Health Financial Systems KING'S DAUGHTERS' HOSPITAL In Lieu of Form CMS-2552-10 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 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 150069 Period: Worksheet S From 01/01/2015 Parts I-III Date/Time Prepared: AND SETTLEMENT SUMMARY 12/31/2015 То 5/18/2016 3:58 pm PART I - COST REPORT STATUS Provider 1. [X] Electronically filed cost report Date: 5/18/2016 Time: 3:58 pm 2.[use only]Manually submitted cost report 3.[0] If this is an amended report enter the number of times the provider resubmitted this cost report 4.[F] Medicare Utilization. Enter "F" for full or "L" for low. 5. [1]Cost Report Status (1) As Submitted Contractor 6. Date Received: 10.NPR Date: (2) Settled without Audit 8. [N] Initial Report for this Provider CCN
 (3) Settled with Audit 9. [N] Final Report for this Provider CCN
 (4) Reopened use only (4) Reopened (5) Amended PART II - CERTIFICATION MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT. CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S) I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by KING'S DAUGHTERS' HOSPITAL (150069) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 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. M - 0-Encryption Information (Signed) ECR: Date: 5/18/2016 Time: 3:58 pm Officer or Administrator of Frovider(s)

ECR: Date: 5/18/2016 Time: 3:58 pm gmKUWqacoiPYIJwe0kCiLTdgt37LQ0 Ylqxn0ARRsHHMH1VgngINUUPfVbEIo L7jq1J1fTm0HPbmp PI: Date: 5/18/2016 Time: 3:58 pm l25cP2.8sxtgxygw:P7d1oe1JL2Ge0 pP5Kt0U1zp18A9c1Xq7keJ7H6FRsNt m2sq0cvP670G5tY0

			Title X	VIII		
		Title V	Part A	Part B	HIT	Title XIX
		1.00	2.00	3.00	4.00	5.00
	PART III - SETTLEMENT SUMMARY					
1.00	Hospital	0	-223,854	40,790	34,356	306,667 1.
2.00	Subprovider – IPF	0	0	0		0 2.
3.00	Subprovider – IRF	0	0	0		0 3.
5.00	Swing bed - SNF	0	0	0		0 5.
6.00	Swing bed - NF	0				0 6.
9.00	HOME HEALTH AGENCY I	0	0	1		0 9.
200.00	Total	0	-223,854	40,791	34,356	306,667 200.

Title

Date

20-16

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

SPI T	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX I		DAUGHTERS'			N: 150069	Period: From 01/01		Works Part Date/	orm CMS- neet S-2 Time Pre 2016 2:2	2 epared
	1.00		00	-	3.00			4.00			
00	Hospital and Hospital Health Care Co Street: ONE KINGS DAUGHTERS DRIVE	PO Box: 4	147								1. (
00	City: MADISON	State: I		p Code	: 47250	- Coun	ty: JEFFERS	ON			2.0
		Component Na		CCN	CBSA	Provi de			nt Sys	stem (P,	
			Nu	umber	Number	- Туре	Certified	-	0, 0		4
		1.00			2.00	1.00	F 00	V	XVII	_	-
	Hospital and Hospital-Based Componen	1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
00	Hospi tal	KING'S DAUGHTERS		50069	99915	1	06/17/1960	5 N	P	0	3.
00	Subprovider - IPF Subprovider - IRF	HOSPI TAL									4. 5.
00 00 00 00	Subprovider - (Other) Swing Beds - SNF Swing Beds - NF Hospital-Based SNF										6. 7. 8. 9.
00	Hospi tal -Based NF										10.
00	Hospi tal -Based OLTC										11.
00	Hospital-Based HHA	KING'S DAUGHTERS	' 15	57141	99915		03/08/198	5 N	P	N	12.
00	Separately Certified ASC	HOSPI TAL HHA									13.
	Hospi tal -Based Hospi ce	KING'S DAUGHTERS	' 15	51535	99915		09/01/199	5			14.
00	Hospital-Based Health Clinic - RHC				,,,,,,						15.
00	Hospital-Based Health Clinic - FQHC										16.
00	Hospital-Based (CMHC) I										17.
	Renal Dialysis Other										18.
00							From	:	T	ō:	17.
							1.00			. 00	
00 00	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions) Inpatient PPS Information						01/01/2	2015 2	12/3	1/2015	20.
00	Does this facility qualify and is it share hospital adjustment, in accord for yes or "N" for no. Is this facil amendment hospital?) In column 2, en	ance with 42 CFR ity subject to 42	§412.106? 2 CFR Secti	In col on §412	lumn 1,	enter "Y				N	22.
01	Did this hospital receive interim un period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r	compensated care es or "N" for no October 1. Enter	payments f for the po in column	or this rtion (2, "Y"	of the for ye	cost s or "N"	Y			Y	22.
02	(see instructions) Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for	? (see instruction e cost reporting	ons) Enter period pri	in colu or to (umn 1, October	"Y" for y€ 1. Enter				N	22.
	or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column	statistical area no for the portic	as adopted on of the c	by CMS ost re	in FY2 porting	015? Enter period	-			N	22.
	cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3,	t more than 499 k "Y" for yes or "N	oeds (as co N″ for no.	unted i	in acco	rdance wit					
	Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per	f census days, or is cost reporting	⁻ 3 if date g period di	of dis fferen	scharge t from	. Is the the method	ł	3		N	23.
			In-State Medicaid paid days	In-St Medic eligi unpa day	ate aid ble M id pa	Out-of State Medicaid	Out-of	Medica HMO da		Other edi cai d days	
			1.00	2.0	0	3.00	4.00	5.00		6.00	
	If this provider is an IPPS hospital in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in	n 1, in-state umn 2, olumn 3, d days in column t unpaid days in	552		831	0	11	1,	350	(24.
	If this provider is an IRF, enter th Medicaid paid days in column 1, the Medicaid eligible unpaid days in col out-of-state Medicaid days in column Medicaid eligible unpaid days in col HMO paid and eligible but unpaid day	e in-state in-state umn 2, 3, out-of-state umn 4, Medicaid	0		Ο	O	0		0		25.

	2		RS' HOSPI TAL		1	n Lieu	u of For	m CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION	I DATA	Provi der		eriod: rom 01/01/ o 12/31/		Workshe Part I Date/Ti 5/18/20	me Pre	pared:
					Urban/Rur 1.00			Geogr	
26.00	Enter your standard geographic classification (no			ginning of the	1.00	2	2.0		26.00
27.00	cost reporting period. Enter "1" for urban or "2" Enter your standard geographic classification (no reporting period. Enter in column 1, "1" for urban	t wage) st n or "2" f	atus at the end or rural. If ap			2			27.00
35.00	enter the effective date of the geographic reclass If this is a sole community hospital (SCH), enter effect in the cost reporting period.			CH status in		1			35.00
					Begi nni 1. 00	-	Endi 2. (
36.00	Enter applicable beginning and ending dates of SCI of periods in excess of one and enter subsequent of		Subscript line	36 for number	01/01/2		12/31/		36.00
	If this is a Medicare dependent hospital (MDH), en is in effect in the cost reporting period.	nter the n				0			37.00
38.00	If line 37 is 1, enter the beginning and ending da greater than 1, subscript this line for the number enter subsequent dates.								38.00
					Y/N 1.00		Y/ 2.0		
39.00	Does this facility qualify for the inpatient hospi hospitals in accordance with 42 CFR §412.101(b)(2) or "N" for no. Does the facility meet the mileage	(ii)? Ĕnt requireme	er in column 1 ents in accordar	"Y" for yes nce with 42	N		N		39.00
40.00	CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for Is this hospital subject to the HAC program reduc "N" for no in column 1, for discharges prior to O no in column 2, for discharges on or after October	tion adjus ctober 1.	tment? Enter ") Enter "Y" for y	(" for yes or	N		N		40. 00
						V	XVIII 2.00	XI X 3.00	
45.00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital pay	mont for	di enconarti anat	to chara in acc	ordanco	N	N	N	45.00
	with 42 CFR Section §412.320? (see instructions)								
46.00	Is this facility eligible for additional payment of pursuant to 42 CFR §412.348(f)? If yes, complete V Pt. III.	exception Wkst. L, P	tor extraordina t. III and Wkst	t. L-1, Pt. I t	ces Through	N	N	N	46.00
47.00 48.00	Is this a new hospital under 42 CFR §412.300 PPS of Is the facility electing full federal capital pays Teaching Hospitals				10.	N N	N	N N	47.00 48.00
56.00	Is this a hospital involved in training residents or "N" for no.	in approv	ed GME programs	s? Enter "Y" f	for yes	N			56.00
57.00	If line 56 is yes, is this the first cost reportin GME programs trained at this facility? Enter "Y"	for yes o	or "N" for no ir	n column 1. If	column 1				57.00
	is "Y" did residents start training in the first r for yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt.	s "Y", com	plete Worksheet						
	If line 56 is yes, did this facility elect cost re defined in CMS Pub. 15-1, chapter 21, §2148? If ye	eimburseme es, comple	nt for physicia te Wkst. D-5.		IS				58.00
	Are costs claimed on line 100 of Worksheet A? If Are you claiming nursing school and/or allied heal					N Y			59.00 60.00
	provider-operated criteria under §413.85? Enter	"Y" for ye	s or "N" for no	D. (see instruc Direct GME	tions)		Di rect	CME	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	1.00	2.00	3.00	4.00	0.00	5.0		61.00
61. 01	column 1. (see instructions) Enter the average number of unweighted primary can FTEs from the hospital's 3 most recent cost report		0.00	0.00	þ				61. 01
	ending and submitted before March 23, 2010. (see instructions)								
61. 02	Enter the current year total unweighted primary ca FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of		0.00	0.00					61.02
61.03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see	or	0.00	0.00					61. 03
61.04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.00	þ				61.04
61. 05	current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (li	5	0.00	0.00					61. 05
61.06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprima care or general surgery. (see instructions)		0.00	0.00					61.06

HOSPITAL AND HOSPITAL HEALTH CA	ARE COMPLE	X IDENTIFICATION DA	ТА	Provi der	1	Period: From 01/01/2015 Fo 12/31/2015	Worksheet S-2 Part I Date/Time Pre 5/18/2016 2:2	pared:
			Program				Direct GME FTE Count	
			1. (00	2.00	3.00	4.00	
 b1.10 Of the FTEs in line 61.0 specialty, if any, and t for each new program. (s column 1, the program na program code, enter in c unweighted count and ent FTE unweighted count. b1.20 Of the FTEs in line 61.0 program specialty, if an residents for each expan instructions) Enter in c enter in column 2, the p 3, the IME FTE unweighted 4, direct GME FTE unweighted 	he number ee instruc me, enter olumn 3, t er in colu 5, specify y, and the ded progra olumn 1, t rogram coc d count ar	of FTE residents tions) Enter in in column 2, the he IME FTE mn 4, direct GME each expanded number of FTE m. (see he program name, e, enter in column d enter in column				0. OC 0. OC		61. 1
			L		1			
							1.00	
ACA Provisions Affecting								
52.00 Enter the number of FTE your hospital received H				this cost	reporting per	I OC TOP WHICH	0.00	62.00
52.01 Enter the number of FTE during in this cost repo	residents rting peri	that rotated from a od of HRSA THC prog	i Teaching H Iram. (see i			your hospital	0.00	62.0
3.00 <u>Teaching Hospitals that</u> Has your facility traine "Y" for yes or "N" for n	d resident	s in nonprovider se	ettings duri				N	63.0
					Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
					1.00	2.00	3.00	
Section 5504 of the ACA period that begins on or					This base year	ris your cost r	reporting	
4.00 Enter in column 1, if li in the base year period, resident FTEs attributab settings. Enter in colu resident FTEs that train of (column 1 divided by	ne 63 is y the numbe le to rota mn 2 the n ed in your	es, or your facilit r of unweighted non tions occurring in umber of unweighted hospital. Enter in + column 2)). (see	y trained r p-primary ca all nonprov non-primar column 3 t instructior	esidents re ider y care he ratio s)	0.0			64.0
		Program Name	Prograr	n Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2. (00	3.00	4.00	5.00	
55.00 Enter in column 1, if I is yes, or your facility trained residents in the year period, the program associated with primary FTEs for each primary ca program in which you tra residents. Enter in colu the program code, enter column 3, the number of unweighted primary care residents attributable t rotations occurring in a non-provider settings. E column 4, the number of unweighted primary care resident FTEs that train your hospital. Enter in 5, the ratio of (column	base name care re ined mn 2, in FTE o II nter in ed in column				0.0	0 0.00	0. 000000	03.0

Health Financial Syst	ems	KING'S E	DAUGHTERS' H	OSPI TAL		In L	ieu of Form CMS	-2552-10
HOSPITAL AND HOSPITAL	_ HEALTH CARE COMPI	LEX IDENTIFICATION DA	TA	Provi der	F	Period: From 01/01/20 Fo 12/31/20		epared:
					Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital		/
Section 5504 o	f the ACA Current	Year FTE Residents ir	Nonnrovi da	r Sotting	1.00	2.00	3.00	
beginning on o	r after July 1, 20	10	•	0	SEffective i	or cost repor		
Enter in colum FTEs that trai	ble to rotations o n 2 the number of ned in your hospit	ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider sett ry care resi 3 the ratio	ings. dent	0.0	0 0.	00 0. 00000	0 66.00
	ded by (column 1 +	column 2)). (see ins Program Name	Program	Code	Unweighted	Unweighted	d Ratio (col. 3	/
		Ū			FTËs Nonprovider Site	FTEs in Hospital	(col. 3 + col 4))	
(7.00 Estas is salve	. 1	1.00	2.0	0	3.00	4.00	5.00	
your primary c which you trai Enter in colum code. Enter in number of unwe care FTE resid to rotations o non-provider s column 4, the unweighted pri resident FTEs your hospital. 5, the ratio o	d with each of are programs in ned residents. n 2, the program column 3, the ighted primary ents attributable ccurring in all ettings. Enter in number of mary care that trained in Enter in column f (column 3 lumn 3 + column				0.0	0 0.	00 0. 00000	0 67.00
Inpatient Psyc	hiatric Facility P	PS				1	. 00 2. 00 3. 00	
70.00 Is this facili	ty an Inpatient Ps	ychiatric Facility (I	PF), or doe	s it conta	ain an IPF sub	provi der?	N	70.00
71.00 If line 70 yes recent cost re 42 CFR 412.424 program in acc Column 3: If c (see instructi Inpatient Reha	port filed on or b (d)(1)(iii)(c)) Co ordance with 42 CF olumn 2 is Y, indi ons) bilitation Facilit	e facility have an ap efore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye y PPS	04? Enter 1ity train 0(D)? Enter ear began du	"Y" for ye residents "Y" for ye ring this	es or "N" for in a new teac es or "N" for cost reportin	no. (see hi ng no.	0	71.00
75.00 Is this facili	ty an Inpatient Re Enter "Y" for yes		/(IRF), or	does it co	ontain an IRF		N	75.00
76.00 If line 75 yes recent cost re no. Column 2: CFR 412.424 (d	: Column 1: Did th porting period end Did this facility)(1)(iii)(D)? Ente	e facility have an ap ing on or before Nove train residents in a r "Y" for yes or "N" n during this cost re	ember 15, 20 new teachin for no. Col	04? Enter g program umn 3: If	"Y" for yes o in accordance column 2 is Y	r "N" for with 42	0	76.00
							1.00	-
81.00 Is this a LTCH "Y" for yes an	term care hospita co-located within d "N" for no.	I (LTCH)? Enter "Y" another hospital for				period? Ente	er N	80. 00 81. 00
	hospital under 42 ity establish a ne	w Other subprovider (excl uded un				D. N	85. 00 86. 00
	al a "subclause (I	r yes and "N" for no. I)" LTCH classified u		n 1886(d)	(1)(B)(iv)(II)	-1	N	87.00
						V 1.00	2.00	-
	lity have title V	and/or XIX inpatient	hospital se	rvi ces? Ei	nter "Y" for	N	Y	90.00
	no in the applica al reimbursed for	ble column. title V and/or XIX th	nrough the c	ost renor	t either in	Ν	Y	91.00
full or in par	t? Enter "Y" for y	es or "N" for no in t	the applicab	le column.				
		ing title XVIII SNF b or "N" for no in the			ion)? (see		N	92.00
93.00 Does this faci	lity operate an IC	F/IID facility for pu applicable column.			d XIX? Enter	Ν	N	93.00
	r XIX reduce capit	al cost? Enter "Y" fo	or yes, and	"N" for no	o in the	N	N	94.00

Heal th Financial Systems KING'S DAUGHTERS'		001 1500/0		n Lie	u of Form		52-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der	CCN: 150069	Period: From 01/01/ To 12/31/		Workshee Part I Date/Tim		red:
			V		5/18/201 XI X		om
			1.00		2.00		
 95.00 If line 94 is "Y", enter the reduction percentage in the appli 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes o applicable column. 			N	0.00	N	0.00 95 96	95.00 96.00
97.00 If line 96 is "Y", enter the reduction percentage in the appli Rural Providers	cable colum	n		0.00		0.00 97	7.00
105.00 Does this hospital qualify as a critical access hospital (CAH) 106.00 If this facility qualifies as a CAH, has it elected the all-in		hod of paymer	nt N)5. 00)6. 00
for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cost r training programs? Enter "Y" for yes or "N" for no in column 1 yes, the GME elimination is not made on WKst. B, Pt. I, col. 2	. (see inst	ructions) lf	N			10	07.00
reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 s this a rural hospital qualifying for an exception to the CR CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	NA fee sche	dul e? See 42	2 N			108	8. 00
	Physi cal	Occupationa			Respi ra		
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1.00 N	2.00 N	3.00 N		4. OC N		9.00
					1.00		
110.00 Did this hospital participate in the Rural Community Hospital the current cost reporting period? Enter "Y" for yes or "N" fo		on project (4	110A Demo)fo	r	N	11(0. 00
				1.00	0 2.00	3.00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or " is yes, enter the method used (A, B, or E only) in column 2. I 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers) Pub. 15-1, chapter 22, §2208.1.	f column 2 for long te	is "E", enter rm care (incl	r in column udes	N		0 115	5.00
116.00 Is this facility classified as a referral center? Enter "Y" fo 117.00 Is this facility legally-required to carry malpractice insuran			-"N" for	N N			6. 00 7. 00
no. 118.00 is the malpractice insurance a claims-made or occurrence polic claim-made. Enter 2 if the policy is occurrence.	y? Enter 1	if the policy	/is	0		118	8. 00
cranin-made. Enter 2 in the pointy is occurrence.		Premiums	Losse	S	Insurar	nce	
		1.00	2.00		3.00		
118.01 List amounts of malpractice premiums and paid losses:		1, 030, 9		0			8. 01
			1.00		2.00		
118.02 Are mal practice premiums and paid losses reported in a cost ce Administrative and General? If yes, submit supporting schedul and amounts contained therein.			N		2.00		8. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold H §3121 and applicable amendments? (see instructions) Enter in c "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments	olumn 1, "Y ifies for t	" for yes or he Outpatient			Y		9.00 0.00
Enter in column 2, "Y" for yes or "N" for no. 121.00Did this facility incur and report costs for high cost implant patients? Enter "Y" for yes or "N" for no.	able device	s charged to	Y			12	1. 00
Transplant Center Information 125.00Does this facility operate a transplant center? Enter "Y" for	yes and "N"	for no. If	N			125	. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, ente in column 1 and termination date, if applicable, in column 2.	r the certi	fication date	e			120	. 00
127.00 If this is a Medicare certified heart transplant center, enter	the certif	ication date				127	7.00
in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.	the certif	ication date				128	8. 00
in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.	the certifi	cation date i	n			129	9. 00
column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, en date in column 1 and termination date, if applicable, in colum		ti fi cati on				130	0. 00
131.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in colum	enter the c	erti fication				13	1. 00
132.00 If this is a Medicare certified islet transplant center, enter in column 1 and termination date, if applicable, in column 2.		ication date				132	2. 00
133.00 If this is a Medicare certified other transplant center, enter in column 1 and termination date, if applicable, in column 2.	the certif	ication date				133	3. 00
134.00 If this is an organ procurement organization (OPO), enter the and termination date, if applicable, in column 2.	0P0 number	in column 1				134	4.00

Health Financial Systems KING'S DAUGHTERS' HOSPITAL In Lieu of Form							2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX			CCN: 150069	Period: From 01/ To 12/		Worksheet S-2 Part I Date/Time Pre 5/18/2016 2:2	pared:
				1	. 00	2.00	
AII Providers					. 00	2.00	
140.00 Are there any related organization of chapter 10? Enter "Y" for yes or "N" are claimed, enter in column 2 the h	for no in column 1.	If yes, and home	office costs		N		140.00
1.00		2. 00			3.00		
If this facility is part of a chain				ame and a	address	of the	
home office and enter the home office 141.00Name:	<u>ce contractor name and</u> Contractor's Name:	l contractor numb		or's Numb	or:		141.00
142.00 Street:	PO Box:		Contract				142.00
143. 00 Ci ty:	State:		Zip Code				143.00
						1.00	
144.00 Are provider based physicians' costs	included in Workshoe	+ 12				1.00 Y	144.00
144. OOM e provider based physicians costs	s mer udeu mi worksnee					1	144.00
				1.	. 00	2.00	
145.00 If costs for renal services are clai inpatient services only? Enter "Y" f no, does the dialysis facility inclu- period? Enter "Y" for yes or "N" for	for yes or "N" for no nde Medicare utilizati pr no in column 2.	in column 1. If o on for this cost	column 1 is reporting		N		145.00
146.00 Has the cost allocation methodology Enter "Y" for yes or "N" for no in c yes, enter the approval date (mm/dd/	olumn 1. (See CMS Pub				N		146.00
						1.00	
147.00 Was there a change in the statistica	l basis? Enter "Y" fo	r ves or "N" for	no.			N 1.00	147.00
148.00 Was there a change in the order of a						N	148.00
149.00 Was there a change to the simplified	l cost finding method?						149.00
		Part A 1.00	Part B 2.00		le V	Title XIX 4.00	
Does this facility contain a provide	er that qualifies for		1				
or charges? Enter "Y" for yes or "N							
155.00Hospi tal		N	N		N	N	155.00
156.00 Subprovider - IPF 157.00 Subprovider - IRF		N	N N		N N	N N	156.00 157.00
158. 00 SUBPROVI DER		IN	IN IN		IN .		158.00
159.00 SNF		N	N		Ν	N	159.00
160.00 HOME HEALTH AGENCY		N	N		Ν	Ν	160. 00
161.00 CMHC			N		N	N	161.00
						1.00	
Multicampus							
165.00 Is this hospital part of a Multicamp	ous hospital that has	one or more camp	uses in diffe	rent CBSA	As?	N	165.00
Enter "Y" for yes or "N" for no.	Name	County	State Zi	p Code	CBSA	FTE/Campus	
-	0	1.00		3.00	4.00	5.00	
166.00 If line 165 is yes, for each							166.00
campus enter the name in column O, county in column 1, state in							
column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in							
column 5 (see instructions)							
						1.00	
Health Information Technology (HIT)	incentive in the Amer	rican Recovery an	d Reinvestmer	t Act		1.00	
167.00 Is this provider a meaningful user u	nder §1886(n)? Enter	"Y" for yes or '	"N" for no.			Y	167.00
168.00 If this provider is a CAH (line 105			e 167 is "Y")	, enter t	the	0	168.00
reasonable cost incurred for the HI 168.01 If this provider is a CAH and is not		,	r qualify for	a hardsh	nin		168.01
exception under §413.70(a)(6)(ii)?				a naru3r	P		
169.00 If this provider is a meaningful use	er (line 167 is "Y") a			"N"), ent	ter the	0.50	169. 00
transition factor. (see instructions	;)			Poet	nni na	Endi ng	
					<u>nni ng</u> . 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beg period respectively (mm/dd/yyyy)	inning date and endin	g date for the re	eporting		1/2014		170.00

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIF	ICATION DATA	Provider CCN: 150069	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Pro 5/18/2016 2:2	epared:
				1.00	
171.00 If line 167 is "Y", does this provider have Medicare cost plans reported on Wkst. S-3, (see instructions)				Ν	171.00

PLL	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE		F	Period: From 01/01/2015 Fo 12/31/2015	Date/Time Pre	epared
				Y/N	5/18/2016 2:2 Date	29 pm
				1.00	2.00	
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	oonses. Enter N for all NO re	sponses. Enter	all dates in t	he	
0	Provider Organization and Operation Has the provider changed ownership immediatel	v prior to the beginning of	the east	N		1 1 1
00	reporting period? If yes, enter the date of t			IN		1.
			Y/N	Date	V/I	
			1.00	2.00	3.00	-
00	Has the provider terminated participation in yes, enter in column 2 the date of terminatic voluntary or "I" for involuntary.		N			2.
00	Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel	, chain home offices, drug d to the provider or its	N			3.
	of directors through ownership, control, or f relationships? (see instructions)					
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2.00	3.00	
00	Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or	Audited, "C" for Compiled, enter date available in	Y	A		4.
00	column 3. (see instructions) If no, see instr Are the cost report total expenses and total those on the filed financial statements? If y	revenues different from	Ν			5.
				Y/N	Legal Oper.	
	F			1.00	2.00	
	Approved Educational Activities Column 1: Are costs claimed for nursing scho	val 2 Calump 2: If yos is th	o providor i c	N		
0	the legal operator of the program?	oor? Corumn 2: IT yes, is th	le provider is	IN		6.
0	Are costs claimed for Allied Health Programs? Were nursing school and/or allied health prog	grams approved and/or renewed	l during the	N N		7. 8.
0	cost reporting period? If yes, see instructic Are costs claimed for Interns and Residents i		aleducation	N		9.
0	program in the current cost report? If yes, s					
00	Was an approved Intern and Resident GME progr		he current	Ν		10.
00	cost reporting period? If yes, see instructic Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see	rs other than I & R in an App	roved	Ν		11.
					Y/N	
					1.00	
	Bad Debts Is the provider seeking reimbursement for bac	debts? If ves see instruct	ions		Y	12.
	If line 12 is yes, did the provider's bad deb			st reporting	N	13.
	period? If yes, submit copy.		0			
	If line 12 is yes, were patient deductibles a	and/or co-payments waived? If	yes, see inst	ructions.	N	14.
	Bed Complement Did total beds available change from the pric	or cost reporting period? If	ves see instr	ructions	N	15.
00	ind total bodo avairabio onango rrom the prie	si dest reperting porredri ri	r'	rt A	Part B	101
		Description	Y/N	Date	Y/N	
	PS&R Data	0	1.00	2.00	3.00	
00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see		N		Ν	16.
00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is		Y	02/22/2016	Y	17.
00	yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional		N		Ν	18.
	claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.					
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		Ν	19.
	If line 16 or 17 is yes, were adjustments		N		Ν	20.

Heal th	Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der		eriod:	Worksheet S-2	2
					rom 01/01/2015 0 12/31/2015	Part II Date/Time Pre	epared:
						5/18/2016 2:2	
					t A	Part B	
		Descri		Y/N 1.00	Date 2.00	Y/N 3.00	
21.00	Was the cost report prepared only using the)	N 1.00	2.00	3.00	21.00
211 00	provider's records? If yes, see						200
	instructions.						
						1 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT					1.00	
	Capital Related Cost	ALS UNLI (LACE					
22.00	Have assets been relifed for Medicare purpose	es? If yes, see	e instructions				22.00
23.00	Have changes occurred in the Medicare depreci	ation expense	due to apprais	als made durin	g the cost		23.00
24 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing	a Longon optoro	d into during	this cost ropo	rting pariod2		24.00
24.00	If yes, see instructions	g reases entere	a mto auring	this cost repo	i ting periou?		24.00
25.00	Have there been new capitalized leases entere	ed into during	the cost repor	ting period? I	f yes, see		25.00
	instructions.				-		
26.00	Were assets subject to Sec. 2314 of DEFRA acqu	uired during th	ie cost reporti	ng period? If	yes, see		26.00
27.00	instructions. Has the provider's capitalization policy char	naed during the	e cost reportin	na period? If v	es submit		27.00
27.00	copy.	iged during the		ig period. If y			27.00
	Interest Expense						
28.00	Were new loans, mortgage agreements or letter	rs of credit en	itered into dur	ing the cost r	eporting		28.00
29.00	period? If yes, see instructions. Did the provider have a funded depreciation a	account and/or	bond funds (De	oht Service Res	erve Fund)		29.00
27.00	treated as a funded depreciation account? If						27.00
30.00	Has existing debt been replaced prior to its	scheduled matu	rity with new	debt? If yes,	see		30.00
21 00	instructions.						21 00
31.00	Has debt been recalled before scheduled matur instructions.	ity without is	suance of new	debt? IT yes,	See		31.00
	Purchased Services						
32.00	Have changes or new agreements occurred in pa			ed through cont	ractual		32.00
22.00	arrangements with suppliers of services? If y						22.00
33.00	If line 32 is yes, were the requirements of S no, see instructions.	sec. 2135.2 app	nied pertainin	ig to competiti	ve braarng? Ti		33.00
	Provi der-Based Physi ci ans						
34.00	Are services furnished at the provider facili	ty under an ar	rangement with	n provi der-base	d physi ci ans?	Y	34.00
25 00	If yes, see instructions.		- + :		and along the second	N	25.00
35.00	If line 34 is yes, were there new agreements physicians during the cost reporting period?			its with the pr	ovi der-based	N	35.00
	physicians during the cost reporting period:	11 yes, see 11			Y/N	Date	
					1.00	2.00	
	Home Office Costs						
	Were home office costs claimed on the cost re If line 36 is yes, has a home office cost sta		onarod by the	homo offico?			36.00 37.00
37.00	If yes, see instructions.	atement been pi	epared by the	nome office:			37.00
38.00	If line 36 is yes , was the fiscal year end o						38.00
	the provider? If yes, enter in column 2 the 1						
39.00	If line 36 is yes, did the provider render se	ervices to othe	er chain compon	ients? If yes,			39.00
40.00	see instructions. If line 36 is yes, did the provider render se	ervices to the	home office?	lf ves, see			40.00
	instructions.						
							_
	Cost Deport Droppers Costast Information		1.	00	2.	00	
41.00	Cost Report Preparer Contact Information Enter the first name, last name and the title	e/position	LUCI A		GERBER		41.00
	held by the cost report preparer in columns f	•	20017		SERBER		
	respectively.						
42.00	Enter the employer/company name of the cost r	report	BLUE & CO., LL	.C			42.00
43.00	preparer. Enter the telephone number and email address	of the cost	502. 992. 3524		LGERBER@BLUEAN	DCO COM	43.00
	report preparer in columns 1 and 2, respectiv						

		KING'S DAUGHTERS		1 1 5 0 0 / 0		u of Form CMS	
IOSPI I.	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNALRE	Provider CCN	1: 150069	Period: From 01/01/2015 To 12/31/2015	Worksheet S- Part II Date/Time Pr 5/18/2016 2:	epare
		Part B				371072010 2.	27 pm
		Date					
		4.00					
	PS&R Data						
							16.
	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)						
7.00	Was the cost report prepared using the PS&R	02/22/2016					17.
	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)						
							18
	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.						
	If line 16 or 17 is yes, were adjustments						19.
	made to PS&R Report data for corrections of						
	other PS&R Report information? If yes, see						
	instructions.						
	If line 16 or 17 is yes, were adjustments						20.
	made to PS&R Report data for Other? Describe						
	the other adjustments:						
21.00							21.
	provider's records? If yes, see						
	instructions.						_
			3.00				
	Cost Report Preparer Contact Information		5.00				
		/position SENI	OR MANAGER				41
11.00	held by the cost report preparer in columns 1		OIT MATHOEIT				
	respectively.						
2.00	Enter the employer/company name of the cost r	report					42
	preparer.						
3.00	Enter the telephone number and email address	of the cost					43.
	report preparer in columns 1 and 2, respectiv						

IOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA		Provi der	CCN: 150069		eriod:	Worksheet S	S-3	
							rom 01/01/2015 p 12/31/2015	Part I Date/Time F 5/18/2016 2		
								I/P Days / C		
	Component	Worksheet A	No	of Beds	Bed Days		CAH Hours	<u>Visits / Tri</u> Title V	ps	
	component	Line Number	NO.	OI Deus	Avai I abl e		CAIT HOULS	nue v		
		1.00		2.00	3.00		4.00	5.00		
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		83	30, 2	95	0.00		0	1. (
	8 exclude Swing Bed, Observation Bed and									
	Hospice days) (see instructions for col. 2									
	for the portion of LDP room available beds)									
. 00	HMO and other (see instructions)									2.0
. 00	HMO I PF Subprovi der									3.
	HMO IRF Subprovider								0	
. 00 . 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF								0	5. 6.
. 00	Total Adults and Peds. (exclude observation			83	30, 2		0.00		0	0. 7.
. 00	beds) (see instructions)			03	30, 2	90	0.00		0	1.
. 00	INTENSIVE CARE UNIT	31.00		6	2, 1	90	0.00		0	8.
. 00	CORONARY CARE UNIT	51.00		0	2,1	/0	0.00		0	9.
D. 00	BURN I NTENSI VE CARE UNI T									10.
1.00	SURGI CAL I NTENSI VE CARE UNI T									11.
2.00	OTHER SPECIAL CARE (SPECIFY)									12.
3.00	NURSERY	43.00							0	13.
4.00	Total (see instructions)			89	32, 4	85	0.00		0	14.
5.00	CAH visits								0	15.
6.00	SUBPROVIDER - IPF									16.
7.00	SUBPROVIDER – IRF									17.
B. 00	SUBPROVI DER									18.
9.00	SKILLED NURSING FACILITY									19.
0.00	NURSING FACILITY									20.
1. 00	OTHER LONG TERM CARE									21.
2.00	HOME HEALTH AGENCY	101.00							0	22.
3.00	AMBULATORY SURGICAL CENTER (D. P.)									23.
4.00	HOSPI CE	116. 00		0		0				24.
4. 10	HOSPICE (non-distinct part)	30. 00								24.
5.00	CMHC - CMHC									25.
6.00	RURAL HEALTH CLINIC									26.
5. 25	FEDERALLY QUALIFIED HEALTH CENTER									26.
7.00	Total (sum of lines 14-26)			89					_	27.
3.00	Observation Bed Days								0	28.
9.00	Ambulance Trips									29.
0.00	Employee discount days (see instruction)									30.
1.00	Employee discount days - IRF			-		~				31.
2.00	Labor & delivery days (see instructions)			0		0				32.
2. 01	Total ancillary labor & delivery room									32.
	outpatient days (see instructions) LTCH non-covered days									33.

HOSPI 1	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC,	AL DATA	Provi der	CCN: 150069	Period: From 01/01/ To 12/31/			epared:
		I/P Days	/ O/P Visits	/ Trips	Full T	ime	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Inte & Reside		Employees On Payroll	
		6.00	7.00	8.00	9.00		10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6, 313	1, 420	10, 5				1.00
2.00	HMO and other (see instructions)	734	739					2.00
3.00	HMO IPF Subprovider	0	0					3.00
4.00	HMO IRF Subprovider	0	0					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 beds) (see instructions)	6, 313	1, 420	10, 5	70			7.00
8.00	INTENSIVE CARE UNIT	918	129	1, 4	40			8.00
9.00	CORONARY CARE UNI T							9.00
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY		354	1, 1	94			13.00
14.00	Total (see instructions)	7, 231	1, 903	13, 2	04	0.00	773.34	14.00
15.00	CAH visits	0	0		0			15.00
16.00	SUBPROVIDER - IPF							16.00
17.00	SUBPROVIDER - IRF							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	6, 728	655	9, 5	63	0.00	16.24	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23.00
24.00	HOSPI CE	0	0		0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)	2, 253	6	2, 5	97			24.10
25.00	CMHC - CMHC							25.00
26.00	RURAL HEALTH CLINIC							26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER							26.25
27.00	Total (sum of lines 14-26)					0.00	789.58	27.00
28.00	Observation Bed Days		545	2, 8	21			28.00
29.00	Ambul ance Trips	1, 943						29.00
30.00	Employee discount days (see instruction)			2	26			30.00
31.00	Employee discount days - IRF				0			31.00
32.00	Labor & delivery days (see instructions)	0	102	1	59			32.00
32.01	Total ancillary labor & delivery room				0			32.01
	outpatient days (see instructions)							
33 00	LTCH non-covered days	0						33.00

iospi t	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	CCN: 150069	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part I Date/Time Pre 5/18/2016 2:20	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1, 67	77 484	3, 220	1.0
2.00 3.00 4.00 5.00 5.00 7.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)			16	56 0 0 0		2.0 3.0 4.0 5.0 6.0 7.0
3.00 9.00 0.00 1.00 2.00 3.00	INTENSI VE CARE UNI T CORONARY CARE UNI T BURN INTENSI VE CARE UNI T SURGI CAL INTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY) NURSERY						8. 0 9. 0 10. 0 11. 0 12. 0 13. 0
4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE	0. 00	0	1, 67	77 484	3, 220	14. (15. (16. (17. (18. (19. (20. (21. (
2.00 3.00 4.00 4.10 5.00 6.00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	0. 00 0. 00					22. (23. (24. (24. (25. (26. (
26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0. 00					26. 2 27. (28. (29. (30. (31. (32. (32. (

ΕΡΙ ΤΑ	Financial Systems L WAGE INDEX INFORMATION			Provi der	1	Period: From 01/01/2015 To 12/31/2015		pared
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Sal ari es (col . 2 ± col .	Related to	Average Hourly Wage (col. 4 ÷ col. 5)	
Ir		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II – WAGE DATA SALARIES							
0	Total salaries (see	200.00	50, 615, 373	391	50, 615, 764	4 1, 675, 992. 60	30. 20	1.0
	instructions)						0.00	
	Non-physician anesthetist Part A		(C		0 0.00	0.00	2.0
0	Non-physician anesthetist Part		529, 567	0	529, 56	7 4, 028. 74	131. 45	3.0
0	B Physician-Part A -		10, 071		10, 07	1 102.00	98. 74	4.0
	Admi ni strati ve		10, 07		10,07	102.00	70.74	4.0
	Physicians - Part A - Teaching)		(0.00		•
	Physician-Part B Non-physician-Part B		2, 668, 791		2, 668, 79	1 11, 680. 00 0 0. 00		
	Interns & residents (in an	21.00	(0.00		
	approved program)			_				
	Contracted interns and residents (in an approved programs)		C) C		0 0.00	0.00	7.0
	Home office personnel		C			0.00	0.00	8.0
	SNF	44.00	C	0 0		0.00		
	Excluded area salaries (see instructions)		20, 327, 144	12, 245	20, 339, 389	9 488, 566. 19	41.63	10.0
	OTHER WAGES & RELATED COSTS Contract Labor: Direct Patient		(0 0.00	0.00	11. (
	Care		C			0.00	0.00	11.0
1	Contract labor: Top level management and other management and administrative		C	D C		0 0.00	0.00	12. (
1	services Contract Labor: Physician-Part		150, 000		150, 000	0 799.75	187. 56	13 (
	A - Administrative		100,000					
	Home office salaries &		C	0		0 0.00	0.00	14. (
	wage-related costs Home office: Physician Part A		C			0.00	0.00	15. (
	- Administrative							
	Home office and Contract Physicians Part A - Teaching		(0		0 0.00	0.00	16. (
	WAGE-RELATED COSTS		0.005.4/1		0.005.44	1		17
	Wage-related costs (core) (see instructions)		8, 285, 461	C	8, 285, 46	1		17. (
00	Wage-related costs (other)		C) c		0		18. (
	(see instructions)		0 411 07		2 411 07	-		10
	Excluded areas Non-physician anesthetist Part		3, 411, 977			0		19. (20. (
	Α			_				
00	Non-physician anesthetist Part		134, 818	B 0	134, 818	8		21. (
00	Þ Physician Part A -		1, 298	c c	1, 298	8		22. (
	Administrative							
	Physician Part A - Teaching		215, 789		215, 789	9		22. (23. (
	Physician Part B Wage-related costs (RHC/FQHC)		(0		23.0
	Interns & residents (in an		(0		25.
	approved program)	<u> </u>						
	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	4.00	29, 939		29, 93	9 2, 048. 37	14.62	26 (
	Administrative & General	5.00	6, 240, 720					
	Administrative & General under contract (see inst.)		721, 832	2 0	721, 832	2 4, 155. 22	173. 72	
	Maintenance & Repairs	6.00)	0		0 0.00		
	Operation of Plant Laundry & Linen Service	7.00 8.00	622, 137 39, 545		622, 13 39, 54			
	Housekeepi ng	9.00	623, 021		623, 02			
	Housekeeping under contract		217, 494		217, 494	4 13, 266. 43	16. 39	33. (
	(see instructions) Dietary	10.00	650 201	_ 261 104	290, 89	5 21 202 40	13.60	21
	Dietary Dietary under contract (see	10.00	652, 301 (-361,406	290,89	5 21, 393. 68 0 0. 00		
	instructions)				Ì			
	Cafeteria	11.00	(361, 406	361, 400			
	Maintenance of Personnel Nursing Administration	12.00 13.00) 265, 958		265, 958	0 0.00 8 7,436.30		
	Central Services and Supply	13.00	265, 958 86, 048		86, 048			
	Pharmacy	15.00	820, 619					

Health Financial Systems		KING'S DAUGHTE	RS' HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der		Period:	Worksheet S-3	
					From 01/01/2015		
					Го 12/31/2015	Date/Time Pre 5/18/2016 2:2	
	Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
			(from	(col.2 ± col.	Salaries in	col. 5)	
			Worksheet A-6)	3)	col. 4		
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00 Medical Records & Medical Records Library	16.00	604, 017	0	604, 01	7 29, 891. 89	20. 21	41.00
42.00 Social Service	17.00	204, 990	0	204, 990	7, 011. 60	29. 24	42.00
43.00 Other General Service	18.00	0	0	(0.00	0.00	43.00

Heal th	Financial Systems		KING'S DAUGHTE	RS' HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provi der		Period: From 01/01/2015	Worksheet S-3 Part III	
						To 12/31/2015		oared:
							5/18/2016 2:2	9 pm
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		48, 356, 341	391	48, 356, 73	2 1, 677, 705. 51	28.82	1.00
	instructions)							
2.00	Excluded area salaries (see		20, 327, 144	12, 245	20, 339, 38	9 488, 566. 19	41.63	2.00
	instructions)							
3.00	Subtotal salaries (line 1		28, 029, 197	-11, 854	28, 017, 34	3 1, 189, 139. 32	23. 56	3.00
	minus line 2)							
4.00	Subtotal other wages & related		150, 000	0	150, 00	0 799.75	187. 56	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		8, 286, 759	0	8, 286, 75	9 0.00	29. 58	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		36, 465, 956	-11, 854	36, 454, 10	2 1, 189, 939. 07	30.64	6.00
7.00	Total overhead cost (see		11, 128, 621	0	11, 128, 62	1 501, 570. 83	22. 19	7.00
	instructions)							

Heal th	Financial Systems	KING'S DAUGHTERS'	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI	TAL WAGE RELATED COSTS		Provider CC	CN: 150069	Period: From 01/01/2015 To 12/31/2015		pared: 9 pm
						Amount Reported	
						1.00	
	PART IV - WAGE RELATED COSTS						
	Part A - Core List						
	RETIREMENT COST						
1.00	401K Employer Contributions					0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contri					0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see					1, 702, 855	3.00
4.00	Qualified Defined Benefit Plan Cost (see in					0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External	Organi zati on)					
5.00	401K/TSA Plan Administration fees					0	5.00
6.00	Legal /Accounting/Management Fees-Pension PI					0	6.00
7.00	Employee Managed Care Program Administratio	n Fees				0	7.00
	HEALTH AND INSURANCE COST						
8.00	Health Insurance (Purchased or Self Funded)					6, 762, 157	8.00
9.00	Prescription Drug Plan					0	9.00
10.00	Dental, Hearing and Vision Plan					0	10.00
11.00	Life Insurance (If employee is owner or ben					78, 777	
12.00	Accident Insurance (If employee is owner or					0	12.00
13.00	Disability Insurance (If employee is owner					138, 602	13.00
14.00	Long-Term Care Insurance (If employee is ow	ner or beneficiary)				0	14.00
15.00	'Workers' Compensation Insurance					219, 596	
16.00	Retirement Health Care Cost (Only current y	ear, not the extrao	rdi nary accru	al require	d by FASB 106.	0	16.00
	Non cumulative portion) TAXES						
17.00	FICA-Employers Portion Only					3, 121, 571	17 00
17.00	Medicare Taxes - Employers Portion Only					3, 121, 571	
19.00	Unemployment Insurance					25, 786	
20.00	State or Federal Unemployment Taxes					25,780	20.00
20.00	OTHER					0	20.00
21.00	Executive Deferred Compensation (Other Than	Retirement Cost Re	ported on lin	es 1 throu	gh 4 above. (see	0	21.00
22.02	instructions))						22.00
22.00	Day Care Cost and Allowances					0	22.00
23.00	Tuition Reimbursement	\ \				0	23.00
24.00	Total Wage Related cost (Sum of Lines 1 -23)				12, 049, 344	24.00
25.00	Part B - Other than Core Related Cost						25.00
25.00	OTHER WAGE RELATED COSTS (SPECIFY)					0	25.00

Heal th	Financial Systems	KING'S DAUGHTERS'	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provi der	CCN: 150069	Peri od:	Worksheet S-3	
					From 01/01/2015		
					To 12/31/2015	Date/Time Pre 5/18/2016 2:2	
	Cost Center Description				Contract Labor		7 pm
					1.00	2.00	
	PART V - Contract Labor and Benefit Cost						
	Hospital and Hospital-Based Component Identi	fication:					
1.00	Total facility's contract labor and benefit	cost			0	0	1.00
2.00	Hospi tal				0	0	2.00
3.00	Subprovider - IPF						3.00
4.00	Subprovider - IRF						4.00
5.00	Subprovider - (Other)				0	0	5.00
6.00	Swing Beds - SNF				0	0	6.00
7.00	Swing Beds - NF				0	0	7.00
8.00	Hospital-Based SNF						8.00
9.00	Hospital-Based NF						9.00
10.00	Hospital-Based OLTC						10.00
11.00	Hospital-Based HHA				0	0	11.00
12.00	Separately Certified ASC						12.00
13.00	Hospital-Based Hospice				0	0	13.00
14.00	Hospital-Based Health Clinic RHC						14.00
15.00	Hospital-Based Health Clinic FQHC						15.00
16.00	Hospital-Based-CMHC						16.00
17.00	Renal Dialysis					1	17.00
18.00	Other				0	0	18.00

Heal th	Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
HOME H	IEALTH AGENCY STATI STI CAL DATA			CCN: 150069	Period: From 01/01/2015		
			Component	t CCN: 157141	To 12/31/2015	5/18/2016 2:2	
					Home Health Agency I	PPS	
					1	00	
0.00	County						0.00
		Title V 1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	Total 5.00	
1.00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	0	C		0 0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00		0.	0.00	0.00	
				Number of Em	ployees (Full Ti	me Equivalent)	
		Enter the numb		Staff	Contract	Total	
		your normal	work week				
		()	1.00	2.00	3.00	
3.00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)		0.00	0.	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.	0.00	0.00	4.00
5.00 6.00	Other Administrative Personnel Direct Nursing Service			0. 0.			
7.00 8.00	Nursi ng Supervi sor Physi cal Therapy Servi ce			0. 0.			
9.00	Physical Therapy Supervisor			0.			
10. 00 11. 00	Occupational Therapy Service Occupational Therapy Supervisor			0. 0.			1
12.00	Speech Pathology Service			0.	0.00	0.00	12.00
13.00 14.00	Speech Pathology Supervisor Medical Social Service			0. 0.			
15.00	Medical Social Service Supervisor			0.	0.00	0.00	15.00
16.00 17.00	Home Health Aide Home Health Aide Supervisor			0. 0.			
18.00	Other (specify)			0.			
19.00	HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where				2		19.00
	you provided services during the cost reporting period.						
20. 00	List those CBSA code(s) in column 1 serviced			50031			20.00
	during this cost reporting period (line 20 contains the first code).						
20. 01			· .	50034			20. 01
		Full Ep Without	With Outliers	LUPA Epi sode	es PEP Only	Total (cols.	
		Outliers 1.00	2.00	3.00	Epi sodes 4. 00	1-4) 5.00	
	PPS ACTIVITY DATA			1		1	04.5-
21.00 22.00	Skilled Nursing Visits Skilled Nursing Visit Charges	2, 337 521, 151			61 52 03 11, 596		1
23.00	Physical Therapy Visits	2, 088	59		22 79	2, 248	23.00
24.00 25.00	Physical Therapy Visit Charges Occupational Therapy Visits	417, 600 416		4,4	00 15, 800 4 20		1
26. 00 27. 00	Occupational Therapy Visit Charges Speech Pathology Visits	91, 936	1, 326	8	84 4, 420 0 1	98, 566 8	1
28.00	Speech Pathology Visit Charges	1, 596	C		0 228		
29.00 30.00	Medical Social Service Visits Medical Social Service Visit Charges	1 302			0 0	1 302	29.00 30.00
31.00	Home Health Aide Visits	1, 108	185		3 15	1, 311	31.00
32.00 33.00	Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27,	145, 148 5, 957			93 1, 965 90 167		1
	29, and 31)						
34.00 35.00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	0 1, 177, 733	-		0 0 80 34,009	0 1, 327, 255	
36.00	30, 32, and 34) Total Number of Episodes (standard/non	314			31 12		
	outlier)	514			12		
37. 00 38. 00	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	101, 248	11 22, 104	1	0 41 1, 031	11 128, 324	

Heal th	Financial Systems		KING'S DAUGHTE	RS' HOSPI TAL		In Lie	u of Form CMS-2	2552-10
H0SPI 1	AL IDENTIFICATION DATA			Provi der	CCN: 150069	Peri od:	Worksheet S-9	
					001 454505	From 01/01/2015	Parts &	
				Component	CCN: 151535	To 12/31/2015	Date/Time Prep 5/18/2016 2:29	
						Hospi ce I	5/10/2010 2.2	² piii
		Unduplicated						
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		cols. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility				
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0		0 0	0	1.00
2.00	Routine Home Care	1, 691	6	0		0 204	1, 901	2.00
3.00	Inpatient Respite Care	2	0	0		0 0	2	3.00
4.00	General Inpatient Care	15	0	0		0 0	15	4.00
5.00	Total Hospice Days	1, 708	6	0		0 204	1, 918	5.00
	Part II - CENSUS DATA							
6.00	Number of Patients Receiving	0	0	0		0 0	0	6.00
	Hospi ce Care							
7.00	Total Number of Unduplicated	0.00		0.00				7.00
	Continuous Care Hours Billable							
	to Medicare							
8.00	Average Length of Stay (line	0. 00	0.00	0.00	0.0	0.00	0. 00	8.00
	5/line 6)							
9.00	Unduplicated Census Count	61	0	0		0 7	68	9.00

Heal th	Financial Systems KING'S DAUGHTERS' H	OSPI TAL		In Lie	eu of Form CMS-2	2552-10	
			CCN: 150069	Peri od:	Worksheet S-1		
				From 01/01/2015			
				To 12/31/2015			
					<u>5/18/2016 2:2</u>	9 piii	
					1,00		
	Uncompensated and indigent care cost computation						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ded by li	ne 202 column	8)	0. 255891	1.00	
	Medicaid (see instructions for each line)	-		· · ·			
2.00	Net revenue from Medicaid				11, 271, 392	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?					3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental	payments	from Medicaid	?		4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from	Medicaid			0	5.00	
6.00	6.00 Medicaid charges						
7.00	Medicaid cost (line 1 times line 6)				10, 321, 435	7.00	
8.00	Difference between net revenue and costs for Medicaid program (I	ine 7 min	us sum of lin	es 2 and 5; if	0	8.00	
	< zero then enter zero)	-					
	State Children's Health Insurance Program (SCHIP) (see instruction	ons for e	ach line)		-		
9.00	Net revenue from stand-al one SCHIP				0	9.00	
10.00	Stand-al one SCHIP charges				0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)				0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 m	inus line 9;	if < zero then	0	12.00	
	enter zero) Other state or local government indigent care program (see instr	uctions f	or each line)				
13.00	Net revenue from state or local indigent care program (Net inclu)	0	13.00	
14.00	Charges for patients covered under state or local indigent care				0		
14.00	10)	program (Not Theradea		, v	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)				0	15.00	
16.00	Difference between net revenue and costs for state or local indi	aent care	program (lin	e 15 minus line	0	16.00	
	13; if < zero then enter zero)	5					
	Uncompensated care (see instructions for each line)				·	1	
17.00	Private grants, donations, or endowment income restricted to fun	ding char	ity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of ho	spital op	erations		0	18.00	
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local	i ndi gent	care program	s (sum of lines	0	19.00	
	8, 12 and 16)						
			Uni nsured	Insured	Total (col. 1		
			patients	patients	+ col . 2)		
20.00	Total initial obligation of patients approved for charity care (at full	1.00 1,331,00	2.00 3 385,711	<u>3.00</u> 1,716,714	20.00	
20.00	charges excluding non-reimbursable cost centers) for the entire		1, 331, 00	3 300,711	1, /10, /14	20.00	
21.00	Cost of initial obligation of patients approved for charity care		340, 59	2 98, 700	439, 292	21.00	
21.00	times line 20)	(THE T	540, 57	2 70,700	437, 272	21.00	
22.00				0 0	0	22.00	
23.00			340, 59	2 98, 700	439, 292		
					1.00		
24.00	Does the amount in line 20 column 2 include charges for patient	days beyo	nd a length o	f stay limit	N	24.00	
	imposed on patients covered by Medicaid or other indigent care p		-	-			
25.00				n of stay limit		25.00	
26.00	Total bad debt expense for the entire hospital complex (see inst				19, 882, 165		
27.00	Medicare bad debts for the entire hospital complex (see instruct				377, 820		
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (lin				19, 504, 345		
29.00							
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				5, 430, 278		
31.00	Total unreimbursed and uncompensated care cost (line 19 plus lin	e 30)			5, 430, 278	31.00	

	<u>Financial Systems</u> SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	KING'S DAUGHTERS			eri od:	u of Form CMS-2 Worksheet A	2552-10
					rom 01/01/2015 o 12/31/2015	Date/Time Pre 5/18/2016 2:2	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
	1	1.00	2.00	3.00	4.00	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT		18, 346, 127	18, 346, 127	204, 191	18, 550, 318	1.00
1.01	00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO		0	10, 010, 12,	23, 993	23, 993	1.01
2.00 3.00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAPITAL RELATED COSTS		0		0	0	
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	29, 939	13, 381, 191	13, 411, 130	-134, 818	13, 276, 312	4.00
5.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	6, 240, 720	12, 164, 260			18, 078, 890	
7.00 8.00	00800 LAUNDRY & LINEN SERVICE	622, 137 39, 545	2, 281, 216 271, 686			2, 903, 353 311, 231	
9.00	00900 HOUSEKEEPING	623, 021	505, 867	1, 128, 888		1, 128, 888	
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	652, 301	472, 940 0	1, 125, 241	-623, 438 623, 438	501, 803 623, 438	
13.00	01300 NURSING ADMINISTRATION	265, 958	741	266, 699	0	266, 699	1
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	86, 048 820, 619	565, 294 4, 209, 821	651, 342 5, 030, 440		651, 342 5, 030, 440	
16.00	01600 MEDICAL RECORDS & LIBRARY	604, 017	4, 209, 821 280, 580	884, 597		5, 030, 440 884, 597	1
17.00	01700 SOCIAL SERVICE	204, 990	2, 241	207, 231	0	207, 231	
19.00 23.00	01900 NONPHYSI CI AN ANESTHETI STS 02300 RADI OLOGY SCHOOL	0 96, 948	0 1, 439	0 98, 387	664, 385	664, 385 98, 387	
23.00	02301 HUB SITE - 3RD YEAR MED STUDENTS	14, 144	1, 439	14, 144		14, 144	
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS	E 021 001	198, 156	E 000 107	704 440	4 525 (07	20.00
30.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	5, 031, 981 906, 327	6, 143	5, 230, 137 912, 470		4, 525, 697 912, 470	
43.00	04300 NURSERY	0	0			330, 836	
50.00	ANCI LLARY SERVI CE COST CENTERS	1, 699, 698	538, 022	2, 237, 720	0	2, 237, 720	50.00
51.00	05100 RECOVERY ROOM	242, 930	2, 366	245, 296		245, 296	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		373, 604	373, 604	
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	1, 404, 617 3, 074, 939	664, 464 1, 063, 237	2, 069, 081 4, 138, 176		1, 539, 514 4, 126, 322	1
54.01	03630 ULTRA SOUND	106, 518	51, 727	158, 245		158, 245	
54.02 55.00	03450 NUCLEAR MEDICINE - DIAGNOSTIC 03480 ONCOLOGY	61, 077 920, 747	178, 580			239, 657 1, 875, 514	1
55.00 57.00	05700 CT SCAN	210, 612	954, 767 244, 304	1, 875, 514 454, 916		454, 916	1
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	134, 976	134, 951	269, 927	0	269, 927	58.00
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	195, 586 1, 571, 518	2, 927 2, 919, 842	198, 513 4, 491, 360		198, 513 4, 491, 360	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 371, 518	308, 620			308, 620	1
65.00	06500 RESPIRATORY THERAPY	612, 570	60, 351	672, 921		672, 921	
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	1, 695, 939 0	41, 628 0	1, 737, 567 C		1, 736, 186 0	1
68.00		0	0		0	0	
69.00	06900 ELECTROCARDI OLOGY	0	0	100 734	0	0	1
69. 01 71. 00	03610 SLEEP LAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	126, 499 0	73, 235 3, 389, 354	199, 734 3, 389, 354		199, 734 3, 389, 354	
71.01	07101 IV SOLUTIONS	0	98, 531	98, 531	0	98, 531	71.01
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	2, 973, 731	2, 973, 731		2, 973, 731 0	1
76.00	03140 CARDI OLOGY	426, 436	83, 017	509, 453	U U	509, 453	
76.97		70, 621	8, 991	79, 612	0	79, 612	76.97
90.00	OUTPATI ENT SERVICE COST CENTERS	130, 039	2, 343	132, 382	0	132, 382	90.00
91.00	09100 EMERGENCY	1, 475, 304	208, 382			1, 683, 686	91.00
92.00	09200 OBSERVATI ON BEDS (NON-DI STINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500 AMBULANCE SERVICES	1, 320, 199	167, 271	1, 487, 470	0	1, 487, 470	95.00
101.00	DIO100 HOME HEALTH AGENCY	903, 658	88, 313	991, 971	391	992, 362	101.00
113.00	SPECIAL PURPOSE COST CENTERS		0	C	0	0	113.00
116.00	11600 HOSPI CE	132, 011	110, 599			242, 219	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	32, 755, 189	67, 057, 255	99, 812, 444	-111, 141	99, 701, 303	118.00
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	C	160, 368	160, 368	
	07950 OTHER NON-REI MBURSABLE	0	0		0		194.00
	07951 MOB 207952 PHYSICIAN CLINICS	1, 365, 217 5, 134, 436	174, 028 1, 345, 733	1, 539, 245 6, 480, 169		1, 538, 376 6, 431, 811	
194.03	07953 PHYS PRAC BUS OFC	598, 646	22, 384	621, 030	0	621, 030	194.03
	07954 MOB - MALIN CAMPUS	202, 458	25, 773	228, 231	0	228, 231	194.04 194.05
	07955 ONCOLOGY - NONREIMBURSABLE 07956 KDH - MC FAMILY PRACTICE	4, 123, 916	0 269, 602	4, 393, 518	0	0 4, 393, 518	
194.07	07957 KDH - MC ORTHOPEDICS	2, 995, 003	437, 832	3, 432, 835	0	3, 432, 835	194.07
	3 07958 KDH – MC GENERAL SURGERY	1, 171, 005	34, 087	1, 205, 092	0	1, 205, 092	194.08

Health Financial Systems	KING'S DAUGHTER	S' HOSPI TAL		In Lie	u of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der		eriod:	Worksheet A	
			F	rom 01/01/2015 o 12/31/2015	Date/Time Pre 5/18/2016 2:2	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
194.0907959 KDH - MC ENT	517, 180	10, 608	527, 788	0	527, 788	194.09
194.1007960 KDH - MC UROLOGY	61, 248	609, 408	670, 656	0	670, 656	194.10
194.1107961KDH - MC OB/GYN	1, 691, 075	361, 361	2, 052, 436	0	2, 052, 436	194. 11
200.00 TOTAL (SUM OF LINES 118-199)	50, 615, 373	70, 348, 071	120, 963, 444	0	120, 963, 444	200. 00

	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der	CCN. 1500		Worksheet	A
					From 01/01/2 To 12/31/2	015 Date/Time	
	Cost Center Description	Adjustments	Net Expenses			5/18/2016	2:29 pr
	·	(See A-8)	For Allocation	1			
	GENERAL SERVICE COST CENTERS	6.00	7.00				
00	00100 NEW CAP REL COSTS-BLDG & FIXT	-2, 209, 835	16, 340, 48	3			1
01	00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO	C		1			1
00	00200 NEW CAP REL COSTS-MVBLE EQUIP	0		b			2
00	00300 OTHER CAPITAL RELATED COSTS	C		D			3
00	00400 EMPLOYEE BENEFITS DEPARTMENT	-2, 512, 812					4
00	00500 ADMINISTRATIVE & GENERAL	-2, 338, 207					5
00	00700 OPERATION OF PLANT	-19, 012					7
00	00800 LAUNDRY & LINEN SERVICE	0					8
00 00	00900 HOUSEKEEPI NG 01000 DI ETARY			1			9
	01100 CAFETERI A	-332,066		1			10
	01300 NURSI NG ADMI NI STRATI ON	-117, 540		1			13
	01400 CENTRAL SERVICES & SUPPLY	0		1			14
	01500 PHARMACY	-22, 434		1			15
00	01600 MEDICAL RECORDS & LIBRARY	-2, 340	882, 25	7			16
	01700 SOCIAL SERVICE	C	207, 23	1			17
	01900 NONPHYSICIAN ANESTHETISTS	-664, 385					19
	02300 RADI OLOGY SCHOOL	C		1			23
01	02301 HUB SITE - 3RD YEAR MED STUDENTS	0	14, 14	4			23
~~	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	124.005	4 401 (0)				
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	-124, 095					30
	04300 NURSERY			1			43
00	ANCI LLARY SERVICE COST CENTERS		<u> </u>	у			
00	05000 OPERATI NG ROOM	-289, 146	1, 948, 57	1			50
	05100 RECOVERY ROOM	0		1			51
	05200 DELIVERY ROOM & LABOR ROOM	0		1			52
00	05300 ANESTHESI OLOGY	-1, 512, 253	3 27, 26	1			53
00	05400 RADI OLOGY-DI AGNOSTI C	-1, 729, 126	2, 397, 19	5			54
	03630 ULTRA SOUND	C					54
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	C					54
	03480 ONCOLOGY	-789, 200					55
	05700 CT SCAN	0					57
	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION			1			58 59
	06000 LABORATORY	-52, 346					60
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	-52, 540		1			62
	06500 RESPIRATORY THERAPY						65
	06600 PHYSI CAL THERAPY	-845		•			66
00	06700 OCCUPATI ONAL THERAPY	0		b			67
00	06800 SPEECH PATHOLOGY	0		b			68
	06900 ELECTROCARDI OLOGY	C		D			69
	03610 SLEEP LAB	-450					69
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C					71
	07101 I V SOLUTI ONS	C					71
	07200 IMPL. DEV. CHARGED TO PATIENTS	0					72
	07300 DRUGS CHARGED TO PATIENTS 03140 CARDI OLOGY	-640					73
	07697 CARDI OLOGY	-640					76
<i>,</i> ,	OUTPATIENT SERVICE COST CENTERS	, C	1 77,01.	-1			
00	09000 CLINIC	0	132, 38	2			90
	09100 EMERGENCY	-176, 204					91
00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	-65					95
1.00	10100 HOME HEALTH AGENCY	0	992, 36	2			101
, <u> </u>	SPECIAL PURPOSE COST CENTERS	-					
	11300 I NTEREST EXPENSE 11600 HOSPI CE						113
3.00 3.00		-12, 893, 001					118
	NONREI MBURSABLE COST CENTERS	12,075,001	30, 000, 30.	-1			
), 00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	160, 36	3			190
	07950 OTHER NON-REI MBURSABLE			1			194
	07951 MOB	0					194
	07952 PHYSICIAN CLINICS	0	6, 431, 81	1			194
1.03	07953 PHYS PRAC BUS OFC	0	621, 03	1			194
	07954 MOB - MAIN CAMPUS	0	228, 23	1			194
1. 05	07955 ONCOLOGY - NONREI MBURSABLE	0		D			194
	07956 KDH - MC FAMILY PRACTICE	0	4, 393, 51				194
			3, 432, 83	51			194
1.07	07957 KDH - MC ORTHOPEDICS	L C					
1. 07 1. 08	07957 KDH - MC ORTHOPEDICS 07958 KDH - MC GENERAL SURGERY 07959 KDH - MC ENT		1, 205, 09	2			194 194

Health Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Lieu	u of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der (CCN: 150069	Period: From 01/01/2015	Worksheet A	
					Date/Time Pre 5/18/2016 2:2	
Cost Center Description	Adjustments	Net Expenses				
	(See A-8)	For Allocation				
	6.00	7.00				
194.11 07961 KDH - MC OB/GYN	0	2, 052, 436				194.11
200.00 TOTAL (SUM OF LINES 118-199)	-12, 893, 001	108, 070, 443				200. 00

CLASS	SI FI CATI ONS			Provi der	CCN: 150069	Period: From 01/01/2015 To 12/31/2015	Worksheet A-6 Date/Time Prepa 5/18/2016 2:29
		Increases					
	Cost Center	Line #	Salary	Other			
	2.00	3.00	4.00	5.00			
	A - CAFETERIA						
00	CAFETERI A	11.00	361, 406	262, 032			
	0		361, 406	262, 032			
	D - RADIOLOGY DIRECTOR		· · ·				
00	PHYSICIAN CLINICS	194.02	11, 854	0			
	0	T	11,854	0			
i	E - DEPRECIATION						
00	NEW CAP REL COSTS-BLDG &	1.01	0	23, 993			
	FIXT HHA/HO						
	0	T		23, 993			
	F - NURSERY- L&D						
00	NURSERY	43.00	326, 031	4, 805			
00	DELIVERY ROOM & LABOR ROOM	52.00	368, 178	5, 426			
	0		694, 209	10, 231			
	H - GIFT SHOP		· · ·				
00	GIFT, FLOWER, COFFEE SHOP, &	190.00	0	160, 368			
	CANTEEN						
	0	T		160, 368			
ĺ	K – CRNA EXPENSE		· · ·				
00	NONPHYSI CI AN ANESTHETI STS	19.00	529, 567	134, 818			
00		0.00	0	0			
	0		529, 567	134, 818			
1	L - TELEPHONE EXPENSE						
00	ADMI NI STRATI VE & GENERAL	5.00	0	62, 462			
00		0.00	0	0			
00		0.00	0	0			
	0	+		62, 462			
	N – INSURANCE	I					
	NEW CAP REL COSTS-BLDG &	1.00	0	228, 184			
	FIXT		1	-,			
		†		228, 184			
	0 - HHA MSW SALARIES			-,			
	HOME HEALTH AGENCY	101.00	391	0			
	TOTALS	+	391				
	Grand Total: Increases		1, 597, 427	882, 088			50

	Financial Systems		KING'S DAUGHTERS'				u of Form CMS-2552
RECLASS	SI FI CATI ONS			Provi der	CCN: 150069	Period: From 01/01/2015 To 12/31/2015	Worksheet A-6 Date/Time Prepare 5/18/2016 2:29 pm
		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	·	
	6.00	7.00	8.00	9.00	10.00		
	A – CAFETERIA						
1.00	DI ETARY	10.00	361, 406	262, 032		0	1.
	0		361, 406	262, 032		7	
	D - RADI OLOGY DI RECTOR					·	
1.00	RADI OLOGY-DI AGNOSTI C	54.00	11, 854	0		0	1.
	0		11, 854	0		1	
	E - DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	23, 993		9	1.
	FIXT						
	0		<u>_</u>	23, 993		1	
	F - NURSERY- L&D						
1.00	ADULTS & PEDIATRICS	30.00	694, 209	10, 231		0	1.
2.00		0.00	0	0		0	2.
			694, 209	10, 231		1	
	H - GIFT SHOP	I	· · ·				
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	160, 368		0	1.
			<u>_</u>	160, 368		1	
	K – CRNA EXPENSE			· ·			
1.00	ANESTHESI OLOGY	53.00	529, 567	0		0	1.
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	134, 818		0	2.
		+	529, 567	134, 818		1	
	L - TELEPHONE EXPENSE	I			1	1	
1.00	PHYSICAL THERAPY	66,00	0	1, 381		0	1.
2.00	МОВ	194.01	0	869		0	2.
3.00	PHYSICIAN CLINICS	194.02	0	60, 212		0	3.
				62, 462		-	1 -
	N – I NSURANCE	I	-1	,			
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	228, 184	1	12	1.
				228, 184			
	0 - HHA MSW SALARIES	I	3	220, 104		1	
1.00	HOSPICE	116.00	0	391		0	1.
			- — — j			Ť	1.
	Grand Total: Decreases		1, 597, 036	882, 479			500.

Heal th	Financial Systems	KING'S DAUGHTER	RS' HOSPI TAL			In Lie	u of Form CMS-2	2552-10
	LLIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150069			Worksheet A-7 Part I	pared:
				Acqui si ti on	s			
		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 ASSET	BALANCES		_				
1.00	Land	4, 087, 536	8, 549		0	8, 549	0	1.00
2.00	Land Improvements	836, 574	5, 125		0	5, 125	0	2.00
3.00	Buildings and Fixtures	112, 651, 666	6, 463, 869		0	6, 463, 869	0	3.00
4.00	Building Improvements	0	0		0	0	0	4.00
5.00	Fixed Equipment	0	0		0	0	0	5.00
6.00	Movable Equipment	57, 482, 148	6, 025, 496		0	6, 025, 496	705, 644	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	175, 057, 924	12, 503, 039		0	12, 503, 039	705, 644	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	175, 057, 924	12, 503, 039		0	12, 503, 039	705, 644	10.00
		Endi ng Bal ance	Fully					
		U U	Depreciated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES						
1.00	Land	4, 096, 085	0					1.00
2.00	Land Improvements	841, 699	0					2.00
3.00	Buildings and Fixtures	119, 115, 535	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	62, 802, 000	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	186, 855, 319	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	186, 855, 319	0					10.00

Heal th	Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS	,	Provi der	CCN: 150069	Period: From 01/01/2015 To 12/31/2015		pared:
			SL	JMMARY OF CAP	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK			nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	12, 554, 036	258, 152	5, 499, 04	19 0	34, 890	1.00
1.01	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	0		0 0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	12, 554, 036	258, 152	5, 499, 04	19 0	34, 890	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM					
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	18, 346, 127				1.00
1.01	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	0				1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	18, 346, 127				3.00

Health Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS			F	eriod: rom 01/01/2015 o 12/31/2015	Date/Time Prep 5/18/2016 2:29	
	COME	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00 NEW CAP REL COSTS-BLDG & FIXT	113, 309, 070	0	113, 309, 070			1.00
1.01 NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	0	C	0. 000000		1.01
2.00 NEW CAP REL COSTS-MVBLE EQUIP	58, 005, 273		58, 005, 273			2.00
3.00 Total (sum of lines 1-2)	171, 314, 343		171, 314, 343			3.00
	ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	Other Capi tal -Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	INTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0	C	12, 531, 208	188, 552	1.00
1.01 NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	0	C	23, 993	0	1.01
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0	C	0	0	2.00
3.00 Total (sum of lines 1-2)	0	0	C	12, 555, 201	188, 552	3.00
		Sl	JMMARY OF CAPIT			
Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	INTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT	3, 357, 649	228, 184	34, 890	0	16, 340, 483	1.00
1.01 NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	0	0	0	23, 993	1.01
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0	C	0	0	2.00
3.00 Total (sum of lines 1-2)	3, 357, 649	228, 184	34, 890	0	16, 364, 476	3.00

	Financial Systems MENTS TO EXPENSES		KING'S DAUGHTE		SPLIAL rovider CCN: 150069	Period:	u of Form CMS-2 Worksheet A-8	
.20001						From 01/01/2015 To 12/31/2015		pared:
					ense Classification o m Which the Amount i			<u>9 pm</u>
	Cost Center Description	1.00	Amount 2.00		Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
. 00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter	В	-37, 150	DNEW CAF	P REL COSTS-BLDG &	1.00	11	1.0
. 01	2) Investment income - NEW CAP REL COSTS-BLDG & FIXT HHA/HO (chapter 2)			NEW CAP	P REL COSTS-BLDG & HA/HO	1.01	0	1.0
. 00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	DNEW CAP	P REL COSTS-MVBLE	2.00	0	2.0
8. 00	Investment income - other (chapter 2)		0	b		0.00	0	3. 0
1.00	Trade, quantity, and time discounts (chapter 8)		0	D		0.00	0	4.0
5.00	Refunds and rebates of expenses (chapter 8)	А	-66, 988	BADMI NI S	STRATIVE & GENERAL	5.00	0	5.0
5.00	Rental of provider space by suppliers (chapter 8)	А	-69, 600	NEW CAF	P REL COSTS-BLDG &	1.00	10	6.0
7.00	Tel ephone services (pay stations excluded) (chapter 21)	A	-2, 628		ON OF PLANT	7.00	0	7.0
8. 00	Television and radio service (chapter 21)	А	-16, 384	4 OPERATI	ON OF PLANT	7.00	0	8. C
0.00 0.00	Parking lot (chapter 21) Provider-based physician adjustment	A-8-2	0 -4, 637, 820			0.00	0	
1. 00	Sale of scrap, waste, etc. (chapter 23)	В	-36,550	RADI OLO	DGY-DI AGNOSTI C	54.00	0	11. (
2.00	Related organization transactions (chapter 10)	A-8-1	0	C			0	12.0
3.00 4.00 5.00	Laundry and linen service Cafeteria-employees and guests Rental of quarters to employee and others		0 -332, 066 0	D CAFETEF D	RI A	0.00 11.00 0.00	0	14. (
6. 00	Sale of medical and surgical supplies to other than patients		0	D		0.00	0	16. (
7.00	Sale of drugs to other than patients		0	C		0.00	0	17. (
8. 00	Sale of medical records and abstracts	В	-2, 340	DMEDI CAL	_ RECORDS & LI BRARY	16.00	0	18.
9. 00	Nursing school (tuition, fees, books, etc.)		C	D		0.00	0	19.0
0. 00 1. 00	Vending machines Income from imposition of interest, finance or penalty		0 0			0.00		
2.00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		C	D		0.00	Ο	22. (
3. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	DRESPI RA	ATORY THERAPY	65.00		23. (
4. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	O	OPHYSI CA	AL THERAPY	66.00		24. (
5.00	limitation (chapter 14) Utilization review - physicians' compensation		0	D*** Cos	st Center Deleted **	* 114.00		25. (
6. 00	(chapter 21) Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP	P REL COSTS-BLDG &	1.00	0	26. (
6. 01	Depreciation - NEW CAP REL COSTS-BLDG & FIXT HHA/HO		C		P REL COSTS-BLDG &	1.01	0	26. (
7.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0		P REL COSTS-MVBLE	2.00	0	27.0
8. 00 9. 00	Non-physician Anesthetist	А	-664, 385		SICIAN ANESTHETISTS	19.00 0.00		28. (29. (
9.00 0.00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0		TI ONAL THERAPY	67.00		29. (30. (
80. 99	limitation (chapter 14) Hospice (non-distinct) (see instructions)		C	DADULTS	& PEDIATRICS	30.00		30. 9

ADJUST	MENTS TO EXPENSES				Period:	Worksheet A-8	
					From 01/01/2015 To 12/31/2015		nared
					10 12/01/2010	5/18/2016 2:2	
				Expense Classification o			
				To/From Which the Amount is	to be Adjusted		
	Cast Captor Decarintian	Deci o (Codo (2)	Amount	Cost Costor	line #	What A 7 Def	
	Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
21 00	Adjustment for speech	A-8-3		SPEECH PATHOLOGY	4.00		31.00
31.00	pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
	limitation (chapter 14)						
32.00			0		0.00	0	32.00
52.00	Depreciation and Interest		0		0.00	0	32.00
33.00	PATIENT PHONES - SALARY	А	-8 769	ADMI NI STRATI VE & GENERAL	5.00	0	33.00
34.00	Internet indices sherici		0,707		0.00		
35.00	PHARMACY - SELF INSURANCE	В	-22 434	PHARMACY	15.00		
36.00	DONATIONS EXPENSE	Ā		ADMINISTRATIVE & GENERAL	5.00		36.00
37.00	ADVERTI SI NG	A		ADMI NI STRATI VE & GENERAL	5.00		
38.00	HOSPITAL ASSOCIATION DUES	A		ADMI NI STRATI VE & GENERAL	5.00		38.00
39.00	SELF INSURANCE	A		EMPLOYEE BENEFITS DEPARTMEN			
40.00	PHYSICIAN RECRUITING	A		ADMI NI STRATI VE & GENERAL	5.00		
41.00	UNNECESSARY BORROWING	A		NEW CAP REL COSTS-BLDG &	1.00		
				FIXT			
42.00	CARRYFORWARD ADJ 1989 PARKING	A	1, 165	NEW CAP REL COSTS-BLDG &	1.00	9	42.00
	GARAGE			FLXT			
43.00	HAF MEDICAID TAX OFFSET	A	-1, 586, 599	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00			0		0.00	0	44.00
45.00	BAXTER PUMP REVENUE	В	-117, 540	NURSING ADMINISTRATION	13.00	0	45.00
50.00	TOTAL (sum of lines 1 thru 49)		-12, 893, 001				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

(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.

Heal th	Financial Syste	ems	KING'S DAUGHT	ERS' HOSPI TAL		In Lie	eu of Form CMS-	2552-10
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provi der	CCN: 150069	Period:	Worksheet A-8	3-2
			_			From 01/01/2015 To 12/31/2015	Date/Time Pre 5/18/2016 2:2	
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component		Physician/Prov ider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADULTS & PEDIATRICS	124, 095	124, 095	(206, 300	0	1.00
2.00		OPERATING ROOM	289, 146					2.00
3.00		ANESTHESI OLOGY	637, 203					3.00
4.00		ANESTHESI OLOGY	875, 050				0	4.00
5.00		RADI OLOGY-DI AGNOSTI C	183, 790			200,200		5.00
6.00		RADI OLOGY-DI AGNOSTI C	1, 508, 786				0	6.00
7.00		ONCOLOGY	352, 682			200,200	0	7.00
8.00		ONCOLOGY	276, 219				0	8.00
9.00		ONCOLOGY	160, 299				0	9.00
10.00		LABORATORY	150, 000				800	10.00
11.00		PHYSI CAL THERAPY	845			206, 300	0	11.00
12.00		SLEEP LAB	10, 071	0	10, 07		97	12.00
13.00		CARDI OLOGY	640				0	13.00
14.00		EMERGENCY AMBULANCE SERVICES	176, 204					14.00
15.00 200.00	95.00	AMBULANCE SERVICES	561 4, 745, 591	4, 584, 959	56 ⁻ 160, 632		5 902	15.00 200.00
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	200.00
	WKSU. A LINE #	I denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Education	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	(0 0	0	1.00
2.00		OPERATING ROOM	0			0 0	0	2.00
3.00		ANESTHESI OLOGY	0				0	3.00
4.00		ANESTHESI OLOGY	0	-		-	0	4.00
5.00		RADI OLOGY-DI AGNOSTI C	0	0	(° °	0	5.00
6.00		RADI OLOGY-DI AGNOSTI C	0	0		-	0	6.00
7.00		ONCOLOGY	0	0	(° °	0	7.00
8.00		ONCOLOGY	0	-			0	8.00
9.00		ONCOLOGY LABORATORY	07 454	0		-	0	9.00
10.00		PHYSICAL THERAPY	97, 654	4, 883	(-	0	10.00
11. 00 12. 00		SLEEP LAB	9, 621	481			0	11. 00 12. 00
12.00		CARDI OLOGY	9,021	401	(0	12.00
14.00		EMERGENCY		0			0	14.00
15.00		AMBULANCE SERVICES	496	-			0	15.00
200.00	/3.00	ANDOLANCE SERVICES	107, 771	5, 389		-	0	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
1.00	1.00		15.00	16.00	17.00	18.00		1 00
1.00		ADULTS & PEDIATRICS	0			124,095		1.00
2.00		OPERATING ROOM	0					2.00
3.00 4.00		ANESTHESI OLOGY ANESTHESI OLOGY	0					3.00
4.00 5.00		RADI OLOGY-DI AGNOSTI C	0					4.00 5.00
6.00		RADI OLOGY-DI AGNOSTI C	0					6.00
7.00		ONCOLOGY	0					7.00
8.00		ONCOLOGY	0					8.00
9.00		ONCOLOGY	0					9.00
10.00		LABORATORY	0	-				10.00
11.00		PHYSI CAL THERAPY	0		(845		11.00
12.00		SLEEP LAB	0		450			12.00
13.00		CARDI OLOGY	0		(13.00
14.00	91.00	EMERGENCY	0	0	(176, 204		14.00
15.00	95.00	AMBULANCE SERVICES	0			65		15.00
200.00			0	107, 771	52, 861	4, 637, 820		200.00

	Financial Systems ALLOCATION - GENERAL SERVICE COSTS	KING'S DAUGHTE		F	In Lie Period: From 01/01/2015 O 12/31/2015		pared:
			CAP	ITAL RELATED CO	OSTS	5/18/2016 2:2	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW BLDG & FIXT HHA/HO	NEW MVBLE EQUI P	EMPLOYEE BENEFI TS DEPARTMENT	
		0	1.00	1.01	2.00	4.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	16, 340, 483	16, 340, 483				1.00
1.01 2.00 4.00	00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	23, 993 0 10, 763, 500	0		0	10, 763, 500	1. 01 2. 00
5.00	00500 ADMI NI STRATI VE & GENERAL	15, 740, 683	1, 768, 329			1, 342, 241	
7.00	00700 OPERATION OF PLANT	2, 884, 341	2, 191, 585			133, 810	
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	311, 231	81, 561	1		8, 505	
9.00 10.00	01000 DI ETARY	1, 128, 888 501, 803	142, 967 269, 289			134, 000 62, 566	
11.00	01100 CAFETERI A	291, 372	108, 905			77, 732	
13.00	01300 NURSI NG ADMI NI STRATI ON	149, 159	95, 597			57, 203	
14.00	01400 CENTRAL SERVICES & SUPPLY	651, 342	132, 483			18, 507	
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	5, 008, 006 882, 257	98, 464 246, 481			176, 500 129, 913	
17.00	01700 SOCIAL SERVICE	207, 231	63, 246			44, 089	
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	C	0	0	1
23.00	02300 RADI OLOGY SCHOOL	98, 387	28, 285			20, 852	
23. 01	02301 HUB SITE - 3RD YEAR MED STUDENTS	14, 144	0	C	0 0	3, 042	23.01
30.00	03000 ADULTS & PEDIATRICS	4, 401, 602	1, 703, 243	C	0	932, 972	30.00
31.00	03100 I NTENSI VE CARE UNI T	912, 470	71, 633			194, 934	1
43.00	04300 NURSERY	330, 836	83, 658	C	0	70, 123	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	1, 948, 574	752, 366	C	ol	365, 573	50.00
50.00	05100 RECOVERY ROOM	245, 296	58, 839			52, 250	
52.00	05200 DELIVERY ROOM & LABOR ROOM	373, 604	0			79, 188	
53.00	05300 ANESTHESI OLOGY	27, 261	5, 563			188, 207	
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	2, 397, 196	463, 906			658, 811	
54.01	03450 NUCLEAR MEDICINE - DIAGNOSTIC	158, 245 239, 657	20, 668			22, 910 13, 137	
55.00	03480 ONCOLOGY	1,086,314	529, 335	1		198, 035	
57.00	05700 CT SCAN	454, 916	38, 299			45, 299	
58.00 59.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON	269, 927	46, 215 36, 544			29, 031	
60.00	06000 LABORATORY	198, 513 4, 439, 014	266, 978			42, 067 338, 004	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	308, 620	11, 939			0	1
65.00	06500 RESPI RATORY THERAPY	672, 921	51, 222			131, 752	
66.00 67.00		1, 735, 341	622, 321	C	0	364, 764	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0			0	67.00 68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	C	0	0	1
69.01	03610 SLEEP LAB	199, 284	35, 902	C	0	27, 208	
71. 00 71. 01	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07101 IV SOLUTIONS	3, 389, 354	0	0	0	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	98, 531 2, 973, 731	0			0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	1
76.00	03140 CARDI OLOGY	508, 813	258, 762		0	91, 718	
76.97	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	79, 612	30, 083	C	0 0	15, 189	76.97
90, 00	09000 CLINIC	132, 382	32, 522	C	ol ol	27, 969	90.00
91.00	09100 EMERGENCY	1, 507, 482	593, 908			317, 310	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
05 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	1, 487, 405	202, 491	l c		283, 950	95.00
	10100 HOME HEALTH AGENCY	992, 362	202,471	1		194, 444	
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE		_				113.00
116.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117)	242, 219 86, 808, 302	0 11, 143, 589	5, 112 23, 993		28, 309 6, 922, 114	116.00
110.00	NONREIMBURSABLE COST CENTERS	80,808,302	11, 143, 309	23, 773	9 <u> </u>	0, 922, 114	
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	160, 368	58, 068	C	0		190. 00
	07950 OTHER NON-REI MBURSABLE	0	0	C	0		194.00
	O7951 MOB 207952 PHYSICIAN CLINICS	1, 538, 376 6, 431, 811	1, 761, 482 1, 489, 498		0	293, 632 1, 104, 320	
	07952 PHYSICIAN CLINICS 07953 PHYS PRAC BUS OFC	621,030	42, 321			1, 104, 320	
194.04	07954 MOB - MAIN CAMPUS	228, 231	1, 845, 525		o o	43, 545	194.04
	07955 ONCOLOGY - NONREI MBURSABLE	0	0	C	-		194.05
194.06	07956 KDH - MC FAMILY PRACTICE	4, 393, 518	0	() C	ן ס	886, 976	194.06

Health Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period:	Worksheet B	
				From 01/01/2015 To 12/31/2015	Part I Date/Time Pre	pared:
					5/18/2016 2:2	9 pm
		CAPI	TAL RELATED	COSTS		
Cost Center Description	Net Expenses	NEW BLDG &	NEW BLDG &	NEW MVBLE	EMPLOYEE	
	for Cost	FLXT	FIXT HHA/HO	EQUI P	BENEFI TS	
	Allocation				DEPARTMENT	
	(from Wkst A					
	col. 7)					
	0	1.00	1.01	2.00	4.00	
194.07 07957 KDH - MC ORTHOPEDICS	3, 432, 835	0		0 0	644, 168	194.07
194.08 07958 KDH – MC GENERAL SURGERY	1, 205, 092	0		0 0	251, 861	194.08
194.0907959KDH - MC ENT	527, 788	0		0 0	111, 236	194.09
194.1007960KDH - MC UROLOGY	670, 656	0		0 0	13, 173	194.10
194.11 07961 KDH - MC OB/GYN	2, 052, 436	0		0 0	363, 718	194.11
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	108, 070, 443	16, 340, 483	23, 99	3 0	10, 763, 500	202.00

	Financial Systems LLLOCATION - GENERAL SERVICE COSTS	KING'S DAUGHTE			eriod: rom 01/01/2015	u of Form CMS- Worksheet B Part I Date/Time Pre 5/18/2016 2:2	pared:
	Cost Center Description	Subtotal	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
	GENERAL SERVICE COST CENTERS	4A	5.00	7.00	8.00	9.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO						1.01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINI STRATIVE & GENERAL	18, 851, 253	18, 851, 253				4.00 5.00
7.00	00700 OPERATI ON OF PLANT	5, 209, 736					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	401, 297			527, 164		8.00
9.00	00900 HOUSEKEEPI NG	1, 405, 855			0	1, 774, 903	
10.00	01000 DI ETARY	833, 658			0	0	
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	478,009 301,959			0	0	
14.00	01400 CENTRAL SERVICES & SUPPLY	802, 332			0	21, 729	1
15.00	01500 PHARMACY	5, 282, 970			0	21, 159	
16.00	01600 MEDI CAL RECORDS & LI BRARY	1, 258, 651			0	0	
17.00	01700 SOCIAL SERVICE	314, 566			0	0	
19.00 23.00	01900 NONPHYSICIAN ANESTHETISTS 02300 RADIOLOGY SCHOOL	0 147, 524	0 31, 170	0 14, 245	0	0 5, 534	
23.00	02301 HUB SITE - 3RD YEAR MED STUDENTS	17, 186			0	3, 334 0	
	INPATIENT ROUTINE SERVICE COST CENTERS	1 7 7			1		
30.00	03000 ADULTS & PEDIATRICS	7, 037, 817			193, 515	931, 132	1
31.00 43.00	03100 I NTENSI VE CARE UNI T 04300 NURSERY	1, 179, 037 484, 617			0	38, 087	
43.00	ANCI LLARY SERVI CE COST CENTERS	484, 017	102, 395	42, 133	0	5, 697	43.00
50.00	05000 OPERATING ROOM	3, 066, 513	647, 927	378, 915	99, 235	114, 708	50.00
51.00	05100 RECOVERY ROOM	356, 385			11, 409	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	452, 792			0	21, 566	
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	221, 031 3, 519, 913			31, 449	0 70, 192	
54.00	03630 ULTRA SOUND	181, 155			3, 124	6, 836	
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	273, 462			2, 054	1, 912	
55.00	03480 ONCOLOGY	1, 813, 684			16, 400	0	
57.00	05700 CT SCAN	538, 514			14, 429	6, 022	1
58.00 59.00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	345, 173 277, 124			3, 966	3, 866 14, 486	1
60.00	06000 LABORATORY	5, 043, 996			0	41, 749	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	320, 559	67, 731	6, 013	0	0	62.00
65.00	06500 RESPI RATORY THERAPY	855, 895			0	0	65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	2, 722, 426	575, 224	313, 421	41, 416	20, 020 0	1
68.00	06800 SPEECH PATHOLOGY			0	0	0	1
69.00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	
69. 01	03610 SLEEP LAB	262, 394			1, 872	13, 835	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 389, 354			0	0	1
	07101 I V SOLUTIONS 07200 I MPL. DEV. CHARGED TO PATIENTS	98, 531 2, 973, 731			0	0	1
73.00	07300 DRUGS CHARGED TO PATIENTS	0	020, 020		0	0	1
76.00	03140 CARDI OLOGY	859, 293	181, 561	130, 321	15, 997	18, 759	
76.97	07697 CARDIAC REHABILITATION	124, 884	26, 387	15, 151	0	12, 289	76.97
90.00	OUTPATIENT SERVICE COST CENTERS	192, 873	40, 752	16, 379	62	10, 946	90.00
91.00	09100 EMERGENCY	2, 418, 700			72, 102	157, 719	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
	OTHER REIMBURSABLE COST CENTERS	1 070 044	417.05/	101.001	11.004		1 05 00
	09500 AMBULANCE SERVICES 10100 HOME HEALTH AGENCY	1, 973, 846 1, 205, 687			11, 984 0		95.00 101.00
101.00	SPECIAL PURPOSE COST CENTERS	1,203,007	234,731	57,225	<u> </u>	0	
	11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	275, 640			0		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	77, 770, 022	12, 449, 005	3, 693, 187	519, 014	1, 538, 243	1118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	218, 436	46, 154	29, 245	0	8, 749	190.00
194.00	07950 OTHER NON-REIMBURSABLE	0		0	0	0	194.00
	07951 MOB	3, 593, 490			1,079		194.01
	07952 PHYSI CLAN CLINICS 07953 PHYS PRAC BUS OFC	9, 025, 629 792, 108			2, 603		194. 02 194. 03
	07953 PHYS PRAC BUS OFC	2, 117, 301			0	0 227, 911	
194.05	07955 ONCOLOGY - NONREI MBURSABLE	0	0	0	o	0	194.05
	07956 KDH - MC FAMILY PRACTICE	5, 280, 494			308		194.06
	07957 KDH - MC ORTHOPEDICS	4,077,003			855		194.07
	07958 KDH – MC GENERAL SURGERY 07959 KDH – MC ENT	1, 456, 953 639, 024			1, 059 0		194. 08 194. 09
	07959 KDH - MC ENT	683, 829			0		194.09
	07961 KDH - MC OB/GYN	2, 416, 154			2, 246		194. 11

Health Financial Systems	KING'S DAUGHTE	ERS' HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		eri od:	Worksheet B	
				rom 01/01/2015		
			T	o 12/31/2015	Date/Time Pre	
	-				5/18/2016 2:2	<u>9 pm</u>
Cost Center Description	Subtotal	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL	PLANT	LINEN SERVICE		
	4A	5.00	7.00	8.00	9.00	
200.00 Cross Foot Adjustments	0)				200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	108, 070, 443	18, 851, 253	6, 310, 506	527, 164	1, 774, 903	202.00

Health Financial Systems	KING'S DAUGHTER				u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		riod: om 01/01/2015 12/31/2015	Worksheet B Part I Date/Time Pre	pared:
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	<u>5/18/2016 2:2</u> PHARMACY	9 pm
	10.00	11.00	13.00	SUPPLY 14.00	15.00	
GENERAL SERVICE COST CENTERS						1.00
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.01 00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMI NI STRATI VE & GENERAL 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVICE 9.00 09000 HOUSEKEEPING 10.00 01000 DI ETARY 11.00 01100 CAFETERIA	1, 145, 424	633, 856				1.00 1.01 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE 19. 00 01900 NONPHYSI CI AN ANESTHETI STS 23. 00 02300 RADI OLOGY 29. 01 02001 WUP OLICE		5, 472 7, 460 16, 592 21, 998 5, 160 0 2, 520	419, 378 0 0 0 0 0 0 0	1, 067, 770 11, 190 0 0 0 0	6, 497, 745 0 0 0 0 0	16.00 17.00 19.00 23.00
23. 01 02301 HUB SITE - 3RD YEAR MED STUDENTS INPATIENT ROUTINE SERVICE COST CENTERS	0	15	0	0	0	23.01
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY	1, 063, 185 82, 239 0	136, 191 20, 654 7, 826	206, 556 31, 325 11, 869	310, 847 2, 575 0	0 0 0	30.00 31.00 43.00
ANCI LLARY SERVI CE COST CENTERS						50.00
50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM	0 0 0	50, 617 5, 511 8, 838	76, 769 8, 359 13, 404	419, 714 5, 757 0	0 0 0	50.00 51.00 52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	12, 263 53, 022	0	26, 591 7, 633	0	53.00 54.00
54. 01 03630 ULTRA SOUND	0	2, 418	0	5, 582	0	54.01
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 55. 00 03480 ONCOLOGY	0	1, 721	0	5, 952	0	54.02 55.00
57. 00 05700 CT SCAN	0	20, 640 6, 180	0	12, 069 4, 328	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	3, 067	0	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0	4, 814 59, 563	0	3, 737 59, 062	0	59.00 60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0	16, 722	0	2, 222	0	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	42, 534 0	0	3, 990	0	66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
69.01 03610 SLEEP LAB 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 613	0	0	0	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATTENTS 71.01 07101 IV SOLUTIONS	0	0	0	0	0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03140 CARDI OLOGY	0	12 250	0	0	6, 497, 745 0	1
76. 97 07697 CARDIAC REHABILITATION	0	13, 250 2, 571	0	3, 351 168	0	1
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY	0	1, 533 46, 876		24 69, 268	0	90.00 91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) OTHER REIMBURSABLE COST CENTERS					-	92.00
95.00 09500 AMBULANCE SERVICES 101.00 10100 HOME HEALTH AGENCY	0	54, 996 0	0	4, 520 4, 967	0	95.00 101.00
SPECIAL PURPOSE COST CENTERS				, ,on	0	
113.00 11300 INTEREST EXPENSE						113.00
116.00 HOSPI CE 118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	0 1, 145, 424	0 633, 637	0 419, 378	0 963, 547	0 6, 497, 745	116. 00 118. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0		190.00
194. 00 07950 OTHER NON-REIMBURSABLE 194. 01 07951 MOB	0	0	0	545 8, 094		194. 00 194. 01
194. 02 07952 PHYSI CLAN CLINICS	0	219	0	38, 351	0	194. 02
194. 03 07953 PHYS PRAC BUS OFC	0	0	0	0		194.03
194. 04 07954 MOB – MALN CAMPUS 194. 05 07955 ONCOLOGY – NONRELMBURSABLE	0	0	0	857 0		194. 04 194. 05
194. 06 07956 KDH - MC FAMILY PRACTICE	0	0	0	12, 960	0	194.06
194. 07 07957 KDH - MC ORTHOPEDI CS	0	0	0	7,943		194.07
194.08 07958 KDH - MC GENERAL SURGERY 194.09 07959 KDH - MC ENT	0	0 0		7, 996 4, 174		194. 08 194. 09
194. 10 07960 KDH - MC UROLOGY	0	0	0	7, 717		194. 10

Health Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period:	Worksheet B	
				From 01/01/2015 To 12/31/2015	Part I Date/Time Pre 5/18/2016 2:2	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI OF	SERVICES &		
				SUPPLY		
	10.00	11.00	13.00	14.00	15.00	
194.11 07961 KDH - MC OB/GYN	0	C) (15, 586	0	194.11
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	C)	0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	1, 145, 424	633, 856	419, 378	3 1, 067, 770	6, 497, 745	202.00

Heal th	Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Lie	u of Form CMS-	2552-10
	LLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 01/01/2015	Worksheet B Part I	
					To 12/31/2015	Date/Time Pre	pared:
	Cost Center Description	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	RADI OLOGY	5/18/2016 2:2 HUB SITE - 3RD	
		RECORDS &		ANESTHETI STS	SCHOOL	YEAR MED	
		LI BRARY 16.00	17.00	19.00	23.00	STUDENTS 23.01	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 2.00	00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.01 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00 8.00	00700 OPERATION OF PLANT						7.00
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8.00 9.00
10.00	01000 DI ETARY						10.00
11.00							11.00
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY						13.00
15.00	01500 PHARMACY						15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 670, 727					16.00
17.00 19.00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	418, 044 0		0		17.00
23.00	02300 RADI OLOGY SCHOOL		0		200, 993		23.00
23.01	02301 HUB SITE - 3RD YEAR MED STUDENTS	0	0			20, 832	
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	00.000	224 (45				1 20 00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	82, 800 17, 242				0	
43.00	04300 NURSERY	8, 951	37, 805		0 0	0	
50.00	ANCI LLARY SERVICE COST CENTERS	470.470					
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	172, 169				0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	10, 108			0 0	0	
53.00	05300 ANESTHESI OLOGY	33, 618			0 0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	42,904			200, 993	20, 832	
54. 01 54. 02	03630 ULTRA SOUND 03450 NUCLEAR MEDICINE - DIAGNOSTIC	11, 617				0	
55.00	03480 ONCOLOGY	33, 514			0 0	0	
57.00	05700 CT SCAN	92, 088			0 0	0	
58.00 59.00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	28, 990 17, 706				0	
60.00	06000 LABORATORY	186,074				0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	9, 596			0 0	0	
65.00	06500 RESPIRATORY THERAPY	37, 200			0 0	0	
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	71, 818				0	
68.00	06800 SPEECH PATHOLOGY	0			0 0	0	
69.00	06900 ELECTROCARDI OLOGY	0	-		0 0	0	
	03610 SLEEP LAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 666 54, 219				0 0	69.01 71.00
71.00	07101 I V SOLUTIONS	16,070			0 0	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	80, 883	0	(0 0	0	
	07300 DRUGS CHARGED TO PATIENTS	373, 202			0 0	0	
76.00 76.97	03140 CARDI OLOGY 07697 CARDI AC REHABI LI TATI ON	59, 877 3, 924				0	
	OUTPATIENT SERVICE COST CENTERS						
90.00		885			0 0	0	
91.00 92.00	09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	126, 674	0		0 0	0	91.00 92.00
72.00	OTHER REIMBURSABLE COST CENTERS						/2.00
	09500 AMBULANCE SERVICES	25, 997			0 C		95.00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	(0 0	0	101.00
113.00	11300 I NTEREST EXPENSE						113.00
	11600 HOSPI CE	0	0		0 0		116.00
118.00		1, 670, 727	418, 044	(200, 993	20, 832	118.00
190.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0 0	0	190.00
	07950 OTHER NON-REI MBURSABLE	0	0		0 0		194.00
		0	0		0 0		194.01
	07952 PHYSI CLAN CLINICS 07953 PHYS PRAC BUS OFC						194. 02 194. 03
	07954 MOB - MAIN CAMPUS		0				194.03
194.05	07955 ONCOLOGY - NONREI MBURSABLE	0	0	(0 0	0	194. 05
	07956 KDH - MC FAMILY PRACTICE	0	0				194.06
194.07 194.08	07957 KDH - MC ORTHOPEDI CS 07958 KDH - MC GENERAL SURGERY						194. 07 194. 08
194.09	07959 KDH - MC ENT		0		0 0	0	194. 09
194.10	07960 KDH - MC UROLOGY	0	0	(0 0	0	194.10

Health Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 01/01/2015	Worksheet B Part I	
		_		To 12/31/2015		
Cost Center Description	MEDI CAL	SOCI AL SERVI CE	NONPHYSI CI AN	RADI OLOGY	HUB SITE - 3RD	
	RECORDS &		ANESTHETI STS	SCHOOL	YEAR MED	
	LI BRARY				STUDENTS	
	16.00	17.00	19.00	23.00	23.01	
194.11 07961 KDH - MC OB/GYN	0	0		0 0	0	194.11
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 118-201)	1, 670, 727	418, 044		0 200, 993	20, 832	202.00

	Financial Systems	KING'S DAUGHT	RS' F						of Form CMS-	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS			Provi der	CCN:	150069	F	rom 01/01/2015 o 12/31/2015	Worksheet B Part I Date/Time Pre 5/18/2016 2:2	epared:
	Cost Center Description	Subtotal		ntern &		Total			571072010 2.2	
				dents Cost & Post						
				tepdown						
				ustments				_		
	GENERAL SERVICE COST CENTERS	24.00		25.00		26.00		1		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT									1.00
1.01	00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO									1.01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP									2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINI STRATI VE & GENERAL									4.00 5.00
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										10.00
11. 00 13. 00	01100 CAFETERIA 01300 NURSING ADMINISTRATION									11.00
	01400 CENTRAL SERVICES & SUPPLY									14.00
15.00	01500 PHARMACY									15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY									16.00
17.00 19.00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS									17.00
	02300 RADIOLOGY SCHOOL									23.00
	02301 HUB SITE - 3RD YEAR MED STUDENTS									23.01
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · ·						1		
30.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	12, 641, 522		0 0		12, 641, 1, 701, 9				30.00
31.00 43.00	04300 NURSERY	1, 701, 950 701, 293		0		701, 2				31.00 43.00
101 00	ANCI LLARY SERVICE COST CENTERS	,017270				70171	_ / 0			
50.00	05000 OPERATI NG ROOM	5, 026, 567		0		5, 026, 5				50.00
51.00 52.00	05100 RECOVERY ROOM	524, 737		0		524,				51.00 52.00
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	602, 379 343, 007		0		602, 3 343, 0				52.00
	05400 RADI OLOGY-DI AGNOSTI C	4, 924, 302		0		4, 924, 3				54.00
	03630 ULTRA SOUND	249, 008		0		249, 0				54.01
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	383, 843		0		383,8				54.02
55.00 57.00	03480 ONCOLOGY 05700 CT SCAN	2, 546, 112 794, 632		0		2, 546, ² 794, 6				55.00 57.00
58.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI)	481, 269		0		481, 2				58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	394, 826		0		394,8				59.00
	06000 LABORATORY	6, 590, 654		0		6, 590, 6				60.00
62.00 65.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPI RATORY THERAPY	403, 899		0		403, 8 1, 118, 6				62.00 65.00
66. 00	06600 PHYSI CAL THERAPY	3, 790, 849		0		3, 790, 8				66.00
67.00	06700 OCCUPATI ONAL THERAPY	(0			0			67.00
	06800 SPEECH PATHOLOGY	0		0			0			68.00
	06900 ELECTROCARDI OLOGY 03610 SLEEP LAB	2(2,002		0		242.0	0			69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	363, 903 4, 159, 713		0		363, 9 4, 159, 1				69.01 71.00
	07101 I V SOLUTI ONS	135, 420		0		135, 4				71.01
	07200 IMPL. DEV. CHARGED TO PATIENTS	3, 682, 937		0		3, 682, 9				72.00
	07300 DRUGS CHARGED TO PATIENTS 03140 CARDI OLOGY	6, 870, 947 1, 282, 409		0		6, 870, 9				73.00
	07697 CARDI OLOGI 07697 CARDI AC REHABI LI TATI ON	1, 282, 409		0		1, 282, 4 185, 3				76.00
/0///	OUTPATIENT SERVICE COST CENTERS	100707				1007	071			
	09000 CLI NI C	263, 454		0		263, 4				90.00
	09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	3, 772, 596		0		3, 772, 5	596	1		91.00
92.00	OTHER REIMBURSABLE COST CENTERS		I	0	1					92.00
95.00	09500 AMBULANCE SERVICES	2, 590, 380		0		2, 590, 3	380)		95.00
101.00	10100 HOME HEALTH AGENCY	1, 524, 628		0		1, 524, 6	628	i .		101.00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE		1		T					113.00
	11600 HOSPI CE	349, 914		0		349, 9	914			116.00
118.00		68, 401, 203		0		68, 401, 2				118.00
4.6.7	NONREIMBURSABLE COST CENTERS									4
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 07950 OTHER NON-REIMBURSABLE	302, 584		0		302, 5	584 545			190.00 194.00
	07950 OTHER NON-REIMBURSABLE	545		0		; 5, 249, 0				194.00 194.01
	07952 PHYSI CLAN CLINICS	11, 724, 035		0		11, 724, (194.02
	07953 PHYS PRAC BUS OFC	980, 787		0		980,	787	,		194. 03
		3, 722, 900) I	0		3, 722, 9	900	i l		194.04
194.04	07954 MOB - MAIN CAMPUS			-						104 05
194. 04 194. 05	07955 ONCOLOGY - NONREI MBURSABLE	0		0			0)		194.05 194.06
194.04 194.05 194.06				0 0 0 0		6, 409, 4 4, 947, 2	0 483			194. 05 194. 06 194. 07

Health Financial Systems	In Lie	u of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 01/01/2015	Worksheet B Part I
				To 12/31/2015	Date/Time Prepared:
					5/18/2016 2:29 pm
Cost Center Description	Subtotal	Intern &	Total		
		Residents Cost			
		& Post			
		Stepdown			
		Adjustments			
	24.00	25.00	26.00		
194.0907959 KDH - MC ENT	778, 218	0	778, 21	8	194.09
194.1007960 KDH - MC UROLOGY	836, 033	0	836, 03	3	194.10
194.1107961KDH - MC OB/GYN	2, 944, 498	0	2, 944, 49	8	194. 11
200.00 Cross Foot Adjustments	0	0		0	200.00
201.00 Negative Cost Centers	0	0		0	201.00
202.00 TOTAL (sum lines 118-201)	108, 070, 443	0	108, 070, 44	3	202.00

Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS	KING'S DAUGHTE		F	eriod: rom 01/01/2015 o 12/31/2015	u of Form CMS-: Worksheet B Part II Date/Time Pre	
		CAP	TAL RELATED CO		5/18/2016 2:2	
Cost Center Description	Directly Assigned New Capital	NEW BLDG & FIXT	NEW BLDG & FIXT HHA/HO	NEW MVBLE EQUI P	Subtotal	
	Related Costs 0	1.00	1.01	2.00	2A	
GENERAL SERVICE COST CENTERS						1 00
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.01 00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DI ETARY 11.00 01100 CAFETERIA 13.00 01300 NURSI NG ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDICAL RECORDS & LI BRARY 17.00 01700 SOCI AL SERVICE 19.00 01900 NONPHYSI CI AN ANESTHETISTS 23.00 02300 RADIOLOGY SCHOOL 23.01 02301 HUB SITE - 3RD YEAR MED STUDENTS		0 1, 768, 329 2, 191, 585 81, 561 142, 967 269, 289 108, 905 95, 597 132, 483 98, 464 246, 481 63, 246 0 28, 285 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 1, 768, 329 2, 191, 585 81, 561 142, 967 269, 289 108, 905 95, 597 132, 483 98, 464 246, 481 63, 246 0 28, 285 0	15.00 16.00 17.00 19.00
INPATIENT ROUTINE SERVICE COST CENTERS		-	-			
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 43. 00 04300 NURSERY	0 0 0	1, 703, 243 71, 633 83, 658	0	0	1, 703, 243 71, 633 83, 658	31.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM 51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY - DI AGNOSTI C 54. 01 03630 ULTRA SOUND 54. 02 03450 NUCLEAR MEDI CI NE - DI AGNOSTI C 55. 00 03480 ONCOLOGY 57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 01 03610 SLEEP LAB 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS </td <td></td> <td>$\begin{array}{c} 752, 366\\ 58, 839\\ 0\\ 5, 563\\ 463, 906\\ 0\\ 20, 668\\ 529, 335\\ 38, 299\\ 46, 215\\ 36, 544\\ 266, 978\\ 11, 939\\ 51, 222\\ 622, 321\\ 0\\ 0\\ 35, 902\\ 0\\ 0\\ 35, 902\\ 0\\ 0\\ 258, 762\\ 30, 083\\ \end{array}$</td> <td></td> <td></td> <td>$\begin{array}{c} 752, 366\\ 58, 839\\ 0\\ 5, 563\\ 463, 906\\ 0\\ 20, 668\\ 529, 335\\ 38, 299\\ 46, 215\\ 36, 544\\ 266, 978\\ 11, 939\\ 51, 222\\ 622, 321\\ 0\\ 0\\ 35, 902\\ 0\\ 0\\ 35, 902\\ 0\\ 0\\ 258, 762\\ 30, 083\\ \end{array}$</td> <td>50.00 51.00 52.00 53.00 54.01 54.02 55.00 57.00 59.00 60.00 62.00 62.00 65.00 65.00 65.00 66.00 67.00 68.00 69.00 71.01 72.00 73.00 73.00 76.00 76.97</td>		$\begin{array}{c} 752, 366\\ 58, 839\\ 0\\ 5, 563\\ 463, 906\\ 0\\ 20, 668\\ 529, 335\\ 38, 299\\ 46, 215\\ 36, 544\\ 266, 978\\ 11, 939\\ 51, 222\\ 622, 321\\ 0\\ 0\\ 35, 902\\ 0\\ 0\\ 35, 902\\ 0\\ 0\\ 258, 762\\ 30, 083\\ \end{array}$			$\begin{array}{c} 752, 366\\ 58, 839\\ 0\\ 5, 563\\ 463, 906\\ 0\\ 20, 668\\ 529, 335\\ 38, 299\\ 46, 215\\ 36, 544\\ 266, 978\\ 11, 939\\ 51, 222\\ 622, 321\\ 0\\ 0\\ 35, 902\\ 0\\ 0\\ 35, 902\\ 0\\ 0\\ 258, 762\\ 30, 083\\ \end{array}$	50.00 51.00 52.00 53.00 54.01 54.02 55.00 57.00 59.00 60.00 62.00 62.00 65.00 65.00 65.00 66.00 67.00 68.00 69.00 71.01 72.00 73.00 73.00 76.00 76.97
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	32, 522 593, 908		0	32, 522 593, 908 0	90.00 91.00 92.00
95. 00 09500 AMBULANCE SERVICES 101. 00 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	202, 491 0		0	202, 491 18, 881	
113.00 11300 INTEREST EXPENSE 116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1-117)	0	0 11, 143, 589	5, 112 23, 993		5, 112 11, 167, 582	113. 00 116. 00 118. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 194. 00 07950 OTHER NON-REI MBURSABLE 194. 01 07951 MOB 194. 02 07952 PHYSI CI AN CLI NI CS 194. 03 07953 PHYSI CI AN CLI NI CS 194. 03 07953 PHYS PRAC BUS OFC 194. 04 07954 MOB - MAI N CAMPUS 194. 05 07955 ONCOLOGY - NONREI MBURSABLE 194. 06 07956 KDH - MC FAMI LY PRACTI CE 194. 07 07957 KDH - MC ORTHOPEDI CS		58, 068 0 1, 761, 482 1, 489, 498 42, 321 1, 845, 525 0 0 0 0	0 0 0 0	0 0 0 0 0 0 0 0	0 1, 761, 482 1, 489, 498 42, 321 1, 845, 525 0 0	194. 02 194. 03

Health Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Lie	u of Form CMS	-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Peri od:	Worksheet B	
				From 01/01/2015 To 12/31/2015		epared:
					5/18/2016 2:	
		CAPI	TAL RELATED			
Cost Center Description	Directly	NEW BLDG &	NEW BLDG &	NEW MVBLE	Subtotal	
	Assigned New	FLXT	FIXT HHA/HO	EQUI P		
	Capi tal					
	Related Costs					
	0	1.00	1.01	2.00	2A	
194.0807958 KDH - MC GENERAL SURGERY	0	0		0 0	(0 194. 08
194.0907959 KDH - MC ENT	0	0		0 0	(0 194. 09
194.1007960 KDH - MC UROLOGY	0	0		0 0	(0 194. 10
194.11 07961 KDH - MC OB/GYN	0	0		0 0	(0 194. 11
200.00 Cross Foot Adjustments		-				200.00
201.00 Negative Cost Centers		0		0 0		201.00
202.00 TOTAL (sum Lines 118-201)	0	16, 340, 483	23, 99	0	16, 364, 47	
		, 510, 100	20, 77		1	1202.00

Health Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	F	eriod: rom 01/01/2015 o 12/31/2015	Worksheet B Part II Date/Time Pre	pared:
Cost Center Description	EMPLOYEE	ADMI NI STRATI VE	OPERATI ON OF	LAUNDRY &	5/18/2016 2:2 HOUSEKEEPI NG	
	BENEFI TS DEPARTMENT	& GENERAL	PLANT	LINEN SERVICE		
	4.00	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.01 2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	0	.,				5.00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE	0	103, 257 7, 954	2, 294, 842 14, 938			7.00 8.00
9. 00 00900 HOUSEKEEPING	0	27, 864	26, 184		197, 015	1
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	0	16, 523 9, 474	49, 320 19, 946		0	
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	5, 985	17, 508		0	13.00
14. 00 01400 CENTRAL_SERVI CES & SUPPLY 15. 00 01500 PHARMACY	0	15, 902 104, 708	24, 264 18, 033		2, 412 2, 349	•
16.00 01600 MEDICAL RECORDS & LIBRARY	0	24, 946	45, 142	0	0	16.00
17. 00 01700 SOCIAL SERVICE 19. 00 01900 NONPHYSICIAN ANESTHETISTS	0	6, 235 0	11, 583 0		0	
23.00 02300 RADI OLOGY SCHOOL	0		5, 180		614	23.00
23. 01 02301 HUB SITE - 3RD YEAR MED STUDENTS INPATIENT ROUTINE SERVICE COST CENTERS	0	341	0	0	0	23.01
30. 00 03000 ADULTS & PEDI ATRI CS	0				103, 357	1
31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY	0		13, 120 15, 322		4, 228 632	•
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM	0	60, 778 7, 064	137, 794 10, 776		12, 733 0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	8, 974	0	0	2, 394	
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	4, 381 69, 765	1, 019 84, 963		0 7, 791	53.00 54.00
54. 01 03630 ULTRA_SOUND	0		04,903		7,791	
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	5, 420	3, 785		212	
55. 00 03480 ONCOLOGY 57. 00 05700 CT_SCAN	0	35, 947 10, 673	96, 946 7, 014		0 668	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	6, 841	8, 464	786	429	
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0	5, 493 99, 972	6, 693 48, 896		1, 608 4, 634	•
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	6, 353	2, 187	0	0	62.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	16, 964 53, 958	9, 381 113, 977	0 8, 206	0 2, 222	
67.00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	
69.01 03610 SLEEP LAB	0	5, 201	6, 575	371	1, 536	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.01 07101 V SOLUTIONS	0	67, 177 1, 953	0	0	0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	58, 939		0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03140 CARDI OLOGY	0	0 17, 031	0 47, 392	0 3, 170	0 2, 082	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	2, 475			1, 364	•
0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C	0	3, 823	5, 956	12	1, 215	90.00
91.00 09100 EMERGENCY	0				17, 507	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
95. 00 09500 AMBULANCE SERVICES	0	39, 122	37, 086	2, 374	0	95.00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	23, 897	21, 537	0	0	101.00
113.00 11300 INTEREST EXPENSE						113.00
116.00 11600 HOSPI CE	0					116.00
118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	0	1, 167, 770	1, 343, 040	102, 838	170, 746	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	4, 329	10, 635			190.00
194. 00 07950 OTHER NON-REI MBURSABLE 194. 01 07951 MOB	0	0 71, 223	0 322, 612	U U		194. 00 194. 01
194. 02 07952 PHYSI CLAN CLI NI CS	0	178, 894	272, 798	516	0	194. 02
194. 03 07953 PHYS PRAC BUS OFC 194. 04 07954 MOB - MAIN CAMPUS	0	15, 700 41, 965	7, 751 338, 006			194. 03 194. 04
194.05079550NCOLOGY - NONREIMBURSABLE	0	0	0	0	0	194.05
194. 06 07956 KDH - MC FAMILY PRACTICE 194. 07 07957 KDH - MC ORTHOPEDICS	0	104, 659 80, 806		61 169		194. 06 194. 07
194.0807958KDH - MC GENERAL SURGERY	0	28, 877	0	210	0	194.08
194. 09 07959 KDH – MC ENT 194. 10 07960 KDH – MC UROLOGY	0	12, 665 13, 553		-		194. 09 194. 10
	. 0	1 10,000	. 0	<u> </u>	0	1

Health Financial Systems	u of Form CMS-	2552-10				
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN: 150069 P	Peri od:	Worksheet B	
			F	rom 01/01/2015		
			T	o 12/31/2015		pared:
					5/18/2016 2:2	9 pm
Cost Center Description	EMPLOYEE	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	BENEFI TS	& GENERAL	PLANT	LINEN SERVICE		
	DEPARTMENT					
	4.00	5.00	7.00	8.00	9.00	
194.11 07961 KDH - MC OB/GYN	0	47,888	C	445	0	194.11
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	C	0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	(1, 768, 329	2, 294, 842	104, 453	197, 015	202.00

Health Financial Systems	KING'S DAUGHTEI	RS' HOSPI TAL		In Lieu	ı of Form CMS-2	<u>2552-10</u>
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	Fr	eriod: rom 01/01/2015	Worksheet B Part II	
			Tc		Date/Time Pre 5/18/2016 2:2	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	PHARMACY	
	10.00	11.00	13.00	SUPPLY 14.00	15.00	
GENERAL SERVICE COST CENTERS	10.00	11.00	13.00	14.00	15.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.01 00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO						1.00 1.01
2.00 00200 NEW CAP REL COSTS-BEDG & TTAT HIM/HO						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT						5.00 7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	335, 132					9.00 10.00
11.00 01100 CAFETERIA	0	138, 325				11.00
13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY	0	1, 194 1, 628		176, 689		13.00 14.00
15.00 01500 PHARMACY	0	3, 621	0	1, 852	229, 027	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	0	4, 801 1, 126	0	0	0 0	16.00 17.00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19.00
23.00 02300 RADIOLOGY SCHOOL 23.01 02301 HUB SITE - 3RD YEAR MED STUDENTS	0	550 3	0 0	0	0 0	23.00 23.01
INPATIENT ROUTINE SERVICE COST CENTERS	211.070	20.710	F0.245	F1 407		20.00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	311, 070 24, 062	29, 719 4, 507		51, 437 426	0 0	30.00 31.00
43. 00 04300 NURSERY	0	1, 708	3, 404	0	0	43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 0PERATI NG ROOM	0	11, 046	22, 019	69, 453	0	50.00
51.00 05100 RECOVERY ROOM	0	1, 203		953	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0	1, 929 2, 676		0 4, 400	0	52.00 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	11, 571	0	1, 263	0	54.00
54.01 03630 ULTRA SOUND 54.02 03450 NUCLEAR MEDICINE – DIAGNOSTIC	0	528 376		924 985	0	54.01 54.02
55. 00 03480 ONCOLOGY	0	4, 504	0	1, 997	0	55.00
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1, 349 669		716 0	0	57.00 58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	1, 051	0	618	0	59.00
60.00 06000 LABORATORY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	12, 998 0	0	9, 773 0	0	60.00 62.00
65. 00 06500 RESPI RATORY THERAPY	0	3, 649	0	368	0	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	0	9, 282 0	0	660 0	0	66.00 67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY 69. 01 03610 SLEEP LAB	0	0 570	0	0	0	69.00 69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	o	0	71.00
71.01 07101 IV SOLUTIONS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71.01 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	229, 027	73.00
76. 00 03140 CARDI OLOGY 76. 97 07697 CARDI AC REHABI LI TATI ON	0	2, 891 561		554 28	0	
OUTPATIENT SERVICE COST CENTERS				20		
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY	0	335 10, 230		4 11, 462	0	90.00 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			20,071	,		92.00
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES	0	12, 002	0	748	0	95.00
101.00 10100 HOME HEALTH AGENCY	0	0		822		101.00
SPECI AL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	0	0	0	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	335, 132	138, 277	120, 284	159, 443	229, 027	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0		190. 00
194. 00 07950 OTHER NON-REI MBURSABLE 194. 01 07951 MOB	0	0	0	90 1, 339		194. 00 194. 01
194. 02 07952 PHYSI CLAN CLI NI CS	0	48	0	6, 346	0	194. 02
194. 03 07953 PHYS PRAC BUS OFC 194. 04 07954 MOB - MAIN CAMPUS	0	0	0	0 142		194. 03 194. 04
194. 05 07955 ONCOLOGY - NONREI MBURSABLE	0	0	Ő	0	0	194. 05
194. 06 07956 KDH - MC FAMILY PRACTICE 194. 07 07957 KDH - MC ORTHOPEDICS	0	0	0	2, 145 1, 314		194. 06 194. 07
194.0807958 KDH - MC GENERAL SURGERY	0	0	Ő	1, 323	0	194. 08
194. 09 07959 KDH – MC ENT 194. 10 07960 KDH – MC UROLOGY	0	0 0	0	691 1, 277		194. 09 194. 10
	, °		, ⁰	., =. , [•	

Health Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Worksheet B Part II				
				From 01/01/2015 To 12/31/2015		
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI O	N SERVICES &		
				SUPPLY		
	10.00	11.00	13.00	14.00	15.00	
194.11 07961 KDH - MC OB/GYN	0	C		2, 579	0	194.11
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	C		o c	0	201.00
202.00 TOTAL (sum lines 118-201)	335, 132	138, 325	120, 28	4 176, 689	229, 027	202.00

Health Financial Systems	KING'S DAUGHTE		CON. 1500/0 D		eu of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	F	eriod: rom 01/01/2015 o 12/31/2015		
Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	RADI OLOGY SCHOOL	HUB SI TE - 3RD YEAR MED STUDENTS	
	16.00	17.00	19.00	23.00	23.01	
GENERAL SERVICE COST CENTERS		I	1		I	1
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.01 00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO						1.00
2.00 00200 NEW CAP REL COSTS-BEDG & TTXT HIA/HO						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMI NI STRATI VE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY						9.00 10.00
11. 00 01100 CAFETERIA						11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00 01500 PHARMACY						15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	321, 370					16.00
17. 00 01700 SOCI AL SERVI CE 19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	82, 190 0				17.00
23. 00 02300 RADI OLOGY SCHOOL	0	0		37, 553		23.00
23.01 02301 HUB SITE - 3RD YEAR MED STUDENTS	0	0			344	
INPATIENT ROUTINE SERVICE COST CENTERS		1	1	T	1	
30. 00 03000 ADULTS & PEDIATRICS	15, 923					30.00
31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY	3, 316					31.00 43.00
ANCI LLARY SERVI CE COST CENTERS	1, 721	7, 433				43.00
50. 00 05000 OPERATING ROOM	33, 108	0				50.00
51.00 05100 RECOVERY ROOM	6, 227					51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 944					52.00
53. 00 05300 ANESTHESI OLOGY	6, 465					53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	8, 251	0				54.00
54.01 03630 ULTRA SOUND 54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	2, 234 5, 875					54.01 54.02
55. 00 03480 ONCOLOGY	6, 445					55.00
57.00 05700 CT SCAN	17, 709					57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	5, 575					58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	3, 405					59.00
60.00 06000 LABORATORY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	35, 782 1, 845					60.00 62.00
65. 00 06500 RESPI RATORY THERAPY	7, 154					65.00
66.00 06600 PHYSI CAL THERAPY	13, 811	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 03610 SLEEP LAB 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 859					69.01 71.00
71. 01 07101 IV SOLUTIONS	3, 090					71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	15, 554					72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	71, 853					73.00
76. 00 03140 CARDI OLOGY	11, 514					76.00
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	755	0	1		I	76.97
90. 00 09000 CLINIC	170	0				90.00
91. 00 09100 EMERGENCY	24, 360					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS	1					
95.00 09500 AMBULANCE SERVICES 101.00 10100 HOME HEALTH AGENCY	4, 999					95.00 101.00
SPECIAL PURPOSE COST CENTERS	0	0				
113. 00 11300 I NTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	0	0				116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	321, 370	82, 190	0	0	0	118.00
			1	1	1	100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 194.00 07950 OTHER NON-REIMBURSABLE	0	0				190.00 194.00
194. 01 07951 MOB	0	0				194.00
194. 02 07952 PHYSI CI AN CLI NI CS		0				194.02
194. 03 07953 PHYS PRAC BUS OFC	0	0				194.03
194.04 07954 MOB - MAIN CAMPUS	0	0				194.04
194.05079550NCOLOGY - NONREIMBURSABLE	0	0				194.05
194. 06 07956 KDH - MC FAMILY PRACTICE 194. 07 07957 KDH - MC ORTHOPEDICS						194.06 194.07
194. 08 07958 KDH - MC GENERAL SURGERY		0				194.07
194.0907959KDH - MC ENT	0	0				194. 09
194.1007960KDH - MC UROLOGY	0	0				194.10

Health Financial Systems	KING'S DAUGHTE	ERS' HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Period: From 01/01/2015	Worksheet B Part II	
				To 12/31/2015		
Cost Center Description	MEDI CAL	SOCI AL SERVI CE	NONPHYSI CI AN	RADI OLOGY	HUB SITE - 3RD	
	RECORDS &		ANESTHETI STS	SCHOOL	YEAR MED	
	LI BRARY				STUDENTS	
	16.00	17.00	19.00	23.00	23.01	
194.11 07961 KDH - MC OB/GYN	C	0 0				194.11
200.00 Cross Foot Adjustments			(37, 553	344	200.00
201.00 Negative Cost Centers	C	0 0	(0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	321, 370	82, 190	(0 37, 553	344	202.00

Health Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Li	eu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN: 150069	Period: From 01/01/201	Worksheet B 5 Part II
				To 12/31/201	5 Date/Time Prepared: 5/18/2016 2:29 pm
Cost Center Description	Subtotal	Intern & Residents Cost	Total		
		& Post			
		Stepdown Adjustments			
	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT		1	1	1	1.00
1. 01 00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO					1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4. 00 00400 EMPLOYEE BENEFI TS DEPARTMENT 5. 00 00500 ADMI NI STRATI VE & GENERAL					4.00
7. 00 00700 OPERATI ON OF PLANT					7.00
8.00 00800 LAUNDRY & LINEN SERVICE					8.00
9. 00 00900 HOUSEKEEPING 10. 00 01000 DI ETARY					9.00 10.00
11. 00 01100 CAFETERI A					11.00
13.00 01300 NURSING ADMINISTRATION					13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY					14. 00 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY					16.00
17.00 01700 SOCIAL SERVICE					17.00
19. 00 01900 NONPHYSICIAN ANESTHETISTS 23. 00 02300 RADI OLOGY SCHOOL					19.00 23.00
23. 01 02300 KAD OLOGT SCHOOL 23. 01 02301 HUB SITE - 3RD YEAR MED STUDENTS					23.00
INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · · · ·	-			
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	2, 829, 566				30.00 31.00
43. 00 04300 NURSERY	123, 483				43.00
ANCI LLARY SERVI CE COST CENTERS	1	1 -			
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM	1, 118, 960 89, 720		.,		50.00 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	19, 085				52.00
53.00 05300 ANESTHESI OLOGY	24, 504				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 03630 ULTRA SOUND	653, 741 8, 654				54.00 54.01
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	37, 728				54.02
55. 00 03480 ONCOLOGY	678, 423				55.00
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	79, 287 68, 979				57.00 58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	55, 412				59.00
60.00 06000 LABORATORY	479, 033				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 65.00 06500 RESPI RATORY THERAPY	22, 324 88, 738				62.00 65.00
66. 00 06600 PHYSI CAL THERAPY	824, 437				66.00
67.00 06700 OCCUPATI ONAL THERAPY	C	C	þ	0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY				0	68.00 69.00
69. 01 03610 SLEEP LAB	52, 014		, 52, 0	-	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	77, 603		77,6		71.00
71. 01 07101 IV SOLUTIONS 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	5, 043 74, 493		5, 0 74, 4		71.01 72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	300, 880		300, 8		73.00
76.00 03140 CARDI OLOGY	343, 396				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	40, 776	(C	40, 7	//6	76. 97
90. 00 09000 CLINIC	44,037	0	44, 0)37	90.00
91.00 09100 EMERGENCY	848, 856			356	91.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) OTHER REIMBURSABLE COST CENTERS		C	1		92.00
95. 00 09500 AMBULANCE SERVICES	298, 822			322	95.00
101.00 10100 HOME HEALTH AGENCY	65, 137	0) 65, 1	137	101.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE					113.00
116. 00 11600 HOSPI CE	16, 406			106	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	9, 532, 146	0	9, 532, 1	46	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	74,003		74,0	003	190.00
194. 00 07950 OTHER NON-REI MBURSABLE	90			90	194.00
194. 01 07951 MOB	2, 156, 870				194.01
194. 02 07952 PHYSI CI AN CLI NI CS 194. 03 07953 PHYS PRAC BUS OFC	1, 948, 100		1, 948, 1 65, 7		194. 02 194. 03
194. 04 07954 MOB - MALIN CAMPUS	2, 250, 936		2, 250, 9		194. 03
194. 05 07955 ONCOLOGY - NONREI MBURSABLE	C	c		0	194. 05
194. 06 07956 KDH – MC FAMILY PRACTICE 194. 07 07957 KDH – MC ORTHOPEDICS	106, 865 82, 289) 106, 8) 82, 2		194.06 194.07
194. 08 07958 KDH - MC GENERAL SURGERY	30, 410				194.07
				1	

Health Financial Systems	KING'S DAUGHTE	ERS' HOSPI TAL		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Period:	Worksheet B
				From 01/01/2015 To 12/31/2015	Part II Date/Time Prepared:
					5/18/2016 2:29 pm
Cost Center Description	Subtotal	Intern &	Total		
		Residents Cost			
		& Post			
		Stepdown			
		Adjustments			
	24.00	25.00	26.00		
194.09 07959 KDH – MC ENT	13, 356	0	13, 35	6	194. 09
194.10 07960 KDH - MC UROLOGY	14, 830	0 0	14, 83	0	194. 10
194.11 07961 KDH - MC OB/GYN	50, 912	2 0	50, 91	2	194. 11
200.00 Cross Foot Adjustments	37, 897	0	37, 89	7	200.00
201.00 Negative Cost Centers	0	0 0		0	201.00
202.00 TOTAL (sum lines 118-201)	16, 364, 476	0	16, 364, 47	6	202.00

	Financial Systems ALLOCATION - STATISTICAL BASIS	KING'S DAUGHTE			Period:	u of Form CMS-2 Worksheet B-1	
					From 01/01/2015 To 12/31/2015	Date/Time Pre 5/18/2016 2:2	
		CAPI	TAL RELATED CO	DSTS			
	Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	NEW BLDG & FIXT HHA/HO (SQUARE FEET)	NEW MVBLE EQUI P (SQUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	Reconciliation	
		1.00	1. 01	2.00	4. 00	5A	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	381, 860		1			1.00
1.01 2.00 4.00 5.00 7.00 8.00 9.00 10.00	00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO 00200 NEW CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY	0 41, 324 51, 215 1, 906 3, 341 6, 293	3, 492 0 0 0 0 0 0 0	385, 352 (41, 324 51, 215 1, 900 3, 34 6, 293	50, 044, 013 6, 240, 720 6 622, 137 7 39, 545 1 623, 021 8 290, 895	0 0 0	1.01 2.00 4.00 5.00 7.00 8.00 9.00 10.00
11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 23. 00 23. 01	01100 CAFETERIA 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS 02300 RADI OLOGY SCHOOL 02301 HUB SI TE - 3RD YEAR MED STUDENTS INPATI ENT ROUTI NE SERVI CE COST CENTERS	2, 545 2, 234 3, 096 2, 301 5, 760 1, 478 0 661 0		2, 234 3, 096 2, 30 5, 766 1, 478 (66	4 265, 958 5 86, 048 8 20, 619 0 604, 017 3 204, 990 0 0 1 96, 948	0 0 0 0 0 0 0 0	13.00 14.00 15.00 16.00 17.00 19.00 23.00
30.00	03000 ADULTS & PEDIATRICS	39, 803	0	39, 803	4, 337, 772	0	30.00
31.00 43.00	03100 I NTENSI VE CARE UNI T	1, 674 1, 955	0			0	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	1,955	0	1, 955	5 326, 031	0	43.00
71. 01 72. 00 73. 00 76. 00 76. 97 90. 00	05000 OPERATI NG ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND 03450 NUCLEAR MEDI CINE - DI AGNOSTI C 03450 NUCLEAR MEDI CINE - DI AGNOSTI C 03480 ONCOLOGY 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 03610 SLEEP LAB 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07101 I V SOLUTI ONS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07100 JUSC CHARGED TO PATI ENTS 0710	17, 582 1, 375 0 130 10, 841 0 483 12, 370 895 1, 080 854 6, 239 279 1, 197 14, 543 0 0 0 0 0 0 0 0 0 0 0 0 0		1, 375 (1) 13, 10, 84 (2) 485 6, 236 277 1, 197 14, 543 (1) (2) (2) (3) (4) (5) (4) (5) (5) (6) (6) (6) (7) (7) (7) (7) (7) (7) (7) (7	242, 930 368, 178 368, 178 875, 050 3, 063, 085 106, 518 61, 077 920, 747 210, 612 134, 976 4195, 586 1, 571, 518 0 0 1, 695, 939 0 <t< td=""><td></td><td>51.00 52.00 53.00 54.01 54.02 55.00 57.00 58.00 57.00 58.00 60.00 62.00 65.00 66.00 67.00 68.00 69.01 71.00 71.01 71.00 71.01 72.00 73.00 76.97</td></t<>		51.00 52.00 53.00 54.01 54.02 55.00 57.00 58.00 57.00 58.00 60.00 62.00 65.00 66.00 67.00 68.00 69.01 71.00 71.01 71.00 71.01 72.00 73.00 76.97
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	13, 879	0			0	92.00
95.00 101.00	09500 AMBULANCE SERVICES 10100 HOME HEALTH AGENCY	4, 732 0	2, 748	4, 732 2, 748			95.00 101.00
	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	0 260, 414	744 3, 492				113. 00 116. 00 118. 00
194.00 194.01 194.02 194.03 194.04 194.05	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 07950 OTHER NON-REI MBURSABLE 07951 MOB 07952 PHYSICIAN CLINICS 07953 PHYS PRAC BUS OFC 07954 MOB - MAIN CAMPUS 07955 ONCOLOGY - NONREI MBURSABLE 07956 KDH - MC FAMILY PRACTICE	1, 357 0 41, 164 34, 808 989 43, 128 0 0	0 0 0 0 0 0 0 0 0	1, 35 (41, 164 34, 806 989 43, 128 ((0 4 1, 365, 217 3 5, 134, 436 9 598, 646 3 202, 458 0 0	0 0 0 0 0	190.00 194.00 194.01 194.02 194.03 194.04 194.05 194.05

Health Financial Systems	KING' S DAUGHTERS' HOSPI TAL			In Lieu of Form CMS-2552-		
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2015 To 12/31/2015		
	CAPI	TAL RELATED CO	STS			
Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	NEW BLDG & FIXT HHA/HO (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
	1.00	1.01	2.00	4.00	5A	
194.07 07957 KDH - MC ORTHOPEDICS	0	0		0 2, 995, 003		194.07
194.0807958 KDH - MC GENERAL SURGERY	0	0		0 1, 171, 005	0	194.08
194.0907959KDH - MC ENT	0	0		0 517, 180	0	194.09
194.1007960 KDH - MC UROLOGY	0	0		0 61, 248	0	194.10
194.1107961KDH - MC OB/GYN	0	0		0 1, 691, 075	0	194.11
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, 340, 483	23, 993		0 10, 763, 500		202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	42. 791816	6. 870848	0.00000	0 0. 215081		203.00
204.00 Cost to be allocated (per Wkst. B, Part II)				0		204.00
205.00 Unit cost multiplier (Wkst. B, Part				0. 000000		205. 00

Heal th Financial Systems COST ALLOCATION - STATISTICAL BASIS	KING'S DAUGHTER		CON 1500/0 D		u of Form CMS-2	2552-10
CUST ALLUCATION - STATISTICAL BASIS		Provider		eriod: com 01/01/2015 o 12/31/2015	Worksheet B-1 Date/Time Pre 5/18/2016 2:2	
Cost Center Description	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (MEALS SERVED)	2 011
	5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101 NEW CAP REL COSTS-BLDG & FIXT HHA/H0 2.00 00200 NEW CAP REL COSTS-BLDG & FIXT HHA/H0 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01100 CAFETERIA	89, 219, 190 5, 209, 736 401, 297 1, 405, 855 833, 658 478, 009	292, 813 1, 906 3, 341 6, 293 2, 545	452, 048 0 0	43, 619 0 0	49, 333 0	1. 01 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00
13.00 01300 NURSING ADMINISTRATION	301, 959	2, 234		0	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY	802, 332 5, 282, 970	3, 096 2, 301	0	534 520	0	14.00 15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	1, 258, 651	5, 760	-	520	0	16.00
17. 00 01700 SOCIAL SERVICE	314, 566	1, 478	0	0	0	17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00 02300 RADIOLOGY SCHOOL 23.01 02301 HUB SITE - 3RD YEAR MED STUDENTS	147, 524 17, 186	661 0	0	136 0	0	23. 00 23. 01
INPATIENT ROUTINE SERVICE COST CENTERS	17,100	0	0	U	0	23.01
30. 00 03000 ADULTS & PEDIATRICS	7, 037, 817	39, 803	165, 942	22, 883	45, 791	30.00
31.00 03100 INTENSIVE CARE UNIT	1, 179, 037	1,674		936	3, 542	31.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	484, 617	1, 955	0	140	0	43.00
50. 00 05000 OPERATING ROOM	3, 066, 513	17, 582	85, 095	2, 819	0	50.00
51.00 05100 RECOVERY ROOM	356, 385	1, 375	9, 783	0	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	452, 792	0	0	530	0	52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	221, 031 3, 519, 913	130 10, 841	0 26, 968	0 1, 725	0	53.00 54.00
54. 01 03630 ULTRA SOUND	181, 155	0,041	2,679	168	0	54.00
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	273, 462	483		47	0	54.02
55. 00 03480 ONCOLOGY	1, 813, 684	12, 370		0	0	55.00 57.00
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	538, 514 345, 173	895 1, 080	12, 373 3, 401	148 95	0	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	277, 124	854	0,101	356	0	59.00
	5, 043, 996	6, 239		1, 026	0	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 65. 00 06500 RESPI RATORY THERAPY	320, 559 855, 895	279 1, 197	0	0	0	62.00 65.00
66. 00 06600 PHYSI CAL THERAPY	2, 722, 426	14, 543	0	492	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY 69. 01 03610 SLEEP LAB	262, 394	839	1, 605	340	0	69. 00 69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 389, 354	0	0	0	0	71.00
71.01 07101 IV SOLUTIONS	98, 531	0	0	0	0	71.01
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	2, 973, 731 0	0	0	0	0	72.00 73.00
76. 00 03140 CARDI OLOGY	859, 293	6, 047	13, 718	461	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	124, 884	703	0	302	0	76. 97
OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC	192, 873	760	53	269	0	90.00
91. 00 09100 EMERGENCY	2, 418, 700	13, 879		3, 876	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	1 072 044	4 722	10.07/	0	0	05 00
95.00 09500 AMBULANCE SERVICES 101.00 10100 HOME HEALTH AGENCY	1, 973, 846 1, 205, 687	4, 732 2, 748		0		95.00 101.00
SPECIAL PURPOSE COST CENTERS	.,			1	-	
113.00 11300 INTEREST EXPENSE				_	_	113.00
116.00 HOSPI CE 118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	275, 640 58, 918, 769	744 171, 367		0 37, 803	0 49, 333	116. 00 118. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	218, 436	1, 357		215		190.00
194. 00 07950 OTHER NON-REI MBURSABLE 194. 01 07951 MOB	0 3, 593, 490	0 41, 164	-	0		194. 00 194. 01
194. 02 07952 PHYSI CLAN CLINICS	9, 025, 629	34, 808		0		194. 01 194. 02
194. 03 07953 PHYS PRAC BUS OFC	792, 108	989	0	0		194. 03
194. 04 07954 MOB - MALN CAMPUS	2, 117, 301	43, 128		5, 601		194. 04 194. 05
194.05079550NCOLOGY - NONREIMBURSABLE 194.0607956KDH - MC FAMILY PRACTICE	5, 280, 494	0	0 264	0		194.05 194.06
194. 07 07957 KDH - MC ORTHOPEDICS	4, 077, 003	0	733	0	0	194.07
194.08 07958 KDH - MC GENERAL SURGERY	1, 456, 953	0		0		194.08
194.09 07959 KDH - MC ENT	639, 024	0	0	0	0	194.09

Health Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period:	Worksheet B-1	
				From 01/01/2015 To 12/31/2015	Date/Time Pre 5/18/2016 2:2	
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL	PLANT	LINEN SERVICE	E (HOURS OF	(MEALS	
	(ACCUM.	(SQUARE	(POUNDS OF	SERVI CE)	SERVED)	
	COST)	FEET)	LAUNDRY)			
	5.00	7.00	8.00	9.00	10.00	
194.1007960 KDH - MC UROLOGY	683, 829	0		0 0	0	194.10
194.11 07961 KDH - MC OB/GYN	2, 416, 154	0	1, 92	6 0	0	194.11
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)	18, 851, 253	6, 310, 506	527, 16	4 1, 774, 903	1, 145, 424	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 211291	21. 551318	1. 16616	8 40. 691052	23. 218211	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	1, 768, 329	2, 294, 842	104, 45	3 197, 015	335, 132	204. 00
205.00 Unit cost multiplier (Wkst. B, Part	0. 019820	7. 837227	0. 23106	6 4. 516724	6. 793262	205.00

Heal th Financial Systems COST ALLOCATION - STATISTICAL BASIS	KING'S DAUGHTE			eri od:	u of Form CMS-: Worksheet B-1	
			FI Te	rom 01/01/2015 p 12/31/2015	Date/Time Pre	pared:
Cost Center Description	CAFETERI A (MEALS SERVED)	NURSI NG ADMI NI STRATI ON (DI RECT	SUPPLY (COSTED	PHARMACY (COSTED REQUIS.)	5/18/2016 2:2 MEDI CAL RECORDS & LI BRARY (TI ME SPENT)	9 pm
	11.00	NRSING HRS) 13.00	REQUIS.) 14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS	1	1	1			
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.01 00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMI NI STRATI VE & GENERAL 7.00 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG 10.00 01100 CAFETERI A 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY 17.00 01700 SOCI AL SERVI CE 19.00 01900 NONPHYSI CI AN ANESTHETI STS 23.00 02300 RADI OLOGY SCHOOL 23.01 INPATI ENT ROUTI NE SERVI CE COST CENTERS	861, 304 7, 436 10, 137 22, 546 29, 892 7, 012 0 3, 424 20	375, 735 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	444, 558 4, 659 0 0 0 0 0	100 0 0 0 0 0 0	262, 469, 855 0 0 0 0 0	$\begin{array}{c} 1. \ 00\\ 1. \ 01\\ 2. \ 00\\ 4. \ 00\\ 5. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 11. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 19. \ 00\\ 23. \ 01\\ 23. \ 01\\ \end{array}$
30. 00 03000 ADULTS & PEDI ATRI CS	185, 061			0	13, 008, 657	30.00
31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY	28, 065		1, 072 0	0	2, 708, 803 1, 406, 264	
ANCI LLARY SERVI CE COST CENTERS			1	-		
50. 00 05000 OPERATI NG ROOM 51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 03630 ULTRA SOUND 54. 02 03450 NUCLEAR MEDI CI NE - DI AGNOSTI C 55. 00 03480 ONCOLOGY 57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 01 03610 SLEEP LAB 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 71. 01 07101 V SOLUTI ONS 72. 00 07200 IMPL. DEV. CHARGED	68, 780 7, 489 12, 009 16, 664 72, 048 3, 285 2, 339 28, 046 8, 398 4, 167 6, 542 80, 936 22, 722 57, 797 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7,489 12,009 0 <	2, 397 0 11, 071 3, 178 2, 324 2, 478 5, 025 1, 802 0 1, 556 24, 590 0 925 1, 661 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	27, 049, 386 5, 087, 506 1, 588, 057 5, 281, 754 6, 740, 656 1, 825, 080 4, 800, 178 5, 265, 296 14, 467, 894 4, 554, 609 2, 781, 778 29, 233, 907 1, 507, 592 5, 844, 407 11, 283, 312 0 0 1, 518, 650 8, 518, 324 2, 524, 691 12, 707, 497 58, 616, 807 9, 407, 176	$\begin{array}{c} 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 01\\ 54.\ 02\\ 55.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 00\\ 62.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 01\\ 71.\ 00\\ 71.\ 01\\ 72.\ 00\\ 73.\ 00\\ \end{array}$
76. 97 07697 CARDI AC REHABI LI TATI ON	3, 493		70	0	616, 452	
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 91.00 09100 92.00 085ERVATI ON BEDS (NON-DI STINCT PART) OTHER REIMBURSABLE COST CENTERS	2, 083 63, 697		10 28, 839	0 0	139, 101 19, 901, 628	90.00 91.00 92.00
95. 00 09500 AMBULANCE SERVICES	74, 730		1, 882	0	4, 084, 393	
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	C	0	2, 068	0	0	101.00
Instant Instant <thinstant< th=""> <thinstant< th=""> <thi< td=""><td>C 861, 006</td><td>0 375, 735</td><td>0 401, 165</td><td>0 100</td><td>0 262, 469, 855</td><td>113. 00 116. 00 118. 00</td></thi<></thinstant<></thinstant<>	C 861, 006	0 375, 735	0 401, 165	0 100	0 262, 469, 855	113. 00 116. 00 118. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 194.00 07950 OTHER NON-REIMBURSABLE 194.01 07951 MOB 194.02 07952 PHYSI CI AN CLI NI CS 194.03 07953 PHYS PRAC BUS OFC 194.04 07954 MOB - MAI N CAMPUS 194.05 07955 ONCOLOGY - NONREIMBURSABLE 194.06 07956 KDH - MC FAMI LY PRACTI CE 194.07 07957 KDH - MC ORTHOPEDI CS			0 227 3, 370 15, 967 0 357 0 5, 396 3, 307 3 329		0 0 0 0 0 0 0 0 0 0	190.00 194.00 194.01 194.02 194.03 194.04 194.05 194.06 194.07 194.08
194.08 07958 KDH - MC GENERAL SURGERY	0	0	3, 329	0	0	194.

Health Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period:	Worksheet B-1	
				rom 01/01/2015 o 12/31/2015		
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON		(COSTED	RECORDS &	
	SERVED)		SUPPLY	REQUIS.)	LI BRARY	
		(DI RECT	(COSTED		(TIME SPENT)	
		NRSING HRS)	REQUIS.)			
	11.00	13.00	14.00	15.00	16.00	
194.0907959KDH - MC ENT	0	0	1, 738	3 0	0	194.09
194.1007960 KDH - MC UROLOGY	0	0	3, 213	3 0	0	194.10
194.1107961 KDH - MC OB/GYN	0	0	6, 489	0	0	194. 11
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)	633, 856	419, 378	1, 067, 770	6, 497, 745	1, 670, 727	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 735926	1. 116154	2. 401869	64, 977. 450000	0.006365	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	138, 325	120, 284	176, 689	229, 027	321, 370	204.00
205.00 Unit cost multiplier (Wkst. B, Part	0. 160600	0. 320130	0. 397449	2, 290. 270000	0. 001224	205.00

Cost Center Description Social Service (SST 0000) Res IT (L = 108) (SST 0000) <thst 0000)<="" th=""> Res IT (L = 108) (SST 00</thst>	Health Financial Systems	KING'S DAUGHTE		CON 1500/0		u of Form CMS-2552-10
Cost Center Description Social Scription Social Scription (1):0 Balt Acad (0):00:00 (1):00:00 Balt Acad (0):00:00 (1):00:00 Balt Acad (0):00:00 (1):00:00 Balt Acad (0):00:00 Balt Acad (0):00:00:00:00:00:00:00:00:00:00:00:00:0	COST ALLOCATION - STATISTICAL BASIS		Provider	F	rom 01/01/2015	Worksheet B-1
AVESULE EVEN IT STS (SCI ORP) (VEST (WF) SCI ORD (VEST (WF) (VEST (WF) VFAR #FD (VEST (WF) (VEST (WF) VFAR #FD (VEST (WF) (VEST (WF) 100 100001 100001 100001 100001 100001 100001 100001 00001 WEST (WF) 100001 23.00 23.01 100001 100001 00001 WEST (WF) 000001 0000000000 000000000000000000000000000000000000	Cost Center Description					
SPERT TUP; TUP; QUEST Constraint 10 00101 NR3 Cop RL COST CENTERS 17.00 19.00 23.00 23.01 1.01 00101 NR3 Cop RL COST-SLUGE A INT INV/ND 10.00 10.00 10.00 10.00 1.00 00000 LUNDER'S ALLOST-SLUGE A INT INV/ND 40.00 40.00 40.00 0.00 00000 LUNDER'S ALLOST-SLUGE A INT INV/ND 40.00 40.00 40.00 0.00 00000 LUNDER'S ALLOST-SLUGE A INT INV/ND 40.00 70.00 70.00 0.00 00000 LUNDER'S ALLOST-SLUGE A INT INV/ND 40.00 70.00 70.00 0.00 00000 LUNDER'S ALLOST-SUPERY 11.00 70.00 70.00 1.00 01000 PARAMACY SUPPRY 11.00 70.00 70.00 1.00 01000 PARAMACY SUPPRY 13.20 0 70.00 70.00 1.00 01000 PARAMACY SUPPRY 13.20 0 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00	cost center bescription		ANESTHETI STS	SCHOOL	YEAR MED	
EVENTION 17.00 19.00 23.00 23.01 1.00 DOTON INS. OVER LOSTS-BLODE A HIT HEARHO 2.00 2.						
DELIGNUS SERVICE COST CENTERS 1.00 0.00000 NEB CAP REL COST SELUCE & FLYT MARKHO 1.00 0.00000 NEB CAP REL COST SELUCE & FLYT MARKHO 4.00 0.00000 NEB CAP REL COST SELUCE & FLYT MARKHO 4.00 0.00000 NEB CAP REL COST SELUCE & FLYT MARKHO 4.00 0.00000 NEB CAP REL COST SELUCE & FLYT MARKHO 5.00 0.00000 NEB CAP REL COST SELUCE & FLYT MARKHO 5.00 0.00000 NEB CARNIN STRATION OF NEARTINE N 9.00 0.00000 NEB CARNING ALL NEW SERVICE 9.00 0.00000 NEB CARNING ALL NEW SERVICE 9.00 0.0000 NEB CARNING ALL NEW SERVICE 9.00 0.0000 NEB CARNING ALL NEW SERVICE 13.203 0.0000 NEB CARNING ALL NEW SERVICES 13.203 0.0000 NEB CARNING ALL NEW SERVICES 13.203 0.0000 NEB CARNING SERVICE STURPTING 0 0.0000 NEB CARNING SERVICE COST CENTERS		17.00	19.00	23.00		
1.01 DOTOL HER OF HEL COST-BLUE & FLX HERAPD 2.00 0.00 DOTOL HER OF HEL COST-BLUE & FLX HERAPD 4.00 0.00 DOTOL HER OF HEL COST-BLUE & FLX HERAPD 4.00 0.00 DOTOL HER OF HEL COST-BLUE & FLX HERAPD 4.00 0.00 DOTOL HERAPTE BERNIT IS LEPARINEWI 5.00 0.00 DOTOL HERAPTE BERNIT SCHWALE CONTRACTORY 5.00 0.00 DOTOL HERAPTE BERNIT SCHWALE CONTRACTORY 10.00 0.00 DOTOL HERAPTE BERNIT SCHWALE CONTRACTORY 10.00 0.00 DOTOL HERAPTE BERNIT SCHWALE CONTRACTORY 10.00 0.00 DOTOL HERAPTE AND TRACTORY OF TRACTORY 13.00 1.000 DOTOL HERAPTE AND TRACTORY OF TRACTORY 13.00 0.00 DOTOL HERAPTE AND TRACTORY OF TRACTORY 10.00 0.00 DOTOL HERAPTE AND AND TRACTORY OF TRACTORY 10.00 <td></td> <td>17.00</td> <td>19.00</td> <td>23.00</td> <td>23.01</td> <td></td>		17.00	19.00	23.00	23.01	
2.00 00200 MU CAP SEL COSTS MUNIT TO UP 4.00 0 0 000 / MU CAP SEL COSTS MUNIT TO UP 4.00 0 0 000 / MU CAP SEL COSTS MUNIT TO UP 4.00 0 0 000 / MU CAP SEL COSTS MUNIT TO UP 4.00 0 0 000 / MUSER SET NO UP 4.00 0 0 000 / MUSER SET NO UP 4.00 0 0 000 / MUSER SET NO UP 4.00 0 0 000 / MUSER SET NO UP 4.00 0 0 000 / MUSER SET NO UP 4.00 0 0 000 / MUSER SET NO UP 4.00 0 0 000 / MUSER SET NO UP 4.00 0 0 000 / MUSER SET NO UP 4.00 0 0 000 / MUSER SET NO UP 4.00 0 0 000 / MUSER SET NO UP 4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
5.00 DORDOL AVAILINE STATUTE & GENERAL 5.00 S.00	2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP					2.00
7.00 000000000 000000000000000000000000000000000000						
9.00 00000 HUSEKEEP NG 9.00 00000 HUSEKEEP NG 9.00 00000 HUSEKEEP NG 9.00 00000 HASEKEE NG 9.00 10.00 11.00 11.00 01100 CAFETER A 10.00 11.00 1100 CAFETER A 10.00 11.0	7.00 00700 OPERATION OF PLANT					7.00
10. 00 01000 DETARY 10. 00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
11.00 01300 MURSING ADDING STRATION 13.00 13.00 13.00 13.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 15.0	10. 00 01000 DI ETARY					10.00
14.00 01400 CNNTRAL SERVICES & SUPPLY 14.00 14.00 14.00 15						
16.00 01400 MECLA RECORDS & LIBRARY 1 1 1 1 1 1 1 0 1 00 1 000 1 000 1 000 1 000 1 000 23.01 1 000 23.01 1 000 23.01 0 23.01 0 23.01 0 23.01 0 23.01 0 23.01 0 23.01 0 23.01 0 23.01 0 0 0 0 23.01 0	14.00 01400 CENTRAL SERVICES & SUPPLY					14.00
17.00 01700 SCRUICE SERVICE 13.203 17.00 23.00 02300 RADIOLOSY SCHOLD 0 1,000 23.00 23.00 02300 RADIOLOSY SCHOLD 0 1,000 23.00 23.00 02301 RADIESA END VEAR MED STUDENTS 0 0 0 23.00 23.00 03100 NITERS ENVICE COST CENTERS 0 0 0 31.00 20.00 05000 OPERATINE SERVICE COST CENTERS 0 0 0 0 20.00 05000 OPERATINE ROM 0 0 0 0 0 20.00 05000 OPERATINE ROM 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
23.00 02300 RADICLORY SCHOOL 23.00 23.00 23.01 23.00 23.	17.00 01700 SOCIAL SERVICE					
23.01 D2201 HUB SITE - 3RD YEAR NED STUDENTS 0 1,000 23.01 INPATTLER NOUTINE SERVICE COST CENTERS 10.650 0 0 0 30.00 <		0				
30. 00 03000 ADULTS & PEDIATELCS 10. 569 0 0 30. 00 50. 00 50. 00 50. 00 50. 00 50. 00 51. 00 52. 00 53. 00 53. 00 53. 00 53. 00 53. 00 54. 01 54. 01 54. 01 54. 01 54. 01 54. 01 54. 01 54. 01 54. 01 55. 00 54. 01 55. 00 54. 01 55. 00 56.	23.01 02301 HUB SITE - 3RD YEAR MED STUDENTS	0				
31.00 03100 INTERSING CARE UNIT 1,1440 0 0 31.00 ANDILLARY SERVICE COST CENTERS		10, 569	c		0	30.00
ANCILLARY SERVICE COST CENTERS 0.00 05000 (PREATIN, ROM 0 <	31. 00 03100 I NTENSI VE CARE UNI T	1, 440	с		0 0	31.00
50. 00 0500.00 0500.00 0500.00 050. 00 50. 00 51. 00 0500.00 RECOVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 53. 00 0 53.00 0 53.00 0 53.00 0 53.00 0 0 0 0 0 0 0 0 54. 00 54. 00 54. 00 54. 00 54. 00 54. 00 54. 00 54. 00 54. 00 55. 00 0 0 0 0 0 0 55. 00 0 0 0 0 0 55. 00 0 55. 00 0 55. 00 0 55. 00 0 55. 00 0 0 0 0 0 0 55. 00 0 <td></td> <td>1, 194</td> <td>C</td> <td>)(</td> <td>) 0</td> <td>43.00</td>		1, 194	C)() 0	43.00
52.00 05200 DELLYERY PROM & LABOR ROOM 0	50. 00 05000 OPERATI NG ROOM	0				
53.00 06300 ANESTNESS OLGGY 0 0 0 53.00 54.00 55.00 57.00 58.00 58.00 58.00 58.00 58.00 58.00 58.00 58.00 58.00 59.00 59.00 5		0				
54. 01 03630 ULTRA SOUND 0 0 0 54. 02 54. 02 03640 ONCLORY 0 0 0 55. 00 0 0 0 55. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 59. 00 71. 0	53. 00 05300 ANESTHESI OLOGY	0	C		0 0	
55.00 03480 0NCLOGY 0 0 0 55.00 57.00 <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td>		0				
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I18.00 SUBTOTALS (SUM OF LINES 1-117) 13,203 0 1,000 1,000 1,000 118.00 NORREI MBURSABLE COST CENTERS NORREI MBURSABLE COST CENTERS 190.00 0 0 0 0 190.00 0 0 190.00 190.00 190.00 0 0 0 190.00 190.00 0 0 0 190.00 190.00 194.00 0 0 0 0 190.00 194.00 0 0 0 0 194.00 0 0 0 0 194.00 194.01 194.02 07952 PHYSI CI AN CLINICS 0 0 0 0 194.02 0 0 0 194.02 07952 PHYSI CI AN CLINICS 0 0 0 194.02 07953 PHYS PRAC BUS OFC 0 0 0 194.02 194.03 07954 MOB - MAI N CAMPUS 0 0 0 194.03 194.03 194.04 07954 MOB - MAI N CAMPUS 0 0 0 194.05		0				
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 190.00 194.00 07950 OTHER NON-REI MBURSABLE 0 0 0 0 194.00 194.01 07950 OTHER NON-REI MBURSABLE 0 0 0 0 194.00 194.02 07952 PHYSI CI AN CLI NI CS 0 0 0 0 194.02 194.03 07953 PHYS PRAC BUS OFC 0 0 0 0 194.03 194.04 07954 MOB MAI N CAMPUS 0 0 0 194.04 194.05 07955 ONCOLOGY NONREI MBURSABLE 0 0 0 194.04 194.05 07956 KDH - MC FAMI LY PRACTICE 0 0 0 194.04 194.07 07956 KDH - MC ORTHOPEDI CS 0 0 0 194.07	118.00 SUBTOTALS (SUM OF LINES 1-117)	13, 203	C	1,000	1,000	
194.00 07950 OTHER NON-REI MBURSABLE 0 0 0 194.00 194.01 07951 MOB 0 0 0 0 194.01 194.02 07952 PHYSI CI AN CLI NI CS 0 0 0 0 194.02 194.03 07952 PHYSI CI AN CLI NI CS 0 0 0 0 194.02 194.03 07953 PHYS PRAC BUS OFC 0 0 0 0 194.03 194.04 07954 MOB - MAI N CAMPUS 0 0 0 194.04 194.05 07955 ONCOLOGY - NONREI MBURSABLE 0 0 0 194.04 194.05 07955 KDH - MC FAMI LY PRACTICE 0 0 0 194.05 194.07 07957 KDH - MC ORTHOPEDI CS 0 0 0 194.07		0				190.00
194.02 07952 PHYSICIAN CLINICS 0 0 0 194.02 194.03 07953 PHYS PRAC BUS OFC 0 0 0 194.03 194.04 07954 MOB - MAIN CAMPUS 0 0 0 194.04 194.05 07955 ONCOLOGY - NONREI MBURSABLE 0 0 0 194.05 194.06 07956 KDH - MC FAMILY PRACTICE 0 0 0 194.06 194.07 07957 KDH - MC ORTHOPEDICS 0 0 0 194.07	194.00 07950 OTHER NON-REIMBURSABLE	0	c		0	194.00
194.03 07953 PHYS PRAC BUS OFC 0 0 0 194.03 194.04 07954 MOB - MAIN CAMPUS 0 0 0 194.04 194.05 07955 ONCOLOGY - NONREI MBURSABLE 0 0 0 194.05 194.06 07956 KDH - MC FAMILY PRACTICE 0 0 0 194.06 194.07 07957 KDH - MC ORTHOPEDICS 0 0 0 194.07		0				
194.05 07955 0NCOLOGY - NONREI MBURSABLE 0 0 0 194.05 194.06 07956 KDH - MC FAMILY PRACTICE 0 0 0 194.06 194.07 07957 KDH - MC ORTHOPEDICS 0 0 0 194.07	194.03 07953 PHYS PRAC BUS OFC	0	C			194. 03
194.06 07956 KDH - MC FAMILY PRACTICE 0 0 0 194.06 194.07 07957 KDH - MC ORTHOPEDICS 0 0 0 194.07		0				
	194.06 07956 KDH - MC FAMILY PRACTICE	0	c			194.06
	194. 07 07957 KDH – MC ORTHOPEDI CS 194. 08 07958 KDH – MC GENERAL SURGERY	0				

Health Finar	ncial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Lie	u of Form CMS-2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1
					From 01/01/2015 To 12/31/2015	Date/Time Prepared: 5/18/2016 2:29 pm
	Cost Center Description	SOCI AL SERVI CE		RADI OLOGY	HUB SITE - 3RD	
			ANESTHETI STS	SCHOOL	YEAR MED	
		(TIME	(ASSI GNED	(ASSI GNED	STUDENTS	
		SPENT)	TIME)	TIME)	(ASSI GNED	
					TIME)	
		17.00	19.00	23.00	23.01	
194.0907959	KDH - MC ENT	0	0	(0 0	194.09
194.1007960	KDH - MC UROLOGY	0	0	(0 0	194.10
194. 11 07961	KDH - MC OB/GYN	0	0	(0 0	194. 11
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B,	418,044	0	200, 993	20, 832	202.00
	Part I)					
203.00	Unit cost multiplier (Wkst. B, Part I)	31.662804	0. 000000	200. 99300	20. 832000	203.00
204.00	Cost to be allocated (per Wkst. B,	82, 190	0	37, 55	3 344	204.00
	Part II)					
205.00	Unit cost multiplier (Wkst. B, Part	6. 225100	0. 000000	37.55300	0. 344000	205.00
1		ļ.		1		1

COMPUTATION OF RATIO OF COSTS TO C	HARGES		Provi der	CCN: 150069	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Pre	pared:
						Date/Time Pre 5/18/2016 2:2	9 pm
				e XVIII	Hospi tal	PPS	
Cost Center Descriptio	n	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE CC	ST CENTERS		2.00	0.00		0.00	
30. 00 03000 ADULTS & PEDI ATRI CS		12, 641, 522		12, 641, 5	22 0	12, 641, 522	30.00
31.00 03100 INTENSIVE CARE UNIT		1, 701, 950		1, 701, 9			
43.00 04300 NURSERY		701, 293		701, 2			
ANCI LLARY SERVICE COST CENTE	RS	1	I				
50. 00 05000 OPERATI NG ROOM		5, 026, 567		5, 026, 5	67 0	5, 026, 567	50.00
51.00 05100 RECOVERY ROOM		524, 737		524, 7			
52.00 05200 DELIVERY ROOM & LABOR	ROOM	602, 379		602, 3			
53. 00 05300 ANESTHESI OLOGY		343,007		343, 0			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		4, 924, 302		4, 924, 3			
54.01 03630 ULTRA SOUND		249,008		249,0			
54. 02 03450 NUCLEAR MEDICINE - DIA	GNOSTLC	383, 843		383, 8			
55. 00 03480 ONCOLOGY		2, 546, 112		2, 546, 1			
57. 00 05700 CT SCAN		794, 632		794, 6			
58.00 05800 MAGNETIC RESONANCE IMA	GING (MRI)	481, 269		481, 2			
59. 00 05900 CARDI AC CATHETERI ZATI 0		394, 826		394, 8			
60. 00 06000 LABORATORY		6, 590, 654		6, 590, 6			
62.00 06200 WHOLE BLOOD & PACKED R	ED BLOOD CELLS	403, 899		403, 8			
65. 00 06500 RESPIRATORY THERAPY	ED DEGOD GEELS	1, 118, 679	l a				
66. 00 06600 PHYSI CAL THERAPY		3, 790, 849					
67. 00 06700 OCCUPATI ONAL THERAPY		3, 7, 0, 047		3, 770, 0	0 0		1
68. 00 06800 SPEECH PATHOLOGY		0	-		0 0	-	
69. 00 06900 ELECTROCARDI OLOGY		0			0 0		
69. 01 03610 SLEEP LAB		363, 903		363, 9	-	-	
71. 00 07100 MEDICAL SUPPLIES CHARG	ED TO DATIENTS	4, 159, 713		4, 159, 7			
71.01 07101 IV SOLUTIONS	ED TO PATTENTS	4, 139, 713		4, 139, 7			
72.00 07200 IMPL. DEV. CHARGED TO		3, 682, 937		3, 682, 9			
73.00 07300 DRUGS CHARGED TO PATIE	PATTENTS	6, 870, 947		6, 870, 9			
73.00 07300 DRUGS CHARGED TO PATTE 76.00 03140 CARDI OLOGY	1115						
		1, 282, 409		1, 282, 4			
76. 97 07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENT		185, 374		185, 3	/4 0	185, 374	76.97
	EKS	263, 454		263, 4	E4 0	262 454	90.00
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY							
	DICTINCT DADT)	3, 772, 596		3, 772, 5		-,,	
92.00 09200 OBSERVATI ON BEDS (NON-		2, 648, 177		2, 648, 1	//	2, 648, 177	92.00
OTHER REIMBURSABLE COST CENT	EKS	2 500 200		2 500 2	00 (5	2 500 445	
95. 00 09500 AMBULANCE SERVICES		2, 590, 380		2, 590, 3			
101.00 10100 HOME HEALTH AGENCY	•	1, 524, 628		1, 524, 6	28	1, 524, 628	101.00
SPECIAL PURPOSE COST CENTERS				1			112 00
113.00 11300 INTEREST EXPENSE		240.014		240.0	1.4	240.014	113.00
116.00 11600 HOSPI CE	:>	349, 914		349, 9		349, 914	
200.00 Subtotal (see instruct	ions)	71, 049, 380	0	, , .		71, 102, 241	
201.00 Less Observation Beds		2, 648, 177	_	2, 648, 1		2, 648, 177	
202.00 Total (see instruction	S)	68, 401, 203	0	68, 401, 2	03 52, 861	68, 454, 064	202.00

DMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150069	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Pre 5/18/2016 2:2	
			e XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Charges Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
D. 00 03000 ADULTS & PEDIATRICS	13, 008, 657		13, 008, 65			30.0
1. 00 03100 INTENSIVE CARE UNIT	2, 708, 803		2, 708, 80			31.0
3. 00 04300 NURSERY	1, 406, 264		1, 406, 26	54		43. (
ANCI LLARY SERVI CE COST CENTERS	I					-
D. 00 05000 OPERATI NG ROOM	7, 266, 793	19, 782, 593			0.00000	
1.00 05100 RECOVERY ROOM	1, 431, 093	3, 656, 413			0.00000	
2. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 584, 118	3, 939			0.00000	
3. 00 05300 ANESTHESI OLOGY	1, 585, 204	3, 696, 550			0.00000	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 283, 776	5, 456, 880			0.00000	
4. 01 03630 ULTRA SOUND	245,601	1, 579, 478			0.00000	
4. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	303, 947	4, 496, 231	4, 800, 17		0.00000	
5. 00 03480 ONCOLOGY	67, 263	5, 198, 033			0.00000	
7. 00 05700 CT SCAN	2, 343, 745	12, 124, 149			0.00000	
3. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	270, 822	4, 283, 787	4, 554, 60		0.00000	
2. 00 05900 CARDIAC CATHETERIZATION D. 00 06000 LABORATORY	598, 988	2, 182, 791	2, 781, 77		0.00000	
	5, 182, 741	24, 051, 167			0.00000	
2. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 5. 00 06500 RESPIRATORY THERAPY	801, 331 4, 649, 597	706, 261 1, 194, 809	1, 507, 59 5, 844, 40		0. 000000 0. 000000	
5. 00 06600 PHYSI CAL THERAPY 7. 00 06700 0CCUPATI ONAL THERAPY	1, 405, 395 0	9, 877, 918		0. 335969 0. 000000	0. 000000 0. 000000	
3. 00 06800 SPEECH PATHOLOGY	0	0		0 0.000000	0. 000000	
2. 00 06800 SPEECH PATHOLOGY 2. 00 06900 ELECTROCARDI OLOGY	0	0		0 0.000000	0. 000000	
2. 01 03610 SLEEP LAB	0	0				
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	۲ ۱	1, 518, 650			0. 000000 0. 000000	
1. 01 07100 MEDICAL SUPPLIES CHARGED TO PATTENTS	3, 732, 343 1, 417, 541	4, 785, 982 1, 107, 150	8, 518, 32 2, 524, 69		0. 000000	
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	9, 550, 154	3, 157, 343			0. 000000	
3. 00 07200 TMPL. DEV. CHARGED TO PATIENTS 3. 00 07300 DRUGS CHARGED TO PATIENTS	27, 930, 913	30, 685, 894			0. 000000	
5. 00 03140 CARDI OLOGY	1, 855, 446	7, 551, 730			0. 000000	
5. 97 07697 CARDI OLOGI 5. 97 07697 CARDI AC REHABI LI TATI ON	679	615, 773			0. 000000	
OUTPATIENT SERVICE COST CENTERS	0/9	015,775	010, 40	0.300711	0.00000	/0.
0. 00 09000 CLINIC	1, 391	137, 710	139, 10	1. 893976	0. 000000	90.
1. 00 09100 EMERGENCY	3, 488, 661	16, 412, 967	19, 901, 62		0. 000000	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	566, 624	1, 844, 016			0. 000000	
OTHER REIMBURSABLE COST CENTERS		., 611, 610	2, 110, 0		0.00000	1
5. 00 09500 AMBULANCE SERVICES	8, 324	4, 076, 069	4, 084, 39	0. 634214	0. 000000	95.
D1. 00 10100 HOME HEALTH AGENCY	0	1, 969, 062				101.
SPECIAL PURPOSE COST CENTERS						1
13.00 11300 I NTEREST EXPENSE						113.
16. 00 11600 HOSPI CE	0	456, 761	456, 76	51		116.
00.00 Subtotal (see instructions)	94, 696, 214	172, 610, 106				200.
01.00 Less Observation Beds						201.
D2.00 Total (see instructions)	94, 696, 214	172, 610, 106	267, 306, 32	20		202.

Health Fi	nancial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lie	u of Form CMS-2	552-10
COMPUTATI	ION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150069	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prep 5/18/2016 2:29	
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
I N	PATIENT ROUTINE SERVICE COST CENTERS					
30.00 03	000 ADULTS & PEDIATRICS					30.00
31.00 03	100 INTENSIVE CARE UNIT					31.00
43.00 04	300 NURSERY					43.00
AN	CILLARY SERVICE COST CENTERS					
50.00 05	OOO OPERATING ROOM	0. 185829				50.00
	100 RECOVERY ROOM	0. 103142				51.00
	200 DELIVERY ROOM & LABOR ROOM	0. 379318				52.00
	300 ANESTHESI OLOGY	0.064942				53.00
	400 RADI OLOGY-DI AGNOSTI C	0. 730538				54.00
	630 ULTRA SOUND	0. 136437				54.01
	450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 079964				54.02
	480 ONCOLOGY	0. 483565				55.00
	1700 CT SCAN	0. 054924				57.00
	800 MAGNETIC RESONANCE IMAGING (MRI)	0. 105666				58.00
		1				59.00
	900 CARDI AC CATHETERI ZATI ON 9000 LABORATORY	0. 141933				60.00
	200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 227236				62.00
		0. 267910				
		0. 191410				65.00
	600 PHYSI CAL THERAPY	0. 335969				66.00
	000 OCCUPATI ONAL THERAPY	0.000000				67.00
	800 SPEECH PATHOLOGY	0.000000				68.00
	900 ELECTROCARDI OLOGY	0.000000				69.00
	610 SLEEP LAB	0. 239919				69.01
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 488325				71.00
	101 IV SOLUTIONS	0. 053638				71.01
	200 I MPL. DEV. CHARGED TO PATIENTS	0. 289824				72.00
	300 DRUGS CHARGED TO PATIENTS	0. 117218				73.00
	140 CARDI OLOGY	0. 136322				76.00
	697 CARDI AC REHABI LI TATI ON	0. 300711				76.97
	TPATIENT SERVICE COST CENTERS	1 00007				
		1.893976				90.00
	100 EMERGENCY	0. 189562				91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 098537				92.00
	HER REIMBURSABLE COST CENTERS					
	500 AMBULANCE SERVI CES	0. 634230				95.00
	100 HOME HEALTH AGENCY				· · · · · · · · · · · · · · · · · · ·	101. 00
	ECIAL PURPOSE COST CENTERS					
	300 INTEREST EXPENSE					113.00
116.0011	600 HOSPI CE					116.00
200.00	Subtotal (see instructions)				2	200. 00
201.00	Less Observation Beds				:	201.00
201.00						

Health Financial S		KING'S DAUGHTE				u of Form CMS-	2552-10
COMPUTATION OF RA	TIO OF COSTS TO CHARGES		Provi der	CCN: 150069	Period: From 01/01/2015	Worksheet C Part I	
					To 12/31/2015	Date/Time Pre 5/18/2016 2:2	epared: 9 pm
			Ti t	le XIX	Hospi tal	Cost	., b
					Costs		
Cost	Center Description	Total Cost (from Wkst. B,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		Part I, col.	-				
		26)					
		1.00	2.00	3.00	4.00	5.00	
	ROUTI NE SERVI CE COST CENTERS	12, 641, 522	1	12, 641, 5	22 0	12, 641, 522	30.00
	SIVE CARE UNIT	1, 701, 950		1, 701, 9			
43.00 04300 NURSE		701, 293		701, 2			
	SERVICE COST CENTERS	1011270		10112		1011/2/0	101.00
50.00 05000 OPERA		5, 026, 567		5, 026, 5	67 0	5, 026, 567	50.00
51.00 05100 RECOV	ERY ROOM	524, 737		524, 73	37 0	524, 737	51.00
52.00 05200 DELI V	'ERY ROOM & LABOR ROOM	602, 379		602, 3	79 0	602, 379	52.00
53.00 05300 ANEST		343, 007		343, 00	07 0	343, 007	53.00
	LOGY-DI AGNOSTI C	4, 924, 302		4, 924, 30		4, 924, 302	
54.01 03630 ULTRA		249, 008		249,00		249, 008	
	AR MEDICINE - DIAGNOSTIC	383, 843		383, 84		383, 843	
55.00 03480 ONCOL		2, 546, 112		2, 546, 1		2, 546, 112	
57.00 05700 CT SC		794, 632		794, 6		794, 632	
	TIC RESONANCE IMAGING (MRI)	481, 269		481, 20		481, 269	
59.00 05900 CARDI 60.00 06000 LABOR	AC CATHETERI ZATI ON	394, 826 6, 590, 654		394, 82 6, 590, 6		394, 826 6, 643, 000	
	BLOOD & PACKED RED BLOOD CELLS	403, 899		403, 8		403, 899	
	RATORY THERAPY	1, 118, 679				1, 118, 679	
	CAL THERAPY	3, 790, 849		.,		3, 790, 849	
	ATIONAL THERAPY	0			0 0	0	
	H PATHOLOGY	0			0 0	0	
	ROCARDI OLOGY	0			0 0	0	
69.01 03610 SLEEP	LAB	363, 903		363, 90	03 450	364, 353	69.01
71.00 07100 MEDIC	AL SUPPLIES CHARGED TO PATIENTS	4, 159, 713		4, 159, 7	13 0	4, 159, 713	71.00
71.01 07101 IV SO	LUTIONS	135, 420		135, 42	20 0	135, 420	71.01
	DEV. CHARGED TO PATIENTS	3, 682, 937		3, 682, 93		3, 682, 937	
	CHARGED TO PATIENTS	6, 870, 947		6, 870, 9		6, 870, 947	
76.00 03140 CARDI		1, 282, 409		1, 282, 40		1, 282, 409	
	AC REHABILITATION	185, 374		185, 3	74 0	185, 374	76.97
	SERVICE COST CENTERS	2/2 454	1	2(2,4)	- 4	2/2 454	
90.00 09000 CLINI 91.00 09100 EMERG		263, 454		263, 4		263, 454	
	VATION BEDS (NON-DISTINCT PART)	3, 772, 596 2, 648, 177		3, 772, 5 2, 648, 1		3, 772, 596 2, 648, 177	
	BURSABLE COST CENTERS	2,040,177		2,040,1		2, 040, 177	92.00
95.00 09500 AMBUL		2, 590, 380		2, 590, 3	30 65	2, 590, 445	95.00
101.00 10100 HOME		1, 524, 628		1, 524, 62		1, 524, 628	
	RPOSE COST CENTERS	., 52., 520	1	., 021, 0.		., 32 ., 820	1
113.00 11300 I NTER							113.00
116.00 11600 HOSPI		349, 914		349, 9	14	349, 914	
	tal (see instructions)	71, 049, 380				71, 102, 241	
201.00 Less	Observation Beds	2, 648, 177		2, 648, 1	77	2, 648, 177	
202.00 Total	(see instructions)	68, 401, 203	l o	68, 401, 20	52, 861	68, 454, 064	202 00

MPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150069	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Pre 5/18/2016 2:2	
			le XIX	Hospi tal	Cost	
Cost Center Description	I npati ent	Charges Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
0. 00 03000 ADULTS & PEDIATRICS	13, 008, 657		13, 008, 65			30.0
. 00 03100 I NTENSI VE CARE UNI T	2, 708, 803		2, 708, 80			31.0
3. 00 04300 NURSERY	1, 406, 264		1, 406, 26	54		43.0
ANCI LLARY SERVICE COST CENTERS		40 300 500	07.040.00		0.000000	1
0. 00 05000 OPERATING ROOM	7, 266, 793	19, 782, 593			0.00000	
0. 00 05100 RECOVERY ROOM	1, 431, 093	3, 656, 413			0.00000	
2. 00 05200 DELIVERY ROOM & LABOR ROOM 3. 00 05300 ANESTHESIOLOGY	1, 584, 118	3, 939			0.00000	
3. 00 05300 ANESTHESI OLOGY 1. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 585, 204 1, 283, 776	3, 696, 550 5, 456, 880			0. 000000 0. 000000	
I. 01 03630 ULTRA SOUND	245, 601	1, 579, 478			0. 000000	
I. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	303, 947	4, 496, 231			0. 000000	
5. 00 03480 ONCOLOGY	67, 263	5, 198, 033			0. 000000	
7. 00 05700 CT SCAN	2, 343, 745	12, 124, 149			0. 000000	
3. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 343, 743 270, 822	4, 283, 787			0. 000000	
2. 00 05900 CARDI AC CATHETERI ZATI ON	598, 988	4, 203, 707 2, 182, 791			0. 000000	
). 00 06000 LABORATORY	5, 182, 741	24, 051, 167			0. 000000	
2.00 06200 HABORATORY 2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CE		706, 261	1, 507, 59		0. 000000	
5. 00 06500 RESPIRATORY THERAPY	4, 649, 597	1, 194, 809			0. 000000	
0. 00 06600 PHYSI CAL THERAPY	1, 405, 395	9, 877, 918			0. 000000	
7. 00 06700 OCCUPATIONAL THERAPY	1, 405, 395	9, 077, 910		0.000000	0. 000000	
3. 00 06800 SPEECH PATHOLOGY	0	0		0 0.000000	0. 000000	
2. 00 06900 ELECTROCARDI OLOGY	0	0		0 0.000000	0.000000	
2. 01 03610 SLEEP LAB	0	1, 518, 650			0. 000000	
00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	0	4, 785, 982			0.000000	
1. 01 07101 IV SOLUTIONS	1, 417, 541	1, 107, 150			0.000000	
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	9, 550, 154	3, 157, 343			0. 000000	
3. 00 07200 TMPE. DEV. CHARGED TO PATIENTS	27, 930, 913	30, 685, 894			0. 000000	
5. 00 03140 CARDI OLOGY	1, 855, 446	7, 551, 730			0. 000000	
5. 97 07697 CARDI AC REHABI LI TATI ON	679	615, 773			0. 000000	
OUTPATIENT SERVICE COST CENTERS	077	015,775	010, 40	0. 300711	0.00000	/0.
0. 00 09000 CLINIC	1, 391	137, 710	139, 10	1. 893976	0.00000	90.
. 00 09100 EMERGENCY	3, 488, 661	16, 412, 967			0.000000	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PA		1, 844, 016			0. 000000	
OTHER REIMBURSABLE COST CENTERS		1, 044, 010	2, 410, 02	1.070337	0.00000	1 /2.
5. 00 09500 AMBULANCE SERVICES	8, 324	4, 076, 069	4, 084, 39	0. 634214	0.00000	95.
01. 00 10100 HOME HEALTH AGENCY	0,021	1, 969, 062			21 000000	101.
SPECIAL PURPOSE COST CENTERS		.,,	.,,			1
3. 00 11300 I NTEREST EXPENSE						113.
6. 00 11600 HOSPI CE	0	456, 761	456, 76	51		116.
0.00 Subtotal (see instructions)	94, 696, 214	172, 610, 106				200.
1.00 Less Observation Beds	, 1, 0, 0, 214	1,2,010,100	207,000,02	~		200.
2.00 Total (see instructions)	94, 696, 214	172, 610, 106	267, 306, 32			201.

Heal th F	inancial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lie	u of Form CMS-255	52-10
COMPUTA	TION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150069	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepar 5/18/2016 2:29 p	red: pm
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Rati o				
		11.00				
	NPATIENT ROUTINE SERVICE COST CENTERS	1				
	03000 ADULTS & PEDIATRICS					30.00
	03100 INTENSIVE CARE UNIT				31	31.00
	04300 NURSERY				43	43.00
A	NCILLARY SERVICE COST CENTERS					
50.00 0	5000 OPERATING ROOM	0. 000000			50	50.00
51.00 0	5100 RECOVERY ROOM	0. 000000			51	51.00
52.00 0	5200 DELIVERY ROOM & LABOR ROOM	0. 000000			52	52.00
53.00 0	5300 ANESTHESI OLOGY	0. 000000			53	53.00
54.00 0	95400 RADI OLOGY-DI AGNOSTI C	0. 000000			54	54.00
	03630 ULTRA SOUND	0. 000000				54.01
	3450 NUCLEAR MEDICINE - DIAGNOSTIC	0.000000				54. 02
	3480 ONCOLOGY	0.000000				55. 00
	05700 CT SCAN	0.000000				55.00 57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000				58.00
	5900 CARDI AC CATHETERI ZATI ON	0. 000000				59.00
	6000 LABORATORY	0. 000000				50.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000				52.00
	06500 RESPI RATORY THERAPY	0.000000				65.00
	6600 PHYSI CAL THERAPY	0. 000000				56.00
67.00 0	06700 OCCUPATI ONAL THERAPY	0. 000000			6	57.00
	06800 SPEECH PATHOLOGY	0. 000000			68	58.00
69.00 0	6900 ELECTROCARDI OLOGY	0. 000000			69	59.00
69.01 0	3610 SLEEP LAB	0. 000000			60	59.01
71.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			7'	71. OC
71.01 0	07101 IV SOLUTIONS	0. 000000			7	71.01
72.00 0	7200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			7:	72.00
	7300 DRUGS CHARGED TO PATIENTS	0, 000000			7	73.00
	03140 CARDI OLOGY	0.000000			70	76.00
	07697 CARDI AC REHABI LI TATI ON	0.000000				76.97
-	UTPATIENT SERVICE COST CENTERS					
	99000 CLINIC	0.000000			90	90.00
	09100 EMERGENCY	0.000000				90.00 91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000				71.00 72.00
	THER REIMBURSABLE COST CENTERS	0.000000			7.	/2.00
	09500 AMBULANCE SERVICES	0.000000				
		0. 000000				95.00
-	0100 HOME HEALTH AGENCY				10	01.00
	PECIAL PURPOSE COST CENTERS	1				
	1300 INTEREST EXPENSE					13.00
	1600 HOSPI CE					16.00
200.00	Subtotal (see instructions)					00.00
201.00	Less Observation Beds					01.00
202.00	Total (see instructions)				203	02.00

Health Financial Systems	KING'S DAUGHTE	RS' H	IOSPI TAL			In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS		Provi der	CCN: 150069	Peri oc		Worksheet D	
						01/01/2015	Part I	
					To ´	2/31/2015		pared:
			T 11	20/11/1			5/18/2016 2:2	9 pm
				e XVIII		spi tal	PPS	
Cost Center Description	Capi tal		ing Bed	Reduced	lota		Per Diem (col.	
	Related Cost	Adj	ustment	Capi tal		Days	3 / col. 4)	
	(from Wkst. B,			Related Cos				
	Part II, col.			(col. 1 - col	l .			
	26)			2)				
	1.00		2.00	3.00		4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00 ADULTS & PEDIATRICS	2, 829, 566		0	2, 829, 5	66	13, 371	211.62	30.00
31.00 INTENSIVE CARE UNIT	162, 609			162, 60	09	1, 440	112.92	31.00
43.00 NURSERY	123, 483			123, 48	83	1, 194	103. 42	43.00
200.00 Total (lines 30-199)	3, 115, 658			3, 115, 6	58	16, 005		200.00
Cost Center Description	I npati ent	١n	pati ent					
	Program days	P	rogram					
		Capi	tal Cost					
		(coi.	5 x col.					
			6)					
	6,00		7.00	1				
INPATIENT ROUTINE SERVICE COST CENTERS							-	
30.00 ADULTS & PEDIATRICS	6, 313		1, 335, 957					30.00
31. 00 I NTENSI VE CARE UNI T	918		103, 661	1				31.00
43. 00 NURSERY	0		00,001	1				43.00
200.00 Total (lines 30-199)	7, 231		1, 439, 618					200.00
200.0010101 (11163 30-177)	1,231	I	1,437,010	'I				1200.00

Health Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT/	AL COSTS		CCN: 150069	Period: From 01/01/2015 To 12/31/2015	Date/Time Pre 5/18/2016 2:2	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	1	1	1	1	r	
50. 00 05000 OPERATI NG ROOM	1, 118, 960					
51.00 05100 RECOVERY ROOM	89, 720					
52.00 05200 DELIVERY ROOM & LABOR ROOM	19, 085				Ű	52.00
53. 00 05300 ANESTHESI OLOGY	24, 504					•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	653, 741					•
54.01 03630 ULTRA SOUND	8, 654					
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	37, 728	4, 800, 178				
55. 00 03480 ONCOLOGY	678, 423	5, 265, 296			5, 705	55.00
57.00 05700 CT SCAN	79, 287					57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	68, 979					
59. 00 05900 CARDI AC CATHETERI ZATI ON	55, 412	2, 781, 779	0. 01992	20 323, 738	6, 449	59.00
60. 00 06000 LABORATORY	479, 033	29, 233, 908	0. 01638	3, 441, 021	56, 385	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	22, 324	1, 507, 592	0. 01480	08 429, 877	6, 366	62.00
65. 00 06500 RESPI RATORY THERAPY	88, 738	5, 844, 406	0. 01518	3, 426, 765	52, 029	65.00
66. 00 06600 PHYSI CAL THERAPY	824, 437	11, 283, 313	0. 07306	67 985, 500	72, 008	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	0.0000	0 00	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.0000	0 00	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.0000	0 00	0	69.00
69.01 03610 SLEEP LAB	52, 014	1, 518, 650	0.0342	50 0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	77,603	8, 518, 325	0.0091	1, 672, 761	15, 239	71.00
71.01 07101 IV SOLUTIONS	5,043			77 788, 381	1, 574	71.01
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	74, 493	12, 707, 497	0.00586	52 5, 199, 734	30, 481	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	300, 880	58, 616, 807	0.00513	33 17, 175, 566	88, 162	73.00
76. 00 03140 CARDI OLOGY	343, 396	9, 407, 176	0. 03650	1, 377, 136	50, 271	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	40, 776					76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	44,037	139, 101	0. 31658	33 51	16	90.00
91.00 09100 EMERGENCY	848, 856					
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	592, 744					•
OTHER REIMBURSABLE COST CENTERS		,, 510				1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	6, 628, 867	243, 672, 380		44, 891, 600	820, 198	

Health Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS			Period: From 01/01/2015 To 12/31/2015	Date/Time Pre 5/18/2016 2:2	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos	t Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0)	0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0 0		0	0	31.00
43. 00 04300 NURSERY	0	o c		0	0	43.00
200.00 Total (lines 30-199)	0			0	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	I npati ent	Inpati ent		
	Days	$5 \div col. 6)$	Program Days			
				Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6,00	7.00	8,00	9,00	1	
INPATIENT ROUTINE SERVICE COST CENTERS	0100	1 1100	0.00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1	
30. 00 03000 ADULTS & PEDI ATRI CS	13, 371	0.00	6, 31	3 0		30.00
31. 00 03100 I NTENSI VE CARE UNI T	1, 440					31.00
43. 00 04300 NURSERY	1, 194					43.00
200.00 Total (lines 30-199)				1 0		200.00
200.00 [10tal (11165 30-199)	16, 005	1	7,23	0	I	1200.00

Health Financial Systems	KING'S DAUGHTE			In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	5 Provi der	CCN: 150069	Period: From 01/01/2015 To 12/31/2015		pared: 9 nm
		Ti †I	e XVIII	Hospi tal	PPS	7 pm
Cost Center Description	Non Physician	Nursing School	Allied Healt		Total Cost	
	Anesthetist	and string contool		Medi cal	(sum of col 1	
	Cost			Education Cost		
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	()	0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	(0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	(0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	(0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	(221, 8	25 0	221, 825	54.00
54.01 03630 ULTRA SOUND	0	(0 0	0	54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	(0 0	0	54.02
55. 00 03480 ONCOLOGY	0	(0 0	0	55.00
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 0	0	59.00
60. 00 06000 LABORATORY	0	(0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	(0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0	(0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	(0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	(0 0	0	67. OC
68.00 06800 SPEECH PATHOLOGY	0	(0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	(0 0	0	69.00
69. 01 03610 SLEEP LAB	0	(0 0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(0 0	0	71.00
71.01 07101 IV SOLUTIONS	0	(0 0	0	71.01
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	(0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	(0 0	0	73.00
76. 00 03140 CARDI OLOGY	0	(0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	(0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0	(0 0	0	90.00
91. 00 09100 EMERGENCY	0	(0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	(0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50-199)	0	(221, 8	25 0	221, 825	200.00

Health Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provi der		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2015 To 12/31/2015		narodi
				10 12/31/2015	5/18/2016 2:2	9 nm
		Ti tl	e XVIII	Hospi tal	PPS	7 pm
Cost Center Description	Total	Total Charges			Inpati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.		. to Charges	Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.	J	
	4)		Í	7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS	-					
50. 00 05000 OPERATI NG ROOM	0	27, 049, 386	0.00000	0 0.000000	3, 293, 753	50.00
51.00 05100 RECOVERY ROOM	0			0.000000		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	1, 588, 057	0. 00000	0.000000	0	52.00
53.00 05300 ANESTHESI OLOGY	0	5, 281, 754				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	221, 825					
54. 01 03630 ULTRA SOUND	0	1, 825, 079				54.01
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	4, 800, 178				
55. 00 03480 ONCOLOGY	0	5, 265, 296				55.00
57. 00 05700 CT SCAN	0					
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	4, 554, 609				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0					•
60. 00 06000 LABORATORY	0					60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1, 507, 592				
65. 00 06500 RESPIRATORY THERAPY	0					
66. 00 06600 PHYSI CAL THERAPY	0					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	11,200,010				67.00
68. 00 06800 SPEECH PATHOLOGY						68.00
69. 00 06900 ELECTROCARDI OLOGY						69.00
69. 01 03610 SLEEP LAB		1, 518, 650				69.01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		8, 518, 325				71.00
71. 01 07101 I V SOLUTIONS	0	2, 524, 691				
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		12, 707, 497				
73. 00 07300 DRUGS CHARGED TO PATIENTS						•
76. 00 03140 CARDI OLOGY		9, 407, 176				
76. 97 07697 CARDI AC REHABI LI TATI ON						•
OUTPATIENT SERVICE COST CENTERS		010, 432	0.00000	0 0.000000	200	/0. //
90. 00 09000 CLINIC	0	139, 101	0.00000	0 0. 000000	51	90.00
91. 00 09100 EMERGENCY						91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						
OTHER REIMBURSABLE COST CENTERS		2, 410, 040	0.00000	0.00000	500,210	/2.00
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	221, 825	243, 672, 380			44, 891, 600	
	221,023	270,012,000	I	1	1 77,071,000	200.00

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	KING'S DAUGHTE		CCN: 150069		eu of Form CMS-2552- Worksheet D
THROUGH COSTS	RVICE UTHER PASS	Provider	CCN: 120069	Period: From 01/01/201	
				To 12/31/201	5 Date/Time Prepared
				11	5/18/2016 2:29 pm
Cost Conton Decerintion	Innationt	Outpatient	e XVIII Outpatient	Hospi tal	PPS
Cost Center Description	Inpatient Program	Program	Program		
	Pass-Through	Charges	Pass-Throug	h	
	Costs (col. 8	charges	Costs (col.		
	x col. 10)		x col. 12)	/	
	11.00	12.00	13.00		
ANCI LLARY SERVI CE COST CENTERS	11100	12100	10100		
50. 00 05000 OPERATI NG ROOM	0	7, 673, 472		0	50.0
51.00 05100 RECOVERY ROOM	0	871, 947		0	51.0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	52.0
53. 00 05300 ANESTHESI OLOGY	0	876, 359		0	53.0
54.00 05400 RADI OLOGY-DI AGNOSTI C	29, 959	1, 647, 382	54, 2	14	54.0
54.01 03630 ULTRA SOUND	0	284, 948		0	54.0
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	2,067,659		0	54.0
55. 00 03480 ONCOLOGY	0	2, 518, 957		0	55.0
57.00 05700 CT SCAN	0	4, 285, 764		0	57.0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1, 380, 050		0	58.0
59.00 05900 CARDI AC CATHETERI ZATI ON	0	1, 016, 196		0	59.0
60. 00 06000 LABORATORY	0	2, 804, 375		0	60. (
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	245, 427		0	62.0
65. 00 06500 RESPI RATORY THERAPY	0	371, 523		0	65.0
66. 00 06600 PHYSI CAL THERAPY	0	3, 319		0	66.0
57.00 06700 OCCUPATI ONAL THERAPY	0	0		0	67.0
58.00 06800 SPEECH PATHOLOGY	0	0		0	68. (
59. 00 06900 ELECTROCARDI OLOGY	0	0		0	69. (
69. 01 03610 SLEEP LAB	0	521, 604		0	69. (
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	941, 429		0	71.0
71.01 07101 IV SOLUTIONS	0	295, 175		0	71.0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 538, 602		0	72.0
73.00 07300 DRUGS CHARGED TO PATIENTS	0	13, 064, 555		0	73.0
76. 00 03140 CARDI OLOGY	0	3, 579, 501		0	76.0
76. 97 07697 CARDIAC REHABILITATION	0	264, 955		0	76.
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0	14, 674		0	90. (
91. 00 09100 EMERGENCY	0	3, 940, 064		0	91. (
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	632, 597		0	92.
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES					95.0
200.00 Total (lines 50-199)	29, 959	50, 840, 534	54, 2	14	200. (

PPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	ND VACCINE COST		CCN: 150069	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Pre 5/18/2016 2:2	pared: 29 pm
		Titl	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)			
	1.00	2.00	3.00	4.00	5.00	<u> </u>
ANCI LLARY SERVI CE COST CENTERS			1			4
0. 00 05000 OPERATI NG ROOM	0. 185829			0 0	1, 425, 954	
I. 00 05100 RECOVERY ROOM	0. 103142			0 0	89, 934	
2.00 05200 DELIVERY ROOM & LABOR ROOM	0. 379318			0 0	0	
3. 00 05300 ANESTHESI OLOGY	0. 064942			0 0	56, 913	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 730538			0 0	1, 203, 475	1
I. 01 03630 ULTRA SOUND	0. 136437			0 0	38, 877	1
4.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 079964			0 0	165, 338	
5. 00 03480 ONCOLOGY	0. 483565			0 10	1, 218, 079	
7. 00 05700 CT SCAN	0. 054924			0 0	235, 391	
3.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 105666			0 0	145, 824	
9. 00 05900 CARDI AC CATHETERI ZATI ON	0. 141933			0 0	144, 232	
D. 00 06000 LABORATORY	0. 225446				632, 235	
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 267910			0 0	65, 752	
5. 00 06500 RESPI RATORY THERAPY	0. 191410			0 0	71, 113	
5. 00 06600 PHYSI CAL THERAPY	0. 335969			0 0	1, 115	
7. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			0 0	0	
3. 00 06800 SPEECH PATHOLOGY	0. 000000			0 0	0	68.00
9. 00 06900 ELECTROCARDI OLOGY	0. 000000			0 0	0	
9. 01 03610 SLEEP LAB	0. 239623			0 0	124, 988	
I. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 488325			0 0	459, 723	
I. 01 07101 I V SOLUTI ONS	0. 053638			0 0	15, 833	
2.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 289824			0 0	445, 924	1
3. 00 07300 DRUGS CHARGED TO PATIENTS	0. 117218			0 30, 770	1, 531, 401	
5. 00 03140 CARDI OLOGY	0. 136322			0 0	487, 965	
5. 97 07697 CARDI AC REHABI LI TATI ON	0. 300711	264, 955		0 0	79, 675	76.97
OUTPATIENT SERVICE COST CENTERS	1 00007/	1	1		07.700	
0.00 09000 CLINIC	1.893976			0 0	27, 792	
I. 00 09100 EMERGENCY	0. 189562			0 23		
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 098537	632, 597	l	0 0	694, 931	92.00
OTHER REIMBURSABLE COST CENTERS	0 (0):01	1				05 65
5. 00 09500 AMBULANCE SERVICES	0. 634214			0	40 400 050	95.00
00.00 Subtotal (see instructions)		50, 840, 534	1, 8		10, 109, 350	1
01.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
000 Only Charges 02.00 Net Charges (line 200 +/- line 201)		50, 840, 534	1, 8	30, 803	10, 109, 350	200 0

	nanci al Systems	KING'S DAUGHTE		0011 4500/0		u of Form CMS-	-2552-1
APPORTI ONI	MENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 150069	Period: From 01/01/2015	Worksheet D Part V	
					To 12/31/2015	Date/Time Pr	
			Ti †I	e XVIII	Hospi tal	5/18/2016 2:: PPS	29 pm
		Cos			nospi tui	110	
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To Ded. & Coins.				
		Ded. & Coins. (see inst.)	(see inst.)				
		6.00	7.00				
ANC	CILLARY SERVICE COST CENTERS	0.00	7.00				
	DOO OPERATING ROOM	0	0				50.00
51.00 051	IOO RECOVERY ROOM	0	0				51.00
52.00 052	200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53.00 053	300 ANESTHESI OLOGY	0	0				53.00
54.00 054	100 RADI OLOGY-DI AGNOSTI C	0	0				54.00
	530 ULTRA SOUND	0	0				54.0
	150 NUCLEAR MEDICINE - DIAGNOSTIC	0	0				54.02
	180 ONCOLOGY	0	5				55.0
	700 CT SCAN	0	0				57.0
	300 MAGNETIC RESONANCE I MAGING (MRI)	0	0				58.00
	200 CARDI AC CATHETERI ZATI ON	0	0				59.00
	DOO LABORATORY	424	0				60.00
	200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0					62.00
	500 RESPI RATORY THERAPY 500 PHYSI CAL THERAPY	0					65.00 66.00
	700 OCCUPATIONAL THERAPY	0					67.0
	BOO SPEECH PATHOLOGY	0					68.0
	200 ELECTROCARDI OLOGY	0	0				69.00
	510 SLEEP LAB	0	0				69.0
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.0
	IO1 I V SOLUTIONS	0	0				71.0
72.00 072	200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.0
73.00 073	BOO DRUGS CHARGED TO PATIENTS	0	3, 607				73.0
76.00 031	40 CARDI OLOGY	0	0				76.00
	597 CARDI AC REHABI LI TATI ON	0	0				76. 9
	PATIENT SERVICE COST CENTERS						
	DOO CLINIC	0	0				90.00
	IOO EMERGENCY	0	4				91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
	IER REI MBURSABLE COST CENTERS						
	500 AMBULANCE SERVICES	0					95.00
200.00	Subtotal (see instructions)	424	3, 616				200.00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
1	Only Charges Net Charges (line 200 +/- line 201)	424	3, 616				202.00

APPORTI ONMI	ENT OF MEDICAL, OTHER HEALTH SERVICES AND) VACCINE COST	Provi der	CCN: 150069	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Pre 5/18/2016 2:2	epared: 29 pm
			Ti	tle XIX	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimburse	d Cost	Cost	PPS Services	
		Ratio From	Services (see	Rei mbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)			
		1.00	2.00	3.00	4.00	5.00	
	LLARY SERVICE COST CENTERS	1					
	O OPERATI NG ROOM	0. 185829		D	0 3, 804, 327	0	
	O RECOVERY ROOM	0. 103142		D	0 788, 610	0	
	O DELIVERY ROOM & LABOR ROOM	0. 379318		D	0 5, 023	0	
	O ANESTHESI OLOGY	0. 064942		D	0 761, 529	0	53.00
54.00 0540	0 RADI OLOGY-DI AGNOSTI C	0. 730538	(0 992, 542	0	54.00
54.01 0363	OULTRA SOUND	0. 136437	(0 426, 902	0	54.01
54.02 0345	ONUCLEAR MEDICINE - DIAGNOSTIC	0. 079964	(D	0 414, 584	0	54.02
55.00 0348	ONCOLOGY	0. 483565	(D	0 330, 781	0	55.00
57.00 0570	O CT SCAN	0. 054924	(0 1, 839, 329	0	57.00
58.00 0580	O MAGNETIC RESONANCE IMAGING (MRI)	0. 105666	(0 758, 873	0	58.00
59.00 0590	O CARDI AC CATHETERI ZATI ON	0. 141933	(D	0 294, 740	0	59.00
60.00 0600	0 LABORATORY	0. 225446	(0 4, 187, 429	0	60.00
62.00 0620	O WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 267910	(0 88, 652	0	62.00
65.00 0650	0 RESPI RATORY THERAPY	0. 191410	(0 213, 731	0	65.00
66.00 0660	0 PHYSI CAL THERAPY	0. 335969	(0 1, 443, 948	0	66.00
67.00 0670	O OCCUPATI ONAL THERAPY	0. 000000	(0 0	0	67.00
68.00 0680	O SPEECH PATHOLOGY	0. 000000	(0 0	0	68.00
69.00 0690	0 ELECTROCARDI OLOGY	0. 000000	(0 0	0	69.00
69.01 0361	O SLEEP LAB	0. 239623	(0 257, 743	0	69.01
71.00 0710	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 488325	(0 58, 450	0	71.00
71.01 0710	1 I V SOLUTIONS	0. 053638	(0 205, 201	0	71.01
72.00 0720	OIMPL. DEV. CHARGED TO PATIENTS	0. 289824	(0 0	0	72.00
73.00 0730	O DRUGS CHARGED TO PATIENTS	0. 117218	(0 3, 245, 631	0	73.00
76.00 0314	O CARDI OLOGY	0. 136322	(0 857, 682	0	76.00
76.97 0769	7 CARDI AC REHABI LI TATI ON	0. 300711			0 15, 771	0	76.97
OUTP	ATIENT SERVICE COST CENTERS			·			
90.00 0900	O CLINIC	1. 893976	(0 10, 970	0	90.00
91.00 0910	OEMERGENCY	0. 189562	(0 5, 186, 663	0	91.00
92.00 0920	O OBSERVATION BEDS (NON-DISTINCT PART)	1.098537	(0 1, 161, 807	0	92.00
	R REIMBURSABLE COST CENTERS		·	·			1
95.00 0950	O AMBULANCE SERVI CES	0. 634214	(0		95.00
200.00	Subtotal (see instructions)		(0 27, 350, 918	0	200.00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges						

Health Financial Systems	KING'S DAUGHTE				u of Form CMS	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	AND VACCINE COST	Provi der	CCN: 150069	Peri od: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Pro 5/18/2016 2::	
		Tit		Hospi tal	Cost	27 pm
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS		1				
50.00 05000 OPERATI NG ROOM	0					50.00
51.00 05100 RECOVERY ROOM	0					51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0					52.00
53.00 05300 ANESTHESI OLOGY	0					53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	725, 090				54.00
54.01 03630 ULTRA SOUND	0					54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0					54.02
55.00 03480 ONCOLOGY	0	1077701				55.00
57.00 05700 CT SCAN	0					57.00
58.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI)	0					58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	11,000				59.00
60.00 06000 LABORATORY	0					60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	20//01				62.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY		10, 710				65.00 66.00
67. 00 06700 OCCUPATIONAL THERAPY	0					67.00
68. 00 06800 SPEECH PATHOLOGY						68.00
69. 00 06900 ELECTROCARDI OLOGY						69.00
69. 01 03610 SLEEP LAB		-				69.01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0					71.00
71. 01 07101 I V SOLUTIONS	0	11,007				71.01
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0					72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	-				73.00
76. 00 03140 CARDI OLOGY	0					76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0					76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	20, 777				90.00
91.00 09100 EMERGENCY	0					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1, 276, 288				92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0					95.00
200.00 Subtotal (see instructions)	0	6, 416, 639				200.00
201.00 Less PBP Clinic Lab. Services-Program	n O					201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	0	6, 416, 639				202.00

MPUT	Financial Systems KING'S DAUGHTERS' ATION OF INPATIENT OPERATING COST	Provi der CCN: 150069	Period: From 01/01/2015 To 12/31/2015	u of Form CMS-: Worksheet D-1 Date/Time Pre	pare
		Title XVIII	Hospi tal	5/18/2016 2:2 PPS	9 pm
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
00 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b			13, 371 13, 371	
00	Private room days (excluding swing-bed and observation bed day		ivate room days,	13, 371	
	do not complete this line.		J .		
00 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		n 21 of the east	10, 570 0	
00	reporting period	in days) thi ough becenibe	1 31 01 the cost	0	
00	Total swing-bed SNF type inpatient days (including private roo	m days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	dave) through Decombor	21 of the cost	0	7
00	reporting period	ruays) thi ough becember	ST OF THE COST	0	'
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) Total inpatient days including private room days applicable to	the Drearen (eveluding	cwing bod and	6, 313	9
00	newborn days)	the Frogram (excruding	swing-bed and	0, 313	7
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on		oom days)	0	10
00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII on		oom dave) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, en		oom days/ arter	0	''
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	12
00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	13
. 00	after December 31 of the cost reporting period (if calendar ye			0	
	Medically necessary private room days applicable to the Progra	m (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
. 00	SWING BED ADJUSTMENT			0	
. 00	Medicare rate for swing-bed SNF services applicable to service	s through December 31 o	f the cost	0.00	17
00	reporting period Medicare rate for swing-bed SNF services applicable to service	s after December 31 of	the cost	0.00	18
. 00	reporting period	S alter becember 51 01	the cost	0.00	
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20
	reporting period				
	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ing period (line	12, 641, 522 0	
. 00	5 x line 17)	i si oi the cost report	rng period (inne	0	22
. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23
00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24
	7 x line 19)			0	
. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	1 of the cost reporting	period (line 8	0	25
. 00	Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		12, 641, 522	27
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)		ui ges)	0	
	Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000 0. 00	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 min	us line 33)(see instruc	tions)	0.00	
	Average per diem private room cost differential (line 34 x lin	e 31)		0.00	
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	nd private room cost di	fferential (line	0 12, 641, 522	
	27 minus line 36)			12, 071, 022] "
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	CTMENTS			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU: Adjusted general inpatient routine service cost per diem (see			945.44	38
	Program general inpatient routine service cost (line 9 x line			5, 968, 563	
. 00	Medically necessary private room cost applicable to the Progra	m (line 14 x line 35)		0	40
00	Total Program general inpatient routine service cost (line 39	+ line 40)		5, 968, 563	41

OMPUTATION OF INPATIENT OPERATING COST	F	rovi der	CCN: 150069	Period: From 01/01/2015	Worksheet D-1	2552-
				To 12/31/2015		
Cost Conton Description	Tatal Ta	Ti tl tal	e XVIII	Hospi tal	PPS	
Cost Center Description	Total To Inpatient CostInpati				(col. 3 x col.	
	1.00 2	00	col. 2) 3.00	4.00	4) 5.00	
2.00 NURSERY (title V & XIX only)	0	C	0.0	0 00	0	42.0
Intensive Care Type Inpatient Hospital Units 3.00 INTENSIVE CARE UNIT	1, 701, 950	1, 440	1, 181.	91 918	1, 084, 993	43.0
4. 00 CORONARY CARE UNIT	1,701,950	1, 440	1, 101.	71 710	1, 004, 993	44.0
5. 00 BURN INTENSIVE CARE UNIT						45.0
6.00 SURGICAL INTENSIVE CARE UNIT						46. (
7.00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.0
cost center bescription					1.00	
8.00 Program inpatient ancillary service cost (W			_		8, 860, 049	
9.00 Total Program inpatient costs (sum of lines	41 through 48)(see in	structio	ns)		15, 913, 605	49.0
PASS THROUGH COST ADJUSTMENTS 0.00 Pass through costs applicable to Program ing	atient routine servic	es (from	Wkst D sur	of Parts L and	1, 439, 618	50 0
1.00 Pass through costs applicable to Program inp	atient ancillary serv	ces (fr	om Wkst. D, s	sum of Parts II	850, 157	51. (
and IV) 2.00 Total Program excludable cost (sum of lines	50 and 51)				2, 289, 775	52 (
3.00 Total Program inpatient operating cost exclu		non-phy	sician anesth	netist, and	13, 623, 830	
medical education costs (line 49 minus line	52)					
4.00 Program discharges					0	54.
5.00 Target amount per discharge						55.
6.00 Target amount (line 54 x line 55)					0	
7.00 Difference between adjusted inpatient operat	line 53)	0				
8.00 Bonus payment (see instructions) 9.00 Lesser of lines 53/54 or 55 from the cost re	ompounded by the	0.00				
market basket	por tring period charing	1770, 0		inpounded by the	0.00	
0.00 Lesser of lines 53/54 or 55 from prior year					0.00	
1.00 If line 53/54 is less than the lower of line which operating costs (line 53) are less that					0	61.0
amount (line 56), otherwise enter zero (see		53 J4 X		the target		
2.00 Relief payment (see instructions)					0	
3.00 Allowable Inpatient cost plus incentive pays PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instructions)			0	63. (
4.00 Medicare swing-bed SNF inpatient routine cos	ts through December 3	1 of the	cost reporti	ng period (See	0	64. (
instructions)(title XVIII only)					_	
5.00 Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after December 31	of the c	ost reportino	g period (See	0	65.0
6.00 Total Medicare swing-bed SNF inpatient routi	ne costs (line 64 plu	s line 6	5)(title XVII	l only). For	0	66. (
CAH (see instructions)					_	
7.00 Title V or XIX swing-bed NF inpatient routir (line 12 x line 19)	e costs through Decem	ber 31 c	of the cost re	eporting period	0	67.0
8.00 Title V or XIX swing-bed NF inpatient routir	e costs after Decembe	r 31 of	the cost repo	orting period	0	68.0
(line 13 x line 20)					_	
9.00 Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N			,		0	69. (
0.00 Skilled nursing facility/other nursing facil)		70.
1.00 Adjusted general inpatient routine service of	ost per diem (line 70					71.
2.00 Program routine service cost (line 9 x line		11	no 2E)			72.
3.00 Medically necessary private room cost applic 4.00 Total Program general inpatient routine serv						73.
5.00 Capital-related cost allocated to inpatient				Part II, column		75.
26, line 45)	2)					_ .
6.00 Per diem capital-related costs (line 75 ÷ li 7.00 Program capital-related costs (line 9 x line	-					76. 77.
8.00 Inpatient routine service cost (line 74 minu						78.
9.00 Aggregate charges to beneficiaries for exces	s costs (from provide		· · ·			79.
0.00 Total Program routine service costs for comp		mi tati or	ı (line 78 mir	nus line 79)		80.
1.00 Inpatient routine service cost per diem limi 2.00 Inpatient routine service cost limitation (I						81. 82.
3.00 Reasonable inpatient routine service cost rimitation (· .					83.
4.00 Program inpatient ancillary services (see in	structions)					84.
5.00 Utilization review - physician compensation		25)				85.
6.00 Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		557			I	86.
7.00 Total observation bed days (see instructions)				2, 801	
 8.00 Adjusted general inpatient routine cost per 9.00 Observation bed cost (line 87 x line 88) (set 		2)			945. 44 2, 648, 177	
						1 20

Health Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Lieu of Form CMS-2552			
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1		
				From 01/01/2015 To 12/31/2015	Date/Time Pre 5/18/2016 2:2		
		Titl	e XVIII	Hospi tal	PPS		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 27)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x 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	2, 829, 566	12, 641, 522	0. 22383	1 2, 648, 177	592, 744	90.00	
91.00 Nursing School cost	0	12, 641, 522	0.00000	2, 648, 177	0	91.00	
92.00 Allied health cost	0	12, 641, 522	0.00000	2, 648, 177	0	92.00	
93.00 All other Medical Education	0	12, 641, 522	0.00000	2, 648, 177	0	93.00	

	Financial Systems KING'S DAUGHTERS' ATION OF INPATIENT OPERATING COST	Provider CCN: 150069 F	Period: From 01/01/2015 0 12/31/2015	u of Form CMS-2 Worksheet D-1 Date/Time Pre	pare
		Title XIX	Hospi tal	5/18/2016 2:2 Cost	9 pr
	Cost Center Description	II LIE AIX	nospi tai		
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
00	Inpatient days (including private room days and swing-bed days			13, 371 13, 371	
00 00	Inpatient days (including private room days, excluding swing-b Private room days (excluding swing-bed and observation bed day		ate room davs	13, 371	
00	do not complete this line.		are room aajo,	Ũ	
00	Semi-private room days (excluding swing-bed and observation be	J <i>i</i>	21 -6	10, 570	
00	Total swing-bed SNF type inpatient days (including private roo reporting period	in days) thi ough beceilber	31 OF the Cost	0	5
00	Total swing-bed SNF type inpatient days (including private roo	m days) after December 31	of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	dave) through December 3	1 of the cost	0	-
00	reporting period	days) through becember 3	I OI THE COST	0	7
00	Total swing-bed NF type inpatient days (including private room	days) after December 31	of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Dreamen (avaluding a	wing had and	1 420	9
00	newborn days)	the Program (excluding s	wing-bed and	1, 420	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on		m days)	0	10
. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII on		m days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, en		in days) arter	0	''
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		room days)	0	12
. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	room dave)	0	13
. 00	after December 31 of the cost reporting period (if calendar ye			0	
. 00	Medically necessary private room days applicable to the Progra	m (excluding swing-bed da	ys)		14
. 00 . 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			1, 194 354	
. 00	SWING BED ADJUSTMENT		I	304	
. 00	Medicare rate for swing-bed SNF services applicable to service	s through December 31 of	the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	c ofter December 21 of th	a cost	0.00	10
. 00	reporting period	Saiter December Si ui ti	le cost	0.00	
. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of t	he cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of the	cost	0.00	20
. 00	reporting period		0031	0.00	
. 00	Total general inpatient routine service cost (see instructions			12, 641, 522	
. 00	Swing-bed cost applicable to SNF type services through Decembe 5 x line 17)	r 31 of the cost reportin	g period (line	0	22
. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23
00	x line 18)			0	
. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	31 of the cost reporting	period (line	0	24
. 00	Swing-bed cost applicable to NF type services after December 3	1 of the cost reporting p	eriod (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		12, 641, 522	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		· · · · ·		
. 00 . 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed char	ges)	0	28
. 00	Semi-private room charges (excluding swing bed charges)			0	
. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.000000	
. 00 . 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
. 00	Average per diem private room charge differential (line 32 min	us line 33)(see instructi	ons)	0.00	
. 00	Average per diem private room cost differential (line 34 x lin			0.00	
. 00 . 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	nd private room cost diff	erential (line	0 12, 641, 522	36
. 00	27 minus line 36)	na private room cost diff	erentiai (IIIIe	12, 041, 522	3/
	PART I I – HOSPITÁL AND SUBPROVIDERS ONLY		-]
. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			945.44	38
	Program general inpatient routine service cost per drem (see			945.44 1, 342, 525	
. 00	Medically necessary private room cost applicable to the Progra	m (line 14 x line 35)		0	40
00	Total Program general inpatient routine service cost (line 39	+ line 40)		1, 342, 525	41

OMPUT	ATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2015	Worksheet D-1	1
					To 12/31/2015		
	Cost Center Description	Total	Ti t Total	le XIX Average Per	Hospital Program Days	Cost Program Cost	
		Inpatient Cost				(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
2.00	NURSERY (title V & XIX only)	701, 293	1, 194	587.3	5 354	207, 922	2 42.
8.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	1, 701, 950	1, 440	1, 181. 9	1 129	152, 466	43.
1.00	CORONARY CARE UNI T	.,,	.,	.,			44.
5.00	BURN INTENSIVE CARE UNIT						45.
	SURGI CAL INTENSI VE CARE UNI T						46.
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.
00		+ D 2 2	11 == 200			1.00	40
. 00 . 00	Program inpatient ancillary service cost (Wks Total Program inpatient costs (sum of lines A			ns)		1, 722, 111 3, 425, 024	
. 00	PASS THROUGH COST ADJUSTMENTS			113 /		0, 120, 021	1 17.
0. 00	Pass through costs applicable to Program inpa	atient routine	services (from	Wkst. D, sum	of Parts I and	C	50.
. 00	<pre>III) Pass through costs applicable to Program inpa</pre>	atient ancillar	v services (fr	om Wkst D s	um of Parts II	0	51.
. 00	and IV)		y services (ii	om wikst. D, S			/ 31.
2.00	Total Program excludable cost (sum of lines !					0	
3. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line 9		lated, non-phy	sician anesth	etist, and	0	53.
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					
. 00	Program di scharges					0	
. 00	Target amount per discharge					0.00	
. 00 . 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ing cost and ta	raet amount (l	ine 56 minus	line 53)		
. 00	Bonus payment (see instructions)	The 55)					
. 00	Lesser of lines 53/54 or 55 from the cost rep	mpounded by the	0.00	59.			
). 00	market basket Lesser of lines 53/54 or 55 from prior year o	act conact up	datad by the m	arkat backat		0.00	60.
I. 00	If line 53/54 is less than the lower of line				the amount by	0.00	
	which operating costs (line 53) are less than	n expected cost					
0.00	amount (line 56), otherwise enter zero (see i	nstructions)					
	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)				
	PROGRAM INPATIENT ROUTINE SWING BED COST						
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	cost reporti	ng period (See	0	64.
5.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reporting	period (See	l c	65.
	instructions)(title XVIII only)				F		
5.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	5)(title XVII	l only). For	0	66.
7.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 o	f the cost re	portina period	l o	67.
	(line 12 x line 19)	0					
3. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after D	ecember 31 of	the cost repo	rting period	0	68.
9.00	Total title V or XIX swing-bed NF inpatient i	routine costs (line 67 + line	68)		0	69.
	PART III - SKILLED NURSING FACILITY, OTHER NU					1	
). 00 . 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co						70.
. 00	Program routine service cost (line 9 x line		The 70 + The	2)			72
. 00	Medically necessary private room cost applica		(line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine servi	•					74.
5. 00	Capital-related cost allocated to inpatient (26, line 45)	routine service	COSTS (TFOM W	OFKSNEET B, P	art II, column		75.
. 00	Per diem capital-related costs (line 75 ÷ lin	ne 2)					76.
. 00	Program capital-related costs (line 9 x line						77.
. 00 . 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		rovi der record	e)			78
. 00	Total Program routine service costs for compa	• •		· · · · · · · · · · · · · · · · · · ·	us line 79)		80
. 00	Inpatient routine service cost per diem limi	tation			<i>,</i>		81
. 00	Inpatient routine service cost limitation (li						82
. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see ins		5)				83
	Utilization review - physician compensation		ns)				85
	Total Program inpatient operating costs (sum	of lines 83 th					86.
00	PART IV - COMPUTATION OF OBSERVATION BED PASS					2.001	07
7.00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per o		line 2)			2, 801 945. 44	
3.00							

Health Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Lieu of Form CMS-2552			
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1		
				From 01/01/2015 To 12/31/2015	Date/Time Pre 5/18/2016 2:2		
		Tit	le XIX	Hospi tal	Cost		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 27)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x 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	2, 829, 566	12, 641, 522	0. 22383	1 2, 648, 177	592, 744	90.00	
91.00 Nursing School cost	0	12, 641, 522	0.00000	0 2, 648, 177	0	91.00	
92.00 Allied health cost	0	12, 641, 522	0.00000	0 2, 648, 177	0	92.00	
93.00 All other Medical Education	0	12, 641, 522	0. 00000	0 2, 648, 177	0	93.00	

al th Financial Systems KING'S DAUGHTERS IPATIENT ANCILLARY SERVICE COST APPORTIONMENT	HOSPI TAL	CCN: 150069	Peri od:	u of Form CMS-: Worksheet D-3	
ATTENT ANGLEART SERVICE COST ATTORTIONMENT	riovider	CCN. 150007	From 01/01/2015	worksheet D-5	,
			To 12/31/2015	Date/Time Pre	
				5/18/2016 2:2	9 pm
	Titl	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	5	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	-
0. 00 03000 ADULTS & PEDIATRICS		1	6, 587, 645		30.0
. 00 03100 NTENSI VE CARE UNI T			1, 699, 490		31.0
00 04300 NURSERY			1, 077, 470		43.0
ANCI LLARY SERVICE COST CENTERS					43.0
0. 00 05000 OPERATI NG ROOM		0. 1858	29 3, 293, 753	612,075	50.0
. 00 05100 RECOVERY ROOM		0. 1838		63, 003	
2. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 1031		03,003	
00 05300 ANESTHESI OLOGY		0.0649		44, 079	1
. 00 05400 RADI OLOGY-DI AGNOSTI C		0.7305		665,062	
. 01 03630 ULTRA SOUND		0. 1364			
. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 0799		15, 747	
0 03480 ONCOLOGY		0. 4835		21, 411	
. 00 05700 CT SCAN		0. 0549			
B. OO 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 1056		17, 785	
00 05900 CARDI AC CATHETERI ZATI ON		0. 1419			
0. 00 06000 LABORATORY		0. 2272		781, 924	
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 2679		115, 168	
00 06500 RESPIRATORY THERAPY		0. 1914		655, 917	
00 06600 PHYSI CAL THERAPY		0. 3359		331,097	
. 00 06700 OCCUPATI ONAL THERAPY		0.0000		0	
8. 00 06800 SPEECH PATHOLOGY		0.0000		0	
00 06900 ELECTROCARDI OLOGY		0.0000		0	
0.01 03610 SLEEP LAB		0. 2399		0	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 4883		816, 851	
. 01 07101 I V SOLUTI ONS		0. 0536		42, 287	
2. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 2898		1, 507, 008	
00 07300 DRUGS CHARGED TO PATIENTS		0. 1172		2, 013, 285	
0. 00 03140 CARDI OLOGY		0. 1363			
0. 97 07697 CARDI AC REHABI LI TATI ON		0. 3007		70	
OUTPATIENT SERVICE COST CENTERS		0.3007	200	/0	, 0.
0. 00 09000 CLINIC		1.8939	76 51	97	90. (
. 00 09100 EMERGENCY		0. 1895		391, 978	
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 0985			
OTHER REI MBURSABLE COST CENTERS				.23, 100	1
00 09500 AMBULANCE SERVICES					95.
0.00 Total (sum of lines 50-94 and 96-98)			44, 891, 600	8, 860, 049	
1.00 Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		0	0,000,017	201.
2.00 Net Charges (line 200 minus line 201)	. (44, 891, 600		202.

al th Financial Systems KING'S DAUGHTE IPATIENT ANCILLARY SERVICE COST APPORTIONMENT	RS' HOSPI TAL	CCN: 150069	Peri od:	u of Form CMS-2 Worksheet D-3	
IPATIENT ANGILLART SERVICE CUST APPORTIONWENT	PLOVEDEL	CCN. 150009	From 01/01/2015	WOLKSHEEL D-3	
			To 12/31/2015	Date/Time Pre	pared:
				5/18/2016 2:2	
	Tit	le XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
·		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
			Ű	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
). 00 03000 ADULTS & PEDIATRICS			2, 034, 580		30.0
. 00 03100 INTENSIVE CARE UNIT			235, 211		31.0
3. 00 04300 NURSERY			804, 390		43.0
ANCI LLARY SERVI CE COST CENTERS			- <u>-</u>		
0. 00 05000 OPERATING ROOM		0. 1858	29 1, 704, 527	316, 751	50.0
. 00 05100 RECOVERY ROOM		0. 1031		23, 273	51.0
2. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 3793		304, 423	52.0
B. 00 05300 ANESTHESI OLOGY		0.0649		15, 921	53.0
I. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 7305		99, 904	54.0
I. 01 03630 ULTRA SOUND		0. 1364		5, 843	
I. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC		0.0799		1, 787	54.0
5. 00 03480 0NC0L0GY		0. 4835		8, 689	55.0
7. 00 05700 CT SCAN		0. 0549		17, 406	57.0
3. OO 05700 01 3CAN 3. OO 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 1056		4, 269	58.0
2. 00 05900 CARDI AC CATHETERI ZATI ON		0. 1030		2,004	59.0
0. 00 06000 LABORATORY		0. 2254			60.0
				183, 522	
2. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.2679		20, 961	62.0 65.0
5. 00 06500 RESPIRATORY THERAPY		0. 1914		75, 756	
6. 00 06600 PHYSI CAL THERAPY		0.3359		29, 131	66.0
7.00 06700 OCCUPATI ONAL THERAPY		0.0000		0	67.0
3. 00 06800 SPEECH PATHOLOGY		0.0000		0	68.0
2. 00 06900 ELECTROCARDI OLOGY		0.0000		0	69.0
0. 01 03610 SLEEP LAB		0. 2396		0	69.0
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 4883		58, 779	71.0
I. 01 07101 IV SOLUTIONS		0. 0536		11, 618	71.0
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2898		0	72.0
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 1172		435, 405	73.0
5. 00 03140 CARDI OLOGY		0. 1363		22, 249	76.0
5. 97 07697 CARDI AC REHABI LI TATI ON		0. 3007	11 0	0	76.9
OUTPATIENT SERVICE COST CENTERS					
D. 00 09000 CLINIC		1.8939		0	90.0
. 00 09100 EMERGENCY		0. 1895		84, 420	91.0
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 0985	37 0	0	92.0
OTHER REIMBURSABLE COST CENTERS					
5. 00 09500 AMBULANCE SERVICES					95.0
00.00 Total (sum of lines 50-94 and 96-98)			9, 603, 986	1, 722, 111	200. 0
11.00 Less PBP Clinic Laboratory Services-Program only char	ges (line 61)		0		201.0
02.00 Net Charges (line 200 minus line 201)	,	1	9, 603, 986		202.0

	Financial Systems KING'S DAUGHTERS'		CCN: 1500(0		u of Form CMS- Worksheet E	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 150069	Period: From 01/01/2015 To 12/31/2015	Part A Date/Time Pre	epared:
		Ti tl	e XVIII	Hospi tal	5/18/2016 2:2 PPS	29 pm
			0	1.00	2.00	
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 occurrin	ng prior		0 9, 195, 171		1.00 1.01
1. 02	to October 1 (see instructions) DRG amounts other than outlier payments for discharges occurrin	na on or		2, 704, 316		1. 02
	after October 1 (see instructions)	5		0		
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)			0		1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	-		0		1.04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			143, 193		2.00 2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instruction	ons)		0		2. 02
3.00 4.00	Managed Care Simulated Payments Bed days available divided by number of days in the cost report	ting		0 74. 21		3.00
	period (see instructions) Indirect Medical Education Adjustment					-
5.00	FTE count for allopathic and osteopathic programs for the most			0.00		5.00
6.00	cost reporting period ending on or before 12/31/1996. (see instr FTE count for allopathic and osteopathic programs which meet th			0.00		6.00
	criteria for an add-on to the cap for new programs in accordanc CFR 413.79(e)	ce with 42				
7.00	MMA Section 422 reduction amount to the IME cap as specified ur	nder 42		0.00		7.00
7.01	CFR §412.105(f)(1)(iv)(B)(1) ACA Section 5503 reduction amount to the IME cap as specified u	under 42		0.00		7.01
	CFR $\frac{12}{10}$ (1)(iv)(B)(2) If the cost report straddles July then see instructions.	1, 2011				
8.00	Adjustment (increase or decrease) to the FTE count for allopath			0.00		8.00
	osteopathic programs for affiliated programs in accordance with 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67					
8. 01	(August 1, 2002). The amount of increase if the hospital was awarded FTE cap slot	ts under		0.00		8. 01
	section 5503 of the ACA. If the cost report straddles July 1, 2 instructions.					
8. 02	The amount of increase if the hospital was awarded FTE cap slot			0.00		8. 02
9.00	closed teaching hospital under section 5506 of ACA. (see instru Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines			0.00		9.00
10. 00	and 8,02) (see instructions) FTE count for allopathic and osteopathic programs in the currer	nt vear		0.00		10.00
	from your records	it you				
11. 00 12. 00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)			0. 00 0. 00		11.00 12.00
13.00 14.00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that year	ended on		0.00 0.00		13.00 14.00
	or after September 30, 1997, otherwise enter zero.	ondoù on				
15. 00 16. 00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program			0. 00 0. 00		15.00 16.00
17. 00 18. 00	Adjustment for residents displaced by program or hospital closu Adjusted rolling average FTE count	ure		0.00 0.00		17.00 18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0. 000000		19.00
20. 00 21. 00	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)			0. 000000 0. 000000		20.00 21.00
22. 00 22. 01	IME payment adjustment (see instructions) IME payment adjustment – Managed Care (see instructions)			0		22.00 22.01
	Indirect Medical Education Adjustment for the Add-on for Section		the MMA			
23.00	Number of additional allopathic and osteopathic IME FTE resider slots under 42 Sec. 412.105 (f)(1)(iv)(C).	nt cap		0.00		23.00
24. 00 25. 00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -O-, then enter the lo	ower of		0. 00 0. 00		24.00 25.00
	line 23 or line 24 (see instructions)	Juict of				
26. 00 27. 00	Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions)			0. 000000 0. 000000		26.00 27.00
28. 00 28. 01	IME add-on adjustment amount (see instructions) IME add-on adjustment amount - Managed Care (see instructions)			0		28.00 28.01
29.00	Total IME payment (sum of lines 22 and 28)			0		29.00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment			0		29.01
30.00	Percentage of SSI recipient patient days to Medicare Part A pat (see instructions)	tient days		4.98		30.00
31.00	Percentage of Medicaid patient days (see instructions)			20.19		31.00
32. 00 33. 00	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions)			25. 17 9. 98		32.00 33.00
34.00	Disproportionate share adjustment (see instructions)			296, 893		34.00

	Financial Systems KING'S DAUGHTERS' ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150069	Period: From 01/01/2015	u of Form CMS-2 Worksheet E Part A	
			To 12/31/2015	Date/Time Prep 5/18/2016 2:29	
		Title XVIII	Hospi tal	PPS	
			Prior to	On/After	
	-	0	0ctober 1 1.00	0ctober 1 2.00	
	Uncompensated Care Adjustment				
	Total uncompensated care amount (see instructions)			6, 406, 145, 534	
	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero,		0. 000086283 659, 862	0. 000087360 559, 643	
5. 02	enter zero on this line) (see instructions)		007,002	007,010	00.0
5. 03	Pro rata share of the hospital uncompensated care payment		493, 540	140, 675	35.0
5.00	amount (see instructions) Total uncompensated care (sum of columns 1 and 2 on line		634, 215		36.0
	35.03)				
	Additional payment for high percentage of ESRD beneficiary dis	scharges (lines 40 throu	igh 46) 0		40.0
0. 00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and		0		40. 0
	685 (see instructions)				
1.00	Total ESRD Medicare discharges excluding MS-DRGs 652,		0		41.0
1.01	682, 683, 684 an 685. (see instructions) Total ESRD Medicare covered and paid discharges excluding		0		41.0
	MS-DRGs 652, 682, 683, 684 an 685. (see instructions)				
2.00	Divide line 41 by line 40 (if less than 10%, you do not		0.00		42.0
3. 00	qualify for adjustment) Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0		43.0
	682, 683, 684 an 685. (see instructions)		_		
4. 00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0. 000000		44.0
5.00	Average weekly cost for dialysis treatments (see		0.00		45.0
(00	instructions)				44.0
5.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.0
7.00	Subtotal (see instructions)		12, 973, 788		47. C
3.00	Hospital specific payments (to be completed by SCH and		13, 243, 737		48. C
9.00	MDH, small rural hospitals only. (see instructions) Total payment for inpatient operating costs (see		13, 243, 737		49.0
	instructions)				
0. 00	Payment for inpatient program capital (from Wkst. L, Pt. I		995, 932		50.0
1.00	and Pt. II, as applicable) Exception payment for inpatient program capital (Wkst. L,		0		51.0
	Pt. III, see instructions)				
2.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.0
3. 00	Nursing and Allied Health Managed Care payment		14, 510		53.0
	Special add-on payments for new technologies		0		54.0
5.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.0
5. 00	Cost of physicians' services in a teaching hospital (see		0		56.0
7 00	intructions) Routine service other pass through costs (from Wkst. D,		0		57.0
/.00	Pt. III, column 9, lines 30 through 35).		0		57.0
3. 00	Ancillary service other pass through costs from Wkst. D,		29, 959		58.0
	Pt. IV, col. 11 line 200)		14 204 120		E0 0
1	Total (sum of amounts on lines 49 through 58) Primary payer payments		14, 284, 138 6, 071		59.0 60.0
	Total amount payable for program beneficiaries (line 59		14, 278, 067		61.0
2.00	minus line 60) Deductibles billed to program beneficiaries		1, 516, 116		62.0
	Coinsurance billed to program beneficiaries		40, 624		63.0
4.00	Allowable bad debts (see instructions)		185, 018		64.0
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see		120, 262 73, 678		65. C 66. C
5.00	instructions)		/3,0/8		00.0
	Subtotal (line 61 plus line 65 minus lines 62 and 63)		12, 841, 589		67.0
3.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.0
9.00	Outlier payments reconciliation (sum of lines 93, 95 and		0		69.0
	96). (For SCH see instructions)				70 0
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT		0		70.0 70.5
	Pioneer ACO demonstration payment adjustment amount (see		0		70.8
	instructions)		_		
0. 90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70. 9
0. 91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.9
D. 92	Bundled Model 1 discount amount (see instructions)		0		70.9
	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)		18, 712 -42, 836		70. 9 70. 9
	Recovery of accel erated depreciation		-42, 030		70.9

	Financial Systems KING'S DAUGHTEI					u of Form CMS-	2002-1
ALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150069		eriod: com 01/01/2015 0 12/31/2015	Worksheet E Part A Date/Time Pre	epared:
			Title XVIII		Hospi tal	5/18/2016 2:2 PPS	29 pm
					Prior to	0n/After	
					October 1	October 1	
			0		1.00	2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy)			0	0		70.9
	(Enter in column 0 the corresponding federal year for the						
	period prior to 10/1)						
70.97	Low volume adjustment for federal fiscal year (yyyy)			0	0		70.9
	(Enter in column 0 the corresponding federal year for the						
	period ending on or after 10/1)						
70. 98	Low Volume Payment-3				0		70.9
	HAC adjustment amount (see instructions)				0		70.9
71.00	Amount due provider (line 67 minus lines 68 plus/minus				12, 817, 465		71.0
	lines 69 & 70)						
	Sequestration adjustment (see instructions)				256, 349		71.0
	Interim payments				12, 784, 970		72.0
	Tentative settlement (for contractor use only)				0		73.0
74.00	Balance due provider (Program) (line 71 minus lines 71.01,				-223, 854		74.0
	72, and 73)						
/5.00	Protested amounts (nonallowable cost report items) in				664, 820		75.0
	accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)						-
	Operating outlier amount from Wkst. E, Pt. A, line 2 (see			- 1	0		90.0
70.00	instructions)				0		90.0
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0		91.0
	Operating outlier reconciliation adjustment amount (see				0		92.0
/2.00	instructions)				0		72.0
93.00	Capital outlier reconciliation adjustment amount (see				0		93.0
0.00	instructions)				0		/
94.00	The rate used to calculate the time value of money (see				0.00		94.0
	instructions)						
95.00	Time value of money for operating expenses (see				0		95.0
	instructions)						
96.00	Time value of money for capital related expenses (see				0		96.0
	instructions)						
						On/After 10/1	
					1.00	2.00	
	HSP Bonus Payment Amount						_
	HSP bonus amount (see instructions)				0	C	100. 0
	HVBP Adjustment for HSP Bonus Payment						
	HVBP adjustment factor (see instructions)		0.000000000	0.000000000			
	HVBP adjustment amount for HSP bonus payment (see instructi	ons)			0	C	102.0
	HRR Adjustment for HSP Bonus Payment						1.0-
	HRR adjustment factor (see instructions)				0.0000		103.0
00	HRR adjustment amount for HSP bonus payment (see instructio	ins)		1	0		104.0

	Financial Systems LUME CALCULATION EXHIBIT 4		KING'S DAUGHTE			Period: From 01/01/2015 To 12/31/2015		t 4 pared:
		W/S E, Part A line	Amounts (from E, Part A)	Titl Pre/Post Entitlement	e XVIII Period Prior to 10/01	Hospital Period On/After 10/01	PPS Total (Col 2 through 4)	•
		0	1.00	2.00	3.00	4.00	5.00	
. 00	DRG amounts other than outlier	1.00	0	0		0 0	0	1.0
. 01	payments DRG amounts other than outlier payments for discharges	1. 01	9, 195, 171	0	9, 898, 77	1 0	9, 898, 771	1.0
. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	2, 704, 316	0		0 3, 351, 526	3, 351, 526	1. 0
. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	O	0		0 0	0	1. C
. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	Ο	0		o c	0	1. C
. 00	Outlier payments for discharges (see instructions)	2.00	143, 193	0	133, 43	3 9, 760	143, 193	2.0
2. 01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	1	0 0	0	2.0
. 00	Operating outlier reconciliation	2.01	0	0		o o	0	3. 0
. 00	Managed care simulated payments	3.00	0	0		0 0	0	4.0
. 00	Indirect Medical Education Adju Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0. 000000	0. 00000	0.000000		5.0
. 00	IME payment adjustment (see	22.00	0	0		o c	0	6. (
. 01	instructions) IME payment adjustment for managed care (see	22.01	О	0		o o	0	6. (
	instructions) Indirect Medical Education Adju	istmont for the	Add on for So	ation 122 of t				
. 00	IME payment adjustment factor	27.00	0. 000000	0. 000000		0. 000000		7.0
. 00	(see instructions) IME adjustment (see	28.00	0	0		0 0	0	
01	instructions) IME payment adjustment add on for managed care (see	28.01	0	0		o o	0	8.
00	instructions) Total IME payment (sum of lines 6 and 8)	29.00	0	0		o o	0	9.
01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0		0 0	0	9.
0. 00	Disproportionate Share Adjustme Allowable disproportionate	ent 33.00	0. 0998	0. 0998	0.099	8 0. 0998		10.
). 00	share percentage (see instructions)	33.00	0. 0998	0. 0998	0.099	0. 0998		10.
I. 00 I. 01	Disproportionate share adjustment (see instructions) Uncompensated care payments	34.00 36.00	296, 893 634, 215	0			296, 893 634, 215	
	Additional payment for high per				473, 34	140,075	034,215	
2.00	Total ESRD additional payment (see instructions)	46.00	0	0		0 0		12.
3.00 4.00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47.00 48.00	12, 973, 788 13, 243, 737	0 0				
5. 00	(see instructions) Total payment for inpatient operating costs (see instructions)	49.00	13, 243, 737	0	9, 892, 21	1 3, 351, 526	13, 243, 737	15.
5.00	Payment for inpatient program capital	50.00	995, 932	0	772, 40	223, 532	995, 932	16.
. 00	Special add-on payments for new technologies	54.00	0	0		0 0	0	17.
7. 01 7. 02	Net organ aquisition cost Credits received from manufacturers for replaced	55.00 68.00	0	0 0			0	
8. 00	devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0		o o	0	18.

Health Financial Systems		KING'S DAUGHTE	RS' HOSPI TAL		In Lie	u of Form CMS-:	2552-10
LOW VOLUME CALCULATION EXHIBIT 4				-	Period: From 01/01/2015 Fo 12/31/2015	Date/Time Pre 5/18/2016 2:2	pared:
			Ti tl	e XVIII	Hospi tal	PPS	
	W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
	line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
	0	1.00	2.00	3.00	4.00	5.00	
19.00 SUBTOTAL			0	10, 664, 61	1 3, 575, 058	14, 239, 669	19.00
	W/S L, line	(Amounts from L)					
	0	1.00	2.00	3.00	4.00	5.00	
20.00 Capital DRG other than outlier	1.00	948, 139	0	731, 344	1 216, 795	948, 139	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	0	0		0	0	20. 01
21.00 Capital DRG outlier payments	2.00	47, 793	0	41, 050	6, 737	47, 793	21.00
21.01 Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0	0	21.01
22.00 Indirect medical education percentage (see instructions)	5.00	0. 0000	0.0000	0.000	0. 0000		22.00
23.00 Indirect medical education adjustment (see instructions)	6.00	0	0	(0 0	0	23.00
24.00 Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0. 0000	0.000	0.0000		24.00
25.00 Disproportionate share adjustment (see instructions)	11.00	0	0		0 0	0	25.00
26.00 Total prospective capital payments (see instructions)	12.00	995, 932	0	772, 400	223, 532	995, 932	26.00
	W/S E, Part A						
	line	Part A)					
	0	1.00	2.00	3.00	4.00	5.00	
27.00 Low volume adjustment factor				0.00000	0. 000000		27.00
28.00 Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			()	0	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

HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5			Period: From 01/01/2015 To 12/31/2015 Hospital		pared:
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01		Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	9, 195, 171			9, 195, 171	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2, 704, 316		2, 704, 316	2, 704, 316	1. 02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0		0	0	1. 03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	143, 193	133, 43	3 9, 759	143, 192	2.00
2. 01	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2. 01
3.00	Operating outlier reconciliation	2.01	0		0 0	0	3.00
4.00	Managed care simulated payments Indirect Medical Education Adjustment	3.00	0		0 0	0	4.00
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0. 00000	0 0. 000000		5.00
6. 00 6. 01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see instructions)	22. 00 22. 01	0		0 0 0 0	0 0	6. 00 6. 01
	Indirect Medical Education Adjustment for the				_		
7.00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0.00000	0 0. 000000		7.00
8. 00 8. 01	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions)	28.00 28.01	0		0 0 0 0	0 0	8. 00 8. 01
9. 00 9. 01	Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of	29. 00 29. 01	0		0 0 0 0	0	9. 00 9. 01
	lines 6.01 and 8.01) Disproportionate Share Adjustment					-	
10.00		33.00	0. 0998	0. 099	8 0.0998		10.00
11. 00	(see instructions) Disproportionate share adjustment (see	34.00	296, 893	229, 42	0 67, 473	296, 893	11. 00
11. 01	instructions) Uncompensated care payments	36.00	634, 215	493, 54	0 140, 675	634, 215	11.01
12.00	Additional payment for high percentage of ESF Total ESRD additional payment (see	2D beneficiary 46.00	di scharges 0		0 0	0	12.00
13.00	instructions) Subtotal (see instructions)	47.00	12, 973, 788	10, 051, 56	5 2, 922, 223	12, 973, 788	13 00
	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see		13, 243, 737		0 0		
15. 00	instructions) Total payment for inpatient operating costs (see instructions)	49.00	13, 243, 737	13, 243, 73	7 0	13, 243, 737	15.00
16.00	Payment for inpatient program capital	50.00 54.00	995, 932	779, 13	7 216, 795	995, 932	16.00
17.00 17.01	Special add-on payments for new technologies Net organ aquisition cost	54.00 55.00				0	17.00 17.01
	Credits received from manufacturers for	68.00	0		o o	0	17.01
17. 02							
17. 02 18. 00	replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		o o	0	18.00

Health Financial Systems HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	KING'S DAUGHTE		CCN: 150069	Peri od:	u of Form CMS- Worksheet E	2552-10
				From 01/01/2015 To 12/31/2015	Part A Exhibi	pared:
		Ti tl	e XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from				
		Wkst. L)				
	0	1.00	2.00	3.00	4.00	
20.00 Capital DRG other than outlier	1.00	948, 139	731, 34	4 216, 795		
20.01 Model 4 BPCI Capital DRG other than outlier	1.01	0		0 0	0	
21.00 Capital DRG outlier payments	2.00	47, 793	47, 79	03 0	47, 793	
21.01 Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	
22.00 Indirect medical education percentage (see instructions)	5.00	0.0000	0.000	0.0000		22.00
23.00 Indirect medical education adjustment (see instructions)	6.00	0		0 0	0	23.00
24.00 Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.000	0.0000		24.00
25.00 Disproportionate share adjustment (see instructions)	11.00	0		0 0	0	25.00
26.00 Total prospective capital payments (see instructions)	12.00	995, 932	779, 13	216, 795	995, 932	26.00
	Wkst. E, Pt.	(Amt. from				
	A, line	Wkst. E, Pt. A)				
	0	1,00	2.00	3.00	4,00	
27.00						27.00
28.00 Low volume adjustment prior to October 1	70, 96	0		0	0	
29.00 Low volume adjustment on or after October 1	70.97	0		0	0	
30.00 HVBP payment adjustment (see instructions)	70, 93	18, 712	7, 34	5 11, 367	18, 712	
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0 0	0	
31.00 HRR adjustment (see instructions)	70, 94	-42, 836	-19, 30	-23, 527	-42, 836	31.00
31.01 HRR adjustment (see HSP bonus payment (see instructions)	70. 91	0	-17, 50	0 0	-42,030	
					(Amt. to Wkst.	
					E, Pt. A)	
	0	1.00	2.00	3.00	4.00	
32.00 HAC Reduction Program adjustment (see instructions)	70.99			0 0		32.00
100.00 Transfer HAC Reduction Program adjustment to Wkst. E. Pt. A.		N				100. 00

	ATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 150069 Period: From 01/01/2015 To 12/31/2015		pared:
	Title XVIII Hospital	PPS	
		1.00	
1.00 2.00 3.00 4.00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions) PPS payments Outlier payment (see instructions)	4, 040 10, 055, 136 11, 110, 580 34, 231	2.00 3.00
5.00 5.00 7.00	Enter the hospital specific payment to cost ratio (see instructions) Line 2 times line 5 Sum of line 3 plus line 4 divided by line 6	0.000 0 0.00	5.00 6.00
3.00 9.00 10.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 Organ acquisitions	0 54, 214 0	8.00
11.00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES	4, 040	11.00
	Reasonable charges	T	
13.00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) Total reasonable charges (sum of lines 12 and 13) Customary charges	32, 683 0 32, 683	13.00
	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 had such payment been made in accordance with 42 CFR §413.13(e)	000	15. 00 16. 00
17.00 18.00 19.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	0. 000000 32, 683 28, 643	18.00
20. 00	instructions) Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20. 00
22.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions) Interns and residents (see instructions)	4, 040 0 0	21.00 22.00 23.00
	Cost of physicians' services in a teaching hospital (see instructions) Total prospective payment (sum of lines 3, 4, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT	11, 199, 025	
26.00	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	0 2, 391, 344 8, 811, 721	26.00
	instructions) Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36)	0	
30.00	Subtotal (sum of lines 27 through 29) Primary payer payments	8, 811, 721 2, 183	30.00
	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	8, 809, 538	
	Composite rate ESRD (from Wkst. I-5, line 11)		33.00
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)	396, 243 257, 558	
	Allowable bad debts for dual eligible beneficiaries (see instructions)	290, 422	
	Subtotal (see instructions)	9, 067, 096	
	MSP-LCC reconciliation amount from PS&R	-38	
39.00 39.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)	0	
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
	Subtotal (see instructions)	9, 067, 134	
	Sequestration adjustment (see instructions)	181, 343	
	Interim payments Tentative settlement (for contractors use only)	8, 845, 001	
13.00 14.00	Balance due provider/program (see instructions)	40, 790 0	43.00
00	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	
	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)	0	93.00

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 150069	Period: From 01/01/2015 To 12/31/2015		parec
		Titl	e XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate		12, 784, 9	70 0	8, 812, 401 0	1. (2. (3. (
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
01	Program to Provider ADJUSTMENTS TO PROVIDER			0 07/17/2015	32, 600	3.
02				0	52,000	3.
03				0	0	3.
04				0	0	3
05				0	0	3.
50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	
52				0	0	3
53				0	0	3
54				0	0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	32, 600	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		12, 784, 9	70	8, 845, 001	4
	TO BE COMPLÉTED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
)1	Program to Provider TENTATIVE TO PROVIDER			0	0	5
)2				0	0	
3				0	0	5
	Provider to Program					_
50 51	TENTATI VE TO PROGRAM			0	0	5
52				0	0	5
9	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			0	40, 790	6
)2	SETTLEMENT TO PROGRAM		223, 8		0	6
00	Total Medicare program liability (see instructions)		12, 561, 1	Contractor	8, 885, 791 NPR Date	- /
				Number	(Mo/Day/Yr)	
		(`	1.00	2.00	

Heal th	Financial Systems	KING'S DAUGHTERS' H	OSPI TAL	In Lie	u of Form CMS-2	2552-10					
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 1500	069 Period: From 01/01/2015	Worksheet E-1 Part II						
	To 12/31/2015 Date/Time Pro										
	5/18/2016 2:29										
			Title XVIII	Hospi tal	PPS						
	TO DE 00000 STED DV 000 TO 000 FOD NONOTANDAD				1.00						
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD										
1.00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14										
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 s	3, 220 7, 231	1.00 2.00								
3.00	5										
4.00											
5.00											
6.00	Total hospital charity care charges from Wkst		20		267, 306, 320 1, 716, 714						
7.00	CAH only - The reasonable cost incurred for t	the purchase of cert	ified HIT technol	ogy Wkst. S-2, Pt. I	0	7.00					
	line 168										
8.00	Calculation of the HIT incentive payment (see				805, 740						
9.00	Sequestration adjustment amount (see instruct				16, 115						
10.00	Calculation of the HIT incentive payment after	· · · · ·	e instructions)		789, 625	10.00					
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH										
30.00	Initial/interim HIT payment adjustment (see i	nstructions)			755, 269						
31.00	Other Adjustment (specify)		21) (+!)	0	31.00					
32.00	Balance due provider (line 8 (or line 10) mir	ius line 30 and line	32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) 34,356								

UNLOUL	Financial Systems KING'S DAUGHTERS' HOS ATION OF REIMBURSEMENT SETTLEMENT P	rovider CCN: 150069	Peri od:	u of Form CMS-2 Worksheet E-3						
			From 01/01/2015 To 12/31/2015	Part VII Date/Time Prep 5/18/2016 2:20	pared: 9 pm					
		Title XIX	Hospi tal	Cost						
			I npati ent	Outpati ent						
			1.00	2.00						
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICE	ES FOR TITLES V OR X	IX SERVICES							
1.00	COMPUTATION OF NET COST OF COVERED SERVICES		3, 425, 024		1.00					
2.00	Medical and other services		5, 425, 024	6, 416, 639	2.00					
3.00	Organ acquisition (certified transplant centers only)		0	0,410,039	3.00					
4.00	Subtotal (sum of lines 1, 2 and 3)		3, 425, 024	6, 416, 639	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)		3, 425, 024	6, 416, 639	7.00					
	COMPUTATION OF LESSER OF COST OR CHARGES									
	Reasonabl e Charges									
8.00	Routi ne servi ce charges		0	07 050 040	8.00					
9.00	Ancillary service charges		9, 603, 986	27, 350, 918	9.00					
10.00	Organ acquisition charges, net of revenue Incentive from target amount computation		0		10.00					
11.00 12.00	Total reasonable charges (sum of lines 8 through 11)		9, 603, 986	27, 350, 918						
12.00	CUSTOMARY CHARGES		7,003,700	27, 330, 710	12.00					
13.00	Amount actually collected from patients liable for payment for ser	rvices on a charge	0	0	13.00					
14.00	basis Amounts that would have been realized from patients liable for pa		n 0	0	14.00					
15 00	a charge basis had such payment been made in accordance with 42 Cl Ratio of line 13 to line 14 (not to exceed 1.000000)	FR §413.13(e)	0,000000	0,000000	15 00					
15.00 16.00	Total customary charges (see instructions)		0.000000 9,603,986	0. 000000 27, 350, 918						
17.00	Excess of customary charges over reasonable cost (complete only in	fline 16 exceeds	6, 178, 962	20, 934, 279						
17.00	line 4) (see instructions)		0, 170, 702	20, 701, 277	17.00					
18.00	Excess of reasonable cost over customary charges (complete only it	fline 4 exceeds lin	e 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 instructi	i ons)	0	0	20.00					
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		3, 425, 024	6, 416, 639	21.00					
22.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be comp	pleted for PPS provi	ders.	0	22.00					
22.00	Other than outlier payments Outlier payments		0	0	22.00					
24.00	Program capital payments		0	0	24.00					
25.00	Capital exception payments (see instructions)		0		25.00					
26.00	Routine and Ancillary service other pass through costs		0	0						
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)		3, 425, 024	6, 416, 639	29.00					
	COMPUTATION OF REIMBURSEMENT SETTLEMENT									
30.00	Excess of reasonable cost (from line 18)		0	0	30.00					
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		3, 425, 024	6, 416, 639						
32.00	Deducti bl es		0	0						
33.00			0	0						
34.00 35.00	Allowable bad debts (see instructions) Utilization review		0	0	34.00 35.00					
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33))	3, 425, 024	6, 416, 639	36.00					
36 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0, 420, 024	0, +10, 039	37.00						
36.00 37.00	Subtotal (line 36 \pm line 37)	3, 425, 024	6, 416, 639							
37.00		-, .20, 021	2, 1.0, 007	39.00						
	Direct graduate medical education payments (from Wkst. E-4)									
37. 00 38. 00	Direct graduate medical education payments (from Wkst. E-4)		3, 425, 024	6, 416, 639	40.00					
37.00 38.00 39.00	Direct graduate medical education payments (from Wkst. E-4)		3, 425, 024 3, 313, 992	6, 416, 639 6, 221, 004						
37.00 38.00 39.00 40.00	Direct graduate medical education payments (from Wkst. E-4) Total amount payable to the provider (sum of lines 38 and 39)				41.00					

LANCE	Financial Systems KING'S DAUGHTE SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column onl	Provi der		Period: From 01/01/2015	u of Form CMS- Worksheet G	
				To 12/31/2015	5/18/2016 2:2	epare 29 pr
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
I	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	16, 607, 672		0 0	0	1
00	Temporary investments	0		0 0	0	
00	Notes receivable	0		0 0	0	3
	Accounts receivable	12, 214, 616		0 0	0	
	Other receivable	0		0 0	0	
	Allowances for uncollectible notes and accounts receivable			0 0	0	
	Inventory Prepaid expenses	2, 580, 826 1, 651, 346		0 0	0	
	Other current assets	173, 898		0 0	0	
	Due from other funds	0		0 0	0	
	Total current assets (sum of lines 1-10)	33, 228, 358		0 0	0	
[FIXED ASSETS					
00	Land	4, 937, 784		0 0	0	
	Land improvements	0		0 0	0	
	Accumulated depreciation			0 0	0	
	Buildings Accumulated depreciation	119, 152, 734 -22, 584, 024		0 0	0	
	Leasehold improvements	-22, 304, 024		0 0	0	
	Accumulated depreciation	0		0 0	0	
	Fixed equipment	0		0 0	0	
. 00	Accumulated depreciation	0		0 0	0	20
. 00	Automobiles and trucks	1, 199, 766		0 0	0	21
	Accumulated depreciation	-1, 011, 813		0 0	0	
	Major movable equipment	61, 661, 998		0 0	0	
	Accumulated depreciation	-38, 399, 490		0 0	0	
	Minor equipment depreciable Accumulated depreciation			0 0	0	
	HIT designated Assets				0	
	Accumulated depreciation	0		0 0	0	
	Mi nor equi pment-nondepreci abl e	0		0 0	0	
	Total fixed assets (sum of lines 12-29)	124, 956, 955		0 0	0	
	OTHER ASSETS					
	Investments	0		0 0	0	
	Deposits on Leases	0		0 0	0	
	Due from owners/officers	0 702 (21		0 0	0	
	Other assets Total other assets (sum of lines 31-34)	90, 783, 631 90, 783, 631		0 0	0	
	Total assets (sum of lines 11, 30, and 35)	248, 968, 944		0 0	0	
	CURRENT LI ABI LI TI ES	240, 700, 744		0	0	
	Accounts payable	2, 506, 516		0 0	0	37
	Salaries, wages, and fees payable	0		0 0	0	38
	Payroll taxes payable	0		0 0	0	
	Notes and Loans payable (short term)	0		0 0	0	
	Deferred income	0		0 0	0	
	Accelerated payments			0 0	0	42
	Due to other funds Other current liabilities	11, 560, 951		0 0	0	
	Total current liabilities (sum of lines 37 thru 44)	14, 067, 467		0 0		
. 00	LONG TERM LI ABI LI TI ES	14,007,407	1	0	0	1 -
. 00	Mortgage payable	0		0 0	0	46
. 00	Notes payable	95, 261, 235		0 0	0	47
	Unsecured Loans	0		0 0	0	
	Other long term liabilities	1, 307, 645		0 0	0	
	Total long term liabilities (sum of lines 46 thru 49	96, 568, 880		0 0	0	
	Total liabilites (sum of lines 45 and 50)	110, 636, 347		0 0	0	51
	CAPITAL ACCOUNTS General fund balance	138, 332, 597	1			52
	Specific purpose fund	130, 332, 397		0		53
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance			0		56
	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion	107 77].
	Total fund balances (sum of lines 52 thru 58)	138, 332, 597		0 0	0	
. 00	Total liabilities and fund balances (sum of lines 51 and	248, 968, 944	1	0 0	0	60

	Provi dor	001 4500/0			
		CCN: 150069	Period: From 01/01/2015 To 12/31/2015	Worksheet G-1 Date/Time Pre 5/18/2016 2:2	pared:
General	Fund	Speci al	Purpose Fund	Endowment Fund	
1.00		3.00		5.00	1.00
	11, 898, 463 138, 332, 597 0 138, 332, 597 0 0			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ \end{array}$
	138, 332, 597		0		19.00
Endowment Fund	PI ant	Fund			
6.00	7.00	8.00			
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
000	0 0 0 0 0 0		0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
	1.00 1.00 0 0 0 0 0 0 0 0 0 0 0 0	Endowment Fund Pl ant 6.00 7.00 0 0 0 0 0 0 0 0 0 0 0 0	Image: constraint of the constrated of the constraint of the constraint of the constraint of the	General Fund Special Purpose Fund 1.00 2.00 3.00 4.00 126,434,134 0 0 0 138,332,597 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4.00 5.00 126, 434, 134 0 0 0 0 138, 332, 597 0 0 0 0 0 0 0 0 0 0 0 138, 332, 597 0

STATE	Financial Systems KING'S DAUGHTERS'		CCN: 150069	Po	ri od:	u of Form CMS-2 Worksheet G-2	
STATEN	IENT OF PATTENT REVENUES AND OPERATING EXPENSES	PLOVE	CCN. 150009		om 01/01/2015	Parts I & II Date/Time Pre	
				10	12/31/2015	5/18/2016 2:2	
	Cost Center Description		I npati ent		Outpati ent	Total	
			1.00		2.00	3.00	
	PART I - PATIENT REVENUES						-
1 00	General Inpatient Routine Services		17.045.4			47.045.455	1 4 00
1.00	Hospi tal		17, 845, 6	55		17, 845, 655	
2.00	SUBPROVIDER - IPF						2.00
3.00 4.00	SUBPROVI DER – I RF SUBPROVI DER						3.00
4.00 5.00	Swing bed - SNF			0		0	
6.00	Swing bed - NF			0		0	
7.00	SKILLED NURSING FACILITY			0		0	7.00
8.00	NURSI NG FACILITY						8.00
9.00	OTHER LONG TERM CARE						9.00
10.00	Total general inpatient care services (sum of lines 1-9)		17, 845, 6	55		17, 845, 655	
	Intensive Care Type Inpatient Hospital Services					· · · ·	1
11.00	INTENSIVE CARE UNIT		3, 019, 4	43		3, 019, 443	11.00
12.00	CORONARY CARE UNI T						12.00
13.00	BURN INTENSIVE CARE UNIT						13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T						14.00
15.00	OTHER SPECIAL CARE (SPECIFY)						15.00
16.00	Total intensive care type inpatient hospital services (sum of I	i nes	3, 019, 4	43		3, 019, 443	16.00
	11-15)						
17.00	Total inpatient routine care services (sum of lines 10 and 16)		20, 865, 0		450 445 705	20, 865, 098	
18.00	Ancillary services		73, 826, 7		150, 115, 795	223, 942, 545	
19.00 20.00	Outpatient services		3, 527, 1		20, 826, 260	24, 353, 432	
20.00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	0	
21.00	HOME HEALTH AGENCY			0	2, 020, 340	2, 020, 340	
23.00	AMBULANCE SERVICES			0	2, 020, 340	2, 020, 340	1
24.00	CMHC			0	0	0	24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)						25.00
26.00	HOSPICE			0	456, 761	456, 761	
27.00	PRO FEES		3, 1	40	81,008,524	81,011,664	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	o Wkst.	98, 222, 1	60	254, 427, 680	352, 649, 840	28.00
	G-3, line 1)						
	PART II - OPERATING EXPENSES						
29.00	Operating expenses (per Wkst. A, column 3, line 200)				120, 963, 444		29.00
30.00	ADD (SPECIFY)			0			30.00
31.00				0			31.00
32.00				0			32.00
33.00				0			33.00
34.00				0			34.00
35.00	Tatal additions (our of Lines 20.25)			0	o		35.00
36.00 37.00	Total additions (sum of lines 30-35) DEDUCT (SPECIFY)			0	0		36.00
37.00	DEDUCT (SPECIFY)			0			37.00
38.00				0			39.00
40.00				0			40.00
40.00				0			41.00
42.00	Total deductions (sum of lines 37-41)			Ĩ	0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer			120, 963, 444		43.00
	to Wkst. G-3, line 4)						

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 150069	Period: From 01/01/2015	Worksheet G-3	
			To 12/31/2015	Date/Time Pre 5/18/2016 2:20	
				371672010 2.2	9 pili
				1.00	
1.00 Total patient revenues (from Wkst.	G-2, Part L, column 3, line	28)		352, 649, 840	1.00
2.00 Less contractual allowances and di	scounts on patients' accounts	5		219, 823, 255	2.00
3.00 Net patient revenues (line 1 minus	line 2)			132, 826, 585	3.00
4.00 Less total operating expenses (fro	m Wkst. G-2, Part II, line 4	3)		120, 963, 444	4.00
5.00 Net income from service to patient	s (line 3 minus line 4)			11, 863, 141	5.00
OTHER I NCOME					
6.00 Contributions, donations, bequests	, etc			499, 146	6.00
7.00 Income from investments				1, 831, 744	7.00
8.00 Revenues from telephone and other	miscellaneous communication :	servi ces		0	8.00
9.00 Revenue from television and radio	servi ce			0	9.00
10.00 Purchase di scounts				0	10.00
11.00 Rebates and refunds of expenses				0	11.00
12.00 Parking lot receipts				0	12.00
13.00 Revenue from Laundry and Linen ser				0	13.00
14.00 Revenue from meals sold to employe				332, 066	
15.00 Revenue from rental of living quar				0	15.00
16.00 Revenue from sale of medical and s		an patients		0	16.00
17.00 Revenue from sale of drugs to othe				0	17.00
18.00 Revenue from sale of medical recor				0	18.00
19.00 Tuition (fees, sale of textbooks,				0	19.00
20.00 Revenue from gifts, flowers, coffe	e shops, and canteen			181, 867	20.00
21.00 Rental of vending machines				0	21.00
22.00 Rental of hospital space				69, 600	
23.00 Governmental appropriations				0	23.00
24.00 OTHER NONPATIENT REVENUE				101, 892	
24.01 GAIN/LOSS ON SALE				780, 563	
24.02 OTHER NONPATIENT OP REVENUE				106, 654	
25.00 Total other income (sum of lines 6	-24)			3, 903, 532	
26.00 Total (line 5 plus line 25)				15, 766, 673	
27.00 GAIN/LOSS ON SALE				3, 868, 210	
28.00 Total other expenses (sum of line				3, 868, 210	
29.00 Net income (or loss) for the period	d (line 26 minus line 28)			11, 898, 463	29.00

	Financial Systems		KING'S DAUGHTE	RS' HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ANALYS	IS OF PROVIDER-BASED HOME HEAL	TH AGENCY COSTS		Provider HHA CCN:		eriod: rom 01/01/2015 o 12/31/2015	Worksheet H Date/Time Pre	pared:
						Home Health Agency I	5/18/2016 2: 2 PPS	
		Sal ari es	Employee Benefits	Transportation (see	chased		Total (sum of cols. 1 thru	
		1.00	2.00	instructions) 3.00	Servi ces 4.00	5.00	5) 6.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	0.00	
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	-	0	
4.00 5.00	Transportation Administrative and General	264, 377	0	0		-	0 276, 585	
0.00	HHA REIMBURSABLE SERVICES	2017077				12,200	2707000	
6.00	Skilled Nursing Care	349, 304				-	386, 124	•
7.00 8.00	Physical Therapy Occupational Therapy	197, 266 47, 168	0	21, 246 5, 063		-	218, 512 52, 231	•
9.00	Speech Pathol ogy	1, 212	0	178			1, 390	
10.00	Medical Social Services	0	0	76		-	76	•
11.00 12.00	Home Health Aide Supplies (see instructions)	44, 331	0	11, 840 0		-	56, 171 882	•
12.00	Drugs	0	0	0			0	•
14.00	DME	0	0	0	0	0	0	14.00
15 00	HHA NONREI MBURSABLE SERVI CES	0	0	0	0	0	0	15 00
15.00 16.00	Home Dialysis Aide Services Respiratory Therapy	0	0	0		-	0	
17.00	Private Duty Nursing	0	0	0		-	0	•
18.00	Clinic	0	0	0	0	-	0	
19.00 20.00	Health Promotion Activities Day Care Program	0	0	0	0	-	0	
20.00	Home Delivered Meals Program	0	0	0		-	0	
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00		0	0	0	0	-	0	
24.00	Total (sum of lines 1-23)	903, 658 Recl assi fi cati		75,223 Adjustments	0 Net Expenses	13, 090	991, 971	24.00
		on	Trial Balance		for Allocation			
			(col. 6 + col.7)		(col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS					1		
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	0	276, 585	0	276, 585			5.00
6.00	Skilled Nursing Care	0	386, 124	0	386, 124			6.00
7.00	Physical Therapy	0	218, 512					7.00
8.00	Occupational Therapy	0	52, 231	0				8.00
9.00 10.00	Speech Pathology Medical Social Services	391	1, 390 467					9.00 10.00
11.00	Home Heal th Ai de	0	56, 171					11.00
12.00	Supplies (see instructions)	0	882					12.00
13.00 14.00	Drugs DME	0	0					13.00 14.00
14.00	HHA NONREI MBURSABLE SERVI CES	0	0	0				14.00
15.00	Home Dialysis Aide Services	0	-					15.00
14 00	Respiratory Therapy	0	0					16.00
	5 5		0	0				17.00 18.00
17.00	lClinic		0	0				19.00
17. 00 18. 00	Clinic Health Promotion Activities	0	0	0	0			19.00
17.00 18.00 19.00 20.00	Health Promotion Activities Day Care Program	0	0	0	0			20.00
17.00 18.00 19.00 20.00 21.00	Health Promotion Activities Day Care Program Home Delivered Meals Program	000000000000000000000000000000000000000	000000000000000000000000000000000000000	0	0			20.00 21.00
18.00 19.00 20.00 21.00 22.00	Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service		0 0 0 0 0	0	0			20.00
17.00 18.00 19.00 20.00 21.00 22.00 23.00	Health Promotion Activities Day Care Program Home Delivered Meals Program	0 0 0 0 0 391	0	0 0 0 0				20.00 21.00 22.00

	Financial Systems		KING'S DAUGHTER				u of Form CMS-	
COST A	LLOCATION - HHA GENERAL SERVICE	COST		Provider HHA CCN:		Period: From 01/01/2015 To 12/31/2015	Worksheet H-1 Part I Date/Time Pre 5/18/2016 2:2	pared:
						Home Health Agency I	PPS	
			Capital Rel	ated Costs				
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	BI dgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportati on	Subtotal (cols. 0-4)	
	· · · · · · · · · · · · · · · · · · ·	0	1.00	2.00	3.00	4.00	4A. 00	
1.00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	0		1		C	1.00
2.00	Fixtures Capital Related - Movable	0		0			C	2.00
3.00	Equipment Plant Operation & Maintenance	0	О	0		0	C	
4.00 5.00	Transportation Administrative and General	0 276, 585	0	0 0		0 0 0 0	276, 585	4.00
(00	HHA REI MBURSABLE SERVI CES						004 404	
6.00 7.00	Skilled Nursing Care Physical Therapy	386, 124 218, 512	0 0	0 0		0 0 0 0	386, 124 218, 512	
8.00	Occupational Therapy Speech Pathology	52, 231	0	0		0 0	52, 231	
9.00 10.00	Medical Social Services	1, 390 467	0	0		0 0	1, 390 467	
11.00	Home Health Aide	56, 171	О	0		0 0	56, 171	
12.00 13.00	Supplies (see instructions) Drugs	882	0	0		0 0	882 C	1
14.00	DME	0	0	0		0 0	C	
15.00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0	0	1	0 0	C	15.00
16.00	Respiratory Therapy	0	0	0		0 0	C	
17.00	Private Duty Nursing	0	0	0		0 0	C	
18.00 19.00	Clinic Health Promotion Activities	0	o	0		0 0	C	
20.00	Day Care Program	0	Ō	0		0 0	C	20.00
21.00 22.00	Home Delivered Meals Program Homemaker Service	0	0	0		0 0	C	
	All Others (specify)	0	0	0		0 0	C	
24.00	Total (sum of lines 1-23)	992, 362 Admi ni strati ve	0 Total (cols	0		0 0	992, 362	24.00
		& General	4A + 5)					
	GENERAL SERVICE COST CENTERS	5.00	6.00					
1.00	Capital Related - Bldg. &							1.00
2.00	Fixtures Capital Related - Movable							2.00
	Equi pment							
3.00 4.00	Plant Operation & Maintenance Transportation							3.00
5.00	Administrative and General	276, 585						5.00
6.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	149, 203	535, 327					6.00
7.00	Physical Therapy	84, 436	302, 948					7.00
8.00 9.00	Occupational Therapy Speech Pathology	20, 183 537	72, 414 1, 927					8.00 9.00
10.00	Medical Social Services	180	647					10.00
11. 00 12. 00	Home Health Aide	21, 705	77,876					11.00
12.00	Supplies (see instructions) Drugs	341 0	1, 223 0					12.00
	DME	0	0					14.00
15.00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00 18.00	Private Duty Nursing Clinic	0	0					17.00
19.00	Health Promotion Activities	0	0					19.00
	Day Care Program	0	0					20.00
21.00 22.00	Home Delivered Meals Program Homemaker Service	0	0					21.00
	All Others (specify)	o o	0					23.00
	Total (sum of lines 1-23)		992, 362					24.00

COST ALLO	OCATION - HHA STATISTICAL BAS			RS' HOSPI TAL			u of Form CMS-2	2332-10
		1 S		Provi der HHA CCN:	CCN: 150069 157141	Period: From 01/01/2015 To 12/31/2015	Worksheet H-1 Part II Date/Time Pre 5/18/2016 2:2	pared:
						Home Health Agency I	PPS	
		Capital Rel	ated Costs	ł				
		. ,	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	(MI LEAGE)	onReconciliation	& General (ACCUM. COST)	_
		1.00	2.00	3.00	4.00	5A. 00	5.00	
	NERAL SERVICE COST CENTERS	-						
	apital Related - Bldg. &	0				0		1.00
2.00 Ca	xtures apital Related – Movable quipment		0			0		2.00
	ant Operation & Maintenance	0	0	0		0		3.00
	ransportation (see	0	0	0		0		4.00
	nstructions)		Ū			0		
	dministrative and General	0	0	C		0 -276, 585	715, 777	5.00
HH.	IA REIMBURSABLE SERVICES							
	killed Nursing Care	0	0	C		0 0	386, 124	
	nysical Therapy	0	0	0		0 0	218, 512	
	ccupational Therapy	0	0	C		0 0	52, 231	
	beech Pathology	0	0	C		0 0	1, 390	
	edical Social Services	0	0	0		0 0	467	
	ome Health Aide	0	0	0		0 0	56, 171	
	upplies (see instructions)	0	0	0		0 0	882	
	rugs	0	0	0		0	0	
	IA NONREI MBURSABLE SERVI CES	0	0	U		0 0	0	14.00
	ome Dialysis Aide Services	0	0	0	1	0 0	0	15.00
	espiratory Therapy	0	0	0		0 0	0	
	rivate Duty Nursing	0	0	0		0 0	0	
	inic	0	0	0		0 0	0	1
19.00 He	ealth Promotion Activities	0	0	C		0 0	0	19.00
20. 00 Da	ay Care Program	0	0	0		0 0	0	20.00
21.00 Ho	ome Delivered Meals Program	0	0	0		0 0	0	21.00
	omemaker Service	0	0	C		0 0	0	22.00
	l Others (specify)	0	0	0		0 0	0	
	otal (sum of lines 1-23)	0	0	C		0 -276, 585	715, 777	
	ost To Be Allocated (per orksheet H-1, Part I)	0	0	C		0	276, 585	25.00
26.00 Un	nit Cost Multiplier	0. 000000	0. 000000	0.00000	0.0000	00	0. 386412	26.00

	TO HHA COST CEN	ILK3	riovidei	CCN: 150069	Peri od:	Worksheet H-2	
			HHA CCN:	157141	From 01/01/2015 To 12/31/2015		
					Home Health Agency I	PPS	
		CAPI	TAL RELATED CO	OSTS			
Cost Center Description	HHA Trial Balance (1)	NEW BLDG & FIXT	NEW BLDG & FIXT HHA/HO	NEW MVBLE EQUI P	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	0	1.00	1.01	2.00	4.00	4A	
.00Administrative and General.00Skilled Nursing Care.00Physical Therapy.00Occupational Therapy.00Speech Pathology.00Medical Social Services.00Home Health Aide.00Supplies (see instructions).00Drugs.00DME1.00Home Dialysis Aide Services2.00Respiratory Therapy3.00Private Duty Nursing4.00Clinic5.00Health Promotion Activities6.00Day Care Program7.00Home Delivered Meals Program8.00Holmers (specify).00Total (sum of lines 1-19) (2)1.00Unit Cost Multiplier: column.26, line 1 divided by the sum			18, 881 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 56, 862 0 75, 129 0 42, 428 0 10, 145 0 261 0 84 0 9, 535 0 0 0 0 0	345, 376 82, 559 2, 188 733 87, 41 0 1, 223 0 (0 0 (0 0 (0 0 (0 0 (0 0 (0 0 (0 0 (3.0 4.0 5.0 6.0 7.0 8.0 9.0 10.0 11.0 12.0 12.0 14.0 15.0 14.0 15.0 18.0 19.0 20.0
of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places. Cost Center Description		OPERATI ON OF	LAUNDRY &	HOUSEKEEPIN	G DI ETARY	CAFETERI A	
	& GENERAL	PLANT	LINEN SERVICE	9.00	10.00	11.00	
 .00 Administrative and General .00 Skilled Nursing Care .00 Physical Therapy .00 Occupational Therapy .00 Speech Pathology .00 Medical Social Services .00 Home Health Aide .00 Drugs .00 DME 1.00 Home Dialysis Aide Services .00 Respiratory Therapy 3.00 Private Duty Nursing 4.00 Clinic 5.00 Health Promotion Activities 6.00 Day Care Program .00 Home Delivered Meals Program 8.00 Home Service 9.00 All Others (specify) 0.00 Unit Cost Multiplier: column 26, line 1 divided by the sur of column 26, line 1, rounded to 6 decimal places. 	5.00 16,004 128,985 72,975 17,444 462 154 18,469 258 0 0 0 0 0 0 0 0 0 0 0 0 0	7.00 59,223 0 0 0 0 0 0 0 0 0 0 0	8.00 0 0 0 0 0 0 0 0 0 0 0 0		10.00 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. (3. (4. (5. (7. (8. (9. (10. (11. (12. (112. (114. (15. (15. (15. (16. (17. (18. (19. (

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

LOCATION OF GENERAL SERVICE COSTS TO	U HHA CUSI CEN	IERS			Period: From 01/01/2015	Worksheet H-2 Part I	
			HHA CCN:	157141	To 12/31/2015	Date/Time Pre 5/18/2016 2:2	parec 9 pm
					Home Health Agency I	PPS	
Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	
	13.00	14.00	15.00	16.00	17.00	19.00	
 Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) DHE Home Dialysis Aide Services Respiratory Therapy Home Delivered Meals Program Home Mealt Service Administrative and fines 1-19) (2) Unit Cost Multiplier: column 26, line 1, rounded to 6 decimal places. 		0 0 0 0 0 0 4, 967 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19.
Cost Center Description	RADI OLOGY SCHOOL	HUB SITE - 3RD YEAR MED STUDENTS	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments		Allocated HHA A&G (see Part II)	
	23.00	23.01	24.00	25.00	26.00	27.00	
 Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DHE Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Haelth Promotion Activities Day Care Program Home Delivered Meals Program Home All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to 			150, 970 739, 441 418, 351 100, 003 2, 650 885 105, 880 6, 448 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 150, 970 0 739, 441 0 418, 351 0 100, 003 0 2, 650 0 285 0 105, 880 0 6, 448 0 0	81, 267 45, 978 10, 991 291 97 11, 637 709 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3 3 4 5 6 7 7 8 9 9 9 100 111 122 133 144 155 166 177 188 19 20

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

Heal th	Financial Systems		KING'S DAUGHTERS'	HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS	Provi der	CCN: 150069	Period:	Worksheet H-2	
				HHA CCN:	157141	From 01/01/2015 To 12/31/2015		nared
				11111 0011	107111	10 12/01/2010	5/18/2016 2:2	
						Home Health	PPS	
						Agency I		
	Cost Center Description	Total HHA						
		<u>Costs</u> 28.00						
1.00	Administrative and General	20.00			1			1.00
2.00	Skilled Nursing Care	820, 708						2.00
3.00	Physical Therapy	464, 329						3.00
4.00	Occupational Therapy	110, 994						4.00
5.00	Speech Pathology	2, 941						5.00
6.00	Medical Social Services	982						6.00
7.00	Home Health Aide	117, 517						7.00
8.00	Supplies (see instructions)	7, 157						8.00
9.00	Drugs	0						9.00
10.00	DME	0						10.00
11.00	Home Dialysis Aide Services	0						11.00
12.00	Respiratory Therapy	0						12.00
13.00	Private Duty Nursing	0						13.00
14.00	Clinic	0						14.00
15.00	Health Promotion Activities	0						15.00
16.00	Day Care Program	0						16.00
17.00	Home Delivered Meals Program	0						17.00 18.00
18. 00 19. 00	Homemaker Service	0						18.00
20.00	All Others (specify) Total (sum of lines 1–19) (2)	1, 524, 628						20.00
20.00	Unit Cost Multiplier: column	1, 524, 020						20.00
21.00	26, line 1 divided by the sum							21.00
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							

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

Health Financial Systems		KING'S DAUGHTE	RS' HOSF	PI TAL		In Lie	eu of Form CMS-2	2552-10
ALLOCATION OF GENERAL SERVICE COSTS T BASIS	O HHA COST CEN	TERS STATISTICA		ovider ACCN:	CCN: 150069 157141	Period: From 01/01/2015 To 12/31/2015		pared:
						Home Health	PPS	<u>, bur</u>
	CAPI	TAL RELATED CO	OSTS			Agency I		
Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	NEW BLDG & FIXT HHA/HO (SQUARE FEET)	NEW M EQU (SQU FEE	l P ARE	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconci I i ati on	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
	1.00	1.01	2.0		4.00	5A	5.00	
 1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 20.00 Total (sum of lines 1-19) 21.00 Total cost to be allocated 22.00 Unit cost multiplier 	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		S OF	349, 30 197, 20 47, 11 1, 2 30 44, 3 44, 3 904, 00 194, 40	04 0 66 0 58 0 12 0 91 0 0 0 <td< td=""><td>610, 456 345, 376 82, 559 2, 188 731 87, 411 1, 223 0 0 0 0 0</td><td>$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ \end{array}$</td></td<>	610, 456 345, 376 82, 559 2, 188 731 87, 411 1, 223 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ \end{array}$
	7.00	8.00	9.0	0	10.00	11.00	NRSING HRS) 13.00	
 1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 20.00 Total (sum of lines 1-19) 21.00 Total cost to be allocated 22.00 Unit cost multiplier 	2, 748 2, 748 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00

Heal th	Financial Systems		KING'S DAUGHTE	RS' HOSPI TAL		In Lie	u of Form CMS-:	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS 1				CCN: 150069	Peri od:	Worksheet H-2	
BASI S				HHA CCN:	157141	From 01/01/2015 To 12/31/2015		
						Home Health Agency I	PPS	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVI		RADI OLOGY	
		SERVICES &	(COSTED	RECORDS &		ANESTHET I STS	SCHOOL	
		SUPPLY (COSTED	REQUIS.)	LIBRARY (TIME SPENT)	(TIME SPENT)	(ASSI GNED TI ME)	(ASSIGNED TIME)	
		REQUIS.)		(TIME SPENT)	SPENT)	IIWE)	IIWE)	
		14.00	15.00	16.00	17.00	19.00	23.00	
1.00	Administrative and General	0	0	0		0 0		
2.00 3.00	Skilled Nursing Care Physical Therapy	0	0	0		0 0	0	
4.00	Occupational Therapy	0	0	0		0 0	0	
5.00	Speech Pathol ogy	0	0	0		0 0	0	
6.00	Medical Social Services	0	0	0		0 0	0	
7.00	Home Health Aide	0	0	0		0 0	0	
8.00 9.00	Supplies (see instructions) Drugs	2,068	0	0		0 0 0 0	0	
10.00	DME	0	0	0		0 0		
11.00	Home Dialysis Aide Services	0	0	0		0 0	0	11.00
12.00	Respiratory Therapy	0	0	0		0 0	0	
13.00 14.00	Private Duty Nursing Clinic	0	0	0		0 0	0	
14.00	Health Promotion Activities	0	0	0	1	0 0	0	
16.00	Day Care Program	0	0	0		0 0	0	
17.00	Home Delivered Meals Program	0	0	0		0 0	0	
18.00	Homemaker Service	0	0	0		0 0	0	
19.00 20.00	All Others (specify) Total (sum of lines 1-19)	0 2, 068	0	0		0 0	0	19.00 20.00
20.00	Total cost to be allocated	4, 967	0	0		0 0	0	20.00
22.00	Unit cost multiplier	2. 401838	0. 000000	0. 000000	0.0000	0. 000000	0. 000000	
	Cost Center Description	HUB SITE - 3RD						
		YEAR MED STUDENTS						
		(ASSI GNED						
		TIME)						
1 00		23.01						1.00
1.00 2.00	Administrative and General Skilled Nursing Care	0						1.00 2.00
3.00	Physical Therapy	0						3.00
4.00	Occupational Therapy	0						4.00
5.00	Speech Pathol ogy	0						5.00
6.00 7.00	Medical Social Services Home Health Aide	0						6.00 7.00
8.00	Supplies (see instructions)	0						8.00
9.00	Drugs	0						9.00
10.00	DME	0						10.00
11.00	Home Dialysis Aide Services	0						11.00
12.00 13.00	Respiratory Therapy Private Duty Nursing	0						12.00 13.00
14.00	Clinic	0						14.00
15.00	Health Promotion Activities	0						15.00
16.00	Day Care Program	0						16.00
17.00 18.00	Home Delivered Meals Program Homemaker Service	0						17.00 18.00
19.00	All Others (specify)	0						18.00
20.00		0						20.00
21.00	Total cost to be allocated	0						21.00
22.00	Unit cost multiplier	0. 000000						22.00

APPORT I (Both H) (D) FATLEN SLAVICE COSTS Provider (CSL 1500A) From (0707201) Period (Prov (SL 1500A)) From (0707201) Period (Prov (SL 1500A)) From (0707201) Period (Prov (SL 1500A)) From (0700) Period (Prov (SL 1500A)) From (07001)	Heal th	n Financial Systems		KING'S DAUGHTE	RS' HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
HA COX: 157141 To 12/31/201 Distract Time Progreed Cost Center Description From, Wat. Facility Costs (from Wat.			S			CCN: 150069	Peri od:	Worksheet H-3	
The Will Inclusion PPS Cost Center Description Frame Mext. H=2. Part I) col. 28, line H=2. Part I) col. 28, line H=2. Part I) part I) part I) Total Wist S (row Mext. Part I) part I) Total Wist S (row Mext. Part I) Total Wist S (row Mext. Part I) Norrege (ost (row Mext. Part I) Norrege (ost (row Mext. Part I) PART I - COMPUTATION OF LESSE OF ACCREGATE PROCEMA COST. Accretion Therapy 2.00 3.00 4.00 5.00 1:00 2.00 3.00 4.00 5.00 100.0 2.00 3.00 4.00 5.00 1:00 Scient Therapy 4.00 110.994 0 110.994 644, 329 3.01 4.00 100.74.00 2:00 Psycin Therapy 4.00 110.994 0 120.74.11 982.070 982.070 982.070 982.070 982.070 982.070 982.070 982.070 982.070 982.070 982.070 982.070 982.070 982.070 982.07 982.00 982.00 982.00 982.07 982.00 982.00 982.00 982.00 982.00 982.00 982.00 982.00					HHA CCN:	157141		Date/Time Pre	pared: 9 pm
Cost Center Description From Wist col 28. Line Jack Line					Ti tl	e XVIII			
H=2, Fart 1, col. 28, Line H=2, Fart 1) Chrom Wist (from Part 1) Col. 1 Per Visit (col. 3+ col. 2, 00 Per Visit (col. 3+ col. 2, 00 PART 1 - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST. AGGREGATE OF THE PROGRAM LIM TATION Cost Per Visit Computation 2, 00 4, 00 5, 00 BREEFICIARY COST LIMITATION Cost Per Visit Computation 2, 00 820, 708 820, 708 4, 200 10, 00 0.00 Skilled Aursing Care 20, 00 2, 00 820, 708 820, 708 4, 00 110, 974, 41 110, 974, 40 110, 974, 41 110, 974, 41 110, 974, 41 110, 974, 41 110, 974, 41 110, 974, 41 110, 974, 41 110, 974, 41 110, 974, 41 110, 974, 41 110, 974, 41 110, 974, 41 110, 974, 41 110, 974, 41 110, 974, 41 110, 974, 41		Cost Center Description	From. Wkst.	Facility Costs	Shared	Total HHA		Average Cost	
PART I - COMPUTATION OF LESSER OF ACCREGATE PROCRAM COST, ACCREGATE OF THE PROCRAM LIMITATION COST, OR 40 PART I - COMPUTATION OF LESSER OF ACCREGATE PROCRAM COST, ACCREGATE OF THE PROCRAM LIMITATION COST, OR 90 State For Visit Computation 200 900 1:00 2:00 900 1:00 2:00 900 1:00 2:00 900 1:00 2:00 900 1:00 2:00 900 1:00 2:00 900 1:00 2:00 900 1:00 2:00 900 1:00 2:01 900 1:00 2:01 900 1:00 2:01 1:00 1:00 2:01 1:00 1:00 2:01 1:00 1:00 1:00 2:01 1:00 1:00 1:00 1:00 1:00 2:00 1:00 1:00 2:00 1:00 1:00 2:00 1:00 1:00 1:00		p							
Description 0 1.00 2.00 3.00 4.00 5.00 BRAT 1 - COMPUTATION OF LESSER 0F AGREGATE PROCEAN LIMITATION COST. OR BENETICIANY COST LIMITATION COST. OR BENETICIANY COST. COST LIMITATION COST. OR BENETICIANY COST. COST LIMITATION COST. OR BENETICIANY COST.			col. 28, line	H-2, Part I)		+ 2)			
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, ÁGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION Cost Per Visit Computation Part A B20,708 4,200 100 2,00 100 2,00 100,701 6,00 100,701 6,00 100,701 6,00 100,701 6,00 100,701 6,00 100,701 6,00 100,701 6,00 100,701 6,00 100,701 6,00 100,701 6,00 100,701 6,00 100,701 6,00 100,701 6,00 100,701 6,00 100,701 6,00 100,701 6,00 100,701 100 100,701 100,701 100,701 100,701 100,701 100,701 100,701 100,700 117,517 100,701 100,700 117,517 100,701 100,700 117,517 100,701 100,700 117,517 100,701 100,700 100,700 100,700 100,700 100,700 100,700 100,700 100,700 100,700 100,700 100,700 100,700 100,700 100,700 100,700 100,700 100,700				1.00		2.00	4.00		
BriteFicIARY COST_LIMITATION Cost_FW Visit_Computation		PART I - COMPUTATION OF LESSER							
1.00 Skilled Nursing Care 2.00 820.708 820.708 4.200 195.41 1.00 2.00 Physical Therapy 3.00 644.339 0 444.339 3.01 195.41 1.00 195.41 1.00 195.41 1.00 195.41 1.00 195.41 1.00 195.41 1.00 195.41 1.00 195.41 1.00 195.41 1.00 195.41 1.00 195.41 1.00 1.00 2.941 0 444.339 0.0 444.339 0.0 444.339 0.0 2.941 1.4 2.00 1.00 2.941 1.0 962.0 5.00 962 1.00 2.941 1.0 962.0 5.00 1.03 1.00 2.041 1.0 2.05 1.0		BENEFICIARY COST LIMITATION							
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O 1.00 2.00 3.00 4.00 5.00 Supplies and Drugs Cost Computations 15.00 Cost of Medical Supplies 8.00 7,157 0 7,157 0 0.000000 16.00 16.00 Cost of Drugs 9.00 0 0 0 0 0 0.000000 16.00 Program Visits Cost of Services Part B Cost Center Description Part A Part B Not Subject to Deductibles & Coinsurance Deductibles & Coinsurance			20, 11116	11-2, Tart I)		+ 2)	Record)		
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16.00 Cost of Drugs 9.00 0				l .	l .			1	
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Cost Center Description Part A Part B Part B Not Subject to Deductibles & Coinsurance Part B Part A Not Subject to Deductibles & Coinsurance Part A PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION Cost Per Visit Computation Program 0 1.00 Skilled Nursing Care 0 2,714 0 530,343 1.00 Speech Pathology 0 446 0 81,957 3.00 O 0 1,681 4.00 5.00 Medical Social Services 0 1,311 0	16.00	Cost of Drugs	9.00			-	0 0	0.000000	16.00
Part BCost Center DescriptionPart APart BPart APart APart BPart BNot Subject to Deductibles & CoinsuranceSubject to Deductibles & CoinsurancePart APart BImage: Colspan="6">Colspan="6">Not Subject to Deductibles & CoinsurancePART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION Cost Per Visit ComputationPart APart BImage: Colspan="6">Not Subject to Deductibles & Coinsurance1.00Skilled Nursing Care Cost Per Visit Computation02,7140530,3431.002.00Physical Therapy Speech Pathology0446081,9573.004.00Speech Pathology0801,6814.005.00Medical Social Services01090,9976.00				FIOGRAFII VISILS					
Cost Center DescriptionPart ANot Subject to Deductibles & CoinsurancePart ANot Subject to Deductibles & CoinsurancePart ANot Subject to Deductibles & CoinsuranceSubject to Deductibles & CoinsuranceSubject to Deductibles & CoinsuranceSubject to Deductibles & CoinsurancePART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATIONPart ANot Subject to Deductibles & Coinsurance1.00Skilled Nursing Care02,7140530,3431.002.00Physical Therapy02,2480342,1232.003.00Occupational Therapy0446081,9573.004.00Speech Pathology0801,6814.005.00Medical Social Services01,311090,9976.00				Par	tВ		Part B		
Deductibles & CoinsuranceDeductibles & CoinsuranceDeductibles & CoinsuranceDeductibles & CoinsurancePART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		Cost Center Description	Part A			Part A		Subject to	
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PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION Cost Per Visit Computation1.00Skilled Nursing Care02,7140530,3431.002.00Physical Therapy02,2480342,1232.003.00Occupational Therapy0446081,9573.004.00Speech Pathology0801,6814.005.00Medical Social Services0109825.006.00Home Health Aide01,311090,9976.00									
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3.00 Occupational Therapy 0 446 0 81,957 3.00 4.00 Speech Pathology 0 8 0 1,681 4.00 5.00 Medical Social Services 0 1 0 982 5.00 6.00 Home Heal th Ai de 0 1,311 0 90,997 6.00						1			
4.00 Speech Pathology 0 8 0 1,681 4.00 5.00 Medical Social Services 0 1 0 982 5.00 6.00 Home Heal th Ai de 0 1,311 0 90,997 6.00						1			
5.00 Medical Social Services 0 1 0 982 5.00 6.00 Home Heal th Ai de 0 1,311 0 90,997 6.00			0						
		Medical Social Services	0	1					
7.00 Total (sum of lines 1-6) 0 6,728 0 1,048,083 7.00									
	7.00	Total (sum of lines 1-6)	0	6, 728		I	0 1, 048, 083		7.00

APPORT	IONMENT OF PATIENT SERVICE COST	S		Provi der	CCN: 150069	Period: From 01/01/2015	Worksheet H-3 Part I	3
				HHA CCN:	157141	To 12/31/2015	Date/Time Pre 5/18/2016 2:2	epared 29 pm
				Ti tl	e XVIII	Home Health Agency I	PPS	•
	Cost Center Description	6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation	0.00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0.00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10100		
8.00 8.01 9.00 9.01	Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy							8. 0 8. 0 9. 0 9. 0
0. 00 0. 01 1. 00	Occupational Therapy Occupational Therapy Speech Pathology							10. 0 10. 0 11. 0
1.01 2.00 2.01	Speech Pathology Medical Social Services Medical Social Services							11. 0 12. 0 12. 0
3.00 3.01 4.00	Home Health Aide Home Health Aide Total (sum of lines 8-13)							13. 0 13. 0 14. 0
	· · · · · · · · · · · · · · · · · · ·	Prog	ram Covered Cha	irges	Cost of Services			
			Par			Part B	0.11.1.1	-
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
5. 00 6. 00	Supplies and Drugs Cost Computa Cost of Medical Supplies Cost of Drugs	ations 0	0	0		0 0	C	
0.00	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00						
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION		PROGRAM COST, A	GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	!	
	Cost Per Visit Computation							
. 00 . 00 . 00	Skilled Nursing Care Physical Therapy Occupational Therapy	530, 343 342, 123 81, 957						1. (2. (3. (
. 00 . 00	Speech Pathology Medical Social Services	1, 681 982						4. (5. (
. 00	Home Health Aide Total (sum of lines 1-6) Cost Center Description	90, 997 1, 048, 083						6. (7. (
		12.00						
. 00	Limitation Cost Computation Skilled Nursing Care							8.
. 01 . 00	Skilled Nursing Care Physical Therapy							8. 9.
01 0.00 0.01	Physical Therapy Occupational Therapy Occupational Therapy							9. 10. 10.
1.00 1.01 2.00	Speech Pathology Speech Pathology Medical Social Services							11. 11. 12.
2.01 3.00 3.01	Medical Social Services Home Health Aide Home Health Aide							12. 13. 13.

Heal th	Financial Systems		KING'S DAUGHTE	RS' HOSPI TAL		In Lie	2552-10	
APPORT	TIONMENT OF PATIENT SERVICE COST	S		Provi der	CCN: 150069	Peri od:	Worksheet H-3	
				HHA CCN:	157141	From 01/01/2015 To 12/31/2015		
				Ti tl	e XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
			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 SERVIC	CES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	VTS		
1.00	Physical Therapy	66.00	0. 335969	0)	0 col. 2, line 2	. 00	1.00
2.00	Occupational Therapy	67.00	0. 000000	0		0 col. 2, line 3	. 00	2.00
3.00	Speech Pathology	68.00	0. 000000	0)	Ocol. 2, line 4	. 00	3.00
4.00			0. 488325	0)	0 col. 2, line 1	5.00	4.00
4.01			0. 053638	0		0 col. 2, line 1	5. 01	4.01
5.00	Cost of Drugs	0. 117218	0)	0 col. 2, line 1	6. 00	5.00	

	Financial Systems KING'S DAUGHTERS' H ATION OF HHA REIMBURSEMENT SETTLEMENT		CCN: 150069	Peri od:	u of Form CMS-: Worksheet H-4	
		HHA CCN:	157141	From 01/01/2015 To 12/31/2015	Part I-II	epare
		Ti tl	e XVIII	Home Health Agency I	PPS	. / pi
					t B	
			Part A	Not Subject to		
					Deductibles &	
				Coi nsurance	Coi nsurance	
	DADT 1 COMPUTATION OF THE LECCED OF DEACONADLE COST OD CHICTOM		1.00	2.00	3.00	-
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMA Reasonable Cost of Part A & Part B Services	ARY CHARGE	5			-
0	Reasonable cost of services (see instructions)			0 0	0	1 1
0	Total charges			0 0		
	Customary Charges		1			
0	Amount actually collected from patients liable for payment for s	servi ces		0 0	0	3
	on a charge basis (from your records)					
00	Amount that would have been realized from patients liable for pa			0 0	0	4
	for services on a charge basis had such payment been made in acc with 42 CEP 8412 12(b)	cordance				
0	with 42 CFR §413.13(b) Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	0. 000000	0. 000000	5
0	Total customary charges (see instructions)		0.0000	0 0.000000	0.000000	
0	Excess of total customary charges over total reasonable cost (co	omplete		0 0	0	
	only if line 6 exceeds line 1)					
0	Excess of reasonable cost over customary charges (complete only	ifline		0 0	0	8
~	1 exceeds line 6)			0 0.040		
0	Primary payer amounts			0 2,940 Part A	O Part B	(
				Services	Services	
				1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
	Total reasonable cost (see instructions)			0		
00	Total PPS Reimbursement - Full Episodes without Outliers			0	,	
	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes			0	28, 815 11, 963	
	Total PPS Reimbursement - PEP Episodes			0	14, 077	
	Total PPS Outlier Reimbursement - Full Episodes with Outliers			0		
00	Total PPS Outlier Reimbursement - PEP Episodes			0	0	
00	Total Other Payments			0	0	1
00	DME Payments			0	0	
00	Oxygen Payments			0	0	
	Prosthetic and Orthotic Payments			0	0	
00 00	Part B deductibles billed to Medicare patients (exclude coinsura	ance)		0	095 149	
	Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8)			0	985, 148 0	
	Subtotal (line 22 minus line 23)			0		
	Coinsurance billed to program patients (from your records)			0	0	
				0	-	
00	Net cost (line 24 minus line 25)				1	1
00 00 00	Reimbursable bad debts (from your records)					2
00 00 00 00	Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins	tructions)	1			28
00 00 00 00 00	Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line 2	tructions) 27)	1	0		28 29
00 00 00 00 00 00	Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line 2 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	tructions) 27)		0	0	28 29 30
00 00 00 00 00 00 50	Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line 2 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)	tructions) 27)		0	0	28 29 30 30
00 00 00 00 00 50 00	Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see inst Total costs - current cost reporting period (line 26 plus line 2 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Subtotal (see instructions)	tructions) 27)		0 0 0	0 0 985, 148	28 29 30 30 31
00 00 00 00 00 50 00 00	Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see inst Total costs - current cost reporting period (line 26 plus line 2 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Subtotal (see instructions) Sequestration adjustment (see instructions)	tructions) 27)		0 0 0 0	0 0 985, 148 19, 703	28 29 30 30 31 31
00 00 00 00 00 50 00 01 00	Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see inst Total costs - current cost reporting period (line 26 plus line 2 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Subtotal (see instructions)	tructions) 27)		0 0 0	0 0 985, 148 19, 703 965, 444	28 29 30 30 31 31 31
. 00 . 00 . 00 . 00 . 00 . 00 . 50	Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see inst Total costs - current cost reporting period (line 26 plus line 2 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Subtotal (see instructions) Sequestration adjustment (see instructions) Interim payments (see instructions)	27)		0 0 0 0 0	0 0 985, 148 19, 703 965, 444 0	30 30 31 31 32 33

	SIS OF PAYMENTS TO PROVIDER-BASED HHAS FOR SERVICES RENDERED T M BENEFICIARIES		vider (CCN:	CCN: 150069 157141		eriod: rom 01/01/2015 o 12/31/2015	Worksheet H-5 Date/Time Prep 5/18/2016 2:29	pared
						Home Health Agency I	PPS	7 piii
		l np	atient	Part A		Par	t B	
		mm/dd/y		Amount		mm/dd/yyyy	Amount	
		1.00		2.00	-	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero				0		965, 444 0	1. (2. (
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							3. (
	Program to Provider					I		
01					0		0	3.
02 03					0		0	3. 3.
)3)4					0		0	3. 3.
)4)5					0		0	3.
.0	Provider to Program				0			0
0					0		0	3
51					0		0	3
2					0		0	3
3					0		0	3
54					0		0	3
9	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0		0	3
	3. 50-3. 98)							
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)				0		965, 444	4
	TO BE COMPLETED BY CONTRACTOR							
0	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							5
	Program to Provider					I		
)1					0		0	5
2					0		0	5
3					0		0	5
	Provider to Program							
0					0		0	5
1					0		0	5
2 9	Subtotal (sum of lines 5.01–5.49 minus sum of lines				0		0	5 5
7	5. 50-5. 98)				U		0	Э
0	Determined net settlement amount (balance due) based on the cost report. (1)							6
)1	SETTLEMENT TO PROVIDER				0		1	6
)2	SETTLEMENT TO PROGRAM				0		0	6
00	Total Medicare program liability (see instructions)				0		965, 445	7
						Contractor	NPR Date	
						Number	(Mo/Day/Yr)	
			0			1.00	2.00	

Heal th	Financial Systems	KING'S DAUGHTER	RS' HOSPI TAL		In Lie	u of Form CMS-:	2552-10
ANALYS	IS OF PROVIDER-BASED HOSPICE COSTS		Provi der	CCN: 150069	Peri od:	Worksheet K	
			Hospi ce (CCN: 151535	From 01/01/2015 To 12/31/2015	Date/Time Pre 5/18/2016 2:2	
					Hospi ce I		
		Salaries (from	Empl oyee	Transportatio	on Contracted	Other	
		Wkst. K-1) E	Benefits (from	(see inst.)	Services (from		
			Wkst. K-2)		Wkst. K-3)		
		1.00	2.00	3.00	4.00	5.00	
4 00	GENERAL SERVICE COST CENTERS	1		1			1 1 00
1.00	Capital Related Costs-Bldg and Fixt.				0	0	
2.00	Capital Related Costs-Movable Equip.				0	0	
3.00	Plant Operation and Maintenance	0	0		0 0	0	
4.00	Transportation - Staff	0	0		0 0	0	
5.00	Volunteer Service Coordination	0	0		0 0	0	
6.00	Administrative and General	33, 835	0		0 0	53, 977	6.00
7 00	I NPATI ENT_CARE_SERVI CE		0	1		0	1 7 00
7.00	Inpatient - General Care	0	0		0 0		
8.00	Inpatient - Respite Care	0	0		0 0	0	8.00
0.00	VI SI TI NG SERVI CES		0		0 0	0	0.00
9.00	Physician Services	0			-		
10.00	Nursing Care	2, 357	0		0 0	0	
11.00	Nursing Care-Continuous Home Care	2 424	0		0	0	
12.00	Physical Therapy	3, 426	0	.,		0	
13.00	Occupational Therapy	278	0	-	0 0	0	
14.00 15.00	Speech/ Language Pathology Medical Social Services	81, 254	0			0	
		81, 254	0			0	
16.00	Spiritual Counseling	0	0		0 0	0	
17.00 18.00	Dietary Counseling Counseling - Other	0	0		0 0	0	
18.00	Home Health Aide and Homemaker	10, 861	0			0	
20.00	HH Aide & Homemaker - Cont. Home Care	10, 881	0		0 0	0	
20.00	Other	0	0		0 0	0	
21.00	OTHER HOSPICE SERVICE COSTS	0	0	1	0 0	0	21.00
22.00	Drugs, Biological and Infusion Therapy	0	0		0 0	39, 869	22.00
23.00	Anal gesi cs	0	0		0 0	0	•
24.00	Sedatives / Hypnotics	0	0		0 0	0	•
25.00	Other - Specify	0	0		0 0	0	
26.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	
27.00	Pati ent Transportati on	0	0		0 0	0	
28.00	Imaging Services	0	0		0 0	0	
29.00	Labs and Diagnostics	0	0		0 0	0	
30.00	Medical Supplies	0	0		0 0	0	
31.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	•
32.00	Radi ati on Therapy	0	0		0 0	0	
33.00	Chemotherapy	0	0		0 0	0	33.00
34.00	Other	0	0		0 0	0	
	HOSPI CE NONREI MBURSABLE SERVI CE	1					1
35.00	Bereavement Program Costs	0	0		0 0	0	35.00
36.00	Volunteer Program Costs	0	0		0 0	0	36.00
37.00	Fundrai si ng	0	0		0 0	0	37.00
38.00	Other Program Costs	0	0		0 0	0	38.00
39.00	Total (sum of lines 1 thru 38)	132, 011	0	16, 75	53 0	93, 846	39.00

Heal th	Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Li	eu of Form CMS-	2552-10
ANALYS	IS OF PROVIDER-BASED HOSPICE COSTS		Provi der	CCN: 150069	Peri od:	Worksheet K	
			llooni oo	CON. 151525	From 01/01/2015		norod.
			Hospi ce	CCN: 151535	To 12/31/2015	5 Date/Time Pre 5/18/2016 2:2	
					Hospi ce I	37 107 2010 2.2	. / piii
		Total (cols.	Recl assi fi cat	Subtotal (co		Total (col. 8	
		1-5)	on	$6 \pm col. 7$		± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
-	GENERAL SERVICE COST CENTERS				I	•	
1.00	Capital Related Costs-Bldg and Fixt.	0		C	0 (0 0	1.00
2.00	Capital Related Costs-Movable Equip.	0		b	0 0	o o	2.00
3.00	Plant Operation and Maintenance	0		b	0 0	o o	3.00
4.00	Transportation - Staff	0		D	0 0	o o	4.00
5.00	Volunteer Service Coordination	0		D	0 0	o o	5.00
6.00	Administrative and General	87, 812		0 87,8	12 (87, 812	6.00
	I NPATI ENT CARE SERVI CE		•	· · · · ·			
7.00	Inpatient - General Care	0		C	0 (0 0	7.00
8.00	Inpatient - Respite Care	0		D	0 0	o o	8.00
	VI SI TI NG SERVI CES					•	
9.00	Physician Services	0		C	0 (0 0	9.00
10.00	Nursing Care	2,357		2,3	57 (2, 357	10.00
11.00	Nursing Care-Continuous Home Care	0		D	0 0	o o	11.00
12.00	Physical Therapy	5, 415		5,4	15 (5, 415	12.00
13.00	Occupational Therapy	342			42 (342	13.00
14.00	Speech/ Language Pathol ogy	0		b	0 0	ol l	14.00
15.00	Medical Social Services	91, 503	-39	1 91, 1	12 (91, 112	15.00
16,00	Spiritual Counseling	304			04 (304	
17.00	Di etary Counsel i ng	0		2	0 0		
18.00	Counseling - Other	0		0	0 0	ol o	18.00
19.00	Home Health Aide and Homemaker	15,008		15,0	08 (15,008	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0)	0 0		
21.00	Other	0			0 0	ol o	
	OTHER HOSPICE SERVICE COSTS		1				
22.00	Drugs, Biological and Infusion Therapy	39, 869		39,8	69 (39, 869	22.00
23.00	Anal gesi cs	0		b	0 0	o o	23.00
24.00	Sedatives / Hypnotics	0		b	0 0	ol l	24.00
25.00	Other - Specify	0			0 0	ol o	
26.00	Durable Medical Equipment/Oxygen	0			0 0	ol o	
27.00	Patient Transportation	0		0	0 0	ol o	
28.00	I maging Services	0			0		
29.00	Labs and Diagnostics	0			0	-	
30.00	Medical Supplies	0			0 0		
31.00	Outpatient Services (including E/R Dept.)	0			0 0		
32.00	Radiation Therapy	0			0 0	-	
33.00	Chemotherapy	0			0 0		
34.00	Other	0			-		
54.00	HOSPICE NONREIMBURSABLE SERVICE		· · · · · · · · · · · · · · · · · · ·	J		۰ ۱	34.00
35.00	Bereavement Program Costs	0		2	0 0	o l	35.00
36.00	Volunteer Program Costs	0			0 0		
37.00	Fundrai si ng	0			0 0		
38.00	Other Program Costs	0			0 0	-	
	Total (sum of lines 1 thru 38)	242, 610	-39	1 242, 2	-	242, 219	
07.00		2.2,010					1 571 65

Heal th	Financial Systems	KING'S DAUGHTER	S' HOSPI TAL			In Lie	u of Form CMS-2	2552-10
	E COMPENSATION ANALYSIS SALARIES AND WAGES		Provi der	CCN: 150069	Pe	ri od:	Worksheet K-1	
					Fr	om 01/01/2015		
			Hospi ce C	CCN: 151535	To	12/31/2015	Date/Time Pre	
							5/18/2016 2:2	9 pm
					L	Hospi ce I	N	
		Admi ni strator	Director	Soci al		Supervi sors	Nurses	
		1.00	2.00	Services 3.00		4,00	5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00		4.00	5.00	
1.00	Capital Related Costs-Bldg and Fixt.							1.00
2.00	Capital Related Costs-Didg and TrXt.							2.00
3.00	Plant Operation and Maintenance	0	0		0	0	0	3.00
4.00	Transportation - Staff	0	0		0	0	0	4.00
4.00 5.00	Volunteer Service Coordination	0	0		0	0	0	4.00 5.00
5.00 6.00	Administrative and General	0	0		0	0	0	6.00
0.00	INPATIENT CARE SERVICE	0	0		0	U	0	0.00
7.00	Inpatient - General Care	0	0		0	0	0	7.00
7.00 8.00		0	0		0	0	0	8.00
0.00	I npatient - Respite Care VI SI TI NG SERVI CES	U	0		0	U	0	0.00
9.00	Physician Services	0	0		0	0	0	9.00
9.00 10.00	Nursi ng Care	0	0		0	0	2,357	9.00 10.00
	5	0	0		0	0		11.00
11.00	Nursing Care-Continuous Home Care	о С	0		-	-	0	
12.00	Physical Therapy	0	0		0	0	0	12.00
13.00	Occupational Therapy	0	0		0	0	0	13.00
14.00	Speech/ Language Pathol ogy	0	0		0	0	0	14.00
15.00	Medical Social Services	0	0	81, 2		0	0	15.00
16.00	Spiritual Counseling	0	0		0	0	0	16.00
17.00	Di etary Counsel i ng	0	0		0	0	0	17.00
18.00	Counseling - Other	0	0		0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0		0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	0	20.00
21.00	Other	0	0		0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy							22.00
23.00	Analgesics							23.00
24.00	Sedatives / Hypnotics							24.00
25.00	Other - Specify							25.00
26.00	Durable Medical Equipment/Oxygen				~			26.00
27.00	Patient Transportation	0	0		0	0	0	27.00
28.00	I magi ng Servi ces	0	0		0	0	0	28.00
29.00	Labs and Diagnostics	0	0		0	0	0	29.00
30.00	Medical Supplies	0	0		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		0	0	0	31.00
32.00	Radiation Therapy	0	0		0	0	0	32.00
33.00	Chemotherapy	0	0		0	0	0	33.00
34.00	Other	0	0		0	0	0	34.00
	HOSPI CE NONREI MBURSABLE SERVI CE	1		1				
35.00	Bereavement Program Costs	0	0		0	0	0	35.00
36.00	Volunteer Program Costs	0	0		0	0	0	36.00
37.00	Fundrai si ng	0	0		0	0	0	37.00
38.00	Other Program Costs	0	0		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	81, 2	54	0	2, 357	39.00

Heal th	Financial Systems	KING'S DAUGHTERS	S' HOSPI TAL		In Lie	u of Form CMS-2552-	10
	E COMPENSATION ANALYSIS SALARIES AND WAGES			CCN: 150069	Peri od:	Worksheet K-1	
					From 01/01/2015		
			Hospi ce C	CN: 151535	To 12/31/2015	Date/Time Prepared	1:
					Hocni co. I	5/18/2016 2:29 pm	
		Total	Ai des	All-Other	Hospice I Total (1)		_
		Therapists	Arues	AIT-Other			
		6.00	7.00	8.00	9, 00		
	GENERAL SERVICE COST CENTERS	0.00	7.00	0.00	7.00		_
1.00	Capital Related Costs-Bldg and Fixt.					1.0	00
2.00	Capital Related Costs-Movable Equip.					2.0	
3.00	Plant Operation and Maintenance		0		0 0	3.0	
4.00	Transportation - Staff		0		0 0	4.0	
5.00	Volunteer Service Coordination		0		0 0	5.0	
6.00	Administrative and General		Ő	33, 8	35 33, 835	6.0	
	I NPATI ENT CARE SERVI CE		-1	, -			
7.00	Inpatient - General Care		0		0 0	7.0	00
8.00	Inpatient - Respite Care		0		0 0	8.0	
	VI SI TI NG SERVI CES				-		
9.00	Physician Services		0		0 0	9.0	00
10.00	Nursing Care		0		0 2,357	10.0	00
11.00	Nursing Care-Continuous Home Care		0		0 0	11. 0	
12.00	Physical Therapy	0	0	3, 4	26 3, 426	12.0	
13.00	Occupational Therapy	0	0		78 278	13.0	
14.00	Speech/ Language Pathology	0	0		0 0	14.0	00
15.00	Medical Social Services		0		0 81, 254	15.0	00
16.00	Spiritual Counseling		0		0 0	16.0	00
17.00	Dietary Counseling		0		0 0	17.0	00
18.00	Counseling - Other		0		0 0	18.0	00
19.00	Home Health Aide and Homemaker		10, 861		0 10, 861	19.0	00
20.00	HH Aide & Homemaker - Cont. Home Care		0		0 0	20.0	00
21.00	Other		0		0 0	21.0	00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy					22.0	00
23.00	Anal gesi cs					23.0	00
24.00	Sedatives / Hypnotics					24.0	00
25.00	Other - Specify					25.0	00
26.00	Durable Medical Equipment/Oxygen					26.0	
27.00	Patient Transportation		0		0 0	27.0	
28.00	Imaging Services		0		0 0	28.0	
29.00	Labs and Diagnostics		0		0 0	29.0	
30.00	Medical Supplies		0		0 0	30.0	00
31.00	Outpatient Services (including E/R Dept.)		0		0 0	31.0	00
32.00	Radiation Therapy		0		0 0	32.0	
33.00	Chemotherapy		0		0 0	33.0	
34.00	Other		0		0 0	34.0	00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0		0 0	35.0	
36.00	Volunteer Program Costs		0		0 0	36.0	
37.00	Fundrai si ng		0		0 0	37.0	
38.00	Other Program Costs		0		0 0	38.0	
39.00	Total (sum of lines 1 thru 38)	0	10, 861	37, 5	39 132, 011	39.0	00

	Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	LLOCATION - HOSPICE GENERAL SERVICE COST			CCN: 150069	Peri od:	Worksheet K-4	
					From 01/01/2015	Part I	
			Hospi ce C	CN: 151535	To 12/31/2015	Date/Time Pre 5/18/2016 2:2	
					Hospi ce I	5/18/2016 2:2	9 pili
			CAPITAL RE	LATED COST	nospice i		
			CALL THE RE	LATED COST			
		NET EXPENSES	BUILDINGS &	MOVABLE	PLANT	TRANSPORTATI ON	
		FOR COST	FIXTURES	EQUI PMENT	OPERATION &		
		ALLOCATI ON			MALNT.		
		0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS	I					
	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0			0		2.00
3.00	Plant Operation and Maintenance	0	0		0 0		3.00
	Transportation - Staff	0	0		0 0	0	4.00
5.00	Volunteer Service Coordination	0	o		0 0	0	5.00
	Administrative and General	87, 812	0		0 0	0	
	INPATIENT CARE SERVICE	0,7012			0		0.00
H H	Inpatient - General Care	0	0		0 0	0	7.00
	Inpatient - Respite Care	0	o		0 0	0	
	VI SI TI NG SERVI CES				0		0.00
	Physi ci an Servi ces	0	0		0 0	0	9.00
	Nursing Care	2, 357	o		0 0	0	1
	Nursing Care-Continuous Home Care	2,007	0 0		0 0	0	11.00
	Physical Therapy	5, 415	0		0 0	0	
	Occupational Therapy	342	0		0 0	0	
	Speech/ Language Pathol ogy	0	0		0 0	0	
	Medical Social Services	91, 112	0		0 0	0	
	Spiritual Counseling	304	0		0 0	0	16.00
	Dietary Counseling	0	0		0 0	0	
	Counseling - Other	0	0		0 0	0	18.00
	Home Health Aide and Homemaker	15,008	0		0 0	0	
	HH Aide & Homemaker - Cont. Home Care	15,008	0		0 0	0	1
	Other	0	0		0 0	0	
	OTHER HOSPICE SERVICE COSTS	0	U		0 0	0	21.00
	Drugs, Biological and Infusion Therapy	39,869	0		0 0	0	22.00
	Anal gesics	39, 809	0		0 0	0	
	Sedatives / Hypnotics	0	0		0 0	0	
		0	0		0 0	0	24.00
	Other - Specify	0	0		0 0	0	
	Durable Medical Equipment/Oxygen	0	0		0 0	-	26.00
	Patient Transportation	0				0	
	Imaging Services	0	0		0 0	0	
	Labs and Diagnostics	0			0 0	0	
	Medical Supplies	0	0		0 0	0	30.00
	Outpatient Services (including E/R Dept.)	0	0		0 0	0	
	Radiation Therapy	0	0		0 0	0	32.00
	Chemotherapy	0	0		0 0	0	33.00
34.00		0	0		0 0	0	34.00
05.05	HOSPI CE NONREI MBURSABLE SERVI CE		-1			-	0.5.0-
	Bereavement Program Costs	0	0		0 0	0	
	Volunteer Program Costs	0	0		0 0	0	36.00
37.00	Fundrai si ng	0	0		0 0	0	
37.00 38.00	Fundraising Other Program Costs Total (sum of lines 1 thru 38)	0 0 242, 219	0 0 0		0 0 0 0 0 0	0 0 0	38.00

Heal th	Financial Systems	KING'S DAUGHTE	FRS' HO	SPI ΤΑΙ		Inlie	u of Form CMS-	2552-10
	LLOCATION - HOSPICE GENERAL SERVICE COST				CCN: 150069	Peri od:	Worksheet K-4	
00017	LEEGGATION THOSPICE GENERALE SERVICE GOOT			i ovi dei	0011. 100007	From 01/01/2015	Part I	
			H	lospi ce 🛛	CCN: 151535	To 12/31/2015	Date/Time Pre	
							5/18/2016 2:2	29 pm
			CUD	TOTAL		Hospi ce I		
		VOLUNTEER SERVI CES		TOTAL		VETOTAL (col. 5A		
		COORDI NATOR	(COLS.	0 - 5)	& GENERAL	± col. 6)		
		5. 00		5A	6.00	7.00		
	GENERAL SERVICE COST CENTERS	3.00		57	0.00	7.00		
1.00	Capital Related Costs-Bldg and Fixt.		1					1.00
2.00	Capital Related Costs-Movable Equip.							2.00
3.00	Plant Operation and Maintenance							3.00
4.00	Transportation - Staff							4.00
5.00	Volunteer Service Coordination	0						5.00
6.00	Administrative and General	0	-	87, 812	87, 8	12		6.00
0.00	I NPATI ENT CARE SERVI CE		-	077012	0,,0			0.00
7.00	Inpatient - General Care	0	b	C)	0 0		7.00
8.00	Inpatient - Respite Care	0		C		0 0		8.00
	VI SI TI NG SERVI CES							
9.00	Physician Services	0	D	C)	0 0		9.00
10.00	Nursing Care	0	c	2, 357	1,3	40 3, 697		10.00
11.00	Nursing Care-Continuous Home Care	0	c	C		0 0		11.00
12.00	Physical Therapy	0	c	5, 415	3,0	80 8, 495		12.00
13.00	Occupational Therapy	0	c	342	1	94 536		13.00
14.00	Speech/ Language Pathol ogy	0	c	C		0 0		14.00
15.00	Medical Social Services	0	c	91, 112	51, 8	16 142, 928		15.00
16.00	Spiritual Counseling	0	c	304	1	73 477		16.00
17.00	Dietary Counseling	0	D	C)	0 0		17.00
18.00	Counseling - Other	0	D	C)	0 0		18.00
19.00	Home Health Aide and Homemaker	0	D	15, 008	8, 5	35 23, 543		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	D	C)	0 0		20.00
21.00	Other	0	0	0)	0 0		21.00
	OTHER HOSPICE SERVICE COSTS				1			
22.00	Drugs, Biological and Infusion Therapy	0	-	39, 869				22.00
23.00	Anal gesi cs	0		C		0 0		23.00
24.00	Sedatives / Hypnotics	0	C	C)	0 0		24.00
25.00	Other - Specify	0	C	C)	0 0		25.00
26.00	Durable Medical Equipment/Oxygen	0	0	C		0 0		26.00
27.00	Patient Transportation	0	2	C)	0 0		27.00
28.00	I magi ng Servi ces	0	2	C)	0 0		28.00
29.00	Labs and Diagnostics	0	5	0		0 0		29.00
30.00	Medical Supplies	0	5	C		0 0		30.00
31.00	Outpatient Services (including E/R Dept.)		1	(0 0		31.00 32.00
32.00	Radiation Therapy					0 0		32.00
33.00 34.00	Chemotherapy Other			(0 0		34.00
34.00	HOSPICE NONREIMBURSABLE SERVICE	0	J		/	0 0		34.00
35.00	Bereavement Program Costs	0	า	(0 0		35.00
36.00	Volunteer Program Costs			(0 0		36.00
37.00	Fundrai si ng			ſ		0 0		37.00
38.00	Other Program Costs		-	ſ		0 0		38.00
	Total (sum of lines 1 thru 38)	0	b	242, 219		242, 219		39.00
		1			1			

Heal th	Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der	CCN: 150069	Peri od:	Worksheet K-4	
					From 01/01/2015	Part II	
			Hospi ce (CCN: 151535	To 12/31/2015	Date/Time Pre 5/18/2016 2:2	
					Hospi ce I	3/10/2010 2.2	. 7 pili
		CAPI TAL RE	LATED COST				
		BUILDINGS &	MOVABLE	PLANT	TRANSPORTATI ON	VOLUNTEER	
		FIXTURES (SQ.	EQUIPMENT (\$	OPERATION 8	(MI LEAGE)	SERVI CES	
		FT.)	VALUE)	MAINT. (SQ.		COORDI NATOR	
		1.00	0.00	FT.)	4.00	(HOURS)	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
2.00	Capital Related Costs-Brug and Fixt.	0	C				2.00
2.00 3.00	Plant Operation and Maintenance	0			0		3.00
4.00	Transportation - Staff	0			0 0		4.00
4.00 5.00	Volunteer Service Coordination	0	-		0 0	0	
6.00	Admini strati ve and General	0			0 0	0	
0.00	I NPATI ENT_CARE_SERVI CE	0			0 0	0	0.00
7.00	Inpatient - General Care	0	C		0 0	0	7.00
8.00	Inpatient - Respite Care	0			0 0	0	
0.00	VI SI TI NG SERVI CES	0		1	0 0	0	0.00
9.00	Physi ci an Servi ces	0	C		0 0	0	9.00
10.00	Nursi ng Care	0			0 0	0	
11.00	Nursing Care-Continuous Home Care	0			0 0	0	
12.00	Physical Therapy	0	C C		0 0	0	
13.00	Occupational Therapy	0	0		0 0	0	
14.00	Speech/ Language Pathol ogy	0	C C		0 0	0	
15.00	Medical Social Services	0	0		0 0	0	
16.00	Spiritual Counseling	0	0		0 0	0	1
17.00	Dietary Counseling	0	C)	0 0	0	
18.00	Counseling - Other	0	C)	0 0	0	18.00
19.00	Home Health Aide and Homemaker	0	C)	0 0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0			0 0	0	
21.00	Other	0	C		0 0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	C		0 0	0	22.00
23.00	Anal gesi cs	0	C		0 0	0	23.00
24.00	Sedatives / Hypnotics	0	C		0 0	0	24.00
25.00	Other - Specify	0	0		0 0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	
27.00	Patient Transportation	0	0		0 0	0	
28.00	Imaging Services	0	0		0 0	0	28.00
29.00	Labs and Diagnostics	0	C		0 0	0	29.00
30.00	Medical Supplies	0	0		0 0	0	
31.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	
32.00	Radiation Therapy	0			0 0	0	
33.00	Chemotherapy	0	-		0 0	0	
34.00	Other	0	C		0 0	0	34.00
	HOSPI CE NONREI MBURSABLE SERVI CE	1					
35.00	Bereavement Program Costs	0			0 0	0	
36.00	Volunteer Program Costs	0	-		0 0	0	
37.00	Fundrai si ng	0	0		0 0	0	
38.00	Other Program Costs	0	0		0 0	0	
39.00	Cost to be Allocated (per Wkst. K-4, Part I)	0. 000000	0. 000000		0	0 0. 000000	
40.00	Unit Cost Multiplier	0.000000	0.00000	η 0.0000	UUUUUUUUUUUUUUUUUUUUUUUUUUUUUUUUUUUUUU	0.00000	40.00

	Financial Systems	KING'S DAUGHTERS			u of Form CMS-	
COST A	LLOCATION - STATISTICAL BASIS		Provi der C Hospi ce CC	Period: From 01/01/2015 To 12/31/2015	Worksheet K-4 Part II Date/Time Pre 5/18/2016 2:2	epared:
				Hospi ce I		
		RECONCILIATION AD	MI NI STRATI VE	· · · · · · · · · · · · · · · · · · ·		
			& GENERAL			
			(ACC. COST)			
		6A	6.00			
1 00	GENERAL SERVICE COST CENTERS					1 1 00
1.00 2.00	Capital Related Costs-Bldg and Fixt. Capital Related Costs-Movable Equip.	0				1.00
3.00	Plant Operation and Maintenance	0				3.00
4.00	Transportation - Staff	0				4.00
5.00	Volunteer Service Coordination	07 010	154 407			5.00
6.00	Administrative and General	-87, 812	154, 407			6.00
7.00	Inpatient - General Care	0	0			7.00
7.00 8.00	Inpatient - General Care	0	0			8.00
8.00	VI SI TI NG SERVI CES	U	U			8.00
9.00	Physician Services	0	0			9.00
10.00	Nursi ng Care	0	2,357			10.00
11.00	Nursing Care-Continuous Home Care	0	2, 357			11.00
12.00	Physical Therapy	0	5, 415			12.00
13.00	Occupational Therapy	0	342			13.00
14.00	Speech/ Language Pathol ogy	0	0			14.00
14.00	Medi cal Soci al Servi ces	0	91, 112			15.00
16.00	Spiritual Counseling	0	304			16.00
17.00	Di etary Counsel i ng	0	0			17.00
18.00	Counseling - Other	0	0			18.00
19.00	Home Health Aide and Homemaker	0	15,008			19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0			20.00
21.00	Other	0	0			21.00
21.00	OTHER HOSPICE SERVICE COSTS	<u> </u>	0			21.00
22.00	Drugs, Biological and Infusion Therapy	0	39, 869			22.00
23.00	Anal gesi cs	0	0			23.00
24.00	Sedatives / Hypnotics	0	0			24.00
25.00	Other - Specify	0	0			25.00
26.00	Durable Medical Equipment/Oxygen	0	0			26.00
27.00	Patient Transportation	0	0			27.00
28.00	Imaging Services	0	0			28.00
29.00	Labs and Diagnostics	0	0			29.00
30.00	Medical Supplies	0	0			30.00
31.00	Outpatient Services (including E/R Dept.)	0	0			31.00
32.00	Radi ati on Therapy	0	0			32.00
33.00	Chemotherapy	0	0			33.00
34.00	Other	0	0			34.00
	HOSPI CE NONREI MBURSABLE SERVI CE					1
35.00	Bereavement Program Costs	0	0			35.00
36.00	Volunteer Program Costs	0	0			36.00
37.00	Fundrai si ng	0	0			37.00
38.00	Other Program Costs	0	0			38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		87, 812			39.00
57.00						

Heal th	Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	TI ON OF GENERAL SERVICE COSTS TO HOSPICE COST		Provi der	CCN: 150069 CCN: 151535	Period: From 01/01/2015	Worksheet K-5 Part I	pared:
					Hospi ce I		
			CAP	I TAL RELATED	COSTS		
	Cost Center Description	Hospice Trial Balance (1)	NEW BLDG & FIXT	NEW BLDG & FIXT HHA/HC		EMPLOYEE BENEFI TS DEPARTMENT	
		0	1.00	1.01	2.00	4.00	
1.00	Administrative and General	-	0			7, 256	1.00
2.00	Inpatient - General Care	0	0		0 0	0	2.00
3.00	Inpatient - Respite Care	0	0		0 0	0	3.00
4.00	Physi ci an Servi ces	0	0		0 0	0	4.00
5.00	Nursi ng Care	3,697	0		0 0	505	5.00
6.00	Nursing Care-Continuous Home Care	3,077	0		0 0	0	6.00
7.00	Physical Therapy	8, 495	0			735	7.00
			-		0 0		
8.00	Occupational Therapy	536	0		0 0	60	8.00
9.00	Speech/ Language Pathol ogy	0	0		0 0	0	9.00
10.00	Medical Social Services	142, 928	0		0 0	17, 424	10.00
11.00	Spiritual Counseling	477	0		0 0	0	11.00
12.00	Dietary Counseling	0	0		0 0	0	12.00
13.00	Counseling - Other	0	0		0 0	0	13.00
14.00	Home Health Aide and Homemaker	23, 543	0		0 0	2, 329	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0)	0 0	0	15.00
16.00	Other	0	0)	0 0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	62, 543	0		0 0	0	17.00
18.00	Anal gesi cs	0	0		0 0	0	18.00
19.00	Sedatives / Hypnotics	0	0		0 0	0	19.00
20.00	Other - Specify	0	0		0 0	0	20,00
21.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	21.00
22.00	Pati ent Transportati on	0	0		0 0	0	22.00
23.00	Imaging Services	0	0		0 0	0	23.00
24.00	Labs and Di agnosti cs	0	0		0 0	0	24.00
24.00	Medical Supplies	0	0		0 0	0	24.00
26.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	26.00
28.00		0	0			0	27.00
	Radiation Therapy	0	0		0 0		
28.00	Chemotherapy	0	0		0 0	0	28.00
29.00	Other	0	0		0 0	0	29.00
30.00	Bereavement Program Costs	0	0		0 0	0	30.00
31.00	Volunteer Program Costs	0	0	1	0 0	0	31.00
32.00	Fundrai si ng	0	0		0 0	0	32.00
33.00	Other Program Costs	0	0		0 0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	242, 219	0	5, 1	12 0	28, 309	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

Heal th	Financial Systems	KING'S DAUGHTE	ERS' HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
	TION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS	Provi de	r CCN: 150069	Peri od:	Worksheet K-5	
					From 01/01/2015		
			Hospi ce	CCN: 151535	To 12/31/2015	Date/Time Pre 5/18/2016 2:2	
					Hospi ce I	57 107 2010 2.2	<u> 7 pili</u>
	Cost Center Description	Subtotal	ADMI NI STRATI V	/E OPERATION C		HOUSEKEEPI NG	
		Gubtotai	& GENERAL	PLANT	LINEN SERVICE	noooeneer noo	
		4A	5.00	7.00	8.00	9.00	
1.00	Administrative and General	12, 368	2, 6	16, C	034 0	0	1.00
2.00	Inpatient - General Care	0		0	0 0	0	2.00
3.00	Inpatient - Respite Care	0		0	0 0	0	3.00
4.00	Physi ci an Servi ces	0		0	0 0	0	4.00
5.00	Nursing Care	4, 202	88	38	0 0	0	5.00
6.00	Nursing Care-Continuous Home Care	0		0	0 0	0	6.00
7.00	Physical Therapy	9, 230			0 0	0	
8.00	Occupational Therapy	596	n 11		0 0	0	
9.00	Speech/ Language Pathology	0		0	0 0	0	1 1.00
10.00	Medical Social Services	160, 352			0 0	0	
11.00	Spiritual Counseling	477	1 10	01	0 0	0	
12.00	Dietary Counseling	0)	0	0 0	0	12.00
13.00	Counseling - Other	0)	0	0 0	0	
14.00	Home Health Aide and Homemaker	25, 872	5,40	56	0 0	0	
15.00	HH Aide & Homemaker - Cont. Home Care	0)	0	0 0	0	
16.00	Other	0		0	0 0	0	
17.00	Drugs, Biological and Infusion Therapy	62, 543	13, 21	5	0 0	0	
18.00	Analgesics	0)	0	0 0	0	
19.00	Sedatives / Hypnotics	0)	0	0 0	0	
20.00	Other - Specify	0)	0	0 0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	2	0	0 0	0	
22.00	Patient Transportation					0	
23.00	I maging Services						
24.00 25.00	Labs and Diagnostics Medical Supplies	0		0	0 0	0	
25.00 26.00	Outpatient Services (including E/R Dept.)	0		0		0	
28.00	Radi ati on Therapy	0		0		0	
27.00	Chemotherapy			0		0	
28.00	Other	0		0		0	
30.00	Bereavement Program Costs	0		0		0	
31.00	Volunteer Program Costs			0		0	
32.00	Fundrai si ng			0		0	
33.00	Other Program Costs	0		0	0 0	0	
34.00	Total (sum of lines 1 thru 33) (2)	275, 640	58, 24	10 16, C	0	0	
35.00	Unit Cost Multiplier (see instructions)	0. 000000		10,0	-	ľ	35.00
			1	I.	I	1	

	Financial Systems	KING'S DAUGHTER	S' HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	ATION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS		CCN: 150069 CCN: 151535	Period: From 01/01/2015 To 12/31/2015	Worksheet K-5 Part I Date/Time Pre 5/18/2016 2:2	pared:
					Hospi ce I	5/10/2010 2.2	⁷ piii
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
				ADMI NI STRATI			
					SUPPLY		
		10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	0	C		0 0	0	1.00
2.00	Inpatient - General Care	0	C		0 0	0	2.00
3.00	Inpatient - Respite Care	0	C		0 0	0	3.00
4.00	Physi ci an Servi ces	0	C		0 0	0	4.00
5.00	Nursing Care	0	C		0 0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	C		0 0	0	6.00
7.00	Physical Therapy	0	C		0 0	0	7.00
8.00	Occupational Therapy	0	C		0 0	0	8.00
9.00	Speech/ Language Pathol ogy	0	C		0 0	0	9.00
10.00	Medical Social Services	0	C		0 0	0	10.00
11.00	Spiritual Counseling	0	C		0 0	0	11.00
12.00	Dietary Counseling	0	0		0 0	0	12.00
13.00	Counseling - Other	0	0		0 0	0	13.00
14.00	Home Health Aide and Homemaker	0	0		0 0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	C		0 0	0	15.00
16.00	Other	0	0		0 0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	C		0 0	0	17.00
18.00	Anal gesi cs	0	C		0 0	0	18.00
19.00	Sedatives / Hypnotics	0	C		0 0	0	19.00
20.00	Other - Specify	0	C		0 0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	C		0 0	0	21.00
22.00	Patient Transportation	0	C		0 0	0	22.00
23.00	I magi ng Servi ces	0	0		0 0	0	23.00
24.00	Labs and Diagnostics	0	0		0 0	0	24.00
25.00	Medical Supplies	0	0		0 0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	26.00
27.00	Radi ati on Therapy	0	0		0 0	0	27.00
28.00	Chemotherapy	0	0		0 0	0	28.00
29.00	Other	0	0		0 0	0	29.00
30.00	Bereavement Program Costs	0	0		0 0	0	30.00
31.00	Volunteer Program Costs	0	0		0 0	0	31.00
32.00	Fundraising	0	0		0 0	0	32.00
33.00	Other Program Costs	0	0		0 0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	Ŭ	1	0 0	0	34.00
35.00	Unit Cost Multiplier (see instructions)	1 1		I	I		35.00

Heal th	Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS		CCN: 150069 CCN: 151535	Period: From 01/01/2015 To 12/31/2015	Worksheet K-5 Part I Date/Time Pre 5/18/2016 2:2	pared:
					Hospi ce I	3/10/2010 2.2	² piii
	Cost Center Description	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI A		HUB SITE - 3RD	
		RECORDS &	BOOTTLE BEITTIE	ANESTHETI ST		YEAR MED	
		LI BRARY			0011002	STUDENTS	
		16.00	17.00	19.00	23.00	23.01	
1.00	Administrative and General	0			0 0		1.00
2.00	Inpatient - General Care	0	C		0 0	o o	2.00
3.00	Inpatient - Respite Care	0	C		0 0	o o	3.00
4.00	Physi ci an Servi ces	0	c c		0 0	o o	4.00
5.00	Nursing Care	0	0		0 0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0		0 0		6.00
7.00	Physical Therapy	0	0		0 0	0	7.00
8.00	Occupational Therapy	0	l d		0 0	ol o	8.00
9.00	Speech/ Language Pathol ogy	0	l d		0 0	ol o	9.00
10,00	Medical Social Services	0	l d		0 0	0 0	10.00
11.00	Spiritual Counseling	0	l d		0 0	ol o	11.00
12.00	Dietary Counseling	0	l d		0 0	ol o	12.00
13.00	Counseling - Other	0	l d)	0 0	0 0	13.00
14.00	Home Health Aide and Homemaker	0	l d)	0 0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	c		0 0	o l	15.00
16.00	Other	0	c		0 0	o l	16.00
17.00	Drugs, Biological and Infusion Therapy	0	c		0 0	o l	17.00
18.00	Anal gesi cs	0	c		0 0	o l	18.00
19.00	Sedatives / Hypnotics	0	c		0 0	o l	19.00
20.00	Other - Specify	0	0)	0 0	0 0	20.00
21.00	Durable Medical Equipment/Oxygen	0	c		0 0	o l	21.00
22.00	Patient Transportation	0	c		0 0	o l	22.00
23.00	Imaging Services	0	0)	0 0	0 0	23.00
24.00	Labs and Diagnostics	0	0)	0 0	0 0	24.00
25.00	Medical Supplies	0	0)	0 0	0 0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0)	0 0	0 0	26.00
27.00	Radiation Therapy	0	C		0 0	o o	27.00
28.00	Chemotherapy	0	C		0 0	o o	28.00
29.00	Other	0	c		0 0	o o	29.00
30.00	Bereavement Program Costs	0	C		0 0	o o	30.00
31.00	Volunteer Program Costs	0	c		0 0	o o	31.00
32.00	Fundrai si ng	0	0		0 0	0 0	32.00
33.00	Other Program Costs	0	0		0 0	0 0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0		0 0	0 0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

	Financial Systems	KING'S DAUGHTE		0.001 4500/5		u of Form CMS-2	
ALLOCA	TION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS		CCN: 150069 CCN: 151535	Period: From 01/01/2015 To 12/31/2015	Worksheet K-5 Part I Date/Time Pre 5/18/2016 2:2	pared:
					Hospi ce I		
	Cost Center Description	Subtotal	Intern &	Subtotal	Allocated	Total Hospice	
		(col s. 4A-23)	Residents Cost	(cols. 24 ±	Hospi ce A&G	Costs (cols.	
			& Post	25)	(See Part II)	26 ± 27)	
			Stepdown				
			Adjustments				
		24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	31, 015					1.00
2.00	Inpatient - General Care	0	0		0 0	0	2.00
3.00	Inpatient - Respite Care	0	0		0 0	0	3.00
4.00	Physician Services	0	0		0 0	0	4.00
5.00	Nursing Care	5,090	0	5, 0	90 495	5, 585	
6.00	Nursing Care-Continuous Home Care	0	0		0 0	0	6.00
7.00	Physical Therapy	11, 180	0	11, 1	80 1, 087	12, 267	7.00
8.00	Occupational Therapy	722	0	7	22 70	792	
9.00	Speech/ Language Pathol ogy	0	0		0 0	0	9.00
10.00	Medical Social Services	194, 233	0	194, 2	33 18, 891	213, 124	10.00
11.00	Spiritual Counseling	578	0	5	78 56	634	11.00
12.00	Dietary Counseling	0	0		0 0	0	12.00
13.00	Counseling - Other	0	0		0 0	0	13.00
14.00	Home Health Aide and Homemaker	31, 338	0	31, 3	38 3, 048	34, 386	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	15.00
16.00	Other	0	0		0 0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	75, 758	0	75, 7	58 7, 368	83, 126	17.00
18.00	Anal gesi cs	0	0		0 0	0	18.00
19.00	Sedatives / Hypnotics	0	0		0 0	0	19.00
20.00	Other - Specify	0	0		0 0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	21.00
22.00	Patient Transportation	0	0		0 0	0	22.00
23.00	Imaging Services	0	0		0 0	0	23.00
24.00	Labs and Diagnostics	0	0		0 0	0	24.00
25.00	Medical Supplies	0	0		0 0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	26.00
27.00	Radiation Therapy	0	0		0 0	0	27.00
28.00	Chemotherapy	0	0		0 0	0	28.00
29.00	Other	0	0		0 0	0	29.00
30.00	Bereavement Program Costs	0	0		0 0	0	30.00
31.00	Volunteer Program Costs	0	0		0 0	0	31.00
32.00	Fundrai si ng	0	0		0 0	0	32.00
33.00	Other Program Costs	0	0		0 0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	349, 914	0	349, 9	14	349, 914	34.00
	Unit Cost Multiplier (see instructions)	1			0. 097256		35.00

Heal th	Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In	Lieu of Form CMS-	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS TO HOSPICE COST TICAL BASIS	CENTERS	Provi der Hospi ce (CCN: 150069 CCN: 151535	Period: From 01/01/20 To 12/31/20	Worksheet K-5 Part II Date/Time Pre	pared:
					lleeni ee l	5/18/2016 2:2	9 pm
		CAD	TAL RELATED CO	OCTC	Hospi ce I		
		CAPI	TAL RELATED CU	3515			
	Cost Center Description	NEW BLDG &	NEW BLDG &	NEW MVBLE	EMPLOYEE	Reconciliation	
	· ·	FLXT	FIXT HHA/HO	EQUI P	BENEFI TS		
		(SQUARE	(SQUARE	(SQUARE	DEPARTMEN	-	
		FEET)	FEET)	FEET)	(GROSS		
		1.00		0.00	SALARI ES)		
1 00		1.00	1.01	2.00	4.00	5A	1.00
1.00	Administrative and General	0	744		0 33, 3		
2.00	Inpatient - General Care	0	0		0	0 0	
3.00	Inpatient - Respite Care	0	0		0	0 0	
4.00	Physician Services	0	0		0	0 0	
5.00	Nursing Care	0	0		0 2,3		
6.00	Nursing Care-Continuous Home Care	0	0		0	0 0	
7.00 8.00	Physical Therapy	0	0				
8.00 9.00	Occupational Therapy	0	0		0	278 0 0 0	
9.00 10.00	Speech/ Language Pathology Medical Social Services	0	0		0 81, 3	-	
11.00	Spiritual Counseling	0			0 01,.	0 0	
12.00	Dietary Counseling	0			0	0 0	
12.00	Counseling - Other	0			0		
14.00	Home Health Aide and Homemaker	0			0 10,8	-	
15.00	HH Aide & Homemaker - Cont. Home Care	0			0 10,1		
16.00	Other	0	0		0	0 0	
17.00	Drugs, Biological and Infusion Therapy	0	0		0	0 0	
18.00	Anal gesi cs	0	0		0	0 0	
19.00	Sedatives / Hypnotics	0	0		0	0 0	
20.00	Other - Specify	0	0		0	0 0	
21.00	Durable Medical Equipment/Oxygen	0	0		0	0 0	21.00
22.00	Patient Transportation	0	0		0	0 0	
23.00	Imaging Services	0	0		0	0 0	23.00
24.00	Labs and Diagnostics	0	0		0	0 0	24.00
25.00	Medical Supplies	0	0		0	0 0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		0	0 0	26.00
27.00	Radiation Therapy	0	0		0	0 0	27.00
28.00	Chemotherapy	0	0		0	0 0	28.00
29.00	Other	0	0		0	0 0	29.00
30.00	Bereavement Program Costs	0	0		0	0 0	30.00
31.00	Volunteer Program Costs	0	0		0	0 0	31.00
32.00	Fundrai si ng	0	0		0	0 0	32.00
33.00	Other Program Costs	0	0		0	0 0	
34.00	Total (sum of lines 1 thru 33) (2)	0	744		0 132, 0		34.00
35.00	Total cost to be allocated	0	5, 112		0 28,		35.00
36.00	Unit Cost Multiplier (see instructions)	0. 000000	6. 870968	0.0000	00 0.214	144	36.00

Health	Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		ln Li€	eu of Form CMS-	2552-10
	TION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS	Provi der	CCN: 150069	Peri od:	Worksheet K-5	5
STATI S	TI CAL BASI S		Hospi ce C	CN: 151535	From 01/01/2015 To 12/31/2015		pared.
			nospi co c	101000	10 12/01/2010	5/18/2016 2:2	29 pm
					Hospi ce I		
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVIC	· · · · ·	(MEALS	
		(ACCUM.	(SQUARE	(POUNDS OF	SERVICE)	SERVED)	
		COST)	FEET)	LAUNDRY)			
1		5.00	7.00	8.00	9.00	10.00	1 00
1.00	Administrative and General	12, 368	744		0 0		
2.00	Inpatient - General Care	0	0		0 0		
3.00	Inpatient - Respite Care	0	0		0 0	0	
4.00	Physi ci an Servi ces	0	0		0 0	0	
5.00	Nursing Care	4, 202	0		0 0	0	
6.00	Nursing Care-Continuous Home Care	0	0		0 0	0	
7.00	Physical Therapy	9, 230	0		0 0	0	
8.00	Occupational Therapy	596	0		0 0	0	
9.00	Speech/ Language Pathol ogy	0	0		0 0	0	
10.00	Medical Social Services	160, 352	0		0 0	0	
11.00	Spiritual Counseling	477	0		0 0	0	
12.00	Di etary Counsel i ng	0	0		0 0	0	
13.00	Counseling - Other	0	0		0 0	0	
14.00	Home Health Aide and Homemaker	25, 872	0		0 0	0	
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	
16.00	Other	0	0		0 0	0	
17.00	Drugs, Biological and Infusion Therapy	62, 543	0		0 0	0	
18.00	Anal gesi cs	0	0		0 0	0	
19.00	Sedatives / Hypnotics	0	0		0 0	0	
20.00	Other - Specify	0	0		0 0	0	
21.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	
22.00	Patient Transportation	0	0		0 0	0	
23.00	I maging Services	0	0		0 0	0	
24.00	Labs and Diagnostics	0	0		0 0	0	
25.00	Medical Supplies	0	0		0 0	0	
26.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	
27.00	Radiation Therapy	0	0		0 0	0	
28.00	Chemotherapy	0	0		0 0	0	
29.00	Other	0	0		0 0	0	
30.00	Bereavement Program Costs	0	0		0 0	0	
31.00	Volunteer Program Costs	0	0		0 0	0	
32.00	Fundraising	0	0		0 0	0	
33.00	Other Program Costs	0	0		0 0	0	
34.00	Total (sum of lines 1 thru 33) (2)	275, 640	744		0 0	0	
35.00	Total cost to be allocated	58, 240	16, 034		0 0	0	
36.00	Unit Cost Multiplier (see instructions)	0. 211290	21. 551075	0.0000	0. 000000	0. 000000	36.00

	Financial Systems ATION OF GENERAL SERVICE COSTS TO HOSPICE COST	KING'S DAUGHT		CCN. 1E00/0			2552-10
	STICAL BASIS	I CENTERS	Provi der	CCN: 150069	Period: From 01/01/2015	Worksheet K-5 Part II	
0			Hospi ce C	CN: 151535	To 12/31/2015	Date/Time Pre 5/18/2016 2:2	pared:
					Hospi ce I	371072010 2.2	7 piii
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(MEALS	ADMI NI STRATI ON		(COSTED	RECORDS &	
		SERVED)	(5) 5507	SUPPLY	REQUIS.)	LI BRARY	
			(DI RECT	(COSTED		(TIME SPENT)	
		11.00	NRSING HRS) 13.00	REQUIS.) 14.00	15.00	16.00	
1.00	Administrative and General		0 0	11.00	0 0	0	1.00
2.00	Inpatient - General Care	(o o		0 0	0	2.00
3.00	Inpatient – Respite Care	(o o		0 0	0	3.00
4.00	Physi ci an Servi ces	(o o		0 0	0	4.00
5.00	Nursing Care	(0 0		0 0	0	5.00
6.00	Nursing Care-Continuous Home Care	(0 0		0 0	0	6.00
7.00	Physi cal Therapy	(0 0		0 0	0	7.00
8.00	Occupational Therapy	(0 0		0 0	0	8.00
9.00	Speech/ Language Pathol ogy	(0 0		0 0	0	9.00
10.00	Medical Social Services	(0 0		0 0	0	10.00
11.00	Spiritual Counseling	(0 0		0 0	0	
12.00	Dietary Counseling	(0 0		0 0	0	
13.00	Counseling - Other		0 0		0 0	0	
14.00	Home Health Aide and Homemaker		0 0		0 0	0	
15.00	HH Aide & Homemaker - Cont. Home Care		0 0		0 0	0	15.00
16.00	Other		0 0		0 0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	(0 0		0 0	0	17.00
18.00	Anal gesi cs	(0 0		0 0	0	18.00
19.00	Sedatives / Hypnotics	(0 0		0 0	0	19.00
20.00	Other - Specify	0	0 0		0 0	0	20.00
21.00	Durable Medical Equipment/Oxygen		0 0		0 0	0	21.00
22.00	Patient Transportation				0 0	0	
23.00	Imaging Services				0 0	0	23.00
24.00 25.00	Labs and Diagnostics Medical Supplies				0 0	0	24.00
25.00	Outpatient Services (including E/R Dept.)				0 0	0	
27.00	Radi ati on Therapy				0 0	0	27.00
27.00	Chemotherapy				0 0	0	27.00
28.00	Other					0	28.00
30.00	Bereavement Program Costs					0	
31.00	Volunteer Program Costs					0	31.00
32.00	Fundrai si ng				0 0	0	
33.00	Other Program Costs		ol 0		0 0	0	•
34.00	Total (sum of lines 1 thru 33) (2)		0 0		0 0	0	
35.00	Total cost to be allocated		0 0		0 0	0	
36.00	Unit Cost Multiplier (see instructions)	0.00000	0. 000000	0.0000	0. 000000	0.000000	

	Financial Systems	KING'S DAUGHTE				u of Form CMS-2552-
	TION OF GENERAL SERVICE COSTS TO HOSPICE COS TICAL BASIS	T CENTERS	Provi der Hospi ce (CCN: 150069 CCN: 151535	Period: From 01/01/2015 To 12/31/2015	Worksheet K-5 Part II Date/Time Prepared 5/18/2016 2:29 pm
					Hospi ce I	0, 10, 2010 212, pm
	Cost Center Description	SOCI AL SERVI CE	NONPHYSI CI AN	RADI OLOGY	HUB SITE - 3RD	
			ANESTHETI STS	SCHOOL	YEAR MED	
		(TIME	(ASSI GNED	(ASSI GNED	STUDENTS	
		SPENT)	TIME)	TIME)	(ASSI GNED	
					TIME)	
	1	17.00	19.00	23.00	23.01	
1.00	Administrative and General	0	0		0 0	1.0
2.00	Inpatient - General Care	0	0		0 0	2.0
3.00	Inpatient - Respite Care	0	0		0 0	3.0
4.00	Physician Services	0	0		0 0	4. C
5.00	Nursing Care	0	0		0 0	5. C
6.00	Nursing Care-Continuous Home Care	0	0		0 0	6. C
7.00	Physical Therapy	0	0		0 0	7.0
8.00	Occupational Therapy	0	0		0 0	8.0
9.00	Speech/ Language Pathol ogy	0	0		0 0	9.0
10.00	Medical Social Services	2, 107	0		0 0	10. C
11.00	Spiritual Counseling	0	0		0 0	11. C
12.00	Di etary Counsel i ng	0	0		0 0	12.0
13.00	Counseling - Other	0	0		0 0	13. C
14.00	Home Health Aide and Homemaker	0	0		0 0	14. C
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	15. C
16.00	Other	0	0		0 0	16. C
17.00	Drugs, Biological and Infusion Therapy	0	0		0 0	17. C
18.00	Anal gesi cs	0	0		0 0	18. C
19.00	Sedatives / Hypnotics	0	0		0 0	19. C
20.00	Other - Specify	0	0		0 0	20.0
21.00	Durable Medical Equipment/Oxygen	0	0		0 0	21.0
22.00	Patient Transportation	0	0		0 0	22.0
23.00	Imaging Services	0	0		0 0	23.0
24.00	Labs and Diagnostics	0	0		0 0	24.0
25.00	Medical Supplies	0	0		0 0	25.0
26.00	Outpatient Services (including E/R Dept.)	0	0		0 0	26. C
27.00	Radiation Therapy	0	0		0 0	27. C
28.00	Chemotherapy	0	0		0 0	28. C
29.00	Other	0	0		0 0	29. C
30.00	Bereavement Program Costs	0	0		0 0	30. C
31.00	Volunteer Program Costs	0	0		0 0	31. C
32.00	Fundrai si ng	0	0		0 0	32.0
33.00	Other Program Costs	0	0		0 0	33. C
34.00	Total (sum of lines 1 thru 33) (2)	2, 107	0		0 0	34. C
35.00	Total cost to be allocated	0	0		0 0	35. C
	Unit Cost Multiplier (see instructions)	0. 000000	0.00000	0.0000	00 0.000000	36.0

Heal th	Financial Systems	KING'S DAUGHTERS'	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF TOTAL HOSPICE SHARED COSTS		Provi der Hospi ce (CCN: 150069 CCN: 151535	Period: From 01/01/2015 To 12/31/2015		pared:
					Hospi ce I		
	Cost Center Description		. C, Part col. 11 line	Cost to Char Ratio	ge Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
			0	1.00	2.00	3.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSI CAL THERAPY		66.00		69 0	0	1.00
2.00	OCCUPATIONAL THERAPY		67.00	0. 0000	00 0	0	2.00
3.00	SPEECH PATHOLOGY		68.00	0. 0000	00 0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS		73.00	0. 1172	18 0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED		96.00				5.00
6.00	LABORATORY		60.00	0. 2272	36 0	0	6.00
6.01	BLOOD LABORATORY		60.01				6. 01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		71.00	0. 4883	25 0	0	7.00
7.01	IV SOLUTIONS		71.01	0. 0536	38 0	0	7.01
8.00	OTHER OUTPATIENT SERVICE COST CENTER		93.00				8.00
9.00	ONCOLOGY		55.00	0. 4835	65 0	0	9.00
10.00	CARDI OLOGY		76.00	0. 1363	22 0	0	10.00
10.97	CARDI AC REHABI LI TATI ON		76.97	0. 3007	11 0	0	10. 97
11.00	Totals (sum of lines 1–10)					0	11.00

Health Financial Systems KING'S DAUGHTE	RS' HOSPI TAL		In Lie	u of Form CMS-2	2552-10
CALCULATION OF HOSPICE PER DIEM COST	Provi der	CCN: 150069	Peri od:	Worksheet K-6	
	Hospi ce CCN: 151535		From 01/01/2015 To 12/31/2015	Date/Time Prepared: 5/18/2016 2:29 pm	
	_		Hospi ce I		
	Title XVIII	Title XIX	Other	Total	
	1.00	2.00	3.00	4.00	
1.00 Total cost (see instructions)				349, 914	1.00
2.00 Total Unduplicated Days (Worksheet S-9, column 6, line 5)				1, 918	2.00
3.00 Average cost per diem (line 1 divided by line 2)				182.44	3.00
4.00 Upduplicated Medicare Days (Worksheet S-9, column 1, line 5)	1, 708				4.00
5.00 Aggregate Medicare cost (line 3 time line 4)	311, 608				5.00
6.00 Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)			6		6.00
7.00 Aggregate Medicaid cost (line 3 time line 60)		1, 09	95		7.00
8.00 Upduplicated SNF Days (Worksheet S-9, column 3, line 5)	0				8.00
9.00 Aggregate SNF cost (line 3 time line 8)	0				9.00
10.00 Unduplicated NF Days (Worksheet S-9, column 4, line 5)			0		10.00
11.00 Aggregate NF cost (line 3 times line 10)			0		11.00
12.00 Other Unduplicated days (Worksheet S-9, column 5, line 5)			204		12.00
13.00 Aggregate cost for other days (line 3 times line 12)			37, 218		13.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 150069	Period: From 01/01/2015 To 12/31/2015 Hospital	Date/Time Pre	
	Title XVIII		5/18/2016 2: 29 PPS	
			1.00	
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
00 Capital DRG other than outlier			948, 139	
01 Model 4 BPCI Capital DRG other than outlier			0	1.
00 Capital DRG outlier payments			47, 793	
01 Model 4 BPCI Capital DRG outlier payments			0	
00 Total inpatient days divided by number of days in the	33.96			
00 Number of interns & residents (see instructions)	0.00			
00 Indirect medical education percentage (see instruction	0.00	5.		
00 Indirect medical education adjustment (multiply line 1.01) (see instructions)	5 by the sum of lines 1 and 1.01	, columns 1 and	0	6.
00 Percentage of SSI recipient patient days to Medicare 30) (see instructions)	Part A patient days (Worksheet E	, part A line	0.00	7.
00 Percentage of Medicaid patient days to total days (se	0.00	8.		
0 Sum of Lines 7 and 8				9.
.00 Allowable disproportionate share percentage (see inst	tructions)		0.00	10.
. 00 Disproportionate share adjustment (see instructions)			0	11.
.00 Total prospective capital payments (see instructions))		995, 932	12.
			1.00	
PART II - PAYMENT UNDER REASONABLE COST			-	
00 Program inpatient routine capital cost (see instructi			0	1.
00 Program inpatient ancillary capital cost (see instruction 00 Total inpatient program capital cost (line 1 plus line 1)			0	2.
				3.
00 Capital cost payment factor (see instructions)	42		0	4.
00 Total_inpatient_program_capital_cost (line 3 x line 4	4)		0	5.
			1.00	
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
00 Program inpatient capital costs (see instructions)			0	1.
00 Program inpatient capital costs for extraordinary cir			0	2.
00 Net program inpatient capital costs (line 1 minus lir 00 Applicable exception percentage (see instructions)			0.00	3. 4.
00 Applicable exception percentage (see instructions) 00 Capital cost for comparison to payments (line 3 x lir	20 (1)		0.00	4. 5.
00 Percentage adjustment for extraordinary circumstances			0.00	
00 Adjustment to capital minimum payment level for extra		line 6)	0.00	7.
00 Capital minimum payment level (line 5 plus line 7)	activities (TTTE 2 A		0	
00 Current year capital payments (from Part I, line 12,	as applicable)		0	
.00 Current year comparison of capital minimum payment le		less line 9)	0	
.00 Carryover of accumulated capital minimum payment leve Worksheet L, Part III, line 14)			0	11.
.00 Net comparison of capital minimum payment level to ca	anital navments (line 10 plus lin	≥ 11)	0	12.
.00 Current year exception payment (if line 12 is positiv			0	
.00 Carryover of accumulated capital minimum payment leve			0	
		see and a second	0	' ''
	ne)			
(if line 12 is negative, enter the amount on this line. 00 Current year allowable operating and capital payment			0	15.
(if line 12 is negative, enter the amount on this lir	(see instructions)		0 0	