	s required by law (42 USC 1395g; 42 CFR 413.20(b)). Fai since the beginning of the cost reporting period being			FORM APPROVED OMB NO. 0938-0050 EXPIRES 05-31-2019
HOSPITAL AND H AND SETTLEMENT	HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION SUMMARY	Provi der CCN: 15-0002	Peri od: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/28/2019 4:50 pm
PART I - COST	REPORT STATUS			
Provi der use onl y	1. [X]Electronically filed cost report 2. []Manually submitted cost report 3. [0]If this is an amended report enter the number 4. [F]Medicare Utilization. Enter "F" for full or "		Date: 5/28/20 resubmitted this c	
Contractor use only	5. [1]Cost Report Status 6. Date Received: (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for (3) Settled with Audit 9. [N] Final Report for (4) Reopened	11.0 or this Provider CCN 12.[or Code: 4 Jumn 1 is 4: Enter des reopened = 0-9.

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 01/01/2018 and ending 12/31/2018 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)
Ti tl	e
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	560, 434	-90, 925	0	-1, 095, 452	1.00
2.00	Subprovi der - IPF	0	33, 997	0		-58, 947	2.00
3.00	Subprovi der - I RF	0	10, 645	0		37, 787	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	605, 076	-90, 924	0	-1, 116, 612	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.

Health Financial Systems METHODIST HOSPITALS, INC In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0002 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/28/2019 4:50 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 600 GRANT STREET 1.00 1.00 PO Box: State: IN 2.00 City: GARY Zi p Code: 46402 County: LAKE 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 METHODIST HOSPITALS. 150002 23844 01/01/1966 Ν 0 3.00 1 I NC Subprovi der - IPF GERIATRIC PSYCH 01/01/2012 4.00 15S002 23844 4 Ν Ρ 0 4.00 5.00 Subprovi der - IRF REHABI LI TATI ON 15T002 23844 5 01/01/1984 Р 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospital -Based HHA METHODIST HOME CARE 157536 23844 02/12/2002 Ν Ρ 0 12.00 SERVI CES 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce 14 00 14 00 15.00 Hospital -Based Health Clinic - RHC 15.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2 00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2018 12/31/2018 20.00 21.00 Type of Control (see instructions) 21.00 2 1.00 2. 00 3.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for 22.00 Ν 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care 22.02 Ν Ν payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν N 22 03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as

	counted in accordance with 42 CFR 412.105)? Enter in ves or "N" for no.	column 3,	"Y" for					
23. 00	Which method is used to determine Medicaid days on I	ines 24 and	d/or 25		3 1	v l		23. 00
	below? In column 1, enter 1 if date of admission, 2							
	if date of discharge. Is the method of identifying t							
	reporting period different from the method used in t	he prior co	st					
	reporting period? In column 2, enter "Y" for yes or	"N" for no).					
		In-State	In-State	Out-of	Out-of	Medicaic		
		Medi cai d	Medicaid	State	State	HMO days		
		paid days	, ,	Medi cai d	Medi cai d		days	
			unpai d	paid days	eligible			
			days		unpai d			
	1	1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
24. 00	If this provider is an IPPS hospital, enter the	2, 933	9, 072	595	678	13, 35	55 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							
	4, Medicaid HMO paid and eligible but unpaid days in							
	column 5, and other Medicaid days in column 6.							
	0 45 5 477 4							
MCRIF3	2 - 15. 5. 166. 1							

Health Financial Systems METHODI	ST HOSPITA	LS, INC			In Lieu	u of Form	n CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA I	Provi der CC	Period:	Period: Worksheet S-2 From 01/01/2018 Part I				
						Date/Ti 5/28/20		
	In-State	In-State	Out-of	Out-of	Medi ca		her	O pili
	Medicaid paid days	Medicaid eligible	State Medicaid	State Medi cai d	HMO da		caid ays	
	paru uays	unpaid	paid days	el i gi bl e		l u	ays	
		days	. ,	unpai d				
25.00 If this provider is an IRF, enter the in-state	1. 00 116	2. 00 467	3.00	4. 00 0	5. 00	442	00	25. 00
Medicaid paid days in column 1, the in-state	110	407		J		772		25.00
Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state								
Medicaid eligible unpaid days in column 4, Medicaid								
HMO paid and eligible but unpaid days in column 5.				Urban/E	Dural S	Date of	Geogr	
				1.		2.0		
26.00 Enter your standard geographic classification (not was cost reporting period. Enter "1" for urban or "2" for		s at the be	ginning of	the	1			26. 00
27.00 Enter your standard geographic classification (not wa	age) status			st	1			27. 00
reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi			ppl i cabl e,					
35.00 If this is a sole community hospital (SCH), enter the			CH status i	n	0			35. 00
effect in the cost reporting period.				Begi n	ni na:	Endi r	od.	
				1.		2. 0		
36.00 Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent date		script line	36 for num	per			-	36.00
37.00 If this is a Medicare dependent hospital (MDH), enter		er of perio	ds MDH state	us	0			37. 00
is in effect in the cost reporting period. 37.01 Is this hospital a former MDH that is eligible for the	ne MDH tran	nsitional n	avment in					37. 01
accordance with FY 2016 OPPS final rule? Enter "Y" fo								07.01
instructions) 38.00 If line 37 is 1, enter the beginning and ending dates	of MDH et	atus If I	ina 37 is					38. 00
greater than 1, subscript this line for the number of								30.00
enter subsequent dates.				Y/	/NI	Y/N	1	
				1.		2. 0		
39.00 Does this facility qualify for the inpatient hospital					I	N		39. 00
hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet				"""				
accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii	i)? Enter	in column :	2 "Y" for y	es				
or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction	n adjustmer	nt? Enter "	Y" for yes	or N	ı	N		40.00
"N" for no in column 1, for discharges prior to Octol			yes or "N"	for				
no in column 2, for discharges on or after October 1.	(see rns)	ructions)			V	XVIII	XIX	
Dreamastive Downant Cyctom (DDC) Canital					1.00	2.00	3. 00	
Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital paymen	nt for disp	proporti ona	te share in	accordance	e N	Υ	N	45. 00
with 42 CFR Section §412.320? (see instructions)	ntion for	ov+roordi n	any al nauma:	tanasa	l N	N	N	46.00
46.00 Is this facility eligible for additional payment exception pursuant to 42 CFR §412.348(f)? If yes, complete Wks	•		-		N	IN I	N	46. 00
Pt. III.		- 1 - 111/ 6				,		47.00
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS (48.00 Is the facility electing full federal capital payment			,		N N	N N	N N	47. 00 48. 00
Teaching Hospitals		-			-			
56.00 Is this a hospital involved in training residents in or "N" for no.	approved (owie program:	s: Enter "	r ror yes	Y			56.00
57.00 If line 56 is yes, is this the first cost reporting p					N N			57. 00
GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mon								
for yes or "N" for no in column 2. If column 2 is "	r", complet	e Workshee						
"N", complete Wkst. D, Parts III & IV and D-2, Pt. II 58.00 If line 56 is yes, did this facility elect cost reim			ans' servic	es as	N			58. 00
defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	complete V	Vkst. D-5.						
59.00 Are costs claimed on line 100 of Worksheet A? If yes	s, complete	wkst. D-2	, Pt. I. NAHE 413.8	35 Worksh	neet A	Pass-Th	rough	59.00
			Y/N	Li n		Qualific	cation	
						Criter Cod		
			1. 00	2.	00	3. 0		
60.00 Are you claiming nursing and allied health education any programs that meet the criteria under §413.85?			Y					60.00
60.01 If line 60 is yes, complete columns 2 and 3 for each					23. 00	2		60. 01
i nstructi ons)								l

Health Financial Systems METHODI HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		PITALS, INC Provider CC		eri od:	worksheet S-2	
			F	rom 01/01/2018 o 12/31/2018	Part I Date/Time Prep 5/28/2019 4:50	
	Y/N	IME	Direct GME	I ME	Direct GME	
(4.00 D)	1.00	2.00	3. 00	4.00	5. 00	(4.00
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	N			0.00	0.00	61. 00
column 1. (see instructions) 61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61. 01
Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61. 02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61. 03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions).						61. 04
Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61. 05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61. 06
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
61.10 Of the FTEs in line 61.05, specify each new program		1. 00	2. 00	3. 00	4.00	61. 10
specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00		61. 20
					1.00	
ACA Provisions Affecting the Health Resources and Sei 62.00 Enter the number of FTE residents that your hospital				iod for which	0.00	62. 00
your hospital received HRSA PCRE funding (see instructed). 2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC process.	ctions) Teach Jram. (ing Health Cen see instructio	iter (THC) into			62. 01
63.00 Has your facility trained residents in Nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this c			N	63. 00
			Unwei ghted FTEs Nonprovi der Si te 1.00	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Base Year FTE Residents in No	onprovi	der Settings				
period that begins on or after July 1, 2009 and before 64.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	y trai n-prima all no l non-p n colum	ned residents ry care nprovider rimary care n 3 the ratio	0.00	0.00	0.000000	64. 00

	1)): (See The Clastic Grey)				
		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider?	Υ			70.00
	Enter "Y" for yes or "N" for no.				l
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most	N		0	71.00
	recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see				
	42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching				
	program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no.				
	Column 3: If column 2 is Y, indicate which program year began during this cost reporting period.				
	(see instructions)				l
	Inpatient Rehabilitation Facility PPS				l
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF	Υ			75. 00
	subprovider? Enter "Y" for yes and "N" for no.				l

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	ALS, INC Provider CCN: 15-0002			of For		
SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0002	Peri od: From 01/01/ To 12/31/	2018 2018	Workshe Part I Date/Ti 5/28/20	me Pre	epare
			1. 00	2.00	3. 00	1
ON If line 75 is yes: Column 1: Did the facility have an approved recent cost reporting period ending on or before November 15, no. Column 2: Did this facility train residents in a new teach CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. C indicate which program year began during this cost reporting p	2004? Enter "Y" for yes ing program in accordan olumn 3: If column 2 is	or "N" for ce with 42 Y,	N		0	76.
				1.0	00	<u> </u>
Long Term Care Hospital PPS .00 Is this a long term care hospital (LTCH)? Enter "Y" for yes a .00 Is this a LTCH co-located within another hospital for part or "Y" for yes and "N" for no.		ng period? E	inter	N N		80. 81.
TEFRA Providers On Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) T Did this facility establish a new Other subprovider (excluded [5413.40(f)(1)(i)]) Fator "Y" for year and "N" for page [5413.40(f)(1)(i)]			no.	N		85. 86.
\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 10 Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	classified under sectio	n		N		87
		V 1. 00		XI 2		
Title V and XIX Services						
.00 Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.				Y		90
00 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 applic 00 Are title XIX NF patients occupying title XVIII SNF beds (dual	able column.	N		N N		91
instructions) Enter "Y" for yes or "N" for no in the applicable 00 Does this facility operate an ICF/IID facility for purposes of	e column.	N		N		93
"Y" for yes or "N" for no in the applicable column. OD Does title V or XIX reduce capital cost? Enter "Y" for yes, an		N		N		94
applicable column. On If line 94 is "Y", enter the reduction percentage in the appli On Does title V or XIX reduce operating cost? Enter "Y" for yes o	cable column.	0. 00 N		O. O N	00	95 96
applicable column. On If line 96 is "Y", enter the reduction percentage in the appli to Does title V or XIX follow Medicare (title XVIII) for the integration of the property of the stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for a standard of the property of the propert	rns and residents post	0. 00 Y		0. 0 Y		97
<pre>column 1 for title V, and in column 2 for title XIX. 01 Does title V or XIX follow Medicare (title XVIII) for the repo C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for titl title XIX.</pre>				Υ		98
O2 Does title V or XIX follow Medicare (title XVIII) for the calc bed 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
O3 Does title V or XIX follow Medicare (title XVIII) for a critic reimbursed 101% of inpatient services cost? Enter "Y" for yes for title V, and in column 2 for title XIX.				N		98
O4 Does title V or XIX follow Medicare (title XVIII) for a CAH re outpatient services cost? Enter "Y" for yes or "N" for no in c in column 2 for title XIX.		d N		N		98
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 col column 2 for title XIX.				Υ		98
O6 Does title V or XIX follow Medicare (title XVIII) when cost re 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
.00Does this hospital qualify as a CAH? .00If this facility qualifies as a CAH, has it elected the all-in	clusive method of payme	N nt N				105 106
for outpatient services? (see instructions) .00 If this facility qualifies as a CAH, is it eligible for cost r training 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. 2	eimbursement for I&R . (see instructions) If	N				107
reimbursed. If yes complete Wkst. D-2, Pt. II. B.OO Is this a rural hospital qualifying for an exception to the CR	NA fee schedule? See 4	2 N				108

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der C		eriod: rom 01/01/ o 12/31/		Worksheet S Part I Date/Time F 5/28/2019 4	repared:
_	Physi cal	Occupati onal	Speec		Respi rator	У
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1.00 N	2. 00 N	3. 00 N		4.00 N	109. 00
110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "complete Worksheet E, Part A, lines 200 through 218, and Worapplicable.	'Y" for yes or	"N" for no. I	f yes,	5	1. 00 N	110.00
			1.00		2. 00	
111.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ac for tele-health services.	ost reporting olumn 1 is Y, rticipating in	period? Enter enter the n column 2.	N			111.00
Miscellaneous Cost Reporting Information				1. 00	2.00 3.0	00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percer psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1.	If column 2 nt for long ters) based on 1	is "E", enter erm care (inclu the definition	in column des		0	
116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insurno.			"N" for	N Y		116. 00 117. 00
118.00 Is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	icy? Enter 1			1		118. 00
		Premi ums	Losse	S	Insurance	
		1. 00	2. 00		3. 00	
118.01 List amounts of malpractice premiums and paid losses:		2, 088, 083		0	1, 147, 5	78 118. 01
			1.00		2. 00	
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 119.00 DO NOT USE THIS LINE			N			118. 02
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	n column 1, "\ ualifies for 1	/" for yes or the Outpatient	N		N	120.00
121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.		Ü	Y			121.00
122.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.			N			122.00
						125. 00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	or yes and "N'	' for no. If	N			
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, er	nter the certi		N			126.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	nter the certi 2. ter the certif	fication date	N			
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified heart transplant center, enter in column 2 127.00 If this is a Medicare certified heart transplant center, enter in the column 2 127.00 If this is a Medicare certified heart transplant center, enter in the column 2 127.00 If this is a Medicare certified heart transplant center, enter in the column 2 127.00 If this is a Medicare certified heart transplant center?	nter the certi 2. ter the certif 2. ter the certif	fication date	N			126. 00 127. 00 128. 00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, end in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 column 1 and termination date, if applicable, in column 2.	nter the certi 2. ter the certif 2. ter the certif 2. er the certifi	fication date fication date fication date cation date in				127. 00 128. 00 129. 00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, entering in column 1 and termination date, if applicable, in column 2 column 1 and termination date, if applicable, in column 2 and termination date, if applicab	ter the certiful tenter the certiful tent	fication date fication date fication date cation date in				127. 00 128. 00 129. 00 130. 00
Transplant Center Information 125. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126. 00 If this is a Medicare certified kidney transplant center, end in column 1 and termination date, if applicable, in column 2 127. 00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2 128. 00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 129. 00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.	ther the certiful ter the certiful ter the certiful ter the certiful ter the certiful terter the cumn 2.	fication date fication date fication date cation date in rtification certification				127. 00 128. 00 129. 00 130. 00
Transplant Center Information 125. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126. 00 If this is a Medicare certified kidney transplant center, end in column 1 and termination date, if applicable, in column 2 127. 00 If this is a Medicare certified heart transplant center, end in column 1 and termination date, if applicable, in column 2 128. 00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 2 129. 00 If this is a Medicare certified lung transplant center, end column 1 and termination date, if applicable, in column 2 130. 00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 1 131. 00 If this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in col	ter the certiful terminal	fication date fication date fication date cation date in fification certification fication date				127. 00

lealth Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	METHODIST HOS IDENTIFICATION DATA	Provider CCN	l: 15-0002		d:	wof Form CMS Worksheet S-	
					01/01/2018 12/31/2018	Part I Date/Time Pr 5/28/2019 4:	
					1. 00	2.00	-
40.00 Are there any related organization chapter 10? Enter "Y" for yes or "N					N N	2.00	140. 0
are claimed, enter in column 2 the	home office chain numbe	r. (see instruct					
1.00 If this facility is part of a chair	2. organization enter en		ab 142 +	ho namo c	3. 00	of the home	-
office and enter the home office co			ıgıı 145 ti	ne name a	anu auun ess	or the nome	
41. 00 Name:	Contractor's Name:		Contra	actor's N	lumber:		141.0
42.00 Street:	PO Box:		7: n C	ada.			142.0
43. 00 Ci ty:	State:		Zip Co	ode:			143.0
						1. 00	
44.00 Are provider based physicians' cost	s included in Worksheet	A?				Y	144.0
					1. 00	2. 00	_
45.00 If costs for renal services are cla	nimed on Wkst. A. line 7	4. are the costs	for		Y	2.00	145. C
inpatient services only? Enter "Y" no, does the dialysis facility incl period? Enter "Y" for yes or "N" f	for yes or "N" for no i ude Medicare utilizatio	n column 1. If c	olumn 1 i				
46.00 Has the cost allocation methodology Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/do	changed from the previcolumn 1. (See CMS Pub.) If	N		146. C
47.00Was there a change in the statistic	ral hasis? Enter "V" for	ves or "N" for	no			1. 00 N	147. (
18.00Was there a change in the statistic						N N	148.
19.00 Was there a change to the simplifie						N	149. (
		Part A	Part I		Title V	Title XIX	4
Does this facility contain a provid				lication			
or charges? Enter "Y" for yes or "N	N" for no for each compo			B. (See			455
55.00 Hospi tal 56.00 Subprovi der – TPF		N N	N N		N N	N N	155. (156. (
57. 00 Subprovi der – IRF		N	N		N	N N	157. (
58. 00 SUBPROVI DER							158. 0
59. 00 SNF		N	N		N	N N	159. (
60.00HOME HEALTH AGENCY 61.00CMHC		N	N N		N N	N N	160. (
51. OO OWITE			IN		IN .		101.
Mul ti campus						1.00	
65.00 Is this hospital part of a Multican Enter "Y" for yes or "N" for no.	npus hospital that has o	ne or more campu	ses in di	fferent	CBSAs?	N	165.0
Enter 1 For yes of N For No.	Name	County	State	Zi p 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)						0.0	00166. 0
						1. 00	
Health Information Technology (HIT)	incentive in the Ameri	can Recovery and	Rei nves	tment Act			
57.00 s this provider a meaningful user 58.00 f this provider is a CAH (line 105 reasonable cost incurred for the HI	is "Y") and is a meani	ngful user (line			er the	Y	167. 0 0168. 0
68.01 If this provider is a CAH and is no	ot a meaningful user, do	es this provider			ırdshi p		168. (
exception under §413.70(a)(6)(ii)? 69.00 f this provider is a meaningful us transition factor. (see instruction	ser (line 167 is "Y") an				enter the	9. 9	99169. (
				В	egi nni ng	Endi ng	
70.00Enter in columns 1 and 2 the EHR be	and and and and and	date for the re	norting	10	1. 00 0/01/2017	2. 00 12/30/2017	170. C
period respectively (mm/dd/yyyy)	graming date and ending	date for the re	portring		5, 01, 2011	12/30/201/	170.0

Health Financial Systems	In Lie	u of Form CM	IS-2552-10		
OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0002 Per				Worksheet S	S-2
			From 01/01/2018 To 12/31/2018		Prepared:
			127 017 2010	5/28/2019	
			1. 00	2. 00	
171.00 If line 167 is "Y", does this provider have			N		0 171. 00
section 1876 Medicare cost plans reported o					
"Y" for yes and "N" for no in column 1. If	on				
1876 Medicare days in column 2. (see instru	ıcti ons)				

Heal th	Financial Systems METHODIST HOS	SPITALS, INC		In Lie	u of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Period: From 01/01/2018	Worksheet S-2	
				o 12/31/2018	Date/Time Pre	
				Y/N	5/28/2019 4:5 Date	DO pm
				1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter mm/dd/yyyy format.	N for all NO re	esponses. Ente	r all dates in	the	
	COMPLETED BY ALL HOSPITALS					
1. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to th	o hogi nni ng of	the cost	N		1.00
1.00	reporting period? If yes, enter the date of the change in			IN		1.00
			Y/N 1. 00	Date 2.00	V/I 3. 00	
2. 00	Has the provider terminated participation in the Medicare	Program? If	N N	2.00	3.00	2.00
	yes, enter in column 2 the date of termination and in colu	mn 3, "V" for				
3. 00	voluntary or "I" for involuntary. Is the provider involved in business transactions, includi	ng management	N			3. 00
	contracts, with individuals or entities (e.g., chain home	offices, drug				
	or medical supply companies) that are related to the proviofficers, medical staff, management personnel, or members					
	of directors through ownership, control, or family and oth					
	relationships? (see instructions)		Y/N	Type	Date	
			1. 00	2. 00	3. 00	
4. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cer	tified Dublic	У	A		4.00
4.00	Accountant? Column 2: If yes, enter "A" for Audited, "C"		'	^		4.00
	or "R" for Reviewed. Submit complete copy or enter date av column 3. (see instructions) If no, see instructions.	ailable in				
5. 00	Are the cost report total expenses and total revenues diff	erent from	N			5. 00
	those on the filed financial statements? If yes, submit re	conciliation.		\/ /NI	11 0	
				Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities	16		N.		
6. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	ir yes, is ti	ne provider is	N		6.00
7. 00	Are costs claimed for Allied Health Programs? If "Y" see i			Y		7. 00
8. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	and/or renewed	d during the	Y		8. 00
9. 00	Are costs claimed for Interns and Residents in an approved		cal education	Υ		9. 00
10. 00	program in the current cost report? If yes, see instructio Was an approved Intern and Resident GME program initiated		the current	N		10.00
	cost reporting period? If yes, see instructions.					
11. 00	Are GME cost directly assigned to cost centers other than Teaching Program on Worksheet A? If yes, see instructions.	I & R in an App	proved	N		11. 00
	Treadming Treagram on worksheet N. Tr yes, see Thetraetrons.				Y/N	
	Bad Debts				1. 00	
12.00	Is the provider seeking reimbursement for bad debts? If ye				Y	12.00
13. 00	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.	policy change	during this co	st reporting	N	13. 00
14. 00	If line 12 is yes, were patient deductibles and/or co-paym	ents waived? I	fyes, see ins	tructions.	N	14. 00
15 00	Bed Complement Did total bods available change from the prior cost report	ing pariod2 lf	vos soo inst	rueti ens	N	15 00
13.00	Did total beds available change from the prior cost report		_yes, see mst t A		t B	15. 00
		Y/N	Date	Y/N	Date	
	PS&R Data	1.00	2. 00	3. 00	4. 00	
16. 00	Was the cost report prepared using the PS&R Report only?	N		N		16. 00
	If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see					
	instructions)					
17. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	Y	03/27/2019	Y	03/27/2019	17. 00
	either column 1 or 3 is yes, enter the paid-through date					
18 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
	Report data for additional claims that have been billed			1		.5. 55
	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.					
	printermation: 11 yes, see this il detroils.	I	I	ı	ı	I

HU3FT I	Financial Systems METHODIST HOS AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CC	CN: 15-0002	Period: From 01/01/2018	Worksheet S-2	
				To 12/31/2018		pared:
	·	Descri	ption	Y/N	Y/N	DO DIII
		0		1.00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.0
		Y/N	Date	Y/N	Date	
	III	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		21.0
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	IOSPI TALS)			
	Capital Related Cost			1		ļ
22.00	Have assets been relifed for Medicare purposes? If yes, see				N	22.0
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	sais made du	ring the cost		23.0
24. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	ed into during	this cost r	eporting period?		24. 0
25. 00	Have there been new capitalized leases entered into during	the cost repor	ting period	? If yes, see		25. 0
2/ 22	instructions.			16		1 ,, ,
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	ne cost reporti	ng period?	ir yes, see		26.0
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reportin	ng period? I	f yes, submit		27. 0
	Interest Expense					
8. 00	Were new loans, mortgage agreements or letters of credit en	t reporting		28.0		
9. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	Reserve Fund)		29.0		
7. 00	treated as a funded depreciation account? If yes, see insti	ikeserve runu)		27.0		
80.00	Has existing debt been replaced prior to its scheduled matu	s, see		30.0		
1. 00	instructions. Has debt been recalled before scheduled maturity without is	s, see		31.0		
	instructions. Purchased Services					-
32. 00	Have changes or new agreements occurred in patient care ser		ed through c	ontractual	N	32.0
22 00	arrangements with suppliers of services? If yes, see instru			: +:	. NI	22.0
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 appling, see instructions.	pired pertainin	ig to compet	itive bidding? ii	N	33.0
	Provi der-Based Physi ci ans					
34. 00	Are services furnished at the provider facility under an a	rrangement with	provi der-b	ased physicians?	Υ	34.0
35. 00		isting agreemen	nts with the	provi der-based	N	35.0
	physicians during the cost reporting period? If yes, see in	nstructions.				
				Y/N 1. 00	<u>Date</u> 2. 00	
	Home Office Costs			1.00	2.00	
36. 00						36.0
	· ·	repared by the	home office	? N N		
37. 00	If line 36 is yes, has a home office cost statement been pulf yes, see instructions. If line 36 is yes, was the fiscal year end of the home office.	fice different	from that o	? N		37.0
37. 00 38. 00	If line 36 is yes, has a home office cost statement been pulf yes, see instructions. If line 36 is yes, was the fiscal year end of the home offithe provider? If yes, enter in column 2 the fiscal year end	fice different d of the home c	from that o	? N f N		37. 0 38. 0
37. 00 38. 00 39. 00	If line 36 is yes, has a home office cost statement been pull yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions.	fice different d of the home c er chain compon	from that o office. ments? If ye	? N f N s, N		37. 0 38. 0 39. 0
37. 00 38. 00 39. 00	If line 36 is yes, has a home office cost statement been pulf yes, see instructions. If line 36 is yes, was the fiscal year end of the home offithe provider? If yes, enter in column 2 the fiscal year end of the provider year, end of the provider year, end of the provider year.	fice different d of the home c er chain compon	from that o office. ments? If ye	? N f N s, N		37. 0 38. 0
37. 00 38. 00 39. 00	If line 36 is yes, has a home office cost statement been pull yes, see instructions. If line 36 is yes, was the fiscal year end of the home office provider? If yes, enter in column 2 the fiscal year end if line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the	fice different d of the home c er chain compon home office?	from that o office. ments? If ye If yes, see	? N f N s, N	00	37. 0 38. 0 39. 0
37. 00 38. 00 39. 00	If line 36 is yes, has a home office cost statement been pull yes, see instructions. If line 36 is yes, was the fiscal year end of the home offithe provider? If yes, enter in column 2 the fiscal year end of the provider in the provider year, and the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions.	fice different d of the home c er chain compon	from that o office. ments? If ye If yes, see	? N f N s, N	00	37. 0 38. 0 39. 0
37. 00 38. 00	If line 36 is yes, has a home office cost statement been pull yes, see instructions. If line 36 is yes, was the fiscal year end of the home office the provider? If yes, enter in column 2 the fiscal year end of the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position	fice different d of the home c er chain compon home office?	from that o office. ments? If ye If yes, see	? N f N s, N	00	37. 0 38. 0 39. 0
37. 00 38. 00 39. 00 40. 00	If line 36 is yes, has a home office cost statement been put yes, see instructions. If line 36 is yes, was the fiscal year end of the home office the provider? If yes, enter in column 2 the fiscal year end of the provider services to other see instructions. If line 36 is yes, did the provider render services to other see instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	fice different d of the home c er chain compon home office?	from that o office. ments? If ye If yes, see	? N f N s, N N	00	37. 0 38. 0 39. 0 40. 0
37. 00 38. 00 39. 00 40. 00	If line 36 is yes, has a home office cost statement been put yes, see instructions. If line 36 is yes, was the fiscal year end of the home office the provider? If yes, enter in column 2 the fiscal year end if line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report	fice different d of the home c er chain compon home office?	from that o office. ments? If ye If yes, see	? N f N s, N N	00	37. 0 38. 0 39. 0 40. 0
37. 00 38. 00 39. 00 40. 00	If line 36 is yes, has a home office cost statement been put yes, see instructions. If line 36 is yes, was the fiscal year end of the home offithe provider? If yes, enter in column 2 the fiscal year end of the provider? If yes, enter in column 2 the fiscal year end of the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer.	fice different d of the home c er chain compon home office?	from that o office. ments? If ye If yes, see	? N f N s, N N		37. 0 38. 0 39. 0 40. 0

Health Financial Systems METHODIST HO	SPITALS, INC	In Lieu of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0002	Peri od: Worksheet S-2	2
		From 01/01/2018 Part II To	enared:
		5/28/2019 4:	
	3.00		
Cost Report Preparer Contact Information			
41.00 Enter the first name, last name and the title/position	DI RECTOR		41.00
held by the cost report preparer in columns 1, 2, and 3,			
respecti vel y.			
42.00 Enter the employer/company name of the cost report			42.00
preparer.			
43.00 Enter the telephone number and email address of the cost			43.00
report preparer in columns 1 and 2, respectively.			

| Period: | Worksheet S-3 | From 01/01/2018 | Part | To | 12/31/2018 | Date/Time Prepared: Heal th Fi nancial SystemsMETHODIHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 15-0002

						То	12/31/2018	Date/Time F 5/28/2019 4		
								I/P Days /		
								0/P Visits	/	
								Tri ps		
	Component	Worksheet A	No	of Beds	Bed Days		CAH Hours	Title V		
		Line Number 1.00		2. 00	Available 3.00		4. 00	5. 00		
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and			382		30	0.00		0	1.00
	8 exclude Swing Bed, Observation Bed and									
	Hospice days)(see instructions for col. 2									
	for the portion of LDP room available beds)									
2.00	HMO and other (see instructions)									2.00
3.00	HMO IPF Subprovider									3.00
4.00	HMO IRF Subprovider									4.00
5.00	Hospital Adults & Peds. Swing Bed SNF								0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF								0	6. 00
7. 00	Total Adults and Peds. (exclude observation			382	139, 43	30	0. 00		0	7.00
	beds) (see instructions)									
8. 00	INTENSIVE CARE UNIT	31.00		39			0. 00		0	8. 00
8. 01	NEONATAL ICU	31. 01		35	12, 77	' 5	0. 00		0	8. 01
9. 00	CORONARY CARE UNIT									9. 00
10.00	BURN INTENSIVE CARE UNIT									10.00
11. 00	SURGI CAL INTENSI VE CARE UNI T									11.00
12.00	OTHER SPECIAL CARE (SPECIFY)	40.00								12.00
13.00	NURSERY	43. 00		457	1// 4/		0.00		0	13.00
14.00	Total (see instructions)			456	166, 44	Ю	0. 00		0	14.00
15.00	CAH visits	40.00		4.4					0	15.00
16.00	SUBPROVIDER - I PF	40.00		14					0	16.00
17. 00	SUBPROVIDER - IRF	41. 00		39	14, 23	55			0	17.00
18. 00 19. 00	SUBPROVI DER									18. 00 19. 00
20.00	SKILLED NURSING FACILITY NURSING FACILITY									20.00
21. 00	OTHER LONG TERM CARE									20.00
22. 00	HOME HEALTH AGENCY	101. 00							0	21.00
23. 00	AMBULATORY SURGICAL CENTER (D.P.)	101.00							۷	23. 00
24. 00	HOSPICE									24.00
24. 00	HOSPICE (non-distinct part)	30. 00								24. 10
25. 00	CMHC - CMHC	30.00								25. 00
26. 00	RURAL HEALTH CLINIC									26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00							0	26. 25
27. 00	Total (sum of lines 14-26)	07.00		509					Ĭ	27. 00
28. 00	Observation Bed Days			007					o	28. 00
29. 00	Ambul ance Trips								Ĭ	29. 00
30.00	Employee discount days (see instruction)				1					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)				1					
33.00	LTCH non-covered days									33.00
33. 01	LTCH site neutral days and discharges									33. 01

| Peri od: | Worksheet S-3 | From 01/01/2018 | Part I | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-0002

1/P Days / O/P Visits / Trips					11	0 12/31/2018	5/28/2019 4:5	
Component			I/P Days	/ O/P Visits	/ Trips	Full Time I		, jui
New York 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see Instructions for col. 2 for the portion of LDP room available beds) 16,059 23,614 2,001							1	
New York 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see Instructions for col. 2 for the portion of LDP room available beds) 16,059 23,614 2,001								
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 27,049 2,931 71,101		Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 7 7 101					Pati ents	& Residents	Payrol I	
8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HM0 and other (see instructions) 3.00 HM0 IPF Subprovi der 4.00 HM0 IPF Subprovi der 4.00 HM0 IPF Subprovi der 4.00 HM0 IPF Subprovi der 5.00 Hospital Adult's & Peds. Swing Bed SNF 5.00 Hospital Adult's & Peds. Swing Bed NF 7.00 Hospital Adult's & Peds. Swing Bed NF 7.00 Total Adult's and Peds. (exclude observation obeds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 9.00 CORONARY CARE UNIT 9.00 CORONARY CARE UNIT 9.00 USURGICAL INTENSIVE CARE UNIT 9.00 USURGICAL INTENSIVE CARE UNIT 9.00 CAH visits 9.00 CAH vi						9. 00	10.00	
Hospice days)(see instructions for col. 2 7	1.00		27, 049	2, 931	71, 101			1.00
For the portion of LDP room avail able beds) 2.00 Mo and other (see instructions) 16,059 23,614 2.00 3.00 3.00 480 IPF Subprovider 48 937 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 6								
2.00 HMO and other (see instructions) 16,059 23,614 3.00 4.00 4.00 1.00								
3.00 HMO IPF Subprovi der		1						
4. 00 MMO IRF Subprovider		, ,						
5. 00		1 · · · · · · · · · · · · · · · · · · ·	l l					
6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 9.00 CORONARY CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 Total (see instructions) 8.01 Available of the provided of the provided observation obser		•	1					
Total Adults and Peds. (exclude observation beds) (see instructions) 27,049 2,931 71,101 8,249 8.00 8.01 NEONATAL ICU 0 0 0 2,601 8.01 9,00 10,000 BURN INTENSIVE CARE UNIT 10,000 10,000 BURN INTENSIVE CARE UNIT 11,000 10,000 BURN INTENSIVE CARE UNIT 11,000 10,000			0	-	-			
Deds) (see instructions) See INTENSIVE CARE UNIT See				۳Į	ŭ			
8. 00 NTENSIVE CARE UNIT 3, 227 0 8, 249 8. 00 NEONATAL I CU 0 0 0 2, 601 8. 01 8. 01 9. 00 10. 00 BURN INTENSIVE CARE UNIT 10. 00 11. 00	7. 00	,	27, 049	2, 931	71, 101			7.00
8. 01 NEONATAL I CU OCRONARY CARE UNIT OCCORNARY CARE UNIT		1 ' '						
9. 00 CORONARY CARE UNIT 10. 00 10. 00 BURN INTENSIVE CARE UNIT 10. 00 11. 00 SURGICAL INTENSIVE CARE UNIT 11. 00 12. 00 OTHER SPECIAL CARE (SPECIFY) 12. 00 13. 00 NURSERY 0 2,869 13. 00 14. 00 Total (see instructions) 30,276 2,931 84,820 3. 00 1,985.81 14,00 15. 00 CAH vi sits 0 0 0 0 16. 00 SUBPROVIDER - IPF 1,267 24 2,936 0.00 16.32 16.00 17. 00 SUBPROVIDER - IRF 5,226 116 8,648 0.00 38.77 17. 00 18. 00 SUBPROVIDER - IRF 5,226 116 8,648 0.00 38.77 17. 00 19. 00 SKILLED NURSING FACILITY 19. 00 19. 00 SKILLED NURSING FACILITY 20. 00 AMBULATORY SURGICAL CENTER (D.P.) 22. 00 10. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 10 10. 01 HOSPICE (non-distinct part) 24. 10 26. 02 FEDERALLY OUALIFIED HEALTH CENTER 0 0 0.00 2,068.81 27. 00 28. 00 OMRC - CAHPC 26. 00 27. 91 27. 00 29. 00 Ambulance Trips 0 0 0.00 2,068.81 27. 00 30. 00 Employee discount days (see instruction) 0 88 96 32. 00 31. 00 Employee discount days (see instructions) 0 88 96 32. 00 32. 01 Total (sum of lines tructions) 0 88 96 32. 00 32. 01 Total (auricillary labor & delivery room outpatient days (see instructions) 0 0.00 0.00 0.00 31. 00 LTCH non-covered days 0 0 0.00 0.00 31. 00 LTCH non-covered days 0 0 0.00 0.00 31. 00 LTCH non-covered days 0 0 0.00 0.00 31. 00 LTCH non-covered days 0 0 0.00 0.00 31. 00 LTCH non-covered days 0 0 0.00 0.00 31. 00 LTCH non-covered days 0 0 0.00 0.00 31. 00 LTCH non-covered days 0 0 0.00 0.00 31. 00 LTCH non-covered days 0 0 0.00 0.00 31. 00 LTCH non-covered days 0 0.00 0.00 31. 00 LTCH non-covered days 0 0.00 0.00 31. 00 LTCH non-covered days 0 0.00 0.00 31. 00 LT			3, 227	-				
10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 11			0	0	2, 601			
11.00 SURGI CAL INTENSIVE CARE (SPECIFY) 11.00 12.00 17.00								
12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 0								
13. 00 NURSERY 0 2,869 3. 00 1,985.81 13. 00 15. 00 CAH vi sit s 0 0 0 0 0 15. 00 CAH vi sit s 15. 00 0 0 0 0 15. 00 CAH vi sit s 15. 00 0 0 0 0 0 15. 00 CAH vi sit s 15. 00 0 0 0 0 0 0 15. 00 CAH vi sit s 15. 00 0 0 0 0 0 0 15. 00 CAH vi sit s 15. 00 0 0 0 0 0 0 0 0 0		1						
14.00 Total (see instructions) 30,276 2,931 84,820 3.00 1,985.81 14.00 15.00 CAH visits 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
15. 00 CAH visits		1		0				ł
16. 00 SUBPROVIDER - IPF 1, 267 24 2,936 0.00 16. 32 16. 00 17. 00 SUBPROVIDER - IRF 5,226 116 8,648 0.00 38. 77 17. 00 18. 00 38. 77 17. 00 18. 00 38. 77 17. 00 18. 00 38. 77 17. 00 18. 00 38. 77 17. 00 18. 00 38. 77 17. 00 18. 00 38. 77 17. 00 18. 00 38. 77 17. 00 38. 77 17. 00 38. 77 17. 00 38. 77 17. 00 38. 77 17. 00 38. 77 17. 00 38. 77 17. 00 38. 77 17. 00 38. 77 17. 00 38. 77 17. 00 38. 77 17. 00 38. 00 38. 77 17. 00 38. 00 38. 77 17. 00 38. 00 38. 77 17. 00 38. 00 38. 77 17. 00 38. 00 38. 77 17. 00 38. 00 38. 77 17. 00 38. 00 38. 77 17. 00 38. 00 38. 77 17. 00 38. 00 38. 77 17. 00 38. 00 38. 77 17. 00 38. 00 38. 77 17. 00 38. 00 38. 77 17. 00 38. 00 38. 77 17. 00 38. 00 38. 77 17. 00 38. 00 38. 77 17. 00 38.		1 '	30, 276	2, 931	84, 820	3. 00	1, 985. 81	
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18. 00 SUBPROVI DER 18. 00 19. 00 SKI LLED NURSI NG FACILITY 20. 00 NURSI NG FACILITY 20. 00 OTHER LONG TERM CARE 21. 00 22. 00 HOME HEALTH AGENCY 8, 051 4, 332 22, 531 0. 00 27. 91 22. 00 23. 00 24. 10 HOSPI CE CMHC CMHC 25. 00 24. 10 HOSPI CE CMHC CMHC 25. 00 26. 25 EDERALLY QUALIFIED HEALTH CENTER 0 0 0 0. 00 0. 00 26. 25 27. 00 Total (sum of lines 14-26) 0. 00 27. 91 27. 00 28. 00 29. 00 Ambul ance Trips 0 0 0 0. 00 0. 00 29. 00 29. 00 29. 00 Ambul ance Trips 0 0 0 0. 00 0.		·						1
19. 00 SKILLED NURSING FACILITY 20. 00 20. 00 21. 00 22. 00 22. 00 22. 00 23. 00 24. 00 24. 00 24. 00 24. 00 25. 00 24. 00 25. 00 26. 25 26. 00 26. 25 27. 00 28. 00 29.			5, 226	116	8, 648	0. 00	38. 77	•
20.00 NURSING FACILITY 20.00 21.00 21.00 22.00 HOME HEALTH AGENCY 8,051 4,332 22,531 0.00 27.91 22.00 23.00 AMBULATORY SURGICAL CENTER (D.P.) 23.00 HOSPICE 24.00 HOSPICE 24.10 25.00 CMHC - CMHC 25.00 26.25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0.00 0.00 26.25 27.00 Total (sum of lines 14-26) 28.00 28.00 Observation Bed Days 0 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 0 88 96 32.00 33.00 LTCH non-covered days 0 LTCH non-covered days 0 LTCH non-covered days 33.00 27.91 22.00 27.91 27.00 27.91 27.00 27.91 27.00 27.00 27.91 27.00		I and the second						•
21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 44.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 0 Uservations 0 Use								
22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 33. 00 LTCH non-covered days 30. 00 LTCH non-covered days 30. 00 LTCH non-covered days 31. 00 LTCH non-covered days 32. 00 AMBULATORY SURGICAL CENTER (D. P.) 4, 332 22, 531 0. 00 27. 91 22. 00 24, 00 24, 10 24, 10 24, 10 24, 10 25. 00 26. 05 26. 00 0 0 0 0 0. 00 0								
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24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 24. 00 24. 10 24. 10 24. 10 24. 10 25. 00 26. 05 26. 00 27. 00 O O O O O O O O O O O O O O O O O O			8, 051	4, 332	22, 531	0. 00	27. 91	
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 24. 10 25. 00 26. 00 26. 00 0 0 0 0. 00								•
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26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambul ance Trips 29.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 26.00 0 0 0 0 0.00 0.00 0.00 0.00 0.00 0.					210			
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27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 21.00 Employee discount days - IRF 20.00 Labor & delivery days (see instructions) 31.00 Total (sum of lines 14-26) 32.00 Employee discount days 33.00 Employee discount days 34.00 Labor & delivery days (see instructions) 35.00 LTCH non-covered days 30.00 Employee discount days 31.00 Employee discount days 31.00 Employee discount days 31.00 Employee discount days 31.00 Employee discount days 32.00 See instructions 33.00 Employee discount days 31.00 See instructions 32.00 See instructions 33.00 Employee discount days 33.00 See instructions 33.00 See								
28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 31.00 Employee discount days - IRF 0 31.00 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 0 33.00		1	0	0	0			
29.00 Ambulance Trips 0 0 29.00 30.00 Employee discount days (see instruction) 0 30.00 31.00 Employee discount days - IRF 0 0 31.00 32.00 Labor & delivery days (see instructions) 0 88 96 32.00 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 0 32.01 0 LTCH non-covered days 0 33.00		,				3. 00	2, 068. 81	
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 30.00 88 96 32.00 32.01 0 33.00		1		6, 036	20, 759			
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 31.00 88 96 32.00 32.01 0 33.00		•	0					
32.00 Labor & delivery days (see instructions) 0 88 96 32.00 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 0 32.01 33.00 LTCH non-covered days 0 33.00								
32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 0 32.01					-			
outpatient days (see instructions) 33.00 LTCH non-covered days 0 33.00		1	0	88	96			
33.00 LTCH non-covered days 0 33.00	32. 01				0			32. 01
33.01 LTCH site neutral days and discharges 0 33.01	33. 01	LICH site neutral days and discharges	0	l				33. 01

| Peri od: | Worksheet S-3 | From 01/01/2018 | Part I | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-0002

				11	0 12/31/2018	5/28/2019 4:50	
		Full Time	•	Di sch	arges		
		Egui val ents			3 * *		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	·	Workers				Pati ents	
		11. 00	12. 00	13.00	14.00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		(5, 038	389	13, 960	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			2, 061	2, 532		2. 00
3.00	HMO IPF Subprovi der				42		3. 00
4. 00	HMO IRF Subprovi der				60		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospi tal Adul ts & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7. 00
0.00	beds) (see instructions)						0.00
8. 00 8. 01	INTENSIVE CARE UNIT						8. 00 8. 01
	NEONATAL I CU						
9. 00 10. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						9. 00 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	(5, 038	389	13, 960	14.00
15. 00	CAH visits	0.00	,	3,030	307	13, 700	15.00
16. 00	SUBPROVI DER - I PF	0.00	(68	2	226	16.00
17. 00	SUBPROVI DER - I RF	0.00		344	9	576	17. 00
18. 00	SUBPROVI DER	0.00	·]	,	0.0	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 32. 01	Labor & delivery days (see instructions)						32. 00 32. 01
32. UI	Total ancillary labor & delivery room outpatient days (see instructions)						32. UT
33. 00	LTCH non-covered days			0			33. 00
	LTCH site neutral days and discharges						33. 00
55. 51	12.5 5. to hour at days and at sorial gos	ı		1			30.01

HOSPI T	AL WAGE INDEX INFORMATION			Provider C	F	eriod: rom 01/01/2018		
						o 12/31/2018	Date/Time Pre 5/28/2019 4:5	pared: O pm
		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries	Adjusted Salaries (col.2 ± col.	Paid Hours Related to Salaries in	Average Hourly Wage (col. 4 ÷	
				(from Wkst. A-6)	3)	col. 4	col . 5)	
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							
1. 00	Total salaries (see	200.00	150, 286, 715	-418, 062	149, 868, 653	4, 303, 134. 00	34. 83	1.00
2. 00	instructions) Non-physician anesthetist Part		0	O	0	0. 00	0. 00	2.00
3. 00	Non-physician anesthetist Part		0	0	0	0.00	0. 00	3. 00
4. 00	Physician-Part A - Administrative		0	О	0	0. 00	0. 00	4.00
4. 01	Physicians - Part A - Teaching		0 0/5 471	0	1	0.00	0.00	
5. 00	Physician and Non Physician-Part B		2, 965, 471	0			121. 36	
6. 00	Non-physician-Part B for hospital-based RHC and FQHC services		0	O	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		274, 518	О	274, 518	6, 240. 00	43. 99	7. 01
8. 00	programs) Home office and/or related organization personnel		0	О	0	0.00	0. 00	8. 00
9. 00 10. 00	SNF	44. 00	0 29, 121, 556	207, 478	0 29, 329, 034	0. 00 561, 157. 00	0.00	
10.00	Excluded area salaries (see instructions)		29, 121, 550	207, 478	29, 329, 034	561, 157.00	52. 27	10.00
11. 00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		1, 018, 363	Ιο	1, 018, 363	14, 151. 00	71. 96	11.00
12. 00	Care Contract Labor: Top Level		0				0. 00	
12.00	management and other management and administrative		Ü		,	0.00	0.00	12.00
13. 00	services Contract Labor: Physician-Part A - Administrative		827, 692	o	827, 692	6, 198. 00	133. 54	13.00
14. 00	Home office and/or related organization salaries and		0	О	0	0.00	0. 00	14. 00
14. 01	wage-related costs Home office salaries		0		0	0.00	0. 00	14. 01
14. 01	Related organization salaries		0	1	0		0.00	
15. 00	Home office: Physician Part A - Administrative		0	0	0	0.00	0. 00	15. 00
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, 513, 059	0	36, 513, 059			17. 00
18. 00	Wage-related costs (other) (see instructions)		0	0	0			18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		7, 032, 438 0	0	7, 032, 438 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		0	0	0			21. 00
22. 00	Physician Part A -		0	О	0			22. 00
22. 01	Administrative Physician Part A - Teaching		0	O	0			22. 01
23. 00	Physician Part B		427, 104	0	427, 104			23.00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0	0			24. 00 25. 00
25. 50	approved program) Home office wage-related		0	0	0			25. 50
25. 51	(core) Related organization		0	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A		0	0	0			25. 52
	- Administrative - wage-related (core)		, and the second					
25. 53	Home office & Contract		0	0	0			25. 53
	Physicians Part A - Teaching - wage-related (core)							

Provi der CCN: 15-0002

					T	o 12/31/2018	Date/Time Pre 5/28/2019 4:5	
		Wkst. A Line	Amount	Recl assi fi cat	Adjusted	Pai d Hours	Average	O pili
		Number	Reported	i on 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)	ĺ		ĺ	
		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, 640, 482	-116, 977	1, 523, 505	34, 411. 00	44. 27	26. 00
27.00	Administrative & General	5. 00	20, 746, 437	-519, 517	20, 226, 920	645, 270. 00	31. 35	27.00
28.00	Administrative & General under		1, 332, 141	0	1, 332, 141	6, 467. 00	205. 99	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0. 00	0. 00	29. 00
30.00	Operation of Plant	7. 00	3, 860, 193	-26, 825	3, 833, 368	149, 770. 00	25. 60	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, 408, 869	-41, 012	4, 367, 857	279, 216. 00	15. 64	32.00
33.00	Housekeeping under contract		0	0	0	0. 00	0. 00	33.00
	(see instructions)							
34.00	Di etary	10. 00	3, 089, 109	-727, 092	2, 362, 017	122, 695. 00	19. 25	34.00
35.00	Dietary under contract (see		0	0	0	0. 00	0. 00	35.00
	instructions)							
36.00	Cafeteri a	11. 00	311, 785	719, 570	1, 031, 355	54, 858. 00		36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0. 00		37.00
38. 00	Nursing Administration	13. 00	2, 816, 664	-24, 160	2, 792, 504	58, 272. 00	47. 92	38. 00
39. 00	Central Services and Supply	14. 00	564, 566	0	564, 566	28, 534. 00	19. 79	39. 00
40.00	Pharmacy	15. 00	0	0	0	0. 00	0. 00	40.00
41.00	Medical Records & Medical	16. 00	1, 997, 624	0	1, 997, 624	82, 153. 00	24. 32	41.00
	Records Library							
42.00	Social Service	17. 00	0	444, 894	444, 894	14, 560. 00		42.00
43.00	Other General Service	18. 00	0	0	0	0. 00	0. 00	43.00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-2552-10
HOSPITAL WAGE INDEX INFORMATION	Provi der CCN: 15-0002	Peri od: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part III Date/Time Prepared: 5/28/2019 4:50 pm

					Ť	o 12/31/2018	Date/Time Prep 5/28/2019 4:50	
		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	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1. 00	Net salaries (see		148, 378, 867	-418, 062	147, 960, 805	4, 278, 925. 00	34. 58	1. 00
	instructions)							
2. 00	Excluded area salaries (see		29, 121, 556	207, 478	29, 329, 034	561, 157. 00	52. 27	2.00
	instructions)							
3. 00	Subtotal salaries (line 1		119, 257, 311	-625, 540	118, 631, 771	3, 717, 768. 00	31. 91	3. 00
	minus line 2)			_				
4. 00	Subtotal other wages & related		1, 846, 055	0	1, 846, 055	20, 349. 00	90. 72	4. 00
	costs (see inst.)		0/ 540 050		0, 540 050		22 72	
5. 00	Subtotal wage-related costs		36, 513, 059	0	36, 513, 059	0. 00	30. 78	5. 00
,	(see inst.)		457 /4/ 405	, , , , , , ,	457 000 005	0 700 447 00	40.00	,
6. 00	Total (sum of lines 3 thru 5)		157, 616, 425				•	
7. 00	Total overhead cost (see		40, 767, 870	-291, 119	40, 476, 751	1, 476, 206. 00	27. 42	7. 00
	instructions)							

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS		Peri od: Worksheet S-3 From 01/01/2018 Part IV To 12/31/2018 Date/Time Prepared:

	To 12/31/201	8 Date/Time Pre 5/28/2019 4:5	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS	•	
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	2, 154, 649	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	6, 150, 693	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	17, 313, 014	8. 02
8.03	Health Insurance (Purchased)	0	
9.00	Prescription Drug Plan	4, 079, 029	9. 00
10.00	Dental, Hearing and Vision Plan	933, 678	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	560, 032	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	418, 062	
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	
15.00		1, 505, 094	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES	_	
		10, 296, 240	
18. 00	Medicare Taxes - Employers Portion Only	0	
19. 00	Unempl oyment Insurance	149, 797	
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. (se	e e 0	21.00
	instructions))		
22. 00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	412, 314	
24.00		43, 972, 602	24.00
	Part B - Other than Core Related Cost		Į.
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

		METHODIST HOSPITALS, INC				
Heal th	ı Financial Systems	In Lieu of Form CMS-2552-10				
HOSPI 7	TAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN:		eri od:	Worksheet S-3	
				rom 01/01/2018		
			Т	o 12/31/2018	Date/Time Prep 5/28/2019 4:50	
	Cost Center Description			Contract	Benefit Cost	о рііі
	oost conten bescription			Labor	Benefit 665t	
				1.00	2. 00	
	PART V - Contract Labor and Benefit Co	st				
	Hospital and Hospital-Based Component	I denti fi cati on:				
1.00	Total facility's contract labor and be	enefit cost		1, 018, 363	43, 972, 602	1.00
2.00	Hospi tal			1, 018, 363	43, 972, 602	2.00
3.00	Subprovi der - IPF			0	0	3.00
4.00	Subprovi der - I RF			O	o	4.00
5.00	Subprovider - (Other)			0	0	5.00
6.00	Swing Beds - SNF			0	0	6.00
7.00	Swing Beds - NF			0	0	7.00
0 00	1			1		

8.00

9.00 10.00 11.00

12.00 13.00 14.00

15.00 16.00

17.00 0 0 18.00

8.00

Hospi tal -Based SNF

12.00 Separately Certified ASC
13.00 Hospital-Based Hospice
14.00 Hospital-Based Health Clinic RHC

15.00 Hospital -Based Health Clinic FQHC 16.00 Hospital -Based-CMHC

9.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11.00 Hospi tal -Based HHA

17.00 Renal Dialysis 18.00 Other

Heal th	Financial Systems	METHODIST HOSP	ITALS, INC		In Lie	u of Form CMS-2	2552-10
HOME I	HEALTH AGENCY STATISTICAL DATA			CN: 15-0002 CCN: 15-7536	Peri od: From 01/01/2018 To 12/31/2018	Worksheet S-4	pared:
					Home Health	PPS	о рііі
					Agency I		
0.00	County				1.	00	0.00
0.00	Todanty	Title V	Title XVIII	Title XIX	Other	Total	0.00
	HOME HEALTH ACENOV CTATICTICAL DATA	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	O	0		0 0	0	1.00
2. 00	Unduplicated Census Count (see instructions)	0.00	425. 00	0. (0. 00	0.00	
				Number of Em	ployees (Full Ti	me Equivalent)	
		Enter the number your normal		Staff	Contract	Total	
		your norman	WOLK MEEK				
		0		1.00	2.00	3. 00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	-		1.50	2.00	3.00	
3.00	Administrator and Assistant Administrator(s)		40. 00				
4. 00 5. 00	Director(s) and Assistant Director(s) Other Administrative Personnel			0. (6. 7		0. 00 6. 78	
6. 00	Direct Nursing Service			11. 9		11. 95	
7. 00	Nursi ng Supervi sor			0. (0.00	
8. 00 9. 00	Physical Therapy Service Physical Therapy Supervisor			4. 3		4. 37 0. 00	8. 00 9. 00
10.00	Occupational Therapy Service			1. (1. 02	
11. 00	Occupational Therapy Supervisor			0.0		0. 00	
12. 00 13. 00	Speech Pathology Service Speech Pathology Supervisor			0. 4		0. 41 0. 00	
14. 00	Medical Social Service			0.0		0.00	
15. 00	Medical Social Service Supervisor			0.0		0.00	15. 00
16.00	Home Health Aide			2. 6			
17. 00 18. 00	Home Health Aide Supervisor Other (specify)			0. (
10.00	HOME HEALTH AGENCY CBSA CODES			0. 0	0.00	0.00	10.00
19. 00					1		19.00
	you provided services during the cost 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).	Full Epi	sodes				
		Wi thout W		LUPA Epi sode		Total (cols.	
		Outliers 1.00	2. 00	3. 00	Epi sodes 4.00	1-4) 5. 00	
	PPS ACTIVITY DATA	1.00	2.00	3.00	4.00	5.00	
21.00	Skilled Nursing Visits	3, 490	871		143		1
22. 00 23. 00	Skilled Nursing Visit Charges Physical Therapy Visits	622, 870 1, 884	154, 749 20		09 25, 418 26 102	817, 446 2, 032	
24. 00	Physical Therapy Visit Charges	366, 412	3, 889			395, 195	
25. 00	Occupational Therapy Visits	309	2		0 20	331	25. 00
26. 00 27. 00	Occupational Therapy Visit Charges Speech Pathology Visits	60, 697 62	383	i.	0 3, 940 2 4	65, 020 75	
28. 00	Speech Pathology Visits Speech Pathology Visit Charges	13, 010	1, 393	42		15, 669	
29. 00	Medical Social Service Visits	25	5	,	0 2	32	29. 00
	Medical Social Service Visit Charges	7, 068 740	1, 420 213	1	0 568 4 39	9, 056 996	
30.00	IHOME Health Aide Visits				20 3, 120	20, 335	
30. 00 31. 00 32. 00	Home Health Aide Visits Home Health Aide Visit Charges	0	16, 895) 3 ₂	5, 120	20, 333	1 32.00
31.00	Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27,	1	16, 895 1, 118	1	13 310	8, 051	33. 00
31. 00 32. 00 33. 00	Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	0 6, 510	1, 118	1	310	8, 051	33.00
31. 00 32. 00	Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27, 29, and 31) Other Charges	0		1	0 0		33. 00 34. 00
31. 00 32. 00 33. 00 34. 00 35. 00	Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27, 29, and 31) Other Charges Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	0 6, 510 56, 265 1, 126, 322	1, 118	20, 22	0 0 21 53, 714	8, 051 56, 265 1, 378, 986	33. 00 34. 00 35. 00
31. 00 32. 00 33. 00 34. 00	Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27, 29, and 31) Other Charges Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34) Total Number of Episodes (standard/non	0 6, 510 56, 265	1, 118	20, 22	0 0	8, 051 56, 265 1, 378, 986	33. 00 34. 00 35. 00
31. 00 32. 00 33. 00 34. 00 35. 00	Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27, 29, and 31) Other Charges Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34) Total Number of Episodes (standard/non outlier)	0 6, 510 56, 265 1, 126, 322	1, 118	20, 22	0 0 21 53, 714	8, 051 56, 265 1, 378, 986	33. 00 34. 00 35. 00 36. 00

Recompensated and Indigent care cost computation Provider COst: 15-0002 Provider COst: 10-0002 Provider COST: 10-0002 Provider COST: 10-0002 Provider COST: 10-002	Heal th	Financial Systems METHODIST HOSPIT.	ALS, INC		In Lie	u of Form CMS-2	2552-10
				N: 15-0002	Peri od:		
Incomponisated and Indigent care cost computation 1.00						Date/Time Pre	pared.
Incompensated and indigent care cost computation 0.00						5/28/2019 4: 5	0 pm
Incompensated and indigent care cost computation 0.00						1 00	
Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8) 0.232572 1.00		Uncompensated and indigent care cost computation				1.00	
Net revenue from Medicald 79,948,607 2.00 2	1.00		vided by li	ne 202 colum	n 8)	0. 232572	1.00
3.00 Not preceive DSH or supplemental payments from Medicaid? 4.00 Filine 3 is yes, obes fine 2 include all DSH and/or supplemental payments from Medicaid? 4.00 6.00							
						79, 948, 607	
If				. C			
Medicaid charges 266, 238, 523 6.00		1			ai d?	0	
Medical d cost ((line 1 times line 6) Medical d program ((line 7 minus sum of lines 2 and 5: if			Tolli wedi cai	u		-	
0		, 9					
		1	(line 7 min	us sum of li	nes 2 and 5; if		
9.00 Net revenue from stand-alone CHIP 0 0.00 0.		< zero then enter zero)	•		·		
10.00 Stand-al one CHIP cost (line 1 times line 10) 0.10.00			or each lin	e)			
11.00 Stand-alone CHIP cost (line 1 times line 10) 0 11.00 0 0 12.00 0 0 0 0 0 0 0 0 0							
12.00 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then of enter zero) Other state or local government indigent care program (see instructions for each line) 13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 0 0 14.00 16.00 Difference between net revenue and costs for state or local indigent care program (Not included in lines 6 or 0 0 14.00 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 15.00 13.1; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state-local indigent care programs (see linstructions for each line) Private grants, donations, or endowment income restricted to funding charity care Or local unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 0 18.00 18.00 Covernment grants, appropriations or transfers for support of hospital operations (sum of lines 0 18.00 18.00 Covernment grants, appropriations or transfers for support of hospital operations (sum of lines 0 18.00 18.00 Covernment grants, appropriations or transfers for support of hospital operations (sum of lines 0 18.00 18.00 Covernment grants, appropriations or transfers for support of hospital operations (sum of lines 0 18.00 18.00 Covernment grants, appropriations or transfers for support of hospital operations (sum of lines 0 18.00 18.00 Covernment grants, appropriations or transfers for support of hospital operations (sum of lines 0 18.00 18.00 Covernment grants, appropriations or transfers for support of hospital operations (sum of lines 0 18.00 18.00 Covernment grants, appropriations or transfers for support of hospital operations (sum of lines 0 18.00 18.00 Covernment grants, appropriations or transfers for support of hospital complex (see instructions) Uncompensated Care (see instru							
enter zero) Other state or local government indigent care program (see instructions for each line) 13.00 Not revenue from state or local indigent care program (Not included on lines 2. 5 or 9) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 15.00 13; if < zero then enter zero) Grants, donations and total unrelmbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 18.00 Government grants, appropriations or transfers for support of hospital operations 0 18.00 18.00 19.00 Total unrelmbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 0 19.00 19.00 Total unrelmbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 0 19.00 19.00 Total unrelmbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 0 19.00 19.00 Total unrelmbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 0 19.00 19.00 Total unrelmbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 0 19.00 19.00 19.00 Total unrelmbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 0 19.00 1			if / zero then	-			
State or local government indigent care program (see instructions for each line) 13.00 1	12.00		(TITIE IT IIII	ilus IIIIe 4,	II < Zero tileli	U	12.00
14. 00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 15. 00 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 or local indigent care program (line 15 minus line 13; If < zero then enter zero) Grants, donations and total unrelmbursed cost for Medicald, CHIP and state/local indigent care programs (see instructions for each line) 17. 00 Private grants, donations, or endowment income restricted to funding charity care 0 17. 00 18. 00 Government grants, appropriations or transfers for support of hospital operations 0 18. 00 19. 00 Total unrelmbursed cost for Medicald , CHIP and state and local indigent care programs (sum of lines 0 19. 00 19. 00 Total unrelmbursed cost for Medicald , CHIP and state and local indigent care programs (sum of lines 0 19. 00 10 Total unrelmbursed cost for Medicald , CHIP and state and local indigent care programs (sum of lines 0 19. 00 10 Total unrelmbursed cost for Medicald , CHIP and state and local indigent care programs (sum of lines 0 19. 00 10 Total unrelmbursed cost for Medicald , CHIP and state and local indigent care programs (sum of lines 0 19. 00 10 Total unrelmbursed cost for Medicald , CHIP and state and local indigent care programs (sum of lines 0 19. 00 10 Total unrelmbursed cost for Medicald , CHIP and state and local indigent care programs (sum of lines 0 19. 00 10 Total unrelmbursed cost for Medicald (col. 1 patients patients patients patients 20. 00 10 Total unrelmbursed cost for Medicald state and local indigent care programs (sum of lines 0 19. 00 10 Total unrelmbursed local for each line) 10 Uncompensated Care (see instructions for each line) 11 Uncompensated Care (see instructions for each line) 12 Uncompensated Care (see instructions) 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			tructions f	or each line)		
10.00 15.00 16.00 16.00 16.00 17.00 18.00 18.00 18.00 18.00 19.00 10.00	13.00	Net revenue from state or local indigent care program (Not inc	luded on li	nes 2, 5 or	9)	0	13.00
15.00 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 or local indigent care program (line 15 minus line 13: if < zero then enter zero) 16.00 16.00 17.00	14.00	Charges for patients covered under state or local indigent car	re program (Not included	in lines 6 or	0	14.00
16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero) Grants, donations and total unrelmbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Pivate grants, donations, or endowment income restricted to funding charity care 18.00 Government grants, appropriations or transfers for support of hospital operations 19.00 Total unrelmbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 0 18.00 19.00 8, 12 and 16) 10.00 Endower lines 16		1 /				_	
13: if < zero then enter zero) Grants, donations and total unrelimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					15!	-	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17. 00 Private grants, donations, or endowment income restricted to funding charity care 0 17. 00 18. 00 Government grants, appropriations or transfers for support of hospital operations 0 18. 00 19. 00 Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 0 19. 00 8, 12 and 16) Uninsured patients patients patients + col . 2) 1. 00 2. 00 3. 00 Uncompensated Care (see instructions for each line) Uncompensated Care (see instructions for each line) Uncompensated Care (see instructions for the entire facility (see instructions) 21. 00 Cost of patients approved for charity care and uninsured discounts (see 10, 032, 673 1, 013, 197 44, 151, 118 20. 00 22. 00 Payments received from patients for amounts previously written off as 0 0 0 0 22. 00 23. 00 Cost of charity care (line 21 minus line 22) 10, 032, 673 1, 013, 197 11, 045, 870 23. 00 24. 00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25. 00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 1 Total bad debt expense for the entire hospital complex (see instructions) 25, 365, 562 26. 00 27. 00 Medicare all lowable bad debts for the entire hospital complex (see instructions) 22, 885, 035 28. 00 29. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 17, 236, 474 30. 00	16.00		idigent care	program (11	ne is minus iine	U	16.00
Instructions for each line) Private grants, donations, or endowment income restricted to funding charity care (a) 0 17.00 (b) 0 18.00 (c) 0 18.00 (c) 0 19.00 (c) 19.			IIP and stat	e/local indi	gent care progra	ms (see	
18.00 Government grants, appropriations or transfers for support of hospital operations 19.00 Total unrel mbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 0 19.00						. (3.7.1	
19.00 Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16) Uninsured patients Insured patients Foundation Foundation							
8, 12 and 16) Uninsured patients Insured patients Total (col. 1 + col. 2)							
Uninsured patients patients patients + col. 2 Uncompensated Care (see instructions for each line) 20.00 Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 22.00 Payments received from patients for amounts previously written off as of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit N 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit N 25.00 1 Total bad debt expense for the entire hospital complex (see instructions) 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.01 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 28.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29) 10.100 10.032, 673 1, 013, 197 11, 045, 870 21.00 0 0 0 22.00 11, 013, 197 11, 045, 870 21.00 0 0 0 22.00 11, 013, 197 11, 045, 870 21.00 0 0 0 22.00 11, 013, 197 11, 045, 870 21.00 11, 013, 197 11, 045, 870 21.00 11, 013, 197 11, 045, 870 22.00 23.00 24.00 25.00 26.00 26.00 27.01 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 28.00 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 10.00	19.00		il indigent	care program	is (sum of lines	0	19.00
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27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29) 10.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 2, 480, 527	26 00		etructione)			25 265 562	26 00
27. 01 Medicare allowable bad debts for the entire hospital complex (see instructions) 2, 480, 527 27. 01 28. 00 Non-Medicare bad debt expense (see instructions) 29. 00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 30. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 2, 480, 527 27. 01 2, 480, 527 27. 01 2, 480, 527 27. 01 2, 885, 035 28. 00 6, 190, 604 29. 00 17, 236, 474 30. 00		,					
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			opense (see	instructions	s)		
31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30) 17,236,474 31.00		1					
	31. 00	Total unreimbursed and uncompensated care cost (line 19 plus I	ine 30)			17, 236, 474	31.00

	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC	CN: 15-0002 F	eri od:	Worksheet A	
				F T	rom 01/01/2018 o 12/31/2018	Date/Time Pre	pared:
	Cost Center Description	Sal ari es	Other		Recl assi fi cat	5/28/2019 4: 5 Recl assi fi ed	O pm
	555t 551/t6.	04.4.7.00	0 11.01	+ col . 2)	ions (See	Trial Balance	
					A-6)	(col. 3 +- col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
1 00	GENERAL SERVICE COST CENTERS		ما		21 004 402	21 004 402	1 00
1. 00 4. 00	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT	1, 640, 482	0 28, 257, 230	29, 897, 712	1 1	21, 984, 403 30, 189, 749	1. 00 4. 00
5. 01	00550 DATA PROCESSING	4, 047, 320	8, 665, 241	12, 712, 561		10, 368, 597	5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES	1, 005, 027	2, 527, 158	3, 532, 185	-146, 152	3, 386, 033	
5. 03 5. 04	00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE	2, 000, 921 2, 222, 826	479, 156 4, 399, 380	2, 480, 077 6, 622, 206		2, 473, 460	1
5. 05	00590 OTHER A&G	10, 929, 158	21, 085, 366	32, 014, 524		6, 554, 333 14, 769, 881	5.04
5.06	00592 PATIENT TRANSPORTATION	541, 185	69, 060	610, 245	-24, 656	585, 589	5. 06
7.00	00700 OPERATION OF PLANT	3, 860, 193	9, 321, 117	13, 181, 310		22, 406, 084	
8. 00 9. 00	O0800 LAUNDRY & LI NEN SERVI CE O0900 HOUSEKEEPI NG	0 4, 408, 869	1, 450, 605 1, 286, 789	1, 450, 605 5, 695, 658	1	1, 450, 605 5, 601, 722	
10.00	01000 DI ETARY	3, 089, 109	3, 088, 669	6, 177, 778		4, 458, 089	
11.00	01100 CAFETERI A	311, 785	35, 714	347, 499		1, 982, 506	
13. 00 14. 00	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY	2, 816, 664 564, 566	480, 589 1, 618, 184	3, 297, 253 2, 182, 750		3, 238, 663 1, 747, 526	
15. 00	01500 PHARMACY	0	15, 743, 520	15, 743, 520		5, 612, 507	
	01600 MEDICAL RECORDS & LIBRARY	1, 997, 624	840, 161	2, 837, 785		2, 826, 545	
17.00	O1700 SOCIAL SERVICE O1701 STAFF EDUCATION	0	0	C	,	444, 894 0	1
	01701 STAIT EDUCATION	0	59, 228	59, 228		59, 195	
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	C	274, 518	274, 518	21.00
22.00		453, 400	0	F21 102	,	31, 168	1
23.00	02300 PARAMED ED PROGRAM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	453, 498	77, 684	531, 182	215, 590	746, 772	23.00
30.00	03000 ADULTS & PEDIATRICS	32, 248, 071	12, 720, 914	44, 968, 985	-1, 461, 380	43, 507, 605	30.00
	03100 INTENSIVE CARE UNIT	6, 505, 688	2, 082, 375	8, 588, 063	I	7, 847, 990	
31. 01 40. 00	03101 NEONATAL CU 04000 SUBPROVI DER - PF	1, 724, 130 1, 291, 468	963, 808 118, 237	2, 687, 938 1, 409, 705		2, 661, 340 1, 388, 636	
41. 00	04100 SUBPROVI DER - I RF	2, 812, 018	441, 712	3, 253, 730		3, 178, 270	
43.00	04300 NURSERY	1, 187, 955	332, 453	1, 520, 408	-100, 837	1, 419, 571	43.00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	4, 239, 026	19, 469, 207	23, 708, 233	-17, 703, 585	6, 004, 648	50.00
50. 00	05001 ENDOSCOPY	1, 158, 613	2, 093, 008	3, 251, 621		2, 720, 516	
51.00	05100 RECOVERY ROOM	1, 055, 038	138, 569	1, 193, 607	-29, 370	1, 164, 237	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 838, 155 0	529, 110 0	3, 367, 265 0		3, 221, 228	
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	2, 392, 852	2, 672, 621	5, 065, 473	- 1	0 4, 252, 133	
54. 01	05401 RADI OLOGY - ULTRASOUND	1, 217, 506	999, 584	2, 217, 090	-529, 360	1, 687, 730	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	469, 049	2, 005, 101	2, 474, 150		1, 692, 576	
56. 00 57. 00	05700 CT SCAN	558, 902 1, 069, 384	1, 473, 900 1, 278, 072	2, 032, 802 2, 347, 456		1, 824, 724 1, 782, 873	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	396, 707	996, 147	1, 392, 854	-740, 096	652, 758	
	05900 CARDI AC CATHETERI ZATI ON	2, 124, 257	6, 889, 904	9, 014, 161		3, 573, 583	
60. 00 60. 01	O6000 LABORATORY O6001 BLOOD LABORATORY	3, 537, 216 0	6, 509, 791 0	10, 047, 007 C		9, 976, 766 0	1
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	J	Ö	C	Ö	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 219, 421	425, 332	1, 644, 753	-8, 998	1, 635, 755	1
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0	C		0	63. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	2, 371, 390	999, 045	3, 370, 435	-314, 227	3, 056, 208	
66. 00	06600 PHYSI CAL THERAPY	1, 503, 615	129, 932	1, 633, 547		1, 616, 462	66.00
67.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	1, 227, 145	109, 674	1, 336, 819		1, 336, 373	
68. 00 69. 00	06900 ELECTROCARDI OLOGY	448, 576 628, 143	50, 271 273, 732	498, 847 901, 875		494, 837 737, 320	
69. 01	06901 CARDI AC REHAB	404, 135	424, 333	828, 468		619, 040	
70.00	07000 ELECTROENCEPHALOGRAPHY	949, 217	8, 904, 268	9, 853, 485		1, 239, 090	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	12, 761, 019 14, 565, 371	12, 761, 019 14, 565, 371	
73. 00	07300 DRUGS CHARGED TO PATIENTS	398, 792	677, 690	1, 076, 482		15, 937, 147	
74. 00	07400 RENAL DIALYSIS	2, 464	2, 337, 035	2, 339, 499	-2, 585	2, 336, 914	74.00
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	2, 708, 649	2, 423, 330	5, 131, 979	-302, 726	4, 829, 253	90.00
91.00	09100 EMERGENCY	7, 145, 334	3, 576, 145	10, 721, 479		9, 605, 619	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	.,,	2, 2, 2, 1, 1	,	1, 110, 000	.,,	92.00
101 01	OTHER REIMBURSABLE COST CENTERS	2 204 (05	270 (27	2 50/ 200	15.040	0 574 0/0	101 00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	2, 206, 695	379, 627	2, 586, 322	-15, 060	2, 571, 262	1101.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	127, 928, 838	181, 909, 778	309, 838, 616	3, 253, 077	313, 091, 693	118.00
100.00	NONREI MBURSABLE COST CENTERS	10.050	4 004	15 044	2 2/4	11 000	100.00
	1900 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH	10, 353 0	4, 891 0	15, 244 0	l l		190. 00 191. 00
	1	31_	<u> </u>		, 9		1

Health Financial Systems	METHODIST HOSE	PITALS, INC		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provi der C		eri od:	Worksheet A	
				rom 01/01/2018 o 12/31/2018		pared: 0 pm
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cat		
			+ col. 2)	ions (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	22, 189, 325	14, 721, 889	36, 911, 214	-1, 254, 310	35, 656, 904	192.00
192. 01 19201 OTHER NON-REIMBURSABLE	0	2, 685, 763	2, 685, 763	-1, 995, 503	690, 260	192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	158, 199	49, 681	207, 880	0	207, 880	192. 02
193. 00 19300 NONPALD WORKERS	0	0	(0	0	193. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	150, 286, 715	199, 372, 002	349, 658, 717	0	349, 658, 717	200. 00

Health FinancialSystemsMETHODISTRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provi der CCN: 15-0002

Peri od: Worksheet A From 01/01/2018 Date/Time Prepared: 5/28/2019 4:50 pm

					5/28/2019 4:5	
		Cost Center Description	Adjustments	Net Expenses		
			(See A-8)	For		
			6. 00	Allocation 7.00		
	GENER	AL SERVICE COST CENTERS	<u> </u>			
1.00	1	CAP REL COSTS-BLDG & FIXT	-1, 961, 574			1.00
4. 00		EMPLOYEE BENEFITS DEPARTMENT	3, 169, 515			4.00
5. 01 5. 02		DATA PROCESSING PURCHASING RECEIVING AND STORES	-181, 805 0			5. 01 5. 02
5. 02		ADMITTING	0	2, 473, 460	1	5. 02
5. 04		CASHI ERI NG/ACCOUNTS RECEI VABLE	-62, 513			5. 04
5.05		OTHER A&G	-360, 744	14, 409, 137	,	5. 05
5. 06		PATI ENT TRANSPORTATI ON	0	585, 589	1	5. 06
7.00	1	OPERATION OF PLANT	-2, 883			7.00
8. 00 9. 00	1	LAUNDRY & LINEN SERVICE HOUSEKEEPING	-2, 377	1, 450, 605 5, 599, 345		8. 00 9. 00
10.00		DI ETARY	-19, 214	4, 438, 875		10.00
11.00		CAFETERI A	-832, 440			11.00
13.00		NURSING ADMINISTRATION	-2, 719	3, 235, 944		13.00
14.00	1	CENTRAL SERVICES & SUPPLY	0			14.00
15.00	1	PHARMACY MEDICAL DECORDS & LIBRARY	0 -118, 896	5, 612, 507		15.00
16. 00 17. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	-118, 890 N	2, 707, 649 444, 894		16. 00 17. 00
17. 00		STAFF EDUCATION	0	0		17. 01
		MEDICAL EDUCATION	0	59, 195		17. 02
21. 00		I&R SERVICES-SALARY & FRINGES APPRVD	0	274, 518		21.00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRVD	0	31, 168		22.00
23. 00		PARAMED ED PROGRAM	-264, 267	482, 505		23. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	-3, 161, 798	40, 345, 807	1	30.00
31. 00	1	INTENSIVE CARE UNIT	0, 101, 770	7, 847, 990	l e e e e e e e e e e e e e e e e e e e	31.00
31. 01		NEONATAL ICU	-805, 693		l e e e e e e e e e e e e e e e e e e e	31.01
40.00		SUBPROVI DER - I PF	0	1, 388, 636		40.00
41.00		SUBPROVI DER - I RF	0	3, 178, 270		41.00
43. 00		NURSERY LARY SERVICE COST CENTERS	0	1, 419, 571		43. 00
50. 00		OPERATING ROOM	0	6, 004, 648		50.00
50. 01	1	ENDOSCOPY	Ö			50. 01
51.00		RECOVERY ROOM	0	1, 164, 237	1	51.00
52.00		DELIVERY ROOM & LABOR ROOM	-590			52.00
53.00		ANESTHESI OLOGY	0	0		53.00
54. 00 54. 01		RADI OLOGY-DI AGNOSTI C RADI OLOGY - ULTRASOUND	0	4, 252, 133 1, 687, 730		54. 00 54. 01
55. 00	1	RADI OLOGY-THERAPEUTI C	0	1, 692, 576		55. 00
56. 00	1	RADI OI SOTOPE	1, 748			56.00
57.00	1	CT SCAN	-462	1, 782, 411		57.00
58.00		MAGNETIC RESONANCE IMAGING (MRI)	0	652, 758	l control of the cont	58. 00
59.00		CARDI AC CATHETERI ZATI ON	0	3, 573, 583		59.00
60. 00 60. 01		LABORATORY BLOOD LABORATORY	-64, 018 0	_		60. 00 60. 01
	1	PBP CLINICAL LAB SERVICES-PRGM ONLY	0		•	61.00
		WHOLE BLOOD & PACKED RED BLOOD CELLS	-64, 087	1, 571, 668		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	1	63.00
64.00		INTRAVENOUS THERAPY	0	0	1	64.00
65.00		RESPI RATORY THERAPY	0	3, 056, 208		65.00
66. 00 67. 00	1	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	0	1, 616, 462 1, 336, 373	•	66. 00 67. 00
68. 00		SPEECH PATHOLOGY	0	494, 837		68.00
69.00		ELECTROCARDI OLOGY	0	737, 320		69.00
69. 01	06901	CARDI AC REHAB	-104, 718	514, 322		69. 01
70.00	1	ELECTROENCEPHALOGRAPHY	-1, 698		•	70.00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12, 761, 019		71.00
72.00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0 255, 018-	14, 565, 371 15, 682, 129		72. 00 73. 00
		RENAL DIALYSIS	-233, 010			74.00
		TIENT SERVICE COST CENTERS				1
90.00	09000	CLINIC	-583			90.00
91.00	1	EMERGENCY	-2, 275	9, 603, 344		91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)				92.00
101 00		REIMBURSABLE COST CENTERS HOME HEALTH AGENCY	0	2, 571, 262		101. 00
101.00		AL PURPOSE COST CENTERS	- U	2, 3, 1, 202	•	1.550
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-5, 099, 109	307, 992, 584		118.00
		IMBURSABLE COST CENTERS				4
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190.00
		RESEARCH PHYSICIANS' PRIVATE OFFICES	0	_		191. 00 192. 00
172.00	17200	TITIOLOLUNG TITIVALE ULLICES	U	33,030,704	TI	1172.00

Health Financial Systems	METHODI ST HOS	PITALS, INC		In Lie	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CO	CN: 15-0002	Peri od:	Worksheet A
				From 01/01/2018	D. I. (Time D I
				To 12/31/2018	Date/Time Prepared: 5/28/2019 4:50 pm
Cost Center Description	Adjustments	Net Expenses			
	(See A-8)	For			
		Allocation			
	6. 00	7. 00			
192. 01 19201 OTHER NON-REI MBURSABLE	0	690, 260			192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	0	207, 880			192. 02
193. 00 19300 NONPALD WORKERS	0	0			193. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	-5, 099, 109	344, 559, 608			200. 00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0002

					5/28/2019 4	
	20112011	Increases	Color	011		
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00		
	A - CAFETERIA	3.00	4.00	3.00		
1.00	CAFETERI A	1100	724, 387	91 <u>6, 2</u> 11		1.00
	0		724, 387	916, 211		
1 00	B - CLINICAL TRAINING COST	22.00	210 (17	0		1 00
1. 00 2. 00	PARAMED ED PROGRAM	23. 00 0. 00	219, 617 0	0		1. 00 2. 00
3. 00		0.00	o	Ö		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			00000	0		7. 00
	C - SOCIAL WORKERS		219, 017	U		_
1. 00	SOCI AL SERVI CE	17. 00	444, 894	0		1.00
	0 — — — —		444, 894	0		
	E - RESIDENTS					
1. 00	I &R SERVI CES-SALARY &	21. 00	0	274, 518		1.00
2. 00	FRINGES APPRVD I&R SERVICES-OTHER PRGM	22. 00	0	31, 168		2. 00
2.00	COSTS APPRVD	22.00	٩	31, 100		2.00
	0			305, 686		•
	F - MED SUPPLY					
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	12, 761, 019		1. 00
2. 00	PATIENTS IMPL. DEV. CHARGED TO	72. 00	0	14, 565, 371		2.00
2.00	PATIENTS	72.00	۷	14, 505, 571		2.00
3.00		0. 00	0	О		3.00
4.00		0.00	O	0		4.00
5. 00		0. 00	0	0		5. 00
6.00		0. 00 0. 00	0	0		6.00
7. 00 8. 00		0.00	0	0		7. 00 8. 00
9. 00		0.00	0	Ö		9.00
10.00		0. 00	Ö	Ö		10.00
11.00		0.00	O	0		11.00
12.00		0.00	O	0		12.00
13.00		0.00	0	0		13.00
14. 00		0. 00	0	0		14. 00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17. 00 18. 00		0. 00 0. 00	0	0		17. 00 18. 00
19. 00		0.00	0	o		19.00
20. 00		0. 00	o	ő		20.00
21. 00		0.00	Ö	Ō		21.00
22.00		0.00	O	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	0	0		28.00
29. 00		0. 00	o	Ö		29.00
30.00		0. 00	o	Ö		30.00
31.00		0.00	O	0		31.00
32.00		0.00	O	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 38. 00		0. 00 0. 00	0	0		37. 00 38. 00
39.00		0.00	0	0		39.00
40. 00		0.00	o	o		40.00
41. 00		0.00_	0	0		41.00
	0		0	27, 326, 390		
4 60	G - LIGHT DUTY	= a.l	0.075	21		
1.00	PATIENT TRANSPORTATION	5. 06 10. 00	9, 075 4, 593	0		1.00
2. 00 3. 00	DI ETARY CAFETERI A	10.00	4, 593 808	0		2. 00 3. 00
4. 00	ADULTS & PEDIATRICS	30.00	35, 405	0		4.00
5. 00	INTENSIVE CARE UNIT	31.00	5, 940	ő		5.00
6.00	SUBPROVI DER - I RF	41. 00	7, 430	0		6. 00
7.00	DRUGS CHARGED TO PATIENTS	73. 00	2, 094	0		7.00
	·	·				

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0002

					5/2	8/2019 4: 50 pm
		Increases				
	Cost Center 2.00	Li ne #	Sal ary 4.00	Other 5 00		
8. 00	OPERATING ROOM	3. 00	18, 655	5. 00		8.00
9. 00	DELIVERY ROOM & LABOR ROOM	52. 00	29, 429	0		9. 00
10.00	EMERGENCY	<u>91.</u> 00	<u>3, 5</u> 48	<u>0</u>		10.00
	0		116, 977	0		
1. 00	H - INTEREST EXPENSE CAP REL COSTS-BLDG & FIXT	1.00	O	3, 246, 411		1.00
2. 00	CAF REE COSTS-BEDG & TTAT	0.00	0	0		2.00
3. 00		0.00	o	Ö		3.00
4.00		0. 00	o	0		4.00
5. 00		0. 00	0	0		5. 00
6.00		0. 00 0. 00	0	0		6.00
7. 00				3, 246, 411		7.00
	I - CORPORATE EXPENSE		<u> </u>	0,210,111		
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	5, 760, 446		1.00
2. 00	OPERATION OF PLANT		0	4, 557, 094		2.00
	J - DRUG EXPENSE		0	10, 317, 540		
1.00	DRUGS CHARGED TO PATIENTS	73. 00	ol	15, 125, 096		1.00
2.00		0.00	O	0		2.00
	0		0	15, 125, 096		
1 00	K - PHYSICIAN RECLASS	د مدا	O	27 050		1 00
1. 00 2. 00	OTHER A&G CLINIC	5. 05 90. 00	0	37, 950 25, 820		1. 00 2. 00
2.00	0		 	$\frac{23,020}{63,770}$		2.00
	L - PSTD RECLASS		-			
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	418, 062		1.00
2.00		0. 00 0. 00	0	0		2.00
3. 00 4. 00		0.00	0	0		3. 00 4. 00
5. 00		0. 00	o	0		5. 00
6.00		0. 00	O	0		6. 00
7. 00		0. 00	0	0		7.00
8.00		0.00	0	0		8.00
9. 00 10. 00		0. 00 0. 00	0	0		9. 00 10. 00
11. 00		0.00	ő	0		11.00
12.00		0.00	О	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15. 00 16. 00		0. 00 0. 00	0	0		15. 00 16. 00
17. 00		0.00	o	0		17. 00
18. 00		0. 00	Ö	Ö		18.00
19.00		0. 00	O	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21. 00 22. 00
22. 00 23. 00		0. 00 0. 00	0	0		23. 00
24. 00		0.00	o	0		24. 00
25.00		0. 00	О	0		25. 00
26. 00		0. 00	0	0		26.00
27. 00 28. 00		0. 00 0. 00	0	0		27. 00 28. 00
28.00		0.00	0	0		29.00
30.00		0.00	o	0		30.00
31.00		0.00	О	0		31.00
32.00		0.00	0	0		32.00
	O M - DEPRECIATION RECLASS		0	418, 062		
1. 00	CAP REL COSTS-BLDG & FLXT	1. 00	0	12, 977, 546		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 6. 00		0. 00 0. 00	0	0		5. 00 6. 00
7. 00		0.00	o	0		7.00
8. 00		0. 00	o	0		8.00
9. 00		0. 00	o	0		9. 00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12. 00 13. 00		0. 00 0. 00	0	0		12. 00 13. 00
14. 00		0.00	o	0		14.00
				'	-	

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-0002

					5/28/2019	4:50 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4. 00	5. 00		
15.00		0. 00	0	0		15. 00
16.00		0. 00	0	0		16. 00
17.00		0.00	0	0		17. 00
18. 00		0. 00	0	0		18. 00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22. 00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0. 00	0	0		25. 00
26.00		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 41. 00		0. 00 0. 00	0	0		40. 00 41. 00
41.00		0.00	0	0		41.00
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	o		47. 00
48. 00		0.00	0	o		48. 00
49. 00		0. 00	0	Ö		49. 00
171.00			— — j	12, 977, 546		17.00
	N - DEPT 9101 RECLASS		-1	, , , , , , , , , , , , , , , , , , , ,		
1.00	PHYSICIANS' PRIVATE OFFICES	192. 00	48, 347	14, 259		1.00
	TOTALS		48, 347	14, 259		
	O - UTILITIES RECLASS					
1.00	OPERATION OF PLANT	7. 00		5, 171, 872		1. 00
2.00		0. 00	0	0		2. 00
3.00		0. 00	0	0		3. 00
4.00		0. 00	0	0		4.00
5. 00		0. 00	0	0		5. 00
6. 00		0. 00	0	0		6. 00
7. 00		0.00	<u> </u>	0		7. 00
F00 00	TOTALS		0	5, 171, 872		F00 00
500.00	Grand Total: Increases	1	1, 554, 222	75, 882, 843		500.00

RECLASSI FI CATI ONS

Provi der CCN: 15-0002

Peri od: Worksheet A-6 From 01/01/2018 To 12/31/2018 Date/Time Prepared:

5/28/2019 4:50 pm

Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 - CAFETERIA 1.00 DI ETARY 10.00 724, 387 916, 211 0 1.00 724, 387 916, 211 CLINICAL TRAINING COST 1.00 ADULTS & PEDIATRICS 30.00 16,814 0 1.00 0 INTENSIVE CARE UNIT 0 2.00 31.00 10, 766 0 2.00 3.00 OPERATING ROOM 50.00 12.348 0 0 3.00 4, 522 0 4.00 **IENDOSCOPY** 50.01 0 4.00 5.00 CARDIAC CATHETERIZATION 59.00 2,620 0 0 5.00 6.00 RESPIRATORY THERAPY 65.00 8, 208 0 0 6.00 7 00 EMERGENCY <u>91.</u>00 7 00 16<u>4,</u> 339 0 0 219, 617 0 - SOCIAL WORKERS 1.00 5. 05 444, 894 1.00 OTHER A&G 0 444, 894 0 E - RESIDENTS 1.00 EMERGENCY 91. 00 0 305, 686 0 1.00 2.00 0.00 0 0 2.00 305<u>, 6</u>86 MED SUPPLY PURCHASING RECEIVING AND 1.00 5.02 130, 830 0 1.00 **STORES** 0 2.00 IADMI TTI NG 5.03 0 175 2.00 3.00 OTHER A&G 5.05 0 88 0 3.00 4.00 OPERATION OF PLANT 7.00 0 63 0 4.00 HOUSEKEEPI NG 0 0 1, 937 9.00 5.00 5.00 6.00 DI FTARY 10.00 0 11 6.00 7.00 NURSING ADMINISTRATION 13.00 0 1, 413 0 7.00 o 0 8.00 CENTRAL SERVICES & SUPPLY 14.00 183, 744 8.00 0 0 9.00 PHARMACY 15.00 72, 119 9.00 10.00 MEDICAL EDUCATION 17.02 0 33 10.00 0 11.00 PARAMED ED PROGRAM 23.00 60 11.00 ADULTS & PEDIATRICS 30.00 0 608, 999 12.00 12.00 INTENSIVE CARE UNIT 0 31.00 0 13.00 172, 251 13.00 14.00 SUBPROVIDER - IPF 40.00 0 16 14.00 SUBPROVIDER - IRF 0 15.00 41.00 50, 631 0 0 0 15.00 0 16.00 NURSERY 43.00 27.741 16.00 0 OPERATING ROOM 17.00 50.00 16, 510, 904 17.00 299, 014 18.00 **ENDOSCOPY** 50.01 0 0 18.00 0 0 19.00 RECOVERY ROOM 51.00 17,615 19.00 20 00 DELIVERY ROOM & LABOR ROOM 52 00 0 0 18, 113 20 00 RADI OLOGY-DI AGNOSTI C 0 0 21.00 54.00 3, 493 21.00 22.00 RADIOLOGY - ULTRASOUND 54.01 o 33, 031 0 22.00 23.00 RADI OLOGY-THERAPEUTI C 55.00 0 20, 193 0 23.00 0 RADI OLSOTOPE 0 56.00 24 00 24 00 353 25.00 CT SCAN 57.00 0 44, 451 0 25.00 26.00 MAGNETIC RESONANCE IMAGING 58.00 o 235 0 26.00 (MRI) CARDÍ AC CATHETERIZATION 0 0 27.00 59.00 4, 768, 851 27.00 28.00 LABORATORY 60.00 0 15, 943 0 28.00 WHOLE BLOOD & PACKED RED 0 29.00 29.00 62.00 331 BLOOD CELLS 30.00 RESPIRATORY THERAPY ol 240, 549 0 30.00 65.00 0 31.00 PHYSI CAL THERAPY 66.00 0 366 31.00 32.00 OCCUPATIONAL THERAPY 67.00 0 0 32.00 ELECTROCARDI OLOGY 0 33.00 69.00 0 6,608 33.00 0 34 00 CARDI AC REHAB 69 01 o 1, 145 34 00 0 35.00 ELECTROENCEPHALOGRAPHY 70.00 0 3, 351, 989 35.00 DRUGS CHARGED TO PATIENTS 0 36.00 73.00 0 253, 650 36.00 0 37.00 RENAL DIALYSIS 74.00 0 2.585 37.00 0 0 38.00 CLINIC 90.00 161, 225 38.00 39.00 **EMERGENCY** 91.00 0 210, 768 0 39.00 0 40.00 HOME HEALTH AGENCY 101.00 0 10, 485 40.00 41 00 PHYSICIANS' PRIVATE OFFICES 192.00 104.378 0 41 00 27, 326, 390 G - LIGHT DUTY EMPLOYEE BENEFITS DEPARTMENT 1.00 4.00 116, 977 0 1.00 2 00 0 00 0 0 2 00 3.00 0.00 0 0 0 3.00 4.00 0.00 0 0 0 4.00 5.00 0.00 0 0 0 5.00 0 0 0 6.00 0.00 6.00 7.00 0.00 0 0 0 7.00 8.00 0.00 8.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0002 Peri od: Worksheet A-6 From 01/01/2018 To 12/31/2018 Date/Time Prepared:

					T	o 12/31/2018 Date/Time Pr 5/28/2019 4:	
		Decreases					
	Cost Center 6.00	Li ne # 7.00	Sal ary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00		
9. 00	0.00	0.00	0.00	9.00			9. 00
10.00	<u></u>	0.00	0	0			10.00
	0		116, 977	0			
1. 00	H - INTEREST EXPENSE OTHER A&G	5. 05	0	1, 699, 837	11		1.00
2. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 044, 837	l t		2. 00
3. 00	RADI OLOGY - ULTRASOUND	54. 01	O	58, 453			3. 00
4.00	CT SCAN	57. 00	0	58, 453	l t		4. 00
5. 00	MAGNETIC RESONANCE I MAGING (MRI)	58. 00	0	58, 453	0		5. 00
6. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	128	o		6. 00
7. 00	OTHER NON-REIMBURSABLE	192. 01	O	1, 254, 180	1		7. 00
	0		0	3, 246, 411			_
1 00	I - CORPORATE EXPENSE OTHER A&G	5. 05	0	10, 317, 540	9		1.00
1. 00 2. 00	OTHER ANG	0.00	0	10, 317, 540	0		2.00
2.00			— — <u> </u>	10, 317, 540			2.00
	J - DRUG EXPENSE						
1.00	PHARMACY	15.00	0	9, 910, 113			1.00
2. 00	ELECTROENCEPHALOGRAPHY	70.00	0	<u>5, 214, 983</u> 15, 125, 096			2.00
	K - PHYSICIAN RECLASS		<u> </u>	10, 120, 070			1
1. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	63, 770			1.00
2. 00		0.00		$$ $ \frac{0}{2.770}$			2. 00
	L - PSTD RECLASS		U_	63, 770			
1. 00	PURCHASING RECEIVING AND	5. 02	722	0	0		1.00
	STORES						
2.00	ADMITTING	5. 03	5, 591	0	-		2.00
3. 00	CASHI ERI NG/ACCOUNTS RECEI VABLE	5. 04	1, 148	0	0		3. 00
4.00	OTHER A&G	5. 05	18, 952	0	o		4.00
5.00	PATIENT TRANSPORTATION	5. 06	8, 938	0	0		5. 00
6. 00	OPERATION OF PLANT	7. 00	26, 825	0	0		6.00
7. 00 8. 00	HOUSEKEEPI NG DI ETARY	9. 00 10. 00	41, 012 7, 298	0	0		7. 00 8. 00
9. 00	CAFETERI A	11. 00	5, 625	0	-		9. 00
10.00	NURSING ADMINISTRATION	13. 00	24, 160	0	0		10.00
11.00	ADULTS & PEDIATRICS	30. 00	52, 592	0			11.00
12. 00 13. 00	NEONATAL I CU SUBPROVI DER - I PF	31. 01 40. 00	1, 152 10, 703	0	0		12. 00 13. 00
14. 00	SUBPROVI DER - I RF	41. 00	22, 880	0			14. 00
15.00	NURSERY	43. 00	13, 786	0	0		15.00
16.00	OPERATING ROOM	50. 00	15, 419	0	0		16.00
17. 00 18. 00	ENDOSCOPY RECOVERY ROOM	50. 01 51. 00	124 9, 112	0	0 0		17. 00 18. 00
19. 00	RADI OLOGY-DI AGNOSTI C	54.00	8, 360	0	1		19.00
20.00	RADI OLOGY - ULTRASOUND	54. 01	5, 225	0	0		20.00
21.00	RADI OLOGY-THERAPEUTI C	55. 00	5, 788	0			21.00
22. 00 23. 00	CT SCAN MAGNETIC RESONANCE IMAGING	57. 00 58. 00	27, 254 7, 226	0	0		22. 00 23. 00
23.00	(MRI)	38.00	7, 220	Ü			23.00
24.00	CARDIAC CATHETERIZATION	59. 00	16, 322	0	0		24.00
25. 00	LABORATORY	60.00	11, 341	0	0		25. 00
26. 00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62. 00	2, 228	0	0		26. 00
27. 00	PHYSI CAL THERAPY	66. 00	14, 820	0	o		27. 00
28. 00	ELECTROCARDI OLOGY	69. 00	12, 001	0	0		28. 00
29. 00	CLINIC	90. 00	1, 042	0	0		29. 00
30. 00 31. 00	EMERGENCY HOME HEALTH AGENCY	91. 00 101. 00	6, 083	0	0		30. 00 31. 00
32.00	PHYSICIANS' PRIVATE OFFICES	192. 00	3, 441 30, 892	0	0		32.00
00	0 — — — — —		418, 062	<u> </u>			
4.05	M - DEPRECIATION RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00 5. 01	0	9, 048	1		1. 00 2. 00
2. 00 3. 00	DATA PROCESSING PURCHASING RECEIVING AND	5. 01 5. 02	0	2, 161, 935 14, 600			3.00
5. 50	STORES	3.02	J	1 1, 300			3.00
4. 00	ADMITTING	5. 03	O	851	0		4.00
5. 00	CASHI ERI NG/ACCOUNTS RECEI VABLE	5. 04	0	3, 652	0		5. 00
6. 00	OTHER A&G	5. 05	0	244, 188	О		6. 00
7. 00	PATIENT TRANSPORTATION	5. 06	0	24, 793			7. 00
8. 00	OPERATION OF PLANT	7. 00	O	477, 304	o		8. 00

Provider CCN: 15-0002

Peri od: From 01/01/2018 To 12/31/2018 Date/Ti me Prepared: 5/28/2019 4:50 pm

						5/28/2019 4: 50) pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
9.00	HOUSEKEEPI NG	9. 00	0	50, 987	0		9.00
10.00	DI ETARY	10. 00	0	76, 375	0		10.00
11.00	CAFETERI A	11. 00	0	774	0		11.00
12.00	NURSING ADMINISTRATION	13. 00	0	33, 017	0		12.00
13.00	CENTRAL SERVICES & SUPPLY	14. 00	O	251, 480	O		13.00
14.00	PHARMACY	15. 00	o	148, 781	O		14.00
15.00	MEDICAL RECORDS & LIBRARY	16. 00	o	11, 240	O		15.00
16.00	PARAMED ED PROGRAM	23. 00	o	3, 967	o		16.00
17.00	ADULTS & PEDIATRICS	30.00	ol	818, 380	o		17.00
18. 00	INTENSIVE CARE UNIT	31.00	o	562, 996			18.00
19. 00	NEONATAL I CU	31. 01	o	25, 446			19.00
20. 00	SUBPROVI DER - I PF	40. 00	0	10, 350			20.00
21. 00	SUBPROVI DER - I RF	41. 00	Ö	9, 379			21.00
22. 00	NURSERY	43. 00	0	59, 310			22. 00
23. 00	OPERATING ROOM	50.00	Ö	1, 183, 569			23. 00
24. 00	ENDOSCOPY	50. 00 50. 01	0				24. 00
25. 00	RECOVERY ROOM	•	0	226, 150			
		51.00	-1	2, 643	0		25. 00
26.00	DELIVERY ROOM & LABOR ROOM	52.00	0	157, 353			26.00
27. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	684, 580			27.00
28. 00	RADI OLOGY - ULTRASOUND	54. 01	0	432, 651	0		28. 00
29. 00	RADI OLOGY-THERAPEUTI C	55. 00	0	755, 593			29. 00
30.00	RADI OI SOTOPE	56. 00	0	207, 725			30.00
31. 00	CT SCAN	57. 00	0	434, 425			31.00
32.00	MAGNETIC RESONANCE IMAGING	58. 00	0	674, 182	0		32.00
	(MRI)						
33.00	CARDIAC CATHETERIZATION	59. 00	0	652, 785	0		33.00
34.00	LABORATORY	60. 00	0	42, 957	0		34.00
35.00	WHOLE BLOOD & PACKED RED	62. 00	0	6, 439	0		35.00
	BLOOD CELLS						
36.00	RESPI RATORY THERAPY	65. 00	0	65, 470	0		36.00
37.00	PHYSI CAL THERAPY	66. 00	0	1, 899	0		37.00
38.00	OCCUPATIONAL THERAPY	67. 00	0	442	0		38.00
39.00	SPEECH PATHOLOGY	68. 00	O	4, 010	o		39.00
40.00	ELECTROCARDI OLOGY	69.00	ol	145, 946	o		40.00
41.00	CARDI AC REHAB	69. 01	ol	165, 249			41.00
42.00	ELECTROENCEPHALOGRAPHY	70. 00	0	47, 423			42.00
43.00	DRUGS CHARGED TO PATIENTS	73. 00	0	12, 875			43.00
44. 00	CLI NI C	90.00	0	166, 279			44.00
45. 00	EMERGENCY	91.00	0	432, 532			45. 00
46. 00	HOME HEALTH AGENCY	101.00	0	1, 134			46. 00
47. 00	GIFT, FLOWER, COFFEE SHOP &	190. 00	0	3, 264	0		47. 00
47.00	CANTEEN	190.00	٥	3, 204	U		47.00
49 00	PHYSICIANS' PRIVATE OFFICES	102.00	o	702 142	0		49.00
48. 00		192.00		793, 143 677, 975			48. 00
49. 00	OTHER NON-REIMBURSABLE	1 <u>92.</u> 01	0				49. 00
	U DEDT 0101 DEGLACE		U	12, 977, 546			
4 00	N - DEPT 9101 RECLASS	5.04	40.047	44.050			4 00
1. 00	CASHI ERI NG/ACCOUNTS	5. 04	48, 347	14, 259	0		1. 00
	RECEI VABLE			— — . .			
	TOTALS		48, 347	14, 259			
	O - UTILITIES RECLASS				T		
1. 00	DATA PROCESSING	5. 01		182, 029		•	1.00
2.00	CASHI ERI NG/ACCOUNTS	5. 04		467	0		2.00
	RECEI VABLE						
3.00	OTHER A&G	5. 05		4, 557, 094	0		3.00
4.00	ENDOSCOPY	50. 01		1, 295	0		4.00
5.00	CARDI AC REHAB	69. 01		43, 034	0		5.00
6.00	PHYSICIANS' PRIVATE OFFICES	192. 00		324, 605	0		6.00
7.00	OTHER NON-REIMBURSABLE	192. 01		63, 348			7.00
	TOTALS		o	5, 171, 872			
500.00	Grand Total: Decreases		1, 972, 284	75, 464, 781			500.00
		,	. ,		'		

Provi der CCN: 15-0002

					o 12/31/2018	Date/Time Pre	pared:
						5/28/2019 4: 5	O pm
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances		0.00		Retirements	
	DART I ANALYSIS OF SUMMERS IN SARITAL ASSE	1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	5, 373, 674	0	(0	0	1.00
2. 00	Land Improvements	6, 652, 127	56, 412		56, 412	0	2.00
3. 00	Buildings and Fixtures	281, 597, 464	0	(0	11, 067, 021	3.00
4. 00	Building Improvements	0	0	(0	0	4. 00
5.00	Fi xed Equi pment	0	0	(0	0	5.00
6.00	Movable Equipment	200, 130, 111	3, 088, 546	(3, 088, 546	0	6. 00
7.00	HIT designated Assets	0	0	(0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	493, 753, 376	3, 144, 958	C	3, 144, 958	11, 067, 021	8. 00
9.00	Reconciling Items	0	0	C	0	0	9. 00
10.00	Total (line 8 minus line 9)	493, 753, 376	3, 144, 958	C	3, 144, 958	11, 067, 021	10.00
		Endi ng	Ful I y				
		Bal ance	Depreciated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	5, 373, 674	0				1.00
2.00	Land Improvements	6, 708, 539	0				2. 00
3.00	Buildings and Fixtures	270, 530, 443	0				3.00
4.00	Building Improvements	o	0				4.00
5.00	Fi xed Equi pment	o	0				5. 00
6.00	Movable Equipment	203, 218, 657	0				6. 00
7. 00	HIT designated Assets	0	0				7.00
8. 00	Subtotal (sum of lines 1-7)	485, 831, 313	0				8.00
9. 00	Reconciling Items	0	n				9. 00
10.00	Total (line 8 minus line 9)	485, 831, 313	0				10.00
	1.222. (6 1.00		Ü	I		'	

Health Financial Systems	METHODIST HOSPITALS, INC			In Lieu of Form CMS-2552-10		
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0002	Peri od: From 01/01/2018 To 12/31/2018	Worksheet A-7 Part II Date/Time Pre 5/28/2019 4:5	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.				
	ed Costs (see	9 through 14)				
	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 & FLXT	0	0		·	·	1.00
3.00 Total (sum of lines 1-2)	0	0				3. 00

Health Financial Systems	METHODIST HOS	SPITALS, INC		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od:	Worksheet A-7	
				From 01/01/2018 o 12/31/2018		oorod:
			'	0 12/31/2018	Date/Time Prep 5/28/2019 4:50	nm
	COM	PUTATION OF RA	TLOS	ALLOCATION OF	OTHER CAPITAL	э рш
		The same of the sa				
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 -			
			col . 2)			
	1. 00	2.00	3. 00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COST	· · ·	1				
1.00 CAP REL COSTS-BLDG & FLXT	485, 831, 313					1. 00
3.00 Total (sum of lines 1-2)	485, 831, 313		,			3. 00
	ALLOCA	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL				
		1 011	I 			
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel at ed Costs				
	6, 00	7.00	through 7) 8.00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COST		7.00	8.00	9.00	10.00	
1.00 CAP REL COSTS-BLDG & FLXT	3 CENTERS 0	0		18, 768, 522	0	1. 00
3.00 Total (sum of lines 1-2)	0	_	1		l .	3. 00
3.00 Total (Sull of Titles 1-2)	0	0 0 0 18, 768, 522 0 SUMMARY OF CAPITAL				3.00
		SUMMART OF CAPITAL				
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
p		(see		Capi tal -Rel at		
		instructions)	ĺ	ed Costs (see		
		,		instructions)		
	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, 254, 307		(0	20, 022, 829	1.00
3.00 Total (sum of lines 1-2)	1, 254, 307	0	(0	20, 022, 829	3.00

ADJUST	MENTS TO EXPENSES			Provider CCN: 15-0002	Peri od: From 01/01/2018	Worksheet A-8	
					To 12/31/2018	Date/Time Pre	
				Expense Classification o	n Worksheet A	5/28/2019 4:5	O pm
		T-	o/From Which the Amount is				
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	cost center bescription	(2)	Amount	oost center	Line "	Ref.	
		1. 00	2. 00	3.00	4. 00	5. 00	
1. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	В	-1, 992, 104 C	AP REL COSTS-BLDG & FIXT	1. 00	11	1.00
2. 00	Investment income - CAP REL		0 *	** Cost Center Deleted **	2.00	0	2.00
	COSTS-MVBLE EQUIP (chapter 2)						
3. 00	Investment income - other		0		0.00	0	3.00
4. 00	(chapter 2) Trade, quantity, and time		o		0.00	0	4.00
	discounts (chapter 8)						
5. 00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6. 00	Rental of provider space by		o		0.00	0	6.00
	suppliers (chapter 8)						
7. 00	Tel ephone servi ces (pay		0		0.00	0	7.00
	stations excluded) (chapter 21)						
8.00	Television and radio service		О		0.00	0	8. 00
0.00	(chapter 21)				0.00		0.00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-3, 968, 506		0.00	0	9. 00 10. 00
	adj ustment	7. 0 2	3,755,555				
11. 00			0		0. 00	0	11.00
12. 00	(chapter 23) Related organization	A-8-1	0			0	12.00
12.00	transactions (chapter 10)	7. 0 1				l J	12.00
13.00	Laundry and linen service		0		0.00	l	
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee	В	-832, 440 C	AFETERIA	11. 00 0. 00		11.00
13.00	and others				0.00		13.00
16. 00	Sale of medical and surgical		o		0.00	0	16.00
	supplies to other than patients						
17. 00	Sale of drugs to other than		o		0.00	0	17. 00
	patients	_				_	
18. 00	Sale of medical records and abstracts	В	-118, 896 _M	EDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	Nursing and allied health		o		0.00	0	19.00
	education (tuition, fees,						
20.00	books, etc.) Vending machines	В	-19, 214 D	ΙΕΤΛΡΥ	10. 00		20.00
	Income from imposition of	В	0	LIMI	0.00		
	interest, finance or penalty						
22 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22. 00
22.00	overpayments and borrowings to				0.00		22.00
	repay Medicare overpayments						
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	OR	ESPI RATORY THERAPY	65. 00		23.00
	limitation (chapter 14)						
24.00		A-8-3	0 P	HYSICAL THERAPY	66. 00		24.00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review -		0 *	** Cost Center Deleted **	114.00		25.00
	physicians' compensation						
26. 00	(chapter 21) Depreciation - CAP REL	А	20 5200	AP REL COSTS-BLDG & FLXT	1.00	9	26.00
20.00	COSTS-BLDG & FLXT	Α	30, 3300.	M NEE COSTS-DEDU & ITAL	1.00	9	20.00
27. 00	Depreciation - CAP REL		0 *	** Cost Center Deleted ***	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0 *	** Cost Center Deleted ***	19.00		28. 00
29.00				cost center bereten """	0.00		
30.00	Adjustment for occupational	A-8-3	00	CCUPATIONAL THERAPY	67. 00		30.00
	therapy costs in excess of limitation (chapter 14)						
30. 99	1 ' ' ' '		OA	DULTS & PEDIATRICS	30. 00		30. 99
	i nstructi ons)		1				

Health Financial Systems			METHODIST HOS		In Lieu of Form CMS-2552-10		
ADJUST	TMENTS TO EXPENSES		Provi der CCN: 15-0002 Peri od:			Worksheet A-8	
					From 01/01/2018 To 12/31/2018		
				Expense Classification or	n Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2)				Ref.	
		1. 00	2. 00	3.00	4. 00	5. 00	
31.00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
	pathology costs in excess of						
	limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0. 00	0	32.00
	Depreciation and Interest		404 005	DATA DD005001110			
33.00	DATA PROCESSING OTHER INCOME	В		DATA PROCESSING	5. 01		00.00
33. 01	CASH, A/R, COLLECTIONS OTHER	В	-50, 633	CASHI ERI NG/ACCOUNTS RECEI VABLE	5. 04	0	33. 01
33. 02	A&G OTHER INCOME	В	220 EU4	OTHER A&G	5. 05	0	33. 02
	PLANT & MAINTENANCE	В		OPERATION OF PLANT	7. 00		34.00
35. 00	ENVI RONMENTAL SERVI CES OTHER	В		HOUSEKEEPI NG	9. 00		
33.00	I NCOME		-2, 377	INOUSEREET THO	7.00		33.00
36.00	NURSING ADMIN OTHER INCOME	В	-2, 719	NURSING ADMINISTRATION	13. 00	0	36, 00
37. 00	PARAMED ED PROGRAM OTHER	В		PARAMED ED PROGRAM	23. 00		37. 00
	INCOME						
38.00	ADULTS & PEDS OTHER INCOME	В	-11, 327	ADULTS & PEDIATRICS	30.00	0	38. 00
40.00	LABOR & DELIVERY	В	-590	DELIVERY ROOM & LABOR ROOM	52. 00	0	40.00
40. 01	RADI OI SOTOPE	В		RADI OI SOTOPE	56. 00		40. 01
40. 02	LAB OTHER INCOME	В	-64, 018	LABORATORY	60.00	0	1 .0.02
40. 03	BLOOD OTHER INCOME	В	-64, 087	WHOLE BLOOD & PACKED RED	62. 00	0	40. 03
		_		BLOOD CELLS			
40. 04	CARDI AC REHAB OTHER I NCOME	В		CARDI AC REHAB	69. 01	0	40.04

-1, 698 ELECTROENCEPHALOGRAPHY

-43,002 EMPLOYEE BENEFITS DEPARTMENT

-255, 018 DRUGS CHARGED TO PATIENTS

3, 212, 517 EMPLOYEE BENEFITS DEPARTMENT

-583 CLI NI C

-2, 275 EMERGENCY

-32, 240 OTHER A&G

-5, 099, 109

-179, 262 PARAMED ED PROGRAM

70.00

90.00

91.00

23.00

4.00

5.05

73.00

4.00

40.05

40.06

40.07

40.08

40.09

41.00

42.00

43.00

50.00

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

В

В

В

В

Α

Α

(2) Basis for adjustment (see instructions).

TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A, column 6, line 200.)

ELECTROCEPHALOGRAPHY OTHER

CLINIC OTHER INCOME

PENSION ADJUSTMENT

EMERGENCY ROOM

EMT OFFSET

EMT OFFSET

RX PROGRAM

DUES/LOBBYI NG

40.05

40.06

40.07

40.08

40.09

41.00

42.00

43.00

50.00

I NCOME

B. Amount Received - if cost cannot be determined.

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

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

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provi der CCN: 15-0002

						-	To 12/31/2018		
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professi ona Component		Provider Component		Physician/Provider Component	
				· ·		<u>'</u>		Hours	
	1. 00	2. 00	3. 00	4. 00		5. 00	6. 00	7. 00	
1. 00		CASHI ERI NG/ACCOUNTS RECEI VABLE	11, 880	11, 8	880	0	0	0	1.00
2.00	30. 00	ADULTS & PEDIATRICS	3, 150, 471	3, 150, 4	471	0	0	0	2.00
3.00	31. 01	NEONATAL ICU	805, 693	805, 6	693	0	0	0	3.00
4.00		CT SCAN	462		462	0	0	0	4.00
5.00	0.00		0		0	0	0	0	5.00
6. 00	0.00		0		0	0	0	0	6.00
7. 00	0.00		0		0	0	0	0	
8. 00	0. 00		0		0	0	0	0	
9.00	0. 00		0		0	0	0	0	
10.00	0. 00		0		0	0	0	0	
200.00			3, 968, 506			0		0	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE			Cost of		Physician Cost	
		l denti fi er	Limit		RCE I	Memberships &		of Malpractice	
				Limit		Continuing	Share of col.	Insurance	
	1.00	2.00	8. 00	0.00		Education	12	14.00	
1. 00	1.00	2. 00 CASHI ERI NG/ACCOUNTS	8.00	9. 00	0	12. 00	13.00		1.00
1.00		RECEI VABLE			U	U	0	0	1.00
2. 00		ADULTS & PEDIATRICS	0		0	0	0	0	2. 00
3. 00		NEONATAL ICU			0	0		0	1
4. 00		CT SCAN			0	0		0	1
5. 00	0.00	o i somi			0	0		0	1
6. 00	0.00		0		0	0	0	0	1
7. 00	0.00		0		0	0	0	o o	1
8. 00	0.00		0		0	0	0	0	1
9. 00	0.00		l o		0	0	l o	0	9. 00
10.00	0.00		l o		0	0	l o	0	1
200.00			0		0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted R	CE	RCE	Adjustment		
		l denti fi er	Component	Limit		Di sal I owance			
			Share of col.						
			14						
	1. 00	2. 00	15. 00	16. 00		17. 00	18. 00		
1. 00		CASHI ERI NG/ACCOUNTS RECEI VABLE	0		0	0	11, 880		1.00
2.00	30.00	ADULTS & PEDIATRICS	0		0	0	3, 150, 471		2.00
3.00	31. 01	NEONATAL ICU	0		0	0	805, 693		3.00
4.00	57. 00	CT SCAN	0		0	0	462		4. 00
5.00	0.00		0		0	0	0		5.00
6.00	0.00		0		0	0	0		6.00
7.00	0.00		0		0	0	0		7.00
8.00	0.00		0		0	0	0		8.00
9.00	0.00		0		0	0	0		9. 00
10.00	0.00		0		0	0	0		10.00
200.00			0		0	0	3, 968, 506		200.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2018 | Part I | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-0002

Carel Center Breazy pit inn				To	12/31/2018	Date/Time Pre 5/28/2019 4:5	
COUNTY C						072072017 1.0	Dill
Part				5451 0V55	5.4.7.4	DUDOUA OLAIO	
SPERSON SERVICE COST CENTERS 1.00	Cost Center Description		BLDG & FIXI				
Cross Series Control					PROCESSING		
Color Colo							
EMERIAL SERVICE COST CENTERS 1.00 COTOL CAP REL COSTS EMERT SI DEPARTMENT 33, 39-7, 264 6.00 DOTOL DEPARTMENT SI DEPARTMENT 34, 36-7, 36							
1.00	CENEDAL SEDVICE COST CENTEDS	0	1.00	4.00	5. 01	5. 02	
0.000 DIAGON IMPLICATE BENEFIT ITS DEPARTMENT 33,359, Zefd 81,861 33,441, T25 50 DIAGON DIAGO		20 022 829	20 022 829				1 00
0.00000 OBSEMENTATION RECEIVED NEW AND STORES 3,316,0033 1014,109 276,412 0 3,716,524 5,07 2,00 3,716,524 5,07 2,00 3,716,524 5,07 2,00 3,716,524 5,07 2,00 3,716,524 5,00 3,716,524 5,00 3,716,524 5,00 3,30 3,0		1		33, 443, 125			
5.03 (0.0570) ZOMITTING 4.40, 40, 40, 40, 40, 40, 40, 40, 40, 40,		1			11, 229, 715	l .	
0.0680 CASHERING/ACCOUNTS RECEIVABLE		1			0		1
0.0590 OFFICE AND 1.409 107 1.413 977 2.399 310 11,229,715 0 5.05 5.06 0.0592 DATE INT TRANSPORTATION 5.85 589 0 122,036 0.0 33.6 5.6 0.0 0.0502 DEFEATION 0.7 0.0		1			0		1
0.000 0.00		1			11, 229, 715		1
0.000 0.0000 LAUNDRY & LINEN SERVICE 1,450,605 253,102 0 0 96 8,00 0.000 0.0000 DETAWN 0 37,634 9,00 0.000 0.0000 DETAWN 0 37,634 9,00 0.000 0.0000 DETAWN 0 37,634 9,00 0.000 0.0000 0.0000 DETAWN 0 37,634 9,00 0.00000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000000		1			0	l .	5.06
0.000 00000 00000 000000 000000 000000					0		1
10.00 01000 01CATE 01 10.00 10.00 01.0000 01.000 01.000 01.000 01.000 01.000 01.000 01.0000 01.000 01.0000 01.0000 01.0000 01.0000 01.0000 01.0000 01.0000 01.0000 01.0000 01.0000 01.0000 01.0000 01.0000 01.0000 01.0000 01.00000 01.00000 01.00000 01.00000 01.00000 01.000000 01.000000 01.000000000				_	0		1
11.00 01100 (CAFETERIA 1.100, 066 187, 104 222, 510 0 123 11.00 13.00 1300 (MINS) MINS IMA SIMIN INSTRATION 3, 235, 944 90, 165 629, 545 0 1, 913 13.00 1300 (MINS) MINS IMA SIMIN INSTRATION 3, 235, 944 17, 276 0 6.815 14.00 14.00 14.00 16.00 17.00 18.5 17.00 18.5 17.00 17.00 18.5 17.00 18.5 17.00 17.00 18.5 17.00 18.5 17.00 17.00 18.5 17.00 18.5 17.00 17.00 18.5 17.00 17.00 18.5 17.00 18.5 17.00 17.00 18.5 17.00 17.00 17.00 18.5 17.00 17.00 17.00 17.00 18.5 17.00 17.00 17.00 17.00 18.5 17.00 17.00 17.00 17.00 18.5 17.00 17.00 17.00 17.00 17.00 18.5 17.00 17.00 17.00 17.00 18.5 17.00					0		•
13.00 01300 NURSING ADMINISTRATION 3, 235, 944 90, 166 629, 545 0 1, 913 12, 00					0		
15. DO 01500 PHARMACY				629, 545	0		
16.00 01600 MEDICAL RECORDS & LIBRARY 2,707, 649 160,551 450,346 0 636 16.00 17.01 01701 STAFF EDUCATION 0 158,279 0 0.17,00 1700 MEDICAL RECORDS & LIBRARY 57,100 17.01 17.01 17.02 17070 MEDICAL REPUIS CALLEY 57,111 0 0 0 0 0 17.01 17.01 17.02 17070 MEDICAL REPUIS CALLEY 57,111 0 0 0 0 0 0 0 0 17.01					-		
17.00 01700 SOCIAL SERVICE		1		-	0		1
17.0 17.0 17.0 STAFF EDUCATION 59 195 5.3 11 0 0 81 17.0 2 17.0 20 17.0 17.0 20 17.0 17.0 20 17.0 20 17.0 20 20 20 20 20 20 20					0		1
21.00 02100 IAR SERVICES-SALARY & FRINCES APPRVD 31, 168 63, 428 0 0 0 0 0 22.00 22.00 02200 RAS SERVICES-OTHER PRROM COSTS APPRVD 31, 168 63, 428 0 0 0 0 0 22.00					0		•
22 00 02200 RAR SERVI CES-OTHER PROM COSTS APPRVD 31, 168 63, 428 0 0 0 0 22 00		59, 195	5, 311	0	0	81	
23. 00 02300 PARAMIED ED PROGRAM 482,505 47,766 151,748 0 465 22. 00		1		0	0		
INPATIENT ROUTINE SERVICE COST CENTERS 40, 345, 807 4, 447, 445 7, 262, 420 0 193, 654 30, 00 310, 0		1					•
30.00 03000 ADULTS & PEDI ATRICS 40, 345, 807 4, 447, 445 7, 262, 420 0 193, 654 30.00 31.00 31010 INTENSIVE CANEL UNIT 7, 847, 990 282, 054 1, 465, 561 0 69, 398 31.00 31.01 03101 NEONATAL I CU 1, 895, 647 32, 062 388, 430 0 415 31.01 04100 SUBPROVI DER - I PF 1, 388, 636 56, 399 288, 737 0 420, 40.00 41.00 04100 SUBPROVI DER - I PF 1, 388, 636 56, 399 264, 706 0 11, 855 41.00 41.00 04100 SUBPROVI DER - I PF 1, 348, 636 56, 399 264, 706 0 11, 855 43.00 43		462, 505	47,700	151, 740	0	405	23.00
31.0		40, 345, 807	4, 447, 445	7, 262, 420	0	193, 654	30.00
40.00 04000 04000 04000 04000 04000 0400 0400 04000		1			-		1
41.00		1			-		1
43. 00 04300 NURSERY 1, 419, 571 346, 802 264, 706 0 11, 855 43. 00		1			-		
ANCILLARY SERVICE COST CENTERS							1
50.01							
51.00 05100 RECOVERY ROOM 1,164,237 206,542 235,795 0 3,069 51.00					-	-,	1
S2.00 05200 05200 05200 05200 05200 05200 0530		1					1
53.00 05.0		1			-		
54. 01 05401 RADI OLOGY - ULTRASOUND 1,687,730 71,763 273,298 0 14,719 54,01	53. 00 05300 ANESTHESI OLOGY	0	0	· ·	0		1
55. 00 05500 RADI OLOCY-THERAPEUTI C 1,692,576 191,477 104,438 0 1,830 55,00 56. 00 05600 RADI OI SOTOPE 1,826,472 128,404 125,999 0 94,700 56,00 57. 00 05700 CT SCAN 1,782,411 121,588 234,939 0 26,904 57,00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 652,758 59,708 87,805 0 7,016 58,00 59. 00 05900 CARDI AC CATHETERI ZATI ON 3,573,583 119,174 474,624 0 73,650 59,00 60. 01 06001 BLOOD LABORATORY 9,912,748 333,938 794,877 0 261,051 60.00 61. 00 06100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY 0 61.00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 1,571,668 5,467 274,405 0 27,408 62.00 63. 00 06400 INTRAVENOUS THERAPY 3,056,208 110,271 532,758 0 42,427 65.00 64. 00 06400 INTRAVENOUS THERAPY 1,616,462 174,225 335,635 0 516 66.00 65. 00 06600 CARDI AC HERAPY 1,616,462 174,225 335,635 0 516 66.00 66. 00 06600 OCCUPATI ONAL THERAPY 1,336,373 149,731 276,649 0 1,388 67.00 69. 01 06900 ELECTROCARDI OLOGY 737,320 0 138,904 0 1,317 69.00 69. 01 06901 CARDI AC REHAB 514,322 0 91,109 0 763 69.00 69. 01 06901 CARDI AC REHAB 514,322 0 91,109 0 763 69.00 69. 01 06901 CARDI AC REHAB 514,322 0 91,109 0 763 69.00 69. 01 06901 CARDI AC REHAB 514,322 0 91,109 0 763 69.00 69. 00 06900 ELECTROCARDI OLOGY 1,237,392 0 213,992 0 0 0 1,260,326 72.00 69. 00 07000 ELECTROCREPHALOGRAPHY 1,237,392 0 213,992 0 0 0 0 0 0 69. 00 07000 ELECTROCREPHALOGRAPHY 1,237,392 0 213,992 0 0 0 0 0 0 69. 00 09000 ELECTROCREPHALOGRAPHY 1,237,392 0 213,992 0 0 0 0 0 0 69. 00 09000 ELECTROCREPHALOGRAPHY 1,237,392 0 213,992 0 0 0 0 0 0 69. 00 09000 ELECTROCREPHALOGRAPHY 1,237,392 0 23,599 90,376 0 28,716 0 69. 00 09000 ELECTR					-		
56. 00 05600 RADIOI SOTOPE 1, 826, 472 128, 404 125, 999 0 94, 700 56, 00 57, 00 05700 CT SCAN 1,782, 411 121, 588 234, 939 0 26, 904 57, 00 58, 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 652, 758 59, 708 87, 805 0 7, 016 58, 00 59, 00 05900 CARDI AC CATHETERI ZATI ON 3, 573, 583 119, 174 474, 624 0 73, 650 59, 00 60, 00 0 0 0 0 0 0 0 0					0		
57. 00 05700 CT SCAN 1, 782, 411 121, 588 234, 939 0 26, 904 57. 00 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 652, 758 59, 708 87. 805 0 7, 016 59. 00 05900 CARDIA C CATHETERI ZATI ON 3, 573, 583 119, 174 474, 624 0 73, 650 59. 00 60. 00 0000 LABORATORY 9, 912, 748 333, 938 794, 877 0 261, 051 60. 00 60. 00 0000 LABORATORY 0 0 0 0 0 0 0 0 0					0		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 652, 758 59, 708 87, 805 0 7, 016 58.00 59.00 05900 CARDIAC CATHETERIZATION 3, 573, 583 119, 174 474, 624 0 73, 650 59.00 60.00 06000 LABORATORY 9, 912, 748 333, 938 794, 877 0 261, 501 60.00 60.01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 0 0 0 0 0 0 0 0 60.01 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 1, 571, 668 5, 467 274, 405 0 27, 408 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 0 0 0 63.00 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 0 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 3, 056, 208 110, 271 532, 758 0 42, 427 65.00 66.00 06600 PHYSI CAL THERAPY 1, 616, 462 174, 225 335, 635 0 516 66.00 6600 06600 PHYSI CAL THERAPY 1, 336, 373 149, 731 276, 649 0 1, 388 67.00 68.00 06800 SPEECH PATHOLOGY 494, 837 25, 502 101, 127 0 661 68.00 6800 SPEECH PATHOLOGY 494, 837 25, 502 101, 127 0 661 68.00 6900 CLECTROCARDIOLOGY 737, 320 0 138, 904 0 1, 317 69, 00 6900 CLECTROCARDIOLOGY 737, 320 0 138, 904 0 1, 317 69, 00 6900 CLECTROCARDIOLOGY 737, 320 0 138, 904 0 1, 317 69, 00 7000 COPOO ELECTROCARDIOLOGY 737, 320 0 138, 904 0 1, 317 69, 00 7000 COPOO ELECTROCARDIOLOGY 737, 320 0 138, 904 0 1, 317 69, 00 7000 COPOO ELECTROCARDIOLOGY 737, 320 0 138, 904 0 1, 317 69, 00 7000 COPOO ELECTROCARDIOLOGY 737, 320 0 138, 904 0 1, 317 69, 00 7000 COPOO ELECTROCARDIOLOGY 737, 320 0 138, 904 0 1, 317 69, 00 7000 COPOO ELECTROCARDIOLOGY 737, 320 0 138, 904 0 1, 317 69, 00 7000 COPOO ELECTROCARDIOLOGY 737, 320 0 91, 109 0 763, 609 0 7000 COPOO CLECTROCARDIOLOGY 737, 320 0 91, 109 0 70, 00 7000 REIGETROCARDIOLOGY 737, 320 0 91, 109 0 70, 00 7000 REIGETROCARDIOLOGY 737, 320 0 91, 109 0 70, 00 7000 REIGETROCARDIOLOGY 737, 320 0 91, 109 0 70, 00 7000 REIGETROCARDIOLOGY 737, 320 0 91, 109 0 70, 00 7000 REIGETROCARDIOLOGY 74, 257, 350 0 91, 109 0 70, 00 7000 REIGETROCARDIOLOGY 74, 257, 350 0 91, 109 0 70, 00 7000 REIGETROCARDIOLOGY 74, 257, 257, 250 0 91, 109 0 70, 00 7000 REIGETROCARDIOLOGY 74, 257, 257, 250 0 91,					-		
60. 00 06000 LABORATORY 9, 912, 748 333, 938 794, 877 0 261, 051 60. 00 60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 61. 00 06100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY 0 0 0 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 1, 571, 668 5, 467 274, 405 0 27, 408 62. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 3, 056, 208 110, 271 532, 758 0 42, 427 65. 00 66. 00 06500 RESPIRATORY THERAPY 1, 616, 462 174, 225 335, 635 0 516 66. 00 66. 00 06600 PHYSI CAL THERAPY 1, 336, 373 149, 731 276, 649 0 1, 388 67. 00 68. 00 06700 OCCUPATI ONAL THERAPY 1, 336, 373 149, 731 276, 649 0 1, 388 67. 00 69. 00 06900 SPECH PATHOLOGY 494, 837 25, 502 101, 127 0 616 68. 00 69. 01 06901 CARDI AC REHAB 514, 322 0 91, 109 0 763 69. 01 70. 00 07000 ELECTROCARDI OLOGY 737, 320 0 138, 904 0 1, 317 69. 00 71. 00 07000 ELECTROENCEPHALOGRAPHY 1, 237, 392 0 213, 992 0 0 70. 00 71. 00 07000 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 12, 761, 019 0 0 0 1, 104, 185 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 14, 565, 371 0 0 0 0 1, 260, 326 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 14, 565, 371 0 0 0 0 1, 260, 326 72. 00 74. 00 07400 RENAL DI ALYSI S 2, 336, 914 62, 235 555 0 2, 800 75. 00 07900 CLINI C 4, 828, 670 1, 081, 713 610, 406 0 6, 861 90. 00 76. 00 07400 RENAL DI ALYSI S 2, 336, 914 62, 235 555 0 2, 800 75. 00 07900 CLINI C 4, 828, 670 1, 081, 713 610, 406 0 6, 861 90. 00 76. 00 07900 CLINI C 4, 828, 670 1, 081, 713 610, 406 0 6, 861 90. 00 76. 00 07900 CLINI C 4, 828, 670 1, 081, 713 610, 406 0 6, 861 90. 00 76. 00 07900 CLINI C 07900 CLINI C 07900 CLINI C 07900 CLINI C 07	58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		59, 708	87, 805	0	7, 016	58. 00
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91. 00 09100 EMERGENCY 9, 603, 344 384, 274 1, 573, 231 0 161, 647 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 071HER REI MBURSABLE COST CENTERS 0 496, 704 0 8, 361 101. 00 10100 HOME HEALTH AGENCY 2, 571, 262 0 496, 704 0 8, 361 101. 00 101		4 000 470	1 001 710	(10, 40)	^	4 0/1	00.00
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OTHER REI MBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 2,571,262 0 496,704 0 8,361 101.00 SPECI AL PURPOSE COST CENTERS	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 555, 544	337, 274	1, 0, 0, 201	0	131,047	
SPECIAL PURPOSE COST CENTERS	OTHER REIMBURSABLE COST CENTERS						
		2, 571, 262	0	496, 704	0	8, 361	101.00
110.00		307 902 504	10 441 142	28 398 807	11 220 715	3 627 250	118 00
	- 100 TOTALO (SOM OF LINES I THE OUGH 117)	1 007, 772, 304	17, 771, 142	20, 070, 007	11,227,113	5,007,230	1. 10. 00

Health Financial Systems	METHODIST HOS	SPITALS, INC		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CC		Period: From 01/01/2018 Fo 12/31/2018	Date/Time Pre	pared:
		CADLTAL			5/28/2019 4:5	O pm
		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					
	col. 7)					
	0	1.00	4. 00	5. 01	5. 02	
NONREI MBURSABLE COST CENTERS				-		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	11, 980	25, 573	2, 33	4 0	0	190. 00
191. 00 19100 RESEARCH	0	0	(0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	35, 656, 904	379, 276	5, 006, 31	9 0	29, 217	192.00
192. 01 19201 OTHER NON-REIMBURSABLE	690, 260	49, 087	(0	46	192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	207, 880	127, 751	35, 66	5 0	33	192. 02
193. 00 19300 NONPALD WORKERS	0	o	(0	0	193. 00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	(0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	344, 559, 608	20, 022, 829	33, 443, 12	11, 229, 715	3, 716, 554	202. 00

Provider CCN: 15-0002

| Peri od: | Worksheet B | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared:

PAPER Continue Description					10) 12/31/2018	Date/lime Pre 5/28/2019 4:5	
SEPTIMENT S. 00		Cost Center Description	ADMITTI NG		Subtotal	OTHER A&G	PATI ENT	
Company Comp								
The Company			5.03		5A 04	5 05		
0.00 0.000 DUROU ENFLOYEE BEREFITS DEPARTMENT		GENERAL SERVICE COST CENTERS	0.00	0.01	<i>571. 6</i> 1	0.00	0.00	
5. 01 DOSSOJONATA PROCESSING 5. 02 DOSSOJONATA PROCESSING 5. 02 DOSSOJONATA PROCESSING 5. 06 DOSSOJONATA PROCESSING 5. 07 DOSSOJONATA PROCESSING 5. 07 DOSSOJONATA PROCESSING 5. 07 DOSSOJONATA PROCESSING 5. 08 DOSSOJONATA PROCESSING 5. 08 DOSSOJONATA PROCESSING 5. 09 DOSSOJONATA PROCESSING 5. 09 DOSSOJONATA PROCESSING 5. 00 DOSSOJONATA PROCESSING								
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				•		3, 723		
192. 00 19200 PHYSICIANS PRIVATE OFFICES 0 0 41, 0/1, /16 3, 833, 141 0 192.00					- 1	0	l e	
	192.00	MIAZOOLAULDICIAND AKINATE OLLICEZ	0	O	41, 0/1, /16	3, 833, 141	1 0	1192.00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0002	Peri od: Worksheet B From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared:		

						5/28/2019 4:5	0 pm
	Cost Center Description	ADMITTI NG	CASHI ERI NG/AC	Subtotal	OTHER A&G	PATI ENT	
			COUNTS			TRANSPORTATIO	
			RECEI VABLE			N	
		5. 03	5. 04	5A. 04	5. 05	5. 06	
192. 01 19201	OTHER NON-REIMBURSABLE	0	0	739, 393	69, 006	0	192. 01
192. 02 19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	371, 329	34, 655	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, 065, 727	7, 418, 870	344, 559, 608	29, 412, 109	774, 032	202.00

Provider CCN: 15-0002

						5/28/2019 4: 5	O pm
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	0.00	10.00	11.00	
	OSMEDAL OFFICE OF ASST OFFITEDO	7. 00	8. 00	9. 00	10.00	11.00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00550 DATA PROCESSING						5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES						5. 02
5. 03	00570 ADMI TTI NG						5.03
5. 04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.04
5. 05	00590 OTHER A&G						5.05
5.06	00592 PATIENT TRANSPORTATION 00700 OPERATION OF PLANT	30, 140, 244					5.06
7. 00 8. 00	1		2 420 274				7. 00 8. 00
9. 00	00800 LAUNDRY & LINEN SERVICE	566, 460	2, 429, 276 0	0 215 747			9.00
10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	655, 759	0	8, 215, 767	4 542 222		10.00
11. 00	01100 CAFETERI A	598, 970 418, 751	0	170, 171 118, 970	6, 563, 222 0	2, 254, 031	1
13. 00	1	201, 796	0		0		1
14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	1, 139, 053	26, 886	57, 331	0	50, 651	1
15. 00	1			323, 611	0	24, 802	1
	01500 PHARMACY	602, 434	15 0	171, 155	0	71 409	
	01600 MEDICAL RECORDS & LIBRARY	359, 325		102, 086	0	71, 408	1
17.00	01700 SOCIAL SERVICE	51, 768	0	14, 708	0	12, 656	
	01701 STAFF EDUCATION	354, 240	0	100, 642	0	0	
	01702 MEDI CAL EDUCATI ON	11, 885	0	3, 377 0	0	0	
	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	141.057	0	J	0	0	21.00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	141, 957	0	40, 331	0	0	22.00
23.00	02300 PARAMED ED PROGRAM	106, 904	0	30, 372	0	23, 166	23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.052.700	1 152 010	2 027 002	4 527 0/0	702 410	20.00
30.00	03000 ADULTS & PEDIATRICS	9, 953, 708	1, 153, 918	2, 827, 902	4, 527, 060	793, 410	1
31.00	03100 NTENSI VE CARE UNI T	631, 257	61, 087	179, 344	791, 701	135, 650	1
31. 01	03101 NEONATAL I CU	71, 757	53, 922	20, 387	0	33, 187	1
40. 00	04000 SUBPROVI DER - I PF	126, 226	0	35, 861	163, 823	29, 513	1
41.00	04100 SUBPROVI DER - I RF	992, 870	0	282, 080	516, 941	70, 244	1
43.00	04300 NURSERY	776, 169	50, 126	220, 514	0	25, 166	43.00
	ANCILLARY SERVICE COST CENTERS				_1		
50. 00	05000 OPERATING ROOM	1, 895, 520	242, 986	538, 527	0	110, 284	1
50. 01	05001 ENDOSCOPY	0	28, 815	0	0	27, 211	1
51. 00	05100 RECOVERY ROOM	462, 257	63, 605	131, 330	0	20, 634	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	222, 548	54, 340	63, 227	218, 756	66, 619	1
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 686, 160	80, 795	479, 047	0	67, 635	54.00
54. 01	05401 RADI OLOGY - ULTRASOUND	160, 611	13, 709	45, 630	0	25, 155	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	428, 539	3, 663	121, 750	0	9, 979	55.00
56.00	05600 RADI OI SOTOPE	287, 377	29, 643	81, 645	0	10, 801	56.00
57.00	05700 CT SCAN	272, 123	18, 621	77, 312	0	28, 281	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	133, 631	7, 444	37, 965	0	10, 004	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	266, 721	53, 190	75, 777	74, 094	42, 234	59.00
60.00	06000 LABORATORY	747, 378	0	212, 334	0	94, 877	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	12, 235	0	3, 476	o	53, 501	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	246, 795	3, 579	70, 116	0	60, 065	65.00
66.00	06600 PHYSI CAL THERAPY	389, 928	29, 350	110, 781	o	31, 293	1
67.00	06700 OCCUPATI ONAL THERAPY	335, 109	0	95, 206	o	25, 785	1
68. 00	06800 SPEECH PATHOLOGY	57, 075	0	16, 215	15, 395	8, 739	1
69. 00	06900 ELECTROCARDI OLOGY	0	13, 952	0	0	17, 853	1
69. 01	06901 CARDI AC REHAB	0	2, 434	0	0	10, 215	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	_,	0	295	20, 767	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS		n	0	0	0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	52, 817	n	15, 005	o	8, 752	1
74. 00	07400 RENAL DIALYSIS	139, 287	111, 960	39, 572	o	0, 732	1
74.00	OUTPATIENT SERVICE COST CENTERS	137, 207	111, 700	37, 372			74.00
90.00	09000 CLI NI C	2, 420, 953	52, 011	687, 806	O	59, 122	90.00
	09100 EMERGENCY	860, 034	259, 636	244, 340	255, 157	174, 372	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	000,034	237, 030	244, 340	255, 157	174, 372	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
101 00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
101.00	SPECIAL PURPOSE COST CENTERS		<u> </u>	o _l	٥	Ü	101.00
118. 00		28, 838, 387	2, 415, 687	7, 845, 903	6, 563, 222	2, 254, 031	118 00
	NONREI MBURSABLE COST CENTERS	20,000,007	2, 713, 007	7,040,700	0, 505, 222	2, 204, 031	1. 13. 30
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	57, 234	0	16, 260	ol	0	190. 00
	19000 GIFT, PLOWER, COFFEE SHOP & CANTEEN	07, 234	0	10, 200	ol		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	848, 848	13, 589	241, 162	ol		191.00
	19200 PHYSICIANS PRIVATE OFFICES	109, 860	13, 389		ol Ol		192.00
192.01	1720 OTHER WON-KETWIDUKSABLE	109, 860) U	31, 212	· η	- 0	1172.01

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der C	eriod: rom 01/01/2018 o 12/31/2018	Worksheet B Part I Date/Time Prepared: 5/28/2019 4:50 pm

						3/20/2019 4.3	U DIII
	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	285, 915	0	81, 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)	30, 140, 244	2, 429, 276	8, 215, 767	6, 563, 222	2, 254, 031	202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-0002

					Io	12/31/2018	Date/lime Pre 5/28/2019 4:5	
		Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
			ADMI NI STRATI O	SERVICES &		RECORDS &	SERVI CE	
			N 13. 00	SUPPLY 14. 00	15. 00	16. 00	17. 00	
	GENER	AL SERVICE COST CENTERS	10.00		10100	10.00		
1. 00		CAP REL COSTS-BLDG & FIXT						1.00
4. 00	1	EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 5. 02	1	DATA PROCESSING PURCHASING RECEIVING AND STORES						5. 01 5. 02
5. 02	1	ADMITTING						5.02
5. 04	1	CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 04
5.05		OTHER A&G						5. 05
5.06		PATIENT TRANSPORTATION						5.06
7.00		OPERATION OF PLANT						7.00
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING						8. 00 9. 00
10.00	1	DI ETARY						10.00
11.00	1	CAFETERI A						11.00
13.00		NURSING ADMINISTRATION	4, 636, 697					13.00
14.00		CENTRAL SERVICES & SUPPLY	0	4, 128, 019				14.00
15.00		PHARMACY	0	0		4 1/1 774		15.00
16. 00 17. 00	1	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	38, 552	0	0	4, 161, 774	739, 046	16. 00 17. 00
17. 00		STAFF EDUCATION	30, 332	0	0	0	737, 040	17. 00
17. 02		MEDICAL EDUCATION	o	0	0	Ō	0	17. 02
21.00	1	I&R SERVICES-SALARY & FRINGES APPRVD	o	0	0	0	0	21.00
22. 00	1	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0		0	0	22.00
23. 00		PARAMED ED PROGRAM	70, 569	0	0	0	0	23. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	2, 416, 906	0	0	344, 496	588, 264	30.00
31.00		INTENSIVE CARE UNIT	413, 220	0		58, 808	0	31.00
31. 01	1	NEONATAL ICU	101, 096	0		17, 983	0	31. 01
40.00	04000	SUBPROVI DER - I PF	89, 903	0	0	15, 055	0	40.00
41.00		SUBPROVI DER - I RF	213, 979	0	I I	24, 886	118, 927	41.00
43. 00		NURSERY	76, 662	0	0	7, 393	0	43. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	335, 950	0	0	523, 246	0	50.00
50. 01	1	ENDOSCOPY	82, 892	0		59, 432	0	50. 01
51.00		RECOVERY ROOM	62, 856	0	0	35, 385	0	51.00
52.00	1	DELIVERY ROOM & LABOR ROOM	202, 935	0	0	18, 498	0	52.00
53.00	1	ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00 54. 01	1	RADI OLOGY - DI AGNOSTI C RADI OLOGY - ULTRASOUND	0	0	0	131, 075 58, 747	0	54. 00 54. 01
55. 00		RADI OLOGY - ULTRASOUND		0	0	49, 268	0	55.00
56. 00		RADI OI SOTOPE	l ő	0	Ö	54, 322	0	56.00
57.00		CT SCAN	0	0	0	406, 804	0	57.00
58. 00	1	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	96, 878	0	58. 00
59.00		CARDI AC CATHETERI ZATI ON	0	0	0	243, 892	0	59.00
60.00		LABORATORY BLOOD LABORATORY	0	0	663, 130 0	507, 951	0	60. 00 60. 01
60. 01 61. 00		PBP CLINICAL LAB SERVICES-PRGM ONLY	٩	U	0	0	Ü	61.00
		WHOLE BLOOD & PACKED RED BLOOD CELLS	o	0	0	29, 300	0	1
63.00		BLOOD STORING, PROCESSING & TRANS.	O	0	0	0	0	63.00
64.00		I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00		RESPI RATORY THERAPY	0	0	0	128, 649	0	65.00
66.00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	0	0	0	25, 732	0	66. 00 67. 00
67. 00 68. 00	1	SPEECH PATHOLOGY		0	0	19, 872 8, 181	0	68.00
69. 00	1	ELECTROCARDI OLOGY	o	0	Ö	75, 771	0	69.00
69. 01		CARDI AC REHAB	O	0	0	2, 931	0	69. 01
70.00		ELECTROENCEPHALOGRAPHY	0	0	0	88, 095	0	70. 00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 927, 718		173, 874	0	71.00
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	2, 200, 301 0		106, 144 502, 912	0	72. 00 73. 00
74.00		RENAL DIALYSIS		0	1	29, 232	0	74.00
, 00		TIENT SERVICE COST CENTERS	<u> </u>		<u> </u>	27,202		7 00
		CLI NI C	0	0	2	84, 557	0	90.00
		EMERGENCY	531, 177	0	0	219, 875	31, 855	1
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)						92.00
101 00		REIMBURSABLE COST CENTERS HOME HEALTH AGENCY	ol	0	9, 961	12, 530	0	101. 00
101.00		AL PURPOSE COST CENTERS	ı U	0	7, 701	12, 530	0	, 101.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4, 636, 697	4, 128, 019	7, 116, 518	4, 161, 774	739, 046	118. 00
		IMBURSABLE COST CENTERS						
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1	0		190.00
		RESEARCH PHYSICIANS' PRIVATE OFFICES	0	0		0		191. 00 192. 00
172.00	117200	THIS STANS THE WATE OFFICES	<u>ا</u>	0	101,000	υĮ	0	11 /2.00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0002	Peri od: Worksheet B From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared:		

						<u> 5/28/2019_4:5</u>	0 pm
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
		ADMI NI STRATI O	SERVICES &		RECORDS &	SERVI CE	
		N	SUPPLY		LI BRARY		
		13. 00	14. 00	15. 00	16. 00	17. 00	
192. 01 19201	OTHER NON-REIMBURSABLE	0	0	0	0	0	192. 01
192. 02 19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0	0	192. 02
193. 00 19300	NONPALD WORKERS	0	0	0	0	0	193.00
200. 00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	4, 636, 697	4, 128, 019	7, 218, 183	4, 161, 774	739, 046	202.00

Provider CCN: 15-0002

				LNTERNO	DECLIDENTS	5/28/2019 4:5	0 pm
				INTERNS &	RESI DENTS		
	Cost Center Description	STAFF	MEDI CAL	SERVI CES_SALA	SERVI CES-OTHE	PARAMED ED	
	dost denter bescription	EDUCATI ON	EDUCATI ON	RY & FRINGES		PROGRAM	
		17. 01	17. 02	21.00	22. 00	23. 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	00550 DATA PROCESSING						5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES						5.02
5.03	00570 ADMITTING						5. 03
5. 04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 04
5. 05	00590 OTHER A&G						5. 05
5. 06	00592 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 11. 00	01000 DI ETARY 01100 CAFETERI A						10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION						13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00	01500 PHARMACY						15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY						16.00
17. 00	01700 SOCIAL SERVICE						17. 00
17. 01	01701 STAFF EDUCATION	627, 933					17. 01
17. 02	01702 MEDI CAL EDUCATI ON	0	85, 877				17. 02
21. 00	02100 &R SERVICES-SALARY & FRINGES APPRVD	o	0	300, 138			21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	O	0		285, 712		22.00
23.00	02300 PARAMED ED PROGRAM	1, 041	0		·	978, 231	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	298, 643	0			0	30.00
31. 00	03100 INTENSIVE CARE UNIT	49, 705	0	0	0	0	31.00
31. 01	03101 NEONATAL I CU	8, 421	0	0	0	0	31. 01
40. 00	04000 SUBPROVI DER - I PF	3, 516	0			0	40.00
41.00	04100 SUBPROVI DER – I RF	20, 277	0	-		0	41.00
43.00	04300 NURSERY	14, 561	0	0	0	0	43. 00
FO 00	ANCILLARY SERVICE COST CENTERS	E4 7/7	0			0	FO 00
50. 00 50. 01	05000 OPERATI NG ROOM 05001 ENDOSCOPY	54, 767 6, 034	0			0	50. 00 50. 01
51. 00	05100 RECOVERY ROOM	3, 690	0			0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	33, 604	0		_	0	52.00
53. 00	05300 ANESTHESI OLOGY	33, 004	0	0		0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	3, 378	0			0	54.00
54. 01	05401 RADI OLOGY - ULTRASOUND	3, 541	0			0	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	1, 390	0			0	55. 00
56.00	05600 RADI 0I S0T0PE	81	0	O		0	56.00
57.00	05700 CT SCAN	2, 568	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	44	0	0	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	34, 651	0	0	0	0	59.00
60.00	06000 LABORATORY	1, 845	0	0	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	711	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	11, 413	0	0	0	0	65.00
66.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	287	0	0	0	0	66. 00 67. 00
67. 00 68. 00	06800 SPEECH PATHOLOGY	723 243	0	0	0	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	3, 615	0	0	0	0	69.00
69. 01	06901 CARDI AC REHAB	3,015	0	0	0	0	69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 496	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 470	0	0	0	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	ol	0	0	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	262	0	Ö	o	0	73. 00
74.00	07400 RENAL DIALYSIS	O	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS	-1					
90.00	09000 CLI NI C	2, 094	0	0	0	0	90.00
91.00		45, 784	85, 877	300, 138	285, 712	978, 231	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	7, 031	0	0	0	0	101. 00
440 -	SPECIAL PURPOSE COST CENTERS	/	0= ==-	00-	00= =1	077	140 0-
118.00	, ,	615, 416	85, 877	300, 138	285, 712	978, 231	118.00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
		<u> </u>	O ₁	·	, <u> </u>		

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002
From 01/01/2018
To 12/31/2018
Date/Time Prepared: 5/28/2019 4:50 pm

						3/20/2019 4.3	o piii
				INTERNS &	RESI DENTS		
	Cost Center Description	STAFF	MEDI CAL	SERVI CES-SALA	SERVI CES-OTHE	PARAMED ED	
		EDUCATI ON	EDUCATI ON	RY & FRINGES	R PRGM COSTS	PROGRAM	
		17. 01	17. 02	21.00	22. 00	23. 00	
192.00 19200	PHYSICIANS' PRIVATE OFFICES	12, 517	0	C	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)	627, 933	85, 877	300, 138	285, 712	978, 231	202.00

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

Control Cont							5/28/2019 4: 5	
Cost 1 A PRINT September			Cost Center Description	Subtotal		Total		
Skepsions								
Chebrol Septice Cost Centres 24.00 25.00 26.00								
1.00								
1.00 000000				24. 00		26.00		
4.00 DOUGO DEPLOYEE BERNET IS DEPARTMENT	4 00			1				1 00
5.01 Obeside Data Processes MS 5.02 5.05								1
Decod PURICINAS INSTRUCT YIN CARD STORES								1
5.04 5.06		1	1					1
5.05								1
5.00 00929 PATIENT TRANSPORTATION								1
0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.00000000		1	1					1
0.000 DOBOOL AURIDRY & LINEN SERVICE 9.00 0.000 DOBOOL FERRY 1.00 1.00 0.000 DETARY 1.000		1	1					1
10.00 01000 DETARY		1	1					1
11.00 10100 CAFETERIA		1	1					1
13.00 1300 NURSING ADMINISTRATION 14.00 1400								1
14.00 1400 CENTRAL SERVICES & SUPPLY		1	1					1
15.00 01500 PHABMACY		1	1					1
17.00 17070 SOCIAL SERVICE								1
17.00 1707 STAFF EDUCATION								1
17. 02 01702 MEDICAL EBUCATION								1
21.00		1	1					1
22.00 02200 RANSERVICES_OTHER PROM COSTS APPRVD								1
IMPATI ENT ROUTINE SERVICE COST CENTERS 81,279,717 0 81,279,777 30.00 30.00 30.00 30.00 AULTS & PEDIATRICS 81,279,717 0 81,279,777 30.00 31.00								1
0.00 0.3000 ADULTS & PEDIATRICS	23. 00							23. 00
13. 00 03100 NTENSIVE CARE UNIT 13. 054, 340 0 13, 054, 340 31. 00 10. 00310 NEMATAL I CU 2, 845, 305 31. 01 03010 NEMATAL I CU 2, 845, 305 0 2, 401, 421 40. 00 40. 00 4000 SUBPROVI DER - I PF 2, 401, 421 0 2, 401, 421 40. 00 43. 00 43.00 NURSERY 3, 3424, 550 0 3, 424, 550 43. 00 43. 00 43. 00 NURSERY 3, 424, 550 0 3, 424, 550 50. 00 3, 424, 550 43. 00 43. 00 NURSERY 3, 44, 550 0 31, 682, 469 50. 00 5000 PERATI NG ROM 13, 682, 469 0 13, 682, 469 50. 01 5001 ENDOSCOPY 3, 714, 439 50. 01 5001 ENDOSCOPY 3, 714, 439 50. 01 5001 ENDOSCOPY 3, 714, 439 50. 01 5001 ENDOSCOPY 6, 72, 729 6, 720 6, 73, 705 0 2, 637, 705 0 50. 00 5010 RECOVERY ROM & LABOR ROM 5, 287, 229 0 5, 287, 229 52. 00 50, 500 6, 72, 720 6, 720 7, 720 6, 7	20 00			01 270 717	٥	91 270 717		20.00
13.1 0 03101 NEONATAL ICU		1	1					
41.00 04100 SUBROVI DER - 1 RF 6, 977, 006 0 6, 977, 006 41.00		1	1					1
43.00 04300 NURSERY 3, 424, 550 0 3, 424, 550 0 3, 424, 550 0 3, 424, 550 0 3, 424, 550 5 0 05000 0FERATI NG ROOM 13, 682, 469 0 13, 682, 469 50, 01 05001 ENDOSCOPY 3, 714, 439 50, 01 15001 ENDOSCOPY 3, 714, 439 50, 01 15001 ENDOSCOPY 51, 00 51, 00 05100 RECOVERY ROOM 2, 637, 105 51, 00 52, 207, 229 52, 00 53, 00 05300 DELIVERY ROOM 4, 26, 07, 229 52, 00 5, 287, 229 52, 00 54, 00 05400 RECOVERY ROOM 4, 26, 2793, 582 0 8, 959, 328 54, 00 54, 00 05400 RABIO LOCY - DIAGNOSTI C 8, 959, 328 0 8, 959, 328 54, 01 05401 RABIO LOCY - DIAGNOSTI C 2, 793, 582 0 2, 793, 582 54, 01 05401 RABIO LOCY - LITRASOUND 2, 793, 582 0 2, 793, 582 54, 01 05500 RABIO LOCY - HERAPEUTI C 2, 731, 201 0 2, 931, 201 55, 00 05500 RABIO LOCY - HERAPEUTI C 2, 731, 201 0 2, 931, 201 55, 00 05500 RABIO LOCY - HERAPEUTI C 3, 036, 498 0 3, 036, 498 56, 00 05500 MAGINETI C RESONANCE I MAGING (MRI) 1, 478, 746 0 1, 478, 746 58, 00 05900 LABORATORY 15, 984, 089 0 15, 984, 089 0 60, 00 0600 LABORATORY 15, 984, 089 0 15, 984, 089 0 60, 00 0600 LABORATORY 10 0 0 0 0 0 0 0 0		1	1					1
ANCILLARY SERVICE COST CENTERS		1	1					1
50. 00 05000 0FEATING ROOM 13, 682, 469 0 13, 682, 469 50. 00	43.00			3, 424, 550	U	3, 424, 550		43.00
50. 01 05001 ENDOSCOPY 3, 714, 439 0 3, 714, 439 50. 01	50.00			13, 682, 469	0	13, 682, 469		50.00
52 00 05200 05200 05200 05200 05300 05400 05401 0540	50. 01	05001	ENDOSCOPY	3, 714, 439	О	3, 714, 439		50. 01
53.00 05300 ANESTHESI OLOGY 0 0 53.00		1	1		_			1
54. 00 05400 RADIO LOGY-DI AGNOSTIC 8. 959, 328 0 8. 959, 328 54. 00 54. 01 05401 RADIO LOGY - ULTREASOUND 2. 793, 582 0 2. 793, 582 54. 01 55. 00 05500 RADIOLOGY - HERAPEUTIC 2. 931, 201 0 2. 931, 201 55. 00 05600 RADIOLOGY-THERAPEUTIC 2. 931, 201 0 2. 931, 201 55. 00 56. 00 05600 RADIOLOGY-THERAPEUTIC 3. 0.36, 498 0 3. 0.36, 498 56. 00 57. 00 5700 CT SCAN 4. 433, 617 57. 00 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 1. 478, 746 0 1. 478, 746 58. 00 59. 00 59900 CARDIAC CATHETERI ZATION 6. 126, 240 0 6. 126, 240 59. 00 60. 00 06. 000					_			1
54. 01 05401 RADI OLOGY - ULTRASQUND 2, 793, 582 0 2, 793, 582 54. 01		1	1	- 1	_			1
56. 00 0500 RADIO I SOTOPE 3, 036, 498 0 3, 036, 498 56. 00		1	1					1
57.00 05700 05700 05700 05800 MAGNETIC RESONANCE IMAGING (MRI) 1, 478, 746 0 1, 478, 746 58.00 05900 CARDIAC CATHETERIZATION 6, 126, 240 0 6, 126, 240 59.00 60.00		1	1	2, 931, 201	0	2, 931, 201		55. 00
58. 00 059.00 05900 CARDIAC E IMAGING (MRI) 1, 478, 746 0 1, 478, 746 59. 00 59. 00 05900 CARDIAC CATHETERIZATION 6, 126, 240 0 6, 126, 240 59. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 01 60. 00 60. 01 60. 00 60. 01 60. 00 60. 01 60. 00 60. 01 60. 00 60. 01 60. 00 60. 01 60. 00 60. 01 60. 00 60. 01 60. 00 60. 01 60. 00 60. 01 60. 00 60. 01 60. 00 60. 01 60. 00 60. 01 60. 00								1
59.00 05900 05900 05800 CARDI AC CATHETERI ZATI ON 6, 126, 240 0 6, 126, 240 0 60.00		1	1					1
60. 00 06000 LABORATORY 15, 984, 089 0 15, 984, 089 0 0 60. 00 60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0					-			1
61.00 06100 PBP CLINICAL LAB SERVICES-PROM ONLY 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 2,234,232 0 2,234,232 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 064.00 NTRAVENOUS THERAPY 4,966,049 0 4,966,049 065.00 065.00 06600 PHYSI CAL THERAPY 2,983,580 0 2,983,580 065.00 06600 PHYSI CAL THERAPY 2,983,580 0 2,983,580 0 060.00 06000 000 06000 000								1
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 2, 234, 232 0 2, 234, 232 0 63.00 63.00 63.00 64.00 06.00 0 0 0 0 0 64.00 64.00 06.00 06.00 0 0 0 0 0 0 0 0 0				0	0			1
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 64. 00 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 65. 00 65. 00 06500 RESPI RATORY THERAPY 2, 983, 580 0 2, 983, 580 66. 00 66. 00 06600 PHYSI CAL THERAPY 2, 460, 216 0 2, 460, 216 67. 00 67. 00 06700 OCCUPATI ONAL THERAPY 2, 460, 216 0 2, 460, 216 67. 00 68. 00 06800 SPECCH PATHOLOGY 808, 521 0 808, 521 68. 00 69. 00 06900 ELECTROCARDI OLOGY 1, 283, 853 0 1, 283, 853 69. 00 69. 01 06901 CARDI AC REHAB 686, 422 0 686, 422 69. 01 70. 00 07000 ELECTROCEPHALOGRAPHY 1, 945, 307 0 1, 739, 723 71. 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 17, 739, 723 0 17, 739, 723 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 19, 901, 483 0 19, 901, 483 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 25, 710, 106 0 25, 710, 106 73. 00 74. 00 07400 RENAL DI ALYSIS 3, 027, 310 0 3, 027, 310 00TPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 10, 676, 806 0 10, 676, 806 90. 00 91. 00 09100 EMERGENCY 3, 427, 468 0 3, 427, 468 91. 00 00THER REIMBURSABLE COST CENTERS 101. 00 SUBTOTALS (SUM OF LINES 1 through 117) 296, 597, 266 -585, 850 296, 011, 416 118. 00 NONREI MBURSABLE COST CENTERS				0				
64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 65. 00 65. 00 65. 00 RESPI RATORY THERAPY 4, 966, 049 0 4, 966, 049 65. 00 66. 00 06600 PHYSI CAL THERAPY 2, 983, 580 0 2, 983, 580 66. 00 66. 00 06600 PHYSI CAL THERAPY 2, 460, 216 0 2, 460, 216 67. 00 66. 00 06700 OCCUPATI ONAL THERAPY 2, 460, 216 0 2, 460, 216 67. 00 68. 00 6800 SPEECH PATHOLOGY 808, 521 0 808, 521 68. 00 69. 00 6900 ELECTROCARDI OLOGY 1, 283, 853 0 1, 283, 853 69. 00 69. 01 06901 CARDI AC REHAB 686, 422 0 686, 422 0 686, 422 69. 01 70. 00 07000 ELECTROCARDI OLOGY 1, 945, 307 0 1, 945, 307 70. 00 71. 00 07000 ELECTROCARDI CARDI AC REHAB 686, 422 0 686, 422 0 686, 422 69. 01 70. 00 07000 ELECTROCARDI ELECTROCARDI TO PATI ENTS 17, 739, 723 0 17, 739, 723 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 19, 991, 483 0 19, 991, 483 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 19, 991, 483 0 19, 991, 483 72. 00 07300 DRUGS CHARGED TO PATI ENTS 25, 710, 106 0 25, 710, 106 73. 00 07400 RENAL DI ALYSI S 3, 027, 310 0 3, 027, 310 0 3, 027, 310 0 74. 00 000 DRUGS CHARGED TO PATI ENTS 10, 676, 806 17, 113, 458 91. 00 09000 [EMERGENCY 17, 699, 308 -585, 850 17, 113, 458 91. 00 09000 [EMERGENCY 17, 699, 308 -585, 850 17, 113, 458 91. 00 09000 [EMERGENCY 3, 427, 468 0 3, 427, 468] 0 10. 00 09000 [SERVATI ON BEDS (NON-DI STI NCT PART) 0 00 00 00 DESERVATI ON BEDS (NON-DI STI NCT PART) 0 00 00 00 DESERVATI ON BEDS (NON-DI STI NCT PART) 0 00 00 00 DESERVATI ON BEDS (NON-DI STI NCT PART) 0 00 00 00 DESERVATI ON BEDS (NON-DI STI NCT PART) 0 00 00 00 DESERVATI ON BEDS (NON-DI STI NCT PART) 0 00 00 00 DESERVATI ON BEDS (NON-DI STI NCT PART) 0 00 00 00 00 DESERVATI ON BEDS (NON-DI STI NCT PART) 0 00 00 00 00 DESERVATI ON BEDS (NON-DI STI NCT PART) 0 00 00 00 00 DESERVATI ON BEDS (NON-DI STI NCT PART) 0 00 00 00 00 00 DESERVATI ON BEDS (NON-DI STI NCT PART) 0 00 00 00 00 00 00 00 00 00 00 00 00				2, 234, 232 0	0	2, 234, 232 N		1
66. 00 06600 PHYSI CAL THERAPY 2, 983, 580 0 2, 983, 580 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 2, 460, 216 0 2, 460, 216 67. 00 680. 0 6800 SPEECH PATHOLOGY 808, 521 0 808, 521 68. 00 66900 ELECTROCARDI OLOGY 1, 283, 853 0 1, 283, 853 69. 069. 01 06901 CARDI AC REHAB 686, 422 0 686, 422 0 686, 422 69. 01 07. 00				Ö	Ö	0		1
67. 00 06700 OCCUPATI ONAL THERAPY 2, 460, 216 0 2, 460, 216 68. 00 68. 00 06800 SPEECH PATHOLOGY 808, 521 0 808, 521 68. 00 69. 00 06900 ELECTROCARDI OLOGY 1, 283, 853 0 1, 283, 853 69. 01 69. 01 06901 CARDI AC REHAB 686, 422 0 686, 422 0 686, 422 70. 00 07000 ELECTROECEPHALOGRAPHY 1, 945, 307 0 1, 945, 307 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 17, 739, 723 0 17, 739, 723 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 19, 901, 483 0 19, 901, 483 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 25, 710, 106 0 25, 710, 106 07400 RENAL DI ALYSI S 3, 027, 310 0 3, 027, 310 74. 00 00 07400 RENAL DI ALYSI S 3, 027, 310 0 3, 027, 310 74. 00 00 07400 RENAL DI ALYSI S 10, 676, 806 17, 113, 458 91. 00 00 09000 CLI NI C 10, 676, 806 17, 699, 308 -585, 850 17, 113, 458 91. 00 00 09000 DRIGGS CHARGED TO PATI ENTS 10, 699, 308 -585, 850 17, 113, 458 91. 00 00 09000 CLI NI C 10, 676, 806 17, 699, 308 -585, 850 17, 113, 458 91. 00 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	1		0			1
68. 00					0			
69. 00					0			1
69. 01 06901 CARDI AC REHAB 686, 422 0 686, 422 0 70. 00 7000 ELECTROENCEPHALOGRAPHY 1, 945, 307 0 1, 945, 307 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 17, 739, 723 0 17, 739, 723 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 19, 901, 483 0 19, 901, 483 72. 00 07300 DRUGS CHARGED TO PATI ENTS 25, 710, 106 0 25, 710, 106 74. 00 07400 RENAL DI ALYSI S 25, 710, 106 0 3, 027, 310 0 00TPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 10, 676, 806 0 10, 676, 806 91. 00 09200 DEMERGENCY 17, 699, 308 -585, 850 17, 113, 458 91. 00 09200 DEMERGENCY 3, 427, 468 0 3, 427, 468 0 3, 427, 468 0 3, 427, 468 0 101. 00 SPECI AL PURPOSE COST CENTERS 118. 00 NONREI MBURSABLE COST CENTERS 118. 00 NONREI MBURSABLE COST CENTERS					-			
71. 00					Ō			
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73. 00 07300 DRUGS CHARGED TO PATIENTS 25, 710, 106 0 25, 710, 106 73. 00 74. 00 07400 RENAL DI ALYSIS 3, 027, 310 0 3, 027, 310 74. 00 000		1	1		_			1
74. 00								
OUTPATI ENT SERVI CE COST CENTERS OUTPATI CE								
91. 00		OUTPA	TIENT SERVICE COST CENTERS		-	,		1
92. 00								1
OTHER REI MBURSABLE COST CENTERS 101. 00				17, 699, 308		17, 113, 458		1
101.00	92.00				U			92.00
SPECIAL PURPOSE COST CENTERS	101.00			3, 427, 468	ol	3, 427, 468		101.00
NONREI MBURSABLE COST CENTERS		SPECI	AL PURPOSE COST CENTERS					
	118.00			296, 597, 266	-585, 850	296, 011, 416		118.00
170.00 117, 104 177, 104 177, 104 177, 104 177, 104 177, 104 177, 104	190 00			117 104	ol	117 104		190 00
	. , 5. 50	. , , , 500	,	, 104	<u> </u>	,, 104		1

Health Financial Systems	METHODIST HOSI	PITALS, INC		In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CC	CN: 15-0002	Peri od: From 01/01/2018 To 12/31/2018	
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	24. 00	25. 00	26. 00		
191. 00 19100 RESEARCH	0	0		0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	46, 122, 638	0	46, 122, 63	38	192. 00
192. 01 19201 OTHER NON-REIMBURSABLE	949, 471	0	949, 47	'1	192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	773, 129	0	773, 12	29	192. 02
193. 00 19300 NONPALD WORKERS	0	0		0	193. 00
200.00 Cross Foot Adjustments	0	0		0	200. 00
201.00 Negative Cost Centers	0	0		0	201.00
202.00 TOTAL (sum lines 118 through 201)	344, 559, 608	-585, 850	343, 973, 75	58	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2018 Part II
To 12/31/2018 Date/Time Prepared: 5/28/2019 4:50 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0002

) 12/31/2018	5/28/2019 4:5	
	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSI NG	
		0	1. 00	2A	4.00	5. 01	
	GENERAL SERVICE COST CENTERS		11.00			0.0.	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	83, 861		83, 861		4.00
5. 01	00550 DATA PROCESSING	0	130, 491		2, 287	132, 778	5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES	0	104, 109		567	0	5. 02
5. 03 5. 04	00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	137, 974 435, 150		1, 127 1, 228	0	5. 03 5. 04
5. 05	00590 OTHER A&G	0	1, 413, 947		5, 913	132, 778	5. 05
5. 06	00592 PATIENT TRANSPORTATION	0	0		306	0	5. 06
7.00	00700 OPERATION OF PLANT	0	4, 250, 247		2, 166	0	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	253, 102		0	0	8.00
9.00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	293, 002	1	2, 468	0	9.00
10. 00 11. 00	01100 CAFETERI A	0	267, 627 187, 104	1	1, 335 583	0	10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION	0	90, 165		1, 578	0	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	508, 944		319	0	14. 00
15.00	01500 PHARMACY	0	269, 175	269, 175	o	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	160, 551		1, 129	0	16.00
17. 00	01700 SOCIAL SERVICE	0	23, 131		251	0	17.00
17. 01	01701 STAFF EDUCATION	0	158, 279		0	0	17. 01
17. 02 21. 00	01702 MEDICAL EDUCATION 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	5, 311 0		0	0	17. 02 21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	63, 428	· ·	0	0	22.00
23. 00	02300 PARAMED ED PROGRAM	0	47, 766		380	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	4, 447, 445		18, 247	0	30.00
31.00	03100 NTENSI VE CARE UNI T	0	282, 054		3, 673	0	31.00
31. 01 40. 00	03101 NEONATAL I CU 04000 SUBPROVI DER - I PF	0	32, 062 56, 399		973 724	0	31. 01 40. 00
41. 00	04100 SUBPROVI DER - I RF	0	443, 627		1, 580	0	41.00
43.00	04300 NURSERY	0			663	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	846, 943		2, 390	0	50.00
50. 01 51. 00	05001 ENDOSCOPY 05100 RECOVERY ROOM	0	0 206, 542		652 591	0	50. 01 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	99, 437		1, 620	0	52.00
53. 00	05300 ANESTHESI OLOGY	0	0		0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	753, 398		1, 347	0	54.00
54. 01	05401 RADI OLOGY - ULTRASOUND	0	71, 763		685	0	54. 01
55.00	05500 RADI OLGGY-THERAPEUTI C	0	191, 477		262	0	55.00
56. 00 57. 00	05600	0	128, 404 121, 588		316 589	0	56. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	59, 708		220	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0			1, 190	0	59.00
60.00	06000 LABORATORY	0	333, 938		1, 992	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		F 4/7	0	400	0	61.00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0	5, 467	5, 467	688 0	0	62. 00 63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0	0	64.00
65. 00	06500 RESPI RATORY THERAPY	0	110, 271	110, 271	1, 335	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	174, 225		841	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	149, 731		693	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	25, 502	25, 502	253	0	68. 00
69. 00 69. 01	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	0	0	0	348 228	0	69. 00 69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		536	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	Ö	Ö	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	О	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	23, 599		227	0	73.00
74. 00	07400 RENAL DIALYSIS	0	62, 235	62, 235	1	0	74. 00
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	0	1, 081, 713	1, 081, 713	1, 530	0	90. 00
91.00	09100 EMERGENCY	0	384, 274		3, 943	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
404 -	OTHER REIMBURSABLE COST CENTERS	1					404 5-
101.00	D10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	1, 245	0	101. 00
118.00		0	19, 441, 142	19, 441, 142	71, 219	132, 778	118. 00
						1	•

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		Peri od: From 01/01/2018 To 12/31/2018		
Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	DATA PROCESSI NG	
	0	1. 00	2A	4. 00	5. 01	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	25, 573	25, 57	3 6		190. 00
191. 00 19100 RESEARCH	0	0		0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	379, 276	379, 27	6 12, 547	0	192.00
192. 01 19201 OTHER NON-REIMBURSABLE	0	49, 087	49, 08	7 0	0	192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	0	127, 751	127, 75	1 89	0	192. 02
193. 00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	20, 022, 829	20, 022, 82	83, 861	132, 778	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2018 Part II
To 12/31/2018 Date/Time Prepared: 5/28/2019 4:50 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0002

					12/31/2018	5/28/2019 4:5	
	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						
1. 00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 5. 02	00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES	104, 676					5. 01 5. 02
5. 02	00570 ADMITTING	126	139, 227				5.02
5. 04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	55	0				5. 04
5.05	00590 OTHER A&G	0	0	0	1, 552, 638		5. 05
5. 06	00592 PATIENT TRANSPORTATION	9	0	_	3, 488	l .	5. 06
7.00	00700 OPERATION OF PLANT	1, 402	0	0	135, 825	l	7.00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	1, 060	0	_	8, 395 34, 069		8. 00 9. 00
10.00	01000 DI ETARY	1, 704	0		26, 111	0	10.00
11. 00	01100 CAFETERI A	3	0	0	7, 734	0	11.00
13.00	01300 NURSING ADMINISTRATION	54	0	0	19, 499	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	192	0	0	11, 778	0	14.00
15.00	01500 PHARMACY	360	0	_	29, 042	0	15.00
16. 00 17. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	18	0	_	16, 354 2, 800	0	16. 00 17. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	780	0	17.00
17. 02	01702 MEDI CAL EDUCATI ON	2	0		318		17. 02
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	O	0	0	1, 353	0	21.00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0		466	0	22. 00
23. 00		13	0	0	3, 363	0	23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	5, 454	11, 483	36, 135	261, 613	1, 480	30.00
31. 00	03100 INTENSIVE CARE UNIT	1, 955	1, 960		48, 349		31.00
31. 01	03101 NEONATAL I CU	12	599		11, 440	0	31. 01
40.00	04000 SUBPROVI DER - I PF	12	502	1, 579	8, 731	0	40.00
41. 00	04100 SUBPROVI DER - I RF	278	830		21, 309	41	41.00
43. 00	04300 NURSERY	334	246	775	10, 157	0	43.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	164	17, 941	54, 779	44, 979	0	50.00
50. 00	05001 ENDOSCOPY	1, 848	1, 981		15, 747	77	50.00
51. 00	05100 RECOVERY ROOM	86	1, 180		8, 370	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	313	617	1, 940	19, 828	34	52.00
53. 00	05300 ANESTHESI OLOGY	0	0	_	0	0	53.00
54.00	05400 RADI OLOGY DI AGNOSTI C	318	4, 369		28, 993	381	54.00
54. 01 55. 00	05401 RADI OLOGY - ULTRASOUND 05500 RADI OLOGY-THERAPEUTI C	415 52	1, 958 1, 642		10, 817 10, 418	421 24	54. 01 55. 00
56. 00	05600 RADI OLOGI - ITIERAF EUTI C	2, 667	1, 811		11, 393	l	56.00
57. 00	05700 CT SCAN	758	13, 560		15, 721	685	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	198	3, 229		5, 180	213	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	2, 074	8, 130		23, 923	l	59. 00
60.00	06000 LABORATORY	7, 352	16, 932		61, 993	0	60.00
60. 01	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	60. 01 61. 00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	772	977	3, 073	9, 621	0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	1	63.00
64.00	06400 I NTRAVENOUS THERAPY	o	0	0	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	1, 195	4, 288		20, 032	1	65.00
66.00	06600 PHYSI CAL THERAPY	15	858		10, 798		66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	39 17	662 273		8, 939 3, 167	0	67.00 68.00
69.00	06900 ELECTROCARDI OLOGY	37	2, 526		5, 264	22	69.00
69. 01	06901 CARDI AC REHAB	21	98		3, 023	0	69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	2, 937		8, 244		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	31, 099	5, 796		70, 472	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	35, 496	3, 538		79, 291	0	72.00
73. 00 74. 00		809 79	16, 764 974		84, 211 12, 200	0	73. 00 74. 00
74.00	OUTPATIENT SERVICE COST CENTERS	19	9/4	3,000	12, 200	0	74.00
90.00		193	2, 819	8, 869	33, 211	2	90.00
91. 00		4, 553	7, 329		60, 486	l	91.00
92. 00							92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	235	418	1, 314	15, 313	0	101. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	103, 851	139, 227	436, 433	1, 344, 608	3 803	118. 00
110.00	NONREI MBURSABLE COST CENTERS	103, 651	137, 221	1 430, 433	1, 344, 000	3,003	11 10.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	197	0	190. 00
191.00	19100 RESEARCH	0	0		0		191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	823	0	0	202, 360	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 01/01/2018 Part II To 12/31/2018 Date/Time Prepared:		

						5/28/2019 4:5	0 pm
	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	1	0	0	3, 643	0	192. 01
192. 02 19202	FAMILY HEALTH/GARY COMM HEALTH	1	0	0	1, 830	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)	104, 676	139, 227	436, 433	1, 552, 638	3, 803	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

					Ic	12/31/2018	Date/lime Pre 5/28/2019 4:5	
		Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
			PLANT	LINEN SERVICE	0.00	10.00	11 00	
	GENER	AL SERVICE COST CENTERS	7. 00	8. 00	9. 00	10. 00	11. 00	
1. 00		CAP REL COSTS-BLDG & FIXT						1.00
4.00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	1	DATA PROCESSING						5. 01
5. 02	1	PURCHASING RECEIVING AND STORES						5.02
5. 03 5. 04	1	ADMITTING CASHIERING/ACCOUNTS RECEIVABLE						5. 03 5. 04
5. 05		OTHER A&G						5. 05
5.06	00592	PATIENT TRANSPORTATION						5.06
7.00	1	OPERATION OF PLANT	4, 389, 640					7. 00
8.00		LAUNDRY & LINEN SERVICE	82, 500	344, 000				8.00
9. 00 10. 00	1	HOUSEKEEPI NG DI ETARY	95, 505 87, 234) 0		392, 837		9. 00 10. 00
11. 00	1	CAFETERI A	60, 987	0		0	262, 581	11.00
13.00	1	NURSING ADMINISTRATION	29, 390	0		0	5, 901	13.00
14. 00		CENTRAL SERVICES & SUPPLY	165, 892	3, 807		0	2, 889	•
15.00		PHARMACY	87, 739			0	0	15.00
16. 00 17. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	52, 332 7, 540	0		0	8, 319 1, 474	16. 00 17. 00
17. 00		STAFF EDUCATION	51, 592	0		0	1, 474	17.00
17. 02		MEDICAL EDUCATION	1, 731	0		Ö	0	17. 02
21.00	1	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRVD	20, 675	0		0	0	22. 00
23. 00		PARAMED ED PROGRAM	15, 570	0	1, 575	0	2, 699	23. 00
30. 00		IENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	1, 449, 662	163, 402	146, 665	270, 965	92, 429	30.00
31.00	1	INTENSIVE CARE UNIT	91, 937	8, 650		47, 387	15, 802	
31. 01		NEONATAL I CU	10, 451	7, 636		0	3, 866	
40.00		SUBPROVI DER - I PF	18, 384	0		9, 805	3, 438	1
41.00	1	SUBPROVI DER - I RF	144, 602			30, 941	8, 183	
43. 00		NURSERY	113, 042	7, 098	11, 437	0	2, 932	43. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	276, 064	34, 408	27, 930	ol	12, 847	50.00
50. 01	1	ENDOSCOPY	270,004	4, 080		o	3, 170	
51.00	1	RECOVERY ROOM	67, 323	9, 007		0	2, 404	51.00
52.00		DELIVERY ROOM & LABOR ROOM	32, 412	7, 695	3, 279	13, 093	7, 761	52.00
53. 00		ANESTHESI OLOGY	0		· -	0	0	53.00
54.00		RADI OLOGY - III TRASOLIND	245, 573	11, 441	24, 845	0	7, 879	54.00
54. 01 55. 00	1	RADI OLOGY - ULTRASOUND RADI OLOGY-THERAPEUTI C	23, 391 62, 413	1, 941 519		ol Ol	2, 930 1, 163	
56. 00		RADI OI SOTOPE	41, 854	4, 198		Ö	1, 258	•
57.00	05700	CT SCAN	39, 632			0	3, 294	
58.00	1	MAGNETIC RESONANCE IMAGING (MRI)	19, 462	1, 054		0	1, 165	
59.00		CARDI AC CATHETERI ZATI ON	38, 845	7, 532		4, 435	4, 920	59.00
60. 00 60. 01		LABORATORY BLOOD LABORATORY	108, 848 0	0		0	11, 053 0	60. 00 60. 01
61. 00		PBP CLINICAL LAB SERVICES-PRGM ONLY	O			٥	O	61.00
		WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 782	0	180	0	6, 232	62.00
		BLOOD STORING, PROCESSING & TRANS.	0		0	0		63.00
64.00	1	I NTRAVENOUS THERAPY	0	0		0	0	
65.00		RESPI RATORY THERAPY	35, 943			0	6, 997	
66. 00 67. 00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	56, 789 48, 805			0	3, 645 3, 004	
68. 00		SPEECH PATHOLOGY	8, 312	0		921	1, 018	
69. 00		ELECTROCARDI OLOGY	0	1, 976		0	2, 080	
69. 01		CARDI AC REHAB	0	345	0	0	1, 190	69. 01
70.00		ELECTROENCEPHALOGRAPHY	0	0		18		70.00
71.00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	7, 692	0	0 778	0	1 020	72.00 73.00
		RENAL DIALYSIS	20, 286			o	1, 020	
		TIENT SERVICE COST CENTERS			,	-1		
90.00	1	CLINIC	352, 589			0	6, 887	90. 00
		EMERGENCY	125, 256	36, 766	12, 673	15, 272	20, 313	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS						92.00
101 00		HOME HEALTH AGENCY	0	0	0	0	0	101. 00
		AL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4, 200, 036	342, 076	406, 921	392, 837	262, 581	118. 00
400 -		I MBURSABLE COST CENTERS				.1		100 0-
		GIFT, FLOWER, COFFEE SHOP & CANTEEN RESEARCH	8, 336 0	0	843	0		190. 00 191. 00
		PHYSICIANS' PRIVATE OFFICES	123, 627	_		0		191.00
		OTHER NON-REIMBURSABLE	16, 000			o		192.00
						-1		·

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 01/01/2018 Part II Date/Time Prepared: 5/20/2019 4:50 pm

						5/28/2019 4:5	U pm
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE				
		7. 00	8. 00	9. 00	10.00	11. 00	
192. 02 19202	FAMILY HEALTH/GARY COMM HEALTH	41, 641	0	4, 213	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, 389, 640	344, 000	426, 104	392, 837	262, 581	202.00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2018 Part II
To 12/31/2018 Date/Time Prepared: 5/28/2019 4:50 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0002

				10		5/28/2019 4:5	
	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 & FIXT						1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00550 DATA PROCESSING						5. 01
5.02	00560 PURCHASING RECEIVING AND STORES						5. 02
5. 03	00570 ADMI TTI NG						5. 03
5. 04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.04
5. 05 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	01100 CAFETERI A	140 540					11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	149, 560	710, 605				13. 00 14. 00
15. 00	01500 PHARMACY		710,003				15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	o o	0		243, 998		16.00
17.00	01700 SOCIAL SERVICE	1, 244	0	0	0	37, 203	17. 00
17. 01	01701 STAFF EDUCATION	0	0	0	0	0	
17. 02	01702 MEDI CAL EDUCATI ON	0	0	0	0	0	1
21. 00 22. 00	02100 &R SERVICES-SALARY & FRINGES APPRVD 02200 &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	21. 00 22. 00
23. 00	1	2, 276	0		o	0	23.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	2,2,0		<u> </u>	<u>~ı</u>		20.00
30.00	03000 ADULTS & PEDIATRICS	77, 958	0	0	20, 227	29, 612	30.00
31. 00	03100 I NTENSI VE CARE UNI T	13, 329	0		3, 453	0	
31. 01	03101 NEONATAL I CU	3, 261	0		1, 056	0	
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	2, 900 6, 902	0	0	884	0 5, 987	40. 00 41. 00
43.00	04300 NURSERY	2, 473	0		1, 461 434	5, 967	1
10.00	ANCILLARY SERVICE COST CENTERS	2, 170		<u> </u>	1011		10.00
50.00	05000 OPERATING ROOM	10, 836	0	0	30, 359	0	50.00
50. 01	05001 ENDOSCOPY	2, 674	0		3, 490	0	
51.00	05100 RECOVERY ROOM	2, 027	0		2, 078	0	
52. 00 53. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	6, 546	0		1, 086 0	0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0	0	7, 696	0	54.00
54. 01	05401 RADI OLOGY - ULTRASOUND	o o	0	Ö	3, 449	0	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	o	0	0	2, 893	0	55.00
56. 00	05600 RADI OI SOTOPE	0	0	0	3, 190	0	56.00
57. 00	05700 CT SCAN	0	0	0	23, 886	0	
58. 00 59. 00	05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON	0	0	0	5, 688	0	58. 00 59. 00
60.00	06000 LABORATORY		0	36, 306	14, 320 29, 825	0	60.00
60. 01	06001 BLOOD LABORATORY	l o	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, 720	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	7 554	0	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		0		7, 554 1, 511	0	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		0		1, 167	0	67.00
68. 00	06800 SPEECH PATHOLOGY		0	0	480	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	4, 449	0	69. 00
69. 01	06901 CARDI AC REHAB	0	0	0	172	0	69. 01
70. 00 71. 00		0	221 020	0	5, 173	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 MPL. DEV. CHARGED TO PATIENTS		331, 838 378, 767		10, 209 6, 232	0	
73. 00			0		29, 529	0	1
74. 00	07400 RENAL DIALYSIS		0		1, 716	0	1
	OUTPATIENT SERVICE COST CENTERS						
90.00		0	0		4, 965	0	90.00
	09100 EMERGENCY	17, 134	0	0	12, 910	1, 604	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
101 00	10100 HOME HEALTH AGENCY	l ol	0	545	736	n	101.00
.51.00	SPECIAL PURPOSE COST CENTERS	<u> </u>			, 30		1
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	149, 560	710, 605	389, 629	243, 998	37, 203	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190.00
) 19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES	0	0		0		191. 00 192. 00
1 /2. 00	PINZOO INI VAIL OITIOLS	<u>, </u>	0	J, 300	Ο _Ι	0	11 /2.00

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 01/01/2018 Part II To 12/31/2018 Date/Time Prepared:

					5/28/2019 4:	ou pm
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
	ADMI NI STRATI O	SERVICES &		RECORDS &	SERVI CE	
	N	SUPPLY		LI BRARY		
	13. 00	14. 00	15. 00	16.00	17.00	
192. 01 19201 OTHER NON-REIMBURSABLE	0	0	0	0	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)	149, 560	710, 605	395, 195	243, 998	37, 203	202.00

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

					5/28/2019 4:5	
			INTERNS &	RESI DENTS		
Cost Center Description	STAFF	MEDI CAL	SERVI CES-SALA	SERVI CES-OTHE	PARAMED ED	
, , , , , , , , , , , , , , , , , , ,	EDUCATI ON	EDUCATI ON	RY & FRINGES		PROGRAM	
OFFICE AND OFFICE OFFICE OFFICE OF OFFICE OF	17. 01	17. 02	21. 00	22. 00	23. 00	
1. 00 GENERAL SERVICE COST CENTERS 1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 00550 DATA PROCESSI NG						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. 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 11. 00 01100 CAFETERI A						10.00 11.00
13. 00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00 01500 PHARMACY						15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY 17. 00 01700 SOCIAL SERVICE						16. 00 17. 00
17. 01 01701 STAFF EDUCATION	215, 871					17. 00
17. 02 01702 MEDI CAL EDUCATI ON	0	7, 537				17. 02
21. 00 02100 I &R SERVI CES-SALARY & FRINGES APPRVD	0	0				21.00
22.00 02200 1&R SERVICES-OTHER PRGM COSTS APPRVD 23.00 02300 PARAMED ED PROGRAM	0 358	0		86, 661	74 000	22.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	330	0			74, 000	23.00
30. 00 03000 ADULTS & PEDI ATRI CS	102, 666	0				30.00
31.00 03100 INTENSIVE CARE UNIT	17, 088	0				31.00
31. 01 03101 NEONATAL CU	2, 895	0				31.01
40. 00 04000 SUBPROVI DER - 1 PF 41. 00 04100 SUBPROVI DER - 1 RF	1, 209 6, 971	0				40. 00 41. 00
43. 00 04300 NURSERY	5, 006	0				43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	18, 828	0				50.00
50. 01 05001 ENDOSCOPY 51. 00 05100 RECOVERY ROOM	2, 074 1, 269	0				50. 01 51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	11, 552	0	l			52.00
53. 00 05300 ANESTHESI OLOGY	0	0				53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	1, 161	0				54.00
54. 01 05401 RADI OLOGY - ULTRASOUND 55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 217 478	0				54. 01 55. 00
56. 00 05600 RADI OI SOTOPE	28	0				56.00
57. 00 05700 CT SCAN	883	0				57.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	15	0				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	11, 912 634	0	ŀ			59. 00 60. 00
60. 01 06000 EABORATORY	034	0				60.00
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	244	0				62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 64. 00 06400 INTRAVENOUS THERAPY	0	0				63. 00 64. 00
65. 00 06500 RESPI RATORY THERAPY	3, 924	0				65.00
66. 00 06600 PHYSI CAL THERAPY	99	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	249	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	84	0				68.00
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB	1, 243	0				69. 00 69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	514	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS	90	0				73. 00 74. 00
OUTPATIENT SERVICE COST CENTERS	١	0				74.00
90. 00 09000 CLI NI C	720	0				90.00
91. 00 09100 EMERGENCY	15, 740	7, 537				91.00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY	2, 417	0				1 01.00
SPECIAL PURPOSE COST CENTERS	2,717]
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 211, 568	7, 537	0	0	0	118. 00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	l ol	0				190. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
<u> </u>	, 9		1	1	1	

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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002 Period: From 01/01/2018 From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/28/2019 4:50 pm

						3/28/2019 4:5	U pili
				INTERNS &	RESI DENTS		
	0	CTAFF	MEDIONI	CEDVILOEC CALA	CEDVI OFC. OTHE	DADAMED ED	
	Cost Center Description	STAFF	MEDI CAL	SERVICES-SALA	SERVI CES-OTHE	PARAMED ED	
		EDUCATI ON	EDUCATI ON	RY & FRINGES	R PRGM COSTS	PROGRAM	
		17. 01	17. 02	21. 00	22. 00	23.00	
192. 00 1920	O PHYSICIANS' PRIVATE OFFICES	4, 303	0				192.00
192. 01 1920	1 OTHER NON-REIMBURSABLE	0	0				192. 01
192. 02 1920	2 FAMILY HEALTH/GARY COMM HEALTH	0	0				192. 02
193. 00 1930	NONPALD WORKERS	0	0				193. 00
200.00	Cross Foot Adjustments			1, 353	86, 661	74, 000	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	215, 871	7, 537	1, 353	86, 661	74, 000	202.00

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

					Т	o 12/31/2018 Date/Time Pr 5/28/2019 4:	
		Cost Center Description	Subtotal	Intern &	Total	9, 29, 20 1 7 11	50 p
				Residents Cost & Post			
				Stepdown			
				Adjustments			
	CENER	AL SERVICE COST CENTERS	24. 00	25. 00	26. 00		
1. 00		CAP REL COSTS-BLDG & FIXT					1.00
4.00		EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 01	1	DATA PROCESSING					5. 01
5. 02 5. 03	1	PURCHASING RECEIVING AND STORES ADMITTING					5. 02 5. 03
5. 04	1	CASHI ERI NG/ACCOUNTS RECEI VABLE					5. 04
5.05		OTHER A&G					5. 05
5.06	1	PATIENT TRANSPORTATION					5.06
7. 00 8. 00	1	OPERATION OF PLANT LAUNDRY & LINEN SERVICE					7. 00 8. 00
9. 00		HOUSEKEEPI NG					9. 00
10.00		DI ETARY					10.00
11. 00 13. 00		CAFETERI A 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	1	MEDICAL RECORDS & LIBRARY					16. 00
17.00		SOCI AL SERVI CE STAFF EDUCATI ON					17. 00 17. 01
17. 01 17. 02	1	MEDICAL EDUCATION					17.01
21. 00	1	I&R SERVICES-SALARY & FRINGES APPRVD					21.00
22. 00	1	I&R SERVICES-OTHER PRGM COSTS APPRVD					22. 00
23. 00		PARAMED ED PROGRAM I ENT ROUTINE SERVICE COST CENTERS					23.00
30. 00		ADULTS & PEDIATRICS	7, 135, 443	0	7, 135, 443		30.00
31.00	1	INTENSIVE CARE UNIT	551, 130	Ö			31.00
31. 01		NEONATAL I CU	77, 194	0	77, 194		31. 01
40. 00 41. 00	1	SUBPROVIDER - I PF	106, 427	0	106, 427 689, 952		40. 00 41. 00
43.00	1	SUBPROVI DER - I RF NURSERY	689, 952 501, 399	0			43.00
		LARY SERVICE COST CENTERS		_			
50.00	1	OPERATING ROOM	1, 378, 468	0			50.00
50. 01 51. 00		ENDOSCOPY RECOVERY ROOM	42, 027 311, 400	0	· ·		50. 01 51. 00
52. 00		DELIVERY ROOM & LABOR ROOM	207, 213	0			52.00
53.00		ANESTHESI OLOGY	0	0	C		53.00
54.00		RADI OLOGY-DI AGNOSTI C	1, 101, 150	0	1, 101, 150		54.00
54. 01 55. 00		RADI OLOGY - ULTRASOUND RADI OLOGY-THERAPEUTI C	127, 516 282, 823	0	127, 516 282, 823		54. 01 55. 00
56. 00	1	RADI OI SOTOPE	205, 269	0			56.00
57. 00		CT SCAN	269, 914	0	269, 914		57.00
58.00		MAGNETIC RESONANCE IMAGING (MRI)	108, 263	0			58.00
59. 00 60. 00		CARDI AC CATHETERI ZATI ON LABORATORY	266, 101 673, 167	0	266, 101 673, 167		59. 00 60. 00
60. 00		BLOOD LABORATORY	0/3, 10/	0			60.00
61.00		PBP CLINICAL LAB SERVICES-PRGM ONLY					61.00
62.00	1	WHOLE BLOOD & PACKED RED BLOOD CELLS	30, 756	0	30, 756		62.00
63. 00 64. 00		BLOOD STORING, PROCESSING & TRANS. INTRAVENOUS THERAPY	0	0			63. 00 64. 00
65.00		RESPI RATORY THERAPY	209, 178	0	209, 178		65.00
66.00	1	PHYSI CAL THERAPY	261, 382	0	261, 382		66.00
67.00		OCCUPATIONAL THERAPY	220, 311	0	220, 311		67.00
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	41, 726 25, 893	0	41, 726 25, 893		68. 00 69. 00
69. 01	1	CARDI AC REHAB	5, 384	0	5, 384		69. 01
70.00	1	ELECTROENCEPHALOGRAPHY	29, 107	0	29, 107		70.00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	467, 652	0	467, 652		71.00
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	514, 458 570, 249		514, 458 570, 249		72. 00 73. 00
		RENAL DIALYSIS	118, 463	0			74.00
	OUTPA	TIENT SERVICE COST CENTERS					
90.00	4	CLINIC EMERCENCY	1, 536, 536	0			90.00
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	748, 877	0			91. 00 92. 00
. 2. 00		REIMBURSABLE COST CENTERS					
101.00		HOME HEALTH AGENCY	22, 223	0	22, 223		101.00
118. 00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	18, 837, 051	0	18, 837, 051		118. 00
110.00		IMBURSABLE COST CENTERS	10, 037, 031	0	10,037,051		110.00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	34, 955	0	34, 955		190. 00

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CO	CN: 15-0002	Peri od: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Prepared: 5/28/2019 4:50 pm
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	742, 934	0	742, 9	34	192. 00
192. 01 19201 OTHER NON-REIMBURSABLE	70, 350	0	70, 3	50	192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	175, 525	0	175, 5	25	192. 02
193. 00 19300 NONPALD WORKERS	0	0		0	193. 00
200.00 Cross Foot Adjustments	162, 014	0	162, 0	14	200. 00
201.00 Negative Cost Centers	0	0		0	201.00
202.00 TOTAL (sum lines 118 through 201)	20, 022, 829	0	20, 022, 8	29	202. 00

STATE BASIS		Trovider ed	F	From 01/01/2018 To 12/31/2018	Date/Time Pre	pared·
	CARLTAL			12,01,2010	5/28/2019 4: 5	O pm
Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSI NG (MACHI NE TI ME)	PURCHASI NG RECEI VI NG AND STORES (PURCHASE REQUI SI TI ONS)	ADMI TTI NG (GROSS CHARGES)	
OFNEDAL CERVI OF COST OFNITERS	1. 00	4. 00	5. 01	5. 02	5. 03	
GENERAL SERVICE COST CENTERS 1. 00 00100 CAP REL COSTS-BLDG & FLXT	1, 410, 133					1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	5, 906	148, 345, 148				4.00
5. 01 00550 DATA PROCESSING	9, 190	4, 047, 320	100			5. 01
5. 02 00560 PURCHASING RECEIVING AND STORES 5. 03 00570 ADMITTING	7, 332 9, 717	1, 004, 305 1, 995, 330	(1, 272, 772, 554	5. 02 5. 03
5. 04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	30, 646	2, 173, 331	(1, 272, 772, 554	5.04
5. 05 00590 OTHER A&G	99, 579	10, 465, 312	100		0	5. 05
5. 06 00592 PATIENT TRANSPORTATION 7. 00 00700 OPERATION OF PLANT	299, 329	541, 322 3, 833, 368	(-,	0	5. 06 7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	17, 825	0, 033, 300	(0	8.00
9. 00 00900 HOUSEKEEPI NG	20, 635	4, 367, 857	(0	9. 00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	18, 848 13, 177	2, 362, 017 1, 031, 355	(0	10.00 11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	6, 350	2, 792, 504	(0	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	35, 843	564, 566	(0	14.00
15. 00 O1500 PHARMACY 16. 00 O1600 MEDI CAL RECORDS & LI BRARY	18, 957 11, 307	0 1, 997, 624	(0	15. 00 16. 00
17. 00 01700 SOCIAL SERVICE	1, 629	444, 894	(0	17.00
17. 01 01701 STAFF EDUCATION	11, 147	0	(-	0	17. 01
17. 02 01702 MEDICAL EDUCATION 21. 00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	374	0	(931	0	17. 02 21. 00
22. 00 02200 Lar Services-Salari & Frinces Airryb	4, 467	o	(-	0	22.00
23. 00 O2300 PARAMED ED PROGRAM	3, 364	673, 115	(5, 369	0	23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	313, 217	32, 214, 070	(2, 238, 050	105, 350, 547	30.00
31. 00 03100 I NTENSI VE CARE UNI T	19, 864	6, 500, 862	(17, 984, 097	31.00
31. 01 03101 NEONATAL CU	2, 258	1, 722, 978	(5, 499, 376	31.01
40. 00 04000 SUBPROVI DER - 1 PF 41. 00 04100 SUBPROVI DER - 1 RF	3, 972 31, 243	1, 280, 765 2, 796, 568	(.,	4, 603, 945 7, 610, 408	1
43. 00 04300 NURSERY	24, 424	1, 174, 169		137, 013	2, 260, 708	43.00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	59, 647	4, 229, 914	(67, 225	160, 072, 673	50.00
50. 00 05000 0FERATTING ROOM 50. 01 05001 ENDOSCOPY	0	1, 153, 967	(18, 174, 858	
51. 00 05100 RECOVERY ROOM	14, 546	1, 045, 926	(10, 821, 121	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	7, 003	2, 867, 584	(5, 656, 816 0	52. 00 53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	53, 059	2, 384, 492	(40, 084, 188	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	5, 054	1, 212, 281	(170, 106	17, 965, 300	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	13, 485 9, 043	463, 261 558, 902	(, , , , ,	15, 066, 732 16, 612, 204	55. 00 56. 00
57. 00 05700 CT SCAN	8, 563	1, 042, 130	(310, 926	124, 404, 760	
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	4, 205	389, 481	(29, 626, 211	
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	8, 393 23, 518	2, 105, 315 3, 525, 875	(74, 584, 802 155, 336, 834	59. 00 60. 00
60. 01 06001 BLOOD LABORATORY	0	0, 020, 070	(0	60.01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	205	4 047 400	,	04/ 75/	0.010.001	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 63.00 06300 BLOOD STORING, PROCESSING & TRANS.	385	1, 217, 193 0	(8, 960, 206 0	62. 00 63. 00
64. 00 06400 I NTRAVENOUS THERAPY	o o	Ö	(0	64.00
65. 00 06500 RESPIRATORY THERAPY	7, 766	2, 363, 182	(39, 342, 354	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	12, 270 10, 545	1, 488, 795 1, 227, 145	(-,	7, 869, 238 6, 077, 206	
68. 00 06800 SPEECH PATHOLOGY	1, 796	448, 576	(2, 501, 738	1
69. 00 06900 ELECTROCARDI OLOGY	0	616, 142	(15, 223	23, 171, 578	1
69. 01 06901 CARDI AC REHAB 70. 00 07000 ELECTROENCEPHALOGRAPHY	0	404, 135 949, 217	(-,	896, 419 26, 940, 508	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	l o	0	(53, 172, 472	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(.,	32, 459, 800	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DI ALYSI S	1, 662 4, 383	400, 886 2, 464	(153, 795, 763 8, 939, 534	73. 00 74. 00
OUTPATIENT SERVICE COST CENTERS	1, 000	2, 101		52,001	0, 707, 001	7 1. 00
90. 00 09000 CLINIC	76, 181	2, 707, 607	(25, 858, 355	90.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	27, 063	6, 978, 460	(1, 868, 145	67, 240, 057	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS		0.000				
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	2, 203, 254		96, 622	3, 831, 746	1101.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 369, 167	125, 969, 816	100	42, 613, 330	1, 272, 772, 554	118.00

Health Financial Systems	METHODIST HOS	PITALS INC		Inlie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	1002 10
				From 01/01/2018 Fo 12/31/2018		
	CAPI TAL RELATED COSTS					
Cost Center Description	BLDG & FIXT	EMPLOYEE	DATA	PURCHASI NG	ADMI TTI NG	
	(SQUARE FEET)	BENEFITS DEPARTMENT	PROCESSI NG (MACHI NE	RECEIVING AND STORES	(GROSS CHARGES)	
		(GROSS	TIME)	(PURCHASE	CHARGES)	
		SALARI ES)	ĺ	REQUISITIONS)		
	1. 00	4. 00	5. 01	5. 02	5. 03	
NONREI MBURSABLE COST CENTERS	1					
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 801	10, 353	(0		190.00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0 711	0 20 700		0	-	191. 00 192. 00
192. 00 19200 PHYSICIANS PRIVATE OFFICES 192. 01 19201 OTHER NON-REIMBURSABLE	26, 711 3, 457			337, 658		192.00
192. 02 19202 FAMILY HEALTH/GARY COMM HEALTH	8, 997			382		192.01
193. 00 19300 NONPALD WORKERS	0, 777	130, 177		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)	20, 022, 829	33, 443, 125	11, 229, 715	3, 716, 554	3, 065, 727	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	14. 199249	0. 225441	112, 297. 15000	0. 086528	0. 002409	203. 00
204.00 Cost to be allocated (per Wkst. B, Part II)		83, 861	132, 778	104, 676	139, 227	204. 00
205.00 Unit cost multiplier (Wkst. B, Part		0. 000565	1, 327. 780000	0. 002437	0. 000109	205. 00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)	i					206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

	Financial Systems	METHODIST HOSP		N. 45 0000 D		u of Form CMS-2	
COST /	ALLOCATION - STATISTICAL BASIS		Provi der CC	F	eriod: rom 01/01/2018 o 12/31/2018	Worksheet B-1 Date/Time Pre 5/28/2019 4:5	nared·
	Cost Center Description	CASHI ERI NG/AC F COUNTS RECEI VABLE	Reconciliatio n	OTHER A&G (ACCUM. COST)	PATI ENT TRANSPORTATI O N	OPERATION OF PLANT (SQUARE FEET)	<u> </u>
		(GROSS CHARGES)			(NUMBER OF TRIPS)		
		5. 04	5A. 05	5. 05	5. 06	7. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 4. 00 5. 01	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00550 DATA PROCESSING						1.00 4.00 5.01
5. 02 5. 03 5. 04	O0560 PURCHASI NG RECEI VI NG AND STORES O0570 ADMITTI NG O0580 CASHI ERI NG/ACCOUNTS RECEI VABLE	1, 272, 772, 554					5. 02 5. 03 5. 04
5. 05 5. 06	00590 OTHER A&G 00592 PATIENT TRANSPORTATION	0	-29, 412, 109 0	315, 147, 499 707, 960			5. 05 5. 06
7. 00	00700 OPERATION OF PLANT	0	0	27, 567, 431		948, 434	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	1, 703, 803		17, 825	8. 00
9.00	00900 HOUSEKEEPI NG	0	0	6, 914, 675		20, 635	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	0	0	5, 299, 490 1, 569, 803		18, 848 13, 177	10.00 11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	o	0	3, 957, 567		6, 350	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	2, 390, 561	0	35, 843	14. 00
15.00	01500 PHARMACY	0	0	5, 894, 461	0	18, 957	1
16. 00 17. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	0	0	3, 319, 182 568, 322		11, 307 1, 629	1
17. 01	01701 STAFF EDUCATION	Ö	Ö	158, 279		11, 147	17. 01
17. 02	01702 MEDICAL EDUCATION	0	0	64, 587		374	17. 02
21. 00 22. 00	02100 &R SERVICES-SALARY & FRINGES APPRVD 02200 &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	274, 518 94, 596		0 4, 467	21. 00 22. 00
23. 00	02300 PARAMED ED PROGRAM	0	0	682, 484		3, 364	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	105, 350, 547 17, 984, 097	0	53, 117, 203		313, 217	30.00
31. 00 31. 01	03100 NTENSI VE CARE UNI T 03101 NEONATAL CU	5, 499, 376	0	9, 813, 156 2, 321, 858		19, 864 2, 258	1
40.00	04000 SUBPROVI DER - I PF	4, 603, 945	Ö	1, 772, 119		3, 972	40.00
41.00	04100 SUBPROVI DER - I RF	7, 610, 408	0	4, 324, 905		31, 243	41.00
43. 00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	2, 260, 708	0	2, 061, 558	0	24, 424	43.00
50. 00	05000 OPERATING ROOM	160, 072, 673	0	9, 129, 181	0	59, 647	50.00
50. 01	05001 ENDOSCOPY	18, 174, 858	0	3, 196, 015		0	50. 01
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	10, 821, 121 5, 656, 816	0	1, 698, 787 4, 024, 255		14, 546 7, 003	51.00 52.00
53. 00	05300 ANESTHESI OLOGY	3, 030, 810	0	4, 024, 255		7,003	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	40, 084, 188	0	5, 884, 590			54.00
54. 01	05401 RADI OLOGY - ULTRASOUND	17, 965, 300	0	2, 195, 508		5, 054	
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	15, 066, 732 16, 612, 204	0	2, 114, 441 2, 312, 427		13, 485 9, 043	
57. 00	05700 CT SCAN	124, 404, 760	Ö	3, 190, 688		· ·	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	29, 626, 211	0	1, 051, 348			58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	74, 584, 802 155, 336, 834	0	4, 855, 461 12, 582, 278		8, 393 23, 518	1
60.00	06001 BL00D LABORATORY	155, 550, 654	0	12, 362, 276		23, 318	60.00
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0				61.00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	8, 960, 206	0	1, 952, 762		385	62.00
64.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0	0	0	0	63. 00 64. 00
65. 00	06500 RESPI RATORY THERAPY	39, 342, 354	Ö	4, 065, 767	13	7, 766	65.00
66. 00	06600 PHYSI CAL THERAPY	7, 869, 238	0	2, 191, 665		12, 270	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	6, 077, 206 2, 501, 738	0	1, 814, 205 642, 692		10, 545 1, 796	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	23, 171, 578	0	1, 068, 428		0	69.00
69. 01	06901 CARDI AC REHAB	896, 419	0	613, 578		0	69. 01
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	26, 940, 508 53, 172, 472	0	1, 673, 320 14, 303, 238		0	70.00 71.00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	32, 459, 800	0	14, 303, 238 16, 093, 101		0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	153, 795, 763	0	17, 091, 790		1, 662	73.00
74. 00	07400 RENAL DIALYSIS	8, 939, 534	0	2, 476, 148	1	4, 383	74.00
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	25, 858, 355	0	6, 740, 671	30	76, 181	90.00
91. 00	09100 EMERGENCY	67, 240, 057	0	12, 276, 419		27, 063	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
101 00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	3, 831, 746	O	3, 107, 893	O	0	101.00
101.00	SPECIAL PURPOSE COST CENTERS	3,031,740					1,01.00
118. 00		1, 272, 772, 554	-29, 412, 109	272, 925, 174	46, 751	907, 468	118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	O	39, 887	O	1 801	190. 00
. , 5. 50	1	, 31	<u> </u>	37,007	, <u> </u>	1,001	1

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

From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/28/2019 4:50 pm Cost Center Description CASHIERING/AC Reconciliatio OTHER A&G PATI ENT OPERATION OF COUNTS (ACCUM. COST) TRANSPORTATIO PLANT n (SQUARE FEET) RECEI VABLE Ν (GROSS CHARGES) (NUMBER OF TRI PS) 5A. 05 5.04 5.05 5.06 7.00 191. 00 19100 RESEARCH 0 0 191.00 26, 711 192. 00 3, 457 192. 01 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 41, 071, 716 0 0 192. 01 19201 OTHER NON-REIMBURSABLE 0 739, 393 0 192.02 19202 FAMILY HEALTH/GARY COMM HEALTH 371, 329 0 8, 997 192. 02 193.00 19300 NONPALD WORKERS 0 o 0 193.00 200.00 200.00 Cross Foot Adjustments 201.00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, 7, 418, 870 29, 412, 109 774, 032 30, 140, 244 202. 00 Part I) 31. 778958 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 0.005829 0.093328 16. 556480 4, 389, 640 204. 00 204.00 Cost to be allocated (per Wkst. B, 436, 433 1, 552, 638 3, 803 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000343 0.004927 0.081346 4. 628303 205. 00 11) 206.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

	Financial Systems	METHODIST HOS				u or form CMS	
COST A	LLOCATION - STATISTICAL BASIS		Provi der CC	F	eriod: rom 01/01/2018 o 12/31/2018	Date/Time Pre	pared:
	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (PRODUCTI VE HOURS)	NURSI NG ADMI NI STRATI O N (DI RECT NURS.	O pili
		27.0.121.7				HRS.)	
	CENIEDAL CEDVICE COCT CENTEDO	8. 00	9. 00	10.00	11. 00	13.00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT						1.00
4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER A&G 00592 PATIENT TRANSPORTATION 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	2, 124, 111 0 0 0 0 23, 509 13 0	909, 974 18, 848 13, 177 6, 350 35, 843 18, 957		2, 593, 204 58, 273 28, 534 0 82, 153	1, 751, 153 0 0 0	4.00 5.01 5.02 5.03 5.04 5.05 5.06 7.00 8.00 9.00 10.00 11.00
17. 01	01701 STAFF EDUCATION	0	11, 147	O		0	17. 01
	01702 MEDI CAL EDUCATI ON	0		0		0	17. 02
21. 00 22. 00	02100 1 & R SERVICES-SALARY & FRINGES APPRVD 02200 1 & R SERVICES-OTHER PRGM COSTS APPRVD	0		0		0	21. 00 22. 00
23. 00	02300 PARAMED ED PROGRAM	0		Ö		26, 652	1
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	1, 008, 964 53, 413		245, 251 42, 890			
	03101 NEONATAL I CU	47, 148					1
40.00	04000 SUBPROVI DER - I PF	0		8, 875			1
41.00	04100 SUBPROVI DER - I RF	42.020					1
43. 00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	43, 829	24, 424	0	28, 953	28, 953	43.00
50.00	05000 OPERATING ROOM	212, 462	59, 647	О	126, 879	126, 879	50.00
50. 01	05001 ENDOSCOPY	25, 195		0	,		
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	55, 615 47, 514		0 11, 851	,		
53.00	05300 ANESTHESI OLOGY	0		0		0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	70, 646		O	, -		54.00
54. 01 55. 00	05401 RADI OLOGY - ULTRASOUND 05500 RADI OLOGY-THERAPEUTI C	11, 987 3, 203		0			54. 01 55. 00
56.00	05600 RADI OI SOTOPE	25, 919		-			
	05700 CT SCAN	16, 282	8, 563	O	32, 536	0	57.00
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	6, 509			,		
60.00	06000 LABORATORY	46, 508 0	8, 393 23, 518	4, 014 0	48, 589 109, 153		60.00
60. 01	06001 BLOOD LABORATORY	0	0	O			
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	385	0	61, 551	0	61. 00 62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.			Ö		0	1
64. 00	06400 I NTRAVENOUS THERAPY	0	0	O		0	64.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	3, 129 25, 663			,		65. 00 66. 00
67.00	06700 OCCUPATI ONAL THERAPY	25,003	10, 545		,	1	67.00
68.00	06800 SPEECH PATHOLOGY	0	1, 796	834	10, 054	0	68.00
69.00	06900 ELECTROCARDI OLOGY	12, 199		0	,		69.00
69. 01 70. 00	O6901 CARDI AC REHAB O7000 ELECTROENCEPHALOGRAPHY	2, 128		0 16			69. 01 70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	O	0			71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	-	1	72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DI ALYSI S	97, 896	1, 662 4, 383	0			73. 00 74. 00
7 1. 00	OUTPATIENT SERVICE COST CENTERS	71,070	1, 555				71.00
90.00	09000 CLI NI C	45, 477		0			
91.00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART)	227, 021	27, 063	13, 823	200, 611	200, 611	91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS					1	, ,2.00
101.00	10100 HOME HEALTH AGENCY	0	0	C	0	0	101.00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	2, 112, 229	869, 008	355, 559	2, 593, 204	1, 751, 153	110 00
110.00	NONREIMBURSABLE COST CENTERS						110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1, 801	O	0	0	190. 00
		<u> </u>				<u> </u>	

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 01/01/2018		

					rom 01/01/2018		narad.
				T	o 12/31/2018	Date/Time Pre 5/28/2019 4:5	
	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	
191. 00 1910		0	0	0	0	l e	191. 00
	PHYSICIANS' PRIVATE OFFICES	11, 882	26, 711	0	0		192.00
	1 OTHER NON-REIMBURSABLE	0	3, 457		0		192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH		0	8, 997	0	0	0	192. 02
193. 00 1930	NONPALD WORKERS	0	0	0	0	0	193. 00
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	2, 429, 276	8, 215, 767	6, 563, 222	2, 254, 031	4, 636, 697	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	1. 143667	9. 028573	18. 458883	0. 869207	2. 647797	203. 00
204.00	Cost to be allocated (per Wkst. B,	344, 000	426, 104	392, 837	262, 581	149, 560	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 161950	0. 468260	1. 104843	0. 101257	0. 085407	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)						

			F	rom 01/01/2018 o 12/31/2018	Date/Time Pre 5/28/2019 4:5	pared:
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)	у р
CENEDAL SEDVICE COST CENTEDS	14. 00	15. 00	16. 00	17. 00	17. 01	
GENERAL SERVICE COST CENTERS 1. 00 00100 CAP REL COSTS-BLDG & FIXT 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 00550 DATA PROCESSING 5. 02 00560 PURCHASING RECEIVING AND STORES 5. 03 00570 ADMITTING 5. 04 00580 CASHIERING/ACCOUNTS RECEIVABLE 5. 05 00590 OTHER A&G 5. 06 00592 PATIENT TRANSPORTATION 7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING 10. 00 01000 DIETARY 11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION 14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDICAL RECORDS & LIBRARY 17. 00 01700 STAFF EDUCATION 17. 02 01702 MEDICAL EDUCATION 21. 00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	27, 326, 389 0 0 0 0	17, 194, 981 0 0 0	1, 272, 772, 554 0 0 0		100, 737 0	1. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 17. 01 17. 01 17. 02 17. 01 17. 02
22. 00 02200 &R SERVI CES-OTHER PRGM COSTS APPRVD 23. 00 02300 PARAMED ED PROGRAM	0	0	0	_	0 167	22. 00 23. 00
1.00 0.2300 PARAMED ED PROGRAM INPATIENT ROUTI NE SERVI CE COST CENTERS 30.00 0.3000 ADULTS & PEDIATRI CS 31.00 0.3100 INTENSI VE CARE UNIT 31.01 0.3101 NEONATAL I CU 40.00 0.4000 SUBPROVI DER - I PF 41.00 0.4100 SUBPROVI DER - I RF 43.00 0.4300 NURSERY 0.300 NURSERY 0.300 0.4300 0.	0 0 0 0 0 0	0 0 0	105, 350, 547 17, 984, 097 5, 499, 376 4, 603, 945 7, 610, 408 2, 260, 708	554 0 0 0 112	47, 910 7, 974 1, 351 564 3, 253	30. 00 31. 00 31. 01 40. 00 41. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0	O	160, 072, 673		8, 786	50.00
50. 01 05001 ENDOSCOPY 51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY - ULTRASOUND 55. 00 05500 RADI OLOGY - ULTRASOUND 56. 00 05500 RADI OLOGY - HERAPEUTI C 56. 00 05600 RADI OLOGY - THERAPEUTI C 57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESONANCE MAGI NG (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06900 LABORATORY 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 64. 00 06400 INTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 01 06901 CARDI AC REHAB 70. 00 07900 CARDI AC REHAB 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS 74. 00 07400 RENAL DI ALYSI S	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, 579, 694 0 0 0 0 0 0 0 0 0	18, 174, 858 10, 821, 121 5, 656, 816 0 40, 084, 188 17, 965, 300 15, 066, 732 16, 612, 204 124, 404, 760 29, 626, 211 74, 584, 802 155, 336, 834 0 8, 960, 206 0 39, 342, 354 7, 869, 238 6, 077, 206 2, 501, 738 23, 171, 578 896, 419 26, 940, 508 53, 172, 472 32, 459, 800 153, 795, 763 8, 939, 534	0 0 0 0 0 0 0 0 0 0 0 0 0 0	968 592 5, 391 0 542 568 223 13 412 7 5, 559 296 0 114 0 0 0 1, 831 46 116 39 580 0 240 0	50. 01 51. 00 52. 00 53. 00 54. 01 55. 00 56. 00 57. 00 58. 00 59. 00 60. 01 61. 00 62. 00 64. 00 65. 00 66. 00
90. 00 09000 CLINIC	0	4	25, 858, 355	0	336	90.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	0	67, 240, 057			
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	23, 729	3, 831, 746	0	1, 128	101. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	27, 326, 389	16, 952, 798	1, 272, 772, 554	696	98, 729	118. 00
NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00

Health Financial Systems	METHODI ST HOS	PITALS, INC		In Lie	In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Period: From 01/01/2018			
				To 12/31/2018	Date/Time Pre 5/28/2019 4:5		
Cost Center Description	CENTRAL SERVI CES &	PHARMACY (COSTED	MEDI CAL RECORDS &	SOCI AL SERVI CE	STAFF EDUCATION		
	SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	(TIME SPENT)		

						5/28/2019 4:5	0 pm
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	STAFF	
	·	SERVICES &	(COSTED	RECORDS &	SERVI CE	EDUCATI ON	
		SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	(TIME SPENT)	
		(COSTED	ŕ	(GROSS	,	,	
		REQUIS.)		CHARGES)			
		14. 00	15. 00	16. 00	17. 00	17. 01	
191. 00 19100	RESEARCH	0	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	242, 183	0	0	2, 008	192.00
192. 01 19201	OTHER NON-REIMBURSABLE	0	0	0	0	0	192. 01
192. 02 19202	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0	0	192. 02
193. 00 19300 NONPALD WORKERS		0	0	0	0	0	193. 00
200. 00	Cross Foot Adjustments						200.00
201. 00	Negative Cost Centers						201.00
202. 00	Cost to be allocated (per Wkst. B,	4, 128, 019	7, 218, 183	4, 161, 774	739, 046	627, 933	202.00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 151063	0. 419784	0.003270	1, 061. 847701	6. 233390	203. 00
204. 00	Cost to be allocated (per Wkst. B,	710, 605	395, 195	243, 998	37, 203	215, 871	204.00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 026004	0. 022983	0. 000192	53. 452586	2. 142917	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 01/01/2018 12/31/2018 Date/Time Prepared: 5/28/2019 4:50 pm INTERNS & RESIDENTS PARAMED ED MEDI CAL SERVI CES-SALA SERVI CES-0THE Cost Center Description **FDUCATION** RY & FRINGES R PRGM COSTS **PROGRAM** (ASSI GNED (ASSI GNED (ASSI GNED (ASSI GNED TIME) TIME) TIME) TIME) 17.02 21.00 22.00 23.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00550 DATA PROCESSING 5.01 5.01 00560 PURCHASING RECEIVING AND STORES 5.02 5.02 00570 ADMITTING 5.03 5.03 5.04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.04 5.05 00590 OTHER A&G 5.05 5.06 00592 PATIENT TRANSPORTATION 5.06 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 01701 STAFF EDUCATION 17 01 17 01 01702 MEDICAL EDUCATION 17.02 100 17.02 02100 I&R SERVICES-SALARY & FRINGES APPRVD 100 21.00 21.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 100 22.00 02300 PARAMED ED PROGRAM 100 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 0 03000 ADULTS & PEDIATRICS C 30.00 0 03100 INTENSIVE CARE UNIT 0 31.00 0 0 31.00 0 31 01 03101 NEONATAL I CU 0 0 31.01 40.00 04000 SUBPROVI DER - I PF 0 0 0 0 40.00 0 41.00 04100 SUBPROVI DER - I RF 0 0 0 41.00 0 04300 NURSERY 0 43.00 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0 50.00 50.01 05001 ENDOSCOPY 0000000000000 0 0 0 50.01 0 51.00 05100 RECOVERY ROOM 0 0 51 00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 52.00 53 00 05300 ANESTHESI OLOGY 0 0 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0 54.00 οĺ 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 HOS	SPITALS, INC		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
				From 01/01/2018		
				To 12/31/2018	Date/Time Pre 5/28/2019 4:5	
		INTERNS &	RESI DENTS		372072017 4.0	, o piii
			11201 521110			
Cost Center Description	MEDI CAL	SERVI CES-SALA	SERVI CES-OTHE	PARAMED ED		
	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		
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190. 00
191. 00 19100 RESEARCH	0	0		0 0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0		192.00
192. 01 19201 OTHER NON-REIMBURSABLE	0	0		0 0		192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	0	0		0 0		192. 02
193. 00 19300 NONPALD WORKERS	0	0		0 0		193. 00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	85, 877	300, 138	285, 71	978, 231		202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	858. 770000			9, 782. 310000		203. 00
204.00 Cost to be allocated (per Wkst. B,	7, 537	1, 353	86, 66	1 74, 000		204. 00
Part II)						
20F 00 Unit cost multiplier (Wkst D Dorst	75 270000	12 520000	044 41000	740 000000		DOE OO

75. 370000

13. 530000

866. 610000

740. 000000

0.000000

205.00

206.00

207. 00

205.00

206.00 207.00 11)

Unit cost multiplier (Wkst. B, Part

NAHE adjustment amount to be allocated (per Wkst. B-2)
NAHE unit cost multiplier (Wkst. D, Parts III and IV)

				o 12/31/2018	Date/Time Pre 5/28/2019 4:5	pared:
		Title	XVIII	Hospi tal	PPS	<u> </u>
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
·	(from Wkst.	Ādj.		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 & PEDI ATRI CS	81, 279, 717		81, 279, 717	0	81, 279, 717	30.00
31.00 03100 INTENSIVE CARE UNIT	13, 054, 340		13, 054, 340	o	13, 054, 340	31.00
31. 01 03101 NEONATAL CU	2, 845, 305		2, 845, 305	o	2, 845, 305	31.01
40. 00 04000 SUBPROVI DER - 1 PF	2, 401, 421		2, 401, 421		2, 401, 421	40.00
41. 00 04100 SUBPROVI DER - RF	6, 977, 006		6, 977, 006		6, 977, 006	41.00
43. 00 04300 NURSERY	3, 424, 550		3, 424, 550		3, 424, 550	
ANCILLARY SERVICE COST CENTERS	27 12 17 22 2		27 12 17 22 2		27 12 17 222	
50. 00 05000 OPERATING ROOM	13, 682, 469		13, 682, 469	0	13, 682, 469	50.00
50. 01 05001 ENDOSCOPY	3, 714, 439		3, 714, 439		3, 714, 439	1
51. 00 05100 RECOVERY ROOM	2, 637, 105		2, 637, 105		2, 637, 105	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	5, 287, 229		5, 287, 229		5, 287, 229	1
53. 00 05300 ANESTHESI OLOGY	0,207,227		0,207,227		0, 207, 227	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	8, 959, 328		8, 959, 328		8, 959, 328	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	2, 793, 582		2, 793, 582		2, 793, 582	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	2, 743, 362		2, 743, 362		2, 743, 362	55.00
56. 00 05600 RADI OLOGT - THERAPEUTI C						56.00
	3, 036, 498		3, 036, 498		3, 036, 498	1
57. 00 05700 CT SCAN	4, 433, 617		4, 433, 617		4, 433, 617	57.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 478, 746		1, 478, 746		1, 478, 746	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	6, 126, 240		6, 126, 240		6, 126, 240	59.00
60. 00 06000 LABORATORY	15, 984, 089		15, 984, 089		15, 984, 089	
60. 01 06001 BLOOD LABORATORY	0		C	_	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		C	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 234, 232		2, 234, 232		2, 234, 232	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0		[C	_	0	63.00
64.00 06400 I NTRAVENOUS THERAPY	0		[C	-	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	4, 966, 049	0			4, 966, 049	65.00
66. 00 06600 PHYSI CAL THERAPY	2, 983, 580	0	2, 983, 580	0	2, 983, 580	1
67. 00 06700 OCCUPATI ONAL THERAPY	2, 460, 216	0	2, 460, 216	0	2, 460, 216	67.00
68.00 06800 SPEECH PATHOLOGY	808, 521	0	808, 521	0	808, 521	68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 283, 853		1, 283, 853	0	1, 283, 853	69.00
69. 01 06901 CARDI AC REHAB	686, 422		686, 422	0	686, 422	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 945, 307		1, 945, 307	0	1, 945, 307	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17, 739, 723		17, 739, 723	0	17, 739, 723	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	19, 901, 483		19, 901, 483	0	19, 901, 483	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	25, 710, 106		25, 710, 106	o	25, 710, 106	73.00
74.00 07400 RENAL DIALYSIS	3, 027, 310		3, 027, 310	o	3, 027, 310	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	10, 676, 806		10, 676, 806	0	10, 676, 806	90.00
91. 00 09100 EMERGENCY	17, 113, 458		17, 113, 458	o	17, 113, 458	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	18, 367, 978		18, 367, 978	3	18, 367, 978	92.00
OTHER REIMBURSABLE COST CENTERS						1
101.00 10100 HOME HEALTH AGENCY	3, 427, 468		3, 427, 468	3	3, 427, 468	101.00
200.00 Subtotal (see instructions)	314, 379, 394	0			314, 379, 394	
201.00 Less Observation Beds	18, 367, 978		18, 367, 978		18, 367, 978	
202.00 Total (see instructions)	296, 011, 416	0			296, 011, 416	
	'	•	•	'		

| Peri od: | Worksheet C | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-0002

					10 12/31/2016	5/28/2019 4: 5	
			Title	XVIII	Hospi tal	PPS	
	·		Charges		·		
	Cost Center Description	Inpatient	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Rati o	I npati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	73, 127, 449		73, 127, 44			30.00
31.00	03100 INTENSIVE CARE UNIT	17, 984, 097		17, 984, 09			31.00
31. 01	03101 NEONATAL I CU	5, 499, 376		5, 499, 37			31. 01
40.00	04000 SUBPROVI DER - I PF	4, 603, 945		4, 603, 94			40.00
41. 00	04100 SUBPROVI DER - I RF	7, 610, 408		7, 610, 40			41.00
43.00	04300 NURSERY	2, 260, 708		2, 260, 70	8		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	87, 821, 341	72, 251, 332			0. 000000	1
50. 01	05001 ENDOSCOPY	3, 878, 941	14, 295, 917			0. 000000	
51.00	05100 RECOVERY ROOM	4, 964, 850	5, 856, 271			0. 000000	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 140, 017	2, 516, 799			0. 000000	1
53.00	05300 ANESTHESI OLOGY	0	0		0. 000000	0. 000000	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	10, 081, 252	30, 002, 936			0. 000000	1
54. 01	05401 RADI OLOGY - ULTRASOUND	5, 142, 237	12, 823, 063			0. 000000	1
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 281, 684	13, 785, 048			0. 000000	
56. 00	05600 RADI OI SOTOPE	5, 778, 731	10, 833, 473			0. 000000	
57.00	05700 CT SCAN	45, 358, 468	79, 046, 292			0. 000000	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	11, 334, 014	18, 292, 197			0. 000000	1
59.00	05900 CARDI AC CATHETERI ZATI ON	32, 543, 932	42, 040, 870			0.000000	
60.00	06000 LABORATORY	61, 679, 761	93, 657, 073	1		0.000000	1
60. 01	06001 BLOOD LABORATORY	0	0	1	0.000000	0.000000	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	(005 105	4 0/5 404	l .	0.000000	0.000000	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	6, 995, 105	1, 965, 101	1		0.000000	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		0	1	0.000000	0.000000	1
64.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	24 250 205	0 004 040		0.000000	0.000000	
65.00	06600 PHYSI CAL THERAPY	34, 358, 305	4, 984, 049			0.000000	1
66.00	1	7, 315, 249	553, 989			0.000000	1
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	5, 728, 371	348, 835			0.000000	1
69.00	06900 ELECTROCARDI OLOGY	2, 263, 691 11, 553, 118	238, 047 11, 618, 460			0. 000000 0. 000000	
69. 00	06901 CARDI AC REHAB	237, 930	658, 489			0. 000000	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	10, 233, 469	16, 707, 039			0. 000000	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	25, 233, 796	27, 938, 676			0. 000000	
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	18, 192, 155	14, 267, 645			0. 000000	1
73.00	07300 DRUGS CHARGED TO PATTENTS	103, 225, 990	50, 569, 773			0. 000000	1
	07400 RENAL DI ALYSI S	8, 009, 959	929, 575			0. 000000	1
74.00	OUTPATIENT SERVICE COST CENTERS	0,007,737	727, 373	0, 737, 33	4 0. 330043	0.000000	74.00
90. 00	09000 CLINIC	531, 406	25, 326, 949	25, 858, 35	0. 412896	0. 000000	90.00
91.00	09100 EMERGENCY	16, 408, 789	50, 831, 268			0. 000000	
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 693, 646	25, 529, 452			0. 000000	1
72.00	OTHER REIMBURSABLE COST CENTERS	0, 073, 040	23, 327, 432	32, 223, 07	J ₁ 0. 370025	0.000000	1 /2.00
101 00	10100 HOME HEALTH AGENCY	0	3, 831, 746	3, 831, 74	5		101.00
200.00		641, 072, 190		1, 272, 772, 55			200.00
201.00		311, 372, 170	331, 700, 304	., 2, 2, 7, 2, 33	1		201.00
202.00	1 I	641, 072, 190	631, 700, 364	1, 272, 772, 55	4		202.00
202.00	1.000 (000 1.000 000)	3, 3, 2, 1, 0	33., 700, 304	1 ., _, _, ,, _, ,00	-n I		

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu	of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0002	From 01/01/2018	Worksheet C Part I Date/Time Prepared: 5/28/2019 4:50 pm

				5/28/2019 4:50 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
31. 01 03101 NEONATAL CU				31.01
40. 00 04000 SUBPROVI DER - I PF				40.00
41. 00 04100 SUBPROVI DER - I RF				41.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 085477			50.00
50. 01 05001 ENDOSCOPY	0. 204372			50. 01
51.00 05100 RECOVERY ROOM	0. 243700			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 934665			52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 223513			54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	0. 155499			54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 194548			55.00
56. 00 05600 RADI OI SOTOPE	0. 182787			56.00
57. 00 05700 CT SCAN	0. 035639			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 049913			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 082138			59.00
50. 00 06000 LABORATORY	0. 102900			60.00
50. 01 06001 BLOOD LABORATORY	0. 000000			60.0
51.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONL				61.00
52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CEL				62.00
33.00 06300 BLOOD STORING, PROCESSING & TRANS.	1			63.00
54. 00 06400 I NTRAVENOUS THERAPY	0. 000000			64.00
55. 00 06500 RESPIRATORY THERAPY	0. 126227			65. 0
66. 00 06600 PHYSI CAL THERAPY	0. 379145			66.00
57. 00 06700 OCCUPATI ONAL THERAPY	0. 404827			67.00
58. 00 06800 SPEECH PATHOLOGY	0. 323184			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 055406			69.00
59. 01 06901 CARDI AC REHAB	0. 765738			69. 0
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 072208			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN				71.00
72.00 07100 MEDICAL SOFTETES CHARGED TO PATIENTS	0. 613112			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 167170			73.00
74. 00 07400 RENAL DI ALYSIS	0. 107170			74.00
OUTPATIENT SERVICE COST CENTERS	0. 338043			74.00
90. 00 09000 CLI NI C	0. 412896			90.00
91. 00 09100 EMERGENCY	0. 412898			91.00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR				92.00
	(1) 0.570025			92.00
OTHER REIMBURSABLE COST CENTERS				101 00
101.00 10100 HOME HEALTH AGENCY				101.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00

Date/Time Prepared: 12/31/2018 5/28/2019 4:50 pm Title XIX Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF 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 81, 279, 717 81, 279, 717 81, 279, 717 30.00 03100 INTENSIVE CARE UNIT 13, 054, 340 13, 054, 340 0 13, 054, 340 31.00 31.00 31.01 03101 NEONATAL ICU 2, 845, 305 2, 845, 305 0 2, 845, 305 31.01 04000 SUBPROVI DER - I PF 0 40.00 40 00 2, 401, 421 2, 401, 421 2, 401, 421 41.00 04100 SUBPROVI DER - I RF 6, 977, 006 6, 977, 006 0 6, 977, 006 41.00 43.00 04300 NURSERY 3, 424, 550 3, 424, 550 0 3, 424, 550 43 00 ANCILLARY SERVICE COST CENTERS 50 00 50.00 05000 OPERATING ROOM 13, 682, 469 13, 682, 469 0 13, 682, 469 3, 714, 439 50.01 05001 ENDOSCOPY 3, 714, 439 0 3, 714, 439 50.01 51.00 05100 RECOVERY ROOM 2, 637, 105 2, 637, 105 0 2, 637, 105 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 5, 287, 229 5, 287, 229 5, 287, 229 52.00 53.00 05300 ANESTHESI OLOGY Ω 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 8, 959, 328 8, 959, 328 0 8, 959, 328 54.00 2, 793, 582 54.01 05401 RADI OLOGY - ULTRASOUND 2, 793, 582 2, 793, 582 0 0 54.01 05500 RADI OLOGY-THERAPEUTI C 2, 931, 201 2, 931, 201 2, 931, 201 55.00 55.00 56.00 05600 RADI OI SOTOPE 3, 036, 498 3, 036, 498 3, 036, 498 56.00 05700 CT SCAN 4, 433, 617 0 57.00 4, 433, 617 4, 433, 617 57.00 1, 478, 746 05800 MAGNETIC RESONANCE IMAGING (MRI) 1, 478, 746 58.00 1, 478, 746 58.00 0 05900 CARDIAC CATHETERIZATION 6, 126, 240 59 00 6, 126, 240 6, 126, 240 59 00 60.00 06000 LABORATORY 15, 984, 089 15, 984, 089 0 15, 984, 089 60.00 0 60.01 06001 BLOOD LABORATORY 60.01 0 61 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY O 61 00 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 2, 234, 232 2, 234, 232 2, 234, 232 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 63.00 64.00 06400 INTRAVENOUS THERAPY 0 0 64.00 0 0 06500 RESPIRATORY THERAPY 4, 966, 049 4, 966, 049 4, 966, 049 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 2, 983, 580 2, 983, 580 2, 983, 580 66.00 06700 OCCUPATI ONAL THERAPY 67.00 2, 460, 216 2, 460, 216 0 0 2, 460, 216 67.00 68 00 06800 SPEECH PATHOLOGY 808 521 808 521 808, 521 68 00 06900 ELECTROCARDI OLOGY 69.00 1, 283, 853 1, 283, 853 1, 283, 853 69.00 06901 CARDI AC REHAB 686, 422 686, 422 0 686, 422 69.01 69.01 0 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 945, 307 1, 945, 307 1, 945, 307 70.00 o 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 17, 739, 723 17, 739, 723 17, 739, 723 71 00 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 19, 901, 483 19, 901, 483 19, 901, 483 72.00 25, 710, 106 07300 DRUGS CHARGED TO PATIENTS 25, 710, 106 25, 710, 106 73.00 73.00 74.00 07400 RENAL DIALYSIS 3, 027, 310 3, 027, 310 3, 027, 310 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 10, 676, 806 10, 676, 806 0 10, 676, 806 90.00 91.00 09100 EMERGENCY 17, 113, 458 17, 113, 458 17, 113, 458 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 18, 367, 978 18, 367, 978 18, 367, 978 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 3, 427, 468 3, 427, 468 3, 427, 468 101. 00 200.00 Subtotal (see instructions) 314, 379, 394 0 314, 379, 394 0 314, 379, 394 200. 00 18, 367, 978 201. 00 18, 367, 978 201.00 Less Observation Beds 18, 367, 978

296, 011, 416

296, 011, 416

296, 011, 416 202. 00

202.00

Total (see instructions)

Peri od: Worksheet C From 01/01/2018 Part I To 12/31/2018 Date/Ti me Prepared: 5/28/2019 4:50 pm Provider CCN: 15-0002

						5/28/2019 4: 5	O pm
			Ti tl	e XIX	Hospi tal	Cost	
	·		Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
	•	'	•	+ col . 7)	Ratio	I npati ent	
				,		Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
•	INPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>					
30.00	03000 ADULTS & PEDIATRICS	73, 127, 449		73, 127, 44	9		30.00
31.00	03100 INTENSIVE CARE UNIT	17, 984, 097		17, 984, 09	7		31.00
31.01	03101 NEONATAL I CU	5, 499, 376		5, 499, 37	6		31.01
40.00	04000 SUBPROVI DER - I PF	4, 603, 945		4, 603, 94	5		40.00
41.00	04100 SUBPROVI DER - I RF	7, 610, 408		7, 610, 40	8		41.00
43.00	04300 NURSERY	2, 260, 708		2, 260, 70			43.00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	87, 821, 341	72, 251, 332	160, 072, 67	3 0. 085477	0.000000	50.00
50. 01	05001 ENDOSCOPY	3, 878, 941	14, 295, 917	18, 174, 85	8 0. 204372	0. 000000	50. 01
51.00	05100 RECOVERY ROOM	4, 964, 850	5, 856, 271	10, 821, 12	0. 243700	0. 000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 140, 017	2, 516, 799			0. 000000	52.00
53.00	05300 ANESTHESI OLOGY	O	0		0. 000000	0. 000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	10, 081, 252	30, 002, 936	40, 084, 18	8 0. 223513	0. 000000	54.00
54. 01	05401 RADI OLOGY - ULTRASOUND	5, 142, 237	12, 823, 063			0. 000000	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	1, 281, 684	13, 785, 048			0. 000000	
56. 00	05600 RADI OI SOTOPE	5, 778, 731	10, 833, 473			0. 000000	
57. 00	05700 CT SCAN	45, 358, 468	79, 046, 292			0. 000000	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	11, 334, 014	18, 292, 197			0. 000000	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	32, 543, 932	42, 040, 870			0. 000000	1
60.00	06000 LABORATORY	61, 679, 761	93, 657, 073			0. 000000	
60. 01	06001 BLOOD LABORATORY	0	0		0.000000	0. 000000	
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0		0. 000000	0. 000000	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	6, 995, 105	1, 965, 101	8, 960, 20		0. 000000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	O	0		0. 000000	0. 000000	
64.00	06400 I NTRAVENOUS THERAPY		0		0. 000000	0. 000000	
65.00	06500 RESPIRATORY THERAPY	34, 358, 305	4, 984, 049	39, 342, 35	4 0. 126227	0. 000000	65.00
66.00	06600 PHYSI CAL THERAPY	7, 315, 249	553, 989	7, 869, 23	8 0. 379145	0. 000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	5, 728, 371	348, 835			0. 000000	67.00
68. 00	06800 SPEECH PATHOLOGY	2, 263, 691	238, 047	2, 501, 73	8 0. 323184	0. 000000	68.00
69.00	06900 ELECTROCARDI OLOGY	11, 553, 118	11, 618, 460			0. 000000	69.00
69. 01	06901 CARDI AC REHAB	237, 930	658, 489			0. 000000	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	10, 233, 469	16, 707, 039	26, 940, 50	0. 072208	0. 000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	25, 233, 796	27, 938, 676	53, 172, 47	2 0. 333626	0. 000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	18, 192, 155	14, 267, 645	32, 459, 80	0. 613112	0. 000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	103, 225, 990	50, 569, 773	153, 795, 76	3 0. 167170	0. 000000	73.00
74.00	07400 RENAL DIALYSIS	8, 009, 959	929, 575	8, 939, 53	0. 338643	0. 000000	74.00
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLI NI C	531, 406	25, 326, 949	25, 858, 35	5 0. 412896	0.000000	90.00
91.00	09100 EMERGENCY	16, 408, 789	50, 831, 268	67, 240, 05	7 0. 254513	0. 000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 693, 646	25, 529, 452	32, 223, 09	0. 570025	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	3, 831, 746	3, 831, 74	6		101.00
200.00		641, 072, 190	631, 700, 364	1, 272, 772, 55	4		200.00
201.00							201.00
202.00	Total (see instructions)	641, 072, 190	631, 700, 364	1, 272, 772, 55	4		202.00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu	of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0002	From 01/01/2018	Worksheet C Part I Date/Time Prepared: 5/28/2019 4:50 pm

				5/28/2019 4:50 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
31. 01 03101 NEONATAL I CU				31.01
40. 00 04000 SUBPROVI DER - I PF				40.00
41. 00 04100 SUBPROVI DER - I RF				41.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 000000			50.00
50. 01 05001 ENDOSCOPY	0. 000000			50. 01
51.00 05100 RECOVERY ROOM	0. 000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	0. 000000			54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55.00
56. 00 05600 RADI 01 SOTOPE	0. 000000			56.00
57. 00 05700 CT SCAN	0. 000000			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
50. 00 06000 LABORATORY	0. 000000			60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000			64.00
55. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
1 1	0. 000000			68.00
· ·	0. 000000			69.00
	0. 000000			
69. 01 06901 CARDI AC REHAB 70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			69. 01 70. 00
	1			•
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
74. 00 O7400 RENAL DIALYSIS	0. 000000			74.00
OUTPATIENT SERVICE COST CENTERS	0.000000			20.00
90. 00 09000 CLI NI C	0.000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00

Health Financial Systems	METHODIST HOS	SPITALS, INC		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der CO		Period: From 01/01/2018 To 12/31/2018		pared: O pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col . 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	7, 135, 443		.,			
31.00 INTENSIVE CARE UNIT	551, 130		551, 13			31.00
31. 01 NEONATAL I CU	77, 194		77, 19		29. 68	
40. 00 SUBPROVI DER - I PF	106, 427		106, 42		36. 25	
41. 00 SUBPROVI DER - I RF	689, 952		689, 95			
43. 00 NURSERY	501, 399		501, 39		174. 76	
200.00 Total (lines 30 through 199)	9, 061, 545		9, 061, 54	5 117, 163		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			1			
30. 00 ADULTS & PEDIATRICS	27, 049					30.00
31. 00 INTENSIVE CARE UNIT	3, 227					31.00
31. 01 NEONATAL I CU	0		1			31. 01
40. 00 SUBPROVI DER - I PF	1, 267					40.00
41. 00 SUBPROVI DER - I RF	5, 226					41.00
43. 00 NURSERY	0	-				43.00
200.00 Total (lines 30 through 199)	36, 769	2, 779, 621	l		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			Period: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Pre 5/28/2019 4:5	pared: O pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col. 26)					
	1. 00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1, 378, 468	160, 072, 673	0. 00861	2 30, 187, 768	259, 977	50.00
50. 01 05001 ENDOSCOPY	42, 027	18, 174, 858	0. 00231	2 1, 681, 294	3, 887	50. 01
51.00 05100 RECOVERY ROOM	311, 400	10, 821, 121	0. 02877	7 1, 451, 355	41, 766	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	207, 213			1 137, 702	5, 044	52.00
53. 00 05300 ANESTHESI OLOGY	0	C	0. 00000	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 101, 150	40, 084, 188	0. 02747	1 4, 341, 322	119, 260	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	127, 516	17, 965, 300	0.00709	8 2, 353, 624	16, 706	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	282, 823	15, 066, 732	0. 01877	1 437, 794	8, 218	55.00
56. 00 05600 RADI 01 SOTOPE	205, 269	16, 612, 204	0. 01235	7 2, 585, 367	31, 947	56.00
57. 00 05700 CT SCAN	269, 914					
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	108, 263					
59. 00 05900 CARDI AC CATHETERI ZATI ON	266, 101					
60. 00 06000 LABORATORY	673, 167	155, 336, 834	0.00433			60.00
60. 01 06001 BLOOD LABORATORY	. 0		0. 00000		l	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	30, 756	8, 960, 206	0.00343	3 2, 935, 208	10, 077	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0				l '	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0		0. 00000		0	64.00
65. 00 06500 RESPIRATORY THERAPY	209, 178	39, 342, 354			68, 456	65.00
66. 00 06600 PHYSI CAL THERAPY	261, 382					
67. 00 06700 OCCUPATI ONAL THERAPY	220, 311					
68. 00 06800 SPEECH PATHOLOGY	41, 726		1			1
69. 00 06900 ELECTROCARDI OLOGY	25, 893					69.00
69. 01 06901 CARDI AC REHAB	5, 384					69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	29, 107					1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	467, 652				93, 387	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	514, 458					1
73.00 07300 DRUGS CHARGED TO PATIENTS	570, 249					
74. 00 07400 RENAL DI ALYSI S	118, 463					
OUTPATIENT SERVICE COST CENTERS	1.0,.00				2.7	1
90. 00 09000 CLINIC	1, 536, 536	25, 858, 355	0.05942	1 129, 753	7, 710	90.00
91. 00 09100 EMERGENCY	748, 877				1	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 612, 506		1			
200.00 Total (lines 50 through 199)		1, 157, 854, 825		194, 592, 403		
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	, , , , , , , , , , , , , , , , , , , ,	, , ,	1	1	, , , , , , , , , , , , , , , , , , , ,	

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS			Peri od: From 01/01/2018 To 12/31/2018		pared:
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		h Allied Health	All Other	
	School	School	Post-Stepdow		Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adj ustments	1.00		0.00	Cost	
INDATIONE DOUTING CERVILOR COST CENTERS	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 03000 ADULTS & PEDI ATRI CS	0	1	1	0	0	
31. 00 03100 I NTENSI VE CARE UNI T	0	0	1	0 0	0	
31. 01 03101 NEONATAL CU	0	0	1	0	0	
40. 00 04000 SUBPROVI DER - 1 PF	0	0		0	0	40.00
41. 00 04100 SUBPROVI DER - RF	0	0	1	0 0	0	
43.00 04300 NURSERY 200.00 Total (Lines 30 through 199)	0	0		0	0	43. 00 200. 00
200.00 Total (lines 30 through 199) Cost Center Description	Swi ng-Bed	Total Costs	Total Patien	t Per Diem	Inpati ent	200.00
cost center bescription	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,	Days	col . 6)	l 11 Ogi alli bays	
				COI. 0)		
	4. 00	5. 00	6.00	7.00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		3. 55			5. 55	
30. 00 03000 ADULTS & PEDIATRICS	0	0	91, 86	0.00	27, 049	30.00
31.00 03100 INTENSIVE CARE UNIT		0	8, 24	19 0.00	3, 227	31.00
31. 01 03101 NEONATAL I CU		0	2, 60		0	31.01
40. 00 04000 SUBPROVI DER - I PF	0	0	2, 93	0.00	1, 267	40.00
41. 00 04100 SUBPROVI DER - I RF	0	0	8, 64	18 0.00	5, 226	
43. 00 04300 NURSERY		0	2, 86	0.00	0	43.00
200.00 Total (lines 30 through 199)		0	117, 16	53	36, 769	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	l				30.00
31. 00 03100 INTENSIVE CARE UNIT	0	l				31.00
31. 01 03101 NEONATAL CU	0					31. 01
40. 00 04000 SUBPROVI DER - 1 PF	0	l .				40.00
41. 00 04100 SUBPROVI DER - RF	0	l .				41.00
43. 00 04300 NURSERY	0	l				43.00
200.00 Total (lines 30 through 199)	0	I				200. 00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0002	Peri od: Worksheet D From 01/01/2018 Part IV To 12/31/2018 Date/Ti me Prepared: 5/28/2019 4:50 pm

				10 12/31/2018	5/28/2019 4: 5	
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anestheti st	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	1	0	0	1 00.00
50. 01 05001 ENDOSCOPY	0	0		0	0	
51.00 05100 RECOVERY ROOM	0	0		0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	02.00
53. 00 05300 ANESTHESI OLOGY	0	0		0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0)	0	0	1 0 00
54. 01 05401 RADI OLOGY - ULTRASOUND	0	0)	0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	55. 00
56. 00 05600 RADI OI SOTOPE	0	0)	0	0	56. 00
57.00 05700 CT SCAN	0	0)	0	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0)	0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0)	0	0	
60. 00 06000 LABORATORY	0	0)	0	0	60.00
60. 01 06001 BL00D 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	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0)	0	0	1 00.00
64.00 06400 INTRAVENOUS THERAPY	0	0)	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0)	0	0	1 00.00
66. 00 06600 PHYSI CAL THERAPY	0	0)	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0)	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0)	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0)	0	0	69. 00
69. 01 06901 CARDI AC REHAB	0	0		0	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0)	0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0)	0 0	_	
91. 00 09100 EMERGENCY	0	0)	0	978, 231	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200.00 Total (lines 50 through 199)	0	0)	0 0	978, 231	200.00

THROUGH COSTS				o 12/31/2018		
		Title	XVIII	Hospi tal	PPS	Орш
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
'	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col . 8)	col. 7)	
			and 4)			
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS			,		,	
50.00 05000 OPERATING ROOM	0	0	(l e	50.00
50. 01 05001 ENDOSCOPY	0	0	1			50. 01
51. 00 05100 RECOVERY ROOM	0	0	(0.000000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		5, 656, 816		1
53. 00 05300 ANESTHESI OLOGY	0	0	(0	0. 000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(
54. 01 05401 RADI OLOGY - ULTRASOUND	0	0	(17, 965, 300	•	1
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	(.0,000,702	•	55.00
56. 00 05600 RADI 01 SOTOPE	0	0	(l	56.00
57. 00 05700 CT SCAN	0	0	(12 1, 10 1, 700		57.00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	(27,020,2	0. 000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	(59.00
60. 00 06000 LABORATORY	0	0	(155, 336, 834		60.00
60. 01 06001 BL00D LABORATORY	0	0	(0	0. 000000	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	_	_				61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	(8, 960, 206		62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(0	0.000000	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	(0	0.000000	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		39, 342, 354		
66. 00 06600 PHYSI CAL THERAPY	0	0		7, 869, 238	l e	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0,011,200		67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	0		_, _,		1
	0	0		20,, 0.0		1
69. 01 06901 CARDI AC REHAB 70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0,0,	l e	69. 01 70. 00
71. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		53, 172, 472	l e	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			l e	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0			l e	73.00
74. 00 07400 RENAL DIALYSIS	0	0				74.00
OUTPATIENT SERVICE COST CENTERS				0, 939, 334	0.000000	74.00
90. 00 09000 CLINIC	0	0		25, 858, 355	0.000000	90.00
91. 00 09100 EMERGENCY		978, 231				1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		770, 231	770, 23			
200.00 Total (lines 50 through 199)	0	978, 231	1	1, 157, 854, 825		200.00
200.00 10tal (111103 00 till ough 177)	1	1 770, 231	1 770, 23	1, 107, 004, 020	I	1200.00

Health Financial Systems	METHODIST HOSPI	ΓALS, INC	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0002		Worksheet D
THROUGH COSTS			From 01/01/2018	Part IV

THROUGH COSTS				rom 01/01/2018 o 12/31/2018	Part IV Date/Time Pre 5/28/2019 4:5		
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	·	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷		Costs (col. 8		Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0. 000000	30, 187, 768				50.00
	05001 ENDOSCOPY	0. 000000	1, 681, 294				50. 01
51.00	05100 RECOVERY ROOM	0. 000000	1, 451, 355	0	1, 847, 707	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	137, 702	0	304, 958	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	0	· ·	_	_	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	4, 341, 322		5, 344, 519	0	54.00
54.01	05401 RADI OLOGY - ULTRASOUND	0. 000000	2, 353, 624		_,,	0	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	437, 794	0	4, 105, 009	0	55.00
56.00	05600 RADI 0I S0T0PE	0. 000000	2, 585, 367	0	3, 057, 287	0	56.00
57.00	05700 CT SCAN	0. 000000	17, 132, 789	C	16, 236, 772	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	4, 332, 094	O	3, 961, 436	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	11, 737, 605	O	15, 382, 145	0	59.00
60.00	06000 LABORATORY	0. 000000	22, 953, 635	O	6, 987, 530	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	2, 935, 208	0	523, 214	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	C	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0. 000000	12, 874, 846	0	512, 747	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	1, 731, 948	0	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	1, 082, 863	0	38, 110	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	841, 565	C	21, 996	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	5, 270, 436	C	3, 052, 886	0	69.00
69. 01	06901 CARDI AC REHAB	0. 000000	269	C	232, 157	0	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	1, 616, 906	C	4, 743, 531	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	10, 618, 191	C	7, 336, 615	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	6, 393, 245	C	4, 422, 886	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	38, 390, 964	C	14, 163, 535	0	73.00
74.00	07400 RENAL DIALYSIS	0. 000000	3, 878, 924	0	403, 917	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 000000	129, 753	C	5, 352, 098	0	90.00
	09100 EMERGENCY	0. 014548	6, 566, 119	95, 524	6, 435, 632	93, 626	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	2, 928, 817				92.00
200.00	Total (lines 50 through 199)		194, 592, 403	95, 524	131, 314, 167	93, 626	200. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0002 Peri od: Worksheet D From 01/01/2018 Part V Date/Time Prepared: 12/31/2018 5/28/2019 4:50 pm Title XVIII Hospi tal PPS Charges Costs PPS Services Cost Center Description Cost to PPS Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) Services (see From Servi ces Services Not Worksheet C, inst.) Subject To Subject To Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 2.00 5.00 1.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0.085477 17, 519, 735 1, 497, 534 50.00 05001 ENDOSCOPY 0 3, 757, 204 0 767, 867 50.01 0. 204372 50.01 05100 RECOVERY ROOM 51.00 0.243700 1,847,707 450, 286 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0. 934665 304, 958 0 0 285, 034 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0 0 53.00 0 0 1, 194, 569 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 223513 5, 344, 519 54 00 0 0 54.01 05401 RADI OLOGY - ULTRASOUND 0. 155499 2, 056, 421 319, 771 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 0. 194548 4, 105, 009 0 798, 621 55.00 0 05600 RADI OI SOTOPE 0.182787 3, 057, 287 0 0 56.00 558, 832 56.00 0 05700 CT SCAN 57.00 0.035639 16, 236, 772 578, 662 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.049913 3, 961, 436 197, 727 58.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 0.082138 15, 382, 145 0 0 1, 263, 459 59.00 06000 LABORATORY 6, 987, 530 0 60 00 0 102900 719, 017 60 00 0 60.01 06001 BLOOD LABORATORY 0.000000 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 0 0 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 0. 249351 523, 214 0 130, 464 62.00 0 06300 BLOOD STORING, PROCESSING & TRANS. 0 0.000000 63 00 C 0 63 00 0 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0 64.00 06500 RESPIRATORY THERAPY 512, 747 0. 126227 64, 723 65.00 0 66.00 06600 PHYSI CAL THERAPY 0.379145 0 0 0 66,00 06700 OCCUPATI ONAL THERAPY 0 404827 38, 110 0 15, 428 67 00 67.00 68.00 06800 SPEECH PATHOLOGY 0. 323184 21, 996 7, 109 68.00 06900 ELECTROCARDI OLOGY 3, 052, 886 0 0 169, 148 69.00 0.055406 69.00 0 06901 CARDI AC REHAB 232, 157 0 177, 771 69.01 0.765738 69.01 0 07000 ELECTROENCEPHALOGRAPHY 4, 743, 531 0 70.00 0.072208 342, 521 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 333626 7, 336, 615 0 0 2, 447, 686 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.613112 4, 422, 886 0 0 2, 711, 724 72.00 07300 DRUGS CHARGED TO PATIENTS 0 180, 407 73 00 0.167170 14, 163, 535 2, 367, 718 73 00 74.00 07400 RENAL DIALYSIS 0.338643 403, 917 0 136, 784 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0. 412896 5. 352. 098 0 0 2, 209, 860 90.00 0 09100 EMERGENCY 1, 637, 952 91.00 91.00 0. 254513 6, 435, 632 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.570025 3, 514, 120 0 2, 003, 136 92.00 200.00 Subtotal (see instructions) 131, 314, 167 0 180, 407 23, 053, 403 200. 00 Less PBP Clinic Lab. Services-Program 0 201. 00 201.00 Only Charges

131, 314, 167

0

180, 407

23, 053, 403 202. 00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST Provider C	CCN: 15-0002

				From 01/01/2018 To 12/31/2018	Part V Date/Time Pre	
		Ti +l o	XVIII	Hospi tal	5/28/2019 4: 5 PPS	ou pm
	Cos		AVIII	l Hospi tai	FF3	
Cost Center Description	Cost	Cost				
cost center bescription	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	0.00	7.00				
50. 00 05000 OPERATING ROOM	0	0				50.00
50. 01 05000 0FERATTING ROOM 50. 01 05001 ENDOSCOPY	0					50.00
51. 00 05100 RECOVERY ROOM	0					51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	0	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	0	0				54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55. 00
56. 00 05600 RADI OI SOTOPE	0	1				56. 00
57. 00 05700 CT SCAN	0	0				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	0	1				60.00
60. 01 06001 BL00D LABORATORY	0	0				60. 01
61.00 O6100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	1				61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1				62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0					63. 00
64.00 06400 INTRAVENOUS THERAPY	0	0				64.00
65. 00 06500 RESPI RATORY THERAPY	0					65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
69. 01 06901 CARDI AC REHAB	0	0				69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	30, 159				73. 00
74.00 07400 RENAL DIALYSIS	0	0				74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0				90.00
91. 00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	0	30, 159				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	30, 159				202.00

Health Financial Systems	METHODIST HOS	CDITALS INC		In Lio	u of Form CMS-2	2552 10
Health Financial Systems APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT		Provi der C	CN: 15 0002	Peri od:	Worksheet D	2332-10
AFFORTIONWENT OF THEATTENT ANGIELARY SERVICE CAFT	AL 00313	FIOVIDE	CN. 15-0002	From 01/01/2018		
		· ·	CCN: 15-S002	To 12/31/2018	Date/Time Pre 5/28/2019 4:5	pared: 0 pm
			e XVIII	Subprovi der - I PF	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col . 26)					
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS		1				
50. 00 05000 OPERATING ROOM	1, 378, 468		1		0	
50. 01 05001 ENDOSCOPY	42, 027		1		0	
51.00 05100 RECOVERY ROOM	311, 400				0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	207, 213				0	
53. 00 05300 ANESTHESI OLOGY	0	_			0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 101, 150				581	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	127, 516		1		87	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	282, 823		1		0	
56. 00 05600 RADI OI SOTOPE	205, 269		1		0	56.00
57. 00 05700 CT SCAN	269, 914		1		147	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	108, 263		1		38	
59. 00 05900 CARDI AC CATHETERI ZATI ON	266, 101				0	
60. 00 06000 LABORATORY	673, 167				858	
60. 01 06001 BL00D LABORATORY	0	0	0. 00000	00	0	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	30, 756		1	· ·	78	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	_			0	
64.00 06400 INTRAVENOUS THERAPY	0	_	0.0000		0	
65. 00 06500 RESPI RATORY THERAPY	209, 178		1		32	1
66. 00 06600 PHYSI CAL THERAPY	261, 382			· ·	204	
67. 00 06700 OCCUPATI ONAL THERAPY	220, 311			· ·	152	
68. 00 06800 SPEECH PATHOLOGY	41, 726				15	
69. 00 06900 ELECTROCARDI OLOGY	25, 893				20	
69. 01 06901 CARDI AC REHAB	5, 384		1		0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	29, 107		1		2	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	467, 652				63	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	514, 458		1		0	
73.00 07300 DRUGS CHARGED TO PATIENTS	570, 249				1, 741	73.00
74. 00 07400 RENAL DIALYSIS	118, 463	8, 939, 534	0. 01325	10, 819	143	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	1, 536, 536				0	
91. 00 09100 EMERGENCY	748, 877		1		696	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	,,	1		0	
200.00 Total (lines 50 through 199)	9, 753, 283	1, 157, 854, 825	I	919, 336	4, 857	200. 00

	Financial Systems	METHODIST HOS		ON 45 0000	15		u of Form CMS-2	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEIGH COSTS	RVICE OTHER PAS	S Provider C	CN: 15-0002	Peri Fro	iod: m 01/01/2018	Worksheet D Part IV	
	333.5		Component	CCN: 15-S002	То	12/31/2018	Date/Time Pre 5/28/2019 4:5	
			Title	: XVIII	Sul	bprovi der -	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Δ1	IPF	Allied Health	
	cost center bescription	Anesthetist	School	School		ost-Stepdown	Airred flear til	
		Cost	Post-Stepdown	0011001		Adjustments		
			Adjustments					
		1.00	2A	2.00		3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	<u>'</u>						
50.00	05000 OPERATING ROOM	0	0		0	0	0	50.00
50. 01	05001 ENDOSCOPY	0	0		0	0	0	50.01
51.00	05100 RECOVERY ROOM	0	0		0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52.00
3.00	05300 ANESTHESI OLOGY	0	0		O	0	0	53.00
4.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
4. 01	05401 RADI OLOGY - ULTRASOUND	0	0		0	0	0	54.0
5.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55.0
6. 00	05600 RADI 0I SOTOPE	0	0		0	0	0	56.0
7. 00	05700 CT SCAN	0	0		0	0	0	57.00
8.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	0	58.00
9.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.0
0.00	06000 LABORATORY	0	0		0	0	0	60.0
0. 01	06001 BLOOD LABORATORY	0	0		0	0	0	60.0
1.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					0	0	61.0
2.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	0	62. 0 63. 0
3.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0		0	0	0	64.0
5.00	06500 RESPIRATORY THERAPY	0	0		0	0	0	65.00
6. 00	06600 PHYSI CAL THERAPY	0	0		0	0	0	66.0
7. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.0
8. 00	06800 SPEECH PATHOLOGY	0	١		0	0	0	68.0
9. 00	06900 ELECTROCARDI OLOGY	0	0		0	0	Ö	69.0
9. 01	06901 CARDI AC REHAB	0	0		0	0	0	69.0
0. 00	07000 ELECTROENCEPHALOGRAPHY	0	l		Ō	ol	0	70.0
1. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	l		0	o	0	71.0
2. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	O	0	72.0
3. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	73.0
4. 00	07400 RENAL DIALYSIS	0	0		0	0	0	74.0
	OUTPATIENT SERVICE COST CENTERS]
0.00	09000 CLI NI C	0	0		0	0	0	90.0
	09100 EMERGENCY	0	0		0	0	978, 231	91.00
22 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		l	1	Ω		0	92 00

0 0 0

0 90.00 978, 231 91.00 0 92.00 978, 231 200.00

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

lealth Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S	METHODIST HOS ERVICE OTHER PAS			Peri od:	u of Form CMS-2 Worksheet D	
THROUGH COSTS		Component		From 01/01/2018 To 12/31/2018	Part IV Date/Time Pre 5/28/2019 4:5	pared: 0 pm
		Titl∈	XVIII	Subprovi der - I PF	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
	Cost	4)	cols. 2, 3, and 4)	col. 8)	col . 7)	
	4. 00	5. 00	6.00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	-		0 160, 072, 673		
0. 01 05001 ENDOSCOPY	0	0		0 18, 174, 858		
1.00 05100 RECOVERY ROOM	0	0		0 10, 821, 121	0. 000000	
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 5, 656, 816	0. 000000	
3. 00 05300 ANESTHESI OLOGY	0	0		0	0. 000000	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 40, 084, 188	0. 000000	
4. 01 05401 RADI OLOGY - ULTRASOUND	0	0		0 17, 965, 300	0. 000000	
5. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 15, 066, 732	0. 000000	
6. 00 05600 RADI 01 SOTOPE	0	0		0 16, 612, 204	0. 000000	
7. 00 05700 CT SCAN	0	0		0 124, 404, 760		
8. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 29, 626, 211	0. 000000	
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 74, 584, 802	0. 000000	
0. 00 06000 LABORATORY	0	0		0 155, 336, 834	0.000000	60.0
D. 01 06001 BLOOD LABORATORY 1. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0 0	0. 000000	60.0
1.00 O6100 PBP CLINICAL LAB SERVICES-PRGM ONLY 2.00 O6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 8, 960, 206	0. 000000	61.0
3.00 06300 BLOOD STORING, PROCESSING & TRANS.	0				0. 000000	63.0
4.00 06400 INTRAVENOUS THERAPY	0			0 0	0. 000000	
5. 00 06500 RESPIRATORY THERAPY				0 39, 342, 354	0. 000000	
5. 00 06600 PHYSI CAL THERAPY	0		•	0 7, 869, 238	0. 000000	
7. 00 06700 OCCUPATI ONAL THERAPY	0			0 6, 077, 206	0. 000000	67.0
B. 00 06800 SPEECH PATHOLOGY	0			0 2, 501, 738		
9. 00 06900 ELECTROCARDI OLOGY	0			0 23, 171, 578	0. 000000	
9. 01 06901 CARDI AC REHAB	0			0 896, 419	0. 000000	
0. 00 07000 ELECTROENCEPHALOGRAPHY	1 0	1 0	•	0 26, 940, 508	0. 000000	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 53, 172, 472	0. 000000	
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 32, 459, 800		
3. 00 07300 DRUGS CHARGED TO PATIENTS	0			0 153, 795, 763		
4. 00 07400 RENAL DIALYSIS	0	O		0 8, 939, 534	0.000000	
OUTPATIENT SERVICE COST CENTERS	•	•				1
0 00 0000 CLINIC	0	0		0 25 858 355	0.000000	00

978, 231

978, 231

0 25, 858, 355 978, 231 67, 240, 057 0 32, 223, 098 978, 231 1, 157, 854, 825

90.00

91.00

92. 00 200. 00

0.000000

0. 014548

0.000000

90. 00 09000 CLI NI C

91. 00 09100 EMERGENCY

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

111 45	Simulation Contains	METHODI CT. HOCOL	TALC INC		1-1:-	£ F CMC /	2552 10
	Financial Systems	METHODIST HOSPI		CN. 1E 0000	Period:	u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE H COSTS	RVICE UIHER PASS	Provi der CCN: 15-0002		From 01/01/2018	Worksheet D Part IV	
THROUG	n CU313		Component	CCN: 15-S002	To 12/31/2018		epared: 50 pm
			Title	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	Charges	Pass-Through	
		(col. 6 ÷		Costs (col.	8	Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	0		0 0	0	50.00
50. 01	05001 ENDOSCOPY	0. 000000	0		0 0	0	50. 01
51.00	05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52.00
53. 00	05300 ANESTHESI OLOGY	0. 000000	0		0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	21, 144		0 0	Ö	
54. 01	05401 RADI OLOGY - ULTRASOUND	0. 000000	12, 245		0 0	ő	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	12, 249		0 0	Ö	
56. 00	05600 RADI OI SOTOPE	0. 000000	0		0 0	0	
57.00	05700 CT SCAN	0. 000000	67, 865		0 0	0	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	10, 357		0 0	0	
59.00	05900 CARDIAC CATHETERIZATION	0. 000000	10, 357		0 0	0	
	06000 LABORATORY	l l			0 0		
60.00		0.000000	198, 074		0	0	
60. 01	06001 BLOOD LABORATORY	0. 000000	0		0	0	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		00 017				61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	22, 817		0	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0	0	
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0	0	
65.00	06500 RESPI RATORY THERAPY	0. 000000	5, 945		0	0	
66.00	06600 PHYSI CAL THERAPY	0. 000000	6, 153		0	0	
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	4, 191		0	0	
68. 00	06800 SPEECH PATHOLOGY	0. 000000	929		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	17, 865		0 241	0	
69. 01	06901 CARDI AC REHAB	0. 000000	0		0	0	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	1, 741		0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	7, 172		0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	469, 527		0	0	73.00
74.00	07400 RENAL DIALYSIS	0. 000000	10, 819		0	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0. 000000	0		0 0	0	90.00
	09100 EMERGENCY	0. 014548	62, 469	90	09	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
200.00	Total (lines 50 through 199)		919, 336	90	9 241	0	200.00
	, ,	'		'	1	•	

Health Financial Systems	Health Financial Systems METHODIST HOSPITALS,				u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	ND VACCINE COST	Provi der C		Peri od: From 01/01/2018	Worksheet D Part V	
	Component	CCN: 15-S002	To 12/31/2018	Date/Time Pre 5/28/2019 4:5		
		Title	: XVIII	Subprovi der -	PPS	
				IPF		
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
	From	Services (see	Servi ces	Servi ces Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins	. Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1 00	2 00	2 00	4.00	5 00	

	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	COST CONTENT DESCRIPTION	Charge Ratio	Reimbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Servi ces (see		Services Not	(300 11131.)	
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.	11131.)	Ded. & Coins.	Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
50.00	05000 OPERATI NG ROOM	0. 085477	0	0	0	0	50.00
50. 01	05001 ENDOSCOPY	0. 204372				0	50.01
51. 00	05100 RECOVERY ROOM	0. 243700		1	_	Ö	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 934665	0		0	0	52.00
53. 00	05300 ANESTHESI OLOGY	0. 000000	0	0	0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 223513				0	54.00
		0. 223513			0	0	54.00
54. 01	05401 RADI OLOGY - ULTRASOUND			0	0	-	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 194548	0	0	_	0	55.00
56.00	05600 RADI OI SOTOPE	0. 182787	0	0	_	0	56.00
57. 00	05700 CT SCAN	0. 035639	ł	0	_	0	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 049913		0	_	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 082138		0		0	59. 00
60.00	06000 LABORATORY	0. 102900		0	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000		0	0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000		0	0		61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 249351	0	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. 126227	0	0	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 379145	0	0	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 404827	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 323184	0	0	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 055406	241	l 0	0	13	69.00
69. 01	06901 CARDI AC REHAB	0. 765738			0	0	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 072208		0	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 333626		0	0	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 613112		0	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 167170		Ö	Ö	Ö	73.00
74.00	07400 RENAL DIALYSIS	0. 338643	0				74.00
74.00	OUTPATIENT SERVICE COST CENTERS	0. 330043					74.00
90.00		0. 412896	0	0	0	0	90.00
91.00	09100 EMERGENCY	0. 254513				l	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 234313	l		_	0	92.00
200.00		0.570025	241	1			200.00
200.00		-	241				200.00
201.00	Only Charges			l "			201.00
202.00		-	241	0	0	10	202. 00
202.00	p Net Glarges (Title 200 - Title 201)	I	1 241	1	1	13	1202.00

	Financial Systems	METHODI ST HOS	·			of Form CMS-	2552-10
APPORT	TONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	ID VACCINE COST	Provi der C	CN: 15-0002	Peri od: From 01/01/2018	Worksheet D	
			Component	CCN: 15-S002	To 12/31/2018		pared: O pm
		_	Titl∈	e XVIII	Subprovi der - I PF	PPS	
		Co	sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.) 6.00	(see inst.) 7.00	-			
	ANCILLARY SERVICE COST CENTERS	0.00	7.00				
	05000 OPERATING ROOM		0	N .			50.00
	05001 ENDOSCOPY						50.01
	05100 RECOVERY ROOM						51.00
	05200 DELIVERY ROOM & LABOR ROOM		l o				52.00
53.00	05300 ANESTHESI OLOGY	C	O				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
	05700 CT SCAN	C	0)			57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	C	0)			58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	C	0)			59.00

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60.01

61.00

62.00

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64.00

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66.00

67.00

68.00

69.00

69.01

70.00

71.00

72.00

73.00

74.00

90.00

91.00

92.00

200.00

201.00

202.00

60. 00 | 06000 | LABORATORY

06001 BLOOD LABORATORY

06400 I NTRAVENOUS THERAPY

06500 RESPIRATORY THERAPY

06700 OCCUPATI ONAL THERAPY

07000 ELECTROENCEPHALOGRAPHY

07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

06600 PHYSI CAL THERAPY

06800 SPEECH PATHOLOGY

06900 ELECTROCARDI OLOGY

06901 CARDI AC REHAB

07400 RENAL DIALYSIS

Only Charges

09000 CLI NI C

09100 EMERGENCY

06100 PBP CLINICAL LAB SERVICES-PRGM ONLY

06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.

07100 MEDICAL SUPPLIES CHARGED TO PATIENTS

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Net Charges (line 200 - line 201)

Less PBP Clinic Lab. Services-Program

Subtotal (see instructions)

07200 IMPL. DEV. CHARGED TO PATIENTS

60.01

62.00

63.00

64.00

65.00

66.00

67.00

68.00

69.00

69. 01

70.00

72.00

73.00

74.00

90.00

91.00

92.00

200.00

201.00

202.00

Health Einancial Systems	METHODIST HOS	CDITALS INC		In Lio	u of Form CMS-2	2552 10
Health Financial Systems APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT			CN: 15-0002	Peri od:	Worksheet D	2552-10
AFFORTIONWENT OF INFATTENT ANCIELARY SERVICE CAFT	AL 00313	FI OVI dei C	CN. 15-0002	From 01/01/2018		
		· ·	CCN: 15-T002	To 12/31/2018	Date/Time Pre 5/28/2019 4:5	pared: 0 pm
			e XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1, 378, 468		•	· ·	2, 072	50.00
50. 01 05001 ENDOSCOPY	42, 027		•		61	50. 01
51. 00 05100 RECOVERY ROOM	311, 400				267	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	207, 213			· ·	41	52.00
53. 00 05300 ANESTHESI OLOGY	0	1			0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 101, 150				3, 210	
54. 01 05401 RADI OLOGY - ULTRASOUND	127, 516		•		277	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	282, 823		•	· ·	1, 968	
56. 00 05600 RADI 0I SOTOPE	205, 269		1	· ·	356	
57.00 05700 CT SCAN	269, 914		1	· ·	586	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	108, 263		1	· ·	369	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	266, 101		1	· ·	433	
60. 00 06000 LAB0RAT0RY	673, 167	1 ' '	1	· ·	3, 682	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0. 00000	00	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	30, 756	8, 960, 206	l	· ·	121	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	1			0	63.00
64.00 06400 I NTRAVENOUS THERAPY	0	1	1 0.0000		0	64.00
65. 00 06500 RESPI RATORY THERAPY	209, 178		•		1, 784	65.00
66. 00 06600 PHYSI CAL THERAPY	261, 382		•		71, 868	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	220, 311			,		
68. 00 06800 SPEECH PATHOLOGY	41, 726				3, 832	
69. 00 06900 ELECTROCARDI OLOGY	25, 893			· ·	33	
69. 01 06901 CARDI AC REHAB	5, 384		•		0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	29, 107		•		4	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	467, 652			· ·	1, 140	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	514, 458	1	•			
73.00 07300 DRUGS CHARGED TO PATIENTS	570, 249				12, 713	
74. 00 07400 RENAL DI ALYSI S	118, 463	8, 939, 534	0. 01325	313, 202	4, 151	74.00
OUTPATIENT SERVICE COST CENTERS						_
90. 00 09000 CLI NI C	1, 536, 536		•		56	
91. 00 09100 EMERGENCY	748, 877		•		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	,,	•		0	92.00
200.00 Total (lines 50 through 199)	9, 753, 283	1, 157, 854, 825	il	10, 549, 423	180, 347	200. 00

	_Financial_Systems TIONMENT OF INPATIENT/OUTPATIENT_ANCILLARY_SE	METHODIST HOS		CN. 1E 0000	Do	ri od:	u of Form CMS-2 Worksheet D	2552-10
	TONMENT OF INPATTENT/OUTPATTENT ANCILLARY SE SH COSTS	RVICE UTHER PAS	S Provider C	CN: 15-0002		erioa: com 01/01/2018		
TTIKOUC	00313		Component	CCN: 15-T002	То		Date/Time Pre 5/28/2019 4:5	
			Titl∈	XVIII	S	Subprovi der -	PPS	•
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Н.	IRF Allied Health	Allied Health	
	300 Conton Bood ptron	Anesthetist	School	School		Post-Stepdown	7.1. T. Gu T. Gui E.T.	
		Cost	Post-Stepdown			Adjustments		
			Adjustments			,		
		1. 00	2A	2.00		3A	3. 00	
	ANCILLARY SERVICE COST CENTERS							
0.00	05000 OPERATING ROOM	0	0		0	0	0	50.00
0. 01	05001 ENDOSCOPY	0	0		0	0	0	50. 01
1.00	05100 RECOVERY ROOM	0	0		0	0	0	51.00
2.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52.00
3.00	05300 ANESTHESI OLOGY	0	0		0	0	0	53.00
4.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
4. 01	05401 RADI OLOGY - ULTRASOUND	0	0		0	0	0	54. 0°
5. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55.00
6. 00	05600 RADI 0I SOTOPE	0	0		0	0	0	56.00
7. 00	05700 CT SCAN	0	0		0	0	0	57.00
8. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	0	58.00
9. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00
0. 00	06000 LABORATORY	0	0		0	0	0	60.00
0. 01	06001 BLOOD LABORATORY	0	0		0	0	0	60.0
1.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	_	_		_	_	_	61.0
2.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	0	62.00
3. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	0	63.00
4.00	06400 NTRAVENOUS THERAPY	0	0		0	0	0	64.00
5.00	06500 RESPI RATORY THERAPY	0			0	0	0	65.00
6.00	06600 PHYSI CAL THERAPY	0			0	0	0	66.00
7. 00 8. 00	06700 OCCUPATI ONAL THERAPY	0			0	0	0	67.00
9.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0			0	0	0	68. 00 69. 00
9.00	06901 CARDI AC REHAB	0			0	0	_	69.00
0.00	07000 ELECTROENCEPHALOGRAPHY				0	0	0	70.00
1. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				0	0	0	71.00
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS				0	0	0	72.00
3.00	07300 DRUGS CHARGED TO PATIENTS				0	0	0	73.0
4. 00	07400 RENAL DIALYSIS	0	1	1	0	0	0	74.0
1. 00	OUTPATIENT SERVICE COST CENTERS				- 0		0	, , 4. 00
0. 00	09000 CLINIC	0	0		0	0	0	90.00
	09100 EMERGENCY	0		•	0	ő	978, 231	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1 0			0	Ī	0	92.00

0 0 0

0 92.00 978, 231 200.00

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
200. 00 Total (lines 50 through 199)

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	METHODIST HOS		CN: 15_0002	Period:	u of Form CMS-2 Worksheet D	2552-1
THROUGH COSTS	WICE OTHER PAS			From 01/01/2018 To 12/31/2018	Part IV Date/Time Pre	pared:
		T. 11	V(/	C. b	5/28/2019 4:5	O pm
		11116	XVIII	Subprovider - IRF	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
'	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)			
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0		0 160, 072, 673	0. 000000	50.00
50. 01 05001 ENDOSCOPY	0	0		0 18, 174, 858	0. 000000	50.0
51. 00 05100 RECOVERY ROOM	0	0		0 10, 821, 121	0. 000000	51.0
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 5, 656, 816	0. 000000	
53. 00 05300 ANESTHESI OLOGY	0	0	•	0 0	0. 000000	53.0
54. 00	0	0		0 40, 084, 188	0. 000000	54.0
54. 01 05401 RADI OLOGY - ULTRASOUND	0	0		0 17, 965, 300	0.000000	54.0
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 15, 066, 732	0.000000	55. 0 56. 0
56. 00 05600 RADI 01 SOTOPE 57. 00 05700 CT SCAN	0	0		0 16, 612, 204 0 124, 404, 760	0.000000	56.0
58.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			0. 000000 0. 000000	57.0
59. 00 05900 MAGNETTC RESUNANCE TMAGTING (MRT)	0	0		0 29, 626, 211 0 74, 584, 802	0. 000000	59.0
60. 00 06000 LABORATORY	0	0		0 155, 336, 834	0. 000000	60.0
50. 01 06000 LABORATORY		0		0 155, 556, 654	0. 000000	60.0
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0			0.000000	61.0
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 8, 960, 206	0. 000000	62.0
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0, 700, 200	0. 000000	63.0
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0	0. 000000	64.0
65. 00 06500 RESPIRATORY THERAPY	0	0	•	0 39, 342, 354	0. 000000	65.0
66. 00 06600 PHYSI CAL THERAPY	0	0		0 7, 869, 238	0. 000000	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 6, 077, 206	0. 000000	67.0
68. 00 06800 SPEECH PATHOLOGY	0	Ö		0 2, 501, 738	0. 000000	68.0
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 23, 171, 578	0.000000	
69. 01 06901 CARDI AC REHAB	0	0		0 896, 419	0.000000	69.0
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 26, 940, 508	0.000000	70.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 53, 172, 472	0.000000	71.0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 32, 459, 800	0.000000	72.0
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 153, 795, 763	0.000000	73.0
74.00 07400 RENAL DIALYSIS	0	0		0 8, 939, 534	0. 000000	74.0
OUTPATIENT SERVICE COST CENTERS						
90 00 09000 CLINIC	0	0		n 25 858 355	0 000000	l on

0 0 0

978, 231

978, 231

25, 858, 355

978, 231 67, 240, 057 0 32, 223, 098 978, 231 1, 157, 854, 825 0.000000

0. 014548

0.000000

90.00

91.00

92. 00 200. 00

90. 00 09000 CLI NI C

91. 00 09100 EMERGENCY

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

Health Financial Systems	METHODIST HOSPI	TAIS INC		In lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY		Provi der C	CN: 15-0002	Peri od:	Worksheet D	2332 10
THROUGH COSTS	52 62 62 17.66		CCN: 15-T002	From 01/01/2018 To 12/31/2018		
		Title	XVIII	Subprovi der - I RF	PPS	<u></u>
Cost Center Description	Outpati ent	Inpatient	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	9	Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	240, 626		0	0	50.00
50. 01 05001 ENDOSCOPY	0. 000000	26, 397		0	0	50. 01
51. 00 05100 RECOVERY ROOM	0. 000000	9, 291		0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	1, 112	1	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	116, 836		0 0	0	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	0. 000000	39, 090)	0	0	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	104, 858		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 000000	28, 850	1	0 0	0	56.00
57. 00 05700 CT SCAN	0. 000000	270, 184		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	100, 920	1	0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	121, 277		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	849, 498		0 0	0	60.00
60. 01 06001 BL00D LABORATORY	0. 000000	0	1	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	35, 283		0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	. 0		0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0.000000	335, 595		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0.000000	2, 163, 670	1	0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0.000000	1, 965, 413	1	0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	229, 752	1	0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	29, 534		0 0	0	69.00
69. 01 06901 CARDI AC REHAB	0. 000000	27,001	1	0 0	Ö	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	3, 381		0 0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	129, 608	1	0 0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	4, 613	1	0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	3, 428, 575	1		0	73.00
74. 00 07400 RENAL DIALYSIS	0.000000	313, 202		0 0	0	
OUTPATIENT SERVICE COST CENTERS	0.000000	313, 202		0 0	0	74.00
90. 00 09000 CLINIC	0. 000000	947	1	0 0	0	90.00
91. 00 09100 EMERGENCY	0. 014548	11	l .	0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 014348	900	l .	0 0	0	
200.00 Total (lines 50 through 199)	0.000000	10, 549, 423	l .	0 0	_	200.00
200.00 10tal (111163 30 till ough 177)	1	10, 547, 425	Т	0	ı o	1200.00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0002	Peri od: From 01/01/2018	Worksheet D-1	
		To 12/31/2018	Date/Time Pre 5/28/2019 4:5	pared: 0 pm
	Title XVIII	Hospi tal	PPS	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				

Title XVIII Hospital	PPS	
Cost Center Description	1. 00	
PART I - ALL PROVIDER COMPONENTS	1.00	
I NPATI ENT DAYS		
1.00 Inpatient days (including private room days and swing-bed days, excluding newborn)	91, 860	1
2.00 Inpatient days (including private room days, excluding swing-bed and newborn days)	91, 860 avs. 0	
3.00 Private room days (excluding swing-bed and observation bed days). If you have only private room do not complete this line.	ays, U	3.0
4.00 Semi-private room days (excluding swing-bed and observation bed days)	71, 101	4.0
5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the		5.0
reporting period		
6.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the co	st 0	6.0
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the c	ost 0	7.0
reporting period		/. 0
8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cos	t 0	8.0
reporting period (if calendar year, enter 0 on this line)		
9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed a newborn days)	nd 27, 049	9.0
10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.0
through December 31 of the cost reporting period (see instructions)		
11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) af	ter 0	11.0
December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	12.0
12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12.0
13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.0
after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)	1 -1	
15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only)	1 -1	
SWING BED ADJUSTMENT		10.0
17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17.0
reporting period	0.00	10.0
18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.0
19.00 Medical drate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19.0
reporting period	0.00	00.0
20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.0
21.00 Total general inpatient routine service cost (see instructions)	81, 279, 717	21.0
22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 0	22.0
5 x line 17)		22.0
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (li x line 18)	ne 6 0	23.0
24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (I	ine 0	24.0
7 x line 19)		
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (lin x line 20)	e 8 0	25. 0
26.00 Total swing-bed cost (see instructions)	0	26.0
27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)		
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges)	0	1
	0. 000000	
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3)	1	1
	1	ı
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)		
34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)		
35.00 Average per diem private room cost differential (line 34 x line 31)	0.00	
36.00 Private room cost differential adjustment (line 3 x line 35)	0	36.0
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 81, 279, 717	37.0
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY		1
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		1
38.00 Adjusted general inpatient routine service cost per diem (see instructions)	884. 82	38.0
ob. of pragration general impatrion routine service cost per urall (see instructions)	1	1
39.00 Program general inpatient routine service cost (line 9 x line 38)	23, 933, 496	
	23, 933, 496 0 23, 933, 496	40.0

	27 III 1 ld 3 1 1 le 30)	1	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		l
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		l
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	884. 82	38.0
39. 00	Program general inpatient routine service cost (line 9 x line 38)	23, 933, 496	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)	23, 933, 496	41.0

	Financial Systems	METHODI ST HOSI				u of Form CMS-2	
COMPU	FATION OF INPATIENT OPERATING COST		Provi der C	F	Period: From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
			Ti +Lo	x XVIII	Hospi tal	5/28/2019 4: 50 PPS	0 pm
	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)	
10.00	Thursday (11 11 11 a 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	0	0	0.00	0	0	42.00
43. 00		13, 054, 340	8, 249	1, 582. 54	3, 227	5, 106, 857	43.00
43. 01		2, 845, 305	2, 601			0	43. 01
44.00							44.00
45. 00							45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
	·					1. 00	
48. 00						32, 174, 233	
49. 00	PASS THROUGH COST ADJUSTMENTS	<u> </u>		,		61, 214, 586	
50. 00			•				
51. 00	and IV)		y services (f	rom Wkst. D, s	um of Parts II	1, 589, 558	
52.00	Total Program excludable cost (sum of lines		Noted === "	uel el en en en	otict on-	3, 906, 320	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		erated, non-pn	ysician anestn	etist, and 	57, 308, 266	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	, , , , , , , , , , , , , , , , , , , ,	ing cost and ta	arget amount (line 56 minus	line 53)	0	57. 00
58. 00						0	58.00
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	ending 1996,	updated and co	mpounded by the	0.00	59. 00
60. 00		cost report, up	dated by the	market basket		0. 00	60.00
	If line 53/54 is less than the lower of line				the amount by	0	61.00
	which operating costs (line 53) are less tha		s (lines 54 x	60), or 1% of	the target		
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	Instructions)				o	62. 00
	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	ember 31 of th	e cost reporti	ng period (See	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)	ne costs (line	64 plus line	65)(title XVII	l only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31	of the cost re	porting period	0	67.00
68. 00	1.	e costs after [December 31 of	the cost repo	rting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil		•				70.00
71. 00							71.00
72. 00	,						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		74. 00 75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00		. *					77.00
78. 00	Inpatient routine service cost (line 74 minu	s line 77)					78. 00
79.00	1 33 3				70)		79.00
80. 00 81. 00			JUST IIMITATIO	n (iine 78 min	us iine 79)	-	80. 00 81. 00
82. 00	· ·		1)				82.00
83. 00	Reasonable inpatient routine service costs (see instruction	* .				83. 00
84.00			>				84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
50.00	PART IV - COMPUTATION OF OBSERVATION BED PASS		Jugii 00 <i>)</i>				55.00
87. 00	Total observation bed days (see instructions)				20, 759	
88. 00	Adjusted general inpatient routine cost per		,			884. 82	
89.00	Observation bed cost (line 87 x line 88) (se	e instructions)	1			18, 367, 978	89.00

Health Financial Systems	METHODI ST HOSI	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC	Provider CCN: 15-0002		Worksheet D-1	
				From 01/01/2018 To 12/31/2018		
		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, 135, 443	81, 279, 717	0. 08778	9 18, 367, 978	1, 612, 506	90.00
91.00 Nursing School cost	0	81, 279, 717	0.00000	0 18, 367, 978	0	91.00
92.00 Allied health cost	0	81, 279, 717	0.00000	0 18, 367, 978	0	92.00
93.00 All other Medical Education	0	81, 279, 717	0.00000	0 18, 367, 978	0	93.00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lie	of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0002	Peri od: From 01/01/2018	Worksheet D-1
	Component CCN: 15-S002		
	Title XVIII	Subprovi der -	PPS
		IPF	

		IPF		
	Cost Center Description		1.00	
	PART I - ALL PROVIDER COMPONENTS		1. 00	
	INPATIENT DAYS			
1. 00	Inpatient days (including private room days and swing-bed days	, excluding newborn)	2, 936	1. 00
2.00	Inpatient days (including private room days, excluding swing-be	ed and newborn days)	2, 936	2.00
3.00	Private room days (excluding swing-bed and observation bed days	s). If you have only private room days,	0	3.00
	do not complete this line.			
4.00	Semi-private room days (excluding swing-bed and observation bed		2, 936	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room reporting period	in days) through becember 31 of the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room	m days) after December 31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	,	_	
7.00	Total swing-bed NF type inpatient days (including private room	days) through December 31 of the cost	0	7.00
	reporting period			
8. 00	Total swing-bed NF type inpatient days (including private room	days) after December 31 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding swing-hed and	1, 267	9. 00
7. 00	newborn days)	the fregram (exertaining swring bed and	1, 20,	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII on	ly (including private room 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 on		0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XIX	ter 0 on this line)	0	12. 00
12.00	through December 31 of the cost reporting period	offiny (Therading private room days)	U	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar year			
14.00	Medically necessary private room days applicable to the Program	m (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT		0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to services	s through December 31 of the cost	0.00	17. 00
17.00	reporting period	3 through becomber 31 of the cost	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services	s after December 31 of the cost	0.00	18.00
	reporting period			
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of the cost	0. 00	20. 00
	reporting period			
21. 00	Total general inpatient routine service cost (see instructions		2, 401, 421	
22. 00	Swing-bed cost applicable to SNF type services through December	r 31 of the cost reporting period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December:	 31 of the cost reporting period (line A	0	23. 00
23.00	x line 18)	or or the cost reporting perrod (Trie o	O	23.00
24.00	Swing-bed cost applicable to NF type services through December	31 of the cost reporting period (line	0	24.00
	7 x line 19)			
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	1 of 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)	2, 401, 421	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
	General inpatient routine service charges (excluding swing-bed	and observation bed charges)		28. 00
	Pri vate room charges (excluding swing-bed charges)		0	
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷	lino 20)	0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	111le 20)	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 min	us line 33)(see instructions)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x line		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 a	nd private room cost differential (line	2, 401, 421	37.00
	27 minus line 36)			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	STMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see		817. 92	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line		1, 036, 305	
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	+ line 40)	1, 036, 305	41.00

Heal th	Financial Systems	METHODI ST HOS	PITALS. INC		In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST		Provi der (Period: From 01/01/2018 To 12/31/2018	Worksheet D-1	
			Titl	e XVIII	Subprovi der -	5/28/2019 4: 5 PPS	O pm
	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)	
		1.00	2. 00	3.00	4. 00	5. 00	
42.00	NURSERY (title V & XIX only)	0	(0.00	0	0	42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	l ol		0.00	0	0	43.00
43. 01	NEONATAL I CU	l o		0. 00			43. 01
44.00	CORONARY CARE UNIT						44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description			'			
40.00	Danier i anti-at anti-li anci-li anci-li anti-li anti-	-+ D 21 1	2 1: 200)			1.00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ons)		142, 282 1, 178, 587	1
47.00	PASS THROUGH COST ADJUSTMENTS	+1 till ough +0)	(See Thisti deti	Olisy		1, 170, 307	77.00
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	om Wkst. D, sum	of Parts I and	45, 929	50. 00
E1 00	Dass through costs applicable to Drogram in	ationt ancillar	su convicos (t	From Wkst D o	um of Dorts II	E 744	E1 00
51. 00	Pass through costs applicable to Program inpland IV)	atrent anciliar	y services (i	TOIII WKSt. D, S	Sum of Parts II	5, 766	51.00
52.00	Total Program excludable cost (sum of lines	50 and 51)				51, 695	52.00
53.00	Total Program inpatient operating cost exclu		elated, non-ph	nysician anesth	etist, and	1, 126, 892	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	•
56.00	Target amount (line 54 x line 55)	ing coot and to	arast amount	(line E/ minue	line E2)	0	56.00
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	arget amount i	(Title 56 IIII flus	11ne 53)	0	57. 00 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	_	l
	market basket					0. 00	60.00
60.00	60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by						
01.00	which operating costs (line 53) are less that					0	61.00
	amount (line 56), otherwise enter zero (see	instructions)			-		
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ont (soo instri	ictions)			0	62. 00 63. 00
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST	ient (see mistro	actions)			0	03.00
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	ne cost reporti	ng period (See	0	64.00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts ofter Decemb	oor 21 of the	cost reporting	noried (See	0	65. 00
03.00	instructions)(title XVIII only)	its after beceilik	sei si di the	cost reporting	perrou (see	0	05.00
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	I only). For	0	66. 00
67.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	no costs through	n Docombor 21	of the cost re	porting ported	0	67. 00
07.00	(line 12 x line 19)	ie costs tili ougi	i beceiibei 31	or the cost re	portring perrou	0	07.00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after [December 31 of	f the cost repo	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs /	(line 67 ± lir	ne 68)		0	69. 00
07.00	PART III - SKILLED NURSING FACILITY, OTHER N					0	07.00
70.00	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	utine service	cost (line 37)			70.00
71. 00 72. 00	Adjusted general inpatient routine service c		line 70 ÷ line	e 2)			71.00
73.00	Program routine service cost (line 9 x line Medically necessary private room cost applic		m (line 14 x l	ine 35)			72. 00 73. 00
74.00	Total Program general inpatient routine serv						74.00
75. 00	Capital-related cost allocated to inpatient	routine service	e costs (from	Worksheet B, F	Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital -related costs (line 9 x line						77. 00
78. 00	Inpatient routine service cost (line 74 minu						78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp			*.	us Lino 70)		79. 00 80. 00
81. 00	Inpatient routine service costs for comp		Jost IIIII tati	on (Title 76 IIII)	ius Title 77)		81.00
82.00	Inpatient routine service cost limitation (I	ine 9 x line 8					82.00
83.00	Reasonable inpatient routine service costs (ns)				83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		nns)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum						86.00
0=	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST					
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		- line 2)			0 00	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (se						89.00
		,					

Health Financial Systems	METHODI ST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Period: From 01/01/2018	Worksheet D-1	
		Component (Component CCN: 15-S002		Date/Time Pre 5/28/2019 4:5	
		Title	XVIII	Subprovi der -	PPS	
				I PF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	106, 427	2, 401, 421	0. 04431	18 0	0	90.00
91.00 Nursing School cost	0	2, 401, 421	0. 00000	00	0	91.00
92.00 Allied health cost	0	2, 401, 421	0. 00000	00	0	92.00
93.00 All other Medical Education	0	2, 401, 421	0. 00000	0 0	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 01/01/2018	Worksheet D-1	
	Component CCN: 15-T002			
	Title XVIII	Subprovi der -	PPS	
		I RF		

Mort ALL PROVIDER CLOREGISTICS			I RF		
MARTIE MAS		Cost Center Description		1.00	
INPATIENT DAYS		DADT I ALL DROVIDED COMPONENTS		1.00	
Inpatient days (including private room days and saing-bed days, excluding newborn) 8,648 2.00					
Developer 31 of the cost reporting period (if cal endar year) called 11 x XIII only (including private room days) after cost of xing-bed XII type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this I ine) report of xing-bed XII type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this I ine) 7.00 Total swing-bed XII type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this I ine) 7.00 Total swing-bed XII type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this I ine) 8.00 Total swing-bed XII type inpatient days applicable to the Program (excluding seing-bed and newborn days) 10.00 XII and XIII	1. 00		xcluding newborn)	8, 648	1.00
do not complete hils line. 4.00 Sein-privater room days (excluding swing-bed and observation bed days) 5.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost 1.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost 1.00 p. 0.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost 1.00 p. 0.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost 1.00 p. 0.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost 1.00 p. 0.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost 1.00 p. 0.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newbork days) 1.00 p. 0.00 through December 31 of the cost 1.00 p. 0.00	2.00	Inpatient days (including private room days, excluding swing-bed	and newborn days)	8, 648	2.00
Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SR type inpatient days (including private room days) after December 31 of the cost Total swing-bed SR type inpatient days (including private room days) after December 31 of the cost Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this iline) Total inpatient days including private room days after December 31 of the cost reporting period (if calendary year, enter 0 on this iline) Total inpatient days applicable to this vinual private room days) Total inpatient days applicable to tilit sW III only (including private room days) Through December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total inpatient days applicable to tilit sW III only (including private room days) Total inpatient days applicable to tilit sW III only (including private room days) Total period III only the days applicable to tilit sW III only (including private room days) Total period III only the days applicable to tilit sW III only (including private room days) Total calendary period III only the days applicable to tilit sW III only (including private room days) Total calendary period III only the days applicable to tilit sW III only (including private room days) Total period III only the days applicable to tilit sW III only (including private room days) Total calendary period III only the days applicable to tilit sW III only (including private room days) Total period III only the days applicable to tilit sW III only (including private room days) Total period III only the days applicable to the Pregram (excluding swing-bed days) Total period III only the days applicable to services after December 31 of the	3.00		If you have only private room days,	0	3.00
Total swing-bod SNF type inpatient days (including private room days) through becember 31 of the cost capering period (including private room days) after December 31 of the cost capering period (including private room days) after December 31 of the cost capering period (including private room days) through December 31 of the cost capering period (including private room days) through December 31 of the cost capering period (including private room days) after December 31 of the cost capering period (including private room days) after December 31 of the cost capering period (including private room days) after December 31 of the cost capering period (including private room days) after December 31 of the cost capering period (including private room days) after December 31 of the cost capering period (including private room days) after December 31 of the cost capering period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (includin			,	0 / 10	
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed SM type inpatient days (including private room days) after December 31 of the cost 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 7.00 Total inpatient days including private room days after December 31 of the cost 7.00 Total inpatient days including private room days after December 31 of the cost 7.00 Newborn days 7.00 Newborn					
1	5.00		ays) through becember 31 of the cost	U	5.00
reporting period (if calendar year, enter 0 on this line) 7.00 Total saing-bod NF type inpatient days (including private room days) through December 31 of the cost 7.00 Total saing-bod NF type inpatient days (including private room days) after December 31 of the cost 7.00 Total inpatient days including private room days apricable to the Program (excluding swing-bed and newborn days) 7.00 New John Section (including private room days applicable to the Program (excluding swing-bed and newborn days) 7.00 New John Section (including private room days) 7.00 New John Section (including pri	6. 00		avs) after December 31 of the cost	0	6. 00
reporting period 8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this ilne) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10. 00 Swing-bed Switzer 31 of the cost reporting period (see instructions) 11. 00 Swing-bed Switzer 31 of the cost reporting period (see instructions) 12. 00 Swing-bed Switzer 31 of the cost reporting period (see instructions) 13. 00 Swing-bed Switzer 31 of the cost reporting period (see instructions) 14. 00 Webl Castler 31 of the cost reporting period (see instructions) 15. 00 Swing-bed Switzer 31 of the cost reporting period (see instructions) 16. 00 Swing-bed Switzer 31 of the cost reporting period (see instructions) 17. 00 Webl Castler 41 type inpatient days applicable to titles V or XIX only (including private room days) of 12. 00 through December 31 of the cost reporting period (see instructions) 18. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) of 13. 00 after December 31 of the cost reporting period (see instructions) 18. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) of 13. 00 after December 31 of the cost reporting period (see instructions) 18. 00 Swing-bed S				_	
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if Callendar year, enter 0 on this line)	7.00		ys) through December 31 of the cost	0	7.00
reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 11.00 December 31 of the cost reporting period (see instructions) 12.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after on the summer of the cost reporting period (including private room days) 12.00 Swing-bed SMF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed SMF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed SMF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed SMF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed SMF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 SWING MEDICAL AND SWING M	0.00		24 - 6 - 1	0	0.00
Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 0.00	8.00		ys) after December 31 of the cost	Ü	8.00
newborn days) newborn days) 10. OS wing-bed SNF type inpatient days applicable to fitte XVIII only (including private room days) 11. OS wing-bed SNF type inpatient days applicable to tritle XVIII only (including private room days) after December 31 of the cost reporting period (is ea instructions) 12. OS wing-bed NF type inpatient days applicable to tritle XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13. OS wing-bed NF type inpatient days applicable to tritles V or XIX only (including private room days) 14. OS of the patient days applicable to tritles V or XIX only (including private room days) 15. OS of the interest of the cost reporting period (if calendar year, enter 0 on this line) 16. OS of the interest days (title V or XIX only) 17. OS of the interest days (title V or XIX only) 18. OS of the interest days (title V or XIX only) 19. ON worsery days (title V or XIX only) 19. ON Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost of reporting period on reporting period (if calendar year, enter 0 on this line) 19. ON Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost of reporting period (in care rate for swing-bed SNF services applicable to services after December 31 of the cost of reporting period (in care rate for swing-bed NF services applicable to services after December 31 of the cost of reporting period (in care rate for swing-bed NF services applicable to services after December 31 of the cost of reporting period (in care rate for swing-bed NF services applicable to services after December 31 of the cost of the cost of reporting period (in care rate for swing-bed NF services applicable to services after December 31 of the cost of the co	9 00		e Program (excluding swing-hed and	5 226	9 00
through December 31 of the cost reporting period (see instructions) 1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Medical I y necessary private room days applicable to the Program (excluding swing-bed days) 1.00 Necessary private room days applicable to the Program (excluding swing-bed days) 1.00 Necessary days (title V or XIX only) 1.00 Necessary days (title Vor XIX only) 1	7. 00	1 3 3 11	o rrogram (exertaining eming bea and	0,220	7. 00
11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 11.00 New part New Part	10.00	Swing-bed SNF type inpatient days applicable to title XVIII only	(including private room days)	0	10.00
December 31 of the cost reporting period (if calendar year, enter 0 on this line) 0 12.00					
12.00 Swing-bed NF type inpatient days applicable to titles \(\tilde{V} \) or XIX only (including private room days) 0 12.00	11. 00			0	11. 00
through December 31 of the cost reporting period 13. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15. 00 Total nursery days (title V or XIX only) 16. 00 Novery days (title V or XIX only) 17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 19. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 19. 00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 x X line 17) 20. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x X line 18) 21. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x X line 19) 22. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x X line 19) 23. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x I line 20) 24. 00 Total swing-bed cost (see instructions) 25. 00 Swi	12 00	December 31 of the cost reporting period (if calendar year, enter	U on this line)	0	12 00
13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 13.00 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 14.00 0 15.00 10.	12.00		Ty (Therduring private room days)	U	12.00
14.00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 0 14.00 0 15.00 16.00 16.00 18.00	13.00		ly (including private room days)	0	13.00
15.00 Total nursery days (title V or XIX only) 0 15.00 16.00 17.00					
16. 00 Nursery days (title v or XIX only) 16. 00 17. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 19. 00			excluding swing-bed days)	-	
SWING BED ADJUSTMENT 17.00 18.00 1		, J		- 1	
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41.00 Total Program general inpatient routine service cost (line 39 + line 40) 4,216,232 41.00		, , , , , , , , , , , , , , , , , , , ,	•	-	
	41.00	Tiotal Program general inpatient routine service cost (line 39 + 1	THE 40)	4, 216, 232	41.00

COMPUT	ATION OF INPATIENT OPERATING COST			CCN: 15-0002 CCN: 15-T002	Peri od: From 01/01/201 To 12/31/201		
			·			5/28/2019 4: 5	
			litle	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Pe Diem (col. ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1. 00	2.00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	0	(0.	. 00	0 0	42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	O		0.	. 00	ol o	43.00
43. 01	NEONATAL ICU	o				ol o	
44. 00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)					•	46. 00 47. 00
47.00	Cost Center Description						47.00
						1. 00	
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			one)		2, 668, 654 6, 884, 886	1
49.00	PASS THROUGH COST ADJUSTMENTS	41 till ough 48) (see mstructi	UIS)		0,004,000	49.00
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	om Wkst. D, s	sum of Parts I a	nd 416, 930	50.00
F1 00		-4:4:!!	(4	W D	£ Dt II	100 247	, ₁
51. 00	Pass through costs applicable to Program inpland IV)	atient anciliar	y services (†	I OIII WKST. D,	sum of Parts II	180, 347	51.00
52. 00	Total Program excludable cost (sum of lines	50 and 51)				597, 277	52.00
53. 00	Total Program inpatient operating cost exclu	9 1	lated, non-ph	ıysi ci an anes	sthetist, and	6, 287, 609	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
54. 00	Program discharges					1 0	54.00
55. 00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)			11 	. 11 50)	0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (iine 56 minu	is line 53)	0	
59.00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and	compounded by the		59.00
	market basket					0.00	
60. 00 61. 00							60.00
	which operating costs (line 53) are less tha		s (lines 54 x	(60), or 1%	of the target		
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	0	62.00				
63.00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)				63.00
	PROGRAM I NPATIENT ROUTINE SWING BED COST			 		T	
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	mber 31 of tr	ie cost repor	rting period (See	9 0	64.00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reporti	ng period (See	0	65.00
	instructions)(title XVIII only)			(5) (1) 11 10			
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line	65)(title XV	/III only). For	0	66.00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost	reporting period	o b	67.00
, , , , ,	(line 12 x line 19)						
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after D	ecember 31 of	the cost re	eporting period	0	68.00
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + lir	ie 68)		0	69.00
70 00	PART III - SKILLED NURSING FACILITY, OTHER NI				\ - \		
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c	,			37)		70.00
72.00	Program routine service cost (line 9 x line		1110 70 . 11110	. 2)			72.00
73. 00	Medically necessary private room cost applic		•				73.00
74.00	Total Program general inpatient routine serv				Dant II aalum	_	74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	COSTS (110III	worksneet B,	Part II, Corumi	1	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		rovi der recor	·ds)			78.00
80.00	Total Program routine service costs for comp				ninus 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 (Program inpatient ancillary services (see in		5)				83.00
85. 00	Utilization review - physician compensation		ns)				85.00
86. 00	Total Program inpatient operating costs (sum	of lines 83 th					86.00
07 00	PART IV - COMPUTATION OF OBSERVATION BED PASS						07.00
87.00	Total observation bed days (see instructions		>			0	87. 00 88. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			() ()()	

Heal th Financial Systems METHODIST HOSPITAL				In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0002			Peri od: From 01/01/2018	Worksheet D-1	
		Component (Component CCN: 15-T002		Date/Time Pre 5/28/2019 4:5	
		Title	XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	689, 952	6, 977, 006	0. 09888	39 0	0	90.00
91.00 Nursing School cost	0	6, 977, 006	0. 00000	00	0	91.00
92.00 Allied health cost	0	6, 977, 006	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	6, 977, 006	0. 00000	00	0	93. 00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-00	02 Period: From 01/01/2018	Worksheet D-1	
		To 12/31/2018	Date/Time Pre 5/28/2019 4:5	
	Title XIX	Hospi tal	Cost	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				
INDATIENT DAVE				1

		Title XIX	Hospi tal	Cost	
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			91, 860	1.00
2.00	Inpatient days (including private room days, excluding swing-		ivete meem dave	91, 860	2.00
3. 00	Private room days (excluding swing-bed and observation bed da do not complete this line.	lys). IT you have only pr	ivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation b	ped days)		71, 101	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro	oom days) through Decembe	r 31 of the cost	0	5.00
	reporting period				,
6. 00	Total swing-bed SNF type inpatient days (including private reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private roo	om davs) through December	31 of the cost	0	7. 00
	reporting period	3 /			
8.00	Total swing-bed NF type inpatient days (including private roo	om days) after December 3	1 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	to the Drogram (eveluding	swing had and	2, 931	9. 00
9.00	newborn days)	to the Program (excruding	Swifig-bed and	2, 931	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private r	oom days)	0	10.00
	through December 31 of the cost reporting period (see instruc			_	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e		oom days) after	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI		e room davs)	0	12.00
	through December 31 of the cost reporting period	3 .			
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			0	14. 00
15. 00	Total nursery days (title V or XIX only)	dir (exer darrig swrrig bed	uays)	2, 869	
16.00	Nursery days (title V or XIX only)			0	16. 00
47.00	SWING BED ADJUSTMENT				47.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	ces through December 31 o	T the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	the cost	0. 00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 of	the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	he cost	0.00	20. 00
	reporting period				
21.00	Total general inpatient routine service cost (see instruction		ing ported (line	81, 279, 717	
22. 00	Swing-bed cost applicable to SNF type services through Decemble 5×1 ine 17)	der 31 of the cost report	rng perroa (rrne	0	22. 00
23.00		31 of the cost reportin	g period (line 6	0	23.00
	x line 18)			_	
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1 = 19$	er 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)	, ,			
26.00		(11 21 -1 11 24)		01 270 717	26.00
27.00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(TITIE 21 IIITIUS TITIE 26)		81, 279, 717	27.00
28. 00	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	arges)	0	28. 00
	Private room charges (excluding swing-bed charges)			0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)	1: 20)		0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ line 28)		0. 000000 0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34. 00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0.00	34.00
35. 00	Average per diem private room cost differential (line 34 x li		,	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 27 minus line 36)	and private room cost di	TTERENTIAL (LINE	81, 279, 717	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	IUSTMENTS			
	Adjusted general inpatient routine service cost per diem (see			884. 82	
39.00	Program general inpatient routine service cost (line 9 x line	•		2, 593, 407	39. 00 40. 00
40.00	Medically necessary private room cost applicable to the Progr Total Program general inpatient routine service cost (line 39			0 2, 593, 407	
	1	/	1	_, 3.3, .07	

7.00	reporting and advantage of the cost	٠Į	7.00
0 00	reporting period	0	0 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	٠Į	8. 00
0 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and	2, 931	9. 00
9. 00	newborn days)	2, 931	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructions)	٥	10.00
11. 00		0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	٥	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
12.00	through December 31 of the cost reporting period	٩	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	ĭ	13.00
14 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
	Total nursery days (title V or XIX only)	2, 869	15. 00
	Nursery days (title V or XIX only)	0	16. 00
10.00	SWING BED ADJUSTMENT		10.00
17 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
17.00	report in a peri od	0.00	17.00
18 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
	reporting period	0.00	
19 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
	reporting period		
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
	reporting period		
21.00	Total general inpatient routine service cost (see instructions)	81, 279, 717	21.00
	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		22. 00
	5 x line 17)		
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line	ol	23.00
	x line 18)		
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	o	24.00
	7 x line 19)		
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	o	25.00
	x line 20)		
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	81, 279, 717	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0. 00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	81, 279, 717	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
	Adjusted general inpatient routine service cost per diem (see instructions)	884. 82	38.00
	Program general inpatient routine service cost (line 9 x line 38)	2, 593, 407	39.00
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2, 593, 407	41.00

Principle CORP. 1 Prin		Financial Systems TATION OF INPATIENT OPERATING COST	METHODI ST HOSI		CN: 15 0002	In Lie Period:	u of Form CMS-2 Worksheet D-1	2552-10
Cost Center Description	COMPUT	ATTON OF INPATIENT OPERATING COST		Provider Co		From 01/01/2018	Date/Time Pre	
Cost Center Description				Ti tl	e XIX	Hospi tal		U pili
Interest vo. Care Type Inpattient Heaptist Unit 12		Cost Center Description	Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
INTEREST VECABLE UNIT 12.064,340 8.269 1,582.54 0 0 43.00	42.00	NURSERY (title V & XIX only)		2, 869	1, 193. 6	4 0	0	42.00
48.00 Program Inpati ent ancillary service cost (Wist. D-3. col. 3. line 200) 2,055,783 48.00 49.00 Total Program Inpati ent costs (com of lines 41 through 48) (see instructions) 4,659,09 49.00 79	43. 01 44. 00 45. 00 46. 00	INTENSIVE CARE UNIT NEONATAL ICU CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	13, 054, 340				0	43. 01 44. 00 45. 00 46. 00
40.00 Program inpatient costs (sum of lines 41 through 48) (see instructions)	49.00	Program innations and Llary sorvice cost (Wk	st D2 col 3	2 line 200)				49.00
III) Sas through costs applicable to Program Inpatient ancillary services (from Wkst. D. sum of Parts II of 51.00 and IV) Science		Total Program inpatient costs (sum of lines			ons)			
51.00 pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II of 11.00 and ITV) 52.00 Total Program excludable cost (sum of Ilnes 50 and 51) 52.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (tine 49 minus line 52) 55.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (tine 49 minus line 52) 55.00 Target amount (line 54 x line 55) 56.00 Target amount (line 54 x line 55) 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58.00 Bonus payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the narket basket on market basket sasket s	50.00		atient routine	services (from	m Wkst. D, sum	of Parts I and	0	50.00
S3.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 44 minus line 52) TARSET AMOUNT AND LIMIT COMPUTATION	51. 00	Pass through costs applicable to Program inp	atient ancillar	ry services (fr	rom Wkst. D, s	sum of Parts II	0	51.00
54 00 Program discharges 0.0 55.00 55.00 Target amount per discharge 0.0 55.00 55.00 Target amount per discharge 0.0 55.00 56.00 Target amount (line 54 x line 55) 0.56.00 56.00 57.00 58.00 59.		Total Program inpatient operating cost exclu	ding capital re	elated, non-phy	ysician anesth	etist, and	_	
1.00 Target amount per discharge 0.00 55.00 0.00			•				_	
56.00 Target amount (I line 54 x line 55) 0 56.00								
88.00 Bonus payment (see instructions) 99.00 Lesser of lines \$3/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 0.00 Lesser of lines \$3/54 or 55 from prior year cost report, updated by the market basket 0.00 Lesser of lines \$3/54 is less than the lower of lines \$5, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line \$3) are less than expected costs (lines \$4 x 60), or 1% of the target amount (line \$6), otherwise enter zero (see instructions) 0.00 All owable Inpatient cost plus incentive payment (see instructions) 0.00 All owable Inpatient cost plus incentive payment (see instructions) 0.00 All owable Inpatient cost plus incentive payment (see instructions) 0.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (see Ins								
Solition Lesser of Fines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the morket basket 0.00 60.00		1	ing cost and ta	arget amount (I	line 56 minus	line 53)		
Lesser of I lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 0		Lesser of lines 53/54 or 55 from the cost re	_					
62.00 Relief payment (see instructions) 63.00 All owable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine service costs (line 37 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine service costs (line 37 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine service costs (line 37 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine service costs (line 37 + line 28) 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37 + line 28) 71.00 Adjusted general inpatient routine service costs (line 72 + line 28) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 75.00 Capital-related costs (line 75 + line 2) 77.00 Program cost line service costs (from 75 + line 2) 78.00 Program capital-related costs (line 75 + line 2) 79.00 Aggregat		If line 53/54 is less than the lower of line which operating costs (line 53) are less tha						
PROGRAM INPATIENT ROUTINE SWING BED COST		Relief payment (see instructions)						
instructions) (title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (See instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 20) 69.00 Total ittle V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total ittle V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, ADD ICF/IID DNLY 69.00 Adjusted general inpatient routine service cost (line 67 + line 68) 69.00 Program routine service cost (line 9 x line 71) 70.00 SKIII ed nursing facility/other nursing facility/other line routine service cost (line 70 + line 2) 71.00 Adjusted general inpatient routine service costs (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Copital related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Program capital related costs (line 74 minus line 77) 77.00 Program capital related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Inpatient routine service cost (line 74 minus line 77) 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Reasonable inpatient ancillary service costs (see instructions) 82.00 Vitilization review - physician compensation (see instructions) 83.00 Vitil Program inpati	00.00	PROGRAM INPATIENT ROUTINE SWING BED COST		<u> </u>	00.00			
instructions) (it le XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 70.00 Skilled nursing facility/Other nursing facility/ICF/IID routine service cost (line 37) 70.00 Skilled nursing facility/Other nursing facility/ICF/IID routine service cost (line 37) 70.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 71.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 72.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 73.00 Total Program capital -related costs (line 75 + line 2) 74.00 Program capital -related costs (line 75 + line 2) 75.00 Capital -related costs (line 9 x line 76) 78.00 Inpatient routine service costs (from provider records) 80.00 Total Program routine service costs (from provider records) 80.00 Total Program routine service costs (see instructions) 81.00 Inpatient routine service cost (line 74 minus line 77) 82.00 Reasonable inpatient routine service costs (see instructions) 82.00 Inpatient routine service cost (see instructions) 83.00 Adjusted general inpatient routine cost (see instructions) 84.00 Program inpatient routine service costs (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient routine cost (see instructions) 87.00 Total Program inpatient routine cost (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Routine SWIT SWIT SWIT SWIT SWIT SWIT SWIT SWIT		instructions)(title XVIII only)	Ü		•			
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(line 12 x line 19) (8.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) (69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) (70.00 Dark III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY (70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) (70.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) (70.00 Program routine service cost (line 9 x line 71) (70.00 Total Program general inpatient routine service costs (line 72 + line 73) (70.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) (70.00 Per diem capital -related costs (line 75 ÷ line 2) (71.00 Program capital -related costs (line 75 ÷ line 2) (72.00 Program capital -related costs (line 74 minus line 77) (73.00 Aggregate charges to beneficiaries for excess costs (from provider records) (74.00 Total Program routine service costs for excess costs (from provider records) (75.00 Dial Program routine service costs for excess costs (from provider records) (76.00 Program routine service cost per diem limitation (77.00 Reasonable inpatient routine service costs (see instructions) (78.00 Inpatient routine service cost per diem limitation (88.00 Program inpatient ancillary services (see instructions) (88.00 Total Program inpatient operating costs (sum of lines 83 through 85) (88.00 Total Program inpatient operating costs (sum of lines 83 through 85) (88.00 Total observation bed days (see instructions) (88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) (88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) (88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) (88.00 Adjusted general inpatient operating costs per diem (line 27 + line 2)		CAH (see instructions)	•	•		3,	-	
Cline 13 x line 20 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		(line 12 x line 19)	9					
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Program capital -related costs (line 75 ÷ line 2) 77.00 Program capital -related costs (line 74 minus line 77) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Willization review - physician compensation (see instructions) 83.00 Willization review - physician compensation (see instructions) 84.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 84.00 Adjusted general inpatient routine served immercial inpatient routine cost per diem (line 27 + line 2) 884.82 88.00		(line 13 x line 20)			•	orting period		
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88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 884.82 88.00	87 ∩∩						20 759	87 NN
	88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷				884. 82	88. 00

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	Worksheet D-1	
				From 01/01/2018 To 12/31/2018			
		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, 135, 443	81, 279, 717	0. 08778	9 18, 367, 978	1, 612, 506	90.00	
91.00 Nursing School cost	0	81, 279, 717	0.00000	0 18, 367, 978	0	91.00	
92.00 Allied health cost	o	81, 279, 717	0.00000	0 18, 367, 978	0	92.00	
93.00 All other Medical Education	o	81, 279, 717	0.00000	0 18, 367, 978	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 01/01/2018	
	Component CCN: 15-S002	To 12/31/2018	Date/Time Prepared:
	'		5/28/2019 4:50 pm
	Title XIX	Subprovi der -	Cost
		IPF	

		IPF		
	Cost Center Description		1.00	
	PART I - ALL PROVIDER COMPONENTS		1. 00	
	INPATIENT DAYS			
1. 00	Inpatient days (including private room days and swing-bed days,	excluding newborn)	2, 936	1.00
2.00	Inpatient days (including private room days, excluding swing-bed	d and newborn days)	2, 936	2.00
3.00	Private room days (excluding swing-bed and observation bed days)). If you have only private room days,	0	3.00
	do not complete this line.			
4. 00	Semi-private room days (excluding swing-bed and observation bed		2, 936	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room reporting period	days) through becember 31 of the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room	days) after December 31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)		· ·	0.00
7.00	Total swing-bed NF type inpatient days (including private room of	days) through December 31 of the cost	0	7. 00
	reporting period			
8. 00	Total swing-bed NF type inpatient days (including private room of	days) after December 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 to	the Drogram (eyeluding ewing had and	24	9. 00
9.00	newborn days)	the Program (excruding swriig-bed and	24	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only	v (including private room davs)	0	10.00
	through December 31 of the cost reporting period (see instruction			
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only		0	11.00
	December 31 of the cost reporting period (if calendar year, enter	er O on this line)	_	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX of	only (including private room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX of	only (including private room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar year		O	13.00
14.00	Medically necessary private room days applicable to the Program		0	14.00
15.00	Total nursery days (title V or XIX only)		2, 869	15.00
16. 00	Nursery days (title V or XIX only)		0	16. 00
	SWING BED ADJUSTMENT			
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 of the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services	after December 31 of the cost	0.00	18. 00
10.00	reporting period	arter becomber 31 or the cost	0.00	10.00
19.00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of the cost	0.00	19. 00
	reporting period			
20. 00	Medicaid rate for swing-bed NF services applicable to services a	after December 31 of the cost	0. 00	20. 00
21 00	reporting period		2 401 421	21 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December	31 of the cost reporting period (line	2, 401, 421 0	21. 00 22. 00
22.00	5 x line 17)	or the cost reporting perrod (rine	O	22.00
23.00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reporting period (line 6	0	23. 00
	x line 18)			
24. 00	Swing-bed cost applicable to NF type services through December 3	31 of the cost reporting period (line	0	24. 00
25 00	7 x line 19)	of the cost reporting period (line 0	0	25 00
25. 00	Swing-bed cost applicable to NF type services after December 31 x line 20)	of the cost reporting period (fine 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 (li	ine 21 minus line 26)	2, 401, 421	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
	General inpatient routine service charges (excluding swing-bed a	and observation bed charges)	-	28. 00
	Private room charges (excluding swing-bed charges)		0	
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ 1	lino 20)	0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	11116 20)	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 minus	s line 33)(see instructions)	0. 00	•
35. 00	Average per diem private room cost differential (line 34 x line		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	d private room cost differential (line	2, 401, 421	37. 00
	27 minus line 36)			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	TMENTS.		
38. 00	Adjusted general inpatient routine service cost per diem (see in		817. 92	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38		19, 630	
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 +	line 40)	19, 630	41.00

Heal th	Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10	
	ATION OF INPATIENT OPERATING COST				Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Pre	pared:	
			Ti t	le XIX	Subprovi der -	5/28/2019 4:5 Cost	о рііі	
	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)		
10.00	huparay (d. d. d	1. 00	2. 00	3.00	4. 00	5. 00	40.00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0		0.0	0 0	0	42.00	
43.00	INTENSIVE CARE UNIT	0		0.0	0 0	0	43. 00	
43. 01	NEONATAL ICU	o		0. 0	0 0	0	43. 01	
44. 00	CORONARY CARE UNIT						44.00	
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00	
47. 00	OTHER SPECIAL CARE (SPECIFY)						47.00	
	Cost Center Description			•	<u>'</u>			
40.00	Program inpatient ancillary service cost (Wk	o+ D 2 ool 1	2 1: 200)			1. 00	40.00	
48. 00 49. 00	Total Program inpatient ancillary service cost (wk			ons)		24, 183 43, 813		
17.00	PASS THROUGH COST ADJUSTMENTS	Tr thi ough 10) ((300 111311 4011	0113)		10, 010	17.00	
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	om Wkst. D, sun	n of Parts I and	0	50.00	
51. 00	III Pass through costs applicable to Program inp	ationt ancillar	su sorvi sos (t	From Wkst D a	sum of Dorte II	0	51.00	
31.00	and IV)	atrent anciria	y services (ITOIII WKSt. D, 3	Sull Of Farts II	0	31.00	
52.00	Total Program excludable cost (sum of lines	50 and 51)				0	52.00	
53.00	Total Program inpatient operating cost exclu		elated, non-pl	nysician anesth	netist, and	0	53.00	
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)						
54.00	Program di scharges					0	54.00	
55.00	Target amount per discharge					0. 00	1	
56.00	Target amount (line 54 x line 55)			/III F/!	1: 52)	0		
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	arget amount	(Tine 56 minus	11ne 53)	0	57. 00 58. 00	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and co	ompounded by the	_		
	market basket							
60. 00 61. 00	60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket							
61.00	61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target							
	amount (line 56), otherwise enter zero (see instructions)							
62.00	62.00 Relief payment (see instructions)							
63.00	63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST							
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	ne cost reporti	ng period (See	0	64. 00	
	instructions)(title XVIII only)					_		
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	per 31 of the	cost reporting	g period (See	0	65.00	
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	I only). For	0	66.00	
	CAH (see instructions)							
67.00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	n December 31	of the cost re	eporting period	0	67.00	
68.00	Title V or XIX swing-bed NF inpatient routin	e costs after [December 31 of	f the cost repo	orting period	0	68.00	
	(line 13 x line 20)		(II) (I	(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		line 70 ÷ line	e 2)			71.00	
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		m (line 1/ v l	ine 35)			72. 00 73. 00	
74. 00	Total Program general inpatient routine serv						74.00	
75.00	Capital-related cost allocated to inpatient	•		•	Part II, column		75. 00	
74 00	26, line 45)	no 2)					74 00	
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00	
78. 00	Inpatient routine service cost (line 74 minu						78.00	
79.00	Aggregate charges to beneficiaries for exces	,		*.	1! 70\		79.00	
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		cost IImitatio	ווא אוו) ווכ	ius iine 79)		80. 00 81. 00	
82. 00	Inpatient routine service cost per dreim frim		1)				82.00	
83.00	Reasonable inpatient routine service costs (see instruction					83.00	
84.00	Program inpatient ancillary services (see in		anc)				84.00	
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00	
22.00	PART IV - COMPUTATION OF OBSERVATION BED PASS						1	
87.00	Total observation bed days (see instructions		1: 0)			0		
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se						88. 00 89. 00	
57.00	(3e)	5 . 115ti deti 0113)	,			0	1 57.00	

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: From 01/01/2018	Worksheet D-1	
		Component	Component CCN: 15-S002		Date/Time Pre 5/28/2019 4:50	
		Ti tl	e XIX	Subprovi der -	Cost	
				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	106, 427	2, 401, 421	0. 04431	8 0	0	90.00
91.00 Nursing School cost	0	2, 401, 421	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	2, 401, 421	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 401, 421	0. 00000	00	0	93.00

Health Financial Systems	METHODIST HOSPITALS, INC		u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0002	Peri od: From 01/01/2018	Worksheet D-1
	Component CCN: 15-T002		
	Title XIX	Subprovi der -	Cost
		I RF	

		I RF		
	Cost Center Description		1.00	
	PART I - ALL PROVIDER COMPONENTS		1. 00	
	INPATIENT DAYS			
1. 00	Inpatient days (including private room days and swing-bed days, exc	cluding newborn)	8, 648	1.00
2.00	Inpatient days (including private room days, excluding swing-bed an	nd newborn days)	8, 648	2.00
3.00	Private room days (excluding swing-bed and observation bed days). I	If you have only private room days,	0	3.00
	do not complete this line.	,	0.440	
4.00	Semi-private room days (excluding swing-bed and observation bed day		8, 648	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room day reporting period	ys) through becember 31 of the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room day	vs) after December 31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)	,,,	_	
7.00	Total swing-bed NF type inpatient days (including private room days	s) through December 31 of the cost	0	7.00
0.00	reporting period	.) . ()		0.00
8. 00	Total swing-bed NF type inpatient days (including private room days reporting period (if calendar year, enter 0 on this line)	s) after December 31 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to the	Program (excluding swing-bed and	116	9. 00
7. 00	newborn days)	og. a (exer aarrig em ing bea and		7. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (i	including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)			
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (i		0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, enter (Swing-bed NF type inpatient days applicable to titles V or XIX only	U on this line)	0	12. 00
12.00	through December 31 of the cost reporting period	y (Therduring private room days)	U	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only	y (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year,			
14.00	Medically necessary private room days applicable to the Program (ex	xcluding swing-bed days)	0	14.00
15. 00 16. 00	Total nursery days (title V or XIX only)		2, 869 0	15. 00 16. 00
10.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT		U	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to services thi	rough December 31 of the cost	0.00	17.00
	reporting period	J. Company		
18. 00	Medicare rate for swing-bed SNF services applicable to services af	ter December 31 of the cost	0. 00	18.00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services thro	ough December 21 of the cost	0.00	19. 00
17.00	reporting period	ough beceinber 31 of the cost	0.00	17.00
20.00	Medicaid rate for swing-bed NF services applicable to services after	er December 31 of the cost	0.00	20.00
	reporting period			
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31	of the cost reporting period (line	6, 977, 006 0	21. 00 22. 00
22.00	5 x line 17)	of the cost reporting period (infle	U	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of	f the cost reporting period (line 6	0	23.00
	x line 18)			
24. 00	Swing-bed cost applicable to NF type services through December 31 (of the cost reporting period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 31 of	the cost reporting period (line 8	0	25. 00
23.00	x line 20)	the cost reporting perrou (Trie o	O	23.00
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)	6, 977, 006	27.00
00.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	The second second	0	00.00
	General inpatient routine service charges (excluding swing-bed and Private room charges (excluding swing-bed charges)	observation bed charges)	0	28. 00 29. 00
30.00	Semi - pri vate room charges (excluding swing-bed charges)		0	
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line	e 28)	0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	e 20)	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 minus li	ing 33)(see instructions)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x line 31)		0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	,	0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and pi	rivate room cost differential (line	6, 977, 006	
37.00	27 minus line 36)	Trvate room cost differential (irine	0, 711, 000	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMEN			
38. 00	Adjusted general inpatient routine service cost per diem (see inst	ructions)	806. 78	
39.00	Program general inpatient routine service cost (line 9 x line 38)		93, 586	
40.00	Medically necessary private room cost applicable to the Program (li Total Program general inpatient routine service cost (line 39 + line		0 93, 586	40.00
41.00	Tiotal Trogram general Theatrent Toutine Service Cost (Tille 39 + 111	110 70)	73, 500	+ 1.00

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 01/01/2018	Worksheet D-1		
			Component		Γο 12/31/2018			
			Ti tl	e XIX	Subprovi der -	5/28/2019 4:5 Cost	о рііі	
	Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost		
	Cost Center Description	Inpati ent	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 0	42.00	
.2. 00	Intensive Care Type Inpatient Hospital Units						12.00	
43. 00 43. 01	INTENSIVE CARE UNIT NEONATAL ICU	0					43. 00 43. 01	
44. 00	CORONARY CARE UNIT	U		0.00			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)		66, 001 159, 587		
47.00	PASS THROUGH COST ADJUSTMENTS	41 till ough 40)	(see mstructi	0113)		137, 307	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 anaeth	estict and	0	52. 00 53. 00	
33.00	medical education costs (line 49 minus line	9 1	erateu, non-pr	ysician anestn	letist, and	0	33.00	
54.00	TARGET AMOUNT AND LIMIT COMPUTATION							
54. 00 55. 00	Program di scharges Target amount per di scharge					0 0. 00		
56. 00	Target amount (line 54 x line 55)					0.00	56.00	
57. 00	Difference between adjusted inpatient operat	ing cost and to	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	endina 1996	undated and co	mnounded by the	0.00	58. 00 59. 00	
07.00	market basket Lesser of lines 53/54 or 55 from prior year			•	pouriuou 25 tirio			
60. 00 61. 00	0.00	60. 00 61. 00						
61.00	61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target							
	amount (line 56), otherwise enter zero (see instructions)							
62. 00 63. 00	0							
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 = \/\/\	I ambod Fam		// 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)		becember of or	the cost repe	a tring period	Ŭ	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, P	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		•	ŕ		81.00	
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82. 00 83. 00	
84. 00	Program inpatient ancillary services (see in:						84.00	
85.00	Utilization review - physician compensation	(see instructi					85. 00	
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		hrough 85)				86. 00	
87. 00	Total observation bed days (see instructions					0	87. 00	
88.00	Adjusted general inpatient routine cost per of	•					88.00	
07. 00	Observation bed cost (line 87 x line 88) (see	e mistructions,)			ı	89. 00	

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (From 01/01/2018 To 12/31/2018		
		Ti tl	e XIX	Subprovi der -	Cost	<u> </u>
				. I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	689, 952	6, 977, 006	0. 09888	9 0	0	90.00
91.00 Nursing School cost	0	6, 977, 006	0.00000	0 0	0	91.00
92.00 Allied health cost	0	6, 977, 006	0.00000	0	0	92.00
93.00 All other Medical Education	0	6, 977, 006	0. 00000	0 0	0	93.00

Health Financial Systems	METHODIST HOSPITALS, INC			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0002	Peri od: From 01/01/2018	Worksheet D-3	
			To 12/31/2018	Date/Time Pre 5/28/2019 4:5	
	Ti tl e	e XVIII	Hospi tal	PPS	о р
Cost Center Description		Ratio of Cos		Inpatient	
'		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col . 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			26, 500, 505		30.00
31. 00 03100 I NTENSI VE CARE UNIT			6, 979, 235		31.00
31. 01 03101 NEONATAL 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. 08547		2, 580, 360	
50. 01 05001 ENDOSCOPY		0. 20437	· · ·	343, 609	
51. 00 05100 RECOVERY ROOM		0. 24370		353, 695	
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 93466		128, 705	•
53. 00 05300 ANESTHESI OLOGY		0.00000		0	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 22351		970, 342	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND		0. 15549	· · ·	365, 986	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 19454		85, 172	
56. 00 05600 RADI OI SOTOPE		0. 18278	· · ·	472, 571	56.00
57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)		0. 03563		610, 595	
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 59. 00 05900 CARDIAC CATHETERIZATION		0.04991		216, 228	
60. 00 06000 LABORATORY		0. 08213 0. 10290		964, 103 2, 361, 929	
60. 01 06000 LABORATORY		0. 10290		2, 301, 929	60.00
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000		0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 24935		731, 897	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 00000		731, 847	63.00
64. 00 06400 I NTRAVENOUS THERAPY		0.00000		0	64.00
65. 00 06500 RESPI RATORY THERAPY		0. 12622		1, 625, 153	
66. 00 06600 PHYSI CAL THERAPY		0. 12022	· · ·	656, 659	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 40482			
68. 00 06800 SPEECH PATHOLOGY		0. 32318		271, 980	
69. 00 06900 ELECTROCARDI OLOGY		0. 05540		292, 014	
69. 01 06901 CARDI AC REHAB		0. 76573		292,014	69.01
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 07220		116, 754	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 33362	· · · · ·	3, 542, 505	•
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 6131		3, 919, 775	
73 OO 07300 DRIIGS CHARGED TO PATIENTS		0.0131			

0. 167170

0.338643

0. 412896

0. 254513

0.570025

3, 878, 924

129, 753

6, 566, 119

2, 928, 817

194, 592, 403

194, 592, 403

6, 417, 817

1, 671, 163

1, 669, 499

1, 313, 570 74. 00

53, 574

32, 174, 233 200. 00

73.00

90.00

91.00

92.00

201.00

202.00

38, 390, 964

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

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0002	Peri od:	Worksheet D-3	}
	Component	CCN: 15-S002	From 01/01/2018 To 12/31/2018	Date/Time Pre 5/28/2019 4:5	
	Title	· XVIII	Subprovi der - I PF	PPS	о р
Cost Center Description	-	Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
LANDATI FAIT DOUTLAND OFFICE COOK OFFICE CO		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 CU			0		31.
00 04000 SUBPROVI DER - I PF			1, 985, 801		40.
00 04100 SUBPROVI DER - I RF			0, 700, 001		41
00 04300 NURSERY					43
ANCILLARY SERVICE COST CENTERS		•			
00 05000 OPERATING ROOM		0. 0854	77 0	0	50
01 05001 ENDOSCOPY		0. 2043		0	50
00 05100 RECOVERY ROOM		0. 2437		0	
00 05200 DELIVERY ROOM & LABOR ROOM		0. 9346		0	
00 05300 ANESTHESI OLOGY		0.0000		0	
00 05400 RADI OLOGY - DI AGNOSTI C		0. 2235		4, 726	
01 05401 RADI OLOGY - ULTRASOUND		0. 1554	1	1, 904	
00 05500 RADI OLOGY-THERAPEUTI C		0. 1945		0	
00 05600 RADI 0I SOTOPE 00 05700 CT SCAN		0. 1827 0. 0356		0 2, 419	
00 05800 MAGNETI C RESONANCE I MAGING (MRI)		0.0336		517	
00 05900 CARDI AC CATHETERI ZATI ON		0. 0444		2	
00 06000 LABORATORY		0. 1029		20, 382	
01 06001 BLOOD LABORATORY		0.0000	· ·	0	
00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0. 0000		ő	
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 2493		5, 689	
00 06300 BLOOD STORING, PROCESSING & TRANS.		0.0000		0	
00 06400 I NTRAVENOUS THERAPY		0.0000	00 0	0	
00 06500 RESPIRATORY THERAPY		0. 1262	27 5, 945	750	65
00 06600 PHYSI CAL THERAPY		0. 3791	45 6, 153	2, 333	66
00 06700 OCCUPATI ONAL THERAPY		0. 4048	27 4, 191	1, 697	67
00 06800 SPEECH PATHOLOGY		0. 3231		300	
00 06900 ELECTROCARDI OLOGY		0. 0554	· ·	990	
01 06901 CARDI AC REHAB		0. 7657		0	
00 07000 ELECTROENCEPHALOGRAPHY		0. 0722		126	
00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0. 3336		2, 393	
00 07200 IMPL. DEV. CHARGED TO PATIENTS 00 07300 DRUGS CHARGED TO PATIENTS		0. 6131		0	
		0. 1671		78, 491	
00 07400 RENAL DI ALYSI S OUTPATI ENT SERVI CE COST CENTERS		0. 3386	43 10, 819	3, 664	74
00 09000 CLI NI C		0. 4128	96 0	0	90
00 09100 EMERGENCY		0. 2545		15, 899	
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5700	· ·	13, 077	1
0.00 Total (sum of lines 50 through 94 and 96 through	98)	0.0700	919, 336	142, 282	
1.00 Less PBP Clinic Laboratory Services-Program only			0.7,000		201
2.00 Net charges (line 200 minus line 201)	3 (21)		919, 336		202

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0002	Peri od:	Worksheet D-3	3
	Component	CCN: 15-T002	From 01/01/2018 To 12/31/2018	Date/Time Pre 5/28/2019 4:5	
	Title	XVIII	Subprovi der - I RF	PPS	. с р
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS .00 03000 ADULTS & PEDIATRICS			51		30.
. 00 03100 INTENSIVE CARE UNIT			0		31.
. 00 03100 INTENSIVE CARE UNIT			0		31.
. 00 04000 SUBPROVI DER - 1 PF			0		40.
. 00 04100 SUBPROVI DER - 1 RF			4, 586, 713		41.
. 00 04300 NURSERY			4, 300, 713		43
ANCILLARY SERVICE COST CENTERS					1 .0
. 00 05000 OPERATING ROOM		0. 0854	77 240, 626	20, 568	50
. 01 05001 ENDOSCOPY		0. 2043		5, 395	50
.00 05100 RECOVERY ROOM		0. 2437	9, 291	2, 264	51
.00 05200 DELIVERY ROOM & LABOR ROOM		0. 9346	65 1, 112	1, 039	52
. 00 05300 ANESTHESI OLOGY		0. 0000		0	
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2235		26, 114	
. 01 05401 RADI OLOGY - ULTRASOUND		0. 1554	· ·	6, 078	
. 00 05500 RADI OLOGY-THERAPEUTI C		0. 1945		20, 400	
. 00 05600 RADI 0I SOTOPE		0. 1827	· ·	5, 273	
. 00 05700 CT SCAN		0. 0356		9, 629	
. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.0499		5, 037	
. 00 05900 CARDI AC CATHETERI ZATI ON		0. 0821		9, 961	
. 00 06000 LABORATORY . 01 06001 BLOOD LABORATORY		0. 1029	· ·	87, 413	
.01 06001 BL00D LABORATORY .00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000		0	
. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 0000 0. 2493		8, 798	
. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 0000		0, 790	
. 00 06400 NTRAVENOUS THERAPY		0. 0000		0	
. 00 06500 RESPI RATORY THERAPY		0. 1262		42, 361	
. 00 06600 PHYSI CAL THERAPY		0. 3791	· ·	820, 345	
. 00 06700 OCCUPATI ONAL THERAPY		0. 4048		795, 652	
. 00 06800 SPEECH PATHOLOGY		0. 3231	84 229, 752	74, 252	68
. 00 06900 ELECTROCARDI OLOGY		0. 0554	06 29, 534	1, 636	69
. 01 06901 CARDI AC REHAB		0. 7657		0	69
. 00 07000 ELECTROENCEPHALOGRAPHY		0. 0722		244	
.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3336		43, 241	
.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 6131	· ·	2, 828	
.00 07300 DRUGS CHARGED TO PATIENTS		0. 1671		573, 155	
. 00 O7400 RENAL DI ALYSI S		0. 3386	43 313, 202	106, 064	74
OUTPATIENT SERVICE COST CENTERS		0.4100	0.1		4
. 00 09000 CLI NI C		0. 4128		391	
. 00 09100 EMERGENCY		0. 2545		3	
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0)	0. 5700		513	
0.00 Total (sum of lines 50 through 94 and 96 through 94 less PBP Clinic Laboratory Services-Program only c			10, 549, 423 0	2, 668, 654	200
					12(1)

Heal th	Financial Systems METHODIS	ST HOSPITALS, INC		In Lie	u of Form CMS-2	2552-10
	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co		Peri od:	Worksheet D-3	
				From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
			V1.V		5/28/2019 4:5	0 pm
		li ti	e XIX	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos	The state of the s	Inpatient	
			To Charges		Program Costs	
				Charges	(col . 1 x	
			1.00	2.00	col. 2) 3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
20.00	03000 ADULTS & PEDIATRICS			2, 078, 748		30.00
	03100 I NTENSI VE CARE UNIT			462, 616		31.00
31.00	03101 NEONATAL I CU			527, 914		31.00
40.00	04000 SUBPROVI DER - I PF			104, 734		40.00
	04100 SUBPROVI DER - TPF			104, 734		40.00
	04300 NURSERY			217, 509		43.00
43.00	ANCILLARY SERVICE COST CENTERS			217, 309		43.00
50. 00	05000 OPERATING ROOM		0. 08547	7 3, 196, 151	273, 197	50.00
	05001 ENDOSCOPY		0. 20437		•	
51. 00	05100 RECOVERY ROOM		0. 24370		41, 443	
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 93466		•	
	05300 ANESTHESI OLOGY		0.00000		0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 22351		55, 881	54.00
54. 01	05401 RADI OLOGY - ULTRASOUND		0. 15549			
55. 00	05500 RADI OLOGY-THERAPEUTI C		0. 19454			55. 00
56.00	05600 RADI OI SOTOPE		0. 18278			
	05700 CT SCAN		0. 03563		•	
	05800 MAGNETIC RESONANCE IMAGING (MRI)		0.04991		•	

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	110VI dei 0	CN: 15-0002	Peri		Worksheet D-3	,
	Component	CCN: 15-S002	To	01/01/2018 12/31/2018	Date/Time Pre 5/28/2019 4:5	
	Ti tl	e XIX	Sub	provi der - I PF	Cost	<i>т</i> о ріп
Cost Center Description		Ratio of Cos	st	Inpatient	Inpatient	
		To Charges	;	Program Charges	Program Costs (col. 1 x col. 2)	
		1.00		2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1		ما		
. 00 03000 ADULTS & PEDI ATRI CS . 00 03100 NTENSI VE CARE UNI T				0		30.
. 00 03100 INTENSIVE CARE UNIT				0		31.
00 04000 SUBPROVI DER - I PF				185, 774		40.
. 00 04100 SUBPROVI DER - RF				103, 774		41.
. 00 04300 NURSERY				o		43.
ANCI LLARY SERVI CE COST CENTERS				٥,		1 .0.
. 00 05000 OPERATING ROOM		0. 0854	.77	0	0	50.
0. 01 05001 ENDOSCOPY		0. 2043	72	0	0	50.
. 00 05100 RECOVERY ROOM		0. 2437		0	0	1
.00 05200 DELIVERY ROOM & LABOR ROOM		0. 9346		50	47	
. 00 05300 ANESTHESI OLOGY		0.0000		0	0	
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2235		1, 668	373	
. 01 05401 RADI OLOGY - ULTRASOUND		0. 1554		1, 277	199	
. 00 05500 RADI OLOGY-THERAPEUTI C . 00 05600 RADI OI SOTOPE		0. 1945	- 1	0	0	
. 00 05000 RADI OFSOTOPE . 00 05700 CT SCAN		0. 1827 0. 0356		1, 157 4, 318	211 154	
. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.0336		1, 198	60	
. 00 05900 CARDI AC CATHETERI ZATI ON		0. 0477		1, 170	0	
00 06000 LABORATORY		0. 1029		22, 021	2, 266	
0. 01 06001 BLOOD LABORATORY		0.0000		0	0	
. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000		o	0	
. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 2493		o	0	
. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0.0000	00	0	0	63.
. 00 06400 INTRAVENOUS THERAPY		0.0000	00	0	0	64.
. 00 06500 RESPI RATORY THERAPY		0. 1262		361	46	
00 06600 PHYSI CAL THERAPY		0. 3791		210	80	
. 00 06700 OCCUPATI ONAL THERAPY		0. 4048		133	54	
00 06800 SPEECH PATHOLOGY		0. 3231		51	16	
. 00 06900 ELECTROCARDI OLOGY . 01 06901 CARDI AC REHAB		0.0554		608	34	1
OF DESCRIPTION OF THE PROPERTY		0.7657		0 558	0	
.00 07000 ELECTROENCEPHALOGRAPHY .00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 0722 0. 3336		31	40 10	1
. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 3330		0	0	
. 00 07300 DRUGS CHARGED TO PATIENTS		0. 1671		53, 692	8, 976	
. 00 07400 RENAL DI ALYSI S		0. 3386		30, 135	10, 205	
OUTPATIENT SERVICE COST CENTERS					.,	1
. 00 09000 CLINIC		0. 4128	96	0	0	90.
. 00 09100 EMERGENCY		0. 2545	-	5, 549	1, 412	
.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5700	25	0	0	
0.00 Total (sum of lines 50 through 94 and 96 through 98)				123, 017	24, 183	
11.00 Less PBP Clinic Laboratory Services-Program only char						201.

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0002	Peri od:	Worksheet D-3	3
	Component	CCN: 15-T002	From 01/01/2018 To 12/31/2018	Date/Time Pre 5/28/2019 4:5	
	Ti tl	e XIX	Subprovi der - I RF	Cost	
Cost Center Description		Ratio of Cos To Charges	st Inpatient Program	Inpatient Program Costs	
		1.00	Charges	(col . 1 x col . 2)	_
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
. 00 03000 ADULTS & PEDIATRICS			0		30.
. 00 03100 I NTENSI VE CARE UNI T			0		31.
. 01 03101 NEONATAL CU			0		31.
00 04000 SUBPROVI DER - I PF			0		40.
. 00 04100 SUBPROVI DER - RF			104, 710		41.
. 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS			0		43.
. 00 OPERATING ROOM		0. 0854	77 1, 004	86	50.
0. 01 05001 ENDOSCOPY		0. 2043	· ·	0	1
. 00 05100 RECOVERY ROOM		0. 2437		43	
.00 05200 DELIVERY ROOM & LABOR ROOM		0. 9346		2, 232	
. 00 05300 ANESTHESI OLOGY		0.0000	00	0	53.
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2235	13 3, 278	733	54.
. 01 05401 RADI OLOGY - ULTRASOUND		0. 1554	99 464	72	54.
. 00 05500 RADI OLOGY-THERAPEUTI C		0. 1945		0	1
. 00 05600 RADI 0I SOTOPE		0. 1827		67	
. 00 05700 CT SCAN		0. 0356		446	
00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 0499	· ·	111	
. 00 05900 CARDI AC CATHETERI ZATI ON		0. 0821		0	
. 00 06000 LABORATORY . 01 06001 BL00D LABORATORY		0. 1029		1, 659	
		0.0000		0	
.00 O6100 PBP CLINICAL LAB SERVICES-PRGM ONLY .00 O6200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 0000 0. 2493		49	
. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 2493		0	
. 00 06400 NTRAVENOUS THERAPY		0.0000		0	
. 00 06500 RESPI RATORY THERAPY		0. 1262		1, 687	
. 00 06600 PHYSI CAL THERAPY		0. 3791		18, 658	
. 00 06700 OCCUPATI ONAL THERAPY		0. 4048		17, 729	
. 00 06800 SPEECH PATHOLOGY		0. 3231	· ·	2, 400	
. 00 06900 ELECTROCARDI OLOGY		0. 0554		31	
. 01 06901 CARDI AC REHAB		0. 7657		0	69.
. 00 07000 ELECTROENCEPHALOGRAPHY		0. 0722	08	0	70.
.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3336		654	
.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 6131		510	
. 00 07300 DRUGS CHARGED TO PATIENTS		0. 1671		16, 528	
. 00 07400 RENAL DIALYSIS		0. 3386	5, 240	1, 774	74.
OUTPATIENT SERVICE COST CENTERS OO OOOO CLINIC		0. 4128	96 1, 289	532	90.
. 00 09000 CET NT C . 00 09100 EMERGENCY		0. 4128		0 532	
. 00 09100 EMERGENCT . 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 2545		0	
0.00 Total (sum of lines 50 through 94 and 96 through 9	8)	0.3700	261, 292	66, 001	
1.00 Less PBP Clinic Laboratory Services-Program only c			201, 272	00,001	201.
2.00 Net charges (line 200 minus line 201)	900 (01)	1	261, 292		202

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0002		Worksheet E Part A Date/Time Prepared: 5/28/2019 4:50 pm
	T1 11 10 11 1		550

	Tit	le XVIII	Hospi tal	5/28/2019 4: 50 PPS	0 pm	
				1. 00		
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00		
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior	to October 1	(500	0 32, 957, 632	1. 00 1. 01	
	instructions)					
1. 02	DRG amounts other than outlier payments for discharges occurring on or instructions)	after October	1 (see	9, 917, 573	1. 02	
1. 03	DRG for federal specific operating payment for Model 4 BPCI for dischard 1 (see instructions)	rges occurring	prior to October	0	1.03	
1. 04	DRG for federal specific operating payment for Model 4 BPCI for dischar October 1 (see instructions)	rges occurring	on or after	0	1. 04	
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			1, 281, 430 0	2. 00 2. 01	
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructions)			Ō	2. 02	
3. 00 4. 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost reporting peri	iod (see instru	uctions)	18, 517, 834 398. 55	3. 00 4. 00	
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most recent of	cost reporting	period ending on	8. 53	5. 00	
	or before 12/31/1996. (see instructions)			0. 00	6. 00	
6. 00	FTE count for allopathic and osteopathic programs that meet the criteri new programs in accordance with 42 CFR 413.79(e)		·			
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified under 42 (ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §			0. 00 0. 00	7. 00 7. 01	
	cost report straddles July 1, 2011 then see instructions.	.,.,	, , , ,			
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(i 1998), and 67 FR 50069 (August 1, 2002).			0. 00	8. 00	
8. 01	The amount of increase if the hospital was awarded FTE cap slots under report straddles July 1, 2011, see instructions.	§ 5503 of the	ACA. If the cost	0. 00	8. 01	
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a under § 5506 of ACA. (see instructions)	a closed teachi	ng hospital	0. 00	8. 02	
9. 00					9. 00	
10.00	FTE count for allopathic and osteopathic programs in the current year to	from your recor	rds	3.00		
11. 00 12. 00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)				11. 00 12. 00	
	Total allowable FTE count for the prior year.			2. 93		
14. 00	Total allowable FTE count for the penultimate year if that year ended otherwise enter zero.	on or after Sep	otember 30, 1997,	2. 93	14. 00	
15.00	Sum of lines 12 through 14 divided by 3.			2. 95	15.00	
	Adjustment for residents in initial years of the program				16.00	
	Adjustment for residents displaced by program or hospital closure				17.00	
	Adjusted rolling average FTE count			2. 95 0. 007402		
	Current year resident to bed ratio (line 18 divided by line 4). Prior year resident to bed ratio (see instructions)			0.007402		
	Enter the lesser of lines 19 or 20 (see instructions)			0.007430		
	, , , , , , , , , , , , , , , , , , , ,			173, 130		
22. 01				74, 775		
	Indirect Medical Education Adjustment for the Add-on for § 422 of the M	има		,		
23. 00	Number of additional allopathic and osteopathic IME FTE resident cap sl $(f)(1)(iv)(C)$.	ots under 42 (CFR 412. 105	0. 00	23. 00	
24.00	IME FTE Resident Count Over Cap (see instructions)			-5. 53	24.00	
25. 00	If the amount on line 24 is greater than -0-, then enter the lower of linstructions)	line 23 or line	e 24 (see	0. 00		
26.00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	26.00	
27.00	IME payments adjustment factor. (see instructions)			0.000000	27.00	
28.00	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 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			173, 130 74, 775	29. 00 29. 01	
	Di sproporti onate Share Adj ustment			, . 70		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient day	ys (see instruc	ctions)	9. 31	30.00	
	Percentage of Medicaid patient days (see instructions)			31. 36	31.00	
32.00	Sum of lines 30 and 31			40. 67		
	Allowable disproportionate share percentage (see instructions)			22. 77		
34. 00	Disproportionate share adjustment (see instructions)		l	2, 440, 671	34.00	

Heal th	Financial Systems METHODIST HOSPI	ITALS INC	In lie	u of Form CMS-2	2552_10
	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0002	Peri od:	Worksheet E	2332-10
ONLOGE	ATTOW OF RETINDOROEMENT SETTEEMENT	11011461 0011. 10 0002	From 01/01/2018	Part A	
			To 12/31/2018	Date/Time Pre 5/28/2019 4:5	pared:
		Title XVIII	Hospi tal	PPS	о рііі
			Prior to 10/1		
			1. 00	2. 00	
	Uncompensated Care Adjustment				
35. 00	Total uncompensated care amount (see instructions)		6, 766, 695, 164		
35. 01 35. 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, ent	ter zero on this line) (s	0. 000831454 ee 5, 626, 195	0. 000669062 5, 535, 062	
33. 02	instructions)	ter zero on this inne) (s	5, 020, 175	5, 555, 002	33.02
35. 03	Pro rata share of the hospital uncompensated care payment am	nount (see instructions)	4, 208, 084	1, 395, 140	35. 03
36. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.		5, 603, 224		36. 00
	Additional payment for high percentage of ESRD beneficiary d				
40. 00	Total Medicare discharges on Worksheet S-3, Part I excluding	g discharges for MS-DRGs	0		40. 00
41. 00	652, 682, 683, 684 and 685 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652, 682,	683 684 an 685 (see	0		41.00
00	instructions)	200, 201 4.1 200. (200			111.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS	S-DRGs 652, 682, 683, 68	1 0		41.01
	an 685. (see instructions)				
42.00	Divide line 41 by line 40 (if less than 10%, you do not qual		0.00		42.00
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 6 instructions)	582, 683, 684 an 685. (se	9 0		43. 00
44. 00	Ratio of average length of stay to one week (line 43 divided	d by line 41 divided by 7	0. 000000		44.00
	days)	,			
45.00	Average weekly cost for dialysis treatments (see instruction	ns)	0. 00		45.00
46.00	Total additional payment (line 45 times line 44 times line 4	11. 01)	0		46. 00
47. 00	Subtotal (see instructions)		52, 373, 660		47.00
48. 00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0		48. 00
	only. (see instructions)			Amount	
				1. 00	
49. 00	Total payment for inpatient operating costs (see instruction	ns)		52, 448, 435	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I a	• • • • • • • • • • • • • • • • • • • •)	3, 824, 393	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt			0	
52.00	Direct graduate medical education payment (from Wkst. E-4, I	ine 49 see instructions)		86, 297 19, 259	
53. 00 54. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies			19, 259	53.00 54.00
54. 01				0	54. 01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see int			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt.		through 35).	0	57.00
58. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		95, 524	
59.00	Total (sum of amounts on lines 49 through 58)			56, 473, 908	ı
60. 00 61. 00	Primary payer payments Total amount payable for program beneficiaries (line 59 minu	is line 60)		21, 804 56, 452, 104	
62.00	Deductibles billed to program beneficiaries	13 TITE 00)		4, 281, 584	1
63. 00				593, 912	
	Allowable bad debts (see instructions)			1, 136, 719	
65.00	Adjusted reimbursable bad debts (see instructions)			738, 867	65.00
66. 00	Allowable bad debts for dual eligible beneficiaries (see ins	structi ons)		232, 410	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	., .,		52, 315, 475	
68.00	Credits received from manufacturers for replaced devices for			0	68.00
69. 00 70. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	. (FOR SCH See THSTRUCTIO	15)	0	69. 00 70. 00
70. 50	Rural Community Hospital Demonstration Project (§410A Demons	stration) adjustment (see	instructions)	0	70.50
70. 87	Demonstration payment adjustment amount before sequestration	•	511 4011 0113)	0	70. 87
70. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	1
70. 89	Pioneer ACO demonstration payment adjustment amount (see ins	structi ons)			70. 89
70. 90	HSP bonus payment HVBP adjustment amount (see instructions)			0	1
70. 91	HSP bonus payment HRR adjustment amount (see instructions)			0	70. 91
70. 92	Bundled Model 1 discount amount (see instructions)			10.704	70. 92
70. 93	HVBP payment adjustment amount (see instructions)			10, 704	70. 93
	UDD adjustment amount (see instructions)			022 410	70 04
70. 94	HRR adjustment amount (see instructions) Recovery of accelerated depreciation			-832, 618 0	70. 94 70. 95

alth Financial Systems METHODIST HOSP	ITALS, INC		In Lie	u of Form CMS-2	2552-1
LCULATION OF REIMBURSEMENT SETTLEMENT	Provi der Co	CN: 15-0002	Peri od: From 01/01/2018 To 12/31/2018		
	Title	XVIII	Hospi tal	PPS	- p
		FF	(yyyy)	Amount	
			0	1. 00	
.96 Low volume adjustment for federal fiscal year (yyyy) (Enter			0	0	70. 96
the corresponding federal year for the period prior to 10/1					
.97 Low volume adjustment for federal fiscal year (yyyy) (Enter the corresponding federal year for the period ending on or a			0	0	
.98 Low Volume Payment-3				0	1
.99 HAC adjustment amount (see instructions)				0	70. 9
.00 Amount due provider (line 67 minus lines 68 plus/minus lines	s 69 & 70)			51, 493, 561	
.01 Sequestration adjustment (see instructions)				1, 029, 871	1
.02 Demonstration payment adjustment amount after sequestration				0	71. 0
.00 Interim payments				49, 903, 256	
.00 Tentative settlement (for contractor use only)	00 70 1			0	73.0
.00 Balance due provider/program (line 71 minus lines 71.01, 71.73)				560, 434	
.00 Protested amounts (nonallowable cost report items) in accord CMS Pub. 15-2, chapter 1, §115.2	dance with			1, 283, 338	75.00
TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)		•			1
.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sur plus 2.04 (see instructions)	n of 2.03			0	90.00
.00 Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
.00 Operating outlier reconciliation adjustment amount (see ins	tructions)			0	1
.00 Capital outlier reconciliation adjustment amount (see instru	uctions)			0	93.00
.00 The rate used to calculate the time value of money (see ins	tructions)			0.00	94.00
.00 Time value of money for operating expenses (see instructions				0	95.00
.00 Time value of money for capital related expenses (see instr	uctions)			0	96.0
			Prior to 10/1		
LIGHT D. D. L. A. L.			1. 00	2. 00	
HSP Bonus Payment Amount			0	0	100. 0
0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			U	U	1100.0
1.00 HVBP adjustment factor (see instructions)			0. 0000000000	0. 0000000000	101 0
2.00 HVBP adjustment amount for HSP bonus payment (see instructions)	nne)		0.0000000000		102.00
HRR Adjustment for HSP Bonus Payment) i i S)			0	1102.00
3.00 HRR adjustment factor (see instructions)			0.0000	0. 0000	103 0
4.00 HRR adjustment amount for HSP bonus payment (see instruction	ns)		0.0000		104. 0
Rural Community Hospital Demonstration Project (§410A Demons		ustment	, , ,		1.01.0
0.00 Is this the first year of the current 5-year demonstration					200. 00
Century Cures Act? Enter "Y" for yes or "N" for no.					
Cost Reimbursement					1
1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, II	ne 49)				201.00
2.00 Medicare discharges (see instructions)					202.00
3.00 Case-mix adjustment factor (see instructions)	CI :	6 11			203. 0
Computation of Demonstration Target Amount Limitation (N/A i period)	n first year	of the curr	ent 5-year demons	trati on	
4.00 Medicare target amount					204.00
5.00 Case-mix adjusted target amount (line 203 times line 204)					205.00

207. 00 208. 00

209.00

210. 00 211. 00

212. 00 213. 00

218. 00

210.00 Reserved for future use
211.00 Total adjustment to Medicare IPPS payments (see instructions)

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

213.00 Low-volume adjustment (see instructions)
218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)

209.00 Adjustment to Medicare IPPS payments (see instructions)

Comparision of PPS versus Cost Reimbursement

(line 212 minus line 213) (see instructions)

Adjustment to Medicare Part A Inpatient Reimbursement

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

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

Health Financial Systems	METHODIST HOSPITALS, INC	,	In Lieu	of Form CMS-2552-10
LOW VOLUME CALCULATION EXHIBIT 4	Provi del		From 01/01/2018 To 12/31/2018	Worksheet E Part A Exhi bi t 4 Date/Ti me Prepared: 5/28/2019 4:50 pm
	T:	+1 o VVIII	Hooni tol	5/20/2017 4. 50 pili

					10		5/28/2019 4:5	
		W (0 E D) A			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)	
1 00	Inno.	0	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	DRG amounts other than outlier payments	1. 00	0	0	0	0	0	1.00
1. 01	DRG amounts other than outlier payments for discharges	1. 01	32, 957, 632	0	32, 957, 632		32, 957, 632	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	9, 917, 573	0		9, 917, 573	9, 917, 573	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	1. 04	0	0		O	0	1. 04
2. 00	October 1 Outlier payments for discharges (see instructions)	2. 00	1, 281, 430	0	1, 017, 514	263, 916	1, 281, 430	2.00
2. 01	Outlier payments for	2. 02	0	0	0	0	0	2. 01
3. 00	discharges for Model 4 BPCI Operating outlier	2. 01	0	0	О	0	0	3.00
4. 00	reconciliation Managed care simulated	3. 00	18, 517, 834	0	13, 850, 321	4, 667, 513	18, 517, 834	4. 00
	payments Indirect Medical Education Adj	ustmant						
5. 00	Amount from Worksheet E, Part	21. 00	0. 007402	0. 007402	0. 007402	0. 007402		5.00
6. 00	A, line 21 (see instructions) IME payment adjustment (see instructions)	22. 00	173, 130	0	133, 083	40, 047	173, 130	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	74, 775	0	74, 775	0	74, 775	6. 01
	instructions)							
7. 00	Indirect Medical Education Adjustment factor	ustment for the	e Add-on for Se 0.000000	ection 422 of 1 0.000000		0. 000000		 7.00
8. 00	(see instructions) IME adjustment (see	28. 00	0.000000	0.000000		0. 000000	0	8.00
8. 01	instructions) IME payment adjustment add on	28. 01	0	0	0	0	0	
0.01	for managed care (see instructions)	20.01	0	0	J	0	0	0.01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	173, 130	0	133, 083	40, 047	173, 130	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	74, 775	0	74, 775	0	74, 775	9. 01
	Disproportionate Share Adjustm							
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 2277	0. 2277	0. 2277	0. 2277		10.00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	2, 440, 671	0	1, 876, 113	564, 558	2, 440, 671	11.00
11. 01	Uncompensated care payments	36.00	5, 603, 224	0	4, 208, 084	1, 395, 140	5, 603, 224	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,	47. 00 48. 00	52, 373, 660 0	0	40, 192, 426 0	12, 181, 234 0	52, 373, 660 0	13. 00 14. 00
15. 00	small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see	49. 00	52, 448, 435	0	40, 267, 201	12, 181, 234	52, 448, 435	15. 00
16. 00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I,	50. 00	3, 824, 393	0	2, 929, 934	894, 459	3, 824, 393	16. 00
17. 00	if applicable) Special add-on payments for new technologies	54. 00	0	0	0	0	0	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

	Financial Systems		METHODIST HOS		N 45 0000		u of Form CMS-1	2552-1
_OW VO	LUME CALCULATION EXHIBIT 4			Provider CO		Peri od: From 01/01/2018 To 12/31/2018		epared:
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1. 00	2.00	3. 00	4. 00	5. 00	
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0		0 0	0	18.0
19. 00	SUBTOTAL			0	43, 197, 13	13, 075, 693	56, 272, 828	19.0
		W/S L, line	(Amounts from L)					
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier		3, 491, 628 0	0	2, 684, 71	806, 917 0 0	3, 491, 628 0	1
21. 00 21. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG	2. 00 2. 01	19, 915 0	0 0	4, 67	73 15, 242 0 0	19, 915 0	1
22. 00	outlier payments Indirect medical education percentage (see instructions)	5. 00	0. 0037	0. 0037	0. 003	0. 0037		22.0
23. 00	Indirect medical education adjustment (see instructions)	6. 00	12, 919	0	9, 93	2, 986	12, 919	23.0
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0859	0. 0859	0. 085	0. 0859		24.0
25. 00	Disproportionate share adjustment (see instructions)	11. 00	299, 931	0	230, 61	69, 314	299, 931	25.0
26. 00	Total prospective capital payments (see instructions)	12. 00	3, 824, 393	0	2, 929, 93	894, 459	3, 824, 393	26.0
		W/S E, Part A	(Amounts to					
		l i ne	E, Part A)					
		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, Pt. A, line)	70. 96			0. 00000	0.000000	0	27. 0 28. 0
9. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	0	29.0
00.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.0

					From 01/01/2018 To 12/31/2018		pared:
			Title	e XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2. 00	3. 00	4. 00	
1. 00 1. 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 00 1. 01	32, 957, 632	32, 957, 63	2	32, 957, 632	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	9, 917, 573	3	9, 917, 573	9, 917, 573	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	C		0	0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	C		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00	1, 281, 430	1, 017, 51	4 263, 916	1, 281, 430	2.00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	C)	0 0	0	2. 01
3. 00 4. 00	Operating outlier reconciliation Managed care simulated payments	2. 01 3. 00	18, 517, 834	14, 291, 26	0 8 4, 226, 567	0 18, 517, 835	3. 00 4. 00
5.00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21	21. 00	0. 007402	0.00740	2 0.007402		5. 00
6. 00	(see instructions) IME payment adjustment (see instructions)	22. 00	173, 130	133, 08	3 40, 047	173. 130	6. 00
6. 01	IME payment adjustment for managed care (see instructions)	22. 01	74, 775	57,70		74, 775	6. 01
	Indirect Medical Education Adjustment for the						
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0.00000	0. 000000		7. 00
8. 00 8. 01	IME adjustment (see instructions) IME payment adjustment add on for managed	28. 00 28. 01	0		0 0	0	8. 00 8. 01
	care (see instructions)		172 120			Ţ.	9. 00
9. 00 9. 01	Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of	29. 00 29. 01	173, 130 74, 775			173, 130 74, 775	9.00
	lines 6.01 and 8.01) Disproportionate Share Adjustment						
10. 00	Allowable disproportionate share percentage	33. 00	0. 2277	0. 227	7 0. 2277		10.00
11. 00	(see instructions) Disproportionate share adjustment (see instructions)	34. 00	2, 440, 671	1, 876, 11	3 564, 558	2, 440, 671	11. 00
11. 01	Uncompensated care payments	36. 00	5, 603, 224	4, 208, 08	4 1, 395, 140	5, 603, 224	11. 01
40.00	Additional payment for high percentage of ESI						
12. 00	Total ESRD additional payment (see instructions)	46. 00	C)	0 0	0	12.00
13.00	Subtotal (see instructions)	47. 00	52, 373, 660	40, 192, 42	6 12, 181, 234	52, 373, 660	
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48. 00	C)	0 0	0	14.00
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	52, 448, 435	40, 250, 13	4 12, 198, 301	52, 448, 435	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	3, 824, 393	2, 929, 93	4 894, 459	3, 824, 393	16. 00
17. 00 17. 01	Special add-on payments for new technologies Net organ acquisition cost	54. 00	С		0 0	0	17. 00 17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	C		0 0	0	•
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	C		0 0	0	18. 00
19. 00	SUBTOTAL			43, 180, 06	8 13, 092, 760	56, 272, 828	19. 00

111 +-	Figure in Contains	METHODI CT. HOC	PRITALC INC		la lia		2552 10
	Financial Systems AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	METHODIST HOS ATION EXHIBIT 5			Period: From 01/01/2018	u of Form CMS-2 Worksheet E Part A Exhibi Date/Time Pre 5/28/2019 4:5	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, 491, 628	2, 684, 71	1 806, 917	3, 491, 628	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	19, 915	4, 67	15, 242	19, 915	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	(0	0	21.01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0037	0. 003	0. 0037		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	12, 919	9, 93	2, 986	12, 919	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0859	0. 085	0. 0859		24.00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	299, 931	230, 61	69, 314	299, 931	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	3, 824, 393	2, 929, 93	894, 459	3, 824, 393	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		O	0	28.00
29.00	Low volume adjustment on or after October 1	70. 97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70. 93	10, 704	6, 42	5 4, 279	10, 704	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-832, 618	-688, 81	4 -143, 804	-832, 618	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0	0	31. 01
	•					(Amt to	

0 70. 99

1.00

Ν

2.00

0

3. 00

0

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

32.00

100.00

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 Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0002		Worksheet E Part B Date/Time Prepared: 5/28/2019 4:50 pm
•			

5.00 Enter the hospital specific payment to cost ratio (see instructions) 6.00 Line 2 times line 5 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 8.00 Transitional corridor payment (see instructions) 7.00 Organ acquisitions 7.01 Organ acquisitions 7.00 Organ acquisition charges (sum of lines 12 and 13) 7.00 Organ acquisition charges (from West D-4, Pt. III, col. 4, line 69) 7.01 Organ acquisition charges (sum of lines 12 and 13) 7.01 Organ acquisition charges (sum of lines 12 and 13) 7.01 Organ acquisition charges (sum of lines 12 and 13) 7.01 Organ acquisition charges (sum of lines 12 and 13) 7.01 Organ acquisition charges (sum of lines 14 CFR §413.13(e) 7.01 Organ acquisition charges (sum of lines 15 to line 16 (not to exceed 1.000000) 7.01 Organ acquisition charges (see instructions) 7.02 Organ acquisition charges (see instructions) 7.03 Organ acquisition charges (see instructions) 7.04 Organ acquisition charges (see instructions) 7.05 Organ acquisition charges (see instructions) 7.07 Organ acquisition charges (see instructions) 7.08 Organ acquisition charges (see instructions) 7.00	2.00 3.00 4.00 4.01 5.00 6.00 7.00 8.00 9.00 10.00 11.00
PART B - MEDICAL AND OTHER HEALTH SERVICES 30, 15	2.00 3.00 4.00 4.01 5.00 6.00 7.00 8.00 9.00 10.00 11.00
PART B - MEDICAL AND OTHER HEALTH SERVICES 30, 15	2.00 3.00 4.00 4.01 5.00 6.00 7.00 8.00 9.00 10.00 11.00
1.00	2.00 3.00 4.00 4.01 5.00 6.00 7.00 8.00 9.00 10.00 11.00
2.0 Medical and other services reimbursed under OPPS (see instructions) 22, 959, 77	2.00 3.00 4.00 4.01 5.00 6.00 7.00 8.00 9.00 10.00 11.00
3.00 OPPS payments 20,932,73 4.01 Outlier payment (see instructions) 216,73 4.01 Outlier prepayment (see instructions) 216,73 4.01 Outlier preconciliation amount (see instructions) 216,73 5.00 Enter the hospital specific payment to cost ratio (see instructions) 21,00 6.00 Line 2 times line 5 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 8.00 Transitional corridor payment (see instructions) 9,00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 93,62 7.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 93,62 7.00 Ancillary service charges 10,00 ancillary service charges (sum of lines 12 and 13) 180,40 ancillary service charges 10,00 ancillary service charges (sum of lines 12 and 13) 180,40 ancillary service charges (sum of lines 12 and 13) 180,40 ancillary service charges (sum of lines 12 and 13) 180,40 ancillary service charges (sum of lines 12 and 13) 180,40 ancillary service charges (sum of lines 12 and 13) 180,40 ancillary service charges (see instructions) 180,40 ancillary serv	3.00 4.00 4.01 5.00 6.00 7.00 8.00 9.00 10.00 11.00
4.01 Outlier payment (see instructions) 4.01 Utlier reconciliation amount (see instructions) 5.00 Enter the hospital specific payment to cost ratio (see instructions) 6.00 Line 2 times line 5 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 8.00 Transitional corridor payment (see instructions) 9.00 Anciliary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 9.01 Anciliary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 9.02 Anciliary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 9.03 Anciliary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 9.01 Anciliary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 9.02 Anciliary service charges 9.03 Anciliary service charges 12.00 Anciliary service charges 12.00 Anciliary service charges 12.00 Anciliary service charges (from Wkst. D-4, Pt. III, col. 4, line 69) 14.00 Total reasonable charges (sum of lines 12 and 13) 180, 40 180, 40 180, 40 180 Anounts that would have been realized from patients liable for payment for services on a charge basis 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) 180, Total customary charges (see instructions) 19.00 Excess of reasonable cost over customary charges (complete only if line 18 exceeds line 11) (see instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 21.01 Interns and residents (see instructions) 22.00 Interns and residents (see instructions) 23.00 Cost of physicians' services in a teaching hospital (see instructions) 24.00 Deductible and Coinsurance amounts (for CAH, see instructions) 25.00 Deductible and Coinsurance amounts (for CAH, see instructions) 26.00 Deductible and Coinsurance amounts (for Wkst. E-4, line 50) 27.00 EXBO direct graduate medical education payments (from Wkst. E-4, line 50) 28.00 Direct graduate medical education costs (from Wkst. E-	4.00 4.01 5.00 6.00 7.00 8.00 9.00 10.00 11.00
4.01 Outflier reconcilitation amount (see instructions) 0.00	4. 01 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
5.00 Enter the hospital specific payment to cost ratio (see instructions) 6.00 Line 2 times line 5 7.00 Sum of lines 3, 4, and 4,01, divided by line 6 8.00 Transitional corridor payment (see instructions) 7.00 Organ acquisitions 7.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 7.00 Organ acquisitions 7.00 Organ acquisitions 7.00 Ancillary service charges 8.00 Organ acquisition charges (From Wkst. D-4, Pt. III, col. 4, line 69) 7.00 Organ acquisition organ acqui	5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
7.00 Sum of lines 3, 4, and 4.01, divided by line 6 8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 93, 62 93, 62 93, 62 10.00 Organ acquisitions 10.00 Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges 13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 14.00 Total reasonable charges (sum of lines 12 and 13) 180, 40 18	7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
8 00 Translitional corridor payment (see instructions) 9,00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 93,62 10.00 Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges Reasonable charges 12.00 Ancillary service charges (from Wkst. D-4, Pt. III, col. 4, line 69) 14.00 Total reasonable charges (sum of lines 12 and 13) 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 18.00 Total customary charges (see instructions) 18.00 Total customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 18.00 Excess of customary charges (see instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 21.00 Lesser of cost or charges (see instructions) 22.00 Lordinary charges (see instructions) 23.00 Cost of physicians' services in a teaching hospital (see instructions) 24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 25.00 Deductibles and Coinsurance amounts (for CAH, see instructions) 26.00 Deductibles and Coinsurance amounts (for CAH, see instructions) 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) 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 29.00 ESRS direct medical education costs (from Wkst. E-4, line 50) 20.00 Subtotal ((line 30 minus line 31) 20.00 Composite rate ESRD (from Wkst. 1-5, line 11) 21.01 Composite rate ESRD (from Wkst. 1-5, line 11)	8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
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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) 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 28.76 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 30.00 Subtotal (sum of lines 27 through 29) 31.00 Primary payer payments 32.00 Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I-5, line 11)	25. 00
instructions) 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 28.76 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 30.00 Subtotal (sum of lines 27 through 29) 31.00 Primary payer payments 32.00 Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I-5, line 11)	1
28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 30.00 Subtotal (sum of lines 27 through 29) 31.00 Primary payer payments 32.00 Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I-5, line 11)	27. 00
29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 30.00 Subtotal (sum of lines 27 through 29) 31.00 Primary payer payments 32.00 Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I-5, line 11)	28. 00
30.00 Subtotal (sum of lines 27 through 29) 31.00 Primary payer payments 32.00 Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I -5, line 11)	29. 00
32.00 Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I-5, line 11)	1
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I-5, line 11)	31.00
33.00 Composite rate ESRD (from Wkst. I-5, line 11)	32. 00
	4
	33.00
34.00 Allowable bad debts (see instructions) 1, 257, 45	1
35.00 Adjusted reimbursable bad debts (see instructions) 817, 34 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 766, 68	1
37. 00 Subtotal (see instructions) 18, 449, 13	1
38.00 MSP-LCC reconciliation amount from PS&R -10	1
	39.00
39.50 Pioneer ACO demonstration payment adjustment (see instructions)	39. 50
39.97 Demonstration payment adjustment amount before sequestration	39. 97
39.98 Partial or full credits received from manufacturers for replaced devices (see instructions)	39. 98
	39. 99
40.00 Subtotal (see instructions) 18,449,24	1
40. 01 Sequestration adjustment (see instructions) 368, 98	•
41.00 Interim payments 42.00 Tentative settlement (for contractors use only)	40.02
43.00 Balance due provider/program (see instructions) -90,92	41.00
	41. 00 42. 00
\$115. 2	41. 00 42. 00 43. 00
TO BE COMPLETED BY CONTRACTOR	41. 00 42. 00
	41. 00 42. 00 43. 00
	41. 00 42. 00 43. 00
92.00 The rate used to calculate the Time Value of Money 0.0	41. 00 42. 00 43. 00 44. 00 90. 00 91. 00
93.00 Time Value of Money (see instructions)	41. 00 42. 00 43. 00 44. 00 90. 00 91. 00 92. 00
94.00 Total (sum of lines 91 and 93)	41. 00 42. 00 43. 00 44. 00 90. 00 91. 00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0002	Peri od:	Worksheet E
		From 01/01/2018	
	Component CCN: 15-S002	To 12/31/2018	Date/Time Prepared:
	·		5/28/2019 4:50 pm
	Title XVIII	Subprovi der -	PPS
		LDE	

		Title XVIII	Subprovider -	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			0	
2.00	Medical and other services reimbursed under OPPS (see instruc	tions)		13	
3. 00 4. 00	OPPS payments Outlier payment (see instructions)			55 0	3. 00 4. 00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instru	ctions)		0. 000	1
6. 00 7. 00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0 0. 00	
8. 00	Transitional corridor payment (see instructions)			0.00	8.00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	9. 00
10.00	Organ acquisitions			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			U	11.00
	Reasonable charges				1
	Ancillary service charges			0	
13. 00 14. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			U	14.00
15. 00	Aggregate amount actually collected from patients liable for			0	15.00
16. 00	Amounts that would have been realized from patients liable fo	. 3	on a chargebasis	0	16.00
17. 00	had such payment been made in accordance with 42 CFR §413.13(Ratio of line 15 to line 16 (not to exceed 1.000000)	e)		0. 000000	17. 00
18. 00	Total customary charges (see instructions)			0.000000	
19. 00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds l	ine 11) (see	0	1
00.00	instructions)		10) (00.00
20. 00	Excess of reasonable cost over customary charges (complete on instructions)	ly it line il exceeds i	ine 18) (see	0	20.00
21. 00	Lesser of cost or charges (see instructions)			0	21.00
22. 00	l ,			0	22. 00
23. 00		ructions)		0 55	
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance amounts (for CAH, see instruction	s)		0	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on lin	•		11	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	plus the sum of lines 2	2 and 23] (see	44	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	,		0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			44	30.00
31.00	Primary payer payments Subtotal (line 30 minus line 31)			0 44	31. 00 32. 00
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)		44	32.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	,		0	33. 00
	Allowable bad debts (see instructions)			0	1
35. 00 36. 00	, ,	ructions)		0	
37.00	Subtotal (see instructions)	1 40 (1 0113)		44	37.00
	MSP-LCC reconciliation amount from PS&R			0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	۵)		0	
39. 50 39. 97	Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration	5)		0	39. 50 39. 97
39. 98	Partial or full credits received from manufacturers for repla	ced devices (see instru	ctions)	0	1
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	1
40.00	· · · · · · · · · · · · · · · · · · ·			44	
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			1	40. 01 40. 02
41. 00	Interim payments			43	
42.00	Tentative settlement (for contractors use only)			0	1
43.00	, , , , , , , , , , , , , , , , , , , ,	nco with CMS Dub 15.0	chaptor 1	0	1
44. 00	Protested amounts (nonallowable cost report items) in accorda §115.2	nce with two Pub. 15-2,	chapter I,	0	44.00
	TO BE COMPLETED BY CONTRACTOR				1
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions)			0 00	91. 00 92. 00
	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	
	Total (sum of lines 91 and 93)			0	
			·	'	

| In Lieu of Form CMS-2552-10 | Period: | Worksheet E-1 | From 01/01/2018 | Part | Date/Time Prepared: | 5/28/2019 4:50 pm | PPS | P Health Financial Systems METHANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED METHODIST HOSPITALS, INC Provider CCN: 15-0002

		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1. 00	Total interim payments paid to provider		48, 675, 335		17, 132, 484	1.00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	12/31/2018	1, 152, 921	12/31/2018	965, 997	3. 01
3. 01	ADJUSTIMENTS TO PROVIDER	07/25/2018	75, 000		72, 700	3. 01
3. 03		0772372010	0	077 237 2010	72,700	3. 02
3. 04			l o		0	3. 04
3. 05			Ö		l ől	3. 05
	Provi der to Program				_	
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3. 51			0		0	3.51
3. 52			0		0	3. 52
3. 53			0		0	3.53
3. 54			0		0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		1, 227, 921		1, 038, 697	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		49, 903, 256		18, 171, 181	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
г оо	TO BE COMPLETED BY CONTRACTOR	I				г оо
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5. 00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		0		0	5.50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5. 99
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		560, 434		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		90, 925	6. 02
7. 00	Total Medicare program liability (see instructions)		50, 463, 690		18, 080, 256	7. 00
				Contractor	NPR Date	
)	Number	(Mo/Day/Yr)	
8. 00	Name of Contractor		J	1. 00	2. 00	8. 00
5.00	Iname of contractor	I	ļ		1	0.00

Health Financial Systems	METHODIST HOSPIT	ALS, INC	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR	SERVICES RENDERED	Provi der CCN: 15-0002	Peri od: From 01/01/2018	Worksheet E-1
		Component CCN: 15-S002	To 12/31/2018	
		Title XVIII	Subprovi der -	PPS
			I PF	

		Title	e XVIII	Subprovi der - I PF	PPS	
		I npati e	nt Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		950, 365		43	1.00
2.00	Interim payments payable on individual bills, either		0	1	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	L		I		
3. 01	ADJUSTMENTS TO PROVIDER		T 0		0	3. 01
3. 02			0		l ol	3. 02
3.03			0		o	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	3.50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3. 53			0		0	3. 53
3. 54	Cultural (0		0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		950, 365		43	4. 00
1. 00	(transfer to Wkst. E or Wkst. E-3, line and column as		700,000		10	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)					
- 04	Program to Provider	ı				
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02 5. 03			0 0		0	5. 02 5. 03
5.03	Provider to Program				U	5.03
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			Ö		0	5. 51
5. 52			Ö		Ö	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		l ol	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		33, 997		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		004.333		0	6. 02
7. 00	Total Medicare program liability (see instructions)		984, 362		43	7. 00
				Contractor Number	NPR Date	
			0	1. 00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		<u> </u>	1.00	2.00	8. 00
		1		1	'	

Health Financial Systems	METHODI ST HOSPI	TALS, INC	In Lieu	u of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICE	CES RENDERED	Provider CCN: 15-0002	Peri od: From 01/01/2018	Worksheet E-1 Part I	
		Component CCN: 15-T002	To 12/31/2018	Date/Time Pre 5/28/2019 4:5	
		Title XVIII	Subprovi der -	PPS	
			I RF		
		Inpatient Part A	Par	t B	

Total interim payments paid to provider 1.00			litle	XVIII	Subprovi der - I RF	PPS	
1.00 Total Interim payments paid to provider 1.00 2.00 3.00 4.00 1.00 1.00 1.100 1			I npati en	t Part A		t B	
1.00 1.00 1.00 2.00 3.00 4.00 1.00			mm/dd/vvvv	Amount	mm/dd/vvvv	Amount	
Interfim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "MONE" or netre a zero							
Submitted or to be Submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero	1. 00	Total interim payments paid to provider		7, 128, 095		0	1.00
Services rendered in the cost reporting period. If none, write "NONE" or enter a zero	2.00			0		0	2.00
write "NONE" or enter a zero . 0. 0. 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 . 0 0 0 3.01 . 0. 0 0 3.03 . 0. 0 0 0 3.03 . 0. 0 0 0 3.03 . 0. 0 0 0 3.03 . 0. 0 0 0 3.03 . 0. 0 0 0 3.03 . 0. 0 0 0 3.03 . 0. 0 0 0 3.03 . 0. 0 0 0 3.03 . 0. 0 0 0 3.03 . 0. 0 0 0 3.03 . 0. 0 0 0 3.05 . 0 0 0 3.05 . 0 0 0 3.05 . 0 0 0 3.55 . 3.51 . 5.51 . 5.52 . 5.50							
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) Program to Provider ADJUSTMENTS TO PROVIDER 3.01 3.02 3.03 3.04 3.05 3.05 3.06 3.07 3.07 3.08 3.09 3.09 3.09 3.09 3.09 3.09 3.09 3.50 3.51 3.51 3.52 3.53 3.54 3.99 3.00 3.01 3.02 3.01 3.02 3.03 3.04 3.05 3.50 3.50 3.50 3.50 3.50 3.50 3.50	2 00						2 00
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	3.00						3.00
Dayment. If none, write "NONE" or enter a zero. (1) Program to Provider							
Program to Provider ADJUSTMENTS TO PROVIDER 0 0 0 3. 01							
3.02 3.03 3.03 3.04 3.05 Provider to Program						•	1
3.03 3.04 3.05 Provider to Program 3.50 3.51 3.51 3.52 3.53 3.54 3.99 3.50-3.99) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR Write "NONE" or enter a zero. (1) Program to Provider 5.00 5.50 7.50 Provider to Program TENTATIVE TO PROGRAM TO TENTATIVE TO PROGRAM TO TENTATIVE TO PROGRAM		ADJUSTMENTS TO PROVI DER		0			
3.04 0 0 0 3.04 3.05							
ADJUSTMENTS TO PROGRAM							
Provider to Program ADJUSTMENTS TO PROGRAM 0 0 0 3.50 3.50 0 0 0 3.51 3.52 0 0 0 0 3.51 3.52 0 0 0 0 3.53 3.53 0 0 0 0 3.53 3.54 0 0 0 0 3.53 3.54 0 0 0 0 3.53 3.54 0 0 0 0 3.53 3.54 0 0 0 0 3.53 3.54 0 0 0 0 3.53 3.54 0 0 0 0 3.53 3.54 0 0 0 0 3.53 3.54 0 0 0 0 3.53 3.54 0 0 0 0 3.59 3.50 3.99 3.50 3.99 0 0 0 0 3.59 3.50 3.99 0 0 0 0 3.59 0 0 0 0 0 0 0 0 0							
ADJUSTMENTS TO PROGRAM	3. 05	Drovi don to Drogram		0		0	3.05
3.51 0 0 3.51 3.52 3.53 0 0 0 3.53 3.53 3.53 3.54 0 0 0 3.53 3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.54 3.59 3.50-3.98 0 0 3.59 3.50-3.98 0 0 3.59 3.50-3.98 0 0 3.50 3.59 3.50-3.98 0 0 0 3.50 3.59 3.50-3.98 0 0 0 0 3.50 3.59 3.50-3.98 0 0 0 0 0 0 0 0 0	3 50			0		0	3 50
3.52 0 0 3.52 3.53 3.54 3.99 0 0 3.53 3.54 3.99 3.50-3.98 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 7, 128, 095 0 4.00		ADJUSTWENTS TO TROOMAW					
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 7,128,095 0 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR						_	3. 52
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.09) 3.99 3.50-3.98) 0 4.00 0 3.59-3.98) 7,128,095 0 4.00 10tal interim payments (sum of lines 1, 2, and 3.99) 7,128,095 0 4.00 4.00 10tal interim payments (sum of lines 1, 2, and 3.99) 7,128,095 0 4.00 4.00 10tal interim payments (sum of lines 1, 2, and 3.99) 7,128,095 0 4.00 4.00 10tal interim payments (sum of lines 1, 2, and 3.99) 7,128,095 0 4.00			•	0		0	
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	3.54			0		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			0		0	3. 99
(transfer to Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER 5.02 0 0 0 5.02 5.03 0 0 0 5.02 5.03 0 0 0 5.02 5.03 0 0 0 5.02 5.04 0 0 0 5.50 5.05 1 0 0 0 5.51 5.50 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 7.00 Total Medicare program liability (see instructions) 8.00 SETTLEMENT TO PROVIDER 8.00 Number (Mo/Day/Yr) 0 1.00 2.00		,		7 400 005			
appropriate TO BE COMPLETED BY CONTRACTOR	4.00			7, 128, 095		0	4.00
TO BE COMPLETED BY CONTRACTOR So Now date of each payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider So Now date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider So Now date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider So Now date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider to Program So Now date of each payment. If none, write "None" or enter a zero. (1) So Now date of each payment. If none, write "None" or enter a zero. (1) So Now date of each payment. If none, write "None" or enter a zero. (1) So None or enter a zero. (1) So Now date of each payment. If none, write "None" or enter a zero. (1) So None or enter a zero. (1)							
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							i
Write "NONE" or enter a zero. (1) Program to Provider	5.00						5.00
Program to Provider		desk review. Also show date of each payment. If none,					
TENTATI VE TO PROVI DER							
5. 02 0		9		_	T	_	
Solution Settlement amount (balance due) based on the cost report. (1) Settlement TO PROGRAM Settlement amount (balance due) based on the cost report. (1) Settlement TO PROGRAM Settlement amount (balance due) based on the cost report. (1) Settlement TO PROGRAM Settlement amount (balance due) based on the cost report. (1) Settlement TO PROGRAM S		TENTATIVE TO PROVIDER				_	
Provider to Program							
TENTATI VE TO PROGRAM	5. 05	Provider to Program					3.03
5.51 0	5. 50			0		0	5.50
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00	5. 51			0		0	5. 51
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				0		_	
the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00	5. 99			0		0	5. 99
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 0 0 6.02 7.138,740 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	6. 00						6. 00
7.00 Total Medicare program liability (see instructions) 7,138,740 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				10, 645			6. 01
Contractor NPR Date Number (Mo/Day/Yr) 0 1.00 2.00	6. 02			0			6. 02
Number (Mo/Day/Yr) 0 1.00 2.00	7. 00	Total Medicare program liability (see instructions)		7, 138, 740			7. 00
0 1.00 2.00							
			()			
	8. 00	Name of Contractor					8.00

Heal th F	Financial Systems METH	IODI ST HOSPI TALS,	INC	In Lieu	of Form CMS-:	2552-10
CALCULAT	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0002 Period: V					
				From 01/01/2018		1
				To 12/31/2018	Date/Time Pre 5/28/2019 4:5	
	PPS	о ріп				
	Title XVIII Hospital					
					1. 00	
Tr	O BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST	T REPORTS				
H	EALTH INFORMATION TECHNOLOGY DATA COLLECTION AND	CALCULATI ON				
1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14						1.00
2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12						2.00
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2						3.00
4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12						4.00
5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200						5. 00
	「otal hospital charity care charges from Wkst. S-i					6. 00
	CAH only - The reasonable cost incurred for the p	urchase of certif	fied HIT technology	Wkst. S-2, Pt. I		7. 00
4	ine 168					
	Calculation of the HIT incentive payment (see ins					8. 00 9. 00
	9.00 Sequestration adjustment amount (see instructions)					
	10.00 Calculation of the HIT incentive payment after sequestration (see instructions)					10.00
	NPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
	nitial/interim HIT payment adjustment (see instru	uctions)				30.00
	Other Adjustment (specify)					31.00
32. 00 B	Balance due provider (line 8 (or line 10) minus li	ine 30 and line 3	31) (see instruction	ns)		32.00

Heal th	Financial Systems	METHODIST HOSPIT	ALS, INC	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-0002	Peri od: From 01/01/2018	Worksheet E-3 Part II	
			Component CCN: 15-S002	To 12/31/2018		
	Title XVIII Subprovider -					
					1. 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)					1.00
2.00	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 t	the most recent c	ost report filed on or b	before November	0.00	4.00

		1. 00	
F	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1, 068, 250	1.00
2.00	Net IPF PPS Outlier Payments	0	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0. 00	4.00
	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	4. 01
	New Teaching program adjustment. (see instructions)	0. 00	5.00
	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0. 00	
	teaching program" (see instuctions)		
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
	Average Daily Census (see instructions)	8. 043836	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	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1, 068, 250	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)	1, 068, 250	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	1, 068, 250	18.00
19. 00	Deducti bl es	58, 960	19.00
20.00	Subtotal (line 18 minus line 19)	1, 009, 290	20.00
21.00	Coi nsurance	39, 530	21.00
22.00	Subtotal (line 20 minus line 21)	969, 760	22.00
23. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	51, 973	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	33, 782	24.00
25. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	-6, 911	25.00
26. 00	Subtotal (sum of lines 22 and 24)	1, 003, 542	26.00
27. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28. 00	Other pass through costs (see instructions)	909	28.00
29. 00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
	Pioneer ACO demonstration payment adjustment (see instructions)	0	30. 50
	Demonstration payment adjustment amount before sequestration	0	
	Total amount payable to the provider (see instructions)	1, 004, 451	
31. 01	Sequestration adjustment (see instructions)	20, 089	
	Demonstration payment adjustment amount after sequestration	0	
32.00	Interim payments	950, 365	
1	Tentative settlement (for contractor use only)	0	
4	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	33, 997	
	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
1	Original outlier amount from Worksheet E-3, Part II, line 2		50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52. 00	The rate used to calculate the Time Value of Money	0.00	
53. 00	Time Value of Money (see instructions)	0	53.00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0002 Component CCN: 15-T002	Peri od: From 01/01/2018 To 12/31/2018		pared:
	Title XVIII	Subprovi der - I RF	PPS	о рііі
			1. 00	

	IRF		
	DART LLL MEDIANE DATE A SERVICE DES	1. 00	
4 00	PART III - MEDICARE PART A SERVICES - IRF PPS	/ 570 005	1 00
1. 00 2. 00	Net Federal PPS Payment (see instructions)	6, 573, 025	1. 00 2. 00
3. 00	Medicare SSI ratio (IRF PPS only) (see instructions) Inpatient Rehabilitation LIP Payments (see instructions)	0. 1005 426, 589	3.00
4. 00	Outlier Payments	337, 150	4.00
5. 00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior	·	5. 00
3.00	to November 15, 2004 (see instructions)	0.00	3.00
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by 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	0. 00	7. 00
0.00	teaching program" (see instructions)	0.00	0.00
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		23. 693151	10.00
11. 00	, , , , , , , , , , , , , , , , , , ,	0. 000000	11. 00
12.00		0	12.00
13.00		7, 336, 764	13.00
14.00		0	14.00
15.00		0	15.00
16. 00 17. 00		- 1	16.00
18.00	·	7, 336, 764 0	17. 00 18. 00
19. 00		7, 336, 764	19.00
20.00	, ,	21, 416	
21. 00		7, 315, 348	
22. 00	, ,	53, 265	
23. 00		7, 262, 083	
24. 00		34, 379	24.00
25. 00		22, 346	25. 00
26. 00	· · · · · · · · · · · · · · · · · · ·	25, 745	
27. 00	,	7, 284, 429	27. 00
28. 00		7, 204, 427	28. 00
29. 00		Ö	29.00
30.00		Ö	30.00
31. 00		0	31.00
31. 50		0	31. 50
31. 99		0	31. 99
32. 00		7, 284, 429	
32. 01		145, 689	
32. 02		0	32. 02
33. 00		7, 128, 095	
34.00		0	34.00
35. 00	,	10, 645	35.00
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	36. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	337, 150	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0. 00	52.00
53. 00	Time Value of Money (see instructions)	0	53.00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0002		Worksheet E-3 Part VII Date/Time Prepared: 5/28/2019 4:50 pm

		1	0 12/31/2018	Date/lime Pre 5/28/2019 4:5	
		Title XIX	Hospi tal	Cost	Орш
		THE STATE	Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	VICES FOR TITLES V OR XI		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	VIOLO I OK TITLES V OK XI	X OLIVI OLO		
1. 00	Inpati ent hospi tal /SNF/NF servi ces		4, 659, 190		1.00
2. 00	Medical and other services		1,007,170	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, 659, 190	0	4.00
5. 00	Inpatient primary payer payments		4, 037, 170	O	5.00
6. 00	Outpatient primary payer payments		٩	0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		4, 659, 190	0	7.00
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		4, 037, 170		7.00
	Reasonable Charges				
8. 00	Routi ne servi ce charges		3, 494, 716		8.00
9. 00	Ancillary service charges		13, 797, 704	0	
	Organ acquisition charges, net of revenue		13, 777, 704	U	10.00
	Incentive from target amount computation				11.00
	Total reasonable charges (sum of lines 8 through 11)		17, 292, 420	0	
12.00	CUSTOMARY CHARGES		17, 272, 420	0	12.00
13. 00	Amount actually collected from patients liable for payment for	services on a charge	O	0	13.00
13.00	basis	services on a charge	٩	U	13.00
14. 00	Amounts that would have been realized from patients liable for	navment for services on	0	0	14.00
14.00	a charge basis had such payment been made in accordance with 4		l	O	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	2 611 3415. 15(6)	0. 000000	0.000000	15.00
16. 00	Total customary charges (see instructions)		17, 292, 420	0.000000	16.00
17. 00	Excess of customary charges over reasonable cost (complete only	v if line 16 exceeds	12, 633, 230	0	17.00
17.00	line 4) (see instructions)	y II IIIIe Ie execcus	12, 000, 200	O	17.00
18.00	Excess of reasonable cost over customary charges (complete only	vifline 4 exceeds line	0	0	18.00
10.00	16) (see instructions)	ye . eneccuee		Ü	10.00
19.00	Interns and Residents (see instructions)		0	0	19.00
	Cost of physicians' services in a teaching hospital (see instr	uctions)	o	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		4, 659, 190	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be				
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		o	0	23. 00
	Program capital payments		o		24.00
	Capital exception payments (see instructions)		o		25. 00
	Routine and Ancillary service other pass through costs		o	0	26.00
	Subtotal (sum of lines 22 through 26)		o	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
	Titles V or XIX (sum of lines 21 and 27)		4, 659, 190	0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		.,,		
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, 659, 190	0	31.00
	Deducti bl es		0	0	32.00
33. 00	Coinsurance		0	0	33.00
	Allowable bad debts (see instructions)		o	0	34.00
35. 00	Utilization review			Ü	35.00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	4, 659, 190	0	36.00
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,	0	0	37.00
	Subtotal (line 36 ± line 37)		4, 659, 190	0	38.00
	Direct graduate medical education payments (from Wkst. E-4)		n ., 557, 176	O	39.00
			4, 659, 190	0	40.00
41. 00	Interim payments		5, 754, 642	0	
42. 00	Balance due provider/program (line 40 minus line 41)		-1, 095, 452	0	42.00
43. 00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub 15-2	0	0	43.00
	chapter 1, §115.2			O	10.00
	1 · · P · · · · · · · · · · · · · · · ·		' '		1

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0002	Peri od: From 01/01/2018	Worksheet E-3
	Component CCN: 15-S002		
	Title XIX	Subprovi der -	Cost
		I PF	

		II tie xix	I PF	COST	
			Inpatient	Outpati ent	
			1, 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES	S FOR TITLES V OR XI		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	S TOR TITLES V OR XI	X SERVICES		
1.00	Inpatient hospital/SNF/NF services		43, 813		1.00
2. 00	Medical and other services		43, 013	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)		43, 813	0	4.00
5. 00	Inpatient primary payer payments		10, 010	O	5.00
6. 00	Outpatient primary payer payments			0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		43, 813	0	7.00
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		10,010		7.00
	Reasonable Charges				
8. 00	Routine service charges		185, 774		8. 00
9. 00	Ancillary service charges		123, 017	0	9. 00
10.00	Organ acquisition charges, net of revenue		0	Ü	10.00
11. 00	Incentive from target amount computation		o		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		308, 791	0	
	CUSTOMARY CHARGES			-	
13.00	Amount actually collected from patients liable for payment for serv	vices on a charge	0	0	13.00
	basis	3.			
14.00	Amounts that would have been realized from patients liable for payr	ment for services on	o	0	14.00
	a charge basis had such payment been made in accordance with 42 CFF	R §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	- ()	0.000000	0.000000	15. 00
16.00	Total customary charges (see instructions)		308, 791	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if	line 16 exceeds	264, 978	0	17.00
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete only if	line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instruction	ons)	0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		43, 813	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be compl	eted 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)		43, 813	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				20.00
	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles		43, 813	0	31.00 32.00
32.00			0	-	
33. 00 34. 00	Coinsurance		0	0	33. 00 34. 00
35.00	Allowable bad debts (see instructions) Utilization review		0	Ü	35.00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		43, 813	0	36.00
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		43, 613	0	37.00
38.00	Subtotal (line 36 ± line 37)		43, 813	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		43,013	U	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		43, 813	0	40.00
41. 00	Interim payments		102, 760	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-58, 947	0	42.00
43. 00	Protested amounts (nonallowable cost report items) in accordance wi	th CMS Pub 15-2	-30, 747	0	43.00
10.00	chapter 1, §115. 2	ONIO 1 GD 10 Z,		O	15.00
	10.0000		1		1

Health Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Peri od: From 01/01/2018	Worksheet E-3
	Component CCN: 15-T002		
	Ti tle XIX	Subprovi der -	Cost
		I RF	

		litle XIX	Subprovi der -	Cost	
			I RF	0 1	
			Inpati ent	Outpati ent	
	DART VILL CALCULATION OF RELABURCEMENT. ALL OTHER HEALTH CER	WHOSE SOR TITLES WAR VI	1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XI	X SERVICES		
1 00	COMPUTATION OF NET COST OF COVERED SERVICES		150 507		1 00
1.00	Inpati ent hospi tal /SNF/NF servi ces		159, 587	0	1.00
2. 00 3. 00	Medical and other services		0	0	2. 00 3. 00
4. 00	Organ acquisition (certified transplant centers only) Subtotal (sum of lines 1, 2 and 3)		159, 587	0	4. 00
5. 00	Inpatient primary payer payments		159, 567	U	5.00
6. 00	Outpatient primary payer payments		١	0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		159, 587	0	7. 00
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		137, 307	0	7.00
	Reasonable Charges				
8. 00	Routine service charges		104, 710		8. 00
9. 00	Ancillary service charges		261, 292	0	9. 00
10.00	Organ acquisition charges, net of revenue		0	J.	10.00
11. 00	Incentive from target amount computation		o		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		366, 002	0	12.00
	CUSTOMARY CHARGES			-	
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
	basis	ű			
14.00	Amounts that would have been realized from patients liable for	payment for services on	o o	0	14.00
	a charge basis had such payment been made in accordance with	12 CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		366, 002	0	16.00
17.00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	206, 415	0	17.00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instr		0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		159, 587	0	21. 00
22 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provid		0	22.00
	Other than outlier payments Outlier payments		0	0	22. 00 23. 00
23.00	Program capital payments		0	U	24.00
25. 00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		o	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		159, 587	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		101,7001	-	
30.00			0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	ı	159, 587	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)		o	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1 33)	159, 587	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		159, 587	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)		159, 587	0	40.00
41. 00	Interim payments		121, 800	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		37, 787	0	42.00
43. 00	Protested amounts (nonallowable cost report items) in accordar	nce with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2		1		

TRECT	Financial Systems METHODIST HOSPI GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	TALS, INC Provider C	CN: 15-0002	Peri od:	u of Form CMS-2 Worksheet E-4	
	L EDUCATION COSTS			From 01/01/2018 To 12/31/2018	Date/Time Pre	pare
		T: +1 o	· XVIII	Hooni tal	5/28/2019 4: 5 PPS	0 pm
		IIIIe	: 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. 83	1.
	ending on or before December 31, 1996.	. 0	·			
00	Unweighted FTE resident cap add-on for new programs per 42 Cl Amount of reduction to Direct GME cap under section 422 of MI		(1) (see inst	ructions)	0. 00 0. 00	2. 3.
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	3.
00	Adjustment (plus or minus) to the FTE cap for allopathic and GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f		programs due	to a Medicare	0. 00	4.
01	ACA Section 5503 increase to the Direct GME FTE Cap (see instandling 7/1/2011)		r cost report	ing periods	0. 00	4.
02	ACA Section 5506 number of additional direct GME FTE cap sloperiods straddling 7/1/2011)	ts (see ins	tructions for	cost reporting	0. 00	4.
00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl 4.02 plus applicable subscripts	lus or minus	line 4 plus	lines 4.01 and	10. 83	5.
00	Unweighted resident FTE count for allopathic and osteopathic records (see instructions)	programs for	r the current	year from your	3. 00	6.
00	Enter the lesser of line 5 or line 6				3. 00	7.
			Primary Care		Total	
00	Weighted FTE count for physicians in an allopathic and osteo	pathi c	1.00	2.00	3. 00 2. 50	8.
00	program for the current year. If line 6 is less than 5 enter the amount from line 8, other	wi se	0. (2. 50	2. 50	9
	multiply line 8 times the result of line 5 divided by the amo					
. 00	Weighted dental and podiatric resident FTE count for the curi			0.00		10
. 01 . 00	Unweighted dental and podiatric resident FTE count for the count weighted FTE count	urrent year	0. (0. 00 2. 50		10
. 00	Total weighted resident FTE count for the prior cost reporti	ng year (see				12
. 00	<pre>instructions) Total weighted resident FTE count for the penultimate cost re year (see instructions)</pre>	eporti ng	0.0	2. 53		13
. 00	Rolling average FTE count (sum of lines 11 through 13 divide	d by 3).	0. 0	2. 49		14
. 00	Adjustment for residents in initial years of new programs	,	0.0			15
. 01	Unweighted adjustment for residents in initial years of new		0. (15
. 00 . 01	Adjustment for residents displaced by program or hospital cloudly under the displaced by program or l		0. 0 0. 0			16 16
. 00	closure Adjusted rolling average FTE count		0. (2. 49		17
. 00	Per resident amount		0.0		040 004	18
. 00	Approved amount for resident costs			0 212, 906	212, 906	19
-00	TALES OF THE PARTY	ETE			1.00	00
	Additional unweighted allopathic and osteopathic direct GME Sec. 413.79(c)(4)		cap siots re	cerved under 42	0. 00	
. 00	Direct GME FTE unweighted resident count over cap (see instru Allowable additional direct GME FTE Resident Count (see instr	,			0. 00 0. 00	
. 00	Enter the locality adjustment national average per resident a		instructions)		0.00	
00	Multiply line 22 time line 23				0	24
00	Total direct GME amount (sum of lines 19 and 24)				212, 906	25
			Inpatient Part A	Managed care		
			1.00	2.00	3. 00	
. 00	COMPUTATION OF PROGRAM PATIENT LOAD Inpatient Days (see instructions)		36, 76	16, 107		26
. 00	Total Inpatient Days (see instructions)		93, 63			27
. 00	Ratio of inpatient days to total inpatient days		0. 39270			28
. 00	Program di rect GME amount		83, 60			29
	Reduction for direct GME payments for Medicare Advantage			5, 175		30
. 00	Net Program direct GME amount				115, 058	31

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT Provider CCN: 15-0002 Period: From 01/01/2018 Date/Time Prepared: 5/28/2019 4: 50 pm Date/Time Prepared: 5/28/2019 4: 50 pm Date/Time Prepared: 5/28/2019 4: 50 pm DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS) 32.00 Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 0 32.00 and 94) 33.00 Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) 8, 939, 534 33.00 and 94) 33.00 Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) 8, 939, 534 33.00 and 94 9, 90	Heal th	Financial Systems METHODIST HOSPIT	TALS, INC	In Lie	u of Form CMS-2	2552-10	
To 12/31/2018 Date/Time Prepared: 5/28/2019 4:50 pm			Provider CCN: 15-0002		Worksheet E-4		
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS) 23.00 Renal dial ysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 0 32.00 and 94) 33.00 Renal dial ysis and home dial ysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) 8, 939, 534 33.00 34.00 Ratio of direct medical education costs to total charges (line 32 + line 33) 0.000000 34.00 35.00 Medicare outpatient ESRD charges (see instructions) 0 35.00 Medicare outpatient ESRD direct medical education costs (line 34 x line 35) 0 36.00 Medicare outpatient ESRD direct medical education costs (line 34 x line 35) 0 36.00 APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY Part A Reasonable Cost (see instructions) 0 38.00 0 0 0 0 0 0 0 0 0	MEDI CA	To 12/31/2018 [
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49.00 Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions) 86,297 49.00	48. 00				115, 058	48. 00	
			(see instructions)		·	1	
					·	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

Peri od: From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/28/2019 4:50 pm

Cubbball ASSETS	——————————————————————————————————————					5/28/2019 4:5	O pm
CURRENT ASSETS Cash on hand in banks 28, 184, 400 0 0 0 0 0 0 0 0 0			General Fund	Speci fi c		Plant Fund	
Display ASSETS			1 00			4.00	
Cash on hand in benks		CURRENT ASSETS	1.00	2.00	3.00	4.00	
2.00 Temporary investments	1. 00		28, 184, 406	0	0	0	1.00
Notes receivable					0		
Other receivable	3.00		0		0	0	3.00
A	4.00	Accounts receivable	46, 562, 847	0	0	0	4.00
1.00 Inventorry 12,465,746 0 0 0 0 0 0 0 0 0	5.00	Other receivable	0	0	0	0	5. 00
8.00 Prepail of expenses				0	0	-	
0.00 Other current assets 17,066,974 0 0 0 0 0 0 0 10.00 0 10.00 0 10.00 0 10.00 0 10.00 0 10.00 11.00 1				0	0		1
10.00 Due from other Funds				0	0	_	
11.00 Total current assets (sum of lines 1-10) 109,861,647 0 0 11.00			17, 065, 974	1	0		
FIXED ASSETS			100 961 647	-	0		
12.00 Land Improvements	11.00		109, 001, 047	<u> </u>		0	11.00
13.00 Land Improvements	12 00		5 373 674	0	0	0	12 00
14.00 Accumulated depreciation -347,944,732 0 0 14.00						-	
16.00 Accumul ated depreciation 0 0 0 0 10.00	14.00				0	0	14. 00
17.00 Leasehold Improvements	15.00	Bui I di ngs	267, 945, 909	0	0	0	15.00
18.00 Accumul ated depreciation 0 0 0 18.00 0 0 19.0	16.00	Accumulated depreciation	0	0	0	0	16. 00
19.00 Fixed equipment		•	2, 584, 534		0	-	1
20. 00 Accumulated depreciation 0 0 0 0 0 20.00		•	0	-	0	_	1
21.00 Automobiles and trucks			0		0	0	
22.00 Accumul ated depreciation 0 0 0 22.00		•	0	-	0	0	
23.00 Major movable equipment 203,218,657 0 0 22.00			0	-	0		1
Accumulated depreciation		•	202 210 657	0	0	_	1
25.00 Minor equipment depreciable 0 0 0 0 25.00			203, 210, 037		0	-	1
Accumulated depreciation		· •		-	0	_	
27.00 HT designated Assets 0 0 0 0 27.00 28.00 Accumulated depreciation 0 0 0 28.00 29.00 Minor equipment-nondepreciable 0 0 0 0 28.00 30.00 Other Control Fixed assets (sum of lines 12-29) 137,886,581 0 0 0 0 29.00 31.00 Other Assets 0 0 0 0 0 0 0 31.00 Other Assets 0 0 0 0 0 0 0 0 32.00 Opensits on leases 0 0 0 0 0 0 0 0 33.00 Due from owners/officers 0 0 0 0 0 0 0 0 33.00 Total other assets (sum of lines 31-34) 112,040,119 0 0 0 0 0 0 0 35.00 Total other assets (sum of lines 11, 30, and 35) 359,788,347 0 0 0 0 0 0 0 0 36.00 Total assets (sum of lines 11, 30, and 35) 359,788,347 0 0 0 0 0 0 0 36.00 Other assets 0 0 0 0 0 0 0 0 0 37.00 Accounts payable 0 0 0 0 0 0 0 0 0 40.00 Notes and Loans payable (short term) 2,552,245 0 0 0 0 0 0 0 40.00 Accelerated payments 0 0 0 0 0 0 0 40.00 Other current liabilities 0 0 0 0 0 0 0 40.00 Other Current liabilities 0 0 0 0 0 0 0 40.00 Other Current liabilities 0 0 0 0 0 0 40.00 Other Current liabilities 0 0 0 0 0 0 40.00 Other Courrent liabilities 0 0 0 0 0 0 40.00 Other Courrent liabilities 0 0 0 0 0 0 40.00 Other Courrent liabilities 0 0 0 0 0 0 40.00 Other Courrent liabilities 0 0 0 0 0 0 40.00 Other Courrent liabilities 0 0 0 0 0 0 40.00 Other Courrent liabilities 0 0 0 0 0 0 40.00 Other Courrent liabilities 0 0 0 0 0 0 0 40.00 Other Courrent liabilities 0 0 0 0 0 0 0 40.00 Other Courrent liabilities 0 0 0 0 0 0 0 0 40.00 Other Courrent liabilities 0 0 0 0 0 0 0 0 40.00 Other Courrent liabilities 0				-	0	_	
28. 00 Accumula fed depreciation 0 0 0 0 28. 00 0 0 29. 00 0 0 0 29. 00 0 0 0 0 29. 00 0 0 0 29. 00 0 0 0 0 29. 00 0 0 0 0 0 0 0 0 0			l o	-	0		1
Total fixed assets (sum of lines 12-29) 137, 886,581 0 0 0 30.00			0	0	0	0	
OTHER ASSETS	29.00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29. 00
31.00	30.00	Total fixed assets (sum of lines 12-29)	137, 886, 581	0	0	0	30.00
32.00 Deposits on leases 0 0 0 0 32.00							
33.00 Due from owners/officers 0 0 0 0 0 33.00			112, 040, 119		0	_	
34.00 Other assets O O O O O O O O O O O O O O O O O O			0	-	0		1
35.00 Total other assets (sum of lines 31-34) 112,040,119 0 0 0 35.00			0	1	0	_	
36.00 Total assets (sum of lines 11, 30, and 35) 359,788,347 0 0 0 36.00			112 040 110		0	-	1
CURRENT LIABILITIES					0	_	1
37.00 Accounts payable	00.00		007,700,017	<u> </u>			00.00
38.00 Salaries, wages, and fees payable 0 0 0 0 38.00 39.00 Payroll taxes payable 0 0 0 0 0 39.00 40.00 Notes and loans payable (short term) 2,552,245 0 0 0 0 40.00 41.00 Deferred income 0 0 0 0 0 41.00 42.00 Accelerated payments 0 0 0 0 0 41.00 43.00 Due to other funds 0 0 0 0 0 43.00 44.00 Other current liabilities 20,696,804 0 0 0 44.00 45.00 Dong TERM LIABILITIES 20,696,804 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	37.00		16, 448, 040	0	0	0	37. 00
40. 00 Notes and Loans payable (short term) 40. 00 Deferred income 40. 00 Deferred income 40. 00 O			0		0	0	38. 00
41.00 Deferred income			0	0	0	0	39. 00
42.00 Accelerated payments 0 0 0 0 0 42.00 43.00 Due to other funds 0 0 0 0 0 0 43.00 Other current liabilities 20,696,804 0 0 0 0 45.00 Total current liabilities (sum of lines 37 thru 44) 39,697,089 0 0 0 0 LONG TERM LIABILITIES 0 0 0 0 0 0 46.00 Mortgage payable 0 0 0 0 0 0 0 47.00 Notes payable 58,689,196 0 0 0 0 0 48.00 49.00 Unsecured loans 0 0 0 0 0 0 48.00 49.00 Other long term liabilities (sum of lines 46 thru 49) 71,829,436 0 0 0 0 0 50.00 Total long term liabilities (sum of lines 46 thru 49) 71,829,436 0 0 0 0 51.00 Total listies (sum of lines 45 and 50) 111,526,525 0 0 0 52.00 General fund balance 248,261,822 52.00 53.00 Specific purpose fund 54.00 55.00 Donor created - endowment fund balance - unrestricted 0 55.00 56.00 Overning body created - endowment fund balance 0 55.00 57.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 0 0 0 0 59.00 Total liabilities and fund balances (sum of lines 51 and 359,788,347 0 0 0 0 0 59.00 Total liabilities and fund balances (sum of lines 51 and 359,788,347 0 0 0 0 0 50.00 Total liabilities and fund balances (sum of lines 51 and 359,788,347 0 0 0 0 0 0 50.00 Total liabilities and fund balances (sum of lines 51 and 359,788,347 0 0 0 0 0 0 50.00 Total liabilities and fund balances (sum of lines 51 and 359,788,347 0 0 0 0 0 0 0 50.00 Total liabilities and fund balances (sum of lines 51 and 359,788,347 0 0 0 0 0 0 0	40.00	Notes and Loans payable (short term)	2, 552, 245	0	0	0	40.00
43.00 Due to other funds			0	0	0	0	
44.00 Other current liabilities			0				1
45. 00 Total current liabilities (sum of lines 37 thru 44) 39, 697, 089 0 0 0 0 45. 00			0		0		
LONG TERM LIABILITIES					-	-	
Mortgage payable 0 0 0 0 0 0 0 0 0	45.00		39, 697, 089	0	0	0	45.00
47. 00 Notes payable	44 00					0	14 00
48.00 Unsecured Loans 49.00 Other Long term Liabilities 50.00 Total long term Liabilities (sum of Lines 46 thru 49) 50.00 Total liabilities (sum of Lines 46 thru 49) 50.00 Total Liabilities (sum of Lines 45 and 50) 51.00 CAPITAL ACCOUNTS 52.00 General fund balance 52.00 Specific purpose fund 53.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 55.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total Liabilities and fund balances (sum of Lines 51 and 359,788,347) 50 Unsecured Loans 13,140,240 0 Unsecured Unserved			59 690 106				
49.00 Other long term liabilities 13,140,240 0 0 0 49.00 50.00 Total long term liabilities (sum of lines 46 thru 49) 71,829,436 0 0 0 50.00 51.00 Total liabilities (sum of lines 45 and 50) 111,526,525 0 0 0 51.00 CAPITAL ACCOUNTS 248,261,822 52.00 Specific purpose fund 0 52.00 53.00 Specific purpose fund 0 53.00 54.00 Donor created - endowment fund balance - restricted 0 54,00 55.00 Governing body created - endowment fund balance 0 55.00 56.00 Plant fund balance - invested in plant 0 0 55.00 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0<			30,007,170		-	-	
Total long term liabilities (sum of lines 46 thru 49) 71,829,436 0 0 0 50.00			13, 140, 240		-		1
Total liabilities (sum of lines 45 and 50)						-	
CAPITAL ACCOUNTS General fund balance 248, 261, 822 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 Governing body created - endowment fund balance 0 56.00 57.00 Plant fund balance - invested in plant 0 57.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 248, 261, 822 0 0 0 0 59.00 0 0 0 0 0 0 0 0 0							
53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 359,788,347) 52.00 Specific purpose fund 53.00 54.00 55.00 55.00 56.00 56.00 57.00 58.00 59.00 60.00				<u>'</u>			
54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 359,788,347) 59.00 Total liabilities and fund balances (sum of lines 51 and 359,788,347)	52.00	General fund balance	248, 261, 822				52.00
55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 359,788,347) 255.00 56.00 56.00 56.00 57.00 58.00 60.00	53.00	Specific purpose fund		0			53.00
56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 359,788,347) 56.00 57.00 57.00 58.00 58.00 59.00 0 0 0 59.00 0 0 60.00					0		
57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 359,788,347) 0 0 0 60.00					0		
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 359,788,347) 0 58.00 0 0 0 59.00 0 0 60.00		1 9 9			0	_	
replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 359,788,347) 0 0 59.00 0 0 60.00		· '				-	
59.00 Total fund balances (sum of lines 52 thru 58) 248, 261, 822 0 0 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 0.00 359, 788, 347 0 0 0 60.00	58.00					0	58.00
60.00 Total liabilities and fund balances (sum of lines 51 and 359,788,347 0 0 60.00	50 00		2/10 2/1 022		0	_	50 00
		l · · · · · · · · · · · · · · · · · · ·				-	1
	55.00		337,730,347		0		55.55
			1	. '		•	•

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

					From 01/01/2018 To 12/31/2018		
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00 2. 00 3. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		248, 080, 028 181, 794 248, 261, 822		0		1. 00 2. 00 3. 00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Additions (credit adjustments) (specify)	0 0 0 0 0			0 0 0 0 0	0 0 0 0 0	6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0 0 0 0	0 248, 261, 822		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 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)		0 248, 261, 822		0		18. 00 19. 00
		Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8. 00			
1. 00 2. 00 3. 00 4. 00 5. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0	0.00	0		1. 00 2. 00 3. 00 4. 00 5. 00
6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0		5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00
17. 00 18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	0		0		17. 00 18. 00 19. 00

Health Financial Systems NSTATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 15-0002

		To	12/31/2018	Date/Time Prep 5/28/2019 4:50	
	Cost Center Description	Inpati ent	Outpati ent	Total	O piii
		1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES			2. 22	
	General Inpatient Routine Services				
1.00	Hospi tal	75, 388, 157		75, 388, 157	1.00
2.00	SUBPROVI DER - I PF	4, 603, 945		4, 603, 945	2.00
3.00	SUBPROVI DER - I RF	7, 610, 408		7, 610, 408	3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	87, 602, 510		87, 602, 510	10.00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT	23, 483, 473		23, 483, 473	
11. 01	NEONATAL I CU	0		0	11. 01
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGI CAL INTENSI VE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)	00 400 470		00 400 470	15.00
16. 00	Total intensive care type inpatient hospital services (sum of lines	23, 483, 473		23, 483, 473	16. 00
17 00	11-15)	111 005 003		111 005 003	17 00
17. 00 18. 00	Total inpatient routine care services (sum of lines 10 and 16) Ancillary services	111, 085, 983	E24 100 0E0	111, 085, 983 1, 032, 533, 317	17. 00 18. 00
19.00	Outpatient services	506, 352, 367 23, 633, 841	101, 687, 669	125, 321, 510	
20.00	RURAL HEALTH CLINIC	23, 633, 641	101, 667, 669	125, 321, 510	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21.00
22. 00	HOME HEALTH AGENCY		3, 831, 746	3, 831, 746	22.00
23. 00	AMBULANCE SERVICES		3, 031, 740	3, 031, 740	23. 00
24.00	CMHC				24.00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPICE				26. 00
27. 00	PRO FEES	549, 632	56, 099, 888	56, 649, 520	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	641, 621, 823		1, 329, 422, 076	
20.00	G-3, line 1)	011/021/020	007, 000, 200	., 02., 122, 0.0	20.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		349, 658, 717		29. 00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38. 00		0			38. 00
39. 00		0			39. 00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		349, 658, 717		43.00
	to Wkst. G-3, line 4)	1			

		DDIST HOSPITALS, INC	_	u of Form CMS-2	
STATEMENT OF REVENUES AND EXPENSES		Provi der CCN: 15-0002	Peri od:	Worksheet G-3	1
			From 01/01/2018 To 12/31/2018	Date/Time Pre	nared.
			10 12/31/2010	5/28/2019 4:5	
	<u> </u>				
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)			1, 329, 422, 076	1.00
2.00	Less contractual allowances and discounts on patie	nts' accounts		989, 134, 467	
3.00	Net patient revenues (line 1 minus line 2)			340, 287, 609	3.00
4.00	Less total operating expenses (from Wkst. G-2, Par	t II, line 43)		349, 658, 717	4.00
5.00	Net income from service to patients (line 3 minus	line 4)		-9, 371, 108	5.00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	
7.00	Income from investments			3, 504, 946	7.00
8.00	Revenues from telephone and other miscellaneous co	mmunication services		0	
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			-103	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	
	1 · · · · · · · · · · · · · · · · · · ·			0	
14.00	Revenue from meals sold to employees and guests			0	14.00
	Revenue from rental of living quarters			0	15.00
	Revenue from sale of medical and surgical supplies	to other than patients		0	16.00
	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			0	18.00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and can	teen		0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	OTHER I NCOME			5, 231, 653	24.00
24.01	NON OPERATING INCOME			35, 000	24. 01
24. 02	CHANGE IN UNREALIZED GAIN/LOSS			-12, 951, 589	24. 02
24.03	REALIZED GAIN/LOSS ON INVESTMENT SAL			13, 852, 558	24.03
24.04	GAIN/LOSS ON ASSET DISPOSAL			94, 712	24.04
24.05	OTHER (SPECIFY)			0	24. 05
24.06	OTHER (SPECIFY)			0	24.06
25 00	Total other income (our of lines (24)			0 7/7 177	1 25 00

9, 767, 177 25. 00 396, 069 26. 00 214, 275 27. 00 214, 275 28. 00 181, 794 29. 00

24.06 UTHER (SPECIFY)
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)

	Financial Systems LLLOCATION - HHA GENERAL SERVICE	COST	METHODIST HOSE	PITALS, INC Provider C	CN: 15 0002	In L	eu of Form CMS- Worksheet H-	
COST A	ALLOCATION - HHA GENERAL SERVICE	<u> </u>				From 01/01/20	8 Part I	
				HHA CCN:	15-7536	To 12/31/20	5/28/2019 4:5	
						Home Health Agency I	PPS	
			Capital Rel	ated Costs		Agency		
		Net Expenses	BI dgs &	Movabl e	PI ant	Transportati	o Subtotal	+
		for Cost	Fixtures	Equi pment	Operation	& n	(col s. 0-4)	
		Allocation (from Wkst.			Maintenanc	e		
		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					1.00
2.00	Fixtures			0				2 00
2. 00	Capital Related - Movable Equipment	0		0				2.00
3.00	Plant Operation & Maintenance	0	0	0	1	0		
4. 00 5. 00	Transportation Administrative and General	0 842, 796	0	0	•	0	0 0 842, 796	4.00
3.00	HHA REIMBURSABLE SERVICES	042,770	J			O _I	0 042,770	3.00
6.00	Skilled Nursing Care	1, 006, 702	l l	0	•	0	0 1, 006, 702	1
7. 00 8. 00	Physical Therapy Occupational Therapy	477, 840 110, 407	0	0	•	0	0 477, 840 0 110, 407	1
9.00	Speech Pathology	44, 952	O	0		0	0 44, 952	1
10. 00 11. 00	Medical Social Services Home Health Aide	4, 361 84, 204	0	0		0	0 4, 36° 0 84, 204	1
12.00	Supplies (see instructions)	0	0	0	•	0	0 0	12.00
13. 00 14. 00	Drugs DME	0 0	- 1	0		0	0	
14.00	HHA NONREI MBURSABLE SERVI CES	0	0			O _I		14.00
	Home Dialysis Aide Services	0		0	•	0	0 (
16. 00 17. 00	Respiratory Therapy Private Duty Nursing	0	0	0	•	0		
18. 00	Clinic	Ö	Ö	0		0	0	1
19. 00 20. 00	Health Promotion Activities Day Care Program	0	0	0		0		
21. 00	Home Delivered Meals Program	0	0	0		0	0	
	Homemaker Service	0	0	0		0	0 (
	All Others (specify) Telemedicine	0	0	0	1	0	0 0	
	Total (sum of lines 1-23)	2, 571, 262	0	0	1	0	0 2, 571, 262	1
		Administrativ e & General	Total (cols. 4A + 5)					
		5. 00	6.00					
1 00	GENERAL SERVICE COST CENTERS	ı						1 00
1. 00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable							2.00
3. 00	Equipment Plant Operation & Maintenance							3.00
4.00	Transportati on							4.00
5. 00	Administrative and General HHA REIMBURSABLE SERVICES	842, 796						5.00
6. 00	Skilled Nursing Care	490, 865						6.00
7. 00 8. 00	Physical Therapy Occupational Therapy	232, 994 53, 834						7. 00 8. 00
9. 00	Speech Pathology	21, 919						9.00
10.00	Medical Social Services	2, 126	6, 487					10.00
11. 00 12. 00	Home Health Aide Supplies (see instructions)	41, 058 0						11.00
13.00	Drugs	0	0					13.00
14. 00	DME HHA NONREI MBURSABLE SERVI CES	0	0					14.00
15. 00	Home Dialysis Aide Services	0	0					15. 00
16.00	Respi ratory Therapy	0						16.00
	Private Duty Nursing Clinic	0	- 1					17. 00 18. 00
19.00	Health Promotion Activities	Ö	0					19.00
	Day Care Program Home Delivered Meals Program	0	0					20.00
	Homemaker Service	0						21. 00 22. 00
23. 00	All Others (specify)	0	О					23. 00
		0						23. 50 24. 00
	Telemedicine Total (sum of lines 1-23)	0	0 2, 571, 262					

Heal th	Financial Systems		METHODIST HOS	SPITALS INC		In lie	u of Form CMS-2	2552-10
	ALLOCATION - HHA STATISTICAL BAS	SIS			CN: 15-0002	Peri od:	Worksheet H-1	
				HHA CCN:	15-7536	From 01/01/2018 To 12/31/2018	Part II Date/Time Pre 5/28/2019 4:5	pared:
						Home Health	PPS	<u> </u>
						Agency I		
		Capital Rel	ated Costs					
		BI dgs &	Movabl e	PI ant	Transportatio	Reconciliatio	Administrativ	
		Fi xtures	Equi pment	Operation &	n (MI LEAGE)	n	e & General	
		(SQUARE FEET)	(DOLLAR VALUE)	Maintenance (SQUARE FEET)			(ACCUM. COST)	
		1. 00	2. 00	3. 00	4.00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2. 00	0.00	1.00	071.00	0.00	
1.00	Capital Related - Bldg. &	0				0		1.00
2. 00	Fixtures Capital Related - Movable		C			0		2.00
2.00	Equi pment			ή				2.00
3.00	Plant Operation & Maintenance	0	C) c		0		3. 00
4.00	Transportation (see	0	C	C		0		4. 00
	instructions)					0.40 70/	4 700 444	
5. 00	Administrative and General HHA REIMBURSABLE SERVICES	0	C) C		0 -842, 796	1, 728, 466	5.00
6. 00	Skilled Nursing Care	0	C		1	0 0	1, 006, 702	6.00
7. 00	Physical Therapy		C		1	0 0		1
8. 00	Occupational Therapy	l o	C		i	o o	110, 407	1
9.00	Speech Pathology	0	C	ol c		0 0	44, 952	9. 00
10.00	Medical Social Services	0	C) c		0 0	4, 361	10.00
11.00	Home Health Aide	0	C	0		0 0	84, 204	11.00
12.00	Supplies (see instructions)	0	C) C	1	0	0	12.00
13.00	Drugs	0	C	1		0		13. 00
14. 00	DME	0	C) <u> </u>		0 0	0	14.00
45.00	HHA NONREI MBURSABLE SERVI CES							45 00
15.00	Home Dialysis Aide Services	0	C		1	0		
16. 00 17. 00	Respiratory Therapy Private Duty Nursing	0				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					0 0	0	20.00
21. 00	Home Delivered Meals Program		(0 0		21.00
22. 00	Homemaker Service		Č			0 0	0	22. 00
23. 00	All Others (specify)	l o	C			o o	ĺ	23. 00
23. 50	Tel emedi ci ne	l	C			o o	ĺ	23. 50
24.00	Total (sum of lines 1-23)	0	C) c		0 -842, 796	1, 728, 466	24.00
25.00	Cost To Be Allocated (per	0	C) c		0	842, 796	25.00
	Washington at 11 1 David 13	I .		1	1	1	ı	1

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0. 487598 26. 00

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

Home Health

PPS

Agency I CAPI TAL RELATED COSTS DATA ADMITTI NG HHA Trial BLDG & FIXT **EMPLOYEE PURCHASI NG** Cost Center Description Bal ance (1) **BENEFITS** PROCESSI NG RECEIVING AND DEPARTMENT **STORES** 0 1. 00 4.00 5. 01 5. 02 5. 03 1.00 Administrative and General 00 496, 704 0 9, 231 1.00 8, 361 1, 497, 567 2.00 Skilled Nursing Care 2.00 Physical Therapy 710, 834 0 0 3.00 000000000000000000 0 3.00 Occupational Therapy 164, 241 0 0 o 4.00 4.00 0 Speech Pathology 66, 871 0 5.00 0 5.00 0 6.00 Medical Social Services 6, 487 0 0 6.00 7.00 Home Heal th Aide 125, 262 0 0 0 7.00 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 11.00 Respiratory Therapy 0 12 00 12 00 13.00 Private Duty Nursing 0 13.00 14.00 0 14.00 Clinic Health Promotion Activities 0 0 15.00 15.00 0 0 0 Day Care Program 16.00 16.00 Ω 17.00 Home Delivered Meals Program 0 0 0 17.00 Homemaker Service 0 18.00 0 18.00 All Others (specify) 0 0 19 00 0 19 00 C 0 19.50 Tel emedi ci ne 0 0 0 19.50 Total (sum of lines 1-19) (2) 2, 571, 262 496, 704 8, 361 9, 231 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 22, 335 536, 631 50, 083 1.00 2.00 Skilled Nursing Care 0 1, 497, 567 139, 765 0 0 2.00 0 0 0 0 0 0 0 0 0 0 0 0 0 Physical Therapy 3.00 0 710,834 66, 341 0 3 00 0 4.00 Occupational Therapy 164, 241 15, 328 4.00 5.00 Speech Pathology 0 66, 871 6, 241 0 5.00 0 6.00 Medical Social Services 0 6, 487 605 0 6.00 0 7.00 Home Health Aide 125, 262 11, 690 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 C 0 0 19.00 19.50 Tel emedi ci ne 0 19.50 3. 107. 893 20.00 20 00 Total (sum of lines 1-19) (2) 22, 335 290, 053 0 21.00 Unit Cost Multiplier: column 0.000000 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.

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

0 0 0 16.00 Day Care Program 0 16.00 0 Home Delivered Meals Program 0 17.00 0 17.00 0 0 18.00 Homemaker Service C 18.00 19.00 All Others (specify) 0 C 0 0 19.00 0 19.50 Tel emedi ci ne 0 19.50 0 20.00 20 00 Total (sum of lines 1-19) (2) 12, 530 7, 031 0 Unit Cost Multiplier: column 21.00 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.

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Home Health Aide

Respiratory Therapy

Private Duty Nursing

Drugs

Clinic

DMF

Supplies (see instructions)

Home Dialysis Aide Services

Health Promotion Activities

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Provider CCN: 15-0002 Peri od: Worksheet H-2 From 01/01/2018 Part I Date/Time Prepared: 5/28/2019 4:50 pm HHA CCN: 15-7536 12/31/2018 To 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 1.00 Administrative and General 0 616, 236 616, 236 1.00 1, 996, 242 2.00 Skilled Nursing Care 1, 637, 332 1, 637, 332 358, 910 2.00 3.00 Physical Therapy 0 777, 175 777, 175 170, 361 947, 536 3.00 Occupational Therapy 0 179, 569 0 179, 569 39, 362 218, 931 4.00 4.00 0 16, 027 Speech Pathology 73, 112 73, 112 89, 139 5.00 5.00 6.00 Medical Social Services 7, 092 0 7, 092 1, 555 8, 647 6.00 136, 952 136, 952 7.00 Home Health Aide 30, 021 166, 973 7.00 Supplies (see instructions) 0 0 0 8.00 8 00 O 0 0 0 9.00 Drugs 0 9.00 10.00 DME 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 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, 427, 468 3, 427, 468 616, 236 3, 427, 468 20.00 21.00 Unit Cost Multiplier: column 0. 219205 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.

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

Peri od:
From 01/01/2018
To 12/31/2018
Worksheet H-2
Part II
Date/Time Prepared:
5/28/2019 4:50 pm
Home Health
PPS BASIS HHA CCN: 15-7536

						Home Health	PPS	
		CAPI TAL				Agency I		
		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	(MACHI NE	STORES	CHARGES)	RECEI VABLE	
			(GROSS	TIME)	(PURCHASE		(GROSS	
			SALARI ES)		REQUISITIONS)		CHARGES)	
		1. 00	4. 00	5. 01	5. 02	5. 03	5. 04	
1. 00	Administrative and General	0	,	0	,	3, 831, 746	3, 831, 746	1.00
2.00	Skilled Nursing Care	0		0		0	I - 1	2.00
3. 00	Physi cal Therapy	0	0	0		0	0	3. 00
4. 00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6. 00 7. 00	Medical Social Services Home Health Aide	0	0	0	0	0	0 0	6. 00 7. 00
8. 00	Supplies (see instructions)		0	0	_	0	0	8. 00
9. 00	Drugs	0	0	0	_	0		9. 00
10.00	DME	0	o o	0		0		10.00
11. 00	Home Dialysis Aide Services	o o	Ö	0		0	l ol	11. 00
12.00	Respiratory Therapy	0	0	0	0	0	o	12.00
13.00	Private Duty Nursing	0	0	0	0	0	o	13.00
14.00	Clinic	0	0	0	0	0	o	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	16.00
17. 00		0	0	0	_	0	0	17. 00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
	All Others (specify)	0	0	0	0	0	0	19.00
19. 50	Tel emedi ci ne	0	0 000 054	0	0, ,,,	0 004 744	0 004 744	19.50
20. 00 21. 00	Total (sum of lines 1-19) Total cost to be allocated	0	2, 203, 254 496, 704	0	96, 622 8, 361	3, 831, 746 9, 231		20. 00 21. 00
21.00	1	0. 000000		0. 000000		0. 002409	22, 335 0. 005829	21.00
22.00	Cost Center Description	Reconciliatio	OTHER A&G	PATI ENT	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	22.00
	ocot conten becompinen	n	(ACCUM. COST)	TRANSPORTATIO	PLANT	LINEN SERVICE	(SQUARE FEET)	
			,	N	(SQUARE FEET)	(POUNDS OF	,	
				(NUMBER OF	,	LAUNDRY)		
				TRI PS)				
1. 00		5A. 05	5. 05	5. 06	7.00	8. 00	9. 00	
	Administrative and General	0	536, 631	5. 06 0	0	8.00	0	1.00
2.00	Skilled Nursing Care		536, 631 1, 497, 567	5. 06 0 0	0		0	2.00
2. 00 3. 00	Skilled Nursing Care Physical Therapy	0	536, 631 1, 497, 567 710, 834	5. 06 0 0	0 0 0		0 0 0	2. 00 3. 00
2. 00 3. 00 4. 00	Skilled Nursing Care Physical Therapy Occupational Therapy	0	536, 631 1, 497, 567 710, 834 164, 241	5. 06 0 0 0	0 0 0 0		0 0 0 0	2.00 3.00 4.00
2. 00 3. 00 4. 00 5. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	0	536, 631 1, 497, 567 710, 834 164, 241 66, 871	5. 06 0 0 0 0	0 0 0 0		0 0 0 0	2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00 6. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	0	536, 631 1, 497, 567 710, 834 164, 241 66, 871 6, 487	5. 06 0 0 0	0 0 0 0 0		0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	0	536, 631 1, 497, 567 710, 834 164, 241 66, 871	5.06 0 0 0 0 0	0 0 0 0 0 0		0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	0	536, 631 1, 497, 567 710, 834 164, 241 66, 871 6, 487	5. 06 0 0 0 0 0 0	0 0 0 0 0 0		0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	0	536, 631 1, 497, 567 710, 834 164, 241 66, 871 6, 487	5. 06 0 0 0 0 0 0	0 0 0 0 0 0 0		0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	0	536, 631 1, 497, 567 710, 834 164, 241 66, 871 6, 487	5.06 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0		0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	0	536, 631 1, 497, 567 710, 834 164, 241 66, 871 6, 487	5.06 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0		0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	0	536, 631 1, 497, 567 710, 834 164, 241 66, 871 6, 487	5.06 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0		0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	0	536, 631 1, 497, 567 710, 834 164, 241 66, 871 6, 487	5.06 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	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	0	536, 631 1, 497, 567 710, 834 164, 241 66, 871 6, 487	5.06 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	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
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	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	0	536, 631 1, 497, 567 710, 834 164, 241 66, 871 6, 487	5.06 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	2.00 3.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	0	536, 631 1, 497, 567 710, 834 164, 241 66, 871 6, 487	5.06 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	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	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	0	536, 631 1, 497, 567 710, 834 164, 241 66, 871 6, 487	5. 06 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 17.00 18.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	0	536, 631 1, 497, 567 710, 834 164, 241 66, 871 6, 487	5.06 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	0	536, 631 1, 497, 567 710, 834 164, 241 66, 871 125, 262 0 0 0 0 0 0 0 0 0	5. 06 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19)	0	536, 631 1, 497, 567 710, 834 164, 241 66, 871 6, 487 125, 262 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5. 06 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 19.50 20.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	0	536, 631 1, 497, 567 710, 834 164, 241 66, 871 125, 262 0 0 0 0 0 0 0 0 0	5. 06 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00

Peri od: Worksheet H-2
From 01/01/2018 Part II
To 12/31/2018 Date/Time Prepared: 5/28/2019 4:50 pm BASIS HHA CCN: 15-7536

						Home Health Agency I	PPS	<u>5 piii </u>
	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			23, 729	3, 831, 746	1. 00
2. 00	Skilled Nursing Care	Ö	0	Ö		0	0	2. 00
3.00	Physi cal Therapy	o	0	0	0	0	o	3.00
4.00	Occupational Therapy	o	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	9. 00 10. 00
11. 00	Home Dialysis Aide Services		0		0	0	0	11. 00
12. 00	Respiratory Therapy		0	l ő		0	Ö	12. 00
13. 00	Private Duty Nursing	Ö	0	Ö		0	Ö	13.00
14.00	Clinic	О	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) Telemedicine	0	0	0	0	0	0	19.00
19. 50 20. 00	Total (sum of lines 1-19)	0	0	0	0	23, 729	3, 831, 746	19. 50 20. 00
21. 00	Total cost to be allocated		0	0	0	9, 961	12, 530	
22. 00	Unit cost multiplier	0. 000000	0. 000000	1			0. 003270	
					INTERNS &			
	Octob Octob December 1	600141	CTAFF	MEDICAL	CEDVI OEC CALA	CEDVI OEC OTHE	DADAMED ED	
	Cost Center Description	SOCI AL SERVI CE	STAFF EDUCATI ON	MEDI CAL EDUCATI ON	SERVICES-SALA RY & FRINGES	R PRGM COSTS	PARAMED ED PROGRAM	
		(TIME SPENT)	(TIME SPENT)	(ASSI GNED	(ASSI GNED	(ASSI GNED	(ASSI GNED	
		(112 0. 2.11)	(112 0. 2.11)	TIME)	TIME)	TIME)	TIME)	
		17. 00	17. 01	17. 02	21.00	22. 00	23.00	
1.00	Administrative and General	0	1, 128	0		0	0	1.00
2. 00	Skilled Nursing Care	0	0	0		0	0	2.00
3.00	Physi cal Therapy	0	0	0	· ·	0	0	3.00
4.00	Occupational Therapy	0	0	0		0	0	4.00
5. 00 6. 00	Speech Pathology Medical Social Services	0	0	0		0	0	5. 00 6. 00
7. 00	Home Heal th Aide		0	0	0	0	0	7. 00
8. 00	Supplies (see instructions)	Ö	0	Ö	Ö	0	o	8. 00
9.00	Drugs	O	0	0	0	0	o	9.00
10.00	DME	0	0	0	0	0	o	10.00
11. 00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0		0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0		_	0	14. 00 15. 00
15. 00 16. 00	Health Promotion Activities Day Care Program	0	0	0		0	0	16. 00
17. 00	Home Delivered Meals Program		0	0	· ·	0	ő	17. 00
18. 00	Homemaker Service	Ö	0	Ö	Ö	0	o	18. 00
19. 00	All Others (specify)	0	0	Ö	0	o	Ō	19.00
19. 50	Tel emedi ci ne	0	0	0	0	0	0	19. 50
20.00	Total (sum of lines 1-19)	0	1, 128			0	0	20.00
21.00	Total cost to be allocated	0 000000	7, 031			0 000000	0	21.00
22.00	Unit cost multiplier	0. 000000	6. 233156	0. 000000	0. 000000	0. 000000	0. 000000	22.00

Heal th	Financial Systems		METHODIST HOS	SPITALS, INC		In Lie	u of Form CMS-2	2552-10
	IONMENT OF PATIENT SERVICE COST	ΓS		Provi der C	CN: 15-0002	Peri od:	Worksheet H-3	
				HHA CCN:	15-7536	From 01/01/2018 To 12/31/2018		
				Title	· XVIII	Home Health Agency I	PPS	<u>o piii</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)			col . 4)	
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - COMPUTATION OF LESSER COST LIMITATION	OF AGGREGATE	PROGRAM COST, A	AGGREGATE OF TH	HE PROGRAM LI	MITATION COST, (OR BENEFICIARY	
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	1, 996, 242		1, 996, 24	42 13, 174	151. 53	1.00
2.00	Physi cal Therapy	3.00	947, 536	0	947, 53	36 5, 329	177. 81	2.00
3.00	Occupational Therapy	4.00	218, 931	0	218, 93	31 1, 138	192. 38	3.00
4.00	Speech Pathology	5.00	89, 139	0	89, 13		407. 03	4.00
5.00	Medical Social Services	6.00	8, 647		8, 64	47 60	144. 12	5.00
6.00	Home Health Aide	7.00	166, 973		166, 97	73 2, 611	63. 95	6.00
7.00	Total (sum of lines 1-6)		3, 427, 468	0	3, 427, 40	68 22, 531		7.00
Program Vi si ts								
					Pa	art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject			
	oost deliter bescription	0031 211111113	OBON NO. (1)	l lare n	to	Deducti bl es		
					Deducti bl es			
					Coi nsurance			
		0	1. 00	2. 00	3.00	4. 00	5. 00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		23844	4, 585		0		8.00
9.00	Physical Therapy		23844	2, 032		0		9. 00
10.00	Occupational Therapy		23844	331		0		10.00
11.00	Speech Pathology		23844	75		0		11.00
12.00	Medical Social Services		23844	32		0		12.00
13.00	Home Health Aide		23844	996		0		13.00
14.00	Total (sum of lines 8-13)			8, 051		0		14.00
	Cost Center Description	From Wkst.	Facility	Shared	Total HHA	Total Charges	Ratio (col. 3	
		H-2 Part I,	Costs (from	Ancillary	Costs (cols.	. (from HHA	÷ col. 4)	
		col. 28, line	Wkst. H-2,	Costs (from	1 + 2)	Records)		
			Part I)	Part II)				
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
	Supplies and Drugs Cost Comput							
15.00	1	8. 00	4		•	0		
16. 00	Cost of Drugs	9. 00				0 0	0. 000000	16. 00
			Program Visits		Cost of			
			_		Servi ces			
				t B		Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
			to	Deductibles &		to	Deductibles &	
			Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
			Coi nsurance			Coi nsurance		
		6. 00	7. 00	8.00	9. 00	10.00	11. 00	
	DART I COMPUTE TO THE TOTAL TOT			AGGREGATE OF TH	HE PROGRAM LI	MITATION COST, (OK BENEFICIARY	
	PART I - COMPUTATION OF LESSER		PROGRAM COST, A	NOOKEONTE OF T				
	COST LIMITATION		PROGRAM COST, A	NOOKEONTE OF T				
1.00	COST LIMITATION Cost Per Visit Computation	OF AGGREGATE				(F		1 00
1. 00	COST LIMITATION Cost Per Visit Computation Skilled Nursing Care	OF AGGREGATE 4, 585	0		694, 76			1.00
2.00	COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy	0F AGGREGATE 4, 585 2, 032	0 0		694, 70 361, 3	10 0		2.00
2. 00 3. 00	COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy	0F AGGREGATE 4, 585 2, 032 331	0 0 0		694, 76 361, 3 63, 6	10 0 78 0		2. 00 3. 00
2. 00 3. 00 4. 00	COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	0F AGGREGATE 4, 585 2, 032 331 75	0 0 0		694, 76 361, 3 63, 6 30, 52	10 0 78 0 27 0		2.00 3.00 4.00
2.00 3.00 4.00 5.00	COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	0F AGGREGATE 4, 585 2, 032 331 75 32	0 0 0 0 0 0 0		694, 76 361, 3 63, 6 30, 52 4, 6	10 0 78 0 27 0 12 0		2.00 3.00 4.00 5.00
2. 00 3. 00 4. 00 5. 00 6. 00	COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	0F AGGREGATE 4, 585 2, 032 331 75 32 996	0 0 0 0 0		694, 76 361, 3 63, 6 30, 55 4, 66 63, 66	10 0 78 0 27 0 12 0 94 0		2. 00 3. 00 4. 00 5. 00 6. 00
2.00 3.00 4.00 5.00	COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	0F AGGREGATE 4, 585 2, 032 331 75 32	0 0 0 0 0		694, 76 361, 3 63, 6 30, 52 4, 6	10 0 78 0 27 0 12 0 94 0		2.00 3.00 4.00 5.00

Heal th	Financial Systems		METHODIST HOS	SPITALS. INC		In Lie	u of Form CMS-:	2552-10
	TONMENT OF PATIENT SERVICE COST	ΓS		Provi der Co	CN: 15-0002 15-7536	Peri od: From 01/01/2018 To 12/31/2018	Worksheet H-3 Part I Date/Time Pre	epared:
				Title	XVIII	Home Health	5/28/2019 4: 5 PPS	00 pm_
	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 9. 00 10. 00 11. 00 12. 00 13. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide							8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
14.00	Total (sum of lines 8-13)	D	0 1 0	<u> </u>	01			14.00
		Progi	ram Covered Ch	arges	Cost of Services			
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance		Part A	Part B Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	Ia	6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
45.00	Supplies and Drugs Cost Comput				<u> </u>			15.00
	Cost of Medical Supplies Cost of Drugs	0	C	 		0 0		
10.00	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00						10.00
	PART I - COMPUTATION OF LESSER COST LIMITATION		PROGRAM COST,	AGGREGATE OF TH	HE PROGRAM L	IMITATION COST, C	OR BENEFICIARY	
1. 00	Cost Per Visit Computation Skilled Nursing Care	694, 765						1.00
2.00	Physi cal Therapy	361, 310						2.00
3.00	Occupational Therapy	63, 678						3. 00
4.00	Speech Pathology	30, 527						4. 00
5. 00	Medical Social Services	4, 612						5.00
6.00	Home Heal th Ai de	63, 694						6.00
7. 00	Total (sum of lines 1-6) Cost Center Description	1, 218, 586						7.00
	cost center bescription	12. 00						-
	Limitation Cost Computation	12.00						
8. 00 9. 00 10. 00 11. 00 12. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services							8. 00 9. 00 10. 00 11. 00 12. 00
13.00	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 COS	ΓS		Provi der C		Peri od:	Worksheet H-3	
				HHA CCN:	15-7536	From 01/01/2018 To 12/31/2018	Date/Time Pre	
							5/28/2019 4:5	0 pm
				Title	: XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Charge Ratio	Charge (from	Ancillary	Part I as		
		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	NTS		
1.00	Physi cal Therapy	66.00	0. 379145	0		0 col. 2, line 2	. 00	1.00
2.00	Occupational Therapy	67.00	0. 404827	0		0 col. 2, line 3	. 00	2.00
3.00	Speech Pathology	68.00	0. 323184	0		0 col. 2, line 4	. 00	3.00
4.00	Cost of Medical Supplies	71.00	0. 333626	0		0 col. 2, line 1	5. 00	4.00
5.00	Cost of Drugs	73.00	0. 167170	0		0 col. 2, line 1	6. 00	5.00

	Financial Systems METHODIST HOSE ATION OF HHA REIMBURSEMENT SETTLEMENT	HODIST HOSPITALS, INC Provider CCN: 15-0002 PORTON PROVIDENCE PROVIDE PROVIDENCE PROVIDE PROVIDENCE PROVIDENCE PROVIDENCE PROVIDENCE PROVIDENCE PROVIDE			eu of Form CMS-2 Worksheet H-4	
ALCUL	ATTON OF THE RETWINDONSEMENT SETTEEMENT	HHA CCN:	15-7536	Peri od: From 01/01/2018 To 12/31/2018	Part I-II	
					5/28/2019 4:5	
		litle	· XVIII	Home Health Agency I	PPS	
			Dort A	Not Subject	rt B Subject to	
			Part A	to	Deductibles &	
				Deductibles &		
			1.00	Coi nsurance 2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CU	STOMARY CHARGI		2.00	3.00	
	Reasonable Cost of Part A & Part B Services				_	
. 00	Reasonable cost of services (see instructions)			0	1	1
. 00	Total charges Customary Charges			0 (0	2.
. 00	Amount actually collected from patients liable for payment	for services		0 (0	3.
00	on a charge basis (from your records)	ar normant				1
. 00	Amount that would have been realized from patients liable f for services on a charge basis had such payment been made i with 42 CFR §413.13(b)			0	0	4.
. 00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000			
. 00 . 00	Total customary charges (see instructions) Excess of total customary charges over total reasonable cos	t (complete		-	0 0	
. 00	only if line 6 exceeds line 1)	it (comprete				′.
. 00	Excess of reasonable cost over customary charges (complete	only if line		0	0	8.
. 00	1 exceeds line 6) Primary payer amounts			0	0	9.
. 00	Trimary payer amounts			Part A	Part B	/.
				Servi ces 1.00	Servi ces 2. 00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
0.00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers				0 1, 032, 234	
2.00	Total PPS Reimbursement - Full Episodes without outliers				59, 295	1
3. 00	Total PPS Reimbursement - LUPA Episodes				19, 119	13.
4. 00	Total PPS Reimbursement - PEP Episodes				26, 586	1
5.00	Total PPS Outlier Reimbursement - Full Episodes with Outlie Total PPS Outlier Reimbursement - PEP Episodes	ers			36, 699 1, 672	
7. 00	Total Other Payments				0	1
3. 00	DME Payments			(0	1
9. 00 0. 00	Oxygen Payments Prosthetic and Orthotic Payments				0 0	1
1. 00	Part B deductibles billed to Medicare patients (exclude coi	nsurance)		`) ő	
2. 00	Subtotal (sum of lines 10 thru 20 minus line 21)				1, 175, 605	
3.00	· · · · · · · · · · · · · · · · · · ·					
4. 00 5. 00	Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records)				1, 175, 605 0	
6. 00	Net cost (line 24 minus line 25)				1, 175, 605	
	Reimbursable bad debts (from your records)					27.
8.00	Reimbursable bad debts for dual eligible beneficiaries (see)	,	1 175 (05	28.
9. 00 0. 00	Total costs - current cost reporting period (line 26 plus I OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	THE 27)			1, 175, 605 0	1
0. 50	Pioneer ACO demonstration payment adjustment (see instructi	ons)			o o	1
0. 99	Demonstration payment adjustment amount before sequestration	n			0	
1. 00 1. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)				1, 175, 605 23, 512	
1. 01	Demonstration adjustment (see instructions) Demonstration payment adjustment amount after sequestration	1			0 23, 512	
2. 00	Interim payments (see instructions)				1, 152, 092	
3.00	Tentative settlement (for contractor use only)				0	
4. 00	Balance due provider/program (line 31 minus lines 31.01, 32 Protested amounts (nonallowable cost report items) in accor		S Dub 15_2		1 0	1
5.00						

Health Financial Systems	METHODIST HOSPI	TALS, INC	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED	HHAS FOR SERVICES RENDERED	Provider CCN: 15-0	002 Period: From 01/01/2018	Worksheet H-5
TO PROGRAM BENEFICIARIES		HHA CCN: 15-		Date/Time Prepared:

					5/28/2019 4: 5	O pm
				Home Health	PPS	
			1 D 1 A	Agency I	D	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4. 00	
1. 00	Total interim payments paid to provider	11.00	2.00	0	1, 152, 092	1.00
2. 00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	11 ogram to 11 ovraci			0	0	3.01
3. 02				0	0	3. 02
3.03				0	0	3.03
3.04				0	0	3.04
3.05				0	0	3.05
	Provi der to Program					
3. 50				0	0	
3. 51 3. 52				0	0	3. 51 3. 52
3. 52 3. 53				0		3.52
3. 54				0	0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)			0	1, 152, 092	4.00
	(transfer to Wkst. H-4, Part II, column as appropriate,					
	To be completed by contractor					
5. 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider			-	•	
5. 01				0	0	5. 01
5. 02				0	0	
5. 03				0	0	5.03
F F0	Provider to Program	l		0		
5. 50 5. 51				0	0	5. 50 5. 51
5. 52				0		
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER			0	1	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	1 152 003	6.02
7. 00	Total Medicare program liability (see instructions)			Contractor	1, 152, 093 NPR Date	7. 00
				Number	(Mo/Day/Yr)	
)	1. 00	2. 00	
8. 00	Name of Contractor					8.00
	•	•		•	. '	

Heal th	Financial Systems METHODIST HOSPI	TALS INC	In lie	u of Form CMS-2	2552-10
	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0002	Peri od: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III	pared:
		Title XVIII	Hospi tal	PPS	<u> </u>
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				
1. 00	Capital DRG other than outlier			3, 491, 628	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			19, 915	2.00
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00	Total inpatient days divided by number of days in the cost re	eporting period (see ins	tructions)	224. 79	
4. 00	Number of interns & residents (see instructions)			2. 95	4.00
5.00	Indirect medical education percentage (see instructions)			0. 37	5.00
6. 00	Indirect medical education adjustment (multiply line 5 by the 1.01)(see instructions)			12, 919	
7. 00	Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions)		E, part A line	9. 31	7. 00
8.00	Percentage of Medicaid patient days to total days (see instr	uctions)		31. 36	
9. 00	Sum of lines 7 and 8			40. 67	
10.00	Allowable disproportionate share percentage (see instructions	s)		8. 59	
11.00	Disproportionate share adjustment (see instructions) Total prospective capital payments (see instructions)			299, 931 3, 824, 393	
12. 00	Total prospective capital payments (see instructions)			3, 824, 393	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)			0	
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	
4.00	Capital cost payment factor (see instructions)			0	
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5.00
	DART LLL COURTET ON OF EVOCOTION DAMESTO			1. 00	
4 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS				1 00
1. 00 2. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstand	oos (soo i netrueti ons)		0	1.00 2.00
3. 00	Net program inpatient capital costs for extraordinary circumstant Net program inpatient capital costs (line 1 minus line 2)	ces (see Thistructions)		0	
4. 00	Applicable exception percentage (see instructions)			0.00	
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0.00	
6. 00	Percentage adjustment for extraordinary circumstances (see i	nstructions)		0.00	
7.00	Adjustment to capital minimum payment level for extraordinary	y circumstances (line 2	x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)			0	8. 00
9.00	Current year capital payments (from Part I, line 12, as appli			0	
10.00	Current year comparison of capital minimum payment level to	1 1 3 1	,	0	
11. 00	Carryover of accumulated capital minimum payment level over (Worksheet L, Part III, line 14)			0	
12.00	Net comparison of capital minimum payment level to capital page 1			0	
13.00	Current year exception payment (if line 12 is positive, enter			0	
14. 00	Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)		following period	0	
15.00	Current year allowable operating and capital payment (see in	structions)		0	
16.00	Current year operating and capital costs (see instructions)			0	
17.00	Current year exception offset amount (see instructions)		l	0	17. 00