This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0002 Worksheet S Period: From 01/01/2021 Parts I-III AND SETTLEMENT SUMMARY 12/31/2021 Date/Time Prepared: 5/27/2022 9:02 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 5/27/2022 9: 02 am Manually prepared cost report use only ] If this is an amended report enter the number of times the provider resubmitted this cost report ] Medicare Utilization. Enter "F" for full or "L" for low. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

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

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by METHODIST HOSPITALS, INC (15-0002) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

|                         |  |                | 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, 103, 412   | -371, 089     | 0              | -1, 147, 059  | 1.00    |
| 2.00                    | Subprovider - IPF                            | 0              | 18, 228       | 0             |                | -92, 197      | 2.00    |
| 3.00                    | Subprovider - IRF                            | 0              | 27, 334       | 0             |                | -39, 285      | 3.00    |
| 5.00                    | Swing Bed - SNF                              | 0              | 0             | 0             |                | 0             | 5.00    |
| 6.00                    | Swing Bed - NF                               | 0              |               |               |                | 0             | 6.00    |
| 9.00                    | HOME HEALTH AGENCY I                         | 0              | 0             | 0             |                | 0             | 9.00    |
| 200.00                  | Total  | 0              | 1, 148, 974   | -371, 089     | 0              | -1, 278, 541  | 200. 00 |
| Tho ob                  | and amounts consecont "due to" or "due from" | the applicable | program for t | he element of | the above comp | lov indicated |         |

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.

22.04 Did this hospital receive a geographic reclassification from urban to Ν Ν N 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, ves or "N" for no. 23 00 Which method is used to determine Medicaid days on lines 24 and/or 25 3 Ν 23 00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for

yes or "N" for no.

Ν

Ν

58.00

59.00

58.00 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as

defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.

| IOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA   |  | Provi der Co                       | F                  | eriod:<br>from 01/01/2021<br>fo 12/31/2021 | Worksheet S-2<br>Part I<br>Date/Time Pre<br>5/27/2022 9:0 | pared: |
|---|--|------------------------------------|--------------------|--|---|--------|
|   |  |                                    | NAHE 413.85<br>Y/N | Worksheet A<br>Line #                      | Pass-Through<br>Qualification<br>Criterion<br>Code        |        |
|   |  |                                    | 1. 00              | 2. 00                                      | 3. 00   |        |
| 00.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in colu 00.01 If line 60 is yes, complete columns 2 and 3 for each | 85? (s<br>umn 1.<br>:R) NAHE<br>ımn 2. | see<br>If column 1<br>E MA payment | Y                  | Y 23. 00                                   | 2   | 60. 00 |
| i nstructi ons)   | Y/N                                    | IME                                | Direct GME         | IME  | Direct GME  |        |
|   |  |                                    |                    |  |   |        |
| 11.00 Did your hospital receive FTE slots under ACA   | 1. 00<br>N                             | 2. 00                              | 3. 00              | 4. 00                                      | 5. 00   | 61.00  |
| section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 1.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports  | 14                                     |                                    |                    | 0.00                                       | 0.00  | 61. 01 |
| ending and submitted before March 23, 2010. (see instructions) 11.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of  |  |                                    |                    |  |   | 61. 02 |
| ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)  |  |                                    |                    |  |   | 61. 03 |
| 11.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).   |  |                                    |                    |  |   | 61. 04 |
| on 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)  |  |                                    |                    |  |   | 61.05  |
| 61.04 minus line 61.03). (see instructions) 1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)  |  |                                    |                    |  |   | 61. 06 |
|   | Pro                                    | ogram Name                         | Program Code       | Unweighted<br>IME FTE Count                | Unweighted<br>Direct GME<br>FTE Count                     |        |
| 1.10 Of the FTEs in line 61.05, specify each new program  |  | 1. 00                              | 2.00               | 3. 00                                      | 4. 00   | 61. 10 |
| specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.  |  |                                    |                    | 0.00                                       | 0. 00   | 01. 10 |
| of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column   |  |                                    |                    | 0.00                                       | 0. 00   | 61. 20 |
| 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.  |  |                                    |                    |  |   |        |
| and direct one fire unitergrited count.   |  |                                    |                    |  | 1. 00   |        |
| ACA Provisions Affecting the Health Resources and Ser<br>22.00 Enter the number of FTE residents that your hospital   |  |                                    |                    | ind for which                              |   | 62. 00 |
| your hospital received HRSA PCRE funding (see instructions). 2.01 Enter the number of FTE residents that rotated from a   | ti ons)<br>Teachi                      | ing Health Cer                     | nter (THC) into    |  |   | 62.01  |
| during in this cost reporting period of HRSA THC prog   | ram. (s                                | see instructio<br>ings             | ons)               |  |   |        |

| Health Financial Systems   | METHODI  | ST HOSPITALS, INC   |   | In Lie                            | u of Form CMS-2   | 2552-10 |
|--|--|---|---|-----------------------------------|---|---------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMP   |  |   |   | eriod:<br>com 01/01/2021          | Worksheet S-2<br>Part I<br>Date/Time Pre<br>5/27/2022 9:0 | pared:  |
|  |  |   | Unweighted<br>FTEs<br>Nonprovider<br>Site | Unweighted<br>FTEs in<br>Hospital | Ratio (col.<br>1/ (col. 1 +<br>col. 2))                   |         |
|  |  |   | 1.00                                      | 2. 00                             | 3. 00   |         |
| Section 5504 of the ACA Base Yea   |  |   |   |                                   |   |         |
| period that begins on or after J  64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 1)  | yes, or your facili-<br>ber of unweighted non<br>tations occurring in<br>number of unweighted<br>ur hospital. Enter in | ty trained residents<br>n-primary care<br>all nonprovider<br>d non-primary care<br>n column 3 the ratio | 0.00                                      | 0.00                              | 0. 000000   | 64.00   |
| jer (eeramir rarvraea z) (eeramir  | Program Name   | Program Code  | Unweighted                                | Unwei ghted                       | Ratio (col.   |         |
|  | ·  |   | FTEs<br>Nonprovi der<br>Si te             | FTEs in<br>Hospital               | 3/ (col. 3 + col. 4))                                     |         |
|  | 1. 00  | 2.00  | 3. 00                                     | 4. 00                             | 5. 00   |         |
| 65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) |  |   | 0.00                                      | 0.00                              | 0.000000<br>Ratio (col.                                   | 65.00   |
|  |  |   | FTEs<br>Nonprovi der<br>Si te             | FTEs in<br>Hospital               | 1/ (col. 1 + col. 2))                                     |         |
|  |  |   | 1. 00                                     | 2. 00                             | 3. 00   |         |
| Section 5504 of the ACA Current  |  | n Nonprovider Setting   | ysEffective f                             | or cost report                    | ing periods   |         |
| beginning on or after July 1, 20 66.00 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +  | unweighted non-priman<br>ccurring in all nonpo<br>unweighted non-priman<br>al. Enter in column 3                       | rovider settings.<br>ry care resident<br>3 the ratio of   | 0.00                                      | 0.00                              | 0. 000000   | 66. 00  |
|  | Program Name   | Program Code  | Unwei ghted                               | Unwei ghted                       | Ratio (col.   |         |
|  |  |   | FTÉs<br>Nonprovi der<br>Si te             | FTEs in<br>Hospital               | 3/ (col. 3 + col. 4))                                     |         |
|  | 1. 00  | 2. 00   | 3. 00                                     | 4. 00                             | 5. 00   |         |
| 67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)   |  |   | 0.00                                      | 0.00                              |   | 67. 00  |

| 1         | *** *****   |    | l . |         |
|-----------|---|----|-----|---------|
|           | es title V or XIX follow Medicare (title XVIII) for the calculation of observation  | Υ  | Y   | 98. 02  |
|           | d costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 r title V, and in column 2 for title XIX.  |    |     |         |
|           | es title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH)  | N  | N   | 98. 03  |
|           | imbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1   |    |     | 70.00   |
|           | r title V, and in column 2 for title XIX.   |    |     |         |
| 98. 04 Do | es title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of  | N  | N   | 98. 04  |
| ou        | tpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and  |    |     |         |
| i n       | column 2 for title XIX.   |    |     |         |
|           | es title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on  | Υ  | Υ   | 98. 05  |
|           | st. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in   |    |     |         |
|           | lumn 2 for title XIX.   |    |     |         |
|           | es title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D,   | Υ  | Y   | 98. 06  |
|           | s. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in  |    |     |         |
|           | lumn 2 for title XIX.   |    |     |         |
|           | ral Providers   | N. |     | 105.00  |
|           | es this hospital qualify as a CAH?  | N  |     | 105.00  |
|           | this facility qualifies as a CAH, has it elected the all-inclusive method of payment  | N  |     | 106. 00 |
|           | r outpatient services? (see instructions)   | N  |     | 107. 00 |
|           | lumn 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R aining programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) | IN |     | 107.00  |
|           | lumn 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an   |    |     |         |
|           | proved medical education program in the CAH's excluded IPF and/or IRF unit(s)?  |    |     |         |
|           | ter "Y" for yes or "N" for no in column 2. (see instructions)   |    |     |         |
|           | (See That detroins)   |    | I   |         |

| Health Financial Systems METHODIST HOSP HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA   | PITALS, INC                                      | CN: 15_0002 Pc                            | In Lie        | eu of Form CMS-<br>Worksheet S-2 |  |
|---|--|---|---------------|----------------------------------|--|
| TIOSTITAL AND TIOSTITAL TILALITI CANE COMILLEN TULNTITION DATA  | l l ovi dei c                                    |   | om 01/01/2021 | Part                             |  |
|   |  | 10  |               | 5/27/2022 9:0                    |  |
|   |  |   | 1. 00         | 2. 00                            | -  |
| 108.00 is this a rural hospital qualifying for an exception to the  | CRNA fee sche                                    | edul e? See 42                            | N             | 2.00                             | 108.00                                   |
| CFR Section §412.113(c). Enter "Y" for yes or "N" for no.   | Physi cal  | Occupati onal                             | Speech        | Respi ratory                     |  |
|   | 1.00   | 2. 00                                     | 3. 00         | 4.00                             |  |
| 109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.   | N  | N   | N             | N                                | 109.00                                   |
|   |  |   | 101           | 1.00                             | 110 00                                   |
| 110.00Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "complete Worksheet E, Part A, lines 200 through 218, and Worapplicable.  | 'Y" for yes or                                   | "N" for no. It                            | f yes,        | N                                | 110.00                                   |
|   |  |   | 1. 00         | 2. 00                            |  |
| 111.00   This facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this construction for y" For yes or "N" for no in column 1. If the response to consider in the properties of the FCHIP demonstration prong of the FCHIP demonstration which this CAH is particle all that apply: "A" for Ambulance services; "B" for action for tele-health services.   | ost reporting<br>olumn 1 is Y,<br>cticipating ir | period? Enter<br>enter the<br>n column 2. | N             |                                  | 111.00                                   |
|   |  | 1.00                                      | 2. 00         | 3.00                             | -  |
| 112.00 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 ceaparticipation in the demonstration, if applicable.   | peri od?<br>s "Y", enter<br>ne                   | N   |               |                                  | 112.00                                   |
| Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or   |  | 1   | <br>0115.00   |                                  |  |
| in column 1. If column 1 is yes, enter the method used (A, E 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.  | 3, or E only)<br>93" percent<br>(includes        |   |               |                                  |  |
| 116.00 is this facility classified as a referral center? Enter "Y" "N" for no.  | for yes or                                       | N   |               |                                  | 116. 00                                  |
| 117.00 Is this facility legally-required to carry malpractice insur   | rance? Enter                                     | Y   |               |                                  | 117. 00                                  |
| "Y" for yes or "N" for no.  118.00 Is the mal practice insurance a claims-made or occurrence pol  | icv? Enter 1                                     | 1   |               |                                  | 118. 00                                  |
| if the policy is claim-made. Enter 2 if the policy is occurr  |  | Din and time                              | 1             |                                  |  |
|   |  | Premi ums                                 | Losses        | Insurance                        |  |
| 110 0411 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1  |  | 1.00                                      | 2. 00         | 3.00                             | 0110 01                                  |
| 118.01 List amounts of malpractice premiums and paid losses:  |  | 1, 190, 494                               | (             | 0                                | 0118.01                                  |
| 110 00  |  |   | 1.00          | 2. 00                            | 110.00                                   |
| 118. 02 Are malpractice premiums and paid losses reported in a cost<br>Administrative and General? If yes, submit supporting sched<br>and amounts contained therein. 119. 00 D0 NOT USE THIS LINE   |  |   | N             |                                  | 118. 02                                  |
| 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.  | n column 1, "\<br>ualifies for t                 | /" for yes or<br>the Outpatient           | N             | N                                | 120.00                                   |
| 121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.  | antable device                                   | es charged to                             | Υ             |                                  | 121. 00                                  |
|   |  |   | N             |                                  | 122.00                                   |
| 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.  |  |   |               |                                  |  |
| 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  125.00 Does this facility operate a transplant center? Enter "Y" for   | or yes and "N"                                   | for no. If                                | N             |                                  | 125. 00                                  |
| the Worksheet A line number where these taxes are included.  Transplant Center Information  125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.  126.00 If this is a Medicare certified kidney transplant center, en  | nter the certi                                   |   | N             |                                  |  |
| 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  125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.  126.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 2 transplant center, enter the workship of the six a Medicare certified heart transplant center, enter the workship of | nter the certi<br>2.<br>ter the certif           | fication date                             | N             |                                  | 126.00                                   |
| 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  125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.  126.00 If this is a Medicare certified kidney transplant center, en   | nter the certi<br>2.<br>ter the certif<br>2.     | fication date                             | N             |                                  | 125. 00<br>126. 00<br>127. 00<br>128. 00 |

| IOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENT  | METHODI ST HOSPI   | _ <del>`</del>   |   |                      |                         | u of Form CMS          |              |
|--|--|--|---|----------------------|-------------------------|------------------------|--------------|
|  | IFICATION DATA   | Provider CC  | N: 15-0002  | Period:              | 1/01/2021               | Worksheet S-<br>  Part | -2           |
|  |  |  |   |                      | 2/31/2021               | Date/Time Pr           |              |
|  |  |  |   |                      |                         | 5/27/2022 9:           | 02 am        |
|  |  |  |   |                      | 1. 00                   | 2. 00                  |              |
| 30.00 If this is a Medicare certified pancreas   |  |  | ti fi cati on   |                      |                         |                        | 130.         |
| date in column 1 and termination date, if<br>31.00 f this is a Medicare certified intestina  | al transplant center   | , enter the c  | erti fi cati or   | n                    |                         |                        | 131. (       |
| date in column 1 and termination date, if<br>32.00  If this is a Medicare certified islet tra  |  |  | ication date  |                      |                         |                        | 132.         |
| in column 1 and termination date, if appl  |  |  | ication date  |                      |                         |                        | 132.         |
| 33.00 Removed and reserved   |  |  |   |                      |                         |                        | 133.         |
| 34.00 If this is an organ procurement organizat<br>and termination date, if applicable, in or<br>and termination date, if applicable, in organization.   |  | e OPO number   | in column 1   |                      |                         |                        | 134.         |
| All Providers 40.00 Are there any related organization or hom  |  |  |   |                      | N                       |                        | 140.         |
| chapter 10? Enter "Y" for yes or "N" for   |  |  |   | ts                   |                         |                        |              |
| are claimed, enter in column 2 the home of   | ottice chain number.<br>2.00   |  | tions)  |                      | 3. 00                   |                        |              |
| If this facility is part of a chain organ  |  |  | ugh 143 the   | name an              |                         | of the home            |              |
| office and enter the home office contract  |  | tor number.  |   |                      |                         |                        |              |
|  | ontractor's Name:<br>) Box:  |  | Contrac   | tor's Nu             | mber:                   |                        | 141. (       |
| 1  | ate:   |  | Zi p Code   | e:                   |                         |                        | 143.         |
| 100  |  |  | 1 1 1   | -                    |                         |                        |              |
| 44 00 Are provider based physicians' costs incl  | Ludad in Warkahaat A   | 2  |   |                      |                         | 1.00                   | 111          |
| 44.00 Are provider based physicians' costs incl  | uded in worksheet A  | i <i>C</i>   |   |                      |                         | Y                      | 144. (       |
|  |  |  |   |                      | 1. 00                   | 2. 00                  |              |
| 45.00 If costs for renal services are claimed of   |  |  |   |                      | Υ                       |                        | 145.         |
| inpatient services only? Enter "Y" for yeno, does the dialysis facility include Me   |  |  |   |                      |                         |                        |              |
| period? Enter "Y" for yes or "N" for no  |  | TOI THIS COST  | reporting   |                      |                         |                        |              |
| 46.00 Has the cost allocation methodology chang  |  | sly filed cos  | t report?   |                      | N                       |                        | 146. (       |
| Enter "Y" for yes or "N" for no in column  |  | 5-2, chapter   | 40, §4020) I  | lf                   |                         |                        |              |
| yes, enter the approval date (mm/dd/yyyy)  | in column 2.   |  |   |                      |                         |                        |              |
|  |  |  |   |                      |                         | 1. 00                  |              |
| 47.00 Was there a change in the statistical bas  |  |  |   |                      |                         | N                      | 147. 0       |
| 48.00 Was there a change in the order of alloca  |  | •  |   |                      |                         | N                      | 148.0        |
| 49.00 Was there a change to the simplified cost  | Trinding method? En  | Part A   | Part B  |                      | itle V                  | N<br>Title XIX         | 149. (       |
|  |  | 1. 00  | 2. 00   |                      | 3. 00                   | 4.00                   |              |
| Does this facility contain a provider tha  |  |  |   |                      |                         |                        |              |
| or charges? Enter "Y" for yes or "N" for 55.00 Hospi tal   | no for each compone  | ent for Part A<br>N  | and Part B<br>N   | . (See 4             | - <u>2 CFR §41</u><br>N | 3. 13)<br>N            | 155.         |
| 56. 00 Subprovi der – TPF  |  | N I  | N   |                      | N                       | N                      | 156.         |
| 57.00 Subprovi der - IRF   |  | N  | N   |                      | N                       | N                      | 157. (       |
| 58. 00 SUBPROVI DER  |  |  |   |                      |                         |                        | 158.         |
| 59. 00 SNF<br>60. 00 HOME HEALTH AGENCY  |  | N<br>N   | N<br>N  |                      | N<br>N                  | N<br>N                 | 159.<br>160. |
| 61. 00 CMHC  |  | IV   | N   |                      | N                       | N                      | 161.         |
|  |  |  |   |                      |                         | 1.00                   |              |
| Multicampus<br>65.00ls this hospital part of a Multicampus ho  |  |  |   | 6                    | DCA-C                   |                        | 1.5          |
| ου, υυμε της ποεριται part or a multicambus no   | əspitai that nas one   | or more camp   | uses in difi  | rerent C             | DSAS?                   | N                      | 165.         |
|  | Name   | County   | State Z   | ip Code              | CBSA                    | FTE/Campus             |              |
| Enter "Y" for yes or "N" for no.   | 0  | 1. 00  | 2. 00   | 3. 00                | 4. 00                   | 5. 00                  | 20111        |
| Enter "Y" for yes or "N" for no.   |  |  |   |                      |                         | 0.0                    | 00 166.      |
| Enter "Y" for yes or "N" for no.  66.00  f   line 165 is yes, for each   |  |  |   |                      |                         |                        |              |
| Enter "Y" for yes or "N" for no.   |  |  |   |                      |                         |                        |              |
| Enter "Y" for yes or "N" for no.  66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,   |  |  |   |                      |                         |                        |              |
| Enter "Y" for yes or "N" for no.  66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in   |  |  |   |                      |                         |                        |              |
| Enter "Y" for yes or "N" for no.  66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,   |  |  |   |                      |                         |                        |              |
| Enter "Y" for yes or "N" for no.  66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)   |  |  |   |                      |                         | 1.00                   |              |
| Enter "Y" for yes or "N" for no.  66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)   | ntive in the America   | in Recovery an   | d Reinvestm   | ent Act              |                         |                        |              |
| Enter "Y" for yes or "N" for no.  66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)  Health Information Technology (HIT) incer 67.00 Is this provider a meaningful user under   | §1886(n)? Enter "Y   | " for yes or   | "N" for no.   |                      | r the                   | 1.00<br>Y              |              |
| Enter "Y" for yes or "N" for no.  66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)  Health Information Technology (HIT) incer 67.00 is this provider a meaningful user under 68.00 if this provider is a CAH (line 105 is ")   | §1886(n)? Enter "Y<br>Y") and is a meaning   | " for yes or ful user (line                                      | "N" for no.   |                      | r the                   |                        | 167. (       |
| Enter "Y" for yes or "N" for no.  66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)  Health Information Technology (HIT) incer 67.00 Is this provider a meaningful user under 68.00 If this provider is a CAH (line 105 is "V reasonable cost incurred for the HIT asse 68.01 If this provider is a CAH and is not a me | \$1886(n)? Enter "Y<br>Y") and is a meaning<br>ets (see instruction<br>eaningful user, does                      | " for yes or<br>ful user (line<br>s)<br>this provide             | "N" for no.<br>e 167 is "Y'<br>r qualify fo                 | '), ente<br>or a har |                         |                        |              |
| Enter "Y" for yes or "N" for no.  66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)  Health Information Technology (HIT) incer 67.00 Is this provider a meaningful user under 68.00 If this provider is a CAH (line 105 is "Yeasonable cost incurred for the HIT asse   | §1886(n)? Enter "Y<br>Y") and is a meaning<br>ets (see instruction<br>eaningful user, does<br>"Y" for yes or "N" | " for yes or<br>ful user (lines)<br>this provide<br>for no. (see | "N" for no.<br>e 167 is "Y'<br>r qualify fo<br>instructions | '), ente<br>or a har | dshi p                  | Y                      | 168.         |

| Health Financial Systems  | METHODIST HOSPIT | In Lie                   | In Lieu of Form CMS-2552-10      |                  |         |
|---|------------------|--------------------------|----------------------------------|------------------|---------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENT   | IFICATION DATA   | Peri od:                 | Worksheet S-2                    |                  |         |
|   |                  |                          | From 01/01/2021<br>To 12/31/2021 |                  | narad.  |
|   |                  | 10 12/31/2021            | Date/Time Pre<br>5/27/2022 9:0   | epareu:<br>12 am |         |
|   |                  |                          | 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  |                  |                          | N                                | 0                | 171. 00 |
| section 1876 Medicare cost plans reported   |                  |                          |                                  |                  |         |
| "Y" for yes and "N" for no in column 1.   |                  | nter the number of secti | on                               |                  |         |
| 1876 Medicare days in column 2. (see ins  | tructions)       |                          |                                  |                  |         |

| Heal th | Financial Systems METHODIST HOS   | SPITALS, INC    |                | In Lie                         | u of Form CMS-           | 2552-10        |  |
|---------|---|-----------------|----------------|--------------------------------|--------------------------|----------------|--|
|         | TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE  | Provi der C     |                | Peri od:                       | Worksheet S-2            |                |  |
|         |   |                 |                | rom 01/01/2021<br>o 12/31/2021 | Part II<br>Date/Time Pre |                |  |
|         |   |                 |                | Y/N                            | 5/27/2022 9:0<br>Date    | 02 am          |  |
|         |   |                 |                | 1. 00                          | 2.00                     |                |  |
|         | General Instruction: Enter Y for all YES responses. Enter   | N for all NO re | esponses. Ente | r all dates in                 | the                      |                |  |
|         | mm/dd/yyyy format.  COMPLETED BY ALL HOSPITALS  |                 |                |                                |                          | +              |  |
|         | Provider Organization and Operation   |                 |                |                                |                          |                |  |
| 1. 00   | Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in |                 |                | N                              |                          | 1.00           |  |
|         | reporting period? If yes, enter the date of the change In   | corumir 2. (See | Y/N            | Date                           | V/I                      |                |  |
|         | T.,   |                 | 1.00           | 2. 00                          | 3. 00                    |                |  |
| 2. 00   | Has the provider terminated participation in the Medicare yes, enter in column 2 the date of termination and in colu  |                 | N              |                                |                          | 2. 00          |  |
|         | voluntary or "I" for involuntary.   | 0, 101          |                |                                |                          |                |  |
| 3. 00   | Is the provider involved in business transactions, includi contracts, with individuals or entities (e.g., chain home  |                 | N              |                                |                          | 3.00           |  |
|         | or medical supply companies) that are related to the provi  |                 |                |                                |                          |                |  |
|         | officers, medical staff, management personnel, or members   | of the board    |                |                                |                          |                |  |
|         | of directors through ownership, control, or family and oth relationships? (see instructions)                          | er similar      |                |                                |                          |                |  |
|         | Total distributions   |                 | Y/N            | Type                           | Date                     |                |  |
|         | Ciarrial Data and Daranta   |                 | 1. 00          | 2. 00                          | 3. 00                    |                |  |
| 4. 00   | Financial Data and Reports  Column 1: Were the financial statements prepared by a Cer                                 | tified Public   | Υ              | A                              |                          | 4.00           |  |
|         | Accountant? Column 2: If yes, enter "A" for Audited, "C"  | for Compiled,   |                |                                |                          |                |  |
|         | or "R" for Reviewed. Submit complete copy or enter date av column 3. (see instructions) If no, see instructions.      | ailable in      |                |                                |                          |                |  |
| 5.00    | Are the cost report total expenses and total revenues diff  | erent from      | N              |                                |                          | 5.00           |  |
|         | those on the filed financial statements? If yes, submit reconciliation.   |                 |                |                                |                          |                |  |
|         |   |                 |                | Y/N<br>1. 00                   | Legal Oper.<br>2.00      |                |  |
|         | Approved Educational Activities   |                 |                |                                |                          |                |  |
| 6. 00   | Column 1: Are costs claimed for a nursing program? Column is the legal operator of the program?                       | 2: If yes, i    | s the provider | N                              |                          | 6.00           |  |
| 7. 00   | Are costs claimed for Allied Health Programs? If "Y" see i  | nstructi ons.   |                | Υ                              |                          | 7.00           |  |
| 8. 00   | Were nursing programs and/or allied health programs approv  | ed and/or rene  | wed during the | Υ                              |                          | 8. 00          |  |
| 9. 00   | cost reporting period? If yes, see instructions.  Are costs claimed for Interns and Residents in an approved          | graduate medi   | cal education  | Υ                              |                          | 9.00           |  |
|         | program in the current cost report? If yes, see instructio  | ns.             |                |                                |                          |                |  |
| 10. 00  | Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.            | or renewed in   | the current    | N                              |                          | 10.00          |  |
| 11. 00  | Are GME cost directly assigned to cost centers other than   | I & R in an Ap  | proved         | N                              |                          | 11.00          |  |
|         | Teaching Program on Worksheet A? If yes, see instructions.  |                 |                |                                | Y/N                      |                |  |
|         |   |                 |                |                                | 1.00                     |                |  |
| 40.00   | Bad Debts   | <u> </u>        |                |                                |                          | 10.00          |  |
| 12.00   | Is the provider seeking reimbursement for bad debts? If ye If line 12 is yes, did the provider's bad debt collection  |                 |                | st reporting                   | Y<br>N                   | 12.00<br>13.00 |  |
|         | period? If yes, submit copy.  | . , ,           | Ü              |                                |                          |                |  |
| 14. 00  | If line 12 is yes, were patient deductibles and/or co-paym Bed Complement   | ents waived? I  | f yes, see ins | tructions.                     | N N                      | 14.00          |  |
| 15. 00  | Did total beds available change from the prior cost report  | ing period? If  | yes, see inst  | ructions.                      | N                        | 15. 00         |  |
|         |   |                 | t A            |                                | t B                      |                |  |
|         |   | 1. 00           | 2. 00          | Y/N<br>3. 00                   | Date<br>4.00             |                |  |
|         | PS&R Data   |                 | =:             |                                |                          |                |  |
| 16. 00  | Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through       | N               |                | N                              |                          | 16.00          |  |
|         | date of the PS&R Report used in columns 2 and 4 (see  |                 |                |                                |                          |                |  |
| 17.00   | instructions)   | V               | 02 (25 (2022   |                                | 00/05/0000               | 17.00          |  |
| 17. 00  | Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If           | Y               | 02/25/2022     | Y                              | 02/25/2022               | 17. 00         |  |
|         | either column 1 or 3 is yes, enter the paid-through date  |                 |                |                                |                          |                |  |
| 18 00   | in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R                         | N               |                | N                              |                          | 18. 00         |  |
| 10.00   | Report data for additional claims that have been billed   | IN IN           |                | IN.                            |                          | 10.00          |  |
|         | but are not included on the PS&R Report used to file this   |                 |                |                                |                          |                |  |
| 19. 00  | cost report? If yes, see instructions.  If line 16 or 17 is yes, were adjustments made to PS&R                        | N               |                | N                              |                          | 19.00          |  |
|         | Report data for corrections of other PS&R Report  |                 |                |                                |                          |                |  |
|         | information? If yes, see instructions.  | I               | I              | 1                              | I                        | I              |  |

| Heal th | Financial Systems METHODIST HOS   | SPITALS, INC    |                | In Lie                                       | u of Form CMS-   | 2552-10          |  |
|---------|---|-----------------|----------------|--|--|------------------|--|
| HOSPI T | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE   | Provi der 0     | CCN: 15-0002   | Peri od:<br>From 01/01/2021<br>To 12/31/2021 | Worksheet S-2<br>Part II<br>Date/Time Pre<br>5/27/2022 9:0 | epared:          |  |
|         |   | Descr           | iption         | Y/N  | Y/N  |                  |  |
|         |   |                 | 0              | 1. 00  | 3. 00  |                  |  |
| 20. 00  | If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:                                     |                 |                | N  | N  | 20.00            |  |
|         |   | Y/N             | Date           | Y/N  | Date   |                  |  |
|         |   | 1.00            | 2.00           | 3. 00  | 4. 00  |                  |  |
| 21. 00  | Was the cost report prepared only using the provider's records? If yes, see instructions.   | N               |                | N  |  | 21.00            |  |
|         |   |                 |                |  | 1. 00  |                  |  |
|         | COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC  | EPT CHILDRENS   | HOSPI TALS)    |  | 1.00   |                  |  |
|         | Capi tal Related Cost   |                 | ,              |  |  | 1                |  |
| 22.00   | Have assets been relifed for Medicare purposes? If yes, se  | e instructions  | 3              |  | N  | 22. 00           |  |
| 23. 00  | Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.  | due to apprai   | sals made dur  | ing the cost                                 |  | 23. 00           |  |
| 24. 00  | Were new leases and/or amendments to existing leases enter  | ed into during  | this cost re   | eporting period?                             |  | 24. 00           |  |
| 25. 00  | If yes, see instructions<br>Have there been new capitalized leases entered into during  | , the cost repo | orting period? | 'If yes, see                                 |  | 25.00            |  |
| 26. 00  | instructions. Were assets subject to Sec. 2314 of DEFRA acquired during t   | he cost report  | ing period? I  | f ves see                                    |  | 26.00            |  |
|         | instructions.   | ·               | 0.             |  |  |                  |  |
| 27. 00  | Has the provider's capitalization policy changed during th copy.  | ne cost reporti | ng period? If  | yes, submit                                  |  | 27. 00           |  |
| 28. 00  | Interest Expense Were new Loans, mortgage agreements or letters of credit e   | entered into du | iring the cost | reporting                                    |  | 28. 00           |  |
|         | period? If yes, see instructions.   |                 |                |  |  |                  |  |
| 29. 00  | Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst                             |                 | ebt Service F  | Reserve Fund)                                |  | 29. 00           |  |
| 30. 00  | Has existing debt been replaced prior to its scheduled mat  |                 | 30.00          |  |  |                  |  |
| 31. 00  | instructions.<br>Has debt been recalled before scheduled maturity without i   |                 | 31.00          |  |  |                  |  |
|         | instructions. Purchased Services  |                 |                |  |  |                  |  |
| 32. 00  | Have changes or new agreements occurred in patient care se  |                 | ned through co | ontractual                                   | N  | 32. 00           |  |
| 33. 00  | arrangements with suppliers of services? If yes, see instr<br>If line 32 is yes, were the requirements of Sec. 2135.2 ap<br>no, see instructions. |                 | ng to competi  | tive bidding? If                             | N  | 33. 00           |  |
|         | Provi der-Based Physi ci ans  |                 |                |  |  |                  |  |
| 34.00   |   | ırrangement wit | th provider-ba | sed physicians?                              | Υ  | 34.00            |  |
| 35. 00  | If yes, see instructions.  If line 34 is yes, were there new agreements or amended ex   |                 | ents with the  | provi der-based                              | N  | 35.00            |  |
|         | physicians during the cost reporting period? If yes, see i  | nstructions.    |                | Y/N  | Date   |                  |  |
|         |   |                 |                | 1. 00  | 2. 00  |                  |  |
| 2/ 22   | Home Office Costs   |                 |                |  |  | 2/ 22            |  |
|         | Were home office costs claimed on the cost report?  If line 36 is yes, has a home office cost statement been p                                    | renared by the  | home office?   | N<br>N                                       |  | 36. 00<br>37. 00 |  |
| 37.00   | If yes, see instructions.   | ,               |                |  |  |                  |  |
| 38. 00  | If line 36 is yes, was the fiscal year end of the home of<br>the provider? If yes, enter in column 2 the fiscal year en                           |                 |                | N  |  | 38.00            |  |
| 39. 00  |   |                 |                | s, N   |  | 39. 00           |  |
| 40. 00  | If line 36 is yes, did the provider render services to the instructions.  | home office?    | If yes, see    | N  |  | 40.00            |  |
|         |   |                 |                |  |  |                  |  |
|         | Cost Donort Droporor Contact Information  | 1.00 2.0        |                |  |  |                  |  |
| 41. 00  | Cost Report Preparer Contact Information  Enter the first name, last name and the title/position  |                 | 41.00          |  |  |                  |  |
|         | held by the cost report preparer in columns 1, 2, and 3, respectively.  | MI CHAEL        |                | ALESSANDRI NI                                |  |                  |  |
| 42. 00  | Enter the employer/company name of the cost report preparer.  | 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.   | I               |                | I  |  | II               |  |

| Health Financial Systems METHODIST H                           | OSPITALS, INC          | In Lie                                       | u of Form CMS-25  | 52-10  |
|--|------------------------|--|---|--------|
| HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE  | Provi der CCN: 15-0002 | Peri od:<br>From 01/01/2021<br>To 12/31/2021 | Worksheet S-2<br>Part II<br>Date/Time Prepa<br>5/27/2022 9:02 | ared:  |
|  |                        |  |   |        |
|  | 3. 00                  |  |   |        |
| Cost Report Preparer Contact Information                       |                        |  |   |        |
| 41.00 Enter the first name, last name and the title/position   | DI RECTOR              |  | 4   | 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       |                        |  | 4   | 42.00  |
| preparer.  |                        |  |   |        |
| 43.00 Enter the telephone number and email address of the cost |                        |  | 4   | 43.00  |
| report preparer in columns 1 and 2, respectively.              |                        |  |   |        |
|  |                        |  |   |        |

| Period: | Worksheet S-3 | From 01/01/2021 | Part | To | 12/31/2021 | Date/Time Prepared: Heal th Fi nancial SystemsMETHODIHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 15-0002

|                  |   |                            |    |            |  | То  | 12/31/2021 | Date/Time P 5/27/2022 9 |     |                  |
|------------------|---|----------------------------|----|------------|--|-----|------------|-------------------------|-----|------------------|
|                  |   |                            |    |            |  |     |            | I/P Days /              | Ī   |                  |
|                  |   |                            |    |            |  |     |            | 0/P Visits /            | /   |                  |
|                  |   |                            |    |            |  |     |            | Trips                   | 4   |                  |
|                  | Component   | Worksheet A<br>Line Number | No | o. of Beds | Bed Days<br>Available  |     | CAH Hours  | Title V                 |     |                  |
|                  |   | 1. 00                      |    | 2. 00      | 3.00   |     | 4. 00      | 5. 00                   |     |                  |
| 1.00             | Hospital Adults & Peds. (columns 5, 6, 7 and                                  | 30. 00                     |    | 348        | 127, 02  | 20  | 0. 00      |                         | 0   | 1.00             |
|                  | 8 exclude Swing Bed, Observation Bed and                                      |                            |    |            |  |     |            |                         |     |                  |
|                  | Hospice days) (see instructions for col. 2                                    |                            |    |            |  |     |            |                         |     |                  |
| 2 00             | for the portion of LDP room available beds)                                   |                            | ŀ  |            |  |     |            |                         |     | 2 00             |
| 2.00             | HMO and other (see instructions)  |                            | ŀ  |            |  |     |            |                         |     | 2.00             |
| 3.00             | HMO IPF Subprovi der  |                            |    |            |  |     |            |                         |     | 3. 00<br>4. 00   |
| 4.00             | HMO IRF Subprovider   |                            | ŀ  |            |  |     |            |                         | 0   | 4. 00<br>5. 00   |
| 5. 00<br>6. 00   | Hospital Adults & Peds. Swing Bed SNF<br>Hospital Adults & Peds. Swing Bed NF |                            | ŀ  |            |  |     |            |                         | 0   | 6. 00            |
| 7. 00            | Total Adults and Peds. (exclude observation                                   |                            |    | 348        | 127, 02  | 20  | 0. 00      |                         | 0   | 7. 00            |
| 7.00             | beds) (see instructions)  |                            |    | 340        | 127,02   | 20  | 0.00       |                         | ۷   | 7.00             |
| 8. 00            | INTENSIVE CARE UNIT   | 31.00                      | ŀ  | 33         | 12, 04   | 15  | 0. 00      |                         | o   | 8. 00            |
| 8. 01            | NEONATAL I CU   | 31.00                      |    | 36         |  |     | 0.00       |                         | n   | 8. 01            |
| 9. 00            | CORONARY CARE UNIT  | 31.01                      |    | 30         | 13, 1-   | 10  | 0.00       |                         | Ĭ   | 9. 00            |
| 10.00            | BURN INTENSIVE CARE UNIT  |                            | ŀ  |            |  |     |            |                         |     | 10.00            |
| 11. 00           | SURGICAL INTENSIVE CARE UNIT  |                            | ŀ  |            |  |     |            |                         |     | 11. 00           |
| 12. 00           | OTHER SPECIAL CARE (SPECIFY)  |                            |    |            |  |     |            |                         |     | 12.00            |
| 13. 00           | NURSERY   | 43.00                      |    |            |  |     |            |                         | ol  | 13.00            |
| 14.00            | Total (see instructions)  |                            |    | 417        | 152, 20  | )5  | 0. 00      |                         | 0   | 14.00            |
| 15.00            | CAH visits  |                            |    |            |  |     |            |                         | 0   | 15.00            |
| 16.00            | SUBPROVIDER - IPF   | 40.00                      |    | 12         | 4, 38  | 30  |            |                         | 0   | 16.00            |
| 17.00            | SUBPROVIDER - IRF   | 41.00                      |    | 24         | 8, 76  | 50  |            |                         | 0   | 17.00            |
| 18.00            | SUBPROVI DER  |                            |    |            |  |     |            |                         |     | 18.00            |
| 19.00            | SKILLED NURSING FACILITY  |                            |    |            |  |     |            |                         |     | 19.00            |
| 20.00            | NURSING FACILITY  |                            |    |            |  |     |            |                         |     | 20.00            |
| 21.00            | OTHER LONG TERM CARE  |                            |    |            |  |     |            |                         |     | 21.00            |
| 22. 00           | HOME HEALTH AGENCY  | 101. 00                    |    |            |  |     |            |                         | 0   | 22.00            |
| 23.00            | AMBULATORY SURGICAL CENTER (D. P.)  |                            |    |            |  |     |            |                         |     | 23.00            |
| 24.00            | HOSPI CE  |                            |    |            |  |     |            |                         |     | 24.00            |
| 24. 10           | HOSPICE (non-distinct part)   | 30. 00                     |    |            |  |     |            |                         |     | 24. 10           |
| 25. 00           | CMHC - CMHC   |                            |    |            |  |     |            |                         |     | 25.00            |
| 26. 00           | RURAL HEALTH CLINIC   |                            |    |            |  |     |            |                         |     | 26.00            |
| 26. 25           | FEDERALLY QUALIFIED HEALTH CENTER   | 89. 00                     |    |            |  |     |            |                         | 0   | 26. 25           |
| 27. 00           | Total (sum of lines 14-26)  |                            |    | 453        |  |     |            |                         |     | 27.00            |
| 28. 00           | Observation Bed Days  |                            |    |            |  |     |            |                         | 0   | 28.00            |
| 29. 00           | Ambulance Trips   |                            |    |            |  |     |            |                         |     | 29.00            |
| 30.00            | Employee discount days (see instruction)                                      |                            |    |            |  |     |            |                         |     | 30.00            |
| 31. 00<br>32. 00 | Employee discount days - IRF<br>Labor & delivery days (see instructions)      |                            |    | 0          | ]  | 0   |            |                         |     | 31. 00<br>32. 00 |
| 32. 00<br>32. 01 | Total ancillary labor & delivery room   |                            |    | Ü          | 1  | U   |            |                         |     | 32. 00<br>32. 01 |
| 32.01            | outpatient days (see instructions)  |                            |    |            |  |     |            |                         |     | 32.01            |
| 33 00            | LTCH non-covered days   |                            |    |            |  |     |            |                         |     | 33. 00           |
|                  | LTCH site neutral days and discharges   |                            |    |            | 1  |     |            |                         |     | 33. 01           |
|                  |   | l                          | 1  |            | T. Control of the Con | - 1 |            |                         | - 1 |                  |

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part I | To 12/31/2021 | Date/Time Prepared: Provi der CCN: 15-0002

|        |  |             |              | 1         | 0 12/31/2021  | 5/27/2022 9:0 |           |
|--------|--|-------------|--------------|-----------|---------------|---------------|-----------|
|        |  | I/P Days    | / O/P Visits | / Trips   | Full Time I   | Equi val ents |           |
|        |  |             |              |           |               |               |           |
|        |  |             |              |           |               |               |           |
|        | Component  | Title XVIII | Title XIX    | Total All | Total Interns | Employees On  |           |
|        |  |             |              | Pati ents | & Residents   | Payrol I      |           |
|        |  | 6. 00       | 7.00         | 8. 00     | 9. 00         | 10.00         |           |
| 1.00   | Hospital Adults & Peds. (columns 5, 6, 7 and                 | 18, 462     | 3, 312       | 66, 690   |               |               | 1.00      |
|        | 8 exclude Swing Bed, Observation Bed and                     |             |              |           |               |               |           |
|        | Hospice days)(see instructions for col. 2                    |             |              |           |               |               |           |
|        | for the portion of LDP room available beds)                  |             |              |           |               |               |           |
| 2. 00  | HMO and other (see instructions)                             | 23, 224     | 22, 641      |           |               |               | 2.00      |
| 3.00   | HMO IPF Subprovider  | 0           | 311          |           |               |               | 3.00      |
| 4.00   | HMO IRF Subprovider  | 0           | 574          |           |               |               | 4.00      |
| 5.00   | Hospital Adults & Peds. Swing Bed SNF                        | 0           | 0            | 0         |               |               | 5.00      |
| 6.00   | Hospital Adults & Peds. Swing Bed NF                         |             | 0            | 0         |               |               | 6.00      |
| 7.00   | Total Adults and Peds. (exclude observation                  | 18, 462     | 3, 312       | 66, 690   |               |               | 7. 00     |
|        | beds) (see instructions)                                     |             |              |           |               |               |           |
| 8. 00  | INTENSIVE CARE UNIT  | 2, 984      | 0            | 9, 195    |               |               | 8. 00     |
| 8. 01  | NEONATAL I CU  | 0           | 0            | 2, 460    |               |               | 8. 01     |
| 9. 00  | CORONARY CARE UNIT   |             |              |           |               |               | 9. 00     |
| 10.00  | BURN INTENSIVE CARE UNIT                                     |             |              |           |               |               | 10.00     |
| 11. 00 | SURGI CAL INTENSI VE CARE UNIT                               |             |              |           |               |               | 11.00     |
| 12.00  | OTHER SPECIAL CARE (SPECIFY)                                 |             | _            |           |               |               | 12.00     |
| 13. 00 | NURSERY  |             | 0            | 2, 056    |               |               | 13.00     |
| 14. 00 | Total (see instructions)                                     | 21, 446     | 3, 312       | 80, 401   | 0. 00         | 1, 827. 27    | 1         |
| 15.00  | CAH visits   | 0           | 0            | 0         |               |               | 15.00     |
| 16.00  | SUBPROVI DER - I PF  | 422         | 58           | 1, 239    |               |               | 16.00     |
| 17.00  | SUBPROVIDER - IRF  | 1, 987      | 129          | 4, 300    | 0. 00         | 23. 27        |           |
| 18.00  | SUBPROVI DER   |             |              |           |               |               | 18.00     |
| 19.00  | SKILLED NURSING FACILITY                                     |             |              |           |               |               | 19.00     |
| 20.00  | NURSING FACILITY   |             |              |           |               |               | 20.00     |
| 21. 00 | OTHER LONG TERM CARE   | ( 252       | 1 10/        | 21 224    | 0.00          | 25.00         | 21.00     |
| 22. 00 | HOME HEALTH AGENCY   | 6, 253      | 1, 136       | 21, 324   | 0. 00         | 25. 98        |           |
| 23. 00 | AMBULATORY SURGICAL CENTER (D. P.)                           |             |              |           |               |               | 23.00     |
| 24. 00 | HOSPI CE   |             |              | 202       |               |               | 24.00     |
| 24. 10 | HOSPICE (non-distinct part)                                  |             |              | 302       |               |               | 24. 10    |
| 25. 00 | CMHC - CMHC  |             |              |           |               |               | 25.00     |
| 26. 00 | RURAL HEALTH CLINIC  |             |              | 0         | 0.00          | 0.00          | 26.00     |
| 26. 25 | FEDERALLY QUALIFIED HEALTH CENTER                            | 0           | 0            | 0         | 0.00          | l e           | 26. 25    |
| 27. 00 | Total (sum of lines 14-26)                                   |             | 2 425        | 14 470    | 0. 00         | 1, 887. 99    | 27.00     |
| 28. 00 | Observation Bed Days   |             | 2, 435       | 14, 472   |               |               | 28.00     |
| 29. 00 | Ambulance Trips  | 0           |              | 0         |               |               | 29.00     |
| 30.00  | Employee discount days (see instruction)                     |             |              | 0         |               |               | 30.00     |
| 31.00  | Employee discount days - IRF                                 | 0           |              | 0         |               |               | 31.00     |
| 32.00  | Labor & delivery days (see instructions)                     | U           | 64           | 70        |               |               | 32.00     |
| 32. 01 | Total ancillary labor & delivery room                        |             |              | 0         |               |               | 32. 01    |
| 33. 00 | outpatient days (see instructions) LTCH non-covered days     | o           |              |           |               |               | 33.00     |
|        | LTCH non-covered days  LTCH site neutral days and discharges | 0           |              |           |               |               | 33.00     |
| 33.01  | TETOT SI LE MEULT AT MAYS AND UT SCHOL YES                   | ı Y         | I            |           |               | I             | J 33. U I |

| Period: | Worksheet S-3 | From 01/01/2021 | Part | To | 12/31/2021 | Date/Time Prepared: Provi der CCN: 15-0002

|        |  |               |         | To          | 12/31/2021 | Date/Time Prep 5/27/2022 9:00 |        |
|--------|--|---------------|---------|-------------|------------|-------------------------------|--------|
|        |  | Full Time     |         | Di scha     | arges      |                               |        |
|        |  | Equi val ents |         |             |            |                               |        |
|        | Component                                    | Nonpai d      | Title V | Title XVIII | Title XIX  | Total All                     |        |
|        |  | Workers       |         |             |            | Pati ents                     |        |
|        |  | 11. 00        | 12. 00  | 13. 00      | 14. 00     | 15. 00                        |        |
| 1.00   | Hospital Adults & Peds. (columns 5, 6, 7 and |               | 0       | 2, 997      | 424        | 11, 507                       | 1.00   |
|        | 8 exclude Swing Bed, Observation Bed and     |               |         |             |            |                               |        |
|        | Hospice days)(see instructions for col. 2    |               |         |             |            |                               |        |
|        | for the portion of LDP room available beds)  |               |         |             |            |                               |        |
| 2. 00  | HMO and other (see instructions)             |               |         | 2, 573      | 3, 576     |                               | 2.00   |
| 3.00   | HMO IPF Subprovider                          |               |         |             | 30         |                               | 3.00   |
| 4. 00  | HMO IRF Subprovider                          |               |         |             | 43         |                               | 4. 00  |
| 5.00   | Hospital Adults & Peds. Swing Bed SNF        |               |         |             |            |                               | 5. 00  |
| 6.00   | Hospital Adults & Peds. Swing Bed NF         |               |         |             |            |                               | 6. 00  |
| 7. 00  | Total Adults and Peds. (exclude observation  |               |         |             |            |                               | 7. 00  |
|        | beds) (see instructions)                     |               |         |             |            |                               |        |
| 8. 00  | INTENSIVE CARE UNIT                          |               |         |             |            |                               | 8. 00  |
| 8. 01  | NEONATAL I CU                                |               |         |             |            |                               | 8. 01  |
| 9. 00  | CORONARY CARE UNIT                           |               |         |             |            |                               | 9. 00  |
| 10.00  | BURN INTENSIVE CARE UNIT                     |               |         |             |            |                               | 10.00  |
| 11. 00 | SURGICAL INTENSIVE CARE UNIT                 |               |         |             |            |                               | 11. 00 |
| 12.00  | OTHER SPECIAL CARE (SPECIFY)                 |               |         |             |            |                               | 12.00  |
| 13.00  | NURSERY                                      |               |         |             |            |                               | 13.00  |
| 14. 00 | Total (see instructions)                     | 0. 00         | 0       | 2, 997      | 424        | 11, 507                       | 14.00  |
| 15. 00 | CAH visits                                   |               |         |             |            |                               | 15.00  |
| 16. 00 | SUBPROVI DER - I PF                          | 0. 00         | 0       | 35          | 5          | 124                           | 16.00  |
| 17. 00 | SUBPROVI DER - I RF                          | 0. 00         | 0       | 145         | 8          | 304                           | 17. 00 |
| 18. 00 | SUBPROVI DER                                 |               |         |             |            |                               | 18. 00 |
| 19. 00 | SKILLED NURSING FACILITY                     |               |         |             |            |                               | 19. 00 |
| 20.00  | NURSING FACILITY                             |               |         |             |            |                               | 20.00  |
| 21. 00 | OTHER LONG TERM CARE                         |               |         |             |            |                               | 21.00  |
| 22. 00 | HOME HEALTH AGENCY                           | 0. 00         |         |             |            |                               | 22.00  |
| 23. 00 | AMBULATORY SURGICAL CENTER (D. P.)           |               |         |             |            |                               | 23.00  |
| 24. 00 | HOSPI CE                                     |               |         |             |            |                               | 24.00  |
| 24. 10 | HOSPICE (non-distinct part)                  |               |         |             |            |                               | 24. 10 |
| 25. 00 | CMHC - CMHC                                  |               |         |             |            |                               | 25.00  |
| 26. 00 | RURAL HEALTH CLINIC                          |               |         |             |            |                               | 26. 00 |
| 26. 25 | FEDERALLY QUALIFIED HEALTH CENTER            | 0. 00         |         |             |            |                               | 26. 25 |
| 27. 00 | Total (sum of lines 14-26)                   | 0. 00         |         |             |            |                               | 27. 00 |
| 28. 00 | Observation Bed Days                         |               |         |             |            |                               | 28. 00 |
| 29. 00 | Ambul ance Tri ps                            |               |         |             |            |                               | 29. 00 |
| 30.00  | Employee discount days (see instruction)     |               |         |             |            |                               | 30.00  |
| 31.00  | Employee discount days - IRF                 |               |         |             |            |                               | 31.00  |
| 32. 00 | Labor & delivery days (see instructions)     |               |         |             |            |                               | 32.00  |
| 32. 01 | Total ancillary labor & delivery room        |               |         |             |            |                               | 32. 01 |
| 00.00  | outpatient days (see instructions)           |               |         |             |            |                               | 00.00  |
| 33.00  | LTCH non-covered days                        |               |         | 0           |            |                               | 33.00  |
| 33. 01 | LTCH site neutral days and discharges        |               |         | 0           |            |                               | 33. 01 |

| HOSPI T          | AL WAGE INDEX INFORMATION  |                        |                    | Provi der C  | F   | Period:<br>From 01/01/2021<br>To 12/31/2021       | Worksheet S-3<br>Part II<br>Date/Time Pre<br>5/27/2022 9:0 | pared:           |
|------------------|--|------------------------|--------------------|--|---|---|--|------------------|
|                  |  | Wkst. A Line<br>Number | Amount<br>Reported | Reclassificat<br>ion of<br>Salaries<br>(from Wkst.<br>A-6) | Adjusted<br>Salaries<br>(col.2 ± col.<br>3) | Paid Hours<br>Related to<br>Salaries in<br>col. 4 | Average<br>Hourly Wage<br>(col. 4 ÷<br>col. 5)             |                  |
|                  |  | 1. 00                  | 2. 00              | 3.00   | 4. 00                                       | 5. 00   | 6. 00  |                  |
|                  | PART II - WAGE DATA<br>SALARIES  |                        |                    |  |   |   |  |                  |
| 1. 00            | Total salaries (see  | 200. 00                | 148, 935, 514      | -398, 181  | 148, 537, 333                               | 3, 933, 303. 00                                   | 37. 76   | 1.00             |
| 2. 00            | instructions)<br>Non-physician anesthetist Part                                    |                        | 0                  | o  | C   | 0. 00   | 0. 00  | 2.00             |
| 3. 00            | A<br>Non-physician anesthetist Part  |                        | 0                  | 0  |   | 0. 00   | 0. 00  | 3.00             |
| 4. 00            | B<br>Physician-Part A -  |                        | 0                  | 0  | ) C   | 0.00  | 0. 00  | 4.00             |
| 4 01             | Administrative<br>Physicians - Part A - Teaching                                   |                        | 0                  | 0  |   | 0.00  | 0. 00  | 4. 01            |
| 4. 01<br>5. 00   | Physician and Non  |                        | 72, 344            | 0  |   |   | 166. 69  |                  |
| 6. 00            | Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC services     |                        | 0                  | 0  | C   | 0. 00   | 0. 00  | 6.00             |
| 7. 00            | Interns & residents (in an   | 21. 00                 | 0                  | 0  | c   | 0.00  | 0. 00  | 7. 00            |
| 7. 01            | approved program) Contracted interns and residents (in an approved                 |                        | 0                  | 0  | C   | 0. 00   | 0. 00  | 7. 01            |
| 8. 00            | programs)<br>Home office and/or related  |                        | 0                  | 0  | C   | 0. 00   | 0. 00  | 8. 00            |
| 9. 00            | organization personnel<br>SNF  | 44.00                  | 0                  | О  | ) c   | 0.00  | 0. 00  | 9. 00            |
| 10. 00           | Excluded area salaries (see instructions)  |                        | 27, 770, 060       | 1, 104, 797  | 28, 874, 857                                | 565, 650. 00                                      | 51. 05   | 10.00            |
| 11. 00           | OTHER WAGES & RELATED COSTS  Contract labor: Direct Patient                        |                        | 23, 443, 361       | 0  | 23, 443, 361                                | 240, 654. 00                                      | 97. 42   | 11.00            |
| 12. 00           | Care<br>Contract Labor: Top Level  |                        | 0                  | 0  | )   |   |  | 12.00            |
|                  | management and other<br>management and administrative<br>services                  |                        |                    |  |   |   |  |                  |
| 13. 00           | Contract Labor: Physician-Part<br>A - Administrative                               |                        | 598, 074           | 0  | 598, 074                                    | 4, 140. 00  | 144. 46  | 13.00            |
| 14. 00           | Home office and/or related organization salaries and wage-related costs            |                        | 0                  | O  | o C   | 0.00  | 0. 00  | 14.00            |
| 14. 01           | Home office salaries   |                        | 0                  | 0  |   | 0.00  |  | 14. 01           |
| 14. 02<br>15. 00 | Related organization salaries<br>Home office: Physician Part A<br>- Administrative |                        | 0                  | 0  | C   | 0.00  | 0. 00<br>0. 00   | 1                |
| 16. 00           | Home office and Contract<br>Physicians Part A - Teaching                           |                        | 0                  | О  | C   | 0.00  | 0. 00  | 16. 00           |
| 16. 01           |  |                        | 0                  | 0  | C   | 0.00  | 0. 00  | 16. 01           |
| 16. 02           | Home office contract Physicians Part A - Teaching                                  |                        | 0                  | 0  | C   | 0.00  | 0. 00  | 16. 02           |
| 17. 00           | WAGE-RELATED COSTS Wage-related costs (core) (see                                  |                        | 32, 976, 576       | 0  | 32, 976, 576                                |   |  | 17. 00           |
|                  | instructions)  |                        | 32, 970, 370       |  | 32, 970, 370                                |   |  |                  |
| 18. 00           | Wage-related costs (other) (see instructions)                                      |                        |                    |  |   |   |  | 18.00            |
| 19. 00<br>20. 00 | Excluded areas<br>Non-physician anesthetist Part<br>A                              |                        | 5, 846, 714<br>0   | 0  | 5, 846, 714<br>C                            |   |  | 19.00<br>20.00   |
| 21. 00           | Non-physician anesthetist Part   |                        | 0                  | 0  | C   | )   |  | 21.00            |
| 22. 00           | Physician Part A -<br>Administrative   |                        | 0                  | 0  | c   | )   |  | 22. 00           |
| 22. 01           | Physician Part A - Teaching  |                        | 0                  | 0  | C   |   |  | 22. 01           |
| 23. 00<br>24. 00 | , , , ,  |                        | 7, 467<br>0        | 0  | 7, 467<br>C                                 |   |  | 23. 00<br>24. 00 |
| 25. 00           | Interns & residents (in an approved program)                                       |                        | 0                  | 0  | C   |   |  | 25.00            |
| 25. 50           | Home office wage-related (core)  |                        | 0                  | 0  | C   |   |  | 25. 50           |
| 25. 51           | Related organization<br>wage-related (core)  |                        | 0                  | 0  | C   |   |  | 25. 51           |
| 25. 52           | Home office: Physician Part A - Administrative - wage-related (core)               |                        | 0                  | O  | C   |   |  | 25. 52           |

| Heal th | Financial Systems              |              | METHODIST HOS    | PITALS, INC      | In Lieu of Form CMS-2552-10 |   |  |        |
|---------|--------------------------------|--------------|------------------|------------------|-----------------------------|---|--|--------|
| HOSPI T | AL WAGE INDEX INFORMATION      |              | Provi der CCN: 1 |                  |                             | Period:<br>From 01/01/2021<br>To 12/31/2021 | Worksheet S-3<br>Part II<br>Date/Time Pre<br>5/27/2022 9:0 | pared: |
|         |                                | Wkst. A Line | Amount           | Recl assi fi cat |                             | Pai d Hours                                 | Average  |        |
|         |                                | Number       | Reported         | ion of           | Sal ari es                  | Related to                                  | Hourly Wage  |        |
|         |                                |              |                  | Sal ari es       | (col.2 ± col                |   | (col. 4 ÷  |        |
|         |                                |              |                  | (from Wkst.      | 3)                          | col. 4                                      | col . 5)   |        |
|         |                                |              |                  | A-6)             |                             |   |  |        |
|         |                                | 1. 00        | 2. 00            | 3.00             | 4. 00                       | 5. 00                                       | 6. 00  |        |
| 25. 53  | Home office: Physicians Part A | \            | 0                | 0                | 1                           | 0   |  | 25. 53 |
|         | - Teaching - wage-related      |              |                  |                  |                             |   |  |        |
|         | (core)                         |              |                  |                  |                             |   |  |        |
|         | OVERHEAD COSTS - DIRECT SALARI |              |                  |                  |                             |   |  |        |
| 26. 00  | Employee Benefits Department   | 4.00         | 2, 242, 852      | •                |                             | ·   | l  | 26. 00 |
| 27.00   | Administrative & General       | 5. 00        | 22, 408, 421     | -1, 345, 193     |                             | ·   | l  | 1      |
| 28. 00  | Administrative & General under | 1            | 6, 941, 665      | 0                | 6, 941, 66                  | 5 109, 168. 00                              | 63. 59   | 28. 00 |
|         | contract (see inst.)           |              |                  |                  |                             |   |  |        |
| 29. 00  | Maintenance & Repairs          | 6. 00        | 0                | 0                |                             | 0.00  |  | 29. 00 |
| 30.00   | Operation of Plant             | 7. 00        | 3, 734, 020      | -20, 212         | 3, 713, 80                  |   | l  | 1      |
| 31.00   | Laundry & Linen Service        | 8. 00        | 0                | 0                |                             | 0.00  |  |        |
| 32.00   | Housekeepi ng                  | 9. 00        | 4, 146, 697      | -14, 834         | 4, 131, 86                  | 3 244, 301. 00                              | 16. 91   | 32.00  |
| 33.00   | Housekeeping under contract    |              | 0                | 0                | 1                           | 0.00  | 0.00   | 33.00  |
|         | (see instructions)             |              |                  |                  |                             |   |  |        |
| 34.00   | Di etary                       | 10.00        | 3, 305, 829      | -1, 994, 130     | 1, 311, 69                  |   | l  | 34.00  |
| 35.00   | Dietary under contract (see    |              | 0                | 0                | 1                           | 0.00  | 0. 00  | 35.00  |
|         | instructions)                  |              |                  |                  |                             |   |  |        |
| 36.00   | Cafeteri a                     | 11. 00       | 263, 420         | 1, 982, 607      | 2, 246, 02                  |   |  | 36. 00 |
| 37.00   | Maintenance of Personnel       | 12. 00       | 0                | 0                | 1                           | 0.00  |  |        |
| 38.00   | Nursing Administration         | 13. 00       | 4, 495, 332      | -27, 930         | 4, 467, 40                  | 66, 480. 00                                 | 67. 20   | 38. 00 |
| 39.00   | Central Services and Supply    | 14. 00       | 595, 750         | 1, 211           | 596, 96                     | 1 29, 601. 00                               | 20. 17   | 39.00  |
| 40.00   | Pharmacy                       | 15. 00       | 0                | 0                |                             | 0.00  | 0.00   | 40.00  |
| 41.00   | Medical Records & Medical      | 16.00        | 2, 094, 369      | -3, 339          | 2, 091, 03                  | 0 84, 352. 00                               | 24. 79   | 41.00  |
|         | Records Library                |              |                  |                  |                             |   |  |        |
| 42.00   | Social Service                 | 17. 00       | 469              | 423, 230         | 423, 69                     | 9 13, 973. 00                               | 30. 32   | 42.00  |
| 43.00   | Other General Service          | 18. 00       | 0                | 0                | )                           | 0.00  | 0.00   | 43.00  |
|         |                                |              |                  |                  |                             |   |  |        |

| Health Financial Systems        |                            | METHODIST HOS      | SPITALS, INC                                       |  | In Lie  | u of Form CMS-2   | 2552-10 |
|---------------------------------|----------------------------|--------------------|--|--|---|---|---------|
| HOSPITAL WAGE INDEX INFORMATION |                            |                    | Provi der Co                                       |  | Period:<br>From 01/01/2021<br>To 12/31/2021       | Worksheet S-3<br>Part III<br>Date/Time Pre<br>5/27/2022 9:0 | pared:  |
|                                 | Worksheet A<br>Line Number | Amount<br>Reported | Reclassificat ion of Salaries (from Worksheet A-6) | Adjusted<br>Salaries<br>(col.2 ± col<br>3) | Paid Hours<br>Related to<br>Salaries in<br>col. 4 | Average<br>Hourly Wage<br>(col. 4 ÷<br>col. 5)              |         |

|       |  | Line Number | Reported      | ion of       | Sal ari es    | Related to      | Hourly Wage |       |  |  |
|-------|--|-------------|---------------|--------------|---------------|-----------------|-------------|-------|--|--|
|       |  |             |               | Sal ari es   | (col.2 ± col. | Salaries in     | (col. 4 ÷   |       |  |  |
|       |  |             |               | (from        | 3)            | col. 4          | col. 5)     |       |  |  |
|       |  |             |               | Worksheet    |               |                 |             |       |  |  |
|       |  |             |               | A-6)         |               |                 |             |       |  |  |
|       |  | 1. 00       | 2. 00         | 3. 00        | 4. 00         | 5. 00           | 6. 00       |       |  |  |
|       | PART III - HOSPITAL WAGE INDEX SUMMARY |             |               |              |               |                 |             |       |  |  |
| 1.00  | Net salaries (see                      |             | 155, 804, 835 | -398, 181    | 155, 406, 654 | 4, 042, 037. 00 | 38. 45      | 1.00  |  |  |
|       | instructions)                          |             |               |              |               |                 |             |       |  |  |
| 2.00  | Excluded area salaries (see            |             | 27, 770, 060  | 1, 104, 797  | 28, 874, 857  | 565, 650. 00    | 51.05       | 2.00  |  |  |
|       | instructions)                          |             |               |              |               |                 |             |       |  |  |
| 3.00  | Subtotal salaries (line 1              |             | 128, 034, 775 | -1, 502, 978 | 126, 531, 797 | 3, 476, 387. 00 | 36. 40      | 3.00  |  |  |
|       | minus line 2)                          |             |               |              |               |                 |             |       |  |  |
| 4.00  | Subtotal other wages & related         |             | 24, 041, 435  | 0            | 24, 041, 435  | 244, 794. 00    | 98. 21      | 4.00  |  |  |
|       | costs (see inst.)                      |             |               |              |               |                 |             |       |  |  |
| 5.00  | Subtotal wage-related costs            |             | 32, 976, 576  | 0            | 32, 976, 576  | 0.00            | 26. 06      | 5.00  |  |  |
|       | (see inst.)                            |             | , , , , , , , |              |               |                 |             |       |  |  |
| 6.00  | Total (sum of lines 3 thru 5)          |             | 185, 052, 786 | -1, 502, 978 | 183, 549, 808 | 3, 721, 181. 00 | 49. 33      | 6.00  |  |  |
| 7. 00 | Total overhead cost (see               |             | 50, 228, 824  |              |               |                 |             | 7. 00 |  |  |
| 7.00  | instructions)                          |             | 00, 220, 02 1 | 1, 100, 002  | 17, 120, 702  | 1,001,002.00    | 02.71       | 7.00  |  |  |
|       | [TIISTI deti olis)                     |             | ļ             |              | l             |                 |             |       |  |  |
|       |  |             |               |              |               |                 |             |       |  |  |
|       |  |             |               |              |               |                 |             |       |  |  |

| Health Financial Systems    | METHODIST HOSPITALS, INC | In Lieu of Form CMS-2552-10 |  |  |
|-----------------------------|--------------------------|-----------------------------|--|--|
| HOSPITAL WAGE RELATED COSTS | Provi der CCN: 15-0002   | Period: Worksheet S-3       |  |  |
|                             |                          | From 01/01/2021   Part IV   |  |  |

|        | To 12/31/2021  | Date/Time Prep 5/27/2022 9:03 | pared:<br>2 am |
|--------|--|-------------------------------|----------------|
|        |  | Amount                        |                |
|        |  | Reported                      |                |
|        |  | 1.00                          |                |
|        | PART IV - WAGE RELATED COSTS                                       |                               |                |
|        | Part A - Core List   |                               |                |
|        | RETIREMENT COST  |                               |                |
| 1.00   | 401K Employer Contributions  | 2, 058, 734                   | 1.00           |
| 2.00   | Tax Sheltered Annuity (TSA) Employer Contribution                  | 0                             | 2.00           |
| 3.00   | Nonqualified Defined Benefit Plan Cost (see instructions)          | 3, 200, 000                   | 3.00           |
| 4.00   | Qualified Defined Benefit Plan Cost (see instructions)             | 0                             | 4.00           |
|        | PLAN ADMINISTRATIVE COSTS (Paid to External Organization)          |                               |                |
| 5.00   | 401K/TSA Plan Administration fees                                  | 0                             | 5.00           |
| 6.00   | Legal /Accounti ng/Management Fees-Pensi on Pl an                  | 0                             | 6.00           |
| 7. 00  | Employee Managed Care Program Administration Fees                  | 0                             | 7.00           |
|        | HEALTH AND INSURANCE COST  |                               |                |
| 8.00   | Health Insurance (Purchased or Self Funded)                        | 0                             | 8.00           |
| 8. 01  | Health Insurance (Self Funded without a Third Party Administrator) | 0                             | 8. 01          |
| 8. 02  | Health Insurance (Self Funded with a Third Party Administrator)    | 18, 063, 946                  | 8. 02          |
| 8. 03  | Health Insurance (Purchased)                                       | 0                             | 8.03           |
| 9.00   | Prescription Drug Plan   | 3, 089, 679                   | 9.00           |
| 10.00  | 3  | 769, 960                      | 10.00          |
| 11.00  |  | 370, 888                      |                |
| 12.00  |  | 0                             | 12.00          |
| 13.00  |  | 0                             | 13.00          |
| 14.00  |  | 0                             | 14.00          |
| 15.00  |  | 732, 561                      | 15.00          |
| 16.00  |  | 0                             | 16.00          |
|        | Non cumulative portion)  |                               |                |
|        | TAXES  |                               |                |
| 17. 00 |  | 10, 253, 898                  |                |
| 18. 00 |  | 0                             | 18.00          |
| 19. 00 | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1                              | 80, 002                       | 19.00          |
| 20.00  |  | 0                             | 20.00          |
|        | OTHER  |                               |                |
| 21. 00 |  | 0                             | 21. 00         |
|        | instructions))   | _                             |                |
| 22. 00 |  | 0                             | 22.00          |
| 23.00  |  | 211, 088                      | 23.00          |
| 24.00  |  | 38, 830, 756                  | 24.00          |
| 05 00  | Part B - Other than Core Related Cost                              |                               | 05.00          |
| 25. 00 | OTHER WAGE RELATED COSTS (SPECIFY)                                 | ı l                           | 25. 00         |

| 111 4- | Figure 1 Contains   | METHODI CT. HOCOLO | FALC INC              | 1 1:-           | u of Form CMS-2 | 2552 10 |
|--------|---|--------------------|-----------------------|-----------------|-----------------|---------|
|        | Financial Systems AL CONTRACT LABOR AND BENEFIT COST  | METHODIST HOSPIT   | Provider CCN: 15-0002 | Period:         | Worksheet S-3   |         |
| позетт | AL CUNTRACT LABOR AND BENEFIT COST  |                    | Provider CCN. 15-0002 | From 01/01/2021 |                 |         |
|        |   |                    |                       | To 12/31/2021   | Date/Time Pre   | pared:  |
|        |   |                    |                       |                 | 5/27/2022 9:0   | 2 am    |
|        | Cost Center Description   |                    |                       | Contract        | Benefit Cost    |         |
|        |   |                    |                       | Labor           | 0.00            |         |
|        | DART W. O. I. a. I. I. I. a. I. B. a. C. I. O. I.   |                    |                       | 1. 00           | 2. 00           |         |
|        | PART V - Contract Labor and Benefit Cost  | £!+!               |                       |                 |                 | -       |
| 1. 00  | Hospital and Hospital-Based Component Identi<br>Total facility's contract labor and benefit |                    |                       | 23, 443, 361    | 20 020 754      | 1.00    |
| 2. 00  | Hospital  | COST               |                       | 23, 443, 361    |                 |         |
| 3. 00  | Subprovi der – TPF  |                    |                       | 23, 443, 301    | 36, 630, 730    | 1       |
| 4. 00  | Subprovi der - TRF  |                    |                       | 0               |                 | 4.00    |
| 5. 00  | Subprovider - (Other)   |                    |                       | 0               |                 | 5.00    |
| 6. 00  | Swing Beds - SNF  |                    |                       | 0               | 0               | 6.00    |
| 7. 00  | Swing Beds - NF   |                    |                       | 0               | 0               |         |
| 8. 00  | Hospi tal -Based SNF  |                    |                       |                 | ١               | 8.00    |
| 9. 00  | Hospi tal -Based NF   |                    |                       |                 |                 | 9.00    |
| 10.00  | Hospi tal -Based OLTC   |                    |                       |                 |                 | 10.00   |
| 11. 00 | Hospi tal -Based HHA  |                    |                       | 0               | 0               | 11.00   |
| 12.00  | Separately Certified ASC  |                    |                       |                 |                 | 12.00   |
| 13.00  | Hospi tal -Based Hospi ce   |                    |                       |                 |                 | 13.00   |
| 14.00  | Hospital-Based Health Clinic RHC  |                    |                       |                 |                 | 14.00   |
| 15.00  | Hospital-Based Health Clinic FQHC   |                    |                       |                 |                 | 15.00   |
| 16.00  | Hospi tal -Based-CMHC   |                    |                       |                 |                 | 16.00   |
| 17.00  | Renal Dialysis  |                    |                       | 0               | 0               | 17. 00  |
| 18. 00 | Other   |                    |                       | 0               | 0               | 18. 00  |
|        |   |                    |                       |                 |                 |         |

| Heal th          | Financial Systems  | METHODIST HOS                 | PITALS, INC       |                 | In Lie                   | u of Form CMS-2             | 2552-10          |
|------------------|--|-------------------------------|-------------------|-----------------|--------------------------|-----------------------------|------------------|
| HOME H           | EALTH AGENCY STATISTICAL DATA  |                               | Provi der C       |                 | eriod:<br>rom 01/01/2021 | Worksheet S-4               |                  |
|                  |  |                               | Component         | CCN: 15-7536 To | 12/31/2021               | Date/Time Pre 5/27/2022 9:0 |                  |
|                  |  |                               |                   |                 | Home Health<br>Agency I  | PPS                         |                  |
|                  |  |                               |                   |                 |                          |                             |                  |
| 0. 00            | County   |                               |                   |                 | 1.                       | 00                          | 0.00             |
| 0.00             | journey  | Title V                       | Title XVIII       | Title XIX       | Other                    | Total                       | 0.00             |
|                  | LIGHT LIFALTH AGENCY CTATLCTI CAL DATA                                       | 1. 00                         | 2. 00             | 3. 00           | 4. 00                    | 5. 00                       |                  |
| 1. 00            | HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours                   | 0                             | 0                 | 0               | 0                        | 0                           | 1.00             |
| 2. 00            | Unduplicated Census Count (see instructions)                                 |                               |                   | 0.00            | 0. 00                    | 0.00                        | 2. 00            |
|                  |  |                               |                   | Number of Empl  | oyees (Full Ti           | me Equivalent)              |                  |
|                  |  |                               |                   |                 |                          |                             |                  |
|                  |  |                               |                   |                 |                          |                             |                  |
|                  |  | Enter the numb<br>your normal |                   | Staff           | Contract                 | Total                       |                  |
|                  |  | your norman                   | WOLK WEEK         |                 |                          |                             |                  |
|                  |  |                               |                   |                 |                          |                             |                  |
|                  |  | C                             | )                 | 1.00            | 2. 00                    | 3. 00                       |                  |
|                  | HOME HEALTH AGENCY - NUMBER OF EMPLOYEES                                     |                               |                   |                 | 2.00                     | 0.00                        |                  |
| 3.00             | Administrator and Assistant Administrator(s)                                 |                               | 40. 00            |                 | 0.00                     |                             | 3.00             |
| 4. 00<br>5. 00   | Director(s) and Assistant Director(s) Other Administrative Personnel         |                               |                   | 0. 00<br>7. 84  | 0. 00<br>0. 00           |                             | 4. 00<br>5. 00   |
| 6. 00            | Direct Nursing Service   |                               |                   | 10. 30          | 0. 00                    |                             | 6.00             |
| 7. 00            | Nursi ng Supervi sor   |                               |                   | 0.00            | 0.00                     |                             | 7. 00            |
| 8. 00<br>9. 00   | Physical Therapy Service<br>Physical Therapy Supervisor                      |                               |                   | 4. 38<br>0. 00  | 0. 00<br>0. 00           |                             | 8. 00<br>9. 00   |
| 10.00            | Occupational Therapy Service   |                               |                   | 1. 56           | 0.00                     |                             | 10.00            |
| 11. 00           | Occupational Therapy Supervisor  |                               |                   | 0.00            | 0. 00                    |                             | 11. 00           |
| 12.00            | Speech Pathology Service   |                               |                   | 0.00            | 0.00                     |                             | 12. 00<br>13. 00 |
| 13. 00<br>14. 00 | Speech Pathology Supervisor<br>Medical Social Service                        |                               |                   | 0. 00<br>0. 05  | 0. 00<br>0. 00           |                             |                  |
| 15. 00           | Medical Social Service Supervisor  |                               |                   | 0.00            | 0. 00                    |                             |                  |
| 16.00            | Home Heal th Ai de   |                               |                   | 1. 86           | 0. 00                    |                             |                  |
| 17. 00<br>18. 00 | Home Health Aide Supervisor<br>Other (specify)                               |                               |                   | 0. 00<br>0. 00  | 0. 00<br>0. 00           |                             |                  |
| 10.00            | (open.)  |                               |                   | 0.00            | 0.00                     | CBSA Data                   | 10.00            |
|                  | HOME HEALTH AGENCY ORGA CODEC  |                               |                   |                 |                          | 1. 00                       |                  |
| 19. 00           | HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where    | vou provided se               | ervices durina    | the cost repor  | ting period.             | 1                           | 19. 00           |
| 20. 00           | List those CBSA code(s) in column 1 serviced                                 |                               |                   |                 |                          |                             | 20.00            |
|                  | first code).   | Full Ep                       | ni sadas          |                 |                          |                             |                  |
|                  |  |                               |                   | LUPA Epi sodes  | PEP Only                 | Total (cols.                |                  |
|                  |  | Outliers                      |                   |                 | Epi sodes                | 1-4)                        |                  |
|                  | PPS ACTIVITY DATA  | 1. 00                         | 2.00              | 3. 00           | 4. 00                    | 5. 00                       |                  |
| 21. 00           | Skilled Nursing Visits   | 2, 952                        | 492               | 58              | 13                       | 3, 515                      | 21.00            |
| 22. 00           | Skilled Nursing Visit Charges  | 621, 276                      |                   |                 | 2, 743                   |                             | 22.00            |
| 23. 00<br>24. 00 | Physical Therapy Visits Physical Therapy Visit Charges                       | 1, 122<br>258, 034            |                   |                 | 3<br>693                 | 1, 436<br>330, 512          |                  |
| 25. 00           | Occupational Therapy Visits  | 406                           |                   |                 | 0                        |                             | 25. 00           |
| 26. 00           | Occupational Therapy Visit Charges   | 94, 458                       |                   |                 | 0                        |                             | 26. 00           |
| 27. 00<br>28. 00 | Speech Pathology Visits Speech Pathology Visit Charges                       | 0                             | 0                 |                 | 0                        |                             | 27. 00<br>28. 00 |
| 29. 00           | Medical Social Service Visits  | 6                             | 3                 | 1               | 0                        |                             | 29.00            |
| 30.00            | Medical Social Service Visit Charges   | 2, 022                        | 1, 011            |                 | 0                        |                             | 30.00            |
| 31.00            | Home Health Aide Visit Charges   | 546                           |                   |                 | 1                        | 676                         |                  |
| 32. 00<br>33. 00 | Home Health Aide Visit Charges<br>Total visits (sum of lines 21, 23, 25, 27, | 51, 654<br>5, 032             | 12, 225<br>1, 128 |                 | 95<br>17                 | •                           | 32. 00<br>33. 00 |
| 00.00            | 29, and 31)  | 3,332                         | ., .20            |                 | .,                       | 0,200                       | 00.00            |
| 34.00            | Other Charges (sum of Lines 22, 24, 26, 28                                   | 1 027 444                     | 0 222 600         | 1               | 2 521                    |                             | 34.00            |
| 35. 00           | Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)                  | 1, 027, 444                   | 233, 688          | 16, 390         | 3, 531                   | 1, 281, 053                 | 35.00            |
| 36.00            | Total Number of Episodes (standard/non                                       | 428                           |                   | 53              | 2                        | 483                         | 36. 00           |
| 37. 00           | outlier)<br>Total Number of Outlier Episodes                                 |                               | 44                |                 | 0                        | 44                          | 37. 00           |
|                  | Total Non-Routine Medical Supply Charges                                     | 157, 971                      |                   |                 |                          |                             |                  |

| 3.00   Did you receive DSH or supplemental payments from Medicaid?   Y   0.00   Fire 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?   37.767.706   5.00   5.00   17.67.706   5.00   5.00   17.67.706   5.00   5.00   6.00   | Heal th | Financial Systems METHODIST HOSPITA  | ALS, INC       |                | In Lie            | u of Form CMS-2                       | 2552-10 |  |  |
|--|---------|--|----------------|----------------|-------------------|---------------------------------------|---------|--|--|
| Uncompensated and indigent care cost computation  1.00 | HOSPI T | TAL UNCOMPENSATED AND INDIGENT CARE DATA   | Provi der CC   | N: 15-0002     | From 01/01/2021   |                                       |         |  |  |
| Incompensated and indigent care cost computation   0,023765   1,00   Cost for charger ratio (Worksheet C, Part I Time 202 column 3 divided by line 202 column 8)   0,23765   1,00   20   20   20   20   20   20   20   |         |  |                |                | To 12/31/2021     |                                       |         |  |  |
|  |         |  |                |                |                   | 1. 00                                 |         |  |  |
| Medicald (see Instructions for each Line)   20.00   Not revenue from Medicaid   3.00   10 d you receive DSH or supplemental payments from Medicaid?   7   3.00      | 1 00    |  |                | 200            | 0)                | 0.0007/5                              | 1 00    |  |  |
| Net revenue from Nedicald   99,748,777   2.00   2   | 1.00    |  | vided by it    | ne 202 coi ui  | iin 8)            | 0. 223765                             | 1.00    |  |  |
|  | 2. 00   | Net revenue from Medicaid  |                |                |                   | 99, 748, 177                          | 2.00    |  |  |
|  | 3.00    |  |                | - 6 M!         | : -10             |                                       | 3.00    |  |  |
| Medicaid charges   |         |  |                |                | cai d?            |                                       | 1       |  |  |
| 0   0   0   0   0   0   0   0   0   0  | 6. 00   |  | Tom mear car   | u              |                   |                                       | 1       |  |  |
| See   Standard   Sta   | 7. 00   | 1  |                |                |                   | 1                                     | 1       |  |  |
| Children's Health Insurance Program (CHIP) (see instructions for each line)  | 8. 00   |  |                |                |                   |                                       |         |  |  |
| Net revenue from stand-alone CHIP charges   0   9.00   10.00   5tand-alone CHIP charges   0   10.00   5tand-alone CHIP charges   0   10.00     |         |  | or each lin    | e)             |                   |                                       | 1       |  |  |
| 11.00   Stand-alone CHIP cost (line 1 times line 10)   11.00   2.00   10.00    | 9. 00   | Net revenue from stand-alone CHIP  |                |                |                   | 0                                     | 9.00    |  |  |
| 12.00 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)  13.00 Net reveue from state or local government indigent care program (see instructions for each line)  14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)  15.00 State or local indigent care program cost (line 1 times line 14)  16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 15.00 Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions) or endowment income restricted to funding charl ty care (see instructions for each line)  17.00 Private grants, donations or endowment income restricted to funding charl ty care (see instructions for each line)  18. 12 and 16)  19.00 Cost of patients approved for charity care and uninsured discounts (see instructions)  20.00 Charity care charges and uninsured discounts for the entire facility (see instructions)  21.00 Cost of patients approved for charity care and uninsured discounts (see instructions)  22.00 Payments received from patients for amounts previously written off as (cost of charity care (line 21 minus line 22)  24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?  25.00 Time 24 is yes, enter the charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?  26.00 Total bad debt expense for the entire hospital complex (see instructions)  27.00 Medicare allowable bad debts for the entire hospital complex (see instructions)  28.00 Cost of non-Medicare and non-reimburssable Medicare bad debt expense (see instructions)  29.00 Cost of non-Medicare and non-reimburssable Medicare bad debt expense (see instructions)  8.77.00 See instructions  8.77.00 See instructions  9.78.00 See instruct |         |  |                |                |                   |                                       |         |  |  |
| enter zero   Other state or local government indigent care program (see instructions for each line)   13.00   Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)  |         |  | (line 11 mi    | nus line 9     | if < zero then    | · ·                                   |         |  |  |
| Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)   0 13.00  | 12.00   |  | (11110 11 1111 | nus iine ,,    | TT V ZOTO THOS    |                                       | 12.00   |  |  |
| 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; If < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 17.00 Private grants, appropriations or transfers for support of hospital operations 18.00 Ocernment grants, appropriations or transfers for support of hospital operations 19.00 Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 0 18.00 19.00 Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 0 19.00 Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 0 19.00 Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 0 19.00 Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 0 19.00 Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 0 19.00 Total unreimbursed (see instructions)  20.00 Charity care charges and uninsured discounts for the entire facility 18,040,428 651,473 18,691,901 (see instructions)  21.00 Cost of patients approved for charity care and uninsured discounts (see 4,036,816 651,473 4,688,289 21.00 Entire the charges for mounts previously written off as 0 0 0 0 0 0 22.00 (see instructions)  22.00 Payments received from patients for amounts previously written off as 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0   |         |  |                |                |                   |                                       |         |  |  |
| 10) 15.00 16 |         |  |                |                |                   |                                       |         |  |  |
| 15.00 State or local indigent care program cost (line 1 times line 14)  16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)  Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  17.00 Private grants, donations, or endowment income restricted to funding charlty care  Private grants, appropriations, or transfers for support of hospital operations  19.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines)  19.00 Uncompensated Care (see instructions for each line)  Uninsured patients patients + col. 2)  1.00 2.00 3.00  Uncompensated Care (see instructions for each line)  Charlty care charges and uninsured discounts for the entire facility (see instructions)  10.00 Cost of patients approved for charity care and uninsured discounts (see 4, 036, 816 651, 473 18, 691, 901 charity care consistent of charity care (line 21 minus line 22)  10.00 Dess the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?  10.00 Dess the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?  10.00 Dess the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?  10.00 Dess the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?  10.00 Total bad debt expense for the entire hospital complex (see instructions)  10.00 Total bad debt expense for the entire hospital complex (see instructions)  10.00 Medicare allowable bad debts for the entire hospital complex (see instructions)  10.00 Non-Medicare b | 14.00   |  | e program (    | NOT THE Ude    | a ili ililes 6 0i | 0                                     | 14.00   |  |  |
| 13: if < zero then enter zero)   Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see   Instructions for each line)   17:00   Private grants, donations, or endowment income restricted to funding charity care   0   17:00   18:00   19:00   10:00    | 15. 00  |  |                |                |                   |                                       |         |  |  |
| Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)  17. 00 Private grants, donations, or endowment income restricted to funding charity care  18. 00 Government grants, appropriations or transfers for support of hospital operations  19. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines  19. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines  19. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines  19. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines  19. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines  19. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines  19. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines  19. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines  19. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines  19. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines  19. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines  19. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines  10. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care local partients  10. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care local partients  10. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care local partients  10. 00 Total local partients  10. 00 To | 16. 00  |  |                |                |                   |                                       |         |  |  |
| 17. 00   Private grants, donations, or endowment income restricted to funding charity care   0   17. 00   18. 00   19. 00   0   0   0   0   0   0   0   0   0  |         | Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see |                |                |                   |                                       |         |  |  |
| 18.00 Government grants, appropriations or transfers for support of hospital operations 19.00 Total unrelimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 0 19.00 1 | 17 00   |  | iundi na char  | ity cara       |                   | 0                                     | 17 00   |  |  |
| 19.00 Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)    Uninsured patients   Insured patients   Total (col. 1 + col. 2)   1.00   2.00   3.00   |         |  |                |                |                   |                                       | 1       |  |  |
| Uncompensated Care (see instructions for each line)  20.00 Charity care charges and uninsured discounts for the entire facility (see instructions)  21.00 Cost of patients approved for charity care and uninsured discounts (see instructions)  22.00 Payments received from patients for amounts previously written off as charity care  23.00 Cost of charity care (line 21 minus line 22)  4,036,816 651,473 4,688,289 21.00 cost of charity care (line 21 minus line 22)  4,036,816 651,473 4,688,289 23.00 cost of charity care (line 21 minus line 22)  4,036,816 651,473 4,688,289 23.00 cost of charity care (line 21 minus line 22)  4,036,816 651,473 4,688,289 23.00 cost of charity care (line 21 minus line 22)  4,036,816 651,473 4,688,289 23.00 cost of charity care (line 21 minus line 22)  4,036,816 651,473 4,688,289 23.00 cost of charity care (line 20 column 2, include charges for patient days beyond a length of stay limit  N 24.00 cost of charity care (line 20 column 2, include charges for patient days beyond a length of stay limit  N 24.00 cost of line 24 is yes, enter the charges for patient days beyond the indigent care program?  25.00 Total bad debt expense for the entire hospital complex (see instructions)  17,703,262 cost of line 24 is yes, enter the entire hospital complex (see instructions)  27.01 Medicare allowable bad debts for the entire hospital complex (see instructions)  10,001,379 cost of line 20 column 3, plus line 29 column 3, plus line 20 column 3, plus line 20 column | 19. 00  | Total unreimbursed cost for Medicaid, CHIP and state and Loca  |                |                | ms (sum of lines  | 0                                     | 19. 00  |  |  |
| Uncompensated Care (see instructions for each line)  20.00   Charity care charges and uninsured discounts for the entire facility (see instructions)  21.00   Cost of patients approved for charity care and uninsured discounts (see instructions)  22.00   Payments received from patients for amounts previously written off as charity care  23.00   Cost of charity care (line 21 minus line 22)   4,036,816   651,473   4,688,289   21.00    24.00   Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?  25.00   If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit   17,703,262   26.00    26.00   Total bad debt expense for the entire hospital complex (see instructions)   17,703,262   26.00    27.00   Medicare allowable bad debts for the entire hospital complex (see instructions)   1,001,379   27.01    28.00   Non-Medicare bad debt expense (see instructions)   16,701,883   28.00    29.00   Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)   4,087,780   8,776,069   30.00    20.00   Cost of uncompensated care (line 23 column 3 plus line 29)   8,776,069   30.00   |         | 157  |                | Uni nsured     | Insured           | Total (col. 1                         |         |  |  |
| Uncompensated Care (see instructions for each line)  20.00 Charity care charges and uninsured discounts for the entire facility 18,040,428 651,473 18,691,901 (see instructions)  21.00 Cost of patients approved for charity care and uninsured discounts (see 4,036,816 651,473 4,688,289 21.00 instructions)  22.00 Payments received from patients for amounts previously written off as 0 0 0 0 22.00 charity care  23.00 Cost of charity care (line 21 minus line 22) 4,036,816 651,473 4,688,289 23.00  24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?  25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions)  27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions)  28.00 Non-Medicare bad debt expense (see instructions)  30.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)  30.00 Cost of uncompensated care (line 23 column 3 plus line 29)  20.00 Cost of uncompensated care (line 23 column 3 plus line 29)  |         |  |                |                |                   | · · · · · · · · · · · · · · · · · · · |         |  |  |
| 20. 00 Charity care charges and uninsured discounts for the entire facility (see instructions) 21. 00 Cost of patients approved for charity care and uninsured discounts (see instructions) 22. 00 Payments received from patients for amounts previously written off as charity care 23. 00 Cost of charity care (line 21 minus line 22) 24. 00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25. 00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 17, 703, 262 26. 00 Total bad debt expense for the entire hospital complex (see instructions) 27. 00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 28. 00 Non-Medicare bad debt expense (see instructions) 30. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 30. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 30. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 31. 00 Cost of solutions (551, 473   |         | Uncompensated Care (see instructions for each line)  |                | 1.00           | 2.00              | 3.00                                  |         |  |  |
| 21.00 Cost of patients approved for charity care and uninsured discounts (see instructions)  22.00 Payments received from patients for amounts previously written off as charity care  23.00 Cost of charity care (line 21 minus line 22)  4,036,816  651,473  4,688,289  21.00  22.00  23.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?  25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit  26.00 Total bad debt expense for the entire hospital complex (see instructions)  77.01 Medicare reimbursable bad debts for the entire hospital complex (see instructions)  80.00 Non-Medicare bad debt expense (see instructions)  10.00  11.00  124.00  125.00  126.00  127.00  128.00  129.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)  129.00 Cost of uncompensated care (line 23 column 3 plus line 29)  120.00 Cost of uncompensated care (line 23 column 3 plus line 29)   | 20. 00  | Charity care charges and uninsured discounts for the entire fa   | cility         | 18, 040, 4     | 28 651, 473       | 18, 691, 901                          | 20.00   |  |  |
| 22.00 Payments received from patients for amounts previously written off as charity care 23.00 Cost of charity care (line 21 minus line 22)  4,036,816  51,473  4,688,289  23.00  24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?  25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit  26.00 Total bad debt expense for the entire hospital complex (see instructions)  27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions)  28.00 Non-Medicare bad debt expense (see instructions)  29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)  30.00 Cost of uncompensated care (line 23 column 3 plus line 29)  8,776,069  20.00  22.00  1.00  1.00  24.00  1.00  25.00  17,703,262  26.00  25.00  17,703,262  26.00  18,701,883  28.00  18,776,069  30.00  | 21. 00  | Cost of patients approved for charity care and uninsured disco   | ounts (see     | 4, 036, 8      | 16 651, 473       | 4, 688, 289                           | 21.00   |  |  |
| 23.00 Cost of charity care (line 21 minus line 22)  4,036,816  551,473  4,688,289  23.00  24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?  25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit  26.00 Total bad debt expense for the entire hospital complex (see instructions)  77.01 Medicare reimbursable bad debts for the entire hospital complex (see instructions)  8650,896  17,703,262  26.00  27.01 Medicare allowable bad debts for the entire hospital complex (see instructions)  18.00 Non-Medicare bad debt expense (see instructions)  19.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)  10.00  11.00  24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit  N  24.00  25.00  25.00  25.00  26.00  27.01 Medicare reimbursable bad debts for the entire hospital complex (see instructions)  17,703,262  26.00  27.01 Medicare allowable bad debts for the entire hospital complex (see instructions)  16,701,883  28.00  29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)  4,087,780  29.00  8,776,069  30.00  | 22. 00  | Payments received from patients for amounts previously written   | off as         |                | 0 0               | 0                                     | 22. 00  |  |  |
| 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?  25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit  26.00 Total bad debt expense for the entire hospital complex (see instructions)  27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions)  27.01 Medicare allowable bad debts for the entire hospital complex (see instructions)  28.00 Non-Medicare bad debt expense (see instructions)  29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)  30.00 Cost of uncompensated care (line 23 column 3 plus line 29)   | 23. 00  |  |                | 4, 036, 8      | 16 651, 473       | 4, 688, 289                           | 23. 00  |  |  |
| 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?  25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit  26.00 Total bad debt expense for the entire hospital complex (see instructions)  27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions)  27.01 Medicare allowable bad debts for the entire hospital complex (see instructions)  28.00 Non-Medicare bad debt expense (see instructions)  29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)  30.00 Cost of uncompensated care (line 23 column 3 plus line 29)   |         |  |                |                |                   | 1 00                                  |         |  |  |
| 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit  26.00 Total bad debt expense for the entire hospital complex (see instructions)  27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions)  27.01 Medicare allowable bad debts for the entire hospital complex (see instructions)  28.00 Non-Medicare bad debt expense (see instructions)  29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)  30.00 Cost of uncompensated care (line 23 column 3 plus line 29)  25.00  17, 703, 262  26.00  650, 896  27.00  1,001, 379  16,701, 883  28.00  4,087,780  9.00  8,776,069  30.00  | 24. 00  | Does the amount on line 20 column 2, include charges for patie   | nt days bey    | ond a Lengt    | n of stay limit   |                                       | 24. 00  |  |  |
| 26.00 Total bad debt expense for the entire hospital complex (see instructions)  27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions)  27.01 Medicare allowable bad debts for the entire hospital complex (see instructions)  28.00 Non-Medicare bad debt expense (see instructions)  29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)  30.00 Cost of uncompensated care (line 23 column 3 plus line 29)  17,703,262 26.00  650,896 27.00  1,001,379 27.01  16,701,883 28.00  29.00 30.00  8,776,069 30.00   | 25. 00  | If line 24 is yes, enter the charges for patient days beyond t   |                | care progra    | am's length of    | 0                                     | 25. 00  |  |  |
| 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions)  650,896 27.00  27.01 Medicare allowable bad debts for the entire hospital complex (see instructions)  1,001,379 27.01  28.00 Non-Medicare bad debt expense (see instructions)  16,701,883 28.00  29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)  30.00 Cost of uncompensated care (line 23 column 3 plus line 29)  8,776,069 30.00   | 26 00   |  | etructions)    |                |                   | 17 702 242                            | 26 00   |  |  |
| 27.01Medicare allowable bad debts for the entire hospital complex (see instructions)1,001,37927.0128.00Non-Medicare bad debt expense (see instructions)16,701,88328.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)4,087,78029.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)8,776,06930.00   |         | 1 ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '  | ,              |                |                   | 1                                     | 1       |  |  |
| 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 4,087,780 29.00 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 8,776,069 30.00  | 27. 01  | •  |                |                |                   |                                       |         |  |  |
| 30.00   Cost of uncompensated care (line 23 column 3 plus line 29)   8,776,069   30.00   |         | ,  |                |                |                   |                                       |         |  |  |
|  |         |  | pense (see     | ı nstructi on: | 5)                |                                       |         |  |  |
|  |         | ,  | ine 30)        |                |                   |                                       | 1       |  |  |

|                  | Financial Systems   | METHODIST HOSP              |                             | CN. 15 0002 D           |                              | u of Form CMS-2               | 2552-10          |
|------------------|---|-----------------------------|-----------------------------|-------------------------|------------------------------|-------------------------------|------------------|
| RECLAS           | SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O                                      | F EXPENSES                  | Provi der CO                |                         | eriod:<br>rom 01/01/2021     | Worksheet A                   |                  |
|                  |   |                             |                             | T                       |                              | Date/Time Pre                 | pared:           |
|                  | Coot Contan Decemintion   | Colorias                    | O+box                       | Total (sol 1            | Dool oooi fi oot             | 5/27/2022 9: 0                | 2 am             |
|                  | Cost Center Description   | Sal ari es                  | Other                       | Total (col. 1 + col. 2) |                              | Reclassified<br>Trial Balance |                  |
|                  |   |                             |                             | 1 (01. 2)               | A-6)                         | (col . 3 +-                   |                  |
|                  |   |                             |                             |                         | ,, 0)                        | col. 4)                       |                  |
|                  |   | 1. 00                       | 2. 00                       | 3. 00                   | 4. 00                        | 5. 00                         |                  |
|                  | GENERAL SERVICE COST CENTERS  |                             |                             |                         |                              |                               |                  |
| 1.00             | 00100 CAP REL COSTS-BLDG & FLXT   |                             | 0                           | 0                       | 19, 027, 402                 | 19, 027, 402                  | 1.00             |
| 4.00             | 00400 EMPLOYEE BENEFITS DEPARTMENT  | 2, 242, 852                 | 29, 643, 790                |                         |                              | 32, 171, 091                  | 4.00             |
| 5. 01            | 00550 DATA PROCESSING   | 4, 556, 912                 | 9, 121, 617                 | 13, 678, 529            |                              | 12, 272, 738                  | 5. 01            |
| 5. 02            | 00560 PURCHASING RECEIVING AND STORES   | 933, 907                    | 2, 481, 598                 | 3, 415, 505             |                              | 3, 321, 674                   | 5. 02            |
| 5. 03            | 00570 ADMITTING   | 2, 445, 747                 | 496, 400                    |                         |                              | 2, 943, 623                   | 5.03             |
| 5. 04<br>5. 05   | 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE<br>00590 OTHER A&G                          | 3, 105, 539<br>10, 881, 652 | 4, 679, 573<br>22, 401, 689 |                         |                              | 6, 594, 592<br>19, 139, 314   | 5. 04<br>5. 05   |
| 5. 06            | 00590 OTHER AAG   | 484, 664                    | 54, 808                     | 539, 472                |                              | 516, 665                      | 5.06             |
| 7. 00            | 00700 OPERATION OF PLANT  | 3, 734, 020                 | 9, 283, 962                 |                         |                              | 19, 019, 898                  | 7.00             |
| 8. 00            | 00800 LAUNDRY & LINEN SERVICE   | 0                           | 1, 309, 444                 |                         |                              | 1, 309, 444                   | 8.00             |
| 9. 00            | 00900 HOUSEKEEPI NG   | 4, 146, 697                 | 1, 156, 002                 |                         |                              | 5, 099, 930                   | 9.00             |
| 10.00            | 01000 DI ETARY  | 3, 305, 829                 | 2, 997, 825                 | 6, 303, 654             |                              | 2, 363, 398                   | 10.00            |
| 11. 00           | 01100 CAFETERI A  | 263, 420                    | 32, 236                     | 295, 656                | 3, 857, 590                  | 4, 153, 246                   | 11.00            |
| 13.00            | 01300 NURSING ADMINISTRATION  | 4, 495, 332                 | 1, 446, 265                 |                         |                              | 5, 787, 671                   | 13.00            |
| 14. 00           | 01400 CENTRAL SERVICES & SUPPLY   | 595, 750                    | 2, 488, 424                 | 3, 084, 174             |                              | 2, 540, 710                   | 14.00            |
| 15.00            | 01500 PHARMACY  | 0                           | 16, 814, 470                |                         |                              | 5, 658, 396                   |                  |
| 16. 00<br>17. 00 | 01600 MEDI CAL RECORDS & LI BRARY<br>01700 SOCI AL SERVI CE                         | 2, 094, 369                 | 836, 100<br>0               | 2, 930, 469<br>0        | -7, 623<br>423, 230          | 2, 922, 846                   |                  |
| 17. 00           | O1700 SOCIAL SERVICE<br>  O1701 STAFF EDUCATION                                     | 0                           | 0                           | 0                       | 423, 230                     | 423, 230<br>0                 | 17. 00<br>17. 01 |
| 17. 01           | 01701 STAIT EDUCATION   | 469                         | 10, 424                     | 10, 893                 | - 1                          | 10, 346                       | 17.01            |
| 21. 00           | 02100 I &R SERVICES-SALARY & FRINGES APPRVD   | 0                           | 10, 424                     | 0,079                   | 254, 151                     | 254, 151                      | 21.00            |
| 22. 00           | 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD   | ő                           | 0                           | Ö                       | 31, 168                      | 31, 168                       | 22. 00           |
| 23. 00           | 02300 PARAMED ED PROGRAM  | 414, 046                    | 87, 904                     | 501, 950                |                              | 789, 372                      | 23.00            |
|                  | INPATIENT ROUTINE SERVICE COST CENTERS  |                             |                             |                         |                              |                               |                  |
| 30.00            | 03000 ADULTS & PEDIATRICS   | 25, 612, 346                | 22, 602, 663                | 48, 215, 009            | -661, 690                    | 47, 553, 319                  | 30.00            |
| 31. 00           | 03100 INTENSIVE CARE UNIT   | 7, 924, 732                 | 3, 785, 477                 |                         |                              | 10, 967, 854                  | 31.00            |
| 31. 01           | 03101 NEONATAL I CU   | 1, 488, 278                 | 1, 377, 590                 |                         |                              | 2, 825, 123                   | 31.01            |
| 40.00            | 04000 SUBPROVI DER - I PF   | 928, 913                    | 88, 071                     | 1, 016, 984             |                              | 1, 006, 634                   | 40.00            |
| 41.00            | 04100 SUBPROVI DER - I RF   | 1, 843, 322                 | 325, 679                    |                         |                              | 2, 126, 988                   | 41.00            |
| 43. 00           | 04300 NURSERY ANCILLARY SERVICE COST CENTERS  | 1, 273, 393                 | 375, 090                    | 1, 648, 483             | -129, 303                    | 1, 519, 180                   | 43.00            |
| 50. 00           | 05000 OPERATING ROOM  | 4, 309, 232                 | 27, 024, 168                | 31, 333, 400            | -15, 403, 975                | 15, 929, 425                  | 50.00            |
| 50. 00           | 05001 ENDOSCOPY   | 718, 482                    | 893, 723                    | 1, 612, 205             |                              | 1, 177, 170                   | 50.00            |
| 51. 00           | 05100 RECOVERY ROOM   | 974, 092                    | 189, 292                    | 1, 163, 384             |                              | 1, 149, 786                   | 51.00            |
| 52. 00           | 05200 DELIVERY ROOM & LABOR ROOM  | 3, 256, 438                 | 1, 172, 320                 | 4, 428, 758             |                              | 4, 168, 593                   | 52.00            |
| 53.00            | 05300 ANESTHESI OLOGY   | 0                           | 0                           | 0                       | 0                            | 0                             | 53.00            |
| 54.00            | 05400 RADI OLOGY-DI AGNOSTI C   | 2, 237, 488                 | 2, 247, 927                 | 4, 485, 415             | -854, 031                    | 3, 631, 384                   | 54.00            |
| 54. 01           | 05401 RADI OLOGY - ULTRASOUND   | 1, 276, 422                 | 635, 508                    |                         | ·                            | 1, 697, 044                   | 54.01            |
| 55. 00           | 05500 RADI OLOGY-THERAPEUTI C   | 499, 222                    | 2, 830, 976                 |                         |                              | 2, 682, 108                   |                  |
| 55. 01           | 05501 I NFUSI ON CENTER   | 18, 571                     | 37, 887                     | 56, 458                 |                              | 47, 264                       | 55. 01           |
| 56.00            | 05600 RADI OI SOTOPE  | 550, 247                    | 1, 314, 051                 |                         |                              | 1, 671, 915                   |                  |
| 57. 00<br>58. 00 | 05700 CT SCAN   | 1, 193, 395<br>462, 789     | 1, 045, 481<br>892, 732     |                         | -164, 122<br>-539, 905       | 2, 074, 754                   |                  |
| 59. 00           | 05800   MAGNETI C RESONANCE I MAGI NG (MRI)<br>  05900   CARDI AC CATHETERI ZATI ON | 2, 511, 807                 | 6, 558, 762                 | 9, 070, 569             |                              | 815, 616<br>3, 372, 364       | 58. 00<br>59. 00 |
| 60. 00           | 06000 LABORATORY  | 3, 820, 133                 | 8, 547, 128                 |                         | -111, 569                    | 12, 255, 692                  | 60.00            |
| 62. 00           | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS  | 1, 170, 472                 | 355, 928                    |                         |                              | 1, 515, 338                   | 62.00            |
| 64.00            | 06400 I NTRAVENOUS THERAPY  | 0                           | 0                           | 0                       | 0                            | 0                             | 64.00            |
| 65.00            | 06500 RESPIRATORY THERAPY   | 2, 775, 997                 | 1, 386, 925                 | 4, 162, 922             | -304, 245                    | 3, 858, 677                   | 65.00            |
| 66.00            | 06600 PHYSI CAL THERAPY   | 1, 377, 198                 | 122, 174                    | 1, 499, 372             | -5, 776                      | 1, 493, 596                   | 66.00            |
| 67. 00           | 06700 OCCUPATI ONAL THERAPY   | 1, 103, 581                 | 96, 257                     | 1, 199, 838             | -809                         | 1, 199, 029                   | 67.00            |
| 68. 00           | 06800 SPEECH PATHOLOGY  | 456, 545                    | 48, 722                     | 505, 267                | -45                          | 505, 222                      | 68. 00           |
| 69.00            | 06900 ELECTROCARDI OLOGY  | 645, 482                    | 313, 854                    | 959, 336                |                              | 787, 632                      | 69.00            |
| 69. 01           | 06901 CARDI AC REHAB  | 394, 960                    | 429, 141                    | 824, 101                | -224, 759                    | 599, 342                      | 69.01            |
| 70.00            | 07000 ELECTROENCEPHALOGRAPHY  | 1, 074, 313                 | 10, 387, 950                |                         |                              | 1, 372, 996                   | 70.00            |
| 71. 00<br>72. 00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS     | 0                           | 0                           | 0                       | 13, 702, 025<br>11, 677, 336 | 13, 702, 025<br>11, 677, 336  | 71. 00<br>72. 00 |
| 73.00            | 07300 DRUGS CHARGED TO PATIENTS   | 360, 465                    | 3, 669, 544                 |                         |                              | 21, 651, 871                  | 73.00            |
| 74. 00           | 07400 RENAL DIALYSIS  | 352                         | 2, 308, 691                 | 2, 309, 043             |                              | 2, 307, 145                   | 74.00            |
| 7 1. 00          | OUTPATIENT SERVICE COST CENTERS   | 002                         | 2,000,071                   | 2,007,010               | 1,070                        | 2,007,110                     | 71.00            |
| 90.00            | 09000 CLI NI C  | 2, 745, 082                 | 2, 943, 965                 | 5, 689, 047             | -200, 190                    | 5, 488, 857                   | 90.00            |
| 91.00            | 09100 EMERGENCY   | 7, 646, 781                 | 8, 402, 466                 |                         |                              | 14, 896, 933                  | 91.00            |
| 92.00            | 09200 OBSERVATION BEDS (NON-DISTINCT PART)  |                             |                             |                         |                              |                               | 92.00            |
|                  | OTHER REIMBURSABLE COST CENTERS   |                             |                             |                         |                              |                               |                  |
| 101.00           | 10100 HOME HEALTH AGENCY  | 2, 167, 399                 | 428, 951                    | 2, 596, 350             | -27, 710                     | 2, 568, 640                   | 101.00           |
| 440 -            | SPECIAL PURPOSE COST CENTERS  | 40/ 510 10:1                | 040 404 (5:1                | 044 700 775             | 4 644 65-1                   | 044 447 755                   | 110 00           |
| 118. 00          |   | 126, 519, 134               | 218, 181, 624               | 344, 700, 758           | 1, 946, 999                  | 346, 647, 757                 | 118.00           |
| 100 00           | NONREIMBURSABLE COST CENTERS<br>  19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN         | 0                           | 733                         | 733                     | E7/                          | 157                           | 190. 00          |
|                  | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN   | 0                           | 733                         | 733                     | -576<br>0                    |                               | 190.00           |
|                  | 19200 PHYSICIANS' PRIVATE OFFICES   | 22, 321, 602                | 14, 696, 718                | _                       |                              | 36, 778, 519                  |                  |
|                  | 1 19201 OTHER NON-REI MBURSABLE   | 0                           | 2, 066, 233                 |                         |                              | 359, 611                      |                  |
|                  |   | ·                           |                             |                         | '                            |                               |                  |

| Health Financial Systems                            | METHODIST HOS | PITALS, INC   |               | In Lie                           | u of Form CMS-2                | 2552-10 |
|---|---------------|---------------|---------------|----------------------------------|--------------------------------|---------|
| RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C | F EXPENSES    | Provi der CO  |               | Peri od:                         | Worksheet A                    |         |
|   |               |               | _             | From 01/01/2021<br>Fo 12/31/2021 | Date/Time Pre<br>5/27/2022 9:0 |         |
| Cost Center Description                             | Sal ari es    | 0ther         | Total (col. 1 | Recl assi fi cat                 | Recl assi fi ed                |         |
|   |               |               | + col . 2)    | ions (See                        | Trial Balance                  |         |
|   |               |               |               | A-6)                             | (col. 3 +-                     |         |
|   |               |               |               |                                  | col. 4)                        |         |
|   | 1. 00         | 2.00          | 3. 00         | 4. 00                            | 5. 00                          |         |
| 192. 02 19202 FAMILY HEALTH/GARY COMM HEALTH        | 94, 778       | 76, 093       | 170, 87°      | 0                                | 170, 871                       | 192. 02 |
| 193. 00 19300 NONPALD WORKERS                       | 0             | 0             | (             | 0                                | 0                              | 193.00  |
| 200.00 TOTAL (SUM OF LINES 118 through 199)         | 148, 935, 514 | 235, 021, 401 | 383, 956, 91  | 5 0                              | 383, 956, 915                  | 200.00  |

Health FinancialSystemsMETHODISTRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 15-0002

| Cost Center Description  |         |  |                |               | To   12/31/2021   Date/Time Pre<br>  5/27/2022 9:0 |         |
|--|---------|--|----------------|---------------|--|---------|
| BATFORNTON SERVICE COST CHITES   S.W   |         | Cost Center Description                | Adjustments    | Net Expenses  |  |         |
|  |         |  | (See A-8)      |               |  |         |
| The First STRIVET COST CENTERS   |         |  | 6.00           |               | 4  |         |
| 4.00 0.0000   PURP PUPP F PUPP F PUPP F PUPP PUPP PUP  |         | GENERAL SERVICE COST CENTERS           | 0.00           | 7.00          |  |         |
| 5.01 DOSSO JATA RRODCESSING DOSSO JATA RRODCE | 1.00    |  | -1, 954, 795   | 17, 072, 607  | 7  | 1.00    |
| 5.02   00seld PURCHOSING RECEIVING AND STORES   0   2,446,262   5,03   5,04   5,05   5 |         | l i                                    |                |               | •  | 1       |
| 5.03   0.0500/GARMITTING 5.04   0.0500/GASHIEN MAR/ACCOUNTS RECEIVABLE   -31, '988   6, 562, 562   5.0   |         | 1 1                                    |                |               |  |         |
| 5.04   0.0580   CASHI EN INCACCOUNTS RECEI VABLE   -31, 968   6, 562, 624   5, 04   5, 05   6, 05   0.0500   CASHI EN IT RESPONDENT TO   0   1, 1516, 666   5, 06   6, 06      |         |  |                |               |  |         |
| D. 00   DOSPO OTHER AGE   DOSPO OF   DOSPO OF   DOSPO OF   |         |  |                |               |  |         |
| 7.00   2000      |         |  |                |               | •  | 1       |
| 8.00   0.0800   JAUNDAY & LI NEN SERVI CE   0   1, 309, 444   8, 00   10.00   0.000   DETARY   -5.50   2, 362, 545   10.00   10.00   0.000   DETARY   -5.50   2, 362, 545   10.00   10.00   0.000   DETARY   -7.26, 338   3, 45, 416   11.00   11.00   0.000   DETARY   -7.26, 338   3, 45, 416   11.00   11.00   0.000   DETARY   -7.26, 338   3, 45, 416   11.00   11.00   0.000   DETARY   -7.26, 338   3, 45, 416   11.00   11.00   DETARY   -7.26, 338   3, 45, 416   11.00   11.00   DETARY   -7.26, 338   3, 45, 416   11.00   DETARY   -7.26, 338   3, 42, 416   DETARY   -7.26, 338   DETARY  |         |  | _              |               |  |         |
| 9.00   0.0900   9.0SERCEPT NO  |         | 1                                      | -              |               |  |         |
| 10.00   0.000   DETARY   |         | 1                                      | -              |               | ·  | 1       |
| 11.00   01100  CAFTERIA   -7-26, 330   3, 426, 916   11.00   13.00   1 |         |  |                |               |  |         |
| 13.00   01300   NURSING ADMINISTRATION   |         |  | l .            |               |  | 1       |
| 15.00   1500   PHASHACY   0   5 , 658, 396   15.00   17.00     | 13.00   | 01300 NURSING ADMINISTRATION           | -7, 930        |               |  | 13.00   |
| 16.00   1000   MEDICAL RECORDS & LIBRARY   -298.069   2.024,777   16.00   170.00     |         |  | 1              |               |  | 1       |
| 17.00   0700   SOCI AL SERVICE   0   432, 230   17.00   17.01   17.01   17.01   17.01   17.01   17.01   17.01   17.01   17.01   17.01   17.01   17.01   18.5EPVICES-SALARY & FRINCES APPRVD   0   0   254, 151   21.00   22.00 |         |  |                |               |  |         |
| 17.01 01701 STAFF FOLICATION   |         |  |                |               |  |         |
| 17. 02 01702 MEDICAL EDUCATION 0 10.346 17.02 21.00 02200 IAR SERVICES-SCALARY & FRINCES APPRVD 0 254.151 22.00 21.00 02200 IAR SERVICES-COTHER PROM COSTS APPRVD 1 31.108 22.00 22.00 02200 IAR SERVICES-COTHER PROM COSTS APPRVD 1 31.108 22.00 22.00 02200 IAR SERVICES-COTHER PROM COSTS APPRVD 1 31.108 22.00 22.00 02200 IAR SERVICES-COTHER PROM COSTS APPRVD 1 144.815 644.557 22.00 22.00 0200 ORNANDED FROM COSTS APPRVD 1 144.815 644.557 22.00 22.00 0200 ORNANDED FROM COSTS APPRVD 1 144.815 644.557 22.00 23.00 0200 ORNANDED FROM COSTS APPRVD 1 10.907.834 31.00 23.10 02100 INTERSIVE CARE UNIT 0 10.907.834 31.00 23.10 02100 INTERSIVE CARE UNIT 0 0.10.907.834 31.00 24.10 02100 ORNANDED FROM COSTS APPRVD 1 1.519.180 24.00 24.10 02100 ORNANDED FROM COSTS APPRVD 1 1.519.180 24.00 25.00 0210 ORNANDED FROM COSTS APPRVD 1 1.519.180 24.00 25.00 0200 ORFARTIN CROSS COST CENTERS 25.00 25.00 0200 ORFART CROSS COST CENTERS 25.00 25.00 0200 O  |         | 1                                      | ĭ              |               |  |         |
| 22.00   02200  RAY SERVICES -OTHER PROM COSTS APPRVD   0   31, 168   22.00   23.00   230.00   240.00   |         | 1                                      | o              |               | -  | 1       |
|  |         |  | 0              | 254, 151      | 1  |         |
| INPATI ENT ROUTINE SERVICE COST CENTERS   3.0 0.0  |         |  | = 1            |               | •  |         |
| 30.00  | 23.00   |  | -144, 815      | 644, 557      | /  | 23.00   |
| 31.00  | 30. 00  |  | -3, 147, 142   | 44, 406, 177  | 7  | 30.00   |
| 40.00   0.0000   SUBPROVI DER - I PF   |         |  |                |               | •  |         |
| 1.00   0.4100   SUBPROVI DER - I RF  | 31. 01  | 03101 NEONATAL I CU                    | -960, 458      | 1, 864, 665   | 5  | 31.01   |
| A3. 00   0.4300   NURSERY  |         | 1 1                                    |                |               |  | 1       |
| ANCIL LARY SERVICE COST CENTERS   50.00  |         |  | l .            |               |  |         |
| SOLID   GOSDOO   DESATTING ROOM  | 43.00   |  | <u> </u>       | 1, 519, 160   | J <sub>1</sub>                                     | 43.00   |
| S1 0 0   05100   RECOVERY ROOM & LABOR ROOM   0   1, 149, 786   52, 00   530 0   05300   DELIVERY ROOM & LABOR ROOM   0   4, 168, 593   52, 00   53 00   05300   AMESTHESI OLOGY   0   0   0   0   0   0   0   0   0   | 50.00   |  | -7, 737, 458   | 8, 191, 967   | 7  | 50.00   |
| S2.00   OS200   OS20   |         |  |                |               | ·  |         |
| 53.00   05300   ANESTHESIOLOGY   0   0   0   53.00   |         | 1                                      | 0              |               | ·  |         |
| 54. 00   05400  RADIOLOGY-DIAGNOSTIC   0   3, 631, 384   54. 00   54. 01   05401  RADIOLOGY-DIAGNOSTIC   -140, 747   2, 541, 361   55. 00   05500  RADIOLOGY-THERAPUTIC   -140, 747   2, 541, 361   55. 00   05500  RADIOLOGY-THERAPUTIC   -140, 747   2, 541, 361   55. 00   55. 01   05501  INFUSION CENTER   0   47, 264   55. 00   55. 00   05500  RADIOLOGY-THERAPUTIC   -140, 747   2, 541, 361   55. 00   55. 00   05500  RADIOLOGY-THERAPUTIC   -140, 747   2, 541, 361   55. 00   55. 00   05500  RADIOLOGY-THERAPUTIC   -14, 488   2, 070, 266   57. 00   05700  CT SCAN   -4, 488   2, 070, 266   58. 00   05800  MAGNETIC RESONANCE IMAGING (MRI)   0   815, 616   58. 00   059. 00   05900  CARDIA CATHETERI ZATION   0   3, 372, 364   59. 00   05900  CARDIA CATHETERI ZATION   0   3, 372, 364   59. 00   06000  LARDRATORY   -60, 422   12, 195, 270   60. 00   06000  LARDRATORY   0   0. 00   06000  LARDRATORY   0   0. 00   06000  LARDRATORY   0   0. 00   06000  RESPIRATORY   140, 440, 440, 440, 440, 440, 440, 440,  |         | 1                                      | 0              |               |  | 1       |
| 54.01   05401   RADIOLOGY - ULTRASQUIND   -2, 160   1, 694, 884   54.01   55.00   05500   RADIOLOGY-THERAPEUTIC   -140, 747   2, 541, 361   55.00   55.00   05500   RADIOLOGY-THERAPEUTIC   -140, 747   2, 541, 361   55.00   55.00   05501   INFUSION CENTER   0   1, 671, 915   56.00   05500   RADIOLOGY-THERAPEUTIC   0   3, 372, 364   59.00   05900   ARDIAC CATHETERI ZATI ON   0   3, 372, 364   59.00   05900   ARDIAC CATHETERI ZATI ON   0   3, 372, 364   59.00   05000   ARDIAC CATHETERI ZATI ON   0   3, 372, 364   59.00   06.00   06000   LABORATORY   60.00   06.00   06000   RADIAC RED BLOOD ELLS   -58, 649   1, 456, 689   62.00   06.00   06.00   06.00   06.00   06.00   RESPIRATORY THERAPY   0   0   0   0   0   0   0   0   0   |         |  | -              | -             |  |         |
| 55. 01   05501   NFUSION CENTER   0   47, 264   55. 01   |         |  | -2, 160        |               |  |         |
| 56. 00   0500   0500   0500   0500   CT SCAN   -4,488   2,070,266   57. 00   58.00   0500   0500   CT SCAN   -4,488   2,070,266   58.00   05   |         |  | -140, 747      | 2, 541, 361   | 1  |         |
| 57.00   05700   CT SCAN     -4,488   2,070,266     57.00   05800   MAGNETIC RESONANCE IMAGING (MRI)   0   815,616     58.00   05900   CARDIAC CATHETERIZATION   0   3,372,364     59.00   06000   CARDIAC CATHETERIZATION   0   3,372,364     59.00   06000   06000   LABORATORY   -60,422   12,195,270     60.00   06000   CABORATORY   66.00   064.00   06500   MEDICE BLOOD & PACKED RED BLOOD CELLS   -58,649   1,456,689   62.00   06000   RSPIRATORY THERAPY   20,400   3,879,077     65.00   06500   RSPIRATORY THERAPY   0   1,493,596   66.00   06600   PHYSI CAL THERAPY   0   1,493,596   66.00   06600   PHYSI CAL THERAPY   0   1,493,596   67.00   06600   PHYSI CAL THERAPY   0   1,493,596   67.00   06600   PHYSI CAL THERAPY   0   1,493,596   67.00   06900   CELETROCARDIOLOGY   0   787,632   69.00   07000   ELECTROENCEPHALOGRAPHY   -1,214   1,371,782   70.00   71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   13,702,025   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   13,702,025   71.00   73.00   07300   DRUGS CHARGED TO PATIENTS   0   13,702,025   73.00   07300   DRUGS CHARGED TO PATIENTS   0   13,702,025   73.00   74.00   07400   ERMERCINCY   -2,215,891   12,681,042   99.00   09000   CILINIC   0   00000   0   0   0   0   0   0  |         |  | _              |               |  | 1       |
| 58. 00   05800   MAGNETI C RESONANCE I IMAGING (MRI)   0   815, 616   59. 00   05900   CARDIAC CATHETERIZATION   0   3, 372, 364   59. 00   60. 00   06000   LABORATORY   -60, 422   12, 195, 270   60. 00   62. 00   62. 00   64. 00   65. 00   66. 0 |         |  | =              |               |  |         |
| 59.00   05900   CARDI AC CATHETERI ZATION   0   3, 372, 364     59.00   60.00   60.00   60.00   60.00   60.00   60.00   60.00   60.20   60.200      |         |  |                |               |  |         |
| 62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   -58, 649   1, 456, 689   0   64. 00   64. 00   64.00   06400   NTRAVENOUS THERAPY   20, 400   3, 879, 077   65. 00   06500   RESPI RATORY THERAPY   20, 400   3, 879, 077   65. 00   06600   PHYSI CAL THERAPY   0   1, 493, 596   66. 00   06600   PHYSI CAL THERAPY   0   1, 493, 596   67. 00   06700   0CCUPATI ONAL THERAPY   0   505, 222   68. 00   06800   SPEECH PATHOLOGY   0   505, 222   68. 00   06900   ELECTROCARDI OLOGY   0   787, 632   69. 00   06901   CARDI AC REHAB   -112, 007   487, 335   69. 01   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   13, 702, 025   77. 00   07200   MPLD LAL SUPPLIES CHARGED TO PATI ENTS   0   13, 702, 025   77. 00   07200   MPLD LAL SUPPLIES CHARGED TO PATI ENTS   0   11, 677, 336   72. 00   07300   DRUGS CHARGED TO PATI ENTS   0   11, 677, 336   72. 00   07300   RENAL DI ALYSIS   0   2, 307, 145   77. 00   07400   RENAL DI ALYSIS   0   2, 307, 145   77. 00   07900   MERGENCY   5, 403, 209   90. 00   9000   CLI NI C   -85, 648   5, 403, 209   90. 00   9000   MERGENCY   -2, 215, 891   12, 681, 042   97. 00   9000   MERGENCY   97. 00   9000   MERGENCY   -2, 215, 891   12, 681, 042   97. 00   9000   MERGENCY   97. 00   9000   MERGENCY   5, 403, 209   90. 00   9000   9000   MERGENCY   5, 403, 209   90. 00   9000 |         |  |                |               | ·  |         |
| 64.00   06400   INTRAVENOUS THERAPY   0   0   0   65.00   65.00   06500   RESPI RATORY THERAPY   20,400   3,879,077   65.00   66.00   06600   PHYSI CAL THERAPY   0   1,493,596   66.00   67.00   06700   0CCUPATI ONAL THERAPY   0   1,199,029   67.00   68.00   06800   SPEECH PATHOLOGY   0   505,222   68.00   69.00   06900   ELECTROCARDI OLOGY   0   787,632   69.00   69.01   06901   CARDI AC REHAB   -112,007   487,335   69.01   70.00   07000   ELECTROENCEPHALOGRAPH   -1,214   1,371,782   70.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   13,702,025   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   11,677,336   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   -175,722   21,476,149   73.00   74.00   07400   RENAL DI ALYSI S   0   2,307,145   74.00   74.00   07400   RENAL DI ALYSI S   0   2,307,145   74.00   75.00   09000   CLINI C   -85,648   5,403,209   90.00   75.00   09000   CLINI C   -85,648   5,403,209   90.00   75.00   09000   OBSERVATI ON BEDS (NON-DISTINCT PART)   791.00   70   0700   RENERGENCY   -2,215,891   12,681,042   91.00   70   09000   OBSERVATI ON BEDS (NON-DISTINCT PART)   792.00   70   09000   CRESCARCH   0   0   0   70   09000   CRESCARCH   0   0   70   09000   0   0   0   0   0   70   0   0   0   0   0   0   70   0   0   0   0   0   0   70   0   0   0   0   0   0   70   0   0   0   0   0   70   0   0   0   0   0   70   0   0   0   0   0   70   0   0   0   0   0   70   0    |         |  |                |               |  | 60.00   |
| 65. 00   06500   RESPI RATORY THERAPY   20,400   3,879,077   66. 00   66. 00   06600   PHYSI CAL THERAPY   0   1,493,596   66. 00   67. 00   06700   06CUPATI ONAL THERAPY   0   1,199,029   67. 00   68. 00   6800   SPEECH PATHOLOGY   0   505,222   68. 00   69. 00   69. 00   69. 00   69. 00   69. 01   06901   CARDI ACR EHAB   -112,007   487,335   69. 01   70. 00   07000   ELECTROENCEPHALOGRAPHY   -1,214   1,371,782   70. 00   71. 00   07000   ELECTROENCEPHALOGRAPHY   -1,214   1,371,782   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   13,702,025   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   11,677,336   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   11,677,336   72. 00   74. 00   07400   RENAL DI ALYSIS   0   2,307,145   74. 00   001704   RENAL DI ALYSIS   0   2,307,145   74. 00   001704   RENAL DI ALYSIS   0   2,2307,145   74. 00   09000   CLI NI C   -85,648   5,403,209   90. 00   91. 00   90000   CLI NI C   -2,215,891   12,681,042   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   91. 00   09100   EMERGENCY   0   2,568,640   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   10. 00   0100   HOME HEALTH AGENCY   0   2,568,640   92. 00   09000   GIT, FLOWER COST CENTERS   10. 00   1000   HOME HEALTH AGENCY   0   2,568,640   10. 00   10 |         |  | 1              |               |  |         |
| 66. 00 6600 PHYSICAL THERAPY 0 1, 493, 596 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 1, 1, 199, 029 67. 00 6800 SPEECH PATHOLOGY 0 505, 222 68. 00 69. 00 6900 ELECTROCARDI OLOGY 0 787, 632 69. 00 69. 00 6900 ELECTROCARDI OLOGY 0 787, 632 69. 00 69. 00 6901 CARDI AC REHAB -112, 007 487, 335 69. 01 06901 CARDI AC REHAB -112, 007 487, 335 69. 01 07000 ELECTROENCEPHALOGRAPHY 1, 3, 371, 782 70. 00 7100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 13, 702, 025 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 11, 677, 336 72. 00 7300 DRUGS CHARGED TO PATI ENTS 0 11, 677, 336 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0 2, 307, 145 74. 00 07400 RENAL DI ALYSIS 0 2, 307, 145 74. 00 07400 RENAL DI ALYSIS 0 2, 307, 145 74. 00 07400 RENAL DI ALYSIS 0 2, 207, 145 91. 00 09100 EMERGENCY -2, 215, 891 12, 681, 042 99. 00 09100 EMERGENCY -2, 215, 891 12, 681, 042 99. 00 09100 EMERGENCY 0 0 2, 368, 640 101. 00 09100 EMERGENCY 0 0 2, 568, 640 101. 00 09100 EMERGENCY 0 0 2, 568, 640 101. 00 09100 EMERGENCY 0 0 2, 568, 640 101. 00 09100 EMERGENCY 0 0 2, 568, 640 101. 00 09100 EMERGENCY 0 0 2, 568, 640 101. 00 09100 EMERGENCY 0 0 2, 568, 640 101. 00 09100 EMERGENCY 0 0 2, 568, 640 101. 00 09100 EMERGENCY 0 0 2, 568, 640 101. 00 09100 EMERGENCY 0 0 2, 568, 640 101. 00 09100 EMERGENCY 0 0 0 2, 568, 640 101. 00 09100 EMERGENCY 0 0 0 2, 568, 640 101. 00 09100 EMERGENCY 0 0 0 2, 568, 640 101. 00 09100 EMERGENCY 0 0 0 2, 568, 640 101. 00 09100 EMERGENCY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0   |         |  |                | -             | 1  | 1       |
| 67. 00   06700   OCCUPATI ONAL THERAPY   0   1, 199, 029   67. 00   68. 00   06800   SPECH PATHOLOGY   0   505, 222   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   787, 632   69. 00   69. 01   06901   CARDI AC REHAB   -112, 007   487, 335   69. 01   70. 00   07000   ELECTROENCEPHALOGRAPHY   -1, 214   1, 371, 782   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   13, 702, 025   71. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   11, 677, 336   72. 00   07300   DRUGS CHARGED TO PATIENTS   -175, 722   21, 476, 149   73. 00   73. 00   07400   RENAL DI ALYSIS   0   2, 307, 145   74. 00   07400   RENAL DI ALYSIS   0   2, 307, 145   74. 00   09000   CLI NIC   -85, 648   5, 403, 209   90. 00   91. 00   BMERGENCY   -2, 215, 891   12, 681, 042   91. 00   92. 00   DSERVATION BEDS (NON-DISTINCT PART)   07HER REIMBURSABLE COST CENTERS   101. 00   DIOD   HOME HEALTH AGENCY   0   2, 568, 640   101. 00   SPECIAL PURPOSE COST CENTERS   101. 00   SPECIAL PURPOSE COST CENTERS   101. 00   NONREI MBURSABLE COST CENTERS   101. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   0   157   190. 00   191. 00   191. 00   192. 00   19200   PSERVATION SPECIAL PURPOSE COST CENTERS   192. 00   19200   PSERVATION SPECIAL PURPOSE COST CENTERS   190. 00   191.  |         |  | 20, 400        |               |  |         |
| 69. 00   |         |  | Ö              |               | •  |         |
| 69. 01 06901 CARDI AC REHAB -112,007 487,335 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY -1,214 1,371,782 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 13,702,025 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0 11,677,336 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS -175,722 21,476,149 73. 00 74. 00 07400 RENAL DIALYSIS 0 2,307,145 74. 00 0UTPATIENT SERVICE COST CENTERS  90. 00 09000 CLINIC -85,648 5,403,209 90. 00 91. 00 09100 EMERGENCY -2,215,891 12,681,042 91. 00 92. 00 09200 DBSERVATION BEDS (NON-DISTINCT PART) 92. 00 0THER REIMBURSABLE COST CENTERS  101. 00 10100 HOME HEALTH AGENCY 0 2,568,640 101. 00  118. 00 SUBTOTALS (SUM OF LINES 1 through 117) -17,895,566 328,752,191 18. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 191. 00 191. 00 19100 RESEARCH 0 0 192. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES -8,393,064 28,385,455 192. 01 192. 00 19201 OTHER NON-REIMBURSABLE 0 192. 01   |         |  | 0              |               |  |         |
| 70. 00   |         |  | 0              |               | •  |         |
| 71. 00   |         | 1                                      | · ·            |               | •  |         |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 11, 677, 336 73. 00 07300 DRUGS CHARGED TO PATIENTS -175, 722 21, 476, 149 73. 00 07400 RENAL DI ALYSI S 0 2, 307, 145 74. 00 00TPATIENT SERVICE COST CENTERS 90. 00 09000 CLI NI C 90. 00 09100 EMERGENCY -2, 215, 891 12, 681, 042 91. 00 09200 DRSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 07400 PRALTH AGENCY 97. 00 09200 DRSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 09200 DRSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 09200 DRSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 09200 DRSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 09200 DRSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 09200 DRSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 09200 DRSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 09200 DRSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 09200 DRSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 09200 DRSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 09200 DRSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 09200 DRSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 09200 DRSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 09200 DRSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 09200 DRSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 09200 DRSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 09200 DRSERVATI ON BEDS (NON-DI STI NCT PART) 92. 01 09200 DRSERVATI ON BEDS (NON-DI STI NCT PART) 92. 01 09200 DRSERVATI ON BEDS (NON-DI STI NCT PART) 92. 01 09200 DRSERVATI ON BEDS (NON-DI STI NCT PART) 92. 01 09200 DRSERVATI ON BEDS (NON-DI STI NCT PART) 92. 01 09200 DRSERVATI ON BEDS (NON-DI STI NCT PART) 92. 01 09200 DRSERVATI ON BEDS (NON-DI STI NCT PART) 92. 01 09200 DRSERVATI ON DRSERVATI ON BEDS (NON-DI STI NCT PART) 92. 01 09200 DRSERVATI ON BEDS (NON-DI STI NCT PART) 92. 01 09200 DRSERVATI ON BEDS (NON-DI STI NCT PART) 92. 01 09200 DRSERVATI ON BEDS (NON-DI STI NCT PART) 92. 01 09200 DRSERVATI ON BEDS (NON-DI STI NCT PART) 92. 01 09200 DRSERVATI ON BEDS (NON-DI STI NCT PART) 92. 01 09200 DRSERVATI ON BEDS (NON-DI STI NCT PART) 92. 01 09200 DRSERVATI ON PART DE NON-DI STI NCT PART DE NON-DI STI NCT PART DE NON-DI S |         |  |                |               | •  |         |
| 74. 00   |         |  |                |               | •  |         |
| OUTPATIENT SERVICE COST CENTERS   OUTP   |         |  | -175, 722      |               |  |         |
| 90. 00   09000   CLINI C   -85, 648   5, 403, 209   91. 00   09100   EMERGENCY   -2, 215, 891   12, 681, 042   91. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   92. 00   OTHER REI MBURSABLE COST CENTERS   101. 00   SUBTOTALS (SUM OF LINES 1 through 117)   -17, 895, 566   328, 752, 191   118. 00   NONREI MBURSABLE COST CENTERS   190. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   190. 00   19100   RESEARCH   0   0   0   191. 00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   -8, 393, 064   28, 385, 455   192. 00   192. 01   19201   OTHER NON-REI MBURSABLE   0   359, 611   192. 01  | 74. 00  |  | 0              | 2, 307, 145   | 5  | 74.00   |
| 91. 00   | 00 00   |  | 05 640         | 5 402 200     |  | 00.00   |
| 92. 00 07200   085ERVATI ON BEDS (NON-DISTINCT PART)   92. 00 07HER REIMBURSABLE COST CENTERS  101. 00   10100   HOME HEALTH AGENCY   0   2,568,640   101. 00 SPECI AL PURPOSE COST CENTERS  118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   -17,895,566   328,752,191   118. 00 NONREI MBURSABLE COST CENTERS  190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   157   190. 00 191. 00   19100   RESEARCH   0   0   0   191. 00 192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   -8,393,064   28,385,455   192. 00 192. 01   19201   OTHER NON-REI MBURSABLE   0   359,611   192. 01  |         |  |                |               | ·  | 1       |
| 101. 00  |         |  | 2,210,071      | .2,00.,0.2    | -  |         |
| SPECIAL PURPOSE COST CENTERS   118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   -17, 895, 566   328, 752, 191   118. 00   NONREI MBURSABLE COST CENTERS   190. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   19100   RESEARCH   0   0   0   0   192. 00   19200   PHYSI CI ANS¹ PRI VATE OFFI CES   -8, 393, 064   28, 385, 455   192. 01   1920   OTHER NON-REI MBURSABLE   0   359, 611   192. 01  |         | OTHER REIMBURSABLE COST CENTERS        |                |               |  |         |
| 118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   -17, 895, 566   328, 752, 191   118. 00   NONREI MBURSABLE COST CENTERS   190. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   0   157   190. 00   191. 00   19100   RESEARCH   0   0   0   191. 00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   -8, 393, 064   28, 385, 455   192. 00   192. 01   19201   OTHER NON-REI MBURSABLE   0   359, 611   192. 01  | 101.00  |  | 0              | 2, 568, 640   | ס  | 101.00  |
| NONRE   MBURSABLE   COST   CENTERS   190. 00   19000   GI FT,   FLOWER,   COFFEE   SHOP & CANTEEN   0   157   190. 00   191. 00   19100   RESEARCH   0   0   191. 00   192. 00   19200   PHYSI   CI   ANS'   PRI VATE   OFFI   CES   -8, 393, 064   28, 385, 455   192. 00   192. 01   19201   OTHER   NON-REI   MBURSABLE   0   359, 611   192. 01  | 110.00  |  | 17 005 57      | 220 752 404   | 1  | 110 00  |
| 190. 00     19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN     0     157     190. 00       191. 00     19100 RESEARCH     0     0     191. 00       192. 00     19200 PHYSI CI ANS' PRI VATE OFFI CES     -8, 393, 064     28, 385, 455     192. 00       192. 01     19201 OTHER NON-REI MBURSABLE     0     359, 611     192. 01   | 118.00  | 3 /                                    | - 17, 895, 566 | 328, 752, 191 | ·  | 1118.00 |
| 191. 00   19100   RESEARCH   | 190. 00 |  | O              | 157           | 7  | 190.00  |
| 192. 01   19201   OTHER NON-REI MBURSABLE 0   359, 611   192. 01   |         |  | o              |               |  |         |
|  |         |  |                |               | •  |         |
| 100 001 70 000 70 000 100 100 000 100 100 000 100 100 000 100  |         |  |                |               | •  |         |
| 192. 02 19202  FAMI LY HEALTH/GARY COMM HEALTH   -100, 002  70, 869    192. 02   | 192.02  | 2 17202 FAWILT HEALIH/GAKT COMM HEALIH | - 100, 002     | /0, 869       | 7  | 1172.02 |

| Health Financial Systems                            | METHODIST HOS | PITALS, INC   |             | In Lieu         | u of Form CMS-: | 2552-10      |
|---|---------------|---------------|-------------|-----------------|-----------------|--------------|
| RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE ( | OF EXPENSES   | Provi der CC  | CN: 15-0002 | Peri od:        | Worksheet A     |              |
|   |               |               |             | From 01/01/2021 |                 |              |
|   |               |               |             | To 12/31/2021   | Date/Time Pre   |              |
|   |               |               |             |                 | 5/27/2022 9:0   | <u> 2 am</u> |
| Cost Center Description                             | Adjustments   | Net Expenses  |             |                 |                 |              |
|   | (See A-8)     | For           |             |                 |                 |              |
|   |               | Allocation    |             |                 |                 |              |
|   | 6. 00         | 7. 00         |             |                 |                 |              |
| 193. 00 19300 NONPALD WORKERS                       | 0             | 0             |             |                 |                 | 193. 00      |
| 200.00   TOTAL (SUM OF LINES 118 through 199)       | -26, 388, 632 | 357, 568, 283 |             |                 |                 | 200.00       |

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0002

|                  |  |                   |             |              | 27/2022 9:02 am  |
|------------------|--|-------------------|-------------|--------------|------------------|
|                  |  | Increases         |             |              |                  |
|                  | Cost Center                              | Li ne #           | Sal ary     | Other        |                  |
|                  | 2. 00<br>A - CAFETERI A                  | 3. 00             | 4. 00       | 5. 00        |                  |
| 1. 00            | CAFETERI A                               | 11. 00            | 1, 983, 510 | 1, 875, 262  | 1.00             |
| 1.00             | 0  |                   | 1, 983, 510 | 1, 875, 262  | 1.00             |
|                  | B - CLINICAL TRAINING COST               | •                 |             | ,            |                  |
| 1.00             | PARAMED ED PROGRAM                       | 23. 00            | 290, 601    | 0            | 1.00             |
| 2.00             |  | 0. 00             | 0           | 0            | 2.00             |
| 3.00             |  | 0. 00             | 0           | 0            | 3.00             |
| 4.00             |  | 0.00              | 0           | 0            | 4.00             |
| 5.00             |  | 0.00              | 0           | 0            | 5.00             |
| 6. 00            |  | 0.00              | 0           | 0            | 6. 00            |
|                  | C - SOCIAL WORKERS                       |                   | 290, 601    | U            |                  |
| 1.00             | SOCIAL SERVICE                           | 17. 00            | 423, 230    | 0            | 1.00             |
|                  | 0  |                   | 423, 230    | 0            |                  |
|                  | E - RESIDENTS                            |                   |             |              |                  |
| 1.00             | I&R SERVICES-SALARY &                    | 21. 00            | 0           | 254, 151     | 1.00             |
| 0.00             | FRI NGES APPRVD                          | 22 22             |             | 04 4/0       | 0.00             |
| 2. 00            | I &R SERVICES-OTHER PRGM<br>COSTS APPRVD | 22. 00            | 0           | 31, 168      | 2.00             |
|                  | 0 — — — — — — — — — — — — — — — — — — —  | +                 |             | 285, 319     |                  |
|                  | F - MED SUPPLY                           |                   |             |              |                  |
| 1.00             | MEDICAL SUPPLIES CHARGED TO              | 71. 00            | 0           | 13, 702, 025 | 1.00             |
|                  | PATI ENTS                                |                   |             |              |                  |
| 2. 00            | IMPL. DEV. CHARGED TO                    | 72. 00            | 0           | 11, 677, 336 | 2.00             |
| 3. 00            | PATI ENTS                                | 0.00              | o           | 0            | 3.00             |
| 4. 00            |  | 0.00              | 0           | 0            | 4.00             |
| 5. 00            |  | 0.00              | o           | 0            | 5. 00            |
| 6. 00            |  | 0. 00             | o           | 0            | 6.00             |
| 7.00             |  | 0.00              | O           | 0            | 7. 00            |
| 8.00             |  | 0.00              | o           | 0            | 8. 00            |
| 9.00             |  | 0. 00             | 0           | 0            | 9. 00            |
| 10.00            |  | 0. 00             | 0           | 0            | 10.00            |
| 11. 00           |  | 0. 00             | 0           | 0            | 11.00            |
| 12.00            |  | 0. 00             | 0           | 0            | 12.00            |
| 13.00            |  | 0.00              | 0           | 0            | 13.00            |
| 14. 00<br>15. 00 |  | 0. 00<br>0. 00    | 0           | 0            | 14. 00<br>15. 00 |
| 16. 00           |  | 0.00              | 0           | 0            | 16. 00           |
| 17. 00           |  | 0.00              | 0           | 0            | 17. 00           |
| 18. 00           |  | 0.00              | ő           | o            | 18. 00           |
| 19. 00           |  | 0.00              | ol          | 0            | 19.00            |
| 20.00            |  | 0.00              | O           | 0            | 20.00            |
| 21.00            |  | 0.00              | o           | 0            | 21.00            |
| 22.00            |  | 0. 00             | 0           | 0            | 22. 00           |
| 23.00            |  | 0. 00             | 0           | 0            | 23. 00           |
| 24. 00           |  | 0. 00             | 0           | 0            | 24.00            |
| 25. 00           |  | 0.00              | 0           | 0            | 25.00            |
| 26.00            |  | 0. 00<br>0. 00    | 0           | 0            | 26.00            |
| 27. 00<br>28. 00 |  | 0.00              | 0           | 0<br>0       | 27. 00<br>28. 00 |
| 29. 00           |  | 0.00              | 0           | 0            | 29.00            |
| 30. 00           |  | 0.00              | o           | 0            | 30.00            |
| 31. 00           |  | 0. 00             | ő           | Ö            | 31.00            |
| 32. 00           |  | 0. 00             | o           | Ö            | 32.00            |
| 33. 00           |  | 0.00              | ō           | 0            | 33.00            |
| 34.00            |  | 0. 00             | O           | 0            | 34.00            |
| 35.00            |  | 0. 00             | 0           | 0            | 35.00            |
| 36. 00           |  | 0. 00             | 0           | 0            | 36.00            |
| 37. 00           |  | 0.00              | 0           | 0            | 37.00            |
| 38. 00           |  | 0.00              | 0           | 0            | 38.00            |
| 39. 00           |  | 0.00              | 0           | 0            | 39.00            |
| 40.00            |  | 0.00              | 0           | 0            | 40.00            |
| 41.00            |  | 0.00              | 0           | 0            | 41.00            |
| 42.00            |  | 0.00              | 0           | 0            | 42.00            |
| 43.00            |  | 0. 00<br>0. 00    | 0           | 0            | 43.00            |
| 44. 00<br>45. 00 |  | 0.00              | 0           | 0            | 44. 00<br>45. 00 |
| 46. 00           |  | 0.00              | 0           | 0            | 46.00            |
| 47. 00           |  | 0.00              | •           | 0            | 47. 00           |
|                  |  | — — <del></del> + | 0           | 25, 379, 361 | 30               |
|                  | . '                                      |                   |             |              |                  |

Health Financial Systems RECLASSIFICATIONS | Peri od: | From 01/01/2021 | To 12/31/2021 | Worksheet A-6 | To 12/31/2021 | Date/Time Prepared: | 5/27/2022 9:02 am Provider CCN: 15-0002

|                  |   |                                       |                   |                    | 10 12/31/2021 | 5/27/2022 9: 02 am |
|------------------|---|---------------------------------------|-------------------|--------------------|---------------|--------------------|
|                  |   | Increases                             |                   |                    |               |                    |
|                  | Cost Center                                     | Li ne #                               | Sal ary           | Other 5.00         |               |                    |
|                  | G - LIGHT DUTY                                  | 3.00                                  | 4. 00             | 5. 00              |               |                    |
| 1. 00            | ADMITTING                                       | 5. 03                                 | 7, 390            | 0                  |               | 1.00               |
| 2. 00            | HOUSEKEEPI NG                                   | 9. 00                                 | 4, 273            | 0                  |               | 2.00               |
| 3. 00            | DI ETARY  | 10.00                                 | 5, 913            | 0                  |               | 3.00               |
| 4.00             | NURSING ADMINISTRATION                          | 13.00                                 | 1, 004            | 0                  |               | 4.00               |
| 5.00             | CENTRAL SERVICES & SUPPLY                       | 14. 00                                | 2, 038            | 0                  |               | 5.00               |
| 6.00             | ADULTS & PEDIATRICS                             | 30.00                                 | 43, 595           | 0                  |               | 6.00               |
| 7. 00            | SUBPROVI DER – I RF                             | 41.00                                 | 171               | 0                  |               | 7. 00              |
| 8. 00            | OPERATING ROOM                                  | 50.00                                 | 13, 652           | 0                  |               | 8.00               |
| 9.00             | ENDOSCOPY<br>RADI OI SOTOPE                     | 50. 01                                | 2, 589            | 0                  |               | 9.00               |
| 10. 00<br>11. 00 | ELECTROCARDI OLOGY                              | 56. 00<br>69. 00                      | 17, 592<br>9, 187 | 0                  |               | 10. 00<br>11. 00   |
| 12.00            | EMERGENCY                                       | 91.00                                 | 2, 068            |                    |               | 12.00              |
| 12.00            | 0   |                                       | 109, 472          | 0                  |               | 12.00              |
|                  | H - INTEREST EXPENSE                            | · · · · · · · · · · · · · · · · · · · | , , , ,           | -,                 |               |                    |
| 1.00             | CAP REL COSTS-BLDG & FIXT                       | 1. 00                                 | 0                 | 2, 048, 826        |               | 1.00               |
| 2.00             |   | 0.00                                  | 0                 | 0                  |               | 2.00               |
| 3. 00            |   | 0.00                                  | 0                 | 0                  |               | 3.00               |
|                  | O CORPORATE EXPENSE                             |                                       | 0                 | 2, 048, 826        |               |                    |
| 1. 00            | I - CORPORATE EXPENSE CAP REL COSTS-BLDG & FLXT | 1.00                                  | 0                 | 6, 157, 522        |               | 1.00               |
| 2. 00            | OPERATION OF PLANT                              | 7. 00                                 | 0                 | 5, 253, 282        |               | 2.00               |
| 2.00             | 0   | — <u> </u>                            | <del> </del> _    | 11, 410, 804       |               | 2.00               |
|                  | J - DRUG EXPENSE                                |                                       | <u> </u>          | 11, 110, 001       |               |                    |
| 1.00             | DRUGS CHARGED TO PATIENTS                       | 73.00                                 | 0                 | 17, 950, 733       |               | 1.00               |
| 2.00             |   | 0.00                                  | O                 | 0                  |               | 2.00               |
| 3.00             |   |                                       |                   | 0                  |               | 3.00               |
|                  | 0   |                                       | 0                 | 17, 950, 733       |               |                    |
| 1 00             | K - PHYSICIAN RECLASS                           |                                       | ما                | 24 500             |               | 1.00               |
| 1. 00<br>2. 00   | OTHER A&G<br>CLINIC                             | 5. 05<br>90. 00                       | 0                 | 34, 500<br>94, 556 |               | 1.00               |
| 2.00             | 0   |                                       | <del> </del>      | 129, 056           |               | 2.00               |
|                  | L - PSTD RECLASS                                | <u>I</u>                              | <u></u>           | 1277 000           |               |                    |
| 1.00             | EMPLOYEE BENEFITS DEPARTMENT                    | 4. 00                                 | 0                 | 398, 181           |               | 1.00               |
| 2. 00            |   | 0.00                                  | 0                 | 0                  |               | 2. 00              |
| 3. 00            |   | 0.00                                  | 0                 | 0                  |               | 3.00               |
| 4. 00            |   | 0.00                                  | 0                 | 0                  |               | 4.00               |
| 5. 00<br>6. 00   |   | 0. 00<br>0. 00                        | 0                 | 0                  |               | 5. 00<br>6. 00     |
| 7. 00            |   | 0.00                                  | O O               | 0                  |               | 7.00               |
| 8. 00            |   | 0.00                                  | O                 | 0                  |               | 8.00               |
| 9. 00            |   | 0.00                                  | o                 | Ö                  |               | 9.00               |
| 10.00            |   | 0.00                                  | 0                 | 0                  |               | 10.00              |
| 11. 00           |   | 0.00                                  | 0                 | 0                  |               | 11.00              |
| 12.00            |   | 0.00                                  | 0                 | 0                  |               | 12.00              |
| 13.00            |   | 0.00                                  | 0                 | 0                  |               | 13.00              |
| 14.00            |   | 0.00                                  | 0                 | 0                  |               | 14.00              |
| 15. 00<br>16. 00 |   | 0. 00<br>0. 00                        | 0                 | 0                  |               | 15. 00<br>16. 00   |
| 17. 00           |   | 0.00                                  | Ö                 | o                  |               | 17. 00             |
| 18. 00           |   | 0.00                                  | Ö                 | Ö                  |               | 18. 00             |
| 19.00            |   | 0.00                                  | 0                 | 0                  |               | 19.00              |
| 20.00            |   | 0.00                                  | O                 | 0                  |               | 20.00              |
| 21.00            |   | 0.00                                  | 0                 | 0                  |               | 21.00              |
| 22. 00           |   | 0.00                                  | 0                 | 0                  |               | 22.00              |
| 23. 00           |   | 0.00                                  | 0                 | 0                  |               | 23.00              |
| 24. 00<br>25. 00 |   | 0. 00<br>0. 00                        | 0                 | 0                  |               | 24. 00<br>25. 00   |
| 26. 00           |   | 0.00                                  | o                 | 0                  |               | 26.00              |
| 27. 00           |   | 0.00                                  | o                 | Ö                  |               | 27. 00             |
| 28. 00           |   | 0.00                                  | o                 | Ö                  |               | 28. 00             |
| 29. 00           |   | 0.00                                  | 0                 | 0                  |               | 29. 00             |
|                  | 0   |                                       |                   | 398, 181           |               |                    |
| 4 00             | M - DEPRECIATION RECLASS                        |                                       |                   | 40.004.054         |               |                    |
| 1.00             | CAP REL COSTS-BLDG & FIXT                       | 1.00                                  | 0                 | 10, 821, 054       |               | 1.00               |
| 2. 00<br>3. 00   |   | 0. 00<br>0. 00                        | 0                 | 0                  |               | 2.00               |
| 4. 00            |   | 0.00                                  | 0                 | 0                  |               | 4.00               |
| 5. 00            |   | 0.00                                  | Ö                 | Ö                  |               | 5. 00              |
| 6. 00            |   | 0.00                                  | ō                 | 0                  |               | 6.00               |
| 7.00             |   | 0.00                                  | О                 | 0                  |               | 7. 00              |
| 8. 00            |   | 0.00                                  | О                 | 0                  |               | 8. 00              |
| 9.00             |   | 0.00                                  | 0                 | 0                  |               | 9.00               |
| 10.00            | 1   | 0.00                                  | 0                 | 0                  |               | 10.00              |

Health Financial Systems RECLASSIFICATIONS

Provider CCN: 15-0002

Peri od: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/27/2022 9: 02 am

|        |                             |                       |                 |                 |  | 5/27/2022 9: | <u>02 am</u> |
|--------|-----------------------------|-----------------------|-----------------|-----------------|--|--------------|--------------|
|        |                             | Increases             |                 |                 |  |              |              |
|        | Cost Center                 | Li ne #               | Sal ary         | 0ther           |  |              |              |
|        | 2. 00                       | 3.00                  | 4. 00           | 5. 00           |  |              |              |
| 11. 00 |                             | 0.00                  | 0               | 0               |  |              | 11.00        |
| 12.00  |                             | 0.00                  | 0               | 0               |  |              | 12.00        |
| 13. 00 |                             | 0.00                  | o               | Ō               |  |              | 13.00        |
| 14. 00 |                             | 0. 00                 | o               | Ö               |  |              | 14.00        |
| 15. 00 |                             | 0. 00                 | Ö               | Ö               |  |              | 15. 00       |
| 16. 00 |                             | 0.00                  | o               | Ö               |  |              | 16.00        |
| 17. 00 |                             | 0.00                  | o               | 0               |  |              | 17.00        |
|        |                             |                       |                 |                 |  |              | 1            |
| 18.00  |                             | 0.00                  | 0               | 0               |  |              | 18.00        |
| 19. 00 |                             | 0. 00                 | 0               | 0               |  |              | 19.00        |
| 20.00  |                             | 0. 00                 | 0               | 0               |  |              | 20.00        |
| 21.00  |                             | 0. 00                 | 0               | 0               |  |              | 21.00        |
| 22.00  |                             | 0. 00                 | 0               | 0               |  |              | 22.00        |
| 23.00  |                             | 0.00                  | 0               | 0               |  |              | 23.00        |
| 24.00  |                             | 0.00                  | 0               | 0               |  |              | 24.00        |
| 25.00  |                             | 0.00                  | 0               | 0               |  |              | 25.00        |
| 26.00  |                             | 0.00                  | o               | 0               |  |              | 26.00        |
| 27. 00 |                             | 0.00                  | o               | Ō               |  |              | 27. 00       |
| 28. 00 |                             | 0. 00                 | o               | Ö               |  |              | 28. 00       |
| 29. 00 |                             | 0. 00                 | o               | Ö               |  |              | 29. 00       |
| 30. 00 |                             | 0.00                  | o               | o               |  |              | 30.00        |
|        |                             | 0.00                  | 0               | 0               |  |              |              |
| 31.00  |                             |                       | -               |                 |  |              | 31.00        |
| 32.00  |                             | 0.00                  | 0               | 0               |  |              | 32.00        |
| 33.00  |                             | 0.00                  | 0               | 0               |  |              | 33.00        |
| 34.00  |                             | 0. 00                 | 0               | 0               |  |              | 34.00        |
| 35.00  |                             | 0. 00                 | 0               | 0               |  |              | 35.00        |
| 36.00  |                             | 0. 00                 | 0               | 0               |  |              | 36.00        |
| 37.00  |                             | 0.00                  | 0               | 0               |  |              | 37.00        |
| 38.00  |                             | 0.00                  | 0               | 0               |  |              | 38. 00       |
| 39.00  |                             | 0.00                  | 0               | 0               |  |              | 39.00        |
| 40.00  |                             | 0.00                  | O               | 0               |  |              | 40.00        |
| 41.00  |                             | 0.00                  | 0               | 0               |  |              | 41.00        |
| 42.00  |                             | 0.00                  | O               | 0               |  |              | 42.00        |
| 43. 00 |                             | 0. 00                 | 0               | 0               |  |              | 43.00        |
| 44. 00 |                             | 0. 00                 | ol              | Ö               |  |              | 44.00        |
| 45. 00 |                             | 0.00                  | Ö               | Ö               |  |              | 45. 00       |
| 46. 00 |                             | 0.00                  | o               | Ö               |  |              | 46.00        |
|        |                             | 0.00                  | 0               | 0               |  |              | 47.00        |
| 47. 00 |                             | •                     | -               |                 |  |              | 1            |
| 48. 00 |                             | 0.00                  | 0               | 0               |  |              | 48.00        |
| 49. 00 |                             | 0.00                  |                 | 0               |  |              | 49. 00       |
|        | U DEDT 0101 PEOLAGO         |                       | O               | 10, 821, 054    |  |              | -            |
| 1 00   | N - DEPT 9101 RECLASS       | 100.00                | 000 207         | 2/0.20/         |  |              | 1 00         |
| 1. 00  | PHYSICIANS' PRIVATE OFFICES | 1 <u>92.</u> 00       | 882, 307        | <u>269, 396</u> |  |              | 1.00         |
|        | 0                           |                       | 882, 307        | 269, 396        |  |              | 1            |
|        | O - UTILITIES RECLASS       |                       |                 |                 |  |              |              |
| 1. 00  | OPERATION OF PLANT          | 7. 00                 | 0               | 1, 124, 448     |  |              | 1.00         |
| 2.00   |                             | 0. 00                 | 0               | 0               |  |              | 2. 00        |
| 3.00   |                             | 0.00                  | 0               | 0               |  |              | 3.00         |
| 4.00   |                             | 0.00                  | 0               | 0               |  |              | 4.00         |
| 5.00   |                             | 0.00                  | ol              | 0               |  |              | 5.00         |
| 6.00   |                             | 0.00                  | ol              | 0               |  |              | 6.00         |
|        | 6 — — — <del>-</del> -      |                       |                 | 1, 124, 448     |  |              |              |
|        | P - C SECTION RECLASS       |                       | 31              | ,               |  |              | 1            |
| 1. 00  | OPERATI NG ROOM             | 50.00                 | 45, 475         | n               |  |              | 1.00         |
|        | 0                           | — — <del>====</del> + | 45, 475         | 0               |  |              | 55           |
| 500 00 | Grand Total: Increases      |                       | 3, 734, 595     | 71, 692, 440    |  |              | 500.00       |
| 555.00 | 12. 22                      | I                     | 3, . 3 1, 3 7 9 | , 5 , 2 , 1 10  |  |              | , 555. 66    |

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0002

| Peri od: | Worksheet A-6 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: |

|                  |  |                    |                 |                                  | 10                      | 12/31/2021 | Date/lime Prepared: 5/27/2022 9:02 am |
|------------------|--|--------------------|-----------------|----------------------------------|-------------------------|------------|---------------------------------------|
|                  |  | Decreases          |                 |                                  |                         |            |                                       |
|                  | Cost Center<br>6.00                                | Li ne #<br>7.00    | Sal ary<br>8.00 | 0ther<br>9.00                    | Wkst. A-7 Ref.<br>10.00 |            |                                       |
|                  | A - CAFETERIA                                      | 7.00               | 8.00            | 9.00                             | 10.00                   |            |                                       |
| 1. 00            | DI ETARY   | 10.00              | 1, 983, 510     | 1, 875, 262                      | 0                       |            | 1.00                                  |
| 00               | 0  |                    | 1, 983, 510     | 1, 875, 262                      |                         |            |                                       |
|                  | B - CLINICAL TRAINING COST                         | <u>'</u>           |                 |                                  | <u>'</u>                |            |                                       |
| 1.00             | INTENSIVE CARE UNIT                                | 31. 00             | 6, 625          | 0                                | 0                       |            | 1.00                                  |
| 2. 00            | OPERATING ROOM                                     | 50.00              | 20, 828         | 0                                | 0                       |            | 2.00                                  |
| 3. 00            | CARDI AC CATHETERI ZATI ON                         | 59. 00             | 3, 643          | 0                                |                         |            | 3.00                                  |
| 4. 00            | DELIVERY ROOM & LABOR ROOM                         | 52. 00             | 25, 133         | 0                                |                         |            | 4.00                                  |
| 5. 00            | RESPIRATORY THERAPY                                | 65. 00             | 10, 407         | 0                                |                         |            | 5.00                                  |
| 5. 00            | EMERGENCY  | <u>91.00</u>       | 223, 965        | 0                                |                         |            | 6.00                                  |
|                  | C - SOCIAL WORKERS                                 |                    | 290, 601        | U                                |                         |            |                                       |
| 1. 00            | OTHER A&G  | 5. 05              | 423, 230        | 0                                | O                       |            | 1.00                                  |
| 1.00             | 0  |                    | 423, 230        | 0                                |                         |            | 1.00                                  |
|                  | E - RESIDENTS                                      |                    | .==,===,        |                                  | 1                       |            |                                       |
| 1. 00            | EMERGENCY  | 91.00              | 0               | 285, 319                         | 0                       |            | 1.00                                  |
| 2. 00            |  | 0.00               | 0               | 0                                |                         |            | 2.00                                  |
|                  | 0  |                    | 0               | 285, 319                         |                         |            |                                       |
|                  | F - MED SUPPLY                                     |                    |                 |                                  | -                       |            |                                       |
| 1. 00            | PURCHASING RECEIVING AND                           | 5. 02              |                 | 45, 920                          | 0                       |            | 1.00                                  |
| 2 00             | STORES   | E 00               |                 | 00                               |                         |            | 2.00                                  |
| 2. 00<br>3. 00   | ADMITTING CASHIERING/ACCOUNTS                      | 5. 03<br>5. 04     |                 | 98<br>6                          |                         |            | 2. 00<br>3. 00                        |
| 5. 00            | RECEI VABLE  | 5. 04              |                 | 0                                | ١                       |            | 3.00                                  |
| 4. 00            | OTHER A&G  | 5. 05              |                 | 706                              | o                       |            | 4.00                                  |
| 5. 00            | PATIENT TRANSPORTATION                             | 5. 06              | •               | 13                               |                         |            | 5. 00                                 |
| 5. 00            | OPERATION OF PLANT                                 | 7. 00              |                 | 215                              |                         |            | 6. 00                                 |
| 7. 00            | HOUSEKEEPI NG                                      | 9. 00              |                 | 1, 726                           | o                       |            | 7.00                                  |
| 3. 00            | DI ETARY   | 10. 00             |                 | 51                               | 0                       |            | 8.00                                  |
| 9. 00            | CAFETERI A   | 11. 00             |                 | 3                                | 0                       |            | 9.00                                  |
| 10.00            | NURSING ADMINISTRATION                             | 13. 00             |                 | 2, 592                           |                         |            | 10.00                                 |
| 11.00            | CENTRAL SERVICES & SUPPLY                          | 14.00              |                 | 143, 914                         | 0                       |            | 11.00                                 |
| 12.00            | PHARMACY   | 15.00              |                 | 5, 396                           |                         |            | 12.00                                 |
| 13. 00<br>14. 00 | MEDICAL RECORDS & LIBRARY MEDICAL EDUCATION        | 16. 00<br>17. 02   |                 | 16<br>547                        | 0                       |            | 13. 00<br>14. 00                      |
| 15. 00           | PARAMED ED PROGRAM                                 | 23. 00             |                 | 321                              | 0                       |            | 15. 00                                |
| 16. 00           | ADULTS & PEDIATRICS                                | 30. 00             |                 | 485, 595                         |                         |            | 16.00                                 |
| 17. 00           | INTENSIVE CARE UNIT                                | 31.00              |                 | 166, 876                         | 1                       |            | 17. 00                                |
| 18. 00           | NEONATAL ICU                                       | 31.01              |                 | 1, 012                           | 1                       |            | 18. 00                                |
| 19. 00           | SUBPROVI DER - I RF                                | 41. 00             |                 | 26, 929                          | O                       |            | 19.00                                 |
| 20. 00           | NURSERY  | 43. 00             |                 | 42, 811                          | 0                       |            | 20.00                                 |
| 21. 00           | OPERATING ROOM                                     | 50. 00             |                 | 14, 596, 716                     |                         |            | 21.00                                 |
| 22. 00           | ENDOSCOPY  | 50. 01             |                 | 328, 516                         | 1                       |            | 22. 00                                |
| 23. 00           | RECOVERY ROOM                                      | 51. 00             |                 | 12, 595                          | 1                       |            | 23.00                                 |
| 24. 00<br>25. 00 | DELIVERY ROOM & LABOR ROOM<br>RADIOLOGY-DIAGNOSTIC | 52. 00<br>54. 00   |                 | 47, 403<br>2, 604                | 0                       |            | 24. 00<br>25. 00                      |
| 26. 00           | RADI OLOGY - ULTRASOUND                            | 54. 01             | •               | 54, 423                          | 0                       |            | 26. 00                                |
| 27. 00           | •  | 55. 00             |                 | 18, 732                          |                         |            | 27. 00                                |
| 28. 00           | INFUSION CENTER                                    | 55. 01             |                 | 8, 160                           |                         |            | 28.00                                 |
| 29. 00           | RADI OI SOTOPE                                     | 56.00              |                 | 680                              |                         |            | 29. 00                                |
| 30. 00           | CT SCAN  | 57.00              |                 | 41, 300                          | O                       |            | 30.00                                 |
| 31. 00           | MAGNETIC RESONANCE IMAGING                         | 58. 00             |                 | 340                              | 0                       |            | 31.00                                 |
|                  | (MRI)  |                    |                 |                                  |                         |            |                                       |
| 32. 00           | CARDI AC CATHETERI ZATI ON                         | 59. 00             |                 | 5, 530, 016                      |                         |            | 32.00                                 |
| 33.00            | LABORATORY   | 60.00              |                 | 6, 614                           |                         |            | 33.00                                 |
| 34. 00           | WHOLE BLOOD & PACKED RED<br>BLOOD CELLS            | 62. 00             |                 | 286                              | 0                       |            | 34.00                                 |
| 35. 00           | RESPIRATORY THERAPY                                | 65. 00             |                 | 183, 543                         | 0                       |            | 35.00                                 |
| 36. 00           | PHYSI CAL THERAPY                                  | 66. 00             |                 | 884                              |                         |            | 36.00                                 |
| 37. 00           | OCCUPATI ONAL THERAPY                              | 67. 00             |                 | 367                              | 0                       |            | 37.00                                 |
| 38. 00           | SPEECH PATHOLOGY                                   | 68. 00             |                 | 45                               | O                       |            | 38.00                                 |
| 39. 00           | ELECTROCARDI OLOGY                                 | 69. 00             |                 | 2, 944                           |                         |            | 39.00                                 |
| 40. 00           | CARDI AC REHAB                                     | 69. 01             |                 | 942                              |                         |            | 40.00                                 |
| 41. 00           | ELECTROENCEPHALOGRAPHY                             | 70. 00             |                 | 2, 781, 113                      |                         |            | 41.00                                 |
| 42.00            | DRUGS CHARGED TO PATIENTS                          | 73.00              |                 | 294, 067                         |                         |            | 42.00                                 |
| 43.00            | RENAL DI ALYSI S                                   | 74. 00             |                 | 1, 753                           |                         |            | 43.00                                 |
| 44. 00           | CLINIC<br>EMEDIENCY                                | 90.00              |                 | 126, 575                         |                         |            | 44.00                                 |
| 45. 00<br>46. 00 | EMERGENCY  | 91.00              |                 | 341, 265                         |                         |            | 45. 00<br>46. 00                      |
| 46. 00<br>47. 00 | HOME HEALTH AGENCY PHYSICIANS' PRIVATE OFFICES     | 101. 00<br>192. 00 |                 | 27, 710<br>45, 021               |                         |            | 47.00                                 |
|                  | LINDIOLUND LIVIVALE OLLIUES                        | 172.00             |                 | 4 <u>5, 02 1</u><br>25, 379, 361 |                         |            | 47.00                                 |

RECLASSI FI CATI ONS

Provider CCN: 15-0002

Peri od: Worksheet A-6 From 01/01/2021 To 12/31/2021 Date/Time Prepared:

5/27/2022 9:02 am Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 G - LIGHT DUTY EMPLOYEE BENEFITS DEPARTMENT 4.00 109, 472 1.00 0 2.00 0.00 0 2.00 3.00 0.00 0 0 0 3.00 0 4.00 0.00 0 0 4.00 5.00 0 0.00 0 0 5.00 0 6.00 0.00 ol 0 6.00 0 0 7.00 0.00 0 7.00 8.00 0.00 0 0 0 8.00 0 0 9.00 0.00 0 9.00 10 00 0 00 ol 0 0 10 00 11.00 0.00 0 0 0 11.00 12.00 0.00 0 12.00 109, 472 H - INTEREST EXPENSE 2, 027, 993 1.00 OTHER A&G 5.05 0 11 1.00 2.00 OPERATING ROOM 50.00 0 19, 287 0 2.00 3.00 RADI OLOGY-THERAPEUTI C 55.00 1,546 0 3.00 0 2,048,826 CORPORATE EXPENSE 1.00 OTHER A&G 5. 05 11, 410, 804 1.00 0 2.00 0.00 0 2.00 0 11, 410, 804 J - DRUG EXPENSE 1.00 PHARMACY 15. 00 0 0 10, 863, 011 1.00 INFUSION CENTER 2.00 55.01 0 0 2.00 3.00 <u>ELECTROENCEPHALOGRAPHY</u> 70. 00 7, 087, 716 0 3.00 ō 17, 950, 733 K - PHYSICIAN RECLASS 1 00 PHYSICIANS' PRIVATE OFFICES 192 00 0 129, 056 0 1 00 2.00 0 0.00 2.00 ō 129, 056 - PSTD RECLASS 1.00 ADMI TTI NG 5.03 4, 177 0 0 1.00 CASHI ERI NG/ACCOUNTS 0 0 2.00 5.04 6,632 2.00 RECEI VABLE 3.00 OTHER A&G 5.05 25.636 0 0 3.00 0 PATIENT TRANSPORTATION 4.00 5.06 10,601 0 4.00 OPERATION OF PLANT 5.00 7.00 20, 212 0 0 5.00 9.00 0 6.00 HOUSEKEEPI NG 19, 107 0 6.00 7 00 DI FTARY 10.00 O 0 7 00 16, 533 0 8.00 CAFETERI A 11.00 903 0 8.00 9.00 NURSING ADMINISTRATION 13.00 28, 934 0 0 9.00 CENTRAL SERVICES & SUPPLY 14.00 827 0 0 10.00 10.00 0 MEDICAL RECORDS & LIBRARY 16.00 3.339 0 11 00 11 00 12.00 ADULTS & PEDIATRICS 30.00 44, 139 0 12.00 13.00 INTENSIVE CARE UNIT 31.00 17, 752 0 13.00 SUBPROVIDER - IRF 41.00 0 0 14.00 7. 259 14.00 NURSERY 43.00 0 15.00 19, 759 15.00 0 16.00 OPERATING ROOM 50.00 47, 708 0 16.00 0 17.00 DELIVERY ROOM & LABOR ROOM 52.00 3,846 0 17.00 0 RADI OLOGY-DI AGNOSTI C 10, 888 54 00 18 00 0 18 00 19.00 RADI OLOGY-THERAPEUTI C 55.00 8, 186 0 0 19.00 CT SCAN 57.00 1, 292 0 20.00 20.00 CARDIAC CATHETERIZATION 59.00 6,023 0 21.00 0 21.00 0 22 00 LABORATORY 60.00 17, 879 0 22.00 23.00 WHOLE BLOOD & PACKED RED 62.00 892 0 23.00 BLOOD CELLS 24.00 RESPIRATORY THERAPY 65.00 2, 343 0 24.00 PHYSI CAL THERAPY 3, 859 0 25.00 66.00 0 25.00 26.00 ELECTROENCEPHALOGRAPHY 70.00 3,758 0 0 26.00 27.00 CLINIC 90.00 2,508 0 27.00 0 28.00 EMERGENCY 91.00 2, 166 0 28.00 PHYSICIANS' PRIVATE OFFICES 29.00 192.00 61,023 0 0 29.00 398, 181 M - DEPRECIATION RECLASS 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.260 1.00 DATA PROCESSING 0 2.00 5.01 0 1, 246, 818 2.00 3.00 PURCHASING RECEIVING AND 5.02 o 47, 911 0 3.00 STORES 4.00 ADMITTING 5.03 1.639 0 4.00 0 CASHI ERI NG/ACCOUNTS 5.00 5.04 0 4, 374 0 5.00 RECEI VABLE 6.00 OTHER A&G 5.05 290, 158 0 6.00

Provider CCN: 15-0002

Peri od: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/27/2022 9: 02 am

|        |                             |                  |             |                   |                | 5/27/2022 9: | 02 am  |
|--------|-----------------------------|------------------|-------------|-------------------|----------------|--------------|--------|
|        |                             | Decreases        |             |                   |                |              |        |
|        | Cost Center                 | Li ne #          | Sal ary     | 0ther             | Wkst. A-7 Ref. |              |        |
|        | 6. 00                       | 7. 00            | 8. 00       | 9. 00             | 10. 00         |              |        |
| 7.00   | PATIENT TRANSPORTATION      | 5. 06            | 0           | 12, 193           | 0              |              | 7. 00  |
| 8.00   | OPERATION OF PLANT          | 7.00             | 0           | 355, 387          | 0              |              | 8. 00  |
| 9.00   | HOUSEKEEPI NG               | 9. 00            | 0           | 57, 066           | 0              |              | 9. 00  |
| 10.00  | DI ETARY                    | 10.00            | O           | 70, 813           | O              |              | 10.00  |
| 11.00  | CAFETERI A                  | 11. 00           | 0           | 276               | o              |              | 11.00  |
| 12.00  | NURSING ADMINISTRATION      | 13. 00           | 0           | 123, 404          | 0              |              | 12.00  |
| 13. 00 | CENTRAL SERVICES & SUPPLY   | 14. 00           | 0           | 400, 761          | O              |              | 13.00  |
| 14. 00 | PHARMACY                    | 15. 00           | 0           | 287, 667          | o              |              | 14.00  |
| 15. 00 | MEDICAL RECORDS & LIBRARY   | 16. 00           | 0           | 4, 268            | o              |              | 15. 00 |
| 16. 00 | PARAMED ED PROGRAM          | •                | 0           |                   | 0              |              | 1      |
|        |                             | 23. 00           | 0           | 2, 858            | 0              |              | 16.00  |
| 17. 00 | ADULTS & PEDIATRICS         | 30. 00           | U           | 175, 551          |                |              | 17.00  |
| 18.00  | INTENSIVE CARE UNIT         | 31. 00           | 0           | 551, 102          | 0              |              | 18.00  |
| 19. 00 | NEONATAL I CU               | 31. 01           | 0           | 39, 733           | 0              |              | 19. 00 |
| 20.00  | SUBPROVI DER - I PF         | 40. 00           | 0           | 10, 350           | 0              |              | 20.00  |
| 21.00  | SUBPROVI DER - I RF         | 41. 00           | 0           | 7, 996            | 0              |              | 21. 00 |
| 22.00  | NURSERY                     | 43. 00           | 0           | 66, 733           | 0              |              | 22.00  |
| 23.00  | OPERATING ROOM              | 50.00            | 0           | 778, 563          | 0              |              | 23.00  |
| 24.00  | ENDOSCOPY                   | 50. 01           | 0           | 109, 108          | 0              |              | 24.00  |
| 25.00  | RECOVERY ROOM               | 51.00            | o           | 1, 003            | O              |              | 25. 00 |
| 26.00  | DELIVERY ROOM & LABOR ROOM  | 52. 00           | ol          | 138, 308          | O              |              | 26. 00 |
| 27. 00 | RADI OLOGY-DI AGNOSTI C     | 54. 00           | 0           | 840, 539          | 0              |              | 27. 00 |
| 28. 00 | RADI OLOGY - ULTRASOUND     | 54. 01           | 0           | 160, 463          | o              |              | 28. 00 |
| 29. 00 | RADI OLOGY-THERAPEUTI C     | 55. 00           | 0           |                   | o              |              | 29. 00 |
|        |                             |                  | o o         | 619, 626          | 0              |              | 1      |
| 30.00  | I NFUSI ON CENTER           | 55. 01           | U           | 1, 028            | l .            |              | 30.00  |
| 31.00  | RADI OI SOTOPE              | 56. 00           | 0           | 209, 295          | 0              |              | 31.00  |
| 32. 00 | CT SCAN                     | 57. 00           | 0           | 121, 530          | 0              |              | 32.00  |
| 33. 00 | MAGNETIC RESONANCE I MAGING | 58. 00           | 0           | 539, 565          | 0              |              | 33. 00 |
|        | (MRI)                       |                  |             |                   |                |              |        |
| 34.00  | CARDI AC CATHETERI ZATI ON  | 59. 00           | 0           | 158, 523          | 0              |              | 34. 00 |
| 35.00  | LABORATORY                  | 60.00            | 0           | 87, 076           | 0              |              | 35.00  |
| 36.00  | WHOLE BLOOD & PACKED RED    | 62.00            | 0           | 9, 884            | 0              |              | 36.00  |
|        | BLOOD CELLS                 |                  |             |                   |                |              |        |
| 37.00  | RESPI RATORY THERAPY        | 65. 00           | 0           | 107, 952          | 0              |              | 37.00  |
| 38.00  | PHYSI CAL THERAPY           | 66. 00           | o           | 1, 033            | o              |              | 38.00  |
| 39. 00 | OCCUPATI ONAL THERAPY       | 67. 00           | 0           | 442               | 0              |              | 39.00  |
| 40. 00 | ELECTROCARDI OLOGY          | 69. 00           | 0           | 177, 947          | o              |              | 40.00  |
| 41. 00 | CARDI AC REHAB              | 69. 01           | o o         | 174, 728          | o              |              | 41.00  |
| 42. 00 | ELECTROENCEPHALOGRAPHY      | 70. 00           | 0           | 216, 680          | o              |              | 42.00  |
|        | 1                           |                  | o o         |                   | l .            |              | 1      |
| 43.00  | DRUGS CHARGED TO PATIENTS   | 73. 00           | U           | 34, 804           | 0              |              | 43.00  |
| 44.00  | RENAL DI ALYSI S            | 74. 00           | U           | 145               | 0              |              | 44.00  |
| 45. 00 | CLINIC                      | 90. 00           | 0           | 165, 663          | 0              |              | 45. 00 |
| 46. 00 | EMERGENCY                   | 91. 00           | 0           | 301, 667          | 0              |              | 46. 00 |
| 47. 00 | GIFT, FLOWER, COFFEE SHOP & | 190. 00          | 0           | 576               | 0              |              | 47. 00 |
|        | CANTEEN                     |                  |             |                   |                |              |        |
| 48. 00 | PHYSICIANS' PRIVATE OFFICES | 192. 00          | 0           | 816, 886          | 0              |              | 48. 00 |
| 49.00  | OTHER NON-REIMBURSABLE      | 192. 01          | 0           | 1, 286, 702       | 0              |              | 49.00  |
|        | 0                           |                  |             | 10, 821, 054      |                |              |        |
|        | N - DEPT 9101 RECLASS       |                  |             |                   |                |              | 1      |
| 1.00   | CASHI ERI NG/ACCOUNTS       | 5. 04            | 882, 307    | 269, 396          | 0              |              | 1.00   |
|        | RECEI VABLE                 |                  | ,           |                   |                |              |        |
|        | 0                           | — — <del> </del> | 882, 307    | 269, 396          |                |              | 1      |
|        | 0 - UTILITIES RECLASS       |                  |             |                   |                |              |        |
| 1.00   | DATA PROCESSING             | 5. 01            | n           | 158, 973          | 0              |              | 1.00   |
| 2. 00  | CASHI ERI NG/ACCOUNTS       | 5. 04            | 0           | 27, 805           | 0              |              | 2.00   |
| 2.00   |                             | 5.04             | ٩           | 27, 603           | U              |              | 2.00   |
| 2 00   | RECEI VABLE                 | 0.00             |             | 100 140           |                |              | 2 00   |
| 3.00   | HOUSEKEEPI NG               | 9. 00            | 0           | 129, 143          | 0              |              | 3.00   |
| 4.00   | CARDI AC REHAB              | 69. 01           | 0           | 49, 089           | 0              |              | 4.00   |
| 5. 00  | PHYSICIANS' PRIVATE OFFICES | 192. 00          | 0           | 339, 518          |                |              | 5. 00  |
| 6. 00  | OTHER NON-REI MBURSABLE     | 1 <u>92.</u> 01  | 0           | 41 <u>9, 9</u> 20 |                |              | 6. 00  |
|        | 0                           |                  | 0           | 1, 124, 448       |                |              | ļ      |
|        | P - C SECTION RECLASS       |                  |             |                   |                |              |        |
| 1.00   | DELIVERY ROOM & LABOR ROOM  | 52. 00           | 45, 475     | 0                 | 0              |              | 1.00   |
|        | 0                           |                  | 45, 475     |                   |                |              |        |
| 500.00 | Grand Total: Decreases      |                  | 4, 132, 776 | 71, 294, 259      |                |              | 500.00 |
|        | . '                         |                  |             |                   | . '            |              | •      |

Provi der CCN: 15-0002

|        |  |               |              |              | To 12/31/2021 | Date/Time Pre<br>5/27/2022 9:0 | pared:<br>2 am |
|--------|--|---------------|--------------|--------------|---------------|--------------------------------|----------------|
|        | ·  |               |              | Acquisitions | _             |                                |                |
|        |  | Begi nni ng   | Purchases    | Donati on    | Total         | Di sposal s and                |                |
|        |  | Bal ances     |              |              |               | Retirements                    |                |
|        |  | 1. 00         | 2.00         | 3. 00        | 4. 00         | 5. 00                          |                |
|        | PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE |               |              |              |               |                                |                |
| 1.00   | Land   | 5, 373, 674   | 0            | (            | 0             | 0                              | 1.00           |
| 2. 00  | Land Improvements                            | 6, 896, 457   | 61, 750      | (            | 61, 750       |                                | 2.00           |
| 3.00   | Buildings and Fixtures                       | 308, 285, 957 | 1, 071, 781  | (            | 1, 071, 781   | 0                              | 3. 00          |
| 4.00   | Building Improvements                        | 1, 230, 154   | 0            | (            | 0             | 0                              | 4. 00          |
| 5.00   | Fixed Equipment                              | 0             | 0            | (            | 0             | 0                              | 5. 00          |
| 6. 00  | Movable Equipment                            | 199, 068, 926 | 0            | (            | 0             | -12, 730, 031                  | 6.00           |
| 7. 00  | HIT designated Assets                        | 0             | 0            | (            | 0             | 0                              | 7.00           |
| 8.00   | Subtotal (sum of lines 1-7)                  | 520, 855, 168 | 1, 133, 531  | (            | 1, 133, 531   | -12, 730, 031                  | 8. 00          |
| 9.00   | Reconciling Items                            | 0             | 0            | (            | 0             | 0                              | 9.00           |
| 10.00  | Total (line 8 minus line 9)                  | 520, 855, 168 | 1, 133, 531  | (            | 1, 133, 531   | -12, 730, 031                  | 10.00          |
|        |  | Endi ng       | Ful I y      |              |               |                                |                |
|        |  | Bal ance      | Depreci ated |              |               |                                |                |
|        |  |               | Assets       |              |               |                                |                |
|        |  | 6. 00         | 7. 00        |              |               |                                |                |
|        | PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE |               |              |              |               |                                |                |
| 1.00   | Land   | 5, 373, 674   | 0            |              |               |                                | 1.00           |
| 2.00   | Land Improvements                            | 6, 958, 207   | 0            |              |               |                                | 2.00           |
| 3.00   | Buildings and Fixtures                       | 309, 357, 738 | 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                            | 211, 798, 957 | 0            |              |               |                                | 6.00           |
| 7. 00  | HIT designated Assets                        | 0             | 0            |              |               |                                | 7.00           |
| 8. 00  | Subtotal (sum of lines 1-7)                  | 534, 718, 730 | 0            |              |               |                                | 8. 00          |
| 9.00   | Reconciling Items                            | 0             | 0            |              |               |                                | 9. 00          |
| 10. 00 | Total (line 8 minus line 9)                  | 534, 718, 730 | 0            |              |               |                                | 10.00          |

| Health Financial Systems                     | METHODIST HOS      | PITALS, INC     |             | In Lie                                       | 2552-10                  |        |
|--|--------------------|-----------------|-------------|--|--------------------------|--------|
| RECONCILIATION OF CAPITAL COSTS CENTERS      |                    | Provider C      | CN: 15-0002 | Peri od:<br>From 01/01/2021<br>To 12/31/2021 |                          | pared: |
|  | SUMMARY OF CAPITAL |                 |             |  |                          |        |
| Cost Center Description                      | Depreciation       | Lease           | Interest    | Insurance<br>(see<br>instructions)           | Taxes (see instructions) |        |
|  | 9. 00              | 10. 00          | 11.00       | 12.00  | 13.00                    |        |
| PART II - RECONCILIATION OF AMOUNTS FROM WOR | RKSHEET A, COLUI   | MN 2, LINES 1   | and 2       |  |                          |        |
| 1.00 CAP REL COSTS-BLDG & FLXT               | 0                  | 0               | )           | 0  | 0                        | 1.00   |
| 3.00 Total (sum of lines 1-2)                | 0                  | 0               | )           | 0 0  | 0                        | 3.00   |
|  | SUMMARY 0          | F CAPITAL       |             |  |                          |        |
| Cost Center Description                      | 0ther              | Total (1)       |             |  |                          |        |
|  | Capi tal -Rel at   | (sum of cols.   |             |  |                          |        |
|  | ed Costs (see      | 9 through 14)   |             |  |                          |        |
|  | instructions)      |                 |             |  |                          |        |
|  | 14. 00             | 15. 00          |             |  |                          |        |
| PART II - RECONCILIATION OF AMOUNTS FROM WOR | RKSHEET A, COLUI   | MN 2, LINES 1 a | and 2       |  |                          |        |
| 1.00 CAP REL COSTS-BLDG & FLXT               | 0                  | 0               |             |  |                          | 1.00   |
| 3.00 Total (sum of lines 1-2)                | 0                  | 0               | )           |  |                          | 3.00   |

| Heal th        | Financial Systems                                  | METHODIST HOS       | PITALS, INC      |                      | In Lie                          | u of Form CMS-2           | 2552-10        |
|----------------|--|---------------------|------------------|----------------------|---------------------------------|---------------------------|----------------|
| RECONC         | CILIATION OF CAPITAL COSTS CENTERS                 |                     | Provi der C      |                      | Peri od:                        | Worksheet A-7             |                |
|                |  |                     |                  |                      | From 01/01/2021<br>o 12/31/2021 | Part III<br>Date/Time Pre | narod:         |
|                |  |                     |                  | '                    | 0 12/31/2021                    | 5/27/2022 9: 0            |                |
|                |  | COMF                | PUTATION OF RA   | TI 0S                | ALLOCATION OF                   | OTHER CAPITAL             |                |
|                |  |                     |                  |                      |                                 |                           |                |
|                | Cost Center Description                            | Gross Assets        | Capi tal i zed   | Gross Assets         | Ratio (see                      | Insurance                 |                |
|                |  |                     | Leases           | for Ratio            | instructions)                   |                           |                |
|                |  |                     |                  | (col. 1 -<br>col. 2) |                                 |                           |                |
|                |  | 1. 00               | 2. 00            | 3.00                 | 4. 00                           | 5. 00                     |                |
|                | PART III - RECONCILIATION OF CAPITAL COSTS C       |                     | 2.00             | 3.00                 | 4.00                            | 3.00                      |                |
| 1. 00          | CAP REL COSTS-BLDG & FIXT                          | 534, 718, 730       | 0                | 534, 718, 730        | 1.000000                        | 0                         | 1.00           |
| 3.00           | Total (sum of lines 1-2)                           | 534, 718, 730       |                  | 534, 718, 730        |                                 | 0                         | 3.00           |
|                |  | ALLOCA <sup>-</sup> | TION OF OTHER (  | CAPI TAL             | SUMMARY O                       | F CAPITAL                 |                |
|                |  |                     |                  |                      |                                 |                           |                |
|                | Cost Center Description                            | Taxes               | 0ther            | Total (sum of        | Depreciation                    | Lease                     |                |
|                |  |                     | Capi tal -Rel at |                      |                                 |                           |                |
|                |  | / 00                | ed Costs         | through 7)           | 0.00                            | 10.00                     |                |
|                | PART III - RECONCILIATION OF CAPITAL COSTS C       | 6. 00               | 7. 00            | 8. 00                | 9. 00                           | 10. 00                    |                |
| 1. 00          | CAP REL COSTS-BLDG & FIXT                          | ENTERS              |                  |                      | 17, 072, 607                    | 0                         | 1. 00          |
| 3. 00          | Total (sum of lines 1-2)                           | 0                   | 0                |                      | 17, 072, 607                    |                           | 3. 00          |
| 3.00           | Total (Suil of Triles 1 2)                         |                     | SI               | JMMARY OF CAPIT      |                                 | J                         | 3.00           |
|                |  |                     |                  |                      |                                 |                           |                |
|                | Cost Center Description                            | Interest            | Insurance        | Taxes (see           | Other                           | Total (2)                 |                |
|                |  |                     | (see             | instructions)        | Capi tal -Rel at                | (sum of cols.             |                |
|                |  |                     | instructions)    |                      | ed Costs (see                   | 9 through 14)             |                |
|                |  |                     |                  |                      | instructions)                   |                           |                |
|                | DADT III DECONOLITATION OF CARLEY COOTS            | 11. 00              | 12. 00           | 13. 00               | 14. 00                          | 15. 00                    |                |
| 1 00           | PART III - RECONCILIATION OF CAPITAL COSTS C       |                     |                  |                      |                                 | 17 072 (07                | 1 00           |
| 1. 00<br>3. 00 | CAP REL COSTS-BLDG & FIXT Total (sum of lines 1-2) | 0                   | ı                | 1                    |                                 |                           | 1. 00<br>3. 00 |
| 3.00           | Total (Suiii of Titles 1-2)                        | 1                   | 0                | () C                 | ار                              | 17, 072, 607              | 3.00           |

| ADJUST          | MENTS TO EXPENSES   |                    |                    | Provider CCN: 15-0002     | Period:<br>From 01/01/2021 | Worksheet A-8               |                  |
|-----------------|---|--------------------|--------------------|---------------------------|----------------------------|-----------------------------|------------------|
|                 |   |                    |                    |                           | To 12/31/2021              | Date/Time Pre 5/27/2022 9:0 |                  |
|                 |   |                    | т-                 | Expense Classification o  |                            |                             |                  |
|                 |   |                    | 10                 | /From Which the Amount is | s to be Adjusted           |                             |                  |
|                 |   |                    |                    |                           |                            |                             |                  |
|                 |   |                    |                    |                           |                            |                             |                  |
|                 |   |                    |                    |                           |                            |                             |                  |
|                 |   |                    |                    |                           |                            |                             |                  |
|                 | Cost Center Description                                     | Basi s/Code<br>(2) | Amount             | Cost Center               | Li ne #                    | Wkst. A-7<br>Ref.           |                  |
|                 |   | 1. 00              | 2. 00              | 3. 00                     | 4. 00                      | 5. 00                       |                  |
| 1. 00           | Investment income - CAP REL                                 | В                  | -2, 048, 826 CA    | P REL COSTS-BLDG & FIXT   | 1. 00                      | 11                          | 1.00             |
| 2. 00           | COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL   |                    | 0 * *              | * Cost Center Deleted *** | 2.00                       | 0                           | 2.00             |
|                 | COSTS-MVBLE EQUIP (chapter 2)                               |                    |                    |                           |                            |                             |                  |
| 3. 00           | Investment income - other (chapter 2)                       |                    | 0                  |                           | 0. 00                      | 0                           | 3. 00            |
| 4.00            | Trade, quantity, and time                                   |                    | O                  |                           | 0.00                       | 0                           | 4.00             |
| 5. 00           | discounts (chapter 8) Refunds and rebates of                |                    | 0                  |                           | 0.00                       | 0                           | 5. 00            |
| 5.00            | expenses (chapter 8)  |                    | o o                |                           | 0.00                       | 0                           | 3.00             |
| 6. 00           | Rental of provider space by                                 |                    | 0                  |                           | 0. 00                      | 0                           | 6. 00            |
| 7. 00           | suppliers (chapter 8) Telephone services (pay               |                    | 0                  |                           | 0. 00                      | 0                           | 7. 00            |
|                 | stations excluded) (chapter                                 |                    |                    |                           |                            | _                           |                  |
| 8. 00           | 21)<br>  Tel evi si on and radi o servi ce                  |                    | 0                  |                           | 0.00                       | 0                           | 8. 00            |
| 0.00            | (chapter 21)  |                    |                    |                           | 0.00                       | O                           | 0.00             |
| 9. 00<br>10. 00 | Parking Lot (chapter 21) Provider-based physician           | A-8-2              | 14 274 057         |                           | 0. 00                      | 0                           |                  |
| 10.00           | adjustment  | A-8-2              | -14, 276, 957      |                           |                            | U                           | 10.00            |
| 11. 00          | Sale of scrap, waste, etc.                                  |                    | O                  |                           | 0. 00                      | 0                           | 11.00            |
| 12. 00          | (chapter 23)<br>Related organization                        | A-8-1              | 0                  |                           |                            | 0                           | 12.00            |
|                 | transactions (chapter 10)                                   | -                  |                    |                           |                            |                             |                  |
|                 | Laundry and linen service<br>Cafeteria-employees and guests | В                  | 0 <br>-726, 330 CA | FFTEDIΛ                   | 0. 00<br>11. 00            | 0                           | 13. 00<br>14. 00 |
| 15. 00          | Rental of quarters to employee                              |                    | -720, 330 CA       | ILILINIA                  | 0.00                       | 0                           | 1                |
| 14 00           | and others  |                    |                    |                           | 0.00                       | 0                           | 16 00            |
| 16. 00          | Sale of medical and surgical supplies to other than         |                    | U                  |                           | 0.00                       | 0                           | 16. 00           |
| 47.00           | pati ents   |                    |                    |                           |                            |                             | 47.00            |
| 17.00           | Sale of drugs to other than patients                        |                    | 0                  |                           | 0.00                       | 0                           | 17. 00           |
| 18. 00          | Sale of medical records and                                 | В                  | -298, 069 ME       | DICAL RECORDS & LIBRARY   | 16. 00                     | 0                           | 18. 00           |
| 19. 00          | abstracts Nursing and allied health                         |                    | 0                  |                           | 0. 00                      | 0                           | 19.00            |
| . 7. 00         | education (tuition, fees,                                   |                    |                    |                           | 0.00                       | · ·                         | .,,              |
| 20.00           | books, etc.)<br>Vending machines                            | В                  | -853 DI            | FTADV                     | 10. 00                     | 0                           | 20.00            |
|                 | Income from imposition of                                   | Ь                  | 0                  | LIANI                     | 0.00                       | 0                           | 1                |
|                 | interest, finance or penalty                                |                    |                    |                           |                            |                             |                  |
| 22. 00          | charges (chapter 21) Interest expense on Medicare           |                    | o                  |                           | 0. 00                      | 0                           | 22. 00           |
|                 | overpayments and borrowings to                              |                    |                    |                           |                            |                             |                  |
| 23 00           | repay Medicare overpayments Adjustment for respiratory      | A-8-3              | ORF                | SPI RATORY THERAPY        | 65. 00                     |                             | 23. 00           |
|                 | therapy costs in excess of                                  |                    |                    |                           |                            |                             |                  |
| 24 00           | limitation (chapter 14) Adjustment for physical             | A-8-3              | OIPH               | YSI CAL THERAPY           | 66. 00                     |                             | 24.00            |
| 24.00           | therapy costs in excess of                                  | X 0 3              |                    | TOT ONE THEIR T           | 00.00                      |                             | 24.00            |
| 25 00           | limitation (chapter 14)<br>Utilization review -             |                    | 0.**               | * Cost Center Deleted *** | 114. 00                    |                             | 25. 00           |
| 25.00           | physicians' compensation                                    |                    | o o                | cost center bereted       | 114.00                     |                             | 25.00            |
| 04 00           | (chapter 21)  |                    | 04 001 04          | D DEL AGGEG DIDO A FLVE   | 1 00                       | 0                           | 0, 00            |
| 26. 00          | Depreciation - CAP REL<br>COSTS-BLDG & FLXT                 | A                  | 94, 03 I CA        | P REL COSTS-BLDG & FIXT   | 1.00                       | 9                           | 26. 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                           | 29. 00           |
| 30. 00          | Adjustment for occupational therapy costs in excess of      | A-8-3              | oloc               | CUPATI ONAL THERAPY       | 67. 00                     |                             | 30.00            |
|                 | limitation (chapter 14)                                     |                    |                    |                           |                            |                             |                  |
| 30. 99          | Hospice (non-distinct) (see instructions)                   |                    | OAD                | ULTS & PEDIATRICS         | 30. 00                     |                             | 30. 99           |
|                 | Fristi ucti ulis <i>)</i>                                   | I                  | I                  |                           | ı                          |                             | I                |

|        |                                  |                 |                 |                              | 12/31/2021  | 5/27/2022 9:0 |          |
|--------|----------------------------------|-----------------|-----------------|------------------------------|-------------|---------------|----------|
|        |                                  |                 |                 | Expense Classification on    | Worksheet A |               |          |
|        |                                  |                 |                 | To/From Which the Amount is  |             |               |          |
|        |                                  |                 |                 |                              | ,           |               |          |
|        |                                  |                 |                 |                              |             |               |          |
|        |                                  |                 |                 |                              |             |               |          |
|        |                                  |                 |                 |                              |             |               |          |
|        |                                  |                 |                 |                              |             |               |          |
|        |                                  |                 |                 |                              |             |               |          |
|        | Cost Center Description          | Basi s/Code     | Amount          | Cost Center                  | Li ne #     | Wkst. A-7     |          |
|        |                                  | (2)             |                 |                              |             | Ref.          |          |
|        |                                  | 1. 00           | 2. 00           | 3. 00                        | 4. 00       | 5. 00         |          |
| 31.00  |                                  | A-8-3           | 0               | SPEECH PATHOLOGY             | 68. 00      |               | 31.00    |
|        | pathology costs in excess of     |                 |                 |                              |             |               |          |
|        | limitation (chapter 14)          |                 |                 |                              |             |               |          |
| 32.00  |                                  |                 | 0               |                              | 0. 00       | 0             | 32.00    |
|        | Depreciation and Interest        |                 |                 |                              |             |               |          |
| 33.00  | DATA PROCESSING OTHER INCOME     | В               |                 | DATA PROCESSING              | 5. 01       | 0             | 33.00    |
| 33. 01 | CASH, A/R, COLLECTIONS OTHER     | В               | -31, 968        | CASHI ERI NG/ACCOUNTS        | 5. 04       | 0             | 33. 01   |
|        | INCOME                           |                 |                 | RECEI VABLE                  |             |               |          |
| 33. 02 | A&G OTHER INCOME                 | В               |                 | OTHER A&G                    | 5. 05       | 0             |          |
| 33. 03 | ENVIRONMENTAL SERVICES OTHER     | В               | -5, 020         | HOUSEKEEPI NG                | 9. 00       | 0             | 33. 03   |
|        | INCOME                           |                 |                 |                              |             |               |          |
| 33. 04 | 1                                | В               |                 | NURSING ADMINISTRATION       | 13. 00      | 0             | 00.0.    |
| 33. 05 | PARAMED ED PROGRAM OTHER         | В               | -30, 859        | PARAMED ED PROGRAM           | 23. 00      | 0             | 33. 05   |
|        | INCOME                           |                 |                 |                              |             |               |          |
| 33. 06 | ADULTS & PEDS OTHER INCOME       | В               |                 | ADULTS & PEDIATRICS          | 30. 00      | 0             |          |
| 33. 07 |                                  | В               |                 | LABORATORY                   | 60. 00      | 0             | 33. 07   |
| 33. 08 | BLOOD OTHER INCOME               | В               | -58, 649        | WHOLE BLOOD & PACKED RED     | 62. 00      | 0             | 33. 08   |
|        |                                  | _               |                 | BLOOD CELLS                  |             |               |          |
| 33. 09 | RESPIRATORY THERAPY OTHER        | В               | -350            | RESPI RATORY THERAPY         | 65. 00      | 0             | 33. 09   |
|        | INCOME                           | _               |                 |                              |             |               |          |
| 33. 10 | · ·                              | В               |                 | CARDI AC REHAB               | 69. 01      | 0             | 000      |
| 33. 11 | ELECTROCEPHALOGRAPHY OTHER       | В               | -1, 214         | ELECTROENCEPHALOGRAPHY       | 70. 00      | 0             | 33. 11   |
|        | INCOME                           | _               |                 |                              |             | _             |          |
| 33. 12 | EMT OFFSET                       | В               |                 | EMPLOYEE BENEFITS DEPARTMENT | 4. 00       | 0             |          |
| 33. 13 | EMT OFFSET                       | В               |                 | PARAMED ED PROGRAM           | 23. 00      | 0             |          |
| 33. 14 | DUES/LOBBYI NG                   | Α               |                 | OTHER A&G                    | 5. 05       | 0             | 00       |
| 33. 15 | RX PROGRAM                       | A               |                 | DRUGS CHARGED TO PATIENTS    | 73. 00      | 0             |          |
| 33. 16 | PENSION ADJUSTMENT               | A               |                 | EMPLOYEE BENEFITS DEPARTMENT | 4. 00       | 0             | 000      |
| 33. 17 | PHYSICIAN OFFICE                 | В               |                 | PHYSICIANS' PRIVATE OFFICES  | 192. 00     | 0             |          |
| 33. 18 | FAMILY HEALTH                    | В               | -100, 002       | FAMILY HEALTH/GARY COMM      | 192. 02     | 0             | 33. 18   |
|        |                                  |                 |                 | HEALTH                       |             |               |          |
| 33. 19 | PHYSICIAN OFFSET                 | A               |                 | PHYSICIANS' PRIVATE OFFICES  | 192. 00     | 0             | 1 00. 17 |
| 50.00  | TOTAL (sum of lines 1 thru 49)   |                 | -26, 388, 632   |                              |             |               | 50.00    |
|        | (Transfer to Worksheet A,        |                 |                 |                              |             |               |          |
|        | column 6, line 200.)             |                 |                 |                              |             |               | L        |
| (1) De | escription - all chapter referer | nces in this co | olumn pertain t | o CMS Pub. 15-1.             |             |               |          |

<sup>(1)</sup> Description - all chapter references in this column pertain to CMS Pub. 15-1. (2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

Professi onal

Component

4. 00

5, 389

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

> Total Remuneration

> > 3. 00

Cost Center/Physician Identifier

2.00

Wkst. A Line #

1.00

200.00

| N: 15-0002   | From 01/01/2021 | worksneet A-8-2  |        |  |
|--------------|-----------------|------------------|--------|--|
|              | To 12/31/2021   |                  |        |  |
| Provi der    | RCE Amount      | Physi ci an/Prov |        |  |
| Component    |                 | ider Component   |        |  |
|              |                 | Hours            |        |  |
| 5. 00        | 6. 00           | 7. 00            |        |  |
|              | 0 211, 500      | 0                | 1.00   |  |
|              | 0 211, 500      | 0                | 2.00   |  |
|              | 0 211, 500      | 0                | 3.00   |  |
|              | 0 246, 400      | 0                | 4.00   |  |
|              | 0 211, 500      | 0                | 5.00   |  |
| 7, 95        | 0 211, 500      | 53               | 6.00   |  |
|              | 0 211, 500      | 0                | 7.00   |  |
|              | 0 211, 500      | 0                | 8. 00  |  |
|              | 0 211, 500      | 0                | 9. 00  |  |
|              | 0 211, 500      | 0                | 10.00  |  |
| 7, 95        | 0               | 53               | 200.00 |  |
| Cost of      | Provi der       | Physician Cost   |        |  |
| emberships & | Component       | of Malpractice   |        |  |
| Conti nui ng | Share of col.   | Insurance        |        |  |
| Educati on   | 12              |                  |        |  |
|              |                 |                  |        |  |

2, 215, 891 14, 276, 957

2, 561

200.00

|                | 1. 00          | 2. 00                               | 3. 00          | 4. 00       |     | 5. 00           | 6. 00         | 7. 00          |                |
|----------------|----------------|-------------------------------------|----------------|-------------|-----|-----------------|---------------|----------------|----------------|
| 1. 00          | 13. 00         | NURSING ADMINISTRATION              | 3, 730         | 3,          | 730 | 0               | 211, 500      | 0              | 1.00           |
| 2.00           | 30.00          | ADULTS & PEDIATRICS                 | 3, 147, 127    |             |     | 0               | 211, 500      | o              | 2.00           |
| 3.00           | 31. 01         | NEONATAL ICU                        | 960, 458       | 960,        | 458 | 0               | 211, 500      | o              | 3.00           |
| 4.00           | 50.00          | OPERATING ROOM                      | 7, 737, 458    | 7, 737,     | 458 | 0               | 246, 400      | o              | 4.00           |
| 5.00           | 54. 01         | RADI OLOGY - ULTRASOUND             | 2, 160         | 2,          | 160 | 0               | 211, 500      | o              | 5.00           |
| 6.00           | 55. 00         | RADI OLOGY-THERAPEUTI C             | 146, 136       | 138,        | 186 | 7, 950          | 211, 500      | 53             | 6.00           |
| 7.00           | 57.00          | CT SCAN                             | 4, 488         | 4,          | 488 | 0               | 211, 500      | o              | 7.00           |
| 8.00           | 65. 00         | RESPI RATORY THERAPY                | -20, 750       | -20,        | 750 | 0               | 211, 500      | o              | 8.00           |
| 9. 00          | 90.00          | CLINIC                              | 85, 648        | 85,         | 648 | 0               | 211, 500      | o              | 9.00           |
| 10.00          | 91.00          | EMERGENCY                           | 2, 215, 891    | 2, 215,     | 891 | 0               | 211, 500      | o              | 10.00          |
| 200.00         |                |                                     | 14, 282, 346   | 14, 274,    | 396 | 7, 950          |               | 53             | 200.00         |
|                | Wkst. A Line # | Cost Center/Physician               | Unadjusted RCE | 5 Percent   | of  | Cost of         | Provi der     | Physician Cost |                |
|                |                | l denti fi er                       | Limit          | Unadj usted | RCE | Memberships &   | Component     | of Malpractice |                |
|                |                |                                     |                | 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          |                | NURSING ADMINISTRATION              | 0              |             | 0   | 0               | 0             | 0              | 1.00           |
| 2.00           |                | ADULTS & PEDIATRICS                 | 0              |             | 0   | 0               | 0             | 0              | 2.00           |
| 3.00           |                | NEONATAL ICU                        | 0              |             | 0   | 0               | 0             | 0              | 3.00           |
| 4.00           |                | OPERATING ROOM                      | 0              |             | 0   | 0               | 0             | 0              | 4.00           |
| 5. 00          |                | RADIOLOGY - ULTRASOUND              | 0              |             | 0   | 0               | 0             | 0              | 5.00           |
| 6. 00          |                | RADI OLOGY-THERAPEUTI C             | 5, 389         |             | 269 | 0               | 0             | 0              | 6.00           |
| 7. 00          |                | CT SCAN                             | 0              |             | 0   | 0               | 0             | 0              | 7.00           |
| 8. 00          |                | RESPI RATORY THERAPY                | 0              |             | 0   | 0               | 0             | 0              | 8.00           |
| 9. 00          |                | CLINIC                              | 0              |             | 0   | 0               | 0             | 0              | 9.00           |
| 10.00          | 91.00          | EMERGENCY                           | 0              |             | 0   | 0               | 0             | 0              | 10.00          |
| 200.00         |                |                                     | 5, 389         |             | 269 |                 | 0             | 0              | 200.00         |
|                | Wkst. A Line # | Cost Center/Physician               | Provi der      | Adjusted R  | CE  | RCE             | Adjustment    |                |                |
|                |                | ldenti fi er                        | Component      | Limit       |     | Di sal I owance |               |                |                |
|                |                |                                     | Share of col.  |             |     |                 |               |                |                |
|                | 1.00           | 2.00                                | 14             | 1/ 00       |     | 47.00           | 10.00         |                |                |
| 1 00           | 1.00           | 2. 00<br>NURSI NG ADMI NI STRATI ON | 15. 00         | 16. 00      | 0   | 17. 00          | 18. 00        |                | 1. 00          |
| 1.00           |                |                                     | 0              |             | 0   | 0               | 3, 730        |                |                |
| 2. 00<br>3. 00 |                | ADULTS & PEDIATRICS<br>NEONATAL ICU | 0              |             | 0   | 0               | 3, 147, 127   |                | 2. 00<br>3. 00 |
|                |                |                                     | 0              |             | 0   | 0               | 960, 458      |                |                |
| 4.00           |                | OPERATING ROOM                      |                |             | U   | 0               | 7, 737, 458   |                | 4.00           |
| 5. 00          |                | RADI OLOGY TUEDADELITIC             |                | _           | 200 | 2 5/1           | 2, 160        |                | 5.00           |
| 6. 00          |                | RADI OLOGY-THERAPEUTI C             |                | 5,          | 389 | 2, 561          | 140, 747      |                | 6.00           |
| 7.00           |                | CT SCAN                             |                |             | 0   | 0               | 4, 488        |                | 7.00           |
| 8.00           |                | RESPIRATORY THERAPY                 |                |             | Ü   | 0               | -20, 750      |                | 8.00           |
| 9. 00          |                | CLINIC                              |                |             | U   | 0               | 85, 648       |                | 9.00           |
| 10.00          | 91.00          | EMERGENCY                           |                | _           | 0   | 0 5/1           | 2, 215, 891   |                | 10.00          |

| Peri od: | Worksheet B | From 01/01/2021 | Part | | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0002

| CAPITAL   RELATED COSTS   BLOG & FIXT   DEPARTMENT   DATA   PROCESSING   RECEIVING AND STORES   STOR   |
|--|
| Cost Center Description  |
| FOR COST   All Cocation (From Wisst A col . 7)   |
| Al l ocation (from West A col . 7)   DEPARTMENT   STORES   Col . 7)   DEPARTMENT   DEP   |
| COL   7  |
| O  |
| CENERAL SERVICE COST CENTERS   |
| 4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT   32, 722, 890   71, 504   32, 794, 394   5. 01   00550   DATA PROCESSI NG   11, 994, 313   111, 264   1, 020, 744   13, 126, 321   5. 02   00560   DATA PROCESSI NG   11, 994, 313   111, 264   1, 020, 744   13, 126, 321   5. 03   00570   ADMI TTI NG   2, 943, 623   117, 645   548, 565   0   5, 252   5. 04   00580   CASHI ERI NG/ACCOUNTS RECEI VABLE   6, 562, 624   371, 034   496, 516   0   1, 126   5. 05   00590   OTHER A&G   00700   OPERATION   0   00900   PRATI ON OF PLANT   010, 19, 898   3, 624, 003   831, 889   0   0   35, 547   7. 00   00900   HOUSEKEEPI NG   00900   00900   00900   HOUSEKEEPI NG   00900   00900   00900   00900   HOUSEKEEPI NG   00900 |
| 5. 01         00550         DATA PROCESSING         11, 994, 313         111, 264         1, 020, 744         13, 126, 321         5.           5. 02         00560         PURCHASI NG RECEI VI NG AND STORES         3, 321, 674         88, 769         209, 194         0         3, 619, 637         5.           5. 03         00570         ADMI TTI NG         2, 943, 623         117, 645         548, 565         0         5, 252         5.           5. 04         00580         CASHI ERI NG/ACCOUNTS RECEI VABLE         6, 562, 624         371, 034         496, 516         0         1, 126, 321         1, 797         5.         5. 05         00590         OTHER A&G         18, 821, 760         1, 205, 612         2, 336, 934         13, 126, 321         1, 797         5.         5. 06         00592         PATI ENT TRANSPORTATI ON         516, 665         0         106, 190         0         582         5.           7. 00         00700         OPERATI ON OF PLANT         19, 019, 898         3, 624, 003         831, 889         0         35, 547         7.           8. 00         0800         LAUNDRY & LI NEN SERVI CE         1, 309, 444         215, 809         0         0         43         8.           9. 00         09000         HOUSEKE  |
| 5. 02         00560 PURCHASI NG RECEI VI NG AND STORES         3, 321, 674         88, 769         209, 194         0         3, 619, 637         5.           5. 03         00570 ADMI TTI NG         2, 943, 623         117, 645         548, 565         0         5, 252         5.           5. 04         00580 CASHI ERI NG/ACCOUNTS RECEI VABLE         6, 562, 624         371, 034         496, 516         0         1, 126         5.           5. 06         00590 OTHER A&G         18, 821, 760         1, 205, 612         2, 336, 934         13, 126, 321         1, 797         5.           5. 06         00592 PATI ENT TRANSPORTATI ON         516, 665         0         0         106, 190         0         582         5.           7. 00         00700 OPERATI ON OF PLANT         19, 019, 898         3, 624, 003         831, 889         0         35, 547         7.           8. 00         00800 LAUNDRY & LI NEN SERVI CE         1, 309, 444         215, 809         0         0         43         8.           9. 00         09000 HOUSEKEEPI NG         5, 094, 910         249, 830         925, 533         0         32, 319         9.           10. 00 D1000 DI ETARY         2, 362, 545         228, 194         293, 819         0         53, 368  |
| 5. 04       00580       CASHI ERI NG/ACCOUNTS RECEI VABLE       6, 562, 624       371, 034       496, 516       0       1, 126       5.         5. 05       00590       OTHER A&G       18, 821, 760       1, 205, 612       2, 336, 934       13, 126, 321       1, 797       5.         5. 06       00592       PATI ENT TRANSPORTATI ON       516, 665       0       106, 190       0       582       5.         7. 00       00700       OPERATI ON OF PLANT       19, 019, 898       3, 624, 003       831, 889       0       35, 547       7.         8. 00       0800       LAUNDRY & LI NEN SERVI CE       1, 309, 444       215, 809       0       0       43       8.         9. 00       09900       HOUSEKEEPI NG       5, 094, 910       249, 830       925, 533       0       32, 319       9.         10. 00       01000       DI ETARY       2, 362, 545       228, 194       293, 819       0       53, 368       10.         13. 00       01300       NURSI NG ADMI NI STRATI ON       5, 779, 741       76, 880       1, 000, 694       0       25, 000       13.         14. 00       01400       CENTRAL SERVI CES & SUPPLY       2, 540, 710       433, 954       133, 719       0       41   |
| 5. 05         00590 OTHER A&G         18, 821, 760 S.06         1, 205, 612 S.06         2, 336, 934 S.06         13, 126, 321 S.06         1, 797 S.06         5. 06 O0592 PATI ENT TRANSPORTATION         106, 190 S.02         0         0         582 S.06         5. 06 O0592 PATI ENT TRANSPORTATION         19, 019, 898 S.0624, 003 S.02         831, 889 S.06         0         0         0         582 S.06         5. 04, 910 S.02         0         0         0         35, 547 S.02         7. 00 O090 P.00 P.00 P.00 P.00 P.00 P.00 P.00 P   |
| 5. 06         00592         PATI ENT TRANSPORTATION         516, 665         0         106, 190         0         582         5.           7. 00         00700         OPERATI ON OF PLANT         19, 019, 898         3, 624, 003         831, 889         0         35, 547         7.           8. 00         00800         LAUNDRY & LI NEN SERVI CE         1, 309, 444         215, 809         0         0         43         8.           9. 00         00900         HOUSEKEEPI NG         5, 094, 910         249, 830         925, 533         0         32, 319         9.           10. 00         01000         DI ETARY         2, 362, 545         228, 194         293, 819         0         53, 368         10           11. 00         01100         CAFETERI A         3, 426, 916         159, 535         503, 108         0         129         11.           13. 00         01300         NURSI NG ADMI NI STRATI ON         5, 779, 741         76, 880         1, 000, 694         0         25,000         13.           14. 00         01400         CENTRAL SERVI CES & SUPPLY         2, 540, 710         433, 954         133, 719         0         41, 702         14.           15. 00         01500         PHARMACY  |
| 8. 00  |
| 9. 00 00900 HOUSEKEEPING 5, 094, 910 249, 830 925, 533 0 32, 319 9. 10. 00 01000 DI ETARY 2, 362, 545 228, 194 293, 819 0 53, 368 10. 11. 00 01100 CAFETERI A 3, 426, 916 159, 535 503, 108 0 129 11. 13. 00 01300 NURSI NG ADMI NI STRATI ON 5, 779, 741 76, 880 1, 000, 694 0 25, 000 13. 14. 00 01400 CENTRAL SERVI CES & SUPPLY 2, 540, 710 433, 954 133, 719 0 41, 702 14. 15. 00 01500 PHARMACY 5, 658, 396 229, 514 0 0 9, 250 15. 16. 00 01600 MEDI CAL RECORDS & LI BRARY 2, 624, 777 136, 895 468, 389 0 532 16. 17. 01 01701 STAFF EDUCATI ON 0 10700 SOCI AL SERVI CE 423, 230 19, 722 94, 803 0 0 177. 17. 02 01702 MEDI CAL EDUCATI ON 0 10, 346 4, 528 105 0 121 17. 17. 02 01702 MEDI CAL EDUCATI ON 10, 346 4, 528 105 0 121 17. 17. 02 01200 I &R SERVI CES-SALARY & FRI NGES APPRVD 254, 151 0 0 0 0 0 22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD 31, 168 54, 082 0 0 0 0 0 22.  |
| 10. 00       01000       DI ETARY       2, 362, 545       228, 194       293, 819       0       53, 368       10.         11. 00       01100       CAFETERI A       3, 426, 916       159, 535       503, 108       0       129       11.         13. 00       01300       NURSI NG ADMI NI STRATI ON       5, 779, 741       76, 880       1, 000, 694       0       25, 000       13.         14. 00       01400       CENTRAL SERVI CES & SUPPLY       2, 540, 710       433, 954       133, 719       0       41, 702       14.         15. 00       01500       PHARMACY       5, 658, 396       229, 514       0       0       9, 250       15.         16. 00       01600       MEDI CAL RECORDS & LI BRARY       2, 624, 777       136, 895       468, 389       0       532       16.         17. 01       01700       SOCI AL SERVI CE       423, 230       19, 722       94, 803       0       0       0       17.         17. 02       01702       MEDI CAL EDUCATI ON       0       134, 958       0       0       0       0       17.         21. 00       0210       1 & R SERVI CES-SALARY & FRI NGES APPRVD       254, 151       0       0       0       0       0 </td   |
| 13. 00     01300     NURSI NG ADMI NI STRATI ON     5, 779, 741     76, 880     1, 000, 694     0     25, 000     13.       14. 00     01400     CENTRAL SERVI CES & SUPPLY     2, 540, 710     433, 954     133, 719     0     41, 702     14.       15. 00     01500     PHARMACY     5, 658, 396     229, 514     0     0     0     9, 250     15.       16. 00     01600     MEDI CAL RECORDS & LI BRARY     2, 624, 777     136, 895     468, 389     0     532     16.       17. 00     01700     SOCI AL SERVI CE     423, 230     19, 722     94, 803     0     0     17.       17. 01     01701     STAFF EDUCATI ON     0     134, 958     0     0     0     17.       21. 00     02 10702     MEDI CAL EDUCATI ON     10, 346     4, 528     105     0     121     17.       21. 00     02 100     I &R SERVI CES-SALARY & FRI NGES APPRVD     254, 151     0     0     0     0     21.       22. 00     02200     I &R SERVI CES-OTHER PRGM COSTS APPRVD     31, 168     54, 082     0     0     0     0     0     0   |
| 14. 00     01400     CENTRAL SERVI CES & SUPPLY     2, 540, 710     433, 954     133, 719     0     41, 702     14.       15. 00     01500     PHARMACY     5, 658, 396     229, 514     0     0     9, 250     15.       16. 00     01600     MEDI CAL RECORDS & LI BRARY     2, 624, 777     136, 895     468, 389     0     532     16.       17. 00     01700     SOCI AL SERVI CE     423, 230     19, 722     94, 803     0     0     17.       17. 01     01701     STAFF EDUCATI ON     0     134, 958     0     0     0     0     17.       21. 00     02100     I &R SERVI CES-SALARY & FRI NGES APPRVD     254, 151     0     0     0     0     121     17.       22. 00     02200     I &R SERVI CES-OTHER PRGM COSTS APPRVD     31, 168     54, 082     0     0     0     0     22.   |
| 15. 00     01500     PHARMACY     5, 658, 396     229, 514     0     0     9, 250     15.       16. 00     01600     MEDI CAL RECORDS & LI BRARY     2, 624, 777     136, 895     468, 389     0     532     16.       17. 00     01700     SOCI AL SERVI CE     423, 230     19, 722     94, 803     0     0     17.       17. 01     01701     STAFF EDUCATI ON     0     134, 958     0     0     0     17.       21. 00     021702     MEDI CAL EDUCATI ON     10, 346     4, 528     105     0     121     17.       21. 00     02100     I &R SERVI CES-SALARY & FRI NGES APPRVD     254, 151     0     0     0     0     0     21.       22. 00     02200     I &R SERVI CES-OTHER PRGM COSTS APPRVD     31, 168     54, 082     0     0     0     0     22.  |
| 16. 00     01600     MEDI CAL RECORDS & LI BRARY     2, 624, 777     136, 895     468, 389     0     532     16.       17. 00     01700     SOCI AL SERVI CE     423, 230     19, 722     94, 803     0     0     17.       17. 01     01701     STAFF EDUCATI ON     0     134, 958     0     0     0     17.       17. 02     01702     MEDI CAL EDUCATI ON     10, 346     4, 528     105     0     121     17.       21. 00     02100     I &R SERVI CES-SALARY & FRI NGES APPRVD     254, 151     0     0     0     0     21.       22. 00     02200     I &R SERVI CES-OTHER PRGM COSTS APPRVD     31, 168     54, 082     0     0     0     0     22.   |
| 17. 01     01701     STAFF EDUCATION     0     134, 958     0     0     0     17.       17. 02     01702     MEDI CAL EDUCATION     10, 346     4, 528     105     0     121     17.       21. 00     02100     I &R SERVI CES-SALARY & FRINGES APPRVD     254, 151     0     0     0     0     0     21.       22. 00     02200     I &R SERVI CES-OTHER PRGM COSTS APPRVD     31, 168     54, 082     0     0     0     0     22.  |
| 17. 02     01702     MEDI CAL EDUCATION     10, 346     4, 528     105     0     121     17.       21. 00     02100     I &R SERVI CES-SALARY & FRI NGES APPRVD     254, 151     0     0     0     0     0     21.       22. 00     02200     I &R SERVI CES-OTHER PRGM COSTS APPRVD     31, 168     54, 082     0     0     0     0     22.   |
| 21. 00   02100   1 &R SERVI CES-SALARY & FRI NGES APPRVD   254, 151   0   0   0   0   21.<br>22. 00   02200   1 &R SERVI CES-OTHER PRGM COSTS APPRVD   31, 168   54, 082   0   0   0   22.   |
|  |
|  |
| 23. 00   02300   PARAMED ED PROGRAM   644, 557   40, 728   157, 840   0   1, 034   23.   INPATI ENT ROUTI NE SERVI CE COST CENTERS   |
| 30. 00 03000 ADULTS & PEDI ATRI CS 44, 406, 177 3, 792, 150 5, 737, 070 0 350, 827 30.   |
| 31. 00 03100 I NTENSI VE CARE UNI T 10, 967, 854 240, 495 1, 769, 672 0 86, 977 31.  |
| 31. 01   03101   NEONATAL   CU   1, 864, 665   27, 338   333, 373   0   2, 234   31. 40. 00   04000   SUBPROVI DER -   PF   1, 006, 634   48, 089   208, 076   0   50   40.  |
| 41. 00   04100   SUBPROVI DER -   1 FF   1,006,034   40,087   208,070   0   30   40.   |
| 43. 00 <u>04300 NURSERY 1, 519, 180 295, 704 280, 813 0 11, 866</u> 43.  |
| ANCI LLARY SERVI CE COST CENTERS  50. 00   05000   OPERATI NG ROOM   8, 191, 967   722, 152   963, 156   0   86, 243   50.   |
| 50. 01   05001   ENDOSCOPY   1, 177, 170   0   161, 519   0   21, 304   50.  |
| 51. 00   05100   RECOVERY ROOM   1, 149, 786   176, 110   218, 196   0   3, 289   51.  |
| 52. 00   05200   DELI VERY ROOM & LABOR ROOM   |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C 3, 631, 384 642, 390 498, 756 0 12, 024 54.   |
| 54. 01     05401     RADI OLOGY - ULTRASOUND     1, 694, 884     61, 189     285, 917     0     9, 244     54.   |
| 55. 00   05500   RADI OLOGY-THERAPEUTI C   2,541,361   163,264   109,992   0   1,743   55.   55. 01   05501   I NFUSI ON CENTER   47,264   4,359   4,160   0   2,179   55.   |
| 56. 00   05600   RADI OI SOTOPE   1, 671, 915   109, 484   127, 195   0   66, 665   56.  |
| 57. 00 05700 CT SCAN 2, 070, 266 103, 673 267, 030 0 27, 543 57.   |
| 58. 00   05800   MAGNETI C RESONANCE I MAGI NG (MRI)   815, 616   50, 910   103, 664   0   5, 338   58.<br>59. 00   05900   CARDI AC CATHETERI ZATI ON   3, 372, 364   97, 256   560, 477   0   31, 638   59.  |
| 59. 00   05900   CARDIAC CATHETERIZATION   3, 372, 304   97, 250   360, 477   0   31, 636   39. 60. 00   06000   LABORATORY   12, 195, 270   284, 735   851, 701   0   267, 742   60.  |
| 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 1, 456, 689 4, 661 261, 985 0 19, 663 62.  |
| 64. 00   06400   I NTRAVENOUS THERAPY   0   0   0   64.  |
| 65. 00   06500   RESPI RATORY THERAPY   3, 879, 077   94, 024   618, 965   0   62, 759   65.<br>66. 00   06600   PHYSI CAL THERAPY   1, 493, 596   148, 554   307, 627   0   1, 331   66.  |
| 67. 00   06700   0CCUPATI ONAL THERAPY   |
| 68. 00   06800   SPEECH PATHOLOGY   505, 222   21, 744   102, 266   0   736   68.  |
| 69. 00   06900   ELECTROCARDI OLOGY   787, 632   0   146, 645   0   1, 406   69.<br>69. 01   06901   CARDI AC REHAB   487, 335   0   88, 471   0   172   69.   |
| 70. 00   07000   ELECTROENCEPHALOGRAPHY  |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 13, 702, 025 0 0 1, 104, 796 71.   |
| 72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   11, 677, 336   0 0 0 941, 532   72. 73. 00   07300   DRUGS CHARGED TO PATIENTS   21, 476, 149 20, 122 80, 744 0 32, 293   73.  |
| 73. 00   07300   DR0GS CHARGED TO PATTENTS   21, 476, 149   20, 122   80, 744   0   32, 293   73.  |
| OUTPATIENT SERVICE COST CENTERS  |
| 90. 00   09000   CLI NI C   5, 403, 209   922, 330   614, 334   0   7, 623   90.<br>91. 00   09100   EMERGENCY   12, 681, 042   327, 654   1, 662, 681   0   181, 675   91.  |
| 91. 00   09100   EMERGENCY   12, 681, 042   327, 654   1, 662, 681   0   181, 675   91.<br>92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   92.  |
| OTHER REIMBURSABLE COST CENTERS  |
| 101. 00 10100 HOME HEALTH AGENCY 2, 568, 640 0 485, 495 0 9, 875 101. SPECI AL PURPOSE COST CENTERS  |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 328,752,191 16,576,629 27,589,181 13,126,321 3,592,172 118.  |
| NONREI MBURSABLE COST CENTERS   190. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   157   21,805   0   0   13   190.  |
| 13/190.  |

| Health Financial Systems                     | METHODIST HOS   | PITALS, INC               |                                    | In Lie                                      | eu of Form CMS-2                         | 2552-10        |
|--|---|---------------------------|------------------------------------|---|--|----------------|
| COST ALLOCATION - GENERAL SERVICE COSTS      |   | Provider CO               |                                    | Period:<br>From 01/01/2021<br>To 12/31/2021 |  | pared:<br>2 am |
|  |   | CAPI TAL<br>RELATED COSTS |                                    |   |  |                |
| Cost Center Description                      | Net Expenses<br>for Cost<br>Allocation<br>(from Wkst A<br>col. 7) | BLDG & FIXT               | EMPLOYEE<br>BENEFITS<br>DEPARTMENT | DATA<br>PROCESSI NG                         | PURCHASI NG<br>RECEI VI NG AND<br>STORES |                |
|  | 0   | 1.00                      | 4. 00                              | 5. 01                                       | 5. 02                                    |                |
| 191. 00 19100 RESEARCH                       | 0   | 0                         |                                    | 0   | 0  | 191. 00        |
| 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES | 28, 385, 455  | 323, 392                  | 5, 183, 98                         | 3 0   | 27, 336                                  | 192.00         |
| 192. 01 19201 OTHER NON-REIMBURSABLE         | 359, 611  | 41, 854                   |                                    | 0   | 78                                       | 192. 01        |
| 192.02 19202 FAMILY HEALTH/GARY COMM HEALTH  | 70, 869   | 108, 927                  | 21, 23                             | 0   | 38                                       | 192. 02        |
| 193. 00 19300 NONPALD WORKERS                | 0   | 0                         |                                    | 0   | 0  | 193. 00        |
| 200.00 Cross Foot Adjustments                |   |                           |                                    |   |  | 200. 00        |
| 201.00 Negative Cost Centers                 |   | 0                         |                                    | 0   | 0  | 201.00         |
| 202.00 TOTAL (sum lines 118 through 201)     | 357, 568, 283   | 17, 072, 607              | 32, 794, 39                        | 13, 126, 321                                | 3, 619, 637                              | 202. 00        |

Provider CCN: 15-0002

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2021 Part I
To 12/31/2021 Date/Time Prepared: 5/27/2022 9:02 am

|                  |         | Cost Center Description                                     | ADMI TTI NG         | CASHI ERI NG/AC       | Subtotal      | OTHER A&G               | 5/27/2022 9: 0<br>PATIENT |                    |
|------------------|---------|---|---------------------|-----------------------|---------------|-------------------------|---------------------------|--------------------|
|                  |         | ·   |                     | COUNTS<br>RECEI VABLE |               |                         | TRANSPORTATIO<br>N        |                    |
|                  | CENED   | AL CEDVICE COCT CENTEDS                                     | 5. 03               | 5. 04                 | 5A. 04        | 5. 05                   | 5. 06                     |                    |
| 1. 00            |         | AL SERVICE COST CENTERS  CAP REL COSTS-BLDG & FIXT          |                     |                       |               |                         |                           | 1. 00              |
| 4. 00            |         | EMPLOYEE BENEFITS DEPARTMENT                                |                     |                       |               |                         |                           | 4. 00              |
| 5. 01            |         | DATA PROCESSING   |                     |                       |               |                         |                           | 5. 01              |
| 5. 02            |         | PURCHASING RECEIVING AND STORES                             | 0 (45 005           |                       |               |                         |                           | 5. 02              |
| 5. 03<br>5. 04   | 1       | ADMITTING CASHIERING/ACCOUNTS RECEIVABLE                    | 3, 615, 085         | 7, 431, 300           |               |                         |                           | 5. 03<br>5. 04     |
| 5. 05            |         | OTHER A&G   | 0                   | 7,431,300             |               | 35, 492, 424            |                           | 5. 05              |
| 5. 06            |         | PATIENT TRANSPORTATION                                      | 0                   | 0                     |               | 68, 702                 | 692, 139                  | 5. 06              |
| 7. 00            | 1       | OPERATION OF PLANT  | 0                   | 0                     |               | 2, 590, 926             | 0                         | 7. 00              |
| 8. 00            |         | LAUNDRY & LINEN SERVICE                                     | 0                   | 0                     |               | 168, 086                | 0                         | 8.00               |
| 9. 00<br>10. 00  |         | HOUSEKEEPI NG<br>DI ETARY                                   | 0                   | 0                     |               | 694, 539<br>323, 757    | 0                         | 9. 00<br>10. 00    |
| 11. 00           | 1       | CAFETERI A  | Ö                   | Ö                     | _, ,          | 450, 680                | 0                         | 11. 00             |
| 13.00            | 01300   | NURSING ADMINISTRATION                                      | 0                   | 0                     | 6, 882, 315   | 758, 424                | 0                         | 13.00              |
| 14.00            |         | CENTRAL SERVICES & SUPPLY                                   | 0                   | 0                     |               | 347, 136                | 0                         | 14.00              |
| 15.00            | 1       | PHARMACY MEDICAL RECORDS & LIBRARY                          | 0                   | 0                     |               | 649, 861                | 0                         | 15. 00<br>16. 00   |
| 16. 00<br>17. 00 |         | SOCIAL SERVICE  | 0                   | 0                     | -,,           | 356, 008<br>59, 260     | 0                         | 17. 00             |
| 17. 01           |         | STAFF EDUCATION   | Ö                   | ő                     |               | 14, 872                 | 0                         | 17. 01             |
| 17. 02           |         | MEDICAL EDUCATION   | 0                   | 0                     | 15, 100       | 1, 664                  | 0                         | 17. 02             |
| 21.00            |         | I &R SERVICES-SALARY & FRINGES APPRVD                       | 0                   | 0                     |               | 28, 007                 | 0                         | 21.00              |
| 22. 00<br>23. 00 |         | I&R SERVICES-OTHER PRGM COSTS APPRVD<br>PARAMED ED PROGRAM  | 0                   | 0                     |               | 9, 394<br>93, 025       | 0                         | 22. 00<br>23. 00   |
| 23.00            |         | IENT ROUTINE SERVICE COST CENTERS                           | <u> </u>            | <u> </u>              | 044, 137      | 75, 025                 | 0                         | 23.00              |
| 30.00            |         | ADULTS & PEDIATRICS   | 273, 642            | 562, 409              | 55, 122, 275  | 6, 074, 406             | 243, 423                  | 30.00              |
| 31.00            |         | INTENSIVE CARE UNIT   | 60, 276             |                       |               | 1, 460, 044             | 4, 194                    | 31.00              |
| 31. 01<br>40. 00 | 1       | NEONATAL ICU<br>SUBPROVIDER - IPF                           | 16, 175<br>5, 858   | 33, 245<br>12, 039    |               | 250, 926                | 0                         | 31. 01<br>40. 00   |
| 41. 00           |         | SUBPROVIDER - IPF   | 11, 386             |                       |               | 141, 137<br>326, 074    | -                         | 40.00              |
| 43. 00           |         | NURSERY   | 5, 092              | 10, 465               |               | 233, 966                | 0                         | 43. 00             |
|                  |         | LARY SERVICE COST CENTERS                                   |                     |                       |               |                         |                           |                    |
| 50.00            |         | OPERATING ROOM  | 431, 866            |                       |               | 1, 243, 374             | 10, 202                   | 50.00              |
| 50. 01<br>51. 00 |         | ENDOSCOPY<br>RECOVERY ROOM                                  | 31, 943<br>30, 698  |                       |               | 160, 625<br>180, 855    | 18, 303<br>0              | 50. 01<br>51. 00   |
| 52. 00           |         | DELIVERY ROOM & LABOR ROOM                                  | 11, 296             | 23, 216               |               | 552, 478                | 9, 184                    |                    |
| 53.00            |         | ANESTHESI OLOGY   | 0                   | 0                     | 0             | 0                       | 0                         | 53.00              |
| 54.00            |         | RADI OLOGY-DI AGNOSTI C                                     | 104, 274            | 214, 311              |               | 562, 361                | 41, 381                   | 54.00              |
| 54. 01<br>55. 00 | 1       | RADI OLOGY - ULTRASOUND<br>RADI OLOGY-THERAPEUTI C          | 57, 887<br>57, 882  | 118, 973<br>118, 963  |               | 245, 534<br>329, 848    | 82, 568<br>3, 656         | 54. 01<br>55. 00   |
| 55. 00           | 1       | INFUSION CENTER   | 332                 | 683                   |               | 6, 499                  | 3, 030                    | 55. 00             |
| 56.00            |         | RADI OI SOTOPE  | 40, 995             |                       | · ·           | 231, 474                | 42, 349                   | 56.00              |
| 57. 00           | 1       | CT SCAN   | 343, 868            |                       |               | 387, 804                | 149, 629                  | 57.00              |
| 58. 00<br>59. 00 |         | MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION    | 79, 764<br>180, 074 | 163, 937<br>370, 100  |               | 134, 358<br>508, 228    | 50, 048<br>24, 067        | 58. 00<br>59. 00   |
| 60.00            |         | LABORATORY  | 570, 614            |                       |               | 1, 690, 909             | 24,067                    | 60.00              |
| 62. 00           |         | WHOLE BLOOD & PACKED RED BLOOD CELLS                        | 31, 117             |                       |               | 202, 553                |                           | 62.00              |
| 64. 00           |         | INTRAVENOUS THERAPY   | 0                   |                       |               | 0                       | 0                         |                    |
| 65.00            |         | RESPI RATORY THERAPY  | 109, 576            |                       |               | 549, 850<br>221, 745    | 194                       | 65.00              |
| 66. 00<br>67. 00 | 1       | PHYSI CAL THERAPY<br>OCCUPATI ONAL THERAPY                  | 20, 004<br>14, 580  | 41, 113<br>29, 965    |               | 178, 456                | 0                         | 66. 00<br>67. 00   |
| 68. 00           |         | SPEECH PATHOLOGY  | 7, 380              | 15, 169               |               | 71, 907                 | Ö                         | 68. 00             |
| 69. 00           | 1       | ELECTROCARDI OLOGY  | 65, 670             |                       |               | 125, 222                | 3, 527                    | 69. 00             |
| 69. 01           |         | CARDI AC REHAB  | 2, 797              | 5, 749                |               | 64, 414                 | 0 21(                     | 69. 01             |
| 70. 00<br>71. 00 | 1       | ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS | 83, 184<br>140, 778 | 170, 966<br>289, 338  |               | 206, 688<br>1, 679, 095 | 8, 216<br>0               | 70. 00<br>71. 00   |
| 72. 00           |         | IMPL. DEV. CHARGED TO PATIENTS                              | 90, 366             |                       |               | 1, 421, 012             | 0                         | 72.00              |
| 73.00            |         | DRUGS CHARGED TO PATIENTS                                   | 414, 044            |                       |               | 2, 520, 728             | 0                         | 73.00              |
| 74. 00           |         | RENAL DIALYSIS TIENT SERVICE COST CENTERS                   | 23, 978             | 49, 281               | 2, 435, 943   | 268, 438                | 22                        | 74. 00             |
| 90. 00           |         | CLINIC  | 61, 296             | 125, 980              | 7, 134, 772   | 786, 245                | 366                       | 90.00              |
| 91. 00           |         | EMERGENCY   | 226, 331            | 465, 172              |               | 1, 712, 994             | 7, 420                    |                    |
|                  | 09200   | OBSERVATION BEDS (NON-DISTINCT PART)                        |                     |                       | 0             |                         |                           | 92.00              |
| 101 00           | OTHER   | REIMBURSABLE COST CENTERS HOME HEALTH AGENCY                | 10, 062             | 20, 681               | 3, 094, 753   | 341, 039                | 0                         | 101. 00            |
| 101.00           |         | AL PURPOSE COST CENTERS                                     | 10, 062             | 20, 061               | 3, 094, 753   | 341, 039                | 0                         | 101.00             |
| 118. 00          |         | SUBTOTALS (SUM OF LINES 1 through 117)                      | 3, 615, 085         | 7, 431, 300           | 323, 023, 535 | 31, 685, 627            | 692, 139                  | 118. 00            |
| 190. 00          |         | GIFT, FLOWER, COFFEE SHOP & CANTEEN                         | 0                   | 0                     | 21, 975       | 2, 422                  | 0                         | 190. 00            |
| 191.00           | 19100   | RESEARCH  | o                   | 0                     | 0             | 0                       | 0                         | 191. 00            |
|                  |         | PHYSICIANS' PRIVATE OFFICES                                 | 0                   | 0                     |               | 3, 737, 968             |                           | 192.00             |
|                  |         | OTHER NON-REIMBURSABLE FAMILY HEALTH/GARY COMM HEALTH       | O<br>O              | 0                     |               | 44, 250<br>22, 157      |                           | 192. 01<br>192. 02 |
| 1,2.02           | -11/202 | 2. HEREITI ONICE COMM HEREITI                               | <u> </u>            | ·                     | 201,004       | 22, 137                 | ١                         | . , 2. 02          |

| Health Financial Systems                   | METHODIST HOS | SPITALS, INC    |              | In Lie                           | u of Form CMS-2           | 2552-10 |
|--|---------------|-----------------|--------------|----------------------------------|---------------------------|---------|
| COST ALLOCATION - GENERAL SERVICE COSTS    |               | Provi der Co    |              | Peri od:                         | Worksheet B               |         |
|  |               |                 |              | From 01/01/2021<br>To 12/31/2021 | Part  <br>  Date/Time Pre | nared:  |
|  |               |                 |              | 10 12/31/2021                    | 5/27/2022 9:0             |         |
| Cost Center Description                    | ADMITTI NG    | CASHI ERI NG/AC | Subtotal     | OTHER A&G                        | PATI ENT                  |         |
|  |               | COUNTS          |              |                                  | TRANSPORTATIO             |         |
|  |               | RECEI VABLE     |              |                                  | N                         |         |
|  | 5. 03         | 5. 04           | 5A. 04       | 5. 05                            | 5. 06                     |         |
| 193. 00 19300 NONPALD WORKERS              | 0             | 0               |              | 0                                | 0                         | 193.00  |
| 200.00 Cross Foot Adjustments              |               |                 |              | 0                                |                           | 200.00  |
| 201.00 Negative Cost Centers               | 0             | 0               |              | 0                                | 0                         | 201.00  |
| 202.00   TOTAL (sum lines 118 through 201) | 3, 615, 085   | 7, 431, 300     | 357, 568, 28 | 35, 492, 424                     | 692, 139                  | 202. 00 |

Provider CCN: 15-0002

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2021 Part I
To 12/31/2021 Date/Time Prepared: 5/27/2022 9:02 am

|                  |  |                      |                       |                    | 12/31/2021  | 5/27/2022 9:0      |                |
|------------------|--|----------------------|-----------------------|--------------------|-------------|--------------------|----------------|
|                  | Cost Center Description  | OPERATION OF         | LAUNDRY &             | HOUSEKEEPI NG      | DI ETARY    | CAFETERI A         |                |
|                  |  | PLANT<br>7. 00       | LINEN SERVICE<br>8.00 | 9. 00              | 10.00       | 11. 00             |                |
|                  | GENERAL SERVICE COST CENTERS   | 7.00                 | 0.00                  | 9.00               | 10.00       | 11.00              |                |
| 1. 00            | 00100 CAP REL COSTS-BLDG & FIXT  |                      |                       |                    |             |                    | 1.00           |
| 4.00             | 00400 EMPLOYEE BENEFITS DEPARTMENT                                       |                      |                       |                    |             |                    | 4. 00          |
| 5. 01            | 00550 DATA PROCESSING  |                      |                       |                    |             |                    | 5. 01          |
| 5. 02            | 00560 PURCHASING RECEIVING AND STORES                                    |                      |                       |                    |             |                    | 5. 02          |
| 5. 03            | 00570 ADMITTING  |                      |                       |                    |             |                    | 5. 03          |
| 5. 04<br>5. 05   | 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE<br>00590 OTHER A&G               |                      |                       |                    |             |                    | 5. 04<br>5. 05 |
| 5. 06            | 00590 OTHER A&G  |                      |                       |                    |             |                    | 5.05           |
| 7. 00            | 00700 OPERATION OF PLANT   | 26, 102, 263         |                       |                    |             |                    | 7.00           |
| 8. 00            | 00800 LAUNDRY & LINEN SERVICE  | 490, 570             |                       |                    |             |                    | 8.00           |
| 9.00             | 00900 HOUSEKEEPI NG  | 567, 905             | 0                     | 7, 565, 036        |             |                    | 9. 00          |
| 10.00            | 01000 DI ETARY   | 518, 724             |                       |                    | 3, 937, 099 |                    | 10.00          |
| 11.00            | 01100 CAFETERI A   | 362, 650             | 0                     | ,                  | 0           | 5, 012, 565        | 1              |
| 13. 00<br>14. 00 | 01300 NURSI NG ADMI NI STRATI ON   | 174, 761             | 2, 935                | 52, 790            | 0           | 147, 479           | 1              |
| 15. 00           | 01400 CENTRAL SERVI CES & SUPPLY<br>01500 PHARMACY                       | 986, 451<br>521, 724 | 1                     |                    | ol<br>Ol    | 65, 668<br>0       | 1              |
| 16. 00           | 01600 MEDICAL RECORDS & LIBRARY  | 311, 185             |                       |                    | o           | 187, 129           | 1              |
| 17. 00           | 01700 SOCIAL SERVICE   | 44, 832              |                       | 13, 543            | Ö           | 0                  | 1              |
| 17. 01           | 01701 STAFF EDUCATION  | 306, 781             | 0                     |                    | О           | 0                  | 17. 01         |
| 17. 02           | 01702 MEDI CAL EDUCATI ON  | 10, 293              | 0                     | 3, 109             | 0           | 0                  | 17. 02         |
| 21. 00           | 02100 I&R SERVICES-SALARY & FRINGES APPRVD                               | 0                    | 0                     | _                  | 0           | 0                  | 21.00          |
| 22. 00           | 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD                               | 122, 938             |                       | ,                  | 0           | 0                  | 22.00          |
| 23. 00           | 02300 PARAMED ED PROGRAM INPATIENT ROUTINE SERVICE COST CENTERS          | 92, 582              | 0                     | 27, 966            | 0           | 47, 672            | 23. 00         |
| 30. 00           |  | 8, 620, 180          | 980, 706              | 2, 603, 920        | 3, 198, 459 | 1, 555, 236        | 30.00          |
| 31. 00           | 03100 I NTENSI VE CARE UNI T   | 546, 686             | 1                     |                    | 158, 050    | 317, 663           | 1              |
| 31. 01           | 03101 NEONATAL I CU  | 62, 143              |                       |                    | 130, 030    | 72, 716            |                |
| 40. 00           | 04000 SUBPROVI DER - I PF  | 109, 315             |                       |                    | 54, 044     | 52, 907            |                |
| 41.00            | 04100 SUBPROVI DER - I RF  | 859, 852             |                       | 259, 738           | 186, 890    | 107, 416           | 41.00          |
| 43.00            | 04300 NURSERY  | 672, 183             | 25, 913               | 203, 048           | 0           | 58, 353            | 43.00          |
| <b>50.00</b>     | ANCILLARY SERVICE COST CENTERS   |                      | 050.004               | 105.070            | -           | 0/0.051            |                |
| 50.00            | 05000 OPERATING ROOM   | 1, 641, 571          | 250, 031              |                    | 0           | 269, 851           | 1              |
| 50. 01<br>51. 00 | 05001   ENDOSCOPY   05100   RECOVERY   ROOM                              | 400, 327             | 34, 693<br>18, 501    | 1                  | 0<br>1, 647 | 40, 539<br>43, 377 | 1              |
| 52. 00           | 05200 DELIVERY ROOM & LABOR ROOM   | 192, 733             |                       | 1                  | 83, 342     | 177, 494           | 1              |
| 53. 00           | 05300 ANESTHESI OLOGY  | 0                    | 0                     | 1                  | 0           | 0                  | 1              |
| 54.00            | 05400 RADI OLOGY-DI AGNOSTI C  | 1, 460, 260          | 42, 999               | 441, 104           | o           | 169, 335           | 54.00          |
| 54. 01           | 05401 RADI OLOGY - ULTRASOUND  | 139, 093             | 20, 263               | 42, 016            | 0           | 71, 251            | 54. 01         |
| 55.00            | 05500 RADI OLOGY-THERAPEUTI C  | 371, 127             | 11, 475               |                    | 0           | 26, 741            | 1              |
| 55. 01           | 05501 I NFUSI ON CENTER  | 9, 908               |                       | ' '                | 0           | 1, 020             | 1              |
| 56. 00<br>57. 00 | 05600  | 248, 876<br>235, 666 |                       |                    | 0<br>0      | 28, 354<br>71, 850 | 1              |
| 58. 00           | 05800 MAGNETIC RESONANCE IMAGING (MRI)                                   | 115, 728             | 1                     |                    | 0           | 31, 466            | 1              |
| 59. 00           | 05900 CARDI AC CATHETERI ZATI ON   | 221, 080             |                       |                    | Ö           | 115, 178           | 1              |
| 60.00            | 06000 LABORATORY   | 647, 249             |                       |                    | Ö           | 257, 459           | 1              |
| 62.00            | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS                               | 10, 596              | 0                     | 3, 201             | O           | 127, 484           | 62.00          |
|                  | 06400 I NTRAVENOUS THERAPY   | 0                    | 0                     | · ·                | 0           | 0                  |                |
|                  | 06500 RESPI RATORY THERAPY   | 213, 731             | 0                     | 64, 562            | 0           | 137, 520           |                |
| 66.00            | 06600 PHYSI CAL THERAPY  | 337, 688             |                       | 102, 006           | 0           | 72, 531            | 1              |
| 67. 00<br>68. 00 | 06700 OCCUPATI ONAL THERAPY<br>06800 SPEECH PATHOLOGY                    | 290, 214<br>49, 428  |                       | 87, 665<br>14, 931 | 0           | 57, 659<br>21, 867 | 1              |
| 69.00            | 06900 ELECTROCARDI OLOGY   | 49, 420              | 3, 516                |                    | 0           | 51, 281            |                |
| 69. 01           | 06901 CARDI AC REHAB   | 0                    | 603                   | 1                  | o           | 24, 152            | 1              |
| 70.00            |  | 0                    | 10, 847               |                    | O           | 58, 828            |                |
| 71.00            |  | 0                    | 0                     | 0                  | 0           | 0                  | 71.00          |
| 72.00            | 07200 I MPL. DEV. CHARGED TO PATIENTS                                    | 0                    | 0                     |                    | 0           | 0                  |                |
| 73.00            |  | 45, 741              | 0                     | 13, 817            | 0           | 17, 581            | 1              |
| 74.00            | 07400 RENAL DI ALYSI S<br>OUTPATI ENT SERVI CE COST CENTERS              | 120, 626             | 14, 512               | 36, 438            | 0           | 18                 | 74. 00         |
| 90 00            | 09000 CLINIC   | 2, 096, 610          | 56, 387               | 633, 328           | ol          | 146, 520           | 90.00          |
| 91. 00           |  | 744, 813             |                       |                    | 254, 667    | 380, 970           |                |
|                  | 09200 OBSERVATION BEDS (NON-DISTINCT PART)                               | , , , , , , ,        | 001,100               | 221,707            | 201,007     | 000,770            | 92.00          |
|                  | OTHER REIMBURSABLE COST CENTERS  |                      |                       | '                  | <u>'</u>    |                    | 1              |
| 101.00           | 10100 HOME HEALTH AGENCY   | 0                    | 0                     | 0                  | 0           | 0                  | 101.00         |
|                  | SPECIAL PURPOSE COST CENTERS   |                      |                       |                    |             |                    |                |
| 118. 00          | J /  | 24, 974, 820         | 2, 183, 952           | 7, 224, 466        | 3, 937, 099 | 5, 012, 565        | 118. 00        |
| 100 00           | NONREIMBURSABLE COST CENTERS   19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 49, 566              | Ιο                    | 14, 973            | ol          | ^                  | 190. 00        |
|                  | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN                                | 49, 566              |                       |                    | ol<br>Ol    |                    | 190.00         |
|                  | 19200 PHYSICIANS' PRIVATE OFFICES  | 735, 125             |                       | 222, 061           | 0           |                    | 192.00         |
|                  | 1 19201 OTHER NON-REI MBURSABLE  | 95, 142              |                       | 28, 740            | o           |                    | 192. 01        |
| 192. 02          | 19202 FAMILY HEALTH/GARY COMM HEALTH                                     | 247, 610             |                       |                    | О           | 0                  | 192. 02        |
| 193.00           | 19300 NONPALD WORKERS  | 0                    | 0                     | 0                  | o           | 0                  | 193. 00        |
|                  |  |                      |                       |                    |             |                    |                |

| Health Financial Systems                | METHODIST HOSE | PITALS, INC  | In Lie                                      | u of Form CMS-2   | 2552-10       |
|---|----------------|--------------|---|---|---------------|
| COST ALLOCATION - GENERAL SERVICE COSTS |                | Provi der Co | Period:<br>From 01/01/2021<br>To 12/31/2021 | Worksheet B<br>Part I<br>Date/Time Pre<br>5/27/2022 9:0 |               |
|   |                |              | <br>  |   | $\overline{}$ |

|         |                                   |              |               |               |             | 5/27/2022 9:0 | 2 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        |        |
| 200.00  | Cross Foot Adjustments            |              |               |               |             |               | 200.00 |
| 201. 00 | Negative Cost Centers             | 0            | 0             | C             | 0           | 0             | 201.00 |
| 202.00  | TOTAL (sum lines 118 through 201) | 26, 102, 263 | 2, 183, 952   | 7, 565, 036   | 3, 937, 099 | 5, 012, 565   | 202.00 |

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2021 | Part I | To 12/31/2021 | Date/Time Prepared: Provider CCN: 15-0002

|                  |  |                       |                            | 10            | 12/31/2021            | Date/lime Pre<br>5/27/2022 9:0 |                    |
|------------------|--|-----------------------|----------------------------|---------------|-----------------------|--------------------------------|--------------------|
|                  | Cost Center Description  | NURSI NG              | CENTRAL                    | PHARMACY      | MEDI CAL              | SOCI AL                        |                    |
|                  |  | ADMI NI STRATI O<br>N | SERVICES & SUPPLY          |               | RECORDS &<br>LI BRARY | SERVI CE                       |                    |
|                  |  | 13. 00                | 14. 00                     | 15. 00        | 16. 00                | 17. 00                         |                    |
|                  | GENERAL SERVICE COST CENTERS   |                       |                            |               |                       |                                |                    |
| 1.00             | 00100 CAP REL COSTS-BLDG & FLXT  |                       |                            |               |                       |                                | 1.00               |
| 4. 00<br>5. 01   | 00400 EMPLOYEE BENEFITS DEPARTMENT<br>00550 DATA PROCESSING                |                       |                            |               |                       |                                | 4. 00<br>5. 01     |
| 5. 02            | 00560 PURCHASING RECEIVING AND STORES                                      |                       |                            |               |                       |                                | 5. 02              |
| 5. 03            | 00570 ADMI TTI NG  |                       |                            |               |                       |                                | 5. 03              |
| 5.04             | 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE                                    |                       |                            |               |                       |                                | 5. 04              |
| 5. 05<br>5. 06   | 00590 OTHER A&G<br>00592 PATIENT TRANSPORTATION                            |                       |                            |               |                       |                                | 5. 05<br>5. 06     |
| 7. 00            | 00700 OPERATION OF PLANT   |                       |                            |               |                       |                                | 7.00               |
| 8. 00            | 00800 LAUNDRY & LINEN SERVICE  |                       |                            |               |                       |                                | 8.00               |
| 9. 00            | 00900 HOUSEKEEPI NG  |                       |                            |               |                       |                                | 9. 00              |
| 10. 00<br>11. 00 | 01000 DI ETARY<br>01100 CAFETERI A   |                       |                            |               |                       |                                | 10. 00<br>11. 00   |
| 13. 00           | 01300 NURSI NG ADMI NI STRATI ON   | 8, 015, 769           |                            |               |                       |                                | 13.00              |
| 14. 00           | 01400 CENTRAL SERVICES & SUPPLY  | 0                     | 4, 850, 254                |               |                       |                                | 14.00              |
| 15.00            | 01500 PHARMACY   | 0                     | 0                          | 7, 226, 343   |                       |                                | 15.00              |
| 16.00            | 01600 MEDI CAL RECORDS & LI BRARY  | 0                     | 0                          | 0             | 4, 178, 915           | /55 000                        | 16.00              |
| 17. 00<br>17. 01 | 01700 SOCIAL SERVICE<br>01701 STAFF EDUCATION                              | 0                     | 0                          | 0             | 0                     | 655, 390<br>0                  | 17. 00<br>17. 01   |
| 17. 01           | 01701 STATE EDUCATION  | 0                     | 0                          | 0             | 0                     | 0                              | 1                  |
| 21. 00           | 02100 I &R SERVICES-SALARY & FRINGES APPRVD                                | 0                     | 0                          | Ö             | 0                     | 0                              | 1                  |
| 22. 00           | 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD                                 | 0                     | 0                          |               | 0                     | 0                              |                    |
| 23. 00           | 02300 PARAMED ED PROGRAM   | 122, 259              | 0                          | 0             | 0                     | 0                              | 23. 00             |
| 30. 00           | INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS           | 3, 988, 554           | 0                          | O             | 316, 335              | 541, 939                       | 30.00              |
| 31. 00           | 03100 INTENSIVE CARE UNIT  | 814, 678              | 0                          |               | 69, 681               | 0                              | 31.00              |
| 31. 01           | 03101 NEONATAL I CU  | 186, 486              | 0                          | 0             | 18, 699               | 0                              | 31. 01             |
| 40.00            | 04000 SUBPROVI DER - I PF  | 135, 686              | 0                          | 0             | 6, 771                | 0                              |                    |
| 41. 00<br>43. 00 | 04100   SUBPROVI DER -   RF<br>  04300   NURSERY                           | 275, 479<br>149, 653  | 0                          | - 1           | 13, 163<br>5, 886     | 86, 260<br>0                   | 1                  |
| 43.00            | ANCILLARY SERVICE COST CENTERS   | 147, 033              | 0                          | ١             | 3, 000                | 0                              | 43.00              |
| 50.00            | 05000 OPERATING ROOM   | 692, 061              | 0                          | 0             | 499, 245              | 0                              | 50.00              |
| 50. 01           | 05001 ENDOSCOPY  | 103, 968              | 0                          | - 1           | 36, 927               | 0                              | 50.01              |
| 51. 00<br>52. 00 | O5100 RECOVERY ROOM   O5200 DELIVERY ROOM & LABOR ROOM                     | 111, 244<br>455, 201  | 0                          | 0             | 35, 487<br>13, 058    | 0                              | 51.00<br>52.00     |
| 53. 00           | 05300 ANESTHESI OLOGY  | 433, 201              | 0                          |               | 13, 030               | 0                              | 1                  |
| 54.00            | 05400 RADI OLOGY-DI AGNOSTI C  | 0                     | 0                          | 0             | 120, 542              | 0                              | 1                  |
| 54. 01           | 05401 RADI OLOGY - ULTRASOUND  | 0                     | 0                          |               | 66, 918               | 0                              |                    |
| 55. 00<br>55. 01 | 05500   RADI OLOGY-THERAPEUTI C<br>  05501   I NFUSI ON CENTER             | 0                     | 0                          | 0             | 66, 912<br>384        | 0                              | 55. 00<br>55. 01   |
| 56. 00           | 05600 RADI OI SOTOPE   | 0                     | 0                          | 0 0           | 47, 390               | 0                              | 56.00              |
| 57. 00           | 05700 CT SCAN  | O                     | 0                          | Ö             | 397, 517              | 0                              | 57.00              |
| 58.00            | 05800 MAGNETIC RESONANCE I MAGING (MRI)                                    | 0                     | 0                          | 0             | 92, 209               | 0                              | 58. 00             |
| 59. 00<br>60. 00 | 05900 CARDI AC CATHETERI ZATI ON<br>06000 LABORATORY                       | 0                     | 0                          | 0             | 208, 168              | 0                              | 59. 00<br>60. 00   |
|                  | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS                                 | 0                     | 0                          | 445, 161<br>0 | 659, 456<br>35, 972   | 0                              | 1                  |
|                  | 06400 I NTRAVENOUS THERAPY   | O                     | 0                          | Ö             | 0                     | 0                              |                    |
| 65.00            |  | 0                     | 0                          | 0             | 126, 672              | 0                              | 1                  |
| 66.00            |  | 0                     | 0                          | 0             | 23, 125               | 0                              |                    |
| 67. 00<br>68. 00 | 06700 OCCUPATI ONAL THERAPY<br>06800 SPEECH PATHOLOGY                      | 0                     | 0                          | 0             | 16, 854<br>8, 532     | 0                              | 67. 00<br>68. 00   |
| 69. 00           | 06900 ELECTROCARDI OLOGY   | O                     | 0                          | Ö             | 75, 915               | 0                              | 69.00              |
| 69. 01           | 06901 CARDI AC REHAB   | 0                     | 0                          | 0             | 3, 234                | 0                              |                    |
| 70.00            |  | 0                     | 0 410 500                  | 0             | 96, 162               | 0                              |                    |
| 71. 00<br>72. 00 |  | 0                     | 2, 618, 598<br>2, 231, 656 |               | 162, 742<br>104, 464  | 0                              |                    |
| 73. 00           |  | o o                   | 0                          |               | 478, 643              | 0                              | 1                  |
| 74.00            | 07400 RENAL DIALYSIS   | 0                     | 0                          |               | 27, 719               | 0                              | 74.00              |
| 00.00            | OUTPATIENT SERVICE COST CENTERS  | 0.4/5                 |                            |               | 70.050                | 0                              | 00.00              |
|                  | 09000   CLI NI C<br>  09100   EMERGENCY                                    | 3, 465<br>977, 035    | 0                          | 1             | 70, 859<br>261, 642   | 0<br>27, 191                   | 1                  |
|                  | 09200 OBSERVATION BEDS (NON-DISTINCT PART)                                 | 777,033               | 0                          |               | 201, 042              | 27, 171                        | 92.00              |
|                  | OTHER REIMBURSABLE COST CENTERS  |                       |                            |               |                       |                                |                    |
| 101.00           | 10100 HOME HEALTH AGENCY   | 0                     | 0                          | 8, 133        | 11, 632               | 0                              | 101.00             |
| 118.00           | SPECIAL PURPOSE COST CENTERS   SUBTOTALS (SUM OF LINES 1 through 117)      | 8, 015, 769           | 4, 850, 254                | 7 156 515     | 4, 178, 915           | 655, 390                       | 110 00             |
| 1 10.00          | NONREI MBURSABLE COST CENTERS  | 0,010,709             | 4, 000, 204                | 7, 156, 515   | 4, 170, 713           | 000, 390                       | 1.10.00            |
|                  | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN                                  | 0                     | 0                          | 0             | 0                     |                                | 190. 00            |
|                  | 19100 RESEARCH   | 0                     | 0                          | 0             | 0                     |                                | 191.00             |
|                  | 0 19200 PHYSI CI ANS' PRI VATE OFFI CES<br>1 19201 OTHER NON-REI MBURSABLE | 0                     | 0                          | 69, 828<br>0  | 0                     |                                | 192. 00<br>192. 01 |
|                  | 19201 OTHER NON-RETWIBURSABLE<br>219202 FAMILY HEALTH/GARY COMM HEALTH     |                       | 0                          |               | 0                     |                                | 192.01             |
|                  | 1  | , 91                  |                            | ,             |                       |                                |                    |

| Health Financial Systems                | METHODI ST HOSPI                  | ITALS, INC                       |          | In Lie                                       | u of Form CMS-2   | 2552-10 |
|---|-----------------------------------|----------------------------------|----------|--|---|---------|
| COST ALLOCATION - GENERAL SERVICE COSTS |                                   | Provi der Co                     |          | Peri od:<br>From 01/01/2021<br>To 12/31/2021 | Worksheet B<br>Part I<br>Date/Time Pre<br>5/27/2022 9:0 |         |
| Cost Center Description                 | NURSI NG<br>ADMI NI STRATI O<br>N | CENTRAL<br>SERVI CES &<br>SUPPLY | PHARMACY | MEDI CAL<br>RECORDS &<br>LI BRARY            | SOCI AL<br>SERVI CE                                     |         |

|        |                                   | N           | CHEDIA      |             | LLDDADY     |          |        |
|--------|-----------------------------------|-------------|-------------|-------------|-------------|----------|--------|
|        |                                   | N           | SUPPLY      |             | LI BRARY    |          |        |
|        |                                   | 13. 00      | 14. 00      | 15. 00      | 16.00       | 17. 00   |        |
| 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) | 8, 015, 769 | 4, 850, 254 | 7, 226, 343 | 4, 178, 915 | 655, 390 | 202.00 |
|        |                                   |             |             |             |             |          |        |
|        |                                   |             |             |             |             |          |        |
|        |                                   |             |             |             |             |          |        |

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002

Peri od: Worksheet B From 01/01/2021 Part I To 12/31/2021 Date/Time Prepared:

5/27/2022 9:02 am INTERNS & RESIDENTS STAFF MEDI CAL SERVI CES-SALA | SERVI CES-OTHE PARAMED ED Cost Center Description **FDUCATION FDUCATION** RY & FRINGES R PRGM COSTS **PROGRAM** 17.01 17.02 21.00 22.00 23.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 4 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 5.01 00550 DATA PROCESSING 5.01 00560 PURCHASING RECEIVING AND STORES 5.02 5.02 5.03 00570 ADMITTING 5.03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.04 5 04 5.05 00590 OTHER A&G 5.05 5.06 00592 PATIENT TRANSPORTATION 5.06 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 01100 CAFETERI A 11.00 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16,00 16 00 17.00 01700 SOCIAL SERVICE 17.00 01701 STAFF EDUCATION 17.01 549, 281 17.01 01702 MEDICAL EDUCATION 30, 225 17.02 17.02 59 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21.00 0 282, 158 21.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 C 254, 718 22.00 02300 PARAMED ED PROGRAM 23.00 190 0 1, 227, 853 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 223, 776 C 0 0 30.00 03100 INTENSIVE CARE UNIT 38, 313 0 0 0 31.00 31.00 o 03101 NEONATAL I CU 0 0 0 31.01 7.645 31.01 04000 SUBPROVI DER - I PF 0 0 40.00 2, 160 0 0 40.00 41.00 04100 SUBPROVI DER - I RF 26, 673 0 0 0 0 41.00 43.00 04300 NURSERY 11, 414 0 0 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 30,080 0 0 0 0 50.00 05001 ENDOSCOPY 14, 453 0 0 0 0 50.01 50.01 0 51.00 05100 RECOVERY ROOM 1, 401 0 0 0 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 29, 997 0 0 52 00 52 00 0 0 53.00 05300 ANESTHESI OLOGY 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 11, 550 0 54.00 0 54.00 54.01 05401 RADI OLOGY - ULTRASOUND 6,713 0 0 0 0 0 54.01 05500 RADI OLOGY-THERAPEUTI C 0 55 00 1,549 0 0 55.00 0 55.01 05501 INFUSION CENTER 0 0 55.01 0 56.00 05600 RADI OI SOTOPE 12 0 0 0 0 0 0 0 56.00 05700 CT SCAN 0 0 57.00 57.00 10,612 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 0 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 19, 468 0 0 0 59.00 60 00 06000 LABORATORY 1, 359 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 510 0 0 62.00 06400 INTRAVENOUS THERAPY 0 64.00 Ω C 0 64.00 06500 RESPIRATORY THERAPY 0 65.00 4, 351 0 65.00 66.00 06600 PHYSI CAL THERAPY 878 0 0 0 0 66.00 06700 OCCUPATI ONAL THERAPY 67.00 368 C 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 410 0 68.00 69.00 06900 ELECTROCARDI OLOGY 6, 962 0 O 69.00 0 0 06901 CARDI AC REHAB 69.01 47 0 0 0 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 4.084 0 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 0 0 0 71.00 o 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 543 C 0 0 0 73.00 74.00 07400 RENAL DIALYSIS 0 0 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 0 n 90.00 09000 CLI NI C 1,424 09100 EMERGENCY 282, 158 254, 718 1, 227, 853 91 00 80, 507 30, 225 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 2, 297 0 0 0 0 101, 00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 540, 805 30, 225 282, 158 254, 718 1, 227, 853 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190 00 C 0 0 0 191. 00 19100 RESEARCH 0 0 0 0 191.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 8, 203 0 0 0 0 192.00 192. 01 19201 OTHER NON-REIMBURSABLE 0 0 0 0 192. 01

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0002 | Period: From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: 5/27/2022 9:02 am

|               |                                   |            |            |                |                | 3/2//2022 9.0 | <u>z aiii                                  </u> |
|---------------|-----------------------------------|------------|------------|----------------|----------------|---------------|---|
|               |                                   |            |            | INTERNS &      | RESI DENTS     |               |   |
|               |                                   |            |            |                |                |               |   |
|               | Cost Center Description           | STAFF      | MEDI CAL   | SERVI CES-SALA | SERVI CES-OTHE | PARAMED ED    |   |
|               |                                   | EDUCATI ON | EDUCATI ON | RY & FRINGES   | R PRGM COSTS   | PROGRAM       |   |
|               |                                   | 17. 01     | 17. 02     | 21.00          | 22.00          | 23. 00        |   |
| 192. 02 19202 | FAMILY HEALTH/GARY COMM HEALTH    | 273        | 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             | O          | 0          | 0              | 0              | 0             | 201.00  |
| 202. 00       | TOTAL (sum lines 118 through 201) | 549, 281   | 30, 225    | 282, 158       | 254, 718       | 1, 227, 853   | 202.00  |

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2021 | Part I | Date/Time | Prepared: | Provider CCN: 15-0002

| 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 00550 DATA PROCESSING 5. 02 00560 PURCHASING RECEIVING AND STORES 5. 03 00570 ADMITTING 5. 04 00580 CASHIERING/ACCOUNTS RECEIVABLE 5. 05 00590 OTHER A&G 5. 06 00592 PATIENT TRANSPORTATION 7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING 10. 00 01000 DIETARY   | 1. 00<br>4. 00<br>5. 01<br>5. 02<br>5. 03 |
|---|---|
| Cost & Post   Stepdown   Adjustments   24.00   25.00   26.00  | 4. 00<br>5. 01<br>5. 02                   |
| Stepdown   Adj ustments   24.00   25.00   26.00   | 4. 00<br>5. 01<br>5. 02                   |
| 24.00   25.00   26.00   | 4. 00<br>5. 01<br>5. 02                   |
| GENERAL SERVICE COST CENTERS   1.00   00100   CAP REL COSTS-BLDG & FIXT   1.4.00   00400   EMPLOYEE BENEFITS DEPARTMENT   1.5.01   00550   DATA PROCESSING   5.02   00560   PURCHASING RECEIVING AND STORES   5.03   00570   ADMITTING   5.04   00580   CASHIERING/ACCOUNTS RECEIVABLE   5.05   00590   OTHER A&G   5.05   00590   OTHER A&G   5.06   00592   PATIENT TRANSPORTATION   5.7.00   00700   OPERATION OF PLANT   5.7.00   00700   ODERATION OF PLANT   6.00   00800   LAUNDRY & LINEN SERVICE   8.9.00   00900   HOUSEKEEPING   9.9.00   001000   DIETARY   10.00   010000   010000   01000   010000   010000   010000   010000   010000   0100000   010000   0100000 | 4. 00<br>5. 01<br>5. 02                   |
| 1. 00   | 4. 00<br>5. 01<br>5. 02                   |
| 5. 01 00550 DATA PROCESSING 5. 02 00560 PURCHASING RECEIVING AND STORES 5. 03 00570 ADMITTING 5. 04 00580 CASHIERING/ACCOUNTS RECEIVABLE 5. 05 00590 OTHER A&G 5. 06 00592 PATIENT TRANSPORTATION 7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING 10. 00 01000 DIETARY  | 5. 01<br>5. 02                            |
| 5. 02   | 5. 02                                     |
| 5. 03   |   |
| 5. 04   |   |
| 5. 05   | 5. 04                                     |
| 7. 00   00700   OPERATI ON OF PLANT   | 5. 05                                     |
| 8. 00   00800   LAUNDRY & LI NEN SERVI CE   | 5. 06                                     |
| 9. 00   00900   HOUSEKEEPI NG<br>10. 00   01000   DI ETARY   9.   | 7. 00<br>3. 00                            |
| 10. 00 01000 DI ETARY 10.   | 9. 00                                     |
| 11 00 01100 CAFETERIA   | 0. 00                                     |
|   | 1.00                                      |
|   | 3.00                                      |
|   | 4. 00<br>5. 00                            |
|   | 5. 00                                     |
|   | 7. 00                                     |
|   | 7. 01                                     |
|   | 7. 02<br>1. 00                            |
|   | 2. 00                                     |
|   | 3. 00                                     |
| INPATIENT ROUTINE SERVICE COST CENTERS  |   |
|   | 0. 00<br>1. 00                            |
|   | 1. 01                                     |
|   | 0. 00                                     |
|   | 1.00                                      |
| 43. 00   04300   NURSERY   3, 483, 536   0   3, 483, 536   43.  | 3. 00                                     |
|   | 0. 00                                     |
| 50. 01   05001   ENDOSCOPY   1, 867, 097   0   1, 867, 097   50.  | 0. 01                                     |
|   | 1.00                                      |
|   | 2. 00<br>3. 00                            |
|   | 1. 00                                     |
|   | 4. 01                                     |
|   | 5. 00                                     |
|   | 5. 01<br>5. 00                            |
|   | 7. 00                                     |
|   | 3. 00                                     |
|   | 9. 00                                     |
|   | 0.00                                      |
|   | 2. 00<br>1. 00                            |
|   | 5. 00                                     |
|   | 5. 00                                     |
|   | 7.00                                      |
|   | 3. 00<br>9. 00                            |
|   | 9. 01                                     |
|   | 0. 00                                     |
|   | 1.00                                      |
|   | 2. 00<br>3. 00                            |
|   | 4. 00                                     |
| OUTPATIENT SERVICE COST CENTERS   |   |
|   | 0. 00<br>1. 00                            |
|   | 2. 00                                     |
| OTHER REI MBURSABLE COST CENTERS  |   |
|   | 1.00                                      |
| SPECIAL PURPOSE COST CENTERS   118.00   SUBTOTALS (SUM OF LINES 1 through 117)   317,670,421   -536,876   317,133,545   118.  | 3. 00                                     |
| 118. UV   | ,. 00                                     |
| 190. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   88, 936   0   88, 936   190.   | 0. 00                                     |
|   | 1.00<br>2.00                              |
| 172. 00  17200  11110  OLNIO TREVATE OLLIOCO   30, 073, 331  0  30, 073, 331    192.  | 00  |

| Health Financial Systems                    | METHODIST HOSE | PITALS, INC  |              | In Lie                      | u of Form CMS-                 | 2552-10 |
|---|----------------|--------------|--------------|-----------------------------|--------------------------------|---------|
| COST ALLOCATION - GENERAL SERVICE COSTS     |                | Provi der CC | CN: 15-0002  | Peri od:<br>From 01/01/2021 | Worksheet B<br>Part I          |         |
|   |                |              |              | To 12/31/2021               | Date/Time Pre<br>5/27/2022 9:0 |         |
| Cost Center Description                     | Subtotal       | Intern &     | Total        |                             |                                |         |
|   |                | Resi dents   |              |                             |                                |         |
|   |                | Cost & Post  |              |                             |                                |         |
|   |                | Stepdown     |              |                             |                                |         |
|   |                | Adjustments  |              |                             |                                |         |
|   | 24. 00         | 25. 00       | 26.00        |                             |                                |         |
| 192. 01 19201 OTHER NON-REIMBURSABLE        | 569, 675       | 0            | 569, 67      | '5                          |                                | 192. 01 |
| 192.02 19202 FAMILY HEALTH/GARY COMM HEALTH | 545, 900       | 0            | 545, 90      | 00                          |                                | 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                | o              | o            |              | 0                           |                                | 201.00  |
| 202.00 TOTAL (sum lines 118 through 201)    | 357, 568, 283  | -536, 876    | 357, 031, 40 | 07                          |                                | 202. 00 |

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

|  |  |   |  |  | 10  | 12/31/2021   | Date/lime Pre<br>  5/27/2022 9:0    |  |
|--|--|---|--|--|---|--|-------------------------------------|--|
|  |  | Cost Center Description   | Directly<br>Assigned New<br>Capital<br>Related Costs | CAPITAL<br>RELATED COSTS<br>BLDG & FIXT                                      | Subtotal  | EMPLOYEE<br>BENEFITS<br>DEPARTMENT                     | DATA<br>PROCESSI NG                 | 2 4111   |
|  |  |   | 0  | 1.00   | 2A  | 4. 00  | 5. 01                               |  |
|  |  | AL SERVICE COST CENTERS   |  |  |   |  |                                     |  |
| 1. 00<br>4. 00<br>5. 01<br>5. 02<br>5. 03<br>5. 04<br>5. 05        | 00400<br>00550<br>00560<br>00570<br>00580<br>00590 | CAP REL COSTS-BLDG & FIXT EMPLOYEE BENEFITS DEPARTMENT DATA PROCESSING PURCHASING RECEIVING AND STORES ADMITTING CASHIERING/ACCOUNTS RECEIVABLE OTHER A&G | 0<br>0<br>0<br>0<br>0                                | 71, 504<br>111, 264<br>88, 769<br>117, 645<br>371, 034<br>1, 205, 612        | 111, 264<br>88, 769<br>117, 645<br>371, 034<br>1, 205, 612  | 71, 504<br>2, 224<br>456<br>1, 195<br>1, 082<br>5, 091 | 113, 488<br>0<br>0<br>0<br>113, 488 | 1.00<br>4.00<br>5.01<br>5.02<br>5.03<br>5.04<br>5.05               |
| 5. 06<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00               | 00700<br>00800<br>00900<br>01000<br>01100          | PATIENT TRANSPORTATION OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA  | 0 0 0 0 0 0  | 0<br>3, 624, 003<br>215, 809<br>249, 830<br>228, 194<br>159, 535             | 3, 624, 003<br>215, 809<br>249, 830<br>228, 194<br>159, 535 | 231<br>1, 812<br>0<br>2, 016<br>640<br>1, 096          | 0<br>0<br>0<br>0                    | 5. 06<br>7. 00<br>8. 00<br>9. 00<br>10. 00                         |
| 13. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00<br>17. 01<br>17. 02 | 01400<br>01500<br>01600<br>01700<br>01701          | NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE STAFF EDUCATION MEDICAL EDUCATION                      | 0              | 76, 880<br>433, 954<br>229, 514<br>136, 895<br>19, 722<br>134, 958<br>4, 528 | 433, 954<br>229, 514<br>136, 895<br>19, 722<br>134, 958     | 2, 180<br>291<br>0<br>1, 020<br>207<br>0               | 0<br>0<br>0<br>0<br>0               | 13. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00<br>17. 01<br>17. 02 |
| 21. 00<br>22. 00<br>23. 00<br>30. 00                               | 02100<br>02200<br>02300<br>I NPAT                  | I &R SERVICES-SALARY & FRINGES APPRVD I &R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PROGRAM I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS     | 0 0 0  | 54, 082<br>40, 728<br>3, 792, 150  | 0<br>54, 082<br>40, 728                                     | 12, 560  | 0 0 0                               | 21. 00<br>22. 00<br>23. 00<br>30. 00                               |
| 31. 00<br>31. 01<br>40. 00<br>41. 00<br>43. 00                     | 03100<br>03101<br>04000<br>04100<br>04300          | INTENSIVE CARE UNIT<br>NEONATAL ICU<br>SUBPROVIDER - IPF<br>SUBPROVIDER - IRF<br>NURSERY  | 0<br>0<br>0<br>0                                     | 240, 495<br>27, 338<br>48, 089<br>378, 262<br>295, 704                       | 240, 495<br>27, 338<br>48, 089<br>378, 262                  | 3, 855<br>726<br>453<br>896<br>612                     | 0<br>0<br>0<br>0                    | 31. 00<br>31. 01<br>40. 00<br>41. 00<br>43. 00                     |
| 50. 00<br>50. 01   | 05000<br>05001                                     | LARY SERVICE COST CENTERS  OPERATING ROOM ENDOSCOPY   | 0  | 722, 152<br>0  | 0   | 2, 098<br>352  | 0                                   | 50. 00<br>50. 01   |
| 51. 00<br>52. 00<br>53. 00<br>54. 00<br>54. 01                     | 05200<br>05300<br>05400                            | RECOVERY ROOM DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY RADIOLOGY-DIAGNOSTIC RADIOLOGY - ULTRASOUND   | 0 0  | 176, 110<br>84, 786<br>0<br>642, 390<br>61, 189                              | 84, 786<br>0<br>642, 390                                    | 475<br>1, 553<br>0<br>1, 087<br>623                    | 0<br>0<br>0<br>0                    | 51. 00<br>52. 00<br>53. 00<br>54. 00<br>54. 01                     |
| 55. 00<br>55. 01<br>56. 00<br>57. 00                               | 05501<br>05600<br>05700                            | RADI OLOGY-THERAPEUTI C<br>I NFUSI ON CENTER<br>RADI OI SOTOPE<br>CT SCAN   | 0<br>0<br>0  | 163, 264<br>4, 359<br>109, 484<br>103, 673                                   | 4, 359<br>109, 484<br>103, 673                              | 240<br>9<br>277<br>582                                 | 0 0 0                               |  |
|  | 05900<br>06000<br>06200<br>06400                   | MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION LABORATORY WHOLE BLOOD & PACKED RED BLOOD CELLS INTRAVENOUS THERAPY RESPIRATORY THERAPY          | 0 0  | 50, 910<br>97, 256<br>284, 735<br>4, 661<br>0<br>94, 024                     | 97, 256<br>284, 735<br>4, 661                               | 226<br>1, 221<br>1, 855<br>571<br>0<br>1, 348          | 0<br>0<br>0<br>0                    |  |
| 66. 00<br>67. 00<br>68. 00<br>69. 00                               | 06600<br>06700<br>06800<br>06900                   | PHYSI CAL THERAPY  OCCUPATI ONAL THERAPY  SPEECH PATHOLOGY  ELECTROCARDI OLOGY  CARDI AC REHAB  | 0 0  | 148, 554<br>127, 669<br>21, 744  | 148, 554<br>127, 669<br>21, 744                             | 670<br>539<br>223<br>319<br>193                        | 0<br>0<br>0<br>0                    | 66. 00<br>67. 00<br>68. 00<br>69. 00                               |
| 70. 00<br>71. 00<br>72. 00<br>73. 00                               | 07000<br>07100<br>07200<br>07300                   | ELECTROENCEPHALOGRAPHY  MEDICAL SUPPLIES CHARGED TO PATIENTS  IMPL. DEV. CHARGED TO PATIENTS  DRUGS CHARGED TO PATIENTS  RENAL DIALYSIS                   | 0 0 0  | 0<br>0<br>0<br>0<br>20, 122<br>53, 065                                       |   | 522<br>0<br>0<br>176                                   | 0<br>0<br>0<br>0                    | 70. 00<br>71. 00<br>72. 00<br>73. 00<br>74. 00                     |
| 90. 00<br>91. 00   | 09000<br>09100<br>09200                            | TIENT SERVICE COST CENTERS  CLINIC EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS   | 0  | 922, 330<br>327, 654   | 922, 330  | 1, 338<br>3, 622                                       | 0 0                                 |  |
| 101. 00<br>118. 00   | 10100<br>SPECI                                     | HOME HEALTH AGENCY AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)   | 0  |  |   | 1, 058<br>60, 164                                      | 113, 488                            | 101. 00<br>118. 00   |
| 190. 00  | NONRE<br>19000                                     | IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN RESEARCH  | 0  | 21, 805  | 21, 805   | 0  | 0                                   | 190. 00<br>191. 00   |
|  |  |   |  |  |   |  |                                     |  |

| Health Financial Systems                     | METHODI ST HOS                                       | PITALS, INC                              |          | In Lie                                      | u of Form CMS-   | 2552-10 |
|--|--|--|----------|---|--|---------|
| ALLOCATION OF CAPITAL RELATED COSTS          |  | Provider Co                              |          | Period:<br>From 01/01/2021<br>To 12/31/2021 | Worksheet B<br>Part II<br>Date/Time Pre<br>5/27/2022 9:0 | epared: |
| Cost Center Description                      | Directly<br>Assigned New<br>Capital<br>Related Costs | CAPI TAL<br>RELATED COSTS<br>BLDG & FIXT | Subtotal | EMPLOYEE<br>BENEFITS<br>DEPARTMENT          | DATA<br>PROCESSI NG                                      |         |
|  | 0  | 1.00                                     | 2A       | 4. 00                                       | 5. 01  |         |
| 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES | 0  | 323, 392                                 | 323, 39  | 2 11, 294                                   | 0  | 192.00  |
| 192. 01 19201 OTHER NON-REIMBURSABLE         | 0  | 41, 854                                  | 41, 85   | 4 0   | 0  | 192. 01 |
| 192.02 19202 FAMILY HEALTH/GARY COMM HEALTH  | 0  | 108, 927                                 | 108, 92  | 7 46  | 0  | 192. 02 |
| 193.00 19300 NONPALD WORKERS                 | 0  | 0  | (        | 0   | 0  | 193. 00 |
| 200 00 Cross Foot Adjustments                |  |  |          | <u> </u>                                    | 1  | 200 00  |

17, 072, 607

71, 504

200. 00 0 201. 00

113, 488 202. 00

0

17, 072, 607

Cross Foot Adjustments Negative Cost Centers

TOTAL (sum lines 118 through 201)

200.00 201.00

202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-0002

|   | Cost Center Description   | PURCHASI NG<br>RECEI VI NG AND<br>STORES | ADMITTING                | CASHI ERI NG/AC<br>COUNTS<br>RECEI VABLE | OTHER A&G                    | 5/27/2022 9:0 PATIENT TRANSPORTATIO |   |
|---|---|--|--------------------------|--|------------------------------|-------------------------------------|---|
|   |   | 5. 02                                    | 5. 03                    | 5. 04                                    | 5. 05                        | 5. 06                               |   |
| 1 00  | GENERAL SERVICE COST CENTERS  | 1  |                          | <u> </u>                                 |                              |                                     | 4 00  |
| 1. 00<br>4. 00<br>5. 01<br>5. 02<br>5. 03<br>5. 04<br>5. 05 | 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 | 89, 225<br>130<br>28<br>44               | 118, 970<br>0            |  | 1, 324, 235                  |                                     | 1. 00<br>4. 00<br>5. 01<br>5. 02<br>5. 03<br>5. 04<br>5. 05 |
| 5. 06<br>7. 00  | 00592 PATIENT TRANSPORTATION<br>00700 OPERATION OF PLANT  | 14<br>876                                | 0                        | 0  | 2, 564<br>96, 679            | 2, 809<br>0                         | 5. 06<br>7. 00  |
| 8. 00<br>9. 00<br>10. 00                                    | O0800   LAUNDRY & LI NEN SERVI CE<br>  O0900   HOUSEKEEPI NG<br>  O1000   DI ETARY  | 797<br>1, 316                            | 0<br>0<br>0              | 0  | 6, 272<br>25, 916<br>12, 081 | 0<br>0<br>0                         | 8. 00<br>9. 00<br>10. 00                                    |
| 11. 00<br>13. 00  | 01100 CAFETERI A  | 3 616                                    | 0                        | 0  | 16, 817<br>28, 300           | 0                                   | 11. 00<br>13. 00  |
| 14. 00<br>15. 00  | 01500 PHARMACY  | 1, 028<br>228                            | 0                        |  | 12, 953<br>24, 249           | 0                                   | 14. 00<br>15. 00  |
| 16. 00<br>17. 00  | 01700 SOCIAL SERVICE  | 13                                       | 0                        | Ō  | 13, 284<br>2, 211            | 0                                   | 16. 00<br>17. 00  |
| 17. 01<br>17. 02<br>21. 00                                  |   | 0<br>3<br>0                              | 0                        | 0 0                                      | 555<br>62<br>1, 045          | 0<br>0<br>0                         | 17. 01<br>17. 02<br>21. 00                                  |
| 22. 00<br>23. 00  | 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD  | 0<br>26                                  | 0                        | 0  | 351<br>3, 471                | 0                                   | 22. 00<br>23. 00  |
| 30. 00  | INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS  | 8, 650                                   | 9, 011                   | 28, 212                                  | 226, 523                     | 989                                 | 30. 00  |
| 31. 00<br>31. 01  | 03100 INTENSIVE CARE UNIT   | 2, 145<br>55                             | 1, 985<br>533            | 6, 214                                   | 54, 481<br>9, 363            | 17<br>0                             | 31. 00<br>31. 01  |
| 40. 00<br>41. 00  | 04100 SUBPROVI DER - I RF   | 1<br>187                                 | 193<br>375               | 1, 174                                   | 5, 266<br>12, 167            | 0<br>15                             | 40. 00<br>41. 00  |
| 43. 00  | ANCILLARY SERVICE COST CENTERS  | 293                                      | 168                      |  | 8, 730                       | 0                                   | 43.00   |
| 50. 00<br>50. 01  | 05000   OPERATI NG ROOM   05001   ENDOSCOPY   | 2, 126<br>525                            | 14, 221<br>1, 052        | 44, 524<br>3, 293                        | 46, 396<br>5, 994            | 0<br>74                             | 50. 00<br>50. 01  |
| 51. 00<br>52. 00  | 05100 RECOVERY ROOM   | 81<br>316                                | 1, 011<br>372            | 3, 165                                   | 6, 748<br>20, 615            | 0<br>37                             | 51. 00<br>52. 00  |
| 53. 00<br>54. 00  | 05400 RADI OLOGY-DI AGNOSTI C   | 0<br>296                                 | 0<br>3, 434              |  | 0<br>20, 984                 | 0<br>168                            | 53. 00<br>54. 00  |
| 54. 01<br>55. 00  |   | 228<br>43                                | 1, 906<br>1, 906         | 5, 967                                   | 9, 162<br>12, 308            | 335<br>15                           | 54. 01<br>55. 00  |
| 55. 01<br>56. 00  |   | 54<br>1, 644                             | 11<br>1, 350             |  | 243<br>8, 637                | 0<br>172                            | 55. 01<br>56. 00  |
| 57. 00<br>58. 00  | 05800 MAGNETIC RESONANCE IMAGING (MRI)  | 679<br>132                               | 11, 323<br>2, 626        | 8, 223                                   | 14, 471<br>5, 013            | 607<br>203                          | 57. 00<br>58. 00  |
| 59. 00<br>60. 00  | 06000 LABORATORY  | 780<br>6, 601                            | 5, 930<br>18, 717        | 58, 271                                  | 18, 964<br>63, 095           | 98<br>0                             | 59. 00<br>60. 00  |
| 62. 00<br>64. 00  | 06400 I NTRAVENOUS THERAPY  | 485                                      | 1, 025<br>0              | 0  | 7, 558<br>0                  | 0                                   | 62. 00<br>64. 00  |
| 65. 00<br>66. 00  | 06600 PHYSI CAL THERAPY   | 1, 547                                   | 3, 608<br>659            | 2, 062                                   | 20, 517<br>8, 274            | 1 0                                 | 65. 00<br>66. 00  |
| 67. 00<br>68. 00  | 06800 SPEECH PATHOLOGY  | 23<br>18                                 | 480<br>243               | 761                                      | 6, 659<br>2, 683             | 0                                   | 67. 00<br>68. 00  |
| 69. 00<br>69. 01  | 06901 CARDI AC REHAB  | 35<br>4                                  | 2, 162<br>92             | 288                                      | 4, 673<br>2, 404             | 14                                  | 69. 00<br>69. 01  |
| 70. 00<br>71. 00  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS  | 243<br>27, 221                           | 2, 739<br>4, 636         | 14, 514                                  | 7, 712<br>62, 654            | 33                                  | 70. 00<br>71. 00  |
| 72. 00<br>73. 00<br>74. 00                                  | 07300 DRUGS CHARGED TO PATIENTS   | 23, 215<br>796<br>59                     | 2, 976<br>13, 634<br>790 | 42, 687                                  | 53, 024<br>94, 059           | 0<br>0<br>0                         | 72.00<br>73.00<br>74.00                                     |
|   | OUTPATIENT SERVICE COST CENTERS   |  |                          |  | 10, 017                      |                                     |   |
| 90. 00<br>91. 00<br>92. 00                                  | 09100 EMERGENCY   | 188<br>4, 479                            | 2, 018<br>7, 453         |  | 29, 338<br>63, 919           | 1<br>30                             | 90. 00<br>91. 00<br>92. 00                                  |
|   | OTHER REIMBURSABLE COST CENTERS 0 10100 HOME HEALTH AGENCY  | 243                                      | 331                      | 1, 037                                   | 12, 726                      | 0                                   | 101. 00   |
| 118. 0  | SPECIAL PURPOSE COST CENTERS  | 88, 548                                  | 118, 970                 |  | 1, 182, 187                  |                                     | 118. 00   |
|   | NONREI MBURSABLE COST CENTERS 0 19000 G FT, FLOWER, COFFEE SHOP & CANTEEN   | 88, 548                                  | 118, 970                 | 3/2, 144                                 | 90                           |                                     | 190.00  |
| 191. 0  | 0 19000 GFF, FLOWER, COFFEE SHOP & CANTEEN<br>0 19100 RESEARCH<br>0 19200 PHYSICIANS' PRIVATE OFFICES   | 0 674                                    | 0                        |  | 90<br>0<br>139, 480          | 0                                   | 190.00<br>191.00<br>192.00                                  |
| 192. 0  | 19200 FATSICIANS FREW ATE OFFICES<br>  19201 OTHER NON-REIMBURSABLE<br>  19202 FAMILY HEALTH/GARY COMM HEALTH   | 2  | 0                        | 0  | 1, 651<br>827                | 0                                   | 192. 00<br>192. 01<br>192. 02                               |
|   |   |  |                          |  |                              |                                     |   |

| Health Financial Systems                 | METHODI ST HOSI | PITALS, INC  |                 | In Lie          | u of Form CMS-2 | 2552-10 |
|--|-----------------|--------------|-----------------|-----------------|-----------------|---------|
| ALLOCATION OF CAPITAL RELATED COSTS      |                 | Provi der Co |                 | Peri od:        | Worksheet B     |         |
|  |                 |              |                 | From 01/01/2021 |                 |         |
|  |                 |              | '               | To 12/31/2021   |                 |         |
|  |                 |              |                 |                 | 5/27/2022 9:0   | 2 am    |
| Cost Center Description                  | PURCHASI NG     | ADMITTI NG   | CASHI ERI NG/AC | OTHER A&G       | PATI ENT        |         |
|  | RECEIVING AND   |              | COUNTS          |                 | TRANSPORTATIO   |         |
|  | STORES          |              | RECEI VABLE     |                 | N               |         |
|  | 5. 02           | 5. 03        | 5. 04           | 5. 05           | 5. 06           |         |
| 193. 00 19300 NONPAI D WORKERS           | 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) | 89, 225         | 118, 970     | 372, 14         | 4 1, 324, 235   | 2, 809          | 202. 00 |

ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-0002

Peri od: Worksheet B From 01/01/2021 Part II To 12/31/2021 Date/Time Prepared:

5/27/2022 9:02 am Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A **PLANT** LINEN SERVICE 7. 00 9.00 10.00 11.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5 01 00550 DATA PROCESSING 5 01 00560 PURCHASING RECEIVING AND STORES 5.02 5.02 5.03 00570 ADMITTING 5.03 5.04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.04 5 05 00590 OTHER A&G 5 05 00592 PATIENT TRANSPORTATION 5.06 5.06 7.00 00700 OPERATION OF PLANT 3, 723, 370 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 69, 978 292,060 8.00 359, 568 00900 HOUSEKEEPING 81 009 9 00 9 00 10.00 01000 DI ETARY 73, 994 7, 448 323, 673 10.00 11.00 01100 CAFETERI A 51, 730 0 5, 207 234, 388 11.00 01300 NURSING ADMINISTRATION 24, 929 6, 896 13.00 2.509 0 C 13.00 01400 CENTRAL SERVICES & SUPPLY 3, 071 140, 713 14, 163 0 14.00 392 14.00 15.00 01500 PHARMACY 74, 422 C 7, 491 0 0 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16 00 44, 389 0 4, 468 8,750 16.00 01700 SOCIAL SERVICE 01701 STAFF EDUCATION 6, 395 0 17.00 0 0 17.00 644 17.01 43, 761 C 4.405 0 17.01 01702 MEDICAL EDUCATION 0 17.02 17.02 1, 468 148 0 02100 | &R SERVICES-SALARY & FRINGES APPRVD 0 21.00 O 0 0 21.00 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 22.00 17.537 0 1,765 0 22.00 23.00 02300 PARAMED ED PROGRAM 13, 206 1, 329 2, 229 23.00 NPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 1, 229, 630 262, 950 30.00 131.150123, 762 72, 722 31.00 03100 INTENSIVE CARE UNIT 77, 982 20, 485 7,849 12, 993 14, 854 31.00 03101 NEONATAL I CU 8,864 892 3, 400 31.01 31.01 04000 SUBPROVI DER - I PF 40.00 15, 593 1,570 4, 443 2, 474 40.00 04100 SUBPROVIDER - IRF 122, 654 41.00 9.726 12, 345 15, 364 5,023 41.00 04300 NURSERY 43.00 95,884 3, 465 9,651 2,729 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 33, 437 23, 569 0 12, 618 50.00 234, 163 50.01 05001 ENDOSCOPY 1.896 50.01 4,639 0 0 51.00 05100 RECOVERY ROOM 57, 105 2, 474 5,748 135 2,028 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 27, 492 6, 492 2, 767 6,852 8,300 52.00 53.00 05300 ANESTHESI OLOGY 53.00 0 0 0 5, 750 05400 RADI OLOGY-DI AGNOSTI C 208, 299 0 7, 918 54.00 20, 966 54.00 54.01 05401 RADI OLOGY - ULTRASOUND 19,841 2,710 1,997 0 3, 332 54.01 05500 RADI OLOGY-THERAPEUTI C 5, 328 0 55.00 52, 940 1, 535 1, 250 55.00 0 55 01 05501 INFUSION CENTER 1, 413 142 48 55 01 05600 RADI OI SOTOPE 56.00 35, 501 1,817 3,573 1, 326 56.00 05700 CT SCAN 33, 617 3, 680 3, 384 0 3, 360 57.00 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 16,508 1, 302 1,662 0 0 1, 471 58.00 05900 CARDI AC CATHETERI ZATI ON 6, 791 59 00 31, 536 5.386 59 00 3.174 06000 LABORATORY 60.00 92, 327 C 9, 293 12,039 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 1,511 0 152 0 5, 961 62.00 06400 I NTRAVENOUS THERAPY 64.00 0 0 64.00 0 0 06500 RESPIRATORY THERAPY 3.069 6, 430 30.488 65.00 0 65 00 66.00 06600 PHYSI CAL THERAPY 48, 170 0 4,848 3, 392 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 41, 398 4, 167 2,696 67.00 0 0 06800 SPEECH PATHOLOGY 7, 051 1, 023 68 00 C 710 68 00 69.00 06900 ELECTROCARDI OLOGY 0 470 0 2, 398 69.00 06901 CARDI AC REHAB 0 0 69.01 8 0 1, 129 69.01 0 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70.00 0 1.451 2, 751 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 0 C 0 0 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 6,525 657 822 73.00 07400 RENAL DIALYSIS 17, 207 1, 941 74.00 732 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 299, 072 7, 541 30, 102 6, 851 90.00 91.00 09100 EMERGENCY 106, 244 44, 731 10, 694 20, 936 17, 814 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS 92.00 92.00 0 101.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 3, 562, 546 292, 060 343, 380 323, 673 234, 388 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 7, 070 712 0 190, 00 191. 00 19100 RESEARCH 0 0 0 191.00 0 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 192.00 10.555 0 104, 862 0 192. 01 19201 OTHER NON-REI MBURSABLE 13, 572 0 1, 366 0 0 192.01 192. 02 19202 FAMILY HEALTH/GARY COMM HEALTH 0 192.02 35, 320 0 3,555 0 193. 00 19300 NONPALD WORKERS 0 0 193.00

| Health Financial Systems            | METHODIST HOSPIT | ALS, INC  |              | In Lie                                       | u of Form CMS-2552-10                                     |
|-------------------------------------|------------------|-----------|--------------|--|---|
| ALLOCATION OF CAPITAL RELATED COSTS |                  | Provi der | CCN: 15-0002 | Peri od:<br>From 01/01/2021<br>To 12/31/2021 | Worksheet B Part II Date/Time Prepared: 5/27/2022 9:02 am |

|   |         |                                   |              |               |               |          | 5/27/2022 9:0 | 2 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        |        |
| - | 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, 723, 370  | 292, 060      | 359, 568      | 323, 673 | 234, 388      | 202.00 |

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

|                  |   |                       |                      | 10           | 12/31/2021            | Date/lime Pre<br>  5/27/2022 9:0 |                  |
|------------------|---|-----------------------|----------------------|--------------|-----------------------|----------------------------------|------------------|
|                  | Cost Center Description   | NURSI NG              | CENTRAL              | PHARMACY     | MEDI CAL              | SOCI AL                          |                  |
|                  |   | ADMI NI STRATI O<br>N | SERVICES & SUPPLY    |              | RECORDS &<br>LI BRARY | SERVI CE                         |                  |
|                  |   | 13. 00                | 14. 00               | 15. 00       | 16. 00                | 17. 00                           |                  |
|                  | GENERAL SERVICE COST CENTERS  |                       |                      |              |                       |                                  |                  |
| 1.00             | 00100 CAP REL COSTS-BLDG & FIXT   |                       |                      |              |                       |                                  | 1.00             |
| 4. 00<br>5. 01   | 00400 EMPLOYEE BENEFITS DEPARTMENT<br>00550 DATA PROCESSING                             |                       |                      |              |                       |                                  | 4. 00<br>5. 01   |
| 5. 02            | 00560 PURCHASING RECEIVING AND STORES   |                       |                      |              |                       |                                  | 5.02             |
| 5. 03            | 00570 ADMITTING   |                       |                      |              |                       |                                  | 5. 03            |
| 5.04             | 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE   |                       |                      |              |                       |                                  | 5. 04            |
| 5. 05            | 00590 OTHER A&G   |                       |                      |              |                       |                                  | 5. 05            |
| 5. 06<br>7. 00   | 00592 PATIENT TRANSPORTATION<br>00700 OPERATION OF PLANT                                |                       |                      |              |                       |                                  | 5. 06<br>7. 00   |
| 8. 00            | 00800 LAUNDRY & LINEN SERVICE   |                       |                      |              |                       |                                  | 8.00             |
| 9. 00            | 00900 HOUSEKEEPI NG   |                       |                      |              |                       |                                  | 9.00             |
| 10.00            | 01000 DI ETARY  |                       |                      |              |                       |                                  | 10.00            |
| 11.00            | 01100 CAFETERI A  | 440.040               |                      |              |                       |                                  | 11.00            |
| 13. 00<br>14. 00 | 01300 NURSING ADMINISTRATION<br>01400 CENTRAL SERVICES & SUPPLY                         | 142, 310              | 404 E4E              |              |                       |                                  | 13. 00<br>14. 00 |
| 15. 00           | 01500 PHARMACY  | 0                     | 606, 565<br>0        | l            |                       |                                  | 15.00            |
| 16. 00           | 01600 MEDICAL RECORDS & LIBRARY   | o                     | 0                    | 0            | 208, 819              |                                  | 16.00            |
| 17.00            | 01700 SOCI AL SERVI CE  | 0                     | 0                    | 0            | 0                     | 29, 179                          | 17. 00           |
| 17. 01           | 01701 STAFF EDUCATION   | 0                     | 0                    | 0            | 0                     | 0                                | 17. 01           |
| 17. 02<br>21. 00 | 01702 MEDI CAL EDUCATI ON   | 0                     | 0                    | 0            | 0                     | 0                                | 17. 02           |
| 22. 00           | 02100   &R SERVICES-SALARY & FRINGES APPRVD 02200   &R SERVICES-OTHER PRGM COSTS APPRVD | 0                     | 0                    | 0            | 0                     | 0                                | 21. 00<br>22. 00 |
| 23. 00           | 02300 PARAMED ED PROGRAM  | 2, 171                | 0                    |              | 0                     | Ö                                | 23.00            |
|                  | INPATIENT ROUTINE SERVICE COST CENTERS  |                       |                      |              |                       |                                  |                  |
| 30.00            | 03000 ADULTS & PEDIATRICS   | 70, 809               | 0                    |              | 15, 768               |                                  | 30.00            |
| 31. 00<br>31. 01 | 03100   INTENSI VE CARE UNIT<br>  03101   NEONATAL   I CU                               | 14, 464<br>3, 311     | 0                    | 0            | 3, 473<br>932         | 0                                | 31.00<br>31.01   |
| 40. 00           | 04000 SUBPROVI DER - I PF   | 2, 409                | 0                    | 0            | 338                   |                                  | 40.00            |
| 41. 00           | 04100 SUBPROVI DER - I RF   | 4, 891                | 0                    |              | 656                   |                                  | ı                |
| 43.00            | 04300 NURSERY   | 2, 657                | 0                    | 0            | 293                   | 0                                | 43.00            |
| F0 00            | ANCILLARY SERVICE COST CENTERS  | 40.007                |                      |              | 04.007                |                                  | 1 50 00          |
| 50. 00<br>50. 01 | 05000 OPERATI NG ROOM<br>05001 ENDOSCOPY  | 12, 287<br>1, 846     | 0                    |              | 24, 886<br>1, 841     | 0                                | 50. 00<br>50. 01 |
| 51. 00           | 05100 RECOVERY ROOM   | 1, 975                | 0                    |              | 1, 769                | 0                                | 51.00            |
| 52.00            | 05200 DELIVERY ROOM & LABOR ROOM  | 8, 082                | 0                    | 0            | 651                   | 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            | 6, 009                | 0                                | 54.00            |
| 54. 01<br>55. 00 | 05401   RADI OLOGY - ULTRASOUND<br>  05500   RADI OLOGY-THERAPEUTI C                    | 0                     | 0                    | 0            | 3, 336<br>3, 335      | 0                                | 54. 01<br>55. 00 |
| 55. 01           | 05501 I NFUSI ON CENTER   |                       | 0                    | 0            | 19                    |                                  | 55. 01           |
| 56.00            | 05600 RADI OI SOTOPE  | 0                     | 0                    | 0            | 2, 362                | 0                                | 56.00            |
| 57.00            | 05700 CT SCAN   | 0                     | 0                    | 0            | 19, 815               |                                  | 57. 00           |
| 58.00            | 05800 MAGNETIC RESONANCE I MAGING (MRI)   | 0                     | 0                    | 0            | 4, 596                | 0                                | 58.00            |
| 59. 00<br>60. 00 | 05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY                               | 0                     | 0                    | 0<br>20, 693 | 10, 377<br>33, 386    | 0                                | 59. 00<br>60. 00 |
|                  | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS  | 0                     | 0                    | 20, 073      | 1, 793                |                                  |                  |
|                  | 06400 I NTRAVENOUS THERAPY  | 0                     | 0                    | 0            | 0                     |                                  |                  |
| 65.00            | 06500 RESPI RATORY THERAPY  | 0                     | 0                    | 0            | 6, 314                | 0                                | 65.00            |
| 66.00            |   | 0                     | 0                    | 0            | 1, 153                |                                  | 66.00            |
| 67. 00<br>68. 00 | 06700 OCCUPATI ONAL THERAPY<br>06800 SPEECH PATHOLOGY                                   | 0                     | 0                    |              | 840<br>425            |                                  | 67. 00<br>68. 00 |
| 69. 00           | 06900 ELECTROCARDI OLOGY  | o                     | 0                    | Ö            | 3, 784                |                                  | 69.00            |
| 69. 01           | 06901 CARDI AC REHAB  | 0                     | 0                    | 0            | 161                   | 0                                | 69. 01           |
| 70.00            | 07000 ELECTROENCEPHALOGRAPHY  | 0                     | 0                    | 0            | 4, 793                |                                  | 70.00            |
| 71.00            | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS         | 0                     | 327, 477<br>279, 088 |              | 8, 112<br>5, 207      | 0                                | 71.00<br>72.00   |
|                  | 07300 DRUGS CHARGED TO PATIENTS   | 0                     | 279,000              |              | 5, 207<br>23, 859     |                                  | 73.00            |
|                  | 07400 RENAL DIALYSIS  | o                     | 0                    |              | 1, 382                | Ö                                | 74.00            |
|                  | OUTPATIENT SERVICE COST CENTERS   |                       |                      |              |                       |                                  |                  |
|                  | 09000 CLINIC  | 62                    | 0                    |              | 3, 532                |                                  | 90.00            |
|                  | 09100 EMERGENCY<br>09200 OBSERVATION BEDS (NON-DISTINCT PART)                           | 17, 346               | 0                    | 0            | 13, 042               | 1, 211                           | 91.00<br>92.00   |
| 92.00            | OTHER REIMBURSABLE COST CENTERS   |                       |                      |              |                       |                                  | 92.00            |
| 101.00           | 10100 HOME HEALTH AGENCY  | 0                     | 0                    | 378          | 580                   | 0                                | 101.00           |
|                  | SPECIAL PURPOSE COST CENTERS  |                       |                      |              |                       |                                  |                  |
| 118.00           |   | 142, 310              | 606, 565             | 332, 658     | 208, 819              | 29, 179                          | 118. 00          |
| 100 00           | NONREIMBURSABLE COST CENTERS   19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN                | ام                    | ^                    |              | 0                     | ^                                | 190. 00          |
|                  | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN   |                       | 0                    |              | 0                     |                                  | 190.00           |
|                  | 19200 PHYSICIANS' PRIVATE OFFICES   |                       | 0                    | 3, 246       | 0                     |                                  | 192.00           |
| 192. 01          | 19201 OTHER NON-REIMBURSABLE  | 0                     | 0                    | 0            | 0                     | 0                                | 192. 01          |
| 192. 02          | 19202 FAMILY HEALTH/GARY COMM HEALTH  | 0                     | 0                    | 0            | 0                     | 0                                | 192. 02          |
|                  |   |                       |                      |              |                       |                                  |                  |

| Health Financial Systems            | METHODIST HOS                | SPITALS, INC          |          | In Lie                                       | u of Form CMS-2  | 2552-10 |
|-------------------------------------|------------------------------|-----------------------|----------|--|--|---------|
| ALLOCATION OF CAPITAL RELATED COSTS |                              | Provi der C           |          | Peri od:<br>From 01/01/2021<br>To 12/31/2021 | Worksheet B<br>Part II<br>Date/Time Pre<br>5/27/2022 9:0 |         |
| Cost Center Description             | NURSI NG<br>ADMI NI STRATI O | CENTRAL<br>SERVICES & | PHARMACY | MEDI CAL<br>RECORDS &                        | SOCI AL<br>SERVI CE                                      |         |

|         |                                   |                  |            |          |           | 5/2//2022 9:0 | <u> </u> |
|---------|-----------------------------------|------------------|------------|----------|-----------|---------------|----------|
|         | 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        |          |
| 193.001 | 9300 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) | 142, 310         | 606, 565   | 335, 904 | 208, 819  | 29, 179       | 202.00   |

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

| Date      |         |       |   |          |          |                |                | 5/27/2022 9:0 |         |
|--|---------|-------|---|----------|----------|----------------|----------------|---------------|---------|
| DECIDITION   SECURATION   PT & PRINCES   R PROCUESTS   PROGRAMA  |         |       |   |          |          | INTERNS &      | RESI DENTS     |               |         |
|  |         |       | Cost Center Description                 | STAFF    | MEDI CAL | SERVI CES-SALA | SERVI CES-OTHE | PARAMED ED    |         |
| Cherent Service COST CENTERS   |         |       | ·                                       |          |          |                |                |               |         |
| 1.00   007000 CAR FELL COSTS-BLUE & FIXT   |         | CENED | AL SEDVICE COST CENTEDS                 | 17. 01   | 17. 02   | 21.00          | 22. 00         | 23. 00        |         |
| 4. 00 0.0000 PARP DIVER EMPRITYS DEPARMENT 5. 01 000550 PARCHESIN ARCHESI VIN AND STORES 5. 01 000550 PARCHESIN ARCHESI VIN AND STORES 5. 00 00050 PARCHESIN ARCHESI VIN ARCHE | 1. 00   |       |   |          |          |                |                |               | 1.00    |
| 5.02   One-of-PuriChasting RECELVING AND STORES   5.02   5.04   ODE-OFF AND TEN IN CASH EVEN PACKAGE RECELVABLE   5.02   5.04   ODE-OFF AND TEN IN CASH EVEN PACKAGE RECELVABLE   5.02   5.04   ODE-OFF AND TEN IT REMANSCRIPT ON   5.04   7.00   ODE-OFF AND TEN IT REMANSCRIPT ON   7.00   7.00   OT-OFF AND TEN IT REMANSCRIPT ON |         |       | 1                                       |          |          |                |                |               | 1       |
| 5.03   00-570   AMM ITTING   5.04   5.05   6 |         |       |   |          |          |                |                |               | 1       |
| 5.04   0.00680   CASHI ENI NOVACOUNTS RECEIVABLE     5.04  |         |       |   |          |          |                |                |               | 1       |
| 5.00   |         | 1     | 1                                       |          |          |                |                |               | 1       |
| 7. 0.0   0.0700   0.0700   0.0FEATION OF PLANT   |         |       |   |          |          |                |                |               | 1       |
| 8.00   00000  CAUNDRY & LINEN SERVICE   9.00   9.00   10.00   DIETARY   11.00   DIETARY   11 |         | 1     | •                                       |          |          |                |                |               | 1       |
| 9.00 (0.900) POLISTEREP ING 11.00 (0.1000) ET FARY 11.00 (0.000) ET FARY 11.0 |         | 1     | •                                       |          |          |                |                |               | 1       |
| 11.00   1100   CAFETERIA   |         | 00900 | HOUSEKEEPI NG                           |          |          |                |                |               | 1       |
| 13.00   01300   MIRSH NG AMM IN STRATION     11.00   14.00     |         | 1     | i e                                     |          |          |                |                |               | 1       |
| 14.00   01400   CENTRAL SERVICES & SUPPLY     14.00   16.00   16.00   MEDICAL RECORDS & LIBRARY     15.00   16.00   MEDICAL RECORDS & LIBRARY     16.00   17.01   17.01   17.00   17.00   17.00   17.00   17.00   17.00   17.01   17   |         |       | i i                                     |          |          |                |                |               |         |
| 15.00   01500   PARABACY   |         |       |   |          |          |                |                |               |         |
| 17.00   01700   SOCIAL SERVICE     17.00   17.01   1   |         |       |   |          |          |                |                |               | 1       |
| 17.01   1702   1702   MEDICATION   183,679   17.01   17.02   17   |         |       |   |          |          |                |                |               | 1       |
| 17.00   0.702   MEDICAL EDUCATION   20   6.229   1.045   1.045   2.100   2.1   |         | 1     | i e                                     | 183 679  |          |                |                |               | 1       |
| 22.00   02200   RAY SERVICES-OTHER PROM COSTS APPRVD   0   0   73,735   03,688   22.00   0300   PARAMED ED PROMORAM   64   0   0   33.00   03.00   03000   AUITS & PEDROGRAM   04   0   0   3.00   03.00   03000   AUITS & PEDROGRAM   04   0   0   31.00   03.00   03100   AUITS & PEDROGRAM   04   0   0   31.00   03100   NUTSINI VIC CARE UNIT   12,812   0   31.00   03100   NUTSINI VIC CARE UNIT   12,812   0   31.00   03.00   NUTSINI VIC CARE UNIT   12,812   0   31.00   04.00   04000   SUBPROVI DER - I PF   7.722   0   40.00   41.00   04100   SUBPROVI DER - I PF   7.722   0   41.00   04100   SUBPROVI DER - I PF   7.722   0   41.00   04100   SUBPROVI DER - I PF   7.722   0   41.00   04100   SUBPROVI DER - I PF   7.722   0   41.00   04100   SUBPROVI DER - I PF   7.722   0   41.00   04100   SUBPROVI DER - I PF   7.722   0   41.00   04100   SUBPROVI DER - I PF   7.722   0   41.00   04100   SUBPROVI DER - I PF   7.722   0   41.00   04100   SUBPROVI DER - I PF   7.722   0   41.00   04100   SUBPROVI DER - I PF   7.722   0   41.00   04100   SUBPROVI DER - I PF   7.722   0   41.00   04100   SUBPROVI DER - I PF   7.722   0   41.00   04100   SUBPROVI DER - I PF   7.722   0   41.00   04100   SUBPROVI DER - I PF   7.722   0   55.00   04100   SUBPROVI DER - I PF   7.722   0   0   55.00   04100   SUBPROVI DER - I PF   7.722   0   0   55.00   04100   SUBPROVI DER - I PF   7.722   0   0   55.00   05.00   SUBPROVI DER - I PF   7.722   0   0   55.00   05.00   SUBPROVI DER - I PF   7.722   0   0   55.00   05.00   SUBPROVI DER - I PF   7.722   0   0   55.00   05.00   SUBPROVI DER - I PF   7.722   0   0   55.00   0   55.00   05.00   SUBPROVI DER - I PF   7.722   0   0   55.00   0   55   |         |       | i e                                     |          | 6, 229   |                |                |               |         |
| 0.3000   PARAMED ED PROCRAM   6-4   0   6.3, 568   23. 00  |         |       |   | 0        |          |                |                |               | 1       |
| INPATI ENT ROUTI NE SERVICE COST CENTERS   30  |         |       | 1                                       | 0        |          |                | 73, 735        | 62 560        |         |
| 30.00  | 23.00   |       |   | 04]      | 0        | l              |                | 03, 500       | 23.00   |
| 31.01  |         | 03000 | ADULTS & PEDIATRICS                     |          |          |                |                |               | 1       |
| 40. 00   040000   SUBPROVI DER - I PF  |         | 1     | l e e e e e e e e e e e e e e e e e e e |          |          |                |                |               | 1       |
| 11.00   04100   SUPROVI DER - I RF   |         | 1     | l e                                     |          |          |                |                |               | 1       |
| ANCIL LLARY SERVICE COST CENTERS   50.00   5   |         | 1     | l e                                     | l l      |          |                |                |               | 1       |
| 50. 00   05000   DEDOSCOPY   | 43.00   |       |   | 3, 817   | 0        |                |                |               | 43.00   |
| 50. 01   OSDO1   ENDOSCOPY   | 50.00   |       |   | 10.050   | 0        |                |                |               | 50.00   |
| 51.00   05100   RECOVERY ROOM   A 648   0   51.00   52.00   05200   DELIVERY ROOM   & LABOR ROOM   10.031   0   52.00   05200   DELIVERY ROOM   & LABOR ROOM   53.00   53.00   05300   ANESTHESI OLOGY   0   0   0   54.00   53.00   54.00   55.00   55.00   55.00   65.00   RADIO LOGY - HERAPEUTI C   518   0   55.00   55.00   55.00   55.00   55.00   65   |         |       |   |          |          |                |                |               | 1       |
| 53.00   05300   ANESTHESI OLOGY   0   0   54.00   54.00   54.00   54.00   54.00   54.00   54.00   54.00   54.00   54.00   54.00   54.00   54.00   54.00   54.00   54.00   54.00   54.00   55.00   55.00   55.00   55.00   55.00   55.00   55.00   55.00   55.00   55.00   55.00   55.00   55.00   55.00   55.00   55.00   55.00   56.00   66   |         | 1     | i e                                     |          |          |                |                |               | 1       |
| 54. 00   05400 RADI OLOGY-DI AGNOSTIC   3,862   0   54. 00   54. 01   55. 00   55. 01   55. 00   55. 01   55. 00   55. 01   55. 00   55. 01   55. 00   55. 01   55. 00   55. 01   55. 00   55. 01   55. 00   55. 01   55. 00   55. 01   55. 00   55. 01   55. 00   55. 01   55. 00   55. 01   55. 00   55. 01   55. 00   55. 00   55. 01   55. 00   55.   |         | 1     | i e                                     | 10, 031  | -        |                |                |               | 1       |
| SA-01   G5401   RADI OLOGY - ULTRASQUIND   2, 245   0   55.0   |         | 1     | i e                                     | 3 863    |          |                |                |               |         |
| 55. 00   05500   RADI OLOGY-THERAPEUTIC   518   0   0   0   0   0   0   0   0   0  |         | 1     | i e                                     |          | -        |                |                |               |         |
| 56.00   05600   RABJO I SOTOPE   4   |         |       |   | 518      |          |                |                |               |         |
| 57.00   05700   05700   05700   05800   MAGNETIC RESONANCE I MAGI NG (MRI )  |         | 1     | •                                       | 0        |          |                |                |               |         |
| 58.00   05900   CARDIAC CATHETERI ZATION   6,510   0   59.00   05900   CARDIAC CATHETERI ZATION   6,510   0   59.00   06000   LABORATORY   455   0   60.00   06000   LABORATORY   455   0   60.00   06400   INTRAVENDUS THERAPY   0   0   0   64.00   06400   INTRAVENDUS THERAPY   0   0   0   06500   RESPIRATORY THERAPY   1,455   0   65.00   06500   RESPIRATORY THERAPY   1,455   0   06.00   06500   RESPIRATORY THERAPY   1,455   0   06.00   06600   06700   0CCUPATIONAL THERAPY   123   0   06700   0CCUPATIONAL THERAPY   123   0   06700   0CCUPATIONAL THERAPY   137   0   06.00   06900   SPEECH PATHOLOGY   137   0   06.00   06900   SPEECH PATHOLOGY   137   0   06.00   06900   SPEECH PATHOLOGY   2,328   0   06.00   06   |         |       |   | 3 549    | 0        |                |                |               | 1       |
| 60. 00   06000   LABORATORY   455   0   60. 00   62. 00   62. 00   62. 00   62. 00   62. 00   62. 00   62. 00   62. 00   62. 00   63. 00   64. 00   64. 00   64. 00   64. 00   64. 00   64. 00   65. 00   65. 00   65. 00   65. 00   65. 00   65. 00   65. 00   65. 00   66. 00   |         | 1     | •                                       | 0        | 0        |                |                |               | 1       |
| 62. 00   66200   WHOLE BLOOD & PACKED RED BLOOD CELLS   171   0   64. 00   64.00   66400   INTRAVENOUS THERAPY   0   0   0   64. 00   66.00   66500   RESPIRATORY THERAPY   1, 455   0   65. 00   66. 00   666. 00   66600   PHYSI CAL THERAPY   294   0   66. 00   66.  |         |       |   |          |          |                |                |               |         |
| 64. 00   06400   INTRAVENOUS THERAPY   0   0   65. 00   65. 00   06500   RESPI RATORY THERAPY   1,455   0   66. 00   66. 00   06600   PHYSI CAL THERAPY   294   0   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   123   0   67. 00   68. 00   06800   SPECH PATHOLOGY   137   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   2,328   0   69. 00   69. 01   06901   CARDI AC REHAB   16   0   69. 01   70. 00   07000   ELECTROENCEPHALOGRAPHY   1,366   0   71. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   71. 00   72. 00   07200   IMPL DEV. CHARGED TO PATI ENTS   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   516   0   72. 00   74. 00   07400   RENAL DI ALYSI S   0   0   0   00   07400   RENAL DI ALYSI S   0   0   0   00   07400   DRUGS CHARGED TO PATI ENTS   516   0   0   00   09000   CLI NIC   0   0   0   00   09100   DRUGS CHARGED TO PATI ENTS   0   0   0   00   09100   DRUGS CHARGED TO PATI ENTS   0   0   0   00   09100   DRUGS CHARGED TO PATI ENTS   0   0   0   00   09100   DRUGS CHARGED TO PATI ENTS   0   0   0   00   09100   DRUGS CHARGED TO PATI ENTS   0   0   0   00   07400   RENAL DI ALYSI S   0   0   0   00   09100   DRUGS CHARGED TO PATI ENTS   0   0   0   00   09100   DRUGS CHARGED TO PATI ENTS   0   0   0   00   09100   DRUGS CHARGED TO PATI ENTS   0   0   0   00   09100   DRUGS CHARGED TO PATI ENTS   0   0   0   00   09100   DRUGS CHARGED TO PATI ENTS   0   0   0   00   09100   DRUGS CHARGED TO PATI ENTS   0   0   0   00   09100   DRUGS CHARGED TO PATI ENTS   0   0   0   00   09100   DRUGS CHARGED TO PATI ENTS   0   0   0   00   09100   DRUGS CHARGED TO PATI ENTS   0   0   0   00   09100   DRUGS CHARGED TO PATI ENTS   0   0   0   00   09100   DRUGS CHARGED TO PATI ENTS   0   0   0   00   09100   DRUGS CHARGED TO PATI ENTS   0   0   0   00   09100   DRUGS CHARGED TO PATI ENTS   0   0   0   00   09100   DRUGS CHARGED TO PATI ENTS   0   0   0   00   09100   DRUGS CHARGED TO PATI ENTS   0   0   0   00   09100   DRUGS CHARGED TO PATI ENTS   0   0   0   00   09100   DRUG |         |       | i e                                     | 1        |          | •              |                |               | 1       |
| 66. 00   06600   PHYSI CAL THERAPY   294   0   66. 00   67. 00   06700   OCCUPATI ONAL THERAPY   123   0   67. 00   68. 00   06800   SPECCH PATHOLOGY   137   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   2, 328   0   69. 00   69. 01   06901   CARDI AC REHAB   16   0   69. 01   70. 00   07000   ELECTROENCEPHALOGRAPHY   1, 366   0   71. 00   71. 00   07100   MEDI CAL 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   516   0   73. 00   74. 00   07400   RENAL DI ALYSIS   0   0   0   74. 00   00100   EMERGENCY   26, 921   6, 229   91. 00   79. 00   09000   CLINIC   476   0   79. 00   09000   DEMERGENCY   26, 921   6, 229   91. 00   70   OTHER REI MBURSABLE COST CENTERS   70   00100   HOME HEALTH AGENCY   768   0   101. 00   70   NONREI MBURSABLE COST CENTERS   70   00   1000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   70   00   00   00   0   0   70   00   0   |         |       |   | ı        |          |                |                |               | 1       |
| 67. 00 06700 0CCUPATI ONAL THERAPY 123 0 68. 00 68. 00 06800 SPEECH PATHOLOGY 137 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 2, 328 0 69. 01 70. 00 06900 ELECTROCARDI OLOGY 2, 328 0 69. 01 70. 00 07000 ELECTROCARDI OLOGY 1, 366 0 69. 01 70. 00 07000 ELECTROCROEPHALOGRAPHY 1, 366 0 70. 00 71. 00 07000 ELECTROENCEPHALOGRAPHY 1, 366 0 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 77. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 0 77. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 516 0 77. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 77. 00 00 00 07400 RENAL DI ALYSI S 0 0 0 0 77. 00 00 09000 CLI NI C 476 0 90. 00 91. 00 09000 CLI NI C 476 0 90. 00 91. 00 09200 DEMERGENCY 26, 921 6, 229 9 91. 00 00 DITHER REI MBURSABLE COST CENTERS  101. 00 10100 HOME HEALTH AGENCY 768 0 10. 101. 00 SPECI AL PURPOSE COST CENTERS  118. 00 SUBTOTALS (SUM OF LI NES 1 through 117) 180, 845 6, 229 0 0 0 0 0 118. 00 NONREI MBURSABLE COST CENTERS  119. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 191. 00 191. 00 19100 RESEARCH 0 0 0 19100 RESEARCH 0 0 0 191. 00 192. 00 19200 DI PASSICH OF PRIVATE OFFI CES 2, 743 0 192. 00  |         |       |   |          | 0        |                |                |               |         |
| 68.00   06800   SPEECH PATHOLOGY   137   0   68.00   69.00   69.00   69.00   ELECTROCARDI OLOGY   2,328   0   69.00   69.01    |         |       | 1                                       | l l      | 0        |                |                |               | 1       |
| 69. 00 06900   ELECTROCARDI OLOGY   2, 328   0   69. 00   69. 01 06901   CARDI AC REHAB   16   0   69. 01   70. 00 07000   ELECTROENCEPHALOGRAPHY   1, 366   0   70. 00   71. 00 07100   MEDI CAL 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   516   0   73. 00   74. 00 07400   RENAL DI ALYSIS   0   0   0   74. 00   00 07400   RENAL DI ALYSIS   0   0   0   01 07400   OFFICIAL DI ALYSIS   0   0   0   09000   CLI NI C   476   0   90. 00 09000   CLI NI C   476   0   91. 00 09100   EMERGENCY   26, 921   6, 229   91. 00   92. 00 09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   92. 00   00 00 00 00 00 00 00 00 00 00 00 00 00   |         |       |   | l l      | 0        |                |                |               | 1       |
| 70. 00   |         | 1     | •                                       | ı        | 0        |                |                |               |         |
| 71. 00   |         |       |   | 1        | 0        |                |                |               |         |
| 72. 00   |         |       |   | 1, 366   | 0        |                |                |               |         |
| 74. 00   |         |       |   | 0        | 0        |                |                |               |         |
| OUTPATIENT SERVICE COST CENTERS   90.00   09000   CLINIC   476   0   90.00   91.00   91.00   91.00   91.00   92.00   09100   EMERGENCY   26,921   6,229   91.00   92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   92.00   OTHER REI MBURSABLE COST CENTERS   101.00   HOME HEALTH AGENCY   768   0   101.00   SPECIAL PURPOSE COST CENTERS   18.00   SUBTOTALS (SUM OF LINES 1 through 117)   180,845   6,229   0   0   0   118.00   NONREI MBURSABLE COST CENTERS   190.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   191.00   191.00   19100   RESEARCH   0   0   0   191.00   192.0   | 73.00   | 07300 | DRUGS CHARGED TO PATIENTS               | 516      |          |                |                |               | 73.00   |
| 90. 00   | 74. 00  |       |   | 0        | 0        |                |                |               | 74. 00  |
| 91. 00   | 90 00   |       |   | 476      | 0        |                |                |               | 90.00   |
| OTHER REIMBURSABLE COST CENTERS   101. 00   10100   HOME HEALTH AGENCY   768   0   101. 00   |         | 1     | •                                       | l l      |          |                |                |               |         |
| 101. 00   10100   HOME   HEALTH   AGENCY   768   0     101. 00   SPECI   AL   PURPOSE   COST   CENTERS     18. 00     SUBTOTALS   (SUM OF LINES 1 through 117)   180, 845   6, 229   0   0   0   0   118. 00     18. 00     190. 00   190. 00   GIFT,   FLOWER,   COFFEE   SHOP & CANTEEN   0   0   0   191. 00   192. 00   19200   PHYSI CI   ANS'   PRI VATE   OFFI CES   2, 743   0   192. 00   | 92. 00  |       |   |          |          |                |                |               | 92.00   |
| SPECIAL PURPOSE COST CENTERS   | 101 00  |       |   | 740      | ^        |                |                |               | 101 00  |
| 118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   180, 845   6, 229   0   0   0   118. 00   | 101.00  |       |   | /08      | 0        |                |                |               | 1101.00 |
| 190. 00     19000 GFT, FLOWER, COFFEE SHOP & CANTEEN     0     0     190. 00       191. 00     191. 00     191. 00     191. 00       192. 00     19200 PHYSI CI ANS' PRI VATE OFFI CES     2, 743     0     192. 00  | 118.00  |       | SUBTOTALS (SUM OF LINES 1 through 117)  | 180, 845 | 6, 229   | 0              | 0              | 0             | 118. 00 |
| 191. 00   19100   RESEARCH 0 0 0 191. 00 192. 00   192.  | 100.00  |       |   | al       | _        |                |                |               | 100.00  |
| 192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES 2, 743 0   192. 00   |         |       |   | - 1      |          |                |                |               |         |
|  | 192.00  | 19200 | PHYSICIANS' PRIVATE OFFICES             | ٩        |          |                |                |               | 192. 00 |
|  | 192. 01 | 19201 | OTHER NON-REIMBURSABLE                  | 0        | 0        |                |                |               | 192. 01 |

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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002 From 01/01/2021 From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/27/2022 9:02 am

|               |                                   |            |            |                |                | 5/2//2022 9:0 | 2 am    |
|---------------|-----------------------------------|------------|------------|----------------|----------------|---------------|---------|
|               |                                   |            |            | INTERNS &      | RESI DENTS     |               |         |
|               |                                   |            |            |                |                |               |         |
|               | Cost Center Description           | STAFF      | MEDI CAL   | SERVI CES-SALA | SERVI CES-OTHE | PARAMED ED    |         |
|               |                                   | EDUCATI ON | EDUCATI ON | RY & FRINGES   | R PRGM COSTS   | PROGRAM       |         |
|               |                                   | 17. 01     | 17. 02     | 21.00          | 22. 00         | 23. 00        |         |
| 192. 02 19202 | FAMILY HEALTH/GARY COMM HEALTH    | 91         | 0          |                |                |               | 192. 02 |
| 193. 00 19300 | NONPALD WORKERS                   | 0          | 0          |                |                |               | 193. 00 |
| 200. 00       | Cross Foot Adjustments            |            |            | 1, 045         | 73, 735        | 63, 568       | 200.00  |
| 201.00        | Negative Cost Centers             | 0          | 0          | 0              | 0              | 0             | 201.00  |
| 202.00        | TOTAL (sum lines 118 through 201) | 183, 679   | 6, 229     | 1, 045         | 73, 735        | 63, 568       | 202.00  |

Health Financial Systems In Lieu of Form CMS-2552-10 METHODIST HOSPITALS, INC Provi der CCN: 15-0002 ALLOCATION OF CAPITAL RELATED COSTS Peri od: Worksheet B From 01/01/2021 Part II Date/Time Prepared: 12/31/2021 5/27/2022 9:02 am Cost Center Description Subtotal Intern & Total Resi dents Cost & Post Stepdown Adj ustments 24. 00 26.00 25.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 4 00 5.01 00550 DATA PROCESSING 5.01 00560 PURCHASING RECEIVING AND STORES 5.02 5.02 00570 ADMITTING 5.03 5.03 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.04 5.04 5.05 00590 OTHER A&G 5.05 00592 PATIENT TRANSPORTATION 5.06 5.06 7 00 00700 OPERATION OF PLANT 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 01701 STAFF EDUCATION 17.01 17.01 01702 MEDICAL EDUCATION 17.02 17.02 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 22.00 23 00 02300 PARAMED ED PROGRAM 23 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 6, 083, 843 6, 083, 843 30.00 03100 INTENSIVE CARE UNIT 31.00 474, 104 0 474, 104 31.00 03101 NEONATAL I CU 59, 638 31 01 59, 638 0 31 01 04000 SUBPROVI DER - I PF 40.00 82, 155 0 82, 155 40.00 04100 SUBPROVI DER - I RF 576, 495 0 576, 495 41.00 41.00 43.00 04300 NURSERY 424, 528 0 424, 528 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 182, 536 0 1, 182, 536 50.00 05001 ENDOSCOPY 50.01 26, 345 26, 345 50.01 51.00 05100 RECOVERY ROOM 259, 292 0 259, 292 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 179, 511 0 179, 511 52.00 53.00 05300 ANESTHESI OLOGY 53.00 54 00 05400 RADI OLOGY-DI AGNOSTI C 931, 913 0 931, 913 54.00 05401 RADI OLOGY - ULTRASOUND 0 112.872 54.01 112,872 54.01 05500 RADI OLOGY-THERAPEUTI C 0 55.00 248, 649 248, 649 55.00 55.01 05501 INFUSION CENTER 6, 332 0 6, 332 55.01 05600 RADI OI SOTOPE 170, 373 0 170, 373 56,00 56, 00 57 00 05700 CT SCAN 234, 192 0 234, 192 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 92, 872 0 92, 872 58.00 59 00 05900 CARDIAC CATHETERIZATION 206, 588 206, 588 59.00 Oı 06000 LABORATORY 601.467 601, 467 60.00 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 27, 096 27, 096 62.00 64.00 06400 I NTRAVENOUS THERAPY 64.00 0 65.00 06500 RESPIRATORY THERAPY 180, 098 180, 098 65.00 66.00 06600 PHYSI CAL THERAPY 0 218, 109 218, 109 66,00 67.00 06700 OCCUPATI ONAL THERAPY 186, 097 0 186, 097 67.00 68.00 06800 SPEECH PATHOLOGY 35, 018 0 35, 018 68.00 0 06900 ELECTROCARDI OLOGY 22, 953 22, 953 69.00 69.00 06901 CARDI AC REHAB 4, 368 69.01 0 4.368 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 30, 186 0 30, 186 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 444, 614 0 444, 614 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 372.826 72.00 372.826 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 515, 440 C 515, 440 73.00 74.00 07400 RENAL DIALYSIS 88,666 88,666 74.00 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 90.00 1 309 168 n 1 309 168 90 00 91.00 09100 EMERGENCY 695, 659 C 695, 659 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00

17, 121

0

17, 121

| Health Financial Systems                    | METHODIST HOSPITALS, INC |              |                       | In Lieu of Form CMS-2552-10      |                             |  |
|---|--------------------------|--------------|-----------------------|----------------------------------|-----------------------------|--|
| ALLOCATION OF CAPITAL RELATED COSTS         |                          | Provi der CO | Provider CCN: 15-0002 |                                  | Worksheet B                 |  |
|   |                          |              |                       | From 01/01/2021<br>To 12/31/2021 | Part II Date/Time Prepared: |  |
|   |                          |              |                       | 10 12/31/2021                    | 5/27/2022 9: 02 am          |  |
| Cost Center Description                     | Subtotal                 | Intern &     | Total                 |                                  |                             |  |
|   |                          | Resi dents   |                       |                                  |                             |  |
|   |                          | Cost & Post  |                       |                                  |                             |  |
|   |                          | Stepdown     |                       |                                  |                             |  |
|   |                          | Adjustments  |                       |                                  |                             |  |
|   | 24. 00                   | 25. 00       | 26. 00                |                                  |                             |  |
| 192. 01 19201 OTHER NON-REI MBURSABLE       | 58, 445                  | 0            | 58, 44                | 15                               | 192. 01                     |  |
| 192.02 19202 FAMILY HEALTH/GARY COMM HEALTH | 148, 767                 | 0            | 148, 70               | 57                               | 192. 02                     |  |
| 193.00 19300 NONPALD WORKERS                | 0                        | 0            |                       | 0                                | 193. 00                     |  |
| 200.00 Cross Foot Adjustments               | 138, 348                 | 0            | 138, 34               | 18                               | 200.00                      |  |
| 201.00 Negative Cost Centers                | O                        | 0            |                       | 0                                | 201.00                      |  |
| 202.00 TOTAL (sum lines 118 through 201)    | 17, 072, 607             | o            | 17, 072, 60           | 07                               | 202. 00                     |  |

|                  | Financiai Systems  | METHODIST HOSE                                  |   |   |   | u or form CMS                             |                  |
|------------------|--|---|---|---|---|---|------------------|
| COST A           | ALLOCATION - STATISTICAL BASIS   |   | Provi der C   | F                                       | eriod:<br>from 01/01/2021<br>fo 12/31/2021                                | Worksheet B-1 Date/Time Pre 5/27/2022 9:0 | pared:           |
|                  | Cost Center Description  | CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET) | EMPLOYEE<br>BENEFITS<br>DEPARTMENT<br>(GROSS<br>SALARIES) | DATA<br>PROCESSING<br>(MACHINE<br>TIME) | PURCHASI NG<br>RECEI VI NG AND<br>STORES<br>(PURCHASE<br>REQUI SI TI ONS) | ADMITTING<br>(GROSS<br>CHARGES)           |                  |
|                  |  | 1. 00   | 4. 00   | 5. 01                                   | 5. 02   | 5. 03                                     |                  |
|                  | GENERAL SERVICE COST CENTERS   |   |   |   |   |   |                  |
| 1. 00            | 00100 CAP REL COSTS-BLDG & FIXT  | 1, 410, 133                                     |   |   |   |   | 1.00             |
| 4.00             | 00400 EMPLOYEE BENEFITS DEPARTMENT                                       | 5, 906  | 146, 403, 953   | •                                       |   |   | 4.00             |
| 5. 01<br>5. 02   | 00550 DATA PROCESSING<br>00560 PURCHASING RECEIVING AND STORES           | 9, 190<br>7, 332                                | 4, 556, 912<br>933, 907                                   | •                                       | 1   |   | 5. 01<br>5. 02   |
| 5. 02            | 00570 ADMITTING  | 9, 717  | 2, 448, 960   |   |   | 1, 417, 261, 476                          | 5.02             |
| 5. 04            | 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE                                  | 30, 646   | 2, 216, 600   |   |   | 0   | 5. 04            |
| 5.05             | 00590 OTHER A&G  | 99, 579   | 10, 432, 786  |   |   | 0   | 5. 05            |
| 5.06             | 00592 PATIENT TRANSPORTATION   | 0   | 474, 063  | C                                       | 7, 220  | 0   | 5.06             |
| 7. 00            | 00700 OPERATION OF PLANT   | 299, 329  | 3, 713, 808   |   |   | 0   | 7.00             |
| 8.00             | 00800 LAUNDRY & LINEN SERVICE  | 17, 825   | 0   | 1                                       |   | 0   | 1                |
| 9.00             | 00900 HOUSEKEEPI NG  | 20, 635   | 4, 131, 863   |   |   | 0   | 9.00             |
| 10. 00<br>11. 00 | 01000 DI ETARY<br>01100 CAFETERI A                                       | 18, 848<br>13, 177                              | 1, 311, 699<br>2, 246, 027                                | C                                       |   | 0   | 10.00            |
| 13. 00           | 01300 NURSI NG ADMI NI STRATI ON   | 6, 350  | 4, 467, 402   | 1                                       | 1   | 0   | 13.00            |
| 14. 00           | 01400 CENTRAL SERVICES & SUPPLY  | 35, 843   | 596, 961  |   |   | 0   | 14.00            |
| 15.00            | 01500 PHARMACY   | 18, 957   | 0   | C                                       |   | 0   | 15.00            |
| 16.00            | 01600 MEDICAL RECORDS & LIBRARY  | 11, 307   | 2, 091, 030   | C                                       | 6, 596  | 0   | 16.00            |
| 17. 00           | 01700 SOCI AL SERVI CE   | 1, 629  | 423, 230  | 1                                       | -   | 0   | 17. 00           |
| 17. 01           | 01701 STAFF EDUCATION  | 11, 147   | 0   | C                                       | -   | 0   | 17.01            |
| 17. 02<br>21. 00 | 01702 MEDICAL EDUCATION<br>02100 I&R SERVICES-SALARY & FRINGES APPRVD    | 374   | 469<br>0  | C                                       | .,  | 0   | 17. 02<br>21. 00 |
| 21.00            | 02200 I &R SERVICES-SALARY & FRINGES APPRVD                              | 4, 467  | 0   |   |   | 0   | 21.00            |
| 23. 00           | 02300 PARAMED ED PROGRAM   | 3, 364  | 704, 647  |   | 1   | 0   | 23.00            |
| 20.00            | INPATIENT ROUTINE SERVICE COST CENTERS                                   | 0,00.1  | 7017017   |   | 1 12, 525   |   | 20.00            |
| 30.00            | 03000 ADULTS & PEDIATRICS  | 313, 217  | 25, 611, 802  | C                                       | 4, 351, 130   | 107, 268, 496                             | 30.00            |
| 31.00            | 03100 INTENSIVE CARE UNIT  | 19, 864   | 7, 900, 355   |   | ,   | 23, 628, 573                              |                  |
| 31. 01           | 03101 NEONATAL I CU  | 2, 258  | 1, 488, 278   |   | ,   | 6, 340, 767                               |                  |
| 40.00            | 04000 SUBPROVI DER - I PF  | 3, 972  | 928, 913  |   |   | 2, 296, 180                               |                  |
| 41. 00<br>43. 00 | 04100 SUBPROVI DER - I RF<br>04300 NURSERY                               | 31, 243<br>24, 424                              | 1, 836, 234<br>1, 253, 634                                |   |   | 4, 463, 400<br>1, 996, 068                |                  |
| 43.00            | ANCILLARY SERVICE COST CENTERS   | 27, 727   | 1, 233, 034   |   | 147, 107  | 1, 770, 000                               | 1 43.00          |
| 50.00            | 05000 OPERATING ROOM   | 59, 647   | 4, 299, 823   | C                                       | 1, 069, 632   | 169, 292, 906                             | 50.00            |
| 50. 01           | 05001 ENDOSCOPY  | 0   | 721, 071  | C                                       |   | 12, 521, 947                              | 1                |
| 51.00            | 05100 RECOVERY ROOM  | 14, 546   | 974, 092  | 1                                       |   | 12, 033, 588                              | 1                |
| 52. 00<br>53. 00 | 05200 DELIVERY ROOM & LABOR ROOM   | 7, 003  | 3, 181, 984   | C                                       |   | 4, 428, 022<br>0                          | 52. 00<br>53. 00 |
| 54.00            | 05300 ANESTHESI OLOGY<br>05400 RADI OLOGY-DI AGNOSTI C                   | 53, 059   | 2, 226, 600   | -                                       | -   | 40, 875, 566                              | 1                |
| 54. 01           | 05401 RADI OLOGY - ULTRASOUND  | 5, 054  | 1, 276, 422   |   | 1   | 22, 691, 762                              | 1                |
| 55. 00           | 05500 RADI OLOGY-THERAPEUTI C  | 13, 485   | 491, 036  |   |   |   |                  |
| 55. 01           | 05501 INFUSION CENTER  | 360   | 18, 571   | C                                       | 27, 022   | 130, 187                                  |                  |
| 56. 00           | 05600 RADI OI SOTOPE   | 9, 043  | 567, 839  |   |   | 16, 069, 979                              | 1                |
| 57.00            | 05700 CT SCAN  | 8, 563  | 1, 192, 103   |   |   | 134, 797, 158                             | 1                |
| 58. 00<br>59. 00 | 05800 MAGNETIC RESONANCE IMAGING (MRI)<br>05900 CARDIAC CATHETERIZATION  | 4, 205<br>8, 033                                | 462, 789<br>2, 502, 141                                   |   |   | 31, 267, 753<br>70, 589, 396              | 1                |
| 60.00            | 06000 LABORATORY   | 23, 518   | 3, 802, 254   |   |   | 223, 819, 693                             | 1                |
| 62.00            | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS                               | 385   | 1, 169, 580   |   | ., ,  | 12, 197, 992                              |                  |
| 64.00            | 06400 I NTRAVENOUS THERAPY   | 0   | 0   | C                                       | 1   | 0   | 64.00            |
| 65.00            | 06500 RESPI RATORY THERAPY   | 7, 766  | 2, 763, 247   | C                                       | 778, 363  | 42, 954, 297                              | 65.00            |
| 66. 00           | 06600 PHYSI CAL THERAPY  | 12, 270   | 1, 373, 339   | 1                                       | .,  | 7, 841, 511                               | 66.00            |
| 67.00            | 06700 OCCUPATI ONAL THERAPY  | 10, 545   | 1, 103, 581   | C                                       | , 00,   | 5, 715, 234                               | 1                |
| 68. 00<br>69. 00 | 06800 SPEECH PATHOLOGY<br>06900 ELECTROCARDI OLOGY                       | 1, 796  | 456, 545<br>654, 669                                      |   | ., .= .   | 2, 893, 110<br>25, 742, 675               |                  |
| 69. 01           | 06901 CARDI AC REHAB   |   | 394, 960  |   | 1   | 1, 096, 565                               |                  |
| 70.00            | 07000 ELECTROENCEPHALOGRAPHY   | O   | 1, 070, 555   |   | 1   | 32, 608, 358                              |                  |
| 71.00            | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS                               | 0   | 0   | i e                                     | 1   | 55, 185, 539                              |                  |
| 72.00            | 07200 IMPL. DEV. CHARGED TO PATIENTS                                     | 0   | 0   | C                                       | , , , , , , , , , , , ,   | 35, 423, 662                              | 72.00            |
| 73.00            | 07300 DRUGS CHARGED TO PATIENTS  | 1, 662  | 360, 465  |   |   | 162, 306, 726                             | 1                |
| 74. 00           | 07400 RENAL DIALYSIS   | 4, 383  | 352   | C                                       | 29, 699   | 9, 399, 418                               | 74.00            |
| 90. 00           | OUTPATIENT SERVICE COST CENTERS  O9000 CLINIC                            | 76, 181   | 2, 742, 574   |   | 94, 540   | 24, 028, 280                              | 90.00            |
| 91.00            | 09100 EMERGENCY  | 27, 063   | 7, 422, 718   |   |   | 88, 722, 447                              | 91.00            |
| 92. 00           | 09200 OBSERVATION BEDS (NON-DISTINCT PART)                               | 27,000  | 7, 122, 710   |   | 2, 200, 220   | 00,722,117                                | 92.00            |
|                  | OTHER REIMBURSABLE COST CENTERS  |   |   |   |   |   | ]                |
| 101.00           | 10100 HOME HEALTH AGENCY   | 0   | 2, 167, 399   | C                                       | 122, 473  | 3, 944, 434                               | 101.00           |
| 440 -            | SPECIAL PURPOSE COST CENTERS   |   | 400 44: 55:   |   | 4. ==   | 4 447 07                                  | 146              |
| 118.00           | SUBTOTALS (SUM OF LINES 1 through 117)<br>  NONREIMBURSABLE COST CENTERS | 1, 369, 167                                     | 123, 166, 289   | 100                                     | 44, 551, 667  | 1, 417, 261, 476                          | J118.00          |
| 190.00           | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN                                | 1, 801  | 0   | С                                       | 157   | 0   | 190. 00          |
|                  | , , , ,  | , ., ., .,                                      |   |   |   |   |                  |

| Health Financial Systems            | METHODIST HOSPITALS, INC | In Lieu of Form CMS-2552-10           |  |  |  |
|-------------------------------------|--------------------------|---------------------------------------|--|--|--|
| COST ALLOCATION - STATISTICAL BASIS | Provi der CCN: 15-0002   | Period: Worksheet B-1 From 01/01/2021 |  |  |  |
|                                     |                          | To 12/31/2021 Date/Time Prepared:     |  |  |  |

|               |  |               |                        | T.                       | rom 01/01/2021<br>o 12/31/2021 | Date/Time Pre<br>5/27/2022 9:0 |         |
|---------------|--|---------------|------------------------|--------------------------|--------------------------------|--------------------------------|---------|
|               |  | CAPI TAL      |                        |                          |                                |                                |         |
|               | 0  | RELATED COSTS | EMDI OVEE              | DATA                     | DUDOUACINO                     | ADMI TTI NO                    |         |
|               | Cost Center Description                                | BLDG & FIXT   | EMPLOYEE               | DATA                     | PURCHASI NG                    | ADMI TTI NG                    |         |
|               |  | (SQUARE FEET) | BENEFITS<br>DEPARTMENT | PROCESSI NG<br>(MACHI NE | RECEIVING AND<br>STORES        | (GROSS<br>CHARGES)             |         |
|               |  |               | (GROSS                 | TIME)                    | (PURCHASE                      | CHARGES)                       |         |
|               |  |               | SALARI ES)             | IIWL)                    | REQUI SI TI ONS)               |                                |         |
|               |  | 1. 00         | 4. 00                  | 5. 01                    | 5. 02                          | 5. 03                          |         |
| 191. 00 19100 | RESEARCH   | 0             | 0                      | 0                        | 0                              | 0                              | 191. 00 |
| 192. 00 19200 | PHYSICIANS' PRIVATE OFFICES                            | 26, 711       | 23, 142, 886           | 0                        | 339, 039                       | 0                              | 192.00  |
| 192. 01 19201 | OTHER NON-REIMBURSABLE                                 | 3, 457        | 0                      | 0                        | 965                            |                                | 192. 01 |
|               | FAMILY HEALTH/GARY COMM HEALTH                         | 8, 997        | 94, 778                | 0                        | 467                            |                                | 192. 02 |
| •             | NONPALD WORKERS  | 0             | 0                      | 0                        | 0                              |                                | 193. 00 |
| 200.00        | Cross Foot Adjustments                                 |               |                        |                          |                                |                                | 200. 00 |
| 201. 00       | Negative Cost Centers                                  |               |                        |                          |                                |                                | 201.00  |
| 202. 00       | Cost to be allocated (per Wkst. B, Part I)             | 17, 072, 607  | 32, 794, 394           | 13, 126, 321             | 3, 619, 637                    | 3, 615, 085                    | 202. 00 |
| 203. 00       | Unit cost multiplier (Wkst. B, Part I)                 | 12. 107090    | 0. 223999              | 131, 263. 21000<br>0     | 0. 080629                      | 0. 002551                      | 203. 00 |
| 204. 00       | Cost to be allocated (per Wkst. B, Part II)            |               | 71, 504                | 113, 488                 | 89, 225                        | 118, 970                       | 204. 00 |
| 205. 00       | Unit cost multiplier (Wkst. B, Part                    |               | 0. 000488              | 1, 134. 880000           | 0. 001988                      | 0. 000084                      | 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 |

|                  | Financial Systems   | METHODIST HOSP                |               | N. 45 0000 D                |  | u of Form CMS-2                |                  |
|------------------|---|-------------------------------|---------------|-----------------------------|--|--------------------------------|------------------|
| COST             | ALLOCATION - STATISTICAL BASIS  |                               | Provi der Co  | F                           | eriod:<br>rom 01/01/2021<br>o 12/31/2021 | Worksheet B-1 Date/Time Pre    | pared:           |
|                  | Cost Center Description   | CASHI ERI NG/AC F             | Reconciliatio | OTHER A&G                   | PATI ENT                                 | 5/27/2022 9: 0<br>OPERATION OF | 2 am             |
|                  | ·   | COUNTS                        | n             | (ACCUM. COST)               | TRANSPORTATIO                            | PLANT                          |                  |
|                  |   | RECEI VABLE<br>(GROSS         |               |                             | N<br>(NUMBER OF                          | (SQUARE FEET)                  |                  |
|                  |   | CHARGES)                      | 54.05         | 5.05                        | TRI PS)                                  | 7.00                           |                  |
|                  | GENERAL SERVICE COST CENTERS  | 5. 04                         | 5A. 05        | 5. 05                       | 5. 06                                    | 7. 00                          |                  |
| 1. 00            | 00100 CAP REL COSTS-BLDG & FLXT   |                               |               |                             |  |                                | 1.00             |
| 4. 00<br>5. 01   | 00400 EMPLOYEE BENEFITS DEPARTMENT<br>00550 DATA PROCESSING                             |                               |               |                             |  |                                | 4. 00<br>5. 01   |
| 5. 02            | 00560 PURCHASING RECEIVING AND STORES   |                               |               |                             |  |                                | 5. 02            |
| 5. 03            | 00570 ADMI TTI NG   |                               |               |                             |  |                                | 5. 03            |
| 5. 04<br>5. 05   | OO580   CASHI ERI NG/ACCOUNTS   RECEI VABLE   OO590   OTHER   A&G                       | 1, 417, 261, 476              | -35, 492, 424 | 322, 075, 859               |  |                                | 5. 04<br>5. 05   |
| 5. 06            | 00592 PATIENT TRANSPORTATION  | o o                           | 00, 172, 121  | 623, 437                    |  |                                | 5.06             |
| 7. 00<br>8. 00   | 00700 OPERATION OF PLANT  | 0                             | 0             | 23, 511, 337                |  | 948, 434                       | 7.00             |
| 9. 00            | 00800 LAUNDRY & LI NEN SERVI CE<br>00900 HOUSEKEEPI NG                                  |                               | 0             | 1, 525, 296<br>6, 302, 592  |  | 17, 825<br>20, 635             | 8. 00<br>9. 00   |
| 10.00            | 01000 DI ETARY  | 0                             | 0             | 2, 937, 926                 | 0  | 18, 848                        | 10.00            |
| 11. 00<br>13. 00 | 01100 CAFETERI A<br>01300 NURSI NG ADMI NI STRATI ON                                    | 0                             | 0             | 4, 089, 688<br>6, 882, 315  |  | 13, 177<br>6, 350              | 11. 00<br>13. 00 |
| 14. 00           | 01400 CENTRAL SERVICES & SUPPLY   | o                             | 0             | 3, 150, 085                 |  | 35, 843                        |                  |
| 15. 00           | 01500 PHARMACY  | 0                             | 0             | 5, 897, 160                 |  | 18, 957                        | 15.00            |
| 16. 00<br>17. 00 | 01600 MEDICAL RECORDS & LIBRARY<br>01700 SOCIAL SERVICE                                 | 0                             | 0             | 3, 230, 593<br>537, 755     |  | 11, 307<br>1, 629              | 16. 00<br>17. 00 |
| 17. 01           | 01701 STAFF EDUCATION   | o o                           | 0             | 134, 958                    |  | 11, 147                        | 17. 01           |
| 17. 02           | 01702 MEDI CAL EDUCATI ON   | 0                             | 0             | 15, 100                     |  | 374                            | 17. 02           |
| 21. 00<br>22. 00 | 02100   &R SERVICES-SALARY & FRINGES APPRVD 02200   &R SERVICES-OTHER PRGM COSTS APPRVD | 0 0                           | 0             | 254, 151<br>85, 250         | 0  | 0<br>4, 467                    | 21. 00<br>22. 00 |
| 23. 00           | 02300 PARAMED ED PROGRAM  | 0                             | 0             | 844, 159                    |  | 3, 364                         | 23. 00           |
| 30. 00           | INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS                        | 107, 268, 496                 | 0             | 55, 122, 275                | 11, 318                                  | 313, 217                       | 30.00            |
| 31. 00           | 03100 INTENSIVE CARE UNIT   | 23, 628, 573                  | 0             | 13, 249, 159                |  | 19, 864                        |                  |
| 31. 01           | 03101 NEONATAL I CU   | 6, 340, 767                   | 0             | 2, 277, 030                 |  | 2, 258                         | 31.01            |
| 40. 00<br>41. 00 | 04000 SUBPROVI DER - I PF<br>04100 SUBPROVI DER - I RF                                  | 2, 296, 180<br>4, 463, 400    | 0             | 1, 280, 746<br>2, 958, 954  |  | 3, 972<br>31, 243              | 40. 00<br>41. 00 |
| 43. 00           | 04300 NURSERY   | 1, 996, 068                   | 0             | 2, 123, 120                 |  | 24, 424                        | 43.00            |
| 50. 00           | ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM                                     | 169, 292, 906                 | 0             | 11, 282, 987                | l ol                                     | 59, 647                        | 50.00            |
| 50. 00           | 05001 ENDOSCOPY   | 12, 521, 947                  | 0             | 1, 457, 589                 |  | 0                              | 50.00            |
| 51.00            | 05100 RECOVERY ROOM   | 12, 033, 588                  | 0             | 1, 641, 171                 | 0  | 14, 546                        | 51.00            |
| 52. 00<br>53. 00 | O5200   DELI VERY ROOM & LABOR ROOM   O5300   ANESTHESI OLOGY                           | 4, 428, 022                   | 0             | 5, 013, 454<br>0            |  | 7, 003<br>0                    | 52. 00<br>53. 00 |
| 54.00            | 05400 RADI OLOGY-DI AGNOSTI C   | 40, 875, 566                  | 0             | 5, 103, 139                 | 1, 924                                   | 53, 059                        | 54.00            |
| 54. 01           | 05401 RADI OLOGY - ULTRASOUND   | 22, 691, 762                  | 0             | 2, 228, 094                 |  | 5, 054                         | 54. 01<br>55. 00 |
| 55. 00<br>55. 01 | 05500   RADI OLOGY-THERAPEUTI C<br>  05501   INFUSI ON CENTER                           | 22, 689, 787<br>130, 187      | 0             | 2, 993, 205<br>58, 977      |  | 13, 485<br>360                 |                  |
| 56.00            | 05600 RADI OI SOTOPE  | 16, 069, 979                  | 0             | 2, 100, 509                 | 1, 969                                   | 9, 043                         | 56.00            |
| 57. 00<br>58. 00 | 05700 CT SCAN<br>05800 MAGNETIC RESONANCE IMAGING (MRI)                                 | 134, 797, 158<br>31, 267, 753 | 0             | 3, 519, 121<br>1, 219, 229  | 6, 957<br>2, 327                         | 8, 563<br>4, 205               | 57. 00<br>58. 00 |
| 59. 00           | 05900 CARDI AC CATHETERI ZATI ON  | 70, 589, 396                  | 0             | 4, 611, 909                 |  | 8, 033                         | 59.00            |
| 60.00            | 06000 LABORATORY  | 223, 819, 693                 | 0             | 15, 344, 144                |  | 23, 518                        | 60.00            |
| 62. 00<br>64. 00 | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06400 INTRAVENOUS THERAPY                    | 12, 197, 992                  | 0             | 1, 838, 069<br>0            | 0  | 385<br>0                       | 62. 00<br>64. 00 |
| 65. 00           | 06500 RESPIRATORY THERAPY   | 42, 954, 297                  | 0             | 4, 989, 610                 | 9  | 7, 766                         | 65.00            |
| 66.00            | 06600 PHYSI CAL THERAPY   | 7, 841, 511                   | 0             | 2, 012, 225                 |  | 12, 270                        | 66.00            |
| 67. 00<br>68. 00 | 06700 OCCUPATI ONAL THERAPY<br>06800 SPEECH PATHOLOGY                                   | 5, 715, 234<br>2, 893, 110    | 0             | 1, 619, 396<br>652, 517     |  | 10, 545<br>1, 796              | 67. 00<br>68. 00 |
| 69. 00           | 06900 ELECTROCARDI OLOGY  | 25, 742, 675                  | 0             | 1, 136, 322                 | 164                                      | 0                              | 69. 00           |
| 69. 01<br>70. 00 | 06901 CARDI AC REHAB<br>07000 ELECTROENCEPHALOGRAPHY                                    | 1, 096, 565<br>32, 608, 358   | 0             | 584, 524<br>1, 875, 588     |  | 0                              | 69. 01<br>70. 00 |
| 71.00            | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS  | 55, 185, 539                  | 0             | 15, 236, 937                |  | 0                              | 71.00            |
| 72. 00           | 07200 I MPL. DEV. CHARGED TO PATIENTS   | 35, 423, 662                  | 0             | 12, 894, 960                |  | 0                              | 72.00            |
| 73. 00<br>74. 00 | 07300 DRUGS CHARGED TO PATIENTS<br>07400 RENAL DIALYSIS                                 | 162, 306, 726<br>9, 399, 418  | 0             | 22, 874, 326<br>2, 435, 943 |  | 1, 662<br>4, 383               | 73. 00<br>74. 00 |
| 74.00            | OUTPATIENT SERVICE COST CENTERS   | 7, 377, 410                   | 0             | 2, 433, 743                 | '  | 4, 303                         | 74.00            |
| 90.00            | 09000 CLINIC  | 24, 028, 280                  | 0             |                             |  | 76, 181                        | 90.00            |
| 91. 00<br>92. 00 | O9100   EMERGENCY   O9200   OBSERVATION   BEDS (NON-DISTINCT PART)                      | 88, 722, 447                  | 0             | 15, 544, 555                | 345                                      | 27, 063                        | 91. 00<br>92. 00 |
|                  | OTHER REIMBURSABLE COST CENTERS   |                               |               |                             |  |                                |                  |
| 101.00           | 10100 HOME HEALTH AGENCY  | 3, 944, 434                   | 0             | 3, 094, 753                 | 0  | 0                              | 101. 00          |
| 118.00           | SPECIAL PURPOSE COST CENTERS   SUBTOTALS (SUM OF LINES 1 through 117)                   | 1, 417, 261, 476              | -35, 492, 424 | 287, 531, 111               | 32, 181                                  | 907, 468                       | 118. 00          |
| 100 00           | NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN                 | 0                             | 0             | 21, 975                     |  | 1 001                          | 190. 00          |
|                  | 19100 RESEARCH  | 0                             | 0             |                             | 1  |                                | 190.00           |
| 192.00           | 19200 PHYSICIANS' PRIVATE OFFICES   | 0                             | 0             | 33, 920, 166                | 0  | 26, 711                        | 192. 00          |
|                  |   |                               |               |                             |  |                                |                  |

| Health Financial Systems            | METHODIST HOS   | PITALS, INC   |           |       | In Lie                         | u of Form CMS-2                | 2552-10 |
|-------------------------------------|-----------------|---------------|-----------|-------|--------------------------------|--------------------------------|---------|
| COST ALLOCATION - STATISTICAL BASIS |                 | Provi der Co  | CN: 15-00 |       | eri od:                        | Worksheet B-1                  |         |
|                                     |                 |               |           |       | rom 01/01/2021<br>o 12/31/2021 | Date/Time Pre<br>5/27/2022 9:0 |         |
| Cost Center Description             | CASHI ERI NG/AC | Reconciliatio | -         |       |                                | OPERATION OF                   |         |
|                                     | COUNTS          | n             | (ACCUM.   | COST) | TRANSPORTATIO                  | PLANT                          |         |
|                                     | RECEI VABLE     |               |           |       | N                              | (SQUARE FEET)                  |         |

|         |  |                 |               | '             | 0 12/01/2021  | 5/27/2022 9:0 |         |
|---------|--|-----------------|---------------|---------------|---------------|---------------|---------|
|         | Cost Center Description                | CASHI ERI NG/AC | Reconciliatio | OTHER A&G     | PATI ENT      | OPERATION OF  |         |
|         |  | COUNTS          | n             | (ACCUM. COST) | TRANSPORTATIO | PLANT         |         |
|         |  | RECEI VABLE     |               |               | N             | (SQUARE FEET) |         |
|         |  | (GROSS          |               |               | (NUMBER OF    |               |         |
|         |  | CHARGES)        |               |               | TRI PS)       |               |         |
|         |  | 5. 04           | 5A. 05        | 5. 05         | 5. 06         | 7. 00         |         |
| 192. 01 | 19201 OTHER NON-REIMBURSABLE           | 0               | 0             | 401, 543      | 0             | 3, 457        | 192. 01 |
| 192. 02 | 19202 FAMILY HEALTH/GARY COMM HEALTH   | 0               | 0             | 201, 064      | 0             | 8, 997        | 192. 02 |
| 193.00  | 19300 NONPALD WORKERS                  | 0               | 0             | 0             | 0             | 0             | 193. 00 |
| 200.00  | Cross Foot Adjustments                 |                 |               |               |               |               | 200. 00 |
| 201.00  | Negative Cost Centers                  |                 |               |               |               |               | 201. 00 |
| 202.00  | Cost to be allocated (per Wkst. B,     | 7, 431, 300     |               | 35, 492, 424  | 692, 139      | 26, 102, 263  | 202. 00 |
|         | Part I)                                |                 |               |               |               |               |         |
| 203.00  | Unit cost multiplier (Wkst. B, Part I) | 0. 005243       |               | 0. 110199     | 21. 507691    | 27. 521433    | 203. 00 |
| 204.00  | Cost to be allocated (per Wkst. B,     | 372, 144        |               | 1, 324, 235   | 2, 809        | 3, 723, 370   | 204.00  |
|         | Part II)                               |                 |               |               |               |               |         |
| 205.00  | Unit cost multiplier (Wkst. B, Part    | 0. 000263       |               | 0. 004112     | 0. 087288     | 3. 925808     | 205. 00 |
|         | 11)                                    |                 |               |               |               |               |         |
| 206.00  | NAHE adjustment amount to be allocated |                 |               |               |               |               | 206. 00 |
|         | (per Wkst. B-2)                        |                 |               |               |               |               |         |
| 207.00  | NAHE unit cost multiplier (Wkst. D,    |                 |               |               |               |               | 207. 00 |
|         | Parts III and IV)                      |                 |               |               |               |               |         |

| COST ALLOCATION - STATISTICAL BASIS  Cost Center Description  |   | Provi der CC                             | Fr  | eriod:<br>com 01/01/2021   | Worksheet B-1                                   |   |
|---|---|--|---|--|---|---|
| Cost Contar Doscription   |   |  | 10  | 12/31/2021   | Date/Time Pre 5/27/2022 9:0                     |   |
| COST CENTER DESCRIPTION   | LAUNDRY &<br>LINEN SERVICE<br>(POUNDS OF                | HOUSEKEEPI NG<br>(SQUARE FEET)           | DI ETARY<br>(MEALS<br>SERVED)                 | CAFETERI A<br>(PRODUCTI VE<br>HOURS)                             | NURSI NG<br>ADMI NI STRATI O<br>N               | z am  |
|   | LAUNDRY)  |  | ·   |  | (DI RECT NURS.                                  |   |
|   | 8. 00   | 9. 00                                    | 10.00   | 11. 00   | HRS. )<br>13. 00                                |   |
| GENERAL SERVICE COST CENTERS  | 0.00  | 7. 00                                    | 10.00   | 11.00  | 10.00   |   |
| 1. 00    00100    CAP REL COSTS-BLDG & FIXT    4. 00    00400    EMPLOYEE BENEFITS DEPARTMENT    5. 01    00550    DATA PROCESSING    5. 02    00560    PURCHASING RECEIVING AND STORES    5. 03    00570    ADMITTING    5. 04    00580    CASHIERING/ACCOUNTS RECEIVABLE    5. 05    00590    OTHER A&G    5. 06    00592    PATIENT TRANSPORTATION    7. 00    00700    OPERATION OF PLANT    8. 00    00800    LAUNDRY & LINEN SERVICE    9. 00    00900    HOUSEKEEPING    10. 00    01000    DIETARY    11. 00    01100    CAFETERIA    13. 00    01300    NURSING ADMINISTRATION | 1, 734, 752<br>0<br>0<br>0<br>0                         | 909, 974<br>18, 848<br>13, 177<br>6, 350 | 274, 937<br>0<br>0                            | 2, 259, 516<br>66, 479   | 1, 408, 903                                     | 1. 00<br>4. 00<br>5. 01<br>5. 02<br>5. 03<br>5. 04<br>5. 05<br>5. 06<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00 |
| 14. 00   01400   CENTRAL SERVICES & SUPPLY   15. 00   01500   PHARMACY   16. 00   01600   MEDICAL RECORDS & LIBRARY   17. 00   01700   SOCIAL SERVICE   17. 01   01701   STAFF EDUCATION   17. 02   01702   MEDICAL EDUCATION   21. 00   02100   I&R SERVICES-SALARY & FRINGES APPRVD   22. 00   02200   I&R SERVICES-OTHER PRGM COSTS APPRVD   23. 00   02300   PARAMED ED PROGRAM   INPATIENT ROUTINE SERVICE COST CENTERS  | 2, 331<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0          | 0<br>4, 467                              | 0<br>0<br>0<br>0<br>0<br>0<br>0               | 29, 601<br>0<br>84, 352<br>0<br>0<br>0<br>0<br>0<br>21, 489      | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>21, 489 | 14. 00<br>15. 00<br>16. 00<br>17. 00<br>17. 01<br>17. 02<br>21. 00<br>22. 00<br>23. 00                              |
| 30. 00   03000   ADULTS & PEDIATRICS<br>31. 00   03100   INTENSIVE CARE UNIT<br>31. 01   03101   NEONATAL I CU<br>40. 00   04000   SUBPROVI DER - I PF<br>41. 00   04100   SUBPROVI DER - I RF<br>43. 00   04300   NURSERY  | 778, 993<br>121, 677<br>0<br>0<br>57, 768<br>20, 583    | 19, 864<br>2, 258<br>3, 972              | 223, 356<br>11, 037<br>0<br>3, 774<br>13, 051 | 701, 054<br>143, 193<br>32, 778<br>23, 849<br>48, 420<br>26, 304 | 23, 849   | 30. 00<br>31. 00<br>31. 01<br>40. 00<br>41. 00<br>43. 00  |
| ANCILLARY SERVICE COST CENTERS  |   |  |   |  |   |   |
| 50. 00   05000   0PERATI NG   ROOM   50. 01   05001   ENDOSCOPY   51. 00   05100   RECOVERY   ROOM   52. 00   05200   DELI VERY   ROOM   & LABOR   ROOM   53. 00   05300   ANESTHESI OLOGY  | 198, 604<br>27, 557<br>14, 696<br>38, 558<br>0          | 0<br>14, 546<br>7, 003                   | 0<br>0<br>115<br>5, 820<br>0                  | 121, 641<br>18, 274<br>19, 553<br>80, 009<br>0                   | 121, 641<br>18, 274<br>19, 553<br>80, 009<br>0  | 50. 00<br>50. 01<br>51. 00<br>52. 00<br>53. 00  |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C<br>54. 01   05401   RADI OLOGY - ULTRASOUND<br>55. 00   05500   RADI OLOGY-THERAPEUTI C<br>55. 01   05501   INFUSI ON CENTER<br>56. 00   05600   RADI OI SOTOPE<br>57. 00   05700   CT SCAN  | 34, 155<br>16, 095<br>9, 115<br>0<br>10, 794<br>21, 861 | 5, 054<br>13, 485<br>360                 | 0<br>0<br>0<br>0<br>0                         | 76, 331<br>32, 118<br>12, 054<br>460<br>12, 781<br>32, 388       | 0   | 54. 00<br>54. 01<br>55. 00<br>55. 01<br>56. 00<br>57. 00  |
| 58.00   05800   MAGNETI C RESONANCE I MAGI NG (MRI)<br>59.00   05900   CARDI AC CATHETERI ZATI ON<br>60.00   06000   LABORATORY<br>62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS<br>64.00   06400   I NTRAVENOUS THERAPY<br>65.00   06500   RESPI RATORY THERAPY   | 7, 735<br>40, 338<br>0<br>0                             | 4, 205<br>8, 033                         | 0       | 14, 184<br>51, 919<br>116, 055<br>57, 466<br>0<br>61, 990        | 0 0 0   | 58. 00<br>59. 00<br>60. 00<br>62. 00<br>64. 00<br>65. 00  |
| 66. 00   06600   PHYSI CAL THERAPY<br>67. 00   06700   OCCUPATI ONAL THERAPY<br>68. 00   06800   SPEECH PATHOLOGY<br>69. 00   06900   ELECTROCARDI OLOGY<br>69. 01   06901   CARDI AC REHAB   | 0<br>0<br>0<br>2, 793<br>479                            | 12, 270<br>10, 545<br>1, 796             | 0<br>0<br>0<br>0                              | 32, 695<br>25, 991<br>9, 857<br>23, 116<br>10, 887               | 0 0 0   | 66. 00<br>67. 00<br>68. 00<br>69. 00<br>69. 01  |
| 70. 00   07000   ELECTROENCEPHALOGRAPHY 71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS 72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS 73. 00   07300   DRUGS CHARGED TO PATI ENTS 74. 00   07400   RENAL DI ALYSIS   OUTPATI ENT SERVI CE COST CENTERS   | 8, 616<br>0<br>0<br>0<br>0<br>11, 527                   | 0<br>0<br>0<br>1, 662<br>4, 383          | 0<br>0<br>0<br>0                              | 26, 518<br>0<br>0<br>7, 925<br>8                                 | 0<br>0<br>0<br>0                                | 70. 00<br>71. 00<br>72. 00<br>73. 00<br>74. 00  |
| 90. 00   09000   CLI NI C   91. 00   09100   EMERGENCY   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   OTHER REI MBURSABLE COST CENTERS  | 44, 789<br>265, 688                                     |  | 0<br>17, 784                                  | 66, 047<br>171, 730  | 609<br>171, 730                                 | 90. 00<br>91. 00<br>92. 00  |
| 101.00 10100 HOME HEALTH AGENCY   | 0   | 0  | 0   | 0  | 0   | 101. 00   |
| SPECIAL PURPOSE COST CENTERS  118.00 SUBTOTALS (SUM OF LINES 1 through 117)  NONREI MBURSABLE COST CENTERS  | 1, 734, 752   | 869, 008                                 | 274, 937                                      | 2, 259, 516  | 1, 408, 903                                     | 118. 00   |
| 190.00 19000 GFT, FLOWER, COFFEE SHOP & CANTEEN 191.00 19100 RESEARCH   | 0   |  | 0   | 0  |   | 190. 00<br>191. 00  |

| Health Financial Systems            | METHODIST HOSPITALS, INC | In Lieu of Form CMS-2552-10           |
|-------------------------------------|--------------------------|---------------------------------------|
| COST ALLOCATION - STATISTICAL BASIS | Provi der CCN: 15-0002   | Period: Worksheet B-1 From 01/01/2021 |

|               |  |               |               | T           | o 12/31/2021 | Date/Time Pre<br>5/27/2022 9:0 |         |
|---------------|--|---------------|---------------|-------------|--------------|--------------------------------|---------|
|               | Cost Center Description                | LAUNDRY &     | HOUSEKEEPI NG | DI ETARY    | CAFETERI A   | NURSI NG                       |         |
|               |  | LINEN SERVICE | (SQUARE FEET) | ,           | (PRODUCTI VE | ADMI NI STRATI O               |         |
|               |  | (POUNDS OF    |               | SERVED)     | HOURS)       | N N                            |         |
|               |  | LAUNDRY)      |               |             |              | (DI RECT NURS.                 |         |
|               |  |               |               |             |              | HRS. )                         |         |
|               |  | 8. 00         | 9. 00         | 10.00       | 11. 00       | 13. 00                         |         |
| 192. 01 19201 | OTHER NON-REIMBURSABLE                 | 0             | 3, 457        |             | 0            |                                | 192. 01 |
| 192. 02 19202 | FAMILY HEALTH/GARY COMM HEALTH         | 0             | 8, 997        | 0           | 0            | 0                              | 192. 02 |
| 193. 00 19300 | NONPALD WORKERS                        | 0             | 0             | 0           | 0            | 0                              | 193.00  |
| 200.00        | Cross Foot Adjustments                 |               |               |             |              |                                | 200.00  |
| 201.00        | Negative Cost Centers                  |               |               |             |              |                                | 201.00  |
| 202. 00       | Cost to be allocated (per Wkst. B,     | 2, 183, 952   | 7, 565, 036   | 3, 937, 099 | 5, 012, 565  | 8, 015, 769                    | 202.00  |
|               | Part I)                                |               |               |             |              |                                |         |
| 203.00        | Unit cost multiplier (Wkst. B, Part I) | 1. 258942     | 8. 313464     | 14. 320004  | 2. 218424    | 5. 689369                      | 203. 00 |
| 204.00        | Cost to be allocated (per Wkst. B,     | 292, 060      | 359, 568      | 323, 673    | 234, 388     | 142, 310                       | 204.00  |
|               | Part II)                               |               |               |             |              |                                |         |
| 205. 00       | Unit cost multiplier (Wkst. B, Part    | 0. 168358     | 0. 395141     | 1. 177262   | 0. 103734    | 0. 101008                      | 205. 00 |
|               | [11]                                   |               |               |             |              |                                |         |
| 206.00        | NAHE adjustment amount to be allocated |               |               |             |              |                                | 206.00  |
|               | (per Wkst. B-2)                        |               |               |             |              |                                |         |
| 207. 00       | NAHE unit cost multiplier (Wkst. D,    |               |               |             |              |                                | 207.00  |
|               | Parts III and IV)                      |               |               |             |              |                                |         |
| Į.            |  | •             | •             | •           |              | •                              |         |

| 11. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00<br>17. 01<br>17. 02<br>21. 00 | 00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER A&G 00592 PATIENT TRANSPORTATION 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01701 STAFF EDUCATION 01702 MEDICAL ESERVICES-SALARY & FRINGES APPRVD 02100 I &R SERVICES-OTHER PRGM COSTS APPRVD | 25, 379, 361<br>0<br>0<br>0<br>0<br>0 | 21, 942, 137<br>0<br>0<br>0<br>0<br>0 |   | 699<br>0<br>0<br>0 | 92, 544<br>10<br>0 | 17. 02<br>21. 00   |
|--|--|---------------------------------------|---------------------------------------|---|--------------------|--------------------|--------------------|
|  | 02300 PARAMED ED PROGRAM   | 0                                     | 0                                     | -                                       | 0                  | 32                 | 1                  |
| 20.25  | INPATIENT ROUTINE SERVICE COST CENTERS   | _1                                    | =                                     | 407.010.151                             |                    | 27 77              |                    |
|  | 03000 ADULTS & PEDIATRICS<br>03100 INTENSIVE CARE UNIT   | 0<br>                                 | 0                                     | 107, 268, 496<br>23, 628, 573           | 578<br>0           | 37, 702<br>6, 455  |                    |
|  | 03101 NEONATAL I CU  |                                       | 0                                     | 6, 340, 767                             | 0                  | 1, 288             |                    |
| 40.00  | 04000 SUBPROVI DER - I PF  | o                                     | 0                                     | 2, 296, 180                             | 0                  | 364                | 40.00              |
|  | 04100   SUBPROVI DER - I RF<br>  04300   NURSERY   | 0                                     | 0                                     | .,                                      | 92<br>0            | 4, 494<br>1, 923   | 1                  |
| 43.00  | ANCILLARY SERVICE COST CENTERS   | U                                     | 0                                     | 1, 996, 068                             | U                  | 1, 923             | 43.00              |
|  | O5000 OPERATING ROOM   | 0                                     | 0                                     |   | 0                  | 5, 068             | 1                  |
|  | 05001 ENDOSCOPY  | 0                                     | 0                                     | , | 0                  | 2, 435             |                    |
|  | 05100  RECOVERY ROOM   05200  DELIVERY ROOM & LABOR ROOM   | J 0                                   | 0                                     | 12, 033, 588<br>4, 428, 022             | 0                  | 236<br>5, 054      | 1                  |
|  | 05300 ANESTHESI OLOGY  |                                       | Ö                                     | 0                                       | Ö                  | 0,001              | 1                  |
|  | 05400 RADI OLOGY-DI AGNOSTI C  | 0                                     | 0                                     | 40, 875, 566                            | 0                  | 1, 946             | 1                  |
|  | 05401   RADI OLOGY - ULTRASOUND<br>  05500   RADI OLOGY-THERAPEUTI C   |                                       | 0                                     | 22, 691, 762<br>22, 689, 787            | 0                  | 1, 131<br>261      | 1                  |
|  | 05501   NFUSION CENTER   | ı                                     | 0                                     | 130, 187                                | 0                  | 0                  | 1                  |
| 56.00  | 05600 RADI OI SOTOPE   | Ō                                     | 0                                     |   | 0                  | 2                  | 56.00              |
|  | 05700 CT SCAN  |                                       | 0                                     | , ,                                     | 0                  | 1, 788             | 1                  |
|  | 05800 MAGNETIC RESONANCE IMAGING (MRI)<br>05900 CARDIAC CATHETERIZATION  | J 0                                   | 0                                     | 31, 267, 753<br>70, 589, 396            | 0                  | 0<br>3, 280        |                    |
|  | 06000 LABORATORY   |                                       | 1, 351, 692                           |   | Ö                  | 229                |                    |
|  | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS   | 0                                     | 0                                     | 12, 197, 992                            | 0                  | 86                 | 1                  |
|  | 06400 I NTRAVENOUS THERAPY<br>06500 RESPI RATORY THERAPY   |                                       | 0                                     | 0<br>42, 954, 297                       | 0                  | 0<br>733           |                    |
|  | 06600 PHYSI CAL THERAPY  | ı                                     | 0                                     | 7, 841, 511                             | 0                  | 148                | 1                  |
| 67.00  | 06700 OCCUPATI ONAL THERAPY  | 0                                     | 0                                     | 5, 715, 234                             | 0                  | 62                 | 1                  |
|  | 06800 SPEECH PATHOLOGY   |                                       | 0                                     | 2, 893, 110                             | 0                  | 69                 |                    |
|  | 06900  ELECTROCARDI OLOGY<br>  06901  CARDI AC REHAB   | J 0                                   | 0                                     | 25, 742, 675<br>1, 096, 565             | 0                  | 1, 173<br>8        | 1                  |
| 70.00  | 07000 ELECTROENCEPHALOGRAPHY   | ı Ö                                   | 0                                     |   | O                  |                    | 70.00              |
|  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS   |                                       | 0                                     | ,,                                      | 0                  |                    | 71.00              |
|  | 07200 IMPL. DEV. CHARGED TO PATIENTS<br>07300 DRUGS CHARGED TO PATIENTS  | 11, 677, 336                          | 0<br>20, 353, 721                     |   | 0                  |                    | 72. 00<br>73. 00   |
|  | 07400 RENAL DIALYSIS   | ı                                     | 20, 333, 721                          |   | o                  | 0                  | 1                  |
|  | OUTPATIENT SERVICE COST CENTERS  |                                       |                                       |   |                    |                    |                    |
|  | 09000 CLI NI C<br>09100 EMERGENCY  | 0                                     | 0                                     |   | 0<br>29            | 240<br>13, 564     | 90. 00<br>91. 00   |
|  | 09200 OBSERVATION BEDS (NON-DISTINCT PART)   | ı                                     | U                                     | 00, 722, 447                            | 29                 | 13, 304            | 91.00              |
|  | OTHER REIMBURSABLE COST CENTERS  |                                       |                                       |   | <u>'</u>           |                    |                    |
| 101.00   | 10100 HOME HEALTH AGENCY   | 0                                     | 24, 696                               | 3, 944, 434                             | 0                  | 387                | 101.00             |
| 118. 00  | SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)  | 25, 379, 361                          | 21 730 100                            | 1, 417, 261, 476                        | 699                | 01 116             | 118. 00            |
|  | NONREI MBURSABLE COST CENTERS  | 23, 377, 301                          | 21,730,107                            | 1, 417, 201, 470                        | 077                | 71, 110            | 1110.00            |
| 190.00   | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN  | 0                                     | 0                                     | -                                       | 0                  |                    | 190. 00            |
|  | 19100 RESEARCH<br>19200 PHYSI CLANS' PRI VATE OFFI CES   | 0                                     | 0<br>212 028                          |   | 0                  |                    | 191. 00<br>192. 00 |
| 192.00   | 1/17200/FATSICIANS PRIVATE UFFICES   | <u>U</u>                              | 212, 028                              | ا ا                                     | ΟĮ                 | 1, 382             | 1192.00            |
| MCRI F3:   | 2 - 17. 4. 174. 1  |                                       |                                       |   |                    |                    |                    |

| Health Financial Systems                    |  | METHODIST HOSPITALS, INC |                        |            | In Lieu of Form CMS-2552-10      |                                |         |  |
|---|--|--------------------------|------------------------|------------|----------------------------------|--------------------------------|---------|--|
| COST ALLOCATION - STATISTICAL BASIS         |  |                          | Provi der CCN: 15-0002 |            | Peri od:                         | Worksheet B-1                  |         |  |
|   |  |                          |                        |            | From 01/01/2021<br>To 12/31/2021 | Date/Time Pre<br>5/27/2022 9:0 |         |  |
|   | 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                         |         |  |
| 192. 01 192                                 | 201 OTHER NON-REIMBURSABLE             | 0                        | 0                      | (          | 0 0                              | 0                              | 192. 01 |  |
| 192.02 19202 FAMILY HEALTH/GARY COMM HEALTH |  | 0                        | 0                      | (          | 0                                | 46                             | 192. 02 |  |
| 193. 00 19300 NONPALD WORKERS               |  | O                        | 0                      |            | 0                                | 0                              | 193. 00 |  |
| 200.00                                      | Cross Foot Adjustments                 |                          |                        |            |                                  |                                | 200. 00 |  |
| 201.00                                      | Negative Cost Centers                  |                          |                        |            |                                  |                                | 201.00  |  |
| 202.00                                      | Cost to be allocated (per Wkst. B,     | 4, 850, 254              | 7, 226, 343            | 4, 178, 91 | 5 655, 390                       | 549, 281                       | 202.00  |  |
|   | Part I)                                |                          |                        |            |                                  |                                |         |  |
| 203.00                                      | Unit cost multiplier (Wkst. B, Part I) | 0. 191110                | 0. 329336              | 0. 00294   | 9 937. 610873                    | 5. 935350                      | 203.00  |  |
| 204.00                                      | Cost to be allocated (per Wkst. B,     | 606, 565                 | 335, 904               | 208, 81    | 9 29, 179                        | 183, 679                       | 204.00  |  |
|   | Part II)                               |                          |                        |            |                                  |                                |         |  |
| 205. 00                                     | Unit cost multiplier (Wkst. B, Part    | 0. 023900                | 0. 015309              | 0. 00014   | 7 41. 743920                     | 1. 984775                      | 205.00  |  |
|   | 11)                                    |                          |                        |            |                                  |                                |         |  |
| 206.00                                      | NAHE adjustment amount to be allocated |                          |                        |            |                                  |                                | 206. 00 |  |
|   | (per Wkst. B-2)                        |                          |                        |            |                                  |                                |         |  |
| 207. 00                                     | NAHE unit cost multiplier (Wkst. D,    |                          |                        |            |                                  |                                | 207.00  |  |
|   | Parts III and IV)                      |                          |                        |            |                                  |                                |         |  |
|   |  | •                        |                        | •          |                                  |                                |         |  |

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0002 Peri od: Worksheet B-1 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/27/2022 9:02 am INTERNS & RESIDENTS PARAMED ED MEDI CAL SERVI CES-SALA SERVI CES-0THE Cost Center Description **FDUCATION** RY & FRINGES R PRGM COSTS **PROGRAM** (ASSI GNED (ASSI GNED (ASSI GNED (ASSI GNED TIME) TIME) TIME) TIME) 17.02 21.00 22.00 23.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00550 DATA PROCESSING 5.01 5.01 00560 PURCHASING RECEIVING AND STORES 5.02 5.02 00570 ADMITTING 5.03 5.03 5.04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.04 5.05 00590 OTHER A&G 5.05 00592 PATIENT TRANSPORTATION 5.06 5.06 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 01701 STAFF EDUCATION 17 01 17 01 01702 MEDICAL EDUCATION 17.02 100 17.02 02100 I&R SERVICES-SALARY & FRINGES APPRVD 100 21.00 21.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 100 22.00 02300 PARAMED ED PROGRAM 100 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 0 03000 ADULTS & PEDIATRICS C 30.00 0 03100 INTENSIVE CARE UNIT 0 31.00 0 0 31.00 0 31 01 03101 NEONATAL I CU 0 0 31.01 40.00 04000 SUBPROVI DER - I PF 0 0 0 0 40.00 0 41.00 04100 SUBPROVI DER - I RF 0 0 0 41.00 0 04300 NURSERY 0 43.00 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0 50.00 50.01 05001 ENDOSCOPY 00000000000000000000000000 0 0 0 50.01 0 51.00 05100 RECOVERY ROOM 0 0 51 00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 52.00 53 00 05300 ANESTHESI OLOGY 0 0 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0 54.00 0 54.01 05401 RADI OLOGY - ULTRASOUND 0 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 55.00 55.01 05501 INFUSION CENTER 0 0 55.01 0 0 56.00 05600 RADI OI SOTOPE 0 56.00 0 0 57.00 05700 CT SCAN 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 05900 CARDI AC CATHETERI ZATI ON 59.00 0 0 0 0 59.00 0 06000 LABORATORY 0 60.00 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 06400 INTRAVENOUS THERAPY 0 64.00 0 0 0 64.00 06500 RESPIRATORY THERAPY 0 0 65.00 65.00 0 66.00 06600 PHYSI CAL THERAPY 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 68.00 0 69 00 06900 ELECTROCARDI OLOGY 0 0 69 00 0 69.01 06901 CARDI AC REHAB C 69.01 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0 0 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 C 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 07400 RENAL DIALYSIS 74.00 0 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 90.00 09100 EMERGENCY 100 100 100 100 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 118.00 100 100 100 100 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 0 0 0 191. 00 19100 RESEARCH 0 0 0 191.00

| Health Financial Systems            | METHODIST HOSPITALS, INC | In Lieu of Form CMS-2552-10                          |
|-------------------------------------|--------------------------|--|
| COST ALLOCATION - STATISTICAL BASIS | Provi der CCN: 15-0002   | Period: Worksheet B-1                                |
|                                     |                          | From 01/01/2021   To 12/21/2021   Date/Time Propaged |

|         |  |                          |                        | T                         | o 12/31/2021          | Date/Time Pre<br>5/27/2022 9:0 | pared:<br>2 am |
|---------|--|--------------------------|------------------------|---------------------------|-----------------------|--------------------------------|----------------|
|         |  |                          | INTERNS &              | RESI DENTS                |                       |                                |                |
|         | Cost Center Description                                | MEDI CAL                 |                        | SERVI CES-OTHE            | PARAMED ED            |                                |                |
|         |  | EDUCATI ON<br>(ASSI GNED | RY & FRINGES (ASSIGNED | R PRGM COSTS<br>(ASSIGNED | PROGRAM<br>(ASSI GNED |                                |                |
|         |  | TIME)                    | TIME)                  | TIME)                     | TIME)                 |                                |                |
|         |  | 17. 02                   | 21. 00                 | 22.00                     | 23. 00                |                                |                |
|         | PHYSICIANS' PRIVATE OFFICES                            | 0                        | 0                      | 0                         | 0                     |                                | 192. 00        |
|         | OTHER NON-REIMBURSABLE                                 | 0                        | 0                      | 0                         | 0                     |                                | 192. 01        |
|         | FAMILY HEALTH/GARY COMM HEALTH                         | 0                        | 0                      | 0                         | 0                     |                                | 192. 02        |
|         | NONPALD WORKERS  | 0                        | 0                      | 0                         | 0                     |                                | 193. 00        |
| 200. 00 | Cross Foot Adjustments                                 |                          |                        |                           |                       |                                | 200. 00        |
| 201. 00 | Negative Cost Centers                                  |                          |                        |                           |                       |                                | 201. 00        |
| 202.00  | Cost to be allocated (per Wkst. B, Part I)             | 30, 225                  | 282, 158               | 254, 718                  | 1, 227, 853           |                                | 202. 00        |
| 203.00  | Unit cost multiplier (Wkst. B, Part I)                 | 302. 250000              | 2, 821. 580000         | 2, 547. 180000            | 12, 278. 530000       |                                | 203. 00        |
| 204. 00 | Cost to be allocated (per Wkst. B, Part II)            | 6, 229                   | 1, 045                 | 73, 735                   | 63, 568               |                                | 204. 00        |
| 205. 00 | Unit cost multiplier (Wkst. B, Part                    | 62. 290000               | 10. 450000             | 737. 350000               | 635. 680000           |                                | 205. 00        |
| 206. 00 | NAHE adjustment amount to be allocated (per Wkst. B-2) |                          |                        |                           | 0                     |                                | 206. 00        |
| 207. 00 | NAHE unit cost multiplier (Wkst. D,                    |                          |                        |                           | 0. 000000             |                                | 207. 00        |
|         | Parts III and IV)                                      |                          |                        |                           |                       |                                |                |
|         |  |                          |                        |                           |                       |                                |                |

| Health Financial Systems                 | METHODIST HOSPITALS, INC | In Lie                      | u of Form CMS-2552-10 |
|--|--------------------------|-----------------------------|-----------------------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | Provi der CCN: 15-0002   | Peri od:<br>From 01/01/2021 |                       |

|        |  |                             |               |                             | o 12/31/2021    | Date/Time Pre<br>5/27/2022 9:0 | pared:  |
|--------|--|-----------------------------|---------------|-----------------------------|-----------------|--------------------------------|---------|
|        |  |                             | Title         | XVIII                       | Hospi tal       | PPS                            | 12 aiii |
|        |  |                             |               |                             | Costs           |                                |         |
|        | Cost Center Description  | Total Cost                  | Therapy Limit | Total Costs                 | RCE             | Total Costs                    |         |
|        | <b>'</b>   | (from Wkst.                 | Áďj.          |                             | Di sal I owance |                                |         |
|        |  | B, Part I,                  | ,             |                             |                 |                                |         |
|        |  | col. 26)                    |               |                             |                 |                                |         |
|        |  | 1. 00                       | 2. 00         | 3. 00                       | 4. 00           | 5. 00                          |         |
| I      | NPATIENT ROUTINE SERVICE COST CENTERS                                |                             |               |                             |                 |                                |         |
| 30.00  | D3000 ADULTS & PEDIATRICS  | 83, 469, 209                |               | 83, 469, 209                | 0               | 83, 469, 209                   | 30.00   |
|        | 03100 INTENSIVE CARE UNIT  | 16, 976, 791                |               | 16, 976, 791                | 0               | 16, 976, 791                   | 31.00   |
| 31. 01 | 03101 NEONATAL ICU   | 2, 894, 417                 |               | 2, 894, 417                 | 0               | 2, 894, 417                    | 31. 01  |
|        | 04000 SUBPROVI DER - I PF  | 1, 815, 787                 |               | 1, 815, 787                 | 0               | 1, 815, 787                    | 40.00   |
| 41.00  | 04100 SUBPROVI DER – I RF  | 5, 176, 818                 |               | 5, 176, 818                 | 0               | 5, 176, 818                    | 41.00   |
|        | 04300 NURSERY  | 3, 483, 536                 |               | 3, 483, 536                 | 0               | 3, 483, 536                    | 43.00   |
|        | ANCILLARY SERVICE COST CENTERS                                       |                             |               |                             |                 |                                |         |
|        | O5000 OPERATING ROOM   | 16, 405, 073                |               | 16, 405, 073                |                 | 16, 405, 073                   | 1       |
|        | 05001 ENDOSCOPY  | 1, 867, 097                 |               | 1, 867, 097                 |                 | 1, 867, 097                    | 1       |
|        | 05100 RECOVERY ROOM  | 2, 554, 938                 |               | 2, 554, 938                 |                 | 2, 554, 938                    |         |
|        | 05200 DELIVERY ROOM & LABOR ROOM                                     | 6, 633, 702                 |               | 6, 633, 702                 |                 | 6, 633, 702                    | 1       |
|        | D5300 ANESTHESI OLOGY  | 0                           |               | 0                           | -               | 0                              |         |
|        | D5400 RADI OLOGY-DI AGNOSTI C  | 7, 952, 671                 |               | 7, 952, 671                 |                 | 7, 952, 671                    |         |
|        | 05401 RADI OLOGY - ULTRASOUND  | 2, 902, 450                 |               | 2, 902, 450                 |                 | 2, 902, 450                    |         |
|        | 05500 RADI OLOGY-THERAPEUTI C  | 3, 916, 620                 |               | 3, 916, 620                 |                 | 3, 919, 181                    | 1       |
|        | 05501 I NFUSI ON CENTER  | 79, 781                     |               | 79, 781                     |                 | 79, 781                        |         |
|        | D5600 RADI OI SOTOPE   | 2, 787, 732                 |               | 2, 787, 732                 |                 | 2, 787, 732                    | 1       |
|        | D5700 CT SCAN  | 4, 870, 909                 |               | 4, 870, 909                 |                 | 4, 870, 909                    | 1       |
|        | D5800 MAGNETIC RESONANCE IMAGING (MRI)                               | 1, 687, 734                 |               | 1, 687, 734                 |                 | 1, 687, 734                    |         |
|        | 05900 CARDI AC CATHETERI ZATI ON                                     | 5, 825, 663                 |               | 5, 825, 663                 |                 | 5, 825, 663                    | 1       |
|        | 06000 LABORATORY   | 19, 241, 253                |               | 19, 241, 253                |                 | 19, 241, 253                   |         |
|        | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS                           | 2, 218, 385                 |               | 2, 218, 385                 |                 | 2, 218, 385                    | 1       |
|        | 06400 I NTRAVENOUS THERAPY   | 0                           |               | 0                           |                 | 0                              | 64.00   |
|        | 06500 RESPI RATORY THERAPY   | 6, 086, 490                 | 0             |                             |                 | 6, 086, 490                    | 1       |
|        | 06600 PHYSI CAL THERAPY  | 2, 770, 198                 | 0             |                             |                 | 2, 770, 198                    | 1       |
|        | 06700 OCCUPATI ONAL THERAPY  | 2, 250, 612                 | 0             | 2, 250, 612                 |                 | 2, 250, 612                    |         |
|        | 06800 SPEECH PATHOLOGY   | 819, 592                    | 0             | ,                           |                 | 819, 592                       | 1       |
|        | 06900 ELECTROCARDI OLOGY   | 1, 402, 745                 |               | 1, 402, 745                 |                 | 1, 402, 745                    | 1       |
|        | 06901 CARDI AC REHAB   | 676, 974                    |               | 676, 974                    |                 | 676, 974                       | 1       |
|        | 07000 ELECTROENCEPHALOGRAPHY   | 2, 260, 413                 |               | 2, 260, 413                 |                 | 2, 260, 413                    |         |
|        | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS                           | 19, 697, 372                |               | 19, 697, 372                |                 | 19, 697, 372                   |         |
|        | D7200 IMPL. DEV. CHARGED TO PATIENTS D7300 DRUGS CHARGED TO PATIENTS | 16, 652, 092                |               | 16, 652, 092                |                 | 16, 652, 092                   | 1       |
|        | 07400 RENAL DIALYSIS   | 32, 655, 600<br>2, 903, 716 |               | 32, 655, 600<br>2, 903, 716 |                 | 32, 655, 600<br>2, 903, 716    | 1       |
|        | DUTPATIENT SERVICE COST CENTERS                                      | 2, 903, 710                 |               | 2, 903, 710                 | ı V             | 2, 903, 710                    | 74.00   |
|        | 09000 CLINIC   | 10, 929, 976                |               | 10, 929, 976                | O               | 10, 929, 976                   | 90.00   |
|        | D9100 EMERGENCY  | 21, 809, 345                |               | 21, 809, 345                |                 | 21, 809, 345                   | 1       |
|        | 09200 OBSERVATION BEDS (NON-DISTINCT PART)                           | 14, 883, 439                |               | 14, 883, 439                |                 | 14, 883, 439                   |         |
|        | OTHER REIMBURSABLE COST CENTERS                                      | 14, 003, 439                |               | 14,000,409                  |                 | 14, 003, 439                   | 1 72.00 |
|        | 10100 HOME HEALTH AGENCY   | 3, 457, 854                 |               | 3, 457, 854                 |                 | 3, 457, 854                    | 101 00  |
| 200.00 | Subtotal (see instructions)  | 332, 016, 984               | 0             |                             |                 | 332, 019, 545                  | 1       |
| 201.00 | Less Observation Beds  | 14, 883, 439                |               | 14, 883, 439                |                 | 14, 883, 439                   | 1       |
| 202.00 | Total (see instructions)   | 317, 133, 545               | 0             |                             |                 | 317, 136, 106                  |         |
| 202.00 | 1.013. (300 111311 4011 0113)  | 317, 100, 040               |               | 317, 100, 040               | 2, 301          | 317, 100, 100                  | 1-32.00 |

Date/Time Prepared: 12/31/2021 5/27/2022 9:02 am Title XVIII Hospi tal PPS Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent TEFRA + col. 7) Ratio Inpati ent Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 80, 353, 912 80, 353, 912 30.00 31.00 03100 INTENSIVE CARE UNIT 23, 628, 573 23, 628, 573 31.00 03101 NEONATAL ICU 6, 340, 767 6, 340, 767 31.01 31.01 40.00 04000 SUBPROVI DER - I PF 2, 296, 180 2, 296, 180 40.00 04100 SUBPROVI DER - I RF 41.00 4, 463, 400 4, 463, 400 41.00 43.00 04300 NURSERY 1, 996, 068 1, 996, 068 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 61, 149, 104 169, 292, 906 0.000000 50.00 108, 143, 802 0.096903 50.00 05001 ENDOSCOPY 50.01 4, 187, 052 8, 334, 895 12, 521, 947 0.149106 0.000000 50.01 51.00 05100 RECOVERY ROOM 3, 850, 256 8, 183, 332 12, 033, 588 0.212317 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 837, 919 2, 590, 103 4, 428, 022 1. 498119 0.000000 52.00 05300 ANESTHESI OLOGY 53.00 0.000000 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 9, 920, 270 30, 955, 296 40, 875, 566 0. 194558 0.000000 54.00 5, 666, 770 17, 024, 992 22, 691, 762 0. 127908 54.01 05401 RADI OLOGY - ULTRASOUND 0.000000 54.01 1, 082, 901 05500 RADI OLOGY-THERAPEUTI C 21, 606, 886 22, 689, 787 0.000000 55.00 0.172616 55.00 05501 INFUSION CENTER 55.01 3, 400 126, 787 130, 187 0.612818 0.000000 55 01 05600 RADI OI SOTOPE 5, 035, 513 11, 034, 466 16, 069, 979 0.173475 0.000000 56.00 56.00 57.00 05700 CT SCAN 49, 862, 919 84, 934, 239 134, 797, 158 0.036135 0.000000 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 11, 881, 745 19, 386, 008 31, 267, 753 58.00 0.053977 0.000000 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 36, 533, 561 34, 055, 835 70, 589, 396 0.082529 0.000000 59.00 60.00 06000 LABORATORY 101, 355, 213 122, 464, 480 223, 819, 693 0.085968 0.000000 60.00 7, 760, 468 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 4, 437, 524 12, 197, 992 0. 181865 0.000000 62.00 62.00 06400 I NTRAVENOUS THERAPY 64.00 0.000000 0.000000 64.00 65.00 06500 RESPIRATORY THERAPY 39, 563, 740 3, 390, 557 42, 954, 297 0.141697 0.000000 65.00 06600 PHYSI CAL THERAPY 6, 908, 324 7, 841, 511 0.353273 66.00 933, 187 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 5, 174, 350 540, 884 5, 715, 234 0.393792 0.000000 67.00 06800 SPEECH PATHOLOGY 68.00 2,607,732 285, 378 2, 893, 110 0.283291 0.000000 68.00 13, 493, 447 69.00 06900 ELECTROCARDI OLOGY 12, 249, 228 25, 742, 675 0.054491 0.000000 69.00 69.01 06901 CARDI AC REHAB 316, 044 780, 521 1, 096, 565 0.617359 0.000000 69.01 70 00 07000 ELECTROENCEPHALOGRAPHY 8.051.747 24, 556, 611 32, 608, 358 0.069320 0.000000 70 00 30, 556, 429 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 55, 185, 539 0.000000 71.00 24, 629, 110 0.356930 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 15, 889, 673 19, 533, 989 35, 423, 662 0.470084 0.000000 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 106, 353, 584 55, 953, 142 162, 306, 726 0.201197 0.000000 73.00 74.00 07400 RENAL DIALYSIS 944, 953 9, 399, 418 0.308925 0.000000 8, 454, 465 74 00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 23, 780, 998 0. 454880 0.000000 247, 282 24, 028, 280 90.00 91 00 09100 EMERGENCY 19, 268, 625 69, 453, 822 88. 722. 447 0. 245815 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 5, 597, 199 21, 317, 385 26, 914, 584 0.552988 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 3, 944, 434 3, 944, 434 101.00 675, 761, 313 200.00 Subtotal (see instructions) 741, 500, 163 1, 417, 261, 476 200.00 201.00 Less Observation Beds 201.00

675, 761, 313

741, 500, 163 1, 417, 261, 476

202.00

202.00

Total (see instructions)

| Health Financial Systems                 | METHODIST HOSPITALS, INC | In Lieu of Form CMS-2552-10   |
|--|--------------------------|---|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | Provi der CCN: 15-0002   | Peri od: Worksheet C From 01/01/2021 Part I Date/Time Prepared: 5/27/2023 0.02 cm |

|  |               |             | 10 12/31/2021 | 5/27/2022 9:02 a |
|--|---------------|-------------|---------------|------------------|
|  |               | Title XVIII | Hospi tal     | PPS              |
| Cost Center Description                          | PPS Inpatient |             |               |                  |
|  | Ratio         |             |               |                  |
|  | 11. 00        |             |               |                  |
| INPATIENT ROUTINE SERVICE COST CENTERS           |               |             |               |                  |
| 0.00 03000 ADULTS & PEDIATRICS                   |               |             |               | 30               |
| 1.00   03100   INTENSIVE CARE UNIT               |               |             |               | 31               |
| 1.01  03101 NEONATAL   CU                        |               |             |               | 31               |
| 0. 00   04000   SUBPROVI DER - I PF              |               |             |               | 40               |
| . 00   04100   SUBPROVI DER - I RF               |               |             |               | 41               |
| . 00   04300   NURSERY                           |               |             |               | 43               |
| ANCILLARY SERVICE COST CENTERS                   |               |             |               |                  |
| 0.00 O5000 OPERATING ROOM                        | 0. 096903     |             |               | 50               |
| . 01   05001   ENDOSCOPY                         | 0. 149106     |             |               | 50               |
| . 00 05100 RECOVERY ROOM                         | 0. 212317     |             |               | 51               |
| . 00 05200 DELIVERY ROOM & LABOR ROOM            | 1. 498119     |             |               | 52               |
| . 00 05300 ANESTHESI OLOGY                       | 0. 000000     |             |               | 53               |
| . 00   05400   RADI OLOGY-DI AGNOSTI C           | 0. 194558     |             |               | 54               |
| . 01   05401   RADI OLOGY - ULTRASOUND           | 0. 127908     |             |               | 54               |
| . 00 05500 RADI OLOGY-THERAPEUTI C               | 0. 172729     |             |               | 55               |
| . 01   05501   I NFUSI ON CENTER                 | 0. 612818     |             |               | 55               |
| . 00   05600   RADI OI SOTOPE                    | 0. 173475     |             |               | 56               |
| . 00   05700   CT   SCAN                         | 0. 036135     |             |               | 57               |
| . 00   05800   MAGNETIC RESONANCE   MAGING (MRI) | 0. 053977     |             |               | 58               |
| 0. 00 05900 CARDI AC CATHETERI ZATI ON           | 0. 082529     |             |               | 59               |
| 0. 00 06000 LABORATORY                           | 0. 085968     |             |               | 60               |
| . 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS  |               |             |               | 62               |
| . 00 06400 I NTRAVENOUS THERAPY                  | 0. 000000     |             |               | 64               |
| · · · · · · · · · · · · · · · · · · ·            | 1             |             |               |                  |
| 6. 00 06500 RESPIRATORY THERAPY                  | 0. 141697     |             |               | 65               |
| 0. 00   06600   PHYSI CAL THERAPY                | 0. 353273     |             |               | 66               |
| 0.00 06700 OCCUPATI ONAL THERAPY                 | 0. 393792     |             |               | 67               |
| 0.00 06800 SPEECH PATHOLOGY                      | 0. 283291     |             |               | 68               |
| . 00 06900 ELECTROCARDI OLOGY                    | 0. 054491     |             |               | 69               |
| O1 06901 CARDI AC REHAB                          | 0. 617359     |             |               | 69               |
| . 00 07000 ELECTROENCEPHALOGRAPHY                | 0. 069320     |             |               | 70               |
| . 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS  |               |             |               | 71               |
| . 00 07200 IMPL. DEV. CHARGED TO PATIENTS        | 0. 470084     |             |               | 72               |
| . 00 07300 DRUGS CHARGED TO PATIENTS             | 0. 201197     |             |               | 73               |
| . 00 O7400 RENAL DIALYSIS                        | 0. 308925     |             |               | 74               |
| OUTPATIENT SERVICE COST CENTERS                  | 0 15 1000     |             |               |                  |
| . 00   09000   CLINIC                            | 0. 454880     |             |               | 90               |
| . 00   09100   EMERGENCY                         | 0. 245815     |             |               | 91               |
| . 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)  | 0. 552988     |             |               | 92               |
| OTHER REIMBURSABLE COST CENTERS                  |               |             |               |                  |
| 1. 00 10100 HOME HEALTH AGENCY                   |               |             |               | 101              |
| 0.00 Subtotal (see instructions)                 |               |             |               | 200              |
| 11.00 Less Observation Beds                      |               |             |               | 201              |
| 02.00  Total (see instructions)                  |               |             |               | 202              |

|   |                             |               |                              | o 12/31/2021    | Date/Time Pre<br>5/27/2022 9:0 | pared:         |
|---|-----------------------------|---------------|------------------------------|-----------------|--------------------------------|----------------|
|   |                             | Ti +I         | e XIX                        | Hospi tal       | Cost                           | z aiii         |
|   |                             | 11 (1         | C XIX                        | Costs           | 0031                           |                |
| Cost Center Description   | Total Cost                  | Therapy Limit | Total Costs                  | RCE             | Total Costs                    |                |
| 555t 5511td. 25551.pt. 511  | (from Wkst.                 | Adj.          | 10141 00010                  | Di sal I owance | .014. 00010                    |                |
|   | B, Part I,                  |               |                              |                 |                                |                |
|   | col. 26)                    |               |                              |                 |                                |                |
|   | 1. 00                       | 2.00          | 3.00                         | 4. 00           | 5. 00                          |                |
| INPATIENT ROUTINE SERVICE COST CENTERS  | •                           |               | •                            |                 |                                |                |
| 30. 00 03000 ADULTS & PEDIATRICS  | 83, 469, 209                |               | 83, 469, 209                 | 0               | 83, 469, 209                   | 30.00          |
| 31.00 03100 INTENSIVE CARE UNIT   | 16, 976, 791                |               | 16, 976, 791                 | 0               | 16, 976, 791                   | 31.00          |
| 31. 01   03101   NEONATAL   CU  | 2, 894, 417                 |               | 2, 894, 417                  | 0               | 2, 894, 417                    | 31. 01         |
| 40. 00   04000   SUBPROVI DER - 1 PF  | 1, 815, 787                 |               | 1, 815, 787                  | 0               | 1, 815, 787                    | 40.00          |
| 41. 00   04100   SUBPROVI DER - I RF  | 5, 176, 818                 |               | 5, 176, 818                  | 0               | 5, 176, 818                    | 41.00          |
| 43. 00 04300 NURSERY  | 3, 483, 536                 |               | 3, 483, 536                  | 0               | 3, 483, 536                    | 43.00          |
| ANCILLARY SERVICE COST CENTERS  |                             |               |                              |                 |                                |                |
| 50.00   05000   OPERATING ROOM  | 16, 405, 073                |               | 16, 405, 073                 | 0               | 16, 405, 073                   | 50.00          |
| 50. 01  05001  ENDOSCOPY  | 1, 867, 097                 |               | 1, 867, 097                  | 0               | 1, 867, 097                    | 50. 01         |
| 51.00   05100   RECOVERY ROOM   | 2, 554, 938                 |               | 2, 554, 938                  | 0               | 2, 554, 938                    | 51.00          |
| 52.00   05200   DELIVERY ROOM & LABOR ROOM  | 6, 633, 702                 |               | 6, 633, 702                  | 0               | 6, 633, 702                    |                |
| 53. 00   05300   ANESTHESI OLOGY  | 0                           |               | 0                            | 0               | 0                              | 53.00          |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C  | 7, 952, 671                 |               | 7, 952, 671                  | 0               | 7, 952, 671                    | 54.00          |
| 54. 01 05401 RADI OLOGY - ULTRASOUND  | 2, 902, 450                 |               | 2, 902, 450                  |                 | 2, 902, 450                    |                |
| 55. 00   05500   RADI OLOGY-THERAPEUTI C  | 3, 916, 620                 |               | 3, 916, 620                  | 2, 561          | 3, 919, 181                    | 55.00          |
| 55. 01   05501   I NFUSI ON CENTER  | 79, 781                     |               | 79, 781                      | 0               | 79, 781                        | 55. 01         |
| 56. 00   05600   RADI OI SOTOPE   | 2, 787, 732                 |               | 2, 787, 732                  |                 | 2, 787, 732                    | 56. 00         |
| 57.00 05700 CT SCAN   | 4, 870, 909                 |               | 4, 870, 909                  | I               | 4, 870, 909                    | 57.00          |
| 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)  | 1, 687, 734                 |               | 1, 687, 734                  |                 | 1, 687, 734                    |                |
| 59. 00   05900   CARDI AC   CATHETERI ZATI ON   | 5, 825, 663                 |               | 5, 825, 663                  |                 | 5, 825, 663                    | 59.00          |
| 60. 00   06000   LABORATORY   | 19, 241, 253                |               | 19, 241, 253                 |                 | 19, 241, 253                   | 60.00          |
| 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS   | 2, 218, 385                 |               | 2, 218, 385                  |                 | 2, 218, 385                    | 1              |
| 64. 00   06400   I NTRAVENOUS THERAPY   | 0                           |               | 0                            | ١               | 0                              | 64.00          |
| 65. 00 06500 RESPIRATORY THERAPY  | 6, 086, 490                 | 0             |                              | I               | 6, 086, 490                    |                |
| 66. 00   06600   PHYSI CAL THERAPY  | 2, 770, 198                 | 0             |                              |                 | 2, 770, 198                    |                |
| 67. 00 06700 OCCUPATI ONAL THERAPY  | 2, 250, 612                 | 0             |                              |                 | 2, 250, 612                    | 67.00          |
| 68. 00 06800 SPEECH PATHOLOGY   | 819, 592                    | 0             |                              |                 | 819, 592                       | 1              |
| 69. 00 06900 ELECTROCARDI OLOGY   | 1, 402, 745                 |               | 1, 402, 745                  | I               | 1, 402, 745                    |                |
| 69. 01   06901   CARDI AC REHAB 70. 00   07000   ELECTROENCEPHALOGRAPHY                     | 676, 974                    |               | 676, 974                     | l .             | 676, 974                       | 1              |
|   | 2, 260, 413<br>19, 697, 372 |               | 2, 260, 413                  | I               | 2, 260, 413                    |                |
| 71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS | 16, 652, 092                |               | 19, 697, 372<br>16, 652, 092 |                 | 19, 697, 372<br>16, 652, 092   | 71.00<br>72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS   | 32, 655, 600                |               | 32, 655, 600                 |                 | 32, 655, 600                   |                |
| 74. 00 07400 RENAL DIALYSIS   | 2, 903, 716                 |               | 2, 903, 716                  |                 | 2, 903, 716                    |                |
| OUTPATIENT SERVICE COST CENTERS   | 2, 903, 710                 |               | 2, 903, 710                  | l ol            | 2, 903, 710                    | 74.00          |
| 90. 00 09000 CLI NI C   | 10, 929, 976                |               | 10, 929, 976                 | ol              | 10, 929, 976                   | 90.00          |
| 91. 00   09100   EMERGENCY  | 21, 809, 345                |               | 21, 809, 345                 |                 | 21, 809, 345                   |                |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)   | 14, 883, 439                |               | 14, 883, 439                 |                 | 14, 883, 439                   |                |
| OTHER REIMBURSABLE COST CENTERS   | 17,000,407                  |               | 17,000,407                   |                 | 17, 000, 407                   | , ,2.00        |
| 101. 00 10100 HOME HEALTH AGENCY  | 3, 457, 854                 |               | 3, 457, 854                  |                 | 3, 457, 854                    | 101 00         |
| 200.00 Subtotal (see instructions)  | 332, 016, 984               | 0             |                              |                 | 332, 019, 545                  |                |
| 201.00 Less Observation Beds  | 14, 883, 439                |               | 14, 883, 439                 |                 | 14, 883, 439                   |                |
| 202.00 Total (see instructions)   | 317, 133, 545               | 0             |                              | I               |                                |                |
|   | 1 2,, 0.10                  | ı             | 1 2,, 0.00                   | _,,             | 3,,                            | , .=3          |

From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/27/2022 9:02 am Title XIX Hospi tal Cost Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent **TEFRA** + col. 7) Ratio Inpati ent Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 80, 353, 912 80, 353, 912 30.00 31.00 03100 INTENSIVE CARE UNIT 23, 628, 573 23, 628, 573 31.00 03101 NEONATAL ICU 6, 340, 767 6, 340, 767 31.01 31.01 40.00 04000 SUBPROVI DER - I PF 2, 296, 180 2, 296, 180 40.00 04100 SUBPROVI DER - I RF 41.00 4, 463, 400 4, 463, 400 41.00 43.00 04300 NURSERY 1, 996, 068 1, 996, 068 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 61, 149, 104 169, 292, 906 0.000000 50.00 108, 143, 802 0.096903 50.00 05001 ENDOSCOPY 50.01 4, 187, 052 8, 334, 895 12, 521, 947 0.149106 0.000000 50.01 51.00 05100 RECOVERY ROOM 3, 850, 256 8, 183, 332 12, 033, 588 0.212317 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 837, 919 2, 590, 103 4, 428, 022 1. 498119 0.000000 52.00 05300 ANESTHESI OLOGY 0.000000 0.000000 53 00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 9, 920, 270 30, 955, 296 40, 875, 566 0.194558 0.000000 54.00 5, 666, 770 17, 024, 992 22, 691, 762 54.01 05401 RADI OLOGY - ULTRASOUND 0.127908 0.000000 54.01 1, 082, 901 05500 RADI OLOGY-THERAPEUTI C 21, 606, 886 22, 689, 787 0.000000 55.00 0.172616 55.00 05501 INFUSION CENTER 55.01 3, 400 126, 787 130, 187 0.612818 0.000000 55 01 05600 RADI OI SOTOPE 5, 035, 513 11, 034, 466 16, 069, 979 0.173475 0.000000 56.00 56.00 57.00 05700 CT SCAN 49, 862, 919 84, 934, 239 134, 797, 158 0.036135 0.000000 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 11, 881, 745 19, 386, 008 31, 267, 753 58.00 0.053977 0.000000 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 36, 533, 561 34, 055, 835 70, 589, 396 0.082529 0.000000 59.00 60.00 06000 LABORATORY 101, 355, 213 122, 464, 480 223, 819, 693 0.085968 0.000000 60.00 7, 760, 468 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 4, 437, 524 12, 197, 992 0. 181865 0.000000 62.00 62.00 06400 I NTRAVENOUS THERAPY 64.00 0.000000 0.000000 64.00 65.00 06500 RESPIRATORY THERAPY 39, 563, 740 3, 390, 557 42, 954, 297 0.141697 0.000000 65.00 06600 PHYSI CAL THERAPY 6, 908, 324 7, 841, 511 0.353273 66.00 933, 187 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 5, 174, 350 5, 715, 234 0.393792 0.000000 540.884 67.00 06800 SPEECH PATHOLOGY 68.00 2,607,732 285, 378 2, 893, 110 0.283291 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 13, 493, 447 12, 249, 228 25, 742, 675 0.054491 0.000000 69.00 69.01 06901 CARDI AC REHAB 316, 044 780, 521 1, 096, 565 0.617359 0.000000 69.01 70 00 07000 ELECTROENCEPHALOGRAPHY 8.051.747 24, 556, 611 32, 608, 358 0.069320 0.000000 70 00 30, 556, 429 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 55, 185, 539 0.000000 71.00 24, 629, 110 0.356930 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 15, 889, 673 19, 533, 989 35, 423, 662 0.470084 0.000000 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 106, 353, 584 55, 953, 142 162, 306, 726 0.201197 0.000000 73.00 74.00 07400 RENAL DIALYSIS 944, 953 9, 399, 418 0.308925 0.000000 8, 454, 465 74 00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 23, 780, 998 0. 454880 0.000000 247, 282 24, 028, 280 90.00 91 00 09100 EMERGENCY 19, 268, 625 69, 453, 822 88. 722. 447 0. 245815 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 5, 597, 199 21, 317, 385 26, 914, 584 0.552988 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 3, 944, 434 3, 944, 434 101.00 675, 761, 313

675, 761, 313

741, 500, 163 1, 417, 261, 476

741, 500, 163 1, 417, 261, 476

200.00

201.00 202.00

200.00

201.00

202.00

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

| Health Financial Systems                 | METHODIST HOSPITALS, INC | In Lieu o                            | of Form CMS-2552-10                          |
|--|--------------------------|--------------------------------------|--|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | Provi der CCN: 15-0002   | From 01/01/2021 P<br>To 12/31/2021 D | Vorksheet C<br>Part I<br>Pate/Time Prepared: |

|   |               |           | 12,01,2021 | 5/27/2022 9: 02 am |
|---|---------------|-----------|------------|--------------------|
|   |               | Title XIX | Hospi tal  | Cost               |
| Cost Center Description                           | PPS Inpatient |           |            |                    |
|   | Ratio         |           |            |                    |
|   | 11. 00        |           |            |                    |
| INPATIENT ROUTINE SERVICE COST CENTERS            |               |           |            |                    |
| 30. 00   03000   ADULTS & PEDI ATRI CS            |               |           |            | 30.00              |
| 31.00 03100 INTENSIVE CARE UNIT                   |               |           |            | 31.00              |
| 31. 01  03101  NEONATAL   CU                      |               |           |            | 31.01              |
| 40. 00   04000   SUBPROVI DER - 1 PF              |               |           |            | 40.00              |
| 41. 00  04100  SUBPROVI DER - I RF                |               |           |            | 41.00              |
| 43. 00 04300 NURSERY                              |               |           |            | 43.00              |
| ANCILLARY SERVICE COST CENTERS                    |               |           |            |                    |
| 50.00   05000   OPERATING ROOM                    | 0. 000000     |           |            | 50.00              |
| 50. 01   05001   ENDOSCOPY                        | 0. 000000     |           |            | 50. 01             |
| 51.00  05100   RECOVERY ROOM                      | 0. 000000     |           |            | 51.00              |
| 52.00  05200 DELIVERY ROOM & LABOR ROOM           | 0. 000000     |           |            | 52.00              |
| 53. 00   05300   ANESTHESI OLOGY                  | 0. 000000     |           |            | 53.00              |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C          | 0. 000000     |           |            | 54.00              |
| 54. 01   05401   RADI OLOGY - ULTRASOUND          | 0. 000000     |           |            | 54. 01             |
| 55. 00   05500   RADI OLOGY-THERAPEUTI C          | 0. 000000     |           |            | 55.00              |
| 55. 01   05501   I NFUSI ON CENTER                | 0. 000000     |           |            | 55. 01             |
| 56. 00   05600   RADI 0I SOTOPE                   | 0. 000000     |           |            | 56.00              |
| 57. 00  05700 CT SCAN                             | 0. 000000     |           |            | 57.00              |
| 58.00   05800   MAGNETIC RESONANCE I MAGING (MRI) | 0. 000000     |           |            | 58.00              |
| 59. 00  05900  CARDI AC CATHETERI ZATI ON         | 0. 000000     |           |            | 59.00              |
| 60. 00   06000   LABORATORY                       | 0. 000000     |           |            | 60.00              |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS  | 0. 000000     |           |            | 62.00              |
| 64. 00   06400   I NTRAVENOUS THERAPY             | 0. 000000     |           |            | 64.00              |
| 65. 00  06500 RESPI RATORY THERAPY                | 0. 000000     |           |            | 65.00              |
| 66. 00  06600  PHYSI CAL THERAPY                  | 0. 000000     |           |            | 66.00              |
| 67. 00  06700 OCCUPATI ONAL THERAPY               | 0. 000000     |           |            | 67.00              |
| 68. 00  06800 SPEECH PATHOLOGY                    | 0. 000000     |           |            | 68.00              |
| 69. 00  06900  ELECTROCARDI OLOGY                 | 0. 000000     |           |            | 69.00              |
| 69. 01  06901  CARDI AC REHAB                     | 0. 000000     |           |            | 69. 01             |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY               | 0. 000000     |           |            | 70.00              |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS  | 0. 000000     |           |            | 71.00              |
| 72.00 07200 MPL. DEV. CHARGED TO PATIENTS         | 0. 000000     |           |            | 72.00              |
| 73.00 07300 DRUGS CHARGED TO PATIENTS             | 0. 000000     |           |            | 73.00              |
| 74. 00 07400 RENAL DIALYSIS                       | 0. 000000     |           |            | 74.00              |
| OUTPATIENT SERVICE COST CENTERS                   |               |           |            |                    |
| 90. 00   09000   CLI NI C                         | 0. 000000     |           |            | 90.00              |
| 91. 00   09100   EMERGENCY                        | 0. 000000     |           |            | 91.00              |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 000000     |           |            | 92.00              |
| OTHER REIMBURSABLE COST CENTERS                   |               |           |            |                    |
| 101.00 10100 HOME HEALTH AGENCY                   |               |           |            | 101.00             |
| 200.00 Subtotal (see instructions)                |               |           |            | 200.00             |
| 201.00 Less Observation Beds                      |               |           |            | 201. 00            |
| 202.00  Total (see instructions)                  |               |           |            | 202. 00            |

| Health Financial Systems                           | METHODIST HOS | SPITALS, INC |              | In Lie                                      | u of Form CMS-2   | 2552-10 |
|--|---------------|--------------|--------------|---|---|---------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL | COSTS         | Provi der C  |              | Period:<br>From 01/01/2021<br>To 12/31/2021 | Worksheet D<br>Part I<br>Date/Time Pre<br>5/27/2022 9:0 |         |
|  |               |              | XVIII        | Hospi tal                                   | PPS   |         |
| Cost Center Description                            | Capi tal      | Swi ng Bed   | Reduced      | Total Patient                               | Per Diem  |         |
|  | Related Cost  | Adjustment   | Capi tal     | Days  | (col. 3 /   |         |
|  | (from Wkst.   |              | Related Cost |   | col. 4)   |         |
|  | B, Part II,   |              | (col. 1 -    |   |   |         |
|  | col. 26)      |              | col . 2)     |   |   |         |
|  | 1. 00         | 2. 00        | 3. 00        | 4. 00                                       | 5. 00   |         |
| INPATIENT ROUTINE SERVICE COST CENTERS             |               |              |              |   |   |         |
| 30.00 ADULTS & PEDIATRICS                          | 6, 083, 843   |              | -,,          |   | 74. 96  |         |
| 31.00   INTENSIVE CARE UNIT                        | 474, 104      |              | 474, 1C      |   |   |         |
| 31. 01 NEONATAL I CU                               | 59, 638       |              | 59, 63       |   |   |         |
| 40. 00   SUBPROVI DER - I PF                       | 82, 155       |              | 82, 15       |   |   |         |
| 41.00 SUBPROVIDER - IRF                            | 576, 495      |              | 576, 49      |   | 134. 07   | 41.00   |
| 43. 00 NURSERY                                     | 424, 528      |              | 424, 52      |   | 206. 48   |         |
| 200.00 Total (lines 30 through 199)                | 7, 700, 763   |              | 7, 700, 76   | 3 100, 412                                  |   | 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                         | 18, 462       |              |              |   |   | 30.00   |
| 31.00 INTENSIVE CARE UNIT                          | 2, 984        |              | 1            |   |   | 31.00   |
| 31. 01 NEONATAL I CU                               | 0             |              | 1            |   |   | 31. 01  |
| 40. 00 SUBPROVI DER - I PF                         | 422           |              |              |   |   | 40.00   |
| 41. 00 SUBPROVI DER - I RF                         | 1, 987        |              | 1            |   |   | 41.00   |
| 43. 00 NURSERY                                     | 0             | -            |              |   |   | 43.00   |
| 200.00 Total (lines 30 through 199)                | 23, 855       | 1, 832, 147  | l            |   |   | 200. 00 |

| Health Financial Systems           | METHODI ST HOSPI         | TALS, INC             | In Lieu                     | u of Form CMS-2552-10  |
|------------------------------------|--------------------------|-----------------------|-----------------------------|------------------------|
| APPORTIONMENT OF INPATIENT ANCILLA | RY SERVICE CAPITAL COSTS | Provider CCN: 15-0002 | Peri od:<br>From 01/01/2021 | Worksheet D<br>Part II |

| Cost Center Description  | APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA | AL COSTS    | Provi der C   |          | Period:<br>From 01/01/2021<br>To 12/31/2021 | Worksheet D<br>Part II<br>Date/Time Pre<br>5/27/2022 9:0 | pared:<br>2 am |
|--|---|-------------|---------------|----------|---|--|----------------|
| Related Cost   Crom Wisst   Col . 1  |   |             |               |          |   |  |                |
| Refrom Wirst.   Repart II, col. 26   1.00   2.00   3.00   4.00   5.00    | Cost Center Description                             |             |               |          |   |  |                |
| B, Part II, col. 8)  |   |             |               |          |   |  |                |
| ANCILLARY SERVICE COST CENTERS   1.00   2.00   3.00   4.00   5.00  |   |             |               |          | Charges                                     | column 4)  |                |
| ANCILLARY SERVICE COST CENTERS   1.00   2.00   3.00   4.00   5.00  |   |             | col. 8)       | col. 2)  |   |  |                |
| ANCILLARY SERVICE COST CENTERS   1,182,536   169,292,906   0.006985   13,413,691   93,695   50.00   050000   050000   050000   050000   050000   050000   050000   050000   050000   050000   0500000   0500   |   |             |               |          |   |  |                |
| SO 00  |   | 1. 00       | 2. 00         | 3. 00    | 4. 00                                       | 5. 00  |                |
| 50.01   05001   ENDOSCOPY   26, 345   12, 521, 947   0, 002104   1, 474, 976   3, 103   50, 01   |   |             |               |          |   |  |                |
| 51.00  |   |             |               |          |   | •  |                |
| 52.00   05200   DELI VERY ROOM & LABOR ROOM   179,511   4,428,022   0.040540   7,272   295   52.00   53.00   05300   ANESTHESI OLOGY   0   0.000000   0   0   53.00   54.00   05400   RADI OLOGY-DI AGNOSTI C   931,913   40,875,566   0.022799   3,310,011   75,465   54.00   54.01   05401   RADI OLOGY - ULTRASOUND   112,872   22,691,762   0.004974   1,411,974   7,023   54.01   55.00   05500   RADI OLOGY-THERAPEUTI C   248,649   22,689,787   0.010959   367,910   4,032   55.00   55.01   05501   INFUSI ON CENTER   6,332   130,187   0.048638   0   0.55.01   56.00   05600   RADI OLOGY-THERAPEUTI C   248,649   22,689,787   0.010959   367,910   4,032   55.00   56.00   05500   RADI OLOGY-THERAPEUTI C   248,649   22,689,787   0.010959   367,910   4,032   55.00   57.00   05500   RADI OLOGY-THERAPEUTI C   248,649   22,689,787   0.010959   367,910   4,032   55.00   58.00   05600   RADI OLOGY-THERAPEUTI C   248,649   22,689,787   0.010959   367,910   4,032   55.00   57.00   05500   CEAN   243,192   343,797,158   0.001737   44,734,253   25,593   57.00   58.00   05600   RADI OLOGY-THERAPEUTI C   234,192   34,797,158   0.001737   44,734,253   25,593   57.00   58.00   05500   CARDI AC CATHETERI ZATI ON   206,588   70,589,396   0.002927   3,471,943   10,312   58.00   59.00   05900   CARDI AC CATHETERI ZATI ON   206,588   70,589,396   0.002927   11,645,073   34,085   59.00   60.00   06000   LABDRATTORY   601,467   223,819,693   0.002687   28,318,209   76,091   60.00   60.00   06000   CABDRATTORY   180,098   42,954,297   0.004193   10,731,920   44,999   65.00   65.00   06500   RESPI RATORY   THERAPY   180,098   42,954,297   0.004193   10,731,920   44,999   65.00   65.00   06600   PHYSI CAL THERAPY   180,098   42,954,297   0.004193   10,731,920   44,999   65.00   65.00   06600   SEETE ATTOONY   THERAPY   180,098   42,954,297   0.004193   10,731,920   44,999   65.00   65.00   06600   SEETE OLOGY   35,018   32,608,358   0.009026   2,636,227   2,441   70.00   66.00   06600   SEETE OLOGY   35,018   32,608,358   0.009026   2,636,227   2,441  |   |             |               |          |   |  |                |
| 53.00   05300   AMESTHESI OLOGY   0   0   0   0   0   0   0   0   0  |   |             |               |          |   |  |                |
| 54. 00   05400   RADI OLOGY - DI AGNOSTI C   931, 913   40, 875, 566   0.022799   3, 310, 011   75, 465   54. 00   54. 01   055401   RADI OLOGY - ULTRASOUND   112, 872   22, 691, 762   0.004974   1, 411, 974   7, 023   55. 00   55. 01   05501   INFUSI ON CENTER   6, 332   130, 187   0.048638   0   0   55. 01   55. 00   05500   RADI OLOGY - THERAPEUTI C   248, 649   22, 689, 787   0.010959   367, 910   4, 022   55. 00   55. 01   05501   INFUSI ON CENTER   6, 332   130, 187   0.048638   0   0   55. 01   56. 00   05500   RADI OLOGY - THERAPEUTI C   6, 332   16, 069, 979   0.010602   1, 555, 406   16, 490   57. 00   05700   CT SCAN   234, 192   134, 797, 158   0.001737   14, 734, 253   25, 593   57. 00   58. 00   05800   MAGNETI C RESONANCE   IMAGI NG (MRI )   92, 872   31, 267, 753   0.002970   3, 471, 943   10, 312   58. 00   59. 00   05900   CARDI AC CATHETERI ZATI ON   206, 588   70, 589, 396   0.002927   11, 645, 073   34, 085   59. 00   60. 00   06000   LABGRATORY   601, 467   223, 819, 693   0.002687   28, 318, 209   76, 091   60. 00   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   27, 096   12, 197, 992   0.002221   2, 038, 533   4, 528   62. 00   64. 00   06400   INTRAVENOUS THERAPY   180, 098   42, 954, 297   0.004193   10, 731, 920   44, 999   65. 00   65. 00   06500   RESPI RATORY THERAPY   180, 098   42, 954, 297   0.004193   10, 731, 920   44, 999   65. 00   66. 00   06600   PHYSI CAL THERAPY   218, 109   7, 841, 511   0.027815   1, 568, 779   43, 636   66. 00   67. 00   07000   CULDATI IONAL THERAPY   30, 186   32, 608, 358   0.00926   2, 636, 227   2, 441   70. 00   71. 00   07000   ELECTROCARDI OLOGY   22, 953   25, 742, 675   0.000892   4, 162, 295   3, 713   69. 00   72. 00   07000   ELECTROCARDI OLOGY   22, 953   25, 742, 675   0.000897   4, 162, 295   3, 713   69. 00   73. 00   07000   ELECTROCARDI OLOGY   22, 953   25, 742, 675   0.000897   4, 162, 295   3, 713   69. 00   74. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   31, 88, 666   9, 399, 418   0.009308   1, 944, 431   79, |   |             |               |          |   |  |                |
| 54.01   05401   RADI OLOGY - ULTRASOUND   112, 872   22, 691, 762   0.004974   1, 411, 974   7, 023   54.01     55.00   05500   RADI OLOGY-THERAPEUTI C   248, 649   22, 669, 787   0.010959   367, 910   4, 032   55.00     55.01   05501   NFUSI ON CENTER   6, 332   130, 187   0.048638   0   0   0.55.01     56.00   05600   RADI OLOGY-THERAPEUTI C   248, 649   22, 669, 787   0.010602   1, 555, 406   16, 490   56.00     57.00   05700   CT SCAN   234, 192   134, 797, 158   0.001737   14, 734, 253   25, 593   57.00     58.00   05800   MAGRETI C RESONANCE   IMAGI NG (MRI )   92, 872   31, 267, 753   0.002970   3, 471, 943   101, 513   58.00     59.00   05900   CARDI AC CATHETERI ZATI ON   206, 588   70, 589, 396   0.002927   11, 645, 073   34, 085   59.00     60.00   06000   LABORATORY   601, 467   223, 819, 693   0.002687   28, 318, 209   76, 091   60.00     60.00   06000   LABORATORY   601, 467   223, 819, 693   0.002687   28, 318, 209   76, 091   60.00     60.00   06400   INTRAVENOUS THERAPY   180, 098   42, 954, 297   0.004193   10, 731, 920   44, 999   65.00     65.00   06500   RESPI RATORY THERAPY   186, 097   5, 715, 234   0.032562   1, 065, 980   34, 710   67.00     68.00   06600   PHSTI CALT THERAPY   218, 109   7, 841, 1511   0.027815   1, 568, 779   43, 636   60.00     69.00   06900   ELECTROCARDI OLOGY   22, 953   25, 742, 675   0.003983   0   0.005988   0.009926   2, 636, 227   2, 441   70.00     69.01   06901   CARDI AC REHAB   4, 636   1, 096, 565   0.003983   0   0.009926   2, 636, 227   2, 441   70.00     71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   372, 826   35, 423, 662   0.010525   5, 571, 189   58, 637   72.00     72.00   07200   DRUGS CHARGED TO PATI ENTS   515, 440   162, 306, 726   0.003176   27, 461, 593   87, 218   73.00     79.00   09000   CLINI C   0.00151   0.   |   | _           | ľ             |          |   | _  |                |
| 55. 00   05500   RADI OLGGY-THERAPEUTI C   248, 649   22, 689, 787   0. 010959   367, 910   4, 032   55. 00   55. 01   05501   INFUSI ON CENTER   6, 332   130, 187   0. 048638   0   0   55. 01   05500   CF SCAN   170, 373   16, 069, 979   0. 010602   1, 555, 406   16, 490   56. 00   05700   CT SCAN   234, 192   134, 797, 158   0. 001737   14, 734, 253   25, 593   57. 00   5800   MAGNETI C RESONANCE I MAGI NG (MRI )   92, 872   31, 267, 753   0. 002970   3, 471, 943   10, 312   58. 00   05900   CARDI AC CATHETERI ZATI ON   206, 588   70, 589, 396   0. 002971   11, 645, 073   34, 085   59. 00   06000   LABORATORY   601, 467   223, 819, 693   0. 002687   28, 318, 209   76, 091   60. 00   60. 00   6000   LABORATORY   601, 467   223, 819, 693   0. 002687   28, 318, 209   76, 091   60. 00   64. 00   06400   INTRAVENOUS THERAPY   180, 098   42, 954, 297   0. 004193   10, 731, 920   44, 999   65. 00   66. 00   6600   PHYSI CAL THERAPY   218, 109   7, 841, 511   0. 027815   1, 568, 779   43, 636   60. 00   6000   Good   Columbat Theraphy   186, 097   5, 715, 234   0. 032562   1, 665, 980   34, 710   67. 00   69. 00   60900   ELECTROCARDI OLOGY   22, 953   25, 742, 675   0. 000892   4, 162, 295   3, 713   69. 00   69. 01   60900   ELECTROCARDI OLOGY   22, 953   25, 742, 675   0. 000892   4, 162, 295   3, 713   69. 00   69. 01   60900   ELECTROCARDI OLOGY   22, 953   32, 608, 358   0. 000926   2, 636, 227   2, 441   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   372, 826   35, 423, 662   0. 010525   5, 571, 189   58, 637   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   315, 440   162, 306, 726   0. 003176   27, 461, 593   87, 218   73. 00   07300   DRUGS CHARGED TO PATI ENTS   515, 440   162, 306, 726   0. 003176   27, 441, 593   87, 218   73. 00   07400   RENAL DI ALYSI S   0. 00900   CLI NI C   0. 00900   CLI NI C   0. 00900   CLI NI C   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 0000 |   | 931, 913    |               |          |   | 75, 465  |                |
| 55. 01   05501   INFUSION CENTER   6,332   130, 187   0.048638   0   0   55. 01  |   |             |               |          |   |  |                |
| 56. 00   05600   RADI OI SOTOPE   170, 373   16, 069, 979   0. 010602   1, 555, 406   16, 490   56. 00   5700   CT SCAN   234, 192   134, 797, 158   0. 001737   14, 734, 253   25, 593   57. 00   5800   MAGNETI C RESONANCE IMAGI NG (MRI )   92, 872   31, 267, 753   0. 002970   3, 471, 943   10, 312   58. 00   05900   CARDI AC CATHETERI ZATI ON   206, 588   70, 589, 396   0. 002927   11, 645, 073   34, 085   59. 00   06000   LABORATORY   601, 467   223, 819, 693   0. 002687   28, 318, 209   76, 091   60. 00   62. 00   WHOLE BLOOD & PACKED RED BLOOD CELLS   27, 096   12, 197, 992   0. 002221   2, 038, 533   4, 528   62. 00   64. 00   06400   Intrravenous Therapy   180, 098   42, 954, 297   0. 004193   10, 731, 920   44, 999   65. 00   66. 00   6600   PHYSI CAL THERAPY   180, 098   42, 954, 297   0. 004193   10, 731, 920   44, 999   65. 00   66. 00   6600   PHYSI CAL THERAPY   186, 097   5, 715, 234   0. 032562   1, 065, 980   34, 710   67. 00   69. 00   60600   SPEECH PATHOLOGY   35, 018   2, 893, 110   0. 012104   827, 068   10, 011   68. 00   69. 00   69. 00   69. 00   69. 00   69. 00   69. 00   69. 01   69. 01   60. 01   60. 01   60. 00   69. 01   60. 01   60. 01   60. 00  | 55. 00   05500   RADI OLOGY-THERAPEUTI C            | 248, 649    | 22, 689, 787  | 0. 01095 | 9 367, 910                                  | 4, 032   | 55.00          |
| 57. 00 05700 CT SCAN 234, 192 134, 797, 158 0.001737 14, 734, 253 25, 593 57. 00 5800 MAGNETIC RESONANCE I MAGI NG (MRI ) 92, 872 31, 267, 753 0.002970 3, 471, 943 10, 312 58. 00 05900 CARDI AC CATHETERI ZATI ON 206, 588 70, 589, 396 0.002927 11, 645, 073 34, 085 59. 00 06000 LABORATORY 601, 467 223, 819, 693 0.002687 28, 318, 209 76, 091 60. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 27, 096 12, 197, 992 0.002221 2, 038, 533 4, 528 62. 00 06000 I NTRAVENOUS THERAPY 0 0 0.000000 0 0 0.000000 0 0 0.000000 0 0 0.000000  | 55. 01   05501   I NFUSI ON CENTER                  | 6, 332      | 130, 187      | 0. 04863 | 8 0   | 0  | 55. 01         |
| 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 92, 872 31, 267, 753 0.002970 3, 471, 943 10, 312 58. 00 59900 CARDIAC CATHETERIZATION 206, 588 70, 589, 396 0.002927 11, 645, 073 34, 085 59. 00 60. 00 6000 LABORATORY 601, 467 223, 819, 693 0.002687 28, 318, 209 76, 091 60. 00 6200 WHOLE BLOOD & PACKED RED BLOOD CELLS 27, 096 12, 197, 992 0.002221 2, 038, 533 4, 528 62. 00 64. 00 64. 00 64. 00 64. 00 64. 00 65. 00 6500 RESPI RATORY THERAPY 180, 098 42, 954, 297 0.004193 10, 731, 920 44, 999 65. 00 66. 00 66600 PHYSI CAL THERAPY 186, 097 5, 715, 234 0.032562 1, 065, 980 34, 710 67. 00 67. 00 06900 ELECTROCARDI OLOGY 35, 018 2, 893, 110 0.012104 827, 068 10, 011 68. 00 69. 01 66901 CARDI AC REHAB 4, 368 1, 096, 565 0.00990 ELECTROCARDI OLOGY 22, 953 25, 742, 675 0.000892 4, 162, 295 3, 713 69. 00 69. 01 06901 CARDI AC REHAB 4, 368 1, 096, 565 0.00990 ELECTROCEPHALOGRAPHY 30, 186 32, 608, 358 0.000926 2, 636, 227 2, 441 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 444, 614 55, 185, 539 0.000567 7, 445, 467 59, 988 71. 00 07300 DRUGS CHARGED TO PATI ENTS 372, 826 35, 423, 662 0.010525 5, 571, 189 58, 637 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 372, 826 35, 423, 662 0.010525 5, 571, 189 58, 637 72. 00 07400 RENAL DI ALYSI S 88, 666 9, 399, 418 0.00943 3, 104, 878 29, 288 74. 00 07400 RENAL DI ALYSI S 88, 666 9, 399, 418 0.00943 3, 104, 878 29, 288 74. 00 07400 RENAL DI ALYSI S 88, 666 9, 399, 418 0.00943 3, 104, 878 29, 288 74. 00 09200 DRUGS CHARGED TO PATI ENTS 1, 309, 168 24, 028, 280 0.00943 3, 104, 878 29, 288 74. 00 09200 DRUGS CHARGED TO PATI ENTS 1, 309, 168 24, 028, 280 0.00943 3, 104, 878 29, 288 74. 00 09400 EMERGENCY 695, 659 88, 722, 447 0.007841 5, 816, 869 45, 610 91. 00 09000 CLINIC 96900 DRUGS CHARGED TO PATI ENTS 1, 309, 168 24, 028, 280 0.00943 3, 104, 471 78, 372 92. 00 09200 DRUGS CHARGED TO PATI ENTS 1, 309, 168 24, 028, 280 0.00943 3, 104, 878 29, 288 74. 00 09400 DRUGS CHARGED TO PATI ENTS 1, 309, 168 24, 028, 280 0.00943 3, 104, 471 78, 372 92. 00 00 09200 DRUGS CHARGED TO PA | 56. 00   05600   RADI 0I SOTOPE                     | 170, 373    | 16, 069, 979  | 0. 01060 | 2 1, 555, 406                               | 16, 490  | 56.00          |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON 200, 588 70, 589, 396 0. 002927 11, 645, 073 34, 085 59. 00 60. 00 06000 LABORATTORY 601, 467 223, 819, 693 0. 002687 28, 318, 209 76, 091 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 27, 096 12, 197, 992 0. 002221 2, 038, 533 4, 528 62. 00 64. 00 06400 INTRAVENOUS THERAPY 0 0 0. 0000000 0 0. 000000 0 0. 000000 0 0. 000000   | 57. 00  05700 CT SCAN                               | 234, 192    | 134, 797, 158 | 0. 00173 | 7 14, 734, 253                              | 25, 593  | 57.00          |
| 60. 00   06000   LABORATORY   601, 467   223, 819, 693   0. 002687   28, 318, 209   76, 091   60. 00   | 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)        | 92, 872     | 31, 267, 753  | 0. 00297 | 0 3, 471, 943                               | 10, 312  | 58.00          |
| 62. 00   | 59. 00   05900   CARDI AC   CATHETERI ZATI ON       | 206, 588    | 70, 589, 396  | 0. 00292 | 7 11, 645, 073                              | 34, 085  | 59.00          |
| 64. 00   | 60. 00   06000   LABORATORY                         | 601, 467    | 223, 819, 693 | 0. 00268 | 7 28, 318, 209                              | 76, 091  | 60.00          |
| 65. 00   | 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS    | 27, 096     | 12, 197, 992  | 0. 00222 | 1 2, 038, 533                               | 4, 528   | 62.00          |
| 66. 00   06600   PHYSI CAL THERAPY   218, 109   7, 841, 511   0.027815   1, 568, 779   43, 636   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   186, 097   5, 715, 234   0.032562   1, 065, 980   34, 710   67. 00   68. 00   06800   SPEECH PATHOLOGY   35, 018   2, 893, 110   0.012104   827, 068   10, 011   68. 00   69. 00   06900   ELECTROCARDI OLOGY   22, 953   25, 742, 675   0.000892   4, 162, 295   3, 713   69. 00   69. 01   06901   CARDI AC REHAB   4, 368   1, 096, 565   0.003983   0   0   0   69. 01   07000   ELECTROENCEPHALOGRAPHY   30, 186   32, 608, 358   0.000926   2, 636, 227   2, 441   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   444, 614   55, 185, 539   0.008057   7, 445, 467   59, 988   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   372, 826   35, 423, 662   0.010525   5, 571, 189   58, 637   72. 00   73. 00   07400   RENAL DI ALYSIS   88, 666   9, 399, 418   0.009433   3, 104, 878   29, 288   74. 00   07400   RENAL DI ALYSIS   88, 666   9, 399, 418   0.009433   3, 104, 878   29, 288   74. 00   00000   00000   CLI INI C   0.00000   0.00000   0.00000   0.000000   0.00000000   | 64. 00 06400 I NTRAVENOUS THERAPY                   | 0           | 0             | 0. 00000 | 0   | 0  | 64.00          |
| 67. 00   | 65. 00 06500 RESPIRATORY THERAPY                    | 180, 098    | 42, 954, 297  | 0. 00419 | 3 10, 731, 920                              | 44, 999  | 65.00          |
| 68. 00   | 66. 00 06600 PHYSI CAL THERAPY                      | 218, 109    | 7, 841, 511   | 0. 02781 | 5 1, 568, 779                               | 43, 636  | 66.00          |
| 69. 00   06900   ELECTROCARDI OLOGY   22, 953   25, 742, 675   0.000892   4, 162, 295   3, 713   69. 00   69. 01   06901   CARDI AC REHAB   4, 368   1, 096, 565   0.003983   0   0   69. 01   0.00092   0.000 | 67. 00 06700 OCCUPATI ONAL THERAPY                  | 186, 097    | 5, 715, 234   | 0. 03256 | 2 1, 065, 980                               | 34, 710  | 67.00          |
| 69. 01 06901 CARDI AC REHAB  | 68. 00 06800 SPEECH PATHOLOGY                       | 35, 018     | 2, 893, 110   | 0. 01210 | 4 827, 068                                  | 10, 011  | 68. 00         |
| 69. 01 06901 CARDI AC REHAB  | 69. 00 06900 ELECTROCARDI OLOGY                     | 22, 953     | 25, 742, 675  | 0. 00089 | 2 4, 162, 295                               | 3, 713   | 69. 00         |
| 71. 00   |   | 4, 368      | 1, 096, 565   | 0. 00398 | 3 0   | 0  | 69. 01         |
| 72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   372, 826   35, 423, 662   0.010525   5, 571, 189   58, 637   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   515, 440   162, 306, 726   0.003176   27, 461, 593   87, 218   73. 00   74. 00   07400   RENAL DI ALYSIS   88, 666   9, 399, 418   0.009433   3, 104, 878   29, 288   74. 00   074000   07400   07400   07400   07400   07400   07400   07400   07400   07400   0 | 70. 00 07000 ELECTROENCEPHALOGRAPHY                 | 30, 186     | 32, 608, 358  | 0. 00092 | 6 2, 636, 227                               | 2, 441   | 70.00          |
| 72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   372, 826   35, 423, 662   0.010525   5, 571, 189   58, 637   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   515, 440   162, 306, 726   0.003176   27, 461, 593   87, 218   73. 00   74. 00   07400   RENAL DI ALYSIS   88, 666   9, 399, 418   0.009433   3, 104, 878   29, 288   74. 00   074000   07400   07400   07400   07400   07400   07400   07400   07400   07400   0 | 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS    | 444, 614    | 55, 185, 539  | 0. 00805 | 7, 445, 467                                 | 59, 988  | 71.00          |
| 74. 00 07400 RENAL DI ALYSI S 88, 666 9, 399, 418 0. 009433 3, 104, 878 29, 288 74. 00 00TPATI ENT SERVI CE COST CENTERS  90. 00 09000 CLI NI C 1, 309, 168 24, 028, 280 0. 054484 40, 959 2, 232 90. 00 91. 00 09100 EMERGENCY 695, 659 88, 722, 447 0. 007841 5, 816, 869 45, 610 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 1, 084, 809 26, 914, 584 0. 040306 1, 944, 431 78, 372 92. 00  | 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS          | 372, 826    | 35, 423, 662  | 0. 01052 |   | 58, 637  | 72.00          |
| OUTPATIENT SERVICE COST CENTERS           90.00         09000 CLINIC         1,309,168         24,028,280         0.054484         40,959         2,232         90.00           91.00         09100 EMERGENCY         695,659         88,722,447         0.007841         5,816,869         45,610         91.00           92.00         09200 OBSERVATION BEDS (NON-DISTINCT PART)         1,084,809         26,914,584         0.040306         1,944,431         78,372         92.00   | 73. 00 07300 DRUGS CHARGED TO PATIENTS              | 515, 440    | 162, 306, 726 | 0. 00317 | 6 27, 461, 593                              | 87, 218  | 73.00          |
| OUTPATIENT SERVICE COST CENTERS         1, 309, 168         24, 028, 280         0.054484         40, 959         2, 232         90. 00           91. 00         09100 EMERGENCY         695, 659         88, 722, 447         0.007841         5, 816, 869         45, 610         91. 00           92. 00         09200 OBSERVATION BEDS (NON-DISTINCT PART)         1,084, 809         26, 914, 584         0.040306         1,944, 431         78, 372         92. 00  | 74.00 07400 RENAL DIALYSIS                          | 88, 666     | 9, 399, 418   | 0.00943  | 3 3, 104, 878                               | 29, 288  | 74.00          |
| 91. 00   09100   EMERGENCY   695, 659   88, 722, 447   0. 007841   5, 816, 869   45, 610   91. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   1,084, 809   26, 914, 584   0. 040306   1, 944, 431   78, 372   92. 00   |   | · ·         |               | •        |   |  |                |
| 91. 00   09100   EMERGENCY   695, 659   88, 722, 447   0. 007841   5, 816, 869   45, 610   91. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   1,084, 809   26, 914, 584   0. 040306   1, 944, 431   78, 372   92. 00   | 90. 00 09000 CLI NI C                               | 1, 309, 168 | 24, 028, 280  | 0. 05448 | 40, 959                                     | 2, 232   | 90.00          |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1,084,809 26,914,584 0.040306 1,944,431 78,372 92.00  |   |             |               |          |   |  |                |
|  | 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)    |             |               |          |   |  |                |
| 200. 00 Total (Lines 50 through 199) 9, 468, 049 1, 294, 238, 142 155, 082, 359 872, 154 200. 00   | 200.00 Total (lines 50 through 199)                 |             |               |          | 155, 082, 359                               |  |                |

| Health Financial Systems                            | METHODIST HOS | SPITALS INC     |               | In lie                                      | u of Form CMS-2   | 2552-10             |
|---|---------------|-----------------|---------------|---|---|---------------------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA |               | STS Provi der C |               | Period:<br>From 01/01/2021<br>Fo 12/31/2021 | Worksheet D<br>Part III<br>Date/Time Pre<br>5/27/2022 9:0 | pared:              |
|   |               | Title           | XVIII         | Hospi tal                                   | PPS   |                     |
| Cost Center Description                             | Nursi ng      | Nursi ng        | Allied Health | Allied Health                               | All Other   |                     |
|   | Program       | Program         | Post-Stepdown | Cost  | Medi cal  |                     |
|   | Post-Stepdown |                 | Adjustments   |   | Educati on  |                     |
|   | Adjustments   |                 |               |   | Cost  |                     |
|   | 1A            | 1.00            | 2A            | 2. 00                                       | 3. 00   |                     |
| INPATIENT ROUTINE SERVICE COST CENTERS              |               |                 |               |   |   |                     |
| 30. 00 03000 ADULTS & PEDIATRICS                    | 0             | 0               | )             | 0   | 0   | 30.00               |
| 31. 00 03100 I NTENSI VE CARE UNI T                 | 0             | -               | l             |   | Ő   | 31.00               |
| 31. 01   03101   NEONATAL   CU                      | 0             |                 |               | 0   | Ö   | 31. 01              |
| 40. 00   04000   SUBPROVI DER -   1 PF              |               |                 |               |   | 0   | 40.00               |
|   | 0             |                 | (             |   |   |                     |
|   | 0             | 0               |               |   | 0   |                     |
| 43. 00 04300 NURSERY                                | 0             | 0               |               | 0   | 0   |                     |
| 200.00   Total (lines 30 through 199)               | 0             | 0               | )             | ) 0   |   | 200.00              |
| Cost Center Description                             | Swi ng-Bed    | Total Costs     | Total_Patient |   | Inpati ent  |                     |
|   | Adjustment    | (sum of cols.   | Days          | (col. 5 ÷                                   | Program Days  |                     |
|   | Amount (see   | 1 through 3,    |               | col . 6)                                    |   |                     |
|   |               | minus col. 4)   |               |   |   |                     |
|   | 4. 00         | 5. 00           | 6. 00         | 7. 00                                       | 8. 00   |                     |
| INPATIENT ROUTINE SERVICE COST CENTERS              | _             | _               |               |   |   |                     |
| 30. 00   03000   ADULTS & PEDI ATRI CS              | 0             |                 |               |   | 18, 462   |                     |
| 31.00 03100 INTENSIVE CARE UNIT                     |               | 0               | .,            |   | 2, 984  | 1                   |
| 31. 01  03101   NEONATAL   CU                       |               | 0               | 2, 46         |   | 0   | 31.01               |
| 40. 00   04000   SUBPROVI DER - 1 PF                | 0             | 0               | 1, 23         |   | 422   | 40.00               |
| 41. 00   04100   SUBPROVI DER - I RF                | 0             | 0               | 4, 30         | 0.00  | 1, 987  | 41.00               |
| 43. 00   04300   NURSERY                            |               | 0               | 2, 05         | 0.00  | 0   | 43.00               |
| 200.00 Total (lines 30 through 199)                 |               | l 0             | 100, 41       | 2   | 23, 855   | 200.00              |
| Cost Center Description                             | Inpatient     |                 |               | -   |   |                     |
| ·   | Program       |                 |               |   |   |                     |
|   | Pass-Through  |                 |               |   |   |                     |
|   | Cost (col. 7  |                 |               |   |   |                     |
|   | x col. 8)     |                 |               |   |   |                     |
|   | 9.00          |                 |               |   |   |                     |
| INPATIENT ROUTINE SERVICE COST CENTERS              |               |                 |               |   |   |                     |
| 30. 00 03000 ADULTS & PEDIATRICS                    | 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 -   1 PF              | 0             | •               |               |   |   | 40.00               |
| 41. 00   04100   SUBPROVI DER -   1 FF              | 0             | •               |               |   |   | 41.00               |
| 43. 00   04300   NURSERY                            |               | 1               |               |   |   | 43.00               |
| 200.00 Total (lines 30 through 199)                 |               | l .             |               |   |   | 200.00              |
| 200.00   Total (Titles 30 tillough 199)             | 1             | I               |               |   |   | <sub>1</sub> 200.00 |

| Health Financial Systems              | METHODIST HOSPITALS, INC                             | In Lieu of Form CMS-2552-10 |
|---------------------------------------|--|-----------------------------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT | ANCILLARY SERVICE OTHER PASS   Provider CCN: 15-0002 | Peri od: Worksheet D        |
| THROUGH COSTS                         |  | From 01/01/2021 Part IV     |

| THROUGH COSTS                                     |               |               |          | To 12/31/2021 | Date/Time Pre<br>5/27/2022 9:0 | pared: |
|---|---------------|---------------|----------|---------------|--------------------------------|--------|
|   |               | Title         | : XVIII  | Hospi tal     | PPS                            |        |
| Cost Center Description                           | Non Physician | Nursi ng      | Nursi ng | Allied Health | Allied Health                  |        |
|   | Anesthetist   | Program       | Program  | Post-Stepdown |                                |        |
|   | Cost          | Post-Stepdown |          | Adjustments   |                                |        |
|   |               | Adjustments   |          |               |                                |        |
|   | 1. 00         | 2A            | 2. 00    | 3A            | 3. 00                          |        |
| ANCILLARY SERVICE COST CENTERS                    |               |               | 1        |               |                                |        |
| 50. 00   05000   OPERATING ROOM                   | 0             | 0             |          | 0             | 0                              |        |
| 50. 01   05001   ENDOSCOPY                        | 0             | 0             |          | 0             | 0                              | 50. 01 |
| 51. 00   05100   RECOVERY ROOM                    | 0             | 0             |          | 0             | 0                              | 51.00  |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM            | 0             | 0             |          | 0             | 0                              | 52.00  |
| 53. 00   05300   ANESTHESI OLOGY                  | 0             | 0             |          | 0             | 0                              |        |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C          | 0             | 0             |          | 0             | 0                              | 54.00  |
| 54. 01   05401   RADI OLOGY - ULTRASOUND          | 0             | 0             |          | 0             | 0                              | 54. 01 |
| 55. 00   05500   RADI OLOGY-THERAPEUTI C          | 0             | 0             |          | 0             | 0                              | 55.00  |
| 55. 01   05501   I NFUSI ON CENTER                | 0             | 0             |          | 0             | 0                              | 55. 01 |
| 56. 00   05600   RADI OI SOTOPE                   | 0             | 0             |          | 0             | 0                              | 56.00  |
| 57. 00  05700 CT SCAN                             | 0             | 0             |          | 0             | 0                              | 57.00  |
| 58.00   05800   MAGNETIC RESONANCE I MAGING (MRI) | 0             | 0             |          | 0             | 0                              | 58. 00 |
| 59. 00   05900   CARDI AC   CATHETERI ZATI ON     | 0             | 0             |          | 0             | 0                              | 59.00  |
| 60. 00   06000   LABORATORY                       | 0             | 0             |          | 0             | 0                              | 60.00  |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS  | 0             | 0             |          | 0             | 0                              | 62.00  |
| 64.00   06400   I NTRAVENOUS THERAPY              | 0             | 0             |          | 0             | 0                              | 64.00  |
| 65. 00 06500 RESPI RATORY THERAPY                 | 0             | 0             |          | 0             | 0                              | 65.00  |
| 66. 00   06600 PHYSI CAL THERAPY                  | 0             | 0             |          | 0             | 0                              | 66.00  |
| 67. 00   06700 OCCUPATI ONAL THERAPY              | 0             | 0             |          | 0             | 0                              | 67.00  |
| 68. 00 06800 SPEECH PATHOLOGY                     | 0             | 0             |          | 0             | 0                              | 68.00  |
| 69. 00 06900 ELECTROCARDI OLOGY                   | 0             | 0             |          | 0             | 0                              | 69.00  |
| 69. 01   06901   CARDI AC   REHAB                 | 0             | 0             |          | 0             | 0                              | 69. 01 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY               | 0             | 0             |          | 0             | 0                              | 70.00  |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS  | 0             | 0             |          | 0             | 0                              | 71.00  |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS        | 0             | 0             |          | 0             | 0                              | 72.00  |
| 73.00 07300 DRUGS CHARGED TO PATIENTS             | 0             | 0             |          | 0 0           | 0                              | 73.00  |
| 74. 00 07400 RENAL DI ALYSI S                     | 0             | 0             |          | 0 0           | 0                              | 74.00  |
| OUTPATIENT SERVICE COST CENTERS                   |               |               |          |               |                                |        |
| 90. 00 09000 CLI NI C                             | 0             | 0             |          | 0 0           | 0                              | 90.00  |
| 91. 00 09100 EMERGENCY                            | 0             | 0             |          | 0 0           | 1, 227, 853                    | 91.00  |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)  | 0             |               |          | 0             | 0                              | 92.00  |
| 200.00 Total (lines 50 through 199)               | 0             | 0             |          | 0 0           | 1, 227, 853                    | 200.00 |
|   |               |               |          |               |                                |        |

| Health Financial Systems              | METHODIST HOSPITALS, INC                             | In Lieu of Form CMS-2552-10 |
|---------------------------------------|--|-----------------------------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT | ANCILLARY SERVICE OTHER PASS   Provider CCN: 15-0002 |                             |
| TURQUEU COCTE                         |  | From 01/01/2021   Part IV   |

THROUGH COSTS To 12/31/2021 Date/Time Prepared: 5/27/2022 9:02 am Title XVIII Hospi tal All Other Ratio of Cost Cost Center Description Total Cost Total Total Charges to Charges Medi cal (sum of cols. Outpati ent (from Wkst. Educati on 1, 2, 3, and Cost (sum of C, Part I, (col. 5 ÷ 4) Cost col s. 2, 3, col. 8) col. 7) and 4) (see instructions) 4. 00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 169, 292, 906 0.000000 50.00 05001 ENDOSCOPY 0 0 12, 521, 947 0.000000 50.01 00000000000000000000000000000 50.01 05100 RECOVERY ROOM 0 12, 033, 588 51.00 0 0.000000 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 4, 428, 022 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 40, 875, 566 0.000000 54.00 22, 691, 762 54.01 05401 RADI OLOGY - ULTRASOUND 0 0 0.000000 54.01 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0 22, 689, 787 0.000000 55.00 55.01 05501 INFUSION CENTER 130, 187 0.000000 55.01 16, 069, 979 134, 797, 158 05600 RADI OI SOTOPE 0 0.000000 56.00 56.00 05700 CT SCAN 0 0 0.000000 57.00 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 31, 267, 753 0.000000 58.00 05900 CARDI AC CATHETERI ZATI ON 0 70, 589, 396 0.000000 59.00 0 59.00 223, 819, 693 06000 LABORATORY 60 00 Ω 0 000000 60 00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 12, 197, 992 0.000000 62.00 64.00 06400 I NTRAVENOUS THERAPY 0 0 0.000000 64.00 06500 RESPIRATORY THERAPY 42, 954, 297 65.00 0 0.000000 65.00 06600 PHYSI CAL THERAPY 0 0.000000 66.00 0 7, 841, 511 66 00 06700 OCCUPATI ONAL THERAPY 0 67.00 0 5, 715, 234 0.000000 67.00 06800 SPEECH PATHOLOGY 2, 893, 110 0.000000 68.00 25, 742, 675 69.00 06900 ELECTROCARDI OLOGY 0 0.000000 69.00 06901 CARDI AC REHAB 0 1, 096, 565 0.000000 69 01 69 01 70.00 07000 ELECTROENCEPHALOGRAPHY 0 32, 608, 358 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 55, 185, 539 0.000000 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 35, 423, 662 72.00 72.00 0 0.000000 07300 DRUGS CHARGED TO PATIENTS 0 Ω 0.000000 73.00 162, 306, 726 73.00 74.00 07400 RENAL DIALYSIS 0 0 9, 399, 418 0.000000 74.00 OUTPATIENT SERVICE COST CENTERS 90 00 0 0.000000 09000 CLI NI C 24, 028, 280 90 00 0 91.00 09100 EMERGENCY 1, 227, 853 1, 227, 853 88, 722, 447 0.013839 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 26, 914, 584 0.000000 92.00 Total (lines 50 through 199) o 1, 227, 853 1, 294, 238, 142 200.00 1, 227, 853 200.00

| Health Financial Systems                            | METHODIST HOSPITALS, INC |             |      |           |              | In Lie                                       | u of Form CMS-2  | 2552-10 |
|---|--------------------------|-------------|------|-----------|--------------|--|--|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS | ANCI LLARY SERVI         | CE OTHER F  | PASS | Provi der | CCN: 15-0002 | Peri od:<br>From 01/01/2021<br>To 12/31/2021 | Worksheet D<br>Part IV<br>Date/Time Pre<br>5/27/2022 9:0 |         |
|   |                          |             |      | Ti tl     | e XVIII      | Hospi tal                                    | PPS  |         |
| Cost Contor Doscription                             |                          | Outpati ont | .    | Innationt | Innationt    | Outpationt                                   | Outpationt   |         |

|   |               |               | '             | 0 12/31/2021 | 5/27/2022 9:0 |        |
|---|---------------|---------------|---------------|--------------|---------------|--------|
|   |               |               | : XVIII       | Hospi tal    | PPS           |        |
| Cost Center Description                           | Outpati ent   | I npati ent   | I npati ent   | Outpati ent  | Outpati ent   |        |
|   | Ratio of Cost | Program       | Program       | Program      | Program       |        |
|   | to Charges    | Charges       | Pass-Through  | Charges      | Pass-Through  |        |
|   | (col. 6 ÷     | ŭ             | Costs (col. 8 | Ü            | Costs (col. 9 |        |
|   | col. 7)       |               | x col. 10)    |              | x col. 12)    |        |
|   | 9. 00         | 10. 00        | 11.00         | 12.00        | 13.00         |        |
| ANCILLARY SERVICE COST CENTERS                    |               |               |               |              |               |        |
| 50. 00   05000 OPERATING ROOM                     | 0. 000000     | 13, 413, 691  | C             | 18, 694, 844 | 0             | 50.00  |
| 50. 01   05001   ENDOSCOPY                        | 0. 000000     | 1, 474, 976   |               | 1, 566, 447  | 0             | 50. 01 |
| 51.00   05100   RECOVERY ROOM                     | 0. 000000     | 955, 453      |               | 1, 229, 776  | 0             | 51.00  |
| 52.00   05200   DELIVERY ROOM & LABOR ROOM        | 0. 000000     | 7, 272        |               | 195, 211     | 0             | 52.00  |
| 53. 00   05300   ANESTHESI OLOGY                  | 0. 000000     | 0             | C             | 0            | 0             | 53.00  |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C          | 0. 000000     | 3, 310, 011   |               | 5, 411, 371  | 0             | 54.00  |
| 54. 01   05401 RADI OLOGY - ULTRASOUND            | 0. 000000     | 1, 411, 974   | (             | 1, 578, 134  | 0             | 54. 01 |
| 55. 00   05500 RADI OLOGY-THERAPEUTI C            | 0. 000000     | 367, 910      | (             | 6, 278, 287  | 0             | 55.00  |
| 55. 01   05501   I NFUSI ON CENTER                | 0. 000000     | 0             | l c           | 0            | 0             | 55. 01 |
| 56. 00   05600   RADI 0I SOTOPE                   | 0. 000000     | 1, 555, 406   | l c           | 2, 375, 120  | 0             | 56.00  |
| 57. 00 05700 CT SCAN                              | 0. 000000     | 14, 734, 253  | l c           |              |               | 57.00  |
| 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)      | 0. 000000     | 3, 471, 943   | l c           | 3, 403, 993  | 0             | 58. 00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON           | 0. 000000     | 11, 645, 073  | l c           | 7, 433, 853  | 0             | 59.00  |
| 60. 00 06000 LABORATORY                           | 0. 000000     | 28, 318, 209  | 1 0           | 7, 176, 749  | 0             | 60.00  |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS  | 0. 000000     | 2, 038, 533   | 1 0           | 223, 629     |               | 62.00  |
| 64. 00 06400 I NTRAVENOUS THERAPY                 | 0. 000000     | 0             |               |              |               | 64.00  |
| 65. 00 06500 RESPI RATORY THERAPY                 | 0. 000000     | 10, 731, 920  | 1 0           | 573, 354     | 0             | 65.00  |
| 66. 00 06600 PHYSI CAL THERAPY                    | 0. 000000     | 1, 568, 779   | 1 0           | 0            | 0             | 66.00  |
| 67. 00 06700 OCCUPATI ONAL THERAPY                | 0. 000000     | 1, 065, 980   |               | 0            | 0             | 67.00  |
| 68.00 06800 SPEECH PATHOLOGY                      | 0. 000000     | 827, 068      |               | 21, 025      | 0             | 68.00  |
| 69. 00 06900 ELECTROCARDI OLOGY                   | 0. 000000     | 4, 162, 295   |               |              |               | 69.00  |
| 69. 01   06901 CARDI AC REHAB                     | 0. 000000     | 0             |               | 263, 274     |               | 69. 01 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY               | 0. 000000     | 2, 636, 227   | ĺ             | 6, 669, 747  |               | 70.00  |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS  | 0. 000000     | 7, 445, 467   |               | 6, 327, 304  |               | 71.00  |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS        | 0. 000000     | 5, 571, 189   |               | 4, 641, 293  |               | 72.00  |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS            | 0. 000000     | 27, 461, 593  |               |              |               | 73.00  |
| 74. 00   07400   RENAL DI ALYSI S                 | 0. 000000     | 3, 104, 878   | •             |              |               | 74.00  |
| OUTPATIENT SERVICE COST CENTERS                   |               | 2, 12 1, 0, 0 |               |              |               | 1      |
| 90. 00 09000 CLI NI C                             | 0. 000000     | 40, 959       |               | 2, 769, 074  | 0             | 90.00  |
| 91. 00   09100   EMERGENCY                        | 0. 013839     | 5, 816, 869   |               |              |               | 91.00  |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 000000     | 1, 944, 431   |               |              |               | 92.00  |
| 200.00 Total (lines 50 through 199)               |               | 155, 082, 359 |               |              |               |        |
|   |               |               |               |              |               | •      |

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0002 Peri od: Worksheet D From 01/01/2021 Part V Date/Time Prepared: 12/31/2021 5/27/2022 9:02 am Title XVIII Hospi tal Charges Costs PPS Services Cost Center Description Cost to PPS Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 1. 00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0.096903 18, 694, 844 1, 811, 586 50.00 05001 ENDOSCOPY 0 0.149106 1, 566, 447 0 50.01 233, 567 50.01 05100 RECOVERY ROOM 51.00 0. 212317 1, 229, 776 261, 102 51.00 292, 449 52.00 05200 DELIVERY ROOM & LABOR ROOM 1. 498119 195, 211 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0 0 0 53.00 0 0. 194558 5, 411, 371 0 1, 052, 826 54.00 05400 RADI OLOGY-DI AGNOSTI C 54 00 0 54.01 05401 RADI OLOGY - ULTRASOUND 0. 127908 1, 578, 134 201, 856 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 0. 172616 6, 278, 287 0 0 0 1, 083, 733 55.00 0 05501 INFUSION CENTER 55.01 0.612818 55.01 0 0 05600 RADI OI SOTOPE 2, 375, 120 412,024 56.00 0.173475 56.00 57.00 05700 CT SCAN 0.036135 13, 333, 744 481, 815 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 3, 403, 993 0 58.00 0.053977 0 0 183, 737 58.00 0 05900 CARDI AC CATHETERI ZATI ON 613, 508 59 00 0.082529 7, 433, 853 59 00 0 60.00 06000 LABORATORY 0.085968 7, 176, 749 616, 971 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0. 181865 223, 629 0 0 40, 670 62.00 06400 I NTRAVENOUS THERAPY 0 0 64.00 0.000000 64.00 0 0 06500 RESPIRATORY THERAPY 0 0 141697 573, 354 81, 243 65 00 65 00 0 66.00 06600 PHYSI CAL THERAPY 0.353273 0 66.00 06700 OCCUPATI ONAL THERAPY 0.393792 0 67.00 0 0 68.00 06800 SPEECH PATHOLOGY 0. 283291 21,025 5, 956 68.00 0 06900 ELECTROCARDI OLOGY 0.054491 2, 114, 992 115, 248 69 00 69 00 o 69. 01 06901 CARDI AC REHAB 0.617359 263, 274 162, 535 69.01 07000 ELECTROENCEPHALOGRAPHY 0 0 462, 347 70.00 0.069320 6, 669, 747 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 2, 258, 405 71.00 0.356930 6, 327, 304 71.00 0. 470084 0 07200 IMPL. DEV. CHARGED TO PATIENTS 2, 181, 798 72.00 4, 641, 293 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 201197 17, 683, 883 0 19,881 3, 557, 944 73.00 07400 RENAL DIALYSIS <u>295,</u> 792 74.00 0.308925 0 0 91, 378 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.454880 2, 769, 074 0 1, 259, 596 90.00 09100 EMERGENCY 0. 245815 6, 998, 165 0 1, 720, 254 91.00 0 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.552988 2, 543, 715 0 1, 406, 644 92.00 0 0 19,881 200.00 Subtotal (see instructions) 119, 802, 776 20, 589, 192 200. 00 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 119, 802, 776 0 19, 881 20, 589, 192 202. 00

Date/Time Prepared: 5/27/2022 9:02 am 12/31/2021 Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 7. 00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 05001 ENDOSCOPY 50.01 0 50.01 51. 00 | 05100 | RECOVERY ROOM 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 53. 00 05300 ANESTHESI OLOGY 0 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 54.01 05401 RADI OLOGY - ULTRASOUND 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0 55.01 05501 INFUSION CENTER 55.01 05600 RADI OI SOTOPE 0 56.00 56.00 57. 00 | 05700 CT SCAN 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 58.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 59 00 60.00 06000 LABORATORY 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 06400 I NTRAVENOUS THERAPY 64.00 64.00 06500 RESPIRATORY THERAPY 0 65 00 65 00 06600 PHYSI CAL THERAPY 0 66.00 66.00 67.00 06700 OCCUPATI ONAL THERAPY 67.00 06800 SPEECH PATHOLOGY 0 68.00 68.00 69 00 06900 ELECTROCARDI OLOGY 0 69 00 69.01 06901 CARDI AC REHAB 0 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 4,000 73.00 07400 RENAL DIALYSIS 74.00 0 0 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 0 91.00 09100 EMERGENCY 91.00 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 C Subtotal (see instructions) 200.00 200.00 4.000

4,000

201.00

202.00

201.00

202.00

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Only Charges

| Health Financial Cystems   | METHODI CT. HOC           | DITALC INC                    |              | la li o                          | u of Form CMC                             | 2552 10  |
|--|---------------------------|-------------------------------|--------------|----------------------------------|---|----------|
| Health Financial Systems APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA                 | METHODIST HOS<br>AL COSTS | Provider C                    | CN: 15-0002  | Period:                          | u of Form CMS-2<br>Worksheet D            | 2552-10  |
|  |                           |                               | CCN: 15-S002 | From 01/01/2021<br>To 12/31/2021 | Part II<br>Date/Time Pre<br>5/27/2022 9:0 | pared:   |
|  |                           | Title                         | xVIII        | Subprovi der -                   | PPS                                       | <u> </u> |
| Cost Center Description  | Capi tal                  | Total Charges                 | Ratio of Cos |                                  | Capital Costs                             |          |
|  | Related Cost              | (from Wkst.                   | to Charges   | Program                          | (column 3 x                               |          |
|  | (from Wkst.               | C, Part I,                    | (col . 1 ÷   | Charges                          | column 4)                                 |          |
|  | B, Part II,               | col. 8)                       | col . 2)     | Ŭ                                | ,   |          |
|  | col. 26)                  |                               |              |                                  |   |          |
|  | 1. 00                     | 2. 00                         | 3.00         | 4. 00                            | 5. 00                                     |          |
| ANCILLARY SERVICE COST CENTERS   |                           |                               |              |                                  |   |          |
| 50.00   05000 OPERATING ROOM   | 1, 182, 536               | 169, 292, 906                 |              |                                  | 1   |          |
| 50. 01   05001   ENDOSCOPY   | 26, 345                   |                               |              |                                  | 7   | 50. 01   |
| 51. 00   05100   RECOVERY ROOM   | 259, 292                  |                               | 1            |                                  | 0   | 51.00    |
| 52. 00 05200 DELIVERY ROOM & LABOR ROOM  | 179, 511                  | 4, 428, 022                   |              |                                  | 0   | 52.00    |
| 53. 00 05300 ANESTHESI OLOGY   | 0                         | 0                             |              |                                  | 0   | 53.00    |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C   | 931, 913                  |                               |              |                                  |   | 54.00    |
| 54. 01   05401   RADI OLOGY - ULTRASOUND   | 112, 872                  | 22, 691, 762                  |              | · ·                              |   | 1        |
| 55. 00   05500   RADI OLOGY-THERAPEUTI C   | 248, 649                  | 22, 689, 787                  |              |                                  | 0   | 55.00    |
| 55. 01   05501   I NFUSI ON CENTER   | 6, 332                    | 130, 187                      |              |                                  | 0   |          |
| 56. 00   05600   RADI OI SOTOPE  | 170, 373                  |                               |              |                                  | •   |          |
| 57. 00 05700 CT SCAN   | 234, 192                  | 134, 797, 158                 |              |                                  | 29  |          |
| 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)  | 92, 872                   | 31, 267, 753                  |              |                                  | l   |          |
| 59. 00   05900   CARDI AC CATHETERI ZATI ON  | 206, 588                  | 70, 589, 396                  |              |                                  | 0   |          |
| 60. 00   06000   LABORATORY<br>62. 00   06200   WHOLE   BLOOD & PACKED   RED   BLOOD   CELLS | 601, 467<br>27, 096       | 223, 819, 693<br>12, 197, 992 |              |                                  | 439<br>25                                 | 62.00    |
| 64. 00   06400   NTRAVENOUS THERAPY  | 27,096                    | 12, 197, 992                  | 1            |                                  | 0   | 64.00    |
| 65. 00   06500   RESPI RATORY   THERAPY  | 180, 098                  | 42, 954, 297                  |              |                                  | 6   | 65.00    |
| 66. 00   06600   PHYSI CAL THERAPY   | 218, 109                  | 7, 841, 511                   |              |                                  | 42  |          |
| 67. 00 06700 OCCUPATI ONAL THERAPY   | 186, 097                  | 5, 715, 234                   |              |                                  | 0   | 1        |
| 68. 00   06800   SPEECH PATHOLOGY  | 35, 018                   |                               |              |                                  | 0   |          |
| 69. 00 06900 ELECTROCARDI OLOGY  | 22, 953                   |                               | 1            |                                  | 20  |          |
| 69. 01   06901   CARDI AC   REHAB  | 4, 368                    | 1, 096, 565                   | 1            |                                  | 0   | 69. 01   |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY  | 30, 186                   | 32, 608, 358                  |              |                                  |   | 70.00    |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS  | 444, 614                  | 55, 185, 539                  |              | · ·                              |   | 1        |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS  | 372, 826                  |                               |              |                                  | 0   | 1        |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS   | 515, 440                  |                               |              |                                  | 738                                       | 1        |
| 74. 00 07400 RENAL DI ALYSI S  | 88, 666                   | 9, 399, 418                   |              |                                  | l e                                       | 1        |
| OUTPATIENT SERVICE COST CENTERS  | 20, 000                   | 7,077,110                     | 0.00710      | <u></u>                          |   | 7 00     |
| 90. 00 09000 CLI NI C  | 1, 309, 168               | 24, 028, 280                  | 0. 05448     | 4 0                              | 0   | 90.00    |
| 91. 00 09100 EMERGENCY   | 695, 659                  |                               | 1            |                                  | 187                                       | 1        |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)   | 0                         | 26, 914, 584                  | 1            |                                  | 0   | 92.00    |
| 200.00   Total (lines 50 through 199)  | 8, 383, 240               | 1, 294, 238, 142              |              | 508, 992                         | 1, 809                                    | 200. 00  |

|                     | inancial Systems<br>DNMENT OF INPATIENT/OUTPATIENT ANCILLARY SE | METHODIST HOS                |                    | ON. 15 0000         | Do  | In Lie<br>eriod:         | u of Form CMS-2             | 2552-10          |
|---------------------|---|------------------------------|--------------------|---------------------|-----|--------------------------|-----------------------------|------------------|
| APPORTIC<br>THROUGH |   | RVICE UTHER PAS              | S Provider C       | JN: 15-0002         | Fr  | erioa:<br>com 01/01/2021 | Worksheet D<br>Part IV      |                  |
|                     |   |                              | Component          | CCN: 15-S002        | To  | 12/31/2021               | Date/Time Pre 5/27/2022 9:0 |                  |
|                     |   |                              | Title              | XVIII               | 5   | Subprovi der -           | PPS                         |                  |
|                     | Oct I Oct I was December 1                                      | N. Di                        | N                  | N                   | Ц,  | I PF                     | ALLS - Lills - Lills        |                  |
|                     | Cost Center Description   | Non Physician<br>Anesthetist | Nursing<br>Program | Nursi ng<br>Program |     | Post-Stepdown            | Allied Health               |                  |
|                     |   | Cost                         | Post-Stepdown      | Fi Ogi alli         |     | Adjustments              |                             |                  |
|                     |   | 0031                         | Adjustments        |                     |     | Adj d3 tillerit3         |                             |                  |
|                     |   | 1. 00                        | 2A                 | 2. 00               |     | 3A                       | 3. 00                       |                  |
| Al                  | NCILLARY SERVICE COST CENTERS                                   |                              |                    |                     |     |                          |                             |                  |
|                     | 5000 OPERATING ROOM   | 0                            | 0                  |                     | 0   | 0                        | 0                           | 50.00            |
|                     | 5001 ENDOSCOPY  | 0                            | 0                  |                     | 0   | 0                        | 0                           | 50. 01           |
| 51.00 0             | 5100 RECOVERY ROOM  | 0                            | 0                  |                     | 0   | 0                        | 0                           | 51.00            |
|                     | 5200 DELIVERY ROOM & LABOR ROOM                                 | 0                            | 0                  |                     | 0   | 0                        | 0                           | 52.00            |
|                     | 5300 ANESTHESI OLOGY  | 0                            | 0                  |                     | 0   | 0                        | 0                           | 53.00            |
|                     | 5400 RADI OLOGY-DI AGNOSTI C                                    | 0                            | 0                  |                     | 0   | 0                        | 0                           | 54.00            |
|                     | 5401 RADI OLOGY - ULTRASOUND                                    | 0                            | 0                  |                     | 0   | 0                        | 0                           | 54. 01           |
|                     | 5500 RADI OLOGY-THERAPEUTI C                                    | 0                            | 0                  |                     | 0   | 0                        | 0                           | 55.00            |
|                     | 5501 I NFUSI ON CENTER  | 0                            | 0                  |                     | 0   | 0                        | 0                           | 55. 01           |
|                     | 5600 RADI OI SOTOPE<br>5700 CT SCAN                             | 0                            | 0                  |                     | 0   | 0                        | 0                           | 56. 00<br>57. 00 |
|                     | 5800 MAGNETIC RESONANCE IMAGING (MRI)                           | 0                            | 0                  |                     | 0   | 0                        | 0                           | 58.00            |
|                     | 5900 CARDIAC CATHETERIZATION                                    | 0                            | 0                  |                     | 0   | 0                        | 0                           | 59.00            |
|                     | 6000 LABORATORY   | 0                            | 0                  |                     | 0   | 0                        | 0                           | 60.00            |
|                     | 6200 WHOLE BLOOD & PACKED RED BLOOD CELLS                       | 0                            | 0                  |                     | 0   | 0                        | Ö                           | 62.00            |
|                     | 6400 I NTRAVENOUS THERAPY                                       | 0                            | 0                  |                     | 0   | 0                        | 0                           | 64.00            |
|                     | 6500 RESPIRATORY THERAPY  | 0                            | 0                  |                     | 0   | 0                        | 0                           | 65.00            |
|                     | 6600 PHYSI CAL THERAPY  | 0                            | 0                  |                     | 0   | 0                        | 0                           | 66.00            |
| 67.00 0             | 6700 OCCUPATI ONAL THERAPY                                      | 0                            | 0                  |                     | 0   | 0                        | 0                           | 67.00            |
| 68.00 0             | 6800 SPEECH PATHOLOGY   | 0                            | 0                  |                     | 0   | 0                        | 0                           | 68.00            |
| 69.00 0             | 6900 ELECTROCARDI OLOGY   | 0                            | 0                  |                     | 0   | 0                        | 0                           | 69.00            |
|                     | 6901 CARDI AC REHAB   | 0                            | 0                  |                     | 0   | 0                        | 0                           | 69. 01           |
|                     | 7000 ELECTROENCEPHALOGRAPHY                                     | 0                            | 0                  |                     | 0   | 0                        | 0                           | 70.00            |
|                     | 7100 MEDICAL SUPPLIES CHARGED TO PATIENTS                       | 0                            | 0                  |                     | 0   | 0                        | 0                           | 71.00            |
|                     | 7200 IMPL. DEV. CHARGED TO PATIENTS                             | 0                            | 0                  |                     | 0   | 0                        | 0                           | 72.00            |
|                     | 7300 DRUGS CHARGED TO PATIENTS                                  | 0                            |                    |                     | 0   | 0                        | 0                           | 73.00            |
|                     | 7400 RENAL DIALYSIS   | 0                            | 0                  |                     | 0   | 0                        | 0                           | 74.00            |
|                     | UTPATIENT SERVICE COST CENTERS                                  | _                            | _                  |                     |     |                          |                             | 00.00            |
| - 1                 | 9000 CLINIC   | 0                            |                    |                     | 0   | 0                        | 1 227 052                   |                  |
|                     | 9100 EMERGENCY<br>9200 OBSERVATION BEDS (NON-DISTINCT PART)     | 0 0                          |                    |                     | 0   | 0                        | 1, 227, 853<br>0            | 91.00<br>92.00   |
|                     | SZULULUD SEKVALLUNI BEUS (NUNI-ULSILING) PART)                  | 1 ()                         | ı                  |                     | 1.7 |                          | ()                          | 1 4/ 11()        |

| Health Financial Systems  APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS  | METHODIST HOS<br>RVICE OTHER PAS | S Provider C  |                        | Peri od:<br>From 01/01/2021 | w of Form CMS-2<br>Worksheet D<br>Part IV |                  |
|--|----------------------------------|---------------|------------------------|-----------------------------|---|------------------|
|  |                                  | Component     | CCN: 15-S002           | To 12/31/2021               | Date/Time Pre 5/27/2022 9:0               | epared:<br>02 am |
|  |                                  |               | XVIII                  | Subprovi der –<br>I PF      | PPS                                       |                  |
| Cost Center Description  | All Other                        | Total Cost    | Total                  | Total Charges               |   |                  |
|  | Medi cal                         | (sum of cols. | Outpati ent            | (from Wkst.                 | to Charges                                |                  |
|  | Education                        | 1, 2, 3, and  | Cost (sum of           |                             | (col. 5 ÷                                 |                  |
|  | Cost                             | 4)            | col s. 2, 3,<br>and 4) | col. 8)                     | col. 7)<br>(see                           |                  |
|  |                                  |               | anu 4)                 |                             | instructions)                             |                  |
|  | 4. 00                            | 5. 00         | 6.00                   | 7. 00                       | 8. 00                                     |                  |
| ANCILLARY SERVICE COST CENTERS   | 1. 00                            | 0.00          | 0.00                   | 7.00                        | 0.00                                      |                  |
| 50. 00   05000   OPERATING ROOM  | 0                                | 0             |                        | 0 169, 292, 906             | 0. 000000                                 | 50.00            |
| 50. 01   05001   ENDOSCOPY   | o                                | 0             |                        | 0 12, 521, 947              | 0.000000                                  | 1                |
| 51. 00 05100 RECOVERY ROOM   | o                                | 0             |                        | 0 12, 033, 588              | 0.000000                                  | 51.00            |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM   | o                                | 0             |                        | 0 4, 428, 022               | 0.000000                                  | 52.00            |
| 53. 00   05300   ANESTHESI OLOGY   | o                                | 0             |                        | 0                           | 0.000000                                  | 53.00            |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C   | 0                                | 0             |                        | 0 40, 875, 566              | 0.000000                                  | 54.00            |
| 54. 01   05401   RADI OLOGY - ULTRASOUND   | 0                                | 0             |                        | 0 22, 691, 762              | 0.000000                                  |                  |
| 55. 00   05500   RADI OLOGY-THERAPEUTI C   | 0                                | 0             |                        | 0 22, 689, 787              | 0.000000                                  |                  |
| 55. 01   05501   I NFUSI ON CENTER   | 0                                | 0             |                        | 0 130, 187                  | 0. 000000                                 |                  |
| 56. 00   05600   RADI OI SOTOPE  | 0                                | 0             | 1                      | 0 16, 069, 979              | 0. 000000                                 |                  |
| 57. 00   05700   CT   SCAN   | 0                                | 0             |                        | 0 134, 797, 158             | 0. 000000                                 |                  |
| 58. 00   05800   MAGNETIC RESONANCE   MAGING (MRI)   | 0                                | 0             |                        | 0 31, 267, 753              | 0. 000000                                 |                  |
| 59. 00   05900   CARDI AC CATHETERI ZATI ON  | 0                                | 0             |                        | 0 70, 589, 396              | 0. 000000                                 |                  |
| 60. 00   06000   LABORATORY  | 0                                | 0             |                        | 0 223, 819, 693             | 0.000000                                  | 1                |
| 62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS<br>64. 00   06400   NTRAVENOUS THERAPY | 0                                | 0             |                        | 0 12, 197, 992<br>0 0       | 0.000000                                  | 1                |
| 64. 00   06400   I NTRAVENOUS THERAPY<br>65. 00   06500   RESPI RATORY THERAPY               | 0                                | 0             |                        | 0 42, 954, 297              | 0. 000000<br>0. 000000                    |                  |
| 66. 00   06600   PHYSI CAL THERAPY   |                                  | 0             |                        | 0 7, 841, 511               | 0. 000000                                 |                  |
| 67. 00 06700 OCCUPATI ONAL THERAPY   |                                  | 0             |                        | 0 5, 715, 234               | 0.000000                                  |                  |
| 68. 00 06800 SPEECH PATHOLOGY  |                                  | 0             |                        | 0 2, 893, 110               | 0. 000000                                 |                  |
| 69. 00 06900 ELECTROCARDI OLOGY  |                                  | 0             |                        | 0 25, 742, 675              | 0. 000000                                 |                  |
| 69. 01   06901   CARDI AC   REHAB  | l ol                             | 0             |                        | 0 1, 096, 565               | 0. 000000                                 | 1                |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY  | o                                | 0             |                        | 0 32, 608, 358              | 0.000000                                  |                  |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS   | o                                | 0             |                        | 0 55, 185, 539              | 0.000000                                  | 71.00            |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS   | o                                | 0             |                        | 0 35, 423, 662              | 0.000000                                  | 72.00            |
| 73.00 07300 DRUGS CHARGED TO PATIENTS  | 0                                | 0             |                        | 0 162, 306, 726             | 0.000000                                  | 73.00            |
| 74. 00 07400 RENAL DIALYSIS  | 0                                | 0             |                        | 0 9, 399, 418               | 0.000000                                  | 74.00            |
| OUTPATIENT SERVICE COST CENTERS  |                                  |               |                        |                             |   | 1                |
| 90. 00   09000   CLINIC  | 0                                | 0             |                        | 0 24, 028, 280              | 0. 000000                                 |                  |
| 91. 00   09100   EMERGENCY   | 0                                | 1, 227, 853   |                        |                             | 0. 013839                                 |                  |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)  | 0                                | 1 227 252     |                        | 0 26, 914, 584              | 0. 000000                                 |                  |
| 200.00   Total (lines 50 through 199)  | 0                                | 1, 227, 853   | J 1, 227, 85           | 3 1, 294, 238, 142          |   | 200.00           |

| Health Financia   | al Systems                           | METHODI ST HOSPI | TALS, INC   |              | In Lie                      | u of Form CMS-2                | 2552-10 |
|-------------------|--------------------------------------|------------------|-------------|--------------|-----------------------------|--------------------------------|---------|
|                   | OF INPATIENT/OUTPATIENT ANCILLARY SE | RVICE OTHER PASS | Provi der C | CN: 15-0002  | Peri od:<br>From 01/01/2021 | Worksheet D<br>Part IV         |         |
| TIROUGH COSTS     |                                      |                  | Component   | CCN: 15-S002 | To 12/31/2021               | Date/Time Pre<br>5/27/2022 9:0 |         |
|                   |                                      |                  | Title       | : XVIII      | Subprovi der -<br>I PF      | PPS                            |         |
| Со                | st Center Description                | Outpati ent      | I npati ent | Inpatient    | Outpati ent                 | Outpati ent                    |         |
|                   |                                      | Ratio of Cost    | Program     | Program      | Program                     | Program                        |         |
|                   |                                      | to Charges       | Charges     | Pass-Through | h Charges                   | Pass-Through                   |         |
|                   |                                      | (col. 6 ÷        |             | Costs (col.  | 8                           | Costs (col. 9                  |         |
|                   |                                      | col. 7)          |             | x col. 10)   |                             | x col. 12)                     |         |
|                   |                                      | 9. 00            | 10. 00      | 11.00        | 12.00                       | 13. 00                         |         |
| ANCI LLAR         | RY SERVICE COST CENTERS              |                  |             |              |                             |                                |         |
| 50. 00 05000 OP   | ERATING ROOM                         | 0. 000000        | 0           | I .          | 0 0                         | 0                              | 50.00   |
| 50. 01   05001 EN | DOSCOPY                              | 0.000000         | 3, 097      |              | 0 0                         | 0                              | 50. 01  |
| 51.00 05100 RE    | COVERY ROOM                          | 0.000000         | 0           |              | 0                           | 0                              | 51.00   |
| 52. 00 05200 DE   | LIVERY ROOM & LABOR ROOM             | 0.000000         | 0           |              | 0                           | 0                              | 52.00   |
| 53.00 05300 AN    | ESTHESI OLOGY                        | 0.000000         | 0           |              | 0                           | 0                              | 53.00   |
| 54. 00 05400 RA   | DI OLOGY-DI AGNOSTI C                | 0. 000000        | 9, 413      |              | 0                           | 0                              | 54.00   |
| 54. 01 05401 RA   | DIOLOGY - ULTRASOUND                 | 0. 000000        | 7, 187      |              | 0                           | 0                              | 54. 01  |
| 55. 00 05500 RA   | DI OLOGY-THERAPEUTI C                | 0. 000000        | 0           |              | 0                           | 0                              | 55.00   |
| 55. 01 05501 I N  | FUSION CENTER                        | 0. 000000        | 0           |              | 0                           | 0                              | 55. 01  |
| 56. 00 05600 RA   | DI OI SOTOPE                         | 0. 000000        | 1, 552      |              | 0                           | 0                              | 56.00   |
| 57. 00 05700 CT   | SCAN                                 | 0. 000000        | 16, 721     |              | 0                           | 0                              | 57.00   |
| 58. 00 05800 MA   | GNETIC RESONANCE IMAGING (MRI)       | 0. 000000        | 10, 755     |              | 0                           | 0                              | 58.00   |
| 59. 00 05900 CA   | RDI AC CATHETERI ZATI ON             | 0. 000000        | 0           |              | 0                           | 0                              | 59.00   |
| 60. 00 06000 LA   | BORATORY                             | 0. 000000        | 163, 376    |              | 0                           | 0                              | 60.00   |
| 62.00 06200 WH    | OLE BLOOD & PACKED RED BLOOD CELLS   | 0. 000000        | 11, 082     |              | 0                           | 0                              | 62.00   |
| 64.00 06400 I N   | TRAVENOUS THERAPY                    | 0. 000000        | 0           |              | 0 0                         | 0                              | 64.00   |
| 65. 00 06500 RE   | SPI RATORY THERAPY                   | 0. 000000        | 1, 501      |              | 0 0                         | 0                              | 65.00   |
| 66.00 06600 PH    | YSI CAL THERAPY                      | 0. 000000        | 1, 500      |              | 0 0                         | 0                              | 66.00   |
| 67. 00 06700 0C   | CUPATI ONAL THERAPY                  | 0. 000000        | 0           |              | 0 0                         | 0                              | 67.00   |
| 68. 00 06800 SP   | EECH PATHOLOGY                       | 0. 000000        | 0           |              | 0                           | 0                              | 68.00   |
| 69. 00 06900 EL   | ECTROCARDI OLOGY                     | 0. 000000        | 22, 541     |              | 0                           | 0                              | 69.00   |
| 69. 01 06901 CA   | RDI AC REHAB                         | 0. 000000        | 0           |              | 0                           | 0                              | 69. 01  |
| 70. 00 07000 EL   | ECTROENCEPHALOGRAPHY                 | 0. 000000        | 2, 053      |              | 0                           | 0                              | 70.00   |
| 71.00 07100 ME    | DICAL SUPPLIES CHARGED TO PATIENTS   | 0. 000000        | 1, 843      |              | 0                           | 0                              | 71.00   |
| 72.00 07200 I M   | PL. DEV. CHARGED TO PATIENTS         | 0. 000000        | 0           |              | 0                           | 0                              | 72.00   |
| 73. 00 07300 DR   | UGS CHARGED TO PATIENTS              | 0. 000000        | 232, 461    |              | 0                           | 0                              | 73.00   |
| 74.00 07400 RE    | NAL DIALYSIS                         | 0. 000000        | 0           |              | 0                           | 0                              | 74.00   |
| OUTPATI E         | NT SERVICE COST CENTERS              |                  |             |              |                             |                                |         |
| 90. 00 09000 CL   | INIC                                 | 0. 000000        | 0           |              | 0 0                         | 0                              | 90.00   |
| 91.00 09100 EM    | ERGENCY                              | 0. 013839        | 23, 910     | 3:           | 31 0                        | 0                              | 91.00   |
| 92. 00 09200 OB   | SERVATION BEDS (NON-DISTINCT PART)   | 0. 000000        | 0           |              | 0 0                         | 0                              | 92.00   |
| 200. 00 To        | tal (lines 50 through 199)           | 1                | 508, 992    |              | 31 0                        |                                | 200.00  |

| Health Financial Systems   | METHODIST HOS              | PITALS. INC                 |                     | In Lie          | u of Form CMS-2             | 2552-10          |
|--|----------------------------|-----------------------------|---------------------|-----------------|-----------------------------|------------------|
| APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA                          |                            | Provi der C                 | CN: 15-0002         | Peri od:        | Worksheet D                 |                  |
|  |                            |                             |                     | From 01/01/2021 | Part II                     |                  |
|  |                            | '                           | CCN: 15-T002        | To 12/31/2021   | Date/Time Pre 5/27/2022 9:0 | pared:<br>2 am   |
|  |                            | Title                       | : XVIII             | Subprovi der -  | PPS                         |                  |
|  |                            |                             |                     | I RF            |                             |                  |
| Cost Center Description  | Capi tal                   | Total Charges               |                     | t Inpatient     | Capital Costs               |                  |
|  | Related Cost               | (from Wkst.                 | to Charges          | Program         | (column 3 x                 |                  |
|  | (from Wkst.<br>B, Part II, | C, Part I,<br>col. 8)       | (col . 1 ÷ col . 2) | Charges         | column 4)                   |                  |
|  | col. 26)                   | COI. 6)                     | (01. 2)             |                 |                             |                  |
|  | 1.00                       | 2. 00                       | 3.00                | 4. 00           | 5. 00                       |                  |
| ANCILLARY SERVICE COST CENTERS   | 1.00                       | 2.00                        | 3.00                | 4.00            | 3.00                        |                  |
| 50. 00   05000   OPERATING ROOM  | 1, 182, 536                | 169, 292, 906               | 0.00698             | 35 225, 447     | 1, 575                      | 50.00            |
| 50. 01   05001   ENDOSCOPY   | 26, 345                    | 12, 521, 947                |                     |                 | 26                          | 50.01            |
| 51. 00   05100   RECOVERY ROOM   | 259, 292                   | 12, 033, 588                | •                   |                 | 157                         | 51.00            |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM                                       | 179, 511                   | 4, 428, 022                 | l .                 |                 | 0                           | 52.00            |
| 53. 00 05300 ANESTHESI OLOGY   | o                          | 0                           | 1                   | oo o            | 0                           | 53.00            |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C   | 931, 913                   | 40, 875, 566                | 0. 02279            | 9 42, 683       | 973                         | 54.00            |
| 54. 01 05401 RADI OLOGY - ULTRASOUND   | 112, 872                   | 22, 691, 762                | 0.00497             | 17, 369         | 86                          | 54. 01           |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C   | 248, 649                   | 22, 689, 787                | 0. 01095            | 59 0            | 0                           | 55.00            |
| 55. 01   05501   I NFUSI ON CENTER   | 6, 332                     | 130, 187                    | 0. 04863            | 88 0            | 0                           | 55. 01           |
| 56. 00 05600 RADI OI SOTOPE  | 170, 373                   | 16, 069, 979                | 0. 01060            |                 | 247                         | 56.00            |
| 57. 00   05700   CT   SCAN   | 234, 192                   | 134, 797, 158               |                     | 119, 437        | 207                         | 57.00            |
| 58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)                            | 92, 872                    | 31, 267, 753                |                     |                 | 112                         | 58.00            |
| 59. 00   05900   CARDI AC   CATHETERI ZATI ON                                | 206, 588                   | 70, 589, 396                |                     |                 | 61                          | 59.00            |
| 60. 00   06000   LABORATORY  | 601, 467                   | 223, 819, 693               |                     |                 | 1, 706                      |                  |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS                             | 27, 096                    | 12, 197, 992                |                     |                 | 32                          | 62.00            |
| 64. 00 06400 I NTRAVENOUS THERAPY  | 0                          | 0                           | 0.0000              |                 | 0                           |                  |
| 65. 00 06500 RESPI RATORY THERAPY  | 180, 098                   | 42, 954, 297                |                     |                 | 1, 069                      | 65.00            |
| 66. 00   06600   PHYSI CAL THERAPY   | 218, 109                   | 7, 841, 511                 | 0. 02781            |                 | 29, 333                     | 66.00            |
| 67. 00 06700 OCCUPATI ONAL THERAPY   | 186, 097                   | 5, 715, 234                 |                     |                 | 28, 716                     | 67.00            |
| 68. 00 06800 SPEECH PATHOLOGY  | 35, 018                    | 2, 893, 110                 |                     |                 | 2, 220                      |                  |
| 69. 00 06900 ELECTROCARDI OLOGY  | 22, 953                    | 25, 742, 675                |                     |                 | 22                          | 69.00            |
| 69. 01   06901   CARDI AC   REHAB<br>70. 00   07000   ELECTROENCEPHALOGRAPHY | 4, 368<br>30, 186          | 1, 096, 565<br>32, 608, 358 |                     |                 | 0 2                         | 69. 01<br>70. 00 |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS                            | 30, 186<br>444, 614        | 55, 185, 539                | l .                 |                 | 594                         |                  |
| 72. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS                            | 372, 826                   | 35, 423, 662                |                     |                 | 262                         |                  |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS                                       | 515, 440                   | 162, 306, 726               | •                   |                 | 3, 730                      | 73.00            |
| 74. 00   07400   RENAL DIALYSIS  | 88, 666                    | 9, 399, 418                 | l .                 |                 | 1, 618                      |                  |
| OUTPATIENT SERVICE COST CENTERS  | 00,000                     | 7, 377, 410                 | 0.00740             | 70 171, 321     | 1,010                       | 7 7. 50          |
| 90. 00 09000 CLINIC  | 1, 309, 168                | 24, 028, 280                | 0. 05448            | 34 0            | 0                           | 90.00            |
| 91. 00 09100 EMERGENCY   | 695, 659                   | 88, 722, 447                |                     |                 | 0                           | 91.00            |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)                            | 0                          | 26, 914, 584                | •                   |                 | 0                           | 92.00            |
|  |                            |                             |                     |                 |                             |                  |

| Health Financial Systems<br>APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF<br>THROUGH COSTS                                       | METHODIST HOS<br>RVICE OTHER PAS     |  |                     |   | eriod:<br>com 01/01/2021                      | u of Form CMS-2<br>Worksheet D<br>Part IV<br>Date/Time Pre<br>5/27/2022 9:0 | pared:                     |
|--|--------------------------------------|--|---------------------|---|---|---|----------------------------|
|  |                                      | Title  | XVIII               | 5 | Subprovider -<br>IRF                          | PPS   |                            |
| Cost Center Description  | Non Physician<br>Anesthetist<br>Cost | Nursing<br>Program<br>Post-Stepdown<br>Adjustments | Nursi ng<br>Program |   | Allied Health<br>Post-Stepdown<br>Adjustments | Allied Health   |                            |
|  | 1. 00                                | 2A   | 2. 00               |   | 3A  | 3. 00   |                            |
| ANCILLARY SERVICE COST CENTERS   |                                      |  |                     |   |   |   |                            |
| 50.00   05000   0PERATING ROOM<br>50.01   05001   ENDOSCOPY<br>51.00   05100   RECOVERY ROOM   | 0 0                                  | · ·  |                     | 0 | 0<br>0<br>0                                   | 0<br>0<br>0   | 50.00<br>50.01<br>51.00    |
| 52. 00   05200   DELI VERY ROOM & LABOR ROOM<br>53. 00   05300   ANESTHESI OLOGY<br>54. 00   05400   RADI OLOGY-DI AGNOSTI C           | 0                                    | 0  |                     | 0 | 0   | 0<br>0<br>0   | 52.00<br>53.00<br>54.00    |
| 54. 01   05400   RADI 0L0GY - DI AGROSTI C<br>54. 01   05401   RADI 0L0GY - ULTRASOUND<br>55. 00   05500   RADI 0L0GY-THERAPEUTI C     | 0                                    | 0  |                     | 0 | 0   | 0   | 54. 00<br>54. 01<br>55. 00 |
| 55. 01   05501   I NFUSI ON CENTER<br>56. 00   05600   RADI OI SOTOPE<br>57. 00   05700   CT   SCAN                                    | 0                                    | 0  |                     | 0 | 0   | 0<br>0<br>0   | 55. 01<br>56. 00<br>57. 00 |
| 58.00   05800   MAGNETIC RESONANCE IMAGING (MRI)<br>59.00   05900   CARDIAC CATHETERIZATION  | 0                                    | 0  |                     | 0 | 0   | 0   | 58. 00<br>59. 00           |
| 60.00  06000 LABORATORY<br>62.00  06200 WHOLE BLOOD & PACKED RED BLOOD CELLS<br>64.00  06400 INTRAVENOUS THERAPY                       | 0 0                                  | 0<br>0<br>0  |                     | 0 | 0<br>0<br>0                                   | 0<br>0<br>0   | 60.00<br>62.00<br>64.00    |
| 65. 00   06500   RESPI RATORY   THERAPY<br>66. 00   06600   PHYSI CAL   THERAPY<br>67. 00   06700   OCCUPATI ONAL   THERAPY            | 0                                    | 0  |                     | 0 | 0   | 0<br>0<br>0   | 65.00<br>66.00<br>67.00    |
| 68. 00   06800   SPEECH PATHOLOGY<br>69. 00   06900   ELECTROCARDI OLOGY   | 0                                    | 0  |                     | 0 | 0   | 0   | 68. 00<br>69. 00           |
| 69. 01   06901   CARDI AC REHAB<br>70. 00   07000   ELECTROENCEPHALOGRAPHY<br>71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS | 0                                    | 0  |                     | 0 | 0   | 0   | 69. 01<br>70. 00<br>71. 00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS<br>73.00 07300 DRUGS CHARGED TO PATIENTS  | 0                                    | 0  |                     | 0 | 0   | 0   | 72.00<br>73.00             |
| 74. 00   07400  RENAL DI ALYSIS   0UTPATI ENT SERVI CE COST CENTERS   90. 00   09000  CLI NI C   | 0                                    |  |                     | 0 | 0   | 0   | 74. 00<br>90. 00           |
| 91. 00   09100   EMERGENCY<br>91. 00   09100   EMERGENCY<br>92. 00   09200   085ERVATION   BEDS   (NON-DISTINCT PART)                  | 0                                    | 0  |                     | 0 | 0   |   | 90.00<br>91.00<br>92.00    |

|                 | al Systems OF INPATIENT/OUTPATIENT ANCILLARY SEF | METHODIST HOSE<br>RVICE OTHER PASS |               |              | Peri od:                         | worksheet D                               | 2552-10          |
|-----------------|--|------------------------------------|---------------|--------------|----------------------------------|---|------------------|
| THROUGH COSTS   |  |                                    | Component     |              | From 01/01/2021<br>To 12/31/2021 | Part IV<br>Date/Time Pre<br>5/27/2022 9:0 | epared:<br>02 am |
|                 |  |                                    |               | XVIII        | Subprovi der –<br>I RF           | PPS                                       |                  |
| Co              | ost Center Description                           | All Other                          | Total Cost    | Total        | Total Charges                    |   |                  |
|                 |  | Medi cal                           | (sum of cols. | Outpati ent  | (from Wkst.                      | to Charges                                |                  |
|                 |  | Education                          | 1, 2, 3, and  | Cost (sum of |                                  | (col. 5 ÷                                 |                  |
|                 |  | Cost                               | 4)            | col s. 2, 3, | col. 8)                          | col . 7)                                  |                  |
|                 |  |                                    |               | and 4)       |                                  | (see                                      |                  |
|                 |  | 4.00                               | F 00          | / 00         | 7.00                             | instructions)                             |                  |
| ANCLLLA         | DV CEDVICE COCT CENTERS                          | 4. 00                              | 5. 00         | 6. 00        | 7. 00                            | 8. 00                                     |                  |
|                 | RY SERVICE COST CENTERS PERATING ROOM            | O                                  | 0             |              | 0 169, 292, 906                  | 0. 000000                                 | 50.00            |
|                 | NDOSCOPY   |                                    | 0             |              | 0 169, 292, 906                  | 0. 000000                                 | 1                |
|                 | ECOVERY ROOM                                     |                                    | 0             |              |                                  | 0. 000000                                 | 1                |
|                 | ELIVERY ROOM & LABOR ROOM                        |                                    | 0             |              | 0 12, 033, 588<br>0 4, 428, 022  | 0. 000000                                 |                  |
|                 | NESTHESI OLOGY                                   |                                    | 0             |              | 0 4, 428, 022                    | 0. 000000                                 |                  |
|                 | ADI OLOGY-DI AGNOSTI C                           |                                    | 0             |              | 0 40, 875, 566                   | 0.000000                                  |                  |
|                 | ADI OLOGY - ULTRASOUND                           |                                    | 0             |              | 0 22, 691, 762                   | 0. 000000                                 |                  |
|                 | ADI OLOGY-THERAPEUTI C                           |                                    | 0             |              | 0 22, 689, 787                   | 0.000000                                  |                  |
|                 | NFUSION CENTER                                   |                                    | 0             |              | 0 130, 187                       | 0. 000000                                 |                  |
|                 | ADI OI SOTOPE                                    |                                    | 0             |              | 0 16, 069, 979                   | 0. 000000                                 |                  |
| 57. 00 05700 C  |  |                                    | 0             |              | 0 134, 797, 158                  | 0. 000000                                 |                  |
|                 | AGNETIC RESONANCE IMAGING (MRI)                  |                                    | 0             |              | 0 31, 267, 753                   | 0. 000000                                 |                  |
|                 | ARDI AC CATHETERI ZATI ON                        |                                    | 0             |              | 0 70, 589, 396                   | 0. 000000                                 |                  |
|                 | ABORATORY  |                                    | 0             |              | 0 223, 819, 693                  | 0. 000000                                 |                  |
|                 | HOLE BLOOD & PACKED RED BLOOD CELLS              | 0                                  | 0             |              | 0 12, 197, 992                   | 0. 000000                                 |                  |
|                 | NTRAVENOUS THERAPY                               | l ol                               | 0             |              | 0 0                              | 0. 000000                                 |                  |
|                 | ESPI RATORY THERAPY                              | o                                  | 0             |              | 0 42, 954, 297                   | 0.000000                                  |                  |
| 66. 00 06600 PI | HYSI CAL THERAPY                                 | o                                  | 0             |              | 0 7, 841, 511                    | 0.000000                                  | 66.00            |
| 67.00 06700 00  | CCUPATI ONAL THERAPY                             | o                                  | 0             |              | 0 5, 715, 234                    | 0.000000                                  | 67.00            |
| 68.00 06800 SF  | PEECH PATHOLOGY                                  | o                                  | 0             |              | 0 2, 893, 110                    | 0.000000                                  | 68.00            |
| 69. 00 06900 EI | _ECTROCARDI OLOGY                                | o                                  | 0             |              | 0 25, 742, 675                   | 0.000000                                  | 69.00            |
| 69. 01 06901 CA | ARDI AC REHAB                                    | o                                  | 0             |              | 0 1, 096, 565                    | 0.000000                                  | 69. 01           |
| 70. 00 07000 EI | LECTROENCEPHALOGRAPHY                            | 0                                  | 0             |              | 0 32, 608, 358                   | 0.000000                                  | 70.00            |
| 71.00 07100 ME  | EDICAL SUPPLIES CHARGED TO PATIENTS              | 0                                  | 0             |              | 0 55, 185, 539                   | 0. 000000                                 | 71.00            |
|                 | MPL. DEV. CHARGED TO PATIENTS                    | 0                                  | 0             |              | 0 35, 423, 662                   | 0.000000                                  | 72.00            |
|                 | RUGS CHARGED TO PATIENTS                         | 0                                  | 0             |              | 0 162, 306, 726                  | 0.000000                                  | 73.00            |
| 74.00 07400 RE  |  | 0                                  | 0             |              | 0 9, 399, 418                    | 0.000000                                  | 74.00            |
|                 | ENT SERVICE COST CENTERS                         | ,                                  |               |              |                                  |   |                  |
| 90. 00 09000 CI |  | 0                                  | 0             |              | 0 24, 028, 280                   | 0. 000000                                 |                  |
|                 | MERGENCY   | 0                                  | 1, 227, 853   |              |                                  | 0. 013839                                 |                  |
|                 | BSERVATION BEDS (NON-DISTINCT PART)              | 0                                  | 0             |              | 0 26, 914, 584                   | 0. 000000                                 |                  |
| 200. 00 To      | otal (lines 50 through 199)                      | 0                                  | 1, 227, 853   | 1, 227, 85   | 3 1, 294, 238, 142               |   | 200.00           |

| Health Financial Systems   | METHODIST HOSPI        | TAIS INC    |              | Inlie                            | u of Form CMS-2                           | 2552_10        |
|--|------------------------|-------------|--------------|----------------------------------|---|----------------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE                              |                        | Provi der C | CN: 15-0002  | Peri od:                         | Worksheet D                               | 2332-10        |
| THROUGH COSTS  |                        |             | CCN: 15-T002 | From 01/01/2021<br>To 12/31/2021 | Part IV<br>Date/Time Pre<br>5/27/2022 9:0 | pared:<br>2 am |
|  |                        | Title       | : XVIII      | Subprovi der -<br>I RF           | PPS                                       |                |
| Cost Center Description  | Outpati ent            | I npati ent | I npati ent  | Outpati ent                      | Outpati ent                               |                |
|  | Ratio of Cost          | Program     | Program      | Program                          | Program                                   |                |
|  | to Charges             | Charges     | Pass-Through |                                  | Pass-Through                              |                |
|  | (col. 6 ÷              |             | Costs (col.  | 8                                | Costs (col. 9                             |                |
|  | col. 7)                |             | x col. 10)   |                                  | x col. 12)                                |                |
|  | 9. 00                  | 10. 00      | 11. 00       | 12. 00                           | 13. 00                                    |                |
| ANCILLARY SERVICE COST CENTERS   |                        |             | 1            |                                  |   |                |
| 50.00   05000   OPERATING ROOM   | 0. 000000              | 225, 447    |              | 0 0                              | 0   | 50.00          |
| 50. 01   05001 ENDOSCOPY   | 0. 000000              | 12, 497     |              | 0 0                              | 0   | 50. 01         |
| 51. 00   05100   RECOVERY ROOM   | 0. 000000              | 7, 269      | 1            | 0 0                              | 0   | 51.00          |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM   | 0. 000000              | 0           | •            | 0                                | 0   | 52.00          |
| 53. 00   05300   ANESTHESI OLOGY   | 0. 000000              | 0           |              | 0                                | 0   | 53.00          |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C   | 0. 000000              | 42, 683     |              | 0 0                              | 0   | 54.00          |
| 54. 01   05401   RADI OLOGY - ULTRASOUND   | 0. 000000              | 17, 369     | •            | 0 0                              | 0   | 54. 01         |
| 55. 00   05500   RADI OLOGY-THERAPEUTI C   | 0. 000000              | 0           |              | 0 0                              | 0   | 55.00          |
| 55. 01   05501   I NFUSI ON CENTER   | 0. 000000              | 0           |              | 0 0                              | 0   | 55. 01         |
| 56. 00   05600   RADI OI SOTOPE  | 0. 000000              | 23, 332     |              | 0 0                              | 0   | 56.00          |
| 57. 00   05700   CT   SCAN   | 0. 000000              | 119, 437    |              | 0 0                              | 0   | 57.00          |
| 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)                                     | 0. 000000              | 37, 785     | l .          | 0 0                              | 0   | 58. 00         |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON  | 0. 000000              | 20, 686     |              | 0                                | 0   | 59.00          |
| 60. 00   06000   LABORATORY  | 0. 000000              | 634, 989    |              | 0 0                              | 0   | 60.00          |
| 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS                                | 0. 000000              | 14, 232     |              | 0                                | 0   | 62.00          |
| 64. 00 06400 I NTRAVENOUS THERAPY  | 0. 000000              | 0           |              | 0 0                              | 0   | 64.00          |
| 65. 00 06500 RESPIRATORY THERAPY   | 0. 000000              | 255, 010    |              | 0 0                              | 0   | 65.00          |
| 66. 00   06600   PHYSI CAL THERAPY   | 0. 000000              | 1, 054, 565 |              | 0                                | 0   | 66.00          |
| 67. 00 06700 OCCUPATI ONAL THERAPY   | 0. 000000              | 881, 888    |              | 0 0                              | 0   | 67.00          |
| 68. 00   06800   SPEECH PATHOLOGY  | 0.000000               | 183, 376    |              | 0                                | 0   | 68.00          |
| 69. 00   06900   ELECTROCARDI OLOGY  | 0. 000000              | 25, 091     |              | 0                                | 0   | 69.00          |
| 69. 01   06901   CARDI AC REHAB  | 0.000000               | 0           | 1            | 0 0                              | 0   | 69. 01         |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY  | 0.000000               | 2, 053      | l .          | 0 0                              | 0   | 70.00          |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS                                | 0.000000               | 73, 702     | l .          | -                                | 0   | 71.00          |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS | 0.000000               | 24, 905     |              | 0 0                              | 0   | 72.00<br>73.00 |
| 73. 00   07300   DRUGS CHARGED TO PATTENTS<br>74. 00   07400   RENAL DI ALYSI S  | 0. 000000<br>0. 000000 | 1, 174, 381 |              | 0 0                              | 0   |                |
| OUTPATIENT SERVICE COST CENTERS  | 0.000000               | 171, 521    |              | U U                              | U   | 74.00          |
| 90. 00   09000   CLINIC  | 0. 000000              | 0           |              | 0 0                              | 0   | 90.00          |
| 91. 00   09100   EMERGENCY   | 0. 013839              | 0           |              | 0 0                              | 0   |                |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)                                | 0.000000               | 0           |              | 0 0                              | 0   | 92.00          |
| 200.00 Total (lines 50 through 199)  | 0.000000               | 5, 002, 218 |              |                                  | _   | 200.00         |
| [  | 1                      | -, -02, 210 | 1            | - 1                              |   | ,              |

| Health Financial Systems                         | METHODIST HOSPIT  | TALS INC              | In Lie          | u of Form CMS-2 | DEE2 10 |
|--|-------------------|-----------------------|-----------------|-----------------|---------|
|  | METHODIST HOSPIT  |                       |                 |                 |         |
| COMPUTATION OF INPATIENT OPERATING COST          |                   | Provider CCN: 15-0002 | Peri od:        | Worksheet D-1   |         |
|  |                   |                       | From 01/01/2021 |                 |         |
|  |                   |                       | To 12/31/2021   | Date/Time Pre   | pared:  |
|  |                   |                       |                 | 5/27/2022 9:0   | 2 am    |
|  |                   | Title XVIII           | Hospi tal       | PPS             |         |
| Cost Center Description                          |                   |                       |                 |                 |         |
|  |                   |                       |                 | 1. 00           |         |
| PART I - ALL PROVIDER COMPONENTS                 |                   |                       |                 |                 |         |
| I NPATI ENT DAYS                                 |                   |                       |                 |                 |         |
| 1 00 Inpatient days (including private room days | and cuing had day | c oveluding newborn)  |                 | 01 142          | 1 00    |

|                  |  | Title XVIII                    | Hospi tal        | PPS               |                  |
|------------------|--|--------------------------------|------------------|-------------------|------------------|
|                  | Cost Center Description  |                                |                  | 1.00              |                  |
|                  | PART I - ALL PROVIDER COMPONENTS   |                                |                  | 1. 00             |                  |
|                  | INPATIENT DAYS   |                                |                  |                   |                  |
| 1.00             | Inpatient days (including private room days and swing-bed day  | s, excluding newborn)          |                  | 81, 162           | 1.00             |
| 2.00             | Inpatient days (including private room days, excluding swing-  | bed and newborn days)          |                  | 81, 162           | 2.00             |
| 3.00             | Private room days (excluding swing-bed and observation bed da  | ys). If you have only pri      | vate room days,  | 0                 | 3.00             |
|                  | do not complete this line.   |                                |                  |                   |                  |
| 4. 00            | Semi -private room days (excluding swing-bed and observation b   |                                | - 21 -6 +1       | 66, 690           | 4.00             |
| 5. 00            | Total swing-bed SNF type inpatient days (including private reporting period  | olli days) trirough beceiliber | 31 OF the cost   | 0                 | 5. 00            |
| 6. 00            | Total swing-bed SNF type inpatient days (including private ro  | om days) after December 3      | 31 of the cost   | 0                 | 6.00             |
|                  | reporting period (if calendar year, enter 0 on this line)  |                                |                  |                   |                  |
| 7. 00            | Total swing-bed NF type inpatient days (including private roo  | m days) through December       | 31 of the cost   | 0                 | 7.00             |
| 0.00             | reporting period   |                                |                  | 0                 | 0.00             |
| 8. 00            | Total swing-bed NF type inpatient days (including private roc<br>reporting period (if calendar year, enter 0 on this line)   | m days) after becember 3       | or the cost      | 0                 | 8. 00            |
| 9. 00            | Total inpatient days including private room days applicable t  | o the Program (excluding       | swi ng-bed and   | 18, 462           | 9. 00            |
|                  | newborn days) (see instructions)   |                                |                  |                   |                  |
| 10.00            | Swing-bed SNF type inpatient days applicable to title XVIII o  |                                | oom days)        | 0                 | 10.00            |
| 11 00            | through December 31 of the cost reporting period (see instruc  |                                | nom dovo) often  | 0                 | 11 00            |
| 11. 00           | Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e |                                | oom days) arter  | U                 | 11. 00           |
| 12. 00           | Swing-bed NF type inpatient days applicable to titles V or XI  |                                | e room days)     | 0                 | 12.00            |
|                  | through December 31 of the cost reporting period   |                                |                  |                   |                  |
| 13.00            | Swing-bed NF type inpatient days applicable to titles V or XI  |                                |                  | 0                 | 13.00            |
| 14.00            | after December 31 of the cost reporting period (if calendar y  |                                |                  | 0                 | 14.00            |
| 14. 00<br>15. 00 | Medically necessary private room days applicable to the Progr<br>Total nursery days (title V or XIX only)                    | am (excluding Swing-bed o      | lays)            | 0                 | 14. 00<br>15. 00 |
| 16. 00           | Nursery days (title V or XIX only)   |                                |                  | 0                 | 16.00            |
|                  | SWI NG BED ADJUSTMENT  |                                |                  |                   |                  |
| 17. 00           | Medicare rate for swing-bed SNF services applicable to service   | es through December 31 of      | the cost         | 0. 00             | 17.00            |
| 40.00            | reporting period   |                                |                  | 0.00              | 40.00            |
| 18. 00           | Medicare rate for swing-bed SNF services applicable to service reporting period  | es after December 31 of 1      | ine cost         | 0.00              | 18. 00           |
| 19. 00           | Medicaid rate for swing-bed NF services applicable to service  | s through December 31 of       | the cost         | 0.00              | 19. 00           |
|                  | reporting period   |                                |                  |                   |                  |
| 20. 00           | Medicaid rate for swing-bed NF services applicable to service  | s after December 31 of th      | ne cost          | 0.00              | 20.00            |
| 21 00            | reporting period   | -1                             |                  | 02 4/0 200        | 21 00            |
| 21. 00<br>22. 00 | Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb  |                                | ng period (line  | 83, 469, 209<br>0 | 21. 00<br>22. 00 |
| 22.00            | 5 x line 17)   | ci 31 oi the cost reporti      | ng perrou (iring | O                 | 22.00            |
| 23. 00           | Swing-bed cost applicable to SNF type services after December  | 31 of the cost reporting       | period (line 6   | 0                 | 23.00            |
|                  | x line 18)   |                                |                  |                   |                  |
| 24. 00           | Swing-bed cost applicable to NF type services through Decembe $7 \times 1$ ine 19)   | r 31 of the cost reportir      | ng period (line  | 0                 | 24. 00           |
| 25. 00           | Swing-bed cost applicable to NF type services after December   | 31 of the cost reporting       | period (line 8   | 0                 | 25. 00           |
| 20.00            | x line 20)   | or or the cost rope, tring     | 7004 (           | Ü                 | 20.00            |
| 26.00            | Total swing-bed cost (see instructions)  |                                |                  | 0                 |                  |
| 27. 00           | General inpatient routine service cost net of swing-bed cost   | (line 21 minus line 26)        |                  | 83, 469, 209      | 27. 00           |
| 20 00            | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be                           | d and observation had abo      | race)            | 0                 | 28. 00           |
| 29.00            | Private room charges (excluding swing-bed charges)   | d and observation bed cha      | ii ges)          | 0                 |                  |
| 30.00            | Semi -private room charges (excluding swing-bed charges)   |                                |                  | 0                 | 30.00            |
| 31. 00           | General inpatient routine service cost/charge ratio (line 27   | ÷ line 28)                     |                  | 0. 000000         |                  |
| 32. 00           | Average private room per diem charge (line 29 ÷ line 3)  |                                |                  | 0. 00             |                  |
| 33. 00           | Average semi-private room per diem charge (line 30 ÷ line 4)   |                                |                  | 0. 00             |                  |
| 34.00            | Average per diem private room charge differential (line 32 mi  | nus line 33)(see instruct      | tions)           | 0.00              |                  |
| 35.00            | Average per diem private room cost differential (line 34 x li  |                                | ,                | 0.00              | 35.00            |
| 36.00            | Private room cost differential adjustment (line 3 x line 35)   |                                |                  | 0                 | 36.00            |
| 37. 00           | General inpatient routine service cost net of swing-bed cost   | and private room cost dif      | ferential (line  | 83, 469, 209      | 37.00            |
|                  | 27 minus line 36)  |                                |                  |                   |                  |
|                  | PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ                       | LISTMENTS                      |                  |                   |                  |
| 38. 00           | Adjusted general inpatient routine service cost per diem (see  |                                | T                | 1, 028. 43        | 38. 00           |
| 39.00            | Program general inpatient routine service cost per drem (see   |                                |                  | 18, 986, 875      |                  |
| 40.00            | Medically necessary private room cost applicable to the Progr  |                                |                  | 0                 | 40.00            |
| 41.00            | Total Program general inpatient routine service cost (line 39  |                                | 1                | 18, 986, 875      |                  |
|                  |  |                                |                  |                   |                  |

| Provider COL 15.000   Particle (1972)   Particle (19   |        | Financial Systems                            | METHODIST HOSE                        |                            |                             |                                       | u of Form CMS-2             |              |
|--|--------|--|---------------------------------------|----------------------------|-----------------------------|---------------------------------------|-----------------------------|--------------|
| Title XVIII   Beguin   Pegram Days   Pegra   | COMPUT | ATION OF INPATIENT OPERATING COST            |                                       | Provi der C                | F                           | rom 01/01/2021                        | Worksheet D-1 Date/Time Pre | pared:       |
| Cast Center Rescription  |        |  |                                       | Ti +Lo                     | Title VVIII Hospital        |                                       |                             | 2 am         |
| NINSERY (TITLE V X XIX only)   |        | Cost Center Description                      | I npati ent                           | Total<br>Inpatient<br>Days | Average Per<br>Diem (col. 1 | · · · · · · · · · · · · · · · · · · · | Program Cost<br>(col. 3 x   |              |
| Intensive Care type Inpatient loop Ital Boil Its   16,976,791   9,195   1,1845.31   2,986   5,509,309   43.01     A 10   INTENSIVE CARE BUILT   2,894,417   2,460   1,176.59   0   43.01     A 10   INTENSIVE CARE BUILT   4.00   43.01     A 10   SURCICAL INTENSIVE CARE BUILT   4.00   43.01     A 10   SURCICAL INTENSIVE CARE BUILT   4.00     A 10   OTHER SPECIAL CARE (SPECIETY)   4.00   4.00   4.00     A 10   OTHER SPECIAL CARE (SPECIETY)   4.00   4.00   4.00     A 10   OTHER SPECIAL CARE (SPECIETY)   4.00   4.00   4.00     A 10   OTHER SPECIAL CARE (SPECIETY)   4.00   4.00   4.00     A 10   OTHER SPECIAL CARE (SPECIETY)   4.00   4.00   4.00     A 10   OTHER SPECIAL CARE (SPECIETY)   4.00   4.00   4.00   4.00     A 10   OTHER SPECIAL CARE (SPECIETY)   4.00   4.00   4.00   4.00     A 10   OTHER SPECIAL CARE (SPECIETY)   4.00   4.00   4.00   4.00     A 10   OTHER SPECIAL CARE (SPECIETY)   4.00   4.00   4.00   4.00     A 10   OTHER SPECIAL CARE (SPECIETY)   4.00   4.00   4.00   4.00     A 10   OTHER SPECIAL CARE (SPECIETY)   4.00   4.00   4.00   4.00     A 10   OTHER SPECIAL CARE (SPECIETY)   4.00   4.00   4.00   4.00     A 10   OTHER SPECI   | 40.00  | MUDGEDY (12 H - M o M) (12 H - M             |                                       |                            |                             |                                       |                             | 40.00        |
|  | 42.00  |  | 0                                     | 0                          | 0.00                        | 0                                     | 0                           | 42.00        |
| MOVANTAL ICLI  | 43. 00 |  | 16, 976, 791                          | 9, 195                     | 1, 846. 31                  | 2, 984                                | 5, 509, 389                 | 43.00        |
| 45.00   SURCIAL INTERSIVE CARE UNIT   46.00   SURCIAL INTERSIVE CARE UNIT   46.00   SURCIAL INTERSIVE CARE (SPECIFY)   46.00   50   SURCIAL INTERSIVE CARE (SPECIFY)   47.00   57.00   | 43.01  |  | · · · · · · · · · · · · · · · · · · · |                            |                             |                                       |                             | 1            |
| 40.00  |        |  |                                       |                            |                             |                                       |                             |              |
| 47.00   Program input tent and litery service cost (West: D-3, col. 3, line 200)   1.00  |        |  |                                       |                            |                             |                                       |                             |              |
| Cost Center Description  1.00  |        |  |                                       |                            |                             |                                       |                             |              |
| 1.00   | 47.00  |  |                                       |                            |                             |                                       |                             | 47.00        |
| 49.00   Program Inpartient costs (sum of lines 41 through 48)(see Instructions)   49.29, 886   49.00   Pass through costs applicable to Program inpatient routine services (from Wkst. D., sum of Parts II and 1,537,767   50.00   1.00   |        | ·  |                                       |                            |                             |                                       | 1. 00                       |              |
| PASS TRROUGH LOST ADJUSTMENTS  |        |  |                                       |                            |                             |                                       |                             |              |
| 111   Seas through costs applicable to Program Inpatient ancillary services (from Wkst. D. sum of Parts II   952, 654   51.00   and IV)   101   Program excludable cost (sum of Ilnes 50 and 51)   24.90, 421   52.00   101   Program inpatient operating cost excluding capital related, non-physician anesthetist, and   46.806, 465   53.00   101   Program inpatient operating cost excluding capital related, non-physician anesthetist, and   46.806, 465   53.00   101   Program inpatient operating cost excluding capital related, non-physician anesthetist, and   66.806, 465   53.00   101   Program inpatient operating cost excluding capital related, non-physician anesthetist, and   66.806, 465   53.00   101   Program inpatient operating cost and target amount performed cost excluding capital related, non-physician anesthetist, and   66.806, 465   53.00   101   Program discharges   0.00   0   |        | PASS THROUGH COST ADJUSTMENTS                | g , ,                                 |                            | ,                           |                                       |                             |              |
| and IV)   17.50   17   |        |  |                                       | •                          |                             |                                       |                             |              |
| Total Program Inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)   | 51. 00 | and IV)                                      |                                       | y services (fi             | rom Wkst. D, s              | um of Parts II                        |                             |              |
| medical education costs (line 4% inios line 52)  |        |  |                                       | loted to                   | uol ol on                   | a+1 a+                                |                             |              |
| 54.00   Program discharges   0.0   55.00   55.00   Target amount per discharges   0.0   55.00   55.00   Target amount (line 54 x line 55)   0.0   55.00   56.00   Target amount (line 54 x line 55)   0.5   56.00   57.00   0.0   0.0    | 53.00  | medical education costs (line 49 minus line  |                                       | erated, non-phy            | ysician anestn              | etist, and                            | 46, 806, 465                | 53.00        |
| 55.00   Target amount per discharge   0.00   55.00   55.00   0.00   55.00   0.00   55.00   0.00   55.00   0.00   55.00   0.00   55.00   0.00   55.00   0.00   55.00   0.00   55.00   0   | 54 OO  |  |                                       |                            |                             |                                       | 0                           | ]<br>] 54 00 |
| 56.00   Target amount (line 54 x line 55)   0.55.00   55.00   57.00   0.75.0 |        |  |                                       |                            |                             |                                       | -                           |              |
| 58.00 Bonus payment (see Instructions)  9.00 Lesser of Ilines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket  9.00 Lesser of Ilines 53/54 is 55 from the lower of Ilines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (Iline 53) are less than expected costs (Ilines 54 x 60), or 1% of the target amount (Iline 56), otherwise enter zero (see instructions)  10.00 Lesser of Ilines 53/54 is less than the lower of Ilines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (Iline 53) are less than expected costs (Ilines 54 x 60), or 1% of the target amount (Iline 56), otherwise enter zero (see instructions)  10.00 Relice payment (see instructions)  10.01 Allowable Inpatient cost plus incentive payment (see instructions)  10.02 Allowable Inpatient cost plus incentive payment (see instructions)  10.03 Allowable Inpatient cost plus incentive payment (see instructions)  10.04 Nedicare swing-bed SMF inpatient routine costs through December 31 of the cost reporting period (See instructions) (III til XVIII only)  10.00 Medicare swing-bed SMF inpatient routine costs (Iline 64 plus Iline 65)(title XVIIII only). For CAM (See Instructions)  10.01 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (Iline 12 x Iline 19)  10.00 Allowable Iline 19)  10.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (Iline 13 x Iline 20)  10.01 Title V or XIX swing-bed NF inpatient routine costs (Iline 67 - Iline 68)  10.02 Allowable Iline 20)  10.03 Allowable Iline 20 Allo |        |  |                                       |                            |                             |                                       |                             | •            |
| 59.00 lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the narket basket   60.00 lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket   60.00 lesser of lines 53/54 is less than the lower of lines 55,59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise senter zero (see instructions)   62.00 Relief payment (see instructions)   63.00 Allowable Inpatient cost plus incentive payment (see instructions)   64.00 Wabable Inpatient cost plus incentive payment (see instructions)   65.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)   66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) (title XVIII only)   67.00 Title Vor XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)   68.00 Title Vor XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)   69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)   69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)   69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)   69.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 87 + line 2)   71.00 Adjusted general inpatient routine service costs (line 70 + line 2)   72.00 Adjusted general inpatient routine service costs (line 70 + line 2)   73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)   74.00 Total Program countine service costs (line 77 + line 2)   75.00 Capital -related costs (line 75 + line 7)   77.00 Total Program capital -related costs (line 75 + line 7)   77.00 Total Program capital -relat |        |  | ing cost and ta                       | irget amount (             | line 56 minus               | line 53)                              | -                           |              |
| market basket  0.00   0 |        |  |                                       |                            |                             |                                       |                             |              |
| 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 1.00 do .00.00 do .00.00 do .00.00 do .00.00 lines 53.5 Sp or .60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56). Otherwise enter zero (see instructions)   | 59.00  |  | porting period                        | ending 1996, i             | updated and co              | mpounded by the                       | 0.00                        | 59.00        |
| 0.1.00   If line 53/54 is less than the lower of lines 55. 50 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)   | 60.00  |  | cost report, up                       | dated by the i             | market basket               |                                       | 0.00                        | 60.00        |
| amount (Ilne S6), otherwise enter zero (see instructions)   0 62 00 63 00  |        |  |                                       |                            |                             | the amount by                         |                             | •            |
| 62.00   Relief payment (see instructions)   0 62.00   63.00   Allowable Inpatient cost plus incentive payment (see instructions)   0 63.00   Allowable Inpatient cost plus incentive payment (see instructions)   0 64.00   REGERMA INPATIENT ROUTINE SWING BED COST   Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)   0 65.00   Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)   0 66.00   CAH (see instructions) (title XVIII only)   0 67.00   CAH (see instructions)   0 67.00   CA   |        |  |                                       | s (lines 54 x              | 60), or 1% of               | the target                            |                             |              |
| Allowable Inpatient cost plus incentive payment (see instructions)   PROCRAM INPATIENT ROUTINE SWING BED COST  | 62 00  |  | Instructions)                         |                            |                             |                                       | 0                           | 62.00        |
| PROGRAM INPATIENT ROUTINE SWING BED COST  64.00 66.00 65.00 Instructions) (title XVIII only) Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)  67.00 CAH (see instructions) Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 PATILII - SKILLED NURSING FACILITY, OHEEN RURSING FACILITY, AND LOFA/ID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  72.00 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  73.00 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  75.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Program capital -related costs (line 75 + line 2)  77.00 Program capital -related costs (line 75 + line 2)  78.00 No apprendent routine service costs (from provider records)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 No linpatient routine service costs (see instructions)  81.00 No Reasonable inpatient routine service costs (see instructions)  82.00 Utilization review - physician compensation (see instructions)  82.00 Tota |        |  | ent (see instru                       | ıcti ons)                  |                             |                                       | -                           |              |
| instructions)(title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)  69.00 Total itile V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 13 x line 20)  69.00 Total itile V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  70.00 Skilled nursing facility/other nursing facility/ICF/IID DNLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  70.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  71.00 Program routine service cost (line 9 x line 71)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (line 72 + line 73)  75.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Program capital -related costs (line 75 + line 2)  77.00 Program capital -related costs (line 75 + line 2)  78.00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79)  80.00 Inpatient routine service cost (line 74 minus line 77)  80.00 Reasonable inpatient routine service costs (see instructions)  81.00 Reasonable inpatient ancillary services (see instructions)  82.00 Inpatient routine service cost (see instructions)  83.00 Reasonable inpatient ancillary services (see instructions)  84.00 Porgram inpatient oberdays (see instructions)  85.00 Utilization review - physic |        |  |                                       | ,                          |                             |                                       |                             |              |
| instructions) (title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)  67. 00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68. 00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  70. 00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  70. 00 Total distructions facility/other nursing facility/ICF/IID routine service cost (line 37)  70. 00 Total Program routine service cost per diem (line 70 + line 2)  71. 00 Total Program general inpatient routine service costs (line 70 + line 2)  72. 00 Total Program general inpatient routine service costs (line 70 + line 10)  73. 00 Total Program general inpatient routine service costs (line 70 + line 70)  74. 00 Total Program general inpatient routine service costs (line 70 + line 70)  75. 00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76. 00 Total Program routine service costs (line 75 + line 2)  77. 00 Total Program routine service costs (line 77 + line 70) Total Program routine service costs (from provider records) Total Program routine service cost (line 74 minus line 77) Total Program inpatient routine service costs (see instructions) Total Program inpatient ancillary services (see instructions) Total Program inpatient ancillary services (see instructions) Total Program inpatient ancillary services (see instructions) Total Program inpatient poperating costs (sum of line 83 through 85) Total Program inpatient routine cost per diem (line 27 + line 2) Total Observation bed days (see instructions) Total Program inpatient routine cost per diem (line 27 + line 2) Total Observation b | 64. 00 |  | ts through Dece                       | ember 31 of the            | e cost reporti              | ng period (See                        | 0                           | 64. 00       |
| CAH (see instructions)  7. 100 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  8. 00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  9. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  9. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  9. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  9. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  9. 00 Total title V or XIX swing-bed NF inpatient routine service cost (line 67 + line 68)  9. 00 Total swing facility/Other nursing facility/ICF/IID routine service cost (line 37)  9. 00 Skilled nursing facility/Other nursing facility/ICF/IID routine service cost (line 37)  9. 00 Program routine service cost (line 9 x line 71)  9. 01 Adjusted general inpatient routine service costs (line 70 + line 2)  9. 02 Program general inpatient routine service costs (line 72 + line 73)  9. 03 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  9. 00 Per diem capital-related costs (line 75 + line 2)  9. 01 Program capital-related costs (line 75 + line 2)  9. 02 Program capital-related costs (line 74 minus line 77)  9. 03 Aggregate charges to beneficiaries for excess costs (from provider records)  9. 04 Aggregate charges to beneficiaries for excess costs (from provider records)  9. 05 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79)  9. 00 Inpatient routine service cost sock (see instructions)  9. 00 Inpatient routine service cost (see instructions)  9. 01 Inpatient routine service cost (see instructions)  9. 02 Ordinary Program inpatient ancillary services (see instructions)  9. 03 Ordinary Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST | 65. 00 |  | ts after Decemb                       | er 31 of the o             | cost reporting              | period (See                           | 0                           | 65. 00       |
| Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)   68.00   Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)   69.00   Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)   0   69.00     FART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICE/IID ONLY   70.00     70.00   Skilled nursing facility/other nursing facility/ICE/IID routine service cost (line 37)   70.00     71.00   Adjusted general inpatient routine service cost period (line 14 x line 35)   72.00     73.00   Program routine service cost (line 9 x line 71)   72.00     74.00   Total Program general inpatient routine service costs (line 72 + line 73)   74.00     75.00   Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26 line 45)   75.00     76.00   Per diem capital -related costs (line 9 x line 76)   77.00     79.00   Aggregate charges to beneficiaries for excess costs (from provider records)   79.00     79.00   Aggregate charges to beneficiaries for excess costs (from provider records)   79.00     79.00   Total Program routine service cost per diem limitation   79.00     79.00   Inpatient routine service cost per diem limitation   79.00     79.00   Reasonable inpatient routine service cost (see instructions)   82.00     79.00   Reasonable inpatient routine service (see instructions)   83.00     70.00   Program inpatient ancillary services (see instructions)   84.00     70.00   Program inpatient operating costs (sum of lines 83 through 85)   70.00     70.00   PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST   70.00   70.0   | 66. 00 |  | ne costs (line                        | 64 plus line               | 65)(title XVII              | I only). For                          | 0                           | 66. 00       |
| Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)   | 67. 00 | Title V or XIX swing-bed NF inpatient routin | e costs through                       | December 31                | of the cost re              | porting period                        | 0                           | 67. 00       |
| 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/(ICF/IID routine service cost (line 37) 70.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 71.00 Program routine service cost (line 9 x line 71) 72.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 73.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Program capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 74 minus line 77) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service cost limitation 80.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient routine service (see instructions) 84.00 Unital program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  70.00 Total observation bed days (see instructions) 84.00 Inpatient observation bed days (see instructions) 85.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 86.00 Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 89.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 89.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 89.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 8 | 68. 00 | Title V or XIX swing-bed NF inpatient routin | e costs after D                       | ecember 31 of              | the cost repo               | rting period                          | 0                           | 68. 00       |
| 70.00 71.00  | 69. 00 | Total title V or XIX swing-bed NF inpatient  |                                       |                            |                             |                                       | 0                           | 69. 00       |
| 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service cost per diem limitation 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  71.00 Total observation bed days (see instructions) 86.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)  71.00 Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)   | 70 00  | ·  |                                       |                            |                             |                                       |                             | 70.00        |
| 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 70.01 Inpatient routine service cost per diem limitation 70.02 Inpatient routine service cost limitation (line 78 minus line 79) 70.01 Inpatient routine service cost limitation (line 9 x line 81) 70.02 Reasonable inpatient routine service costs (see instructions) 70.03 Reasonable inpatient ancillary services (see instructions) 70.04 Program inpatient operating costs (sum of lines 83 through 85) 70.00 Reasonable inpatient operating costs (sum of lines 83 through 85) 70.00 Reasonable inpatient routine bed days (see instructions) 70.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2) 70.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2) 71.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2)   |        | 9 9  | ,                                     |                            | , ,                         |                                       |                             | •            |
| Total Program general inpatient routine service costs (line 72 + line 73)  74.00  75.00  76.00  76.00  76.00  76.00  77.00  78.00  78.00  78.00  79.00  79.00  70.0 |        | ,  |                                       |                            |                             |                                       |                             | •            |
| 75.00  Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00  Per diem capital-related costs (line 75 ÷ line 2)  Program capital-related costs (line 9 x line 76)  77.00  Routed Program capital-related costs (line 74 minus line 77)  Aggregate charges to beneficiaries for excess costs (from provider records)  Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  1 Inpatient routine service cost per diem limitation  1 Inpatient routine service cost limitation (line 9 x line 81)  Reasonable inpatient routine service costs (see instructions)  Program inpatient ancillary services (see instructions)  Total Program inpatient ancompensation (see instructions)  Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  75.00  76.00  77.00  77.00  78.00  78.00  79.00  80.00  19.00  80.00  10.00  |        | 1 3.   |                                       | •                          | ,                           |                                       |                             | 1            |
| 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service costs per diem limitation 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  76.00 77 |        | Capital-related cost allocated to inpatient  |                                       |                            |                             | art II, column                        |                             | 1            |
| 77. 00 Program capital -related costs (line 9 x line 76) 78. 00 Inpatient routine service cost (line 74 minus line 77) 79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 80. 00 Reasonable inpatient routine service cost limitation (line 9 x line 81) 81. 00 Reasonable inpatient routine service costs (see instructions) 82. 00 Reasonable inpatient routine services (see instructions) 83. 00 Reasonable inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions) 87. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1, 028. 43 88. 00   | 76 00  |  | ne 2)                                 |                            |                             |                                       |                             | 76 00        |
| 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Program inpatient ancillary services (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  17.00 Total Observation bed days (see instructions) 17.00 Aggregate charges to beneficiaries for excess costs (from provider records) 97.00 Total Program routine service costs (from provider records) 98.00 Adjusted general inpatient routine 27 ÷ line 20 98.00 Aggregate charges to beneficiaries for excess costs (from provider records) 97.00 Total Program routine service costs (from provider records) 98.00 Aggregate charges to beneficiaries for excess costs (from provider records) 98.00 Aggregate charges to beneficiaries for excess costs (from provider records) 98.00 Aggregate charges to beneficiaries for excess costs (from provider records) 98.00 Aggregate charges to beneficiance for excess costs (from provider records) 98.00 Aggregate charges to beneficiance for excess costs (from provider records) 98.00 Aggregate charges to beneficiance for excess costs (from provider records) 98.00 Aggregate charges for excess (from provider records) 98.00 Aggregate charges for excess (from provider records) 98.00 Aggregate charges for excess (from provider records) 98.00 Ag |        | 1 .  |                                       |                            |                             |                                       |                             | 1            |
| 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 89.00 Total Program routine service costs (see instructions) 80.00 Section (line 78 minus line 79) 80.00 Sectio | 78.00  |  |                                       |                            |                             |                                       |                             | 78. 00       |
| 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 81.00 Inpatient routine service cost per diem limitation 81.00 Sec. 00 82.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  |        | 00 0   |                                       |                            |                             | uo lir- 70)                           |                             | 1            |
| 82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Program inpatient ancillary services (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  |        |  |                                       | JOST ILMITATIO             | n (iine 78 min              | us line 79)                           |                             |              |
| 83.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  85.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  |        |  |                                       | )                          |                             |                                       |                             |              |
| 85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  |        | Reasonable inpatient routine service costs ( | see instruction                       | •                          |                             |                                       |                             | 83. 00       |
| 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  7 Total observation bed days (see instructions) Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  |        | 1  |                                       |                            |                             |                                       |                             | 1            |
| PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  1,028.43 88.00   |        |  |                                       |                            |                             |                                       |                             | 1            |
| 87.00 Total observation bed days (see instructions)  11,472 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  1,028.43 88.00  | 50.00  |  |                                       | n Jugir 65)                |                             |                                       |                             | , 55.00      |
|  | 87. 00 |  |                                       |                            |                             |                                       | 14, 472                     | 87. 00       |
| 89. UU   UDSERVATION DEC COST (Tine 87 x Tine 88) (see instructions)   14,883,439   89.00  |        | ,  | •                                     |                            |                             |                                       |                             |              |
|  | 89.00  | Ubservation bed cost (line 8/ x line 88) (se | e instructions)                       |                            |                             |                                       | 14, 883, 439                | 89.00        |

| Health Financial Systems                    | METHODIST HOS | PITALS, INC  |            | In Lie                           | u of Form CMS-2                | 2552-10 |
|---|---------------|--------------|------------|----------------------------------|--------------------------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST     |               | Provi der CO |            | Peri od:                         | Worksheet D-1                  |         |
|   |               |              |            | From 01/01/2021<br>To 12/31/2021 | Date/Time Pre<br>5/27/2022 9:0 |         |
|   |               | Title        | XVIII      | Hospi tal                        | PPS                            |         |
| Cost Center Description                     | Cost          | Routine Cost | column 1 ÷ | Total                            | Observation                    |         |
|   |               | (from line   | column 2   | Observati on                     | Bed Pass                       |         |
|   |               | 21)          |            | Bed Cost                         | Through Cost                   |         |
|   |               |              |            | (from line                       | (col. 3 x                      |         |
|   |               |              |            | 89)                              | col. 4) (see                   |         |
|   |               |              |            |                                  | instructions)                  |         |
|   | 1. 00         | 2.00         | 3. 00      | 4. 00                            | 5. 00                          |         |
| COMPUTATION OF OBSERVATION BED PASS THROUGH | COST          |              |            |                                  |                                |         |
| 90.00 Capital-related cost                  | 6, 083, 843   | 83, 469, 209 | 0. 07288   | 7 14, 883, 439                   | 1, 084, 809                    | 90.00   |
| 91.00 Nursing Program cost                  | 0             | 83, 469, 209 | 0.00000    | 0 14, 883, 439                   | 0                              | 91.00   |
| 92.00 Allied health cost                    | o             | 83, 469, 209 | 0.00000    | 0 14, 883, 439                   | 0                              | 92.00   |
| 93.00 All other Medical Education           | o             | 83, 469, 209 | 0.00000    | 0 14, 883, 439                   | 0                              | 93.00   |

| Health Financial Systems                | METHODIST HOSPITALS, INC | In Lieu                     | u of Form CMS-2552-10 |
|---|--------------------------|-----------------------------|-----------------------|
| COMPUTATION OF INPATIENT OPERATING COST | Provi der CCN: 15-0002   | Peri od:<br>From 01/01/2021 | Worksheet D-1         |
|   | Component CCN: 15-S002   |                             |                       |
|   | Title XVIII              | Subprovi der -              | PPS                   |
|   |                          | IPF                         |                       |

|        |  | I PF                                  |             |        |
|--------|--|---------------------------------------|-------------|--------|
|        | Cost Center Description  | _                                     | 1.00        |        |
|        | PART I - ALL PROVIDER COMPONENTS   |                                       | 1. 00       |        |
|        | INPATIENT DAYS   |                                       |             |        |
| 1.00   | Inpatient days (including private room days and swing-bed days, exc  | luding newborn)                       | 1, 239      | 1.00   |
| 2.00   | Inpatient days (including private room days, excluding swing-bed an  |                                       | 1, 239      | 2.00   |
| 3.00   | Private room days (excluding swing-bed and observation bed days). I  | f you have only private room days,    | 0           | 3.00   |
|        | do not complete this line.   |                                       |             |        |
| 4. 00  | Semi-private room days (excluding swing-bed and observation bed day  |                                       | 1, 239      | 4.00   |
| 5. 00  | Total swing-bed SNF type inpatient days (including private room day  | s) through December 31 of the cost    | 0           | 5. 00  |
| 6. 00  | reporting period Total swing-bed SNF type inpatient days (including private room day   | s) after December 31 of the cost      | 0           | 6. 00  |
| 0.00   | reporting period (if calendar year, enter 0 on this line)  | 3) arter beceiiber 31 of the cost     | 0           | 0.00   |
| 7. 00  | Total swing-bed NF type inpatient days (including private room days  | ) through December 31 of the cost     | 0           | 7.00   |
|        | reporting period   | ,                                     |             |        |
| 8.00   | Total swing-bed NF type inpatient days (including private room days  | ) after December 31 of the cost       | 0           | 8.00   |
|        | reporting period (if calendar year, enter 0 on this line)  |                                       |             |        |
| 9. 00  | Total inpatient days including private room days applicable to the   | Program (excluding swing-bed and      | 422         | 9. 00  |
| 10.00  | newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (i                                       | ncluding private room days)           | 0           | 10.00  |
| 10.00  | through December 31 of the cost reporting period (see instructions)  | nerdaring private room days)          | 0           | 10.00  |
| 11. 00 | Swing-bed SNF type inpatient days applicable to title XVIII only (i  | ncluding private room days) after     | 0           | 11.00  |
|        | December 31 of the cost reporting period (if calendar year, enter 0  | on this line)                         |             |        |
| 12.00  | Swing-bed NF type inpatient days applicable to titles V or XIX only  | (including private room days)         | 0           | 12.00  |
|        | through December 31 of the cost reporting period   |                                       | _           |        |
| 13. 00 | Swing-bed NF type inpatient days applicable to titles V or XIX only  |                                       | 0           | 13.00  |
| 14. 00 | after December 31 of the cost reporting period (if calendar year, e<br>Medically necessary private room days applicable to the Program (ex |                                       | 0           | 14. 00 |
| 15. 00 | Total nursery days (title V or XIX only)   | cruding swriig-bed days)              | 0           | 15.00  |
| 16. 00 | Nursery days (title V or XIX only)   |                                       | 0           |        |
|        | SWI NG BED ADJUSTMENT  | <u>'</u>                              | -           |        |
| 17.00  | Medicare rate for swing-bed SNF services applicable to services thr  | ough December 31 of the cost          | 0.00        | 17.00  |
|        | reporting period   |                                       |             |        |
| 18. 00 | Medicare rate for swing-bed SNF services applicable to services aft  | er December 31 of the cost            | 0. 00       | 18. 00 |
| 19. 00 | reporting period   | ugh Dagambar 21 of the cost           | 0.00        | 19. 00 |
| 19.00  | Medicaid rate for swing-bed NF services applicable to services thro reporting period   | ugh beceiliber 31 of the cost         | 0.00        | 19.00  |
| 20. 00 | Medicaid rate for swing-bed NF services applicable to services afte  | r December 31 of the cost             | 0.00        | 20.00  |
|        | reporting period   |                                       |             |        |
| 21.00  | Total general inpatient routine service cost (see instructions)  |                                       | 1, 815, 787 | 21.00  |
| 22. 00 | Swing-bed cost applicable to SNF type services through December 31   | of the cost reporting period (line    | 0           | 22.00  |
|        | 5 x line 17)   |                                       |             |        |
| 23. 00 | Swing-bed cost applicable to SNF type services after December 31 of x line 18)   | the cost reporting period (line 6     | 0           | 23. 00 |
| 24. 00 | Swing-bed cost applicable to NF type services through December 31 o  | f the cost reporting period (line     | 0           | 24.00  |
| 24.00  | 7 x line 19)   | The cost reporting period (Time       | O           | 24.00  |
| 25.00  | Swing-bed cost applicable to NF type services after December 31 of   | the cost reporting period (line 8     | 0           | 25.00  |
|        | x line 20)   |                                       |             |        |
| 26. 00 | Total swing-bed cost (see instructions)  |                                       | 0           | 26.00  |
| 27. 00 | General inpatient routine service cost net of swing-bed cost (line   | 21 minus line 26)                     | 1, 815, 787 | 27.00  |
| 28. 00 | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and                                   | observation had charges)              | 0           | 28. 00 |
| 29. 00 | Private room charges (excluding swing-bed charges)   | observation bed charges)              | 0           |        |
| 30.00  | Semi -private room charges (excluding swing-bed charges)   |                                       | 0           |        |
| 31. 00 | General inpatient routine service cost/charge ratio (line 27 ÷ line  | 28)                                   | 0. 000000   |        |
| 32.00  | Average private room per diem charge (line 29 ÷ line 3)  | ·                                     | 0.00        | 32.00  |
| 33.00  | Average semi-private room per diem charge (line 30 ÷ line 4)   |                                       | 0. 00       | 33.00  |
| 34.00  | Average per diem private room charge differential (line 32 minus li  | ne 33)(see instructions)              | 0. 00       |        |
| 35. 00 | Average per diem private room cost differential (line 34 x line 31)  |                                       | 0.00        |        |
| 36.00  | Private room cost differential adjustment (line 3 x line 35)   | ivata room cost differential (1:-     | 1 015 707   | 36.00  |
| 37. 00 | General inpatient routine service cost net of swing-bed cost and pr 27 minus line 36)  | ivate room cost differential (IINe    | 1, 815, 787 | 37. 00 |
|        | PART II - HOSPITAL AND SUBPROVIDERS ONLY   |                                       |             |        |
|        | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENT   | TS                                    |             |        |
| 38. 00 | Adjusted general inpatient routine service cost per diem (see instr  |                                       | 1, 465. 53  | 38. 00 |
| 39. 00 | Program general inpatient routine service cost (line 9 x line 38)  | ·                                     | 618, 454    |        |
| 40. 00 | Medically necessary private room cost applicable to the Program (li  | · · · · · · · · · · · · · · · · · · · | 0           | 40.00  |
| 41. 00 | Total Program general inpatient routine service cost (line 39 + lin  | e 40)                                 | 618, 454    | 41. 00 |
|        |  |                                       |             |        |

| Heal th          | Financial Systems  | METHODIST HOSE   | PITALS, INC     |                    | In Lie                      | u of Form CMS-2             | 2552-10          |
|------------------|--|------------------|-----------------|--------------------|-----------------------------|-----------------------------|------------------|
| COMPUT           | ATION OF INPATIENT OPERATING COST  |                  | Provi der C     |                    | Peri od:<br>From 01/01/2021 | Worksheet D-1               |                  |
|                  |  |                  | Component       |                    | To 12/31/2021               | Date/Time Pre 5/27/2022 9:0 |                  |
|                  |  |                  | Titl€           | xVIII              | Subprovi der -              | PPS                         | <u> 2 am</u>     |
|                  | Cost Center Description  | Total            | Total           | Average Per        | IPF<br>Program Days         | Program Cost                |                  |
|                  | beschiptren  | I npati ent      | I npati ent     | Diem (col. 1       |                             | (col. 3 x                   |                  |
|                  |  | 1.00             | Days<br>2.00    | ÷ col . 2)<br>3.00 | 4. 00                       | col . 4)<br>5.00            |                  |
| 42. 00           | NURSERY (title V & XIX only)   | 0                | 2.00<br>C       |                    |                             |                             | 42.00            |
| 40.00            | Intensive Care Type Inpatient Hospital Units   | 0                |                 |                    |                             |                             | 40.00            |
| 43. 00<br>43. 01 | INTENSIVE CARE UNIT<br>NEONATAL ICU  | 0                | C               |                    |                             | 0<br>0                      | 43. 00<br>43. 01 |
| 44. 00           | CORONARY CARE UNIT   |                  |                 |                    |                             |                             | 44.00            |
| 45. 00<br>46. 00 | BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT  |                  |                 |                    |                             |                             | 45. 00<br>46. 00 |
|                  | OTHER SPECIAL CARE (SPECIFY)   |                  |                 |                    |                             |                             | 47.00            |
|                  | Cost Center Description  |                  |                 |                    |                             | 1.00                        |                  |
| 48. 00           | Program inpatient ancillary service cost (Wk   | st. D-3. col. 3  | 3. Line 200)    |                    |                             | 1. 00<br>76, 144            | 48. 00           |
|                  | Total Program inpatient costs (sum of lines  |                  |                 | ons)               |                             | 694, 598                    |                  |
| 50. 00           | PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inpa   | ationt routino   | sorvices (fro   | m Wkst D sur       | m of Darte L and            | 27, 983                     | 50. 00           |
| 30.00            | III)   | atrent routine   | services (110   | iii wkst. D, Sui   | ii Oi Faits I aiic          | 21, 703                     | 30.00            |
| 51.00            | Pass through costs applicable to Program inpo  | atient ancillar  | y services (f   | rom Wkst. D,       | sum of Parts II             | 2, 140                      | 51.00            |
| 52. 00           | and IV) Total Program excludable cost (sum of lines!   | 50 and 51)       |                 |                    |                             | 30. 123                     | 52. 00           |
| 53.00            | Total Program inpatient operating cost exclu   | ding capital re  | elated, non-ph  | ysician anestl     | netist, and                 | 664, 475                    |                  |
|                  | medical education costs (line 49 minus line !<br>TARGET AMOUNT AND LIMIT COMPUTATION                                   | 52)              |                 |                    |                             |                             |                  |
| 54.00            | Program di scharges  |                  |                 |                    |                             | 0                           | 54.00            |
| 55. 00<br>56. 00 | Target amount per discharge<br>Target amount (line 54 x line 55)   |                  |                 |                    |                             | 0. 00<br>0                  | 55. 00<br>56. 00 |
|                  | Difference between adjusted inpatient operati  | ing cost and ta  | arget amount (  | line 56 minus      | line 53)                    | 0                           | 57.00            |
| 58. 00           | Bonus payment (see instructions)   | S                |                 |                    | ŕ                           | 0.00                        | 58.00            |
| 59. 00           | 00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket |                  |                 |                    |                             |                             | 59. 00           |
| 60.00            |  |                  |                 |                    |                             |                             | 60.00            |
| 61. 00           | If line 53/54 is less than the lower of line which operating costs (line 53) are less that                             |                  |                 |                    |                             | 0                           | 61. 00           |
|                  | amount (line 56), otherwise enter zero (see  |                  | .5 (TITIES 54 X | 00), 01 1% 0       | i the target                |                             |                  |
|                  | Relief payment (see instructions)  | ont (ooo i notsu | inti ana)       |                    |                             | 0                           |                  |
| 63. 00           | Allowable Inpatient cost plus incentive paymer PROGRAM INPATIENT ROUTINE SWING BED COST                                | ent (see mstru   | ictions)        |                    |                             | 0                           | 63. 00           |
| 64. 00           | Medicare swing-bed SNF inpatient routine cos   | ts through Dece  | ember 31 of th  | e cost report      | ing period (See             | 0                           | 64. 00           |
| 65. 00           | instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos   | ts after Decemb  | er 31 of the    | cost reportin      | a period (See               | 0                           | 65. 00           |
|                  | instructions)(title XVIII only)  |                  |                 |                    |                             |                             |                  |
| 66. 00           | Total Medicare swing-bed SNF inpatient routing CAH (see instructions)  | ne costs (line   | 64 plus line    | 65)(title XVI      | II only). For               | 0                           | 66. 00           |
| 67. 00           | Title V or XIX swing-bed NF inpatient routing  | e costs through  | December 31     | of the cost re     | eporting period             | 0                           | 67. 00           |
| 68. 00           | (line 12 x line 19)<br>Title V or XIX swing-bed NF inpatient routing   | a costs after D  | December 31 of  | the cost ren       | orting period               | 0                           | 68. 00           |
| 00.00            | (line 13 x line 20)  |                  | recember 51 or  | the cost rep       | or tring period             |                             | 00.00            |
| 69. 00           | Total title V or XIX swing-bed NF inpatient  |                  |                 |                    |                             | 0                           | 69. 00           |
| 70. 00           | PART III - SKILLED NURSING FACILITY, OTHER NU<br>Skilled nursing facility/other nursing facili                         |                  |                 |                    | )                           |                             | 70. 00           |
| 71.00            | Adjusted general inpatient routine service of  |                  | ine 70 ÷ line   | 2)                 |                             |                             | 71.00            |
| 72. 00<br>73. 00 | Program routine service cost (line 9 x line Medically necessary private room cost applications)                        | ,                | ı (line 14 x l  | ine 35)            |                             |                             | 72. 00<br>73. 00 |
| 74.00            | Total Program general inpatient routine servi  | ice costs (line  | e 72 + line 73  | )                  |                             |                             | 74.00            |
| 75. 00           | Capital-related cost allocated to inpatient (26, line 45)  | routine service  | costs (from     | Worksheet B, I     | Part II, column             |                             | 75. 00           |
| 76. 00           | Per diem capital-related costs (line 75 ÷ li   |                  |                 |                    |                             |                             | 76. 00           |
| 77. 00<br>78. 00 | Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus                             |                  |                 |                    |                             |                             | 77. 00<br>78. 00 |
| 79. 00           | Aggregate charges to beneficiaries for excess  |                  | rovi der recor  | ds)                |                             |                             | 79.00            |
| 80. 00<br>81. 00 | Total Program routine service costs for compa  |                  | cost limitatio  | n (line 78 mi      | nus line 79)                |                             | 80. 00<br>81. 00 |
| 81.00            | Inpatient routine service cost per diem limi<br> Inpatient routine service cost limitation (I                          |                  | )               |                    |                             |                             | 81.00            |
| 83. 00           | Reasonable inpatient routine service costs (   | see instruction  |                 |                    |                             |                             | 83.00            |
| 84. 00<br>85. 00 | Program inpatient ancillary services (see in:<br>Utilization review - physician compensation                           |                  | ons)            |                    |                             |                             | 84. 00<br>85. 00 |
| 86. 00           | Total Program inpatient operating costs (sum   | of lines 83 th   |                 |                    |                             |                             | 86.00            |
| 87. 00           | PART IV - COMPUTATION OF OBSERVATION BED PASS<br>Total observation bed days (see instructions)                         |                  |                 |                    |                             | 0                           | 87. 00           |
| 88. 00           | Adjusted general inpatient routine cost per  | diem (line 27 ÷  | ,               |                    |                             | 0.00                        | 88. 00           |
| 89. 00           | Observation bed cost (line 87 x line 88) (see  | e instructions)  |                 |                    |                             | 0                           | 89. 00           |

| Health Financial Systems                    | METHODI ST HOS | PITALS, INC  |              | In Lie                           | u of Form CMS-2                | 2552-10 |
|---|----------------|--------------|--------------|----------------------------------|--------------------------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST     |                | Provi der CO |              | Peri od:                         | Worksheet D-1                  |         |
|   |                | Component (  | CCN: 15-S002 | From 01/01/2021<br>To 12/31/2021 | Date/Time Pre<br>5/27/2022 9:0 |         |
|   |                | Title        | XVIII        | Subprovi der -                   | PPS                            |         |
|   |                |              |              | I PF                             |                                |         |
| Cost Center Description                     | Cost           | Routine Cost | column 1 ÷   | Total                            | Observation                    |         |
|   |                | (from line   | column 2     | Observati on                     | Bed Pass                       |         |
|   |                | 21)          |              | Bed Cost                         | Through Cost                   |         |
|   |                |              |              | (from line                       | (col. 3 x                      |         |
|   |                |              |              | 89)                              | col. 4) (see                   |         |
|   |                |              |              |                                  | instructions)                  |         |
|   | 1. 00          | 2.00         | 3.00         | 4. 00                            | 5. 00                          |         |
| COMPUTATION OF OBSERVATION BED PASS THROUGH | COST           |              |              |                                  |                                |         |
| 90.00 Capital-related cost                  | 82, 155        | 1, 815, 787  | 0. 04524     | 15 0                             | 0                              | 90.00   |
| 91.00 Nursing Program cost                  | 0              | 1, 815, 787  | 0. 00000     | 00                               | 0                              | 91.00   |
| 92.00 Allied health cost                    | 0              | 1, 815, 787  | 0. 00000     | 00                               | 0                              | 92.00   |
| 93.00 All other Medical Education           | 0              | 1, 815, 787  | 0. 00000     | 00                               | 0                              | 93.00   |

| Health Financial Systems                | METHODIST HOSPITALS, INC | In Lieu                     | u of Form CMS-2552-10 |
|---|--------------------------|-----------------------------|-----------------------|
| COMPUTATION OF INPATIENT OPERATING COST |                          | Peri od:<br>From 01/01/2021 | Worksheet D-1         |
|   | Component CCN: 15-T002   |                             |                       |
|   | Title XVIII              | Subprovi der -              | PPS                   |
|   |                          | IRF                         |                       |

|                  |  | I RF  |                           |        |
|------------------|--|---|---------------------------|--------|
|                  | Cost Center Description  |   | 1 00                      |        |
|                  | PART I - ALL PROVIDER COMPONENTS   |   | 1. 00                     |        |
|                  | INPATIENT DAYS   |   |                           |        |
| 1.00             | Inpatient days (including private room days and swing-bed days   | s, excluding newborn)   | 4, 300                    | 1.00   |
| 2.00             | Inpatient days (including private room days, excluding swing-b   | ped and newborn days)   | 4, 300                    | 2.00   |
| 3.00             | Private room days (excluding swing-bed and observation bed day   | /s). If you have only private room days,  | 0                         | 3.00   |
|                  | do not complete this line.   |   |                           |        |
| 4. 00            | Semi-private room days (excluding swing-bed and observation be   |   | 4, 300                    | 4.00   |
| 5. 00            | Total swing-bed SNF type inpatient days (including private roc<br>reporting period   | om days) through becember 31 of the cost  | 0                         | 5. 00  |
| 6. 00            | Total swing-bed SNF type inpatient days (including private roo   | om days) after December 31 of the cost  | 0                         | 6. 00  |
| 0.00             | reporting period (if calendar year, enter 0 on this line)  | mi days) arter becomber 31 or the cost  | O                         | 0.00   |
| 7.00             | Total swing-bed NF type inpatient days (including private room   | n days) through December 31 of the cost   | 0                         | 7.00   |
|                  | reporting period   |   |                           |        |
| 8. 00            | Total swing-bed NF type inpatient days (including private room   | n days) after December 31 of the cost   | 0                         | 8.00   |
| 9. 00            | reporting period (if calendar year, enter 0 on this line)  | the Drogram (eveluding swing had and  | 1, 987                    | 9. 00  |
| 9.00             | Total inpatient days including private room days applicable to newborn days) (see instructions)                                  | The Program (excruding swring-bed and   | 1, 907                    | 9.00   |
| 10.00            | Swing-bed SNF type inpatient days applicable to title XVIII on   | nly (including private room days)   | 0                         | 10.00  |
|                  | through December 31 of the cost reporting period (see instruct   |   |                           |        |
| 11.00            | Swing-bed SNF type inpatient days applicable to title XVIII on   |   | 0                         | 11.00  |
|                  | December 31 of the cost reporting period (if calendar year, en   | nter 0 on this line)  |                           |        |
| 12. 00           | Swing-bed NF type inpatient days applicable to titles V or XIX   | ( only (including private room days)  | 0                         | 12.00  |
| 13. 00           | through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX                  | (only (including private room days)   | 0                         | 13. 00 |
| 13.00            | after December 31 of the cost reporting period (if calendar ye   |   | U                         | 13.00  |
| 14. 00           | Medically necessary private room days applicable to the Progra   |   | 0                         | 14.00  |
| 15.00            | Total nursery days (title V or XIX only)   | (   | 0                         | 15.00  |
| 16.00            | Nursery days (title V or XIX only)   |   | 0                         | 16.00  |
|                  | SWI NG BED ADJUSTMENT  |   |                           |        |
| 17. 00           | Medicare rate for swing-bed SNF services applicable to service   | es through December 31 of the cost  | 0. 00                     | 17. 00 |
| 18. 00           | reporting period Medicare rate for swing-bed SNF services applicable to service  | os after December 21 of the cost  | 0.00                      | 18. 00 |
| 16.00            | reporting period   | es after beceiliber 31 of the cost  | 0.00                      | 16.00  |
| 19. 00           | Medicaid rate for swing-bed NF services applicable to services   | s through December 31 of the cost   | 0. 00                     | 19.00  |
|                  | reporting period   |   |                           |        |
| 20.00            | Medicaid rate for swing-bed NF services applicable to services   | after December 31 of the cost   | 0.00                      | 20.00  |
|                  | reporting period   | ,   |                           |        |
| 21. 00           | Total general inpatient routine service cost (see instructions   |   | 5, 176, 818               |        |
| 22. 00           | Swing-bed cost applicable to SNF type services through Decembe $5 \times 1$ ine 17)  | er 31 of the cost reporting period (line  | 0                         | 22. 00 |
| 23. 00           | Swing-bed cost applicable to SNF type services after December  | 31 of the cost reporting period (line 6   | 0                         | 23. 00 |
|                  | x line 18)   | The second process of | _                         |        |
| 24.00            | Swing-bed cost applicable to NF type services through December   | 31 of the cost reporting period (line   | 0                         | 24.00  |
|                  | 7 x line 19)   |   |                           |        |
| 25. 00           | Swing-bed cost applicable to NF type services after December 3   | 31 of the cost reporting period (line 8   | 0                         | 25. 00 |
| 26. 00           | x line 20)<br> Total swing-bed cost (see instructions)   |   | 0                         | 26. 00 |
| 27.00            | General inpatient routine service cost net of swing-bed cost (   | line 21 minus line 26)  | 5, 176, 818               |        |
| 27.00            | PRI VATE ROOM DI FFERENTI AL ADJUSTMENT  | 1.110 21  | 5/1/5/515                 | 27.00  |
| 28. 00           | General inpatient routine service charges (excluding swing-bed   | l and observation bed charges)  | 0                         | 28.00  |
|                  | Private room charges (excluding swing-bed charges)   |   | 0                         |        |
| 30.00            | Semi-private room charges (excluding swing-bed charges)  |   | 0                         |        |
| 31.00            | General inpatient routine service cost/charge ratio (line 27 ÷   | - line 28)  | 0.000000                  |        |
| 32. 00<br>33. 00 | Average private room per diem charge (line 29 ÷ line 3)  |   | 0. 00<br>0. 00            |        |
| 34.00            | Average semi-private room per diem charge (line 30 ÷ line 4)<br>  Average per diem private room charge differential (line 32 min | nus line 33)(see instructions)  | 0.00                      |        |
| 35.00            | Average per diem private room cost differential (line 34 x lin   |   | 0.00                      |        |
| 36. 00           | Private room cost differential adjustment (line 3 x line 35)   |   | 0.00                      | 36.00  |
| 37. 00           | General inpatient routine service cost net of swing-bed cost a   | and private room cost differential (line  | -                         |        |
|                  | 27 minus line 36)  | ·   |                           |        |
|                  | PART II - HOSPITAL AND SUBPROVIDERS ONLY   | ACTUS NTO   |                           |        |
| 20.00            | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU   |   | 1 202 21                  | 20.00  |
| 38. 00<br>39. 00 | Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line      | *   | 1, 203. 91<br>2, 392, 169 |        |
| 40.00            | Medically necessary private room cost applicable to the Progra   | •   | 2, 392, 109               | 40.00  |
|                  | Total Program general inpatient routine service cost (line 39  | ,   | 2, 392, 169               |        |
|                  | 5 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1  | ,   | , ,                       |        |

| Heal th   | Financial Systems   | METHODIST HOS   | PITALS, INC     |                   | In Lie                     | u of Form CMS-2             | 2552-10  |
|---|---|-----------------|-----------------|-------------------|----------------------------|-----------------------------|--|
| COMPUT  | ATION OF INPATIENT OPERATING COST   |                 | Provi der C     |                   | Period:<br>From 01/01/2021 | Worksheet D-1               |  |
|   |   |                 | Component       |                   | Γο 12/31/2021              | Date/Time Pre 5/27/2022 9:0 |  |
|   |   |                 | Title           | e XVIII           | Subprovi der -             | PPS                         | <u> 2 aiii                                </u> |
|   | Cost Center Description   | Total           | Total           | Average Per       | IRF<br>Program Days        | Program Cost                |  |
|   | cost center bescription   | I npati ent     | Inpatient       | Di em (col. 1     | 11 ogi alli bays           | (col. 3 x                   |  |
|   |   | Cost            | Days            | ÷ col . 2)        | 4.00                       | col . 4)                    |  |
| 42. 00  | NURSERY (title V & XIX only)  | 1.00            | 2.00            | 3.00              | 4.00                       | 5. 00                       | 42.00  |
|   | Intensive Care Type Inpatient Hospital Units  | _               |                 |                   |                            |                             |  |
| 43. 00<br>43. 01  | INTENSIVE CARE UNIT<br>NEONATAL ICU   | 0               |                 |                   |                            | 0                           | 43. 00<br>43. 01                               |
| 44. 00  | CORONARY CARE UNIT  | 9               |                 | )                 |                            | · ·                         | 44. 00   |
| 45.00   | BURN I NTENSI VE CARE UNI T   |                 |                 |                   |                            |                             | 45.00  |
| 46. 00<br>47. 00  | SURGICAL INTENSIVE CARE UNIT<br>OTHER SPECIAL CARE (SPECIFY)  |                 |                 |                   |                            |                             | 46. 00<br>47. 00                               |
|   | Cost Center Description   |                 |                 |                   |                            |                             |  |
| 48. 00  | Program inpatient ancillary service cost (Wk  | st D-3 col      | 3 line 200)     |                   |                            | 1. 00<br>1, 241, 769        | 48. 00   |
| 49. 00  | Total Program inpatient costs (sum of lines   |                 |                 | ons)              |                            | 3, 633, 938                 | 1  |
| EO 00   | PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program inp                                 | a+lan+ mau+lna  | condicae (fra   | m Wko+ D oum      | of Donto L one             | 2// 207                     | FO 00  |
| 50. 00  | Pass through costs appricable to Program imp<br>  | atrent routine  | services (110   | III WKSt. D, Sull | I OI PAILS I AIIC          | 266, 397                    | 50.00  |
| 51.00   | Pass through costs applicable to Program inp  | atient ancilla  | ry services (f  | rom Wkst. D, s    | um of Parts II             | 72, 748                     | 51.00  |
| 52. 00  | and IV) Total Program excludable cost (sum of lines   | 50 and 51)      |                 |                   |                            | 339, 145                    | 52.00  |
| 53.00   | Total Program inpatient operating cost exclu  | ding capital r  | elated, non-ph  | ysician anesth    | etist, and                 | 3, 294, 793                 | 1  |
|   | medical education costs (line 49 minus line<br>TARGET AMOUNT AND LIMIT COMPUTATION                          | 52)             |                 |                   |                            |                             |  |
| 54.00   | Program di scharges   |                 |                 |                   |                            | 0                           | 54.00  |
| 55.00   | Target amount per discharge   |                 |                 |                   |                            | 0.00                        | 1  |
| 56. 00<br>57. 00  | Target amount (line 54 x line 55) Difference between adjusted inpatient operat                              | ing cost and t  | arget amount (  | line 56 minus     | line 53)                   | 0                           | 56. 00<br>57. 00                               |
| 58.00   | Bonus payment (see instructions)  | · ·             |                 |                   | ,                          | 0.00                        | 58. 00   |
| 59. 00  | 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the |                 |                 |                   |                            |                             | 59. 00   |
| 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket |   |                 |                 |                   | 0.00                       | 60. 00                      |  |
| 61. 00  | If line 53/54 is less than the lower of line  |                 |                 |                   |                            | 0                           | 61.00  |
|   | which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see                    |                 | ts (Titles 54 X | . 60), 01 1% 01   | the target                 |                             |  |
| 62.00   | Relief payment (see instructions)   |                 |                 |                   |                            | 0                           | 62.00  |
| 63. 00  | Allowable Inpatient cost plus incentive paym<br>PROGRAM INPATIENT ROUTINE SWING BED COST                    | ent (see instr  | uctions)        |                   |                            | 0                           | 63.00  |
| 64.00   | Medicare swing-bed SNF inpatient routine cos  | ts through Dec  | ember 31 of th  | e cost reporti    | ng period (See             | 0                           | 64. 00   |
| 65. 00  | <pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>                     | ts after Decemb | her 31 of the   | cost reporting    | neriod (See                | 0                           | 65. 00   |
| 00.00   | instructions)(title XVIII only)   |                 |                 |                   |                            | o o                         | 00.00  |
| 66. 00  | Total Medicare swing-bed SNF inpatient routi CAH (see instructions)   | ne costs (line  | 64 plus line    | 65)(title XVII    | I only). For               | 0                           | 66. 00   |
| 67. 00  | Title V or XIX swing-bed NF inpatient routin  | e costs through | h December 31   | of the cost re    | porting period             | 0                           | 67. 00   |
| 40.00   | (line 12 x line 19)   |                 | Dogombor 21 of  | the east rone     | eting poriod               | 0                           | 40.00  |
| 68. 00  | Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)  | e costs after i | December 31 of  | the cost repo     | orting period              | 0                           | 68. 00   |
| 69. 00  | Total title V or XIX swing-bed NF inpatient   |                 |                 |                   |                            | 0                           | 69. 00   |
| 70. 00  | PART III - SKILLED NURSING FACILITY, OTHER NI<br>Skilled nursing facility/other nursing facil               |                 |                 |                   |                            |                             | 70. 00   |
| 71.00   | Adjusted general inpatient routine service c  | ost per diem (  |                 |                   |                            |                             | 71.00  |
| 72. 00<br>73. 00  | Program routine service cost (line 9 x line Medically necessary private room cost applic                    |                 | m (line 14 v l  | ine 35)           |                            |                             | 72. 00<br>73. 00                               |
| 74.00   | Total Program general inpatient routine serv  |                 | •               |                   |                            |                             | 74.00  |
| 75. 00  | Capital-related cost allocated to inpatient   | routine servic  | e costs (from   | Worksheet B, P    | art II, column             |                             | 75. 00   |
| 76. 00  | 26, line 45)<br> Per diem capital-related costs (line 75 ÷ li   | ne 2)           |                 |                   |                            |                             | 76. 00   |
| 77. 00  | Program capital-related costs (line 9 x line  | 76)             |                 |                   |                            |                             | 77. 00   |
| 78. 00<br>79. 00  | Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces                   |                 | provider recor  | ds)               |                            |                             | 78. 00<br>79. 00                               |
| 80.00   | Total Program routine service costs for comp  |                 |                 | *.                | us line 79)                |                             | 80.00  |
| 81. 00<br>82. 00  | Inpatient routine service cost per diem limi<br>Inpatient routine service cost limitation (I                |                 | 1)              |                   |                            |                             | 81. 00<br>82. 00                               |
| 83. 00  | Reasonable inpatient routine service costs (  |                 |                 |                   |                            |                             | 83. 00   |
| 84.00   | Program inpatient ancillary services (see in  |                 | one)            |                   |                            |                             | 84.00  |
| 85. 00<br>86. 00  | Utilization review - physician compensation<br>Total Program inpatient operating costs (sum                 |                 |                 |                   |                            |                             | 85. 00<br>86. 00                               |
|   | PART IV - COMPUTATION OF OBSERVATION BED PASS   | S THROUGH COST  | <u> </u>        |                   |                            |                             |  |
| 87. 00<br>88. 00  | Total observation bed days (see instructions Adjusted general inpatient routine cost per                    |                 | ÷ line 2)       |                   |                            | 0.00                        | 87. 00<br>88. 00                               |
|   | Observation bed cost (line 87 x line 88) (se  | •               |                 |                   |                            |                             | 89. 00   |
|   |   |                 |                 |                   |                            |                             |  |

| Health Financial Systems                    | METHODIST HOS | PITALS, INC  |              | In Lie                           | u of Form CMS-2                | 2552-10 |
|---|---------------|--------------|--------------|----------------------------------|--------------------------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST     |               | Provi der CO | CN: 15-0002  | Peri od:                         | Worksheet D-1                  |         |
|   |               | Component (  | CCN: 15-T002 | From 01/01/2021<br>To 12/31/2021 | Date/Time Pre<br>5/27/2022 9:0 |         |
|   |               | Title        | XVIII        | Subprovi der -                   | PPS                            |         |
|   |               |              |              | I RF                             |                                |         |
| Cost Center Description                     | Cost          | Routine Cost | column 1 ÷   | Total                            | Observation                    |         |
|   |               | (from line   | column 2     | Observation                      | Bed Pass                       |         |
|   |               | 21)          |              | Bed Cost                         | Through Cost                   |         |
|   |               |              |              | (from line                       | (col. 3 x                      |         |
|   |               |              |              | 89)                              | col. 4) (see                   |         |
|   |               |              |              |                                  | instructions)                  |         |
|   | 1. 00         | 2.00         | 3. 00        | 4. 00                            | 5. 00                          |         |
| COMPUTATION OF OBSERVATION BED PASS THROUGH | COST          |              |              |                                  |                                |         |
| 90.00 Capital -related cost                 | 576, 495      | 5, 176, 818  | 0. 11136     | 0                                | 0                              | 90.00   |
| 91.00 Nursing Program cost                  | 0             | 5, 176, 818  | 0. 00000     | 00                               | 0                              | 91.00   |
| 92.00 Allied health cost                    | 0             | 5, 176, 818  | 0.00000      | 0 0                              | 0                              | 92.00   |
| 93.00 All other Medical Education           | 0             | 5, 176, 818  | 0. 00000     | 00                               | 0                              | 93. 00  |

| Health Financial Systems                | METHODIST HOSPITALS, INC | In Lie                        | u of Form CMS-              | 2552-10          |
|---|--------------------------|-------------------------------|-----------------------------|------------------|
| COMPUTATION OF INPATIENT OPERATING COST | Provi der CCN: 15-000    | D2 Period:<br>From 01/01/2021 | Worksheet D-1               |                  |
|   |                          | To 12/31/2021                 | Date/Time Pre 5/27/2022 9:0 | epared:<br>02 am |
|   | Ti tle XIX               | Hospi tal                     | Cost                        |                  |
| Cost Center Description                 |                          |                               |                             |                  |
|   |                          |                               | 1. 00                       |                  |
| PART I - ALL PROVIDER COMPONENTS        |                          |                               |                             |                  |
| I NPATI ENT DAYS                        |                          |                               |                             |                  |

|                  |  | Title XIX                 | Hospi tal         | Cost              |                  |
|------------------|--|---------------------------|-------------------|-------------------|------------------|
|                  | Cost Center Description  |                           |                   | 1. 00             |                  |
|                  | PART I - ALL PROVIDER COMPONENTS   |                           |                   | 1.00              |                  |
|                  | INPATIENT DAYS   |                           |                   |                   |                  |
| 1.00             | Inpatient days (including private room days and swing-bed days,  | excluding newborn)        |                   | 81, 162           | 1. 00            |
| 2.00             | Inpatient days (including private room days, excluding swing-be  |                           |                   | 81, 162           | 2.00             |
| 3. 00            | Private room days (excluding swing-bed and observation bed days  | s). If you have only pr   | ivate room days,  | 0                 | 3. 00            |
| 4. 00            | do not complete this line.<br>Semi-private room days (excluding swing-bed and observation bed                                      | l days)                   |                   | 66, 690           | 4. 00            |
| 5. 00            | Total swing-bed SNF type inpatient days (including private room  |                           | r 31 of the cost  | 00, 040           | 5. 00            |
| 0.00             | reporting period   | . days, sag ssssss        | . 01 01 1110 0001 | Ü                 | 0.00             |
| 6.00             | Total swing-bed SNF type inpatient days (including private room  | n days) after December    | 31 of the cost    | 0                 | 6. 00            |
|                  | reporting period (if calendar year, enter 0 on this line)  |                           |                   |                   |                  |
| 7. 00            | Total swing-bed NF type inpatient days (including private room reporting period  | days) through December    | 31 of the cost    | 0                 | 7. 00            |
| 8. 00            | Total swing-bed NF type inpatient days (including private room   | days) after December 3    | 1 of the cost     | 0                 | 8. 00            |
|                  | reporting period (if calendar year, enter 0 on this line)  |                           |                   | _                 |                  |
| 9. 00            | Total inpatient days including private room days applicable to   | the Program (excluding    | swing-bed and     | 3, 312            | 9. 00            |
| 10.00            | newborn days) (see instructions)   | v (including private r    | soom dovo)        | 0                 | 10.00            |
| 10. 00           | Swing-bed SNF type inpatient days applicable to title XVIII onl<br>through December 31 of the cost reporting period (see instructi |                           | oolii days)       | 0                 | 10. 00           |
| 11. 00           | Swing-bed SNF type inpatient days applicable to title XVIII onl  | y (including private r    | oom days) after   | 0                 | 11. 00           |
|                  | December 31 of the cost reporting period (if calendar year, ent  | er O on this line)        |                   |                   |                  |
| 12. 00           | Swing-bed NF type inpatient days applicable to titles V or XIX   | only (including privat    | e room days)      | 0                 | 12. 00           |
| 13. 00           | through December 31 of the cost reporting period<br>Swing-bed NF type inpatient days applicable to titles V or XIX                 | only (including privat    | e room days)      | 0                 | 13. 00           |
| 13.00            | after December 31 of the cost reporting period (if calendar year   |                           |                   | O                 | 13.00            |
| 14.00            | Medically necessary private room days applicable to the Program  | •                         | ′                 | 0                 | 14.00            |
| 15. 00           | Total nursery days (title V or XIX only)   |                           |                   |                   | 15.00            |
| 16. 00           | Nursery days (title V or XIX only)   |                           |                   | 0                 | 16. 00           |
| 17. 00           | SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to services  | through December 31 c     | f the cost        | 0.00              | 17. 00           |
| 17.00            | reporting period   | till odgir beecimber 31 e | Tile cost         | 0.00              | 17.00            |
| 18.00            | Medicare rate for swing-bed SNF services applicable to services  | after December 31 of      | the cost          | 0.00              | 18. 00           |
| 40.00            | reporting period   |                           |                   |                   | 40.00            |
| 19. 00           | Medical drate for swing-bed NF services applicable to services reporting period  | through December 31 of    | the cost          | 0. 00             | 19. 00           |
| 20. 00           | Medicaid rate for swing-bed NF services applicable to services   | after December 31 of t    | he cost           | 0.00              | 20. 00           |
|                  | reporting period   |                           |                   |                   |                  |
| 21. 00           | Total general inpatient routine service cost (see instructions)  |                           |                   | 83, 469, 209      |                  |
| 22. 00           | Swing-bed cost applicable to SNF type services through December  | 31 of the cost report     | ing period (line  | 0                 | 22. 00           |
| 23. 00           | 5 x line 17)<br>Swing-bed cost applicable to SNF type services after December 3  | 31 of the cost reportin   | a period (line A  | 0                 | 23. 00           |
| 20.00            | x line 18)   | TO THE COST TOPOLET       | g perrou (Trile o | · ·               | 20.00            |
| 24.00            | Swing-bed cost applicable to NF type services through December   | 31 of the cost reporti    | ng period (line   | 0                 | 24.00            |
| 05.00            | 7 x line 19)   | . 6 11                    |                   | 0                 | 05.00            |
| 25. 00           | Swing-bed cost applicable to NF type services after December 31 x line 20)   | or the cost reporting     | period (line 8    | 0                 | 25. 00           |
| 26. 00           | Total swing-bed cost (see instructions)  |                           |                   | 0                 | 26. 00           |
| 27.00            | General inpatient routine service cost net of swing-bed cost (   | ine 21 minus line 26)     |                   | 83, 469, 209      | 27.00            |
|                  | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT   |                           |                   |                   |                  |
|                  | General inpatient routine service charges (excluding swing-bed   | and observation bed ch    | arges)            | 0                 |                  |
| 29. 00<br>30. 00 | Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)                         |                           |                   | 0                 |                  |
| 31. 00           | General inpatient routine service cost/charge ratio (line 27 ÷   | line 28)                  |                   | 0. 000000         |                  |
| 32. 00           | Average private room per diem charge (line 29 ÷ line 3)  | ==,                       |                   | 0. 00             |                  |
| 33.00            | Average semi-private room per diem charge (line 30 ÷ line 4)   |                           |                   | 0.00              | 33.00            |
| 34.00            | Average per diem private room charge differential (line 32 minu  |                           | tions)            | 0.00              |                  |
| 35.00            | Average per diem private room cost differential (line 34 x line  | 9 31)                     |                   | 0.00              |                  |
| 36. 00<br>37. 00 | Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost ar       | nd private room cost di   | fferential (line  | 0<br>83, 469, 209 | 36. 00<br>37. 00 |
| 37.00            | 27 minus line 36)  | ia private room cost ur   |                   | 03, 407, 207      | 37.00            |
|                  | PART II - HOSPITAL AND SUBPROVIDERS ONLY   |                           | <u> </u>          |                   |                  |
|                  | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS  |                           |                   |                   |                  |
| 38. 00           | Adjusted general inpatient routine service cost per diem (see i  |                           |                   | 1, 028. 43        |                  |
| 39. 00<br>40. 00 | Program general inpatient routine service cost (line 9 x line 3 Medically necessary private room cost applicable to the Program    | •                         |                   | 3, 406, 160<br>0  | 39. 00<br>40. 00 |
|                  | Total Program general inpatient routine service cost (line 39 +  |                           |                   | 3, 406, 160       |                  |
| 00               | 1.2.2  |                           | 1                 | 5, 100, 100       |                  |

| 7.00   | report ing period  | o l                | 7.00             |
|--------|--|--------------------|------------------|
| 8. 00  | Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost                               | 0                  | 8. 00            |
| 0.00   | reporting period (if calendar year, enter 0 on this line)  | J                  | 0.00             |
| 9. 00  | Total inpatient days including private room days applicable to the Program (excluding swing-bed and                              | 3, 312             | 9.00             |
|        | newborn days) (see instructions)   | .,                 |                  |
| 10.00  | Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)                                   | 0                  | 10.00            |
|        | through December 31 of the cost reporting period (see instructions)  |                    |                  |
| 11.00  | Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after                             | 0                  | 11.00            |
|        | December 31 of the cost reporting period (if calendar year, enter 0 on this line)  |                    |                  |
| 12.00  | Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)                                | 0                  | 12.00            |
|        | through December 31 of the cost reporting period   |                    |                  |
| 13.00  | Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)                                | 0                  | 13.00            |
|        | after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  |                    |                  |
|        | Medically necessary private room days applicable to the Program (excluding swing-bed days)                                       | 0                  | 14.00            |
|        | Total nursery days (title V or XIX only)   | 2, 056             | 15.00            |
| 16. 00 | Nursery days (title V or XIX only)   | 0                  | 16.00            |
| 47.00  | SWING BED ADJUSTMENT   | 0.00               | 47.00            |
| 17.00  | Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost                                  | 0. 00              | 17. 00           |
| 10 00  | reporting period   | 0.00               | 10 00            |
| 18. 00 | Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period                   | 0. 00              | 18. 00           |
| 10 00  | Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost                                   | 0. 00              | 19. 00           |
| 17.00  | reporting period   | 0.00               | 17.00            |
| 20 00  | Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost                                     | 0. 00              | 20.00            |
| 20.00  | reporting period   | 0.00               | 20.00            |
| 21. 00 | Total general inpatient routine service cost (see instructions)  | 83, 469, 209       | 21.00            |
| 22. 00 |  | 0                  | 22. 00           |
|        | 5 x line 17)   |                    |                  |
| 23.00  | Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6                            | 0                  | 23.00            |
|        | x line 18)   |                    |                  |
| 24.00  | Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line                             | 0                  | 24.00            |
|        | 7 x line 19)   |                    |                  |
| 25.00  | Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8                             | 0                  | 25.00            |
|        | x line 20)   |                    |                  |
|        | Total swing-bed cost (see instructions)  | 0                  | 26.00            |
| 27. 00 | General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)   | 83, 469, 209       | 27.00            |
|        | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT   |                    |                  |
|        | General inpatient routine service charges (excluding swing-bed and observation bed charges)                                      | 0                  | 28.00            |
|        | Pri vate room charges (excluding swing-bed charges)  | 0                  | 29.00            |
|        | Semi-private room charges (excluding swing-bed charges)  |                    | 30.00            |
|        | General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  Average private room per diem charge (line 29 ÷ line 3) | 0. 000000<br>0. 00 | 31. 00<br>32. 00 |
|        | Average semi-private room per diem charge (line 30 ÷ line 4)   | 0.00               | 33. 00           |
|        | Average per diem private room charge differential (line 32 minus line 33)(see instructions)                                      | 0.00               |                  |
|        | Average per diem private room cost differential (line 34 x line 31)  | 0.00               | 35.00            |
|        | Private room cost differential adjustment (line 3 x line 35)   | 0.00               | 36.00            |
|        | General inpatient routine service cost net of swing-bed cost and private room cost differential (line                            |                    | 37.00            |
| 37.00  | 27 minus line 36)  | 03, 407, 207       | 37.00            |
|        | PART II - HOSPITAL AND SUBPROVIDERS ONLY   |                    |                  |
|        | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  |                    |                  |
| 38. 00 | Adjusted general inpatient routine service cost per diem (see instructions)  | 1, 028. 43         | 38. 00           |
|        | Program general inpatient routine service cost (line 9 x line 38)  | 3, 406, 160        | 39. 00           |
|        | Medically necessary private room cost applicable to the Program (line 14 x line 35)  | 0                  | 40.00            |
|        | Total Program general inpatient routine service cost (line 39 + line 40)   | 3, 406, 160        |                  |
|        |  |                    |                  |
|        |  |                    |                  |
|        |  |                    |                  |
|        |  |                    |                  |

|                  | Financial Systems   | METHODI ST HOSI            |                            |  |   | u of Form CMS-2                |                  |
|------------------|---|----------------------------|----------------------------|--|---|--------------------------------|------------------|
| COMPUT           | ATION OF INPATIENT OPERATING COST   |                            | Provi der Co               | F  | Period:<br>From 01/01/2021<br>Fo 12/31/2021 | Worksheet D-1 Date/Time Pre    |                  |
|                  |   |                            | T: ±1                      | - VIV                                    |   | 5/27/2022 9:0                  | 2 am             |
|                  | Cost Center Description   | Total<br>Inpatient<br>Cost | Total<br>Inpatient<br>Days | Average Per<br>Diem (col. 1<br>÷ col. 2) | Hospi tal Program Days                      | Program Cost (col. 3 x col. 4) |                  |
| 42.00            | NURSERY (title V & XIX only)  | 1. 00<br>3, 483, 536       | 2. 00<br>2, 056            | 3. 00<br>1, 694. 33                      | 4. 00<br>3 0                                | 5. 00                          | 42.00            |
| 42.00            | Intensive Care Type Inpatient Hospital Units  | 3, 463, 530                | 2,030                      | 1, 094. 30                               | 5  0  | 0                              | 42.00            |
| 43.00            | INTENSIVE CARE UNIT   | 16, 976, 791               | 9, 195                     |  |   |                                |                  |
| 43. 01<br>44. 00 | NEONATAL ICU<br>CORONARY CARE UNIT  | 2, 894, 417                | 2, 460                     | 1, 176. 59                               | 0   | 0                              | 43. 01<br>44. 00 |
| 45.00            | BURN INTENSIVE CARE UNIT  |                            |                            |  |   |                                | 45. 00           |
| 46.00            | SURGICAL INTENSIVE CARE UNIT<br>OTHER SPECIAL CARE (SPECIFY)  |                            |                            |  |   |                                | 46. 00<br>47. 00 |
| 47.00            | Cost Center Description   |                            |                            |  |   |                                | 47.00            |
| 40.00            | Drogram i mosti ent ancillary compiles cost (Wilde  | a+ D 2 aal 2               | ) Line 200)                |  |   | 1.00                           | 40.00            |
| 48. 00<br>49. 00 | Program inpatient ancillary service cost (Wk<br>Total Program inpatient costs (sum of lines<br>PASS THROUGH COST ADJUSTMENTS  |                            |                            | ons)                                     |   | 2, 813, 282<br>6, 219, 442     | 1                |
| 50.00            | Pass through costs applicable to Program inp  | atient routine             | servi ces (from            | m Wkst. D, sum                           | of Parts I and                              | 0                              | 50.00            |
| 51. 00           | <pre>        Pass through costs applicable to Program inp</pre>   | atient ancillar            | y services (fi             | rom Wkst. D, s                           | um of Parts II                              | 0                              | 51.00            |
| F2 00            | and IV)   |                            |                            |  |   | 0                              | F2 00            |
| 52. 00<br>53. 00 | Total Program excludable cost (sum of lines<br>Total Program inpatient operating cost exclu   |                            | elated, non-ph             | ysician anesth                           | etist, and                                  | 0                              |                  |
|                  | medical education costs (line 49 minus line   | 52)                        |                            |  |   |                                |                  |
| 54.00            | TARGET AMOUNT AND LIMIT COMPUTATION Program discharges  |                            |                            |  |   | 0                              | 54.00            |
| 55.00            | Target amount per discharge   |                            |                            |  |   | 0.00                           |                  |
| 56. 00<br>57. 00 | Target amount (line 54 x line 55) Difference between adjusted inpatient operat  | ing cost and to            | argot amount (             | lino 56 minus                            | lino 52)                                    | 0                              |                  |
| 58. 00           | Bonus payment (see instructions)  | ring cost and te           | inger amount (i            | Title 50 IIITlus                         | 11116 33)                                   | Ö                              |                  |
| 59. 00           | Lesser of lines 53/54 or 55 from the cost re  | porting period             | endi ng 1996, เ            | updated and co                           | mpounded by the                             | 0.00                           | 59. 00           |
| 60.00            | market basket<br>Lesser of lines 53/54 or 55 from prior year  | cost report, up            | odated by the r            | market basket                            |   | 0.00                           | 60.00            |
| 61. 00           | 00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0. 00 60.00 00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target |                            |                            |  |   |                                |                  |
| 62. 00           | amount (line 56), otherwise enter zero (see Relief payment (see instructions)   | instructions)              |                            |  |   | 0                              | 62.00            |
|                  | Allowable Inpatient cost plus incentive paym  | ent (see instru            | ıcti ons)                  |  |   | 0                              | •                |
| 64. 00           | PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos   | ts through Dece            | ember 31 of the            | e cost reporti                           | na period (See                              | 0                              | 64.00            |
| 65. 00           | instructions)(title XVIII only)   |                            |                            |  |   |                                | 65. 00           |
|                  | instructions)(title XVIII only)   |                            |                            |  |   |                                |                  |
| 66. 00           | 00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions) 00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period  |                            |                            |  |   |                                | 66.00            |
|                  | (line 12 x line 19)   |                            |                            |  |   | 0                              |                  |
| 68. 00           | Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)  |                            |                            | •  | rting period                                | 0                              | 68. 00           |
| 69. 00           | Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N  |                            |                            |  |   | 0                              | 69.00            |
| 70.00            | Skilled nursing facility/other nursing facil  |                            | •                          |  |   |                                | 70.00            |
| 71. 00<br>72. 00 | Adjusted general inpatient routine service c<br>Program routine service cost (line 9 x line   |                            | ine 70 ÷ line              | 2)                                       |   |                                | 71.00<br>72.00   |
| 73.00            | Medically necessary private room cost applic  |                            | n (line 14 x li            | ine 35)                                  |   |                                | 73.00            |
| 74.00            | Total Program general inpatient routine serv  |                            |                            |  |   |                                | 74.00            |
| 75. 00           | Capital-related cost allocated to inpatient 26, line 45)  | routine service            | e costs (Trom )            | worksneet B, P                           | art II, column                              |                                | 75. 00           |
| 76. 00<br>77. 00 | Per diem capital-related costs (line 75 ÷ li<br>Program capital-related costs (line 9 x line  |                            |                            |  |   |                                | 76. 00<br>77. 00 |
| 78. 00           | Inpatient routine service cost (line 74 minu  |                            |                            |  |   |                                | 78.00            |
| 79.00            | Aggregate charges to beneficiaries for exces  | , ,                        |                            |  | 1: 70)                                      |                                | 79.00            |
| 80. 00<br>81. 00 | Total Program routine service costs for comp<br>Inpatient routine service cost per diem limi  |                            | ost iimitatioi             | n (iine /ʊ min                           | us IIIIe /9)                                |                                | 80. 00<br>81. 00 |
| 82.00            | Inpatient routine service cost limitation (I  | ine 9 x line 81            | ,                          |  |   |                                | 82.00            |
| 83. 00<br>84. 00 | Reasonable inpatient routine service costs (<br>Program inpatient ancillary services (see in  |                            | ıs)                        |  |   |                                | 83. 00<br>84. 00 |
| 85.00            | 1 -   |                            | ons)                       |  |   |                                | 85.00            |
|                  | Total Program inpatient operating costs (sum  | of lines 83 th             |                            |  |   |                                | 86. 00           |
| 87. 00           | PART IV - COMPUTATION OF OBSERVATION BED PASS<br>Total observation bed days (see instructions   |                            |                            |  |   | 14, 472                        | 87. 00           |
| 88. 00           | Adjusted general inpatient routine cost per   | diem (line 27 ÷            |                            |  |   | 1, 028. 43                     | 88. 00           |
| 89. UU           | Observation bed cost (line 87 x line 88) (se  | e instructions)            | 1                          |  |   | 14, 883, 439                   | 89. UU           |

| Health Financial Systems                    | METHODI ST HOS | PITALS, INC  |            | In Lie                           | u of Form CMS-2                | 2552-10 |
|---|----------------|--------------|------------|----------------------------------|--------------------------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST     |                | Provi der CO |            | Peri od:                         | Worksheet D-1                  |         |
|   |                |              |            | From 01/01/2021<br>To 12/31/2021 | Date/Time Pre<br>5/27/2022 9:0 |         |
|   |                | Ti tl        | e XIX      | Hospi tal                        | Cost                           |         |
| Cost Center Description                     | Cost           | Routine Cost | column 1 ÷ | Total                            | Observation                    |         |
|   |                | (from line   | column 2   | Observati on                     | Bed Pass                       |         |
|   |                | 21)          |            | Bed Cost                         | Through Cost                   |         |
|   |                |              |            | (from line                       | (col. 3 x                      |         |
|   |                |              |            | 89)                              | col. 4) (see                   |         |
|   |                |              |            |                                  | instructions)                  |         |
|   | 1. 00          | 2.00         | 3. 00      | 4. 00                            | 5. 00                          |         |
| COMPUTATION OF OBSERVATION BED PASS THROUGH | COST           |              |            |                                  |                                |         |
| 90.00 Capital-related cost                  | 6, 083, 843    | 83, 469, 209 | 0. 07288   | 14, 883, 439                     | 1, 084, 809                    | 90.00   |
| 91.00 Nursing Program cost                  | 0              | 83, 469, 209 | 0.00000    | 14, 883, 439                     | 0                              | 91.00   |
| 92.00 Allied health cost                    | o              | 83, 469, 209 | 0. 00000   | 14, 883, 439                     | 0                              | 92.00   |
| 93.00 All other Medical Education           | 0              | 83, 469, 209 | 0. 00000   | 14, 883, 439                     | 0                              | 93.00   |

| Health Financial Systems                | METHODIST HOSPITALS, INC | In Lieu                     | u of Form CMS-2552-10 |
|---|--------------------------|-----------------------------|-----------------------|
| COMPUTATION OF INPATIENT OPERATING COST |                          | Peri od:<br>From 01/01/2021 | Worksheet D-1         |
|   | Component CCN: 15-S002   |                             |                       |
|   | Title XIX                | Subprovi der -              | Cost                  |
|   |                          | I PF                        |                       |

| Sept 1 - AL PROMOBING COMPONENTS   1.00  |        |  | IPF                                      |             |        |
|--|--------|--|--|-------------|--------|
| NeXT LEAR DIMON   Next Dimon    |        | Cost Center Description  |  | 1.00        |        |
| INPATIENT DAYS   |        | DADT I ALL DROVIDED COMPONENTS                                   |  | 1.00        |        |
| Inpatient days (including private room days and saing-bed days, excluding newborn)   1,239   1,00  |        |  |  |             |        |
| Inpatt ent days (including pri vate room days, excluding swing-bed and newborn days)   1,299   2,00  | 1. 00  |  | excluding newborn)                       | 1, 239      | 1. 00  |
| do not complete this line.  4. 00 Sein-private room days (excluding swing-bed and observation bed days)  7. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7. 00 Total sing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  8. 00 Total sing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9. 00 Total sing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and new form days) (see instructions)  10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after on through December 31 of the cost reporting period (see Instructions)  11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see Instructions)  12. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  13. 00 Swing-bed SNF type inpatient days applicable to title SNIII only (including private room days)  14. 00 Swing-bed SNF type inpatient days applicable to title SNIII only (including private room days)  15. 00 Swing-bed SNF type inpatient days applicable to title SNIII only (including private room days)  16. 00 Swing-bed SNF type inpatient days applicable to SNI only (including private room days)  17. 00 Swing-bed SNF type spritent days applicable to services through December 31 of the cost reporting period (including private room days)  18. 00 Swing-bed SNF type spritent days applicable to services through December 31 of the cost reporting period (including private room days)   | 2. 00  |  |  |             |        |
| 5.00 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period regular in period of the cost reporting period (line and the cost reporting period (line and the cost reporting period (line and the cost reporting period  | 3.00   |  | s). If you have only private room days,  | 0           | 3.00   |
| Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  |        |  |  |             |        |
| report Ing period 6. 00 Total swing-bed SNF type Inpatient days (including private room days) after December 31 of the cost 7. 00 Froger Ing period (if callendar year, enter 0 on this line) 7. 00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost 7. 00 Froger International Properties (if callendar year, enter 0 on this line) 8. 00 Froger International Properties (if callendar year, enter 0 on this line) 9. 00 Total Inpatient days including private room days) after December 31 of the cost 7. 00 Froger International Properties (if callendar year, enter 0 on this line) 10. 00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 10. 00 Swing-bed MF type inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed MF type inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed MF type inpatient days applicable to title XVIII only (including private room days) 12. 00 Swing-bed MF type inpatient days applicable to title XVIII only (including private room days) 13. 00 Swing-bed MF type inpatient days applicable to title XVIII only (including private room days) 13. 00 Swing-bed MF type inpatient days applicable to title XVIII only (including private room days) 13. 00 Swing-bed MF type inpatient days applicable to title XVIII only (including private room days) 13. 00 Swing-bed MF type inpatient days applicable to title XVIII only (including private room days) 13. 00 Swing-bed WF type inpatient days applicable to title XVIII only (including private room days) 13. 00 Swing-bed WF type services applicable to title XVIII only  |        |  |  |             |        |
| Total swing-bed SNF type Inpatient days (Including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this I ine)   | 5.00   |  | i days) through December 31 of the cost  | 0           | 5.00   |
| reporting period (if calendar year, enter 0 on this iline) 7.00 Total swing-bod MF type inpatient days (including private room days) through December 31 of the cost 7.00 Total swing-bod MF type inpatient days (including private room days) after December 31 of the cost 7.00 Total inpatient days including private room days applicable to the Program (excluding swing-bod and newborn days) (see Instructions) 7.00 Swing-bod SMF type inpatient days applicable to title XVIII only (including private room days) of through December 31 of the cost reporting period (see instructions) 7.00 Swing-bod SMF type inpatient days applicable to title XVIII only (including private room days) after 0 December 31 of the cost reporting period (feelendar year, enter 0 on this line) 7.00 December 31 of the cost reporting period (including private room days) after 0 December 31 of the cost reporting period (including private room days) 7.00 Swing-bod SMF type inpatient days applicable to titles V or XX only (including private room days) 7.00 Swing-bod SMF type inpatient days applicable to titles V or XX only (including private room days) 7.00 Swing-bod SMF type inpatient days applicable to titles V or XX only (including private room days) 7.00 Swing-bod SMF type inpatient days applicable to titles V or XX only (including private room days) 7.00 Swing-bod SMF type inpatient days applicable to titles V or XX only (including private room days) 7.00 Swing-bod SWF type services applicable to the Program (excluding swing-bod days) 7.00 Swing-bod SWF type services applicable to services through December 31 of the cost 0.00 Swing-bod SWF type services applicable to services through December 31 of the cost 0.00 Swing-bod Cost applicable SWF services applicable to services after December 31 of the cost 1.815,787,700 Swing-bod cost applicable to SWF type services after December 31 of the cost reporting period (line 0.00 Swing-bod cost applicable to SWF type services after December 31 of the cost reporting period (line 0.00 Swing-bod cost applicable t | 6 00   |  | days) after December 31 of the cost      | 0           | 6 00   |
| 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost preporting period (if calendar year, enter 0 on this line) 7.00 Total inpatient days including private room days apticable to the Program (excluding swing-bed and private room days applicable to the Program (excluding swing-bed and through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and through December 31 of the cost reporting period (see instructions) 7.00 Swing-bed SNF type inpatient days applicable to title XVII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 7.01 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 7.02 Swing-bed NF type inpatient days applicable to title V or XIX only (including private room days) 7.03 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 7.04 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 7.05 On Total nursery days (title V or XIX only) 7.06 Swing-bed NF type inpatient days applicable to services through December 31 of the cost open days applicable to services after December 31 of the cost open days applicable to services after December 31 of the cost open days applicable to services after December 31 of the cost open days applicable to services after December 31 of the cost open days applicable to SNF type services after December 31 of the cost open days applicable to SNF type services after December 31 of the cost reporting period (line open days) 7.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line open days) 7.01 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting per | 0.00   |  | days) after becember 31 of the cost      | 0           | 0.00   |
| reporting period  No Total sing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  No Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  No Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  No Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 on December 31 of the cost reporting period (see instructions)  No Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 on December 31 of the cost reporting period (if calendar year, enter 0 on this line)  No Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) on 12.00 through becember 31 of the cost reporting period (if calendar year, enter 0 on this line)  No Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) on 13.00 after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  No Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) on 14.00 after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  No Weld call ly necessary private room days applicable to services through December 31 of the cost period (including transport year) (including private room days) on 16.00 after a rate for swing-bed SNF services applicable to services after December 31 of the cost period (including transporting period (including period (including transporting period (including transporting period (includin | 7. 00  |  | days) through December 31 of the cost    | 0           | 7. 00  |
| reporting period (if calendar year, enter 0 on this line)   58   9.00  |        | reporting period   |  |             |        |
| Total inpatitent days including private room days applicable to the Program (excluding swing-bed and neaborn days) (see instructions)   0.00   | 8.00   |  | days) after December 31 of the cost      | 0           | 8. 00  |
| newborn days) (see instructions)   0   10   00   10   00   10   00   10   00   10   00   10   00   10   00   10   00   10      |        |  |  |             |        |
| 10.00   Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)   0   10.00   | 9. 00  |  | the Program (excluding swing-bed and     | 58          | 9.00   |
| through December 31 of the cost reporting period (see instructions)  1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)  1.00 Swing-bed NF type or om days applicable to the Program (excluding swing-bed days)  1.00 Swing-y days (title V or XIX only)  1.00 Swing-bed cost applicable SNF services applicable to services through December 31 of the cost on the cost of the cost of the cost on the cost of the cos | 10 00  |  | v (including private room days)          | 0           | 10 00  |
| 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days)  15.00 Necessary private room days applicable to the Program (excluding swing-bed days)  16.00 Nursery days (title V or XIX only)  17.00 Nursery days (title V or XIX only)  18.00 Nursery days (title V or XIX only)  19.00 Nursery days (title V or XIX only)  20.00 Nursery days ( | 10.00  |  |  | 0           | 10.00  |
| December 31 of the cost reporting period (if calendar year, enter 0 on this line)   0   12.00  | 11. 00 |  |  | 0           | 11. 00 |
| through December 31 of the cost reporting period  13. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15. 00 Total nursery days (title V or XIX only)  16. 00 Nursery days (title V or XIX only)  17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost  18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19. 00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line of x line 18)  20. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of x line 18)  21. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of x line 20)  22. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of x line 20)  23. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of x line 20)  24. 00 Total swing-bed cost applicable to NF type service after December 31 o |        | December 31 of the cost reporting period (if calendar year, ent  | er 0 on this line)                       |             |        |
| 13.00   Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)   13.00   14.00   Medically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00   16.00     | 12.00  |  | only (including private room days)       | 0           | 12.00  |
| after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   14,00   14,00   15.00   10   10   10   10   10   10   10   |        |  |  | _           |        |
| 14.00   Modically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00   16.00   16.00   Nursery days (title V or XIX only)   0   16.00   16.00   Nursery days (title V or XIX only)   0   16.00   16.00   Nursery days (title V or XIX only)   17.00   17.00   17.00   18.00   18.00   18.00   18.00   18.00   18.00   19.0   | 13. 00 |  |  | 0           | 13.00  |
| Total nursery days (title V or XIX only)   2,056   15,00   | 14 00  |  |  | 0           | 14 00  |
| 16.00   Nursery days (title V or XIX only)   16.00   17.00   17.00   17.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   19.00     |        |  | (excluding swing-bed days)               |             |        |
| SWING BED ADJUSTMENT  18.00  19.00  19.00  19.00  10.00  1 |        | 1  |  |             |        |
| reporting period  Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (19.00)  Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost (19.00)  Descripting period (19.00)  Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost (19.00)  Descripting period (19.00)  Description period (19.0 |        |  |  | -           |        |
| 18. 00   Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period   19. 00   19. 0   | 17.00  | Medicare rate for swing-bed SNF services applicable to services  | through December 31 of the cost          | 0.00        | 17.00  |
| reporting period Medicald rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 reporting period 21.00 Total general inpatient routine service cost (see instructions) 1,815,787 21.00 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Total general inpatient routine service safter December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20) 25.00 2 |        | 1  | -  |             |        |
| 19.00   Medical d rate for swing-bed NF services applicable to services through December 31 of the cost reporting period   20.00   2   | 18. 00 | 1  | after December 31 of the cost            | 0. 00       | 18. 00 |
| reporting period  Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (1:00 Total general inpatient routine service cost (see instructions)  1,815,787 21.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 17)  300 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  400 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)  400 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20)  400 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  400 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  401 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  401 Total swing-bed cost (see instructions)  402 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  403 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  404 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  405 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  406 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  407 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 27 line 20)  408 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 27 line 20)  409 Total swing-bed cost applicable to NF type services after December 31 of the cost report | 10.00  |  | through Docombon 21 of the cost          | 0.00        | 10.00  |
| 20.00   Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period   1,815,787   21.00  | 19.00  | 1  | through becember 31 of the cost          | 0.00        | 19.00  |
| reporting period Total general inpatient routine service cost (see instructions)  21.00  22.00  22.00  23.00  24.00  25.00  25.00  26.00  27.00  28.00  28.00  29.00  29.00  20.0 | 20.00  | 1  | after December 31 of the cost            | 0. 00       | 20.00  |
| 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 FRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 30 ÷ line 4)  33.00 Average per diem private room cost differential (line 3 x line 31)  34.00 Average per diem private room cost differential (line 34 x line 31)  35.00 Average per diem private room cost differential (line 3 x line 31)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)   |        |  |  |             |        |
| 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  27.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  28.00 General inpatient routine service charges (excluding swing-bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 + line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 34)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost reporting period (line 6 2 24.00  24.00 Average per diem private room cost differential (line 3 x line 31)  38.00 Adjusted general inpatient routine service cost net of Swing-bed cost and private room cost differential (line 1, 815, 787)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)   | 21. 00 |  |  |             | 21.00  |
| 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line of x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service cost net of swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room per diem charge (line 29 + line 3)  30.00 Average per diem private room charge (line 29 + line 3)  30.00 Average per diem private room charge (line 30 + line 4)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 37 minus line 36)  30.00 Private room cost differential djustment (line 3 x line 35)  30.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 37 minus line 36)  40.00 Program general inpatient routine service cost per diem (see instructions)  30.00 Agusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  | 22. 00 |  | 31 of the cost reporting period (line    | 0           | 22.00  |
| x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20)  26.00 Total swing-bed cost (see instructions) 0 26.00 Total swing-bed cost (see instructions) 0 26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 1,815,787 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 28.00 29.00 Private room charges (excluding swing-bed charges) 0 29.00 Semi-private room charges (excluding swing-bed charges) 0 29.00 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 0.0000 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 0.0000 31.00 31.00 32.00 Average private room per diem charge (line 30 + line 4) 0.00 32.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 0.00 34.00 Average per diem private room cost differential (line 3 x line 31) 0.00 35.00 Average per diem private room cost differential (line 3 x line 31) 0.00 35.00 Average per diem private room cost differential (line 3 x line 35) 0.00 Average line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,465.53 38.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00 40.00   | 22.00  | 1  | 11 -6 +1++                               | 0           | 22.00  |
| 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 x line 20)  26.00 Total swing-bed cost (see instructions)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ± line 28)  32.00 Average per diem private room per diem charge (line 29 ± line 3)  33.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 3 x line 35)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3 x line 35)  38.00 Agiusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  50 Aucon dedically necessary private room cost applicable to the Program (line 14 x line 35)   | 23.00  |  | or the cost reporting period (line o     | U           | 23.00  |
| 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8   | 24 00  |  | 31 of the cost reporting period (line    | 0           | 24 00  |
| x line 20)  26. 00 Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32. 00 Average private room per diem charge (line 29 ÷ line 3)  33. 00 Average semi-private room per diem charge (line 30 ÷ line 4)  34. 00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  35. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 815, 787)  PRIVATE ROOM DIFFERENTIAL ADD SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  38. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40. 00  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 26. 00  27. 00  28. 00  28. 00  29. 00  28. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  20. | 2 00   |  | or or the cost reporting period (into    | · ·         | 2 00   |
| 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  28.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  30.00 Average private room per diem charge (line 29 + line 3)  30.00 Average semi-private room per diem charge (line 30 + line 4)  30.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Private room cost differential adjustment (line 3 x line 35)  30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVI DERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  | 25.00  | Swing-bed cost applicable to NF type services after December 31  | of the cost reporting period (line 8     | 0           | 25.00  |
| 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRI VATE ROOM DIFFERENTI AL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 General inpatient routine service cost/charge ratio (line 27 + line 28)  30. 00 Average private room per diem charge (line 29 + line 3)  30. 00 Average semi-private room per diem charge (line 30 + line 4)  30. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  30. 00 Average per diem private room cost differential (line 34 x line 31)  30. 00 Average per diem private room cost differential (line 34 x line 31)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem  |        | 1  |  |             |        |
| PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  28.00  Pri vate room charges (excluding swing-bed charges)  30.00  Semi-private room charges (excluding swing-bed charges)  General inpatient routine service cost/charge ratio (line 27 + line 28)  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 minus line 33) (see instructions)  Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 815, 787)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28.00  28.00  29.00  20.00  30.00  |        | , ,  |  |             |        |
| 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 815, 787) 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28.00 Average per diem private room cost applicable to the Program (line 14 x line 35)   | 27.00  |  | ine 21 minus line 26)                    | 1, 815, 787 | 27.00  |
| 29.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1,815,787)  38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 30.00 31.00 32 | 28 00  |  | and observation had charges)             | 0           | 28 00  |
| 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 815, 787)  Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 30.00 31.00 0.00 32.00 0.00 33.00 0.00 33.00 0.00 33.00 0.00 33.00 0.00 33.00 0.00 33.00 0.00 33.00 0.00 33.00 0.00 33.00 0.00 33.00 0.00 33.00 0.00 35.00 0.00  |        |  | and observation bed charges)             |             |        |
| 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1,815,787)  37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost (line 9 x line 38)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  31.00 0.00 32.00  32.00 33.00  32.00 33.00  32.00 33.00  35.00 0.00 33.00  37.00 0.00 33.00  37.00 2.00 33.00  37.00 35.00 0.00 35.00  37.00 35.00 0.00 35.00  37.00 2.00 35.00  37.00 2.00 35.00  37.00 2.00 35.00  37.00 2.00 35.00  37.00 2.00 35.00  37.00 2.00 33.00  37.00 35.00 35.00  37.00 35.00 35.00  37.00 2 |        |  |  |             |        |
| 33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1,815,787)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 33.00  34.00  35.00  36.00  37.00  37.00  37.00  37.00  37.00  37.00  38.00  40.00   |        | ,                          | line 28)                                 | 0.000000    | 31.00  |
| Average per diem private room charge differential (line 32 minus line 33) (see instructions)  Average per diem private room cost differential (line 34 x line 31)  35.00  Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1,815,787)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00  34.00  35.00  36.00  37.00  37.00  37.00  38.00  37.00  37.00  38.00  39.00  40.00   | 32.00  | Average private room per diem charge (line 29 ÷ line 3)          |  | 0.00        | 32.00  |
| 35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 815, 787)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  79.00 Program general inpatient routine service cost (line 9 x line 38)  80.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  80.00 Average per diem private room cost differential (line 1, 815, 787)  81.00 Adjusted general inpatient routine service cost per diem (see instructions)  82.00 Adjusted general inpatient routine service cost (line 9 x line 38)  83.00 Adjusted general inpatient routine service cost (line 9 x line 38)  84.00 Adjusted general inpatient routine service cost (line 9 x line 38)  85.00 Adjusted general inpatient routine service cost (line 9 x line 38)  85.00 Adjusted general inpatient routine service cost (line 9 x line 38)  85.00 Adjusted general inpatient routine service cost (line 9 x line 38)  85.00 Adjusted general inpatient routine service cost (line 9 x line 38)   |        |  |  |             |        |
| 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  36.00 37.0 |        |  |  |             |        |
| 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37.00  40.00  |        |  | : 31)                                    |             |        |
| 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  38.00 40.00   |        |  | id private room cost differential (line  | -           |        |
| PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1, 465. 53 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00  | 37.00  |  | na private room cost differential (IIII) | 1,010,787   | 37.00  |
| PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,465.53 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00  |        |  |  |             |        |
| 38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,465.53 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  1,465.53 38.00 39.00 40.00  |        |  | TMENTS                                   |             |        |
| 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00  | 38. 00 | Adjusted general inpatient routine service cost per diem (see i  | nstructions)                             | 1, 465. 53  | 38.00  |
|  |        |  | ·  |             |        |
| 41.00   Total Program general impatient routine service cost (Tine 39 + Tine 40)   |        | ,                          | ,  |             |        |
|  | 41.00  | Tiotal Program general impatrent routine service cost (Tine 39 + | TITIE 40)                                | 85,001      | 41.00  |

| COMPUT  | ATION OF INPATIENT OPERATING COST   |                            |                            | CCN: 15-0002<br>CCN: 15-S002     |         | od:<br>n 01/01/2021<br>12/31/2021 | Worksheet D-1 Date/Time Pre          |                  |
|---|---|----------------------------|----------------------------|----------------------------------|---------|-----------------------------------|--------------------------------------|------------------|
|   |   |                            | · ·                        |                                  |         |                                   | 5/27/2022 9:0                        |                  |
|   |   |                            | 111                        | le XIX                           | Sui     | oprovider -<br>IPF                | Cost                                 |                  |
|   | Cost Center Description   | Total<br>Inpatient<br>Cost | Total<br>Inpatient<br>Days | Average Per Diem (col. ÷ col. 2) | 1       | rogram Days                       | Program Cost<br>(col. 3 x<br>col. 4) |                  |
|   | I   | 1. 00                      | 2. 00                      | 3.00                             |         | 4. 00                             | 5. 00                                |                  |
| 42. 00  | NURSERY (title V & XIX only)<br>Intensive Care Type Inpatient Hospital Units                    | 0                          |                            | 0                                | . 00    | 0                                 | 0                                    | 42.00            |
| 43. 00  | INTENSIVE CARE UNIT   | 0                          | (                          | 0                                | . 00    | 0                                 | 0                                    | 43.00            |
| 43. 01  | NEONATAL ICU  | 0                          | (                          | 0                                | . 00    | 0                                 | 0                                    | 43.01            |
| 44.00   | CORONARY CARE UNIT  |                            |                            |                                  |         |                                   |                                      | 44.00            |
| 45. 00<br>46. 00  | BURN INTENSIVE CARE UNIT<br>SURGICAL INTENSIVE CARE UNIT  |                            |                            |                                  |         |                                   |                                      | 45. 00<br>46. 00 |
|   | OTHER SPECIAL CARE (SPECIFY)  |                            |                            |                                  |         |                                   |                                      | 47.00            |
|   | Cost Center Description   | '                          |                            | •                                |         |                                   |                                      |                  |
| 40.00   | Drogram i poeti ent ancil Lary comitae acet (Wk   | o+ D 2 ool 2               | line 200)                  |                                  |         |                                   | 1.00                                 | 40.00            |
| 48. 00<br>49. 00  | Program inpatient ancillary service cost (Wk. Total Program inpatient costs (sum of lines       |                            |                            | ons)                             |         |                                   | 33, 306<br>118, 307                  |                  |
| 17.00   | PASS THROUGH COST ADJUSTMENTS   | TT till ought 10) (        | 300 111311 4011            | 01137                            |         |                                   | 110,007                              | 17.00            |
| 50. 00  | Pass through costs applicable to Program inp  | atient routine             | services (fro              | om Wkst. D, s                    | sum of  | Parts I and                       | 0                                    | 50.00            |
| E1 00   | Dass through costs applicable to Drogram inc  | ationt ancillar            | y convices (t              | From Wkst D                      | CLIM    | of Dorte II                       | 0                                    | E1 00            |
| 51. 00  | Pass through costs applicable to Program inpand IV)   |                            | y services (1              | I OIII WKSt. D,                  | , Suiil | ui railS II                       |                                      | 51.00            |
| 52. 00  | Total Program excludable cost (sum of lines   | 50 and 51)                 |                            |                                  |         |                                   | 0                                    | 52.00            |
| 53. 00  | Total Program inpatient operating cost exclu  |                            | lated, non-ph              | nysician anes                    | stheti  | st, and                           | 0                                    | 53.00            |
|   | medical education costs (line 49 minus line ETARGET AMOUNT AND LIMIT COMPUTATION                | 52)                        |                            |                                  |         |                                   |                                      | 1                |
| 54. 00  | Program di scharges   |                            |                            |                                  |         |                                   | 0                                    | 54.00            |
|   | Target amount per discharge   |                            |                            |                                  |         |                                   | l                                    | 55.00            |
| 56.00   | Target amount (line 54 x line 55)   |                            |                            | (): F/ -:                        |         | - 52)                             | 0                                    |                  |
| 57. 00<br>58. 00  | Difference between adjusted inpatient operat<br>Bonus payment (see instructions)                | ing cost and ta            | rget amount (              | iine 56 mini                     | us IIn  | e 53)                             | 0                                    | 57.00<br>58.00   |
| 59.00   | Lesser of lines 53/54 or 55 from the cost re  | porting period             | endi ng 1996,              | updated and                      | compo   | unded by the                      |                                      | 59.00            |
|   | market basket   |                            | <u> </u>                   |                                  | ·       | ,                                 |                                      |                  |
| 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target |   |                            |                            |                                  |         | 0.00                              | 1                                    |                  |
|   | amount (line 56), otherwise enter zero (see instructions)                                       |                            |                            |                                  |         |                                   |                                      |                  |
| 62. 00<br>63. 00  | Relief payment (see instructions)<br>Allowable Inpatient cost plus incentive paym               | ont (coo instru            | etions)                    |                                  |         |                                   | 0                                    | 62.00            |
| PROGRAM INPATIENT ROUTINE SWING BED COST  |   |                            |                            |                                  |         |                                   |                                      | 1 63.00          |
| 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (Sec  |   |                            |                            |                                  |         |                                   | 0                                    | 64.00            |
| instructions)(title XVIII only)   |   |                            |                            |                                  |         |                                   | 0                                    | 45.00            |
| 65. 00  | instructions)(title XVIII only)   | ts arter beceilib          | er 31 or the               | cost reporti                     | ing pe  | rrod (see                         | 0                                    | 65.00            |
| 66. 00  | Total Medicare swing-bed SNF inpatient routi  | ne costs (line             | 64 plus line               | 65)(title X                      | VIII c  | nly). For                         | 0                                    | 66.00            |
| /7 00   | CAH (see instructions)  | 4- 46                      | D 21                       | -6 -1                            |         |                                   |                                      | /7.00            |
| 67.00   | Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)                               | e costs through            | December 31                | or the cost                      | r epor  | ting period                       | 0                                    | 67.00            |
| 68. 00  | Title V or XIX swing-bed NF inpatient routing   | e costs after D            | ecember 31 of              | the cost re                      | eporti  | ng period                         | 0                                    | 68.00            |
| (0.00   | (line 13 x line 20)   | routing costs (            | lino 47 . lin              | no (0)                           |         |                                   |                                      | 40.00            |
| 69. 00  | Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU       |                            |                            |                                  |         |                                   | 0                                    | 69.00            |
| 70. 00  | Skilled nursing facility/other nursing facil  |                            |                            |                                  | 37)     |                                   |                                      | 70.00            |
| 71.00   | Adjusted general inpatient routine service of   |                            | ine 70 ÷ line              | 2)                               |         |                                   |                                      | 71.00            |
| 72. 00<br>73. 00  | Program routine service cost (line 9 x line Medically necessary private room cost applications) | •                          | (line 14 x l               | ine 35)                          |         |                                   |                                      | 72.00            |
| 74. 00  | Total Program general inpatient routine serv  |                            | •                          |                                  |         |                                   |                                      | 74.00            |
| 75. 00  | Capital-related cost allocated to inpatient   | routine service            | costs (from                | Worksheet B,                     | , Part  | II, column                        |                                      | 75.00            |
| 76. 00  | 26, line 45)<br>  Per diem capital-related costs (line 75 ÷ li                                  | ne 2)                      |                            |                                  |         |                                   |                                      | 76.00            |
| 77. 00  | Program capital related costs (line 9 x line  |                            |                            |                                  |         |                                   |                                      | 77.00            |
|   | Inpatient routine service cost (line 74 minus   |                            |                            |                                  |         |                                   |                                      | 78.00            |
| 79.00   | Aggregate charges to beneficiaries for excess   |                            |                            |                                  | mi nuc  | lino 70)                          |                                      | 79.00            |
| 80. 00<br>81. 00  | Total Program routine service costs for compa<br>Inpatient routine service cost per diem limi   |                            | USI IIMITATIO              | n (iine /8 f                     | III NUS | 111le /9)                         |                                      | 80.00            |
| 82. 00  | Inpatient routine service cost limitation (   |                            | )                          |                                  |         |                                   |                                      | 82.00            |
| 83. 00  | Reasonable inpatient routine service costs (  | see instruction            |                            |                                  |         |                                   |                                      | 83.00            |
| 84.00   | Program inpatient ancillary services (see in:   |                            | nc)                        |                                  |         |                                   |                                      | 84.00            |
| 85. 00<br>86. 00  | Utilization review - physician compensation<br>Total Program inpatient operating costs (sum     |                            |                            |                                  |         |                                   |                                      | 85. 00<br>86. 00 |
| , 50  | PART IV - COMPUTATION OF OBSERVATION BED PASS   |                            |                            |                                  |         |                                   |                                      | ]                |
|   | I T   | `                          |                            |                                  |         |                                   | 0                                    | 87.00            |
| 87. 00<br>88. 00  | Total observation bed days (see instructions Adjusted general inpatient routine cost per        |                            | 11                         |                                  |         |                                   | l                                    | 88.00            |

| Health Financial Systems                    | METHODIST HOSPITALS, INC In Lieu of Form CMS- |              |              |                                  |                                | 2552-10 |
|---|---|--------------|--------------|----------------------------------|--------------------------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST     |   | Provi der CO |              | Peri od:                         | Worksheet D-1                  |         |
|   |   | Component (  | CCN: 15-S002 | From 01/01/2021<br>To 12/31/2021 | Date/Time Pre<br>5/27/2022 9:0 |         |
|   |   | Ti tl        | e XIX        | Subprovi der -                   | Cost                           |         |
|   |   |              |              | I PF                             |                                |         |
| Cost Center Description                     | Cost  | Routine Cost | column 1 ÷   | Total                            | Observation                    |         |
|   |   | (from line   | column 2     | Observation                      | Bed Pass                       |         |
|   |   | 21)          |              | Bed Cost                         | Through Cost                   |         |
|   |   |              |              | (from line                       | (col. 3 x                      |         |
|   |   |              |              | 89)                              | col. 4) (see                   |         |
|   |   |              |              |                                  | instructions)                  |         |
|   | 1. 00   | 2. 00        | 3. 00        | 4. 00                            | 5. 00                          |         |
| COMPUTATION OF OBSERVATION BED PASS THROUGH | COST  |              |              |                                  |                                |         |
| 90.00 Capital-related cost                  | 82, 155                                       | 1, 815, 787  | 0. 04524     | 5 0                              | 0                              | 90.00   |
| 91.00 Nursing Program cost                  | 0   | 1, 815, 787  | 0. 00000     | 0 0                              | 0                              | 91.00   |
| 92.00 Allied health cost                    | 0   | 1, 815, 787  | 0. 00000     | 0 0                              | 0                              | 92.00   |
| 93.00 All other Medical Education           | 0   | 1, 815, 787  | 0. 00000     | 00                               | 0                              | 93.00   |

| Health Financial Systems                | METHODIST HOSPITALS, INC | In Lie          | u of Form CMS-2552-10 |
|---|--------------------------|-----------------|-----------------------|
| COMPUTATION OF INPATIENT OPERATING COST | Provi der CCN: 15-0002   |                 | Worksheet D-1         |
|   |                          | From 01/01/2021 |                       |
|   | Component CCN: 15-T002   | To 12/31/2021   |                       |
|   | ·                        |                 | 5/27/2022 9:02 am     |
|   | Title XIX                | Subprovi der -  | Cost                  |
|   |                          | IRF             |                       |

|                  |  | I RF          |                |                  |
|------------------|--|---------------|----------------|------------------|
|                  | Cost Center Description  | -             | 1. 00          |                  |
|                  | PART I - ALL PROVIDER COMPONENTS   |               | 1.00           |                  |
|                  | I NPATI ENT DAYS   |               |                |                  |
| 1.00             | Inpatient days (including private room days and swing-bed days, excluding newborn)   |               | 4, 300         | 1.00             |
| 2. 00<br>3. 00   | Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private  | to room days  | 4, 300<br>0    | 2. 00<br>3. 00   |
| 3.00             | do not complete this line.   | te room days, | U              | 3.00             |
| 4.00             | Semi-private room days (excluding swing-bed and observation bed days)  |               | 4, 300         | 4.00             |
| 5.00             | Total swing-bed SNF type inpatient days (including private room days) through December 3   | 1 of the cost | 0              | 5.00             |
|                  | reporting period   | 6 11          |                | , 00             |
| 6. 00            | Total swing-bed SNF type inpatient days (including private room days) after December 31 of reporting period (if calendar year, enter 0 on this line)   | of the cost   | 0              | 6. 00            |
| 7. 00            | Total swing-bed NF type inpatient days (including private room days) through December 31   | of the cost   | 0              | 7. 00            |
|                  | reporting period   |               | _              |                  |
| 8.00             | Total swing-bed NF type inpatient days (including private room days) after December 31 of  | f the cost    | 0              | 8. 00            |
| 9. 00            | reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swi  | ng bod and    | 129            | 9. 00            |
| 9.00             | newborn days) (see instructions)   | ng-bed and    | 129            | 9.00             |
| 10.00            | Swing-bed SNF type inpatient days applicable to title XVIII only (including private room   | days)         | 0              | 10.00            |
|                  | through December 31 of the cost reporting period (see instructions)  |               |                |                  |
| 11. 00           | Swing-bed SNF type inpatient days applicable to title XVIII only (including private room   | days) after   | 0              | 11. 00           |
| 12. 00           | December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XLX only (including private ro  | nom days)     | 0              | 12. 00           |
| 12.00            | through December 31 of the cost reporting period   | Join days)    | · ·            | 12.00            |
| 13.00            | Swing-bed NF type inpatient days applicable to titles V or XIX only (including private ro  | oom days)     | 0              | 13.00            |
| 14.00            | after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  | - \           | 0              | 14 00            |
| 14. 00<br>15. 00 | Medically necessary private room days applicable to the Program (excluding swing-bed days Total nursery days (title V or XIX only)   | 5)            | 0<br>2, 056    | 14. 00<br>15. 00 |
| 16. 00           | Nursery days (title V or XIX only)   |               | 2, 030         | 16. 00           |
|                  | SWING BED ADJUSTMENT   |               |                |                  |
| 17. 00           | Medicare rate for swing-bed SNF services applicable to services through December 31 of the   | ne cost       | 0. 00          | 17.00            |
| 18. 00           | reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the  | cost          | 0. 00          | 18. 00           |
| 10.00            | reporting period   | COST          | 0.00           | 10.00            |
| 19. 00           | Medicaid rate for swing-bed NF services applicable to services through December 31 of the  | e cost        | 0.00           | 19. 00           |
| 20.00            | reporting period   |               | 0.00           | 20.00            |
| 20. 00           | Medicaid rate for swing-bed NF services applicable to services after December 31 of the direporting period   | JOST          | 0. 00          | 20. 00           |
| 21.00            | Total general inpatient routine service cost (see instructions)  |               | 5, 176, 818    | 21.00            |
| 22. 00           | Swing-bed cost applicable to SNF type services through December 31 of the cost reporting   | period (line  | 0              | 22.00            |
| 22.00            | 5 x line 17)   | oriod (lino 4 | 0              | 22.00            |
| 23. 00           | Swing-bed cost applicable to SNF type services after December 31 of the cost reporting polynomials (see the cost applicable to SNF type services after December 31 of the cost reporting polynomials (see the cost applicable to SNF type services after December 31 of the cost reporting polynomials (see the cost applicable to SNF type services after December 31 of the cost reporting polynomials (see the cost applicable to SNF type services after December 31 of the cost reporting polynomials (see the cost applicable to SNF type services after December 31 of the cost reporting polynomials (see the cost applicable to SNF type services after December 31 of the cost reporting polynomials (see the cost applicable to SNF type services after December 31 of the cost reporting polynomials (see the cost applicable to SNF type services). | erioa (iine o | U              | 23. 00           |
| 24.00            | Swing-bed cost applicable to NF type services through December 31 of the cost reporting p  | period (line  | 0              | 24.00            |
|                  | 7 x line 19)   |               |                |                  |
| 25. 00           | Swing-bed cost applicable to NF type services after December 31 of the cost reporting per x line 20)   | riod (line 8  | 0              | 25. 00           |
| 26. 00           | Total swing-bed cost (see instructions)  |               | 0              | 26. 00           |
| 27. 00           | General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)   |               | 5, 176, 818    |                  |
| 66               | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT   |               |                | 00.5-            |
| 28. 00<br>29. 00 | General inpatient routine service charges (excluding swing-bed and observation bed charge Private room charges (excluding swing-bed charges)   | es)           | 0              | 28. 00<br>29. 00 |
| 30.00            | Semi-private room charges (excluding swing-bed charges)  |               | 0              | 30.00            |
| 31. 00           | General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  |               | 0. 000000      | 31.00            |
| 32.00            | Average private room per diem charge (line 29 ÷ line 3)  |               | 0.00           | 32.00            |
| 33.00            | Average semi-private room per diem charge (line 30 ÷ line 4)   |               | 0.00           | 33.00            |
| 34.00            | Average per diem private room charge differential (line 32 minus line 33)(see instruction Average per diem private room cost differential (line 34 x line 31)  | ns)           | 0. 00<br>0. 00 | 34. 00<br>35. 00 |
| 35. 00<br>36. 00 | Private room cost differential adjustment (line 34 x line 31)  |               | 0.00           | 35. 00<br>36. 00 |
| 37. 00           | General inpatient routine service cost net of swing-bed cost and private room cost differ  | ential (line  |                | 37.00            |
|                  | 27 minus line 36)  | •             |                |                  |
|                  | PART II - HOSPITAL AND SUBPROVIDERS ONLY   |               |                |                  |
| 38. 00           | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)   |               | 1, 203. 91     | 38. 00           |
| 39. 00           | Program general inpatient routine service cost per drem (see instructions)   |               | 1, 203, 91     | 39.00            |
| 40. 00           | Medically necessary private room cost applicable to the Program (line 14 x line 35)  |               | 0              | 40. 00           |
| 41. 00           | Total Program general inpatient routine service cost (line 39 + line 40)   |               | 155, 304       | 41.00            |

| COMPUT  | ATION OF INPATIENT OPERATING COST  |                            |                            | CCN: 15-0002<br>CCN: 15-T002          |             | /01/2021<br>/31/2021 | Worksheet D-1 Date/Time Pre          |                  |
|---|--|----------------------------|----------------------------|---------------------------------------|-------------|----------------------|--------------------------------------|------------------|
|   |  |                            | ·                          |                                       |             |                      | 5/27/2022 9:0                        |                  |
|   |  |                            | ΠΤ                         | le XIX                                |             | vider -<br>RF        | Cost                                 |                  |
|   | Cost Center Description  | Total<br>Inpatient<br>Cost | Total<br>Inpatient<br>Days | Average Pe<br>Diem (col.<br>÷ col. 2) | 1           | am Days              | Program Cost<br>(col. 3 x<br>col. 4) |                  |
|   |  | 1.00                       | 2. 00                      | 3.00                                  | 4           | . 00                 | 5. 00                                |                  |
| 42. 00  | NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units                    | 0                          | (                          | 0                                     | . 00        | 0                    | 0                                    | 42.00            |
| 43. 00  | INTENSIVE CARE UNIT  | O                          | (                          | 0                                     | . 00        | 0                    | 0                                    | 43.00            |
| 43. 01  | NEONATAL I CU  | o                          |                            | 1                                     | . 00        | 0                    | 0                                    |                  |
| 44.00   | CORONARY CARE UNIT   |                            |                            |                                       |             |                      |                                      | 44.00            |
| 45. 00<br>46. 00  | BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT  |                            |                            |                                       |             |                      |                                      | 45. 00<br>46. 00 |
| 47. 00  | OTHER SPECIAL CARE (SPECIFY)   |                            |                            |                                       |             |                      |                                      | 47.00            |
|   | Cost Center Description  |                            |                            | •                                     | •           |                      |                                      |                  |
| 40.00   | Program inpatient ancillary service cost (Wk   | a+ D 2 aal 2               | Line 200)                  |                                       |             |                      | 1.00                                 | 40.00            |
| 48. 00<br>49. 00  | Total Program inpatient costs (sum of lines  |                            |                            | ons)                                  |             |                      | 214, 597<br>369, 901                 |                  |
| .,. 00  | PASS THROUGH COST ADJUSTMENTS  | 11 till ough 10) (         |                            | 00)                                   |             |                      | 0077701                              | 1                |
| 50. 00  | Pass through costs applicable to Program inp   | atient routine             | servi ces (fro             | om Wkst. D, s                         | sum of Par  | ts I and             | 0                                    | 50.00            |
| 51. 00  |  | ationt ancillar            | v sarvicas (f              | From Wkst D                           | sum of E    | Darte II             | 0                                    | 51.00            |
| J 1. UU   | and IV)  | ationi andiiidi            | y services (I              | TOIL WAST. D,                         | Julii UI F  | ui to II             |                                      | 31.00            |
| 52. 00  | Total Program excludable cost (sum of lines  |                            |                            |                                       |             |                      | 0                                    |                  |
| 53. 00  | Total Program inpatient operating cost exclu   |                            | lated, non-ph              | nysician anes                         | sthetist,   | and                  | 0                                    | 53.00            |
|   | medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION              | 52)                        |                            |                                       |             |                      |                                      |                  |
| 54. 00  | Program di scharges  |                            |                            |                                       |             |                      | 0                                    | 54.00            |
| 55. 00  | Target amount per discharge  |                            |                            |                                       |             |                      |                                      | 55.00            |
| 56. 00<br>57. 00  | Target amount (line 54 x line 55) Difference between adjusted inpatient operat               | ing cost and ta            | ract amount /              | Tino 56 minu                          | ıs Lino 53  | 2)                   | 0                                    |                  |
| 58. 00  | Bonus payment (see instructions)   | ing cost and ta            | rget amount (              | Title 50 IIII II                      | 15 TITLE 50 | )                    | 0                                    |                  |
| 59. 00  | Lesser of lines 53/54 or 55 from the cost re   | porting period             | endi ng 1996,              | updated and                           | compounde   | ed by the            | 0.00                                 | 59.00            |
| market basket   |  |                            |                            |                                       |             |                      |                                      | (0.00            |
| 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target |  |                            |                            |                                       |             |                      | 0. 00<br>0                           | 1                |
|   | amount (line 56), otherwise enter zero (see  |                            | 3 (111103 01 )             | ( 00), 01 1%                          | 01 1110 10  | ii go t              |                                      |                  |
| 62.00 Relief payment (see instructions)   |  |                            |                            |                                       |             |                      |                                      | 62.00            |
| 63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST   |  |                            |                            |                                       |             |                      |                                      | 63.00            |
| 64. 00  | Medicare swing-bed SNF inpatient routine cos   | ts through Dece            | mber 31 of th              | ne cost repor                         | ting peri   | od (See              | 0                                    | 64.00            |
| <b>.</b>  | instructions)(title XVIII only)  |                            |                            |                                       |             |                      | 0                                    | / 5 0/           |
| 65. 00  | Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)                 | ts after Decemb            | er 31 of the               | cost reporti                          | ng period   | i (See               | 0                                    | 65.00            |
| 66. 00  | Total Medicare swing-bed SNF inpatient routi   | ne costs (line             | 64 plus line               | 65)(title X\                          | /III only)  | . For                | 0                                    | 66.00            |
| / <del>7</del> 00   | CAH (see instructions)   |                            | D                          | . 6 11                                |             |                      | 0                                    | (7.0)            |
| 67.00   | Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)                             | e costs through            | December 31                | or the cost                           | reporting   | g perioa             | 0                                    | 67.00            |
| 68. 00  | Title V or XIX swing-bed NF inpatient routin   | e costs after D            | ecember 31 of              | the cost re                           | eporting p  | peri od              | 0                                    | 68.00            |
| , o oo  | (line 13 x line 20)  |                            | 1: /7 1:-                  | (0)                                   |             |                      | 0                                    | (0.00            |
| 69. 00  | Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N     |                            |                            |                                       |             |                      | 0                                    | 69.00            |
| 70. 00  | Skilled nursing facility/other nursing facil   |                            |                            |                                       | 37)         |                      |                                      | 70.00            |
| 71.00   | Adjusted general inpatient routine service c   |                            | ine 70 ÷ line              | 2)                                    |             |                      |                                      | 71.00            |
| 72. 00<br>73. 00  | Program routine service cost (line 9 x line Medically necessary private room cost applic     |                            | (line 14 x l               | ine 35)                               |             |                      |                                      | 72.00            |
| 74. 00  | Total Program general inpatient routine serv   |                            | •                          |                                       |             |                      |                                      | 74.00            |
| 75. 00  | Capital-related cost allocated to inpatient  | routine service            | costs (from                | Worksheet B,                          | Part II,    | col umn              |                                      | 75.00            |
| 76. 00  | 26, line 45)<br> Per diem capital-related costs (line 75 ÷ li                                | ne 2)                      |                            |                                       |             |                      |                                      | 76.00            |
| 77. 00  | Program capital -related costs (line 9 x line  |                            |                            |                                       |             |                      |                                      | 77.00            |
| 78. 00  | Inpatient routine service cost (line 74 minu   |                            |                            |                                       |             |                      |                                      | 78.00            |
| 79. 00<br>80. 00  | Aggregate charges to beneficiaries for exces<br>Total Program routine service costs for comp |                            |                            |                                       | ninus line  | 2 70)                |                                      | 79.00            |
| 81. 00  | Inpatient routine service costs for comp   |                            | SSC TIME CALL              | (11110-70-11                          | 1145 11116  | - ' ' ' '            |                                      | 81.00            |
| 82. 00  | Inpatient routine service cost limitation (  | ine 9 x line 81            |                            |                                       |             |                      |                                      | 82.00            |
| 83.00   | Reasonable inpatient routine service costs (   |                            | s)                         |                                       |             |                      |                                      | 83.00            |
| 84. 00<br>85. 00  | Program inpatient ancillary services (see in Utilization review - physician compensation     |                            | ns)                        |                                       |             |                      |                                      | 84.00            |
| 86. 00  | Total Program inpatient operating costs (sum   |                            |                            |                                       |             |                      |                                      | 86.00            |
| 07.5  | PART IV - COMPUTATION OF OBSERVATION BED PASS  | S THROUGH COST             |                            |                                       |             |                      |                                      | 67.              |
| 87. 00  | Total observation bed days (see instructions Adjusted general inpatient routine cost per     |                            | line 2)                    |                                       |             |                      | 0 00                                 | 87.00            |
| 88. 00  |  | a. om allio 4/ 7           |                            |                                       |             |                      | 0.00                                 | 1 00.00          |

| Health Financial Systems                    | METHODIST HOSPITALS, INC In Lieu of Form |              |            |                                  |                                | 2552-10 |
|---|--|--------------|------------|----------------------------------|--------------------------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST     |  | Provi der CC |            | Peri od:                         | Worksheet D-1                  |         |
|   |  | Component (  |            | From 01/01/2021<br>To 12/31/2021 | Date/Time Pre<br>5/27/2022 9:0 |         |
|   |  | Ti tl        | e XIX      | Subprovi der -                   | Cost                           |         |
|   |  |              |            | I RF                             |                                |         |
| Cost Center Description                     | Cost                                     | Routine Cost | column 1 ÷ | Total                            | Observation                    |         |
|   |  | (from line   | column 2   | Observati on                     | Bed Pass                       |         |
|   |  | 21)          |            | Bed Cost                         | Through Cost                   |         |
|   |  | ŕ            |            | (from line                       | (col. 3 x                      |         |
|   |  |              |            | 89)                              | col. 4) (see                   |         |
|   |  |              |            |                                  | instructions)                  |         |
|   | 1. 00                                    | 2.00         | 3. 00      | 4. 00                            | 5. 00                          |         |
| COMPUTATION OF OBSERVATION BED PASS THROUGH | COST                                     |              |            |                                  |                                |         |
| 90.00 Capital-related cost                  | 576, 495                                 | 5, 176, 818  | 0. 11136   | 0                                | 0                              | 90.00   |
| 91.00 Nursing Program cost                  | 0  | 5, 176, 818  | 0.00000    | 0 0                              | 0                              | 91.00   |
| 92.00 Allied health cost                    | 0  | 5, 176, 818  | 0.00000    | 0 0                              | 0                              | 92.00   |
| 93.00 All other Medical Education           | 0  | 5, 176, 818  | 0.00000    | 0 0                              | 0                              | 93.00   |

| Heal th Fi nanci al Systems METHODI ST HOSPI                                   |             | ON 45 0000         |                             | eu of Form CMS-                |         |
|--|-------------|--------------------|-----------------------------|--------------------------------|---------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT                                 | Provi der C | CN: 15-0002        | Peri od:<br>From 01/01/2021 | Worksheet D-3                  | 3       |
|  |             |                    | To 12/31/2021               | Date/Time Pro<br>5/27/2022 9:0 |         |
|  | Titl∈       | XVIII              | Hospi tal                   | PPS                            |         |
| Cost Center Description  |             | Ratio of Cos       |                             | I npati ent                    |         |
|  |             | To Charges         | Program                     | Program Costs                  |         |
|  |             |                    | Charges                     | (col . 1 x                     |         |
|  |             | 1 00               | 2.00                        | col . 2)<br>3.00               |         |
| INPATIENT ROUTINE SERVICE COST CENTERS   |             | 1.00               | 2. 00                       | 3.00                           |         |
| 30. 00 03000 ADULTS & PEDIATRICS   |             |                    | 21, 814, 682                |                                | 30.00   |
| 31. 00   03100   NTENSI VE CARE UNI T  |             |                    | 7, 613, 480                 |                                | 31.00   |
| 31. 01   03101   NEONATAL   I CU   |             |                    | 7,013,400                   | l                              | 31.00   |
| 40. 00   04000   SUBPROVI DER -   PF   |             |                    |                             |                                | 40.00   |
| 41. 00   04100   SUBPROVI DER -   I RF   |             |                    | 0                           |                                | 41.00   |
| 43. 00   04300   NURSERY   |             |                    |                             |                                | 43.00   |
| ANCILLARY SERVICE COST CENTERS   |             | 1                  |                             |                                | 1       |
| 50. 00 05000 OPERATING ROOM  |             | 0. 0969            | 03 13, 413, 691             | 1, 299, 827                    | 50.00   |
| 50. 01 05001 ENDOSCOPY   |             | 0. 1491            | 06 1, 474, 976              | 219, 928                       | 50. 01  |
| 51.00   05100   RECOVERY ROOM  |             | 0. 2123            | 17 955, 453                 | 202, 859                       | 51.00   |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM   |             | 1. 4981            | 19 7, 272                   | 10, 894                        | 52.00   |
| 53. 00   05300   ANESTHESI OLOGY   |             | 0.0000             | 00                          | C                              | 53.00   |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C                                       |             | 0. 1945            | 58 3, 310, 011              | 643, 989                       | 54.00   |
| 54. 01   05401   RADI OLOGY - ULTRASOUND                                       |             | 0. 1279            | 08 1, 411, 974              | 180, 603                       | 54. 01  |
| 55. 00   05500   RADI OLOGY-THERAPEUTI C                                       |             | 0. 1727            | 29 367, 910                 | 63, 549                        |         |
| 55. 01   05501   I NFUSI ON CENTER   |             | 0. 6128            |                             | _                              |         |
| 56. 00   05600   RADI OI SOTOPE  |             | 0. 1734            |                             |                                |         |
| 57. 00   05700   CT   SCAN   |             | 0. 0361            |                             | · ·                            |         |
| 58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)                              |             | 0. 0539            |                             |                                |         |
| 59. 00   05900   CARDI AC CATHETERI ZATI ON                                    |             | 0. 0825            |                             |                                | 1       |
| 60. 00   06000   LABORATORY  |             | 0. 0859            |                             |                                | 1       |
| 62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS                          |             | 0. 1818            |                             |                                | 1       |
| 64. 00   06400   I NTRAVENOUS THERAPY<br>65. 00   06500   RESPI RATORY THERAPY |             | 0.0000             |                             |                                |         |
| 66. 00   06600   PHYSI CAL THERAPY   |             | 0. 1416<br>0. 3532 |                             |                                |         |
| 67. 00   06700   0CCUPATI ONAL THERAPY   |             | 0. 3532            | 1                           |                                | 1       |
| 68. 00   06800   SPEECH PATHOLOGY  |             | 0. 3937            |                             |                                | 1       |
| 69. 00   06900   ELECTROCARDI OLOGY  |             | 0. 2832            |                             |                                |         |
| 69. 01   06901   CARDI AC   REHAB  |             | 0. 6173            |                             |                                | 1       |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY  |             | 0.0693             |                             |                                |         |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS                              |             | 0. 3569            | 1                           |                                | 1       |
| 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS                                   |             | 0. 4700            |                             |                                |         |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS   |             | 0. 2011            |                             |                                |         |
| 74. 00   07400   RENAL DI ALYSI S  |             | 0. 3089            |                             |                                |         |
| OUTPATIENT SERVICE COST CENTERS  |             |                    |                             |                                |         |
| 90. 00 09000 CLI NI C  |             | 0. 4548            | 80 40, 959                  | 18, 631                        | 90.00   |
| 91. 00   09100   EMERGENCY   |             | 0. 2458            | 15 5, 816, 869              | 1, 429, 874                    | 91.00   |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)                               |             | 0. 5529            |                             |                                |         |
| 200 00 Total (sum of Lines 50 through 94 and 96 through 98)                    |             |                    | 155 082 359                 | 24 800 622                     | 1200 00 |

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

155, 082, 359

155, 082, 359

24, 800, 622 200. 00

201.00

202.00

200.00

201.00

202.00

| INPATI                               | ENT ANCILLARY SERVICE COST APPORTIONMENT   | Provi der C    |                            | Peri od:                          | Worksheet D-3                             |  |
|--------------------------------------|--|----------------|----------------------------|-----------------------------------|---|--|
|                                      |  | Component      |                            | From 01/01/2021<br>To 12/31/2021  | Date/Time Pre<br>5/27/2022 9:0            |  |
|                                      |  | Title          | : XVIII                    | Subprovi der -                    | PPS                                       |  |
|                                      | Cost Center Description  |                | Ratio of Cos<br>To Charges | t Inpatient<br>Program<br>Charges | Inpatient Program Costs (col. 1 x col. 2) |  |
|                                      |  |                | 1. 00                      | 2. 00                             | 3. 00                                     |  |
|                                      | INPATIENT ROUTINE SERVICE COST CENTERS   |                |                            |                                   |   | 1  |
| 31. 00<br>31. 01<br>40. 00<br>41. 00 | 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03101 NEONATAL ICU 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY |                |                            | 799, 986                          |   | 30. 00<br>31. 00<br>31. 00<br>40. 00<br>41. 00<br>43. 00 |
|                                      | ANCILLARY SERVICE COST CENTERS   |                | 1 00000                    | اه.                               |   |  |
| 50. 00<br>50. 01                     | 05000 OPERATING ROOM<br>05001 ENDOSCOPY  |                | 0. 09690                   |                                   | 0   |  |
|                                      | 05100 RECOVERY ROOM  |                | 0. 14910<br>0. 21231       |                                   | 462<br>0                                  |  |
|                                      | 05200 DELIVERY ROOM & LABOR ROOM   |                | 1. 49811                   |                                   | 0   |  |
| 53.00                                | 05300 ANESTHESI OLOGY  |                | 0. 00000                   |                                   | 0   | 53. 0  |
| 54. 00                               | 05400 RADI OLOGY-DI AGNOSTI C  |                | 0. 19455                   |                                   | 1, 831                                    |  |
| 54. 01                               | 05401 RADI OLOGY - ULTRASOUND  |                | 0. 12790                   |                                   | 919                                       |  |
| 55. 00                               | 05500 RADI OLOGY-THERAPEUTI C  |                | 0. 17272                   |                                   | 0   |  |
| 55. 01                               | 05501 I NFUSI ON CENTER  |                | 0. 61281                   | 8 0                               | 0   | 55.0   |
| 56.00                                | 05600 RADI 0I S0T0PE   |                | 0. 17347                   | 75 1, 552                         | 269                                       | 56.0   |
| 57. 00                               | 05700 CT SCAN  |                | 0. 03613                   |                                   | 604                                       |  |
|                                      | 05800 MAGNETIC RESONANCE IMAGING (MRI)   |                | 0. 05397                   |                                   | 581                                       |  |
| 59. 00                               | 05900 CARDI AC CATHETERI ZATI ON   |                | 0. 08252                   |                                   | 0   |  |
| 60.00                                | 06000 LABORATORY   |                | 0. 08596                   |                                   | 14, 045                                   |  |
|                                      | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS   |                | 0. 18186                   |                                   | 2, 015                                    |  |
| 64. 00<br>65. 00                     | 06400 I NTRAVENOUS THERAPY<br>06500 RESPI RATORY THERAPY   |                | 0.00000                    |                                   | 0<br>213                                  |  |
|                                      | 06600 PHYSI CAL THERAPY  |                | 0. 14169<br>0. 35327       |                                   | 530                                       | 1  |
| 67. 00                               | 06700 OCCUPATI ONAL THERAPY  |                | 0. 39379                   |                                   | 0   |  |
| 68. 00                               | 06800 SPEECH PATHOLOGY   |                | 0. 28329                   |                                   | 0   | 1  |
|                                      | 06900 ELECTROCARDI OLOGY   |                | 0. 05449                   |                                   | 1, 228                                    |  |
| 69. 01                               | 06901 CARDI AC REHAB   |                | 0. 61735                   | 9 0                               | 0   | 69.0   |
| 70. 00                               | 07000 ELECTROENCEPHALOGRAPHY   |                | 0. 06932                   | 2, 053                            | 142                                       | 70.0   |
| 71. 00                               | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS   |                | 0. 35693                   |                                   | 658                                       | 71.0   |
| 72. 00                               | 07200 IMPL. DEV. CHARGED TO PATIENTS   |                | 0. 47008                   |                                   | 0   |  |
|                                      | 07300 DRUGS CHARGED TO PATIENTS  |                | 0. 20119                   |                                   | 46, 770                                   |  |
| 74. 00                               | 07400 RENAL DI ALYSI S   |                | 0. 30892                   | 25 0                              | 0   | 74.0   |
| 00 00                                | OUTPATIENT SERVICE COST CENTERS  |                | 0.45400                    | 20                                |   | 1 00 0   |
|                                      | 09000 CLINIC   |                | 0. 45488                   |                                   | 0<br>E 977                                |  |
| 91. 00<br>92. 00                     | 09100 EMERGENCY<br>09200 OBSERVATION BEDS (NON-DISTINCT PART)  |                | 0. 24581<br>0. 55298       |                                   | 5, 877<br>0                               | 1  |
| 92. 00<br>200. 00                    |  |                | 0. 55298                   | 508, 992                          | 76, 144                                   |  |
| 200.00                               | Less PBP Clinic Laboratory Services-Program only charge  | es (line 61)   |                            | 500, <del>7</del> 92              | 70, 144                                   | 201.00   |
| 202.00                               |  | ,00 (11110 01) | 1                          | 508, 992                          |   | 202.00   |

| PATIENT ANCILLARY SERVICE COST APPORTIONMENT   | Provi der C     | CN: 15-0002                | Peri od:                         | Worksheet D-3                             | 3   |
|--|-----------------|----------------------------|----------------------------------|---|-----|
|  | Component       | CCN: 15-T002               | From 01/01/2021<br>To 12/31/2021 | Date/Time Pre<br>5/27/2022 9:0            |     |
|  | Titl∈           | · XVIII                    | Subprovi der –<br>I RF           | PPS                                       |     |
| Cost Center Description  |                 | Ratio of Cos<br>To Charges | Program<br>Charges               | Inpatient Program Costs (col. 1 x col. 2) |     |
|  |                 | 1.00                       | 2. 00                            | 3. 00                                     |     |
| INPATIENT ROUTINE SERVICE COST CENTERS   |                 | ı                          |                                  |   |     |
| .00   03000   ADULTS & PEDIATRICS<br>.00   03100   INTENSIVE CARE UNIT                       |                 |                            |                                  |   | 30. |
| . 01   03101   NEONATAL   I CU   |                 |                            |                                  |   | 31. |
| . 00   04000   SUBPROVI DER - I PF   |                 |                            |                                  |   | 40. |
| . 00   04100   SUBPROVI DER - I RF   |                 |                            | 2, 088, 139                      |   | 41. |
| . 00 O4300 NURSERY   |                 |                            |                                  |   | 43. |
| ANCILLARY SERVICE COST CENTERS  . 00   05000   OPERATING ROOM                                |                 | 0. 0969                    | 03 225, 447                      | 21, 846                                   | 50. |
| 05000 OFERATING ROOM   |                 | 0. 0404                    | ·                                | 1, 863                                    |     |
| . 00   05100   RECOVERY ROOM   |                 | 0. 2123                    |                                  | 1, 543                                    |     |
| . 00   05200   DELIVERY ROOM & LABOR ROOM  |                 | 1. 4981                    |                                  | 0   |     |
| . 00 05300 ANESTHESI OLOGY   |                 | 0.0000                     | 00 0                             | 0   | 53. |
| . 00   05400   RADI OLOGY-DI AGNOSTI C   |                 | 0. 1945                    | 58 42, 683                       | 8, 304                                    | 54. |
| . 01   05401   RADI OLOGY - ULTRASOUND   |                 | 0. 1279                    |                                  | 2, 222                                    |     |
| . 00   05500   RADI OLOGY-THERAPEUTI C   |                 | 0. 1727                    |                                  | 0   |     |
| . 01   05501   NFUSI ON CENTER   |                 | 0. 6128                    |                                  | 0   |     |
| . 00   05600   RADI OI SOTOPE<br>. 00   05700   CT   SCAN                                    |                 | 0. 1734                    |                                  | 4, 048                                    |     |
| . 00   05800   MAGNETIC RESONANCE I MAGING (MRI)   |                 | 0. 0361<br>0. 0539         |                                  | 4, 316<br>2, 040                          |     |
| . 00   05900 CARDI AC CATHETERI ZATI ON  |                 | 0.0825                     | ·                                | 1, 707                                    |     |
| 00 06000 LABORATORY  |                 | 0. 0859                    |                                  | 54, 589                                   |     |
| . 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS  |                 | 0. 1818                    |                                  | 2, 588                                    |     |
| . 00 06400 I NTRAVENOUS THERAPY  |                 | 0.0000                     | ·                                | 0   |     |
| . 00 06500 RESPI RATORY THERAPY  |                 | 0. 1416                    | 97 255, 010                      | 36, 134                                   | 65  |
| . 00 06600 PHYSI CAL THERAPY   |                 | 0. 3532                    |                                  | 372, 549                                  |     |
| . 00 06700 OCCUPATI ONAL THERAPY   |                 | 0. 3937                    |                                  | 347, 280                                  |     |
| 0.00 06800 SPEECH PATHOLOGY  |                 | 0. 2832                    |                                  | 51, 949                                   |     |
| . 00   06900   ELECTROCARDI OLOGY  |                 | 0.0544                     |                                  | 1, 367                                    |     |
| O6901 CARDI AC REHAB OO O7000 ELECTROENCEPHALOGRAPHY   |                 | 0. 6173<br>0. 0693         |                                  | 0<br>142                                  |     |
| . 00   07000   ELECTROENCEPHALOGRAPHY<br>. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS |                 | 0.0693                     | ·                                | 26, 306                                   |     |
| . 00 07200 IMPL. DEV. CHARGED TO PATIENTS  |                 | 0. 3309                    | ·                                | 11, 707                                   |     |
| . 00 07300 DRUGS CHARGED TO PATIENTS   |                 | 0. 2011                    |                                  | 236, 282                                  |     |
| . 00   07400   RENAL DI ALYSI S  |                 | 0. 3089                    |                                  | 52, 987                                   |     |
| OUTPATIENT SERVICE COST CENTERS  |                 |                            |                                  |   |     |
| . 00 09000 CLI NI C  |                 | 0. 4548                    |                                  | 0   |     |
| . 00   09100   EMERGENCY   |                 | 0. 2458                    |                                  | 0   |     |
| .00 09200 OBSERVATION BEDS (NON-DISTINCT PART)   |                 | 0. 5529                    |                                  | 0   | 1   |
| 0.00 Total (sum of lines 50 through 94 and 96 through 98)                                    |                 |                            | 5, 002, 218                      | 1, 241, 769                               |     |
| 1.00 Less PBP Clinic Laboratory Services-Program only cha                                    | arnas (lina 61) | 1                          | 0                                | 1   | 201 |

| Health Financial Systems                                      | METHODIST HOSPITALS, INC |                      |                                  | u of Form CMS-2                |        |
|---|--------------------------|----------------------|----------------------------------|--------------------------------|--------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT                | Provi der C              |                      | Peri od:                         | Worksheet D-3                  |        |
|   |                          |                      | From 01/01/2021<br>To 12/31/2021 | Date/Time Pre<br>5/27/2022 9:0 |        |
|   | Ti tl                    | e XIX                | Hospi tal                        | Cost                           |        |
| Cost Center Description                                       |                          | Ratio of Cos         | t Inpatient                      | I npati ent                    |        |
|   |                          | To Charges           | Program                          | Program Costs                  |        |
|   |                          |                      | Charges                          | (col. 1 x                      |        |
|   |                          | 1.00                 | 0.00                             | col . 2)                       |        |
| INPATIENT ROUTINE SERVICE COST CENTERS                        |                          | 1.00                 | 2. 00                            | 3. 00                          |        |
| 30. 00 03000 ADULTS & PEDIATRICS                              |                          |                      | 2, 615, 985                      |                                | 30.00  |
| 31. 00   03100   NTENSI VE CARE UNIT                          |                          |                      | 683, 970                         |                                | 31.00  |
| 31. 01   03101   NEONATAL   CU                                |                          |                      | 698, 102                         |                                | 31.00  |
| 40. 00   04000   SUBPROVI DER - I PF                          |                          |                      | 79, 338                          |                                | 40.00  |
| 41. 00   04100   SUBPROVI DER -   I RF                        |                          |                      | 88, 510                          |                                | 41.00  |
| 43. 00   04300 NURSERY  |                          |                      | 219, 118                         |                                | 43.00  |
| ANCILLARY SERVICE COST CENTERS                                |                          | 1                    |                                  |                                | 1      |
| 50. 00 05000 OPERATING ROOM                                   |                          | 0. 09690             | 2, 440, 942                      | 236, 535                       | 50.00  |
| 50. 01   05001   ENDOSCOPY                                    |                          | 0. 14910             | 122, 486                         | 18, 263                        | 50. 01 |
| 51. 00   05100   RECOVERY ROOM                                |                          | 0. 21231             | 7 144, 761                       | 30, 735                        | 51.00  |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM                        |                          | 1. 49811             |                                  | 436, 055                       | 1      |
| 53. 00   05300   ANESTHESI OLOGY                              |                          | 0.00000              |                                  | 0                              | 53.00  |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C                      |                          | 0. 19455             |                                  | 57, 503                        |        |
| 54. 01   05401 RADI OLOGY - ULTRASOUND                        |                          | 0. 12790             |                                  | 27, 229                        | 1      |
| 55. 00   05500   RADI OLOGY-THERAPEUTI C                      |                          | 0. 17261             |                                  | 4, 127                         | 55.00  |
| 55. 01   05501   NFUSI ON CENTER                              |                          | 0. 61281             |                                  | 0                              | 55. 01 |
| 56. 00   05600   RADI OI SOTOPE<br>57. 00   05700   CT   SCAN |                          | 0. 17347<br>0. 03613 |                                  | 24, 879<br>54, 980             |        |
| 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)                  |                          | 0.05397              |                                  | 20, 007                        | 58.00  |
| 59. 00   05900   CARDI AC CATHETERI ZATI ON                   |                          | 0. 03347             |                                  | 98, 439                        |        |
| 60. 00   06000   LABORATORY                                   |                          | 0. 08596             |                                  | 315, 728                       | 1      |
| 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS             |                          | 0. 18186             |                                  | 11, 209                        | 1      |
| 64. 00 06400 I NTRAVENOUS THERAPY                             |                          | 0.00000              |                                  | 0                              | 64.00  |
| 65. 00 06500 RESPIRATORY THERAPY                              |                          | 0. 14169             |                                  | 188, 629                       | 1      |
| 66. 00 06600 PHYSI CAL THERAPY                                |                          | 0. 35327             |                                  | 50, 528                        | •      |
| 67. 00 06700 OCCUPATI ONAL THERAPY                            |                          | 0. 39379             | 108, 175                         | 42, 598                        | 67.00  |
| 68. 00 06800 SPEECH PATHOLOGY                                 |                          | 0. 28329             | 48, 701                          | 13, 797                        | 68.00  |
| 69. 00 06900 ELECTROCARDI OLOGY                               |                          | 0. 05449             | 376, 949                         | 20, 540                        | 69.00  |
| 69. 01   06901   CARDI AC REHAB                               |                          | 0. 61735             | 6, 792                           | 4, 193                         | 69. 01 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY                           |                          | 0. 06932             |                                  | 20, 191                        | 70.00  |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS              |                          | 0. 35693             |                                  | 95, 624                        |        |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS                   |                          | 0. 47008             |                                  | 125, 939                       |        |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS                        |                          | 0. 20119             |                                  | 669, 646                       |        |
| 74. 00  07400 RENAL DLALYSES                                  |                          | 0 30892              | ·5l 154 280l                     | 4 / 661                        | 74 00  |

267, 908 3, 328, 310 154, 280

7, 017

793, 504

17, 619, 287

17, 619, 287

669, 646 47, 661

3, 192

2, 813, 282 200. 00

195, 055

74.00

90.00

91.00

92.00 0

201.00

202.00

0. 308925

0. 454880

0. 245815

0. 552988

07400 RENAL DIALYSIS

OUTPATIENT SERVICE COST CENTERS

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Net charges (line 200 minus line 201)

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

Less PBP Clinic Laboratory Services-Program only charges (line 61)

74.00

200.00

201.00

202.00

90. 00 09000 CLI NI C

91. 00 09100 EMERGENCY

| Cost Center Description  | omponent ( | CCN: 15-S002               | From 01/01/2021<br>To 12/31/2021 | Doto/Time Dro                             |  |
|--|------------|----------------------------|----------------------------------|---|--|
| Cost Center Description  | Ti tl      | - VIV                      |                                  | Date/Time Pre<br>5/27/2022 9:0            |  |
| Cost Center Description  |            | e xix                      | Subprovi der –<br>I PF           | Cost                                      |  |
|  |            | Ratio of Cos<br>To Charges |                                  | Inpatient Program Costs (col. 1 x col. 2) |  |
|  |            | 1. 00                      | 2. 00                            | 3. 00                                     |  |
| INPATIENT ROUTINE SERVICE COST CENTERS   |            |                            |                                  |   |  |
| 0. 00   03000   ADULTS & PEDIATRICS<br>1. 00   03100   INTENSIVE CARE UNIT<br>1. 01   03101   NEONATAL I CU<br>0. 00   04000   SUBPROVI DER - I PF<br>1. 00   04100   SUBPROVI DER - I RF<br>3. 00   04300   NURSERY |            |                            | 409, 545                         |   | 30.<br>31.<br>31.<br>40.<br>41.<br>43. |
| ANCI LLARY SERVI CE COST CENTERS   |            |                            |                                  |   | 1                                      |
| O. 00 05000 OPERATING ROOM   |            | 0. 0969                    | 03                               | 0   | 50.                                    |
| 0. 01   05001   ENDOSCOPY  |            | 0. 1491                    |                                  | 0   |  |
| 1.00   05100   RECOVERY ROOM   |            | 0. 2123                    |                                  | 0   |  |
| 2.00 05200 DELIVERY ROOM & LABOR ROOM  |            | 1. 4981                    |                                  | 0   |  |
| 3. 00   05300   ANESTHESI OLOGY  |            | 0.0000                     |                                  | 0   | 1                                      |
| I. 00   05400   RADI OLOGY - DI AGNOSTI C  |            | 0. 1945                    |                                  | 1, 131                                    |  |
| 4. 01   05401   RADI OLOGY - ULTRASOUND  |            | 0. 1279                    |                                  | 521                                       |  |
| 5. 00   05500   RADI OLOGY-THERAPEUTI C<br>5. 01   05501   INFUSI ON CENTER  |            | 0. 1726<br>0. 6128         |                                  | 0   |  |
| 5. 00   05600   RADI 01 SOTOPE   |            | 0. 6128                    |                                  | 0   |  |
| 7. 00   05700   CT   SCAN  |            | 0. 1734                    |                                  | 0   |  |
| B. OO OSTOO DI SONIV<br>B. OO OSBOO MAGNETIC RESONANCE IMAGING (MRI)   |            | 0. 0539                    |                                  | 0   |  |
| 2. OO O5900 CARDI AC CATHETERI ZATI ON   |            | 0. 0825                    |                                  | 0   |  |
| 0. 00   06000   LABORATORY   |            | 0. 0859                    |                                  | 7, 375                                    |  |
| 2. OO 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS   |            | 0. 1818                    | 65 7, 625                        | 1, 387                                    |  |
| . 00 06400 INTRAVENOUS THERAPY   |            | 0.0000                     | 00                               | 0   | 64                                     |
| 0.00 06500 RESPI RATORY THERAPY  |            | 0. 1416                    |                                  | 0   |  |
| o. 00   06600   PHYSI CAL THERAPY  |            | 0. 3532                    |                                  | 420                                       |  |
| 7. 00 06700 OCCUPATI ONAL THERAPY  |            | 0. 3937                    |                                  | 0   |  |
| 8. 00   06800   SPEECH PATHOLOGY   |            | 0. 2832                    |                                  | 0   |  |
| 2. 00   06900   ELECTROCARDI OLOGY   |            | 0.0544                     |                                  | 456                                       |  |
| P. 01   06901   CARDI AC REHAB<br>P. 00   07000   ELECTROENCEPHALOGRAPHY   |            | 0.6173                     |                                  | 0   |  |
| .00   07000  ELECTROENCEPHALOGRAPHY .00   07100  MEDICAL SUPPLIES CHARGED TO PATIENTS  |            | 0. 0693<br>0. 3569         |                                  | 6   | 1                                      |
| 2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS   |            | 0. 4700                    |                                  | 0   |  |
| 5. 00 07300 DRUGS CHARGED TO PATIENTS  |            | 0. 2011                    |                                  | 18, 668                                   |  |
| . 00   07400   RENAL DI ALYSI S  |            | 0. 3089                    |                                  |   | 74                                     |
| OUTPATIENT SERVICE COST CENTERS  |            |                            |                                  |   | 1                                      |
| 0. 00 09000 CLI NI C   |            | 0. 4548                    | 80 0                             | 0   | 90                                     |
| . 00   09100   EMERGENCY   |            | 0. 2458                    | ·                                | 3, 342                                    | 91                                     |
| 2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)   |            | 0. 5529                    |                                  | 0   |  |
| OO.00 Total (sum of lines 50 through 94 and 96 through 98)   |            |                            | 219, 246                         | 33, 306                                   |  |
| D1.00 Less PBP Clinic Laboratory Services-Program only charges (ID2.00 Net charges (line 200 minus line 201)   | line 61)   |                            | 0<br>219, 246                    |   | 201<br>202                             |

| PATIENT ANCILLARY SERVICE COST APPORTIONMENT   | Trovider C   | CN: 15-0002        | Peri od:<br>From 01/01/2021 | Worksheet D-3                  | ,   |
|--|--------------|--------------------|-----------------------------|--------------------------------|-----|
|  | Component    | CCN: 15-T002       | To 12/31/2021               | Date/Time Pre<br>5/27/2022 9:0 |     |
|  | Ti tl        | e XIX              | Subprovi der -<br>I RF      | Cost                           |     |
| Cost Center Description  |              | Ratio of Cos       | st Inpatient                | I npati ent                    |     |
|  |              | To Charges         | Program<br>Charges          | Program Costs<br>(col. 1 x     |     |
|  |              | 1.00               | 2. 00                       | col . 2)<br>3.00               |     |
| INPATIENT ROUTINE SERVICE COST CENTERS   |              | 1.00               | 2.00                        | 0.00                           |     |
| . 00 03000 ADULTS & PEDIATRICS   |              |                    |                             |                                | 30. |
| . 00 03100 INTENSIVE CARE UNIT   |              |                    |                             |                                | 31. |
| . 01 03101 NEONATAL ICU  |              |                    |                             |                                | 31. |
| 0.00   04000   SUBPROVI DER -   1 PF   |              |                    | 005 070                     |                                | 40. |
| . 00   04100   SUBPROVI DER - I RF   |              |                    | 385, 970                    |                                | 41. |
| . 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS                                      |              |                    |                             |                                | 43. |
| 05000 OPERATING ROOM   |              | 0. 0969            | 03 0                        | 0                              | 50. |
| 0. 01   05001   ENDOSCOPY  |              | 0. 1491            |                             |                                |     |
| . 00   05100   RECOVERY ROOM   |              | 0. 2123            |                             |                                |     |
| .00 05200 DELIVERY ROOM & LABOR ROOM   |              | 1. 4981            | 19 0                        | 0                              | 52. |
| . 00   05300   ANESTHESI OLOGY   |              | 0.0000             | 00                          | 0                              | 53. |
| . 00   05400   RADI OLOGY-DI AGNOSTI C   |              | 0. 1945            |                             |                                |     |
| . 01   05401   RADI OLOGY - ULTRASOUND   |              | 0. 1279            |                             |                                |     |
| . 00   05500   RADI OLOGY-THERAPEUTI C   |              | 0. 1726            |                             | 0                              |     |
| . 01   05501   I NFUSI ON CENTER<br>. 00   05600   RADI OI SOTOPE                        |              | 0. 6128            |                             | 0                              |     |
| . 00   05600  RADI 01 SOTOPE<br>. 00   05700  CT   SCAN                                  |              | 0. 1734<br>0. 0361 |                             | 304<br>912                     |     |
| . 00   05800   MAGNETIC RESONANCE I MAGING (MRI)   |              | 0.0539             |                             | 252                            |     |
| . 00   05900 CARDI AC CATHETERI ZATI ON  |              | 0. 0825            |                             | 0                              |     |
| 00 06000 LABORATORY  |              | 0. 0859            |                             | 10, 763                        |     |
| . 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS  |              | 0. 1818            |                             |                                |     |
| . 00 06400 I NTRAVENOUS THERAPY  |              | 0.0000             |                             | 0                              | 64. |
| . 00 06500 RESPIRATORY THERAPY   |              | 0. 1416            | 97 9, 065                   | 1, 284                         | 65. |
| . 00   06600   PHYSI CAL THERAPY   |              | 0. 3532            |                             |                                |     |
| . 00   06700   OCCUPATI ONAL THERAPY   |              | 0. 3937            |                             | 64, 741                        |     |
| . 00   06800   SPEECH PATHOLOGY  |              | 0. 2832            |                             |                                |     |
| . 00   06900   ELECTROCARDI OLOGY  |              | 0.0544             |                             |                                |     |
| . 01   06901   CARDI AC REHAB<br>. 00   07000   ELECTROENCEPHALOGRAPHY                   |              | 0. 6173            |                             | 0 23                           |     |
| .00   07000  ELECTROENCEPHALOGRAPHY<br>.00   07100  MEDICAL SUPPLIES CHARGED TO PATIENTS |              | 0. 0693<br>0. 3569 |                             | 2, 121                         |     |
| . 00   07100   MEDICAL SUPPLIES CHARGED TO PATTENTS                                      |              | 0. 3369            | ·                           |                                |     |
| . 00 07300 DRUGS CHARGED TO PATIENTS   |              | 0. 4700            |                             |                                |     |
| . 00   07400   RENAL DI ALYSI S  |              | 0. 3089            |                             |                                |     |
| OUTPATIENT SERVICE COST CENTERS  |              |                    | ., =                        |                                | 1   |
| . 00 09000 CLINIC  |              | 0. 4548            |                             | 24                             | 90. |
| . 00   09100   EMERGENCY   |              | 0. 2458            |                             | 735                            |     |
| . 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)  |              | 0. 5529            |                             | 0                              |     |
| 0.00 Total (sum of lines 50 through 94 and 96 through 98)                                |              |                    | 836, 297                    | 214, 597                       |     |
| 1.00 Less PBP Clinic Laboratory Services-Program only charge                             | o (1: no (1) | 1                  | 0                           | 1                              | 201 |

| Health Financial Systems                | METHODIST HOSPITALS, INC | In Lie                                       | u of Form CMS-2552-10   |
|---|--------------------------|--|---|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-0002   | Peri od:<br>From 01/01/2021<br>To 12/31/2021 | Worksheet E<br>Part A<br>Date/Time Prepared:<br>5/27/2022 9:02 am |

|                  |   |                         | 10 12/31/2021    | 5/27/2022 9:0        |                |
|------------------|---|-------------------------|------------------|----------------------|----------------|
|                  |   | Title XVIII             | Hospi tal        | PPS                  |                |
|                  |   |                         |                  |                      |                |
|                  | DADT A LANDATI SHT HOODI TAL OFFINI OF A LINDED ADDO  |                         |                  | 1. 00                |                |
| 1 00             | PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS   |                         |                  | 0                    | 1 00           |
| 1. 00<br>1. 01   | DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring                          | a prior to October 1 (  |                  | 0                    | 1. 00<br>1. 01 |
| 1.01             | instructions)   | g piror to october i (  | See              | 24, 239, 334         | 1.01           |
| 1. 02            | DRG amounts other than outlier payments for discharges occurring  | a on or after October   | 1 (see           | 7, 191, 662          | 1. 02          |
| 02               | instructions)   | g a. te. eetebe.        | . (333           | 77 17 17 002         |                |
| 1.03             | DRG for federal specific operating payment for Model 4 BPCI for   | di scharges occurri ng  | prior to October | 0                    | 1.03           |
|                  | 1 (see instructions)  |                         |                  |                      |                |
| 1.04             | DRG for federal specific operating payment for Model 4 BPCI for   | di scharges occurri ng  | on or after      | 0                    | 1.04           |
|                  | October 1 (see instructions)  |                         |                  |                      |                |
| 2.00             | Outlier payments for discharges. (see instructions)   |                         |                  | 0                    | 2.00           |
| 2. 01<br>2. 02   | Outlier reconciliation amount   | na)                     |                  | 0                    | 2. 01<br>2. 02 |
| 2. 02            | Outlier payment for discharges for Model 4 BPCI (see instruction Outlier payments for discharges occurring prior to October 1 (se | •                       |                  | 1, 106, 412          | 2.02           |
| 2. 03            | Outlier payments for discharges occurring on or after October 1   |                         |                  | 463, 809             | 2.03           |
| 3. 00            | Managed Care Simulated Payments   | (See Thistractions)     |                  | 29, 257, 814         | 3.00           |
| 4. 00            | Bed days available divided by number of days in the cost report   | ina period (see instru  | ctions)          | 376. 52              | 4.00           |
|                  | Indirect Medical Education Adjustment   |                         | ,                |                      |                |
| 5.00             | FTE count for allopathic and osteopathic programs for the most  | recent cost reporting   | period ending on | 8. 53                | 5.00           |
|                  | or before 12/31/1996. (see instructions)  |                         |                  |                      |                |
| 6. 00            | FTE count for allopathic and osteopathic programs that meet the   | criteria for an add-c   | n to the cap for | 0. 00                | 6. 00          |
|                  | new programs in accordance with 42 CFR 413.79(e)  |                         |                  |                      |                |
| 7.00             | MMA Section 422 reduction amount to the IME cap as specified un   | - ,                     | . , . , . , . ,  | 0.00                 | 7.00           |
| 7. 01            | ACA § 5503 reduction amount to the IME cap as specified under 4.  | 2 CFR §412. 105(T)(1)(1 | V)(B)(2) IT the  | 0. 00                | 7. 01          |
| 8. 00            | cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopath         | ic and osteonathic pro  | arams for        | 0. 00                | 8. 00          |
| 0.00             | affiliated programs in accordance with 42 CFR 413.75(b), 413.79   |                         |                  | 0.00                 | 0.00           |
|                  | 1998), and 67 FR 50069 (August 1, 2002).  |                         |                  |                      |                |
| 8. 01            | The amount of increase if the hospital was awarded FTE cap slots  | s under § 5503 of the   | ACA. If the cost | 0.00                 | 8. 01          |
|                  | report straddles July 1, 2011, see instructions.  |                         |                  |                      |                |
| 8. 02            | The amount of increase if the hospital was awarded FTE cap slot   | s from a closed teachi  | ng hospi tal     | 0.00                 | 8. 02          |
|                  | under § 5506 of ACA. (see instructions)   |                         |                  |                      |                |
| 9. 00            | Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines   | (8, 8,01 and 8,02) (    | see              | 8. 53                | 9. 00          |
| 10.00            | instructions)   |                         | !-               | 2 00                 | 10.00          |
| 10. 00<br>11. 00 | FTE count for allopathic and osteopathic programs in the curren   | t year from your recor  | as               |                      | 10.00<br>11.00 |
|                  | FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)                           |                         |                  |                      | 12.00          |
| 13. 00           | Total allowable FTE count for the prior year.   |                         |                  |                      | 13.00          |
| 14. 00           | Total allowable FTE count for the penultimate year if that year   | ended on or after Ser   | tember 30. 1997. | 3. 00                | 1              |
|                  | otherwise enter zero.   |                         |                  | 2. 22                |                |
| 15.00            | Sum of lines 12 through 14 divided by 3.  |                         |                  | 3.00                 | 15.00          |
| 16.00            | Adjustment for residents in initial years of the program  |                         |                  | 0. 00                | 16.00          |
| 17. 00           | Adjustment for residents displaced by program or hospital closu   | re                      |                  |                      | 17. 00         |
|                  | Adjusted rolling average FTE count  |                         |                  |                      | 18. 00         |
|                  | Current year resident to bed ratio (line 18 divided by line 4).   |                         |                  | 0. 007968            | 1              |
|                  | Prior year resident to bed ratio (see instructions)   |                         |                  | 0.007423             |                |
| 21. 00           | Enter the lesser of lines 19 or 20 (see instructions)  IME payment adjustment (see instructions)                                  |                         |                  | 0.007423             |                |
| 22. 00<br>22. 01 | TME payment adjustment (see firstructions)  IME payment adjustment - Managed Care (see instructions)                              |                         |                  | 127, 296<br>118, 494 |                |
| 22.01            | Indirect Medical Education Adjustment for the Add-on for § 422 (  | of the MMA              |                  | 110, 474             | 22.01          |
| 23. 00           | Number of additional allopathic and osteopathic IME FTE residen   |                         | FR 412 105       | 0. 00                | 23.00          |
| 20.00            | (f)(1)(iv)(C).  | t sup store under the   |                  | 0.00                 | 20.00          |
| 24.00            | IME FTE Resident Count Over Cap (see instructions)  |                         |                  | -5. 53               | 24.00          |
| 25.00            | If the amount on line 24 is greater than -0-, then enter the lo   | wer of line 23 or line  | 24 (see          | 0.00                 | 1              |
|                  | instructions)   |                         |                  |                      |                |
| 26. 00           | Resident to bed ratio (divide line 25 by line 4)  |                         |                  | 0. 000000            |                |
|                  | IME payments adjustment factor. (see instructions)  |                         |                  | 0. 000000            |                |
|                  | IME add-on adjustment amount (see instructions)   |                         |                  |                      |                |
|                  | IME add-on adjustment amount - Managed Care (see instructions)  |                         |                  |                      | 28. 01         |
| 29. 00           |   |                         |                  |                      | 29.00          |
| 29. 01           | Total IME payment - Managed Care (sum of lines 22.01 and 28.01)   | 118, 494                | 29. 01           |                      |                |
| 30. 00           | Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A pat                                 | ient days (see instruc  | tions)           | 8. 90                | 30.00          |
|                  | Percentage of Medicaid patient days (see instructions)  | ieni uays (See institut | LI UIIS)         | 32. 33               |                |
| 32. 00           | l · · · · · · · · · · · · · · · · · · ·   |                         |                  | 41. 23               | 1              |
| 33. 00           | Allowable disproportionate share percentage (see instructions)  |                         |                  | 23. 23               | 1              |
|                  | Disproportionate share adjustment (see instructions)  |                         |                  | 1, 825, 355          | 1              |
|                  |   |                         | '                |                      |                |

|   | Financial Systems METHODIST HOSPI ATION OF REIMBURSEMENT SETTLEMENT   | Provider CCN: 15-0002    | Peri od:                         | u of Form CMS-2<br>Worksheet E           | 2552-10          |  |
|---|---|--------------------------|----------------------------------|--|------------------|--|
|   |   |                          | From 01/01/2021<br>To 12/31/2021 | Part A<br>Date/Time Pre<br>5/27/2022 9:0 | pared:<br>2 am   |  |
|   |   | Title XVIII              | Hospi tal                        | PPS                                      |                  |  |
|   |   |                          | Prior to 10/1<br>1.00            | 0n/After 10/1<br>2.00                    |                  |  |
|   | Uncompensated Care Adjustment   |                          | 1.00                             | 2.00                                     |                  |  |
| 35.00   | Total uncompensated care amount (see instructions)  |                          | 0                                | 0  | 35.00            |  |
| 35. 01  | Factor 3 (see instructions)   |                          | 0. 000000000                     | 0. 000000000                             | •                |  |
| 35. 02  | Hospital uncompensated care payment (If line 34 is zero, enteriors)   | er zero on this line) (s | ee 3, 595, 654                   | 3, 496, 630                              | 35. 02           |  |
| 35. 03  | instructions) Pro rata share of the hospital uncompensated care payment amounts are payment and payment amounts.              | ount (see instructions)  | 2, 689, 351                      | 881, 343                                 | 35. 03           |  |
| 36.00   | Total uncompensated care (sum of columns 1 and 2 on line 35.0   | 03)                      | 3, 570, 694                      |  | 36.00            |  |
|   | Additional payment for high percentage of ESRD beneficiary di   | scharges (lines 40 thro  |                                  |  |                  |  |
| 40.00   | Total Medicare discharges (see instructions)  |                          | 0                                |  | 40.00            |  |
| 41. 00<br>41. 01                                    | Total ESRD Medicare discharges (see instructions) Total ESRD Medicare covered and paid discharges (see instructions)          | ti ons)                  | 0                                |  | 41.00            |  |
| 41.01   | Divide line 41 by line 40 (if less than 10%, you do not quali   |                          | 0. 00                            |  | 41. 01<br>42. 00 |  |
| 43. 00  | Total Medicare ESRD inpatient days (see instructions)   | rry ron adjustment)      | 0.00                             |  | 43.00            |  |
| 44. 00  | Ratio of average length of stay to one week (line 43 divided  | by line 41 divided by 7  | 0. 000000                        |  | 44.00            |  |
|   | days)   |                          |                                  |  |                  |  |
| 45. 00  | Average weekly cost for dialysis treatments (see instructions<br>Total additional payment (line 45 times line 44 times line 4 |                          | 0.00                             |  | 45.00            |  |
| 46. 00<br>47. 00                                    | Subtotal (see instructions)   | 1.01)                    | 38, 524, 562                     |  | 46. 00<br>47. 00 |  |
| 48. 00  | Hospital specific payments (to be completed by SCH and MDH, s   | small rural hospitals    | 0 30, 324, 302                   |  | 48.00            |  |
|   | only. (see instructions)  |                          |                                  |  |                  |  |
|   |   |                          |                                  | Amount                                   |                  |  |
| 49. 00  | Total payment for inpatient operating costs (see instructions   | 2)                       |                                  | 1. 00<br>38. 643. 056                    | 49.00            |  |
| 50.00   | Payment for inpatient program capital (from Wkst. L, Pt. I am   |                          | )                                | 2, 705, 090                              |                  |  |
| 51.00   | Exception payment for inpatient program capital (Wkst. L, Pt.   |                          | ,                                | 2, 700, 070                              | 51.00            |  |
| 52.00   | Direct graduate medical education payment (from Wkst. E-4, Li   |                          |                                  | 92, 479                                  | 1                |  |
| 53.00   | Nursing and Allied Health Managed Care payment  |                          |                                  | 56, 781                                  | 53.00            |  |
| 54.00   | Special add-on payments for new technologies  |                          |                                  | 541, 828                                 |                  |  |
| 54. 01  | Islet isolation add-on payment  | (0)                      |                                  | 0  | 54. 01           |  |
| 55. 00<br>56. 00                                    | Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line (Cost of physicians' services in a teaching hospital (see into    |                          |                                  | 0  | 55. 00<br>56. 00 |  |
| 57. 00  | Routine service other pass through costs (from Wkst. D, Pt. 1   | •                        | through 35)                      | 0  | 57.00            |  |
| 58. 00  | Ancillary service other pass through costs from Wkst. D, Pt.  |                          | till ough oo).                   | 80, 500                                  | 1                |  |
| 59.00   | Total (sum of amounts on lines 49 through 58)   | ,                        |                                  | 42, 119, 734                             | 59.00            |  |
| 60.00   | Primary payer payments  |                          |                                  | 0  | 60.00            |  |
| 61. 00  | Total amount payable for program beneficiaries (line 59 minus   | s line 60)               |                                  | 42, 119, 734                             | 61.00            |  |
| 62.00   | Deductibles billed to program beneficiaries   |                          |                                  | 2, 846, 240                              |                  |  |
| 63.00   | Coinsurance billed to program beneficiaries   |                          |                                  | 470, 552                                 | 1                |  |
| 64. 00<br>65. 00                                    | Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)                                     |                          |                                  | 643, 742<br>418, 432                     | •                |  |
| 66. 00  | Allowable bad debts for dual eligible beneficiaries (see ins  | tructions)               |                                  | 410, 432                                 | 66.00            |  |
|   | Subtotal (line 61 plus line 65 minus lines 62 and 63)   | tructions)               |                                  | 39, 221, 374                             | 1                |  |
|   | Credits received from manufacturers for replaced devices for  | applicable to MS-DRGs (  | see instructions)                | 0  | 1                |  |
| 69. 00  | Outlier payments reconciliation (sum of lines 93, 95 and 96).   | (For SCH see instructio  | ns)                              | 0  | 69.00            |  |
| 70.00   | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  |                          |                                  | 0  | 70.00            |  |
| 70. 50  | Rural Community Hospital Demonstration Project (§410A Demons  | tration) adjustment (see | instructions)                    | 0  | 70.50            |  |
| 70. 87<br>70. 88                                    | Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)      |                          |                                  | 0  | 70. 87<br>70. 88 |  |
| 70. 88  | Pioneer ACO demonstration payment adjustment amount (see ins  | tructions)               |                                  | ا  | 70.88            |  |
| 70. 90  | HSP bonus payment HVBP adjustment amount (see instructions)   |                          |                                  | 0  | 70. 90           |  |
| 70. 91  | , ,   |                          |                                  |  |                  |  |
| 70. 92  |   |                          |                                  |  |                  |  |
| 70. 93  | HVBP payment adjustment amount (see instructions)   |                          |                                  | -42, 173                                 | 1                |  |
| 70.94 HRR adjustment amount (see instructions) -404 |   |                          |                                  |  | 1                |  |
|   | Recovery of accelerated depreciation  |                          |                                  | () (                                     | 70. 95           |  |

| Health Financial Systems CALCULATION OF REIMBURSEME         |  | ODIST HOSPITALS, INC<br>Provider ( | CCN: 15-0002 | Peri od:<br>From 01/01/2021<br>To 12/31/2021 |               | pared:             |
|---|--|------------------------------------|--------------|--|---------------|--------------------|
|   |  | Ti †I                              | e XVIII      | Hospi tal                                    | PPS           | ız aiii            |
| ·   |  | ,                                  |              | Y (yyyy)                                     | Amount        |                    |
|   |  |                                    |              | 0  | 1.00          |                    |
|   | nt for federal fiscal year (yyy                                    |                                    |              | 0  | 0             | 70. 96             |
|   | ederal year for the period pric                                    |                                    |              |  |               |                    |
|   | nt for federal fiscal year (yyy                                    |                                    |              | 0  | 0             | 70. 97             |
|   | ederal year for the period endi                                    | ng on or after 10/1)               |              |  |               | 70. 98             |
| 70.98 Low Volume Payment-<br>70.99 HAC adjustment amou      | nt (see instructions)  |                                    |              |  | 0             | 1                  |
|   | (line 67 minus lines 68 plus/m                                     | ninus lines 69 & 70)               |              |  | 38, 774, 966  |                    |
|   | tment (see instructions)   |                                    |              |  | 00,771,700    | 1                  |
|   | nt adjustment amount after sequ                                    | uestrati on                        |              |  | Ö             | 1                  |
|   | tment-PARHM pass-throughs  |                                    |              |  |               | 71.03              |
| 72.00 Interim payments                                      |  |                                    |              |  | 37, 671, 554  | 72.00              |
| 72.01   Interim payments-PA                                 |  |                                    |              |  |               | 72. 01             |
|   | t (for contractor use only)  |                                    |              |  | 0             |                    |
|   | t-PARHM (for contractor use onl                                    |                                    |              |  | 4 400 440     | 73. 01             |
| 74.00 Balance due provi de 73)                              | /program (line 71 minus lines                                      | 71.01, 71.02, 72, and              |              |  | 1, 103, 412   | 74.00              |
| 1 1   | r/program-PARHM (see instruction                                   | ons)                               | •            |  |               | 74. 01             |
|   | nonallowable cost report items)                                    |                                    |              |  | 985, 142      | 1                  |
| CMS Pub. 15-2, chap   | '  | , in accordance in th              |              |  | ,00,112       | 70.00              |
|   | CONTRACTOR (lines 90 through 96                                    | o)                                 |              |  |               | 1                  |
|   | nount from Wkst. E, Pt. A, line                                    | e 2, or sum of 2.03                |              |  | 0             | 90.00              |
| plus 2.04 (see inst   |  |                                    |              |  |               |                    |
|   | n Wkst. L, Pt. I, line 2   |                                    |              |  | 0             |                    |
|   | econciliation adjustment amount                                    |                                    |              |  | 0             | 1                  |
|   | onciliation adjustment amount (<br>culate the time value of money  |                                    |              |  | 0.00          |                    |
|   | for operating expenses (see in                                     |                                    |              |  | 0.00          | 1                  |
| 1   | for capital related expenses (                                     | •                                  |              |  | Ö             | 1                  |
|   |  | ,                                  | •            | Prior to 10/1                                | On/After 10/1 |                    |
|   |  |                                    |              | 1. 00  | 2. 00         |                    |
| HSP Bonus Payment Ar  |  |                                    |              |  |               |                    |
| 100.00 HSP bonus amount (s                                  |  |                                    |              | 0  | 0             | 100.00             |
| HVBP Adjustment for   |  |                                    |              | 0.000000000                                  | 0.000000000   | 101 00             |
| 101.00 HVBP adjustment fac                                  | unt for HSP bonus payment (see                                     | instructions)                      |              | 0. 0000000000                                |               | 101.00             |
| HRR Adjustment for I  |  | Tristructions)                     |              | 0  |               | 1102.00            |
| 103.00 HRR adjustment fact                                  |  |                                    |              | 0.0000                                       | 0.000         | 103.00             |
|   | nt for HSP bonus payment (see i                                    | nstructions)                       |              | 0  |               | 104.00             |
|   | oital Demonstration Project (§4                                    |                                    | ustment      |  | •             | 1                  |
| 200.00 Is this the first y                                  | ear of the current 5-year demor                                    | nstration period under             | the 21st     |  |               | 200.00             |
| Century Cures Act?  | Enter "Y" for yes or "N" for no                                    | D.                                 |              |  |               |                    |
| Cost Reimbursement  |  | D                                  |              |  | T             |                    |
|   | service costs (from Wkst. D-1,                                     | Pt. II, line 49)                   |              |  |               | 201.00             |
| 202.00 Medi care di scharges<br>203.00 Case-mi x adjustment | ,  |                                    |              |  |               | 202. 00<br>203. 00 |
|   | istration Target Amount Limitat                                    | ion (N/A in first year             | of the curr  | ent 5-vear demons                            | tration       | 1203.00            |
| peri od)  | Stration ranget Amount Limitat                                     | (W/A TII TITSE YEAT                | or the curr  | orre o year deliloris                        | 51.41.011     |                    |
| 204.00 Medicare target amo                                  | ınt  |                                    |              |  |               | 204. 00            |
|   | arget amount (line 203 times li                                    | ne 204)                            |              |  |               | 205.00             |
| 206.00 Medicare inpatient                                   | routine cost cap (line 202 time                                    | es line 205)                       |              |  |               | 206. 00            |
|   | re Part A Inpatient Reimbursem                                     |                                    |              |  |               | ļ                  |
|   | nt under the §410A Demonstration                                   |                                    |              |  |               | 207.00             |
|   | atient service costs (from Wkst<br>are LPPS payments (see instruct |                                    |              |  |               | 208.00             |
|   |  |                                    |              |  |               |                    |

209. 00

210.00

211. 00

212. 00 213. 00 218. 00

210.00 Reserved for future use

209.00 Adjustment to Medicare IPPS payments (see instructions)

(line 212 minus line 213) (see instructions)

211.00 Total adjustment to Medicare IPPS payments (see instructions)

Comparision of PPS versus Cost Reimbursement
212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)

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

| Hearth Frhancial Systems         | METHODIST HOSPIT | ALS, INC      |        | in Lieu   | 1 01 F01111 CW3-2552-10 |
|----------------------------------|------------------|---------------|--------|-----------|-------------------------|
| LOW VOLUME CALCULATION EXHIBIT 4 |                  | Provider CCN: |        |           | Worksheet E             |
|                                  |                  |               |        |           | Part A Exhibit 4        |
|                                  |                  |               |        |           | Date/Time Prepared:     |
|                                  |                  |               |        |           | 5/27/2022 9:02 am       |
|                                  |                  | Ti +Lo VI     | /1.1.1 | Hocni tal | DDC                     |

|                  |   |                         |                          |                         | 10                       | ) 12/31/2021                 | 5/27/2022 9:0              |                  |
|------------------|---|-------------------------|--------------------------|-------------------------|--------------------------|------------------------------|----------------------------|------------------|
|                  |   |                         | 1                        |                         | XVIII                    | Hospi tal                    | PPS                        |                  |
|                  |   | W/S E, Part A<br>line   | Amounts (from E, Part A) | Pre/Post<br>Entitlement | Period Prior<br>to 10/01 | Peri od<br>On/After<br>10/01 | Total (Col 2<br>through 4) |                  |
|                  |   | 0                       | 1. 00                    | 2.00                    | 3. 00                    | 4. 00                        | 5. 00                      |                  |
| 1. 00            | DRG amounts other than outlier payments   | 1. 00                   | 0                        | 0                       | 0                        | 0                            | 0                          | 1.00             |
| 1. 01            | DRG amounts other than outlier payments for discharges occurring prior to October 1                             | 1. 01                   | 24, 239, 334             | 0                       | 24, 239, 334             |                              | 24, 239, 334               | 1. 01            |
| 1. 02            | DRG amounts other than outlier<br>payments for discharges<br>occurring on or after October                      | 1. 02                   | 7, 191, 662              | 0                       |                          | 7, 191, 662                  | 7, 191, 662                | 1. 02            |
| 1. 03            | DRG for Federal specific operating payment for Model 4 BPCI occurring prior to                                  | 1. 03                   | 0                        | 0                       | 0                        |                              | 0                          | 1.03             |
| 1. 04            | October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1           | 1. 04                   | O                        | 0                       |                          | 0                            | 0                          | 1. 04            |
| 2. 00            | Outlier payments for discharges (see instructions)  | 2. 00                   |                          |                         |                          |                              |                            | 2.00             |
| 2. 01            | Outlier payments for discharges for Model 4 BPCI  | 2. 02                   | 0                        | 0                       | 0                        | 0                            | 0                          | 2. 01            |
| 2. 02            | Outlier payments for discharges occurring prior to  | 2. 03                   | 1, 106, 412              | 0                       | 1, 106, 412              |                              | 1, 106, 412                | 2. 02            |
| 2. 03            | October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see               | 2. 04                   | 463, 809                 | 0                       |                          | 463, 809                     | 463, 809                   | 2.03             |
| 3. 00            | instructions) Operating outlier reconciliation  | 2. 01                   | 0                        | 0                       | 0                        | 0                            | 0                          | 3. 00            |
| 4. 00            | Managed care simulated payments   | 3. 00                   | 29, 257, 814             | 0                       | 22, 190, 513             | 7, 067, 301                  | 29, 257, 814               | 4.00             |
|                  | Indirect Medical Education Adj  | ustment                 |                          |                         |                          |                              |                            |                  |
| 5. 00            | Amount from Worksheet E, Part A, line 21 (see instructions)   | 21. 00                  | 0. 007423                | 0. 007423               | 0. 007423                | 0. 007423                    |                            | 5.00             |
| 6. 00            | IME payment adjustment (see instructions)   | 22. 00                  | 127, 296                 | 0                       | 98, 170                  | 29, 126                      | 127, 296                   | 6. 00            |
| 6. 01            | IME payment adjustment for managed care (see instructions)  | 22. 01                  | 118, 494                 | 0                       | 89, 871                  | 28, 623                      | 118, 494                   | 6. 01            |
|                  | Indirect Medical Education Adj  | ustment for th          |                          |                         | the MMA                  |                              |                            |                  |
| 7. 00            | IME payment adjustment factor (see instructions)  | 27. 00                  | 0. 000000                | 0. 000000               | 0. 000000                | 0. 000000                    |                            | 7. 00            |
| 8. 00            | IME adjustment (see instructions)   | 28. 00                  | 0                        | 0                       | 0                        | 0                            | 0                          |                  |
| 8. 01            | IME payment adjustment add on for managed care (see instructions)   | 28. 01                  | 0                        | 0                       | 0                        | 0                            | 0                          | 8. 01            |
| 9. 00            | Total IME payment (sum of lines 6 and 8)  | 29. 00                  | 127, 296                 | 0                       | 98, 170                  | 29, 126                      | 127, 296                   | 9. 00            |
| 9. 01            | Total IME payment for managed care (sum of lines 6.01 and 8.01)   | 29. 01                  | 118, 494                 | 0                       | 89, 871                  | 28, 623                      | 118, 494                   | 9. 01            |
| 40               | Disproportionate Share Adjustm  |                         |                          |                         |                          |                              |                            | 46               |
| 10. 00           | Allowable disproportionate share percentage (see instructions)  | 33. 00                  | 0. 2323                  | 0. 2323                 | 0. 2323                  | 0. 2323                      |                            | 10.00            |
| 11. 00           | Disproportionate share adjustment (see instructions)  | 34.00                   | 1, 825, 355              | 0                       | 1, 407, 699              | 417, 656                     | 1, 825, 355                | 11.00            |
| 11. 01           | Uncompensated care payments   | 36. 00                  | 3, 570, 694              | 0                       | 2, 689, 351              | 881, 343                     | 3, 570, 694                | 11. 01           |
| 12. 00           | Additional payment for high pe<br>Total ESRD additional payment   | rcentage of ES<br>46.00 | RD beneficiary<br>0      | di scharges<br>0        | 0                        | 0                            | 0                          | 12.00            |
| 13. 00<br>14. 00 | (see instructions) Subtotal (see instructions) Hospital specific payments                                       | 47. 00<br>48. 00        | 38, 524, 562<br>0        | 0                       | 29, 540, 966<br>0        | 8, 983, 596<br>0             | 38, 524, 562<br>0          | 13. 00<br>14. 00 |
| 15. 00           | (completed by SCH and MDH,<br>small rural hospitals only.)<br>(see instructions)<br>Total payment for inpatient | 49. 00                  | 38, 643, 056             | 0                       | 29, 630, 837             | 9, 012, 219                  | 38, 643, 056               | 15 00            |
| . 5. 66          | operating costs (see<br>instructions)   | 00                      | 33, 010, 000             |                         | 27,000,007               | ,, 0,12, 217                 | 25, 010, 000               | .5. 65           |

| LOW VO           | LUME CALCULATION EXHIBIT 4  |                       |                          | Provi der Co            | CN: 15-0002              | Period:<br>From 01/01/2021<br>To 12/31/2021 | Worksheet E<br>Part A Exhibi<br>Date/Time Pre<br>5/27/2022 9:0 | pared:           |
|------------------|---|-----------------------|--------------------------|-------------------------|--------------------------|---|--|------------------|
|                  |   |                       |                          | Title                   | XVIII                    | Hospi tal                                   | PPS  |                  |
|                  |   | W/S E, Part A<br>line | Amounts (from E, Part A) | Pre/Post<br>Entitlement | Period Prior<br>to 10/01 | Peri od<br>On/After<br>10/01                | Total (Col 2<br>through 4)                                     |                  |
|                  |   | 0                     | 1. 00                    | 2. 00                   | 3. 00                    | 4. 00                                       | 5. 00  |                  |
| 16. 00           | Payment for inpatient program   | 50, 00                | 2, 705, 090              | 2.00                    |                          |   | 2, 705, 090  | 16 00            |
| 10.00            | capital (from Wkst. L, Pt. I, if applicable)  | 30.00                 | 2, 703, 040              | 0                       | 2, 072, 30               | 012, 550                                    | 2, 703, 040  | 10.00            |
|                  | Special add-on payments for new technologies  | 54. 00                | 541, 828                 | 0                       | 334, 74                  | 207, 088                                    | 541, 828   |                  |
| 17. 01           | Net organ aquisition cost   |                       |                          |                         |                          |   |  | 17. 01           |
| 17. 02           | Credits received from<br>manufacturers for replaced<br>devices for applicable MS-DRGs                 | 68. 00                | 0                        | 0                       |                          | 0 0   | 0  | 17. 02           |
| 18. 00           | Capital outlier reconciliation adjustment amount (see instructions)                                   | 93. 00                | 0                        | 0                       |                          | 0 0   | O  | 18. 00           |
| 10 00            | SUBTOTAL  |                       |                          | 0                       | 32, 058, 13              | 9, 831, 837                                 | 41, 889, 974   | 10 00            |
| 17.00            | JOBIOTAL  | W/S L, line           | (Amounts from            | 0                       | 32, 030, 13              | 7, 031, 037                                 | 41,007,774   | 17.00            |
|                  |   | W/ 3 L, TITIC         | L)                       |                         |                          |   |  |                  |
|                  |   | 0                     | 1. 00                    | 2. 00                   | 3. 00                    | 4. 00                                       | 5. 00  |                  |
| 20. 00           | Capital DRG other than outlier  | 1. 00                 | 2, 401, 235              | 0                       |                          |   | 2, 401, 235  | 20.00            |
| 20. 01           | Model 4 BPCI Capital DRG other<br>than outlier  | 1. 01                 | 0                        | 0                       |                          | 0 0   | 0  |                  |
| 21. 00<br>21. 01 | Capital DRG outlier payments<br>Model 4 BPCI Capital DRG<br>outlier payments                          | 2. 00<br>2. 01        | 85, 342<br>0             | 0<br>0                  | 57, 87                   | 0 27, 472<br>0 0                            | 85, 342<br>0   | 21. 00<br>21. 01 |
| 22. 00           | Indirect medical education percentage (see instructions)  | 5. 00                 | 0. 0039                  | 0. 0039                 | 0. 003                   | 0. 0039                                     |  | 22. 00           |
| 23. 00           | Indirect medical education adjustment (see instructions)  | 6. 00                 | 9, 365                   | 0                       | 7, 27                    | 2, 091                                      | 9, 365   | 23.00            |
| 24. 00           | Allowable disproportionate share percentage (see instructions)  | 10. 00                | 0. 0871                  | 0. 0871                 | 0. 087                   | 0. 0871                                     |  | 24.00            |
| 25. 00           | Disproportionate share adjustment (see instructions)  | 11. 00                | 209, 148                 | 0                       | 162, 44                  | 46, 708                                     | 209, 148   | 25.00            |
| 26. 00           | Total prospective capital payments (see instructions)   | 12. 00                | 2, 705, 090              | 0                       | 2, 092, 56               | 612, 530                                    | 2, 705, 090  | 26. 00           |
|                  |   | W/S E, Part A         | (Amounts to              |                         |                          |   |  |                  |
|                  |   | line                  | E, Part A)               |                         |                          |   |  |                  |
|                  |   | 0                     | 1. 00                    | 2. 00                   | 3. 00                    | 4.00  | 5. 00  |                  |
| 27. 00<br>28. 00 | Low volume adjustment factor<br>Low volume adjustment<br>(transfer amount to Wkst. E,<br>Pt. A, line) | 70. 96                |                          |                         | 0. 00000                 | 0.000000                                    | 0  | 27. 00<br>28. 00 |
| 29. 00           | Low volume adjustment<br>(transfer amount to Wkst. E,   | 70. 97                |                          |                         |                          | 0   | O  | 29. 00           |
| 100.00           | Pt. A, line)<br>Transfer low volume<br>adjustments to Wkst. E, Pt. A.                                 |                       | Y                        |                         |                          |   |  | 100. 00          |

|        |  |                |                 | To           | 12/31/2021  | Date/Time Pre<br>5/27/2022 9:00 |        |
|--------|--|----------------|-----------------|--------------|-------------|---------------------------------|--------|
|        |  |                | Title           | XVIII        | Hospi tal   | PPS                             |        |
|        |  | Wkst. E, Pt.   | Amt. from       | Period to    | Peri od on  | Total (cols.                    |        |
|        |  | A, line        | Wkst. E, Pt.    | 10/01        | after 10/01 | 2 and 3)                        |        |
|        |  |                | A)              |              |             |                                 |        |
|        |  | 0              | 1. 00           | 2. 00        | 3. 00       | 4. 00                           |        |
| 1.00   | DRG amounts other than outlier payments  | 1. 00          |                 |              |             |                                 | 1.00   |
| 1. 01  | DRG amounts other than outlier payments for                                    | 1. 01          | 24, 239, 334    | 24, 239, 334 |             | 24, 239, 334                    | 1. 01  |
|        | discharges occurring prior to October 1  |                |                 |              |             |                                 |        |
| 1. 02  | DRG amounts other than outlier payments for                                    | 1. 02          | 7, 191, 662     |              | 7, 191, 662 | 7, 191, 662                     | 1. 02  |
| 4 00   | discharges occurring on or after October 1                                     | 4 00           |                 |              |             |                                 | 4 00   |
| 1. 03  | DRG for Federal specific operating payment                                     | 1. 03          | 0               | 0            |             | 0                               | 1. 03  |
|        | for Model 4 BPCI occurring prior to October                                    |                |                 |              |             |                                 |        |
| 1. 04  | DRG for Federal specific operating payment                                     | 1. 04          | 0               |              | 0           | 0                               | 1. 04  |
| 1.04   | for Model 4 BPCI occurring on or after   | 1.04           |                 |              | Ö           | O                               | 1.04   |
|        | October 1  |                |                 |              |             |                                 |        |
| 2.00   | Outlier payments for discharges (see   | 2. 00          |                 |              |             |                                 | 2. 00  |
|        | instructions)  |                |                 |              |             |                                 |        |
| 2. 01  | Outlier payments for discharges for Model 4                                    | 2. 02          | 0               | 0            | 0           | 0                               | 2. 01  |
|        | BPCI   |                |                 |              |             |                                 |        |
| 2.02   | Outlier payments for discharges occurring                                      | 2. 03          | 1, 106, 412     | 1, 106, 412  |             | 1, 106, 412                     | 2.02   |
|        | prior to October 1 (see instructions)  |                |                 |              |             |                                 |        |
| 2. 03  | Outlier payments for discharges occurring on                                   | 2. 04          | 463, 809        |              | 463, 809    | 463, 809                        | 2. 03  |
|        | or after October 1 (see instructions)  | 0.04           |                 |              |             |                                 |        |
| 3.00   | Operating outlier reconciliation   | 2. 01          | 00 057 014      | 00 400 540   | 7 0/7 001   | 0                               | 3.00   |
| 4. 00  | Managed care simulated payments  | 3. 00          | 29, 257, 814    | 22, 190, 513 | 7, 067, 301 | 29, 257, 814                    | 4. 00  |
| E 00   | Indirect Medical Education Adjustment Amount from Worksheet E. Part A. Line 21 | 21. 00         | 0. 007423       | 0. 007423    | 0. 007423   |                                 | 5. 00  |
| 5. 00  | (see instructions)   | 21.00          | 0.007423        | 0.007423     | 0.007423    |                                 | 5.00   |
| 6. 00  | IME payment adjustment (see instructions)                                      | 22. 00         | 127, 296        | 98. 170      | 29, 126     | 127, 296                        | 6. 00  |
| 6. 01  | IME payment adjustment for managed care (see                                   |                | 118, 494        | 89, 871      | 28, 623     | 118, 494                        | 6. 01  |
|        | instructions)  |                | ,               | 21,211       | ,           | ,                               |        |
|        | Indirect Medical Education Adjustment for the                                  | e Add-on for S | ection 422 of t | he MMA       |             |                                 |        |
| 7.00   | IME payment adjustment factor (see   | 27. 00         | 0. 000000       | 0.000000     | 0. 000000   |                                 | 7.00   |
|        | instructions)  |                |                 |              |             |                                 |        |
| 8. 00  | IME adjustment (see instructions)  | 28. 00         | 0               | 0            | 0           | 0                               | 8. 00  |
| 8. 01  | IME payment adjustment add on for managed                                      | 28. 01         | 0               | 0            | 0           | 0                               | 8. 01  |
| 0.00   | care (see instructions)  | 00.00          | 407.00/         | 00 470       | 00.40/      | 407.004                         | 0.00   |
| 9.00   | Total IME payment (sum of lines 6 and 8)                                       | 29. 00         | 127, 296        | 98, 170      | 29, 126     | 127, 296                        | 9.00   |
| 9. 01  | Total IME payment for managed care (sum of                                     | 29. 01         | 118, 494        | 89, 871      | 28, 623     | 118, 494                        | 9. 01  |
|        | lines 6.01 and 8.01) Disproportionate Share Adjustment                         |                |                 |              |             |                                 |        |
| 10.00  | Allowable disproportionate share percentage                                    | 33. 00         | 0. 2323         | 0. 2323      | 0. 2323     |                                 | 10.00  |
| 10.00  | (see instructions)   | 00.00          | 0.2020          | 0. 2020      | 0. 2020     |                                 | 10.00  |
| 11.00  | Disproportionate share adjustment (see   | 34. 00         | 1, 825, 355     | 1, 407, 699  | 417, 656    | 1, 825, 355                     | 11.00  |
|        | instructions)  |                |                 |              |             |                                 |        |
| 11. 01 | Uncompensated care payments  | 36. 00         | 3, 570, 694     | 2, 689, 351  | 881, 343    | 3, 570, 694                     | 11. 01 |
|        | Additional payment for high percentage of ESI                                  |                | di scharges     |              |             |                                 |        |
| 12.00  | Total ESRD additional payment (see   | 46. 00         | 0               | 0            | 0           | 0                               | 12.00  |
| 40.05  | instructions)  | 47.00          | 00 504 515      | 00 540 0::   | 0.000.55    | 00 504 5:5                      | 40.00  |
| 13.00  | Subtotal (see instructions)  | 47. 00         | 38, 524, 562    | 29, 540, 966 | 8, 983, 596 |                                 |        |
| 14. 00 | Hospital specific payments (completed by SCH                                   | 48. 00         | 0               | U            | U           | 0                               | 14. 00 |
|        | and MDH, small rural hospitals only.) (see instructions)                       |                |                 |              |             |                                 |        |
| 15. 00 | Total payment for inpatient operating costs                                    | 49. 00         | 38, 643, 056    | 29, 630, 837 | 9, 012, 219 | 38, 643, 056                    | 15. 00 |
| 13.00  | (see instructions)   | 47.00          | 30, 043, 030    | 27, 030, 037 | 7, 012, 217 | 30, 043, 030                    | 13.00  |
| 16. 00 | Payment for inpatient program capital (from                                    | 50. 00         | 2, 705, 090     | 2, 092, 560  | 612, 530    | 2, 705, 090                     | 16. 00 |
| .0.00  | Wkst. L, Pt. I, if applicable)   | 00.00          | 2,,00,0,0       | 2,0,2,000    | 0.2,000     | 2,700,070                       |        |
| 17.00  | Special add-on payments for new technologies                                   | 54. 00         | 541, 828        | 334, 740     | 207, 088    | 541, 828                        | 17.00  |
| 17. 01 | Net organ acquisition cost   |                |                 |              | . ,         |                                 | 17. 01 |
| 17. 02 | Credits received from manufacturers for  | 68. 00         | o               | 0            | o           | 0                               | 17. 02 |
|        | replaced devices for applicable MS-DRGs  |                |                 |              |             |                                 |        |
| 18.00  | Capital outlier reconciliation adjustment                                      | 93. 00         | o               | 0            | o           | 0                               | 18.00  |
|        | amount (see instructions)  |                |                 |              |             |                                 |        |
| 19. 00 | SUBTOTAL   |                |                 | 32, 058, 137 | 9, 831, 837 | 41, 889, 974                    | 19. 00 |
|        |  |                |                 |              |             |                                 |        |

|                  | Financial Systems   | METHODIST HOS           |                            |            |   | eu of Form CMS-    | 2552-10 |
|------------------|---|-------------------------|----------------------------|------------|---|--------------------|---------|
| HOSPI T          | AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA   | ATION EXHIBIT 5         | Provider Co                |            | Period:<br>From 01/01/2021<br>To 12/31/2021 |                    | pared:  |
|                  |   |                         | Title                      | XVIII      | Hospi tal                                   | PPS                |         |
|                  |   | Wkst. L, line           | (Amt. from<br>Wkst. L)     |            |   |                    |         |
|                  |   | 0                       | 1.00                       | 2.00       | 3. 00                                       | 4. 00              |         |
| 20.00            | Capital DRG other than outlier  | 1. 00                   | 2, 401, 235                | 1, 864, 97 | 6 536, 259                                  | 2, 401, 235        | 20.00   |
| 20. 01           | Model 4 BPCI Capital DRG other than outlier   | 1. 01                   | 0                          |            | 0   | 0                  | 20. 01  |
| 21.00            | Capital DRG outlier payments  | 2. 00                   | 85, 342                    | 57, 87     | 0 27, 472                                   | 85, 342            | 21.00   |
| 21. 01           | Model 4 BPCI Capital DRG outlier payments   | 2. 01                   | 0                          |            | 0   | 0                  | 21. 01  |
| 22. 00           | Indirect medical education percentage (see instructions)                                | 5. 00                   | 0. 0039                    | 0. 003     | 0. 0039                                     |                    | 22.00   |
| 23. 00           | Indirect medical education adjustment (see instructions)                                | 6. 00                   | 9, 365                     | 7, 27      | 2, 091                                      | 9, 365             | 23.00   |
| 24. 00           | Allowable disproportionate share percentage (see instructions)                          | 10. 00                  | 0. 0871                    | 0. 087     | 0. 0871                                     |                    | 24.00   |
| 25. 00           | Disproportionate share adjustment (see instructions)                                    | 11. 00                  | 209, 148                   | 162, 44    | 46, 708                                     | 209, 148           | 25. 00  |
| 26. 00           | Total prospective capital payments (see instructions)                                   | 12. 00                  | 2, 705, 090                | 2, 092, 56 | 612, 530                                    | 2, 705, 090        | 26. 00  |
|                  |   | Wkst. E, Pt.<br>A, line | (Amt. from<br>Wkst. E, Pt. |            |   |                    |         |
|                  |   | 0                       | A)                         | 2.00       | 2.00  | 4.00               |         |
| 27. 00           |   | 0                       | 1.00                       | 2.00       | 3. 00                                       | 4. 00              | 27. 00  |
|                  | Law valuma adjustment najan ta Ostahan 1  | 70. 96                  |                            |            |   | 0                  |         |
| 28. 00<br>29. 00 | Low volume adjustment prior to October 1<br>Low volume adjustment on or after October 1 | 70. 96                  | 0                          |            | ١   | 0                  |         |
| 30.00            | HVBP payment adjustment (see instructions)  | 70. 97                  | -42, 173                   | -42, 17    | /2  | -42, 173           |         |
| 30. 00           | HVBP payment adjustment for HSP bonus   | 70. 93                  | -42, 1/3                   | -42, 17    | 0   | -42, 1/3<br>0      | 1       |
| 30.01            | payment (see instructions)  | 70. 90                  |                            |            |   | 0                  | 30.01   |
| 31.00            | HRR adjustment (see instructions)   | 70. 94                  | -404, 235                  | -329, 29   | -74, 942                                    | -404, 235          | 31.00   |
| 31. 01           | HRR adjustment for HSP bonus payment (see instructions)                                 | 70. 91                  | 0                          |            | 0 0   | 0                  | 31.01   |
|                  |   |                         |                            |            |   | (Amt. to           |         |
|                  |   |                         |                            |            |   | Wkst. E, Pt.<br>A) |         |
|                  |   | 0                       | 1.00                       | 2.00       | 3. 00                                       | 4. 00              |         |
| 32 00            | HAC Reduction Program adjustment (see   | 70 99                   | 1                          | I          | 0   | Ι 0                | 32.00   |

0 70. 99

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

0

32.00

100.00

| Health Financial Systems                | METHODIST HOSPITALS, INC | In Lieu of Form CMS-2552-10                  |   |  |
|---|--------------------------|--|---|--|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-0002   | Peri od:<br>From 01/01/2021<br>To 12/31/2021 | Worksheet E<br>Part B<br>Date/Time Prepared:<br>5/27/2022 9:02 am |  |

|                  |  | Title XVIII            | Hospi tal        | 5/27/2022 9: 0<br>PPS | 2 am             |
|------------------|--|------------------------|------------------|-----------------------|------------------|
|                  |  |                        |                  |                       |                  |
|                  | PART B - MEDICAL AND OTHER HEALTH SERVICES   |                        |                  | 1. 00                 |                  |
| 1.00             | Medical and other services (see instructions)  |                        |                  | 4, 000                | 1.00             |
| 2. 00            | Medical and other services reimbursed under OPPS (see instruction  | ons)                   |                  | 20, 492, 344          |                  |
| 3.00             | OPPS payments  |                        |                  | 17, 661, 811          | 3.00             |
| 4. 00            | Outlier payment (see instructions)   |                        |                  | 265, 073              |                  |
| 4. 01            | Outlier reconciliation amount (see instructions)   |                        |                  | 0                     |                  |
| 5. 00<br>6. 00   | Enter the hospital specific payment to cost ratio (see instructi<br>Line 2 times line 5  |                        | 0.000            |                       |                  |
| 7. 00            | Sum of lines 3, 4, and 4.01, divided by line 6   |                        |                  | 0.00                  |                  |
| 8. 00            | Transitional corridor payment (see instructions)   |                        |                  | 0.00                  | 1                |
| 9. 00            | Ancillary service other pass through costs from Wkst. D, Pt. IV,   | col. 13, line 200      |                  | 96, 848               |                  |
| 10.00            | Organ acqui si ti ons  |                        |                  | 0                     |                  |
| 11. 00           | Total cost (sum of lines 1 and 10) (see instructions)  |                        |                  | 4, 000                | 11.00            |
|                  | COMPUTATION OF LESSER OF COST OR CHARGES   |                        |                  |                       | -                |
| 12. 00           | Reasonable charges Ancillary service charges   |                        |                  | 19, 881               | 12.00            |
|                  | Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line   | e 69)                  |                  | 17, 001               | 1                |
| 14. 00           | Total reasonable charges (sum of lines 12 and 13)  | , 0,,                  |                  | 19, 881               |                  |
|                  | Customary charges  |                        |                  |                       |                  |
| 15. 00           | Aggregate amount actually collected from patients liable for page  |                        |                  | 0                     |                  |
| 16. 00           | Amounts that would have been realized from patients liable for patients liable for patients liable for patients.                 | payment for services o | on a chargebasis | 0                     | 16. 00           |
| 17. 00           | 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)             |                        |                  | 0. 000000             | 17. 00           |
| 18. 00           | Total customary charges (see instructions)   |                        |                  | 19, 881               |                  |
| 19. 00           | Excess of customary charges over reasonable cost (complete only  | if line 18 exceeds li  | ne 11) (see      | 15, 881               |                  |
|                  | instructions)  |                        | , (3.3.3         | ,                     |                  |
| 20.00            | Excess of reasonable cost over customary charges (complete only  | if line 11 exceeds li  | ne 18) (see      | 0                     | 20. 00           |
|                  | instructions)  |                        |                  | 4 000                 |                  |
| 21.00            | Lesser of cost or charges (see instructions)   |                        |                  | 4, 000<br>0           | 1                |
|                  | Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instruc                        | ctions)                |                  | 0                     | 1                |
| 24. 00           | Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)   | 18, 023, 732           |                  |                       |                  |
|                  | COMPUTATION OF REIMBURSEMENT SETTLEMENT  |                        |                  |                       |                  |
| 25.00            | Deductibles and coinsurance amounts (for CAH, see instructions)  |                        |                  | 0                     | 25.00            |
| 26.00            | Deductibles and Coinsurance amounts relating to amount on line 2   |                        |                  | 2, 634, 501           | 1                |
| 27. 00           | Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plu   | us the sum of lines 22 | 2 and 23] (see   | 15, 393, 231          | 27. 00           |
| 28. 00           | instructions)  Direct graduate medical education payments (from Wkst. E. 4. Line   | 2 EO)                  |                  | 35, 501               | 28. 00           |
|                  | Direct graduate medical education payments (from Wkst. E-4, line ESRD direct medical education costs (from Wkst. E-4, line 36)   | <i>5</i> 50)           |                  | 35, 501               |                  |
| 30.00            | Subtotal (sum of lines 27 through 29)  |                        |                  | 15, 428, 732          | 1                |
| 31.00            | Pri mary payer payments  |                        |                  | 7, 792                | 31.00            |
| 32. 00           | Subtotal (line 30 minus line 31)   |                        |                  | 15, 420, 940          | 32.00            |
| 00.00            | ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES   | 5)                     |                  |                       | 00.00            |
|                  | Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)   |                        |                  | 0<br>322, 535         |                  |
|                  | Adjusted reimbursable bad debts (see instructions)   |                        |                  | 209, 648              |                  |
|                  | Allowable bad debts for dual eligible beneficiaries (see instruc   | ctions)                |                  | 0                     | 1                |
| 37.00            | Subtotal (see instructions)  | ,                      |                  | 15, 630, 588          | 37.00            |
| 38.00            | MSP-LCC reconciliation amount from PS&R  |                        |                  | 244                   | 38.00            |
| 39. 00           | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   |                        |                  | 0                     |                  |
| 39. 50           | Pioneer ACO demonstration payment adjustment (see instructions)  |                        |                  | 0                     | 39. 50           |
| 39. 97           | Demonstration payment adjustment amount before sequestration<br>Partial or full credits received from manufacturers for replaced | d dovices (see instru  | stions)          | 0                     | 1                |
| 39. 99           | RECOVERY OF ACCELERATED DEPRECIATION   | devices (see ilistiud  | , ti olis)       | 0                     | 1                |
|                  | Subtotal (see instructions)  |                        |                  | 15, 630, 344          | 1                |
| 40. 01           | Sequestration adjustment (see instructions)  |                        |                  | 0                     | 1                |
| 40. 02           | Demonstration payment adjustment amount after sequestration  |                        |                  | 0                     | 40. 02           |
|                  | Sequestration adjustment-PARHM pass-throughs   |                        |                  |                       | 40. 03           |
|                  | Interim payments   |                        |                  | 16, 001, 433          | 1                |
| 41. 01<br>42. 00 | Interim payments-PARHM Tentative settlement (for contractors use only)   |                        |                  | 0                     | 41. 01<br>42. 00 |
| 42. 00           |  |                        |                  |                       | 42.00            |
| 43. 00           | Balance due provider/program (see instructions)  | -371, 089              | 1                |                       |                  |
| 43. 01           | Balance due provider/program-PARHM (see instructions)  |                        |                  | ,,,,,,,,              | 43. 01           |
| 44.00            | Protested amounts (nonallowable cost report items) in accordance   | e with CMS Pub. 15-2,  | chapter 1,       | 0                     | 1                |
|                  | §115. 2  |                        |                  |                       | ļ                |
| 00.00            | TO BE COMPLETED BY CONTRACTOR  |                        |                  | ^                     | 00.00            |
|                  | Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)                           |                        |                  | 0                     |                  |
|                  | The rate used to calculate the Time Value of Money   |                        |                  | 0.00                  |                  |
|                  | Time Value of Money (see instructions)   |                        |                  | 0.00                  | 1                |
|                  | Total (sum of lines 91 and 93)   |                        |                  |                       | 94.00            |
|                  |  |                        |                  |                       |                  |

Health Financial Systems METH ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1 From 01/01/2021 Part I To 12/31/2021 Date/Time Prepared: Provi der CCN: 15-0002

|       |  |            |             |              | 5/27/2022 9: 02 | 2 am   |
|-------|--|------------|-------------|--------------|-----------------|--------|
|       |  |            | XVIII       | Hospi tal    | PPS             |        |
|       |  | Inpatien   | t Part A    | Par          | rt B            |        |
|       |  | mm/dd/yyyy | Amount      | mm/dd/yyyy   | Amount          |        |
|       |  | 1.00       | 2. 00       | 3. 00        | 4.00            |        |
| 1. 00 | Total interim payments paid to provider                  |            | 36, 657, 66 | 3            | 15, 285, 773    | 1. 00  |
| 2.00  | Interim payments payable on individual bills, either     |            |             | 0            | 0               | 2.00   |
|       | submitted or to be submitted to the contractor for       |            |             |              |                 |        |
|       | services rendered in the cost reporting period. If none, |            |             |              |                 |        |
|       | write "NONE" or enter a zero                             |            |             |              |                 |        |
| 3.00  | List separately each retroactive lump sum adjustment     |            |             |              |                 | 3.00   |
|       | amount based on subsequent revision of the interim rate  |            |             |              |                 |        |
|       | for the cost reporting period. Also show date of each    |            |             |              |                 |        |
|       | payment. If none, write "NONE" or enter a zero. (1)      |            |             |              |                 |        |
|       | Program to Provider                                      |            |             |              |                 |        |
| 3. 01 | ADJUSTMENTS TO PROVIDER                                  | 12/31/2021 | 780, 69     | 1 12/31/2021 | 715, 660        | 3.01   |
| 3.02  |  | 12/31/2021 | 233, 20     | 0            | 0               | 3. 02  |
| 3.03  |  |            |             | 0            | 0               | 3.03   |
| 3.04  |  |            |             | o            | l ol            | 3.04   |
| 3.05  |  |            |             | o            | 0               | 3.05   |
|       | Provider to Program                                      |            |             | -            |                 |        |
| 3.50  | ADJUSTMENTS TO PROGRAM                                   |            |             | ol           | 0               | 3. 50  |
| 3. 51 |  |            |             | ol           | l ol            | 3. 51  |
| 3. 52 |  |            |             | o            |                 | 3. 52  |
| 3. 53 |  |            |             | Ö            | l ol            | 3. 53  |
| 3. 54 |  |            |             | Ö            | 0               | 3. 54  |
| 3. 99 | Subtotal (sum of lines 3.01-3.49 minus sum of lines      |            | 1, 013, 89  |              | 715, 660        | 3. 99  |
| 0. 77 | 3. 50-3. 98)   |            | 1,010,07    | '            | 710,000         | 0. , , |
| 4. 00 | Total interim payments (sum of lines 1, 2, and 3.99)     |            | 37, 671, 55 | 4            | 16, 001, 433    | 4. 00  |
| 00    | (transfer to Wkst. E or Wkst. E-3, line and column as    |            | 0.70,.700   |              | 10,001,100      | 00     |
|       | appropriate)   |            |             |              |                 |        |
|       | TO BE COMPLETED BY CONTRACTOR                            |            |             |              |                 |        |
| 5.00  | List separately each tentative settlement payment after  |            |             |              |                 | 5. 00  |
|       | desk review. Also show date of each payment. If none,    |            |             |              |                 |        |
|       | write "NONE" or enter a zero. (1)                        |            |             |              |                 |        |
|       | Program to Provider                                      |            |             |              |                 |        |
| 5. 01 | TENTATI VE TO PROVI DER                                  |            |             | o            | 0               | 5. 01  |
| 5. 02 |  |            |             | Ö            | l ol            | 5. 02  |
| 5. 03 |  |            |             | Ö            | 0               | 5. 03  |
|       | Provider to Program                                      |            |             | -1           | _               |        |
| 5. 50 | TENTATI VE TO PROGRAM                                    |            |             | 0            | 0               | 5. 50  |
| 5. 51 | TENTH VE TO THOUSE UNI                                   |            |             | o o          | l ol            | 5. 51  |
| 5. 52 |  |            |             | 0            |                 | 5. 52  |
| 5. 99 | Subtotal (sum of lines 5.01-5.49 minus sum of lines      |            |             | 0            |                 | 5. 99  |
| 5. 77 | 5. 50-5. 98)   |            |             |              | Ĭ               | 5. //  |
| 6. 00 | Determined net settlement amount (balance due) based on  |            |             |              |                 | 6. 00  |
| 5. 50 | the cost report. (1)                                     |            |             |              |                 | 0.00   |
| 6. 01 | SETTLEMENT TO PROVIDER                                   |            | 1, 103, 41  | 2            | 0               | 6. 01  |
| 6. 02 | SETTLEMENT TO PROGRAM                                    |            |             | 0            | 371, 089        | 6. 02  |
| 7. 00 | Total Medicare program liability (see instructions)      |            | 38, 774, 96 | -            | 15, 630, 344    | 7. 00  |
| 7.00  | Total medicale program traditity (see this tructions)    |            | 30, 114, 90 | Contractor   | NPR Date        | 7.00   |
|       |  |            |             | Number       | (Mo/Day/Yr)     |        |
|       |  |            | )           | 1. 00        | 2. 00           |        |
| 8. 00 | Name of Contractor                                       |            | ,           | 1.00         | 2.00            | 8. 00  |
| 0.00  | INAMIC OF CONTRACTOR                                     |            |             | 1            | 1               | 0.00   |

| Health Financial Systems                | METHODIST HOSPIT  | ΓALS, INC |                              | In Lie                                       | u of Form CMS-2552-10   |
|---|-------------------|-----------|------------------------------|--|---|
| ANALYSIS OF PAYMENTS TO PROVIDERS FOR S | ERVI CES RENDERED |           | CCN: 15-0002<br>CCN: 15-S002 | Peri od:<br>From 01/01/2021<br>To 12/31/2021 | Worksheet E-1<br>Part I<br>Date/Time Prepared:<br>5/27/2022 9:02 am |

|          |  |            |          |                | 5/27/2022 9: | 02 a |
|----------|--|------------|----------|----------------|--------------|------|
|          |  | Titl∈      | XVIII    | Subprovi der - | PPS          |      |
|          |  | Inpatier   | t Part A | I PF<br>Par    | t B          |      |
|          |  |            |          |                |              |      |
|          |  | mm/dd/yyyy | Amount   | mm/dd/yyyy     | Amount       |      |
|          | T  | 1.00       | 2. 00    | 3. 00          | 4. 00        |      |
| 00       | Total interim payments paid to provider  |            | 336, 867 |                |              | 0 1  |
| 00       | Interim payments payable on individual bills, either submitted or to be submitted to the contractor for  |            | (        | )              | 1            | 0 2  |
|          | services rendered in the cost reporting period. If none,   |            |          |                |              |      |
|          | write "NONE" or enter a zero   |            |          |                |              |      |
| 00       | List separately each retroactive lump sum adjustment   |            |          |                |              | 3    |
|          | 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)  |            |          |                |              |      |
| 01       | Program to Provider ADJUSTMENTS TO PROVIDER  | I          |          | 7              | I            | 0 3  |
| )2       | ADJUSTIMENTS TO PROVIDER   |            |          | -              |              | 0 3  |
| 03       |  |            |          |                |              | 0 3  |
| 04       |  |            | ď        |                |              | 0 3  |
| 05       |  |            | (        |                |              | 0 3  |
|          | Provider to Program  |            |          |                |              |      |
| 0        | ADJUSTMENTS TO PROGRAM   |            | (        |                |              | 0 3  |
| 51       |  |            | (        |                |              | 0 3  |
| 52<br>53 |  |            | (        |                |              | 0 3  |
| 54       |  |            |          |                |              | 0 3  |
| 99       | Subtotal (sum of lines 3.01-3.49 minus sum of lines  |            |          |                |              | 0 3  |
| , ,      | 3. 50-3. 98)   |            | `        |                |              |      |
| 00       | Total interim payments (sum of lines 1, 2, and 3.99)   |            | 336, 867 | 7              |              | 0 4  |
|          | (transfer to Wkst. E or Wkst. E-3, line and column as  |            |          |                |              |      |
|          | appropri ate)  |            |          |                |              |      |
| 00       | TO BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after   |            |          |                |              | ٦ ,  |
| 00       | desk review. Also show date of each payment. If none,  |            |          |                |              | `    |
|          | write "NONE" or enter a zero. (1)  |            |          |                |              |      |
|          | Program to Provider  |            |          |                |              |      |
| )1       | TENTATI VE TO PROVI DER  |            | (        |                |              | 0 5  |
| )2       |  |            | (        |                |              | 0 5  |
| 03       | Dravi dan ta Dragnam   |            |          | )              |              | 0 5  |
| 50       | Provider to Program TENTATIVE TO PROGRAM   |            |          |                |              | 5 5  |
| 51       | TENTATI VE TO TROOTONI   |            |          | -              |              | 0 5  |
| 52       |  |            | ď        |                |              | 0 5  |
| 9        | Subtotal (sum of lines 5.01-5.49 minus sum of lines  |            | (        |                |              | 0 5  |
|          | 5. 50-5. 98)   |            |          |                |              |      |
| 00       | Determined net settlement amount (balance due) based on  |            |          |                |              | 6    |
| 1        | the cost report. (1) SETTLEMENT TO PROVIDER  |            | 18, 228  |                |              | 0 6  |
| )2       | SETTLEMENT TO PROVIDER   |            | 18, 226  |                |              |      |
| 00       | Total Medicare program liability (see instructions)  |            | 355, 095 | -              |              | 0 7  |
|          | ,, (22221. 221. 210)   |            |          | Contractor     | NPR Date     |      |
|          |  |            |          | Number         | (Mo/Day/Yr)  |      |
|          | To the second se |            | )        | 1. 00          | 2. 00        |      |
| 00       | Name of Contractor   |            |          |                |              | 8    |

| Health Financial Systems                | METHODI ST HOSI    | PITALS, INC            | In Lie                      | u of Form CMS-2552-10                 |
|---|--------------------|------------------------|-----------------------------|---------------------------------------|
| ANALYSIS OF PAYMENTS TO PROVIDERS FOR S | SERVI CES RENDERED | Provider CCN: 15-0002  | Peri od:<br>From 01/01/2021 | Worksheet E-1<br>Part I               |
|   |                    | Component CCN: 15-T002 | To 12/31/2021               | Date/Time Prepared: 5/27/2022 9:02 am |
|   |                    | Title XVIII            | Subprovi der -              | PPS                                   |

|                |   | Title      | XVIII       | Subprovi der  -<br>I RF | PPS         |                |
|----------------|---|------------|-------------|-------------------------|-------------|----------------|
|                |   | Inpatien   | t Part A    | Par                     | t B         |                |
|                |   | mm/dd/yyyy | Amount      | mm/dd/yyyy              | Amount      |                |
|                |   | 1. 00      | 2.00        | 3. 00                   | 4. 00       |                |
| 1.00           | Total interim payments paid to provider   |            | 3, 586, 771 |                         | 0           | 1.00           |
| 2. 00          | Interim payments payable on individual bills, either submitted or to be submitted to the contractor for |            | O           |                         | 0           | 2.00           |
|                | services rendered in the cost reporting period. If none,  |            |             |                         |             |                |
|                | write "NONE" or enter a zero  |            |             |                         |             |                |
| 3.00           | List separately each retroactive lump sum adjustment  |            |             |                         |             | 3.00           |
|                | amount based on subsequent revision of the interim rate   |            |             |                         |             |                |
|                | for the cost reporting period. Also show date of each   |            |             |                         |             |                |
|                | payment. If none, write "NONE" or enter a zero. (1)   |            |             |                         |             |                |
| 3. 01          | Program to Provider ADJUSTMENTS TO PROVIDER   |            |             |                         | 0           | 3.01           |
| 3. 01          | ADJUSTMENTS TO PROVIDER   |            |             |                         | 0           | 3.01           |
| 3. 03          |   |            |             |                         | 0           | 3.03           |
| 3. 04          |   |            | O           |                         | 0           | 3. 04          |
| 3.05           |   |            | O           |                         | 0           | 3.05           |
|                | Provider to Program   |            |             |                         |             |                |
| 3.50           | ADJUSTMENTS TO PROGRAM  |            | 0           |                         | 0           | 3. 50          |
| 3. 51          |   |            | 0           |                         | 0           | 3. 51          |
| 3. 52<br>3. 53 |   |            |             |                         | 0           | 3. 52<br>3. 53 |
| 3. 53          |   |            |             |                         | 0           | 3.54           |
| 3. 99          | Subtotal (sum of lines 3.01-3.49 minus sum of lines   |            |             |                         |             | 3. 99          |
| 0. 77          | 3. 50-3. 98)  |            |             |                         |             | 0. 77          |
| 4.00           | Total interim payments (sum of lines 1, 2, and 3.99)  |            | 3, 586, 771 |                         | 0           | 4.00           |
|                | (transfer to Wkst. E or Wkst. E-3, line and column as   |            |             |                         |             |                |
|                | appropri ate)   |            |             |                         |             |                |
| 5. 00          | TO BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after                  |            | I           | I                       | I           | F 00           |
| 5.00           | desk review. Also show date of each payment. If none,   |            |             |                         |             | 5. 00          |
|                | write "NONE" or enter a zero. (1)   |            |             |                         |             |                |
|                | Program to Provider   |            |             |                         |             |                |
| 5. 01          | TENTATI VE TO PROVIDER  |            | C           |                         | 0           | 5. 01          |
| 5. 02          |   |            | 0           |                         | 0           |                |
| 5. 03          |   |            | 0           |                         | 0           | 5.03           |
| F F0           | Provider to Program TENTATIVE TO PROGRAM  |            |             |                         | 0           |                |
| 5. 50<br>5. 51 | TENTATIVE TO PROGRAM  |            |             |                         |             | 5. 50<br>5. 51 |
| 5. 52          |   |            |             |                         |             | 5.52           |
| 5. 99          | Subtotal (sum of lines 5.01-5.49 minus sum of lines   |            | ĺ           |                         | l ő         | 5. 99          |
|                | 5. 50-5. 98)  |            |             |                         |             |                |
| 6.00           | Determined net settlement amount (balance due) based on   |            |             |                         |             | 6.00           |
|                | the cost report. (1)  |            |             |                         |             | ,              |
| 6. 01          | SETTLEMENT TO PROVIDER  |            | 27, 334     |                         | 0           | 6. 01          |
| 6. 02<br>7. 00 | SETTLEMENT TO PROGRAM   Total Medicare program liability (see instructions)                             |            | 3, 614, 105 |                         | 0           | 6. 02<br>7. 00 |
| 7.00           | Tiotal medicale program Habitity (see Histructions)   |            | 3,014,105   | Contractor              | NPR Date    | 7.00           |
|                |   |            |             | Number                  | (Mo/Day/Yr) |                |
|                |   | (          | )           | 1. 00                   | 2.00        |                |
| 8. 00          | Name of Contractor  |            |             |                         |             | 8. 00          |
|                |   |            |             |                         |             |                |

| Health Financial Systems METHODIST HOSPITALS, INC In Lieu |  |                  |   | u of Form CMS-:  | 2552-10                     |          |
|---|--|------------------|---|------------------|-----------------------------|----------|
|   | ATION OF REIMBURSEMENT SETTLEMENT FOR HIT                    |                  | Provi der CCN: 15-0002                  | Peri od:         | Worksheet E-1               |          |
|   |  |                  |   | From 01/01/2021  | Part II                     |          |
|   |  |                  |   | To 12/31/2021    | Date/Time Pre 5/27/2022 9:0 |          |
| -   |  |                  | Title XVIII                             | Hospi tal        | PPS                         | <u> </u> |
|   |  |                  |   |                  |                             |          |
|   |  |                  |   |                  | 1.00                        |          |
|   | TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD                | COST REPORTS     |   |                  |                             |          |
|   | HEALTH INFORMATION TECHNOLOGY DATA COLLECTION                | AND CALCULATION  |   |                  |                             |          |
| 1.00  | Total hospital discharges as defined in AARA                 |                  |   |                  |                             | 1.00     |
| 2.00  | Medicare days (Wkst. S-3, Pt. I, col. 6, sum                 |                  | 8 through 12, and plus 1                | for cost         |                             | 2.00     |
|   | reporting periods beginning on or after 10/01/2013, line 32) |                  |   |                  |                             |          |
| 3. 00   | Medicare HMO days from Wkst. S-3, Pt. I, col.                |                  |   |                  |                             | 3.00     |
| 4. 00   | Total inpatient days (Wkst. S-3, Pt. I, col.                 |                  | 1, and 8 through 12, and                | d plus for cost  |                             | 4.00     |
| F 00  | reporting periods beginning on or after 10/01.               |                  |   |                  |                             | F 00     |
| 5.00  | Total hospital charges from Wkst C, Pt. I, co                |                  |   |                  |                             | 5.00     |
| 6.00  | Total hospital charity care charges from Wkst                |                  |   | WI - 1 C O D     |                             | 6.00     |
| 7. 00   | CAH only - The reasonable cost incurred for the line 168     | ne purchase or c | ertified Hil technology                 | WKSt. 5-2, Pt. I |                             | 7.00     |
| 8. 00   | Calculation of the HIT incentive payment (see                | instructions)    |   |                  |                             | 8.00     |
| 9. 00   | Sequestration adjustment amount (see instruct                |                  |   |                  |                             | 9.00     |
| 10.00   |  |                  | (see instructions)                      |                  |                             | 10.00    |
| 10.00   | INPATIENT HOSPITAL SERVICES UNDER THE IPPS & (               |                  | (See Tristructions)                     |                  |                             | 10.00    |
| 30 00   | Initial/interim HIT payment adjustment (see in               |                  |   |                  |                             | 30.00    |
|   | Other Adjustment (specify)                                   | nstructions)     |   |                  |                             | 31.00    |
|   |  |                  |   |                  |                             | 32.00    |
|   | 1  |                  | , (111111111111111111111111111111111111 | -/               |                             | 1        |

| Health Financial Systems                | METHODIST HOSPITALS, INC | In Lieu                     | u of Form CMS-2552-10                 |
|---|--------------------------|-----------------------------|---------------------------------------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-0002   | Peri od:<br>From 01/01/2021 | Worksheet E-3<br>Part II              |
|   | Component CCN: 15-S002   | To 12/31/2021               | Date/Time Prepared: 5/27/2022 9:02 am |
|   | Title XVIII              | Subprovi der -              | PPS                                   |
|   |                          | IDF                         |                                       |

|   |   | . I PF            |                        |      |
|---|---|-------------------|------------------------|------|
|   |   | -                 | 1. 00                  |      |
| PART II - MEDICARE PART A SERVICES - IPF PPS  |   |                   |                        |      |
| 00 Net Federal IPF PPS Payments (excluding outlier, ECT, and med  | cal education payments)                 |                   | 369, 439               | 7    |
| Net IPF PPS Outlier Payments  |   |                   | 0                      |      |
| Net IPF PPS ECT Payments  |   |                   | 0                      |      |
| OO Unweighted intern and resident FTE count in the most recent co   | ost report filed on or b                | efore November    | 0. 00                  |      |
| 15, 2004. (see instructions)  |   |                   |                        |      |
| Of Cap increases for the unweighted intern and resident FTE coun  | t for residents that wer                | e displaced by    | 0. 00                  |      |
| program or hospital closure, that would not be counted withou   | t a temporary cap adjust                | ment under 42     |                        |      |
| CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)   |   |                   |                        |      |
| New Teaching program adjustment. (see instructions)   |   |                   | 0. 00                  |      |
| OO Current year's unweighted FTE count of I&R excluding FTEs in   | the new program growth p                | eriod of a "new   | 0. 00                  |      |
| teaching program" (see instuctions)   |   |                   | 0.00                   |      |
| Current year's unweighted I&R FTE count for residents within  | the new program growth p                | eriod of a "new   | 0. 00                  | )    |
| teaching program" (see instuctions)  Intern and resident count for IPF PPS medical education adjus                                    | tmant (ass instructions)                |                   | 0. 00                  |      |
| On Intern and resident count for IPF PPS medical education adjust<br>Average Daily Census (see instructions)                          | tment (see instructions)                |                   | 3. 394521              |      |
| 00   Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to   | the power of 5150 1)                    |                   | 0. 000000              |      |
| 00   Teaching Adjustment (line 1 multiplied by line 10).  | the power or .5150 -1).                 |                   | 0.000000               |      |
| 00 Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)  |   |                   | 369, 439               |      |
| ON Nursing and Allied Health Managed Care payment (see instruction  | an)                                     |                   | 0                      |      |
| 00 Organ acquisition (DO NOT USE THIS LINE)   | 511)                                    |                   | O                      | Ίί   |
| 00 Cost of physicians' services in a teaching hospital (see insti   | ructions)                               |                   | 0                      |      |
| 00   Subtotal (see instructions)  | de (1 0113)                             |                   | 369, 439               |      |
| On Primary payer payments   |   |                   | 0                      |      |
| 00 Subtotal (line 16 less line 17).   |   |                   | 369, 439               |      |
| 00 Deductibles  |   |                   | 32, 572                |      |
| 00 Subtotal (line 18 minus line 19)   |   |                   | 336, 867               |      |
| 00   Coi nsurance   |   |                   | 0                      |      |
| 00 Subtotal (line 20 minus line 21)   |   |                   | 336, 867               | 1 2  |
| 00 Allowable bad debts (exclude bad debts for professional service  | ces) (see instructions)                 |                   | 27, 534                |      |
| 00 Adjusted reimbursable bad debts (see instructions)   | , ( , , , , , , , , , , , , , , , , , , |                   | 17, 897                |      |
| 00 Allowable bad debts for dual eligible beneficiaries (see inst  | ructions)                               |                   | 0                      | ) 2  |
| 00 Subtotal (sum of lines 22 and 24)  | •                                       |                   | 354, 764               | 1 2  |
| 00 Direct graduate medical education payments (see instructions)  |   |                   | 0                      | ) 2  |
| 00 Other pass through costs (see instructions)  |   |                   | 331                    | 1 2  |
| 00 Outlier payments reconciliation  |   |                   | 0                      | ) 2  |
| OO OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   |   |                   | 0                      | ) 3  |
| 50 Pioneer ACO demonstration payment adjustment (see instructions   | s)                                      |                   | 0                      | ) 3  |
| 98 Recovery of accelerated depreciation.  |   |                   | 0                      | ) 3  |
| 99 Demonstration payment adjustment amount before sequestration   |   |                   | 0                      | -    |
| 00 Total amount payable to the provider (see instructions)  |   |                   | 355, 095               |      |
| 01   Sequestration adjustment (see instructions)  |   |                   | 0                      |      |
| 02 Demonstration payment adjustment amount after sequestration  |   |                   | 0                      |      |
| 00  Interim payments  |   |                   | 336, 867               |      |
| OD Tentative settlement (for contractor use only)   |   |                   | 0                      |      |
| 00 Balance due provider/program (line 31 minus lines 31.01, 31.0)   | •                                       |                   | 18, 228                |      |
| On Protested amounts (nonallowable cost report items) in accordance   | nce with CMS Pub. 15-2,                 | chapter 1,        | 0                      | ) 3  |
| §115. 2   |   |                   |                        | -    |
| TO BE COMPLETED BY CONTRACTOR   |   |                   |                        | ١.   |
| On Original outlier amount from Worksheet E-3, Part II, line 2  |   |                   | 0                      | 1 ~  |
| 00 Outlier reconciliation adjustment amount (see instructions)  |   |                   | 0                      |      |
| On The rate used to calculate the Time Value of Money   |   |                   | 0. 00                  |      |
| OD Time Value of Money (see instructions)   | DECLINIUM DEFORE THE EN                 | ) OF THE COVER 10 | 0                      | ) 5  |
| FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND   |   |                   |                        | 4 ~  |
| 00 Teaching Adjustment Factor for the cost reporting period immed<br>01 Calculated Teaching Adjustment Factor for the current year. ( | <b>3</b> .                              | y 27, 2020.       | 0. 000000<br>0. 000000 |      |
| or partared reaching Aujustilicit ractor for the current year. (  | see riisti uetrulis)                    | I                 | 0.000000               | '  7 |

| Heal th | Financial Systems                             | METHODI ST HOSPI | TALS, INC              | In Lie                      | u of Form CMS-2                  | 552-10         |
|---------|---|------------------|------------------------|-----------------------------|----------------------------------|----------------|
| CALCUL  | ATION OF REIMBURSEMENT SETTLEMENT             |                  | Provider CCN: 15-0002  | Peri od:<br>From 01/01/2021 | Worksheet E-3<br>Part III        |                |
|         |   |                  | Component CCN: 15-T002 | To 12/31/2021               | Date/Time Prep<br>5/27/2022 9:02 | oared:<br>2 am |
|         |   |                  | Title XVIII            | Subprovi der -              | PPS                              |                |
|         |   |                  |                        | I RF                        |                                  |                |
|         |   |                  |                        |                             |                                  |                |
|         |   |                  |                        |                             | 1. 00                            |                |
|         | PART III - MEDICARE PART A SERVICES - IRF PPS | )                |                        |                             |                                  |                |
| 1.00    | Net Federal PPS Payment (see instructions)    |                  |                        |                             | 3, 298, 636                      | 1.00           |
| 2.00    | Medicare SSI ratio (IRF PPS only) (see instru | uctions)         |                        |                             | 0. 0777                          | 2.00           |
| 3.00    | Inpatient Rehabilitation LIP Payments (see in | nstructions)     |                        |                             | 234, 533                         | 3.00           |

|                  |  | 1. 00            |        |
|------------------|--|------------------|--------|
|                  | PART III - MEDICARE PART A SERVICES - IRF PPS  |                  |        |
| 1.00             | Net Federal PPS Payment (see instructions)   | 3, 298, 636      | 1.00   |
| 2.00             | Medicare SSI ratio (IRF PPS only) (see instructions)   | 0. 0777          | 2.00   |
| 3.00             | Inpatient Rehabilitation LIP Payments (see instructions)   | 234, 533         | 3.00   |
| 4.00             | Outlier Payments   | 106, 068         | 4. 00  |
| 5.00             | Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior         | 0.00             | 5. 00  |
|                  | to November 15, 2004 (see instructions)  |                  |        |
| 5. 01            | Cap increases for the unweighted intern and resident FTE count for residents that were displaced by          | 0. 00            | 5. 01  |
|                  | program or hospital closure, that would not be counted without a temporary cap adjustment under 42           |                  |        |
| 6. 00            | CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)  New Teaching program adjustment. (see instructions) | 0.00             | 6. 00  |
| 7. 00            | Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new         | 0.00             | 7.00   |
| 7.00             | teaching program" (see instructions)   | 0.00             | 7.00   |
| 8.00             | Current year's unweighted I&R FTE count for residents within the new program growth period of a "new         | 0.00             | 8. 00  |
|                  | teaching program" (see instructions)   |                  |        |
| 9.00             | Intern and resident count for IRF PPS medical education adjustment (see instructions)                        | 0.00             | 9.00   |
| 10.00            | Average Daily Census (see instructions)  | 11. 780822       | 10.00  |
| 11. 00           | Teaching Adjustment Factor (see instructions)  | 0. 000000        | 1      |
| 12. 00           | Teaching Adjustment (see instructions)   | 0                |        |
| 13. 00           |  | 3, 639, 237      |        |
| 14.00            | Nursing and Allied Health Managed Care payments (see instruction)  | 0                |        |
|                  | 5  |                  | 15.00  |
| 16.00            | Cost of physicians' services in a teaching hospital (see instructions)                                       | 0                |        |
|                  | Subtotal (see instructions)  | 3, 639, 237      | 1      |
|                  | Primary payer payments Subtotal (line 17 less line 18).  | 0<br>3, 639, 237 | •      |
|                  | Deductibles  | 13, 356          |        |
|                  | Subtotal (line 19 minus line 20)   | 3, 625, 881      |        |
| 22. 00           |  | 16, 695          | 1      |
| 23. 00           |  | 3, 609, 186      | •      |
|                  | Allowable bad debts (exclude bad debts for professional services) (see instructions)                         |                  | 24.00  |
|                  | Adjusted reimbursable bad debts (see instructions)   | 4, 919           | •      |
|                  | Allowable bad debts for dual eligible beneficiaries (see instructions)                                       | 0                | 26.00  |
| 27.00            | Subtotal (sum of lines 23 and 25)  | 3, 614, 105      | 27. 00 |
| 28.00            | Direct graduate medical education payments (from Wkst. E-4, line 49)   | 0                | 28. 00 |
|                  | Other pass through costs (see instructions)  | 0                | 29. 00 |
|                  | Outlier payments reconciliation  | 0                |        |
|                  | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   | 0                |        |
|                  | Pioneer ACO demonstration payment adjustment (see instructions)  | 0                |        |
| 31. 98           | Recovery of accel erated depreciation.   | 0                |        |
| 31. 99           | Demonstration payment adjustment amount before sequestration   | 0                |        |
| 32. 00<br>32. 01 |  | 3, 614, 105<br>0 |        |
|                  | Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration     |                  |        |
|                  | Interim payments   | 3, 586, 771      |        |
|                  | Tentative settlement (for contractor use only)   | 3, 300, 771      | 1      |
| 35. 00           | Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)                                  | 27, 334          | 1      |
| 36. 00           | Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,              | 0                | 36.00  |
|                  | §115. 2  | -                |        |
|                  | TO BE COMPLETED BY CONTRACTOR  |                  |        |
| 50.00            | Original outlier amount from Wkst. E-3, Pt. III, line 4  | 106, 068         | 50.00  |
| 51.00            | Outlier reconciliation adjustment amount (see instructions)  | 0                | 51.00  |
| 52.00            | · · · · · · · · · · · · · · · · · · ·  | 0.00             |        |
| 53.00            | Time Value of Money (see instructions)   | 0                | 53.00  |
|                  | FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-1        |                  |        |
| 99.00            |  | 0. 000000        | 1      |
| 99. 01           | Calculated Teaching Adjustment Factor for the current year. (see instructions)                               | 0.000000         | 99.01  |

| Health Financial Systems                | METHODIST HOSPITALS, INC | In Lie                                       | u of Form CMS-2552-10   |
|---|--------------------------|--|---|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-0002   | Peri od:<br>From 01/01/2021<br>To 12/31/2021 | Worksheet E-3<br>Part VII<br>Date/Time Prepared:<br>5/27/2022 9:02 am |

|        |  | 7                        | o 12/31/2021     | Date/Time Pre 5/27/2022 9:0 |                  |
|--------|--|--------------------------|------------------|-----------------------------|------------------|
| -      |  | Title XIX                | Hospi tal        | Cost                        | 2 4111           |
|        |  |                          | Inpatient        | Outpati ent                 |                  |
|        |  |                          | 1. 00            | 2.00                        |                  |
|        | PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV  | ICES FOR TITLES V OR XI  | X SERVICES       |                             |                  |
|        | COMPUTATION OF NET COST OF COVERED SERVICES  |                          |                  |                             |                  |
| 1.00   | Inpatient hospital/SNF/NF services   |                          | 6, 219, 442      |                             | 1.00             |
| 2.00   | Medical and other services   |                          |                  | 0                           | 2.00             |
| 3.00   | Organ acquisition (certified transplant centers only)  |                          | o                |                             | 3.00             |
| 4.00   | Subtotal (sum of lines 1, 2 and 3)   |                          | 6, 219, 442      | 0                           | 4.00             |
| 5.00   | Inpatient primary payer payments   |                          | 0                |                             | 5.00             |
| 6.00   | Outpatient primary payer payments  |                          |                  | 0                           | 6.00             |
| 7.00   | Subtotal (line 4 less sum of lines 5 and 6)  |                          | 6, 219, 442      | 0                           | 7. 00            |
|        | COMPUTATION OF LESSER OF COST OR CHARGES   |                          |                  |                             |                  |
|        | Reasonable Charges   |                          |                  |                             |                  |
| 8.00   | Routine service charges  |                          | 4, 385, 022      |                             | 8.00             |
| 9.00   | Ancillary service charges  |                          | 17, 619, 287     | 0                           |                  |
| 10.00  | Organ acquisition charges, net of revenue  |                          | 0                |                             | 10.00            |
| 11. 00 | Incentive from target amount computation   |                          | 0                |                             | 11.00            |
| 12. 00 | Total reasonable charges (sum of lines 8 through 11)   |                          | 22, 004, 309     | 0                           | 12.00            |
| 40.00  | CUSTOMARY CHARGES  | <del> </del>             |                  |                             |                  |
| 13. 00 | Amount actually collected from patients liable for payment for   | services on a charge     | 0                | 0                           | 13.00            |
| 14 00  | basis  | normant for convices on  |                  | 0                           | 14 00            |
| 14. 00 | Amounts that would have been realized from patients liable for   | 1 3                      | 0                | 0                           | 14. 00           |
| 15. 00 | a charge basis had such payment been made in accordance with 42 Ratio of line 13 to line 14 (not to exceed 1.000000) | 2 CFR 9413. 13(e)        | 0. 000000        | 0. 000000                   | 15. 00           |
|        | Total customary charges (see instructions)   |                          | 22, 004, 309     | 0.000000                    | 16.00            |
| 17. 00 | Excess of customary charges over reasonable cost (complete only  | if line 16 exceeds       | 15, 784, 867     | 0                           | 1                |
| 17.00  | line 4) (see instructions)   | , it tille to exceeds    | 13, 704, 007     | U                           | 17.00            |
| 18. 00 | Excess of reasonable cost over customary charges (complete only  | if line 4 exceeds line   | 0                | 0                           | 18. 00           |
| 10.00  | 16) (see instructions)   | ,                        |                  | Ü                           | 10.00            |
| 19.00  | Interns and Residents (see instructions)   |                          | o                | 0                           | 19.00            |
| 20.00  | Cost of physicians' services in a teaching hospital (see instru  | ıcti ons)                | o                | 0                           | 20.00            |
| 21.00  | Cost of covered services (enter the lesser of line 4 or line 16  | ) ·                      | 6, 219, 442      | 0                           | 21.00            |
|        | PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be c  | completed for PPS provid | ers.             |                             |                  |
| 22.00  | Other than outlier payments  |                          | 0                | 0                           | 22. 00           |
| 23.00  | Outlier payments   |                          | 0                | 0                           | 23. 00           |
| 24.00  | Program capital payments   |                          | 0                |                             | 24. 00           |
|        | Capital exception payments (see instructions)  |                          | 0                |                             | 25. 00           |
| 26. 00 | Routine and Ancillary service other pass through costs   |                          | 0                | 0                           | 26. 00           |
| 27. 00 | Subtotal (sum of lines 22 through 26)  |                          | 0                | 0                           |                  |
| 28. 00 | Customary charges (title V or XIX PPS covered services only)   |                          | 0                | 0                           | =0.00            |
| 29. 00 | Titles V or XIX (sum of lines 21 and 27)   |                          | 6, 219, 442      | 0                           | 29. 00           |
| 20.00  | COMPUTATION OF REIMBURSEMENT SETTLEMENT  |                          |                  |                             | 00.00            |
| 30.00  | Excess of reasonable cost (from line 18)   |                          | 0                | 0                           |                  |
|        | Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)   |                          | 6, 219, 442<br>0 | 0                           |                  |
| 32.00  | Deductibles  |                          |                  | 0                           | 32. 00<br>33. 00 |
| 34. 00 |  |                          | 0                | 0                           | 34.00            |
|        | · ·  |                          | 0                | U                           | 35.00            |
|        | Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)   |                          | 6, 219, 442      | 0                           | 36.00            |
|        | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   | 30)                      | 0, 217, 112      | 0                           | 37.00            |
|        | Subtotal (line 36 ± line 37)   |                          | 6, 219, 442      | 0                           | 38.00            |
|        | Direct graduate medical education payments (from Wkst. E-4)  |                          | 0,217,112        | Ü                           | 39.00            |
|        | Total amount payable to the provider (sum of lines 38 and 39)  |                          | 6, 219, 442      | 0                           | 40.00            |
| 41. 00 |  |                          | 7, 366, 501      | 0                           | 1                |
| 42. 00 | Balance due provider/program (line 40 minus line 41)   |                          | -1, 147, 059     | 0                           |                  |
| 43.00  | ,  | ce with CMS Pub 15-2,    | 0                | 0                           | 43.00            |
|        | chapter 1, §115.2  |                          |                  |                             |                  |
|        |  |                          |                  |                             |                  |

| Health Financial Systems                | METHODIST HOSPITALS, INC | In Lieu                     | u of Form CMS-2552-10                 |
|---|--------------------------|-----------------------------|---------------------------------------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-0002   | Peri od:<br>From 01/01/2021 | Worksheet E-3<br>Part VII             |
|   | Component CCN: 15-S002   | To 12/31/2021               | Date/Time Prepared: 5/27/2022 9:02 am |
|   | Title XIX                | Subprovi der -              | Cost                                  |
|   |                          | I DF                        |                                       |

|                | '  | itie xix            | I PF       | COST        |        |
|----------------|--|---------------------|------------|-------------|--------|
|                |  |                     | Inpati ent | Outpati ent |        |
|                |  |                     | 1.00       | 2. 00       |        |
|                | PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FO                   | OD TITLES V OD VI   |            | 2.00        |        |
|                |  | JR TITLES V UR AT   | X SERVICES |             |        |
| 1. 00          | COMPUTATION OF NET COST OF COVERED SERVICES Inpatient hospital/SNF/NF services           |                     | 118, 307   |             | 1.00   |
| 2. 00          | Medical and other services   |                     | 118, 307   | 0           | 2.00   |
|                |  |                     | 0          | Ü           | 3.00   |
| 3. 00<br>4. 00 | Organ acquisition (certified transplant centers only) Subtotal (sum of lines 1, 2 and 3) |                     |            | 0           | 4.00   |
| 4. 00<br>5. 00 |  |                     | 118, 307   | Ü           | 5.00   |
| 6. 00          | Inpatient primary payer payments   |                     | ٩          | 0           | 6.00   |
| 7. 00          | Outpatient primary payer payments  |                     | 110 207    | 0           | 7.00   |
| 7.00           | Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES     |                     | 118, 307   | 0           | 7.00   |
|                | Reasonable Charges   |                     |            |             |        |
| 8. 00          | Routi ne servi ce charges  |                     | 409, 545   |             | 8. 00  |
| 9. 00          | Ancillary service charges  |                     | 219, 246   | 0           | 9.00   |
| 10.00          | Organ acquisition charges, net of revenue  |                     | 219, 240   | U           | 10.00  |
| 11. 00         | Incentive from target amount computation   |                     |            |             | 11.00  |
| 12.00          | Total reasonable charges (sum of lines 8 through 11)                                     |                     | 628, 791   | 0           |        |
| 12.00          | CUSTOMARY CHARGES  |                     | 020, 791   | 0           | 12.00  |
| 13. 00         | Amount actually collected from patients liable for payment for service                   | as on a charge      | O          | 0           | 13. 00 |
| 13.00          | basis  | es on a charge      | ١          | U           | 13.00  |
| 14. 00         | Amounts that would have been realized from patients liable for paymen                    | t for services or   | o          | 0           | 14.00  |
| 14.00          | a charge basis had such payment been made in accordance with 42 CFR §                    |                     | ٥          | U           | 14.00  |
| 15. 00         | Ratio of line 13 to line 14 (not to exceed 1.000000)                                     | +13. 13(0)          | 0. 000000  | 0. 000000   | 15. 00 |
| 16. 00         | Total customary charges (see instructions)   |                     | 628, 791   | 0.000000    | 16.00  |
| 17. 00         | Excess of customary charges over reasonable cost (complete only if lin                   | ne 16 exceeds       | 510, 484   | 0           |        |
| 17.00          | line 4) (see instructions)   | то то слоссия       | 010, 101   | O           | 17.00  |
| 18. 00         | Excess of reasonable cost over customary charges (complete only if lin                   | ne 4 exceeds line   | 0          | 0           | 18. 00 |
| .0.00          | 16) (see instructions)   | 10 1 0/100040 11110 |            | Ü           | 10.00  |
| 19.00          | Interns and Residents (see instructions)   |                     | o          | 0           | 19. 00 |
| 20.00          | Cost of physicians' services in a teaching hospital (see instructions)                   | )                   | o          | 0           | 20.00  |
| 21.00          | Cost of covered services (enter the lesser of line 4 or line 16)                         | ,                   | 118, 307   | 0           | 21.00  |
|                | PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be complete                   | ed for PPS provid   |            |             |        |
| 22.00          | Other than outlier payments  |                     | 0          | 0           | 22. 00 |
| 23.00          | Outlier payments   |                     | o          | 0           | 23. 00 |
| 24.00          | Program capital payments   |                     | o          |             | 24.00  |
| 25.00          | Capital exception payments (see instructions)  |                     | o          |             | 25. 00 |
| 26.00          | Routine and Ancillary service other pass through costs                                   |                     | o          | 0           | 26.00  |
| 27.00          | Subtotal (sum of lines 22 through 26)  |                     | o          | 0           | 27. 00 |
| 28.00          | Customary charges (title V or XIX PPS covered services only)                             |                     | 0          | 0           | 28. 00 |
| 29.00          | Titles V or XIX (sum of lines 21 and 27)   |                     | 118, 307   | 0           | 29. 00 |
|                | COMPUTATION OF REIMBURSEMENT SETTLEMENT  |                     |            |             |        |
| 30.00          | Excess of reasonable cost (from line 18)   |                     | 0          | 0           | 30.00  |
| 31.00          | Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)                           |                     | 118, 307   | 0           | 31.00  |
| 32.00          | Deducti bl es  |                     | O          | 0           | 32.00  |
| 33.00          | Coinsurance  |                     | 0          | 0           | 33.00  |
| 34.00          | Allowable bad debts (see instructions)   |                     | 0          | 0           | 34.00  |
| 35.00          | Utilization review   |                     | 0          |             | 35.00  |
| 36.00          | Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)                       |                     | 118, 307   | 0           | 36.00  |
| 37.00          |  |                     | 0          | 0           | 37.00  |
| 38.00          | Subtotal (line 36 ± line 37)   |                     | 118, 307   | 0           | 38. 00 |
| 39.00          | Direct graduate medical education payments (from Wkst. E-4)                              |                     | 0          |             | 39. 00 |
| 40.00          | Total amount payable to the provider (sum of lines 38 and 39)                            |                     | 118, 307   | 0           | 40.00  |
| 41.00          | Interim payments   |                     | 210, 504   | 0           | 41.00  |
| 42.00          | Balance due provider/program (line 40 minus line 41)                                     |                     | -92, 197   | 0           | 42.00  |
| 43.00          | Protested amounts (nonallowable cost report items) in accordance with                    | CMS Pub 15-2,       | 0          | 0           | 43.00  |
|                | chapter 1, §115.2  |                     |            |             |        |
|                |  |                     |            |             |        |

| Health Financial Systems                | METHODIST HOSPITALS, INC | In Lieu of Form CMS-2552-10 |                           |  |  |
|---|--------------------------|-----------------------------|---------------------------|--|--|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-0002   | Peri od:<br>From 01/01/2021 | Worksheet E-3<br>Part VII |  |  |
|   | Component CCN: 15-T002   |                             |                           |  |  |
|   | Title XIX                | Subprovi der -              | Cost                      |  |  |
|   |                          | I RF                        |                           |  |  |

|                | l l   | itle XIX          | Subprovi der -                        | Cost        |                  |
|----------------|---|-------------------|---------------------------------------|-------------|------------------|
|                |   |                   | I RF                                  | 0.1         |                  |
|                |   |                   | Inpatient                             | Outpati ent |                  |
|                | DART MALE CALCULATION OF DELINDURCHIENT ALL OTHER HEALTH CERVICORS F  | 0D TITLEC W 0D W  | 1.00                                  | 2. 00       |                  |
|                | PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FO  | JR TITLES V OR XI | X SERVICES                            |             |                  |
| 1 00           | COMPUTATION OF NET COST OF COVERED SERVICES   |                   | 2/0 001                               |             | 1 00             |
| 1.00           | Inpatient hospital/SNF/NF services  |                   | 369, 901                              | 0           | 1.00             |
| 2.00           | Medical and other services  |                   |                                       | Ü           |                  |
| 3.00           | Organ acquisition (certified transplant centers only)   |                   | 340 001                               | 0           | 3.00             |
| 4. 00<br>5. 00 | Subtotal (sum of lines 1, 2 and 3)<br>  Inpatient primary payer payments  |                   | 369, 901                              | U           | 4. 00<br>5. 00   |
| 6. 00          | Outpatient primary payer payments   |                   | ٩                                     | 0           |                  |
| 7. 00          | Subtotal (line 4 less sum of lines 5 and 6)   |                   | 369, 901                              | 0           |                  |
| 7.00           | COMPUTATION OF LESSER OF COST OR CHARGES  |                   | 307, 701                              |             | 7.00             |
|                | Reasonable Charges  |                   |                                       |             |                  |
| 8. 00          | Routine service charges   |                   | 385, 970                              |             | 8.00             |
| 9. 00          | Ancillary service charges   |                   | 836, 297                              | 0           |                  |
| 10. 00         | Organ acquisition charges, net of revenue   |                   | 0                                     | ŭ           | 10.00            |
| 11. 00         | Incentive from target amount computation  |                   | 0                                     |             | 11.00            |
| 12. 00         |   |                   | 1, 222, 267                           | 0           | 1                |
|                | CUSTOMARY CHARGES   |                   | , , , , ,                             |             |                  |
| 13.00          | Amount actually collected from patients liable for payment for service  | es on a charge    | 0                                     | 0           | 13.00            |
|                | basis   | _                 |                                       |             |                  |
| 14.00          | Amounts that would have been realized from patients liable for paymen   |                   | 0                                     | 0           | 14.00            |
|                | a charge basis had such payment been made in accordance with 42 CFR §   | 413. 13(e)        |                                       |             |                  |
| 15. 00         | Ratio of line 13 to line 14 (not to exceed 1.000000)  |                   | 0. 000000                             | 0. 000000   |                  |
| 16. 00         | Total customary charges (see instructions)  |                   | 1, 222, 267                           | 0           |                  |
| 17. 00         | Excess of customary charges over reasonable cost (complete only if li   | ne 16 exceeds     | 852, 366                              | 0           | 17. 00           |
| 10.00          | line 4) (see instructions)  |                   |                                       | 0           | 10.00            |
| 18. 00         | Excess of reasonable cost over customary charges (complete only if lile) (see instructions)                       | ne 4 exceeds fine | 0                                     | 0           | 18. 00           |
| 19. 00         | Interns and Residents (see instructions)  |                   | o                                     | 0           | 19.00            |
| 20. 00         | Cost of physicians' services in a teaching hospital (see instructions   | )                 |                                       | 0           | 20.00            |
| 21. 00         | Cost of covered services (enter the lesser of line 4 or line 16)  | ,                 | 369, 901                              | 0           |                  |
| 200            | PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be complete  | ed for PPS provid | · · · · · · · · · · · · · · · · · · · |             | 200              |
| 22.00          | Other than outlier payments   |                   | 0                                     | 0           | 22.00            |
| 23.00          | Outlier payments  |                   | 0                                     | 0           | 23.00            |
| 24.00          | Program capital payments  |                   | 0                                     |             | 24.00            |
| 25.00          | Capital exception payments (see instructions)   |                   | 0                                     |             | 25.00            |
| 26.00          | Routine and Ancillary service other pass through costs  |                   | 0                                     | 0           | 26.00            |
|                | Subtotal (sum of lines 22 through 26)   |                   | 0                                     | 0           |                  |
| 28. 00         | Customary charges (title V or XIX PPS covered services only)  |                   | 0                                     | 0           | 28. 00           |
| 29. 00         |   |                   | 369, 901                              | 0           | 29. 00           |
|                | COMPUTATION OF REIMBURSEMENT SETTLEMENT   |                   |                                       |             |                  |
|                | Excess of reasonable cost (from line 18)  |                   | 0                                     | 0           |                  |
|                | Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  |                   | 369, 901                              | 0           |                  |
|                | Deducti bl es   |                   | 0                                     | 0           |                  |
|                | Coinsurance   |                   | 0                                     | 0           |                  |
| 34.00          | Allowable bad debts (see instructions)  |                   | 0                                     | 0           | 34.00            |
| 35.00          | Utilization review  |                   | 3/0 001                               | 0           | 35. 00<br>36. 00 |
| 36.00          | Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) |                   | 369, 901                              | 0           | 37.00            |
| 38. 00         | Subtotal (line 36 ± line 37)  |                   | 369, 901                              | 0           | 38.00            |
|                |   |                   | 309, <del>3</del> 01                  | U           | 39.00            |
|                | Total amount payable to the provider (sum of lines 38 and 39)   |                   | 369, 901                              | 0           |                  |
|                | Interim payments  |                   | 409, 186                              | 0           | 1                |
| 42. 00         | Balance due provider/program (line 40 minus line 41)  |                   | -39, 285                              | 0           |                  |
| 43. 00         |   | CMS Pub 15-2.     | 0                                     | 0           |                  |
|                | chapter 1, §115.2   | •                 |                                       |             |                  |
|                |   |                   |                                       |             |                  |

|                | GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT L EDUCATION COSTS   | Provi der Co  | CN: 15-0002   | Peri od:<br>From 01/01/2021<br>To 12/31/2021 | Worksheet E-4 Date/Time Pre 5/27/2022 9:0 | pared:         |
|----------------|---|---------------|---------------|--|---|----------------|
|                |   | Title         | XVIII         | Hospi tal                                    | PPS                                       |                |
|                |   |               |               |  | 1. 00                                     |                |
|                | COMPUTATION OF TOTAL DIRECT GME AMOUNT  |               |               |  |   |                |
| 00             | Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.   | programs for  | r cost report | ing periods                                  | 10. 83                                    | 1.00           |
| 00             | Unweighted FTE resident cap add-on for new programs per 42 CF   |               | (1) (see inst | ructions)                                    | 0.00                                      | 2.0            |
| 00             | Amount of reduction to Direct GME cap under section 422 of MN Direct GME cap reduction amount under ACA §5503 in accordance   |               | R §413.79 (m) | . (see                                       | 0. 00<br>0. 00                            | 3. 0<br>3. 0   |
| . 00           | instructions for cost reporting periods straddling 7/1/2011) Adjustment (plus or minus) to the FTE cap for allopathic and GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f) |               | programs due  | to a Medicare                                | 0. 00                                     | 4. 0           |
| 01             | ACA Section 5503 increase to the Direct GME FTE Cap (see inst   |               | r cost report | ing periods                                  | 0. 00                                     | 4.0            |
| . 02           | straddling 7/1/2011)<br>ACA Section 5506 number of additional direct GME FTE cap slot   | 0. 00         | 4.02          |  |   |                |
| . 00           | periods straddling 7/1/2011)<br>FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl   | 10. 83        | 5. 00         |  |   |                |
| . 00           | 4.02 plus applicable subscripts Unweighted resident FTE count for allopathic and osteopathic  | programs for  | r the current | year from your                               | 3. 00                                     | 6. 00          |
| . 00           | records (see instructions) Enter the lesser of line 5 or line 6   |               |               |  | 3. 00                                     | 7.00           |
|                |   |               | Primary Care  |  | Total                                     |                |
| 00             | Weighted FTE count for physicians in an allopathic and osteop   | pathi c       | 1.00          | 2.00   | 3. 00<br>2. 53                            | 8.0            |
| . 00           | program for the current year.<br>If line 6 is less than 5 enter the amount from line 8, otherw  |               | 0. (          |  | 2. 53                                     | 9. 0           |
|                | multiply line 8 times the result of line 5 divided by the amo   | ount on line  |               |  |   |                |
| 0. 00          | Weighted dental and podiatric resident FTE count for the curr   |               |               | 0.00   |   | 10.0           |
| 0. 01<br>1. 00 | Unweighted dental and podiatric resident FTE count for the cu<br>Total weighted FTE count   | irrent year   | 0. (          | 0. 00<br>2. 53                               |   | 10.0           |
| 2. 00          | Total weighted resident FTE count for the prior cost reportininstructions)  | ng year (see  |               |  |   | 12.0           |
| 3. 00          | Total weighted resident FTE count for the penultimate cost re<br>year (see instructions)  | eporti ng     | 0. (          | 2. 50  |   | 13. 0          |
| 4. 00          | Rolling average FTE count (sum of lines 11 through 13 divided   | d by 3).      | 0. (          | 2. 51  |   | 14.00          |
| 5. 00          | Adjustment for residents in initial years of new programs   |               | 0. (          |  |   | 15.0           |
| 5. 01          | Unweighted adjustment for residents in initial years of new p   |               | 0.0           |  |   | 15.0           |
| 6. 00<br>6. 01 | Adjustment for residents displaced by program or hospital clouds of the displaced by program or hospital clouds of the displaced by program or hospital course.                         |               | 0. (<br>0. (  | 1  |   | 16. 0<br>16. 0 |
| 7. 00          | closure<br>Adjusted rolling average FTE count   |               | 0. (          | 2. 51  |   | 17.00          |
| 8. 00          | Per resident amount   |               | 92, 787. 3    |  |   | 18.0           |
| 9. 00          | Approved amount for resident costs  |               |               | 0 232, 896                                   | 232, 896                                  | 19. 00         |
|                |   |               |               |  | 1. 00                                     |                |
| 0. 00          | Additional unweighted allopathic and osteopathic direct GME F   | TE resident   | cap slots re  | ceived under 42                              | 0. 00                                     | 20.00          |
| 1. 00          | Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instru   | uctions)      |               |  | 0. 00                                     | 21.00          |
| 2. 00          | Allowable additional direct GME FTE Resident Count (see instr   | ,             |               |  | 0. 00                                     |                |
| 3. 00          | Enter the locality adjustment national average per resident a   | amount (see i | instructions) |  | 92, 787. 39                               | 23.0           |
| 4. 00          | Multiply line 22 time line 23   |               |               |  | 0   | 24.0           |
| 5. 00          | Total direct GME amount (sum of lines 19 and 24)  |               | Inpatient     | Managed Care                                 | 232, 896<br>Total                         | 25. 00         |
|                |   |               | Part A        |  |   |                |
|                | COMPUTATION OF PROGRAM PATIENT LOAD   |               | 1.00          | 2. 00  | 3. 00                                     |                |
| 5. 00          | Inpatient Days (see instructions) (Title XIX - see S-2 Part I 3.02, column 2)   | X, line       | 23, 8         | 55 23, 224                                   |   | 26.00          |
| 7. 00          | Total Inpatient Days (see instructions)   |               | 83, 95        |  |   | 27. 0          |
| 8.00           | Ratio of inpatient days to total inpatient days   |               | 0. 28414      | 1  | 400 /                                     | 28.00          |
| 9. 00<br>9. 01 | Program direct GME amount   |               | 66, 17        |  | 130, 602                                  | 29.0           |
|                | Percent reduction for MA DGME   |               |               | 4. 07  |   | 29. 0          |
| 0. 00          | Reduction for direct GME payments for Medicare Advantage  |               |               | 2, 622                                       | 2, 622                                    | 30.00          |

| Heal th          | Financial Systems METHODIST HOSPI  | TALS INC                | In lie                           | u of Form CMS-2                | 2552-10 |  |  |  |  |
|------------------|--|-------------------------|----------------------------------|--------------------------------|---------|--|--|--|--|
|                  | GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT                                      | Provi der CCN: 15-0002  | Peri od:                         | Worksheet E-4                  |         |  |  |  |  |
| MEDI CA          | AL EDUCATION COSTS   |                         | From 01/01/2021<br>To 12/31/2021 | Date/Time Pre<br>5/27/2022 9:0 |         |  |  |  |  |
|                  |  | Title XVIII             | Hospi tal                        | PPS                            |         |  |  |  |  |
|                  |  |                         |                                  |                                |         |  |  |  |  |
|                  |  |                         |                                  | 1. 00                          |         |  |  |  |  |
|                  | DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITL EDUCATION COSTS)                 | E XVIII ONLY (NURSING P | ROGRAM AND PARAME                | DI CAL                         |         |  |  |  |  |
| 32. 00           | Renal dialysis direct medical education costs (from Wkst. B, and 94)                           | Pt. I, sum of col. 20 a | nd 23, lines 74                  | 0                              | 32.00   |  |  |  |  |
| 33.00            | Renal dialysis and home dialysis total charges (Wkst. C, Pt.                                   | I, col. 8, sum of lines | 74 and 94)                       | 9, 399, 418                    | 33.00   |  |  |  |  |
| 34.00            | Ratio of direct medical education costs to total charges (lir                                  |                         | ,                                | 0.000000                       | 34.00   |  |  |  |  |
| 35.00            | Medicare outpatient ESRD charges (see instructions)  |                         |                                  | 0                              | 35. 00  |  |  |  |  |
| 36.00            | Medicare outpatient ESRD direct medical education costs (line                                  | e 34 x line 35)         |                                  | 0                              | 36.00   |  |  |  |  |
|                  | APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY                             |                         |                                  |                                |         |  |  |  |  |
|                  | Part A Reasonable Cost   |                         |                                  |                                |         |  |  |  |  |
| 37. 00           |  |                         |                                  | 53, 625, 422                   |         |  |  |  |  |
| 38. 00           | 3  |                         |                                  | 0                              |         |  |  |  |  |
|                  | Cost of physicians' services in a teaching hospital (see inst                                  | ructions)               |                                  | 0                              | 07.00   |  |  |  |  |
| 40. 00           | 1 3 1 3 1 1 3 1 1 1 1 1 1 1 1 1 1 1 1 1  |                         |                                  | 0                              | 10.00   |  |  |  |  |
| 41. 00           | Total Part A reasonable cost (sum of lines 37 through 39 minu                                  | us line 40)             |                                  | 53, 625, 422                   | 41.00   |  |  |  |  |
| 40.00            | Part B Reasonable Cost   |                         |                                  | 00 500 400                     | 40.00   |  |  |  |  |
|                  | Reasonable cost (see instructions)   |                         |                                  | 20, 593, 192                   |         |  |  |  |  |
| 43. 00<br>44. 00 | Primary payer payments (see instructions) Total Part B reasonable cost (line 42 minus line 43) |                         |                                  | 7, 792<br>20, 585, 400         |         |  |  |  |  |
|                  | Total reasonable cost (sum of lines 41 and 44)   |                         |                                  | 74, 210, 822                   |         |  |  |  |  |
| 46. 00           | 1  | ne 41 ± line 45)        |                                  | 0. 722609                      |         |  |  |  |  |
|                  | Ratio of Part B reasonable cost to total reasonable cost (III                                  |                         |                                  | 0. 277391                      |         |  |  |  |  |
| 47.00            | ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA                                  |                         |                                  | 0. 211371                      | 77.00   |  |  |  |  |
| 48 00            | Total program GME payment (line 31)  |                         |                                  | 127, 980                       | 48 00   |  |  |  |  |
|                  | Part A Medicare GME payment (line 46 x 48) (title XVIII only)                                  | (see instructions)      |                                  | 92, 479                        |         |  |  |  |  |
|                  | Part B Medicare GME payment (line 47 x 48) (title XVIII only)                                  |                         |                                  | 35, 501                        |         |  |  |  |  |
|                  |  | •                       | '                                |                                | •       |  |  |  |  |

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

Provi der CCN: 15-0002

Peri od: From 01/01/2021 To 12/31/2021 Date/Ti me Prepared: 5/27/2022 9:02 am

General Fund Speci fi c Endowment Plant Fund Purpose Fund Fund 1.00 2.00 4.00 3.00 CURRENT ASSETS 1.00 Cash on hand in banks 103, 986, 573 0 0 0 1.00 0 0 2.00 Temporary investments 617, 043 0 2.00 0 3 00 Notes receivable 0 0 3 00 0 4.00 Accounts receivable 44, 297, 264 0 4.00 5.00 0 0 0 5.00 Other receivable ol 6.00 Allowances for uncollectible notes and accounts receivable 0 0 6.00 o 13, 135, 392 0 7 00 7 00 0 Inventory 0 8.00 Prepaid expenses 4, 617, 356 0 0 8.00 18, 770, 540 0 9.00 Other current assets 0 9.00 10.00 Due from other funds 112, 750 0 ol 0 10.00 Total current assets (sum of lines 1-10) 185, 536, 918 11.00 0 0 0 11.00 FIXED ASSETS 12.00 Land 5, 373, 674 0 0 0 12.00 Land improvements 0 0 13.00 6, 958, 207 0 13.00 οĺ -397, 185, 511 14.00 Accumulated depreciation 0 14.00 Bui I di ngs 0 15.00 309, 357, 738 0 0 15.00 0 16.00 Accumulated depreciation 0 0 16.00 0 0 Leasehold improvements 1, 230, 154 17.00 17.00 0 0 18 00 Accumulated depreciation 0 18 00 Fixed equipment 19.00 19.00 0 0 20.00 Accumulated depreciation 0 0 0 20.00 0 21.00 Automobiles and trucks C 0 21.00 22.00 Accumulated depreciation 0 22.00 23.00 Major movable equipment 211, 798, 957 0 0 0 0 23.00 Accumulated depreciation 0 24.00 0 24.00 0 25.00 Minor equipment depreciable r 0 25.00 Accumulated depreciation 0 0 26.00 26.00 C 0 0 27.00 HIT designated Assets 0 0 0 27.00 0 28.00 Accumulated depreciation 0 0 28.00 0 0 29.00 Mi nor equi pment-nondepreci abl e 0 29.00 Total fixed assets (sum of lines 12-29) 30.00 137, 533, 219 0 0 0 30.00 OTHER ASSETS 31 00 31.00 Investments 125, 730, 753 0 0 0 0 32.00 Deposits on Leases 0 0 32.00 0 0 33.00 Due from owners/officers 0 33.00 ol 34.00 Other assets 387.086 0 34.00 0 Total other assets (sum of lines 31-34) 0 0 35.00 126, 117, 839 0 35.00 36.00 Total assets (sum of lines 11, 30, and 35) 449, 187, 976 0 0 0 36.00 CURRENT LIABILITIES 37 00 25, 275, 478 0 0 n 37 00 Accounts payable 0 0 38.00 Salaries, wages, and fees payable -287 0 38.00 Payroll taxes payable 0 0 0 39.00 39.00 40.00 Notes and Loans payable (short term) 2,690,000 0 0 0 40.00 o Deferred income 0 41 00 41 00 C 0 42.00 Accelerated payments C 42.00 43.00 Due to other funds 0 0 0 43.00 Other current liabilities 56, 128, 197 ol 44.00 0 0 44.00 0 Total current liabilities (sum of lines 37 thru 44) 45.00 84, 093, 388 0 0 45.00 ONG TERM LIABILITIES 46.00 Mortgage payable 0 0 0 46.00 0 32, 939, 220 0 Notes payable 0 47.00 47.00 48.00 Unsecured Loans 0 0 0 48.00 Other long term liabilities 0 0 49.00 49.00 50, 050, 845 0 Total long term liabilities (sum of lines 46 thru 49) 82, 990, 065 0 ol 0 50.00 50.00 167, 083, 453 51.00 Total liabilities (sum of lines 45 and 50) 0 0 0 51.00 CAPITAL ACCOUNTS 282, 104, 523 52.00 General fund balance 52.00 0 Specific purpose fund 53.00 53.00 54 00 Donor created - endowment fund balance - restricted 0 54 00 Donor created - endowment fund balance - unrestricted 0 55.00 56.00 Governing body created - endowment fund balance 0 56.00 Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, 57.00 57.00 0 58.00 0 58.00 replacement, and expansion Total fund balances (sum of lines 52 thru 58) 282, 104, 523 0 0 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 449, 187, 976 0 0 0 60.00

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

|                  |   |           |                |          | То  | 12/31/2021 | Date/Time Pre<br>5/27/2022 9:0 |                  |
|------------------|---|-----------|----------------|----------|-----|------------|--------------------------------|------------------|
|                  |   | General   | Fund           | Speci al | Pur | pose Fund  | Endowment<br>Fund              |                  |
|                  |   |           |                |          |     |            |                                |                  |
|                  |   | 1. 00     | 2. 00          | 3. 00    |     | 4. 00      | 5. 00                          |                  |
| 1.00             | Fund balances at beginning of period  |           | 266, 439, 110  | 1        |     | 0          |                                | 1.00             |
| 2.00             | Net income (loss) (from Wkst. G-3, line 29)                                     |           | 15, 665, 413   | l .      |     | 0          |                                | 2.00             |
| 3. 00<br>4. 00   | Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)       |           | 282, 104, 523  |          | 0   | 0          | 0                              | 3. 00<br>4. 00   |
| 4. 00<br>5. 00   | Additions (credit adjustments) (specify)  |           |                |          | 0   |            | 0                              |                  |
| 6. 00            |   |           |                |          | 0   |            | 0                              | 1                |
| 7. 00            |   | o o       |                |          | 0   |            | Ö                              |                  |
| 8. 00            |   | o         |                |          | 0   |            | 0                              |                  |
| 9.00             |   | o         |                |          | 0   |            | 0                              | 9.00             |
| 10.00            | Total additions (sum of line 4-9)   |           | 0              |          |     | 0          |                                | 10.00            |
| 11. 00           | Subtotal (line 3 plus line 10)  |           | 282, 104, 523  |          |     | 0          |                                | 11. 00           |
| 12.00            | Deductions (debit adjustments) (specify)  | 0         |                |          | 0   |            | 0                              |                  |
| 13. 00           |   | 0         |                |          | 0   |            | 0                              |                  |
| 14.00            |   | 0         |                |          | 0   |            | 0                              |                  |
| 15. 00<br>16. 00 |   | 0         |                |          | 0   |            | 0                              |                  |
| 17. 00           |   |           |                |          | 0   |            | 0                              |                  |
| 18. 00           | Total deductions (sum of lines 12-17)   | 9         | 0              |          | U   | 0          |                                | 18.00            |
| 19. 00           | Fund balance at end of period per balance                                       |           | 282, 104, 523  |          |     | 0          |                                | 19.00            |
| 171.00           | sheet (line 11 minus line 18)   |           | 2027 10 17 020 |          |     | ŭ.         |                                | 17.00            |
|                  |   | Endowment | PI ant         | Fund     |     |            |                                |                  |
|                  |   | Fund      |                | ı        |     |            |                                |                  |
|                  |   | 6. 00     | 7. 00          | 8.00     |     |            |                                |                  |
| 1.00             | Fund balances at beginning of period  | 0         |                |          | 0   |            |                                | 1.00             |
| 2. 00            | Net income (loss) (from Wkst. G-3, line 29)                                     | _         |                |          | _   |            |                                | 2.00             |
| 3.00             | Total (sum of line 1 and line 2)  | 0         |                |          | 0   |            |                                | 3.00             |
| 4.00             | Additions (credit adjustments) (specify)  |           | 0              |          |     |            |                                | 4.00             |
| 5. 00<br>6. 00   |   |           | 0              |          |     |            |                                | 5. 00<br>6. 00   |
| 7. 00            |   |           | 0              |          |     |            |                                | 7.00             |
| 8. 00            |   |           | 0              |          |     |            |                                | 8.00             |
| 9. 00            |   |           | 0              |          |     |            |                                | 9.00             |
| 10.00            | Total additions (sum of line 4-9)   | o         |                |          | 0   |            |                                | 10.00            |
| 11.00            | Subtotal (line 3 plus line 10)  | 0         |                |          | 0   |            |                                | 11.00            |
| 12.00            | Deductions (debit adjustments) (specify)  |           | 0              |          |     |            |                                | 12.00            |
| 13.00            |   |           | 0              |          |     |            |                                | 13.00            |
| 14.00            |   |           | 0              |          |     |            |                                | 14.00            |
| 15.00            |   |           | 0              |          |     |            |                                | 15.00            |
| 16.00            |   |           | 0              |          |     |            |                                | 16.00            |
| 17.00            | Total deductions (sum of lines 12 17)   |           | 0              |          |     |            |                                | 17. 00<br>18. 00 |
| 18. 00<br>19. 00 | Total deductions (sum of lines 12-17) Fund balance at end of period per balance |           |                |          | 0   |            |                                | 19.00            |
|                  | sheet (line 11 minus line 18)   |           |                |          |     |            |                                |                  |

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

|                  |  | Te            | 0 12/31/2021  | Date/Time Pre 5/27/2022 9:0 |                  |
|------------------|--|---------------|---------------|-----------------------------|------------------|
|                  | Cost Center Description  | I npati ent   | Outpati ent   | Total                       | z aiii           |
|                  | oust denter bescription  | 1. 00         | 2. 00         | 3. 00                       |                  |
|                  | PART I - PATIENT REVENUES  | 1.00          | 2.00          | 0.00                        |                  |
|                  | General Inpatient Routine Services                                       |               |               |                             |                  |
| 1.00             | Hospi tal  | 80, 568, 821  |               | 80, 568, 821                | 1.00             |
| 2. 00            | SUBPROVI DER - I PF  | 2, 296, 207   |               | 2, 296, 207                 | 2.00             |
| 3.00             | SUBPROVI DER - I RF  | 4, 463, 507   |               | 4, 463, 507                 | 3.00             |
| 4. 00            | SUBPROVI DER   | 1, 100, 007   |               | 1, 100, 007                 | 4. 00            |
| 5. 00            | Swing bed - SNF  | 0             |               | 0                           | 5. 00            |
| 6. 00            | Swing bed - NF   | 0             |               | 0                           | 6. 00            |
| 7. 00            | SKILLED NURSING FACILITY   |               |               | ·                           | 7. 00            |
| 8. 00            | NURSING FACILITY   |               |               |                             | 8. 00            |
| 9. 00            | OTHER LONG TERM CARE   |               |               |                             | 9.00             |
| 10.00            | Total general inpatient care services (sum of lines 1-9)                 | 87, 328, 535  |               | 87, 328, 535                | 10.00            |
| 10.00            | Intensive Care Type Inpatient Hospital Services                          | 07, 320, 333  |               | 07, 320, 333                | 10.00            |
| 11. 00           | INTENSIVE CARE UNIT  | 30, 128, 086  |               | 30, 128, 086                | 11. 00           |
| 11. 01           | NEONATAL I CU  | 30, 120, 000  |               | 0                           | 11. 01           |
| 12. 00           | CORONARY CARE UNIT   |               |               |                             | 12.00            |
| 13. 00           | BURN INTENSIVE CARE UNIT   |               |               |                             | 13. 00           |
| 14. 00           | SURGICAL INTENSIVE CARE UNIT   |               |               |                             | 14. 00           |
| 15. 00           | OTHER SPECIAL CARE (SPECIFY)   |               |               |                             | 15. 00           |
| 16. 00           | Total intensive care type inpatient hospital services (sum of lines      | 30, 128, 086  |               | 30, 128, 086                | 16.00            |
| 10.00            | 11-15)   | 30, 120, 000  |               | 30, 120, 000                | 16.00            |
| 17. 00           | Total inpatient routine care services (sum of lines 10 and 16)           | 117, 456, 621 |               | 117, 456, 621               | 17. 00           |
| 18. 00           | Ancillary services   | 529, 241, 750 | 427 202 E40   | 1, 166, 625, 290            | 18.00            |
| 19. 00           | Outpatient services  | 24, 246, 764  |               |                             | 19.00            |
| 20. 00           | RURAL HEALTH CLINIC  | 24, 246, 764  | 104, 997, 760 | 129, 244, 544               | 20.00            |
| 21. 00           |  | 0             | 0             | 0                           | 21.00            |
|                  | FEDERALLY QUALIFIED HEALTH CENTER   HOME HEALTH AGENCY                   |               | 2 044 424     |                             | 22.00            |
| 22. 00           |  |               | 3, 944, 434   | 3, 944, 434                 |                  |
| 23. 00           | AMBULANCE SERVICES   |               |               |                             | 23. 00           |
| 24. 00           | CMHC   |               |               |                             | 24.00            |
| 25. 00           | AMBULATORY SURGICAL CENTER (D. P. )                                      |               |               |                             | 25.00            |
| 26.00            | HOSPI CE   | 440 ((2       | F0 071 0F0    | F0 F00 701                  | 26.00            |
| 27. 00           | PROFESSIONAL REVENUES  | 449, 663      | · ·           |                             | 27.00            |
| 28. 00           | Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.   | 671, 394, 798 | 798, 396, 812 | 1, 469, 791, 610            | 28. 00           |
|                  | G-3, line 1) PART II - OPERATING EXPENSES                                |               |               |                             |                  |
| 29. 00           | Operating expenses (per Wkst. A, column 3, line 200)                     |               | 383, 956, 915 |                             | 29. 00           |
| 30.00            | ADD (SPECIFY)  | 0             | 303, 930, 913 |                             | 30.00            |
| 31. 00           | ADD (SPECIFT)  | 0             |               |                             | 31.00            |
|                  |  | 0             |               |                             | 32.00            |
| 32.00            |  | 0             |               |                             |                  |
| 33.00            |  | 0             |               |                             | 33.00            |
| 34. 00<br>35. 00 |  | 0             |               |                             | 34. 00<br>35. 00 |
|                  | T-+-1  | 0             | 0             |                             |                  |
| 36.00            | Total additions (sum of lines 30-35)                                     |               | U             |                             | 36.00            |
| 37. 00           | DEDUCT (SPECIFY)   | 0             |               |                             | 37.00            |
| 38. 00           |  | 0             |               |                             | 38.00            |
| 39.00            |  | 0             |               |                             | 39.00            |
| 40.00            |  | 0             |               |                             | 40.00            |
| 41.00            | Total daductions (com of lines 27 44)                                    | 0             | _             |                             | 41.00            |
| 42.00            | Total deductions (sum of lines 37-41)                                    |               | 0             |                             | 42.00            |
| 43. 00           | Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer |               | 383, 956, 915 |                             | 43.00            |
|                  | to Wkst. G-3, line 4)  | 1             | Ĭ             | I                           |                  |

| Provider CCN: 15-0002  line 28)  counts  ne 43) | Peri od:<br>From 01/01/2021<br>To 12/31/2021 | 1. 00<br>1, 469, 791, 610 | pared   |
|---|--|---------------------------|---|
| counts  |  | 1. 00<br>1, 469, 791, 610 |   |
| counts  |  | 1, 469, 791, 610          |   |
| counts  |  | 1, 469, 791, 610          |   |
| counts  |  |                           | 1.  |
|   |  | 1, 107, 150, 452          |   |
| ne 43)  |  | 362, 641, 158             |   |
| •   |  | 383, 956, 915             |   |
|   |  | -21, 315, 757             |   |
|   |  |                           | İ   |
|   |  | 0                         | 6.  |
|   |  | 4, 893, 071               | 7.  |
| ion services                                    |  | 0                         | 8.  |
|   |  | 0                         | 9.  |
|   |  | 0                         | 10.   |
|   |  | 0                         | 11  |
|   |  | 0                         | 12  |
|   |  | 0                         | 1 . ~   |
|   |  | 0                         |   |
|   |  | 0                         |   |
| er than patients                                |  | 0                         |   |
|   |  | 0                         | 1   |
|   |  | 0                         |   |
|   |  | 0                         | 1   |
|   |  | 0                         | 1   |
|   |  |                           | 1   |
|   |  | 0                         |   |
|   |  | -                         | 1   |
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|   |  |                           | 1   |
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|   |  |                           |   |
|   |  |                           |   |
|   |  |                           |   |
|   |  | •                         |   |
|   |  |                           | 1 27  |
|   | j  | 15, 132<br>226, 010       |   |
| •   | r than patients                              | r than patients           | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>9, 467, 301<br>389, 235<br>3, 977, 198<br>-5, 230<br>59, 300<br>18, 426, 305<br>37, 207, 180<br>15, 891, 423<br>210, 878 |

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

|                  | Financial Systems  | - COCT   | METHODIST HOSE          |                      | CN 15 0002                       |  | u of Form CMS-2                          |                  |
|------------------|--|--|-------------------------|----------------------|----------------------------------|--|--|------------------|
| COSTA            | LLOCATION - HHA GENERAL SERVICE                          | : (051   |                         | HHA CCN:             | CN: 15-0002<br>15-7536           | Peri od:<br>From 01/01/2021<br>To 12/31/2021 | Worksheet H-1<br>Part I<br>Date/Time Pre |                  |
|                  |  |  |                         | TITA CCIV.           | 15-7550                          |  | 5/27/2022 9:0                            |                  |
|                  |  |  |                         |                      |                                  | Home Health<br>Agency I                      | PPS                                      |                  |
|                  |  |  | Capital Rela            | ated Costs           |                                  |  |  |                  |
|                  |  | Net Expenses<br>for Cost<br>Allocation<br>(from Wkst.<br>H, col. 10) | BI dgs &<br>Fi xtures   | Movable<br>Equipment | Plant<br>Operation<br>Maintenanc |  | Subtotal<br>(col s. 0-4)                 |                  |
|                  |  | 0  | 1. 00                   | 2. 00                | 3. 00                            | 4. 00  | 4A. 00                                   |                  |
| 1. 00            | GENERAL SERVICE COST CENTERS  Capital Related - Bldg. &  | 0  | O                       |                      |                                  |  | 0  | 1.00             |
|                  | Fixtures   |  |                         |                      |                                  |  | -  |                  |
| 2. 00            | Capital Related - Movable<br>Equipment                   | 0  |                         | С                    |                                  |  | 0  | 2.00             |
| 3. 00<br>4. 00   | Plant Operation & Maintenance<br>Transportation          | 0  | 0                       | C                    |                                  | 0 0  | 0  | 3. 00<br>4. 00   |
| 5. 00            | Administrative and General                               | 961, 634   | 0                       | C                    | 1                                | 0 0  | 961, 634                                 | 1                |
| 6. 00            | HHA REIMBURSABLE SERVICES Skilled Nursing Care           | 933, 120   | O                       | C                    |                                  | 0 0  | 933, 120                                 | 6.00             |
| 7. 00            | Physi cal Therapy  | 450, 219   | 0                       | C                    |                                  | 0 0  | 450, 219                                 | 7.00             |
| 8. 00<br>9. 00   | Occupational Therapy Speech Pathology                    | 159, 101<br>0  | 0                       | C                    | 1                                | 0 0  | 159, 101<br>0                            | 1                |
| 10.00            | Medical Social Services                                  | 2, 992   | 0                       | C                    | 1                                | 0 0  |  | 10.00            |
| 11. 00<br>12. 00 | Home Health Aide<br>Supplies (see instructions)          | 61, 574<br>0   | 0                       | C                    | 1                                | 0 0  | 01,574                                   | 11.00            |
| 13. 00<br>14. 00 | Drugs<br>DME   | 0  | 0                       | C                    | 1                                | 0  | 0  |                  |
|                  | HHA NONREIMBURSABLE SERVICES                             |  |                         |                      |                                  |  |  |                  |
| 15. 00<br>16. 00 | Home Dialysis Aide Services<br>Respiratory Therapy       | 0  | 0                       | C                    | 1                                | 0 0  | 0  | 1                |
| 17. 00           | Private Duty Nursing                                     | 0  | 0                       | C                    |                                  | 0 0  | O  | 17.00            |
| 18. 00<br>19. 00 | Clinic<br>Health Promotion Activities                    | 0  | 0                       | C                    | l .                              | 0 0  | 0  |                  |
| 20.00            | Day Care Program   | 0  | 0                       | C                    | 1                                | 0 0  | 0  |                  |
| 21. 00<br>22. 00 |  | 0  | 0                       | C                    |                                  | 0 0  | 0  |                  |
| 23.00            | All Others (specify) Telemedicine                        | 0  | 0                       | C                    | 1                                | 0 0  | 0  |                  |
|                  | Total (sum of lines 1-23)                                | 2, 568, 640  | 0                       | C                    |                                  | 0 0  | 2, 568, 640                              | 1                |
|                  |  | Administrativ<br>e & General   | Total (cols.<br>4A + 5) |                      |                                  |  |  |                  |
|                  | CENEDAL SERVICE COST CENTERS                             | 5. 00  | 6. 00                   |                      |                                  |  |  |                  |
| 1. 00            | GENERAL SERVICE COST CENTERS Capital Related - Bldg. &   |  |                         |                      |                                  |  |  | 1.00             |
| 2. 00            | Fixtures Capital Related - Movable                       |  |                         |                      |                                  |  |  | 2.00             |
|                  | Equi pment   |  |                         |                      |                                  |  |  |                  |
| 3. 00<br>4. 00   | Plant Operation & Maintenance<br>Transportation          |  |                         |                      |                                  |  |  | 3. 00<br>4. 00   |
| 5. 00            | Administrative and General HHA REIMBURSABLE SERVICES     | 961, 634   |                         |                      |                                  |  |  | 5.00             |
| 6.00             | Skilled Nursing Care                                     | 558, 381   | 1, 491, 501             |                      |                                  |  |  | 6. 00            |
| 7. 00<br>8. 00   | Physical Therapy Occupational Therapy                    | 269, 411<br>95, 206  | 719, 630<br>254, 307    |                      |                                  |  |  | 7.00             |
| 9. 00            | Speech Pathology   | 0  | 0                       |                      |                                  |  |  | 9. 00            |
| 10. 00<br>11. 00 | Medical Social Services Home Health Aide                 | 1, 790<br>36, 846  | 4, 782<br>98, 420       |                      |                                  |  |  | 10.00            |
| 12.00            | Supplies (see instructions)                              | 0  | 0                       |                      |                                  |  |  | 12.00            |
| 13. 00<br>14. 00 |  | 0  | 0                       |                      |                                  |  |  | 13.00            |
| 15. 00           | HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services | 0  | 0                       |                      |                                  |  |  | 15. 00           |
| 16.00            | Respiratory Therapy                                      | 0  | О                       |                      |                                  |  |  | 16.00            |
| 17. 00<br>18. 00 | Private Duty Nursing<br>Clinic                           | 0  | 0                       |                      |                                  |  |  | 17. 00<br>18. 00 |
| 19.00            | Health Promotion Activities                              | 0  | 0                       |                      |                                  |  |  | 19.00            |
| 21.00            | Day Care Program<br>Home Delivered Meals Program         | 0  | 0                       |                      |                                  |  |  | 20.00            |
| 22. 00<br>23. 00 |  | 0  | 0                       |                      |                                  |  |  | 22. 00<br>23. 00 |
| 23. 50           | Tel emedi ci ne  | 0  | 0                       |                      |                                  |  |  | 23. 50           |
| 24. 00           | Total (sum of lines 1-23)                                |  | 2, 568, 640             |                      |                                  |  |  | 24.00            |

|                  | 5  |               | METUODI OT 1100 | NDI TALO 1110 |              |                                  | 6.5. 040.4                       |         |
|------------------|--|---------------|-----------------|---------------|--------------|----------------------------------|----------------------------------|---------|
|                  | <u>Financial Systems</u><br>ALLOCATION - HHA STATISTICAL BAS | SLS           | METHODIST HOS   | Provider C    | CN: 15-0002  | Period:                          | u of Form CMS-2<br>Worksheet H-1 |         |
|                  |  |               |                 | HHA CCN:      |              | From 01/01/2021<br>To 12/31/2021 | Part II                          | pared:  |
|                  |  |               |                 |               |              | Home Health                      | PPS                              |         |
|                  |  |               |                 |               |              | Agency I                         |                                  |         |
|                  |  | Capital Rel   | ated Costs      |               |              |                                  |                                  |         |
|                  |  | BI dgs &      | Movabl e        | Plant         | Transportati | o Reconciliatio                  | Administrativ                    |         |
|                  |  | Fi xtures     | Equi pment      | Operation &   | n (MI LEAGE) | n                                | e & General                      |         |
|                  |  | (SQUARE FEET) | (DOLLAR         | Mai ntenance  |              |                                  | (ACCUM. COST)                    |         |
|                  |  |               | VALUE)          | (SQUARE FEET) |              |                                  |                                  |         |
|                  |  | 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<br>Equipment                       |               | 0               |               |              | 0                                |                                  | 2.00    |
| 3.00             | Plant Operation & Maintenance                                | 0             | 0               | 0             |              | 0                                |                                  | 3.00    |
| 4. 00            | Transportation (see  | l ol          | 0               | l o           | i            | 0                                |                                  | 4.00    |
|                  | instructions)  |               | _               |               |              |                                  |                                  |         |
| 5.00             | Administrative and General                                   | o             | 0               | 0             |              | 0 -961, 634                      | 1, 607, 006                      | 5.00    |
|                  | HHA REIMBURSABLE SERVICES                                    |               |                 |               |              |                                  |                                  | 1       |
| 6.00             | Skilled Nursing Care   | 0             | 0               | 0             |              | 0 0                              | 933, 120                         | 6.00    |
| 7.00             | Physi cal Therapy  | 0             | 0               | 0             |              | 0                                | 450, 219                         | 7. 00   |
| 8.00             | Occupational Therapy   | 0             | 0               | 0             |              | 0                                | 159, 101                         | 8.00    |
| 9.00             | Speech Pathology   | 0             | 0               | 0             | 1            | 0                                | 0                                |         |
| 10.00            | Medical Social Services                                      | 0             | 0               | 0             | 1            | 0                                | 2, 992                           |         |
| 11. 00           | Home Health Aide   | 0             | 0               | 0             |              | 0                                |                                  | 11.00   |
| 12. 00           | Supplies (see instructions)                                  | 0             | 0               | 0             | 1            | 0                                | 0                                |         |
| 13. 00           | Drugs  | 0             | 0               | _             | 1            | 0                                | 0                                | 13.00   |
| 14.00            | DME  | 0             | 0               | 0             | 1            | 0 0                              | 0                                | 14.00   |
| 45.00            | HHA NONREI MBURSABLE SERVI CES                               |               |                 |               |              |                                  |                                  | 45 00   |
| 15.00            | Home Dialysis Aide Services                                  | 0             | 0               |               |              | 0 0                              | 0                                |         |
| 16.00            | Respiratory Therapy  | 0             | 0               |               |              |                                  | 0                                | 16.00   |
| 17. 00<br>18. 00 | Private Duty Nursing   | 0             | 0               |               |              |                                  | 0                                |         |
| 19. 00           | Health Promotion Activities                                  | 0             | 0               |               |              |                                  | 0                                | 19.00   |
| 20. 00           | Day Care Program   |               | 0               |               |              |                                  | 0                                | 20.00   |
| 21. 00           | Home Delivered Meals Program                                 |               | 0               |               |              |                                  | 0                                | 21.00   |
| 22. 00           | Homemaker Service  |               | 0               |               |              |                                  | 1 0                              | 22.00   |
| 23. 00           | All Others (specify)   |               | 0               |               |              |                                  | 1                                | 23.00   |
| 23. 50           | Tel emedi ci ne  |               | 0               |               |              |                                  | 1 0                              | 23.50   |
| 24. 00           | Total (sum of lines 1-23)                                    | ا             | 0               |               |              | 0 -961, 634                      | 1, 607, 006                      |         |
| 25. 00           | Cost To Be Allocated (per                                    |               | 0               | 1             |              | 0                                | 961, 634                         |         |
| 20.00            | Westernest II 1 Deat I)                                      | ı             | 0               | 1             | 1            | <u> </u>                         | 1 ,51,054                        | 1 -0.00 |

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0. 598401 26. 00

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

|  |  |  |  |  |                       |   | 5/27/2022 9: 0  | <u> 2 am </u>  |
|--|--|--|--|--|-----------------------|---|---|--|
|  |  |  |  |  |                       | Home Health   | PPS   |  |
|  |  |  |  |  |                       | Agency I  |   |  |
|  |  |  | CAPI TAL   |  |                       |   |   |  |
|  |  |  | RELATED COSTS  |  |                       |   |   |  |
|  | Cost Center Description  | HHA Trial  | BLDG & FIXT  | EMPLOYEE   | DATA                  | PURCHASI NG   | ADMITTI NG  |  |
|  |  | Bal ance (1)   |  | BENEFITS   | PROCESSI NG           | RECEIVING AND   |   |  |
|  |  |  |  | DEPARTMENT   |                       | STORES  |   |  |
|  |  | 0  | 1. 00  | 4. 00  | 5. 01                 | 5. 02   | 5. 03   |  |
| 1.00   | Administrative and General   | 0  | 0  | 485, 495   | C                     | 9, 875  | 10, 062   | 1.00   |
| 2.00   | Skilled Nursing Care   | 1, 491, 501  | 0  | 0  | C                     | 0   | 0   | 2.00   |
| 3.00   | Physi cal Therapy  | 719, 630   | 0  | 0  |                       | 0   | 0   | 3.00   |
| 4.00   | Occupational Therapy   | 254, 307   | O  | 0  | l                     | 0   | 0   | 4.00   |
| 5.00   | Speech Pathology   | 0  | 0  | 0  |                       | 0   | 0   | 5.00   |
| 6.00   | Medical Social Services  | 4, 782   | 0  | 0  | 1                     | 0   | 0   | 6.00   |
| 7.00   | Home Health Aide   | 98, 420  | 0  | 0  | (                     | 0   | 0   | 7. 00  |
| 8. 00  | Supplies (see instructions)  | 0  | o  | 0  | ď                     | n n   | 0   | 8. 00  |
| 9. 00  | Drugs  | 0  | 0  | 0  | ď                     | 0   | 0   | 9. 00  |
| 10. 00   | DME  | o o  | 0  | 0  |                       | _   | 0   | 10.00  |
| 11. 00   | Home Dialysis Aide Services  | o o  | o  | 0  |                       | _   | o<br>O  | 11. 00   |
| 12. 00   | Respiratory Therapy  |  | o  | 0  |                       | _   | 0   | 12.00  |
| 13. 00   | Private Duty Nursing   |  | 0  | 0  |                       | 1   | 0   | 13.00  |
| 14. 00   | Clinic   |  | 0  | 0  |                       | _   | 0   | 14.00  |
|  | ·  |  | -  | 0  |                       | _   | 0   |  |
| 15.00  | Health Promotion Activities  |  | 0  | 0  | -                     | _   | 0   | 15.00  |
| 16.00  | Day Care Program   | 0  | 0  | 0  | C                     | _   | 0   | 16.00  |
| 17. 00   | Home Delivered Meals Program   | 0  | 0  | 0  | 0                     | -   | 0   | 17.00  |
| 18. 00   | Homemaker Service  | 0  | 0  | 0  | C                     | _   | 0   | 18. 00   |
| 19. 00   | All Others (specify)   | 0  | 0  | 0  | (                     | 0   | 0   | 19.00  |
| 19. 50   | Tel emedi ci ne  | 0  | 0  | 0  | (                     | 0   | 0   | 19. 50   |
| 20.00  | Total (sum of lines 1-19) (2)  | 2, 568, 640  | 0  | 485, 495   | (                     | 9, 875  | 10, 062   |  |
| 21. 00   | Unit Cost Multiplier: column   |  |  |  |                       |   |   | 21. 00   |
|  | 26, line 1 divided by the sum  |  |  |  |                       |   |   |  |
|  | of column 26, line 20 minus  |  |  |  |                       |   |   |  |
|  |  |  |  |  |                       |   |   |  |
|  | column 26, line 1, rounded to  |  |  |  |                       |   |   |  |
|  | 6 decimal places.  |  |  |  |                       |   |   |  |
|  |  | CASHI ERI NG/AC  | Subtotal   | OTHER A&G  | PATI ENT              | OPERATION OF  | LAUNDRY &   |  |
|  | 6 decimal places.  | COUNTS   | Subtotal   | OTHER A&G  | TRANSPORTATI 0        |   | LAUNDRY &<br>LINEN SERVICE  |  |
|  | 6 decimal places.  | COUNTS<br>RECEI VABLE  |  |  | TRANSPORTATION        | PLANT   | LINEN SERVICE   |  |
| 1.00   | 6 decimal places. Cost Center Description  | COUNTS<br>RECEI VABLE<br>5. 04   | 5A. 04   | 5. 05  | TRANSPORTATION N 5.06 | PLANT<br>7. 00  | LINEN SERVICE<br>8.00   | 1.00   |
| 1.00   | 6 decimal places. Cost Center Description  Administrative and General  | COUNTS<br>RECEI VABLE  | 5A. 04<br>526, 113   | 5. 05<br>57, 977   | TRANSPORTATION N 5.06 | 7.00<br>0   | LINEN SERVICE<br>8.00   | 1.00   |
| 2.00   | 6 decimal places.  Cost Center Description  Administrative and General Skilled Nursing Care  | COUNTS<br>RECEI VABLE<br>5. 04   | 5A. 04<br>526, 113<br>1, 491, 501  | 5. 05<br>57, 977<br>164, 362   | TRANSPORTATION N 5.06 | 7.00<br>0   | 8.00<br>0   | 2. 00  |
| 2. 00<br>3. 00   | Administrative and General Skilled Nursing Care Physical Therapy   | COUNTS<br>RECEI VABLE<br>5. 04   | 5A. 04<br>526, 113<br>1, 491, 501<br>719, 630  | 5. 05<br>57, 977<br>164, 362<br>79, 303  | TRANSPORTATION N 5.06 | 7. 00<br>0<br>0<br>0<br>0   | 8.00<br>0<br>0  | 2. 00<br>3. 00   |
| 2. 00<br>3. 00<br>4. 00  | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy  | COUNTS<br>RECEI VABLE<br>5. 04   | 5A. 04<br>526, 113<br>1, 491, 501<br>719, 630<br>254, 307  | 5. 05<br>57, 977<br>164, 362<br>79, 303<br>28, 024   | TRANSPORTATION N 5.06 | 7. 00<br>0<br>0<br>0<br>0   | 8.00<br>0<br>0<br>0   | 2. 00<br>3. 00<br>4. 00  |
| 2. 00<br>3. 00<br>4. 00<br>5. 00   | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology   | COUNTS<br>RECEI VABLE<br>5. 04   | 5A. 04<br>526, 113<br>1, 491, 501<br>719, 630<br>254, 307<br>0   | 5. 05<br>57, 977<br>164, 362<br>79, 303<br>28, 024<br>0  | TRANSPORTATION N 5.06 | 7. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0                                    | 8. 00<br>0<br>0<br>0<br>0<br>0  | 2. 00<br>3. 00<br>4. 00<br>5. 00   |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00  | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services   | COUNTS<br>RECEI VABLE<br>5. 04   | 5A. 04<br>526, 113<br>1, 491, 501<br>719, 630<br>254, 307<br>0<br>4, 782   | 5. 05<br>57, 977<br>164, 362<br>79, 303<br>28, 024<br>0<br>527   | TRANSPORTATION N 5.06 | 7. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0                                    | 8. 00<br>0<br>0<br>0<br>0<br>0<br>0   | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00  |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00   | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide  | COUNTS<br>RECEI VABLE<br>5. 04   | 5A. 04<br>526, 113<br>1, 491, 501<br>719, 630<br>254, 307<br>0   | 5. 05<br>57, 977<br>164, 362<br>79, 303<br>28, 024<br>0  | TRANSPORTATION N 5.06 | 7. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 8. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0                               | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00   |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00  | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)  | COUNTS<br>RECEI VABLE<br>5. 04   | 5A. 04<br>526, 113<br>1, 491, 501<br>719, 630<br>254, 307<br>0<br>4, 782   | 5. 05<br>57, 977<br>164, 362<br>79, 303<br>28, 024<br>0<br>527   | TRANSPORTATION N 5.06 | 7. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 8.00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0                                | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00  |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00   | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs  | COUNTS<br>RECEI VABLE<br>5. 04   | 5A. 04<br>526, 113<br>1, 491, 501<br>719, 630<br>254, 307<br>0<br>4, 782<br>98, 420  | 5. 05<br>57, 977<br>164, 362<br>79, 303<br>28, 024<br>0<br>527   | TRANSPORTATION N 5.06 | 7. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 8.00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0                           | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00   |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00   | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME  | COUNTS<br>RECEI VABLE<br>5. 04   | 5A. 04<br>526, 113<br>1, 491, 501<br>719, 630<br>254, 307<br>0<br>4, 782<br>98, 420  | 5. 05<br>57, 977<br>164, 362<br>79, 303<br>28, 024<br>0<br>527   | TRANSPORTATION N 5.06 | 7. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 8.00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0                                | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00   |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00   | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services  | COUNTS<br>RECEI VABLE<br>5. 04   | 5A. 04<br>526, 113<br>1, 491, 501<br>719, 630<br>254, 307<br>0<br>4, 782<br>98, 420  | 5. 05<br>57, 977<br>164, 362<br>79, 303<br>28, 024<br>0<br>527   | TRANSPORTATION N 5.06 | 7. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 8.00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0                           | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00   |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00   | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy  | COUNTS<br>RECEI VABLE<br>5. 04   | 5A. 04<br>526, 113<br>1, 491, 501<br>719, 630<br>254, 307<br>0<br>4, 782<br>98, 420  | 5. 05<br>57, 977<br>164, 362<br>79, 303<br>28, 024<br>0<br>527   | TRANSPORTATION N 5.06 | 7. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 8.00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0                           | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00   |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00   | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing   | COUNTS<br>RECEI VABLE<br>5. 04   | 5A. 04<br>526, 113<br>1, 491, 501<br>719, 630<br>254, 307<br>0<br>4, 782<br>98, 420  | 5. 05<br>57, 977<br>164, 362<br>79, 303<br>28, 024<br>0<br>527   | TRANSPORTATION N 5.06 | 7. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 8. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0                     | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00   |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00   | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing   | COUNTS<br>RECEI VABLE<br>5. 04   | 5A. 04<br>526, 113<br>1, 491, 501<br>719, 630<br>254, 307<br>0<br>4, 782<br>98, 420<br>0<br>0<br>0<br>0  | 5. 05<br>57, 977<br>164, 362<br>79, 303<br>28, 024<br>0<br>527   | TRANSPORTATION N 5.06 | 7. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 8. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0           | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00   |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00   | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing   | COUNTS<br>RECEI VABLE<br>5. 04   | 5A. 04<br>526, 113<br>1, 491, 501<br>719, 630<br>254, 307<br>0<br>4, 782<br>98, 420<br>0<br>0<br>0<br>0  | 5. 05<br>57, 977<br>164, 362<br>79, 303<br>28, 024<br>0<br>527   | TRANSPORTATION N 5.06 | PLANT  7. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0                             | 8. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00   |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00   | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic  | COUNTS<br>RECEI VABLE<br>5. 04   | 5A. 04<br>526, 113<br>1, 491, 501<br>719, 630<br>254, 307<br>0<br>4, 782<br>98, 420<br>0<br>0<br>0<br>0  | 5. 05<br>57, 977<br>164, 362<br>79, 303<br>28, 024<br>0<br>527   | TRANSPORTATION N 5.06 | PLANT  7. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0                             | 8. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0           | 2.00<br>3.00<br>4.00<br>5.00<br>6.00<br>7.00<br>8.00<br>9.00<br>10.00<br>11.00<br>12.00<br>13.00<br>14.00  |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00   | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program   | COUNTS<br>RECEI VABLE<br>5. 04   | 5A. 04<br>526, 113<br>1, 491, 501<br>719, 630<br>254, 307<br>0<br>4, 782<br>98, 420<br>0<br>0<br>0<br>0  | 5. 05<br>57, 977<br>164, 362<br>79, 303<br>28, 024<br>0<br>527   | TRANSPORTATION N 5.06 | PLANT  7. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0                             | 8. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0           | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00   |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00   | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program  | COUNTS<br>RECEI VABLE<br>5. 04   | 5A. 04<br>526, 113<br>1, 491, 501<br>719, 630<br>254, 307<br>0<br>4, 782<br>98, 420<br>0<br>0<br>0<br>0  | 5. 05<br>57, 977<br>164, 362<br>79, 303<br>28, 024<br>0<br>527   | TRANSPORTATION N 5.06 | PLANT  7. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0                             | 8. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0           | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00                              |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>17. 00<br>18. 00                               | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service  | COUNTS<br>RECEI VABLE<br>5. 04   | 5A. 04<br>526, 113<br>1, 491, 501<br>719, 630<br>254, 307<br>0<br>4, 782<br>98, 420<br>0<br>0<br>0<br>0  | 5. 05<br>57, 977<br>164, 362<br>79, 303<br>28, 024<br>0<br>527   | TRANSPORTATION N 5.06 | PLANT  7. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0                             | 8. 00<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0           | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00<br>18. 00           |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>17. 00<br>18. 00<br>19. 00                     | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)   | COUNTS<br>RECEI VABLE<br>5. 04   | 5A. 04<br>526, 113<br>1, 491, 501<br>719, 630<br>254, 307<br>0<br>4, 782<br>98, 420<br>0<br>0<br>0<br>0  | 5. 05<br>57, 977<br>164, 362<br>79, 303<br>28, 024<br>0<br>527   | TRANSPORTATION N 5.06 | PLANT  7. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0                             | 8. 00  8. 00  0  0  0  0  0  0  0  0  0  0  0  0                            | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00<br>18. 00<br>19. 00 |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00<br>18. 00<br>19. 00<br>19. 50           | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine  | COUNTS RECEI VABLE 5. 04 20, 681 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 5A. 04  526, 113 1, 491, 501 719, 630 254, 307 0 4, 782 98, 420 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0  | 5. 05<br>57, 977<br>164, 362<br>79, 303<br>28, 024<br>0<br>527<br>10, 846<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | TRANSPORTATION N 5.06 | PLANT  7. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0                             | 8. 00  8. 00  0  0  0  0  0  0  0  0  0  0  0  0                            | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>14. 00<br>15. 00<br>17. 00<br>18. 00<br>19. 50                     |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00<br>18. 00<br>19. 00<br>19. 50<br>20. 00 | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)  | COUNTS<br>RECEI VABLE<br>5. 04   | 5A. 04<br>526, 113<br>1, 491, 501<br>719, 630<br>254, 307<br>0<br>4, 782<br>98, 420<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 5. 05<br>57, 977<br>164, 362<br>79, 303<br>28, 024<br>0<br>527   | TRANSPORTATION N 5.06 | PLANT  7. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0                             | 8. 00  8. 00  0  0  0  0  0  0  0  0  0  0  0  0                            | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>17. 00<br>18. 00<br>19. 50<br>20. 00 |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00<br>18. 00<br>19. 00<br>19. 50           | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column                              | COUNTS RECEI VABLE 5. 04 20, 681 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 5A. 04  526, 113 1, 491, 501 719, 630 254, 307 0 4, 782 98, 420 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0  | 5. 05<br>57, 977<br>164, 362<br>79, 303<br>28, 024<br>0<br>527<br>10, 846<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | TRANSPORTATION N 5.06 | PLANT  7. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0                             | 8. 00  8. 00  0  0  0  0  0  0  0  0  0  0  0  0                            | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>14. 00<br>15. 00<br>17. 00<br>18. 00<br>19. 50                     |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00<br>18. 00<br>19. 00<br>19. 50<br>20. 00 | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum                             | COUNTS RECEI VABLE 5. 04 20, 681 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 5A. 04<br>526, 113<br>1, 491, 501<br>719, 630<br>254, 307<br>0<br>4, 782<br>98, 420<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 5. 05<br>57, 977<br>164, 362<br>79, 303<br>28, 024<br>0<br>527<br>10, 846<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | TRANSPORTATION N 5.06 | PLANT  7. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0                             | 8. 00  8. 00  0  0  0  0  0  0  0  0  0  0  0  0                            | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>17. 00<br>18. 00<br>19. 50<br>20. 00 |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00<br>18. 00<br>19. 00<br>19. 50<br>20. 00 | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column                              | COUNTS RECEI VABLE 5. 04 20, 681 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 5A. 04<br>526, 113<br>1, 491, 501<br>719, 630<br>254, 307<br>0<br>4, 782<br>98, 420<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 5. 05<br>57, 977<br>164, 362<br>79, 303<br>28, 024<br>0<br>527<br>10, 846<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | TRANSPORTATION N 5.06 | PLANT  7. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0                             | 8. 00  8. 00  0  0  0  0  0  0  0  0  0  0  0  0                            | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>17. 00<br>18. 00<br>19. 50<br>20. 00 |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00<br>18. 00<br>19. 00<br>19. 50<br>20. 00 | Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus | COUNTS RECEI VABLE 5. 04 20, 681 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 5A. 04<br>526, 113<br>1, 491, 501<br>719, 630<br>254, 307<br>0<br>4, 782<br>98, 420<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 5. 05<br>57, 977<br>164, 362<br>79, 303<br>28, 024<br>0<br>527<br>10, 846<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | TRANSPORTATION N 5.06 | PLANT  7. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0                             | 8. 00  8. 00  0  0  0  0  0  0  0  0  0  0  0  0                            | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>17. 00<br>18. 00<br>19. 50<br>20. 00 |

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

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21.00

Clinic

Day Care Program

Homemaker Service

6 decimal places.

Tel emedi ci ne

All Others (specify)

Health Promotion Activities

Home Delivered Meals Program

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

Unit Cost Multiplier: column

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

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

From 01/01/2021 Part I Date/Time Prepared: 5/27/2022 9:02 am HHA CCN: 15-7536 12/31/2021 To Home Health Agency I PARAMED ED Allocated HHA Total HHA Cost Center Description Subtotal Intern & Subtotal A&G (see Part PROGRAM Resi dents Costs Cost & Post II) Stepdown Adjustments 23. 00 24. 00 25. 00 26.00 27. 00 28. 00 Administrative and General 1.00 0 606, 152 1.00 606, 152 2,007,830 2.00 Skilled Nursing Care 1, 655, 863 1, 655, 863 351, 967 2.00 3.00 Physical Therapy 0 798, 933 798, 933 169, 820 968, 753 3.00 Occupational Therapy 0 282, 331 0 282, 331 60, 012 342, 343 4.00 4.00 0 Speech Pathology 5.00 5.00 6.00 Medical Social Services 5, 309 0 5, 309 1, 128 6, 437 6.00 7.00 Home Health Aide 109, 266 109, 266 23, 225 132, 491 7.00 Supplies (see instructions) 0 0 0 8.00 8 00 O 0 0 0 9.00 Drugs 0 0 0 0 9.00 10.00 DME 0 10.00 0 11.00 Home Dialysis Aide Services 0 0 0 0 0 0 0000000 0 0 11.00 0 Respiratory Therapy 0 0 12.00 12.00

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3, 457, 854

Private Duty Nursing

Day Care Program

Homemaker Service

6 decimal places.

Tel emedi ci ne

All Others (specify)

Health Promotion Activities

Home Delivered Meals Program

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

Unit Cost Multiplier: column

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

13.00

14.00

15.00

16.00

17.00

18.00

19.00

19.50

20.00

21.00

Clinic

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

BASIS HHA CCN: 15-7536

| Cost Center Description   Cost Center Desc   |   |  |   |  |   |               | Home Health<br>Agency I   | PPS                                     |  |
|--|---|--|---|--|---|---------------|---|---|--|
| Cost Center Description  |   |  | CAPI TAL  |  |   |               | Agency  |   |  |
| COUNTS   C   |   |  | RELATED COSTS   |  |   |               |   |   |  |
| Name   |   | Cost Center Description  | BLDG & FIXT   | EMPLOYEE   | DATA  | PURCHASI NG   | ADMI TTI NG   | CASHI ERI NG/AC                         |  |
| Company  |   |  | (SQUARE FEET)   | BENEFITS   |   |               |   |   |  |
| SALARIES   REQUISITIONS   CHARGES   CHARGES  |   |  |   |  | ,   |               | CHARGES)  |   |  |
| 1.00   |   |  |   |  | TIME)   |               |   |   |  |
| 1.00   |   |  |   |  |   |               |   |   |  |
| 2.00   Skilled Nursing Care   0  | 1.00  |  |   |  |   |               |   |   |  |
| 3.00   Physical Therapy  |   | 1  |   |  | 0   | 122, 4/3      | 3, 944, 434   | 3, 944, 434                             |  |
| 4.00   |   | _  | 0   | _  | 0   | 0             | 0   | 0                                       |  |
| 5.00   Speech Pathology   0   0   0   0   0   0   0   0   0  |   |  | 0   | _  | 0   | 0             | 0   | 1                                       |  |
| 6.00   Medical Social Services   0   0   0   0   0   0   0   0   0   |   |  | 0   | Ū  | 0   | 0             | 0   | 1 1                                     |  |
| Note   Home Heal th Aide   |   |  | 0   | -  | 0   | ľ             | _   | 1                                       |  |
| Supplies (see instructions)  |   | 1  | 0   | -  | 0   | ľ             | _   | 1 1                                     |  |
| 9.00   Drugs   0   0   0   0   0   0   0   0   0   |   | 4  | 0   | _  | 0   |               | 0   |   |  |
| 10.00   DME   DM   |   |  | 0   | _  | 0   | 0             | 0   |   |  |
| 11.00   Home Dialysis Aide Services   0   0   0   0   0   0   0   11.00  |   |  | 0   | _  | 0   | 0             | 0   | 1 1                                     |  |
| 12.00   Respiratory Therapy   0   0   0   0   0   0   0   0   0  |   | 1  | 0   |  | 0   | 0             | 0   |   |  |
| 13.00   Private Dufy Nursing   0   0   0   0   0   0   0   13.00   |   |  | 0   | -  | 0   | 0             | 0   |   |  |
| 14.00   Clinic   15.00   Lalth Promotion Activities   0   0   0   0   0   0   0   0   0  |   |  | 0   |  | _   | · ·           | 0   |   |  |
| 15.00   Heal th Promotion Activities   0   0   0   0   0   0   0   0   15.00   |   |  | 0   | _  | Ŭ   | ľ             | 0   |   |  |
| 16.00   Day Care Program   0   |   |  | 0   | 0  | 0   | 0             | 0   | j o                                     |  |
| 17.00   Home Del I vered Meals Program   0   0   0   0   0   0   0   17.00   |   |  | 0   | 0  | 0   | 0             | 0   | o o                                     |  |
| 18.00  |   |  | 0   | 0  | 0   | 0             | 0   | ol                                      |  |
| 19.00   All Others (specify)   0   0   0   0   0   0   0   0   19.50   | 18.00   | _  | 0   | 0  | 0   | 0             | 0   | o                                       | 18.00  |
| 20.00   Total (sum of lines 1-19)   0   2,167,399   0   122,473   3,944,434   3,944,434   20.00   20   | 19.00   | All Others (specify)   | 0   | 0  | 0   | 0             | 0   | 0                                       | 19.00  |
| 21.00   Total cost to be all located   0.00000   0.23999   0.000000   0.080630   0.002551   0.005243   22.00   | 19. 50  | Tel emedi ci ne  | 0   | 0  | 0   | 0             | 0   | 0                                       | 19.50  |
| 22.00   Unit cost multiplier   0.000000   0.223999   0.000000   0.080630   0.002551   0.005243   22.00   | 20.00   | Total (sum of lines 1-19)  | 0   | 2, 167, 399  | 0   | 122, 473      | 3, 944, 434   | 3, 944, 434                             | 20.00  |
| Cost Center Description   Reconciliation   N   | 21.00   | Total cost to be allocated   | 0   |  | 0   | 9, 875        | 10, 062   |   | 21.00  |
| Name   | 22. 00  |  |   |  |   |               |   |   | 22.00  |
| Note   |   | Cost Center Description  |   |  |   |               |   |   |  |
| SA 05   S. 05   S. 06   7. 00   8. 00   9. 00  |   |  | n   | (ACCUM. COST)  |   |               |   | (SQUARE FEET)                           |  |
| TRIPS    SA.05   S.05   S.06   T.00   S.00   |   |  |   |  |   | (SQUARE FEET) |   |   |  |
| 1.00   Administrative and General   0   52.6   13   0   0   0   0   0   0   0   0   0  |   |  |   |  |   |               | LAUNDRY)  |   |  |
| 1.00   Administrative and General   0   526, 113   0   0   0   0   0   0   1.00  |   |  | 54.05   | 5.05   |   | 7 00          | 8 00  | 9 00                                    |  |
| 2.00         Skilled Nursing Care         0         1,491,501         0         0         0         0         2.00           3.00         Physical Therapy         0         719,630         0         0         0         0         3.00           4.00         Occupational Therapy         0         254,307         0         <  | 1 00  | Administrative and General   |   |  |   |               | 0.00  |   | 1 00   |
| 3.00   Physical Therapy   0   719,630   0   0   0   0   3.00   4.00   Occupational Therapy   0   254,307   0   0   0   0   5.00   Speech Pathology   0   0   0   0   0   6.00   Medical Social Services   0   4,782   0   0   0   0   7.00   Home Health Aide   0   98,420   0   0   0   0   8.00   Supplies (see instructions)   0   0   0   0   0   9.00   Drugs   0   0   0   0   0   10.00   DME   0   0   0   0   0   11.00   Home Dialysis Aide Services   0   0   0   0   12.00   Respiratory Therapy   0   0   0   0   13.00   Private Duty Nursing   0   0   0   0   14.00   Clinic   0   0   0   0   15.00   Health Promotion Activities   0   0   0   0   17.00   Home Delivered Meals Program   0   0   0   0   18.00   Home Delivered Meals Program   0   0   0   0   18.00   Home Maker Service   0   0   0   0   19.50   Telemedicine   0   0   0   0   20.00   Total (sum of lines 1-19)   3,094,753   0   0   0   21.00   Total cost to be allocated   341,039   0   0   0    10.00   Total cost to be allocated   341,039   0   0   0    10.00   1.00   0   0   0   0    10.00   0   0   0   0   0    10.00   0   0   0   0   0    10.00   0   0   0   0    10.00   0   0   0   0    10.00   0   0   0   0    10.00   0   0   0    10.00   0   0   0    10.00   0   0   0    10.00   0   0   0    10.00   0    10.00   0   0    10.00   0    10.00   0    10.00   0    10.00   0    10.00   0    10.00   0    10.00   0    10.00   0    10.00   0    10.00   0    10.00   0    10.00   0    10.00   0    10.00   0    10.00   0    10.00   0    10.00   0    10.00   0    10.0 |   | 1  | _   |  | Ŭ   |               |   |   |  |
| 4.00       Occupational Therapy       0       254, 307       0       0       0       0       4.00         5.00       Speech Pathology       0  |   | _  |   |  |   | l o           | 0   | - 1                                     |  |
| 5.00         Speech Pathology         0         0         0         0         0         5.00           6.00         Medical Social Services         0         4,782         0         0         0         0         6.00           7.00         Home Health Aide         0         98,420            |   | TPHVSI Call Therapy  | 0   |  | 0<br>  0  | 0             | 0   | 0                                       | 2.00   |
| 7.00 Home Health Aide  | 4.00  | 1 3  | 0   | 719, 630   | 0<br>0<br>0   | 0 0           | 0 0   | 0                                       | 2. 00<br>3. 00   |
| 8.00 Supplies (see instructions) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0   |   | Occupational Therapy   | 0 0   | 719, 630<br>254, 307   | 0<br>0<br>0<br>0  | 0             | 0<br>0<br>0<br>0  | 0<br>0<br>0                             | 2. 00<br>3. 00<br>4. 00  |
| 9.00 Drugs 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0   | 5.00  | Occupational Therapy<br>Speech Pathology   | 0<br>0<br>0   | 719, 630<br>254, 307<br>0  | 0   | 0             | 0<br>0<br>0<br>0  | 0<br>0<br>0<br>0                        | 2. 00<br>3. 00<br>4. 00<br>5. 00   |
| 10.00       DME       0       0       0       0       0       0       10.00         11.00       Home Dial ysis Aide Services       0       0       0       0       0       0       0       0       11.00         12.00       Respiratory Therapy       0   | 5. 00<br>6. 00  | Occupational Therapy<br>Speech Pathology<br>Medical Social Services  | 0 0 0   | 719, 630<br>254, 307<br>0<br>4, 782  | 0   | 0             | 0<br>0<br>0<br>0<br>0   | 0<br>0<br>0<br>0                        | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00  |
| 11.00       Home Dialysis Aide Services       0       0       0       0       0       0       11.00         12.00       Respiratory Therapy       0       0       0       0       0       0       0       12.00         13.00       Private Duty Nursing       0       0       0       0       0       0       0       0       0       0       0       13.00         14.00       Clinic       0       0       0       0       0       0       0       0       0       14.00         15.00       Heal th Promotion Activities       0       0       0       0       0       0       0       0       0       15.00         16.00       Day Care Program       0       0       0       0       0       0       0       0       0       0       0       0       16.00         17.00       Home Deli vered Meals Program       0  | 5. 00<br>6. 00<br>7. 00   | Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)   | 0<br>0<br>0<br>0<br>0   | 719, 630<br>254, 307<br>0<br>4, 782  | 0   | 0             | 0<br>0<br>0<br>0<br>0<br>0  | 0<br>0<br>0<br>0<br>0<br>0              | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00   |
| 12.00       Respiratory Therapy       0       0       0       0       0       12.00         13.00       Private Duty Nursing       0       0       0       0       0       0       0       0       13.00         14.00       Clinic       0       0       0       0       0       0       0       0       14.00         15.00       Heal th Promotion Activities       0       0       0       0       0       0       0       0       0       0       0       0       15.00         16.00       Day Care Program       0  | 5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00   | Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)   | 0<br>0<br>0<br>0<br>0<br>0  | 719, 630<br>254, 307<br>0<br>4, 782  | 0   | 0             | 0<br>0<br>0<br>0<br>0<br>0  | 0 0 0 0 0 0 0 0 0 0 0 0                 | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00  |
| 13.00     Private Duty Nursing     0     0     0     0     0     0     13.00       14.00     Clinic     0     0     0     0     0     0     0     14.00       15.00     Health Promotion Activities     0     0     0     0     0     0     0     0     15.00       16.00     Day Care Program     0     0     0     0     0     0     0     0     0     16.00       17.00     Home Delivered Meals Program     0  | 5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00   | Occupational Therapy<br>Speech Pathology<br>Medical Social Services<br>Home Health Aide<br>Supplies (see instructions)<br>Drugs<br>DME   | 0<br>0<br>0<br>0<br>0<br>0  | 719, 630<br>254, 307<br>0<br>4, 782  | 0   | 0             | 0<br>0<br>0<br>0<br>0<br>0<br>0   | 0 0 0 0 0 0 0 0 0 0 0 0                 | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00   |
| 14.00       Clinic       0       0       0       0       0       0       14.00         15.00       Health Promotion Activities       0       0       0       0       0       0       0       0       0       15.00         16.00       Day Care Program       0       0       0       0       0       0       0       0       16.00         17.00       Home Delivered Meals Program       0 <td>5. 00<br/>6. 00<br/>7. 00<br/>8. 00<br/>9. 00<br/>10. 00<br/>11. 00</td> <td>Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services</td> <td>0<br/>0<br/>0<br/>0<br/>0<br/>0<br/>0</td> <td>719, 630<br/>254, 307<br/>0<br/>4, 782</td> <td>0</td> <td>0</td> <td>0<br/>0<br/>0<br/>0<br/>0<br/>0<br/>0<br/>0</td> <td>0 0 0 0 0 0 0 0 0 0 0 0</td> <td>2. 00<br/>3. 00<br/>4. 00<br/>5. 00<br/>6. 00<br/>7. 00<br/>8. 00<br/>9. 00<br/>10. 00<br/>11. 00</td>  | 5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00   | Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services   | 0<br>0<br>0<br>0<br>0<br>0<br>0   | 719, 630<br>254, 307<br>0<br>4, 782  | 0   | 0             | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0  | 0 0 0 0 0 0 0 0 0 0 0 0                 | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00   |
| 15.00     Health Promotion Activities     0     0     0     0     0     0     15.00       16.00     Day Care Program     0     0     0     0     0     0     0     0     16.00       17.00     Home Delivered Meals Program     0     0     0     0     0     0     0     0     17.00       18.00     Homemaker Service     0     0     0     0     0     0     0     0     18.00       19.00     All Others (specify)     0     0     0     0     0     0     0     0     19.50       20.00     Total (sum of lines 1-19)     3,094,753     0     0     0     0     0     20.00       21.00     Total cost to be allocated     341,039     0     0     0     0     0     21.00  | 5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00   | Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy   | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0  | 719, 630<br>254, 307<br>0<br>4, 782  | 0   | 0             | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0  | 0 | 2.00<br>3.00<br>4.00<br>5.00<br>6.00<br>7.00<br>8.00<br>9.00<br>10.00<br>11.00<br>12.00  |
| 16.00     Day Care Program     0     0     0     0     0     0     16.00       17.00     Home Delivered Meals Program     0     0     0     0     0     0     0     17.00       18.00     Homemaker Service     0     0     0     0     0     0     0     0     18.00       19.00     All Others (specify)     0     0     0     0     0     0     0     0     19.50       19.50     Tel emedicine     0     0     0     0     0     0     0     19.50       20.00     Total (sum of lines 1-19)     3,094,753     0     0     0     0     0     20.00       21.00     Total cost to be allocated     341,039     0     0     0     0     0     21.00  | 5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00   | Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing  | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0   | 719, 630<br>254, 307<br>0<br>4, 782  | 0   | 0             | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0   | 0 | 2.00<br>3.00<br>4.00<br>5.00<br>6.00<br>7.00<br>8.00<br>9.00<br>10.00<br>11.00<br>12.00<br>13.00   |
| 17.00     Home Delivered Meals Program     0     0     0     0     0     17.00       18.00     Homemaker Service     0     0     0     0     0     0     18.00       19.00     All Others (specify)     0     0     0     0     0     0     0     19.00       19.50     Tel emedicine     0     0     0     0     0     0     19.50       20.00     Total (sum of lines 1-19)     3,094,753     0     0     0     0     0     20.00       21.00     Total cost to be allocated     341,039     0     0     0     0     21.00   | 5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00   | Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic   | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0   | 719, 630<br>254, 307<br>0<br>4, 782<br>98, 420<br>0<br>0<br>0<br>0<br>0  | 0   | 0             | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0   |   | 2.00<br>3.00<br>4.00<br>5.00<br>6.00<br>7.00<br>8.00<br>9.00<br>10.00<br>11.00<br>12.00<br>13.00<br>14.00  |
| 18.00     Homemaker Service     0     0     0     0     0     18.00       19.00     All Others (specify)     0     0     0     0     0     0     19.00       19.50     Tel emedicine     0     0     0     0     0     0     19.50       20.00     Total (sum of lines 1-19)     3,094,753     0     0     0     0     0     20.00       21.00     Total cost to be allocated     341,039     0     0     0     0     21.00  | 5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00   | Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities   | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0  | 719, 630<br>254, 307<br>0<br>4, 782<br>98, 420<br>0<br>0<br>0<br>0<br>0<br>0   | 0   | 0             | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0   |   | 2.00<br>3.00<br>4.00<br>5.00<br>6.00<br>7.00<br>8.00<br>9.00<br>10.00<br>11.00<br>12.00<br>13.00<br>14.00<br>15.00   |
| 19.00     All Others (specify)     0     0     0     0     0     19.00       19.50     Tel emedicine     0     0     0     0     0     0     19.50       20.00     Total (sum of lines 1-19)     3,094,753     0     0     0     0     0     20.00       21.00     Total cost to be allocated     341,039     0     0     0     0     21.00  | 5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00   | Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program  | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0  | 719, 630<br>254, 307<br>0<br>4, 782<br>98, 420<br>0<br>0<br>0<br>0<br>0<br>0   | 0   | 0             | 000000000000000000000000000000000000000   |   | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00   |
| 19. 50     Tel emedicine     0     0     0     0     0     19. 50       20. 00     Total (sum of lines 1-19)     3,094,753     0     0     0     0     0     20. 00       21. 00     Total cost to be allocated     341,039     0     0     0     0     0     21. 00   | 5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00                     | Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program   | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0  | 719, 630<br>254, 307<br>0<br>4, 782<br>98, 420<br>0<br>0<br>0<br>0<br>0<br>0   | 0   | 0             | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0  |   | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00                     |
| 20. 00     Total (sum of lines 1-19)     3,094,753     0     0     0     0     20.00       21. 00     Total cost to be allocated     341,039     0     0     0     0     21.00   | 5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00<br>18. 00                     | Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service   | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0   | 719, 630<br>254, 307<br>0<br>4, 782<br>98, 420<br>0<br>0<br>0<br>0<br>0<br>0   | 0   | 0             | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0   |   | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>17. 00<br>18. 00                     |
| 21.00 Total cost to be allocated 341,039 0 0 0 21.00   | 5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00<br>18. 00<br>19. 00           | Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)  | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0                               | 719, 630<br>254, 307<br>0<br>4, 782<br>98, 420<br>0<br>0<br>0<br>0<br>0<br>0   | 0   | 0             | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 |   | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00<br>18. 00<br>19. 00 |
|  | 5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00<br>18. 00<br>19. 00<br>19. 50 | Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine                           | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 719, 630<br>254, 307<br>0<br>4, 782<br>98, 420<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0  | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0      | 0             | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 |   | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00<br>18. 00<br>19. 00<br>19. 50 |
|  | 5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>12. 00<br>13. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00<br>19. 50<br>20. 00           | Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 719, 630<br>254, 307<br>0<br>4, 782<br>98, 420<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 0             | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 |   | 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>14. 00<br>15. 00<br>16. 00<br>17. 00<br>18. 00<br>19. 00<br>19. 00 |

Worksheet H-2
Part II
Date/Time Prepared:
5/27/2022 9: 02 am Peri od: From 01/01/2021 To 12/31/2021 BASIS HHA CCN: 15-7536

|                  |  |                   |                        |                       |                     | Home Health<br>Agency I | PPS                    | <u> </u>         |
|------------------|--|-------------------|------------------------|-----------------------|---------------------|-------------------------|------------------------|------------------|
|                  | Cost Center Description                              | DI ETARY          | CAFETERI A             | NURSI NG              | CENTRAL             | PHARMACY                | MEDI CAL               |                  |
|                  |  | (MEALS<br>SERVED) | (PRODUCTI VE<br>HOURS) | ADMI NI STRATI O<br>N | SERVICES & SUPPLY   | (COSTED<br>REQUIS.)     | RECORDS &<br>LI BRARY  |                  |
|                  |  | ,                 | ,                      | (DI RECT NURS.        | (COSTED             | ,                       | (GROSS                 |                  |
|                  |  | 10. 00            | 11. 00                 | HRS. )<br>13. 00      | REQUIS. )<br>14. 00 | 15. 00                  | CHARGES)<br>16.00      |                  |
| 1. 00            | Administrative and General                           | 10.00             | 11.00                  |                       |                     |                         | 3, 944, 434            | 1. 00            |
| 2.00             | Skilled Nursing Care                                 | 0                 | 0                      | 0                     | 0                   | 0                       | 0                      | 2.00             |
| 3.00             | Physical Therapy                                     | 0                 | 0                      | 0                     |                     | 0                       | 0                      | 3.00             |
| 4. 00<br>5. 00   | Occupational Therapy Speech Pathology                | 0                 | 0                      | 0                     |                     | 0                       | 0                      | 4. 00<br>5. 00   |
| 6. 00            | Medical Social Services                              | Ö                 | 0                      | Ö                     | 1                   |                         | Ö                      | 6. 00            |
| 7. 00            | Home Heal th Ai de                                   | 0                 | 0                      | 0                     | 1                   |                         | 0                      | 7. 00            |
| 8. 00<br>9. 00   | Supplies (see instructions) Drugs                    | 0                 | 0                      | 0                     | 0                   | 0                       | 0                      | 8. 00<br>9. 00   |
| 10.00            | DME  | 0                 | 0                      |                       |                     | 0                       | 0                      | 10.00            |
| 11. 00           | Home Dialysis Aide Services                          | 0                 | 0                      | 0                     | 0                   | 0                       | 0                      | 11. 00           |
| 12.00            | Respiratory Therapy                                  | 0                 | 0                      | 0                     |                     |                         | 0                      | 12.00            |
| 13. 00<br>14. 00 | Private Duty Nursing                                 |                   | 0                      |                       | _                   |                         | 0                      | 13. 00<br>14. 00 |
| 15. 00           | Health Promotion Activities                          | Ö                 | Ō                      | Ö                     | Ö                   |                         | Ö                      | 15. 00           |
| 16.00            | Day Care Program                                     | 0                 | 0                      | 0                     | 0                   | 0                       | 0                      | 16.00            |
| 17. 00<br>18. 00 | Home Delivered Meals Program Homemaker Service       | 0                 | 0                      | 0                     | 0                   | 0                       | 0                      | 17. 00<br>18. 00 |
| 19. 00           | All Others (specify)                                 | Ö                 | 0                      | Ö                     | Ö                   | 0                       | 0                      | 19. 00           |
| 19. 50           | Tel emedi ci ne                                      | 0                 | 0                      | 0                     | 0                   | 0                       | 0                      | 19. 50           |
| 20. 00<br>21. 00 | Total (sum of lines 1-19) Total cost to be allocated | 0                 | 0                      | 0                     | 0                   | 24, 696<br>8, 133       | 3, 944, 434<br>11, 632 |                  |
| 22. 00           | Unit cost multiplier                                 | 0. 000000         | 0. 000000              | 1                     | _                   |                         | 0. 002949              |                  |
|                  |  |                   |                        |                       | INTERNS &           | RESI DENTS              |                        |                  |
|                  | Cost Center Description                              | SOCI AL           | STAFF                  | MEDI CAL              | SERVI CES-SALA      | SERVI CES-OTHE          | PARAMED ED             |                  |
|                  | oost conton bood i pin en                            | SERVI CE          | EDUCATI ON             | EDUCATI ON            | RY & FRINGES        | R PRGM COSTS            | PROGRAM                |                  |
|                  |  | (TIME SPENT)      | (TIME SPENT)           | (ASSI GNED            | (ASSIGNED<br>TIME)  | (ASSI GNED<br>TIME)     | (ASSIGNED<br>TIME)     |                  |
|                  |  | 17. 00            | 17. 01                 | TI ME)<br>17. 02      | 21. 00              | 22. 00                  | 23. 00                 |                  |
| 1. 00            | Administrative and General                           | 0                 | 387                    | 0                     | 0                   | 0                       | 0                      | 1. 00            |
| 2. 00<br>3. 00   | Skilled Nursing Care                                 | 0                 | 0                      | 0                     |                     | 0                       | 0                      | 2. 00<br>3. 00   |
| 4. 00            | Physical Therapy Occupational Therapy                |                   | 0                      |                       |                     | 0                       | 0                      | 4.00             |
| 5.00             | Speech Pathology                                     | 0                 | 0                      | 0                     | 0                   | 0                       | 0                      | 5. 00            |
| 6.00             | Medical Social Services                              | 0                 | 0                      | 0                     | _                   |                         | 0                      | 6.00             |
| 7. 00<br>8. 00   | Home Health Aide<br>Supplies (see instructions)      | 0                 | 0                      | 0                     | 0                   |                         | 0                      | 7. 00<br>8. 00   |
| 9. 00            | Drugs  | Ö                 | Ō                      | Ö                     | Ö                   | 0                       | Ö                      | 9. 00            |
| 10.00            | DME  | 0                 | 0                      | 0                     | _                   | 0                       | 0                      | 10.00            |
| 11. 00<br>12. 00 | Home Dialysis Aide Services<br>Respiratory Therapy   | 0                 | 0                      |                       | 0                   | 0                       | 0                      | 11. 00<br>12. 00 |
| 13. 00           | Pri vate Duty Nursing                                | Ö                 | 0                      | Ö                     | •                   |                         | Ö                      | 13.00            |
| 14.00            | Clinic   | 0                 | 0                      | 0                     |                     |                         | 0                      |                  |
| 15. 00<br>16. 00 | Health Promotion Activities Day Care Program         | 0                 | 0                      | 0                     |                     |                         | 0                      | 15. 00<br>16. 00 |
| 17. 00           | Home Delivered Meals Program                         | l o               | 0                      |                       |                     | -                       | 0                      | 17. 00           |
| 18. 00           | Homemaker Service                                    | О                 | 0                      | 0                     | _                   | 0                       | 0                      | 18. 00           |
| 19. 00<br>19. 50 | All Others (specify) Telemedicine                    | 0                 | 0                      | 0                     | _                   |                         | 0                      | 19. 00<br>19. 50 |
| 20.00            | Total (sum of lines 1-19)                            | 0                 | 387                    |                       | -                   | _                       | 0                      |                  |
| 21.00            | Total cost to be allocated                           | 0                 | 2, 297                 | 0                     | 0                   | 0                       | 0                      | 21.00            |
| 22. 00           | Unit cost multiplier                                 | 0. 000000         | 5. 935401              | 0. 000000             | 0. 000000           | 0. 000000               | 0. 000000              | 22. 00           |

| Uool +h  | Financial Systems   |  | METHODIST HOS                                    | DITALS INC                            |                                    | In Lio                           | u of Form CMS 1                          | DEE2 10 |
|----------|---|--|--|---------------------------------------|------------------------------------|----------------------------------|--|---------|
|          | <u>Financial Systems</u><br>TONMENT OF PATLENT SERVICE COST | TS.  | METHODIST HOS                                    | Provi der C                           | CN: 15_0002                        | Peri od:                         | u of Form CMS-2<br>Worksheet H-3         |         |
| AL LOICE | TONNENT OF TATTENT SERVICE 6031                             | 13   |  | HHA CCN:                              | 15-7536                            | From 01/01/2021<br>To 12/31/2021 | Part I<br>Date/Time Pre                  | pared:  |
|          |   |  |  | Titl∈                                 | XVIII                              | Home Health<br>Agency I          | 5/27/2022 9: 0<br>PPS                    | 2 4111  |
|          | Cost Center Description                                     | From, Wkst.<br>H-2, Part I,<br>col. 28, line | Facility<br>Costs (from<br>Wkst. H-2,<br>Part I) | Shared Ancillary Costs (from Part II) | Total HHA<br>Costs (cols<br>1 + 2) | Total Visits                     | Average Cost Per Visit (col. 3 ÷ col. 4) |         |
|          |   | 0  | 1.00   | 2.00                                  | 3.00                               | 4. 00                            | 5. 00                                    |         |
|          | PART I - COMPUTATION OF LESSER COST LIMITATION              |  |  |                                       |                                    |                                  |  |         |
|          | Cost Per Visit Computation                                  |  |  |                                       |                                    |                                  |  |         |
| 1. 00    | Skilled Nursing Care  | 2. 00  |  |                                       | 2, 007, 8                          |                                  |  |         |
| 2. 00    | Physi cal Therapy   | 3. 00  |  |                                       |                                    |                                  |  |         |
| 3. 00    | Occupational Therapy  | 4.00   | 1  |                                       | 342, 3                             |                                  |  |         |
| 4. 00    | Speech Pathology  | 5. 00  |  |                                       |                                    | 0 0                              |  |         |
| 5. 00    | Medical Social Services                                     | 6. 00  |  |                                       | 6, 4                               |                                  |  |         |
| 6. 00    | Home Heal th Ai de  | 7. 00  | 1  |                                       | 132, 4                             |                                  | 62. 09                                   |         |
| 7. 00    | Total (sum of lines 1-6)                                    |  | 3, 457, 854                                      | 0                                     | -1                                 |                                  |  | 7.00    |
|          |   |  | 1  |                                       | Program Visi                       |                                  |  |         |
|          |   |  | 0004 11 (4)                                      |                                       |                                    | art B                            |  |         |
|          | Cost Center Description                                     | Cost Limits                                  | CBSA No. (1)                                     | Part A                                | Not Subject                        |                                  |  |         |
|          |   |  |  |                                       | to<br>Deductibles                  |                                  |  |         |
|          |   | 0  | 1. 00  | 2. 00                                 | Coi nsurance<br>3.00               | 4.00                             | 5. 00                                    |         |
|          | Limitation Cost Computation                                 |  | 1.00   | 2.00                                  | 3.00                               | 4.00                             | 3.00                                     |         |
| 8. 00    | Skilled Nursing Care  |  | 23844  | 0                                     | 3, 5                               | 15                               |  | 8.00    |
| 9. 00    | Physical Therapy  |  | 23844  |                                       |                                    |                                  |  | 9.00    |
| 10.00    | Occupational Therapy  |  | 23844  |                                       |                                    | 17                               |  | 10.00   |
| 11. 00   | Speech Pathology  |  | 23844  |                                       |                                    | 0                                |  | 11.00   |
| 12.00    | Medical Social Services                                     |  | 23844  |                                       |                                    | 9                                |  | 12.00   |
| 13.00    | Home Health Aide  |  | 23844  |                                       |                                    | 76                               |  | 13.00   |
| 14. 00   | 1   |  |  | l o                                   | 6, 2                               |                                  |  | 14.00   |
|          | Cost Center Description                                     | From Wkst.<br>H-2 Part I,<br>col. 28, line   | Facility<br>Costs (from<br>Wkst. H-2,<br>Part I) | Shared Ancillary Costs (from Part II) | Total HHA<br>Costs (cols<br>1 + 2) | Total Charges                    | Ratio (col. 3<br>÷ col. 4)               |         |
|          |   | 0  | 1.00   | 2.00                                  | 3.00                               | 4.00                             | 5. 00                                    |         |
|          | Supplies and Drugs Cost Comput                              |  | 1.00   | 2.00                                  | 3.00                               | 4.00                             | 3.00                                     |         |
| 15. 00   | Cost of Medical Supplies                                    | 8.00   | 0  | 0                                     |                                    | 0 0                              | 0. 000000                                | 15.00   |
|          | Cost of Drugs   | 9. 00  | 4  | O                                     |                                    | 0 0                              |  | 1       |
|          |   |  | Program Visits                                   |                                       | Cost of<br>Services                |                                  |  |         |
|          |   |  |  | t B                                   |                                    | Part B                           |  |         |
|          | Cost Center Description                                     | Part A                                       | Not Subject                                      | Subject to                            | Part A                             | Not Subject                      | Subject to                               |         |
|          |   |  | to   | Deductibles &                         |                                    | to                               | Deductibles &                            |         |
|          |   |  | Deductibles &                                    | Coi nsurance                          |                                    | Deductibles &                    | Coi nsurance                             |         |
|          |   |  | Coi nsurance                                     | 0.00                                  | 0.00                               | Coi nsurance                     | 44.00                                    |         |
|          | DART I COMPUTATION OF LECCED                                | 6.00   | 7. 00  | 8.00                                  | 9.00                               | 10.00                            | 11.00                                    |         |
|          | PART I - COMPUTATION OF LESSER COST LIMITATION              | UF AGGREGATE                                 | PROGRAM COST, A                                  | AGGREGATE OF T                        | HE PRUGRAM LI                      | MITATION COST, C                 | JR BENEFICIARY                           |         |
| 1. 00    | Cost Per Visit Computation Skilled Nursing Care             | 0  | 3, 515   |                                       |                                    | 0 563, 068                       |  | 1.00    |
| 2. 00    | Physical Therapy  |  | 1, 436   |                                       |                                    | 0 288, 378                       |  | 2.00    |
| 3. 00    | Occupational Therapy  |  | 617  |                                       |                                    | 0 288, 378                       |  | 3.00    |
| 4. 00    | Speech Pathology  |  | 017  |                                       |                                    | 0 110, 137                       |  | 4.00    |
| 5. 00    | Medical Social Services                                     |  | 9  |                                       |                                    | 0 1, 317                         |  | 5.00    |
| 6. 00    | Home Heal th Ai de  |  | 676  | l .                                   |                                    | 0 41, 973                        |  | 6.00    |
| 7. 00    | Total (sum of lines 1-6)                                    |  | 1  |                                       |                                    | 0 1, 012, 873                    |  | 7.00    |
|          | ,   | , ,  | 0, 200   | I                                     | I                                  | ., 0.12, 070                     | 1  |         |

| Heal th        | Financial Systems                                 |               | METHODIST HOS   | SPITALS INC     |                        | In lie                                       | u of Form CMS-                           | 2552-10      |
|----------------|---|---------------|-----------------|-----------------|------------------------|--|--|--------------|
|                | TIONMENT OF PATIENT SERVICE COST                  | ΓS            |                 | Provi der Co    | CN: 15-0002<br>15-7536 | Peri od:<br>From 01/01/2021<br>To 12/31/2021 | Worksheet H-3<br>Part I<br>Date/Time Pre | epared:      |
|                |   |               |                 |                 |                        |  | 5/27/2022 9:0                            | <u>)2 am</u> |
|                |   |               |                 | Title           | XVIII                  | Home Health                                  | PPS                                      |              |
|                | Cost Center Description                           |               |                 |                 |                        | Agency I                                     |  |              |
|                | cost center bescription                           | 6. 00         | 7. 00           | 8.00            | 9. 00                  | 10.00  | 11. 00                                   |              |
|                | Limitation Cost Computation                       | 0.00          | 7.00            | 0.00            | 7.00                   | 10.00  | 11.00                                    |              |
| 8. 00          | Skilled Nursing Care                              |               |                 |                 |                        |  |  | 8.00         |
| 9. 00          | Physical Therapy                                  |               |                 |                 |                        |  |  | 9.00         |
| 10.00          | Occupational Therapy                              |               |                 |                 |                        |  | •  | 10.00        |
| 11. 00         | Speech Pathology                                  |               |                 |                 |                        |  |  | 11.00        |
| 12.00          | Medical Social Services                           |               |                 |                 |                        |  |  | 12.00        |
| 13.00          | Home Health Aide                                  |               |                 |                 |                        |  |  | 13.00        |
| 14.00          | Total (sum of lines 8-13)                         |               |                 |                 |                        |  |  | 14.00        |
|                |   | Progi         | ram Covered Cha | arges           | Cost of                |  |  |              |
|                |   |               |                 |                 | Servi ces              |  |  |              |
|                |   |               |                 |                 |                        |  |  |              |
|                |   |               |                 | t B             |                        | Part B                                       |  |              |
|                | Cost Center Description                           | Part A        | Not Subject     | Subject to      | Part A                 | Not Subject                                  | Subject to                               |              |
|                |   |               | to              | Deductibles &   |                        | to   | Deductibles &                            |              |
|                |   |               | Deductibles &   | Coi nsurance    |                        | Deductibles &                                | Coi nsurance                             |              |
|                |   | 6. 00         | Coi nsurance    | 0.00            | 9. 00                  | Coi nsurance                                 | 11 00                                    |              |
|                | Supplies and Drugs Cost Comput                    |               | 7. 00           | 8. 00           | 9.00                   | 10. 00                                       | 11.00                                    |              |
| 15 00          | Cost of Medical Supplies                          | 0             | 207, 097        | Ο               |                        | 0 0  | С  | 15.00        |
|                | Cost of Drugs                                     |               | 207,077         |                 |                        | 0  |  | 1            |
| 10.00          | Cost Center Description                           | Total Program |                 |                 |                        |  |  | 10.00        |
|                |   | Cost (sum of  |                 |                 |                        |  |  |              |
|                |   | col s. 9-10)  |                 |                 |                        |  |  |              |
|                |   | 12. 00        |                 |                 |                        |  |  |              |
|                | PART I - COMPUTATION OF LESSER                    | OF AGGREGATE  | PROGRAM COST,   | AGGREGATE OF TH | HE PROGRAM L           | IMITATION COST, C                            | R BENEFICIARY                            |              |
|                | COST LIMITATION                                   |               |                 |                 |                        |  |  |              |
|                | Cost Per Visit Computation                        |               |                 |                 |                        |  |  |              |
| 1. 00          | Skilled Nursing Care                              | 563, 068      |                 |                 |                        |  |  | 1.00         |
| 2. 00          | Physi cal Therapy                                 | 288, 378      |                 |                 |                        |  |  | 2.00         |
| 3.00           | Occupational Therapy                              | 118, 137      |                 |                 |                        |  |  | 3.00         |
| 4.00           | Speech Pathology                                  | 0             |                 |                 |                        |  |  | 4.00         |
| 5.00           | Medical Social Services                           | 1, 317        |                 |                 |                        |  |  | 5.00         |
| 6. 00<br>7. 00 | Home Heal th Ai de                                | 41, 973       |                 |                 |                        |  |  | 6.00         |
| 7.00           | Total (sum of lines 1-6)  Cost Center Description | 1, 012, 873   |                 |                 |                        |  |  | 7.00         |
|                | cost center bescription                           | 12. 00        |                 |                 |                        |  |  |              |
|                | Limitation Cost Computation                       | 12.00         |                 |                 |                        |  | <u></u>                                  |              |
| 8. 00          | Skilled Nursing Care                              | I             |                 |                 |                        |  |  | 8.00         |
| 9. 00          | Physical Therapy                                  |               |                 |                 |                        |  |  | 9.00         |
| 10.00          | Occupational Therapy                              |               |                 |                 |                        |  |  | 10.00        |
| 11. 00         | Speech Pathology                                  |               |                 |                 |                        |  |  | 11.00        |
| 12. 00         | Medical Social Services                           |               |                 |                 |                        |  |  | 12.00        |
| 13. 00         | Home Health Aide                                  |               |                 |                 |                        |  |  | 13.00        |
| 14.00          | Total (sum of lines 8-13)                         |               |                 |                 |                        |  |  | 14.00        |
|                |   | •             | •               |                 |                        |  |  | •            |

| Heal th | Financial Systems               |                | METHODIST HOS   | PITALS, INC    |              | In Lie                           | u of Form CMS-2                            | 2552-10 |
|---------|---------------------------------|----------------|-----------------|----------------|--------------|----------------------------------|--|---------|
| APP0R1  | TIONMENT OF PATIENT SERVICE COS | ΓS             |                 | Provi der C    | CN: 15-0002  | Peri od:                         | Worksheet H-3                              |         |
|         |                                 |                |                 | HHA CCN:       | 15-7536      | From 01/01/2021<br>To 12/31/2021 | Part II<br>Date/Time Pre<br>5/27/2022 9:00 |         |
|         |                                 |                |                 | Title          | : XVIII      | Home Health                      | PPS  |         |
|         |                                 |                |                 |                |              | Agency I                         |  |         |
|         | Cost Center Description         | From Wkst. C,  | Cost to         | Total HHA      | HHA Shared   | Transfer to                      |  |         |
|         |                                 | Part I, col.   | Charge Ratio    | Charge (from   | Ancillary    | Part I as                        |  |         |
|         |                                 | 9, line        |                 | provi der      | Costs (col.  | 1 Indicated                      |  |         |
|         |                                 |                |                 | records)       | x col. 2)    |                                  |  |         |
|         |                                 | 0              | 1. 00           | 2. 00          | 3.00         | 4. 00                            |  |         |
|         | PART II - APPORTIONMENT OF COS  | T OF HHA SERVI | CES FURNISHED E | BY SHARED HOSP | TAL DEPARTME | ENTS                             |  |         |
| 1.00    | Physi cal Therapy               | 66.00          | 0. 353273       | 0              |              | 0 col. 2, line 2                 | . 00                                       | 1.00    |
| 2.00    | Occupational Therapy            | 67.00          | 0. 393792       | 0              |              | 0 col. 2, line 3                 | . 00                                       | 2.00    |
| 3.00    | Speech Pathology                | 68.00          | 0. 283291       | 0              |              | Ocol. 2, line 4                  | . 00                                       | 3.00    |
| 4.00    | Cost of Medical Supplies        | 71.00          | 0. 356930       | 0              |              | 0 col. 2, line 1                 | 5. 00                                      | 4.00    |
| 5.00    | Cost of Drugs                   | 73.00          | 0. 201197       | 0              |              | 0 col. 2, line 1                 | 6. 00                                      | 5.00    |

|                | Financial Systems METHODIST H ATION OF HHA REIMBURSEMENT SETTLEMENT   | OSPITALS, INC<br>Provider CO | CN: 15-0002 | Peri od:   | In Lie             | u of Form CMS-2<br>Worksheet H-4 |            |
|----------------|---|------------------------------|-------------|------------|--------------------|----------------------------------|------------|
| ALCUL          | ATTOM OF THE RETWINDINGSEMENT SETTEMBENT  | HHA CCN:                     | 15-7536     | From 01/0  | 01/2021<br>31/2021 | Part I-II<br>Date/Time Pre       | pare       |
|                |   | Title                        | XVIII       | Home He    | eal th             | 5/27/2022 9: 0<br>PPS            | 2 am       |
|                |   |                              |             | Agenc      | y I<br>Par         | t B                              |            |
|                |   |                              | Part A      | Not Su     | ıbj ect            | Subject to                       |            |
|                |   |                              |             | Deducti    | bles &             | Deductibles & Coinsurance        |            |
|                |   |                              | 1.00        | Coi nsu    |                    | 3. 00                            |            |
|                | PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR  | CUSTOMARY CHARGE             |             | <u> </u>   |                    |                                  |            |
| 00             | Reasonable Cost of Part A & Part B Services Reasonable cost of services (see instructions)                            |                              |             | 0          | 0                  | 0                                | 1.         |
| 00             | Total charges   |                              |             | 0          | 0                  | 0                                | 2.         |
| 00             | Customary Charges   |                              |             |            |                    | 3                                | _          |
| 00             | Amount actually collected from patients liable for paymen   | nt for services              |             | 0          | 0                  | 0                                | 3.         |
| 00             | on a charge basis (from your records) Amount that would have been realized from patients liable                       | e for navment                |             | 0          | 0                  | 0                                | 4.         |
| 00             | for services on a charge basis had such payment been made   |                              |             |            | Ĭ                  | o .                              |            |
|                | with 42 CFR §413.13(b)  |                              |             |            |                    |                                  | _          |
| 00             | Ratio of line 3 to line 4 (not to exceed 1.000000) Total customary charges (see instructions)                         |                              | 0. 0000     | 0.         | 000000             | 0.000000                         | 5<br>6     |
| 00             | Excess of total customary charges over total reasonable of  | cost (complete               |             | 0          | o                  | 0                                | 7          |
|                | only if line 6 exceeds line 1)  |                              |             |            | _                  | _                                |            |
| 00             | Excess of reasonable cost over customary charges (comple: 1 exceeds line 6)   | te only if line              |             | 0          | 0                  | 0                                | 8          |
| 00             | Primary payer amounts   |                              |             | 0          | 0                  | 0                                | 9          |
|                | • •   |                              |             | Par        |                    | Part B                           |            |
|                |   |                              |             | Serv<br>1. |                    | Servi ces<br>2. 00               |            |
|                | PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT   |                              |             |            |                    |                                  |            |
| . 00           | Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers                     |                              |             |            | 0                  | 0<br>863, 458                    | 10<br>  11 |
| . 00           | Total PPS Reimbursement - Full Episodes without outriers  |                              |             |            | 0                  | 88, 051                          |            |
| . 00           | Total PPS Reimbursement - LUPA Episodes   |                              |             |            | 0                  | 12, 604                          | 13         |
| . 00           | Total PPS Reimbursement - PEP Episodes  |                              |             |            | 0                  | 1, 894                           |            |
| . 00<br>. 00   | Total PPS Outlier Reimbursement - Full Episodes with Outl<br>Total PPS Outlier Reimbursement - PEP Episodes           | iers                         |             |            | 0                  | 15, 433<br>0                     | 15<br>  16 |
| . 00           | Total Other Payments  |                              |             |            | o                  | 0                                | 17         |
| . 00           | DME Payments  |                              |             |            | 0                  | 0                                | 18         |
| . 00           | Oxygen Payments Prosthetic and Orthotic Payments  |                              |             |            | 0                  | 0                                | 19         |
| . 00           | Part B deductibles billed to Medicare patients (exclude of  | coi nsurance)                |             |            |                    | 0                                | 21         |
| 00             | Subtotal (sum of lines 10 thru 20 minus line 21)  | •                            |             |            | 0                  | 981, 440                         |            |
| . 00           | Excess reasonable cost (from line 8)  |                              |             |            | 0                  | 001 440                          | 23         |
| . 00           | Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records                            | 5)                           |             |            | U                  | 981, 440<br>0                    | 24         |
| . 00           | Net cost (line 24 minus line 25)  | -,                           |             |            | 0                  | 981, 440                         |            |
|                | Reimbursable bad debts (from your records)  |                              |             |            | 0                  | 0                                | 27         |
| . 00<br>. 00   | Reimbursable bad debts for dual eligible beneficiaries (<br>Total costs - current cost reporting period (line 26 plus |                              | )           |            | 0                  | 0<br>981, 440                    | 28         |
| . 00           | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  | 3 11110 27)                  |             |            | 0                  | 0                                | 30         |
| . 50           | Pioneer ACO demonstration payment adjustment (see instruc   |                              |             |            | 0                  | 0                                | 30         |
| . 99           | Demonstration payment adjustment amount before sequestra  | ti on                        |             |            | 0                  | 981, 440                         | 30         |
| . 00<br>. 01   | Subtotal (see instructions) Sequestration adjustment (see instructions)   |                              |             |            | 0                  | 981, 440                         | 31<br>31   |
| . 02           | Demonstration payment adjustment amount after sequestrati   |                              |             |            | Ö                  | 0                                | 31         |
|                | Sequestration adjustment for non-claims based amounts (se   | ee instructions)             |             |            | 0                  | 0                                | 31         |
|                | Interim payments (see instructions)   |                              |             |            | 0                  | 981, 440                         |            |
| 1. 75<br>2. 00 | Tentative settlement (for contractor use only)  |                              |             |            | (A)                |                                  |            |
|                | Tentative settlement (for contractor use only) Balance due provider/program (line 31 minus lines 31.01,               | 32, and 33)                  |             |            | 0                  | 0                                | 33         |

| Health Financial Systems               | METHODIST HOSPIT           | TALS, INC     |             | In Lieu                          | ı of Form CMS-2552-10 |
|--|----------------------------|---------------|-------------|----------------------------------|-----------------------|
| ANALYSIS OF PAYMENTS TO HOSPITAL-BASED | HHAS FOR SERVICES RENDERED | Provi der CCI | CN: 15-0002 | Peri od:                         | Worksheet H-5         |
| TO PROGRAM BENEFICIARIES               |                            | HHA CCN:      | 15-7536     | From 01/01/2021<br>To 12/31/2021 | Date/Time Prepared:   |
|  |                            |               |             |                                  | 5/27/2022 9:02 am     |

|          |  |                    |          |   | 5/27/2022 9: 02 | 2 am |
|----------|--|--------------------|----------|---|-----------------|------|
|          |  |                    |          | Home Health                               | PPS             |      |
|          | <u> </u>   |                    |          | Agency I                                  |                 |      |
|          |  | I npati en         | t Part A | Pa  | rt B            |      |
|          |  | mm /dd /\nnn/      | Amount   | mm /dd /\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | Amount          |      |
|          |  | mm/dd/yyyy<br>1.00 | 2. 00    | mm/dd/yyyy<br>3.00                        | 4. 00           |      |
| 00       | Total interim payments paid to provider                  | 1.00               |          | 0   | 981, 440        | 1.   |
| 00       | Interim payments payable on individual bills, either     |                    |          | 0   | 761, 440        | 2.   |
| 00       | submitted or to be submitted to the contractor for       |                    |          | O .                                       |                 | ۷.   |
|          | services rendered in the cost reporting period. If none, |                    |          |   |                 |      |
|          | write "NONE" or enter a zero                             |                    |          |   |                 |      |
| 00       | List separately each retroactive lump sum adjustment     |                    |          |   |                 | 3.   |
|          | 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                                      |                    |          | <u> </u>                                  | •               |      |
| 01       |  |                    |          | 0   | 0               | 3.   |
| 02       |  |                    |          | 0   | 0               | 3.   |
| 03       |  |                    |          | 0   | 0               | 3.   |
| 04       |  |                    |          | 0   | 0               | 3.   |
| 05       |  |                    |          | 0   | 0               | 3.   |
|          | Provider to Program                                      | T                  |          |   |                 |      |
| 50       |  |                    |          | 0   | 0               | 3.   |
| 51       |  |                    |          | 0   | 0               | 3    |
| 2        |  |                    |          | -   | 1               | 3    |
| 53<br>54 |  |                    |          | 0   | 0               | 3    |
| 99       | Subtotal (sum of lines 3.01-3.49 minus sum of lines      | •                  |          | 0   | 0               | 3.   |
| 77       | 3. 50-3. 98)   |                    |          | U   |                 | ا ا  |
| 00       | Total interim payments (sum of lines 1, 2, and 3.99)     |                    |          | 0   | 981, 440        | 4.   |
|          | (transfer to Wkst. H-4, Part II, column as appropriate,  |                    |          |   | 70.7.1.0        |      |
|          | line 32)   |                    |          |   |                 |      |
|          | TO BE COMPLETED BY CONTRACTOR                            |                    |          |   | •               |      |
| 00       | List separately each tentative settlement payment after  |                    |          |   |                 | 5    |
|          | desk review. Also show date of each payment. If none,    |                    |          |   |                 |      |
|          | write "NONE" or enter a zero. (1)                        |                    |          |   |                 |      |
|          | Program to Provider                                      | 1                  |          |   |                 |      |
| )1       |  |                    |          | 0   | 0               | 5    |
| )2       |  |                    |          | 0   | 0               | 5    |
| )3       | Provider to Program                                      |                    |          | 0   | 0               | 5    |
| 0        | i rovi dei -to i rogi alli                               |                    |          | o   | 0               | 5    |
| 1        |  |                    |          | Ö   | 0               | 5    |
| 2        |  |                    |          | Ö   | 0               | 5    |
| 9        | Subtotal (sum of lines 5.01-5.49 minus sum of lines      |                    |          | o   | 0               | 5    |
|          | 5. 50-5. 98)   |                    |          |   |                 |      |
| 00       | Determined net settlement amount (balance due) based on  |                    |          |   |                 | 6.   |
|          | the cost report. (1)                                     |                    |          |   |                 |      |
| )1       | SETTLEMENT TO PROVIDER                                   |                    |          | 0   | 0               | 6.   |
| )2       | SETTLEMENT TO PROGRAM                                    |                    |          | 0   | 0               | 6.   |
| 00       | Total Medicare program liability (see instructions)      |                    |          | 0   | 981, 440        | 7    |
|          |  |                    |          | Contractor                                | NPR Date        |      |
|          |  |                    |          | Number                                    | (Mo/Day/Yr)     |      |
|          |  |                    | )        | 1, 00                                     | 2.00            |      |

|  | Financial Systems METHODIST HO  |  |  | u of Form CMS-2  | 2552-10   |
|--|---|--|--|--|---|
| CALCUI   | LATION OF CAPITAL PAYMENT   | Provi der CCN: 15-0002   | Peri od:<br>From 01/01/2021<br>To 12/31/2021 | Worksheet L<br>Parts I-III<br>Date/Time Pre<br>5/27/2022 9:0 |   |
|  |   | Title XVIII  | Hospi tal                                    | PPS  |   |
|  |   |  |  | 4 00   |   |
|  | PART I - FULLY PROSPECTIVE METHOD   |  |  | 1. 00  |   |
|  | CAPITAL FEDERAL AMOUNT  |  |  |  | <u> </u>  |
| 1. 00  | Capital DRG other than outlier  |  |  | 2, 401, 235  | 1.00  |
| 1. 01  | Model 4 BPCI Capital DRG other than outlier   |  |  | 0  | 1.01  |
| 2.00   | Capital DRG outlier payments  |  |  | 85, 342  | 2.00  |
| 2. 01  | Model 4 BPCI Capital DRG outlier payments   |  |  | 0  | 2. 01   |
| 3.00   | Total inpatient days divided by number of days in the cos   | t reporting period (see ins  | tructions)                                   | 214. 84  | 3.00  |
| 4.00   | Number of interns & residents (see instructions)  |  |  | 3. 00  | 4.00  |
| 5.00   | Indirect medical education percentage (see instructions)  |  |  | 0. 39  | 5.00  |
| 6. 00  | Indirect medical education adjustment (multiply line 5 by 1.01) (see instructions)  | the sum of lines 1 and 1.0   | 1, columns 1 and                             | 9, 365   | 6.00  |
| 7. 00  | Percentage of SSI recipient patient days to Medicare Part   | A patient days (Worksheet  | E, part A line                               | 8. 90  | 7. 00   |
|  | 30) (see instructions)  |  | •  |  |   |
| 8.00   | Percentage of Medicaid patient days to total days (see in   | istructi ons)  |  | 32. 33   |   |
| 9.00   | Sum of lines 7 and 8  | .:>  |  | 41. 23   |   |
| 10. 00<br>11. 00   | 1 1 3 1   | ions)  |  | 8. 71<br>209, 148  |   |
| 12. 00   |   |  |  | 2, 705, 090  |   |
| 12.00  | Total prospective capital payments (see mistractions)   |  |  | 2, 703, 070  | 12.00   |
|  |   |  |  | 1. 00  |   |
|  | PART II - PAYMENT UNDER REASONABLE COST   |  |  | _  |   |
| 1.00   | Program inpatient routine capital cost (see instructions)   |  |  | 0  |   |
| 2.00   | Program inpatient ancillary capital cost (see instruction Total inpatient program capital cost (line 1 plus line 2)   |  |  | 0  |   |
| 4. 00  | Capital cost payment factor (see instructions)  |  |  | 0  |   |
| 5. 00  | Total inpatient program capital cost (line 3 x line 4)  |  |  | 0  |   |
|  |   |  |  | 1.00   |   |
|  | PART III - COMPUTATION OF EXCEPTION PAYMENTS  |  |  | 1. 00  |   |
| 1. 00  | Program inpatient capital costs (see instructions)  |  |  | 0  | 1.00  |
|  |   |  |  |  |   |
| 2. 00  | Throdian impatient capital costs for extraordinary circums  | tances (see instructions)  |  | 0  | 2.00  |
|  | Program inpatient capital costs for extraordinary circums<br>Net program inpatient capital costs (line 1 minus line 2)  |  |  | 0  |   |
| 2.00   |   |  |  |  | 3.00  |
| 2. 00<br>3. 00   | Net program inpatient capital costs (line 1 minus line 2)<br>Applicable exception percentage (see instructions)<br>Capital cost for comparison to payments (line 3 x line 4)  |  |  | 0<br>0. 00<br>0  | 3. 00<br>4. 00<br>5. 00   |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00  | Net program inpatient capital costs (line 1 minus line 2)<br>Applicable exception percentage (see instructions)<br>Capital cost for comparison to payments (line 3 x line 4)<br>Percentage adjustment for extraordinary circumstances (see  | e instructions)  |  | 0<br>0. 00<br>0<br>0. 00                                     | 3. 00<br>4. 00<br>5. 00<br>6. 00  |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00   | Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (se Adjustment to capital minimum payment level for extraordi  | e instructions)  | x line 6)                                    | 0<br>0. 00<br>0<br>0. 00<br>0                                | 3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00   |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00  | Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (se Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7)   | ee instructions)<br>nary circumstances (line 2   | x line 6)                                    | 0. 00<br>0. 00<br>0. 00<br>0. 00<br>0                        | 3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00  |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00   | Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (se Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a   | ee instructions) nary circumstances (line 2  | ,  | 0.00<br>0.00<br>0.00<br>0.00<br>0                            | 3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00   |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00   | Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (se Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level  | ee instructions)<br>nary circumstances (line 2<br>applicable)<br>to capital payments (line 8   | less line 9)                                 | 0. 00<br>0. 00<br>0. 00<br>0 0<br>0                          | 3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00   |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00   | Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (se Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a   | ee instructions)<br>nary circumstances (line 2<br>applicable)<br>to capital payments (line 8   | less line 9)                                 | 0.00<br>0.00<br>0.00<br>0.00<br>0                            | 3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00   |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00   | Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (se Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level ov Worksheet L, Part III, line 14)  | ee instructions)<br>nary circumstances (line 2<br>applicable)<br>to capital payments (line 8<br>er capital payment (from pr  | less line 9)<br>ior year                     | 0. 00<br>0. 00<br>0. 00<br>0 0<br>0                          | 3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00                               |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00                               | Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (se Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level ov Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital   | ee instructions) nary circumstances (line 2 applicable) to capital payments (line 8 eer capital payment (from pr   | less line 9)<br>ior year<br>ne 11)           | 0.00<br>0.00<br>0.00<br>0<br>0<br>0                          | 3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00                               |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00                               | Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (se Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level ov Worksheet L, Part III, line 14)  Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, e Carryover of accumulated capital minimum payment level ov  | per instructions) nary circumstances (line 2 applicable) to capital payments (line 8 aver capital payment (from pr all payments (line 10 plus li anter the amount on this line   | less line 9)<br>ior year<br>ne 11)<br>e)     | 0.00<br>0.00<br>0.00<br>0<br>0<br>0                          | 3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00           |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00 | Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (se Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level ov Worksheet L, Part III, line 14)  Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, e Carryover of accumulated capital minimum payment level ov (if line 12 is negative, enter the amount on this line)  | pee instructions) nary circumstances (line 2 applicable) to capital payments (line 8 aver capital payment (from pr all payments (line 10 plus li anter the amount on this lin aver capital payment for the               | less line 9)<br>ior year<br>ne 11)<br>e)     | 0.00<br>0.00<br>0.00<br>0<br>0<br>0                          | 3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00 |
| 2. 00<br>3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00           | Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordi Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level ov Worksheet L, Part III, line 14)  Net comparison of capital minimum payment level to capital Current year exception payment (if line 12 is positive, eccarryover of accumulated capital minimum payment level ov (if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see | pee instructions) nary circumstances (line 2 applicable) to capital payments (line 8 wer capital payment (from pr all payments (line 10 plus li enter the amount on this lin wer capital payment for the e instructions) | less line 9)<br>ior year<br>ne 11)<br>e)     | 0.00<br>0.00<br>0.00<br>0<br>0<br>0                          | 3. 00<br>4. 00<br>5. 00<br>6. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>12. 00<br>13. 00<br>14. 00 |