This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0069 Worksheet S Peri od: From 01/01/2019 Parts I-III AND SETTLEMENT SUMMARY 12/31/2019 Date/Time Prepared: 5/21/2020 10:03 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically filed cost report Date: 5/21/2020 Time: 10:03 am use only Manually submitted cost report] If this is an amended report enter the number of times the provider resubmitted this cost report] Medicare Utilization. Enter "F" for full or "L" for low. 6. Date Received: 7. Contractor No. 10. NPR Date: Contractor]Cost Report Status As Submitted
7. Contractor No.

Settled without Audit
8. [N] Initial Report for this Provider CCN 12. [0] If line 5, column 1 is 4: Enter 5. Settled with Audit 9. [N] Final Report for this Provider CCN 12. [0] If line 5, column 1 is 4: Enter 12. [0] If line 5, column 1 is 4: Enter 13. Settled with Audit 14. Settled with Audit 15. Settled with Audit 16. Settled with Audit 17. Settled with Audit 18. [N] Final Report for this Provider CCN 18. Settled with Audit 19. Set 11. Contractor's Vendor Code: (1) As Submitted use only (2) Settled with Audit number of times reopened = 0-9. (4) Reopened

PART II - CERTIFICATION

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by KING'S DAUGHTERS' HOSPITAL (15-0069) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 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.

[X]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed) JOHN PRICE
Officer or Administrator of Provider(s)

CFO
Title

(Dated when report is electronically signed.)

Title XVIII Cost Center Description Title V Part A Part B HI T Title XIX 1.00 2.00 3.00 4.00 5.00 PART III - SETTLEMENT SUMMARY 1 00 Hospi tal 0 -269, 748 -26, 956 Λ 1 00 2.00 Subprovider - IPF 0 0 0 2.00 Subprovider - IRF 3.00 0 0 0 0 3.00 Swing bed - SNF Swing bed - NF 5.00 0 0 0 5.00 6.00 0 6.00 HOME HEALTH AGENCY I 9.00 0 0 0 9.00 200.00 Total 0 -269, 748 -26, 956 0 200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Health Financial Systems KING'S DAUGHTERS' HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0069 Peri od: Worksheet S-2 From 01/01/2019 Part I 12/31/2019 Date/Time Prepared: 5/21/2020 10:03 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: PO Box: 447 Street: ONE KINGS DAUGHTERS DRIVE 1.00 1.00 State: IN Zi p Code: 47250-**JEFFERSON** 2.00 City: MADISON County: 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Туре XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal KING'S DAUGHTERS' 150069 99915 06/17/1966 3.00 HOSPI TAL Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospital -Based HHA KING'S DAUGHTERS' 157141 99915 03/08/1985 Ν Ρ Ν 12.00 HOSPITAL HHA 13.00 Separately Certified ASC 13.00 14 00 Hospi tal -Based Hospi ce KING'S DAUGHTERS' 151535 99915 09/01/1995 14 00 15.00 Hospital-Based Health Clinic - RHC 15.00 Hospital-Based Health Clinic - FQHC 16.00 Hospital-Based (CMHC) I 17.00 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2 00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2019 12/31/2019 20.00 21.00 Type of Control (see instructions) 21.00 2 1.00 2. 00 3.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for 22.00 Ν 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care 22.02 Ν Ν payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to 22.03

23. 00	rural as a result of the OMB standards for delineating adopted by CMS in FY2015? Enter in column 1, "Y" for for the portion of the cost reporting period prior to in column 2, "Y" for yes or "N" for no for the portion reporting period occurring on or after October 1. (So Does this hospital contain at least 100 but not more counted in accordance with 42 CFR 412.105)? Enter in yes or "N" for no. Which method is used to determine Medicaid days on I		3 1	N		23.00		
	below? In column 1, enter 1 if date of admission, 2	if census d	ays, or 3					
	if date of discharge. Is the method of identifying the reporting period different from the method used in the second control of the							
	reporting period? In column 2, enter "Y" for yes or							
		In-State	In-State	Out-of	Out-of	Medi cai d	0ther	
		Medicaid paid days	Medicaid eligible	State Medi cai d	State Medicaid	HMO days	Medicaid days	
		para days	unpai d	pai d days	eligible		days	
			days		unpai d			
		1.00	2. 00	3.00	4. 00	5. 00	6. 00	
	If this provider is an IPPS hospital, enter the	819	640	210	42	732	89	24. 00
	in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid paid days in column 3,							
	out-of-state Medicaid eligible unpaid days in column							
	4, Medicaid HMO paid and eligible but unpaid days in							
	column 5, and other Medicaid days in column 6.							
MCRIF3	2 - 15. 13. 167. 1							

Health Financial Systems KING'S DAUGHTERS' HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0069 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 5/21/2020 10:03 am In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d days paid days eligible Medi cai d Medi cai d unpai d pai d days el i gi bl e days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6. 00 25.00 If this provider is an IRF, enter the in-state 25, 00 \cap Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 1.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 10/01/2019 27.00 27.00 enter the effective date of the geographic reclassification in column 2. If this is a sole community hospital (SCH), enter the number of periods SCH status in 35.00 effect in the cost reporting period. Begi nni ng: Endi ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number 01/01/2019 12/31/2019 36.00 of periods in excess of one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 37 00 37 00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in 37.01 accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38 00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38 00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39 00 hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for 40 00 N Ν no in column 2, for discharges on or after October 1. (see instructions) XVIII 1.00 2. 00 3. 00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance 45.00 Ν Ν Ν with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III. 47.00 | Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. Ν Ν 47.00 Ν 48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. N Ν N 48.00 Teaching Hospitals 56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes 56.00 or "N" for no. 57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved 57.00 GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as 58.00 defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 Pt. 59.00 NAHE 413.85 Pass-Through Worksheet A Y/N Line # Qual i fi cati on Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60.00 any programs that meet the criteria under §413.85? (see instructions) If line 60 is yes, complete columns 2 and 3 for each program. (see 23.00 60.01 1 instructions)

lealth Financial Systems KING'S D HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der CC	CN: 15-0069	Peri od: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Pre 5/21/2020 10:	pared:
	Y/N	IME	Direct GME	IME	Direct GME	
	1. 00	2.00	3.00	4. 00	5. 00	
p1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				0.00	0.00	61.0
1.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.0
1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.0
on the first surgery all opathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's						61. 0
primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61. 0
	Pro	ogram Name	Program Cod	e Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 4.00	
st. 10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 1.20 Of the FTEs in line 61.05, specify each expanded		00	2. 00	0.00	0. 00	61. 1
program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						
					1. 00	
ACA Provisions Affecting the Health Resources and Sei 2.00 Enter the number of FTE residents that your hospital				eriod for which	0.00	62.0
your hospital received HRSA PCRE funding (see instruction 2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC progression of the cost reporting period of the cost reporting the cost reporting period of the cost reporting the cost r	n Teach gram. (ing Health Cen see instructio		to your hospital	0. 00	62.0
3.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this c		J 1	N	63.0
, , , , , , , , , , , , , , , , , , ,			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Base Year FTE Residents in No	onprovi	der Settinas	1.00 This base ye	2.00 aris your cost	3.00 reporting	
period that begins on or after July 1, 2009 and before 4.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighter resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	re June Ty trai n-prima all no I non-p n colum	e 30, 2010. ned residents ry care nprovider rimary care n 3 the ratio	0.			64.0

Health Financial Systems KING'S DAUGHTERS' HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0069 Peri od: Worksheet S-2 From 01/01/2019 Part I 12/31/2019 Date/Time Prepared: 5/21/2020 10:03 am Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTĔs FTEs in 3/ (col. 3 + col. 4)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0.000000 65.00 0.00 0. 00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ (col. 1 + col. 2)) FTEs in FTFs Nonprovi der Hospi tal Si te 1.00 2. 00 3. 00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTĔs 3/ (col. 3 + FTEs in Nonprovi der col. 4)) Hospi tal Si te 1. 00 2.00 3. 00 4. 00 5.00 67.00 Enter in column 1, the program 0. 00 0. 00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)

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

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Pr	rovider CCN: 15-0069	Period: From 01/01/ To 12/31/	′2019 ′2019	Workshe Part I Date/Ti 5/21/20	me Pre	epared:
			1.00	2.00	3. 00	1
6.00 If line 75 is yes: Column 1: Did the facility have an approved Grecent cost reporting period ending on or before November 15, 20 no. Column 2: Did this facility train residents in a new teaching CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Colindicate which program year began during this cost reporting per	04? Enter "Y" for yes g program in accordar umn 3: If column 2 is	s or "N" for nce with 42 s Y,		2.00	0	76.0
Larry Tarry Carra Harrital DDC				1. 0	0	<u> </u>
Long Term Care Hospital PPS 0.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and 1.00 Is this a LTCH co-located within another hospital for part or al "Y" for yes and "N" for no. TEFRA Providers		ng period? I	Enter	N N		80. 0 81. 0
5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEF 6.00 Did this facility establish a new Other subprovider (excluded un §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			no.	N		85. 0 86. 0
7.00 Is this hospital an extended neoplastic disease care hospital cl. 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	assified under sectio	on		N		87.0
1000(d)(1)(b)(VI)? EIILEI T TOI YES OF N TOF IIO.		V		XIX	(
Title Wand VIV Coming		1.00		2. 0	0	1
Title V and XIX Services 0.00 Does this facility have title V and/or XIX inpatient hospital se yes or "N" for no in the applicable column.	rvices? Enter "Y" for	- N		Υ		90.0
yes of N for horn the approache column. 1.00 Is this hospital reimbursed for title V and/or XIX through the cloud full or in part? Enter "Y" for yes or "N" for no in the applicab		N		Υ		91.0
2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual cinstructions) Enter "Y" for yes or "N" for no in the applicable	ertification)? (see			N		92.0
3.00 Does this facility operate an ICF/IID facility for purposes of t "Y" for yes or "N" for no in the applicable column.		- N		N		93.0
4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and applicable column.	"N" for no in the	N		N		94.0
5.00 If line 94 is "Y", enter the reduction percentage in the applical 6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or applicable column.		0. 00 N		0. 0 N	0	95. 0 96. 0
7.00 If line 96 is "Y", enter the reduction percentage in the applical 3.00 Does title V or XIX follow Medicare (title XVIII) for the intermstepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yold column 1 for title V, and in column 2 for title XIX.	s and residents post	0. 00 Y		0. 0 Y	0	97. 0 98. 0
B. 01 Does title V or XIX follow Medicare (title XVIII) for the report C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title title XIX.				Υ		98. (
B.O2 Does title V or XIX follow Medicare (title XVIII) for the calcul- bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N for title V, and in column 2 for title XIX.	ation of observation " for no in column 1	Y		Υ		98. (
3.03 Does title V or XIX follow Medicare (title XVIII) for a critical reimbursed 101% of inpatient services cost? Enter "Y" for yes or for title V, and in column 2 for title XIX.				N		98. (
3.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reim outpatient services cost? Enter "Y" for yes or "N" for no in colin column 2 for title XIX.		nd N		N		98. (
3.05 Does title V or XIX follow Medicare (title XVIII) and add back t Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in colum column 2 for title XIX.				Υ		98. (
8.06 Does title V or XIX follow Medicare (title XVIII) when cost reim Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 ficolumn 2 for title XIX. Rural Providers		Y		Y		98.
D5.00 Does this hospital qualify as a CAH? D6.00 If this facility qualifies as a CAH, has it elected the all-incl	usive method of payme	ent N				105. (106. (
for outpatient services? (see instructions) 07.00 If this facility qualifies as a CAH, is it eligible for cost rein 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. 25 in reimbursed. If yes complete Wkst. D-2, Pt. II.	(see instructions) I1					107.
08.00 s this a rural hospital qualifying for an exception to the CRNA	fee schedule? See 4	12 N				108.0

Health Financial Systems KING'S DAUGHTERS' HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0069 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 5/21/2020 10:03 am Physi cal Occupati onal Speech Respi ratory 1.00 2. 00 3. 00 4. 00 109.00 If this hospital qualifies as a CAH or a cost provider, are Ν Ν Ν Ν 109.00 therapy services provided by outside supplier? Enter for yes or "N" for no for each therapy. 1.00 110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes 110 00 N complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as appl i cabl e. 1.00 2.00 111.00|f this facility qualifies as a CAH, did it participate in the Frontier Community Ν 111.00 Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services. 1.00 2.00 3.00 Miscellaneous Cost Reporting Information 115.00|Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 Ν 0 115.00 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1. 116.00 s this facility classified as a referral center? Enter "Y" for yes or "N" for no. N 116.00 117.00|s this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for Ν 117.00 no. 118.00 118.00 s the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is \cap claim-made. Enter 2 if the policy is occurrence. Premi ums Losses Insurance 1.00 2.00 3.00 0118.01 118.01 List amounts of mal practice premiums and paid losses: 1, 041, 300 1. 00 2.00 118.02 Are mal practice premiums and paid losses reported in a cost center other than the 118. 02 Ν Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. 119.00 DO NOT USE THIS LINE 119 00 120.00|s this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA Υ 120.00 §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or 'N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 121.00|Did this facility incur and report costs for high cost implantable devices charged to 121.00 patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the 5.00 122. 00 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If Ν 125.00 yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 of this is a Medicare certified kidney transplant center, enter the certification date 126.00 in column 1 and termination date, if applicable, in column 2. 127.00|If this is a Medicare certified heart transplant center, enter the certification date 127.00 in column 1 and termination date, if applicable, in column 2. 128.00 of this is a Medicare certified liver transplant center, enter the certification date 128.00 in column 1 and termination date, if applicable, in column 2. 129.00|If this is a Medicare certified lung transplant center, enter the certification date in 129, 00 column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, enter the certification 130.00 date in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare certified intestinal transplant center, enter the certification 131.00 date in column 1 and termination date, if applicable, in column 2. 132.00 If this is a Medicare certified islet transplant center, enter the certification date 132.00 in column 1 and termination date, if applicable, in column 2. 133.00 If this is a Medicare certified other transplant center, enter the certification date 133.00 in column 1 and termination date, if applicable, in column 2. 134.00 of this is an organ procurement organization (OPO), enter the OPO number in column 1 134 00 and termination date, if applicable, in column 2. All Providers

OSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der CCI	N: 15-0069		: 1/01/2019 2/31/2019	Worksheet S- Part I Date/Time Pr 5/21/2020 10	epared:
		•				0,21,2020 10	
40.00	66	1.6 1	D 1 45 4		1.00	2. 00	1.10.00
40.00 Are there any related organization chapter 10? Enter "Y" for yes or ' are claimed, enter in column 2 the	"N" for no in column 1. I	f yes, and home	office co		N		140.00
1.00		00		•	3. 00		
If this facility is part of a cha			ugh 143 th	ne name ar	nd address	of the home	
office and enter the home office of 41.00 Name:	contractor name and contr Contractor's Name:	ractor number.	Contra	ctor's Nu	ımher:		141. 0
42. 00 Street:	PO Box:		Contra	ictor 3 Nu	illiber.		142. 0
43. 00 Ci ty:	State:		Zi p Co	de:			143.0
	·						
44.00	and a first to the West about	10				1.00	1110
44.00 Are provider based physicians' cos	sts included in Worksheet	A?				Υ	144. 0
					1. 00	2. 00	\dashv
45.00 f costs for renal services are clinpatient services only? Enter "Y' no, does the dialysis facility inc period? Enter "Y" for yes or "N" Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o	" for yes or "N" for no i clude Medicare utilizatio for no in column 2. gy changed from the previ n column 1. (See CMS Pub.	n column 1. If on for this cost ously filed cost	column 1 i reporting t report?		N		145. 0
							_
47.00	i i -2 -					1.00	147.0
47.00 Was there a change in the statisti 48.00 Was there a change in the order of						N N	147. C
49.00 Was there a change to the simplifi				for no.		N	149.0
		Part A	Part E		itle V	Title XIX	1
		1. 00	2. 00		3. 00	4. 00	
Does this facility contain a provi							
or charges? Enter "Y" for yes or ' 55.00Hospital	"N" for no for each compo			B. (See 4	12 CFR §41 N		 155. 0
55. 00 H0Spi tai 56. 00 Subprovi der – TPF		N N	N N		N N	N N	156. 0
57. 00 Subprovi der – IRF		N I	N		N	N	157.0
58. 00 SUBPROVI DER						•	158. C
59. 00 SNF		N	N		N	N	159.0
60. 00 HOME HEALTH AGENCY		N	N		N	N	160.0
61. 00 CMHC			N		N	N	161. C
						1. 00	-
Multicampus						1.00	
65.00 s this hospital part of a Multica	ampus hospital that has o	ne or more campu	uses in di	fferent C	BSAs?	N	165.0
Enter "Y" for yes or "N" for no.							
	Name	County		Zip Code	CBSA	FTE/Campus	_
66.00 f line 165 is yes, for each	0	1. 00	2. 00	3. 00	4.00	5. 00	00 166. 0
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.0	70 100.0
						1.00	
Health Information Technology (HI	T) incentive in the Ameri	can Recovery and	d Reinvest	ment Act		1. 00	
67.00 s this provider a meaningful user 68.00 f this provider is a CAH (line 10	r under §1886(n)? Enter	"Y" for yes or "	'N" for no		r the	Y	167. 0 168. 0
reasonable cost incurred for the l				6	1.1.1		4.0 -
68.01 If this provider is a CAH and is a					ashi p		168. 0
exception under §413.70(a)(6)(ii)					enter the	9. 9	99169. 0
69.00 If this provider is a meaningful transition factor. (see instruction							- 1
				Ве	gi nni ng	Endi ng	
	ons)				gi nni ng 1. 00	Endi ng 2. 00	170.0

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lie	eu of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIF	ICATION DATA	Provider CCN: 15-0069	Peri od:	Worksheet S-2	2
			From 01/01/2019 To 12/31/2019	Plant i Date/Time Pre	narod:
			10 12/31/2019	5/21/2020 10:	
			1. 00	2.00	
171.00 If line 167 is "Y", does this provider have	any days for indiv	viduals enrolled in	N		171.00
section 1876 Medicare cost plans reported o					
"Y" for yes and "N" for no in column 1. If	on				
1876 Medicare days in column 2. (see instru	ıctions)				

	Financial Systems KING'S DAUGHTE	RS' HOSPITAL		In Lie	u of Form CMS-	-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Peri od: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Pro	
					5/21/2020 10	
				Y/N 1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N	N for all NO re	esponses. Ent			
	mm/dd/yyyy format.					
	COMPLETED BY ALL HOSPITALS					-
1. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	e heainnina of	the cost	N		1.00
1.00	reporting period? If yes, enter the date of the change in o					1.00
			Y/N	Date	V/I	
2. 00	Has the provider terminated participation in the Medicare F	Drogram? If	1. 00 N	2. 00	3. 00	2.00
2.00	yes, enter in column 2 the date of termination and in colum		IN IN			2.00
	voluntary or "I" for involuntary.	,				
3. 00	Is the provider involved in business transactions, including		N			3.00
	contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide					
	officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and other					
	relationships? (see instructions)					
			Y/N	Type	Date	
	Financial Data and Reports		1. 00	2. 00	3. 00	
4. 00	Column 1: Were the financial statements prepared by a Ceri	tified Public	Υ	A	05/18/2020	4.00
	Accountant? Column 2: If yes, enter "A" for Audited, "C" i	for Compiled,				
	or "R" for Reviewed. Submit complete copy or enter date ava	ailable in				
5. 00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diffe	arent from	l N			5.00
3.00	those on the filed financial statements? If yes, submit received		"			3.00
				Y/N	Legal Oper.	
				1. 00	2. 00	
6 00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	If you is t	ho providor i	s N		6.00
6. 00	the legal operator of the program?	ii yes, is t	ne provider i	5 IN		0.00
7. 00	Are costs claimed for Allied Health Programs? If "Y" see in	nstructions.		N		7.00
8. 00	Were nursing school and/or allied health programs approved	and/or renewe	d during the	N		8. 00
9. 00	cost reporting period? If yes, see instructions.	araduata madi	aal aduaatian	N		0.00
9.00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cai education	N		9.00
10. 00	Was an approved Intern and Resident GME program initiated of		the current	N		10.00
	cost reporting period? If yes, see instructions.					
11. 00	Are GME cost directly assigned to cost centers other than I	I & Rin an Ap	proved	N		11.00
	Teaching Program on Worksheet A? If yes, see instructions.				Y/N	
					1. 00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes				Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.	policy change	during this c	ost reporting	N	13.00
14. 00	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? I	f ves. see in	structi ons.	N	14.00
	Bed Complement		.			
15. 00	Did total beds available change from the prior cost reporti				N	15. 00
		Y/N	t A Date	Y/N	t B Date	
		1. 00	2.00	3. 00	4. 00	
	PS&R Data					
16. 00	Was the cost report prepared using the PS&R Report only?	N		N		16. 00
	If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see					
	instructions)					
17.00	Was the cost report prepared using the PS&R Report for	Υ	03/11/2020	Υ	03/11/2020	17. 00
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date					
18. 00	in columns 2 and 4. (see instructions)	N		N		18.00
10.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	IN IN		N		10.00
	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					1
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
19.00	Donort data for corrections of other DCOD Danast					
19.00	Report data for corrections of other PS&R Report information? If yes, see instructions.					

Heal th	Financial Systems KING'S DAUGHTE	RS' HOSPITAL		In Lie	u of Form CMS	-2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0069	Peri od: From 01/01/2019 To 12/31/2019	Worksheet S- Part II Date/Time Pr 5/21/2020 10	epared:			
		Descr	iption	Y/N	Y/N	7. 00 diii			
			0	1.00	3. 00				
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00			
	•	Y/N 1. 00	Date 2.00	Y/N 3. 00	Date 4.00				
21. 00	Was the cost report prepared only using the provider's	N N	2.00	3.00 N	4.00	21.00			
	records? If yes, see instructions.					21.00			
					1. 00				
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE Capital Related Cost	EPT CHILDRENS	HOSPI TALS)						
22. 00	Have assets been relifed for Medicare purposes? If yes, see	e instructions				22.00			
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	ring the cost		23. 00					
24. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	ed into during	this cost r	eporting period?		24. 00			
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repo	rting period	? If yes, see		25. 00			
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	ne cost report	ing period?	If yes, see		26. 00			
27. 00	Has the provider's capitalization policy changed during the copy.	f yes, submit		27. 00					
28. 00									
29. 00									
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu		debt? If ye	s, see		30.00			
31.00	instructions.								
32. 00	Purchased Services Have changes or new agreements occurred in patient care ser		ed through c	ontractual		32.00			
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to compet	itive bidding? If	-	33. 00			
	Provi der-Based Physi ci ans								
34. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rrangement wit	h provider-b	ased physicians?	Υ	34.00			
35. 00	If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in	sting agreemenstructions.	nts with the	provi der-based	N	35.00			
				Y/N	Date				
				1.00	2. 00				
27.00	Home Office Costs					2/ 00			
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr	repared by the	home office	?		36. 00 37. 00			
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off			f		38. 00			
39. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other conjustructions.			S,		39. 00			
40. 00	see instructions. If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see			40. 00			
		1	00	2.	00				
	Cost Report Preparer Contact Information	1.		2.					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	LUCI A		GERBER		41.00			
42. 00		BLUE & CO., LL	_C			42.00			
43. 00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	502. 992. 3524		LGERBER@BLUEAN	DCO. COM	43. 00			

Health Financial Systems		KING'S DAUGHTE	RS' HOSPITAL	-		In Lieu	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CAR	REI MBURSEMENT	QUESTI ONNAI RE	Provi der	CCN: 15-0069		ri od: om 01/01/2019 12/31/2019	Worksheet S-2 Part II Date/Time Pre	
					Ц,		5/21/2020 10:	03 am
				3. 00				
Cost Report Preparer Conta	ct Information							
41.00 Enter the first name, last			SENIOR MANAG	SER				41.00
held by the cost report pr	eparer in colum	ns 1, 2, and 3,						
respecti vel y.								
42.00 Enter the employer/company	name of the co	st report						42.00
preparer.								
43.00 Enter the telephone number	and email addr	ess of the cost						43.00
report preparer in columns	1 and 2, respe	cti vel y.						

 Health Financial
 Systems
 KING'S D

 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provi der CCN: 15-0069

						o 12/31/2019	Date/Time Pr 5/21/2020 10		
							1/P Days /	Ť	J dill
							0/P Visits /	,	
							Trips		
	Component	Worksheet A	No. c	of Beds	Bed Days	CAH Hours	Title V	\top	
	'	Line Number			Avai I abl e				
		1. 00		. 00	3. 00	4. 00	5. 00		
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		76	27, 740	0.00		0	1.00
	8 exclude Swing Bed, Observation Bed and								
	Hospice days) (see instructions for col. 2								
	for the portion of LDP room available beds)								
2. 00	HMO and other (see instructions)								2.00
3. 00	HMO IPF Subprovider								3. 00
4. 00	HMO I RF Subprovi der								4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						l .	0	5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						l	0	6.00
7. 00	Total Adults and Peds. (exclude observation			76	27, 740	0.00		0	7.00
0.00	beds) (see instructions)	04.00		,	0.400	0.00			0.00
8. 00	INTENSIVE CARE UNIT	31. 00		6	2, 190	0.00		0	8.00
9.00	CORONARY CARE UNIT								9.00
10.00	BURN INTENSIVE CARE UNIT								10.00
11.00	SURGICAL INTENSIVE CARE UNIT								11.00
12.00	OTHER SPECIAL CARE (SPECIFY)	40.00						- 1	12.00
13.00	NURSERY	43. 00	1	0.0	20.020	0.00	1		13.00
14. 00	Total (see instructions)			82	29, 930	0.00	l .		14.00
15.00	CAH visits								15.00
16.00	SUBPROVIDER - I PF							- 1	16.00
17. 00	SUBPROVI DER - I RF							- 1	17.00
18.00	SUBPROVI DER							- 1	18.00
19.00	SKILLED NURSING FACILITY							- 1	19.00
20.00	NURSING FACILITY							- 1	20. 00 21. 00
21. 00	OTHER LONG TERM CARE	101 00						- 1	
22. 00	HOME HEALTH AGENCY	101. 00							22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	444 00			0.45				23.00
24. 00	HOSPI CE	116.00	l .	1	365)			24.00
24. 10 25. 00	HOSPICE (non-distinct part)	30. 00							24. 10
	CMHC - CMHC								25. 00 26. 00
26. 00	RURAL HEALTH CLINIC	89. 00							26. 00
26. 25 27. 00	FEDERALLY QUALIFIED HEALTH CENTER	89.00		83					26. 25
28.00	Total (sum of lines 14-26)			83					28.00
	Observation Bed Days								
29. 00 30. 00	Ambulance Trips Employee discount days (see instruction)								29. 00 30. 00
30.00	. 3								30.00
31.00	Employee discount days - IRF Labor & delivery days (see instructions)			0	(31.00
32. 00	Total ancillary labor & delivery room			U		,		- 1	32. 00
32.01	outpatient days (see instructions)								JZ. U I
33. 00	LTCH non-covered days						l		33. 00
	LTCH site neutral days and discharges								33. 00
55.01	Lion of to heatral days and dischaliges		1		I	ı	İ	- 1	JJ. U I

| Peri od: | Worksheet S-3 | From 01/01/2019 | Part I | To 12/31/2019 | Date/Time Prepared: Provi der CCN: 15-0069

				11	0 12/31/2019	5/21/2020 10:	
		I/P Davs	/ O/P Visits	/ Trips	Full Time I	Equi val ents	l am
			, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	·			Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	4, 715	1, 311	9, 023			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)	1, 521	784				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	4, 715	1, 311	9, 023			7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT	698	198	1, 305			8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL INTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)		450				12.00
13.00	NURSERY	5 440	150	' ' '		750.44	13.00
14.00	Total (see instructions)	5, 413	1, 659	· ·	0. 00	752. 14	
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVI DER - I PF						16.00
17. 00	SUBPROVI DER - I RF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20. 00 21. 00
21.00	OTHER LONG TERM CARE	3, 681	382	, 701	0.00	13. 65	
22. 00 23. 00	HOME HEALTH AGENCY	3, 081	382	6, 781	0. 00	13.05	22. 00 23. 00
	AMBULATORY SURGICAL CENTER (D. P.)	21	0	21	0.00	1 22	
24. 00 24. 10	HOSPICE HOSPICE (non-distinct part)	31	U	31	0. 00	1. 22	24. 00 24. 10
25. 00	CMHC - CMHC			U			25.00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0. 00	0.00	
27. 00	Total (sum of lines 14-26)	o _l	U	U	0.00		
28. 00	Observation Bed Days		416	2, 526	0.00	707.01	28.00
29.00	Ambulance Trips	2, 085	410	2, 320			29.00
30.00	Employee discount days (see instruction)	2,003		114			30.00
31.00	Employee discount days (see l'istruction)			0			31.00
32. 00	Labor & delivery days (see instructions)	0	89	152			32.00
32. 00	Total ancillary labor & delivery room	۷	07	0			32.00
JZ. UI	outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days	n					33.00
	LTCH site neutral days and discharges	0					33. 01
	i i i i i i i i i i i i i i i i i i i	١		1	ļ	ı	,

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Period: Worksheet S-3 From 01/01/2019 Part I Provi der CCN: 15-0069

					To	12/31/2019	Date/Time Pre 5/21/2020 10:0	pared: 03 am
		·	Full Time		Di sch	arges		
			Equi val ents					
		Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
			Workers				Pati ents	
			11. 00	12. 00	13. 00	14.00	15. 00	
1	. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2		0	1, 453	427	2, 972	1.00
_		for the portion of LDP room available beds)			244	205		2 00
	. 00	HMO and other (see instructions)			344	295		2.00
	. 00	HMO IPF Subprovi der				U O		3. 00 4. 00
	. 00	HMO IRF Subprovider				Ч		5.00
	. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF						6.00
	. 00	Total Adults and Peds. (exclude observation						7.00
,	. 00	beds) (see instructions)						7.00
Q	. 00	INTENSIVE CARE UNIT						8. 00
	. 00	CORONARY CARE UNIT						9.00
	0.00	BURN INTENSIVE CARE UNIT						10.00
	1. 00	SURGICAL INTENSIVE CARE UNIT						11.00
	2. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
	3. 00	NURSERY						13.00
	4. 00	Total (see instructions)	0.00	0	1, 453	427	2, 972	
	5. 00	CAH visits	0.00	Ŭ	1, 100	127	2, 7,2	15.00
	6. 00	y control of the cont						16.00
	7. 00	SUBPROVI DER - I RF						17.00
	8. 00	SUBPROVI DER						18.00
	9. 00	4						19.00
	0.00							20.00
	1. 00							21.00
	2.00	HOME HEALTH AGENCY	0.00					22.00
2	3. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
2	4. 00		0.00					24.00
2	4. 10	HOSPICE (non-distinct part)						24. 10
2	5. 00	CMHC - CMHC						25. 00
2	6. 00							26.00
2	6. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
2	7. 00	Total (sum of lines 14-26)	0.00					27.00
2	8. 00	Observation Bed Days						28. 00
2	9.00	Ambul ance Tri ps						29. 00
2	0 00	Employee discount days (see instruction)	1					20 00

30.00

31.00 32.00 32.01

33.00

33. 01

30.00 Employee discount days (see instruction)

31.00 Employee discount days - IRF
32.00 Labor & delivery days (see instructions)
32.01 Total ancillary labor & delivery room outpatient days (see instructions)

33.01 LTCH site neutral days and discharges

33.00 LTCH non-covered days

Health Financial Systems KING'S DAUGHTERS' HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0069 Peri od: Worksheet S-3 From 01/01/2019 Part II Date/Time Prepared: 12/31/2019 5/21/2020 10:03 am Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Reported ion of Sal ari es Related to Sal ari es (col. 2 ± col. Salaries in (from Wkst 3) col 4 A-6) 1.00 2.00 3.00 4.00 5.00 6.00 PART II - WAGE DATA SALARI ES 200 00 422, 993 51, 049, 904 1.00 Total salaries (see 50, 626, 911 1, 595, 368. 00 32.00 1.00 instructions) 2.00 Non-physician anesthetist Part 0.00 0.00 2.00 3 00 307 146 307 146 3, 317. 00 92.60 3 00 Non-physician anesthetist Part C 4.00 Physician-Part A -40,028 40,028 197.00 203.19 4.00 Administrative 4. 01 Physicians - Part A - Teaching 0.00 0.00 4.01 18, 934. 00 5.00 Physician and Non 3, 168, 570 3, 168, 570 167.35 5.00 Physician-Part B 6.00 Non-physician-Part B for 0 0.00 0.00 6.00 hospital-based RHC and FQHC servi ces Interns & residents (in an 21.00 7.00 7.00 0 0.00 0.00 approved program) 7.01 Contracted interns and 0 0.00 0.00 7.01 residents (in an approved programs) 8.00 Home office and/or related 0 0.00 0.00 8.00 organization personnel 9 00 44 00 SNF 0.00 0 00 9 00 73, 473 10.00 Excluded area salaries (see 19, 875, 793 19, 949, 266 497, 923. 00 40.06 10.00 instructions) OTHER WAGES & RELATED COSTS 11.00 Contract labor: Direct Patient 421, 559 421, 559 6, 574. 00 64. 13 11.00 Contract Labor: Top Level 0 0.00 12.00 0 0.00 12.00 management and other management and administrative servi ces 13.00 Contract Labor: Physician-Part 1, 304, 250 0 1, 304, 250 7, 897. 00 165. 16 13.00 A - Administrative 14.00 Home office and/or related 0 0 0 0.00 14.00 0.00 organization salaries and wage-related costs 14.01 Home office salaries 0 0.00 0.00 14.01 Related organization salaries 0.00 14.02 14.02 0 0 0.00 15.00 Home office: Physician Part A 0 0 0.00 0.00 15.00 - Administrative C 0 0.00 16.00 Home office and Contract 0 0.00 16.00 Physicians Part A - Teaching WAGE-RELATED COSTS 17.00 Wage-related costs (core) (see 7, 188, 249 n 7, 188, 249 17.00 instructions) 18.00 Wage-related costs (other) 18.00 (see instructions) 19.00 19.00 Excluded areas 4, 955, 749 4, 955, 749 20.00 Non-physician anesthetist Part 20.00 21.00 Non-physician anesthetist Part 72, 346 C 72, 346 21.00 22.00 Physician Part A -9, 396 9,396 22.00 Administrative 22 01 Physician Part A - Teaching 22 01 23.00 Physician Part B 735, 116 735, 116 23.00 Wage-related costs (RHC/FQHC) 24.00 0 24.00 Interns & residents (in an 25.00 0 0 25.00 approved program) 25.50 Home office wage-related 0 C 0 25.50 (core) 25.51 Related organization 0 25.51 wage-related (core) 0 25.52 Home office: Physician Part A 0 C 25.52 - Administrative wage-related (core) Home office & Contract 25.53

Physicians Part A - Teaching

wage-related (core)

Provi der CCN: 15-0069

| Peri od: | Worksheet S-3 | From 01/01/2019 | Part II | To 12/31/2019 | Date/Time Prepared:

					10	0 12/31/2019	5/21/2020 10:	
		Wkst. A Line	Amount	Reclassi fi cat	Adjusted	Pai d Hours	Average	US alli
		Number	Reported	i on of	Sal ari es	Related to	Hourly Wage	
		Number	Reported	Sal ari es	(col. 2 ± col.	Salaries in	(col. 4 ÷	
				(from Wkst.	3)	col. 4	col . 5)	
				A-6)	3)	COI . 4	COI. 3)	
		1. 00	2. 00	3.00	4. 00	5. 00	6. 00	
	OVERHEAD COSTS - DIRECT SALARI		2.00	3.00	4.00	3.00	0.00	
26. 00	Employee Benefits Department	4.00	0	0	0	0. 00	0.00	26. 00
27. 00	Administrative & General	5. 00	6, 526, 464	422, 993	6, 949, 457			27. 00
28. 00	Administrative & General under		862, 280		862, 280	· ·		
20.00	contract (see inst.)		002, 200	Ĭ	002, 200	0, 170.00	207.00	20.00
29. 00	Maintenance & Repairs	6. 00	0	0	0	0. 00	0.00	29. 00
30.00	Operation of Plant	7. 00	566, 546	0	566, 546			
31. 00	Laundry & Linen Service	8. 00	45, 976		45, 976	· ·		
32. 00	Housekeepi ng	9. 00	718, 776	ł .	718, 776			32.00
33. 00	Housekeeping under contract	7.00	228, 583	ł .	228, 583			
00.00	(see instructions)		220,000	Ĭ	220, 000	11, 200. 00	20. 11	00.00
34.00	Di etary	10. 00	705, 190	-260, 089	445, 101	28, 142. 00	15 82	34.00
35. 00	Dietary under contract (see	10.00	700, 170	200,007	110, 101	0.00		35. 00
33.00	instructions)		O			0.00	0.00	33.00
36. 00	Cafeteria	11. 00	0	260, 089	260, 089	16, 445. 00	15 82	36. 00
37. 00	Maintenance of Personnel	12.00	0	200,007	200,007	0.00		37. 00
38. 00	Nursi ng Admi ni strati on	13. 00	433, 103	0	433, 103			
39. 00	Central Services and Supply	14. 00	81, 424		81, 424			39. 00
40. 00	Pharmacy	15. 00	691, 553		691, 553			40.00
41. 00	Medical Records & Medical	16.00	524, 540	l e	524, 540			41. 00
41.00	Records Library	10.00	324, 340		324, 340	23, 703.00	∠1. 74	71.00
42.00	Social Service	17. 00	0	0	n	0. 00	0 00	42.00
	Other General Service	18. 00	0		١	0.00		43. 00
75.00	Tottici ociici di Dei Vi Ce	10.00	U	1	1 0	0.00	0.00	75.00

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lie	u of Form CMS-2552-10
HOSPITAL WAGE INDEX INFORMATION		Provi der CCN: 15-0069	Peri od:	Worksheet S-3

	AL WAGE TIMES THE ONWATTON			. Trovider c		From 01/01/2019 To 12/31/2019	Part III Date/Time Pre 5/21/2020 10:	pared:
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Pai d Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col	. Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		48, 242, 058	422, 993	48, 665, 05	1, 587, 512. 00	30. 65	1.00
	instructions)							
2.00	Excluded area salaries (see		19, 875, 793	73, 473	19, 949, 26	66 497, 923. 00	40. 06	2.00
	instructions)							
3.00	Subtotal salaries (line 1		28, 366, 265	349, 520	28, 715, 78	35 1, 089, 589. 00	26. 35	3.00
	minus line 2)							
4. 00	Subtotal other wages & related		1, 725, 809	0	1, 725, 80	14, 471. 00	119. 26	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		7, 197, 645	0	7, 197, 64	15 0.00	25. 07	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		37, 289, 719	349, 520	37, 639, 23	1, 104, 060. 00	34. 09	6.00
7.00	Total overhead cost (see		11, 384, 435	422, 993	11, 807, 42	468, 080. 00	25. 23	7.00
	instructions)							

Health Financial Systems	KING'S DAUGHTERS' HOSP	1 TAL	In Lieu	of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Prov	ider CCN: 15-0069		Worksheet S-3
			From 01/01/2019	Part IV

PART IV - WAGE RELATED COSTS 1.00		To 12/31/2019	Date/Time Pre 5/21/2020 10:	
PART IV - WAGE RELATED COSTS			1'	
PART IV - WAGE RELATED COSTS			Reported	
Part A - Core List				
RETIREMENT COST		PART IV - WAGE RELATED COSTS		
1.00				
2.00		RETI REMENT COST		
3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 0.00 0.0	1.00	401K Employer Contributions	0	1.00
A.00	2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
PLAM ADMINISTRATIVE COSTS (Paid to External Organization) 401K/TSA Pl an Administration fees 0 0 5.00	3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1, 853, 592	3.00
5.00 d01K/TSA Plan Administration fees 0 5.00 color Legal /Accounting/Management Fees-Pension Plan 0 6.00 color Co	4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
		PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
Employee Managed Care Program Administration Fees 0 7.00	5.00	401K/TSA Plan Administration fees	0	5.00
HEALTH AND INSURANCE COST	6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
8.00 Heal th Insurance (Purchased or Self Funded) 0 8.00 8.01 Heal th Insurance (Self Funded without a Third Party Administrator) 0 8.01 8.02 Heal th Insurance (Self Funded with a Third Party Administrator) 6.278,919 8.02 8.03 Heal th Insurance (Purchased) 0 8.03 9.00 Prescription Drug Plan 1,389,499 9.00 10.00 Dental , Hearing and Vision Plan 0 10.00 Dental , Hearing and Vision Plan 0 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 0 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 168,966 13.00 10.300	7.00		0	7.00
Heal th Insurance (Self Funded without a Third Party Administrator) 8. 01		HEALTH AND INSURANCE COST		
Real th Insurance (Self Funded with a Third Party Administrator) 8. 02 8. 03 Heal th Insurance (Purchased) 0 8. 03 1,389,499 9. 00 00 00 00 00 00 00	8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 03 Heal th Insurance (Purchased) 0 8. 03 9. 00 Prescription Drug Plan 1,389,499 9. 00 10. 00 Dental, Hearing and Vision Plan 0 11. 00 Life Insurance (If employee is owner or beneficiary) 0 11. 00 12. 00 Accident Insurance (If employee is owner or beneficiary) 0 12. 00 13. 00 Disability Insurance (If employee is owner or beneficiary) 168,961 13. 00 15. 00 Ung-Term Care Insurance (If employee is owner or beneficiary) 0 14. 00 15. 00 Workers' Compensation Insurance 0 15. 00 16. 00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16. 00 Non cumulative portion) 16. 00 Non cumulative portion 18. 00 Medicare Taxes - Employers Portion Only 0 18. 00 Medicare Taxes - Employers Portion Only 0 18. 00 OTHER 19. 00 OTHER 1	8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
9.00 Prescription Drug Plan 1,389,499 9.00 10.00 10.00 10.10 11.00 11.	8.02	Health Insurance (Self Funded with a Third Party Administrator)	6, 278, 919	8. 02
10.00 Dental, Hearing and Vision Plan 0 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 0 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 168, 966 13.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 0 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion 17.00 Non cumulative portion 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 3,007 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Relimbursement 0 23.00 24.00 Part B - Other than Core Related Cost 24.00 24.00 Part B - Other than Core Related Cost 24.00 25.00 Contact Contact Cost Cos	8. 03	Health Insurance (Purchased)	0	8. 03
11.00 Life Insurance (If employee is owner or beneficiary) 0 11.00 12.00 13.00 13.00 Disability Insurance (If employee is owner or beneficiary) 168,966 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 0 15.00 Workers' Compensation Insurance 0 16.00 Non cumulative portion) TAXES	9.00	Prescription Drug Plan	1, 389, 499	9. 00
12.00	10.00	Dental, Hearing and Vision Plan	0	10.00
13.00 Disability Insurance (If employee is owner or beneficiary) Long-Term Care Insurance (If employee is owner or beneficiary) 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) Norkers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumul ative portion) TAXES 17.00 FICA-Employers Portion Only Medicare Taxes - Employers Portion Only Unemployment Insurance State or Federal Unemployment Taxes OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) Day Care Cost and Allowances Tuition Reimbursement OTATION OF THER 24.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	11.00		0	11.00
14. 00 Long-Term Care Insurance (If employee is owner or beneficiary) 15. 00 16. 00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17. 00 FICA-Employers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 19. 00 Unemployment Insurance 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 29. 00 20. 00 2	12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
15.00 'Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FICA-Empl oyers Portion Only 18.00 Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance 20.00 State or Federal Unemployment Taxes 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 23.00 Tuition Reimbursement 24.00 Part B - Other than Core Related Cost 15.00 15.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 17.00 18.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00	13.00		168, 966	13.00
16.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FI CA-Employers Portion Only Medicare Taxes - Employers Portion Only Unemployment Insurance 20.00 State or Federal Unemployment Taxes 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement 24.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
Non cumulative portion) TAXES 17. 00 FICA-Employers Portion Only 18. 00 Medicare Taxes - Employers Portion Only 19. 00 Unemployment Insurance 20. 00 State or Federal Unemployment Taxes 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 23. 00 Tuition Reimbursement 24. 00 Part B - Other than Core Related Cost 17. 00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	15.00		0	15.00
TAXES 17.00 FI CA-Employers Portion Only 3, 266, 873 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 3, 007 19.00 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 0 23.00 24.00 Part B - Other than Core Related Cost 24.00 Part B - Other than Core Related Cost 24.00 Part B - Other than Core Related Cost 24.00 25.00	16.00		0	16.00
17. 00 FI CA-Employers Portion Only 3, 266, 873 17. 00 18. 00 Medicare Taxes - Employers Portion Only 0 18. 00 19. 00 Unemployment Insurance 3, 007 19. 00 20. 00 OTHER 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22. 00 Day Care Cost and Allowances 0 22. 00 23. 00 Tuition Reimbursement 0 23. 00 24. 00 Part B - Other than Core Related Cost 24. 00 Part B - Other than Core Related Cost 24. 00 25				
18.00 Medicare Taxes - Employers Portion Only Unemployment Insurance 3,007 19.00 State or Federal Unemployment Taxes 0 20.00 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 0 22.00 Tuit ion Reimbursement 0 23.00 Total Wage Related cost (Sum of Lines 1 -23) 12,960,856 Part B - Other than Core Related Cost				
19.00 Unemployment Insurance 20.00 State or Federal Unemployment Taxes 0 THER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 23.00 Tuition Reimbursement 24.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost 19.00 20.00 20.00 20.00 21.00 22.00 22.00 23.00 23.00 Total Wage Related cost (Sum of Lines 1 -23) 24.00 Part B - Other than Core Related Cost	17. 00		3, 266, 873	1
20.00 State or Federal Unemployment Taxes 0 0 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 0 22.00 Tuition Reimbursement 0 23.00 Total Wage Related cost (Sum of Lines 1 -23) 12,960,856 Part B - Other than Core Related Cost			_	
OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement 24.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost 21.00 21.00 22.00 22.00 23.00 24.00 24.00				
21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement 24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost	20. 00		0	20.00
instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement 24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost				
22. 00	21. 00		9 0	21.00
23.00				
24.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost 12,960,856 24.00				
Part B - Other than Core Related Cost				
	24. 00		12, 960, 856	24.00
25. UU UTHER WAGE RELATED COSTS (SPECIFY)	25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	Į į	25.00

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lieu of Form CMS-2552		
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0069	From 01/01/2019	Worksheet S-3 Part V Date/Time Prepared:	

		To	12/31/2019	Date/Time Pre 5/21/2020 10:	
	Cost Center Description		Contract	Benefit Cost	
			Labor		
			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		421, 559	12, 960, 856	1.00
2.00	Hospi tal		421, 559	12, 960, 856	2.00
3.00	Subprovi der - I PF				3.00
4.00	Subprovi der - I RF				4.00
5. 00	Subprovi der - (0ther)		0	0	5.00
6. 00	Swing Beds - SNF		0	0	6.00
7. 00	Swing Beds - NF		0	0	7.00
8. 00	Hospi tal -Based SNF				8.00
9. 00	Hospi tal -Based NF				9.00
10. 00	Hospi tal -Based OLTC				10.00
11. 00	Hospi tal -Based HHA		0	0	
12.00	Separately Certified ASC				12.00
13. 00	Hospi tal -Based Hospi ce		0	0	13.00
14.00	Hospital-Based Health Clinic RHC				14.00
15. 00	Hospital-Based Health Clinic FQHC				15.00
16. 00	Hospi tal -Based-CMHC				16.00
	Renal Dialysis				17.00
18. 00	Other		0	0	18.00

Heal th	Financial Systems	KING'S DAUGHTERS	S' HOSPITAL		In Lie	u of Form CMS-2	2552-10
	EALTH AGENCY STATISTICAL DATA		Provi der C	CN: 15-0069 CCN: 15-7141	Peri od: From 01/01/2019 To 12/31/2019	Worksheet S-4	pared:
					Home Health	PPS	US alli
					Agency I		
					1.	00	
0.00	County	T: +1 - 1/	T: +1 - \/\/\	T: +1 - VIV	JEFFERSON	Tabal	0.00
		Title V 1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	Total 5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1. 00 2. 00	Home Health Aide Hours Unduplicated Census Count (see instructions)	0.00	412 308. 00	•	0 382 00 289. 00	l e	1. 00 2. 00
					ployees (Full Ti		
					-	·	
		Enter the number your normal		Staff	Contract	Total	
		your morman	NOTIC MEEK				
		0		1.00	2.00	3. 00	
3. 00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)		40. 00	0. (0. 00	0.00	3.00
4. 00	Director(s) and Assistant Director(s)		40.00	0.		l	
5.00	Other Administrative Personnel			4.			
6. 00 7. 00	Direct Nursing Service Nursing Supervisor			5		•	6. 00 7. 00
8.00	Physi cal Therapy Servi ce			2.	0.00	2. 39	8. 00
9.00	Physical Therapy Supervisor			0.0		l	9. 00 10. 00
10. 00 11. 00	Occupational Therapy Service Occupational Therapy Supervisor			0.		l	
12.00	Speech Pathology Service			0. (
13. 00 14. 00	Speech Pathology Supervisor Medical Social Service			0. (
15. 00	Medical Social Service Supervisor			0.		1	15. 00
16.00	Home Heal th Aide			0.		l	
17. 00 18. 00	Home Health Aide Supervisor Other (specify)			0. (
	HOME HEALTH AGENCY CBSA CODES						
19. 00	Enter in column 1 the number of CBSAs where you provided services during the cost				1		19.00
	reporting period.						
20. 00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20			99915			20.00
	contains the first code).						
		Full Epi:		LUPA Episode	s PEP Only	Total (cols.	
		Outliers	itii outireis	LUPA EPI SOUE	Epi sodes	1-4)	
	DDC ACTIVITY DATA	1. 00	2. 00	3. 00	4. 00	5. 00	
21. 00	PPS ACTIVITY DATA Skilled Nursing Visits	1, 481	27	1	75 49	1, 632	21.00
22. 00	Skilled Nursing Visit Charges	356, 445	6, 507			392, 780	22. 00
23. 00 24. 00	Physical Therapy Visits Physical Therapy Visit Charges	1, 481 317, 959	0		34 38 10 8, 164		
25. 00	Occupational Therapy Visits	383	0		2 9	394	
26. 00 27. 00	Occupational Therapy Visit Charges	91, 439 13	0		78 2, 151 1 0	94, 068 14	26. 00 27. 00
28. 00	Speech Pathology Visits Speech Pathology Visit Charges	3, 198	0	•	16 0	3, 444	
29. 00	Medical Social Service Visits	0	0	1	0 0	0	29.00
30. 00 31. 00	Medical Social Service Visit Charges Home Health Aide Visits	0 79	0	•	0 0 9	0 88	
32.00	Home Health Aide Visit Charges	11, 139	0		0 1, 245	12, 384	32.00
33. 00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3, 437	27	1	12 105	3, 681	33. 00
34. 00	Other Charges	o	0		0 0	0	34.00
35. 00	Total Charges (sum of lines 22, 24, 26, 28,	780, 180	6, 507	26, 1			
36. 00	30, 32, and 34) Total Number of Episodes (standard/non	286			36 9	331	36.00
	outlier)						
37. 00 38. 00	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	0	1		0 0	l .	37. 00 38. 00
30.00	1.02a. Non Noatt no moar our Suppry Griar ges	١	O	П	σ ₁ 0	1	1 55. 55

Hoal +h	Financial Systems		KING'S DAUGHTE	DS' HOSDITAI		In Lie	u of Form CMS-2	0552 10
	AL-BASED HOSPICE IDENTIFICATION	J DATA	KING 3 DAUGITL	Provi der C	CN: 15-0069	Peri od:	Worksheet S-9	
1100111	THE BROOD HOST FOR THE PRINTERS	. 5/1/1				From 01/01/2019	PARTS I THROU	GH IV
				Hospi ce CC	N: 15-1535	To 12/31/2019	Date/Time Pre 5/21/2020 10:	
						Hospi ce I	3/21/2020 10.	US alli
		Unduplicated				1103pr cc 1		
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		cols. 1, 2 &	
				Nursi ng	Facility		5)	
		1 00	0.00	Facility	4.00	F 00		
	PART I - ENROLLMENT DAYS FOR C	1. 00	2. 00	3. 00	4.00	5. 00	6. 00	
1. 00	Hospice Continuous Home Care	USI KEPUKIING	PERIODS BEGINN	TING BEFORE OCT	UBER 1, 2015 T			1.00
2. 00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
4. 00	Hospice General Inpatient Care							4.00
5. 00	Total Hospice Days							5.00
Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015								
6.00	Number of patients receiving							6. 00
	hospi ce care							
7. 00	Total number of unduplicated							7.00
	Continuous Care hours billable to Medicare							
8. 00	Average Length of Stay (line 5							8.00
0.00	/ line 6)							0.00
9.00	Unduplicated census count							9.00
NOTE:	Parts I and II, columns 1 and 2	also include	the days repor	ted in columns	3 and 4.			<u> </u>
				Title XVIII	Title XIX	Other	Total (sum of	
							col s. 1	
							through 3)	
	DART LLL FURNILLMENT DAVO FOR	0007 DEDODTIN	0 0501 000 0501	1.00	2.00	3.00	4. 00	
10 00	PART III - ENROLLMENT DAYS FOR Hospice Continuous Home Care	COST REPORTIN	G PERIODS BEGI	NNING ON OR AF	TER OCTOBER 1	· -	1 0	10.00
10. 00 11. 00	Hospice Continuous Home Care			1, 825		0 0 5	_	11.00
12.00	Hospice Inpatient Respite Care			1, 623	1	0 0	1, 919	ı
13. 00	Hospice General Inpatient Care			19		0 0		13.00
14. 00	Total Hospice Days			1, 856	1	5 89		14.00
20	PART IV - CONTRACTED STATISTIC	AL DATA FOR CO	ST REPORTING P					1
15.00	Hospice Inpatient Respite Care			0		0 0	0	15.00
16.00	Hospice General Inpatient Care			0		0 0	0	16. 00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Heal th	Financial Systems KING'S DAUGHTERS'	HOSPI TAL		In Lie	u of Form CMS-2	2552-10			
Incorporasted and Indigent care cost computation 1.00				CN: 15-0069	Peri od:					
						D-+- /T: D				
Uncompensated and Indigent care cost computation					10 12/31/2019	5/21/2020 10:	pareu: O3 am			
Incompensated and Indigent care cost computation 0.00										
						1. 00				
Medicald (see Instructions for each line) 11,981,229 2.00										
Net revenue from Medical 11,981,229 2.00 2.	1. 00		vided by li	ine 202 colur	n 8)	0. 249766	1. 00			
3.00 Indivour receive DSH or supplemental payments from Medicaid? Y 3.00 1 Filine 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid? Y 4.00 5.00 If line 4 is no, then enter DSH and/or supplemental payments from Medicaid? Y 4.00 5.00 Medicaid charges 45,351,16 6.00 This is the control of the control o	2 00					11 001 220	2.00			
1			tal navmen	ts from Media	rai d?					
Medicaid charges					our u .	· ·				
8.00 Care then enter evenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5: if care then enter zero) Children's Heal th Insurance Program (CHIP) (see instructions for each line) 0,000 0.0000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000		1								
Care See Instructions See See Instructions See	7.00	Medicaid cost (line 1 times line 6)				11, 327, 192	7.00			
Children's Health Insurance Program (CHIP) (see instructions for each line)	8.00		(line 7 min	nus sum of li	nes 2 and 5; if	0	8. 00			
9.00 Net revenue From stand-al one CHIP 0 9.00 10.00				``						
10.00 Stand-al one CHIP cost (line 1 times line 10) 0.0.00	0.00		or each lir	ne)		0	0.00			
11. 00 Stand-al one CHIP cost "(line 1 times line 10) 10. 00										
12.00 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then 0 12.00										
ther state or local government indigent care program (see instructions for each line) 13.00 Not revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14.00 15.00 Not revenue from state or local indigent care program (Not included in lines 6 or 10.10) 15.00 State or local indigent care program (Not included in lines 6 or 10.10) 15.00 State or local indigent care program (Not included in lines 6 or 10.10) 15.00 State or local indigent care program (Not included in lines 6 or 10.10) 15.00 State or local indigent care program (Not included in lines 6 or 10.10) 15.00 State or local indigent care program (Not included in lines 6 or 10.10) 15.00 State or local indigent care program (Not included in lines 6 or 10.10) 15.00 State or local indigent care program (Not included in lines 6 or 10.10) 15.00 State or local indigent care program (Not included in lines 6 or 10.10) 15.00 State or local indigent care program (Not included in lines 6 or 10.10) 15.00 State or local indigent care program (Not included in lines 6 or 10.10) 16.00 17.00 Private grants, donations and total unrelimbursed cost for Medicaid, CHIP and state/local indigent care programs (see Instructions for each line) 17.00 18.00 State or local indigent care program (Instructions for each line) 18.00 19.00 19.00 10.			(line 11 mi	inus line 9:	if < zero then	_				
13.00 Net revenue from state or local Indigent care program (Not included on lines 2, 5 or 9) 0 13.00 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 0 0 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 indigent care program (line 15 minus line 0 16.00 13.										
14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10.01 14.00 15.00 15.00 State or local indigent care program cost (line 1 times line 14)										
10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; lf < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 18.00 18.00 Government grants, appropriations or transfers for support of hospital operations 0 18.00 19.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 0 19.00 19.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 0 19.00 19.00 Lincompensated Care (see instructions for each line) 10.00 Lincompensated Care (see instructions for each line) 20.00 Charity care charges and uninsured discounts for the entire facility 2,159,045 434,428 2,593,473 20.00 21.00 Cost of patients approved for charity care and uninsured discounts (see 539,256 434,428 973,684 21.00 22.00 Payents received from patients for amounts previously written off as 0 0 0 22.00 23.00 Cost of Charity care (line 21 minus line 22) 539,256 434,428 973,684 23.00 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit inposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit in 100 200 Medicare and indigent care program (line 29) 12,775,085 26.00 26.00 Total bad debt expense for the entire hospital complex (see instructions) 12,459,894 28.00 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 12,459,894 28.00 28.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 3,222,374 29.00 29.00 Cost of uncompensated care (line 23 column 3 plus line 29) 4,196,065 3										
15.00 State or local indigent care program cost (line 1 times line 14) 0 15.00 16.00	14.00									
10. 00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13: if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17. 00 Private grants, donations, or endowment income restricted to funding charity care 18. 00 Government grants, appropriations or transfers for support of hospital operations 19. 00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 0 18. 00 19. 00 18. 00 19	15 00		4)			0	15 00			
13; if < zero then enter zero) Grants, donations and total unrelimbursed cost for Medicaid, CHIP and state/local indigent care programs (see linstructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care 0 17.00 18.00 18.00 18.00 18.00 19.00				e program (Li	ne 15 minus line					
instructions for each line) Private grants, donations, or endowment income restricted to funding charity care (Sovernment grants, appropriations or transfers for support of hospital operations (Sovernment grants, appropriations or transfers for support of hospital operations (Sovernment grants, appropriations or transfers for support of hospital operations (Sovernment grants, appropriations or transfers for support of hospital operations (Sovernment grants, appropriations or transfers for support of hospital operations (Sovernment grants, appropriations or transfers for support of hospital operations (Sovernment grants, appropriations) Uninsured patients Insured patients Total (col. 1 patients Fotal. 2)		13; if < zero then enter zero)								
17. 00 Private grants, donations, or endowment income restricted to funding charity care Sovernment grants, appropriations or transfers for support of hospital operations Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 0 19.00 1			IP and stat	te/local indi	gent care progra	ms (see				
Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16) Uninsured patients Insured patients + col. 2 1.00 2.00 3.00	17.00		undi ng chai	rity care		0	17. 00			
8, 12 and 16) Uninsured patients Data (col. 1 + col. 2)										
Unionsured patients patients patients +col. 2 Uncompensated Care (see instructions for each line) 20.00 Charity care charges and uninsured discounts for the entire facility (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see 539, 256 434, 428 973, 684 21.00 22.00 Payments received from patients for amounts previously written off as 0 0 0 23.00 Cost of charity care (line 21 minus line 22) 539, 256 434, 428 973, 684 23.00 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit N 24.00 25.00 Total bad debt expense for the entire hospital complex (see instructions) 12, 775, 085 26.00 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 20, 459, 894 28.00 28.00 Cost of non-Medicare bad debt expense (see instructions) 3, 222, 374 20.00 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 3, 222, 374 20.00 3.00 Cost of uncompensated care (line 23 column 3 plus line 29) 4, 196, 058 30.00	19. 00		l indigent	care program	ns (sum of lines	0	19. 00			
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Uncompensated Care (see instructions for each line) 20.00 Charity care charges and uninsured discounts for the entire facility (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see 539, 256 day, 428 973, 684 21.00 instructions) 22.00 Payments received from patients for amounts previously written off as 0 0 0 0 22.00 charity care 23.00 Cost of charity care (line 21 minus line 22) 539, 256 day, 428 973, 684 23.00 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit N 24.00 imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 12, 775, 085 26.00 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 12, 775, 085 27.00 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 315, 191 27.01 28.00 Non-Medicare bad debt expense (see instructions) 3, 222, 374 29.00 30.00 Cost of nuncompensated care (line 23 column 3 plus line 29) 4, 196, 058 30.00										
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22.00 Payments received from patients for amounts previously written off as charity care 23.00 Cost of charity care (line 21 minus line 22) 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 3, 222, 374 29.00 4, 196, 058 30.00	21. 00		unts (see	539, 2	56 434, 428	973, 684	21. 00			
23.00 Cost of charity care (line 21 minus line 22) 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.01 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 315, 191 27.00 29.00 Cost of uncompensated care (line 23 column 3 plus line 29) 4, 196, 058 30.00	22. 00		off as		0 0	0	22. 00			
24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 315, 191 27.01 29.00 Cost of uncompensated care (line 23 column 3 plus line 29) 1.00 1.0	22.00			E20. 2	424 420	072 404	22.00			
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stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 3.222,374 29.00 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 4,196,058 30.00		imposed on patients covered by Medicaid or other indigent care	-							
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27. 01 Medicare allowable bad debts for the entire hospital complex (see instructions) 28. 00 Non-Medicare bad debt expense (see instructions) 29. 00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 315, 191 27. 01 12, 459, 894 28. 00 30. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 4, 196, 058 30. 00		1 ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '								
28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 12, 459, 894 28.00 3, 222, 374 29.00 4, 196, 058 30.00		•	•							
29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 3,222,374 29.00 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 4,196,058 30.00		, , ,	see instru	ctions)						
30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 4,196,058 30.00			nonco (coo	i netructi on	.)					
		·	hense (see	THIS ET UC ET OHS	?)					
1.00 10tal an orman sea and uncompensated eare cost (11th 17 prus 11th 00)		Total unreimbursed and uncompensated care cost (line 19 plus li	i ne 30)							

Control Cont		Financial Systems	KING'S DAUGHTERS	_			u of Form CMS-2	2552-10
Cost Center Description	RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der Co		Period:	Worksheet A	
Cost Center Description						To 12/31/2019		
Control Mark Stew of Cost Centres		Cook Cooks Doors at a	Calasia	0+1	T-+-1 (1 (D1: 6:+		03 am
CEBIHAL SERVICE LOSI CERTERS		Cost Center Description	Sararres	otner.				
					+ COI. 2)			
Column C								
1.00			1. 00	2.00	3. 00	4. 00	5. 00	
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3.00 00000 OTHER CART TAL RELATED COSTS 4.00 00000 DEUTYCE SEMENT SEPRATIVES 5.00 00000 AUMIN STRATI VE & GENERAL 5.00 000000 AUMIN STRATI VE & GENERAL 5.00 00000 AUMIN STRATI VE & GENERAL 5.00 00000 AUMIN STRATI VE & GENERAL 5.00 00000 DEUTYCE SEMENT SERVICE 5.00 000000 DEUTYCE SEMENT SERVICE 5.00 00000 DEUTYCE SEMENT SERVICE SERVICE 5.00 00000 DEUTYCE SEMENT SERVICE SERVICE 5.00 00000 DEUTYCE SERVICE SERVICE 5.00 000000 DEUTYCE SERVICE SERVICE 5.00 00000 DEUTYCE SERVICE SERVICE SERVICE 5.00 00000 DEUTYCE SERVICE SERVICE SERVICE 5.00 00000 DEUTYCE SERVICE SERVICE SERVICE 5.00 000000 DEUTYCE SERVICE SERVICE SERVICE 5.00 00000 DEUTYCE SERVICE SERVICE SERVICE SERVICE 5.00 00000 DEUTYCE SERVICE SERVI				0			· ·	
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7.00 DOTOO) DOTOO] OFFRATION OF PLANT 5.00 COSSOD_LANDRY & LINES ESPENCE 4.67 976 359, 293 40, 209 209 40, 209 40, 105, 209 80, 209 90, 200 200 200 200 200 200 200 200 200 2	4.00		0	14, 197, 917	14, 197, 91	7 -277, 942	13, 919, 975	4.00
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15.00 01500 PIAMBIACY 591, 553 9, 265, 135 9, 944, 689 -8, 635, 969 1, 318, 719 15.00 19.00 01900 MORPHYSICI AN AMESTHETISTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	13.00	01300 NURSING ADMINISTRATION	433, 103	1, 508	434, 61			1
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30.00	23.00		127, 301	11, 323	137,02	0 0	137, 020	23.00
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MICH LARY SERVICE COST CENTERS 50.00 GROOD OPERATING ROOM 2.008, 317 4,843, 248 6,851,565 -4,316,443 2,535,125 50.00 51.00 05100 PREATING ROOM 278, 984 14,147 293,131 -9,674 228,3457 51.00 52.00 052	31.00	03100 INTENSIVE CARE UNIT	1, 071, 288	5, 667	1, 076, 95	5 -742	1, 076, 213	31.00
50.00	43.00		0	0		0 512, 433	512, 433	43.00
51.00 05100 RECOVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0	FO 00		2 000 217	4 042 240	/ 051.5/	T 4 217 442	2 525 422	F0 00
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53.00 05300 ANESTHESI OLOGY 1, 595, 409 986, 619 2, 572, 028 .403, 208 2, 188, 820 53.00 .401 .00 .401 .00 .400 .600 .401 .400		1	· ·					
54. 00 05400 RADIOLOGY-DI AGNOSTIC 2, 882, 586 994, 581 3, 877, 167 1.71, 648 3, 859, 519 54. 00 54. 01 03450 ULTRA SOUND 118. 800 54. 058 172, 588 -3. 886 68. 972 54. 00 55. 01 03480 OKOLOGY THERAPEUTI C 0 0 0 0. 05. 00 0. 05.			1 1	ŭ				•
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 68, 139 192, 950 261, 089 -1, 213 259, 876 54. 02 055 00 0550 00 050 0 0	54.00							•
55.00 05500 ADDIOLOGY - THERAPEUTIC 0 0 0 0 0 0 55.00 55.01 55.01 03500 OSCOURD OSCOUR		l	118, 800	54, 058	172, 85	-3, 886	168, 972	54. 01
55. 01 03480 ONCOLOGY 926, 070 1, 425, 421 2, 351, 491 -66, 967 2, 284, 524 55. 01			68, 139	192, 950	261, 08			1
57.00 OS700 OS700 CT SCAN 152, 111 285, 614 437, 725 -15, 470 422, 255 57.00 59.00 OS900 CARDITA C CATHETERI ACTI ON 0 0 0 0 0 0 0 59.00 59.00 OS900 CARDITA C CATHETERI ACTI ON 0 0 0 0 0 0 0 59.00 59.00 0.00 0.00 0 0 0 0 0			024 070	1 425 421	2 251 40	-	_	
58. 00 06800 MAGNETIC RESONANCE I MAGING (MRI) 143,640 126,543 270,183 -1,394 268,789 58. 00 0590 06900 CARDIAC CATHETERIZATION 0 0 0 0 0 0 0 0 0			1 1					1
59 00 05900 CARDIAC CATHETERIZATION 0		l I	1 1					1
Color Colo			0		1			
65. 00 06500 RESPI RATORY THERAPY 630, 419 122, 019 752, 438 .81, 210 671, 228 65, 00 66. 00 06600 PHYSI CAL THERAPY 1, 332, 876 40, 312 1, 373, 188 .77, 944 .66, 00 67. 00 06700 0CCUPATI ONAL THERAPY 192, 034 7, 639 199, 673 -2, 893 196, 780 67, 00 68. 00 06800 SPECH PATHOLOGY 163, 933 3, 858 167, 791 -1, 986 165, 805 68, 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 6, 69 00 69. 01 03610 SLEEP LAB 140, 145 85, 391 225, 536 -7, 237 218, 299 69, 01 71. 00 17010 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 2, 540, 075 2, 540, 075 71, 00 71. 01 07101 IV SOLUTI ONS 0 0 0 0 0 0 2, 36, 38 93, 638 71, 01 71. 01 07101 V SOLUTI ONS 0 0 0 0 0 0 2, 784, 199 2, 784, 199 72, 00 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0, 2, 784, 199 2, 784, 199 72, 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0, 2, 784, 199 2, 784, 199 72, 00 76. 00 0310 SLEEP LAB 0.00 0 0 0 0 0 0 0, 0, 75, 74 10, 037, 574 73, 00 76. 00 03140 CARDI OLOGY 446, 573 218, 189 664, 762 -21, 263 643, 499 76, 09 76. 00 0340 CARDI OLOGY 446, 573 218, 189 664, 762 -21, 263 643, 499 76, 09 76. 00 03791 CARDI AC REHABI LI TATI ON 75, 853 7, 296 83, 149 -248 82, 901 76, 97 77. 00 07900 CLINI C 102, 607 11, 464 114, 071 -8, 311 105, 760 90, 00 77. 00 07900 CLINI C 1, 737, 307 1, 407, 295 3, 144, 602 -240, 426 2, 904, 176 91, 00 78. 00 07900 OSEPIXATION BEDS (NON-DI STI INCT PART) 1, 737, 307 1, 407, 295 85, 026 984, 548 667 985, 155 101, 00 78. 00 07900 OSEPIXATION BEDS (NON-DI STI INCT PART) 1, 737, 307 1, 407, 295 85, 026 984, 548 667 985, 155 101, 00 78. 00 07900 OSEPIXATION BEDS (NON-DI STI INCT PART) 1, 594, 069 192, 987 1, 787, 056 -47, 867 1, 739, 189 50, 00 78. 00 07900 OSEPIXATION BEDS (NON-DI STI INCT		06000 LABORATORY	1, 562, 983			7 -1, 425, 936	2, 979, 341	60.00
66.00 06600 PHYSI CAL THERAPY 1,332,876 40,312 1,373,188 -77,944 1,295,244 66.00 67.00 67.00 06700 0CCUPATIONAL THERAPY 192,034 7,639 1,973,188 167,791 -1,986 165,805 68.00 68.00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 0 0 69.00 06900 0.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0					1
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68.00 06900 06900 ELECTROCARDIOLOGY 163, 933 3, 858 167, 791 -1, 966 165, 805 88. 00 06900 06900 06900 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 0 0								1
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69.01 03610 SLEEP LAB 140, 145 85, 391 225, 536 -7, 237 218, 299 69, 017 100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 2, 540, 075 2, 540, 075 71, 00 71, 01 07101 IV SOLUTIONS 0 0 0 0 0 0 2, 784, 199 22, 784, 199 72, 00 73,			1		1			1
71.01	69. 01		140, 145	85, 391	225, 53	6 -7, 237	218, 299	69. 01
72. 00 07200 MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 10, 337, 574 10, 337, 574 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 10, 337, 574 10, 337, 574 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 10, 337, 574 10, 337, 574 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 10, 337, 574 10, 337, 574 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1		1			
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76. 00 03140 CARDI OLOGY 446, 573 218, 189 664, 762 -21, 263 643, 499 76. 00 76. 97 CARDI AC REHABILITATION 75, 853 7, 296 83, 149 -248 82, 901 76. 97			1	0				•
76. 97 O7697 CARDI AC REHABILITATION 75, 853 7, 296 83, 149 -248 82, 901 76, 97			١	218 189				•
OUTPATIENT SERVICE COST CENTERS 102,607 11,464 114,071 -8,311 105,760 90.00 90.00 90.00 90.00 90.00 90.00 91.00 91.00 91.00 91.00 91.00 92.00 92.00 90.00 92.00 90.00 92.00 90.00 92.00 90.00 92.00 90.00 92.00 90.00 92.00 92.00 92.00 92.00 92.00 90.00 92								
91. 00 09100 EMERGENCY 1,737,307 1,407,295 3,144,602 -240,426 2,904,176 91. 00 92. 00 085ERVATION BEDS (NON-DISTINCT PART) 92. 00 09200 085ERVATION BEDS (NON-DISTINCT PART) 92. 00 09500 AMBULANCE SERVI CES 1,594,069 192,987 1,787,056 -47,867 1,739,189 95. 00 101.00 HOME HEALTH AGENCY 899,522 85,026 984,548 607 985,155 101.00 101.00 HOME HEALTH AGENCY 899,522 85,026 984,548 607 985,155 101.00 113.00 113.00 11300 INTEREST EXPENSE 69,109 55,386 124,495 58,998 183,493 116.00 116.00 HOME HBURSABLE COST CENTERS 90.00 110				.,=			3=7.10	1
92. 00						1 -8, 311	105, 760	
OTHER REIMBURSABLE COST CENTERS 1,594,069 192,987 1,787,056 -47,867 1,739,189 95.00		l	1, 737, 307	1, 407, 295	3, 144, 60	2 -240, 426	2, 904, 176	•
95. 00	92. 00							92.00
101. 00 10100 HOME HEALTH AGENCY 899, 522 85, 026 984, 548 607 985, 155 101. 00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 0 0 0 0 113. 00 116.00 HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) 33, 441, 319 69, 398, 654 102, 839, 973 -334, 988 102, 504, 985 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 33, 441, 319 69, 398, 654 102, 839, 973 -334, 988 102, 504, 985 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 190000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 91, 288 1, 713 93, 001 0 93, 001 194. 00 194. 01 07951 MOB 2, 830, 049 293, 514 3, 123, 563 0 3, 123, 563 194. 01 194. 01 07952 PHYSI CI AN CLI NI CS 4, 873, 502 1, 598, 122 6, 471, 624 -42, 826 6, 428, 798 194. 02 194. 03 07953 PHYS PRAC BUS OFC 621, 301 10, 094 631, 395 681, 833 1, 313, 228 194. 03 194. 04 07954 MOB - MAIN CAMPUS 394, 332 -2, 956 391, 376 0 391, 376 194. 04 194. 05 07955 ONCOLOGY - NONREI MBURSABLE 0 0 0 0 0 0 0 194. 05 194. 06 07956 KDH - MC FAMI LY PRACTI CE 2, 811, 011 227, 037 3, 038, 048 -136, 685 2, 901, 363 194. 06 194. 08 07958 KDH - MC GENERAL SURGERY 1, 119, 168 619, 539 1, 738, 707 0 1, 738, 707 194. 08	05 00		1 504 060	102 007	1 707 05	47 947	1 720 100	05.00
SPECIAL PURPOSE COST CENTERS 13.00 11300 INTEREST EXPENSE 69,109 55,386 124,495 58,998 183,493 116.00 116.0								
116. 00			0777022	00,020	70.70.	<u> </u>	7007.00	1
18. 00 SUBTOTALS (SUM OF LINES 1 through 117) 33, 441, 319 69, 398, 654 102, 839, 973 -334, 988 102, 504, 985 118. 00	113.00	11300 I NTEREST EXPENSE		0		0 0	0	113.00
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190. 00	118.00		33, 441, 319	69, 398, 654	102, 839, 97	3 -334, 988	102, 504, 985	118.00
194. 00 07950 OTHER NON-REIMBURSABLE 91, 288 1, 713 93, 001 0 93, 001 194. 00 194. 01 07951 MOB 2, 830, 049 293, 514 3, 123, 563 0 3, 123, 563 194. 01 194. 02 07952 Physician Clan Clinics 4, 873, 502 1, 598, 122 6, 471, 624 -42, 826 6, 428, 798 194. 02 194. 03 07953 Phys Prace Bus ofc 621, 301 10, 094 631, 395 681, 833 1, 313, 228 194. 03 194. 04 07954 MOB - MAIN CAMPUS 394, 332 -2, 956 391, 376 0 391, 376 194. 04 07954 ONCOLOGY - NONREIMBURSABLE 0 0 0 0 0 194. 04 07954 MOB - MAIN CAMPUS 194. 04 07956 KDH - MC FAMILTY PRACTICE 2, 811, 011 227, 037 3, 038, 048 -136, 685 2, 901, 363 194. 06 194. 07 07957 KDH - MC ORTHOPEDICS 1, 875, 875 673, 952 2, 549, 827 -23, 001 2, 526, 826 194. 07 194. 08 07958 KDH - MC GENERAL SURGERY 1, 119, 168 619, 539 1, 738, 707 0 1, 738, 707 194. 08	100.00			0	1		0	100.00
194. 01 07951 MOB 2, 830, 049 293, 514 3, 123, 563 0 3, 123, 563 194. 01 194. 02 07952 PHYS I CI AN CLI NI CS 4, 873, 502 1, 598, 122 6, 471, 624 -42, 826 6, 428, 798 194. 02 194. 03 07953 PHYS PRAC BUS OFC 621, 301 10, 094 631, 395 681, 833 1, 313, 228 194. 03 194. 04 07954 MOB - MAI N CAMPUS 394, 332 -2, 956 391, 376 0 391, 376 194. 04 194. 05 07955 ONCOLOGY - NONREI MBURSABLE 0 0 0 0 194. 06 07956 KDH - MC FAMI LY PRACTI CE 2, 811, 011 227, 037 3, 038, 048 -136, 685 2, 901, 363 194. 06 194. 08 07958 KDH - MC ORTHOPEDI CS 1, 875, 875 673, 952 2, 549, 827 -23, 001 2, 526, 826 194. 07 194. 08 07958 KDH - MC GENERAL SURGERY 1, 119, 168 619, 539 1, 738, 707 0 1, 738, 707 194. 08			91 288	1 713	93.00	1 0		
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194. 06 07956 KDH - MC FAMILY PRACTICE 2, 811, 011 227, 037 3, 038, 048 -136, 685 2, 901, 363 194. 06 194. 07 07957 KDH - MC ORTHOPEDICS 1, 875, 875 673, 952 2, 549, 827 -23, 001 2, 526, 826 194. 07 194. 08 07958 KDH - MC GENERAL SURGERY 1, 119, 168 619, 539 1, 738, 707 0 1, 738, 707 194. 08								
194. 07 07957 KDH - MC ORTHOPEDICS 1, 875, 875 673, 952 2, 549, 827 -23, 001 2, 526, 826 194. 07 194. 08 07958 KDH - MC GENERAL SURGERY 1, 119, 168 619, 539 1, 738, 707 0 1, 738, 707 194. 08			-1	ŭ				
194. 08 07958 KDH - MC GENERAL SURGERY 1, 119, 168 619, 539 1, 738, 707 0 1, 738, 707 194. 08								
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Health Financial Systems	KING'S DAUGHTERS	S' HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provi der Co		Peri od:	Worksheet A	
				From 01/01/2019 To 12/31/2019		nared·
				12,01,201,	5/21/2020 10:	03 am
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
			+ col . 2)	ions (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
194. 10 07960 KDH - MC UROLOGY	72, 885	365, 424	438, 30	9 0	438, 309	194. 10
194.11 07961 KDH - MC OB/GYN	1, 834, 960	608, 737	2, 443, 69	7 -15, 275	2, 428, 422	194. 11
200.00 TOTAL (SUM OF LINES 118 through 199)	50, 626, 911	73, 824, 718	124, 451, 629	9 0	124, 451, 629	200. 00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0069

Peri od: Worksheet A From 01/01/2019 To 12/31/2019 Date/Time Prepared:

5/21/2020 10:03 am Cost Center Description Adjustments Net Expenses (See A-8) For Allocation 6. 00 7.00 GENERAL SERVICE COST CENTERS -1, 154, 407 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 13, 307, 363 1.00 00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO 1.01 0 7,859 1.01 00200 NEW CAP REL COSTS-MVBLE EQUIP 2 00 0 2 00 0 3.00 00300 OTHER CAPITAL RELATED COSTS 0 3.00 Ω 12, 854, 622 00400 EMPLOYEE BENEFITS DEPARTMENT -1, 065, 353 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL -5, 056, 028 13, 013, 517 5.00 00700 OPERATION OF PLANT 7.00 3, 100, 386 -28, 688 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 405, 269 8.00 9 00 00900 HOUSEKEEPI NG 0 1, 151, 504 9 00 01000 DI ETARY 708, 831 10.00 10.00 0 01100 CAFETERI A -405, 565 11.00 8, 631 11.00 434, 611 13.00 01300 NURSING ADMINISTRATION 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 83, 560 14.00 15.00 01500 PHARMACY 15.00 1, 318, 719 0 16.00 01600 MEDICAL RECORDS & LIBRARY -215 870, 125 16.00 01900 NONPHYSICIAN ANESTHETISTS 19 00 -307, 146 19.00 02300 RADI OLOGY SCHOOL 23.00 23.00 -45, 225 93, 801 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS -918, 423 30.00 30.00 3, 764, 119 03100 INTENSIVE CARE UNIT 31.00 1,076,213 31.00 0 04300 NURSERY 512, 433 43.00 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 2, 535, 122 50.00 51.00 05100 RECOVERY ROOM 0 283, 457 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 656, 263 52.00 53.00 05300 ANESTHESI OLOGY -2, 336, 572 -167, 752 53.00 05400 RADI OLOGY-DI AGNOSTI C -1, 870, 544 54.00 1, 988, 975 54.00 03630 ULTRA SOUND 168, 972 54.01 54.01 03450 NUCLEAR MEDICINE - DIAGNOSTIC 54.02 0 259, 876 54.02 55.00 05500 RADI OLOGY - THERAPEUTI C 55.00 03480 ONCOLOGY 55.01 -615, 125 1,669,399 55.01 57 00 05700 CT SCAN 422, 255 57 00 0 |05800|MAGNETIC RESONANCE IMAGING (MRI) 58.00 0 268, 789 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 06000 LABORATORY 60.00 -96, 563 2,882,778 60.00 278, 419 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62 00 0 62 00 06500 RESPIRATORY THERAPY 65.00 0 671, 228 65.00 06600 PHYSI CAL THERAPY 0 1, 295, 244 66.00 66.00 67 00 06700 OCCUPATIONAL THERAPY 196, 780 67 00 0 0 06800 SPEECH PATHOLOGY 68.00 165, 805 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 69.01 03610 SLEEP LAB 0 0 218, 299 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2, 540, 075 71 00 71 00 71.01 07101 IV SOLUTIONS 93, 638 71.01 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 2, 784, 199 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 73.00 10.037.574 0 03140 CARDI OLOGY 643, 499 76.00 76.00 76.97 07697 CARDIAC REHABILITATION 82, 901 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 105, 760 90.00 -511, 137 91 00 09100 EMERGENCY 2, 393, 039 91 00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00 -2,8101, 736, 379 101.00 10100 HOME HEALTH AGENCY 985, 155 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 183.493 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 -14, 413, 801 88, 091, 184 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 194.00 07950 OTHER NON-REIMBURSABLE 190.00 0 0 93, 001 194 00 0 194. 01 07951 MOB 3, 123, 563 194.01 194. 02 07952 PHYSICIAN CLINICS 0 0 6, 428, 798 194.02 194. 03 07953 PHYS PRAC BUS OFC 1, 313, 228 194.03 194.04 07954 MOB - MAIN CAMPUS 391, 376 194. 04 194. 05 07955 ONCOLOGY - NONREI MBURSABLE 194. 05 0 0 0 194.06 07956 KDH - MC FAMILY PRACTICE 2, 901, 363 194.06 194. 07 07957 KDH - MC ORTHOPEDICS 2, 526, 826 l194. 07 194.08 07958 KDH - MC GENERAL SURGERY 1, 738, 707 194.08 194.09 07959 KDH - MC ENT 563, 051 194.09 194. 10 07960 KDH - MC UROLOGY 194. 10 438, 309

Health Financial Systems	KING'S DAUGHTE	RS' HOSPITAL		In Lieu	of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der C	CN: 15-0069	Peri od:	Worksheet A	
				From 01/01/2019 To 12/31/2019	Date/Time Pre	enared.
				12,01,201,	5/21/2020 10:	
Cost Center Description	Adjustments	Net Expenses				
	(See A-8)	For				
		Allocation				
	6. 00	7. 00				
194. 11 07961 KDH - MC OB/GYN	0	2, 428, 422				194. 11
200.00 TOTAL (SUM OF LINES 118 through 199)	-14, 413, 801	110, 037, 828	8			200.00

Health Financial Systems RECLASSIFICATIONS KING'S DAUGHTERS' HOSPITAL In Lieu of Form CMS-2552-10

Provider CCN: 15-0069

					5/21/2020 10:	:03 am
	Cont. Contan	Increases	C=1 = ·	0+1		
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00		
	A - CAFETERIA	0.00		0.00		
1.00	CAFETERI A	1100	260, 089	154, 107		1.00
	D MEDICAL IMACING TIME		260, 089	154, 107		-
1. 00	B - MEDICAL IMAGING TIME PHYSICIAN CLINICS	194. 02	13, 868	0		1.00
1.00	0		13, 868	0		1.00
	C - DEPRECIATION					
1.00	NEW CAP REL COSTS-BLDG &	1. 01	0	7, 859		1.00
	FIXT HHA/HO	+		7, 859		
	D - NURSERY- L&D		<u> </u>	7,009		-
1. 00	NURSERY	43. 00	471, 379	41, 054		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52. 00	603, 686	5 <u>2, 5</u> 77		2.00
	0		1, 075, 065	93, 631		
1 00	E - CRNA EXPENSE	10.00	207 144			1 00
1. 00	NONPHYSI CI AN ANESTHETI STS		30 <u>7, 1</u> 46 307, 146	0		1.00
	F - PHYSICIAN BILLING AND COL	LECTI ONS	307, 140	<u> </u>		1
1.00	PHYS PRAC BUS OFC	194. 03	0	681, 833		1.00
	0		0	681, 833		
1 00	G - EMPLOYEE BENEFITS	F 001	400.000			1 00
1. 00 2. 00	ADMINISTRATIVE & GENERAL	5. 00 0. 00	422, 993	0		1.00 2.00
3. 00		0.00	0	0		3.00
4. 00		0. 00	Ö	Ö		4. 00
5.00		0.00	0	0		5.00
6. 00		0.00	0	0		6.00
	0		422, 993	0		
1. 00	I - MED/SURG SUPPLIES MEDICAL SUPPLIES CHARGED TO	71. 00	ol	2, 540, 075		1.00
1.00	PATIENTS	71.00	٩	2, 540, 075		1.00
2.00	.,	0.00	o	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4. 00
5. 00		0.00	0	0		5.00
6. 00 7. 00		0. 00 0. 00	0	0		6. 00 7. 00
8. 00		0.00	0	0		8.00
9. 00		0. 00	Ö	Ö		9.00
10.00		0.00	0	0		10.00
11.00		0. 00	0	0		11.00
12.00		0. 00	0	0		12.00
13.00		0.00	0	0		13.00
14. 00 15. 00	1	0. 00 0. 00	0	0		14. 00 15. 00
16. 00		0. 00	Ö	Ö		16.00
17. 00		0.00	o	Ō		17. 00
18.00		0.00	O	0		18. 00
19. 00		0. 00	0	0		19.00
20.00		0.00	0	0		20.00
21. 00 22. 00		0. 00 0. 00	O O	0		21. 00 22. 00
23. 00		0.00	0	0		23. 00
24. 00		0. 00	Ö	Ö		24. 00
25.00		000		0		25. 00
	0			2, 540, 075		1
1 00	J - IV SOLUTIONS	71 01	ما	02 (20		1 00
1. 00 2. 00	IV SOLUTIONS	71. 01 0. 00	0	93, 638 0		1.00 2.00
3. 00		0.00	0	0		3.00
4. 00	1	0. 00	ő	Ö		4. 00
5.00		0.00	О	0		5.00
6. 00		0. 00	O	0		6.00
7. 00		0.00	0	0		7.00
8. 00 9. 00		0. 00 0. 00	O	0		8. 00 9. 00
7. 00				93, 638		7.00
	K - IMPLANTS		٥,	70, 000		1
1.00	IMPL. DEV. CHARGED TO	72. 00	0	2, 784, 199		1.00
	PATI ENTS					
	ĮU	I	0	2, 784, 199		I

Heal th Financial Systems KING'S DAUGHTERS' HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 15-0069 From 01/01/2019 To 12/31/2019 Prepared:

					5/21/2020 10): 03 am
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3. 00	4. 00	5. 00		
	L - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	10, 037, 574		1.00
2. 00		0. 00	0	0		2. 00
3.00		0.00	0	0		3.00
4. 00		0. 00	0	0		4. 00
5.00		0. 00	0	0		5. 00
6.00		0. 00	0	0		6. 00
7.00		0. 00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
	0		0	10, 037, 574		
	M - INSURANCE					
1.00	NEW CAP REL COSTS-BLDG &	1. 00	0	277, 942		1. 00
	FI XT					
	0		0	277, 942		
	N - HOME HEALTH DIRECTOR					
1. 00	HOME HEALTH AGENCY	1 <u>01.</u> 00	5 <u>9, 6</u> 05	0		1.00
	0		59, 605	0		
	0 - HOSPI CE					
1. 00	HOSPICE	1 <u>16.</u> 00	5 <u>8, 9</u> 98	0		1.00
	0		58, 998	0		
500.00	Grand Total: Increases		2, 197, 764	16, 670, 858		500.00

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: Provi der CCN: 15-0069

					Ic	Prepared: 10:03 am
		Decreases				
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.	
	6. 00 A - CAFETERIA	7. 00	8. 00	9. 00	10. 00	
1.00	DI ETARY	10.00	260, 089	154, 107	0	1.00
	0 = = = =		260, 089	154, 107		
	B - MEDICAL IMAGING TIME					
1.00	RADI OLOGY-DI AGNOSTI C	54.00	13, 868	0	0	1. 00
	0		13, 868	0		
1. 00	C - DEPRECIATION NEW CAP REL COSTS-BLDG &	1.00	O	7. 859	9	1.00
1.00	FIXT	1.00		7,037		1.00
	0 — — — — —		0	7, 859		
	D - NURSERY- L&D					
1.00	ADULTS & PEDIATRICS	30.00	1, 075, 065	93, 631	0	1.00
2. 00		0.00	00 1, 075, 065	0 93, 631	0	2.00
	E - CRNA EXPENSE		1, 073, 003	73, 031		
1.00	ANESTHESI OLOGY	53.00	307, 146	0	0	1.00
	0		307, 146			
4 00	F - PHYSICIAN BILLING AND COI			(04 000		4.00
1. 00	ADMI NI STRATI VE & GENERAL			68 <u>1, 8</u> 33 681, 833		1.00
	G - EMPLOYEE BENEFITS	L	ΟĮ	001, 033		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	62, 280	0	1.00
2.00	PHYSICIAN CLINICS	194. 02	0	56, 694	О	2. 00
3. 00	KDH - MC FAMILY PRACTICE	194. 06	0	136, 685	0	3. 00
4. 00	KDH - MC ORTHOPEDICS	194. 07	0	23, 001	0	4.00
5. 00 6. 00	KDH - MC ENT KDH - MC OB/GYN	194. 09 194. 11	O O	129, 058 15, 275	0	5. 00 6. 00
0.00	0	— · · · · · · · · · · · · · · · · · · ·	- — —	422, 993		0.00
	I - MED/SURG SUPPLIES					
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	347	0	1.00
2.00	OPERATION OF PLANT PHARMACY	7. 00	0	10 57/	0	2.00
3. 00 4. 00	ADULTS & PEDIATRICS	15. 00 30. 00	0	10, 576 399, 775	- 1	3. 00 4. 00
5. 00	INTENSIVE CARE UNIT	31.00	Ö	742	0	5. 00
6.00	OPERATING ROOM	50.00	O	1, 513, 561	0	6. 00
7. 00	RECOVERY ROOM	51.00	0	9, 139	0	7. 00
8.00	ANESTHESI OLOGY	53.00	0	61, 219	0	8.00
9. 00 10. 00	RADI OLOGY-DI AGNOSTI C ULTRA SOUND	54. 00 54. 01	O O	2, 750 3, 456	0	9. 00 10. 00
11. 00	NUCLEAR MEDICINE -	54. 02	0	1, 123	0	11.00
00	DI AGNOSTI C	0 02	٦	., .20		
12.00	ONCOLOGY	55. 01	0	64, 902	0	12.00
13.00	CT SCAN	57. 00	0	15, 470	0	13.00
14. 00	MAGNETIC RESONANCE IMAGING (MRI)	58. 00	O	1, 394	0	14. 00
15. 00	LABORATORY	60.00	0	86, 246	0	15. 00
16. 00	RESPI RATORY THERAPY	65. 00	Ö	47, 838	o	16.00
17. 00	PHYSI CAL THERAPY	66. 00	O	13, 961	О	17. 00
18.00	OCCUPATIONAL THERAPY	67. 00	0	2, 893	0	18.00
19. 00 20. 00	SPEECH PATHOLOGY SLEEP LAB	68. 00 69. 01	O O	1, 986 7, 237	0	19. 00 20. 00
21. 00	CARDI OLOGY	76. 00	0	21, 263	0	21.00
22. 00	CARDI AC REHABI LI TATI ON	76. 97	Ö	248	O	22. 00
23.00	CLINIC	90. 00	0	8, 311	О	23. 00
24. 00	EMERGENCY	91. 00	0	229, 104	0	24. 00
25. 00	AMBULANCE SERVICES	95.00	0	36, 532 2, 540, 075		25. 00
	J - IV SOLUTIONS		U U	2, 540, 075		
1. 00	PHARMACY	15. 00	0	41, 706	0	1.00
2.00	ADULTS & PEDIATRICS	30. 00	0	18, 522	0	2. 00
3.00	OPERATING ROOM	50.00	0	18, 683	0	3.00
4.00	RECOVERY ROOM	51.00	0	535	0	4.00
5. 00 6. 00	RADI OLOGY-DI AGNOSTI C ONCOLOGY	54. 00 55. 01	0	70 2, 065	0	5. 00 6. 00
7. 00	RESPIRATORY THERAPY	65. 00	ol	2, 003	0	7. 00
8.00	EMERGENCY	91.00	O	11, 322	0	8. 00
9. 00	AMBULANCE SERVICES	95.00			0	9. 00
	U LMDLANTS		0	93, 638		
1. 00	K - IMPLANTS OPERATING ROOM	50.00	O	2, 784, 199	0	1.00
1.00	0			2, 784, 199		1.00
	1	' '	=1	. = ., ., .,	1	T.

Health Financial Systems RECLASSIFICATIONS KING'S DAUGHTERS' HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0069

						5/21/2020 10	<u>:03 am</u>
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	L - DRUGS						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	29, 524	C		1.00
2.00	PHARMACY	15. 00	0	8, 583, 687	C		2.00
3.00	ANESTHESI OLOGY	53. 00	0	34, 843	C		3.00
4.00	RADI OLOGY-DI AGNOSTI C	54. 00	0	960	C		4.00
5.00	ULTRA SOUND	54. 01	0	430	C		5. 00
6.00	NUCLEAR MEDICINE -	54. 02	0	90	C		6.00
	DI AGNOSTI C						
7.00	LABORATORY	60. 00	0	1, 339, 690	C		7. 00
8.00	RESPI RATORY THERAPY	65. 00	0	33, 346	C		8. 00
9.00	PHYSI CAL THERAPY	66. 00	0	4, 378	C		9. 00
10.00	AMBULANCE SERVICES	95. 00	0	10, 626	C		10.00
	0			10, 037, 574			
	M - INSURANCE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	277, 942	12		1.00
	0			277, 942			
	N - HOME HEALTH DIRECTOR						
1.00	PHYSI CAL THERAPY	66. 00	59, 605	0	C		1.00
	0		59, 605				
	0 - HOSPI CE						
1.00	HOME HEALTH AGENCY	101. 00	58, 998	0	C		1.00
	0 — — — — —		58, 998	_			
500.00	Grand Total: Decreases		1, 774, 771	17, 093, 851		7	500.00

Provi der CCN: 15-0069

					o 12/31/2019	Date/Time Pre 5/21/2020 10:	pared:
				Acqui si ti ons		3/21/2020 10.	US alli
		Begi nni ng Bal ances	Purchases	Donati on	Total	Disposals and Retirements	
		1. 00	2.00	3. 00	4.00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	3, 499, 119	0	C	0	5, 913	1.00
2.00	Land Improvements	540, 656	0	C	0	44, 306	2.00
3.00	Buildings and Fixtures	117, 953, 918	549, 685	C	549, 685	0	3.00
4.00	Building Improvements	0	0	C	0	0	4. 00
5.00	Fixed Equipment	0	0	C	0	0	5.00
6.00	Movable Equipment	65, 943, 153	0	C	0	4, 109, 038	6.00
7.00	HIT designated Assets	0	0	C	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	187, 936, 846	549, 685	C	549, 685	4, 159, 257	8. 00
9.00	Reconciling Items	0	0	C	0	0	9. 00
10.00	Total (line 8 minus line 9)	187, 936, 846	549, 685	C	549, 685	4, 159, 257	10.00
		Endi ng	Ful I y				
		Bal ance	Depreciated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	3, 493, 206	0				1.00
2.00	Land Improvements	496, 350	0				2. 00
3.00	Buildings and Fixtures	118, 503, 603	0				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fixed Equipment	0	0				5. 00
6.00	Movable Equipment	61, 834, 115	0				6. 00
7. 00	HIT designated Assets	0	0				7. 00
8. 00	Subtotal (sum of lines 1-7)	184, 327, 274	0				8. 00
9. 00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	184, 327, 274	0				10.00

	n Financial Systems	KING'S DAUGHTE				u of Form CMS-2	
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Peri od:	Worksheet A-7	
					From 01/01/2019		
					Го 12/31/2019	Date/Time Pre 5/21/2020 10:	
			SII	IMMARY OF CAPI	ΤΛΙ	3/21/2020 10.	US alli
			30	WWART OF CALL	IAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see	instructions)	
					instructions)	l matructions)	
		9, 00	10. 00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WO				12.00		
1. 00	NEW CAP REL COSTS-BLDG & FIXT	8, 898, 588			0	22, 692	1.00
1. 01	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0,070,000	00, 12,	(1 22,072	1.01
2. 00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	ì		ĺ	2.00
3. 00	Total (sum of lines 1-2)	8, 898, 588	58, 127	5, 212, 280		22, 692	1
0.00	Total (Sam of Titles 1 2)	SUMMARY 0	· · · · · · · · · · · · · · · · · · ·	0, 212, 200	<u>, </u>	22,072	0.00
		John Titt O	0/11 1/12				
	Cost Center Description	Other	Total (1)				
	5551 551161 25551 Pt. 611	Capi tal -Rel at					
		ed Costs (see					
		instructions)	, oug,				
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WO			and 2			
1. 00	NEW CAP REL COSTS-BLDG & FIXT	0	14, 191, 687				1.00
1 01	NEW CAP REL COSTS_BLDG & FLXT HHA/HO		0.17.17.17.007				1 01

1.00
. 01
2. 00
3. 00
l . 2.

Heal th	n Financial Systems	KING'S DAUGHTEI	RS' HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2019 To 12/31/2019	Date/Time Prep 5/21/2020 10:0	pared:
		COMP	PUTATION OF RA	TI 0S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio (col. 1 -	instructions)		
				col . 2)			
		1. 00	2. 00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	NEW CAP REL COSTS-BLDG & FIXT	122, 493, 159	0	122, 493, 15			1.00
1. 01	NEW CAP REL COSTS-BLDG & FLXT HHA/HO	0	0		0. 000000		1. 01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	61, 834, 115	0	61, 834, 11			2.00
3. 00	Total (sum of lines 1-2)	184, 327, 274	0	184, 327, 27			3.00
		ALLOCAT	TION OF OTHER (CAPI TAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at				
			ed Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C			T	. T		
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0		0 8, 890, 729		1.00
1. 01	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	0		7, 859	l .	1. 01
2. 00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		0	0	2.00
3.00	Total (sum of lines 1-2)	0	0		0 8, 898, 588	36, 647	3. 00
			St	JMMARY OF CAPI	IAL		
	Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
			(see	instructions)	Capi tal -Rel at		
			instructions)		ed Costs (see	9 through 14)	
					instructions)		
		11. 00	12. 00	13. 00	14. 00	15. 00	
4 05	PART III - RECONCILIATION OF CAPITAL COSTS C		077	1 00 10	al -	40.007.5:5	
1.00	NEW CAP REL COSTS-BLDG & FIXT	4, 079, 353	277, 942			., ,	1.00
1. 01	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	0		0	,	1. 01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		0	۱	2.00
3. 00	Total (sum of lines 1-2)	4, 079, 353	277, 942	22, 69	2 0	13, 315, 222	3. 00

Health Financial Systems
ADJUSTMENTS TO EXPENSES KING'S DAUGHTERS' HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0069 Peri od: From 01/01/2019 To 12/31/2019 Worksheet A-8 Date/Time Prepared: 5/21/2020 10:03 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted

				To/From Which the Amount is t	o be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2. 00	3.00	4.00	5. 00	
1. 00	Investment income - NEW CAP	В	-268, 242	NEW CAP REL COSTS-BLDG &	1. 00	11	1.00
	REL COSTS-BLDG & FIXT (chapter 2)			FLXT			
1. 01	Investment income - NEW CAP REL COSTS-BLDG & FIXT HHA/HO			NEW CAP REL COSTS-BLDG & FIXT HHA/HO	1. 01	0	1. 01
2. 00	(chapter 2) Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter		0	NEW CAP REL COSTS-MVBLE EQUIP	2. 00	O	2.00
3. 00	2) Investment income - other (chapter 2)		0		0. 00	0	3.00
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0. 00	0	4. 00
5.00	Refunds and rebates of		0		0. 00	0	5.00
6. 00	expenses (chapter 8) Rental of provider space by	В	-21, 480	NEW CAP REL COSTS-BLDG &	1. 00	10	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay	А	-3, 441	FIXT ADMINISTRATIVE & GENERAL	5. 00	0	7. 00
	stations excluded) (chapter 21)						
8. 00	Television and radio service (chapter 21)	А	-28, 688	OPERATION OF PLANT	7. 00	0	8. 00
9. 00	Parking Lot (chapter 21)		0		0. 00	0	9. 00
10. 00	Provi der-based physician adjustment	A-8-2	-6, 360, 883			0	10. 00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11. 00
12. 00	Related organization transactions (chapter 10)	A-8-1	0			0	
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В	405 545	CAFETERI A	0. 00 11. 00	0	13. 00 14. 00
15. 00	Rental of quarters to employee	Ь	-405, 565 0	CAFETERIA	0.00	0	
16. 00	and others Sale of medical and surgical		0		0. 00	0	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than patients		0		0. 00	0	17. 00
18. 00	Sale of medical records and abstracts	В	-215	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	Nursing and allied health education (tuition, fees, books, etc.)		0		0. 00	0	19. 00
	Vendi ng machi nes		0		0. 00	0	
21. 00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21. 00
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0. 00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14)	A-8-3	0	PHYSI CAL THERAPY	66. 00		24.00
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-BLDG &	1. 00	0	26. 00
26. 01	COSTS-BLDG & FIXT Depreciation - NEW CAP REL			FIXT NEW CAP REL COSTS-BLDG &	1. 01	0	26. 01
27. 00				FIXT HHA/HO NEW CAP REL COSTS-MVBLE	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist	А	-307, 146	EQUIP NONPHYSICIAN ANESTHETISTS	19. 00		28. 00
	Physicians' assistant	A		ADULTS & PEDIATRICS	30. 00	o	29. 00

Heal th	Financial Systems		KING'S DAUGHTE	RS' HOSPITAL	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES			F	eriod: rom 01/01/2019 o 12/31/2019	Worksheet A-8 Date/Time Pre	
					0 12/31/2019	5/21/2020 10:	03 am
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	·	(2)				Ref.	
	,	1. 00	2. 00	3. 00	4. 00	5. 00	
30.00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30.00
	therapy costs in excess of						
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
04 00	instructions)	4.0.0		CDEFOUL DATUGLOOV			04.00
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
	limitation (chapter 14)						
32 00	CAH HIT Adjustment for		0		0.00	0	32.00
02.00	Depreciation and Interest				0.00	· ·	02.00
33.00	RADIOLOGY TUITION	В	-45, 225	RADI OLOGY SCHOOL	23. 00	0	33.00
33. 01	AMBULANCE REVENUE	В	-2, 677	AMBULANCE SERVICES	95.00	0	33. 01
33. 02	ADVERTI SI NG	A		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 03	SELF-I NSURANCE	A		EMPLOYEE BENEFITS DEPARTMENT		0	33. 03
33. 04	HOSPITAL ASSOCIATION FEES	A	•	ADMINISTRATIVE & GENERAL	5. 00	0	00.01
33. 05	HAF MEDICAID	Α	•	ADMINISTRATIVE & GENERAL	5. 00	0	33. 05
33.06	PHYSI CI AN RECRUI TMENT	A		ADMINISTRATIVE & GENERAL	5. 00	0	00.00
33. 07	PHYSICIAN LAB SALARY OFFSET	A		LABORATORY	60.00	0	00.07
33. 08 33. 09	PHYSICIAN LAB BENEFIT OFFSET	A		EMPLOYEE BENEFITS DEPARTMENT		0	00.00
33. 09	CRNA BENEFIT OFFSET PA BENEFIT OFFSET	A A	•	EMPLOYEE BENEFITS DEPARTMENT EMPLOYEE BENEFITS DEPARTMENT		0	
33. 10	DONATIONS	A	•	ADMINISTRATIVE & GENERAL	5. 00		
33. 11	REALIZED GAIN/LOSS	B	•	NEW CAP REL COSTS-BLDG &	1. 00	11	
00. 12	METEL 225 3/11 W 2033			FIXT	1.00		00.12
33. 13	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 13

-14, 413, 801

50.00

column 6, line 200.) (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

50.00 TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A,

B. Amount Received - if cost cannot be determined.

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

⁽²⁾ Basis for adjustment (see instructions).

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

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

Provi der CCN: 15-0069

| Peri od: | Worksheet A-8-2 | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared:

						0 12/31/2019	5/21/2020 10:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	OS dill
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2.00	3. 00	4.00	5. 00	6. 00	7. 00	
1. 00	5. 00	ADMINISTRATIVE & GENERAL	449, 252	437, 250	12, 002	211, 500	26	1.00
2. 00	30.00	ADULTS & PEDIATRICS	580, 764	580, 764	0	211, 500	o	2.00
3. 00	53. 00	ANESTHESI OLOGY	2, 339, 565	2, 316, 826	22, 739	239, 400	26	3.00
4. 00	54. 00	RADI OLOGY-DI AGNOSTI C	1, 870, 544	1, 870, 544	0	271, 900	o	4.00
5. 00	55. 01	ONCOLOGY	641, 969	587, 802	54, 167	211, 500	264	5.00
6. 00	60. 00	LABORATORY	150, 000	0	150, 000	260, 300	1, 841	6.00
7. 00	69. 01	SLEEP LAB	13, 165	0	13, 165	211, 500	142	7.00
8. 00	91. 00	EMERGENCY	1, 100, 083	0	1, 100, 083	211, 500	5, 792	8.00
9. 00	95. 00	AMBULANCE SERVICES	438	0	438	211, 500	3	9.00
10.00	0. 00		0	0	0	0	o	10.00
200.00			7, 145, 780	5, 793, 186	1, 352, 594		8, 094	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Mal practi ce	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1. 00		ADMINISTRATIVE & GENERAL	2, 644	132	0	0		1. 00
2. 00		ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3. 00		ANESTHESI OLOGY	2, 993	150	0	0	0	3.00
4.00		RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	4. 00
5.00		ONCOLOGY	26, 844		0	0	0	5.00
6. 00		LABORATORY	230, 390		0	0	0	6. 00
7. 00		SLEEP LAB	14, 439		0	0	0	7. 00
8. 00		EMERGENCY	588, 946		0	0	0	8. 00
9. 00		AMBULANCE SERVICES	305		0	0	0	9. 00
10. 00	0. 00		0	0	0	0		10.00
200.00			866, 561		0	0	0	200.00
	Wkst. A Line #	3	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	14	1/ 00	47.00	10.00		
1 00	1.00	2.00	15. 00	16.00	17. 00	18. 00		1 00
1.00		ADMINISTRATIVE & GENERAL	0	2, 644	9, 358	446, 608		1.00
2.00		ADULTS & PEDIATRICS	0	2 002	10 74/	580, 764		2.00
3.00		ANESTHESI OLOGY	0	2, 993	19, 746	2, 336, 572		3.00
4. 00		RADI OLOGY-DI AGNOSTI C	0	2/ 044	07 222	1, 870, 544		4.00
5.00		ONCOLOGY	0	26, 844	27, 323	615, 125		5.00
6. 00		LABORATORY	0	230, 390	0	0		6.00
7.00		SLEEP LAB		14, 439	0 511 127	0 F11 127		7.00
8. 00		EMERGENCY		588, 946	511, 137	511, 137		8.00
9.00		AMBULANCE SERVICES		305	133	133 0		9.00
10.00	0. 00			0	0 547 407			10.00
200. 00	I	I	0	866, 561	567, 697	0, 300, 883	l l	200.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0069

					To	12/31/2019	Date/Time Pre 5/21/2020 10:	
				CAPI	TAL RELATED CO	STS	372172020 10.	OS dill
		Cost Center Description	Net Expenses	NEW BLDG &	NEW BLDG &	NEW MVBLE	EMPLOYEE	
			for Cost	FIXT	FIXT HHA/HO	EQUI P	BENEFITS	
			Allocation (from Wkst A				DEPARTMENT	
			col. 7)					
	CENER	RAL SERVICE COST CENTERS	0	1. 00	1. 01	2.00	4. 00	
1. 00		NEW CAP REL COSTS-BLDG & FLXT	13, 307, 363	13, 307, 363				1.00
1. 01		NEW CAP REL COSTS-BLDG & FLXT HHA/HO	7, 859	0	7, 859			1.01
2. 00 4. 00		NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT	0 12, 854, 622	0	o	0	12, 854, 622	2.00 4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13, 013, 517	1, 564, 688		o	1, 762, 766	5. 00
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE	3, 100, 386 405, 269	1, 478, 424 68, 536	0	0	145, 007 11, 768	7. 00 8. 00
9.00	00900	HOUSEKEEPI NG	1, 151, 504	120, 137	0	ō	183, 971	9. 00
10. 00 11. 00	1	DI ETARY CAFETERI A	708, 831 8, 631	226, 285 91, 514		0	113, 924 66, 570	
13. 00		NURSING ADMINISTRATION	434, 611	73, 283	O	ő	110, 853	
14.00		CENTRAL SERVICES & SUPPLY PHARMACY	83, 560	111, 327	0	0	20, 840	
15. 00 16. 00		MEDICAL RECORDS & LIBRARY	1, 318, 719 870, 125	82, 740 10, 500		0	177, 003 134, 256	
19. 00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	o	0	19. 00
23. 00		RADIOLOGY SCHOOL TENT ROUTINE SERVICE COST CENTERS	93, 801	23, 768	0	0	32, 634	23. 00
30.00	03000	ADULTS & PEDIATRICS	3, 764, 119	1, 431, 211	0	0	962, 988	30.00
31.00		INTENSIVE CARE UNIT	1, 076, 213	60, 194		0	274, 196	
43. 00		NURSERY LARY SERVICE COST CENTERS	512, 433	70, 298	0	U	120, 649	43.00
50.00		OPERATING ROOM	2, 535, 122	662, 927	0	0	514, 029	50.00
51. 00 52. 00		RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	283, 457 656, 263	49, 443 0	0	0	71, 406 154, 513	
53.00	05300	ANESTHESI OLOGY	-167, 752	4, 675	0	Ö	327, 171	
54. 00 54. 01		RADI OLOGY-DI AGNOSTI C ULTRA SOUND	1, 988, 975 168, 972	389, 824 0	0	0	734, 248 30, 407	
54. 01		NUCLEAR MEDICINE - DIAGNOSTIC	259, 876	17, 368		0	17, 440	
55.00		RADIOLOGY - THERAPEUTIC	0	0	0	o	0	55.00
55. 01 57. 00	1	ONCOLOGY CT SCAN	1, 669, 399 422, 255	440, 381 32, 183	0	0	237, 028 38, 933	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	268, 789	38, 835	0	ō	36, 765	58. 00
59. 00 60. 00		CARDI AC CATHETERI ZATI ON LABORATORY	0 2, 882, 778	0 224, 344	0	0	0 375, 330	59. 00 60. 00
62.00		WHOLE BLOOD & PACKED RED BLOOD CELLS	278, 419	10, 032	Ö	ő	0	62.00
65.00		RESPI RATORY THERAPY	671, 228 1, 295, 244	43, 042 445, 918	0	0	161, 356	
66. 00 67. 00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	1, 295, 244	51, 061	0	0	325, 894 49, 151	66. 00 67. 00
68. 00	06800	SPEECH PATHOLOGY	165, 805	12, 082	0	o	41, 959	
69. 00 69. 01		ELECTROCARDI OLOGY SLEEP LAB	0 218, 299	0 30, 169	0	0	0 35, 870	69. 00 69. 01
		MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 540, 075	0	Ö	Ö		71.00
		IV SOLUTIONS IMPL. DEV. CHARGED TO PATIENTS	93, 638 2, 784, 199	0		0	0	
72. 00 73. 00		DRUGS CHARGED TO PATTENTS	10, 037, 574	0	0	0	0	73.00
76.00	03140	CARDI OLOGY	643, 499	217, 440		o	114, 300	
76.97		CARDIAC REHABILITATION CTIENT SERVICE COST CENTERS	82, 901	25, 279	0	0	19, 415	76. 97
90.00	09000	CLINIC	105, 760	31, 284		0	26, 262	90.00
		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	2, 393, 039	499, 065	0	0	444, 664	91. 00 92. 00
72.00		R REIMBURSABLE COST CENTERS						72.00
		AMBULANCE SERVICES	1, 736, 379	170, 155		0	408, 002	
101.00		HOME HEALTH AGENCY AL PURPOSE COST CENTERS	985, 155	0	6, 185	U _I	230, 388	101.00
		I NTEREST EXPENSE	100 100				00 700	113.00
116. 00 118. 00		HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	183, 493 88, 091, 184	0 8, 808, 412	1, 674 7, 859	0	32, 789 8, 544, 745	
	NONRE	I MBURSABLE COST CENTERS	3070717101			٦		
		GIFT, FLOWER, COFFEE SHOP, & CANTEEN OTHER NON-REIMBURSABLE	93, 001	27, 041 0	0	0	0 23, 365	190.00
194. 01	07951	MOB	3, 123, 563	1, 892, 660		o	724, 351	194. 01
		PHYSICIAN CLINICS	6, 428, 798	992, 232		o	1, 236, 412	
		PHYS PRAC BUS OFC MOB - MAIN CAMPUS	1, 313, 228 391, 376	35, 563 0	0	ol Ol	159, 022 100, 929	
194. 05	07955	ONCOLOGY - NONREI MBURSABLE	O	0	0	ō	0	194. 05
		KDH - MC FAMILY PRACTICE KDH - MC ORTHOPEDICS	2, 901, 363 2, 526, 826	1, 551, 455 0		0	684, 494 474, 243	
. , -, 0 /	101/01	INC. MO OKTHOLEDIOS	2, 520, 620	U	١	υ	7,7,243	1.77.07

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0069	From 01/01/2019	Worksheet B Part I Date/Time Prepared:

					5/21/2020 10:	03 am
		CAPI	TAL RELATED CO	OSTS		
Cost Center Description	Net Expenses	NEW BLDG &	NEW BLDG &	NEW MVBLE	EMPLOYEE	
	for Cost	FLXT	FIXT HHA/HO	EQUI P	BENEFITS	
	Allocation				DEPARTMENT	
	(from Wkst A					
	col. 7)					
	0	1.00	1. 01	2. 00	4. 00	
194.08 07958 KDH - MC GENERAL SURGERY	1, 738, 707	0	0	0	286, 451	194. 08
194.09 07959 KDH - MC ENT	563, 051	0	0	0	136, 207	194. 09
194.10 07960 KDH - MC UROLOGY	438, 309	0	0	0	18, 655	194. 10
194.11 07961 KDH - MC OB/GYN	2, 428, 422	0	0	0	465, 748	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 through 201)	110, 037, 828	13, 307, 363	7, 859	0	12, 854, 622	202.00

Provi der CCN: 15-0069

Peri od: Worksheet B From 01/01/2019 Part I To 12/31/2019 Date/Ti me Prepared:

BUREAU SERVICE COST - SALON BETT 1,000 1					0 12/31/2019	5/21/2020 10:	
PART SERVICE COST CENTRES AA 5.00 7.00 0.00	Cost Center Description	Subtotal				HOUSEKEEPI NG	
GENERAL SERVICE DOST CENTERS 1. 00 00100 NEW CAR PRIL COSTS CENTERS 1. 00 00100 NEW CAR PRIL COS		ΛΔ				9 00	
1.00	GENERAL SERVICE COST CENTERS	44	3.00	7.00	8.00	7.00	
2.00 00000 MENUYER PERIOR TS DIGHTMENT 5.00 00000 MENUSER PERIOR TS DIGHTMENT 5.00 000000 MENUSER PERIOR TS DIGHTMENT 5.00 00000 00000 00000 00000 00000 00000 00000 000000							1.00
4. 00 DOSOD DEPLOYEE DEEPENT IS DEPARTMENT 7. 00 DOSOD OFF WITH STRATIF C. SCHERAL 7. 00 DOSO OFF WITH STRATIF C. SCHERAL 7. 00 DOSO OFF WITH STRATIF C. 7.							1. 01
5.00 DOSCO ARMIN ISTRATION A CEMINAL 16,340,971 16,340,971 18,340,971 1	2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
1.00 00000 00000 00000 00000 00000 00000 000000	4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						
B. DO DOUGN LAURIERY S. LINEN STEWLEC 488, 573 84, 688 36, 596 0 0 0 1,773, 627 0 0 0 0 0 0 0 0 0	5. 00 00500 ADMINISTRATIVE & GENERAL	16, 340, 971	16, 340, 971				5.00
0.000 0.000		4, 723, 817					
10.00 01000 DETARY 1.049, PAID 189, 986 120, 826 0 0 10.00	· · · · · · · · · · · · · · · · · · ·		l '		606, 853		
11.00 01100 CAFFERR A 166, 715 29, 076 48, 864 0 0 11.00 13.			l '		- 1		
0.300 MIRSING ABM NISTRATION					0		
14.00 01400 CENTRAL SERVICES & SUPPLY 215, 727 37, 623 59, 443 0 16, 694 14, 00 13.00 15	1		l '		0		
15.00 01500 PHARMACY 1.578. A62 275. Zep			i '		0	-	
16.00 01400 MEDICAL RECORDS & LIBRARY 1,014,881 176,998 5,000 0 0 10,00 10,			i '		0	· ·	
19.00 1900 1900 1900 1900 1900 20 19.00 20 19.00 20.19 19.00 20.19			l '		0		
23.00		1,014,881	170, 998		0		
IMPATI ENT ROUTI NE SERVICE COST CENTERS 6.158, 318 1.074, 029 7.64, 198 198, 767 863, 440 30.00 31.00 03100 INTERSI VE CARE UNIT 1.410, 603 246, 013 32, 141 0 48, 605 31.00 31.00 31.00 03100 INTERSI VE CARE UNIT 7.073, 380 122, 672 37, 536 12, 784 8.674 43.00 35.00 035.		150 203	26 106	_ ~	0		
30.00		150, 203	20, 170	12,091	U	3, 540	23.00
31.00 03100 MITERIST VE CARE UNIT		6 158 318	1 074 029	764 198	198 767	863 440	30 00
43.00 04300 NURSERY 703, 380 12, 672 37, 536 12, 784 8, 074 47, 00						,	
MICLILARY SERVICE COST CENTERS 5.0. 00 SOSOO GPEATINE ROOM 5.1. 00 05100 GPEATINE ROOM 5.1. 00 05100 GPEATINE ROOM 5.1. 00 05100 GPEATINE ROOM 5.2. 00 05200 GPEATINE ROOM 5.3. 00 05300					12, 784	· ·	
15.00 05500 RECOVERY ROOM & LABOR ROOM 1810, 776 1414, 402 0 15, 373 36, 386 52, 00 05200 DELIVERY ROOM & LABOR ROOM 1810, 776 1414, 402 0 16, 373 36, 386 52, 00 05300 ANESTRESI CLOGY 164, 094 28, 618 2, 496 0 0 4, 536 15, 025 54, 01 03630 ULTRA SOUND 199, 379 34, 772 0 4, 536 15, 025 54, 01 03630 ULTRA SOUND 199, 379 34, 772 0 4, 536 15, 025 54, 01 03630 ULTRA SOUND 199, 379 34, 772 0 4, 536 15, 025 54, 01 03630 ULTRA SOUND 160, 00 0 0 0 0 0 0 0 0		<u> </u>				·	
52.00 05200 DELIVERY ROOM & LABOR ROOM	50. 00 05000 OPERATING ROOM	3, 712, 078	647, 398	353, 971	95, 992	92, 032	50.00
153.00 05300 ANESTHESIOLOGY 104,094 28,618 2,496 0 0 53.00 54.00 05400 RADIOLOGY-10 JAGNOSTIC 3,113,047 542,925 298,147 41,262 57,710 54.00 54.01 30330 ULTRA SOUND 199,379 34,772 0,44,536 15,025 54.01 54.02 34560 NUCLEAR MEDI CINE - DI AGNOSTIC 294,684 51,394 9,274 2,642 4,164 54.02 55.00 05500 RADIOLOGY - THERAPEUTIC 0 0 0 0 0 0 0 0 0	51.00 05100 RECOVERY ROOM	404, 306	70, 512	26, 400	13, 863	0	51.00
54.00 064000 RADIOLOGY-DI AGNOSTIC 3, 113, 047 542, 295 208, 147 41, 262 57, 710 54, 05 54, 01 03450 ULTRA SOUND 199, 379 34, 772 0	52.00 05200 DELIVERY ROOM & LABOR ROOM	810, 776	141, 402	0	16, 373	36, 386	52.00
199, 379 34, 772 0 4, 526 15, 025 54, 01 54, 02 03500 MULCEAR MEDICINE - DIAGNOSTIC 294, 684 51, 794 9, 274 2, 642 41, 644 54, 02 55, 00 05500 RADI LOGY - THERAPEUTIC 0 0 0 0 0 55, 00 05500 RADI LOGY - THERAPEUTIC 2, 346, 808 409, 290 225, 142 22, 201 111, 279 55, 01 03500 00500 MAINTER CRESONANCE HMAGINS (MRI) 344, 389 60, 662 20, 736 4, 391 5, 717 55, 00 05500 LARGRATORY 1, 184 20, 254 6, 119 57, 00 69, 00 05900 LARGRATORY 1, 184 20, 254 6, 119 57, 00 69, 00 05900 LARGRATORY 1, 184 20, 254 6, 119 57, 00 69, 00 05900 LARGRATORY 1, 184 20, 254 6, 119 57, 00 69, 00 05900 LARGRATORY 1, 184 20, 254 6, 119 57, 00 6, 00 60, 00 05900 LARGRATORY 1, 184 20, 254 6, 119 57, 00 6, 00 60, 00 05900 LARGRATORY 3, 482, 452 60, 7550 119, 789 0 59, 737 60, 00 62, 00 06200 MROLELE BLOOD & PACKED RED BLOOD CELLS 288, 451 50, 307 5, 357 0 0 62, 00 65, 00 65, 00 6500 06500 MROLELE BLOOD & PACKED RED BLOOD CELLS 288, 451 50, 307 5, 357 0 0 65, 00 65, 00 6600 06500 SPEICRATORY 2, 264, 20 0 0 65, 00 6600 06500 SPEICRATORY 2, 264, 20 0 0 0 0 0 0 0 0 0	53. 00 05300 ANESTHESI OLOGY	164, 094	28, 618	2, 496	0	0	53.00
54 02 03450 NUCLEAR MEDICINE - DI AGNOSTIC 294, 684 51, 394 9, 274 0, 642 4, 164 54, 02 0 0 0 0 0 0 55, 00 55, 00 03480 ONCOLORY 2, 346, 808 409, 290 225, 142 22, 201 110, 279 55, 01 57, 00 570, 00 57							
55.00 OSSOO RADIOLOGY - THERAPEUTIC 0 0 0 0 0 0 55.0 1 OSSOO CASON							
10,000 1			1		2, 642	· ·	
57.00 OSTOOL CT SCAN 493, 371 86, 045 17, 184 20, 254 6, 119 57, 00 59.00 OSGOOL MARCHETIC RESONANCE IMAGI ING (MRI) 344, 389 60, 062 20, 736 4, 391 5, 177 58, 00 59.00 OSGOOL (ABORATORY 34, 2452 607, 350 119, 789 0 5, 737 60, 00 60, 00 600, 00		_	Ĭ		0		
SB. 00 OSBOO MAGNETIC RESONANCE IMAGING (MRI) 344, 389 60, 062 20, 736 4, 391 5, 177 88, 00							
99.00 05900 CARDIA C CATHETERIZATION 0 0 0 0 59.00			l '				
60.0 0.0000 0.0000 LABORATORY 0.0 0.	` '		60, 062		4, 391	•	
62.00 06200 MOLDE BLOOD & PACKED RED BLOOD CELLS 288, 451 50, 307 5, 357 0 0 0 62 00 66.00 06600 06600 06600 0700 0700 0700 066 00 06600 0700	· · · · · · · · · · · · · · · · · · ·	_	407.250		0		
65.00 06500 RESPIRATORY THERAPY 2,067,066 152,712 22,982 0 0 05.00 06.50 06.00	· · · · · · · · · · · · · · · · · · ·		l '		0		
66.00 06600 PHYSI CAL THERAPY 2,067,056 360,501 238,099 21,893 24,488 66.00 67.00 06700 0CCUPATIONAL THERAPY 296,992 51,796 27,244 0 0 0 0 0 0 0 68.00 68.00 06800 SPECH PATHOLOGY 219,846 38,342 6,451 0 0 0 0 0 0 0 0 0			l '		0		
67. 00 06700 0CCUPATIONAL THERAPY 296, 992 51,796 27,264 0 0 67,00 68. 00 06800 SPECH PATHOLOGY 219, 846 38, 342 6,451 0 0 68,00 69. 01 03610 ELECTROCARDIOLOGY 219, 846 38, 342 6,451 0 0 0 69,00 69. 01 03610 ELECTROCARDIOLOGY 219, 846 38, 342 6,451 0 0 0 0 0 69. 01 03610 ELECTROCARDIOLOGY 219, 846 38, 342 6,451 0 0 0 0 0 69. 01 03610 ELECTROCARDIOLOGY 219, 846 38, 342 6,451 0 0 0 0 69. 01 03610 ELECTROCARDIOLOGY 28,400 71, 00 71. 01 07101 IV SOLUTIONS 93, 638 16, 331 0 0 0 71, 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 2,784, 199 485, 573 0 0 0 0 72, 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 10, 337, 574 1,750, 541 0 0 0 0 7, 200 74. 00 07300 DRUGS CHARGED TO PATIENTS 10, 337, 574 1, 750, 541 0 0 0 0 7, 200 76. 07 07697 CARDIAC REHABILITATION 127, 595 22, 253 13, 498 0 0 7, 60 76. 07 07697 CARDIAC REHABILITATION 127, 595 22, 253 13, 498 0 0 7, 60 79. 00 09000 CLINIC 163, 306 28, 481 16, 704 0 0 7, 060 79. 00 09000 CLINIC 163, 306 28, 481 16, 704 0 0 7, 060 79. 00 09000 CLINIC 163, 306 28, 481 16, 704 0 0 7, 060 79. 00 09000 CLINIC 17, 706 17, 706 17, 706 17, 706 79. 00 09000 08ERCENCY 3, 336, 768 581, 942 266, 477 109, 080 128, 200 91, 00 79. 00 07000 08ERCENCY 1, 221, 728 213, 073 52, 762 0 0 101, 00 79. 00 07000 08ERCENCY 1, 221, 728 213, 073 52, 762 0 0 101, 00 79. 00 07000 070			i '		21 803		
68.00 06800 SPEECH PATHOLOGY 219, 846 38, 342 6, 451 0 0 68, 00 69, 00 6900 ELECTRICARDI OLOGY 0 0 0 0 0 0 69, 00 69, 00 06000 ELECTRICARDI OLOGY 0 0 0 0 0 0 0 0 0			l '		21, 073	· ·	
69.00 06900 Color Colo			l '		0		
69.01 03610 SLEEP LAB 284, 338 49, 589 16, 109 1, 522 23, 750 69, 01 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2, 540, 075 442, 997 0		217,010	00,012	0, 101	0		
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 2,540,075 442,97 0 0 0 0 71. 00 71. 01 70. 01 170.		284. 338	49. 589	16, 109	1, 522	-	
71.0 07101 1V SOLUTIONS		2, 540, 075	442, 997		0		
73.00 07300 DRUGS CHARGED TO PATIENTS 10, 037, 574 1, 750, 541 0 0 0 73.00 76.00 76.00 03140 CARDI OLOGY 975, 239 170, 085 116, 102 24, 894 7, 277 76.00 76.97					0	0	71. 01
76. 07 03140 CARDI OLOGY 975, 239 170, 085 116, 102 24, 894 7, 277 76, 00 76, 97 CARDI AC REHABILITATION 127, 595 22, 253 13, 498 0 0 7, 060 97, 060 99, 00 09000 CLI NI C 163, 306 28, 481 16, 704 0 7, 060 99, 00 99, 00 09000 CLI NI C 3, 336, 768 581, 942 266, 477 109, 080 128, 200 91, 00 92, 00 09500 ABBURSABLE COST CENTERS	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 784, 199	485, 573	0	0	0	72.00
76. 97 O7697 CARDI AC REHABILITATION		10, 037, 574	1, 750, 541	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS 163,306 28,481 16,704 0 7,060 90.00		975, 239	170, 085	116, 102	24, 894	7, 277	76. 00
90. 00		127, 595	22, 253	13, 498	0	0	76. 97
91. 00 09100 EMERGENCY 3, 336, 768 581, 942 266, 477 109, 080 128, 200 91. 00 92. 00 095ERVATION BEDS (NON-DISTINCT PART) 0 92. 00 075ER REI MBURSABLE COST CENTERS 2, 314, 536 403, 662 90, 854 7, 704 0 95. 00 101. 00 10100 HOME HEALTH AGENCY 1, 221, 728 213, 073 52, 762 0 0 101. 00 101. 00 1000 HOME HEALTH AGENCY 1, 221, 728 213, 073 52, 762 0 0 101. 00 101.							
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0							
OTHER REIMBURSABLE COST CENTERS 2, 314, 536 403, 662 90, 854 7, 704 0 95. 00 101. 00 10100 HOME HEALTH AGENCY 1, 221, 728 213, 073 52, 762 0 0 101. 00				266, 477	109, 080	128, 200	
95. 00		0					92.00
101.00 10100 HOME HEALTH AGENCY 1, 221, 728 213, 073 52, 762 0 0 101.00 SPECIAL PURPOSE COST CENTERS		2 214 524	402 ((2	00.054	7 704	0	05 00
113. 00 11300 NTEREST EXPENSE 217, 956 38, 012 14, 285 0 0 116.00 116.00 105PI CE 217, 956 38, 012 14, 285 0 0 116.00 11							
113.00 113.00 113.00 114.00 115.00 116.00 11		1, 221, 720	213,073	52, 702	U	0	101.00
116. 00							113 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 79, 282, 356 10, 977, 124 3, 145, 439 598, 158 1, 551, 218 118. 00		217 956	38 012	14 285	0	0	
NONRE MBURSABLE COST CENTERS 190.00 1900 197.00 1900							
190. 00 190. 0		7.77.2027.000	10/7/7/121	57 1 107 107	0707.00	1,001,210	
194. 00 07950 OTHER NON-REI MBURSABLE 116, 366 20, 295 0 0 194. 00 194. 01 194. 01 194. 02 194. 02 197951 194. 02 194. 03 194. 03 194. 03 194. 04 194. 05 194. 05 194. 05 194. 06 194. 07 194. 06 194. 07 194. 07 194. 08 194. 07 194. 08 194. 07 194. 08 194. 08 194. 08 194. 08 194. 09 194. 08 194. 09 194. 09 194. 09 194. 09 194. 09 194. 08 194. 01 194.		27, 041	4, 716	14, 438	0	0	190. 00
194. 02 07952 PHYSI CI AN CLI NI CS						0	194. 00
194. 02 07952 PHYSI CI AN CLI NI CS 8, 657, 442 1, 509, 884 529, 805 2, 407 0 194. 02 194. 03 07953 PHYS PRAC BUS OFC 1, 507, 813 262, 967 18, 989 0 0 194. 03 194. 04 07954 MOB - MAI N CAMPUS 492, 305 85, 859 0 0 222, 404 194. 04 194. 05 07955 ONCOLOGY - NONREI MBURSABLE 0 0 0 0 0 194. 05 194. 07 07957 KDH - MC FAMI LY PRACTI CE 5, 137, 312 895, 963 828, 403 25 0 194. 06 194. 08 07958 KDH - MC ORTHOPEDI CS 3, 001, 069 523, 395 0 534 0 194. 07 194. 08 07958 KDH - MC GENERAL SURGERY 2, 025, 158 353, 194 0 2, 029 0 194. 08 194. 10 07960 KDH - MC UROLOGY 456, 964 79, 696 0 0 0 194. 10 194. 11 07961 KDH - MC OB/GYN 2, 894, 170 504, 752 0 2, 639 0 194. 11	194. 01 07951 MOB	5, 740, 574	1, 001, 173	1, 010, 591	1, 061	0	194. 01
194. 04 07954 MOB - MAIN CAMPUS 492, 305 85, 859 0 0 222, 404 194. 04 194. 05 07955 ONCOLOGY - NONREI MBURSABLE 0 0 0 0 0 194. 05 194. 06 07956 KDH - MC FAMI LY PRACTI CE 5, 137, 312 895, 963 828, 403 25 0 194. 06 194. 08 07957 KDH - MC ORTHOPEDI CS 3, 001, 069 523, 395 0 534 0 194. 07 194. 09 07958 KDH - MC GENERAL SURGERY 2, 025, 158 353, 194 0 2, 029 0 194. 08 194. 09 07959 KDH - MC ENT 699, 258 121, 953 0 0 0 194. 09 194. 10 07960 KDH - MC UROLOGY 456, 964 79, 696 0 0 0 0 194. 10 194. 11 07961 KDH - MC OB/GYN 2, 894, 170 504, 752 0 2, 639 0 194. 11	194. 02 07952 PHYSICIAN CLINICS	8, 657, 442	1, 509, 884		2, 407	0	194. 02
194. 05 07955 ONCOLOGY - NONREI MBURSABLE					o		
194. 06 07956 KDH - MC FAMI LY PRACTI CE 5, 137, 312 895, 963 828, 403 25 0 194. 06 194. 07 194. 08 194. 08 194. 09 194. 09 194. 09 194. 10 194. 10 194. 11 19796 KDH - MC UROLOGY 194. 11 19796 KDH - MC OB/GYN 2, 894, 170 194. 11 19796 KDH - MC OB/GYN 2, 894, 170 194. 11 19796 KDH - MC OB/GYN 2, 894, 170 194. 12 194. 13 194. 14 194. 15 194. 15 194. 15 194. 16 194. 16 194. 16 194. 16 194. 16 194. 16 194. 17 194. 17 194. 18			l		0		
194. 07 07957 KDH - MC ORTHOPEDI CS 3,001,069 523,395 0 534 0 194.07 194. 08 07958 KDH - MC GENERAL SURGERY 2,025,158 353,194 0 2,029 0 194.08 194. 09 07959 KDH - MC ENT 699,258 121,953 0 0 0 194.09 194. 10 07960 KDH - MC UROLOGY 456,964 79,696 0 0 0 194.10 194. 11 07961 KDH - MC OB/GYN 2,894,170 504,752 0 2,639 0 194.11		_			0		
194. 08 07958 KDH - MC GENERAL SURGERY 2, 025, 158 353, 194 0 2, 029 0 194. 08 194. 09 07959 KDH - MC ENT 699, 258 121, 953 0 0 0 194. 09 194. 10 07960 KDH - MC UROLOGY 456, 964 79, 696 0 0 0 194. 10 194. 11 07961 KDH - MC 0B/GYN 2, 894, 170 504, 752 0 2, 639 0 194. 11							
194. 09 07959 KDH - MC ENT 699, 258 121, 953 0 0 0 194. 09 194. 10 07960 KDH - MC UROLOGY 456, 964 79, 696 0 0 0 194. 10 194. 11 07961 KDH - MC OB/GYN 2, 894, 170 504, 752 0 2, 639 0 194. 11							
194. 10 07960 KDH - MC UROLOGY 456, 964 79, 696 0 0 194. 10 194. 11 07961 KDH - MC 0B/GYN 2, 894, 170 504, 752 0 2, 639 0 194. 11					2, 029		
194. 11 07961 KDH - MC 0B/GYN 2, 894, 170 504, 752 0 2, 639 0 194. 11					0		
					0 (22		
200.00				0	2, 639	0	
	200. 00 CLOSS LOUT AUJUSTINETITS	1 0	<u> </u>	l			200.00

Health Financial Systems	KING'S DAUGHTER	RS' HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co	CN: 15-0069	Peri od:	Worksheet B	
				From 01/01/2019		
				To 12/31/2019	Date/Time Pre	pared:
					5/21/2020 10:	03 am_
Cost Center Description	Subtotal	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		E & GENERAL	PLANT	LINEN SERVICE		

0 110, 037, 828 5.00

0 16, 340, 971 7.00

0 5, 547, 665 8. 00

0 606, 853 9. 00

0 201. 00 1, 773, 622 202. 00

201. 00 202. 00 Negative Cost Centers TOTAL (sum lines 118 through 201)

Provider CCN: 15-0069

Peri od: Worksheet B From 01/01/2019 Part I To 12/31/2019 Date/Ti me Prepared:

				12/31/2019	5/21/2020 10:	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI O N	SERVI CES & SUPPLY		
	10.00	11. 00	13.00	14. 00	15. 00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 01 00101 NEW CAP REL COSTS-BLDG & FLXT HHA/HO						1.01
2.00 O0200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5.00
7. 00 00700 OPERATION OF PLANT						7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE						8.00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY	1, 352, 822					10.00
11. 00 01100 CAFETERI A	0	244, 655				11.00
13.00 01300 NURSING ADMINISTRATION	0	0	765, 788			13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	1, 733	0	331, 180		14.00
15. 00 01500 PHARMACY	0	6, 242	0	1, 770	1, 939, 395	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	7, 604	0	345	0	16.00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS	0	1 250	0	0	0	19.00
23. 00 02300 RADI OLOGY SCHOOL I NPATI ENT ROUTI NE SERVI CE COST CENTERS	U	1, 350	<u> </u>	43	0	23. 00
30. 00 03000 ADULTS & PEDIATRICS	1, 259, 496	45, 385	308, 766	7, 435	0	30.00
31. 00 03100 NTENSI VE CARE UNI T	93, 326	9, 224	62, 755	16	0	31.00
43. 00 04300 NURSERY	0	4, 752	32, 331	0	0	43.00
ANCILLARY SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·		, , , , , , ,	- 1		
50. 00 05000 OPERATING ROOM	0	24, 014	163, 383	8, 648	0	50.00
51.00 05100 RECOVERY ROOM	O	2, 551	17, 355	141	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	6, 086	41, 406	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	2, 075	0	589	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	18, 412	0	3, 203	0	54.00
54. 01 03630 ULTRA SOUND	0	1, 034	0	1, 344	0	54.01
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 55. 00 05500 RADIOLOGY - THERAPEUTIC	0	694	0	96	0	54. 02 55. 00
55. 00 03300 RADIOLOGY - THERAPEUTIC	0	9, 057	0	2, 125	0	55. 00
57. 00 05700 CT SCAN	0	1, 753	0	6, 202	0	57. 00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1, 330	0	828	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	Ö	0	Ö	0	0	59.00
60. 00 06000 LABORATORY	O	24, 002	0	1, 803	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0	7, 257	0	192	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	14, 147	0	373	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	1, 488	0	13	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	1, 343	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
69. 01 03610 SLEEP LAB	0	1, 161	0	120 010	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.01 07101 IV SOLUTIONS	0	0	0	129, 818 4, 786	0	71. 00 71. 01
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	142, 295	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	Ö	0	l ö	1, 817	1, 939, 395	73.00
76. 00 03140 CARDI OLOGY	o	5, 520		214	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	O	1, 021	0	20	0	76. 97
OUTPATIENT SERVICE COST CENTERS		·		,		
90. 00 09000 CLINIC	0	897	0	9	0	90.00
91. 00 09100 EMERGENCY	0	20, 547	139, 792	2, 167	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS	ما	00.07/		200		05.00
95.00 09500 AMBULANCE SERVI CES 101.00 10100 HOME HEALTH AGENCY	0	23, 976	0	328	0	95. 00 101. 00
SPECIAL PURPOSE COST CENTERS	U	0	l o	1, 472	0	101.00
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 352, 822	244, 655	765, 788	318, 095	1, 939, 395	
NONREI MBURSABLE COST CENTERS	, , . ,				, , , , , , , , , , , , , , , , , , , ,	
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190. 00
194.00 07950 OTHER NON-REIMBURSABLE	0	0	0	58	0	194. 00
194. 01 07951 MOB	0	0	0	1, 213		194. 01
194. 02 07952 PHYSI CI AN CLI NI CS	0	0	0	3, 909		194. 02
194. 03 07953 PHYS PRAC BUS OFC	0	0	0	411		194. 03
194. 04 07954 MOB - MAIN CAMPUS	0	0	0	443		194.04
194. 05 07955 ONCOLOGY - NONREI MBURSABLE	0	0	0	0		194.05
194.06 07956 KDH - MC FAMILY PRACTICE	0	0	0	1, 263		194.06
194. 07 07957 KDH - MC ORTHOPEDI CS 194. 08 07958 KDH - MC GENERAL SURGERY	0	0	0	1, 784 1, 465		194. 07 194. 08
194.08 07958 KDH - MC GENERAL SURGERY 194.09 07959 KDH - MC ENT	0	0	0	395		194. 08
194. 10 07960 KDH - MC UROLOGY	0	0		897		194. 09
194. 11 07961 KDH - MC OB/GYN	0	0		1, 247		194. 10
	91		. 9	., = ., [<u> </u>

Health Financial Systems	KING'S DAUGHTER	RS' HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der (Peri od:	Worksheet B	
				From 01/01/2019	Part I	
				To 12/31/2019	Date/Time Pre	pared:
					5/21/2020 10:	03 am
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI (SERVICES &		
			N	SUPPLY		
	10.00	11. 00	13. 00	14. 00	15. 00	

0 1, 352, 822 0 765, 788

244, 655

0 331, 180 200. 00 0 201. 00 1, 939, 395 202. 00

200. 00 201. 00 202. 00 Cross Foot Adjustments Negative Cost Centers TOTAL (sum lines 118 through 201) Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0069 Peri od: Worksheet B From 01/01/2019 Part I To 12/31/2019 Date/Time Prepared:

				1	J 12/31/201 9	Date/lime Pre 5/21/2020 10:	
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	NONPHYSI CI AN ANESTHETI STS	RADI OLOGY SCHOOL	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		16. 00	19. 00	23. 00	24. 00	25. 00	
1. 00 1. 01 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 13. 00 14. 00 15. 00 16. 00 19. 00 23. 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01900 NONPHYSICIAN ANESTHETISTS 02300 RADIOLOGY SCHOOL INPATIENT ROUTINE SERVICE COST CENTERS	1, 205, 434 0 0	0	194, 031			1. 00 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 19. 00 23. 00
30.00	03000 ADULTS & PEDIATRICS	37, 845	0	0	10, 717, 679	0	30.00
31.00	03100 NTENSI VE CARE UNI T	12, 958	0		1, 915, 731	0	
43.00	04300 NURSERY	6, 207	0	0	927, 736	0	43. 00
F0 00	ANCILLARY SERVICE COST CENTERS	107,000	0		F 204 22F	0	F0 00
72. 00 73. 00 76. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY 05400 RADIOLOGY-DIAGNOSTIC 03630 ULTRA SOUND 03450 NUCLEAR MEDICINE - DIAGNOSTIC 05500 RADIOLOGY - THERAPEUTIC 03480 ONCOLOGY 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06600 PHYSICAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 03610 SLEEP LAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07101 IV SOLUTIONS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03140 CARDIOLOGY 07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	106, 809 19, 199 7, 749 22, 257 28, 551 7, 881 23, 690 0 27, 877 67, 433 16, 986 0 132, 586 8, 266 29, 592 38, 265 4, 825 3, 584 0 7, 378 37, 216 5, 255 50, 500 317, 444 48, 753 2, 889	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 194, 031 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5, 204, 325 554, 327 1, 060, 178 220, 129 4, 207, 288 263, 971 386, 638 0 3, 162, 779 698, 361 453, 899 0 4, 427, 719 352, 381 1, 088, 361 2, 764, 772 382, 378 269, 566 0 383, 850 3, 150, 106 120, 010 3, 462, 567 14, 046, 771 1, 348, 084 167, 276	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	51. 00 52. 00 53. 00 54. 00 54. 01 54. 02 55. 01 57. 00 58. 00 69. 00 66. 00 67. 00 68. 00 69. 01 71. 00 71. 01 72. 00 73. 00 76. 00
91.00	09000 CLI NI C 09100 EMERGENCY	542 109, 548	0		216, 999 4, 694, 521	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS					0	92.00
	09500 AMBULANCE SERVICES 10100 HOME HEALTH AGENCY	23, 349 0	0				95. 00 101. 00
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113.00
	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	0 1, 205, 434	0	0 194, 031	270, 253 71, 272, 099	0	116. 00 118. 00
194. 00 194. 01 194. 02 194. 03 194. 04 194. 05 194. 06 194. 08	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 07950 OTHER NON-REI MBURSABLE 07951 MOB 07952 PHYSICIAN CLINICS 07954 MOB - MAIN CAMPUS 07955 ONCOLOGY - NONREI MBURSABLE 07956 KDH - MC FAMILY PRACTICE 07957 KDH - MC ORTHOPEDICS 07958 KDH - MC GENERAL SURGERY 07959 KDH - MC ENT	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	46, 195 136, 719 7, 754, 612 10, 703, 447 1, 790, 180 801, 011 0 6, 862, 966 3, 526, 782 2, 381, 846 821, 606	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. 09

Health Financial Systems	KING'S DAUGHTE	RS' HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C	CN: 15-0069	Peri od:	Worksheet B	
				From 01/01/2019		
				To 12/31/2019		
					5/21/2020 10:	U3 am
Cost Center Description	MEDI CAL	NONPHYSI CI AN	RADI OLOGY	Subtotal	Intern &	
	RECORDS &	ANESTHETI STS	SCH00L		Resi dents	
	LI BRARY				Cost & Post	
					Stepdown	
					Adjustments	
	16. 00	19. 00	23. 00	24. 00	25.00	
194.10 07960 KDH - MC UROLOGY	0	0		0 537, 557	0	194. 10
194.11 07961 KDH - MC OB/GYN	0	0		0 3, 402, 808	0	194. 11
200.00 Cross Foot Adjustments		0		0 0	0	200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	1, 205, 434	0	194, 03	110, 037, 828	0	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS KING'S DAUGHTERS' HOSPITAL In Lieu of Form CMS-2552-10

Peri od: Worksheet B From 01/01/2019 Part I To 12/31/2019 Date/Ti me Prepared: 5/21/2020 10:03 am Provider CCN: 15-0069

Service Description Total 26.00	1. 00 1. 01 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 14. 00 15. 00
GENERAL SERVICE COST - ENTRES	1. 01 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00
1.00 00100 NEW CAP PEL COSTS-BLDG & F1XT HHA/HO 2.00 00200 NEW CAP PEL COSTS-BLDG & F1XT HHA/HO 2.00 00200 NEW CAP PEL COSTS-MYBLE FOULP 1.00 00100 MEDICYSE BENEFIT S DEPARTMENT 5.00 00500 ADMIN ISTRATI VE & GENERAL 00500 ADMIN ISTRATI VE & GENERAL 00600 ADMIN STRATI VE & GENERAL 00600 OHOLYSEE BEING 006000 OHOLYSEE BEING 00600 00600 00600 OHOLYSEE BEING 00600 0060	1. 01 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00
1. 01 00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO 00400 NEW CAP REL COSTS-MUSE EQUIP 00400 NEW CAP REL COSTS-MUSE EQUIP 00400 NEW CAP REL COSTS-MUSE EQUIP 00400 00400 NEW CAP REL COSTS-MUSE 00400 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
2.00	2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00
4. 00. 00400 EMPLOYCE BENEFITS DEPARTMENT 0. 00800 ADMIN ISTRATI VE & GENERAL 0. 00800 ADMIN ISTRATI VE & GENERAL 0. 00800 LAUNDRY & LINEN SERVICE 0. 00900 HOUSEKEEPI NG 0. 00900 HURSI NG ADMINISTRATION 0. 00900 HOUSEKEEPI NG 0. 00900	4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00
7. 00 00700 00FBATI ON OF PLANT 8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DUSEKEEPI NG 11. 00 01100 CAFETERI ADMINISTRATI ON 13. 00 01300 OURSI NG ADMINISTRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY 19. 00 01900 NONPHYSI CI AN ANESTHETI STS 23. 00 02300 RADI DLOGY OS CHOOL INPATI ENT ROUTH NE SERVI CE COST CENTERS 23. 00 02300 ADULTS & PEDI ATRICS 24. 00 04300 AULTS & SPETI ATRICS 25. 00 04300 NURSERY 26. 00 04300 NURSERY 27. 736 ARCI LLARY SERVICE COST CENTERS 27. 736 27. 736 27. 736 27. 736 27. 736 27. 736 27. 737 27. 736 27. 737 27. 738 27. 738 27. 739 27. 739 27. 730	7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00
8. 00 OGBOO LAUNDRY & LINEN SERVICE	8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00
9. 00 00900 HOUSEKEEPING 10. 00 10. 00 10. 00 10. 00 11. 0	9. 00 10. 00 11. 00 13. 00 14. 00 15. 00
10.00 01000 015TARY	10.00 11.00 13.00 14.00 15.00
111.00 01100 CAETERIA 13.00 1300 NURSIN RAM AMIN STRATION 14.00 1400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDICAL RECORDS & LIBRARY 19.00 01900 NORPHYSICIAN AMESTHETISTS 23.00 20300 RADIOLOGY SCHOOL INPATIENT ROUTINE SERVICE COST CENTERS 10,717,679 31.00 03100 INTENSI VE CARE UNIT 1,915,731 43.00 43300 NURSERY 927,736 AMCILLARY SERVICE COST CENTERS 10,717,679 13.00 03100 INTENSI VE CARE UNIT 1,915,731 43.00 43300 NURSERY 927,736 AMCILLARY SERVICE COST CENTERS 10,717,679 10,717,769 10,717,779 10,717,779 10,717,779 10,717,779 10,717,779 10,717,779 10,717,	11. 00 13. 00 14. 00 15. 00
13. 00	13. 00 14. 00 15. 00
14. 00	14. 00 15. 00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY 19. 00 01900 MONPHYSI CI AN ANESTHETI STS 23. 00 02300 RADI OLOGY SCHOOL INPATI ENT ROUTI NE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRICS 31. 00 03100 INTENSI VE CARE UNIT 31. 00 03100 INTENSI VE CARE UNIT 31. 00 03100 INTENSI VE CARE UNIT 32. 00 04300 INDRSERY ANCI LLARY SERVICE COST SOCO 05000 OPERATI NO ROOM 55. 204, 325 51. 00 05100 RECOVERY ROOM 55. 4, 327 52. 00 05200 DELI VERY ROOM 554, 327 53. 00 05300 ANESTHESI OLOGY 220, 129 54. 00 05400 RADI OLOGY-DI AGNOSTI C 4, 207, 288 54. 01 03450 NUCLEAR MEDI CI NE - DI AGNOSTI C 386, 638 55. 00 05500 RADI OLOGY - THERAPEUTI C 0 05500 RADI OLOGY - THERAPEUTI C 0 05700 (T SCAN 55. 01 03480 ONCOLOGY 57. 00 05700 (T SCAN 58. 00 05800 MARETI C RESONANCE I MAGI NG (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY 60. 00 06000 PRIST LA THERAPY 60. 00 06000 PRIST LA THERAPY 61. 00 06700 OCCUPATI ONAL THERAPY 62. 00 06900 CARDI AC LATHETERI ZATI ON 63. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 64. 00 06600 PHYSI CAL THERAPY 65. 00 06600 PHYSI CAL THERAPY 66. 00 06600 PHYSI CAL THERAPY 76. 00 06700 OCCUPATI ONAL THERAPY 76. 00 06700 OCCUPATI ONAL THERAPY 76. 00 06700 OCCUPATI ONAL THERAPY 77. 00 0700 MEDI CAL THERAPY 78. 00 0700 OCCUPATI ONAL THERAPY 79. 00 0700 OCCUPATI ONAL THERAPY 70. 00 0700 OCCUPATI ONAL THERAPY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 71. 00 07101 IV SOLUTI ONS 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 71. 00 07300 DRUGS CHARG	15.00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS 23. 00 02300 RADI OLOGY SCHOOL	16 00
23. 00 02300 RADI OLOGY SCHOOL INPATI ENT ROUTI NE SERVI CE COST CENTERS 10, 717, 679 31. 00 03000 ADULTS & PEDI ATRI CS 1, 915, 731 43. 00 03000 ADULTS & PEDI ATRI CS 1, 915, 731 43. 00 03000 NURSERY 927, 736 43. 00 03000 NURSERY 928, 736 43. 00 03000 NURSERY 928, 736 43. 00 03000 ADULTAR SOUND 554, 327 929, 736 92	10.00
INPAT_IENT_ROUTINE_SERVICE_COST_CENTERS 10,717,679	19.00
30. 00	23.00
31.00 03100 INTENSIVE CARE UNIT 1, 915, 731 927, 736	20.00
43. 00	30.00
ANCILLARY SERVICE COST CENTERS	43.00
50. 00 05000 OPERATI NG ROOM 5, 204, 325 51. 00 05100 RECOVERY ROOM 554, 327 52. 00 05200 DELI VERY ROOM & LABOR ROOM 1, 060, 178 53. 00 05300 ANESTHESI OLOGY 220, 129 54. 00 05400 RADI OLOGY-DI AGNOSTI C 4, 207, 288 54. 01 03630 ULTRA SOUND 263, 971 54. 02 03450 NUCLEAR MEDI CI NE - DI AGNOSTI C 386, 638 55. 00 05500 RADI OLOGY - THERAPEUTI C 0 55. 01 03480 ONCOLOGY 3, 162, 779 57. 00 05700 CT SCAN 698, 361 58. 00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 453, 899 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 60. 00 06000 LABORATORY 4, 427, 719 62. 00 06500 RESPI RATORY THERAPY 1, 088, 361 65. 00 06500 RESPI RATORY THERAPY 2, 764, 772 67. 00 06600 PHYSI CAL THERAPY 382, 378 68. 00 06600 SPEECH PATHOLOGY 269, 566 69. 00 06900 ELECTROCARDI OLOGY 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 3, 150, 106 71. 01 07101 IV SOLUTI ONS 120, 010 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 3, 462, 567 73. 00 07300 DRUGS CHARGED TO PATI ENTS 14, 046, 771	43.00
51. 00	50.00
53. 00	51.00
54. 00	52.00
54. 01 03630 ULTRA SOUND 54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 55. 01 03480 ONCOLOGY	53.00
54. 02	54.00
55. 00	54. 01
55. 01 03480 ONCOLOGY 3, 162, 779 57. 00 05700 CT SCAN 698, 361 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 453, 899 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 60. 00 06000 LABORATORY 4, 427, 719 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 352, 381 65. 00 06500 RESPI RATORY THERAPY 1, 088, 361 66. 00 06600 PHYSI CAL THERAPY 2, 764, 772 67. 00 06700 OCCUPATI ONAL THERAPY 382, 378 68. 00 06800 SPEECH PATHOLOGY 269, 566 69. 00 06900 ELECTROCARDI OLOGY 0 69. 01 03610 SLEEP LAB 383, 850 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 7, 150, 106 71. 01 07101 IV SOLUTI ONS 120, 010 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 3, 462, 567 73. 00 07300 DRUGS CHARGED TO PATI ENTS 14, 046, 771	54. 02 55. 00
57. 00 05700 CT SCAN 698, 361 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 453, 899 59. 00 05900 CARDIAC CATHETERIZATION 0 60. 00 06000 LABORATORY 4, 427, 719 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 65. 00 06500 RESPIRATORY THERAPY 1, 088, 361 65. 00 06500 RESPIRATORY THERAPY 2, 764, 772 67. 00 06700 0CCUPATIONAL THERAPY 382, 378 68. 00 06800 SPEECH PATHOLOGY 269, 566 69. 00 06900 ELECTROCARDIOLOGY 0 69. 01 03610 SLEEP LAB 383, 850 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71. 01 07101 IV SOLUTIONS 120, 010 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 3, 462, 567 73. 00 07300 DRUGS CHARGED TO PATIENTS 14, 046, 771	55. 00
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 453,899 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 60. 00 06000 LABORATORY 4, 427,719 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 352, 381 65. 00 06500 RESPI RATORY THERAPY 1, 088, 361 66. 00 06600 PHYSI CAL THERAPY 2, 764, 772 67. 00 06700 OCCUPATI ONAL THERAPY 382, 378 68. 00 06800 SPEECH PATHOLOGY 269, 566 69. 01 03610 SLEEP LAB 383, 850 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 3, 150, 106 71. 01 07101 IV SOLUTI ONS 120, 010 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 3, 462, 567 73. 00 07300 DRUGS CHARGED TO PATI ENTS 14, 046, 771	57.00
60. 00 06000 LABORATORY 4, 427, 719 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 352, 381 1, 088, 361 65. 00 06500 RESPI RATORY THERAPY 1, 088, 361 66. 00 06600 PHYSI CAL THERAPY 2, 764, 772 67. 00 06700 0CCUPATI ONAL THERAPY 382, 378 68. 00 06800 SPEECH PATHOLOGY 269, 566 69. 00 06900 ELECTROCARDI OLOGY 0 03610 SLEEP LAB 383, 850 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 71. 01 07101 IV SOLUTIONS 120, 010 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 3, 462, 567 73. 00 07300 DRUGS CHARGED TO PATI ENTS 14, 046, 771	58.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 352, 381 65. 00 06500 RESPI RATORY THERAPY 1, 088, 361 66. 00 06600 PHYSI CAL THERAPY 2, 764, 772 67. 00 06700 OCCUPATI ONAL THERAPY 382, 378 68. 00 06800 SPEECH PATHOLOGY 269, 566 69. 00 06900 ELECTROCARDI OLOGY 0 69. 01 03610 SLEEP LAB 383, 850 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 3, 150, 106 71. 01 07101 IV SOLUTI ONS 120, 010 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 3, 462, 567 73. 00 07300 DRUGS CHARGED TO PATI ENTS 14, 046, 771	59.00
65. 00	60.00
66. 00 06600 PHYSI CAL THERAPY 2, 764, 772 382, 378 68. 00 06800 SPEECH PATHOLOGY 269, 566 69. 00 06900 ELECTROCARDI OLOGY 0 03610 SLEEP LAB 383, 850 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 71. 01 07101 IV SOLUTI ONS 120, 010 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 3, 462, 567 73. 00 07300 DRUGS CHARGED TO PATI ENTS 14, 046, 771	62.00
67. 00 06700 0CCUPATI ONAL THERAPY 382, 378 68. 00 06800 SPEECH PATHOLOGY 269, 566 69. 00 06900 ELECTROCARDI OLOGY 0 03610 SLEEP LAB 383, 850 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 71. 01 07101 IV SOLUTI ONS 120, 010 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 3, 462, 567 73. 00 07300 DRUGS CHARGED TO PATI ENTS 14, 046, 771	65.00
68. 00 06800 SPEECH PATHOLOGY 269, 566 69. 00 06900 ELECTROCARDI OLOGY 0 03610 SLEEP LAB 383, 850 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 71. 01 07101 IV SOLUTIONS 120, 010 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 3, 462, 567 73. 00 07300 DRUGS CHARGED TO PATIENTS 14, 046, 771	66. 00 67. 00
69. 00 06900 ELECTROCARDI OLOGY 0 383,850 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 3, 150, 106 71. 01 07101 I V SOLUTI ONS 120, 010 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 3, 462, 567 73. 00 07300 DRUGS CHARGED TO PATIENTS 14, 046, 771	68.00
69. 01 03610 SLEEP LAB 383, 850 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 120, 010 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 3, 462, 567 73. 00 07300 DRUGS CHARGED TO PATIENTS 14, 046, 771	69.00
71. 01 07101 I V SOLUTIONS 120, 010 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 3, 462, 567 14, 046, 771 14, 046, 771	69. 01
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 3, 462, 567 14, 046, 771 3, 462,	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 14, 046, 771	71. 01
	72.00
	73.00
76. 00 03140 CARDI OLOGY	76. 00 76. 97
OUTPATIENT SERVICE COST CENTERS	70.97
90. 00 09000 CLI NI C 216, 999	90.00
91. 00 09100 EMERGENCY 4, 694, 521	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REI MBURSABLE COST CENTERS	
95. 00 09500 AMBULANCE SERVI CES 2, 864, 409	95.00
101. 00 10100 HOME HEALTH AGENCY 1, 489, 035	101.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE	113.00
116. 00 11600 HOSPI CE 270, 253	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 71, 272, 099	118.00
NONREI MBURSABLE COST CENTERS	1.10.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 46,195	190. 00
194. 00 07950 OTHER NON-REI MBURSABLE 136, 719	194. 00
194. 01 07951 MOB 7, 754, 612	194. 01
194. 02 07952 PHYSI CI AN CLI NI CS 10, 703, 447	194. 02
194. 03 07953 PHYS PRAC BUS OFC 1, 790, 180	194. 03
194. 04 07954 MOB - MAIN CAMPUS 801, 011 194. 05 07955 ONCOLOGY - NONREIMBURSABLE 0	194. 04 194. 05
194. 05 07955 ONCOLOGY - NONRET MBURSABLE 0 194. 06 07956 KDH - MC FAMI LY PRACTI CE 6, 862, 966	194.05
194. 00 07930 RDH - MC PAMILET PRACTICE 0, 862, 960 194. 07 07957 KDH - MC ORTHOPEDICS 3, 526, 782	194.00
194. 08 07958 KDH - MC GENERAL SURGERY 2, 381, 846	194. 08
194. 09 07959 KDH - MC ENT 821, 606	194. 09
194. 10 07960 KDH - MC UROLOGY 537, 557	194. 10
194. 11 07961 KDH - MC OB/GYN 3, 402, 808	194. 11
200.00 Cross Foot Adjustments 0	200.00
201.00 Negative Cost Centers 0	201.00

Health Financial Systems	KING'S DAUGHTERS'	' HOSPI TAL	In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CCN: 15-0069	Peri od:	Worksheet B	
			From 01/01/2019		
			To 12/31/2019	Date/Time Pre	epared:
				5/21/2020 10:	03 am
Cost Center Description	Total				
	26. 00				
202.00 TOTAL (sum lines 118 through 201)	110, 037, 828				202.00

| Peri od: | Worksheet B | From 01/01/2019 | Part | I | To | 12/31/2019 | Date/Time Prepared: Provi der CCN: 15-0069

				T	0 12/31/2019	Date/Time Pre 5/21/2020 10:	
			CAPI	TAL RELATED CO	STS	072172020 10.	00 4111
	Cost Center Description	Di rectly Assigned New Capital	NEW BLDG & FLXT	NEW BLDG & FIXT HHA/HO	NEW MVBLE EQUIP	Subtotal	
		Related Costs 0	1. 00	1. 01	2. 00	2A	
	GENERAL SERVICE COST CENTERS						
1. 00 1. 01 2. 00 4. 00 5. 00 7. 00 9. 00 10. 00 11. 00 14. 00 15. 00 16. 00 19. 00 23. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01900 NONPHYSICIAN ANESTHETISTS 02300 RADIOLOGY SCHOOL	0 0 0 0 0 0 0 0	0 1, 564, 688 1, 478, 424 68, 536 120, 137 226, 285 91, 514 73, 283 111, 327 82, 740 10, 500 0 23, 768	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	0 1, 564, 688 1, 478, 424 68, 536 120, 137 226, 285 91, 514 73, 283 111, 327 82, 740 10, 500 0 23, 768	1. 00 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 19. 00 23. 00
30. 00 31. 00	l i	0	1, 431, 211 60, 194	0	0	1, 431, 211 60, 194	30. 00 31. 00
43. 00	04300 NURSERY	0	70, 298		-		43.00
	ANCILLARY SERVICE COST CENTERS						
72. 00 73. 00 76. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND 03450 NUCLEAR MEDICINE - DI AGNOSTI C 05500 RADI OLOGY - THERAPEUTI 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 RESPIRATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06900 ELECTROCARDI OLOGY 06900 ELECTROCARDI OLOGY 03610 SLEEP LAB 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07101 IV SOLUTI ONS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 03140 CARDI OLOGY 07697 CARDI AC REHABI LI TATI ON 0UTPATI ENT SERVI CE COST CENTERS	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	662, 927 49, 443 0 4, 675 389, 824 0 17, 368 0 440, 381 32, 183 38, 835 0 224, 344 10, 032 43, 042 445, 918 51, 061 12, 082 0 30, 169 0 0 217, 440 25, 279	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	662, 927 49, 443 0 4, 675 389, 824 0 17, 368 0 440, 381 32, 183 38, 835 0 224, 344 10, 032 43, 042 445, 918 51, 061 12, 082 0 30, 169 0 0 217, 440 25, 279	50. 00 51. 00 52. 00 53. 00 54. 01 54. 02 55. 00 55. 01 57. 00 58. 00 62. 00 66. 00 66. 00 67. 00 68. 00 69. 01 71. 01 72. 00 73. 00 76. 97
91. 00 92. 00	09100 EMERGENCY	o	499, 065		0	499, 065 0	
	09500 AMBULANCE SERVICES 0 10100 HOME HEALTH AGENCY	0	170, 155 0		-		95. 00 101. 00
113. 0	SPECIAL PURPOSE COST CENTERS 0 11300 INTEREST EXPENSE 0 11600 HOSPI CE	0	0 8, 808, 412	1, 674	0	1, 674	113. 00 116. 00
194. 0 194. 0 194. 0 194. 0 194. 0 194. 0 194. 0	0 19000 G FT, FLOWER, COFFEE SHOP, & CANTEEN 0 07950 OTHER NON-REIMBURSABLE 1 07951 MOB 2 07952 PHYSICIAN CLINICS 3 07953 PHYS PRAC BUS OFC 4 07954 MOB - MAIN CAMPUS 5 07955 ONCOLOGY - NONREIMBURSABLE 6 07956 KDH - MC FAMILY PRACTICE 7 07957 KDH - MC ORTHOPEDICS 8 07958 KDH - MC GENERAL SURGERY	0 0 0 0 0 0 0 0	27, 041 0 1, 892, 660 992, 232 35, 563 0 0 1, 551, 455	0 0 0 0 0 0	0 0 0 0 0	1, 892, 660 992, 232 35, 563 0 0 1, 551, 455	194. 00 194. 01 194. 02 194. 03 194. 04 194. 05

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0069	Peri od: From 01/01/2019 To 12/31/2019	Worksheet B Part II Date/Time Pre 5/21/2020 10:	
		CAPITAL RELATED	COSTS		

						5/21/2020 10:	<u>03 am</u>
			CAPI TAL RELATED COSTS				
	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. 09 07959	KDH - MC ENT	0	0	C	0	0	194. 09
194. 10 07960	KDH - MC UROLOGY	0	0	C	0	0	194. 10
194. 11 07961	KDH - MC OB/GYN	0	0	C	0	0	194. 11
200. 00	Cross Foot Adjustments					0	200.00
201. 00	Negative Cost Centers		0	0	0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	0	13, 307, 363	7, 859	0	13, 315, 222	202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2019 | Part II | To 12/31/2019 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-0069

			T	o 12/31/2019	Date/Time Pre 5/21/2020 10:	
Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	oe a
OFNEDAL CEDIU OF COCT OFNITEDO	4. 00	5. 00	7. 00	8. 00	9. 00	
1. 00 O0100 NEW CAP REL COSTS-BLDG & FLXT 1. 01 O0101 NEW CAP REL COSTS-BLDG & FLXT HHA/HO 2. 00 O0200 NEW CAP REL COSTS-MVBLE EQUIP						1.00 1.01 2.00
4. 00	0 0 0	1, 564, 688 78, 883 8, 109	1, 557, 307	l .		4. 00 5. 00 7. 00 8. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	0 0 0	24, 307 17, 518 2, 784 10, 332	18, 007 33, 917 13, 717	0 0 0	162, 451 0 0 0	11.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDICAL RECORDS & LIBRARY	0 0	3, 602 26, 359 16, 947	16, 687 12, 402	0	1, 525 3, 064 0	14. 00 15. 00 16. 00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS 23. 00 02300 RADI OLOGY SCHOOL I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	0 0	,		28, 467	79, 086	23.00
31. 00 03100 INTENSIVE CARE UNIT 43. 00 04300 NURSERY ANCILLARY SERVICE COST CENTERS	0 0	23, 556	9, 022	0 1, 831	4, 460 739	31.00
50. 00 05000 OPERATING ROOM	0	61, 988		· · ·	8, 429	1
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0 0	6, 752 13, 539 2, 740	0 701	1, 986 2, 345 0	0 3, 333 0	52.00 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 03630 ULTRA SOUND 54. 02 03450 NUCLEAR MEDI CI NE - DI AGNOSTI C	0	51, 985 3, 329 4, 921		650	5, 286 1, 376 381	54. 01 54. 02
55. 00 05500 RADI OLOGY - THERAPEUTI C 55. 01 03480 ONCOLOGY 57. 00 05700 CT SCAN	0 0	0 39, 189 8, 239	4, 824	2, 901	0 10, 101 560	55. 01 57. 00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 59. 00 05900 CARDIAC CATHETERIZATION 60. 00 06000 LABORATORY	0 0	5, 751 0 58, 153		l .	474 0 5, 472	59. 00 60. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 65. 00 06500 RESPIRATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0 0 0 0 0	4, 817 14, 622 34, 518 4, 959 3, 671	6, 451 66, 838	0 3, 136	0 0 2, 238 0	65. 00 66. 00 67. 00
69. 00 06900 ELECTROCARDI OLOGY 69. 01 03610 SLEEP LAB 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0 0 0	0 4, 748 42, 417	0 4, 522 0	0 218 0	0 2, 175 0	69. 01 71. 00
71. 01 07101 I V SOLUTIONS 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03140 CARDI OLOGY	0 0	l ·	0 0 32, 592	3, 566	0 0 0 667	72. 00 73. 00 76. 00
76. 97 07697 CARDI AC REHABILITATION OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC	0	2, 727	4, 689	0	647	90.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0				11, 742	92.00
95. 00 09500 AMBULANCE SERVI CES 101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0 0				0	101. 00
113.00 11300 INTEREST EXPENSE 116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0				0 142, 080	113. 00 116. 00 118. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	452	4, 053	ol	0	190. 00
194. 00 07950 OTHER NON-REIMBURSABLE 194. 01 07951 MOB 194. 02 07952 PHYSICIAN CLINICS	0 0	1, 943	0 283, 685	0 152	0	194. 00 194. 01 194. 02
194. 03 07953 PHYS PRAC BUS OFC 194. 04 07954 MOB - MAIN CAMPUS 194. 05 07955 ONCOLOGY - NONREI MBURSABLE	0 0	25, 179 8, 221 0	5, 330 0	l .	0 20, 371	194. 03 194. 04 194. 05
194.06 07956 KDH - MC FAMILY PRACTICE 194.07 07957 KDH - MC ORTHOPEDICS 194.08 07958 KDH - MC GENERAL SURGERY 194.09 07959 KDH - MC ENT	0 0 0	85, 788 50, 115 33, 818 11, 677	0	76	0 0 0	194. 06 194. 07 194. 08 194. 09
194. 10 07960 KDH - MC UROLOGY 194. 11 07961 KDH - MC OB/GYN	0	7, 631	0	l .		194. 10 194. 11

Health Fina	ancial Systems	KING'S DAUGHTE	ERS' HOSPITAL		In Lie	u of Form CMS-	2552-10
ALLOCATI ON	OF CAPITAL RELATED COSTS		Provi der Co		eri od:	Worksheet B	
					rom 01/01/2019		narad.
					o 12/31/2019	Date/Time Pre 5/21/2020 10:	
	Cost Center Description	EMPLOYEE	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		BENEFITS	E & GENERAL	PLANT	LINEN SERVICE		
		DEPARTMENT					
		4. 00	5. 00	7.00	8. 00	9. 00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	C	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	1, 564, 688	1, 557, 307	86, 918	162, 451	202.00

Provider CCN: 15-0069

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2019 Part II
To 12/31/2019 Date/Time Prepared: 5/21/2020 10:03 am

				12/31/2019	5/21/2020 10:	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O	CENTRAL SERVICES &	PHARMACY	
	10.00		N	SUPPLY	15.00	
GENERAL SERVICE COST CENTERS	10. 00	11. 00	13. 00	14. 00	15. 00	
1.00 O0100 NEW CAP REL COSTS-BLDG & FLXT						1.00
1. 01 00101 NEW CAP REL COSTS-BLDG & FLXT HHA/HO						1.01
2.00 O0200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5. 00 00500 ADMINISTRATIVE & GENERAL						5.00
7. 00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE						8. 00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY	277, 720	100 015				10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	0	108, 015 0				11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	o o	765		133, 906		14.00
15. 00 01500 PHARMACY	O	2, 756		716	128, 037	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	3, 357	0	139	0	16.00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0		0	0	19.00
23. 00 02300 RADI OLOGY SCHOOL I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	596	0	18	0	23. 00
30. 00 03000 ADULTS & PEDIATRICS	258, 561	20, 038	38, 142	3, 006	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	19, 159	4, 072		6	0	31.00
43. 00 04300 NURSERY	0	2, 098		0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	10, 602		3, 497	0	50.00
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	1, 126 2, 687	1	57 0	0	51. 00 52. 00
53. 00 05300 ANESTHESI OLOGY	0	916	1	238	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	o	8, 129	1	1, 295	0	54.00
54. 01 03630 ULTRA SOUND	O	456	0	544	0	54. 01
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	306		39	0	54.02
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	2 000	0	0	0	55.00
55. 01 03480 0NCOLOGY 57. 00 05700 CT SCAN	0	3, 999 774	0	859 2, 508	0	55. 01 57. 00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	587		335	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	Ö	0	Ō	0	0	59.00
60. 00 06000 LABORATORY	0	10, 597	0	729	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	3, 204		78	0	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	6, 246 657		151	0	66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	0	593		0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	o	0	Ö	ő	0	69.00
69. 01 03610 SLEEP LAB	0	513	0	1	0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	52, 491	0	71.00
71. 01 07101 I V SOLUTIONS	0	0	0	1, 935	0	71.01
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	57, 533 735	0 128, 037	72. 00 73. 00
76. 00 07300 DR0GS CHARGED TO PATTENTS	0	2, 437		87	120, 037	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	o	451	1	8	0	76. 97
OUTPATIENT SERVICE COST CENTERS				,		
90. 00 09000 CLI NI C	0	396	1	4	0	90.00
91. 00 09100 EMERGENCY	0	9, 071	17, 269	876	0	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
95. 00 09500 AMBULANCE SERVICES	0	10, 586	0	132	0	95. 00
101.00 10100 HOME HEALTH AGENCY	O	0	0	595	0	101.00
SPECIAL PURPOSE COST CENTERS				,		
113. 00 11300 INTEREST EXPENSE						113.00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	277, 720	108, 015	94, 599	128, 617	128, 037	116.00
NONREIMBURSABLE COST CENTERS	211, 120	100, 015	74, 377	120, 017	120, 037	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190. 00
194.00 07950 OTHER NON-REIMBURSABLE	0	0	0	23	0	194. 00
194. 01 07951 MOB	0	0	0	490		194. 01
194. 02 07952 PHYSI CI AN CLI NI CS	0	0	0	1, 580		194. 02
194. 03 07953 PHYS PRAC BUS OFC	0	0	0	166		194. 03 194. 04
194. 04 07954 MOB - MAIN CAMPUS 194. 05 07955 ONCOLOGY - NONREIMBURSABLE		0		179		194. 04 194. 05
194. 06 07956 KDH - MC FAMILY PRACTICE	0	0	0	511		194. 05
194.07 07957 KDH - MC ORTHOPEDICS	ő	0	Ö	721		194. 07
194.08 07958 KDH - MC GENERAL SURGERY	o	0	0	592		194. 08
194. 09 07959 KDH - MC ENT	0	0	0	160		194. 09
194. 10 07960 KDH - MC UROLOGY 194. 11 07961 KDH - MC OB/GYN	0	0		363 504		194. 10 194. 11
וועא וועא וועא אווע אווע אווע אוועא	l 이	0	<u>'I</u> U	504	0	174.11

Health Financial Systems	KING'S DAUGHTERS	S' HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der Co		Period: From 01/01/2019 To 12/31/2019	Worksheet B Part II Date/Time Pre 5/21/2020 10:	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI (CENTRAL SERVICES &	PHARMACY	

						5/21/2020 10:	03 am
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
				ADMI NI STRATI O	SERVICES &		
				N	SUPPLY		
		10.00	11. 00	13. 00	14. 00	15. 00	
200.00	Cross Foot Adjustments						200.00
201. 00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	277, 720	108, 015	94, 599	133, 906	128, 037	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2019 | Part II | To 12/31/2019 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-0069

			T	o 12/31/2019	Date/Time Pre 5/21/2020 10:	
Cost Center Description	MEDI CAL	NONPHYSI CI AN	RADI OLOGY	Subtotal	Intern &	
	RECORDS &	ANESTHETI STS	SCH00L		Resi dents	
	LI BRARY				Cost & Post	
					Stepdown Adjustments	
	16. 00	19. 00	23.00	24. 00	25. 00	
GENERAL SERVICE COST CENTERS						
1.00 OO100 NEW CAP REL COSTS-BLDG & FLXT						1.00
1. 01 00101 NEW CAP REL COSTS-BLDG & FLXT HHA/HO						1.01
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
7. 00 00700 OPERATION OF PLANT						7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE						8.00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11.00
13.00 O1300 NURSING ADMINISTRATION						13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY						14.00
15. 00 01500 PHARMACY	00 547					15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	32, 517					16.00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS 23. 00 02300 RADI OLOGY SCHOOL	0	0				19. 00 23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			30, 778			23.00
30. 00 03000 ADULTS & PEDIATRICS	1, 020			2, 176, 890	0	30.00
31. 00 03100 NTENSI VE CARE UNI T	349			128, 570	0	31.00
43. 00 04300 NURSERY	167			101, 410	0	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	2, 878			883, 618	0	50.00
51.00 05100 RECOVERY ROOM	517			69, 436	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	209			27, 228	0	52.00
53. 00 05300 ANESTHESI OLOGY	600			9, 870	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	769			521, 628	0	54.00
54. 01 03630 ULTRA SOUND 54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	212 638			6, 567 26, 634	0	54. 01 54. 02
55. 00 05500 RADI OLOGY - THERAPEUTI C	038		•	20, 034	0	55.00
55. 01 03480 ONCOLOGY	751			564, 468	0	55. 01
57. 00 05700 CT SCAN	1, 817			53, 806	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	458			52, 890	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			o	0	59.00
60. 00 06000 LABORATORY	3, 573			336, 494	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	223			16, 576	0	62.00
65. 00 06500 RESPIRATORY THERAPY	797			68, 194	0	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 031			560, 076	0	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	130 97			64, 465	0	67. 00 68. 00
69. 00 06900 SPEECH PATHOLOGY	97			18, 254	0	69.00
69. 01 03610 SLEEP LAB	199		•	42, 545	0	69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 003			95, 911	0	71.00
71. 01 07101 I V SOLUTIONS	142			3, 641	0	71. 01
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 361			105, 387	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	8, 588			305, 020	0	73.00
76. 00 03140 CARDI OLOGY	1, 314			274, 389	0	76. 00
76. 97 O7697 CARDI AC REHABILI TATI ON	78			31, 736	0	76. 97
OUTPATIENT SERVICE COST CENTERS	4.5			20.7/0		00.00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	15 2, 952			39, 762	0	90. 00 91. 00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 952			687, 123	0	91.00
OTHER REIMBURSABLE COST CENTERS					0	72.00
95. 00 09500 AMBULANCE SERVICES	629			246, 759	0	95.00
101.00 10100 HOME HEALTH AGENCY	0			41, 993		101.00
SPECIAL PURPOSE COST CENTERS			•	·		
113. 00 11300 I NTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	0			9, 324		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	32, 517	0	0	7, 570, 664	0	118. 00
NONREI MBURSABLE COST CENTERS			1	04.54		
190. 00 19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 194. 00 07950 OTHER NON-REIMBURSABLE	0			31, 546 1, 966		190. 00 194. 00
194. 01 07951 MOB	0			2, 272, 849		194.00
194. 01 07931 MOB 194. 02 07952 PHYSI CI AN CLI NI CS	0			1, 287, 452		194. 01
194. 03 07953 PHYS PRAC BUS OFC	0			66, 238		194. 02
194.04 07954 MOB - MAIN CAMPUS	0			28, 771		194. 04
194. 05 07955 ONCOLOGY - NONREI MBURSABLE	0			o		194. 05
194.06 07956 KDH - MC FAMILY PRACTICE	0			1, 870, 302		194. 06
194. 07 07957 KDH - MC ORTHOPEDICS	0			50, 912		194. 07
194. 08 07958 KDH - MC GENERAL SURGERY	0			34, 701		194. 08
194.09 07959 KDH - MC ENT	0			11, 837	0	194. 09

Health Financial Systems	KING'S DAUGHTE	RS' HOSPITAL		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der Co	CN: 15-0069	Peri od:	Worksheet B	
				From 01/01/2019		
				To 12/31/2019		
					5/21/2020 10:	03 am
Cost Center Description	MEDI CAL	NONPHYSI CI AN	RADI OLOGY	Subtotal	Intern &	
	RECORDS &	ANESTHETI STS	SCH00L		Resi dents	
	LI BRARY				Cost & Post	
					Stepdown	
					Adjustments	
	16. 00	19. 00	23.00	24.00	25. 00	
194.10 07960 KDH - MC UROLOGY	0			7, 994	0	194. 10
194.11 07961 KDH - MC OB/GYN	0			49, 212	0	194. 11
200.00 Cross Foot Adjustments		0	30, 77	78 30, 778	0	200. 00
201.00 Negative Cost Centers	0	0)	0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	32, 517	0	30, 77	78 13, 315, 222	0	202. 00

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 01/01/2019 | Part II | Date/Time Prepared: 5/21/2020 10: 03 am Provider CCN: 15-0069

		5/21/2020 10: 03 am
Cost Center Description	Total	372172020 10. 03 dill
· ·	26. 00	
GENERAL SERVICE COST CENTERS		
1.00 O0100 NEW CAP REL COSTS-BLDG & FLXT		1.00
1. 01 00101 NEW CAP REL COSTS-BLDG & FLXT HHA/HO		1.01
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP		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 & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG		8.00
10. 00 01000 DI ETARY		10.00
11. 00 01100 CAFETERI A		10.00
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		16.00
19.00 01900 NONPHYSICIAN ANESTHETISTS		19. 00
23. 00 02300 RADI OLOGY SCHOOL		23.00
INPATIENT ROUTINE SERVICE COST CENTERS		
30. 00 03000 ADULTS & PEDIATRICS	2, 176, 890	30.00
31.00 03100 INTENSIVE CARE UNIT	128, 570	31.00
43. 00 04300 NURSERY	101, 410	43.00
ANCILLARY SERVICE COST CENTERS		
50. 00 05000 OPERATI NG ROOM	883, 618	50.00
51. 00 05100 RECOVERY ROOM	69, 436	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	27, 228	52.00
53. 00 05300 ANESTHESI OLOGY	9, 870	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	521, 628	54.00
54. 01 03630 ULTRA SOUND	6, 567	54.01
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 55. 00 05500 RADIOLOGY - THERAPEUTIC	26, 634	54.02
55. 00 05500 RADI OLOGY - THERAPEUTI C 55. 01 03480 ONCOLOGY	564, 468	55. 00 55. 01
57. 00 05700 CT SCAN	53, 806	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	52, 890	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	59. 00
60. 00 06000 LABORATORY	336, 494	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	16, 576	62.00
65. 00 06500 RESPIRATORY THERAPY	68, 194	65. 00
66. 00 06600 PHYSI CAL THERAPY	560, 076	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	64, 465	67.00
68.00 06800 SPEECH PATHOLOGY	18, 254	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	69.00
69. 01 03610 SLEEP LAB	42, 545	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	95, 911	71.00
71. 01 07101 I V SOLUTI ONS	3, 641	71. 01
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	105, 387	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	305, 020	73.00
76. 00 03140 CARDI OLOGY	274, 389	76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	31, 736	76. 97
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC	39, 762	90.00
91. 00 09100 EMERGENCY	687, 123	90.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	007, 123	92.00
OTHER REIMBURSABLE COST CENTERS		72.00
95. 00 09500 AMBULANCE SERVICES	246, 759	95.00
101. 00 10100 HOME HEALTH AGENCY	41, 993	101.00
SPECIAL PURPOSE COST CENTERS		
113. 00 11300 I NTEREST EXPENSE		113. 00
116. 00 11600 H0SPI CE	9, 324	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	7, 570, 664	118. 00
NONREI MBURSABLE COST CENTERS		
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	31, 546	190.00
194. 00 07950 OTHER NON-REIMBURSABLE	1, 966	194. 00
194. 01 07951 MOB	2, 272, 849	194. 01
194. 02 07952 PHYSI CI AN CLI NI CS	1, 287, 452	194. 02
194. 03 07953 PHYS PRAC BUS OFC	66, 238	194. 03
194. 04 07954 MOB - MAIN CAMPUS	28, 771	194. 04
194. 05 07955 ONCOLOGY - NONREI MBURSABLE	1 070 202	194. 05
194. 06 07956 KDH - MC FAMILY PRACTICE	1, 870, 302	194.06
194. 07 07957 KDH - MC ORTHOPEDI CS	50, 912	194.07
194.08 07958 KDH - MC GENERAL SURGERY 194.09 07959 KDH - MC ENT	34, 701	194. 08 194. 09
194. 10 07959 KDH - MC ENT 194. 10 07960 KDH - MC UROLOGY	11, 837 7, 994	194.09
194. 10 07960 KDH - MC OROLOGY 194. 11 07961 KDH - MC OB/GYN	7, 994 49, 212	194. 10
200.00 Cross Foot Adjustments	49, 212 30, 778	194.11
201.00 Negative Cost Centers	30, 778	200.00
	0	201.00

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lieu	of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CCN: 15-0069	From 01/01/2019	Worksheet B Part II Date/Time Pre 5/21/2020 10:	
Cost Center Description	Total				
	26. 00				
202.00 TOTAL (sum lines 118 through 201)	13, 315, 222				202.00

Health Financial Systems KING'S DAUGHTERS' HOSPITAL In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0069 | Period: From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: 5/21/2020 10: 03 am

					To	12/31/2019	Date/Time Pre 5/21/2020 10:	
			CAPI	TAL RELATED CO	OSTS			
		Cost Center Description	NEW BLDG &	NEW BLDG &	NEW MVBLE	EMPLOYEE	Reconciliatio	
			FI XT (SQUARE	FIXT HHA/HO (SQUARE	EQUI P (SQUARE	BENEFITS DEPARTMENT	n	
			FEET)	FEET)	FEET)	(GROSS		
			1. 00	1. 01	2.00	4. 00	5A	
	GENER	AL SERVICE COST CENTERS	1.00	1.01	2.00	4.00	<u> </u>	
1.00		NEW CAP REL COSTS-BLDG & FIXT	370, 078					1.00
1. 01 2. 00		NEW CAP REL COSTS-BLDG & FIXT HHA/HO NEW CAP REL COSTS-MVBLE EQUIP	0	3, 492	373, 570			1. 01 2. 00
4. 00		EMPLOYEE BENEFITS DEPARTMENT	0	0		50, 223, 202		4.00
5.00		ADMINISTRATIVE & GENERAL	43, 514	0		6, 887, 177	-16, 340, 971	5.00
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE	41, 115 1, 906	0		566, 546 45, 976	l e	7. 00 8. 00
9. 00		HOUSEKEEPI NG	3, 341	0	.,	718, 776	0	9. 00
10.00	1	DIETARY	6, 293	0		445, 101	0	10.00
11. 00 13. 00	1	CAFETERIA NURSI NG ADMINI STRATI ON	2, 545 2, 038	0	,	260, 089 433, 103	0	11. 00 13. 00
14.00	01400	CENTRAL SERVICES & SUPPLY	3, 096		3, 096	81, 424	0	14. 00
15. 00 16. 00		PHARMACY MEDICAL RECORDS & LIBRARY	2, 301 292	0	,	691, 553 524, 540	0	15. 00 16. 00
19. 00	1	NONPHYSICIAN ANESTHETISTS	292	0		524, 540	0	19.00
23. 00		RADI OLOGY SCHOOL	661	0	661	127, 501	0	23. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	39, 802	0	39, 802	3, 762, 407	0	30. 00
31. 00		INTENSIVE CARE UNIT	1, 674			1, 071, 288	l e	31.00
43. 00		NURSERY	1, 955	0	1, 955	471, 379	0	43.00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	18, 436	0	18, 436	2, 008, 317	0	50.00
51.00	05100	RECOVERY ROOM	1, 375	0		278, 984	0	51.00
52.00		DELIVERY ROOM & LABOR ROOM	0	0		603, 686	0	52.00
53. 00 54. 00	1	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	130 10, 841	0		1, 278, 263 2, 868, 718	0	53. 00 54. 00
54. 01	03630	ULTRA SOUND	0	0		118, 800	0	54. 01
54. 02 55. 00		NUCLEAR MEDICINE - DIAGNOSTIC RADIOLOGY - THERAPEUTIC	483 0	0		68, 139 0	0 0	54. 02 55. 00
55. 00	1	ONCOLOGY - THERAPEUTIC	12, 247	0		926, 070	0	55. 00
57.00	05700	CT SCAN	895	0	895	152, 111	0	57. 00
58. 00 59. 00		MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION	1, 080	0	.,	143, 640	0	58. 00 59. 00
60.00		LABORATORY	6, 239	0		1, 466, 420	ő	60.00
62.00	1	WHOLE BLOOD & PACKED RED BLOOD CELLS	279	0		0	0	62.00
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	1, 197 12, 401	0		630, 419 1, 273, 271	0	65. 00 66. 00
67. 00	06700	OCCUPATI ONAL THERAPY	1, 420	0		192, 034	0	67. 00
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	336	0		163, 933	0	68. 00 69. 00
69. 00		SLEEP LAB	839	0		140, 145	0	69.00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	
71. 01 72. 00		IV SOLUTIONS IMPL. DEV. CHARGED TO PATIENTS	0	0	-	0	0	71. 01 72. 00
73. 00		DRUGS CHARGED TO PATIENTS	0	0		0	ő	73.00
76.00	03140	CARDI OLOGY	6, 047	0		446, 573	l	76.00
76. 97		CARDIAC REHABILITATION TIENT SERVICE COST CENTERS	703	0	703	75, 853	0	76. 97
90.00	09000	CLINIC	870			102, 607	0	90.00
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	13, 879	0	13, 879	1, 737, 307	0	91. 00 92. 00
92.00		REIMBURSABLE COST CENTERS						92.00
		AMBULANCE SERVICES	4, 732			1, 594, 069		95. 00
101.00		HOME HEALTH AGENCY AL PURPOSE COST CENTERS	0	2, 748	2, 748	900, 129	0	101. 00
	11300	INTEREST EXPENSE						113. 00
		HOSPI CE	0	744		128, 107		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	244, 962	3, 492	248, 454	33, 384, 455	-16, 340, 971	1118.00
	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	752	0	752	0	•	190. 00
194. 00 194. 01		OTHER NON-REIMBURSABLE	0 F2 43F	_		91, 288		194. 00 194. 01
		PHYSICIAN CLINICS	52, 635 27, 594	0	52, 635 27, 594	2, 830, 049 4, 830, 676	l e	194. 01 194. 02
194. 03	07953	PHYS PRAC BUS OFC	989	0	989	621, 301	0	194. 03
		MOB - MAIN CAMPUS ONCOLOGY - NONREIMBURSABLE	0	0		394, 332 0		194. 04 194. 05
		KDH - MC FAMILY PRACTICE	43, 146	_	· ·	2, 674, 326	1	194. 05
	1	KDH - MC ORTHOPEDICS	0			1, 852, 874	l e	194. 07

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0069	Peri od: From 01/01/2019	Worksheet B-1

				T	o 12/31/2019	Date/Time Pre 5/21/2020 10:	
		CAPI	TAL RELATED CO	OSTS		072172020 10.	00 4111
	Cost Center Description	NEW BLDG &	NEW BLDG &	NEW MVBLE	EMPLOYEE	Reconciliatio	
		FI XT	FIXT HHA/HO	EQUI P	BENEFITS	n	
		(SQUARE	(SQUARE	(SQUARE	DEPARTMENT		
		FEET)	FEET)	FEET)	(GROSS		
					SALARI ES)		
		1. 00	1. 01	2. 00	4. 00	5A	
	RDH - MC GENERAL SURGERY	0	0	0	1, 119, 168		194. 08
•	PKDH - MC ENT	0	0	0	532, 163		194. 09
•	KDH - MC UROLOGY	0	0	0	72, 885		194. 10
•	KDH - MC OB/GYN	0	0	0	1, 819, 685	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,	13, 307, 363	7, 859	0	12, 854, 622		202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	35. 958266	2. 250573	0. 000000	0. 255950		203. 00
204. 00	Cost to be allocated (per Wkst. B,				0		204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part				0. 000000		205. 00
	[11]						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)	ļ					

| Period: | Worksheet B-1 | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 15-0069

Description				Ť	o 12/31/2019	Date/Time Pre 5/21/2020 10:	
	Cost Center Description					DI ETARY	US alli
COSET) FEET LIAMBRY							
STATEMENT OF THE TOTAL CHATTERS		COST)	FEET)	LAUNDRY)	,		
1.00	CENEDAL SEDVICE COST CENTEDS	5. 00	7. 00	8. 00	9. 00	10. 00	
2.00 00000 MEW CAP REL COSTS-MANUE SOUT P 4.00 00000 ADMINISTRATIVE AS GENERAL 5.00 00000 ADMINISTRATIVE AS GENERAL 5.00 00000 ADMINISTRATIVE AS GENERAL 5.00 00000 ADMINISTRATIVE AS GENERAL 6.00 000000 ADMINISTRATIVE AS GENERAL 6.00 00000 ADMINISTRATIVE AS GENERAL 6.00							1. 00
4. 00 00400 EMPLOYEE BENEFIT IS DEPARTMENT 93, 696, 857 7.00 00500 OFFENT TO 0.01 PLANTED OF PLANT							
5.00 DOSON DEPART ION OF PRINT 4.72, 817 7.88, 94 8.00 7.00 DOTON OPERATION OF PRINT 4.72, 817 7.88, 94 8.00 7.00 DOTON OPERATION OF PRINT 4.72, 817 7.00 DOTON OPERATION OF PRINT 4.85, 573 1.900 413, 926 48, 989 8.00 0 47, 618 0.00 11.00 0.00 0.00 0.00 11.00 0.00 0.00 0.00 11.00 0.00							
B. OD 000000 MANDRY N. LINEN STEPLICE 4415. 573 3.491 0.489.89 47, 618 10.00 10.00 10.00 10.740 10.00 10.00 10.740 10.00 10.00 10.740 10.0		93, 696, 857					
0.000 00000 000000 00000000000000		1					
10.00 01000 DETARY 1,049,040 6,203 0 0 47,618 10,00 11.00 10100 CAFFERT A 10.60,715 777 2,038 0 0 0 11.00 10100 CAFFERT A 10.60,715 777 2,038 0 0 0 11.00 10100 CAFFERT A 10.00 CAFFER		1			18 080		
0 0 0 13.00 0 0 13.00 0 0 13.00 0 13.00 0 13.00		1			40, 707	47, 618	
14.00 01400 CENTRAL SERVICES & SUPPLY 215, 727 3,00% 0 44.00 11.0 15.00 15.		1		0	0		
15.00 01500 PHARMACY 1.578, 462 2.301 0 924 0 15.00 19.00		1		0	0 460		
19.00 1900 NOMPHYSICI AM AMESTHEITS 150, 203 661 0 98 0 23.00 1000 1000 AULTS & PEIDLA TRICKS 150, 203 661 0 98 0 23.00 1000 AULTS & PEIDLA TRICKS 1.000 1.000 AULTS & PEIDLA TRICKS 1.		1		Ĭ		-	
23.00		1, 014, 881		0	0	-	
INPATT PAT ROUTE NET SCHOLD COST CENTERS 30,000 03000 ADULTS & PEDIATRICS 1,410,603 1,674 0 1,345 3,285 31,000 31,000 ADULTS & PEDIATRICS 703,880 1,955 8,720 233 04 43,00 31,000 ADULTS & PEDIATRICS 703,880 1,955 8,720 233 04 43,00 31,000 ADULTS & PEDIATRICS 703,880 1,955 8,720 233 04 43,00 3,712,078 18,430 65,475 2,542 0 50,00 0 0 0 0 0 0 0 0 0		150 202	-	0	0		
31.00 03100 NITERSY VE CARE UNIT		150, 203	001	0	70	0	23.00
A3. DO		1 1		· ·			
ANCILLARY SERVICE COST CENTERS				_			
10		703, 300	1, 755	0,720	223	0	43.00
52.00 05200 DELLUTERY BOOM & LABOR ROOM 810,776 0 11,166 1,005 052.00 53.00 05300 ABSTHESI DLOGY 104,094 130 0 0 0 0 53.00 53.00 05300 ABSTHESI DLOGY 104,094 130 0 0 0 0 54.00 54.00 54.01 03360 UITRA SOUND 199,379 0 3,094 415 0 54.01 54.02 03450 UITRA SOUND 199,379 0 0 0 0 0 0 0 0 0						-	
153.00 055000 ANESTHESI OLOGY 104, 094 130 0 0 0 0 53.00		1					
54.00		1	- 1		0		
54. 02 03450 NUCLEAR MEDICINE - DIACNOSTIC 294, 684						-	
55.00 05500 RADIOLOGY - THERAPEUTIC 0 0 0 0 0 55.01		1	-				
15.0 03480 0MCDLOGY		1	403		0		
SBS 00 OSBOO MAGNETIC RESONANCE I MAGING (MRI) 344, 339 1,080 2,995 143 0 58,00	55. 01 03480 ONCOLOGY	2, 346, 808	12, 247	15, 143	3, 046	0	
99.00 05900 CARDIAC CATHETERIZATION 0 0 0 0 0 0 0 0 0		1 1				-	
60.00 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.00000000		1	1,080	2, 995	0		
65.00 06500 RESPI RATORY THERAPY 2,067,056 12,401 14,933 675 0,66 00 67.00 06700 0CCUPATI ONAL THERAPY 2,067,056 12,401 14,933 675 0,66 00 67.00 06700 0CCUPATI ONAL THERAPY 296,992 1,420 0 0 0 0 0 0 0 68.00 06800 RECETORACROI OLOGY 219,846 336 0 0 0 0 0 0 0 0 69.01 03670 SPECH PATHOLOGY 219,846 336 0 0 0 0 0 0 0 0 69.01 03670 SLEEP LAB 284,338 839 1,038 656 0 69,00 71.01 07101 V SOLUTI ONS 93,638 0 0 0 0 0 71,00 71.01 07101 V SOLUTI ONS 93,638 0 0 0 0 0 71,00 72.00 07200 IMPL DeV CHARGED TO PATI ENTS 2,784,199 0 0 0 0 0 0 72,00 73.00 07300 DRUGS CHARGED TO PATI ENTS 10,037,574 0 0 0 0 0 0 0 73.00 76.00 03140 CARDI OLOGY 975,239 6,047 16,980 201 0 76.90 76.00 03740 CARDI OLOGY 975,239 6,047 16,980 201 0 76.90 77.00 007000 CLINIC 10 10 10 10 10 10 10 1	60. 00 06000 LABORATORY	1		0	1, 650		60.00
66.00 06600 PMSI CAL THERAPY 2, 067, 056 12, 401 14, 933 675 0 66. 00 67. 00 67. 00 68. 00 68. 00 69. 0		1		0			
67.00 067.00 067.00 069.		1		14. 933	٩	-	
69. 00 06900 06900 0	67. 00 06700 OCCUPATI ONAL THERAPY	1		0	0	-	
69.01 03610 SLEEP LAB 284, 338 839 1, 038 656 0 69.01		219, 846		0	0	-	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2, 540, 075 0 0 0 0 71. 00 0710 1V SOLUTIONS 93, 638 0 0 0 0 0 71. 01 0710 1V SOLUTIONS 72. 00 72. 00 72. 00 73. 00 07200 MPL. DEV. CHARGED TO PATIENTS 2, 784, 199 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 10, 037, 574 0 0 0 0 0 0 73. 00 076. 00 03140 CARDI OLOGY 975, 239 6, 047 16, 980 201 0 76. 00 0 76. 00 0 0 76. 00 0 0 0 0 0 0 0 0 0		284, 338	ŭ,	1. 038	656		
72. 00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1		0	0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS 10, 037, 574 0 0 0 0 73.00 76.00 03140 CARDI OLOGY 975, 239 6, 047 16, 980 201 0 76.00 76.97 07697 CARDI AC REHABI LITATION 127, 595 703 0 0 0 0 76.00 76.97 00079 000 000 000 000 000 000 000 76.90 000 000 000 000 000 000 000 000 76.90 000 000 000 000 000 000 000 000 000 76.90 000 000 000 000 000 000 000 000 76.90 000 000 000 000 000 000 000 000 76.90 000 000 000 000 000 000 000 000 76.90 000 000 000 000 000 000 000 000 76.90 000 000 000 000 000 000 000 000 76.90 000 000 000 000 000 000 000 000 76.90 000 000 000 000 000 000 000 000 76.90 000 000 000 000 000 000 000 000 76.90 000 000 000 000 000 000 000 000 000 76.90 000 000 000 000 000 000 000 000 000 76.90 000 000 000 000 000 000 000 000 000 76.90 000 000 000 000 000 000 000 000 000 000 76.90 000		1	0	0	0		
76. 07 03140 CARDI OLOGY 076.70 07697 CARDI AC REHABILITATI ON 127, 595 703 0 0 0 0 76. 00 76. 97 076. 97 07697 CARDI AC REHABILITATI ON 127, 595 703 0 0 0 0 0 76. 97 076. 97					-	-	
90. 00 09000 CLINIC 163, 306 870 0 195 0 90. 00	76. 00 03140 CARDI OLOGY						
90. 00 09000 CLINIC 163, 306 870 0 195 0 90. 00 91. 00 99. 00		127, 595	703	0	0	0	76. 97
91. 00		163, 306	870	0	195	0	90.00
95.00 OFFICE RELIMBURSABLE COST CENTERS 95.00 OFFICE RELIMBURSABLE COST CENTERS 100 OFFICE RELIMBURSABLE COST CENTERS 113.00 I 10100 HOME HEALTH AGENCY 1, 221, 728 2, 748 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 I 11300 I INTEREST EXPENSE 217, 956 744 0 0 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 62, 941, 385 163, 825 407, 995 42, 846 47, 618 118.00 NONRELIMBURSABLE COST CENTERS 190.00 1 90000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 27, 041 752 0 0 0 190.00 194.00 194.00 07950 OTHER NON-RELIMBURSABLE 116, 366 0 0 0 0 194.00 194.01 194.01 107951 MOB 5, 740, 574 52, 635 724 0 0 194.01 194.01 194.02 07952 PHYSI CI AN CLI NIC CS 8, 657, 442 27, 594 1, 642 0 0 194.01 194.02 07953 PHYSI CI AN CLI NIC CS 8, 657, 442 27, 594 1, 642 0 0 194.02 194.03 07953 PHYS PRAC BUS OFC 1, 507, 813 989 0 0 0 0 194.03 194.04 07954 MOB - MAIN CAMPUS 492, 305 0 0 0 6, 143 0194.04 194.05 07955 ONCOLOGY - NONRELIMBURSABLE 0 0 0 0 0 194.05 194.06 07956 KDH - MC FAMILLY PRACTICE 5, 137, 312 43, 146 17 0 0 194.05 194.06 07956 KDH - MC FAMILLY PRACTICE 5, 137, 312 43, 146 17 0 0 194.06 194.07 07957 KDH - MC GENERAL SURGERY 2, 025, 158 0 0 0 0 0 194.08 194.09 07959 KDH - MC GENERAL SURGERY 2, 025, 158 0 0 0 0 0 194.08 194.09 07959 KDH - MC ENT	91. 00 09100 EMERGENCY						91.00
95. 00							92.00
101.00 1010 HOME HEALTH AGENCY 1, 221, 728 2, 748 0 0 0 101.00 1		2, 314, 536	4. 732	5, 255	0	0	95. 00
113. 00 11600 11600 11600 HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) 62,941,385 163,825 407,995 42,846 47,618 118.00 119	101.00 10100 HOME HEALTH AGENCY						
116. 00 11600 HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) 62,941,385 163,825 407,995 42,846 47,618 118.00 NONREI MBURSABLE COST CENTERS							112 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 62, 941, 385 163, 825 407, 995 42, 846 47, 618 118. 00		217, 956	744	0	0	0	
190. 00 190. 0	118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1		407, 995	42, 846		
194. 00 07950 OTHER NON-REI MBURSABLE 116, 366 0 0 0 194. 00 194. 01 194. 01 194. 02 194. 01 194. 02 194. 02 194. 03 194. 04 194. 04 194. 05 194. 06 194. 07 19750 KDH - MC GENERAL SURGERY 194. 09 194.		27 041	752	0	٥	0	100 00
194. 01 07951 MOB 5, 740, 574 52, 635 724 0 0 194. 01 194. 02 07952 PHYSI CI AN CLI NI CS 8, 657, 442 27, 594 1, 642 0 0 194. 02 194. 03 07953 PHYS PRAC BUS OFC 1, 507, 813 989 0 0 0 194. 03 194. 04 07954 MOB - MAI N CAMPUS 492, 305 0 0 6, 143 0 194. 04 194. 05 07955 OCCOLOGY - NONREI MBURSABLE 0 0 0 0 0 0 194. 06 07956 KDH - MC FAMI LY PRACTI CE 5, 137, 312 43, 146 17 0 0 194. 05 194. 07 07957 KDH - MC ORTHOPEDI CS 3, 001, 069 0 364 0 0 194. 07 194. 08 07958 KDH - MC GENERAL SURGERY 2, 025, 158 0 1, 384 0 0 194. 08 194. 09 07959 KDH - MC ENT 699, 258 0 0 0 0 194. 09		1	752				
194. 03 07953 PHYS PRAC BUS OFC 1,507,813 989 0 0 0 194. 03 194. 04 07954 MOB - MAI N CAMPUS 492, 305 0 0 0 6,143 0 194. 04 194. 05 194. 06 07955 ONCOLOGY - NONREI MBURSABLE 0 0 0 0 0 194. 05 194. 06 07956 KDH - MC FAMI LY PRACTI CE 5, 137, 312 43, 146 17 0 0 194. 06 194. 07 07957 KDH - MC ORTHOPEDI CS 3, 001, 069 0 364 0 0 194. 07 194. 08 07958 KDH - MC GENERAL SURGERY 2, 025, 158 0 1, 384 0 0 194. 09 194. 09 194. 09 07959 KDH - MC ENT		1			0		
194. 04 07954 MOB - MAIN CAMPUS 492, 305 0 0 6, 143 0 194. 04 194. 05 07955 0NCOLOGY - NONREI MBURSABLE 0 0 0 194. 05 194. 06 194. 07 07957 KDH - MC ORTHOPEDI CS 3, 001, 069 0 194. 07 194. 08 07958 KDH - MC GENERAL SURGERY 2, 025, 158 0 1, 384 0 0 194. 08 194. 09 07959 KDH - MC ENT 699, 258 0 0 0 194. 09		1			0		
194. 05 07955 ONCOLOGY - NONREI MBURSABLE 0 0 0 0 194. 05 194. 06 07956 KDH - MC FAMI LY PRACTI CE 5, 137, 312 43, 146 17 0 0 194. 06 194. 07 07957 KDH - MC ORTHOPEDI CS 3, 001, 069 0 364 0 0 194. 07 194. 08 07958 KDH - MC GENERAL SURGERY 2, 025, 158 0 1, 384 0 0 194. 08 194. 09 07959 KDH - MC ENT 699, 258 0 0 0 0 194. 09		1	0 789	_	6. 143		
194. 07 07957 KDH - MC ORTHOPEDI CS 3, 001, 069 0 364 0 0 194. 07 194. 08 07958 KDH - MC GENERAL SURGERY 2, 025, 158 0 1, 384 0 0 194. 08 194. 09 07959 KDH - MC ENT 699, 258 0 0 0 0 194. 09	194.05 07955 ONCOLOGY - NONREIMBURSABLE	0	O	Ō	0	0	194. 05
194. 08 07958 KDH - MC GENERAL SURGERY 2, 025, 158 0 1, 384 0 0 194. 08 194. 09 07959 KDH - MC ENT 699, 258 0 0 0 194. 09					0		
194. 09 07959 KDH - MC ENT 699, 258 0 0 0 0 194. 09		l I	-		0		
194. 10 07960 KDH - MC UROLOGY 456, 964 0 0 0 194. 10	194.09 07959 KDH - MC ENT	699, 258	0	0	0	0	194. 09
	194. 10 07960 KDH - MC UROLOGY	456, 964	0	0	0	0	194. 10

Health Financial	Systems	KING'S DAUGHTERS'	HOSPI TAL		In Lieu	u of Form CMS-2552-10
COST ALLOCATION	- STATISTICAL BASIS		Provi der Co	CN: 15-0069	From 01/01/2019	Worksheet B-1 Date/Time Prepared:

				''	0 12/31/2017	5/21/2020 10:	
	Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		E & GENERAL	PLANT	LINEN SERVICE	(HOURS OF	(MEALS	
		(ACCUM.	(SQUARE	(POUNDS OF	SERVICE)	SERVED)	
		COST)	FEET)	LAUNDRY)			
		5. 00	7. 00	8. 00	9. 00	10.00	
194. 11	07961 KDH - MC OB/GYN	2, 894, 170	0	1, 800	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,	16, 340, 971	5, 547, 665	606, 853	1, 773, 622	1, 352, 822	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 174403	19. 199992	1. 466091	36. 204495	28. 409887	203. 00
204.00	Cost to be allocated (per Wkst. B,	1, 564, 688	1, 557, 307	86, 918	162, 451	277, 720	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 016699	5. 389706	0. 209984	3. 316071	5. 832248	205. 00
	11)						
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0069 Peri od: Worksheet B-1 From 01/01/2019 12/31/2019 Date/Time Prepared: 5/21/2020 10:03 am Cost Center Description CAFETERI A NURSI NG CENTRAL PHARMACY MEDI CAL ADMI NI STRATI O SERVICES & (COSTED RECORDS & (MEALS SERVED) Ν **SUPPLY** REQUIS.) LI BRARY (DI RECT (COSTED (GROSS NRSI NG HRS) REQUIS.) CHARGES) 11. 00 13. 00 14.00 15.00 16.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO 1.01 1 01 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10.00 11.00 01100 CAFETERI A 769, 024 11.00 13.00 01300 NURSING ADMINISTRATION 353, 799 13.00 01400 CENTRAL SERVICES & SUPPLY 5, 446 6, 479, 980 14.00 14.00 C 01500 PHARMACY 19, 622 15.00 C 34, 633 100 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 23, 903 6,748 0 280, 019, 463 16.00 C 01900 NONPHYSICIAN ANESTHETISTS 19.00 C 0 0 0 19.00 02300 RADI OLOGY SCHOOL 849 23.00 4, 245 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 142, 652 142, 652 145, 478 0 8, 790, 903 30.00 03100 INTENSIVE CARE UNIT 28, 993 28, 993 0 3,009,989 31.00 313 31.00 14, 937 04300 NURSERY 1, 441, 732 43.00 14.937 0 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 75, 484 75, 484 169, 216 24, 810, 414 50.00 51 00 05100 RECOVERY ROOM 8.018 8.018 2, 753 0 4, 459, 589 51 00 05200 DELIVERY ROOM & LABOR ROOM 0 1, 799, 931 52.00 19, 130 19, 130 0 52.00 53.00 05300 ANESTHESI OLOGY 6,523 11, 531 0 5, 170, 083 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 57, 876 0 62,663 0 0 6, 631, 943 54.00 03630 ULTRA SOUND 54 01 3 250 Ω 26 305 1, 830, 655 54 01 03450 NUCLEAR MEDICINE - DIAGNOSTIC 54.02 2, 181 C 1,870 5, 502, 953 54.02 05500 RADIOLOGY - THERAPEUTIC 55.00 55.00 0 0 0 0 55.01 03480 ONCOLOGY 28, 469 41, 579 6, 475, 570 55.01 05700 CT SCAN 121, 351 57 00 5 511 0 15, 663, 943 57 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 4, 181 0 16, 202 3, 945, 731 58.00 05900 CARDIAC CATHETERIZATION 0 59.00 59.00 60.00 06000 LABORATORY 75. 447 0 35, 287 0 0 30, 798, 051 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 1, 920, 068 62.00 Ω C 0 62.00 65.00 06500 RESPIRATORY THERAPY 22, 812 3,762 6, 873, 955 65.00 66.00 06600 PHYSI CAL THERAPY 44, 469 7, 293 0 0 8, 888, 497 66.00 06700 OCCUPATI ONAL THERAPY 1, 120, 867 67.00 4,676 0 67.00 263 06800 SPEECH PATHOLOGY 68.00 4, 222 0 832, 433 68 00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 0 03610 SLEEP LAB 69.01 0 1, 713, 855 69.01 3,649 56 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 0 2, 540, 075 8, 644, 924 71.00 71.01 07101 IV SOLUTIONS 0 0 93, 638 0 1, 220, 672 71.01 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 2, 784, 199 0 11, 730, 531 72.00 100 07300 DRUGS CHARGED TO PATIENTS 0 35, 552 73.00 73, 750, 136 73.00 0 76.00 03140 CARDI OLOGY 17.352 C 4, 191 0 11, 324, 733 76.00 07697 CARDIAC REHABILITATION 382 671, 096 76.97 3, 208 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 2.818 178 125, 948 90.00 91.00 09100 EMERGENCY 64, 585 64, 585 42, 402 0 25, 446, 581 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 95. 00 09500 AMBULANCE SERVICES 75, 365 6, 409 5, 423, 680 101.00 10100 HOME HEALTH AGENCY C 28, 794 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 0 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 769,024 353, 799 6, 223, 980 100 280, 019, 463 118. 00 NONREI MBURSABLE COST CENTERS 190, 00 19000 GLFT, FLOWER, COFFEE SHOP, & CANTEEN 0 190, 00 194. 00 07950 OTHER NON-REIMBURSABLE 0 0 194.00 0 0 1, 129 194. 01 07951 MOB 0 0 23, 728 0 0 194. 01 0 194. 02 07952 PHYSICIAN CLINICS 0 0 76, 478 0 194. 02 0 194. 03 07953 PHYS PRAC BUS OFC 8.049 0 194. 03 Ω 194. 04 07954 MOB - MAIN CAMPUS 0 0 8,662 0 0 194.04 194. 05 07955 ONCOLOGY - NONREI MBURSABLE o 0 194.05 0 0 0 0 194.06 07956 KDH - MC FAMILY PRACTICE 0 24 719 0 194.06 194. 07 07957 KDH - MC ORTHOPEDICS 0 34, 906 0 194.07 194.08 07958 KDH - MC GENERAL SURGERY 0 194.08 28.657 194. 09 07959 KDH - MC ENT 7,726 0 194. 09

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0069	Peri od:	Worksheet B-1

					rom 01/01/2019 o 12/31/2019	Date/Time Pre	pared.
						5/21/2020 10:	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(MEALS	ADMI NI STRATI O	SERVICES &	(COSTED	RECORDS &	
		SERVED)	N	SUPPLY	REQUIS.)	LI BRARY	
			(DI RECT	(COSTED		(GROSS	
			NRSING HRS)	REQUI S.)		CHARGES)	
		11. 00	13. 00	14. 00	15. 00	16. 00	
4	7960 KDH - MC UROLOGY	0	0	17, 545	0		194. 10
4	7961 KDH - MC OB/GYN	0	0	24, 401	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,	244, 655	765, 788	331, 180	1, 939, 395	1, 205, 434	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 318137	2. 164472	0. 051108	19, 393. 950000	0. 004305	203. 00
204.00	Cost to be allocated (per Wkst. B,	108, 015	94, 599	133, 906	128, 037	32, 517	204.00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 140457	0. 267381	0. 020665	1, 280. 370000	0. 000116	205.00
	11)						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

KING'S DAUGHTERS' HOSPITAL In Lieu of Form CMS-2552-10

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0069 Peri od: Worksheet B-1 From 01/01/2019 To 12/31/2019 Date/Time Prepared:

				10 12/31/2019 Date/lime 5/21/2020	
	Cost Center Description	NONPHYSI CI AN ANESTHETI STS (ASSI GNED TI ME)	RADI OLOGY SCHOOL (ASSI GNED TI ME)	372172020	10. 03 am
	CENEDAL CEDALCE COCT CENTEDO	19. 00	23. 00		
1 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT				1.00
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 5. 00 7. 00	OO400 EMPLOYEE BENEFITS DEPARTMENT OO500 ADMINISTRATIVE & GENERAL OO700 OPERATION OF PLANT				4. 00 5. 00 7. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG				8. 00 9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A				10.00
14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY				13. 00 14. 00 15. 00
16.00	01600 MEDI CAL RECORDS & LIBRARY 01900 NONPHYSI CI AN ANESTHETI STS	0			16. 00 19. 00
	02300 RADIOLOGY SCHOOL INPATIENT ROUTINE SERVICE COST CENTERS		1, 000		23. 00
30.00	03000 ADULTS & PEDIATRICS	0	0		30.00
	03100 INTENSIVE CARE UNIT 04300 NURSERY ANCILLARY SERVICE COST CENTERS	0	0		31. 00 43. 00
50. 00	05000 OPERATING ROOM	0	0		50.00
	05100 RECOVERY ROOM	0	o		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
	05300 ANESTHESI OLOGY	0	0		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 000		54.00
	03630 ULTRA SOUND	0	0		54. 01
54. 02 55. 00	03450 NUCLEAR MEDICINE - DIAGNOSTIC 05500 RADIOLOGY - THERAPEUTIC	0	0		54. 02 55. 00
55. 01	03480 ONCOLOGY		o		55. 01
57. 00	05700 CT SCAN		o		57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	O		58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		59.00
60.00	06000 LABORATORY	0	0		60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
	06500 RESPI RATORY THERAPY	0	0		65.00
66. 00 67. 00	06600 PHYSI CAL THERAPY	0	0		66.00
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0		68.00
	06900 ELECTROCARDI OLOGY		0		69. 00
	03610 SLEEP LAB		o		69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	l o	Ö		71.00
71. 01	07101 IV SOLUTIONS	0	o		71. 01
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
	03140 CARDI OLOGY	0	0		76.00
76. 97	O7697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0	0		76. 97
90 00	09000 CLINIC	0	0		90.00
	09100 EMERGENCY		o		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		-		92.00
	OTHER REIMBURSABLE COST CENTERS				
	09500 AMBULANCE SERVI CES	0	0		95.00
101.00	10100 HOME HEALTH AGENCY	0	0		101.00
110.00	SPECIAL PURPOSE COST CENTERS				110.00
	11300 INTEREST EXPENSE 11600 HOSPICE		0		113. 00 116. 00
118.00	l	0	1, 000		118.00
110.00	NONREI MBURSABLE COST CENTERS	<u> </u>	1,000		110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	O	0		190. 00
	07950 OTHER NON-REIMBURSABLE	0	o		194.00
	07951 MOB	0	О		194. 01
	07952 PHYSICIAN CLINICS	0	0		194. 02
	07953 PHYS PRAC BUS OFC	0	0		194. 03
	07954 MOB - MAIN CAMPUS	0	0		194. 04
	07955 ONCOLOGY - NONREI MBURSABLE	0	0		194. 05
	07956 KDH - MC FAMILY PRACTICE		0		194. 06 194. 07
	07957 KDH - MC ORTHOPEDICS 07958 KDH - MC GENERAL SURGERY	0	0		194.07
	07959 KDH - MC GENERAL SURGERY	0	0		194.08
	07960 KDH - MC UROLOGY	0	o		194. 10
		·	٩		1

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0069	Peri od: From 01/01/2019	Worksheet B-1 Date/Time Prepared:
			10 12/31/2017	E /21 /2020 10: 02 am

				5/21/2020 10:03 am	
	Cost Center Description	NONPHYSI CI AN	RADI OLOGY		Ī
		ANESTHETI STS	SCH00L		
		(ASSI GNED	(ASSI GNED		
		TIME)	TIME)		
		19. 00	23. 00		
194. 11 07961	KDH - MC OB/GYN	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,	0	194, 031	202.00)
	Part I)				
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	194. 031000	203.00)
204. 00	Cost to be allocated (per Wkst. B,	0	30, 778	204.00)
	Part II)				
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	30. 778000	205.00)
	11)				
206. 00	NAHE adjustment amount to be allocated		0	206. 00)
	(per Wkst. B-2)				
207. 00	NAHE unit cost multiplier (Wkst. D,		0. 000000	207.00)
	Parts III and IV)				

Health Financial Systems	KING'S DAUGHTERS' HOSPITAL		In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der 0	CCN: 15-0069		Worksheet C
			From 01/01/2019	
			To 10/01/2010	Data/Tima Droparado

Title XVIII Hospital PPS
Cost Center Description
Total Cost (from Wkst. B, Part I, col. 26) Total Costs B, Part I Costs B, Part I Costs Cost Center Description Total Costs Total Costs Disallowance D
(from Wkst. B, Part I, col. 26) 1.00 2.00 3.00 4.00 5.00
B, Part I, col. 26) 1.00 2.00 3.00 4.00 5.00
Col. 26
1.00 2.00 3.00 4.00 5.00
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 10,717,679 10,717,679 0 10,717,679 30.00 31.00 03100 INTENSIVE CARE UNIT 1,915,731 1,915,731 0 1,915,731 31.00 43.00 04300 NURSERY 927,736 927,736 927,736 43.00
30. 00 03000 ADULTS & PEDIATRICS 10, 717, 679 10, 717, 679 0 10, 717, 679 30. 00 31. 00 03100 INTENSI VE CARE UNI T 1, 915, 731 1, 915, 731 0 1, 915, 731 31. 00 43. 00 04300 NURSERY 927, 736 927, 736 0 927, 736 43. 00
31.00 03100 INTENSIVE CARE UNIT 1,915,731 1,915,731 0 1,915,731 31.00 43.00 04300 NURSERY 927,736 927,736 0 927,736 43.00
43. 00 04300 NURSERY 927, 736 927, 736 0 927, 736 43. 00
50. 00 05000 OPERATI NG ROOM 5, 204, 325 5, 204, 325 0 5, 204, 325 50. 00
51. 00 05100 RECOVERY ROOM 554, 327 554, 327 0 554, 327 51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 1, 060, 178 1, 060, 178 0 1, 060, 178 52. 00
53. 00 05300 ANESTHESI OLOGY 220, 129 220, 129 19, 746 239, 875 53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 4, 207, 288 4, 207, 288 0 4, 207, 288 54. 00
54. 01 03630 ULTRA SOUND 263, 971 0 263, 971 0 263, 971 54. 01
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 386, 638 386, 638 0 386, 638 54. 02
55. 00 05500 RADI OLOGY - THERAPEUTI C 0 0 0 55. 00
55. 01 03480 0NC0L0GY 3, 162, 779 3, 162, 779 27, 323 3, 190, 102 55. 01
57. 00 05700 CT SCAN 698, 361 698, 361 57. 00
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI)
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 59. 00
60. 00 06000 LABORATORY
1 11 11 11 11 11 11 11 11 11 11 11 11 1
65. 00 06500 RESPI RATORY THERAPY 1, 088, 361 0 1, 088, 361 0 1, 088, 361 65. 00
66. 00 06600 PHYSI CAL THERAPY 2, 764, 772 0 2, 764, 772 0 2, 764, 772 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY 382, 378 0 382, 378 0 382, 378 67. 00
68. 00 06800 SPEECH PATHOLOGY 269, 566 0 269, 566 0 269, 566 68. 00
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 69. 00
69. 01 03610 SLEEP LAB 383, 850 383, 850 0 383, 850 69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 3, 150, 106 3, 150, 106 0 3, 150, 106 71. 00
71. 01 07101 I V SOLUTI ONS 120, 010 120, 010 0 120, 010 71. 01
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 3, 462, 567 3, 462, 567 0 3, 462, 567 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 14, 046, 771 14, 046, 771 0 14, 046, 771 73. 00
76. 00 03140 CARDI OLOGY 1, 348, 084 1, 348, 084 0 1, 348, 084 76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON 167, 276 167, 276 0 167, 276 76. 97
OUTPATIENT SERVICE COST CENTERS
90. 00
91. 00 09100 EMERGENCY 4, 694, 521 4, 694, 521 511, 137 5, 205, 658 91. 00
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 2, 344, 179 2, 344, 179 2, 344, 179 2, 344, 179 2, 344, 179
OTHER REIMBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVI CES 2, 864, 409 2, 864, 409 133 2, 864, 542 95. 00
101.00 10100 HOME HEALTH AGENCY 1, 489, 035 1, 489, 035 1, 489, 035 1, 489, 035
SPECIAL PURPOSE COST CENTERS
113. 00 11300 I NTEREST EXPENSE 113. 00
116. 00 11600 HOSPI CE 270, 253 270, 253 116. 00
200.00 Subtotal (see instructions) 73,616,278 0 73,616,278 558,339 74,174,617 200.00
201. 00 Less Observation Beds 2, 344, 179 2, 344, 179 2, 344, 179 201. 00
202. 00 Total (see instructions) 71, 272, 099 0 71, 272, 099 558, 339 71, 830, 438 202. 00
202.00 101.01 (300 1.101.101.101.101.101.101.101.101.101

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lieu	ı of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0069	Peri od: From 01/01/2019	Worksheet C Part I

То 12/31/2019 Date/Time Prepared: 5/21/2020 10:03 am Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TEFRA + col. 7) Ratio I npati ent Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 8, 790, 903 30.00 03000 ADULTS & PEDIATRICS 8, 790, 903 30.00 31.00 03100 INTENSIVE CARE UNIT 3,009,989 3,009,989 31.00 1, 441, 732 1, 441, 732 43.00 43.00 04300 NURSERY ANCILLARY SERVICE COST CENTERS 0. 209764 50.00 5, 094, 893 19, 715, 521 24, 810, 414 0.000000 50.00 05000 OPERATING ROOM 3, 434, 015 51.00 05100 RECOVERY ROOM 1,025,574 4, 459, 589 0.124300 0.000000 51.00 0. 589010 52 00 05200 DELIVERY ROOM & LABOR ROOM 1, 778, 808 21, 123 1, 799, 931 0.000000 52 00 05300 ANESTHESI OLOGY 1, 806, 838 3, 363, 245 5, 170, 083 0.042577 0.000000 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 1, 202, 153 5, 429, 790 6, 631, 943 0.634397 0.000000 54 00 54.01 03630 ULTRA SOUND 226, 063 1,604,592 1,830,655 0.144195 0.000000 54.01 54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 357, 293 5, 145, 660 5, 502, 953 0.070260 0.000000 54.02 55 00 05500 RADI OLOGY - THERAPEUTI C 0.000000 0.000000 55 00 55.01 03480 ONCOLOGY 56, 325 6, 419, 245 6, 475, 570 0.488417 0.000000 55.01 05700 CT SCAN 13, 283, 494 0.044584 57 00 57 00 2, 380, 449 15, 663, 943 0.000000 05800 MAGNETIC RESONANCE I MAGING (MRI) 3, 682, 859 3, 945, 731 58.00 262, 872 0.115035 0.000000 58.00 05900 CARDI AC CATHETERI ZATI ON 59 00 0.000000 0.000000 59 00 06000 LABORATORY 5, 360, 252 25, 437, 799 30, 798, 051 0.143766 0.000000 60.00 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 996, 748 923, 320 1, 920, 068 0.183525 0.000000 62.00 06500 RESPIRATORY THERAPY 65.00 5.052.039 1,821,916 6, 873, 955 0.158331 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 688, 531 8, 199, 966 8, 888, 497 0.311051 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 279,000 841, 867 1, 120, 867 0.341145 0.000000 67.00 06800 SPEECH PATHOLOGY 117, 522 714, 911 0.323829 0.000000 68.00 832, 433 68.00 69 00 06900 FLECTROCARDI OLOGY 0 0.000000 0.000000 69 00 69.01 03610 SLEEP LAB 0 1, 713, 855 1, 713, 855 0.223969 0.000000 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 8, 644, 924 71.00 3, 969, 081 4, 675, 843 0.364388 0.000000 71.00 07101 IV SOLUTIONS 778.899 1, 220, 672 0.098315 0.000000 71.01 441, 773 71.01 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 5, 161, 002 6, 569, 529 11, 730, 531 0.295176 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 18, 621, 245 55, 128, 891 73, 750, 136 0.190464 0.000000 73.00 76.00 03140 CARDI OLOGY 1, 876, 336 9, 448, 397 11, 324, 733 0.119039 0.000000 76.00 76 97 07697 CARDIAC REHABILITATION 752 670, 344 671 096 0. 249258 0.000000 76 97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 125, 948 125, 948 1. 722925 0.000000 90.00 91.00 09100 EMERGENCY 4, 573, 295 20, 873, 286 25, 446, 581 0.184485 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 484, 966 2, 904, 238 3, 389, 204 0.691661 0.000000 92 00 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 5, 422, 457 5, 423, 680 0. 528130 0.000000 95.00 1, 223 101.00 10100 HOME HEALTH AGENCY 1, 621, 654 101 00 1, 621, 654 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 325, 526 325, 526 116.00 75, 394, 783 Subtotal (see instructions) 200 00 209, 961, 064 285, 355, 847 200 00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 75, 394, 783 209, 961, 064 285, 355, 847 202.00

Health Financial Systems KING'S DAUGHTERS' HOSPITAL In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0069
Period: From 01/01/2019 To 12/31/2019 Date/Time Prepared: 5/21/2020 10: 03 am

IMPATIENT ROUTINE SERVICE COST CENTERS 11.00					5/21/2020 10:03 am
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 ADULTS & PEDIATRICS 30.00 30.00 ADULTS & PEDIATRICS 31.00 31.00 AUGUST & PEDIATRICS 31.00 31.00 AUGUST & PEDIATRICS 31.00 AUGUST & AUGUST & AUGUST & AUGUST & 31.00 AUGUST & AUGU			Title XVIII	Hospi tal	PPS
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 303000 ADULTS & PEDIATRI CS 33.00 31.00	Cost Center Description	PPS Inpatient			
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 303000 ADULTS & PEDIATRICS 30.00 31.00	·	Ratio			
30.00 30000 ADULTS & PEDIATRICS 33.00 33.00 43.00 NITERSIVE CARE UNIT		11. 00			
30.00 30000 ADULTS & PEDIATRICS 33.00 33.00 43.00 NITERSIVE CARE UNIT	INPATIENT ROUTINE SERVICE COST CENTERS				
31.00 0.3100 INTERSIVE CARE UNIT 33.00 0.300 NURSERY 34.00 0.300 NURSERY 34.00 0.300 NURSERY 35.00 0.5000 OPERATI NG ROOM 0.209764 55.00 0.5100 RECOVERY ROOM 0.124300 51.00 0.5200 DELI VERY ROOM 0.124300 51.00 0.5200 DELI VERY ROOM 0.124300 52.00 0.5400 ALBOR ROOM 0.589010 52.00 0.5400 ALBOR ROOM 0.589010 52.00 0.5400 ALBOR ROOM 0.589010 0.5400 RADIOLOGY - DI AGNOSTI C 0.634397 54.00 0.5400 RADIOLOGY - DI AGNOSTI C 0.070260 54.01 0.3630 ULTRA SOUND 0.144195 54.01 0.5400 RADIOLOGY - THERAPEUTI C 0.00000 55.00 0.5500 RADIOLOGY - THERAPEUTI C 0.00000 55.00 0.5500 RADIOLOGY - THERAPEUTI C 0.00000 55.00 0.5500 RADIOLOGY - THERAPEUTI C 0.044584 57.00 57.00 0.5700 CT SCAN 57.00 0.5700 CT SCAN 57.00 0.5900 CREDIOLOGY - THERAPEUTI C 0.00000 0.5800 MAGNETI C RESONANCE I MAGI NN (MRI) 0.115035 58.00 0.5800 MAGNETI C RESONANCE I MAGI NN (MRI) 0.115035 58.00 0.6000 CARDI NA CATHETERI ZATI ON 0.00000 0.6000 CARDI NA CATHETERI ZATI ON 0.00000 0.6000 CARDI NA CATHETERI ZATI ON 0.00000 0.6000 PHYSI CAL THERERAY 0.14356 6.00 0.0000 0.6000 PHYSI CAL THERAPY 0.311051 66.00 0.00000 0.6000 0.6000 PHYSI CAL THERAPY 0.311051 0.00000 0.6000 0.6000 PHYSI CAL THERAPY 0.311051 0.000000 0.6					30.00
A3. 00 O4300 NURSERY					
ANCILLARY SERVICE COST CENTERS 50.00	l l				
50.00					10.00
51.00 05100 RECOVERY ROOM		0.209764			50.00
52.00 05200 DELI VERY ROOM & LABOR ROOM 0.589010 52.00 053.00 05300 ABSTHESI OLOGY 0.04397 53.00 054.00 05400 RADI OLOGY-DI AGNOSTI C 0.634397 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.634397 54.00 054.00 03630 ULTRA SOUND 0.144195 54.01 03630 ULTRA SOUND 54.01 0.070260 54.02 0.0550 NADI OLOGY - THERAPEUTI C 0.000000 55.00 05500 RADI OLOGY - THERAPEUTI C 0.000000 55.01 03480 0NCOLOGY - THERAPEUTI C 0.000000 55.01 03480 0NCOLOGY - THERAPEUTI C 0.000000 55.01 03480 0NCOLOGY - THERAPEUTI C 0.000000 0.5700 0.		1			
53.00 05300 ARSTHESI OLOGY 0.046397 53.00 05400 RADIOLOGY-DI AGNOSTI C 0.634397 54.00 54.00 05400 RADIOLOGY-DI AGNOSTI C 0.634397 54.00 54.01 03630 ULTRA SOUND 0.144195 54.01 54.01 54.02 03450 NUCLEAR MEDICI NE - DI AGNOSTI C 0.000000 55.00 55.00 05500 RADIOLOGY - THERAPEUTI C 0.000000 55.00 55.00 03500 RADIOLOGY - THERAPEUTI C 0.004584 55.01 57.00 57.00 57.00 57.00 57.00 CT SCAN 57.00 5		1			
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54. 02 03450 NUCLEAR MEDI CINE - DI AGNOSTI C 0. 070260 55. 00 05500 RADIOLOGY - THERAPEUTI C 0. 000000 55. 00 05500 RADIOLOGY - THERAPEUTI C 0. 000000 55. 00 05500 RADIOLOGY - THERAPEUTI C 0. 000000 55. 00 05700 CT SCAN 0. 492636 55. 01 03480 0NCOLOGY 0. 492636 55. 01 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0. 115035 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0. 115035 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0. 113056 59. 00 06000 LABORATORY 0. 143766 0. 000000 06000 LABORATORY 0. 143766 0. 000 06000 LABORATORY 0. 143766 0. 000 06000 LABORATORY 0. 183525 0. 00000 06000 RASPI RATORY THERAPY 0. 111051 0. 000000 06000 RASPI RATORY THERAPY 0. 111051 0. 000000 06000 RASPI RATORY THERAPY 0. 111051 0. 000000 06000 06000 CUPATI ONAL THERAPY 0. 341145 0. 0000000 0. 0000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000	• • • • • • • • • • • • • • • • • • •	1			
55. 00 05500 RADIOLOGY - THERAPEUTI C 0. 000000 55. 01 55. 01 03480 ONCOLOGY 0. 492636 55. 01 57. 00 05700 CT SCAN 0. 044584 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0. 115035 58. 00 59. 00 05900 CARDIA C CATHETERI ZATI ON 0. 000000 59. 00 60. 00 06000 LABORATORY 0. 143766 60. 00 62. 00 06200 MILLE BLOOD & PACKED RED BLOOD CELLS 0. 183525 62. 00 65. 00 06500 RESPI RATORY THERAPY 0. 183351 65. 00 66. 00 06600 PIYSI CAL THERAPY 0. 311051 66. 00 67. 00 06700 DCCUPATI ONAL THERAPY 0. 341145 67. 00 68. 00 06900 ELECTROCARDI OLOGY 0. 323829 68. 00 69. 01 03610 SLEEP LAB 0. 223969 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 364388 71. 01 71. 01 07101 IV SOLUTI ONS 0. 998315 71. 01 72. 00 07200 I IMPL. DEV. CHARGED TO PATI ENTS 0. 2949258 76. 00 76. 07 07697 CARDI AC REHABI LI TATI ON 0. 249258 76. 00 70. 00 09000 QUILDI IN C 1. 722925 91. 00 90. 00 <td></td> <td></td> <td></td> <td></td> <td></td>					
55. 01 03480 0NCOLOGY 0. 492636 55. 01 57. 00 05700 CT SCAN 0. 492636 55. 01 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0. 115035 58. 00 59. 00 05900 CARDIAC CATHETERIZATION 0. 000000 60. 00 06000 LABORATORY 0. 143766 60. 00 60. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0. 183525 62. 00 65. 00 06500 RESPIRATORY THERAPY 0. 311051 66. 00 66. 00 06600 PHYSI CAL THERAPY 0. 311051 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0. 341145 67. 00 68. 00 06600 SPEECH PATHOLOGY 0. 323829 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 000000 69. 00 69. 01 03610 SLEEP LAB 0. 223969 69. 01 71. 00 07100 MBCI CAL SUPPLIES CHARGED TO PATIENTS 0. 364388 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0. 295176 72. 00 70. 00 07300 DRUGS CHARGED TO PATIENTS 0. 190464 73. 00 76. 97 07697 CARDIAC REHABILITATION 0. 249258 76. 97 90. 00 09000 CLINIC 0. 119039 76. 97 90. 00 09000 CLINIC 0. 119039 76. 97 90. 00 09000 CLINIC 0. 12925 0. 204572 91. 00 90. 00 09000 CLINIC 0. 528155 95. 00 10. 00 10100 HOME HEALTH AGENCY 91. 00 59. 00 09000 MAGNETIC REMBINE 113. 00 113. 00 11300 INTEREST EXPENSE 113. 00 113. 00 11500 HOSTREST EXPENSE 113. 00		1			
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65. 00 06500 RESPI RATORY THERAPY 0. 158331 66. 00 66. 00 06600 PHYSI CAL THERAPY 0. 311051 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0. 341145 67. 00 06800 SPECH PATHOLOGY 0. 323829 68. 00 06900 ELECTROCARDI OLOGY 0. 000000 69. 00 69. 00 69. 01 03610 SLEEP LAB 0. 223969 69. 01 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 364388 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 098315 71. 01 07101 IV SOLUTI ONS 0. 098315 71. 01 07101 IV SOLUTI ONS 0. 295176 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 190464 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 190464 73. 00 03140 CARDI OLOGY 0. 119039 76. 00 76. 97 00000 CLI IN C 0. 00000 CLI IN C 0. 000000 0. 00000 0. 00000 0. 00000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000	60. 00 06000 LABORATORY	0. 143766			60.00
66. 00 06600 PHYSI CAL THERAPY 0. 311051 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0. 341145 67. 00 68. 00 6800 SPEECH PATHOLOGY 0. 323829 68. 00 69. 00 69. 00 ELECTROCARDI OLOGY 0. 000000 69. 00 69. 01 03610 SLEEP LAB 0. 223969 69. 01 07. 00 07. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 364388 71. 00 07. 10 1 V SOLUTI ONS 0. 098315 71. 01 07. 10 1 V SOLUTI ONS 0. 098315 72. 00 07. 200 IMPL DEV. CHARGED TO PATI ENTS 0. 295176 72. 00 07. 200 DRUGS CHARGED TO PATI ENTS 0. 190464 72. 00 07.	62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 183525			62.00
67. 00 06700 OCCUPATI ONAL THERAPY 0.341145 67. 00 68. 00 O6800 SPEECH PATHOLOGY 0.323829 68. 00 06900 ELECTROCARDI OLOGY 0.000000 69. 00 03610 SLEEP LAB 0.223969 69. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.364388 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.098315 71. 01 07101 IV SOLUTI ONS 0.098315 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0.190464 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0.190464 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.190464 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.190464 73. 00 07400 CARDI OLOGY 0.119039 76. 00 07697 CARDI AC REHABI LI TATI ON 0.249258 76. 97 00000 CLI NI C 0.00000 0.00000 0.0000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.00000000	65. 00 06500 RESPIRATORY THERAPY	0. 158331			65.00
68. 00 06800 SPEECH PATHOLOGY 0. 323829 68. 00 69. 00 69. 00 6	66. 00 06600 PHYSI CAL THERAPY	0. 311051			66.00
69. 00 06900 ELECTROCARDI OLOGY 0. 000000 69. 01 03610 SLEEP LAB 0. 223969 69. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 364388 71. 00 07101 IV SOLUTI ONS 0. 098315 71. 01 07101 IV SOLUTI ONS 0. 098315 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 190464 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 190464 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 190464 73. 00 07400 CARDI OLOGY 0. 119039 76. 00 00 00 00 CLI NI C 0. 1. 722925 0. 00 09000 CLI NI C 0. 249258 0. 204572 90. 00 09100 EMERGENCY 0. 204572 90. 00 09100 EMERGENCY 0. 204572 91. 00 09100 EMERGENCY 0. 204572 91. 00 09100 EMERGENCY 0. 204572 92. 00 09200 DRSERVATI ON BEDS (NON-DI STI NCT PART) 0. 691661 01. 00 07400 HOME HEALTH AGENCY 0. 528155 95. 00 07500 AMBULANCE SERVI CES 0. 528155 95. 00 113. 00 11300 INTEREST EXPENSE 113. 00 11300 INTEREST EXPENSE 113. 00 11300 INTEREST EXPENSE 116. 00	67. 00 06700 OCCUPATI ONAL THERAPY	0. 341145			67.00
69. 00 06900 ELECTROCARDI OLOGY 0. 000000 69. 01 03610 SLEEP LAB 0. 223969 69. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 364388 71. 00 07101 IV SOLUTI ONS 0. 098315 71. 01 07101 IV SOLUTI ONS 0. 098315 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 190464 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 190464 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 190464 73. 00 07400 CARDI OLOGY 0. 119039 76. 00 00 00 00 CLI NI C 0. 1. 722925 0. 00 09000 CLI NI C 0. 249258 0. 204572 90. 00 09100 EMERGENCY 0. 204572 90. 00 09100 EMERGENCY 0. 204572 91. 00 09100 EMERGENCY 0. 204572 91. 00 09100 EMERGENCY 0. 204572 92. 00 09200 DRSERVATI ON BEDS (NON-DI STI NCT PART) 0. 691661 01. 00 07400 HOME HEALTH AGENCY 0. 528155 95. 00 07500 AMBULANCE SERVI CES 0. 528155 95. 00 113. 00 11300 INTEREST EXPENSE 113. 00 11300 INTEREST EXPENSE 113. 00 11300 INTEREST EXPENSE 116. 00	68. 00 06800 SPEECH PATHOLOGY	0. 323829			68.00
69. 01 03610 SLEEP LAB 0. 223969 69. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 364388 71. 00 71. 01 07101 IV SOLUTIONS 0. 098315 71. 01 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 295176 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 190464 73. 00 76. 00 03140 CARDI OLOGY 0. 119039 76. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0. 249258 76. 97 0UTPATIENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 1. 722925 91. 00 91. 00 09100 EMERGENCY 0. 204572 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0. 691661 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 0. 528155 95. 00 101. 00 11600 HOME HEALTH AGENCY 113. 00 113. 00 11300 I NTEREST EXPENSE 113. 00 116. 00 11600 HOSPI CE 116. 00					
71. 00	69. 01 03610 SLEEP LAB	1			69. 01
71. 01 07101 IV SOLUTIONS 0. 098315 71. 01 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 295176 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 190464 73. 00 76. 00 03140 CARDI OLOGY 0. 119039 76. 00 76. 97 07697 CARDI AC REHABILITATION 0. 249258 76. 97 00TPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 1. 722925 91. 00 91. 00 09100 EMERGENCY 0. 204572 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 691661 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0. 528155 95. 00 101. 00 10100 HOME HEALTH AGENCY 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 116. 00 11600 HOSPICE 116. 00					
72. 00					
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 190464 73. 00 76. 00 03140 CARDI OLOGY 0. 119039 76. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0. 249258 76. 97 OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLI NI C 1. 722925 91. 00 91. 00 09100 EMERGENCY 0. 204572 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0. 691661 92. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 0. 528155 95. 00 101. 00 10100 HOME HEALTH AGENCY 97. 00 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 116. 00 11600 HOSPI CE 116. 00					
76. 00	l l				
76. 97 O7697 CARDI AC REHABI LI TATI ON O. 249258 76. 97 OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 1. 722925 90. 00 91. 00 09100 EMERGENCY 0. 204572 91. 00 O9200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0. 691661 92. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 0. 528155 95. 00 101. 00 10100 HOME HEALTH AGENCY SPECI AL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 116. 00 11600 HOSPI CE 116. 00		1			
OUTPATI ENT SERVI CE COST CENTERS 90. 00					
90. 00		0. 247230			70. 77
91. 00		1 722025			90.00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0. 691661 92. 00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 0. 528155 95. 00 101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 116. 00 11600 HOSPI CE 116. 00					
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 0. 528155 95. 00 101.00 10100 HOME HEALTH AGENCY 101.00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 116.00 HOSPI CE 116. 00 116.00					
95. 00		0.091001			92.00
101.00		0 520155			05.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 116. 00 11600 HOSPI CE 116. 00		U. 528155			I
113. 00 11300 INTEREST EXPENSE					101.00
116. 00 11600 HOSPI CE 116. 00					
200.00 Subtotal (see instructions)					
	1 1				
201.00 Less Observation Beds 201.00					
202.00 Total (see instructions) 202.00	202.00 Total (see instructions)				202.00

Health Financial Systems	KING'S DAUGHTERS' HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-00	
		From 01/01/2019 Part I
		To 12/21/2010 Date/Time Drenared

				o 12/31/2019	Date/Time Pre 5/21/2020 10:	pared:
		Ti +I	e XIX	Hospi tal	Cost	US alli
		11 (1	C XIX	Costs	0031	
Cost Center Description	Total Cost (from Wkst. B, Part I,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	col . 26)					
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	10, 717, 679		10, 717, 679	0	10, 717, 679	30.00
31. 00 03100 NTENSI VE CARE UNI T	1, 915, 731		1, 915, 731			
43. 00 04300 NURSERY	927, 736		927, 736			
ANCI LLARY SERVI CE COST CENTERS	721,130		721, 130	,	721, 130	45.00
50. 00 05000 OPERATING ROOM	5, 204, 325		5, 204, 325	0	5, 204, 325	50.00
51. 00 05100 RECOVERY ROOM						1
	554, 327		554, 327		554, 327	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 060, 178		1, 060, 178		1, 060, 178	
53. 00 05300 ANESTHESI OLOGY	220, 129		220, 129		239, 875	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 207, 288		4, 207, 288		4, 207, 288	
54. 01 03630 ULTRA SOUND	263, 971		263, 971		263, 971	
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	386, 638		386, 638		386, 638	
55. 00 05500 RADI OLOGY - THERAPEUTI C	0		(, I	0	55.00
55. 01 03480 ONCOLOGY	3, 162, 779		3, 162, 779	27, 323	3, 190, 102	55. 01
57. 00 05700 CT SCAN	698, 361		698, 361	0	698, 361	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	453, 899		453, 899	0	453, 899	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		(0	0	59.00
60. 00 06000 LABORATORY	4, 427, 719		4, 427, 719	0	4, 427, 719	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	352, 381		352, 381		352, 381	
65. 00 06500 RESPIRATORY THERAPY	1, 088, 361	0			1, 088, 361	
66. 00 06600 PHYSI CAL THERAPY	2, 764, 772	0			2, 764, 772	1
67. 00 06700 OCCUPATI ONAL THERAPY	382, 378		_, ,		382, 378	
68. 00 06800 SPEECH PATHOLOGY	269, 566		269, 566		269, 566	
69. 00 06900 ELECTROCARDI OLOGY	207, 300	0	207, 300	o o	207, 300	69.00
69. 01 03610 SLEEP LAB	383, 850		383, 850	-	383, 850	
	· ·					1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 150, 106		3, 150, 106		3, 150, 106	
71. 01 07101 I V SOLUTIONS	120, 010		120, 010		120, 010	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 462, 567		3, 462, 567		3, 462, 567	
73.00 07300 DRUGS CHARGED TO PATIENTS	14, 046, 771		14, 046, 771		14, 046, 771	
76. 00 03140 CARDI OLOGY	1, 348, 084		1, 348, 084		1, 348, 084	1
76. 97 O7697 CARDI AC REHABI LI TATI ON	167, 276		167, 276	0	167, 276	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	216, 999		216, 999	0	216, 999	90.00
91. 00 09100 EMERGENCY	4, 694, 521		4, 694, 521	511, 137	5, 205, 658	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 344, 179		2, 344, 179		2, 344, 179	92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES	2, 864, 409		2, 864, 409	133	2, 864, 542	95.00
101.00 10100 HOME HEALTH AGENCY	1, 489, 035		1, 489, 035		1, 489, 035	101.00
SPECIAL PURPOSE COST CENTERS	.,,		.,,		.,,	1
113. 00 11300 INTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	270, 253		270, 253		270, 253	
200.00 Subtotal (see instructions)	73, 616, 278	l e				
201.00 Less Observation Beds	2, 344, 179		2, 344, 179		2, 344, 179	
		l e				
202.00 Total (see instructions)	71, 272, 099	ı	71, 272, 099	558, 339	/ 1, 830, 438	12U2. UU

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0069	Peri od:	Worksheet C

To 12/31/2019 | Date/Time Prepared: 5/21/2020 10:03 am Title XIX Hospi tal Cost Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent **TEFRA** + col. 7) Ratio Inpati ent Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 8, 790, 903 30.00 03000 ADULTS & PEDIATRICS 8, 790, 903 30.00 31.00 03100 INTENSIVE CARE UNIT 3,009,989 3,009,989 31.00 04300 NURSERY 1, 441, 732 1, 441, 732 43.00 43.00 ANCILLARY SERVICE COST CENTERS 0. 209764 50.00 5, 094, 893 19, 715, 521 24, 810, 414 0.000000 50.00 05000 OPERATING ROOM 3, 434, 015 51.00 05100 RECOVERY ROOM 1,025,574 4, 459, 589 0.124300 0.000000 51.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 1, 778, 808 21, 123 1, 799, 931 0.589010 0.000000 52 00 05300 ANESTHESI OLOGY 1, 806, 838 3, 363, 245 5, 170, 083 0.042577 0.000000 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 1, 202, 153 5, 429, 790 6, 631, 943 0.634397 0.000000 54 00 54.01 03630 ULTRA SOUND 226, 063 1,604,592 1,830,655 0.144195 0.000000 54.01 54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 357, 293 5, 145, 660 5, 502, 953 0.070260 0.000000 54.02 05500 RADIOLOGY - THERAPEUTIC 55 00 0.000000 0.000000 55 00 55.01 03480 ONCOLOGY 56, 325 6, 419, 245 6, 475, 570 0.488417 0.000000 55.01 05700 CT SCAN 13, 283, 494 57 00 57 00 2, 380, 449 15, 663, 943 0.044584 0.000000 05800 MAGNETIC RESONANCE I MAGING (MRI) 3, 682, 859 3, 945, 731 58.00 262, 872 0.115035 0.000000 58.00 05900 CARDI AC CATHETERI ZATI ON 59 00 0.000000 0.000000 59 00 06000 LABORATORY 5, 360, 252 25, 437, 799 30, 798, 051 0.143766 0.000000 60.00 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 996, 748 923, 320 1, 920, 068 0.183525 0.000000 62.00 06500 RESPIRATORY THERAPY 65.00 5, 052, 039 1,821,916 6, 873, 955 0.158331 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 688, 531 8, 199, 966 8, 888, 497 0.311051 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 279,000 841, 867 1, 120, 867 0.341145 0.000000 67.00 06800 SPEECH PATHOLOGY 117, 522 714, 911 0.323829 0.000000 68.00 832, 433 68.00 69 00 06900 FLECTROCARDI OLOGY 0 0.000000 0.000000 69 00 69.01 03610 SLEEP LAB 0 1, 713, 855 1, 713, 855 0.223969 0.000000 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 8, 644, 924 71.00 3, 969, 081 4, 675, 843 0.364388 0.000000 71.00 07101 IV SOLUTIONS 778.899 1, 220, 672 0.098315 0.000000 71.01 441, 773 71.01 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 5, 161, 002 6, 569, 529 11, 730, 531 0.295176 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 18, 621, 245 55, 128, 891 73, 750, 136 0.190464 0.000000 73.00 76.00 03140 CARDI OLOGY 1, 876, 336 9, 448, 397 11, 324, 733 0.119039 0.000000 76.00 670, 344 76 97 07697 CARDIAC REHABILITATION 752 671 096 0. 249258 0.000000 76 97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 125, 948 125, 948 1. 722925 0.000000 90.00 91.00 09100 EMERGENCY 4, 573, 295 20, 873, 286 25, 446, 581 0.184485 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 484, 966 2, 904, 238 3, 389, 204 0.691661 0.000000 92 00 92.00 OTHER REIMBURSABLE COST CENTERS 5, 422, 457 5, 423, 680 95. 00 09500 AMBULANCE SERVICES 0. 528130 0.000000 95.00 1, 223 101.00 10100 HOME HEALTH AGENCY 1, 621, 654 101.00 1, 621, 654 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 325, 526 325, 526 116.00 75, 394, 783 Subtotal (see instructions) 200 00 209, 961, 064 285, 355, 847 200 00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 75, 394, 783 209, 961, 064 285, 355, 847 202.00

Health Financial Systems KING'S DAUGHTERS' HOSPITAL In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0069 | Period: From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: 5/21/2020 10: 03 am

				5/21/2020 10:03 am
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43.00
ANCI LLARY SERVI CE COST CENTERS				10.00
50. 00 05000 OPERATING ROOM	0. 000000			50.00
51. 00 05100 RECOVERY ROOM	0. 000000			51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0. 000000			52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
· · · · · · · · · · · · · · · · · · ·	1 1			54.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 03630 ULTRA SOUND	0. 000000 0. 000000			54.00
1				
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 000000			54. 02
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 000000			55. 00
55. 01 03480 0NC0L0GY	0. 000000			55. 01
57. 00 05700 CT SCAN	0. 000000			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
60. 00 06000 LABORATORY	0. 000000			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
69. 01 03610 SLEEP LAB	0. 000000			69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
71. 01 07101 IV SOLUTIONS	0. 000000			71. 01
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
76. 00 03140 CARDI OLOGY	0. 000000			76.00
76. 97 07697 CARDI OLOGI 76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76. 97
OUTPATIENT SERVICE COST CENTERS	0.000000			70. 47
90. 00 09000 CLINI C	0.000000			90.00
	0. 000000			90.00
	0.000000			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS	0.000000			05.00
95. 00 09500 AMBULANCE SERVI CES	0. 000000			95.00
101. 00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113.00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00

Health Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der CO		Peri od:	Worksheet D	
				From 01/01/2019 To 12/31/2019		narod:
				10 12/31/2019	5/21/2020 10:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2, 176, 890		2, 176, 89			
31.00 INTENSIVE CARE UNIT	128, 570		128, 57			
43. 00 NURSERY	101, 410		101, 41			
200.00 Total (lines 30 through 199)	2, 406, 870		2, 406, 87	14, 010		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	4, 715	•			ļ	30.00
31.00 INTENSIVE CARE UNIT	698	68, 767			ļ	31.00
43. 00 NURSERY	0	0			ļ	43.00
200.00 Total (lines 30 through 199)	5, 413	957, 497				200. 00

Health Financial Systems	KING'S DAUGHTE	RS' HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Period: From 01/01/2019 To 12/31/2019		pared:
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	t Inpatient Program Charges	Capital Costs (column 3 x column 4)	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM	883, 618 69, 436		•	,	73, 394 5, 930	1

Cost Center Description	Capi tal	Total Charges	Ratio of Cost	I npati ent	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	883, 618			2, 060, 751	73, 394	50.00
51.00 05100 RECOVERY ROOM	69, 436	4, 459, 589		380, 869	5, 930	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	27, 228		0. 015127	4, 734	72	52.00
53. 00 05300 ANESTHESI OLOGY	9, 870			442, 003	844	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	521, 628	6, 631, 943	0. 078654	753, 600	59, 274	54.00
54.01 03630 ULTRA SOUND	6, 567	1, 830, 655	0. 003587	106, 098	381	54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	26, 634	5, 502, 953	0.004840	222, 795	1, 078	54.02
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0	0.000000	0	0	55.00
55. 01 03480 ONCOLOGY	564, 468	6, 475, 570	0. 087169	41, 147	3, 587	55.01
57. 00 05700 CT SCAN	53, 806	15, 663, 943	0. 003435	1, 436, 993	4, 936	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	52, 890	3, 945, 731	0. 013404	149, 839	2, 008	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.000000	0	0	59.00
60. 00 06000 LABORATORY	336, 494	30, 798, 051	0. 010926	3, 157, 451	34, 498	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	16, 576	1, 920, 068	0. 008633	599, 812	5, 178	62.00
65. 00 06500 RESPIRATORY THERAPY	68, 194	6, 873, 955	0. 009921	3, 279, 543	32, 536	65.00
66. 00 06600 PHYSI CAL THERAPY	560, 076			421, 637	26, 568	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	64, 465			161, 265		67.00
68. 00 06800 SPEECH PATHOLOGY	18, 254			81, 432	1, 786	68.00
69. 00 06900 ELECTROCARDI OLOGY	0			0	0	69.00
69. 01 03610 SLEEP LAB	42, 545	1, 713, 855	0. 024824	0	0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	95, 911	8, 644, 924		1, 657, 583	18, 389	71.00
71. 01 07101 IV SOLUTIONS	3, 641	1, 220, 672		543, 911	1, 622	71. 01
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	105, 387			2, 097, 582	18, 845	
73.00 07300 DRUGS CHARGED TO PATIENTS	305, 020			9, 078, 747	37, 550	73.00
76. 00 03140 CARDI OLOGY	274, 389			1, 162, 378		76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	31, 736			121	6	76. 97
OUTPATIENT SERVICE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,	, , , , , ,				
90. 00 09000 CLI NI C	39, 762	125, 948	0. 315702	0	0	90.00
91. 00 09100 EMERGENCY	687, 123			2, 706, 465	73, 083	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	476, 131			365, 281	51, 317	92.00
OTHER REIMBURSABLE COST CENTERS		, , =		, = v .		- -
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50 through 199)	5, 341, 849	264, 742, 363		30, 912, 037	490, 320	
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		, , . ,	1			

Health Financial Systems	KING'S DAUGHTE	RS' HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS	TS Provider C	1	Period: From 01/01/2019 Fo 12/31/2019		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng School Post-Stepdown Adj ustments	Nursi ng School		Allied Health Cost	All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0 0 0	0 0 0 0	(0 0 0 0	31.00
Cost Center Description		Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	(col. 5 ÷ col. 6)	Inpatient Program Days	
LUDATI ENT. DOUTLINE OFFICE OF COST. OFFITEDO	4. 00	5. 00	6. 00	7. 00	8. 00	
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 43.00 04300 NURSERY 200.00 Total (Lines 30 through 199)	0	0 0 0	1, 309 1, 156	0. 00 6 0. 00	698 0	31.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 43. 00 04300 NURSERY 200. 00 Total (lines 30 through 199)	0 0 0					30. 00 31. 00 43. 00 200. 00

Health Financial Systems	KING'S DAUGHTERS' HOS	SPI TAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS Prov		od: 01/01/2019 12/31/2019 Worksheet D Part IV Date/Time Prepared: 5/21/2020 10:03 am

					10 12/31/2019	5/21/2020 10:	
			Title	: XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	·	Anesthetist	School	School	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0	0	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
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	194, 031	54.00
	03630 ULTRA SOUND	0	0		0	0	54. 01
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0		0	0	54.02
55.00	05500 RADI OLOGY - THERAPEUTI C	0	0		0	0	55.00
55. 01	03480 ONCOLOGY	0	0		0	0	55. 01
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	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		0	0	69.00
69. 01	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	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		0 0	0	90.00
	09100 EMERGENCY	0	0		0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	0	0	1	0 0	194, 031	200.00

Health Financial Systems	KING'S DAUGHTERS' HOSF	PITAL In Li	eu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Prov	ider CCN: 15-0069 Period:	Worksheet D
THROUGH COSTS		From 01/01/201	9 Part IV

THROUGH COSTS				o 12/31/2019	Date/Time Pre 5/21/2020 10:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)			
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	(24, 810, 414	0.000000	
51.00 05100 RECOVERY ROOM	0	0	C	4, 459, 589	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	C	1, 799, 931	0.000000	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	C	5, 170, 083	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	194, 031	194, 031	6, 631, 943	0. 029257	54.00
54. 01 03630 ULTRA SOUND	0	0	C	1, 830, 655	0.000000	54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0		5, 502, 953	0.000000	54.02
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0	(0	0.000000	55.00
55. 01 03480 ONCOLOGY	0	0	(6, 475, 570	0.000000	55. 01
57. 00 05700 CT SCAN	0	0	(15, 663, 943	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		3, 945, 731	0.000000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0.000000	59.00
60. 00 06000 LABORATORY	0	0		30, 798, 051	0.000000	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	1 0	1, 920, 068	0. 000000	62.00
65. 00 06500 RESPIRATORY THERAPY	0	0	1 0	6, 873, 955	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		8, 888, 497	0. 000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		1, 120, 867		1
68.00 06800 SPEECH PATHOLOGY	0	0		832, 433		1
69. 00 06900 ELECTROCARDI OLOGY	0	0			0.000000	
69. 01 03610 SLEEP LAB	0	0		1, 713, 855	0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0.000000	1
71. 01 07101 IV SOLUTIONS	0	0	l	1, 220, 672	0. 000000	71.01
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			0.000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		1		1
76. 00 03140 CARDI OLOGY	0	0	Ċ	1		1
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	ď			
OUTPATIENT SERVICE COST CENTERS	-					1
90. 00 09000 CLINIC	0	0	C	125, 948	0.000000	90.00
91. 00 09100 EMERGENCY	Ö	1		1	0. 000000	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	Ö					1
OTHER REIMBURSABLE COST CENTERS				,, 201	2.223000	1
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50 through 199)	0	194, 031	194, 031	264, 742, 363		200.00
	1				•	

Health Financial Systems	KI NG'	S DAUGHTERS	' HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE	OTHER PASS	Provi der	CCN: 15-0069	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Pre 5/21/2020 10:	
			Ti tl	e XVIII	Hospi tal	PPS	
Cost Contor Doscription	Out	nationt	Innationt	Innationt	Outpationt	Outpationt	

Title XVIII Hospital PPS Hospital PPS PPS Hospital PPS Hospital Program Pr						, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	5/21/2020 10:	
Ratio of Cost to Charges to Charges (col. 6 + col. 7) Program (Charges (col. 8 + col. 7) Program (Charges (col. 8 + col. 7) Program (Charges (col. 8 + col. 10) Program (Charges (col. 9 + col. 12) Program (Charges (col. 9 + col. 10) Program (Charges (col. 10) Program (Char				Title	XVIII	Hospi tal	PPS	
Charges		Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
Col. 6 Col. 7 Col. 10 Col. 10 Col. 12 Col. 1		·	Ratio of Cost	Program	Program	Program	Program	
ANCILLARY SERVICE COST CENTERS			to Charges	Charges	Pass-Through	Charges	Pass-Through	
ANCILLARY SERVICE COST CENTERS 9.00 10.00 11.00 12.00 13.00			(col. 6 ÷	ŭ	Costs (col. 8	ŭ	Costs (col. 9	
ANCILLARY SERVICE COST CENTERS			col. 7)		x col. 10)		x col. 12)	
SO 00			9. 00	10. 00	11. 00	12.00	13. 00	
51.00 05100 RECOVERY ROOM 0.000000 380,869 0 1,029,056 0 51.00		ANCILLARY SERVICE COST CENTERS						
52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 4.734 0 0 0 52.00	50.00	05000 OPERATING ROOM	0. 000000	2, 060, 751	0	6, 345, 086	0	50.00
53.00 05300 AMESTHESI OLOGY 0.000000 442, 003 0 764, 490 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.00257 753, 600 22, 048 1, 443, 262 42, 226 54.00 54.01 03630 ULTRA SOUND 0.000000 106, 098 0 369, 549 0 54.01 54.02 03450 NUCLEAR MEDI CI NE - DI AGNOSTI C 0.000000 222, 795 0 2, 167, 425 0 54.02 55.00 05500 RADI OLOGY - THERAPEUTI C 0.000000 0 0 0 55.00 55.01 03480 0NCOLOGY 0.000000 0 0 0 0 0 55.00 05500 RADIO LOGY - THERAPEUTI C 0.000000 1, 436, 993 0 4, 209, 654 0 57.00 57.00 05700 CT SCAN 0.000000 1, 436, 993 0 4, 209, 654 0 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 1, 436, 993 0 4, 209, 654 0 57.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 0 0 0 0 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 0 0 0 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 3, 157, 451 0 2, 804, 566 0 60.00 65.00 06500 RESPI RATORY THERAPY 0.000000 3, 279, 543 0 466, 065 0 65.00 66.00 06600 OSESPI RATORY THERAPY 0.000000 3, 279, 543 0 466, 065 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 3, 279, 543 0 466, 065 0 65.00 68.00 06900 SPECH PATHOLOGY 0.000000 161, 265 0 30, 995 0 67.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 0 0 0 69.01 03610 SLEEP LAB 0.000000 0 0 52, 044 0 69.01 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 543, 911 0 247, 628 0 71.00 71.01 07101 IV SOLUTI ONS 0.000000 0 0 5, 554, 315 0 72.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 0 0 5, 554, 315 0 72.00 74.00 07407 CARDI AC REHABI LITATI ON 0.000000 0 0 0 15, 388 0 90.00 74.00 07407 CARDI AC REHABI LITATI ON 0.000000 0 0 0 15, 388 0 90.00 74.00 07407 CARDI AC REHABI LITATI ON	51.00	05100 RECOVERY ROOM	0. 000000	380, 869	0	1, 029, 056	0	51.00
54.00 05400 RADI OLOGY-DI AGNOSTI C 0.029257 753, 600 22, 048 1, 443, 262 42, 226 54.00 54.01 03630 ULTRA SOUND 0.000000 106, 098 0 369, 549 0 54.01 54.02 03450 NUCLEAR MEDI CI NE - DI AGNOSTI C 0.000000 0 0 0 0 0 55.01 03480 NUCLEAR MEDI CI NE - DI AGNOSTI C 0.000000 0 0 0 0 0 55.01 03480 ONCOLOGY 0.000000 0 0 0 0 0 55.01 03480 ONCOLOGY 0.000000 0 0 0 0 0 55.01 03480 ONCOLOGY 0.000000 1, 436, 993 0 4, 209, 654 0 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 149, 839 0 1, 270, 995 0 58.00 59.00 05800 CARDI AG CATHETERI ZATI ON 0.000000 0 0 0 0 60.00 06000 LABORATORY 0.000000 3, 157, 451 0 2, 804, 566 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 599, 812 0 294, 513 0 62.00 66.00 06600 PHYSI CAL THERAPY 0.000000 3, 279, 543 0 466, 065 0 66.00 66.00 06600 PHYSI CAL THERAPY 0.000000 3, 279, 543 0 68, 084 0 66.00 66.00 06600 CARDIA CHARLER CHAR	52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	4, 734	0	o	0	52.00
54. 01 03630 ULTRA SOUND	53.00	05300 ANESTHESI OLOGY	0. 000000	442, 003	0	764, 490	0	53.00
54. 02 03450 NUCLEAR MEDI CINE - DI AGNOSTI C 0.000000 222, 795 0 2, 167, 425 0 54. 02 55. 00 05500 RADI OLOGY - THERAPEUTI C 0.000000 0 0 0 0 55. 01 03480 ONCOLOGY 0.000000 41, 147 0 3, 270, 326 0 55. 01 57. 00 05700 CT SCAN 0.000000 41, 436, 993 0 4, 209, 654 0 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 149, 839 0 1, 270, 995 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 0 0 0 0 59. 00 60. 00 06000 LABORATORY 0.000000 3, 157, 451 0 2, 804, 566 0 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 3, 279, 543 0 466, 065 0 65. 00 66. 00 06500 RESPI RATORY THERAPY 0.000000 3, 279, 543 0 466, 065 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.000000 421, 637 0 68, 084 0 66. 00 67. 00 06700 CCUPATI ONAL THERAPY 0.000000 411, 265 0 30, 995 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.000000 81, 432 0 2, 191 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 0 0 0 0 0 69. 01 03610 SLEEP LAB 0.000000 0 0 0 0 0 69. 01 0310 SLEEP LAB 0.000000 0 0 0 0 0 67. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 543, 911 0 247, 628 0 71. 01 71. 01 07101 1V SOLUTI ONS 0.000000 543, 911 0 247, 628 0 71. 01 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 5, 7582 0 2, 554, 315 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 1, 62, 378 0 3, 953, 764 0 76. 00 74. 67. 70 09700 CLINIC C 0.000000 0 0 0 0 0 0 75. 00 09900 EMERGENCY 0.000000 0, 798, 064 0 90. 00 90. 00 09900 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 15, 388 0 90. 00 09900 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 0 0 0 90. 00 09900 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 0 0 0	54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 029257	753, 600	22, 048	1, 443, 262	42, 226	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C 0.000000 0 0 0 0 0 55. 00	54.01	03630 ULTRA SOUND	0. 000000	106, 098	0	369, 549	0	54. 01
55. 00 05500 RADI OLGGY - THERAPEUTI C 0.000000 0 0 0 0 55. 00 55. 01 03480 ONCOLOGY 0.000000 41,147 0 3,270,326 0 0 55. 00 57. 00 05700 CT SCAN 0.000000 1,436,993 0 4,209,654 0 57. 00 58. 00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 0.000000 149,839 0 1,270,995 0 0 58. 00 59. 00 05900 CARDI AC CATHETER ZATI ON 0.000000 0.000000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.00000000	54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 000000	222, 795	0	2, 167, 425	0	54.02
55. 01 03480 0NCOLOGY 0.000000 41, 147 0 3, 270, 326 0 55. 01	55.00	05500 RADI OLOGY - THERAPEUTI C	0. 000000			0	0	55.00
58. 00 05800 MAGNETI C RESONANCE IMAGING (MRI) 0.000000 149,839 0 1,270,995 0 58. 00 59. 00 6500 (ARDI AC CATHETER ZATI ON 0.000000 0 0 0 59. 00 60.	55. 01		0. 000000	41, 147	0	3, 270, 326	0	55. 01
58. 00	57.00	05700 CT SCAN	0. 000000	1, 436, 993	0	4, 209, 654	0	57.00
59,00 05900 CARDI AC CATHETERI ZATI ON 0,000000 0 0 0 0 0 59,00	58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	149, 839	0		0	58.00
60. 00 06000 LABORATORY 0. 000000 3, 157, 451 0 2, 804, 566 0 60. 00 62. 00 WHOLE BLOOD & PACKED RED BLOOD CELLS 0. 0000000 599, 812 0 294, 513 0 62. 00 65. 00 66500 RESPI RATORY THERAPY 0. 0000000 3, 279, 543 0 466, 065 0 65. 00 66. 00 66600 PHYSI CAL THERAPY 0. 000000 421, 637 0 68, 084 0 66. 00 667. 00 06700 OCCUPATI ONAL THERAPY 0. 000000 161, 265 0 30, 995 0 67. 00 68. 00 68800 SPEECH PATHOLOGY 0. 000000 81, 432 0 2, 191 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 000000 0 0 0 2, 191 0 68. 00 69. 01 03610 SLEEP LAB 0. 000000 0 0 52, 044 0 69. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 000000 543, 911 0 247, 628 0 71. 01 71. 01 07101 IV SOLUTI ONS 0. 000000 543, 911 0 247, 628 0 71. 01 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 000000 2, 097, 582 0 2, 554, 315 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 9, 078, 747 0 25, 602, 718 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 1, 162, 378 0 3, 953, 764 0 76. 00 03140 CARDI OLOGY 0. 000000 121 0 365, 001 0 76. 97 07697 CARDI AC REHABI LI TATI ON 0. 000000 121 0 365, 001 0 76. 97 07697 CARDI AC REHABI LI TATI ON 0. 000000 2, 706, 465 0 4, 681, 249 0 91. 00 07100 DETAIL SERVI CE COST CENTERS 0. 000000 365, 281 0 798, 064 0 92. 00 0798, 00 09500 BABBULANCE SERVI CES 95. 00	59.00		0. 000000	. 0	0	0	0	59.00
62. 00	60.00			3, 157, 451	0	2, 804, 566	0	60.00
65. 00			l l				0	
66. 00 06600 PHYSI CAL THERAPY 0. 000000 421, 637 0 68, 084 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0. 000000 161, 265 0 30, 995 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 000000 81, 432 0 2, 191 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 000000 0 0 0 0 69. 01 03610 SLEEP LAB 0. 000000 0 0 52, 044 0 69. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 000000 1, 657, 583 0 1, 135, 379 0 71. 00 71. 01 07101 IV SOLUTI ONS 0. 000000 543, 911 0 247, 628 0 71. 01 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 000000 2, 097, 582 0 2, 554, 315 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 9, 078, 747 0 25, 602, 718 0 73. 00 76. 00 03140 CARDI OLOGY 0. 000000 1, 162, 378 0 3, 953, 764 0 76. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0. 000000 121 0 365, 001 0 76. 97 001TPATI ENT SERVI CE COST CENTERS 0. 000000 2, 706, 465 0 4, 681, 249 0 91. 00 91. 00 09000 DESERVATI ON BEDS (NON-DI STI NCT PART) 0. 000000 365, 281 0 798, 064 0 92. 00 01HER REI MBURSABLE COST CENTERS 95. 00 00 09500 AMBULANCE SERVI CES 95. 00				· ·		·	0	
67. 00						·	0	66.00
68. 00							0	
69. 00 06900 ELECTROCARDI OLOGY 0.000000 0 0 0 0 0 69. 00 69. 01 03610 SLEEP LAB 0.000000 0 0 52, 044 0 69. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 1, 657, 583 0 1, 135, 379 0 71. 00 71. 01 07101 IV SOLUTI ONS 0.000000 543, 911 0 247, 628 0 71. 01 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 2, 097, 582 0 2, 554, 315 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 9, 078, 747 0 25, 602, 718 0 73. 00 76. 00 03140 CARDI OLOGY 0.000000 1, 162, 378 0 3, 953, 764 0 76. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0.000000 121 0 365, 001 0 76. 97 0UTPATI ENT SERVI CE COST CENTERS 0.000000 2, 706, 465 0 4, 681, 249 0 91. 00 92. 00 09100 EMERGENCY 0.000000 2, 706, 465 0 4, 681, 249 0 91. 00 0THER REI MBURSABLE COST CENTERS 95. 00 95. 00 09500 AMBULANCE SERVI CES 95. 00							0	
69. 01				0.,	0	_, 0		
71. 00				0	0	52.044	0	
71. 01 07101 IV SOLUTIONS 0.000000 543, 911 0 247, 628 0 71. 01 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 2,097, 582 0 2,554, 315 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 9,078,747 0 25,602,718 0 73. 00 76. 00 03140 CARDIOLOGY 0.000000 1,162,378 0 3,953,764 0 76. 00 076. 97				1 657 583	0	·	0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 000000 2, 097, 582 0 2, 554, 315 0 72. 00 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 9, 078, 747 0 25, 602, 718 0 73. 00 76. 00 0. 000000 1, 162, 378 0 3, 953, 764 0 76. 00 0. 000000 0 0 0 365, 001 0 76. 97 0. 000000 0 0 0 0 0 0 0							0	
73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 9,078,747 0 25,602,718 0 73.00 76. 00 03140 CARDI OLOGY 0.000000 1,162,378 0 3,953,764 0 76.00 76. 97 07697 CARDI AC REHABI LI TATI ON 0.000000 121 0 365,001 0 76. 97 000000 00000 00000 000000 000000			· •	· ·			0	
76. 00							0	
76. 97 07697 CARDI AC REHABI LI TATI ON 0. 000000 121 0 365, 001 0 76. 97							0	
OUTPATIENT SERVICE COST CENTERS O O O O O O O O O							0	
90. 00 09000 CLI NI C 0. 000000 0 0 15, 388 0 90. 00 09100 EMERGENCY 0. 000000 2, 706, 465 0 4, 681, 249 0 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0. 000000 365, 281 0 798, 064 0 92. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95. 00	, 0. , ,		0.000000			000,001		70.77
91. 00 09100 EMERGENCY 0. 000000 2, 706, 465 0 4, 681, 249 0 91. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0. 000000 365, 281 0 798, 064 0 92. 00 0798, 064 0 92. 00 09500 AMBULANCE SERVI CES 95. 00 09500 AMBULANCE SERVI CES 95. 00 0950	90.00		0. 000000	0	0	15, 388	0	90.00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0. 000000 365, 281 0 798, 064 0 92. 00 0THER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95. 00				2, 706, 465			0	
OTHER REIMBURSABLE COST CENTERS 95. 00 O9500 AMBULANCE SERVI CES 95. 00			l I					
95. 00 09500 AMBULANCE SERVICES 95. 00			2. 222300	222, 201		, 00 1		
	95.00							95.00
				30, 912, 037	22, 048	63, 941, 807	42, 226	

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0069	Peri od:	Worksheet D

From 01/01/2019 Part V To 12/31/2019 Date/Time Prepared: 5/21/2020 10:03 am Title XVIII Hospi tal Charges Costs Cost Center Description Cost to PPS Cost Cost PPS Services Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, Subject To inst.) Subject To Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 2.00 5.00 1.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 6, 345, 086 50.00 05000 OPERATING ROOM 0. 209764 1, 330, 971 50.00 05100 RECOVERY ROOM 0 0 0 51.00 0.124300 1,029,056 51.00 127, 912 05200 DELIVERY ROOM & LABOR ROOM 52.00 0.589010 0 52.00 764, 490 53.00 05300 ANESTHESI OLOGY 0.042577 0 32, 550 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.634397 1, 443, 262 0 0 915, 601 54.00 0 0 53, 287 54 01 03630 ULTRA SOUND 0.144195 369, 549 54 01 0 54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0.070260 2, 167, 425 152, 283 54.02 55.00 05500 RADI OLOGY - THERAPEUTI C 0.000000 0 0 0 55.00 0 03480 ONCOLOGY 0.488417 3, 270, 326 1, 597, 283 55.01 55.01 0 05700 CT SCAN 4, 209, 654 187, 683 57.00 0.044584 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.115035 1, 270, 995 146, 209 58.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 0.000000 0 0 0 59.00 2, 804, 566 0 06000 LABORATORY 403, 201 60 00 0 143766 60 00 0 294, 513 54, 050 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.183525 62.00 65.00 06500 RESPIRATORY THERAPY 0.158331 466, 065 0 0 73, 793 65.00 0 0 66.00 06600 PHYSI CAL THERAPY 0. 311051 68, 084 21, 178 66.00 0 06700 OCCUPATIONAL THERAPY 30, 995 0 10, 574 67 00 0 341145 67 00 68.00 06800 SPEECH PATHOLOGY 0.323829 2, 191 710 68.00 06900 ELECTROCARDI OLOGY 0.000000 0 69.00 69.00 0 0 69.01 03610 SLEEP LAB 0.223969 52,044 11,656 69.01 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.364388 1, 135, 379 413, 718 71 00 71 00 o 71.01 07101 IV SOLUTIONS 0.098315 247, 628 24, 346 71.01 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 295176 2, 554, 315 0 0 753, 972 72.00 07300 DRUGS CHARGED TO PATIENTS 0. 190464 0 6, 859 4, 876, 396 73.00 25, 602, 718 73.00 ō 0. 119039 03140 CARDI OLOGY 76.00 3, 953, 764 0 470, 652 76.00 76.97 07697 CARDIAC REHABILITATION 0. 249258 365, 001 0 0 90, 979 76.97 OUTPATIENT SERVICE COST CENTERS 90 00 1.722925 15, 388 0 26, 512 90 00 09000 CLI NI C 0 91.00 09100 EMERGENCY 0. 184485 4, 681, 249 0 0 863, 620 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0.691661 798,064 0 551, 990 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 95 00 109500 AMBULANCE SERVICES 0.528130 200.00 Subtotal (see instructions) 63, 941, 807 0 6,859 13, 191, 126 200. 00 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges 13, 191, 126 202. 00 202.00 Net Charges (line 200 - line 201) 63, 941, 807 0 6, 859

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0069	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prepared:

				10 12/31/2019	5/21/2020 10:	
		Title	XVIII	Hospi tal	PPS	00 4
	Cos					
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7. 00				
ANCILLARY SERVICE COST CENTERS	0.00	7.00				
50. 00 05000 OPERATING ROOM	0	0				50.00
51. 00 05100 RECOVERY ROOM	o	0				51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY		0				53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0				54.00
54. 01 03630 ULTRA SOUND		0				54.00
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC		0				
	0	- 1				54. 02
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0				55.00
55. 01 03480 ONCOLOGY	0	0				55. 01
57. 00 05700 CT SCAN	0	0				57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59. 00
60. 00 06000 LABORATORY	0	0				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62. 00
65. 00 06500 RESPI RATORY THERAPY	0	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68. 00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69. 00
69. 01 03610 SLEEP LAB	0	0				69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
71.01 07101 IV SOLUTIONS	0	0				71. 01
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	1, 306				73.00
76. 00 03140 CARDI OLOGY	o	. 0				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	o	0				76. 97
OUTPATIENT SERVICE COST CENTERS		-				1
90. 00 09000 CLINIC	0	0				90.00
91. 00 09100 EMERGENCY	o	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
OTHER REIMBURSABLE COST CENTERS	. 0	0				1 /2.00
95. 00 09500 AMBULANCE SERVICES	0					95.00
200.00 Subtotal (see instructions)	0	1, 306				200.00
201.00 Less PBP Clinic Lab. Services-Progra		1, 300				200.00
Only Charges	"" "					201.00
202.00 Net Charges (line 200 - line 201)	0	1, 306				202.00
202.00 Net Glarges (Title 200 - Title 201)	ı	1, 300	l			1202.00

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0069	Peri od:	Worksheet D

From 01/01/2019 To 12/31/2019 Part V Date/Time Prepared: 5/21/2020 10:03 am Title XIX Hospi tal Cost Charges Costs PPS Services Cost Center Description Cost to PPS Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, Subject To Subject To inst.) Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 2.00 5.00 1.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 209764 2, 521, 163 50.00 05100 RECOVERY ROOM 0 887, 462 51.00 0.124300 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0.589010 6,056 0 52.00 53.00 05300 ANESTHESI OLOGY 0.042577 0 0 672, 334 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.634397 0 1, 038, 335 54.00 54 01 03630 ULTRA SOUND 0.144195 0 0 368.342 54.01 0 0 54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0.070260 0 653, 599 0 54.02 55.00 05500 RADI OLOGY - THERAPEUTI C 0.000000 55.00 0 03480 ONCOLOGY 0.488417 0 225, 458 55.01 55.01 0 0 2, 231, 605 05700 CT SCAN 0.044584 0 57.00 57.00 0 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.115035 551, 934 0 58.00 05900 CARDIAC CATHETERIZATION 0 59.00 59.00 0.000000 0 5, 021, 280 06000 LABORATORY 0 60 00 0 143766 60 00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0. 183525 0 29, 085 0 62.00 65.00 06500 RESPIRATORY THERAPY 0.158331 374, 063 0 65.00 66.00 06600 PHYSI CAL THERAPY 0. 311051 1, 396, 715 0 66.00 06700 OCCUPATIONAL THERAPY 0 0 67 00 67 00 0 341145 0 0 0 68.00 06800 SPEECH PATHOLOGY 0.323829 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 69.00 0 69.01 03610 SLEEP LAB 0. 223969 0 0 0 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.364388 0 0 924, 504 71.00 71 00 0 71.01 07101 IV SOLUTIONS 0.098315 0 103, 961 0 71.01 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 295176 0 0 529, 847 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0. 190464 0 0 5, 270, 696 73.00 0 73.00 0. 119039 0 03140 CARDI OLOGY Ω 76.00 1, 433, 740 0 76.00 76.97 07697 CARDIAC REHABILITATION 0. 249258 0 0 27,600 0 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 1.722925 0 0 2.907 0 0 91.00 09100 EMERGENCY 0. 184485 0 6, 075, 675 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 92.00 0.691661 563, 858 0 OTHER REIMBURSABLE COST CENTERS 95.00 0.528130 0 0 95.00 109500 AMBULANCE SERVICES 0 200.00 Subtotal (see instructions) 0 30, 910, 219 0 200.00 0 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges 0 202.00

0

30, 910, 219

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, C	OTHER HEALTH SERVICES AND VACCINE COST		From 01/01/2019	Worksheet D Part V Date/Time Prepared:

				To 12/31/2019	Date/Time Pre 5/21/2020 10:	
		Ti tl	e XIX	Hospi tal	Cost	OS alli
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	528, 849	1			50.00
51.00 05100 RECOVERY ROOM	0	110, 312				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	3, 567				52.00
53. 00 05300 ANESTHESI OLOGY	0	28, 626				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	658, 717				54.00
54. 01 03630 ULTRA SOUND	0	53, 113				54. 01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	45, 922				54. 02
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0				55.00
55. 01 03480 ONCOLOGY	0	110, 118				55. 01
57. 00 05700 CT SCAN	0	99, 494				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	63, 492				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	0	721, 889				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	5, 338				62.00
65. 00 06500 RESPIRATORY THERAPY	0	59, 226				65.00
66. 00 06600 PHYSI CAL THERAPY	0	434, 450				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	0	0				69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	336, 878				71.00
71. 01 07101 IV SOLUTIONS	0	10, 221				71. 01
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	156, 398				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1, 003, 878				73.00
76. 00 03140 CARDI OLOGY	0	170, 671				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	6, 880				76. 97
OUTPATIENT SERVICE COST CENTERS	_					
90. 00 09000 CLINIC	0	5, 009				90.00
91. 00 09100 EMERGENCY	0	·				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
OTHER REIMBURSABLE COST CENTERS	-					
95. 00 09500 AMBULANCE SERVI CES	0					95.00
200.00 Subtotal (see instructions)	Ö					200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	6, 123, 918				202.00
[[] [] [] [] [] [] [] [] [] ['		1		!	

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lieu	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0069	From 01/01/2019	Date/Time Pre	
				5/21/2020 10:0	03 am_
		Title XVIII	Hospi tal	PPS	
Cook Cooker Doored at the					

		Title XVIII	Hospi tal	5/21/2020 10: PPS	03 am_
	Cost Center Description	THE AVIII	поэрт саг		
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			11, 549	1.00 2.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days) 11,549 Private room days (excluding swing-bed and observation bed days). If you have only private room days, 0				
3. 00	do not complete this line.	ys). If you have only pr	rivate room days,	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation b	ed days)		9, 023	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro	om days) through Decembe	er 31 of the cost	0	5.00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private ro	om days) after December	21 of the cost	0	6.00
0.00	reporting period (if calendar year, enter 0 on this line)	om days) arter becember	31 Of the cost	0	0.00
7. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roo	m daya) aftar Dagambar ()1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	ili days) arter beceiliber s	of the cost	0	0.00
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	g swing-bed and	4, 715	9. 00
10.00	newborn days)			0	10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruc		room days)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, e			_	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	X only (including privat	te room days)	0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	te room days)	0	13.00
	after December 31 of the cost reporting period (if calendar y	ear, enter 0 on this lir	ne)		
	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	14. 00 15. 00
15. 00 16. 00	Nursery days (title V or XIX only)			0	
	SWI NG BED ADJUSTMENT			<u> </u>	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	of the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18.00
10.00	reporting period	es arter becember 51 or	the cost	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0.00	19.00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	the cost	0.00	20.00
20.00	reporting period	3 arter becomber 31 or	ine cost	0.00	20.00
21. 00	Total general inpatient routine service cost (see instruction			10, 717, 679	
22. 00	Swing-bed cost applicable to SNF type services through Decemb 5×1 line 17)	er 31 of the cost report	ting period (line	0	22.00
23. 00	,	31 of the cost reportir	na period (line 6	0	23. 00
	x line 18)	·			
24. 00] 3 11 31	r 31 of the cost reporti	ng period (line	0	24.00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)		, , , , , , , , , , , , , , , , , , , ,		
26. 00	Total swing-bed cost (see instructions)	(11 01 11 04)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Tine 21 minus Tine 26)		10, 717, 679	27.00
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	28. 00
29. 00				0	
30.00	Semi-private room charges (excluding swing-bed charges)	11 20)		0	
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ line 28)		0. 000000 0. 00	1
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	1
34. 00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	rtions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x li			0.00	35.00
36. 00	Private room cost differential adjustment (line 3 x line 35)	317		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line		
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	LISTMENTS			
38 00	Adjusted general inpatient routine service cost per diem (see			928. 02	38 00
39. 00	Program general inpatient routine service cost per drem (see			4, 375, 614	
	Medically necessary private room cost applicable to the Progr	•		4, 373, 014	1
	Total Program general inpatient routine service cost (line 39			4, 375, 614	1

Heal th	ı Financial Systems KING'S DAUGHTERS' HOSPITAL In Li	eu of Form CMS-2	2552-10
	FATION OF INPATIENT OPERATING COST Provider CCN: 15-0069 Period:	Worksheet D-1	
	From 01/01/201 To 12/31/201		nared·
		5/21/2020 10:	
	Cost Center Description Total Total Average Per Program Days	PPS Program Cost	
	Inpatient Inpatient Diem (col. 1	(col. 3 x	
	Cost Days ÷ col . 2)	col . 4)	
10.00	1.00 2.00 3.00 4.00	5. 00	10.00
42.00	NURSERY (title V & XIX only) 0 0 0.00 Intensive Care Type Inpatient Hospital Units	0 0	42.00
43.00		1, 024, 657	43.00
44.00			44.00
	BURN INTENSIVE CARE UNIT		45.00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)		46. 00 47. 00
	Cost Center Description		
10.00		1.00	10.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) Total Program inpatient costs (sum of lines 41 through 48) (see instructions)	6, 359, 845 11, 760, 116	1
47.00	PASS THROUGH COST ADJUSTMENTS	11,700,110	77.00
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I a	nd 957, 497	50.00
51. 00	III) Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts I	E12 240	51.00
51.00	land IV)	512, 368	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1, 469, 865	52.00
53. 00		10, 290, 251	53.00
	medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program di scharges	0	54.00
55.00		0.00	•
56. 00 57. 00		0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	0	58.00
59. 00		he 0.00	
40.00	market basket	0.00	40.00
60. 00 61. 00		•	60. 00 61. 00
01.00	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target		01.00
	amount (line 56), otherwise enter zero (see instructions)		,,,,,,,
62. 00 63. 00		0	
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST		03.00
64.00		е 0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See	0	65.00
03.00	instructions) (title XVIII only)		03.00
66. 00		0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting perio	0	67. 00
07.00	(line 12 x line 19)		07.00
68. 00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69. 00
07.00	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		09.00
70.00			70. 00
71. 00 72. 00			71. 00 72. 00
73.00	, ,		73.00
74. 00	Total Program general inpatient routine service costs (line 72 + line 73)		74. 00
75. 00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, colum	n	75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ line 2)		76. 00
77. 00			77. 00
78. 00			78.00
79. 00 80. 00	1 33 3 7		79. 00 80. 00
81.00			81.00
82.00			82.00
83. 00 84. 00			83. 00 84. 00
85.00			85.00
	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
07 00	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation had days (see instructions)	2 52/	07.00
87. 00 88. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2, 526 928. 02	1
	Observation bed cost (line 87 x line 88) (see instructions)	2, 344, 179	

Health Financial Systems	KING'S DAUGHTE	RS' HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2019 To 12/31/2019		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	2, 176, 890	10, 717, 679	0. 20311	2, 344, 179	476, 131	90.00
91.00 Nursing School cost	o	10, 717, 679	0.00000	00 2, 344, 179	0	91.00
92.00 Allied health cost	o	10, 717, 679	0.00000	00 2, 344, 179	0	92.00
93.00 All other Medical Education	o	10, 717, 679	0. 00000	2, 344, 179	0	93. 00

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0069	Peri od: From 01/01/2019	Worksheet D-1	
			To 12/31/2019	Date/Time Pre 5/21/2020 10:	
		Title XIX	Hospi tal	Cost	
0					

		Title XIX	Hospi tal	5/21/2020 10: Cost	03 am_	
	Cost Center Description	THE XIX	поэрг саг	0031		
	DADT I DECLUSED COMPONENTO			1. 00		
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS					
1. 00						
2.00	Inpatient days (including private room days, excluding swing-	bed and newborn days)		11, 549	2.00	
3.00	Private room days (excluding swing-bed and observation bed da	ys). If you have only pr	rivate room days,	0	3.00	
4 00	do not complete this line.	ad daya)		0.022	4 00	
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		or 31 of the cost	9, 023	4. 00 5. 00	
0.00	reporting period	om days) tri odgr becombe	. 01 01 110 0031	G	0.00	
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00	
	reporting period (if calendar year, enter 0 on this line)					
7. 00	Total swing-bed NF type inpatient days (including private roo reporting period	m days) through December	31 of the cost	0	7. 00	
8. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	R1 of the cost	0	8. 00	
0.00	reporting period (if calendar year, enter 0 on this line)	iii days) arter becember e	or or the cost	O	0.00	
9.00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	1, 311	9. 00	
	newborn days)			_		
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc		room days)	0	10. 00	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11. 00	
00	December 31 of the cost reporting period (if calendar year, e		com dayo, artor	Ü		
12.00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12.00	
	through December 31 of the cost reporting period			_		
13.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13. 00	
14. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14. 00	
15. 00	Total nursery days (title V or XIX only)	am (exertialing swring bea	uays)	1, 156		
	Nursery days (title V or XIX only)			150		
	SWING BED ADJUSTMENT					
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	of the cost	0. 00	17. 00	
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	os after December 21 of	the cost	0.00	18. 00	
10.00	reporting period	es aitei beceilibei 31 01	the cost	0.00	10.00	
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0. 00	19. 00	
	reporting period	-				
20. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	the cost	0. 00	20. 00	
21. 00	reporting period Total general inpatient routine service cost (see instruction	e)		10, 717, 679	21. 00	
22. 00	Swing-bed cost applicable to SNF type services through Decemb		ing period (line		22. 00	
	5 x line 17)		3 1 1			
23.00		31 of the cost reportir	ng period (line 6	0	23.00	
24.00	x line 18)	. 21 -6	(1:	0	24.00	
24. 00	Swing-bed cost applicable to NF type services through Decembe 7×1 ine 19)	r 31 or the cost reporti	ng period (iine	0	24. 00	
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25. 00	
	x line 20)		, ,			
26. 00	Total swing-bed cost (see instructions)			0	26. 00	
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		10, 717, 679	27. 00	
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narnes)	0	28. 00	
29. 00	1	d and observation bed er	iai ges)	0	29. 00	
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00	
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	31.00	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00	
34.00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	ctions)	0.00	34.00	
35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	35.00	
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00	
37.00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	10, 717, 679	37.00	
	27 minus line 36)					
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	LISTMENTS				
38 00	Adjusted general inpatient routine service cost per diem (see			928. 02	38 00	
39. 00	Program general inpatient routine service cost (line 9 x line			1, 216, 634	39. 00	
	Medically necessary private room cost applicable to the Progr	•		0	40. 00	
41.00	Total Program general inpatient routine service cost (line 39	+ line 40)		1, 216, 634	41.00	

	Financial Systems	KING'S DAUGHTER		ON 45 00/0 5		u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der Co	F	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Pre	
			T: ±1	- VIV		5/21/2020 10:	03 am
	Cost Center Description	Total Inpati ent	Total Inpati ent	Average Per Diem (col. 1	Hospital Program Days	Program Cost (col. 3 x	
		1. 00	Days 2.00	÷ col . 2) 3.00	4. 00	col . 4) 5.00	
42. 00	NURSERY (title V & XIX only)	927, 736	1, 156				42.00
40.00	Intensive Care Type Inpatient Hospital Units		4 005	4 4/7 00	100	200 ((2	40.00
43. 00 44. 00 45. 00 46. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	1, 915, 731	1, 305	1, 467. 99	198	290, 662	43. 00 44. 00 45. 00 46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk	cst D-3 col 3	line 200)			1. 00 2, 353, 497	48. 00
	Total Program inpatient costs (sum of lines			ons)		3, 981, 174	1
	PASS THROUGH COST ADJUSTMENTS					_	
50. 00	Pass through costs applicable to Program inp	oatient routine s	services (from	m Wkst. D, sum	of Parts I and	0	50.00
51. 00	Pass through costs applicable to Program inp	patient ancillar	y services (fi	rom Wkst. D, s	um of Parts II	О	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line	uding capital rel	lated, non-phy	ysician anesth	etist, and	0	
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge					0.00	
56. 00	Target amount (line 54 x line 55)					0	1
	Difference between adjusted inpatient operat	ting cost and ta	rget amount (I	ine 56 minus	line 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	enorting period	anding 1006 i	indated and co	mnounded by the	0.00	
39.00	market basket	sporting period (ending 1990, t	apuateu anu co	inpounded by the	0.00	39.00
60.00						0.00	
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see	an expected costs				0	61.00
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ŕ	ctions)			0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	sts through Dece	mber 31 of the	e cost reporti	ng period (See	0	64.00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	sts after Decembe	er 31 of the o	cost reporting	period (See	0	65.00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line (65)(title XVII	l only). For	0	66.00
67. 00]	ne costs through	December 31	of the cost re	porting period	0	67.00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	ne costs after Do	ecember 31 of	the cost repo	rting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00
70. 00	Skilled nursing facility/other nursing facil						70.00
71. 00	Adjusted general inpatient routine service of	cost per diem (li					71.00
72.00	Program routine service cost (line 9 x line	,	(line 14 v li	no 25)			72.00
73. 00 74. 00	Medically necessary private room cost application of the service o		•				73. 00 74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	•			art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li						76. 00
77. 00	Program capital-related costs (line 9 x line	,					77.00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces	,	rovider roccr	46)			78. 00 79. 00
80.00	Total Program routine service costs for comp				us line 79)		80.00
81. 00	Inpatient routine service cost per diem limi	tati on		•	ŕ		81.00
82.00	Inpatient routine service cost limitation (I		· .				82.00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		5)				83. 00 84. 00
85. 00	Utilization review - physician compensation		ns)				85.00
86. 00	Total Program inpatient operating costs (sum	n of lines 83 th					86.00
07.00	PART IV - COMPUTATION OF OBSERVATION BED PAS					0.501	07.00
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	*	line 2)			2, 526 928. 02	1
	Observation bed cost (line 87 x line 88) (se	•				2, 344, 179	
		-/				•	•

Health Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2019 To 12/31/2019		pared: 03 am
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	2, 176, 890	10, 717, 679	0. 20311	2, 344, 179	476, 131	90.00
91.00 Nursing School cost	0	10, 717, 679	0.00000	0 2, 344, 179	0	91.00
92.00 Allied health cost	o	10, 717, 679	0.00000	0 2, 344, 179	0	92.00
93.00 All other Medical Education	0	10, 717, 679	0.00000	0 2, 344, 179	0	93.00

llool +b	Financial Cyctoms VINCIC DAUGUTEDS:	HOCDI TAI		la li o	u of Form CMC	2552 10
	Financial Systems KING'S DAUGHTERS' ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN. 1E 00/0	Peri od:	u of Form CMS-2 Worksheet D-3	
INPAII	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0069	From 01/01/2019	worksneet D-3	1
				To 12/31/2019	Date/Time Pre 5/21/2020 10:	pared: 03 am
		Titl∈	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col . 2)	
	LANDATI ENT. DOUTLING OFFICE OFFICE		1.00	2. 00	3. 00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			1 010 000	<u> </u>	
30.00	03000 ADULTS & PEDIATRICS			4, 913, 388		30.00
31.00	03100 INTENSIVE CARE UNIT			1, 397, 521		31.00
43. 00	04300 NURSERY					43.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM		0. 2097	64 2, 060, 751	422 271	50.00
50.00	05100 RECOVERY ROOM		0. 2097		432, 271 47, 342	
51.00	05200 DELIVERY ROOM & LABOR ROOM		0. 1243		2, 788	1
53. 00	05300 ANESTHESI OLOGY		0. 0463	· ·	20, 508	
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 6343		478, 082	
54. 00	03630 ULTRA SOUND		0. 0343	· ·	15, 299	
54. 01	03450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 0702		15, 244	
55. 00	05500 RADI OLOGY - THERAPEUTI C		0.0000		13,034	
55. 01	03480 ONCOLOGY		0. 4926		20, 270	
57. 00	05700 CT SCAN		0. 0445		64, 067	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 1150		17, 237	
59. 00	05900 CARDI AC CATHETERI ZATI ON		0.0000	· ·	0	1
60. 00	06000 LABORATORY		0. 1437		453, 934	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 1835		110, 080	
65. 00	06500 RESPI RATORY THERAPY		0. 1583		519, 253	
66.00	06600 PHYSI CAL THERAPY		0. 3110		131, 151	66.00
67.00	06700 OCCUPATI ONAL THERAPY		0. 3411	45 161, 265	55, 015	67.00
68.00	06800 SPEECH PATHOLOGY		0. 3238	29 81, 432	26, 370	68. 00
69.00	06900 ELECTROCARDI OLOGY		0.0000	00	0	69.00
69. 01	03610 SLEEP LAB		0. 2239	69 0	0	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3643	88 1, 657, 583	604, 003	71.00
71.01	07101 IV SOLUTIONS		0. 0983	15 543, 911	53, 475	71. 01
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 2951	76 2, 097, 582	619, 156	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 1904	64 9, 078, 747	1, 729, 174	73.00
76.00	03140 CARDI OLOGY		0. 1190		138, 368	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON		0. 2492	58 121	30	76. 97
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C		1. 7229		1	
91. 00	09100 EMERGENCY		0. 2045		553, 667	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 6916	61 365, 281	252, 651	92.00
	OTHER REIMBURSABLE COST CENTERS		T.		Г	
	09500 AMBULANCE SERVICES				,	95.00
200.00		(1.1)		30, 912, 037	6, 359, 845	
201.00		(IIne 61)		0 010 027		201.00
202.00	Net charges (line 200 minus line 201)		I	30, 912, 037	I	202.00

Health Financial Systems KING'S DAUG	HTERS' HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0069	Peri od:	Worksheet D-3	
			From 01/01/2019		
			To 12/31/2019		
	T; +I	e XIX	Hospi tal	5/21/2020 10:	<u>03 am</u>
Cost Center Description	11 (1	Ratio of Cos		Cost Inpatient	
cost center bescription		To Charges	Program	Program Costs	
		10 charges	Charges	(col. 1 x	
			onal ges	col . 2)	
		1.00	2, 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			1, 479, 794		30.00
31. 00 03100 NTENSI VE CARE UNI T			407, 798		31.00
43. 00 04300 NURSERY			839, 955		43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM		0. 20976	1, 034, 694	217, 042	50.00
51. 00 05100 RECOVERY ROOM		0. 12430	269, 509	33, 500	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 58901	10 871, 396	513, 261	52.00
53. 00 05300 ANESTHESI OLOGY		0.04257	77 542, 318	23, 090	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 63439	143, 279	90, 896	54.00
54. 01 03630 ULTRA SOUND		0. 14419	95 56, 177	8, 100	54.01
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC		0.07026	26, 280	1, 846	54.02
55. 00 05500 RADI OLOGY - THERAPEUTI C		0.00000	00	0	55.00
55. 01 03480 ONCOLOGY		0. 48841	17 0	0	55. 01
57. 00 05700 CT SCAN		0. 04458	330, 081	14, 716	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 11503	52, 740	6, 067	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.00000	00	0	59.00
60. 00 06000 LABORATORY		0. 14376	· ·	135, 710	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 18352	· ·	12, 907	62.00
65. 00 06500 RESPI RATORY THERAPY		0. 15833	· ·	90, 263	
66. 00 06600 PHYSI CAL THERAPY		0. 31105		28, 419	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 34114		0	
68. 00 06800 SPEECH PATHOLOGY		0. 32382		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0.00000		0	
69. 01 03610 SLEEP LAB		0. 22396		0	69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 36438		254, 577	1
71. 01 07101 I V SOLUTI ONS		0. 09831	· ·	15, 134	
72. 00 O7200 I MPL. DEV. CHARGED TO PATIENTS		0. 29517	· ·	96, 596	
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 19046		662, 770	
76. 00 03140 CARDI OLOGY		0. 11903		25, 981	
76. 97 O7697 CARDI AC REHABI LI TATI ON		0. 24925	58 0	0	76. 97
90. 00 09000 CLI NI C		1. 72292	25 0	0	90.00
91. 00 09100 ELFNIC 91. 00 09100 EMERGENCY		0. 18448		102, 709	
		0. 18448			
92.00 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS		0.09100	51 28, 790	19, 913	72.00
95. 00 09500 AMBULANCE SERVICES					95.00
200 00 Total (sum of Lines 50 through 94 and 96 through 9	187		10 465 587	2 353 407	

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

2, 353, 497 200. 00 201. 00 202. 00

10, 465, 587 10, 465, 587

200. 00 201. 00 202. 00

Health Financial Systems	KING'S DAUGHTERS' HOSPIT	AL	In Lieu	ı of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi d	er CCN: 15-0069	Peri od: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 5/21/2020 10:03 am

		T: +1 - W/// 1	11! +-1	5/21/2020 10:	03 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			0	1. 00
1. 00 1. 01					1. 00
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)				1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCl for October 1 (see instructions)	di scharges occurri ng	on or after	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			0	2. 00 2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instruction	ns)		0	2. 02
2. 03	Outlier payments for discharges occurring prior to October 1 (se	•		9, 417	2. 03
2.04	Outlier payments for discharges occurring on or after October 1	(see instructions)		7, 187	2.04
3.00	Managed Care Simulated Payments			2, 378, 537	3.00
4. 00	Bed days available divided by number of days in the cost report Indirect Medical Education Adjustment	ing period (see instru	ctions)	75. 08	4. 00
5. 00	FTE count for allopathic and osteopathic programs for the most or before 12/31/1996. (see instructions)	recent cost reporting	period ending on	0.00	5. 00
6. 00	FTE count for allopathic and osteopathic programs that meet the new programs in accordance with 42 CFR 413.79(e)	criteria for an add-c	n to the cap for	0. 00	6. 00
7. 00	MMA Section 422 reduction amount to the IME cap as specified un			0. 00	7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 4 cost report straddles July 1, 2011 then see instructions.	. , , , , ,	, , , , ,	0. 00	7. 01
8. 00	Adjustment (increase or decrease) to the FTE count for allopath affiliated programs in accordance with 42 CFR 413.75(b), 413.79			0. 00	8. 00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slot- report straddles July 1, 2011, see instructions.	s under § 5503 of the	ACA. If the cost	0. 00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slot- under § 5506 of ACA. (see instructions)	s from a closed teachi	ng hospital	0.00	8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines instructions)	(8, 8,01 and 8,02) (see	0. 00	9. 00
10.00	FTE count for allopathic and osteopathic programs in the curren	t year from your recor	ds	0.00	10.00
11. 00	FTE count for residents in dental and podiatric programs.			0. 00	11.00
12.00	Current year allowable FTE (see instructions)			0. 00	
13. 00	Total allowable FTE count for the prior year.			0. 00	
14. 00	Total allowable FTE count for the penultimate year if that year otherwise enter zero.	ended on or after Sep	tember 30, 1997,	0. 00	14. 00
15. 00	Sum of lines 12 through 14 divided by 3.			0.00	15. 00
	Adjustment for residents in initial years of the program				16. 00
	Adjustment for residents displaced by program or hospital closu	re		0.00	17. 00
18. 00	Adjusted rolling average FTE count			0. 00	18.00
	Current year resident to bed ratio (line 18 divided by line 4).			0. 000000	
	Prior year resident to bed ratio (see instructions)			0. 000000	
	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	
	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)			0	22. 00 22. 01
22.01	Indirect Medical Education Adjustment for the Add-on for § 422 (of the MMA		U	22.01
23. 00	Number of additional allopathic and osteopathic IME FTE residen $(f)(1)(iv)(C)$.		FR 412. 105	0. 00	23. 00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24.00
25. 00	If the amount on line 24 is greater than -0-, then enter the low instructions)	wer of line 23 or line	24 (see	0. 00	25. 00
26. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000	
	IME add-on adjustment amount (see instructions)			0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29. 00 29. 01
	Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A pat	ient days (see instruc	tions)	4. 66	30.00
	Percentage of Medicaid patient days (see instructions)			21. 55	
	Sum of lines 30 and 31			26. 21	
	Allowable disproportionate share percentage (see instructions)			10. 84	
34.00	Disproportionate share adjustment (see instructions)			261, 035	34.00

CALCUL	LATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0069	Peri od: From 01/01/2019				
			To 12/31/2019	Date/Time Pre 5/21/2020 10:	pared: 03 am		
		Title XVIII	Hospi tal	PPS			
			Prior to 10/1 1.00	2. 00			
	Uncompensated Care Adjustment						
35. 00 35. 01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		8, 272, 872, 447 0. 000138012	8, 350, 599, 096 0. 000175732	1		
35. 02		nter zero on this line) (s					
35. 03 36. 00	Pro rata share of the hospital uncompensated care payment amount (see instructions) Total uncompensated care (sum of columns 1 and 2 on line 35.03) Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				35. 03 36. 00		
40. 00	Total Medicare discharges on Worksheet S-3, Part I excluding 652, 682, 683, 684 and 685 (see instructions)		0		40. 00		
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, instructions)	, 683, 684 an 685. (see	0		41.00		
41. 01	Total ESRD Medicare covered and paid discharges excluding lan 685. (see instructions)	MS-DRGs 652, 682, 683, 68	4 0		41. 01		
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not quantotal Medicare ESRD inpatient days excluding MS-DRGs 652, instructions)		0.00 e 0		42. 00 43. 00		
44. 00	Ratio of average length of stay to one week (line 43 divide days)	ed by line 41 divided by 7	0. 000000		44. 00		
45.00	Average weekly cost for dialysis treatments (see instruction		0.00		45.00		
46. 00 47. 00	Total additional payment (line 45 times line 44 times line Subtotal (see instructions)	41.01)	11, 109, 709		46. 00 47. 00		
48. 00	Hospital specific payments (to be completed by SCH and MDH, only. (see instructions)	, small rural hospitals	10, 964, 608		48. 00		
				Amount			
49. 00	Total payment for inpatient operating costs (see instruction	ons)		1. 00 11, 109, 709	49.00		
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I	and Pt. II, as applicable)	780, 329	50.00		
51. 00 52. 00	Exception payment for inpatient program capital (Wkst. L, I Direct graduate medical education payment (from Wkst. E-4,			0			
53. 00	Nursing and Allied Health Managed Care payment	Title 47 See That detroils)	•	2, 639			
54.00	Special add-on payments for new technologies			0			
54. 01 55. 00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	a 69)		0	1		
56. 00	Cost of physicians' services in a teaching hospital (see in			0	1		
57. 00	Routine service other pass through costs (from Wkst. D, Pt.		through 35).	0	57.00		
58. 00 59. 00	Ancillary service other pass through costs from Wkst. D, P. Total (sum of amounts on lines 49 through 58)	t. IV, col. 11 line 200)		22, 048 11, 914, 725			
60.00	, ,			3, 218	1		
61.00	Total amount payable for program beneficiaries (line 59 min	nus line 60)		11, 911, 507	1		
62. 00 63. 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			1, 400, 612 8, 866	62.00		
64. 00	Allowable bad debts (see instructions)			92, 347			
65. 00	1			60, 026			
66. 00 67. 00	Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63)	nstructi ons)		35, 068 10, 562, 055	1		
68. 00	Credits received from manufacturers for replaced devices for	or applicable to MS-DRGs (see instructions)	10, 302, 033			
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96			0	1		
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	notrotion) odivotmont (coo	inatruationa)	0			
70. 50 70. 87	Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestration	, , ,	THS LI UC LI ONS)	0			
70. 88	SCH or MDH volume decrease adjustment (contractor use only))		0	70.88		
	1 3 3			0	70.89		
	HSP bonus payment HVBP adjustment amount (see instructions))		0	1		
70. 89 70. 90 70. 91	THSP bonus payment HRR adjustment amount (see instructions)			U			
	1		Bundled Model 1 discount amount (see instructions)				
70. 90 70. 91	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)			0 39, 523 -57, 329	70. 93		

ealth Financial Systems KING'S DAUGHT	ERS' HOSPI TAL		In Lie	u of Form CMS-2	2552-1
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CN: 15-0069	Peri od:	Worksheet E	
			From 01/01/2019	Part A	
			To 12/31/2019	Date/Time Pre 5/21/2020 10:	
	Ti tl e	: XVIII	Hospi tal	PPS	OS ani
·	11 11 0		/ (yyyy)	Amount	
			0	1. 00	
70.96 Low volume adjustment for federal fiscal year (yyyy) (Enterthe the corresponding federal year for the period prior to 10/			2019	372, 651	70. 90
70.97 Low volume adjustment for federal fiscal year (yyyy) (Enter the corresponding federal year for the period ending on or	er in column 0		2020	168, 247	70. 9 ⁻
70. 98 Low Volume Payment-3	arter 10/1)			0	70. 98
0.99 HAC adjustment amount (see instructions)				0	
'1.00 Amount due provider (line 67 minus lines 68 plus/minus lir	nos 60 8 70)			11, 085, 147	1
1.01 Sequestration adjustment (see instructions)	163 07 & 70)			221, 703	1
1.02 Demonstration payment adjustment amount after sequestration	nn.			221, 703	71.0
2.00 Interim payments	лі			11, 133, 192	
3.00 Tentative settlement (for contractor use only)				11, 133, 172 0	73.0
44.00 Balance due provider/program (line 71 minus lines 71.01, 773)	71.02, 72, and			-269, 748	
5.00 Protested amounts (nonallowable cost report items) in acco	ordance with			1, 206, 194	75. 0
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					1
0.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or s	sum of 2 03			0	90.0
plus 2.04 (see instructions)	Julii 01 2.05			O	70.0
11.00 Capital outlier from Wkst. L, Pt. I, line 2				0	91.0
2.00 Operating outlier reconciliation adjustment amount (see in	nstructions)			0	
3.00 Capital outlier reconciliation adjustment amount (see inst				0	
4.00 The rate used to calculate the time value of money (see in				0.00	
75.00 Time value of money for operating expenses (see instruction				0	
6.00 Time value of money for capital related expenses (see inst				0	1
or or area or money for outstand or area expenses (eee fine)	40 (1 0.10)		Prior to 10/1		70.0
			1, 00	2.00	
HSP Bonus Payment Amount					
00.00 HSP bonus amount (see instructions)			0	0	100. 0
HVBP Adjustment for HSP Bonus Payment					
01.00 HVBP adjustment factor (see instructions)			0. 0000000000	0. 0000000000	101.0
02.00 HVBP adjustment amount for HSP bonus payment (see instruct	ions)		o	0	102.0
HRR Adjustment for HSP Bonus Payment	,				
03.00 HRR adjustment factor (see instructions)			0.0000	0.0000	103.0
04.00 HRR adjustment amount for HSP bonus payment (see instructi	ons)		o		104.0
Rural Community Hospital Demonstration Project (§410A Demo		ustment			
00.00 Is this the first year of the current 5-year demonstration					200.0
Century Cures Act? Enter "Y" for yes or "N" for no.	·				
Cost Reimbursement			<u> </u>		
01.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II,	line 49)				201.0
02.00 Medicare discharges (see instructions)	•				202.0
03.00 Case-mix adjustment factor (see instructions)					203.0
Computation of Demonstration Target Amount Limitation (N/A	in first year	of the curr	ent 5-year demons	tration	
peri od)			,		
04.00 Medicare target amount					204. 0
05.00 Case-mix adjusted target amount (line 203 times line 204)					205.0
206 00 Medicare inpatient routine cost can (line 202 times line 2					

207.00

208.00

209. 00 210. 00 211. 00

212. 00 213. 00

218. 00

210.00 Reserved for future use

206.00 Medicare inpatient routine cost cap (line 202 times line 205)

211.00 Total adjustment to Medicare IPPS payments (see instructions)

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

209.00 Adjustment to Medicare IPPS payments (see instructions)

Comparision of PPS versus Cost Reimbursement

(line 212 minus line 213) (see instructions)

213.00 Low-volume adjustment (see instructions)

Adjustment to Medicare Part A Inpatient Reimbursement
207.00 Program reimbursement under the §410A Demonstration (see instructions)

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

218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provi der CCN: 15-0069 Peri od: Worksheet E From 01/01/2019 Part A Exhi bit 4 To 12/31/2019 Date/Time Prepared:

					10	0 12/31/2019	Date/lime Pre 5/21/2020 10:	
					XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
1.00	DRG amounts other than outlier	1. 00	0	0	0	0	0	1.00
1. 01	payments DRG amounts other than outlier payments for discharges	1. 01	7, 166, 065	0	7, 166, 065		7, 166, 065	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	2, 466, 243	0		2, 466, 243	2, 466, 243	1.02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1. 03	0	0	0		0	1.03
1. 04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1.04
2. 00	Outlier payments for discharges (see instructions)	2. 00						2. 00
2. 01	Outlier payments for	2. 02	0	0	0	0	0	2. 01
2. 02	discharges for Model 4 BPCI Outlier payments for discharges occurring prior to	2. 03	9, 417	0	9, 417		9, 417	2. 02
2. 03	October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see	2. 04	7, 187	0		7, 187	7, 187	2.03
3. 00	instructions) Operating outlier	2. 01	0	0	0	0	0	3. 00
4. 00	reconciliation Managed care simulated payments	3. 00	2, 378, 537	0	1, 745, 820	632, 717	2, 378, 537	4. 00
	Indirect Medical Education Adj							
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
6. 00	IME payment adjustment (see instructions)	22. 00	0	0	0	0	0	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	O	0	0	0	0	6. 01
	instructions) Indirect Medical Education Adju	ustment for the	Add-on for Se	ection 422 of 1	the MMA			
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
8. 00	IME adjustment (see	28. 00	0	0	0	0	0	8. 00
8. 01	instructions) IME payment adjustment add on for managed care (see	28. 01	O	0	0	0	0	8. 01
9. 00	instructions) Total IME payment (sum of	29. 00	0	0	0	0	0	9. 00
9. 01	lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and	29. 01	0	0	0	0	0	9. 01
	8.01) Disproportionate Share Adjustmo	ent						
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 1084	0. 1084	0. 1084	0. 1084		10.00
11. 00	Di sproporti onate share	34. 00	261, 035	0	194, 200	66, 835	261, 035	11.00
11. 01	adjustment (see instructions) Uncompensated care payments	36.00	1, 199, 762	di sahargas	830, 891	368, 871	1, 199, 762	11. 01
12. 00	Additional payment for high pe Total ESRD additional payment	rcentage of ESI 46.00	ku beneticiary 0	di scharges 0	0	0	0	12.00
13. 00 14. 00	(see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH,	47. 00 48. 00	11, 109, 709 0	0	8, 200, 573 0	2, 909, 136 0	11, 109, 709 0	ı
15. 00	small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions)	49. 00	11, 109, 709	0	8, 200, 573	2, 909, 136	11, 109, 709	15. 00

	LUME CALCULATION EXHIBIT 4			Provider Ci		Period: From 01/01/2019 To 12/31/2019	Date/Time Pre 5/21/2020 10:	pared.
					XVIII	Hospi tal	PPS	
		W/S E, Part A		Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
		0	1. 00	2. 00	3.00	4. 00	5. 00	
16. 00	Payment for inpatient program	50.00	780, 329	0	583, 39	4 196, 935	780, 329	16.00
	capital (from Wkst. L, Pt. I, if applicable)							
17. 00	Special add-on payments for new technologies	54. 00	0	0		0 0	0	
17. 01	Net organ aquisition cost							17. 01
17. 02	Credits received from	68. 00	0	0		0 0	0	17. 02
	manufacturers for replaced							
	devices for applicable MS-DRGs							
18. 00	Capital outlier reconciliation	93. 00	0	0		0	0	18. 00
	adjustment amount (see							
	instructions)			_				
19. 00	SUBTOTAL	W (0 1 1 1 1	(1)	0	8, 783, 96	7 3, 106, 071	11, 890, 038	19.00
		W/S L, line	(Amounts from					
		0	L) 1. 00	2. 00	3.00	4. 00	5. 00	
20. 00	Capital DRG other than outlier	-	774, 893	2.00	579, 47		774, 893	20.00
20. 00	Model 4 BPCI Capital DRG other		774,075	0	377,47	0 173, 422	774, 673	20.00
20.01	than outlier	1.01		0				20.01
21. 00	Capital DRG outlier payments	2.00	5, 436	0	3, 92	3 1, 513	5, 436	21.00
21. 01	Model 4 BPCI Capital DRG	2. 01	0, 100	0	0, 72	0 1,010	0, 100	
2	outlier payments	2.0.	, and the second	, and the second se			Ĭ	
22. 00	Indirect medical education	5. 00	0. 0000	0.0000	0.000	0. 0000		22.00
	percentage (see instructions)							
23.00	Indirect medical education	6. 00	0	0		0 0	0	23.00
	adjustment (see instructions)							
24.00	Allowable disproportionate	10.00	0. 0000	0.0000	0.000	0.0000		24.00
	share percentage (see							
	i nstructi ons)							
25.00	Disproportionate share	11. 00	0	0		0	0	25.00
	adjustment (see instructions)							
26. 00	Total prospective capital	12. 00	780, 329	0	583, 39	4 196, 935	780, 329	26. 00
	payments (see instructions)	W/C F Doub A	(//					
		W/S E, Part A	(Amounts to E, Part A)					
		line 0	E, Part A) 1.00	2.00	3.00	4. 00	5. 00	
27. 00	Low volume adjustment factor	0	1.00	2.00	0. 04242		3.00	27. 00
28. 00	Low volume adjustment	70. 96			372, 65		372, 651	
20.00	(transfer amount to Wkst. E,	, 5. , 5] 3,2,00		3,2,031	20.00
	Pt. A, line)							
29. 00	Low volume adjustment	70. 97				168, 247	168, 247	29.00
	(transfer amount to Wkst. E,					,	1,,	
	Pt. A, line)							
100.00	Transfer low volume		Υ					100.00
	adjustments to Wkst. E, Pt. A.							
			•					

| Peri od: | Worksheet E | From 01/01/2019 | Part A Exhibit 5 | To 12/31/2019 | Date/Time Prepared: Health Financial SystemsKING'S DAUGHTERHOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 Provider CCN: 15-0069

				To	12/31/2019	Date/Time Pre 5/21/2020 10:	
			Title	XVIII	Hospi tal	PPS	00 4
		Wkst. E, Pt.	Amt. from	Period to	Period on	Total (col s.	
		A, line	Wkst. E, Pt.	10/01	after 10/01	2 and 3)	
			A)	0.00	0.00		
1 00	DDC	0	1.00	2. 00	3. 00	4. 00	1 00
1. 00 1. 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for	1. 00 1. 01	7, 166, 065	7, 166, 065		7 144 045	1. 00 1. 01
1.01	discharges occurring prior to October 1	1.01	7, 100, 003	7, 100, 003		7, 166, 065	1.01
1. 02	DRG amounts other than outlier payments for	1. 02	2, 466, 243		2, 466, 243	2, 466, 243	1. 02
1.02	di scharges occurring on or after October 1	1. 02	2, 100, 210		2, 100, 210	2, 100, 210	1.02
1.03	DRG for Federal specific operating payment	1. 03	o	0		0	1.03
	for Model 4 BPCI occurring prior to October						
	1				_		
1. 04	DRG for Federal specific operating payment	1. 04	0		O	0	1. 04
	for Model 4 BPCI occurring on or after October 1						
2. 00	Outlier payments for discharges (see	2. 00					2. 00
2.00	instructions)	2.00					2.00
2. 01	Outlier payments for discharges for Model 4	2. 02	o	0	o	0	2. 01
	BPCI						
2. 02	Outlier payments for discharges occurring	2. 03	9, 417	9, 417		9, 417	2. 02
0.00	prior to October 1 (see instructions)	0.04	7 407		7 407	7 407	0.00
2. 03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2. 04	7, 187		7, 187	7, 187	2. 03
3. 00	Operating outlier reconciliation	2. 01	0	0	o	0	3.00
4. 00	Managed care simulated payments	3. 00	2, 378, 537	0	o	0	4.00
	Indirect Medical Education Adjustment		,	- 1			
5.00	Amount from Worksheet E, Part A, line 21	21. 00	0. 000000	0. 000000	0. 000000		5.00
	(see instructions)						
6.00	IME payment adjustment (see instructions)	22. 00	0	0	0	0	6.00
6. 01	IME payment adjustment for managed care (see	22. 01	0	0	O	0	6. 01
	instructions) Indirect Medical Education Adjustment for the	a Add on for S	oction 122 of t	the MMA			
7. 00	IME payment adjustment factor (see	27. 00	0. 000000	0. 000000	0. 000000		7.00
		27.00	0.00000	0.00000	0.00000		
7.00	instructions)						
8. 00	instructions) IME adjustment (see instructions)	28. 00	0	0	0	0	8. 00
		28. 00 28. 01	0	0	0	0	8. 00 8. 01
8. 00 8. 01	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions)	28. 01	0	0	0	0	8. 01
8. 00 8. 01 9. 00	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8)	28. 01 29. 00	0	0	0	0	8. 01 9. 00
8. 00 8. 01	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of	28. 01	0 0	0 0 0	0 0 0	0	8. 01
8. 00 8. 01 9. 00	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01)	28. 01 29. 00	0 0 0	0 0 0	0 0 0	0	8. 01 9. 00
8. 00 8. 01 9. 00 9. 01	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment	28. 01 29. 00 29. 01	0	0	0 0 0 0	0	8. 01 9. 00 9. 01
8. 00 8. 01 9. 00	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage	28. 01 29. 00	0 0 0 0	0 0 0 0. 1084	0 0 0 0. 1084	0	8. 01 9. 00
8. 00 8. 01 9. 00 9. 01	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment	28. 01 29. 00 29. 01	0	0	0. 1084 66, 835	0	8. 01 9. 00 9. 01
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)	28. 01 29. 00 29. 01 33. 00 34. 00	0. 1084 261, 035	0. 1084 194, 200	66, 835	261, 035	9. 00 9. 01 10. 00 11. 00
8. 00 8. 01 9. 00 9. 01	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments	28. 01 29. 00 29. 01 33. 00 34. 00 36. 00	0. 1084 261, 035 1, 199, 762	0. 1084		261, 035	8. 01 9. 00 9. 01 10. 00
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESI	28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 RD beneficiary	0. 1084 261, 035 1, 199, 762	0. 1084 194, 200	66, 835	261, 035 714, 437	8. 01 9. 00 9. 01 10. 00 11. 00
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESI Total ESRD additional payment (see	28. 01 29. 00 29. 01 33. 00 34. 00 36. 00	0. 1084 261, 035 1, 199, 762	0. 1084 194, 200	66, 835	261, 035	9. 00 9. 01 10. 00 11. 00
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESI Total ESRD additional payment (see instructions)	28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 RD beneficiary 46. 00	0. 1084 261, 035 1, 199, 762 di scharges	0. 1084 194, 200 621, 461	66, 835 92, 976	261, 035 714, 437	8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESI Total ESRD additional payment (see instructions) Subtotal (see instructions)	28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 RD beneficiary 46. 00 47. 00	0. 1084 261, 035 1, 199, 762	0. 1084 194, 200 621, 461	66, 835	261, 035 714, 437 0	8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESI Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH	28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 RD beneficiary 46. 00	0. 1084 261, 035 1, 199, 762 di scharges	0. 1084 194, 200 621, 461	66, 835 92, 976	261, 035 714, 437	8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESI Total ESRD additional payment (see instructions) Subtotal (see instructions)	28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 RD beneficiary 46. 00 47. 00	0. 1084 261, 035 1, 199, 762 di scharges	0. 1084 194, 200 621, 461	66, 835 92, 976	261, 035 714, 437 0	8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESI Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 RD beneficiary 46. 00 47. 00	0. 1084 261, 035 1, 199, 762 di scharges	0. 1084 194, 200 621, 461 0 8, 476, 468 0	66, 835 92, 976	261, 035 714, 437 0	8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00 14. 00	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESI Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions)	28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 RD beneficiary 46. 00 47. 00 48. 00 49. 00	0. 1084 261, 035 1, 199, 762 di scharges 0 11, 109, 709 0 11, 109, 709	0. 1084 194, 200 621, 461 0 8, 476, 468 0	66, 835 92, 976 0 2, 633, 241 0 2, 633, 241	261, 035 714, 437 0 11, 109, 709 0	8. 01 9. 00 9. 01 10. 00 11. 01 12. 00 13. 00 14. 00 15. 00
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00 14. 00	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESI Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions)	28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 RD beneficiary 46. 00 47. 00 48. 00	0. 1084 261, 035 1, 199, 762 di scharges 0 11, 109, 709 0	0. 1084 194, 200 621, 461 0 8, 476, 468 0	66, 835 92, 976 0 2, 633, 241 0	261, 035 714, 437 0 11, 109, 709 0	8. 01 9. 00 9. 01 10. 00 11. 01 12. 00 13. 00 14. 00
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESI Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 RD beneficiary 46. 00 47. 00 48. 00 49. 00 50. 00	0. 1084 261, 035 1, 199, 762 di scharges 0 11, 109, 709 0 11, 109, 709	0. 1084 194, 200 621, 461 0 8, 476, 468 0	66, 835 92, 976 0 2, 633, 241 0 2, 633, 241	261, 035 714, 437 0 11, 109, 709 0 11, 109, 709 780, 329	8. 01 9. 00 9. 01 10. 00 11. 01 12. 00 13. 00 14. 00 15. 00 16. 00
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESI Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) Special add-on payments for new technologies	28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 RD beneficiary 46. 00 47. 00 48. 00 49. 00 50. 00	0. 1084 261, 035 1, 199, 762 di scharges 0 11, 109, 709 0 11, 109, 709	0. 1084 194, 200 621, 461 0 8, 476, 468 0	66, 835 92, 976 0 2, 633, 241 0 2, 633, 241	261, 035 714, 437 0 11, 109, 709 0	8. 01 9. 00 9. 01 10. 00 11. 01 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 17. 01	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESI Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) Special add-on payments for new technologies Net organ acquisition cost	28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 RD beneficiary 46. 00 47. 00 48. 00 49. 00 50. 00 54. 00	0. 1084 261, 035 1, 199, 762 di scharges 0 11, 109, 709 0 11, 109, 709	0. 1084 194, 200 621, 461 0 8, 476, 468 0	66, 835 92, 976 0 2, 633, 241 0 2, 633, 241	0 0 0 261, 035 714, 437 0 11, 109, 709 0 11, 109, 709 780, 329	8. 01 9. 00 9. 01 10. 00 11. 01 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 17. 01
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESI Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) Special add-on payments for new technologies	28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 RD beneficiary 46. 00 47. 00 48. 00 49. 00 50. 00	0. 1084 261, 035 1, 199, 762 di scharges 0 11, 109, 709 0 11, 109, 709	0. 1084 194, 200 621, 461 0 8, 476, 468 0 8, 476, 468 583, 394	66, 835 92, 976 0 2, 633, 241 0 2, 633, 241	261, 035 714, 437 0 11, 109, 709 0 11, 109, 709 780, 329	8. 01 9. 00 9. 01 10. 00 11. 01 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 17. 01	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESI Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) Special add-on payments for new technologies Net organ acquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment	28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 RD beneficiary 46. 00 47. 00 48. 00 49. 00 50. 00 54. 00	0. 1084 261, 035 1, 199, 762 di scharges 0 11, 109, 709 0 11, 109, 709	0. 1084 194, 200 621, 461 0 8, 476, 468 0 8, 476, 468 583, 394	66, 835 92, 976 0 2, 633, 241 0 2, 633, 241	0 0 0 261, 035 714, 437 0 11, 109, 709 0 11, 109, 709 780, 329	8. 01 9. 00 9. 01 10. 00 11. 01 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 17. 01
8. 00 8. 01 9. 00 9. 01 10. 00 11. 01 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 17. 01 17. 02	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESI Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) Special add-on payments for new technologies Net organ acquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see instructions)	28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 RD beneficiary 46. 00 47. 00 48. 00 49. 00 50. 00 54. 00 68. 00	0. 1084 261, 035 1, 199, 762 di scharges 0 11, 109, 709 0 11, 109, 709 780, 329 0	0. 1084 194, 200 621, 461 0 8, 476, 468 0 8, 476, 468 583, 394	66, 835 92, 976 0 2, 633, 241 0 2, 633, 241 196, 935 0 0	261, 035 714, 437 0 11, 109, 709 0 11, 109, 709 780, 329 0 0	8. 01 9. 00 9. 01 10. 00 11. 01 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 17. 01 17. 02 18. 00

Heal th	Financial Systems	KING'S DAUGHTE	RS' HOSPLTAL		In lie	u of Form CMS-2	2552-10
	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA		Provider CO	-	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Exhibi Date/Time Pre 5/21/2020 10:	t 5 pared:
				XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1. 00	2. 00	3. 00	4. 00	
20.00	Capital DRG other than outlier	1. 00	774, 893	579, 47°	195, 422	774, 893	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	(0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	5, 436	3, 923	1, 513	5, 436	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	(0	0	21.01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	(0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0.0000	0. 0000	0.0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	(0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	780, 329	583, 394	196, 935	780, 329	26. 00
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
		0	1.00	2.00	3.00	4. 00	
27. 00					0.00	7, 22	27. 00
28. 00	Low volume adjustment prior to October 1	70. 96	372, 651	372, 65°		372, 651	28.00
29. 00	Low volume adjustment on or after October 1	70. 97	168, 247	,	168, 247	168, 247	29.00
30.00	HVBP payment adjustment (see instructions)	70. 93	39, 523	21, 776		39, 523	
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-57, 329	-57, 329	0	-57, 329	31.00
31. 01	HRR adjustment for HSP bonus payment (see linstructions)	70. 91	0	(Ö	0	1
	· · · · · · · · · · · · · · · · · · ·					(Am+ +a	

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

1.00

Ν

2.00

0

3.00

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

32. 00 100. 00

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0069	Peri od: From 01/01/2019	
			10 12/31/2019	Date/Time Prepared: 5/21/2020 10:03 am
		T: +1 - \/\/	11	DDC

			10 12/01/2017	5/21/2020 10:	03 am
		Title XVIII	Hospi tal	PPS	
			'		
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			1, 306	1.00
2.00	Medical and other services reimbursed under OPPS (see instruc	tions)		13, 148, 900	2.00
3.00	OPPS payments			13, 400, 415	3.00
4.00	Outlier payment (see instructions)			10, 337	4.00
4.01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instru	ctions)		0.000	5.00
6.00	Line 2 times line 5			0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		42, 226	9.00
10.00	Organ acqui si ti ons			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			1, 306	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
12.00	Ancillary service charges			6, 859	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			6, 859	14.00
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable fo	r payment for services o	n a chargebasis	0	16.00
	had such payment been made in accordance with 42 CFR §413.13(e)	,		
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.00
18.00	Total customary charges (see instructions)			6, 859	18.00
19.00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds li	ne 11) (see	5, 553	19.00
	instructions)				
20.00	Excess of reasonable cost over customary charges (complete on	ly if line 11 exceeds li	ne 18) (see	0	20.00
	instructions)				
21.00	Lesser of cost or charges (see instructions)			1, 306	21.00
22.00	Interns and residents (see instructions)			0	22.00
23.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			13, 452, 978	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instruction	s)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on lin	e 24 (for CAH, see instr	uctions)	2, 532, 229	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	plus the sum of lines 22	and 23] (see	10, 922, 055	27.00
	instructions)				
28. 00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30. 00	Subtotal (sum of lines 27 through 29)			10, 922, 055	
31. 00	Primary payer payments			2, 955	
32. 00	Subtotal (line 30 minus line 31)	>		10, 919, 100	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)	1		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions)			222, 844	
35.00	Adjusted reimbursable bad debts (see instructions)			144, 849	
36.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		129, 817 11, 063, 949	
	Subtotal (see instructions)				
38. 00 39. 00	MSP-LCC reconciliation amount from PS&R			46	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	c)		0	
39. 50 39. 97	Prioneer ACO demonstration payment adjustment (see instruction	5)		0	39. 50 39. 97
	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for repla	and dayless (see instruc	tions)	0	39. 97 39. 98
39. 98 39. 99	·	ced devices (see ilistiuc	LI UIIS)	0	39. 96 39. 99
	RECOVERY OF ACCELERATED DEPRECIATION				
40.00	Subtotal (see instructions)			11, 063, 903	
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			221, 278	40. 01 40. 02
				10 040 501	40. 02
41.00	Interim payments			10, 869, 581	
42.00	Tentative settlement (for contractors use only)			0 -26, 956	42.00
43.00	Balance due provider/program (see instructions)	noo with CMC Dub 1E 2	ahantar 1		
44. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter I,	172, 707	44. 00
	\$115. 2				
00 00	TO BE COMPLETED BY CONTRACTOR			0	00 00
	Original outlier amount (see instructions)				90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 00	91.00
	The rate used to calculate the Time Value of Money				92.00
93.00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93. 00 94. 00
74. UU	Total (Suil Of FFIES 71 and 73)		I	U	74.00

Health Financial Systems KING' ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: From 01/01/2019 To 12/31/2019 Date/Ti me Prepared: Provider CCN: 15-0069

				0 12,01,201,	5/21/2020 10:	03 am
			XVIII	Hospi tal	PPS	
		Inpati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		11, 133, 192		10, 869, 581	1.00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
2 01	Program to Provider ADJUSTMENTS TO PROVIDER	I			0	2 01
3. 01	ADJUSTMENTS TO PROVIDER		0		0	
3. 02 3. 03			0		0	
			_		0	
3. 04 3. 05			0		0	
3.05	Provider to Program				U	3.05
3. 50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3. 51	ADJUSTINIENTS TO TROURAIN		0		0	
3. 52			Ö		0	
3. 53			,		0	
3. 54			ő		0	0.00
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		o o		0	
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		11, 133, 192		10, 869, 581	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)]
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
F 04	Program to Provider				0	- 01
5. 01	TENTATI VE TO PROVI DER		0		0	
5. 02 5. 03			0		0	
5. 03	Provider to Program		0		U	5.03
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51	I ENTATIVE TO TROOKAW		0		0	
5. 52			0		0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		o o		0	
0. ,,	5. 50-5. 98)		Ŭ		, and the second se	0.77
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		0		0	6. 01
6.02	SETTLEMENT TO PROGRAM		269, 748		26, 956	6. 02
7. 00	Total Medicare program liability (see instructions)		10, 863, 444		10, 842, 625	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
8. 00	Name of Contractor	()	1. 00	2. 00	8.00

Heal th	Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lie	u of Form CMS-	2552-10	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0069	Peri od:	Worksheet E-		
				From 01/01/2019 To 12/31/2019		epared:	
					5/21/2020 10:		
			Title XVIII	Hospi tal	PPS		
					1 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDAL	DD COST DEDODTS			1. 00		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION						
1. 00							
2. 00							
3.00							
4.00	Total inpatient days from S-3, Pt. I col. 8		-12			4.00	
5. 00	Total hospital charges from Wkst C, Pt. I,					5. 00	
6. 00	Total hospital charity care charges from Wk					6.00	
7. 00	CAH only - The reasonable cost incurred for line 168	the purchase of c	ertified HII technology	WKSt. S-2, Pt. I		7. 00	
8. 00	Calculation of the HIT incentive payment (s	aa instructions)				8.00	
9. 00	Sequestration adjustment amount (see instru					9.00	
10.00	Calculation of the HIT incentive payment af	,	(see instructions)			10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS			· '			
30.00	Initial/interim HIT payment adjustment (see	instructions)				30.00	
	Other Adjustment (specify)					31.00	
32. 00	Balance due provider (line 8 (or line 10) m	inus line 30 and l	ine 31) (see instruction	ns)		32.00	

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL		In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der	CCN: 15-0069		Worksheet E-3 Part VII Date/Time Prepared: 5/21/2020 10:03 am
•					

			0 12/31/2019	Date/lime Pre 5/21/2020 10:	
		Title XIX	Hospi tal	Cost	00 4
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		3, 981, 174		1.00
2. 00	Medical and other services			6, 123, 918	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		3, 981, 174	6, 123, 918	4.00
5.00	Inpatient primary payer payments		o	., .,	5.00
6. 00	Outpatient primary payer payments			0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		3, 981, 174	6, 123, 918	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES			-, -, -, -	
	Reasonabl e Charges				
8.00	Routine service charges		0		8.00
9. 00	Ancillary service charges		10, 465, 587	30, 910, 219	9. 00
10.00	Organ acquisition charges, net of revenue		0		10.00
	Incentive from target amount computation		o		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		10, 465, 587	30, 910, 219	
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
	basis	ű			
14.00	Amounts that would have been realized from patients liable for	payment for services or	0	0	14.00
	a charge basis had such payment been made in accordance with 4	2 CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		10, 465, 587	30, 910, 219	16.00
17.00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	6, 484, 413	24, 786, 301	17.00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	19.00
			0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		3, 981, 174	6, 123, 918	21.00
00.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provid			00.00
	Other than outlier payments		0	0	
	Outlier payments		0	0	23.00
24. 00			0		24. 00 25. 00
26. 00	Capital exception payments (see instructions) Routine and Ancillary service other pass through costs		0	0	26.00
			0	0	26.00
28. 00	Subtotal (sum of lines 22 through 26) Customary charges (title V or XIX PPS covered services only)		0	0	28.00
	Titles V or XIX (sum of lines 21 and 27)		3, 981, 174	6, 123, 918	
29.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		3, 901, 174	0, 123, 910	29.00
20 00	Excess of reasonable cost (from line 18)		0	0	30.00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		3, 981, 174	6, 123, 918	
32. 00	Deductibles		3, 901, 174	0, 123, 910	32.00
33. 00	Coinsurance		0	0	33.00
	Allowable bad debts (see instructions)		0	0	34.00
35. 00	Utilization review		0	U	35.00
36. 00		22)	3, 981, 174	6, 123, 918	
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	33)	3, 701, 174	0, 123, 910	37.00
	Subtotal (line 36 ± line 37)		3, 981, 174	6, 123, 918	
39. 00	Direct graduate medical education payments (from Wkst. E-4)			0, 123, 710	39.00
40. 00				6, 123, 918	
41. 00				6, 123, 918	
42. 00				0, 123, 710	
43. 00	Protested amounts (nonallowable cost report items) in accordan	0	0	43. 00	
	chapter 1, §115.2			· ·	
			'		•

lealth Financial Systems KING'S DAUGHTERS' HOSPITAL In Lieu of Form CMS-2552-10

Health Financial Systems KING'S DAUGH BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 15-0069

Peri od: Worksheet G From 01/01/2019 To 12/31/2019 Date/Ti me Prepared: 5/21/2020 10: 03 am

37	· · · · · · · · · · · · · · · · · · ·	General Fund	Speci fi c	Endowment	5/21/2020 10: Plant Fund	03 am
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	14, 394, 881	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes recei vable	0 040 005	0	0	0	3.00
4. 00 5. 00	Accounts receivable Other receivable	9, 960, 805	0	0	0	4. 00 5. 00
6. 00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7. 00	Inventory	2, 442, 862	Ö	Ö	0	7. 00
8.00	Prepai d expenses	4, 114, 174	0	О	0	8. 00
9. 00	Other current assets	235, 176	0	0	0	9. 00
10.00	Due from other funds	0	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	31, 147, 898	0	0	0	11.00
12. 00	FIXED ASSETS Land	3, 989, 556	0	ol	0	12.00
13. 00	Land improvements	3, 707, 330	0	o	0	13.00
14. 00	Accumulated depreciation	-1, 723, 169	- 1	Ö	0	14.00
15.00	Bui I di ngs	118, 507, 606	0	O	0	15. 00
16. 00	Accumulated depreciation	-39, 562, 491	0	0	0	16. 00
17. 00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19. 00 20. 00	Fixed equipment Accumulated depreciation	0	0	0	0	19. 00 20. 00
21. 00	Automobiles and trucks	1, 220, 059	-	0	0	21.00
22. 00	Accumulated depreciation	-1, 025, 427	o o	o	0	22.00
23. 00	Major movable equipment	60, 610, 053	0	O	0	23.00
24.00	Accumulated depreciation	-46, 094, 360	0	0	0	24.00
25. 00	Mi nor equipment depreciable	0	0	0	0	25.00
26. 00	Accumulated depreciation	0	0	0	0	26.00
27. 00 28. 00	HIT designated Assets	0	0	O O	0	27. 00 28. 00
29. 00	Accumulated depreciation Minor equipment-nondepreciable	0	0	0	0	29.00
30. 00	Total fixed assets (sum of lines 12-29)	95, 921, 827	Ö	0	0	30.00
	OTHER ASSETS		-,	-1		
31.00	Investments	0	0	0	0	31.00
32. 00	Deposits on Leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34. 00 35. 00	Other assets Total other assets (sum of lines 31-34)	172, 480, 857 172, 480, 857	1	0	0	34. 00 35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	299, 550, 582	0	0	0	36.00
00.00	CURRENT LIABILITIES	27770007002	<u> </u>	<u>~</u> 1		00.00
37.00	Accounts payable	1, 269, 496	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	0	0	0	0	38. 00
39. 00	Payrol I taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term) Deferred income	653, 245	0	0	0	40.00
41. 00 42. 00	Accel erated payments		0	U U	U	41. 00 42. 00
43. 00	Due to other funds	0	0	0	0	43.00
44. 00	Other current liabilities	12, 908, 184	0	Ö	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	14, 830, 925	0	0	0	45.00
	LONG TERM LIABILITIES	,				
46. 00	Mortgage payable	0	0	0	0	46. 00
47. 00	Notes payable	89, 095, 285		0	0	47.00
48. 00 49. 00	Unsecured Loans Other Long term Liabilities	993, 908	0	0	0	48. 00 49. 00
50. 00	Total long term liabilities (sum of lines 46 thru 49)	90, 089, 193	1	0	0	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	104, 920, 118	1	o	0	51.00
	CAPITAL ACCOUNTS			- 1		
52.00	General fund balance	194, 630, 464				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56. 00 57. 00	Governing body created - endowment fund balance Plant fund balance - invested in plant			٩	0	56. 00 57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58.00
55. 55	replacement, and expansion				O	55.55
59. 00	Total fund balances (sum of lines 52 thru 58)	194, 630, 464	0	О	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	299, 550, 582	0	o	0	60.00
	[59]	I	I I			l

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES KING'S DAUGHTERS' HOSPITAL In Lieu of Form CMS-2552-10

Period: Worksheet G-1 From 01/01/2019 Provi der CCN: 15-0069

					То	12/31/2019	Date/Time Pro 5/21/2020 10:	epared: 03 am
		General	Fund	Speci al	Purpo	ose Fund	Endowment Fund	
		1. 00	2. 00	3.00		4.00	5. 00	
1. 00 2. 00 3. 00 4. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	167, 631, 418 26, 999, 046 194, 630, 464		0	0	0. 00	1. 00 2. 00 3. 00 4. 00
5. 00 6. 00 7. 00 8. 00 9. 00	, , , , , , , , , , , , , , , , , , ,	0 0 0 0 0			0 0 0 0		((((6. 00 7. 00 8. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0 0	0 194, 630, 464		0 0 0 0	0		13. 00 14. 00 15. 00 16. 00
17. 00 18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	0 194, 630, 464		U	0 0	C	17. 00 18. 00 19. 00
		Endowment Fund	PI ant	Fund				
		6. 00	7. 00	8. 00				
1. 00 2. 00 3. 00 4. 00 5. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0		0			1.00 2.00 3.00 4.00 5.00
6. 00 7. 00 8. 00 9. 00	Total additions (sum of line 4.0)		0 0 0		0			6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0 0 0 0		0			10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0			18. 00 19. 00

Health Financial Systems KI STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 15-0069

			10 12/31/2019	5/21/2020 10:	
	Cost Center Description	I npati ent	Outpati ent	Total	OS alli
	555 551151 55551 Pt. 511	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	11, 885, 2	10	11, 885, 210	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF		0	0	5.00
6.00	Swing bed - NF		0	0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9. 00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	11, 885, 2	10	11, 885, 210	10.00
	Intensive Care Type Inpatient Hospital Services		1		
11. 00	I NTENSI VE CARE UNI T	2, 847, 7	98	2, 847, 798	
12. 00	CORONARY CARE UNIT				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)			0 047 700	15.00
16. 00	Total intensive care type inpatient hospital services (sum of lines	2, 847, 7	98	2, 847, 798	16. 00
17 00	11-15)	14 700 0	20	14 722 000	17.00
17. 00 18. 00	Total inpatient routine care services (sum of lines 10 and 16) Ancillary services	14, 733, 0		14, 733, 008	
19.00	Outpatient services	62, 213, 2		273, 802, 256 71, 896, 345	
20.00	RURAL HEALTH CLINIC		0 71, 896, 345	71, 690, 343	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER				21.00
22. 00	HOME HEALTH AGENCY		1, 621, 654	-	
23. 00	AMBULANCE SERVICES	1, 2			
24. 00	CMHC	1,2	5, 447, 555	3, 430, 730	24.00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE		0 325, 526	325, 526	
27. 00	OTHER OUTPATIENT		0 127, 261	127, 261	27. 00
28. 00	Total patient revenues (sum of lines 17-27) (transfer column 3 to Wks	st. 76, 947, 5	·		
	G-3, line 1)		,	, , , , , , , , , , , , , , , , , , , ,	
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		124, 451, 629		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	T		0		35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37. 00	DEDUCT (SPECIFY)		0		37.00
38.00			0		38.00
39.00			0		39.00
40.00			0		40.00
41. 00 42. 00	Total deductions (sum of lines 37-41)		٦		41. 00 42. 00
42.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(trar	nsfer	124, 451, 629		42.00
45.00	to Wkst. G-3, line 4)	131 51	124, 431, 029		45.00
	10 mat. 5 5, 1176 4)	I .	1	1	ı

Heal th	Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lie	u of Form CMS-2	2552-10	
	MENT OF REVENUES AND EXPENSES		Provi der CCN: 15-0069	Peri od:	Worksheet G-3		
				From 01/01/2019 To 12/31/2019	Date/Time Pre 5/21/2020 10:		
					1. 00		
1. 00	Total patient revenues (from Wkst. G-2, Par	t I. column 3. lin	e 28)		367, 956, 806	1. 00	
2. 00	Less contractual allowances and discounts or				246, 126, 557	2.00	
3.00	Net patient revenues (line 1 minus line 2)	•			121, 830, 249	3.00	
4.00	Less total operating expenses (from Wkst. G	-2, Part II, line	43)		124, 451, 629	4. 00	
5.00	Net income from service to patients (line 3	minus line 4)			-2, 621, 380	5. 00	
	OTHER I NCOME						
6.00	Contributions, donations, bequests, etc				272, 174	6.00	
7.00	Income from investments				4, 084, 984	7. 00	
8.00	.00 Revenues from telephone and other miscellaneous communication services						
9.00	.00 Revenue from television and radio service						
10.00	Purchase di scounts				0		
11. 00	Rebates and refunds of expenses				0		
	Parking lot receipts				0		
	Revenue from Laundry and Linen service				0		
	Revenue from meals sold to employees and gue	ests			405, 565		
	Revenue from rental of living quarters					15.00	
	Revenue from sale of medical and surgical su		han patients		0		
	Revenue from sale of drugs to other than pa				0		
	Revenue from sale of medical records and abs				-	18. 00	
	Tuition (fees, sale of textbooks, uniforms,				0		
20.00	Revenue from gifts, flowers, coffee shops, a	and canteen			0	20.00	
21. 00	Rental of vending machines				0	21.00	
22. 00	Rental of hospital space				0	22. 00	
	Governmental appropriations				58, 396		
	OTHER OPERATING INCOME				24, 799, 092		
	Total other income (sum of lines 6-24)				29, 620, 426		
	Total (line 5 plus line 25)				26, 999, 046		
	OTHER EXPENSES (SPECIFY)				0		
טא אני	Total other evenence (sum of line 27 and sul	necrinte)			Λ	28 00	

26, 999, 046 29. 00

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

	Financial Systems SIS OF HOSPITAL-BASED HOME HEAL		KING'S DAUGHTER	RS' HOSPITAL Provi der CO	CN: 15-0069	Peri od:	u of Form CMS-2 Worksheet H	2552-10
				HHA CCN:	15-7141	From 01/01/2019 To 12/31/2019	Date/Time Pre	pared:
						Home Health	5/21/2020 10: PPS	
						Agency I		
		Sal ari es	Benefits	Transportatio n (see instructions)	Contracted/F rchased Servi ces	u Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
1. 00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &			ما			0	1.00
1.00	Fixtures					0	0	1.00
2. 00	Capital Related - Movable Equipment			0		0	0	2.00
3. 00 4. 00	Plant Operation & Maintenance Transportation	0	0	0		0 0	0	3. 00 4. 00
5. 00	Administrative and General	899, 373	149	220		0 10, 636	910, 378	
	HHA REIMBURSABLE SERVICES							1
6. 00 7. 00	Skilled Nursing Care Physical Therapy	0	0	25, 222 23, 841		0 0	25, 222 23, 841	
8. 00	Occupational Therapy	0	0	23, 041		0 0	23, 041	
9. 00	Speech Pathology	0	0	0		0 0	0	
10. 00 11. 00	Medical Social Services Home Health Aide	0	0	0 1, 593		0 0	0 1, 593	10.00
12. 00	Supplies (see instructions)		0	1, 373		0 23, 507	23, 507	
13.00	Drugs	0	0	O		0 7	7	13.00
14. 00	HHA NONREI MBURSABLE SERVI CES	0	0	0		0 0	0	14.00
15. 00	Home Dialysis Aide Services	0	0	O		0 0	0	15.00
16.00	Respi ratory Therapy	0	0	0		0 0	0	16.00
17.00	Private Duty Nursing	0	0	0		0 0	0	17.00
18. 00 19. 00	Clinic Health Promotion Activities	0	0	0			0	18. 00 19. 00
20.00	Day Care Program	0	0	Ö		0 0	0	20.00
21. 00	Home Delivered Meals Program	0	0	0		0 0	0	21.00
22. 00 23. 00	Homemaker Service All Others (specify)	0	0	0		0 0	0	22. 00 23. 00
23. 50	Tel emedi ci ne	0	0	Ö		0 0	0	23.50
24. 00	Total (sum of lines 1-23)	899, 373	149	50, 876		0 34, 150	984, 548	24.00
		Recl assi fi cat	Reclassified Trial Balance	Adjustments	Net Expenses	5		
		1011	(col . 6 +		Allocation			
			col . 7)		(col. 8 +			
		7. 00	8. 00	9. 00	col . 9) 10.00	_		-
	GENERAL SERVICE COST CENTERS							
1. 00	Capital Related - Bldg. &	0	0	0		0		1.00
2. 00	Fixtures Capital Related - Movable Equipment	0	0	0		0		2. 00
3. 00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportati on	0	0	0		0		4. 00
5. 00	Administrative and General HHA REIMBURSABLE SERVICES	-626, 182	284, 196	0	284, 19	96		5.00
6. 00	Skilled Nursing Care	354, 536	379, 758	0	379, 7	58		6.00
7. 00	Physical Therapy	196, 834	220, 675	0	220, 6			7.00
8. 00 9. 00	Occupational Therapy Speech Pathology	61, 383 2, 195	61, 383 2, 195	0	61, 38 2, 19			8. 00 9. 00
10.00	Medical Social Services	2, 193	2, 143	0	2, 1	0		10.00
11.00	Home Health Aide	11, 841	13, 434	0	13, 43			11.00
12. 00 13. 00	Supplies (see instructions)	0	23, 507	0	23, 50)7 7		12. 00 13. 00
14. 00	Drugs DME		7	0		0		14.00
	HHA NONREIMBURSABLE SERVICES		-	-				
15.00	Home Dialysis Aide Services	0	0	0		0		15.00
16. 00 17. 00	Respiratory Therapy Private Duty Nursing		0	0		0		16. 00 17. 00
18. 00	Clinic	Ö	Ö	ő		O		18.00
19.00	Health Promotion Activities	0	0	O		0		19.00
20. 00 21. 00	Day Care Program Home Delivered Meals Program	0	0	0		0		20.00
22. 00	Homemaker Service	0	0	o		Ō		22.00
23. 00	All Others (specify)	0	O	o		0		23.00
23. 50	Telemedicine Total (sum of lines 1-23)	607	0 985, 155	0	985, 1!	55		23. 50 24. 00
_ 1. 00	1.2.2. (32 01 111103 1 20)	1 007	,00, 100	٩	,,,,,,,	1		00

Heal th	Financial Systems		KING'S DAUGHTER	RS' HOSPITAL		In Lie	eu of Form CMS-:	2552-10
	ALLOCATION - HHA GENERAL SERVICE			Provi der C	CN: 15-0069	Peri od:	Worksheet H-1	
				HHA CCN:	15-7141	From 01/01/2019 To 12/31/2019	Date/Time Pre	pared:
						Home Health	5/21/2020 10: PPS	03 am
						Agency I	FF3	
			Capital Rela	ated Costs				
		Net Expenses for Cost Allocation (from Wkst.	BI dgs & Fi xtures	Movable Equipment	Plant Operation & Maintenance		Subtotal (col s. 0-4)	
		H, col . 10)						
	OFNEDAL CEDIU OF OCCT OFNITEDO	0	1. 00	2. 00	3.00	4. 00	4A. 00	
1. 00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	ol				1 0	1.00
	Fixtures							
2. 00	Capital Related - Movable Equipment	0		0			0	2.00
3. 00	Plant Operation & Maintenance	0	О	0		0	0	3.00
4.00	Transportati on	0	0	0		0 0		4.00
5. 00	Administrative and General HHA REIMBURSABLE SERVICES	284, 196	0	0		0 0	284, 196	5.00
6. 00	Skilled Nursing Care	379, 758	0	0		0 0	379, 758	6.00
7. 00	Physi cal Therapy	220, 675	0	0	•	0 0		
8. 00 9. 00	Occupational Therapy Speech Pathology	61, 383 2, 195	0	0	•	0 0		
10.00	Medical Social Services	2,173	o	0		0 0		1
11. 00	Home Heal th Ai de	13, 434	O	0		0 0	10, 101	1
12. 00 13. 00	Supplies (see instructions) Drugs	23, 507	0	0		0 0	23, 507	1
14. 00	DME	Ó	Ö	0		0 0	•	1
45.00	HHA NONREI MBURSABLE SERVI CES	1			ı		T .	45.00
15. 00 16. 00	Home Dialysis Aide Services Respiratory Therapy	0	0	0		0 0	l .	1
17. 00	Private Duty Nursing	0	Ö	0		0 0	O	
18.00	Clinic	0	0	0		0 0	0	
19. 00 20. 00	Health Promotion Activities Day Care Program	0	0	0		0 0	0	
21. 00	Home Delivered Meals Program	0	O	0		0 0	O	1
22. 00	Homemaker Service	0	0	0		0 0	0	
23. 00 23. 50	All Others (specify) Telemedicine		0	0		0 0	_	
	Total (sum of lines 1-23)	985, 155	0	0		0 0	985, 155	1
		Administrativ e & General	Total (cols. 4A + 5)					
		5. 00	6. 00					-
	GENERAL SERVICE COST CENTERS							
1. 00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable							2.00
2 00	Equipment							2 00
3. 00 4. 00	Plant Operation & Maintenance Transportation							3. 00 4. 00
5. 00	Administrative and General	284, 196						5.00
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	153, 968	533, 726					6.00
7. 00	Physical Therapy	89, 470						7. 00
8. 00	Occupational Therapy	24, 887	86, 270					8.00
9. 00 10. 00	Speech Pathology Medical Social Services	890	3, 085					9. 00 10. 00
11. 00	Home Heal th Aide	5, 447	18, 881					11.00
12.00	Supplies (see instructions)	9, 531	33, 038					12.00
13. 00 14. 00	Drugs DME	3 0	10					13. 00 14. 00
11.00	HHA NONREI MBURSABLE SERVI CES							11.00
15.00	Home Dialysis Aide Services	0	0					15.00
16. 00 17. 00	Respiratory Therapy Private Duty Nursing	0	0					16. 00 17. 00
18.00	Clinic	0	0					18. 00
19.00	Health Promotion Activities	0	O					19.00
20. 00 21. 00		0	0					20. 00 21. 00
22. 00	Homemaker Service		0					22. 00
	All Others (specify)	0	0					23.00
23. 50 24. 00	Telemedicine Total (sum of lines 1-23)		0 985, 155					23. 50 24. 00
	, (a) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	'	, .30					

Heal th	Financial Systems		KING'S DAUGHTE	'RS' HOSPLTAL		Inlie	u of Form CMS-2	2552_10
	LLOCATION - HHA STATISTICAL BAS		KING 3 DAGGITE	Provi der C	CN: 15-0069	Peri od:	Worksheet H-1	
				HHA CCN:		From 01/01/2019 To 12/31/2019	Part II	pared:
						Home Health	PPS	
						Agency I		
		Capital Rel	ated Costs					
		BI dgs &	Movabl e	PI ant	Transportatio	Reconciliatio	Administrativ	
		Fi xtures	Equi pment	Operation &	n (MI LEAGE)	n	e & General	
		(SQUARE FEET)	(DOLLAR	Mai ntenance			(ACCUM. COST)	
		1.00	VALUE)	(SQUARE FEET)	4.00	FA 00	F 00	
	GENERAL SERVICE COST CENTERS	1. 00	2. 00	3. 00	4.00	5A. 00	5. 00	
1. 00	Capital Related - Bldg. &	0				0		1.00
1.00	Fixtures	J						1.00
2.00	Capital Related - Movable		0			0		2.00
	Equi pment							
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see	0	0	0		0		4. 00
	instructions)						700 050	
5. 00	Administrative and General HHA REIMBURSABLE SERVICES	0	0	0		0 -284, 196	700, 959	5.00
6. 00	Skilled Nursing Care	O	0	0		0 0	379, 758	6.00
7. 00	Physical Therapy		0			0 0	220, 675	
8. 00	Occupational Therapy	0	0			0 0	61, 383	
9. 00	Speech Pathology	Ö	0	Ö		o o	2, 195	
10.00	Medical Social Services	o	0	0		0 0	0	10.00
11.00	Home Health Aide	0	0	0		0 0	13, 434	11. 00
12.00	Supplies (see instructions)	0	0	0		0	23, 507	
13.00	Drugs	0	0			0	7	13.00
14.00	DME	0	0	0		0 0	0	14.00
15. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	O	0	0	1	0 0	0	15.00
16. 00	Respiratory Therapy		0			0 0	0	
17. 00	Private Duty Nursing	0	0		1	0 0	0	
18. 00	Clinic	0	0	1		0 0	0	
19. 00	Health Promotion Activities	Ö	0			o o	Ö	
20.00	Day Care Program	O	0	Ö		0	0	1
21.00	Home Delivered Meals Program	o	0	0		0 0	0	21.00
22.00	Homemaker Service	0	0	0		0 0	0	
	All Others (specify)	0	0	0		0	0	23. 00
23. 50	Tel emedi ci ne	0	0	0		0	0	23.50
24. 00	Total (sum of lines 1-23)	0	0	0		0 -284, 196	700, 959	
25. 00	Cost To Be Allocated (per Worksheet H-1, Part I)		Ü			U I	284, 196	25. 00
26. 00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0. 00000	О	0. 405439	26. 00

Peri od: Worksheet H-2
From 01/01/2019 Part I
To 12/31/2019 Date/Time Prepared: 5/21/2020 10: 03 am HHA CCN: 15-7141

Home Health

						Agency I	113	
			CAPI	TAL RELATED CO	OSTS			
	Cost Center Description	HHA Trial Balance (1)	NEW BLDG & FIXT	NEW BLDG & FIXT HHA/HO	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		0	1. 00	1. 01	2.00	4. 00	4A	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to	0 533, 726 310, 145 86, 270 3, 085 0 18, 881 33, 038 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	000000000000000000000000000000000000000	6, 185 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	230, 388 0 0 0 0 0 0 0 0 0 0 0 0	236, 573 533, 726 310, 145 86, 270 3, 085 0 18, 881 33, 038 10 0 0 0 0 0 0	9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00
	6 decimal places. Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	cost center bescription	E & GENERAL	PLANT	LINEN SERVICE				
	1	5. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 50 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	41, 259 93, 083 54, 090 15, 046 538 0 3, 293 5, 762 2 0 0 0 0 0 0 0 0 0 213, 073	52, 762 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	

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

0

6.00

7.00

Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0 0 0 0 0 0 0 0 0	0 1, 472 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 50 20. 00 21. 00
Cost Center Description	Subtotal	Intern &	Subtotal	Allocated HHA	Total HHA		
					Costs		
		Stepdown		,			
	24.00		27.00	27.00	20.00		
Administrative and General				27.00	20.00		1. 00
		0	·	178, 878	805. 687		2.00
9		0	·				3.00
1 3	101, 316	0	·	· ·	130, 229		4. 00
Speech Pathology	3, 623	0	·	· ·	4, 657		5.00
Medical Social Services	O	0	0	0	0		6.00
Home Health Aide	22, 174	0	22, 174		28, 502		7.00
Supplies (see instructions)	40, 272	0	40, 272	11, 493	51, 765		8.00
	12	0			15		9. 00
4	0	0	-	_	- 1		10.00
	0	0	ŭ	١	٧,		11.00
	0	-	-	_	٧,		12. 00 13. 00
	0	ĭ,	-	1	۳۱		14.00
	0	-	-	1	۳۱		15. 00
4	l o	o	-	_	o		16. 00
Home Delivered Meals Program	O	0	0	0	0		17.00
Homemaker Service	O	0	0	0	0		18.00
All Others (specify)	0	0	0	0	0		19.00
	0	0	0	1	-1		19. 50
	1, 489, 035	0	1, 489, 035		1, 489, 035		20.00
				0. 2853/8			21. 00
120, TIME I GIVIGEG BY LIFE SUIII	1			ı			
of column 26 line 20 minus		I			I		
of column 26, line 20 minus column 26, line 1, rounded to							
	Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places. Cost Center Description Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Home Delivered Meals Program	Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program On Delivered Meals Program Home Delivered Meals Program Home Delivered Meals Program On De	Supplies (see instructions) O	Supplies (see instructions)	Supplies (see instructions) 0	Supplies (see instructions)	Suppl os (see instructions) 0

6.00

7.00

Home Health Aide

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

Peri od: Worksheet H-2
From 01/01/2019 Part II
To 12/31/2019 Date/Time Prepared: 5/21/2020 10: 03 am BASIS HHA CCN: 15-7141 Home Health PPS

						Home Health	PPS	
		CAPI	TAL RELATED CO	STS		Agency I		
		CAFI	TAL KLLATED CC	1313				
	Cost Center Description	NEW BLDG & FLXT (SQUARE FEET)	NEW BLDG & FIXT HHA/HO (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMI NI STRATI V E & GENERAL (ACCUM. COST)	
		1. 00	1. 01	2. 00	4. 00	5A	5. 00	
1. 00 A	Administrative and General	0	2, 748	2, 748	900, 129		236, 573	1.00
2. 00 S 3. 00 P 4. 00 0 5. 00 S 6. 00 M 7. 00 H 8. 00 S 9. 00 D 11. 00 H 12. 00 R 13. 00 P 14. 00 C 15. 00 H 16. 00 D 17. 00 H 18. 00 H 19. 00 A 19. 00 T 20. 00 T 21. 00 T	Administrative and General Schilled Nursing Care Physical Therapy Docupational Therapy Deech Pathology Medical Social Services Home Health Aide Home Dialysis Aide Services Despiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Home Delivered Meals Program	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 748 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 748 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	00 00 00 00 00 00 00 00 00 00 00 00 00		236, 573 533, 726 310, 145 86, 270 3, 085 0 18, 881 33, 038 10 0 0 0 0 0 0 0 0 0 1, 221, 728 213, 073 0. 174403 NURSI NG	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 20. 00 21. 00
		(SQUARE FEET)	(POUNDS OF LAUNDRY)	SERVI CE)	SERVED)	SERVED)	N (DIRECT NRSING HRS)	
		7. 00	8. 00	9. 00	10.00	11. 00	13. 00	
2. 00 S 3. 00 P 4. 00 0 5. 00 S 6. 00 M 7. 00 H 8. 00 S 9. 00 D 11. 00 H 12. 00 R 13. 00 P 14. 00 C 15. 00 H 16. 00 D 17. 00 H 18. 00 H 19. 00 A 19. 00 T 20. 00 T 21. 00 T	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Orugs ME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service MI Others (specify) Felemedicine Total (sum of lines 1-19) Total cost to be allocated Unit cost multiplier	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	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 50 20. 00 21. 00 22. 00

Health Financial Systems	KING'S DAUGHTERS' HOSPITAL	In Lieu of Form CMS-2552-10
		Period: Worksheet H-2 From 01/01/2019 Part II
BASIS		

12/31/2019 Date/Time Prepared: 5/21/2020 10:03 am Home Health Agency I RADI OLOGY Cost Center Description CENTRAL PHARMACY MEDI CAL NONPHYSI CI AN SERVICES & (COSTED RECORDS & **ANESTHETI STS** SCH00L (ASSI GNED SUPPLY REQUIS.) LI BRARY (ASSI GNED (COSTED (GROSS TIME) TIME) REQUIS.) CHARGES) 14. 00 15. 00 16. 00 19.00 23. 00 1.00 Administrative and General 0 0 0 1.00 0 2.00 Skilled Nursing Care 2.00 3.00 Physical Therapy 0 3.00 0 0 0 0 0 0 0 0 0 4.00 Occupational Therapy 0 4.00 0 5.00 Speech Pathology 5.00 0 6.00 Medical Social Services 6.00 0 7.00 Home Health Aide 0 0 0 0 7.00 Supplies (see instructions) 0 8.00 28, 794 8.00 01 0 0 9.00 Drugs 9.00 10.00 DME 0 10.00 Home Dialysis Aide Services 0 0 11.00 11.00 0 0 0 0 0 Respiratory Therapy 0 0 0 0 12.00 12 00 13.00 Private Duty Nursing 0 13.00 14.00 Clinic 0 0 0 0 14.00 Health Promotion Activities 0 0 15.00 0 15.00 OI 0 16.00 Day Care Program 16.00 17.00 Home Delivered Meals Program 0 17.00 0 Homemaker Service 0 0 0 18.00 18.00 All Others (specify) 0 0 0 19.00 19 00 0 0 0 19.50 Tel emedi ci ne 19.50 0 0 20.00 Total (sum of lines 1-19) 28, 794 0 0 20.00 0 0 21.00 Total cost to be allocated 1, 472 0 0 21.00

0. 000000

0.051122

0.000000

0.000000

0.000000

22.00

22.00 Unit cost multiplier

	Financial Systems		KING'S DAUGHTE				u of Form CMS-2	
APPORT	TIONMENT OF PATIENT SERVICE COST	ΓS		Provi der C	CN: 15-0069	Period: From 01/01/2019	Worksheet H-3 Part I	
				HHA CCN:		Γο 12/31/2019		pared:
				Title	XVIII	Home Health Agency I	PPS	OS alli
	Cost Center Description	From, Wkst.	Facility	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I,	Costs (from	Ancillary	Costs (cols.		Per Visit	
		col. 28, line	Wkst. H-2,	Costs (from	1 + 2)		(col. 3 ÷	
		0	Part I) 1.00	Part II) 2.00	2.00	4.00	col . 4) 5. 00	
	PART I - COMPUTATION OF LESSER				3.00			
	COST LIMITATION	OI MOOREONIE	TROOMAW COST, 7	NOUNEONTE OF T	IL TROOKAW ETW	II IMITON COST, C	OK BENEFI OTAKI	
	Cost Per Visit Computation							İ
1.00	Skilled Nursing Care	2.00	805, 687		805, 68	7 3, 347	240. 72	1.00
2.00	Physical Therapy	3.00	468, 180	0	468, 180	2, 547	183. 82	2.00
3.00	Occupational Therapy	4.00	· ·					
4.00	Speech Pathology	5.00			., 00			
5. 00	Medical Social Services	6. 00		•		0		•
6.00	Home Heal th Ai de	7. 00			28, 50		197. 93	•
7. 00	Total (sum of lines 1-6)		1, 437, 255	0	.,,			7. 00
					Program Visit	5		
					Pa	rt B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject	Subject to		
	oost center beserret on	0031 211111113	OBS/C No. (1)	l lare /	to	Deducti bl es		
					Deductibles &			
					Coi nsurance			
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
	Limitation Cost Computation	1	I	_		_1		
8. 00	Skilled Nursing Care		99915	0				8.00
9.00	Physical Therapy		99915	0				9.00
10.00	Occupational Therapy Speech Pathology		99915 99915	0				10.00
11. 00 12. 00	Medical Social Services		99915	0	1.			11. 00 12. 00
13. 00	Home Health Aide		99915		8			13.00
	Total (sum of lines 8-13)		77713	0				14.00
	Cost Center Description	From Wkst.	Facility	Shared	Total HHA		Ratio (col. 3	
	, , , , , , , , , , , , , , , , , , , ,	H-2 Part I,	Costs (from	Ancillary	Costs (cols.	(from HHA	÷ col . 4)	
		col. 28, line	Wkst. H-2,	Costs (from	1 + 2)	Records)		
			Part I)	Part II)				
	la	0	1. 00	2.00	3. 00	4. 00	5. 00	
15 00	Supplies and Drugs Cost Comput		F1 7/F		F4 7/1	- 22.000	1, 572974	1 - 00
	Cost of Medical Supplies Cost of Drugs	8. 00 9. 00						
10.00	Cost of brugs	7.00	Program Visits		Cost of	239	0.037413	10.00
			rrogram vrsi ts		Servi ces			
			Par	t B		Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
	·			Deductibles &		to	Deductibles &	
			Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
			Coi nsurance			Coi nsurance		
	PART I - COMPUTATION OF LESSER	6. 00	7. 00	8.00	9. 00	10.00	11. 00	
	COST LIMITATION	OF AGGREGATE	FRUGRAW CUST, A	MOUREUATE UF II	IL PRUGKAWI LIN	II TATTON COST, C	DENEFICIARY	
	Cost Per Visit Computation							
1. 00	Skilled Nursing Care	0	1, 632			392, 855		1.00
2. 00	Physical Therapy	ĺ				285, 472		2.00
3. 00	Occupational Therapy	0	394			71, 763		3.00
4.00	Speech Pathology	0	14			2, 328		4.00
5.00	Medical Social Services	0	0			0	l I	5.00
6.00	Home Health Aide	0	88			17, 418		6.00
7. 00	Total (sum of lines 1-6)	0	3, 681		[769, 836		7. 00

	Financial Systems		KING'S DAUGHTE	RS' HOSPITAL		In Lie	u of Form CMS-2	2552-10
	TONMENT OF PATIENT SERVICE COS	TS		Provider CO	CN: 15-0069 15-7141	Peri od: From 01/01/2019 To 12/31/2019	Worksheet H-3 Part I Date/Time Pre	3
				TITIA CCIV.	15-7141	10 12/31/2019	5/21/2020 10:	03 am
				Title	: XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description							
		6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
0.00	Limitation Cost Computation	1			1			
8. 00 9. 00	Skilled Nursing Care Physical Therapy							8. 00 9. 00
10.00	Occupational Therapy							10.00
11. 00	Speech Pathology							11.00
12.00	Medical Social Services	•						12.00
13.00	Home Heal th Aide							13.00
	Total (sum of lines 8-13)							14.00
		Progr	ram Covered Cha	arges	Cost of			
				Ŭ	Servi ces			
			r					
			Par			Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
			to	Deductibles &		to	Deductibles &	
			Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
		6, 00	Coi nsurance 7.00	8. 00	9. 00	Coi nsurance 10.00	11. 00	
	Supplies and Drugs Cost Comput		7.00	0.00	7.00	10.00	11.00	
15. 00		0	0	0		0 0	0	15.00
	Cost of Drugs		0		l .	0	0	
	Cost Center Description	Total Program		,	•			
		Cost (sum of						
		col s. 9-10)						
		12. 00						
	PART I - COMPUTATION OF LESSER	OF AGGREGATE	PROGRAM COST, A	AGGREGATE OF TH	HE PROGRAM LI	MITATION COST, C	R BENEFICIARY	
	COST LIMITATION Cost Per Visit Computation							-
1. 00	Skilled Nursing Care	392, 855						1.00
2. 00	Physical Therapy	285, 472						2.00
3. 00	Occupational Therapy	71, 763						3.00
4. 00	Speech Pathology	2, 328						4.00
5. 00	Medical Social Services	0						5.00
6. 00	Home Heal th Ai de	17, 418						6.00
7. 00	Total (sum of lines 1-6)	769, 836						7.00
7.00	· · _ · _ ·							
7.00	Cost Center Description							Ī
7.00		12. 00						
	Limitation Cost Computation	12.00						
8. 00	Limitation Cost Computation Skilled Nursing Care	12. 00						8.00
8. 00 9. 00	Limitation Cost Computation Skilled Nursing Care Physical Therapy	12.00						9.00
8. 00 9. 00 10. 00	Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy	12.00						9. 00 10. 00
8. 00 9. 00 10. 00 11. 00	Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	12.00						9. 00 10. 00 11. 00
8. 00 9. 00 10. 00 11. 00 12. 00	Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	12.00						9. 00 10. 00 11. 00 12. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	12.00						9. 00 10. 00 11. 00

Heal th	Financial Systems		KING'S DAUGHTE	RS' HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORT	TIONMENT OF PATIENT SERVICE COS	ΓS		Provi der C		Peri od:	Worksheet H-3	
				HHA CCN:	15-7141	From 01/01/2019 To 12/31/2019		
				Title	: XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Charge Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1. 00	2. 00	3. 00	4. 00		
	PART II - APPORTIONMENT OF COS	T OF HHA SERVI	CES FURNISHED E	BY SHARED HOSPI	TAL DEPARTME	NTS		
1.00	Physi cal Therapy	66.00	0. 311051	0		0 col. 2, line 2	. 00	1.00
2.00	Occupational Therapy	67.00	0. 341145	0		0 col. 2, line 3	. 00	2.00
3.00	Speech Pathology	68. 00	0. 323829	0		0 col. 2, line 4	. 00	3.00
4.00	Cost of Medical Supplies	71.00	0. 364388	0		0 col. 2, line 1	5. 00	4.00
4.01	Cost of Medical Supplies 1	71. 01	0. 098315	0		0 col. 2, line 1	5. 01	4. 01
5.00	Cost of Drugs	73.00	0. 190464	0		0 col. 2, line 1	6. 00	5.00

	Financial Systems KING'S DAUGHTERS' ATION OF HHA REIMBURSEMENT SETTLEMENT	HOSPITAL Provi der C	^N: 15_0060	Peri od:	u of Form CMS-2 Worksheet H-4	
ALCUL	ATTON OF THE RETWINDORSEMENT SETTEMBENT	HHA CCN:	15-7141	From 01/01/2019 To 12/31/2019	Part I-II	
			XVIII	Home Health	5/21/2020 10: PPS	
			7,111	Agency I		
			Part A	Not Subject	t B Subject to	
				to	Deductibles &	
				Deductibles & Coinsurance	Coi nsurance	
			1.00	2. 00	3. 00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUST Reasonable Cost of Part A & Part B Services	OMARY CHARGI	<u>:S</u>			-
00	Reasonable cost of services (see instructions)			0 0	0	1.
00	Total charges			0 0	0	2.
00	Customary Charges Amount actually collected from patients liable for payment fo	or services		0 0	0] 3.
. 00	on a charge basis (from your records)	n services			O] 5.
. 00	Amount that would have been realized from patients liable for for services on a charge basis had such payment been made in with 42 CFR §413.13(b)			0 0	0	4.
. 00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 0000	0. 000000	0.000000	5.
. 00 . 00	Total customary charges (see instructions) Excess of total customary charges over total reasonable cost	(complete		0 0	0	6. 7.
. 00	only if line 6 exceeds line 1)	(compile te		0	U	/
. 00	Excess of reasonable cost over customary charges (complete on	ly if line		0 0	0	8.
00	1 exceeds line 6) Primary payer amounts			0 0	0	9.
00	Trinary bayor amounts			Part A	Part B	,
				Servi ces 1.00	Servi ces 2. 00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers			0	0 735, 992	1
2. 00	Total PPS Reimbursement - Full Episodes without outliers			0	2, 013	1
3. 00	Total PPS Reimbursement - LUPA Episodes			0	17, 298	1
4. 00 5. 00	Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers			0	10, 297 601	1
5. 00	Total PPS Outlier Reimbursement - PEP Episodes with outliers	•		0	0	16.
7. 00	Total Other Payments			0	0	17.
3. 00	DME Payments			0	0	18
9. 00). 00	Oxygen Payments Prosthetic and Orthotic Payments			0	0	19 20
1.00	Part B deductibles billed to Medicare patients (exclude coins	surance)			0	21
2. 00	Subtotal (sum of lines 10 thru 20 minus line 21)			0	766, 201	
. 00	Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23)			0	766, 201	23
5. 00	Coinsurance billed to program patients (from your records)				700, 201	25
	Net cost (line 24 minus line 25)			0	766, 201	1
	Reimbursable bad debts (from your records)					27
3. 00 9. 00	Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin)	0	766, 201	28 29
0.00	ZERO OUT SETTLEMENT	10 27)		ő	1	30
. 50	Pioneer ACO demonstration payment adjustment (see instruction	ıs)		0	0	
). 99	Demonstration payment adjustment amount before sequestration			0	744 202	30
∣. 00 ∣. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			0	766, 202 15, 324	
1. 02	Demonstration payment adjustment amount after sequestration			Ö	0	31
2.00	Interim payments (see instructions)			0	750, 878	1
3. 00 4. 00	Tentative settlement (for contractor use only) Balance due provider/program (line 31 minus lines 31.01, 32,	and 33)		0	0	
	Darance due provider/program (TITE 31 MITIUS TITES 31.01, 32,	uilu JJ)		ı	U	1 34

Health Financial Systems KING'S DAUGHTER ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED In Lieu of Form CMS-2552-10 KING'S DAUGHTERS' HOSPITAL Provider CCN: 15-0069

Peri od: From 01/01/2019 To 12/31/2019 Date/Ti me Prepared: 5/21/2020 10: 03 am PPS TO PROGRAM BENEFICIARIES HHA CCN: 15-7141

				Home Health	PPS	20 a
			+ D+ A	Agency I		
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider			0	750, 878	1.00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for			0	0	2. 00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		l			
3. 01				0	0	3. 01
3. 02				0	0	3. 02
3. 03				0	0	3. 03
3. 04 3. 05				0	0 0	3. 04 3. 05
3. 05	Provider to Program			<u>u</u>	0	3.05
3. 50	110VI del 110gi dill			0	0	3. 50
3. 51				0	0	3.51
3.52				0	0	3. 52
3. 53				0	0	3. 53
3. 54 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0 0	3. 54 3. 99
5. 77	3. 50-3. 98)					3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)			0	750, 878	4.00
	(transfer to Wkst. H-4, Part II, column as appropriate,					
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
0.00	desk review. Also show date of each payment. If none,					0.00
	write "NONE" or enter a zero. (1)					
	Program to Provider			-1		
5. 01 5. 02				0	0 0	5. 01 5. 02
5. 02				0		5. 02
3. 03	Provider to Program			<u> </u>		5. 05
5. 50				0	0	5.50
5. 51				0	0	5. 51
5. 52	Subtatal (sum of lines E 01 E 40 minus sum of lines			0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			O		5. 99
6. 00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER			0	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	750.070	6. 02
7. 00	Total Medicare program liability (see instructions)			O Contractor	750, 878 NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1.00	2.00	
8. 00	Name of Contractor					8. 00

ANALYS	SIS OF HOSPITAL-BASED HOSPICE COSTS		Provi der C		Peri od:	Worksheet 0	
			Hospi ce CCI		From 01/01/2019 To 12/31/2019	Date/Time Pre 5/21/2020 10:	pared: 03 am
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col. 1 plus	RECLASSI FI - CATI ONS	SUBTOTAL	
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
1.00	CAP REL COSTS-BLDG & FIXT*		0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0		0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	70.40	0 0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	69, 109	3, 513	72, 62	2 36, 446	109, 068	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0		0	0	5.00
6. 00 7. 00	LAUNDRY & LINEN SERVICE* HOUSEKEEPING*		0		0	0	6. 00 7. 00
8. 00	DI ETARY*		0		0	0	8.00
9. 00	NURSI NG ADMI NI STRATI ON*		0		0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		o o	Ö	10.00
11.00	MEDICAL RECORDS*	0	0		0	0	11.00
12.00	STAFF TRANSPORTATION*	O	125	12	5 0	125	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0		0 107	107	13.00
14.00	PHARMACY*	0	6, 770	6, 77	0 0	6, 770	14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES*	0	0		0	0	15.00
16. 00	OTHER GENERAL SERVI CE*	0	0		0	0	16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
25 00	DI RECT PATIENT CARE SERVICE COST CENTERS			1		0	25 00
25. 00 26. 00	I NPATI ENT CARE-CONTRACTED** PHYSI CI AN SERVI CES**		0		0 0	0	25. 00 26. 00
27. 00	NURSE PRACTITIONER**		0		0	0	27.00
28. 00	REGISTERED NURSE**		6, 464	6, 46	4 2, 245	8, 709	28.00
29. 00	LPN/LVN**		0, 404	0,40	0 2,243	0, 707	29.00
30.00	PHYSI CAL THERAPY**	0	1, 159	1, 15	9 276	1, 435	1
31.00	OCCUPATIONAL THERAPY**	o	. 0	1	0 103	103	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		0 0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	906	90	6 4, 993	5, 899	33.00
34.00	SPIRITUAL COUNSELING**	0	0		0 0	0	34.00
35.00	DI ETARY COUNSELI NG**	0	0		0	0	35.00
36.00	COUNSELING - OTHER**	0	0		0 0	0	36.00
37. 00	HOSPI CE AI DE & HOMEMAKER SERVI CES**	0	3, 286			18, 115	37.00
38. 00 39. 00	DURABLE MEDI CAL EQUI PMENT/OXYGEN** PATI ENT TRANSPORTATI ON**	0	33, 162	33, 16	2	33, 162 0	38.00
40.00	IMAGING SERVICES**		0		0	0	39. 00 40. 00
41.00	LABS & DI AGNOSTI CS**		0		0	0	41.00
42. 00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0		0	0	42.00
42. 50	DRUGS CHARGED TO PATIENTS**	0	0		o o	Ö	42. 50
43.00	OUTPATIENT SERVICES**	o	0		0 0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		0 0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		0 0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		0 0	0	46. 00
	NONREI MBURSABLE COST CENTERS			1			
60.00	BEREAVEMENT PROGRAM *	0	0		0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0		0	0	
62.00	FUNDRALSING*		0			0	
63. 00 64. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS* PALLIATIVE CARE PROGRAM*		0			0	1
65.00	OTHER PHYSICIAN SERVICES*		0			0	
66.00	RESIDENTI AL CARE*		0			0	
67. 00	ADVERTI SI NG*		0		o o	0	
68. 00	TELEHEALTH/TELEMONI TORI NG*		0		o o	Ö	1
	THRI FT STORE*		0		o o	0	1
70 00	NURSING FACILITY ROOM & BOARD*	ا ما	0			0	70 00

69, 109

0

0 0 0

124, 494

0

58, 999

70.00

0 0 71.00

183, 493 100. 00

100.00 TOTAL

70. 00 NURSING FACILITY ROOM & BOARD*
71. 00 OTHER NONREIMBURSABLE (SPECIFY)*

^{*} Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

				Hospi ce I	
		ADJUSTMENTS	TOTAL (col. 5		
			± col . 6)		
	GENERAL SERVICE COST CENTERS	6. 00	7. 00		
1. 00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2. 00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		3.00
4. 00	ADMINISTRATIVE & GENERAL*	o o	109, 068		4.00
5. 00	PLANT OPERATION & MAINTENANCE*	o o	0		5.00
6. 00	LAUNDRY & LINEN SERVICE*	o o	Ő		6.00
7. 00	HOUSEKEEPI NG*	Ö	0		7.00
8. 00	DI ETARY*	Ö	0		8.00
9. 00	NURSI NG ADMI NI STRATI ON*	Ö	Ö		9. 00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		10.00
11. 00	MEDICAL RECORDS*	0	0		11.00
12. 00	STAFF TRANSPORTATION*	0	125		12.00
13. 00	VOLUNTEER SERVICE COORDINATION*	0	107		13.00
14.00	PHARMACY*	0	6, 770		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	I NPATI ENT CARE-CONTRACTED**	0	0		25. 00
26.00	PHYSI CI AN SERVI CES**	0	0		26.00
27.00	NURSE PRACTITIONER**	0	0		27.00
28. 00	REGI STERED NURSE**	0	8, 709		28. 00
29. 00	LPN/LVN**	0	0		29. 00
30.00	PHYSI CAL THERAPY**	0	1, 435		30.00
31.00	OCCUPATIONAL THERAPY**	0	103		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	5, 899		33.00
34.00	SPIRITUAL COUNSELING**	0	0		34.00
35.00	DI ETARY COUNSELI NG**	0	0		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	18, 115		37.00
38. 00	DURABLE MEDI CAL EQUI PMENT/OXYGEN**	0	33, 162		38. 00
39. 00	PATI ENT TRANSPORTATI ON**	0	0		39. 00
40.00	I MAGING SERVI CES**	0	0		40.00
41.00	LABS & DI AGNOSTI CS**	0	0		41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0		42.50
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE CHEMOTHERAPY**	0	0		44.00
45. 00 46. 00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)** NONREIMBURSABLE COST CENTERS	U	U		46. 00
60. 00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62. 00	FUNDRAI SI NG*	0	0		62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64. 00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65. 00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66. 00	RESI DENTI AL CARE*	0	0		66.00
67. 00	ADVERTI SI NG*	0	0		67.00
68. 00	TELEHEALTH/TELEMONI TORI NG*	0	0		68.00
69. 00	THRI FT STORE*	0	0		69.00
70. 00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	o o	n		71.00
	TOTAL	o o	183, 493		100.00
	1				

^{*} Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

0

0

0

44, 780

0

0

22,070

0 43.00

0

0

0

66, 850 100. 00

44.00

45.00

46.00

C

C

44, 780

100. 00 TOTAL * Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

OUTPATIENT SERVICES

PALLIATIVE CHEMOTHERAPY

PALLIATIVE RADIATION THERAPY

46.00 OTHER PATIENT CARE SERVICES (SPECIFY)

43.00

44.00

45.00

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6. 00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED			25. 00
26.00	PHYSI CI AN SERVI CES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27. 00
28.00	REGI STERED NURSE	0	8, 563	28. 00
29. 00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	1, 411	30.00
31.00	OCCUPATI ONAL THERAPY	0	101	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	5, 801	33.00
34.00	SPI RI TUAL COUNSELI NG	0	0	34.00
35.00	DI ETARY COUNSELI NG	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	17, 812	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	33, 162	38. 00
39. 00	PATI ENT TRANSPORTATION	0	0	39.00
40.00	I MAGING SERVICES	0	0	40.00
41.00	LABS & DI AGNOSTI CS	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	42.00
42. 50	DRUGS CHARGED TO PATIENTS	0	0	42. 50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	66, 850	100.00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

26. 00 PHYSI CI AN SERVI CES 0 0 0 0 26. 00 27. 00 NURSE PRACTI TI ONER 0 0 0 0 0 27. 00 28. 00 REGI STERED NURSE 0 42 42 15 57 28. 00 29. 00 LPN/LVN 0 0 0 0 0 0 29. 00 30. 00 PHYSI CAL THERAPY 0 0 7 7 7 2 9 90. 00 31. 00 OCCUPATI ONAL THERAPY 0 0 0 0 1 1 31. 00 32. 00 SPEECH/LANGUAGE PATHOLOGY 0 0 0 0 0 0 0 0 32. 00 33. 00 MEDI CAL SOCI AL SERVI CES 0 6 6 32 38 33. 00 34. 00 SPIRI TUAL COUNSELI NG 0 0 0 0 0 0 0 0 0 34. 00 35. 00 0 0 0 0 0 0 0 0 0 0 0 <	Heal th	Financial Systems	KING'S DAUGHTERS'	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
Hospi ce CN: 15-1535 To 12/31/2019 Date/Time Prepared: 5/21/2020 10:03 am	ANALYS	IS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC	CE INPATIENT	Provi der CC	N: 15-0069		Worksheet 0-3	3
SALARI ES	RESPI T	E CARE		Hospi ce CCN	: 15-1535			
Col . 1 + Col . 2) CATIONS CATIONS COL . 2) CATIONS						Hospi ce I		
DIRECT PATIENT CARE SERVICE COST CENTERS 25.00 INPATIENT CARE-CONTRACTED 0 0 0 0 0 0 25.00			SALARI ES	OTHER	(col. 1 +		SUBTOTAL	
25. 00			1. 00	2.00		4. 00	5. 00	
26. 00 PHYSI CI AN SERVI CES 0 0 0 0 26. 00 27. 00 NURSE PRACTI TI ONER 0 0 0 0 0 27. 00 28. 00 REGI STERED NURSE 0 42 42 15 57 28. 00 29. 00 LPN/LVN 0 0 0 0 0 0 29. 00 30. 00 PHYSI CAL THERAPY 0 0 7 7 7 2 9 90. 00 31. 00 OCCUPATI ONAL THERAPY 0 0 0 0 1 1 31. 00 32. 00 SPEECH/LANGUAGE PATHOLOGY 0 0 0 0 0 0 0 0 32. 00 33. 00 MEDI CAL SOCI AL SERVI CES 0 6 6 32 38 33. 00 34. 00 SPIRI TUAL COUNSELI NG 0 0 0 0 0 0 0 0 0 34. 00 35. 00 0 0 0 0 0 0 0 0 0 0 0 <		DIRECT PATIENT CARE SERVICE COST CENTERS						
27. 00 NURSE PRACTITIONER 0 0 0 0 27. 00 28. 00 REGISTERED NURSE 0 42 42 15 57 28. 00 29. 00 LPN/LVN 0 0 0 0 0 29. 00 30. 00 PHYSI CAL THERAPY 0 7 7 2 9 30. 00 31. 00 OCCUPATI ONAL THERAPY 0 0 0 0 1 1 31. 00 32. 00 SPEECH/LANGUAGE PATHOLOGY 0	25.00	I NPATI ENT CARE-CONTRACTED		0		0 0	0	25.00
28. 00 REGI STERED NURSE 0 42 42 15 57 28. 00 29. 00 LPN/LVN 0 0 0 0 0 0 0 0 29. 00 30. 00 PHYSI CAL THERAPY 0 7 7 2 9 30. 00 31. 00 OCCUPATI ONAL THERAPY 0 0 7 7 7 2 9 9 30. 00 32. 00 SPEECH/LANGUAGE PATHOLOGY 0 0 0 0 1 1 1 31. 00 32. 00 SPECH/LANGUAGE PATHOLOGY 0 0 0 0 0 0 0 32. 38 33. 00 34. 00 SPI RI TUAL COUNSELI NG 0 0 0 0 0 0 34. 00 35. 00 DI ETARY COUNSELI NG 0 0 0 0 0 0 35. 00 36. 00 COUNSELI NG 0 0 0 0 0 0 0 36. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 21 21 96 117 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 0 0 0 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0		0	0	26.00
29. 00 LPN/LVN 0 0 0 0 0 0 0 29. 00 30. 00 PHYSI CAL THERAPY 0 7 7 2 9 30. 00 31. 00 OCCUPATI ONAL THERAPY 0 0 0 0 1 1 1 31. 00 32. 00 SPEECH/LANGUAGE PATHOLOGY 0 0 0 0 0 0 0 32. 00 33. 00 MEDI CAL SOCI AL SERVI CES 0 0 6 6 32 38 33. 00 35. 00 SPI RI TUAL COUNSELI NG 0 0 0 0 0 0 34. 00 35. 00 DI ETARY COUNSELI NG 0 0 0 0 0 0 35. 00 36. 00 COUNSELI NG 0 0 0 0 0 0 0 36. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 0 21 21 96 117 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 0 0 0 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0		0	· ·	27. 00
30. 00 PHYSI CAL THERAPY 0 0 7 7 2 9 30. 00 31. 00 OCCUPATI ONAL THERAPY 0 0 0 0 1 1 1 31. 00 32. 00 SPECH/LANGUAGE PATHOLOGY 0 0 0 0 0 0 32. 00 33. 00 MEDI CAL SOCI AL SERVI CES 0 6 6 32 38 33. 00 34. 00 SPIR TUAL COUNSELI NG 0 0 0 0 0 0 0 34. 00 35. 00 DI ETARY COUNSELI NG 0 0 0 0 0 0 0 35. 00 36. 00 COUNSELI NG 0 0 0 0 0 0 0 36. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 21 21 96 117 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 0 0 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 0 0 0 39. 00 41. 00 LABS & DI AGNOSTI CS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	42	4	42 15	57	
31. 00 OCCUPATIONAL THERAPY 0 0 0 0 1 1 1 31. 00 32. 00 SPEECH/LANGUAGE PATHOLOGY 0 0 0 0 0 0 32. 00 33. 00 MEDICAL SOCIAL SERVICES 0 6 6 6 32 38 33. 00 34. 00 SPIRITUAL COUNSELING 0 0 0 0 0 0 0 34. 00 35. 00 DIETARY COUNSELING 0 0 0 0 0 0 0 35. 00 36. 00 COUNSELING 0 0 0 0 0 0 0 0 35. 00 37. 00 HOSPICE AIDE & HOMEMAKER SERVICES 0 21 21 96 117 37. 00 38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN 0 0 0 0 0 0 38. 00 39. 00 PATIENT TRANSPORTATION 0 0 0 0 0 0 39. 00 40. 00 IMAGING SERVICES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0		0	0	
32. 00 SPEECH/LANGUAGE PATHOLOGY 0 0 0 0 0 32. 00 33. 00 MEDI CAL SOCI AL SERVI CES 0 0 6 6 32 38 33. 00 34. 00 SPI RI TUAL COUNSELI NG 0 0 0 0 0 0 34. 00 35. 00 DI ETARY COUNSELI NG 0 0 0 0 0 0 35. 00 36. 00 COUNSELI NG - OTHER 0 0 0 0 0 0 0 36. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 21 21 96 117 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 0 0 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 0 0 0 38. 00 40. 00 IMAGI NG SERVI CES 0 0 0 0 0 0 0 0 40. 00 41. 00 LABS & DI AGNOSTI CS 0 0 0 0 0 0 0 42. 00			0	7		7 2	9	
33. 00 MEDI CAL SOCI AL SERVI CES 34. 00 SPI RI TUAL COUNSELI NG 50 DI ETARY COUNSELI NG 60 D			0	0		0 1	1	
34. 00 SPIRITUAL COUNSELING 0 0 0 0 0 34. 00 35. 00 DI ETARY COUNSELI NG 0 0 0 0 0 0 35. 00 36. 00 COUNSELI NG - OTHER 0 0 0 0 0 0 0 36. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 21 21 96 117 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 0 0 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 0 0 0 38. 00 40. 00 IMAGI NG SERVI CES 0 0 0 0 0 0 0 0 0 40. 00 41. 00 LABS & DI AGNOSTI CS 0 0 0 0 0 0 0 0 41. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0		0	0	
35. 00 DI ETARY COUNSELING 0 0 0 0 0 0 35. 00 36. 00 COUNSELING - OTHER 0 0 0 0 0 0 36. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 21 21 96 117 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 0 0 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 0 0 0 0 39. 00 40. 00 I MAGI NG SERVI CES 0 0 0 0 0 0 0 41. 00 41. 00 LABS & DI AGNOSTI CS 0 0 0 0 0 0 42. 00			0	6		6 32	38	
36.00 COUNSELING - OTHER 0 0 0 0 36.00 37.00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 21 21 96 117 37.00 38.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 0 0 0 38.00 39.00 PATI ENT TRANSPORTATI ON 0 0 0 0 0 39.00 40.00 I MAGI NG SERVI CES 0 0 0 0 0 0 40.00 41.00 LABS & DI AGNOSTI CS 0 0 0 0 0 0 41.00 42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 0 0 0 0 0 0	34.00	SPIRITUAL COUNSELING	0	0		0 0	0	34.00
37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 21 21 96 117 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 0 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 0 0 0 0 39. 00 40. 00 IMAGI NG SERVI CES 0 0 0 0 0 0 0 0 0 41. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 0 0 0 0 0 0 0 42. 00	35.00	DI ETARY COUNSELI NG	0	0		0 0	0	35.00
38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 0 0 38. 00 39. 00 9ATI ENT TRANSPORTATI ON 0 0 0 0 39. 00 40. 00 1 MAGI NG SERVI CES 0 0 0 0 0 0 41. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 0 0 0 0 42. 00 0 0 0 0 0 0 0 0 0	36.00	COUNSELING - OTHER	0	0		0 0	0	36.00
39.00 PATIENT TRANSPORTATION 0 0 0 0 39.00 40.00 IMAGING SERVICES 0 0 0 0 0 0 40.00 41.00 LABS & DIAGNOSTICS 0 0 0 0 0 0 41.00 42.00 MEDICAL SUPPLIES-NON-ROUTINE 0 0 0 0 0 0 42.00	37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	21		21 96	117	37.00
40.00 I MAGI NG SERVI CES 0 0 0 0 40.00 41.00 LABS & DI AGNOSTI CS 0 0 0 0 0 41.00 42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 0 0 0 0 42.00	38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		0 0	0	38.00
41. 00 LABS & DI AGNOSTI CS 0 0 0 0 0 41. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 0 0 0 42. 00	39.00	PATI ENT TRANSPORTATION	0	0		0 0	0	39. 00
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 0 0 42. 00	40.00	I MAGING SERVICES	0	0		0 0	0	40.00
	41.00	LABS & DIAGNOSTICS	0	0		0 0	0	41.00
	42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		0 0	0	42.00
42.50 DRUGS CHARGED TO PATIENTS 0 0 0 0 42.50	42.50	DRUGS CHARGED TO PATIENTS	0	0		0	0	42.50
43. 00 OUTPATI ENT SERVI CES 0 0 0 0 43. 00	43.00	OUTPATIENT SERVICES	0	0		0 0	0	43.00
44.00 PALLIATIVE RADIATION THERAPY 0 0 0 0 0 44.00	44.00	PALLIATIVE RADIATION THERAPY	0	0		0 0	0	44.00
45.00 PALLIATIVE CHEMOTHERAPY 0 0 0 0 45.00	45.00	PALLIATIVE CHEMOTHERAPY	0	o		0 0	0	45.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 0 0 46.00	46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	o		0 0	0	46.00
100. 00 TOTAL * 0 76 76 146 222 100. 00	100.00	TOTAL *	0	76	-	76 146	222	100.00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5		
		6. 00	± col . 6) 7.00		
DI	IRECT PATIENT CARE SERVICE COST CENTERS	0.00	7.00	<u> </u>	
	NPATIENT CARE-CONTRACTED	0	0		25. 00
	PHYSI CI AN SERVI CES	0	o		26.00
27. 00 NI	NURSE PRACTITIONER	0	o		27.00
28. 00 RI	REGI STERED NURSE	0	57		28.00
29. 00 LI	_PN/LVN	0	O		29.00
30. 00 PI	PHYSI CAL THERAPY	0	9		30.00
31.00 0	OCCUPATIONAL THERAPY	0	1		31.00
32. 00 SI	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33. 00 MI	MEDICAL SOCIAL SERVICES	0	38		33.00
34. 00 SI	SPIRITUAL COUNSELING	0	0		34.00
35. 00 D	DI ETARY COUNSELING	0	0		35.00
36. 00 C	COUNSELING - OTHER	0	0		36.00
37.00 H	HOSPICE AIDE & HOMEMAKER SERVICES	0	117		37.00
	OURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
	PATI ENT TRANSPORTATION	0	0		39.00
	MAGING SERVICES	0	0		40.00
	_ABS & DIAGNOSTICS	0	0		41.00
	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
	DRUGS CHARGED TO PATIENTS	0	0		42.50
	DUTPATI ENT SERVI CES	0	0		43.00
	PALLIATIVE RADIATION THERAPY	0	0		44.00
	PALLIATIVE CHEMOTHERAPY	0	0		45.00
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46. 00
100. 00 To	TOTAL *	0	222		100.00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC	CE GENERAL	Provi der CC	N: 15-0069	Peri od:	Worksheet 0-4	
I NPATI ENT CARE		Hospi ce CCN	: 15-1535	From 01/01/2019 To 12/31/2019	Date/Time Pre 5/21/2020 10:	
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL	RECLASSIFI -	SUBTOTAL	
			(col. 1 +	CATI ONS		
	1.00	0.00	col . 2)	4.00	F 00	
DI DECT. DATI ENT. CADE CEDVI CE COCT. CENTEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
DI RECT PATIENT CARE SERVICE COST CENTERS 25.00 INPATIENT CARE-CONTRACTED		ما			0	25.00
26. 00 PHYSICIAN SERVICES		0			0	26.00
27. 00 NURSE PRACTITIONER		0			0	27.00
28. 00 REGISTERED NURSE	0	66		66 23	89	
29. 00 LPN/LVN		00	,	0 23	0	29.00
30. 00 PHYSI CAL THERAPY		12		12 3	15	
31. 00 OCCUPATIONAL THERAPY		0		0 1	1	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY		0		0	0	32.00
33. 00 MEDI CAL SOCI AL SERVI CES		9		9 51	60	33.00
34. 00 SPIRITUAL COUNSELING	l ol	o		0 0	0	34.00
35. 00 DIETARY COUNSELING	o	o		0 0	0	35.00
36. 00 COUNSELING - OTHER	0	0		0 0	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	0	34		34 152	186	37.00
38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN	o	0		0 0	0	38.00
39. 00 PATIENT TRANSPORTATION	0	0		0 0	0	39.00
40.00 I MAGING SERVICES	0	0		0 0	0	40.00
41. 00 LABS & DIAGNOSTICS	0	0		0 0	0	41.00
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0		0 0	0	42.00
42.50 DRUGS CHARGED TO PATIENTS	0	0		0	0	42. 50
43. 00 OUTPATIENT SERVICES	0	0		0	0	43.00
44.00 PALLIATIVE RADIATION THERAPY	0	0		0	0	44.00
45.00 PALLIATIVE CHEMOTHERAPY	0	0		0	0	45. 00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		0 0	0	46.00
100.00 TOTAL *	0	121	1:	21 230	351	100.00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5	
		6. 00	± col . 6) 7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS	0.00	7.00	
25. 00	I NPATI ENT CARE-CONTRACTED	0	0	25.00
26. 00	PHYSI CI AN SERVI CES	0	o	26. 00
27. 00	NURSE PRACTITIONER	0	o	27.00
28. 00	REGI STERED NURSE	0	89	28. 00
29. 00	LPN/LVN	0	0	29.00
30.00	PHYSI CAL THERAPY	0	15	30.00
31.00	OCCUPATI ONAL THERAPY	0	1	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	o	32.00
33.00	MEDICAL SOCIAL SERVICES	0	60	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DI ETARY COUNSELI NG	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	186	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	I MAGING SERVICES	0	0	40.00
41.00	LABS & DI AGNOSTI CS	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	42.00
42. 50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	351	100.00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

	LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET ES FOR ALLOCATION	Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet 0-5 Date/Time Pre 5/21/2020 10:	pared:
				Hospi ce I		
	Descriptions		instructions)	(see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
	DENIEDAL DEDIKIDE DOOT DENIEDO		1.00	2. 00	3. 00	
	GENERAL SERVICE COST CENTERS			al	4 /74	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL PLANT OPERATION & MAINTENANCE LAUNDRY & LINEN SERVICE		109, 06	0 14, 285 0 0	1, 674 0 32, 789 147, 080 14, 285	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
7. 00 8. 00 9. 00 10. 00	HOUSEKEEPI NG DI ETARY NURSI NG ADMI NI STRATI ON ROUTI NE MEDI CAL SUPPLI ES			0 0 0 0 0 0	0 0 0 0	7. 00 8. 00 9. 00 10. 00
11. 00 12. 00 13. 00 14. 00 15. 00	MEDICAL RECORDS STAFF TRANSPORTATION VOLUNTEER SERVICE COORDINATION PHARMACY PHYSICIAN ADMINISTRATIVE SERVICES		12 10 6, 77	7 0 0 0	0 125 107 6, 770 0	15.00
16. 00 17. 00	OTHER GENERAL SERVI CE PATI ENT/RESI DENTI AL CARE SERVI CES		1	0 0	0	16. 00 17. 00
50. 00	LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE			0	0	50.00
51. 00 52. 00 53. 00	HOSPICE ROUTINE HOME CARE HOSPICE INPATIENT RESPITE CARE HOSPICE GENERAL INPATIENT CARE		66, 85 22 35	0	66, 850 222 351	
60.00	NONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM			0	0	40.00
60.00 61.00 62.00 63.00	VOLUNTEER PROGRAM FUNDRAISING			0 0 0	0	60. 00 61. 00 62. 00
64. 00 65. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS PALLIATIVE CARE PROGRAM OTHER PHYSICIAN SERVICES			0	0	63. 00 64. 00 65. 00
66. 00 67. 00 68. 00	RESI DENTI AL CARE ADVERTI SI NG TELEHEALTH/TELEMONI TORI NG			0 0 0	0 0 0	66. 00 67. 00 68. 00
69. 00 70. 00 71. 00 99. 00	THRIFT STORE NURSING FACILITY ROOM & BOARD OTHER NONREIMBURSABLE (SPECIFY) NEGATIVE COST CENTER			0 0 0 0	0 0 0	69. 00 70. 00 71. 00 99. 00

0 99.00 270, 253 100.00

183, 493

86, 760

70.00 NURSING FACILITY ROOM & BOARD
71.00 OTHER NONREIMBURSABLE (SPECIFY)
99.00 NEGATIVE COST CENTER
100.00 TOTAL

			Hospi ce cc	N: 15-1535 1	0 12/31/2019	5/21/2020 10:	
					Hospi ce I		
	Descriptions	TOTAL	CAP REL BLDG	CAP REL MVBLE	EMPLOYEE	SUBTOTAL	
		EXPENSES	& FIX	EQUI P	BENEFI TS		
					DEPARTMENT		
		0	1. 00	2.00	3. 00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1, 674	1, 674	i			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT	32, 789	0	· ·	32, 789		3. 00
4. 00	ADMINISTRATIVE & GENERAL	147, 080	1, 674	0	22, 089	170, 843	4.00
5. 00	PLANT OPERATION & MAINTENANCE	14, 285	0	0	0	14, 285	5.00
6. 00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPI NG	0	0	0	0	0	7.00
8. 00	DI ETARY	0	0	0	0	0	8.00
9.00	NURSI NG ADMI NI STRATI ON	0	0	0	0	0	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11. 00	MEDI CAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	125	0	0	0	125	12.00
13.00	VOLUNTEER SERVICE COORDINATION	107	0	0	51	158	13.00
14.00	PHARMACY	6, 770	0	0	0	6, 770	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	66, 850			10, 471	77, 321	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	222	0	0		291	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	351	0	0	109	460	53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	_		0	60.00
61. 00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAI SI NG	0	0	0	0	0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64. 00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65. 00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66. 00	RESI DENTI AL CARE	0	0	0	0	0	66.00
67. 00	ADVERTI SI NG	0	0	0	0	0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	0	0	0	0	0	68.00
69. 00	THRI FT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99. 00	NEGATI VE COST CENTER	0	0	0	0		99. 00
100.00	TOTAL	270, 253	1, 674	0	32, 789	270, 253	100. 00

			nospi ce co	10-1555	10 12/31/2019	5/21/2020 1		
					Hospi ce I			
	Descriptions	ADMI NI STRATI V	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY		
	'	E & GENERAL	OPERATION &	LINEN SERVICE				
			MAI NTENANCE					
		4. 00	5. 00	6.00	7. 00	8. 00		
	GENERAL SERVICE COST CENTERS	'		•				
1.00	CAP REL COSTS-BLDG & FIXT							1.00
2.00	CAP REL COSTS-MVBLE EQUIP							2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT							3.00
4.00	ADMINISTRATIVE & GENERAL	170, 843						4.00
5.00	PLANT OPERATION & MAINTENANCE	24, 550	38, 835					5.00
6. 00	LAUNDRY & LINEN SERVICE	0	0	1				6.00
7. 00	HOUSEKEEPI NG	0	0		0			7.00
8. 00	DI ETARY	0	0		0		ol	8.00
9. 00	NURSI NG ADMI NI STRATI ON	0	0		0		-	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	0	0		0		-	10.00
11. 00	MEDI CAL RECORDS	0	0		0		- 1	11. 00
12. 00	STAFF TRANSPORTATION	215	0		0			12.00
13. 00	VOLUNTEER SERVICE COORDINATION	272	0		0		- 1	13. 00
14. 00	PHARMACY	11, 635	0		0			14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	11,033	0		0		- 1	15. 00
16. 00	OTHER GENERAL SERVICE		0		0		- 1	16. 00
	PATIENT/RESIDENTIAL CARE SERVICES		0		0			17. 00
17.00	LEVEL OF CARE	<u> </u>						17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0		I			-	50. 00
51. 00	HOSPICE ROUTINE HOME CARE	132, 880						51. 00
52. 00	HOSPICE INPATIENT RESPITE CARE	500	15, 146	1 .	0			52.00
	HOSPICE GENERAL INPATIENT CARE	791	23, 689		0			53. 00
55.00	NONREI MBURSABLE COST CENTERS	/71	23,009	'	J 0		-U '	33.00
60.00	BEREAVEMENT PROGRAM	0	0	I	0		┥,	60.00
61. 00	VOLUNTEER PROGRAM		0		0			61. 00
62. 00	FUNDRAI SI NG		0		0			62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0		0			63. 00
64. 00	PALLIATIVE CARE PROGRAM		0		0			64. 00
65. 00	OTHER PHYSICIAN SERVICES		0		0			65. 00
66. 00	RESIDENTIAL CARE		0		0			66. 00
67. 00	ADVERTI SI NG		0	`				67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG		0					68. 00
69. 00	THRIFT STORE		0					69. 00
70.00	NURSING FACILITY ROOM & BOARD	١	U	Ï				70. 00
	OTHER NONREIMBURSABLE (SPECIFY)		0		1			70. 00 71. 00
99. 00			0					99. 00
		170, 843	38, 835				- 1	99. 00 00. 00
100.00	TOTAL	170, 843	აი, 835	1 '	ار ا		olic	JU. UU

Health Financial	Systems		KING'S DAUGH	HTERS' HOSE	'I TAL			In Lieu of	Form CMS-2552	2-10
COST ALLOCATION	- HOSPITAL-BASED HOS	PICE GENERAL	SERVICE COSTS	Prov	ider CCN:	15-0069	Peri od:	Wor	ksheet 0-6	

Form 01/01/2019 Part I
To 12/31/2019 Date/Time Prepared: 5/21/2020 10:03 am Hospi ce CCN: 15-1535 Hospi ce I NURSI NG ROUTI NE MEDI CAL VOLUNTEER Descriptions STAFF ADMI NI STRATI O MEDI CAL RECORDS TRANSPORTATI O SERVI CE COORDI NATI ON SUPPLI ES Ν N 11.00 9.00 10.00 12.00 13.00 GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT 1.00 1.00 2 00 CAP REL COSTS-MVBLE EQUIP 2.00 3.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 4.00 ADMINISTRATIVE & GENERAL 4.00 PLANT OPERATION & MAINTENANCE 5.00 5.00 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 HOUSEKEEPI NG 7.00 8.00 DI ETARY 8.00 NURSING ADMINISTRATION 9.00 9.00 000000 ROUTINE MEDICAL SUPPLIES 10.00 Ω 10.00 11.00 MEDICAL RECORDS 11.00 12.00 STAFF TRANSPORTATION 340 12.00 VOLUNTEER SERVICE COORDINATION 13.00 430 13.00 0 14.00 PHARMACY 0 0 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 15.00 0 OTHER GENERAL SERVICE 0 0 16.00 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 0 50.00 0 50.00 0 0 HOSPICE ROUTINE HOME CARE 51.00 335 422 51.00 0 52.00 HOSPICE INPATIENT RESPITE CARE 0 4 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 0 0 4 53.00 NONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM 60.00 0 0 0 0 0 0 0 0 0 60.00 VOLUNTEER PROGRAM 61.00 0 61.00 62.00 FUNDRAI SI NG 0 0 0 0 0 0 62.00 0 HOSPICE/PALLIATIVE MEDICINE FELLOWS 63.00 0 63.00 PALLIATIVE CARE PROGRAM 64.00 0 64.00 65.00 OTHER PHYSICIAN SERVICES 0 65.00 RESIDENTIAL CARE 0 66.00 66.00 67 00 ADVERTI SI NG 0 67.00 TELEHEALTH/TELEMONI TORI NG 68.00 0 68.00 69.00 THRIFT STORE 0 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 70.00 71 00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 0 Ω 71.00 0 99.00 NEGATIVE COST CENTER 0 0 99.00 100.00 TOTAL 340 430 100.00

Heal th FinancialSystemsKING'S DAUGHCOST ALLOCATION- HOSPITAL-BASED HOSPICE GENERALSERVICE COSTS In Lieu of Form CMS-2552-10 KING'S DAUGHTERS' HOSPITAL

			nospi ce co	10-1555	0 12/31/2019	5/21/2020 10:	
					Hospi ce I		
	Descriptions	PHARMACY	PHYSI CI AN	OTHER GENERAL	PATI ENT/	TOTAL	
			ADMI NI STRATI V	SERVI CE	RESI DENTI AL		
			E SERVICES		CARE SERVICES		
		14. 00	15. 00	16. 00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS	ı		T		Г	
1. 00	CAP REL COSTS-BLDG & FIXT						1.00
2. 00	CAP REL COSTS-MVBLE EQUIP						2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4. 00	ADMI NI STRATI VE & GENERAL						4.00
5. 00	PLANT OPERATION & MAINTENANCE						5.00
6. 00	LAUNDRY & LINEN SERVICE						6.00
7. 00	HOUSEKEEPI NG						7.00
8. 00	DI ETARY						8. 00
9. 00	NURSI NG ADMI NI STRATI ON						9. 00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDI CAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13. 00	VOLUNTEER SERVICE COORDINATION						13.00
14. 00	PHARMACY	18, 405					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16. 00	OTHER GENERAL SERVICE	0		(16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES				0		17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			0	
51.00	HOSPICE ROUTINE HOME CARE	18, 097	0	1		229, 055	
52.00	HOSPICE INPATIENT RESPITE CARE	120	0	1		16, 063	
53. 00	HOSPICE GENERAL INPATIENT CARE	188	0	(0	25, 135	53.00
(0.00	NONREI MBURSABLE COST CENTERS			1 .	\ \		(0.00
60. 00 61. 00	BEREAVEMENT PROGRAM VOLUNTEER PROGRAM	0				0	60. 00 61. 00
	FUNDRALSING	0					1
62.00		0				0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0				0	63.00
64. 00 65. 00	PALLIATIVE CARE PROGRAM OTHER PHYSICIAN SERVICES	0				0	64. 00 65. 00
	1	0	0		0	0	
66.00	RESI DENTI AL CARE ADVERTI SI NG	0	0	'		1	66.00
67. 00 68. 00	TELEHEALTH/TELEMONI TORI NG	0				0	67. 00 68. 00
	I and the second	0				0	
69. 00 70. 00	THRIFT STORE NURSING FACILITY ROOM & BOARD	١			ή		69. 00 70. 00
70.00	OTHER NONREIMBURSABLE (SPECIFY)		0			0	1
99.00	NEGATIVE COST CENTER		0	_	-	0	99.00
	TOTAL	18, 405	0	1	_		
100.00	I TOTAL	10, 405	U	1	ار	210, 253	1100.00

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE STATISTICAL BASIS	E GENERAL SERVICE COSTS	Provider CCN:	From 01/01/2019	Worksheet 0-6 Part II Date/Time Prepared: 5/21/2020 10:03 am

			Hospi ce CC	N: 15-1535 T	o 12/31/2019	Date/Time Pre 5/21/2020 10:	
					Hospi ce I	072172020 10.	oo aiii
	Cost Center Descriptions	CAP REL BLDG & FLX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATIO N	ADMINISTRATIV E & GENERAL (ACCUMULATED COSTS)	
		1. 00	2.00	3.00	4A	4. 00	
	GENERAL SERVICE COST CENTERS				1		
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL PLANT OPERATION & MAINTENANCE LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY NURSING ADMINISTRATION ROUTINE MEDICAL SUPPLIES MEDICAL RECORDS STAFF TRANSPORTATION VOLUNTEER SERVICE COORDINATION PHARMACY PHYSICIAN ADMINISTRATIVE SERVICES OTHER GENERAL SERVICE	744 0 744 0 0 0 0 0 0 0 0 0 0 0		69, 109 46, 557 0 0 0 0 0 0 0 107	-170, 843 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	14, 285 0 0 0 0 0 125 158 6, 770 0	5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
17. 00	PATI ENT/RESI DENTI AL CARE SERVI CES LEVEL OF CARE	0	0		0	0	17. 00
50. 00 51. 00 52. 00 53. 00	HOSPICE CONTINUOUS HOME CARE HOSPICE ROUTINE HOME CARE HOSPICE INPATIENT RESPITE CARE HOSPICE GENERAL INPATIENT CARE NONREIMBURSABLE COST CENTERS	0	0		0 0	291	51. 00 52. 00
99. 00 100. 00	BEREAVEMENT PROGRAM VOLUNTEER PROGRAM FUNDRAI SI NG HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS PALLI ATI VE CARE PROGRAM OTHER PHYSI CI AN SERVI CES RESI DENTI AL CARE ADVERTI SI NG TELEHEALTH/TELEMONI TORI NG	0 0 0 0 0 0 0 0 0 0 0 0 1,674 2.250000	000000000000000000000000000000000000000	32, 789		ľ	61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 99. 00

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HO		Provider CCN Hospice CCN:	 Peri od: From 01/01/2019 To 12/31/2019	Worksheet 0-6 Part II Date/Time Prepared: 5/21/2020 10:03 am

			Hospi ce cc	N: 15-1535 I	0 12/31/2019	5/21/2020 10:	
					Hospi ce I		
	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
		OPERATION &	LINEN SERVICE	(SQUARE FEET)	(IN-FACILITY	ADMINISTRATIO	
		MAI NTENANCE	(IN-FACILITY		DAYS)	N	
		(SQUARE FEET)	DAYS)			(DI RECT NURS.	
						HRS.)	
		5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS				1		
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	100					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPI NG	0		0			7.00
8. 00	DI ETARY	0		0	0		8.00
9.00	NURSI NG ADMI NI STRATI ON	0		0		0	9.00
10. 00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDI CAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	39	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	61	0	0	0	0	53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	
61.00	VOLUNTEER PROGRAM	0		0		0	
62.00	FUNDRAI SI NG	0		0		0	
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	
64.00	PALLIATIVE CARE PROGRAM	0		0		0	
65.00	OTHER PHYSICIAN SERVICES	0		0		0	
66.00	RESI DENTI AL CARE	0	0	0	0	0	
67.00	ADVERTI SI NG	0		0		0	
68.00	TELEHEALTH/TELEMONI TORI NG	0		0		0	
69.00	THRI FT STORE	0		0		0	69. 00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	
99. 00	NEGATI VE COST CENTER						99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	38, 835		0	0		100.00
101.00	UNIT COST MULTIPLIER	388. 350000	0. 000000	0. 000000	0. 000000	0. 000000	101.00

	Financial Systems	KING'S DAUGHTER				u of Form CMS-2	
	NLLOCATION - HOSPITAL-BASED HOSPICE GENERAL S STICAL BASIS	ERVICE COSTS	Provider C Hospice CC		Peri od: From 01/01/2019 To 12/31/2019	Date/Time Pre	pared:
					Hospi ce I	5/21/2020 10:	03 am
	Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
	·	MEDI CAL	RECORDS	TRANSPORTATI	0 SERVI CE	(CHARGES)	
		SUPPLI ES	(PATI ENT	N	COORDI NATI ON		
		(PATI ENT	DAYS)	(MI LEAGE)	(HOURS OF		
		DAYS)			SERVICE)		
	OFNEDAL CEDIMOS OCCI OFNITEDO	10. 00	11. 00	12. 00	13.00	14. 00	
1 00	GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FLXT	T T					1 1 00
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT						1.00 2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4. 00	ADMI NI STRATI VE & GENERAL						4.00
5. 00	PLANT OPERATION & MAINTENANCE						5.00
6. 00	LAUNDRY & LINEN SERVICE						6.00
7. 00	HOUSEKEEPI NG						7.00
8. 00	DI ETARY						8.00
9. 00	NURSI NG ADMI NI STRATI ON						9.00
10.00	ROUTINE MEDICAL SUPPLIES	O					10.00
11.00	MEDI CAL RECORDS		C				11.00
12.00	STAFF TRANSPORTATION			11, 85	55		12.00
13.00	VOLUNTEER SERVICE COORDINATION				0 107		13.00
14.00	PHARMACY				0 0	6, 770	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES				0 0	0	15.00
16. 00	OTHER GENERAL SERVICE				0	0	16.00
17. 00	PATI ENT/RESI DENTI AL CARE SERVI CES						17. 00
	LEVEL OF CARE			1	-1		
50.00	HOSPICE CONTINUOUS HOME CARE	0	C	1	0 0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	C	1		6, 657	
52.00	HOSPICE INPATIENT RESPITE CARE	0	C		77 1	44	52.00
53. 00	HOSPICE GENERAL INPATIENT CARE NONREIMBURSABLE COST CENTERS	0	C) 12	21 1	69	53.00
60. 00	BEREAVEMENT PROGRAM				0 0	0	60.00
61. 00	VOLUNTEER PROGRAM					0	61.00
62. 00	FUNDRAI SI NG					0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS					0	63.00
64. 00	PALLIATIVE CARE PROGRAM					0	64.00
65. 00	OTHER PHYSICIAN SERVICES					0	65.00
66. 00	RESI DENTI AL CARE				ol ol	0	66.00
67 00		1				0	67 00

0.000000

0 67.00

0 69.00 70.00

18, 405 100. 00 2. 718612 101. 00

0

0

430

4. 018692

340

0. 028680

0.000000

68.00

71.00

99.00

ADVERTI SI NG

68. 00 | TELEHEALTH/TELEMONI TORI NG

69. 00 THRIFT STORE
70. 00 NURSING FACILITY ROOM & BOARD
71. 00 OTHER NONE BURSABLE (SPECIFY)

99.00 NEGATIVE COST CENTER
100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I)
101.00 UNIT COST MULTIPLIER

67.00

Health Financial Systems	KING'S DAUGHTERS' HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GEI STATISTICAL BASIS	IERAL SERVI CE COSTS Provi der CCN: 15-006	Period: Worksheet 0-6 From 01/01/2019 Part II
STATISTICAL BASIS	Hospi ce CCN: 15-153	To 12/31/2019 Date/Time Prepared:

						5/21/2020 10:0	03 am
					Hospi ce I		
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL				
		ADMI NI STRATI V	SERVI CE	RESI DENTI AL			
		E SERVICES	(SPECI FY	CARE SERVICES	S		
		(PATI ENT	BASIS)	(IN-FACILITY			
		DAYS)		DAYS)			
		15. 00	16. 00	17. 00			
	GENERAL SERVICE COST CENTERS		•	•	<u>'</u>		
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2. 00	CAP REL COSTS-MVBLE EQUIP						2. 00
	EMPLOYEE BENEFITS DEPARTMENT						3.00
4. 00	ADMINISTRATIVE & GENERAL						4.00
5. 00	PLANT OPERATION & MAINTENANCE						5.00
		1					
6. 00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPI NG						7.00
8. 00	DI ETARY						8. 00
9. 00	NURSING ADMINISTRATION						9. 00
	ROUTINE MEDICAL SUPPLIES						10.00
11. 00	MEDI CAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY						14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES						15.00
16. 00	OTHER GENERAL SERVICE		0				16.00
	PATIENT/RESIDENTIAL CARE SERVICES				o		17.00
	LEVEL OF CARE		•	•	-		
	HOSPICE CONTINUOUS HOME CARE	C	0				50.00
	HOSPICE ROUTINE HOME CARE						51.00
	HOSPICE INPATIENT RESPITE CARE				o		52.00
	HOSPICE GENERAL INPATIENT CARE			l .	0		53.00
	NONREI MBURSABLE COST CENTERS		1	'	O _I		33.00
	BEREAVEMENT PROGRAM		1 0	ı			60.00
	VOLUNTEER PROGRAM	1		1			61.00
	FUNDRAL SI NG		0	1			62.00
	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0				63.00
	PALLIATIVE CARE PROGRAM			1			64.00
	OTHER PHYSICIAN SERVICES		0	1	_		65.00
	RESI DENTI AL CARE		0		0		66.00
	ADVERTI SI NG		0	1			67. 00
	TELEHEALTH/TELEMONI TORI NG		0	1			68.00
69.00	THRI FT STORE		0	1			69.00
70.00	NURSING FACILITY ROOM & BOARD			1			70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	c	0)	0		71.00
99.00	NEGATIVE COST CENTER						99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, F	Part I)	0		ol	-	100.00
	UNIT COST MULTIPLIER	0. 000000	0. 000000	0. 00000	_1		101.00

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF HOSPITAL-BASED HOSPICE	SHARED SERVICE COSTS BY	Provider CCN: 15-0069		Worksheet 0-7
LEVEL OF CARE			From 01/01/2019	
		Hospi ce CCN: 15-1535	To 12/31/2019	Date/Time Prepared:
				5/21/2020 10:03 am

LEVEL OF CARE			Hospi ce CCI	N: 15-1535 T	0 12/31/2019	Date/Time Pre 5/21/2020 10:	
					Hospi ce I	0,21,2020 101	00 4
				Charges by L	OC (from Provi	der Records)	
				onar ges by E	.00 (110111 11011	aci necci as,	
Cost Center Descr	intions	From Wkst. C,	Cost to	HCHC	HRHC	HI RC	
COST CENTER DESCR	1 p t 1 0 1 3	Part I, Col.	Charge Ratio	Hone	TIKITO	TH NO	
		9 line	Charge Ratio				
		0	1.00	2.00	2.00	4 00	
ANCILLARY SERVICE COST	CENTERS	0	1.00	2.00	3. 00	4. 00	
	CENTERS	44.00	0. 311051		O	0	1 00
		66.00		0	_	-	1.00
2. 00 OCCUPATI ONAL THERAPY		67. 00			0	0	2.00
3.00 SPEECH PATHOLOGY		68. 00			0	0	3. 00
4.00 DRUGS CHARGED TO PATIE		73.00		0	0	0	4.00
5. 00 DURABLE MEDICAL EQUIP-	RENTED	96.00					5.00
6. 00 LABORATORY		60.00	0. 143766	0	0	0	6.00
7. 00 MEDI CAL SUPPLI ES CHARGE	ED TO PATIENTS	71.00	0. 364388	0	0	0	7. 00
7. 01 IV SOLUTIONS		71. 01	0. 098315	0	ol	0	7. 01
8.00 OTHER OUTPATIENT SERVICE	CE COST CENTER	93.00					8.00
9. 00 RADI OLOGY - THERAPEUTI (55. 00		0	ol	0	9. 00
9. 01 ONCOLOGY		55. 01	0. 488417		ام	0	9. 01
10. 00 CARDI OLOGY		76.00			0	0	10.00
10. 97 CARDI AC REHABI LI TATI ON		76. 97				0	10. 00
11.00 Totals (sum of lines 1-	11)	70.97	0. 249230	0	l 4	U	10. 97
11.00 Total's (Suill of Titles 1-	- 11)	Charges by		Charad Carvi o	Costs by LOC		11.00
		LOC (from		Shared Service	costs by Loc		
		Provi der					
0 - 1 - 0 - 1 B		Records)	110110 (1 4	LIBUO (l . d	III DO (I 4	HOLD (l . d	
Cost Center Descr	i pti ons	HGI P	HCHC (col. 1	HRHC (col. 1	HIRC (col. 1	HGIP (col. 1	
			x col. 2)	x col. 3)	x col. 4)	x col. 5)	
		5. 00	6. 00	7. 00	8. 00	9. 00	
ANCILLARY SERVICE COST	CENTERS	_	_	_	_1		
1. 00 PHYSI CAL THERAPY		0			0	0	1.00
2. 00 OCCUPATI ONAL THERAPY		0	1		=	0	2. 00
3.00 SPEECH PATHOLOGY		0	0	ľ		0	3.00
4.00 DRUGS CHARGED TO PATIE		0	0	0	0	0	4.00
5. 00 DURABLE MEDICAL EQUIP-	RENTED						5. 00
6. 00 LABORATORY		0	0	0	0	0	6. 00
7. 00 MEDICAL SUPPLIES CHARGE	ED TO PATIENTS	0	0	0	ol	0	7. 00
7. 01 IV SOLUTIONS		0	0	0	ol	0	7. 01
8.00 OTHER OUTPATIENT SERVICE	CE COST CENTER					_	8.00
9. 00 RADI OLOGY - THERAPEUTI (0	0	0	o	0	9.00
9. 01 ONCOLOGY	-			· ·	=	0	
10. 00 CARDI OLOGY			0			0	10.00
10. 97 CARDI AC REHABI LI TATI ON					=		10.00
4	11)	0				0	
11.00 Totals (sum of lines 1	- 11)		0	0	0	0	11. 00

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL		In Lieu	u of Form CMS-2552-10
CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COS	Т	Provi der (CCN: 15-0069	Peri od: From 01/01/2019	Worksheet 0-8
		Hospi ce CC	CN: 15-1535		Date/Time Prepared:

					5/21/2020 10: (03 am_
				Hospi ce I		
	<u> </u>		TITLE XVIII	TITLE XIX	TOTAL	
			MEDI CARE	MEDI CAI D		
			1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE		•			
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-	7, col. 6,			0	1.00
	line 11)					
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)				0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, lir	e 10)		0 0		4.00
5.00	Program cost (line 3 times line 4)	ŕ		0 0		5.00
	HOSPI CE ROUTI NE HOME CARE			<u>'</u>		
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-	7, col. 7,			229, 055	6.00
	line 11)				·	
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				1, 919	7.00
8.00	Total average cost per diem (line 6 divided by line 7)				119. 36	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 11)	1, 82	25 5		9.00
10.00	Program cost (line 8 times line 9)	,	217, 83	597		10.00
	HOSPICE INPATIENT RESPITE CARE					
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-	7, col. 8,			16, 063	11.00
	line 11)					
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)				12	12.00
13.00	Total average cost per diem (line 11 divided by line 12)				1, 338. 58	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 12)	1	2 0		14.00
15.00	Program cost (line 13 times line 14)		16, 06	0		15.00
	HOSPICE GENERAL INPATIENT CARE					
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-	7, col. 9,			25, 135	16.00
	line 11)					
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)				19	17.00
18.00	Total average cost per diem (line 16 divided by line 17)				1, 322. 89	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 13)	1	9 0		19.00
20.00	Program cost (line 18 times line 19)		25, 13	0		20.00
	TOTAL HOSPICE CARE					
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)				270, 253	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)				1, 950	22.00
23.00	Average cost per diem (line 21 divided by line 22)				138. 59	23.00
			•	*		

	Fig. 1. C. A. SI JUGGOLTAL		C F ONC .	2550 40	
	Financial Systems KING'S DAUGHTERS ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0069	Peri od: From 01/01/2019 To 12/31/2019	w of Form CMS-2 Worksheet L Parts I-III Date/Time Pre 5/21/2020 10:	pared:
		Title XVIII	Hospi tal	PPS	<u>00 am</u>
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			774, 893	1
1. 01	Model 4 BPCI Capital DRG other than outlier			0	
2. 00 2. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments			5, 436 0	
3. 00	Total inpatient days divided by number of days in the cost re	operting period (see ins	tructions)	29. 02	
4. 00	Number of interns & residents (see instructions)	eportring perrou (see rins	tructrons)	0.00	
5. 00	Indirect medical education percentage (see instructions)			0.00	
6. 00	Indirect medical education adjustment (multiply line 5 by the	e sum of lines 1 and 1 0	1 columns 1 and	0.00	1
0.00	1.01) (see instructions)	e sam of fiftes f and f. o	i, corumis rana	o .	0.00
7. 00	Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions)	patient days (Worksheet	E, part A line	0. 00	7. 00
8. 00	Percentage of Medicaid patient days to total days (see instru	uctions)		0. 00	8.00
9. 00	Sum of lines 7 and 8	0. 00			
10.00	Allowable disproportionate share percentage (see instructions	s)		0. 00	10.00
11.00		-,		0	11.00
12.00	2.00 Total prospective capital payments (see instructions)				
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	
2.00	Program inpatient ancillary capital cost (see instructions)			0	
3. 00 4. 00	Total inpatient program capital cost (line 1 plus line 2)			0	
4. 00 5. 00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4)			0	
3.00	Total Tripatrent program capital cost (Trile 3 x Trile 4)			U	3.00
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1. 00	
1. 00	Program inpatient capital costs (see instructions)			0	1.00
2. 00	Program inpatient capital costs (see instructions)	cas (saa instructions)		0	
3. 00	Net program inpatient capital costs (line 1 minus line 2)	ces (see mistractions)		0	
4. 00	Applicable exception percentage (see instructions)			0. 00	
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0	1
6. 00	Percentage adjustment for extraordinary circumstances (see in	nstructions)		0. 00	
7. 00	Adjustment to capital minimum payment level for extraordinary		x line 6)	0	1
8. 00	Capital minimum payment level (line 5 plus line 7)	,	,	0	8.00
9.00	Current year capital payments (from Part I, line 12, as appl	i cabl e)		0	9. 00
10.00	Current year comparison of capital minimum payment level to	capital payments (line 8	less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over	capital payment (from pr	ior year	0	11.00
	Worksheet L, Part III, line 14)				
12.00				0	
13. 00				0	
14. 00		capital payment for the	following period	0	14.00
45.00	(if line 12 is negative, enter the amount on this line)			_ :	45.00
15.00		STructions)		0	
16.00	00 Current year operating and capital costs (see instructions)				16. 00
17 00	Current year exception offset amount (see instructions)		l	0	17.00