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 01/01/2020 and ending 12/31/2020 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 statements ignature on this certification statement to be the legal ${\sf I}$	
(Si aned)	MATT DOYLE
	Officer or Administrator of Provider(s)
	CEO
Ti t	e
	(Dated when report is electronically signed.)
Dat	9

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY			_			
1.00	Hospi tal	0	1, 945, 959	-27, 960	0	-931, 180	1.00
2.00	Subprovider - IPF	0	378	-2		-362, 105	2.00
3.00	Subprovider - IRF	0	70, 804	0		-39, 637	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	2, 017, 141	-27, 962	0	-1, 332, 922	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.

DSPI T	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX		T HOSPITA	LS, INC Provider	CCN: 15	-0002	Peri od:		i of For Workshe		
							From 01/01/ To 12/31/		Part I Date/Ti	me Pre	epared
	1.00	2.0	0	3.	00			4.00	7/23/20	021 10:	58 an
	Hospital and Hospital Health Care Co										
	Street: 600 GRANT STREET City: GARY	PO Box: State: IN	7:	p Code: 4	6402	Cours	ty: LAKE				1.0
00	CITY. GART	Component Nam				Provi der		Pavme	ent Syst	em (P.	2.0
					umber	Туре	Certified		, 0, or		
								V	XVIII		_
	Hospital and Hospital-Based Componer	1.00	2	. 00	3.00	4.00	5.00	6.00	7.00	8.00	
00		METHODI ST HOSPI TAL	_S, 15	0002 2	3844	1	01/01/1966	N	Р	0	3. (
		I NC									
00	Subprovider - IPF	GERIATRIC PSYCH		-	3844	4 5	01/01/2012		P P	0	4.0
	Subprovider - IRF Subprovider - (Other)	REHABI LI TATI ON	10	T002 2	3844	5	01/01/1984	N			5. 6.
	Swing Beds - SNF										7.
00	Swing Beds - NF										8.
	Hospital-Based SNF										9.
	Hospital-Based NF Hospital-Based OLTC										10.
	Hospital-Based HHA	METHODIST HOME CAR	2F 15	7536 2	3844		02/12/2002	N	P	0	12.
. 00		SERVI CES		/000 2	0011		02/12/2002		.		12.
	Separately Certified ASC										13.
	Hospital-Based Hospice Hospital-Based Health Clinic - RHC							-			14.
	Hospital-Based Health Clinic - FQHC										15.
	Hospital - Based (CMHC) I										17.
	Renal Dialysis										18.
. 00	Other						From:	<u> </u>	To		19.
							1.00		2. (-
00	Cost Reporting Period (mm/dd/yyyy)						01/01/2		12/31/		20.
00	Type of Control (see instructions)						2				21.
						1.00	2.00		3. (00	-
	Inpatient PPS Information								0.10		
. 00	Does this facility qualify and is it					Y	N				22.
	disproportionate share hospital adju										
	§412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section §										
	hospital?) In column 2, enter "Y" fo										
01	Did this hospital receive interim un					Y	Y				22.
	cost reporting period? Enter in colu the portion of the cost reporting pe										
	Enter in column 2, "Y" for yes or "N				t						
	reporting period occurring on or aft	er October 1. (see	e instruct	ions)	-						
	Is this a newly merged hospital that					Ν	N				22.
	payments to be determined at cost re Enter in column 1, "Y" for yes or "N	port settlement? (" for po for the	see instr	uctions)							
	cost reporting period prior to Octob				<						
	or "N" for no, for the portion of th										
	October 1.		_								
03	Did this hospital receive a geograph					N	N		N		22.
	rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c				5						
	for the portion of the cost reportin	g period prior to	October 1	. Enter							
	in column 2, "Y" for yes or "N" for										
	reporting period occurring on or aft Does this hospital contain at least										
	counted in accordance with 42 CFR 41										
	yes or "N" for no.										
	Which method is used to determine Me						3 N				23.
	below? In column 1, enter 1 if date if date of discharge. Is the method										
	reporting period different from the				۲						
	reporting period? In column 2, ente	r "Y" for yes or "	N" for no								
			In-State	In-Stat		t-of		ledi ca		ther	
			Medicaid Daid days	Medicai eligibl		tate li cai d	State ⊦ Medicaid	IMO da	- I	li cai d lays	
		P	ara aays	unpai d			eligible			ays	
				days			unpai d				
00			1.00	2.00		. 00	4.00	5.00		o. 00	
	If this provider is an IPPS hospital in-state Medicaid paid days in colum		4, 112	6, 8	65	0	983	14,	026	C	24.
00											
00	Medicaid eligible unpaid davs in col				1	1			1		
	Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c										
	out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai	olumn 3, d days in column									
	out-of-state Medicaid paid days in c	olumn 3, d days in column t unpaid days in									

	stems AL HEALTH CARE COMPLEX IDE	NTIFICATION DATA	P	rovider CC	N: 15-0002	Peri od:		Workshe		2552
						From 01/0		Part I Date/Ti 7/23/20	me Pre	pare
		Me	n-State edicaid id days	ln-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d	Medica HMO da	id 0 ys Mec c	ther li cai d lays	
Medicaid paid Medicaid elig out-of-state Medicaid elig	der is an IRF, enter the i l days in column 1, the in- ible unpaid days in columr Medicaid days in column 3, ible unpaid days in columr eligible but unpaid days i	n-state -state n 2, out-of-state n 4, Medicaid	<u>1.00</u> 195	2.00 327	3.00	4.00	5.00	478	0.00	25.
						Urban/F		Date of 2.0		-
cost reportin	andard geographic classifi g period. Enter "1" for ur	rban or "2" for r	ural.		0	the	1	2.0		26.
reporting per enter the eff	andard geographic classifi iod. Enter in column 1, "1 fective date of the geograp	1" for urban or": phic reclassifica	2" for ru tion in d	ural. If aj column 2.	pplicable,		1			27.
	sole community hospital (S cost reporting period.	SCH), enter the h	umber or	periods S	UH STATUS IN		0			35.
						Begi n 1.		Endi 2. (
of periods in .00 If this is a	ble beginning and ending of excess of one and enter s Medicare dependent hospita	subsequent dates. al (MDH), enter t					0			36. 37.
.01 Is this hospi	in the cost reporting peri tal a former MDH that is e th FY 2016 OPPS final rule	eligible for the H								37.
	1, enter the beginning an 1, subscript this line for									38
						Y/ 1.		Y/ 2. (-
hospitals in 1 "Y" for yes accordance wi	ility qualify for the inpa accordance with 42 CFR §41 or "N" for no. Does the f th 42 CFR 412.101(b)(2)(i) (see instructions)	12.101(b)(2)(i), facility meet the	(ii), or mileage	(iii)? En requiremen	ter in colum nts in	ume N nn		N		39.
.00 Is this hospi "N" for no in	tal subject to the HAC pro- column 1, for discharges 2, for discharges on or af	prior to October	1. Enter	Y" for			V	N XVIII	XIX	40.
Prospective P	Payment System (PPS)-Capita						1.00	2.00	3.00	
.00 Does this fac	ility qualify and receive	Capital payment	for di spr	oporti ona	te share in	accordance	e N	Y	N	45.
.00 Is this facil	ection §412.320? (see inst ity eligible for additiona 2 CFR §412.348(f)? If yes,	al payment except			5		N	N	N	46.
.00 Is this a new	hospital under 42 CFR §41 ty electing full federal c						N N	N N	N N	47 48
Teaching Hosp .00 Is this a hos "N" for no in	pital involved in training column 1. If column 1 is	"Y", are you imp	acted by	CR 11642				Y		56
Teaching Hosp 1s this a hos "N" for no in GME payment r GME programs is "Y" did re for yes or "N "N", complete	pital involved in training column 1. If column 1 is eduction? Enter "Y" for y yes, is this the first co trained at this facility? sidents start training in " for no in column 2. If e Wkst. D, Parts III & IV a	"Y", are you imp yes or "N" for no ost reporting per Enter "Y" for yu the first month column 2 is "Y", and D-2, Pt. II,	in colur iod durin res or "N" of this of complete if applic	CR 11642 nn 2. ng which re for no in cost report e Workshee cable.	(or subseque esidents in n column 1. ting periodí t E-4. lf co	approved If column ? Enter "` blumn 2 is	A N 1 ("	Y		57
Teaching Hosp 15 this a hos "N" for no in GME payment r OO If line 56 is GME programs is "Y" did re for yes or "N "N", complete OO If line 56 is defined in CM	pital involved in training column 1. If column 1 is reduction? Enter "Y" for y yes, is this the first co trained at this facility? sidents start training in " for no in column 2. If wkst. D, Parts III & IV a yes, did this facility el S Pub. 15-1, chapter 21, §	"Y", are you imp yes or "N" for no ost reporting per Enter "Y" for y the first month column 2 is "Y", and D-2, Pt. II, ect cost reimbur: §2148? If yes, com	in colur iod durin res or "N" of this of complete if applic sement for mplete WH	CR 11642 in 2. ing which re for no in cost reporte Workshee cable. or physicia kst. D-5.	(or subseque esidents in n column 1. ting period? t E-4. If co ans' service	approved If column ? Enter "` blumn 2 is	A 1 (" N	Y		56 57 58
Teaching Hosp 15 this a hos "N" for no in GME payment r OO If line 56 is GME programs is "Y" did re for yes or "N "N", complete OO If line 56 is defined in CM	pital involved in training column 1. If column 1 is reduction? Enter "Y" for y syes, is this the first co trained at this facility? sidents start training in " for no in column 2. If wkst. D, Parts III & IV a syes, did this facility el	"Y", are you imp yes or "N" for no ost reporting per Enter "Y" for y the first month column 2 is "Y", and D-2, Pt. II, ect cost reimbur: §2148? If yes, com	in colur iod durin res or "N" of this of complete if applic sement for mplete WH	CR 11642 in 2. ing which re for no in cost reporte Workshee cable. or physicia kst. D-5.	(or subseque esidents in n column 1. ting period? t E-4. If co ans' service	ent CRĴ, M/ approved If column ? Enter "\ blumn 2 is es as	A 1 (" N N neet A	Pass-TI Qualifi Crite	cation rion	57 58 59
Teaching Hosp 100 Is this a hos "N" for no in GME payment r GME programs is "Y" did re for yes or "N "N", complete .00 If line 56 is defined in CM	pital involved in training column 1. If column 1 is reduction? Enter "Y" for y yes, is this the first co trained at this facility? sidents start training in "for no in column 2. If wkst. D, Parts III & IV a yes, did this facility el S Pub. 15-1, chapter 21, §	"Y", are you imp yes or "N" for no ost reporting per Enter "Y" for y the first month column 2 is "Y", and D-2, Pt. II, ect cost reimbur: §2148? If yes, com	in colur iod durin res or "N" of this of complete if applic sement for mplete WH	CR 11642 in 2. ing which re for no in cost reporte Workshee cable. or physicia kst. D-5.	(or subseque esidents in n column 1. ting period? t E-4. If co ans' service <u>, Pt. I.</u> NAHE 413.8	ent CR), M/ approved If column ? Enter "` olumn 2 is es as 5 Worksh	N N N N N N eeet A e #	Pass-TI Qual i fi	cation rion de	57 58 59
 Teaching Hosp 1s this a hos "N" for no in GME payment r GME programs is "Y" did refor yes or "N "N", complete OO If line 56 is defined in CM OO Are you claim any programs instructions) is "Y", are y 	pital involved in training column 1. If column 1 is reduction? Enter "Y" for y yes, is this the first co trained at this facility? sidents start training in "for no in column 2. If wkst. D, Parts III & IV a yes, did this facility el S Pub. 15-1, chapter 21, §	"Y", are you imp yes or "N" for no ost reporting per Enter "Y" for yu the first month column 2 is "Y", and D-2, Pt. II, ect cost reimburs \$2148? If yes, con neet A? If yes, of alth education (N. der 42 CFR 413.85 ' for no in colum pr subsequent CR)	Aacted by in coluring of this of complete if applic sement for mplete WH complete AHE) cost AHE) cost n 1. If NAHE MA	CR 11642 an 2. ag which ra for no in cost repor- workshee- cable. or physicia sst. D-5. Wkst. D-2. wkst. D-2.	(or subseque esidents in n column 1. ting period? t E-4. If co ans' service , Pt. I. NAHE 413.8 Y/N	ent CR), M/ approved If column 2 Enter "`` olumn 2 is es as 5 Worksh Lin	N N N N N N N N N N N N OO	Pass-TH Qualifi Crite Coo	cation rion de	57 58 59

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CO		eriod: com 01/01/2020 o 12/31/2020	Worksheet S-2 Part I Date/Time Pre 7/23/2021 10:	pared
	Y/N	IME	Direct GME	IME	Direct GME	
	1.00 N	2.00	3.00	4.00	5.00	61.0
 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 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) Denter the current year total unweighted primary care 				0.00	0.00	61.0
FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						
1.03 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)						61.0
 04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 						61.0
1.05 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)						61.0
 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) 						61.0
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
1.10 Of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	4.00	61.
 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 1.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. 				0. 00		61. :
					1.00	
 ACA Provisions Affecting the Health Resources and Ser 2.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct) 2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC proceeds 	traine ctions) a Teach	d in this cost ing Health Cer	reporting per ter (THC) into			62. (62. (
Teaching Hospitals that Claim Residents in Nonprovide 3.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this c			N	63.0
			Unweighted FTEs Nonprovider Site	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	1.00 This base vear	2.00 is vour cost	3.00 reporting	
period that begins on or after July 1, 2009 and befor 4.00 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	re June ty trai n-prima all no d non-p n colum	2 30, 2010. ned residents ry care nprovider rimary care n 3 the ratio	0.00			64.0

	EX IDENTIFICATION D	ATA Provider C		eriod:	u of Form CMS- Worksheet S-2	2
			TC	rom 01/01/2020 0 12/31/2020	Date/Time Pre	epare
	Program Name	Program Code	Unweighted	Unweighted	7/23/2021 10: Ratio (col.	<u>58 a</u>
	0		FTĔs	FTEsin	3/ (col. 3 +	
			Nonprovider Site	Hospi tal	col. 4))	
-	1.00	2.00	3.00	4.00	5.00	1
00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care residents TEs that trained in	1.00	2.00	0.00			0 65.
your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			Site			
Contion EEOA of the AOA O	(oon FTF Deet 1 1 1	n Nonnessi day C. Litt	1.00	2.00	3.00	
Section 5504 of the ACA Current Y beginning on or after July 1, 201		n Nonprovider Settin	ysErrective f	or cost report	ing periods	
00 Enter in column 1 the number of u	inweighted non-prima		0.00	0.00	0. 00000	66.
	nweighted non-prima ccurring in all nonp nweighted non-prima nl. Enter in column	provider settings. Try care resident 3 the ratio of	Unweighted FTEs Nonprovider	0.00 Unweighted FTEs in Hospital	0.000000 Ratio (col. 3/ (col. 3 + col. 4))	
00 Enter in column 1 the number of u FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita	nweighted non-prima curring in all nonp nweighted non-prima nl. Enter in column column 2)). (see ir	provider settings. Ary care resident 3 the ratio of Astructions)	Unweighted FTEs	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	
 OD Enter in column 1 the number of u FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + OO Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 	unweighted non-prima curring in all nonp unweighted non-prima al. Enter in column column 2)). (see in Program Name	provider settings. hry care resident 3 the ratio of hstructions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	
 OD Enter in col umn 1 the number of u FTEs attributable to rotations of Enter in col umn 2 the number of u FTEs that trained in your hospita (col umn 1 divided by (col umn 1 + OD Enter in col umn 1, the program name associated with each of your primary care programs in which you trained residents. Enter in col umn 2, the program code. Enter in col umn 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in col umn 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in col umn 5, the ratio of (col umn 3 divided by (col umn 3 + col umn 4)). (see instructions) 	unweighted non-prima curring in all nonp unweighted non-prima ul. Enter in column <u>column 2)). (see ir</u> Program Name <u>1.00</u>	Provi der settings. Iny care resident 3 the ratio of Istructions) Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00 0.00	Unwei ghted FTEs in Hospi tal 4.00 0.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000	0 67.
 OD Enter in col umn 1 the number of u FTEs attributable to rotations of Enter in col umn 2 the number of u FTEs that trained in your hospita (col umn 1 divided by (col umn 1 + OO Enter in col umn 1, the program name associated with each of your primary care programs in which you trained residents. Enter in col umn 2, the program code. Enter in col umn 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in col umn 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in col umn 5, the ratio of (col umn 3 divided by (col umn 3 + col umn 4)). (see instructions) 	unweighted non-prima curring in all nonp unweighted non-prima al. Enter in column column 2)). (see ir Program Name 1.00	Provi der settings. Iny care resident 3 the ratio of Istructions) Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00 0.00	Unwei ghted FTEs in Hospi tal 4.00 0.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000	
00 Enter in col umn 1 the number of u FTEs attributable to rotations oc Enter in col umn 2 the number of u FTEs that trained in your hospita (col umn 1 divided by (col umn 1 + (col umn 1 divided by (col umn 1 +)) 00 Enter in col umn 1, the program name associated with each of your primary care programs in which you trained residents. Enter in col umn 2, the program code. Enter in col umn 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in col um 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in col umn 5, the ratio of (col umn 3 divided by (col umn 3 + col umn 4)). (see instructions)	unweighted non-prima curring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u>	TPF), or does it con approved GME teach (D)? Enter "Y" for (D)? Enter "Y" for	Unweighted FTEs Nonprovider Site 3.00 0.00 tain an IPF subj ing program in yes or "N" for is in a new teacl yes or "N" for is	Unwei ghted FTEs in Hospi tal 4.00 0.00 0.00 1.00 provi der? Y the most no. (see hi ng no.	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000	D 67.
 OD Enter in column 1 the number of u FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + OD Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility PF OD Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no. OD If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412. 424(d)(1)(iii)(c)) Col program in accordance with 42 CFR 	unweighted non-prima ccurring in all nonp unweighted non-prima ul. Enter in column column 2)). (see ir Program Name 1.00 1.00 25 7 7 7 7 7 8 7 7 8 7 7 8 7 8 7 8 7 8 7	TPF), or does it con approved GME teach (D)? Enter "Y" for program during thi	Unweighted FTEs Nonprovider Site 3.00 0.00 tain an IPF sub ing program in yes or "N" for in s in a new teacl yes or "N" for in s cost reporting	Unwei ghted FTEs in Hospi tal 4.00 0.00 0.00 1.00 provi der? Y the most no. (see hi ng no.	Rati o (col . 3/ (col . 3 + col . 4)) 5.00 0.0000000 0.0000000 0.000000 0.0000000 0.00000000	0 67.

DSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	ovider CCN: 15-0002	Period: From 01/01/20 To 12/31/20	Workshe 20 Part I 20 Date/Ti 7/23/20	me Pre	pared:
		1	00 2.00	3.00	
6.00 If line 75 is yes: Column 1: Did the facility have an approved G recent cost reporting period ending on or before November 15, 20 no. Column 2: Did this facility train residents in a new teaching CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Col indicate which program year began during this cost reporting per	04? Enter "Y" for yes g program in accordar umn 3: If column 2 is	n the most s or "N" for ice with 42 s Y,	N N	0	76.00
Long Term Care Hospital PPS			1. (00	
0.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and 1.00 Is this a LTCH co-located within another hospital for part or al "Y" for yes and "N" for no. TEFRA Providers		ng period? Ent	er N		80. 00 81. 00
 5. 00 Is this a new hospital under 42 CFR Section §413. 40(f)(1)(i) TEF 6. 00 Did this facility establish a new Other subprovider (excluded un §413. 40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 			o. N		85. 00 86. 00
7. 00 Is this hospital an extended neoplastic disease care hospital cl. 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	assified under sectio		N		87.00
		V 1.00	2. C		
Title V and XIX Services		1.00	2.0		
D. 00 Does this facility have title V and/or XIX inpatient hospital se yes or "N" for no in the applicable column.			Y		90.00
1.00 Is this hospital reimbursed for title V and/or XIX through the c full or in part? Enter "Y" for yes or "N" for no in the applicab 2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual c	le column.	N	Y N		91.00 92.00
instructions) Enter "Y" for yes or "N" for no in the applicable of 3.00 Does this facility operate an ICF/IID facility for purposes of t	column.	N	N		93.00
"Y" for yes or "N" for no in the applicable column. 1.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and applicable column.	"N" for no in the	N	N		94.00
5.00 If line 94 is "Y", enter the reduction percentage in the applica 6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or applicable column.		0. 00 N	0. C N		95.00 96.00
7.00 If line 96 is "Y", enter the reduction percentage in the applical 8.00 Does title V or XIX follow Medicare (title XVIII) for the intern stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for y column 1 for title V, and in column 2 for title XIX.	s and residents post	0.00 Y	0. (Y		97.00 98.00
Containing the view of and the containing to the XVIII) for the report C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title title XIX.			Y		98.01
3. 02 Does title V or XIX follow Medicare (title XVIII) for the calcul- bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N for title V, and in column 2 for title XIX.		Y	Y		98.02
8.03 Does title V or XIX follow Medicare (title XVIII) for a critical reimbursed 101% of inpatient services cost? Enter "Y" for yes or			N		98.03
for title V, and in column 2 for title XIX. 8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reim outpatient services cost? Enter "Y" for yes or "N" for no in col in column 2 for title XIX.		N	N		98.04
8.05 Does title V or XIX follow Medicare (title XVIII) and add back t Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in colum column 2 for title XIX.			Y		98.05
B. OG Does title V or XIX follow Medicare (title XVIII) when cost reim Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for column 2 for title XIX. Rural Providers		Y	Y		98.06
05.00 Does this hospital qualify as a CAH? 06.00 If this facility qualifies as a CAH, has it elected the all-incl	usive method of payme	ent N			105.00 106.00
for outpatient services? (see instructions) 07.00 Column 1: If line 105 is Y, is this facility eligible for cost r training programs? Enter "Y" for yes or "N" for no in column 1. Column 2: If column 1 is Y and line 70 or line 75 is Y, do you approved medical education program in the CAH's excluded IPF an Enter "Y" for yes or "N" for no in column 2. (see instructions)	(see instructions) train I&Rs in an	Ν			107. 00
08.00 Is this a rural hospital qualifying for an exception to the CRNA CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	fee schedul e? See 4	2 N			108.00

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider (eri od:	worksheet S-	-2
		Fr To	rom 01/01/2020 0 12/31/2020) Date/Time Pr	
	Physi cal	Occupati onal	Speech	7/23/2021 10 Respi ratory	
	1.00	2.00	3.00	4.00	
9.00 f this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.
				1.00	-
D. 00 Did this hospital participate in the Rural Community Hospita Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	"Y" for yes o	r "N" for no. I	f yes,	N	110.
			1.00	2.00	-
1.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this constrained in the response to constrain the program of the FCHIP demonstration that apply: "A" for Ambulance services; "B" for action tele-health services.	ost reporting olumn 1 is Y, rticipating i	period? Enter enter the n column 2.	N		111.
		1.00	2.00	3.00	-
2.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital cear participation in the demonstration, if applicable.	period? s "Y", enter ne	N			112.
Miscellaneous Cost Reporting Information .00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, E	B, or E only)	N			0115
in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1.	(includes				
0.00 Is this facility classified as a referral center? Enter "Y"	for yes or	N			116
"N" for no. .00 Is this facility legally-required to carry malpractice insur	rance? Enter	Y			117.
"Y" for yes or "N" for no. 3.00 s the malpractice insurance a claims-made or occurrence pol	licv? Enter 1	1			118
if the policy is claim-made. Enter 2 if the policy is occurr					
		Dromiume	Loccoc	Incuranco	
		Premiums	Losses	Insurance	
		Premi ums	Losses 2.00	I nsurance	
.01 List amounts of malpractice premiums and paid losses:			2.00		0118
		1. 00 1, 095, 852	2.00	3.00	0118
0.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheo and amounts contained therein.		1.00 1,095,852 than the	2.00	3.00	118
 .02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schect and amounts contained therein. .00 D0 NOT USE THIS LINE .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 qualifies provision in ACA \$3121 and applicable amendments? 	dule listing d Harmless pr n column 1, " ualifies for	1.00 1,095,852 than the cost centers ovision in ACA Y" for yes or the Outpatient	2.00	3.00	118
 .02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein. .00 DO NOT USE THIS LINE .00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified Harmless provision in ACA §3121 and applicable amendment for no. .00 DO Harmless for una 2, "Y" for yes or "N" for no. .00 Did this facility incur and report costs for high cost implation. 	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins	1.00 1,095,852 than the cost centers ovision in ACA Y" for yes or the Outpatient tructions)	2.00 (1.00 N	3.00 0 2.00	118 119 120
 .02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schect and amounts contained therein. .00 D0 NOT USE THIS LINE .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 qu Hold Harmless provision in ACA §3121 and applicable amendment for no. .00 Did this facility incur and report costs for nigh cost implations? Enter "Y" for yes or "N" for no. .00 Does the cost report contain heal thcare 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. 	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190	1.00 1.095,852 than the cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the	2.00 (1.00 N	3.00 0 2.00	118 119 120 121
 .02Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. .00D0 NOT USE THIS LINE .00Is 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 qu Hold Harmless provision in ACA §3121 and applicable amendments? .00Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. .00Does 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. Transplant Center Information 	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent	1.00 1,095,852 than the cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2	2.00 (1.00 N N Y	3.00 0 2.00	118 119 120 121 122
 .02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. .00 DO NOT USE THIS LINE .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 qu Hold Harmless provision in ACA \$3121 and applicable amendment for no. .00 Did this facility incur and report costs for high cost implations? Enter "Y" for yes or "N" for no. .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. Transplant Center Information .00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent pr yes and "N	1.00 1.095,852 T than the cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 " for no. If	2.00 (1.00 N N Y N	3.00 0 2.00	118 119 120 121 122 125
 .02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. .00 D0 NOT USE THIS LINE .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 qu Hold Harmless provision in ACA \$3121 and applicable amendments? .00 Did this facility incur and report costs for high cost implations? Enter "Y" for yes or "N" for no. .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. Transplant Center Information .00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. .00 If this is a Medicare certified kidney transplant center, er in column 1 and termination date, if applicable, in column 2 	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent or yes and "N nter the cert 2.	1.00 1,095,852 than the cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w) (3) of the er in column 2	2.00 (1.00 N N Y N	3.00 0 2.00	118 119 120 121 122 125 126
 .02Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. .00D0 NOT USE THIS LINE .00Is 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 qu Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in Enter in column 2, "Y" for yes or "N" for no. .00Does 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. Transplant Center Information .00Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. .00If this is a Medicare certified heart transplant center, entin column 1 and termination date, if applicable, in column 2 	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent or yes and "N nter the cert 2.	1.00 1.095,852 T than the cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w) (3) of the er in column 2 " for no. If ification date fication date	2.00 (1.00 N N Y N	3.00 0 2.00	118 119 120 121 122 125 126 127
 O2 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. O0D NOT USE THIS LINE O0 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 qu Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. O0D Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. O0Does 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. Transplant Center Information O0Does this is a Medicare certified kidney transplant center, er in column 1 and termination date, if applicable, in column 2. O0 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2. 	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent or yes and "N nter the cert 2. ter the certi 2.	1.00 1,095,852 Than the cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w) (3) of the er in column 2 " for no. If ification date fication date	2.00 (1.00 N N Y N	3.00 0 2.00	118 119 120 121 122 125 126 127 128
 3. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 3. 00 NOT USE THIS LINE 3. 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 que Hold Harmless provision in ACA §3121 and applicable amendmenter Enter in column 2, "Y" for yes or "N" for no. 4. 00 Does the cost report contain heal thcare 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. Transplant Center Information 5. 00 Does this is a Medicare certified kidney transplant center, end in column 1 and termination date, if applicable, in column 2. 6. 00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 2. 	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent or yes and "N nter the cert 2. ter the certi 2.	1.00 1,095,852 Than the cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w) (3) of the er in column 2 " for no. If ification date fication date	2.00 (1.00 N N Y N	3.00 0 2.00	0118 118 119 120 121 122 125 126 127 128 129
 and amounts contained therein. and amounts contained therein. 00 DD NOT USE THIS LINE 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 que Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no. 100 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 00 Does the cost report contain heal thcare 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. Transplant Center Information 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 00 If this is a Medicare certified heart transplant center, end in column 1 and termination date, if applicable, in column 2. 00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 2. 00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 2. 	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent or yes and "N nter the cert 2. ter the cert 2. ter the cert 2. ter the cert 2. ter the cert 2. ter the cert 3.	1.00 1,095,852 than the cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w) (3) of the er in column 2 " for no. If ification date fication date ication date in	2.00 (1.00 N N Y N	3.00 0 2.00	118 119 120 121 122 125 126 127 128

Health Financial Systems	METHODI ST HOSI	PITALS, INC		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	EX IDENTIFICATION DATA	Provider CC		Period: From 01/01/2020	Worksheet S-2 Part I	2
				To 12/31/2020	Date/Time Pre	epared:
					7/23/2021 10:	58 am
				1.00	2.00	
132.00 If this is a Medicare certified is in column 1 and termination date,			ication date			132.00
133.00 Removed and reserved						133.00
134.00 If this is an organ procurement of and termination date, if applicable		he OPO number	in column 1			134.00
Al I Provi ders					1	
140.00 Are there any related organization chapter 10? Enter "Y" for yes or "				N		140.00
are claimed, enter in column 2 the	<u>e home office chain number</u>	. (see instruc				
<u> </u>	2.0 2.0		uah 143 the n	3.00 ame and address	of the home	-
office and enter the home office	contractor name and contra		-			
141.00Name: 142.00Street:	Contractor's Name: PO Box:		Contracto	r's Number:		141.00 142.00
143. 00 Ci ty:	State:		Zip Code:			143.00
					1.00	_
144.00 Are provider based physicians' cos	sts included in Worksheet	A?			1.00 Y	144.00
						_
145.00 If costs for renal services are cl	laimed on Wkst A line 74	are the cost	s for	1.00 Y	2.00	145.00
inpatient services only? Enter "Y	" for yes or "N" for no in	column 1. If	column 1 is			
no, does the dialysis facility in period? Enter "Y" for yes or "N"		for this cost	reporting			
146.00 Has the cost allocation methodolog		usly filed cos	t report?	N		146.00
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o		15-2, chapter	40, §4020) If			
	uu/yyyy) TH Corumn 2.					
147 00 Was there a shares in the statistication	and hand of Entry WVW for				1.00	147.00
147.00 Was there a change in the statisti 148.00 Was there a change in the order or					N N	147.00 148.00
149.00 Was there a change to the simplifi		nter "Y" for y	es or "N" for		N	149.00
		Part A 1.00	Part B 2.00	Title V 3.00	Title XIX 4.00	-
Does this facility contain a prov					er of costs	
or charges? Enter "Y" for yes or 155.00 Hospi tal	"N" for no for each compon	N	A and Part B. N	(See 42 CFR §41	3.13) N	155.00
156.00 Subprovi der – IPF		N	N	N	N	156.00
157. 00 Subprovi der – IRF 158. 00 SUBPROVI DER		N	N	N	N	157.00 158.00
159. 00 SNF		N	N	Ν	N	159.00
160.00 HOME HEALTH AGENCY		Ν	N	N	N	160.00
161.00 CMHC			N	N	N	161.00
					1.00	
Multicampus 165.00Is this hospital part of a Multica	ampus hospital that has on	e or more camp	uses in diffe	rent CBSAs?	N	165.00
Enter "Y" for yes or "N" for no.	· ·					
	Name 0	County 1.00		Code CBSA	FTE/Campus 5.00	-
166.00 If line 165 is yes, for each		1.00	2.00 5	4.00		0166.00
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)						
lleal the Information Tachnal any (III)	T) inconting in the Americ		d Dei nucetmen	+ Ao+	1.00	
Heal th Information Technology (HI 167.00 Is this provider a meaningful use				IL ACL	Y	167.00
168.00 If this provider is a CAH (line 10	D5 is "Y") and is a meanin	gful user (lin		, enter the		168.00
reasonable cost incurred for the l 168.01 If this provider is a CAH and is n			er qualify for	a hardshi p		168.01
exception under §413.70(a)(6)(ii)	? Enter "Y" for yes or "N"	for no. (see	instructions)			
169.00 If this provider is a meaningful transition factor. (see instruction		is not a CAH	(line 105 is	"N"), enter the	9.9	9169.00
	,				1	I.

Health Financial Systems	METHODI ST HOSP	In Lie	u of Form CMS-	2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENT	IFICATION DATA		Period:	Worksheet S-2	2
			From 01/01/2020 To 12/31/2020		onorod.
			10 12/31/2020	Date/Time Pro 7/23/2021 10	
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					170.00
	1.00	2.00			
171.00 If line 167 is "Y", does this provider ha	ive any days for ind	lividuals enrolled in	N		0171.00
section 1876 Medicare cost plans reported	lon Wkst. S-3, Pt.	I, line 2, col. 6? Enter			
"Y" for yes and "N" for no in column 1. I	f column 1 is yes,	enter the number of section	on		
1876 Medicare days in column 2. (see inst	ructions)				

IOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet S- Part II Date/Time Pr 7/23/2021 10	epared
				Y/N	Date	_
		Constant NO		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	for all NU re	esponses. En	ter all dates in	the	
	COMPLETED BY ALL HOSPITALS					_
	Provider Organization and Operation					_
. 00	Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.0
	reporting period? If yes, enter the date of the change in c	olumn 2. (see	instruction:	s)		
			Y/N	Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	in column 2 the date of termination and in column 3, "V" for provident of the second sec				2.0
. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home o or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members o of directors through ownership, control, or family and othe relationships? (see instructions)	ffices, drug er or its f the board	N			3. (
			Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					
. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled, ilable in	Y	A		4. C
. 00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5.0
	Those on the fired finalicial statements? If yes, submit fee			Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities		-			
. 00	Column 1: Are costs claimed for nursing school? Column 2:	lfyes, is t	he provider i	is N		6.0
	the legal operator of the program?					
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		d during the	Y Y		7. C 8. C
. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	n Y		9.0
0.00	Was an approved Intern and Resident GME program initiated o cost reporting period? If yes, see instructions.			Ν		10.0
1.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an Ap	proved	N	Y/N	11. (
				-	1.00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			cost reporting	Y N	12. (13. (
4.00	If line 12 is yes, were patient deductibles and/or co-payme	nts waived? I	f yes, see i	nstructions.	Ν	14.0
	Bed Complement			I		
5.00	Did total beds available change from the prior cost reporti	<u><u>v</u> .</u>			Ν	15. (
			t A	Par		_
	-	Y/N 1.00	Date 2.00	Y/N	Date 4.00	
	PS&R Data	1.00	2.00	3.00	4.00	
6. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see	N		N		16.0
7.00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	03/19/2021	Y	03/19/2021	17. (
8. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		N		18.
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		Ν		19.

Heal th	Fi nanci al	Systems	

METHODI ST HOSPI TALS, INC

In Lieu of Form CMS-2552-10

Health Financial Systems METHODIST HO	SPITALS, INC		In Lie	u of Form CMS	- <u>2552-1</u> 0
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider 0		Period: From 01/01/2020 To 12/31/2020	Date/Time Pr	epared:
	Docor	intion	Y/N	7/23/2021 10 Y/N	:58 am
		iption 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:		0	N	N	20.00
	Y/N	Date	Y/N	Date	
	1.00	2.00	3.00	4.00	
21.00 Was the cost report prepared only using the provider's	N		Ν		21.00
records? If yes, see instructions.					
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC Capital Related Cost	JEPT UNILUKENS	HUSPITALS)			_
22.00 Have assets been relifed for Medicare purposes? If yes, se	ee instructions	5		N	22.00
23.00 Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.			ng the cost		23.00
24.00 Were new Leases and/or amendments to existing Leases enter If yes, see instructions	red into during	g this cost rep	porting period?		24.00
25.00 Have there been new capitalized leases entered into during instructions.	g the cost repo	orting period?	lf yes, see		25.00
26.00 Were assets subject to Sec. 2314 of DEFRA acquired during 1 instructions.	the cost report	ing period? If	fyes, see		26.00
27.00 Has the provider's capitalization policy changed during the copy.		27.00			
28.00 Were new Loans, mortgage agreements or letters of credit e		28.00			
period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or	r bond funds (D)ebt Service Re	eserve Fund)		29.00
treated as a funded depreciation account? If yes, see inst 30.00 Has existing debt been replaced prior to its scheduled mat		/debt?lfyes,	see		30.00
instructions. 31.00 Has debt been recalled before scheduled maturity without i	issuance of new	v debt? If yes,	see		31.00
instructions. Purchased Services					-
32.00 Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr		ned through cor	ntractual	Ν	32.00
33.00 If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.		ng to competit	tive bidding? If	N	33.00
Provi der-Based Physi ci ans					
34.00 Are services furnished at the provider facility under an a	arrangement wit	h provider-bas	sed physi ci ans?	Y	34.00
If yes, see instructions. 35.00 If line 34 is yes, were there new agreements or amended ex		ents with the p	provi der-based	Ν	35.00
physicians during the cost reporting period? If yes, see i	instructions.		Y/N	Date	
			1.00	2.00	
Home Office Costs					
 36.00 Were home office costs claimed on the cost report? 37.00 If line 36 is yes, has a home office cost statement been p 	prepared by the	e home office?	N N		36.00 37.00
If yes, see instructions. 38.00 If line 36 is yes , was the fiscal year end of the home of			Ν		38.00
the provider? If yes, enter in column 2 the fiscal year er 39.00 If line 36 is yes, did the provider render services to oth			Ν		39.00
40.00 If line 36 is yes, did the provider render services to the	e home office?	lf yes, see	Ν		40.00
instructions.					
	1.	. 00	2.	00	
41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	MI CHAEL		ALESSANDRI NI		41.00
respectively. 42.00 Enter the employer/company name of the cost report	BLUE & CO., LI	LC			42.00
43.00 Enter the telephone number and email address of the cost	317-713-7959		MALESSANDRI NI @	BLUEANDCO. COM	43.00
report preparer in columns 1 and 2, respectively.					

Health Financial Systems METHODIST	HOSPI TALS, I NC	In Lieu	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0002	Peri od:	Worksheet S-2	
		From 01/01/2020 To 12/31/2020	Part II Date/Time Pre	nared
		10 12/31/2020	7/23/2021 10:	
	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 cos	t			43.00
report preparer in columns 1 and 2, respectively.				

10SPI 1	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	METHODIST HOSE AL DATA	Provider CC	CN: 15-0002	Period: From 01/01/2020	u of Form CMS-: Worksheet S-3 Part I	
					To 12/31/2020		
						I/P Days / O/P Visits /	
						Tri ps	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number	2.00	Available 3.00	4.00	F 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1.00 30.00	2.00	<u> </u>	4.00 16 0.00	5.00	1.0
1.00	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2	30.00	370	137,0	0.00	0	1.0
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.0
3.00	HMO I PF Subprovi der						3.0
. 00 . 00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF					0	4. 5.
o. 00 o. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF					0	
7.00	Total Adults and Peds. (exclude observation		376	137, 61	0.00	0	
. 00	beds) (see instructions)		570	157,0	0.00	0	/ / /
. 00	INTENSIVE CARE UNIT	31.00	33	12, 07	0.00	0	8.
. 01	NEONATAL ICU	31.01	36	13, 17	76 0.00	0	8.
00	CORONARY CARE UNIT						9.
0. 00	BURN INTENSIVE CARE UNIT						10.
1.00	SURGI CAL INTENSI VE CARE UNI T						11.
2.00	OTHER SPECIAL CARE (SPECIFY)						12.
3.00	NURSERY	43.00				0	
4.00	Total (see instructions)		445	162, 87	0.00	0	
5.00	CAH visits	10.00	10	4.00		0	
6.00	SUBPROVIDER - IPF	40.00	12	4, 39		0	
7.00	SUBPROVIDER - IRF	41.00	39	14, 27	/4	0	
8.00 9.00	SUBPROVIDER SKILLED NURSING FACILITY						18. 19.
0.00	NURSING FACILITY						20.
1.00	OTHER LONG TERM CARE						21.
2.00	HOME HEALTH AGENCY	101.00				0	
3.00	AMBULATORY SURGICAL CENTER (D. P.)	101100				, i	23.
4.00	HOSPICE						24.
4. 10	HOSPICE (non-distinct part)	30.00					24.
5.00	CMHC - CMHC						25.
6.00	RURAL HEALTH CLINIC						26.
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	
7.00	Total (sum of lines 14-26)		496				27.
8.00	Observation Bed Days					0	
9.00	Ambul ance Trips						29.
0.00	Employee discount days (see instruction)						30.
1.00	Employee discount days - IRF		0		0		31.
2.00	Labor & delivery days (see instructions) Total ancillary labor & delivery room		0		U		32. 32.
o∠. ∪ I	outpatient days (see instructions)						32.
33.00	LTCH non-covered days						33.
	LTCH site neutral days and discharges						33.

)SPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 01/01/2020 To 12/31/2020	Worksheet S-3 Part I Date/Time Pre 7/23/2021 10:	epare
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	-
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)	19, 768	4, 106	63, 49		10.00	1
00	HMO and other (see instructions)	18, 379	21, 784				2
00	HMO IPF Subprovider	0	447				3
00	HMO IRF Subprovider	0	805				4
00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5
00	Hospital Adults & Peds. Swing Bed NF		0		0		6
00	Total Adults and Peds. (exclude observation beds) (see instructions)	19, 768	4, 106	63, 49	1		7
00	INTENSIVE CARE UNIT	3, 100	0	9,40	3		8
01	NEONATAL ICU	0	0	3, 04	7		8
00	CORONARY CARE UNI T						9
. 00	BURN INTENSIVE CARE UNIT						10
. 00	SURGICAL INTENSIVE CARE UNIT						11
. 00	OTHER SPECIAL CARE (SPECIFY)						12
. 00	NURSERY		0	2, 54	5		13
. 00	Total (see instructions)	22, 868	4, 106	78, 48	6 3.00	1, 832. 61	14
. 00	CAH visits	0	0		0		15
. 00	SUBPROVIDER - IPF	949	70	2, 51	5 0.00	14.00	16
00	SUBPROVIDER - IRF	2,666	195	5,40		30. 22	117
00	SUBPROVI DER						118
00	SKILLED NURSING FACILITY						19
. 00	NURSING FACILITY						20
00	OTHER LONG TERM CARE						21
. 00	HOME HEALTH AGENCY	7, 805	1, 182	23, 97	9 0.00	28.16	
. 00	AMBULATORY SURGICAL CENTER (D. P.)	,	, -				23
. 00	HOSPI CE						24
. 10	HOSPICE (non-distinct part)			18	2		24
. 00	CMHC - CMHC				_		25
. 00	RURAL HEALTH CLINIC						26
. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0.00	0.00	
. 00	Total (sum of lines 14-26)		U.S.		3.00		
. 00	Observation Bed Days		4, 045	14, 77			28
00	Ambul ance Trips	0	1, 010	,			29
. 00	Employee discount days (see instruction)	0			0		30
. 00	Employee discount days (see first detroit)				0		31
. 00	Labor & delivery days (see instructions)	0	96	10			32
. 00	Total ancillary labor & delivery room	0	70		0		32
. 01	outpatient days (see instructions)						32
3.00	LTCH non-covered days	0					33
	LIGH HUH-COVELEU Udys	0			1	1	1 33

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	<u>METHODIST HOSP</u> AL DATA		CN: 15-0002	Peri od:	u of Form CMS-2 Worksheet S-3	
					From 01/01/2020 To 12/31/2020	Part I Date/Time Pre 7/23/2021 10:	
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Patients	
1 00	Useritel Adulte O Dada (selumna E. (. 7 and	11.00	12.00	13.00	14.00	15.00	1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 8.01 9.00 10.00	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) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT NEONATAL ICU CORONARY CARE UNIT BURN INTENSIVE CARE UNIT		C	2, 1		11, 565	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 8.01 9.00 10.00
11.00 12.00 13.00 14.00 15.00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits	0.00	C	3, 3	83 514	11, 565	11.00 12.00 13.00 14.00 15.00
16.00 17.00 18.00 19.00 20.00 21.00	SUBPROVI DER - I PF SUBPROVI DER - I RF SUBPROVI DER SKI LLED NURSI NG FACI LI TY NURSI NG FACI LI TY OTHER LONG TERM CARE	0. 00 0. 00	C C		42 3 83 14	173 372	16.00 17.00 18.00 19.00 20.00 21.00
22.00 23.00 24.00 24.10 25.00 26.00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	0. 00					22.00 23.00 24.00 24.10 25.00 26.00
26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0. 00 0. 00					26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 01
33. 00 33. 01	LTCH non-covered days LTCH site neutral days and discharges				0 0		33. 00 33. 01

SPI T	Financial Systems AL WAGE INDEX INFORMATION		METHODI ST HOS	Provider C		eriod:	Worksheet S-3	
						rom 01/01/2020 o 12/31/2020	Part II Date/Time Pre	par
			A	D. I. Start			7/23/2021 10:	58
		Wkst. A Line Number	Amount Reported	Reclassificat	Adj usted Sal ari es	Paid Hours Related to	Average Hourly Wage	
		i dinio o i	nopor cou	Sal ari es	$(col.2 \pm col.$	Salaries in	(col . 4 ÷	
				(from Wkst.	3)	col. 4	col. 5)	
		1.00	2.00	A-6) 3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
0	SALARIES Total salaries (see	200.00	148, 683, 146	-388,650	148, 294, 496	3, 967, 910. 00	37.37	1 1
0	instructions)	200.00	140, 003, 140	- 300, 030	140, 294, 490	3, 907, 910. 00	37.37	
0	Non-physician anesthetist Part		0	0	0	0.00	0.00	
0	A Non-physician anesthetist Part		0	0	0	0. 00	0.00	3
0	В		Ū			0.00	0.00	
0	Physician-Part A -		26,000	0	26, 000	145.00	179. 31	4
)1	Administrative Physicians - Part A - Teaching		0	0	0	0.00	0.00	
0	Physician and Non		2, 217, 675					
	Physician-Part B					0.00	0.00	
00	Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0.00	0.00	6
	servi ces							
00	Interns & residents (in an	21.00	0	0	0	0.00	0.00	
)1	approved program) Contracted interns and		252, 816	0	252, 816	6, 240. 00	40. 52	7
	residents (in an approved					2, 210, 30		
0	programs) Home office and/or related		0	0	_	0.00	0.00	6
0	organizati on personnel		0		0	0.00	0.00	
00	SNĚ	44.00	0	0	0	0.00	0.00	
00	Excluded area salaries (see instructions)		27, 760, 199	552, 708	28, 312, 907	547, 724. 00	51.69	10
	OTHER WAGES & RELATED COSTS			<u> </u>				
00	Contract Labor: Direct Patient		11, 161, 434	0	11, 161, 434	172, 765. 00	64.60	1.
00	Care Contract Labor: Top Level		0	0	0	0.00	0.00	1.
00	management and other		0		0	0.00	0.00	
	management and administrative							
00	services Contract Labor: Physician-Part		744, 375	0	744, 375	4, 518. 00	164. 76	11
00	A - Administrative		744, 575		, , , , , , , , , , , , , , , , , , , ,	4, 510.00	104.70	
00	Home office and/or related		0	0	0	0.00	0.00	14
	organization salaries and wage-related costs							
01	Home office salaries		0	0	0	0.00	0.00	
02	Related organization salaries		0	0	0		0.00	
00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	
00	Home office and Contract		0	0	0	0.00	0.00	16
0.1	Physicians Part A - Teaching					0.00	0.00	
01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	
02	Home office contract		0	0	0	0.00	0.00	16
	Physicians Part A - Teaching WAGE-RELATED COSTS							
00	Wage-related costs (core) (see		33, 113, 497	0	33, 113, 497			117
	instructions)			-				
00	Wage-related costs (other) (see instructions)							18
00	Excluded areas		5, 885, 021	0	5, 885, 021			19
	Non-physician anesthetist Part		0	0	0			20
00	A Non-physician anesthetist Part		0	_	_			2
50	B		0					[∠]
00	Physician Part A -		2, 617	0	2, 617			22
01	Administrative Physician Part A - Teaching		0	n	n			22
	Physician Part B		316, 583	0	316, 583			23
00	Wage-related costs (RHC/FQHC)		0	0	0			24
00	Interns & residents (in an approved program)		0	0	0			25
50	Home office wage-related		0	о	о			25
	(core)		-		-			
51	Related organization wage-related (core)		0	0	0			25
52	Home office: Physician Part A		0	о	о			25
	- Administrative - wage-related (core)							

	Financial Systems		METHODI ST HOS				u of Form CMS-2	
HOSPI T	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2020 To 12/31/2020		pared:
		Wkst. A Line	Amount	Recl assi fi cat		Paid Hours	Average	
		Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.		(col. 4 ÷	
				(from Wkst. A-6)	3)	col. 4	col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A		0	0		0		25.53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARI							
26.00	Employee Benefits Department	4.00						26.00
27.00	Administrative & General	5.00	22, 275, 602					
28.00	Administrative & General under		1, 787, 185	0	1, 787, 18	8, 890. 00	201.03	28.00
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00	0	0		0 0.00		29.00
30.00	Operation of Plant	7.00	3, 889, 109	-21, 236	3, 867, 87			
31.00	Laundry & Linen Service	8.00	0	0		0 0.00		
32.00	Housekeepi ng	9.00	4, 147, 379	-15, 377	4, 132, 00			
33.00	Housekeeping under contract (see instructions)		0	0		0 0.00		
34.00	Dietary	10.00	3, 081, 985	-1, 078, 470	2, 003, 51			34.00
35.00	Dietary under contract (see instructions)		0	0		0 0.00	0.00	35.00
36.00	Cafeteri a	11.00	346, 372	1, 077, 725	1, 424, 09	65, 395. 00	21.78	36.00
37.00	Maintenance of Personnel	12.00	0	0		0 0.00	0.00	37.00
38.00	Nursing Administration	13.00	3, 636, 319	-5, 421	3, 630, 89	60, 257. 00	60.26	38.00
39.00	Central Services and Supply	14.00	616, 865	-9, 779	607, 08	6 28, 730. 00	21.13	39.00
40.00	Pharmacy	15.00	0	0		0 0.00	0.00	40.00
41.00	Medi cal Records & Medi cal Records Library	16.00	2, 030, 401	-4, 893	2, 025, 50	8 81, 604. 00	24.82	41.00
42.00	Social Service	17.00	699	441, 467	442, 16	6 14, 487. 00	30. 52	42.00
43.00	Other General Service	18.00	0			0 0.00		43.00

Heal th	Financial Systems		METHODIST HOS	SPITALS, INC		In Lie	u of Form CMS-2	2552-10
HOSPI	TAL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2020 To 12/31/2020		
						10 12/01/2020	7/23/2021 10:	
		Worksheet A	Amount	Recl assi fi cat		Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.		(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY				-		
1.00	Net salaries (see		147, 999, 840	-388,650	147, 611, 19	0 3, 949, 369. 00	37.38	1.00
	instructions)							
2.00	Excluded area salaries (see		27, 760, 199	552, 708	28, 312, 90	7 547, 724. 00	51.69	2.00
	instructions)							
3.00	Subtotal salaries (line 1		120, 239, 641	-941, 358	119, 298, 28	3 3, 401, 645. 00	35.07	3.00
	minus line 2)							
4.00	Subtotal other wages & related		11, 905, 809	0	11, 905, 80	9 177, 283. 00	67.16	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		33, 116, 114	0	33, 116, 11	4 0.00	27.76	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		165, 261, 564					
7.00	Total overhead cost (see		43, 727, 948	-604, 928	43, 123, 02	0 1, 404, 497. 00	30.70	7.00
	instructions)							

Heal th	Financial Systems	METHODI ST HOSPI	TALS. INC		In Lieu	u of Form CMS-2	2552-10	
	AL WAGE RELATED COSTS			CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet S-3 Part IV	pared:	
						Amount		
					-	Reported 1.00		
	PART IV - WAGE RELATED COSTS					1.00		
	Part A - Core List							
	RETIREMENT COST							
1.00	401K Employer Contributions					2, 140, 624	1.00	
2.00	Tax Sheltered Annuity (TSA) Employer Contribu	ution				2, 110, 021	2.00	
3.00	Nonqualified Defined Benefit Plan Cost (see i					3, 200, 000		
4.00	Qualified Defined Benefit Plan Cost (see inst					0,200,000	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	ı				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					0		
8.02	Health Insurance (Self Funded with a Third Pa	arty Administrato	or)			15, 831, 309		
8.03	Health Insurance (Purchased)					0		
9.00	Prescription Drug Plan					3, 893, 759		
10.00	Dental, Hearing and Vision Plan					825, 918		
11.00	Life Insurance (If employee is owner or benef					451, 764		
12.00	Accident Insurance (If employee is owner or b					0		
13.00	Disability Insurance (If employee is owner or					388, 650		
	Long-Term Care Insurance (If employee is owned	er or beneficiary	()			0		
15.00	'Workers' Compensation Insurance					1, 500, 804		
16.00	Retirement Health Care Cost (Only current yea	ir, not the extra	aordinary a	ccruai requir	ed by FASB 106.	0	16.00	
	Non cumulative portion) TAXES				I			
17 00	FICA-Employers Portion Only					10, 132, 435	17 00	
18.00	Medicare Taxes - Employers Portion Only					10, 132, 435		
	Unemployment Insurance					746, 374		
	State or Federal Unemployment Taxes					0		
20.00	OTHER						20.00	
21.00	Executive Deferred Compensation (Other Than R instructions))	Retirement Cost R	Reported on	lines 1 thro	ugh 4 above. (see	0	21.00	
22.00	Day Care Cost and Allowances					0	22.00	
23.00	Tuition Reimbursement					206, 080	23.00	
24.00	Total Wage Related cost (Sum of lines 1 -23)					39, 317, 717		
	Part B - Other than Core Related Cost							
25.00	OTHER WAGE RELATED COSTS (SPECIFY)						25.00	

Heal th	Financial Systems	METHODI ST HOSPI TALS, INC		In Lieu	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-00	F	eriod: rom 01/01/2020		
			T	o 12/31/2020	Date/Time Pre 7/23/2021 10:	
	Cost Center Description			Contract	Benefit Cost	
				Labor 1.00	2.00	
	PART V - Contract Labor and Benefit Cost				2100	
	Hospital and Hospital-Based Component Identi	fi cati on:				
1.00	Total facility's contract labor and benefit	cost		11, 161, 434	39, 317, 717	1.00
2.00	Hospi tal			11, 161, 434	39, 317, 717	2.00
3.00	Subprovider - IPF			0	0	3.00
4.00	Subprovider - IRF			0	0	4.00
5.00	Subprovider - (Other)			0	0	5.00
6.00	Swing Beds - SNF			0	0	6.00
7.00	Swing Beds - NF			0	0	7.00
8.00	Hospital-Based SNF					8.00
9.00	Hospital-Based NF					9.00
10.00	Hospital-Based OLTC					10.00
11.00	Hospital-Based HHA			0	0	11.00
12.00	Separately Certified ASC					12.00
13.00	Hospital-Based Hospice					13.00
14.00	Hospital-Based Health Clinic RHC					14.00
15.00	Hospital-Based Health Clinic FQHC					15.00
16.00	Hospital-Based-CMHC					16.00
17.00	Renal Dialysis			0	0	17.00
18.00	Other			0	0	18.00

Index Index <th< th=""><th>Health Financial Systems</th><th>METHODI ST HOS</th><th>PITALS INC</th><th></th><th>Inlie</th><th>u of Form CMS-:</th><th>2552-10</th></th<>	Health Financial Systems	METHODI ST HOS	PITALS INC		Inlie	u of Form CMS-:	2552-10
Component 00% 15-753 To 12/12/13 The Head th Autmount 0.00 Country 100 100 0.00 1.00 1.00 2.00 3.00 4.00 5.00 1.00 1.00 2.00 3.00 0.00 0.00 0.00 1.00 1.00 2.00 3.00 0.00 <t< td=""><td></td><td></td><td></td><td>CN: 15-0002</td><td>Period:</td><td>Worksheet S-4</td><td></td></t<>				CN: 15-0002	Period:	Worksheet S-4	
Home Head Head Age			Component	CCN: 15-7536		Date/Time Pre	
0.00 County Title V Title V Title V Title V Total 0.00 1.00 1.00 2.00 4.00 4.00 5.00 1.00 5.00 1.00 1.00 2.00 3.00 0							<u>50 alli</u>
0.00 County Title V Title VIII Title VIIII Title VIII Title VIIII					Agency I		
Title V Title V Title V Title XI Other Total 1.00 2.00 3.00 4.00 5.00 1.00 Mone Mail h Ade Nors See Transmission 0					1.	00	
Index HALTH ADENCY STATISTICAL DATA 0 <	0.00 County	Title V	Title XVIII	Title XIX	Other	Total	0.00
1.00 Hene Heal th Al de Hours 0<		1.00	2.00	3.00	4.00	5.00	
Number of Employees (Full Time Equivalent) Enter the number of hours in your normal work week Staff Contract Total 0 0.00 0.00 0.00 0.00 0.00 0.00 1.00 Protect Assistant Administrator(s) 0.00 0.00 0.00 0.00 0.00 0.00 0.00 Director(s) and Assistant Director(s) 0.00		0	0		0 0	0	1.00
Enter The number Staff Contract Total 900 1.00 2.00 3.00 0.00	2.00 Unduplicated Census Count (see instructions)	0.00	320.00				2.00
VPME HEALTH AGENCY - NUMBER OF EMPLOYES 0 1.00 2.00 3.00 10 Administrator and Assistant Administrator(s) 0.00 0.0					proyees (Full II	ille Equi vai erri)	
VPME HEALTH AGENCY - NUMBER OF EMPLOYES 0 1.00 2.00 3.00 10 Administrator and Assistant Administrator(s) 0.00 0.0							
Image: Instruction Image:				Staff	Contract	Total	
Howe HEALTH AGENCY - NUMBER OF EMPLOYEES 100 Addin INSTrator and Assistant Addin ISTRATO(S) 0.00		your normal	work week				
Howe HEALTH AGENCY - NUMBER OF EMPLOYEES 100 Addin INSTrator and Assistant Addin ISTRATO(S) 0.00							
Howe HEALTH AGENCY - NUMBER OF EMPLOYEES 100 Addin INSTrator and Assistant Addin ISTRATO(S) 0.00		()	1.00	2.00	3.00	
4.00 Director(s) and Assistant Director(s) 0.00				1		1	0.00
5:00 Other Administrative Personnel 0.00			0.00				
Process Nursing SuperVisor 0.00	5.00 Other Administrative Personnel			0.0	0. 00	0.00	5.00
8.00 Physical Therapy Supervisor 0.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
10.00 0ccupational Thérapy Spervice 0.00 0.00 0.00 0.00 10.00 11.00 0ccupational Thérapy Spervicsor 0.00 0.00 0.00 0.00 10.00 12.00 Speech Pathology Supervisor 0.00 0.00 0.00 0.00 10.00 13.00 Speech Pathology Supervisor 0.00 0.00 0.00 10.00 16.00 Hold cal Social Service Supervisor 0.00 0.00 0.00 10.00 16.00 Hold cal Social Scotal Services 0.00 0.00 0.00 16.00 17.00 Home Healt Hi de Supervisor 0.00 0.00 0.00 16.00 17.00 Chene Healt Hi de Supervisor 0.00 0.00 0.00 16.00 19.00 List these CBSA code(s) in column 1 serviced during this cost reporting period (line 20 23844 19.00 1.400 1.400 1.400 1.400 1.400 1.400 1.400 1.400 1.400 1.400 1.400 1.400 1.400 1.400 1.400 1.400							1
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13.00 Speech Pathology Supervisor 0.00 0.00 0.00 0.00 0.00 13.00 14.00 Medical Social Service Supervisor 0.00 0.00 0.00 0.00 0.00 13.00 14.00 Medical Social Service Supervisor 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 15.00 16.00 Home Healt h Aide 0.00 0.00 0.00 0.00 0.00 0.00 17.00 17.00 Dotter (specify) 0.00 0.00 0.00 0.00 18.00 19.00 Enter in column 1 the number of CBSAs where reyour old edservices during the cost reporting period. 23844 20.00 19.00 20.00 List those CBSA code(s) in column 1 serviced during this cost reporting period. 20.00 2.00 3.00 4.00 5.00 21.00 Skilled Nursing Visit S 3.376 731 82 29 4.218 21.00 22.00 Skilled Nursing Visit Charges 670,009 145,260 16.285 5,606 837,160 22.00 23.00 Physical Therapy Visit S							
14.00 Medical Social Service 0.00 0.00 0.00 0.00 14.00 15.00 Medical Social Service Supervisor 0.00 0.00 0.00 0.00 0.00 0.00 15.00 16.00 Home Heal th Aide Supervisor 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 17.00 HOME HEALTH AGENCY CBSA CODES 0.00 0.00 0.00 0.00 0.00 0.00 0.00 18.00 Properting period. 20.00 Lift those CBSA code(s) in column 1 serviced 23844 20.00 20.00 4.00 5.00 PES ACTIVITY DATA 1.00 2.00 3.00 4.00 5.00 22.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
15:00 Medical Social Service Supervisor 0.00<							
17:00 Home Health Aide Supervisor 0.00 0.00 0.00 0.00 0.00 17:00 18:00 Other (specify) 0.00 <td< td=""><td>15.00 Medical Social Service Supervisor</td><td></td><td></td><td>0.0</td><td>0. 00</td><td>0.00</td><td>15.00</td></td<>	15.00 Medical Social Service Supervisor			0.0	0. 00	0.00	15.00
18.00 Other (speci Fy) 0.00 0.00 0.00 18.00 HOME HEALTH AGENCY CBSA CODES 1 1 1 1 1 1 1 1 1 1 0 0 0.00 0.00 0.00 0.00 0.00 1 1 1 1 1 0 1 0 1 1 1 0 1 0 0 0 0.00 0.00 0.00 0.00 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
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26.00 Occupational Therapy Visit Charges 95,475 46,368 219 876 142,938 26.00 27.00 Speech Pathology Visits 35 16 0 1 52 27.00 28.00 Speech Pathology Visit Charges 8,147 3,760 0 235 12,142 28.00 29.00 Medical Social Service Visits 16 2 0 0 18 29.00 30.00 Medical Social Service Visit Charges 5,072 634 0 0 5,706 30.00 31.00 Home Heal th Aide Visits 627 149 1 19 796 31.00 32.00 Home Heal th Aide Visit Charges 55,703 13,211 89 1,656 70,659 32.00 33.00 Total visits (sum of Lines 21, 23, 25, 27, 6,161 1,465 104 75 7,805 33.00 29, and 31) 0 0 0 0 0 0 0 34.00 35.00 Total Charges (sum of Lines 22, 24, 26, 28, 1,195,584 286,160 20,933 13,063 1,515,740 35.00					1 4, 690		
28.00 Speech Pathology Visit Charges 8,147 3,760 0 235 12,142 28.00 29.00 Medical Social Service Visits 16 2 0 0 18 29.00 30.00 Medical Social Service Visits 16 2 0 0 18 29.00 30.00 Medical Social Service Visit Charges 5,072 634 0 0 5,706 30.00 31.00 Home Heal th Aide Visits 627 149 1 19 796 31.00 32.00 Home Heal th Aide Visit Charges 55,703 13,211 89 1,656 70,659 32.00 33.00 Total visits (sum of lines 21, 23, 25, 27, 29, and 31) 6,161 1,465 104 75 7,805 33.00 34.00 Other Charges 0 0 0 0 30.00 34.00 35.00 Total Charges (sum of lines 22, 24, 26, 28, 1,195,584 286,160 20,933 13,063 1,515,740 35.00 36.00 Total Number of Episodes (standard/non of 000 60 6 573 36.00 0 59	26.00 Occupational Therapy Visit Charges	95, 475	46, 368	21		142, 938	26.00
29.00 Medical Social Service Visits 16 2 0 0 18 29.00 30.00 Medical Social Service Visit Charges 5,072 634 0 0 5,706 30.00 31.00 Home Heal th Aide Visits 627 149 1 19 796 31.00 32.00 Home Heal th Aide Visit Charges 55,703 13,211 89 1,656 70,659 32.00 33.00 Total visits (sum of lines 21, 23, 25, 27, 29, and 31) 6,161 1,465 104 75 7,805 33.00 34.00 Other Charges 0 0 0 0 34.00 35.00 Total Charges (sum of lines 22, 24, 26, 28, 1,195,584 286,160 20,933 13,063 1,515,740 35.00 36.00 Total Number of Episodes (standard/non of contil er) 507 60 60 6 573 36.00 37.00 Total Number of Outlier Episodes 59 0 59 37.00							
31.00 Home Heal th Ai de Visits 627 149 1 19 796 31.00 32.00 Home Heal th Ai de Visit Charges 55,703 13,211 89 1,656 70,659 32.00 33.00 Total visits (sum of lines 21, 23, 25, 27, 29, and 31) 6,161 1,465 104 75 7,805 33.00 34.00 Other Charges 0 0 0 0 0 34.00 35.00 Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34) 1,195,584 286,160 20,933 13,063 1,515,740 35.00 36.00 Total Number of Episodes (standard/non outlier) 507 60 60 673 36.00 37.00 Total Number of Outlier Episodes 59 0 59 37.00	29.00 Medical Social Service Visits	16	2		0 0	18	29.00
32.00 Home Health Aide Visit Charges 55,703 13,211 89 1,656 70,659 32.00 33.00 Total visits (sum of lines 21, 23, 25, 27, 29, and 31) 6,161 1,465 104 75 7,805 33.00 34.00 Other Charges 0 0 0 0 0 34.00 35.00 Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34) 1,195,584 286,160 20,933 13,063 1,515,740 35.00 36.00 Total Number of Episodes (standard/non outlier) 507 60 60 673 36.00 37.00 Total Number of Outlier Episodes 59 0 59 37.00	5						
29, and 31) 29, and 31) 34.00 Other Charges 0 0 0 0 0 34.00 35.00 Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34) 1,195,584 286,160 20,933 13,063 1,515,740 35.00 36.00 Total Number of Episodes (standard/non outlier) 507 60 60 6 573 36.00 37.00 Total Number of Outlier Episodes 59 0 59 37.00	32.00 Home Health Aide Visit Charges		13, 211	8	39 1, 656	70, 659	32.00
34.00 Other Charges 0 0 0 0 34.00 35.00 Total Charges (sum of Lines 22, 24, 26, 28, 30, 32, and 34) 1,195,584 286,160 20,933 13,063 1,515,740 35.00 36.00 Total Number of Episodes (standard/non outlier) 507 60 60 6 573 36.00 37.00 Total Number of Outlier Episodes 59 0 59 37.00	•	6, 161	1, 465	10	75	7, 805	33.00
30, 32, and 34) Total Number of Episodes (standard/non outlier) 507 60 6 573 36.00 37.00 Total Number of Outlier Episodes 59 0 59 37.00	34.00 Other Charges	0	C		-	0	34.00
36.00Total Number of Episodes (standard/non outlier)50760657336.0037.00Total Number of Outlier Episodes5905937.00		1, 195, 584	286, 160	20, 93	13, 063	1, 515, 740	35.00
37.00 Total Number of Outlier Episodes 59 0 59 37.00	36.00 Total Number of Episodes (standard/non	507		6	60 6	573	36.00
			59		0	59	37.00
		191, 266					

Heal th	Financial Systems METHODIST HOSPITA	LS, INC		In Lie	u of Form CMS-2	2552-10	
		Provider CCN:		Period:	Worksheet S-1	0	
				rom 01/01/2020			
			٦	o 12/31/2020	Date/Time Pre		
				-	7/23/2021 10:	58 811	
					1.00		
	Uncompensated and indigent care cost computation				1.00		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	vided by line	e 202 column	8)	0. 239014	1.00	
	Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid				66, 695, 202	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement	tal payments	from Medica	i d?	N	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments fr	rom Medicaid			47, 216, 205	5.00	
6.00	Medi cai d charges				399, 692, 071	6.00	
7.00	Medicaid cost (line 1 times line 6)				95, 532, 001 0	7.00 8.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if						
	<pre>< zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions for </pre>	an agab lina	N				
9.00	Net revenue from stand-al one CHIP		0	9.00			
	Stand-al one CHIP charges				0	10.00	
	Stand-alone CHIP cost (line 1 times line 10)				0	11.00	
	Difference between net revenue and costs for stand-al one CHIP ((line 11 minu	us line 9 [,] i	f < zero then	0	12.00	
121 00	enter zero)	(2010 11011	, i i i i i i i i i i i i i i i i i i i	12100	
	Other state or local government indigent care program (see inst	tructions for	r each line)				
13.00	Net revenue from state or local indigent care program (Not incl	luded on line	es 2, 5 or 9)	0	13.00	
14.00	Charges for patients covered under state or local indigent care	e program (No	ot included	in lines 6 or	0	14.00	
	10)						
15.00	State or local indigent care program cost (line 1 times line 14			45 1 11	0	15.00	
16.00	Difference between net revenue and costs for state or local inc	digent care p	program (IIn	e 15 minus line	0	16.00	
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHI	IP and state	/local india	ent care progra	ame (see		
	instructions for each line)		rocar rhurg	ent care progra	unis (366		
17.00	Private grants, donations, or endowment income restricted to fu	unding chari [.]	tv care		0	17.00	
	Government grants, appropriations or transfers for support of h				0	18.00	
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local	l indigent ca	are programs	(sum of lines	0	19.00	
	8, 12 and 16)						
			Uni nsured	Insured	Total (col. 1		
			patients	pati ents	+ col. 2)		
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00		
20 00	Charity care charges and uninsured discounts for the entire fac	cility	22, 447, 98	1, 471, 028	23, 919, 009	20.00	
20.00	(see instructions)		22, 117, 70	1, 171, 020	20, 717, 007	20.00	
21.00	Cost of patients approved for charity care and uninsured discou	unts (see	5, 365, 382	1, 471, 028	6, 836, 410	21.00	
	instructions)						
22.00	Payments received from patients for amounts previously written	off as	(0 0	0	22.00	
	charity care						
23.00	Cost of charity care (line 21 minus line 22)		5, 365, 382	1, 471, 028	6, 836, 410	23.00	
					1.00		
24.00	Does the amount on line 20 column 2, include charges for patier	nt dave bevor	nd a length	of stav limit	N 1.00	24.00	
24.00	imposed on patients covered by Medicaid or other indigent care		nu a rength	or stay rimit	IN IN	24.00	
25.00	If line 24 is yes, enter the charges for patient days beyond th		care program	's lenath of	0	25.00	
	stay limit			- · · · · · · · · · · · · · · · · · · ·			
26.00	Total bad debt expense for the entire hospital complex (see ins	structions)			22, 074, 259	26.00	
	Medicare reimbursable bad debts for the entire hospital complex				1, 325, 239	27.00	
	Medicare allowable bad debts for the entire hospital complex (s	see instructi	i ons)		2, 038, 829 20, 035, 430		
	00 Non-Medicare bad debt expense (see instructions)						
	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	pense (see in	nstructions)		5, 502, 338		
	Cost of uncompensated care (line 23 column 3 plus line 29)				12, 338, 748		
31.00	Total unreimbursed and uncompensated care cost (line 19 plus li	ine 30)			12, 338, 748	31.00	

NLULA.	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provider CO	CN: 15-0002 P	eriod: rom 01/01/2020	Worksheet A	2552-10
					o 12/31/2020	Date/Time Pre 7/23/2021 10:	
	Cost Center Description	Sal ari es	Other		Recl assi fi cat	Recl assi fi ed	
				+ col. 2)	ions (See A-6)	Trial Balance (col. 3 +-	
					K 0)	col . 4)	
		1.00	2.00	3.00	4.00	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		0	0	20, 004, 108	20, 004, 108	1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 916, 032	29, 778, 429	31, 694, 461		32, 004, 005	4.00
5.01	00550 DATA PROCESSI NG	4, 421, 091	8, 992, 508	13, 413, 599		11, 728, 486	
5.02 5.03	00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING	934, 029 2, 187, 720	2, 812, 395 514, 081	3, 746, 424 2, 701, 801		3, 581, 730 2, 700, 160	
5.03 5.04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	2, 187, 720	4, 299, 083	6, 887, 320		6, 396, 363	5.03
5.05	00590 OTHER A&G	11, 626, 002	24, 891, 726	36, 517, 728		23, 077, 419	5.05
5.06	00592 PATIENT TRANSPORTATION	518, 523	55, 754	574, 277		549, 152	5.06
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	3, 889, 109 0	8, 368, 050 1, 265, 392	12, 257, 159 1, 265, 392		17, 401, 287 1, 265, 392	7.00 8.00
9.00	00900 HOUSEKEEPI NG	4, 147, 379	1, 275, 491	5, 422, 870		5, 195, 429	9.00
10.00	01000 DI ETARY	3, 081, 985	2, 697, 123	5, 779, 108		3, 529, 352	
11.00		346, 372	37, 498	383, 870		2, 560, 254	11.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	3, 636, 319 616, 865	1, 175, 906 1, 616, 223	4, 812, 225 2, 233, 088		4, 713, 134 1, 746, 366	
15.00	01500 PHARMACY	0	15, 625, 959	15, 625, 959		6,003,417	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	2,030,401	908, 120	2, 938, 521		2, 929, 307	16.00
17.00 17.01	01700 SOCIAL SERVICE 01701 STAFF EDUCATION	0	0	0		441, 467 0	17.00 17.01
17.02	01702 MEDICAL EDUCATION	699	18, 617	19, 316	-	19, 195	
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	252, 816	252, 816	21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0		31, 168	
23.00	02300 PARAMED ED PROGRAM	392, 097	63, 757	455, 854	198, 802	654, 656	23.00
30.00	03000 ADULTS & PEDIATRICS	28, 804, 106	15, 050, 480	43, 854, 586	-754, 846	43, 099, 740	30.00
31.00	03100 I NTENSI VE CARE UNI T	8, 115, 908	3, 138, 791	11, 254, 699		10, 532, 853	
31.01		1, 717, 684	1, 506, 107	3, 223, 791		3, 183, 242	
40.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	1, 120, 792 2, 209, 465	103, 002 414, 910	1, 223, 794 2, 624, 375		1, 213, 444 2, 583, 934	
43.00	04300 NURSERY	1, 481, 686	416, 880	1, 898, 566		1, 768, 818	
	ANCI LLARY SERVICE COST CENTERS	0 747 407	4 4 707 400	00 404 005	11 001 005	0.440.000	1 50 00
50.00 50.01	05000 OPERATI NG ROOM 05001 ENDOSCOPY	3, 717, 487 864, 851	16, 707, 498 1, 088, 451	20, 424, 985 1, 953, 302		8, 443, 980 1, 598, 696	
51.00	05100 RECOVERY ROOM	954, 520	110, 464	1, 064, 984		1, 078, 341	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 884, 565	1, 240, 328	4, 124, 893	-231, 100	3, 893, 793	
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 2, 335, 542	0 2, 298, 903	0 4, 634, 445	0 -872, 226	0 3, 762, 219	53.00 54.00
54.00	05401 RADI OLOGY - ULTRASOUND	1, 135, 713	872, 273	2, 007, 986		1, 569, 337	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	490, 377	2, 408, 391	2, 898, 768		2, 153, 632	
55.01	05501 I NFUSI ON CENTER	10, 712	28,647	39, 359		29, 950	
56.00 57.00	05600 RADI OI SOTOPE 05700 CT SCAN	515, 023 1, 143, 733	1, 484, 734 1, 207, 073	1, 999, 757 2, 350, 806		1, 757, 010 1, 977, 227	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	398, 968	1, 070, 650	1, 469, 618		768, 129	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	2, 346, 104	6, 326, 033	8, 672, 137		4, 162, 092	
60.00 60.01	06000 LABORATORY 06001 BLOOD LABORATORY	3, 570, 772 0	10, 947, 780 0	14, 518, 552 0		14, 456, 476 0	60.00 60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 165, 554	348, 436	1, 513, 990	-12, 390	1, 501, 600	
63.00 64.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	2, 538, 307	0 1, 288, 847	3, 827, 154	-316, 521	3, 510, 633	64.00 65.00
66.00	06600 PHYSI CAL THERAPY	1, 370, 351	131, 731	1, 502, 082		1, 494, 031	66.00
67.00	06700 OCCUPATI ONAL THERAPY	1, 119, 504	92, 396	1, 211, 900	-500	1, 211, 400	
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	436, 319 728, 670	43, 755 324, 994	480, 074 1, 053, 664		480, 067 872, 540	68.00 69.00
69.00 69.01	06901 CARDI AC REHAB	386, 936	324, 994 366, 110	753, 046		533, 141	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1,004,508	9, 777, 162	10, 781, 670	-9, 554, 083	1, 227, 587	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		10, 389, 568	
72.00 73.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	403, 891	0 2, 724, 440	3, 128, 331	10, 149, 884 15, 880, 811	10, 149, 884 19, 009, 142	72.00
74.00	07400 RENAL DI ALYSI S	0	2, 426, 281	2, 426, 281	-1, 263	2, 425, 018	74.00
00.00		0.440.045	0 474 574	4 000 700	222 221	4 (00 705	
90.00 91.00	09000 CLINIC 09100 EMERGENCY	2, 448, 215 6, 892, 178	2, 474, 574 5, 936, 070	4, 922, 789 12, 828, 248		4, 690, 705 11, 644, 927	90.00 91.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0,072,170	5, 750, 070	12, 020, 240	1, 103, 321	11, 044, 727	91.00
	OTHER REIMBURSABLE COST CENTERS	·			·		
101.00	10100 HOME HEALTH AGENCY	2, 377, 380	442, 674	2, 820, 054	-25, 140	2, 794, 914	101.00
	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	127, 022, 681	197, 194, 977	324, 217, 658	2, 535, 075	326, 752, 733	118 00
118 00							
118.00	NONREI MBURSABLE COST CENTERS 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN						190.00

Health Financial Systems	METHODI ST HOSP	PITALS, INC		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provider CC		Period: From 01/01/2020	Worksheet A	
				To 12/31/2020		
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
			+ col. 2)	ions (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
191. 00 19100 RESEARCH	0	0	(0 0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	21, 587, 240	12, 673, 531	34, 260, 771	-797, 284	33, 463, 487	192.00
192.01 19201 OTHER NON-REI MBURSABLE	0	2, 081, 251	2, 081, 251	-1, 736, 638	344, 613	192.01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	73, 225	26, 922	100, 147	0	100, 147	192.02
193. 00 19300 NONPALD WORKERS	0	0	(0 0	0	193.00
200.00 TOTAL (SUM OF LINES 118 through 199)	148, 683, 146	211, 977, 950	360, 661, 096	6 O	360, 661, 096	200.00

Health Financial Systems	METHODI ST HOS	PITALS, INC	In Lie	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider CCN: 15-0002	Period: From 01/01/2020	Worksheet A
				Date/Time Prepared: 7/23/2021 10:58 am
Cost Center Description	Adjustments	Net Expenses		

5 OF TRIAL BALANCE C	IF EXPENSES	Provider CCN: 1	5-0002 Period: From 01/0	Worksheet A
				31/2020 Date/Time Prep 7/23/2021 10:5
i on	Adjustments	Net Expenses		

				7/23/2021 10:	:58 am
	Cost Center Description	Adjustments	Net Expenses For		
		(See A-8)	Allocation		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS	0.011.100	17 700 (70		
1.00	00100 CAP REL COSTS-BLDG & FIXT	-2, 214, 438			1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	791, 862			4.00
5. 01 5. 02	00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES	-207, 657 0	11, 520, 829 3, 581, 730		5.01
5.02	00570 ADMI TTI NG	0	2, 700, 160		5.02
5.03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	-27,608	6, 368, 755		5.04
5.05	00590 OTHER A&G	-384, 159	22, 693, 260		5.05
5.06	00592 PATIENT TRANSPORTATION	0	549, 152		5.06
7.00	00700 OPERATION OF PLANT	0	17, 401, 287		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	1, 265, 392		8.00
9.00	00900 HOUSEKEEPI NG	-790	5, 194, 639		9.00
10.00	01000 DI ETARY	-540	3, 528, 812		10.00
11.00		-606, 218			11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	-620	4, 712, 514		13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	1, 746, 366 6, 003, 417		14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-93, 419	2, 835, 888		16.00
	01700 SOCIAL SERVICE	- ,3, 419	441, 467		17.00
17.01	01701 STAFF EDUCATION	0	0		17.0
	01702 MEDI CAL EDUCATI ON	0	19, 195		17.02
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	252, 816		21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	31, 168		22.00
23.00	02300 PARAMED ED PROGRAM	-202, 966	451, 690		23.00
	INPATIENT ROUTINE SERVICE COST CENTERS			1	
30.00	03000 ADULTS & PEDIATRICS	-7, 812, 201	35, 287, 539		30.00
31.00	03100 INTENSIVE CARE UNIT	0	10, 532, 853		31.00
	03101 NEONATAL I CU	-1, 007, 871	2, 175, 371		31.0
40.00	04000 SUBPROVIDER - IPF	0	1, 213, 444		40.00
	04100 SUBPROVI DER – I RF 04300 NURSERY	0	2, 583, 934 1, 768, 818		41.00
43.00	ANCI LLARY SERVICE COST CENTERS	0	1,700,010		- 45.00
50.00	05000 OPERATI NG ROOM	-1, 236, 001	7, 207, 979		50.00
50.01	05001 ENDOSCOPY	0	1, 598, 696		50.01
51.00	05100 RECOVERY ROOM	0	1, 078, 341		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	3, 893, 793		52.00
53.00	05300 ANESTHESI OLOGY	0	0		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	3, 762, 219		54.00
54.01	05401 RADI OLOGY - ULTRASOUND	-3, 342	1, 565, 995		54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	2, 153, 632		55.00
55.01	05501 I NFUSI ON CENTER	0	29, 950		55.01
56.00	05600 RADI OI SOTOPE	0	1, 757, 010		56.00
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	-6, 369 0	1, 970, 858 768, 129		57.00
59.00	05900 CARDIAC CATHETERIZATION	0	4, 162, 092		59.00
60.00	06000 LABORATORY	-62, 767	14, 393, 709		60.00
	06001 BLOOD LABORATORY	02,707			60.01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	-69, 123	1, 432, 477		62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		64.00
65.00	06500 RESPI RATORY THERAPY	0	3, 510, 633		65.00
66.00	06600 PHYSI CAL THERAPY	0	1, 494, 031		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	1, 211, 400		67.00
68.00		0	480, 067		68.00
69.00	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	0 100	872, 540		69.00
69.01	06901 CARDI AC REHAB 07000 ELECTROENCEPHALOGRAPHY	-99, 190	433, 951		69.0 [°] 70.00
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-200 0	1, 227, 387 10, 389, 568		70.00
	07200 I MPL. DEV. CHARGED TO PATTENTS	0	10, 389, 388		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	-241, 465	18, 767, 677		73.00
	07400 RENAL DI ALYSI S	0	2, 425, 018		74.00
	OUTPATIENT SERVICE COST CENTERS			·	
90.00	09000 CLI NI C	-316	4, 690, 389		90.00
91.00	09100 EMERGENCY	-2, 290, 590	9, 354, 337		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			<u> </u>	92.00
	OTHER REIMBURSABLE COST CENTERS				4
101.00	10100 HOME HEALTH AGENCY	0	2, 794, 914		101.00
	SPECIAL PURPOSE COST CENTERS	45 335 655	040 074 7:-		1110 0
		-15, 775, 988	310, 976, 745	<u> </u>	118.00
118.00	NONDELMOUDEADLE COST CENTERS				
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	116		190.00

Health Financial Systems	METHODI ST HOS	PITALS, INC		In Lieu	of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	OF EXPENSES	Provider CCN	N: 15-0002	Period:	Worksheet A	
				From 01/01/2020 To 12/31/2020	Date/Time Pre 7/23/2021 10:	epared: 58 am
Cost Center Description	Adjustments	Net Expenses				
	(See A-8)	For				
		Allocation				
	6.00	7.00				
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	33, 463, 487				192.00
192.01 19201 OTHER NON-REIMBURSABLE	0	344, 613				192.01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	0	100, 147				192.02
193. 00 19300 NONPALD WORKERS	0	0				193.00
200.00 TOTAL (SUM OF LINES 118 through 199)	-15, 775, 988	344, 885, 108				200.00

Financial Systems SIFICATIONS		METHODIST HOSE	Provi der CCN: 15-00		u of Form CMS-2552 Worksheet A-6
				To 12/31/2020	Date/Time Prepare 7/23/2021 10:58 a
	Increases	Cala	011		172072021 10.00 0
Cost Center 2.00	Line # 3.00	Salary 4.00	0ther 5.00		
A - CAFETERIA	3.00	4.00	5.00		
CAFETERI A	<u>11.</u> 00	<u>1, 078, 7</u> 03	<u>1,099,2</u> 10		1.
0 B - CLINICAL TRAINING COST		1, 078, 703	1, 099, 210		
PARAMED ED PROGRAM	23.00	202, 791	0		1.
	0.00	0	0		2
	0.00	0	0		3
	0.00 0.00	0	0 0		4
	0.00	0			6
0		202, 791	<u>0</u>		
C - SOCI AL WORKERS SOCI AL SERVI CE	17.00	441, 467	0		1
		441,467	<u>0</u>		1.
E - RESIDENTS					
I &R SERVICES-SALARY &	21.00	0	252, 816		1.
FRINGES APPRVD I&R SERVICES-OTHER PRGM	22.00	o	31, 168		2
COSTS APPRVD	22.00	0	31, 100		2
0			283, 984		
F - MED SUPPLY	71 00		10,000 5/0		1
MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	71.00	0	10, 389, 568		1
IMPL. DEV. CHARGED TO	72.00	0	10, 149, 884		2
PATIENTS	0.00				
	0.00 0.00	0	0 0		3
	0.00	0	0		5
	0.00	0	0		6
	0.00	0	0		7
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	0.00	0	Ö		10
	0.00	0	0		11
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	0.00	0	0		15
	0.00	0	0		16
	0.00	0	0		17
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	0.00	0	0		20
	0.00	0	0		21
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	0.00	0	0		30
	0.00	0	Ö		31
	0.00	0	0		32
	0.00	0	0		33
	0. 00 0. 00	0	0 0		34
	0.00	0	0		36
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	0. 00 0. 00	0	0 0		41
	0.00	0	0		42
	0.00	0	0		44
	0.00	0	0		45
	0.00	0	0		46
	0.00	0_	0		47

Health Financial Systems RECLASSIFICATIONS

METHODI ST HOSPI TALS, INC Provi der CCN: 15-0002 Peri od:

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

Increases Increases Increases Increases a Light School 100 <td< th=""><th>RECLAS</th><th>SI FI CATI ONS</th><th></th><th></th><th>Provider (</th><th>CCN: 15-0002</th><th>Period: From 01/01/2020</th><th>Worksheet A-</th><th>6</th></td<>	RECLAS	SI FI CATI ONS			Provider (CCN: 15-0002	Period: From 01/01/2020	Worksheet A-	6
Image: control control Control control Control <thcontrol< th=""> Control C</thcontrol<>								Date/Time Pr	epared:
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0 - LIGH QUY									
2:00 DELARY 10:00 3,063 0 2,00 3,063 0 3,063 0 3,063 0 3,063 0 3,063 0 3,063 0 3,063 0 3,063 0 3,063 0 3,063 0		G – LIGHT DUTY							
3:00 CENTRAL SERVICES & SUPPLY 11.00 /// 0 4.00 4.00 5:00 INTEREMYE LARE HUT 31.00 0.285 0 4.00 6:00 INTEREMYE LARE HUT 31.00 0.2857 0 7.00 00 OPERATING HOW 51.00 22.225 0 9 00 PARECEVY 0 0 2.00 3.00 1:00 0.00 0 0.00 0 3.00 1:00 0.00 0 0 0 3.00 1:00 0.00 0 0 0 3.00 1:00 0.00 0 0 0 3.00 1:00 0.00 0 0 0 0 0 1:00 0.00 0 0 0 0 0 0 1:00 0 0.00 0 0 0 0 0 0 0 0 0 0 0 0 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>									
4.00 ALUES & PUBLANICS 30.00 9.25 0 4.00 4.00 5.00 DITERE VICE - INF 1.00 10.4537 0 5.00 5.00 6.00 DEPROVINCE - INF 1.00 10.4537 0 5.00 8.00 7.00 PONOPROVER - INF 1.00 2.157 0 7.00 9.00 8.00 1.00 AN REL COSTS-BLOG & FLXT 1.00 0 2.320, 975 0 2.00 2.00 2.00 AN REL COSTS-BLOG & FLXT 1.00 0 2.320, 975 0 2.00 2.00 2.00 2.00 DEPORT 0.00 0<									
6.10 SUBPRIVIDEX - INF 4.1.00 10.433 0 6.00 6.00 100 RECOVERY ROOM 5.00 7.2.97 0 6 6 100 RECOVERY ROOM 5.00 7.2.91 0 6 6 100 RECOVERY ROOM 5.00 7.2.91 0 7 6 100 RECOVERY ROOM 0.00 0 0 0 7 <td>4.00</td> <td></td> <td>30.00</td> <td>9, 235</td> <td>0</td> <td></td> <td></td> <td></td> <td>4.00</td>	4.00		30.00	9, 235	0				4.00
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8.00 BECOVERY ROUM 51.00 26.225 0 0 8.00 8.00 0 <t< td=""><td></td><td></td><td></td><td></td><td>-</td><td></td><td></td><td></td><td>4</td></t<>					-				4
0 - - - 71, 319 - 6 1.00 AP REL COSIS-BLDE & FIXT 1.00 0 2.00 1.00 0.00 0 0.00 0 0.00 </td <td></td> <td>RECOVERY ROOM</td> <td>51.00</td> <td>26, 225</td> <td>0</td> <td></td> <td></td> <td></td> <td>1</td>		RECOVERY ROOM	51.00	26, 225	0				1
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J - DRUC EXPENSE Image: Control of the second									1
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K - HYSI CLAR RECLASS - - - - - - - - - - - 0	3.00								3.00
2.00 CLINC		K - PHYSICIAN RECLASS		- U	10, 155, 759				-
0 - - - - - 57, 410 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 388, 650 1.00 3.00 0.00 0 0 388, 650 2.00 3.00 0.00 0 0 3.00 3.00 5.00 0.00 0 0 0 3.00 5.00 0.00 0 0 0 0.00 7.00 0.00 0 0 7.00 7.00 7.00 0.00 0 0 0 7.00 7.00 7.00 0.00 0 0 0 7.00 7.00 7.00 7.00 0.00 0 0 0 0 7.00 7.00 7.00 0.00 0.00 0 0 7.00 7.00 7.00 7.00 7.00 0.00 0.00 0 0 7.00 7.00 7.00 7.00 7.00 7.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>1</td>									1
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22.00 0.00 0 0 23.00 23.00 24.00 0.00 0 0 23.00 23.00 24.00 0.00 0 0 24.00 24.00 25.00 0.00 0 0 25.00 26.00 25.00 26.00 0.00 0 0 0 25.00 26.00 27.00 28.00 0.00 0 0 0 28.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 20.00 <td>20.00</td> <td></td> <td>0.00</td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td>20.00</td>	20.00		0.00		0				20.00
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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 26.00 28.00 0.00 0 0 27.00 28.00 0.00 0 0 28.00 29.00 0 0 0 388,650 M - DEPRECIATION RECLASS 0.00 0 11,603,493 1.00 1.00 2.00 0 0 0 3.00 4.00 0.00 0 0 0 3.00 4.00 0.00 0 0 0 3.00 4.00 0.00 0 0 0 3.00 4.00 0.00 0 0 0 5.00 6.00 0.00 0 0 0 6.00 7.00 0.00 0 0 0 6.00 7.00 0.00 0 0 0 7.00 8.00 0.00									
26.00 0.00 0 0 26.00 27.00 28.00 0.00 0 0 0 27.00 28.00 0.00 0 0 28.00 28.00 29.00 0 0 0 0 28.00 29.00 0 0 0 0 388,650 29.00 29.00 0 0 0 0 388,650 1.00 29.00 0 0 0 0 0 388,650 1.00 29.00 1.00 CAP REL COSTS-BLDG & FIXT 1.00 0 11,603,493 1.00 2.00 3.00 0.00 0 0 0 0 3.00 4.00 5.00 0.00 0 0 0 0 0 5.00 5.00 6.00 0.00 0 0 0 0 6.00 6.00 7.00 0.00 0 0 0 8.00 8.00			0.00	Ō					
27.00 0.00 0 0 27.00 27.00 28.00 28.00 28.00 28.00 29.00 0 0 0 0 29.00 20.00 38.650 29.00 20.00 30.00 20.00 30.00 20.00 30.00 20.00 30.00 20.00 30.00 4.00 20.00 30.00 4.00 5.00 6.00 5.00 6.00 5.00 6.00 6.00 7.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00 <td< td=""><td></td><td></td><td>0.00</td><td>-</td><td></td><td></td><td></td><td></td><td></td></td<>			0.00	-					
28.00 0 0 0 0 28.00 28.00 29.00 20.00 30.00 20.00 20.00 30.00 20.00 30.00 20.00 30.00 20.00 30.00 40.00 50.00 50.00 60.00 50.00 50.00 50.00 50.00 60.00 70.00 80.00 80.00 80.00 80.00 80.00 80.00 80.00 80.00 80.00									
O O 388,650 M - DEPRECIATION RECLASS 1.00 11,603,493 1.00 2.00 0.00 0 0 2.00 3.00 0.00 0 0 3.00 4.00 0.00 0 0 3.00 5.00 0.00 0 0 4.00 5.00 0.00 0 0 6.00 7.00 0.00 0 0 7.00 8.00 0.00 0 0 8.00	28.00		0.00						28.00
M - DEPRECIATION RECLASS 1.00 CAP REL COSTS-BLDG & FIXT 1.00 0 11,603,493 1.00 2.00 2.00 0.00 0 0 0 2.00 3.00 2.00 3.00 4.00 0.00 0 0 3.00 4.00 5.00 6.00 0 0 0.00 6.00 5.00 6.00 5.00 6.00 7.00 8.00 0.00 0 0 8.00 8.00 8.00 8.00 0.00 0 0.00 0 0.00 0 0.00 0.	29.00								29.00
2.00 0.00 0 0 2.00 3.00 0.00 0 0 3.00 4.00 0.00 0 0 4.00 5.00 0.00 0 0 5.00 6.00 0.00 0 0 6.00 7.00 0.00 0 0 7.00 8.00 0.00 0 0 8.00									1
3.00 0.00 0 0 3.00 4.00 0.00 0 0 4.00 5.00 0.00 0 0 5.00 6.00 0.00 0 0 6.00 7.00 0.00 0 0 7.00 8.00 0.00 0 0 8.00		CAP REL COSTS-BLDG & FIXT							
4.00 0.00 0 0 4.00 5.00 0.00 0 0 5.00 6.00 0.00 0 0 6.00 7.00 0.00 0 0 7.00 8.00 0.00 0 0 8.00									
5.00 0.00 0 0 5.00 6.00 0.00 0 0 6.00 7.00 0.00 0 0 7.00 8.00 0.00 0 0 8.00	4.00		0.00		0				4.00
7.00 0.00 0 7.00 8.00 0.00 0 0 8.00				-					
8.00 0.00 0 0 8.00									
9.00 0.00 9.00	8.00		0.00	0	0				8.00
	9.00		0.00	0	0				9.00

Heal th	Fi nanci al	Systems				
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METHODI ST HOSPI TALS, INC

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

Provi der CCN: 15-0002

	a of form omo 2002 fo
Peri od:	Worksheet A-6
From 01/01/2020	Worksheet A-6 Date/Time Prepared: 7/23/2021 10:58 am
To 12/31/2020	Date/Time Prepared:
	7/23/2021 10:58 am

						7/23/2021 1	0:58 am
		Increases					
	Cost Center	Line #	Sal ary	0ther			
	2.00	3.00	4.00	5.00			
10.00		0.00	0	0			10.00
11.00		0.00	0	0			11.00
12.00		0.00	0	0			12.00
13.00		0.00	0	0			13.00
14.00		0.00	0	0 0			14.00
15.00		0.00	О	0			15.00
16.00		0.00	О	0			16.00
17.00		0.00	O	0			17.00
18.00		0.00	O	0			18.00
19.00		0.00	0	0 0			19.00
20.00		0.00	0	0			20.00
21.00		0.00	o	0 0			21.00
22.00		0.00	0	0			22.00
23.00		0.00	0	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 0			26.00
27.00		0.00	0	0			27.00
28.00		0.00	0	0 0			28.00
29.00		0.00	0	0			29.00
30.00		0.00	Ö	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 0			35.00
36.00		0.00	0	0			36.00
37.00		0.00	0	0 0			37.00
38.00		0.00	0	0			38.00
39.00		0.00	0	0 0			39.00
40.00		0.00	0	0			40.00
41.00		0.00	0	0			40.00
42.00		0.00	0	0			42.00
43.00		0.00	0	0			43.00
44.00		0.00	0	0 0			44.00
45.00		0.00	0	0			45.00
46.00		0.00	0	0			46.00
40.00		0.00	0	0			40.00
48.00		0.00	0	0			48.00
48.00		0.00	0	0			48.00
47.00	<u> </u>		— — — 0	11, 603, 493			49.00
	N - DEPT 9101 RECLASS		Ч	11,003,493			-
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	420, 367	30, 631			1.00
1.00			420, 367	30, 631			1.00
	0 - UTILITIES RECLASS	I	120,007	00,001			_
1.00	OPERATION OF PLANT	7.00	0	1,042,519			1.00
2.00		0.00	0	0,042,017			2.00
3.00		0.00	0	0			3.00
4.00		0.00	0	0			4.00
5.00		0.00	0	0			5.00
6. 00		0.00	0	0			6.00
0.00			— — — 0	1, 042, 519			0.00
	P - C SECTION RECLASS		9	1, 042, 317			-
1.00	OPERATI NG ROOM	50.00	42, 510	0			1.00
1.00			42,510	<u>0</u>			1.00
500 00	Grand Total: Increases		2, 257, 157	64, 087, 317			500.00
555.00		I	2,201,101	07,007,017			1 300.00

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METHODIST HOSPITALS, INC Provider CCN: 15-0002

In Lieu of Form CMS-2552-10 Period: Worksheet A-6 From 01/01/2020

						From 01/01/2020 To 12/31/2020	Date/Time 7/23/2021	
	Cost Center	Decreases Line #	Salary	Other	Wkst. A-7 Ref	· · · · ·		
	6. 00	7.00	8.00	9.00	10.00			
ŀ	A – CAFETERIA							
1.00	DI ETARY	<u> </u>	1,078,703	<u>1,099,2</u> 10		<u>D</u>		1.00
C	B - CLINICAL TRAINING COST		1, 078, 703	1, 099, 210				_
	ADULTS & PEDIATRICS	30.00	8, 593	0		b		1.00
	OPERATING ROOM	50.00	7, 986	0				2.00
	CARDI AC CATHETERI ZATI ON	59.00	5, 755	0	(b		3.00
	DELIVERY ROOM & LABOR ROOM	52.00	8, 662	0				4.00
	RESPI RATORY THERAPY EMERGENCY	65.00 91.00	12, 855 158, 940	0				5.00
5.00 E		91.00	202, 791	0		5		0.00
C	C - SOCIAL WORKERS				1			
.00	<u>OTHER A&G</u>	5.05	441, 467	0		<u>D</u>		1.00
	DE - RESI DENTS		441, 467	0				_
-	EMERGENCY	91.00	0	283, 984		D		1.00
. 00		0.00	0	0				2.00
C			0	283, 984				
-	F - MED SUPPLY	E 00		115 0/0				1.00
	PURCHASING RECEIVING AND STORES	5.02	0	115, 962	(1.00
	ADMI TTI NG	5. 03	О	2	(b		2.00
	CASHI ERI NG/ACCOUNTS	5.04	Ō	2		D		3.00
	RECEIVABLE		_					
	OTHER A&G PATI ENT TRANSPORTATI ON	5. 05 5. 06	0	576 12				4.00
	OPERATION OF PLANT	5.08	0	250				6.00
	HOUSEKEEPING	9.00	0	859				7.00
. 00 [DI ETARY	10.00	0	28	(С		8.00
	NURSING ADMINISTRATION	13.00	0	1, 179		C		9.00
	CENTRAL SERVICES & SUPPLY	14.00	0	111, 261				10.00
	PHARMACY MEDICAL RECORDS & LIBRARY	15.00 16.00	0	49, 441 53				11.00
	MEDICAL EDUCATION	17.02	0	121				13.00
	PARAMED ED PROGRAM	23.00	0	363		D		14.00
	ADULTS & PEDIATRICS	30.00	0	486, 221		C		15.00
	INTENSIVE CARE UNIT	31.00	0	189, 050				16.00
	NEONATAL I CU SUBPROVI DER – I RF	31.01 41.00	0	816 35, 075				17.0
	NURSERY	41.00	0	53, 437				19.0
	OPERATING ROOM	50.00	0	11, 376, 735		D		20.0
	ENDOSCOPY	50. 01	0	261, 477		D		21.00
	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	51.00	0	11, 865				22.00
	RADI OLOGY-DI AGNOSTI C	52.00 54.00	0	52, 810 3, 893				23.00
	RADIOLOGY - ULTRASOUND	54.01	0	56, 193				25.00
6.00 F	RADI OLOGY-THERAPEUTI C	55.00	О	5, 168	(C		26.00
	INFUSION CENTER	55.01	0	5,809		D D		27.00
	RADI OI SOTOPE	56.00 57.00	0	273				28.0
	CT SCAN MAGNETIC RESONANCE IMAGING	57.00 58.00		43, 040 242				29.0 30.0
	(MRI)	00.00	5	272		-		00.0
. 00	CARDÍ AC CATHETERI ZATI ON	59.00	О	4, 147, 983		c		31.0
		60.00	0	2, 389				32.0
	NHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	350	(D		33.0
	RESPIRATORY THERAPY	65.00	0	208, 572		b		34.0
	PHYSI CAL THERAPY	66.00	Ō	6, 318				35.0
	OCCUPATIONAL THERAPY	67.00	0	58		c		36.0
	SPEECH PATHOLOGY	68.00	0	7	(D		37.0
	ELECTROCARDI OLOGY CARDI AC REHAB	69.00 69.01	0	3, 070 1, 170				38. 0 39. 0
	ELECTROENCEPHALOGRAPHY	70.00	0	2, 535, 578				40.0
	DRUGS CHARGED TO PATIENTS	73.00	0	2, 333, 378		Ď		40.0
	RENAL DI ALYSI S	74.00	Ō	1, 263	(c		42.0
	CLINIC	90.00	0	79, 529		c		43.0
		91.00	0	392, 979				44.0
	HOME HEALTH AGENCY	101.00	0	23, 337				45.00
	PHYSICIANS' PRIVATE OFFICES OTHER NON-REIMBURSABLE	192.00 192.01	0	39, 608 133				46.00
-			— — — <u>o</u>	20, 539, 452				-7.00

Heal th	Financial Systems		METHODI ST HOSE	PITALS, INC			In Lieu	u of Form (CMS-2552-10
RECLAS	SIFICATIONS			Provi der	CCN: 15-0002		i od:	Worksheet	A-6
						From	m 01/01/2020 12/31/2020	Date/Time	Prenared
					_		12/ 31/ 2020	7/23/2021	
		Decreases			_				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Re	<u>f.</u>			
	6.00 G - LIGHT DUTY	7.00	8.00	9.00	10.00				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	71, 319	(0			1.00
2.00	LMI LOTEL DENEITTS DEFARTMENT	0.00	0			0			2.00
3.00		0.00	0		5	0			3.00
4.00		0.00	0	(-	0			4.00
5.00		0.00	0	()	0			5.00
6.00		0.00	0	(5	0			6.00
7.00		0.00	0	(D	0			7.00
8.00		0.00	0	(D	0			8.00
9.00		0.00	0		D	0			9.00
	0		71, 319	(0				
	H - INTEREST EXPENSE				1				
1.00	OTHER A&G	5.05	0	2, 143, 869		11			1.00
2.00	RADI OLOGY-DI AGNOSTI C	54.00	0	13, 220		0			2.00
3.00	RADI OLOGY - ULTRASOUND	54.01	0	6, 610		0			3.00
4.00	RADI OLOGY-THERAPEUTI C	55.00	0	2, 240		0			4.00
5.00 6.00	CT SCAN MAGNETIC RESONANCE IMAGING	57.00 58.00	0	6, 610 6, 610		0			5.00 6.00
0.00	(MRI)	56.00	0	0, 010	J	9			0.00
7.00	OTHER NON-REIMBURSABLE	192.01	0	141, 816	4	0			7.00
7.00			— — — ö	2, 320, 975		7			/.00
	I - CORPORATE EXPENSE		0	2,020,770	5				
1.00	OTHER A&G	5.05	0	10, 565, 234	4	9			1.00
2.00		0.00	0	(D	0			2.00
	0			10, 565, 234	4				
	J - DRUG EXPENSE				1				
1.00	PHARMACY	15.00	0	9, 338, 634		0			1.00
2.00	INFUSION CENTER	55.01	0	2, 572		0			2.00
3.00	ELECTROENCEPHALOGRAPHY		• •	<u>6, 814, 5</u> 53		0			3.00
			0	16, 155, 759	7				
1 00	K - PHYSICIAN RECLASS	102.00	ol	F7 410		0			1.00
1.00 2.00	PHYSICIANS' PRIVATE OFFICES	192.00 0.00	0	57, 410		0			1.00 2.00
2.00			<u>0</u>	57, 410		4			2.00
	L - PSTD RECLASS		9	57,410	<u></u>				
1.00	PURCHASING RECEIVING AND	5.02	790	(D	0			1.00
	STORES								
2.00	CASHI ERI NG/ACCOUNTS	5.04	8, 853	(D	0			2.00
	RECEI VABLE								
3.00	OTHER A&G	5.05	36, 600		D	0			3.00
4.00	PATIENT TRANSPORTATION	5.06	9, 548	(0	0			4.00
5.00	OPERATION OF PLANT	7.00	21, 236	()	0			5.00
6.00	HOUSEKEEPING	9.00	19, 185	(0			6.00
7.00	DI ETARY CAFETERI A	10. 00 11. 00	2, 830 978	(0			7.00 8.00
8.00 9.00	NURSING ADMINISTRATION	13.00	5, 421	(0			9.00
10.00	CENTRAL SERVICES & SUPPLY	14.00	10, 576			o			10.00
11.00	MEDICAL RECORDS & LIBRARY	16.00	4, 893			o			11.00
12.00	ADULTS & PEDIATRICS	30.00	77, 405		5	0			12.00
13.00	INTENSIVE CARE UNIT	31.00	3, 350			o			13.00
14.00	SUBPROVI DER – I RF	41.00	5, 891	(D	0			14.00
15.00	NURSERY	43.00	6, 324	(D	0			15.00
16.00	OPERATING ROOM	50.00	14, 048	(D	0			16.00
17.00	ENDOSCOPY	50.01	662		D	0			17.00
18.00	DELIVERY ROOM & LABOR ROOM	52.00	675		D	0			18.00
19.00	RADI OLOGY-DI AGNOSTI C	54.00	17, 755		D	0			19.00
20.00	RADIOLOGY - ULTRASOUND	54.01	4, 951		D	0			20.00
21.00	RADI OLOGY-THERAPEUTI C	55.00	2,990	(U			21.00
22.00	CARDI AC CATHETERI ZATI ON	59.00	9, 597	(0			22.00
23.00	LABORATORY	60.00	14, 410			0			23.00
24.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	3, 259	(D				24.00
25.00	RESPIRATORY THERAPY	65.00	3, 753	ſ		0			25.00
26.00	CLINIC	90.00	5, 626	(0			26.00
27.00	EMERGENCY	91.00	22, 032	(D	o			27.00
28.00	HOME HEALTH AGENCY	101.00	1, 236	(Ö			28.00
29.00	PHYSICIANS' PRIVATE OFFICES	192.00	73, 776	(0	0			29.00
	0		388, 650						
	M - DEPRECIATION RECLASS								
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7, 787		9			1.00
2.00	DATA PROCESSING	5.01	0	1, 531, 195		0			2.00
3.00	PURCHASING RECEIVING AND	5.02	0	47, 942	2	0			3.00
1 00	STORES	F 00		4 / 0/					4.00
4.00	ADMI TTI NG	5.03	0	1, 639	7	0			4.00

Health Financial Systems RECLASSIFICATIONS

Health Financial Systems RECLASSIFICATIONS

METHODI ST HOSPI TALS, INC

	Financial Systems		METHODIST HOSE		CCN: 15-0002	In Lieu Period:	u of Form CMS-25 Worksheet A-6	552-10
						From 01/01/2020 To 12/31/2020	Date/Time Prep	bared:
		Decreases					7/23/2021 10:5	58 am
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref.	1		
	6.00	7.00	8.00	9.00	10.00			
5.00	CASHI ERI NG/ACCOUNTS	5.04	0	4, 374	C	2		5.00
6.00	RECEI VABLE OTHER A&G	5.05	o	289, 763	C			6.00
7.00	PATIENT TRANSPORTATION	5.06	0	15, 565				7.00
8.00	OPERATION OF PLANT	7.00	0	362, 499				8.00
9.00	HOUSEKEEPING	9.00	0	58, 984				9.00
10.00	DI ETARY	10.00	0	72, 048	C)		10.00
11.00	CAFETERI A	11.00	0	551				11.00
12.00	NURSING ADMINISTRATION	13.00	0	92, 491	C			12.00
13.00	CENTRAL SERVICES & SUPPLY	14.00	0	365, 682				13.00
14.00		15.00	0	234, 467				14.00
15.00 16.00	MEDICAL RECORDS & LIBRARY PARAMED ED PROGRAM	16.00 23.00	0	4, 268 3, 626				15.00 16.00
17.00	ADULTS & PEDIATRICS	30.00	0	3, 020 191, 862			1	17.00
18.00	INTENSI VE CARE UNI T	31.00	0	532, 150				18.00
19.00	NEONATAL I CU	31.01	0	39, 733				19.00
20.00	SUBPROVI DER – I PF	40.00	0	10, 350				20.00
21.00	SUBPROVI DER – I RF	41.00	0	9, 928				21.00
22.00	NURSERY	43.00	0	69, 987	C			22.00
23.00	OPERATI NG ROOM	50.00	0	637, 583				23.00
24.00	ENDOSCOPY	50. 01	0	92, 467				24.00
25.00	RECOVERY ROOM	51.00	0	1,003				25.00
26.00	DELIVERY ROOM & LABOR ROOM	52.00	0	126, 443				26.00
27.00	RADI OLOGY-DI AGNOSTI C	54.00	0	837, 358				27.00
28.00	RADI OLOGY - ULTRASOUND	54.01	0	370, 895				28.00
29.00	RADI OLOGY-THERAPEUTI C	55.00	0	734, 738				29.00
30.00 31.00	I NFUSI ON CENTER RADI OI SOTOPE	55. 01 56. 00	0	1, 028 242, 474				30.00 31.00
32.00	CT SCAN	57.00	0	323, 929				32.00
33.00	MAGNETIC RESONANCE I MAGI NG	58.00	0	694, 637				33.00
00.00	(MRI)	00100		0,1,00,				00.00
34.00	CARDÍ AC CATHETERI ZATI ON	59.00	0	346, 710	C			34.00
35.00	LABORATORY	60.00	0	45, 277	C			35.00
36.00	WHOLE BLOOD & PACKED RED	62.00	0	8, 781	C)		36.00
	BLOOD CELLS							
37.00	RESPI RATORY THERAPY	65.00	0	91, 341	C			37.00
38.00	PHYSI CAL THERAPY	66.00	0	1, 733				38.00
39.00	OCCUPATIONAL THERAPY	67.00	0	442				39.00
40.00 41.00	ELECTROCARDI OLOGY CARDI AC REHAB	69.00 69.01	0	178, 054 173, 055				40.00 41.00
41.00	ELECTROENCEPHALOGRAPHY	70.00	0	203, 952				41.00
43.00	DRUGS CHARGED TO PATIENTS	73.00	0	40, 053	-	-	1	43.00
44.00	CLINIC	90.00	0	167, 139				44.00
45.00	EMERGENCY	91.00	0	327, 583				45.00
46.00	HOME HEALTH AGENCY	101.00	0	567				46.00
47.00	GIFT, FLOWER, COFFEE SHOP &	190.00	0	1, 153	C			47.00
	CANTEEN							
48.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	737, 946				48.00
49.00	OTHER NON-REIMBURSABLE	1 <u>92.</u> 01	0	<u>1, 270, 261</u>		4		49.00
			0	11, 603, 493				
1 00	N - DEPT 9101 RECLASS	F 04	420, 367	20 (21	C			1 00
1.00	CASHI ERI NG/ACCOUNTS	5.04	420, 367	30, 631	L L	/		1.00
	RECEI VABLE	+	420, 367	30, 631		-		
	0 - UTILITIES RECLASS		120, 307	50, 001	I	1		
1.00	DATA PROCESSI NG	5.01	0	153, 918	C)		1.00
2.00	CASHI ERI NG/ACCOUNTS	5.04	0	26, 730				2.00
	RECEI VABLE							
3.00	HOUSEKEEPING	9.00	0	152, 221)		3.00
4.00	CARDI AC REHAB	69.01	0	45, 680				4.00
5.00	PHYSI CI ANS' PRI VATE OFFI CES	192.00	0	339, 542		1		5.00
6.00	OTHER_NON_REIMBURSABLE	1 <u>92.</u> 01	<u>0</u>	324, 428		4		6.00
			0	1, 042, 519				
1 00	P - C SECTION RECLASS DELIVERY ROOM & LABOR ROOM	E2 00	10 E10	^		1		1 00
		52.00	42, 510	0		/		1.00
1.00		+	42, 510			1	1	

Health Financial Systems	METHODI ST HOS	PITALS, INC			In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-0002	Peri From To	od: n 01/01/2020 12/31/2020		pared:
			Acquisitior	าร			
	Begi nni ng	Purchases	Donati on		Total	Disposals and	
	Bal ances					Retirements	
	1.00	2.00	3.00		4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL AS	SET BALANCES						
1.00 Land	5, 373, 674	0		0	0	0	1.00
2.00 Land Improvements	6, 844, 912	51, 545		0	51, 545	0	2.00
3.00 Buildings and Fixtures	270, 428, 699	37, 857, 258		0	37, 857, 258	0	3.00
4.00 Building Improvements	0	1, 230, 154		0	1, 230, 154	0	4.00
5.00 Fixed Equipment	0	0		0	0	0	5.00
6.00 Movable Equipment	211, 854, 063	0		0	0	12, 785, 137	6.00
7.00 HIT designated Assets	0	0		0	0	0	7.00
8.00 Subtotal (sum of lines 1-7)	494, 501, 348	39, 138, 957		0	39, 138, 957	12, 785, 137	8.00
9.00 Reconciling Items	0	0		0	0	0	9.00
10.00 Total (line 8 minus line 9)	494, 501, 348	39, 138, 957		0	39, 138, 957	12, 785, 137	10.00
	Endi ng	Fully					
	Bal ance	Depreciated					
		Assets					
	6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL AS	SET BALANCES						
1.00 Land	5, 373, 674	0					1.00
2.00 Land Improvements	6, 896, 457	0					2.00
3.00 Buildings and Fixtures	308, 285, 957	0					3.00
4.00 Building Improvements	1, 230, 154	0					4.00
5.00 Fixed Equipment	0	0					5.00
6.00 Movable Equipment	199, 068, 926	0					6.00
7.00 HIT designated Assets	0	0					7.00
8.00 Subtotal (sum of lines 1-7)	520, 855, 168	0					8.00
9.00 Reconciling Items	0	0					9.00
10.00 Total (line 8 minus line 9)	520, 855, 168	0					10.00

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-:	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0002	Period:	Worksheet A-7	
				From 01/01/2020 To 12/31/2020	Date/Time Pre	pared:
					7/23/2021 10:	<u>58 am</u>
		SL	JMMARY OF CAP	1 TAL		
Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
				(see	instructions)	
				instructions)		
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	<u>MN 2, LINES 1 a</u>	and 2			
1.00 CAP REL COSTS-BLDG & FIXT	0	0		0 0	0	1.00
3.00 Total (sum of lines 1-2)	0	0		0 0	0	3.00
	SUMMARY O	F CAPI TAL				
Cost Center Description	Other	Total (1)				
	Capi tal -Rel at	(sum of cols.				
	ed Costs (see	9 through 14)				
	instructions)	-				
	14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	MN 2, LINES 1 a	and 2			
1.00 CAP REL COSTS-BLDG & FIXT	0	0				1.00
3.00 Total (sum of lines 1-2)	0	0				3.00

Health Financial Systems	METHODI ST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2020 To 12/31/2020		
					7/23/2021 10:	<u>58 am</u>
	COMF	PUTATION OF RA	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 -			
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00 CAP REL COSTS-BLDG & FIXT	520, 855, 168	0	520, 855, 16	8 1.000000	0	1.00
3.00 Total (sum of lines 1-2)	520, 855, 168	0	520, 855, 16	8 1.000000	0	3.00
	ALLOCAT	FION OF OTHER (CAPI TAL	SUMMARY C	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum o	Depreciation	Lease	
		Capi tal -Rel at	cols. 5			
		ed Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00 CAP REL COSTS-BLDG & FIXT	0	0		0 17, 647, 854	0	1.00
3.00 Total (sum of lines 1-2)	0	0		0 17, 647, 854	0	3.00
		SL	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
		(see	instructions	Capital-Relat	(sum of cols.	
		instructions)		ed Costs (see	9 through 14)	
				instructions)	-	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C				-		
1.00 CAP REL COSTS-BLDG & FIXT	141, 816			0 0		1.00
3.00 Total (sum of lines 1-2)	141, 816	0	1	0 0	17, 789, 670	3.00

In Lieu of Form CMS-2552-10 Worksheet A-8

	MENTS TO EXPENSES			Provider CCN: 15-0002	Period: From 01/01/2020	Worksheet A-8	
					To 12/31/2020	Date/Time Pre 7/23/2021 10:	pared:
				Expense Classification of		172372021 10.	
			-	To/From Which the Amount i	s to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
		(2)				Ref.	
1.00	Investment income - CAP REL	1.00 B	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00	1.00
1.00	COSTS-BLDG & FIXT (chapter 2)	В	-2, 177, 137	CAF REL COSTS-DEDG & TIXT	1.00		1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted **	* 2.00	0	2.00
3.00	Investment income - other		О		0.00	0	3.00
4 00	(chapter 2)		0		0.00	0	1 1 00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of		0		0.00	0	5.00
6.00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.00
	suppliers (chapter 8)						
7.00	Telephone services (pay stations excluded) (chapter		0		0.00	0	7.00
	21)						
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provi der-based physi ci an	A-8-2	-12, 345, 948			0	10.00
11.00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11.00
10.00	(chapter 23)	A 0 1				0	10.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service	_	0		0.00	0	
14.00 15.00	Cafeteria-employees and guests Rental of quarters to employee	В	-606, 218	CAFETERI A	11. 00 0. 00	0	
	and others						
16.00	Sale of medical and surgical supplies to other than		0		0.00	0	16.00
	patients						
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and	В	-93, 419	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	abstracts		0		0.00	0	19.00
19.00	Nursing and allied health education (tuition, fees,		0		0.00	0	19.00
20.00	books, etc.)	D	F 40		10.00	0	
	Vending machines Income from imposition of	В	-5401	DI ETARY	10. 00 0. 00	0	20.00 21.00
	interest, finance or penalty						
22.00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22.00
	overpayments and borrowings to						
23.00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
	therapy costs in excess of						
24 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
21.00	therapy costs in excess of				00.00		21.00
25 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted **	* 114.00		25.00
20.00	physicians' compensation		0	obst center bereted	114.00		20.00
26.00	(chapter 21) Depreciation - CAP REL	А	25 270	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
∠U. UU	COSTS-BLDG & FIXT	A	-30, 219	ONI NEL OUSIS-DEDU & FIAI	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	Physicians' assistant		0		0.00	0	
30.00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30.00
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

		METHODIST HOS				
ADJUSTMENTS TO EXPENSES				Period: From 01/01/2020	Worksheet A-8	}
				To 12/31/2020		pared: 58 am
			Expense Classification or	n Worksheet A		
			To/From Which the Amount is	to be Adjusted		
Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
	(2)	Allouire		Erno "	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	_				-	
33. 00 DATA PROCESSING OTHER INCOME	В		DATA PROCESSING	5.01	0	00.00
33. 01 CASH, A/R, COLLECTIONS OTHER	В		CASHI ERI NG/ACCOUNTS	5.04	0	33.01
33. 02 A&G OTHER INCOME	D		RECEI VABLE OTHER A&G	5.05	0	33.02
33. 02 PAG OTHER INCOME 33. 03 ENVIRONMENTAL SERVICES OTHER	B		HOUSEKEEPING	9.00	0	33.02
I NCOME	D	- / 90	HOUSEREEPING	9.00	0	33.03
33. 04 NURSING ADMIN OTHER INCOME	В	-620	NURSING ADMINISTRATION	13.00	0	33.04
33. 05 PARAMED ED PROGRAM OTHER	В		PARAMED ED PROGRAM	23.00	0	33.05
I NCOME						
33.06 ADULTS & PEDS OTHER INCOME	В	-10, 626	ADULTS & PEDIATRICS	30.00	0	33.06
33.07 LAB OTHER INCOME	В	-62, 767	LABORATORY	60.00	0	33.07
33.08 BLOOD OTHER INCOME	В		WHOLE BLOOD & PACKED RED	62.00	0	33.08
			BLOOD CELLS			
33. 09 CARDIAC REHAB OTHER INCOME	В		CARDIAC REHAB	69.01	0	33.09
33. 10 CLINIC OTHER INCOME	В			90.00	0	33.10
33. 11 EMT OFFSET	В		EMPLOYEE BENEFITS DEPARTMEN		0	33.11
33. 12 EMT OFFSET	В		PARAMED ED PROGRAM	23.00	0	33.12
33.13 DUES/LOBBYING 33.14 RX PROGRAM	A		OTHER A&G	5.05	0	33.13
33. 14 RX PROGRAM 33. 15 PENSI ON ADJUSTMENT	A		DRUGS CHARGED TO PATIENTS EMPLOYEE BENEFITS DEPARTMEN	73.00 T 4.00		33.14 33.15
50.00 TOTAL (sum of lines 1 thru 49)		-15, 775, 988		4.00	0	50.00
(Transfer to Worksheet A,		-10,770,988	1			50.00
column 6, line 200.)						
	1	I	l			1

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

(2) Basis for adjustment (see instructions).

(2) basis for adjustment (see first detroits).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Syste	ms	METHODIST HO	SPI TALS, INC		In Li	eu of Form CMS-	2552-10
	ER BASED PHYSICI			Provider (CCN: 15-0002	Peri od:	Worksheet A-8	8-2
						From 01/01/2020		
						To 12/31/2020	Date/Time Pre 7/23/2021 10:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6,00	7.00	
1.00		ADULTS & PEDIATRICS	7, 816, 319		30, 78	1 211, 500	145	1.00
2.00	31.01	IEONATAL ICU	1,007,871	1,007,871		211,500	0	2.00
3.00	50.000	PERATING ROOM	1, 236, 001	1, 236, 001	(246, 400	0	3.00
4.00	54.01 F	RADI OLOGY - ULTRASOUND	3, 342	3, 342	(211, 500		4.00
5.00	57.000	CT SCAN	6, 369	6, 369	(211, 500	0	5.00
6.00	70. OO E	ELECTROENCEPHALOGRAPHY	200	200	(211, 500	0	6.00
7.00	91. OO E	MERGENCY	2, 290, 590	2, 290, 590	(211, 500	0	7.00
8.00	0.00		0	0	(c c	0	8.00
9.00	0.00		0	0	(o c	0	9.00
10.00	0.00		0	0	(o c	0	10.00
200.00			12, 360, 692	12, 329, 911	30, 78	1	145	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		Identifier	Limit	Unadjusted RCE	Memberships 8	Component	of Mal practi ce	
				Limit	Conti nui ng	Share of col.	Insurance	
					Education	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADULTS & PEDIATRICS	14, 744			o c	-	
2.00		NEONATAL I CU	0) C	-	
3.00		PERATING ROOM	0			D C	0	
4.00		RADIOLOGY - ULTRASOUND	0	0	() C	0	
5.00		CT SCAN	0	0	(C C	0	
6.00		LECTROENCEPHALOGRAPHY	0	0	() C	0	
7.00		EMERGENCY	0	0	(D C	0	
8.00	0.00		0	0			0	
9.00	0.00		0	0	(0	
10.00	0.00		0	0	(0	
200.00			14, 744				0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component Share of col.	Limit	Di sal I owance			
			14					
	1.00	2.00	14	16.00	17.00	18.00	-	
1.00		ADULTS & PEDIATRICS	15.00					1.00
2.00		IEONATAL ICU	0			1,007,871		2.00
3.00		DERATING ROOM	0	0		1, 236, 001		3.00
4.00		RADIOLOGY - ULTRASOUND	0	0		3, 342		4.00
5.00		CT SCAN	0	0		6, 369		5.00
6.00		ELECTROENCEPHALOGRAPHY	0	0		200		6.00
7.00		EMERGENCY	0	, v		2, 290, 590		7.00
8.00	0.00		0	0				8.00
9.00	0.00		0	0				9.00
10.00	0.00		0					10.00
200.00			0		16, 03	12, 345, 948		200.00

	Financial Systems	METHODI ST HOS		NI 15 0002 D		u of Form CMS-2	2552-10
CUST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC	F	eriod: rom 01/01/2020 o 12/31/2020		narodi
						7/23/2021 10:	
			CAPI TAL RELATED COSTS				
	Cost Center Description	Net Expenses	BLDG & FIXT	EMPLOYEE	DATA	PURCHASI NG	
		for Cost Allocation		BENEFI TS DEPARTMENT	PROCESSI NG	RECEI VI NG AND STORES	
		(from Wkst A					
		<u>col. 7)</u>	1.00	4.00	5. 01	5.02	
	GENERAL SERVICE COST CENTERS	1			0.01	0.02	
1.00 4.00	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT	17, 789, 670 32, 795, 867		32, 870, 375			1.00 4.00
4.00 5.01	00550 DATA PROCESSING	11, 520, 829		32, 870, 373 992, 305			5.01
5.02	00560 PURCHASING RECEIVING AND STORES	3, 581, 730	92, 498	209, 464	0	3, 883, 692	
5.03 5.04	00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	2, 700, 160 6, 368, 755		491, 029 484, 587	0	5, 102 1, 052	5.03 5.04
5.04	00590 OTHER A&G	22, 693, 260		2, 502, 132	12, 629, 071	367	5.02
5.06	00592 PATIENT TRANSPORTATION	549, 152	0	114, 238	0	252	5.06
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	17, 401, 287		868, 136 0	-	41, 527 49	7.00
8.00 9.00	00900 HOUSEKEEPING	5, 194, 639		927, 420		49 42, 081	9.00
10.00	01000 DI ETARY	3, 528, 812	237, 779	449, 685	0	61, 617	10.00
11.00		1, 954, 036		319, 636		90	11.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	4, 712, 514		814, 948 136, 259	0	17, 954 29, 614	13.00 14.00
15.00	01500 PHARMACY	6, 003, 417		0	0	16, 267	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	2, 835, 888		454, 621	0	683	16.00
17.00 17.01	01700 SOCIAL SERVICE 01701 STAFF EDUCATION	441, 467	20, 551 140, 626	99, 086 0	0	0	17.00 17.01
	01702 MEDICAL EDUCATION	19, 195		157	0	153	
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	252, 816		0	-	0	
	02200 I & SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PROGRAM	31, 168		0 133, 521	0	0 667	22.00 23.00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	431, 090	42,437	133, 321	0	007	23.00
	03000 ADULTS & PEDIATRICS	35, 287, 539		6, 447, 807	0	320, 797	30.00
31.00 31.01	03100 INTENSIVE CARE UNIT 03101 NEONATAL ICU	10, 532, 853 2, 175, 371		1, 821, 454 385, 531	0	105, 234 2, 207	
40.00	04000 SUBPROVI DER – I PF	1, 213, 444		251, 560	-	12	40.00
41.00	04100 SUBPROVI DER – I RF	2, 583, 934		496, 934		9, 445	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	1, 768, 818	308, 123	331, 142	0	15, 605	43.00
50.00	05000 OPERATING ROOM	7, 207, 979	752, 483	841, 860	0	165, 560	50.00
50.01	05001 ENDOSCOPY	1, 598, 696		193, 965	0	29, 985	50.01
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	1, 078, 341 3, 893, 793		220, 126 635, 798		2, 469 14, 766	
53.00	05300 ANESTHESI OLOGY	C	00,017	000,770	0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	3, 762, 219		520, 223		17, 842	
	05401 RADI OLOGY - ULTRASOUND 05500 RADI OLOGY-THERAPEUTI C	1, 565, 995 2, 153, 632		253, 797 109, 393		13, 734 1, 607	
55.01	05501 I NFUSI ON CENTER	29, 950		2, 404	0	1, 841	55.01
56.00	05600 RADI OI SOTOPE	1, 757, 010		115, 596	0	101, 197	56.00
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 970, 858 768, 129		256, 709 89, 548	0	28, 833 6, 781	57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	4, 162, 092		523, 133		66, 920	
60.00	06000 LABORATORY	14, 393, 709	296, 694	798, 218		330, 362	60.00
60.01 61.00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0	0	0	0	60.01 61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 432, 477	4, 857	260, 875	0	23, 479	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	C	0	0	0	0	63.00
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	3, 510, 633	0 97, 973	0 565, 990	0	0 62, 039	64.00 65.00
66. 00	06600 PHYSI CAL THERAPY	1, 494, 031		307, 573		1, 561	66.00
67.00	06700 OCCUPATI ONAL THERAPY	1, 211, 400	133, 031	251, 270		854	67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	480, 067 872, 540		97, 931 163, 549	0	753 1, 157	68.00 69.00
69.00 69.01	06901 CARDI AC REHAB	433, 951		86, 847	0	214	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 227, 387	0	225, 460	0	10, 863	70.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	10, 389, 568		0	0	1, 038, 170 1, 014, 237	
	07200 IMPL. DEV. CHARGED TO PATIENTS	18, 767, 677		90, 653	0	37, 852	
	07400 RENAL DI ALYSI S	2, 425, 018		0		3, 865	
00 00		4 400 200	041.040	E40.004		E 022	
	09000 CLINIC 09100 EMERGENCY	4, 690, 389 9, 354, 337		548, 234 1, 506, 810	0	5, 932 192, 376	90.00 91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	.,,					92.00
	OTHER REIMBURSABLE COST CENTERS						
101 00	10100 HOME HEALTH AGENCY	2, 794, 914	0	533, 321	0	10, 612	101 00

Health Financial Systems	METHODI ST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period: From 01/01/2020 To 12/31/2020		
Cost Center Description	Net Expenses for Cost	CAPI TAL RELATED COSTS BLDG & FI XT	EMPLOYEE BENEFI TS	DATA PROCESSI NG	PURCHASI NG RECEI VI NG AND	
	Allocation (from Wkst A col. 7)		DEPARTMENT		STORES	
	0	1.00	4.00	5.01	5.02	
SPECIAL PURPOSE COST CENTERS	1				1	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	310, 976, 745	17, 272, 859	27, 930, 93	5 12, 629, 071	3, 856, 636	118.00
NONREI MBURSABLE COST CENTERS	1	1				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	116	22, 721	(0 0		190.00
191. 00 19100 RESEARCH	0	0	(0 0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	33, 463, 487	336, 975	4, 923, 00	5 0	27, 013	
192.01 19201 OTHER NON-REIMBURSABLE	344, 613	43, 612		0 0	8	192.01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	100, 147	113, 503	16, 43	5 0	26	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	201.00
202.00 TOTAL (sum lines 118 through 201)	344, 885, 108	17, 789, 670	32, 870, 37	5 12, 629, 071	3, 883, 692	202.00

COST A	I Financial Systems ALLOCATION - GENERAL SERVICE COSTS		Provider CC		eriod: com 01/01/2020 0 12/31/2020	Worksheet B Part I Date/Time Pre	pared:
	Cost Center Description	ADMI TTI NG	CASHI ERI NG/AC COUNTS RECEI VABLE	Subtotal	OTHER A&G	7/23/2021 10: PATIENT TRANSPORTATIO N	<u>58 am</u>
		5.03	5.04	5A. 04	5.05	5.06	
1.00 4.00 5.01 5.02 5.03 5.04 5.05 5.06 7.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER A&G 00592 PATIENT TRANSPORTATION 00700 OPERATION OF PLANT	3, 318, 877 0 0 0	7, 241, 012 0 0	39, 081, 079 663, 642 22, 087, 164	39, 081, 079 84, 812 2, 822, 695	748, 454 0	1.00 4.00 5.01 5.02 5.03 5.04 5.05 5.06 7.00
8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.01 17.01 17.02 21.00 22.00 23.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 01701 STAFF EDUCATI ON 01702 MEDI CAL EDUCATI ON 02100 I & SERVI CES-SALARY & FRI NGES APPRVD 02200 I & SERVI CES-OTHER PRGM COSTS APPRVD	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1, 490, 314 6, 424, 463 4, 277, 893 2, 439, 998 5, 625, 525 2, 364, 420 6, 258, 838 3, 433, 837 561, 104 140, 626 24, 223 252, 816 87, 522 628, 317	190, 459 821, 034 546, 706 311, 827 718, 931 302, 168 799, 867 438, 838 71, 708 17, 972 3, 096 32, 309 11, 185 80, 298		8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00 17.00 21.00 22.00 23.00
30.00 31.00 31.01 40.00 41.00 43.00	03101 NEONATAL I CU 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04300 NURSERY	259, 653 60, 552 19, 751 11, 670 14, 086 6, 309	566, 587 132, 130 43, 098 25, 465 30, 736 13, 766	46, 833, 800 12, 902, 819 2, 654, 444 1, 552, 260 3, 529, 284 2, 443, 763	5, 985, 199 1, 648, 954 339, 233 198, 376 451, 035 312, 308	275, 308 4, 511 0 0 6, 847 23	31.0 ² 40.00 41.00
	ANCI LLARY SERVICE COST CENTERS	247 227	757 (0)	10 072 701	1 207 202	0	
50.00 50.01 51.00 52.00	05000 OPERATING ROOM 05001 ENDOSCOPY 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	347, 227 32, 172 24, 190 12, 195	757, 682 70, 203 52, 785 26, 611	10, 072, 791 1, 925, 021 1, 561, 417 4, 671, 510	1, 287, 283 246, 014 199, 546 597, 010	0 19, 453 23 8, 489	
53.00 54.01 55.00 55.01 56.00 57.00 58.00 59.00 60.00 60.01	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05401 RADI OLOGY - ULTRASOUND 05500 RADI OLOGY-THERAPEUTI C 05501 I NFUSI ON CENTER 05600 RADI OI SOTOPE 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY	0 99, 941 53, 382 52, 019 67 34, 241 319, 278 71, 972 172, 235 502, 563 0	0 218, 079 116, 484 113, 511 146 74, 716 696, 694 157, 050	0 5, 287, 675 2, 067, 151 2, 600, 283 38, 950 2, 196, 843 3, 380, 399 1, 146, 529 5, 401, 554 17, 417, 099 0	0 675, 754 264, 178 332, 311 4, 978 280, 752 432, 008 146, 524 690, 308 2, 225, 870 0	0 52, 785 90, 003 4, 811 0 44, 643 167, 978 49, 223 3, 562 0 0	54.0 [°] 55.0 [°] 55.0 [°] 56.0 [°] 57.0 [°] 58.0 [°] 59.0 [°] 60.0 [°] 60.0 [°]
61.00 62.00 63.00 64.00	06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY	27, 540 0 0	60, 095 0 0	0 1, 809, 323 0 0	231, 228 0 0	0 0 0	61.00 62.00 63.00 64.00
65.00 66.00 67.00 68.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	101, 217 20, 031 14, 989 6, 707	220, 865 43, 710 32, 707 14, 635	4, 558, 717 2, 021, 699 1, 644, 251 622, 751	582, 595 258, 369 210, 132 79, 586	162 0 0 0	66.00 67.00 68.00
69.00 69.01 70.00 71.00 72.00	06901 CARDI AC REHAB 07000 ELECTROENCEPHALOGRAPHY	59, 741 2, 566 66, 161 128, 047 73, 754	130, 361 5, 598 144, 369 279, 411 160, 938	1, 227, 348 529, 176 1, 674, 240 11, 835, 196 11, 398, 813	156, 853 67, 628 213, 965 1, 512, 514 1, 456, 746	2, 383 0 5, 135 0 0	70.00 71.00
73.00		73, 754 425, 371 26, 975 61, 299	928, 200 58, 862	20, 270, 720 2, 570, 014 6, 400, 684	1, 456, 746 2, 590, 557 328, 443 817, 995	0	
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	199, 918	436, 240	12, 031, 097 0	1, 537, 550	12, 953	91.00 92.00
101.00	DIO100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	11, 058	24, 131	3, 374, 036	431, 195	0	101.00
118.00		3, 318, 877	7, 241, 012	305, 493, 438	34, 046, 902	748, 454	118. 00 190. 00
0. 00	19000 GITT, TEOWER, COTTEE SHOP & CANTEEN	0		22, 840	2, 720		190. C

Health Financial Systems	METHODI ST HOS	PITALS, INC		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CCN: 15-0002			Worksheet B Part I		
				From 01/01/2020 To 12/31/2020			
Cost Center Description	ADMI TTI NG	CASHI ERI NG/AC	Subtotal	OTHER A&G	PATIENT		
		COUNTS			TRANSPORTATI 0		
		RECEI VABLE			N		
	5.03	5.04	5A. 04	5.05	5.06		
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	38, 750, 48	0 4, 952, 234	0	192.00	
192.01 19201 OTHER NON-REI MBURSABLE	0	0	388, 23	3 49, 615	0	192.01	
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	0	0	230, 11	1 29, 408	0	192.02	
193.00 19300 NONPALD WORKERS	0	0	(0 0	0	193.00	
200.00 Cross Foot Adjustments				C		200.00	
201.00 Negative Cost Centers	0	0		0 0	0	201.00	
202.00 TOTAL (sum lines 118 through 201)	3, 318, 877	7, 241, 012	344, 885, 10	39, 081, 079	748, 454	202.00	

	n Financial Systems ALLOCATION - GENERAL SERVICE COSTS	METHODI ST HOS	Provider C		eriod: rom 01/01/2020	u of Form CMS- Worksheet B Part I Date/Time Pre 7/23/2021 10:	epared:
	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		7.00	8.00	9.00	10.00	11.00	
1 00	GENERAL SERVICE COST CENTERS						1 1 00
1.00 4.00	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT						1.00
5.01	00550 DATA PROCESSING						5.01
5.02	00560 PURCHASING RECEIVING AND STORES						5.02
5.03							5.03
5.04 5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER A&G						5.04
5.06	00592 PATIENT TRANSPORTATION						5.06
7.00	00700 OPERATION OF PLANT	24, 909, 859					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	468, 159	2, 148, 932				8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	541, 962 495, 028	0		5, 480, 926		9.00
11.00	01100 CAFETERI A	346, 083	0		0,400,720	3, 210, 675	
13.00	01300 NURSI NG ADMI NI STRATI ON	166, 778	77, 467		0	83, 282	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	941, 388	1, 621	306, 741	0	39, 708	
15.00 16.00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	497, 890 296, 969	0		0	0 112, 786	
17.00		42, 784	0	13, 941	0	19, 979	
17.01	01701 STAFF EDUCATION	292, 767	0		0	0	
17.02		9, 823	0		0	0	
21.00		0 117, 322	0		0	0	
22.00 23.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PROGRAM	88, 353	0		0	34, 493	22.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	00,000		20, 107		01, 170	20.00
30.00		8, 226, 394	884, 760	2, 680, 474	4, 382, 649	1, 051, 018	30. 00
31.00	03100 INTENSIVE CARE UNIT	521, 712	141, 681	169, 994	203, 336	215, 654	
31.01 40.00	03101 NEONATAL I CU 04000 SUBPROVI DER – I PF	59, 305 104, 321	0		0 155, 782	50, 696 40, 239	
40.00	04100 SUBPROVI DER – I RF	820, 572	93, 145		330, 639	86, 869	
43.00		641, 477	40, 945		0	42, 412	
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 566, 581	259, 360		0	145, 204	
50.01 51.00	05001 ENDOSCOPY 05100 RECOVERY ROOM	0 382, 039	31, 009 15, 716		0 1, 747	29, 699 27, 094	
52.00	05200 DELIVERY ROOM & LABOR ROOM	183, 928	54, 505		146, 723	101, 203	
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 393, 552	50, 685		0	106, 213	
54.01 55.00	05401 RADI OLOGY – ULTRASOUND 05500 RADI OLOGY-THERAPEUTI C	132, 739 354, 173	18, 433 12, 822		0	39, 540 17, 438	
55.01	05501 I NFUSI ON CENTER	9, 455	12, 022		0	341	
56.00	05600 RADI OI SOTOPE	237, 507	12, 073		0	15, 597	
57.00		224, 900	25, 837		0	42, 127	
	05800 MAGNETIC RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON	110, 441	11,463		0	10/101	
60.00		210, 980 617, 681	51, 265 0		0	62, 260 152, 141	
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	
61.00							61.00
62.00		10, 112	0	3, 295	0	81, 861	
63.00 64.00		0	0	0	0	0 0	
65.00		203, 968	0	66, 461	0	91, 010	
66.00	06600 PHYSI CAL THERAPY	322, 262	0	105, 005	0	45, 082	
67.00		276, 956	0	90, 243	0	36, 404	
68.00 69.00		47, 171	0 3, 319	15, 370 0	0	12, 432 27, 734	
69.00 69.01		0	3, 319		0	27, 734 14, 778	
	07000 ELECTROENCEPHALOGRAPHY	o o	14, 358		0 0	33, 740	
71.00		0	0	0	0	0	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	14 222	0	0 12 457	
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	43, 651 115, 116	0 23, 734	14, 223 37, 509	0	13, 657 0	
50	OUTPATIENT SERVICE COST CENTERS	113,110	20,704		0	0	1
	09000 CLI NI C	2, 000, 833	53, 462		0	81, 195	
	09100 EMERGENCY	710, 788	271,000	231, 602	260, 050	240, 028	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
101.00	DIALON HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						1
118.00		23, 833, 920	2, 148, 932	7, 436, 876	5, 480, 926	3, 210, 675	118.00
100 0	NONREIMBURSABLE COST CENTERS D19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	47, 302	0	15 /12	0	0	190.00
	D19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	47,302	0		0		190.00
191 ()(0	0	U U	0	

Health Financial Systems	METHODI ST HOS	PITALS, INC		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Peri od:	Worksheet B		
				rom 01/01/2020		norod.	
			1	o 12/31/2020	Date/Time Pre 7/23/2021 10:	58 am	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A		
	PLANT	LINEN SERVICE					
	7.00	8.00	9.00	10.00	11.00		
192.01 19201 OTHER NON-REIMBURSABLE	90, 795	0	29, 585	5 O	0	192.01	
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	236, 299	0	76, 995	5 0	0	192.02	
193.00 19300 NONPALD WORKERS	0	0	C	0 0	0	193.00	
200.00 Cross Foot Adjustments						200.00	
201.00 Negative Cost Centers	0	0	C	0 0	0	201.00	
202.00 TOTAL (sum lines 118 through 201)	24, 909, 859	2, 148, 932	7, 787, 459	5, 480, 926	3, 210, 675	202.00	

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	METHODI ST HOSI	Provi der CC	CN: 15-0002	Period: From 01/01/2020	u of Form CMS-: Worksheet B Part I	2002
					To 12/31/2020		epare
	Cost Center Description	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	
		13.00	14.00	15.00	16.00	17.00	
	GENERAL SERVICE COST CENTERS	1					1 1
00 00	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT						1.
01	00550 DATA PROCESSING						5.
02	00560 PURCHASING RECEIVING AND STORES						5.
03 04	00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 5.
04 05	00590 OTHER A&G						5.
06	00592 PATIENT TRANSPORTATION						5.
00	00700 OPERATION OF PLANT						7.
00 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8. 9.
	01000 DI ETARY						10
	01100 CAFETERI A						111.
	01300 NURSING ADMINISTRATION	6, 726, 326					13.
	01400 CENTRAL SERVICES & SUPPLY	0	3, 956, 046	7 740 0			14
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	0	7, 718, 8	0 4, 379, 194		15
	01700 SOCIAL SERVICE	64, 464	0		0 0	773, 980	
01	01701 STAFF EDUCATION	0	0		0 0	0	17
	01702 MEDI CAL EDUCATI ON	0	0		0 0	0	
	02100 I & R SERVICES-SALARY & FRINGES APPRVD 02200 I & R SERVICES-OTHER PRGM COSTS APPRVD	0	0		0 0 0 0	0	
	02300 PARAMED ED PROGRAM	111, 300	0		0 0	0	
	INPATIENT ROUTINE SERVICE COST CENTERS		- 1				
	03000 ADULTS & PEDIATRICS	3, 391, 317	0		0 342, 687	618, 078	
	03100 INTENSIVE CARE UNIT 03101 NEONATAL ICU	695, 850 163, 581	0		0 79, 916 0 26, 067	0	
	04000 SUBPROVI DER – I PF	129, 839	0		0 15, 402	0	
	04100 SUBPROVI DER – I RF	280, 299	0		0 18, 590	123, 837	
00	04300 NURSERY	136, 849	0		0 8, 326	0	43
00	ANCILLARY SERVICE COST CENTERS	468, 528	0		0 458, 267	0	50
	05001 ENDOSCOPY	408, 528 95, 829	0		0 438, 267 0 42, 461	0	
	05100 RECOVERY ROOM	87, 423	0		0 31, 926	0	
	05200 DELIVERY ROOM & LABOR ROOM	326, 550	0		0 16, 095	0	
	05300 ANESTHESI OLOGY	0	0		0 0 0 131,900	0	
	05400 RADI OLOGY-DI AGNOSTI C 05401 RADI OLOGY - ULTRASOUND	0	0		0 131, 900 0 70, 453	0	
	05500 RADI OLOGY-THERAPEUTI C	0	0		0 68, 654	0	
01	05501 INFUSION CENTER	0	0		0 88	0	
	05600 RADI OI SOTOPE	0	0		0 45, 190	0	
	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 421, 380 0 94, 988	0	
	05900 CARDI AC CATHETERI ZATI ON	0	0		0 227, 314	0	
	06000 LABORATORY	0	0	505,82		0	60
	06001 BLOOD LABORATORY	0	0		0 0	0	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 36, 347	0	61
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	
	06400 INTRAVENOUS THERAPY	0	0		0 0	0	
	06500 RESPI RATORY THERAPY	0	0		0 133, 585	0	
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	0		0 26, 437 0 19, 782	0	
	06800 SPEECH PATHOLOGY	0	0		0 8,852	0	
	06900 ELECTROCARDI OLOGY	0	0		0 78, 846	0	
	06901 CARDI AC REHAB	0	0		0 3, 386	0	
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0 2, 001, 107		0 87, 318 0 168, 995	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS		2,001,107		0 168, 995	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0	7, 133, 40		0	
00	07400 RENAL DI ALYSI S	0	0		0 35, 601	0	74
00					0 00 000	-	
	09000 CLINIC 09100 EMERGENCY	0 774, 497	0		0 80, 902 0 263, 850	0 32, 065	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	//4,47/	0		203,030	52,005	91
	OTHER REIMBURSABLE COST CENTERS	· · ·					
. 00	10100 HOME HEALTH AGENCY	0	0	1	12 14, 595	0	101
3. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	6, 726, 326	3, 956, 046	7, 639, 3	47 4, 379, 194	773, 980	112
		5,720,320	5, 750, 040	1,007,0	··	113,700	1'''
	NONREIMBURSABLE COST CENTERS						

Health Financial Systems	METHODI ST HOSI	PITALS, INC		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS	Provider CCN: 15-0002			Period:	Worksheet B		
				From 01/01/2020 To 12/31/2020			
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL		
	ADMI NI STRATI O	SERVICES &		RECORDS &	SERVI CE		
	N	SUPPLY		LI BRARY			
	13.00	14.00	15.00	16.00	17.00		
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	79, 48	0 0		0 192.00	
192.01 19201 OTHER NON-REI MBURSABLE	0	0		0 0		0 192.01	
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	0	0		0 0		0 192.02	
193.00 19300 NONPALD WORKERS	0	0		0 0		0 193.00	
200.00 Cross Foot Adjustments						200.00	
201.00 Negative Cost Centers	0	0		0 0		0 201.00	
202.00 TOTAL (sum lines 118 through 201)	6, 726, 326	3, 956, 046	7, 718, 82	7 4, 379, 194	773, 9	80 202. 00	

JI ALI	inancial Systems LOCATION - GENERAL SERVICE COSTS		Provider C	F	Period: From 01/01/2020	Worksheet B Part I	
					o 12/31/2020	Date/Time Pre 7/23/2021 10:	par 58
			·	I NTERNS &	RESI DENTS		
	Cost Center Description	STAFF	MEDI CAL	SERVI CES-SALA	SERVI CES-OTHE	PARAMED ED	
		EDUCATI ON	EDUCATI ON	RY & FRI NGES		PROGRAM	
G	ENERAL SERVICE COST CENTERS	17.01	17.02	21.00	22.00	23.00	-
	0100 CAP REL COSTS-BLDG & FIXT						1
	0400 EMPLOYEE BENEFITS DEPARTMENT						4
	0550 DATA PROCESSING 0560 PURCHASING RECEIVING AND STORES						5
	0570 ADMITTING						5
	0580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5
	0590 OTHER A&G						5
	0592 PATIENT TRANSPORTATION						5
	0700 OPERATION OF PLANT 0800 LAUNDRY & LINEN SERVICE						7
	0900 HOUSEKEEPING						9
	1000 DI ETARY						10
	1100 CAFETERI A						11
	1300 NURSING ADMINISTRATION						13
	1400 CENTRAL SERVI CES & SUPPLY 1500 PHARMACY						14
	1600 MEDI CAL RECORDS & LI BRARY						16
	1700 SOCI AL SERVI CE						17
	1701 STAFF EDUCATION	546, 760	10.115				17
	1702 MEDICAL EDUCATION 2100 I&R SERVICES-SALARY & FRINGES APPRVD	72 0	40, 415 0				17
	2200 I &R SERVICES-SALARI & TRINGES AFFRVD	0	0		254, 257		22
	2300 PARAMED ED PROGRAM	567	0			972, 117	23
	NPATIENT ROUTINE SERVICE COST CENTERS			-			4
	3000 ADULTS & PEDIATRICS 3100 INTENSIVE CARE UNIT	233, 322 49, 085	0			0	
	3101 NEONATAL I CU	49,085	0			0	
	4000 SUBPROVI DER – I PF	2, 446	0		-	0	
. 00 0	4100 SUBPROVI DER – I RF	32, 140	0			0	41
	4300 NURSERY	25, 073	0	(0 0	0	43
	NCI LLARY SERVI CE COST CENTERS	41, 739	0	(0	0	50
	5001 ENDOSCOPY	9, 585	0			0	
	5100 RECOVERY ROOM	1, 349	0			0	51
	5200 DELIVERY ROOM & LABOR ROOM	35, 949	0			0	52
	5300 ANESTHESI OLOGY 5400 RADI OLOGY-DI AGNOSTI C	0 11, 636	0		-	0	
	5401 RADI OLOGY - ULTRASOUND	3, 472	0			0	
	5500 RADI OLOGY-THERAPEUTI C	2, 224	0	0	0	0	
	5501 INFUSION CENTER	387	0	0	0	0	
	5600 RADI OI SOTOPE 5700 CT SCAN	22	0			0	
	5700 CT SCAN 5800 MAGNETIC RESONANCE IMAGING (MRI)	6, 342	0			0	
	5900 CARDI AC CATHETERI ZATI ON	30, 031	0		-	0	
	6000 LABORATORY	1, 492	0	0	0 0	0	
	6001 BLOOD LABORATORY	0	0	0	0 0	0	
	6100 PBP CLINICAL LAB SERVICES-PRGM ONLY 6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 134	0			0	61
	6300 BLOOD STORING, PROCESSING & TRANS.	0	0		-	0	
	6400 INTRAVENOUS THERAPY	0	0	0	0 0	0	
	6500 RESPI RATORY THERAPY	5, 890	0	0	0 0	0	65
		1, 134	0		0	0	66
	6700 OCCUPATI ONAL THERAPY 6800 SPEECH PATHOLOGY	1, 198 495	0			0	67
1	6900 ELECTROCARDI OLOGY	847	0		0	0	
. 01 0	6901 CARDI AC REHAB	43	0	C	0	0	69
1	7000 ELECTROENCEPHALOGRAPHY	2, 145	0	(0	0	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 7200 IMPL. DEV. CHARGED TO PATIENTS	0	0			0	
	7300 DRUGS CHARGED TO PATIENTS	65	0	-	-	0	
00 0	7400 RENAL DI ALYSI S	0	0			0	
	UTPATIENT SERVICE COST CENTERS						
	9000 CLINIC 9100 EMERGENCY	2, 210	0			0 072 117	
	9100 EMERGENCY 9200 OBSERVATION BEDS (NON-DISTINCT PART)	34, 357	40, 415	285, 125	254, 257	972, 117	91
	THER REIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·		L			1 ′′
0	0100 HOME HEALTH AGENCY	2, 697	0	(0 0	0	101
1.001							
1.00 <u>1</u> S	PECIAL PURPOSE COST CENTERS	E20 (2)	10 115	DOF 405		070 447	1110
1.00 <u>1</u> S 8.00		539, 636	40, 415	285, 125	254, 257	972, 117]118

Health Financial Systems	METHODI ST HOSI	PITALS, INC		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2020			
				To 12/31/2020	Date/Time Pre 7/23/2021 10:	pared: 58 am	
			INTERNS &	RESI DENTS			
Cost Center Description	STAFF	MEDI CAL	SERVI CES-SALA	SERVI CES-OTHE	PARAMED ED		
	EDUCATI ON	EDUCATI ON	RY & FRINGES	R PRGM COSTS	PROGRAM		
	17.01	17.02	21.00	22.00	23.00		
191. 00 19100 RESEARCH	0	0		0 0	0	191.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	7, 124	0		0 0	0	192.00	
192.01 19201 OTHER NON-REI MBURSABLE	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)	546, 760	40, 415	285, 12	5 254, 257	972, 117	202.00	

ST ALL	OCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-0002	Period: Worksheet From 01/01/2020 Part I	В
					To 12/31/2020 Date/Time 7/23/2021	
	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
CE		24.00	25.00	26.00		
	NERAL SERVICE COST CENTERS 1100 CAP REL COSTS-BLDG & FIXT					1
00 00 01 00 02 00 03 00 04 00 05 00 06 00 00 00 00 00 00 00 00 01 00 01 00 01 00 01 00 01 00 01 00 01 00 01 00 01 00 01 00 01	 1400 EMPLOYEE BENEFITS DEPARTMENT 1550 DATA PROCESSING 1560 PURCHASING RECEIVING AND STORES 1570 ADMITTING 1580 CASHIERING/ACCOUNTS RECEIVABLE 1590 OTHER A&G 1592 PATIENT TRANSPORTATION 1590 PATION OF PLANT 1800 LAUNDRY & LINEN SERVICE 100 OPERATION 101 CAFETERIA 100 CAFETERIA 101 STARY 102 CAL SERVICE 103 STAFF EDUCATION 					2 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5
02 01 00 02 00 02 00 02	702 MEDICAL EDUCATION 100 I &R SERVICES-SALARY & FRINGES APPRVD 200 I &R SERVICES-OTHER PRGM COSTS APPRVD 300 PARAMED ED PROGRAM PATIENT ROUTINE SERVICE COST CENTERS					1 2 2 2
	000 ADULTS & PEDIATRICS	74, 905, 006	0	74, 905, 00	06	30
1	100 I NTENSI VE CARE UNI T	16, 633, 512		16, 633, 51		31
	101 NEONATAL I CU 1000 SUBPROVI DER – I PF	3, 313, 138 2, 232, 657	0	3, 313, 13 2, 232, 65		31
	100 SUBPROVIDER - IRF	6, 040, 631	0	6, 040, 63		4
	300 NURSERY	3, 860, 194		3, 860, 19		4:
	CILLARY SERVICE COST CENTERS					
	OOO OPERATING ROOM	14, 810, 206		14, 810, 20		50
	1001 ENDOSCOPY	2, 399, 071	0	2, 399, 07		50
	100 RECOVERY ROOM 2000 DELIVERY ROOM & LABOR ROOM	2, 432, 763 6, 201, 893		2, 432, 76 6, 201, 89		5
	3300 ANESTHESI OLOGY	0, 201, 079	0	0,201,01	0	5
	400 RADI OLOGY-DI AGNOSTI C	8, 164, 273	-	8, 164, 27	73	54
01 05	401 RADI OLOGY - ULTRASOUND	2, 729, 221	0	2, 729, 22		54
	500 RADI OLOGY-THERAPEUTI C	3, 508, 119		3, 508, 11		5
	1501 I NFUSI ON CENTER	57, 280		57, 28		5
	600 RADI OI SOTOPE 5700 CT SCAN	2, 910, 016 4, 774, 252		2, 910, 01 4, 774, 25		50
	100 MAGNETIC RESONANCE IMAGING (MRI)	1, 611, 915		4, 774, 25		58
	1900 CARDI AC CATHETERI ZATI ON	6, 746, 020		6, 746, 02		5
	000 LABORATORY	21, 783, 629		21, 783, 62		60
	001 BLOOD LABORATORY	0	0		0	60
	100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0 170 00	0	6
	200 WHOLE BLOOD & PACKED RED BLOOD CELLS 300 BLOOD STORING, PROCESSING & TRANS.	2, 173, 300 0	0	2, 173, 30		62
	400 I NTRAVENOUS THERAPY	0	0		0	64
	500 RESPI RATORY THERAPY	5, 642, 388		5, 642, 38		6
00 06	600 PHYSI CAL THERAPY	2, 779, 988	0	2, 779, 98	38	60
	000 OCCUPATI ONAL THERAPY	2, 278, 966		2, 278, 96		6
	800 SPEECH PATHOLOGY 900 ELECTROCARDI OLOGY	786, 657 1, 497, 330		786, 65 1, 497, 33		68
	900 CARDI AC REHAB	615, 283		615, 28		69
	000 ELECTROENCEPHALOGRAPHY	2, 030, 901	0	2, 030, 90		70
00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	15, 517, 812		15, 517, 81	12	7
	200 IMPL. DEV. CHARGED TO PATIENTS	14, 907, 837		14, 907, 83		72
	300 DRUGS CHARGED TO PATIENTS	30, 627, 682		30, 627, 68		73
	400 RENAL DIALYSIS TPATIENT SERVICE COST CENTERS	3, 110, 417	0	3, 110, 41		74
	000 CLINIC	10, 089, 392	0	10, 089, 39	92	90
	100 EMERGENCY	17, 951, 751		17, 412, 36		9
	200 OBSERVATION BEDS (NON-DISTINCT PART)		0			92
	HER REIMBURSABLE COST CENTERS					
	100 HOME HEALTH AGENCY	3, 822, 635	0	3, 822, 63	35	101
	ECIAL PURPOSE COST CENTERS					

Health Financial Systems	METHODI ST HOSPI TALS, INC			In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS	Provider CCN: 15-0002			Period:	Worksheet B	
				From 01/01/2020 To 12/31/2020	Part I Date/Time Prepared:	
					7/23/2021 10:58 am	
Cost Center Description	Subtotal	Intern &	Total			
		Resi dents				
		Cost & Post				
		Stepdown				
		Adjustments		_		
	24.00	25.00	26.00			
NONREI MBURSABLE COST CENTERS		1				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	88, 481	0	88, 48	1	190.00	
191. 00 19100 RESEARCH	0	0		0	191.00	
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	44, 719, 451	0	44, 719, 45	1	192.00	
192.01 19201 OTHER NON-REI MBURSABLE	558, 228	0	558, 22	8	192.01	
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	572, 813	0	572, 81	3	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, 885, 108	-539, 382	344, 345, 72	6	202.00	

	nancial Systems ON OF CAPITAL RELATED COSTS	METHODI ST HOSP	ITALS, INC Provider CC		eriod: com 01/01/2020	u of Form CMS-2 Worksheet B Part II Date/Time Pre	pared:
	Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL RELATED COSTS BLDG & FI XT	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	DATA PROCESSI NG	<u>58 am</u>
		0	1.00	2A	4.00	5.01	
	NERAL SERVICE COST CENTERS	1					1 00
$\begin{array}{ccccc} 4 & 00 & 00 \\ 5 & 01 & 00 \\ 5 & 02 & 00 \\ 5 & 03 & 00 \\ 5 & 04 & 00 \\ 5 & 05 & 00 \\ 5 & 06 & 00 \\ 7 & 00 & 00 \\ 8 & 00 & 00 \\ 9 & 00 & 00 \\ 10 & 00 & 01 \\ 11 & 00 & 01 \\ 13 & 00 & 01 \end{array}$	100 CAP REL COSTS-BLDG & FIXT 400 EMPLOYEE BENEFITS DEPARTMENT 550 DATA PROCESSING 560 PURCHASING RECEIVING AND STORES 570 ADMITTING 580 CASHIERING/ACCOUNTS RECEIVABLE 590 OTHER A&G 592 PATIENT TRANSPORTATION 700 OPERATION OF PLANT 800 LAUNDRY & LINEN SERVICE 900 HOUSEKEEPING 000 DI ETARY 100 CAFETERIA 300 NURSING ADMINISTRATION		74, 508 115, 937 92, 498 122, 586 386, 618 1, 256, 249 0 3, 776, 214 224, 873 260, 323 237, 779 166, 236 80, 109	74, 508 115, 937 92, 498 122, 586 386, 618 1, 256, 249 0 3, 776, 214 224, 873 260, 323 237, 779 166, 236 80, 109	74, 508 2, 250 475 1, 114 1, 099 5, 674 259 1, 969 0 2, 103 1, 020 725 1, 848	118, 187 0 0 118, 187 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1.00\\ 4.00\\ 5.01\\ 5.02\\ 5.03\\ 5.04\\ 5.05\\ 5.06\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 13.00\\ \end{array}$
15.00 01 16.00 01 17.00 01 17.01 01 17.02 01 21.00 02 23.00 02 IN IN	400 CENTRAL SERVICES & SUPPLY 500 PHARMACY 600 MEDICAL RECORDS & LIBRARY 700 SOCIAL SERVICE 701 STAFF EDUCATION 702 MEDICAL EDUCATION 100 I&R SERVICES-SALARY & FRINGES APPRVD 200 I&R SERVICES-OTHER PRGM COSTS APPRVD 300 PARAMED ED PROGRAM PATIENT ROUTINE SERVICE COST CENTERS		452, 181 239, 154 142, 645 20, 551 140, 626 4, 718 0 56, 354 42, 439	452, 181 239, 154 142, 645 20, 551 140, 626 4, 718 0 56, 354 42, 439	309 0 1, 031 225 0 0 0 0 0 0 0 0 303		14.00 15.00 16.00 17.00 17.01 17.02 21.00 22.00 23.00
31.00 03 31.01 03 40.00 04 41.00 04 43.00 04	000 ADULTS & PEDIATRICS 100 INTENSIVE CARE UNIT 101 NEONATAL ICU 000 SUBPROVIDER - IPF 100 SUBPROVIDER - IRF 300 NURSERY CILLARY SERVICE COST CENTERS		3, 951, 417 250, 596 28, 486 50, 109 394, 149 308, 123	3, 951, 417 250, 596 28, 486 50, 109 394, 149 308, 123	14, 588 4, 131 874 570 1, 127 751	0 0 0 0 0	30. 00 31. 00 31. 01 40. 00 41. 00 43. 00
$\begin{array}{cccccccccccccccccccccccccccccccccccc$	000 OPERATING ROOM 001 ENDOSCOPY 100 RECOVERY ROOM 200 DELIVERY ROOM & LABOR ROOM 300 ANESTHESIOLOGY 400 RADIOLOGY-DIAGNOSTIC 401 RADIOLOGY - ULTRASOUND 500 RADIOLOGY - THERAPEUTIC 501 INFUSION CENTER 600 RADIOISOTOPE 700 CT SCAN 800 MAGNETIC RESONANCE IMAGING (MRI) 900 CARDIAC CATHETERIZATION 000 LABORATORY 001 BLOOD LABORATORY 100 PBP CLINICAL LAB SERVICES-PRGM ONLY 200 WHOLE BLOOD & PACKED RED BLOOD CELLS 300 BLOOD STORING, PROCESSING & TRANS. 400 INTRAVENOUS THERAPY 500 RESPIRATORY THERAPY 600 PHYSICAL THERAPY 600 SPECH PATHOLOGY		$\begin{array}{c} 752,483\\ 0\\ 183,506\\ 88,347\\ 0\\ 669,371\\ 63,759\\ 170,121\\ 4,542\\ 114,083\\ 108,027\\ 53,049\\ 101,341\\ 296,694\\ 0\\ 4,857\\ 0\\ 0\\ 97,973\\ 154,793\\ 133,031\\ 22,658\\ \end{array}$	$\begin{array}{c} 752,483\\ 0\\ 183,506\\ 88,347\\ 0\\ 0\\ 669,371\\ 63,759\\ 170,121\\ 4,542\\ 114,083\\ 108,027\\ 53,049\\ 101,341\\ 296,694\\ 0\\ 0\\ 4,857\\ 0\\ 0\\ 97,973\\ 154,793\\ 133,031\\ 22,658\\ \end{array}$	$\begin{array}{c} 1, 909 \\ 440 \\ 499 \\ 1, 442 \\ 0 \\ 1, 180 \\ 576 \\ 248 \\ 5 \\ 5 \\ 262 \\ 582 \\ 203 \\ 1, 186 \\ 1, 810 \\ 0 \\ 592 \\ 0 \\ 0 \\ 1, 284 \\ 698 \\ 570 \\ 222 \end{array}$		$\begin{array}{c} 55.\ 01\\ 56.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 01\\ 61.\ 00\\ 62.\ 00\\ 63.\ 00\\ 64.\ 00\\ 65.\ 00\\ 66.\ 00\\ 66.\ 00\\ 68.\ 00\\ \end{array}$
69.00 06 69.01 06 70.00 07 71.00 07 72.00 07 73.00 07 74.00 07 90.00 09 91.00 09	900 ELECTROCARDI OLOGY 901 CARDI AC REHAB 000 ELECTROENCEPHALOGRAPHY 100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 200 I MPL. DEV. CHARGED TO PATI ENTS 300 DRUGS CHARGED TO PATI ENTS 400 RENAL DI ALYSI S TPATI ENT SERVICE COST CENTERS 000 CLI NI C 100 EMERGENCY 200 OBSERVATI ON BEDS (NON-DI STI NCT PART)		0 0 0 20, 967 55, 294 961, 069 341, 416	0 0 0 20, 967 55, 294 961, 069 341, 416 0	371 197 511 0 206 0 1, 243 3, 417		69.00 69.01 70.00 71.00 72.00 73.00 74.00 90.00 91.00 92.00
ОТ 101. 00 <u>10</u>	HER REIMBURSABLE COST CENTERS 100 HOME HEALTH AGENCY ECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	1, 209 63, 307	0 118, 187	101. 00

Health Financial Systems	METHODI ST HOS	PITALS, INC		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C	1	Period: From 01/01/2020 Fo 12/31/2020		
Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL RELATED COSTS BLDG & FI XT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSI NG	
	0	1.00	2A	4.00	5. 01	
NONREI MBURSABLE COST CENTERS			_			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22, 721	22, 72	0	0	190.00
191. 00 19100 RESEARCH	0	0	(0 0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	336, 975	336, 975	5 11, 164	0	192.00
192.01 19201 OTHER NON-REI MBURSABLE	0	43, 612	43, 612	2 0	0	192.01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	0	113, 503	113, 503	3 37	0	192.02
193. 00 19300 NONPALD WORKERS	0	0	(0 0	0	193.00
200.00 Cross Foot Adjustments			(D		200.00
201.00 Negative Cost Centers		0	(0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	17, 789, 670	17, 789, 670	74, 508	118, 187	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	METHODIST HOSP	ITALS, INC Provider C	CN: 15-0002 P	In Lie eriod:	u of Form CMS-2 Worksheet B	2552-10
ALLOUA	TION OF CAPITAL RELATED COSTS		FIOVIDEI C		rom 01/01/2020	Part II Date/Time Pre 7/23/2021 10:	pared: 58 am
	Cost Center Description	PURCHASI NG RECEI VI NG AND STORES	ADMI TTI NG	CASHI ERI NG/AC COUNTS RECEI VABLE	OTHER A&G	PATIENT TRANSPORTATIO N	
		5.02	5.03	5.04	5.05	5.06	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550 DATA PROCESSING						5.01
5.02	00560 PURCHASING RECEIVING AND STORES	92, 973					5.02
5.03 5.04	00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	122	123, 822 0				5.03 5.04
5.04 5.05	00590 OTHER A&G	23	0		1, 380, 119		5.04
5.06	00592 PATIENT TRANSPORTATION	6	0		2, 995	3, 260	5.06
7.00	00700 OPERATION OF PLANT	994	0		99, 679	0	7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	1, 007	0 0		6, 726 28, 994	0	8.00 9.00
10.00	01000 DI ETARY	1, 475	0		19, 306	0	10.00
11.00	01100 CAFETERI A	2	0		11, 012	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	430	0		25, 388	0	13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	709 389	0		10, 671 28, 246	0	14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	16	0		15, 497	0	16.00
17.00	01700 SOCI AL SERVI CE	0	0	0	2, 532	0	17.00
17.01	01701 STAFF EDUCATION	0	0	-	635	0	17.01
17.02 21.00	01702 MEDICAL EDUCATION 02100 I&R SERVICES-SALARY & FRINGES APPRVD	4	0		109 1, 141	0	17.02 21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	-	395	0	22.00
23.00	02300 PARAMED ED PROGRAM	16	0	0	2, 836	0	23.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	7 (70)	0 / 71	20.201	011 007	1 100	
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	7, 679 2, 519	9, 671 2, 255		211, 387 58, 230	1, 199 20	30.00 31.00
31.01	03101 NEONATAL I CU	53	736		11, 980	0	31.01
40.00	04000 SUBPROVI DER - I PF	0	435		7, 005	0	40.00
41.00	04100 SUBPROVIDER - IRF	226	525		15, 928	30	41.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	374	235	738	11, 029	0	43.00
50.00	05000 OPERATING ROOM	3, 963	12, 933	40, 627	45, 459	0	50.00
50.01	05001 ENDOSCOPY	718	1, 198		8, 688	85	50.01
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	59 353	901 454		7, 047 21, 083	0 37	51.00 52.00
52.00 53.00	05300 ANESTHESI OLOGY	0	434		21,083	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	427	3, 722	11, 694	23, 863	230	
54.01	05401 RADI OLOGY - ULTRASOUND	329	1, 988		9, 329	392	54.01
55.00 55.01	05500 RADI OLOGY-THERAPEUTI C 05501 I NFUSI ON CENTER	38	1, 938 2		11, 735 176	21 0	55.00 55.01
56.00	05600 RADI OI SOTOPE	2, 422	1, 275	-	9, 914	194	56.00
	05700 CT SCAN	690	11, 892		15, 256	732	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	162	2, 681		5, 174	214	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	1, 602 7, 908	6, 415 18, 926		24, 377 78, 603	16 0	59.00 60.00
60.01	06001 BLOOD LABORATORY	0	10, 720		0,005	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	562	1, 026		8, 165	0	62.00
63.00 64.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY	0	0		0	0	63.00 64.00
65.00	06500 RESPI RATORY THERAPY	1, 485	3, 770	-	20, 573	1	65.00
66.00	06600 PHYSI CAL THERAPY	37	746	2, 344	9, 124	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	20	558		7,421	0	67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	18 28	250 2, 225		2, 810 5, 539	0 10	68.00 69.00
69.00	06901 CARDI AC REHAB	5	2, 223		2, 388	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	260	2, 464	7, 741	7, 556	22	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	24,860	4, 769		53, 412	0	71.00
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	24, 279 906	2, 747 15, 843		51, 443 91, 482	0	72.00 73.00
	07400 RENAL DI ALYSI S	93	1, 005		11, 598	0	74.00
	OUTPATIENT SERVICE COST CENTERS						
90.00 91.00	09000 CLINIC	142	2,283		28, 886 54, 206	1	90.00 91.00
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 605	7,446	23, 392	54, 296	56	91.00
	OTHER REIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·		· · · · · · · · · · · · · · · · · · ·			_ 00
101.00	10100 HOME HEALTH AGENCY	254	412	1, 294	15, 227	0	101.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	92, 325	123, 822	387, 742	1, 202, 345	2 240	118.00
110.00	NONREIMBURSABLE COST CENTERS	72, 325	123, 822	307,742	1, 202, 345	3, 200	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		103		190.00
	19100 RESEARCH	0	0	0	0	0	191.00

Health Financial Systems	METHODI ST HOSI	PITALS, INC		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period:	Worksheet B	
				From 01/01/2020 To 12/31/2020		pared:
					7/23/2021 10:	58 am
Cost Center Description	PURCHASI NG	ADMI TTI NG	CASHI ERI NG/AG	OTHER A&G	PATI ENT	
	RECEI VI NG AND		COUNTS		TRANSPORTATI 0	
	STORES		RECEI VABLE		N	
	5.02	5.03	5.04	5.05	5.06	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	647	0		0 174, 881	0	192.00
192.01 19201 OTHER NON-REI MBURSABLE	0	0		0 1, 752	0	192.01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	1	0		0 1, 038	0	192.02
193. 00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
200.00 Cross Foot Adjustments			1			200.00
201.00 Negative Cost Centers	0	0	1	0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	92, 973	123, 822	387, 74	2 1, 380, 119	3, 260	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	METHODI ST HOS			eri od:	u of Form CMS-: Worksheet B Part II	2552-10
				To	rom 01/01/2020 b 12/31/2020	Date/Time Pre 7/23/2021 10:	pared:
	Cost Center Description	OPERATI ON OF	LAUNDRY &	HOUSEKEEPING	DI ETARY	CAFETERI A	
		PLANT 7. 00	LINEN SERVICE 8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS						
1.00 4.00	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT						1.00
4.00 5.01	00550 DATA PROCESSING						5.01
5.02	00560 PURCHASING RECEIVING AND STORES						5.02
5.03	00570 ADMI TTI NG						5.03
5.04 5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER A&G						5.04 5.05
5.06	00592 PATIENT TRANSPORTATION						5.06
7.00	00700 OPERATION OF PLANT	3, 878, 856					7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	72, 900 84, 392					8.00 9.00
9.00 10.00	01000 DI ETARY	77, 084			344, 469		10.00
11.00	01100 CAFETERI A	53, 891	0		0	237, 323	•
13.00	01300 NURSI NG ADMI NI STRATI ON	25, 970			0	6, 156	
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	146, 589 77, 529			0	2, 935 0	•
16.00	01600 MEDI CAL RECORDS & LI BRARY	46, 243			0	8, 337	16.00
17.00	01700 SOCI AL SERVI CE	6, 662		0,0	0	1, 477	17.00
17.01 17.02	01701 STAFF EDUCATION	45, 588 1, 530		.,	0	0	17.01
21.00	01702 MEDICAL EDUCATION 02100 I&R SERVICES-SALARY & FRINGES APPRVD	1, 550			0	0	21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	18, 269	0	1, 850	0	0	22.00
23.00	02300 PARAMED ED PROGRAM	13, 758	0	1, 393	0	2, 550	23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	1, 280, 978	125, 369	129, 699	275, 444	77, 687	30.00
31.00	03100 I NTENSI VE CARE UNI T	81, 239			12, 779	15, 941	31.00
31.01	03101 NEONATAL I CU	9, 235			0	3, 747	•
40.00	04000 SUBPROVIDER - IPF	16, 244			9, 791	2,974	•
41.00 43.00	04100 SUBPROVI DER – I RF 04300 NURSERY	127, 776 99, 888			20, 780 0	6, 421 3, 135	41.00 43.00
	ANCILLARY SERVICE COST CENTERS				-1	-1	
50.00	05000 OPERATING ROOM	243, 941	36, 751		0	10, 733	
50. 01 51. 00	05001 ENDOSCOPY 05100 RECOVERY ROOM	0 59, 489	.,		0 110	2, 195 2, 003	•
52.00	05200 DELIVERY ROOM & LABOR ROOM	28, 641	7,723		9, 221	7, 481	52.00
53.00	05300 ANESTHESI OLOGY	0	, s	-	0	0	53.00
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 05401 RADI OLOGY - ULTRASOUND	216, 998 20, 670			0	7, 851 2, 923	54.00 54.01
55.00	05500 RADI OLOGY - THERAPEUTI C	55, 150			0	1, 289	•
55.01	05501 INFUSION CENTER	1, 472	0	149	О	25	55.01
56.00 57.00	05600 RADI OI SOTOPE	36, 984 35, 021			0	1, 153	•
57.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	17, 197			0	3, 114 1, 239	57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	32, 853			Ō	4, 602	
60.00	06000 LABORATORY	96, 183		.,	0	11, 246	•
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	60.01 61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 575	0	159	0	6, 051	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0	0	0	0	
65.00 66.00	06600 PHYSI CAL THERAPY	31, 761 50, 181		3, 216 5, 081	0	6, 727 3, 332	65.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	43, 126		4, 367	Ő	2, 691	
68.00	06800 SPEECH PATHOLOGY	7, 345			0	919	•
69.00 69.01	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	0	470		0	2, 050 1, 092	•
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2,034		0	2, 494	•
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	Ō	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	6, 797 17, 925		688 1, 815	0	1, 009 0	•
	OUTPATIENT SERVICE COST CENTERS	T	1				
		311, 561			0	6,002	•
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	110, 681	38, 400	11, 207	16, 344	17, 742	91.00 92.00
, <u> </u>	OTHER REIMBURSABLE COST CENTERS	1	1				,2.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	3, 711, 316	304, 500	359, 854	344, 469	237, 323	118 00
110. UU	NONREIMBURSABLE COST CENTERS	3,711,310		1 339,854	344, 409	231, 323	110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	7, 366			0		190.00
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES	0 109, 241	-		0		191.00 192.00
172.00	17200 FITSICIANS PRIVATE UFFICES	109, 241	1 0	ין וו, טסו	0	0	1172.00

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2552-10	
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO	CN: 15-0002	Peri od:	Worksheet B	
				rom 01/01/2020		
				To 12/31/2020		
	1				7/23/2021 10:58 am	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERIA	
	PLANT	LINEN SERVICE				
	7.00	8.00	9.00	10.00	11.00	
192. 01 19201 OTHER NON-REI MBURSABLE	14, 138	0	1, 43	2 0	0 192.01	
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	36, 795	0	3, 72	5 0	0 192.02	
193. 00 19300 NONPALD WORKERS	0	0	(0 0	0 193.00	
200.00 Cross Foot Adjustments					200.00	
201.00 Negative Cost Centers	0	0	(0 0	0 201.00	
202.00 TOTAL (sum lines 118 through 201)	3, 878, 856	304, 500	376, 81	344, 469	237, 323 202.00	

Health Financial Systems	METHODI ST HOS				u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-0002	Period: From 01/01/2020	Worksheet B Part II	
				To 12/31/2020	Date/Time Pre 7/23/2021 10:	pared: 58 am
Cost Center Description	NURSI NG ADMI NI STRATI O	CENTRAL SERVICES &	PHARMACY	MEDI CAL RECORDS &	SOCI AL SERVI CE	
	N	SUPPLY		LI BRARY		
GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	16.00	17.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 00550 DATA PROCESSING						4.00
5. 02 00560 PURCHASING RECEIVING AND STORES						5.02
5. 03 00570 ADMI TTI NG 5. 04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.03 5.04
5. 04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5. 05 00590 OTHER A&G						5.04
5. 06 00592 PATIENT TRANSPORTATION						5.06
7. 00 00700 0PERATI ON OF PLANT 8. 00 00800 LAUNDRY & LI NEN SERVI CE						7.00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A						10.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	153, 508					13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	0	628, 467 0		0		14.00 15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	0		0 218, 451		16.00
17.00 01700 SOCIAL SERVICE	1, 471	0		0 0	33, 593	
17. 01 01701 STAFF EDUCATION 17. 02 01702 MEDICAL EDUCATION	0	0		0 0	0	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0		0 0	0	
22. 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 23. 00 02300 PARAMED ED PROGRAM	0 2, 540	0		0 0	0	
INPATIENT ROUTINE SERVICE COST CENTERS	2, 540	0		0 0	0	23.00
30. 00 03000 ADULTS & PEDIATRICS	77, 398	0		0 17,095	26, 826	
31.00 03100 INTENSIVE CARE UNIT 31.01 03101 NEONATAL ICU	15, 881 3, 733	0 0		0 3, 987 0 1, 300	0	
40. 00 04000 SUBPROVI DER – I PF	2, 963	0		0 768	0	40.00
41. 00 04100 SUBPROVI DER – I RF 43. 00 04300 NURSERY	6, 397 3, 123	0 0		0 927 0 415	5, 375 0	
ANCILLARY SERVICE COST CENTERS			1			
50. 00 05000 OPERATING ROOM 50. 01 05001 ENDOSCOPY	10, 693 2, 187	0 0		0 22, 861 0 2, 118	0	
51. 00 05100 RECOVERY ROOM	1, 995	0		0 1, 593	0	
52.00 O5200 DELIVERY ROOM & LABOR ROOM	7,452	0		0 803	0	
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0 0		0 0 0 6,580	0	
54. 01 05401 RADI OLOGY - ULTRASOUND	0	0		0 3, 515	0	1
55. 00 05500 RADI OLOGY-THERAPEUTI C 55. 01 05501 I NFUSI ON CENTER	0	0		0 3, 425 0 4	0	
56. 00 05600 RADI OI SOTOPE	0	0		0 2,254	0	
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0 0		0 21,021 0 4,739	0	
59. 00 05900 CARDIAC CATHETERIZATION	0	0		0 11, 340	0	
	0	0			0	
60.01 06001 BLOOD LABORATORY 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0 0	0	60.01 61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 1, 813	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 64.00 06400 I NTRAVENOUS THERAPY	0	0		0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 6,664	0	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 1, 319 0 987	0	66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0 987	0	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 3, 933	0	
69. 01 06901 CARDI AC REHAB 70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 169 0 4, 356	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o o	317, 901		0 8, 430	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	310, 566 0		0 4,856 32 28,006	0	
74.00 07400 RENAL DIALYSIS	0	0		0 1,776	0	
OUTPATI ENT SERVICE COST CENTERS 90. 00 09000 CLINIC	0	0		0 4,036	0	90.00
91. 00 09100 EMERGENCY	0 17, 675	0		0 4,036 0 13,162	1, 392	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY	0	0		5 728	0	101.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	153, 508	628, 467	349, 53	218, 451	33, 593	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
191. 00 19100 RESEARCH	0	0	1	0 0	•	191.00

Health Financial Systems	METHODI ST HOSI	PITALS, INC		In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period:	Worksheet B		
				From 01/01/2020 To 12/31/2020			
					7/23/2021 10:58 am		
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL		
	ADMI NI STRATI O	SERVICES &		RECORDS &	SERVI CE		
	N	SUPPLY		LI BRARY			
	13.00	14.00	15.00	16.00	17.00		
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	3, 63	57 0	0 192.00		
192.01 19201 OTHER NON-REI MBURSABLE	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 NONPAI D WORKERS	0	0		0 0	0 193.00		
200.00 Cross Foot Adjustments					200.00		
201.00 Negative Cost Centers	0	0		0 0	0 201.00		
202.00 TOTAL (sum lines 118 through 201)	153, 508	628, 467	353, 16	218, 451	33, 593 202. 00		

	i Financial Systems ATION OF CAPITAL RELATED COSTS	METHODI ST HOSE	Provi der C		Period:	u of Form CMS-2 Worksheet B	2002
					From 01/01/2020 To 12/31/2020	Part II Date/Time Pre	par
					RESI DENTS	7/23/2021 10:	58 ;
	Cost Center Description	STAFF	MEDI CAL		SERVI CES-OTHE	PARAMED ED	
		EDUCATION 17.01	EDUCATI ON 17. 02	RY & FRI NGES 21.00	R PRGM COSTS 22.00	PROGRAM 23.00	
	GENERAL SERVICE COST CENTERS	17.01	17.02	21.00	22.00	23.00	
00	00100 CAP REL COSTS-BLDG & FIXT						1
00	00400 EMPLOYEE BENEFITS DEPARTMENT						4
01 02	00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES						5
)2)3	00570 ADMI TTI NG						5
) 24	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5
25	00590 OTHER A&G						5
06	00592 PATI ENT TRANSPORTATI ON						5
00	00700 OPERATION OF PLANT						7
00 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8
00	01000 DI ETARY						10
00	01100 CAFETERI A						11
. 00	01300 NURSI NG ADMI NI STRATI ON						13
. 00	01400 CENTRAL SERVICES & SUPPLY						14
. 00							15
. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE						16
. 01	01701 STAFF EDUCATION	191, 465					17
. 02	01702 MEDI CAL EDUCATI ON	25	6, 541				17
. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0				21
. 00		0	0		76, 868		22
00	02300 PARAMED ED PROGRAM	198	0			66, 033	23
00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	81, 703	0				30
00	03100 I NTENSI VE CARE UNI T	17, 189	0				31
01	03101 NEONATAL I CU	171	0				31
. 00	04000 SUBPROVI DER – I PF	857	0				40
. 00	04100 SUBPROVI DER – I RF	11, 255	0				41
. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	8, 780	0				43
. 00	05000 OPERATING ROOM	14, 616	0				50
. 01	05001 ENDOSCOPY	3, 356	0				50
. 00	05100 RECOVERY ROOM	472	0				51
. 00	05200 DELIVERY ROOM & LABOR ROOM	12, 589	0				52
. 00 . 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 4, 075	0				53 54
. 00	05400 RADI OLOGY - ULTRASOUND	1, 216	0				54
. 00	05500 RADI OLOGY-THERAPEUTI C	779	0				55
01	05501 INFUSION CENTER	136	0				55
	05600 RADI OI SOTOPE	8	0				56
	05700 CT SCAN	2, 221	0				57
00	05800 MAGNETIC RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON	0 10, 516	0				58
00	06000 LABORATORY	523	0				60
01	06001 BLOOD LABORATORY	0	0				60
00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61
00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	397	0				62
00	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY	0	0				63
00	06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY	0 2, 063	0				64 65
00	06600 PHYSI CAL THERAPY	397	0				66
00	06700 OCCUPATI ONAL THERAPY	420	0				67
00	06800 SPEECH PATHOLOGY	173	0				68
00	06900 ELECTROCARDI OLOGY	296	0				69
01 00	06901 CARDI AC REHAB 07000 ELECTROENCEPHALOGRAPHY	15 751	0				69
00		/51	0				70
00		0	0				72
00	07300 DRUGS CHARGED TO PATIENTS	23	0				73
00	07400 RENAL DI ALYSI S	0	0				74
00	OUTPATIENT SERVICE COST CENTERS		_	1	1		
		12 021	0 6 541				90
00		12, 031	6, 541				91
00	OTHER REIMBURSABLE COST CENTERS			1			1 '2
. 00		0.45	0				101
	10100 HOME HEALTH AGENCY	945	0				1.01
1.00	SPECIAL PURPOSE COST CENTERS			1			
	SPECIAL PURPOSE COST CENTERS	188, 970	6, 541	1	0 0	0	118

Health Financial Systems METHODIST HOSPITALS, INC In Li					u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS				Period: Worksheet B		
				From 01/01/2020 To 12/31/2020		narod
				10 12/31/2020	7/23/2021 10:	58 am
			INTERNS &	RESI DENTS		
Cost Center Description	STAFF	MEDI CAL		SERVI CES-OTHE	PARAMED ED	
	EDUCATI ON	EDUCATI ON	RY & FRINGES	R PRGM COSTS	PROGRAM	
	17.01	17.02	21.00	22.00	23.00	
191. 00 19100 RESEARCH	0	0				191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	2, 495	0				192.00
192.01 19201 OTHER NON-REIMBURSABLE	0	0				192.01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	0	0				192.02
193.00 19300 NONPALD WORKERS	0	0				193.00
200.00 Cross Foot Adjustments			1, 14	1 76, 868	66, 033	200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	191, 465	6, 541	1, 14	1 76, 868	66, 033	202.00

alth Financial Systems LOCATION OF CAPITAL RELATED COSTS	METHODI ST HOS	Provi der CC		In Lieu of Form CM Period: Worksheet	
				From 01/01/2020 Part II To 12/31/2020 Date/Time	
Cost Center Description	Subtotal	Intern &	Total	7/23/2021	<u>10: 58</u>
		Residents Cost & Post			
		Stepdown Adjustments		_	
GENERAL SERVICE COST CENTERS	24.00	25.00	26.00		_
00 00100 CAP REL COSTS-BLDG & FLXT					1
00 00400 EMPLOYEE BENEFITS DEPARTMENT					4
00550 DATA PROCESSING 02 00560 PURCHASING RECEIVING AND STORES					5
00570 ADMITTING					Ę
00580 CASHI ERI NG/ACCOUNTS RECEI VABLE					5
05 00590 OTHER A&G					5
06 00592 PATIENT TRANSPORTATION					5
00 00700 OPERATION OF PLANT					
00 00800 LAUNDRY & LINEN SERVICE 00 00900 HOUSEKEEPING					8
00 01000 DI ETARY					10
00 01100 CAFETERIA					11
00 01300 NURSING ADMINISTRATION					13
00 01400 CENTRAL SERVICES & SUPPLY					14
00 01500 PHARMACY					15
00 01600 MEDICAL RECORDS & LIBRARY 00 01700 SOCIAL SERVICE					16
01 01700 STAFF EDUCATION					17
02 01702 MEDICAL EDUCATION					17
00 02100 I&R SERVICES-SALARY & FRINGES APPRVD)				21
00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD)				22
00 02300 PARAMED ED PROGRAM					23
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 00 03000 ADULTS & PEDI ATRI CS	6, 318, 521	0	6, 318, 52	21	30
00 03100 I NTENSI VE CARE UNI T	500, 154	0	500, 15		31
01 03101 NEONATAL I CU	63, 561	0	63, 56		31
00 04000 SUBPROVI DER – I PF	94, 726	0	94, 72		40
00 04100 SUBPROVI DER - I RF	618, 701	0	618, 70		41
00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS	452, 507	0	452, 50)/	43
00 05000 OPERATING ROOM	1, 221, 669	0	1, 221, 66	59	50
01 05001 ENDOSCOPY	29, 143	0	29, 14		50
00 05100 RECOVERY ROOM	268, 754	0	268, 75		51
00 05200 DELIVERY ROOM & LABOR ROOM	189, 953	0	189, 95		52
00 05300 ANESTHESI OLOGY 00 05400 RADI OLOGY-DI AGNOSTI C	075 145	0	975, 14	0	53
01 05401 RADI OLOGY - ULTRASOUND	975, 145 115, 648	0	975, 14 115, 64		54
00 05500 RADI OLOGY-THERAPEUTI C	258, 232	0	258, 23		55
01 05501 INFUSION CENTER	6, 563	0	6, 56		55
00 05600 RADI OI SOTOPE	178, 011	0	178, 01		56
00 05700 CT SCAN	243, 120	0	243, 12		57
00 05800 MAGNETIC RESONANCE IMAGING (MRI) 00 05900 CARDIAC CATHETERIZATION	96, 444 224, 990	0	96, 44 224, 99		58
00 06000 LABORATORY	636, 024	0	636, 02		60
01 06001 BLOOD LABORATORY	030, 024	0	000, 02	0	60
00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					6
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0	28, 41		62
00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	63
00 06400 I NTRAVENOUS THERAPY 00 06500 RESPI RATORY THERAPY	0 187, 360	0	187, 36	0	64
00 06600 PHYSICAL THERAPY	228, 052	0	228, 05		66
00 06700 OCCUPATI ONAL THERAPY	194, 945	0	194, 94		6
00 06800 SPEECH PATHOLOGY	36, 366	0	36, 36	56	68
00 06900 ELECTROCARDI OLOGY	21, 912	0	21, 91		69
01 06901 CARDI AC REHAB	4, 301	0	4,30		69
00 07000 ELECTROENCEPHALOGRAPHY 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	28, 189 424, 354	0	28, 18 424, 35		70
00 07200 IMPL. DEV. CHARGED TO PATIENTS	402, 521	0	402, 52		72
00 07300 DRUGS CHARGED TO PATIENTS	542, 080		542, 08		73
00 07400 RENAL DI ALYSI S	96, 025	0	96, 02		74
OUTPATIENT SERVICE COST CENTERS					
	1, 362, 290		1, 362, 29		90
00 09100 EMERGENCY 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	679, 803	0	679, 80		91 92
OTHER REIMBURSABLE COST CENTERS		0			
1. 00 10100 HOME HEALTH AGENCY	20, 074	0	20, 07	74	101
SPECIAL PURPOSE COST CENTERS					
B. 00 SUBTOTALS (SUM OF LINES 1 through 11	7) 16, 748, 557	0	16, 748, 55	57	118

Health Financial Systems	METHODI ST HOS	PITALS, INC		In Lieu of Form CMS-255		
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	Provider CCN: 15-0002		Worksheet B Part II	
				From 01/01/2020 To 12/31/2020		
Cost Center Description	Subtotal	Intern &	Total			
		Residents				
		Cost & Post				
		Stepdown				
		Adjustments				
	24.00	25.00	26.00			
NONREI MBURSABLE COST CENTERS				1		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	30, 936	0	30, 9	36	190.00	
191. 00 19100 RESEARCH	0	0		0	191.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	650, 101	0	650, 1	01	192.00	
192.01 19201 OTHER NON-REI MBURSABLE	60, 934	0	60, 9	34	192.01	
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	155, 100	0	155, 1	00	192.02	
193.00 19300 NONPALD WORKERS	0	0		0	193.00	
200.00 Cross Foot Adjustments	144, 042	0	144, 0	42	200.00	
201.00 Negative Cost Centers	0	0		0	201.00	
202.00 TOTAL (sum lines 118 through 201)	17, 789, 670	О	17, 789, 6	70	202.00	

CUST A	Financial Systems LLOCATION - STATISTICAL BASIS		PITALS, INC Provider C		eri od:	Worksheet B-1	2552-10
					rom 01/01/2020 o 12/31/2020		
	Cost Center Description	CAPI TAL RELATED COSTS BLDG & FI XT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	DATA PROCESSING (MACHINE TIME)	PURCHASI NG RECEI VI NG AND STORES (PURCHASE	ADMI TTI NG (GROSS CHARGES)	58 am
		1.00	SALARI ES) 4.00	5.01	REQUISITIONS) 5.02	5.03	
	GENERAL SERVICE COST CENTERS	1.00	4.00	5.01	5. 02	3.03	
1.00	00100 CAP REL COSTS-BLDG & FIXT	1, 410, 133					1.00
4.00 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT 00550 DATA PROCESSING	5, 906 9, 190	146, 449, 783 4, 421, 091	100			4.00 5.01
5.01	00560 PURCHASING RECEIVING AND STORES	7, 332	933, 239	0			5.01
5.03	00570 ADMI TTI NG	9, 717	2, 187, 720	0		1, 248, 490, 741	5.03
5.04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	30, 646	2, 159, 017	0		0	5.04
5.05 5.06	00590 OTHER A&G 00592 PATI ENT TRANSPORTATI ON	99, 579 0	11, 147, 935 508, 975	100 0		0	5.05 5.06
7.00	00700 OPERATION OF PLANT	299, 329	3, 867, 873	0		0	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	17, 825	0	0		0	8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	20, 635 18, 848	4, 132, 002 2, 003, 515	0		0	9.00 10.00
10.00	01100 CAFETERI A	13, 177	1, 424, 097			0	11.00
13.00	01300 NURSING ADMINISTRATION	6, 350	3, 630, 898	0	179, 671	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	35, 843	607, 086	0		0	14.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	18, 957 11, 307	0 2, 025, 508	0		0	15.00 16.00
17.00	01700 SOCIAL SERVICE	1, 629	441, 467	0		0	17.00
17.01	01701 STAFF EDUCATION	11, 147	0	0		0	17.01
17.02 21.00	01702 MEDICAL EDUCATION 02100 I&R SERVICES-SALARY & FRINGES APPRVD	374	699 0	0	.,	0	17.02
21.00	02200 I &R SERVICES-SALART & FRINGES APPRVD	4, 467	0			0	21.00
23.00	02300 PARAMED ED PROGRAM	3, 364	594, 888	0	6, 676	0	23.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	212 217	20 727 242	0	2 210 245	07 (07 220	20.00
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	313, 217 19, 864	28, 727, 343 8, 115, 262	0		97, 687, 339 22, 781, 049	
31.01	03101 NEONATAL I CU	2, 258	1, 717, 684	0		7, 430, 733	
40.00	04000 SUBPROVIDER - IPF	3, 972	1, 120, 792	0	-	4, 390, 602	40.00
41.00 43.00	04100 SUBPROVI DER – I RF 04300 NURSERY	31, 243 24, 424	2, 214, 027 1, 475, 362	0		5, 299, 296 2, 373, 522	41.00 43.00
101.00	ANCI LLARY SERVICE COST CENTERS		17 17 67 662			2,0,0,022	101.00
50.00	05000 OPERATING ROOM	59, 647	3, 750, 800	0		130, 634, 836	
50.01 51.00	05001 ENDOSCOPY 05100 RECOVERY ROOM	0 14, 546	864, 189 980, 745	0		12, 103, 945 9, 100, 944	50.01 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	7,003	2, 832, 718	0		4, 588, 061	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0		0	53.00
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 05401 RADI OLOGY - ULTRASOUND	53, 059 5, 054	2, 317, 787 1, 130, 762	0		37, 599, 891 20, 083, 443	
55.00	05500 RADI OLOGY - THERAPEUTI C	13, 485	487, 387	0		19, 570, 831	
55.01	05501 INFUSION CENTER	360	10, 712	0	18, 424	25, 146	55.01
56.00	05600 RADI OI SOTOPE	9,043	515, 023	0		12, 882, 091	56.00
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	8, 563 4, 205	1, 143, 733 398, 968	0	288, 542 67, 862	120, 119, 715 27, 077, 576	57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	8, 033	2, 330, 752	0		64, 798, 733	
60.00	06000 LABORATORY	23, 518	3, 556, 362	0		188, 928, 767	60.00
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	60.01 61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	385	1, 162, 295	0	234, 962	10, 361, 291	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		28 080 245	64.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	7, 766 12, 270	2, 521, 699 1, 370, 351	0		38, 080, 245 7, 536, 136	65.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	10, 545	1, 119, 504	0		5, 639, 108	
68.00	06800 SPEECH PATHOLOGY	1, 796	436, 319	0		2, 523, 295	68.00
69. 00 69. 01	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	0	728, 670 386, 936	0	11, 581 2, 141	22, 476, 024 965, 245	69.00 69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	1, 004, 508	0		24, 891, 183	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	10, 389, 568	48, 174, 273	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		27, 747, 861	
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	1, 662 4, 383	403, 891 0	0		160, 034, 418 10, 148, 623	
,	OUTPATIENT SERVICE COST CENTERS						,
90.00	09000 CLI NI C	76, 181	2, 442, 589	0		23, 062, 202	90.00
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	27, 063	6, 713, 403	0	1, 925, 189	75, 213, 874	91.00 92.00
		1			1		1 12.00
	OTHER REIMBURSABLE COST CENTERS	·					

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0002 Provider CCN: 15-0002 Provider CCN: 15-0002 Provider CCN: 15-0002 Or 12/31/2020 Or krack term term term term term term term term	Health Fina	ancial Systems	METHODI ST HOSE	PITALS, INC		In Lie	u of Form CMS-2	2552-10
Cost Center Description CAPITAL ReLATED COSTS BLDG & FIXT (SOUARE FEET) EMPLOYEE BLDG & FIXT (SOUARE FEET) DATA EMPLOYEE BLDG & FIXT (SOUARE FEET) PURCHASING RECEIVING AND DEPARTMENT (MRCHN ADMITTING (GROSS (MRCSS) 18.00 SPECIAL PURPOSE COST CENTERS 1.00 4.00 5.01 5.02 5.03 19.00 SUBTOTALS (SUM OF LINES 1 through 117) 1.369,167 124,442,727 100 38,595,109 1.248,490,741 118.00 190.001000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0019100 RESEARCH 0 0 0 87 0 190.00 192.01 19200 PHYSICIANS' PRIVATE OFFICES 26,711 21,933,831 0 270,326 0 192.00 192.01 19201 OTHER MORKERS 0	COST ALLOC	ATION - STATISTICAL BASIS		Provider CO			Worksheet B-1	
Cost Center Description CAP TAL RELATED COSTS BLOG & FLXT (SOUARE FEET) EMPLOYEE DEPARTMENT (SOUARE FEET) DATA PROCESSING (RROSS SALARIES) PURCHASING RECEIVING AND STORES (PURCHASE (PURCHASE (PURCHASE (PURCHASE REOULISTIONS) ADMITTING (CROSS CHARGES) 118.00 4.00 5.01 5.02 5.03 118.00 4.00 5.01 5.02 5.03 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1,369,167 124,442,727 100 38,595,109 1,248,490,741 118.00 NOMRET MURSABLE COST CENTERS 1.801 0 0 87 0 190,00 190.0019000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1.801 0 0 87 0 192.00 192.01 19201 OTHER NON-REI MBURSABLE 3,457 0 0 83 192.01 192.01 19201 OTHER NON-REI MBURSABLE 3,457 0 0 0 0 193.00 201.00 Cost S foot Adj Ustments 0 0 0 0 0 0 0 193.00 202.00 Cost to be al located (per Wkst. B, Part 1) 12.615597 0.224								
RELATED COSTS BLDG & FIXT (SOUARE FEET) EMPLOYEE BENEFITS SALARIES DATA PROCESSING (MACHINE TIME) PURCHASING RECEIVING AND STORES (MACHINE TIME) ADMITTING (CROSS CHARGES) SPECIAL PURPOSE COST CENTERS 1.00 4.00 5.01 5.02 5.03 18.00 SUBTOTALS (SUM OF LINES 1 through 117) 1.369,167 124,442,727 100 38,595,109 1.248,490,741 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1.801 0 0 87 0 190.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1.801 0 0 83 0 192.00 192.00 19200 PHYSICLARS' FRIVATE OFFICES 26,711 21,933,831 0 270,326 0 192.00 193.00 19300 NONPARID WORKERS 0 0 0 0 0 0 193.00 201.00 Cost to be allocated (per Wkst. B, Part I) 12.615597 0.224448 126,290,7100 0.099926 0.002658 203.00 203.00 Cost to be allocated (per Wkst. B, Part I) 12.615597 0.224448 126,290,71000 0.002392 0.002682 203.00 <td></td> <td>-</td> <td></td> <td></td> <td></td> <td></td> <td>7/23/2021 10:</td> <td><u>58 am</u></td>		-					7/23/2021 10:	<u>58 am</u>
Cost Center Description BLDG & FIXT (SQUARE FEET) EMPLOYEE BENEFITS DEPARTMENT (GROSS DATA PROCESSING (MACHINE TIME) PURCHASING RECEIVING AND STORES (PURCHASE REQUISITIONS) ADMITTING (GROSS CHARGES) SPECIAL PURPOSE COST CENTERS 1.00 4.00 5.01 5.02 5.03 SUBTOTALS (SUM OF LINES 1 through 117) 1.369, 167 124, 442, 727 100 38, 595, 109 1, 248, 490, 741 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 100. 019000 1, 801 0 0 0 0 192.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 26, 711 21, 933, 831 0 270, 326 0 192.00 192. 01 19200 THER MON-REIMBURSABLE 3, 457 0 0 0 192.01 192.02 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
SPECIAL PURPOSE COST CENTERS (SOUARE FEET) BENEFITS DEPARTMENT (GROSS SALARIES) PROCESSING (MACHINE TIME) RECEI VING AND STORES (PURCHASE (PURCHASE REQUISITIONS) C(GROSS CHARGES) 118.00 SPECIAL PURPOSE COST CENTERS 1.00 4.00 5.01 5.02 5.03 190.00 ISUBTOTALS (SUM OF LINES 1 through 117) 1,369,167 124,442,727 100 38,595,109 1,248,490,741 118.00 190.00 IGFT, FLOWER, COFFEE SHOP & CANTEEN 1,801 0 0 87 0 190.00 192.00 19200 PHYSIC LANS' PRI VATE OFFICES 26,711 21,933,831 0 270,326 0 192.00 192.00 19200 PHYSIC LANS' PRI VATE OFFICES 26,711 21,933,831 0 270,326 0 192.02 192.01 19200 PHALTH/GARY COMM HEALTH 8,997 73,225 0 258 0 192.02 193.00 NONPAILD WORKERS 0 0 0 0 0 0 0 0 0 0 0 0 0 <t< td=""><td></td><td></td><td></td><td></td><td>DATA</td><td>DUDOUACINO</td><td></td><td></td></t<>					DATA	DUDOUACINO		
JEPARTMENT (GROSS CMACHINE TI ME) STORES (PURCHASE REUUISITIONS) CHARGES) 118.00 5.01 5.02 5.03 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1, 369, 167 124, 442, 727 100 38, 595, 109 1, 248, 490, 741 118.00 NONREI MBURSABLE COST CENTERS 1 0 0 87 0 190.00 190.00 19100 RESEARCH 0 0 0 0 192.01 192.01 19200 PHYSI CLANS' PRI VATE OFFICES 26, 711 21, 933, 831 0 270, 326 0 192.01 192.01 19200 PHYSI CLANS' PRI VATE OFFICES 26, 711 21, 933, 831 0 270, 326 0 192.01 192.02 19202 FAMILY HEALTH/GARY COMM HEALTH 8, 997 73, 225 0 258 0 192.02 02 1930 NONPAL DWREKES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		Cost Center Description						
SPECIAL PURPOSE COST CENTERS I.OO 4.OO 5.01 FREQUISITIONS 118.00 SUBTOTALS (SUM OF LINES 1 through 1177) 1.369,167 124,442,727 100 38,595,109 1.248,490,741 118.00 SUBTOTALS (SUM OF LINES 1 through 1177) 1.369,167 124,442,727 100 38,595,109 1.248,490,741 118.00 MONREI MBURSABLE COST CENTERS			(SQUARE FEET)					
SALARI ES) REQUISITIONS Reduisitions SPECIAL PURPOSE COST CENTERS 1.00 4.00 5.01 5.02 5.03 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1.369,167 124,442,727 100 38,595,109 1,248,490,741 118.00 NORRE IMBURSABLE COST CENTERS 0 0 87 0 190.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1,801 0 0 0 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 26,711 21,933,831 0 270,326 192.00 192.01 192.02 19200 PHYSI CI ANS' PRI VATE OFFI CES 26,711 21,933,831 0 270,326 0 192.02 192.02 192.02 192.02 192.02 192.02 192.02 193.00 0 0 0 0 192.02 192.02 193.00 193.00 200.00 Cross Foot Adj ustments 200.00 0 0 0 193.00 203.00 201.00 20.00 0 0.002658 203.00 201.00 202.00 201.00 202.00							CHARGES)	
SPECIAL PURPOSE COST CENTERS 1.00 4.00 5.01 5.02 5.03 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1.369,167 124,442,727 100 38,595,109 1.248,490,741 118.00 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 190.00 0 0 0 190.00 0 190.00 0 0 0 0 0 0 0 0 0 0 0 0 190.00 0 192.00 192.00 192.01 192.01 0 0 0 0 0 0 0 0 0 0 192.00 192.00 192.01 192.01 192.01 0 83 0 192.02 192.01 192.02 FAMI LY HEALTH/GARY COMM HEALTH 8,997 73,225 0 258 0 193.00 0 0 0 0 193.00 0 0 0 0 0 0 0 0 0 0 0 0 <td></td> <td></td> <td></td> <td></td> <td>IIWE)</td> <td></td> <td></td> <td></td>					IIWE)			
SPECIAL PURPOSE COST CENTERS 118.00 SPECIAL PURPOSE COST CENTERS 118.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1,369,167 124,442,727 100 38,595,109 1,248,490,741 118.00 190.00 190.00 19T, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190.00 0 191.00 191.00 191.00 192.01 0 0 0 0 0 0 0 0 192.01 0 0 0 192.02 192.02 FAMI LY HEALTH/CARY COIM HEALTH 8,997 73,225 0 258 0 192.02 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 0 0 0 0 0 0 193.00 193.00 193.00 200.00 0 0 193.00 200.00 0 0 193.00 193.00 200.00 200.00 0 0 0 200.00 200.00			1.00	,	E 01		E 02	
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1,369,167 124,442,727 100 38,595,109 1,248,490,741 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1,801 0 0 87 0 190.00 191.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1,801 0 0 0 0 0 190.00 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 26,711 21,933,831 0 270,326 0 192.00 192.01 OTHER NON-REI MBURSABLE 3,457 0 0 83 0 192.01 192.02 IMULY HEALTH/GARY COMM HEALTH 8,97 73,225 0 258 0 192.02 193.00 I9300 NONPAI D WORKERS 0 0 0 0 193.00 200.00 200.00 200.00 200.00 201.00 201.00 200.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00	SDEC		1.00	4.00	5.01	5.02	5.05	
NONREI MBURSABLE COST CENTERS 0			1 260 167	124 442 727	10	0 29 505 100	1 249 400 741	110 00
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1,801 0 0 87 0 190.00 191.00 RESEARCH 0 <			1, 307, 107	124, 442, 727	10	0 30, 375, 107	1, 240, 470, 741	110.00
191.00 19100 RESEARCH 0 0 0 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 26,711 21,933,831 0 270,326 0 192.00 192.01 19201 OTHER NON-REIMBURSABLE 3,457 0 0 83 0 192.02 192.02 FAMILY HEALTH/GARY COMM HEALTH 8,997 73,225 0 258 0 192.02 193.00 19300 NONPAID WORKERS 0 0 0 193.00 200.00 0 0 193.00 200.00 <			1 801	0		0 87	0	100 00
192.00 19200 PHYSICLANS' PRIVATE OFFICES 26,711 21,933,831 0 270,326 0 192.00 192.01 19201 OTHER NON-REIMBURSABLE 3,457 0 0 83 0 192.01 192.02 19202 FAMILY HEALTH/GARY COMM HEALTH 8,997 73,225 0 258 0 192.02 193.00 NONPAID WORKERS 0 0 0 0 200.00 200.00 0 0 193.00 200.00 20				0		0 0/		
192.01 192.01 0THER NON-REIMBURSABLE 3,457 0 0 83 0 192.01 192.02 19202 FAMILY HEALTH/GARY COMM HEALTH 8,997 73,225 0 258 0 192.02 193.00 19300 NONPAID WORKERS 0			-	21 022 821		0 270 326		
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH 8,997 73,225 0 258 0 192.02 193.00 19300 NONPAID WORKERS 0 0 0 0 0 193.00 200.00 Cross Foot Adjustments 0 0 0 0 0 200.00 201.00 Negative Cost Centers 10 200.00 200.00 201.00 201.00 200.00 201.00 201.00 200.00 201.00 200.00 201.00 201.00 201.00 200.00 201.00 201.00 201.00 200.00 201.00 201.00 202.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 202.00 202.00 203.00 0 0.002658 203.00 203.00 0 0.002658 203.00 0 0.002658 203.00 0 0 0.002658 203.00 0 0 0.002658 203.00 0 0 0.002658 203.00 0 0 0 0.002392 0.000099 205.00 0 0 0 0 0 <td></td> <td></td> <td></td> <td>21, 755, 051</td> <td></td> <td></td> <td></td> <td></td>				21, 755, 051				
193.00 19300 NONPAID WORKERS 0 0 0 0 193.00 200.00 Cross Foot Adjustments 0 0 0 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 201.00 200.00 201.0				73 225				
200.00 Cross Foot Adjustments 200.00 200.00 201.00 Negative Cost Centers 200.00 201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 17,789,670 32,870,375 12,629,071 3,883,692 3,318,877 202.00 203.00 Unit cost multiplier (Wkst. B, Part I) 12.615597 0.224448 126,290.71000 0.099926 0.002658 203.00 204.00 Cost to be allocated (per Wkst. B, Part I) 12.615597 0.224448 126,290.71000 0.099926 0.002658 203.00 205.00 Unit cost multiplier (Wkst. B, Part II) 12.615597 0.000509 1,181.870000 0.002392 0.000099 205.00 205.00 Unit cost multiplier (Wkst. B, Part II) 0.000509 1,181.870000 0.002392 0.000099 205.00 11) NAHE adjustment amount to be allocated (per Wkst. B, Part II) 206.00 206.00 206.00 206.00 207.00			0, 777	/ 3, 223		0 230		
201.00 Negative Cost Centers 201.00 32,870,375 12,629,071 3,883,692 3,318,877 202.00 203.00 Unit cost multiplier (Wkst. B, Part I) 12.615597 0.224448 126,290.71000 0.099926 0.002658 203.00 204.00 Cost to be allocated (per Wkst. B, Part I) 12.615597 0.224448 126,290.71000 0.099926 0.002658 203.00 205.00 Unit cost multiplier (Wkst. B, Part II) 0.000509 1,181.870000 0.002392 0.000099 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. D, 0.000509 1,181.870000 0.002392 0.000099 205.00 207.00 NAHE unit cost multiplier (Wkst. D, 0.000509 1,0000000 207.00 207.00			0	0		0		
202.00 Cost to be allocated (per Wkst. B, Part I) 17,789,670 32,870,375 12,629,071 3,883,692 3,318,877 202.00 203.00 Unit cost multiplier (Wkst. B, Part I) 12.615597 0.224448 126,290.71000 0.099926 0.002658 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 12.615597 0.224448 126,290.71000 0.099926 0.002658 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 12.615597 0.224448 118,187 92,973 123,822 204.00 205.00 Unit cost multiplier (Wkst. B, Part II) 0.000509 1,181.870000 0.002392 0.000099 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. D, 0.000509 1,181.870000 0.002392 0.000099 206.00 207.00 NAHE unit cost multiplier (Wkst. D, 0.000509 10.000509 207.00 207.00								
203.00 Part I) Unit cost multiplier (Wkst. B, Part I) 12.615597 0.224448 126,290.71000 0 0.099926 0.002658 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 12.615597 0.224448 126,290.71000 0 0.099926 0.002658 203.00 205.00 Unit cost multiplier (Wkst. B, Part II) 0.000509 1,181.870000 0.002392 0.000099 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 0.00100 1,181.870000 0.002392 0.000099 205.00 207.00 NAHE unit cost multiplier (Wkst. D, 0.00100 0.00100 207.00 207.00			17 789 670	32 870 375	12 629 07	1 3 883 692		
203.00 Unit cost multiplier (Wkst. B, Part I) 12.615597 0.224448 126,290.71000 0.099926 0.002658 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 12.615597 0.224448 126,290.71000 0 0.99926 0.002658 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 0.000509 118,187 92,973 123,822 204.00 205.00 Unit cost multiplier (Wkst. B, Part II) 0.000509 1,181.870000 0.002392 0.000099 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B, 2) 0.000509 1,181.870000 0.002392 0.000099 205.00 207.00 NAHE unit cost multiplier (Wkst. D, 0.000509 1.000 0.002392 0.000099 205.00	202.00		17,707,070	02,010,010	12,027,07	0,000,072	0,010,077	202.00
204.00 Cost to be allocated (per Wkst. B, Part II) 74,508 118,187 92,973 123,822 204.00 205.00 Unit cost multiplier (Wkst. B, Part II) 0.000509 1,181.870000 0.002392 0.000099 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 0.000509 1,181.870000 0.002392 0.000099 205.00 207.00 NAHE unit cost multiplier (Wkst. D, 0.000509 1.000 0.0002392 0.000099 205.00	203 00		12 615597	0 224448	126 290 7100	0 0 099926	0 002658	203 00
205.00 Part II) 0.000509 1,181.870000 0.002392 0.000099 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 0.000509 1,181.870000 0.002392 0.000099 205.00 207.00 NAHE unit cost multiplier (Wkst. D, 0.000509 1,181.870000 0.002392 0.000099 205.00	200100		121010077	0.221110	120, 2, 01, 100	0	01002000	2001.00
205.00 Part II) 0.000509 1,181.870000 0.002392 0.000099 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 0.000509 1,181.870000 0.002392 0.000099 205.00 207.00 NAHE unit cost multiplier (Wkst. D, 0.000509 1,181.870000 0.002392 0.000099 205.00	204.00	Cost to be allocated (per Wkst. B.		74, 508	118, 18	7 92.973	123, 822	204.00
205.00 Unit cost multiplier (Wkst. B, Part 0.000509 1,181.870000 0.002392 0.000099 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 0.000509 1,181.870000 0.002392 0.000099 205.00 207.00 NAHE unit cost multiplier (Wkst. D, 0.000509 1,181.870000 0.002392 0.000099 205.00				,			,	
206.0011) NAHE adjustment amount to be allocated (per Wkst. B-2)206.00207.00NAHE unit cost multiplier (Wkst. D,207.00	205.00			0.000509	1, 181, 87000	0 0. 002392	0,000099	205.00
207.00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00								
207.00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00	206.00	NAHE adjustment amount to be allocated						206.00
	207.00	NAHE unit cost multiplier (Wkst. D,						207.00
		Parts III and IV)						

	LOCATION - STATISTICAL BASIS		Provider C		eriod: rom 01/01/2020	Worksheet B-1	. –
					o 12/31/2020	Date/Time Pre	par
	Cost Center Description	CASHI ERI NG/AC	Reconciliatio	OTHER A&G	PATI ENT	7/23/2021 10: OPERATION OF	58
		COUNTS	n	(ACCUM. COST)	TRANSPORTATI O	PLANT	
		RECEI VABLE (GROSS			N (NUMBER OF	(SQUARE FEET)	
		CHARGES)			TRI PS)		
		5.04	5A. 05	5.05	5.06	7.00	
	GENERAL SERVICE COST CENTERS						1 1
	DO400 EMPLOYEE BENEFITS DEPARTMENT						4
	DO550 DATA PROCESSING						5
	00560 PURCHASING RECEIVING AND STORES						5
	00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	1, 248, 490, 741					5
	D0590 OTHER A&G	1, 240, 470, 741	-39,081,079	305, 804, 029			5
	00592 PATIENT TRANSPORTATION	0	0	663, 642			5
	DO700 OPERATION OF PLANT	0	0	22, 087, 164			
	DO800 LAUNDRY & LINEN SERVICE	0	0	1, 490, 314			
	00900 HOUSEKEEPI NG 01000 DI ETARY	0	0	6, 424, 463 4, 277, 893			
	D1100 CAFETERI A	0	0	2, 439, 998	-		
	01300 NURSING ADMINISTRATION	0	0	5, 625, 525			
	01400 CENTRAL SERVICES & SUPPLY	0	0	2, 364, 420			
		0	0	6, 258, 838			
	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	0	0	3, 433, 837 561, 104			
	D1701 STAFF EDUCATION	0	0	140, 626			
	01702 MEDI CAL EDUCATI ON	0	0	24, 223			
	D2100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	252, 816			
	D2200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	87, 522			
	D2300 PARAMED ED PROGRAM NPATIENT ROUTINE SERVICE COST CENTERS	0	0	628, 317	0	3, 364	23
	03000 ADULTS & PEDIATRICS	97, 687, 339	0	46, 833, 800	11, 902	313, 217	30
	03100 INTENSIVE CARE UNIT	22, 781, 049	0				
	D3101 NEONATAL I CU	7, 430, 733	0	2, 654, 444			
	04000 SUBPROVIDER - IPF	4, 390, 602	0	1, 552, 260			
	04100 SUBPROVI DER – I RF 04300 NURSERY	5, 299, 296 2, 373, 522	0 0	3, 529, 284 2, 443, 763		31, 243 24, 424	
	ANCI LLARY SERVICE COST CENTERS	2, 575, 522	0	2,443,703	1	24,424	1 1
00	D5000 OPERATING ROOM	130, 634, 836	0	10, 072, 791	0	59, 647	50
	D5001 ENDOSCOPY	12, 103, 945	0	1, 925, 021			
	D5100 RECOVERY ROOM D5200 DELIVERY ROOM & LABOR ROOM	9, 100, 944 4, 588, 061	0	1, 561, 417			
	D5300 ANESTHESI OLOGY	4, 566, 001	0	4, 671, 510 0			
	D5400 RADI OLOGY-DI AGNOSTI C	37, 599, 891	0	5, 287, 675	2, 282		
	05401 RADI OLOGY – ULTRASOUND	20, 083, 443	0	2, 067, 151		5, 054	
	05500 RADI OLOGY-THERAPEUTI C	19, 570, 831	0	2, 600, 283			
	05501 I NFUSI ON CENTER 05600 RADI OI SOTOPE	25, 146 12, 882, 091	0	38, 950 2, 196, 843			
	D5700 CT SCAN	120, 119, 715	0	3, 380, 399			
	D5800 MAGNETIC RESONANCE IMAGING (MRI)	27, 077, 576	0	1, 146, 529			
	05900 CARDI AC CATHETERI ZATI ON	64, 798, 733	0	5, 401, 554			
		188, 928, 767	0	17, 417, 099			
	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	60
	D6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	10, 361, 291	0	1, 809, 323	0	385	
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0		
	06400 I NTRAVENOUS THERAPY	0	0	0	0		
		38, 080, 245	0	4, 558, 717		7,766	
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	7, 536, 136 5, 639, 108	0	2, 021, 699 1, 644, 251			
	06800 SPEECH PATHOLOGY	2, 523, 295	0	622, 751			
	06900 ELECTROCARDI OLOGY	22, 476, 024	0	1, 227, 348			
01 0	D6901 CARDI AC REHAB	965, 245	0	529, 176	0		69
	07000 ELECTROENCEPHALOGRAPHY	24, 891, 183	0	1, 674, 240			
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	48, 174, 273	0 0	11, 835, 196 11, 398, 813			
	D7200 I MPL. DEV. CHARGED TO PATI ENTS D7300 DRUGS CHARGED TO PATI ENTS	27, 747, 861 160, 034, 418	0	20, 270, 720			
	07400 RENAL DI ALYSI S	10, 148, 623	0				
C	DUTPATIENT SERVICE COST CENTERS					· ·	
	09000 CLINIC	23, 062, 202	0			76, 181	
	09100 EMERGENCY	75, 213, 874	0	12, 031, 097	560	27, 063	
	D9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS					I	92
	10100 HOME HEALTH AGENCY	4, 160, 443	0	3, 374, 036	0	0	101
. 001							- · ·

th Financial Systems	METHODI ST HOS	PITALS, INC		In Lie	u of Form CMS-	2552-10
T ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
				From 01/01/2020 To 12/31/2020	Date/Time Pre 7/23/2021 10:	
Cost Center Description	CASHI ERI NG/AC	Reconciliatio	OTHER A&G	PATI ENT	OPERATION OF	
	COUNTS	n	(ACCUM. COST)	TRANSPORTATI 0	PLANT	
	RECEI VABLE			N	(SQUARE FEET)	
	(GROSS			(NUMBER OF		
	CHARGES)			TRI PS)		
	5.04	5A. 05	5.05	5.06	7.00	
NONREI MBURSABLE COST CENTERS				-		
00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	22, 846	6 0		190.00
00 19100 RESEARCH	0	0	(0 0		191.00
00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	38, 750, 480	0 0		192.00
01 19201 OTHER NON-REI MBURSABLE	0	0	388, 233	3 0		192.01
02 19202 FAMILY HEALTH/GARY COMM HEALTH	0	0	230, 11	1 0		192.02
00 19300 NONPALD WORKERS	0	0	(0 0	0	193.00
.00 Cross Foot Adjustments						200.00
.00 Negative Cost Centers						201.00
COO Cost to be allocated (per Wkst. B, Part I)	7, 241, 012		39, 081, 079	9 748, 454	24, 909, 859	202.00
.00 Unit cost multiplier (Wkst. B, Part I) 0.005800		0. 127798	8 23. 131131	26. 264199	203.00
.00 Cost to be allocated (per Wkst. B, Part II)	387, 742		1, 380, 119	9 3, 260	3, 878, 856	204.00
.00 Unit cost multiplier (Wkst. B, Part	0. 000311		0.004513	3 0. 100751	4. 089748	205.00
.00 NAHE adjustment amount to be allocate (per Wkst. B-2)	ed					206. 00
.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

JST ALLU	CATION - STATISTICAL BASIS		Provider CC		eriod: com 01/01/2020 12/31/2020	Worksheet B-1 Date/Time Pre	
	Cost Center Description	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (PRODUCTI VE HOURS)	7/23/2021 10: NURSI NG ADMI NI STRATI O N (DI RECT NURS.	58 a
		8.00	9.00	10.00	11.00	HRS.) 13.00	
	NERAL SERVICE COST CENTERS	1					
00 004 01 005 02 005 03 005 04 005 05 005 00 007 00 008 00 007 00 008 00 007 00 008 00 013 3.00 014 5.00 014 5.00 014 5.00 014 5.00 017 7.01 017 1.00 021 1.00 021 2.00 022 3.00 023	100 CAP REL COSTS-BLDG & FIXT 100 EMPLOYEE BENEFITS DEPARTMENT 100 DATA PROCESSING 100 PURCHASING RECEIVING AND STORES 100 PURCHASING RECEIVING AND STORES 100 PURCHASING RECEIVING AND STORES 100 CASHI ERING/ACCOUNTS RECEIVABLE 100 OTHER A&G 100 OFERATION OF PLANT 100 CAFETERIA 100 CAFETERIA 100 CAFETERIA 100 CAFETERIA 100 CAFETERIA 100 CAFETERIA 100 CATETERIA 100 CAL RECORDS & LIBRARY 100 STAFF EDUCATION 100 I&R SERVICE 100 FRINGES APPRVD 100 I&R SERVICES-SALARY & FRINGES APPRVD 100 I&R SERVICES-OTHER PRGM COSTS APPRVD 100 I&R SERVICES-OTHER PRGM COSTS APPRVD 100 IAR DED PROGRAM 101 IAR TRUTINE SERVICE COST CENTERS	1, 454, 194 0 0 52, 422 1, 097 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	909, 974 18, 848 13, 177 6, 350 35, 843 18, 957 11, 307 1, 629 11, 147 374 0 4, 467 3, 364	269, 820 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 323, 013 60, 257 28, 730 0 81, 604 14, 455 0 0 0 0 24, 957	1, 508, 258 0 0 14, 455 0 0 0 24, 957	14. 15. 16.
	DOO ADULTS & PEDIATRICS	598, 722	313, 217	215, 753	760, 442	760, 442	30.
	100 INTENSIVE CARE UNIT	95, 876		10, 010	156, 032	156, 032	
	101 NEONATAL I CU DOO SUBPROVI DER – I PF	0	2, 258 3, 972	0 7, 669	36, 680 29, 114	36, 680 29, 114	31 40
	100 SUBPROVI DER – I RF	63, 032	31, 243	16, 277	62, 852	62, 852	41
	300 NURSERY	27, 708	24, 424	0	30, 686	30, 686	43
	CILLARY SERVICE COST CENTERS	175, 510	59, 647	0	105, 059	105, 059	50
	DO1 ENDOSCOPY	20, 984		0	21, 488	21, 488	
	100 RECOVERY ROOM	10, 635		86	19, 603	19, 603	51
	200 DELIVERY ROOM & LABOR ROOM	36, 884	7,003	7, 223	73, 223	73, 223	52
	300 ANESTHESI OLOGY 400 RADI OLOGY-DI AGNOSTI C	34, 299	0 53, 059	0	0 76, 848	0	53 54
	401 RADI OLOGY - ULTRASOUND	12, 474	5, 054	0	28, 608	0	54
00 055	500 RADI OLOGY-THERAPEUTI C	8, 677	13, 485	0	12, 617	0	55
	501 I NFUSI ON CENTER	0	360	0	247	0	
	500 RADI OI SOTOPE 700 CT SCAN	8, 170 17, 484		0	11, 285 30, 480	0	56 57
	BOO MAGNETIC RESONANCE IMAGING (MRI)	7, 757	4, 205	0	12, 127	0	58
	200 CARDI AC CATHETERI ZATI ON	34, 691	8, 033	0	45, 047	0	59
		0	23, 518	0	110, 078	0	60
	DO1 BLOOD LABORATORY 100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	60 61
	200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	385	0	59, 229	0	62
	300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63
		0	0	0	0	0	64 65
	500 RESPI RATORY THERAPY 500 PHYSI CAL THERAPY		7, 766 12, 270	0	65, 848 32, 618	0	66
	700 OCCUPATI ONAL THERAPY	0	10, 545	0	26, 339	0	67
	BOO SPEECH PATHOLOGY	0	1, 796	0	8, 995	0	68
	900 ELECTROCARDI OLOGY 901 CARDI AC REHAB	2, 246	0	0	20, 066	0	69
	DOO ELECTROENCEPHALOGRAPHY	9, 716	0	0	10, 692 24, 412	0	70
00 071	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71
	200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72
	300 DRUGS CHARGED TO PATIENTS 400 RENAL DIALYSIS	14 041	1,662	0	9, 881	0	73
	IPATIENT SERVICE COST CENTERS	16, 061	4, 383	0	0	0	1 14
		36, 178	76, 181	0	58, 747	0	90
00 091	100 EMERGENCY	183, 387		12, 802	173, 667	173, 667	91
	200 OBSERVATION BEDS (NON-DISTINCT PART)						92
	HER REIMBURSABLE COST CENTERS 100 HOME HEALTH AGENCY	0	0	0	0	0	101
	ECIAL PURPOSE COST CENTERS	0	. U	0	0	0	1.01
	SUBTOTALS (SUM OF LINES 1 through 117)		869, 008	269, 820	2, 323, 013	1, 508, 258	1

Health Financial Systems	METHODI ST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC		Period:	Worksheet B-1	
				From 01/01/2020 To 12/31/2020		
Cost Center Description	(POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (PRODUCTI VE HOURS)	NURSI NG ADMI NI STRATI O N (DI RECT NURS. HRS.)	
	8.00	9.00	10.00	11.00	13.00	
NONREI MBURSABLE COST CENTERS		1			1	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1, 801		0 0		190.00
191. 00 19100 RESEARCH	0	0		0 0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	26, 711		0 0		192.00
192.01 19201 OTHER NON-REI MBURSABLE	0	3, 457		0 0		192.01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	0	8, 997		0 0		192.02
193.00 19300 NONPAI D WORKERS	0	0		0 0	0	193.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	2, 148, 932	7, 787, 459	5, 480, 92	6 3, 210, 675	6, 726, 326	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	1. 477748	8. 557892	20. 31326	8 1. 382117	4. 459665	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	304, 500	376, 819	344, 46	9 237, 323	153, 508	204.00
205.00 Unit cost multiplier (Wkst. B, Part	0. 209394	0. 414099	1. 27666	2 0. 102162	0. 101778	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

ST ALLUC	CATION - STATISTICAL BASIS		Provider CO		Period: From 01/01/2020	Worksheet B-1	
					To 12/31/2020	Date/Time Pre 7/23/2021 10:	par 58
	Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUI S.)	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES)	SOCI AL SERVI CE (TI ME SPENT)	STAFF EDUCATION (TIME SPENT)	
0.5.1		14.00	15.00	16.00	17.00	17.01	
-	ERAL SERVICE COST CENTERS	Г Г					1 1
00 0044 01 0053 02 00503 03 0055 055 00550 06 00570 00 00700 00 00800 00 01000 00 013100 00 014400 00 015600 00 017000 01 0177000 02 01771000 03 000000000000000000000000000000000000	00 CAP REL COSTS-BLOG & PTAT 00 EMPLOYEE BENEFITS DEPARTMENT 50 DATA PROCESSING 60 PURCHASING RECEIVING AND STORES 70 ADMITTING 80 CASHIERING/ACCOUNTS RECEIVABLE 90 OTHER A&G 92 PATIENT TRANSPORTATION 00 OPERATION OF PLANT 00 DERATION 00 DI ETARY 00 CAFETERIA 00 NURSING ADMINISTRATION 00 CENTRAL SERVICES & SUPPLY 00 PHARMACY 00 MEDICAL RECORDS & LIBRARY 00 SOCIAL SERVICE 01 SAFF EDUCATION 02 MEDICAL EDUCATION 03 I&R SERVICES-SALARY & FRINGES APPRVD 00 I&R SERVICES-OTHER PRGM COSTS APPRVD 00 PARAMED ED PROGRAM <td>20, 539, 452 0 0 0 0 0 0 0 0 0</td> <td>19, 260, 879 0 0 0 0 0 0 0 0 0</td> <td></td> <td>1 0 700 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td> <td>76, 213 10 0 79</td> <td>4 5 5 5 5 5 5 5 5 5 7 7 8 9 9 10 111 133 14 15 16 17 7 7 21 22</td>	20, 539, 452 0 0 0 0 0 0 0 0 0	19, 260, 879 0 0 0 0 0 0 0 0 0		1 0 700 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	76, 213 10 0 79	4 5 5 5 5 5 5 5 5 5 7 7 8 9 9 10 111 133 14 15 16 17 7 7 21 22
	ATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	0		0 0	19	23
00 030	00 ADULTS & PEDI ATRI CS	0	0			32, 523	
	DO INTENSIVE CARE UNIT	0	0	22, 781, 04		6, 842	
	01 NEONATAL I CU 00 SUBPROVI DER – I PF	0	0	7, 430, 73 4, 390, 60		68 341	
	DO SUBPROVI DER – I RF	0	0	5, 299, 29		4, 480	
	DO NURSERY	0	0	2, 373, 52		3, 495	
	I LLARY SERVICE COST CENTERS	-1	-	_/ = . = / = =		-,	
	OO OPERATING ROOM	0	0	130, 634, 83	6 0	5, 818	50
01 0500	01 ENDOSCOPY	0	0	12, 103, 94	5 0	1, 336	50
	DO RECOVERY ROOM	0	0	9, 100, 94		188	
	DO DELIVERY ROOM & LABOR ROOM	0	0	4, 588, 06		5, 011	
	DO ANESTHESI OLOGY	0	0	27 500 90	0 0 1 0	0	
	00 RADI OLOGY-DI AGNOSTI C 01 RADI OLOGY - ULTRASOUND	0	0	37, 599, 89 20, 083, 44		1, 622 484	
	00 RADI OLOGY - ULTRASOUND	0	0	19, 570, 83		310	
	D1 I NFUSI ON CENTER	0	0	25, 14			55
	00 RADI OI SOTOPE	0	0	12, 882, 09	-	3	
00 0570	DO CT SCAN	0	0	120, 119, 71		884	
	DO MAGNETIC RESONANCE IMAGING (MRI)	0	0	27, 077, 57		0	
	00 CARDI AC CATHETERI ZATI ON	0	0	64, 798, 73		4, 186	
		0	1, 262, 195	188, 928, 76		208	
	01 BLOOD LABORATORY 00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0 0	0	60
	00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	10, 361, 29	1 0	158	
	00 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	
	DO INTRAVENOUS THERAPY	0	0		0 0	0	
	00 RESPI RATORY THERAPY	0	0	38, 080, 24		821	
	00 PHYSI CAL THERAPY	0	0	7, 536, 13		158	
	00 OCCUPATI ONAL THERAPY	0	0	5, 639, 10		167	
		0	0	2, 523, 29		69	
	00 ELECTROCARDI OLOGY 01 CARDI AC REHAB	0	0	22, 476, 02		118	
	00 ELECTROENCEPHALOGRAPHY		0	965, 24 24, 891, 18		299	
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 389, 568	0	48, 174, 27		233	
	00 I MPL. DEV. CHARGED TO PATIENTS	10, 149, 884	0	27, 747, 86		0	
00 0730	DO DRUGS CHARGED TO PATIENTS	0	17, 800, 078			9	
00 0740	00 RENAL DI ALYSI S	0	0	10, 148, 62		0	
	PATIENT SERVICE COST CENTERS				- 1		4
	DO CLINIC	0	0	23, 062, 20		308	
	00 EMERGENCY	0	0	75, 213, 87	4 29	4, 789	
	00 OBSERVATION BEDS (NON-DISTINCT PART)						92
	ER REIMBURSABLE COST CENTERS		200	1 140 44	2	170	1101
	CIAL PURPOSE COST CENTERS	0	280	4, 160, 44	3 0	376	101

Health Financial Systems	METHODI ST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC		Period:	Worksheet B-1	
				From 01/01/2020 To 12/31/2020	Date/Time Pre 7/23/2021 10:	
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	STAFF	
	SERVICES &	(COSTED	RECORDS &	SERVI CE	EDUCATI ON	
	SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	(TIME SPENT)	
	(COSTED		(GROSS			
	REQUIS.)		CHARGES)			
	14.00	15.00	16.00	17.00	17.01	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANT	EEN O	0	(0 0		190.00
191. 00 19100 RESEARCH	0	0	(0 0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	198, 326	(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 NONPAI D 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. Part I)	B, 3, 956, 046	7, 718, 827	4, 379, 19	4 773, 980	546, 760	202.00
203.00 Unit cost multiplier (Wkst. B, P	Part I) 0. 192607	0. 400752	0.00350	8 1, 105. 685714	7. 174104	203.00
204.00 Cost to be allocated (per Wkst. Part II)		353, 168	218, 45	1 33, 593	191, 465	204.00
205.00 Unit cost multiplier (Wkst. B, P	Part 0. 030598	0. 018336	0. 00017	5 47. 990000	2. 512235	205.00
206.00 NAHE adjustment amount to be all (per Wkst. B-2)	ocated					206. 00
207.00 NAHE unit cost multiplier (Wkst. Parts III and IV)	D,					207.00

	Financial Systems LLOCATION - STATISTICAL BASIS	METHODI ST HOS		CN: 15-0002	Period: From 01/01/2020	u of Form CMS-2552- Worksheet B-1
					To 12/31/2020	Date/Time Prepare 7/23/2021 10:58 a
			I NTERNS &	RESI DENTS		172372021 10.30 4
	Cost Center Description	MEDI CAL EDUCATI ON (ASSI GNED TI ME) 17. 02	SERVI CES-SALA RY & FRI NGES (ASSI GNED TI ME) 21.00	SERVI CES-OTH R PRGM COSTS (ASSI GNED TI ME) 22.00		
	GENERAL SERVICE COST CENTERS			1		
1.00 3.00 4.00 5.00 6.00 7.00 7.01 7.02 1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER A&G 00592 PATIENT TRANSPORTATION 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01701 STAFF EDUCATION 01702 MEDICAL EDUCATION 01702 MEDICAL EDUCATION 02100 I & SERVICES-SALARY & FRINGES APPRVD 02200 I & SERVICES-OTHER PRGM COSTS APPRVD	100 0 0		10		1. 4. 5. 5. 5. 5. 5. 7. 8. 9. 10. 11. 13. 14. 15. 16. 17. 17. 17. 21. 22. 22
3.00	02300 PARAMED ED PROGRAM INPATIENT ROUTINE SERVICE COST CENTERS	0			100	23.
	03000 ADULTS & PEDI ATRI CS	0			0 0	30.
	03100 INTENSIVE CARE UNIT 03101 NEONATAL ICU	0			0 0 0 0	31.
	04000 SUBPROVI DER - I PF	0	C		0 0	40.
	04100 SUBPROVI DER – I RF 04300 NURSERY	0			0 0	41.
	ANCI LLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM 05001 ENDOSCOPY	0		1	0 0 0 0	50. 50.
1.00	05100 RECOVERY ROOM	0	C	1	0 0	51.
	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0			0 0	52.
	05400 RADI OLOGY-DI AGNOSTI C				0 0	53.
	05401 RADI OLOGY - ULTRASOUND	0	C		0 0	54.
	05500 RADI OLOGY-THERAPEUTI C	0	C		0 0	55.
	05501 I NFUSI ON CENTER 05600 RADI OI SOTOPE	0		1	0 0	55. 56.
	05700 CT SCAN				0 0	57.
8.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0 0	58
	05900 CARDI AC CATHETERI ZATI ON	0	C		0 0	59.
	06000 LABORATORY 06001 BLOOD LABORATORY	0			0 0 0 0	60 60
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0	61.
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C		0 0	62.
	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0			0 0	63. 64.
	06500 RESPIRATORY THERAPY	0			0 0	65.
	06600 PHYSI CAL THERAPY	0	C		0 0	66.
	06700 OCCUPATI ONAL THERAPY	0	C	1	0 0	67.
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY				0 0	68. 69.
	06901 CARDI AC REHAB	0			0 0	69.
. 00	07000 ELECTROENCEPHALOGRAPHY	0	C		0 0	70.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 0	71.
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS				0 0	72.
	07400 RENAL DI ALYSI S	0			0 0	73.
	OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·	· ~			
	09000 CLINIC	0			0 0	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	100	100	10	00 100	91. 92.
2.00	OTHER REIMBURSABLE COST CENTERS	I	I	1		92.
				-		
01.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	C		0 0	101.

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CO		Period: From 01/01/2020	Worksheet B-1
				To 12/31/2020	
		I NTERNS &	RESI DENTS		172072021 10.00 dill
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 PHYSI CLANS' PRI VATE OFFI CES	0	0	(0 0	192.00
192.01 19201 OTHER NON-REI MBURSABLE	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, Part I)	40, 415	285, 125	254, 25	7 972, 117	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	404. 150000	2, 851. 250000	2, 542. 57000	9, 721. 170000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	6, 541	1, 141	76, 86	66, 033	204.00
205.00 Unit cost multiplier (Wkst. B, Part	65. 410000	11. 410000	768.68000	660. 330000	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)				0	206.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0. 000000	207.00

Health Financial Systems	METHODI ST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Peri od:	Worksheet C	
				From 01/01/2020 To 12/31/2020	Part I Date/Time Pre	narod
				10 12/31/2020	7/23/2021 10:	58 am
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst.	Adj.		Di sal I owance		
	B, Part I,					
	<u>col. 26)</u> 1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDI ATRI CS	74, 905, 006		74, 905, 00	6 16, 037	74, 921, 043	30.00
31. 00 03100 I NTENSI VE CARE UNI T	16, 633, 512		16, 633, 51		16, 633, 512	
31.01 03101 NEONATAL ICU	3, 313, 138		3, 313, 13		3, 313, 138	31.01
40.00 04000 SUBPROVIDER - IPF	2, 232, 657		2, 232, 65	7 0	2, 232, 657	40.00
41.00 04100 SUBPROVIDER – IRF	6, 040, 631		6, 040, 63	1 0	6, 040, 631	41.00
43. 00 04300 NURSERY	3, 860, 194		3, 860, 19	4 0	3, 860, 194	43.00
ANCILLARY SERVICE COST CENTERS	1	1		-		
50.00 05000 OPERATING ROOM	14, 810, 206		14, 810, 20			50.00
50. 01 05001 ENDOSCOPY	2, 399, 071		2, 399, 07		2, 399, 071	50.01
51.00 05100 RECOVERY ROOM	2, 432, 763		2, 432, 76		2, 432, 763	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 201, 893		6, 201, 89		6, 201, 893	52.00
53. 00 05300 ANESTHESI OLOGY	0			0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	8, 164, 273		8, 164, 27		8, 164, 273	54.00
54.01 05401 RADI OLOGY - ULTRASOUND 55.00 05500 RADI OLOGY-THERAPEUTI C	2, 729, 221		2, 729, 22		2, 729, 221	54.01 55.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 55. 01 05501 I NFUSI ON CENTER	3, 508, 119 57, 280		3, 508, 11 57, 28		3, 508, 119 57, 280	
56. 00 05600 RADI 0I SOTOPE	2, 910, 016		2, 910, 01		2, 910, 016	56.00
57. 00 05700 CT SCAN	4, 774, 252		4, 774, 25		4, 774, 252	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 611, 915		1, 611, 91		1, 611, 915	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	6, 746, 020		6, 746, 02	-	6, 746, 020	59.00
60. 00 06000 LABORATORY	21, 783, 629		21, 783, 62		21, 783, 629	60.00
60. 01 06001 BLOOD LABORATORY	0			0 0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0 0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 173, 300		2, 173, 30	0 0	2, 173, 300	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0			0 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0			0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	5, 642, 388		5, 642, 38		5, 642, 388	65.00
66. 00 06600 PHYSI CAL THERAPY	2, 779, 988		2, 779, 98		2, 779, 988	66.00
67.00 06700 OCCUPATI ONAL THERAPY	2, 278, 966		2, 278, 96		2, 278, 966	67.00
68.00 06800 SPEECH PATHOLOGY	786, 657		786, 65		786, 657	68.00
69.00 06900 ELECTROCARDI OLOGY	1, 497, 330		1, 497, 33		1, 497, 330	69.00
69. 01 06901 CARDI AC REHAB	615, 283		615, 28		615, 283	
70. 00 07000 ELECTROENCEPHALOGRAPHY	2,030,901		2,030,90		2,030,901	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	15, 517, 812		15, 517, 81		15, 517, 812	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	14, 907, 837 30, 627, 682		14, 907, 83		14, 907, 837	72.00 73.00
73.00 07300 DR0GS CHARGED TO PATTENTS 74.00 07400 RENAL DIALYSIS	30, 627, 682		30, 627, 68 3, 110, 41		30, 627, 682 3, 110, 417	73.00
OUTPATIENT SERVICE COST CENTERS	3, 110, 417		5, 110, 41	7 0	5, 110, 417	74.00
90. 00 09000 CLINIC	10, 089, 392		10, 089, 39	2 0	10, 089, 392	90.00
91. 00 09100 EMERGENCY	17, 412, 369		17, 412, 36		17, 412, 369	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	14, 142, 045		14, 142, 04		14, 142, 045	•
OTHER REIMBURSABLE COST CENTERS	, 112, 040	1	,	-1	, 112, 040	12.00
101.00 10100 HOME HEALTH AGENCY	3, 822, 635		3, 822, 63	5	3, 822, 635	101.00
200.00 Subtotal (see instructions)	312, 548, 798		312, 548, 79		312, 564, 835	
201.00 Less Observation Beds	14, 142, 045		14, 142, 04		14, 142, 045	
202.00 Total (see instructions)	298, 406, 753	0	298, 406, 75	3 16, 037	298, 422, 790	202.00

COMPUTATIC	ancial Systems N OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0002	Peri od:	u of Form CMS- Worksheet C	
					From 01/01/2020 To 12/31/2020	Part I Date/Time Pre 7/23/2021 10:	epared
			Title	e XVIII	Hospi tal	PPS	50 alli
	· · · · · · · · · · · · · · · · · · ·		Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient	
		6.00	7.00	8.00	9.00	<u>Rati o</u> 10.00	
LND	ATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	8.00	9.00	10.00	-
	00 ADULTS & PEDIATRICS	71, 846, 210		71, 846, 21	0		30.0
	DO INTENSIVE CARE UNIT	22, 781, 049		22, 781, 04			31.0
	01 NEONATAL I CU	7, 430, 733		7, 430, 73			31.0
	00 SUBPROVIDER - IPF	4, 390, 602		4, 390, 60			40.0
	00 SUBPROVIDER - IPF						40.0
	00 NURSERY	5, 299, 296 2, 373, 522		5, 299, 29			41.0
	I LLARY SERVICE COST CENTERS	2, 373, 522		2, 373, 52	22		43.0
	00 OPERATING ROOM	57, 185, 055	73, 449, 781	130, 634, 83	0. 113371	0. 000000	50. 0
	01 ENDOSCOPY	3, 237, 175	8, 866, 770			0. 000000	
	DO RECOVERY ROOM	3, 340, 823	5, 760, 121			0. 000000	
	00 DELIVERY ROOM & LABOR ROOM	1, 972, 099	2, 615, 962			0. 000000	
	00 ANESTHESI OLOGY		2,015,902			0. 000000	
		10 244 270	-				
	00 RADI OLOGY-DI AGNOSTI C	10, 346, 278	27, 253, 613			0.00000	
	01 RADI OLOGY - ULTRASOUND	4, 872, 619	15, 210, 824			0.00000	
	00 RADI OLOGY-THERAPEUTI C	1, 257, 688	18, 313, 143			0.00000	
	01 INFUSION CENTER	1, 249	23, 897			0.00000	
	DO RADI OI SOTOPE	4, 412, 286	8, 469, 805			0.00000	
	DO CT SCAN	45, 909, 764	74, 209, 951			0.00000	
8.00 058	DO MAGNETIC RESONANCE IMAGING (MRI)	10, 162, 357	16, 915, 219			0.00000	
	00 CARDI AC CATHETERI ZATI ON	31, 140, 170	33, 658, 563			0.00000	
		85, 685, 178	103, 243, 589			0.00000	
	01 BLOOD LABORATORY	0	0		0 0.000000	0.00000	
	00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	10.0/1.0/	0 0.000000	0.00000	
	00 WHOLE BLOOD & PACKED RED BLOOD CELLS	7, 555, 301	2, 805, 990	10, 361, 29		0.00000	
	00 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0. 000000	0.00000	
	DO I NTRAVENOUS THERAPY	0	0		0 0.000000	0.00000	
		34, 817, 142	3, 263, 103			0.00000	
	00 PHYSI CAL THERAPY	6, 795, 719	740, 417			0.00000	
	00 OCCUPATI ONAL THERAPY	5, 181, 357	457, 751			0.00000	
	DO SPEECH PATHOLOGY	2, 301, 780	221, 515			0.00000	
	DO ELECTROCARDI OLOGY	12, 250, 033	10, 225, 991			0.00000	
	01 CARDI AC REHAB	188, 463	776, 782			0.00000	
	00 ELECTROENCEPHALOGRAPHY	6, 769, 637	18, 121, 546			0.00000	
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	22, 615, 962	25, 558, 311			0.00000	
	00 IMPL. DEV. CHARGED TO PATIENTS	13, 105, 136	14, 642, 725			0.00000	
	DO DRUGS CHARGED TO PATIENTS	104, 879, 767	55, 154, 651			0.00000	
	00 RENAL DI ALYSI S	9, 263, 118	885, 505	10, 148, 62	0. 306487	0. 000000	0 74.0
	PATIENT SERVICE COST CENTERS	,ı					_
	DO CLINIC	300, 480	22, 761, 722			0.00000	
	DO EMERGENCY	18, 613, 397	56, 600, 477			0.00000	
2.00 092 0TH	00 OBSERVATION BEDS (NON-DISTINCT PART) ER REIMBURSABLE COST CENTERS	5, 468, 994	20, 372, 135	25, 841, 12	0. 547269	0. 000000	92.0
	DO HOME HEALTH AGENCY	0	4, 160, 443	4, 160, 44	13		101.
00.00	Subtotal (see instructions)	623, 750, 439	624, 740, 302				200.
	Less Observation Beds	020, 100, 407	027, 140, 302	1, 270, 470, 72			200.0
201.00							

Health F	inancial Systems	METHODI ST HOSPI	TALS, INC	In Lieu	u of Form CMS-2	2552-10
COMPUTAT	TION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre	pared:
					7/23/2021 10:	
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
	NPATI ENT ROUTI NE SERVI CE COST CENTERS 3000 ADULTS & PEDI ATRI CS					30.00
	3100 I NTENSI VE CARE UNI T					31.00
	3100 INTENSIVE CARE UNIT					31.00
	4000 SUBPROVI DER – I PF					40.00
	4100 SUBPROVI DER – I RF					41.00
	4300 NURSERY					43.00
	NCI LLARY SERVICE COST CENTERS					10.00
	5000 OPERATING ROOM	0, 113371				50.00
	5001 ENDOSCOPY	0. 198206				50.01
	5100 RECOVERY ROOM	0. 267309				51.00
	5200 DELIVERY ROOM & LABOR ROOM	1.351746				52.00
	5300 ANESTHESI OLOGY	0. 000000				53. OC
	5400 RADI OLOGY-DI AGNOSTI C	0. 217136				54.OC
	5401 RADI OLOGY - ULTRASOUND	0. 135894				54.01
55.00 0	5500 RADI OLOGY-THERAPEUTI C	0. 179252				55.00
55.01 0	5501 INFUSION CENTER	2. 277897				55.01
56.00 0	5600 RADI OI SOTOPE	0. 225896				56. OC
	5700 CT SCAN	0. 039746				57.00
58.00 0	5800 MAGNETIC RESONANCE IMAGING (MRI)	0. 059530				58.00
59.00 0	5900 CARDI AC CATHETERI ZATI ON	0. 104107				59.00
	6000 LABORATORY	0. 115301				60.00
	6001 BLOOD LABORATORY	0. 000000				60.01
	6100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000				61.00
	6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 209752				62.00
	6300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.00
	6400 I NTRAVENOUS THERAPY	0. 000000				64.00
	6500 RESPI RATORY THERAPY	0. 148171				65.OC
	6600 PHYSI CAL THERAPY	0. 368888				66.00
	6700 OCCUPATI ONAL THERAPY	0. 404136				67.00
	6800 SPEECH PATHOLOGY	0. 311758				68.00
	6900 ELECTROCARDI OLOGY	0. 066619				69.00
	6901 CARDI AC REHAB	0. 637437				69.01
	7000 ELECTROENCEPHALOGRAPHY	0. 081591				70.00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 7200 IMPL. DEV. CHARGED TO PATIENTS	0. 322118 0. 537261				71.00 72.00
	7300 DRUGS CHARGED TO PATIENTS	0. 191382				73.00
	7400 RENAL DIALYSIS	0. 306487				74.00
	UTPATIENT SERVICE COST CENTERS	0. 300407				/4.00
	9000 CLINIC	0. 437486				90.00
	9100 EMERGENCY	0. 231505				91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 547269				92.00
	THER REIMBURSABLE COST CENTERS	0.01.207				1
	0100 HOME HEALTH AGENCY					101.00
200.00	Subtotal (see instructions)					200.00
201.00	Less Observation Beds					201.00

Health Financial Systems	METHODI ST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period:	Worksheet C	
				From 01/01/2020 To 12/31/2020	Part I Date/Time Pre	pared:
					7/23/2021 10:	58 am
			e XIX	<u>Hospi tal</u> Costs	Cost	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst.	Adj .		Di sal I owance		
	B, Part I,					
	<u>col. 26)</u> 1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDI ATRI CS	74, 905, 006		74, 905, 00	6 16, 037	74, 921, 043	30.00
31.00 03100 INTENSIVE CARE UNIT	16, 633, 512		16, 633, 51		16, 633, 512	
31.01 03101 NEONATAL ICU	3, 313, 138		3, 313, 13		3, 313, 138	31.01
40. 00 04000 SUBPROVI DER - I PF	2, 232, 657		2, 232, 65		2, 232, 657	40.00
41.00 04100 SUBPROVIDER - IRF	6, 040, 631		6, 040, 63		6, 040, 631	41.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	3, 860, 194		3, 860, 19	4 0	3, 860, 194	43.00
50. 00 05000 OPERATING ROOM	14, 810, 206	1	14, 810, 20	6 0	14, 810, 206	50.00
50. 01 05001 ENDOSCOPY	2, 399, 071		2, 399, 07		2, 399, 071	50.01
51.00 05100 RECOVERY ROOM	2, 432, 763		2, 432, 76		2, 432, 763	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 201, 893		6, 201, 89	3 0	6, 201, 893	52.00
53. 00 05300 ANESTHESI OLOGY	0			0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	8, 164, 273		8, 164, 27		8, 164, 273	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND 55. 00 05500 RADI OLOGY-THERAPEUTI C	2, 729, 221 3, 508, 119		2, 729, 22 3, 508, 11		2, 729, 221 3, 508, 119	54.01 55.00
55. 01 05501 INFUSI ON CENTER	57, 280		57, 28		57, 280	
56. 00 05600 RADI OI SOTOPE	2, 910, 016		2, 910, 01		2, 910, 016	56.00
57. 00 05700 CT SCAN	4, 774, 252		4, 774, 25		4, 774, 252	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 611, 915		1, 611, 91	5 0	1, 611, 915	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	6, 746, 020		6, 746, 02		6, 746, 020	59.00
60. 00 06000 LABORATORY	21, 783, 629		21, 783, 62		21, 783, 629	60.00
60. 01 06001 BLOOD LABORATORY 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0 0 0 0	0	60.01 61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 173, 300		2, 173, 30		2, 173, 300	62.00
63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	2, 173, 300		2, 175, 50	0 0	2, 173, 300	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0			0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	5, 642, 388	0	5, 642, 38	8 0	5, 642, 388	65.00
66. 00 06600 PHYSI CAL THERAPY	2, 779, 988		2, 779, 98		2, 779, 988	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	2, 278, 966		2, 278, 96		2, 278, 966	67.00
68. 00 06800 SPEECH PATHOLOGY	786, 657		786, 65		786, 657	68.00
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB	1, 497, 330 615, 283		1, 497, 33 615, 28		1, 497, 330 615, 283	69.00 69.01
70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 030, 901		2, 030, 90		2, 030, 901	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	15, 517, 812		15, 517, 81		15, 517, 812	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	14, 907, 837		14, 907, 83		14, 907, 837	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	30, 627, 682		30, 627, 68		30, 627, 682	73.00
74.00 07400 RENAL DI ALYSI S	3, 110, 417		3, 110, 41	7 0	3, 110, 417	74.00
OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C	10,000,000		10,000,00		10,000, 202	
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	10, 089, 392 17, 412, 369		10, 089, 39 17, 412, 36		10, 089, 392 17, 412, 369	90.00 91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	14, 142, 045		14, 142, 04		14, 142, 045	
OTHER REIMBURSABLE COST CENTERS	,2, 510		,	- <u>_</u>	, 112, 310	
101.00 10100 HOME HEALTH AGENCY	3, 822, 635		3, 822, 63	5	3, 822, 635	101.00
200.00 Subtotal (see instructions)	312, 548, 798		312, 548, 79		312, 564, 835	
201.00 Less Observation Beds	14, 142, 045		14, 142, 04		14, 142, 045	
202.00 Total (see instructions)	298, 406, 753	0	298, 406, 75	3 16, 037	298, 422, 790	202.00

COMPUTATION	ancial Systems N OF RATIO OF COSTS TO CHARGES		PITALS, INC Provider C	CN: 15-0002	Peri od:	u of Form CMS- Worksheet C	2002
				011. 10 0002	From 01/01/2020 To 12/31/2020	Part I Date/Time Pre 7/23/2021 10:	epared
				e XIX	Hospi tal	Cost	50 ali
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS						
30. 00 0300	0 ADULTS & PEDIATRICS	71, 846, 210		71, 846, 21	10		30.0
31.00 0310	O INTENSIVE CARE UNIT	22, 781, 049		22, 781, 04	19		31.0
31.01 0310	1 NEONATAL ICU	7, 430, 733		7, 430, 73	33		31.0
0.00 0400	O SUBPROVI DER – I PF	4, 390, 602		4, 390, 60)2		40.0
	O SUBPROVI DER – I RF	5, 299, 296		5, 299, 29			41.0
	IO NURSERY	2, 373, 522		2, 373, 52	22		43.0
	LLARY SERVICE COST CENTERS						
	O OPERATING ROOM	57, 185, 055	73, 449, 781			0.00000	
	1 ENDOSCOPY	3, 237, 175	8, 866, 770			0.00000	
	O RECOVERY ROOM	3, 340, 823	5, 760, 121			0.00000	
	O DELIVERY ROOM & LABOR ROOM	1, 972, 099	2, 615, 962	4, 588, 06		0.00000	
	O ANESTHESI OLOGY	0	0		0 0. 000000	0.00000	
	O RADI OLOGY-DI AGNOSTI C	10, 346, 278	27, 253, 613			0.00000	
	1 RADI OLOGY - ULTRASOUND	4, 872, 619	15, 210, 824			0.00000	
	O RADI OLOGY-THERAPEUTI C	1, 257, 688	18, 313, 143			0.00000	
	1 INFUSION CENTER	1, 249	23, 897			0.00000	
	O RADI OI SOTOPE	4, 412, 286	8, 469, 805		0. 225896	0.00000	56.
	OCT SCAN	45, 909, 764	74, 209, 951			0.00000	
8.00 0580	O MAGNETIC RESONANCE IMAGING (MRI)	10, 162, 357	16, 915, 219			0.00000	
	O CARDI AC CATHETERI ZATI ON	31, 140, 170	33, 658, 563			0.000000	
	O LABORATORY	85, 685, 178	103, 243, 589	188, 928, 76		0.000000	
	1 BLOOD LABORATORY	0	0		0 0.000000	0.00000	
	O PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0 0. 000000	0.00000	
	WHOLE BLOOD & PACKED RED BLOOD CELLS	7, 555, 301	2, 805, 990	10, 361, 29		0.000000	
	O BLOOD STORING, PROCESSING & TRANS.	0	0		0 0.000000	0.000000	
	O I NTRAVENOUS THERAPY	0	0		0 0. 000000	0.00000	
	O RESPI RATORY THERAPY	34, 817, 142	3, 263, 103			0.00000	
	O PHYSI CAL THERAPY	6, 795, 719	740, 417			0.000000	
	O OCCUPATI ONAL THERAPY	5, 181, 357	457, 751			0.000000	
	O SPEECH PATHOLOGY	2, 301, 780	221, 515			0.00000	
	O ELECTROCARDI OLOGY	12, 250, 033	10, 225, 991			0.00000	
	1 CARDI AC REHAB	188, 463	776, 782			0.00000	
	0 ELECTROENCEPHALOGRAPHY	6, 769, 637	18, 121, 546			0.00000	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	22, 615, 962	25, 558, 311			0.00000	
	O IMPL. DEV. CHARGED TO PATIENTS	13, 105, 136	14, 642, 725			0.00000	
	O DRUGS CHARGED TO PATIENTS	104, 879, 767	55, 154, 651			0.00000	
	0 RENAL DI ALYSI S	9, 263, 118	885, 505	10, 148, 62	0. 306487	0. 000000	74.
	ATIENT SERVICE COST CENTERS	I		1			
	O CLINIC	300, 480	22, 761, 722			0.00000	
	O EMERGENCY	18, 613, 397	56, 600, 477			0.00000	
	0 OBSERVATION BEDS (NON-DISTINCT PART) R REIMBURSABLE COST CENTERS	5, 468, 994	20, 372, 135	25, 841, 12	0. 547269	0. 000000	92.
	O HOME HEALTH AGENCY	0	4, 160, 443	4, 160, 44	13		101.
00.00	Subtotal (see instructions)	623, 750, 439	624, 740, 302				200.
01.00	Less Observation Beds	020,700,107	32.,,10,302				201.
	Total (see instructions)	623, 750, 439	(04 740 000	1, 248, 490, 74			202.

Health Financial Systems	METHODI ST HOSPI			u of Form CMS-	2552-1
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre 7/23/2021 10:	
		Title XIX	Hospi tal	Cost	50 am
Cost Center Description	PPS Inpatient			0001	
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
31.01 03101 NEONATAL I CU					31.0
40. 00 04000 SUBPROVI DER - I PF					40.0
41.00 04100 SUBPROVIDER - IRF					41.0
43. 00 04300 NURSERY					43.0
ANCILLARY SERVICE COST CENTERS	1 1				
50.00 05000 OPERATING ROOM	0. 000000				50.00
50. 01 05001 ENDOSCOPY	0. 000000				50.0
51.00 05100 RECOVERY ROOM	0. 000000				51.0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.0
53. 00 05300 ANESTHESI OLOGY	0. 000000				53.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.0
54. 01 05401 RADI OLOGY - ULTRASOUND	0. 000000				54.0
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000				55.0
55. 01 05501 I NFUSI ON CENTER	0. 000000				55.0
56. 00 05600 RADI OI SOTOPE	0. 000000				56.0
57. 00 05700 CT SCAN	0. 000000				57.0
58. 00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 59. 00 05900 CARDI AC CATHETERIZATI ON	0. 000000				58.0
	0. 000000				59.0
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	0. 000000 0. 000000				60.0
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000				61.0
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000				62.0
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0.000000				63.0
64. 00 06400 I NTRAVENOUS THERAPY	0.000000				64.0
65. 00 06500 RESPIRATORY THERAPY	0. 000000				65.0
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.0
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.0
68. 00 06800 SPEECH PATHOLOGY	0. 000000				68.0
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.0
69. 01 06901 CARDI AC REHAB	0. 000000				69.0
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.0
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.0
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0.000000				72.0
73. 00 07300 DRUGS CHARGED TO PATIENTS	0.000000				73.0
74.00 07400 RENAL DI ALYSI S	0.000000				74.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	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	· · · · · · · · · · · · · · · · · · ·		u of Form CMS-2	2552-10		
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 01/01/2020	Worksheet D Part I	
				To 12/31/2020		pared:
					7/23/2021 10:	58 am
			× XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1	I	1	1		
30. 00 ADULTS & PEDIATRICS	6, 318, 521	0	6, 318, 52		80. 73	
31.00 INTENSIVE CARE UNIT	500, 154		500, 15		53.19	
31.01 NEONATAL ICU	63, 561		63, 56		20.86	
40. 00 SUBPROVIDER - IPF	94, 726	0	94, 72		37.66	
41.00 SUBPROVIDER – IRF	618, 701	0	618, 70		114.38	
43.00 NURSERY	452, 507		452, 50		177.80	
200.00 Total (lines 30 through 199)	8, 048, 170		8, 048, 17	0 101, 183		200.00
Cost Center Description	I npati ent	Inpatient				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)	-			
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30.00 ADULTS & PEDIATRICS	19, 768		•			30.00
31.00 INTENSIVE CARE UNIT	3, 100					31.00
31.01 NEONATAL ICU	0	0				31.01
40.00 SUBPROVIDER - IPF	949					40.00
41.00 SUBPROVIDER - IRF	2,666					41.00
43.00 NURSERY	0	, s				43.00
200.00 Total (lines 30 through 199)	26, 483	2, 101, 436				200.00

PORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provider C	CN: 15-0002	Peri od:	Worksheet D	
				From 01/01/2020	Part II	
				To 12/31/2020	Date/Time Pre	epared
					7/23/2021 10:	58 ar
			XVIII	Hospi tal	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	·	•	•			
0. 00 05000 OPERATING ROOM	1, 221, 669	130, 634, 836	0.00935	52 13, 096, 883	122, 482	50.
0. 01 05001 ENDOSCOPY	29, 143	12, 103, 945	0.00240	1, 158, 308	2, 789	50.
. 00 05100 RECOVERY ROOM	268, 754				24, 690	
2. 00 05200 DELIVERY ROOM & LABOR ROOM	189, 953				794	
8. 00 05300 ANESTHESI OLOGY	0				0	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	975, 145	-	0. 02593		95, 928	
. 01 05401 RADI OLOGY - ULTRASOUND	115, 648				7,679	
5. 00 05500 RADI OLOGY-THERAPEUTI C	258, 232				8, 515	
5. 01 05501 I NFUSI ON CENTER	6, 563				0, 515	
					-	
0. 00 05600 RADI 0I SOTOPE	178, 011	12, 882, 091			20, 296	
7.00 05700 CT SCAN	243, 120				31, 058	
B. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	96, 444				11, 951	
P. 00 05900 CARDI AC CATHETERI ZATI ON	224, 990				32, 347	
0. 00 06000 LABORATORY	636, 024				88, 126	
0. 01 06001 BLOOD LABORATORY	0	0	0.00000	0 00	0	60.
. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.
2. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	28, 419	10, 361, 291	0. 00274	43 2, 231, 931	6, 122	62.
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000	0 00	0	63.
00 06400 INTRAVENOUS THERAPY	0	0	0. 00000	0 00	0	64.
5. 00 06500 RESPI RATORY THERAPY	187, 360	38, 080, 245	0.00492	10, 300, 539	50, 679	65.
0. 00 06600 PHYSI CAL THERAPY	228, 052				46, 966	66
2.00 06700 OCCUPATI ONAL THERAPY	194, 945				35, 983	
B. 00 06800 SPEECH PATHOLOGY	36, 366				11, 336	
0. 00 06900 ELECTROCARDI OLOGY	21, 912				4, 031	
0.01 06901 CARDI AC REHAB	4, 301				0	
0. 00 07000 ELECTROENCEPHALOGRAPHY	28, 189				3, 102	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	424, 354				66, 421	
2. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	402, 521	27, 747, 861	0.00880		48, 082	
	542,080					
00 07400 RENAL DI ALYSI S	96, 025	10, 148, 623	0.00946	3, 485, 511	32, 980	74.
OUTPATIENT SERVICE COST CENTERS	4 0/0 000	00.0(0.000	0.0500		0 757	
0. 00 09000 CLINIC	1, 362, 290				3, 757	
. 00 09100 EMERGENCY	679, 803					
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 192, 684				88, 716	
00.00 Total (lines 50 through 199)	9, 872, 997	1, 130, 208, 886		152, 931, 951	1,007,405	200.

Health Financial Systems	METHODI ST HOS	SPITALS, INC		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS	STS Provider C	CN: 15-0002	Period: From 01/01/2020 To 12/31/2020		epared: 58 am
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		h Allied Health	All Other	
	School	School	Post-Stepdov		Medi cal	
	Post-Stepdown		Adj ustments	5	Educati on	
	Adjustments				Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 03000 ADULTS & PEDI ATRI CS	0			0 0	-	
31.00 03100 INTENSIVE CARE UNIT	0	-		0 0	0	
31.01 03101 NEONATAL ICU	0	0	0	0 0	0	
40. 00 04000 SUBPROVI DER – I PF	0	0	D	0 0	0	
41.00 04100 SUBPROVIDER - IRF	0	0	D	0 0	0	1
43. 00 04300 NURSERY	0	0	D	0 0	0	
200.00 Total (lines 30 through 199)	0	0)	0 0		200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patier		Inpati ent	
	Adj ustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)		
		minus col. 4)	(00	7.00	0.00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	5.00	6.00	7.00	8.00	
30. 00 03000 ADULTS & PEDIATRICS	0	0	78, 2	64 0.00	19, 768	30.00
31. 00 03100 INTENSIVE CARE UNIT	0					
31. 01 03101 NEONATAL I CU						
40. 00 04000 SUBPROVIDER - 1PF	0		2,5			
40.00 04100 SUBPROVIDER - TPP 41.00 04100 SUBPROVIDER - TRF						
43. 00 04300 NURSERY	0					1
200.00 Total (lines 30 through 199)						200.00
Cost Center Description	I npati ent	0	<u>, 101, 1</u>	03	20, 403	200.00
cost center bescription	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9,00	-				
INPATIENT ROUTINE SERVICE COST CENTERS	7.00	1				
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31. 00 03100 I NTENSI VE CARE UNI T	0					31.00
31. 01 03101 NEONATAL I CU	0					31.01
40. 00 04000 SUBPROVI DER - I PF	0					40.00
41. 00 04100 SUBPROVI DER - I RF	0					41.00
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00
	1 0	1				

Health Financial Systems	METHODI ST HOS	PITALS, INC		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PAS			Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 7/23/2021 10:	pared: 58 am
		Title	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	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 0	0	50.00
50. 01 05001 ENDOSCOPY	0			0 0		50.01
51. 00 05100 RECOVERY ROOM	0			0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
	0	0			-	
53.00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
54. 01 05401 RADI OLOGY – ULTRASOUND	0	0		0 0	0	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
55. 01 05501 INFUSION CENTER	0	0		0 0	0	55.01
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	56.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0		0 0		60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	Ŭ	i i			Ŭ	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
	0	0				64.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0	0	
65.00 06500 RESPI RATORY THERAPY	0	0		0 0		65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0 0		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
69. 01 06901 CARDI AC REHAB	0	0		0 0	0	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0		73.00
74. 00 07400 RENAL DI ALYSI S	0			0 0		74.00
OUTPATIENT SERVICE COST CENTERS			1	- 0		1
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0			0 0		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	972,117	1
200.00 Total (lines 50 through 199)	0			0 0		
	0	0	I	9	1 712,117	200.00

	Financial Systems	METHODIST HOS			In Lie	u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provider C	CN: 15-0002	Period:	Worksheet D	
THROUG	GH COSTS				From 01/01/2020 To 12/31/2020	Part IV Date/Time Pre	nared
					10 12/01/2020	7/23/2021 10:	58 am
			Title	XVIII	Hospi tal	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)	cols. 2, 3,	col. 8)	col. 7)	
				and 4)		(see	
						instructions)	
		4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0			0 130, 634, 836	0. 000000	50.00
50.01	05001 ENDOSCOPY	0	0		0 12, 103, 945		50.01
51.00	05100 RECOVERY ROOM	0	0		0 9, 100, 944	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 4, 588, 061	0.00000	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0.00000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 37, 599, 891	0.00000	54.00
54.01	05401 RADI OLOGY - ULTRASOUND	0	0		0 20, 083, 443	0. 000000	54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 19, 570, 831	0. 000000	55.00
55.01	05501 INFUSION CENTER	0	0)	0 25, 146	0.00000	55.01
56.00	05600 RADI OI SOTOPE	0	0)	0 12, 882, 091	0.000000	56.00
57.00	05700 CT SCAN	0	0)	0 120, 119, 715	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 27, 077, 576	0.00000	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	l o		0 64, 798, 733		59.00
60.00	06000 LABORATORY	0	l o		0 188, 928, 767	0.00000	60.00
60.01	06001 BLOOD LABORATORY	0	l o		0 0	0.00000	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	l o		0 10, 361, 291	0.00000	•
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0.000000	•
64.00	06400 INTRAVENOUS THERAPY	0	0		0 0	0.000000	•
65.00	06500 RESPI RATORY THERAPY	0	0		0 38, 080, 245	0.000000	•
66.00	06600 PHYSI CAL THERAPY	0			0 7, 536, 136		•
67.00	06700 OCCUPATI ONAL THERAPY	0			0 5, 639, 108	0.000000	•
68.00	06800 SPEECH PATHOLOGY	0			0 2, 523, 295	0. 000000	•
69.00	06900 ELECTROCARDI OLOGY	0			0 22, 476, 024	0. 000000	•
69.01	06901 CARDI AC REHAB	0			0 965, 245	0.000000	•
	07000 ELECTROENCEPHALOGRAPHY	0			0 24, 891, 183		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 48, 174, 273		
	07200 I MPL. DEV. CHARGED TO PATIENTS				0 27, 747, 861	0.000000	•
72.00	07300 DRUGS CHARGED TO PATIENTS	0	-		0 160, 034, 418		•
74.00	07400 RENAL DI ALYSI S	0			0 10, 148, 623	0.000000	•
74.00	OUTPATIENT SERVICE COST CENTERS	0	. 0	1	0 10, 140, 023	0.000000	1 74.00
90.00		0	0		0 23, 062, 202	0.000000	90.00
90.00 91.00	09100 EMERGENCY	0					•
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0 25, 841, 129		•
200.00		0			7 1, 130, 208, 886		200.00
200.00		0	1 7/2, 11/	1 7/2, 1	1, 130, 200, 000	l	I≥00.00

Health Financial Systems	METHODI ST HOSPI	TALS, INC		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE		Provider C	CN: 15-0002	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2020		
				To 12/31/2020	Date/Time Pre 7/23/2021 10:	pared:
		Title	XVIII	Hospi tal	PPS	Jo alli
Cost Center Description	Outpati ent	Inpatient	Inpatient	Outpatient	Outpati ent	
cost center bescription	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷	onal goo	Costs (col.		Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS	· · · ·					
50. 00 05000 OPERATI NG ROOM	0. 000000	13, 096, 883		0 15, 035, 359	0	50.00
50. 01 05001 ENDOSCOPY	0. 000000	1, 158, 308		0 2, 465, 906	0	50.01
51.00 05100 RECOVERY ROOM	0. 000000	836, 111		0 1, 055, 071	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	19, 187		0 106, 254	0	52.00
53.00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	3, 698, 801		0 3, 857, 690	0	54.00
54.01 05401 RADI OLOGY - ULTRASOUND	0. 000000	1, 333, 623		0 1, 480, 270	0	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	645, 346		0 4, 857, 574	0	55.00
55.01 05501 INFUSION CENTER	0. 000000	0		0 649	0	55.01
56. 00 05600 RADI OI SOTOPE	0. 000000	1, 468, 832		0 2, 143, 998	0	56.00
57. 00 05700 CT SCAN	0. 000000	15, 344, 738		0 13, 221, 246	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	3, 355, 029		0 3, 084, 740	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	9, 316, 436		0 9, 534, 478	0	59.00
60. 00 06000 LABORATORY	0. 000000	26, 181, 211		0 6, 506, 477	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, 231, 931		0 199, 695	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	10, 300, 539		0 577, 518		65.00
66.00 06600 PHYSI CAL THERAPY	0. 000000	1, 552, 017		0 59		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0.000000	1, 040, 871		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	786, 589		0 23, 537	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0.000000	4, 134, 769		0 1, 903, 885	0	69.00
69. 01 06901 CARDI AC REHAB	0.000000	0		0 184, 792	0	69.01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	2, 740, 132		0 4, 679, 897	0	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0.000000	7, 540, 121		0 5, 823, 112	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0.000000	3, 314, 597		0 3, 499, 005	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	30, 990, 253		0 17, 210, 817 0 393, 735	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	3, 485, 511		0 393, 735	0	74.00
0UTPATI ENT_SERVI CE_COST_CENTERS 90. 00 09000 CLI NI C	0,000000	(2.404	1	0 4 074 000	0	
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY	0. 000000 0. 012925	63, 606		0 4, 276, 800		90.00 91.00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 012925	6, 374, 326 1, 922, 184				91.00
200.00 Total (lines 50 through 199)	0.000000	1, 922, 184			-	
200.00 Total (Thes so through 199)	1 1	132, 731, 931	02, 30	0 110, 525, 569	00, 423	200.00

Health Financial Systems	METHODI ST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 01/01/2020 To 12/31/2020		narod
				10 12/31/2020	7/23/2021 10:	
		Title	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins			
	9	2.00	(see inst.)	(see inst.)	F 00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	0. 113371	15,035,359	3	2 0	1, 704, 574	50.00
50. 01 05001 ENDOSCOPY	0. 198206			0 0		50.00
51.00 05100 RECOVERY ROOM	0. 267309			0 0	282,030	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1. 351746			0 0	143, 628	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 217136			0 0	837,643	
54. 01 05401 RADI OLOGY - ULTRASOUND	0. 135894			0 0		•
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 179252			0 0	870, 730	•
55. 01 05501 INFUSION CENTER	2. 277897	649		2 0	1, 478	•
56. 00 05600 RADI 0I SOTOPE	0. 225896	2, 143, 998		0 0	484, 321	56.00
57.00 05700 CT SCAN	0. 039746	13, 221, 246		0 0	525, 492	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 059530	3, 084, 740		0 0	183, 635	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 104107	9, 534, 478		0 0	992, 606	59.00
60. 00 06000 LABORATORY	0. 115301	6, 506, 477	28, 87	9 0	750, 203	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			0 0		60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			0 0		61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 209752					•
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			0 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000			0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 148171	577, 518		0 0		65.00
66.00 06600 PHYSICAL THERAPY	0. 368888			0 0	22	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0. 404136 0. 311758			0 0 0 0	0	67.00 68.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0. 066619			0 0	7, 338 126, 835	•
69. 01 06901 CARDI AC REHAB	0. 637437			0 0	120, 835	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 081591	4, 679, 897		5 0	381, 837	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 322118			0 0	1, 875, 729	•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 522110	3, 499, 005		0 0	1, 879, 879	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 191382			0 40,085	3, 293, 841	
74. 00 07400 RENAL DI ALYSI S	0. 306487	393, 735		0 0	120, 675	•
OUTPATIENT SERVICE COST CENTERS	01000107	0,0,700		0	120/070	1
90. 00 09000 CLINIC	0. 437486	4, 276, 800		0 0	1, 871, 040	90.00
91.00 09100 EMERGENCY	0. 231505			1 131	1, 440, 491	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 547269			0 0	1, 192, 355	92.00
200.00 Subtotal (see instructions)		110, 523, 589	32, 71	3 40, 216	19, 901, 549	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		110, 523, 589	32, 71	3 40, 216	19, 901, 549	202.00

Health Financial Systems	METHODIST HOS				u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider CO	CN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Pre 7/23/2021 10:	
		Title	XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS	4	0	1			50.00
	4	0				
50. 01 05001 ENDOSCOPY	0	0				50.01
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				51.00 52.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESIOLOGY	0	0				52.00
54. 00 05400 RADI OLOGY - 01 AGNOSTI C	0	0				53.00
54. 01 05400 RADIOLOGY - ULTRASOUND	0	0				54.00
55. 00 05500 RADI OLOGY - ULTRASOUND	0	0				55.00
55. 01 05501 I NFUSI ON CENTER	5	0				55.00
56. 00 05600 RADI OI SOTOPE	0	0				56.00
57. 00 05700 CT SCAN	0	0				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	3, 330	0				60.00
60. 01 06001 BLOOD LABORATORY	0	0				60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0				61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	460	0				62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
64.00 06400 INTRAVENOUS THERAPY	0	0				64.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
69. 01 06901 CARDI AC REHAB	0	0				69.01
70. 00 07000 ELECTROENCEPHALOGRAPHY	1	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	7,672				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	368	30				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	4, 168	7, 702				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges	4 4 4 0	7 700				202.00
202.00 Net Charges (line 200 - line 201)	4, 168	7, 702	I			202.00

Health Financial Systems		SPITALS, INC			u of Form CMS-2	2552-1
APPORTIONMENT OF INPATIENT ANCILLARY SER	/ICE CAPITAL COSTS	Provider C	CN: 15-0002	Peri od:	Worksheet D	
		Component	CCN: 15-S002	From 01/01/2020 To 12/31/2020		nared
		component	0011. 13 3002	10 12/31/2020	7/23/2021 10:	
		Title	e XVIII	Subprovider -	PPS	
		_		I PF		_
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS		1	1	- 1		
50.00 05000 OPERATING ROOM	1, 221, 66					
50. 01 05001 ENDOSCOPY	29, 14				-	50.0
51.00 05100 RECOVERY ROOM	268, 75				-	51.0
52.00 05200 DELIVERY ROOM & LABOR ROOM	189, 95				0	52.0
53. 00 05300 ANESTHESI OLOGY		D C	0.00000		0	53.0
54.00 05400 RADI OLOGY-DI AGNOSTI C	975, 14					54.0
54.01 05401 RADIOLOGY - ULTRASOUND	115, 64					54.0
55. 00 05500 RADI OLOGY-THERAPEUTI C	258, 23	2 19, 570, 831			0	55.0
55.01 05501 INFUSION CENTER	6, 56				0	55.0
56. 00 05600 RADI OI SOTOPE	178, 01				81	56.0
57.00 05700 CT SCAN	243, 12			.4 36, 118	73	57.0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 96,44	4 27, 077, 576			-	58.0
59. 00 05900 CARDI AC CATHETERI ZATI ON	224, 99					59.0
50. 00 06000 LABORATORY	636, 02	4 188, 928, 767	0. 00336	6 175, 235	590	60.0
60.01 06001 BLOOD LABORATORY		D C	0.00000	0 0	0	60.0
51.00 06100 PBP CLINICAL LAB SERVICES-PR	GM ONLY					61.0
52.00 06200 WHOLE BLOOD & PACKED RED BLO	OD CELLS 28, 41	9 10, 361, 291	0.00274	3 10, 682	29	62.0
53.00 06300 BLOOD STORING, PROCESSING &	TRANS.	D C	0. 00000	0 0	0	63.0
54.00 06400 INTRAVENOUS THERAPY		D C	0. 00000	0 0	0	64.0
5. 00 06500 RESPI RATORY THERAPY	187, 36			4, 315	21	65.0
6. 00 06600 PHYSI CAL THERAPY	228, 05	2 7, 536, 136	0. 03026	3, 442	104	66.0
57.00 06700 OCCUPATI ONAL THERAPY	194, 94	5 5, 639, 108	0. 03457	0 660	23	67.0
58.00 06800 SPEECH PATHOLOGY	36, 36	6 2, 523, 295	0. 01441	2 0	0	68.0
59. 00 06900 ELECTROCARDI OLOGY	21, 91	2 22, 476, 024	0. 00097	21, 916	21	69.0
59. 01 06901 CARDI AC REHAB	4, 30	1 965, 245			0	69.0
70.00 07000 ELECTROENCEPHALOGRAPHY	28, 18	24, 891, 183			0	70.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO	PATIENTS 424, 35	4 48, 174, 273			21	71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIEN	TS 402, 52	1 27, 747, 861	0. 01450	06 0	0	72.0
73.00 07300 DRUGS CHARGED TO PATIENTS	542, 08	160, 034, 418			1, 575	73.0
74.00 07400 RENAL DIALYSIS	96, 02	5 10, 148, 623	0. 00946	2 124, 434	1, 177	74.0
OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					1
90. 00 09000 CLINIC	1, 362, 29	23, 062, 202	0. 05907	0 0	0	90.0
91.00 09100 EMERGENCY	679, 80	3 75, 213, 874	0. 00903	8 27,650	250	91.0
92.00 09200 OBSERVATION BEDS (NON-DISTIN	CT PART)	25, 841, 129	0. 00000	0 0	0	92.00

Health Financial Systems	METHODI ST HOSI	PITALS, INC		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider CO	CN: 15-0002	Peri od:	Worksheet D	
THROUGH COSTS		Component (CON. 15 COOD	From 01/01/2020) Part IV	norod.
		component (CCN: 15-S002	To 12/31/2020	Date/Time Pre 7/23/2021 10:	58 am
		Title	XVIII	Subprovider -	PPS	<u></u>
				I PF		
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS		-		-	-	
50. 00 05000 OPERATING ROOM	0	0		0 0	°	50.00
50. 01 05001 ENDOSCOPY	0	0		0 0	, v	50.01
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	0	0		0 0	0	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
55. 01 05501 INFUSI ON CENTER	0	0		0 0	0	55.01
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	56.00
57. 00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0		0	0	60.01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0				61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0	0		0		64.00 65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0		67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0		69.00
69. 01 06901 CARDI AC REHAB	0	0		0		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0		70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0		73.00
74. 00 07400 RENAL DIALYSIS	0	0				74.00
OUTPATIENT SERVICE COST CENTERS	0	0		0 (<u>л</u> 0	74.00
90. 00 09000 CLINIC	0	0		0 (0	90.00
91. 00 09100 EMERGENCY	0	0		0 0	-	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		õ	0	92.00
200.00 Total (lines 50 through 199)	0	0		0 0	972, 117	
		0	I	-1	······································	

PORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE ROUGH COSTS	RVICE OTHER PAS		1	Period: From 01/01/2020 Fo 12/31/2020		
		Title	XVIII	Subprovider -	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)	cols. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVICE COST CENTERS	-	-				
. 00 05000 OPERATING ROOM	0	-		130, 634, 836		
. 01 05001 ENDOSCOPY	0	-		12, 103, 945	0.000000	
. 00 05100 RECOVERY ROOM	0	0		9, 100, 944	0.000000	
. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		4, 588, 061	0.000000	
. 00 05300 ANESTHESI OLOGY	0	0		0 0	0.000000	
. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		37, 599, 891	0.000000	
. 01 05401 RADI OLOGY - ULTRASOUND	0	0		20, 083, 443	0.000000	
. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		19, 570, 831	0.000000	
. 01 05501 I NFUSI ON CENTER	0	0		25, 146		
. 00 05600 RADI OI SOTOPE	0	0		12, 882, 091	0.000000	
. 00 05700 CT SCAN	0	0		120, 119, 715	0.000000	
. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		27,077,576	0.000000	
. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		64, 798, 733	0.000000	
. 00 06000 LABORATORY	0	0		188, 928, 767	0.000000	
. 01 06001 BLOOD LABORATORY	0	0	(0 0	0. 000000	
. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				10 0/1 001	0,000000	61.
. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		10, 361, 291	0.000000	
. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0			0.000000	
. 00 06400 I NTRAVENOUS THERAPY	0			5	0.000000	
. 00 06500 RESPI RATORY THERAPY . 00 06600 PHYSI CAL THERAPY	0				0.000000	
	0			7, 536, 136	0.000000	
. 00 06700 OCCUPATI ONAL THERAPY	0	0		5, 639, 108 2, 523, 295	0.000000	
. 00 06800 SPEECH PATHOLOGY . 00 06900 ELECTROCARDI OLOGY	0			2/020/2/0	0. 000000 0. 000000	
. 00 06900 ELECTROCARDI OLOGY . 01 06901 CARDI AC_REHAB	0				0.000000	
. 00 07000 ELECTROENCEPHALOGRAPHY	0			0 965, 245 0 24, 891, 183	0.000000	
	0	0				
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS . 00 07200 IMPL. DEV. CHARGED TO PATIENTS				0 48, 174, 273 27, 747, 861	0. 000000 0. 000000	
. 00 07200 TMPL. DEV. CHARGED TO PATIENTS				160, 034, 418		
. 00 07300 DRUGS CHARGED TO PATTENTS . 00 07400 RENAL DIALYSIS		,		10, 148, 623	0.000000	
OUTPATIENT SERVICE COST CENTERS	0	0		10, 140, 023	0.00000	1 /4.
. 00 09000 CLINIC	0	0	· · · · · · · · · · · · · · · · · · ·	23, 062, 202	0. 000000	90.
. 00 09000 CEINIC . 00 09100 EMERGENCY	0					
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				25, 841, 129		
0.00 Total (lines 50 through 199)		-		7 1, 130, 208, 886		200.

Health Financial Systems	METHODI ST HOSPI				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLAR	Y SERVICE OTHER PASS	Provider C	CN: 15-0002	Peri od:	Worksheet D	
THROUGH COSTS		Component (CCN: 15-S002	From 01/01/2020 To 12/31/2020		
		Title	XVIII	Subprovider - IPF	PPS	
Cost Center Description	Outpatient	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	h Charges	Pass-Through	
	(col. 6 ÷	, i i i i i i i i i i i i i i i i i i i	Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVICE COST CENTERS	· · ·		•			
50. 00 05000 OPERATI NG 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	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	6, 748		0 1, 105		54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	0. 000000	5, 513		0 444	0	54.01
55. 00 05500 RADI OLOGY THERAPEUTI C	0. 000000	5, 513		0 0	0	55.00
55. 01 05501 I NFUSI ON CENTER	0. 000000	0		0 0	0	55.00
		0		0 0	0	
56. 00 05600 RADI OI SOTOPE	0. 000000	5,843		-	-	56.00
57.00 05700 CT SCAN	0.00000	36, 118		0 2, 527	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0.00000	0		0 0		58.00
59.00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	12, 745		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	175, 235		0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONL						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CEL	LS 0. 000000	10, 682		0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	4, 315		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	3, 442		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	660		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	21, 916		0 536	0	69.00
69. 01 06901 CARDI AC REHAB	0. 000000	0		0 0	0	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN		2, 379		0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	464, 965		0 0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	124, 434		0 0		
OUTPATI ENT SERVICE COST CENTERS		, 101				1
90. 00 09000 CLINIC	0.000000	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 012925	27,650		57 0	0	91.00
					0	1 2 1 . 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR		. 0		0 0	0	92.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider: 15-002 Port 0: Component CCN: 15-002 Worksheet D To Port 0: 12/3/22021 Worksheet D TO Cost Center Description Cost to Drage Ratio Provider - IPF Title XVIII Subprovider - IPF PPS PPS Micri LAPY SERVICE COST CENTERS Drage Ratio Provider - IPF Cost to Drage Ratio Services (See Inst.) Cost to Drage Ratio Services (See Inst.) Cost Provider - Drage Inst.) PPS Services Services (See Inst.) PPS Services PPS Services (See Inst.) 00 0000000 PREATING FOOM Societ Inst.) 0	<u>Health Fina</u>	ncial Systems	METHODI ST HOS	PITALS, INC		In Lie	u of Form CMS-	2552-10
Component CCN: 15-5002 To 12/31/2020 Date/Time Prepared: T2/31/2010 Ba m Title XVIII Subprovider - IPF Transport PPS Cost Center Description Cost to Charge Ratio Cost to Charge Ratio To at 2/31/2020 PPS Cost to Reinbursed PPS Cost Center Description Cost to Charge Ratio Cost to Pert I, col. PPS Cost to Bed & Coins. Pes Services	APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-0002			
Cost Center Description Cost to Charges Charges PPS Cost to Cost to Charges Charges Reinburged Services Cost of Reinburged Services Cost of Reinburged Services PS Services Subject of Subject To Ded & Coins PS Services NCLLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0000 FEATI IN CROM 0.113371 0 <td></td> <td></td> <td></td> <td>Component</td> <td>CCN: 15-5002</td> <td></td> <td></td> <td>narod</td>				Component	CCN: 15-5002			narod
Cost Center Description Cost to Charge Ratio From Worksheet C, PT Cost to Charge Ratio From Worksheet C, PT Cost Relimbursed Subject Cost (see Inst.) Cost Relimbursed Subject Cost (see Inst.) Cost Relimbursed Relimbursed Subject Relimbursed Relimbursed Subject Relimbursed Subject Relimbursed Relimbursed Subject Relimbursed Relimbursed Subject Relimbursed Relimbursed Subject Relimbursed Relim				component	CCN. 13-3002	10 12/31/2020		
Cost Center Description Cost to Charge Ratio From Worksheet C, 9 Cost to Charge Ratio From Worksheet C, 9 Cost Sources Costs Costs (see inst.) 9 0 Cost (see inst.) 0 Cost (see inst.) (see inst.) 9 0 2.00 3.00 4.00 50.00 50.00 50.00 05000 (PECATING ROOM 05000 (PECATING ROOM 05100 RECOVERY ROOM 05100 RECOVERY ROOM 05100 RECOVERY ROOM 05100 RECOVERY ROOM 05100 RECOVERY ROOM 05100 RECOVERY ROOM 05100 INFECOVERY ROOM 05100 INFECOVERY 05100 INFECOVERY ROOM 05100 INFECOVERY ROOM 05100 INFECOVERY 05100 INFECOVERY ROOM 05100 INFECOVERY 05100 INFECOVERY ROOM 05100 INFECOVERY 05100 INFECOVERY 05100 INFECOVERY 05100 INF				Title	e XVIII	Subprovider -		
Cost Center Description Cost to Charge Ratio By Orksheet C, Pert I, col. PPS Rel mbursed Services (see inst.) Cost Rel mbursed Subject To Subject						I PF		
ANCILLARY SERVICE COST CENTERS Centre Rel indursed From Worksheet C, Part I, col. Rel indursed inst.) Rel indursed Services (see Inst.) Rel indursed Subject To Ded. & Coins. Services Not Subject Subject To Ded. & Coins. 0 1.00 2.00 3.00 4.00 5.00 0 05000 (See Inst.) 0 0 0 0 0 0.00 05001 (ENDSCOPY 0.198206 0 0 0 0 50.00 51.00 05000 RECOVERY ROM 0.267309 0 0 0 53.00 51.00 05000 RECOVERY ROM A LABOR ROM 1.351746 0 0 0 0 53.00 51.00 05000 RADI LOGY - ULTRASOUND 0.13594 1.444 0 0 66 54.01 55.01 05500 RADI LOGY - ULTRASOUND 0.13594 1.444 0 0 65.01 55.01 05500 CT SCAN 0.039746 2.527 0 0 0 55.01 56.00 05600 RADI LOGY - ULTRASOUND 0.135301 0 0 0					· · · · · · · · · · · · · · · · · · ·			
Image: Provide of the service of the servic		Cost Center Description						
Worksheet C, Part I, col. inst.) Subject To Ded. & Coins. (see inst.) Subject To Ded. & Coins. (see inst.) MCILLARY SERVICE COST CENTERS -							(see inst.)	
Part I, col. Ped. & Coins. Ded. & Coins. 1.00 2.00 3.00 4.00 5.00 50.00 05000 (DPEATING ROM 0.113371 0 0 0 50.00 50.00 05000 (DPEATING ROM 0.313371 0 0 0 50.00 51.00 05000 (DPENDSCOPY 0.198206 0 0 0 51.00 52.00 05200 (DELIVERY ROM 0.267309 0 0 0 53.00 53.00 05300 ANESTHESI OLOCY 0.200000 0 0 0 53.00 54.01 05400 RADIOLOCY - ULTRASOUND 0.135894 4444 0 0 655.00 55.00 05500 RADIOLOCY - HIERAPEUTI C 0.179252 0 0 0 55.00 55.00 05500 CT SCAN 0.39746 2.527 0 0 0 55.00 59.00 05700 CT SCAN 0.039746 2.527 0 0 0 58.00 59.00 05900 CABDIAL CATHETER LATION								
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201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 0nl y Charges 0 0 201.00			0. 547269					
Only Charges				4,012			430	
5 5	201.00					0		201.00
	202.00			4, 612		0 0	436	202.00

	ncial Systems	METHODIST HOSPITALS, INC D VACCINE COST Provider CCN: 15-00					of Form CMS-2552-1	
PPORTIONMEN	NT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C	CN: 15-0002	Period: From 01/01/2020	Worksheet D Part V		
			Component	CCN: 15-S002	To 12/31/2020		repared D:58 am	
			Titl€	e XVIII	Subprovider - IPF	PPS		
		Cost	s			I		
	Cost Center Description	Cost	Cost]				
		Reimbursed	Reimbursed					
			Services Not					
		Subject To	Subject To					
			ed. & Coins.					
			<u>(see inst.)</u>	-				
ANCLL	LARY SERVICE COST CENTERS	6.00	7.00				_	
	OPERATING ROOM	0	0				50.0	
	ENDOSCOPY	0	0				50.0	
	RECOVERY ROOM	0	0				51.0	
	DELIVERY ROOM & LABOR ROOM	0	0	1			52.0	
	ANESTHESI OLOGY	0	0	1			53.	
	RADI OLOGY-DI AGNOSTI C	0	0				54.	
	RADIOLOGY - ULTRASOUND	0	0				54.	
5.00 05500	RADI OLOGY-THERAPEUTI C	0	0				55.	
5.01 05501	INFUSION CENTER	0	0				55.	
6.00 05600	RADI OI SOTOPE	0	0				56.	
7.00 05700	CT SCAN	0	0				57.	
B. 00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.	
	CARDI AC CATHETERI ZATI ON	0	0				59.	
	LABORATORY	0	0				60.	
	BLOOD LABORATORY	0	0				60.	
	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	_				61.	
	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.	
	BLOOD STORING, PROCESSING & TRANS.	0	0				63.	
	I NTRAVENOUS THERAPY	0	0				64.	
	RESPI RATORY THERAPY PHYSI CAL THERAPY	0	0				65. 66.	
	OCCUPATIONAL THERAPY	0	0				67.	
	SPEECH PATHOLOGY	0	0				68.	
	ELECTROCARDI OLOGY	0	0				69.	
	CARDI AC REHAB	0	0				69.	
	ELECTROENCEPHALOGRAPHY	0	0	1			70.	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0)			71.	
2.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0				72.	
3.00 07300	DRUGS CHARGED TO PATIENTS	0	0				73.	
4.00 07400	RENAL DIALYSIS	0	0				74.	
	TI ENT SERVICE COST CENTERS							
	CLINIC	0	0				90.	
	EMERGENCY	0	0				91.	
	OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.	
00.00	Subtotal (see instructions)	0	0				200.	
	Less PBP Clinic Lab. Services-Program	0					201.	
01.00	Only Charges							

ealth Financial Systems	METHODI ST HOS				u of Form CMS-2	2552-1
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C	CN: 15-0002	Peri od:	Worksheet D	
		Component	CCN: 15-T002	From 01/01/2020 To 12/31/2020	Part II Date/Time Pre	nared
		component	0011. 10 1002	10 12/31/2020	7/23/2021 10:	
		Title	XVIII	Subprovider -	PPS	
				I RF		-
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	1, 221, 669	130, 634, 836				
50. 01 05001 ENDOSCOPY	29, 143	12, 103, 945				50.01
51.00 05100 RECOVERY ROOM	268, 754	9, 100, 944			293	
52.00 05200 DELIVERY ROOM & LABOR ROOM	189, 953	4, 588, 061	0. 04140		0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0. 00000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	975, 145	37, 599, 891	0. 02593		2, 010	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	115, 648	20, 083, 443	0.00575			54.0
55. 00 05500 RADI OLOGY-THERAPEUTI C	258, 232	19, 570, 831	0. 01319	95 131, 892	1, 740	55.0
55.01 05501 INFUSION CENTER	6, 563	25, 146	0. 26099	06 0	0	55.0
56. 00 05600 RADI 0I SOTOPE	178, 011	12, 882, 091	0. 01381			56.00
57. 00 05700 CT SCAN	243, 120	120, 119, 715		24 128, 397	260	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	96, 444	27,077,576			248	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	224, 990	64, 798, 733	0.00347	2 35, 044	122	59.00
50. 00 06000 LABORATORY	636, 024	188, 928, 767	0.00336	6 739, 931	2, 491	60.00
50. 01 06001 BLOOD LABORATORY	0	0	0.00000	0 0	0	60.0
51.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.0
52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	28, 419	10, 361, 291	0.00274	3 27, 409	75	62.0
53. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000	0 0	0	63.0
54.00 06400 INTRAVENOUS THERAPY	0	0	0.00000	0 0	0	64.0
55. 00 06500 RESPI RATORY THERAPY	187, 360	38, 080, 245	0. 00492	20 262, 024	1, 289	65.0
56. 00 06600 PHYSI CAL THERAPY	228, 052	7, 536, 136	0. 03026	1, 325, 831	40, 121	66.00
57.00 06700 OCCUPATI ONAL THERAPY	194, 945	5, 639, 108	0. 03457	70 1, 143, 885	39, 544	67.0
58.00 06800 SPEECH PATHOLOGY	36, 366	2, 523, 295	0. 01441	2 120, 199	1, 732	68.00
59. 00 06900 ELECTROCARDI OLOGY	21, 912	22, 476, 024	0.00097		27	69.00
59. 01 06901 CARDI AC REHAB	4, 301	965, 245			0	69.0
0.00 07000 ELECTROENCEPHALOGRAPHY	28, 189	24, 891, 183			12	70.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	424, 354	48, 174, 273	0.00880		848	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	402, 521	27, 747, 861	0. 01450	26, 030	378	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	542, 080	160, 034, 418			6, 050	73.00
74.00 07400 RENAL DIALYSIS	96, 025	10, 148, 623	0.00946	206, 721	1, 956	74.00
OUTPATIENT SERVICE COST CENTERS						
20. 00 09000 CLINIC	1, 362, 290	23, 062, 202				90.00
91.00 09100 EMERGENCY	679, 803	75, 213, 874			16	•
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	25, 841, 129	0.00000	0 0	0	92.00
200.00 Total (lines 50 through 199)		1, 130, 208, 886		6, 484, 922	101, 518	

Health Financial Systems	METHODI ST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C	CN: 15-0002	Peri od:	Worksheet D	
THROUGH COSTS		Composite	20N 15 T002	From 01/01/2020	Part IV	
		component	CCN: 15-T002	To 12/31/2020	Date/Time Pre 7/23/2021 10:	pared: 58 am
		Title	XVIII	Subprovider -	PPS	<u>50 ann</u>
		1110		IRF	110	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS					_	
50.00 05000 OPERATING ROOM	0	0		0 0	0	50.00
50. 01 05001 ENDOSCOPY	0	0		0 0	0	50.01
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
54. 01 05401 RADI OLOGY – ULTRASOUND	0	0		0 0	0	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
55.01 05501 INFUSION CENTER	0	0		0 0	0	55.01
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	56.00
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0		0 0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
69. 01 06901 CARDI AC REHAB	0	0		0 0	0	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
74.00 O7400 RENAL DIALYSIS	0	0		0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS				-	-	
90. 00 09000 CLINIC	0	0		0 0	-	
91.00 09100 EMERGENCY	0	0		0 0		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	~		U O	0	92.00
200.00 Total (lines 50 through 199)	0	0	l	0 0	972, 117	∠UU. UU

PORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE ROUGH COSTS	RVICE OTHER PAS		1	Period: From 01/01/2020 Fo 12/31/2020		
		Title	XVIII	Subprovider -	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)	cols. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS	-					
00 05000 OPERATING ROOM	0	-		130, 634, 836		
01 05001 ENDOSCOPY	0	-		12, 103, 945	0.000000	
. 00 05100 RECOVERY ROOM	0	0		9, 100, 944	0.000000	
. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		4, 588, 061	0.000000	
. 00 05300 ANESTHESI OLOGY	0	0		0 0	0.000000	
. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		37, 599, 891	0.000000	
. 01 05401 RADI OLOGY - ULTRASOUND	0	0		20, 083, 443	0.000000	
. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		19, 570, 831	0.000000	
. 01 05501 I NFUSI ON CENTER	0	0		25, 146		
. 00 05600 RADI 0I SOTOPE	0	0		12, 882, 091	0.000000	
. 00 05700 CT SCAN	0	0		120, 119, 715	0.000000	
00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		27, 077, 576	0.000000	
. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	(64, 798, 733	0.000000	
. 00 06000 LABORATORY	0	0	(188, 928, 767	0.000000	
. 01 06001 BLOOD LABORATORY	0	0	(0 0	0.000000	
. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				10.0/1.001		61.
. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		10, 361, 291	0.000000	
. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0.000000	
. 00 06400 I NTRAVENOUS THERAPY	0	0		0	0.000000	
. 00 06500 RESPIRATORY THERAPY	0	0		38, 080, 245	0.000000	
. 00 06600 PHYSI CAL THERAPY	0	0		7, 536, 136	0.000000	
. 00 06700 OCCUPATI ONAL THERAPY	0	0		5, 639, 108 2, 523, 295	0.000000	
. 00 06800 SPEECH PATHOLOGY . 00 06900 ELECTROCARDI OLOGY	0			2/020/2/0	0. 000000 0. 000000	
. 01 06901 CARDI AC_REHAB	0				0.000000	
. 00 07000 ELECTROENCEPHALOGRAPHY	0				0.000000	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				24, 891, 183 48, 174, 273	0.000000	
. 00 07200 IMPL. DEV. CHARGED TO PATIENTS				27, 747, 861	0.000000	
. 00 07200 TMPL. DEV. CHARGED TO PATTENTS				160, 034, 418		
. 00 07400 RENAL DIALYSIS		°		10, 148, 623	0.000000	
OUTPATIENT SERVICE COST CENTERS	0	0		10, 140, 023	0.000000	/ * .
. 00 09000 CLINIC	0	0	(23, 062, 202	0. 000000	90.
. 00 09100 EMERGENCY	0					
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			25, 841, 129		
0.00 Total (lines 50 through 199)	0	-		1, 130, 208, 886		200.

	ial Systems	METHODI ST HOSPI				eu of Form CMS-	2552-1
	OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-0002	Period: From 01/01/2020	Worksheet D Part IV	
THROUGH COSTS			Component (CCN: 15-T002	To 12/31/2020		nared
			component	50N. 15 1002	10 12/31/2020	7/23/2021 10:	
			Title	XVIII	Subprovider -	PPS	
					I RF		
C	cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Throug		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	
	ARY SERVICE COST CENTERS	0.000000					
	PERATING ROOM	0. 000000	217, 418		0 0		
	NDOSCOPY	0. 000000	18, 194		0 0		
	ECOVERY ROOM	0. 000000	9, 930		0 0		
	ELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0		
	NESTHESI OLOGY	0. 000000	0		0 0		
	ADI OLOGY-DI AGNOSTI C	0. 000000	77, 511		0 0		
	ADIOLOGY - ULTRASOUND	0. 000000	11, 010		0 0		
	ADI OLOGY-THERAPEUTI C	0. 000000	131, 892		0 0		
	NFUSION CENTER	0. 000000	0		0 0		
	ADI OI SOTOPE	0. 000000	11, 983		0 0		
57.00 05700 C		0. 000000	128, 397		0 0		
58.00 05800 M	AGNETIC RESONANCE IMAGING (MRI)	0. 000000	69, 661		0 0	0	58. C
59.00 05900 C	ARDI AC CATHETERI ZATI ON	0. 000000	35, 044		0 0	0	59.0
0.00 06000 L	ABORATORY	0. 000000	739, 931		0 0	0	60.0
0.01 06001 B	LOOD LABORATORY	0. 000000	0		0 0	0	60.0
51.00 06100 P	BP CLINICAL LAB SERVICES-PRGM ONLY						61.0
2.00 06200 W	HOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	27, 409		0 0	0	62.0
3.00 06300 B	LOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.0
4.00 06400 I	NTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.0
5.00 06500 R	ESPI RATORY THERAPY	0. 000000	262, 024		0 0	0	65.0
6.00 06600 P	HYSI CAL THERAPY	0. 000000	1, 325, 831		0 0	0	66.0
7.00 06700 0	CCUPATIONAL THERAPY	0. 000000	1, 143, 885		0 0	0	67.0
8. 00 06800 S	PEECH PATHOLOGY	0. 000000	120, 199		0 0	0	68.0
9.00 06900 E	LECTROCARDI OLOGY	0. 000000	27, 243		0 0	0	69.0
	ARDI AC REHAB	0. 000000	0		0 0	0	69.0
	LECTROENCEPHALOGRAPHY	0. 000000	10, 415		0 0		
	IEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 000000	96, 241		0 0	0	
	MPL. DEV. CHARGED TO PATIENTS	0. 000000	26,030		0 0		
	RUGS CHARGED TO PATIENTS	0. 000000	1, 786, 137		0 0		
	ENAL DIALYSIS	0. 000000	206, 721		0 0		
	ENT SERVICE COST CENTERS	1.111500					1
0.00 09000 C		0. 000000	0		0 0	0	90.0
	MERGENCY	0. 012925	1, 816		23 0		
	BSERVATION BEDS (NON-DISTINCT PART)	0. 000000	1,010		0 0		
	otal (lines 50 through 199)	0.000000	6, 484, 922		23 0		200.0

	Financial Systems METHODIST HOSPITA ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0002	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 01/01/2020 To 12/31/2020	Date/Time Pre 7/23/2021 10:	
		Title XVIII	Hospi tal	PPS	1
	Cost Center Description		·	1.00	
	PART I - ALL PROVIDER COMPONENTS				
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	excluding newborn)		78, 264	1 1.
	Inpatient days (including private room days, excluding swing-b			78, 264	
00	Private room days (excluding swing-bed and observation bed day	s). If you have only p	rivate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	d davs)		63, 491	4
00	Total swing-bed SNF type inpatient days (including private roo		er 31 of the cost	0	5
00	reporting period Total swing-bed SNF type inpatient days (including private roo	m davs) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line)	in days) arter becember	ST OF the cost	0	
00	Total swing-bed NF type inpatient days (including private room	days) through Decembe	r 31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private room	days) after December	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)	5.1		Ũ	
00	Total inpatient days including private room days applicable to newborn days) (see instructions)	the Program (excludin	g swing-bed and	19, 768	9
. 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			0	11
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, en		room days) arter	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		te room days)	0	12
. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	only (including priva	te room days)	0	13
00	after December 31 of the cost reporting period (if calendar ye			0	
	Medically necessary private room days applicable to the Program			0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT		1		
. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	s through December 31	of the cost	0.00	17
. 00	Medicare rate for swing-bed SNF services applicable to service	s after December 31 of	the cost	0.00	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 o	f the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of	the cost	0.00	20
00	reporting period	`		74 004 040	
	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ting period (line	74, 921, 043 0	
	5 x line 17)		0 1		22
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporti	ng period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through December	31 of the cost report	ing period (line	0	24
	7 x line 19)			_	
. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	ι υτ τηe cost reportin	y period (line 8	0	25
	Total swing-bed cost (see instructions)			0	
. 00	General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	line 21 minus line 26)		74, 921, 043	27
. 00	General inpatient routine service charges (excluding swing-bed	and observation bed c	harges)	0	28
	Private room charges (excluding swing-bed charges)		0	0	
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)	1111e 20)		0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33
	Average per diem private room charge differential (line 32 min		ctions)	0.00	
	Average per diem private room cost differential (line 34 x lin	e 31)		0.00	
	Private room cost differential adjustment (line 3 x line 35)	nd privata saam aast -	fforontial (11-	0	
. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	nu private room cost d	inerential (IIne	74, 921, 043	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS			057.00	1
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			957. 29 18, 923, 709	
	Medically necessary private room cost applicable to the Progra	-		10, 723, 707	
. 00					

leal th Financial Systems COMPUTATION OF INPATIENT OPERATING COST	METHODI ST HOSE		CN: 15-0002	Period:	u of Form CMS-: Worksheet D-1		
Some of Africa of The Africa of Ekaring Cost			CN. 13-0002	From 01/01/2020			
				To 12/31/2020	Date/Time Pre 7/23/2021 10:		
			XVIII	Hospital Program Days	PPS		
Cost Center Description	Cost Center Description Total Total Average Per Inpatient Inpatient Diem (col.				Program Cost (col. 3 x		
	Cost	Days	÷ col . 2)	1	col. 4)		
	1.00	2.00	3.00	4.00	5.00		
12.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.0	00 0	0	42.00	
43. 00 INTENSIVE CARE UNIT	16, 633, 512	9, 403	1, 768. 9	3, 100	5, 483, 776	43.00	
43.01 NEONATAL I CU	3, 313, 138	3, 047			0		
44.00 CORONARY CARE UNI T						44.00	
45.00 BURN INTENSIVE CARE UNIT 46.00 SURGICAL INTENSIVE CARE UNIT						45.00 46.00	
47.00 OTHER SPECIAL CARE (SPECIFY)						40.00	
Cost Center Description						17100	
					1.00		
48.00 Program inpatient ancillary service cost (W4 49.00 Total Program inpatient costs (sum of lines			onc)		25, 690, 063 50, 097, 548		
PASS THROUGH COST ADJUSTMENTS		see mistruction	0115)		50, 097, 546	49.00	
50.00 Pass through costs applicable to Program inp	patient routine	services (fro	m Wkst. D, su	m of Parts I and	1, 760, 760	50.00	
					1 000 700		
51.00 Pass through costs applicable to Program inp and IV)	batient ancillar	y services (f	rom Wkst. D,	sum of Parts II	1, 089, 793	51.00	
52.00 Total Program excludable cost (sum of lines	50 and 51)				2, 850, 553	52.00	
53.00 Total Program inpatient operating cost exclu	uding capital re	lated, non-ph	ysician anest	hetist, and	47, 246, 995		
medical education costs (line 49 minus line	52)					-	
TARGET AMOUNT AND LIMIT COMPUTATION 54.00 Program discharges					0	54.00	
55.00 Target amount per discharge	0.00						
56.00 Target amount (line 54 x line 55)					0		
57.00 Difference between adjusted inpatient operat	ting cost and ta	rget amount (line 56 minus	line 53)	0		
8.00 Bonus payment (see instructions) 0.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the							
market basket	sporting period	enuring 1990,		ompounded by the	0.00	59.00	
60.00 Lesser of lines 53/54 or 55 from prior year					0.00		
51.00 If line 53/54 is less than the lower of line					0	61.00	
which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% c	r the target			
52.00 Relief payment (see instructions)					0	62.00	
53.00 Allowable Inpatient cost plus incentive paym	nent (see instru	ctions)			0	63.00	
PROGRAM INPATIENT ROUTINE SWING BED COST 54.00 Medicare swing-bed SNF inpatient routine cost	te through Doco	mbor 21 of th	a cast report	ing pariod (Saa	0	64.00	
64.00 Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts through bece		e cost report	riig period (see	0	04.00	
55.00 Medicare swing-bed SNF inpatient routine cos	sts after Decemb	er 31 of the	cost reportir	g period (See	0	65.00	
instructions)(title XVIII only)		(A)					
56.00 Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66.00	
57.00 Title V or XIX swing-bed NF inpatient routir	ne costs through	December 31	of the cost r	eporting period	0	67.00	
(line 12 x line 19)	-						
58.00 Title V or XIX swing-bed NF inpatient routir	ne costs after D	ecember 31 of	the cost rep	orting period	0	68.00	
(line 13 x line 20) 59.00 Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + lin	e 68)		0	69.00	
PART III - SKILLED NURSING FACILITY, OTHER N							
70.00 Skilled nursing facility/other nursing facil	2		•)		70.00	
71.00 Adjusted general inpatient routine service of		ine 70 ÷ line	2)			71.00	
72.00 Program routine service cost (line 9 x line 73.00 Medically necessary private room cost applic		(line 14 x l	ine 35)			72.00	
74.00 Total Program general inpatient routine serv	, e	•				74.00	
75.00 Capital-related cost allocated to inpatient	routine service	costs (from	Worksheet B,	Part II, column		75.00	
26, line 45) 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 Inpatient routine service cost (line 74 minu	us line 77)					78.00	
79.00 Aggregate charges to beneficiaries for exces				pup 11 70)		79.00	
30.00 Total Program routine service costs for comp 31.00 Inpatient routine service cost per diem limi		UST IIMITATIO	n (iine /8 mi	nus i ne 79)		80.00	
32.00 Inpatient routine service cost per drem rim)				82.00	
33.00 Reasonable inpatient routine service costs ((see instruction					83.00	
84.00 Program inpatient ancillary services (see in		>				84.00	
35.00 Utilization review – physician compensation 36.00 Total Program inpatient operating costs (sur						85.00 86.00	
PART I V - COMPUTATION OF OBSERVATION BED PAS		i ougir 00)			1	00.00	
37.00 Total observation bed days (see instructions					14, 773	87.00	
38.00 Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			957.29	88.00	
39.00 Observation bed cost (line 87 x line 88) (se		,			14, 142, 045	00 01	

Health Financial Systems	METHODI ST HOS	PITALS, INC		In Lieu of Form CMS-2552			
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2020	Worksheet D-1		
				To 12/31/2020		pared: 58 am	
		Title	XVIII	Hospi tal	PPS		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line	column 2	Observati on	Bed Pass		
		21)		Bed Cost	Through Cost		
				(from line	(col. 3 x		
				89)	col. 4) (see		
					instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST						
90.00 Capital-related cost	6, 318, 521	74, 921, 043	0.08433	6 14, 142, 045	1, 192, 684	90.00	
91.00 Nursing School cost	0	74, 921, 043	0.00000	0 14, 142, 045	0	91.00	
92.00 Allied health cost	0	74, 921, 043	0.00000	0 14, 142, 045	0	92.00	
93.00 All other Medical Education	0	74, 921, 043	0.00000	0 14, 142, 045	0	93.00	

INPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0002	Period: From 01/01/2020	Worksheet D-1	
		Component CCN: 15-S002	To 12/31/2020	Date/Time Pre 7/23/2021 10:	
		Title XVIII	Subprovider -	PPS	<u>50 a</u>
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
~~	INPATIENT DAYS			0.545	
00 00	Inpatient days (including private room days and swing-bed da Inpatient days (including private room days, excluding swing			2, 515 2, 515	1. 2.
00	Private room days (excluding swing-bed and observation bed d		rivate room davs	2, 515	3.
00	do not complete this line.		i i varo i oom aajo,	0	
00	Semi-private room days (excluding swing-bed and observation	5 /		2, 515	
00	Total swing-bed SNF type inpatient days (including private r	room days) through Decemb	er 31 of the cost	0	5
00	reporting period	and dave) ofter December	21 of the east	0	
00	Total swing-bed SNF type inpatient days (including private r reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private ro	om days) through Decembe	r 31 of the cost	0	7
	reporting period			0	
00	Total swing-bed NF type inpatient days (including private ro	oom days) after December	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable	to the Program (excludin	g swing-bed and	949	9
00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII	only (including private	room davc)	0	10
00	through December 31 of the cost reporting period (see instru		room uays)	0	
00	Swing-bed SNF type inpatient days applicable to title XVIII		room davs) after	0	11
	December 31 of the cost reporting period (if calendar year,			-	
00	Swing-bed NF type inpatient days applicable to titles V or X	(IX only (including priva	te room days)	0	12
~ ~	through December 31 of the cost reporting period				
00	Swing-bed NF type inpatient days applicable to titles V or X after December 31 of the cost reporting period (if calendar			0	13
00	Medically necessary private room days applicable to the Prog			0	14
	Total nursery days (title V or XIX only)		uuys)	0	
	Nursery days (title V or XIX only)			0	16
	SWING BED ADJUSTMENT				
00	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31	of the cost	0.00	17
00	reporting period Medicare rate for swing-bed SNF services applicable to servi	cos after December 21 of	the cost	0.00	10
00	reporting period	ces al tel December 31 01	the cost	0.00	
00	Medicaid rate for swing-bed NF services applicable to servic	es through December 31 o	f the cost	0.00	19
	reporting period	-			
00	Medicaid rate for swing-bed NF services applicable to servic	es after December 31 of	the cost	0.00	20
00	reporting period Total general inpatient routine service cost (see instructio			2, 232, 657	21
00	Swing-bed cost applicable to SNF type services through Decem		ting period (line		
00	5 x line 17)	bei 31 01 the cost repor	ting period (inte	0	22
00	Swing-bed cost applicable to SNF type services after Decembe	er 31 of the cost reporti	ng period (line 6	0	23
	x line 18)				
00	Swing-bed cost applicable to NF type services through Decemb	per 31 of the cost report	ing period (line	0	24
00	7 x line 19) Swing had east appliable to NE type convises often December	21 of the east reporting	a partial (line 0	0	25
00	Swing-bed cost applicable to NF type services after December x line 20)	ST OF THE COST REPORTIN		0	25
. 00	Total swing-bed cost (see instructions)			0	26
00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 232, 657	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
00	General inpatient routine service charges (excluding swing-b	ed and observation bed c	harges)	0	
00 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
00	General inpatient routine service cost/charge ratio (line 27	'÷line 28)		0. 000000	
00	Average private room per diem charge (line 29 ÷ line 3)	20)		0.00	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
00	Average per diem private room charge differential (line 32 m		ctions)	0.00	
00	Average per diem private room cost differential (line 34 x l			0.00	
00	Private room cost differential adjustment (line 3 x line 35)		fforontial (11	0	36
00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost d	illerential (line	2, 232, 657	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD	JUSTMENTS			1
00	Adjusted general inpatient routine service cost per diem (se			887.74	38
. 00	Program general inpatient routine service cost (line 9 x lin			842, 465	
	Medically necessary private room cost applicable to the Prog			0	
	Total Program general inpatient routine service cost (line 3	9 + Line 4())		842, 465	41

MPUTATI ON	ncial Systems I OF INPATIENT OPERATING COST	METHODIST HOS		CN: 15-0002	Period: From 01/01/2020	u of Form CMS- Worksheet D-1	
			Component	CCN: 15-S002	To 12/31/2020		
			Title	e XVIII	Subprovider -	PPS	50 8
	Cost Center Description	Total I npati ent Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	ERY (title V & XIX only) nsive Care Type Inpatient Hospital Units	0	C	0.	00 0	C	42
	NSIVE CARE UNIT	0	0	0.	00 0	C	43
	ATAL ICU	0	C	0.	00 0	c c	
	NARY CARE UNIT INTENSIVE CARE UNIT						44
	ICAL INTENSIVE CARE UNIT						45
	R SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	
00 Prog	ram inpatient ancillary service cost (Wk	st D_3 col 3	3 line 200)			1.00	9 48
	I Program inpatient costs (sum of lines			ons)		1, 009, 134	
PASS	THROUGH COST ADJUSTMENTS	<u> </u>	•	,			
	through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, su	um of Parts I and	35, 739	9 5C
00 Pass	through costs applicable to Program inp	atient ancillar	ry services (f	rom Wkst D	sum of Parts II	4, 573	51
and	o 11 o 1		, 301 VI 063 (I	. Sin WKSt. D,	can or runto II	+, 575	
00 Tota	Program excludable cost (sum of lines					40, 312	
	I Program inpatient operating cost exclu	0 1	elated, non-ph	ysi ci an anest	thetist, and	968, 822	2 53
	cal education costs (line 49 minus line ET AMOUNT AND LIMIT COMPUTATION	52)				1	1
00 Prog	ram di scharges					C	
00 Target amount per discharge 00 Target amount (line 54 x line 55)							$55 \\ 56 \\ 56 \\ 56 \\ 56 \\ 56 \\ 56 \\ 56 \\$
	et amount (IINe 54 X IINe 55) erence between adjusted inpatient operat	ing cost and ta	arget amount (line 56 minus	s line 53)		
	s payment (see instructions)	9 1991 and 10	ger amount (C C	
00 Less	er of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and o	compounded by the	0.00	5
	et basket er of lines 53/54 or 55 from prior year	cost roport ur	dated by the	markat backat	F	0.00	60
	ine 53/54 is less than the lower of line					0.00	
	h operating costs (line 53) are less tha						
	nt (line 56), otherwise enter zero (see	instructions)					
1	ef payment (see instructions) wable Inpatient cost plus incentive paym	ent (see instru	(ctions)				
	RAM INPATIENT ROUTINE SWING BED COST						1 00
	care swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost report	ting period (See	C	64
	ructions)(title XVIII only) care swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the	cost reportir	na period (See	c c	65
	ructions)(title XVIII only)				ig poir ou (ooo		
	I Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	ll only). For	C	66
	(see instructions) e V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost r	cenorting period		67
	e 12 x line 19)		r becember 51	of the cost i	cporting period		<u> </u> 0,
	e V or XIX swing-bed NF inpatient routin	e costs after [December 31 of	the cost rep	porting period	C	68
	e 13 x line 20) I title V or XIX swing-bed NF inpatient	routine costs /	(line 67 ± lin	o 68)		C	69
	III - SKILLED NURSING FACILITY, OTHER N						1 0,
	led nursing facility/other nursing facil	2		•	7)		70
1 3	sted general inpatient routine service c ram routine service cost (line 9 x line		ıne 70 ÷ line	2)			71
1 5	cally necessary private room cost applic		n (line 14 x l	ine 35)			73
00 Tota	I Program general inpatient routine serv	ice costs (line	e 72 + line 73)			74
	tal-related cost allocated to inpatient line 45)	routine service	e costs (from	Worksheet B,	Part II, column		75
	diem capital-related costs (line 75 ÷ li	ne 2)					76
	ram capital-related costs (line 9 x line						77
	tient routine service cost (line 74 minu egate charges to beneficiaries for exces		rovider recor	ds)			78
	I Program routine service costs for comp				nus line 79)		80
00 I npa	tient routine service cost per diem limi	tation					81
	tient routine service cost limitation (I						82
	onable inpatient routine service costs (ram inpatient ancillary services (see in		15)				83
	ization review - physician compensation		ons)				85
. 00 <u>Tota</u>	I Program inpatient operating costs (sum	of lines 83 th					86
	IV - COMPUTATION OF OBSERVATION BED PAS						1 0-
	l observation bed days (see instructions sted general inpatient routine cost per		÷line 2)			0. 00	
. ()() IAALU						0.00	1 00

Health Financial Systems	th Financial Systems METHODIST HOSPITALS, INC					2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period: From 01/01/2020	Worksheet D-1	
		Component (Component CCN: 15-SOO2		Date/Time Pre 7/23/2021 10:	pared: 58 am
		Title	XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	94, 726	2, 232, 657	0. 04242	27 0	0	90.00
91.00 Nursing School cost	0	2, 232, 657	0.0000	0 00	0	91.00
92.00 Allied health cost	0	2, 232, 657	0.0000	0 00	0	92.00
93.00 All other Medical Education	0	2, 232, 657	0. 00000	0 00	0	93.00

MPUT	Financial Systems METHODIST HOSPI ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0002	Peri od:	u of Form CMS-2 Worksheet D-1	
		Component CCN: 15-T002	From 01/01/2020 To 12/31/2020	Date/Time Pre	pare
		Title XVIII	Subprovider -	7/23/2021 10: PPS	<u>58 a</u>
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS		I	1.00	
	INPATIENT DAYS				
00	Inpatient days (including private room days and swing-bed day			5, 409	
00	Inpatient days (including private room days, excluding swing			5,409	
00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ays). If you have only p	rivate room days,	0	3
00	Semi-private room days (excluding swing-bed and observation b	hed days)		5,409	4
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0, 107	
	reporting period				
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
~~	reporting period (if calendar year, enter 0 on this line)		- 01 -6 +6+	0	_
00	Total swing-bed NF type inpatient days (including private roor reporting period	om days) (nrough Decembe	r 31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private roo	om davs) after December	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable	to the Program (excludin	g swing-bed and	2, 666	9
00	newborn days) (see instructions)			0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruc		room days)	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		room davs) after	0	11
	December 31 of the cost reporting period (if calendar year, e				
. 00	Swing-bed NF type inpatient days applicable to titles V or XI	IX only (including priva	te room days)	0	12
	through December 31 of the cost reporting period				
. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendary			0	13
. 00	Medically necessary private room days applicable to the Progr			0	14
	Total nursery days (title V or XIX only)			0	
	Nursery days (title V or XIX only)			0	16
	SWING BED ADJUSTMENT		<u> </u>		
. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	ces through December 31	of the cost	0.00	17
. 00	Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	the cost	0.00	18
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19
00	reporting period	ac often December 21 of	the east	0.00	20
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es alter december 31 01	the cost	0.00	20
. 00	Total general inpatient routine service cost (see instruction	ns)		6, 040, 631	21
. 00	Swing-bed cost applicable to SNF type services through Decem		ting period (line		
	5 x line 17)				
. 00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reporti	ng period (line 6	0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost report	ing period (line	0	24
. 00	7 x line 19)			0	2
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25
	x line 20)			_	
. 00 . 00	Total swing-bed cost (see instructions)	(line 21 minus line 24)		0	
. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(TTHE 21 IIITIUS TTHE 20)		6, 040, 631	27
. 00	General inpatient routine service charges (excluding swing-be	ed and observation bed c	narges)	0	28
	Private room charges (excluding swing-bed charges)			0	
00	Semi-private room charges (excluding swing-bed charges)			0	
00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
00 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
00	Average per diem private room charge differential (line 32 mi	inus line 33)(see instru	ctions)	0.00	
00	Average per diem private room cost differential (line 34 x li		,	0.00	
	Private room cost differential adjustment (line 3 x line 35)			0	
. 00	General inpatient routine service cost net of swing-bed cost	and private room cost d	fferential (line	6, 040, 631	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			1
00	Adjusted general inpatient routine service cost per diem (see			1, 116. 77	38
. 00	Program general inpatient routine service cost (line 9 x line	e 38)		2,977,309	39
. 00	Medically necessary private room cost applicable to the Progr			0 2, 977, 309	
	Total Program general inpatient routine service cost (line 39				

MPUTATION OF INPATIENT OPERATING COST		PITALS, INC Provider C	CN: 15-0002	Period: From 01/01/2020	u of Form CMS- Worksheet D-1	
		Component	CCN: 15-T002	To 12/31/2020		
		Title	e XVIII	Subprovider -	PPS	
Cost Center Description	Total Inpatient	Total I npati ent	Average Per Diem (col.		Program Cost (col. 3 x	
	Cost 1.00	Days 2.00	÷ col. 2) 3.00	4.00	col. 4) 5.00	-
00 NURSERY (title V & XIX only)	0	C	0.	00 0	C) 42
Intensive Care Type Inpatient Hospital Ur 00 INTENSIVE CARE UNIT			0.	00 0	С	0 43
01 NEONATAL I CU	0	C	1			
OO CORONARY CARE UNI T						44
00 BURN INTENSIVE CARE UNIT 00 SURGICAL INTENSIVE CARE UNIT						45
00 OTHER SPECIAL CARE (SPECIFY)						47
Cost Center Description					1.00	
00 Program inpatient ancillary service cost	(Wkst D-3 col 3	Line 200)	-		1.00	3 48
00 Total Program inpatient costs (sum of lin			ons)		4, 637, 782	
PASS THROUGH COST ADJUSTMENTS						
00 Pass through costs applicable to Program [111]	inpatient routine	services (fro	m Wkst. D, sı	um of Parts I and	304, 937	/ 50
00 Pass through costs applicable to Program	inpatient ancillar	y services (f	rom Wkst. D,	sum of Parts II	101, 541	51
and IV)					404 472	
00 Total Program excludable cost (sum of lin 00 Total Program inpatient operating cost ex		lated non-ph	vsician anest	thetist and	406, 478 4, 231, 304	
medical education costs (line 49 minus li	0 1					
TARGET AMOUNT AND LIMIT COMPUTATION						
00 Program discharges 00 Target amount per discharge					0. 00	
00 Target amount (line 54 x line 55)					C	
00 Difference between adjusted inpatient op	erating cost and ta	arget amount (line 56 minus	s line 53)	C	
00 Bonus payment (see instructions)00 Lesser of lines 53/54 or 55 from the cos⁻	t reporting period	onding 1006	undated and d	compounded by the	0. OC	
market basket	t reporting period	ending 1990,		compounded by the	0.00	
00 Lesser of lines 53/54 or 55 from prior ye					0.00	
.00 If line 53/54 is less than the lower of which operating costs (line 53) are less					C) 61
amount (line 56), otherwise enter zero (s		.3 (11163 54 X	00), 01 1/0 0	on the target		
00 Relief payment (see instructions)					C	
00 Allowable Inpatient cost plus incentive PROGRAM INPATIENT ROUTINE SWING BED COST	payment (see instru	ictions)			C) 63
.00 Medicare swing-bed SNF inpatient routine	costs through Dece	mber 31 of th	e cost report	ting period (See	C	64
instructions)(title XVIII only)						
.00 Medicare swing-bed SNF inpatient routine instructions)(title XVIII only)	costs after Decemb	er 31 of the	cost reportir	ng period (See	C	65
.00 Total Medicare swing-bed SNF inpatient re	outine costs (line	64 plus line	65)(title XVI	II only). For	C	66
CAH (see instructions)						
.00 Title V or XIX swing-bed NF inpatient rou (line 12 x line 19)	utine costs through	December 31	of the cost r	reporting period		67
.00 Title V or XIX swing-bed NF inpatient rou (line 13 x line 20)	utine costs after [ecember 31 of	the cost rep	porting period	C	68
00 Total title V or XIX swing-bed NF inpatie	<u>ent routine costs (</u>	<u>line 67 + l</u> in	e 68)		C	69
PART III - SKILLED NURSING FACILITY, OTHE				7)		
00 Skilled nursing facility/other nursing fa 00 Adjusted general inpatient routine servio	2		•	()		70
00 Program routine service cost (line 9 x li			_/			72
00 Medically necessary private room cost ap	U U	•				73
 00 Total Program general inpatient routines 00 Capital-related cost allocated to inpatie 26 Lipo 45 			·	Part II, column		74
26, line 45) 00 Per diem capital-related costs (line 75 ·	÷line 2)					76
00 Program capital-related costs (line 9 x)	line 76)					77
00 Inpatient routine service cost (line 74 m 00 Aggregate charges to beneficiaries for ex	,	rovidor rocar	de)			78
00 Aggregate charges to beneficiaries for ex 00 Total Program routine service costs for ex				nus line 79)		80
00 Inpatient routine service cost per diem	limitation					81
.00 Inpatient routine service cost limitation	•					82
 00 Reasonable inpatient routine service cos 00 Program inpatient ancillary services (see 		15)				83
00 Utilization review - physician compensati		ons)				85
00 Total Program inpatient operating costs		nrough 85)				86
PART IV - COMPUTATION OF OBSERVATION BED 00 Total observation bed days (see instruction					С	0 87
00 Adjusted general inpatient routine cost		line 2)			0.00	
00 Observation bed cost (line 87 x line 88)						89

Health Financial Systems	th Financial Systems METHODIST HOSPITALS, INC					2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2020	Worksheet D-1	
		Component (Component CCN: 15-T002		Date/Time Pre 7/23/2021 10:	
		Title	XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		, i		(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	618, 701	6, 040, 631	0. 10242	23 0	0	90.00
91.00 Nursing School cost	0	6, 040, 631	0.0000	0 0	0	91.00
92.00 Allied health cost	0	6, 040, 631	0.0000	0 0	0	92.00
93.00 All other Medical Education	0	6, 040, 631			0	93.00

JVIPU	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0002	Period: From 01/01/2020	Worksheet D-1	
			To 12/31/2020	Date/Time Pre 7/23/2021 10:	
	Cost Center Description	Title XIX	Hospi tal	Cost	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	vs excluding newborn)		78, 264	1 1.
00	Inpatient days (including private room days, excluding swing-	bed and newborn days)		78, 264	
00	Private room days (excluding swing-bed and observation bed da do not complete this line.	nys). If you have only p	rivate room days,	0	3.
00	Semi-private room days (excluding swing-bed and observation b	ed days)		63, 491	4.
00	Total swing-bed SNF type inpatient days (including private ro reporting period	oom days) through Decemb	er 31 of the cost	0	5.
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	m dave) through Decembe	r 31 of the cost	0	7
00	reporting period	in days) through becembe	1 51 01 the cost	0	'
00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	8
00	Total inpatient days including private room days applicable t	o the Program (excludin	g swing-bed and	4, 106	9
00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private	room days)	0	10
00	through December 31 of the cost reporting period (see instruc	tions)	5 .		
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e		room days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12
. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	13
	after December 31 of the cost reporting period (if calendar y	ear, enter 0 on this li	ne)		
00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	ram (excluding swing-bed	days)	0 2, 545	
	Nursery days (title V or XIX only)			0	
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	es through December 31	of the cost	0.00	1 17
	reporting period	C			
. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es arter becember 31 of	the cost	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 o	f the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instruction	is)		74, 905, 006	21
. 00	Swing-bed cost applicable to SNF type services through Decemb		ting period (line		
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	ng period (line 6	0	23
~~	x line 18)				
. 00	Swing-bed cost applicable to NF type services through Decembe 7 x line 19)	er 31 of the cost report	ing period (iine	0	24
. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reportin	g period (line 8	0	25
. 00	Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		74, 905, 006	27
. 00	General inpatient routine service charges (excluding swing-be	ed and observation bed c	harges)	0	28
	Private room charges (excluding swing-bed charges)			0	
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷line 28)		0 0. 000000	
00				0.00	
00 00				0.00	33
00 00 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	0.4
00 00 00 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	, ,	ctions)	0.00	34
00 00 00 00 00 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li	, ,	ctions)	0.00 0.00	35
00 00 00 00 00 00 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	, ,	ctions)	0. 00 0. 00 0	35 36
. 00 . 00 . 00 . 00 . 00 . 00 . 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	ne 31)	,	0.00 0.00	35 36
. 00 . 00 . 00 . 00 . 00 . 00 . 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	ne 31) and private room cost d	,	0. 00 0. 00 0	35 36
. 00 . 00 . 00 . 00 . 00 . 00 . 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	ne 31) and private room cost d USTMENTS	,	0. 00 0. 00 0 74, 905, 006	35 36 37
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see	ne 31) and private room cost d USTMENTS e instructions)	,	0.00 0.00 0 74,905,006 957.08	35 36 37 37
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	ne 31) and private room cost d USTMENTS e instructions) e 38)	,	0. 00 0. 00 0 74, 905, 006	35 36 37 38 38

Health Financial Systems COMPUTATION OF INPATIENT OPERAT	ING COST	METHODI ST HOSI	PITALS, INC Provider C	CN: 15-0002 F	Period:	u of Form CMS-2 Worksheet D-1	
				F	rom 01/01/2020		
				1	o 12/31/2020	Date/Time Pre 7/23/2021 10:	
Cont Conton Decemin	41 a.a.	Tatal		e XIX	Hospi tal	Cost	
Cost Center Descrip	tion	Total Inpati ent	Total Inpatient	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
		Cost	Days	÷ col . 2)		col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX or		3, 860, 194	2, 545	1, 516. 78	3 0	0	42.00
43.00 INTENSIVE CARE UNIT	Tent Hospital Units	16, 633, 512	9, 403	1, 768. 96	0	0	43.00
43. 01 NEONATAL I CU		3, 313, 138	3, 047			0	
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGI CAL I NTENSI VE CARE U 47.00 OTHER SPECI AL CARE (SPECI							46.00 47.00
Cost Center Descrip		1		I			47.00
						1.00	
48.00 Program inpatient ancilla				``````````````````````````````````````		3, 210, 282	
49.00 Total Program inpatient of PASS THROUGH COST ADJUSTM		41 through 48)(see instructi	ons)		7, 140, 052	49.00
50.00 Pass through costs applic		atient routine	services (fro	m Wkst D sum	of Parts L and	0	50.00
			30111003 (110			0	50.00
51.00 Pass through costs applie	cable to Program inp	atient ancillar	ry services (f	rom Wkst. D, s	um of Parts II	0	51.00
and IV) 52.00 Total Program excludable	cost (sum of lines	50 and $E(1)$				0	52.00
53.00 Total Program excludable			elated. non-ph	vsician anesth	etist, and	0	
medical education costs (Ū	
TARGET AMOUNT AND LIMIT C	COMPUTATI ON						
54.00 Program di scharges						0 0.00	
55.00 Target amount per dischar 56.00 Target amount (line 54 x						0.00	
57.00 Difference between adjust		ing cost and ta	arget amount (line 56 minus	line 53)	0	1
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							
60.00 Lesser of lines 53/54 or	55 from prior year	cost report ur	dated by the	market hasket		0.00	60.00
61.00 If line 53/54 is less that					the amount by	0.00	1
which operating costs (li	ne 53) are less that	n expected cost					
amount (line 56), otherwi		instructions)					1 1 0 00
62.00 Relief payment (see instr 63.00 Allowable Inpatient cost	0						
PROGRAM INPATIENT ROUTINE							00.00
64.00 Medicare swing-bed SNF in		ts through Dece	ember 31 of th	e cost reporti	ng period (See	0	64.00
65.00 Medicare swing-bed SNF ir		te aftar Dacamh	or 21 of the	cost roporting	pariod (Saa	0	65.00
instructions)(title XVIII			Del 31 OI 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	l only). For	0	66.00
CAH (see instructions)						_	
67.00 Title V or XIX swing-bed (line 12 x line 19)	NF inpatient routin	e costs through	December 31	of the cost re	porting period	0	67.00
68.00 Title V or XIX swing-bed	NF inpatient routin	e costs after [ecember 31 of	the cost repo	rtina period	0	68.00
(line 13 x line 20)	F				5 1 1		
69.00 Total title V or XIX swir	<u>v</u> .		•			0	69.00
70.00 Skilled nursing facility							70.00
71.00 Adjusted general inpatier							71.00
72.00 Program routine service of							72.00
73.00 Medically necessary priva		, U	•				73.00
74.00 Total Program general inp 75.00 Capital-related cost allo		•			art II column		74.00 75.00
75.00 Capital-related cost allo 26, line 45)	cated to impatient		CUSIS (ITUM	WULKSHEEL B, P	artir, corumn		/5.00
76.00 Per diem capital -related	costs (line 75 ÷ li	ne 2)					76.00
77.00 Program capital -related of	-						77.00
78.00 Inpatient routine service		,	rovidor rocar	de)			78.00 79.00
79.00 Aggregate charges to bene 80.00 Total Program routine ser					us line 79)		80.00
81.00 Inpatient routine service				(. <u>.</u>			81.00
82.00 Inpatient routine service	•						82.00
83.00 Reasonable inpatient rout			is)				83.00
84.00 Program inpatient ancilla 85.00 Utilization review - phys			ns)				84.00 85.00
86.00 Total Program inpatient of	•						86.00
PART IV - COMPUTATION OF	OBSERVATION BED PASS	S THROUGH COST					
87.00 Total observation bed day						14, 773	
88.00 Adjusted general inpatier	nt routine cost per (aiem (line 27 ÷	- iine 2)			957.08	
89.00 Observation bed cost (lir	1000000000000000000000000000000000000	- instructions)				14, 138, 943	80 00

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lieu of Form CMS-255			
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2020	Worksheet D-1		
				To 12/31/2020		pared: 58 am	
		Titl	e XIX	Hospi tal	Cost		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line	column 2	Observati on	Bed Pass		
		21)		Bed Cost	Through Cost		
				(from line	(col. 3 x		
				89)	col. 4) (see		
					instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST						
90.00 Capital-related cost	6, 318, 521	74, 905, 006	0.08435	4 14, 138, 943	1, 192, 676	90.00	
91.00 Nursing School cost	0	74, 905, 006	0.00000	0 14, 138, 943	0	91.00	
92.00 Allied health cost	0	74, 905, 006	0.00000	0 14, 138, 943	0	92.00	
93.00 All other Medical Education	0	74, 905, 006	0.00000	0 14, 138, 943	0	93.00	

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0002	Period:	Worksheet D-1	
		Component CCN: 15-S002	From 01/01/2020 To 12/31/2020	Date/Time Pre 7/23/2021 10:	
		Title XIX	Subprovider -	Cost	<u> </u>
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS		I		
	Inpatient days (including private room days and swing-bed da			2, 515	1.
	Inpatient days (including private room days, excluding swing Private room days (excluding swing-bed and observation bed o		rivato room dave	2, 515 0	2
00	do not complete this line.	aays). Ti you have only p	rivate room days,	0	
00	Semi-private room days (excluding swing-bed and observation	bed days)		2, 515	4
00	Total swing-bed SNF type inpatient days (including private r	room days) through Decemb	er 31 of the cost	0	5
	reporting period		04		
00	Total swing-bed SNF type inpatient days (including private r reporting period (if calendar year, enter 0 on this line)	room days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private ro	oom days) through Decembe	r 31 of the cost	0	7
	reporting period			0	
00	Total swing-bed NF type inpatient days (including private ro	oom days) after December	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)			70	
00	Total inpatient days including private room days applicable newborn days) (see instructions)	to the program (excludin	g swing-bed and	70	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII	only (including private	room davs)	0	10
	through December 31 of the cost reporting period (see instru		days)	0	
00	Swing-bed SNF type inpatient days applicable to title XVIII		room days) after	0	11
	December 31 of the cost reporting period (if calendar year,				
. 00	Swing-bed NF type inpatient days applicable to titles V or >	KIX only (including priva	te room days)	0	12
. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or >	(IX only (including priva	te room days)	0	13
	after December 31 of the cost reporting period (if calendar			0	
	Medically necessary private room days applicable to the Proc	gram (excluding swing-bed	days)	0	14
	Total nursery days (title V or XIX only)			2, 545	
	Nursery days (title V or XIX only)			0	16
	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servi	ces through December 31	of the cost	0.00	1 17
	reporting period	ees through becomber of		0.00	
00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost	0.00	18
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to servic reporting period	ces through December 31 o	f the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to servic	ces after December 31 of	the cost	0.00	20
	reporting period				
	Total general inpatient routine service cost (see instruction			2, 232, 657	21
00	Swing-bed cost applicable to SNF type services through Decen	nber 31 of the cost repor	ting period (line	0	22
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after Decembe	or 21 of the cost reporti	ng pariod (line 4	0	23
	x line 18)	er si or the cost reporti	ng period (inne o	0	23
	Swing-bed cost applicable to NF type services through Decemb	per 31 of the cost report	ing period (line	0	24
	7 x line 19)				
. 00	Swing-bed cost applicable to NF type services after December	⁻ 31 of the cost reportin	g period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost	t (line 21 minus line 26)		2, 232, 657	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		I.	2/202/00/	
	General inpatient routine service charges (excluding swing-b	oed and observation bed c	harges)	0	28
	Private room charges (excluding swing-bed charges)			0	29
	Semi-private room charges (excluding swing-bed charges)	$7 \cdot 1$ inc. 28)		0	30
1	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)			0. 000000 0. 00	
	Average semi-private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4))		0.00	
	Average per diem private room charge differential (line 32 m		ctions)	0.00	
	Average per diem private room cost differential (line 34 x l			0.00	35
	Private room cost differential adjustment (line 3 x line 35)			0	36
00	General inpatient routine service cost net of swing-bed cost	t and private room cost d	ifferential (line	2, 232, 657	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD	JUSTMENTS			ł
	Adjusted general inpatient routine service cost per diem (se			887.74	38
. 00	Program general inpatient routine service cost (line 9 x lir	ne 38)		62, 142	39
. 00	Medically necessary private room cost applicable to the Prog			0	40
	Total Program general inpatient routine service cost (line 3	20 + 1 i no (10)		62, 142	1 / 1

OMPUTA	Financial Systems ATION OF INPATIENT OPERATING COST	METHODI ST HOSI	Provider C	CN: 15-0002	Period: From 01/01/2020	u of Form CMS- Worksheet D-1	
			Component	CCN: 15-S002	To 12/31/2020		
			Ti tl	e XIX	Subprovider -	Cost	50 a
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.	00 0	0	42.
E E	INTENSIVE CARE UNIT	0	0	0.	00 0	0	43.
	NEONATAL I CU	0	0	0.	00 0	0	
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44.
	SURGI CAL I NTENSI VE CARE UNI T						46.
. 00	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1.00	
. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			68, 995	i 48.
. 00	Total Program inpatient costs (sum of lines			ons)		131, 137	49.
	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp.	ationt routing	convigos (fro	m Wkat D a	m of Darte L and	0	50.
. 00			Services (110	WK31. D, 30		0	/ 50.
. 00	Pass through costs applicable to Program inpa	atient ancillar	ry services (f	rom Wkst. D,	sum of Parts II	0	51.
. 00	and IV) Total Program excludable cost (sum of lines !	50 and 51)				o	52.
	Total Program inpatient operating cost exclusion		elated, non-ph	ysician anest	thetist, and	0	
	medical education costs (line 49 minus line	5 1		-			1
	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54
	Target amount per discharge					0.00	
	Target amount (line 54 x line 55)					0	
	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	irget amount (line 56 minus	s line 53)	0	
	Lesser of lines 53/54 or 55 from the cost re	porting period	ending 1996,	updated and o	compounded by the		
	market basket	0.1	0		. ,		
	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line					0.00	
	which operating costs (line 53) are less that					0	101
	amount (line 56), otherwise enter zero (see	instructions)			0		
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ont (soo instru	uctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						1 03
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost report	ting period (See	0	64
. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reportir	na neriod (See	0	65
. 00	instructions)(title XVIII only)				ig period (see		/ 00
. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66
. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost r	reporting period	0	67.
. 00	(line 12 x line 19)				opor tring period		/ 0/.
3.00	Title V or XIX swing-bed NF inpatient routing	e costs after [ecember 31 of	the cost rep	oorting period	0	68.
. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient (routine costs (line 67 + lin	e 68)		0	69.
	PART III - SKILLED NURSING FACILITY, OTHER N			,			
	Skilled nursing facility/other nursing facil	2		•	7)		70.
	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		The 70 ÷ The	2)			71
	Medically necessary private room cost application		n (line 14 x l	ine 35)			73
1	Total Program general inpatient routine serv	•			Davet II and when		74
. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (from	worksneet B,	Part II, column		75
. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76
1	Program capital -related costs (line 9 x line						77
	Inpatient routine service cost (line 74 minu: Aggregate charges to beneficiaries for exces		rovi den inecon	ds)			78
	Total Program routine service costs for comp	• •			nus line 79)		80
1	Inpatient routine service cost per diem limi		\ \				81
	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82
1	Program inpatient ancillary services (see in:						84
. 00	Utilization review - physician compensation	(see instructio					85
	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rough 85)				86.
	Total observation bed days (see instructions					0	87.
3. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	,			0.00	88.
00	Observation bed cost (line 87 x line 88) (see	e instructions)				0	89

Health Financial Systems	METHODI ST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	
		Component (CCN: 15-S002	From 01/01/2020 To 12/31/2020		pared: 58 am
		Ti tl	e XIX	Subprovider -	Cost	
				I PF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	94, 726	2, 232, 657	0. 04242	27 0	0	90.00
91.00 Nursing School cost	0	2, 232, 657	0.0000	0 00	0	91.00
92.00 Allied health cost	0	2, 232, 657	0.0000	0 00	0	92.00
93.00 All other Medical Education	0	2, 232, 657	0. 00000	0 00	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0002	Period:	Worksheet D-1	
		Component CCN: 15-T002	From 01/01/2020 To 12/31/2020	Date/Time Pre 7/23/2021 10:	
		Title XIX	Subprovider -	Cost	<u></u>
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
~~	INPATIENT DAYS			F 100	
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			5, 409 5, 409	
00	Private room days (excluding swing-bed and observation bed days)		rivate room davs	5,409	
00	do not complete this line.	gest in you have only p	rivere room days,	0	
00	Semi-private room days (excluding swing-bed and observation I			5, 409	4
00	Total swing-bed SNF type inpatient days (including private re	oom days) through Decemb	er 31 of the cost	0	5
00	reporting period Total swing-bed SNF type inpatient days (including private re	and dave) after December	21 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line)	Som days) at ter becember	31 OF THE COST	0	0
00	Total swing-bed NF type inpatient days (including private roo	om davs) through Decembe	r 31 of the cost	0	7
	reporting period	3 . 0			
00	Total swing-bed NF type inpatient days (including private roo	om days) after December	31 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable	to the Drogram (aveludin	a civiling bod and	195	9
50	newborn days) (see instructions)	to the Frogram (excrudin	y swilly-bed and	195	'
00	Swing-bed SNF type inpatient days applicable to title XVIII (only (including private	room days)	0	10
	through December 31 of the cost reporting period (see instruc		5 .		
00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11
00	December 31 of the cost reporting period (if calendar year, of Swing-bed NF type inpatient days applicable to titles V or XI		to room days)	0	12
. 00	through December 31 of the cost reporting period	IX ONLY (THEFUUTING PITVA	te room uays)	0	'2
. 00	Swing-bed NF type inpatient days applicable to titles V or XI	IX only (including priva	te room days)	0	13
	after December 31 of the cost reporting period (if calendar	year, enter 0 on this li	ne)		
	Medically necessary private room days applicable to the Prog	ram (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only)			2, 545 0	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	
. 00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31	of the cost	0.00	17
	reporting period				
00	Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	the cost	0.00	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19
	reporting period			0.00	
. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20
	reporting period	`			
. 00 . 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ting pariod (ling	6, 040, 631 0	
. 00	5 x line 17)	bei 31 01 the cost repor	ting period (inte	0	22
. 00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reporti	ng period (line 6	0	23
	x line 18)				
. 00	Swing-bed cost applicable to NF type services through December 7×1 (ine 19)	er 31 of the cost report	ing period (line	0	24
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	a period (line 8	0	25
	x line 20)		9 p	-	
. 00	Total swing-bed cost (see instructions)			0	
. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		6, 040, 631	27
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	ed and observation bed c	harges)	0	28
	Private room charges (excluding swing-bed charges)		ildi geo)	0	
00	Semi-private room charges (excluding swing-bed charges)			0	30
00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
00 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
00	Average per diem private room per diem charge (inne 30 ÷ inne 4) Average per diem private room charge differential (line 32 mi	inus line 33)(see instru	ctions)	0.00	
00	Average per diem private room cost differential (line 34 x li			0.00	
00	Private room cost differential adjustment (line 3 x line 35)			0	
00	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	6, 040, 631	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
	PART IT - HOSPITAL AND SUBPROVIDERS UNLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			1
. 00	Adjusted general inpatient routine service cost per diem (see			1, 116. 77	38
. 00	Program general inpatient routine service cost (line 9 x line	e 38)		217, 770	39
	Medically necessary private room cost applicable to the Prog			0	
	Total Program general inpatient routine service cost (line 3	7 + line 40)		217, 770	41

DMPUT	Financial Systems ATION OF INPATIENT OPERATING COST		PITALS, INC Provider C	CN: 15-0002	Peri od:	u of Form CMS- Worksheet D-1	
			Component	CCN: 15-T002	From 01/01/2020 To 12/31/2020	Date/Time Pre	
			Ti tl	e XIX	Subprovi der -	7/23/2021 10: Cost	<u>58</u> 8
	Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. ÷ col. 2)	1	(col. 3 x col. 4)	
. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00 C) 42.
	Intensive Care Type Inpatient Hospital Units	1-	-	-			
	INTENSIVE CARE UNIT NEONATAL ICU	0	0				
	CORONARY CARE UNIT	0	0	0.	00 0		43
. 00	BURN INTENSIVE CARE UNIT						45
	SURGI CAL I NTENSI VE CARE UNI T						46
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
						1.00	
	Program inpatient ancillary service cost (Wk					337, 918	
	Total Program inpatient costs (sum of lines	41 through 48)(see instructi	ons)		555, 688	3 49
	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D. si	um of Parts I and	C	50
	111)						
. 00	Pass through costs applicable to Program inp	atient ancillar	ry services (f	rom Wkst. D,	sum of Parts II	C	51
. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				c	52
	Total Program inpatient operating cost exclu		elated, non-ph	ysician anes	thetist, and	C	
	medical education costs (line 49 minus line	52)					
	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					C	54
	Target amount per discharge					0.00	
00	Target amount (line 54 x line 55)					C	56
	Difference between adjusted inpatient operat	ing cost and ta	arget amount (line 56 minus	s line 53)	C	
	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting period	ending 1996	undated and (compounded by the	0. 00	
00	market basket	por tring period	ending 1990,		compounded by the	0.00	
	Lesser of lines 53/54 or 55 from prior year					0.00	
. 00	If line 53/54 is less than the lower of line					C	61
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		.s (TTHES 54 X	60), OF 1% (on the target		
. 00	Relief payment (see instructions)	,				C	62
	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			C) 63
	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of th	e cost repor	ting period (See	C	64
. 00	instructions)(title XVIII only)	to through boot					
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the	cost reporti	ng period (See	C) 65
. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line	64 nlus line	65)(title XV	II only) For	С) 66
. 00	CAH (see instructions)		o4 prus rine	05)(11110 X	TT Only). TO		
. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost i	reporting period	C	67
00	(line 12 x line 19)	o costs ofter [locombor 21 of	the cost re	porting ported) 68
. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)		Jecelliber 31 01	the cost re	boi tring period		68
. 00	Total title V or XIX swing-bed NF inpatient	routine costs ((line 67 + lin	e 68)		C	69
	PART III - SKILLED NURSING FACILITY, OTHER N				7		
	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c	2			/)		70
	Program routine service cost (line 9 x line			-/			72
	Medically necessary private room cost applic	, U	•				73
	Total Program general inpatient routine serv	•			Dart II column		74
. 00	Capital-related cost allocated to inpatient 26, line 45)		CUSIS (ITUM	WULKSHEEL B,	raitii, cuiumn		/ '
	Per diem capital-related costs (line 75 \div li						76
	Program capital -related costs (line 9 x line						77
	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		provi der recor	ds)			78
1	Total Program routine service costs for comp	• •			nus line 79)		80
00	Inpatient routine service cost per diem limi	tation					81
	Inpatient routine service cost limitation (I						82
	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		15)				83
	Utilization review - physician compensation		ons)				85
. 00	Total Program inpatient operating costs (sum	of lines 83 th					86
	PART IV - COMPUTATION OF OBSERVATION BED PASS					C	87
	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)			0.00	
-	Observation bed cost (line 87 x line 88) (se	•					89

Health Financial Systems	METHODI ST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	
		Component (CCN: 15-T002	From 01/01/2020 To 12/31/2020		pared: 58 am
		Titl	e XIX	Subprovider -	Cost	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		,		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	618, 701	6, 040, 631	0. 10242	23 0	0	90.00
91.00 Nursing School cost	0	6, 040, 631	0.0000	0 00	0	91.00
92.00 Allied health cost	0	6, 040, 631	0.0000	0 00	0	92.00
93.00 All other Medical Education	0	6, 040, 631			0	93.00

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0002	Peri od:	Worksheet D-3	3
			From 01/01/2020		
			To 12/31/2020	Date/Time Pre 7/23/2021 10:	pared
	Title	e XVIII	Hospi tal	PPS	50 aii
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
0.00 03000 ADULTS & PEDIATRICS			22, 069, 681		30.0
1. 00 03100 INTENSIVE CARE UNIT			7, 465, 016		31.0
1. 01 03101 NEONATAL I CU			7,403,010		31.0
0. 00 04000 SUBPROVIDER - IPF			0		40.0
1. 00 04100 SUBPROVI DER – I RF			0		41.0
3. 00 04300 NURSERY			0		43.0
ANCI LLARY SERVI CE COST CENTERS					10.1
0.00 05000 OPERATING ROOM		0. 1133	71 13, 096, 883	1, 484, 807	50.
0. 01 05001 ENDOSCOPY		0. 19820	06 1, 158, 308	229, 584	50.
1.00 05100 RECOVERY ROOM		0. 26730	09 836, 111	223, 500	51.
2.00 05200 DELIVERY ROOM & LABOR ROOM		1. 35174	46 19, 187	25, 936	52.
3. 00 05300 ANESTHESI OLOGY		0.0000	0 00	0	53.
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 21713	36 3, 698, 801	803, 143	54.
4. 01 05401 RADI OLOGY – ULTRASOUND		0. 13589	94 1, 333, 623	181, 231	54.
5. 00 05500 RADI OLOGY-THERAPEUTI C		0. 1792		115, 680	55.
5. 01 05501 INFUSION CENTER		2. 27789		0	
6. 00 05600 RADI OI SOTOPE		0. 22589		331, 803	
7. 00 05700 CT SCAN		0. 03974		609, 892	
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.05953		199, 725	
9. 00 05900 CARDI AC CATHETERI ZATI ON		0. 10410		969, 906	
D. 00 06000 LABORATORY		0. 11530		3, 018, 720	
0.01 06001 BLOOD LABORATORY		0.0000		0	
1.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 00000		0 468, 152	
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 20975		468, 152	
4. 00 06400 INTRAVENOUS THERAPY		0.00000		0	
5. 00 06500 RESPIRATORY THERAPY		0. 1481		1, 526, 241	
6. 00 06600 PHYSI CAL THERAPY		0. 36888		572, 520	
7. 00 06700 OCCUPATI ONAL THERAPY		0. 40413		420, 653	
8. 00 06800 SPEECH PATHOLOGY		0. 31175		245, 225	
9. 00 06900 ELECTROCARDI OLOGY		0. 0666		275, 454	
9. 01 06901 CARDI AC REHAB		0. 63743		270, 101	1
0. 00 07000 ELECTROENCEPHALOGRAPHY		0. 08159		223, 570	
1. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS		0. 3221		2, 428, 809	
2.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 53720		1, 780, 804	
3.00 07300 DRUGS CHARGED TO PATIENTS		0. 19138		5, 930, 977	
4. 00 07400 RENAL DIALYSIS		0. 30648	3, 485, 511	1,068,264	74.
OUTPATIENT SERVICE COST CENTERS		-			
0. 00 09000 CLINIC		0. 43748		27,827	
1.00 09100 EMERGENCY		0. 23150		1, 475, 688	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 54720		1,051,952	
00.00 Total (sum of lines 50 through 94 and 96 through 98)	(1) (3)		152, 931, 951	25, 690, 063	
01.00 Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		0		201.
02.00 Net charges (line 200 minus line 201)		1	152, 931, 951		202.

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0002	Peri od:	Worksheet D-3	3
	Composit	CON 15 COOD	From 01/01/2020		
	component	CCN: 15-S002	To 12/31/2020	Date/Time Pre 7/23/2021 10:	58 a
	Title	e XVIII	Subprovider -	PPS	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
		1.00		col . 2)	
INDATIENT DOUTINE CEDVICE COST CENTERS		1.00	2.00	3.00	-
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 00 03000 ADULTS & PEDI ATRI CS			0		30
00 03100 INTENSIVE CARE UNIT			0		31
01 03101 NEONATAL I CU			0		31
00 04000 SUBPROVIDER - IPF			1, 652, 382		40
00 04100 SUBPROVIDER - IRF			1, 032, 302		41
00 04300 NURSERY			0		43
ANCI LLARY SERVICE COST CENTERS					1.0
00 05000 OPERATING ROOM		0. 1133	71 0	0	50
01 05001 ENDOSCOPY		0. 1982	0 0	0	50
00 05100 RECOVERY ROOM		0. 2673	0 00	0	51
00 05200 DELIVERY ROOM & LABOR ROOM		1. 3517		-	
00 05300 ANESTHESI OLOGY		0.0000		-	
00 05400 RADI OLOGY-DI AGNOSTI C		0. 2171			
01 05401 RADI OLOGY - ULTRASOUND		0. 1358			
00 05500 RADI OLOGY-THERAPEUTI C		0. 1792			
01 05501 I NFUSI ON CENTER		2.2778			
00 05600 RADI OI SOTOPE		0. 2258			
00 05700 CT SCAN		0.0397			
00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 00 05900 CARDI AC CATHETERI ZATI ON		0.0595		0	
00 06000 LABORATORY		0. 10410			
01 06001 BLOOD LABORATORY		0. 0000			
00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000			
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 2097			
00 06300 BLOOD STORING, PROCESSING & TRANS.		0.0000			
00 06400 I NTRAVENOUS THERAPY		0.0000		-	
00 06500 RESPI RATORY THERAPY		0. 1481			
00 06600 PHYSI CAL THERAPY		0.3688			
00 06700 OCCUPATI ONAL THERAPY		0.4041	36 660	267	67
00 06800 SPEECH PATHOLOGY		0. 3117	58 0	0	68
00 06900 ELECTROCARDI OLOGY		0. 0666		1, 460	69
01 06901 CARDI AC REHAB		0. 63743	37 0		
00 07000 ELECTROENCEPHALOGRAPHY		0. 0815	91 0	0	70
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3221			
00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 5372		0	
00 07300 DRUGS CHARGED TO PATIENTS		0. 1913			
00 07400 RENAL DI ALYSI S		0. 3064	87 124, 434	38, 137	74
		0 4074	24		1 00
00 09000 CLINIC 00 09100 EMERGENCY		0. 4374			
		0. 23150			
00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.00 Total (sum of lines 50 through 94 and 96 through 98)		0. 54720	902, 645	0 166, 669	
1.00 Less PBP Clinic Laboratory Services-Program only cha			902, 645	100,009	200
2.00 Net charges (line 200 minus line 201)	iges (inte of)	1	902, 645		201

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0002	Period:	Worksheet D-3	3
	Component	CCN: 15-T002	From 01/01/2020 To 12/31/2020	Date/Time Pre	
			Subaravi dan	7/23/2021 10:	58 ai
	11 11 6	e XVIII	Subprovider - IRF	PPS	
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		1			1
. 00 03000 ADULTS & PEDI ATRI CS			0		30.
. 00 03100 I NTENSI VE CARE UNI T			0		31.
. 01 03101 NEONATAL I CU			0		31.
. 00 04000 SUBPROVIDER - IPF			0		40.
. 00 04100 SUBPROVIDER - IRF			2, 634, 763		41.
. 00 04300 NURSERY					43.
ANCI LLARY SERVICE COST CENTERS		0 1122	71 017 410	24.440	
. 00 05000 OPERATING ROOM		0. 1133			
		0. 1982		3,606	
. 00 05100 RECOVERY ROOM . 00 05200 DELIVERY ROOM & LABOR ROOM		0.2673			
		1.3517		0	
		0.0000		0	
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2171		16, 830	
. 01 05401 RADI OLOGY - ULTRASOUND . 00 05500 RADI OLOGY-THERAPEUTI C		0. 1358		1, 496	
. 01 05501 INFUSION CENTER					
. 00 05600 RADI 0I SOTOPE		2. 2778 0. 2258		0 2, 707	
. 00 05700 CT_SCAN		0. 2258			
				5, 103	
. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) . 00 05900 CARDIAC CATHETERIZATION		0.0595		4, 147	
		0.1041			
. 00 06000 LABORATORY . 01 06001 BLOOD LABORATORY		0. 1153		85, 315 0	
		0.0000			
. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY . 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.0000		-	
		0.2097		0,749 0	
. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. . 00 06400 I NTRAVENOUS THERAPY		0.0000			
. 00 06500 RESPIRATORY THERAPY		0. 1481		38, 824	
. 00 06600 PHYSI CAL THERAPY		0. 3688		489, 083	
. 00 06700 OCCUPATI ONAL THERAPY		0. 4041		462, 285	
. 00 06800 SPEECH PATHOLOGY		0. 3117		37, 473	
. 00 06900 ELECTROCARDI OLOGY		0. 0666		1, 815	
. 01 06901 CARDI AC REHAB		0.6374		0	
. 00 07000 ELECTROENCEPHALOGRAPHY		0.0374			
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3221		31, 001	
. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 5372			
. 00 07300 DRUGS CHARGED TO PATIENTS		0. 1913		341, 834	
. 00 07400 RENAL DIALYSIS		0. 3064		63, 357	
OUTPATIENT SERVICE COST CENTERS		0.0001	200,721		1
. 00 09000 CLINIC		0. 4374	86 0	0	90.
. 00 09100 EMERGENCY		0. 2315			
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5472		0	
0.00 Total (sum of lines 50 through 94 and 96 through 98)			6, 484, 922	1, 660, 473	
1.00 Less PBP Clinic Laboratory Services-Program only cha	rges (line 61)	1	0		201
2.00 Net charges (line 200 minus line 201)	J	1	6, 484, 922	1	202

Health Financial Systems METHODIST HO: INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	SPITALS, INC Provider C	CN: 15-0002	Peri od:	u of Form CMS-3 Worksheet D-3	
	in ovrider o	011. 10 0002	From 01/01/2020		•
			To 12/31/2020	Date/Time Pre 7/23/2021 10:	epared:
	Ti tl	e XIX	Hospi tal	Cost	50 alli
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			2, 829, 950		30.00
31. 00 03100 I NTENSI VE CARE UNI T			785, 317		31.00
31. 01 03101 NEONATAL CU			990, 981		31.01
40. 00 04000 SUBPROVI DER – I PF			120, 404		40.00
41.00 04100 SUBPROVI DER - I RF			132, 526		41.00
43. 00 04300 NURSERY			305, 415		43.00
ANCI LLARY SERVICE COST CENTERS		1	000,110		10100
50. 00 05000 OPERATI NG ROOM		0. 1133	71 3, 106, 300	352, 164	50.00
50. 01 05001 ENDOSCOPY		0. 19820	06 103, 508	20, 516	50.01
51.00 05100 RECOVERY ROOM		0. 26730	09 141, 746	37, 890	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		1. 35174	46 370, 920	501, 390	52.00
53. 00 05300 ANESTHESI OLOGY		0.0000	0 00	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 21713	36 360, 923	78, 369	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND		0. 13589		27, 001	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 1792		5, 049	
55. 01 05501 INFUSION CENTER		2. 27789		0	
56. 00 05600 RADI OI SOTOPE		0. 22589		35, 135	
57.00 05700 CT SCAN		0. 03974		68, 655	
58.00 O5800 MAGNETIC RESONANCE IMAGING (MRI)		0.05953		23, 761	1
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 10410		166, 230	
		0. 11530		427, 721	
60. 01 06001 BLOOD LABORATORY 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000		0	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.0000		0 11, 808	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 20973		0	
64. 00 06400 I NTRAVENOUS THERAPY		0.00000		0	1
65. 00 06500 RESPI RATORY THERAPY		0. 1481		209, 512	
66. 00 06600 PHYSI CAL THERAPY		0. 36888		65, 768	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 40413		55, 769	
68. 00 06800 SPEECH PATHOLOGY		0. 31175		18, 621	
69. 00 06900 ELECTROCARDI OLOGY		0. 0666		28, 592	
69. 01 06901 CARDI AC REHAB		0. 63743		3, 505	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 08159		15, 717	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3221		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 53720		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 19138		753, 118	73.00
74. 00 07400 RENAL DI ALYSI S		0. 30648		82, 743	
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0. 43748		6, 678	
91. 00 09100 EMERGENCY		0. 23150		214, 570	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 54726		0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)			19, 519, 453	3, 210, 282	
201.00 Less PBP Clinic Laboratory Services-Program only cha	rges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			19, 519, 453		202.00

ATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0002	Peri od:	Worksheet D-3	3
	Component	CON. 15 5000	From 01/01/2020		
	Component	CCN: 15-S002	To 12/31/2020	Date/Time Pre 7/23/2021 10:	
	Ti ti	e XIX	Subprovider - IPF	Cost	
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					_
00 03000 ADULTS & PEDIATRICS			0		30
00 03100 INTENSIVE CARE UNIT			0		31
01 03101 NEONATAL ICU			0		31
00 04000 SUBPROVI DER – I PF			1, 083, 510		40
00 04100 SUBPROVI DER – I RF			0		41
00 04300 NURSERY			0		43
ANCI LLARY SERVICE COST CENTERS		0.1100	74		
		0. 1133		-	
01 05001 ENDOSCOPY 00 05100 RECOVERY ROOM		0. 1982			
		0.26730		-	
		1.3517		-	
		0.0000		-	
00 05400 RADI OLOGY - DI AGNOSTI C		0. 2171			
01 05401 RADI OLOGY - ULTRASOUND 00 05500 RADI OLOGY-THERAPEUTI C		0. 1358			
		0. 1792		-	
01 05501 I NFUSI ON CENTER 00 05600 RADI OI SOTOPE		2. 2778			
00 05700 CT SCAN				-	
		0.0397			
00 05800 MAGNETIC RESONANCE IMAGING (MRI) 00 05900 CARDIAC CATHETERIZATION		0.0595			
		0. 10410			
00 06000 LABORATORY 01 06001 BLOOD LABORATORY		0. 11530			
		0.0000			
00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 0000		-	
		0. 20973			
00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 00 06400 I NTRAVENOUS THERAPY		0.00000		-	
00 06500 RESPIRATORY THERAPY		0. 1481			
00 06600 PHYSICAL THERAPY		0. 3688			
00 06700 OCCUPATI ONAL THERAPY		0. 40413			
00 06800 SPEECH PATHOLOGY		0. 3117			
00 06900 ELECTROCARDI OLOGY		0. 0666		-	
01 06901 CARDI AC REHAB		0.63743			
00 07000 ELECTROENCEPHALOGRAPHY		0.0815			
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3221		-	
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 5221		-	
00 07200 TMPL. DEV. CHARGED TO PATTENTS		0. 1913		42, 768	
00 07300 DRUGS CHARGED TO PATTENTS		0. 1913			
OUTPATIENT SERVICE COST CENTERS		0. 30040	0	0	"
00 09000 CLINIC		0.4374	36 0	0	90
00 09100 EMERGENCY		0. 23150		-	
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5472			
.00 Total (sum of lines 50 through 94 and 96	through 98)		424, 958		
.00 Less PBP Clinic Laboratory Services-Prog			0		201
.00 Net charges (line 200 minus line 201)	, <u>j</u>	1	424, 958		202

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0002	Peri od:	Worksheet D-3	3
	Component	CCN: 15-T002	From 01/01/2020 To 12/31/2020		epared
				7/23/2021 10:	
	Titl	e XIX	Subprovider - IRF	Cost	
Cost Center Description		Ratio of Cos		Inpatient	
·		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
		1.00		col . 2)	
		1.00	2.00	3.00	-
0.00 O3000 ADULTS & PEDIATRICS		1	0		30.0
1. 00 03100 INTENSIVE CARE UNIT			0		31.0
1. 01 03101 NEONATAL CU			0		31.0
D. 00 04000 SUBPROVI DER – I PF			0		40.0
1. 00 04100 SUBPROVI DER – I RF			558, 502		41.0
3. 00 04300 NURSERY			0		43.0
ANCI LLARY SERVICE COST CENTERS		•		I	
D. 00 05000 OPERATING ROOM		0. 1133	71 0	0	50.
D. 01 05001 ENDOSCOPY		0. 1982	06 1, 647	326	50.
1.00 05100 RECOVERY ROOM		0. 2673		0	
2.00 05200 DELIVERY ROOM & LABOR ROOM		1. 3517		0	
3. 00 05300 ANESTHESI OLOGY		0.0000		0	
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2171			
4. 01 05401 RADI OLOGY - ULTRASOUND		0.1358		494	
5. 00 05500 RADI OLOGY-THERAPEUTI C		0. 1792		0	
5. 01 05501 I NFUSI ON CENTER 5. 00 05600 RADI 0I SOTOPE		2.2778		0	
5. 00 05600 RADI 0I SOTOPE 7. 00 05700 CT SCAN		0. 2258			
3. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0595		1, 462 1, 138	
2. 00 05900 CARDI AC CATHETERI ZATI ON		0. 10410		I, 130	
0. 00 06000 LABORATORY		0. 11530		14, 453	
D. 01 06001 BLOOD LABORATORY		0.0000		0	
1. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000		0	
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 2097		1, 117	
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0.0000		0	
4. 00 06400 I NTRAVENOUS THERAPY		0.0000		0	64.
5. 00 06500 RESPI RATORY THERAPY		0. 1481	71 38, 507	5, 706	65.
5. 00 06600 PHYSI CAL THERAPY		0.3688	88 287, 353	106, 001	66.
7. 00 06700 OCCUPATI ONAL THERAPY		0.4041		96, 702	
3. 00 06800 SPEECH PATHOLOGY		0. 3117		15, 035	
9. 00 06900 ELECTROCARDI OLOGY		0. 0666		442	
9. 01 06901 CARDI AC REHAB		0.6374		0	
D. 00 07000 ELECTROENCEPHALOGRAPHY		0.0815		340	
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3221			
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 3. 00 07300 DRUGS CHARGED TO PATIENTS		0.5372		962	
3. 00 07300 DRUGS CHARGED TO PATIENTS 4. 00 07400 RENAL DIALYSIS		0. 1913		72, 177	
00 OT400 RENAL DIALTSIS		0.3064	30, 620	11,224	1 /4.
0. 00 09000 CLINIC		0. 4374	86 52	23	90.
1. 00 09100 EMERGENCY		0. 23150		0	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5472			
00.00 Total (sum of lines 50 through 94 and 96 through 98)			1, 262, 166		
01.00 Less PBP Clinic Laboratory Services-Program only cha			0		201.
D2.00 Net charges (line 200 minus line 201)	5		1, 262, 166		202.

	Financial Systems METHODIST HOSPITA ATION OF REIMBURSEMENT SETTLEMENT	ALS, INC Provider CCN: 15-0002	In Lieu Period: From 01/01/2020	u of Form CMS-2 Worksheet E Part A	2552-10
			To 12/31/2020	Part A Date/Time Pre 7/23/2021 10:	
		Title XVIII	Hospi tal	PPS	
			-	1.00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				1
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurri instructions)	ng prior to October 1	(see	0 24, 501, 826	
1. 02	DRG amounts other than outlier payments for discharges occurri instructions)	ng on or after October	1 (see	9, 999, 138	1.02
1. 03	DRG for federal specific operating payment for Model 4 BPCI fo 1 (see instructions)	or di scharges occurri ng	prior to October	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI fo October 1 (see instructions)	or di scharges occurri ng	on or after	0	
2.00 2.01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			0	2.00
2.01	Outlier payment for discharges for Model 4 BPCI (see instructi	ons)		0	
2.03	Outlier payments for discharges occurring prior to October 1 (-		714, 298	
2.04	Outlier payments for discharges occurring on or after October			292, 537	2.04
3.00	Managed Care Simulated Payments			24, 468, 631	
4.00	Bed days available divided by number of days in the cost repor Indirect Medical Education Adjustment	ting period (see instr	uctions)	404.14	4.00
5.00	FTE count for all opathic and osteopathic programs for the most or before 12/31/1996. (see instructions)	recent cost reporting	period ending on	8. 53	5.00
6.00	FTE count for allopathic and osteopathic programs that meet th new programs in accordance with 42 CFR 413.79(e)	ne criteria for an add-	on to the cap for	0.00	6.00
7.00 7.01	MMA Section 422 reduction amount to the IME cap as specified u ACA \S 5503 reduction amount to the IME cap as specified under			0. 00 0. 00	
8.00	cost report straddles July 1, 2011 then see instructions.	bic and actoonathic pr	ograme for	0.00	8.00
8.00	Adjustment (increase or decrease) to the FTE count for allopat affiliated programs in accordance with 42 CFR 413.75(b), 413.7 1998), and 67 FR 50069 (August 1, 2002).			0.00	0.00
8. 01	The amount of increase if the hospital was awarded FTE cap slo report straddles July 1, 2011, see instructions.	ots under § 5503 of the	ACA. If the cost	0.00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slo under § 5506 of ACA. (see instructions)	ots from a closed teach	ing hospital	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line instructions)		-	8. 53	
10.00	FTE count for allopathic and osteopathic programs in the curre FTE count for residents in dental and podiatric programs.	ent year from your reco	rds		10.00
11.00 12.00	Current year allowable FTE (see instructions)			3.00	
13.00	Total allowable FTE count for the prior year.			3.00	
14.00	Total allowable FTE count for the penultimate year if that yea otherwise enter zero.	nr ended on or after Se	ptember 30, 1997,		14.00
15.00	Sum of lines 12 through 14 divided by 3.			3.00	15.00
	Adjustment for residents in initial years of the program				16.00
17.00	Adjustment for residents displaced by program or hospital clos Adjusted rolling average FTE count	sure			17.00
	Current year resident to bed ratio (line 18 divided by line 4)			0.007423	
20.00	Prior year resident to bed ratio (see instructions)			0.007026	
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.007026	
22.00	IME payment adjustment (see instructions)			132, 277	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			93, 813	22.01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 Number of additional allopathic and osteopathic IME FTE reside		CFR 412.105	0.00	23.00
24.00 25.00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -O-, then enter the l	ower of line 23 or lin	e 24 (see	-5.53 0.00	
26.00	instructions) Resident to bed ratio (divide line 25 by line 4)		24 (300	0. 000000	
27.00	IME payments adjustment factor. (see instructions)			0. 000000	
28.00	IME add-on adjustment amount (see instructions)			0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)			0	
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)		132, 277 93, 813	
20.00	Disproportionate Share Adjustment	tiont dave (ass isst	ations)	0.00	20.00
30.00 31.00	Percentage of SSI recipient patient days to Medicare Part A pa Percentage of Medicaid patient days (see instructions)	ittent days (see instru	ctions)	8. 39 33. 07	
31.00	Sum of Lines 30 and 31			41.46	
	Allowable disproportionate share percentage (see instructions)			23.42	
33.00					

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0002	Peri od:	Worksheet E Part A	
			From 01/01/2020 To 12/31/2020	Date/Time Pre	
		Title XVIII	Hospi tal	7/23/2021 10: PPS	00 alli
			Prior to 10/1		
			1.00	2.00	
	Uncompensated Care Adjustment				
	Total uncompensated care amount (see instructions)		0	0	
35.01	Factor 3 (see instructions)	ton zono on this line) (co	0.00000000	0.00000000	
35. UZ	Hospital uncompensated care payment (If line 34 is zero, en instructions)	ter zero on this time) (se	e 4, 631, 104	3, 595, 654	35.0
35.03	Pro rata share of the hospital uncompensated care payment a	mount (see instructions)	3, 467, 002	906, 303	35.0
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35		4, 373, 305		36.0
	Additional payment for high percentage of ESRD beneficiary of	discharges (lines 40 throu	gh 46)		
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683,	684 and 685. (see	0		40. C
11 00	instructions)				44.0
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682,	683, 684 an 685. (see	0		41.0
41.01	instructions) Total ESRD Medicare covered and paid discharges excluding M	IS_DDGs 652 682 683 684	0		41.0
	an 685. (see instructions)	002, 002, 003, 004	0		-1.0
42.00	Divide line 41 by line 40 (if less than 10%, you do not qua	lify for adjustment)	0.00		42.0
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0		43.0
	instructions)				
44.00	Ratio of average length of stay to one week (line 43 divide	d by line 41 divided by 7	0. 000000		44.0
45.00	days) Average weekly cost for dialysis treatments (see instructio	upc)	0.00		45.0
46.00	Total additional payment (line 45 times line 44 times line		0.00		46.0
47.00	Subtotal (see instructions)	11.01)	42,033,413		47.0
48.00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0		48.0
	only. (see instructions)				
				Amount	
49.00	Total payment for inpatient operating costs (see instructio	unc)		1.00 42,127,226	10 0
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I			2, 957, 254	
51.00	Exception payment for inpatient program capital (Wkst. L, P			0	51.0
52.00	Direct graduate medical education payment (from Wkst. E-4,			84, 173	52.0
53.00	Nursing and Allied Health Managed Care payment			58, 596	53.0
54.00	Special add-on payments for new technologies			120, 148	
	Islet isolation add-on payment			0	
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line			0	55.
56.00 57.00	Cost of physicians' services in a teaching hospital (see in Routine service other pass through costs (from Wkst. D, Pt.		brough 2E)	0	56.0 57.0
58.00	Ancillary service other pass through costs from Wkst. D, Pt.		ni ougir 35).	82, 388	
59.00	Total (sum of amounts on lines 49 through 58)	. 10, 001. 11 1110 200)		45, 429, 785	
50.00	Primary payer payments			14, 216	
51.00	Total amount payable for program beneficiaries (line 59 min	us line 60)		45, 415, 569	61.
52.00	Deductibles billed to program beneficiaries			3, 028, 432	
53.00	Coinsurance billed to program beneficiaries			350, 867	
54.00	Allowable bad debts (see instructions)			1, 159, 574	
55.00	Adjusted reimbursable bad debts (see instructions)	etructione)		753, 723	
56.00 57.00	Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63)	istructrons)		153, 233 42, 789, 993	
57.00	Credits received from manufacturers for replaced devices fo	r applicable to MS_DRGs (s	ee instructions)	42, 789, 993	68.
9.00	Outlier payments reconciliation (sum of lines 93, 95 and 96		· · · · · · · · · · · · · · · · · · ·	0	
0.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.
0.50	Rural Community Hospital Demonstration Project (§410A Demon	stration) adjustment (see	instructions)	0	
70. 87	Demonstration payment adjustment amount before sequestratio			0	70.
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	
	Pioneer ACO demonstration payment adjustment amount (see in			_	70.
70. 89	HSP bonus payment HVBP adjustment amount (see instructions)			0	
70. 89 70. 90					
70. 89 70. 90 70. 91	HSP bonus payment HRR adjustment amount (see instructions)			0	
70. 89 70. 90 70. 91 70. 92	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0	70.
70.89 70.90 70.91 70.92 70.93	HSP bonus payment HRR adjustment amount (see instructions)			-	70. 70.

	Financial Systems METHODIST HOSPI ATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CN: 15-0002	Peri od:	Worksheet E	2552-1
				From 01/01/2020 To 12/31/2020	Part A Date/Time Pre	pared
		Ti +Le	xvi i	Hospi tal	7/23/2021 10: PPS	58 am
				(yyyy)	Amount	
				0	1.00	
0. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column O		0	0	70.9
	the corresponding federal year for the period prior to 10/1)					
0. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter i			0	0	70.9
0. 98	the corresponding federal year for the period ending on or af Low Volume Payment-3	ter 10/1)			0	70.9
0.98	HAC adjustment amount (see instructions)				0	
1.00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			42, 201, 838	
1.01	Sequestration adjustment (see instructions)				278, 532	
1.02	Demonstration payment adjustment amount after sequestration				0	
1.03	Sequestration adjustment-PARHM pass-throughs					71.0
2.00	Interim payments				39, 977, 347	
2.01	Interim payments-PARHM					72.0
'3.00 '3.01	Tentative settlement (for contractor use only)				0	73.0
4.00	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (line 71 minus lines 71.01, 71.0)2 72 and			1, 945, 959	
4.00		<i>72, 72,</i> and			1, 743, 737	/ 4. 0
4.01	Balance due provider/program-PARHM (see instructions)					74.0
5.00	Protested amounts (nonallowable cost report items) in accorda	ance with			1, 209, 886	75.0
	CMS Pub. 15-2, chapter 1, §115.2					
0 00	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		1		0	
0.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum plus 2.04 (see instructions)	OT 2.03			0	90.0
1.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.0
2.00	Operating outlier reconciliation adjustment amount (see instr	uctions)			0	92.0
3.00	Capital outlier reconciliation adjustment amount (see instruc	,			0	93.0
4.00	The rate used to calculate the time value of money (see instr	ructions)			0.00	94. (
5.00	Time value of money for operating expenses (see instructions)				0	95.0
6.00	Time value of money for capital related expenses (see instruc	ctions)			0	96.0
				D.1. 1. 10/1	0. (0.01	
				Prior to 10/1		
	HSP Bonus Payment Amount			Prior to 10/1 1.00	0n/After 10/1 2.00	
00.00	HSP Bonus Payment Amount HSP bonus amount (see instructions)				2.00	100. (
	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			1.00	2.00	
01.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)			0. 0000000000	2.00 0 0.000000000	101.
01. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction	15)		1.00	2.00 0 0.000000000	101. (
01. 00 02. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment	ns)		1.00 0 0.0000000000 0	2.00 0 0.000000000 0	101. (102. (
01. 00 02. 00 03. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)			1.00 0 0.000000000 0 0.0000	2.00 0.000000000 0 0.0000	101. (102. (103. (
01. 00 02. 00 03. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions)	5)	ustment	1.00 0 0.0000000000 0	2.00 0.000000000 0 0.0000	102.0
01.00 02.00 03.00 04.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)	s) ration) Adj		1.00 0 0.000000000 0 0.0000	2.00 0.000000000 0 0.0000 0 0.0000 0	101. 102. 103. 104.
01.00 02.00 03.00 04.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no.	s) ration) Adj		1.00 0 0.000000000 0 0.0000	2.00 0.000000000 0 0.0000 0 0.0000 0	101. (102. (103. (104. (
01. 00 02. 00 03. 00 04. 00 00. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	s) rration) Adj eriod under		1.00 0 0.000000000 0 0.0000	2.00 0.000000000 0 0.0000 0	101. (102. (103. (104. (200. (
01. 00 02. 00 03. 00 04. 00 00. 00 01. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir	s) rration) Adj eriod under		1.00 0 0.000000000 0 0.0000	2.00 0.000000000 0 0.0000 0	101. (102. (103. (104. (200. (201. (
01.00 02.00 03.00 04.00 00.00 00.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions)	s) rration) Adj eriod under		1.00 0 0.000000000 0 0.0000	2.00 0.000000000 0 0.0000 0	101. (102. (103. (104. (200. (201. (202. (
01.00 02.00 03.00 04.00 00.00 01.00 02.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)	s) ration) Adj eriod under ne 49)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0 0.0000 0	101. (102. (103. (104. (200. (201. (202. (
01.00 02.00 03.00 04.00 00.00 01.00 02.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions)	s) ration) Adj eriod under ne 49)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0 0.0000 0	101. (102. (103. (104. (200. (201. (202. (
01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	s) ration) Adj eriod under ne 49)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0.0000 0.0000 0	101. (102. (103. (104. (
01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	s) rration) Adj eriod under ne 49) n first year	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0.0000 0.0000 0	101. (102. (103. (104. (200. (201. (202. (203. (203. (204. (205. (
01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	s) rration) Adj eriod under ne 49) n first year	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0.0000 0.0000 0	101. (102. (103. (104. (200. (201. (202. (203. (203. (204. (205. (
01.00 02.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00 06.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	s) rration) Adj eriod under ne 49) n first year	the 21st	1.00 0.000000000 0 0.0000 0 0	2.00 0.0000000000 0 0.0000 0	101. (102. (103. (104. (200. (201. (203. (203. (203. (205. (205. (
01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00 05.00 05.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVR adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir period) Medicare inpatient routine cost cap (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst	s) rration) Adj eriod under ne 49) n first year	the 21st	1.00 0.000000000 0 0.0000 0 0	2.00 0.00000000000000000000000000000000	101. (102. (103. (104. (200. (201. (202. (203. (205. (205. (206. (207. (
01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00 06.00 06.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir period) Medicare inpatient routine cost cap (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	s) rration) Adj eriod under ne 49) n first year	the 21st	1.00 0.000000000 0 0.0000 0 0	2.00 0.000000000 0.0000 0.0000 0	101. (102. (103. (104. (200. (201. (202. (203. (204. (205. (206. (20
01. 00 02. 00 03. 00 004. 00 00. 00 01. 00 02. 00 03. 00 04. 00 05. 00 06. 00 07. 00 08. 00 09. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions)	s) rration) Adj eriod under ne 49) n first year	the 21st	1.00 0.000000000 0 0.0000 0 0	2.00 0.000000000 0.0000 0.0000 0	101. (102. (103. (103. (200. (200. (200. (201. (202. (203. (204. (206. () 206. () 206. () 206. () 207. () 208. () 208. () 208. () 209. () 208. () 209. (
 D1. 00 D2. 00 D3. 00 D3. 00 D0. 00 D1. 00 D1. 00 D2. 00 D2. 00 D3. 00 D4. 00 D5. 00 D4. 00 D5. 00 D6. 00 D7. 00 D8. 00 D9. 00 10. 00 	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment for HSP Bonus payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Redicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	s) rration) Adj eriod under ne 49) n first year ructions) line 59)	the 21st	1.00 0.000000000 0 0.0000 0 0	2.00 0.000000000 0.0000 0.0000 0	101. (102. (103. (103. (200. (200. (201. (202. (203. (204. (205. (206. (206. (206. (207. (208. (208. (209. (208. (209. (201. (20
01.00 02.00 03.00 00.00 00.00 01.00 02.00 03.00 04.00 05.00 06.00 07.00 08.00 09.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions)	s) rration) Adj eriod under ne 49) n first year ructions) line 59)	the 21st	1.00 0.000000000 0 0.0000 0 0	2.00 0.000000000 0.0000 0.0000 0	101. (102. (103. (103. (200. (200. (201. (202. (203. (204. (205. (206. (206. (206. (207. (208. (208. (209. (200. (
01. 00 02. 00 03. 00 04. 00 00. 00 01. 00 02. 00 03. 00 04. 00 05. 00 06. 00 07. 00 08. 00 09. 00 11. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	s) rration) Adj eriod under ne 49) n first year ructions) line 59)	the 21st	1.00 0.000000000 0 0.0000 0 0	2.00 0.000000000 0.0000 0.0000 0 0.0000 0 0 0 0 0	101. (102. (103. (200. (201. (202. (203. (203. (
01. 00 02. 00 03. 00 04. 00 00. 00 01. 00 02. 00 03. 00 04. 00 05. 00 06. 00 07. 00 08. 00 09. 00 11. 00 11. 00 12. 00 13. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	s) rration) Adj eriod under ne 49) first year first year in rructions) line 59) 211)	of the curre	1.00 0.000000000 0 0.0000 0 0	2.00 0.000000000 0.0000 0.0000 0 .tration	101. (102. (103. (104. (200. (201. (202. (203. (204. (205. (206. (207. (208. (209. (211. (

	Financial Systems LUME CALCULATION EXHIBIT 4		METHODI ST HOS	Provider C		Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 7/23/2021 10:	t 4 epared
		l i ne	Amounts (from E, Part A)	Pre/Post Entitlement	XVIII Period Prior to 10/01	0n/After 10/01	PPS Total (Col 2 through 4)	
0	DRG amounts other than outlier	0	1.00	2.00	3.00	4.00	5.00	1.
00	payments	1.00	0	0		0 0	0	1.
)1	DRG amounts other than outlier payments for discharges	1.01	24, 501, 826	0	24, 501, 82	6	24, 501, 826	1.
)2	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	9, 999, 138	0		9, 999, 138	9, 999, 138	1.
)3	1 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1.03	0	0		0	0	1.
)4	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.
00	Outlier payments for	2.00						2.
01	discharges (see instructions) Outlier payments for	2.02	0	0		0 0	0	2.
	discharges for Model 4 BPCI	2.02	0	0			0	2.
)2	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	714, 298	0	714, 29	8	714, 298	2
)3	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	292, 537	0		292, 537	292, 537	2
0	Operating outlier	2.01	0	0		0 0	0	3
00	reconciliation Managed care simulated payments	3.00	24, 468, 631	0	17, 676, 49	6, 792, 136	24, 468, 631	4
	Indirect Medical Education Adju		0.00700/	0.00700/	0.00700			
0	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 007026	0.007026	0. 00702	.6 0. 007026		5.
0	IME payment adjustment (see instructions)	22.00	132, 277		93, 94	.0 38, 337	132, 277	6
)1	IME payment adjustment for managed care (see instructions)	22.01	93, 813	0	67, 77	2 26, 041	93, 813	6
	Indirect Medical Education Adju	ustment for the	e Add-on for Se	ection 422 of	the MMA			
0	IME payment adjustment factor (see instructions)	27.00	0. 000000	0.00000	0.00000	0 0. 000000		7
0	IME adjustment (see instructions)	28.00	0	0		0 0	0	8
1	IME payment adjustment add on for managed care (see instructions)	28.01	0	0		0 0	0	8
0	Total IME payment (sum of lines 6 and 8)	29.00	132, 277	0	93, 94	0 38, 337	132, 277	9
)1	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	93, 813	0	67, 77	2 26, 041	93, 813	9
	Disproportionate Share Adjustm				1	-		
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 2342	0. 2342	0. 234	2 0. 2342		10
00	Disproportionate share adjustment (see instructions)	34.00	2, 020, 032	0	1, 434, 58	2 585, 450	2, 020, 032	11.
01	Uncompensated care payments	36.00	4, 373, 305		3, 467, 00	906, 303	4, 373, 305	11
00	Additional payment for high per Total ESRD additional payment	<u>centage of ESI</u> 46.00		di scharges 0		0 0	0	12
00	(see instructions) Subtotal (see instructions) Hospital specific payments	47.00 48.00	42, 033, 413	0			42, 033, 413 0	13
00	(completed by SCH and MDH, small rural hospitals only.) (see instructions)	40. UU	0	0			U	14
00	Total payment for inpatient operating costs (see instructions)	49.00	42, 127, 226	0	30, 279, 42	0 11, 847, 806	42, 127, 226	15

LOW VO	LUME CALCULATION EXHIBIT 4			Provider C	CN: 15-0002	Period: From 01/01/2020 To 12/31/2020		pared:
				Title	XVIII	Hospi tal	PPS	
		W/S E. Part A	Amounts (from	Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	0n/After	through 4)	
						10/01		
		0	1.00	2.00	3.00	4.00	5.00	
6.00	Payment for inpatient program	50.00	2, 957, 254	0			2, 957, 254	16.0
10.00	capital (from Wkst. L, Pt. I,	50.00	2, 737, 234	0	2, 127, 00	027,022	2, 757, 254	10.0
	if applicable)							
17.00		E4 00	120 140	0		0 120, 148	120 140	17 0
17.00	Special add-on payments for	54.00	120, 148	0		0 120, 148	120, 148	17.0
	new technologies							17.0
17.01	Net organ aquisition cost							17.0
17.02	Credits received from	68.00	0	0		0 0	0	17.0
	manufacturers for replaced							
	devices for applicable MS-DRGs							
18.00	Capital outlier reconciliation	93.00	0	0		0 0	0	18.0
	adjustment amount (see							
	instructions)							
19.00	SUBTOTAL			0	32, 407, 05	52 12, 797, 576	45, 204, 628	19.0
		W/S L, line	(Amounts from					
			L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier		2, 660, 433	0			2, 660, 433	20.0
20.00	Model 4 BPCI Capital DRG other		2,000,433	0	.,,.	0 0	2,000,433	
20.01	•	1.01	0	0		0 0	0	20.0
01 00	than outlier	2.00	50.050	0	27.40	15 2/0		21 0
21.00	Capital DRG outlier payments	2.00	52, 859	0	37, 49	90 15, 369	52, 859	
21.01	Model 4 BPCI Capital DRG	2.01	0	0		0 0	0	21.0
	outlier payments							
22.00	Indirect medical education	5.00	0. 0041	0. 0041	0.004	41 0. 0041		22.0
	percentage (see instructions)							
23.00	Indirect medical education	6.00	10, 908	0	7, 85	50 3, 058	10, 908	23.0
	adjustment (see instructions)							
24.00	Allowable disproportionate	10.00	0. 0876	0. 0876	0.087	76 0. 0876		24.0
	share percentage (see							
	instructions)							
25.00	Disproportionate share	11.00	233, 054	0	167, 7	65, 337	233, 054	25 0
201.00	adjustment (see instructions)		2007001	0			200,001	20.0
26.00	Total prospective capital	12.00	2, 957, 254	0	2, 127, 63	829, 622	2, 957, 254	26 0
20.00	payments (see instructions)	12.00	2, 757, 254	0	2, 127, 03	027,022	2, 737, 234	20.0
	payments (see first uctions)	W/S E, Part A	(Amounts to					
		line 0	E, Part A)	2.00	2.00	4.00	F 00	
7 00		0	1.00	2.00	3.00	4.00	5.00	07.0
27.00	Low volume adjustment factor				0.0000	0. 000000	_	27.0
28.00	Low volume adjustment	70. 96				0	0	28.0
	(transfer amount to Wkst. E,							
	Pt. A, line)							
29.00	Low volume adjustment	70. 97				0	0	29.0
	(transfer amount to Wkst. E,							
	Pt. A, line)							
100 00	Transfer I ow volume		Y					100.0
	adjustments to Wkst. E, Pt. A.							1.00.0

	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5		F	Period: rom 01/01/2020 o 12/31/2020	Worksheet E Part A Exhibi Date/Time Pre 7/23/2021 10:	t 5 pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt.	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	A) 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	24, 501, 826			24, 501, 826	1. 00 1. 01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	9, 999, 138		9, 999, 138	9, 999, 138	1. 02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	C		0	1. 03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	C	0	0	2. 01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	714, 298	714, 298		714, 298	2. 02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	292, 537		292, 537	292, 537	2.03
3.00 4.00	Operating outlier reconciliation Managed care simulated payments	2. 01 3. 00	0 24, 468, 631	0 17, 676, 495		0 24, 468, 631	3.00 4.00
F 00	Indirect Medical Education Adjustment	21.00	0.00700/	0.00700/	0.00700/		F 00
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00 22.00	0. 007026	0. 007026 93, 940			5.00 6.00
6. 00 6. 01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see instructions)		132, 277 93, 813			132, 277 93, 813	6. 00 6. 01
	Indirect Medical Education Adjustment for the	e Add-on for S	ection 422 of t	the MMA			
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	C		0	8.00 8.01
	care (see instructions)				-		
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	132, 277 93, 813	93, 940 67, 772		132, 277 93, 813	9.00 9.01
7.01	Disproportionate Share Adjustment	27.01	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0,,,,,	20,011	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	7.01
10.00	Al I owable di sproporti onate share percentage	33.00	0. 2342	0. 2342	0. 2342		10.00
	(see instructions)	34.00					
11.00	Disproportionate share adjustment (see instructions)		2, 020, 032	1, 434, 582			
	Uncompensated care payments Additional payment for high percentage of ESM			3, 467, 002			
12.00	Total ESRD additional payment (see instructions)	46.00	0	C	0	0	12.00
13.00 14.00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	47.00 48.00	42, 033, 413 0	30, 211, 648 (11, 821, 765 0 0	42, 033, 413 0	13.00 14.00
15.00	instructions) Total payment for inpatient operating costs (see instructions)	49.00	42, 127, 226	30, 279, 420	11, 847, 806	42, 127, 226	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2, 957, 254	2, 127, 632	829, 622	2, 957, 254	16.00
17. 00 17. 01	Special add-on payments for new technologies Net organ acquisition cost	54.00	120, 148	С	120, 148	120, 148	17.00 17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	C	0 0	0	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	C	0	0	18.00
19.00	SUBTOTAL			32, 407, 052	12, 797, 576	45, 204, 628	19.00

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

Health Financial Systems

HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	6 Provider C		Period: From 01/01/2020 To 12/31/2020		pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	2, 660, 433	1, 914, 57	745, 858	2, 660, 433	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0		0 0	0	20.01
21.00	Capital DRG outlier payments	2.00	52, 859	37,49	0 15, 369	52, 859	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2. 01	0		0 0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0041	0.004	0. 0041	-	22.00
	Indirect medical education adjustment (see instructions)	6.00	10, 908	7,85	3, 058	10, 908	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0876	0. 087	0. 0876		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	233, 054	167, 71	7 65, 337	233, 054	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2, 957, 254	2, 127, 63	829, 622	2, 957, 254	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70. 96	0		0	0	28.00
29.00	Low volume adjustment on or after October 1	70. 97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70. 93	-116, 882	-99, 51	6 -17, 366	-116, 882	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	30. 0 [.]
31.00	HRR adjustment (see instructions)	70. 94	-471, 273	-335, 67	4 -135, 599	-471, 273	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	31.0
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70. 99			0 0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

PART B - MEDICAL AND OTHER HEALTH SERVICES 1.00 Medical and other services (see instructions) 2.00 Medical and other services reimbursed under OPPS (see instructions) 3.00 OPPS payments 4.00 Outlier payment (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 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 0.00 Organ acquisitions 11.00 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 15.00 Angreges 15.00 Angreges 16.00 Amounts that would have been realized from patients liable for payment for services on a charge had such payment been made in accordance with 42 CFR §413.13(e) 17.00 Ratio of line 15 too line 16 (ont to exceed 1.000000)	1/01/2020 Part B 2/31/2020 Date/Time I spi tal PPS 1.00 11, € 19, 821, 1 16, 604, 9 212, 3 0. € 0.10, 604, 9 11, € 11, € 11, € 11, € 11, € 11, € 11, € 11, € 11, € 11, € 11, € 11, € 11, € 11, € 11, € 11, € 11, € 11, € 11, € 11, € 11, € 11, € 11, € 0.000 11, € 0.000 72, €	Prepared: 10: 58 am S 870 1.00 126 2.00 970 3.00 327 4.00 0 4.01 000 5.00 0 4.01 000 5.00 0 6.00 0 8.00 423 9.00 0 10.00 870 11.00 970 12.00 0 13.00 929 12.00 0 13.00 929 12.00 0 13.00 10.00 10.00 8.00 10.00 1
PART B - MEDICAL AND OTHER HEALTH SERVICES 1.00 Medical and other services (see instructions) 2.00 Medical and other services reimbursed under OPPS (see instructions) 3.00 OPPS payments 4.00 Outlier payment (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 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 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 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 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge 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 1.00000) 18.00 Total customary charges (see instructions) 19.00 </td <td>spi tal PPS 1.00 1.00 1.00 11, 8 19, 821, 1 16, 604, 9 212, 3 0.0 0. 80, 4 11, 8 72, 9 72, 9</td> <td>S 870 1.00 126 2.00 970 3.00 327 4.00 0 4.01 000 5.00 0 4.01 000 7.00 0 8.00 423 9.00 0 10.00 870 11.00 929 12.00 0 13.00 929 14.00 0 15.00 0 15.00 0 17.00</td>	spi tal PPS 1.00 1.00 1.00 11, 8 19, 821, 1 16, 604, 9 212, 3 0.0 0. 80, 4 11, 8 72, 9 72, 9	S 870 1.00 126 2.00 970 3.00 327 4.00 0 4.01 000 5.00 0 4.01 000 7.00 0 8.00 423 9.00 0 10.00 870 11.00 929 12.00 0 13.00 929 14.00 0 15.00 0 15.00 0 17.00
PART B - MEDICAL AND OTHER HEALTH SERVICES 1.00 Medical and other services (see instructions) 2.00 Medical and other services reimbursed under OPPS (see instructions) 3.00 OPPS payments 4.00 Outlier payment (see instructions) 4.01 Outlier 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 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 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 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 13.00 Organ acquisition charges (from patients liable for payment for services on a charge had such payment been made in accordance with 42 CFR §413.13(e) 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge had	1.00 11, (19, 821, 1 16, 604, 9 212, 3 0. (0. 80, 4 11, 8 72, 9 72, 9 73, 9 72,	870 1.00 126 2.00 970 3.00 327 4.00 0 4.01 000 5.00 0 6.00 0.00 7.00 0 8.00 423 9.00 0 10.00 870 11.00 929 12.00 0 13.00 929 14.00 0 15.00 0 17.00
 Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions) OPPS payments Outlier payment (see instructions) Outlier payment (see instructions) Enter the hospital specific payment to cost ratio (see instructions) Enter the hospital specific payment (see instructions) Unie 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges Ancillary service charges (from Wkst. D-4, Pt. III, col. 4, line 69) Organ acquisition charges (sum of lines 12 and 13) Customary charges O Aggregate amount actually collected from patients liable for payment for services on a charg had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000) Ratio of line 15 to line 16 (not to exceed 1.000000) Costemary charges (see instructions) Excess of reasonable cost over customary charges (complete only if line 18 exceeds line 11) instructions) Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) instructions) Lesser of cost or charges (see instructions) 	11, 8 19, 821, 1 16, 604, 9 212, 3 0, 0 0, 80, 4 11, 8 72, 9 72, 9 72, 9 72, 9 72, 9 72, 9 72, 9 72, 9	126 2.00 970 3.00 327 4.00 0 4.01 000 5.00 0 6.00 .00 7.00 0 8.00 423 9.00 0 10.00 870 11.00 929 12.00 0 13.00 929 14.00 0 15.00 0 15.00 0 17.00
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 2.00 Medical and other services reimbursed under OPPS (see instructions) 3.00 OPPS payments 4.00 Outlier payment (see instructions) 5.00 Enter the hospital specific payment to cost ratio (see instructions) 5.00 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 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 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) Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge 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) 18.00 Total customary charges (see instructions) 10.01 Excess of customary charges (see instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 18 exceeds line 11) instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) instructions) 21.00 Excess of cost or charges (see instructions) 	19, 821, 1 16, 604, 9 212, 3 0, 0 0, 80, 4 11, 8 72, 9 72, 9 72, 9 72, 9 72, 9 72, 9 72, 9 72, 9 72, 9	126 2.00 970 3.00 327 4.00 0 4.01 000 5.00 0 6.00 .00 7.00 0 8.00 423 9.00 0 10.00 870 11.00 929 12.00 0 13.00 929 14.00 0 15.00 0 15.00 0 17.00
 4.00 Outlier payment (see instructions) 4.01 Outlier 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 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 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 22.00 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) Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge 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) 18.00 Total customary charges over reasonable cost (complete only if line 18 exceeds line 11) instructions) 20.00 Excess of customary charges over reasonable cost (complete only if line 11 exceeds line 18) instructions) 21.00 Lesser of cost or charges (see instructions) 	212, 3 0. (0. 80, 4 11, 8 72, 9 72, 9	327 4.00 0 4.01 000 5.00 0 6.00 0 8.00 423 9.00 0 10.00 870 11.00 929 12.00 0 13.00 929 14.00 0 15.00 0 16.00 000 17.00
 4.01 Outlier 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 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 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 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) Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charg 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) 18.00 Total customary charges (see instructions) 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) instructions) 21.00 Lesser of cost or charges (see instructions) 	0. 0 0. 80, 4 11, 8 72, 9 72, 9 72, 9 72, 9 72, 9 72, 9 72, 9 72, 9 72, 9 72, 9	0 4.01 000 5.00 0 6.00 0 7.00 0 8.00 423 9.00 0 10.00 870 11.00 929 12.00 0 13.00 929 14.00 0 15.00 0 17.00
 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) 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 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 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) Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charg 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) 18.00 Total customary charges (see instructions) 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) instructions) 21.00 Lesser of cost or charges (see instructions) 	0. 80, 4 11, 8 72, 9 72, 9 72, 9 72, 9 72, 9 72, 9 0. 0000 72, 9	000 5.00 0 6.00 0 7.00 0 8.00 423 9.00 0 10.00 870 11.00 929 12.00 929 14.00 0 15.00 0 16.00 0 17.00
 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 00 Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges 0 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 10 Total reasonable charges (sum of lines 12 and 13) Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charg 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) 18.00 Total customary charges (see instructions) 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) instructions) 21.00 Lesser of cost or charges (see instructions) 	80, 4 11, 8 72, 9 72, 9 72, 9 72, 9 72, 9 9e basi s argebasi s 0. 0000 72, 9	.00 7.00 0 8.00 423 9.00 0 10.00 870 11.00 929 12.00 0 13.00 929 14.00 0 15.00 0 16.00 0 17.00
 8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 0.00 Organ acquisitions 11.00 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) Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge 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) 18.00 Total customary charges (see instructions) 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) instructions) 21.00 Lesser of cost or charges (see instructions) 	80, 4 11, 8 72, 9 72, 9 72, 9 72, 9 72, 9 9e basi s argebasi s 0. 0000 72, 9	0 8.00 423 9.00 0 10.00 870 11.00 929 12.00 0 13.00 929 14.00 0 15.00 0 16.00 000 17.00
 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 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 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) Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge Amounts that would have been realized from patients liable for payment for services on a charge 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) 18.00 Total customary charges (see instructions) 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) instructions) 21.00 Lesser of cost or charges (see instructions) 	11, 8 72, 9 72, 9 72, 9 72, 9 72, 9 72, 9 0. 0000 72, 9	423 9.00 0 10.00 870 11.00 929 12.00 0 13.00 929 14.00 0 15.00 0 16.00 00 17.00
 11.00 Total cost (sum of lines 1 and 10) (see instructions) <u>COMPUTATION OF LESSER OF COST OR CHARGES</u> <u>Reasonable charges</u> 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) <u>Customary charges</u> 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge 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) 18.00 Total customary charges (see instructions) 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) instructions) 21.00 Lesser of cost or charges (see instructions) 	72, 9 72, 9 72, 9 72, 9 72, 9 0. 0000 72, 9	870 11.00 929 12.00 0 13.00 929 14.00 0 15.00 0 16.00 000 17.00
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 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge 16.00 Amounts that would have been realized from patients liable for payment for services on a charge 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) 18.00 Total customary charges (see instructions) 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) instructions) 21.00 Lesser of cost or charges (see instructions)	72, 9 72, 9 72, 9 72, 9 72, 9 0. 0000 72, 9	929 12.00 0 13.00 929 14.00 0 15.00 0 16.00 000 17.00
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) Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge 16.00 Amounts that would have been realized from patients liable for payment for services on a charge 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) 18.00 Total customary charges (see instructions) 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) instructions) 21.00 Lesser of cost or charges (see instructions)	ge basi s argebasi s 0.0000 72,5	0 13.00 929 14.00 0 15.00 0 16.00 000 17.00
 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) Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge Amounts that would have been realized from patients liable for payment for services on a charge 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) 18.00 Total customary charges (see instructions) 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) instructions) 21.00 Lesser of cost or charges (see instructions) 	ge basi s argebasi s 0.0000 72,5	0 13.00 929 14.00 0 15.00 0 16.00 000 17.00
 14.00 Total reasonable charges (sum of lines 12 and 13) Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charg Amounts that would have been realized from patients liable for payment for services on a charg 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) 18.00 Total customary charges (see instructions) 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) instructions) 21.00 Lesser of cost or charges (see instructions) 	ge basi s argebasi s 0.0000 72,9	929 14.00 0 15.00 0 16.00 000 17.00
Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charg 16.00 Amounts that would have been realized from patients liable for payment for services on a charg 16.00 Amounts that would have been realized from patients liable for payment for services on a charg 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 18.00 Total customary charges (see instructions) 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) instructions) 21.00 Lesser of cost or charges (see instructions)	ge basi s argebasi s 0.0000 72,9	0 15.00 0 16.00 000 17.00
 15.00 Aggregate amount actually collected from patients liable for payment for services on a charg 16.00 Amounts that would have been realized from patients liable for payment for services on a charg 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 18.00 Total customary charges (see instructions) 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) instructions) 21.00 Lesser of cost or charges (see instructions) 	0. 0000 72, 9	0 16.00 000 17.00
 had such payment been made in accordance with 42 CFR §413.13(e) 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 18.00 Total customary charges (see instructions) 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) instructions) 21.00 Lesser of cost or charges (see instructions) 	0.0000	000 17.00
 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 18.00 Total customary charges (see instructions) 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) instructions) 21.00 Lesser of cost or charges (see instructions) 	72, 9	
 18.00 Total customary charges (see instructions) 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) instructions) 21.00 Lesser of cost or charges (see instructions) 		929 18 00
<pre>instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) instructions) 21.00 Lesser of cost or charges (see instructions)</pre>	(see 61, 0	
 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) instructions) 21.00 Lesser of cost or charges (see instructions) 		059 19.00
21.00 Lesser of cost or charges (see instructions)	(see	0 20.00
5 ,	11 (870 21.00
22.00 Interns and residents (see instructions)	11, 0	0 22.00
23.00 Cost of physicians' services in a teaching hospital (see instructions)		0 23.00
24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT	16, 897, 7	720 24.00
25.00 Deductibles and coinsurance amounts (for CAH, see instructions)		0 25.00
26.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions	s) 2, 531, 3	379 26.00
27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23	3] (see 14, 378, 2	211 27.00
instructions) 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50)	30, 0	063 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) 31.00 Primary payer payments	14, 408, 2	274 30.00 136 31.00
31.00 Primary payer payments 32.00 Subtotal (line 30 minus line 31)	9, 14, 399, 1	
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00 Composite rate ESRD (from Wkst. I-5, line 11)	070 /	0 33.00
34.00 Allowable bad debts (see instructions) 35.00 Adjusted reimbursable bad debts (see instructions)	879, 2 571, 5	
36.00 Allowable bad debts for dual eligible beneficiaries (see instructions)	368, 2	231 36.00
37.00 Subtotal (see instructions)	14, 970, 6	
38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		139 38.00 0 39.00
39.50 Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97 Demonstration payment adjustment amount before sequestration		0 39.97
39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION		0 39.98 0 39.99
40.00 Subtotal (see instructions)	14, 970, 5	
40.01 Sequestration adjustment (see instructions)	98, 8	
40.02 Demonstration payment adjustment amount after sequestration 40.03 Sequestration adjustment-PARHM pass-throughs		0 40.02 40.03
41. 00 Interim payments	14, 899, 6	
41.01 Interim payments-PARHM		41.01
42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only)		0 42.00 42.01
43.00 Balance due provider/program (see instructions)	-27, 9	
43.01 Balance due provider/program-PARHM (see instructions)		43.01
44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter §115.2	· 1,	0 44.00
TO BE COMPLETED BY CONTRACTOR		
90.00 Original outlier amount (see instructions)		0 90.00
91.00 Outlier reconciliation adjustment amount (see instructions)	_	0 91.00
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions)	0.	. 00 92. 00 0 93. 00
94.00 Total (sum of lines 91 and 93)		0 94.00

	Financial Systems METHODIST HOSPI ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0002	Period:	u of Form CMS-2 Worksheet E	2002-1
		Component CCN: 15-S002	From 01/01/2020 To 12/31/2020	Date/Time Pre	
		Title XVIII	Subprovider -	7/23/2021 10: PPS	<u>58 am</u>
			I PF		
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)	-+:)		0	
2.00 3.00	Medical and other services reimbursed under OPPS (see instruct OPPS payments	ctions)		436 446	
4.00	Outlier payment (see instructions)			0	4.0
4.01 5.00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instru	uctions)		0 0.000	4.0 5.0
6.00	Line 2 times line 5			0	6.0
7.00 3.00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	
9.00 9.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	
10.00	Organ acquisitions			0	
11.00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			0	11.0
	Reasonable charges				
12.00 13.00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, 1	line 69)		0	12.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0	
15.00	Customary charges Aggregate amount actually collected from patients liable for	navmont for sorvices on	a chargo basi s	0	15.0
16.00	Amounts that would have been realized from patients liable for			0	
17 00	had such payment been made in accordance with 42 CFR §413.13	(e)		0,000000	17 0
17.00 18.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 0	
19. 00	Excess of customary charges over reasonable cost (complete or	nly if line 18 exceeds l	ine 11) (see	0	19.0
20. 00	instructions) Excess of reasonable cost over customary charges (complete ou	nlvifline 11 exceeds l	ine 18) (see	0	20.0
	instructions)		(
21.00 22.00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			0	21.0 22.0
23.00	Cost of physicians' services in a teaching hospital (see ins	tructions)		0	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			446	24.0
25.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instruction	ns)		0	25.0
26.00	Deductibles and Coinsurance amounts relating to amount on lin	ne 24 (for CAH, see inst		89	
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	357	27.0
28.00	Direct graduate medical education payments (from Wkst. E-4,			0	
29.00 30.00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29))		0 357	29.0 30.0
31.00	Primary payer payments			0	31.0
32.00	Subtotal (line 30 minus line 31)	050)		357	32.0
33.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI Composite rate ESRD (from Wkst. I-5, line 11)	GES)		0	33.0
34.00	Allowable bad debts (see instructions)			0	
35.00 36.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		0	35.0 36.0
37.00	Subtotal (see instructions)	,		357	37. C
38.00 39.00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	38. C 39. C
39.50 39.50	Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	39.5
39.97	Demonstration payment adjustment amount before sequestration	and daviana (and instru	ati ana)	0	
39.98 39.99	Partial or full credits received from manufacturers for repla RECOVERY OF ACCELERATED DEPRECIATION	aced devices (see instru	ctrons)	0	39.9 39.9
40.00	Subtotal (see instructions)			357	40. C
10.01	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			2	40. 0 40. 0
40. 03	Sequestration adjustment-PARHM pass-throughs			0	40.0
41.00 41.01	Interim payments			357	41.0 41.0
42.00	Interim payments-PARHM Tentative settlement (for contractors use only)			0	
42.01	Tentative settlement-PARHM (for contractor use only)			2	42.0
43.00 43.01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			-2	43.0 43.0
44.00	Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub. 15-2,	chapter 1,	0	
	§115.2 TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90.0
91.00 92.00	Outlier reconciliation adjustment amount (see instructions)			0	
92.00 93.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00 0	
94.00	Total (sum of lines 91 and 93)			0	94.0

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-0002	Period: From 01/01/2020 To 12/31/2020		pared
		Title		Hospi tal	PPS	
		Inpati en	t Part A	Par	тВ	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate		39, 244, 2	41 0	14, 192, 943 0	1. (2. (3. (
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	I				
01 02 03	ADJUSTMENTS TO PROVIDER	12/31/2020	733, 1	0 0	706, 727 0 0	3. 3. 3.
04 05				0	0	3. 3.
00	Provider to Program					
50 51 52 53 54	ADJUSTMENTS TO PROGRAM			0 0 0 0	0 0 0 0	3 3 3 3
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)		733, 1	-	706, 727	3
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)		39, 977, 3	47	14, 899, 670	4
	TO BE COMPLETED BY CONTRACTOR					
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	TENTATI VE TO PROVIDER			0	0	5
22				0	0	5
03				0	0	5
50	Provider to Program TENTATIVE TO PROGRAM			0	0	5
50 51				0	0) 5
52				0	0	5
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)		1 0 5 5	50	_	6
01 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		1, 945, 9	59	0 27, 960	6
02	Total Medicare program liability (see instructions)		41, 923, 3	06	27, 960 14, 871, 710	
				Contractor Number	NPR Date (Mo/Day/Yr)	
		C		1.00	2.00	

IALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C Component	CN: 15-0002 CCN: 15-S002	Period: From 01/01/20 To 12/31/20		pare
		Title	e XVIII	Subprovi der I PF		
		Inpatien	it Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyy		
00	Total interim payments paid to provider	1.00	2.00	3.00	4.00	1.
00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		073, 8	0	0	2.
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	3.
03				0	0	
04 05				0	0	
05	Provider to Program			0	0	
50	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	3
52				0	0	
53				0	0	3
54 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	3
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)		673, 8	97	357	4
	TO BE COMPLETED BY CONTRACTOR		1			
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
~ ^	Program to Provider		1			
01 02	TENTATI VE TO PROVI DER			0	0	
02				0	0	
	Provider to Program					
50	TENTATI VE TO PROGRAM			0	0	
51 52				0	0	
52 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER		3	78	0	
02 00	SETTLEMENT TO PROGRAM		674, 2	0	2 355	
00	Total Medicare program liability (see instructions)		0/4,2	Contractor		- /
				Number	(Mo/Day/Yr)	
		(C	1.00	2.00	

IALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		CN: 15-0002 CCN: 15-T002	Period: From 01/01/202 To 12/31/202	Worksheet E- 0 Part I 0 Date/Time Pr 7/23/2021 10	epare
		Title	e XVIII	Subprovider - IRF		100 4
		I npati er	nt Part A		art B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
00		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		4, 385, 4	0		0 1. 0 2.
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
01	ADJUSTMENTS TO PROVIDER			0	(0 3.
02				0		0 3.
03				0	(0 3.
04				0		0 3.
05	Descriders to Description			0	(0 3.
50	Provider to Program ADJUSTMENTS TO PROGRAM		1	0		0 3
50 51				0		0 3
52				0	(0 3
53				0	(0 3
54				0		0 3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	(0 3.
00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		4, 385, 4	25		0 4.
	(transfer to Wkst. E or Wkst. E-3, line and column as		.,,.			
	appropriate)					_
00	TO BE COMPLETED BY CONTRACTOR 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)					5
~ -	Program to Provider					
01 02	TENTATI VE TO PROVI DER			0		0 5 0 5
02 03				0		0 5
00	Provider to Program				`	
50	TENTATI VE TO PROGRAM			0	(0 5
51				0		0 5
52	Subtatal (our of lines E 01 E 40 minute our of lines			0		0 5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0		0 5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER		70, 8	04		0 6
02	SETTLEMENT TO PROGRAM		4, 456, 2	0		0 6. 0 7.
00	Total Medicare program liability (see instructions)		4,456,2	29 Contractor	NPR Date	0 7
				Number	(Mo/Day/Yr)	
			0	1.00	2.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0002 Period: From 01/01/2020 Worksheet To be completed by contractor for Nonstandard cost reports 1.00 1.00	Prepared: 10:58 am
Title XVIII Hospital PI To be completed by contractor for nonstandard cost reports To be completed by contractor for nonstandard cost reports	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS	_
ILEATTH INFORMATION TECHNOLOCY DATA COLLECTION AND CALCULATION	
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
6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20	6.00
7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	7.00
8.00 Calculation of the HIT incentive payment (see instructions)	8.00
9.00 Sequestration adjustment amount (see instructions)	9.00
10.00 Calculation of the HIT incentive payment after sequestration (see instructions)	10.00
I NPATI ENT HOSPITAL SERVICES UNDER THE IPPS & CAH	
30.00 Initial/interim HIT payment adjustment (see instructions)	30.00
31.00 Other Adjustment (specify)	31.00
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	32.00

		HOSPITALS, INC		u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0002	Period: From 01/01/2020	Worksheet E-3 Part II	
		Component CCN: 15-S002	To 12/31/2020	Date/Time Pre	
		Title XVIII	Subprovi der -	7/23/2021 10: PPS	<u>58 a</u>
			I PF		
	PART II - MEDICARE PART A SERVICES - IPF PPS			1.00	
. 00	Net Federal IPF PPS Payments (excluding outlier, ECT, an	nd medical education payments)	823, 503	1
00	Net IPF PPS Outlier Payments	1.3	, ,	41,059	2
00	Net IPF PPS ECT Payments			0	3
00	Unweighted intern and resident FTE count in the most rec 15, 2004. (see instructions)	cent cost report filed on or l	before November	0.00	4
. 01	Cap increases for the unweighted intern and resident FTE program or hospital closure, that would not be counted w CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	vithout a temporary cap adjus		0.00	4
00	New Teaching program adjustment. (see instructions)			0.00	5
00	Current year's unweighted FTE count of I&R excluding FTE teaching program" (see instuctions)	Es in the new program growth	period of a "new	0.00	6
00	Current year's unweighted I&R FTE count for residents wi teaching program" (see instuctions)	thin the new program growth	period of a "new	0.00	7
00	Intern and resident count for IPF PPS medical education	adjustment (see instructions))	0.00	8
00	Average Daily Census (see instructions)			6.871585	ļ
	Teaching Adjustment Factor {((1 + (line 8/line 9)) raise	ed to the power of .5150 -1}.		0.000000	
	Teaching Adjustment (line 1 multiplied by line 10).			0	11
	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and			864, 562	
	Nursing and Allied Health Managed Care payment (see inst	truction)		0	
	Organ acquisition (DO NOT USE THIS LINE)	i notructi ono)		0	14
	Cost of physicians' services in a teaching hospital (see Subtotal (see instructions)	e instructions)		864, 562	
	Primary payer payments			004, 502	17
	Subtotal (line 16 less line 17).			864, 562	
	Deducti bl es			32, 340	
	Subtotal (line 18 minus line 19)			832, 222	
	Coinsurance			153, 824	
	Subtotal (line 20 minus line 21)			678, 398	
	Allowable bad debts (exclude bad debts for professional	services) (see instructions)		0	23
	Adjusted reimbursable bad debts (see instructions)	, , , , , , , , , , , , , , , , , , , ,		0	24
5.00	Allowable bad debts for dual eligible beneficiaries (see	e instructions)		0	25
5.00	Subtotal (sum of lines 22 and 24)			678, 398	26
7.00	Direct graduate medical education payments (see instruct	tions)		0	27
	Other pass through costs (see instructions)			357	
	Outlier payments reconciliation			0	29
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	30
	Pioneer ACO demonstration payment adjustment (see instru			0	30
	Demonstration payment adjustment amount before sequestra	ation		0	30
	Total amount payable to the provider (see instructions)			678, 755	
1.01 1.02	Sequestration adjustment (see instructions)	tion		4, 480 0	
	Demonstration payment adjustment amount after sequestrat			673, 897	
	Interim payments Tentative settlement (for contractor use only)			073, 897	32
	Balance due provider/program (line 31 minus lines 31.01,	31 02 32 and 33)		378	
	Protested amounts (nonallowable cost report items) in ac §115.2		chapter 1,	0	35
	TO BE COMPLETED BY CONTRACTOR	20. 2		41 050	E /
	Original outlier amount from Worksheet E-3, Part II, lin			41, 059	
	Outlier reconciliation adjustment amount (see instruction The rate used to calculate the Time Value of Money	(200		0 0. 00	51
				0.00	i 07

		HOSPITALS, INC		J OF Form CMS-2	
ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0002	Peri od: From 01/01/2020		
		Component CCN: 15-T002	To 12/31/2020	Date/Time Pre 7/23/2021 10:	
		Title XVIII	Subprovider - IRF	PPS	
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
. 00	Net Federal PPS Payment (see instructions)			3, 988, 740	
. 00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0822	2
. 00	Inpatient Rehabilitation LIP Payments (see instructions)			311, 521	3
00	Outlier Payments			221, 808	4
00	Unweighted intern and resident FTE count in the most rec to November 15, 2004 (see instructions)		0 1	0.00	
01	Cap increases for the unweighted intern and resident FTE			0.00	5
	program or hospital closure, that would not be counted w		tment under 42		
00	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00	
. 00 . 00	New Teaching program adjustment. (see instructions)	s in the new program growth	poriod of a "now	0.00 0.00	
00	Current year's unweighted FTE count of I&R excluding FTE teaching program" (see instructions)	s fill the new program growth		0.00	'
. 00	Current year's unweighted I&R FTE count for residents wi	thin the new program growth	period of a "new	0.00	6
. 00	teaching program" (see instructions)			0.00	
. 00	Intern and resident count for IRF PPS medical education	adjustment (see instructions)	0.00	9
D. 00	Average Daily Census (see instructions)		ŕ	14.778689	10
1.00	Teaching Adjustment Factor (see instructions)			0.000000	1
2.00	Teaching Adjustment (see instructions)			0	12
3.00	Total PPS Payment (see instructions)			4, 522, 069	13
1.00	Nursing and Allied Health Managed Care payments (see ins	struction)		0	14
5.00	5 1 1				1
5.00	Cost of physicians' services in a teaching hospital (see	e instructions)		0	
7.00				4, 522, 069	
3.00	Primary payer payments			4 522 040	
). 00). 00	Subtotal (line 17 less line 18). Deductibles			4, 522, 069 14, 080	
1.00	Subtotal (line 19 minus line 20)			4, 507, 989	
	Coi nsurance			22, 176	
3.00	Subtotal (line 21 minus line 22)			4, 485, 813	
1.00	· · · · · · · · · · · · · · · · · · ·	services) (see instructions)		4, 403, 013	24
5.00	Adjusted reimbursable bad debts (see instructions)			0	25
5.00	3	e instructions)		0	20
7.00	Subtotal (sum of lines 23 and 25)			4, 485, 813	27
3. 00	Direct graduate medical education payments (from Wkst. E	-4, line 49)		0	28
9.00	Other pass through costs (see instructions)			23	29
D. 00	Outlier payments reconciliation			0	30
1.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31
1.50	Pioneer ACO demonstration payment adjustment (see instru	-		0	31
1.99	Demonstration payment adjustment amount before sequestra	ition		0	31
2.00	Total amount payable to the provider (see instructions)			4, 485, 836	
2.01	Sequestration adjustment (see instructions)	i en		29, 607	
2.02 3.00	Demonstration payment adjustment amount after sequestrat Interim payments	.1 011		0 4, 385, 425	
1.00	Tentative settlement (for contractor use only)			4, 365, 425	34
5.00	Balance due provider/program (line 32 minus lines 32.01,	32,02, 33, and 34)		70, 804	
6. 00	Protested amounts (nonallowable cost report items) in ac	· · · · ·	chapter 1,	0	36
	§115.2 TO BE COMPLETED BY CONTRACTOR				
0.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			221, 808	50
1.00	Outlier reconciliation adjustment amount (see instructio	ons)		0	51
2.00	The rate used to calculate the Time Value of Money			0.00	
2.00					53

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VII Date/Time Pre 7/23/2021 10:	pared
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR	XIX SERVICES		-
~ ~	COMPUTATION OF NET COST OF COVERED SERVICES	7 4 40 050			
00	Inpatient hospital/SNF/NF services		7, 140, 052	0	1.0
00	Medical and other services Organ acquisition (certified transplant centers only)		0	0	2.0
00 00	Subtotal (sum of lines 1, 2 and 3)		7, 140, 052	0	3.0
00	Inpatient primary payer payments		7, 140, 032	0	5.0
00	Outpatient primary payer payments		0	0	
00	Subtotal (line 4 less sum of lines 5 and 6)		7, 140, 052	0	
	COMPUTATION OF LESSER OF COST OR CHARGES		.,		1
	Reasonabl e Charges				1
00	Routine service charges		5, 164, 593		8.0
00	Ancillary service charges		19, 519, 453	0	9.0
0. 00	Organ acquisition charges, net of revenue		0		10.0
. 00	Incentive from target amount computation		0		11. (
2.00	Total reasonable charges (sum of lines 8 through 11)		24, 684, 046	0	12.0
	CUSTOMARY CHARGES		0	0	1 1 2 0
8.00	Amount actually collected from patients liable for payment for basis	services on a charge	0	0	13.0
1.00	Amounts that would have been realized from patients liable for	navment for services	on 0	0	14.0
F. 00	a charge basis had such payment been made in accordance with 4		011 0	0	14.0
5.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	2 611 3413. 15(6)	0. 000000	0.000000	15.
5.00	Total customary charges (see instructions)		24, 684, 046	0	
. 00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	17, 543, 994	0	17.
	line 4) (see instructions)				
3.00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds li	ne 0	0	18.0
	16) (see instructions)				
9.00	Interns and Residents (see instructions)		0	0	
0.00	Cost of physicians' services in a teaching hospital (see instr		7 140 052	0	
. 00	Cost of covered services (enter the lesser of line 4 or line 1 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be		7, 140, 052	0	21.
	Other than outlier payments		0	0	22.
3.00	Outlier payments		0	0	
1.00	Program capital payments		0	-	24.
5.00	Capital exception payments (see instructions)		0		25.
6.00	Routine and Ancillary service other pass through costs		0	0	26.
7.00	Subtotal (sum of lines 22 through 26)		0	0	27.
3. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28.
9.00	Titles V or XIX (sum of lines 21 and 27)		7, 140, 052	0	29.
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
). 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)		7, 140, 052	0	
. 00	Deductibles		0	0	
. 00	Coinsurance Allowable bad debts (see instructions)		0	0	
. 00	Utilization review		0	0	34.
b. 00		33)	7, 140, 052	0	
7.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
3.00	Subtotal (line 36 \pm line 37)		7, 140, 052	0	
. 00	Direct graduate medical education payments (from Wkst. E-4)		0	Ũ	39.
0. 00	Total amount payable to the provider (sum of lines 38 and 39)		7, 140, 052	0	
. 00	Interim payments		8, 071, 232	0	41.
2.00	Balance due provider/program (line 40 minus line 41)		-931, 180	0	42.
		ice with CMS Pub 15-2,		0	43.

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0002	Period: From 01/01/2020	Worksheet E-3 Part VII	i
		Component CCN: 15-S002	To 12/31/2020		
		Title XIX	Subprovider - IPF	Cost	
			I npati ent	Outpati ent	
		DVICES FOD TITLES V OD		2.00	-
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEI COMPUTATION OF NET COST OF COVERED SERVICES	RVICES FOR TITLES V OR	ALA SERVICES		1
00	Inpatient hospital/SNF/NF services		131, 137		1 1
00	Medical and other services		0		
00	Organ acquisition (certified transplant centers only)		0		3
00	Subtotal (sum of lines 1, 2 and 3)		131, 137	0	4
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments		101 107	0	
00	Subtotal (line 4 less sum of lines 5 and 6)		131, 137	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges				-
00	Routi ne servi ce charges		424, 960		1 8
00	Ancillary service charges		424, 900	0	
00	Organ acquisition charges, net of revenue		424, 730	0	10
. 00	Incentive from target amount computation		0		1
. 00	Total reasonable charges (sum of lines 8 through 11)		849, 918	0	12
	CUSTOMARY CHARGES				
. 00	Amount actually collected from patients liable for payment fo	r services on a charge	0	0	13
~ ~	basi s				
. 00	Amounts that would have been realized from patients liable fo		on 0	0	14
. 00	a charge basis had such payment been made in accordance with Ratio of line 13 to line 14 (not to exceed 1.000000)	42 CFR 9413.13(e)	0, 000000	0,000000	15
. 00	Total customary charges (see instructions)	, , ,			
. 00	Excess of customary charges over reasonable cost (complete on				
. 00	line 4) (see instructions)				
. 00	Excess of reasonable cost over customary charges (complete on	ly if line 4 exceeds li	ne 0	0	18
	16) (see instructions)				
. 00	Interns and Residents (see instructions)		0	0	
. 00	Cost of physicians' services in a teaching hospital (see inst		0	0	
. 00	Cost of covered services (enter the lesser of line 4 or line		131, 137	0	2
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS prov		0	1 ~
2.00 3.00	Other than outlier payments Outlier payments		0	0	
. 00	Program capital payments		0	0	24
. 00	Capital exception payments (see instructions)		0		2
. 00	Routine and Ancillary service other pass through costs		0	0	
. 00	Subtotal (sum of lines 22 through 26)		0	0	
. 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)		131, 137	0	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
. 00	Excess of reasonable cost (from line 18)		0	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	131, 137	0	
	Deducti bl es		0	0	1 .
. 00 . 00	Coinsurance Allowable bad debts (see instructions)		0	0	
. 00	Utilization review		0	0	34
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 an	d 33)	131, 137	0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	/	0	0	
. 00	Subtotal (line 36 ± line 37)		131, 137	0	
	Direct graduate medical education payments (from Wkst. E-4)		0		30
. 00	Total amount payable to the provider (sum of lines 38 and 39)		131, 137	0	
. 00	Interim payments		493, 242	0	
. 00	Balance due provider/program (line 40 minus line 41)		-362, 105	0	
3.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2,	0	0	43

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0002	Peri od:	Worksheet E-3	3
		Component CCN: 15-T002	From 01/01/2020 To 12/31/2020	Part VII Date/Time Pre 7/23/2021 10:	
		Title XIX	Subprovi der – I RF	Cost	
			I npati ent	Outpati ent	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH S	EDVICES FOR TITLES V OR		2.00	-
	COMPUTATION OF NET COST OF COVERED SERVICES	ERVICES FOR TITLES V OR A	AIA SERVICES		1
00	Inpatient hospital /SNF/NF services		555, 688		1 1
00	Medical and other services			0	
00	Organ acquisition (certified transplant centers only)		0		
00	Subtotal (sum of lines 1, 2 and 3)		555, 688	0	
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments		FFF (00	0	
00	Subtotal (line 4 less sum of lines 5 and 6)		555, 688	0	
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges				-
00	Routi ne servi ce charges		558, 502		1 8
00	Ancillary service charges		1, 262, 166	0	
. 00	Organ acquisition charges, net of revenue		0	Ũ	10
. 00	Incentive from target amount computation		0		1
. 00			1, 820, 668	0	1:
	CUSTOMARY CHARGES				١.,
. 00	Amount actually collected from patients liable for payment f	for services on a charge	0	0	13
00	basis		0	1	
. 00	Amounts that would have been realized from patients liable f		on 0	0	14
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	harge basis had such payment been made in accordance with 42 CFR §413.13(e)			
. 00	Total customary charges (see instructions)				
. 00	Excess of customary charges over reasonable cost (complete o				
	line 4) (see instructions)				
. 00	Excess of reasonable cost over customary charges (complete o	only if line 4 exceeds li	ne 0	0	18
	16) (see instructions)				
. 00	Interns and Residents (see instructions)	+	0	0	
. 00	Cost of physicians' services in a teaching hospital (see ins		0 555, 688	0	
. 00	Cost of covered services (enter the lesser of line 4 or line PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only b			0	12
. 00		e compreted for fr5 provi	0	0	22
. 00	Outlier payments		0	0	
. 00			0		24
. 00	Capital exception payments (see instructions)		0		2
. 00			0	0	
. 00	Subtotal (sum of lines 22 through 26)		0	0	
. 00	Customary charges (title V or XIX PPS covered services only)		0	0	1
. 00			555, 688	0	20
00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Excess of reasonable cost (from line 18)		0	0	30
. 00		6)	555, 688	0	
	Deductibles		0	0	
00			0	0	
00	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review		0		3!
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 a	ind 33)	555, 688	0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
. 00	Subtotal (line 36 ± line 37)		555, 688	0	
	Direct graduate medical education payments (from Wkst. E-4) Total amount payable to the provider (sum of lines 38 and 39			0	3
. 00	Interim payments	·)	555, 688 595, 325	0	
. 00	Balance due provider/program (line 40 minus line 41)		-39, 637	0	
. 00	Protested amounts (nonal lowable cost report items) in accord	lance with CMS Pub 15-2	-37,037	0	
	chapter 1, §115.2		0	0	1

	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	TALS, INC Provider C	CN: 15-0002	Period:	u of Form CMS-2 Worksheet E-4			
DICA	L EDUCATION COSTS			From 01/01/2020 To 12/31/2020	Date/Time Pre			
		Title	XVIII	Hospi tal	7/23/2021 10: PPS	58 an		
					1.00			
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				10. 83	1.0		
00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.							
00	Unweighted FTE resident cap add-on for new programs per 42 CF		(1) (see inst	ructions)	0.00			
00 01	Amount of reduction to Direct GME cap under section 422 of MM Direct GME cap reduction amount under ACA §5503 in accordance		R §413.79 (m)	. (see	0.00 0.00			
00	instructions for cost reporting periods straddling 7/1/2011) Adjustment (plus or minus) to the FTE cap for allopathic and		,		0.00			
01	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f) ACA Section 5503 increase to the Direct GME FTE Cap (see inst) .			0.00	4.		
	straddling 7/1/2011)			0.1				
02	ACA Section 5506 number of additional direct GME FTE cap slot periods straddling 7/1/2011)	is (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	us 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 fo	r the current	year from your	3.00	6.		
00	Enter the lesser of line 5 or line 6		Primary Car	e Other	3.00 Total	7.		
			1. 00	2.00	3.00			
00	Weighted FTE count for physicians in an allopathic and osteop program for the current year.	bathi c	0. (2. 50	2.50	8.		
00	If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo		0. (2.50	2.50	9.		
. 00	6. Weighted dental and podiatric resident FTE count for the curr	ent year		0.00		10.		
. 01	Unweighted dental and podiatric resident FTE count for the cu	urrent year		0.00		10.		
. 00 . 00	Total weighted FTE count Total weighted resident FTE count for the prior cost reportir	ng year (see	0. (0. (11. 12.		
. 00	instructions) Total weighted resident FTE count for the penultimate cost re year (see instructions)	eporting	0. (2. 50		13.		
. 00	Rolling average FTE count (sum of lines 11 through 13 divided	1 by 3).	0. (14.		
. 00 . 01	Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new p	rograme	0. (0. (15		
. 01	Adjustment for residents displaced by program or hospital clo		0.0			16		
. 01	Unweighted adjustment for residents displaced by program or h closure		0. (16		
. 00	Adjusted rolling average FTE count		0. (17.		
. 00 . 00	Per resident amount Approved amount for resident costs		0. (0 88, 050. 00 0 220, 125	220, 125	18. 19		
				,				
00	Additional unweighted allopathic and osteopathic direct GME F	TE resident	cap slots re	ceived under 42	1.00	20		
. 00	Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instru	uctions)			0.00	21.		
. 00	Allowable additional direct GME FTE Resident Count (see instr				0.00			
. 00	Enter the locality adjustment national average per resident a		nstructions)		88,050.00			
00	Multiply line 22 time line 23				0	24		
00	Total direct GME amount (sum of lines 19 and 24)		I mart i	Managarad	220, 125	25.		
			Inpatient Part A	Managed Care	Total			
	COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2.00	3.00			
. 00	Inpatient Days (see instructions) (Title XIX - see S-2 Part I 3.02, column 2)	X, line	26, 48	33 18, 379		26.		
. 00	Total Inpatient Days (see instructions)		83, 90			27.		
	Ratio of inpatient days to total inpatient days		0. 31539			28.		
. 00	Program direct GME amount		69, 42		117, 609			
. 01 . 00	Percent reduction for MA DGME Reduction for direct GME payments for Medicare Advantage			7.00 3,373	3, 373	29. 30.		
	Net Program direct GME amount			5, 575	114, 236			

Heal th	Financial Systems MET	HODI ST HOSPI T	ALS, INC	In Lieu	u of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIE	NT DI RECT	Provider CCN: 15-0002	Period:	Worksheet E-4	
MEDI CA	L EDUCATION COSTS			From 01/01/2020 To 12/31/2020	Date/Time Pre	narod
				10 12/31/2020	7/23/2021 10:	
			Title XVIII	Hospi tal	PPS	
					1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE EDUCATION COSTS)	E RATE – TITL	E XVIII ONLY (NURSING S	CHOOL AND PARAMED	ICAL	
	Renal dialysis direct medical education costs (fr	rom Wkst. B,	Pt. I, sum of col. 20 a	nd 23, lines 74	0	32.00
	and 94)					
33.00	Renal dialysis and home dialysis total charges (V	Nkst. C, Pt.	I, col. 8, sum of lines	74 and 94)	10, 148, 623	33.00
	Ratio of direct medical education costs to total		e 32 ÷ line 33)		0.00000	34.00
	Medicare outpatient ESRD charges (see instruction				0	35.00
	Medicare outpatient ESRD direct medical education				0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST -	- TITLE XVIII	ONLY			
	Part A Reasonable Cost					
	Reasonable cost (see instructions)				55, 744, 464	
	Organ acquisition costs (Wkst. D-4, Pt. III, col.	. ,			0	38.00
	Cost of physicians' services in a teaching hospit	tal (see inst	ructions)		0	39.00
	Primary payer payments (see instructions)		- 15 (0)		14, 216	
	<u>Total Part A reasonable cost (sum of lines 37 thr</u> Part B Reasonable Cost	rougn 39 minu	s Tine 40)		55, 730, 248	41.00
	Reasonable cost (see instructions)				19, 913, 855	42.00
	Primary payer payments (see instructions)				9, 272	43.00
	Total Part B reasonable cost (line 42 minus line	43)			19, 904, 583	
	Total reasonable cost (sum of lines 41 and 44)	10)			75, 634, 831	
	Ratio of Part A reasonable cost to total reasonable	ble cost (lin	e 41 ÷ line 45)		0. 736833	
	Ratio of Part B reasonable cost to total reasonab				0.263167	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN F	PART A AND PA	RT B			
48.00	Total program GME payment (line 31)				114, 236	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title	e XVIII only)	(see instructions)		84, 173	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title	e XVIII only)	(see instructions)		30, 063	50.00

und-ty	SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C	Fi	eriod: ^om 01/01/2020 o 12/31/2020	Worksheet G	naro
nl y)		General Fund	Speci fi c	Endowment	Date/Time Pre 7/23/2021 10: Plant Fund	58 a
	-	1.00	Purpose Fund 2.00	Fund 3.00	4.00	
	CURRENT ASSETS					
	Cash on hand in banks	112, 222, 084	0	0	0	
	Temporary investments Notes receivable	616, 969	0	0	0	2. 3.
	Accounts receivable	39, 897, 780	0	0	0	4.
	Other receivable	0	0	0	0	5.
00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6
	Inventory	12, 736, 109	0	0	0	
	Prepaid expenses	3, 884, 320 24, 830, 939		0	0	
	Other current assets Due from other funds	24, 830, 939 0	0	0	0	9
	Total current assets (sum of lines 1-10)	194, 188, 201	0	0	0	
-	FIXED ASSETS	,		-1	-	
	Land	5, 373, 674	0	0	0	12
	Land improvements	6, 896, 457	0	0	0	13
	Accumulated depreciation	-382, 761, 666	0	0	0	
	Buildings Accumulated depreciation	308, 285, 957	0	0	0	15 16
	Leasehold improvements	1, 230, 154	0	0	0	17
	Accumul ated depreciation	0	0	0	0	18
	Fixed equipment	0	0	0	0	19
	Accumulated depreciation	0	0	0	0	20
	Automobiles and trucks	0	0	0	0	21
	Accumulated depreciation Major movable equipment	0 199, 068, 926	0	0	0	22
	Accumul ated depreciation	199,000,920	0	0	0	24
	Mi nor equi pment depreci abl e	0	0	0	0	25
	Accumulated depreciation	0	0	0	0	26
	HIT designated Assets	0	0	0	0	27
	Accumulated depreciation	0	0	0	0	28
	Minor equipment-nondepreciable	0 138, 093, 502	0	0	0	29
	Total fixed assets (sum of lines 12-29)	136, 093, 502	0	0	0	1 30
	Investments	117, 777, 851	0	0	0	31
	Deposits on Leases	0	0	0	0	32
	Due from owners/officers	0	0	0	0	33
	Other assets	688, 643		0	0	34
	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	118, 466, 494 450, 748, 197		0	0	35
	CURRENT LIABILITIES	430, 748, 197	0	0	0	1 30
	Accounts payable	21, 422, 227	0	0	0	37
. 00	Salaries, wages, and fees payable	0	0	0	0	
	Payroll taxes payable	0	0	0	0	
	Notes and Loans payable (short term)	2, 570, 000	0	0	0	40
	Deferred income Accelerated payments	0	0	0	0	41
	Due to other funds	0	0	0	0	
	Other current liabilities	73, 092, 550	0	0	0	
	Total current liabilities (sum of lines 37 thru 44)	97, 084, 777	0	0	0	45
	LONG TERM LIABILITIES	-	-			l
	Mortgage payable	70 (10 022	0	0	0	
	Notes payable Unsecured Loans	70, 619, 022	0	0	0	
	Other long term liabilities	24, 563, 340	-	0	0	49
	Total long term liabilities (sum of lines 46 thru 49)	95, 182, 362		0	0	50
	Total liabilities (sum of lines 45 and 50)	192, 267, 139	0	0	0	51
	CAPITAL ACCOUNTS					
-	General fund balance	258, 481, 058	0			52
	Specific purpose fund Donor created - endowment fund balance - restricted		0	0		53
-	Donor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance			Ő		56
. 00	Plant fund balance - invested in plant				0	57
	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion	250 401 050		~	0	E
	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	258, 481, 058 450, 748, 197	0	0	0	
	59)	430, 740, 197	0	0	0	1 00

Health Financial Systems	METHODI ST HOSP	ITALS, INC		In Lie	u of Form CMS-	2552-10
STATEMENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0002	Period: From 01/01/2020 To 12/31/2020	Worksheet G-1 Date/Time Pre 7/23/2021 10:	epared:
	General	Fund	Speci al	Purpose Fund	Endowment Fund	
	1.00	2.00	3.00	4.00	5.00	
1.00Fund balances at beginning of period2.00Net income (loss) (from Wkst. G-3, line 29)3.00Total (sum of line 1 and line 2)4.00Additions (credit adjustments) (specify)5.00.006.00.007.008.009.0010.0010.00Total additions (sum of line 4-9)11.00Subtotal (line 3 plus line 10)12.00Deductions (debit adjustments) (specify)13.0014.0015.0016.0017.0018.0018.00Total deductions (sum of lines 12-17)19.00Fund balance at end of period per balance	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	242, 801, 511 15, 679, 547 258, 481, 058 0 258, 481, 058 0 258, 481, 058			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
sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
	6.00	7.00	8.00			
 1.00 Fund balances at beginning of period 2.00 Net income (loss) (from Wkst. G-3, line 29) 3.00 Total (sum of line 1 and line 2) 4.00 Additions (credit adjustments) (specify) 5.00 6.00 7.00 8.00 9.00 	0	0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 10.00 Total additions (sum of line 4-9) 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) (specify) 13.00 14.00 15.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 12-17)	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 Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		19.00

STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider (CCN: 15-0002	Period:	Worksheet G-2	2552-10
				From 01/01/2020 To 12/31/2020	Date/Time Pre	pared:
			1		7/23/2021 10:	58 am
	Cost Center Description		Inpatient	Outpatient	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					-
1.00	General Inpatient Routine Services Hospital		71, 895, 04	10	71, 895, 042	1.00
2.00	SUBPROVIDER - IPF		4, 390, 60		4, 390, 602	2.00
3.00	SUBPROVIDER - IPF		5, 299, 85		4, 390, 802 5, 299, 851	3.00
4.00	SUBPROVIDER - TRF		5, 299, 63	51	5, 299, 651	4.00
4.00 5.00	Subprovider Swing bed - SNF			0	0	5.00
6.00	Swing bed - NF			0	0	6.00
7.00	SKILLED NURSING FACILITY			0	0	7.00
8.00	NURSING FACILITY					8.00
8.00 9.00	OTHER LONG TERM CARE					9.00
9.00 10.00	Total general inpatient care services (sum of lines 1-9)		81, 585, 49		01 505 405	1
10.00	Intensi ve Care Type Inpatient Hospital Services		01, 303, 4	90	81, 585, 495	10.00
11.00	INTENSIVE CARE UNIT		30, 377, 14	41	30, 377, 141	111 00
11.00	NEONATAL I CU		30, 377, 14			11.00
				0	0	
12.00	CORONARY CARE UNIT					12.00
13.00	BURN I NTENSI VE CARE UNI T					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)		00 077 1		00 077 444	15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines	30, 377, 14	41	30, 377, 141	16.00
17 00	11-15)		111 0/0 //		111 0/0 /0/	17 00
17.00	Total inpatient routine care services (sum of lines 10 and 16))	111, 962, 63		111, 962, 636	
18.00	Ancillary services		483, 484, 49		1,068,565,094	18.00
19.00	Outpatient services		24, 021, 4			
20.00	RURAL HEALTH CLINIC			0 0		20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	-	21.00
22.00	HOME HEALTH AGENCY			4, 239, 040	4, 239, 040	
23.00	AMBULANCE SERVICES					23.00
24.00	СМНС					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPICE					26.00
27.00	OTHER (SPECIFY)			0 0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	619, 468, 55	56 678, 195, 654	1, 297, 664, 210	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES		-			
29.00	Operating expenses (per Wkst. A, column 3, line 200)			360, 661, 096		29.00
30.00	ADD (SPECI FY)			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)			C		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)			Ŭ C		42.00
			1			
43.00	Total operating expenses (sum of lines 29 and 36 minus line 43	2)(transfer	~	360, 661, 096		43.00

		THODIST HOSPITALS, INC		u of Form CMS-2	
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN:	15-0002 Period: From 01/01/2020	Worksheet G-3	
			To 12/31/2020	Date/Time Pre	pared:
				7/23/2021 10:	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I,	column 3 line 28)		1, 297, 664, 210	1.00
	Less contractual allowances and discounts on pa			968, 790, 134	
	Net patient revenues (line 1 minus line 2)			328, 874, 076	
	Less total operating expenses (from Wkst. G-2,	Part II, line 43)		360, 661, 096	
	Net income from service to patients (line 3 mir			-31, 787, 020	5.00
	OTHER INCOME	,			1
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			3, 107, 936	7.00
8.00	Revenues from telephone and other miscellaneous	s communication services		0	8.00
	Revenue from television and radio service			0	9.00
	Purchase di scounts			0	10.00
	Rebates and refunds of expenses			0	11.00
	Parking lot receipts			0	
	Revenue from Laundry and Linen service			0	
	Revenue from meals sold to employees and guests			0	14.00
	Revenue from rental of living quarters			0	
	Revenue from sale of medical and surgical suppl			0	
	Revenue from sale of drugs to other than patier Revenue from sale of medical records and abstra			0	17.00 18.00
	Tuition (fees, sale of textbooks, uniforms, etc			0	
	Revenue from gifts, flowers, coffee shops, and	<i>,</i>		0	20.00
	Rental of vending machines	canteen		0	
	Rental of hospital space			0	
	Governmental appropriations			0	23.00
	OTHER OPERATING INCOME			7, 371, 890	
	NON OPERATING INCOME			-641, 333	
	CHANGE IN UNREALIZED GAIN/LOSS			3, 017, 551	
	REALIZED GAIN/LOSS INVESTMENT SALE			2, 174, 118	
	GAIN/LOSS ON ASSET DI SPOSAL			-240, 344	
24.50	COVI D-19 PHE Fundi ng			32, 881, 752	
25.00	Total other income (sum of lines 6-24)			47, 671, 570	25.00
26.00	Total (line 5 plus line 25)			15, 884, 550	26.00
	FOUNDATION SALARIES			191, 386	
	FOUNDATION OTHER			13, 617	
	Total other expenses (sum of line 27 and subscr			205, 003	
29.00	Net income (or loss) for the period (line 26 mi	nus line 28)		15, 679, 547	29.00

	Financial Systems SIS OF HOSPITAL-BASED HOME HEALT	TH AGENCY COSTS	METHODI ST HOSI	PITALS, INC Provider C HHA CCN:		eriod: rom 01/01/2020	u of Form CMS- Worksheet H Date/Time Pre 7/23/2021 10: PPS	pared:
		Sal ari es			Contracted/Pu rchased	Other Costs	Total (sum of	
				n (see instructions)	Servi ces		cols. 1 thru 5)	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	6.00	
1.00	Capital Related - Bldg. &			0		0	0	1.00
2.00	Fixtures Capital Related - Movable			0		0	o	2.00
	Equi pment							
3.00 4.00	Plant Operation & Maintenance Transportation	0	0	0	0	0	0	3.00 4.00
5.00	Administrative and General	544, 227	0	0	0	442, 674	986, 901	5.00
6.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	1, 081, 968	0	0	0	0	1, 081, 968	6.00
7.00	Physical Therapy	492, 860		0	-		492, 860	
8.00 9.00	Occupational Therapy Speech Pathology	155, 042 37, 059	0 0	0 0	-		155, 042 37, 059	
10.00	Medical Social Services	4, 585	0	0	-		4, 585	1
11.00 12.00	Home Health Aide Supplies (see instructions)	61, 640 0	0	0	0	0	61, 640 0	1
13.00	Drugs	0	0	0			0	
14.00	DME HHA NONREI MBURSABLE SERVI CES	0	0	0	0	0	0	14.00
15.00	Home Di al ysi s Ai de Servi ces	0	0	0	0	0	0	15.00
16.00 17.00	Respiratory Therapy	0	0	0			0	
17.00	Private Duty Nursing Clinic	0	0	0 0	-	0	0	
19.00	Health Promotion Activities	0	0	0	0	0	0	
20.00 21.00	Day Care Program Home Delivered Meals Program	0	0	0	0	0	0	20.00 21.00
22.00	Ũ	0	0	0	0	0	0	1
23.00 23.50	All Others (specify) Telemedicine	0	0	0	0	0	0	
	Total (sum of lines 1-23)	2, 377, 381	0	0	0	442, 674	2, 820, 055	1
		Recl assi fi cat i on	Reclassified Trial Balance	Adjustments	Net Expenses for			
		Ton	(col. 6 +		Allocation			
			col . 7)		(col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
1.00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	0	0	0			1.00
	Fixtures			c .	_			
2.00	Capital Related – Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0				3.00
4.00 5.00	Transportation Administrative and General	0 -25, 141	0 961, 760	0 0				4.00 5.00
	HHA REIMBURSABLE SERVICES	207111			· ·			
6.00 7.00	Skilled Nursing Care Physical Therapy	0	1, 081, 968 492, 860	0				6.00 7.00
8.00	Occupational Therapy	0	155, 042	0				8.00
9.00	Speech Pathology	0	37, 059	0	37,059			9.00
10. 00 11. 00	Medical Social Services Home Health Aide	0	4, 585 61, 640	0	.,			10.00 11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00 14.00	5	0	0	0 0				13.00 14.00
14.00	HHA NONREI MBURSABLE SERVI CES	0		0				14.00
15.00 16.00	Home Dialysis Aide Services Respiratory Therapy	0	0	0				15.00 16.00
17.00		0	0	0	0			17.00
18.00	Clinic	0	0	0	-			18.00
19.00 20.00		0	0	0 0	0			19.00 20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00 23.00	Homemaker Service All Others (specify)	0	0	0	0			22.00 23.00
23.50	Tel emedi ci ne	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	-25, 141	2, 794, 914	0	2, 794, 914			24.00

Heal th	Financial Systems		METHODI ST HOSP	ITALS, INC		In Lie	u of Form CMS-:	2552-10
	LLOCATION - HHA GENERAL SERVICI	E COST		Provider C HHA CCN:	CN: 15-0002 15-7536	Period: From 01/01/2020 To 12/31/2020	Worksheet H-1 Part I	pared:
						Home Health	PPS	00 411
			Capital Rela	nted Costs		Agency I		
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	BI dgs & Fi xtures	Movabl e Equipment	Plant Operation & Maintenance		Subtotal (col s. 0-4)	_
	OFNERAL CERVILOF COCT OFNERO	0	1.00	2.00	3.00	4.00	4A. 00	
1.00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	0				0	1.00
	Fixtures							
2.00	Capital Related - Movable Equipment	0		C)		0	2.00
3.00	Plant Operation & Maintenance	0	0	C	þ	0	0	3.00
4.00 5.00	Transportation Administrative and General	0 961, 760	0	C		0 0 0 0	961, 760	4.00 5.00
5.00	HHA REI MBURSABLE SERVI CES	901,700	0			0 0	701, 700	5.00
6.00	Skilled Nursing Care	1, 081, 968	0	C		0 0	1, 081, 968	•
7.00 8.00	Physical Therapy Occupational Therapy	492, 860 155, 042	0	0		0 0 0 0	492, 860 155, 042	•
9.00	Speech Pathology	37, 059	0	C		0 0	37, 059	
10.00 11.00	Medical Social Services Home Health Aide	4, 585 61, 640	0	(0 0	4, 585 61, 640	•
12.00	Supplies (see instructions)	0	Ö	C		0 0	01,010	12.00
13.00 14.00	Drugs DME	0	0	C		0 0	0	
14.00	HHA NONREI MBURSABLE SERVI CES			- C				14.00
15.00 16.00	Home Dialysis Aide Services Respiratory Therapy	0	0	C		0 0	0	
17.00	Private Duty Nursing	0	0	C		0 0	0	•
18.00	Clinic	0	0	C		0 0	0	
19.00 20.00	Health Promotion Activities Day Care Program	0	0	C		0 0 0 0	0	
21.00	Home Delivered Meals Program	0	0	C		0 0	0	
22.00 23.00	Homemaker Service All Others (specify)	0	0	0		0 0	0	22.00 23.00
23.50	Tel emedi ci ne	0	0	C		0 0	0	23.50
24.00	Total (sum of lines 1-23)	2, 794, 914 Administrativ	0 Total (cols.			0 0	2, 794, 914	24.00
		e & General	4A + 5)					
	GENERAL SERVICE COST CENTERS	5.00	6.00					
1.00	Capital Related - Bldg. &							1.00
2.00	Fixtures Capital Related - Movable							2.00
2.00	Equi pment							2.00
3.00 4.00	Plant Operation & Maintenance Transportation							3.00 4.00
5.00	Administrative and General	961, 760						5.00
6.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	567, 652	1, 649, 620					6.00
7.00	Physical Therapy	258, 578	751, 438					7.00
8.00 9.00	Occupational Therapy Speech Pathology	81, 342 19, 443	236, 384 56, 502					8.00 9.00
9.00 10.00	Medical Social Services	2, 406	6, 991					10.00
11.00	Home Health Aide	32, 339	93, 979					11.00
12.00 13.00	Supplies (see instructions) Drugs	0	0					12.00 13.00
14.00		0	0					14.00
15.00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0					15.00
16.00	Respi ratory Therapy	0	0					16.00
17.00 18.00	Private Duty Nursing Clinic		0					17.00 18.00
19.00	Health Promotion Activities	0 0	0					19.00
20.00 21.00		0	0					20.00 21.00
22.00	Homemaker Service	0	0					22.00
	All Others (specify) Telemedicine	0	0					23.00 23.50
	Total (sum of lines 1-23)	0	2, 794, 914					23.50

Heal th	Financial Systems		METHODI ST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COST A	ALLOCATION - HHA STATISTICAL BAS	SI S		Provider C HHA CCN:	CN: 15-0002 15-7536	Period: From 01/01/2020 To 12/31/2020	Date/Time Pre	pared:
						Home Health	7/23/2021 10: PPS	38 811
		Capital Rel	ated Costs			Agency I		
		BIdgs &	Movabl e	Pl ant	Trancportati	o Reconciliatio	Administrativ	-
		Fixtures (SQUARE FEET)	Equi pment (DOLLAR VALUE)	Operation & Maintenance (SQUARE FEET)	n (MILEAGE)	n	e & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A. 00	5.00	
	GENERAL SERVICE COST CENTERS				•			
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see	0	0	0		0		4.00
	instructions)							
5.00	Administrative and General	0	0	0		0 -961, 760	1, 833, 154	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0		0 0	.,	
7.00	Physical Therapy	0	0	0		0 0	492, 860	
8.00 9.00	Occupational Therapy Speech Pathology	0	0	0		0 0	155, 042 37, 059	
9.00	Medical Social Services	0	0	0		0 0	4, 585	
10.00	Home Health Aide	0	0	0		0 0	4, 585 61, 640	
12.00	Supplies (see instructions)	0	0	0			01, 040	
13.00	Drugs	0	0	0		0 0	0	
14.00	DME	0	0	0		0 0	0	
14.00	HHA NONREI MBURSABLE SERVI CES		0	0		0 0	0	14.00
15.00	Home Dialysis Aide Services	0	0	0		0 0	0	15.00
16.00	Respiratory Therapy	0	0	0		0 0	0	16.00
17.00	Private Duty Nursing	0	0	0		0 0	0	17.00
18.00	Clinic	0	0	0		0 0	0	18.00
19.00	Health Promotion Activities	0	0	0		0 0	0	19.00
20.00		0	0	0		0 0	0	20.00
21.00	Home Delivered Meals Program	0	0	0		0 0	0	21.00
22.00	Homemaker Service	0	0	0		0 0	0	22.00
23.00		0	0	0		0 0	0	
23.50		0	0	0		0 0	0	
24.00		0	0	0		0 -961, 760		
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0		0	961, 760	25.00
26.00	Unit Cost Multiplier	0. 000000	0. 000000	0.000000	0. 00000	0	0. 524648	26.00

	n Financial Systems		METHODI ST HOS				ieu of Form CMS-	
ALLOC.	ATION OF GENERAL SERVICE COSTS	TO HHA COST CEN	ITERS	Provider C HHA CCN:	CN: 15-0002 15-7536	Period: From 01/01/20 To 12/31/20	Worksheet H-2 20 Part I 20 Date/Time Pre 7/23/2021 10:	epared:
						Home Health Agency I		
	Cost Center Description	HHA Trial Balance (1)	CAPI TAL RELATED COSTS BLDG & FI XT	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSI NG	PURCHASI NO		_
		0	1.00	4.00	5.01	5.02	5.03	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 7.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 50\\ 20.\ 00\\ 21.\ 00\\ \end{array}$	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) (2)	0 1, 649, 620 751, 438 236, 384 56, 502 6, 991 93, 979 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0	533, 321 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 10, 6 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 13.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 15.00 14.00 15.
	Cost Center Description	CASHI ERI NG/AC COUNTS RECEI VABLE	Subtotal	OTHER A&G	PATI ENT TRANSPORTATI N	0 OPERATION C 0 PLANT	OF LAUNDRY & LINEN SERVICE	
		5.04	5A. 04	5.05	5.06	7.00	8.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ \end{array}$	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) (2)	24, 131 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	751, 438 236, 384 56, 502 6, 991 93, 979 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	74, 011 210, 819 96, 032 30, 209 7, 221 893 12, 010 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 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Health Financial Systems		METHODI ST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF GENERAL SERVICE COSTS	TO HHA COST CEN	TERS	Provider C HHA CCN:	CN: 15-0002 15-7536	Period: From 01/01/2020 To 12/31/2020		pared:
					Home Health Agency I	PPS	
Cost Center Description	HOUSEKEEPING	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI N	CENTRAL	PHARMACY	
	9.00	10. 00	11.00	13.00	14.00	15.00	
 Administrative and General O Skilled Nursing Care O Physical Therapy O Occupational Therapy O Speech Pathology O Medical Social Services Home Health Aide O Supplies (see instructions) O Drugs O Home Dialysis Aide Services O Home Dialysis Aide Services O Respiratory Therapy O Clinic O Day Care Program O Home Delivered Meals Program O Home Dialysis Cipecify Telemedicine O Diverse O Linic O Day Care Program O Home Dialyservice O Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to 6 decimal places. 							$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 19.\ 50\\ \end{array}$
Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	STAFF EDUCATI ON	MEDI CAL EDUCATI ON	I NTERNS & RESI DENTS SERVI CES-SALA RY & FRI NGES	SERVICES-OTHE R PRGM COSTS	
	16.00	17.00	17.01	17.02	21.00	22.00	
 Administrative and General O Skilled Nursing Care O Physical Therapy O Occupational Therapy O Occupational Therapy O Speech Pathology O Medical Social Services O Home Health Aide O Supplies (see instructions) O Drugs O MME O Home Dialysis Aide Services O Respiratory Therapy O Respiratory Therapy O Private Duty Nursing O Day Care Program O Home Delivered Meals Program O Home Dial (sum of lines 1-19) (2) O Total (sum of lines 1-19) (2) O Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to 6 decimal places. 	14, 595 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	2,697 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				$\begin{array}{c} 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Heal th	Financial Systems		METHODI ST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
	ATION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS	Provider CO	CN: 15-0002 15-7536	Period: From 01/01/2020 To 12/31/2020	Worksheet H-2 Part I	
					10 / 000	10 12/01/2020	7/23/2021 10:	
						Home Health	PPS	
						Agency I		
	Cost Center Description	PARAMED ED	Subtotal	Intern &	Subtotal	Allocated HHA	Total HHA	
		PROGRAM		Resi dents		A&G (see Part	Costs	
				Cost & Post		11)		
				Stepdown				
	-	00.00	04.00	Adjustments	04.00	07.00	00.00	
1 00	Admini strative, and Consume	23.00	24.00	25.00	26.00	27.00	28.00	1.00
1.00 2.00	Administrative and General	0	670, 537	0	670, 53		2 254 204	1.00 2.00
2.00 3.00	Skilled Nursing Care	0	1, 860, 439	0	1, 860, 4			
3.00 4.00	Physical Therapy Occupational Therapy	0	847, 470 266, 593	0	847, 4 266, 5			
4.00 5.00	Speech Pathology	0	63, 723	0	200, 5 63, 7			
5.00 6.00	Medi cal Soci al Servi ces	0	7, 884	0	7,8			
7.00	Home Heal th Aide	0	105, 989	0	105, 98			
8.00	Supplies (see instructions)	0	103, 969	0	105, 90	0 22, 347	120, 030	7.00 8.00
9.00	Drugs	0	0	0		0 0	0	9.00
10.00	DME	0	0	0		0 0	0	7.00 10.00
11.00	Home Dialysis Aide Services	0	0	0			0	11.00
12.00	Respiratory Therapy	0	0	0		0 0	0	
13.00	Private Duty Nursing	0	0	0		0 0	0	
14.00	Clinic	0	0	0		0 0	0	
15.00	Health Promotion Activities	0	0	0		0 0	0	15.00
16.00	Day Care Program	Ō	ō	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	o	0		0 0	0	18.00
19.00	All Others (specify)	0	0	0		0 0	0	19.00
19.50	Tel emedi ci ne	0	0	0		0 0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	3, 822, 635	0	3, 822, 6	670, 537	3, 822, 635	20.00
21.00	Unit Cost Multiplier: column					0. 212727		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 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Health Financial Systems		METHODI ST HOS			In Lie	u of Form CMS-2	
ALLOCATION OF GENERAL SERVICE COSTS BASIS	TO HHA COST CEN	TERS STATISTIC	AL Provider C	CN: 15-0002 15-7536	Period: From 01/01/2020 To 12/31/2020	Worksheet H-2 Part II Date/Time Pre 7/23/2021 10:	
					Home Health Agency I	PPS	
Cost Center Description	CAPI TAL RELATED COSTS BLDG & FI XT (SQUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	DATA PROCESSI NG (MACHI NE TI ME)	PURCHASI NG RECEI VI NG AN STORES (PURCHASE REQUI SI TI ONS	ADMI TTI NG D (GROSS CHARGES)	CASHI ERI NG/AC COUNTS RECEI VABLE (GROSS CHARGES)	
	1.00	4.00	5.01	5.02	5.03	5.04	
1.00Administrative and General2.00Skilled Nursing Care3.00Physical Therapy4.00Occupational Therapy5.00Speech Pathology6.00Medical Social Services7.00Home Health Aide8.00Supplies (see instructions)9.00Drugs10.00DME11.00Home Dialysis Aide Services12.00Respiratory Therapy13.00Private Duty Nursing14.00Clinic15.00Health Promotion Activities16.00Day Care Program17.00Home Delivered Meals Program18.00All Others (specify)19.50Telemedicine20.00Total (sum of lines 1-19)21.00Total cost to be allocated		2, 376, 144 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	106, 19	0 0 0 0 11,058 11,058		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
22.00 Unit cost multiplier Cost Center Description	0.000000 Reconciliatio n	0. 224448 OTHER A&G (ACCUM. COST)	PATI ENT TRANSPORTATI 0 N (NUMBER OF TRI PS)	OPERATION OF PLANT (SQUARE FEET	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	22.00
	5A. 05	5.05	5.06	7.00	8.00	9.00	
 Administrative and General Administrative and General Skilled Nursing Care O Skilled Nursing Care O Physical Therapy O Occupational Therapy Sou Speech Pathology O Medical Social Services O Home Heal th Aide Supplies (see instructions) O Drugs O DME O Home Dialysis Aide Services O Respiratory Therapy O Heal th Promotion Activities O Heal th Promotion Activities O Day Care Program O Home Delivered Meals Program O Home Delivered Meals Program O Home Delivered Service O All Others (specify) Sou Telemedicine O Total (sum of lines 1-19) O Total cost to be allocated 		579, 122 1, 649, 620 751, 438 236, 384 56, 502 6, 991 93, 979 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 14.00 15.00 14.00 19.00 19.50 20.00

Health Financial Systems		METHODI ST HOS	PLTALS. INC		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF GENERAL SERVICE COSTS	TO HHA COST CEN				Peri od:	Worksheet H-2	
BASI S			HHA CCN:		From 01/01/2020 To 12/31/2020	Part II Date/Time Pre 7/23/2021 10:	
					Home Health	PPS	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	Agency I PHARMACY	MEDI CAL	
cost center bescription	(MEALS	(PRODUCTI VE	ADMI NI STRATI O	SERVICES &	(COSTED	RECORDS &	
	SERVED)	HOURS)	N	SUPPLY	REQUIS.)	LI BRARY	
			(DI RECT NURS.	(COSTED		(GROSS	
	10.00	11.00	HRS.) 13.00	REQUIS.) 14.00	15.00	CHARGES) 16.00	
1.00 Administrative and General	0	0	0		0 280	4, 160, 443	1.00
2.00 Skilled Nursing Care	0	0	-		0 0	0	2.00
3.00 Physical Therapy	0	0	-		0 0	0	
4.00 Occupational Therapy 5.00 Speech Pathology	0	0	-		0 0 0 0	0	
6.00 Medical Social Services	0	0	-		0 0	0	
7.00 Home Health Aide	0	0	0		0 0	0	
8.00 Supplies (see instructions)	0	0	0		0 0	0	
9.00 Drugs	0	0	0		0 0	0	
10.00 DME 11.00 Home Dialysis Aide Services	0	0	0		0 0 0 0	0	10.00 11.00
12. 00 Respi ratory Therapy	0	0	0		0 0	0	
13.00 Private Duty Nursing	0	0	0		0 0	0	13.00
14.00 Clinic	0	0	0		0 0	0	
15.00 Health Promotion Activities 16.00 Day Care Program	0	0	0		0 0 0 0	0	
17.00 Home Delivered Meals Program	0	0	0		0 0	0	
18.00 Homemaker Service	0	0	0		0 0	0	18.00
19.00 All Others (specify)	0	0	0		0 0	0	19.00
19.50 Tel emedi ci ne	0	0	0		0 0	0	19.50
20.00 Total (sum of lines 1-19) 21.00 Total cost to be allocated	0	0	0		0 280 0 112	4, 160, 443 14, 595	
22.00 Unit cost multiplier	0. 000000	0. 000000	0. 000000			0. 003508	
				I NTERNS	& RESI DENTS		
Cost Center Description	SOCI AL	STAFF	MEDI CAL	SERVI CES-SAL	A SERVI CES-OTHE	PARAMED ED	
	SERVI CE	EDUCATI ON	EDUCATI ON	RY & FRINGES	R PRGM COSTS	PROGRAM	
	(TIME SPENT)	(TIME SPENT)	(ASSI GNED	(ASSI GNED	(ASSI GNED	(ASSI GNED	
	17.00	17.01	TIME) 17.02	TIME) 21.00	TIME) 22.00	TI ME) 23.00	
1.00 Administrative and General	0	376	0		0 0	23.00	1.00
2.00 Skilled Nursing Care	0	0	0		0 0	0	
3.00 Physical Therapy	0	0	0		0 0	0	
4.00 Occupational Therapy 5.00 Speech Pathology	0	0	0		0 0 0 0	0	
6.00 Medical Social Services	0	0	0		0 0	0	
7.00 Home Heal th Ai de	0	0	0		0 0	0	7.00
8.00 Supplies (see instructions)	0	0	0		0 0	0	
9.00 Drugs	0	0	0		0 0	0	
10.00 DME 11.00 Home Dialysis Aide Services		0	0		0 0 0 0	0	
12.00 Respiratory Therapy	0	0	0		0 0	0	
13.00 Private Duty Nursing	0	0	0		0 0	0	
14.00 Clinic	0	0	0		0 0	0	
15.00 Health Promotion Activities	0	0	0		0 0 0 0	0	
16.00 Day Care Program 17.00 Home Delivered Meals Program		0			0 0	0	
18.00 Homemaker Service	0	0	0		0 0	0	
19.00 All Others (specify)	0	0	0		0 0	0	19.00
19.50 Telemedicine	0	0	-		0 0	0	
20.00 Total (sum of lines 1-19) 21.00 Total cost to be allocated	0	376			0 0	0	
) A07			()	()	
22.00 Unit cost multiplier	0 0. 000000	2, 697 7. 172872			0 0.000000	0 0. 000000	

Heal th	Financial Systems		METHODI ST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
APPORT	FIONMENT OF PATIENT SERVICE COS	TS		Provider C	CN: 15-0002	Peri od:	Worksheet H-3	
				HHA CCN:	15-7536	From 01/01/2020 To 12/31/2020		
				Title	e XVIII	Home Health Agency I	PPS	
	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, C	OR BENEFICIARY	
	Cost Per Visit Computation	-						
1.00	Skilled Nursing Care	2.00			2, 256, 20	04 13, 720	164.45	1.00
2.00	Physical Therapy	3.00	1, 027, 750	0	1, 027, 7	50 5, 898	174.25	2.00
3.00	Occupational Therapy	4.00	323, 305	0	323, 30	05 1, 726	187.31	3.00
4.00	Speech Pathology	5.00	77, 279	0	77, 2	79 149	518.65	4.00
5.00	Medical Social Services	6.00			9,50			
6.00	Home Health Aide	7.00			128, 5			
7.00	Total (sum of lines 1-6)	7.00	3, 822, 635	0				7.00
7.00	Total (sum of Triles 1-6)		3, 022, 035		Program Visi			7.00
					FIOGLAIII VISI	15		
					P	art B		İ
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject	Subject to		
	···· · · · · · · · · · · · · · · · · ·				to	Deducti bl es		
					Deductibles	&		
					Coi nsurance			
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation	1		-				
8.00	Skilled Nursing Care		23844	0				8.00
9.00	Physical Therapy		23844	0				9.00
10.00	Occupational Therapy		23844	0	6	54		10.00
11.00	Speech Pathology		23844	0		52		11.00
12.00	Medical Social Services		23844	0		18		12.00
13.00	Home Health Aide		23844	0	79	96		13.00
14.00	Total (sum of lines 8-13)			0	7,80	05		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		÷ col. 4)	
		col. 28, line		Costs (from	1 + 2)	Records)		
		20, 1110	Part I)	Part II)				
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Comput	ations						
15.00	Cost of Medical Supplies	8.00	0	0		0 0	0. 000000	15.00
16.00	Cost of Drugs	9.00		0		0 0	0. 000000	16.00
			Program Visits		Cost of			
					Servi ces			
			Par			Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
			to	Deductibles &		to	Deductibles &	
			Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
			Coi nsurance			Coi nsurance		
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE	PROGRAM COST, A	AGGREGATE OF TH	HE PROGRAM LI	MITATION COST, C	OR BENEFICIARY	
	Cost Per Visit Computation	1			1			
1.00	Skilled Nursing Care	C				0 693, 650		1.00
2.00	Physical Therapy	0				0 360, 175		2.00
	Occupational Therapy	0	654			0 122, 501		3.00
3.00					1			4.00
3.00 4.00	Speech Pathology	0	52			0 26, 970		4.00
	Speech Pathology Medical Social Services					0 26,970 0 2,494		5.00
4.00 5.00		0	18			0 2, 494		5.00
4.00	Medical Social Services		18 796					

	Financial Systems		METHODI ST HOSP	ITALS, INC		In Lie	u of Form CMS-	2552-10
APPORT	IONMENT OF PATIENT SERVICE COST	S		Provider CC	CN: 15-0002	Peri od:	Worksheet H-3	3
				HHA CCN:	15-7536	From 01/01/2020 To 12/31/2020	Part I Date/Time Pre 7/23/2021 10:	
				Title	XVIII	Home Health Agency I	PPS	
	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
	Skilled Nursing Care							8.00
	Physical Therapy							9.00
	Occupational Therapy							10.00
	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00
		Prog	ram Covered Char	rges	Cost of			
		-		-	Servi ces			
			Part	В		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	
	Supplies and Drugs Cost Comput	ations						
15.00	Cost of Medical Supplies	0	245, 619	0		0 0	(15.00
16.00	Cost of Drugs		0	0		0	(16.00
	Cost Center Description	Total Program						
		Cost (sum of						
		cols. 9-10)						
		12.00						
	PART I - COMPUTATION OF LESSER COST LIMITATION	OF AGGREGATE	PROGRAM COST, AG	GGREGATE OF TH	IE PROGRAM LI	MITATION COST, O	R BENEFICIARY	
	Cost Per Visit Computation							_
	Skilled Nursing Care	693, 650						1.00
	Physical Therapy	360, 175						2.00
	Occupational Therapy	122, 501						3.00
4.00	Speech Pathology	122, 501 26, 970						3.00 4.00
4.00		122, 501						3.00 4.00
4.00 5.00	Speech Pathology	122, 501 26, 970						3.00 4.00 5.00
4.00 5.00 6.00	Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6)	122, 501 26, 970 2, 494						3.00 4.00 5.00 6.00
4.00 5.00 6.00	Speech Pathology Medical Social Services Home Health Aide	122, 501 26, 970 2, 494 42, 331 1, 248, 121						3. 00 4. 00 5. 00 6. 00 7. 00
4.00 5.00 6.00 7.00	Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description	122, 501 26, 970 2, 494 42, 331						3.00 4.00 5.00 6.00
4.00 5.00 6.00 7.00	Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation	122, 501 26, 970 2, 494 42, 331 1, 248, 121						3. 00 4. 00 5. 00 6. 00 7. 00
4.00 5.00 6.00 7.00 8.00	Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care	122, 501 26, 970 2, 494 42, 331 1, 248, 121						3. 00 4. 00 5. 00 6. 00 7. 00
4.00 5.00 6.00 7.00 8.00	Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation	122, 501 26, 970 2, 494 42, 331 1, 248, 121						3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
4.00 5.00 6.00 7.00 8.00 9.00	Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care	122, 501 26, 970 2, 494 42, 331 1, 248, 121						3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
4.00 5.00 6.00 7.00 8.00 9.00 10.00	Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy	122, 501 26, 970 2, 494 42, 331 1, 248, 121						3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy	122, 501 26, 970 2, 494 42, 331 1, 248, 121						3.00 4.00 5.00 6.00
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	122, 501 26, 970 2, 494 42, 331 1, 248, 121						3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00

Health Financial Systems		METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF PATIENT SERVICE COS	TS		Provider C	CN: 15-0002	Period:	Worksheet H-3	
			HHA CCN:	15-7536	From 01/01/2020 To 12/31/2020	Date/Time Pre	pared:
						7/23/2021 10:	58 am
			ΠΤΙΕ	e XVIII	Home Health	PPS	
					Agency I		
Cost Center Description	From Wkst. C,	Cost to	Total HHA	HHA Shared	Transfer to		
	Part I, col.	Charge Ratio	Charge (from	Ancillary	Part I as		
	9, line	0	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 FURNI SHED	BY SHARED HOSP	ITAL DEPARTME	ENTS		
1.00 Physical Therapy	66.00	0. 368888	0		0 col. 2, line 2	. 00	1.00
2.00 Occupational Therapy	67.00	0. 404136	0)	0 col. 2, line 3	. 00	2.00
3.00 Speech Pathology	68.00	0. 311758	0		0 col. 2, line 4	. 00	3.00
4.00 Cost of Medical Supplies	71.00	0. 322118	0		0 col. 2, line 1	5.00	4.00
5.00 Cost of Drugs	73.00	0. 191382	0		0 col. 2, line 1	6.00	5.00

ALCUL	Financial Systems METHODIST HOSP ATION OF HHA REIMBURSEMENT SETTLEMENT	Provider C	CN: 15-0002	Peri od:	u of Form CMS-2 Worksheet H-4	
		HHA CCN:	15-7536	From 01/01/2020 To 12/31/2020		
		Title	e XVIII	Home Health	PPS	
				Agency I Par	t B	
			Part A	Not Subject to Deductibles &	Subject to Deductibles &	
			1.00	Coi nsurance	2.00	-
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUS	STOMARY CHARGE	1.00 FS	2.00	3.00	-
	Reasonable Cost of Part A & Part B Services					1
00	Reasonable cost of services (see instructions)			0 0	0] 1
00	Total charges			0 0	0	2
~ ~	Customary Charges	<u> </u>				Ι.
00	Amount actually collected from patients liable for payment on a charge basis (from your records)	for services		0 0	0	
00	Amount that would have been realized from patients liable for services on a charge basis had such payment been made i			0 0	0	4
	with 42 CFR §413.13(b)					
00 00	Ratio of line 3 to line 4 (not to exceed 1.000000) Total customary charges (see instructions)		0.0000	00 0.000000		
00	Excess of total customary charges over total reasonable cos only if line 6 exceeds line 1)	t (complete		0 0		
00	Excess of reasonable cost over customary charges (complete 1 exceeds line 6)	onlyifline		0 0	0	8
00	Primary payer amounts			0 136		
				Part A Services	Part B Services	
				1.00	2.00	-
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
00	Total reasonable cost (see instructions)			0		
00	Total PPS Reimbursement - Full Episodes without Outliers			0		
00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes			0		
00	Total PPS Reimbursement - PEP Episodes			0		
00	Total PPS Outlier Reimbursement - Full Episodes with Outlie	rs		0		
. 00	Total PPS Outlier Reimbursement - PEP Episodes			0	0	
. 00	Total Other Payments			0	0	
. 00	DME Payments			0	0	1
00	Oxygen Payments			0	0	
. 00	Prosthetic and Orthotic Payments			0	0	
. 00 . 00	Part B deductibles billed to Medicare patients (exclude coil	nsurance)		0	0	
()()	Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8)			0		
	Subtotal (line 22 minus line 23)			0		
. 00	, , , , , , , , , , , , , , , , , , ,			0	0	
. 00 . 00	Coinsurance billed to program patients (from your records)					
. 00 . 00 . 00	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25)			0		2
. 00 . 00 . 00 . 00	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records)			0		1 4
00 00 00 00 00	Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see)	0		2
00 00 00 00 00 00 00	Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see Total costs - current cost reporting period (line 26 plus l)	0	1, 199, 797	20
00 00 00 00 00 00 00 00	Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see Total costs - current cost reporting period (line 26 plus l OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ine 27))	0	1, 199, 797 0	20 20 30
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see Total costs - current cost reporting period (line 26 plus l OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	ine 27) ons))	0 0 0	1, 199, 797 0 0	28 29 30 30
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see Total costs - current cost reporting period (line 26 plus l OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment before sequestration	ine 27) ons))	000000000000000000000000000000000000000	1, 199, 797 0 0 0	28 29 30 30 30
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see Total costs - current cost reporting period (line 26 plus l OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Subtotal (see instructions)	ine 27) ons))	0 0 0 0 0 0	1, 199, 797 0 0 1, 199, 797	28 20 30 30 30 30
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see Total costs - current cost reporting period (line 26 plus l OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment before sequestration	ine 27) ons) n)	000000000000000000000000000000000000000	1, 199, 797 0 0 1, 199, 797 8, 870	28 29 30 30 30 30 31 31
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see Total costs - current cost reporting period (line 26 plus l OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Subtotal (see instructions) Sequestration adjustment (see instructions)	ine 27) ons) n)	0 0 0 0 0 0 0 0	1, 199, 797 0 0 1, 199, 797 8, 870 0	28 29 30 30 30 30 31 31 31 31 31
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see Total costs - current cost reporting period (line 26 plus l OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration	ine 27) ons) n)	0 0 0 0 0 0 0 0 0 0	1, 199, 797 0 0 1, 199, 797 8, 870 0 1, 190, 927	28 29 30 30 30 31 31 31 32 32 33
8.00 4.00 5.00 5.00	Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see Total costs - current cost reporting period (line 26 plus l OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Interim payments (see instructions)	i ne 27) ons) n , and 33)			1, 199, 797 0 0 1, 199, 797 8, 870 0 1, 190, 927 0 0	28 29 30 30 30 31 31 32 32 32 32

NALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED O PROGRAM BENEFICIARIES		Provider CCN: 15-0002		Period:		Worksheet H-5	
		HHA CCN:	15-7536		rom 01/01/2020 o 12/31/2020		
					Home Health Agency I	PPS	00 0
		Inpatien	it Part A	Part B		't B	
	_	mm/dd/yyyy 1.00	Amount 2.00		mm/dd/yyyy 3.00	Amount 4.00	
00	Total interim payments paid to provider	1.00	2.00	0		1, 190, 927	1
00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0		0	2
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)						3
	Program to Provider						
)1				0		0	3
)2)3				0		0	
)4				0		0	
)5				0		0	3
0	Provider to Program			0		0	
1				0		0	
2				0		0	
3 4				0		0	
9	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0		0	3
0	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0		1, 190, 927	2
0	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after						5
0	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						
1	Program to Provider			0		0	
)1)2				0		0	5
3				0		0	5
0	Provider to Program		1	0		0	5
1				0		0	5
2				0		0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on			0		0	5
)0)1	the cost report. (1) SETTLEMENT TO PROVIDER			0		0	6
)2	SETTLEMENT TO PROGRAM			0		0	6
0	Total Medicare program liability (see instructions)			0		1, 190, 927	7
					Contractor Number	NPR Date (Mo/Day/Yr)	
	Name of Contractor	(0		1.00	2.00	8

ALCULATION OF CAPITAL PAYMENT		eriod: com 01/01/2020 o 12/31/2020	Worksheet L Parts I-III Date/Time Pre 7/23/2021 10:	pared:				
	Title XVIII	Hospi tal	PPS	<u>50 a</u>				
			1.00					
PART I - FULLY PROSPECTIVE METHOD								
CAPITAL FEDERAL AMOUNT	CAPITAL FEDERAL AMOUNT							
	Capital DRG other than outlier							
01 Model 4 BPCI Capital DRG other than outlier			0 52, 859	1. 2.				
	Capital DRG outlier payments							
01 Model 4 BPCI Capital DRG outlier payments	0							
00 Total inpatient days divided by number of days	207.77	3.						
00 Number of interns & residents (see instructions	3.00	4.						
00 Indirect medical education percentage (see inst	0.41	5.						
00 Indirect medical education adjustment (multiply 1.01) (see instructions)	10, 908							
00 Percentage of SSI recipient patient days to Med 30) (see instructions)	8.39	7.						
00 Percentage of Medicaid patient days to total da	33.07	8						
00 Sum of lines 7 and 8	41.46 8.76							
Allowable disproportionate share percentage (see instructions)								
.00 Disproportionate share adjustment (see instruct	233, 054							
2.00 Total prospective capital payments (see instruc	ctions)		2, 957, 254	12				
		-	1.00					
PART II - PAYMENT UNDER REASONABLE COST			1.00					
00 Program inpatient routine capital cost (see ins	structions)		0	1 1				
00 Program inpatient ancillary capital cost (see in			0	2				
00 Total inpatient program capital cost (line 1 pl			0					
00 Capital cost payment factor (see instructions)			0					
00 Total inpatient program capital cost (line 3 x	line 4)		0					
		-	1.00					
PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00					
00 Program inpatient capital costs (see instruction	ons)		0	1				
00 Program inpatient capital costs for extraordina	ary circumstances (see instructions)		0	2				
00 Net program inpatient capital costs (line 1 mir	nus line 2)		0	3				
00 Applicable exception percentage (see instruction	ons)		0.00	4				
00 Capital cost for comparison to payments (line 3	3 x line 4)		0	5				
00 Percentage adjustment for extraordinary circums	stances (see instructions)		0.00	6				
00 Adjustment to capital minimum payment level for		ine 6)	0					
00 Capital minimum payment level (line 5 plus line			0					
00 Current year capital payments (from Part I, lir			0	9				
.00 Current year comparison of capital minimum payr	0	10						
.00 Carryover of accumulated capital minimum paymer Worksheet L, Part III, line 14)		5	0	11.				
.00 Net comparison of capital minimum payment level		11)	0					
.00 Current year exception payment (if line 12 is p			0	13.				
.00 Carryover of accumulated capital minimum paymer (if line 12 is negative, enter the amount on th		lowing period	0	14				
(IT THE 12 IS negative, enter the amount of the			_	1 4 -				
5.00 Current year allowable operating and capital pa	ayment (see instructions)		0	15				
	nstructions)		0 0 0	16				