 099	1. (
.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for			0	0	2. (
services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
Oliginary 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.
payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
01			0	0	3.
02			o	0	3.
03			0	0	3.
04			0	0	3.
05			0	0	3.
Provider to Program			_1		_
50 51			0	0	3
52			0		3
53			0	0	3
54			o	0	3
99 Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3
3. 50-3. 98)					
OD Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate,			0	1, 100, 099	4.
TO BE COMPLETED BY CONTRACTOR					
OD List separately each tentative settlement payment after					5
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3
Program to Provider					
01			0	0	5
02			0	0	5
Provider to Program			0	0	5
50			0	0	5
51			o	0	5
52			Ö	0	5
99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5
Determined net settlement amount (balance due) based on the cost report. (1)					6
O1 SETTLEMENT TO PROVIDER			0	1	6
O2 SETTLEMENT TO PROGRAM			0	0	6
OO   Total Medicare program liability (see instructions)			Contractor	1, 100, 100 NPR Date	7
			Contractor Number	(Mo/Day/Yr)	
OO News of Contractor	-	)	1. 00	2. 00	8
00 Name of Contractor	1		I	1 1	?

CALCUL	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0002	Peri od: From 01/01/2017 To 12/31/2017	Worksheet L Parts I-III Date/Time Pre	
		Title XVIII	Hospi tal	5/30/2018 8: 2 PPS	2 am
		1 1113 7111	noop: tai	1.10	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				]
1.00	Capital DRG other than outlier			3, 752, 656	1.0
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1.0
2. 00	Capital DRG outlier payments			5, 736	2.0
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2.0
3. 00	Total inpatient days divided by number of days in the	cost reporting period (see ins	tructions)	229. 31	3.0
1.00	Number of interns & residents (see instructions)	`		2. 95	4.0
5.00	Indirect medical education percentage (see instruction			0. 36	5.0
5. 00	Indirect medical education adjustment (multiply line 5 1.01) (see instructions)	•		13, 510	
'. 00	Percentage of SSI recipient patient days to Medicare F 30) (see instructions)	, , , , , , , , , , , , , , , , , , , ,	E, part A line	10. 92	7.0
3. 00	Percentage of Medicaid patient days to total days (see	e instructions)		31. 51	8.0
. 00	Sum of lines 7 and 8			42. 43	9.0
0.00	Allowable disproportionate share percentage (see instr	ructions)		8. 97	
1.00	Disproportionate share adjustment (see instructions)			336, 613	
2. 00	Total prospective capital payments (see instructions)			4, 108, 515	12.0
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST			1.00	
. 00	Program inpatient routine capital cost (see instruction	ons)		0	1.0
. 00	Program inpatient ancillary capital cost (see instruct			0	2.0
3. 00	Total inpatient program capital cost (line 1 plus line			0	3.0
1. 00	Capital cost payment factor (see instructions)			0	4.0
5. 00	Total inpatient program capital cost (line 3 x line 4)	<u> </u>		0	5.0
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
. 00	Program inpatient capital costs (see instructions)			0	1.0
2. 00	Program inpatient capital costs for extraordinary circ			0	2.0
3. 00	Net program inpatient capital costs (line 1 minus line	2)		0	3.0
. 00	Applicable exception percentage (see instructions)			0. 00	4.0
. 00	Capital cost for comparison to payments (line 3 x line			0	5.0
. 00	Percentage adjustment for extraordinary circumstances	,	1: ()	0.00	6. (
. 00 . 00	Adjustment to capital minimum payment level for extract	ordinary circumstances (line 2	x line 6)	0	7. 0 8. 0
. 00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, a	os applicable)		0	9.0
0. 00	Current year comparison of capital minimum payment lev	11 /	loss lino 0)	0	10.0
1. 00	Carryover of accumulated capital minimum payment level			0	11. (
1.00	Worksheet L, Part III, Line 14)	over capital payment (110m pr	i oi yeai	U	' ' ' '
12.00	Net comparison of capital minimum payment level to cap	oital payments (line 10 plus li	ne 11)	0	12.0
13. 00	Current year exception payment (if line 12 is positive			0	13.0
4. 00	Carryover of accumulated capital minimum payment level			0	14.0
	(if line 12 is negative, enter the amount on this line		3 1 2 2	-	
15. 00	,			0	15. (
13.00					
	Current year operating and capital costs (see instruct	i ons)		0	16. (