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 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0002 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/29/2024 9:08 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/29/2024 Time: 9:08 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, "L" for low, or "N" for no. [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 01/01/2023 and ending 12/31/2023 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			SIGNATURE STATEMENT	
1	M	att 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				
		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	906, 869	-60, 195	0	-1, 583, 443	1.00
2.00	SUBPROVIDER - IPF	0	2, 212	0		-164, 729	2.00
3.00	SUBPROVIDER - IRF	0	25, 886	0		-143, 658	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	1		0	9.00
200.00	TOTAL	0	934, 967	-60, 194	0	-1, 891, 830	200.00
The ob	and amounts represent "due to" or "due from"	the engliceble	6 1	hl		Lance County and American	

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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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.

21.00 Type of Control (see i	nstructions)		2		21.
		1.00	2. 00	3. 00	
Inpatient PPS Informat	i on				
disproportionate share §412.106? In column 1 facility subject to 42	lify and is it currently receiving payments hospital adjustment, in accordance with 42 (, enter "Y" for yes or "N" for no. Is this CFR Section §412.106(c)(2)(Pickle amendment , enter "Y" for yes or "N" for no.	CFR	N		22.
.01 Did this hospital rece this cost reporting pe for the portion of the 1. Enter in column 2,	ive interim UCPs, including supplemental UCPs riod? Enter in column 1, "Y" for yes or "N" cost reporting period occurring prior to Oc "Y" for yes or "N" for no for the portion of occurring on or after October 1. (see	for no tober	Y		22.
.02 Is this a newly merged determined at cost rep. 1, "Y" for yes or "N" period prior to Octobe	hospital that requires a final UCP to be ort settlement? (see instructions) Enter in of for no, for the portion of the cost reporting r 1. Enter in column 2, "Y" for yes or "N" for cost reporting period on or after October 1.	g or no,	N		22.
2.03 Did this hospital rece rural as a result of the adopted by CMS in FY20 for the portion of the in column 2, "Y" for your reporting period occur Does this hospital con	ive a geographic reclassification from urban he OMB standards for delineating statistical 15? Enter in column 1, "Y" for yes or "N" for cost reporting period prior to October 1. Enter in column 1, "Y" for yes or "N" for no for the portion of the cost ring on or after October 1. (see instructions tain at least 100 but not more than 499 beds with 42 CFR 412.105)? Enter in column 3, "Y"	to N areas r no nter s) (as	N	N	22.
rural as a result of the adopted by CMS in FY 20 for the portion of the in column 2, "Y" for you reporting period occur Does this hospital con	ive a geographic reclassification from urban he revised OMB delineations for statistical a D21? Enter in column 1, "Y" for yes or "N" for cost reporting period prior to October 1. Eles or "N" for no for the portion of the cost ring on or after October 1. (see instructions tain at least 100 but not more than 499 beds with 42 CFR 412.105)? Enter in column 3, "Y"	areas or no nter s) (as			22.
below? In column 1, en if date of discharge. reporting period diffe	o determine Medicaid days on lines 24 and/or ter 1 if date of admission, 2 if census days, Is the method of identifying the days in this rent from the method used in the prior cost column 2, enter "Y" for yes or "N" for no.	, or 3	3 N		23.

complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.

Health Financial Systems METHODIST HOSPITALS, INC In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0002 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/29/2024 9: 08 am 1. 00 2.00 3.00 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. Ν 58.00 Pt. I 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see 60 00 Υ instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. If line 60 is yes, complete columns 2 and 3 for each program. (see 23.00 60.01 2 instructions) Y/N LME Direct GME IME Direct GME 1.00 2.00 3.00 4. 00 5. 00 61.00 Did your hospital receive FTE slots under ACA Ν 0 00 0.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)
61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary 61.05 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unwei ahted Unwei ahted IME FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0 00 0.00 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 61.20 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 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 the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 62.00 your hospital received HRSA PCRE funding (see instructions) 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 63.00 N

"Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

Health Financial Systems	METHODI	ST HOSPITALS, INC		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP				eriod: com 01/01/2023	Worksheet S-2 Part I Date/Time Pre 5/29/2024 9:00	pared:
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
C+: FFO4 +b- ACA D V	- FTE Danidanta in No		1.00	2.00	3.00	
Section 5504 of the ACA Base Year period that begins on or after a			-inis base year	is your cost	reporting	
64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to resettings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column	s yes, or your facilit wher of unweighted nor otations occurring in o number of unweighted our hospital. Enter ir 1 + column 2)). (see	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio instructions)	0. 00			64.00
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
			FTEs Nonprovi der	FTEs in Hospital	3/ (col. 3 + col. 4))	
			Si te	Hospi tai	COI. 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)	1.00	2.00	Unwei ghted FTEs Nonprovi der Si te 1.00			65. 00
Section 5504 of the ACA Current		n Nonprovider Settinç	gsEffective 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 of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column	unweighted non-primar occurring in all nonpr unweighted non-primar al. Enter in column 3 column 2)). (see ins	rovider settings. ry care resident 3 the ratio of structions)	0.00			66.00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 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	0. 000000	67.00

	Financial Systems METHODIST HOSPITALS, INC "AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA" Provider CCI	F	In Period: From 01/01/20 To 12/31/20	023 Pa	rkshe art l	et S-2 me Pre	
		'	12/31/20		29/20	24 9:0	8 am
					1. 0	0	
68. 00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-4900 For a cost reporting period beginning prior to October 1, 2022, did you obtained to apply the new DGME formula in accordance with the FY 2023 IPPS Final (August 10, 2022)?	otain permissi	ion from you				68. 00
			-	1.00	2. 00	3. 00	
70 00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it conta	ain an IPE sul	nnrovi der2	Υ			70.00
	Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teachir recent cost report filed on or before November 15, 2004? Enter "Y" for ye 42 CFR 412. 424(d)(1)(iii)(c)) Column 2: Did this facility train residents program in accordance with 42 CFR 412. 424 (d)(1)(iii)(D)? Enter "Y" for ye Column 3: If column 2 is Y, indicate which program year began during this (see instructions)	ng program in es or "N" for in a new tead es or "N" for	the most no. (see ching no.	N	N	0	71.00
75 00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it co	ntain an IDE		Υ			75. 00
	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teachir recent cost reporting period ending on or before November 15, 2004? Enter no. Column 2: Did this facility train residents in a new teaching program CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If	ng program in "Y" for yes o in accordance	or "N" for e with 42	N	N	0	76.00
	indicate which program year began during this cost reporting period. (see						
					1. 0	0	
	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for r Is this a LTCH co-located within another hospital for part or all of the c"Y" for yes and "N" for no.		g period? En	ter	N N		80. 00 81. 00
	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter Did this facility establish a new Other subprovider (excluded unit) under			no.	N		85. 00 86. 00
87. 00	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified unterpretated (1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	under section			N		87. 00
			Approved f Permanen Adjustmer (Y/N) 1.00	t nt	Number Appro Permar djustn 2.0	ved nent nents	
88. 00	Column 1: Is this hospital approved for a permanent adjustment to the TEFF amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete co. 89. (see instructions)		N		2.0		88.00
	Column 2: Enter the number of approved permanent adjustments.	Wkst. A Line	Effecti v	е	Appro	ved	
		No.	Date	Д Д	Permar Adjust Amount Discha	nent ment Per	
89. 00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number	1. 00	2. 00	_	3. 0		89. 00
071.00	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge.	0.0				J	071.00
	Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.						
			V 1. 00		XI > 2. 0		
90. 00	<u>Title V and XIX Services</u> Does this facility have title V and/or XIX inpatient hospital services? Er	nter "Y" for	N		Y		90.00
91. 00	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N		Υ		91.00
92. 00	Are title XIX NF patients occupying title XVIII SNF beds (dual certificati instructions) Enter "Y" for yes or "N" for no in the applicable column.				N		92.00
93. 00	Does this facility operate an ICF/IID facility for purposes of title V and "Y" for yes or "N" for no in the applicable column.	XIX? Enter	N		N		93. 00
	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no	in the	N		N		94.00
94. 00	lappi i capi e coi umn.						
95. 00	applicable column. If line 94 is "Y", enter the reduction percentage in the applicable column Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no applicable column.		0. 00 N		0. 0 N	0	95. 00 96. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				u of Form CMS-	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX FUENTITICATION DATA	Provi der Co	F	eriod: rom 01/01/2023 o 12/31/2023	Date/Time Pr	epared:
			V	5/29/2024 9: XI X	08 am
98.00 Does title V or XIX follow Medicare (title XVIII) for the i	interns and res	cidents nost	1. 00 Y	2. 00 Y	98.00
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" column 1 for title V, and in column 2 for title XIX.	for yes or "N"	for no in		·	
98.01 Does title V or XIX follow Medicare (title XVIII) for the r C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for t title XIX.			Y	Y	98. 01
98.02 Does title V or XIX follow Medicare (title XVIII) for the obed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes for title V, and in column 2 for title XIX.		Y	Y	98. 02	
98.03 Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y for title V, and in column 2 for title XIX.		N	N	98. 03	
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAP outpatient services cost? Enter "Y" for yes or "N" for no i in column 2 for title XIX.			N	N	98. 04
98.05 Does title V or XIX follow Medicare (title XVIII) and add by Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 2 for title XIX.			Y	Y	98. 05
98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in colum column 2 for title XIX.			Y	Y	98. 06
Rural Providers					
105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the all	l-inclusive met	hod of payment	N N		105. 00 106. 00
for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for outpatient in the services? (see instructions) training programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do	mn 1. (see ins	structions)	N		107. 00
approved medical education program in the CAH's excluded I Enter "Y" for yes or "N" for no in column 2. (see instruct 107.01 of this facility is a REH (line 3, column 4, is "12"), is i	tions)				107. 01
reimbursement for I&R training programs? Enter "Y" for yes instructions)	or "N" for no.	(see			
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N	Dani matama	108. 00
	Physi cal 1.00	Occupational 2.00	Speech 3. 00	Respiratory 4.00	+
109.00 olf 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	109. 00
				1.00	\dashv
110.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	"Y" for yes or	"N" for no. I		N	110.00
		ines 200 throu			
		Thes 200 throu	gh 215, as		
111 00 of this facility qualifies as a CAH did it participate in	the Frontier (1.00	2.00	111 00
111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to dintegration prong of the FCHIP demo in which this CAH is participated in the project of th	cost reporting column 1 is Y, articipating ir	Community period? Enter enter the n column 2.	gh 215, as	2.00	111.00
Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to of integration prong of the FCHIP demo in which this CAH is partner all that apply: "A" for Ambulance services; "B" for a for tele-health services.	cost reporting column 1 is Y, articipating ir additional beds	Community period? Enter enter the n column 2.	1.00	2.00	111.00
Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to of integration prong of the FCHIP demo in which this CAH is particled that apply: "A" for Ambulance services; "B" for a	cost reporting column 1 is Y, articipating ir additional beds alth Model reporting column 1 is ipating in the	Community period? Enter enter the n column 2. s; and/or "C"	1.00 N		
Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to dintegration prong of the FCHIP demo in which this CAH is particle. The services integrated in the pennsyl vania Rural Health services. 112.00 Did this hospital participate in the Pennsyl vania Rural Health services. 112.00 Did this hospital participate in the Pennsyl vania Rural Health services. 112.00 Did this hospital participate in the Pennsyl vania Rural Health services. 112.00 Did this hospital participate in the Pennsyl vania Rural Health services. 112.00 Did this hospital participate in the Pennsyl vania Rural Health services. 112.00 Did this hospital participate in the Pennsyl vania Rural Health services. 112.00 Did this hospital participate in the Pennsyl vania Rural Health services. 112.00 Did this hospital participate in the Pennsyl vania Rural Health services. 112.00 Did this hospital participate in the Pennsyl vania Rural Health services. 112.00 Did this hospital participate in the Pennsyl vania Rural Health services. 112.00 Did this hospital participate in the Pennsyl vania Rural Health services. 112.00 Did this hospital participate in the Pennsyl vania Rural Health services. 112.00 Did this hospital participate in the Pennsyl vania Rural Health services. 112.00 Did this hospital participate in the Pennsyl vania Rural Health services. 112.00 Did this hospital participate in the Pennsyl vania Rural Health services. 112.00 Did this hospital participate in the Pennsyl vania Rural Health services.	cost reporting column 1 is Y, articipating ir additional beds alth Model reporting column 1 is ipating in the eased	Community period? Enter enter the n column 2. s; and/or "C" 1.00 N	1.00 N	3.00	112.00
Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to dintegration prong of the FCHIP demo in which this CAH is particle. Integration prong of the FCHIP demo in which this CAH is particle. Integration prong of the FCHIP demo in which this CAH is particle. Integration prong of the FCHIP demo in which this CAH is particle. Integration and provides: Integration and provides are the pennsylvania Rural Head (PARHM) demonstration for any portion of the current cost in period? Enter "Y" for yes or "N" for no in column 1. If of "Y", enter in column 2, the date the hospital began particle demonstration. In column 3, enter the date the hospital content particle particle particle particle provides? Enter "Y" for yes on the particle provides and particle particle particle provides and particle provides and particle particle provides and particle provides	cost reporting column 1 is Y, articipating ir additional beds alth Model reporting column 1 is ipating in the eased or "N" for no B, or E only) "93" percent (includes	Community period? Enter enter the n column 2. s; and/or "C"	1.00 N	3.00	
Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to dintegration prong of the FCHIP demo in which this CAH is particle. The second of the services in the pennsyl variant apply: "A" for Ambulance services; "B" for a for tele-health services. 112.00 Did this hospital participate in the Pennsyl vania Rural Health (PARHM) demonstration for any portion of the current cost of period? Enter "Y" for yes or "N" for no in column 1. If of "Y", enter in column 2, the date the hospital began participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care	cost reporting column 1 is Y, articipating ir additional beds alth Model reporting column 1 is ipating in the eased or "N" for no B, or E only) "93" percent (includes ers) based on	Community period? Enter enter the n column 2. s; and/or "C" 1.00 N	1.00 N	3.00	112.00
Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to dintegration prong of the FCHIP demo in which this CAH is particle. Integration prong of the FCHIP demo in which this CAH is particle. Integration prong of the FCHIP demo in which this CAH is particle. Integration prong of the FCHIP demo in which this CAH is particle. Integration prong of the FCHIP demo in which this CAH is particle. Integration of the current cost in period? Enter "Y" for yes or "N" for no in column 1. If of "Y", enter in column 2, the date the hospital began particle demonstration. In column 3, enter the date the hospital content of particle. Integration in the demonstration, if applicable. Miscellaneous Cost Reporting Information Integration in the demonstration. In column 1. If column 1 is yes, enter the method used (A, in column 2. If column 1 is yes, enter the method used (A, in column 2. If column 1 is "E", enter in column 3 either for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub. 15-1, chapter 22, §2208.1. Incolumn 2. If solity classified as a referral center? Enter "Y"	cost reporting column 1 is Y, articipating ir additional beds alth Model reporting column 1 is ipating in the eased or "N" for no B, or E only) "93" percent (includes ers) based on "for yes or urance? Enter	Community period? Enter enter the n column 2. s; and/or "C" 1.00 N	1.00 N	3.00	112.00

Health Financial Systems			ITALS, INC	45 000			In Lieu	u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENIIFICATION DATA	1	Provi der CC	N: 15-0002			01/2023 31/2023	Worksheet S- Part I Date/Time Pr 5/29/2024 9:	epared:
								1 00	
147.00 Was there a change in the statist	cal basis? Entor "V"	for v	os or "N" for	no				1. 00 N	147. 0
148.00 Was there a change in the order of								N	148. 0
149.00Was there a change to the simplif					for r	10.		N	149. 0
· · · · · · · · · · · · · · · · · · ·			Part A	Part			le V	Title XIX	1
			1. 00	2. 00)	3.	. 00	4. 00	
Does this facility contain a prov or charges? Enter "Y" for yes or			ent for Part A	and Part			CFR §41	3. 13)	
155. 00 Hospi tal			N	N			N	N	155. 0
156.00 Subprovider - IPF			N	N			N	N	156. 0
157.00 Subprovi der - I RF 158.00 SUBPROVI DER			N	N			N	N	157. 00 158. 00
158. 00 SUBPROVI DER 159. 00 SNF			N	N			N	N	159. 0
160.00HOME HEALTH AGENCY			N	N			N	N	160. 0
161. 00 CMHC				N			N	N	161. 0
		<u> </u>						1. 00	
Mul ti campus									
65.00 s this hospital part of a Multico Enter "Y" for yes or "N" for no.	ampus hospital that ha	as one	e or more camp	uses in d				N	165. 0
	Name		County	State	Zip (CBSA	FTE/Campus	4
1// 001 5 11 1/5 1 6	0		1. 00	2. 00	3. (00	4. 00	5. 00	00166.0
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.0	00100.0
								1. 00	+
Health Information Technology (HI	T) incentive in the Ar	meri ca	an Recovery an	d Rei nves	tment	Act			
167.00 s this provider a meaningful use	under §1886(n)? Ent	ter "Y	" for yes or	"N" for n	Ο.			Y	167. 0
68.00 If this provider is a CAH (line 10				e 167 is	"Y"),	enter	the		168. 0
reasonable cost incurred for the					6				4.00
68.01 If this provider is a CAH and is						a hards	shi p		168. 0
exception under §413.70(a)(6)(ii)(69.00) If this provider is a meaningful transition factor. (see instruction	user (line 167 is "Y")					N"), er	nter the	9. 9	99169. 0
transition ractor. (See Thistraction	5113)					Beai	nni ng	Endi ng	
					İ		. 00	2. 00	
70.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	oegi nni ng date and end	ding d	late for the r	eporti ng					170. 0
						1	. 00	2. 00	
171.00 ffline 167 is "Y", does this pro	vider have any days fo	or ind	li vi dual s enco	lledin			N	2.00	0171.0
section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2.	reported on Wkst. S-3, umn 1. If column 1 is	Pt.	I, line 2, co	I. 6? Ent			IN		0171.00

Heal th	Financial Systems METHODIST HOS	SPITALS INC		In lie	u of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0002	Peri od:	Worksheet S-2	
				From 01/01/2023 To 12/31/2023	Date/Time Pro	
				Y/N	5/29/2024 9:0 Date	08 am
				1. 00	2. 00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSI General Instruction: Enter Y for all YES responses. Enter I mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS			er all dates in	the	
4 00	Provider Organization and Operation			N		1
1. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in			N S)		1.00
			Y/N	Date	V/I	
2. 00	Has the provider terminated participation in the Medicare	Drogram2 If	1. 00 N	2. 00	3. 00	2.00
3.00	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary. Is the provider involved in business transactions, includicontracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provious officers, medical staff, management personnel, or members of directors through ownership, control, or family and other	mn 3, "V" for ng management offices, drug der or its of the board	N			3.00
	relationships? (see instructions)		Y/N	Type	Date	
			1.00	2. 00	3. 00	
4 00	Financial Data and Reports	1. 6 1 5 11.	l v		l	4 00
4. 005. 00	Column 1: Were the financial statements prepared by a Cer Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date av. column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diff.	for Compiled, ailable in erent from	Y N	A		4. 00 5. 00
	those on the filed financial statements? If yes, submit re	conciliation.		Y/N	Legal Oper.	
				1. 00	2. 00	
	Approved Educational Activities				I	
6. 00	Column 1: Are costs claimed for a nursing program? Column the legal operator of the program?	2: If yes, I	s the provide	er N		6.00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see i Were nursing programs and/or allied health programs approv- cost reporting period? If yes, see instructions.		wed during th	y Y		7. 00 8. 00
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated		the current	N		10.00
11. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than Teaching Program on Worksheet A? If yes, see instructions.	I & R in an Ap	proved	N		11.00
	Treadming Trogram on norkaneet N. Tr yes, see That detrons.				Y/N	
	0.10.11				1. 00	
12 00	Bad Debts Is the provider seeking reimbursement for bad debts? If ye	s see instruc	tions		Y	12.00
	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			cost reporting	N	13. 00
14. 00	If line 12 is yes, were patient deductibles and/or coinsur- instructions. Bed Complement	ance amounts w	aived? If yes	s, see	N	14.00
15. 00	Did total beds available change from the prior cost report	ing period? If	yes, see ins	tructions.	N	15. 00
			t A		t B	
		1. 00	2. 00	Y/N 3.00	Date 4. 00	
	PS&R Data	1.00	2.00	3.00	7.00	
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 date of the PS&R Report used in columns 2 and 4 (see instructions)	N		N		16.00
17. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	03/13/2024	Y	03/13/2024	17. 00
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18. 00
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

Heal th	Financial Systems METHODIST HOS	SPITALS, INC		In Lie	u of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der 0	CCN: 15-0002	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Pre 5/29/2024 9:0	epared:
			iption	Y/N	Y/N	
	1.6.1. 44 47.1		0	1.00	3. 00	00.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		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	
	Capital Related Cost					1
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, se Have changes occurred in the Medicare depreciation expense			ing the cost	N	22. 00 23. 00
24. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases enter	ed into durino	this cost re	enorting period?		24. 00
	If yes, see instructions		•			
25. 00	Have there been new capitalized leases entered into during instructions.		0 .			25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during tinstructions.	he cost report	ing period? I	f yes, see		26. 00
27. 00	Has the provider's capitalization policy changed during th	ne cost reporti	ng period? If	yes, submit		27. 00
	Copy. Interest Expense					
28. 00	Were new loans, mortgage agreements or letters of credit e period? If yes, see instructions.	entered into du	ıring the cost	reporting		28. 00
29. 00	Did the provider have a funded depreciation account and/or		Oebt Service F	Reserve Fund)		29. 00
30. 00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat		debt? If yes	s, see		30.00
31. 00	instructions. Has debt been recalled before scheduled maturity without i	ssuance of new	debt? If ves	s see		31.00
	instructions.					1
32. 00	Purchased Services 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 If line 32 is yes, were the requirements of Sec. 2135.2 ap		ng to competi	tive bidding? If	N	33. 00
	no, see instructions. Provider-Based Physicians					
34. 00	Were services furnished at the provider facility under an If yes, see instructions.	arrangement wi	th provider-b	ased physicians?	Υ	34.00
35. 00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i		ents with the	provi der-based	N	35. 00
	This craims during the doct reporting period. It jees doct t	1.5 (1. 4.5 (1. 51.5)		Y/N	Date	
				1. 00	2. 00	
0,	Home Office Costs			1		
36. 00 37. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	repared by the	e home office?	N N		36. 00 37. 00
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of	fice different	: from that of	- N		38.00
	the provider? If yes, enter in column 2 the fiscal year en	nd of the home	offi ce.			39. 00
	If line 36 is yes, did the provider render services to oth see instructions.	·	,			
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 00
		1	. 00	2.	00	
	Cost Report Preparer Contact Information	1.		Ζ.		
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	MI CHAEL		ALESSANDRI NI		41.00
42. 00	respectively. Enter the employer/company name of the cost report	BLUE & CO., LI	LC			42.00
	preparer.			MALECCANDDIAL O	DI LIEANDOO COM	
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7959		MALESSANDRI NI @	DLUEANDCU. CUM	43.00

Health Fir	nancial Systems	METHODIST HOS	SPITALS, IN	IC	In Lieu	u of Form CMS-	2552-10
HOSPI TAL /	AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi d	er CCN: 15-0002	eriod: fom 01/01/2023 o 12/31/2023	Worksheet S-2 Part II Date/Time Pre 5/29/2024 9:0	pared:
				3. 00			
Cos	st Report Preparer Contact Information			3.00			
41.00 Ent	ter the first name, last name and the t ld by the cost report preparer in colum		DI RECTOR				41.00
42. 00 Ent	spectively. ter the employer/company name of the co eparer.	ost report					42.00
43. 00 Ent	ter the telephone number and email addr port preparer in columns 1 and 2, respe						43. 00

Heal th Fi nancial SystemsMETHODIHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA METHODIST HOSPITALS, INC In Lieu of Form CMS-2552-10 Provider CCN: 15-0002

Component Worksheet A No. of Beds Bed Days CAH/REH Hours Title V	
Component Worksheet A No. of Beds Bed Days CAH/REH Hours Title V	
Component Worksheet A No. of Beds Bed Days CAH/REH Hours Title V	
Line No. Available	
1. 00 2. 00 3. 00 4. 00 5. 00 PART I - STATISTICAL DATA	
PART I - STATISTICAL DATA	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 30.00 331 120,815 0.00 0 1.00	00
8 exclude Swing Bed, Observation Bed and	
Hospi ce days) (see instructions for col. 2	
for the portion of LDP room available beds)	
2.00 HMO and other (see instructions)	00
3.00 HMO IPF Subprovider 3.00	00
4.00 HMO IRF Subprovider 4.00	00
5.00 Hospital Adults & Peds. Swing Bed SNF 0 5.00	00
6.00 Hospital Adults & Peds. Swing Bed NF 0 6.00	
7.00 Total Adults and Peds. (exclude observation 331 120,815 0.00 0 7.00	00
beds) (see instructions)	
8. 00 INTENSÎVE CARE UNIT 31. 00 39 14, 235 0. 00 0 8. 00	00
8. 01 NEONATAL I CU 31. 01 35 12, 775 0. 00 0 8. 01	
9.00 CORONARY CARE UNIT	
10.00 BURN INTENSIVE CARE UNIT	
11. 00 SURGI CAL INTENSIVE CARE UNIT	
12.00 OTHER SPECIAL CARE (SPECIFY)	
13.00 NURSERY 43.00 0 13.00	
14. 00 Total (see instructions) 405 147, 825 0. 00 0 14. 00	
15. 00 CAH vi si ts	
15. 10 REH hours and visits 0. 00 0 15. 10	
16. 00 SUBPROVI DER - I PF 40. 00 12 4, 380 0 16. 00	
17. 00 SUBPROVIDER - I RF 40.00 24 8, 760 0 17. 00	
17. 00 SUBPROVI DER - 1 RF 41. 00 24 8, 760 18. 00 18.	
19. 00 SKILLED NURSING FACILITY	
20. 00 NURSING FACILITY 20. 00	
22. 00 HOME HEALTH AGENCY 101. 00 22. 00	
23. 00 AMBULATORY SURGICAL CENTER (D. P.)	
24. 00 HOSPI CE 24. 00	
24. 10 HOSPICE (non-distinct part) 30. 00 24. 10	
25. 00 CMHC - CMHC	
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) 441 27.00	
28.00 Observation Bed Days	
29. 00 Ambul ance Tri ps 29. 00	
30.00 Employee discount days (see instruction) 30.00	
31.00 Employee discount days - IRF	
32.00 Labor & delivery days (see instructions) 0 0 32.00	
32.01 Total ancillary labor & delivery room 32.01	UΊ
outpatient days (see instructions)	00
33.00 LTCH non-covered days	
33.01 LTCH site neutral days and discharges	
34.00 Temporary Expansi on COVI D-19 PHE Acute Care 30.00 0 0 0 34.00	UU

Provi der CCN: 15-0002

Peri od: Worksheet S-3 From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/39/2024 9:08 am

				'	0 12/01/2020	5/29/2024 9:0	8 am
		I/P Davs	/ O/P Visits	/ Trips	Full Time F	qui val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	Compension:			Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA	0.00	7.00	0.00	7. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	14, 839	3, 385	63, 458			1.00
1.00	8 exclude Swing Bed, Observation Bed and	14, 037	3, 303	03, 430			1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2 00		24 144	21 742				2.00
2.00	HMO and other (see instructions)	26, 144	21, 743				
3.00	HMO IPF Subprovi der	0	260				3.00
4. 00	HMO I RF Subprovi der	0	920	_			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	14, 839	3, 385	63, 458			7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	1, 895	0	7, 609			8.00
8. 01	NEONATAL I CU	0	0	2, 024			8. 01
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	2, 108			13.00
14.00	Total (see instructions)	16, 734	3, 385	75, 199		1, 844. 95	
15. 00	CAH visits	0	0,000	, 5, 1, 7		., 0 , 0	15.00
15. 10	REH hours and visits	0	0	0			15. 10
16. 00	SUBPROVI DER - I PF	256	41	1, 312		10. 46	
17. 00	SUBPROVIDER - IRF	808	48	3, 461		17. 34	
18. 00	SUBPROVI DER	000	40	3, 401	0.00	17.54	18.00
19. 00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
							1
21.00	OTHER LONG TERM CARE			47.540			21.00
22. 00	HOME HEALTH AGENCY	0	0	16, 540	0. 00	23. 39	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)			176			24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				2. 86	1, 896. 14	27.00
28.00	Observation Bed Days		3, 411	11, 312			28. 00
29.00	Ambul ance Trips	o					29. 00
30.00	Employee discount days (see instruction)			0			30.00
31. 00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	48	56			32.00
32. 01	Total ancillary labor & delivery room		10	0			32.00
02.01	outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days	0					33.00
33. 01	LTCH site neutral days and discharges						33. 01
	Temporary Expansion COVID-19 PHE Acute Care	o	0	0			34.00
34.00	Tremporary Expansion Covid-19 File Acute Care	ı Y	Ч	1	1 1		1 34.00

| Period: | Worksheet S-3 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Health Financial Systems METHODIS HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 15-0002

				To	12/31/2023	Date/Time Pre 5/29/2024 9:0	
		Full Time		Di sch	arges	372972024 9.0	o alli
		Equi val ents			. 5		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13.00	14.00	15. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		C	2, 433	542	11, 482	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
0.00	for the portion of LDP room available beds)			0.400	4 500		0.00
2.00	HMO and other (see instructions)			3, 192	4, 580		2.00
3.00	HMO IPF Subprovi der				26 54		3. 00 4. 00
4. 00 5. 00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF				54		5.00
6. 00	Hospital Adults & Peds. Swing Bed SNF						6.00
7. 00							7.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
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	C	2, 433	542	11, 482	14.00
15.00	CAH visits					·	15.00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVIDER - IPF	0.00	C	15	3	123	16.00
17.00	SUBPROVI DER - I RF	0.00	C	67	4	240	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 25. 00	HOSPICE (non-distinct part) CMHC - CMHC						24. 10 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	0.00					28.00
29. 00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care				l		34.00

Heal th	Financial Systems		METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provi der C	F	Period: From 01/01/2023 To 12/31/2023		pared:
		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	DADT II WACE DATA	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							
1.00	Total salaries (see	200.00	163, 242, 818	-415, 172	162, 827, 646	3, 942, 742. 00	41. 30	1.00
2 00	instructions)		0			0.00	0.00	2 00
2. 00	Non-physician anesthetist Part A		0			0.00	0. 00	2.00
3. 00	Non-physician anesthetist Part		0	c	(0.00	0. 00	3. 00
4. 00	Physician-Part A - Administrative		0	С) (0.00	0.00	4. 00
4. 01	Physicians - Part A - Teaching		0	c		0.00	0. 00	4. 01
5.00	Physician and Non		430, 755	C	430, 755	2, 080. 00	207. 09	5.00
6. 00	Physician-Part B Non-physician-Part B for		0	_		0.00	0. 00	6.00
0.00	hospital-based RHC and FQHC		0			0.00	0.00	0.00
7. 00	services Interns & residents (in an	21. 00	0	C)	0.00	0. 00	7. 00
7. 01	approved program) Contracted interns and		297, 137	C	297, 137	5, 949. 00	49. 95	7. 01
	residents (in an approved programs)		,					
8. 00	Home office and/or related organization personnel		0	c	(0.00	0. 00	8. 00
9. 00	SNF	44.00	0	C		0.00	0.00	9.00
10.00	Excluded area salaries (see		30, 952, 460	1, 511, 276	32, 463, 736	589, 471. 00	55. 07	10.00
	instructions) OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient		17, 166, 517	C	17, 166, 517	164, 996. 00	104. 04	11.00
12. 00	Care Contract Labor: Top Level		0	C) (0.00	0. 00	12. 00
	management and other management and administrative services							
13. 00	Contract Labor: Physician-Part A - Administrative		761, 280	c	761, 280	4, 859. 00	156. 67	13.00
14. 00	Home office and/or related organization salaries and		0	C)	0.00	0.00	14. 00
14. 01	wage-related costs Home office salaries		0			0.00	0.00	14. 01
14. 02	Related organization salaries		0				0. 00	
15. 00	Home office: Physician Part A		0	C		0.00	0. 00	15. 00
16. 00	- Administrative Home office and Contract		0	_		0.00	0.00	16. 00
10.00	Physicians Part A - Teaching		O)	0.00	0.00	10.00
16. 01	Home office Physicians Part A		0	C) (0.00	0. 00	16. 01
16. 02	- Teaching Home office contract		0			0.00	0.00	16. 02
	Physicians Part A - Teaching WAGE-RELATED COSTS		_					
17.00	Wage-related costs (core) (see		30, 865, 942	C	30, 865, 942	2		17.00
18. 00	instructions) Wage-related costs (other)							18. 00
16.00	(see instructions)							18.00
19.00	Excluded areas		5, 689, 375	[c	5, 689, 375	5		19.00
20. 00	Non-physician anesthetist Part A		0	C				20.00
21. 00	Non-physician anesthetist Part B		0	C	()		21.00
22. 00	Physician Part A - Administrative		0	C				22. 00
22. 01	Physician Part A - Teaching		0	C) (22. 01
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		35, 620		35, 620			23. 00 24. 00
25. 00	Interns & residents (in an		0					25.00
	approved program)		2					
25. 50	Home office wage-related (core)		0	[,		25. 50
25. 51	Related organization wage-related (core)		0	C				25. 51
25. 52	Home office: Physician Part A		0	C				25. 52
	- Administrative - wage-related (core)							
		'		•	•	'		

Hear th	Financial Systems		METHODIST HOS	PLIALS, INC		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider Co		Period: From 01/01/2023 To 12/31/2023	5/29/2024 9:0	pared:
		Wkst. A Line	Amount	Recl assi fi cat		Paid Hours	Average	
		Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.		(col. 4 ÷	
				(from Wkst.	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		0		25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARI							
26. 00	Employee Benefits Department	4. 00						26. 00
27.00	Administrative & General	5. 00	23, 945, 142	-1, 665, 207		•	l	27. 00
28.00	Administrative & General under		2, 280, 643	0	2, 280, 64	3 11, 750. 00	194. 10	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0		0. 00		29. 00
30.00	Operation of Plant	7. 00	5, 282, 304	-3, 587	5, 278, 71	•		30.00
31.00	Laundry & Linen Service	8. 00	0	0		0.00		31.00
32.00	Housekeepi ng	9. 00	4, 722, 254	-28, 001	4, 694, 25	3 245, 885. 00	19. 09	32.00
33.00	Housekeeping under contract		0	0		0.00	0.00	33.00
	(see instructions)							
34.00	Di etary	10.00	4, 021, 138	-1, 380, 298	2, 640, 84	0 94, 977. 00		34.00
35.00	Dietary under contract (see		0	0		0.00	0.00	35. 00
	instructions)							
36.00	Cafeteri a	11. 00	249, 114	1, 375, 923	1, 625, 03	7 58, 603. 00	27. 73	36. 00
37.00	Maintenance of Personnel	12. 00	0	0		0.00		
38.00	Nursing Administration	13. 00	6, 162, 512	-11, 841	6, 150, 67	1 96, 642. 00	63. 64	38. 00
39.00	Central Services and Supply	14. 00	776, 128	0	776, 12	8 36, 682. 00	21. 16	39.00
40.00	Pharmacy	15. 00	0	0		0.00	0.00	40.00
41.00	Medical Records & Medical	16. 00	2, 283, 430	-1, 788	2, 281, 64	2 83, 950. 00	27. 18	41.00
	Records Library							
42.00	Social Service	17. 00	157, 499	469, 866	627, 36	5 16, 841. 00	37. 25	42.00
43.00	Other General Service	18. 00	0	0		0.00	0.00	43.00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10
HOSPITAL WAGE INDEX INFORMATION	Provi der CCN: 15-0002	
		From 01/01/2023 Part

						o 12/31/2023	Date/Time Prep 5/29/2024 9:0	
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1. 00	Net salaries (see		164, 795, 569	-415, 172	164, 380, 397	3, 946, 463. 00	41. 65	1.00
	instructions)							
2.00	Excluded area salaries (see		30, 952, 460	1, 511, 276	32, 463, 736	589, 471. 00	55. 07	2.00
	instructions)							
3.00	Subtotal salaries (line 1		133, 843, 109	-1, 926, 448	131, 916, 661	3, 356, 992. 00	39. 30	3.00
	minus line 2)							
4.00	Subtotal other wages & related		17, 927, 797	0	17, 927, 797	169, 855. 00	105. 55	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		30, 865, 942	0	30, 865, 942	0.00	23. 40	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		182, 636, 848	-1, 926, 448	180, 710, 400	3, 526, 847. 00	51. 24	6.00
7.00	Total overhead cost (see		51, 955, 597	-1, 319, 947	50, 635, 650	1, 475, 372. 00	34. 32	7.00
	instructions)							

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu	of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0002	Peri od: From 01/01/2023	Worksheet S-3 Part IV
			Date/Time Prepared:

	To 12/31/2023	B Date/Time Pre 5/29/2024 9:0	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Empl oyer Contributions	2, 721, 771	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1, 066, 667	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	15, 198, 586	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	4, 097, 969	9. 00
10.00	Dental, Hearing and Vision Plan	666, 468	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	772, 477	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	415, 174	
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00		531, 512	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Noncumul ative portion)		
	TAXES		
		11, 046, 801	
18. 00	Medicare Taxes - Employers Portion Only	0	18. 00
19. 00	Unempl oyment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (se	e 0	21.00
	instructions))		
22. 00	Day Care Cost and Allowances	0	22.00
23. 00	Tuition Reimbursement	73, 512	23. 00
24. 00		36, 590, 937	24.00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Heal th	Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part V Date/Time Pre 5/29/2024 9:0	pared:
	Cost Center Description		Contract Labor	Benefit Cost	
			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identif	i cati on:			1
1.00	Total facility's contract labor and benefit of	cost	17, 166, 517	36, 590, 937	1.00
2.00	Hospi tal		17, 166, 517	36, 590, 937	2.00

		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	17, 166, 517	36, 590, 937	1.00
2.00	Hospi tal	17, 166, 517	36, 590, 937	2.00
3.00	SUBPROVI DER - I PF	0	0	3.00
4.00	SUBPROVI DER - I RF	0	0	4.00
5.00	Subprovi der - (0ther)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9. 00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11. 00	Hospi tal -Based HHA	0	0	11.00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I			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 I	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		Period: From 01/01/2023		
			Component	CCN: 15-7536 T	o 12/31/2023	Date/Time Pre 5/29/2024 9:0	
					Home Health Agency I	PPS	
					1.	00	
0. 00	County						0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1. 00	2. 00	3.00	4.00	5. 00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	•			
2. 00	Unduplicated Census Count (see instructions)	0.00	144. 00		0.00 oyees (Full Ti		2.00
				Number of Emp	oyees (Full II	me Equivarent)	
		Enter the numb	er of hours in	Staff	Contract	Total	
		your normal	work week				
		C	١	1.00	2.00	3. 00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES)	1.00	2.00	3.00	
3. 00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4. 00	Director(s) and Assistant Director(s)		101.00	0.00			1
5.00	Other Administrative Personnel			9. 15			
6.00	Direct Nursing Service			7. 07	0.00	7. 07	6.00
7.00	Nursi ng Supervi sor			0.00			7. 00
8.00	Physical Therapy Service			3. 98			
9. 00	Physi cal Therapy Supervisor			0.00			
10.00	Occupational Therapy Service			1. 37			1
11.00	Occupational Therapy Supervisor			0.00			
12.00	Speech Pathology Service			0.00			
13. 00 14. 00	Speech Pathology Supervisor Medical Social Service			0.00			1
15. 00	Medical Social Service Supervisor			0.08			
16. 00	Home Heal th Ai de			1. 75			1
17. 00	Home Health Aide Supervisor			0.00			
	Other (specify)			0.00			18.00
						CBSA Data	
						1. 00	
	HOME HEALTH AGENCY CBSA CODES		 				
19.00	Enter in column 1 the number of CBSAs where					1	19.00
20. 00	List those CBSA code(s) in column 1 serviced first code).	iduring this co	ost reporting	period (iine 2	o contains the	23844	20.00
	inist code).	Full Ep	oi sodes				
				LUPA Epi sodes	PEP Only	Total (cols.	
		Outliers		,	Epi sodes	1-4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PPS ACTIVITY DATA	1 000	050			1 000	
21.00	Skilled Nursing Visits	1, 039		1		1, 322	
22. 00 23. 00	Skilled Nursing Visit Charges Physical Therapy Visits	246, 428 611	60, 032 298		0	313, 600 915	
24. 00	Physical Therapy Visits Physical Therapy Visit Charges	158, 365			_	237, 180	
25. 00	Occupational Therapy Visits	153			0	325	1
26. 00	Occupational Therapy Visit Charges	40, 026	44, 697	1	0	84, 985	
27. 00	Speech Pathology Visits	0	0	1		0	1
28. 00	Speech Pathology Visit Charges	0	0) (0	0	28. 00
29. 00	Medical Social Service Visits	8	9	1		17	29. 00
30.00	Medical Social Service Visit Charges	2, 996	3, 420	l e		6, 416	
31. 00	Home Health Aide Visits	330	103	1		434	
32.00	Home Health Aide Visit Charges	35, 521	11, 124			46, 753	
33. 00	Total visits (sum of lines 21, 23, 25, 27,	2, 141	834	38	0	3, 013	33.00
24 00	29, and 31)	0	0		0	0	24 00
34. 00 35. 00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	0 483, 336	0 196, 528			-	
55.00	30, 32, and 34)	403, 330	170, 320	7,070		000, 734	33.00
36.00	Total Number of Episodes (standard/non	223		28	0	251	36.00
27 00	outlier)		0.5		_	0.5	27.00
37. 00 38. 00	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	53, 833	35 10, 470	•	0	35 67, 865	
_ 5. 55	, suppry onar gos	, 55, 555	.0, 170	1 3,002	'	1 37,000	, 23. 30

	PITALS, INC			u of Form CMS-2	
SPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der Co	CN: 15-0002	Peri od: From 01/01/2023	Worksheet S-1	0
			To 12/31/2023	Parts I & II Date/Time Pre	nare
<u> </u>				5/29/2024 9:0	
				1. 00	
PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				1. 00	
Uncompensated and Indigent Care Cost-to-Charge Ratio					١.
Cost to charge ratio (see instructions)				0. 203379	1.
Medicaid (see instructions for each line)				70 (00 45)	1
Net revenue from Medicaid	2			79, 608, 456	
Did you receive DSH or supplemental payments from Medicaid			-: -10	Y	3
Of If line 3 is yes, does line 2 include all DSH and/or supple			ai d?	N 12 220 717	4
00 If line 4 is no, then enter DSH and/or supplemental paymen [*] 00 Medicaid charges	ts from Medical	a		12, 338, 717	5
				564, 824, 644	
Medicaid cost (line 1 times line 6)	rom (ooo i notri	inti ana)		114, 873, 471	
Difference between net revenue and costs for Medicaid progr				22, 926, 298	8
Children's Health Insurance Program (CHIP) (see instruction Net revenue from stand-alone CHIP	is for each fir	ie)	1	0	9
				0	
3				0	
00 Stand-alone CHIP cost (line 1 times line 10) 00 Difference between net revenue and costs for stand-alone CH	IIID (ooo i notri	inti ana)		0	
OD Difference between net revenue and costs for stand-alone CH Other state or local government indigent care program (see			.\	0	12
				0	13
00 Net revenue from state or local indigent care program (Not 00 Charges for patients covered under state or local indigent				0	
10)	care program	(NOT THE LUCE	i ili ililes o oi	U	14
00 State or local indigent care program cost (line 1 times lin	no 14)			0	15
00 Difference between net revenue and costs for state or local		nrogram (se	e instructions)	0	
Grants, donations and total unreimbursed cost for Medicaid,					''
instructions for each line)	, only and star	terrocar riidi	gent care progra		
OD Private grants, donations, or endowment income restricted	to fundi na chai	ritv care		0	1 17
00 Government grants, appropriations or transfers for support				0	18
00 Total unreimbursed cost for Medicaid, CHIP and state and I			s (sum of lines	22, 926, 298	19
8, 12 and 16)	3	, 3	`		
		Uni nsured	Insured	Total (col. 1	
		pati ents	pati ents	+ col . 2)	
		1.00	2. 00	3. 00	
Uncompensated care cost (see instructions for each line) OD Charity care charges and uninsured discounts (see instructions)	i one)	16, 837, 30	1, 057, 795	17, 895, 162	20
00 Cost of patients approved for charity care and uninsured di		3, 424, 30		4, 482, 162	
instructions)	iscounts (see	3, 424, 30	1,037,793	4, 402, 102	21
00 Payments received from patients for amounts previously writing	tton off ac		o	0	22
charity care	tten on as			U	22
00 Cost of charity care (see instructions)		3, 424, 3	1, 057, 795	4, 482, 162	23
oo poot of onarry care (ood riser dott one)		07 12 17 0	1,007,770		
00 Does the amount on line 20 col. 2, include charges for pati	i ant daya haya	ad a langth a	of atou limit	1. 00 N	24
imposed on patients covered by Medicaid or other indigent	, ,	iu a rengtii C	n stay IIIIII l	ΙΝ	24
		t cara progra	m's longth of	0	25
	na the rhargen	care progra	iii s rengtii or	Ü	25
stay limit O1 (charges for insured nationts' liability (see instructions)				0	25
O1 Charges for insured patients' liability (see instructions)				-	
00 Bad debt amount (see instructions)				33, 451, 647	
00 Medicare reimbursable bad debts (see instructions)				675, 702 1, 039, 541	
01 Medicare allowable bad debts (see instructions)					

32, 412, 106 28. 00 6, 955, 781 29. 00 11, 437, 943 30. 00 34, 364, 241 31. 00

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)

31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

28.00 Non-Medicare bad debt amount (see instructions)
29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

0001	Financial Systems METHODIST HOSPITA		F 0000		u of Form CMS-2	
OSPI	FAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 1		Period: From 01/01/2023 To 12/31/2023		pare
					1. 00	
	PART II - HOSPITAL DATA					
	Uncompensated and Indigent Care Cost-to-Charge Ratio					
00	Cost to charge ratio (see instructions)				0. 198903	1.
	Medicaid (see instructions for each line)					
00	Net revenue from Medicaid					2.
00	Did you receive DSH or supplemental payments from Medicaid?					3.
00	If line 3 is yes, does line 2 include all DSH and/or supplemen		rom Medica	ii d'?		4.
00	If line 4 is no, then enter DSH and/or supplemental payments f	rom Medicaid				5.
00	Medicaid charges Medicaid cost (line 1 times line 6)					6. 7.
00	Difference between net revenue and costs for Medicaid program	(saa instructi	one)			8.
00	Children's Health Insurance Program (CHIP) (see instructions for		5113)			1 0.
00	Net revenue from stand-alone CHIP	or cach fine)				9.
0. 00	Stand-alone CHIP charges					10.
. 00						11.
2. 00	Difference between net revenue and costs for stand-alone CHIP	(see instructio	ons)			12.
	Other state or local government indigent care program (see ins	tructions for e	each line)			1
8. 00	Net revenue from state or local indigent care program (Not inc	luded on lines	2, 5 or 9	9)		13.
. 00	Charges for patients covered under state or local indigent care	e program (Not	i ncl uded	in lines 6 or		14.
	10)					
. 00						15
5. 00						16
	Grants, donations and total unreimbursed cost for Medicaid, CH	P and state/Id	ocal indig	jent care progra	ıms (see	
7. 00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to f</pre>	undi na chari ty	caro			17.
3. 00	Government grants, appropriations or transfers for support of	5				18.
9. 00				(sum of lines		19.
, , 00	8, 12 and 16)	. That gont oan	p. og. a	(34 31 1133		
		Ur	ni nsured	Insured	Total (col. 1	
		р	ati ents	pati ents	+ col . 2)	
			1. 00	2. 00	3. 00	
	Uncompensated care cost (see instructions for each line)					
0.00	Charity care charges and uninsured discounts (see instructions	· I	16, 837, 36	· · · ·		
. 00	Cost of patients approved for charity care and uninsured disco	unts (see	3, 349, 00	1, 009, 035	4, 358, 038	21.
2. 00	instructions) Payments received from patients for amounts previously written	off as		0	0	22.
2. 00	charity care	UII as	,	5	U	22.
3. 00			3, 349, 00	1, 009, 035	4, 358, 038	23
,, 00	joost of charty care (coo fricti actions)		0,017,00	1,007,000	1,000,000	
					1. 00	
1. 00	Does the amount on line 20 col. 2, include charges for patient	days beyond a	Length of	stay limit	N	24.
	imposed on patients covered by Medicaid or other indigent care	program?	G	•		
5. 00	If line 24 is yes, enter the charges for patient days beyond t	he indigent car	re progran	n's length of	0	25.
	stay limit					
5. 01	Charges for insured patients' liability (see instructions)				0	
5. 00					33, 339, 065	
7.00					666, 995	
	Medicare allowable bad debts (see instructions)				1, 026, 145	
	Non-Medicare bad debt amount (see instructions)				32, 312, 920	
8. 00						
7. 01 8. 00 9. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt am	ounts (see inst	tructions)		6, 786, 287	
8. 00 9. 00 0. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt am	·	tructions)		6, 786, 287 11, 144, 325 11, 144, 325	30.

Heal th	Financial Systems	METHODI ST HOSP	ITALS, INC		In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC	CN: 15-0002 P	eri od:	Worksheet A	
					rom 01/01/2023		
				T	o 12/31/2023		
		0.1.1		T 1 1 1 1 1	5	5/29/2024 9:0	8 am
	Cost Center Description	Sal ari es	0ther		Reclassi fi cat	Reclassified	
				+ col. 2)	i ons (See	Tri al Bal ance	
					A-6)	(col. 3 +-	
						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	20, 285, 335	20, 285, 335	1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 075, 433	29, 713, 357	31, 788, 790		32, 124, 707	4.00
5. 01	00550 DATA PROCESSING	4, 389, 933	11, 286, 540	15, 676, 473		13, 782, 778	5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES	1, 185, 105	2,000,059	3, 185, 164		3, 089, 056	5. 02
5. 03	00570 ADMITTING	5, 050, 368	1, 032, 967	6, 083, 335		5, 605, 761	5. 03
5. 04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	3, 636, 060	4, 425, 734	8, 061, 794		6, 508, 214	5. 04
5. 05	00590 OTHER A&G						5. 05
		9, 128, 992	25, 434, 372	34, 563, 364		19, 804, 899	
5. 06	00592 PATIENT TRANSPORTATION	554, 684	48, 789	603, 473		603, 465	5.06
7. 00	00700 OPERATION OF PLANT	5, 282, 304	9, 712, 790	14, 995, 094		20, 906, 172	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	1, 386, 424	1, 386, 424		1, 386, 415	
9.00	00900 HOUSEKEEPI NG	4, 722, 254	1, 302, 918	6, 025, 172	-203, 978	5, 821, 194	9.00
10.00	01000 DI ETARY	4, 021, 138	3, 598, 760	7, 619, 898	-2, 805, 605	4, 814, 293	10.00
11.00	01100 CAFETERI A	249, 114	36, 013	285, 127	2, 728, 346	3, 013, 473	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	6, 162, 512	855, 236	7, 017, 748		6, 889, 129	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	776, 128	2, 336, 368	3, 112, 496		2, 647, 782	
15. 00	01500 PHARMACY	0	14, 087, 188			6, 059, 491	
16. 00	01600 MEDICAL RECORDS & LIBRARY	2, 283, 430	931, 322	3, 214, 752		3, 212, 540	
17. 00		2, 203, 430	731, 322	3, 214, 732			1
	01700 SOCI AL SERVI CE	U	U O	_	,	469, 866	1
17. 01	01701 STAFF EDUCATION	0	0	0	0	0	17. 01
17. 02	01702 MEDI CAL EDUCATI ON	157, 499	49, 530	207, 029		203, 617	1
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	297, 137	297, 137	
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	31, 168	31, 168	22.00
23.00	02300 PARAMED ED PROGRAM	592, 438	118, 756	711, 194	394, 385	1, 105, 579	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00	03000 ADULTS & PEDIATRICS	24, 199, 579	19, 781, 355	43, 980, 934	-1, 040, 181	42, 940, 753	30.00
31. 00	03100 INTENSIVE CARE UNIT	6, 849, 882	2, 501, 917				1
31. 01	03101 NEONATAL I CU	1, 731, 093	2, 383, 408	4, 114, 501		4, 070, 219	1
40.00	04000 SUBPROVI DER - I PF	968, 593	89, 404	1, 057, 997		1, 047, 647	
41. 00	04100 SUBPROVI DER - I RF	1, 628, 726	357, 696	1, 986, 422		1, 951, 478	1
43.00	04300 NURSERY	1, 296, 492	375, 555	1, 672, 047	-118, 715	1, 553, 332	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	5, 743, 339	27, 415, 877	33, 159, 216	-15, 670, 627	17, 488, 589	50.00
50.01	05001 ENDOSCOPY	612, 103	939, 334	1, 551, 437	-542, 616	1, 008, 821	50. 01
51.00	05100 RECOVERY ROOM	1, 191, 406	295, 678	1, 487, 084	-18, 971	1, 468, 113	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 975, 339	852, 447	4, 827, 786		4, 559, 273	
53. 00	05300 ANESTHESI OLOGY	0	0	0		0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 859, 813	3, 429, 010	-	-		
54. 01	05401 RADI OLOGY - ULTRASOUND	1, 411, 077	759, 390	2, 170, 467		2, 145, 180	
55. 00	05500 RADI OLOGY-THERAPEUTI C	473, 412	2, 474, 696	2, 948, 108		2, 427, 948	
55. 01	05501 I NFUSI ON CENTER	716, 079	24, 634, 366	25, 350, 445			
56. 00	05600 RADI 01 SOTOPE	756, 967	1, 323, 430				
57.00	05700 CT SCAN	1, 324, 407	1, 253, 252	2, 577, 659	-109, 685	2, 467, 974	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	499, 966	644, 501	1, 144, 467	-106, 069	1, 038, 398	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	2, 616, 381	8, 949, 865	11, 566, 246	-7, 306, 777	4, 259, 469	59.00
60.00	06000 LABORATORY	4, 459, 801	10, 162, 386	14, 622, 187		14, 436, 525	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 238, 124	361, 469	1, 599, 593		1, 576, 352	1
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0		0	64.00
65. 00	06500 RESPIRATORY THERAPY	2, 644, 859	2, 590, 716	5, 235, 575	-	4, 924, 385	
66. 00	06600 PHYSI CAL THERAPY	1, 722, 283	2, 340, 710	1, 970, 423		1, 961, 288	
	06700 OCCUPATI ONAL THERAPY						
67.00		1, 121, 036	97, 218	1, 218, 254		1, 216, 910	1
68. 00	06800 SPEECH PATHOLOGY	485, 239	47, 034	532, 273		532, 265	
69. 00	06900 ELECTROCARDI OLOGY	838, 421	246, 233	1, 084, 654		996, 681	
69. 01	06901 CARDI AC REHAB	466, 181	436, 986	903, 167	·	701, 715	
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 276, 080	14, 128, 413	15, 404, 493	-13, 696, 907	1, 707, 586	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	О	0	15, 183, 398	15, 183, 398	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	ol	0		14, 331, 609	
73. 00	07300 DRUGS CHARGED TO PATIENTS	448, 590	7, 651, 134	8, 099, 724		42, 702, 220	73.00
74. 00	07400 RENAL DIALYSIS	0	2, 346, 940				
. 1. 00	OUTPATIENT SERVICE COST CENTERS	٩	2,010,740	2,570,740	10, 102	2, 000, 770	1 55
90. 00	09000 CLINIC	2 550 117	2 077 200	4 424 E04	145 404	4 471 010	00 00
	1 1	2, 559, 117	2, 077, 389	4, 636, 506			
91.00	09100 EMERGENCY	9, 098, 338	7, 463, 735	16, 562, 073	-1, 290, 235	15, 271, 838	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	2, 115, 440	346, 830	2, 462, 270	-40, 111	2, 422, 159	101.00
	SPECIAL PURPOSE COST CENTERS						
118.00		137, 595, 555	255, 022, 927	392, 618, 482	1, 979, 592	394, 598, 074	118.00
	NONREI MBURSABLE COST CENTERS						1
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	ol	0	O	Λ	190. 00
	19100 RESEARCH	o	0	0			191.00
	19200 PHYSICIANS' PRIVATE OFFICES	25, 571, 496	19, 568, 507	-	-		
						348, 428	
192.0	19201 OTHER NON-REIMBURSABLE	0	2, 328, 938	2, 328, 938	-1, 980, 510	348, 428	1192.01

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	OF EXPENSES	Provi der CO		Peri od:	Worksheet A	
		_	From 01/01/2023 Fo 12/31/2023	Date/Time Pre 5/29/2024 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	75, 767	72, 312	148, 079	9 0	148, 079	192. 02
193. 00 19300 NONPALD WORKERS	0	0	(0	0	193.00
200.00 TOTAL (SUM OF LINES 118 through 199)	163, 242, 818	276, 992, 684	440, 235, 502	0	440, 235, 502	200.00

Health FinancialSystemsMETHODISTRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 15-0002

Peri od: Worksheet A From 01/01/2023 Date/Ti me Prepared: 5/20/2024 9:08 am

				5/29/2024 9:0	
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For		
		4.00	Allocation	_	
	GENERAL SERVICE COST CENTERS	6. 00	7. 00		
1. 00	00100 CAP REL COSTS-BLDG & FLXT	-3, 501, 200	16, 784, 135	5	1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	-3, 039, 301			4.00
5. 01	00550 DATA PROCESSING	-252, 060			5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES	0	1		5. 02
5. 03	00570 ADMI TTI NG	0	5, 605, 761		5.03
5.04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	-30, 204			5.04
5.05	00590 OTHER A&G	-99, 544	19, 705, 355	5	5.05
5.06	00592 PATIENT TRANSPORTATION	0	603, 465	5	5.06
7.00	00700 OPERATION OF PLANT	0	20, 906, 172	2	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	1, 386, 415	5	8. 00
9.00	00900 HOUSEKEEPI NG	-60	5, 821, 134	4	9. 00
10.00	01000 DI ETARY	0	4, 814, 293	3	10.00
11. 00	01100 CAFETERI A	-1, 203, 412			11.00
13. 00	01300 NURSING ADMINISTRATION	0	6, 889, 129		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	2, 647, 782		14.00
15.00	01500 PHARMACY	0	6, 059, 491		15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	-173, 073	1		16.00
17.00		0	469, 866		17.00
17. 01	01701 STAFF EDUCATION	0	202 417	-1	17. 01
17. 02 21. 00	01702 MEDICAL EDUCATION 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	203, 617 297, 137		17. 02 21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	31, 168		22.00
23. 00	02300 PARAMED ED PROGRAM	-249, 020	l ·		23.00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	-247, 020	030, 337	7	23.00
30. 00	03000 ADULTS & PEDIATRICS	-3, 747, 144	39, 193, 609	9	30.00
31. 00	03100 I NTENSI VE CARE UNI T	0, 717, 111	8, 549, 779		31.00
31. 01	03101 NEONATAL I CU	-2, 111, 003	1		31.01
40.00	04000 SUBPROVI DER - I PF	0	1, 047, 647		40.00
41.00	04100 SUBPROVI DER - I RF	0	1, 951, 478		41.00
43.00	04300 NURSERY	0	1, 553, 332		43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-7, 064, 871	10, 423, 718	8	50.00
50. 01	05001 ENDOSCOPY	0	1, 008, 821	1	50. 01
51.00	05100 RECOVERY ROOM	0	1, 468, 113	3	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	4, 559, 273	3	52.00
53.00	05300 ANESTHESI OLOGY	0	C	-1	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-429	5, 619, 256		54.00
54. 01	05401 RADI OLOGY - ULTRASOUND	-6, 788			54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	-187, 612			55. 00
55. 01	05501 I NFUSI ON CENTER	-5, 429, 954			55. 01
56.00	05600 RADI OI SOTOPE	0	2, 005, 827		56.00
57. 00	05700 CT SCAN	-10, 379	1	1	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	,		58.00
59. 00 60. 00	06000 LABORATORY	0 -50, 092	4, 259, 469 14, 386, 433	•	59. 00 60. 00
62.00	1	-21, 046	1		62.00
64. 00	1	-21, 040	1, 333, 300		64.00
65. 00	06500 RESPI RATORY THERAPY	0	4, 924, 385		65.00
66. 00	06600 PHYSI CAL THERAPY	0	1, 961, 288	•	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	1, 216, 910	I and the second	67.00
68. 00	06800 SPEECH PATHOLOGY	0	532, 265		68.00
69. 00	06900 ELECTROCARDI OLOGY	0	996, 681		69.00
69. 01	06901 CARDI AC REHAB	-46, 800	654, 915	5	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	-58, 433	l ·		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	15, 183, 398		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	14, 331, 609		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	-179, 765			73.00
74.00	07400 RENAL DI ALYSI S	0	2, 336, 778	8	74.00
	OUTPATIENT SERVICE COST CENTERS	507.555	0.040.455	-	
90.00	09000 CLINIC	-507, 555			90.00
91.00	09100 EMERGENCY	0	15, 271, 838	8	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
101 00	OTHER REIMBURSABLE COST CENTERS	0	2 422 150		101 00
101.00	D10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	2, 422, 159	۲	101.00
118.00		27 060 745	266 620 220	ol	110 00
110.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	-27, 969, 745	366, 628, 329	7	118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 966	2, 966	6	190. 00
	19100 RESEARCH	2, 900			191.00
	19200 PHYSICIANS' PRIVATE OFFICES	-31, 014, 365	1	~	192.00
	1 19201 OTHER NON-REI MBURSABLE	0	348, 428		192.01
	19202 FAMILY HEALTH/GARY COMM HEALTH	-93, 733	l ·		192. 02
				•	

Health Financial Systems	METHODIST HOS	SPITALS, INC		In Lieu	u of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provi der Co	CN: 15-0002	Peri od: From 01/01/2023	Worksheet A	
					Date/Time Pro 5/29/2024 9:	
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)	-59, 074, 877	381, 160, 625				200.00

Health Financial Systems RECLASSIFICATIONS | Peri od: | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: | 5/29/2024 9:08 am Provider CCN: 15-0002

Const. Center						12/31/2023	5/29/2024 9: 08 am
Company Comp		Cook Cooks	Increases	C-1	0+1		
A CAPTERIA							
1.00			3.00	4.00	5.00		
1.00 PARAMENT FD PROCESMI	1.00		11. 00	1, 382, 357	1, 352, 670		1.00
1.00 MANAGE ED PRICIGIANI 23.00 408,128 0 2.00 3.00		0		1, 382, 357	1, 352, 670		
2 00 0 00 0 0 0 0 0 0 0 0 0 0 0 0 0	1 00		22.00	400 400			1.00
3 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		PARAMED ED PROGRAM					•
1.00							•
1.00				O			1
1.00				0			1
1.00	6. 00		0.00	0	0		6. 00
1.00		C SOCIAL WORKERS		408, 128	0		
Company Comp	1 00		17 00	469 866	0		1 00
1.00		0			<u> </u>		
FRI NOSES APPRIVO 100 31, 168 005TS, APPRIVO 100 100 10, 100		E - RESIDENTS		<u> </u>			
A	1. 00		21. 00	0	297, 137		1.00
COSTS APPRIVO	2 00		22 00		21 140		2.00
1.00	2.00		22.00	٩	31, 100		2.00
F - MED SUPPLY TO NO NO TO T		0			328, 305		
DATLENTS COLOR C							
MPL DEV. CHARGED TO	1. 00		71. 00	0	15, 183, 398		1.00
ATIENTS 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0	2 00		72 00		14 331 400		2.00
3.00 4.00 5.00 6.00 6.00 7.00 9.00 9.00 9.00 9.00 9.00 9.00 9	2.00		72.00	۷	14, 331, 009		2.00
5.00 6.00 7.00 8.00 9.00 9.00 10.00 9.00 11.00 11.00 10.00 10.00 11.00 1	3.00		0.00	o	0		3.00
6.00 7.00 8.00 9.00 10.0							•
7. 00 0.00 0.00 0 0 0 8. 00 9. 00 10. 00 9. 00 10. 00 10. 00 10. 00 11. 00 11. 00 12. 00 12. 00 12. 00 13. 00 14. 00 15. 00 16. 00 15. 00 16. 00 17. 00 17. 00 18. 00 17. 00 18. 00 17. 00 18. 00 17. 00 18. 00 18. 00 17. 00 18. 00				-			1
9.00 9.00 10				-1			1
9.00 10.00 10.00 11.00 10.00 10.00 10.00 11.00 1							1
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G - LI GHT DUTY 1. 00 OTHER A&G 5. 05 8, 771 0 1. 00 2. 00 DI ETARY 10. 00 2, 785 0 2. 00	46.00		0.00		0		46.00
1. 00 OTHER A&G 5. 05 8, 771 0 1. 00 2. 00 DI ETARY 10. 00 2, 785 0 2. 00		G - LIGHT DUTY		U	27, 313, 007	 	
2. 00 DI ETARY 10. 00 2, 785 0 2. 00	1. 00		5. 05	8, 771	0		1.00
3.00 ADULTS & PEDI ATRI CS 30.00 21,087 0 3.00	2.00	DI ETARY	10. 00	2, 785	0		2.00
	3. 00	ADULTS & PEDIATRICS	30. 00	21, 087	0	 	3. 00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/29/2024 9: 08 am Provider CCN: 15-0002

						5/29/2024 9:08 am
	Cost Center	Increases Line #	Sal ary	Other		
	2.00	3. 00	4. 00	5. 00		
4. 00	SUBPROVI DER - I RF	41. 00	2, 645	0	,	4. (
5.00	OPERATING ROOM	50. 00	8, 361	0		5. 0
6.00	RECOVERY ROOM	51.00	1, 193	0		6.0
7. 00	RADI OLOGY - ULTRASOUND	54. 01	658	0		7. (
8. 00	CT SCAN	57. 00	18, 589	0		8.0
9. 00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62. 00	1, 472	0		9.0
10.00	EMERGENCY	91. 00	6, 815	0		10.0
	0		72, 376	<u>0</u>		
	H - INTEREST EXPENSE					
1. 00	CAP REL COSTS-BLDG & FIXT	1. 00	0	3, 482, 115		1. (
2. 00		0.00	0	0		2.0
	I - CORPORATE EXPENSE		U	3, 482, 115		
1. 00	CAP REL COSTS-BLDG & FLXT	1.00	0	5, 913, 940		1. (
2. 00	OPERATION OF PLANT	7. 00	o	5, 229, 267		2.0
	0		0	11, 143, 207		
1 00	J - DRUG EXPENSE	70.00	ما	05 000 070		
1. 00 2. 00	DRUGS CHARGED TO PATIENTS	73. 00 0. 00	0	35, 023, 378 0		1.0
3. 00		0.00	0	0		3.0
0.00			- — ŏ	35, 023, 378		3.0
	K - PHYSICIAN RECLASS					
1.00	OTHER A&G	5. 05	0	50, 000		1. (
2. 00	CLINIC	9000	0	115, 580		2.0
	L - PSTD RECLASS		0	165, 580		
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	415, 172		1.0
2.00		0.00	O	0		2.0
3.00		0. 00	0	0		3.0
4.00		0. 00	0	0		4.0
5. 00		0.00	0	0		5. (
6.00		0.00	0	0		6.0
7. 00 8. 00	1	0. 00 0. 00	0	0		7. 0
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11.00		0. 00	O	0		11. (
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13.00		0.00	0	0		13. (
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19.00		0. 00	0	0		19. (
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36.00		0. 00	0	0		36.0
37. 00		0.00	•	0		37.0
	M - DEPRECIATION RECLASS		0	415, 172		
1. 00	CAP REL COSTS-BLDG & FLXT	1.00	0	10, 889, 280		1.0
2. 00		0. 00	0	0		2.0
3.00		0. 00	0	0		3.0
4. 00		0. 00	0	0		4. 0
5.00		0.00	0	0		5. (
6. 00 7. 00		0. 00 0. 00	0	0		6.0
8. 00		0.00	0	0		8.0
0.00		0.00	٦	9		0.0

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0002

	5/29/2024 9:08 am
Increases	
Cost Center Line # Salary Other	
2.00 3.00 4.00 5.00 9.00 0.00 0 0	9.00
9. 00 0 0 0 0 0 0 10. 00 0 0 0 0 0 0 0 0	10.00
11.00	11.00
12.00	12.00
13.00	13.00
14.00	14.00
15.00 0.00 0	15. 00
16. 00	16.00
17. 00 0. 00 0	17. 00
18. 00 0. 00 0	18.00
19.00	19. 00
20. 00 0 0 0 0 0 0 1 0 0 0 0 0 0 0 0 0 0	20.00
22.00	22.00
23.00	23.00
24.00	24.00
25.00	25. 00
26.00 0.00 0	26. 00
27.00 0.00 0	27. 00
28.00 0.00 0	28. 00
29.00 0.00 0	29. 00
30.00 0 0	30.00
31.00 0.00 0	31.00
32. 00 0. 00 0 0 0 33. 00 0. 00 0 0	32. 00 33. 00
34.00	33.00
35.00	35.00
36.00	36.00
37.00 0.00 0 0	37.00
38.00 0.00 0 0	38.00
39.00 0 0 0	39.00
40.00 0.00 0	40.00
41.00	41.00
42.00	42.00
43. 00	43. 00 44. 00
45.00	45.00
46.00	46.00
0 10, 889, 280	
N - DEPT 9101 RECLASS	
1. 00 PHYSICI ANS' PRI VATE OFFI CES 192. 001, 171, 295 319, 701	1.00
0 1, 171, 295 319, 701	
0 - UTILITIES RECLASS	
1. 00 OPERATION OF PLANT 7. 00 0 1, 225, 559	1.00
2. 00 3. 00 0. 00 0 0	2.00
4.00	4.00
5.00	5.00
6.00	6.00
0 0 1, 225, 559	0.00
P - C SECTION RECLASS	
1. 00 OPERATI NG ROOM 50. 00 22, 010 0 22, 010 0	1.00
500.00 Grand Total: Increases 3,526,032 93,859,974	500.00

Health Financial Systems RECLASSIFICATIONS | Peri od: | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: | 5/29/2024 9:08 am Provider CCN: 15-0002

Cost Centrer							5/29/2024	9: 08 am
A. CAPETERIA 10.00		Cook Cooker	Decreases	C-1	0+4	w+ 4 7 D-E		
A. CAPTERIA								
DEFTANK 10.00 1.382_367 1.352_670 0 0 0 0 0 0 0 0 0			7.00	0.00	7. 00	10.00		
B	1.00		10.00	1, 382, 357	1, 352, 670	0		1.00
ADDITION OF PRINTING SOME Company Compan		0		1, 382, 357	1, 352, 670			
0.00 0.00	4 00		20.00	00 070	0			1 00
0.00 CARDI AC CATHETER IZATION 50.00 9.358 0 0			l l			- 1		1. 00 2. 00
DELIVERY ROOM & LABOR ROOM 52.00 17,970 0 0 0 0 0 0 0 0 0			l l					3.00
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AGR 128	5.00	RESPI RATORY THERAPY	65. 00	22, 735	0	o		5. 00
C - SOCIAN MORPIES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6.00	EMERGENCY	<u>91.</u> 00					6. 00
ADMITTING		0		408, 128	0			
1.00 EMERGENCY	1 00		E 03	140 044	0			1.00
Company Comp	1.00	O ITTING			0	— — — 4		1.00
2.00		E - RESIDENTS		107, 000				
The color of the	1.00	EMERGENCY	91. 00	0	328, 305			1.00
F. MED SUPPLY	2.00		0.00					2. 00
DISCRIPTION		0 CURRLY		0	328, 305			
STORES	1 00		5 02	٥	50.002	٥		1.00
2.00 OTHER A&G S. 05 O B O 4.00 LAUNDRY & LINEN SERVICE B. 00 O 9 O 5.00 OPERATION OF PLANT 7.00 O 175 O 6.00 MOUSEKEEPING 9.00 O 2.008 O 7.00 DIETRY OTHER SERVICE O O O 8.00 CAFETERI OTHER SERVICE O O O 8.00 CAFETERI OTHER SERVICE O O 8.00 CAFETERI O O O O 8.00 CAFETERI O O O 8.00 O O O O O 8.00 O O O O O 9.00 O O O O O 9.00 O O O O O O 9.00 O O O O O O 9	1.00		5. 02	٥	30, 772	U		1.00
A. O. LAUNDRY & LINEN SERVICE 8. O. O 9 O O O O O O O O	2.00		5. 05	o	205	o		2. 00
5.00 OPERATION OF PLANT		PATIENT TRANSPORTATION	5. 06	o		О		3. 00
0.00 HOUSEKEEPING			l l	0		-		4. 00
1.00		l l	•	0				5.00
0.00 CAFETERIA 11.00 0 247 0		1		0		-		6.00
9.00 NURSING ADMINISTRATION 13.00 0 5,390 0 11.00 PARAMACY 15.00 0 7,365 0 11.00 PARAMACY 15.00 0 7,365 0 12.00 MEDICAL FECORDS & LIBRARY 16.00 0 297 0 13.00 MEDICAL FECORDS & LIBRARY 16.00 0 297 0 13.00 MEDICAL FECORDS & LIBRARY 17.02 0 3,412 0 14.00 PARAMACY 17.02 0 3,412 0 15.00 ADULTS & PEDIATRICS 30.00 0 5584 0 15.00 ADULTS & PEDIATRICS 30.00 0 558,782 0 17.00 ADULTS & PEDIATRICS 31.00 0 169,468 0 17.00 NEONATAL ICU 31.01 0 701 0 18.00 SUBPROVIDER - IRF 41.00 0 27,402 0 19.00 NURSERY 43.00 0 40.076 0 19.00 NURSERY 43.00 0 40.076 0 10.00 ENDOSCOPY 50.01 0 313,824 0 12.00 ENDOSCOPY 50.01 0 13,924 0 12.00 ENDOSCOPY 50.01 0 0 12.00 ENDOSCOPY 50.01 0 0 13.00 ENDOSCOPY 50.01				0				7. 00 8. 00
10. 00 CENTRAL SERVICES & SUPPLY		l ·		0		-		9.00
11. 00 PHARMACY 15. 00 0 7. 365 0 12. 00 MEDI CAL ECORDS & LIBRARY 16. 00 0 297 0 0 13. 00 MEDI CAL EDUCATI ON 17. 02 0 3. 412 0 0 14. 00 PARAMED ED PROGRAM 23. 00 0 558, 782 0 14. 00 PARAMED ED PROGRAM 23. 00 0 558, 782 0 14. 00 PARAMED ED PROGRAM 23. 00 0 558, 782 0 14. 00 PARAMED ED PROGRAM 23. 00 0 558, 782 0 14. 00 PARAMED ED PROGRAM 23. 00 0 169, 466 0 17. 00 NOWATAL ICU 31. 01 0 701 0 0 18. 00 SIBPROVI DER - IRF 41. 00 0 27. 402 0 19. 00 PARAMED ED PROGRAM 50. 00 0 40. 076 0 0 0 0 0 0 0 0 0		1	l l	Ö		- 1		10.00
13. 00 MEDICAL EDUCATION		1	•	0		O		11.00
14. 00 PARAMED ED PROGRAM 15. 00 ADULTS & PEDIATRICS 30. 00 0 558, 782 0 16. 00 INTENSIVE CARE UNIT 31. 00 0 169, 468 0 17. 00 NEONATAL ICU 31. 00 0 701 0 18. 00 SUBPROVI DER - I RF 41. 00 0 22, 402 0 19. 00 NINSERY 43. 00 0 40, 076 0 20. 00 OPERATI NG ROOM 50. 00 0 14, 962, 795 0 20. 00 OPERATI NG ROOM 50. 00 0 14, 962, 795 0 21. 00 INDOSCOPY 50. 01 0 313, 824 0 22. 00 RECOVERY ROOM 51. 00 0 17, 477 0 23. 00 DELI VERY ROOM 8 LABOR ROOM 52. 00 0 111, 814 0 24. 00 RADIO LOGY - INTERASOUND 54. 01 0 182, 206 0 25. 00 RADIO LOGY - ULTRASOUND 54. 01 0 182, 206 0 27. 00 INFUSION CENTER 55. 01 0 23, 982 0 29. 00 CT SCAN 50. 00 0 1, 118 0 30. 00 MAGNETI C RESONANCE IMAGI NG 58. 00 0 308 0 (MRI) 31. 00 CARDIA C CATHETERI ZATI ON 59. 00 0 1, 713 0 32. 00 LABORATORY 60. 00 0 2, 494 0 33. 00 WHOLE BLOOD & PACKED RED BLOOD CLUST HERRAPY 66. 00 0 383 0 0 40. 00 RADIO LOGUST HERRAPY 67. 00 0 1, 1713 0 34. 00 RESPIRATION THERRAPY 66. 00 0 383 0 0 36. 00 COUPATI THERRAPY 67. 00 0 1, 1713 0 0 37. 00 SPEECH PATHOLOGY 68. 00 0 1, 20, 60 0 38. 00 PHYSI CAL THERRAPY 67. 00 0 1, 1713 0 0 38. 00 PHYSI CAL THERRAPY 67. 00 0 1, 1713 0 0 38. 00 PHYSI CAL THERRAPY 67. 00 0 1, 14, 924 0 0 39. 00 CARDIA C REHAB 69. 01 0 1, 20, 60 0 39. 00 CARDIA C REHAB 69. 01 0 1, 641 0 0 40. 00 ELECTROCARD IOLOGY 69. 00 0 7, 087, 681 0 40. 00 SEPECH PATHOLOGY 68. 00 0 8 0 0 40. 00 SEPECH PATHOLOGY 69. 00 0 1, 20, 60 0 40. 00 ELECTROCARD IOLOGY 99. 00 0 1, 641 0 0 40. 00 ELECTROCARD IOLOGY 99. 00 0 1, 641 0 0 40. 00 ELECTROCARD IOLOGY 99. 00 0 1, 641 0 0 40. 00 ELECTROCARD IOLOGY 99. 00 0 1, 74, 99. 0 40. 00 ELECTROCARD IOLOGY 99. 00 0 1, 74, 99. 0 40. 00 PHYSI CAL THERRAPY 70. 00 0 1, 74, 99. 0 40. 00 ELECTROCARD IOLOGY 99. 00 0 1, 74, 99. 0 40. 00 ELECTROCARD IOLOGY 99. 00 0 1, 74, 99. 0 40. 00 ELECTROCARD IOLOGY 99. 00 0 1, 74, 99. 0 40. 00 ELECTROCARD IOLOGY 99. 00 0 1, 74, 99. 0 40. 00 ELECTROCARD IOLOGY 99. 00 0 1, 74, 99. 0 40. 00 ELECTROCARD IOLOGY 99. 00 0 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	12.00	MEDICAL RECORDS & LIBRARY	16. 00	O		0		12. 00
15. 00 ADULTS & PEDIATRICS 30. 00 0 558, 782 0 0 169, 468 0 0 17. 00 NEONATAL I CU 31. 01 0 701 0 0 0 0 0 0 0 0 0			•	0		- 1		13. 00
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17.00 NEONATAL I CU				-1				15.00
18. 00 SUBPROVIDER - IRF			l l	-1				16. 00 17. 00
19.00 NURSERY			•	٩				18.00
20.00 OPERATING ROOM			•	-1		- 1		19. 00
22.00 RECOVERY ROOM & LABOR ROOM 51.00 0 17,477 0 0 0 0 0 0 0 0 0		OPERATING ROOM	l l	О		O		20.00
23. 00 DELIVERY ROOM & LABOR ROOM 24. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 130, 517 0 RADI OLOGY-DI AGNOSTI C 54. 01 0 18, 206 0 RADI OLOGY-THERAPEUTI C 55. 00 0 9, 206 0 26. 00 RADI OLOGY-THERAPEUTI C 55. 01 0 9, 206 0 27. 00 INFUSION CENTER 55. 01 0 23, 982 0 RADI OLOGY-THERAPEUTI C 55. 00 0 1, 118 0 28. 00 RADI OLOGY-THERAPEUTI C 55. 00 0 9, 206 0 29. 00 CT SCAN 57. 00 0 1, 118 0 30. 00 MAGNETI C RESONANCE I MAGI NG (MRI) 30. 00 MAGNETI C RESONANCE I MAGI NG (MRI) 31. 00 CARDI AC CATHETERI ZATI ON 59, 00 0 7, 087, 681 0 32. 00 LABORATORY 60. 00 0 1, 713 0 BLOOD CELLS 34. 00 RESPI RATORY THERAPY 65. 00 0 1, 713 0 BLOOD CELLS 35. 00 PHYSI CAL THERAPY 66. 00 0 383 0 36. 00 OCCUPATI ONAL THERAPY 67. 00 0 400 0 37. 00 SPEECH PATHOLOGY 68. 00 0 8 0 38. 00 ELECTROCARDI OLOGY 69, 00 0 1, 206 0 39. 00 CARDI AC REHAB 69, 01 0 1, 641 0 40. 00 ELECTROCARDI OLOGY 69, 00 0 1, 206 0 40. 00 ELECTROCARDI OLOGY 69, 00 0 1, 206 0 40. 00 ELECTROCARDI OLOGY 69, 00 0 1, 206 0 40. 00 ELECTROCARDIOLOGY 69, 00 0 1, 206 0 40. 00 ELECTROCARDIOLOGY 69, 00 0 1, 206 0 40. 00 ELECTROCARDIOLOGY 69, 00 0 1, 206 0 40. 00 ELECTROCARDICALORAPHY 70, 00 0 384, 156 0 42. 00 RENAL DI ALYSI S 74, 00 0 9, 873 0 44. 00 EMERGENCY 91, 00 0 322, 715 0 46. 00 EMERGENCY 91, 00 0 29, 515, 007 0 G - LIGHT DUTY 1. 00 EMPLOYEE BENEFITS DEPARTMENT 4, 00 72, 376 0 0 0 2. 00 0 0 0 0 0 0 2. 04PT OLOR THERAPY 10 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0	21.00		50. 01	O	313, 824	0		21.00
24. 00 RADI OLOGY - DI AGNOSTI C 54. 00			•	0				22. 00
25. 00 RADI OLOGY - ULTRASOUND 54. 01 0 18, 206 0 26. 00 RADI OLOGY - THERAPEUTI C 55. 00 0 9, 206 0 27. 00 IN FUSION CENTER 55. 01 0 23, 982 0 28. 00 RADI OLOGY-THERAPEUTI C 55. 00 0 9, 206 0 28. 00 RADI OLOGY-THERAPEUTI C 55. 00 0 9, 206 0 28. 00 RADI OLOGY-THERAPEUTI C 55. 00 0 646 0 29. 00 CT SCAN 57. 00 0 1, 118 0 30. 00 MAGNETI C RESONANCE I MAGI NG 58. 00 0 308 0 (MRI) 31. 00 CARDI AC CATHETERI ZATI ON 59. 00 0 7, 087, 681 0 32. 00 LABORATORY 60. 00 0 7, 087, 681 0 33. 00 WHOLE BLOOD & PACKED RED 62. 00 0 1, 713 0 BLOOD CELLS 34. 00 RESPI RATORY THERAPY 65. 00 0 147, 924 0 35. 00 PHYSI CAL THERAPY 66. 00 0 383 0 36. 00 OCCUPATI ONAL THERAPY 67. 00 0 400 0 37. 00 SPEECH PATHOLOGY 69. 00 0 1, 206 0 39. 00 CARDI AC REHAB 69. 01 0 1, 266 0 39. 00 CARDI AC REHAB 69. 01 0 1, 641 0 40. 00 ELECTROCARDI OLOGY 69. 00 0 384, 156 0 41. 00 DRUGS CHARGED TO PATI ENTS 73. 00 0 384, 156 0 42. 00 RENAL DI ALYSI S 74. 00 0 9, 873 0 44. 00 EMERGENCY 91. 00 0 10, 499 0 44. 00 EMERGENCY 91. 00 0 10, 499 0 45. 00 HOME HEALTH AGENCY 91. 00 0 29, 515, 007 0 6 - LIGHT DUTY 1. 00 EMPLOYEE BENEFITS DEPARTMENT 4. 00 72, 376 0 0 0 2. 00 0 0 0 0 0 0 3. 00 0 0 0 0 0 0		1	l l	0				23.00
26. 00 RADI OLOCY-THERAPEUTI C 55. 00 0 9, 206 0 27. 00 INFUSION CENTER 55. 01 0 23, 982 0 28. 00 RADI OL SOTOPE 56. 00 0 646 0 29. 00 CT SCAN 57. 00 0 1, 118 0 30. 00 MAGNETI C RESONANCE I MAGI NG 58. 00 0 308 0 (MRI) 31. 00 CARDI AC CATHETERI ZATI ON 59. 00 0 7, 087, 681 0 32. 00 LABORATORY 60. 00 0 2, 494 0 33. 00 WHOLE BLOOD & PACKED RED 62. 00 0 1, 713 0 BLOOD CELLS 34. 00 RESPIRATORY THERAPY 65. 00 0 147, 924 0 35. 00 PHYSI CAL THERAPY 66. 00 0 383 0 36. 00 OCCUPATI ONAL THERAPY 67. 00 0 400 0 37. 00 SPEECH PATHOLOGY 68. 00 0 8 0 38. 00 ELECTROCARDI OLOGY 69. 00 0 1, 206 0 39. 00 CARDI AC REHAB 69. 01 0 1, 641 0 40. 00 ELECTROCARDI OLOGY 70. 00 0 48. 39. 261 0 41. 00 DRUGS CHARGED TO PATI ENTS 73. 00 0 384, 156 0 42. 00 RENAL DI ALYSIS 74. 00 0 9, 873 0 43. 00 CLINIC 90. 00 0 104, 499 0 44. 00 EMERGENCY 91. 00 0 17, 499 0 44. 00 EMERGENCY 91. 00 0 29, 515, 007 0 6 - LIGHT DUTY 1. 00 EMPLOYEE BENEFITS DEPARTMENT 4. 00 72, 376 0 0 0 2. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0 0 0 0				0		- 1		24. 00 25. 00
27. 00 INFUSI ON CENTER 55. 01 0 23, 982 0 28. 00 RADI OI SOTOPE 56. 00 0 646 0 0 0 0 0 0 1 118 0 0 0 0 0 0 0 0 0			•	0		- 1		26.00
28. 00 RADI OI SOTOPE			•	O				27. 00
30. 00 MAGNETI C RESONANCE I MAGI NG (MRI) 31. 00 CARDI AC CATHETERI ZATI ON 59. 00 0 7, 087, 681 0 32. 00 LABORATORY 60. 00 2, 494 0 33. 00 WHOLE BLOOD & PACKED RED 62. 00 0 1, 713 0 BLOOD CELLS 34. 00 RESPI RATORY THERAPY 65. 00 0 147, 924 0 35. 00 PHYSI CAL THERAPY 66. 00 0 383 0 36. 00 OCCUPATI ONAL THERAPY 67. 00 0 400 0 38. 00 SPEECH PATHOLOGY 68. 00 0 8 0 38. 00 ELECTROCARDI OLOGY 69. 00 0 1, 206 0 39. 00 CARDI AC REHAB 69. 01 0 1, 641 0 ELECTROCRECPHALOGRAPHY 70. 00 0 4, 839, 261 0 DRUGS CHARGED TO PATI ENTS 73. 00 0 384, 156 0 42. 00 RENAL DI ALYSI S 74. 00 0 9, 873 0 ELECTROCRECPHALOGRAPHY 70. 00 0 104, 499 0 44. 00 EMERGENCY 91. 00 0 332, 715 0 EMPLOYEE BENEFI TS DEPARTMENT 4. 00 72, 376 0 0 EMPLOYEE BENEFI TS DEPARTMENT 4. 00 72, 376 0 0 EMPLOYEE BENEFI TS DEPARTMENT 4. 00 72, 376 0 0 EMPLOYEE BENEFI TS DEPARTMENT 4. 00 72, 376 0 0 EMPLOYEE BENEFI TS DEPARTMENT 4. 00 72, 376 0 0 EMPLOYEE BENEFI TS DEPARTMENT 4. 00 72, 376 0 0 EMPLOYEE BENEFI TS DEPARTMENT 4. 00 72, 376 0 0 EMPLOYEE BENEFI TS DEPARTMENT 4. 00 72, 376 0 0 EMPLOYEE BENEFI TS DEPARTMENT 4. 00 72, 376 0 0 EMPLOYEE BENEFI TS DEPARTMENT 4. 00 0 0 0 0 0 3. 00 0 0 0 0 0 0 0 0			l l	o				28. 00
MRI O CARDI AC CATHETERI ZATI ON 59.00 0 7,087,681 0 0 0 0 0 0 0 0 0	29.00	CT SCAN	57. 00	0	1, 118	o		29. 00
31. 00 CARDÍ AC CATHETERI ZATI ON 59. 00 0 7, 087, 681 0 0 32. 00 LABORATORY 60. 00 0 2, 494 0 0 33. 00 WHOLE BLOOD & PACKED RED 62. 00 0 1, 713 0 0 BLOOD CELLS 34. 00 RESPI RATORY THERAPY 65. 00 0 147, 924 0 0 35. 00 PHYSI CAL THERAPY 66. 00 0 383 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30.00		58. 00	0	308	0		30.00
32. 00	21 00		FO. 00		7 007 (01			21 00
33. 00			l l	0		- 1		31. 00 32. 00
BLOOD CELLS RESPIRATORY THERAPY 65.00 0 147,924 0 0 35.00 PHYSI CAL THERAPY 66.00 0 383 0 0 0 0 0 0 0 0 0		1		0		-		33.00
34. 00 RESPIRATORY THERAPY 65. 00 0 147, 924 0 0 35. 00 PHYSI CAL THERAPY 66. 00 0 383 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	55. 55		02.00	9	1, 713			33.00
36. 00 OCCUPATI ONAL THERAPY 67. 00 0 400 0 37. 00 SPEECH PATHOLOGY 68. 00 0 8 0 0 38. 00 ELECTROCARDI OLOGY 69. 00 0 1, 206 0 0 39. 00 CARDI AC REHAB 69. 01 0 1, 641 0 0 0 0 0 0 0 0 0	34.00		65. 00	o	147, 924	О		34.00
37. 00 SPEECH PATHOLOGY 68. 00 0 8 0 0 38. 00 0 38. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				o				35. 00
38. 00 ELECTROCARDI OLOGY 69. 00 0 1, 206 0 0 39. 00 CARDI AC REHAB 69. 01 0 1, 641 0 0 0 0 0 0 0 0 0				0		-		36.00
39. 00 CARDI AC REHAB 69. 01 0 1, 641 0 40. 00 ELECTROENCEPHALOGRAPHY 70. 00 0 4, 839, 261 0 41. 00 DRUGS CHARGED TO PATIENTS 73. 00 0 384, 156 0 42. 00 RENAL DI ALYSIS 74. 00 0 9, 873 0 43. 00 CLI NI C 90. 00 0 104, 499 0 44. 00 EMERGENCY 91. 00 0 332, 715 0 45. 00 HOME HEALTH AGENCY 101. 00 0 17, 493 0 46. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 29, 515, 007 G - LI GHT DUTY 1. 00 EMPLOYEE BENEFI TS DEPARTMENT 4. 00 72, 376 0 0 2. 00 0 0 0 0 0 3. 00 0				0	_			37.00
40. 00 ELECTROENCEPHALOGRAPHY 70. 00 0 4,839, 261 0 0 0 0 0 0 0 0 0				O		0		38. 00 39. 00
41. 00 DRUGS CHARGED TO PATIENTS 73. 00 0 384, 156 0 42. 00 RENAL DI ALYSI S 74. 00 0 9, 873 0 43. 00 CLI NI C 90. 00 0 104, 499 0 44. 00 EMERGENCY 91. 00 0 332, 715 0 45. 00 HOME HEALTH AGENCY 101. 00 0 17, 493 0 46. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 29, 515, 007 G - LI GHT DUTY				0		0		40.00
42. 00 RENAL DI ALYSI S 74. 00 0 9, 873 0 43. 00 CLI NI C 90. 00 104, 499 0 44. 00 EMERGENCY 91. 00 0 332, 715 0 45. 00 HOME HEALTH AGENCY 101. 00 0 17, 493 0 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 29, 515, 007 G - LI GHT DUTY 1. 00 EMPLOYEE BENEFI TS DEPARTMENT 4. 00 72, 376 0 0 2. 00 3. 00 0 0 0 0 3. 00 0 0 0 0 0			l l	0		0		41.00
43. 00				o		o		42.00
45. 00 HOME HEALTH AGENCY 101. 00 0 17, 493 0 0 20, 427 0 0 0 29, 515, 007 0 0 29, 515, 007 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				o		- 1		43. 00
46. 00 PHYSICIANS' PRIVATE OFFICES 192. 00 0 20, 427 0 0 29, 515, 007 0 29, 515, 007 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			l l					44.00
0				71				45. 00
G - LIGHT DUTY 1. 00 EMPLOYEE BENEFITS DEPARTMENT	46. 00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00			의		46. 00
1. 00 EMPLOYEE BENEFITS DEPARTMENT		G - LIGHT DUTY		U	∠ y , 515, 007			
2. 00 0. 00 0 0 0 3. 00 0. 00 0 0 0	1. 00		4. 00	72, 376	0	0		1.00
				Ó				2. 00
4, 00 0 0 0 0								3.00
	4. 00		0. 00	0	0	0		4. 00

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0002

					То	12/31/2023 Date/Time 5/29/2024	
		Decreases				, , , , , , , , , , , ,	
	Cost Center 6.00	Li ne # 7.00	Sal ary 8. 00	0ther 9.00	Wkst. A-7 Ref. 10.00		
5. 00	5.50	0.00	0	0			5.00
6.00		0.00	0	0			6.00
7. 00 8. 00	1	0. 00 0. 00	0	0	0		7. 00 8. 00
9. 00		0. 00	Ö	0	0		9. 00
10.00		0.00	0	0	0		10.00
	H - INTEREST EXPENSE		72, 376	0			
1.00	OTHER A&G	5. 05	0	3, 481, 947	11		1.00
2. 00	RADI OLOGY-THERAPEUTI C	5500	•	168			2. 00
	U		0	3, 482, 115			
1.00	OTHER A&G	5. 05	0	11, 143, 207	9		1.00
2.00		0.00		0	0		2. 00
	J - DRUG EXPENSE		0	11, 143, 207			
1. 00	PHARMACY	15. 00	0	7, 777, 977	0		1.00
2.00	INFUSION CENTER	55. 01	0	18, 588, 696			2.00
3. 00	ELECTROENCEPHALOGRAPHY		0	<u>8, 656, 705</u> 35, 023, 378			3.00
	K - PHYSICIAN RECLASS		<u> </u>	00, 020, 010			
1.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	165, 580			1.00
2. 00		0.00	0	00 165, 580	0		2. 00
	L - PSTD RECLASS		<u> </u>	100,000			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	2, 638	0			1.00
2. 00 3. 00	DATA PROCESSING PURCHASING RECEIVING AND	5. 01 5. 02	249 6, 951	0	1		2. 00 3. 00
0.00	STORES	0.02	0, 701	J			0.00
4.00	ADMITTING	5. 03	3, 857	0			4.00
5. 00	CASHI ERI NG/ACCOUNTS RECEI VABLE	5. 04	11, 752	0	0		5. 00
6. 00	OTHER A&G	5. 05	10, 008	0	0		6.00
7.00	OPERATION OF PLANT	7. 00	3, 587	0			7. 00
8. 00 9. 00	HOUSEKEEPI NG DI ETARY	9. 00 10. 00	28, 001 726	0			8. 00 9. 00
10.00	CAFETERI A	11. 00	6, 434	0			10.00
11.00	NURSING ADMINISTRATION	13. 00	11, 841	0	O		11.00
12.00	MEDICAL RECORDS & LIBRARY	16. 00	1, 788	0			12.00
13. 00 14. 00	PARAMED ED PROGRAM ADULTS & PEDIATRICS	23. 00 30. 00	1, 502 39, 708	0			13. 00 14. 00
15. 00	INTENSIVE CARE UNIT	31. 00	61, 401	0			15.00
16.00	NEONATAL ICU	31. 01	3, 660	0	1		16.00
17.00	SUBPROVI DER - I RF	41. 00	535	0	1		17. 00
18. 00 19. 00	NURSERY OPERATING ROOM	43. 00 50. 00	24, 395 3, 097	0	-		18. 00 19. 00
20.00	RECOVERY ROOM	51. 00	1, 905	0			20.00
21.00	DELIVERY ROOM & LABOR ROOM	52. 00	6, 314	0	0		21.00
22. 00	RADI OLOGY - DI AGNOSTI C	54.00	7, 723	0			22.00
23. 00 24. 00	RADI OLOGY - ULTRASOUND RADI OLOGY-THERAPEUTI C	54. 01 55. 00	3, 698 2, 622	0			23. 00 24. 00
25. 00	INFUSION CENTER	55. 01	2, 792	0	1		25. 00
26.00	RADI OI SOTOPE	56. 00	1, 726	0	1		26. 00
27. 00	MAGNETIC RESONANCE IMAGING (MRI)	58. 00	3, 268	0	0		27. 00
28. 00	CARDI AC CATHETERI ZATI ON	59. 00	8, 920	0	0		28. 00
29. 00	LABORATORY	60. 00	34, 841	0			29. 00
30. 00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62. 00	14, 142	0	0		30.00
31. 00	RESPIRATORY THERAPY	65. 00	15, 822	0	0		31.00
32.00	PHYSI CAL THERAPY	66.00	8, 378	0	0		32.00
33.00	OCCUPATI ONAL THERAPY	67. 00	482	0	0		33.00
34. 00 35. 00	CLI NI C EMERGENCY	90. 00 91. 00	10, 305 1, 349	0	T		34. 00 35. 00
36.00	HOME HEALTH AGENCY	101.00	22, 618	0			36.00
37. 00	PHYSICIANS' PRIVATE OFFICES	192.00	4 <u>6, 1</u> 37	0	0		37. 00
	O M - DEPRECIATION RECLASS		415, 172	0			
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	4, 241	9		1.00
2.00	DATA PROCESSING	5. 01	o	1, 722, 196	0		2. 00
3.00	PURCHASING RECEIVING AND	5. 02	0	38, 165	0		3.00
4. 00	STORES ADMI TTI NG	5. 03	0	3, 851	o		4.00
50	1	0.00	91	0,001	١		,

Health Financial Systems RECLASSIFICATIONS

Provider CCN: 15-0002

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/29/2024 9:08 am

						5/29/2024 9:	08 am
		Decreases					
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
5.00	CASHI ERI NG/ACCOUNTS	5. 04	0	31, 120	0		5. 00
	RECEI VABLE						
6.00	OTHER A&G	5. 05	0	181, 869	0		6.00
7.00	OPERATION OF PLANT	7.00	0	539, 986	0		7. 00
8.00	HOUSEKEEPI NG	9. 00	0	33, 790	0		8. 00
9.00	DI ETARY	10.00	ol	72, 615	0		9.00
10.00	NURSING ADMINISTRATION	13. 00	0	111, 388	0		10.00
11. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	359, 617	0		11.00
12. 00	PHARMACY	15. 00	Ö	242, 355	0		12.00
13. 00	•		ĭ		0		13.00
	MEDICAL RECORDS & LIBRARY	16.00	0	127			1
14.00	PARAMED ED PROGRAM	23. 00	0	11, 657	0		14.00
15. 00	ADULTS & PEDIATRICS	30. 00	0	442, 399	0		15.00
16. 00	INTENSIVE CARE UNIT	31. 00	0	571, 151	0		16. 00
17.00	NEONATAL I CU	31. 01	0	39, 921	0		17. 00
18.00	SUBPROVI DER - I PF	40.00	0	10, 350	0		18. 00
19.00	SUBPROVI DER - I RF	41.00	ol	9, 652	0		19.00
20.00	NURSERY	43.00	0	54, 244	0		20.00
21. 00	OPERATI NG ROOM	50. 00	0	715, 480	0		21.00
22. 00	ENDOSCOPY	50. 01	0	228, 792	0		22. 00
	•		T1		0		1
23. 00	RECOVERY ROOM	51.00	0	782			23.00
24.00	DELIVERY ROOM & LABOR ROOM	52. 00	0	110, 396	0		24. 00
25. 00	RADI OLOGY-DI AGNOSTI C	54. 00	0	530, 898	0		25. 00
26.00	RADI OLOGY - ULTRASOUND	54. 01	0	4, 041	0		26.00
27.00	RADI OLOGY-THERAPEUTI C	55. 00	0	508, 164	0		27. 00
28.00	INFUSION CENTER	55. 01	ol	174, 176	0		28. 00
29. 00	RADI OI SOTOPE	56.00	0	72, 198	0		29.00
30.00	CT SCAN	57. 00	0	127, 156	0		30.00
	MAGNETIC RESONANCE IMAGING		0		0		1
31. 00		58. 00	U	102, 493	U		31.00
	(MRI)	50.00		000 040			
32. 00	CARDI AC CATHETERI ZATI ON	59. 00	0	200, 818	0		32.00
33.00	LABORATORY	60. 00	0	148, 327	0		33. 00
34.00	WHOLE BLOOD & PACKED RED	62.00	0	8, 858	0		34.00
	BLOOD CELLS						
35.00	RESPI RATORY THERAPY	65. 00	o	124, 709	0		35.00
36.00	PHYSI CAL THERAPY	66.00	0	374	0		36.00
37. 00	OCCUPATIONAL THERAPY	67. 00	0	462	0		37.00
38. 00	ELECTROCARDI OLOGY	69.00	0		0		38.00
	•		U O	86, 767			1
39. 00	CARDI AC REHAB	69. 01	0	145, 733	0		39.00
40. 00	ELECTROENCEPHALOGRAPHY	70. 00	0	200, 941	0		40. 00
41. 00	DRUGS CHARGED TO PATIENTS	73. 00	0	36, 726	0		41.00
42.00	RENAL DI ALYSI S	74.00	0	289	0		42.00
43.00	CLINIC	90.00	0	166, 272	0		43.00
44.00	EMERGENCY	91.00	ol	316, 630	0		44.00
45.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	935, 266	0		45.00
46. 00	OTHER NON-REIMBURSABLE	192. 01	0	1, 461, 838	0		46.00
40.00	OTTER NON-KET MBORSABLE						40.00
	N - DEPT 9101 RECLASS		U	10, 889, 280			+
1 00		E 04	1 171 205	210 701	0		1 00
1. 00	CASHI ERI NG/ACCOUNTS	5. 04	1, 171, 295	319, 701	0		1.00
	RECEI VABLE	+					
	0		1, 171, 295	319, 701			
	O - UTILITIES RECLASS						
1.00	DATA PROCESSING	5. 01		171, 250	0		1.00
2.00	CASHI ERI NG/ACCOUNTS	5. 04		19, 712	0		2.00
	RECEI VABLE	- []					
3.00	HOUSEKEEPI NG	9. 00		139, 179	0		3.00
4. 00	CARDI AC REHAB	69. 01		54, 078	0		4.00
	•				0		
5. 00	PHYSICIANS' PRIVATE OFFICES	192.00		322, 668	-		5.00
6. 00	OTHER NON-REIMBURSABLE	1 <u>92.</u> 01	+	518, 672	0		6.00
	0		0	1, 225, 559			1
	P - C SECTION RECLASS						
1.00	DELIVERY ROOM & LABOR ROOM _	52.00	2 <u>2, 0</u> 10	0	0		1.00
	0		22, 010	0			1
500.00	Grand Total: Decreases		3, 941, 204	93, 444, 802			500.00
	•		• •		'	•	•

Period: Worksheet A-7
From 01/01/2023 Part I Provider CCN: 15-0002

				To	12/31/2023	Date/Time Pre 5/29/2024 9:0	
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1. 00	2.00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	5, 800, 874	0	0	0	32, 921	1.00
2.00	Land Improvements	7, 039, 139	73, 864	0	73, 864	0	2.00
3.00	Buildings and Fixtures	314, 922, 393	3, 950, 380	0	3, 950, 380	0	3.00
4.00	Building Improvements	2, 011, 838	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	212, 060, 196	13, 453, 935	0	13, 453, 935	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	541, 834, 440	17, 478, 179	0	17, 478, 179	32, 921	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	541, 834, 440	17, 478, 179	0	17, 478, 179	32, 921	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, 767, 953	0				1.00
2.00	Land Improvements	7, 113, 003	0				2.00
3.00	Buildings and Fixtures	318, 872, 773	0				3.00
4. 00	Building Improvements	2, 011, 838	0				4.00
5. 00	Fixed Equipment	0	0				5.00
6. 00	Movable Equipment	225, 514, 131	0				6.00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	559, 279, 698	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	559, 279, 698	0				10.00

Health Financial Systems	METHODIST HOSPITALS, INC			In Lieu of Form CMS-2552-10				
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0002	Peri od: From 01/01/2023 To 12/31/2023		pared:		
		Sl	JMMARY OF CAP	I TAL				
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)			
	9. 00	10. 00	11.00	12.00	13.00			
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2								
1.00 CAP REL COSTS-BLDG & FLXT	0	0)	0	0	1.00		
3.00 Total (sum of lines 1-2)	0	0)	0 0	0	3.00		
	SUMMARY O	F CAPITAL						
Cost Center Description	0ther	Total (1)	1					
	Capi tal -Rel at	(sum of cols.						
	ed Costs (see	9 through 14)						
	instructions)							
	14. 00	15. 00						
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2								
1.00 CAP REL COSTS-BLDG & FLXT	0	0				1.00		
3.00 Total (sum of lines 1-2)	0	0)			3.00		

Health Financial Systems		METHODIST HOSPITALS, INC			In Lieu of Form CMS-2552-10		
RECONCILIATION OF CAPITAL COSTS CENTERS			Provi der C		Peri od:	Worksheet A-7	
					From 01/01/2023 To 12/31/2023		narod:
				'	12/31/2023	5/29/2024 9: 0	
		COMPUTATION OF RATIOS		ALLOCATION OF	OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 - col. 2)			
		1, 00	2. 00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						3.00	
1. 00	CAP REL COSTS-BLDG & FIXT	559, 279, 698	0	559, 279, 698	1. 000000	0	1.00
3.00	Total (sum of lines 1-2)	559, 279, 698		559, 279, 698		0	3.00
		ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL				F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at				
		/ 00	ed Costs	through 7)	0.00	10.00	
						10.00	
1. 00	CAP REL COSTS-BLDG & FIXT	LIVIERS	0		16, 784, 135	0	1. 00
3. 00	Total (sum of lines 1-2)	0	0		16, 784, 135		3. 00
SUMMARY OF CAPITAL						- J	0.00
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
			(see	instructions)			
			instructions)		ed Costs (see	9 through 14)	
		11.00	10.00	10.00	instructions)	45.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	11. 00	12. 00	13.00	14.00	15. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	ENTERS	0		0	16, 784, 135	1. 00
3. 00	Total (sum of lines 1-2)		0				
5.00	110tal (3am 01 111103 1 2)	1	۰ ۰	1	1 0	10, 704, 133	3.00

ADJUST	WENTS TO EXPENSES			Provider CCN. 15-0002	From 01/01/2023 To 12/31/2023	Date/Time Pre	
				Evenes Classification a		5/29/2024 9:0	
			To	Expense Classification o From Which the Amount is			
					·		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	В	-3, 482, 115 C	AP REL COSTS-BLDG & FIXT	1.00	11	1.00
2. 00	Investment income - CAP REL		0 * ;	** Cost Center Deleted ***	2. 00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		o		0.00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0		0.00	0	4.00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	
	expenses (chapter 8)						
6. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6. 00
7. 00	Tel ephone services (pay stations excluded) (chapter		0		0. 00	0	7. 00
8. 00	21) Tel evi si on and radi o servi ce		0		0.00	0	8. 00
	(chapter 21)		9			_	
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-19, 065, 735		0. 00	0	
11. 00	adjustment Sale of scrap, waste, etc.		О		0.00	0	11.00
12. 00	(chapter 23) Related organization	A-8-1	o			0	12.00
13. 00	transactions (chapter 10)	-			0.00	0	
14. 00	Laundry and linen service Cafeteria-employees and guests	В	-1, 203, 412 CA	AFETERI A	11. 00	0	1
15. 00	Rental of quarters to employee and others		0		0. 00	0	15. 00
16. 00	Sale of medical and surgical supplies to other than		О		0. 00	0	16. 00
47.00	patients						47.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18. 00	Sale of medical records and abstracts	В	-173, 073 ME	EDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	Nursing and allied health education (tuition, fees,		0		0. 00	0	19. 00
	books, etc.)						
	Vending machines Income from imposition of	В	O DI	ETARY	10. 00 0. 00	0	
21.00	interest, finance or penalty		S		0.00		21.00
22. 00	charges (chapter 21) Interest expense on Medicare		o		0.00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	ORI	ESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	OPI	HYSI CAL THERAPY	66. 00		24.00
25. 00	limitation (chapter 14)		0.*:	** Cost Center Deleted ***	114 00		25. 00
25.00	physicians' compensation		O _m .	Cost Center Dereted """	114. 00		25.00
26. 00	(chapter 21) Depreciation - CAP REL	А	-19, 085 CA	AP REL COSTS-BLDG & FIXT	1. 00	9	26. 00
27. 00	COSTS-BLDG & FLXT Depreciation - CAP REL		0 * :	** Cost Center Deleted ***	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist			** Cost Center Deleted ***			28. 00
29. 00	Physicians' assistant		0	JOST GOITTOI DELECT	0.00	0	1
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0 00	CCUPATI ONAL THERAPY	67. 00		30.00
20.00	limitation (chapter 14)			OULTS & DEDLATELOS	20.00		20.00
30. 99	Hospice (non-distinct) (see instructions)		OAL	DULTS & PEDIATRICS	30. 00		30. 99

				To/From Which the Amount is t			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1. 00	2. 00	3. 00	4. 00	5. 00	
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
32. 00	limitation (chapter 14) CAH HIT Adjustment for Depreciation and Interest		0		0. 00	0	32.00
33.00	DATA PROCESSING OTHER INCOME	В	-252, 060	DATA PROCESSING	5. 01	0	33.00
33. 01	CASH, A/R, COLLECTIONS OTHER INCOME	В	-30, 204	CASHI ERI NG/ACCOUNTS RECEI VABLE	5. 04	0	33. 01
33. 02	A&G OTHER INCOME	В		OTHER A&G	5. 05	0	33. 02
33. 03	ENVI RONMENTAL SERVI CES OTHER I NCOME	В		HOUSEKEEPI NG	9. 00	0	33. 03
33. 04	PARAMED ED PROGRAM OTHER I NCOME	В		PARAMED ED PROGRAM	23. 00	0	33. 04
33. 05	LAB OTHER INCOME	В		LABORATORY	60.00	0	33. 05
33. 06	BLOOD OTHER INCOME	В		WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	33. 06
33. 07	CARDIAC REHAB OTHER INCOME	В		CARDI AC REHAB	69. 01	0	33. 07
33. 08	ELECTROCEPHALOGRAPHY OTHER I NCOME	В		ELECTROENCEPHALOGRAPHY	70. 00	0	33. 08
33. 09	GIFT, FLOWER, COFFEE SHOP & CANTEEN	В		GIFT, FLOWER, COFFEE SHOP & CANTEEN	190. 00	0	33. 09
33. 10	PHYSICIAN OFFICE	В		PHYSICIANS' PRIVATE OFFICES	192. 00	0	33. 10
33. 11	FAMILY HEALTH	В		FAMILY HEALTH/GARY COMM HEALTH	192. 02	0	33. 11
33. 12	A Company of the Comp	В		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 12
33. 13	EMT OFFSET	В		PARAMED ED PROGRAM	23. 00	0	33. 13
33. 14	DUES/LOBBYI NG	A		OTHER A&G	5. 05	0	33. 14
33. 15	RX PROGRAM	A		DRUGS CHARGED TO PATIENTS	73. 00	0	33. 15
33. 16	PENSION ADJUSTMENT	A		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 16
33. 17	PHYSICIAN CONTRACT OFFSET	A		PHYSICIANS' PRIVATE OFFICES	192. 00	0	33. 17
33. 18	PHYSICIAN SALARY OFFSET	A		PHYSICIANS' PRIVATE OFFICES	192. 00	0	33. 18
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-59, 074, 877				50.00
(1) Do	escription - all chapter referen	soc in this co	lump portoin t	o CMC Dub. 1E 1	•		

- (1) Description all chapter references in this column pertain to CMS Pub. 15-1.
- (2) Basis for adjustment (see instructions).A. Costs if cost, including applicable overhead, can be determined.
 - B. Amount Received if cost cannot be determined.
- (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
- Note: See instructions for column 5 referencing to Worksheet A-7.

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

West. A Line # Cost Center/Physician Identifier Total Remuneration Professional Component Comp							To 12/31/2023	Date/Time Pre 5/29/2024 9:0	
1.00		Wkst. A Line #					RCE Amount		
1.00			l denti fi er	Remuneration	Component	Component			
1.00		1 00	2 00	3 00	4 00	5.00	6.00		
2.00	1. 00								1.00
3.00 S0.00 DEPRATING ROOM							1	_	
S. 00				1			o	0	1
Continuing	4.00	54.00	RADI OLOGY-DI AGNOSTI C	429	42	9	o o	0	4. 00
7.00	5.00	54. 01	RADI OLOGY - ULTRASOUND	6, 788	6, 78	8 0	0	0	5. 00
B. 00	6.00	55. 00	RADI OLOGY-THERAPEUTI C				0	0	6. 00
90.00 90.00 20.0	7.00			5, 429, 954	5, 429, 95	4 0	0	0	7. 00
10,00	8.00						0	0	8. 00
19,065,735 19,065,735 19,065,735 19,065,735 19,065,735 19,065,735 19,065,735 19,065,735 19,065,735 19,065,735 19,065,735 10,065,735 12,000 1,000				507, 555	507, 55	5 0	0	0	
Wkst. A Line # Cost Center/Physician Identifier Unadjusted RCE Limit Unadjusted RCE Unit Unit Unadjusted RCE Unit Unit Unadjusted RCE Unit Unit Unadjusted RCE Unit Un		0.00		0		0 0	0	0	
Identifier	200.00)	0	
1.00		Wkst. A Line #	J						
1.00			l denti fi er	Limit					
1.00					Limit			Insurance	
1.00		1 00	2.00	0.00	0.00			14.00	
2.00	1 00			8.00					1 00
3. 00						-	1	_	1
4. 00						-	1	_	1
S. 00				0			1	_	
6. 00				0				0	
7.00				0				0	
8. 00 57. 00 CT SCAN 0 0 0 0 0 0 0 0 0				0				0	
9. 00 90. 00 CLINIC 0 0 0 0 0 0 0 0 0				l o			ol o	0	
Number Cost Center/Physician Cost Center/Physician Identifier Component Share of col. 14				0		o d	o	0	9. 00
Wkst. A Li ne # Cost Center/Physici an I denti fi er Component Share of col. Li mi t Di sal I owance Di sal I	10.00	0.00		0		o c	o	0	10.00
1.00	200.00			0		0	o o	0	200.00
Share of col. 14		Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
14			l denti fi er		Limit	Di sal I owance			
1.00									
1. 00 30. 00 ADULTS & PEDI ATRICS 0 0 3,747,144 1. 00 2. 00 31. 01 NEONATAL I CU 0 0 0 2,111,003 2. 00 3. 00 50. 00 OPERATI NG ROOM 0 0 0 7,064,871 3. 00 4. 00 54. 00 RADI OLOGY-DI AGNOSTI C 0 0 0 429 4. 00 5. 00 54. 01 RADI OLOGY - ULTRASOUND 0 0 0 6,788 5. 00 6. 00 55. 00 RADI OLOGY-THERAPEUTI C 0 0 0 187,612 6. 00 7. 00 55. 01 I NFUSI ON CENTER 0 0 0 5,429,954 7. 00 8. 00 57. 00 CT SCAN 0 0 0 10,379 8. 00 9. 00 90. 00 CLI NI C 0 0 0 507,555 9. 00 10. 00 0 0 0 0 0 10. 00		1.00	0.00		1/ 00	47.00	10.00		
2. 00 31. 01 NEONATAL I CU 0 0 0 2, 111, 003 2. 00 3. 00 50. 00 OPERATI NG ROOM 0 0 0 7, 064, 871 3. 00 4. 00 54. 00 RADI OLOGY-DI AGNOSTI C 0 0 0 429 4. 00 5. 00 54. 01 RADI OLOGY - ULTRASOUND 0 0 6. 788 5. 00 6. 00 55. 00 RADI OLOGY-THERAPEUTI C 0 0 187, 612 6. 00 7. 00 55. 01 I NFUSI ON CENTER 0 0 5, 429, 954 7. 00 8. 00 57. 00 CT SCAN 0 0 10, 379 8. 00 9. 00 90. 00 CLI NI C 0 0 507, 555 9. 00 10. 00 0 0 0 0 0 10. 00	1 00								1 00
3. 00 50. 00 OPERATI NG ROOM 0 0 0 7, 064, 871 3. 00 4. 00 54. 00 RADI OLOGY-DI AGNOSTI C 0 0 0 429 4. 00 5. 00 54. 01 RADI OLOGY - ULTRASOUND 0 0 0 6, 788 5. 00 6. 00 55. 00 RADI OLOGY - THERAPEUTI C 0 0 0 187, 612 6. 00 7. 00 55. 01 I NFUSI ON CENTER 0 0 0 5, 429, 954 7. 00 8. 00 57. 00 CT SCAN 0 0 0 0 10, 379 8. 00 90. 00 CLI NI C 0 0 0 507, 555 9. 00 10. 00 0 0 0 0 0 10. 00 0 0 0 0 0 0 0 0				0		-	-, ,	•	
4. 00 54. 00 RADI OLOGY-DI AGNOSTI C 0 0 429 4. 00 5. 00 54. 01 RADI OLOGY - ULTRASOUND 0 0 0 6. 788 5. 00 6. 00 55. 00 RADI OLOGY - THERAPEUTI C 0 0 0 187, 612 6. 00 7. 00 55. 01 I NFUSI ON CENTER 0 0 0 5, 429, 954 7. 00 8. 00 57. 00 CT SCAN 0 0 0 10, 379 8. 00 9. 00 90. 00 CLI NI C 0 0 507, 555 9. 00 10. 00 0 0 0 0 0 10. 00				0		-			
5. 00 54. 01 RADI OLOGY - ULTRASOUND 0 0 6,788 5. 00 6. 00 55. 00 RADI OLOGY-THERAPEUTI C 0 0 187,612 6. 00 7. 00 55. 01 I NFUSI ON CENTER 0 0 5,429,954 7. 00 8. 00 57. 00 CT SCAN 0 0 0 10,379 8. 00 9. 00 90. 00 CLI NI C 0 0 507,555 9. 00 10. 00 0 0 0 0 0 10. 00				0		۷			4
6. 00							l .	•	
7. 00 55. 01 NFUSI ON CENTER 0 0 0 5, 429, 954 7. 00 8. 00 57. 00 CT SCAN 0 0 0 10, 379 8. 00 90. 00 CLI NI C 0 0 0 0 507, 555 9. 00 10. 00 0 0 0 0 10. 00 10. 00 10. 00 0 0 0 0 0 10. 00 10. 00 0 0 0 0 0 10. 00						٦ ٠	1	•	
8. 00 57. 00 CT SCAN 0 0 10, 379 8. 00 9. 00 90. 00 CLINIC 0 0 0 507, 555 9. 00 10. 00 0 0 0 0 0 10. 00							1	•	1
9. 00 90. 00 CLINIC 0 0 0 507, 555 9. 00 10. 00 0 0 10. 00						٦ ٠		•	
10.00 0.00 0 0 0 10.00									
				1 0		٦ ٠	1	1	
200, 00 0	200.00	0.00				-			200.00

In Lieu of Form CMS-2552-10

Worksheet B
Part I
31/2023 Date/Time Prepared:
5/29/2024 9:08 am Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS METHODIST HOSPITALS, INC Peri od: From 01/01/2023 To 12/31/2023 Provider CCN: 15-0002 CAPI TAL

		CAPI TAL RELATED COSTS				
Cost Center Description	Net Expenses	BLDG & FLXT	EMPLOYEE	DATA	PURCHASI NG	
	for Cost		BENEFITS	PROCESSI NG	RECEIVING AND	
	Allocation (from Wkst A		DEPARTMENT		STORES	
	col. 7)					
OFFICE ASSESSMENT OFFICE	0	1. 00	4. 00	5. 01	5. 02	
GENERAL SERVICE COST CENTERS 1. 00 00100 CAP REL COSTS-BLDG & FLXT	16, 784, 135	16, 784, 135				1. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	29, 085, 406		29, 155, 702			4.00
5. 01 00550 DATA PROCESSING	13, 530, 718		795, 788	14, 435, 890		5. 01
5. 02 00560 PURCHASING RECEIVING AND STORES	3, 089, 056			0	3, 389, 908	5. 02
5. 03 00570 ADMITTING	5, 605, 761		829, 682	0	.,	5.03
5. 04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5. 05 00590 OTHER A&G	6, 478, 010 19, 705, 355		444, 697 1, 654, 734	14, 435, 890	575 1, 699	5. 04 5. 05
5. 06 00592 PATIENT TRANSPORTATION	603, 465		100, 556	14, 433, 670	66	5. 06
7.00 00700 OPERATION OF PLANT	20, 906, 172		956, 957	0	33, 401	7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	1, 386, 415		0	0	12	8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	5, 821, 134 4, 814, 293			0	,	9. 00 10. 00
11. 00 01100 CAFETERI A	1, 810, 061			0	76	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	6, 889, 129		1, 115, 031	0		13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	2, 647, 782		140, 701	0	-,	14.00
15. 00 01500 PHARMACY	6, 059, 491			0		15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	3, 039, 467 469, 866		413, 630 85, 180	0	495 0	16. 00 17. 00
17. 01 01700 SOCIAL SERVICE	409, 800	132, 677	0 85, 180	0		17.00
17. 02 01702 MEDI CAL EDUCATI ON	203, 617	4, 452	28, 552	0	567	17. 02
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	297, 137		0	0	_	21. 00
22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	31, 168			0	0	22.00
23. 00 02300 PARAMED ED PROGRAM INPATIENT ROUTINE SERVICE COST CENTERS	856, 559	40, 040	181, 116	0	336	23. 00
30. 00 03000 ADULTS & PEDIATRICS	39, 193, 609	3, 728, 074	4, 379, 975	0	161, 211	30. 00
31.00 03100 INTENSIVE CARE UNIT	8, 549, 779			0	,	31.00
31. 01 03101 NEONATAL I CU	1, 959, 216		313, 159	0		31.01
40. 00 04000 SUBPROVI DER - PF 41. 00 04100 SUBPROVI DER - RF	1, 047, 647 1, 951, 478		175, 592 295, 648	0		40. 00 41. 00
43. 00 04300 NURSERY	1, 553, 332		230, 613	0		43.00
ANCILLARY SERVICE COST CENTERS	,	,				
50. 00 05000 OPERATING ROOM	10, 423, 718		1, 042, 573	0		50.00
50. 01 05001 ENDOSCOPY 51. 00 05100 RECOVERY ROOM	1, 008, 821	172 124	110, 966 215, 856	0		50. 01 51. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	1, 468, 113 4, 559, 273		712, 279	0		52.00
53. 00 05300 ANESTHESI OLOGY	0		0	0		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 619, 256		517, 044	0	,	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	2, 138, 392		255, 257	0	6, 448	
55. 00 05500 RADI OLOGY-THERAPEUTI C 55. 01 05501 I NFUSI ON CENTER	2, 240, 336 1, 130, 845		85, 348 129, 309	0		55. 00 55. 01
56. 00 05600 RADI OI SOTOPE	2, 005, 827		136, 915	Ö		56. 00
57. 00 05700 CT SCAN	2, 457, 595		243, 466	0		57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 038, 398			0		
59. 00 05900 CARDI AC CATHETERI ZATI ON	4, 259, 469		471, 000 802, 183	0		
60. 00 06000 LABORATORY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	14, 386, 433 1, 555, 306		222, 158	0		60. 00 62. 00
64. 00 06400 I NTRAVENOUS THERAPY	0		0	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	4, 924, 385		472, 486	0	63, 961	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 961, 288		310, 707	0		66.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	1, 216, 910 532, 265		203, 141 87, 967	0	753 541	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	996, 681	21, 377	151, 994	0	1, 489	69.00
69. 01 06901 CARDI AC REHAB	654, 915	0	84, 512	0		69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 649, 153		231, 335	0	6, 669	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 MPL. DEV. CHARGED TO PATIENTS	15, 183, 398		0	0	.,	71.00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS	14, 331, 609 42, 522, 455		ŭ	0	987, 505 43, 359	72. 00 73. 00
74. 00 07400 RENAL DI ALYSI S	2, 336, 778		· ·	0		74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	3, 963, 455		462, 064	0		90.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	15, 271, 838	322, 118	1, 592, 734	0	169, 527	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS						,2.00
101.00 10100 HOME HEALTH AGENCY	2, 422, 159	0	379, 399	0	3, 851	101. 00
SPECIAL PURPOSE COST CENTERS	244 420 220	14 204 527	24 202 254	14 425 000	2 250 (40	110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	366, 628, 329	16, 296, 537	24, 302, 256	14, 435, 890	3, 359, 649	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 966	21, 436	0	0	0	190. 00
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Health Financial Sy	stems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - G	SENERAL SERVICE COSTS		Provi der C		Peri od: From 01/01/2023	Worksheet B	
						Date/Time Pre 5/29/2024 9:0	
			CAPI TAL RELATED COSTS				
0 0 .	and a second second second	Maria E a caración	DI DO A FLVT	1	DATA	DUDOUACIAIO	1

					3/27/2024 7.0	o am
		CAPI TAL RELATED COSTS				
Cost Center Description	Net Expenses	BLDG & FIXT	EMPLOYEE	DATA	PURCHASI NG	
	for Cost		BENEFITS	PROCESSI NG	RECEIVING AND	
	Allocation		DEPARTMENT		STORES	
	(from Wkst A					
	col. 7)					
	0	1. 00	4. 00	5. 01	5. 02	
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	14, 126, 556	317, 928	4, 839, 711	0	30, 259	192. 00
192. 01 19201 OTHER NON-REIMBURSABLE	348, 428	41, 147	0	0	0	192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	54, 346	107, 087	13, 735	0		192. 02
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	381, 160, 625	16, 784, 135	29, 155, 702	14, 435, 890	3, 389, 908	202. 00

Provider CCN: 15-0002

		Cost Center Description	ADMI TTI NG	CASHI ERI NG/AC COUNTS RECEI VABLE	Subtotal	OTHER A&G	5/29/2024 9: 0 PATIENT TRANSPORTATIO	
			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	1	EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01		DATA PROCESSING						5. 01
5.02	00560	PURCHASING RECEIVING AND STORES						5. 02
5. 03	1	ADMI TTI NG	6, 555, 262					5. 03
5. 04		CASHI ERI NG/ACCOUNTS RECEI VABLE	0	7, 288, 047	2/ 002 010	27 002 010		5.04
5. 05 5. 06	1	OTHER A&G PATIENT TRANSPORTATION	0	0	36, 982, 919 704, 087	36, 982, 919 75, 656	779, 743	5. 05 5. 06
7. 00		OPERATION OF PLANT	0	o	25, 459, 299	2, 735, 678	0	7.00
8. 00		LAUNDRY & LINEN SERVICE	0	Ō	1, 598, 589	171, 773	0	8.00
9. 00		HOUSEKEEPI NG	0	0	6, 946, 410	746, 413	0	9. 00
10.00		DIETARY	0	0	5, 563, 639	597, 830	0	10.00
11. 00 13. 00	1	CAFETERIA NURSING ADMINISTRATION	0	0	2, 261, 572	243, 013	0	11. 00 13. 00
14.00		CENTRAL SERVICES & SUPPLY	0	0	8, 082, 274 3, 219, 090	868, 465 345, 901	0	14.00
15. 00		PHARMACY	Ö	o		676, 853	ő	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	o	3, 588, 174	385, 560	0	16. 00
17. 00		SOCIAL SERVICE	0	0	574, 435	61, 725	0	17. 00
17. 01		STAFF EDUCATION	0	0	132, 677	14, 257	0	17. 01
17. 02 21. 00		MEDICAL EDUCATION I&R SERVICES-SALARY & FRINGES APPRVD	0	0	237, 188 297, 137	25, 487 31, 928	0	17. 02 21. 00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRVD	0	o		9, 062	0	22.00
23. 00		PARAMED ED PROGRAM	0	Ō	- ', '	115, 840	0	23. 00
		IENT ROUTINE SERVICE COST CENTERS						
30.00		ADULTS & PEDIATRICS	417, 165			5, 194, 674		30.00
31. 00 31. 01		INTENSIVE CARE UNIT NEONATAL ICU	82, 014 20, 982	91, 168 23, 324		1, 101, 044 251, 918	2, 402 0	31. 00 31. 01
40.00		SUBPROVI DER - I PF	10, 160			138, 827	0	40.00
41. 00		SUBPROVI DER - I RF	15, 077	16, 760		285, 342	3, 256	
43.00		NURSERY	8, 584	9, 542		226, 028	27	43.00
		LARY SERVICE COST CENTERS						
50.00		OPERATING ROOM	740, 511	823, 165		1, 481, 185	27	50.00
50. 01 51. 00		ENDOSCOPY RECOVERY ROOM	37, 006 50, 378	41, 137 56, 001	1, 213, 975 1, 972, 477	130, 445 211, 949	19, 482 0	50. 01 51. 00
52. 00		DELIVERY ROOM & LABOR ROOM	25, 114	27, 917	5, 420, 106	582, 407	9, 741	52.00
53.00		ANESTHESI OLOGY	0	O		0	0	53.00
54.00		RADI OLOGY-DI AGNOSTI C	201, 684	224, 196		774, 186	47, 930	
54. 01		RADI OLOGY - ULTRASOUND	93, 598	104, 046		285, 599	96, 821	
55. 00 55. 01	1	RADI OLOGY-THERAPEUTI C I NFUSI ON CENTER	108, 259 65, 727	120, 342 73, 064		285, 320 158, 222	7, 366 0	55. 00 55. 01
56.00		RADI OI SOTOPE	83, 123	92, 401	2, 487, 119	267, 248	44, 247	
57. 00		CT SCAN	634, 645	705, 482	4, 163, 553	447, 386	185, 208	
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	130, 069	144, 587		156, 672	52, 920	58. 00
59.00		CARDI AC CATHETERI ZATI ON	326, 634	363, 092		599, 675	29, 276	
60. 00 62. 00		LABORATORY WHOLE BLOOD & PACKED RED BLOOD CELLS	891, 625 104, 480	991, 145 116, 142		1, 905, 213 217, 019		60. 00 62. 00
64. 00	1	INTRAVENOUS THERAPY	104, 480	110, 142		217,019	0	
65. 00		RESPI RATORY THERAPY	203, 778			642, 952	53	
66.00		PHYSI CAL THERAPY	58, 302	64, 810	2, 542, 102	273, 156	0	66.00
67.00		OCCUPATIONAL THERAPY	27, 739	30, 835		172, 450	0	67.00
68.00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	11, 238	12, 492	665, 880	71, 551	0	68.00
69. 00 69. 01	1	CARDI AC REHAB	121, 894 7, 104	135, 499 7, 897	1, 407, 557 754, 851	151, 246 81, 111	3, 656 0	69. 00 69. 01
70. 00	1	ELECTROENCEPHALOGRAPHY	171, 061	190, 155	· ·	241, 594	2, 535	
71. 00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	172, 692	191, 967	16, 594, 257	1, 783, 103	0	71. 00
72.00	1	IMPL. DEV. CHARGED TO PATIENTS	161, 665	179, 709		1, 682, 766	0	72.00
73.00		DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	976, 016			4, 806, 265	0	73.00
74. 00		TIENT SERVICE COST CENTERS	43, 598	48, 464	2, 482, 429	266, 744	27	74. 00
90.00		CLINIC	49, 931	55, 504	5, 442, 656	584, 830	240	90.00
91.00		EMERGENCY	489, 916			1, 976, 139	11, 235	
92.00		OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
404 00		REIMBURSABLE COST CENTERS	40.400	44.000	0.000.004	204 544		101 00
101.00		HOME HEALTH AGENCY AL PURPOSE COST CENTERS	13, 493	14, 999	2, 833, 901	304, 511	0	101. 00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117)	6, 555, 262	7, 288, 047	361, 257, 026	34, 844, 218	779, 743	118. 00
		IMBURSABLE COST CENTERS	2, 300, 202	., 200, 017		2., 3, 210	,.10	
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	24, 402	2, 622		190. 00
	1	RESEARCH	0	0	0	0		191.00
		PHYSI CI ANS' PRI VATE OFFI CES OTHER NON-REI MBURSABLE	0	0		2, 075, 396 41, 861		192. 00 192. 01
		FAMILY HEALTH/GARY COMM HEALTH	n	0		18, 822		192. 01
			9	٩ - ١	,	-,	·	

H	leal th Finan	cial Systems	METHODI ST HOS	SPITALS, INC		In Lie	u of Form CMS-	2552-10
(COST ALLOCAT	TION - GENERAL SERVICE COSTS		Provi der Co		Peri od:	Worksheet B	
						From 01/01/2023		
						To 12/31/2023		
_							5/29/2024 9:0	<u>8 am</u>
		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)	6, 555, 262	7, 288, 047	381, 160, 62	5 36, 982, 919	779, 743	202. 00

Provider CCN: 15-0002

| Peri od: | Worksheet B | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared:

				10	12/31/2023	Date/lime Pre 5/29/2024 9:0	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	0.00	10.00	11 00	
	GENERAL SERVICE COST CENTERS	7. 00	8. 00	9. 00	10. 00	11. 00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00550 DATA PROCESSING						5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES						5.02
5. 03 5. 04	00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 03 5. 04
5. 05	00590 OTHER A&G						5.05
5. 06	00592 PATIENT TRANSPORTATION						5. 06
7. 00	00700 OPERATION OF PLANT	28, 194, 977					7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	529, 900					8.00
9.00	00900 HOUSEKEEPI NG	613, 436			4 002 024		9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	560, 312 391, 725	0		6, 893, 826 0	3, 016, 590	10.00 11.00
13. 00	01300 NURSING ADMINISTRATION	188, 772	0		0	133, 244	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 065, 538	2, 072		0	50, 437	1
15.00	01500 PHARMACY	563, 552	0	173, 040	0	0	15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	336, 134	0	,	0	115, 430	1
17.00	01700 SOCIAL SERVICE	48, 427	0	14, 870	0	0	
17. 01 17. 02	O1701 STAFF EDUCATION O1702 MEDICAL EDUCATION	331, 377 11, 118	0	101, 750 3, 414	0	0	17. 01 17. 02
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	11,110	0		0	0	1
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	132, 795	Ö		0	0	1
23.00	02300 PARAMED ED PROGRAM	100, 005	0	30, 707	0	43, 913	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	9, 311, 292			5, 604, 122	748, 106	1
31. 00 31. 01	03100 INTENSIVE CARE UNIT 03101 NEONATAL I CU	590, 516	147, 989 0		281, 683 0	175, 431	1
40. 00	04000 SUBPROVI DER – I PF	67, 126 118, 079	_	,	103, 617	47, 631 29, 903	
41. 00	04100 SUBPROVI DER – I RF	928, 790		,	276, 337	49, 789	1
43.00	04300 NURSERY	726, 075	28, 463		0	31, 534	1
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 773, 182	239, 998		0	189, 103	1
50. 01 51. 00	05001 ENDOSCOPY 05100 RECOVERY ROOM	422 422	26, 706 14, 944		0	16, 468	1
51.00	05200 DELIVERY ROOM & LABOR ROOM	432, 422 208, 185	14, 844 63, 745		166, 221	31, 493 115, 540	1
53. 00	05300 ANESTHESI OLOGY	200, 103	03, 743		100, 221	113, 340	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 577, 334	52, 743	484, 324	0	115, 426	1
54. 01	05401 RADI OLOGY - ULTRASOUND	150, 245	25, 158	46, 133	0	44, 910	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	249, 447	8, 503		0	15, 576	1
55. 01	05501 I NFUSI ON CENTER	151, 434			0	29, 427	1
56. 00 57. 00	05600 RADI OI SOTOPE 05700 CT SCAN	268, 830 254, 560			0	20, 060 43, 539	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	125, 006			0	19, 395	
59. 00	05900 CARDI AC CATHETERI ZATI ON	249, 506	54, 971	76, 611	ő	73, 545	
60.00	06000 LABORATORY	699, 141	0		0	167, 602	1
62.00		11, 445	0		0	74, 168	1
	06400 I NTRAVENOUS THERAPY	0	0	0	0	_	64.00
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	230, 867	0	70, 888 112, 001	0	85, 038 51, 943	65.00
66. 00 67. 00		364, 762 313, 481	0	96, 255	0	34, 885	1
68. 00		53, 391	0	16, 394	0	13, 860	1
69. 00		0	4, 546		Ö	32, 565	1
69. 01	06901 CARDI AC REHAB	0	820		0	16, 453	
	07000 ELECTROENCEPHALOGRAPHY	0	23, 648	0	0	42, 113	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	1
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	40.400	0	_	0	12 225	
	07400 RENAL DIALYSIS	49, 408 130, 298		15, 171 40, 008	0	13, 335 0	
74.00	OUTPATIENT SERVICE COST CENTERS	130, 270	22, 437	1 40,000	<u> </u>	0	74.00
	09000 CLI NI C	2, 264, 703	57, 985	695, 382	0	78, 313	90.00
	09100 EMERGENCY	804, 527	317, 551		461, 846	266, 415	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
101 00	OTHER REIMBURSABLE COST CENTERS 0 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
101.00	SPECIAL PURPOSE COST CENTERS	0	0	l 0	U	0	1101.00
118.00		26, 977, 143	2, 300, 262	7, 932, 320	6, 893, 826	3, 016, 590	118. 00
	NONREI MBURSABLE COST CENTERS				, .===,		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	53, 540	0		0		190. 00
	19100 RESEARCH	0 704 040	0	0	0		191.00
	0 19200 PHYSI CI ANS' PRI VATE OFFI CES 1 19201 OTHER NON-REI MBURSABLE	794, 063 102, 769		243, 818 31, 556	0		192. 00 192. 01
	19201 OTHER NON-RETWOORSABLE 219202 FAMILY HEALTH/GARY COMM HEALTH	267, 462		82, 125	0		192.01
	19300 NONPALD WORKERS	0			Ö		193. 00
					I		

Health Financial	Systems	METHODIST HOSP	ITALS, INC	In Lie	u of Form CMS-	2552-10
COST ALLOCATION -	GENERAL SERVICE COSTS		Provi der C	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Pre 5/29/2024 9:0	

						5/29/2024 9:0	08 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)	28. 194. 977	2, 300, 262	8, 306, 259	6, 893, 826	3, 016, 590	202.00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared: 5/29/2024 9:08 am Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0002

						5/29/2024 9:0	
	Cost Center Description	NURSI NG ADMI NI STRATI O	CENTRAL SERVICES &	PHARMACY	MEDICAL RECORDS &	SOCI AL SERVI CE	
		N N	SUPPLY		LI BRARY	SERVI CE	
	CENEDAL CEDIU CE COCT CENTEDO	13. 00	14. 00	15. 00	16. 00	17. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00550 DATA PROCESSING						5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES						5. 02
5. 03	00570 ADMITTING						5. 03
5. 04 5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER A&G						5. 04 5. 05
5. 06	00590 OTHER AND OCCUPANT ON THE OCCUPANT ON THE OCCUPANT OF TH						5.06
7. 00	00700 OPERATION OF PLANT						7.00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A						10. 00 11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	9, 330, 718					13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	5, 010, 214				14.00
15.00	01500 PHARMACY	O	0	l			15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	4, 528, 508		16. 00
17.00	01700 SOCIAL SERVICE	0	0	0	0	699, 457	1
17. 01 17. 02	01701 STAFF EDUCATION 01702 MEDICAL EDUCATION	0	0	0	0	0	17. 01 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	l o	0	Ö	Ö	0	22.00
23.00	1 1	233, 175	0	0	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	3, 972, 422	0		288, 197	638, 635	1
31. 00 31. 01	03100 NTENSI VE CARE UNI T 03101 NEONATAL CU	931, 531 252, 917	0	1	56, 659 14, 495	0	
40. 00	04000 SUBPROVI DER - I PF	158, 784	0	0	7, 019	0	40.00
41. 00	04100 SUBPROVI DER – I RF	264, 380	0	1	10, 416	39, 100	1
43.00	04300 NURSERY	167, 443	0	0	5, 930	0	43.00
50.00	ANCILLARY SERVICE COST CENTERS	1 004 405			544 570l		
50. 00 50. 01	05000 OPERATING ROOM 05001 ENDOSCOPY	1, 004, 125 87, 445	0		511, 579 25, 566	0	
51. 00	05100 RECOVERY ROOM	167, 224	0		34, 803	0	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	613, 510	0		17, 350	0	
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	139, 333	0	54.00
54. 01	05401 RADI OLOGY - ULTRASOUND	0	0	0	64, 662	0	54. 01
55. 00 55. 01	O5500 RADI OLOGY-THERAPEUTI C O5501 I NFUSI ON CENTER	0	0	0	74, 790 45, 407	0	55. 00 55. 01
56. 00	05600 RADI OI SOTOPE	0	0	0	57, 425	0	56.00
57. 00	05700 CT SCAN	0	0	Ö	438, 442	0	1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	89, 858	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	225, 654	0	59.00
	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	214, 359 0	615, 975 72, 180	0	1
	06400 I NTRAVENOUS THERAPY	0	0		72, 180 N	0	
65. 00	06500 RESPI RATORY THERAPY	l ő	0		140, 779	0	
66.00	06600 PHYSI CAL THERAPY	o	0	0	40, 278	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	19, 163	0	
68. 00	06800 SPEECH PATHOLOGY	0	0	0	7, 763	0	68.00
69. 00 69. 01	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	0	0		84, 210 4, 908	0	69. 00 69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY		0	0	118, 177	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	O	2, 577, 409	O	119, 304	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	2, 432, 805		111, 685	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		674, 110	0	1
74. 00	07400 RENAL DI ALYSI S OUTPATI ENT SERVI CE COST CENTERS	0	0	0	30, 119	0	74.00
90 00	09000 CLINIC	63, 111	0	0	34, 494	0	90.00
	09100 EMERGENCY	1, 414, 651	0		338, 456	21, 722	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	0	0	9, 322	0	101.00
110 00	SPECIAL PURPOSE COST CENTERS	0 220 719	E 010 214	7 470 405	4 520 500	400 457	110 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	9, 330, 718	5, 010, 214	7, 679, 495	4, 528, 508	699, 457	1118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	ol	0	0	0	0	190. 00
191.00	19100 RESEARCH	0	0	T .	0	0	191.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	33, 009	0		192.00
	19201 OTHER NON-REIMBURSABLE 19202 FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0		192. 01 192. 02
17Z. UZ	- 1/202 I AWIL I HEALIII/ BAKT COWW REALIR	<u>ı</u>	0	1 0	·	0	1172.02

Health Financial Systems	METHODIST HOSPIT	TALS, INC		In Lieu	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		Peri od: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Pre 5/29/2024 9:0	
Cost Center Description	NURSING ADMINISTRATIO	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	

0

14. 00

5, 010, 214

15.00

7, 712, 504

0

16.00

4, 528, 508

0

17.00

0 193.00 200.00 0 201.00 699, 457 202.00

13.00

9, 330, 718

193.00 19300 NONPAID WORKERS
200.00 Cross Foot Adjustments
201.00 Negative Cost Centers
202.00 TOTAL (sum lines 118 through 201)

Provider CCN: 15-0002

						5/29/2024 9:0	8 am
				INTERNS &	RESI DENTS		
	Cost Center Description	STAFF	MEDI CAL		SERVI CES-OTHE	PARAMED ED	
		EDUCATI ON	EDUCATI ON	RY & FRINGES	R PRGM COSTS	PROGRAM	
	OFNEDAL CEDILLOF COCT OFNEDC	17. 01	17. 02	21. 00	22. 00	23. 00	
1 00	GENERAL SERVICE COST CENTERS			I			1 00
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00550 DATA PROCESSING						5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES						5. 02
5. 03	00570 ADMI TTI NG						5. 03
5.04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 04
5.05	00590 OTHER A&G						5. 05
5.06	00592 PATIENT TRANSPORTATION						5.06
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11.00
13. 00	01300 NURSING ADMINISTRATION						13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00	01500 PHARMACY						15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY						16. 00
17. 00	01700 SOCIAL SERVICE						17. 00
17. 00	01701 STAFF EDUCATION	E00 041					17.00
		580, 061	277 247				
	01702 MEDI CAL EDUCATI ON	40	277, 247				17. 02
21. 00	02100 &R SERVICES-SALARY & FRINGES APPRVD	0	0				21.00
22. 00	02200 &R SERVICES-OTHER PRGM COSTS APPRVD	0	0		266, 969	4 (04 00)	22.00
23. 00	02300 PARAMED ED PROGRAM	205	0			1, 601, 896	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00	03000 ADULTS & PEDI ATRI CS	156, 906	0			69, 084	30.00
31.00	03100 INTENSIVE CARE UNIT	55, 790	0	0	0	0	31. 00
31. 01	03101 NEONATAL I CU	14, 572	0	0	0	0	31. 01
40.00	04000 SUBPROVI DER - I PF	419	0	0	0	0	40.00
41.00	04100 SUBPROVI DER - I RF	10, 494	0	0	0	0	41.00
43.00	04300 NURSERY	4, 165	0	0	o	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	82, 903	0	C	0	69, 084	50.00
50. 01	05001 ENDOSCOPY	5, 690	0		o	0	50. 01
51. 00	05100 RECOVERY ROOM	14, 438	0			0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	40, 736	0			69, 084	52.00
53. 00	05300 ANESTHESI OLOGY	0	0		-	0,,001	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 086	0			0	54.00
54. 01	05401 RADI OLOGY - ULTRASOUND	1, 209	0		-	0	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	40	0			0	55.00
55. 00	05501 NFUSION CENTER	79	0		0	0	55. 00
		0	-	1	0	0	
56.00	05600 RADI OI SOTOPE		0		U		56.00
57. 00	05700 CT SCAN	15, 560	0	1	0	0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	158	0	0		0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	17, 006	0			34, 542	59.00
60.00	06000 LABORATORY	988	0	0	0	0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	735	0	0	0	0	62.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	7, 057	0	0	0	103, 627	65.00
66. 00	06600 PHYSI CAL THERAPY	680	0	0	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	411	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	300	0	0	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	3, 896	0	0	0	0	69.00
69. 01	06901 CARDI AC REHAB	0	0	0	0	0	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	2, 331	0	0	o	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	O	0		o	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	l 0	ol	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 773	0		0	0	73.00
74. 00	07400 RENAL DI ALYSI S	0	0		ol	0	74.00
, ,, ,,	OUTPATIENT SERVICE COST CENTERS	<u> </u>			<u> </u>		7 00
90.00	09000 CLI NI C	2, 039	0	0	ام	0	90.00
91.00	09100 EMERGENCY	114, 418	277, 247	1	-	1, 256, 475	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	114,410	211, 241	327,003	200, 707	1, 230, 473	92.00
7Z. UU				<u> </u>			72.00
101 00	OTHER REIMBURSABLE COST CENTERS	2 (24		_		^	101 00
101.00	10100 HOME HEALTH AGENCY	2, 631	0	0	0	0	101. 00
110 0	SPECIAL PURPOSE COST CENTERS	E/0 7EE	077 047	200 615	044 049	1 (01 00)	110 00
118.00		562, 755	277, 247	329, 065	266, 969	1, 601, 896	118.00
46	NONREI MBURSABLE COST CENTERS	.1		1	.1		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190. 00
	19100 RESEARCH	0	0	0	0		191. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	17, 243	0	0	0		192.00
192. 01	19201 OTHER NON-REIMBURSABLE	0	0	<u> </u>	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 01/01/2023 | Part I |
To 12/31/2023 | Date/Time Prepared: 5/29/2024 9: 08 am

						5/29/2024 9:0	<u>8 alli</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	63	0	0	0	0	192. 02
193.00 19300	NONPALD WORKERS	0	0	0	0	0	193.00
200. 00	Cross Foot Adjustments			0	0	0	200.00
201. 00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	580, 061	277, 247	329, 065	266, 969	1, 601, 896	202.00

In Lieu of Form CMS-2552-10 Health Financial Systems METHODIST HOSPITALS, INC COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0002 Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/29/2024 9:08 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 78, 524, 304 78, 524, 304 30.00 03100 INTENSIVE CARE UNIT 31.00 13, 771, 115 0 13, 771, 115 31.00 03101 NEONATAL ICU 31 01 3 013 716 0 3, 013, 716 31 01 04000 SUBPROVI DER - I PF 40.00 1,884,886 0 1,884,886 40.00 04100 SUBPROVI DER - I RF 4, 879, 945 0 4, 879, 945 41.00 41.00 43.00 04300 NURSERY 3, 516, 115 0 3, 516, 115 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 19, 680, 141 0 19, 680, 141 50.00 05001 ENDOSCOPY 1, 525, 777 1, 525, 777 50.01 50.01 51.00 05100 RECOVERY ROOM 3, 012, 426 0 3, 012, 426 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 7, 370, 549 7, 370, 549 52.00 53.00 05300 ANESTHESI OLOGY 53.00 54 00 05400 RADI OLOGY-DI AGNOSTI C 10, 398, 239 10, 398, 239 54.00 05401 RADI OLOGY - ULTRASOUND 3, 372, 633 0 3, 372, 633 54.01 54.01 05500 RADI OLOGY-THERAPEUTI C 0 55.00 3, 372, 939 3, 372, 939 55.00 55.01 05501 INFUSION CENTER 1, 903, 544 1, 903, 544 55.01 05600 RADI OI SOTOPE 3, 244, 350 0 3, 244, 350 56,00 56,00 57 00 05700 CT SCAN 5, 658, 169 0 5, 658, 169 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 1, 953, 776 1, 953, 776 58.00 59 00 05900 CARDIAC CATHETERIZATION 6, 941, 594 6, 941, 594 59.00 06000 LABORATORY 21, 548, 612 0 21, 548, 612 60.00 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 2, 398, 721 2, 398, 721 62.00 64.00 06400 I NTRAVENOUS THERAPY 64.00 65.00 06500 RESPIRATORY THERAPY 7, 264, 829 7, 264, 829 65.00 06600 PHYSI CAL THERAPY 3, 384, 922 3, 384, 922 66.00 66,00 67.00 06700 OCCUPATI ONAL THERAPY 2, 241, 535 2, 241, 535 67.00 829, 139 68.00 06800 SPEECH PATHOLOGY 829, 139 68.00 06900 ELECTROCARDI OLOGY 1, 687, 676 1, 687, 676 69.00 69.00 06901 CARDI AC REHAB 69.01 858, 143 0 858, 143 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 2, 678, 771 0 2, 678, 771 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 21, 074, 073 21, 074, 073 71.00 19, 887, 744 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 19, 887, 744 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 57, 757, 195 C 57, 757, 195 73.00 74.00 07400 RENAL DIALYSIS 2, 972, 062 2, 972, 062 74.00 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 90.00 9 223 753 9 223 753 90 00 91.00 09100 EMERGENCY 26, 494, 479 -596, 034 25, 898, 445 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 3, 150, 365 0 3, 150, 365 SPECIAL PURPOSE COST CENTERS

357, 476, 237

22, 477, 983

97,004

-596, 034

356, 880, 203

22, 477, 983

97,004

118.00

190.00

191.00

192.00

191. 00 19100 RESEARCH

118.00

SUBTOTALS (SUM OF LINES 1 through 117)

NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN

192. 00 19200 PHYSICIANS' PRIVATE OFFICES

Health Financial Sy	stems	METHODI ST HOSI	PITALS, INC		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS			Provi der CO	CN: 15-0002	Peri od:	Worksheet B	
					From 01/01/2023 To 12/31/2023	Part Date/Time Pre	narod:
					10 12/31/2023	5/29/2024 9:0)8 am
Cost Ce	enter Description	Subtotal	Intern &	Total			
			Resi dents				
			Cost & Post				
			Stepdown				
			Adjustments				
		24. 00	25. 00	26.00			
192. 01 19201 OTHER N	NON-REI MBURSABLE	565, 761	0	565, 70	51		192. 01
192. 02 19202 FAMI LY	HEALTH/GARY COMM HEALTH	543, 640	0	543, 6	10		192. 02
193. 00 19300 NONPALE) WORKERS	0	0		0		193.00
200.00 Cross F	Foot Adjustments	0	0		0		200.00
201.00 Negati v	ve Cost Centers	0	0		0		201.00
202. 00 TOTAL ((sum lines 118 through 201)	381, 160, 625	-596, 034	380, 564, 59	91		202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | From 01/2024 | Prepared: | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0002

					10	12/31/2023	Date/lime Pre 5/29/2024 9:0	
		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSI NG	o am
			0	1.00	2A	4. 00	5. 01	
		AL SERVICE COST CENTERS						
1. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05	00400 00550 00560 00570 00580	CAP REL COSTS-BLDG & FIXT EMPLOYEE BENEFITS DEPARTMENT DATA PROCESSING PURCHASING RECEIVING AND STORES ADMITTING CASHIERING/ACCOUNTS RECEIVABLE OTHER A&G	0 0 0 0	70, 296 109, 384 87, 269 115, 657 364, 765 1, 185, 241	109, 384 87, 269 115, 657 364, 765	70, 296 1, 918 515 2, 000 1, 072 3, 989	111, 302 0 0 0 111, 302	1.00 4.00 5.01 5.02 5.03 5.04 5.05
5. 06 7. 00 8. 00 9. 00 10. 00 11. 00	00700 00800 00900 01000	PATIENT TRANSPORTATION OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA	0 0 0 0 0	0 3, 562, 769 212, 162 245, 608 224, 339 156, 839	3, 562, 769 212, 162 245, 608 224, 339	242 2, 307 0 2, 051 1, 154 710	0 0 0 0 0	5. 06 7. 00 8. 00 9. 00 10. 00 11. 00
13. 00 14. 00 15. 00 16. 00 17. 00 17. 01 17. 02	01400 01500 01600 01700 01701	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE STAFF EDUCATION	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	75, 581 426, 622 225, 636 134, 582 19, 389 132, 677	426, 622 225, 636 134, 582 19, 389 132, 677	2, 688 339 0 997 205 0 69	0 0 0 0 0	13. 00 14. 00 15. 00 16. 00 17. 00 17. 01 17. 02
21. 00 22. 00 23. 00 30. 00	02100 02200 02300 I NPAT	MEDICAL EDUCATION L&R SERVICES-SALARY & FRINGES APPRVD L&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PROGRAM LENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	0 0 0	4, 452 0 53, 169 40, 040	0 53, 169 40, 040	0 0 0 437 10, 558	0 0 0	21. 00 22. 00 23. 00 30. 00
31. 00 31. 01 40. 00 41. 00 43. 00	03100 03101 04000 04100 04300	INTENSIVE CARE UNIT NEONATAL ICU SUBPROVIDER - IPF SUBPROVIDER - IRF NURSERY	0 0 0 0 0	3, 728, 074 236, 432 26, 876 47, 277 371, 870 290, 707	236, 432 26, 876 47, 277 371, 870	10, 536 2, 967 755 423 713 556	0 0 0 0	31. 00 31. 01 40. 00 41. 00 43. 00
50. 00 50. 01 51. 00 52. 00	05000 05001 05100 05200	LARY SERVICE COST CENTERS OPERATING ROOM ENDOSCOPY RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	0 0 0	709, 950 0 173, 134 83, 353	0 173, 134 83, 353	2, 513 267 520 1, 717	0 0 0	50. 00 50. 01 51. 00 52. 00
53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00	05400 05401 05500 05501 05600	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RADI OLOGY - ULTRASOUND RADI OLOGY-THERAPEUTI C I NFUSI ON CENTER RADI OI SOTOPE ICT SCAN	0 0 0	0 631, 536 60, 155 99, 874 60, 631 107, 634 101, 921	631, 536 60, 155 99, 874 60, 631 107, 634	0 1, 246 615 206 312 330 587	0 0 0 0 0	53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00
	05800 05900 06000 06200 06400	MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION LABORATORY WHOLE BLOOD & PACKED RED BLOOD CELLS INTRAVENOUS THERAPY RESPIRATORY THERAPY	0 0 0 0 0	50, 050 99, 898 279, 923 4, 582 0 92, 435	50, 050 99, 898 279, 923 4, 582 0	217 1, 135 1, 934 536 0 1, 139	0 0 0 0 0	58. 00
66. 00 67. 00 68. 00 69. 00 69. 01 70. 00	06700 06800 06900 06901	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPECH PATHOLOGY ELECTROCARDI OLOGY CARDI AC REHAB ELECTROENCEPHALOGRAPHY	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	146, 044 125, 512 21, 377 0 0	125, 512 21, 377	749 490 212 366 204 558	0 0 0 0	66. 00 67. 00 68. 00 69. 00 69. 01 70. 00
71. 00 72. 00 73. 00 74. 00	07100 07200 07300 07400 0UTPA	MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS RENAL DIALYSIS TIENT SERVICE COST CENTERS	0 0 0	0 0 19, 782 52, 169	52, 169	0 0 196 0	0 0 0 0	71. 00 72. 00 73. 00 74. 00
90. 00 91. 00 92. 00	09100 09200 0THER	CLINIC EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS HOME HEALTH AGENCY	0 0	906, 746 322, 118	322, 118 0	1, 114 3, 839 915	0	90. 00 91. 00 92. 00
118.00	SPECI	AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	0			58, 582	111, 302	
	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN RESEARCH	0			0 0		190. 00 191. 00

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CO		Peri od:	Worksheet B	
				From 01/01/2023 Fo 12/31/2023		pared:
					5/29/2024 9:0	
		CAPI TAL				
		RELATED COSTS				
Cost Center Description	Di rectly	BLDG & FIXT	Subtotal	EMPLOYEE	DATA	
	Assigned New			BENEFI TS	PROCESSI NG	
	Capi tal			DEPARTMENT		
	Related Costs					
	0	1.00	2A	4. 00	5. 01	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	317, 928	317, 92	11, 681	0	192.00
192. 01 19201 OTHER NON-REIMBURSABLE	0	41, 147	41, 14	7 0	0	192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	0	107, 087	107, 08	7 33	0	192. 02
193. 00 19300 NONPALD WORKERS	0	0	(0	0	193. 00
200.00 Cross Foot Adjustments			(200.00
201.00 Negative Cost Centers		0	(0	0	201.00
202 00 TOTAL (sum Lines 119 through 201)		16 70/ 125	16 70/ 12	70 206	111 202	202 00

70, 296

111, 302 202. 00

16, 784, 135

16, 784, 135

Cross Foot Adjustments
Negative Cost Centers
TOTAL (sum lines 118 through 201)

202.00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared: 5/29/2024 9:08 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0002

					10		5/29/2024 9:0	
		Cost Center Description	PURCHASING RECEIVING AND	ADMI TTI NG	CASHI ERI NG/AC COUNTS	OTHER A&G	PATI ENT TRANSPORTATI 0	
			STORES		RECEI VABLE		N	
	CENED	AL SERVICE COST CENTERS	5. 02	5. 03	5. 04	5. 05	5. 06	
1. 00		CAP REL COSTS-BLDG & FIXT						1. 00
4. 00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 5. 02		DATA PROCESSING	07 704					5. 01
5. 02		PURCHASING RECEIVING AND STORES ADMITTING	87, 784 108	117, 765				5. 02 5. 03
5. 04	1	CASHI ERI NG/ACCOUNTS RECEI VABLE	15	0				5. 04
5. 05		OTHER A&G	44	0		1, 300, 576	l	5. 05
5.06		PATIENT TRANSPORTATION	2	0	_	2, 661	2, 905	5.06
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE	865 0	0		96, 211 6, 041	0	7. 00 8. 00
9. 00		HOUSEKEEPI NG	742	0		26, 250	ő	9. 00
10.00	1	DI ETARY	1, 198	0	_	21, 025	0	10.00
11.00		CAFETERI A	2	0		8, 546	0	11.00
13. 00 14. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	66 103	0		30, 543 12, 165	0	13. 00 14. 00
15. 00	1	PHARMACY	361	0		23, 804	0	15.00
16.00		MEDICAL RECORDS & LIBRARY	13	0	0	13, 560	0	16.00
17.00	1	SOCIAL SERVICE	0	0		2, 171	0	17.00
17. 01 17. 02	1	STAFF EDUCATION MEDICAL EDUCATION	0 15	0	_	501 896	0	17. 01 17. 02
21. 00		I&R SERVICES-SALARY & FRINGES APPRVD	13	0		1, 123		21. 00
22. 00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	o	0		319	0	22. 00
23. 00		PARAMED ED PROGRAM	9	0	0	4, 074	0	23. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	4, 174	7, 481	23, 225	182, 620	981	30. 00
31.00	1	INTENSIVE CARE UNIT	1, 468	1, 471		38, 722	901	31.00
31. 01		NEONATAL ICU	23	376		8, 860	ó	31. 01
40. 00		SUBPROVI DER - I PF	0	182		4, 882	0	40. 00
41.00		SUBPROVI DER - I RF	121	270		10, 035	12	41.00
43. 00		NURSERY LARY SERVICE COST CENTERS	278	154	478	7, 949	0	43.00
50.00		OPERATI NG ROOM	1, 154	13, 280	41, 228	52, 092	0	50.00
50. 01	1	ENDOSCOPY	415	664		4, 588	l	50. 01
51.00		RECOVERY ROOM	233	903		7, 454	0	51.00
52. 00 53. 00		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	315	450 0		20, 483 0	36	52. 00 53. 00
54. 00	1	RADI OLOGY-DI AGNOSTI C	289	3, 617	-	27, 227	179	54.00
54. 01	1	RADI OLOGY - ULTRASOUND	167	1, 679	5, 211	10, 044	361	54. 01
55.00		RADI OLOGY-THERAPEUTI C	30	1, 941		10, 034	27	55.00
55. 01 56. 00	1	I NFUSI ON CENTER RADI OI SOTOPE	334 1, 585	1, 179 1, 491		5, 564 9, 399	0 165	55. 01 56. 00
57. 00		CT SCAN	529	11, 381		15, 734	690	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	127	2, 333		5, 510	197	58. 00
59. 00		CARDI AC CATHETERI ZATI ON	1, 572	5, 858		21, 090	109	59.00
60. 00 62. 00	1	LABORATORY WHOLE BLOOD & PACKED RED BLOOD CELLS	9, 822 440	15, 990 1, 874		67, 004 7, 632	0	60. 00 62. 00
64. 00		INTRAVENOUS THERAPY	0	1, 874		7, 032		64.00
65.00		RESPI RATORY THERAPY	1, 656	3, 654	11, 345	22, 612	0	65.00
66. 00	1	PHYSI CAL THERAPY	25	1, 046		9, 607	0	66.00
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	20 14	497 202		6, 065 2, 516	0	67. 00 68. 00
69.00		ELECTROCARDI OLOGY	39	2, 186		5, 319	i e	69.00
69. 01		CARDI AC REHAB	11	127		2, 853	0	69. 01
70.00		ELECTROENCEPHALOGRAPHY	173	3, 068		8, 497	9	70.00
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	27, 099 25, 568	3, 097		62, 710 50, 191	0	71. 00 72. 00
72.00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	1, 123	2, 899 17, 710		59, 181 169, 031	0	72.00
74. 00		RENAL DIALYSIS	37	782		9, 381	ő	74.00
		TIENT SERVICE COST CENTERS						
90.00		CLI NI C EMERGENCY	128	895		20, 568	l	90.00
91. 00 92. 00		OBSERVATION BEDS (NON-DISTINCT PART)	4, 389	8, 786	27, 276	69, 499	42	91. 00 92. 00
72.00		REIMBURSABLE COST CENTERS						72.00
101.00	10100	HOME HEALTH AGENCY	100	242	751	10, 709	0	101. 00
440.00		AL PURPOSE COST CENTERS	07.004	447.77	1 0/5 050	4 005 074	0.005	
118.00		SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	87, 001	117, 765	365, 852	1, 225, 361	2, 905	118. 00
190. 00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	92	0	190. 00
191.00	19100	RESEARCH	0	0		0	0	191. 00
		PHYSI CLANS' PRI VATE OFFI CES	783	0		72, 989		192.00
		OTHER NON-REIMBURSABLE FAMILY HEALTH/GARY COMM HEALTH	0	0		1, 472 662		192. 01 192. 02
. /2. 02	., , , 202	1 21 HEALTH OAKT COMM HEALTH	·	0	, 0	002	<u> </u>	. , 2. 02

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C	CN: 15-0002	Peri od:	Worksheet B	
				From 01/01/2023		
			-	Γo 12/31/2023	Date/Time Pre	
					5/29/2024 9:0	<u>8 am</u>
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	

0

0 87, 784

193.00 19300 NONPAI D WORKERS
200.00 Cross Foot Adjustments
201.00 Negative Cost Centers
202.00 TOTAL (sum lines 118 through 201)

117, 765

365, 852

1, 300, 576

0

0 193.00 200.00 0 201.00 2, 905 202.00

Provider CCN: 15-0002

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared: 5/29/2024 9:08 am

					12/31/2023	5/29/2024 9:0	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		7. 00	LINEN SERVICE 8.00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS	7.00	8.00	9.00	10.00	11.00	
1.00	00100 CAP REL COSTS-BLDG & 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 5. 05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER A&G						5. 04 5. 05
5. 06	00592 PATIENT TRANSPORTATION						5. 06
7. 00	00700 OPERATION OF PLANT	3, 662, 152					7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	68, 827	287, 030				8. 00
9.00	00900 HOUSEKEEPI NG	79, 677	0	354, 328			9. 00
10.00	01000 DI ETARY	72, 777	0		327, 832		10.00
11.00	01100 CAFETERI A	50, 880	i e		0	222, 108	11.00
13.00	01300 NURSING ADMINISTRATION	24, 519	0	_,	0	9, 811	13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	138, 399 73, 198	l e		0	3, 714 0	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	43, 659			0	8, 499	16.00
17. 00	01700 SOCI AL SERVI CE	6, 290		634	ő	0, 177	17. 00
17. 01	01701 STAFF EDUCATION	43, 041	Ö		Ö	0	17. 01
17. 02	01702 MEDI CAL EDUCATI ON	1, 444	0	146	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	17, 248	l .	.,	0	0	22. 00
23. 00	02300 PARAMED ED PROGRAM	12, 989	0	1, 310	0	3, 233	23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	1 200 414	134, 112	121 040	266, 501	55, 080	30. 00
31. 00	03100 INTENSIVE CARE UNIT	1, 209, 414 76, 700			13, 395	12, 917	31.00
31. 00	03101 NEONATAL I CU	8, 719			13, 373	3, 507	31. 01
40. 00	04000 SUBPROVI DER - I PF	15, 337	Ö	1, 547	4, 927	2, 202	40.00
41.00	04100 SUBPROVI DER - I RF	120, 637	8, 903		13, 141	3, 666	41.00
43.00	04300 NURSERY	94, 307	3, 552	9, 510	0	2, 322	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	230, 313	l '		0	13, 923	50.00
50. 01 51. 00	05001 ENDOSCOPY 05100 RECOVERY ROOM	0 56, 166	3, 332 1, 852		0	1, 213 2, 319	50. 01 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	27, 040			7, 905	2, 319 8, 507	52.00
53. 00	05300 ANESTHESI OLOGY	27,040	7, 734	2, 727	7, 703	0, 307	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	204, 875	1	20, 660	o	8, 499	54.00
54. 01	05401 RADI OLOGY - ULTRASOUND	19, 515	l '		o	3, 307	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	32, 400	1, 061	3, 267	0	1, 147	55.00
55. 01	05501 I NFUSI ON CENTER	19, 669	ŀ	.,	0	2, 167	55. 01
56. 00	05600 RADI 0I SOTOPE	34, 917			0	1, 477	56.00
57. 00	05700 CT SCAN	33, 064			0	3, 206	57.00
58. 00 59. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	16, 237 32, 408	1, 664 6, 859		0	1, 428 5, 415	58. 00 59. 00
60. 00	06000 LABORATORY	90, 809			0	12, 340	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 487	Ö		o	5, 461	62.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	o	0	64.00
65.00	06500 RESPIRATORY THERAPY	29, 987	0	3, 024	0	6, 261	65.00
66. 00	06600 PHYSI CAL THERAPY	47, 378	l .	4, 778	0	3, 824	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	40, 717		4, 106	0	2, 569	67.00
68. 00	06800 SPEECH PATHOLOGY	6, 935		699	0	1, 020	68.00
69. 00 69. 01	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	0	567 102	0	U O	2, 398 1, 211	69. 00 69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	2, 951		0	3, 101	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	Ö	o	0, 131	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	o	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	6, 417	0	647	O	982	73.00
74.00	07400 RENAL DIALYSIS	16, 924	2, 800	1, 707	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS	004.455	7 005		ما		
90.00	09000 CLI NI C 09100 EMERGENCY	294, 155			0	5, 766	90.00
91. 00 92. 00		104, 497	39, 625	10, 538	21, 963	19, 616	91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
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)	3, 503, 972	287, 030	338, 377	327, 832	222, 108	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	6, 954	0	701	0		190.00
) 19100 RESEARCH) 19200 PHYSI CI ANS' PRI VATE OFFI CES	102 129	1	· -	0		191. 00 192. 00
	19200 PHYSICIANS PRIVATE OFFICES 19201 OTHER NON-REIMBURSABLE	103, 138 13, 348		10, 401 1, 346	0		192. 00 192. 01
	219201 OTHER NON-RETWIBURSABLE	34, 740	l		O O		192. 01
	19300 NONPALD WORKERS	0		1	o		193. 00
	i i	·	<u>. </u>		<u> </u>		

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0002	Peri od: Worksheet B From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared: 5/29/2024 9:08 am

						5/29/2024 9:0	8 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, 662, 152	287, 030	354, 328	327, 832	222, 108	202.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | From 01/2024 | Prepared: | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0002

				10	12/31/2023	Date/lime Pre 5/29/2024 9:0	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
		ADMI NI STRATI O N	SERVICES & SUPPLY		RECORDS & 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 5. 01	00400 EMPLOYEE BENEFITS DEPARTMENT 00550 DATA PROCESSING						4. 00 5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES						5. 02
5. 03	00570 ADMITTING						5.03
5.04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.04
5. 05	00590 OTHER A&G						5. 05
5.06	00592 PATIENT TRANSPORTATION						5.06
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	145, 681	505 550				13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	595, 558				14. 00 15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0	330, 381 0	205, 713		16.00
17. 00	01700 SOCIAL SERVICE	0	0	0	203, 713	28, 689	1
17. 01	01701 STAFF EDUCATION	0	0	0	0	0	17. 01
17. 02	01702 MEDI CAL EDUCATI ON	0	0	0	0	0	1
21.00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0	0	0	0	0	
22. 00 23. 00	O2200 1 & R SERVICES-OTHER PRGM COSTS APPRVD O2300 PARAMED ED PROGRAM	2 441	0		0	0	
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	3, 641	0	<u> </u>		0	23.00
30.00	03000 ADULTS & PEDI ATRI CS	62, 022	0	0	13, 064	26, 194	30.00
31.00	03100 INTENSIVE CARE UNIT	14, 544	0	0	2, 568	0	31.00
31. 01	03101 NEONATAL I CU	3, 949	0	0	657	0	31.01
40.00	04000 SUBPROVI DER - I PF	2, 479	0	0	318	0	
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	4, 128 2, 614	0		472 269	1, 604 0	1
43.00	ANCI LLARY SERVICE COST CENTERS	2,014] 0	207		43.00
50.00	05000 OPERATING ROOM	15, 677	0	0	23, 191	0	50.00
50. 01	05001 ENDOSCOPY	1, 365	0		1, 159	0	50. 01
51.00	05100 RECOVERY ROOM	2, 611	0	_	1, 578	0	51.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	9, 579	0	0	786 0	0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	6, 316	0	1
54. 01	05401 RADI OLOGY - ULTRASOUND	Ö	0	_	2, 931	0	1
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	3, 390	0	55.00
55. 01	05501 I NFUSI ON CENTER	0	0	0	2, 058	0	55. 01
56.00	05600 RADI OI SOTOPE	0	0	0	2, 603	0	56.00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	19, 875 4, 073	0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		10, 229	0	59.00
	06000 LABORATORY	0	0	9, 182	27, 923	0	1
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	3, 272	0	02.00
	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0	0	6, 382 1, 826	0	
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	869	0	67.00
68.00	06800 SPEECH PATHOLOGY	Ö	0	Ö	352	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	3, 817	0	69. 00
69. 01	06901 CARDI AC REHAB	0	0	0	222	0	
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	5, 357	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	306, 375 289, 183		5, 408 5, 063	0	
	07300 DRUGS CHARGED TO PATIENTS	0	209, 103		30, 990	0	1
74.00	07400 RENAL DIALYSIS	0	0		1, 365	0	1
	OUTPATIENT SERVICE COST CENTERS				·		
	09000 CLI NI C	985	0		1, 564	0	
	09100 EMERGENCY	22, 087	0	0	15, 343	891	1
92.00	O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
101 00	10100 HOME HEALTH AGENCY	0	0	0	423	0	101.00
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>		<u> </u>	120		101.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	145, 681	595, 558	328, 967	205, 713	28, 689	118. 00
	NONREI MBURSABLE COST CENTERS	1					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
) 19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	1, 414	0		191. 00 192. 00
	19201 OTHER NON-REIMBURSABLE		0	0	0		192.00
	19202 FAMILY HEALTH/GARY COMM HEALTH		0		o		192.02

Health Financial Systems	METHODIST HOSPITALS, INC			In Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C		Peri od: From 01/01/2023	Worksheet B Part II	
				To 12/31/2023	Date/Time Pre 5/29/2024 9:0	
Cost Center Description	NURSI NG ADMI NI STRATI O	CENTRAL SERVICES &	PHARMACY	MEDI CAL RECORDS &	SOCI AL SERVI CE	

						3/27/2024 7.0	o alli
	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	
193.00 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)	145, 681	595, 558	330, 381	205, 713	28, 689	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0002

Peri od: Worksheet B From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared:

5/29/2024 9:08 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 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16,00 16 00 17.00 01700 SOCIAL SERVICE 17.00 01701 STAFF EDUCATION 17.01 180, 559 17.01 01702 MEDICAL EDUCATION 7,034 17.02 12 17.02 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21.00 0 1, 123 21.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 C 72, 475 22.00 02300 PARAMED ED PROGRAM 23.00 0 65, 797 23.00 64 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 48, 843 C 30.00 03100 INTENSIVE CARE UNIT 17, 366 31.00 31.00 03101 NEONATAL I CU 0 31.01 4.536 31.01 04000 SUBPROVI DER - I PF 40.00 130 0 40.00 41.00 04100 SUBPROVI DER - I RF 3, 267 0 41.00 04300 NURSERY 43.00 1, 296 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 25,806 0 50.00 50.01 05001 ENDOSCOPY 1, 771 0 50.01 51.00 05100 RECOVERY ROOM 4, 494 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 12, 680 0 52 00 52 00 05300 ANESTHESI OLOGY 53.00 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 649 54.00 54.00 54.01 05401 RADI OLOGY - ULTRASOUND 376 0 54.01 05500 RADI OLOGY-THERAPEUTI C 0 55 00 12 55 00 55.01 05501 INFUSION CENTER 25 0 55.01 56.00 05600 RADI OI SOTOPE 56.00 05700 CT SCAN 57.00 4,843 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 49 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 5, 293 0 59.00 60 00 06000 LABORATORY 307 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 229 62.00 06400 I NTRAVENOUS THERAPY 64.00 Ω C 64.00 06500 RESPIRATORY THERAPY 2, 197 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 212 0 66.00 06700 OCCUPATI ONAL THERAPY 67.00 128 0 67.00 68.00 06800 SPEECH PATHOLOGY 93 0 68.00 69.00 06900 ELECTROCARDI OLOGY 1, 213 0 69.00 06901 CARDI AC REHAB 69.01 69.01 0 70.00 07000 ELECTROENCEPHALOGRAPHY 726 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 486 C 73.00 74.00 07400 RENAL DIALYSIS C 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 635 09100 EMERGENCY 91 00 35, 615 7,034 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 819 0 101.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 175, 172 7,034 0 0 0 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190 00 C 0 191. 00 19100 RESEARCH 0 0 191.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 192.00 5, 367 192. 01 19201 OTHER NON-REIMBURSABLE 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 | Period: From 01/01/2023 | Part II To 12/31/2023 | Date/Time Prepared: 5/29/2024 9:08 am

						5/29/2024 9:0	<u>8 am</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	20	0				192. 02
193. 00 19300	NONPALD WORKERS	0	0				193. 00
200.00	Cross Foot Adjustments			1, 123	72, 475	65, 797	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	180, 559	7, 034	1, 123	72, 475	65, 797	202.00

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: 5/29/2024 9:08 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS METHODIST HOSPITALS, INC Provider CCN: 15-0002

					5/29/2024 9	
	Cost Center Description	Subtotal	Intern &	Total		
			Residents			
			Cost & Post			
			Stepdown Adjustments			
		24. 00	25. 00	26. 00		
	GENERAL SERVICE COST CENTERS		•			
1.00	00100 CAP REL COSTS-BLDG & FLXT					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 01	00550 DATA PROCESSING					5. 01
5. 02 5. 03	00560 PURCHASING RECEIVING AND STORES					5. 02
5. 03	00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE					5. 03 5. 04
5. 05	00590 OTHER A&G					5. 05
5. 06	00592 PATIENT TRANSPORTATION					5. 06
7. 00	00700 OPERATION OF PLANT					7.00
8.00	00800 LAUNDRY & LINEN SERVICE					8.00
9.00	00900 HOUSEKEEPI NG					9. 00
10.00	01000 DI ETARY					10.00
11. 00	01100 CAFETERI A					11.00
13. 00	01300 NURSING ADMINISTRATION					13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY					14.00
15.00	1 1					15.00
16. 00 17. 00	1					16. 00 17. 00
17. 00	01700 SOCIAL SERVICE					17.00
17. 01	1 1					17. 01
21. 00						21.00
22. 00	1 1					22. 00
23.00	02300 PARAMED ED PROGRAM					23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS	5, 894, 303	0	5, 894, 303		30.00
31. 00		449, 326	0	449, 326		31.00
31. 01	03101 NEONATAL I CU	60, 305	0	60, 305		31.01
40.00	1 1	80, 270	0	80, 270		40.00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	551, 843	0	551, 843		41.00
43.00	ANCI LLARY SERVICE COST CENTERS	413, 992	U	413, 992		43.00
50. 00		1, 182, 300	O	1, 182, 300		50.00
50. 01	05001 ENDOSCOPY	16, 907	o	16, 907		50. 01
51.00	1 1	259, 733	O	259, 733		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	184, 930	0	184, 930		52.00
53.00	05300 ANESTHESI OLOGY	0	0	0		53.00
54.00	1 1	922, 903	0	922, 903		54.00
54. 01	05401 RADI OLOGY - ULTRASOUND	109, 468	0	109, 468		54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	159, 416	0	159, 416		55. 00
55. 01 56. 00	05501 NFUSION CENTER	97, 582	0	97, 582		55. 01
56.00	05600 RADI OI SOTOPE 05700 CT SCAN	169, 856 234, 461	0	169, 856 234, 461		56. 00 57. 00
58. 00	1 1	90, 764	0	90, 764		58.00
	05900 CARDIAC CATHETERIZATION	211, 319	- 1	211, 319		59.00
	06000 LABORATORY	574, 033	o	574, 033		60.00
62. 00		31, 480	Ö	31, 480		62.00
64.00	06400 I NTRAVENOUS THERAPY	0	o	0		64.00
65.00	06500 RESPI RATORY THERAPY	180, 692	0	180, 692		65.00
66.00		218, 735	0	218, 735		66.00
67. 00		182, 517	0	182, 517		67.00
68. 00		34, 046	0	34, 046		68. 00
69.00	1 1	22, 705	0	22, 705		69.00
69. 01 70. 00	1 1	5, 126	0	5, 126		69. 01
	07100 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	33, 964 414, 304	0	33, 964 414, 304		70. 00 71. 00
71.00		414, 304 390, 895	0	390, 895		71.00
	07300 DRUGS CHARGED TO PATIENTS	623, 378	o	623, 378		73.00
	07400 RENAL DIALYSIS	87, 592	Ö	87, 592		74. 00
	OUTPATIENT SERVICE COST CENTERS	,	-,	,		
	09000 CLI NI C	1, 272, 236	0	1, 272, 236		90.00
	09100 EMERGENCY	713, 158		713, 158		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0			92. 00
404 :	OTHER REIMBURSABLE COST CENTERS		-1			404
101.00	10100 HOME HEALTH AGENCY	13, 959	0	13, 959		101.00
	SPECIAL PURPOSE COST CENTERS	15, 888, 498	ما	1E 000 400		110 00
110 0		15 888 498	0	15, 888, 498		118. 00
118.00		13, 000, 470				
	NONREI MBURSABLE COST CENTERS		n	29 183		190 00
190. 00		29, 183	0	29, 183 0		190. 00 191. 00
190. 00 191. 00	NONREIMBURSABLE COST CENTERS D 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	29, 183				190. 00 191. 00 192. 00

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CC	CN: 15-0002	Peri od:	Worksheet B
				From 01/01/2023 To 12/31/2023	Part II Date/Time Prepared:
				10 12/31/2023	5/29/2024 9: 08 am
Cost Center Description	Subtotal	Intern &	Total		
		Resi dents			
		Cost & Post			
		Stepdown			
		Adjustments			
	24. 00	25. 00	26.00		
192. 01 19201 OTHER NON-REIMBURSABLE	57, 313	0	57, 3	13	192. 01
192.02 19202 FAMILY HEALTH/GARY COMM HEALTH	146, 045	0	146, 04	15	192. 02
193.00 19300 NONPALD WORKERS	0	0		0	193. 00
200.00 Cross Foot Adjustments	139, 395	0	139, 39	95	200. 00
201.00 Negative Cost Centers	0	o		0	201.00
202.00 TOTAL (sum lines 118 through 201)	16, 784, 135	o	16, 784, 13	35	202. 00

5.01 0.0560 DATA PROCESSING 9,190 4,399,684 100 5,00 5,00 0.0560 DICHCHASING RECEIVING AND STORES 7,332 1,784,756,455 0 40,197,529 5,00 0.0560 DICHCHASING RECEIVING AND STORES 9,177 4,576,465 0 66,403 1,754,756,267 5,00 0.0560 DICHCHASING RECEIVING AND STORES 99,579 9,127,755 100 24,604 0 5,00 0.0560 DICHCHASING RECEIVING AND STORES 99,579 9,127,755 100 24,604 0 5,00 0.0560 DICHCHASING RECEIVING AND STORES 1,784,756,267 5,00 0 10,700 DICHCHASING AND STORES 1,784,756,267 5,00 0 10,700 DICHCHASING AND STORES 1,784,756,267 5,00 0 10,700 DICHAGING AND STORES 1,784,756,267 5,00 0 10,700 DICHAGING AND STORES 1,784,756,267 5,00 0 10,700 DICHAGING AND STORES 1,784,756,267 1,784,756,278 1,784,756		ALLOCATION - STATISTICAL BASIS	WETHODIST HOSE	Provi der Co	CN: 15-0002 F	Peri od:	Worksheet B-1	
COST Center Description					F	rom 01/01/2023	Date/Time Dre	nared:
Could Centler Description						0 12/31/2023	5/29/2024 9:0	8 am
ADDITION COUNTY								
COUNTY C		Cost Contor Doscription		EMDI OVEE	DATA	DIIDCHASI NG	ADMLTTI NG	
BURNATHENT CORREST TURE STOKES CHANGES CHANG		cost center bescription						
CARREAGE SERVICE COST CENTERS 1.00			(SQUARE TEET)					
DEBERAL SERVICE COST CENTERS 1.410.133					7	(PURCHASE		
CARRIENT SERVICE COST CENTERS 1,410,133					,			
0.000 0.000 CAP REL COSTS-BLIDG & FIXT		OFFICE OFFICE COOK OFFICE CO	1. 00	4. 00	5. 01	5. 02	5. 03	
4.00 GODD IMPLICATE REMAIN ITS DEPARTMENT 5, 506 160, 1877, 277 5	1 00		1 /10 133					1 1 00
5.01 DOSSODIATA PROCESSING 9,190 4,389,684 100 49,197,529 5.0 5.0 20050 PRIMASING RECEIVING AND STORES 7,332 1,178,154 0 49,197,529 5.0				160 827 227				4.00
0.0000 DOSCO PURCHASIN REFICE VINES AND STORES 7,333 1,178,154 0 49,197,279 5.00 0.0000 0.0001 7,54,756,267 5.00 0.0000 0.0001					100			5. 01
5.04 0.0560 CASH JENN RAYACCOUNTS RECEIVABLE 90.646 2, 453, 013 0 8, 340 0 5.0 0.0592 PATHENT INFORMATION 99.579 15.0 0.0542 PATHENT STATE PATH 1	5.02	00560 PURCHASING RECEIVING AND STORES	1			49, 197, 529		5.02
5.06 0.0590 OTHER ARG 99.579 9.127.755 100 24.644 0 5.06 0.0590 OTHER ARG 0 0.000 OTHER ARG 0 0.000 0.000 OTHER ARG 0 0.000 0.000 OTHER ARG 0 0.0000 0.000 0.000 0.000 0.000 0.0000 0.0000 0.0000 0.0000			1					
0.0599 ATT FIRT TRANSPORTATION 0 554, 684 0 9-60 0 5 0 5 0 0 0 0 0						-,	-	
7.00 00700 DERATION OF PLANT 299, 329 5,278,777 0 484,733 0 7.0			1				-	
8.00 00800 AUNIDRY & LINEN SERVICE 17, 825							0	7.00
10.00 01000 DETARY 18 B48					d		0	1
11.00 0 1100 (CAFETRIA 13,177 1,625,037 0 1,100 0 11.0 14.00 0 1400 (CHITRAL SERVICES & SUPPLY 35,843 776,128 0 57,841 0 14.0 15.00 0 1500 (MEDI CAL, RECORDS & LIBRARY 11,307 2,281,642 0 7,180 0 16.0 17.00 0 1700 (STAFF EDUCATION 1,620 1,620 1,620 1,620 1,620 1,620 1,620 17.00 0 1700 (STAFF EDUCATION 1,620	9.00	00900 HOUSEKEEPI NG	20, 635	4, 694, 253	C	416, 021	0	9.00
13.00 01300 MURSING ADMINISTRATION 6, 350 6, 150, 671 0 36, 761 0 13.0							-	
14.00 01400 (ENTRAL SERVICES & SUPPLY 35, 843 776, 128 0 577, 841 0 14.00 16.00 16.00 01600 MEDICAL RECORDS & LIBRARY 11, 307 2, 281, 642 0 7, 180 0 16.00 0 0 0 0 0 17.00 17.						, , , ,	0	
15.00 01500 PHARMACY 18, 957 0 0 202,192 0 15.0							0	
16.00 01600 MEDICAL RECORDS & LIBRARY 11, 307 2, 281, 642 0 7, 180 0 10, 0 17, 17, 00 1700 0700 SITAFF EDUCATION 11, 147 0 0 0 0 0 17, 0 1700 1700 0700 MEDICAL RECORDS & LIBRARY 11, 147 0 0 0 0 0 0 17, 0 1700 1700 1700 0700 0 0 0 0 0 0 0							0	15. 00
17.00 01700 SOCI AL SERVICE			1	_			0	16.00
17.00 01700 MEDICAL EDUCATION 374 157, 499 0 8, 224 0 17.00 22.00 02000 18R SERVICES-SALARY & FRINGES APPRVD 4, 467 0 0 0 0 0 0 27.00 22.00 20200 18R SERVICES-OTHER PROGRAM 3,364 999,064 0 4, 873 0 0.20 27.00						, , ,	0	17. 00
21.00	17. 01	01701 STAFF EDUCATION	11, 147	0	C		0	17. 01
22.00 02200 RAR SERVI CES-OTHER PROM COSTS APPRVID 4, 467 9, 0 0 0 0 0 22.0			1	157, 499	1		0	17. 02
23.00 02300 PARAMED ED PROGRAM 3, 364 999, 064 0 4,873 0, 25.0			-	0			-	
INPATI ENT ROUTI NE SERVICE COST CENTERS 310.00 03000 DULTS & PEDIATRIC S\$ 313. 217 24, 160, 579 0 2, 339, 643 111, 660, 931 331. 01 03100 INTERSI VE CARE UNIT 19, 864 6, 788, 481 0 822, 892 21, 952, 331 31. 01 03101 INTERSI VE CARE UNIT 19, 864 6, 788, 481 0 822, 892 21, 952, 331 31. 01 03101 INTERSI VE CARE UNIT 19, 864 6, 788, 481 0 822, 892 21, 952, 331 31. 01 03101 INTERSI VE CARE UNIT 19, 864 6, 788, 481 0 822, 892 21, 952, 331 31. 01 031			1	000.044			-	
30. 00 30000 ADULTS & PEDI ATRICS 313, 217 24, 160, 579 0 2, 339, 643 111, 660, 931 30, 031 10 3010 NITENSIVE CARE UNIT 19, 804 6, 788, 481 0 822, 892 21, 952, 331 30, 031 10 3010 NEONATAL I CU 2, 258 1, 727, 433 0 12, 895 5, 616, 128 31, 340 31, 00 3100 SUBPROVI DER - IPF 3, 972 968, 593 0 168 2, 719, 524 40, 00 4000 SUBPROVI DER - IPF 31, 244 1, 630, 836 0 67, 772 4, 035, 526 41, 00 430, 00 4300 MURSERY 24, 424 1, 272, 097 0 155, 707 2, 297, 605 41, 00 430, 00 4300 MURSERY 24, 424 1, 272, 097 0 155, 707 2, 297, 605 41, 00 430, 00 4300 OBERDATION 19, 209, 504 50, 00 5000 OPERATINE ROOM 59, 647 5, 550, 987 0 646, 973 198, 209, 545 50, 00 5000 OPERATINE ROOM 14, 546 1, 190, 694 0 130, 540	23.00		3, 304	999, 064		4,873	0	23.00
31.00 03100 INTERSIVE CARE UNIT	30.00		313, 217	24, 160, 579	C	2, 339, 643	111, 660, 931	30.00
40. 00 04000 SUBPROVI DER - I IPF 3. 972 968, 593 0 168 2. 719, 542 40. 00 410. 00 410. 00 5100 SUBPROVI DER - I IPF 31. 243 1, 530, 836 0 67, 772 4. 035, 526 41. 04. 00 410. 00 5100 SUBPROVI DER - I IPF 24. 424 1, 272, 997 0 155, 707 2. 297, 605 43. 00 430.			1		i e			1
11.00 04100 SUBPROVI DER - I IFF 31, 243 1, 630, 836 0 67, 772 4, 035, 526 41.0	31. 01	03101 NEONATAL I CU		1, 727, 433	C	12, 895		
A3. 00 O4300 NURSERY C O57 CENTERS								1
ANCILLARY SERVICE COST CENTERS Sp. 00 Common Sp. 647 Sp. 750, 987 O Common Sp. 648 Sp. 996, 506 Sp. 00			1					
50.00 0500	43.00		24, 424	1, 272, 097		155, 707	2, 297, 605	43.00
SOOI	50.00		59, 647	5. 750. 987	C	646, 973	198, 209, 654	50.00
S200 DELIVERY ROOM & LABOR ROOM 7, 03 3, 929, 036 0 176, 620 6, 722, 192 52, 52 0 0 0 0 0 0 0 0 0			1					
S3.00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 0 0			14, 546					
54. 01 05400 RADI OLOGY - DI LARSOUND 5. 054 1, 408, 037 0 93, 578 25, 053, 114 54. 050 0500 RADI OLOGY - ULTRASOUND 5. 054 1, 408, 037 0 93, 578 25, 053, 114 54. 050 0500 RADI OLOGY - LOTRASOUND 5. 054 1, 408, 037 0 161, 048 28, 977, 173 55. 055. 01 05501 INFUSI ON CENTER 5. 094 713, 287 0 187, 238 17, 592, 973 55. 050 0500 RADIOLOGY-THERAPEUTIC 8. 391 470, 790 0 16, 618 28, 977, 173 55. 05. 01 05501 INFUSI ON CENTER 5. 094 713, 287 0 187, 238 17, 592, 973 55. 050 0500 RADIOLOGY-THERAPEUTIC 8. 391 470, 790 0 180, 488, 466 22, 249, 155 56. 050 0500 RADIOLOGY-THERAPEUTIC 8. 31, 342, 996 0 296, 706 169, 872, 853 57. 050 0500 MAGNETI C RESONANCE I MAGING (MRI) 4, 205 496, 698 0 71, 133 34, 814, 997 58. 059, 00 05900 CARDI AC CATHETERI ZATI ON 8. 393 2, 598, 103 0 881, 158 87, 428, 837 59. 00 05900 CARDI AC CATHETERI ZATI ON 8. 393 2, 598, 103 0 881, 158 87, 428, 837 59. 00 05900 CARDI AC CATHETERI ZATI ON 8. 393 2, 598, 103 0 881, 158 87, 428, 837 59. 00 05900 CARDI AC CATHETERI ZATI ON 8. 393 2, 598, 103 0 881, 158 87, 428, 837 59. 00 05900 CARDI AC CATHETERI ZATI ON 8. 393 2, 598, 103 0 881, 158 87, 428, 837 59. 00 05900 CARDI AC CATHETERI ZATI ON 8. 393 2, 598, 103 0 881, 158 87, 428, 837 59. 00 05900 CARDI AC CATHETERI ZATI ON 8. 393 2, 598, 103 0 881, 158 87, 428, 837 59. 00 05900 CARDI AC CATHETERI ZATI ON 8. 393 2, 598, 103 0 881, 158 87, 428, 837 59. 00 05900 CARDI AC CATHETERI ZATI ON 8. 393 2, 598, 103 0 881, 158 87, 428, 837 59. 00 05900 CARDI AC CATHETERI ZATI ON 8. 393 2, 598, 103 0 881, 158 87, 428, 837 59. 00 05900 CARDI AC CATHETERI ZATI ON 8. 393 2, 598, 103 0 881, 158 87, 428, 837 59. 00 05900 CARDI AC CATHETERI ZATI ON 100 00000 CARDI AC CATHETERI ZATI ON 8. 393 2, 598, 103 0 881, 158 87, 428, 837 59. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		05200 DELIVERY ROOM & LABOR ROOM	7, 003	3, 929, 036				
Section Sect			0	0 052 000				
55.00 05500 RADI OLOGY-THERAPEUTI C 8, 391 470, 790 0 16, 618 28, 977, 173 55.00								1
55.01 05501 INFUSI ON CENTER 5,094 713,287 0 187,238 17,592,973 55.0 56.00 05500 RADIOI SOTOPE 9,043 755,241 0 888,466 22,249,155 56.0 57.00 05700 CT SCAN 8,563 1,342,996 0 296,706 169,872,853 57.0 58.00 05800 MAGNETI C RESONANCE IMAGING (MRI) 4,205 496,698 0 71,133 34,814,997 58.0 59.00 05900 CARDIAC CATHETERIZATI ON 8,393 2,598,103 0 881,158 87,428,837 59.0 60.00 06000 LABDRATORY 23,518 4,424,960 0 5,505,519 238,657,576 60.0 62.00 06000 LABDRATORY 23,518 4,424,960 0 5,505,519 238,657,576 60.0 64.00 04000 INTRAVENOUS THERAPY 0 0 0 0 0 65.00 06500 RESPIRATORY THERAPY 7,766 2,606,302 0 928,261 54,544,456 65.0 66.00 06600 RESPIRATORY THERAPY 12,270 1,713,905 0 13,807 15,605,528 66.00 06600 CADDRATIONAL THERAPY 10,545 1120,554 0 10,935 7,424,674 67.0 67.00 05700 05700 05700 05700 05700 05700 05700 69.00 06900 ELECTROCARDIOLOGY 0 838,421 0 21,615 32,626,784 69.01 06901 CARDIAC REHAB 0 466,181 0 6,136 1,901,575 69.0 69.01 06901 CARDIAC REHAB 0 466,181 0 6,136 1,901,575 71.00 0700 ELECTROCARDIOLOGY 0 15,183,405 46,223,757 71.00 0700 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 14,331,609 43,272,141 72.0 72.00 0700 ELECTROENCEPHALOGRAPHY 0 1,276,080 0 96,781 45,787,304 70.0 74.00 07400 RENAS CHARGED TO PATIENTS 0 0 0 14,331,609 43,272,141 72.0 74.00 07400 RENES CHARGED TO PATIENTS 0 0 0 2,460,330 131,133,709 74.00 07400 RENES CHARGED TO PATIENTS 0 0 0 2,460,330 131,133,709 74.00 07400 RENES CHARGED TO PATIENTS 0 0 0 55,894 3,611,718 74.00 07400 RENES CHARGED TO PATIENTS 0 0 0 55,894 3,611,718 74.00 07400 RENES RESPIRATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0								
56. 00 05600 RADIO I SOTOPE 9, 0.43 755, 241 0 888, 466 22, 249, 155 56. 00 05700 CT SCAN 8, 563 1, 342, 996 0 296, 706 169, 872, 853 57. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 4, 205 496, 698 0 71, 133 34, 814, 997 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 4, 205 496, 698 0 71, 133 34, 814, 997 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 4, 205 496, 698 0 71, 133 34, 814, 997 58. 00 05900 CARDI AC CATHETERI ZATI ON 8, 393 2, 598, 103 0 881, 158 87, 428, 837 59. 00 00000 LABORATORY 23, 518 4, 424, 960 0 5, 505, 519 238, 657, 576 60. 00 60. 00 0 0 0 0 0 0 0 0								
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 4, 205 496, 698 0 71, 133 34, 814, 997 58. 0 59. 00 05900 CARDIAC CATHETERI ZATION 8, 393 2, 598, 103 0 881, 158 87, 428, 837 59. 0 60. 00 06000 LABORATORY 23, 518 4, 424, 960 0 5, 505, 519 238, 657, 576 60. 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 385 1, 225, 454 0 246, 611 27, 965, 735 62. 0 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 7, 766 2, 606, 302 0 928, 261 54, 544, 456 65. 0 65. 00 06500 RESPI RATORY THERAPY 12, 270 1, 713, 905 0 13, 807 15, 605, 528 66. 00 06600 PHYSI CAL THERAPY 10, 545 1, 120, 554 0 10, 935 7, 424, 674 67. 00 06700 0CCUPATI ONAL THERAPY 10, 545 1, 120, 554 0 10, 935 7, 424, 674 68. 00 06800 SPEEC PATHOLOGY 1, 796 485, 239 0 7, 855 3, 007, 899 69. 00 06900 ELECTROCARDI OLOGY 0 838, 421 0 21, 615 32, 626, 784 69. 01 06901 CARDIAC REHAB 0 466, 181 0 6, 136 1, 901, 575 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 15, 183, 405 46, 223, 757 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 15, 183, 405 46, 223, 757 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 15, 183, 405 46, 223, 757 71. 00 07300 PRUSC CHARGED TO PATI ENTS 0 0 0 14, 331, 609 43, 272, 141 72. 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 29, 606 11, 669, 578 74. 00 07400 RENAL DI ALYSIS 0 0 71, 926 13, 364, 701 90. 0 75. 00 07300 DRUSC CHARGED TO PATI ENTS 0 0 0 0 0 0 29, 606 11, 669, 578 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 55, 894 3, 611, 718 74. 00 09100 DREREGENCY 0 2, 092, 822 0 55, 894 3, 611, 718 74. 00 09100 DREREGENCY 0 2, 092, 822 0 55, 894 3, 611, 718 74. 00 09100 DREREGENCY 0 0 0 0 0 0 0 0	56.00	05600 RADI 0I SOTOPE		755, 241	C			
59. 00 05900 CARDI AC CATHETERI ZATI ON 8, 393 2, 598, 103 0 881, 158 87, 428, 837 59. 00 06000 LABORATORY 23, 518 4, 424, 960 0 5, 505, 519 238, 657, 576 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 385 1, 225, 454 0 246, 611 27, 965, 735 62. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 0 0			8, 563	1, 342, 996				
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66. 00 06600 PHYSICAL THERAPY 12, 270 1, 713, 905 0 13, 807 15, 605, 528 66. 06. 06. 00 06600 OCCUPATIONAL THERAPY 10, 545 1, 120, 554 0 10, 935 7, 424, 674 67. 06. 00 06800 SPEECH PATHOLOGY 1, 796 485, 239 0 7, 855 32, 007, 899 68. 06. 00 06900 ELECTROCARDI OLOGY 0 838, 421 0 21, 615 32, 626, 784 69. 00 06901 CARDI AC REHAB 0 466, 181 0 6, 136 1, 901, 575 69. 00 07000 ELECTROENCEPHALOGRAPHY 0 1, 276, 080 0 96, 781 45, 787, 304 70. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 15, 183, 405 46, 223, 757 71. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 144, 331, 609 43, 272, 141 72. 00 07300 DRUGS CHARGED TO PATIENTS 1, 662 448, 590 0 629, 269 261, 382, 357 73. 00 07400 RENAL DI ALYSI S 4, 383 0 0 0 0 20, 606 11, 669, 578 74. 00 07400 RENAL DI ALYSI S 4, 383 0 0 0 0 20, 606 11, 669, 578 74. 00 09100 EMERGENCY 27, 063 8, 785, 753 0 2, 460, 330 131, 133, 709 91. 00 09000 CLINIC 76, 181 2, 548, 812 0 71, 926 13, 364, 701 90. 09100 EMERGENCY 27, 063 8, 785, 753 0 2, 460, 330 131, 133, 709 91. 00 09000 CLINIC 76, 181 2, 548, 812 0 71, 926 13, 364, 701 90. 09100 EMERGENCY 27, 063 8, 785, 753 0 2, 460, 330 131, 133, 709 91. 00 09000 CLINIC 76, 181 2, 548, 812 0 546, 330 131, 133, 709 91. 00 09000 CLINIC 76, 181 2, 548, 812 0 546, 330 131, 133, 709 91. 00 09000 CLINIC 76, 181 2, 548, 812 0 546, 330 131, 133, 709 91. 00 09000 CLINIC 77, 926 13, 364, 701 90. 09100 EMERGENCY 90. 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 09200 OBSERVA			-	2, 606, 302				
68.00 06800 SPECH PATHOLOGY 1,796 485,239 0 7,855 3,007,899 68.00 69.00 06900 ELECTROCARDI OLOGY 0 838,421 0 21,615 32,626,784 69.00 69.01 06901 CARDI AC REHAB 0 466,181 0 6,136 1,901,575 69.00 71,000 70,000 ELECTROENCEPHALOGRAPHY 0 1,276,080 0 96,781 45,787,304 70.00 70,000 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 15,183,405 46,223,757 71.00 71.00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 14,331,609 43,272,141 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1,662 448,590 0 629,269 261,382,357 73.00 73.00 07400 RENAL DI ALYSIS 4,383 0 0 20,606 11,669,578 74.00 0000 CLI NI C 76,181 2,548,812 0 71,926 13,364,701 90.00 91.00 EMERGENCY 27,063 8,785,753 0 2,460,330 131,133,709 91.00 91.00 09200 DSERVATI ON BEDS (NON-DI STI NCT PART) 92.00 09200 DSERVATI ON BEDS (NON-DI STI NCT PART) 0 2,092,822 0 55,894 3,611,718 101.00 101.00 HMEALTH AGENCY 0 2,092,822 0 55,894 3,611,718 101.00 SPECIAL PURPOSE COST CENTERS	66.00	06600 PHYSI CAL THERAPY	1				15, 605, 528	66.00
69. 00			1					
69. 01 06901 CARDI AC REHAB 0 466, 181 0 6, 136 1, 901, 575 69. 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 1, 276, 080 0 96, 781 45, 787, 304 70. 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 15, 183, 405 46, 223, 757 71. 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 14, 331, 609 43, 272, 141 72. 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 1, 662 448, 590 0 629, 269 261, 382, 357 73. 0 74. 00 07400 RENAL DI ALYSIS 4, 383 0 0 0 20, 606 11, 669, 578 74. 0 00TPATIENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 76, 181 2, 548, 812 0 71, 926 13, 364, 701 90. 0 91. 00 09100 EMERGENCY 27, 063 8, 785, 753 0 2, 460, 330 131, 133, 709 91. 0 92. 00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART) 0THER REI MBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 0 2,092, 822 0 55, 894 3, 611, 718 101. 0 SPECI AL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 1, 369, 167 134, 054, 806 100 48, 758, 375 1, 754, 756, 267 118. 0			1, 796	•		,		1
70. 00			0					
71. 00		l i						
72. 00		1 1	1					
73. 00			o	0		.,		
OUTPATIENT SERVICE COST CENTERS OUTP	73.00	07300 DRUGS CHARGED TO PATIENTS	1, 662	448, 590	C	629, 269	261, 382, 357	73.00
90. 00	74.00		4, 383	0	C	20, 606	11, 669, 578	74.00
91. 00	00.00		7/ 101	2 540 012		71 00/	12 2/4 701	00.00
92. 00								1
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 2, 092, 822 0 55, 894 3, 611, 718 101.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1, 369, 167 134, 054, 806 100 48, 758, 375 1, 754, 756, 267 118.00 NONREI MBURSABLE COST CENTERS 118.00 NONREI			27,003	0, 700, 703		2,400,330	131, 133, 709	91.00
101.00 10100 HOME HEALTH AGENCY 0 2, 092, 822 0 55, 894 3, 611, 718 101.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 1, 369, 167 134, 054, 806 100 48, 758, 375 1, 754, 756, 267 118.00 NONREI MBURSABLE COST CENTERS	, 2. 00							1 .2.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1,369,167 134,054,806 100 48,758,375 1,754,756,267 118.0 NONREI MBURSABLE COST CENTERS	101.00		0	2, 092, 822	C	55, 894	3, 611, 718]101. 00
NONREI MBURSABLE COST CENTERS								1
	118.00		1, 369, 167	134, 054, 806	100	48, 758, 375	1, 754, 756, 267	J118. 00
170. UQ 1700UQ GTTT, TEUWEN, COTTEE SHOF & CANTEEN 1,001 UQ	100 00		1 001	^			^	100 00
	190.00	PITTOOO OITT, ILOWER, COFFEE SHUP & CANTEEN	1, 801	0	1	<u>'l</u> U		1170.00

Health Financial Systems	METHODIST HOSPI	ITALS, INC	In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0002	Peri od: From 01/01/2023 To 12/31/2023	Worksheet B-1 Date/Time Prepared: 5/29/2024 9:08 am
	CADLTAL			

				Т	o 12/31/2023	Date/Time Pre 5/29/2024 9:0	
		CAPI TAL					
		RELATED COSTS					
	Cost Center Description	BLDG & FIXT	EMPLOYEE	DATA	PURCHASI NG	ADMI TTI NG	
		(SQUARE FEET)	BENEFI TS	PROCESSI NG	RECEIVING AND	(GROSS	
			DEPARTMENT	(MACHI NE	STORES	CHARGES)	
			(GROSS	TIME)	(PURCHASE		
			SALARI ES)		REQUISITIONS)		
		1. 00	4. 00	5. 01	5. 02	5. 03	
	00 RESEARCH	0	0	0	0		191. 00
	200 PHYSICIANS' PRIVATE OFFICES	26, 711	26, 696, 654	0	439, 154		192. 00
	O1 OTHER NON-REIMBURSABLE	3, 457	0	0	0		192. 01
	02 FAMILY HEALTH/GARY COMM HEALTH	8, 997	75, 767	0	0		192. 02
	OO 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)	16, 784, 135	29, 155, 702	14, 435, 890	3, 389, 908	6, 555, 262	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	11. 902519	0. 181286	144, 358. 90000 0	0. 068904	0. 003736	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)		70, 296	111, 302	87, 784	117, 765	204.00
205. 00	Unit cost multiplier (Wkst. B, Part		0. 000437	1, 113. 020000	0. 001784	0. 000067	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 B		u of Form CMS-2	
COST A	ALLOCATION - STATISTICAL BASIS		Provi der CC	F	eriod: rom 01/01/2023 o 12/31/2023		pared:
	Cost Center Description	CASHI ERI NG/AC F	Reconciliatio	OTHER A&G	PATI ENT	5/29/2024 9: 0 OPERATION OF	8 am
		COUNTS	n	(ACCUM. COST)	TRANSPORTATIO	PLANT	
		RECEI VABLE (GROSS			N (NUMBER OF	(SQUARE FEET)	
		CHARGES)			TRI PS)		
	January 1	5. 04	5A. 05	5. 05	5. 06	7. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00550 DATA PROCESSING						5. 01
5. 02	00560 PURCHASING RECEIVING AND STORES						5.02
5. 03 5. 04	00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	1, 754, 756, 267					5. 03 5. 04
5. 05	00590 OTHER A&G	1, 754, 750, 207	-36, 982, 919	344, 177, 706			5.05
5.06	00592 PATIENT TRANSPORTATION	0	0	704, 087			5.06
7.00	00700 OPERATION OF PLANT	0	0	25, 459, 299		948, 434	7.00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	0	1, 598, 589 6, 946, 410		17, 825 20, 635	8. 00 9. 00
10.00	01000 DI ETARY	0	0	5, 563, 639		18, 848	10.00
11. 00	01100 CAFETERI A	0	0	2, 261, 572		13, 177	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0	8, 082, 274		6, 350	13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	0	0	3, 219, 090 6, 299, 059		35, 843 18, 957	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	3, 588, 174		11, 307	
17. 00	01700 SOCI AL SERVI CE	0	0	574, 435		1, 629	17.00
17. 01	01701 STAFF EDUCATION	0	0	132, 677		11, 147	17.01
17. 02 21. 00	01702 MEDICAL EDUCATION 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	237, 188 297, 137		374 0	17. 02 21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	84, 337		4, 467	22.00
23. 00	02300 PARAMED ED PROGRAM	0	0	1, 078, 051		3, 364	23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	111 ((0.021	0	40 242 7/2	0.044	212 217	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	111, 660, 931 21, 952, 331	0	48, 343, 762 10, 246, 751		313, 217 19, 864	30. 00 31. 00
31. 01	03101 NEONATAL I CU	5, 616, 128	Ö	2, 344, 446		2, 258	31.01
40. 00	04000 SUBPROVI DER - I PF	2, 719, 542	0	1, 291, 982		3, 972	40.00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	4, 035, 526 2, 297, 605	0	2, 655, 503 2, 103, 507		31, 243 24, 424	41. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	2, 247, 003	O _J	2, 103, 507	'	24, 424	43.00
50.00	05000 OPERATING ROOM	198, 209, 654	0	13, 784, 496		59, 647	50.00
50. 01	05001 ENDOSCOPY	9, 905, 306	0	1, 213, 975		14 546	50.01
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	13, 484, 448 6, 722, 192	0	1, 972, 477 5, 420, 106		14, 546 7, 003	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	0	Ö	0, 120, 100		0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	53, 984, 010	0	7, 204, 877		53, 059	54.00
54. 01 55. 00	05401 RADI OLOGY - ULTRASOUND 05500 RADI OLOGY-THERAPEUTI C	25, 053, 114 28, 977, 173	0	2, 657, 896 2, 655, 304		5, 054 8, 391	54. 01 55. 00
55. 00	05501 I NFUSI ON CENTER	17, 592, 973	0	1, 472, 477		5, 094	
	05600 RADI OI SOTOPE	22, 249, 155	0	2, 487, 119		·	56.00
57.00	05700 CT SCAN	169, 872, 853	0	4, 163, 553			57.00
58. 00 59. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	34, 814, 997 87, 428, 837	0	1, 458, 049 5, 580, 808		4, 205 8, 393	58. 00 59. 00
60. 00	06000 LABORATORY	238, 657, 576	0	17, 730, 661		23, 518	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	27, 965, 735	0	2, 019, 660	0	385	62.00
64.00	06400 NTRAVENOUS THERAPY	0	0	5 003 5(0	-	0	64.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	54, 544, 456 15, 605, 528	0	5, 983, 568 2, 542, 102		7, 766 12, 270	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	7, 424, 674	Ö	1, 604, 890		10, 545	
68. 00	06800 SPEECH PATHOLOGY	3, 007, 899	0	665, 880		1, 796	68. 00
69. 00 69. 01	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	32, 626, 784 1, 901, 575	0	1, 407, 557 754, 851		0	69. 00 69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	45, 787, 304	0	2, 248, 373		0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	46, 223, 757	0	16, 594, 257		0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	43, 272, 141	0	15, 660, 488		0	72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	261, 382, 357 11, 669, 578	0	44, 728, 997 2, 482, 429		1, 662 4, 383	73. 00 74. 00
74.00	OUTPATIENT SERVICE COST CENTERS	11,009,570	U	2, 402, 429	I I	4, 303	74.00
90.00	09000 CLI NI C	13, 364, 701	0	5, 442, 656	9	76, 181	90.00
91.00	09100 EMERGENCY	131, 133, 709	0	18, 390, 731	421	27, 063	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
101.00	10100 HOME HEALTH AGENCY	3, 611, 718	0	2, 833, 901	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
118. 00		1, 754, 756, 267	-36, 982, 919	324, 274, 107	29, 218	907, 468	118. 00
190. ດເ	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	24, 402	0	1. 801	190. 00
191.00	19100 RESEARCH	0	0	O	0	0	191. 00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	19, 314, 454	0	26, 711	192. 00

Health Financial Systems	METHODIST HOS	SPITALS, INC		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C	CN: 15-0002	Peri od:	Worksheet B-1	
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre	pared:
					5/29/2024 9:0	8 am
Cost Center Description	CASHI ERI NG/AC	Reconciliatio	OTHER A&G	PATI ENT	OPERATION OF	
	COUNTS	n	(ACCUM. COS			
	DECELVABLE			NI	(COLLADE EEET)	

						5/29/2024 9:0	8 am
	Cost Center Description	CASHI ERI NG/AC	Reconciliatio	OTHER A&G	PATI ENT	OPERATION OF	
		COUNTS	n	(ACCUM. COST)	TRANSPORTATI 0	PLANT	
		RECEI VABLE			N	(SQUARE FEET)	
		(GROSS			(NUMBER OF		
		CHARGES)			TRI PS)		
		5. 04	5A. 05	5. 05	5. 06	7. 00	
192.01	19201 OTHER NON-REIMBURSABLE	0	0	389, 575	0	3, 457	192. 01
192. 02	19202 FAMILY HEALTH/GARY COMM HEALTH	0	0	175, 168	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, 288, 047		36, 982, 919	779, 743	28, 194, 977	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 004153		0. 107453	26. 687076	29. 727927	203. 00
204.00	Cost to be allocated (per Wkst. B,	365, 852		1, 300, 576	2, 905	3, 662, 152	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 000208		0.003779	0. 099425	3. 861262	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)						

	Financial Systems	METHODIST HOS				u of Form CMS-2	
COST A	ALLOCATION - STATISTICAL BASIS		Provi der C		eriod: rom 01/01/2023 o 12/31/2023	Worksheet B-1 Date/Time Pre 5/29/2024 9:0	pared:
	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (PRODUCTI VE HOURS)	NURSI NG ADMI NI STRATI O N	O diii
		LAUNDRY)				(DI RECT NURS.	
		8. 00	9.00	10.00	11. 00	HRS.) 13. 00	
	GENERAL SERVICE COST CENTERS	0.00	7.00	10.00	11.00	13.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
4. 00 5. 01 5. 02 5. 03 5. 04 5. 05	00400 EMPLOYEE BENEFITS DEPARTMENT 00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER A&G						4.00 5.01 5.02 5.03 5.04 5.05
5. 06 7. 00 8. 00	00592 PATIENT TRANSPORTATION 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	1, 689, 669	l .				5. 06 7. 00 8. 00
9.00	00900 HOUSEKEEPI NG	0					9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	0	18, 848 13, 177		2, 193, 914		10.00 11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	Ö	6, 350		96, 906	1, 277, 991	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 522			36, 682	0	14.00
15. 00 16. 00	01500 PHARMACY	0		0	0 83, 950	0	15. 00 16. 00
17. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE		,		03, 930	0	17.00
17. 01	01701 STAFF EDUCATION	0	, -	0	0	0	17. 01
17. 02	01702 MEDI CAL EDUCATI ON	0		0	0	0	17. 02
21. 00 22. 00	02100 &R SERVICES-SALARY & FRINGES APPRVD 02200 &R SERVICES-OTHER PRGM COSTS APPRVD	0		0	0	0	21. 00 22. 00
23. 00	02300 PARAMED ED PROGRAM	Ö			31, 937	31, 937	23.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	700 470	242 247	040.050	F.4.4 .007	544.007	00.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	789, 473 108, 706	1		544, 087 127, 588	544, 087 127, 588	30. 00 31. 00
31. 01	03101 NEONATAL I CU	0	1		34, 641	34, 641	31.01
40.00	04000 SUBPROVI DER - I PF	0	-,		21, 748	21, 748	40.00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	52, 411 20, 908	31, 243 24, 424		36, 211 22, 934	36, 211 22, 934	41. 00 43. 00
10.00	ANCILLARY SERVICE COST CENTERS	20,700	21, 121		22, 701	22,701	10.00
50.00	05000 OPERATING ROOM	176, 292		0	137, 531	137, 531	50.00
50. 01 51. 00	05001 ENDOSCOPY 05100 RECOVERY ROOM	19, 617 10, 904	l .	-	11, 977 22, 904	11, 977 22, 904	50. 01 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	46, 824		_	84, 030		52.00
53.00	05300 ANESTHESI OLOGY	0		0	0	0	53.00
54. 00 54. 01	O5400 RADI OLOGY-DI AGNOSTI C O5401 RADI OLOGY - ULTRASOUND	38, 743 18, 480		0	83, 947 32, 662	0	54. 00 54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	6, 246		0	11, 328	0	55.00
55. 01	05501 I NFUSI ON CENTER	0			21, 402	0	55. 01
	05600 RADI OI SOTOPE	12, 396			14, 589		56.00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	23, 328 9, 795			31, 665 14, 106	0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	40, 379			53, 488	0	59.00
60.00	06000 LABORATORY	0			121, 894	0	60.00
62. 00 64. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06400 INTRAVENOUS THERAPY		385	0	53, 941 0	0	62. 00 64. 00
65.00	06500 RESPI RATORY THERAPY	0	7, 766	0	61, 847	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	12, 270		37, 777	0	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	10, 545 1, 796		25, 371 10, 080	0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	3, 339	1	Ö	23, 684	0	69.00
69. 01	06901 CARDI AC REHAB	602	0	0	11, 966	0	69. 01
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17, 371	0	0	30, 628	0	70. 00 71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		Ö	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1, 662		9, 698	0	73. 00
74. 00	07400 RENAL DI ALYSI S	16, 481	4, 383	0	0	0	74.00
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	42, 593	76, 181	0	56, 956	8, 644	90.00
91.00	09100 EMERGENCY	233, 259			193, 759		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
101.00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	1, 689, 669	869, 008	263, 068	2, 193, 914	1, 277, 991	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1, 801	0	0		190. 00
	19100 RESEARCH	0	l .		0		191.00
192.00	19200 PHYSICIANS'PRIVATE OFFICES	0	26, 711	0	0	0	192. 00

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 01/01/2023

					o 12/31/2023	Date/Time Prepared: 5/29/2024 9:08 am	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
		LI NEN SERVI CE	(SQUARE FEET)		(PRODUCTI VE	ADMI NI STRATI O	
		(POUNDS OF		SERVED)	HOURS)	N	
		LAUNDRY)				(DI RECT NURS.	
						HRS.)	
		8. 00	9. 00	10.00	11. 00	13. 00	
	OTHER NON-REIMBURSABLE	0	3, 457	•	0		192. 01
192. 02 19202	FAMILY HEALTH/GARY COMM HEALTH	0	8, 997	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, 300, 262	8, 306, 259	6, 893, 826	3, 016, 590	9, 330, 718	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	1. 361368	9. 128018	26. 205491	1. 374981	7. 301083	203. 00
204.00	Cost to be allocated (per Wkst. B,	287, 030	354, 328	327, 832	222, 108	145, 681	204.00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 169874	0. 389383	1. 246187	0. 101238	0. 113992	205.00
	11)						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						
'				•	•		•

			FI To	rom 01/01/2023 b 12/31/2023	Date/Time Pre 5/29/2024 9:0	pared:	
	Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	STAFF EDUCATION (TIME SPENT)	O aiii
	CENEDAL SEDVICE COST CENTEDS	14. 00	15. 00	16. 00	17. 00	17. 01	
1. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER A&G 00592 PATIENT TRANSPORTATION 00700 OPERATION OF PLANT 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	29, 515, 014 0 0 0	41, 744, 096 0 0	1, 754, 756, 267 0	805		1. 00 4. 00 5. 01 5. 02 5. 03 5. 04 5. 05 5. 06 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00
17. 01	01701 STAFF EDUCATION 01702 MEDICAL EDUCATION 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PROGRAM	0 0 0 0	0 0 0 0	0 0 0 0	0 0 0 0	73, 404 5 0 0 26	17. 01 17. 02 21. 00 22. 00 23. 00
30. 00 31. 00 31. 01 40. 00 41. 00 43. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03101 NEONATAL I CU 04000 SUBPROVIDER - I PF 04100 SUBPROVIDER - I RF 04300 NURSERY ANCILLARY SERVICE COST CENTERS	0 0 0 0 0	0 0 0 0 0	111, 660, 931 21, 952, 331 5, 616, 128 2, 719, 542 4, 035, 526 2, 297, 605	735 0 0 0 0 45 0	19, 856 7, 060 1, 844 53 1, 328 527	30. 00 31. 00 31. 01 40. 00 41. 00 43. 00
71.00 72.00 73.00 74.00	05000 OPERATING ROOM 05001 ENDOSCOPY 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05200 ANESTHESIOLOGY 05400 RADIOLOGY-DIAGNOSTIC 05401 RADIOLOGY - ULTRASOUND 05500 RADIOLOGY - ULTRASOUND 05500 RADIOLOGY-THERAPEUTIC 05501 INFUSION CENTER 05600 RADIOLOSTOPE 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 06901 CARDIAC REHAB 07000 ELECTROCARDIOLOGY 06901 CARDIAC REHAB 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07400 RENAL DIALYSIS OUTPATIENT SERVICE COST CENTERS	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 1, 160, 220 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	198, 209, 654 9, 905, 306 13, 484, 448 6, 722, 192 0 53, 984, 010 25, 053, 114 28, 977, 173 17, 592, 973 22, 249, 155 169, 872, 853 34, 814, 997 87, 428, 837 238, 657, 576 27, 965, 735 0 54, 544, 456 15, 605, 528 7, 424, 674 3, 007, 899 32, 626, 784 1, 901, 575 45, 787, 304 46, 223, 757 43, 272, 141 261, 382, 357 11, 669, 578	0 0 0 0 0 0	10, 491 720 1, 827 5, 155 0 264 153 5 10 0 1, 969 20 2, 152 125 93 0 893 86 522 38 493 0 295 0 604 0	58. 00 59. 00 60. 00 62. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 71. 00 72. 00 73. 00 74. 00
	09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	0	13, 364, 701 131, 133, 709	0 25	258 14, 479	90. 00 91. 00 92. 00
101.00	10100 HOME HEALTH AGENCY	0	0	3, 611, 718	0	333	101. 00
118.00	NONREI MBURSABLE COST CENTERS	29, 515, 014	41, 565, 435	1, 754, 756, 267	805	71, 214	118. 00
191.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES	0 0 0	0 0 178, 661	0 0 0	0 0 0	0	190. 00 191. 00 192. 00

Health Fina	ncial Systems	METHODIST HOSE	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CO		eri od:	Worksheet B-1	
					rom 01/01/2023 o 12/31/2023	Date/Time Pre 5/29/2024 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.)	45.00	CHARGES)	47.00	47.04	
100 01 1000	OTHER MON RELABINGARIE	14. 00	15. 00	16.00	17. 00	17. 01	100.01
	OTHER NON-REI MBURSABLE	0	0	0	0		192. 01
•	FAMILY HEALTH/GARY COMM HEALTH	0	0	0	0		192. 02
•	NONPAI D WORKERS	U	0	0	0		193.00
200. 00	Cross Foot Adjustments						200.00
201. 00	Negative Cost Centers	F 040 044	7 740 504	4 500 500	/00 457		201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	5, 010, 214	7, 712, 504	4, 528, 508	699, 457	580, 061	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 169751	0. 184757	0. 002581	868. 890683	7. 902308	203. 00
204.00	Cost to be allocated (per Wkst. B,	595, 558	330, 381	205, 713	28, 689	180, 559	204.00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 020178	0. 007914	0. 000117	35. 638509	2. 459798	205. 00
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)						

Provi der CCN: 15-0002 COST ALLOCATION - STATISTICAL BASIS Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/29/2024 9:08 am INTERNS & RESIDENTS PARAMED ED MEDI CAL SERVI CES-SALA SERVI CES-0THE Cost Center Description **FDUCATION** RY & FRINGES R PRGM COSTS **PROGRAM** (ASSI GNED (ASSI GNED (ASSI GNED (ASSI GNED TIME) TIME) TIME) TIME) 17.02 21.00 22.00 23.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00550 DATA PROCESSING 5.01 5.01 00560 PURCHASING RECEIVING AND STORES 5.02 5.02 00570 ADMITTING 5.03 5.03 5.04 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.04 5.05 00590 OTHER A&G 5.05 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 17.00 01700 SOCIAL SERVICE 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 8, 904 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 0 03000 ADULTS & PEDIATRICS C 384 30.00 0 03100 INTENSIVE CARE UNIT 0 31.00 0 0 31.00 0 31 01 03101 NEONATAL ICU 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 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 384 50.00 50.01 05001 ENDOSCOPY 00000000000000000000000000 0 0 50.01 0 0 51.00 05100 RECOVERY ROOM 0 0 51 00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 384 52.00 53 00 05300 ANESTHESI OLOGY 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0 0 54.00 0 54.01 05401 RADI OLOGY - ULTRASOUND 0 0 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 55.00 55.01 05501 INFUSION CENTER 0 0 0 55.01 56.00 05600 RADI OI SOTOPE 0 0 0 56.00 57.00 05700 CT SCAN C 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 0 192 59.00 0 06000 LABORATORY 0 60.00 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 62.00 06400 I NTRAVENOUS THERAPY 0 64.00 0 0 64.00 06500 RESPIRATORY THERAPY 0 0 65.00 65.00 576 0 66.00 06600 PHYSI CAL THERAPY 0 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 67.00 06800 SPEECH PATHOLOGY 68.00 0 68.00 69 00 06900 ELECTROCARDI OLOGY 0 0 0 69 00 0 69.01 06901 CARDI AC REHAB C 0 69.01 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 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 90.00 09100 EMERGENCY 100 100 100 6, 984 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 8, 904 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 0 0 0 191. 00 19100 RESEARCH 0 0 0 0 191.00

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

				To	nom 01/01/2023 o 12/31/2023	Date/Time Pre 5/29/2024 9:0	
			INTERNS &	RESI DENTS			
	Cost Center Description	MEDI CAL		SERVI CES-0THE	PARAMED ED		
		EDUCATI ON	RY & FRINGES		PROGRAM		
		(ASSI GNED	(ASSI GNED	(ASSI GNED	(ASSI GNED		
	•	TIME) 17. 02	TIME) 21.00	TIME) 22.00	TI ME) 23. 00		
192 00 19	9200 PHYSICIANS' PRIVATE OFFICES	17.02	21.00	22.00	23.00		192.00
	9201 OTHER NON-REIMBURSABLE	0	0	0	0		192.01
	9202 FAMILY HEALTH/GARY COMM HEALTH	0	Ō	Ō	0		192. 02
193. 00 19	9300 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)	277, 247	329, 065	266, 969	1, 601, 896		202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	2, 772. 470000	3, 290. 650000	2, 669. 690000	179. 907457		203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	7, 034	1, 123	72, 475	65, 797		204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	70. 340000	11. 230000	724. 750000	7. 389600		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 Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0002	Period: Worksheet C From 01/01/2023 Part I
		To 12/31/2023 Date/Time Prepared:

			T	o 12/31/2023		pared:
		Title	XVIII	Hospi tal	PPS	o alli
		11110	XVIII	Costs	113	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
555 551151 55551 pt 51	(from Wkst.	Adj.	1014. 00010	Di sal I owance	1014. 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	78, 524, 304		78, 524, 304	0	78, 524, 304	30.00
31.00 03100 INTENSIVE CARE UNIT	13, 771, 115		13, 771, 115	0	13, 771, 115	31.00
31. 01 03101 NEONATAL CU	3, 013, 716		3, 013, 716	0	3, 013, 716	31.01
40. 00 04000 SUBPROVI DER - 1 PF	1, 884, 886		1, 884, 886	0	1, 884, 886	40.00
41. 00 04100 SUBPROVI DER - I RF	4, 879, 945		4, 879, 945	0	4, 879, 945	41.00
43. 00 04300 NURSERY	3, 516, 115		3, 516, 115	0	3, 516, 115	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	19, 680, 141		19, 680, 141	0	19, 680, 141	50.00
50. 01 05001 ENDOSCOPY	1, 525, 777		1, 525, 777	0	1, 525, 777	
51.00 05100 RECOVERY ROOM	3, 012, 426		3, 012, 426	0	3, 012, 426	
52.00 05200 DELIVERY ROOM & LABOR ROOM	7, 370, 549		7, 370, 549	0	7, 370, 549	
53. 00 05300 ANESTHESI OLOGY	0		0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	10, 398, 239		10, 398, 239	0	10, 398, 239	
54. 01 05401 RADI OLOGY - ULTRASOUND	3, 372, 633		3, 372, 633	0	3, 372, 633	
55. 00 05500 RADI OLOGY-THERAPEUTI C	3, 372, 939		3, 372, 939	0	3, 372, 939	1
55. 01 05501 I NFUSI ON CENTER	1, 903, 544		1, 903, 544	0	1, 903, 544	
56. 00 05600 RADI 01 SOTOPE	3, 244, 350		3, 244, 350	0	3, 244, 350	
57. 00 05700 CT SCAN	5, 658, 169		5, 658, 169	0	5, 658, 169	
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 953, 776		1, 953, 776		1, 953, 776	
59. 00 05900 CARDI AC CATHETERI ZATI ON	6, 941, 594		6, 941, 594	0	6, 941, 594	
60. 00 06000 LABORATORY	21, 548, 612		21, 548, 612	0	21, 548, 612	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 398, 721		2, 398, 721	0	2, 398, 721	
64. 00 06400 I NTRAVENOUS THERAPY	7 0/4 000		7 0/4 000	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	7, 264, 829	0		0	7, 264, 829	
66. 00 06600 PHYSI CAL THERAPY	3, 384, 922	0		0	3, 384, 922	
67. 00 06700 OCCUPATI ONAL THERAPY	2, 241, 535	· ·	2, 241, 535	0	2, 241, 535	
68. 00 06800 SPEECH PATHOLOGY	829, 139	0	,	0	829, 139	
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB	1, 687, 676		1, 687, 676	0	1, 687, 676	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	858, 143 2, 678, 771		858, 143 2, 678, 771	0	858, 143 2, 678, 771	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	21, 074, 073		21, 074, 073		21, 074, 073	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	19, 887, 744		19, 887, 744	0	19, 887, 744	
73. 00 07300 DRUGS CHARGED TO PATIENTS	57, 757, 195		57, 757, 195	0	57, 757, 195	1
74. 00 07400 RENAL DIALYSIS	2, 972, 062		2, 972, 062		2, 972, 062	
OUTPATIENT SERVICE COST CENTERS	2, 112, 002		2, 772, 002	<u> </u>	2, 772, 002	74.00
90. 00 09000 CLINIC	9, 223, 753		9, 223, 753	ol	9, 223, 753	90.00
91. 00 09100 EMERGENCY	25, 898, 445		25, 898, 445	0	25, 898, 445	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	11, 879, 976		11, 879, 976	J	11, 879, 976	
OTHER REIMBURSABLE COST CENTERS	11,017,710		11,077,770		11,077,770	72.00
101. 00 10100 HOME HEALTH AGENCY	3, 150, 365		3, 150, 365		3, 150, 365	101.00
200.00 Subtotal (see instructions)	368, 760, 179	0		o	368, 760, 179	
201.00 Less Observation Beds	11, 879, 976		11, 879, 976		11, 879, 976	
202.00 Total (see instructions)	356, 880, 203	0			356, 880, 203	
		•		-1		•

Date/Time Prepared: 12/31/2023 5/29/2024 9:08 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 87, 880, 095 87, 880, 095 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 21, 952, 331 21, 952, 331 31.00 03101 NEONATAL ICU 31.01 5, 616, 128 5, 616, 128 31.01 40.00 04000 SUBPROVI DER - I PF 2, 719, 542 2, 719, 542 40.00 04100 SUBPROVI DER - I RF 4, 035, 526 41.00 4, 035, 526 41.00 43.00 04300 NURSERY 2, 297, 605 2, 297, 605 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 72, 844, 794 0.000000 50.00 125, 364, 860 198, 209, 654 0.099290 50.00 05001 ENDOSCOPY 50.01 5, 367, 165 4, 538, 141 9, 905, 306 0.154036 0.000000 50.01 51.00 05100 RECOVERY ROOM 4, 223, 257 9, 261, 191 13, 484, 448 0.223400 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 3, 365, 530 3, 356, 662 6, 722, 192 1.096450 0.000000 52.00 05300 ANESTHESI OLOGY 53.00 0.000000 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 13, 728, 689 40, 255, 321 53, 984, 010 0.192617 0.000000 54.00 05401 RADI OLOGY - ULTRASOUND 19, 043, 706 25, 053, 114 54.01 6,009,408 0. 134619 0.000000 54.01 28, 070, 422 05500 RADI OLOGY-THERAPEUTI C 28, 977, 173 0.000000 55.00 906, 751 0.116400 55.00 05501 INFUSION CENTER 17, 592, 973 55.01 8.853 17, 584, 120 0.108199 0.000000 55 01 05600 RADI OI SOTOPE 5, 646, 607 16, 602, 548 22, 249, 155 0.145819 0.000000 56.00 56.00 60, 991, 099 57.00 05700 CT SCAN 108, 881, 754 169, 872, 853 0.033308 0.000000 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 21, 965, 323 34, 814, 997 12, 849, 674 58.00 0.056119 0.000000 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 50, 869, 319 36, 559, 518 87, 428, 837 0.079397 0.000000 59.00 60.00 06000 LABORATORY 96, 361, 045 142, 296, 531 238, 657, 576 0.090291 0.000000 60.00 15, 025, 570 27, 965, 735 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 12, 940, 165 0.085774 0.000000 62.00 62.00 06400 I NTRAVENOUS THERAPY 64.00 0 0.000000 0.000000 64.00 65.00 06500 RESPIRATORY THERAPY 51, 287, 462 3, 256, 994 54, 544, 456 0.133191 0.000000 65.00 06600 PHYSI CAL THERAPY 8, 276, 665 15, 605, 528 66.00 7, 328, 863 0. 216905 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 1, 757, 587 7. 424. 674 0.301903 0.000000 5, 667, 087 67.00 06800 SPEECH PATHOLOGY 437, 212 3,007,899 68.00 2, 570, 687 0.275654 0.000000 68.00 15, 980, 433 69.00 06900 ELECTROCARDI OLOGY 16, 646, 351 32, 626, 784 0.051727 0.000000 69.00 1, 901, 575 69.01 06901 CARDI AC REHAB 515, 991 1, 385, 584 0.451280 0.000000 69.01 15. 257. 987 70 00 07000 ELECTROENCEPHALOGRAPHY 30 529 317 45, 787, 304 0.058505 0.000000 70 00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENTS 26, 140, 994 0.000000 71.00 20, 082, 763 46, 223, 757 0.455914 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 24, 318, 034 18, 954, 107 43, 272, 141 0.459597 0.000000 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 91, 077, 808 170, 304, 549 261, 382, 357 0.220968 0.000000 73.00 74.00 07400 RENAL DIALYSIS 10, 6<u>55, 370</u> 1, 014, 208 0.000000 11, 669, 578 0.254685 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0. 690158 0.000000 57.352 13, 307, 349 13, 364, 701 90.00 91 00 09100 EMERGENCY 22 495 507 108, 638, 202 131, 133, 709 0. 197496 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 6, 160, 147 17, 620, 689 23, 780, 836 0.499561 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 1, 105 3, 610, 613 3, 611, 718 101.00 751, 076, 212 1, 003, 680, 055 1, 754, 756, 267 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00

751, 076, 212 1, 003, 680, 055 1, 754, 756, 267

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 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

			10 12/31/2023	5/29/2024 9:08 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
31. 01 03101 NEONATAL CU				31.0
40. 00 04000 SUBPROVI DER - 1 PF				40.00
41. 00 04100 SUBPROVI DER - 1 RF				41.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 099290			50.00
50. 01 05001 ENDOSCOPY	0. 154036			50.0
51.00 05100 RECOVERY ROOM	0. 223400			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1. 096450			52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 192617			54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	0. 134619			54.0
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 116400			55.0
55. 01 05501 I NFUSI ON CENTER	0. 108199			55.0
56. 00 05600 RADI 0I SOTOPE	0. 145819			56.0
57. 00 05700 CT SCAN	0. 033308			57.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 056119			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 079397			59.00
60. 00 06000 LABORATORY	0. 090291			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 085774			62.00
64. 00 06400 INTRAVENOUS THERAPY	0. 000000			64. 0
65. 00 06500 RESPIRATORY THERAPY	0. 133191			65. 0
66. 00 06600 PHYSI CAL THERAPY	0. 216905			66.0
67. 00 06700 OCCUPATI ONAL THERAPY	0. 301903			67. 0
68. 00 06800 SPEECH PATHOLOGY	0. 275654			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 051727			69. 00
69. 01 06901 CARDI AC REHAB	0. 451280			69. 0
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 058505			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 455914			71. 0
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 459597			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0, 220968			73. 0
74. 00 07400 RENAL DI ALYSI S	0. 254685			74. 0
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 690158			90.00
91. 00 09100 EMERGENCY	0. 197496			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 499561			92.00
OTHER REIMBURSABLE COST CENTERS	27 177001			,2.0
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
[10tal (300 1113th dot10113)	ı			1202.

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-1		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Peri od: From 01/01/2023		

					o 12/31/2023	Date/Time Pre 5/29/2024 9:0	pared:
			Ti tl	e XIX	Hospi tal	Cost	
			<u> </u>		Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	, , , , , , , , , , , , , , , , , , ,	(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col . 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
1.1	NPATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDIATRICS	78, 524, 304		78, 524, 304	0	78, 524, 304	30.00
	3100 INTENSIVE CARE UNIT	13, 771, 115		13, 771, 115		13, 771, 115	
	3101 NEONATAL I CU	3, 013, 716		3, 013, 716		3, 013, 716	1
	4000 SUBPROVI DER - I PF	1, 884, 886		1, 884, 886		1, 884, 886	1
	4100 SUBPROVI DER - I RF	4, 879, 945		4, 879, 945		4, 879, 945	
	4300 NURSERY	3, 516, 115		3, 516, 115		3, 516, 115	1
	NCILLARY SERVICE COST CENTERS	3,510,115		3, 510, 110	ol Ol	3, 510, 115	43.00
	5000 OPERATING ROOM	19, 680, 141		19, 680, 141	O	19, 680, 141	50.00
	5000 OPERATING ROOM 5001 ENDOSCOPY	1, 525, 777		1, 525, 777		1, 525, 777	
	5100 RECOVERY ROOM	1					1
	5200 DELIVERY ROOM & LABOR ROOM	3, 012, 426 7, 370, 549		3, 012, 426		3, 012, 426	
	5200 ANESTHESI OLOGY	7, 370, 549		7, 370, 549		7, 370, 549 0	
	•	10 200 220		`		-	53.00
	5400 RADI OLOGY-DI AGNOSTI C	10, 398, 239		10, 398, 239		10, 398, 239	
	5401 RADI OLOGY - ULTRASOUND	3, 372, 633		3, 372, 633		3, 372, 633	
	5500 RADI OLOGY-THERAPEUTI C	3, 372, 939		3, 372, 939		3, 372, 939	
	5501 I NFUSI ON CENTER	1, 903, 544		1, 903, 544		1, 903, 544	
	5600 RADI OI SOTOPE	3, 244, 350		3, 244, 350		3, 244, 350	
	5700 CT SCAN	5, 658, 169		5, 658, 169		5, 658, 169	
	5800 MAGNETIC RESONANCE IMAGING (MRI)	1, 953, 776		1, 953, 776		1, 953, 776	
	5900 CARDI AC CATHETERI ZATI ON	6, 941, 594		6, 941, 594		6, 941, 594	
	6000 LABORATORY	21, 548, 612		21, 548, 612		21, 548, 612	1
	6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 398, 721		2, 398, 721		2, 398, 721	1
	6400 INTRAVENOUS THERAPY	0		(1	0	
	6500 RESPI RATORY THERAPY	7, 264, 829	0			7, 264, 829	
	6600 PHYSI CAL THERAPY	3, 384, 922	0	3, 384, 922		3, 384, 922	
	6700 OCCUPATI ONAL THERAPY	2, 241, 535	0	2, 241, 535		2, 241, 535	
	6800 SPEECH PATHOLOGY	829, 139	0	02// 10/		829, 139	
69.00 06	6900 ELECTROCARDI OLOGY	1, 687, 676		1, 687, 676	0	1, 687, 676	69. 00
69. 01 06	6901 CARDI AC REHAB	858, 143		858, 143	0	858, 143	
70.00 07	7000 ELECTROENCEPHALOGRAPHY	2, 678, 771		2, 678, 771	0	2, 678, 771	70.00
71.00 07	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	21, 074, 073		21, 074, 073	0	21, 074, 073	71.00
72.00 07	7200 IMPL. DEV. CHARGED TO PATIENTS	19, 887, 744		19, 887, 744	0	19, 887, 744	72.00
73.00 07	7300 DRUGS CHARGED TO PATIENTS	57, 757, 195		57, 757, 195	0	57, 757, 195	73.00
	7400 RENAL DIALYSIS	2, 972, 062		2, 972, 062	el o	2, 972, 062	74.00
OL	JTPATIENT SERVICE COST CENTERS						
	9000 CLI NI C	9, 223, 753		9, 223, 753	0	9, 223, 753	90.00
91.00 09	9100 EMERGENCY	25, 898, 445		25, 898, 445	o	25, 898, 445	91.00
92.00 09	9200 OBSERVATION BEDS (NON-DISTINCT PART)	11, 879, 976		11, 879, 976		11, 879, 976	
	THER REIMBURSABLE COST CENTERS	, - , -			'	, , , , , ,	
	0100 HOME HEALTH AGENCY	3, 150, 365		3, 150, 365	j	3, 150, 365	101.00
200.00	Subtotal (see instructions)	368, 760, 179	0			368, 760, 179	
201.00	Less Observation Beds	11, 879, 976		11, 879, 976		11, 879, 976	
202. 00	Total (see instructions)	356, 880, 203				356, 880, 203	
			1	,,, ==-	-1	, ,	

				o 12/31/2023		pared:
		Ti tl	e XIX	Hospi tal	Cost	o alli
		Charges	CAIA	nospi tui	0031	
Cost Center Description	Inpati ent	Outpati ent	Total (col 6	Cost or Other	TEFRA	
oust deliter bescription	Impatrent	outputient	+ col . 7)	Ratio	I npati ent	
			1 001. 7)	Ratio	Ratio	
	6. 00	7. 00	8. 00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7. 00	10.00	
30. 00 03000 ADULTS & PEDIATRICS	87, 880, 095		87, 880, 095			30.00
31. 00 03100 I NTENSI VE CARE UNI T	21, 952, 331		21, 952, 331			31.00
31. 01 03101 NEONATAL CU	5, 616, 128		5, 616, 128			31.00
40. 00 04000 SUBPROVI DER - PF	2, 719, 542		2, 719, 542			40.00
41. 00 04100 SUBPROVI DER - I RF	4, 035, 526		4, 035, 526			41.00
43. 00 04300 NURSERY	2, 297, 605		2, 297, 605			43.00
ANCILLARY SERVICE COST CENTERS	2, 291, 003		2, 291, 003			43.00
50. 00 05000 OPERATING ROOM	72, 844, 794	125, 364, 860	198, 209, 654	0.099290	0.000000	50.00
50. 01 05001 ENDOSCOPY	5, 367, 165	4, 538, 141			0. 000000	
51. 00 05100 RECOVERY ROOM	4, 223, 257	9, 261, 191			0. 000000	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	3, 365, 530	3, 356, 662			0. 000000	1
53. 00 05300 ANESTHESI OLOGY	3, 303, 330	3, 330, 002		0. 000000	0.000000	
		· ·	1 ~		0.000000	
	13, 728, 689	40, 255, 321				
54. 01 05401 RADI OLOGY - ULTRASOUND	6, 009, 408	19, 043, 706			0.000000	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	906, 751	28, 070, 422			0. 000000	55.00
55. 01 05501 I NFUSI ON CENTER	8, 853	17, 584, 120			0. 000000	55. 01
56. 00 05600 RADI 01 SOTOPE	5, 646, 607	16, 602, 548			0. 000000	56.00
57. 00 05700 CT SCAN	60, 991, 099	108, 881, 754		1	0. 000000	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	12, 849, 674	21, 965, 323		l l	0. 000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	50, 869, 319	36, 559, 518			0. 000000	59.00
60. 00 06000 LABORATORY	96, 361, 045	142, 296, 531			0. 000000	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	12, 940, 165	15, 025, 570			0.000000	62.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	1	0. 000000	0. 000000	1
65. 00 06500 RESPIRATORY THERAPY	51, 287, 462	3, 256, 994			0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	8, 276, 665	7, 328, 863		1	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	5, 667, 087	1, 757, 587	7, 424, 674	0. 301903	0.000000	67.00
68. 00 06800 SPEECH PATHOLOGY	2, 570, 687	437, 212			0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	15, 980, 433	16, 646, 351			0.000000	69.00
69. 01 06901 CARDI AC REHAB	515, 991	1, 385, 584			0.000000	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	15, 257, 987	30, 529, 317	45, 787, 304	0. 058505	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	26, 140, 994	20, 082, 763	46, 223, 757	0. 455914	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	24, 318, 034	18, 954, 107	43, 272, 141	0. 459597	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	91, 077, 808	170, 304, 549	261, 382, 357	0. 220968	0.000000	73.00
74.00 07400 RENAL DIALYSIS	10, 655, 370	1, 014, 208	11, 669, 578	0. 254685	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	57, 352	13, 307, 349	13, 364, 701	0. 690158	0.000000	90.00
91. 00 09100 EMERGENCY	22, 495, 507	108, 638, 202	131, 133, 709	0. 197496	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 160, 147	17, 620, 689	23, 780, 836	0. 499561	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	1, 105	3, 610, 613				101.00
200.00 Subtotal (see instructions)	751, 076, 212	1, 003, 680, 055	1, 754, 756, 267	1		200.00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	751, 076, 212	1, 003, 680, 055	1, 754, 756, 267	1		202. 00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0002	Peri od: Worksheet C From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

				10 12/31/2023	5/29/2024 9:08	
			Title XIX	Hospi tal	Cost	J dill
	Cost Center Description	PPS Inpatient	THE XIX	nospi tui	0031	
	000 t 0011ton 20001 i pti 011	Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00						30.00
31. 00	1					31.00
31. 01	03101 NEONATAL I CU					31. 01
40.00	1					40.00
41.00	+ I					41.00
43.00						43.00
	ANCILLARY SERVICE COST CENTERS	'				
50.00		0. 000000				50.00
50. 01	05001 ENDOSCOPY	0. 000000				50. 01
51.00	1 1	0. 000000				51.00
52. 00	1 1	0. 000000				52.00
53.00	i i	0. 000000				53.00
54.00	1 1	0. 000000				54.00
54. 01	05401 RADI OLOGY - ULTRASOUND	0. 000000				54.01
55. 00	+ I	0. 000000				55.00
55. 01	05501 I NFUSI ON CENTER	0. 000000				55. 01
56. 00	1	0. 000000				56.00
57. 00		0. 000000				57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000				59. 00
60.00	06000 LABORATORY	0. 000000				60.00
62. 00		0. 000000				62.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000				64.00
65.00	06500 RESPIRATORY THERAPY	0. 000000				65.00
66. 00	1	0. 000000				66. 00
67. 00	1	0. 000000				67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000				68. 00
69. 00	1 1	0. 000000				69. 00
69. 01	06901 CARDI AC REHAB	0. 000000				69. 01
70.00	1 1	0. 000000				70.00
71. 00	+ I	0. 000000				71.00
72. 00	1 1	0. 000000				72.00
73. 00	1 1	0. 000000				73.00
74.00	07400 RENAL DIALYSIS	0. 000000				74.00
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>				
90.00		0. 000000				90.00
91.00	1 1	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	PITALS. INC		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL		Provi der Co		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part I Date/Time Pre	pared:
					5/29/2024 9:0	.8 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capital Related Cost	Days	(col. 3 /	
	(from Wkst. B, Part II,		(col. 1 -		col . 4)	
	col. 26)		col. 2)			
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30. 00 ADULTS & PEDIATRICS	5, 894, 303	0	5, 894, 30	3 74, 770	78. 83	30.00
31. 00 INTENSIVE CARE UNIT	449, 326		449, 32			
31. 01 NEONATAL I CU	60, 305		60, 30			
40. 00 SUBPROVIDER - IPF	80, 270	0	80, 27			40.00
41. 00 SUBPROVI DER - I RF	551, 843	0	551, 84		159. 45	41.00
43. 00 NURSERY	413, 992		413, 99	2, 108	196. 39	43.00
200.00 Total (lines 30 through 199)	7, 450, 039		7, 450, 03	9 91, 284		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col . 6)				
INPATIENT ROUTINE SERVICE COST CENTERS	6. 00	7. 00				
30. 00 ADULTS & PEDIATRICS	14, 839	1, 169, 758				30.00
31. 00 INTENSIVE CARE UNIT	1, 895					31.00
31. 01 NEONATAL ICU	1, 073	l '	•			31.00
40. 00 SUBPROVI DER - I PF	256					40.00
41. 00 SUBPROVI DER - I RF	808					41.00
43. 00 NURSERY	0	· ·	•			43.00
200.00 Total (lines 30 through 199)	17, 798	1				200. 00

Health Financial Systems	METHODIST HOSPIT	ALS, INC	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SER	RVICE CAPITAL COSTS	Provider CCN: 15-0002	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Prepared: 5/29/2024 9:08 am
		Title XVIII	Hospi tal	PPS

				From 01/01/2023 Fo 12/31/2023		
		T	\0.00 L		5/29/2024 9: 0	8 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col . 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1 100 000	100 000 (54	0.00504	- 40 500 004		
50. 00 05000 OPERATING ROOM	1, 182, 300					
50. 01 05001 ENDOSCOPY	16, 907		•		•	
51. 00 05100 RECOVERY ROOM	259, 733		•			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	184, 930			· ·		52.00
53. 00 05300 ANESTHESI OLOGY	0	ļ	0.0000		_	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	922, 903				•	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	109, 468				6, 788	
55. 00 05500 RADI OLOGY-THERAPEUTI C	159, 416				1, 705	
55.01 05501 INFUSION CENTER	97, 582				0	55. 01
56. 00 05600 RADI 0I SOTOPE	169, 856	22, 249, 155	0.00763	1, 211, 431	9, 248	56.00
57. 00 05700 CT SCAN	234, 461	169, 872, 853	0. 00138	14, 644, 117	20, 209	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	90, 764	34, 814, 997	0.00260	7 2, 861, 102	7, 459	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	211, 319	87, 428, 837	0. 00241	7 12, 319, 988	29, 777	59.00
60. 00 06000 LABORATORY	574, 033	238, 657, 576	0.00240	22, 302, 883	53, 638	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	31, 480	27, 965, 735	0.00112	1, 810, 654	2, 039	62.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0.00000	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	180, 692	54, 544, 456			36, 039	65.00
66. 00 06600 PHYSI CAL THERAPY	218, 735	15, 605, 528	0. 01401	1, 628, 033	22, 820	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	182, 517					67.00
68. 00 06800 SPEECH PATHOLOGY	34, 046	3, 007, 899	0. 01131	673, 310	7, 621	68.00
69. 00 06900 ELECTROCARDI OLOGY	22, 705					
69. 01 06901 CARDI AC REHAB	5, 126				0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	33, 964				2, 481	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	414, 304		•			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	390, 895				57, 800	
73. 00 07300 DRUGS CHARGED TO PATIENTS	623, 378					
74. 00 07400 RENAL DI ALYSI S	87, 592					
OUTPATIENT SERVICE COST CENTERS	07,072	11,007,070	3. 55750	2,017,042	17, 130	1 55
90. 00 09000 CLINIC	1, 272, 236	13, 364, 701	0. 09519	1 2, 238	213	90.00
91. 00 09100 EMERGENCY	713, 158					
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	891, 747				49, 416	
200.00 Total (lines 50 through 199)		1, 626, 643, 322		137, 859, 450		
200.00 10tal (111103 30 till dagil 177)	7, 510, 247	1 1, 520, 545, 522	I	137, 037, 430	1 000,410	1200.00

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS			Period: From 01/01/2023 To 12/31/2023	Worksheet D Part III Date/Time Pre 5/29/2024 9:0	epared: 08 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursing Program	Post-Stepdow Adjustments		All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 31. 01 03101 NEONATAL I CU 40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1		0 69, 084 0 0 0 0 0 0 0 0	0 0 0 0 0	31. 00 31. 01 40. 00 41. 00
200.00 Total (lines 30 through 199)	0	0		0 69, 084		200.00
Cost Center Description	Swi ng-Bed Adj ustment Amount (see instructions) 4.00	Total Costs (sum of cols. 1 through 3, minus col. 4) 5.00	Total Patien Days	<u> </u>	Inpatient Program Days	200.00
INPATIENT ROUTINE SERVICE COST CENTERS	1. 00	0,00	0.00	71.00	0.00	
30. 00	0 0	69, 084 0 0 0 0 0 0 0 69, 084	7, 60 2, 02 1, 31 3, 46 2, 10	9 0.00 4 0.00 2 0.00 1 0.00 8 0.00	14, 839 1, 895 0 256 808 0 17, 798	31. 00 31. 01 40. 00 41. 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 31.00 03100 INTENSIVE CARE UNIT 31.01 03101 NEONATAL ICU 40.00 04000 SUBPROVIDER - IPF 41.00 04100 SUBPROVIDER - IRF 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	13, 652 0 0 0 0 0 0 13, 652					30. 00 31. 00 31. 01 40. 00 41. 00 43. 00 200. 00

Heal t	h Financial Systems		METHODI ST	HOSPI 7	TALS, INC		In Lieu	ı of Form CMS-2552-10
	TIONMENT OF INPATIENT/OUTPATIENT GH COSTS	ANCILLARY S	SERVICE OTHER	PASS	Provi der	CCN: 15-0002	From 01/01/2023	Worksheet D Part IV Date/Time Prepared:

				To 12/31/2023	Date/lime Pre 5/29/2024 9:0	
		Title	e XVIII	Hospi tal	PPS	<u>o ani</u>
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						
50.00 05000 OPERATING ROOM	0	0	1	0	69, 084	
50. 01 05001 ENDOSCOPY	0	0	1	0	0	50. 01
51.00 05100 RECOVERY ROOM	0	0	1	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	69, 084	
53. 00 05300 ANESTHESI OLOGY	0	0		0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	0	0		0	0	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 0I SOTOPE	0	0		0	0	56.00
57.00 05700 CT SCAN	0	0		0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	1	0	34, 542	
60. 00 06000 LABORATORY	0	0	1	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	1	0	0	62.00
64.00 06400 I NTRAVENOUS THERAPY	0	0	1	0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	0	0	1	0	103, 627	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	1	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	1	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	1	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	1	0	0	69.00
69. 01 06901 CARDI AC REHAB	0	0	1	0	0	69. 01
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	1	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	1	0	0	73.00
74. 00 07400 RENAL DI ALYSI S	0	0		0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS			1	-1		
90. 00 09000 CLI NI C	0	0	1	0	0	90.00
91. 00 09100 EMERGENCY	0	0	1	0	1, 256, 475	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			U	10, 454	1
200.00 Total (lines 50 through 199)	0	0	1	0 0	1, 543, 266	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	Period: Worksheet D
THROUGH COSTS		From 01/01/2023 Part IV

THROUGH COSTS				o 12/31/2023	Date/Time Pre 5/29/2024 9:0	pared:
		Title	: XVIII	Hospi tal	PPS	<u> </u>
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
·	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	69, 084			0. 000349	
50. 01 05001 ENDOSCOPY	0	0	C	.,	0. 000000	l
51. 00 05100 RECOVERY ROOM	0	0	C		0. 000000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	69, 084	69, 084	6, 722, 192	0. 010277	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	C		0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	C	, ,	0. 000000	1
54. 01 05401 RADI OLOGY - ULTRASOUND	0	0	(25, 053, 114	0. 000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	(20, ,,,,	0. 000000	1
55. 01 05501 I NFUSI ON CENTER	0	0	(,,	0.000000	
56. 00 05600 RADI 01 SOTOPE	0	0	(, ,	0. 000000	
57.00 05700 CT SCAN	0	0	(.07,072,000	0. 000000	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	(34, 814, 997	0. 000000	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	34, 542	34, 542		0. 000395	
60. 00 06000 LABORATORY	0	0	(0. 000000	1
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	(27, 965, 735	0. 000000	
64.00 06400 I NTRAVENOUS THERAPY	0	0	(0	0. 000000	
65. 00 06500 RESPI RATORY THERAPY	0	103, 627	103, 627		0. 001900	1
66. 00 06600 PHYSI CAL THERAPY	0	0	(.0,000,020	0.000000	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(7, 121,071	0. 000000	1
68. 00 06800 SPEECH PATHOLOGY	0	0	(-,,	0. 000000	1
69. 00 06900 ELECTROCARDI OLOGY	0	0	(32, 626, 784	0. 000000	1
69. 01 06901 CARDI AC REHAB	0	0	(1, 901, 575	0.000000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	(45, 787, 304	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(46, 223, 757	0.000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(43, 272, 141	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	C	261, 382, 357	0.000000	
74. 00 07400 RENAL DIALYSIS	0	0	C	11, 669, 578	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	(13, 364, 701	0.000000	90.00
91. 00 09100 EMERGENCY	0	1, 256, 475				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					1
200.00 Total (lines 50 through 199)	0	1, 543, 266	1, 543, 266	1, 626, 643, 322		200. 00

Health Financial Systems	METHODIST HOSPI	TALS, INC	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0002	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 5/29/2024 9:08 am
		Title XVIII	Hospi tal	PPS

				0 12/31/2023	5/29/2024 9:0	
		Title	XVIII	Hospi tal	PPS	o ani
Cost Center Description	Outpati ent	Inpatient	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷	J	Costs (col. 8	3	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. 000349	12, 509, 094	4, 366	17, 903, 088	6, 248	
50. 01 05001 ENDOSCOPY	0. 000000	1, 451, 420	C	910, 662	0	50. 01
51. 00 05100 RECOVERY ROOM	0. 000000	560, 674	C	1, 042, 262	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 010277	260, 512	2, 677	314, 311	3, 230	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	3, 297, 379	C	3, 928, 315	0	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	0. 000000	1, 553, 747	C	1, 211, 643	0	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	310, 019	C	5, 733, 646	0	55.00
55. 01 05501 I NFUSI ON CENTER	0. 000000	0	C	2, 714, 566	0	55. 01
56. 00 05600 RADI 0I SOTOPE	0. 000000	1, 211, 431	C	2, 836, 549	0	56.00
57. 00 05700 CT SCAN	0. 000000	14, 644, 117	C	13, 027, 528	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	2, 861, 102	C	3, 436, 864	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000395	12, 319, 988	4, 866	5, 297, 885	2, 093	59.00
60. 00 06000 LABORATORY	0. 000000	22, 302, 883	0	8, 431, 811	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	1, 810, 654	0	436, 217	0	62.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	0	0	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 001900	10, 878, 081	20, 668	350, 989	667	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 628, 033	0	42, 045	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	975, 505	0	18, 255	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	673, 310	0	23, 706	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	3, 806, 996	0	2, 227, 890	0	69.00
69. 01 06901 CARDI AC REHAB	0. 000000	0	0	363, 757	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	3, 343, 258	0	6, 160, 519	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	6, 123, 600	0	4, 329, 004	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	6, 398, 801	0	3, 667, 888	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	19, 737, 113	0	40, 803, 256	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	2, 549, 642	0	255, 944	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	2, 238	C	2, 323, 188	0	90.00
91. 00 09100 EMERGENCY	0. 009582	5, 332, 062	51, 092	10, 100, 603	96, 784	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000440	1, 317, 791	580	1, 234, 716		
200.00 Total (lines 50 through 199)		137, 859, 450	84, 249	139, 127, 107	109, 565	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0002 Peri od: Worksheet D From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 5/29/2024 9:08 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.) 2.00 5.00 1.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0.099290 17, 903, 088 1, 777, 598 50.00 05001 ENDOSCOPY 0 50.01 0.154036 910, 662 0 140, 275 50.01 05100 RECOVERY ROOM 0 51.00 0. 223400 1,042,262 232, 841 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 1.096450 314, 311 0 0 344, 626 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0 0 0 53.00 3, 928, 315 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.192617 756, 660 54 00 0 54.01 05401 RADI OLOGY - ULTRASOUND 0. 134619 1, 211, 643 163, 110 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 0. 116400 5, 733, 646 0 0 0 667, 396 55.00 0 05501 INFUSION CENTER 0.108199 2, 714, 566 55.01 293, 713 55.01 0 05600 RADI OI SOTOPE 0.145819 56.00 2, 836, 549 413, 623 56.00 57.00 05700 CT SCAN 0.033308 13, 027, 528 433, 921 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 0.056119 3, 436, 864 0 0 192, 873 58.00 0 05900 CARDI AC CATHETERI ZATI ON 0.079397 5, 297, 885 59 00 420, 636 59 00 0 60.00 06000 LABORATORY 0.090291 8, 431, 811 761, 317 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.085774 436, 217 0 0 37, 416 62.00 06400 I NTRAVENOUS THERAPY 0 0 64.00 0.000000 64.00 0 0 06500 RESPIRATORY THERAPY 0 0 133191 350, 989 46, 749 65 00 65 00 0 66.00 06600 PHYSI CAL THERAPY 0. 216905 42,045 9, 120 66.00 06700 OCCUPATI ONAL THERAPY 0.301903 18, 255 0 5, 511 67.00 67.00 0 23, 706 0 68.00 06800 SPEECH PATHOLOGY 0.275654 6,535 68.00 06900 ELECTROCARDI OLOGY 0.051727 2, 227, 890 0 115, 242 69 00 69 00 o 69.01 06901 CARDI AC REHAB 0.451280 363, 757 164, 156 69.01 07000 ELECTROENCEPHALOGRAPHY 0.058505 6, 160, 519 0 0 360, 421 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 1, 973, 654 71.00 0.455914 4.329.004 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.459597 3, 667, 888 0 1, 685, 750 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 220968 40, 803, 256 0 27, 780 9, 016, 214 73.00 07400 RENAL DIALYSIS <u>255,</u> 944 <u>65, 1</u>85 74.00 0. 254685 0 0 74.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.690158 2, 323, 188 0 0 1, 603, 367 90.00 09100 EMERGENCY 0. 197496 10, 100, 603 0 1, 994, 829 91.00 91.00 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 499561 1, 234, 716 0 616, 816 92.00 0 0 27, 780 200.00 Subtotal (see instructions) 139, 127, 107 24, 299, 554 200. 00 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 139, 127, 107 0 27, 780 24, 299, 554 202. 00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0002	Period: Worksheet D From 01/01/2023 Part V

					From 01/01/2023 To 12/31/2023	Part V Date/Time Pr 5/29/2024 9:	
			Title	XVIII	Hospi tal	PPS	00 4111
		Cos	sts				
	Cost Center Description	Cost	Cost				
	·	Rei mbursed	Rei mbursed				
		Servi ces	Servi ces Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
	ANCILLARY SERVICE COST CENTERS	,					
	05000 OPERATING ROOM	0	0				50.00
50. 01	05001 ENDOSCOPY	0	0				50. 01
51.00	05100 RECOVERY ROOM	0	0				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53.00	05300 ANESTHESI OLOGY	0	0				53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
54.01	05401 RADI OLOGY - ULTRASOUND	0	0				54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
55. 01	05501 INFUSION CENTER	0	0				55. 01
56.00	05600 RADI 0I SOTOPE	0	0				56.00
57.00	05700 CT SCAN	0	0				57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60.00	06000 LABORATORY	0	0				60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.00
64.00	06400 I NTRAVENOUS THERAPY	0	0				64.00
65.00	06500 RESPI RATORY THERAPY	0	0				65.00
66.00	06600 PHYSI CAL THERAPY	0	0				66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00	06800 SPEECH PATHOLOGY	0	0				68.00
69.00	06900 ELECTROCARDI OLOGY	0	0				69.00
69. 01	06901 CARDI AC REHAB	0	0				69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	6, 138				73.00
74.00	07400 RENAL DIALYSIS	0	0				74.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0				90.00
91.00	09100 EMERGENCY	0	o				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
200.00			6, 138				200.00
201.00)				201.00
	Only Charges						
202. 00	1 1 3 0	0	6, 138				202. 00

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CA	PLTAL COSTS	Provi der C	CN: 15-0002	Peri od:	Worksheet D	
		Component	CCN: 15-S002	From 01/01/2023 To 12/31/2023	Part II Date/Time Pre 5/29/2024 9:0	pared:
		Title	e XVIII	Subprovi der -	PPS	o alli
				I PF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col. 26)	2.00	2.00	4.00	F 00	
ANCILLARY SERVICE COST CENTERS	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	1, 182, 300	198, 209, 654	0.00596	55 0	0	50.00
50. 01 05001 ENDOSCOPY	1, 162, 300				0	50.00
51. 00 05100 RECOVERY ROOM	259, 733				0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	184, 930		•		0	52.00
53. 00 05300 ANESTHESI OLOGY	104, 730				0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	922, 903				139	
54. 01 05401 RADI OLOGY - ULTRASOUND	109, 468				0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	159, 416		1		0	55.00
55. 01 05501 NFUSI ON CENTER	97, 582				0	55.01
56. 00 05600 RADI OI SOTOPE	169, 856				0	56.00
57. 00 05700 CT SCAN	234, 461	169, 872, 853			29	57.00
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	90, 764				0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	211, 319				0	1
60. 00 06000 LABORATORY	574, 033				125	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL			•		3	62.00
64. 00 06400 NTRAVENOUS THERAPY	0 0 0				0	
65. 00 06500 RESPIRATORY THERAPY	180, 692				2	65.00
66. 00 06600 PHYSI CAL THERAPY	218, 735				0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	182, 517	7, 424, 674			6	67.00
68. 00 06800 SPEECH PATHOLOGY	34, 046		•		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	22, 705		•		12	
69. 01 06901 CARDI AC REHAB	5, 126				0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	33, 964		•		0	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT			•		0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	390, 895			33 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	623, 378				230	73.00
74. 00 07400 RENAL DIALYSIS	87, 592	11, 669, 578	0. 00750	06	0	74.00
OUTPATIENT SERVICE COST CENTERS	<u>'</u>					1
90. 00 09000 CLI NI C	1, 272, 236	13, 364, 701	0. 09519	94 0	0	90.00
91. 00 09100 EMERGENCY	713, 158	131, 133, 709	0. 00543	38 29, 164	159	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	23, 780, 836	0. 00000	0	0	92.00
200.00 Total (lines 50 through 199)	0 424 500	1, 626, 643, 322	ol	226, 953	705	200.00

ealth Financial Systems PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE HROUGH COSTS	METHODIST HOS RVICE OTHER PAS	Component (CCN: 15-S002	Fro To	ri od: om 01/01/2023 12/31/2023	u of Form CMS-2 Worksheet D Part IV Date/Time Pre 5/29/2024 9:0	pared:
		Title	XVIII	S	ubprovi der - I PF	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	F		Allied Health	
	1. 00	2A	2. 00		3A	3. 00	
ANCILLARY SERVICE COST CENTERS							
50. 00 05000 OPERATING ROOM	0			0	0	69, 084	50.00
50. 01 05001 ENDOSCOPY	0	· -		0	0	0	50.0
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	51. 0 52. 0
53. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0	0		0	0	69, 084 0	53.0
44. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.0
4. 01 05401 RADI OLOGY - ULTRASOUND	0	0		0	Ö	0	54.0
5. 00 05500 RADI OLOGY-THERAPEUTI C	0	Ō		0	ō	0	55.0
5. 01 05501 I NFUSI ON CENTER	0	0		0	o	0	55.0
66. 00 05600 RADI OI SOTOPE	0	0		0	o	0	56.0
7.00 05700 CT SCAN	0	0		0	0	0	57.0
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	0	58.0
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	34, 542	
00. 00 06000 LABORATORY	0	0		0	0	0	60.0
22. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	0	62.0
04.00 06400 INTRAVENOUS THERAPY 05.00 06500 RESPIRATORY THERAPY	0	0		0	ol Ol	103, 627	64. 0 65. 0
66. 00 06600 PHYSI CAL THERAPY	0	0		0	ol	103, 627	66.0
57. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.0
8. 00 06800 SPEECH PATHOLOGY	0	0		0	ol	0	68.0
9. 00 06900 ELECTROCARDI OLOGY	0	Ō		0	ō	0	69.0
99. 01 06901 CARDI AC REHAB	0	0		0	o	0	69.0
O. OO 07000 ELECTROENCEPHALOGRAPHY	0	0		0	o	0	70.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.0
73. 00 07300 DRUGS CHARGED TO PATIENTS	0			0	0	0	73.0
74. 00 07400 RENAL DIALYSIS	0	0		0	0	0	74.0
OUTPATIENT SERVICE COST CENTERS		_			ام		
0.00 09000 CLINIC 01.00 09100 EMERGENCY	0 0			0	0	0 1, 256, 475	
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				0	٩	1, 256, 475	91.00
200.00 Total (lines 50 through 199)				0	О	1, 532, 812	

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C	CN: 15-0002	Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-S002	From 01/01/2023 To 12/31/2023	Part IV Date/Time Pre 5/29/2024 9:0	pared: 8 am
			XVIII	Subprovi der - I PF	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges		
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
	Cost	4)	cols. 2, 3,	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 OPERATI NG ROOM	0	69, 084	69, 08		0. 000349	1
50. 01 05001 ENDOSCOPY	0	0		9, 905, 306	0. 000000	•
51. 00 05100 RECOVERY ROOM	0	0		0 13, 484, 448	0. 000000	1
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	69, 084	69, 08		0. 010277	1
53. 00 05300 ANESTHESI OLOGY	0	0		0	0. 000000	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 53, 984, 010	0.000000	
54. 01 05401 RADI OLOGY - ULTRASOUND	0	0		0 25, 053, 114	0. 000000	1
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 28, 977, 173	0. 000000	1
55. 01 05501 I NFUSI ON CENTER	0	0		0 17, 592, 973	0. 000000	1
56. 00 05600 RADI 01 SOTOPE	0	0		0 22, 249, 155	0. 000000	1
57. 00 05700 CT SCAN	0	0		0 169, 872, 853	0. 000000	•
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 34, 814, 997	0. 000000	•
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	34, 542	34, 54		0. 000395	1
60. 00 06000 LABORATORY	0	0		0 238, 657, 576	0. 000000	1
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 27, 965, 735	0. 000000	1
64. 00 06400 NTRAVENOUS THERAPY	0	100 (07		0 0	0.000000	1
65. 00 06500 RESPI RATORY THERAPY	0	103, 627	103, 62		0.001900	1
66. 00 06600 PHYSI CAL THERAPY	0	0		0 15, 605, 528	0.000000	
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	0		0 7, 424, 674 0 3,007, 899	0.000000	1
69. 00 06900 SPEECH PATHOLOGY	0	0		0 3, 007, 899 0 32, 626, 784	0. 000000 0. 000000	1
69. 01 06901 CARDI AC REHAB	0	0		0 32, 626, 784	0.000000	1
70. 00 07000 ELECTROENCEPHALOGRAPHY		0			0.000000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0		0 45, 787, 304 0 46, 223, 757	0.000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0		0 43, 272, 141	0.000000	•
73. 00 07300 DRUGS CHARGED TO PATTENTS		0		0 261, 382, 357	0.000000	1
74. 00 07400 RENAL DI ALYSI S		0		0 11, 669, 578	0.000000	•
OUTPATIENT SERVICE COST CENTERS	<u> </u>			0 11,009,570	0.000000	74.00
90. 00 09000 CLINI C	O	0		0 13, 364, 701	0. 000000	90.00
91. 00 09100 EMERGENCY		1, 256, 475				
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1, 230, 473 N		0 23, 780, 836	0.000000	•
200.00 Total (lines 50 through 199)		1, 532, 812		2 1, 626, 643, 322		200.00
	١	., 552, 612	., 552, 61			

Health Financial Systems	METHODI ST HOSPI	TALS INC		Inlie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER		Provi der Co	CN: 15-0002	Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-S002	From 01/01/2023 To 12/31/2023	Part IV Date/Time Pre 5/29/2024 9:0	pared: 8 am
		Title	XVIII	Subprovi der – I PF	PPS	
Cost Center Description	Outpati ent	Inpatient	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n Charges	Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 000349	0		0	0	
50. 01 05001 ENDOSCOPY	0. 000000	0		0	0	
51.00 05100 RECOVERY ROOM	0. 000000	0		0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 010277	0		0	0	
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	8, 109		0	0	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	0. 000000	0		0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0	55.00
55. 01 05501 I NFUSI ON CENTER	0. 000000	0		0	0	55. 01
56. 00 05600 RADI 0I SOTOPE	0. 000000	0		0	0	56.00
57. 00 05700 CT SCAN	0. 000000	21, 077		0	0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000395	0		0	0	
60. 00 06000 LABORATORY	0. 000000	52, 169		0	0	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	2, 533		0 0	0	
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	0	1	0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 001900	666		1 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	0		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	264		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	16, 654	1	0 0	0	69.00
69. 01 06901 CARDI AC REHAB	0. 000000	0		0 0	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	96, 317		0 0	0	
74. 00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
OUTPATIENT SERVICE COST CENTERS	0.000000					00.00
90. 00 09000 CLI NI C	0.000000	0		0 0	0	
91. 00 09100 EMERGENCY	0. 009582	29, 164	27		0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	224 052	20	0 0	0	
200.00 Total (lines 50 through 199)	1	226, 953	28	0 0	l 0	200.00

	METHODI OT 1100				6.5	
Health Financial Systems APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	METHODIST HOS		ON 15 0000		u of Form CMS-	2552-10
APPORTIONMENT OF INPATTENT ANCILLARY SERVICE CAPITA	AL CUSIS	Provi der C	CN: 15-0002	Peri od: From 01/01/2023	Worksheet D Part II	
		Component	CCN: 15-T002	To 12/31/2023	Date/Time Pre 5/29/2024 9:0	
		Title	XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	1, 182, 300				49	50.00
50. 01 05001 ENDOSCOPY	16, 907				6	50. 01
51. 00 05100 RECOVERY ROOM	259, 733				0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	184, 930				0	52.00
53. 00 05300 ANESTHESI OLOGY	0	1	0.0000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	922, 903				325	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	109, 468				15	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	159, 416				0	55.00
55. 01 05501 I NFUSI ON CENTER	97, 582				0	55. 01
56. 00 05600 RADI 0I SOTOPE	169, 856				0	56.00
57. 00 05700 CT SCAN	234, 461	169, 872, 853			52	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	90, 764				12	
59. 00 05900 CARDI AC CATHETERI ZATI ON	211, 319				0	59. 00
60. 00 06000 LABORATORY	574, 033				729	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	31, 480				19	62.00
64. 00 06400 I NTRAVENOUS THERAPY	0				0	64. 00
65. 00 06500 RESPI RATORY THERAPY	180, 692				601	65.00
66. 00 06600 PHYSI CAL THERAPY	218, 735				6, 825	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	182, 517				10, 573	67.00
68.00 06800 SPEECH PATHOLOGY	34, 046				771	68. 00
69. 00 06900 ELECTROCARDI OLOGY	22, 705				19	69. 00
69. 01 06901 CARDI AC REHAB	5, 126				0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	33, 964				3	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	414, 304				324	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	390, 895				21	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	623, 378				890	73.00
74. 00 07400 RENAL DI ALYSI S	87, 592	11, 669, 578	0. 00750	95, 680	718	74.00
OUTPATIENT SERVICE COST CENTERS		T				
90. 00 09000 CLI NI C	1, 272, 236				0	90.00
91. 00 09100 EMERGENCY	713, 158		1		0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	23, 780, 836	1		0	92.00
200.00 Total (lines 50 through 199)	8, 424, 500	1, 626, 643, 322	1	2, 102, 683	21, 952	J200. 00

ealth Financial Systems PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE HROUGH COSTS	METHODIST HOS RVICE OTHER PAS	S Provider CC Component (CCN: 15-T002	Fro To	ri od: om 01/01/2023 12/31/2023		pared:
		Title	XVIII	Sı	ubprovi der - I RF	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	F		Allied Health	
	1. 00	2A	2.00		3A	3. 00	
ANCILLARY SERVICE COST CENTERS							
0.00 O5000 OPERATING ROOM	0	· ·		0	0	69, 084	50.00
0.01 05001 ENDOSCOPY 1.00 05100 RECOVERY ROOM	0	0		0	0	0	50. 0 51. 0
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	69, 084	52.0
3. 00 05300 ANESTHESI OLOGY	0	0		0	0	07,004	53.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	Ö		0	0	Ö	54.0
4. 01 05401 RADI OLOGY - ULTRASOUND	0	0		0	0	0	54.0
5. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55. C
5. 01 05501 I NFUSI ON CENTER	0	0		0	0	0	55.0
6. 00 05600 RADI 01 SOTOPE	0	0		0	0	0	56.0
7. 00 05700 CT SCAN	0	0		0	0	0	57.0
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 9.00 05900 CARDIAC CATHETERIZATION	0	0		0	0	0 34, 542	58. C
0. 00 06000 LABORATORY	0	0		0	0	34, 342	60.0
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	Ö	62.0
4. 00 06400 I NTRAVENOUS THERAPY	0	Ö		0	0	Ö	64.0
5. 00 06500 RESPIRATORY THERAPY	0	О		0	0	103, 627	65. C
6. 00 06600 PHYSI CAL THERAPY	0	0		0	0	0	66.0
7. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67. C
8. 00 06800 SPEECH PATHOLOGY	0	0		0	0	0	68.0
9. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.0
9. 01 06901 CARDI AC REHAB 0. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	69. 0 70. 0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	71.0
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.0
3. 00 07300 DRUGS CHARGED TO PATIENTS	0	Ö		0	0	Ö	73.0
4.00 07400 RENAL DIALYSIS	0	0		0	0	0	74.0
OUTPATIENT SERVICE COST CENTERS							
0. 00 09000 CLI NI C	0			0	0	0	
1. 00 09100 EMERGENCY	0			0	0	,	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0		0	92.0

Health Financial Systems	METHODIST HOSE	PITALS, INC		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SETTHROUGH COSTS		S Provider Co		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV	pared:
		Title	XVIII	Subprovi der - I RF	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,	col. 8)	col . 7)	
			and 4)		(see	
	4. 00	5. 00	6. 00	7. 00	instructions)	
ANCILLARY SERVICE COST CENTERS	4.00	5.00	0.00	7.00	8. 00	
50. 00 05000 OPERATING ROOM	0	69, 084	69, 08	198, 209, 654	0. 000349	50.00
50. 01 05001 ENDOSCOPY	0	07,004		9, 905, 306	0.000000	
51. 00 05100 RECOVERY ROOM		0		13, 484, 448	0. 000000	
52. 00 05200 DELI VERY ROOM & LABOR ROOM		69, 084			0. 010277	
53. 00 05300 ANESTHESI OLOGY	0	07,001		0, 722, 172	0.000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		53, 984, 010	0. 000000	
54. 01 05401 RADI OLOGY - ULTRASOUND	0	0		25, 053, 114	0. 000000	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	o	0		28, 977, 173	0. 000000	
55. 01 05501 I NFUSI ON CENTER	o	0		17, 592, 973	0.000000	
56. 00 05600 RADI OI SOTOPE	o	0		22, 249, 155	0.000000	
57. 00 05700 CT SCAN	o	0		169, 872, 853	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		34, 814, 997	0.000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	o	34, 542	34, 54	2 87, 428, 837	0. 000395	59.00
60. 00 06000 LABORATORY	0	0		238, 657, 576	0.000000	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		27, 965, 735	0.000000	62.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0	0.000000	
65. 00 06500 RESPI RATORY THERAPY	0	103, 627	103, 62		0. 001900	
66. 00 06600 PHYSI CAL THERAPY	0	0		15, 605, 528	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		7, 424, 674	0. 000000	
68. 00 06800 SPEECH PATHOLOGY	0	0		3, 007, 899	0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		32, 626, 784	0.000000	
69. 01 06901 CARDI AC REHAB	0	0		1, 901, 575	0.000000	
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		45, 787, 304 46, 223, 757	0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 MPL. DEV. CHARGED TO PATIENTS		0		46, 223, 757	0. 000000 0. 000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0		261, 382, 357	0.000000	
74. 00 07400 RENAL DI ALYSI S	0	0		11, 669, 578	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS	0			5 11,007,570	0.000000	74.00
90. 00 09000 CLI NI C	O	0		13, 364, 701	0.000000	90.00
91. 00 09100 EMERGENCY		1, 256, 475				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	o	0		23, 780, 836	0. 000000	
200.00 Total (lines 50 through 199)	l o	1, 532, 812		2 1, 626, 643, 322	2. 223000	200.00
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	-1	, ,	,		•	

Health Financial Systems	METHODIST HOSPI	TALS INC		In Lio	u of Form CMS-2	2552 10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE		Provi der Co	CN: 15-0002	Peri od:	Worksheet D	2552-10
THROUGH COSTS		Component (CCN: 15-T002	From 01/01/2023 To 12/31/2023	Part IV Date/Time Pre 5/29/2024 9:0	pared: 8 am
		Title	XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Outpati ent	Inpatient	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷		Costs (col.	3	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. 000349	8, 244		3 0	0	
50. 01 05001 ENDOSCOPY	0. 000000	3, 480		0	0	
51. 00 05100 RECOVERY ROOM	0. 000000	0		0	0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0. 010277	0		0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	19, 012		0	0	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND	0. 000000	3, 523		0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0	55.00
55. 01 05501 NFUSI ON CENTER	0. 000000	0		0	0	
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0	0	
57. 00 05700 CT SCAN	0. 000000	37, 354		0	0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	4, 792		0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000395	0		0	0	59.00
60. 00 06000 LABORATORY	0. 000000	303, 232		0	0	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	17, 058		0	0	62.00
64. 00 06400 I NTRAVENOUS THERAPY	0.000000	0		0 0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 001900	181, 528	34		0	65.00
66. 00 06600 PHYSI CAL THERAPY	0.000000	486, 885		0 0	0	
67. 00 06700 OCCUPATI ONAL THERAPY	0.000000	430, 123		٥	0	
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0. 000000 0. 000000	68, 140 27, 947		0 0	0	
		•		0 0		
69. 01 06901 CARDI AC REHAB 70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000 0. 000000	0 3, 956		0 0	0	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 000000	36, 202		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	2, 279		0 0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	373, 248		0 0	0	73.00
74. 00 07400 RENAL DI ALYSI S	0. 000000	95, 680		0 0	0	
OUTPATIENT SERVICE COST CENTERS	0. 000000	73, 000		0	0	74.00
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 000000	0		0 0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	
200.00 Total (lines 50 through 199)	3. 333300	2, 102, 683	34			200.00
	1	2, .02, 000		-1		1-30.00

Health Financial Systems	METHODIST HOSPIT	ALS, INC	In Lieu	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0002	Peri od: From 01/01/2023	Worksheet D-1	
			To 12/31/2023	Date/Time Pre 5/29/2024 9:0	pared: 8 am
		Title XVIII	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS					
1 00 Innationt days (including private room days	and swing had day	c oveluding newborn)		74 770	1 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 days, excluding newborn)		74, 770	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		74, 770	2.00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days this time.	m days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed days)	ŀ	63, 458	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of t	he cost	03, 430	5. 00
	reporting period		_	
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the	cost	0	6.00
7.00	reporting period (if calendar year, enter 0 on this line)		0	7.00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the reporting period	e cost	0	7. 00
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-be	ed and	14, 839	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)		0	10.00
10.00	through December 31 of the cost reporting period (see instructions)		U	10.00
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)	ıys)	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)	we)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	lys)	O	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	İ	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
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services through December 31 of the cos	+ 1	0. 00	17. 00
17.00	reporting period	,,	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	İ	0.00	18.00
	reporting period			
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	:	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	ŀ	0. 00	20. 00
20.00	reporting period		0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)		78, 524, 304	21.00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period	od (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period	(line A	0	23. 00
23.00	Swing-bed cost approcable to swintype services after became of the cost reporting period	(Trile 0	O	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period	l (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 (x line 20)	line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)	ŀ	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	ľ	78, 524, 304	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	Pri vate room charges (excluding swing-bed charges)	ŀ	0	29.00
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	ŀ	0. 00	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	İ	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0. 00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential	ا الم	0 78, 524, 304	36. 00 37. 00
37.00	27 minus line 36)	11 (11110	10, 324, 304	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, 050. 21	38.00
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line 38)		15, 584, 066 0	39. 00 40. 00
41. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35) Total Program general inpatient routine service cost (line 39 + line 40)		15, 584, 066	
00	1.1.1	ı	.5, 551, 566	

7.00	local swing-bed NF type inpatient days (including private room days) through becember 31 of the cost	۰Į	7.00
0.00	reporting period	0	0.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	۰Į	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	14, 839	9. 00
9.00	newborn days) (see instructions)	14, 037	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
10.00	through December 31 of the cost reporting period (see instructions)	ĭ	10.00
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)	آ ا	
12.00	Swing-bed NF type inpatient days applicable to titles V or XLX 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)	o	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
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
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17.00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18.00
	reporting period		
19. 00	Medicald rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19.00
	reporting period		
20. 00	Medicald rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20.00
04 00	reporting period	70 504 004	04 00
	Total general inpatient routine service cost (see instructions)	78, 524, 304	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	o	23. 00
23.00	x line 18	١	23.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
24.00	7 x line 19)	١	24.00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
25.00	x line 20)	Ĭ	23.00
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)	78, 524, 304	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
	Private room charges (excluding swing-bed charges)	ol	29. 00
	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	78, 524, 304	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
	Adjusted general inpatient routine service cost per diem (see instructions)	1, 050. 21	
	Program general inpatient routine service cost (line 9 x line 38)	15, 584, 066	
	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)	15, 584, 066	41.00

∐oal ±h	Financial Systems	METHODIST HOSE	DITALS INC		In Lio	u of Eorm CMS 1	2552 10
	Financial Systems ATION OF INPATIENT OPERATING COST	METHODI ST HOSE			eri od:	u of Form CMS-2 Worksheet D-1	
				To	com 01/01/2023 0 12/31/2023		
-			Ti tl e	xVIII	Hospi tal	5/29/2024 9: 0 PPS	8 am
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1. 00	2.00	3.00	4. 00	5. 00	42.00
42.00	Intensive Care Type Inpatient Hospital Units				-		
43. 00 43. 01	INTENSIVE CARE UNIT NEONATAL ICU	13, 771, 115 3, 013, 716	7, 609 2, 024		1, 895 0	3, 429, 666 0	43. 00 43. 01
44. 00	CORONARY CARE UNIT	3,013,710	2,024	1, 400. 77	Ĭ	Ü	44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description				•	1. 00	
48. 00	Program inpatient ancillary service cost (Wk					21, 859, 952	48.00
48. 01 49. 00	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines				column 1)	0 40, 873, 684	48. 01 49. 00
F0 00	PASS THROUGH COST ADJUSTMENTS	3	(6)	, W I . D	C David and		
50. 00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	1, 295, 310	50.00
51. 00	Pass through costs applicable to Program inp and IV)		ry services (f	rom Wkst. D, su	m of Parts II	719, 659	
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated non-ph	vsician anesthe	otist and	2, 014, 969 38, 858, 715	
00.00	medical education costs (line 49 minus line		ratea, non pri	ysr er um unestne	erst, and		00.00
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55.00	Target amount per discharge					0.00	•
55. 01 55. 02	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	use onlv)				0. 00 0. 00	•
56.00	Target amount (line 54 x sum of lines 55, 55	. 01, and 55. 02)			>	0	56.00
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (line 56 minus I	ine 53)	0	57. 00 58. 00
59. 00	Trended costs (lesser of line 53 ÷ line 54,		the cost rep	orting period e	endi ng 1996,	0.00	ı
60.00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54, market basket)	0.00	60.00				
61. 00							
62. 00	lenter zero. (see instructions) Relief payment (see instructions)					0	62. 00
63.00	Allowable Inpatient cost plus incentive paym	ent (see instru	ıcti ons)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost reportir	ng period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	or 21 of the	oost roporting	pariod (Saa	0	65. 00
05.00	instructions)(title XVIII only)	ts after becenic	del 31 di tile	cost reporting	perrou (see	O	05.00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line	64 plus line	65)(title XVIII	only); for	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31	of the cost rep	porting period	0	67.00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)			·	ting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY	, AND ICF/IID	ONLY		0	
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c						70. 00 71. 00
72.00	Program routine service cost (line 9 x line	71)					72. 00
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv						73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient 26, line 45)	•			ırt II, column		75. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
	Inpatient routine service cost (line 74 minu						78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				ıs line 70)		79. 00 80. 00
81.00	Inpatient routine service cost per diem limi	tati on		(11116 70 1111110	15 TTHE / 1/1		81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82. 00 83. 00
84.00	Program inpatient ancillary services (see in	structi ons)	•				84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	ii ougii oo <i>j</i>				
87. 00	Total observation bed days (see instructions)				11, 312	87.00

Health Financial Systems	Health Financial Systems METHODIST HOSPITALS, INC In Lieu			u of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023		
		Title	Title XVIII Hospital			
Cost Center Description						
					1. 00	
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88. 00
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			11, 879, 976	89. 00
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	5, 894, 303	78, 524, 304	0. 07506	3 11, 879, 976	891, 747	90.00
91.00 Nursing Program cost	0	78, 524, 304	0.00000	0 11, 879, 976	ol	91.00
92.00 Allied health cost	69, 084	78, 524, 304	0. 00088	0 11, 879, 976	10, 454	92.00
93.00 All other Medical Education	0	78, 524, 304	0.00000	0 11, 879, 976	ol	93.00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu	of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0002	Peri od: From 01/01/2023	Worksheet D-1
	Component CCN: 15-S002		
	Title XVIII	Subprovi der -	PPS
		IPF	

		In the XVIII	I PF	113	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day	s, excluding newborn)		1, 312	1.00
2. 00	Inpatient days (including private room days, excluding swing-			1, 312	2.00
3. 00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ys). If you have only pr	rivate room days,	0	3.00
4. 00	Semi-private room days (excluding swing-bed and observation b	ed davs)		1, 312	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost		5. 00
	reporting period				,
6. 00	Total swing-bed SNF type inpatient days (including private roreporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7.00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)	m days) after December 3	31 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	256	9.00
	newborn days) (see instructions)		,		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10.00
11. 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII o		nom days) after	0	11.00
11.00	December 31 of the cost reporting period (if calendar year, e		dom days) arter	O	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12.00
12 00	through December 31 of the cost reporting period	V (:		0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13.00
14. 00	Medically necessary private room days applicable to the Progr			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	of the cost	0.00	17. 00
17.00	reporting period	es in ough becomber or e	, the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18. 00
10 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through Docombor 21 of	the cost	0.00	19.00
19.00	reporting period	s through becember 31 of	the cost	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0.00	20.00
04 00	reporting period			1 004 007	04 00
21. 00 22. 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ing period (line	1, 884, 886 0	21. 00 22. 00
22.00	5 x line 17)	ci 31 di the cost report	ing perrou (ini	0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportir	ng period (line 🏻	0	23. 00
24.00	x line 18)	. 21 -6	(1:	0	24.00
24. 00	Swing-bed cost applicable to NF type services through Decembe 7×1 (ine 19)	i 31 of the cost reporti	ng perrod (Trne	0	24.00
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25.00
	x line 20)			_	
26.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 1, 884, 886	26.00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Trie 21 illinus Trie 20)		1, 004, 000	27.00
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)		28. 00
	Private room charges (excluding swing-bed charges)			0	1
30.00	Semi-private room charges (excluding swing-bed charges)	. line 20)		0 000000	
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ 11 ne 28)		0. 000000 0. 00	1
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	1
34.00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0.00	ı
35. 00	Average per diem private room cost differential (line 34 x li			0.00	•
36.00	Private room cost differential adjustment (line 3 x line 35)	/		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line		37.00
	27 minus line 36)	·			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	LICTMENTS			
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ		T	1 494 45	20 00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 436. 65 367, 782	
40. 00	Medically necessary private room cost applicable to the Progr	*		0	40.00
	Total Program general inpatient routine service cost (line 39			367, 782	ł
	•	•	'		

	Financial Systems	METHODI ST HOSE		ON 45 0000		eu of Form CMS-2	
COMPUI	ATION OF INPATIENT OPERATING COST			CN: 15-0002	Peri od: From 01/01/2023		
			Component	CCN: 15-S002	To 12/31/2023	Date/Time Pre 5/29/2024 9:0	
			Titl∈	× XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. + col. 2)	1	(col. 3 x col. 4)	
	I	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	0.	00 C	0	42.00
43.00	INTENSIVE CARE UNIT	0	0				
43. 01 44. 00	NEONATAL ICU CORONARY CARE UNIT	0	0	0.	00	0	43. 01 44. 00
45.00	BURN INTENSIVE CARE UNIT						45. 00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
10.00			11			1.00	40.00
48. 00 48. 01	Program inpatient ancillary service cost (WP Program inpatient cellular therapy acquisiti	kst. D-3, col. 3 on cost (Worksh	6, line 200) Beet D-6. Part	III. line 10). column 1)	35, 264 0	1
	Total Program inpatient costs (sum of lines					403, 046	
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	pationt routing	sorvi cos (fro	m Wkst D si	um of Parts I and	15, 662	50.00
30.00	[111]	Datrent routine	services (110	III WKSt. D, St	un or Farts Fan	15,002	30.00
51.00	Pass through costs applicable to Program inpand IV)	oatient ancillar	y services (f	rom Wkst. D,	sum of Parts II	985	51.00
52. 00	Total Program excludable cost (sum of lines	50 and 51)				16, 647	52.00
53. 00	Total Program inpatient operating cost exclu	0 .	lated, non-ph	ysician anest	thetist, and	386, 399	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
54.00	Program di scharges					0	
55. 00 55. 01	Target amount per discharge Permanent adjustment amount per discharge					0. 00 0. 00	
55. 02	, ,	use onl v)				0.00	
56. 00	Target amount (line 54 x sum of lines 55, 55	J.				0	1
57. 00	Difference between adjusted inpatient operat	ting cost and ta	irget amount (line 56 minus	s line 53)	0	•
58. 00 59. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54,	or line EE from	the cost ron	orting porto	d anding 1004	0.00	
39.00	updated and compounded by the market basket)		i the cost rep	or tring period	a enaring 1990,	0.00	39.00
60.00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 fro	m prior year	cost report,	updated by the	0.00	60.00
61. 00	Continuous improvement bonus payment (if lir					0	61.00
	55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54)		,		,		
	enter zero. (see instructions)	(00), OI I % OI	the target a	mount (Time s	oo), Otherwise		
62.00	Relief payment (see instructions)					0	1
63. 00	Allowable Inpatient cost plus incentive paymer PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see instru	ictions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	sts through Dece	ember 31 of th	e cost repor	ting period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	sts after Decemb	er 31 of the	cost renorti:	na period (See	0	65. 00
	instructions)(title XVIII only)			•			
66. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line	64 plus line	65)(title XVI	II only); for	0	66. 00
67. 00		ne costs through	December 31	of the cost i	reporting period	0	67.00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	ne costs after D	December 21 of	the cost ro	norting period	0	68. 00
JU. UU	(line 13 x line 20)			·	on tring periou		
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil				7)		70.00
71. 00	Adjusted general inpatient routine service of	cost per diem (I		•	,		71.00
72.00	Program routine service cost (line 9 x line		(line 14 v l	ino 2E\			72. 00 73. 00
74. 00	Medically necessary private room cost applications and program general inpatient routine serv						74.00
75. 00	Capital -related cost allocated to inpatient	•		•	Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	•						77.00
78. 00	Inpatient routine service cost (line 74 minu	us line 77)					78.00
79. 00 80. 00	Aggregate charges to beneficiaries for excess				nuc line 70)		79.00
OLI [III]	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ost iimitatio	n (iine /8 Mi	nus iine 79)		80. 00 81. 00
	1 .)				82.00
81. 00	Impatrent routine service cost inilitation (i	THE 7 X TIME OF	,				
81. 00 82. 00 83. 00	Reasonable inpatient routine service costs ((see instruction	* .				83.00
	1 ,	(see instruction nstructions)	is)				83. 00 84. 00 85. 00

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (From 01/01/2023 To 12/31/2023		pared: 8 am
		Title	XVIII	Subprovi der – I PF	PPS	
Cost Center Description						
					1. 00	
PART IV - COMPUTATION OF OBSERVATION BED PAS						
87.00 Total observation bed days (see instructions	s)				0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 0.00 88.0				88. 00		
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			0	89. 00
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	80, 270	1, 884, 886	0. 04258	6 0	0	90.00
91.00 Nursing Program cost	0	1, 884, 886	0.00000	0 0	0	91.00
92.00 Allied health cost	0	1, 884, 886	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	1, 884, 886	0. 00000	0	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: From 01/01/2023	Worksheet D-1
	Component CCN: 15-T002		
	Title XVIII	Subprovi der -	PPS
		IRF	

PART 1—ALL PROVIDER COMPONENTS INPACT LETN DAYS Impatient days (including private room days and swing-bed days, excluding newborn) Impatient days (including private room days and swing-bed days, excluding memborn) Impatient days (including private room days, excluding swing-bed and resdorn days) 7 vivote room days (excluding swing-bed and observation bed days) 8 part 1 you have only private room days. 9 3, 461			I RF		
NAME THE MAY NAME		Cost Center Description		1 00	
MPATE NT DAYS		PART I - ALL PROVIDER COMPONENTS		1.00	
Inpati ent days (including private room days and swing-bed days, excluding newborn) 3,461 2.00					
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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 37.00	34.00	Average per diem private room charge differential (line 32 minus line 33)(see inst	ructions)	0.00	34.00
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 24, 879, 945) 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) Medically necessary private room cost applicable to the Program (line 14 x line 35) 37.00 4.879, 945 4.879, 945 37.00 4.879, 945					1
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) 1,409.98 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 1,139,264 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			-11: EE1 : 1 : (1 :		ł
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) 1,409.98 38.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.00 40.00	37.00		uitterential (line	4, 8/9, 945	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,409.98 38.00 Program general inpatient routine service cost (line 9 x line 38) 1,139,264 39.00 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) 1,409.98 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 1,409.98 38.00 40.00					
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	38.00			1, 409. 98	38.00
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 1,139,264 41.00		1)		1
	41.00	Tiotal Program general inpatient routine service cost (line 39 + line 40)	l	1, 139, 264	41.00

	Financial Systems	METHODIST HOS			In Lie	u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C		eriod: rom 01/01/2023	Worksheet D-1	
			Component	CCN: 15-T002	o 12/31/2023	Date/Time Pre 5/29/2024 9:0	
			Title	e XVIII	Subprovi der -	PPS	<u> </u>
	Cost Center Description	Total	 Total	Average Per	IRF Program Days	Program Cost	
	·	I npati ent	I npati ent	Diem (col. 1		(col . 3 x	
		Cost 1.00	2. 00	÷ col. 2) 3.00	4. 00	col . 4) 5.00	
42.00	NURSERY (title V & XIX only)	0	C	0.00	0	0	42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	ol	C	0.00	0	0	43. 00
43. 01	NEONATAL I CU	O	C	1		0	43. 01
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
	SURGI CAL I NTENSI VE CARE UNI T						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	cost center bescription					1. 00	
48. 00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	3, line 200)	111 1: 10	1 1)	440, 343	1
48. 01 49. 00	Program inpatient cellular therapy acquisition Total Program inpatient costs (sum of lines of the costs)				column I)	1, 579, 607	48. 01 49. 00
	PASS THROUGH COST ADJUSTMENTS	, , ,	, ,	,			
50. 00	Pass through costs applicable to Program inpa	atient routine	services (fro	m Wkst. D, sum	of Parts I and	128, 836	50.00
51.00	Pass through costs applicable to Program inpa	atient ancillar	ry services (f	rom Wkst. D, s	um of Parts II	22, 300	51.00
52. 00	and IV) Total Program excludable cost (sum of lines!	50 and 51)				151, 136	52.00
53.00	Total Program inpatient operating cost exclude		elated, non-ph	ysician anesth	etist, and	1, 428, 471	53. 00
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges					0	
	Target amount per discharge Permanent adjustment amount per discharge					0. 00 0. 00	•
	Adjustment amount per discharge (contractor	use only)				0.00	•
56. 00	,					0	
57. 00 58. 00	Difference between adjusted inpatient operations payment (see instructions)	ing cost and ta	arget amount (line 56 minus	line 53)	0	57. 00 58. 00
59. 00	Trended costs (lesser of line 53 ÷ line 54, o	or line 55 from	m the cost rep	ortina period	endi na 1996.	0.00	
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,			0 .	9		60.00
(1.00	market basket)					0	(1.00
61. 00	Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less	ser of 50% of t	the amount by	which operatin	g costs (line	0	61.00
	53) are less than expected costs (lines 54 x enter zero. (see instructions)	60), or 1 % of	f the target a	mount (line 56), otherwise		
	Relief payment (see instructions)					0	
63. 00	Allowable Inpatient cost plus incentive paymer PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	uctions)			0	63. 00
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost reporti	ng period (See	0	64.00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the	cost reporting	period (See	0	65. 00
	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routing CAH, see instructions	•	·	, ,	3,	0	
67. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	n December 31	of the cost re	porting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after [December 31 of	the cost repo	rting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
	Skilled nursing facility/other nursing facili	ity/ICF/IID rou	utine service	cost (line 37)			70. 00
71. 00 72. 00	Adjusted general inpatient routine service of		ine 70 ÷ line	2)			71. 00 72. 00
	Program routine service cost (line 9 x line Medically necessary private room cost applications)		m (line 14 x l	ine 35)			73.00
74.00	Total Program general inpatient routine servi	-	7	,			74.00
75. 00	Capital-related cost allocated to inpatient	routine service	e costs (from	Worksheet B, P	art II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line	76)					77. 00
78.00	Inpatient routine service cost (line 74 minus		arovi don nocen	de)			78.00
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa				us line 79)		79. 00 80. 00
81.00	Inpatient routine service cost per diem limi			(/ 5 / 1	,		81.00
82.00	Inpatient routine service cost limitation (li		* .				82.00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		ns)				83. 00 84. 00
85.00	Utilization review - physician compensation	,	ons)				85.00
	Total Program inpatient operating costs (sum						86. 00

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (CCN: 15-T002	From 01/01/2023 To 12/31/2023		pared: 8 am
		Title	XVIII	Subprovi der – I RF	PPS	
Cost Center Description						
					1. 00	
PART IV - COMPUTATION OF OBSERVATION BED PAS						
87.00 Total observation bed days (see instructions	5)				0	87.00
88.00 Adjusted general inpatient routine cost per	diem (line 27 -	÷ line 2)			0. 00	88. 00
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			0	89. 00
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	551, 843	4, 879, 945	0. 11308	34 0	0	90.00
91.00 Nursing Program cost	0	4, 879, 945	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	4, 879, 945	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	4, 879, 945	0. 00000	00	0	93. 00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lie	eu of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-000	Peri od: From 01/01/2023	Worksheet D-1	I
		To 12/31/2023	Date/Time Pre 5/29/2024 9:0	epared: 08 am
	Title 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)		74, 770	1. 00
2.00	Inpatient days (including private room days, excluding swing-b			74, 770	2.00
3. 00	Private room days (excluding swing-bed and observation bed day	s). If you have only pr	ivate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	d days)		63, 458	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	03, 430	5. 00
	reporting period	, .,		_	
6.00	Total swing-bed SNF type inpatient days (including private roo	m days) after December	31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)	to a National de Branches	24 . 6 . 11	0	7.00
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)	3 ,			
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	3, 385	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII on	ly (including private r	oom days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instruct		com days)	O	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII on	y (including private r	oom days) after	0	11.00
40.00	December 31 of the cost reporting period (if calendar year, en				40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including privat	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye				
14. 00	Medically necessary private room days applicable to the Progra	m (excluding swing-bed	days)	0	14.00
15.00	Total nursery days (title V or XIX only)				15. 00 16. 00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	s through December 31 c	f the cost	0. 00	17. 00
	reporting period	-			
18. 00	Medicare rate for swing-bed SNF services applicable to service	s after December 31 of	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00
	reporting period	···· g. · · · · · · · ·			
20.00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions			78, 524, 304	21. 00
22. 00	Swing-bed cost applicable to SNF type services through Decembe		ing period (line	0	22. 00
	5 x line 17)	·			
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reporti	na period (line	0	24. 00
21.00	7 x line 19)	or or the cost reports	ing portion (itino	· ·	2 00
25. 00	Swing-bed cost applicable to NF type services after December 3	1 of the cost reporting	period (line 8	0	25.00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
	General inpatient routine service cost net of swing-bed cost (ine 21 minus line 26)		78, 524, 304	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	,			
	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	
29. 00 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)	1111e 20)		0.00000	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 min	us line 33)(see instruc	tions)	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	nd private room cost di	fferential (line	78, 524, 304	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20. 20	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUI			1 050 01	20.00
38.00	Adjusted general inpatient routine service cost per diem (see			1, 050. 21	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progra	•		3, 554, 961 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39			3, 554, 961	
		•	'		•

7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	3, 385	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	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)	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13. 00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
	Total nursery days (title V or XIX only)	2, 108	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17. 00
18. 00	reporting period	0. 00	18. 00
	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		
20. 00	reporting period	0. 00	20. 00
	Total general inpatient routine service cost (see instructions)	78, 524, 304	21.00
22. 00	5 x line 17)	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24. 00
25. 00	x line 20)	0	25. 00
	Total swing-bed cost (see instructions)	70 524 204	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	78, 524, 304	27. 00
20 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
	Private room charges (excluding swing-bed charges)	0	29.00
	Semi -pri vate room charges (excluding swing-bed charges)	0	30.00
	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31.00
	Average private room per diem charge (line 29 ÷ line 3)	0. 00	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	34.00
	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	o	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	78, 524, 304	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
	Adjusted general inpatient routine service cost per diem (see instructions)	1, 050. 21	38.00
	Program general inpatient routine service cost (line 9 x line 38)	3, 554, 961	39.00
	Medically necessary private room cost applicable to the Program (line 14 x line 35) Total Program general inpatient routine service cost (line 39 + line 40)	0 3, 554, 961	40. 00 41. 00

	ATION OF INPATIENT OPERATING COST		Provi der CO	CN: 15-0002	Peri od: From 01/01/2023	Worksheet D-1	<u>2552-10</u>
					To 12/31/2023	Date/Time Pre 5/29/2024 9:0	
	Cost Center Description	Total	Ti tl	e XIX Average Per	Hospital Program Days	Cost Program Cost	
	'	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
		1.00	2. 00	3. 00	4.00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	3, 516, 115	2, 108	1, 667. 9	09 0	0	42.00
	INTENSIVE CARE UNIT	13, 771, 115	7, 609			0	•
43. 01 44. 00	NEONATAL ICU CORONARY CARE UNIT	3, 013, 716	2, 024	1, 488. 9	0	0	43. 01 44. 00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (W					3, 658, 233	
48. 01 49. 00	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines				, column 1)	0 7, 213, 194	
	PASS THROUGH COST ADJUSTMENTS	Ü		,			
50. 00	Pass through costs applicable to Program in [III]	oatient routine s	services (from	n Wkst. D, su	m of Parts I and	0	50.00
51.00	Pass through costs applicable to Program in and IV)	oatient ancillary	services (fr	om Wkst. D,	sum of Parts II	0	51.00
52. 00	Total Program excludable cost (sum of lines					0	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ated, non-phy	/sician anest	hetist, and	0	53.00
F4 00	TARGET AMOUNT AND LIMIT COMPUTATION	,				0	F
	Program discharges Target amount per discharge					0 0. 00	54.00 55.00
55. 01	Permanent adjustment amount per discharge					0.00	•
56. 00	Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 59)					0. 00 0	1
57.00	Difference between adjusted inpatient opera		get amount (I	ine 56 minus	line 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost repo	orting period	ending 1996,	0 0. 00	
60 00	updated and compounded by the market basket Expected costs (lesser of line 53 ÷ line 54,		n prior vear o	cost report	undated by the	0.00	60.00
	market basket)			•			
61. 00	Continuous improvement bonus payment (if li 55.01, or line 59, or line 60, enter the le					0	61.00
	53) are less than expected costs (lines 54 : enter zero. (see instructions)	x 60), or 1 % of	the target an	mount (line 5	6), otherwise		
	Relief payment (see instructions)					0	
63.00	Allowable Inpatient cost plus incentive pays PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see instruc	:trons)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine coninstructions)(title XVIII only)	sts through Decem	ber 31 of the	e cost report	ing period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	sts after Decembe	er 31 of the d	cost reportin	g period (See	0	65.00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ine costs (line 6	4 plus line 6	55)(title XVI	II only); for	0	66.00
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routing	ne costs through	December 31 (of the cost r	enorting period	0	67.00
	(line 12 x line 19)	-				-	
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	ne costs after De	ecember 31 of	the cost rep	orting 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	lity/ICF/IID rout	ine service d	cost (line 37)		70.00
71.00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ne 70 ÷ line	2)			71.00
73. 00	Medically necessary private room cost applic	•	(line 14 x li	ne 35)			73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•			Part II, column		74. 00 75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
77. 00	Program capital-related costs (line 9 x line	e 76)					77.00
78. 00 79. 00	Inpatient routine service cost (line 74 min		ovi don rocera	4c)			78.00 79.00
	Aggregate charges to beneficiaries for exce Total Program routine service costs for com	, ,			nus line 79)		80.00
81. 00	Inpatient routine service cost per diem lim	tati on			,		81.00
82. 00 83. 00	Inpatient routine service cost limitation (82. 00 83. 00
	Reasonable inpatient routine service costs Program inpatient ancillary services (see in		· /				84.00
84. 00	program ripatient ancirrary services (see in						
84. 00 85. 00	Utilization review - physician compensation Total Program inpatient operating costs (sur	(see instruction					85. 00 86. 00

Health Financial Systems	METHODIST HOSPITALS, INC			In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO			Period: Worksheet D-1 From 01/01/2023	
					Date/Time Prepared: 5/29/2024 9:08 am	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description						
					1. 00	
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1, 050. 21	88. 00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					11, 879, 976	89. 00
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	5, 894, 303	78, 524, 304	0. 07506	3 11, 879, 976	891, 747	90.00
91.00 Nursing Program cost	0	78, 524, 304	0.00000	0 11, 879, 976	0	91.00
92.00 Allied health cost	0	78, 524, 304	0.00000	0 11, 879, 976	0	92.00
93.00 All other Medical Education	O	78, 524, 304	0. 00000	0 11, 879, 976	0	93. 00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Peri od: From 01/01/2023	Worksheet D-1	
	Component CCN: 15-S002			
	Title XIX	Subprovi der -	Cost	
		IPF		

			I PF			
	Cost Center Description			4.00		
PART I - ALL PROVIDER COMPONENTS						
	I NPATI ENT DAYS					
1. 00	Inpatient days (including private room days and swing-bed day			1, 312	•	
2. 00 3. 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		room days	1, 312 0		
3.00	do not complete this line.	ys). If you have only private	1 00iii uays,	Ü	3.00	
4.00	Semi-private room days (excluding swing-bed and observation b	ed days)	İ	1, 312	4.00	
5.00					5.00	
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost				6. 00	
	reporting period (if calendar year, enter 0 on this line)					
7. 00	Total swing-bed NF type inpatient days (including private roo reporting period	m days) through December 31 of	the cost	0	7. 00	
8. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December 31 of t	he cost	0	8. 00	
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	o the Program (excluding swing	-bed and	41	9. 00	
10.00	newborn days) (see instructions)				40.00	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc		ys)	0	10.00	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e		ys) after	0	11.00	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI		days)	0	12. 00	
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	X only (including private room	days)	0	13. 00	
14. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14. 00	
15. 00	Total nursery days (title V or XIX only)	all (exertialing swring bed days)			15. 00	
16. 00	Nursery days (title V or XIX only)			0	16. 00	
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 of the	cost	0.00	17. 00	
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	<u> </u>			18. 00	
	reporting period					
19. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s through December 31 of the c	ost	0. 00	19. 00	
20. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s after December 31 of the cos	t	0. 00	20.00	
21. 00	Total general inpatient routine service cost (see instruction	•		1, 884, 886	•	
22. 00	Swing-bed cost applicable to SNF type services through Decemb 5×1 ine 17)	er 31 of the cost reporting pe	riod (line	0	22. 00	
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting peri	od (line 6	0	23. 00	
24. 00	Swing-bed cost applicable to NF type services through Decembe 7×1 ine 19)	r 31 of the cost reporting per	iod (line	0	24. 00	
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting perio	d (line 8	0	25. 00	
26 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00	
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		1, 884, 886		
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
	General inpatient routine service charges (excluding swing-be	d and observation bed charges)			28.00	
29. 00 30. 00	Private room charges (excluding swing-bed charges)		-	0	29. 00 30. 00	
31.00	Semi-private room charges (excluding swing-bed charges) 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)	÷ 1111e 20)		0.00000		
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	•	
34. 00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instructions)	1	0.00		
35. 00	Average per diem private room cost differential (line 34 x li		1	0.00	•	
36. 00	Private room cost differential adjustment (line 3 x line 35)		1	0.00	36.00	
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost differen	tial (line	1, 884, 886	•	
	27 minus line 36)					
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS				
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see		T	1 494 45	20 00	
38. 00 39. 00	Program general inpatient routine service cost per diem (see	*	-	1, 436. 65 58, 903		
40.00	Medically necessary private room cost applicable to the Progr	•	1	58, 903 0		
					41.00	
00	,		1	55, 700		

Heal th	Financial Systems	METHODIST HOSE	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST				Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Pre	
-			·	e XIX	Subprovi der -	5/29/2024 9:0 Cost	
	Cook Cooker December on	Tatal			. I PF		
	Cost Center Description	Total Inpatient Cost	Total I npati ent Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NUDCEDY (4: 41 - V 0 VIV1.)	1.00	2. 00	3.00	4.00	5. 00	42.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.0	0 0	0	42.00
43.00	INTENSIVE CARE UNIT	0	0			0	
43. 01 44. 00	NEONATAL ICU CORONARY CARE UNIT	0	0	0.0	0	0	43. 01 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45.00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
48. 00	Program inpatient ancillary service cost (Wk	st D 2 col 2	Line 200)			1. 00 48, 589	49.00
48. 01	Program inpatient cellular therapy acquisiti			III, line 10,	column 1)	40, 307	
49. 00	Total Program inpatient costs (sum of lines	41 through 48.C	1)(see instru	ctions)		107, 492	49. 00
50.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	servi ces (fro	m Wkst. D, sur	n of Parts I and	0	50.00
51. 00	III) Pass through costs applicable to Program inp	ationt ancillar	y sorvices (f	rom Wkst D	cum of Darte II	0	51.00
31.00	and IV)	atrent ancirial	y services (i	TOII WKSt. D, S	Sum of Farts II		31.00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated non nh	vei ei an anaeth	notict and	0	
33.00	medical education costs (line 49 minus line	9 1	rated, non-pri	ysi ci ali aliesti	ietist, and		33.00
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
54. 00 55. 00	Target amount per discharge						55.00
55. 01	Permanent adjustment amount per discharge						55. 01
55. 02 56. 00	Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 55					0.00	1
57.00	Difference between adjusted inpatient operat			line 56 minus	line 53)	0	57.00
58. 00	Bonus payment (see instructions)					0	
59. 00	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket)	or line 55 from	the cost rep	orting period	ending 1996,	0. 00	59. 00
60. 00	Expected costs (lesser of line 53 ÷ line 54, market basket)			•			60.00
61. 00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x	ser of 50% of t	he amount by	which operatir	ng costs (line	0	61.00
(2.00	enter zero. (see instructions)		_				(2.00
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ıcti ons)			0	
44.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	to through Doo	mbor 21 of th	a agat manamti	ng norted (Coo	0	64.00
64.00	instructions)(title XVIII only)						
65. 00	<pre>Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)</pre>	ts after Decemb	er 31 of the	cost reportino	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line	64 plus line	65)(title XVII	I only); for	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31	of the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after D	ecember 31 of	the cost repo	orting 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 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c						70. 00 71. 00
71.00	Program routine service cost (line 9 x line		THE 70 - TITLE	2)			72.00
73.00	Medically necessary private room cost applic						73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•		•	Part II. column		74. 00 75. 00
	26, line 45)		,				
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	. *					76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu	s line 77)					78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				nus line 701		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limi			(70 1111	, ,		81.00
82.00	Inpatient routine service cost limitation (I		•				82.00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		15)				83. 00 84. 00
85.00	Utilization review - physician compensation	(see instructio					85.00
86.00	Total Program inpatient operating costs (sum	or rines 83 th	ıı ougn 85)			I	86.00

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (CCN: 15-S002	From 01/01/2023 To 12/31/2023		pared: 8 am
		Ti tl	e XIX	Subprovi der - I PF	Cost	
Cost Center Description						
					1. 00	
PART IV - COMPUTATION OF OBSERVATION BED PAS						
87.00 Total observation bed days (see instructions	s)				0	87.00
88.00 Adjusted general inpatient routine cost per	diem (line 27 -	÷ line 2)			0.00	88. 00
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			0	89. 00
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	80, 270	1, 884, 886	0. 04258	86 0	0	90.00
91.00 Nursing Program cost	0	1, 884, 886	0. 00000	00	0	91.00
92.00 Allied health cost	0	1, 884, 886	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	1, 884, 886	0. 00000	00	0	93.00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0002	Peri od: From 01/01/2023	Worksheet D-1
	Component CCN: 15-T002		
	Title XIX	Subprovi der -	Cost
		IRF	

		IRF		
	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, ex	xcluding newborn)	3, 461	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed a	and newborn days)	3, 461	2.00
3.00	Private room days (excluding swing-bed and observation bed days).	If you have only private room days,	0	3.00
	do not complete this line.	,		
4. 00	Semi-private room days (excluding swing-bed and observation bed da		3, 461	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room da reporting period	ays) through December 31 of the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room da	avs) after December 31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	ays) area becomber or or the cost	· ·	0.00
7.00	Total swing-bed NF type inpatient days (including private room day	ys) through December 31 of the cost	0	7.00
	reporting period			
8. 00	Total swing-bed NF type inpatient days (including private room day	ys) after December 31 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line)	Drogram (oveluding swing had and	48	9. 00
9.00	Total inpatient days including private room days applicable to the newborn days) (see instructions)	e Program (excruding swing-bed and	40	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 (0	11. 00
	December 31 of the cost reporting period (if calendar year, enter			
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX onl	y (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 onl	y (including private room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar year,		U	13.00
14. 00	Medically necessary private room days applicable to the Program (e		0	14. 00
15.00	Total nursery days (title V or XIX only)	3 3 ,	2, 108	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 services the	nrough December 31 of the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services af	ftor Docombor 21 of the cost	0.00	18. 00
10.00	reporting period	itel becember 31 of the cost	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services thr	rough December 31 of the cost	0.00	19. 00
	reporting period			
20.00	Medicaid rate for swing-bed NF services applicable to services aft	ter December 31 of the cost	0.00	20.00
21 00	reporting period		4 070 045	21 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31	1 of the cost reporting period (line	4, 879, 945 0	21. 00 22. 00
22.00	5 x line 17)	i of the cost reporting perrod (iffice	U	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 c	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)			05.00
25. 00	Swing-bed cost applicable to NF type services after December 31 of x line 20)	t the cost reporting period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)		0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line	e 21 minus Line 26)	4, 879, 945	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		.,,	
	General inpatient routine service charges (excluding swing-bed and	d 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 ÷ lin	ne 28)	0.000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3)		0. 00 0. 00	
34.00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus l	ine 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)	<i>'</i>	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and p	orivate room cost differential (line	4, 879, 945	
	27 minus line 36)	•		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	-1170		
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTME		1 400 00	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see inst Program general inpatient routine service cost (line 9 x line 38)	ti ucti ons)	1, 409. 98 67, 679	
40.00	Medically necessary private room cost applicable to the Program (I	ine 14 x line 35)	07,079	40.00
	Total Program general inpatient routine service cost (line 39 + li		67, 679	
		· · · · · · · · · · · · · · · · · · ·	. ,	

Heal th	Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C		Period: From 01/01/2023	Worksheet D-1	
			Component		To 12/31/2023	Date/Time Pre 5/29/2024 9:0	
			Ti tl	e XIX	Subprovi der -	Cost	o un
	Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
		I npati ent	I npati ent	Diem (col. 1		(col. 3 x	
		Cost 1.00	Days 2. 00	÷ col. 2) 3.00	4.00	col . 4) 5.00	
42. 00	NURSERY (title V & XIX only)	0	2.00				42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	O		0.00	0	0	43.00
	NEONATAL ICU	0		1		0	
	CORONARY CARE UNIT						44.00
	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	3, line 200)			192, 612	48. 00
	Program inpatient cellular therapy acquisition				column 1)	0	
49. 00	Total Program inpatient costs (sum of lines A PASS THROUGH COST ADJUSTMENTS	41 through 48.0	JI)(See Instru	CTIONS)		260, 291	49.00
50.00	Pass through costs applicable to Program inpa	atient routine	services (fro	m Wkst. D, sum	of Parts I and	0	50.00
51. 00		atient ancilla	rv services (f	rom Wkst D s	um of Parts II	0	51.00
01.00	and IV)		1 9 301 11 003 (1	Tom Witse. B, S	am or rares rr	Ü	
52. 00 53. 00	Total Program excludable cost (sum of lines! Total Program inpatient operating cost exclu	,	olated non ph	veician anoeth	otist and	0	
55.00	medical education costs (line 49 minus line !	0 .	erated, non-pri	ysi ci aii aliestii	etist, and	0	33.00
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION					0	F4 00
	Program discharges Target amount per discharge					0 0. 00	
55. 01	Permanent adjustment amount per discharge					0. 00	1
	Adjustment amount per discharge (contractor of Target amount (line 54 x sum of lines 55, 55.		`			0. 00 0	1
57. 00	Difference between adjusted inpatient operati			line 56 minus	line 53)	0	1
58.00	Bonus payment (see instructions)					0	58.00
59. 00	Trended costs (lesser of line 53 ÷ line 54, of updated and compounded by the market basket)	or line 55 trom	m the cost rep	orting period	enaing 1996,	0. 00	59. 00
60.00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	om prior year	cost report, u	pdated by the	0. 00	60.00
61. 00	market basket) Continuous improvement bonus payment (if line	e 53 ÷ line 54	is less than	the lowest of	lines 55 plus	0	61.00
	55.01, or line 59, or line 60, enter the less	ser of 50% of	the amount by	which operatin	g costs (line		
	53) are less than expected costs (lines 54 x enter zero. (see instructions)	60), or 1 % of	f the target a	mount (line 56), otherwise		
	Relief payment (see instructions)					0	
63. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	uctions)			0	63.00
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost reporti	ng period (See	0	64.00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Necemb	her 31 of the	cost reporting	neriod (See	0	65.00
03.00	instructions)(title XVIII only)	ts after becenii	bei 31 di tile	cost reporting	perrou (see	0	05.00
66.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line	65)(title XVII	l only); for	0	66.00
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routing	e costs through	h December 31	of the cost re	porting period	0	67.00
40.00	(line 12 x line 19)	o occto often l	Dogombor 21 of	the east rone	mting nomind	0	68. 00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after t	December 31 of	the cost repo	rting period	0	08.00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili						70.00
71.00	Adjusted general inpatient routine service co	ost per diem (I					71.00
	Program routine service cost (line 9 x line Medically necessary private room cost applications)		m (line 14 v l	ine 35)			72. 00 73. 00
	Total Program general inpatient routine servi		•				74.00
75. 00	Capital-related cost allocated to inpatient	routine service	e costs (from	Worksheet B, P	art II, column		75.00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
	Program capital-related costs (line 9 x line	,					77.00
78. 00 79. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		provider recor	ds)			78. 00 79. 00
80.00	Total Program routine service costs for compa	arison to the o			us line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		1)				81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (* .				83.00
84.00	Program inpatient ancillary services (see in		one)				84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
	, J production of the control of the		J/		ļ		

Health Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
		Component	CCN: 15-T002	From 01/01/2023 To 12/31/2023		
		Ti tl	e XIX	Subprovi der – I RF	Cost	
Cost Center Description						
					1. 00	
PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					
87.00 Total observation bed days (see instructions)				0	87.00
88.00 Adjusted general inpatient routine cost per	diem (line 27 –	÷ line 2)			0.00	88. 00
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			0	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	551, 843	4, 879, 945	0. 11308	4 0	0	90.00
91.00 Nursing Program cost	0	4, 879, 945	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	4, 879, 945	0. 00000	0 0	0	92.00
93.00 All other Medical Education	o	4, 879, 945	0. 00000	0	0	93.00

Health Financial Systems	METHODIST HOSPITALS, INC		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
			From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 9:0	pared: 8 am
	Titl∈	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col . 1 x	
		1.00	2.00	col. 2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			19, 014, 874		30.00
31.00 03100 INTENSIVE CARE UNIT			5, 428, 809		31.00
31. 01 03101 NEONATAL CU			0		31.01
40. 00 04000 SUBPROVI DER - I PF			445, 868		40. 00
41. 00 04100 SUBPROVI DER - I RF			0		41.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM		0. 09929	12 500 004	1 242 020	
50. 00 05000 OPERATI NG ROOM 50. 01 05001 ENDOSCOPY		0. 09929		1, 242, 028 223, 571	50. 00 50. 01
51. 00 05100 RECOVERY ROOM		0. 13403		125, 255	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		1. 09645	· ·	285, 638	1
53. 00 05300 ANESTHESI OLOGY		0.00000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 19261		635, 131	54.00
54. 01 05401 RADI OLOGY - ULTRASOUND		0. 13461	9 1, 553, 747	209, 164	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 11640		36, 086	
55. 01 05501 I NFUSI ON CENTER		0. 10819		0	55. 01
56. 00 05600 RADI 01 SOTOPE		0. 14581		176, 650	56.00
57. 00 05700 CT SCAN		0.03330		487, 766	ł
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION		0. 05611 0. 07939		160, 562 978, 170	58. 00 59. 00
60. 00 06000 LABORATORY		0. 07939		2, 013, 750	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 04024		155, 307	62.00
64. 00 06400 I NTRAVENOUS THERAPY		0.00000		133, 307	64.00
65. 00 06500 RESPI RATORY THERAPY		0. 13319		1, 448, 862	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 21690		353, 128	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 30190	975, 505	294, 508	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 27565	673, 310	185, 601	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 05172		196, 924	69. 00
69. 01 06901 CARDI AC REHAB		0. 45128		0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 05850		195, 597	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 45591		2, 791, 835	•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS		0. 45959 0. 2209 <i>6</i>		2, 940, 870 4, 361, 270	•
73.00 07300 DRUGS CHARGED TO PATTENTS		0. 22090			

0. 254685

0. 690158

0. 197496

0. 499561

2, 549, 642

5, 332, 062 1, 317, 791

137, 859, 450

137, 859, 450

2, 238

74.00

90.00

91.00

92.00

201.00

202.00

649, 356

1, 053, 061

658, 317

1, 545

21, 859, 952 200. 00

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

AITH FINANCIAL SYSTEMS METHODIST HO PATIENT ANCILLARY SERVICE COST APPORTIONMENT	SPITALS, INC Provider C	CN: 15-0002	Peri od:	u of Form CMS-2 Worksheet D-3	
	Component	CCN: 15-S002	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 9:0	epare
	Title	× XVIII	Subprovi der -	PPS	0 0
Cost Center Description		Ratio of Cos To Charges	t Inpatient	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
. 00 03000 ADULTS & PEDIATRICS . 00 03100 INTENSIVE CARE UNIT . 01 03101 NEONATAL I CU . 00 04000 SUBPROVI DER - I PF . 00 04100 SUBPROVI DER - I RF . 00 04300 NURSERY			527, 577		30. 31. 31. 40. 41. 43.
ANCILLARY SERVICE COST CENTERS					
.00 05000 OPERATING ROOM		0. 0992		0	
. 01 05001 ENDOSCOPY		0. 1540		0	1
. 00 05100 RECOVERY ROOM		0. 2234		0	1
.00 05200 DELIVERY ROOM & LABOR ROOM .00 05300 ANESTHESIOLOGY		1. 0964		0	
. 00 05300 ANESTHESI OLOGY . 00 05400 RADI OLOGY-DI AGNOSTI C		0. 0000 0. 1926		0 1, 562	
. 01 05401 RADI OLOGY - ULTRASOUND		0. 1926		1, 562	1
. 00 05500 RADI OLOGY - OLITRASOUND		0. 1346		0	
. 01 05501 I NFUSI ON CENTER		0.1184		0	
. 00 05600 RADI OI SOTOPE		0. 1458		0	
. 00 05700 CT SCAN		0. 0333		702	
. OO O5800 MAGNETIC RESONANCE IMAGING (MRI)		0. 0561		0	
. 00 05900 CARDI AC CATHETERI ZATI ON		0. 0793		0	
. 00 06000 LABORATORY		0. 0902		4, 710	
. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 0857		217	
. 00 06400 I NTRAVENOUS THERAPY		0.0000		0	
. 00 06500 RESPI RATORY THERAPY		0. 1331		89	65
. 00 06600 PHYSI CAL THERAPY		0. 2169	05 0	0	66
. 00 06700 OCCUPATI ONAL THERAPY		0. 3019	03 264	80	67
. 00 06800 SPEECH PATHOLOGY		0. 2756	54 0	0	68
. 00 06900 ELECTROCARDI OLOGY		0. 0517	27 16, 654	861	69
. 01 06901 CARDI AC REHAB		0. 4512	80 0	0	69
. 00 07000 ELECTROENCEPHALOGRAPHY		0. 0585	05 0	0	70
.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 4559	14 0	0	71
.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 4595		0	
.00 07300 DRUGS CHARGED TO PATIENTS		0. 2209		21, 283	
. 00 07400 RENAL DI ALYSI S		0. 2546	85 0	0	74
OUTPATIENT SERVICE COST CENTERS		0 (001	F0 0		4
. 00 09000 CLI NI C		0. 6901		0	
. 00 09100 EMERGENCY		0. 1974		5, 760	
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 4995		0 25 244	
Total (sum of lines 50 through 94 and 96 through 98)			226, 953	35, 264	
1.00 Less PBP Clinic Laboratory Services-Program only cha	irges (Tine 61)	I	0		201

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der 0	CN: 15-0002	Peri od:	Worksheet D-3	3
	Component	CCN: 15-T002	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 9:0	
	Ti tl e	e XVIII	Subprovi der - I RF	PPS	
Cost Center Description		Ratio of Cos To Charges	st Inpatient	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					١
0. 00 03000 ADULTS & PEDI ATRI CS					30.
1. 00 03100 INTENSIVE CARE UNIT					31.
1. 01 03101 NEONATAL I CU					31.
0. 00 04000 SUBPROVI DER - 1 PF			050 505		40.
1. 00 04100 SUBPROVI DER - I RF 3. 00 04300 NURSERY			952, 535		41
3. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS					43
D. 00 05000 OPERATING ROOM		0. 0992	90 8, 244	819	50
D. 01 05001 ENATTING ROOM		0. 1540		536	
1. 00 05100 RECOVERY ROOM		0. 2234		0	
2.00 05200 DELIVERY ROOM & LABOR ROOM		1. 0964		Ö	
B. 00 05300 ANESTHESI OLOGY		0.0000		, o	
1. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1926		3, 662	
1. 01 05401 RADI OLOGY - ULTRASOUND		0. 1346		474	1
5. 00 05500 RADI OLOGY-THERAPEUTI C		0. 1164		0	55
5. 01 05501 I NFUSI ON CENTER		0. 1081	99 0	0	55
6. 00 05600 RADI 0I SOTOPE		0. 1458		0	56
7.00 05700 CT SCAN		0. 0333	08 37, 354	1, 244	57
3.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 0561		269	58
P. 00 05900 CARDI AC CATHETERI ZATI ON		0. 0793		0	1
0. 00 06000 LABORATORY		0. 0902	· ·	27, 379	
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 0857		1, 463	
1. 00 06400 I NTRAVENOUS THERAPY		0.0000		0	
5. 00 06500 RESPIRATORY THERAPY		0. 1331		24, 178	
5. 00 06600 PHYSI CAL THERAPY		0. 2169		105, 608	
7. 00 06700 OCCUPATI ONAL THERAPY		0. 3019		129, 855	
3. 00 06800 SPEECH PATHOLOGY 9. 00 06900 ELECTROCARDI OLOGY		0. 2756		18, 783	
		0.0517		1, 446	1
9. 01 06901 CARDI AC REHAB D. 00 07000 ELECTROENCEPHALOGRAPHY		0. 4512		0 231	
1. 00 07100 BEDICAL SUPPLIES CHARGED TO PATIENTS		0. 0585 0. 4559		16, 505	
2.00 07100 MEDICAL SUPPLIES CHARGED TO PATTENTS		0. 4595		1, 047	
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 4343	· ·	82, 476	
1. 00 07400 RENAL DIALYSIS		0. 2546		24, 368	
OUTPATIENT SERVICE COST CENTERS		3. 2040	75, 300	21,000	1 ′ ີ
0. 00 09000 CLINIC		0. 6901	58 0	0	90
1. 00 09100 EMERGENCY		0. 1974		0	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 4995		0	92
Total (sum of lines 50 through 94 and	6 through 98)		2, 102, 683	440, 343	200
D1.00 Less PBP Clinic Laboratory Services-Pr			0		201
02.00 Net charges (line 200 minus line 201)			2, 102, 683		202

Health Financial Systems	METHODIST HOSPITALS, I			In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provid	der C		Peri od:	Worksheet D-3	
				From 01/01/2023 To 12/31/2023	5/29/2024 9:0	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description			Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x	
			1.00	2.00	col. 2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS				3, 475, 468		30.00
31. 00 03100 NTENSI VE CARE UNI T				815, 930		31.00
31. 01 03101 NEONATAL CU				747, 836		31. 01
40. 00 04000 SUBPROVI DER - 1 PF				88, 590		40.00
41. 00 04100 SUBPROVI DER - RF				148, 105		41.00
43. 00 04300 NURSERY				321, 749		43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM			0. 09929		315, 961	50.00
50. 01 05001 ENDOSCOPY			0. 15403		31, 542	
51. 00 05100 RECOVERY ROOM			0. 22340		41, 307	
52.00 05200 DELIVERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY			1. 09645 0. 00000		621, 617	
54. 00 05300 ANESTHESTOLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C			0. 19261		93, 033	
54. 01 05400 RADI OLOGY - ULTRASOUND			0. 19261		35, 348	
55. 00 05500 RADI OLOGY-THERAPEUTI C			0. 13401		5, 537	
55. 01 05501 NFUSI ON CENTER			0. 10819		125	
56. 00 05600 RADI OI SOTOPE			0. 14581		31, 495	
57. 00 05700 CT SCAN			0. 03330		75, 796	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)			0. 05611		25, 515	
59. 00 05900 CARDI AC CATHETERI ZATI ON			0. 07939	2, 197, 488	174, 474	59.00
60. 00 06000 LABORATORY			0. 09029	4, 378, 141	395, 307	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS			0. 08577	160, 848	13, 797	62.00
64.00 06400 INTRAVENOUS THERAPY			0. 00000	0 0	0	64.00
65. 00 06500 RESPIRATORY THERAPY			0. 13319	1, 930, 246	257, 091	65.00
66. 00 06600 PHYSI CAL THERAPY			0. 21690		52, 882	
67. 00 06700 OCCUPATI ONAL THERAPY			0. 30190		53, 450	
68.00 06800 SPEECH PATHOLOGY			0. 27565		17, 135	
69. 00 06900 ELECTROCARDI OLOGY			0. 05172		29, 145	
69. 01 06901 CARDI AC REHAB			0. 45128		6, 510	
70. 00 07000 ELECTROENCEPHALOGRAPHY			0. 05850		23, 834	
71 OO O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS			∩ 455Q1	4 349 266	150 235	ı /1 ()∩

0. 455914

0. 459597

0. 220968

0. 254685

0. 690158

0. 197496

0. 499561

349, 266

349, 266

248, 505

905, 827

23, 465, 771

23, 465, 771

3, 598, 112

71.00

72.00

73.00

74.00

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91.00

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201.00

202.00

159, 235

160, 522

795, 068 63, 290

178, 897

320

0

3, 658, 233 200. 00

71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Net charges (line 200 minus line 201)

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

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

07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

07400 RENAL DIALYSIS

09000 CLI NI C

91. 00 09100 EMERGENCY

73.00 74.00

90.00

200.00

201.00

202.00

INPATIENT ROUTINE SERVICE COST CENTERS	15-0002	Peri od:	Worksheet D-3	,
INPATIENT ROUTINE SERVICE COST CENTERS	I: 15-S002	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 9:0	
INPATIENT ROUTINE SERVICE COST CENTERS	XI X	Subprovi der – I PF	Cost	
0.00 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 1.01 03101 NEONATAL I CU 0.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04100 SUBPROVI DER - I RF 04300 NURSERY ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 05000 PEDOSCOPY 05100 RECOVERY ROOM 05200 DELIVERY ROOM 05200 DELIVERY ROOM 05200 DELIVERY ROOM 05200 DELIVERY ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY - DI AGNOSTI C 05401 RADI OLOGY - DI AGNOSTI C 05401 RADI OLOGY - ULTRASOUND 05500 RADI OLOGY - THERAPEUTI C 05501 INFUSI ON CENTER 05501 INFUSI ON CENTER 05600 RADI OLOGY - THERAPEUTI C 05600 RADI OLOGY - THERAPEUTI C 05600 RADI OLOGY - THERAPEUTI C 05700 CT SCAN 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06900 LABORATORY 06900 LABORATORY 06000 LABORATORY 06000 LABORATORY 06000 MHOLE BLOOD & PACKED RED BLOOD CELLS 06400 INTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06500 RESPI RATORY THERAPY 06700 OCCUPATI ONAL THERAPY 06700 OCCUPATI ONAL THERAPY 06700 OCCUPATI ONAL THERAPY 06700 OCCUPATI ONAL THERAPY 06700 CARDI AC REHAB 0.00 06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB 0.00 07000 ELECTROCARDI OLOGY 06901 CARDI AC REHAB 0.00 07000 ELECTROCARDI OLOGY 06901 CARDI AC REHAB 0.00 07000 ELECTROCARDI OLOGY 07000 MEDICAL SUPPLIE S CHARGED TO PATI ENTS 07200 IMPL DEV. CHARGED TO PATI ENTS 07200 IMPL DEV. CHARGED TO PATI ENTS 07200 IMPL DEV. CHARGED TO PATI ENTS 07200 IMPL DEV. CHARGED TO PATI ENTS 07200 IMPL DEV. CHARGED TO PATI ENTS 07200 IMPL DEV. CHARGED TO PATI ENTS 07200 IMPL DEV. CHARGED TO PATI ENTS 07200 IMPL DEV. CHARGED TO PATI ENTS 07200 IMPL DEV. CHARGED TO PATI ENTS 07200 IMPL DEV. CHARGED TO PATI ENTS 07200 IMPL DEV. CHARGED TO PATI ENTS 07200 IMPL DEV. CHARGED TO PATI ENTS 07200 IMPL DEV. CHARGED TO PATI ENTS 07200 IMPL DEV. CHAR	itio of Cos To Charges		Inpatient Program Costs (col. 1 x col. 2)	
0.00 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 1.01 03101 NEONATAL I CU 0.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04100 SUBPROVI DER - I RF 04100 SUBPROVI DER - I RF 05000 04000 NURSERY ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 05000 PEDISOCOPY 0.01 05001 ENDOSCOPY 05100 RECOVERY ROOM 05200 DELIVERY ROOM 05200 DELIVERY ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY - DI AGNOSTI C 05401 RADI OLOGY - DI AGNOSTI C 05401 RADI OLOGY - DI AGNOSTI C 05500 RADI OLOGY - THERAPEUTI C 05501 INFUSI ON CENTER 05501 INFUSI ON CENTER 05500 O5500 RADI OLOGY - THERAPEUTI C 05501 INFUSI ON CENTER 05500 DAGNOSTI C CROWN 05500 MAGNETI C RESONANCE IMAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06000 LABORATORY 06000 LABORATORY 06000 RESPIRATORY THERAPY 06000 RESPIRATORY THERAPY 06000 RESPIRATORY THERAPY 06700 OCCUPATI ONAL THERAPY 06700 OCCUPATI ONAL THERAPY 06700 OCCUPATI ONAL THERAPY 06700 OCCUPATI ONAL THERAPY 06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB 07000 ELECTROCARDI OLOGY 0700 06900 ELECTROCARDI OLOGY 0700 06900 ELECTROCARDI OLOGY 0700 06900 ELECTROCARDI OLOGY 0700	1. 00	2. 00	3. 00	
1. 00 03100 INTENSI VE CARE UNIT 1. 01 03101 NEONATAL LCU 0. 00 04000 SUBPROVI DER - I PF 1. 00 04100 SUBPROVI DER - I RF 0. 04100 SUBPROVI DER - I RF 0. 04000 NURSERY ANCELLARY SERVICE COST CENTERS 0. 00 05000 OPERATI NG ROOM 0. 01 05001 ENDOSCOPY 1. 00 05100 RECOVERY ROOM 2. 00 05200 DELI VERY ROOM & LABOR ROOM 3. 00 05300 ANESTHESI OLOGY 4. 01 05400 RADI OLOGY - DI AGNOSTI C 4. 01 05400 RADI OLOGY - ULTRASOUND 5. 00 05501 INFUSI ON CENTER 6. 00 05500 RADI OLOGY - HERAPEUTI C 6. 01 05501 INFUSI ON CENTER 6. 00 05600 RADI OLOGY - THERAPEUTI C 6. 00 05700 CT SCAN 8. 00 05800 MAGNETI C RESONANCE IMAGI NG 9. 00 05000 CARDI AC CATHETERI ZATI ON 0. 00 06000 LABORATORY 0. 00 06000 WOLDE BLOOD & PACKED RED BLOOD CELLS 06400 INTRAVENOUS THERAPY 06500 06500 PHSI CAL THERAPY 0600 06600 PHSI CAL THERAPY 0600 06600 PHSI CAL THERAPY 06700 0CCUPATI ONAL THERAPY 06900 CARDI AC CATHETERI SATION 06900 CARDI AC REHAB 0. 00 06901 CARDI AC REHAB 0. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07400 RENGENCY 0. 00 09000 CLINI C 09100 EMERGENCY 0. 00 09100 EMERGENCY 0. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)				
10.00 05000 0PERATI NG ROOM 05001 ENDOSCOPY 05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05200 DELI VERY ROOM & LABOR ROOM 05200 DELI VERY ROOM & LABOR ROOM 05200 ANESTHESI OLOGY 05401 RADI OLOGY - DI AGNOSTI C 05401 RADI OLOGY - DI AGNOSTI C 05401 RADI OLOGY - ULTRASOUND 05500 RADI OLOGY - THERAPEUTI C 05500 RADI OLOGY - THERAPEUTI C 05500 RADI OLOGY - THERAPEUTI C 05500 RADI OLOGY - THERAPEUTI C 05500 RADI OLOGY - THERAPEUTI C 05600 RADI OLOGY - THERAPEUTI C 05700 CT SCAN 05700 CT SCAN 05700 CT SCAN 05700 CARDI AC CATHETERI ZATI ON 06900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06500 RESPIRATORY THERAPY 06500 RESPIRATORY THERAPY 06700 0CCUPATI ONAL THERAPY 06700 0CCUPATI ONAL THERAPY 06700 0CCUPATI ONAL THERAPY 06700 0CCUPATI ONAL THERAPY 07100 06900 ELECTROCARDI OLOGY 09900 ELECTROCARDI OLOGY 07000 0CUPATI ONAL THERAPY 07100 07000 ELECTROCARDI OLOGY 07000 0CUPATI ONAL THERAPY 07100 07000 0CUPATI ONAL THERAPY 07100 07000 ELECTROCARDI OLOGY 07000 0CUPATI ONAL THERAPY 07100 07000 ELECTROCARDI OLOGY 07000 0CUPATI ONAL THERAPY 07100 07000 0CUPATI ONAL THERAPY 07100 07000 0CUPATI ONAL THERAPY 07100 07000 0CUPATI ONAL THERAPY 07100 07000 0CUPATI ONAL THERAPY 07100 07000 0CUPATI ONAL THERAPY 07100 07000 0CUPATI ONAL THERAPY 07100 07000 0CUPATI ONAL THERAPY 07100 07000 0CUPATI ONAL THERAPY 07100 07000 0CUPATI ONAL THERAPY 07100 07000 0CUPATI ONAL THERAPY 07100 07000 0CUPATI ONAL THERAPY 07100 07000 0CUPATI ONAL THERAPY 07100 07000 0CUPATI ONAL THERAPY 07100 07000 0CUPATI ONAL THERAPY 07100 07000 0CUPATI ONAL THERAPY 07100 07000 0CU		585, 543		30. 31. 31. 40. 41. 43.
0. 01 05001 ENDOSCOPY				
1. 00	0. 09929		0	
2. 00 05200 DELI VERY ROOM & LABOR ROOM 3. 00 05300 ANESTHESI OLOGY 4. 00 05400 RADI OLOGY - DI AGNOSTI C 4. 01 05401 RADI OLOGY - ULTRASOUND 5. 00 05500 RADI OLOGY - THERAPEUTI C 5. 01 05501 INFUSI ON CENTER 6. 00 05600 RADI OI SOTOPE 7. 00 05700 CT SCAN 8. 00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 9. 00 05900 CARDI AC CATHETERI ZATI ON 0. 00 06000 LABORATORY 2. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 4. 00 06400 INTRAVENOUS THERAPY 5. 00 06500 RESPI RATORY THERAPY 6. 00 06600 PHYSI CAL THERAPY 7. 00 06700 OCCUPATI ONAL THERAPY 9. 00 06900 ELECTROCARDI OLOGY 9. 01 06901 CARDI AC REHAB 0. 00 07000 ELECTROCARDI OLOGY 9. 01 06901 CARDI AC REHAB 0. 00 07000 ELECTROENCEPHALOGRAPHY 1. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 2. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 3. 00 07300 DRUGS CHARGED TO PATI ENTS 4. 00 07400 RENAL DI ALYSI S 0UTPATI ENT SERVI CE COST CENTERS 0. 00 09100 EMERGENCY 2. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	0. 15403		0	1
3. 00	0. 22340		0	
4. 00	1. 09645 0. 00000		0	
1. 01				
0.00 05500 RADI OLOGY-THERAPEUTI C 05501 INFUSI ON CENTER 05600 RADI OI SOTOPE 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON 06900 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06400 INTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 06000 PHYSI CAL THERAPY 06700 06000 PHYSI CAL THERAPY 06700 06600 PHYSI CAL THERAPY 06700 06600 PHYSI CAL THERAPY 00700 06600 SPEECH PATHOLOGY 06700 0CCUPATI ONAL THERAPY 00700 06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB 07000 ELECTROENCEPHALOGRAPHY 007100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 07100 RENAL DI ALYSI S 000 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 000 09100 EMERGENCY 000 09100 EMERGENCY 000 09100 EMERGENCY 000 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 19261 0. 13461		3, 832 43	
0.00	0. 13401		0	
0.00 05600 RADI OI SOTOPE 0.00 05700 CT SCAN 0.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.00 05900 CARDI AC CATHETERI ZATI ON 0.00 06000 LABORATORY 0.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.00 06400 I NTRAVENOUS THERAPY 0.00 06500 RESPI RATORY THERAPY 0.00 06600 PHYSI CAL THERAPY 0.00 06700 OCCUPATI ONAL THERAPY 0.00 06900 SPECCH PATHOLOGY 0.01 06901 CARDI AC REHAB 0.00 07000 ELECTROCARDI OLOGY 0.01 06901 CARDI AC REHAB 0.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0.00 07300 DRUGS CHARGED TO PATI ENTS 0.00 07400 RENAL DI ALYSI S 0.00 07400 RENAL DI ALYSI S 0.00 09000 CLI NI C 0.00 09100 EMERGENCY 0.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 11040		0	
0.00	0. 14581		0	
0.00 05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06400 I NTRAVENOUS THERAPY 06500 MESPI RATORY THERAPY 06500 MESPI RATORY THERAPY 000 06500 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 OCCUPATI ONAL THERAPY 06800 SPECH PATHOLOGY 06900 ELECTROCARDI OLOGY 06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 000 07400 RENAL DI ALYSI S 000 09100 EMERGENCY 09000 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 03330		0	
0.00	0. 05611		0	
00	0. 07939		0	
. 00	0. 09029		9, 587	
. 00 06400	0. 08577		408	
. 00	0. 00000		0	
. 00	0. 13319		Ö	
. 00	0. 21690		1, 004	
. 00	0. 30190		476	
. 00	0. 27565		0	
0.00 0.7000 ELECTROENCEPHALOGRAPHY 0.7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.7200 IMPL. DEV. CHARGED TO PATIENTS 0.7300 DRUGS CHARGED TO PATIENTS 0.7400 RENAL DIALYSIS 0.7400 RENAL DIALYSIS 0.7400 RENAL DIALYSIS 0.7400 CLINIC COST CENTERS 0.7400 CLINIC COST CENTERS 0.7400 CLINIC COST CENTERS 0.7400 CLINIC COST CENTERS 0.7400 CLINIC COST CENTERS 0.7400 CLINIC COST CENTERS 0.7400 CLINIC COST CENTERS 0.7400 CLINIC COST CENTERS 0.7400 CLINIC COST CENTERS 0.7400 CLINIC COST CENTERS 0.7400 CLINIC COST CENTERS 0.7400 CLINIC COST CENTERS 0.7400 CLINIC COST CENTERS 0.7400 CLINIC	0. 05172		1, 482	69
. 00	0. 45128		0	69
. 00	0. 05850	05 0	0	70
. 00 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DI ALYSIS 0UTPATIENT SERVICE COST CENTERS 09000 CLI NI C 09010 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 45591	14 0	0	71
. 00 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09000 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 45959	97 0	0	72
OUTPATIENT SERVICE COST CENTERS O9000 CLINIC O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART) O9200 OBSERVATION O9200 O9200 OSSERVATION	0. 22096	108, 996	24, 085	73
. 00	0. 25468	35 0	0	74
. 00 09100 EMERGENCY . 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				
.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 69015		0	90
	0. 19749		7, 672	
	0. 49956		0	
10.00 Total (sum of lines 50 through 94 and 96 through 98)		313, 855	48, 589	
D1.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) D2.00 Net charges (line 200 minus line 201)		0 313, 855		201 202

NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0002	Peri od:	Worksheet D-3	,
		Component	CCN: 15-T002	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 9:0	
		Ti tl	e XIX	Subprovi der – I RF	Cost	
	Cost Center Description		Ratio of Cos To Charges	st Inpatient	Inpatient Program Costs (col. 1 x col. 2)	
			1. 00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		ı			4
1. 00 1. 01 0. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03101 NEONATAL ICU 04000 SUBPROVIDER - IPF					30. 31. 31. 40.
	04100 SUBPROVI DER - I RF			432, 283		41.
3. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS					43.
0. 00	05000 OPERATING ROOM		0. 0992	90 3, 304	328	50.
0. 01	05001 ENDOSCOPY		0. 1540	•	0	
1.00	05100 RECOVERY ROOM		0. 2234	00 0	0	51.
2. 00	05200 DELIVERY ROOM & LABOR ROOM		1. 0964	50 0	0	52
. 00	05300 ANESTHESI OLOGY		0.0000	00 0	0	53
	05400 RADI OLOGY-DI AGNOSTI C		0. 1926		2, 410	
	05401 RADI OLOGY - ULTRASOUND		0. 1346		286	
. 00	05500 RADI OLOGY-THERAPEUTI C		0. 1164		0	
	05501 I NFUSI ON CENTER		0. 1081		0	
	05600 RADI OI SOTOPE		0. 1458		0	
. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 0333 0. 0561		663	1
	05900 CARDI AC CATHETERI ZATI ON		0.0381		0	
. 00	06000 LABORATORY		0.0793		10, 399	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 0857		287	
. 00	06400 I NTRAVENOUS THERAPY		0.0000	•	0	
. 00	06500 RESPI RATORY THERAPY		0. 1331		9, 402	65
. 00	06600 PHYSI CAL THERAPY		0. 2169	05 227, 062	49, 251	66
. 00	06700 OCCUPATI ONAL THERAPY		0. 3019	03 199, 086	60, 105	67
. 00	06800 SPEECH PATHOLOGY		0. 2756		6, 892	
	06900 ELECTROCARDI OLOGY		0. 0517		21	
	06901 CARDI AC REHAB		0. 4512		0	
	07000 ELECTROENCEPHALOGRAPHY		0. 0585		16	
. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 4559		5, 592	
. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS		0. 4595 0. 2209		0 44, 883	
	07400 RENAL DIALYSIS		0. 2209		2,077	
. 00	OUTPATIENT SERVICE COST CENTERS		0. 2540	0, 100	2,077	′4
. 00	09000 CLINIC		0. 6901	58 0	0	90
	09100 EMERGENCY		0. 1974		ő	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 4995		0	
0.00				902, 334	192, 612	
1. 00		ges (line 61)		0		201
2.00	Net charges (line 200 minus line 201)			902, 334	I	202

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0002	From 01/01/2023	Worksheet E Part A Date/Time Prepared: 5/29/2024 9:08 am
	T1.1 \0.011		000

	Title XVII	11	Hospi tal	5/29/2024 9: 0 PPS	8 am
		<u> </u>		1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to Octinstructions)	ober 1 (s	see	0 20, 273, 506	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after instructions)	October 1	l (see	6, 070, 066	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges oc 1 (see instructions)	ccurring p	orior to October	0	1.03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges oc October 1 (see instructions)	ccurring o	on or after	0	1.04
2.00	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			0	2.00
2. 02 2. 03 2. 04	Outlier payment for discharges for Model 4 BPCI (see instructions) Outlier payments for discharges occurring prior to October 1 (see instruction Outlier payments for discharges occurring on or after October 1 (see instruct			0 1, 298, 509	2. 03
3. 00 4. 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost reporting period (se	,	rtions)	138, 968 36, 406, 528 373. 53	3.00
	Indirect Medical Education Adjustment				
5. 00	FTE count for allopathic and osteopathic programs for the most recent cost re or before 12/31/1996. (see instructions)				5.00
5. 01 6. 00	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see in FTE count for allopathic and osteopathic programs that meet the criteria for new programs in accordance with 42 CFR 413.79(e)			0.00	5. 01 6. 00
6. 26	Rural track program FTE cap limitation adjustment after the cap-building wind the CAA 2021 (see instructions)			0.00	
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §41. ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105 cost report straddles July 1, 2011 then see instructions.	` ,		0. 00 0. 00	7. 00 7. 01
7. 02	Adjustment (increase or decrease) to the hospital's rural track program FTE I track programs with a rural track for Medicare GME affiliated programs in acc and 87 FR 49075 (August 10, 2022) (see instructions)		` '	0. 00	7. 02
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopa affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 1998), and 67 FR 50069 (August 1, 2002).			0. 00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 report straddles July 1, 2011, see instructions.	of the A	ACA. If the cost	0. 00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a close under § 5506 of ACA. (see instructions)	ed teachir	ng hospital	0.00	8. 02
8. 21	The amount of increase if the hospital was awarded FTE cap slots under $\S126$ o instructions)			0.00	
9. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus line minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instruc	ctions)		8. 53	
11. 00	FTE count for allopathic and osteopathic programs in the current year from yo FTE count for residents in dental and podiatric programs.	our record	is		11.00
12. 00 13. 00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.			2. 86 3. 00	12. 00 13. 00
14. 00	Total allowable FTE count for the penultimate year if that year ended on or a otherwise enter zero.	ıfter Sept	tember 30, 1997,	3. 00	14. 00
	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program (see instructions)				15. 00 16. 00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	
18. 00 19. 00	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4).			2. 95 0. 007898	
	Prior year resident to bed ratio (see instructions)			0. 008043	
21. 00 22. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 007898 113, 488	1
22. 00	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)			156, 839	
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA Number of additional allopathic and osteopathic IME FTE resident cap slots un (E)(1)(1)(2)(2)	nder 42 CF	FR 412. 105	0.00	23. 00
24. 00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than 0, then enter the lower of line 22.	or lin-	24 (500	-5. 67	1
25. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 instructions) Posidont to had ratio (divide Line 25 by Line 4)	ou line	z4 (See	0.00	
	Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions)			0. 000000 0. 000000	27. 00
	IME add-on adjustment amount (see instructions) IME add-on adjustment amount - Managed Care (see instructions)			0	28. 00 28. 01
	Total IME payment (sum of lines 22 and 28)			113, 488	1
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment			156, 839	•
30. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (see	instruct	tions)	8. 43	30.00
31.00	Percentage of Medicaid patient days (see instructions)			33. 45	•
	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions)			41. 88 23. 77	32. 00 33. 00
	printendente di apriopor tronato snare percentage (see Histractions)		l	23.77	

	ı Financial Systems METHODIST I LATION OF REIMBURSEMENT SETTLEMENT	HOSPITALS, INC Provider CCN: 15-0002	Period:	u of Form CMS-2 Worksheet E	2552-10
CALCUI	ATTOW OF RETWINDORSEMENT SETTLEMENT	110VI dei CGN. 13-0002	From 01/01/2023 To 12/31/2023	Part A	pared:
		Title XVIII	Hospi tal	5/29/2024 9: 0 PPS	8 am
		II tile Aviii	nospi tai	FF3	
0.4.00				1.00	0.4.00
34.00	Disproportionate share adjustment (see instructions)		Prior to 10/1	1,565,467	34.00
			1. 00	2.00	
	Uncompensated Care Payment Adjustment				
35. 00 35. 01	Total uncompensated care amount (see instructions)		0 00000000	0. 000000000	
35. 01	Factor 3 (see instructions) Hospital UCP, including supplemental UCP (see instructions)	nns)	0. 000000000 3, 397, 293	2, 666, 360	
35. 03			2, 540, 988	670, 232	
36. 00		03)	3, 211, 220		36.00
40.00	Additional payment for high percentage of ESRD beneficia	ary discharges (lines 40 thro			1 40 0
40. 00 41. 00	Total Medicare discharges (see instructions) Total ESRD Medicare discharges (see instructions)		0		40.00
41. 01	Total ESRD Medicare covered and paid discharges (see ins	structions)	0		41.0
42. 00	Divide line 41 by line 40 (if less than 10%, you do not		0.00		42.00
43. 00	Total Medicare ESRD inpatient days (see instructions)		0		43.00
44. 00	Ratio of average length of stay to one week (line 43 dividays)	vided by line 41 divided by	7 0.000000		44.00
45. 00	Average weekly cost for dialysis treatments (see instruc	ctions)	0.00		45.00
46. 00	1 3 1	ne 41.01)	0		46.00
47.00	Subtotal (see instructions)	ADII omali rural baanitala	32, 671, 224		47.00
48. 00	Hospital specific payments (to be completed by SCH and Nonly. (see instructions)	лон, smail rural nospitals	0		48. 0
	Toni y. (See That detrona)			Amount	
10.00	The state of the s			1. 00	40.00
49. 00 50. 00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		2)	32, 828, 063 2, 233, 437	
51. 00			*	2, 233, 437	51.0
52. 00				90, 134	52.0
53. 00	Nursing and Allied Health Managed Care payment			49, 002	
54.00	Special add-on payments for new technologies			227, 700	1
54. 01 55. 00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, I	ine 69)		0	54. 0 55. 0
55. 01	Cellular therapy acquisition cost (see instructions)	1116 07)		0	55.0
56. 00	Cost of physicians' services in a teaching hospital (see	e intructions)		0	56.0
57. 00	Routine service other pass through costs (from Wkst. D,		through 35).	13, 652	
58.00	Ancillary service other pass through costs from Wkst. D,	Pt. IV, col. 11 line 200)		84, 249	
59. 00 60. 00	Total (sum of amounts on lines 49 through 58) Primary payer payments			35, 526, 237 0	59. 00 60. 00
61. 00		minus line 60)		35, 526, 237	
62. 00	Deductibles billed to program beneficiaries	,		2, 415, 576	
63. 00	Coinsurance billed to program beneficiaries			357, 810	
	Allowable bad debts (see instructions)			422, 130	
65. 00 66. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see	instructions)		274, 385 77, 508	ı
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	e Histi ucti olis)		33, 027, 236	67.0
68.00	Credits received from manufacturers for replaced devices	s for applicable to MS-DRGs	(see instructions)	0	68.00
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and	d 96).(For SCH see instructi	ons)	0	69.0
70. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70. 50	Rural Community Hospital Demonstration Project (§410A De		e instructions)	0	70.50
70. 75 70. 87	N95 respirator payment adjustment amount (see instruction Demonstration payment adjustment amount before sequestration)			0	70. 7! 70. 8
70. 88	SCH or MDH volume decrease adjustment (contractor use or			0	70.8
70. 89	Pioneer ACO demonstration payment adjustment amount (see	3,		_	70.8
70. 90	HSP bonus payment HVBP adjustment amount (see instruction			0	70. 9
70. 91	HSP bonus payment HRR adjustment amount (see instruction	ns)		0	70.9
70. 92 70. 93	,			-71 780	70. 92 70. 93
70. 93 70. 94	1 7 7			-71, 780 -102, 348	
70. 94				.02,010	,

Health Financial Systems	METHODIST HOSPITALS, I	NC.		Inlie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			CN: 15-0002 P	Peri od:	Worksheet E	2332 10
				rom 01/01/2023	Part A	
				o 12/31/2023	Date/Time Pre 5/29/2024 9:0	pared: 8 am
		Title	XVIII	Hospi tal	PPS	<u> </u>
				(уууу)	Amount	
				0	1. 00	
70.96 Low volume adjustment for federal fisca the corresponding federal year for the		mn 0	,	0	0	70. 96
70. 97 Low volume adjustment for federal fisca the corresponding federal year for the	al year (yyyy) (Enter in colu		(0	0	70. 97
70. 98 Low Volume Payment-3	period ending on or arter to	' ')		0	0	70. 98
70. 99 HAC adjustment amount (see instructions	5)				77, 073	
71.00 Amount due provider (line 67 minus line		0)			32, 776, 035	
71.01 Sequestration adjustment (see instructi	ons)	<u> </u>			655, 521	71. 01
71.02 Demonstration payment adjustment amount	after sequestration				0	71. 02
71.03 Sequestration adjustment-PARHM pass-thr	roughs					71. 03
72.00 Interim payments					31, 213, 645	
72.01 Interim payments-PARHM						72. 01
73.00 Tentative settlement (for contractor us					0	
73. 01 Tentative settlement-PARHM (for contrac					00/ 0/0	73.01
74.00 Balance due provider/program (line 71 r	ninus iines /i.ui, /i.uz, /z,	and			906, 869	74.00
74.01 Balance due provider/program-PARHM (see						74. 01
75.00 Protested amounts (nonallowable cost re	eport items) in accordance wi	th			921, 851	75. 00
CMS Pub. 15-2, chapter 1, §115.2						
TO BE COMPLETED BY CONTRACTOR (lines 90 90.00 Operating outlier amount from Wkst. E,		2			0	90.00
plus 2.04 (see instructions)	Pt. A, Title 2, Of Sull Of 2.0	3			U	90.00
91.00 Capital outlier from Wkst. L, Pt. I, Ii	ne 2				0	91.00
92.00 Operating outlier reconciliation adjust		s)			0	92.00
93.00 Capital outlier reconciliation adjustme					0	93.00
94.00 The rate used to calculate the time val					0.00	94.00
95.00 Time value of money for operating exper	nses (see instructions)				0	95.00
96.00 Time value of money for capital related	d expenses (see instructions)				0	96. 00
				Prior to 10/1		
HSP Bonus Payment Amount				1. 00	2. 00	
100.00 HSP bonus amount (see instructions)				0	0	100.00
HVBP Adjustment for HSP Bonus Payment				o _l		100.00
101.00 HVBP adjustment factor (see instruction	ns)			0. 0000000000	0. 0000000000	101.00
102.00 HVBP adjustment amount for HSP bonus pa				0		102.00
HRR Adjustment for HSP Bonus Payment						
103.00 HRR adjustment factor (see instructions				0. 0000	0. 0000	
104.00 HRR adjustment amount for HSP bonus pay				0	0	104.00
Rural Community Hospital Demonstration						
200.00 Is this the first year of the current s		nder t	rne 21st			200.00
Century Cures Act? Enter "Y" for yes or	"N" TOP NO.					
Cost Reimbursement 201.00 Medicare inpatient service costs (from	Wkst D-1 Dt II lino 40)					201. 00
202.00 Medicare discharges (see instructions)	WKSt. D-1, Ft. 11, 11116 49)					202.00
203. 00 Case-mix adjustment factor (see instructions)	rtions)					202.00
Computation of Demonstration Target Amo		year	of the curren	t 5-year demons		
peri od)	(
204.00 Medicare target amount						204.00

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Peri od: Worksheet E From 01/01/2023 Part A Exhi bit 4 To 12/31/2023 Date/Time Prepared: 5/29/2024 9.08 am Provider CCN: 15-0002

					10) 12/31/2023	5/29/2024 9:0	
		W (0 5 5 · A			XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After	Total (Col 2 through 4)	
		TTTIC	L, rait A)	LITTI TI CINCITE	10 10/01	10/01	tili ougii +)	
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	DRG amounts other than outlier payments	1. 00	0	0	0	0	0	1.00
1. 01	DRG amounts other than outlier payments for discharges	1. 01	20, 273, 506	0	20, 273, 506		20, 273, 506	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	6, 070, 066	0		6, 070, 066	6, 070, 066	1. 02
1. 03	1 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1. 03	0	0	0		0	1.03
1. 04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1. 04
2.00	Outlier payments for	2. 00						2.00
2. 01	discharges (see instructions) 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, 298, 509	0	1, 298, 509		1, 298, 509	2. 02
2. 03	October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see	2. 04	138, 968	0		138, 968	138, 968	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	36, 406, 528	0	27, 801, 104	8, 605, 424	36, 406, 528	4. 00
5. 00	Indirect Medical Education Adj	ustment 21.00	0. 007898	0. 007898	0. 007898	0. 007898		5. 00
6. 00	A, line 21 (see instructions) IME payment adjustment (see instructions)	22. 00	113, 488	0	87, 338	26, 150	113, 488	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	156, 839	0	119, 767	37, 072	156, 839	6. 01
	instructions) Indirect Medical Education Adj	ustmont for the	a Add on for Sa	oction 122 of t	the MMA			
7. 00	IME payment adjustment factor	27. 00	0. 000000	0. 000000	0.000000	0. 000000		7. 00
8. 00	(see instructions) IME adjustment (see instructions)	28. 00	0	0	0	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see	28. 01	O	0	0	0	0	8. 01
9. 00	<pre>instructions) Total IME payment (sum of lines 6 and 8)</pre>	29. 00	113, 488	0	87, 338	26, 150	113, 488	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and	29. 01	156, 839	0	119, 767	37, 072	156, 839	9. 01
	8.01)							
10. 00	Disproportionate Share Adjustm Allowable disproportionate	ent 33. 00	0. 2377	0. 2377	0. 2377	0. 2377		10.00
44.00	share percentage (see instructions)	0.1.00			4 004 750	010 741	4 5/5 4/3	
11.00	Disproportionate share adjustment (see instructions)	34.00	1, 565, 467	0	1, 204, 753	360, 714	1, 565, 467	
11. 01	Uncompensated care payments Additional payment for high pe	36.00 rcentage of ESI	3, 211, 220 RD beneficiary		2, 540, 988	670, 232	3, 211, 220	11.01
12. 00	Total ESRD additional payment	46. 00	0	0	0	0	0	12.00
13. 00 14. 00	(see instructions) Subtotal (see instructions) Hospital specific payments	47. 00 48. 00	32, 671, 224 0	0	25, 405, 094 0	7, 266, 130 0	32, 671, 224 0	13. 00 14. 00
15. 00	(completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions)	49. 00	32, 828, 063	0	25, 524, 861	7, 303, 202	32, 828, 063	15. 00

LOW VO	LUME CALCULATION EXHIBIT 4			Provi der C		Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 9:0	pared:
					XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3. 00	4. 00	5. 00	
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	2, 233, 437	O	1, 718, 16	3 515, 274	2, 233, 437	16.00
17. 00	new technologies	54. 00	227, 700	0	222, 12	7 5, 572	227, 699	
17. 01 17. 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0		0 0	0	17. 01 17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)		0	0		0 0	0	
19. 00	SUBTOTAL			0	27, 465, 15	1 7, 824, 048	35, 289, 199	19.00
		W/S L, line	(Amounts from L)					
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
20. 00 20. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier	1. 00 1. 01	1, 996, 818 0	0	1, 526, 11	5 470, 703 0 0	1, 996, 818 0	20. 00 20. 01
21. 00 21. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments	2. 00 2. 01	51, 514 O	0	50, 57	7 0 937 0 0	51, 514 0	21. 00 21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0042	0. 0042	0. 004	2 0.0042		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	8, 387	0	6, 41	0 1, 977	8, 387	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0885	0. 0885	0. 088	5 0.0885		24.00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	176, 718	0	135, 06	1 41, 657	176, 718	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	2, 233, 437	0	1, 718, 16	3 515, 274	2, 233, 437	26. 00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1. 00	2.00	3. 00	4. 00	5. 00	
27. 00 28. 00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			0. 00000	0.000000	0	27. 00 28. 00
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	0	29. 00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

Health Financial Systems

METHODIST HOSPITALS, INC

In Lieu of Form CMS-2552-10

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 15-0002

Period:
From 01/01/2023
To 12/31/2023

Part A Exhibit 5
Date/Time Prepared:
5/29/2024 9: 08 am

Next Pit Wist Pit Pit Wist Pit Pit Pit Wist Pi					To	12/31/2023	Date/Time Pre 5/29/2024 9:0	
Nest Period to				Title	XVIII	Hospi tal		
No. DRG emounts other than outilier payments 0 1,00 2,00 3,00 4,00			Wkst. E, Pt.			Peri od on	Total (cols.	
1.00 BRG amounts other than outlier payments For 1.00 2.073,506 20,273,506 20,273,506 1.00			A, line	Wkst. E, Pt.	10/01	after 10/01	2 and 3)	
1.00 BRG amounts other than outlier payments for 1.01 20,273,506 20,273,506 1.01								
1.01 BRC amounts other than outli in payments for discharges occurring prior to October 1 1.02 6.070.066 6.070.066 6.070.066 1.02				1. 00	2. 00	3. 00	4. 00	
1.00 Displayments from conting prior to October 1 1.02 6.070,066 6.070,066 6.070,066 1.02 1.03 1								
1.02 DNS amounts other than outli ler payments for discharges occurring on or after to October 1 1.03 0 0 0 0 0 0 1.03	1. 01		1. 01	20, 273, 506	20, 273, 506		20, 273, 506	1. 01
discharges occurring on or after October 1.03 0.0 0.								
1.03 DRC for Federal specific operating payment 1.03 0 0 0 0 0 0 1.03	1. 02		1. 02	6, 070, 066		6, 070, 066	6, 070, 066	1. 02
Tor Model 4 BPCI occurring prior to October			4 00					4 00
1.04 DRS for Federal specific operating payment 1.04 0 0 0 0 1.04	1.03		1.03	١	Ü		0	1.03
For Model 4 BPCI occurring on or after		10 Model 4 BPCI occurring prior to october						
For Model 4 BPCI occurring on or after	1 04	DRG for Federal specific operating payment	1 04			٥	0	1 04
October 1	1.04		1.04	Ĭ		ď	O	1.04
2.00 Outlier payments for discharges (see 2.00 Outlier payments for discharges for Model 4 2.02 Outlier payments for discharges for Model 4 2.02 Outlier payments for discharges for Model 4 2.02 Outlier payments for discharges occurring 2.03 1,298,599 1,298,599 1,298,599 1,298,599 2.02 2.02 2.02 2.02 2.03 2.04 338,968 338,968 338,968 2.03 0.03 0.04 2.01 0.00 0.								
instructions	2.00		2.00					2. 00
2.01 Outlier payments for discharges for Model 4 2.02 0 0 0 0 0 0 2.01								
2. 02 Outlier payments for discharges occurring prior to October 1 (see instructions) 2. 03	2.01	*	2. 02	o	0	o	0	2. 01
Drior to October 1 (see instructions) 2.04 138,968 138,968 138,968 2.03 2.03 2.01 2.01 2.01 2.01 2.01 2.01 2.01 2.01 3.00		BPCI						
2.03 outlier payments for discharges occurring on control of the first ordinary of the first outlier of the end of the first outlier of the first outlier of the first outlier of the first outlier of the first outlier outli	2.02		2. 03	1, 298, 509	1, 298, 509		1, 298, 509	2.02
0								
1.00	2.03	1 3	2. 04	138, 968		138, 968	138, 968	2. 03
A.00 Managed Care simulated payments 3.00 36,406,528 27,801,105 8,605,423 36,406,528 4.00								
Indirect Medical Education Adjustment		. 3		0	0	0		
Amount from Worksheet E, Part A, Line 21 21.00 0.007898 0.	4. 00		3.00	36, 406, 528	27, 801, 105	8, 605, 423	36, 406, 528	4.00
See Instructions Comparison Comparis			24.22	0.007000	0.007000	0.007000		
6.00 IME payment adjustment (see instructions) 22.00 113,488 87,338 26,150 113,488 6.00	5.00		21.00	0.007898	0.007898	0.007898		5.00
IME payment adjustment for managed care (see 22.01 156,839 119,767 37,072 156,839 6.01	6 00		22.00	112 /00	07 220	26 150	112 /00	6 00
Instructions Note		, ,			·	·	·	
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA IME payment adjustment factor (see 27.00 0.00000000	0.01		22.01	130, 037	117, 707	37, 072	130, 037	0.01
The payment adjustment factor (see 27.00 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000			e Add-on for S	ection 422 of t	he MMA			
Instructions IME adjustment (see instructions) 28.00 0 0 0 0 0 8.00	7. 00	3				0. 000000		7. 00
Section IME payment adjustment add on for managed 28.01 0 0 0 0 0 0 8.01								
Care (See instructions) Care (See instru	8.00	IME adjustment (see instructions)	28. 00	0	0	0	0	8.00
9.00 Total IME payment (sum of lines 6 and 8) 29.00 113,488 87,338 26,150 113,488 9.00 Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage (see instructions) 11.00 Disproportionate share adjustment (see 34.00 1,565,467 1,204,753 360,714 1,565,467 11.00 instructions) 11.01 Uncompensated care payments 36.00 3,211,220 2,540,988 670,232 3,211,220 11.01 Uncompensated care payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46.00 0 0 0 0 12.00 instructions) 13.00 Subtotal (see instructions) 47.00 32,671,224 25,405,094 7,266,130 32,671,224 13.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs 49.00 32,828,063 25,524,861 7,303,202 32,828,063 15.00 (see instructions) 16.00 Payment for inpatient operating costs 49.00 32,828,063 25,524,861 7,303,202 32,828,063 15.00 (see instructions) 17.00 Special add-on payments for new technologies 54.00 227,700 222,128 5,572 227,700 17.00 17.01 Net organ acquisition cost 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8. 01	IME payment adjustment add on for managed	28. 01	0	0	0	0	8. 01
Total IME payment for managed care (sum of lines 6. 01 and 8. 01) 156, 839 119, 767 37, 072 156, 839 9. 01		care (see instructions)						
Lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 All lowable of sproportionate share percentage 33.00 0.2377 0.2377 0.2377 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 1.565,467 1.204,753 360,714 1.565,467 11.00 instructions) 11.01 Uncompensated care payments 36.00 3.211,220 2.540,988 670,232 3.211,220 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46.00 0 0 0 0 0 12.00 13.00 Subtotal (see instructions) 47.00 32,671,224 25,405,094 7,266,130 32,671,224 13.00 14.00 48.00 0 0 0 0 0 14.00 14.00 15.00					·		·	
Disproportionate Share Adjustment	9. 01	. 3	29. 01	156, 839	119, 767	37, 072	156, 839	9. 01
10.00 Allowable disproportionate share percentage (see instructions) 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 1,565,467 1,204,753 360,714 1,565,467 11.00 instructions) 11.01 Uncompensated care payments 36.00 3,211,220 2,540,988 670,232 3,211,220 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46.00 0 0 0 0 12.00 instructions) 13.00 Subtotal (see instructions) 47.00 32,671,224 25,405,094 7,266,130 32,671,224 13.00 14.00 48.00 0 0 0 0 14.00 15.00								
11.00 Disproportionate share adjustment (see 34.00 1,565,467 1,204,753 360,714 1,565,467 11.00 instructions) Uncompensated care payments 36.00 3,211,220 2,540,988 670,232 3,211,220 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46.00 0 0 0 0 0 12.00 instructions) 13.00 Subtotal (see instructions) 47.00 32,671,224 25,405,094 7,266,130 32,671,224 13.00 14.00 Hospital specific payments (completed by SCH 48.00 0 0 0 0 0 14.00 14.00 14.00 14.00 15.0	10.00		22.00	0.0077	0.0077	0 0077		40.00
11. 00 Disproportionate share adjustment (see instructions) 11. 01 Uncompensated care payments Additional payment for high percentage of ESRD beneficiary discharges 12. 00 Instructions) 13. 00 Subtotal (see instructions) 14. 00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15. 00 Total payment for inpatient operating costs (see instructions) 16. 00 Payment for inpatient program capital (from wikst. L, Pt. I, if applicable) 17. 00 Special add-on payments for new technologies 54. 00 227, 700 222, 128 5, 572 227, 700 17. 00 17. 00 Credits received from manufacturers for replaced devices for applicable MS-DRGs amount (see instructions) 18. 00 Capital outlier reconciliation adjustment amount (see instructions) 19. 00 Capital outlier reconciliation adjustment amount (see instructions) 19. 00 Disproportionate share adjustment in p. 56. 467 1. 204, 753 360, 714 1. 204, 753 360, 714 1. 204, 753 360, 714 1. 204, 753 360, 714 1. 204, 753 360, 714 1. 205, 740 12. 205, 740, 988 670, 232 3. 211, 220 11. 01 11. 01 Additional payment for high percentage of ESRD beneficiary discharges 46. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00		33.00	0. 23//	0. 2377	0. 2377		10.00
11.01	11 00		24 00	1 565 467	1 204 752	260 714	1 565 467	11 00
11. 01 Uncompensated care payments 36. 00 3, 211, 220 2, 540, 988 670, 232 3, 211, 220 11. 01 Additional payment for high percentage of ESRD beneficiary discharges 12. 00 Total ESRD additional payment (see 46. 00 0 0 0 0 12. 00 Instructions Subtotal (see instructions) 47. 00 32, 671, 224 25, 405, 094 7, 266, 130 32, 671, 224 13. 00 Hospital specific payments (completed by SCH 48. 00 0 0 0 0 0 0 14. 00 Instructions Ins	11.00		34.00	1, 303, 407	1, 204, 733	300, 714	1, 303, 407	11.00
Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46.00 0 0 0 0 12.00 instructions) 13.00 Subtotal (see instructions) 47.00 32,671,224 25,405,094 7,266,130 32,671,224 13.00 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs 49.00 32,828,063 25,524,861 7,303,202 32,828,063 15.00 (see instructions) 16.00 Payment for inpatient program capital (from 50.00 2,233,437 1,718,163 515,274 2,233,437 16.00 17.00 Net organ acquisition cost 17.01 Net organ acquisition cost 17.01 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 0 0 0 0 18.00 18.00 18.00 19.0	11. 01		36, 00	3, 211, 220	2, 540, 988	670, 232	3, 211, 220	11. 01
Total ESRD additional payment (see 46.00 0 0 0 0 0 12.00					270107700	0,0,202	0/2:1/220	
13.00 Subtotal (see instructions) 47.00 32,671,224 25,405,094 7,266,130 32,671,224 13.00 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 49.00 32,828,063 25,524,861 7,303,202 32,828,063 15.00 15.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 7,00 223,437 1,718,163 515,274 2,233,437 16.00 17.00 Special add-on payments for new technologies 54.00 227,700 222,128 5,572 227,700 17.00 17.01 Net organ acquisition cost 17.01 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 0 0 0 0 18.00 18.00 Capital outlier reconciliation adjustment 93.00 0 0 0 0 0 0 0 0 0	12. 00			Ol	0	ol	0	12.00
13.00 Subtotal (see instructions) 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 7.00 Pospital add-on payments for new technologies 7.00 Pospital acquisition cost 7.00 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions) 47.00 32,671,224 25,405,094 7,266,130 0 0 14.00 0 0 0 14.00 0 0 14.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				1	آ ا	آ		
14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies of the organ acquisition cost of the organ acquisition cost of the organ acquisition cost of the organ acquisition cost of the organ acquisition cost of the organ acquisition cost of the organ acquisition cost of the organ acquisition cost of the organ acquisition cost of the organ acquisition cost of the organ acquisition cost of the organ acquisition cost of the organ acquisition cost of the organ acquisition cost of the organ acquisition cost of the organ acquisition cost of the organ acquisition adjustment of the organ acquisition adjustment of the organ acquisition adjustment of the organ acquisition adjustment of the organ acquisition adjustment of the organ acquisition adjustment of the organ acquisition adjustment of the organ acquisition adjustment of the organ acquisition adjustment of the organ acquisition adjustment of the organ acquisition adjustment of the organ acquisition organ acquisition adjustment of the organ acquisition organ acquisition adjustment of the organ acquisition adjustment of the organ acquisition organ acquisition adjustment of the organ acquisition adjustment of the organ acquisition organ acquisition adjustment of the organ acquisition organ acquisition adjustment organ acquisition organ acquisition acquisition adjustment organ acquisition organ acquisition adjustment organ acquisition organ acquisition ac	13.00		47. 00	32, 671, 224	25, 405, 094	7, 266, 130	32, 671, 224	13.00
15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 17.01 Net organ acquisition cost 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions) 18.00 32,828,063 25,524,861 7,303,202 32,828,063 15.00 15.00 2233,437 1,718,163 515,274 2,233,437 16.00 227,700 222,128 5,572 227,700 17.00 17.01 17.01 Net organ acquisition cost 17.01 17.02 17.02 17.03 17.04 17.05	14.00	Hospital specific payments (completed by SCH	48. 00	0	0	0	0	14.00
15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 17.01 Net organ acquisition cost 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions) 18.00 Total payment for inpatient operating costs 49.00 22, 828, 063 25, 524, 861 7, 303, 202 32, 828, 063 15.00 2, 233, 437 1, 718, 163 515, 274 2, 233, 437 16.00 227, 700 222, 128 5, 572 227, 700 17.00 17.01 O O O O O O O O O O O O O O O O O O O		and MDH, small rural hospitals only.) (see						
(see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 227,700 222,128 5,572 227,700 17.00 Net organ acquisition cost 17.01 Net organ acquisition cost 17.01 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions) 18.00 Instructions 20.00 2,233,437 1,718,163 515,274 2,233,437 16.00 227,700 222,128 5,572 227,700 17.00 17.00 227,700 222,128 1.00 20.00 17.00 17.00 20.00 17.00 17.00 20.00 17.00 17.00 20.00 17.00 20.00 17.00 20.00 17.00 20.00 17.00 20.00 17.00 20.00 17.00 20								
16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 50.00 2,233,437 1,718,163 515,274 2,233,437 16.00 17.00 Special add-on payments for new technologies 54.00 227,700 222,128 5,572 227,700 17.00 17.01 Oredits received from manufacturers for replaced devices for applicable MS-DRGs 68.00 0 0 0 0 0 0 17.02 18.00 Capital outlier reconciliation adjustment amount (see instructions) 93.00 0 0 0 0 0 0 18.00	15. 00		49. 00	32, 828, 063	25, 524, 861	7, 303, 202	32, 828, 063	15. 00
Wkst. L, Pt. I, if applicable) 17. 00 Special add-on payments for new technologies 54.00 227,700 222,128 5,572 227,700 17.01 17. 01 Net organ acquisition cost 54.00 0 0 0 0 17.01 17. 02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18. 00 Capital outlier reconciliation adjustment amount (see instructions) 93.00 0 0 0 0 0 18.00								
17. 00 Special add-on payments for new technologies 54.00 227,700 222,128 5,572 227,700 17.01 Net organ acquisition cost 17. 02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18. 00 Capital outlier reconciliation adjustment amount (see instructions) 93.00 0 0 0 0 0 18.00	16. 00		50.00	2, 233, 437	1, 718, 163	515, 274	2, 233, 437	16.00
17.01 Net organ acquisition cost 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions) 17.01 Net organ acquisition cost 68.00 0 0 0 0 17.02 0 0 0 0 0 18.00	47.00		F4 00	007 700	000 400	F F70	007 700	47.00
17. 02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18. 00 Capital outlier reconciliation adjustment amount (see instructions) 68. 00 0 0 17. 02 0 18. 00 0 0 0 18. 00			54.00	227, 700	222, 128	5, 5/2	227, 700	
replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions) 93.00 0 0 18.00			40.00					
18.00 Capital outlier reconciliation adjustment 93.00 0 0 0 18.00 amount (see instructions)	17.02		08.00	ا ا	O	٥	0	17.02
amount (see instructions)	18 00		93 00		0		0	18 00
	10.00		73.00	"	U	Ч		10.00
1 1 277 1007 1021 77 02 77 000 177 000	19.00				27, 465, 152	7, 824, 048	35, 289, 200	19, 00
		1	!	'	,,	, == ., = .0		

Heal th	Financial Systems	METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5	Provider Co		Period: From 01/01/2023 To 12/31/2023		pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1. 00	2. 00	3. 00	4. 00	
	Capital DRG other than outlier	1. 00	1, 996, 818	1, 526, 11	5 470, 703	1, 996, 818	
	Model 4 BPCI Capital DRG other than outlier	1. 01	0	(0		20. 01
21. 00	Capital DRG outlier payments	2. 00	51, 514	50, 57	7 937	51, 514	21.00
	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. 0042	0. 0042	0. 0042		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	8, 387	6, 410	1, 977	8, 387	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0885	0. 088!	0. 0885		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	176, 718	135, 06 ⁻	1 41, 657	176, 718	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	2, 233, 437	1, 718, 163	515, 274	2, 233, 437	26. 00
	Thisti uctions)	Wkst. E. Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
		0	1. 00	2.00	3. 00	4. 00	
27. 00							27. 00
28. 00	Low volume adjustment prior to October 1	70. 96	0	(C	0	28. 00
29. 00	Low volume adjustment on or after October 1	70. 97	0		0	0	29. 00
30. 00	HVBP payment adjustment (see instructions)	70. 93	-71, 780	(71, 780	-71, 780	
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	(0	0	30. 01
21 00	HDD adjustment (see instructions)	70.04	102 240	E7 200	44 040	102 240	21 00

70. 94

70. 91

0

70. 99

-102, 348

1.00

Υ

-57, 388

0

3.00

77, 073

2.00

-102, 348

77, 073

(Amt. to Wkst. E, Pt. A) 4.00 31.00

31.01

32.00

100.00

31.00 HRR adjustment (see instructions)
31.01 HRR adjustment for HSP bonus payment (see instructions)

32.00 HAC Reduction Program adjustment (see

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

instructions)

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0002	Peri od: Worksheet E From 01/01/2023 Part B To 12/31/2023 Date/Time Prepared: 5/29/2024 9:08 am

		5/29/2024 9: 0	8 am
	Title XVIII Hospital	PPS	
		1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES	.,	
1.00	Medical and other services (see instructions)	6, 138	1.0
2.00	Medical and other services reimbursed under OPPS (see instructions)	24, 189, 989	2.0
3.00	OPPS or REH payments	24, 335, 945	
4. 00 4. 01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)	139, 053	4.0
5. 00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	
6. 00	Line 2 times line 5	0	6.0
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.0
8. 00	Transitional corridor payment (see instructions)	0	8.0
9. 00	Ancillary service other pass through costs including REH direct graduate medical education costs from	109, 565	9.0
10. 00	Wkst. D, Pt. IV, col. 13, line 200 Organ acquisitions	0	10.0
	Total cost (sum of lines 1 and 10) (see instructions)	6, 138	
11.00	COMPUTATION OF LESSER OF COST OR CHARGES	0, 100	1
	Reasonable charges		İ
12.00	Ancillary service charges	27, 780	12.0
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	
14. 00	Total reasonable charges (sum of lines 12 and 13)	27, 780	14.0
15 00	Customary charges		1 1 5 0
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	15. 0 16. 0
10.00	had such payment been made in accordance with 42 CFR §413.13(e)		10.0
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0. 000000	17. C
	Total customary charges (see instructions)	27, 780	18.0
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	21, 642	19.0
	instructions)	_	
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20.0
21 00	instructions) Lesser of cost or charges (see instructions)	6, 138	21.0
	Interns and residents (see instructions)	0, 130	22.0
	Cost of physicians' services in a teaching hospital (see instructions)		ı
24. 00		24, 584, 563	1
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	4, 118, 486	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	20, 472, 215	27.0
28. 00	instructions) Direct graduate medical education payments (from Wkst. E-4, line 50)	51, 107	28.0
	REH facility payment amount (see instructions)	31, 107	28.5
	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	1
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	20, 523, 322	30. C
31. 00	Primary payer payments	5, 462	•
32. 00	Subtotal (line 30 minus line 31)	20, 517, 860	32.0
22 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		22 (
	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)	0 604, 015	
	Adjusted reimbursable bad debts (see instructions)	392, 610	•
	Allowable bad debts for dual eligible beneficiaries (see instructions)	434, 155	•
	Subtotal (see instructions)	20, 910, 470	
38. 00	MSP-LCC reconciliation amount from PS&R	72	1
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.0
	Pioneer ACO demonstration payment adjustment (see instructions)	_	39.5
39. 75	N95 respirator payment adjustment amount (see instructions)	0	39.7
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices (see instructions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION		1
	Subtotal (see instructions)	20, 910, 398	
40. 01	Sequestration adjustment (see instructions)	418, 208	
	Demonstration payment adjustment amount after sequestration	0	
40. 03	Sequestration adjustment-PARHM pass-throughs		40.0
	Interim payments	20, 552, 385	1
	Interim payments-PARHM		41.0
42. 00 42. 01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)	0	42. C
42.01	Balance due provider/program (see instructions)	-60, 195	1
43. 00	Balance due provider/program-PARHM (see instructions)	-00, 193	43. (
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	1
	\$115. 2		' ' '
	TO BE COMPLETED BY CONTRACTOR		
	Original outlier amount (see instructions)	0	
91.00	Outlier reconciliation adjustment amount (see instructions)	0	
92.00		0.00	92. 0 93. 0
J. UU	Time Value of Money (see instructions)	<u> </u>	J 93.

Health Financial Systems	METHODIST HOSPIT	ALS, INC	In Lieu	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0002	Peri od:	Worksheet E	
			From 01/01/2023		
			To 12/31/2023		:pared:
				5/29/2024 9:0)8 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
94.00 Total (sum of lines 91 and 93)				0	94.00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200.00

Health Financial Systems METHANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provi der CCN: 15-0002

					5/29/2024 9: 08	8 am
		Title	XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2, 00	3. 00	4, 00	
1. 00	Total interim payments paid to provider		30, 332, 151		19, 947, 554	1. 00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		(0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.00
3. 01	ADJUSTMENTS TO PROVIDER	12/31/2023	739, 994	12/31/2023	447, 931	3. 01
3. 02 3. 03 3. 04 3. 05	ADJUSTIMENTS TO PROVIDER	12/31/2023	141, 500	12/31/2023	156, 900 0 0	3. 02 3. 03 3. 04 3. 05
	Provider to Program					
3. 50 3. 51 3. 52	ADJUSTMENTS TO PROGRAM		()	0 0 0	3. 50 3. 51 3. 52
3.53			(0	3. 53
3.54			1		ol	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		881, 494		604, 831	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		31, 213, 645		20, 552, 385	4.00
F 00	IU BE COMPLETED BY CONTRACTOR		I			F 00
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		(0	5. 01
5.02			(0	5. 02
5.03)	0	5.03
	Provider to Program			•		
5. 50	TENTATI VE TO PROGRAM		(0	5. 50
5. 51					0	5. 51
5. 52					0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)				0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		906, 869		0	6. 01
6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		700,009		60, 195	6. 02
	l l		22 120 51	'	· ·	
7. 00	Total Medicare program liability (see instructions)		32, 120, 514		20, 492, 190	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
)	1. 00	2. 00	
8. 00	Name of Contractor					8. 00

					5/29/2024 9) : 08	3 am
		Titl∈	· XVIII	Subprovi der - I PF	PPS	5	
		I npati er	it Part A		t B		
						_	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
00	Tabal laboria normanta asid to manidan	1.00	2.00	3.00	4. 00	0	1. 0
	Total interim payments paid to provider Interim payments payable on individual bills, either		214, 14	0		0	2. 0
2.00	submitted or to be submitted to the contractor for			U		۷	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)						
	Program to Provider ADJUSTMENTS TO PROVIDER	T	I	0	I	0	3.
. 01	ADJUSTMENTS TO PROVIDER			0		0	3. 3.
03				0		0	3.
. 04				Ö		ol	3.
. 05				Ö		o	3.
	Provider to Program	.		-			
50	ADJUSTMENTS TO PROGRAM			0		0	3.
51				0		0	3.
52				0		0	3.
53				0		0	3.
54	Cultural (1) 2 01 2 10 1)			0		0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			U		ال	3.
. 00	Total interim payments (sum of lines 1, 2, and 3.99)		214, 14	5		0	4.
. 00	(transfer to Wkst. E or Wkst. E-3, line and column as		217,17	5		Ĭ	٦.
	appropri ate)						
	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)						
01	Program to Provider TENTATIVE TO PROVIDER			0		0	5.
02	TENTATIVE TO PROVIDER			0		ol	5.
03				Ö		0	5.
	Provider to Program			-			-
50	TENTATI VE TO PROGRAM			0		0	5.
51				0		0	5
52				0		0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0		0	5.
00	Determined net settlement amount (balance due) based on the cost report. (1)						6.
01	SETTLEMENT TO PROVIDER		2, 21	2		0	6
	SETTLEMENT TO PROGRAM		_, _,	О		0	6
1	Total Medicare program liability (see instructions)		216, 35	7		0	7.
				Contractor Number	NPR Date (Mo/Day/Yr)	$ \top $	
)	1. 00	2. 00	_	
00	Name of Contractor		<i>-</i>	1.00	2.00		8.

Health Financial Systems	METHODIST HOSPIT	ALS, INC	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERV	/I CES RENDERED	Provi der CCN: 15-0002 Component CCN: 15-T002	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part I Date/Time Prepared: 5/29/2024 9:08 am

					5/29/2024 9:0)8 am
		Title	e XVIII	Subprovi der - I RF	PPS	
		Inpatien	 it Part A		it B	
		·				
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1. 00	Total interior as monto asid to annotate	1. 00	2.00	3. 00	4.00	1.0
2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either		1, 645, 637		0	1
2.00	submitted or to be submitted to the contractor for			,	0	2.0
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment					3.0
	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			1	0	3.0
3. 02	ADJUSTIMENTS TO TROVIDER					1
3. 03					Ö	1 .
3. 04					0	
3. 05			()	0	3. (
	Provider to Program					
3. 50	ADJUSTMENTS TO PROGRAM		C		0	
3. 51			C		0	
3. 52					0	
3. 53 3. 54				1	0	1
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines					1 .
J. //	3. 50-3. 98)] 5.
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 645, 637	,	0	4. (
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					1
5. 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after	I	Ī		I	5.0
5. 00	desk review. Also show date of each payment. If none,					5.1
	write "NONE" or enter a zero. (1)					
	Program to Provider	'		•	•	
. 01	TENTATI VE TO PROVI DER		C		0	
5. 02			C		0	1
5. 03)	0	5.0
- FO	Provider to Program TENTATIVE TO PROGRAM	Ι		,	0	5. !
5. 50 5. 51	TENTATIVE TO PROGRAM				0	
5. 52					0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				l o	
	5. 50-5. 98)					
5. 00	Determined net settlement amount (balance due) based on					6.0
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		25, 886		0	
6. 02 7. 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		1, 671, 523	1	0	1
7.00	Trotal medicale program frability (see Instructions)		1,0/1,523	Contractor	NPR Date	/. (
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8.0

Heal th	Financial Systems METHODIST HO	SPITALS, INC	In Lie	u of Form CMS-	2552-10
CALCUI	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0002	Peri od:	Worksheet E-1	
			From 01/01/2023		
			To 12/31/2023	Date/Time Pre 5/29/2024 9:0	
	Title XVIII Hospital				
				PPS	
				1. 00	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULAT	TI ON			
1.00	Total hospital discharges as defined in AARA §4102 from W	kst. S-3, Pt. I col. 15 lin	e 14		1.00
2.00	d. 00 Medicare days (see instructions)				2.00
3.00	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days (see instructions)				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200)			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col.	3 line 20			6. 00
7.00	CAH only - The reasonable cost incurred for the purchase of	of certified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions	5)			8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	The same of the sa	on (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
32. 00	Balance due provider (line 8 (or line 10) minus line 30 an	nd line 31) (see instructio	ns)		32.00

Health Financial Systems	METHODIST HOSPITALS, INC	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0002		Worksheet E-3
	Component CCN, 1E COO2	From 01/01/2023	
	Component CCN: 15-S002	10 12/31/2023	5/29/2024 9:08 am
	Title XVIII	Subprovi der -	PPS
		LDE	

	I PF		_
		1. 00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
C	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	234, 214	
)	Net IPF PPS Outlier Payments	6, 702	
)	Net IPF PPS ECT Payments	0	
)	Unweighted intern and resident FTE count in the most recent cost report filed on or before November	0. 00	1
	15, 2004. (see instructions)	0.00	
1	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42	0. 00	1
	CFR \(\frac{9412.424(d)(1)(iii)(F)(1) \) or (2) \(\frac{942}{2}\) (see instructions)		
)	New Teaching program adjustment. (see instructions)	0. 00	
0	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0. 00	
	teaching program" (see instuctions)		
0	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0. 00	ı
	teaching program" (see instuctions)		
0	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0. 00	
0	Average Daily Census (see instructions)	3. 594521	
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).	0	
00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	240, 916	
00	Nursing and Allied Health Managed Care payment (see instruction)	0	
00	Organ acquisition (DO NOT USE THIS LINE)		
00	Cost of physicians' services in a teaching hospital (see instructions)	0	
00	Subtotal (see instructions)	240, 916	
00	Primary payer payments	0	
00	Subtotal (line 16 less line 17). Deductibles	240, 916	
00	Subtotal (line 18 minus line 19)	17, 600 223, 316	
00		4, 800	
00	Subtotal (line 20 minus line 21)	218, 516	
00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	3, 040	
00	Adjusted reimbursable bad debts (see instructions)	1, 976	
00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	
00	Subtotal (sum of lines 22 and 24)	220, 492	
00	Direct graduate medical education payments (see instructions)	0	
00	Other pass through costs (see instructions)	280	
00	Outlier payments reconciliation	0	1 2
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	1 3
50	Pioneer ACO demonstration payment adjustment (see instructions)	0	1 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)	220, 772	
01	Sequestration adjustment (see instructions)	4, 415	
02	Demonstration payment adjustment amount after sequestration	0	
00	1	214, 145	
00	Tentative settlement (for contractor use only)	0	
00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	2, 212	
00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	3
	§115. 2 TO BE COMPLETED BY CONTRACTOR		
00	Original outlier amount from Worksheet E-3, Part II, line 2	6, 702	
	Outlier reconciliation adjustment amount (see instructions)	0, 702	
00	The rate used to calculate the Time Value of Money	0. 00	
0C		0.00	
-	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (TH		Ι,
	COVI D-19 PHE)		
00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0. 000000	
	Cal cul ated Teaching Adjustment Factor for the current year. (see instructions)	0. 000000	

Health Financial Systems	METHODIST HOSPITALS, INC	In Lie	u of Form CMS-25	552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0002	Peri od: From 01/01/2023	Worksheet E-3	
	Component CCN: 15-T002			
	Title XVIII	Subprovi der -	PPS	
		I RF		

	IRF		
		1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS	1.00	
1. 00	Net Federal PPS Payment (see instructions)	1, 565, 851	1.00
2. 00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0313	2.00
3. 00	Inpatient Rehabilitation LIP Payments (see instructions)	140, 613	3.00
4.00	Outlier Payments	23, 693	4.00
5. 00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)		5. 00
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5. 01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0. 00	7. 00
8. 00	Current year's unweighted L&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0. 00	8. 00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9. 00
10.00	Average Daily Census (see instructions)	9. 482192	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	1, 730, 157	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	
17.00	Subtotal (see instructions)	1, 730, 157	17. 00
18. 00	Primary payer payments	0	18. 00
19. 00	Subtotal (line 17 less line 18).	1, 730, 157	
20.00	Deducti bl es	16, 000	
21. 00		1, 714, 157	
22. 00		15, 600	
23. 00	Subtotal (line 21 minus line 22)	1, 698, 557	
24. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	10, 356	
25. 00	Adjusted reimbursable bad debts (see instructions)	6, 731	25. 00
26. 00	, ,	8, 800	
27. 00	Subtotal (sum of lines 23 and 25)	1, 705, 288	
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28. 00
29. 00	Other pass through costs (see instructions)	348	
30. 00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31. 98	Recovery of accelerated depreciation.	0	31. 98
31. 99	Demonstration payment adjustment amount before sequestration	0	31. 99
32.00	Total amount payable to the provider (see instructions)	1, 705, 636	
32. 01	Sequestration adjustment (see instructions)	34, 113	
32. 02	Demonstration payment adjustment amount after sequestration	0	32. 02
33.00	Interim payments	1, 645, 637	33.00
34. 00 35. 00	Tentative settlement (for contractor use only)	0	34.00
	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	25, 886	35.00
36. 00	§115. 2	0	36. 00
FO 00	TO BE COMPLETED BY CONTRACTOR	00.700	F0 00
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	23, 693	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0 00	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	
53.00	Time Value of Money (see instructions) FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THEORY 10 DUE)	E END OF THE	53.00
99. 00	COVID-19 PHE) Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	00 00
	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0.000000	
77. UI	paredicated reading adjustment ractor for the current year. (see That detroils)	0.000000	77.01

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: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/29/2024 9:08 am

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES COMPUTATION OF NET COST OF COVERED SERVICES 1.00 Inpatient hospital/SNF/NF services 2.00 Medical and other services 3.00 Organ acquisition (certified transplant programs only) 4.00 Subtotal (sum of lines 1, 2 and 3) 5.00 Inpatient primary payer payments 6.00 Outpatient primary payer payments 7.00 Subtotal (line 4 less sum of lines 5 and 6) 7, 213, 194 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 8.00 Routine service charges 9.00 Ancillary service charges 23, 465, 771	0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES COMPUTATION OF NET COST OF COVERED SERVICES 1.00 Inpatient hospital/SNF/NF services 3.00 Medical and other services 3.00 Organ acquisition (certified transplant programs only) 4.00 Subtotal (sum of lines 1, 2 and 3) 5.00 Inpatient primary payer payments 6.00 Outpatient primary payer payments 7.00 Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 8.00 Routine service charges 5,597,680	2.00	2.00 3.00 4.00 5.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES COMPUTATION OF NET COST OF COVERED SERVICES 1.00 Inpatient hospital/SNF/NF services 2.00 Medical and other services 3.00 Organ acquisition (certified transplant programs only) 4.00 Subtotal (sum of lines 1, 2 and 3) 5.00 Inpatient primary payer payments 6.00 Outpatient primary payer payments 7.00 Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 8.00 Routine service charges Four intervious for Titles V OR XIX SERVICES 7, 213, 194 7, 21	0 0	2.00 3.00 4.00 5.00
COMPUTATION OF NET COST OF COVERED SERVICES 1.00 Inpatient hospital/SNF/NF services 7, 213, 194 2.00 Medical and other services 0 3.00 Organ acquisition (certified transplant programs only) 0 4.00 Subtotal (sum of lines 1, 2 and 3) 7, 213, 194 5.00 Inpatient primary payer payments 0 6.00 Outpatient primary payer payments 0 7.00 Subtotal (line 4 less sum of lines 5 and 6) 7, 213, 194 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 7, 200, 680	0	2.00 3.00 4.00 5.00
1.00 Inpatient hospital/SNF/NF services 7, 213, 194 2.00 Medical and other services 3.00 Organ acquisition (certified transplant programs only) 0 4.00 Subtotal (sum of lines 1, 2 and 3) 7, 213, 194 5.00 Inpatient primary payer payments 0 6.00 Outpatient primary payer payments 5 Subtotal (line 4 less sum of lines 5 and 6) 7, 213, 194 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 7, 213, 194 Routine service charges 5, 597, 680	0	2.00 3.00 4.00 5.00
2.00 Medical and other services 3.00 Organ acquisition (certified transplant programs only) 4.00 Subtotal (sum of lines 1, 2 and 3) 5.00 Inpatient primary payer payments 6.00 Outpatient primary payer payments 7.00 Subtotal (line 4 less sum of lines 5 and 6) 7, 213, 194 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 8.00 Routine service charges 5, 597, 680	0	2.00 3.00 4.00 5.00
3.00 Organ acquisition (certified transplant programs only) 4.00 Subtotal (sum of lines 1, 2 and 3) 5.00 Inpatient primary payer payments 6.00 Outpatient primary payer payments 7.00 Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 8.00 Routine service charges 5,597,680	0	3. 00 4. 00 5. 00
4.00 Subtotal (sum of lines 1, 2 and 3) 7, 213, 194 5.00 Inpatient primary payer payments 0 6.00 Outpatient primary payer payments 7.00 Subtotal (line 4 less sum of lines 5 and 6) 7, 213, 194 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 8.00 Routine service charges 5, 597, 680	0	4. 00 5. 00
5.00 Inpatient primary payer payments 0 6.00 Outpatient primary payer payments 7.00 Subtotal (line 4 less sum of lines 5 and 6) 7, 213, 194 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 8.00 Routine service charges 5, 597, 680	0	5.00
6.00 Outpatient primary payer payments 7.00 Subtotal (line 4 less sum of lines 5 and 6) 7, 213, 194 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 8.00 Routine service charges 5, 597, 680	~	
7.00 Subtotal (line 4 less sum of lines 5 and 6) 7,213,194 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 8.00 Routine service charges 5,597,680	~	
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 8.00 Routine service charges 5,597,680	0	6. 00
Reasonable Charges 8. 00 Routine service charges 5, 597, 680		7. 00
8.00 Routine service charges 5,597,680		
9.00 Ancillary service charges 23.465.771		8.00
	0	9.00
10.00 Organ acquisition charges, net of revenue		10.00
11.00 Incentive from target amount computation 0		11.00
12.00 Total reasonable charges (sum of lines 8 through 11) 29,063,451	0	12.00
CUSTOMARY CHARGES 13.00 Amount actually collected from patients liable for payment for services on a charge 0	0	13. 00
basis	۷	13.00
14.00 Amounts that would have been realized from patients liable for payment for services on 0	0	14. 00
a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	٥	14.00
15.00 Ratio of line 13 to line 14 (not to exceed 1.000000) 0.000000	0. 000000	15.00
16.00 Total customary charges (see instructions) 29,063,451		16. 00
17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 21,850,257		17. 00
line 4) (see instructions)	1	
18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 0	0	18.00
16) (see instructions)		
19.00 Interns and Residents (see instructions) 0	0	19.00
20.00 Cost of physicians' services in a teaching hospital (see instructions)	•	20.00
21.00 Cost of covered services (enter the lesser of line 4 or line 16) 7,213,194	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.		
22.00 Other than outlier payments	I	22.00
23.00 Outlier payments	I	23.00
24.00 Program capital payments	I	24.00
25.00 Capital exception payments (see instructions)	I	25.00
26.00 Routine and Ancillary service other pass through costs 27.00 Subtotal (sum of lines 22 through 26)	I	26.00
27.00 Subtotal (sum of lines 22 through 26) 28.00 Customary charges (title V or XIX PPS covered services only) 0	I	27. 00 28. 00
3, 3, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4,		29.00
29.00 Titles V or XIX (sum of lines 21 and 27) 7,213,194 COMPUTATION OF REIMBURSEMENT SETTLEMENT	0	29.00
30.00 Excess of reasonable cost (from line 18)	0	30. 00
31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 7, 213, 194		31.00
32. 00 Deducti bl es 0		32. 00
33.00 Coi nsurance		33. 00
34.00 Allowable bad debts (see instructions)		34.00
35.00 Utilization review	~	35. 00
36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 7,213,194		36. 00
37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	37.00
38.00 Subtotal (line 36 ± line 37) 7, 213, 194	•	38.00
39.00 Direct graduate medical education payments (from Wkst. E-4)		39.00
40.00 Total amount payable to the provider (sum of lines 38 and 39) 7,213,194	0	40.00
41.00 Interim payments 8,796,637	0	41.00
42.00 Balance due provider/program (line 40 minus line 41) -1,583,443	0	42.00
43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	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: From 01/01/2023	Worksheet E-3
	Component CCN: 15-S002		
	Ti tle XIX	Subprovi der -	Cost
		IDE	

		I ti c Xi X	I PF	0031	
			Inpatient	Outpati ent	
			1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FO	OR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		107, 492		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant programs only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		107, 492	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)		107, 492	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		585, 543		8.00
9. 00	Ancillary service charges		313, 855	0	9. 00
10.00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		0		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		899, 398	0	12.00
40.00	CUSTOMARY CHARGES			0	40.00
13. 00	Amount actually collected from patients liable for payment for service basis	es on a cnarge	0	0	13. 00
14. 00	Amounts that would have been realized from patients liable for payment	for services on	o	0	14. 00
14.00	a charge basis had such payment been made in accordance with 42 CFR §4		i i	O	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)		899, 398	0.000000	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only if lir	ne 16 exceeds	791, 906	0	17. 00
	line 4) (see instructions)		,	_	
18.00	Excess of reasonable cost over customary charges (complete only if lir	ne 4 exceeds line	ol	0	18.00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	1	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		107, 492	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be complete	ed for PPS provid			
	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	, , , , , , , , , , , , , , , , , , , ,		0	_	25.00
26. 00	Routine and Ancillary service other pass through costs		0	0	26.00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		107, 492	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Excess of reasonable cost (from line 18)		O	0	30. 00
30. 00 31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		107, 492	0	31.00
32. 00	Deductibles		107, 492	0	32.00
33. 00	Coinsurance		0	0	33. 00
34. 00	Allowable bad debts (see instructions)			0	34. 00
35. 00	Utilization review		0	O	35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		107, 492	0	36.00
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
38.00	, , , , ,		107, 492	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)		107, 492	0	40.00
41.00	Interim payments		272, 221	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-164, 729	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: From 01/01/2023	Worksheet E-3
	Component CCN: 15-T002		
	Title XIX	Subprovi der -	Cost
		IDE	

		litle XIX	Subprovi der -	Cost	
			I RF	0.1	
			Inpati ent	Outpati ent	
	DART WALL ON OUR ATLANTAGE RELABILISTED. ALL OTHER HEALTH OFFI	# 050 500 TITLED W 00 W	1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	VICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES		0.00001		
1.00	Inpatient hospital/SNF/NF services		260, 291		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant programs only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		260, 291	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments		0/0 004	0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		260, 291	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
0.00	Reasonabl e Charges		400.000		0.00
8.00	Routine service charges		432, 283		8.00
9.00	Ancillary service charges		902, 334	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0	0	11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		1, 334, 617	0	12.00
12 00	CUSTOMARY CHARGES			0	12.00
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
14. 00	basis	normant for condition on	o	0	14. 00
14.00	Amounts that would have been realized from patients liable for		٩	U	14.00
15. 00	a charge basis had such payment been made in accordance with 43 Ratio of line 13 to line 14 (not to exceed 1.000000)	2 CFR 9413. 13(e)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		1, 334, 617	0.000000	16.00
17. 00	Excess of customary charges over reasonable cost (complete only	v if line 16 exceeds	1, 074, 326	0	17. 00
17.00	line 4) (see instructions)	y II IIIle 16 exceeds	1, 074, 320	U	17.00
18. 00	Excess of reasonable cost over customary charges (complete only	v if line 1 exceeds line	0	0	18. 00
10.00	16) (see instructions)	y II IIIle 4 exceeds IIIle	٩	O	10.00
19. 00	Interns and Residents (see instructions)		o	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instru	uctions)	0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1)		260, 291	0	21.00
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			0	21.00
22 00	Other than outlier payments	compreted for 113 provid	T 0	0	22. 00
23. 00	Outlier payments			0	23. 00
	Program capital payments			o .	24.00
25. 00	Capital exception payments (see instructions)				25. 00
26. 00	Routine and Ancillary service other pass through costs			0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)			0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		260, 291	0	29. 00
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		200/27.	0	27.00
30.00			0	0	30. 00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		260, 291	0	31.00
32. 00	Deductibles		0	0	32.00
33. 00	Coinsurance			0	33. 00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35. 00	Utilization review			o ,	35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	260, 291	0	36. 00
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
38. 00	Subtotal (line 36 ± line 37)		260, 291	0	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		260, 291	0	40. 00
41. 00	Interim payments		403, 949	0	41. 00
42. 00	Balance due provider/program (line 40 minus line 41)		-143, 658	0	42.00
43. 00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub 15-2.	0	0	43.00
	chapter 1, §115.2				
			1	· ·	•

	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der CC	CN: 15-0002	Peri od: From 01/01/2023 To 12/31/2023		pared:
		Title	XVIII	Hospi tal	5/29/2024 9: 08 PPS	8 8111
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				1.00	
. 00	Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.	programs for	cost report	ing periods	10. 83	1.00
. 01	FTE cap adjustment under §131 of the CAA 2021 (see instruction	,			0. 00	1. 01
00 26	Unweighted FTE resident cap add-on for new programs per 42 CF Rural track program FTE cap limitation adjustment after the c the CAA 2021 (see instructions)				0. 00 0. 00	2. 00 2. 26
00 01	Amount of reduction to Direct GME cap under section 422 of MM Direct GME cap reduction amount under ACA §5503 in accordance		R §413.79 (m)	. (see	0. 00 0. 00	3. 00 3. 01
02	instructions for cost reporting periods straddling 7/1/2011) Adjustment (increase or decrease) to the hospital's rural traprograms with a rural track Medicare GME affiliation agreemen		0. 00	3. 02		
00	49075 (August 10, 2022) (see instructions) Adjustment (plus or minus) to the FTE cap for allopathic and GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)	to a Medicare	0. 00	4.00		
01	ACA Section 5503 increase to the Direct GME FTE Cap (see inst straddling 7/1/2011)	ructions for	•		0. 00	4. 01
02	ACA Section 5506 number of additional direct GME FTE cap slot periods straddling 7/1/2011)	•		'	0.00	4. 02
21 00	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)					4. 21 5. 00
00	3.01, plus or minus line 3.02, plus or minus line 4, plus lines 4.01 through 4.27					6.00
00	records (see instructions) Enter the lesser of line 5 or line 6	pg		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2. 86 2. 86	
			Primary Car		Total	
00	Weighted FTE count for physicians in an allopathic and osteop	athi c	1.00	2. 00	3. 00 2. 36	8.00
	program for the current year.					
00	If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo 6. For cost reporting periods beginning on or after October 1 if Worksheet S-2, Part I, line 68, is "Y", see instructions.	ount on line	0. (2. 36	2. 36	9.00
					1	
	, ,			0.00		
. 01	Unweighted dental and podiatric resident FTE count for the cu Total weighted FTE count	irrent year	0. (0. 00		10. 0°
. 00	Unweighted dental and podiatric resident FTE count for the cu	irrent year		0. 00 2. 36		10. 01 11. 00
. 00	Unweighted dental and podiatric resident FTE count for the cu Total weighted FTE count Total weighted resident FTE count for the prior cost reportin	irrent year		0. 00 2. 36 00 2. 50		10. 0° 11. 00 12. 00
0. 01 1. 00 2. 00 3. 00	Unweighted dental and podiatric resident FTE count for the cu Total weighted FTE count Total weighted resident FTE count for the prior cost reportin instructions) Total weighted resident FTE count for the penultimate cost re year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided	nrent year ng year (see	0. (0. (0. (0. 00 2. 36 00 2. 50 00 2. 50		10. 0° 11. 00 12. 00 13. 00
0. 01 . 00 2. 00 3. 00 4. 00	Unweighted dental and podiatric resident FTE count for the cu Total weighted FTE count Total weighted resident FTE count for the prior cost reportin instructions) Total weighted resident FTE count for the penultimate cost re year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs	g year (see eporting	0. (0. (0. (0. 00 2. 36 00 2. 50 00 2. 50 00 2. 45 00 0. 00		10. 0° 11. 00 12. 00 13. 00 14. 00 15. 00
0. 01 . 00 . 00 . 00 . 00 . 00 . 01	Unweighted dental and podiatric resident FTE count for the cu Total weighted FTE count Total weighted resident FTE count for the prior cost reportin instructions) Total weighted resident FTE count for the penultimate cost re year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new p	nrent year ng year (see eporting l by 3). programs	0. (0. (0. (0. (0. 00 2. 36 00 2. 50 00 2. 50 00 2. 45 00 0. 00 0. 00		10. 0° 11. 00 12. 00 13. 00 14. 00 15. 00 15. 0
0. 01 1. 00 2. 00 3. 00 4. 00 5. 00 5. 01 5. 00	Unweighted dental and podiatric resident FTE count for the cu Total weighted FTE count Total weighted resident FTE count for the prior cost reportin instructions) Total weighted resident FTE count for the penultimate cost re year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs	errent year ng year (see eporting by 3). norograms esure	0. (0. (0. (0. 00 2. 36 00 2. 50 00 2. 50 00 2. 45 00 0. 00 0. 00 0. 00		10. 0° 11. 00 12. 00 13. 00 14. 00 15. 0° 16. 00
0. 01 . 00 2. 00 3. 00 4. 00 6. 01 6. 01 6. 01 7. 00	Unweighted dental and podiatric resident FTE count for the cu Total weighted FTE count Total weighted resident FTE count for the prior cost reportin instructions) Total weighted resident FTE count for the penultimate cost re year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new p Adjustment for residents displaced by program or hospital clo Unweighted adjustment for residents displaced by program or h closure Adjusted rolling average FTE count	errent year ng year (see eporting by 3). norograms esure	0. 0 0. 0 0. 0 0. 0 0. 0	0. 00 2. 36 00 2. 50 00 2. 50 00 2. 45 00 0. 00 0. 00		10. 0° 11. 00 12. 00 13. 00 14. 00 15. 0° 16. 0° 16. 0° 17. 00
0. 01 . 00 2. 00 3. 00 3. 00 3. 01 3. 00 5. 01 5. 00 6. 01	Unweighted dental and podiatric resident FTE count for the cu Total weighted FTE count Total weighted resident FTE count for the prior cost reportin instructions) Total weighted resident FTE count for the penultimate cost re year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new p Adjustment for residents displaced by program or hospital clo Unweighted adjustment for residents displaced by program or h closure Adjusted rolling average FTE count Per resident amount	errent year ng year (see eporting by 3). norograms esure	0. (0. (0. (0. (0. (0. (0. (0. (0.00 2.36 00 2.50 00 2.50 00 2.45 00 0.		10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 00
0. 01 1. 00 2. 00 3. 00 4. 00 5. 00 5. 01 6. 01 7. 00 3. 00 3. 01	Unweighted dental and podiatric resident FTE count for the cu Total weighted FTE count Total weighted resident FTE count for the prior cost reportin instructions) Total weighted resident FTE count for the penultimate cost re year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new p Adjustment for residents displaced by program or hospital clo Unweighted adjustment for residents displaced by program or h closure Adjusted rolling average FTE count Per resident amount	errent year ng year (see eporting by 3). norograms esure	0. 0 0. 0 0. 0 0. 0 0. 0	0.00 2.36 00 2.50 00 2.50 00 2.45 00 0.		10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 00
0. 01 1. 00 2. 00 3. 00 4. 00 5. 00 5. 01 6. 00 7. 00 7. 00 9. 00	Unweighted dental and podiatric resident FTE count for the cu Total weighted FTE count Total weighted resident FTE count for the prior cost reportin instructions) Total weighted resident FTE count for the penultimate cost re year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new p Adjustment for residents displaced by program or hospital clo Unweighted adjustment for residents displaced by program or h closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs	errent year ag year (see aporting by 3). brograms bsure bospital	0. (0. (0. (0. (0. (0. (0. (0. 00 0. 00 2. 36 00 2. 50 00 00 00 00 00 00 00 00 00	255, 423 1. 00	10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 16. 01 17. 00 18. 00 19. 00
0. 01 1. 00 2. 00 3. 00 4. 00 5. 00 5. 01 5. 00 6. 01 7. 00 8. 01 7. 00 9. 00	Unweighted dental and podiatric resident FTE count for the cu Total weighted FTE count Total weighted resident FTE count for the prior cost reportin instructions) Total weighted resident FTE count for the penultimate cost re year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new p Adjustment for residents displaced by program or hospital clo Unweighted adjustment for residents displaced by program or h closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021	errent year ag year (see aporting by 3). brograms bsure bospital	0. (0. (0. (0. (0. (0. (0. (0. 00 0. 00 2. 36 00 2. 50 00 00 00 00 00 00 00 00 00	255, 423	10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 00 19. 00
0. 01 1. 00 2. 00 3. 00 3. 00 5. 01 5. 00 5. 01 7. 00 8. 00 9. 00	Unweighted dental and podiatric resident FTE count for the cu Total weighted FTE count Total weighted resident FTE count for the prior cost reportin instructions) Total weighted resident FTE count for the penultimate cost re year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new p Adjustment for residents displaced by program or hospital clo Unweighted adjustment for residents displaced by program or h closure Adjusted rolling average FTE count Per resident amount Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME F Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instru	arrent year ag year (see eporting by 3). brograms sure cospital	0. (0. (0. (0. (0. (0. (0. (0. 00 0. 00 2. 36 00 2. 50 00 00 00 00 00 00 00 00 00	255, 423 1. 00 0. 00 0. 00	10. 0° 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00
0.000 0.000	Unweighted dental and podiatric resident FTE count for the cu Total weighted FTE count Total weighted resident FTE count for the prior cost reportin instructions) Total weighted resident FTE count for the penultimate cost re year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new p Adjustment for residents displaced by program or hospital clo Unweighted adjustment for residents displaced by program or h closure Adjusted rolling average FTE count Per resident amount Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME F Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instru Allowable additional direct GME FTE Resident Count (see instru	arrent year ag year (see eporting by 3). brograms brough tal TE resident actions) cuctions)	0.0 0.0 0.0 0.0 0.0 0.0 0.0	0. 00 2. 36 00 2. 50 00 2. 50 00 2. 45 00 00 00 00 00 00 00 00 00 00 00 00 00	255, 423 1. 00 0. 00 0. 00 0. 00	10. 0° 11. 00 12. 00 13. 00 14. 00 15. 00 16. 0° 16. 0° 17. 00 18. 0° 19. 00 20. 00 21. 00 22. 00
7. 00 3. 00 3. 01 9. 00 0. 00 1. 00 2. 00 3. 00	Unweighted dental and podiatric resident FTE count for the cu Total weighted FTE count Total weighted resident FTE count for the prior cost reportin instructions) Total weighted resident FTE count for the penultimate cost re year (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new p Adjustment for residents displaced by program or hospital clo Unweighted adjustment for residents displaced by program or h closure Adjusted rolling average FTE count Per resident amount Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME F Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instru	arrent year ag year (see eporting by 3). brograms brough tal TE resident actions) cuctions)	0.0 0.0 0.0 0.0 0.0 0.0 0.0	0. 00 2. 36 00 2. 50 00 2. 50 00 2. 45 00 00 00 00 00 00 00 00 00 00 00 00 00	255, 423 1. 00 0. 00 0. 00	10. 0 11. 0 12. 0 13. 0 14. 0 15. 0 15. 0 16. 0 17. 0 18. 0 19. 0 20. 0 21. 0 22. 0 23. 0

	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der C	CN: 15-0002	Peri od:	Worksheet E-4	
EDI CA	L EDUCATION COSTS			From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 9:00	
		Title	XVIII	Hospi tal	PPS	
			Inpati ent	Managed Care	Total	
			Part A 1.00	2.00	3. 00	
	COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2.00	3.00	
5. 00	Inpatient Days (see instructions) (Title XIX - see S-2 Part I	X. line	17, 79	98 26, 144		26.00
	3. 02, col umn 2)	,	,			
. 00	Total Inpatient Days (see instructions)		77, 92	20 77, 920		27.0
. 00	Ratio of inpatient days to total inpatient days		0. 22841	0. 335524		28.0
00 .	Program direct GME amount		58, 34	12 85, 701	144, 043	29.00
. 01	Percent reduction for MA DGME			3. 27		29.0
				2, 802	2, 802	
. 00	Net Program di rect GME amount				141, 241	31.0
					1 00	
	DIDECT MEDICAL EDUCATION COSTS FOR ESDD COMPOSITE DATE. TITL	E VIIII ONII	/ (NUIDCLNC DD	OCDAM AND DADAME	1. 00	
		E XVIII UNL	Y (NURSTING PR	UGRAW AND PARAWE	DICAL	
. 00		Pt I sum o	of col 20 an	d 23 lines 74	0	32.0
	and 94)		o. 00 20 a	20, 111100 / 1	J.	02.0
. 00					11, 669, 578	33.0
. 00				,	0.000000	34.0
5. 00	Medicare outpatient ESRD charges (see instructions)				0	35.0
. 00	duction for direct GME payments for Medicare Advantage Program direct GME amount ECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAM CATION COSTS) Tal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 in 94) Tal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) Tal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) Tal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) Tal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) Tal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) Tal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) Tal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) Tal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) Tal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) Tal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) Tal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) Tal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		0	36.0		
		ONLY				
	Part A Reasonable Cost					
7.00	Reasonable cost (see instructions)	`			42, 856, 337	
3. 00	Organ acquisition and HSCT acquisition costs (see instruction				0	
00	Cost of physicians' services in a teaching hospital (see inst	ructions)			0	
00	Primary payer payments (see instructions) Total Part A reasonable cost (sum of lines 37 through 39 minu	s line 40)			0 42, 856, 337	
. 00	Part B Reasonable Cost	S TITIE 40)			42, 830, 337	41.0
. 00	Reasonable cost (see instructions)				24, 305, 692	42.0
	Primary payer payments (see instructions)				5, 462	
. 00	Total Part B reasonable cost (line 42 minus line 43)				24, 300, 230	
5. 00	Total reasonable cost (sum of lines 41 and 44)				67, 156, 567	
. 00	Ratio of Part A reasonable cost to total reasonable cost (lin	e 41 ÷ line	45)		0. 638156	
	Ratio of Part B reasonable cost to total reasonable cost (lin				0. 361844	
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA					1
3. 00	Total program GME payment (line 31)				141, 241	48.0
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)				90, 134	49.0
	Part B Medicare GME payment (line 47 x 48) (title XVIII only)					50.0

Heal th	Financial Systems METHODIST HOSE	PITALS, INC	In Lieu	of Form CMS-2	552-10
OUTLIE	R RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0002	Peri od:	Worksheet E-5	
			From 01/01/2023 To 12/31/2023	Date/Time Prep 5/29/2024 9:08	
		Title XVIII		PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or su	m of 2.03 plus 2.04 (see	instructions)	0	1.00
1.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions) 2.00 Capital outlier from Wkst. L, Pt. I, line 2					2.00
3.00	Operating outlier reconciliation adjustment amount (see ins	tructions)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instr	uctions)		0	4.00
5.00	The rate used to calculate the time value of money (see ins	tructions)		0. 00	5.00
6.00	Time value of money for operating expenses (see instruction	s)		0	6.00
7.00	Time value of money for capital related expenses (see instr	uctions)		0	7.00

Health Financial Systems METHODIST F
BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column

Provider CCN: 15-0002

Peri od: Worksheet G From 01/01/2023 | Worksheet G | From 12/31/2023 | Date/Time Prepared:

onl y)			10	5 12/31/2023	Date/lime Pre 5/29/2024 9:0	
		General Fund	Speci fi c	Endowment	Plant Fund	l alli
		1. 00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	9, 134, 727	0	0	0	1.00
2.00	Temporary investments	646, 313	1	0	0	
3.00	Notes recei vabl e	0	0	0	0	
4. 00 5. 00	Accounts recei vabl e Other recei vabl e	62, 099, 750	0	0	0	
6. 00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	
7. 00	Inventory	18, 346, 449	ő	o	0	
8.00	Prepai d expenses	6, 777, 079	0	o	0	8. 00
9. 00	Other current assets	18, 151, 917	1	0	0	
10.00	Due from other funds	30, 750	1	0	0	10.00
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	115, 186, 985	0	0	0	11. 00
12. 00	Land	5, 767, 953	0	ol	0	12.00
13. 00	Land improvements	7, 113, 003	i	ō	0	
14.00	Accumulated depreciation	-420, 841, 010	0	o	0	
15. 00	Bui I di ngs	318, 872, 773	0	0	0	1
16.00	Accumulated depreciation	0 2, 011, 838	0	0	0	16. 00 17. 00
17. 00 18. 00	Leasehold improvements Accumulated depreciation	2,011,838		0	0	18.00
19. 00	Fixed equipment	0	Ö	ő	0	1
20.00	Accumulated depreciation	0	0	o	0	20.00
21.00	Automobiles and trucks	0	0	O	0	
22.00	Accumulated depreciation	0	0	0	0	
23. 00	Major movable equipment	225, 514, 131	0	0	0	23.00
24. 00 25. 00	Accumulated depreciation Minor equipment depreciable	0	0	0	0	24. 00 25. 00
26. 00	Accumulated depreciation	0	0	o	0	26. 00
27.00	HIT designated Assets	0	0	o	0	27. 00
28.00	Accumulated depreciation	0	0	o	0	
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	138, 438, 688	0	0	0	30.00
31. 00	Investments	117, 603, 050	0	ol	0	31.00
32.00	Deposits on Leases	0	1 -	Ö	0	
33.00	Due from owners/officers	0	0	o	0	33.00
34.00	Other assets	305, 949	1	0	0	
35.00	Total other assets (sum of lines 31-34)	117, 908, 999	1	0	0	
36. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	371, 534, 672	0	0	0	36.00
37. 00	Accounts payable	28, 374, 086	0	ol	0	37. 00
38.00	Salaries, wages, and fees payable	0	_	o	0	1
39. 00	Payroll taxes payable	0	0	0	0	
40.00	Notes and Loans payable (short term)	2, 845, 000	0	0	0	
41. 00 42. 00	Deferred income Accelerated payments	0	0	U	0	41. 00 42. 00
43.00		0	0	o	0	1
	Other current liabilities	19, 600, 482	_	Ö	0	
45.00	Total current liabilities (sum of lines 37 thru 44)	50, 819, 568		0	0	45. 00
	LONG TERM LIABILITIES		_	_1	_	
46.00	Mortgage payable	OF 40F 424	0	0	0	1
47. 00 48. 00	Notes payable Unsecured Loans	25, 495, 434	0	0 0	0	
49. 00	Other long term liabilities	37, 574, 555	Ö	ő	0	1
50.00	Total long term liabilities (sum of lines 46 thru 49)	63, 069, 989		o	0	1
51.00	Total liabilities (sum of lines 45 and 50)	113, 889, 557	0	0	0	51.00
F0 00	CAPI TAL ACCOUNTS	057 (45 445	1			
52. 00 53. 00	General fund balance Specific purpose fund	257, 645, 115	0			52. 00 53. 00
54. 00	Donor created - endowment fund balance - restricted			o		54.00
55.00	Donor created - endowment fund balance - unrestricted			Ö		55.00
56.00	Governing body created - endowment fund balance			o		56.00
57. 00	Plant fund balance - invested in plant				0	1
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	257, 645, 115		o	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	371, 534, 672	1	0	0	1
	59)	, ,		٦	, and a	

| Period: | Worksheet G-1 | From 01/01/2023 | To 12/21/2023 | Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 15-0002

					To 12/31/2023	Date/Time Pre 5/29/2024 9:0	pared: 8 am
		General	Fund	Special F	Purpose Fund	Endowment Fund	
		1. 00	2. 00	3. 00	4.00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)	0 0 0 0 0 0 0 0	2. 00 267, 288, 357 -9, 643, 242 257, 645, 115 0 257, 645, 115		4.00 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)		257, 645, 115		0		19. 00
		Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8. 00	_		
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0		0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)	0	0 0 0 0 0		0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		19.00

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

		1	o 12/31/2023	Date/Time Pre 5/29/2024 9:0	
	Cost Center Description	I npati ent	Outpati ent	Total	o alli
	555 C 55.115.1 55551 F L 5.1	1.00	2.00	3. 00	
	PART I - PATIENT REVENUES	•			
	General Inpatient Routine Services				
1.00	Hospi tal	88, 342, 323	3	88, 342, 323	1.00
2.00	SUBPROVI DER - I PF	2, 720, 801		2, 720, 801	2.00
3.00	SUBPROVI DER - I RF	4, 038, 040		4, 038, 040	3.00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF			0	5.00
6.00	Swing bed - NF			0	6.00
7.00	SKILLED NURSING FACILITY				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)	95, 101, 164		95, 101, 164	10.00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT	27, 799, 829		27, 799, 829	11. 00
11. 01	NEONATAL ICU	5, 727, 734		5, 727, 734	11. 01
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGI CAL 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	33, 527, 563	3	33, 527, 563	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	128, 628, 727		128, 628, 727	17.00
18. 00	Ancillary services	593, 009, 006		1, 476, 829, 695	18. 00
19. 00	Outpati ent servi ces	22, 582, 506	123, 104, 244	145, 686, 750	19.00
20.00	RURAL HEALTH CLINIC		0	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21.00
22. 00	HOME HEALTH AGENCY		3, 611, 718	3, 611, 718	22. 00
23.00	AMBULANCE SERVICES				23. 00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26.00	HOSPI CE				26. 00
27.00	PROFESSI ONAL REVENUES	2, 095, 678			27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	746, 315, 917	1, 073, 414, 839	1, 819, 730, 756	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES	1			
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		440, 235, 502		29. 00
30.00	ADD (SPECIFY)				30.00
31.00					31.00
32.00					32.00
33.00					33.00
34.00					34.00
35.00	T				35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)				37.00
38.00					38.00
39.00					39.00
40.00					40.00
41.00	Total deductions (our of lines 27 41)				41.00
42. 00	Total deductions (sum of lines 37-41)		440 225 502		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		440, 235, 502		43. 00
	LU WKSL. U-3, TITE 4)	1	1		I

	Financial Systems ENT OF REVENUES AND EXPENSES	METHODIST HOSPITALS, INC	CCN: 15-0002	Peri od:	u of Form CMS-2 Worksheet G-3	
SIAIEW	ENT OF REVENUES AND EXPENSES	Provider	CCN. 13-0002	From 01/01/2023	WOLKSHEET G-3	
				To 12/31/2023	Date/Time Pre 5/29/2024 9:0	
					372972024 9.0	o alli
					1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part	t I, column 3, line 28)			1, 819, 730, 756	1.00
2. 00	Less contractual allowances and discounts or	n patients' accounts			1, 414, 970, 732	2.00
3. 00	Net patient revenues (line 1 minus line 2)				404, 760, 024	3.00
4. 00	Less total operating expenses (from Wkst. G-				440, 235, 502	
5. 00	Net income from service to patients (line 3	minus line 4)			-35, 475, 478	5.00
	OTHER I NCOME					
5. 00	Contributions, donations, bequests, etc				0	
7. 00	Income from investments				6, 291, 832	
3.00	Revenues from telephone and other miscellane	eous communication services			0	
9.00	Revenue from television and radio service				0	
10.00	Purchase discounts Rebates and refunds of expenses				0	
	Parking Lot receipts				0	
	Revenue from Laundry and Linen service				0	
	Revenue from meals sold to employees and que	asts			0	
	Revenue from rental of living quarters	.313			0	
	Revenue from sale of medical and surgical su	upplies to other than patien	ts		0	
	Revenue from sale of drugs to other than pat	• • • • • • • • • • • • • • • • • • • •				17.00
	Revenue from sale of medical records and abs				0	18.00
19. 00	Tuition (fees, sale of textbooks, uniforms,	etc.)			0	19.00
20. 00	Revenue from gifts, flowers, coffee shops, a	and canteen			0	20.00
21. 00	Rental of vending machines				0	21.00
22. 00	Rental of hospital space				0	22.00
	Governmental appropriations				0	23.00
24. 00	OTHER OPERATING INCOME				15, 863, 014	
	NON OPERATING INCOME				378, 318	
	CHANGE IN UNREALIZED GAIN/LOSS				3, 247, 727	
	REALIZED GAIN/LOSS ON INVESTMENT SAL				174, 498	
	GAIN/LOSS ON ASSET DI SPOSAL				117, 075	
	COVI D-19 PHE Fundi ng				0	
	Total other income (sum of lines 6-24)				26, 072, 464	
	Total (line 5 plus line 25)				-9, 403, 014	
	FOUNDATION SALARIES				223, 605	
	FOUNDATION OTHER	agari nto)			16, 623	
	Total other expenses (sum of line 27 and sub	1 /			240, 228	
17. UU	Net income (or loss) for the period (line 26	minus iine zoj			-9, 643, 242	1 29. U

	Financial Systems		METHODI ST HOSP				u of Form CMS-	
COST A	ALLOCATION - HHA GENERAL SERVICE	E COST		Provi der C	CN: 15-0002	Peri od: From 01/01/2023	Worksheet H-1 Part I	
				HHA CCN:	15-7536	To 12/31/2023	Date/Time Pre	
						Home Health	5/29/2024 9: 0 PPS	08 am
						Agency I	113	
			Capital Rela	ated Costs				
		Not Eyponess	Pl dac 0	Movabl e	DI ont	Transportatio	Subtotal	-
		Net Expenses for Cost	BI dgs & Fi xtures	Equi pment	Plant Operation 8	Transportatio n	Subtotal (cols. 0-4)	
		Allocation	TTXtures	Equi piliorre	Mai ntenance		(6613. 6 1)	
		(from Wkst.						
		H, col . 10)	1.00	2.00	2.00	4.00	44.00	
	GENERAL SERVICE COST CENTERS	0	1. 00	2. 00	3. 00	4. 00	4A. 00	
1. 00	Capital Related - Bldg. &	0	0				О	1.00
	Fixtures							
2.00	Capital Related - Movable	0		0			0	2.00
3. 00	Equipment Plant Operation & Maintenance		0	0		0		3.00
4. 00	Transportation		o	0		0 0		4.00
5.00	Administrative and General	1, 043, 511	0	0		0 0	1, 043, 511	1
	HHA REIMBURSABLE SERVICES							
6. 00	Skilled Nursing Care	727, 820	0	0	•	0 0		
7. 00 8. 00	Physical Therapy Occupational Therapy	432, 703 146, 489	0	0	1	0 0	432, 703 146, 489	
9. 00	Speech Pathology	0	ol ol	0		0 0	140, 407	1
10.00	Medical Social Services	5, 855	O	0		0 0	5, 855	10.00
11.00	Home Heal th Ai de	65, 781	0	0)	0 0	65, 781	
12. 00 13. 00	Supplies (see instructions)	0	0	0		0	0	1
14. 00	Drugs DME		0	0		0 0	0	1
00	HHA NONREI MBURSABLE SERVI CES	<u> </u>	<u> </u>		1	<u> </u>		1 55
15.00	Home Dialysis Aide Services	0	0	0)	0 0	0	1
16.00	Respiratory Therapy	0	0	0)	0 0	1	1
17. 00 18. 00	Private Duty Nursing Clinic	0	0	0		0 0	0	
19. 00	Health Promotion Activities		0	0	S .			1
20.00	Day Care Program	0	0	0		0 0	0	1
21. 00	Home Delivered Meals Program	0	0	0		0 0	0	
22. 00	Homemaker Service	0	0	0)	0 0	0	
23. 00 23. 50	All Others (specify) Telemedicine		0	0		0 0	0	
	Total (sum of lines 1-23)	2, 422, 159	Ö	0		0 0	2, 422, 159	1
		Admi ni strati v						
		e & General	4A + 5)					-
	GENERAL SERVICE COST CENTERS	5. 00	6. 00					
1.00	Capital Related - Bldg. &							1.00
	Fixtures							
2.00	Capital Related - Movable							2. 00
3. 00	Equipment Plant Operation & Maintenance							3.00
4. 00	Transportation							4.00
5. 00	Administrative and General	1, 043, 511						5.00
,	HHA REIMBURSABLE SERVICES	550 055	4 070 745					, , , , ,
6. 00 7. 00	Skilled Nursing Care Physical Therapy	550, 893 327, 517	1, 278, 713 760, 220					6. 00 7. 00
7. 00 8. 00	Occupational Therapy	110, 879	257, 368					8.00
9. 00	Speech Pathology	0	0					9. 00
10.00	Medical Social Services	4, 432	10, 287					10.00
11.00	Home Heal th Ai de	49, 790	115, 571					11.00
12. 00 13. 00	Supplies (see instructions) Drugs	0	0					12. 00 13. 00
14. 00			0					14.00
	HHA NONREIMBURSABLE SERVICES		- 1					
15.00	Home Dialysis Aide Services	0	0					15.00
16. 00 17. 00	Respiratory Therapy Private Duty Nursing	0	0					16. 00 17. 00
17.00	Clinic		0					18.00
19. 00	Health Promotion Activities		o					19.00
20.00	Day Care Program	0	0					20.00
21.00		0	0					21.00
22. 00 23. 00	Homemaker Service All Others (specify)	0	0					22. 00 23. 00
	Telemedicine		0					23. 50
	Total (sum of lines 1-23)		2, 422, 159					24.00
		'	'					

Heal th	Financial Systems		METHODIST HOS	SPITALS, INC		In Lie	u of Form CMS-2	2552-10
COST A	ALLOCATION - HHA STATISTICAL BAS	SIS		Provi der C		Peri od:	Worksheet H-1	
				HHA CCN:		From 01/01/2023 To 12/31/2023		pared: 8 am
						Home Health	PPS	
		Capital Rel	atad Casts			Agency I		
		Capital Rei	ated Costs					
		BI dgs &	Movabl e	Plant	Transportatio	Reconciliatio	Administrativ	
		Fi xtures	Equi pment	Operation &	n (MI LEAGE)	n	e & General	
		(SQUARE FEET)	(DOLLAR	Mai ntenance			(ACCUM. COST)	
		1.00	VALUE) 2, 00	(SQUARE FEET)	4.00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3. 00	4.00	5A. 00	5.00	
1.00	Capital Related - Bldg. &	0				0		1.00
	Fixtures							
2. 00	Capital Related - Movable Equipment		0			0		2. 00
3. 00	Plant Operation & Maintenance	0	0	0		0		3.00
4. 00	Transportation (see	O	0	O		0		4. 00
	instructions)							
5. 00	Administrative and General	0	0	0	(-1, 043, 511	1, 378, 648	5.00
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	0	0		J ,	0	727, 820	6.00
7. 00	Physical Therapy		0	_	1		432, 703	
8. 00	Occupational Therapy	l ő	0			0	146, 489	
9. 00	Speech Pathology	O	0	0		0	0	9. 00
10.00	Medical Social Services	0	0	0		0	5, 855	
11.00	Home Heal th Ai de	0	0	0		0	65, 781	
12.00	Supplies (see instructions)	0	0	0		0	l ~	
13. 00 14. 00	Drugs DME	0	0	_		0	1	
14.00	HHA NONREI MBURSABLE SERVI CES	<u> </u>			1	5		14.00
15. 00	Home Dialysis Aide Services	0	0	0	(0 0	0	15.00
16. 00	Respi ratory Therapy	0	0	0	1	0	0	
17. 00	Private Duty Nursing	0	0	0		0	0	17. 00
18.00	Clinic Health Promotion Activities	0	0	0		0	0	
19. 00 20. 00	Day Care Program	0	0		1		0	19. 00 20. 00
21. 00	Home Delivered Meals Program		0		l .		0	21.00
22. 00	Homemaker Service	Ö	0	Ö		-	Ö	22.00
23. 00	All Others (specify)	0	0	0		0 0	0	23. 00
23. 50	Tel emedi ci ne	0	0	0		0	0	23. 50
24. 00	Total (sum of lines 1-23)	0	0	0	1	-1, 043, 511		
25. 00	Cost To Be Allocated (per		0	1	'	O	1, 043, 511	25. 00

0.000000

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0. 756909 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

Home Health PPS Agency I CAPI TAL RELATED COSTS DATA ADMITTI NG HHA Trial BLDG & FIXT **EMPLOYEE PURCHASI NG** Cost Center Description Bal ance (1) **BENEFITS** PROCESSI NG RECEIVING AND DEPARTMENT **STORES** 0 1. 00 4.00 5. 01 5. 02 5. 03 1.00 Administrative and General 00 379.399 0 3, 851 13, 493 1.00 1, 278, 713 2.00 Skilled Nursing Care 2.00 Physical Therapy 0 0 3.00 760, 220 000000000000000000 0 3.00 Occupational Therapy 257, 368 0 0 o 4.00 4.00 0 Speech Pathology 0 5.00 C 5.00 0 6.00 Medical Social Services 10, 287 0 0 6.00 7.00 Home Heal th Aide 115, 571 o 7.00 0 0 0 0 8 00 Supplies (see instructions) 0 8 00 0 0 9.00 Drugs C 9.00 10.00 DMF 10.00 11.00 Home Dialysis Aide Services 0 0 0 0 0 11.00 Respiratory Therapy 0 12 00 12 00 Private Duty Nursing 13.00 0 0 13.00 14.00 0 14.00 Clinic Health Promotion Activities 0 0 15.00 15.00 0 0 0 Day Care Program 16.00 16.00 Ω 17.00 Home Delivered Meals Program 0 C 0 0 17.00 Homemaker Service 0 18.00 0 18.00 All Others (specify) 0 0 19 00 0 19 00 Ω 0 19.50 Tel emedi ci ne 0 0 19.50 Total (sum of lines 1-19) (2) 2, 422, 159 379, 399 3, 851 13, 493 20.00 20.00 21.00 Unit Cost Multiplier: column 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places CASHI ERI NG/AC OPERATION OF LAUNDRY & Cost Center Description Subtotal OTHER A&G PATI ENT COUNTS TRANSPORTATI O PLANT LINEN SERVICE RECEI VABLE N 5. 05 5.06 7. 00 8.00 5. 04 5A. 04 1.00 Administrative and General 14, 999 411, 742 44, 243 1.00 2.00 Skilled Nursing Care 0 1, 278, 713 137, 402 0 0 2.00 0 0 Physical Therapy 3.00 0 760, 220 81, 688 0 3 00 0 0 4.00 Occupational Therapy 257, 368 27, 655 4.00 5.00 Speech Pathology 0 0 0 0 0 0 0 0 0 0 0 0 5.00 0 6.00 Medical Social Services 10, 287 1, 105 0 6.00 0 7.00 Home Health Aide 115, 571 12, 418 7.00 8.00 0 Supplies (see instructions) 8.00 9.00 9.00 Drugs 0 0 0 0 10.00 DMF 0 0 0 10.00 11.00 Home Dialysis Aide Services 0 C 0 11.00 12.00 Respiratory Therapy 0 12.00 13.00 Private Duty Nursing 0 0 0 0 13.00 0 0 14.00 Clinic C 14.00 15.00 Health Promotion Activities C 15.00 0 0 0 16.00 Day Care Program 0 0 0 16.00 0 Home Delivered Meals Program 17.00 0 17.00 0 0 18.00 Homemaker Service C 18.00 19.00 All Others (specify) 0 0 C 0 0 19.00 19.50 Tel emedi ci ne 0 19.50 0 14, 999 2. 833. 901 20.00 20 00 Total (sum of lines 1-19) (2) 304, 511 0 21.00 Unit Cost Multiplier: column 0.000000 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.

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

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20 00

21.00

Drugs

Clinic

Home Dialysis Aide Services

Health Promotion Activities

Home Delivered Meals Program

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

Unit Cost Multiplier: column

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

Respiratory Therapy

Private Duty Nursing

Day Care Program

Homemaker Service

6 decimal places.

Tel emedi ci ne

All Others (specify)

DMF

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

ncai tri	Titianciai Systems		WILTHOUT 31 1103	I I IALS, INC		III LI C	u or roriii civi3-2	2002 10
ALLOCA	ATION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS	Provi der C		Peri od:	Worksheet H-2	
				HHA CCN:		From 01/01/2023 To 12/31/2023		
						Home Health	PPS	
						Agency I		
	Cost Center Description	PARAMED ED	Subtotal	Intern &	Subtotal	Allocated HHA	Total HHA	
		PROGRAM		Resi dents		A&G (see Part	Costs	
				Cost & Post		11)		
				Stepdown				
		23. 00	24. 00	Adjustments 25.00	26. 00	27. 00	28. 00	
1. 00	Administrative and General	23.00	467, 938	25.00	467, 93		20.00	1.00
2. 00	Skilled Nursing Care	0	1, 416, 115	0	1, 416, 11		1, 663, 151	2.00
3. 00	Physical Therapy	0	841, 908	0	841, 90	·	988, 775	
4. 00	Occupational Therapy	0	285, 023	0	285, 02	·	334, 744	
5. 00	Speech Pathology	Ö	0	0		0 0	0	5.00
6.00	Medical Social Services	0	11, 392	0	11, 39	2 1, 987	13, 379	6.00
7.00	Home Health Aide	0	127, 989	0	127, 98	9 22, 327	150, 316	7.00
8.00	Supplies (see instructions)	0	0	0)	o o	0	8.00
9.00	Drugs	0	0	0)	0 0	0	9. 00
10.00	DME	0	0	0	1	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	1	0	0	12.00
13. 00	Private Duty Nursing	0	0	0	1	0 0	0	13.00
14.00	Clinic	0	0	0	1	0	0	14.00
15.00	Health Promotion Activities	0	0	0		0	0	15.00
16. 00 17. 00	Day Care Program Home Delivered Meals Program	0	0	0			0	16. 00 17. 00
18.00	Homemaker Service	0	0	0		0	0	18.00
19. 00	All Others (specify)	0	0	0		0	0	19.00
19. 50	Tel emedi ci ne	0	0	0			0	19.50
20.00	Total (sum of lines 1-19) (2)	0	3, 150, 365	0	3, 150, 36	5 467, 938	3, 150, 365	
21. 00	Unit Cost Multiplier: column	, i	0, 100, 000	· ·	37.007.00	0. 174446	07 .007 000	21.00
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							

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

Peri od: Worksheet H-2
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared: 5/29/2024 9:08 am BASIS HHA CCN: 15-7536 Home Health PPS

						Home Health	PPS	
		CAPI TAL				Agency I		
		RELATED COSTS						
	Cost Center Description	BLDG & FIXT	EMPLOYEE	DATA	PURCHASI NG	ADMITTI NG	CASHI ERI NG/AC	
	dest deriter beserr per en	(SQUARE FEET)	BENEFITS	PROCESSI NG	RECEIVING AND	(GROSS	COUNTS	
		(SQUINC TEET)	DEPARTMENT	(MACHI NE	STORES	CHARGES)	RECEI VABLE	
			(GROSS	TIME)	(PURCHASE	0.11.11.02.0)	(GROSS	
			SALARI ES)		REQUISITIONS)		CHARGES)	
		1. 00	4. 00	5. 01	5. 02	5. 03	5. 04	
1. 00	Administrative and General	0						1. 00
2.00	Skilled Nursing Care	0		0	1	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	o	3.00
4.00	Occupational Therapy	0	0	0	0	0	o	4.00
5.00	Speech Pathology	0	0	0	0	0	o	5.00
6.00	Medical Social Services	0	0	0	0	0	ol	6.00
7.00	Home Health Aide	0	0	0	0	0	o	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	o	8.00
9.00	Drugs	0	0	0	0	0	o	9.00
10.00	DME	0	0	0	0	0	o	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	o	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19. 00	All Others (specify)	0	0	0	0	0	0	19.00
19. 50	Tel emedi ci ne	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	2, 092, 822	0	,			20.00
21. 00	Total cost to be allocated	0	379, 399	l .	-,			
22.00	Unit cost multiplier	0 000000		0 000000				
		0. 000000						22. 00
	Cost Center Description	Reconciliatio	OTHER A&G	PATI ENT	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	22. 00
				PATI ENT TRANSPORTATI O	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	22. 00
		Reconciliatio	OTHER A&G	PATI ENT TRANSPORTATI O N	OPERATION OF	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG	22. 00
		Reconciliatio	OTHER A&G	PATIENT TRANSPORTATIO N (NUMBER OF	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	22. 00
		Reconciliatio n	OTHER A&G (ACCUM. COST)	PATIENT TRANSPORTATIO N (NUMBER OF TRIPS)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	22.00
	Cost Center Description	Reconciliatio n 5A. 05	OTHER A&G (ACCUM. COST)	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET) 9.00	
1.00	Cost Center Description Administrative and General	Reconciliatio n	OTHER A&G (ACCUM. COST) 5. 05 411, 742	PATIENT TRANSPORTATION N (NUMBER OF TRIPS) 5.06	OPERATION OF PLANT (SQUARE FEET) 7.00	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00	HOUSEKEEPI NG (SQUARE FEET) 9.00	1.00
1. 00 2. 00	Cost Center Description Administrative and General Skilled Nursing Care	Reconciliation SA. 05	OTHER A&G (ACCUM. COST) 5. 05 411, 742 1, 278, 713	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06	OPERATION OF PLANT (SQUARE FEET) 7.00 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00	HOUSEKEEPI NG (SQUARE FEET) 9.00 0	1.00
1. 00 2. 00 3. 00	Cost Center Description Administrative and General Skilled Nursing Care Physical Therapy	Reconciliation SA. 05	OTHER A&G (ACCUM. COST) 5. 05 411, 742 1, 278, 713 760, 220	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06	OPERATION OF PLANT (SQUARE FEET) 7.00 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00	HOUSEKEEPI NG (SQUARE FEET) 9.00	1. 00 2. 00 3. 00
1. 00 2. 00	Cost Center Description Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy	Reconciliation SA. 05	OTHER A&G (ACCUM. COST) 5. 05 411, 742 1, 278, 713	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06	OPERATION OF PLANT (SQUARE FEET) 7.00 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00	9.00	1.00
1. 00 2. 00 3. 00 4. 00	Cost Center Description Administrative and General Skilled Nursing Care Physical Therapy	Reconciliation SA. 05	OTHER A&G (ACCUM. COST) 5. 05 411, 742 1, 278, 713 760, 220 257, 368 0	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06	OPERATION OF PLANT (SQUARE FEET) 7.00 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00	9.00 0 0 0 0	1. 00 2. 00 3. 00 4. 00
1. 00 2. 00 3. 00 4. 00 5. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	Reconciliation SA. 05	OTHER A&G (ACCUM. COST) 5. 05 411, 742 1, 278, 713 760, 220 257, 368	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5.06 0 0 0 0	OPERATION OF PLANT (SQUARE FEET) 7.00 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 0 0	9.00 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	Reconciliation SA. 05	OTHER A&G (ACCUM. COST) 5. 05 411, 742 1, 278, 713 760, 220 257, 368 0 10, 287	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5.06	OPERATION OF PLANT (SQUARE FEET) 7.00 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 0 0 0	9.00 9.00 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Cost Center Description Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	Reconciliation SA. 05	OTHER A&G (ACCUM. COST) 5. 05 411, 742 1, 278, 713 760, 220 257, 368 0 10, 287	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06	OPERATION OF PLANT (SQUARE FEET) 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 9.00 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	Reconciliation SA. 05	OTHER A&G (ACCUM. COST) 5. 05 411, 742 1, 278, 713 760, 220 257, 368 0 10, 287	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06	OPERATION OF PLANT (SQUARE FEET) 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 00 9. 00 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	Reconciliation SA. 05	OTHER A&G (ACCUM. COST) 5. 05 411, 742 1, 278, 713 760, 220 257, 368 0 10, 287	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06	OPERATION OF PLANT (SQUARE FEET) 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 00 9. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	Reconciliation SA. 05	OTHER A&G (ACCUM. COST) 5. 05 411, 742 1, 278, 713 760, 220 257, 368 0 10, 287	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06	OPERATION OF PLANT (SQUARE FEET) 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 00 9. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.00 2.00 3.00 4.00 5.00 7.00 8.00 9.00 10.00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services	Reconciliation SA. 05	OTHER A&G (ACCUM. COST) 5. 05 411, 742 1, 278, 713 760, 220 257, 368 0 10, 287	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5. 06	OPERATION OF PLANT (SQUARE FEET) 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 00 9. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	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	Reconciliation SA. 05	OTHER A&G (ACCUM. COST) 5. 05 411, 742 1, 278, 713 760, 220 257, 368 0 10, 287	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5.06	OPERATION OF PLANT (SQUARE FEET) 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 9.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	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	Reconciliation SA. 05	OTHER A&G (ACCUM. COST) 5. 05 411, 742 1, 278, 713 760, 220 257, 368 0 10, 287	PATI ENT TRANSPORTATI O N (NUMBER OF TRI PS) 5.06	OPERATION OF PLANT (SQUARE FEET) 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 9.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 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	Reconciliation SA. 05	0THER A&G (ACCUM. COST) 5. 05 411, 742 1, 278, 713 760, 220 257, 368 0 10, 287 115, 571 0 0 0 0 0 0 0 0 0	PATI ENT TRANSPORTATI 0 N (NUMBER OF TRI PS) 5. 06	OPERATION OF PLANT (SQUARE FEET) 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 00 9. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Cost Center Description 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	Reconciliation SA. 05	0THER A&G (ACCUM. COST) 5. 05 411, 742 1, 278, 713 760, 220 257, 368 0 10, 287 115, 571 0 0 0 0 0 0 0 0 0 0	PATI ENT TRANSPORTATI 0 N (NUMBER OF TRI PS) 5. 06	OPERATION OF PLANT (SQUARE FEET) 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 00 9. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	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	Reconciliation SA. 05	0THER A&G (ACCUM. COST) 5. 05 411, 742 1, 278, 713 760, 220 257, 368 0 10, 287 115, 571 0 0 0 0 0 0 0 0 0 0	PATI ENT TRANSPORTATI 0 N (NUMBER OF TRI PS) 5. 06	OPERATION OF PLANT (SQUARE FEET) 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 9.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 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)	Reconciliation SA. 05	0THER A&G (ACCUM. COST) 5. 05 411, 742 1, 278, 713 760, 220 257, 368 0 10, 287 115, 571 0 0 0 0 0 0 0 0 0 0	PATI ENT TRANSPORTATI 0 N (NUMBER OF TRI PS) 5. 06	OPERATION OF PLANT (SQUARE FEET) 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 9.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	Reconciliation SA. 05	0THER A&G (ACCUM. COST) 5. 05 411, 742 1, 278, 713 760, 220 257, 368 0 10, 287 115, 571 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	PATI ENT TRANSPORTATI 0 N (NUMBER OF TRI PS) 5. 06	OPERATION OF PLANT (SQUARE FEET) 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 9.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 17. 00 19. 00 19. 00 19. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 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)	Reconciliation SA. 05	0THER A&G (ACCUM. COST) 5. 05 411, 742 1, 278, 713 760, 220 257, 368 0 10, 287 115, 571 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	PATI ENT TRANSPORTATI 0 N (NUMBER OF TRI PS) 5. 06	OPERATION OF PLANT (SQUARE FEET) 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 00 9. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 11. 00 12. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 17. 00 19. 00 19. 00 19. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) Total cost to be allocated	Reconciliation SA. 05	0THER A&G (ACCUM. COST) 5. 05 411, 742 1, 278, 713 760, 220 257, 368 0 10, 287 115, 571 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	PATI ENT TRANSPORTATI 0 N (NUMBER OF TRI PS) 5. 06	7.00 7.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY) 8.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 00 9. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00

Peri od: Worksheet H-2
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared: 5/29/2024 9:08 am BASIS HHA CCN: 15-7536

							3/29/2024 9.0	o aiii
						Home Health	PPS	
						Agency I		
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(MEALS	(PRODUCTI VE	ADMI NI STRATI O	SERVICES &	(COSTED	RECORDS &	
		SERVED)	HOURS)	N (DI DECT NUDC	SUPPLY	REQUIS.)	LI BRARY	
				(DI RECT NURS.	(COSTED		(GROSS	
		10.00	11. 00	HRS.) 13. 00	REQUIS.) 14.00	15. 00	CHARGES) 16.00	
1. 00	Administrative and General	10.00	0			15.00	3, 611, 718	1. 00
2. 00	Skilled Nursing Care		0	0		0	3, 011, 710	2.00
3. 00	Physical Therapy		0	0		0	0	3. 00
4. 00	Occupational Therapy		0	0	0	0	0	4. 00
5. 00	Speech Pathology		0	0	ĺ	0	0	5. 00
6. 00	Medical Social Services	l ő	0	0	0	0	0	6. 00
7. 00	Home Heal th Ai de	l ő	0	0	·	0	0	7. 00
8. 00	Supplies (see instructions)	l ő	0	0		0	0	8. 00
9. 00	Drugs	0	0	Ö	1	0	0	9. 00
10.00	DME	0	0	0		0	0	10.00
11. 00	Home Dialysis Aide Services	0	0	Ö		0	0	11. 00
12.00	Respi ratory Therapy	0	0	0		0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	O	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19. 50	Tel emedi ci ne	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	0	0	3, 611, 718	20.00
21. 00	Total cost to be allocated	0	0	0	0	0	9, 322	
22. 00	Unit cost multiplier	0. 000000	0. 000000	0. 000000			0. 002581	22. 00
					INTERNS &	RESI DENTS		
	Cook Cooks Books at the	COCLAI	CTAFF	MEDICAL	CEDVI CEC CALA	CEDVI CEC OTHE	DADAMED ED	
	Cost Center Description	SOCI AL SERVI CE	STAFF EDUCATI ON	MEDI CAL EDUCATI ON	RY & FRINGES	SERVICES-OTHE R PRGM COSTS	PARAMED ED PROGRAM	
		(TIME SPENT)	(TIME SPENT)	(ASSI GNED	(ASSI GNED	(ASSI GNED	(ASSI GNED	
		(ITWL SILNI)	(ITWL SILNI)	TIME)	TIME)	TIME)	TIME)	
		17. 00	17. 01	17. 02	21.00	22. 00	23.00	
1. 00	Administrative and General	0	333	0		0	0	1. 00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	O	0		1 ^		_	
5.00	Speech Pathology			U	0	0	0	4.00
6.00	Topecen ratheregy	0	0	0	·	0	0	4. 00 5. 00
7.00	Medical Social Services	0	0	0		0 0	0	
		0 0	0	0 0	0	0 0	0 0 0	5.00
8.00	Medical Social Services	0 0 0 0	0 0 0 0	0	0	0 0	0	5. 00 6. 00
9. 00	Medical Social Services Home Health Aide Supplies (see instructions) Drugs	0 0 0 0	0 0 0 0	0 0 0 0	000000000000000000000000000000000000000	0 0 0	0	5. 00 6. 00 7. 00 8. 00 9. 00
9. 00 10. 00	Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	0 0 0	0 0 0 0 0	0 0 0 0	000000000000000000000000000000000000000	0 0 0	0 0 0	5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
9. 00 10. 00 11. 00	Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services	0 0 0 0 0	0 0 0 0 0 0	0 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0	5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
9. 00 10. 00 11. 00 12. 00	Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0	5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
9. 00 10. 00 11. 00 12. 00 13. 00	Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0 0	0 0	0 0 0 0 0	5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	0 0 0 0 0	0 0 0 0 0 0	5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	000000000000000000000000000000000000000	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	000000000000000000000000000000000000000	0 0 0 0 0 0 0	5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	0 0 0 0 0	0 0 0 0 0 0 0	5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	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	000000000000000000000000000000000000000	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	000000000000000000000000000000000000000	0 0 0 0 0 0 0	5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	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	000000000000000000000000000000000000000	0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	000000000000000000000000000000000000000	0 0 0 0 0 0 0	5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	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)	000000000000000000000000000000000000000	0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	000000000000000000000000000000000000000	0 0 0 0 0 0 0	5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50	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	000000000000000000000000000000000000000	0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0	000000000000000000000000000000000000000	000000000000000000000000000000000000000	5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50
9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 50 20. 00	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)	000000000000000000000000000000000000000	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	000000000000000000000000000000000000000	0 0 0 0 0 0 0	5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00
9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00 21. 00	Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) Total cost to be allocated	000000000000000000000000000000000000000	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00 21. 00

	n Financial Systems		METHODI ST HOS	PITALS INC		Inlie	u of Form CMS-2	552-10
	TIONMENT OF PATIENT SERVICE COST	ΓS	METHODI OT 1100	Provi der C	CN: 15-0002	Peri od:	Worksheet H-3	1002 10
				HHA CCN:	15-7536	From 01/01/2023 To 12/31/2023	Part I Date/Time Pre	
				Title	XVIII	Home Health Agency I	5/29/2024 9: 0 PPS	o alli
	Cost Center Description	From, Wkst.	Facility	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I,	Costs (from	Ancillary	Costs (cols		Per Visit	
		col. 28, line	Wkst. H-2,	Costs (from	1 + 2)		(col. 3 ÷	
			Part I)	Part II)			col . 4)	
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - COMPUTATION OF LESSER COST LIMITATION	OF AGGREGATE	PROGRAM COST, A	AGGREGATE OF TI	HE PROGRAM LI	MITATION COST, C	OR BENEFICIARY	
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	1, 663, 151		1, 663, 1	51 8, 919	186. 47	1.00
2.00	Physical Therapy	3.00	988, 775	0	988, 7 ⁻	75 4, 614	214. 30	2.00
3.00	Occupational Therapy	4.00	334, 744	0	334, 74	44 1, 557	214. 99	3.00
4.00	Speech Pathology	5.00	0	0		0 0	0.00	4.00
5.00	Medical Social Services	6.00			13, 3 ⁻	79 72	185. 82	5.00
6. 00	Home Health Aide	7. 00			150, 3			6.00
7. 00	Total (sum of lines 1-6)	7.00	3, 150, 365	0				7. 00
7.00	Total (sum of Times 1-0)		3, 130, 303		Program Visi			7.00
					110graiii VI31			
					P	art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject	Subject to		
					to	Deducti bl es		
					Deducti bl es	&		
					Coi nsurance	•		
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		23844	0				8.00
9.00	Physi cal Therapy		23844	0		15		9.00
10.00	Occupational Therapy		23844	0	3:	25		10.00
11.00			23844	0		0		11.00
12.00	Medical Social Services		23844	0		17		12 00
13.00	Home Heel th Aide							12.00
	Home Health Aide		23844	0	4:	34		12.00
14.00	1		23844	_		34		
14.00	Total (sum of lines 8-13) Cost Center Description	From Wkst.		0		34 13	Ratio (col. 3	13.00
14.00	Total (sum of lines 8-13)	From Wkst. H-2 Part I,	23844 Facility Costs (from	0	3, 0	34 13 Total Charges	Ratio (col. 3 ÷ col. 4)	13.00
14.00	Total (sum of lines 8-13)		Facility	0 0 Shared	3, 0 ⁻ Total HHA	34 13 Total Charges		13.00
14.00	Total (sum of lines 8-13)	H-2 Part I,	Facility Costs (from	0 0 Shared Ancillary	3,0° Total HHA Costs (cols	34 13 Total Charges (from HHA		13.00
14.00	Total (sum of lines 8-13) Cost Center Description	H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2,	Shared Ancillary Costs (from	3,0° Total HHA Costs (cols	34 13 Total Charges (from HHA		13.00
	Total (sum of lines 8-13) Cost Center Description Supplies and Drugs Cost Comput	H-2 Part I, col. 28, line 0 ations	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II) 2.00	3,0 Total HHA Costs (cols 1 + 2)	Total Charges (from HHA Records)	÷ col . 4)	13. 00 14. 00
15. 00	Total (sum of lines 8-13) Cost Center Description Supplies and Drugs Cost Comput Cost of Medical Supplies	H-2 Part I, col. 28, line 0 ations 8.00	Facility Costs (from Wkst. H-2, Part I) 1.00	Shared Ancillary Costs (from Part II) 2.00	3,0 Total HHA Costs (cols 1 + 2)	Total Charges (from HHA Records) 4.00	5. 00 0. 000000	13. 00 14. 00
15. 00	Total (sum of lines 8-13) Cost Center Description Supplies and Drugs Cost Comput	H-2 Part I, col. 28, line 0 ations 8.00 9.00	Facility Costs (from Wkst. H-2, Part I) 1.00	Shared Ancillary Costs (from Part II) 2.00	3,0 Total HHA Costs (cols 1 + 2)	Total Charges (from HHA Records)	5. 00 0. 000000	13. 00 14. 00
15. 00	Total (sum of lines 8-13) Cost Center Description Supplies and Drugs Cost Comput Cost of Medical Supplies	H-2 Part I, col. 28, line 0 ations 8.00 9.00	Facility Costs (from Wkst. H-2, Part I) 1.00	Shared Ancillary Costs (from Part II) 2.00	3,0 Total HHA Costs (cols 1 + 2) 3.00	Total Charges (from HHA Records) 4.00	5. 00 0. 000000	13. 00 14. 00
15. 00	Total (sum of lines 8-13) Cost Center Description Supplies and Drugs Cost Comput Cost of Medical Supplies	H-2 Part I, col. 28, line 0 ations 8.00 9.00	Facility Costs (from Wkst. H-2, Part I) 1.00 O Program Visits	Shared Ancillary Costs (from Part II) 2.00	3,0 Total HHA Costs (cols 1 + 2)	Total Charges (from HHA Records) 4.00	5. 00 0. 000000	13. 00 14. 00
15. 00	Total (sum of lines 8-13) Cost Center Description Supplies and Drugs Cost Comput Cost of Medical Supplies Cost of Drugs	H-2 Part I, col. 28, line 0 ations 8.00 9.00	Facility Costs (from Wkst. H-2, Part I) 1.00 O Program Visits	Shared Ancillary Costs (from Part II) 2.00	3,0' Total HHA Costs (cols 1 + 2) 3.00 Cost of Services	Total Charges (from HHA Records) 4.00 Part B	5.00 0.000000 0.000000	13. 00 14. 00
15. 00	Total (sum of lines 8-13) Cost Center Description Supplies and Drugs Cost Comput Cost of Medical Supplies	H-2 Part I, col. 28, line 0 ations 8.00 9.00	Facility Costs (from Wkst. H-2, Part I) 1.00 O Program Visits Par Not Subject	Shared Ancillary Costs (from Part II) 2.00 t B Subject to	3,0 Total HHA Costs (cols 1 + 2) 3.00	Total Charges (from HHA Records) 4.00 Part B Not Subject	5.00 0.000000 0.000000 Subject to	13. 00 14. 00
15. 00	Total (sum of lines 8-13) Cost Center Description Supplies and Drugs Cost Comput Cost of Medical Supplies Cost of Drugs	H-2 Part I, col. 28, line 0 ations 8.00 9.00	Facility Costs (from Wkst. H-2, Part I) 1.00 O O Program Visits Par Not Subject to	Shared Ancillary Costs (from Part II) 2.00 t B Subject to Deductibles &	3,0' Total HHA Costs (cols 1 + 2) 3.00 Cost of Services	Total Charges (from HHA Records) 4.00 Part B Not Subject to	5.00 0.000000 0.000000 Subject to Deductibles &	13. 00 14. 00
15. 00	Total (sum of lines 8-13) Cost Center Description Supplies and Drugs Cost Comput Cost of Medical Supplies Cost of Drugs	H-2 Part I, col. 28, line 0 ations 8.00 9.00	Facility Costs (from Wkst. H-2, Part I) 1.00 O Program Visits Par Not Subject to Deductibles &	Shared Ancillary Costs (from Part II) 2.00 t B Subject to Deductibles &	3,0' Total HHA Costs (cols 1 + 2) 3.00 Cost of Services	Total Charges (from HHA Records) 4.00 Part B Not Subject to Deductibles &	5.00 0.000000 0.000000 Subject to Deductibles &	13. 00 14. 00
15. 00	Total (sum of lines 8-13) Cost Center Description Supplies and Drugs Cost Comput Cost of Medical Supplies Cost of Drugs	H-2 Part I, col. 28, line 0 ations 8.00 9.00 Part A	Facility Costs (from Wkst. H-2, Part 1) 1.00 O Program Visits Par Not Subject to Deductibles & Coinsurance	Shared Ancillary Costs (from Part II) 2.00 t B Subject to Deductibles & Coinsurance	3,0 Total HHA Costs (cols 1 + 2) 3.00 Cost of Services Part A	Total Charges (from HHA Records) 4.00 Part B Not Subject to Deducti bl es & Coi nsurance	÷ col. 4) 5.00 0.000000 0.000000 Subject to Deductibles & Coinsurance	13. 00 14. 00
15. 00	Total (sum of lines 8-13) Cost Center Description Supplies and Drugs Cost Comput Cost of Medical Supplies Cost of Drugs Cost Center Description	H-2 Part I, col. 28, line 0 ations 8.00 9.00 Part A	Facility Costs (from Wkst. H-2, Part I) 1.00 O Program Visits Par Not Subject to Deductibles & Coinsurance 7.00	Shared Ancillary Costs (from Part II) 2.00 t B Subject to Deductibles & Coinsurance 8.00	3,0 Total HHA Costs (cols 1 + 2) 3.00 Cost of Services Part A	Total Charges (from HHA Records) 4.00 Part B Not Subject to Deductibles & Coinsurance 10.00	5.00 0.000000 0.000000 Subject to Deductibles & Coinsurance	13. 00 14. 00 15. 00
15. 00	Total (sum of lines 8-13) Cost Center Description Supplies and Drugs Cost Comput Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER	H-2 Part I, col. 28, line 0 ations 8.00 9.00 Part A	Facility Costs (from Wkst. H-2, Part I) 1.00 O Program Visits Par Not Subject to Deductibles & Coinsurance 7.00	Shared Ancillary Costs (from Part II) 2.00 t B Subject to Deductibles & Coinsurance 8.00	3,0 Total HHA Costs (cols 1 + 2) 3.00 Cost of Services Part A	Total Charges (from HHA Records) 4.00 Part B Not Subject to Deductibles & Coinsurance 10.00	5.00 0.000000 0.000000 Subject to Deductibles & Coinsurance	13. 00 14. 00
15. 00	Total (sum of lines 8-13) Cost Center Description Supplies and Drugs Cost Comput Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION	H-2 Part I, col. 28, line 0 ations 8.00 9.00 Part A	Facility Costs (from Wkst. H-2, Part I) 1.00 O Program Visits Par Not Subject to Deductibles & Coinsurance 7.00	Shared Ancillary Costs (from Part II) 2.00 t B Subject to Deductibles & Coinsurance 8.00	3,0 Total HHA Costs (cols 1 + 2) 3.00 Cost of Services Part A	Total Charges (from HHA Records) 4.00 Part B Not Subject to Deductibles & Coinsurance 10.00	5.00 0.000000 0.000000 Subject to Deductibles & Coinsurance	13. 00 14. 00
15. 00 16. 00	Cost Center Description Supplies and Drugs Cost Comput Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation	H-2 Part I, col. 28, line 0 ations 8.00 9.00 Part A 6.00 OF AGGREGATE	Facility Costs (from Wkst. H-2, Part I) 1.00 O Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A	Shared Ancillary Costs (from Part II) 2.00 t B Subject to Deductibles & Coinsurance 8.00	3,0 Total HHA Costs (cols 1 + 2) 3.00 Cost of Services Part A	Total Charges (from HHA Records) 4.00 Part B Not Subject to Deductibles & Coinsurance 10.00 MITATION COST, (÷ col. 4) 5.00 0.000000 0.000000 Subject to Deductibles & Coinsurance 11.00 OR BENEFICIARY	13. 00 14. 00 15. 00 16. 00
15. 00 16. 00	Cost Center Description Supplies and Drugs Cost Comput Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care	H-2 Part I, col. 28, line 0 ations 8.00 9.00 Part A 6.00 OF AGGREGATE	Facility Costs (from Wkst. H-2, Part I) 1.00 O Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A	Shared Ancillary Costs (from Part II) 2.00 t B Subject to Deductibles & Coinsurance 8.00 AGGREGATE OF TI	3,0 Total HHA Costs (cols 1 + 2) 3.00 Cost of Services Part A	Total Charges (from HHA Records) 4.00 Part B Not Subject to Deductibles & Coinsurance 10.00 MITATION COST, (÷ col. 4) 5.00 0.000000 0.000000 Subject to Deductibles & Coinsurance 11.00 OR BENEFICIARY	13. 00 14. 00 15. 00 16. 00
15. 00 16. 00 1. 00 2. 00	Cost Center Description Supplies and Drugs Cost Comput Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy	H-2 Part I, col. 28, line 0 ations 8.00 9.00 Part A 6.00 OF AGGREGATE	Facility Costs (from Wkst. H-2, Part I) 1.00 O Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A	Shared Ancillary Costs (from Part II) 2.00 t B Subject to Deductibles & Coinsurance 8.00 AGGREGATE OF Ti	3,0 Total HHA Costs (cols 1 + 2) 3.00 Cost of Services Part A	Total Charges (from HHA Records) 4.00 Part B Not Subject to Deductibles & Coinsurance 10.00 MITATION COST, CO 246,513 0 246,513	÷ col. 4) 5.00 0.000000 0.000000 Subject to Deductibles & Coinsurance 11.00 DR BENEFICIARY	13. 00 14. 00 15. 00 16. 00
15. 00 16. 00 1. 00 2. 00 3. 00	Cost Center Description Supplies and Drugs Cost Comput Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy	H-2 Part I, col. 28, line 0 ations 8.00 9.00 Part A 6.00 OF AGGREGATE	Facility Costs (from Wkst. H-2, Part I) 1.00 O Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A	Shared Ancillary Costs (from Part II) 2.00 t B Subject to Deductibles & Coinsurance 8.00 AGGREGATE OF Ti	3,0 Total HHA Costs (cols 1 + 2) 3.00 Cost of Services Part A	Total Charges (from HHA Records)	÷ col. 4) 5.00 0.000000 0.000000 Subject to Deductibles & Coinsurance 11.00 R BENEFICIARY	13. 00 14. 00 15. 00 16. 00 1. 00 2. 00 3. 00
1. 00 2. 00 3. 00 4. 00	Cost Center Description Supplies and Drugs Cost Comput Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	H-2 Part I, col. 28, line 0 ations 8.00 9.00 Part A 6.00 0F AGGREGATE	Facility Costs (from Wkst. H-2, Part I) 1.00 O Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A 1,322 915 325 0	Shared Ancillary Costs (from Part II) 2.00 t B Subject to Deductibles & Coinsurance 8.00 AGGREGATE OF Ti	3,0 Total HHA Costs (cols 1 + 2) 3.00 Cost of Services Part A	Total Charges (from HHA Records)	÷ col. 4) 5.00 0.000000 0.000000 Subject to Deductibles & Coinsurance 11.00 OR BENEFICIARY	13. 00 14. 00 15. 00 16. 00 1. 00 2. 00 3. 00 4. 00
15. 00 16. 00 1. 00 2. 00 3. 00 4. 00 5. 00	Cost Center Description Supplies and Drugs Cost Comput Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	H-2 Part I, col. 28, line 0 ations 8.00 9.00 Part A 6.00 OF AGGREGATE	Facility Costs (from Wkst. H-2, Part I) 1.00 O Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A 1,322 915 325 0 17	Shared Ancillary Costs (from Part II) 2.00 t B Subject to Deductibles & Coinsurance 8.00 AGGREGATE OF Ti	3,0 Total HHA Costs (cols 1 + 2) 3.00 Cost of Services Part A	Total Charges (from HHA Records)	÷ col. 4) 5.00 0.000000 0.000000 Subject to Deductibles & Coinsurance 11.00 DR BENEFICIARY	13. 00 14. 00 15. 00 16. 00 1. 00 2. 00 3. 00 4. 00 5. 00
15. 00 16. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	Cost Center Description Supplies and Drugs Cost Comput Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	H-2 Part I, col. 28, line 0 ations 8.00 9.00 Part A 6.00 OF AGGREGATE	Facility Costs (from Wkst. H-2, Part I) 1.00 O O Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A 1,322 915 325 0 17 434	Shared Ancillary Costs (from Part II) 2.00 t B Subject to Deductibles & Coinsurance 8.00 AGGREGATE OF Ti	3,0 Total HHA Costs (cols 1 + 2) 3.00 Cost of Services Part A	Total Charges (from HHA Records)	÷ col. 4) 5.00 0.000000 0.000000 Subject to Deductibles & Coinsurance 11.00 OR BENEFICIARY	13. 00 14. 00 15. 00 16. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
15. 00 16. 00 1. 00 2. 00 3. 00 4. 00 5. 00	Cost Center Description Supplies and Drugs Cost Comput Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	H-2 Part I, col. 28, line 0 ations 8.00 9.00 Part A 6.00 OF AGGREGATE	Facility Costs (from Wkst. H-2, Part I) 1.00 O O Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A 1,322 915 325 0 17 434	Shared Ancillary Costs (from Part II) 2.00 t B Subject to Deductibles & Coinsurance 8.00 AGGREGATE OF Ti	3,0 Total HHA Costs (cols 1 + 2) 3.00 Cost of Services Part A	Total Charges (from HHA Records)	÷ col. 4) 5.00 0.000000 0.000000 Subject to Deductibles & Coinsurance 11.00 OR BENEFICIARY	13. 00 14. 00 15. 00 16. 00 1. 00 2. 00 3. 00 4. 00 5. 00

111-4-	Figure in Company		METHODI CT. HOC	CDITALC INC		1 11-		2552 10
	Financial Systems TIONMENT OF PATIENT SERVICE COS	TC	METHODIST HOS	Provi der C	CN. 1E 0000	Peri od:	u of Form CMS- Worksheet H-3	
APPURI	TONMENT OF PATTENT SERVICE COS	15		HHA CCN:	15-7536	From 01/01/2023 To 12/31/2023	Part I Date/Time Pre	pared:
							5/29/2024 9:0	8 am
				Title	XVIII	Home Health	PPS	
		1				Agency I		
	Cost Center Description							
		6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
8. 00	Limitation Cost Computation Skilled Nursing Care	1		1	I		I	8.00
9. 00	Physical Therapy							9.00
10.00	Occupati onal Therapy							10.00
11. 00	Speech Pathology							11.00
12. 00	Medical Social Services							12.00
13. 00	Home Heal th Ai de							13.00
	Total (sum of lines 8-13)							14.00
14.00	Total (Suil of Titles 0-15)	Progr	ram Covered Cha	arnes	Cost of			14.00
		11091	am covered em	ui ges	Servi ces			
					00. 1. 000			
			Par	t B		Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
	·		to	Deductibles &		to	Deductibles &	
			Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
			Coi nsurance			Coi nsurance		
		6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
	Supplies and Drugs Cost Comput							
	Cost of Medical Supplies Cost of Drugs	0	67, 865 0			0 0		
	Cost Center Description	Total Program						
		Cost (sum of						
		col s. 9-10)						
	1	12. 00						
	PART I - COMPUTATION OF LESSER	OF AGGREGATE	PROGRAM COST,	AGGREGATE OF TI	HE PROGRAM LI	MITATION COST, (OR BENEFICIARY	
	COST LIMITATION							1
1 00	Cost Per Visit Computation	24/ 512						1 00
1. 00 2. 00	Skilled Nursing Care	246, 513 196, 085						1.00 2.00
3. 00	Physical Therapy Occupational Therapy	69, 872						3.00
4. 00	Speech Pathology	09, 872						4.00
5. 00	Medical Social Services	3, 159						5.00
6. 00	Home Heal th Ai de	47, 341						6.00
7. 00	Total (sum of lines 1-6)	562, 970						7.00
7.00	Cost Center Description	302, 770						7.00
	cost center bescription	12. 00						1
	Limitation Cost Computation	12.00						
8. 00	Skilled Nursing Care							8.00
9. 00	Physical Therapy							9. 00
10.00	Occupational Therapy							10.00
11. 00	Speech Pathology							11.00
12. 00	Medical Social Services							12.00
13. 00	Home Heal th Ai de							13.00
14.00	Total (sum of lines 8-13)							14.00
		•	•					

Heal th	Financial Systems		METHODIST HOS	PITALS, INC		In Lie	u of Form CMS-2	2552-10
APP0R1	TIONMENT OF PATIENT SERVICE COS	ΓS		Provi der C		Peri od:	Worksheet H-3	
				HHA CCN:	15-7536	From 01/01/2023 To 12/31/2023		pared:
							5/29/2024 9: 0	
						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 I	BY SHARED HOSP	TAL DEPARTME	NTS		
1.00	Physi cal Therapy	66.00	0. 216905	0		0 col. 2, line 2	. 00	1.00
2.00	Occupational Therapy	67.00	0. 301903	0		0 col. 2, line 3	. 00	2.00
3.00	Speech Pathology	68.00	0. 275654	0		0 col. 2, line 4	. 00	3.00
4.00	Cost of Medical Supplies	71.00	0. 455914	0		0 col. 2, line 1	5. 00	4.00
5.00	Cost of Drugs	73.00	0. 220968	0		0 col. 2, line 1	6. 00	5.00

	Financial Systems METHODIST ATION OF HHA REIMBURSEMENT SETTLEMENT	HOSPITALS, INC Provider Co	CN: 15-0002	Peri od:	u of Form CMS-2 Worksheet H-4	
_00L	ATTOW OF THE RETWINDOWSEMENT SETTEMENT	HHA CCN:	15-7536	From 01/01/2023 To 12/31/2023	Part I-II	
					5/29/2024 9:0	
		Title	XVIII	Home Health Agency I	PPS	
			Dort A		t B	
			Part A	Not Subject to	Subject to Deductibles &	
				Deductibles &	Coi nsurance	
			1.00	Coi nsurance 2.00	3. 00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST C	R CUSTOMARY CHARGE		2.00	3.00	
_	Reasonable Cost of Part A & Part B Services					Ι.
0 0	Reasonable cost of services (see instructions) Total charges			0 0		
0	Customary Charges			0 0	0	1 1
0	Amount actually collected from patients liable for paym	ent for services		0 0	0	3
0	on a charge basis (from your records) Amount that would have been realized from patients liab	ale for navment		0 0	0	4
•	for services on a charge basis had such payment been ma				Ü	'
	with 42 CFR §413.13(b)		0.0000	00 000000	0 000000	_
0 0	Ratio of line 3 to line 4 (not to exceed 1.000000) Total customary charges (see instructions)		0. 0000	0.00000	0. 000000 0	1
0	Excess of total customary charges over total reasonable	e cost (complete		0 0	_	
	only if line 6 exceeds line 1)	-+ ! & !				_ ا
00	Excess of reasonable cost over customary charges (compl 1 exceeds line 6)	ete only it line		0 0	0	8
0	Primary payer amounts			0 0		9
				Part A Services	Part B Servi ces	
				1.00	2. 00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					١.,
00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outlier	·c		0	0 458, 210	
00	Total PPS Reimbursement - Full Episodes with Outliers	3		0	75, 547	
00	Total PPS Reimbursement - LUPA Episodes			0	6, 483	
00 00	Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Ou	ıtliers		0	0 18, 982	
00	Total PPS Outlier Reimbursement - PEP Episodes			0	0	1
00	Total Other Payments			0	0	
00 00	DME Payments Oxygen Payments			0	0	1
00	Prosthetic and Orthotic Payments			0	0	
00	Part B deductibles billed to Medicare patients (exclude	e coi nsurance)			0	
00 00	Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8)			0	559, 222 0	
00				0	559, 222	
00	Coinsurance billed to program patients (from your recor	rds)		_	0	
00	Net cost (line 24 minus line 25) Allowable bad debts (from your records)			0	559, 222 0	1
01	Adjusted reimbursable bad debts (see instructions)				0	
00	Allowable bad debts for dual eligible (see instructions				0	
00	Total costs - current cost reporting period (see instru OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ıcti ons)		0		1
50	Pioneer ACO demonstration payment adjustment (see instr	ructions)		0	_	
99	Demonstration payment adjustment amount before sequestr	,		0	_	30
00 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			0		
02	Demonstration payment adjustment amount after sequestra	iti on		0	,	1
75	Sequestration adjustment for non-claims based amounts (0	0	31
00	Interim payments (see instructions) Tentative settlement (for contractor use only)			0		
	CLEULACTURE SELLI RIBERTI, CLOR. CONTERCIOE USA ONLVI			0	0	33
00	1	. 31, 02, 31, 75, 33	2. and 33)	0	1	34

Health Financial Systems	METHODIST HOSPIT	ΓALS, INC		In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED TO PROGRAM BENEFICIARIES	HHAS FOR SERVICES RENDERED	Provi der CC	CN: 15-0002	Peri od: From 01/01/2023	Worksheet H-5
TO PROGRAM DENEFT CLARIES		HHA CCN:	15-7536		Date/Time Prepared:

5/29/2024 9:08 am Home Health Agency I Inpatient Part A Part B mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 548, 037 1.00 2.00 Interim payments payable on individual bills, either 0 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3. 01 3.01 3. 02 0 0 3.02 3.03 0 3.03 3.04 0 0 3.04 0 3.05 3.05 Provider to Program 3.50 0 0 3.50 3. 51 0 0 3.51 0 3.52 0 3.52 3.53 0 3.53 3.54 0 0 3.54 0 3. 99 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3. 50-3. 98) Total interim payments (sum of lines 1, 2, and 3.99) 4.00 0 548, 037 4.00 (transfer to Wkst. H-4, Part II, column as appropriate, line 32) 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 0 n 5.01 0 0 5.02 5.02 5.03 0 0 5.03 Provider to Program 5.50 0 5.50 n 5. 51 0 0 5.51 5. 52 0 0 5. 52 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 5. 50-5. 98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.01 0 6.02 SETTLEMENT TO PROGRAM 6.02 0 Total Medicare program liability (see instructions) n 548, 038 7.00 7.00 NPR Date Contractor Number (Mo/Day/Yr) 0 1.00 2.00

8. 00

8.00 Name of Contractor

	n Financial Systems METHODIST HOS			u of Form CMS-2	<u> 2552-10</u>
CALCUL	LATION OF CAPITAL PAYMENT	Provi der CCN: 15-0002	Peri od: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Pre 5/29/2024 9:0	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				
1. 00	Capital DRG other than outlier			1, 996, 818	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1.01
2.00	Capital DRG outlier payments			51, 514	2.00
2.01	Model 4 BPCI Capital DRG outlier payments			0	2.01
3.00	Total inpatient days divided by number of days in the cost	t reporting period (see ins	tructions)	200. 40	
4. 00	Number of interns & residents (see instructions)			2. 95	
5. 00	Indirect medical education percentage (see instructions)			0. 42	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	8, 387	6. 00
7. 00	Percentage of SSI recipient patient days to Medicare Part	A natient days (Worksheet	F nart Δ line	8. 43	7.00
7.00	30) (see instructions)	A patrent days (norksheet	E, part A Triic	0. 43	7.00
8.00	Percentage of Medicaid patient days to total days (see ins	structions)		33. 45	8.00
9.00	Sum of lines 7 and 8	,		41. 88	9.00
10.00	Allowable disproportionate share percentage (see instructi	ons)		8. 85	10.00
11.00	Disproportionate share adjustment (see instructions)			176, 718	11.00
12.00	Total prospective capital payments (see instructions)			2, 233, 437	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST			1.00	
1.00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions	s)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	
4.00	Capital cost payment factor (see instructions)			0	
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5.00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1. 00	Program inpatient capital costs (see instructions)			0	
2.00	Program inpatient capital costs for extraordinary circumst	tances (see instructions)		0	
3. 00 4. 00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)			0 0. 00	
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0.00	•
6. 00	Percentage adjustment for extraordinary circumstances (see	instructions)		0. 00	
7. 00	Adjustment to capital minimum payment level for extraordin		x line 6)	0.00	
8. 00	Capital minimum payment level (line 5 plus line 7)	9 01.04000 (1.102	,, ,,,,,,	0	
9.00	Current year capital payments (from Part I, line 12, as ap	oplicable)		0	9.00
10.00	Current year comparison of capital minimum payment level t	to capital payments (line 8	less line 9)	0	10.00
11. 00	Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	er capital payment (from pr	ior year	0	11.00
12. 00		payments (line 10 nlus li	ne 11)	0	12.00
13. 00				0	
				0	
14. 00	(if line 12 is negative, enter the amount on this line)	1 1 3	9 11	_	
	(IT TITLE 12 IS HEGALIVE, EITHER THE AMOUNT ON THIS TITLE)				
	Current year allowable operating and capital payment (see			0	15.00
14. 00 15. 00 16. 00	Current year allowable operating and capital payment (see			0	