This report is required by law (42 USC 1395g;	42 CFR 413.20(b)). Failure 1	to report can resul	t in all interimi	ORM APPROVED
payments made since the beginning of the cost	reporting period being deeme	ed overpayments (42	USC 1395g). (MB NO. 0938-0050
			E	EXPIRES 05-31-2019
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST	REPORT CERTIFICATION Provi			Vorksheet S
AND SETTLEMENT SUMMARY			From 01/01/2017 F	Parts I-III

			To 12/31/2017	Date/Time Pro 5/23/2018 1:	
PART I - COST	REPORT STATUS				
Provi der use only	1. [X] Electronically filed cost report 2. [] Manually submitted cost report		Date: 5/23/20		1: 17 pm
	3. [0]If this is an amended report enter the number 4. [F]Medicare Utilization. Enter "F" for full or "L		resubmitted this c	ost report	
Contractor use only	5. [1]Cost Report Status 6. Date Received: (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report fo (3) Settled with Audit 9. [N] Final Report for (4) Reopened (5) Amended	11. r this Provider CCN 12.	NPR Date: Contractor's Vendo [O]If line 5, co number of tim	lumn 1 is 4:	

PART II - CERTIFICATION

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

CERTIFICATION BY 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 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Si	gned)Officer or Administrator of Provider(s)
	Ti tl e
	Date

	·		Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-201, 811	4, 695	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
200.00	Total	0	-201, 811	4, 695	0	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 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/23/2018 1:12 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: ONE KINGS DAUGHTERS DRIVE PO Box: 447 1.00 1.00 Zi p Code: 47250-2.00 City: MADISON State: IN County: **JEFFERSON** 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Туре Certi fi ed Number Number 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 KING'S DAUGHTERS' 150069 99915 06/17/1966 3.00 HOSPI TAI 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 Hospital -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 17.00 Hospital -Based (CMHC) I 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) 01/01/2017 12/31/2017 20.00 21.00 Type of Control (see instructions) 21.00 2 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for disproportionate 22.00 Ν 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 cost reporting 22.01 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 payments to be Ν 22.02 22.02 Ν 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. Did this hospital receive a geographic reclassification from urban to rural as a result Ν N 22.03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 23 00 N 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

	In-State	In-State	Out-of	Out-of	Medicaid	Other	
	Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
	pai d days	el i gi bl e	Medi cai d	Medi cai d		days	
		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	
24.00 If this provider is an IPPS hospital, enter the	772	655	66	50	909	79	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	ו						
4, Medicaid HMO paid and eligible but unpaid days in	ו						
column 5, and other Medicaid days in column 6.							
25.00 If this provider is an IRF, enter the in-state	0	0	0	0	0		25.00
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.							

Health Financial Systems KING'S D	AUGHTER	S' HOSPITAL		Li	n Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provi der CC	CN: 15-0069	Peri od: From 01/01/		Worksheet S-	
				To 12/31		Date/Time Pr	
				Urban/Rui	ral S	17	
2/ 00 Enter your standard geographic close fiestion (not we	202 0+0	+a a+ +ba ba	alnning of t	1.00	1	2. 00	26. 00
26.00 Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for			grinning or th	ie	'		26.00
27.00 Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	~ "2" fo	or rural. If a		t	1	10/01/2015	27. 00
35.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status in		1		35. 00
				Begi nni 1. 00			-
36.00 Enter applicable beginning and ending dates of SCH st		Subscript line	36 for number				36.00
of periods in excess of one and enter subsequent date 37.00 If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		umber of perio	ds MDH statu	S	0		37. 00
37.01 Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for				N			37. 01
instructions) 38.00 If line 37 is 1, enter the beginning and ending dates	s of MDH	lstatus Ifl	ine 37 is				38.00
greater than 1, subscript this line for the number of							
enter subsequent dates.				Y/N		Y/N	
20 00 Doos this facility qualify for the innetical hospitals	no. mor	at adi uatmant	for law value	1. 00	ı		20,00
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? 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) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)						IN IN	39.00
40.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	per 1. E	nter "Y" for				N	40.00
no fil cordilli 2, for discharges on or after october 1.	(See I	ristructrons)					
Prospective Payment System (PPS)-Capital					1.00	0 2.00 3.00	
45.00 Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions)	nt for c	di sproporti ona	te share in a	accordance	N	N N	45. 00
46.00 Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.					N	N N	46. 00
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS of the facility electing full federal capital payment					1	1 1	47. 00 48. 00
Teaching Hospitals 56.00 Is this a hospital involved in training residents in or "N" for no.	approve	ed GME program	s? Enter "Y	for yes	N		56.00
57.00 If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes or th of th (", comp	"N" for no i nis cost repor Diete Workshee	n column 1. ting period?	If column 1 Enter "Y"			57.00
58.00 If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,			ans' service	s as			58. 00
59.00 Are costs claimed on line 100 of Worksheet A? If yes					N		59.00
			NAHE 413.85 Y/N	5 Workshee Li ne		Qualification Criterion	
	*****		1.00	2. 00)		
60.00 Are you claiming nursing and allied health education any programs that meet the criteria under §413.85? (60.01 If line 60 is yes, complete columns 2 and 3 for each	(see ins	structions)	Y		23. 00) 1	60. 00
i nstructi ons)	Y/N	IME	Direct GME			Direct GME	
	1.00	2. 00	3. 00	4. 00)	5. 00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	1.00	2.00	3.00	4.00	0. 00		00 61.00
column 1. (see instructions) 61.01 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							61.01
instructions) 61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs, added under section 5502 of							61.02
and primary care FTEs added under section 5503 of ACA). (see instructions)							

ealth Financial Systems KING'S OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D		Provi der C		Peri od:	u of Form CMS-2 Worksheet S-2	
				From 01/01/2017 To 12/31/2017	Part I Date/Time Pre 5/23/2018 1:1	pared: 2 pm
	Y/N	IME	Direct GME	I ME	Direct GME	
	1.00	2. 00	3. 00	4. 00	5. 00	
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
1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.0
1.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)	?					61. C
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 Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
1.10 Of the FTEs in line 61.05, specify each new program		1. 00	2. 00	3. 00	4. 00	61. 1
specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						
1. 20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.	١			0.00	0.00	61.2
					1. 00	-
ACA Provisions Affecting the Health Resources and Se	ervi ces <i>i</i>	Administration	n (HRSA)			
2.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instru		d in this cost	reporting pe	eriod for which	0.00	62.0
2.01 Enter the number of FTE residents that rotated from during in this cost reporting period of HRSA THC pro Teaching Hospitals that Claim Residents in Nonprovio	a Teachi gram. (s	see instructio		to your hospital	0.00	62.0
3.00 Has your facility trained residents in nonprovider s	settings	during this d			N	63.0
"Y" for yes or "N" for no in column 1. If yes, compl	ete IIne	es 64 through	Unweighted	Unweighted	Ratio (col.	
			FTEs Nonprovider Site	FTES in Hospital	1/ (col. 1 + col. 2))	
Section 5504 of the ACA Base Year FTE Residents in N	Johnnovi (der Settings-	1.00 -This base ve	2.00	3.00	
period that begins on or after July 1, 2009 and before	ore June	30, 2010.	,			
4.00 Enter in column 1, if line 63 is yes, or your facili in the base year period, the number of unweighted no resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighte resident FTEs that trained in your hospital. Enter i of (column 1 divided by (column 1 + column 2)). (see	on-primar n all nor ed non-pr n columr	ry care nprovider rimary care n 3 the ratio	0.0	0.00	0. 000000	64.(
Program Name	1	ogram Code	Unwei ghted FTEs Nonprovi der	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
1.00		2 00	Si te	4.00	5.00	
1 (1/1)		/ [][]	1 3 (1(1)	4 (1(1	5 (10)	

2. 00

3.00

5. 00

4. 00

1. 00

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 01/01/2017 Part I 12/31/2017 Date/Time Prepared: 5/23/2018 1:12 pm 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 F	PPS							
70.00	Is this facility an Inpatient Ps	sychiatric Facility (IPF), or does it cont	ain an IPF sub	provi der?	N			70.00
	Enter "Y" for yes or "N" for no).							
71.00	If line 70 is yes: Column 1: Did	d the facility have a	n approved GME teachi	ng program in	the most			0	71.00
	recent cost report filed on or k	oefore November 15, 2	004? Enter "Y" for y	es or "N" for	no. (see				
	42 CFR 412. 424(d)(1)(iii)(c)) Co								
	program in accordance with 42 CF	R 412.424 (d)(1)(iii)(D)? Enter "Y" for y	es or "N" for	no.				
	Column 3: If column 2 is Y, indi	cate which program y	ear began during this	cost reportin	g period.				
	(see instructions)								
	Inpatient Rehabilitation Facili	ty PPS							
75.00	Is this facility an Inpatient Re		y (IRF), or does it c	ontain an IRF		N			75.00
	subprovider? Enter "Y" for yes	and "N" for no.							

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN:		Period: From 01/01/ To 12/31/	2017 2017	Workshe Part I Date/Ti 5/23/20	me Pre	pared:
			1. 00	2.00	3. 00	-
If line 75 is yes: Column 1: Did the facility have an approved GME teaching recent cost reporting period ending on or before November 15, 2004? Enter "\no. Column 2: Did this facility train residents in a new teaching program in CFR 412.424 (d)(1)(iii)(D)? Enter "\" for yes or "\" for no. Column 3: If coindicate which program year began during this cost reporting period. (see in	/" for yes n accordand olumn 2 is	or "N" for ce with 42 Y,	1.00	2.00	0	76. 0
				1. 0	0	
Long Term Care Hospital PPS 1.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 1.00 Is this a LTCH co-located within another hospital for part or all of the cos "Y" for yes and "N" for no.		ng period? E	Enter	N N		80. 0 81. 0
TEFRA Providers 5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter " 5.00 Did this facility establish a new Other subprovider (excluded unit) under 42			no.	N		85. 0 86. 0
§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 7.00 Is this hospital an extended neoplastic disease care hospital classified unc			-	N		87.0
1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		V		XI X	<	
Title V and XIX Services		1. 00		2. 0	0	
 OD Does this facility have title V and/or XIX inpatient hospital services? Enterpress or "N" for no in the applicable column. 	er "Y" for	N		Υ		90.0
1.00 Is this hospital reimbursed for title V and/or XIX through the cost report of full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N		Υ		91.0
2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification instructions) Enter "Y" for yes or "N" for no in the applicable column. 3.00 Does this facility operate an ICF/IID facility for purposes of title V and X		N		N N		92.0
"Y" for yes or "N" for no in the applicable column. 1.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no i		N		N		94. (
applicable column. 5.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 5.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no i	n the	0. 00 N		0. 0 N	0	95. 0 96. 0
applicable column. 7.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 8.00 Does title V or XIX follow Medicare (title XVIII) for the interns and reside stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for column 1 for title V, and in column 2 for title XIX.	ents post or no in	0. 00 Y		0. 0 Y	0	97. 0 98. 0
B.O1 Does title V or XIX follow Medicare (title XVIII) for the reporting of charge. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in co				Υ		98. (
title XIX. 3.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of obsoled costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in for title V, and in column 2 for title XIX.		Y		Υ		98. (
B.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hosp reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no for title V, and in column 2 for title XIX.				N		98.0
3.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for ti in column 2 for title XIX.	of tle V, and	N		N		98. (
3.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disal Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for titl				Υ		98.
column 2 for title XIX. 1.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for V Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, column 2 for title XIX. Rural Providers		Y		Y		98.
05.00 Does this hospital qualify as a CAH?		N				105.0
06.00 If this facility qualifies as a CAH, has it elected the all-inclusive method for outpatient services? (see instructions)	d of paymer	nt N				106.0
07.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement f training programs? Enter "Y" for yes or "N" for no in column 1. (see instruc yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the prog	ctions) If	N				107. (
reimbursed. If yes complete Wkst. D-2, Pt. II. 08.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedul	e? See 4'	2 N				108.

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 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/23/2018 1:12 pm 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, 094, 433 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 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

OFFINE AND HOOFFINE HEALTH OAK	E COMPLEX IDENTIFICATION DATA	Provi der CCI	N: 15-0069	Period:	: 1/01/2017	Worksheet S- Part I	2
					2/31/2017	Date/Time Pr 5/23/2018 1:	
					1.00	2.00	
0.00 Are there any related orga	nization or home office costs	as defined in CMS	Pub. 15-1.		1. 00 N	2. 00	140.0
chapter 10? Enter "Y" for	yes or "N" for no in column 1.	. If yes, and home	office cos				
1.00	mn 2 the home office chain num	2. 00	LI ONS)		3. 00		
If this facility is part o	f a chain organization, enter	on lines 141 thro	ugh 143 th	e name ar		of the home	
office and enter the home 1.00 Name:	office contractor name and con Contractor's Name		Contra	ctor's Nu	ımber:		141.
2.00 Street:	PO Box:						142.
3. 00 Ci ty:	State:		Zi p Co	de:			143.
						1. 00	
4.00 Are provider based physicia	ans' costs included in Workshe	eet A?				ΥΥ	144.
					1. 00	2. 00	
no, does the dialysis faci period? Enter "Y" for yes 6.00 Has the cost allocation me	nter "Y" for yes or "N" for no lity include Medicare utilizat or "N" for no in column 2. thodology changed from the pre	o in column 1. If o tion for this cost eviously filed cost	column 1 is reporting t report?		N		145.
	or no in column 1. (See CMS Pute (mm/dd/yyyy) in column 2.	ub. 15-2, chapter ² ————————————————————————————————————	40, §4020)	I f			1
						1. 00	-
7.00 Was there a change in the						N	147.
3.00 Was there a change in the				For no		N	148.
9.00 Was there a change to the	simplified cost finding method	Part A	Part B		itle V	N Title XIX	149.
		1.00	2. 00		3. 00	4.00	1
	a provider that qualifies for yes or "N" for no for each con						
5. 00 Hospi tal	yes or in for no for each con	N N	and Part N	в. (See 4	N N	3. 13) N	 155.
6.00 Subprovi der - IPF		N	N		N	N	156.
7.00 Subprovi der - IRF		N	N		N	N	157.
B. OO SUBPROVI DER		N	N		NI .	N	158.
9.00 SNF D.OO HOME HEALTH AGENCY		N N	N N		N N	N N	159. 160.
1. 00 CMHC			N		N	N	161.
						1. 00	+
Multicampus 5.00Is this hospital part of a	Mul ti compus bosni tal, that box	c one or more campi	ucos in di	Eforant C	DCAc2	N	165.
Enter "Y" for yes or "N" for		s one or more campu	uses III ui	i i ei eiit C	DSAS?	IN	105.
	Name O	County 1.00	State 2.00	Zip Code 3.00	4. 00	FTE/Campus 5.00	-
		1.00	2.00	3.00	4.00	0. 0	0166.
6.00 If line 165 is yes, for ear campus enter the name in composition of the column 1, state column 2, zip code in column 2 cBSA in column 4, FTE/Camposolumn 5 (see instructions)	olumn tein mn 3, usin						
campus enter the name in co O, county in column 1, sta column 2, zip code in colu CBSA in column 4, FTE/Campu column 5 (see instructions	olumn tein mn 3, usin)					1. 00	
campus enter the name in co 0, county in column 1, sta column 2, zip code in colum CBSA in column 4, FTE/Campus column 5 (see instructions) Health Information Technology 7.00 Is this provider a meaning 8.00 If this provider is a CAH	olumn te in mn 3, us in) ogy (HIT) incentive in the Am ful user under §1886(n)? Ente (line 105 is "Y") and is a mea	er "Y" for yes or " aningful user (line	"N" for no.		r the	Y	
campus enter the name in co 0, county in column 1, sta column 2, zip code in column CBSA in column 4, FTE/Campus column 5 (see instructions) Health Information Technology 7.00 Is this provider a meaning 8.00 If this provider is a CAH reasonable cost incurred for this provider is a CAH 1.01 If this provider is a CAH 1.02 In this provider is a CAH 1.03 In this provider is a CAH 1.04 In this provider is a CAH 1.05 In this provider is a CAH 1.06 In this provider is a CAH 1.07 In this provider is a CAH 1.08 In this provider is a CAH 1.09 In this provider is	ogy (HIT) incentive in the Amm ful user under §1886(n)? Ente (line 105 is "Y") and is a mea or the HIT assets (see instruction	er "Y" for yes or " aningful user (line ctions) does this provider	"N" for no. e 167 is "' r qualify 1	Y"), ente for a har		Y	0168.
campus enter the name in co 0, county in column 1, sta column 2, zip code in colu CBSA in column 4, FTE/Campus column 5 (see instructions) Health Information Technol 7.00 Is this provider a meaning 3.00 If this provider is a CAH reasonable cost incurred for 3.01 If this provider is a CAH exception under §413.70(a)	olumn te in mn 3, us in) ogy (HIT) incentive in the Ame ful user under §1886(n)? Ente (line 105 is "Y") and is a mea for the HIT assets (see instruct and is not a meaningful user, (6)(ii)? Enter "Y" for yes or ingful user (line 167 is "Y")	er "Y" for yes or " aningful user (line ctions) does this provider "N" for no. (see i	"N" for no. e 167 is "\ r qualify i instruction	Y"), ente for a har ns)	dshi p	Y	0168. 168.
campus enter the name in co 0, county in column 1, sta column 2, zip code in column CBSA in column 4, FTE/Campus column 5 (see instructions) Health Information Technol 7.00 Is this provider a meaning 3.00 If this provider is a CAH exception under §413.70(a) 9.00 If this provider is a mean	olumn te in mn 3, us in) ogy (HIT) incentive in the Ame ful user under §1886(n)? Ente (line 105 is "Y") and is a mea for the HIT assets (see instruct and is not a meaningful user, (6)(ii)? Enter "Y" for yes or ingful user (line 167 is "Y")	er "Y" for yes or " aningful user (line ctions) does this provider "N" for no. (see i	"N" for no. e 167 is "\ r qualify i instruction	Y"), ente for a har ns) is "N"),	dshi p	Y	167. 0168. 168. 9169.

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL		In Lie	u of Form CM	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIF	ICATION DATA	Provider CCN: 15-0069			Worksheet S	5-2
				rom 01/01/2017) 12/31/2017		
				1. 00	2. 00	
171.00 If line 167 is "Y", does this provider have	any days for indiv	viduals enrolled in		N		0171.00
section 1876 Medicare cost plans reported o	n Wkst. S-3, Pt. I,	, line 2, col. 6? Enter				
"Y" for yes and "N" for no in column 1. If		nter the number of secti	on			
1876 Medicare days in column 2. (see instru	ctions)					

	Financial Systems KING'S DAUGHTER		ON 45		u of Form CMS-	
HOSPI TA	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Date/Time Pro	epared:
	<u> </u>			Y/N	5/23/2018 1: Date	12 pm
				1. 00	2. 00	
r	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	for all NO re	esponses. Ent			
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					-
	Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.00
	reporting period? If yes, enter the date of the change in co	olumn 2. (see	1			
			1.00	2.00	V/I 3. 00	
2. 00	Has the provider terminated participation in the Medicare Pr	rogram? If	1.00 N	2.00	3.00	2.00
	yes, enter in column 2 the date of termination and in column					
	voluntary or "I" for involuntary.					
	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of		N			3.00
	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	r similar				
	relationships? (see instructions)		Y/N	Type	Date	
			1.00	2. 00	3.00	
I	Financial Data and Reports					
	Column 1: Were the financial statements prepared by a Certi		Y	С		4.00
	Accountant? Column 2: If yes, enter "A" for Audited, "C" for					
	or "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions.	паргетп				
	Are the cost report total expenses and total revenues differ	rent from	N			5.00
	those on the filed financial statements? If yes, submit reco	onciliation.				
				Y/N 1. 00	Legal Oper. 2.00	
1	Approved Educational Activities			1.00	2.00	
	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is the	he provider i	s N		6.00
	the legal operator of the program?					
	Are costs claimed for Allied Health Programs? If "Y" see ins		d dusing the	N N		7.00
	Were nursing school and/or allied health programs approved a cost reporting period? If yes, see instructions.	and/or renewed	a durring the	IN		8.00
	Are costs claimed for Interns and Residents in an approved of	graduate medi	cal education	n N		9.00
	program in the current cost report? If yes, see instructions					
	Was an approved Intern and Resident GME program initiated on cost reporting period? If yes, see instructions.	r renewed in	the current	N		10.00
	Are GME cost directly assigned to cost centers other than I	& R in an Ap	proved	N		11.00
	Teaching Program on Worksheet A? If yes, see instructions.					
					Y/N	
Ti.	Bad Debts				1. 00	
-	Is the provider seeking reimbursement for bad debts? If yes,	, see instruc	tions.		Υ	12.00
13. 00	If line 12 is yes, did the provider's bad debt collection po			cost reporting	N	13.00
	period? If yes, submit copy.		e !		, ,	14.00
	lf line 12 is yes, were patient deductibles and/or co-paymen Bed Complement	nts warved? I	r yes, see rr	ISTRUCTIONS.	N N	14. 00
	Did total beds available change from the prior cost reporting	ng period? If	yes, see ins	structions.	N	15. 00
			t A		t B	
		Y/N	Date	Y/N	Date	
ı	PS&R Data	1. 00	2. 00	3. 00	4. 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) Was the cost report prepared using the PS&R Report for	Υ	03/14/2018	Υ	03/14/2018	17.00
	totals and the provider's records for allocation? If	•	03/ 14/ 2010	'	03/ 14/ 2010	17.00
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)	N		N.		10.00
	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	N		N		18.00
	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
		N.I.	I .	N	l .	19.00
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		IN		1 17.00
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	IN .		IN.		17.00

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 01/01/2017 To 12/31/2017	Worksheet S- Part II Date/Time Pr 5/23/2018 1:	epared:	
		Descr	iption	Y/N	Y/N	TZ piii	
			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.						
					1. 00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHI LDRENS	HOSPI TALS)				
	Capital Related Cost						
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.			ring the cost		22. 00 23. 00	
24. 00	Were new leases and/or amendments to existing leases entere lf 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.	e cost reporti	ng period? I	f yes, submit		27. 00	
28. 00							
29. 00							
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 exiphysicians during the cost reporting period? If yes, see in	sting agreeme nstructions.	nts with the	provi der-based	N	35. 00	
				Y/N	Date		
	U 066: 0t-			1.00	2. 00		
36 00	Home Office Costs Were home office costs claimed on the cost report?					36.00	
	If line 36 is yes, has a home office cost statement been pr	repared by the	home office	?		37.00	
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end			f		38. 00	
39. 00	If line 36 is yes, did the provider render services to other see instructions.			S,		39. 00	
40. 00	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			
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LUCI A		GERBER		41.00	
42.00	'	BLUE & CO., LL	_C			42.00	
43. 00		502. 992. 3524		LGERBER@BLUEAN	DCO. COM	43.00	

Health Financial Systems KING'S DA	JGHTERS' HOSPI TAL	In Lieu of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIR	Provider CCN: 15-0069	Peri od: Worksheet S-	2
		From 01/01/2017 Part II To 12/31/2017 Date/Time Pr	oparod:
		5/23/2018 1:	12 pm
	3.00		
Cost Report Preparer Contact Information			
41.00 Enter the first name, last name and the title/position	SENIOR MANAGER		41.00
held by the cost report preparer in columns 1, 2, and	3,		
respecti vel y.			
42.00 Enter the employer/company name of the cost report			42. 00
preparer.			
43.00 Enter the telephone number and email address of the co	st		43.00
report preparer in columns 1 and 2, respectively.			

| Period: | Worksheet S-3 | From 01/01/2017 | Part | To | 12/31/2017 | Date/Time Prepared: Health Financial Systems KING'S DA HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0069

						To 12/31/2017	Date/Time Pre 5/23/2018 1:1	
							1/P Days /	Z piii
							0/P Visits /	
							Tri ps	
	Component	Worksheet A	No.	. of Beds	Bed Days	CAH Hours	Title V	
	·	Line Number			Avai I abl e			
		1. 00		2. 00	3.00	4.00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		82	29, 93	0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
0.00	for the portion of LDP room available beds)							0.00
2.00	HMO and other (see instructions)							2.00
3.00	HMO I PF Subprovi der							3.00
4.00	HMO I RF Subprovi der							4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF			00	00.00	0 00	0	
7. 00	Total Adults and Peds. (exclude observation			82	29, 93	0.00	0	7. 00
0 00	beds) (see instructions)	21 00		,	2.10	0 00		0.00
8. 00	INTENSIVE CARE UNIT	31. 00		6	2, 19	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)	42.00						12.00
13.00	NURSERY	43.00		00	22.12	0 00	0	
14.00	Total (see instructions)			88	32, 12	0.00		
15.00	CAH visits						0	15.00
16.00	SUBPROVIDER - I PF							16.00
17.00	SUBPROVIDER - I RF							17.00
18.00	SUBPROVI DER							18.00
19.00	SKILLED NURSING FACILITY							19. 00 20. 00
20.00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE	101. 00					0	1
22. 00 23. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.)	101.00					0	23.00
	1	114 00		1	2,	_		1
24. 00 24. 10	HOSPICE HOSPICE (non-distinct part)	116. 00 30. 00		ı	36	5		24. 00 24. 10
25. 00	CMHC - CMHC	30.00						25.00
26. 00	RURAL HEALTH CLINIC							26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	
27. 00	Total (sum of lines 14-26)	69.00		89			0	27.00
28. 00	Observation Bed Days			09			0	
29. 00	Ambul ance Tri ps						0	29.00
30.00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days (see Histruction)							31.00
32. 00	Labor & delivery days (see instructions)			0		0		32.00
32. 00	Total ancillary labor & delivery room			U		<u> </u>		32.00
JZ. U1	outpatient days (see instructions)							32.01
33. 00	LTCH non-covered days							33.00
	LTCH site neutral days and discharges							33. 01
50.01	12.1 2. 12	ļ	ı		1	ı	1	, 55.5.

Health Financial Systems KING'S DA HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Peri od: Worksheet S-3 From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared: Provi der CCN: 15-0069

				T	o 12/31/2017	Date/Time Pre 5/23/2018 1:1	
		I/P Davs	/ O/P Visits	/ Trips	Full Time E	Egui val ents	Z piii
						1	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
		6. 00	7. 00	Pati ents 8.00	& Residents 9.00	Payrol I 10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	6, 199	1, 345	10, 258	7.00	10.00	1.00
1.00	8 exclude Swing Bed, Observation Bed and	0, 177	1,010	10, 200			1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	1, 125	718				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	6, 199	1, 345	10, 258			7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT	771	157	1, 248			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)		222	1 107			12.00
13. 00 14. 00	NURSERY Total (see instructions)	6, 970	232 1, 734	1, 127 12, 633	0.00	779. 09	13. 00 14. 00
15. 00	CAH visits	6, 970	1, 734	12, 033	0.00	779.09	15.00
16. 00	SUBPROVIDER - IPF	۷	U	U			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	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	5, 312	703	8, 187	0.00	14. 99	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)	·		•			23.00
24.00	HOSPI CE	27	0	30	0.00	0. 89	24.00
24. 10	HOSPICE (non-distinct part)	O	0	0			24. 10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0.00	794. 97	27. 00
28.00	Observation Bed Days		522	2, 447			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			148			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	79	162			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days	0					33.00
33. UI	LTCH site neutral days and discharges	٠Į	ļ				33. 01

				10) 12/31/201/	Date/IIme Pre 5/23/2018 1:1:	
		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	
	Hospital Adults & Peds. (columns 5, 6, 7 and		0	1, 756	412	3, 240	1. 00
	B exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)			278	197		2.00
	HMO and other (see instructions) HMO IPF Subprovider			2/8	197		3.00
	HMO IRF Subprovider				0		4.00
- 1	Hospital Adults & Peds. Swing Bed SNF				٩		5.00
	Hospital Adults & Peds. Swing Bed NF						6.00
	Total Adults and Peds. (exclude observation						7.00
I .	peds) (see instructions)						7.00
1	NTENSI VE CARE UNIT						8. 00
- 1	CORONARY CARE UNIT						9.00
1	BURN INTENSIVE CARE UNIT						10.00
1	SURGICAL INTENSIVE CARE UNIT						11.00
	OTHER SPECIAL CARE (SPECIFY)						12.00
	NURSERY						13.00
1	Total (see instructions)	0.00	0	1, 756	412	3, 240	14.00
4	CAH visits			,			15.00
16. 00	SUBPROVIDER - IPF						16.00
17. 00 9	SUBPROVIDER - IRF						17. 00
18. 00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00 N	NURSING FACILITY						20.00
4	OTHER LONG TERM CARE						21.00
	HOME HEALTH AGENCY	0.00					22. 00
1	AMBULATORY SURGICAL CENTER (D. P.)						23.00
	HOSPI CE	0. 00					24.00
	HOSPICE (non-distinct part)						24. 10
	CMHC - CMHC						25.00
4	RURAL HEALTH CLINIC						26.00
4	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
	Total (sum of lines 14-26)	0.00					27. 00
	Observation Bed Days						28. 00
	Ambulance Trips						29. 00 30. 00
	Employee discount days (see instruction) Employee discount days - LRF						30.00
	_abor & delivery days (see instructions)						32.00
	Total ancillary labor & delivery room						32.00
	outpatient days (see instructions)						32.01
	_TCH non-covered days			o			33.00
	_TCH site neutral days and discharges						33. 01
30.01	2. S. S. C. Houti ai days and ai sonal ges	ı		١	1		30.01

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION KING'S DAUGHTERS' HOSPITAL Provider CCN: 15-0069

					10) 12/31/2017	Date/lime Prep 5/23/2018 1:13	
		Wkst. A Line	Amount	Recl assi fi cat		Paid Hours	Average	
		Number	Reported	i on of	Sal ari es	Related to	Hourly Wage	
				Salaries (from Wkst.	(col.2 ± col. 3)	Salaries in col. 4	(col. 4 ÷ col. 5)	
				A-6)	3)	COI . 4	COI. 3)	
		1. 00	2. 00	3. 00	4.00	5. 00	6. 00	
	PART II - WAGE DATA							
1. 00	SALARIES Total salaries (see	200.00	51, 722, 385	483, 931	52, 206, 316	1, 653, 546. 13	31. 57	1. 00
1.00	instructions)	200.00	31, 722, 303	403, 931	52, 200, 310	1, 000, 040. 10	31. 37	1.00
2.00	Non-physician anesthetist Part		0	0	0	0. 00	0.00	2.00
	A			_				
3. 00	Non-physician anesthetist Part		436, 447	0	436, 447	5, 113. 56	85. 35	3. 00
4. 00	Physician-Part A -		10, 000	0	10, 000	126. 00	79. 37	4. 00
	Admi ni strati ve		·					
4. 01	Physicians - Part A - Teaching		0	0	_	0.00	0.00	4. 01
5. 00	Physician and Non Physician-Part B		3, 084, 569	0	3, 084, 569	13, 631. 00	226. 29	5. 00
6. 00	Non-physician-Part B for		0	0	0	0. 00	0. 00	6. 00
	hospital-based RHC and FQHC							
7.00	servi ces	21.00	0			0.00	0.00	7 00
7. 00	Interns & residents (in an approved program)	21. 00	0	0	0	0. 00	0. 00	7. 00
7. 01	Contracted interns and		0	0	o	0. 00	0. 00	7. 01
	residents (in an approved							
8. 00	programs)		^	0		0.00	0.00	0 00
8.00	Home office and/or related organization personnel		Ü	0	0	0. 00	0. 00	8. 00
9. 00	SNF	44.00	0	0	0	0. 00	0. 00	9.00
10.00	Excluded area salaries (see		21, 469, 261	11, 195	21, 480, 456	524, 016. 89	40. 99	10.00
	instructions) OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient		361, 534	Ο	361, 534	8, 036. 08	44, 99	11. 00
	Care		,					
12.00	Contract Labor: Top Level		0	0	0	0. 00	0. 00	12.00
	management and other management and administrative							
	servi ces							
13.00	Contract Labor: Physician-Part		510, 881	0	510, 881	3, 891. 72	131. 27	13.00
14. 00	A - Administrative Home office and/or related		0	0	0	0. 00	0.00	14. 00
14.00	orgainzation salaries and		O	٥		0.00	0.00	14.00
	wage-related costs							
14. 01	Home office salaries		0	0	0	0.00		14.01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0		0	0. 00 0. 00		14. 02 15. 00
.0.00	- Administrative		· ·			0.00	0.00	
16.00	Home office and Contract		0	0	0	0. 00	0. 00	16.00
	Physicians Part A - Teaching WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see		7, 572, 846	0	7, 572, 846			17. 00
	instructions)							
18. 00	Wage-related costs (other)		0	0	0			18. 00
19. 00	(see instructions) Excluded areas		4, 454, 091	0	4, 454, 091			19. 00
20. 00	Non-physician anesthetist Part		0	0	0			20.00
24 00	A Non physician and the state of the state o		// 005		// 005			21 00
21. 00	Non-physician anesthetist Part		66, 825	"	66, 825			21. 00
22. 00	Physician Part A -		1, 778	0	1, 778			22. 00
00	Administrative		_					00.5
22. 01 23. 00	Physician Part A - Teaching Physician Part B		0 372, 812	0	0 372, 812			22. 01 23. 00
24. 00	Wage-related costs (RHC/FQHC)		0 0		0			24.00
25. 00	Interns & residents (in an		0	0	o			25. 00
OF 50	approved program)		_					25 52
25. 50	Home office wage-related (core)		0	0	0			25. 50
25. 51	Related organization		0	0	o			25. 51
	wage-related (core)							
25. 52	Home office: Physician Part A		0	0	0			25. 52
	- Administrative - wage-related (core)							
25. 53	Home office & Contract		0	0	О			25. 53
	Physicians Part A - Teaching -							
	wage-related (core)	l		I	1	l	ı l	

Provi der CCN: 15-0069

| Period: | Worksheet S-3 | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared:

					1	o 12/31/2017	Date/lime Pre 5/23/2018 1:1	
		Wkst. A Line	Amount	Recl assi fi cat	Adjusted	Pai d Hours	Average	Z DIII
		Number	Reported	i on of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from Wkst.	3)	col. 4	col. 5)	
				A-6)	ĺ		ĺ	
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	OVERHEAD COSTS - DIRECT SALARI	ES						
26.00	Employee Benefits Department	4.00	30, 823	0	30, 823	1, 968. 60	15. 66	26. 00
27.00	Administrative & General	5. 00	6, 474, 406	483, 931	6, 958, 337	280, 045. 61	24. 85	27.00
28.00	Administrative & General under		448, 249	0	448, 249	3, 451. 50	129. 87	28. 00
	contract (see inst.)							
29.00	Maintenance & Repairs	6. 00	0	0	0	0.00	0. 00	29. 00
30.00	Operation of Plant	7. 00	634, 581	0	634, 581	28, 349. 30	22. 38	30.00
31.00	Laundry & Linen Service	8. 00	42, 017	0	42, 017	4, 157. 80	10. 11	31.00
32.00	Housekeepi ng	9. 00	658, 503	0	658, 503	59, 439. 22	11. 08	32.00
33.00	Housekeeping under contract		242, 577	0	242, 577	9, 251. 32	26. 22	33.00
	(see instructions)							
34.00	Di etary	10.00	654, 226	-210, 780	443, 446	33, 666. 90	13. 17	34.00
35.00	Dietary under contract (see		0	0	0	0.00	0. 00	35.00
	instructions)							
36.00	Cafeteri a	11. 00	0	210, 780	210, 780	11, 956. 00	17. 63	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0. 00	37.00
38.00	Nursing Administration	13. 00	422, 458	0	422, 458	11, 771. 72	35. 89	38. 00
39.00	Central Services and Supply	14. 00	77, 940	0	77, 940	5, 589. 50	13. 94	39. 00
40.00	Pharmacy	15. 00	755, 691	0	755, 691	20, 895. 04	36. 17	40.00
41.00	Medical Records & Medical	16. 00	507, 392	0	507, 392	24, 655. 15	20. 58	41.00
	Records Library							
42.00	Social Service	17. 00	0	0	0	0.00	0. 00	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43.00

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

						rom 01/01/2017 o 12/31/2017		
		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, 892, 195	483, 931	49, 376, 126	1, 647, 504. 39	29. 97	1.00
	instructions)							
2.00	Excluded area salaries (see		21, 469, 261	11, 195	21, 480, 456	524, 016. 89	40. 99	2.00
	instructions)							
3.00	Subtotal salaries (line 1		27, 422, 934	472, 736	27, 895, 670	1, 123, 487. 50	24. 83	3.00
	minus line 2)							
4.00	Subtotal other wages & related		872, 415	0	872, 415	11, 927. 80	73. 14	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		7, 574, 624	0	7, 574, 624	0.00	27. 15	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		35, 869, 973	472, 736	36, 342, 709	1, 135, 415. 30	32. 01	6.00
7.00	Total overhead cost (see		10, 948, 863	483, 931	11, 432, 794	495, 197. 66	23. 09	7.00
	instructions)							

Health Financial Systems	KING'S DAUGHTERS' H	HOSPI TAL		In Lieu	of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Pi	Provider CCN: 1	5-0069	Peri od:	Worksheet S-3
				From 01/01/2017	
					D-4- /T! D

	To 12/31/2017	Date/Time Prep 5/23/2018 1:13	
		Amount	_ p
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	o	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1, 880, 762	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	O	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	o	6.00
7.00	Employee Managed Care Program Administration Fees	o	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	6, 107, 362	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	0	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	1, 045, 242	9.00
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
	Disability Insurance (If employee is owner or beneficiary)	225, 185	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
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Non cumulative portion)		ı
	TAXES		
	FICA-Employers Portion Only	3, 191, 132	
	Medicare Taxes - Employers Portion Only	0	
	Unemployment Insurance	18, 670	
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))	0	21. 00
22.00	Day Care Cost and Allowances	0	22. 00
23.00	Tuition Reimbursement	0	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)	12, 468, 353	24.00
	Part B - Other than Core Related Cost		I
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lieu	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provi der CCN: 15-0069	Peri od: From 01/01/2017	Worksheet S-3
				Date/Time Prepared

		To 12/31/2017		
	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	361, 534		1.00
2. 00	Hospi tal	361, 534	12, 468, 353	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	11.00
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 Di al ysi s			17. 00
18. 00	Other	0	0	18. 00

Heal th	Financial Systems	KING'S DAUGHTE	RS' HOSPLTAL		In lie	u of Form CMS-2	2552-10
	IEALTH AGENCY STATISTICAL DATA	KING O BROOME	Provi der C		Period: From 01/01/2017	Worksheet S-4	
			Component		To 12/31/2017		
					Home Health	5/23/2018 1:1 PPS	z piii
					Agency I		
	T.					00	
0.00	County	Title V	Title XVIII	Title XIX	JEFFERSON Other	Total	0.00
		1. 00	2. 00	3.00	4.00	5. 00	
1. 00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	l ol	1, 070	Ι	0 645	1, 715	1.00
2. 00	Unduplicated Census Count (see instructions)	1	382.00	0.0	0 230.00	612.00	
				Number of Emp	oloyees (Full Ti	me Equivalent)	
		Enter the number	er of hours in	Staff	Contract	Total	
		your normal					
				4.00	0.22	0.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	0)	1.00	2. 00	3. 00	
3.00	Administrator and Assistant Administrator(s)		40.00	l .			
4. 00 5. 00	Director(s) and Assistant Director(s) Other Administrative Personnel			0. 9 9. 3		0. 96 9. 38	
6.00	Direct Nursing Service			0. 5	0.00	0. 52	6.00
7. 00 8. 00	Nursing Supervisor Physical Therapy Service			0. C 2. 5		0. 00 2. 59	1
9. 00	Physi cal Therapy Supervi sor			O. C	0.00	0.00	9. 00
10. 00 11. 00	Occupational Therapy Service Occupational Therapy Supervisor			0. 7 0. 0		0. 70 0. 00	
12.00	Speech Pathology Service			O. C	0.00	0. 06	12.00
13. 00 14. 00	Speech Pathology Supervisor Medical Social Service			0. C 0. C		0. 00 0. 00	
15. 00	Medical Social Service Supervisor			0.0		0.00	15.00
16. 00 17. 00	Home Health Aide Home Health Aide Supervisor			0. 8 0. 0			1
18. 00	Other (specify)			0. 0			
19. 00	HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where				2		19.00
19.00	you provided services during the cost				2		19.00
20. 00	reporting period. List those CBSA code(s) in column 1 serviced			31140			20.00
20.00	during this cost reporting period (line 20			31140			20.00
20. 01	contains the first code).			99915			20. 01
20. 01		Full Ep					20.01
		Wi thout Outliers	With Outliers	LUPA Epi sode:	S PEP Only Epi sodes	Total (cols. 1-4)	
		1. 00	2.00	3. 00	4. 00	5. 00	
21. 00	PPS ACTIVITY DATA Skilled Nursing Visits	1, 908	193	11	4 71	2, 286	21.00
22. 00	Skilled Nursing Visit Charges	445, 500	45, 114	26, 66	16, 614	533, 892	22. 00
23. 00 24. 00	Physical Therapy Visits Physical Therapy Visit Charges	2, 017 421, 113	21 4, 359		7 35 3 7, 315		
25. 00	Occupational Therapy Visits	508	16		7 6	537	1
26. 00 27. 00	Occupational Therapy Visit Charges Speech Pathology Visits	117, 694 38	3, 712 0		1, 392 1 1	124, 422 40	1
28. 00	Speech Pathology Visits Charges	9, 070	0	•	-1	9, 548	
29. 00 30. 00	Medical Social Service Visits	1 316	0	•	0 0	1 316	29. 00 30. 00
31. 00	Medical Social Service Visit Charges Home Health Aide Visits	299	25		2 2	328	
32.00	Home Health Aide Visit Charges	40, 798	3, 410			44, 756	1
33. 00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4, 771	255	17	115	5, 312	33.00
34.00	Other Charges	0	0 E4 E0E		0	1 151 244	1
35. 00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1, 034, 491	56, 595	34, 44	25, 834	1, 151, 364	35.00
36. 00	Total Number of Episodes (standard/non	336		5	7 12	405	36.00
37. 00	outlier) Total Number of Outlier Episodes		O		0	0	
38. 00	Total Non-Routine Medical Supply Charges	13, 911	835	57	6 0	15, 322	38.00

Heal th	Financial Systems		KING'S DAUGHTE	ERS' HOSPITAL		In Lie	u of Form CMS-2	2552-10	
	AL-BASED HOSPICE IDENTIFICATION	I DATA		Provi der C	CN: 15-0069	Peri od:	Worksheet S-9		
				Hospi ce CC	N: 15-1535	From 01/01/2017 To 12/31/2017		pared:	
						Hospi ce I			
		Undupl i cated							
		Days							
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of		
				Skilled	Nursi ng		cols. 1, 2 &		
				Nursi ng	Facility		5)		
				Facility					
	1	1. 00	2. 00	3. 00	4.00	5. 00	6. 00		
	PART I - ENROLLMENT DAYS FOR CO	OST REPORTING	PERIODS BEGINN	ING BEFORE OCT	OBER 1, 2015				
1.00	Hospice Continuous Home Care							1.00	
2.00	Hospice Routine Home Care							2.00	
3.00	Hospice Inpatient Respite Care Hospice General Inpatient Care							3. 00 4. 00	
4. 00 5. 00	Total Hospice Days			1				5.00	
Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015									
6. 00	Number of patients receiving	KLFOKIING FLK	I ODS BEGINNING	BLIOKE OCTOBE	1, 2015			6. 00	
0.00	hospi ce care							0.00	
7. 00	Total number of unduplicated							7. 00	
7.00	Continuous Care hours billable							7.00	
	to Medicare								
8.00	Average Length of Stay (line 5							8. 00	
	/ line 6)								
9.00	Unduplicated census count							9.00	
NOTE:	Parts I and II, columns 1 and 2	also include	the days repor						
				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		
40.00	PART III - ENROLLMENT DAYS FOR	COST REPORTIN	G PERIODS BEGI			· -		40.00	
10.00	Hospice Continuous Home Care			1 500	1	0 0	0		
11.00	Hospice Routine Home Care Hospice Inpatient Respite Care			1, 500	1	11 130 0 0		11. 00 12. 00	
12. 00 13. 00	Hospice General Inpatient Care			17	1	0 0	17 13		
	Total Hospice Days			1, 530		11 130	-		
14.00	PART IV - CONTRACTED STATISTICA	AL DATA FOR CO	ST REPORTING D					14.00	
15. 00	Hospice Inpatient Respite Care		ST REFORTING F	CKTODS BEGINNI		0 0		15. 00	
	Hospice General Inpatient Care					0 0			
10.00	The second of th			1	1	51	١		

USDI T	Financial Systems KING'S DAUGHTERS' F TAL UNCOMPENSATED AND INDIGENT CARE DATA P	rovider CCN: 15-00)69 D	eri od:	u of Form CMS-2 Worksheet S-1					
USFII	AL UNCOMPLINGATED AND INDIGENT CARE DATA	TOVIDEL CON. 15-00		om 01/01/2017	WOLKSHEET 3-1	U				
			To		Date/Time Pre 5/23/2018 1:1					
					1. 00					
	Uncompensated and indigent care cost computation									
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by line 202	col umn	8)	0. 237228	1.				
00	Medicaid (see instructions for each line)				0 440 450					
00	Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid?				9, 410, 153 Y	2. 3.				
00	If line 3 is yes, does line 2 include all DSH and/or supplement	al navments from	Medi cai	d?	N	4.				
00	If line 4 is no, then enter DSH and/or supplemental payments fr		wear ear	u.	627, 702	1				
00	Medi cai d charges				46, 023, 529					
00	Medicaid cost (line 1 times line 6)				10, 918, 070	7.				
00	Difference between net revenue and costs for Medicaid program (< zero then enter zero)	line 7 minus sum	of line	s 2 and 5; if	880, 215	8.				
	Children's Health Insurance Program (CHIP) (see instructions fo	r each line)								
00	Net revenue from stand-alone CHIP				0	1				
0.00	Stand-alone CHIP charges				0	1				
1. 00 2. 00	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (ling 11 minus lin	ο O·if	zero then	0	1				
2.00	enter zero)									
	Other state or local government indigent care program (see inst	ructions for each	line)							
3. 00	Net revenue from state or local indigent care program (Not incl					13.				
. 00	Charges for patients covered under state or local indigent care 10)	program (Not inc	luded i	n lines 6 or	0	14.				
5. 00	State or local indigent care program cost (line 1 times line 14)			0	15.				
5. 00	Difference between net revenue and costs for state or local ind	igent care progra	m (line	15 minus line	0	16.				
	13; if < zero then enter zero)	D	!!!	-+	(-				
	Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line)	P and State/Local	i nai ge	nt care progra	ims (see					
7. 00		9			0					
	Government grants, appropriations or transfers for support of h			(cum of Lines	000 315					
9. 00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	Thurgent care pr	ogi allis	(Suiii OI TITIES	880, 215	19.				
		Uni ns		Insured	Total (col. 1					
		patie		patients	+ col . 2)					
	Uncompensated Care (see instructions for each line)	1. (JU	2. 00	3. 00					
0. 00	Charity care charges and uninsured discounts for the entire fac (see instructions)	ility 2,8	310, 936	345, 006	3, 155, 942	20.				
1. 00	Cost of patients approved for charity care and uninsured discou	nts (see	666, 833	345, 006	1, 011, 839	21.				
00	instructions)		300, 000	0.107.000	., 0, 00,					
2. 00	Payments received from patients for amounts previously written	off as	0	0	0	22.				
3. 00	charity care Cost of charity care (line 21 minus line 22)		566, 833	345, 006	1, 011, 839	23				
, 00	ossi or sharry sars (rine 2) minas rine 22)		300, 000	0.07.000		20.				
1. 00	Door the amount on Line 20 column 2 include charges for notion	+ daya bayand a l	anath a	f atau limit	1. 00 N	24				
. 00	Does the amount on line 20 column 2, include charges for patien imposed on patients covered by Medicaid or other indigent care		engtii c	I Stay IIIII t	IN	24.				
. 00	If line 24 is yes, enter the charges for patient days beyond th stay limit	e indigent care p	rogram'	s length of	0	25.				
. 00	Total bad debt expense for the entire hospital complex (see ins	tructions)			9, 093, 548	26.				
. 00	Medicare reimbursable bad debts for the entire hospital complex	,	ıs)		391, 838					
	Medicare allowable bad debts for the entire hospital complex (s	ee instructions)			602, 827					
7. 01	INC. M. P. C. C. L. L. L. L. L. C.				8, 490, 721	28.				
8. 00	Non-Medicare bad debt expense (see instructions)									
7. 01 8. 00 9. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see instruc	tions)		2, 225, 226	29.				
3. 00 9. 00 0. 00		•	ctions)			29 30				

	•	KING S DAUGHIERS		ON 15 00/0 D		U OF FORM CMS	2332-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CO	F	eriod: rom 01/01/2017	Worksheet A	
				I	o 12/31/2017	Date/Time Pre 5/23/2018 1:1	
	Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cat	Recl assi fi ed	ļ
				+ col. 2)	i ons (See	Trial Balance	
					A-6)	(col. 3 +- col. 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 1. 01	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO		15, 658, 978	15, 658, 978	246, 606 7, 897	15, 905, 584 7, 897	1. 00 1. 01
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP		0		7, 377	7, 677	2.00
3.00	00300 OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	30, 823	14, 269, 402	14, 300, 225		13, 218, 548	
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	6, 474, 406 634, 581	10, 970, 594 2, 264, 652		·	17, 157, 327 2, 899, 167	5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	42, 017	284, 961	326, 978		326, 978	
9. 00	00900 HOUSEKEEPI NG	658, 503	444, 884			1, 103, 387	
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	654, 226	409, 941 0	1, 064, 167		721, 312	
13.00	01300 NURSI NG ADMI NI STRATI ON	422, 458	499	422, 957	342, 855 0	342, 855 422, 957	
14. 00	01400 CENTRAL SERVICES & SUPPLY	77, 940	1, 795			79, 735	
15. 00	01500 PHARMACY	755, 691	6, 355, 450			1, 177, 364	
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	507, 392 0	236, 037 0	743, 429 0	1	743, 429 0	16. 00 17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0		436, 447	436, 447	
23. 00	02300 RADI OLOGY SCHOOL	120, 287	13, 478	133, 765		133, 765	
23. 01	02301 HUB SITE - 3RD YEAR MED STUDENTS	0	0	0	0	0	23. 01
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	4, 817, 157	733, 993	5, 551, 150	-1, 388, 152	4, 162, 998	30.00
31. 00	03100 NTENSI VE CARE UNIT	988, 148	6, 859			994, 469	
43.00	04300 NURSERY	0	0			451, 898	
FO 00	ANCILLARY SERVICE COST CENTERS	1 042 110	7 007 050	0 /70 177	/ 00/ 073	2 0/2 204	 FO 00
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	1, 843, 118 291, 130	7, 827, 059 37, 699			2, 863, 204 297, 988	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	020,027		531, 276	1
53.00	05300 ANESTHESI OLOGY	1, 560, 306	547, 985			1, 572, 195	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 588, 877	864, 801	3, 453, 678		3, 424, 452	1
54. 01 54. 02	03630 ULTRA SOUND 03450 NUCLEAR MEDICINE - DIAGNOSTIC	101, 329 66, 736	23, 419 207, 189			121, 069 273, 538	1
55. 00	03480 ONCOLOGY	1, 209, 102	1, 156, 926			2, 291, 458	
57. 00	05700 CT SCAN	204, 567	294, 026			483, 780	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	126, 251	133, 251	259, 502		258, 143	
59. 00 60. 00	06000 LABORATORY	150, 466 1, 487, 732	189, 204 3, 096, 120			159, 853 3, 096, 681	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	294, 613			294, 613	
65.00	06500 RESPI RATORY THERAPY	593, 450	102, 324			611, 512	
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	1, 661, 478	122, 762 0	1, 784, 240	-30, 184	1, 754, 056 0	1
68. 00	06800 SPEECH PATHOLOGY	0	0	0	o	0	1
69. 00	06900 ELECTROCARDI OLOGY	0	0	0		0	
	03610 SLEEP LAB	133, 708	79, 300	213, 008		207, 263	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07101 IV SOLUTIONS	0	0	0	3, 501, 834 110, 676	3, 501, 834 110, 676	
	07200 I MPL. DEV. CHARGED TO PATIENTS	Ö	Ö	Ö	4, 537, 480	4, 537, 480	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	8, 182, 618	8, 182, 618	
76. 00	03140 CARDI OLOGY 07697 CARDI AC REHABI LI TATI ON	425, 277	105, 705 7, 089			509, 819 76, 078	1
70. 97	OUTPATIENT SERVICE COST CENTERS	69, 315	7,069	70, 404	-320	76,076	70.97
90.00	09000 CLI NI C	124, 155	10, 002	134, 157	-9, 141	125, 016	90.00
91.00	09100 EMERGENCY	1, 552, 785	699, 288	2, 252, 073	-231, 751	2, 020, 322	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
95. 00	09500 AMBULANCE SERVICES	1, 410, 886	194, 839	1, 605, 725	-44, 578	1, 561, 147	95.00
	10100 HOME HEALTH AGENCY	919, 060	95, 152			1, 014, 212	1
112 00	SPECIAL PURPOSE COST CENTERS		٥				1112 00
	11300 I NTEREST EXPENSE 11600 HOSPI CE	55, 293	0 65, 645			120, 938	113.00
118.00		32, 758, 650	67, 805, 921	100, 564, 571		100, 287, 338	
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 07950 OTHER NON-REIMBURSABLE	0	0	0	0		190. 00 194. 00
	07951 MOB	1, 650, 651	272, 328	1, 922, 979	0	1, 922, 979	
194. 02	07952 PHYSICIAN CLINICS	5, 009, 954	1, 535, 167	6, 545, 121		6, 503, 075	
	07953 PHYS PRAC BUS OFC	641, 369	14, 802			1, 391, 693	
	07954 MOB - MAIN CAMPUS 07955 ONCOLOGY - NONREIMBURSABLE	334, 867	4, 177 0	339, 044 0	0	339, 044 0	194. 04 194. 05
	07956 KDH - MC FAMILY PRACTICE	3, 991, 755	331, 689	4, 323, 444	-135, 521	4, 187, 923	
194. 07	07957 KDH - MC ORTHOPEDICS	3, 697, 435	452, 406	4, 149, 841	-193, 601	3, 956, 240	194. 07
194. 08	07958 KDH - MC GENERAL SURGERY	1, 196, 562	245, 185	1, 441, 747	0	1, 441, 747	<u> </u> 194. 08

Health Financial Systems	KING'S DAUGHTERS	' HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der C		Peri od:	Worksheet A	
				From 01/01/2017		
				To 12/31/2017	Date/Time Pre	
					5/23/2018 1:1	2 pm
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
			+ col . 2)	i ons (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
194. 09 07959 KDH - MC ENT	623, 729	32, 660	656, 38	9 -72, 601	583, 788	194. 09
194. 10 07960 KDH - MC UROLOGY	103, 868	598, 125	701, 99	3 0	701, 993	194. 10
194.11 07961 KDH - MC OB/GYN	1, 713, 545	610, 126	2, 323, 67	1 -14, 520	2, 309, 151	194. 11
200.00 TOTAL (SUM OF LINES 118 through 199)	51, 722, 385	71, 902, 586	123, 624, 97	1 0	123, 624, 971	200. 00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 15-0069 Peri

Peri od: Worksheet A From 01/01/2017 To 12/31/2017 Date/Time Prepared:

5/23/2018 1:12 pm Cost Center Description Adjustments Net Expenses (See A-8) For Allocation 6. 00 7.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT -3, 096, 248 12, 809, 336 1.00 00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO 1.01 0 7, 897 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 00400 EMPLOYEE BENEFITS DEPARTMENT -1, 278, 992 11, 939, 556 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL -3, 647, 449 13, 509, 878 5.00 00700 OPERATION OF PLANT 7.00 2,877,636 -21.5317 00 8.00 00800 LAUNDRY & LINEN SERVICE 326, 978 8.00 9 00 00900 HOUSEKEEPI NG 0 1, 103, 387 9 00 01000 DI ETARY 10.00 10.00 0 721. 312 01100 CAFETERI A 11.00 -366, 454 -23, 599 11.00 13.00 01300 NURSING ADMINISTRATION -29, 385 393, 572 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 79, 735 14.00 15. 00 01500 PHARMACY 1, 177, 364 15.00 0 16.00 01600 MEDICAL RECORDS & LIBRARY -127 743, 302 16.00 01700 SOCIAL SERVICE 17.00 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 -436, 447 19.00 0 02300 RADI OLOGY SCHOOL 23.00 -45, 350 88, 415 23 00 02301 HUB SITE - 3RD YEAR MED STUDENTS 23.01 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDLATRICS 3, 947, 476 30.00 -215, 522 30.00 31.00 03100 INTENSIVE CARE UNIT 994, 469 31.00 43.00 04300 NURSERY 451, 898 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 -350.5932, 512, 611 50.00 51.00 05100 RECOVERY ROOM -197, 066 100, 922 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 531, 276 52.00 53.00 05300 ANESTHESI OLOGY -1, 671, 598 -99, 403 53.00 05400 RADI OLOGY-DI AGNOSTI C 1, 449, 673 54.00 -1, 974, 779 54.00 54.01 03630 ULTRA SOUND 121,069 54.01 03450 NUCLEAR MEDICINE - DIAGNOSTIC 54.02 273, 538 54.02 55 00 03480 ONCOLOGY -966, 514 1, 324, 944 55 00 05700 CT SCAN 57.00 0 483, 780 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 258, 143 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 159, 853 59.00 06000 LABORATORY -177, 461 2, 919, 220 60 00 60 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 294, 613 62.00 0 62.00 06500 RESPIRATORY THERAPY 611, 512 65.00 65.00 66 00 06600 PHYSI CAL THERAPY -2, 945 1, 751, 111 66 00 06700 OCCUPATIONAL THERAPY 67.00 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 03610 SLEEP LAB 207, 263 69 01 0 69 01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 3, 501, 663 71.00 07101 IV SOLUTIONS 0 110, 676 71.01 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 4.537.480 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 73 00 0 8, 182, 618 76.00 03140 CARDI OLOGY -627 509, 192 76.00 07697 CARDIAC REHABILITATION 76.97 76,078 76.97 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLINIC 125, 016 90.00 09100 EMERGENCY -167, 684 91.00 91.00 1, 852, 638 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES -3, 040 1, 558, 107 95.00 101.00 10100 HOME HEALTH AGENCY 1,014,212 101.00 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 120, 938 116.00 SUBTOTALS (SUM OF LINES 1 through 117) -14, 649, 983 85, 637, 355 118.00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 190.00 194. 00 07950 OTHER NON-REI MBURSABLE 0 194.00 0 194. 01 07951 MOB 1, 922, 979 194.01 0 194. 02 07952 PHYSICIAN CLINICS 6,503,075 194.02 194. 03 07953 PHYS PRAC BUS OFC 1, 391, 693 194. 03 194. 04 07954 MOB - MAIN CAMPUS 194.04 0 0 0 339, 044 194. 05 07955 ONCOLOGY - NONREI MBURSABLE 194.05 194.06 07956 KDH - MC FAMILY PRACTICE 4, 187, 923 l194. 06 194. 07 07957 KDH - MC ORTHOPEDICS 3, 956, 240 194.07 194.08 07958 KDH - MC GENERAL SURGERY 1, 441, 747 194.08 194. 09 07959 KDH - MC ENT 194. 09 583, 788

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 CC	CN: 15-0069	Peri od:	Worksheet A	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/23/2018 1:1	
Cost Center Description	Adjustments	Net Expenses		L .	3/23/2010 1.	IZ PIII
oust deficer beschiptron	(See A-8)	For				
	()	Allocation				
	6. 00	7. 00				
194. 10 07960 KDH - MC UROLOGY	0	701, 993				194. 10
194.11 07961 KDH - MC OB/GYN	0	2, 309, 151				194. 11
200.00 TOTAL (SUM OF LINES 118 through 199)	-14, 649, 983	108, 974, 988				200. 00

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

Provi der CCN: 15-0069

	,				10 12	5/23/2018 1	
	2011 2011	Increases	6.1	011			
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00			
	A - CAFETERIA	3.00	4.00	3.00			
1.00	CAFETERI A	1100	210, 780	132, 075			1.00
	0		210, 780	132, 075			
1. 00	B - MEDICAL IMAGING TIME PHYSICIAN CLINICS	194. 02	11, 195	0			1.00
1.00	TOTALS	194.02	11, 195	<u>0</u>			1.00
	C - DEPRECIATION		117 170	<u> </u>			
1.00	NEW CAP REL COSTS-BLDG &	1. 01	0	7, 897			1.00
	FIXT_HHA/HO			7, 897			
	D - NURSERY- L&D		UU	7, 897			
1. 00	NURSERY	43.00	438, 497	13, 401			1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	51 <u>5, 5</u> 21	1 <u>5, 7</u> 55			2. 00
	0		954, 018	29, 156			
1 00	E - CRNA EXPENSE	10.00	424 447				1.00
1. 00	NONPHYSI CI AN ANESTHETI STS	19. 00	43 <u>6, 4</u> 47 436, 447	<u>o</u>			1.00
	F - PHYSICIAN BILLING AND COL	LECTI ONS	100, 117	<u> </u>			
1.00	PHYS_PRAC_BUS_OFC	194. 03	0	735, 522			1.00
	0		0	735, 522			
1. 00	G - EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL	5. 00	483, 931	0			1.00
2. 00	ADMINISTRATIVE & GENERAL	0.00	483, 931	0			2.00
3. 00		0. 00	ő	Ö			3. 00
4.00		0.00	О	0			4. 00
5.00		0.00	0	0			5. 00
6. 00			00 483, 931	<u>o</u>			6. 00
	I - MED/SURG SUPPLIES		483, 931	U			
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	3, 501, 834			1.00
	PATI ENTS						
2.00		0.00	0	0			2.00
3. 00 4. 00		0. 00 0. 00	0	0			3. 00 4. 00
5. 00		0.00	0	0			5.00
6. 00		0. 00	O	Ö			6. 00
7. 00		0. 00	0	0			7. 00
8.00		0.00	0	0			8.00
9. 00 10. 00		0. 00 0. 00	0	0			9. 00 10. 00
11. 00		0.00	o	0			11.00
12. 00		0. 00	Ö	Ö			12.00
13.00		0. 00	0	0			13.00
14.00		0. 00	0	0			14.00
15. 00 16. 00		0. 00 0. 00	0	0			15. 00 16. 00
17. 00		0.00	0	0			17.00
18. 00		0. 00	Ö	Ö			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	0	0			21. 00 22. 00
23. 00		0.00	0	0			23.00
24. 00		0. 00	Ö	Ö			24.00
	TOTALS		0	3, 501, 834			
4 00	J - IV SOLUTIONS	I	21	446 (7)			
1. 00 2. 00	IV SOLUTIONS	71. 01 0. 00	0	110, 676			1. 00 2. 00
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 9. 00		0. 00 0. 00	O O	0			8. 00 9. 00
10.00		0.00	o	o			10.00
	TOTALS			110, 676			
	K - IMPLANTS						
1. 00	I MPL. DEV. CHARGED TO	72. 00	0	4, 537, 480			1. 00
	PATI ENTS	+		4, 537, 480			
	1. 2.7.20	I	બ	., 557, 400			ı

Heal th Financial Systems KING'S DAUGHTERS' HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 15-0069 From 01/01/2017 To 12/31/2017 Date/Time Prepared:

					5/23/2018 1: 1	12 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	L - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	8, 182, 618		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
	TOTALS			8, 182, 618		
	M - INSURANCE					
1.00	NEW CAP REL COSTS-BLDG &	1. 00	0	254, 503		1.00
	FI XT					1
	0		0	254, 503		1
500.00	Grand Total: Increases		2, 096, 371	17, 491, 761		500.00

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: Provi der CCN: 15-0069

1.00 D 0 B 1.00 R T C 1.00 N	Cost Center 6.00 A - CAFETERIA DIETARY B - MEDICAL IMAGING TIME RADIOLOGY-DIAGNOSTIC TOTALS C - DEPRECIATION	Decreases Li ne # 7.00 10.00	Sal ary 8. 00	9. 00	Wkst. A-7 Ref. 10.00	5/23/2018 1	
1. 00 D 0 B 1. 00 R T C 1. 00 N	6. 00 A - CAFETERI A DI ETARY DI B - MEDI CAL I MAGI NG TI ME RADI OLOGY-DI AGNOSTI C TOTALS	7.00	8. 00 	9. 00			
1. 00 D 0 B 1. 00 R T C 1. 00 N	A - CAFETERIA DIETARY DI S - MEDICAL IMAGING TIME RADIOLOGY-DIAGNOSTIC TOTALS	10.00	210, 780		10.00		
1. 00 D 0 B 1. 00 R T C 1. 00 N	DI ETARY DI CONTROLL I MAGING TIME RADI OLOGY-DI AGNOSTI C TOTALS						
1.00 R T C 1.00 N	B - MEDICAL IMAGING TIME RADIOLOGY-DIAGNOSTIC TOTALS			132, 075	0		1.00
1.00 R T C 1.00 N	RADI <u>OLOGY-DI</u> AGNOSTI C		210, 780	132, 075			
1. 00 N	TOTALS						
1.00 N F		<u>54.</u> 00	11, 195	0	0		1.00
1.00 N			11, 195	0			
F	NEW CAP REL COSTS-BLDG &	1. 00	٥	7, 897	Q		1.00
_	FLXT	1.00		7,077	1		1.00
		+		7, 897			
) - NURSERY- L&D						
•	ADULTS & PEDIATRICS	30. 00	954, 018	29, 156			1.00
2.00	+	0.00	0	0			2.00
0	E - CRNA EXPENSE		954, 018	29, 156			_
_	ANESTHESI OLOGY	53.00	436, 447	0	0		1.00
0)		436, 447	0			
F	- PHYSICIAN BILLING AND COL	LECTI ONS					
1. 00 A	ADMINISTRATIVE & GENERAL	5.00	0	735, 522			1.00
0)		0	735, 522			
_	G - EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL	5. 00	O	14, 447	O		1.00
	PHYSICIAN CLINICS	194. 02	0	53, 241	0		2.00
	KDH - MC FAMILY PRACTICE	194. 06	o	135, 521	o		3.00
4.00 K	CDH - MC ORTHOPEDICS	194. 07	0	193, 601	o		4. 00
5.00 K	KDH - MC ENT	194. 09	0	72, 601	0		5.00
6.00 K	CDH - MC OB/GYN	1 <u>94.</u> 11	•	1 <u>4, 5</u> 20	0		6. 00
Ю) MED (CUDE CUDDI LEC		0	483, 931			
_	- MED/SURG SUPPLIES ADMINISTRATIVE & GENERAL	5. 00	0	1, 802	0		1.00
	OPERATION OF PLANT	7. 00	0	1, 002			2.00
	PHARMACY	15. 00	o	13, 693	- I		3.00
4. 00 A	ADULTS & PEDIATRICS	30. 00	0	388, 578	o		4.00
	NTENSIVE CARE UNIT	31. 00	0	538			5. 00
	OPERATING ROOM	50.00	0	2, 243, 482	l •		6.00
	RECOVERY ROOM ANESTHESI OLOGY	51. 00 53. 00	O O	30, 158 69, 834	0		7. 00 8. 00
	RADI OLOGY-DI AGNOSTI C	54. 00	0	7, 006	0		9.00
	JLTRA SOUND	54. 01	o	3, 679			10.00
11.00 N	NUCLEAR MEDICINE -	54. 02	0	387	o		11.00
-	DI AGNOSTI C						
	ONCOLOGY	55.00	0	73, 713			12.00
	CT SCAN MAGNETIC RESONANCE IMAGING	57. 00 58. 00	0	14, 813 1, 359			13. 00 14. 00
	(MRI)	36.00	U	1, 339	٥		14.00
	CARDI AC CATHETERI ZATI ON	59. 00	o	179, 188	o		15.00
	ABORATORY	60.00	0	106, 038	o		16. 00
	RESPI RATORY THERAPY	65. 00	0	49, 422			17. 00
	PHYSI CAL THERAPY	66.00	0	26, 945			18.00
	SLEEP LAB CARDI OLOGY	69. 01 76. 00	O O	5, 745	l •		19. 00 20. 00
	CARDI AC REHABI LI TATI ON	76. 00 76. 97	0	21, 163 326			21.00
	CLINIC	90.00	Ö	9, 141	o		22. 00
	EMERGENCY	91.00	O	222, 183	0		23. 00
24.00 A	AMBULANCE SERVICES	95.00	o	3 <u>2, 5</u> 75			24.00
	TOTALS		0	3, 501, 834			
_	J - IV SOLUTIONS	15.00		FF 044			1 00
	PHARMACY ADULTS & PEDIATRICS	15. 00 30. 00	0	55, 944 16, 400			1. 00 2. 00
	OPERATING ROOM	50.00	0	26, 011	0		3.00
	RECOVERY ROOM	51.00	ŏ	683			4. 00
	RADI OLOGY-DI AGNOSTI C	54.00	О	4	O		5. 00
	DNCOLOGY	55. 00	0	857	0		6. 00
	CARDI AC CATHETERI ZATI ON	59. 00	0	629	0		7.00
	RESPIRATORY THERAPY	65. 00	ol	22	l •		8.00
	EMERGENCY AMBULANCE SERVICES	91. 00 95. 00	O O	9, 568 558	l •		9.00
	TOTALS			<u></u>			10.00
_	C - IMPLANTS			113, 070			
	DPERATING ROOM	50.00	0	4, 537, 480	0		1.00
T	TOTALS — — — —			4, 537, 480			

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

 RECLASSIFICATIONS
 Provider CCN: 15-0069
 Period: From 01/2017 Publication of Form CMS-2552-10

					То	12/31/2017 Date/Time Pr 5/23/2018 1:	epared: 12 pm
		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	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	827, 174	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	19, 833	0		2.00
3.00	PHARMACY	15. 00	0	5, 864, 140	0		3.00
4.00	ANESTHESI OLOGY	53. 00	0	29, 815	0		4.00
5.00	RADI OLOGY-DI AGNOSTI C	54. 00	0	11, 021	0		5.00
6.00	LABORATORY	60.00	0	1, 381, 133	0		6.00
7.00	PHYSI CAL THERAPY	66. 00	0	3, 239	0		7. 00
8.00	RESPI RATORY THERAPY	65. 00	0	34, 818	0		8. 00
9.00	AMBULANCE SERVICES	<u>95.</u> 00	0	11, 445			9. 00
	TOTALS		0	8, 182, 618	3		_
	M - INSURANCE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	25 <u>4, 5</u> 03	9		1.00
	0		0	254, 503			
500.00	Grand Total: Decreases		1, 612, 440	17, 975, 692	2		500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS KING'S DAUGHTERS' HOSPITAL

Provi der CCN: 15-0069

				T	o 12/31/2017	Date/Time Pre 5/23/2018 1:1	
			<u> </u>	Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	4, 096, 085	47, 720	0	47, 720		1
2.00	Land Improvements	841, 699	0	0	0	294, 900	2.00
3.00	Buildings and Fixtures	119, 248, 527	129, 904	0	129, 904	1, 390, 971	3. 00
4. 00	Building Improvements	0	0	0	0	0	4. 00
5. 00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	64, 213, 779	3, 054, 229	0	3, 054, 229	3, 601, 290	1
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8. 00	Subtotal (sum of lines 1-7)	188, 400, 090	3, 231, 853	0	3, 231, 853	5, 931, 847	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10. 00	Total (line 8 minus line 9)	188, 400, 090	3, 231, 853	0	3, 231, 853	5, 931, 847	10.00
		Endi ng	Fully				
		Bal ance	Depreciated				
			Assets				
	DART I ANALYCIC OF CHANCEC IN CARLTAL ACCE	6. 00	7. 00				
1 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		0				1 00
1.00	Land	3, 499, 119	0				1.00
2.00	Land Improvements	546, 799	0				2.00
3.00	Buildings and Fixtures	117, 987, 460	0				3.00
4.00	Building Improvements	0	0				4. 00 5. 00
5.00	Fi xed Equi pment	(2 (((710	0				
6. 00 7. 00	Movable Equipment	63, 666, 718	0				6. 00 7. 00
	HIT designated Assets	105 700 004	0				
8. 00 9. 00	Subtotal (sum of lines 1-7) Reconciling Items	185, 700, 096	0				8. 00 9. 00
9. 00 10. 00		185, 700, 096	0				10.00
10.00	Total (line 8 minus line 9)	185, 700, 096	U				, 10.00

Heal th	Financial Systems	KING'S DAUGHTE	RS' HOSPITAL	' HOSPITAL In Lieu of Form CN		u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS			Provi der CO	F	Period: From 01/01/2017 To 12/31/2017		pared:
			SU	IMMARY OF CAPI	ΓAL		·
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9. 00	10. 00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FLXT	10, 235, 213	63, 488	5, 348, 712	2 0	11, 565	1.00
1. 01	NEW CAP REL COSTS-BLDG & FLXT HHA/HO	0	0	(0	0	1. 01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	(0	0	2.00
3.00	Total (sum of lines 1-2)	10, 235, 213	63, 488	5, 348, 712	2 0	11, 565	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	0ther	Total (1)				
		Capi tal -Relat					
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				

		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	MN 2, LINES 1 a	and 2	
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	15, 658, 978		1.00
1. 01	NEW CAP REL COSTS-BLDG & FLXT HHA/HO	0	0		1. 01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	15, 658, 978		3.00
				•	

Heal th	n Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS			Provi der CCN: 15-0069		Peri od: From 01/01/2017 Worksheet A Part III To 12/31/2017 Date/Ti me P 5/23/2018 1		
		COMF	PUTATION OF RA	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1. 00	2. 00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS O	ENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	122, 033, 378	0	122, 033, 378	0. 657153	0	1.00
1.01	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	0		0. 000000	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	63, 666, 718	0	63, 666, 718	0. 342847	0	2.00
3.00	Total (sum of lines 1-2)	185, 700, 096		185, 700, 09	1. 000000	0	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 O	1		1			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0		10, 481, 819		1.00
1. 01	NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	0	1	7, 897	0	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	() () () () () () () () () (10, 489, 716	20, 582	3.00
	SUMMARY OF CAPITAL						
	Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
			(see	instructions)			
			instructions)		ed Costs (see	9 through 14)	
		11.00	10.00	40.00	instructions)	45.00	
	DART III DECONCILIATION OF CARLTAL COCTE O	11. 00	12. 00	13. 00	14. 00	15. 00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS OF NEW CAP REL COSTS-BLDG & FIXT		0	11, 56	- 0	12, 809, 336	1. 00
1. 00 1. 01	NEW CAP REL COSTS-BLDG & FIXT	2, 295, 370			0 0		1.00
2. 00	NEW CAP REL COSTS-BLDG & FIXT HHA/HU				0		2.00
3. 00	Total (sum of lines 1-2)	2, 295, 370	0		9	۱ ۱	3.00
3.00	Total (Suil Of TITIES 1-2)	2, 290, 370	ı	1 11, 50	ا ا	12,017,233	3.00

In Lieu of Form CMS-2552-10

Period: Worksheet A-8
From 01/01/2017
To 12/31/2017 Health Financial Systems
ADJUSTMENTS TO EXPENSES Provi der CCN: 15-0069

				Fr To	Date/Time Prepared: 5/23/2018 1:12 pm		
				Expense Classification on			2 pili
				To/From Which the Amount is t	to be Adjusted		
	Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2) 1. 00	2. 00	3.00	4. 00	Ref. 5. 00	
1. 00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	В		NEW CAP REL COSTS-BLDG & FIXT	1. 00	11	1.00
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	0	2.00
3. 00	2) Investment income - other (chapter 2)		0		0. 00	0	3. 00
4. 00	Trade, quantity, and time		0		0. 00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0. 00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by suppliers (chapter 8)	В	-42, 906	NEW CAP REL COSTS-BLDG &	1. 00	10	6. 00
7. 00	Telephone services (pay stations excluded) (chapter	А	-4, 031	ADMINISTRATIVE & GENERAL	5. 00	0	7. 00
8. 00	Tel evi si on and radio servi ce	А	-21, 531	OPERATION OF PLANT	7. 00	0	8. 00
9. 00 10. 00	(chapter 21) Parking Lot (chapter 21) Provi der-based physician	A-8-2	0 -5, 725, 757		0. 00	0	9. 00 10. 00
11. 00	adj ustment Sal e of scrap, waste, etc.	N 0 2	0, 723, 737		0. 00	0	
12. 00	(chapter 23) Related organization	A-8-1	0			0	12.00
13. 00	transactions (chapter 10) Laundry and linen service		0		0. 00	0	13.00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee	В	-366, 454 0	CAFETERI A	11. 00 0. 00	0	14. 00 15. 00
16. 00	and others Sale of medical and surgical supplies to other than	В	-171	MEDICAL SUPPLIES CHARGED TO PATIENTS	71. 00	0	16. 00
17. 00]		0		0. 00	0	17. 00
18. 00	patients Sale of medical records and abstracts	В	-127	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00			0		0. 00	0	19. 00
20.00	Vendi ng machi nes		0		0. 00 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	RESPIRATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	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			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	COSTS-BLDG & FIXT HHA/HO Depreciation - NEW CAP REL			FIXT HHA/HO NEW CAP REL COSTS-MVBLE	2. 00	0	
	COSTS-MVBLE EQUIP			EQUI P			
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant	А	-436, 447 0	NONPHYSICIAN ANESTHETISTS	19. 00 0. 00		28. 00 29. 00

Heal th	Financial Systems		KING'S DAUGHTE	RS' HOSPITAL	In Lie	u of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES					eri od:	Worksheet A-8	
			From 01/01/2017			7	
			То			Date/Time Pre 5/23/2018 1:1	
			Expense Classification on Worksheet A				
				To/From Which the Amount is			
	Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	cost center bescription	(2)	Amount	Cost center	LITIE #	Ref.	
		1.00	2. 00	3.00	4. 00	5. 00	
30. 00	Adjustment for occupational	A-8-3		OCCUPATI ONAL THERAPY	67. 00	0.00	30.00
	therapy costs in excess of						
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
	instructions)						
31.00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
	pathology costs in excess of						
	limitation (chapter 14)						
32.00	1		0		0. 00	0	32.00
	Depreciation and Interest	_				_	
	RADI OLOGY TUITI ON	В		RADI OLOGY SCHOOL	23. 00	0	00.00
33. 01		В		RECOVERY ROOM	51.00		00.0.
33. 02 33. 03	BAXTER PUMP REVENUE AMBULANCE REVENUE	B B		NURSING ADMINISTRATION AMBULANCE SERVICES	13. 00 95. 00		33. 02 33. 03
33. 03	ADVERTI SI NG	A A		ADMINISTRATIVE & GENERAL	95. 00 5. 00	0	33. 03
33. 04	SELF-I NSURANCE	B		EMPLOYEE BENEFITS DEPARTMENT		0	33.04
33. 06		A	•	ADMINISTRATIVE & GENERAL	5. 00		
33. 07		Ä		ADMINISTRATIVE & GENERAL	5. 00		33. 07
33. 08	PHYSI CI AN RECRUI TMENT	l A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 08
33. 09	PHYSICIAN LAB SALARY OFFSET	l A	•	LABORATORY	60.00	0	33. 09
33. 10		A		EMPLOYEE BENEFITS DEPARTMENT		Ö	
33. 11		A	•	EMPLOYEE BENEFITS DEPARTMENT			33. 11
33. 12	DONATI ONS	A	•	ADMINISTRATIVE & GENERAL	5. 00		33. 12
33. 13	GAI N/LOSS	В	-2, 900, 638	NEW CAP REL COSTS-BLDG &	1.00	11	33. 13
				FIXT			
EO 00	TOTAL (cum of lines 1 thru 40)	1	14 440 002				E0 00

-14, 649, 983

50.00

50.00 TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A,

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

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

B. Amount Received - if cost cannot be determined.

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

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0069

Peri od: Worksheet A-8-2 From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/23/2018 1:12 pm

							5/23/2018 1: 1	12 pm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00		ADMINISTRATIVE & GENERAL	375, 218					1. 00
2.00		ADULTS & PEDIATRICS	215, 522	215, 522		211, 500	•	2.00
3. 00		OPERATING ROOM	350, 593					3. 00
4. 00		ANESTHESI OLOGY	1, 671, 598			239, 400		4.00
5. 00		RADI OLOGY-DI AGNOSTI C	1, 974, 779			271, 900	•	5. 00
6. 00		ONCOLOGY	966, 514	966, 514	1 0	211, 500		6. 00
7.00	60.00	LABORATORY	150, 000	(150, 000	260, 300	1, 991	7. 00
8.00	66.00	PHYSICAL THERAPY	2, 945	2, 945	5 0	211, 500	0	8.00
9.00	69, 01	SLEEP LAB	11, 777		11, 777	211, 500	126	9. 00
10.00		CARDI OLOGY	627	62		211, 500		10.00
11. 00		EMERGENCY	360, 881	(211, 500		
12. 00		AMBULANCE SERVICES	989					12.00
	93.00	AWIDULANCE SERVICES				,		
200.00	WI:-+ A I: //	C+ C+ (Db	6, 081, 443		<u> </u>		4, 024	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		l denti fi er	Limit		Memberships &	Component	of Mal practice	
				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	0	(1	_	1.00
2.00	30. 00	ADULTS & PEDIATRICS	0	(0	0	2.00
3.00	50. 00	OPERATING ROOM	0	(0	0	0	3.00
4.00	53. 00	ANESTHESI OLOGY	0	(0	0	0	4.00
5.00	54.00	RADI OLOGY-DI AGNOSTI C	0		0	0	0	5.00
6. 00	55, 00	ONCOLOGY	1 0	1	0	0	0	6.00
7. 00	60.00	LABORATORY	249, 162	12, 458	0	0	0	7. 00
8. 00		PHYSI CAL THERAPY	0	(0	0	8. 00
9. 00		SLEEP LAB	12, 812	64	-	0	_	9. 00
10.00		CARDI OLOGY	12,012			١	0	10.00
11. 00		EMERGENCY	193, 197	9, 660	-	0		11.00
						0	1	
12.00	95.00	AMBULANCE SERVICES	712	36		0	_	12.00
200.00	MI . I A I	0 - 1 0 - 1 - (Pl-	455, 883	22, 795			0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1. 00		ADMINISTRATIVE & GENERAL	0	(-			1.00
2. 00		ADULTS & PEDIATRICS	0	(-			2.00
3.00	50.00	OPERATING ROOM	0	(0	350, 593		3.00
4.00	53. 00	ANESTHESI OLOGY	0	(0	1, 671, 598		4.00
5.00	54.00	RADI OLOGY-DI AGNOSTI C	0		0	1, 974, 779		5.00
6. 00		ONCOLOGY	0		0	966, 514		6.00
7. 00		LABORATORY	l o	249, 162	0	0		7. 00
8. 00		PHYSI CAL THERAPY	0	2177101		2, 945		8. 00
9. 00		SLEEP LAB	0	12, 812	٠	2, 743	•	9. 00
10. 00		CARDI OLOGY	1	12,012		627		10.00
11. 00		EMERGENCY	0	193, 197	,			11.00
12.00						1	1	12.00
	95.00	AMBULANCE SERVICES		712		277		
200. 00	l l		0	455, 883	167, 961	5, 725, 757	I	200.00

| Peri od: | Worksheet B | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0069

				To	12/31/2017	Date/Time Pre 5/23/2018 1:1	
			CAPI	TAL RELATED CO	STS	37 237 2010 1. 1	Z piii
	Cost Center Description	Net Expenses	NEW BLDG &	NEW BLDG &	NEW MVBLE	EMPLOYEE	
	oust center bescription	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	
1 00	GENERAL SERVICE COST CENTERS	12 000 22/	12 000 22/	I			1 00
1. 00 1. 01	OO100 NEW CAP REL COSTS-BLDG & FIXT OO101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO	12, 809, 336 7, 897	12, 809, 336 0				1. 00 1. 01
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP	0		,, , , , ,	О		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	11, 939, 556	0	0	0	11, 939, 556	
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	13, 509, 878 2, 877, 636	1, 494, 679 1, 419, 091	0	0	1, 403, 669 148, 335	5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	326, 978	65, 786		ő	9, 822	
9. 00	00900 HOUSEKEEPI NG	1, 103, 387	115, 315		0	153, 927	9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	721, 312 -23, 599	217, 204 87, 841	0	0	103, 657 49, 270	
13. 00	01300 NURSI NG ADMI NI STRATI ON	393, 572	77, 107		0	98, 751	
14.00	01400 CENTRAL SERVICES & SUPPLY	79, 735	106, 859		0	18, 219	14.00
	01500 PHARMACY	1, 177, 364	79, 419		0	176, 645	
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	743, 302	10, 078 0		0	118, 604 0	1
	01900 NONPHYSI CI AN ANESTHETI STS	0	0	_	Ö	0	1
	02300 RADI OLOGY SCHOOL	88, 415	22, 815		О	28, 117	1
23. 01	02301 HUB SITE - 3RD YEAR MED STUDENTS NPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	23. 01
30. 00	03000 ADULTS & PEDIATRICS	3, 947, 476	1, 373, 772	0	o	903, 020	30.00
	03100 INTENSIVE CARE UNIT	994, 469	57, 778	0	0	230, 983	31.00
43. 00	04300 NURSERY	451, 898	67, 477	0	0	102, 500	43.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	2, 512, 611	606, 846	0	ol	430, 834	50.00
	05100 RECOVERY ROOM	100, 922	47, 458		o	68, 053	
	05200 DELIVERY ROOM & LABOR ROOM	531, 276	0		0	120, 505	
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	-99, 403 1, 449, 673	4, 487 374, 179	0	0	262, 705 602, 541	
54. 01	03630 ULTRA SOUND	121, 069	0	Ö	Ö	23, 686	
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	273, 538	16, 671	0	0	15, 600	1
55. 00 57. 00	03480 ONCOLOGY 05700 CT SCAN	1, 324, 944 483, 780	426, 953 30, 891	0	0	282, 631 47, 818	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	258, 143	37, 276	_	0	29, 512	
59. 00	05900 CARDI AC CATHETERI ZATI ON	159, 853	29, 476		o	35, 172	
60.00	06000 LABORATORY	2, 919, 220	215, 340		0	306, 280	1
62. 00 65. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPIRATORY THERAPY	294, 613 611, 512	9, 630 41, 315		0	0 138, 721	62. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 751, 111	488, 631		Ö	388, 375	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0	_	0	0	
	03610 SLEEP LAB	207, 263	28, 9 58		0	31, 255	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 501, 663	0		o	0	71.00
	07101 IV SOLUTIONS	110, 676	0	0	0	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	4, 537, 480 8, 182, 618	0	0	0	0	72. 00 73. 00
76. 00	03140 CARDI OLOGY	509, 192	208, 713	Ö	Ö	99, 410	
76. 97	07697 CARDI AC REHABILITATION	76, 078	24, 264	0	0	16, 203	76. 97
90.00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	125, 016	26, 232	O	ol	29, 022	90.00
	09100 EMERGENCY	1, 852, 638	479, 036		o	362, 968	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
95 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES	1, 558, 107	163, 326		ol	329, 799	95.00
	10100 HOME HEALTH AGENCY	1, 014, 212	0		o	214, 833	
440.00	SPECIAL PURPOSE COST CENTERS	T					140.00
	11300 INTEREST EXPENSE 11600 HOSPICE	120, 938	0	1, 683	0	12 925	113. 00 116. 00
118.00		85, 637, 355	8, 454, 903		Ö	7, 394, 367	
400.00	NONREI MBURSABLE COST CENTERS	1			ما		
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 07950 OTHER NON-REIMBURSABLE	0	0	0	0		190. 00 194. 00
	07951 MOB	1, 922, 979	1, 633, 120	_	ol	385, 845	
	07952 PHYSI CI AN CLI NI CS	6, 503, 075	1, 197, 987	0	О	1, 186, 154	194. 02
	07953 PHYS PRAC BUS OFC 07954 MOB - MAIN CAMPUS	1, 391, 693	34, 135 0		0	149, 922	194. 03 194. 04
	07954 MOB - MATN CAMPUS 07955 ONCOLOGY - NONREIMBURSABLE	339, 044 0	0	0	n		194. 04
	07956 KDH - MC FAMILY PRACTICE	4, 187, 923	1, 489, 191		o	964, 763	

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0069	From 01/01/2017	Worksheet B Part I Date/Time Prepared: 5/23/2018 1:12 pm

			'	0 12/31/201/	5/23/2018 1: 1	
		CAPITAL RELATED COSTS				
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW BLDG & FIXT HHA/HO	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
	0	1. 00	1. 01	2. 00	4. 00	
194. 07 07957 KDH - MC ORTHOPEDICS	3, 956, 240	0	0	0	909, 541	194. 07
194.08 07958 KDH - MC GENERAL SURGERY	1, 441, 747	0	0	0	279, 700	194. 08
194.09 07959 KDH - MC ENT	583, 788	0	0	0	162, 769	194. 09
194. 10 07960 KDH - MC UROLOGY	701, 993	0	0	0	24, 279	194. 10
194.11 07961 KDH - MC OB/GYN	2, 309, 151	0	0	0	403, 940	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)	108, 974, 988	12, 809, 336	7, 897	О	11, 939, 556	202. 00

Provider CCN: 15-0069

Peri od: Worksheet B From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared:

					12/31/201/	5/23/2018 1: 1	
	Cost Center Description	Subtotal	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
		4A	5. 00	7. 00	8. 00	9. 00	
4 00	GENERAL SERVICE COST CENTERS		T	I			1 00
1. 00 1. 01	OO100 NEW CAP REL COSTS-BLDG & FLXT OO101 NEW CAP REL COSTS-BLDG & FLXT HHA/HO						1. 00 1. 01
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	16, 408, 226	16, 408, 226				5.00
7. 00	00700 OPERATION OF PLANT	4, 445, 062	787, 923				7.00
8.00	00800 LAUNDRY & LI NEN SERVI CE	402, 586	1		508, 318	1 /7/ 105	8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	1, 372, 629 1, 042, 173	1		0 0	1, 676, 185 0	9. 00 10. 00
11. 00	01100 CAFETERI A	113, 512	1		0	0	11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	569, 430	1		ō	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	204, 813	36, 305	55, 829	o	16, 450	14.00
15. 00	01500 PHARMACY	1, 433, 428	1	1	0	28, 772	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	871, 984	154, 566	5, 266	0	0	16.00
17. 00 19. 00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0		0	0	0	17. 00 19. 00
23. 00	02300 RADI OLOGY SCHOOL	139, 347	24, 700	11, 920	0	2, 378	ı
23. 01	02301 HUB SITE - 3RD YEAR MED STUDENTS	0		1	o	0	1
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	6, 224, 268		717, 738	160, 585	787, 041	30.00
31.00	03100 INTENSI VE CARE UNI T	1, 283, 230			0	41, 225	31.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	621, 875	110, 232	35, 254	8, 435	6, 937	43. 00
50. 00	05000 OPERATING ROOM	3, 550, 291	629, 317	317, 051	102, 051	176, 527	50.00
51. 00	05100 RECOVERY ROOM	216, 433			12, 714	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	651, 781	115, 533		9, 916	23, 222	52.00
53.00	05300 ANESTHESI OLOGY	167, 789	29, 742	2, 344	O	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 426, 393			31, 623	53, 183	1
54. 01	03630 ULTRA SOUND	144, 755	1	1	3, 531	10, 075	•
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	305, 809	1		2, 183	3, 402	1
55.00	03480 ONCOLOGY	2, 034, 528	1		14, 462	77, 330	
57. 00 58. 00	05700 CT SCAN	562, 489 324, 931	99, 706 57, 597		15, 523 3, 488	6, 640 5, 450	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	224, 501	39, 795		3, 466	13, 973	1
60. 00	06000 LABORATORY	3, 440, 840			ol	46, 510	1
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	304, 243	1		Ö	0	62.00
65.00	06500 RESPI RATORY THERAPY	791, 548	140, 308	21, 585	o	0	65.00
66. 00	06600 PHYSI CAL THERAPY	2, 628, 117	465, 855	255, 289	30, 066	20, 150	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69. 00 69. 01	06900 ELECTROCARDI OLOGY 03610 SLEEP LAB	0 267, 476	47, 412	15, 129	2, 022	0 19, 027	69. 00 69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 501, 663	1	1	2, 022	19,027	71.00
71. 01	07101 IV SOLUTIONS	110, 676		i i	o	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	4, 537, 480			ō	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8, 182, 618	1, 450, 435	0	o	0	73.00
	03140 CARDI OLOGY	817, 315				·	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	116, 545	20, 659	12, 677	0	8, 060	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS	100 070	21.054	12 705	ام	0.722	00.00
	09000 CLI NI C 09100 EMERGENCY	180, 270 2, 694, 642			75, 023	8, 622 116, 771	90. 00 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,074,042		250, 270	75,025	110, 771	92.00
72.00	OTHER REIMBURSABLE COST CENTERS				1		72.00
95.00	09500 AMBULANCE SERVICES	2, 051, 232		85, 331	11, 768	0	95.00
101.00	10100 HOME HEALTH AGENCY	1, 235, 259	218, 960	49, 554	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS		1	1			
	11300 I NTEREST EXPENSE	105 547	24 027	10 41/			113.00
116.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	135, 546 76, 737, 733			500, 490	1, 478, 814	116.00
110.00	NONREI MBURSABLE COST CENTERS	70, 737, 733	10,073,070	2,751,711	300, 470	1, 470, 014]110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190. 00
	07950 OTHER NON-REIMBURSABLE	0	0	О	o	0	194. 00
	07951 MOB	3, 941, 944	698, 741	853, 238	1, 257		194. 01
	07952 PHYSICIAN CLINICS	8, 887, 216			2, 687		194. 02
	07953 PHYS PRAC BUS OFC	1, 575, 750	1		0		194. 03
	07954 MOB - MAIN CAMPUS	417, 320		i	0	197, 371	
	07955 ONCOLOGY - NONREIMBURSABLE 07956 KDH - MC FAMILY PRACTICE	() 7 6 6 1 1 0 7 7	0 1 177 326	_	0 126		194. 05 194. 06
	07950 KDH - MC FAMILY PRACTICE	6, 641, 877 4, 865, 781	1, 177, 326 862, 499		126 898		194. 06
	07958 KDH - MC GENERAL SURGERY	1, 721, 447	305, 140		761		194. 07
194. 09	07959 KDH - MC ENT	746, 557			0		194. 09
194.10	07960 KDH - MC UROLOGY	726, 272	128, 738	0	o	0	194. 10
194. 11	07961 KDH - MC OB/GYN	2, 713, 091	480, 917	0	2, 099	0	194. 11

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part I Date/Time Prepared:

						5/23/2018 1:1	2 pm
	Cost Center Description	Subtotal	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
			E & GENERAL	PLANT	LINEN SERVICE		
		4A	5. 00	7. 00	8. 00	9. 00	
200.00	Cross Foot Adjustments	0					200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum Lines 118 through 201)	108, 974, 988	16, 408, 226	5, 232, 985	508, 318	1, 676, 185	202 00

Provi der CCN: 15-0069

			10	12/31/2017	Date/lime Pre 5/23/2018 1:1	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	_ p
			ADMINISTRATIO 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 & FLXT						1.00
1. 01 O0101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO 2. 00 O0200 NEW CAP REL COSTS-MVBLE EQUIP						1. 01 2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINI STRATI VE & GENERAL						5.00
7. 00 O0700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY	1, 340, 387					10.00
11. 00 01100 CAFETERI A	0	179, 526				11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	1 200	710, 651	214 (07		13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	0	1, 300 4, 861	0	314, 697 746	1, 763, 387	14. 00 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	5, 736	0	251	1, 703, 307	16.00
17. 00 01700 SOCI AL SERVI CE	0	0,730	0	0	0	17.00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	ő	0	Ö	o	0	19.00
23. 00 02300 RADI OLOGY SCHOOL	0	966	0	35	0	23. 00
23.01 02301 HUB SITE - 3RD YEAR MED STUDENTS	0	0	0	0	0	23. 01
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	1, 253, 181	36, 973	310, 426	4, 583	0	30.00
31. 00 03100 INTENSIVE CARE UNIT	87, 206	13, 102	110, 005	17	0	31.00
43. 00 O4300 NURSERY ANCILLARY SERVICE COST CENTERS	0	3, 196	26, 832	0	0	43.00
50. 00 O5000 OPERATING ROOM	0	10, 803	90, 703	160, 676	0	50.00
51. 00 05100 RECOVERY ROOM	0	2, 041	17, 134	100, 070	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	o	3, 757	31, 547	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	1, 446	0	457	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	О	11, 742	0	1, 958	0	54.00
54. 01 03630 ULTRA SOUND	0	625	0	476	0	54. 01
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	580	0	72	0	54.02
55. 00 03480 0NCOLOGY	0	6, 647	0	479	0	55.00
57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1, 840 898	0	4, 012	0	57. 00 58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	1, 131	0	548 128	0	59.00
60. 00 06000 LABORATORY	0	14, 909	0	1, 236	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	Ö	0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0	5, 346	0	1, 261	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	13, 027	0	326	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
69. 01 03610 SLEEP LAB	0	852	0	110 012	0	69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71. 01 07101 IV SOLUTIONS	0	0	0	118, 012 3, 730	0	71. 00 71. 01
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	Ö	3, 730	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	Ö	o	1, 763, 387	
76. 00 03140 CARDI OLOGY	0	4, 120	0	155	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	718		11	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	813	0	18	0	90.00
91. 00 09100 EMERGENCY	0	14, 769	124, 004	1, 236	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
95. 00 09500 AMBULANCE SERVICES	0	17, 328	0	344	0	95.00
101.00 10100 HOME HEALTH AGENCY	o	17, 320	Ö	805		101.00
SPECIAL PURPOSE COST CENTERS	-1	-	- 1			
113. 00 11300 I NTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	0	0	0	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 340, 387	179, 526	710, 651	301, 685	1, 763, 387	118. 00
NONREI MBURSABLE COST CENTERS			-			
190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0		190.00
194. 00 07950 OTHER NON-REI MBURSABLE	0	0	0	027		194.00
194. 01 07951 MOB 194. 02 07952 PHYSI CLAN CLINICS	0	0	0	937		194. 01 194. 02
194. 03 07953 PHYS PRAC BUS OFC	0	0	0	3, 124 422		194. 02
194.04 07954 MOB - MAIN CAMPUS	0	0		469		194.03
194. 05 07955 ONCOLOGY - NONREI MBURSABLE	0	0		0		194.05
194. 06 07956 KDH - MC FAMILY PRACTICE	ol	0	Ö	734		194.06
194. 07 07957 KDH - MC ORTHOPEDICS	o	0	o	3, 595		194. 07
194.08 07958 KDH - MC GENERAL SURGERY	0	0	O	2, 073		194. 08
194.09 07959 KDH - MC ENT	0	0	0	151		194. 09
194. 10 07960 KDH - MC UROLOGY	0	0	0	676	0	194. 10

Health Financial Systems	KING'S DAUGHTERS	S' HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C		Peri od:	Worksheet B	
				From 01/01/2017		
				To 12/31/2017	Date/Time Pre	pared:
					5/23/2018 1:1	2 pm
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
· ·			ADMI NI STRATI (SERVICES &		
			N	SUPPLY		
	40.00	44 00	40.00	44.00	45.00	

0

179, 526

0 1, 340, 387 0 194. 11 200. 00 0 201. 00 1, 763, 387 202. 00

831

0 314, 697

0 710, 651

194.11 07961 KDH - MC 0B/GYN
200.00 Cross Foot Adjustments
201.00 Negative Cost Centers
202.00 TOTAL (sum lines 118 through 201)

Provi der CCN: 15-0069

				11	J 12/31/2017	Date/lime Pre 5/23/2018 1:1	
	Cost Center Description	MEDI CAL	SOCI AL	NONPHYSI CI AN	RADI OLOGY	HUB SITE -	
		RECORDS & LI BRARY	SERVI CE	ANESTHETI STS	SCH00L	3RD YEAR MED STUDENTS	
		16. 00	17. 00	19. 00	23. 00	23. 01	
1 00	GENERAL SERVICE COST CENTERS						1 00
1. 00 1. 01	OO1OO NEW CAP REL COSTS-BLDG & FLXT OO1O1 NEW CAP REL COSTS-BLDG & FLXT HHA/HO						1.00
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						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 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00
11. 00	01100 CAFETERI A						11.00
13. 00	01300 NURSING ADMINISTRATION						13.00
	01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY						15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	1, 037, 803	0				16.00
	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	0				17. 00 19. 00
	02300 RADI OLOGY SCHOOL	o	0		179, 346		23.00
	02301 HUB SITE - 3RD YEAR MED STUDENTS	0	0			0	1
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	36, 172	0		0	0	
31. 00 43. 00	03100 INTENSIVE CARE UNIT 04300 NURSERY	9, 587 5, 159	0		0	1	
43.00	ANCILLARY SERVICE COST CENTERS	5, 154	0	0	0	0	43.00
50.00	05000 OPERATING ROOM	105, 321	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	21, 775	0	0	0	0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	5, 913	0		0	0	
53.00	05300 ANESTHESI OLOGY	22, 697	0		170.24/	0	53.00
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	25, 227 6, 464	0		179, 346	0	54. 00 54. 01
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	19, 961	0		0	0	1
55. 00	03480 ONCOLOGY	23, 948	0		0	0	1
57.00	05700 CT SCAN	54, 119	0	0	0	0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	14, 187	0		0	0	58.00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	6, 919 103, 908	0	0	0	0	59. 00 60. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	7, 171	0	0	0	0	62.00
65. 00	06500 RESPIRATORY THERAPY	26, 777	0		0	Ö	65.00
66.00	06600 PHYSI CAL THERAPY	40, 374	0	0	0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0	
69. 00 69. 01	06900 ELECTROCARDI OLOGY 03610 SLEEP LAB	6, 245	0	0	0	0	69. 00 69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	42, 624	0	0	0	0	71.00
71.00	07101 IV SOLUTIONS	8, 957	0	Ö	0	Ö	71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	68, 498	0	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	226, 096	0	ı	0	0	,
	03140 CARDI OLOGY	37, 650	0		0		
76. 97	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	2, 251	0	0	0	0	76. 97
90.00	09000 CLINIC	557	0	0	0	0	90.00
	09100 EMERGENCY	92, 285	0		0		1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS			г		г	
	09500 AMBULANCE SERVICES	16, 961 0	0		0	•	
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	U	0	0	0		101.00
113.00	11300 NTEREST EXPENSE						113.00
	11600 HOSPI CE	О	0		0	0	116.00
118.00	, , ,	1, 037, 803	0	0	179, 346	0	118.00
	NONREI MBURSABLE COST CENTERS			_		_	
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0		190.00
	07950 OTHER NON-REIMBURSABLE 07951 MOB		0	0	0	l .	194. 00 194. 01
	07952 PHYSICIAN CLINICS	0	0	0	0	l	194.01
	07953 PHYS PRAC BUS OFC	ő	0	0	0	l	194. 03
	07954 MOB - MAIN CAMPUS	О	0	0	0	l	194. 04
	07955 ONCOLOGY - NONREI MBURSABLE	0	0	0	0	l	194. 05
	07956 KDH - MC FAMILY PRACTICE	0	0	0	0	l	194.06
	07957 KDH - MC ORTHOPEDICS 07958 KDH - MC GENERAL SURGERY	0	0	0	0	l	194. 07 194. 08
	07959 KDH - MC ENT	0	0	0	0		194.08
	07960 KDH - MC UROLOGY	o	0	Ö	0		194. 10
		· ·					

Health Financial Systems	KING'S DAUGHTERS	S' HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C		Peri od:	Worksheet B	
				From 01/01/2017	Part I	
				To 12/31/2017	Date/Time Pre	
					5/23/2018 1: 1:	2 pm
Cost Center Description	MEDI CAL	SOCI AL	NONPHYSI CI AI	RADI OLOGY	HUB SITE -	
	RECORDS &	SERVI CE	ANESTHETI STS	S SCHOOL	3RD YEAR MED	
	LI BRARY				STUDENTS	

	LI BRARY				STUDENTS	
	16. 00	17. 00	19. 00	23. 00	23. 01	
194. 11 07961 KDH - MC OB/GYN	0	0	0	0	0	194. 11
200.00 Cross Foot Adjustments			0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	1, 037, 803	0	0	179, 346	0	202.00
	,					

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2017 | Part I | To 12/31/2017 | Date/Time Prepared: | 5/23/2018 1:12 pm Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS KING'S DAUGHTERS' HOSPITAL Provi der CCN: 15-0069

				5/23/2018 1: 1	2 pm
Cost Center Description	Subtotal	Intern &	Total		
		Resi dents			
		Cost & Post			
		Stepdown			
	24.00	Adjustments	27.00		
GENERAL SERVI CE COST CENTERS	24. 00	25. 00	26. 00		
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT					1. 00
1. 01 00101 NEW CAP REL COSTS-BLDG & FLXT HHA/HO					1. 00
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP					2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 00 00500 ADMINI STRATI VE & GENERAL					5. 00
7. 00 00700 OPERATION OF PLANT					7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00 00900 HOUSEKEEPI NG					9. 00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERI A					11.00
13.00 01300 NURSING ADMINISTRATION					13.00
14.00 01400 CENTRAL SERVICES & SUPPLY					14.00
15. 00 01500 PHARMACY					15.00
16.00 01600 MEDICAL RECORDS & LIBRARY					16.00
17.00 01700 SOCIAL SERVICE					17.00
19.00 O1900 NONPHYSICIAN ANESTHETISTS					19.00
23. 00 02300 RADI OLOGY SCHOOL					23.00
23. 01 02301 HUB SITE - 3RD YEAR MED STUDENTS					23. 01
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS	10, 634, 268	0	10, 634, 268		30.00
31. 00 03100 INTENSIVE CARE UNIT	1, 802, 022	0	1, 802, 022		31.00
43. 00 04300 NURSERY	817, 920	0	817, 920		43.00
ANCILLARY SERVICE COST CENTERS	F 440 740		F 440 740		F0 00
50. 00 05000 OPERATING ROOM	5, 142, 740	0	5, 142, 740		50.00
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	333, 365	0	333, 365		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 53.00 05300 ANESTHESIOLOGY	841, 669	0	841, 669		52. 00 53. 00
54. 00 05400 RADI OLOGY 54. 00 05400 RADI OLOGY DI AGNOSTI C	224, 475 3, 355, 063	0	224, 475 3, 355, 063		54.00
54. 00 03400 RADI OLOGI - DI AGNOSTI C 54. 01 03630 ULTRA SOUND	191, 585	ol .	191, 585		54. 00
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	394, 924	0	394, 924		54.01
55. 00 03480 0NCOLOGY	2, 741, 095	0	2, 741, 095		55.00
57. 00 05700 CT SCAN	760, 468	Ö	760, 468		57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	426, 574	o	426, 574		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	301, 847	Ö	301, 847		59.00
60. 00 06000 LABORATORY	4, 329, 825	o	4, 329, 825		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	370, 375	0	370, 375		62.00
65. 00 06500 RESPIRATORY THERAPY	986, 825	0	986, 825		65.00
66. 00 06600 PHYSI CAL THERAPY	3, 453, 204	0	3, 453, 204		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0		69.00
69. 01 03610 SLEEP LAB	358, 167	0	358, 167		69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 282, 997	0	4, 282, 997		71.00
71. 01 07101 IV SOLUTIONS	142, 981	0	142, 981		71. 01
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	5, 410, 283	0	5, 410, 283		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	11, 622, 536	0	11, 622, 536		73.00
76. 00 03140 CARDI OLOGY	1, 137, 320	0	1, 137, 320		76. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	160, 921	0	160, 921		76. 97
OUTPATIENT SERVICE COST CENTERS	205 240		225 242		
90. 00 09000 CLI NI C	235, 948	0	235, 948		90.00
91. 00 09100 EMERGENCY	3, 846, 653	0	3, 846, 653		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS		0			92.00
95. 00 09500 AMBULANCE SERVICES	2, 546, 561	O	2, 546, 561		95. 00
101.00 10100 HOME HEALTH AGENCY	1, 504, 578	ol .	1, 504, 578		101.00
SPECIAL PURPOSE COST CENTERS	1, 304, 376	U _I	1, 504, 576		101.00
113. 00 11300 I NTEREST EXPENSE					113. 00
116. 00 11600 HOSPI CE	172, 989	o	172, 989		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	68, 530, 178	Ö	68, 530, 178		118. 00
NONREI MBURSABLE COST CENTERS	20,720,7110	-,			
190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	O	0		190. 00
194. 00 07950 OTHER NON-REIMBURSABLE	o o	ol	Ö		194. 00
194. 01 07951 MOB	5, 496, 117	ō	5, 496, 117		194. 01
194. 02 07952 PHYSI CI AN CLI NI CS	11, 094, 279	o	11, 094, 279		194. 02
194.03 07953 PHYS PRAC BUS OFC	1, 873, 320	o	1, 873, 320		194. 03
194.04 07954 MOB - MAIN CAMPUS	689, 133	o	689, 133		194. 04
194. 05 07955 ONCOLOGY - NONREI MBURSABLE	0	o	0		194. 05
194.06 07956 KDH - MC FAMILY PRACTICE	8, 598, 102	O	8, 598, 102		194. 06
194.07 07957 KDH - MC ORTHOPEDICS	5, 732, 773	O	5, 732, 773		194. 07
194.08 07958 KDH - MC GENERAL SURGERY	2, 029, 421	0	2, 029, 421		194. 08

Health Financial Systems	KING'S DAUGHTER	S' HOSPITAL		In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CC	CN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part I Date/Time Prepared: 5/23/2018 1:12 pm
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	24. 00	25. 00	26. 00		
194. 09 07959 KDH - MC ENT	879, 041	0	879, 04	11	194. 09
194.10 07960 KDH - MC UROLOGY	855, 686	0	855, 68	36	194. 10
194.11 07961 KDH - MC OB/GYN	3, 196, 938	o	3, 196, 93	88	194. 11
200.00 Cross Foot Adjustments	0	o		0	200. 00
201.00 Negative Cost Centers	0	0		0	201.00
202.00 TOTAL (sum lines 118 through 201)	108, 974, 988	o	108, 974, 98	88	202. 00

| Peri od: | Worksheet B | From 01/01/2017 | Part | I | To | 12/31/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-0069

			To	12/31/2017	Date/Time Pre 5/23/2018 1:1	
		CAPI	TAL RELATED CO	STS	37 237 2010 1. 1	Z piii
Cost Center Description	Di rectly	NEW BLDG &	NEW BLDG &	NEW MVBLE	Subtotal	
oost conten bescription	Assigned New	FLXT	FIXT HHA/HO	EQUI P	oubtotui	
	Capital Related Costs					
	0	1. 00	1. 01	2. 00	2A	
GENERAL SERVICE COST CENTERS						1 00
1.00 00100 NEW CAP REL COSTS-BLDG & FLXT 1.01 00101 NEW CAP REL COSTS-BLDG & FLXT HHA/HO						1. 00 1. 01
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	
5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT	0	1, 494, 679 1, 419, 091	0	0	1, 494, 679 1, 419, 091	5. 00 7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	Ö	65, 786	Ö	Ö	65, 786	1
9. 00 00900 HOUSEKEEPI NG	0	115, 315	0	0	115, 315	
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	0	217, 204 87, 841	0	0	217, 204 87, 841	
13. 00 01300 NURSING ADMINISTRATION	O	77, 107	Ö	Ö	77, 107	13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	0	106, 859	0	0	106, 859	1
15.00 01500 PHARMACY 16.00 01600 MEDICAL RECORDS & LIBRARY	0	79, 419 10, 078	0	0	79, 419 10, 078	1
17. 00 01700 SOCIAL SERVICE	0	0	Ō	Ō	0	17. 00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS 23. 00 02300 RADI OLOGY SCHOOL	0	0 22, 815	0	0	22.015	19. 00 23. 00
23. 00 02300 RADI OLOGY SCHOOL 23. 01 02301 HUB SI TE - 3RD YEAR MED STUDENTS	0	22, 815	0	0	22, 815 0	ı
INPATIENT ROUTINE SERVICE COST CENTERS				-		
30. 00 03000 ADULTS & PEDIATRICS	0	1, 373, 772	0	0	1, 373, 772	1
31. 00 03100 INTENSI VE CARE UNI T 43. 00 04300 NURSERY	0	57, 778 67, 477	0	0	57, 778 67, 477	1
ANCILLARY SERVICE COST CENTERS						
50. 00 O5000 OPERATING ROOM 51. 00 O5100 RECOVERY ROOM	0	606, 846 47, 458	0	0	606, 846 47, 458	1
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	47, 438	0	0	47, 438	1
53. 00 05300 ANESTHESI OLOGY	0	4, 487	0	0	4, 487	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 03630 ULTRA SOUND	0	374, 179 0	0	0	374, 179 0	ı
54. 01 03030 0ETKA 300ND 54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	16, 671	0	0	16, 671	ı
55. 00 03480 ONCOLOGY	o	426, 953	0	0	426, 953	1
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE MAGING (MRI)	0	30, 891 37, 276	0	0	30, 891 37, 276	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	o	29, 476	o O	o	29, 476	1
60. 00 06000 LABORATORY	0	215, 340	0	0	215, 340	1
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 65.00 06500 RESPIRATORY THERAPY	0	9, 630 41, 315	0	0	9, 630 41, 315	1
66. 00 06600 PHYSI CAL THERAPY	o	488, 631	o O	o	488, 631	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	O	0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	68. 00 69. 00
69. 01 03610 SLEEP LAB	Ö	28, 9 58	- 1	Ö	28, 958	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	1
71. 01 07101 IV SOLUTIONS 72. 00 07200 MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	O	0	Ö	Ö	0	73.00
76. 00 03140 CARDI OLOGY	0	208, 713		0	208, 713	1
76. 97 O7697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	j Uj	24, 264	0	0	24, 264	76. 97
90. 00 09000 CLI NI C	0	26, 232		0	26, 232	1
91. 00 09100 EMERGENCY 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART)	0	479, 036	0	0	479, 036 0	1
OTHER REIMBURSABLE COST CENTERS					0	92.00
95. 00 09500 AMBULANCE SERVICES	0	163, 326		0	163, 326	
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	6, 214	0	6, 214	101. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	0	0	1, 683	0		116. 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	0	8, 454, 903	7, 897	0	8, 462, 800	118. 00
NONREIMBURSABLE 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	O	0	194. 00
194. 01 07951 MOB 194. 02 07952 PHYSI CI AN CLI NI CS	0	1, 633, 120 1, 197, 987	0	0	1, 633, 120 1, 197, 987	
194. 03 07953 PHYS PRAC BUS OFC		34, 135		o		194. 02
194. 04 07954 MOB - MAIN CAMPUS	0	0	0	0	0	194. 04
194.05 07955 ONCOLOGY - NONREIMBURSABLE 194.06 07956 KDH - MC FAMILY PRACTICE	0	0 1, 489, 191	0	0	0 1, 489, 191	194. 05 194. 06
194. 07 07957 KDH - MC ORTHOPEDICS	Ö	1, 407, 171	-	ő		194. 07
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Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0069	Peri od: From 01/01/2017	
			To 12/31/2017	Date/Time Prepared:

					5/23/2018 1:1	2 pm
		CAPITAL RELATED COSTS				
Cost Center Description	Di rectly	NEW BLDG &	NEW BLDG &	NEW MVBLE	Subtotal	
	Assigned New	FLXT	FLXT HHA/HO	EQUI P		
	Capi tal					
	Related Costs					
	0	1. 00	1. 01	2. 00	2A	
194. 08 07958 KDH - MC GENERAL SURGERY	0	0	0	0	0	194. 08
194.09 07959 KDH - MC ENT	0	0	0	0	0	194. 09
194. 10 07960 KDH - MC UROLOGY	0	0	0	0	0	194. 10
194.11 07961 KDH - MC OB/GYN	0	0	0	0	0	194. 11
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	o	12, 809, 336	7, 897	0	12, 817, 233	202. 00

Provider CCN: 15-0069

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | T

				1	0 12/31/2017	/ Date/lime Pre 5/23/2018 1:1	
	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	, p
		4. 00	5. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
19. 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 01700 SOCIAL SERVICE	0 0 0 0 0 0 0 0	1, 494, 679 71, 774 6, 501 22, 164 16, 828 1, 833 9, 195 3, 307 23, 146 14, 080	1, 490, 865 9, 792 17, 164 32, 330 13, 075 11, 477 15, 906 11, 821 1, 500 0	82, 079 0 0 0 0 0 0 0	154, 643 0 0 0 0 1, 518 2, 654 0 0 0	10.00 11.00 13.00 14.00 15.00 16.00 17.00 19.00
23. 00 23. 01	02300 RADI OLOGY SCHOOL 02301 HUB SITE - 3RD YEAR MED STUDENTS	0	2, 250 0	3, 396	0	219	1
23.01	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	0	0			23.01
30.00	03000 ADULTS & PEDIATRICS	0	100, 503	204, 482	25, 932	72, 613	30.00
31. 00	03100 INTENSIVE CARE UNIT	0	20, 720			-,	1
43. 00	04300 NURSERY	0	10, 041	10, 044	1, 362	2 640	43.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	ol	57, 327	90, 327	16, 478	16, 286	50.00
51. 00	05100 RECOVERY ROOM	Ö	3, 495		2, 053		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	o	10, 524	0	1, 601	1	1
53.00	05300 ANESTHESI OLOGY	0	2, 709		0	1	53.00
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	0	39, 179 2, 337		5, 106 570	1	1
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	o	4, 938		352	l .	54. 02
55.00	03480 ONCOLOGY	O	32, 852	63, 551	2, 335	7, 134	55.00
57. 00	05700 CT SCAN	0	9, 083			1	1
58. 00 59. 00	05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON	0	5, 247 3, 625	5, 548 4, 387	563 0		1
60.00	06000 LABORATORY	ő	55, 559		o o	4, 291	•
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	O	4, 913		0	0	62.00
65.00	06500 RESPI RATORY THERAPY	0	12, 781			1	
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	42, 436 0	72, 731 0	4, 855 0		
68. 00	06800 SPEECH PATHOLOGY		0		0	1	68.00
69. 00	06900 ELECTROCARDI OLOGY	o	0	0	0	0	69.00
69. 01	03610 SLEEP LAB	0	4, 319	4, 310	327		
71. 00 71. 01	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07101 V SOLUTIONS	0	56, 541 1, 787	0	0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	o o	73, 267	0	0		1
	07300 DRUGS CHARGED TO PATIENTS	o	132, 125	0	0	0	1
	03140 CARDI OLOGY	0	13, 197			1	76.00
76. 97	O7697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0	1, 882	3, 612	0	744	76. 97
90.00	09000 CLINIC	O	2, 911	3, 904	1	795	90.00
	09100 EMERGENCY	o	43, 510		12, 114	l .	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
05 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	O	33, 121	24, 311	1, 900	0	95.00
	10100 HOME HEALTH AGENCY	0	19, 946				101.00
	SPECIAL PURPOSE COST CENTERS	-	,				
	11300 INTEREST EXPENSE						113.00
116. 00 118. 00)11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	0	2, 189				116.00
110.00	NONREI MBURSABLE COST CENTERS	<u> </u>	974, 142	042, / 19	00, 613	130, 434	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190. 00
	07950 OTHER NON-REIMBURSABLE	0	0	0	0		194.00
	07951 M0B 2 07952 PHYSLCIAN CLINICS	0	63, 651			1	194. 01
194.02	BO7953 PHYS PRAC BUS OFC	0	143, 504 25, 444		434 0		194. 02 194. 03
	07954 MOB - MAIN CAMPUS	o	6, 738		Ö	1	194. 04
194. 05	07955 ONCOLOGY - NONREI MBURSABLE	0	0	0	0	0	194. 05
	07956 KDH - MC FAMILY PRACTICE	0	107, 246		20	l .	194.06
	7 07957 KDH - MC ORTHOPEDICS 8 07958 KDH - MC GENERAL SURGERY		78, 568 27, 796		145 123		194. 07 194. 08
	07959 KDH - MC ENT	o	12, 055				194. 09
194. 10	07960 KDH - MC UROLOGY	o	11, 727	0	0	0	194. 10

Health Financial Systems	KING'S DAUGHTE	RS' HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der Co		Peri od:	Worksheet B	
			F	rom 01/01/2017	Part II	
			7	To 12/31/2017	Date/Time Pre	
					5/23/2018 1:1	2 pm
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	
194.11 07961 KDH - MC OB/GYN	0	43, 808	(339	0	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)	0	1, 494, 679	1, 490, 865	82, 079	154, 643	202. 00

Provi der CCN: 15-0069

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | T

			10	12/31/2017	Date/lime Pre 5/23/2018 1:1	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O	CENTRAL SERVICES &	PHARMACY	
			N	SUPPLY		
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 & FIXT 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 ADMINISTRATIVE & GENERAL						5.00
7.00 O0700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE						8. 00
9. 00 00900 HOUSEKEEPI NG	244 242					9.00
10. 00 01000 DI ETARY	266, 362	00 010				10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	0	90, 812 0	97, 779			11. 00 13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	0	658	97, 779	128, 248		14.00
15. 00 01500 PHARMACY	Ö	2, 459	o o	304	119, 803	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	o	2, 901	0	102	0	16.00
17. 00 01700 SOCIAL SERVICE	0	0	0	0	0	17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
23. 00 02300 RADI OLOGY SCHOOL	0	489	0	14	0	23. 00
23. 01 02301 HUB SITE - 3RD YEAR MED STUDENTS	0	0	0	0	0	23. 01
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	249, 032	18, 704	42, 710	1, 868	0	30.00
31. 00 03100 NTENSI VE CARE UNIT	17, 330	6, 627	15, 136	/	0	31.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	1, 617	3, 692	0	0	43.00
50. 00 05000 OPERATING ROOM	0	5, 464	12, 480	65, 478	0	50.00
51. 00 05100 RECOVERY ROOM	o	1, 032	2, 358	45	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	o	1, 901	4, 341	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	731	0	186	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	5, 940	0	798	0	54.00
54. 01 03630 ULTRA SOUND	0	316	0	194	0	54. 01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	293	0	29	0	54.02
55. 00 03480 0NC0L0GY	0	3, 362	0	195	0	55.00
57. 00 05700 CT SCAN	0	931	0	1, 635	0	57.00
58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI)	0	454	0	223	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0	572 7, 542	0	52 504	0	59. 00 60. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	7, 342 0	0	0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0	2, 704	0	514	0	65.00
66. 00 06600 PHYSI CAL THERAPY	o	6, 590	o o	133	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
69. 01 03610 SLEEP LAB	0	431	0	2	0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	48, 094	0	71.00
71. 01 07101 I V SOLUTI ONS	0	0	0	1, 520	0	71.01
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATLENTS 76. 00 03140 CARDI OLOGY	0	2.004] 0] 0	0	119, 803 0	
76. 00 03140 CARDI OLOGY 76. 97 07697 CARDI AC REHABI LI TATI ON	0	2, 084 363		63 5	0	
OUTPATIENT SERVICE COST CENTERS	· ·	303	<u> </u>			70. 77
90. 00 09000 CLINIC	0	411	0	7	0	90.00
91. 00 09100 EMERGENCY	o	7, 471	17, 062	504	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		•	,			92.00
OTHER REIMBURSABLE COST CENTERS	•					
95. 00 09500 AMBULANCE SERVICES	0	8, 765		140	0	
101.00 10100 HOME HEALTH AGENCY	0	0	0	328	0	101.00
SPECIAL PURPOSE COST CENTERS			Г			
113. 00 11300 INTEREST EXPENSE						113.00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	244 242	00.013	07 770	122 044	119, 803	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	266, 362	90, 812	97, 779	122, 944	119, 803	1118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0		0	ol	0	190. 00
194. 00 07950 OTHER NON-REI MBURSABLE	0	0	0			194.00
194. 01 07951 MOB	o	0	0	382		194. 01
194. 02 07952 PHYSI CI AN CLI NI CS	o	0	0	1, 273		194. 02
194. 03 07953 PHYS PRAC BUS OFC	o	Ō	o o	172		194. 03
194.04 07954 MOB - MAIN CAMPUS	0	0	0	191		194. 04
194. 05 07955 ONCOLOGY - NONREI MBURSABLE	0	0	0	0		194. 05
194.06 07956 KDH - MC FAMILY PRACTICE	0	0	0	299		194. 06
194. 07 07957 KDH - MC ORTHOPEDICS	0	0	0	1, 465		194. 07
194. 08 07958 KDH - MC GENERAL SURGERY	0	0	0	845		194.08
194. 09 07959 KDH - MC ENT	0	0	0	62		194. 09
194. 10 07960 KDH - MC UROLOGY	0	0	0	276	0	194. 10

Health Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C		Peri od:	Worksheet B	
				From 01/01/2017	Part II	
				To 12/31/2017	Date/Time Pre	pared:
			_		5/23/2018 1:1	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI	O SERVICES &		
				OUDDLY/		

						5/23/2018 1: 1	2 pm
	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	
194. 11 07961	KDH - MC OB/GYN	0	0	0	339	0	194. 11
200. 00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	11, 937	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	266, 362	102, 749	97, 779	128, 248	119, 803	202.00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2017 Part II
To 12/31/2017 Date/Time Prepared: 5/23/2018 1:12 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0069

Company Comp					12/31/201/	5/23/2018 1:1	
ILBRARY	Cost Center Description						
			SERVICE	ANESTHETISTS	SCHOOL		
0.000 NOTE CAP REL COST S-BLD & FIXT			17. 00	19.00	23. 00		
1.01 0.010 INIT CAP REL COSTSTBIDG A FIXT HIAL/HO 2.0 0.00		1		T			
2. 00 DOZDO RAY CAP REL DOSIS-WESTE EDUIP 4. 00 DOZDO ADMIN'S TRATTIVE & GERERAL 5. 00 DOZDO ADMIN'S TRATTIVE & GERERAL 6. 00 DOZDO ADMIN'S TRATTIVE & GERERAL 7. 13 DO DOZDO ADMIN'S TRATTIVE & GERERAL 7. 14 DOZDO ADMIN'S TRATTIVE & GERERAL 7. 15 DOZDO ADMIN'S TRATTIVE & GERERAL 7. 16 DOZDO ADMIN'S TRATTIVE & GERERAL 7. 16 DOZDO ADMIN'S TRATTIVE & GERERAL 7. 16 DOZDO ADMIN'S TRATTIVE & GERERAL 7. 17 DOZDO ADMIN'S TRATTIVE & GERERAL 7. 18 DOZDO				•			1
0.000 0.00				•			1
5.00 00500 ADMINISTRATIVE & CENERAL							1
2.00 00700 DEPART 100 OF PLANT							1
9.00 00000 000000 000000000000000000							1
10.00 10000 10 17 18 10 10 10 10 10 10 10	8.00 00800 LAUNDRY & LINEN SERVICE						8.00
11.00 0 1100 (CAFETERIA 11.00 11.0	9. 00 00900 HOUSEKEEPI NG						9. 00
13.00 0.1300 NURSING ADMINISTRATION 13.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 15.00							1
14.00 01400 CENTRAL SERVICES & SUPPLY 11.5 00 1500 1600 MEDICAL RECORDS & LIBRARY 28.661 1.6 00 1.6 00 1.7 00 170							1
15.00 01500 PHABINACY 15.00 15.00 17.00							1
16. 0.0 1600 MEDICAL RECORDS & LIBRARY 28. 661 0. 0 17. 00 1700 0.0 0.0 17. 00 1700 0.0 0.0 17. 00 1700 0.0 0.0 17. 00 1700 0.0							1
17.00 01700 SOCIAL SERVICE 0 0 0 17.00 19.00		20 661					1
19.00 0.900 MORPHYSIC I AM AMESTHEITSISS 0 0 0 29, 183 0.23		1	0				1
23.00 02300 RADIOLORY SCHOOL 0 0 29, 183 23, 00 02301 RADIOLORY SCHOOL 0 0 0 0 0 0 0 0 0		1					1
23.01 102301 HUB SITE - 3RD YEAR MED STUDENTS 0 0 3.0.00 3.0.		1			29, 183		1
INPATE EAT ROUTH INS SERVICE COST CENTERS 999 0 30 .00 30 .00 31 .00		1		1	=1,100	0	
31.00 03100 NUTERIX VE CARE UNIT 2.55 0 43.00 43.00 AND UNISERY 13.3 0 43.00 43.00 AND UNISERY 13.3 0 43.00 43.00 AND UNISERY 13.3 0 5.0.00							
43. 00 04300 NURSERY 143 0 44. 00	30. 00 03000 ADULTS & PEDIATRICS	999	0				30.00
MICHILIARY SERVICE COST CENTERS 50.00 50				1			
50.00		143	0				43.00
15.1.00 OSTOO RECOVERY ROOM ALBOR ROOM 10.3 0 10.3		2 010	0	ı			
10.00 0.00	i i	1		1			1
1.53.00 05300 MAISTHESI OLOGY		1					1
54.00 OS400 RADIOLGOY-DI AGNOSTIC 697 0 54.01 54.01 OS300 ULTRA SOUND 1779 0 54.01 54.02 O3450 NUCLEAR MEDICINE - DI AGNOSTIC 551 0 54.02 55.00 O3450 ONCOLCEAR MEDICINE - DI AGNOSTIC 551 0 54.02 55.00 O3450 ONCOLCEAR MEDICINE - DI AGNOSTIC 551 0 55.00 57.00 O5700 OS CAON OS CAO		1					1
54.01 03630 ULTRA SOUND		1					1
55.00 03480 0MCDLOGY 55.00 55.00 55.00 55.00 57.00 5		1	0				1
57.00 05700 CT SCAN 57.00 58.00 59		551	0				54. 02
S8. 00 OSBOO MAGNETI C RESONANCE I MAGING (MRI) 392 0 59. 00 590 OSBOO CARDIAC CATHETERIZATION 191 0 59. 00 60.	55. 00 03480 ONCOLOGY	662	0				55.00
59.00 05900 CARDI AC CATHETER ZATI ON 191 0 6.00 6.00 07.10 07.10		1, 495	0				57.00
60. 00 06000 LABORATORY 2,871 0 62. 00 62. 00 62. 00 62. 00 62. 00 62. 00 62. 00 62. 00 62. 00 66. 00		1	-				1
62. 00 06200 MORLIC BLOOD & PACKED RED BLOOD CELLS 198 0 65. 00 65. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 67. 00 67. 00 67. 00 67. 00 67. 00 68. 00 6800 6800 6800 6800 6800 6800 6800 6800 69. 00		1					•
65. 00 06500 RESPI RATORY THERAPY 740 0 06600 PHYSI CAL THERAPY 1, 115 0 066. 00 06600 PHYSI CAL THERAPY 0 0 0 067. 00 067.		1					1
66.00 06600 PMSI CAL THERAPY 1,115 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 0 0 67.00 68.00 06700 OCCUPATIONAL THERAPY 0 0 0 68.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 69.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 69.01 03610 SLEEP LECTROCARDIOLOGY 0 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 1,178 0 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 1,178 0 71.01 72.00 07200 IMPL DEV. CHARGED TO PATIENTS 1,892 0 71.01 73.00 07300 PROSE CHARGED TO PATIENTS 6,236 0 73.00 76.00 03140 CARDIOLOGY 1,040 0 76.90 76.97 07970 CARDIOLOGY 1,040 0 76.90 76.97 07970 CARDIOLOGY 1,040 0 76.90 79.00 09000 CLINIC 15 0 90.00 79.00 09000 CLINIC 5 0 90.00 79.00 09000 DEREGRENCY 2,549 0 91.00 79.00 09000 DEREGRENCY 2,549 0 91.00 79.00 09500 AMBULANCE SERVICES 469 0 95.00 79.10.00 09500 MBULANCE SERVICES 469 0 95.00 79.10.00 10100 THOUR HEALTH AGENCY 0 91.00 79.10.00 OSUBIOTALIS (SUM OF LINES 1 through 117) 28,661 0 0 0 194.00 79.00 19000 OFFICE SERVICES 0 0 194.00 79.00 09000 OSUBIOTALIS (SUM OF LINES 1 through 117) 28,661 0 0 0 194.00 79.01 09000 OSUBIOTALIS (SUM OF LINES 1 through 117) 28,661 0 0 0 194.00 79.01 09000 OSUBIOTALIS (SUM OF LINES 1 through 117) 28,661 0 0 194.00 79.02 09000 09000 09000 09000 09000 09000 79.00 09000 09000 09000 09000 09000 09000 79.00 09000 09000 09000 09000 09000 09000 79.00 09000 09000 09000 09000 09000 09000 79.00 09000 09000 09000 09000 09000 09000 79.00 09000 09000 09000 09000 09000 09000 79.00 09000 09000 09000 09000 09000 09000 79.00 09000 09000 09000 09000 09000 09000 79.00 090000 09000 09000 09000 09000 09000 79.00 09000 09		1					•
67.00 06700 06CUPATI ONAL THERAPY 0 0 0 68.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 69.01 03600 SPEECH PATHOLOGY 0 0 0 0 69.01 03610 SLEEP LAB 173 0 0 0 69.01 03610 SLEEP LAB 173 0 0 0 69.01 071.00 071.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 1,178 0 71.00 71.10 07101 V SOLUTIONS 247 0 71.00 72.00 072.00 IMPL. DEV. CHARGED TO PATIENTS 1,892 0 72.00 73.00 073.00 073.00 073.00 073.00 073.00 76.00 073.00 074.00 074.00 0 76.00 76.00 03140 CARDIOLOGY 1,040 0 76.00 76.97 07697 CARDIA C REHABILITATION 62 0 76.97 76.97 07697 CARDIA C REHABILITATION 62 0 90.00 79.00 09000 00000 00000 00000 00000 79.00 09000 00000 00000 00000 00000 79.00 09000 00000 00000 00000 00000 79.00 09000 00000 00000 00000 79.00 09000 00000 00000 00000 79.00 09000 00000 00000 00000 79.00 09000 00000 00000 00000 79.00 09000 00000 00000 00000 79.00 09000 00000 00000 00000 79.00 09000 00000 00000 00000 79.00 09000 00000 00000 00000 79.00 09000 00000 00000 00000 79.00 09000 00000 00000 00000 79.00 09000 00000 00000 00000 79.00 09000 00000 00000 00000 79.00 09000 000000 000000 000000 79.00 09000 000000 000000 000000 79.00 09000 0000000 000000000 79.00 09000 0000000000000000000000000		1	-				1
68. 00 06800 SPEECH PATHOLOGY 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 69. 00 69. 01 03610 SLEEP LAB 173 0 71. 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1,178 0 71. 00 71. 01 07101 IV SOLUTI ONS 2,247 0 71. 01 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 1,892 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 6,236 0 73. 00 76. 00 03140 CARDI OLOGY 1,040 0 76. 00 76. 00 03140 CARDI OLOGY 1,040 0 76. 00 76. 97 07697 CARDI ACCENTERS 1,040 0 76. 97 90. 00 09000 CLINIC 15 0 90. 00 91. 00 09000 CLINIC 99. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 95. 00 09500 AMBULANCE SERVI CES 469 0 95. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 118. 00 118. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 116. 00 11600 HOSPI CE 0 0 0 0 118. 00 117. 00 NONREI MBURSABLE COST CENTERS 113. 00 1300 INTEREST EXPENSE 100. 00 190. 00 190. 00 194. 00 1		1					1
69.00 06900 LECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	-				1
69.01 03610 SLEEP LAB		1					1
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 1, 178 0 71. 00 71. 01 07101 IV SOLUTIONS 247 0 71. 01 72. 00 72. 00 73. 00 73. 00 73. 00 73.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1, 892 0 72. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 76. 00		173					1
71. 01 07101 V SOLUTIONS 247 0 77. 01		1, 178	0				71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 6, 236 0 76. 00	71.01 07101 IV SOLUTIONS		0				71.01
76. 00		1, 892		1			
76. 97 O7697 CARDI AC REHABI LITATION 62 0 76. 97			-				1
OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 15 0 90.00 97.00 09100 EMERGENCY 2,549 0 97.00				1			
90. 00 09000 CLINIC 15 0 990. 00 991. 00 992.00 09200 095ERVATION BEDS (NON-DISTINCT PART) 92. 00 09200 095ERVATION BEDS (NON-DISTINCT PART) 92. 00 075ER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 469 0 101. 00 0010 HOME HEALTH AGENCY 0 0 0 101. 00 001 001.		62	0				76.97
91. 00 09100 EMERGENCY 2, 549 0 91. 00 92. 00 095ERVATI ON BEDS (NON-DISTINCT PART) 92. 00 07000 0		15	0	1			00 00
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 92.00 0THER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVI CES 469 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 1113.00 1300 INTEREST EXPENSE 113.00 11600 HOSPI CE 0 0 0 116.00 116.00 11600 NONREIMBURSABLE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 28,661 0 0 0 0 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 194.00 194.00 19750 MOB 0 194.00 194.00 19750 MOB 0 194.00 194.00 194.01 194.01 194.01 194.01 194.02 19752 PHYSI CI AN CLI NI CS 0 0 194.01 194.01 194.02 194.03 07953 PHYS PRAC BUS OFC 0 0 194.03 194.03 194.04 07954 MOB MAIN CAMPUS 0 0 194.04 194.05 07955 ONCOLOGY - NONREIMBURSABLE 0 0 194.05 194.05 194.05 194.05 194.06 194.07 194.07 194.08 07956 KDH - MC FAMILY PRACTICE 0 0 194.06 194.07 194.08 19758 KDH - MC GENERAL SURGERY 0 0 194.08 194.08 19758 KDH - MC GENERAL SURGERY 0 0 194.08 194.09 194.08 194.09 194.09 194.08 194.09 194.08 194.0							1
OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVI CES 469 0 0 0 0 0 0 0 0 0		2, 347	0				
95. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 101. 00				1			72.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 116. 0		469	0				95.00
113. 00	101.00 10100 HOME HEALTH AGENCY	0	0				101.00
116. 00 118. 00 118. 00 118. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 28, 661 0 0 0 0 118. 00 NONREI MBURSABLE COST CENTERS							
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 28, 661 0 0 0 0 118. 00							
NONRE MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 190. 00 194. 00 194. 00 194. 00 194. 00 194. 00 194. 00 194. 01 194. 02 194. 01 194. 02 194. 03 194. 04 194. 04 194. 04 194. 05 194. 05 194. 05 194. 06 194. 06 194. 06 194. 07 194. 08 194. 08 194. 08 194. 08 194. 09		1		1	_	_	
190. 00 190. 0	9 /	28, 661	0	0	0	0	1118.00
194. 00 07950 0THER NON-REI MBURSABLE 0 0 0 0 194. 00 194. 01 194. 01 194. 02 194. 03 194. 02 194. 03 194. 04 194. 05 194. 06 194. 06 194. 06 194. 07 1975 KDH - MC GENERAL SURGERY 0 0 0 0 194. 08 194. 09 1975 KDH - MC ENT 0 0 0 0 194. 08 194. 09 1975 KDH - MC ENT 0 0 0 0 194. 08 194. 09 1975 KDH - MC ENT 0 0 0 0 0 194. 08 194. 09 1975 KDH - MC ENT 0 0 0 0 194. 09			0				100 00
194. 01 07951 MOB		1		1			
194. 02 07952 PHYSI CI AN CLI NI CS 194. 03 07953 PHYS PRAC BUS OFC 194. 04 07954 MOB - MAI N CAMPUS 194. 05 07955 ONCOLOGY - NONREI MBURSABLE 194. 06 07956 KDH - MC FAMI LY PRACTI CE 194. 07 07957 KDH - MC ORTHOPEDI CS 194. 08 07958 KDH - MC GENERAL SURGERY 194. 09 07959 KDH - MC ENT		1	-				
194. 03 07953 PHYS PRAC BUS OFC 194. 04 07954 MOB - MAI N CAMPUS 194. 05 07955 ONCOLOGY - NONREI MBURSABLE 194. 06 07956 KDH - MC FAMI LY PRACTI CE 194. 07 07957 KDH - MC ORTHOPEDI CS 194. 08 07958 KDH - MC GENERAL SURGERY 194. 09 07959 KDH - MC ENT 194. 09 194. 09 194. 09			-				1
194. 04 07954 MOB - MAIN CAMPUS 0 0 194. 05 194. 05 07955 ONCOLOGY - NONREI MBURSABLE 0 0 0 194. 06 194. 06 07956 KDH - MC FAMI LY PRACTI CE 0 0 0 194. 07 194. 08 07958 KDH - MC GENERAL SURGERY 0 0 0 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09 194. 09			-				1
194. 05 07955 ONCOLOGY - NONREI MBURSABLE 0 0 0 194. 05 194. 06 07956 KDH - MC FAMI LY PRACTI CE 0 0 0 194. 07 07957 KDH - MC ORTHOPEDI CS 0 0 0 194. 07 194. 08 07958 KDH - MC GENERAL SURGERY 0 0 0 194. 09 194. 09 07959 KDH - MC ENT			-				1
194. 06 07956 KDH - MC FAMILY PRACTICE 0 0 0 194. 07 194. 08 07958 KDH - MC ORTHOPEDICS 0 0 194. 08 194. 09 07959 KDH - MC GENERAL SURGERY 0 0 0 194. 09 194. 09 07959 KDH - MC ENT			0				
194. 08 07958 KDH - MC GENERAL SURGERY 0 0 194. 09 194. 09 194. 09 0 194. 09		o	0				
194. 09 07959 KDH - MC ENT 0 0 194. 09		0	0				
		1		1			
194. TO 0/960 KDH - MC UROLOGY 0 0 194. 10		1					
	194. 10 07960 KDH - MC UROLOGY	0	0	1			1194. 10

Health Financial Systems	KING'S DAUGHTERS	S' HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der Co		Peri od:	Worksheet B	
				From 01/01/2017	Part II	
				To 12/31/2017	Date/Time Pre	
					5/23/2018 1:1	2 pm
Cost Center Description	MEDI CAL	SOCI AL	NONPHYSI CI AN	RADI OLOGY	HUB SITE -	
	RECORDS &	SERVI CE	ANESTHETI STS	SCH00L	3RD YEAR MED	
	LI BRARY				STUDENTS	
	16. 00	17. 00	19. 00	23. 00	23. 01	
194.11 07961 KDH - MC OB/GYN	0	0				194. 11
200.00 Cross Foot Adjustments				0 29, 183	0	200. 00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	28, 661	0		0 29, 183	0	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-0069

				To 12/31/2017 Date/Time F 5/23/2018 1	
Cost Center Description	Subtotal	Intern &	Total		
		Residents Cost & Post			
		Stepdown			
		Adjustments			
CENEDAL CEDALCE COCT CENTEDO	24. 00	25. 00	26. 00		
GENERAL SERVICE COST CENTERS 1. 00 00100 NEW CAP REL COSTS-BLDG & FLXT					1.00
1. 01 00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO					1. 01
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP					2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 00 00500 ADMINISTRATIVE & GENERAL 7. 00 00700 OPERATION OF PLANT					5. 00 7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE					8.00
9. 00 00900 HOUSEKEEPI NG					9. 00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON					11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY					14.00
15. 00 01500 PHARMACY					15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY					16. 00
17. 00 01700 SOCI AL SERVI CE					17. 00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS 23. 00 02300 RADI OLOGY SCHOOL					19. 00 23. 00
23. 00 02300 RADI OLOGY SCHOOL 23. 01 02301 HUB SITE - 3RD YEAR MED STUDENTS					23.00
INPATIENT ROUTINE SERVICE COST CENTERS					25.01
30. 00 03000 ADULTS & PEDIATRICS	2, 090, 615	0	2, 090, 6	515	30.00
31. 00 03100 INTENSIVE CARE UNIT	130, 266	0	130, 2		31.00
43. 00 O4300 NURSERY	95, 016	0	95, C	016	43.00
ANCILLARY SERVICE COST CENTERS 50.00 O5000 OPERATING ROOM	873, 596	0	873, 5	596	50.00
51. 00 05100 RECOVERY ROOM	64, 107	Ö	64, 1		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	20, 672	0	20, 6		52.00
53. 00 05300 ANESTHESI OLOGY	9, 408	0	9, 4		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 03630 ULTRA SOUND	486, 501 4, 526	0	486, 5 4, 5		54. 00 54. 01
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	25, 629	0	25, 6		54. 01
55. 00 03480 0NCOLOGY	537, 044	0	537, 0		55. 00
57. 00 05700 CT SCAN	51, 752	0	51, 7		57.00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	50, 206	0	50, 2		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	39, 592 318, 160	0	39, 5 318, 1		59. 00 60. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	16, 174	0	16, 1		62.00
65. 00 06500 RESPIRATORY THERAPY	64, 204	0	64, 2		65. 00
66. 00 06600 PHYSI CAL THERAPY	618, 350	0	618, 3		66.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	0		0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	0		0	68. 00 69. 00
69. 01 03610 SLEEP LAB	40, 275	Ö	40, 2		69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	105, 813	0	105, 8		71.00
71. 01 07101 IV SOLUTIONS	3, 554	0	3, 5		71. 01
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	75, 159 258, 164	0	75, 1 258, 1		72. 00 73. 00
76. 00 03140 CARDI OLOGY	259, 575	0	259, 5		76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	30, 932	0	30, 9		76. 97
OUTPATIENT SERVICE COST CENTERS		_		1	
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	34, 276	0	34, 2		90. 00 91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	644, 322	0	644, 3	322	91.00
OTHER REIMBURSABLE COST CENTERS		J			72.00
95. 00 09500 AMBULANCE SERVICES	232, 032	0	232, 0		95. 00
101.00 10100 HOME HEALTH AGENCY	40, 606	0	40, 6	006	101.00
SPECIAL PURPOSE COST CENTERS 113, 00 11300 INTEREST EXPENSE					113.00
116. 00 11600 HOSPI CE	7, 694	0	7, 6	94	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	7, 228, 220				118.00
NONREI MBURSABLE COST CENTERS					
190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0	190.00
194. 00 07950 OTHER NON-REI MBURSABLE 194. 01 07951 MOB	0 1, 940, 442	0	1, 940, 4	142	194. 00 194. 01
194. 02 07952 PHYSI CI AN CLINICS	1, 521, 515	0	1, 521, 5		194. 02
194. 03 07953 PHYS PRAC BUS OFC	64, 832	0	64, 8	332	194. 03
194. 04 07954 MOB - MAIN CAMPUS	25, 138	0	25, 1		194. 04
194. 05 07955 ONCOLOGY - NONREIMBURSABLE 194. 06 07956 KDH - MC FAMILY PRACTICE	0 1 010 410	0	1 010 4	0	194. 05 194. 06
194.06 07956 KDH - MC FAMILY PRACTICE 194.07 07957 KDH - MC ORTHOPEDICS	1, 818, 418 80, 178	0	1, 818, 4 80, 1		194.06
194. 08 07958 KDH - MC GENERAL SURGERY	28, 764	0	28, 7		194. 08
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Health Financial Systems	KING'S DAUGHTER	S' HOSPITAL		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der Co		Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Prepared: 5/23/2018 1:12 pm
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown	Total		

			Cost & Post			
			Stepdown			
			Adjustments			
		24. 00	25. 00	26. 00		
194. 09 0795	9 KDH - MC ENT	12, 117	0	12, 117	194.	09
194. 10 0796	O KDH - MC UROLOGY	12, 003	0	12, 003	194.	10
194. 11 0796	1 KDH - MC OB/GYN	44, 486	0	44, 486	194.	11
200. 00	Cross Foot Adjustments	29, 183	0	29, 183	200.	00
201. 00	Negative Cost Centers	11, 937	0	11, 937	201.	00
202. 00	TOTAL (sum lines 118 through 201)	12, 817, 233	0	12, 817, 233	202.	00
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KING'S DAUGHTERS' HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0069 Peri od: Worksheet B-1 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/23/2018 1:12 pm CAPITAL RELATED COSTS Cost Center Description NEW BLDG & NEW BLDG & NEW MVBLE **EMPLOYEE** Reconciliatio FIXT HHA/HO **FOULP BENEFITS** FLXT n (SQUARE (SQUARE (SQUARE DEPARTMENT FEET) FEET) FEET) (GROSS SALARIES) 1. 00 1. 01 2.00 4.00 5A GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 371, 122 1 00 00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO 1.01 3, 492 1.01 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 374, 614 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 51, 077, 654 5.00 00500 ADMINISTRATIVE & GENERAL 43, 305 C 43, 305 6,004,922 -16, 408, 226 5.00 7.00 00700 OPERATION OF PLANT 41, 115 41, 115 634, 581 0 7.00 00800 LAUNDRY & LINEN SERVICE 1.906 1.906 8 00 Ω 42 017 0 8 00 00900 HOUSEKEEPI NG 9.00 3, 341 C 3, 341 658, 503 0 9.00 6, 293 10.00 01000 DI ETARY 6, 293 443, 446 0 10.00 11.00 01100 CAFETERI A 2,545 2,545 210, 780 0 11.00 01300 NURSING ADMINISTRATION 2, 234 13 00 13 00 2 234 422, 458 0 14.00 01400 CENTRAL SERVICES & SUPPLY 3,096 0 3,096 77, 940 0 14.00 01500 PHARMACY 2, 301 2, 301 755, 691 0 15.00 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 507, 392 16.00 292 292 0 01700 SOCIAL SERVICE 17 00 0 Ω 0 0 0 17.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 0 0 19.00 23.00 02300 RADI OLOGY SCHOOL 0 120, 287 0 23.00 661 661 02301 HUB SITE - 3RD YEAR MED STUDENTS O 23 01 23 01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 39, 802 39, 802 0 30.00 3, 863, 139 31.00 03100 INTENSIVE CARE UNIT 1,674 0 1.674 988, 148 0 31.00 04300 NURSERY 1,955 0 1, 955 438, 497 43.00 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 17, 582 17, 582 1, 843, 118 0 50.00 0 05100 RECOVERY ROOM 1, 375 1, 375 291, 130 51.00 51.00 0 0 05200 DELIVERY ROOM & LABOR ROOM 52 00 0 0 515, 521 0 52.00 53.00 05300 ANESTHESI OLOGY 130 0 130 1, 123, 859 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54 00 10,841 10,841 2, 577, 682 54.00 54.01 03630 ULTRA SOUND 0 101, 329 0 54.01 0 0 03450 NUCLEAR MEDICINE - DIAGNOSTIC 54 02 483 C 483 66, 736 0 54.02 55.00 03480 ONCOLOGY 1, 209, 102 0 55.00 12, 370 12, 370 05700 CT SCAN 57 00 895 0 895 204, 567 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 1,080 58.00 0 1,080 126, 251 58.00 0 05900 CARDI AC CATHETERI ZATI ON 59.00 854 0 854 150, 466 0 59.00 6, 239 60.00 06000 LABORATORY 6, 239 1, 310, 271 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 279 279 62.00 0 62.00 06500 RESPIRATORY THERAPY 1, 197 0 1, 197 593 450 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 14, 157 C 14, 157 1, 661, 478 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 67.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 68.00 68.00 06900 ELECTROCARDI OLOGY 69.00 0 C 0 0 0 69.00 69.01 03610 SLEEP LAB 839 839 133, 708 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 0 0 71.00 0 0 07101 IV SOLUTIONS 71 01 71 01 0 C 0 0 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 C 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 0 0 0 73.00 03140 CARDI OLOGY 425, 277 76.00 6.047 0 6.047 0 76.00 07697 CARDIAC REHABILITATION 76. 97 703 703 69, 315 0 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 760 760 124, 155 0 90.00 09100 EMERGENCY 13 879 C 13,879 1, 552, 785 Ω 91 00 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 4, 732 1, 410, 886 0 95.00 4,732 101.00 10100 HOME HEALTH AGENCY 0 101.00 2,748 2.748 919,060 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 744 744 55, 293 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 118.00 244, 962 3, 492 -16, 408<u>, 226</u> 118. 00 248, 454 31, 633, 240 190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 190. 00 194. 00 07950 OTHER NON-REI MBURSABLE C 0 194.00 0 C 0 194. 01 07951 MOB 0 194.01 47.316 0 47, 316 1, 650, 651 194. 02 07952 PHYSICIAN CLINICS 34, 709 34, 709 5, 074, 390 0 194. 02

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334, 867

4, 127, 276

0 194.03

0 194.04

0 194.05

0 194.06

194. 03 07953 PHYS PRAC BUS OFC

194. 04 07954 MOB - MAIN CAMPUS

194. 05 07955 ONCOLOGY - NONREI MBURSABLE

194.06 07956 KDH - MC FAMILY PRACTICE

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

						o 12/31/2017	Date/Time Pre 5/23/2018 1:1	
			CAPI	TAL RELATED CO	STS			
	Cost Center Description	ı	NEW BLDG &	NEW BLDG &	NEW MVBLE		Reconciliatio	
			FLXT	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	
194	1.07 07957 KDH - MC ORTHOPEDICS		0	0	(3, 891, 036	0	194. 07
194	1.08 07958 KDH - MC GENERAL SURGER	Y	0	0	(1, 196, 562	0	194. 08
194	1.09 07959 KDH - MC ENT		0	0	(696, 330	0	194. 09
194	1.10 07960 KDH - MC UROLOGY		0	0	(103, 868	0	194. 10
194	1.1107961 KDH - MC OB/GYN		0	0	(1, 728, 065	0	194. 11
200	0.00 Cross Foot Adjustments							200.00
201	1.00 Negative Cost Centers							201.00
202	2.00 Cost to be allocated (p	er Wkst. B,	12, 809, 336	7, 897	(11, 939, 556		202. 00
	Part I)							
	3.00 Unit cost multiplier (W	kst. B, Part I)	34. 515162	2. 261455	0. 000000	0. 233753		203. 00
204	1.00 Cost to be allocated (p	er Wkst. B,				0		204. 00
	Part II)							
205	5.00 Unit cost multiplier (W	kst. B, Part				0. 000000		205. 00
00/								00/ 00
206	NAHE adjustment amount	to be allocated						206. 00
207	(per Wkst. B-2) 7.00 NAHE unit cost multipli	or (Wkst D						207. 00
207	7.00 NAHE unit cost multipli Parts III and IV)	ei (WKSt. D,						207.00
	raits ill allu IV)							I

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 15-0069

				Τ̈́	o 12/31/2017	Date/Time Pre	
	Cost Center Description	ADMI NI STRATI V	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	Z pili
		E & GENERAL (ACCUM.	PLANT (SQUARE	LINEN SERVICE (POUNDS OF	(HOURS OF SERVICE)	(MEALS SERVED)	
		COST)	FEET)	LAUNDRY)	SERVICE)	JERVED)	
	CENEDAL SEDVICE COST CENTEDS	5. 00	7. 00	8. 00	9. 00	10. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 01	00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO						1. 01
2. 00 4. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	92, 566, 762					5.00
7. 00	00700 OPERATION OF PLANT	4, 445, 062	290, 194				7. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	402, 586 1, 372, 629	1, 906 3, 341		50, 743		8. 00 9. 00
10.00	01000 DI ETARY	1, 042, 173	6, 293		0	52, 920	
11.00	01100 CAFETERI A	113, 512	2, 545		O	0	11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	569, 430 204, 813	2, 234 3, 096		0 498	0	13. 00 14. 00
15. 00	01500 PHARMACY	1, 433, 428	2, 301		871	0	15. 00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	871, 984	292 0	•	0	0	16. 00 17. 00
17.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0			0	19.00
23. 00	02300 RADI OLOGY SCHOOL	139, 347	661	0	72	0	23. 00
23. 01	02301 HUB SITE - 3RD YEAR MED STUDENTS INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	23. 01
30.00	03000 ADULTS & PEDIATRICS	6, 224, 268	39, 802	140, 158	23, 826	49, 477	30.00
31.00	03100 NTENSIVE CARE UNIT	1, 283, 230	1, 674		1, 248	3, 443	
43. 00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	621, 875	1, 955	7, 362	210	0	43.00
50.00	05000 OPERATING ROOM	3, 550, 291	17, 582		5, 344	0	50. 00
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	216, 433 651, 781	1, 375 0		0 703	0	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	167, 789	130		0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 426, 393	10, 841		1, 610	0	54.00
54. 01 54. 02	03630 ULTRA SOUND 03450 NUCLEAR MEDICINE - DIAGNOSTIC	144, 755 305, 809	0 483	-,	305 103	0	54. 01 54. 02
55. 00	03480 ONCOLOGY	2, 034, 528	12, 370		2, 341	0	55. 00
57.00	05700 CT SCAN	562, 489	895		201	0	57.00
58. 00 59. 00	05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON	324, 931 224, 501	1, 080 854		165 423	0	58. 00 59. 00
60.00	06000 LABORATORY	3, 440, 840	6, 239	•	1, 408	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	304, 243	279	•	0	0	62.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	791, 548 2, 628, 117	1, 197 14, 157		0 610	0	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	o	0	67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0		0	0	68. 00 69. 00
69. 01	03610 SLEEP LAB	267, 476	839	-	· - 1	0	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 501, 663	0		O	0	71.00
71. 01 72. 00	07101 V SOLUTIONS 07200 MPL. DEV. CHARGED TO PATIENTS	110, 676 4, 537, 480	0		0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	8, 182, 618		0	Ö	0	73. 00
76. 00	03140 CARDI OLOGY 07697 CARDI AC REHABI LI TATI ON	817, 315	6, 047 703		214 244	0	76. 00 76. 97
70. 97	OUTPATIENT SERVICE COST CENTERS	116, 545	703		244	0	70.97
		180, 270	760		261	0	90.00
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 694, 642	13, 879	65, 479	3, 535	0	91. 00 92. 00
	OTHER REIMBURSABLE COST CENTERS						72.00
	09500 AMBULANCE SERVI CES	2, 051, 232	4, 732		0		95.00
101.00	D10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	1, 235, 259	2, 748	0	0	0	101. 00
	11300 I NTEREST EXPENSE						113. 00
116. 00 118. 00) 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	135, 546 60, 329, 507	744 164, 034	•	0 44, 768	0 52, 920	116.00
110.00	NONREI MBURSABLE COST CENTERS	00, 327, 307	104, 034	430, 023	44, 700	32, 720	1110.00
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0		190.00
	007950 OTHER NON-REIMBURSABLE	3, 941, 944	0 47, 316		0		194. 00 194. 01
194. 02	07952 PHYSICIAN CLINICS	8, 887, 216	34, 709	2, 345	Ö	0	194. 02
	307953 PHYS PRAC BUS OFC 407954 MOB - MAIN CAMPUS	1, 575, 750 417, 320	989 0	•	0 5, 975		194. 03 194. 04
	07955 ONCOLOGY - NONREI MBURSABLE	417, 320	0	0	0, 9/5		194. 04 194. 05
194.06	07956 KDH - MC FAMILY PRACTICE	6, 641, 877	43, 146	110	o	0	194. 06
	707957 KDH - MC ORTHOPEDICS 307958 KDH - MC GENERAL SURGERY	4, 865, 781 1, 721, 447	0		0		194. 07 194. 08
	07959 KDH - MC ENT	746, 557	0		0		194. 09
		,					

Health Financial Systems	KING'S DAUGHTERS' I	HOSPI TAL		In Lieu	of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASI	F	Provi der (CCN: 15-0069	Period: From 01/01/2017	Worksheet B-1

				To	o 12/31/2017	Date/Time Pre 5/23/2018 1:1	
	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. 10 07960	KDH - MC UROLOGY	726, 272	0	0	0	0	194. 10
194. 11 07961	KDH - MC OB/GYN	2, 713, 091	0	1, 832	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, 408, 226	5, 232, 985	508, 318	1, 676, 185	1, 340, 387	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 177258	18. 032713	1. 145751	33. 032832	25. 328553	203. 00
204.00	Cost to be allocated (per Wkst. B,	1, 494, 679	1, 490, 865	82, 079	154, 643	266, 362	204.00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 016147	5. 137477	0. 185006	3. 047573	5. 033296	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)						

Health Financial Systems KING'S DAUGHTERS' HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0069 Peri od: Worksheet B-1 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/23/2018 1:12 pm 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 771, 699 11.00 13.00 01300 NURSING ADMINISTRATION 363, 824 13.00 01400 CENTRAL SERVICES & SUPPLY 5, 590 9, 338, 171 14.00 14.00 C 01500 PHARMACY 20, 895 15.00 C 22, 123 100 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 24,655 C 7, 456 0 283, 852, 461 16.00 01700 SOCIAL SERVICE 17.00 0 0 0 0 17.00 0 01900 NONPHYSICIAN ANESTHETISTS 19 00 0 19 00 \cap C \cap 0 23.00 02300 RADI OLOGY SCHOOL 4, 154 C 1,047 0 0 23.00 02301 HUB SITE - 3RD YEAR MED STUDENTS 23.01 0 0 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 158, 925 158, 925 136,001 0 9, 893, 895 30.00 31.00 03100 INTENSIVE CARE UNIT 56, 318 56, 318 498 0 2, 622, 289 31.00 04300 NURSERY 43.00 13, 737 13, 737 1, 411, 072 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 46, 436 46, 436 4, 767, 809 28, 807, 802 50.00 05100 RECOVERY ROOM 8,772 8, 772 0 5, 955, 982 51.00 3, 242 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 16, 151 16, 151 1,617,375 52.00 0 0 05300 ANESTHESI OLOGY 53 00 6, 215 13, 559 6, 208, 131 53 00 C 54.00 05400 RADI OLOGY-DI AGNOSTI C 50, 475 C 58, 091 6, 900, 108 54.00 03630 ULTRA SOUND 2,686 14, 129 0 1, 767, 993 54.01 0 54.01 54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 2, 493 0 2, 137 0 0 5, 459, 702 54.02 03480 ONCOLOGY 28.572 55 00 Ω 6, 550, 376 14, 216 55 00 57.00 05700 CT SCAN 7, 909 0 119,040 14, 802, 692 57.00 o 05800 MAGNETIC RESONANCE IMAGING (MRI) 3, 880, 563 58.00 3,862 16, 264 58.00 1, 892, 584 59.00 05900 CARDI AC CATHETERI ZATI ON 4.863 0 3, 790 0 0 59.00 28, 421, 223 06000 LABORATORY 36, 677 60.00 64,086 C 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 1, 961, 390 62.00 65 00 06500 RESPIRATORY THERAPY 22, 980 37, 424 0 7, 324, 068 65.00 0 06600 PHYSI CAL THERAPY 55, 997 11, 043, 177 66.00 9,679 66,00 06700 OCCUPATI ONAL THERAPY 67.00 0 0 Λ 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 0 06900 ELECTROCARDI OLOGY 69.00 0 69.00 0 0 0 03610 SLEEP LAB 69.01 3.664 0 117 1, 708, 227 69.01 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 3, 501, 834 11, 658, 522 71.00 71 01 07101 IV SOLUTIONS 0 110, 676 0 2, 449, 919 71.01 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 0 18, 735, 903 72.00 0 0 0 72.00 73.00 Λ C 0 100 61, 832, 039 73 00 03140 CARDI OLOGY 17, 711 10, 298, 129 76.00 4,609 76.00 07697 CARDIAC REHABILITATION 76. 97 3,088 329 615, 693 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 3.496 545 0 152, 327 90.00 91.00 09100 EMERGENCY 63, 485 63, 485 36, 663 25, 242, 147 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 74, 484 0 10, 220 0 4, 639, 133 95.00 101.00 10100 HOME HEALTH AGENCY 0 23, 895 0 0 101.00 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 771, 699 363, 824 8, 952, 070 100 283, 852, 461 118. 00 NONREI MBURSABLE COST CENTERS 0 190, 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 194.00 07950 OTHER NON-REIMBURSABLE 0 0 0 0 0 194.00 0 194. 01 07951 MOB 0 0 194. 01 0 27, 795 0 194. 02 07952 PHYSICIAN CLINICS 0 194. 02 Ω 92,686 194. 03 07953 PHYS PRAC BUS OFC 0 0 12, 511 0 0 194.03 194. 04 07954 MOB - MAIN CAMPUS o 0 194.04 0 0 0 13, 927

0

0 194. 05

0 194.06

0 194.07

0 194.08

0

0

0

21, 768

106, 674

61,520

194. 05 07955 ONCOLOGY - NONREI MBURSABLE

194.06 07956 KDH - MC FAMILY PRACTICE

194.08 07958 KDH - MC GENERAL SURGERY

194. 07 07957 KDH - MC ORTHOPEDICS

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

From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/23/2018 1:12 pm Cost Center Description CAFETERI A NURSI NG CENTRAL PHARMACY MEDI CAL (MEALS ADMI NI STRATI O SERVICES & (COSTED RECORDS & SERVED) SUPPLY REQUIS.) LI BRARY (DI RECT (COSTED (GROSS NRŜI NG HRS) REQUIS.) CHARGES) 15.00 11.00 13. 00 14.00 16.00 194.09 07959 KDH - MC ENT 4, 490 0 194. 09 194. 10 07960 KDH - MC UROLOGY 194. 11 07961 KDH - MC OB/GYN 0 0 194. 10 20, 073 0 0 0 0 194. 11 24, 657 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 1, 037, 803 202. 00 Cost to be allocated (per Wkst. B, 179, 526 314, 697 202.00 710, 651 1, 763, 387 Part I) 203.00 1. 953282 0.003656 203.00 Unit cost multiplier (Wkst. B, Part I) 0. 232637 0.033700 17, 633. 870000 204.00 Cost to be allocated (per Wkst. B, 102, 749 97, 779 128, 248 119, 803 28, 661 204. 00 Part II) 205.00 0.000101 205.00 Unit cost multiplier (Wkst. B, Part 0. 117678 0. 268754 0.013734 1, 198. 030000 11) 206.00 NAHE adjustment amount to be allocated 206. 00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00 207.00 Parts III and IV)

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

COST ALLOCATION - STATISTICAL BASIS	KING 3 DAGGITI	Provi der C		Peri od:	Worksheet B-1
				rom 01/01/2017 o 12/31/2017	Date/Time Prepared: 5/23/2018 1:12 pm
Cost Center Description	SOCI AL SERVI CE (TI ME SPENT)	NONPHYSI CI AN ANESTHETI STS (ASSI GNED TI ME)	RADI OLOGY SCHOOL (ASSI GNED TI ME)	HUB SITE - 3RD YEAR MED STUDENTS (ASSIGNED	372372016 1. 12 piii
	,	,	,	TIME)	
GENERAL SERVICE COST CENTERS	17. 00	19. 00	23. 00	23. 01	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.01 00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO 2.00 00200 NEW CAP REL COSTS-MYBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DIETARY 11.00 01100 CAFETERIA					1. 00 1. 01 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00
13. 00 01300 NURSI NG ADMINISTRATION 14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 19. 00 01900 NONPHYSICIAN ANESTHETISTS 23. 00 02300 RADIOLOGY SCHOOL 23. 01 02301 HUB SITE - 3RD YEAR MED STUDENTS INPATIENT ROUTINE SERVICE COST CENTERS	•	0 0	1,000	0	13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 23. 00 23. 01
30. 00 03000 ADULTS & PEDIATRICS		0) C	0	30.00
31.00 03100 INTENSIVE CARE UNIT 43.00 04300 NURSERY ANCILLARY SERVICE COST CENTERS	•	0 0	•		31. 00 43. 00
50. 00 OPERATING ROOM		0	C	0	50.00
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM				-	51. 00 52. 00
53. 00 05300 ANESTHESI OLOGY					53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 03630 ULTRA SOUND		0	1,000	0	54. 00 54. 01
54. 02 03450 NUCLEAR MEDICINE - DI AGNOSTI C				0	54. 02
55. 00 03480 0NCOLOGY		0) c	0	55.00
57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)					57. 00 58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		o o	Ö	o o	59.00
60. 00 06000 LABORATORY		0	C	0	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 65. 00 06500 RESPIRATORY THERAPY					62. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY		o o	C	O	66.00
67. 00 06700 OCCUPATIONAL THERAPY		0		0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY					68. 00 69. 00
69. 01 03610 SLEEP LAB		0	C	0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.01 07101 IV SOLUTIONS				0	71. 00 71. 01
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		o o		o o	72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS 76. 00 03140 CARDI OLOGY		0	C	0	73. 00 76. 00
76. 00 03140 CARDI OLOGT 76. 97 07697 CARDI AC REHABI LI TATI ON				0	
OUTPATIENT SERVICE COST CENTERS					00.00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY		o 0	1		90.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					92. 00
95. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 O9500 AMBULANCE SERVI CES	1	o lc	ol c	ol ol	95. 00
101.00 10100 HOME HEALTH AGENCY	•			1	
SPECIAL PURPOSE COST CENTERS		T	I		112.00
113. 00 11300 I NTEREST EXPENSE 116. 00 11600 HOSPI CE			C	o	113. 00 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)		0	1,000		
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN		o lo) (0	190. 00
194. 00 07950 OTHER NON-REIMBURSABLE					194. 00
194. 01 07951 MOB		0	C	0	194. 01
194. 02 07952 PHYSI CI AN CLI NI CS 194. 03 07953 PHYS PRAC BUS 0FC					194. 02 194. 03
194.04 07954 MOB - MAIN CAMPUS		o o		o o	194.04
194. 05 07955 ONCOLOGY - NONREI MBURSABLE		0	C	0	194. 05
194.06 07956 KDH - MC FAMILY PRACTICE 194.07 07957 KDH - MC ORTHOPEDICS					194. 06 194. 07
194.08 07958 KDH - MC GENERAL SURGERY		0) c	o	194. 08

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0069	Peri od: From 01/01/2017	Worksheet B-1
				Date/Time Prepared

				T	o 12/31/2017	Date/Time Prepared: 5/23/2018 1:12 pm
	Cost Center Description	SOCI AL SERVI CE (TI ME SPENT)	NONPHYSI CI AN ANESTHETI STS (ASSI GNED TI ME)	RADI OLOGY SCHOOL (ASSI GNED TI ME)	HUB SITE - 3RD YEAR MED STUDENTS (ASSIGNED TIME)	372372010 1. 12 piii
	I and the second	17. 00	19. 00	23. 00	23. 01	
	PKDH - MC ENT	0	0	0	0	194. 09
	KDH - MC UROLOGY	0	0	0	0	194. 10
194. 11 07961	KDH - MC OB/GYN	0	0	0	0	194. 11
200.00	Cross Foot Adjustments					200. 00
201.00	Negative Cost Centers					201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	0	0	179, 346	0	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	179. 346000	0. 000000	203.00
204. 00	Cost to be allocated (per Wkst. B, Part II)	0	0	29, 183	0	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	29. 183000	0. 000000	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)			0	0	206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)			0. 000000	0. 000000	207. 00

Health Financial Systems	KING'S DAUGHTERS' HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCI	Worksheet C 01/2017 Part I
		31/2017 Date/Time Prepared

					To 12/31/2017	Date/Time Pre 5/23/2018 1:1	pared:
			Title	XVIII	Hospi tal	PPS	2 piii
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col . 26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
1.1	NPATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDIATRICS	10, 634, 268		10, 634, 268	3 0	10, 634, 268	30.00
	3100 INTENSIVE CARE UNIT	1, 802, 022		1, 802, 022			31.00
	4300 NURSERY	817, 920		817, 920		817, 920	
	NCILLARY SERVICE COST CENTERS				-1		1
	5000 OPERATING ROOM	5, 142, 740		5, 142, 740	0	5, 142, 740	50.00
	5100 RECOVERY ROOM	333, 365		333, 365		333, 365	1
	5200 DELIVERY ROOM & LABOR ROOM	841, 669		841, 669		841, 669	52.00
	5300 ANESTHESI OLOGY	224, 475		224, 475		224, 475	
	5400 RADI OLOGY-DI AGNOSTI C	3, 355, 063		3, 355, 063		3, 355, 063	
	3630 ULTRA SOUND	191, 585		191, 585		191, 585	
	3450 NUCLEAR MEDICINE - DIAGNOSTIC	394, 924		394, 924		394, 924	1
	3480 ONCOLOGY	2, 741, 095		2, 741, 095	1	2, 741, 095	
	5700 CT SCAN	760, 468		760, 468		760, 468	1
	5800 MAGNETIC RESONANCE IMAGING (MRI)	426, 574		426, 574	1	426, 574	
	5900 CARDI AC CATHETERI ZATI ON	301, 847		301, 847		301, 847	59.00
	6000 LABORATORY	4, 329, 825		4, 329, 825		4, 329, 825	
	6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	370, 375		370, 375		370, 375	
	6500 RESPIRATORY THERAPY	986, 825	0			986, 825	1
	6600 PHYSI CAL THERAPY	3, 453, 204	0			3, 453, 204	66.00
	6700 OCCUPATI ONAL THERAPY	3, 433, 204	0	3, 433, 20	1	0, 455, 204	67.00
	6800 SPEECH PATHOLOGY		0			0	68.00
	6900 ELECTROCARDI OLOGY		O		-	0	69.00
	3610 SLEEP LAB	358, 167		358, 167	-	358, 167	69. 01
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 282, 997		4, 282, 997	-	4, 282, 997	
	7100 MEDICAL SUPPLIES CHARGED TO PATTENTS	142, 981		142, 98		142, 981	1
	710111 SOLUTIONS 7200 IMPL. DEV. CHARGED TO PATIENTS	5, 410, 283		5, 410, 283		5, 410, 283	1
	7300 DRUGS CHARGED TO PATTENTS	1 1				11, 622, 536	1
	3140 CARDI OLOGY	11, 622, 536 1, 137, 320		11, 622, 536 1, 137, 320	1	1, 137, 320	
	7697 CARDI AC REHABI LI TATI ON	1, 137, 320		1, 137, 320		1, 137, 320	
	JTPATIENT SERVICE COST CENTERS	100, 921		100, 92	II U	100, 921	70.97
	9000 CLINIC	235, 948		235, 948	3 0	235, 948	90.00
	9100 EMERGENCY	3, 846, 653		3, 846, 653		4, 014, 337	91.00
		1					
	9200 OBSERVATION BEDS (NON-DISTINCT PART) THER REIMBURSABLE COST CENTERS	2, 048, 163		2, 048, 163		2, 048, 163	92.00
	9500 AMBULANCE SERVICES	2, 546, 561		2, 546, 56	277	2 544 020	05 00
	0100 HOME HEALTH AGENCY	1				2, 546, 838	
		1, 504, 578		1, 504, 578	3	1, 504, 578	1101.00
	PECIAL PURPOSE COST CENTERS	1			1		112 00
	1300 I NTEREST EXPENSE	172 000		170 000			113.00
	1600 HOSPI CE	172, 989	0	172, 989		172, 989	
200.00	Subtotal (see instructions)	70, 578, 341	0			70, 746, 302	
201.00	Less Observation Beds	2, 048, 163	^	2, 048, 163		2, 048, 163	
202.00	Total (see instructions)	68, 530, 178	0	68, 530, 178	167, 961	68, 698, 139	1202.00

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	From 01/01/2017	Worksheet C Part I Date/Time Prepared:

				Го 12/31/2017	Date/Time Pre 5/23/2018 1:1	
		Title	XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
			+ col. 7)	Rati o	I npati ent	
		7.00		0.00	Ratio	
INDATIONE DOUTING CODY OF COCT CENTERS	6. 00	7. 00	8. 00	9. 00	10. 00	
30.00 O3000 ADULTS & PEDIATRICS	9, 893, 895		9, 893, 89	-1		30.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	2, 622, 289		2, 622, 28			31.00
43. 00 04300 NURSERY	1, 411, 072		1, 411, 07			43.00
ANCI LLARY SERVI CE COST CENTERS	1,411,072		1,411,07.	<u> </u>		43.00
50. 00 05000 OPERATING ROOM	7, 719, 194	21, 088, 608	28, 807, 80	0. 178519	0. 000000	50.00
51. 00 05100 RECOVERY ROOM	1, 798, 944	4, 157, 038			0. 000000	1
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 617, 375	1, 107, 000			0. 000000	1
53. 00 05300 ANESTHESI OLOGY	2, 291, 436	3, 916, 695			0. 000000	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 306, 280	5, 593, 828			0. 000000	1
54. 01 03630 ULTRA SOUND	223, 125	1, 544, 868	1, 767, 99		0. 000000	
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	346, 476	5, 113, 226			0. 000000	
55. 00 03480 0NC0L0GY	100, 690	6, 449, 686			0. 000000	1
57. 00 05700 CT SCAN	2, 300, 959	12, 501, 733			0. 000000	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	301, 672	3, 578, 891	3, 880, 56		0. 000000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	234, 104	1, 658, 480	1, 892, 58	0. 159489	0.000000	59.00
60. 00 06000 LABORATORY	5, 116, 227	23, 304, 996	28, 421, 22	0. 152345	0.000000	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	979, 934	981, 456	1, 961, 39	0. 188833	0.000000	62.00
65. 00 06500 RESPIRATORY THERAPY	5, 438, 673	1, 885, 395	7, 324, 06		0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 516, 987	9, 526, 190	11, 043, 17		0. 000000	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0. 000000	0. 000000	
68.00 06800 SPEECH PATHOLOGY	0	0		0. 000000	0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0. 000000	0. 000000	1
69. 01 03610 SLEEP LAB	0	1, 708, 227			0. 000000	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1	5, 490, 365			0. 000000	1
71. 01 07101 I V SOLUTI ONS	1, 334, 803	1, 115, 116			0. 000000	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	12, 470, 362	6, 265, 541	18, 735, 90		0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	22, 616, 401	39, 215, 638			0.000000	
76. 00 03140 CARDI OLOGY	2, 039, 241	8, 258, 888			0.000000	
76. 97 O7697 CARDI AC REHABI LI TATI ON	969	614, 724	615, 69	0. 261366	0. 000000	76. 97
90.00 OUTPATIENT SERVICE COST CENTERS 90.00 O9000 CLINIC	O	152, 327	152, 32	1. 548957	0. 000000	90.00
91. 00 09100 EMERGENCY	4, 310, 418	20, 931, 729			0.000000	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	530, 856	2, 265, 834			0.000000	
OTHER REIMBURSABLE COST CENTERS	550, 650	2, 205, 054	2, 170, 07	0.732333	0.00000	72.00
95. 00 09500 AMBULANCE SERVICES	6, 556	4, 632, 577	4, 639, 13	0. 548930	0. 000000	95.00
101.00 10100 HOME HEALTH AGENCY	0, 550	1, 840, 934			0.00000	101.00
SPECIAL PURPOSE COST CENTERS	٦	1,010,701	1,010,70	'		101.00
113. 00 11300 NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	0	388, 825	388, 82	5		116.00
200.00 Subtotal (see instructions)	94, 697, 095	194, 181, 815				200.00
201.00 Less Observation Beds		, ,				201. 00
202.00 Total (see instructions)	94, 697, 095	194, 181, 815	288, 878, 91			202.00
	, , , , , ,			. '	•	•

Heal th 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 01/01/2017
To 12/31/2017
Part I
To 12/31/2017
Part I
To 12/31/2017
Prepared:
From 201/2018 1:13

			10 12/31/2017	Date/IIme Prepar 5/23/2018 1:12 p	
		Title XVIII	Hospi tal	PPS	<u> </u>
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS				30	0.00
31. 00 03100 INTENSIVE CARE UNIT				3.	1.00
43. 00 04300 NURSERY				43	3.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM	0. 178519			50	0.00
51. 00 05100 RECOVERY ROOM	0. 055971			5	1.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 520392			52	2.00
53. 00 05300 ANESTHESI OLOGY	0. 036158			•	3.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 486233			•	4.00
54. 01 03630 ULTRA SOUND	0. 108363			•	4.01
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 072334				4. 02
55. 00 03480 0NCOLOGY	0. 418464				5.00
57. 00 05700 CT SCAN	0. 051374				7.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 109926				8.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 159489				9. 00
60. 00 06000 LABORATORY	0. 152345				0.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 188833				2.00
65. 00 06500 RESPIRATORY THERAPY	0. 134737				5.00
66. 00 06600 PHYSI CAL THERAPY	0. 312700				6.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				7. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000				8.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				9. 00
69. 01 03610 SLEEP LAB	0. 209672				9. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 367370				1.00
71. 01 07101 IV SOLUTIONS	0. 058362				1. 01
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 288766			I	2.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 187969			•	3.00
76. 00 03140 CARDI OLOGY	0. 110439				6.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 261366			•	6. 97
OUTPATIENT SERVICE COST CENTERS	0.201000			, ,	0. 77
90. 00 09000 CLI NI C	1. 548957			90	0.00
91. 00 09100 EMERGENCY	0. 159033				1.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 732353				2.00
OTHER REIMBURSABLE COST CENTERS	0. 732333			, , , , , , , , , , , , , , , , , , ,	2.00
95. 00 09500 AMBULANCE SERVICES	0. 548990			QI	5. 00
101. 00 10100 HOME HEALTH AGENCY	0.010770			•	1.00
SPECIAL PURPOSE COST CENTERS				10	50
113. 00 11300 NTEREST EXPENSE				111	3. 00
116. 00 11600 HOSPI CE				•	6. 00
200.00 Subtotal (see instructions)					0.00
201.00 Less Observation Beds					1.00
202.00 Total (see instructions)					2.00
	1			1=0.	

Health Financial Systems	KING'S DAUGHTERS' HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-006	
		From 01/01/2017 Part I

					o 12/31/2017	Date/Time Pre 5/23/2018 1:1	pared: 2 pm
			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	·	(from Wkst.	Adj .		Di sal I owance		
		B, Part I,	•				
		col. 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
I NF	PATIENT ROUTINE SERVICE COST CENTERS						
30.00 030	DOO ADULTS & PEDIATRICS	10, 634, 268		10, 634, 268	0	10, 634, 268	30.00
31.00 031	100 INTENSIVE CARE UNIT	1, 802, 022		1, 802, 022	<u> </u>	1, 802, 022	31.00
	BOO NURSERY	817, 920		817, 920	o	817, 920	43.00
ANC	CILLARY SERVICE COST CENTERS						1
	OOO OPERATING ROOM	5, 142, 740		5, 142, 740	0	5, 142, 740	50.00
51.00 051	100 RECOVERY ROOM	333, 365		333, 365	o o	333, 365	51.00
52. 00 052	200 DELIVERY ROOM & LABOR ROOM	841, 669		841, 669	o	841, 669	52.00
53.00 053	BOO ANESTHESI OLOGY	224, 475		224, 475	ol ol	224, 475	53.00
54. 00 054	400 RADI OLOGY-DI AGNOSTI C	3, 355, 063		3, 355, 063	s ol	3, 355, 063	54.00
54. 01 036	630 ULTRA SOUND	191, 585		191, 585	ol ol	191, 585	54.01
54. 02 034	450 NUCLEAR MEDICINE - DIAGNOSTIC	394, 924		394, 924	ıl ol	394, 924	54.02
55. 00 034	480 ONCOLOGY	2, 741, 095		2, 741, 095	ol ol	2, 741, 095	55.00
57. 00 057	700 CT SCAN	760, 468		760, 468	sl ol	760, 468	57.00
58. 00 058	BOO MAGNETIC RESONANCE IMAGING (MRI)	426, 574		426, 574	ıl ol	426, 574	58.00
	900 CARDI AC CATHETERI ZATI ON	301, 847		301, 847	ol	301, 847	59.00
60.00 060	DOO LABORATORY	4, 329, 825		4, 329, 825	ol ol	4, 329, 825	60.00
62. 00 062	200 WHOLE BLOOD & PACKED RED BLOOD CELLS	370, 375		370, 375	ol ol	370, 375	62.00
	500 RESPIRATORY THERAPY	986, 825	0			986, 825	1
	500 PHYSI CAL THERAPY	3, 453, 204	0			3, 453, 204	
	700 OCCUPATI ONAL THERAPY	0	0	(0	1
	BOO SPEECH PATHOLOGY	O	0		ol ol	0	68.00
	900 ELECTROCARDI OLOGY	O			ol ol	0	69.00
	S10 SLEEP LAB	358, 167		358, 167	ol ol	358, 167	69. 01
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 282, 997		4, 282, 997		4, 282, 997	1
	101 IV SOLUTIONS	142, 981		142, 98		142, 981	1
	200 IMPL. DEV. CHARGED TO PATIENTS	5, 410, 283		5, 410, 283		5, 410, 283	1
	BOO DRUGS CHARGED TO PATIENTS	11, 622, 536		11, 622, 536		11, 622, 536	1
	140 CARDI OLOGY	1, 137, 320		1, 137, 320	-	1, 137, 320	
	697 CARDI AC REHABI LI TATI ON	160, 921		160, 92		160, 921	1
	FPATIENT SERVICE COST CENTERS	1007721		100/ /2	91	100,721	1
	DOO CLINIC	235, 948		235, 948	s ol	235, 948	90.00
•	100 EMERGENCY	3, 846, 653		3, 846, 653		4, 014, 337	1
•	200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 048, 163		2, 048, 163		2, 048, 163	1
	HER REIMBURSABLE COST CENTERS	2,010,100		2,010,100	<u>′</u> 11	2,010,100	72.00
	500 AMBULANCE SERVICES	2, 546, 561		2, 546, 56	277	2, 546, 838	95.00
	100 HOME HEALTH AGENCY	1, 504, 578		1, 504, 578		1, 504, 578	
	ECLAL PURPOSE COST CENTERS	1,001,070		1,001,070	1	1, 55 1, 576	1.51.55
	BOO INTEREST EXPENSE						113.00
	500 HOSPI CE	172, 989		172, 989	,	172, 989	
200. 00	Subtotal (see instructions)	70, 578, 341	0			70, 746, 302	
201. 00	Less Observation Beds	2, 048, 163	0	2, 048, 163		2, 048, 163	1
202. 00	Total (see instructions)	68, 530, 178	0				
202.00	Tiotal (See Thisti de Crons)	00, 000, 170	U	1 00, 550, 170	, 107, 901	00, 070, 137	1202.00

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0069	Peri od: From 01/01/2017	Worksheet C Part I

					To 12/31/2017	Date/Time Pre 5/23/2018 1:1	pared:
			Ti tl	e XIX	Hospi tal	Cost	<u> </u>
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	·	'	·	+ col . 7)	Ratio	I npati ent	
				,		Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	9, 893, 895		9, 893, 89	5		30.00
31.00	03100 INTENSIVE CARE UNIT	2, 622, 289		2, 622, 28	9		31.00
43.00	04300 NURSERY	1, 411, 072		1, 411, 07	2		43.00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	7, 719, 194	21, 088, 608	28, 807, 80	0. 178519	0.000000	50.00
51.00	05100 RECOVERY ROOM	1, 798, 944	4, 157, 038	5, 955, 98	0. 055971	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 617, 375	0	1, 617, 37	5 0. 520392	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	2, 291, 436	3, 916, 695	6, 208, 13	0. 036158	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 306, 280	5, 593, 828	6, 900, 10	0. 486233	0.000000	54.00
54.01	03630 ULTRA SOUND	223, 125	1, 544, 868	1, 767, 99	0. 108363	0.000000	54. 01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	346, 476	5, 113, 226	5, 459, 70	0. 072334	0.000000	54. 02
55.00	03480 ONCOLOGY	100, 690	6, 449, 686	6, 550, 37	6 0. 418464	0.000000	55.00
57.00	05700 CT SCAN	2, 300, 959	12, 501, 733	14, 802, 69	0. 051374	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	301, 672	3, 578, 891	3, 880, 56	0. 109926	0.000000	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	234, 104	1, 658, 480	1, 892, 58	0. 159489	0.000000	59.00
60.00	06000 LABORATORY	5, 116, 227	23, 304, 996	28, 421, 22	0. 152345	0.000000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	979, 934	981, 456	1, 961, 39	0. 188833	0.000000	62.00
65.00	06500 RESPI RATORY THERAPY	5, 438, 673	1, 885, 395	7, 324, 06	0. 134737	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	1, 516, 987	9, 526, 190	11, 043, 17	7 0. 312700	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0. 000000	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	O	0		0. 000000	0.000000	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0. 000000	0.000000	69.00
69. 01	03610 SLEEP LAB	0	1, 708, 227	1, 708, 22	7 0. 209672	0.000000	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 168, 157	5, 490, 365	11, 658, 52	0. 367370	0. 000000	71.00
71. 01	07101 IV SOLUTIONS	1, 334, 803	1, 115, 116	2, 449, 91	9 0. 058362	0.000000	71.01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	12, 470, 362	6, 265, 541			0. 000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	22, 616, 401	39, 215, 638			0. 000000	73.00
76.00	03140 CARDI OLOGY	2, 039, 241	8, 258, 888			0. 000000	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	969	614, 724	615, 69	0. 261366	0.000000	76. 97
	OUTPATIENT SERVICE COST CENTERS	•					1
90.00	09000 CLI NI C	0	152, 327	152, 32	7 1. 548957	0.000000	90.00
91.00	09100 EMERGENCY	4, 310, 418	20, 931, 729	25, 242, 14	7 0. 152390	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	530, 856	2, 265, 834	2, 796, 69	0. 732353	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						1
	09500 AMBULANCE SERVICES	6, 556	4, 632, 577	4, 639, 13	0. 548930	0.000000	95. 00
101.00	10100 HOME HEALTH AGENCY	0	1, 840, 934	1, 840, 93	4		101.00
	SPECIAL PURPOSE COST CENTERS						1
113.00	11300 INTEREST EXPENSE						113.00
116.00	11600 H0SPI CE	0	388, 825	388, 82	5		116.00
200.00	Subtotal (see instructions)	94, 697, 095	194, 181, 815	288, 878, 91	0		200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	94, 697, 095	194, 181, 815	288, 878, 91	0		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 01/01/2017
To 12/31/2017
Date/Time Prepared:
5/23/2018 1: 12 pm

				5/23/2018 1:12 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 000000			50.00
51.00 05100 RECOVERY ROOM	0. 000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
54.01 03630 ULTRA SOUND	0. 000000			54. 01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 000000			54. 02
55. 00 03480 ONCOLOGY	0. 000000			55.00
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 AC REHABI LI TATI ON	0. 000000			76. 97
OUTPATIENT SERVICE COST CENTERS	<u> </u>			
90. 00 09000 CLI NI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS	<u>'</u>			
95. 00 09500 AMBULANCE SERVICES	0. 000000			95.00
101.00 10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS	<u>'</u>			
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
• • • • • • • • • • • • • • • • • • • •				1

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 C		Peri od:	Worksheet D	
				From 01/01/2017	Part I	
				To 12/31/2017	Date/Time Pre 5/23/2018 1:1	
		Ti +l o	xVIII	Hospi tal	972372016 1. I	z piii
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
COST Center Description	Related Cost	Adjustment	Capi tal		(col. 3 /	
		Auj us tillerit		Days		
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col . 26)		col . 2)	4.00		
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	,		,			
30.00 ADULTS & PEDIATRICS	2, 090, 615	0	2, 090, 61			1
31.00 INTENSIVE CARE UNIT	130, 266		130, 26	1, 248	104. 38	31.00
43. 00 NURSERY	95, 016		95, 01	6 1, 127	84. 31	43.00
200.00 Total (lines 30 through 199)	2, 315, 897		2, 315, 89	7 15, 080		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	<u> </u>					
30. 00 ADULTS & PEDIATRICS	6, 199	1, 020, 045				30.00
31.00 INTENSIVE CARE UNIT	771	80, 477	1			31.00
43. 00 NURSERY	0	00,				43.00
200.00 Total (lines 30 through 199)	6, 970	1, 100, 522				200.00
			•			

Health Financial Sys	items	KING'S DAUGHTE	ERS' HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INP	PATIENT ANCILLARY SERVICE CAPI	TAL COSTS	Provi der C		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Pre 5/23/2018 1:1	
			Title	e XVIII	Hospi tal	PPS	
Cost Cen	nter Description	Capital Related Cost (from Wkst.	Total Charges (from Wkst. C, Part I,		t Inpatient Program Charges	Capital Costs (column 3 x column 4)	

						5/23/2018 1:1	2 pm
				XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
		Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
		(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
		B, Part II,	col. 8)	col . 2)			
		col. 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	873, 596				113, 099	
51.00	05100 RECOVERY ROOM	64, 107	5, 955, 982	0. 010763	1, 009, 340	10, 864	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	20, 672	1, 617, 375	0. 01278°	7, 325	94	52.00
53.00	05300 ANESTHESI OLOGY	9, 408	6, 208, 131	0. 00151	824, 515	1, 249	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	486, 501	6, 900, 108	0. 07050	947, 566	66, 809	54.00
54.01	03630 ULTRA SOUND	4, 526	1, 767, 993			325	54. 01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	25, 629	5, 459, 702	0. 004694	255, 542	1, 200	54.02
55.00	03480 ONCOLOGY	537, 044	6, 550, 376			5, 402	55.00
57.00	05700 CT SCAN	51, 752	14, 802, 692	0. 003496	1, 665, 363	5, 822	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	50, 206	3, 880, 563	0. 012938	157, 844	2, 042	58. 00
		39, 592					
		318, 160					
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	16, 174					62.00
65.00	06500 RESPIRATORY THERAPY	64, 204					65.00
66. 00	06600 PHYSI CAL THERAPY	618, 350					66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0. 000000		0	67.00
		0	0	0. 000000		0	68.00
	06900 ELECTROCARDI OLOGY	0	0	0. 000000		0	69.00
	03610 SLEEP LAB	40, 275	1, 708, 227			0	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	105, 813				29, 913	
	07101 I V SOLUTIONS	3, 554					1
	07200 IMPL. DEV. CHARGED TO PATIENTS	75, 159					
	07300 DRUGS CHARGED TO PATIENTS	258, 164					
		259, 575					
	07697 CARDI AC REHABI LI TATI ON	30, 932					76. 97
, 0. , ,	OUTPATIENT SERVICE COST CENTERS	007702	0.07070	0.00020			70.77
90 00	09000 CLI NI C	34, 276	152, 327	0. 225010	0	0	90.00
	09100 EMERGENCY	644, 322	25, 242, 147			1	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	402, 652					
00	OTHER REIMBURSABLE COST CENTERS	1027002	_,,,,,,,,,,,	3. 1 1077	., 0,0,010	00/01/	1
95.00	09500 AMBULANCE SERVI CES						95.00
200.00		5, 034, 643	268, 082, 762		47, 288, 896	623, 612	
	, , , , , , , , , , , , , , , , , , ,	2,001,010	,,	1	, 200, 070	020,0.2	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 Co		Period: From 01/01/2017 To 12/31/2017		epared: 2 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	School	School	Post-Stepdowr	Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
43. 00 04300 NURSERY	0	0		0	0	43.00
200.00 Total (lines 30 through 199)	0	0		0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem	I npati ent	
·	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)		
	instructions)	minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	12, 70	5 0.00	6, 199	30.00
31.00 03100 INTENSIVE CARE UNIT		0	1, 24	0.00	771	31.00
43. 00 04300 NURSERY		0	1, 12	7 0.00	0	43.00
200.00 Total (lines 30 through 199)		0	15, 08	O	6, 970	200.00
Cost Center Description	Inpati ent					
·	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00
	•					

Health Financial Systems	KING'S DAUGHTERS' HO	OSPI TAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Pr		riod: Worksheet D
THROUGH COSTS		Fro	om 01/01/2017 Part IV

					To 12/31/2017	Date/Time Pre 5/23/2018 1:1	
			Title	: XVIII	Hospi tal	PPS	Ζ μιιι
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health		
	'	Anesthetist	School	School	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 0	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	179, 346	54.00
54. 01	03630 ULTRA SOUND	0	0		0 0	0	54. 01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0		0 0	0	54.02
55.00	03480 ONCOLOGY	0	0		0 0	0	55.00
57.00	05700 CT SCAN	0	0		0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60.00	06000 LABORATORY	0	0		0 0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	62.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
	06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
69. 01	03610 SLEEP LAB	0	0		0 0	0	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
71. 01	07101 IV SOLUTIONS	0	0		0 0	0	71. 01
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
	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						
	09000 CLI NI C	0	0		0	0	90.00
91.00	09100 EMERGENCY	0	0		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95.00
200.00	Total (lines 50 through 199)	0	0		0 0	179, 346	200.00

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0069	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared:

Title XVII Hospital PPS Total Cost Cost Center Description All Other Modical Education Cost Cos				'	0 12/31/2017	5/23/2018 1: 1	
Medical Education Cost Cost (Sum of col 1 through col. Col. 2, 3 and Cost (Sum of Col. 2, 3 and Col. 7)			Title	: XVIII	Hospi tal		
Education Cost Sum of Col. 2, 3 and Col. 8) Col. 7) Col.	Cost Center Description	All Other		Total		Ratio of Cost	
Cost 4)		Medi cal	(sum of col 1	Outpati ent	(from Wkst.	to Charges	
ANCILLARY SERVICE COST CENTERS		Educati on	through col.	Cost (sum of	C, Part I,	(col. 5 ÷	
A.00 5.00 6.00 7.00 8.00		Cost	4)	col . 2, 3 and	col. 8)	col. 7)	
ANCI LLARY SERVICE COST CENTERS							
50.00		4. 00	5. 00	6. 00	7. 00	8. 00	
51.00 05100 RECOVERY ROOM & LABOR ROOM 0 0 0 0 5,955,982 0,000000 51.00							
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 1,617,375 0.000000 52.00		0	0	C			
53.00 05300 AMESTHESI OLOGY 0 0 0 0 6, 208, 131 0.000000 53.00		0	0	C			
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 179, 346 179, 346 6, 900, 108 0.025992 54. 00 54. 01 3350 UITRA SOUND 0 0 0 0 0 5, 459, 702 0.000000 54. 01 54.		0	0	C		0. 000000	
54. 01 03630 ULTRA SQUID 54. 02 03450 NUCLEAR MEDICINE - DI AGNOSTIC 55. 00 03480 ONCOLOGY 0 0 0 0 5, 459, 702 0.000000 54. 01 55. 00 03480 ONCOLOGY 0 0 0 0 6, 550, 376 0.000000 55. 00 57. 00 05700 CT SCAN 0 0 0 0 0 14, 802, 692 0.000000 57. 00 58. 00 05900 OSBOO MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 14, 802, 692 0.000000 58. 00 05900 CARDIAC CATHETERIZATION 0 0 0 0 1, 892, 584 0.000000 59. 00 60. 00 06000 LABORATORY 0 0 0 0 28, 421, 223 0.000000 62. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 1, 961, 390 0.00000 62. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 11, 043, 177 0.000000 66. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 11, 043, 177 0.000000 66. 00 68. 00 06900 SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0		C			
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0 0 0 5, 459, 702 0.000000 54. 02 55. 00 03480 ONCOLOGY 0 0 0 0, 550, 376 0.000000 55. 00 57. 00 05700 CT SCAN 0 0 0 14, 802, 692 0.000000 55. 00 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 3, 880, 563 0.000000 58. 00 59. 00 05900 CARDIAC CATHETERIZATION 0 0 0 1, 892, 584 0.000000 59. 00 60. 00 06000 LABORATORY 0 0 0 0 28, 421, 233 0.000000 60. 00 60. 00 06000 LABORATORY 0 0 0 0 1, 961, 390 0.000000 62. 00 65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 1, 961, 390 0.000000 62. 00 66. 00 06600 PRISTICAL THERAPY 0 0 0 0 7, 324, 068 0.000000 65. 00 67. 00 06700 CCUPATIONAL THERAPY 0 0 0 0 11, 043, 177 0.000000 66. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0.000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0.000000 69. 00 69. 01 03610 SLEEP LAB 0 0 0 1, 708, 227 0.000000 69. 00 69. 01 03610 SLEEP LAB 0 0 0 1, 658, 522 0.000000 71. 01 71. 00 07101 IV SOLUTIONS 0 0 0 2, 449, 919 0.000000 71. 01 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 18, 735, 903 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 18, 735, 903 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 18, 735, 903 0.000000 72. 00 76. 07 07407 CARDIAC REHABILITATION 0 0 0 152, 327 0.000000 76. 07 76. 07 07407 CARDIAC REHABILITATION 0 0 0 152, 327 0.000000 90. 00		0	179, 346	179, 346	6, 900, 108	0. 025992	54.00
55.00 03480 0NCOLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0	C	1, 767, 993	0.000000	
57. 00 05700 CT SCAN 0 0 0 14,802,692 0.000000 57. 00 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 3,880,563 0.000000 58. 00 59. 00 05900 CARDIA C CATHETERIZATION 0 0 0 1,892,584 0.000000 58. 00 06000 LABORATORY 0 0 0 28,421,223 0.000000 60. 0	54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	C	5, 459, 702	0. 000000	54. 02
58. 00		0	0	C	6, 550, 376	0. 000000	55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 1,892,584 0.000000 59. 00 60. 00 06000 LABORATORY 0 0 0 28,421,223 0.000000 60. 00 0 28,421,223 0.000000 60. 00 0 0.00000 60. 00 0.000000 60. 00 0.00000 60. 00 0.00000 60. 00 0.000000 60. 00 0.000000 60. 00 0.00000 60. 00 0.00000 60. 00 0.00000 60. 00 0.000000 60. 00 0.00000 60. 00 0.000000 60. 00 0.000000 60. 00 0.0000000 6	57. 00 05700 CT SCAN	0	0	C	14, 802, 692	0.000000	57.00
60.00 06000 LABORATORY 0 0 0 28, 421, 223 0.000000 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 1, 961, 390 0.000000 62.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 7, 324, 068 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0.000000 65.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0.000000 69.00 69.01 03610 SLEEP LAB 0 0 0 1, 708, 227 0.000000 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 1, 708, 227 0.000000 71.00 71.01 07101 V SOLUTI ONS 0 0 0 2, 449, 919 0.000000 71.00 72.00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 0 0 0 18, 735, 903 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 61, 832, 039 0.000000 76.00 76.00 03140 CARDI OLOGY 0 0 0 0 152, 327 0.000000 76.00 76.00 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 25, 242, 147 0.000000 76.97 001794 O9900 CLI NI C 0 0 0 0 25, 242, 147 0.000000 91.00 92.00 09500 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 2, 796, 690 0.000000 92.00 95.00 09500 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 2, 796, 690 0.000000 92.00 95.00 09500 AMBULANCE SERVI CES	58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	C	3, 880, 563	0.000000	58.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 1, 961, 390 0.000000 62. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 7, 324, 068 0.000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 11, 043, 177 0.000000 66. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0.000000 67. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0.000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0.000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0.000000 69. 00 69. 01 03610 SLEEP LAB 0 0 0 1, 708, 227 0.000000 69. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 11, 658, 522 0.000000 71. 01 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 0 0 2, 449, 919 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 18, 735, 903 0.000000 72. 00 74. 00 03140 CARDI OLOGY 0 0 0 0 615, 693 0.000000 76. 00 75. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 615, 693 0.000000 76. 00 79. 00 09000 CLI NI C 0 0 0 0 2, 796, 690 0.000000 91. 00 79. 00 09100 EMERGENCY 0 0 0 0 2, 796, 690 0.000000 91. 00 79. 00 09500 AMBULANCE SERVI CES 95. 00 79. 00 09500 AMBULANCE SERVI CES 95. 00	59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	C	1, 892, 584	0.000000	59.00
65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 7, 324, 068 0.000000 65. 00 66. 00 06500 PHYSI CAL THERAPY 0 0 0 0 11, 043, 177 0.000000 66. 00 0 0 0700 OCCUPATI ONAL THERAPY 0 0 0 0 0 11, 043, 177 0.000000 66. 00 0 0 0 0 0.000000 66. 00 0 0 0	60. 00 06000 LABORATORY	0	0	C	28, 421, 223	0.000000	60.00
66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 11, 043, 177 0.000000 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0.000000 67. 00 68. 00 06800 SPECH PATHOLOGY 0 0 0 0 0.000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0.000000 68. 00 69. 01 03610 SLEEP LAB 0 0 0 0 0.000000 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 11, 658, 522 0.000000 71. 00 71. 01 07101 IV SOLUTI ONS 0 0 0 2, 449, 919 0.000000 71. 01 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 18, 735, 903 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 18, 335, 903 0.000000 73. 00 76. 90 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 152, 327 0.000000 76. 00 79. 00 09000 CLI NI C 0 0 0 0 25, 242, 147 0.000000 91. 00 79. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0, 796, 690 0.000000 75. 00 09500 AMBULANCE SERVI CES 95. 00 75. 00 09500 AMBULANCE SERVI CES 95. 00 75. 00 09500 AMBULANCE SERVI CES 95. 00 75. 00 00 00 00 00 0.000000 75. 00 00 00 0.000000 76. 00 00 00 0.000000 77. 00 00 00 0.000000 78. 00 00 00 0.000000 79. 00 00 00 00 0.000000 79. 00 00 00 00 0.000000 79. 00 00 00 00 0.000000 79. 00 00 00 00 0.000000 79. 00 00 00 00 00 00 79. 00 00 00 00 00 00 79. 00 00 00 00 00 79. 00 00 00 00 00 00 79. 00 00 00 00 00 00 79. 00 00 00 00 00 00 79. 00 00 00 00 00 00 00 79. 00 00 00 00 00 00 00 79. 00 00 00 00 00 00 00 79. 00 00 00 00 00 00 00 79. 00 00 00 00 00 00 00 00	62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	C	1, 961, 390	0.000000	62.00
67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0	65. 00 06500 RESPIRATORY THERAPY	0	0	C	7, 324, 068	0.000000	65.00
68. 00	66. 00 06600 PHYSI CAL THERAPY	0	0	l c	11, 043, 177	0.000000	66.00
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0	67. 00 06700 OCCUPATI ONAL THERAPY	0	0	l c	0	0.000000	67.00
69. 01 03610 SLEEP LAB 0 0 0 1, 708, 227 0. 000000 69. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 11, 658, 522 0. 000000 71. 00 71. 01 07101 I V SOLUTI ONS 0 0 0 2, 449, 919 0. 000000 71. 01 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 0 18, 735, 903 0. 000000 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 61, 832, 039 0. 000000 73. 00 76. 00 03140 CARDI OLOGY 0 0 0 10, 298, 129 0. 000000 76. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 10, 298, 129 0. 000000 76. 97 0UTPATIENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0 0 0 152, 327 0. 000000 90. 00 91. 00 09100 EMERGENCY 0 0 0 25, 242, 147 0. 000000 91. 00 92. 00 09500 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 2, 796, 690 0. 000000 92. 00 0THER REI MBURSABLE COST CENTERS	68. 00 06800 SPEECH PATHOLOGY	0	0	l c	0	0.000000	68.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 11, 658, 522 0.000000 71. 00 71. 01 07101 IV SOLUTIONS 0 0 0 2, 449, 919 0.000000 71. 01 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 18, 735, 903 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 618, 832, 039 0.000000 73. 00 74. 00 0.001000 74. 00 0.0010000 74. 00 0.0010000 74. 00 0.00100000 74. 00 0.00100000 74. 00 0.00100000 74. 00 0.00100000 74. 00 0.001000000 74. 00 0.001000000 74. 00 0.0010000000000000000000000000000	69. 00 06900 ELECTROCARDI OLOGY	0	0	l c	0	0.000000	69.00
71. 01 07101 IV SOLUTIONS 0 0 0 2, 449, 919 0. 000000 71. 01 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 18, 735, 903 0. 000000 72. 00 73. 00 73. 00 73. 00 73. 00 74. 00 0 0 0 0 0 0 0 0 0	69. 01 03610 SLEEP LAB	0	0	l c	1, 708, 227	0.000000	69. 01
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 18, 735, 903 0.000000 72. 00 73. 00 73. 00 73. 00 73. 00 73. 00 74. 00 0 0 0 0 0 10, 298, 129 0.000000 76. 00 76. 97 0.000000 76. 00 0 0 0 0 0 0 0 0 0	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	l c	11, 658, 522	0.000000	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 61,832,039 0.000000 73.00 76.00 03140 CARDI OLOGY 0 0 0 0 10,298,129 0.000000 76.00 76.97 07697 CARDI AC REHABILITATION 0 0 0 615,693 0.000000 76.97 00000000 000000000000000000000000	71. 01 07101 IV SOLUTIONS	0	0	l c	2, 449, 919	0.000000	71. 01
76. 00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	l c	18, 735, 903	0.000000	72.00
76. 00	73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	l c		0. 000000	73.00
OUTPATIENT SERVICE COST CENTERS 90.00 00 00 152, 327 0.000000 90.00 91.00 91.00 92.00 92.00 92.00 93.00 94.00 95	76. 00 03140 CARDI OLOGY	0	0	l c			76.00
OUTPATIENT SERVICE COST CENTERS 90.00 00 00 152,327 0.000000 90.00 91.00 91.00 92.00 92.00 08SERVATION BEDS (NON-DISTINCT PART) 0 0 0 2,796,690 0.000000 92.00 07HER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95	76. 97 07697 CARDI AC REHABI LI TATI ON	0	l o	l c	615, 693	0.000000	76. 97
91. 00 09100 EMERGENCY 0 0 0 25, 242, 147 0. 000000 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 2, 796, 690 0. 000000 92. 00 000000 0000000 0000000000000	OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY 0 0 0 25, 242, 147 0. 000000 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 2, 796, 690 0. 000000 92. 00 000000 0000000 0000000000000	90. 00 09000 CLI NI C	0	0	C	152, 327	0.000000	90.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 0 2,796,690 0.000000 92. 00		0	0				
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		l e	•			
		•					1
200.00 Total (Lines 50 through 199) 0 179, 346 179, 346 268, 082, 762 200.00	95. 00 09500 AMBULANCE SERVI CES						95.00
	200.00 Total (lines 50 through 199)	0	179, 346	179, 346	268, 082, 762		200.00

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENTHROUGH COSTS	F ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0069	Peri od: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/23/2018 1:12 pm

				10	0 12/31/2017	Date/lime Pre 5/23/2018 1:1	
			Title	XVIII	Hospi tal	PPS	2 piii
	Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
	'	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷	ŭ	Costs (col. 8	ŭ	Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12. 00	13.00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0. 000000	3, 729, 557	0	7, 220, 891	0	00.00
	05100 RECOVERY ROOM	0. 000000	1, 009, 340	0	1, 224, 344	0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	7, 325	0	0	0	52.00
	05300 ANESTHESI OLOGY	0. 000000	824, 515		980, 478	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 025992	947, 566	24, 629	1, 627, 960	42, 314	54.00
	03630 ULTRA SOUND	0. 000000	127, 114		373, 366	0	54. 01
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 000000	255, 542	0	2, 260, 265	0	54. 02
55.00	03480 ONCOLOGY	0. 000000	65, 890	0	3, 258, 027	0	55.00
57.00	05700 CT SCAN	0. 000000	1, 665, 363	0	4, 263, 711	0	57.00
58.00	O5800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	157, 844	0	1, 252, 069	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	137, 022	0	728, 668	0	59.00
60.00	06000 LABORATORY	0. 000000	3, 471, 381	0	2, 876, 180	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	735, 229	0	293, 143	0	62.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	3, 929, 230	0	497, 619	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	1, 029, 076	0	40, 854	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	0	0	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	0	0	0	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	0	0	0	0	69.00
69. 01	03610 SLEEP LAB	0. 000000	0	0	717, 101	0	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	3, 295, 827	0	1, 217, 578	0	71.00
71. 01	07101 IV SOLUTIONS	0. 000000	769, 915	0	317, 702	0	71. 01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	7, 239, 165	0	1, 487, 763	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	13, 271, 491	0	17, 653, 815	0	73.00
76.00	03140 CARDI OLOGY	0. 000000	1, 458, 108	0	3, 650, 189	0	76.00
76. 97	07697 CARDIAC REHABILITATION	0. 000000	414	0	331, 166	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 000000	0	0	15, 277	0	90.00
91.00	09100 EMERGENCY	0. 000000	2, 791, 434	0	5, 214, 371	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	370, 548	0	768, 867	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		47, 288, 896	24, 629	58, 271, 404	42, 314	200.00

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

ALT ORT	TOTAL OF MEDICAL, OTHER HEALTH SERVICES AND	WHOCHNE GOST	Trovider c		From 01/01/2017 To 12/31/2017		pared: 2 pm
			Title	XVIII	Hospi tal	PPS	
				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	Servi ces Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins.			
		9		(see inst.)	(see inst.)		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0. 178519	7, 220, 891		0	1, 289, 066	1
51. 00	05100 RECOVERY ROOM	0. 055971	1, 224, 344		0	68, 528	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 520392	0	1	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 036158	980, 478		0 0	35, 452	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 486233	1, 627, 960)	0 0	791, 568	54.00
54.01	03630 ULTRA SOUND	0. 108363	373, 366		0 0	40, 459	54. 01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 072334	2, 260, 265		0 0	163, 494	54.02
55.00	03480 ONCOLOGY	0. 418464	3, 258, 027		0 0	1, 363, 367	55.00
57.00	05700 CT SCAN	0. 051374	4, 263, 711		0 0	219, 044	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 109926	1, 252, 069		0	137, 635	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 159489	728, 668		0	116, 215	59.00
60.00	06000 LABORATORY	0. 152345	2, 876, 180	1	0	438, 172	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 188833	293, 143		0 0	55, 355	62.00
65.00	06500 RESPI RATORY THERAPY	0. 134737	497, 619		0 0	67, 048	65.00
66. 00	06600 PHYSI CAL THERAPY	0. 312700	40, 854		0 0	12, 775	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	O		0 0	0	69.00
	03610 SLEEP LAB	0. 209672	717, 101		0 0	150, 356	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 367370	1, 217, 578		0	447, 302	
	07101 IV SOLUTIONS	0. 058362	317, 702		0	18, 542	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 288766	1, 487, 763		0 0	429, 615	
	07300 DRUGS CHARGED TO PATIENTS	0. 187969	17, 653, 815		0 16, 270		
	03140 CARDI OLOGY	0. 110439			0 0	403, 123	
	07697 CARDI AC REHABI LI TATI ON	0. 261366	331, 166	l .	0 0		1
	OUTPATIENT SERVICE COST CENTERS	0. 201000	001, 100	1	<u> </u>	00,000	70.77
	09000 CLI NI C	1. 548957	15, 277		0 0	23, 663	90.00
	09100 EMERGENCY	0. 152390			0 0	l '	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 732353	768, 867	1	0 0	l '	92.00
	OTHER REIMBURSABLE COST CENTERS	0.752555	700,007	1	<u> </u>	303, 002	1 /2.00
	09500 AMBULANCE SERVICES	0. 548930			0		95.00
200. 00		0. 545750	58, 271, 404		0 16, 270	11, 033, 405	
200.00	,		30, 271, 404		0 10, 270	11,033,403	201.00
201.00	Only Charges						201.00
202. 00	, , ,		58, 271, 404		0 16, 270	11, 033, 405	202 00
202.00	mot sharges (Trile 200 Trile 201)	l .	30, 2, 1, 404	I	5, 270	11,000,400	1202.00

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	Provi der CCN: 15-0069	From 01/01/2017	Worksheet D Part V Date/Time Prepared:

				To 12/31/2017	Date/Time Prepared: 5/23/2018 1:12 pm
		Title	: XVIII	Hospi tal	PPS
	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	0			50.00
51.00 05100 RECOVERY ROOM	0	0			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0			52.00
53. 00 05300 ANESTHESI OLOGY	0	0			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0			54.00
54. 01 03630 ULTRA SOUND	0	0			54. 01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0			54. 02
55. 00 03480 ONCOLOGY	0	0			55.00
57.00 05700 CT SCAN	0	0			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0			59.00
60. 00 06000 LABORATORY	0	0			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0			62.00
65. 00 06500 RESPIRATORY 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	0	3, 058			73.00
76. 00 03140 CARDI OLOGY	0	0	1		76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0			76. 97
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0	0			90.00
91. 00 09100 EMERGENCY	0	Ö	1		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	•		92.00
OTHER REIMBURSABLE COST CENTERS					1 - 1 - 1
95. 00 09500 AMBULANCE SERVICES	0				95.00
200.00 Subtotal (see instructions)	0	3, 058			200.00
201.00 Less PBP Clinic Lab. Services-Program	0]			201.00
Only Charges					[-366
202.00 Net Charges (line 200 - line 201)	0	3, 058			202. 00
1 1 1 2 2 3 2 2 2 2 2 2 2 2 2 2 2 2 2 2	1		'		,

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

From 01/01/2017 Part V To 12/31/2017 Date/Time Prepared: 5/23/2018 1:12 pm Title XIX Hospi tal Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Part I, col. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 3, 031, 087 0. 178519 50.00 05100 RECOVERY ROOM 0 0.055971 51.00 0 1, 139, 157 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0. 520392 0 52.00 53.00 05300 ANESTHESI OLOGY 0.036158 0 0 830, 271 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 486233 0 1, 129, 326 54.00 03630 ULTRA SOUND 380, 291 54.01 0.108363 0 0 0 54.01 0 54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0.072334 0 477, 578 0 54.02 55.00 03480 ONCOLOGY 0. 418464 638, 580 55.00 57.00 05700 CT SCAN 0.051374 0 0 2, 314, 203 57.00 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0.109926 0 554, 614 58.00 58.00 0 59.00 05900 CARDI AC CATHETERI ZATI ON 0.159489 221, 183 0 59.00 06000 LABORATORY 0 60.00 0.152345 4, 766, 692 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.188833 62 00 64, 586 0 62 00 65.00 06500 RESPIRATORY THERAPY 0.134737 0 381, 179 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.312700 1, 552, 411 0 66.00 06700 OCCUPATI ONAL THERAPY 67.00 0.000000 0 67.00 0 06800 SPEECH PATHOLOGY 0 0 68 00 0.000000 0 68 00 0 0 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 0 69.00 69.01 03610 SLEEP LAB 0. 209672 0 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0.367370 0 1, 034, 472 0 71.00 0 07101 IV SOLUTIONS 0.058362 0 224, 590 71.01 71 01 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 288766 0 722, 830 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0. 187969 0 0 4, 304, 525 0 73.00 73.00 03140 CARDI OLOGY 0.110439 0 0 1, 423, 236 76.00 0 76.00 ō 07697 CARDIAC REHABILITATION 76.97 76.97 0. 261366 17, 317 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 1. 548957 0 11, 242 0 90.00 0 09100 EMERGENCY 6, 772, 137 91.00 0.152390 Ω Ω 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0.732353 0 0 620, 519 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0. 548930 0 0 95.00 0 Subtotal (see instructions) 200.00 32, 612, 026 0 200.00 0 0 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 32, 612, 026 0 202.00

Health Financial Systems	KING'S DAUGHTERS' HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTHER HE	ALTH SERVICES AND VACCINE COST Provider Co	CN: 15-0069
		To 12/31/2017 Date/Time Prepared

				To 12/31/2017	Date/Time Prepared: 5/23/2018 1:12 pm
		Ti tl	e XIX	Hospi tal	Cost
	Co	sts			
Cost Center Description	Cost	Cost			
	Rei mbursed	Rei mbursed			
	Servi ces	Services Not			
	Subject To	Subject To			
	Ded. & Coins.				
	(see inst.)	(see inst.)	_		
ANCILLARY SERVICE COST CENTERS	6. 00	7. 00			
50. 00 05000 OPERATING ROOM	C	541, 107			50.00
51. 00 05100 RECOVERY ROOM					51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		1			52.00
53. 00 05300 ANESTHESI OLOGY		-			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		1			54.00
54. 01 03630 ULTRA SOUND		41, 209			54. 01
54. 02 03450 NUCLEAR MEDICINE - DI AGNOSTI C		34, 545			54. 02
55. 00 03480 ONCOLOGY		267, 223			55.00
57. 00 05700 CT SCAN		118, 890	1		57.00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		1	1		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		1			59.00
60. 00 06000 LABORATORY		1			60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		12, 196			62.00
65. 00 06500 RESPIRATORY THERAPY		1			65.00
66. 00 06600 PHYSI CAL THERAPY	C	485, 439	1		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	C	0	1		67.00
68. 00 06800 SPEECH PATHOLOGY	C	0			68.00
69. 00 06900 ELECTROCARDI OLOGY	C	0			69.00
69. 01 03610 SLEEP LAB	C	0			69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	380, 034			71.00
71. 01 07101 IV SOLUTIONS	C	13, 108			71. 01
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	C	,			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	C	809, 117			73.00
76. 00 03140 CARDI OLOGY	C		1		76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	C	4, 526			76. 97
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	C				90.00
91. 00 09100 EMERGENCY	C		1		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	C	454, 439			92. 00
95. 00 09500 AMBULANCE SERVI CES		1			95.00
200.00 Subtotal (see instructions)	C	1			200.00
201.00 Subtotal (see Instructions) 201.00 Less PBP Clinic Lab. Services-Program			-		200.00
Only Charges		Ί			201.00
202.00 Net Charges (line 200 - line 201)	C	6, 093, 842			202. 00
202. 00 mot onarges (Time 200 Time 201)	1	0,075,042	I		₁ 202.00

Health Financial Systems	KING'S DAUGHTERS' HOSPITAL	-	In Lieu	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der		Peri od: From 01/01/2017	Worksheet D-1	
				Date/Time Pre 5/23/2018 1:1	
	Ti t	le XVIII	Hospi tal	PPS	
Cost Center Description					

		Title XVIII	Hospi tal	5/23/2018 1:1 PPS	2 pm
	Cost Center Description	THE AVIII	1103pi tui	113	
	·			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	excluding newborn)		12, 705	1.00
2. 00	Inpatient days (including private room days, excluding swing-			12, 705	2.00
3.00	Private room days (excluding swing-bed and observation bed da	ys). If you have only pr	ivate room days,	0	3.00
	do not complete this line.			10.050	
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	10, 258 0	4. 00 5. 00
3. 00	reporting period	om days) thi ough become	or or the cost		3.00
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 rool 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	31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	,			
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	6, 199	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	unly (including privato r	coom days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instruc		oom days)	U	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom 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	re room days)	0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room davs)	0	13.00
	after December 31 of the cost reporting period (if calendar y	ear, enter O on this lir	ne)		
	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	14.00
15.00				0	15. 00 16. 00
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			U	16.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 d	of the cost	0.00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0.00	18. 00
19. 00	Medicald rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0.00	19. 00
	reporting period	g			
20.00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instruction	ie)		10, 634, 268	21. 00
22. 00	Swing-bed cost applicable to SNF type services through Decemb		ing period (line		22.00
	5 x line 17)	·			
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportir	ng period (line 6	0	23. 00
24. 00		er 31 of the cost reporti	na period (line	0	24. 00
	7 x line 19)				
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		10, 634, 268	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	,		0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	33.00
34.00	Average per diem private room charge differential (line 32 mi		ctions)	0. 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)		66	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	rrerential (line	10, 634, 268	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
	Adjusted general inpatient routine service cost per diem (see			837. 01	
39.00	Program general inpatient routine service cost (line 9 x line	•		5, 188, 625	39.00
	Medically necessary private room cost applicable to the Progr Total Program general inpatient routine service cost (line 39			0 5, 188, 625	40. 00 41. 00
55	1	· ···= · ·=/	1	2, .00, 020	

Heal th	h Financial Systems KING'S DAUGHTERS' HOSPITAL	In Lie	u of Form CMS-2	2552-10
	JTATION OF INPATIENT OPERATING COST Provider CCN: 15-0069 Perio	od:	Worksheet D-1	1002 10
		01/01/2017 12/31/2017	Date/Time Pre	nared:
			5/23/2018 1:1	
		ospital ogram Days	PPS Program Cost	
	Inpatient Inpatient Diem (col. 1	igi alli bays	(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		771	1, 113, 270	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)		9, 637, 352 15, 939, 247	
47.00	PASS THROUGH COST ADJUSTMENTS		13, 737, 247	47.00
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of I	Parts I and	1, 100, 522	50.00
51. 00		f Dorte II	440 241	51. 00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum o and IV)	i Parts II	648, 241	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		1, 748, 763	52.00
53. 00		t, and	14, 190, 484	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		52)	0	56. 00 57. 00
58. 00		33)	0	58.00
59. 00		nded by the	0.00	
40.00	market basket		0. 00	40.00
60. 00 61. 00		amount by	0.00	60. 00 61. 00
01.00	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the		o .	01.00
	amount (line 56), otherwise enter zero (see instructions)			
62. 00 63. 00			0	62. 00 63. 00
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST		0	03.00
64.00		eriod (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting peri	ind (See	0	65. 00
03.00	instructions)(title XVIII only)	ou (see	O	03.00
66.00		ly). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost report	ing period	0	67. 00
07.00	(line 12 x line 19)	ng perrou	O	07.00
68. 00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting	g 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		0	07.00
70.00				70. 00
71. 00 72. 00	, , , , , , , , , , , , , , , , , , , ,			71. 00 72. 00
73.00				73.00
74. 00				74.00
75. 00		II, column		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 99 9 9	ine 79)		79. 00 80. 00
81. 00				81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)			82.00
83.00				83.00
84. 00 85. 00				84. 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		2.1=	07.00
87. 00 88. 00			2, 447 837. 01	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (see instructions)		2, 048, 163	
			'	

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 01/01/2017 To 12/31/2017	Date/Time Pre 5/23/2018 1:1	pared: 2 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	2, 090, 615	10, 634, 268	0. 19659	2 2, 048, 163	402, 652	90.00
91.00 Nursing School cost	0	10, 634, 268	0.00000	0 2, 048, 163	0	91.00
92.00 Allied health cost	0	10, 634, 268	0.00000	0 2, 048, 163	0	92.00
93.00 All other Medical Education	0	10, 634, 268	0.00000	0 2, 048, 163	0	93.00

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0069	Peri od: From 01/01/2017	Worksheet D-1	
				Date/Time Pre 5/23/2018 1:1	
		Title XIX	Hospi tal	Cost	
Cost Center Description					

		Title XIX	Hospi tal	5/23/2018 1:1 Cost	2 pm
	Cost Center Description	THE XIX	nospi tai		
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			12, 705	1.00
2. 00	Inpatient days (including private room days, excluding swing-	3 ,		12, 705	2.00
3. 00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ys). If you have only pr	rivate room days,	0	3. 00
4. 00	Semi-private room days (excluding swing-bed and observation b	ned days)		10, 258	4.00
5. 00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost		5.00
	reporting period	3 , 3			
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	m daya) thrayah Dagambar	21 of the cost	0	7 00
7. 00	reporting period	ill days) through beceiliber	31 Of the Cost		7.00
8. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	g swing-bed and	1, 345	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	unly (including privato r	coom days)	0	10.00
10.00	through December 31 of the cost reporting period (see instruc		oolii days)		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	X only (including privat	te room days)	0	12.00
13 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	Y only (including privat	e room days)	0	13.00
13.00	after December 31 of the cost reporting period (if calendar y				13.00
14.00	Medically necessary private room days applicable to the Progr			0	14.00
15. 00	Total nursery days (title V or XIX only)		-	1, 127	
16. 00	Nursery days (title V or XIX only)			232	16.00
17 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through Dosember 21 o	of the cost	0.00	17.00
17.00	reporting period	es till ough becelliber 31 t	or the cost	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18.00
	reporting period				
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	he cost	0. 00	20.00
20.00	reporting period	is after becomber of or			20.00
21. 00	Total general inpatient routine service cost (see instruction			10, 634, 268	21.00
22. 00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost report	ing period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the cost reporting	na ported (lipe A	o	23. 00
23.00	x line 18)	31 of the cost reportin	ig period (Title d		23.00
24.00		r 31 of the cost reporti	ng period (line	0	24.00
	7 x line 19)				
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25.00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		10, 634, 268	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	,			
	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	1
29. 00				0	
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	+ 1111e 20)		0.00000	1
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	
34.00	Average per diem private room charge differential (line 32 mi		ctions)	0. 00	1
35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	35.00
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35)	and private room cost di	fforential (line	10 634 268	36.00
37. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	rielentiai (IIN6	10, 634, 268	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			
	Adjusted general inpatient routine service cost per diem (see			837. 01	1
39.00	Program general inpatient routine service cost (line 9 x line	•		1, 125, 778	
	Medically necessary private room cost applicable to the Progr Total Program general inpatient routine service cost (line 39			0 1, 125, 778	40.00
	1.03a. Trogram general ripatront routine service cost (IIIIe 37	. 11110 70)		1, 123, 170	1 . 1. 00

Heal th	Financial Systems KING'S DAUGHTERS' HOSPITAL In Lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST Provider CCN: 15-0069 Period:	Worksheet D-1	
	From 01/01/2017 To 12/31/2017		pared:
		5/23/2018 1:1	
	Cost Center Description Total Total Average Per Program Days	Cost Program Cost	
	Inpatient Inpatient Diem (col. 1	(col. 3 x	
	Cost Days ÷ col. 2) 1.00 2.00 3.00 4.00	col . 4) 5.00	
42. 00	NURSERY (title V & XIX only) 817, 920 1, 127 725. 75 232		42.00
40.00	Intensive Care Type Inpatient Hospital Units	1 20/ /07	40.00
43. 00 44. 00	INTENSIVE CARE UNIT	226, 697	43. 00 44. 00
	BURN INTENSIVE CARE UNIT		45. 00
46.00			46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description		47. 00
		1.00	
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)	2, 101, 317	
49.00	PASS THROUGH COST ADJUSTMENTS	3, 622, 166	49.00
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I an	d 0	50. 00
51. 00	III Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II	0	51.00
31.00	and IV)		31.00
52. 00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53. 00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
	Program di scharges	0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)	0.00	55. 00 56. 00
57. 00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	Ö	57.00
58. 00	Bonus payment (see instructions)	0	58.00
59. 00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	
61. 00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target	0	61. 00
	amount (line 56), otherwise enter zero (see instructions)		
62.00		0	62.00
63. 00	Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST	0	63.00
64.00		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
65.00	instructions) (title XVIII only)		65.00
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 period	0	67. 00
07.00	(line 12 x line 19)		
68. 00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70. 00 71. 00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		70. 00 71. 00
72. 00	Program routine service cost (line 9 x line 71)		72.00
73.00			73.00
74. 00 75. 00	Total Program general inpatient routine service costs (line 72 + line 73) Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column		74. 00 75. 00
	26, line 45)		
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76)		76. 00 77. 00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79. 00			79. 00
80. 00 81. 00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) Inpatient routine service cost per diem limitation		80. 00 81. 00
82.00	Inpatient routine service cost per drein frim tatron [Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83. 00
84. 00 85. 00	Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions)		84. 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 (con instructions)	2 447	07.00
87. 00 88. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2, 447 837. 01	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (see instructions)	2, 048, 163	

Health Financial Systems	KING'S DAUGHTE	RS' HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/23/2018 1:1	
		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	H COST					
90.00 Capital -related cost	2, 090, 615	10, 634, 268	0. 19659	2, 048, 163	402, 652	90.00
91.00 Nursing School cost	o	10, 634, 268	0.00000	0 2, 048, 163	ol	91.00
92.00 Allied health cost	o	10, 634, 268	0.00000	0 2, 048, 163	0	92.00
93.00 All other Medical Education	o	10, 634, 268	0.00000	0 2, 048, 163	0	93.00

NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0069	Peri od:	Worksheet D-3	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/23/2018 1:1	pared
		Title	XVIII	Hospi tal	PPS	<u>_ p</u>
	Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col . 1 x	
			1.00	2.00	col . 2) 3.00	_
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
0. 00	03000 ADULTS & PEDIATRICS			6, 321, 201		30.0
1. 00	03100 INTENSIVE CARE UNIT			1, 498, 971		31.0
3. 00	04300 NURSERY			, ,		43.0
	ANCILLARY SERVICE COST CENTERS					
0.00	05000 OPERATING ROOM		0. 1785	19 3, 729, 557	665, 797	50.0
1.00	05100 RECOVERY ROOM		0. 0559	· · ·	56, 494	
2.00	05200 DELIVERY ROOM & LABOR ROOM		0. 52039		3, 812	
3. 00	05300 ANESTHESI OLOGY		0. 0361		29, 813	•
4. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 48623		460, 738	
4. 01	03630 ULTRA SOUND		0. 10836		13, 774	
4. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 07233		18, 484	1
5.00	03480 ONCOLOGY		0. 41846		27, 573	
7. 00 8. 00	05700 CT SCAN		0. 0513 0. 10992		85, 556 17, 351	
9.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION		0. 10992		21, 854	
0.00	06000 LABORATORY		0. 15234		528, 848	1
2. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 18883		138, 835	1
5. 00	06500 RESPIRATORY THERAPY		0. 13473	·	529, 413	1
6. 00	06600 PHYSI CAL THERAPY		0. 31270		321, 792	
7. 00	06700 OCCUPATI ONAL THERAPY		0. 00000		0	1
8. 00	06800 SPEECH PATHOLOGY		0.00000		0	68.
9. 00	06900 ELECTROCARDI OLOGY		0.00000	00	0	69.
9. 01	03610 SLEEP LAB		0. 2096	72 0	0	69.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3673	· · ·	1, 210, 788	71.
1. 01	07101 IV SOLUTIONS		0. 05836		44, 934	1
	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 28876	· · ·	2, 090, 425	1
3. 00	07300 DRUGS CHARGED TO PATIENTS		0. 1879	· · ·	2, 494, 629	1
6. 00	03140 CARDI OLOGY		0. 11043	· · ·	161, 032	
6. 97	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS		0. 26136	66 414	108	76.
0.00	09000 CLINIC		1. 54895	57 0	0	90.
1. 00	09100 EMERGENCY		0. 15903		443, 930	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 7323		271, 372	
	OTHER REIMBURSABLE COST CENTERS		1 1 1 1 2 2 3			
5. 00	09500 AMBULANCE SERVICES					95.
00. 00				47, 288, 896	9, 637, 352	200.
01.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201. (
02.00	Net charges (line 200 minus line 201)			47, 288, 896		202.

NPATI I	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0069	Peri od:	Worksheet D-3	į
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/23/2018 1:1	pared
		Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col . 2)	
	INDATIENT DOUTINE CEDVICE COCT CENTERS		1.00	2. 00	3. 00	_
	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS			1, 378, 050		30.
	03100 INTENSIVE CARE UNIT			305, 365		30.
	04300 NURSERY			736, 990		43.
	ANCI LLARY SERVI CE COST CENTERS			730, 770		43.
	05000 OPERATING ROOM		0. 1785	1, 045, 152	186, 579	50.
	05100 RECOVERY ROOM		0. 0559		16, 620	1
	05200 DELIVERY ROOM & LABOR ROOM		0. 52039		381, 213	1
	05300 ANESTHESI OLOGY		0. 03615		18, 406	1
	05400 RADI OLOGY-DI AGNOSTI C		0. 48623		64, 563	
- 1	03630 ULTRA SOUND		0. 10836		3, 817	
	03450 NUCLEAR MEDICINE - DIAGNOSTIC		0. 07233		1, 256	
	03480 ONCOLOGY		0. 41846		41	55.
7. 00	05700 CT SCAN		0. 0513	74 252, 808	12, 988	57.
8.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 10992	26 54, 188	5, 957	58.
9. 00	05900 CARDI AC CATHETERI ZATI ON		0. 15948	13, 891	2, 215	59.
0. 00	06000 LABORATORY		0. 15234	45 773, 757	117, 878	60.
2.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 18883	33 54, 964	10, 379	62.
	06500 RESPI RATORY THERAPY		0. 13473		73, 353	
	06600 PHYSI CAL THERAPY		0. 31270		26, 792	
	06700 OCCUPATI ONAL THERAPY		0.00000		0	
	06800 SPEECH PATHOLOGY		0.00000		0	
	06900 ELECTROCARDI OLOGY		0.00000		0	
	03610 SLEEP LAB		0. 2096		0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3673		243, 360	
	07101 I V SOLUTI ONS		0.05836		11, 491	1
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 28876		164, 137	
	07300 DRUGS CHARGED TO PATIENTS		0. 18796		622, 201	
	03140 CARDI OLOGY 07697 CARDI AC REHABI LI TATI ON		0. 11043		22, 723	
	OUTPATIENT SERVICE COST CENTERS		0. 2613	66 0	0	76.
	09000 CLINIC		1. 5489!	57 0	0	90.
	09100 EMERGENCY		0. 15239		78, 153	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 7323		37, 195	1
	OTHER REIMBURSABLE COST CENTERS		0.7525	30, 707	37, 173	/2.
	09500 AMBULANCE SERVICES					95.
00.00	Total (sum of lines 50 through 94 and 96 through 98)		1	10, 056, 122	2, 101, 317	1
01. 00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0	2, 101, 017	201.
02.00	Net charges (line 200 minus line 201)	(1	10, 056, 122		202.

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 Part A Date/Time Prepared: 5/23/2018 1:12 pm
•					

		T		5/23/2018 1:1	2 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurri	ng prior to October 1 (see	0 9, 229, 177	1. 00 1. 01
1. 02	instructions) DRG amounts other than outlier payments for discharges occurri	ng on or after October	1 (see	3, 337, 245	1. 02
1. 03	<pre>instructions) DRG for federal specific operating payment for Model 4 BPCI fo 1 (see instructions)</pre>	prior to October	0	1. 03	
1. 04	DRG for federal specific operating payment for Model 4 BPCI for October 1 (see instructions)	0	1. 04		
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			133, 102 0	2. 00 2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructi	ons)		0	2. 02
3.00	Managed Care Simulated Payments			2, 060, 063	3.00
4. 00	Bed days available divided by number of days in the cost repor Indirect Medical Education Adjustment	rting period (see instru	ctions)	81. 30	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 which meet to for new programs in accordance with 42 CFR 413.79(e)	the criteria for an add-	on to the cap	0. 00	6. 00
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified ι ACA § 5503 reduction amount to the IME cap as specified under			0. 00 0. 00	7. 00 7. 01
8. 00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopat affiliated programs in accordance with 42 CFR 413.75(b), 413.73(1908), and 47 FP 5060 (August 1, 2003)	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 slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.				8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)				8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)				9. 00
10. 00 11. 00	FTE count for allopathic and osteopathic programs in the current year from your records FTE count for residents in dental and podiatric programs.				10.00 11.00
12.00	Current year allowable FTE (see instructions)				12.00
13. 00 14. 00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that yea	ar ended on or after Ser	tember 30 1997	0. 00 0. 00	1
	otherwise enter zero.		, , , , , , , , , , , , ,		
15.00	Sum of lines 12 through 14 divided by 3.				15.00
	Adjustment for residents in initial years of the program				16.00
	Adjustment for residents displaced by program or hospital clos	sure			17. 00 18. 00
	Adjusted rolling average FTE count 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)			0.000000	22.00
22. 00	IME payment adjustment (see Firstructions) IME payment adjustment - Managed Care (see instructions)			0	1
	Indirect Medical Education Adjustment for the Add-on for § 422				
	Number of additional allopathic and osteopathic IME FTE reside $(f)(1)(iv)(C)$.	ent cap slots under 42 (FR 412.105	0.00	
24. 00 25. 00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -0-, then enter the I	ower of line 23 or line	24 (see		24. 00 25. 00
	i nstructi ons)	ower or true 20 or true	21 (300		
26. 00 27. 00	Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions)			0. 000000 0. 000000	1
	, , , , , , , , , , , , , , , , , , , ,			0.000000	1
	IME add-on adjustment amount (see instructions) IME add-on adjustment amount - Managed Care (see instructions)				ł
					28. 01
29. 00 29. 01					29. 00 29. 01
	Disproportionate Share Adjustment				
	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)				30.00
	Percentage of Medicaid patient days (see instructions)				31.00
	Sum of Lines 30 and 31				32.00
	Allowable disproportionate share percentage (see instructions))		8. 72	1
34. 00	Disproportionate share adjustment (see instructions)	273, 948	34.00		

Heal th	Financial Systems KING'S DAUGHTER	RS' HOSPITAL	In Lie	u of Form CMS-2	2552-10		
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0069	Peri od:	Worksheet E			
			From 01/01/2017 To 12/31/2017	Part A Date/Time Pre 5/23/2018 1:1	pared:		
	Title WILL Heggital						
		Title XVIII	Hospital Prior to 10/1	PPS On/After 10/1			
			1. 00	2. 00			
25 00	Uncompensated Care Adjustment		E 077 402 147	4 7/4 (OF 1/4	35.00		
35. 00 35. 01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		5, 977, 483, 147 0. 000081381	6, 766, 695, 164 0, 000109990			
35. 02	Hospital uncompensated care payment (If line 34 is zero, en	ter zero on this line) (se		744, 269			
35. 03	instructions) Pro rata share of the hospital uncompensated care payment a	mount (see instructions)	363, 841	187, 597	35. 03		
	Total uncompensated care (sum of columns 1 and 2 on line 35		551, 438		36.00		
40.00	Additional payment for high percentage of ESRD beneficiary				40.00		
40. 00	Total Medicare discharges on Worksheet S-3, Part I excludin 652, 682, 683, 684 and 685 (see instructions)	g discharges for MS-DRGS	0		40.00		
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682,	683, 684 an 685. (see	0		41.00		
41. 01	instructions) Total ESRD Medicare covered and paid discharges excluding M	IS-DRGs 652, 682, 683, 68	4 0		41.01		
	an 685. (see instructions)						
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not qua Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0.00		42. 00 43. 00		
43.00	instructions)	002, 003, 004 an 003. (3e			43.00		
44. 00	Ratio of average length of stay to one week (line 43 divide days)	d by line 41 divided by 7	0. 000000		44.00		
45. 00	Average weekly cost for dialysis treatments (see instruction	ns)	0.00		45.00		
46. 00	Total additional payment (line 45 times line 44 times line		0		46. 00		
47. 00 48. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH,	small rural bosnitals	13, 524, 910 14, 223, 042		47. 00 48. 00		
40.00	only. (see instructions)	Silari Turai Hospitars	14, 223, 042		46.00		
	Amount						
49. 00	Total payment for inpatient operating costs (see instruction	ns)		1. 00 14, 223, 042	49.00		
50. 00	Payment for inpatient program capital (from Wkst. L, Pt. I)	1, 054, 468			
51.00	Exception payment for inpatient program capital (Wkst. L, P			0	51.00		
52. 00 53. 00	Direct graduate medical education payment (from Wkst. E-4, Nursing and Allied Health Managed Care payment	Title 49 see Histructions)		0 11, 407	52. 00 53. 00		
54.00	Special add-on payments for new technologies			0	54.00		
54. 01	1 3	(0)		0	54.01		
55. 00 56. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see in			0	55. 00 56. 00		
57. 00	Routine service other pass through costs (from Wkst. D, Pt.	*	through 35).	0	57.00		
58. 00	Ancillary service other pass through costs from Wkst. D, Pt	. IV, col. 11 line 200)		24, 629			
59. 00 60. 00	Total (sum of amounts on lines 49 through 58) Primary payer payments			15, 313, 546 4, 745	1		
61. 00	Total amount payable for program beneficiaries (line 59 min	us line 60)		15, 308, 801			
62.00	Deductibles billed to program beneficiaries			1, 652, 448	1		
63.00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			22, 043 208, 409	1		
65. 00	Adjusted reimbursable bad debts (see instructions)			135, 466	1		
66. 00	Allowable bad debts for dual eligible beneficiaries (see in	structi ons)		60, 171	66.00		
67. 00 68. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	ur applicable to MS DBCs (coo instructions)	13, 769, 776 0	67.00		
69. 00	Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96			0	69.00		
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70. 00 70. 50		
70. 50							
70. 87 70. 88	Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)			0	70. 87 70. 88		
70. 89	70.89 Pioneer ACO demonstration payment adjustment amount (see instructions)						
70. 90	70.90 HSP bonus payment HVBP adjustment amount (see instructions)						
70. 91 70. 92	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0	70. 91 70. 92		
70. 93	HVBP payment adjustment amount (see instructions)			121, 601	70. 93		
	.94 HRR adjustment amount (see instructions)						
	Recovery of accelerated depreciation			-323, 196 0	1		

Heal th	Financial Systems KING'S DAUGHTERS'	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CN: 15-0069	Peri od:	Worksheet E	
				From 01/01/2017	Part A	
				To 12/31/2017	Date/Time Pre 5/23/2018 1:1	
		Ti tl e	e XVIII	Hospi tal	PPS	z pili
		11116		(yyyy)	Amount	
			- '''	0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		0		70. 96
70. 70	the corresponding federal year for the period prior to 10/1)	ii corumii o		O	0	70.70
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column O		0	0	70. 97
70. 77	the corresponding federal year for the period ending on or af			O	l o	70.77
70. 98	Low Volume Payment-3	10/1)			0	70. 98
70. 70	HAC adjustment amount (see instructions)				0	
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			13, 568, 181	
71.00	Sequestration adjustment (see instructions)	07 & 70)			271, 364	
71.01	Demonstration payment adjustment amount after sequestration				271, 304	71.01
71.02	Interim payments				13, 498, 628	
73. 00	Tentative settlement (for contractor use only)				13, 470, 020	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.0	12 72 and			-201, 811	
74.00	73)	12, 72, and			-201, 011	74.00
75. 00	Protested amounts (nonallowable cost report items) in accorda	nco with			1, 170, 540	75. 00
75.00	CMS Pub. 15-2, chapter 1, §115.2	ince with			1, 170, 340	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see ins	tructions)			0	90.00
	, ,	iti ucti ons)				
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0	
92.00	Operating outlier reconciliation adjustment amount (see instr				0	
93.00	Capital outlier reconciliation adjustment amount (see instruc				0	
94.00	The rate used to calculate the time value of money (see instr				0.00	
95.00	Time value of money for operating expenses (see instructions)				0	
96. 00	Time value of money for capital related expenses (see instruc	TIONS)		D.1. 1. 10/1	0 (4.6) - 10 (1	96.00
				Pri or to 10/1 1.00	2. 00	
	HSP Bonus Payment Amount			1.00	2.00	
100 00	HSP bonus amount (see instructions)			0	0	100.00
100.00	HVBP Adjustment for HSP Bonus Payment				0	1100.00
101 00	HVBP adjustment factor (see instructions)			0. 000000000	0. 0000000000	101 00
	HVBP adjustment amount for HSP bonus payment (see instruction	ie)		0.000000000		102.00
102.00	HRR Adjustment for HSP Bonus Payment	15)			0	102.00
102 00	HRR adjustment factor (see instructions)			0.0000	0.0000	102 00
	HRR adjustment amount for HSP bonus payment (see instructions	.)		0.0000		104.00
104.00	Rural Community Hospital Demonstration Project (§410A Demonst		uetmont		0	104.00
200 00	Is this the first year of the current 5-year demonstration pe					200. 00
200.00	Century Cures Act? Enter "Y" for yes or "N" for no.	irrod dilder	the 213t			200.00
	Cost Reimbursement					
201 00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin	10. 40)				201. 00
	Medicare discharges (see instructions)	le 49)				201.00
	,					202.00
203.00	Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	first waar	of the ourse	nt E voor domono	L +==+! ==	203.00
	period)	iiist year	or the curre	erit 5-year delilons	stration	
204 00	,					204. 00
	Medicare target amount Case mix adjusted target amount (line 202 times line 204)					204.00
	Case-mix adjusted target amount (line 203 times line 204)					1
∠∪6. 00	Medicare inpatient routine cost cap (line 202 times line 205)					206. 00
207.22	Adjustment to Medicare Part A Inpatient Reimbursement					207.00
	Program reimbursement under the §410A Demonstration (see inst	,				207. 00
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	iine 59)				208. 00
	Adjustment to Medicare IPPS payments (see instructions)					209. 00 210. 00
7 1 (1) (1)(1)	Reserved for future use			i i	1	1210 (10)

210.00

211. 00

212. 00 213. 00 218. 00

210.00 Reserved for future use

211.00 Total adjustment to Medicare IPPS payments (see instructions)

Comparision of PPS versus Cost Reimbursement

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

213.00 Low-volume adjustment (see instructions)
218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)
(line 212 minus line 213) (see instructions)

Health Financial Systems KING'S DAUGHTER: HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 Provider CCN: 15-0069 Peri od: Worksheet E From 01/01/2017 Part A Exhi bit 5 To 12/31/2017 Date/Time Prepared:

No. No.					11	0 12/31/2017	5/23/2018 1:1:	
1.00 DRC amounts other than outlier payments 0				Title	XVIII	Hospi tal		- In 111
1.00 DRG amounts other than outlier payments 0 1.00 2.00 3.00 4.00 1.0			Wkst. E, Pt.	Amt. from	Period to	Period on	Total (cols.	
1.00 DRG amounts other than outlier payments 1.00 1.00 2.00 3.00 4.00 1.01 1.01 1.02 1.00			A, line	Wkst. E, Pt.	10/01	after 10/01	2 and 3)	
1.00 DRC amounts other than outlier payments 1.00 0,229,177 0,229,177 0,229,177 1.01 0.01 DRC amounts other than outlier payments for 1.01 0,229,177 0,229,177 0,01 0.01								
1.01 DRC amounts other than outlier payments for discharges occurring prior to totober 1 1.02 3.337,245 3.337,245 3.337,245 1.02 discharges occurring prior to October 1 1.03 0 0 0 0 0 1.04 1.05				1. 00	2. 00	3. 00	4. 00	
discharges occurring prior to October 1 1.02 3,337,245 3,337,245 3,337,245 1.02								
DRC amounts other than outlier payments for discharges occurring por art for October 1 1.03	1. 01		1. 01	9, 229, 177	9, 229, 177		9, 229, 177	1. 01
di scharges accurring on or after October 1 1.03 0 0 0 0 0 0 0 1.03	4 00		4 00	0 007 045		0 007 045	0 007 045	4 00
1.03	1. 02		1. 02	3, 337, 245		3, 337, 245	3, 337, 245	1.02
For Model 4 BPCI occurring prior to October 1	1 02		1 02		0		0	1 02
1.04 DRG for Federal specific operating payment 1.04 0 0 0 0 1.04	1.03		1. 03	U	U		U	1.03
For Model 4 BPCI occurring on or after October 1 2.00		1						
For Model 4 BPCI occurring on or after October 1 2.00	1. 04	DRG for Federal specific operating payment	1. 04	0		0	0	1. 04
October 1 Color								
Instructions								
2.01 Outlier payments for discharges for Model 4 2.02 0 0 0 0 0 0 0 0 0	2.00	Outlier payments for discharges (see	2. 00	133, 102	95, 374	37, 728	133, 102	2.00
BPCI		instructions)						
0 Operating outlier reconciliation 2.01 0 0 0 0 0 0 3.00 3.00 4.00	2. 01		2. 02	0	0	0	0	2.01
A.00 Managed care simulated payments				_	_	_	_	
Indirect Medical Education Adjustment				0	0	0	0	
Amount from Worksheet E, Part A, Line 21 21.00 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.00000000	4.00		3. 00	2, 060, 063	1, 489, 667	570, 397	2, 060, 064	4.00
See Instructions	E 00		21 00	0.000000	0.000000	0.000000		F 00
Mathematics	5.00		21.00	0.00000	0.000000	0.000000		5.00
IME payment adjustment for managed care (see 22.01 0 0 0 0 0 0 0 0 0	6 00		22 00	0	0	0	0	6 00
Instructions				0		0		
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA	0.01		22.01	J	Ü	Ö	Ü	0.01
Tool ME payment adjustment factor (see 27.00 0.0000000 0.000000 0.000000 0.000000 0.000000 0.00000 0.0000000 0.0000000 0.000000 0.0000000 0.00000000			e Add-on for Se	ection 422 of 1	the MMA			
8.00	7.00					0.000000		7.00
8.01 IME payment adjustment add on for managed care (see instructions) 9.01 Total IME payment (sum of lines 6 and 8) 29.00 0 0 0 0 0 0 9.01 9.01 Total IME payment for managed care (sum of lines 6.01 and 8.01) 0 0 0 0 0 0 9.01 10 Imes 6.01 and 8.01) 0 0 0 0 0 0 0 9.01 10 Imes 6.01 and 8.01) 0 0 0 0 0 0 0 0 10 Imes 6.01 and 8.01) 0 0 0 0 0 0 0 0 10 Imes 6.01 and 8.01) 0 0 0 0 0 0 0 10 Imes 6.01 and 8.01) 0 0 0 0 0 0 0 10 Imes 6.01 and 8.01) 0 0 0 0 0 0 0 0 10 10		instructions)						
Care (see instructions) Care instructions) Care instructions Care in				0	0	0	0	8.00
9.00 Total IME payment (sum of lines 6 and 8) 29.00 0 0 0 0 0 0 0 9.01 Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage (see instructions) 11.00 Disproportionate share adjustment (see 34.00 273,948 201,196 72,752 273,948 11.00 instructions) 11.01 Uncompensated care payments 36.00 551,438 363,841 187,597 551,438 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46.00 0 0 0 0 0 12.00 instructions) 13.00 Subtotal (see instructions) 47.00 13,524,910 9,889,588 3,635,322 13,524,910 13.00 Hospital specific payments (completed by SCH 48.00 14,223,042 0 0 0 14.00 and MDH, small rural hospitals only.) (see instructions) 15.00 Total IME payment for inpatient operating costs 49.00 14,223,042 14,223,042 0 14,223,042 15.00 Capital subjective for inpatient program capital (from 50.00 1,054,468 773,982 280,486 1,054,468 16.00 Whst. L., Pt. I., if applicable) 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 0 0 0 17.00 replaced devices for applicable MS-DRGS 18.00 Capital outlier reconciliation adjustment 93.00 0 0 0 0 0 0 0 18.00 amount (see instructions)	8. 01		28. 01	0	0	0	0	8. 01
9.01 Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage (see instructions) 11.00 Disproportionate share adjustment (see 34.00 273,948 201,196 72,752 273,948 11.00 instructions) 11.01 Uncompensated care payments 36.00 551,438 363,841 187,597 551,438 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46.00 0 0 0 0 12.00 instructions) 13.00 Subtotal (see instructions) 47.00 13,524,910 9,889,588 3,635,322 13,524,910 14.00 instructions) 14.00 Hospital specific payments (completed by SCH 48.00 14,223,042 0 0 0 14.00 instructions) 15.00 Total payment for inpatient operating costs 49.00 14,223,042 14,223,042 0 14,223,042 15.00 (see instructions) 16.00 Payment for inpatient program capital (from 50.00 1,054,468 773,982 280,486 1,054,468 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 0 0 17.00 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 0 0 0 0 0 0 18.00 amount (see instructions)				_	_	_	_	
Lines 6.01 and 8.01) Disproportionate Share Adjustment				0	0	0	-	
Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0.0872 0.0872 0.0872 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 273,948 201,196 72,752 273,948 11.00 instructions) 11.01 Nucompensated care payments 36.00 551,438 363,841 187,597 551,438 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46.00 0 0 0 0 12.00 instructions) 13.00 Subtotal (see instructions) 47.00 13,524,910 9,889,588 3,635,322 13,524,910 13.00 14.00 Hospital specific payments (completed by SCH 48.00 14,223,042 0 0 0 0 14.00 and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs 49.00 14,223,042 14,223,042 0 14,223,042 15.00 (see instructions) 15.00 Total payment for inpatient program capital (from 50.00 1,054,468 773,982 280,486 1,054,468 16.00 Wkst. L, Pt. I, if applicable 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 0 0 17.00 17.01 17.01 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGS 18.00 Capital outlier reconciliation adjustment 93.00 0 0 0 0 0 18.00	9. 01		29. 01	0	0	0	0	9.01
10.00 Allowable disproportionate share percentage (see instructions) 11.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 273,948 201,196 72,752 273,948 11.00 instructions) 11.01 Uncompensated care payments 36.00 551,438 363,841 187,597 551,438 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46.00 0 0 0 0 0 12.00 instructions) 13.00 Subtotal (see instructions) 47.00 13,524,910 9,889,588 3,635,322 13,524,910 13.00 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs 49.00 14,223,042 0 0 14,223,042 0 14,223,042 15.00 (see instructions) 15.00 Payment for inpatient program capital (from bound wisser L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 0 0 17.00 17.01 Net organ acquisition cost 17.01 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 0 0 0 0 0 18.00								
11.00 Disproportionate share adjustment (see 34.00 273,948 201,196 72,752 273,948 11.00 instructions) Uncompensated care payments 36.00 551,438 363,841 187,597 551,438 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46.00 0 0 0 0 0 12.00 instructions) 13.00 Subtotal (see instructions) 47.00 13,524,910 9,889,588 3,635,322 13,524,910 13.00 14.00 Hospital specific payments (completed by SCH 48.00 14,223,042 0 0 0 14.00 14.00 14.00 15.00 Total payment for inpatient operating costs 49.00 14,223,042 14,223,042 0 14,223,042 15.00 (see instructions) 16.00 Payment for inpatient program capital (from 50.00 1,054,468 773,982 280,486 1,054,468 16.00 Wkst. L, Pt. I, if applicable 17.01 Net organ acquisition cost 17.01 Net organ acquisition cost 17.01 Total ESRD additional payment for inpatient program capital (from 50.00 0 0 0 0 0 0 0 0 0	10 00		22 00	0.0072	0 0072	0.0072		10.00
11. 00 Disproportionate share adjustment (see instructions) 11. 01 Uncompensated care payments Additional payment for high percentage of ESRD beneficiary discharges 12. 00 Instructions) 13. 00 Subtotal (see instructions) 14. 00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15. 00 Total payment for inpatient operating costs (see instructions) 16. 00 Payment for inpatient program capital (from wkst. L, Pt. I, if applicable) 17. 00 Special add-on payments for new technologies 54. 00 18. 00 Capital outlier reconciliation adjustment 93. 00 18. 00 Capital outlier reconciliation adjustment 93. 00 10	10.00		33.00	0.0672	0.0672	0.0672		10.00
11.01	11. 00		34. 00	273. 948	201, 196	72, 752	273. 948	11.00
Additional payment for high percentage of ESRD beneficiary discharges					,	, -	.,	
12.00 Total ESRD additional payment (see 46.00 0 0 0 0 12.00 13.00 Subtotal (see instructions) 47.00 13,524,910 9,889,588 3,635,322 13,524,910 13.00 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 17.00 17.01 Net organ acquisition cost 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 0 0 0 0 0 18.00 18.00 Total ESRD additional payment (see instructions) 13,524,910 9,889,588 3,635,322 13,524,910 13.00 14.00 15.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 15.00 15.00 15.00 15.00 16.00	11. 01	Uncompensated care payments	36. 00	551, 438	363, 841	187, 597	551, 438	11.01
13.00 Subtotal (see instructions) 47.00 13,524,910 9,889,588 3,635,322 13,524,910 13.00 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 49.00 14,223,042 14,223,042 0 14,223,042 15.00 15.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 50.00 1,054,468 773,982 280,486 1,054,468 16.00 17.00 Net organ acquisition cost 17.01 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions) 93.00 0 0 0 18.00 18.00 18.00 18.00 19,889,588 3,635,322 13,524,910 13.00 13.00 14.223,042 0 0 0 0 0 0 14,223,042 14,223,042 0 0 14,223,042 0 0 0 0 14,223,042 14,223,042 0 0 0 0 0 0 0 15.00 17.00 0 0 0 0 0 0 17.01 0 0 0 0 0 0 0 18.00 0 0 0 0 0 0 18.00 0 0 0 0 0 0 18.00 0 0 0 0 0 18.00 0 0 0 0 0 0 18.00 0 0 0 0 0 18.00 0 0 0 0 0 18.00 0 0 0 0 19.00 0 0 0 0 19.00 0 0 0 0 19.00 0 0 0 0 19.00 0 0 0 0 19.00 0 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 19.00 0 0 0 19.00 0 0 0 19.00 0 0 0			RD beneficiary	di scharges				
13.00 Subtotal (see instructions) 47.00 13,524,910 9,889,588 3,635,322 13,524,910 13.00 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 48.00 14,223,042 0 0 0 14.00 15.00 Total payment for inpatient operating costs (see instructions) 49.00 14,223,042 14,223,042 0 14,223,042 15.00 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 50.00 1,054,468 773,982 280,486 1,054,468 16.00 17.01 Net organ acquisition cost 54.00 0 0 0 0 0 17.00 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 68.00 0 0 0 0 0 0 17.02 18.00 Capital outlier reconciliation adjustment amount (see instructions) 93.00 0 0 0 0 0 0 18.00	12.00		46. 00	0	0	0	0	12.00
14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 17.00 17.01 Net organ acquisition cost 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions) 14.00 14.223,042 0 14,223,042 0 14,223,042 15.00 0 14,223,042 15.00 0 0 0 0 0 0 17.00 0 0 0 0 17.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 0 0 0 0 17.00 17.01 Net organ acquisition cost 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					9, 889, 588	3, 635, 322		
instructions) Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) Total payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) Total payment for inpatient program capital (from So. 00	14.00		48. 00	14, 223, 042	0	0	0	14.00
Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 17.01 Net organ acquisition cost 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions) 14, 223, 042 14, 223, 042 14, 223, 042 0 14, 223, 042 0 0 0 0 0 0 0 17. 054, 468 17.02 Crodits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions)								
(see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 17.01 Net organ acquisition cost 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions) 18.00 (see instructions) 50.00 1,054,468 773,982 280,486 1,054,468 16.00 0 0 0 0 0 0 17.00 17.01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15 00		40.00	14 222 042	14 222 042	0	14 222 042	15 00
16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 17.01 Net organ acquisition cost 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions) 50.00 1,054,468 773,982 280,486 1,054,468 17.00 0 0 0 0 0 17.00 17.01 17.02	13.00		47.00	14, 223, 042	14, 223, 042	U	14, 223, 042	13.00
Wkst. L, Pt. I, if applicable) 17. 00 Special add-on payments for new technologies 54.00 0 0 0 17.00 17. 01 Net organ acquisition cost 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions) 93.00 0 0 0 0 18.00	16 00		50.00	1 054 468	773 982	280 486	1 054 468	16 00
17.00 Special add-on payments for new technologies 54.00 0 0 0 0 17.00 17.01 Net organ acquisition cost 0 0 0 0 0 17.01 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions) 93.00 0 0 0 0 18.00			00.00	1,001,100	7.707.702	2007 100	1,001,100	
17.01 Net organ acquisition cost 17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions) 17.01 17.01 17.02 18.00 0 0 0 18.00	17. 00		54. 00	0	0	О	o	17.00
17. 02 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18. 00 Capital outlier reconciliation adjustment amount (see instructions) 68. 00 0 0 17. 02 18. 00 0 0 18. 00								
18.00 Capital outlier reconciliation adjustment 93.00 0 0 0 18.00 amount (see instructions)			68. 00	0	0	О	0	17.02
amount (see instructions)								
	18. 00		93. 00	0	0	0	0	18. 00
19. 00 SUBTUTAL 14, 997, 024 280, 486 15, 277, 510 19. 00	40						4- 6	40
	19. 00	PORTOTAL			14, 997, 024	280, 486	15, 277, 510	19. 00

		W. NO. O. DANIOUTE				6.5	
	Financial Systems AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	KING'S DAUGHTE ATION EXHIBIT 5	Provider Co	!	Period: From 01/01/2017 To 12/31/2017	Date/Time Pre 5/23/2018 1:1	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	1, 015, 100	743, 88	271, 220	1, 015, 100	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	39, 368	30, 10	9, 266	39, 368	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. 000	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. 000	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	1, 054, 468	773, 98.	280, 486	1, 054, 468	26. 00
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt. A)				
		0	1.00	2.00	3. 00	4. 00	
27. 00							27.00
28.00	Low volume adjustment prior to October 1	70. 96	0		O	0	28. 00
29.00	Low volume adjustment on or after October 1	70. 97	0		0	0	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	121, 601	80, 93	40, 665	121, 601	30.00
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	-323, 196	-250, 11	73, 086	-323, 196	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0	(0	0	31. 01
						(A+ +-	

0 70. 99

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

1.00

2.00

0

3.00

0

(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		Provi der	CCN: 15-0069		Worksheet E Part B Date/Time Prepared: 5/23/2018 1:12 pm
•					

PART B - MEDICAL AND OTHER HEALTH SERVICES 1.00					5/23/2018 1:1	
PART 8 - MEDICAL AND OTHER MEALTH SERVICES 3,008 1.00			Title XVIII	Hospi tal		
PART 8 - MEDICAL AND OTHER MEALTH SERVICES 3,008 1.00						
					1. 00	
Medical and other services relabursed under OPPS (see instructions) 10,991,091 20 30 30 0PPS payments 12,087126 30 30 0PPS payments (see instructions) 20,361 40 40 40 40 40 40 40 4		PART B - MEDICAL AND OTHER HEALTH SERVICES				
10,00 Differ payment (see instructions) 29,331 30,00 10,00 10,00 11,00 12,00 13,00 10,00	1.00	Medical and other services (see instructions)			3, 058	1.00
0.01 criter payment (see Instructions)	2.00	Medical and other services reimbursed under OPPS (see instruc	tions)		10, 991, 091	2.00
0.00 0.00	3.00	OPPS payments		12, 087, 526	3.00	
Enter the hospital specific payment to cost ratio (see instructions) 0.000 5.00	4.00	Outlier payment (see instructions)		29, 351	4.00	
Line 2 times line 5	4.01	Outlier reconciliation amount (see instructions)			0	4. 01
Sum of Fines 3	5.00	Enter the hospital specific payment to cost ratio (see instru	ctions)		0.000	5.00
3.00 Architery service other pages through costs from West. D. Pt. IV. col. 13, line 200 42, 314 9.00 Architery service other pages through costs from West. D. Pt. IV. col. 13, line 200 42, 314 9.00 10.00 7 10.00 7 10.00 7 10.00 7 10.00 7 10.00 7 10.00 7 10.00 7 10.00	6.00	Line 2 times line 5			0	6.00
9.00 Ancillary service other pass through costs from Wist. D, Pt. IV, col. 13, line 200 42, 314 9.00	7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
0.00 organ acquisitions 0.10 0.00	8.00	Transitional corridor payment (see instructions)			0	8.00
0.00 organ acquisitions 0.10 0.00	9.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		42, 314	9.00
COMPUTATION OF FIRSTR OF COST OR CHARGES 12.00 Ancillary service charges 12.00 Ancillary service charges 12.00 Ancillary service charges 16.270 12.00 13.00 Organ acquist ion charges (from West. D-4, Pt. 111, col. 4, line 69) 16.270 13.00 13.00 Organ acquist ion charges (from West. D-4, Pt. 111, col. 4, line 69) 15.270 14.00 15.270 14.00 15.270 14.00 15.270 14.00 15.270 14.00 15.270 14.00 15.270 14.00 15.270 14.00 15.270 14.00 15.270 14.00 15.270 14.00 15.270 14.00 15.270 14.00 15.270 14.00 15.270 14.00 15.270 14.00 15.270 14.00 15.270 14.00 15.270	10.00				0	10.00
COMPUTATION OF FIRSTR OF COST OR CHARGES 12.00 Ancillary service charges 12.00 Ancillary service charges 12.00 Ancillary service charges 16.270 12.00 13.00 Organ acquist ion charges (from West. D-4, Pt. 111, col. 4, line 69) 16.270 13.00 13.00 Organ acquist ion charges (from West. D-4, Pt. 111, col. 4, line 69) 15.270 14.00 15.270 14.00 15.270 14.00 15.270 14.00 15.270 14.00 15.270 14.00 15.270 14.00 15.270 14.00 15.270 14.00 15.270 14.00 15.270 14.00 15.270 14.00 15.270 14.00 15.270 14.00 15.270 14.00 15.270 14.00 15.270 14.00 15.270 14.00 15.270	11.00	Total cost (sum of lines 1 and 10) (see instructions)			3, 058	11.00
Reasonable charges 10.200 Ancil lary service charges 10.200 Ancil lary service charges 10.200 Ancil lary service charges (sum of lines 12 and 13) 10.270 13.00 13.					·	1
12.00 Ancil larry service charges 16,270 12.00 1014 1016 102 1014 1016 102 1014 1016 1014 1016 1014 1016 1014 1016 1014 1016 1014 1016 1014 1016 1014 1016 1014 1016 1014 1016 1014 1016 1014 1016 1014 1016 1014 1016 1014 1016 1014 1016 1014 1016 101						1
13.00 Organ acquisition charges (from Mkst. D-4, Pt. III, col. 4, line 69) 0 13.00	12.00				16, 270	1 12.00
14. 00 Total reasonable charges (sum of lines 12 and 13)		, o	ine 69)			1
Customery_charges			,		16, 270	1
15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15.00						1
16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis Nature Amounts Nature	15.00		payment for services on	a charge basis	0	15.00
had such payment been made in accordance with 42 CFR \$413.13(e)*						1
17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 17.00						
18. 00 Total customary charges (see instructions) 16. 270 18. 00	17.00		-,		0.000000	17.00
19. 00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 13, 212 9, 00 18. 20. 00 19. 00						1
Instructions			lv if line 18 exceeds li	ne 11) (see		1
20. 00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20. 00			,	, (-,	
Instructions 3,058 21.00	20.00		lv if line 11 exceeds li	ne 18) (see	0	20.00
21.00 Lesser of cost or charges (see instructions) 0, 22.00 22.00 Cost of physicians' services in a teaching hospital (see instructions) 0, 22.00 23.00 Cost of physicians' services in a teaching hospital (see instructions) 12,159,191 24.00 24.00 25.00 25.00 26.00		3 3 1	. ,	, (
22.00 Interns and residents (see instructions) 0.2.00 22.00 23.00 23.00 24.00 12.159, 191 24.00 24.0	21.00				3, 058	21.00
23.00 Cost of physicians' services in a teaching hospital (see instructions) 12, 159, 191		ÿ ,				1
24. 00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 12, 159, 191 24. 00 COMPUTATION OF REIMBURSEMINT SETTLEMENT		· · · · · · · · · · · · · · · · · · ·	ructions)			
COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance (for CAH, see instructions) 0 25. 00 26. 00 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) 2, 447, 442 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 instructions) 0 28. 00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 29. 00		. ,	. 401. 5.1.5)		-	
25.00 Deductibles and coinsurance (for CAH, see instructions) 2.6407, 422 6.00	21.00				12/10//1/	1 00
26.00 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) 2, 447, 442 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 instructions) 9,714,807 27.00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 36) 0 28.00 30.00 Subtotal (sum of lines 27 through 29) 9,714,807 30.00 31.00 Subtotal (line 30 minus line 31) 9,710,969 ALIOWABLE BAD DEBTS (FCRULDE BAD DEBTS FOR PROFESSIONAL SERVICES) 9,710,969 33.00 Composite rate ESRD (from Wkst. I-5, line 11) 394,418 34.00 Allowable bad debts (see instructions) 394,418 35.00 Allowable bad debts (see instructions) 256,372 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 258,742 38.00 MSP-LCC reconciliation amount from PS&R 9,967,341 39.00 THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39,96 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 40.01 Sequestration adjustment dise instructions) 9,967,343 40.02 <td>25 00</td> <td></td> <td></td> <td></td> <td>0</td> <td>25 00</td>	25 00				0	25 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 instructions)			r CAH see instructions)			
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28. 00	27.00		prus the sum of filles 22	ana 20] (300	7, 714, 007	27.00
29.00 ESRD diffect medical education costs (from Wkst. E-4, line 36) 0 29.00	28 00		ine 50)		0	28 00
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	94.00	iotai (SUM of lines 91 and 93)		ļ	0	94.00

Health Financial Systems KING' ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: Provi der CCN: 15-0069

				10 12/31/201/	5/23/2018 1: 12	
		Title	XVIII	Hospi tal	PPS	
		Inpatier	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		13, 498, 62	8	9, 763, 359	1.00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			ol	0	3. 01
3. 02	ADJUSTWIENTS TO TROVIDER			o o		3. 02
3. 03				Ö	l o	3. 02
3. 04				o	o o	3. 04
3. 05				o	Ö	3. 05
0.00	Provider to Program			<u> </u>	J	0.00
3.50	ADJUSTMENTS TO PROGRAM			o	0	3. 50
3.51				o	0	3. 51
3.52				0	0	3. 52
3.53				0	0	3.53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
	3. 50-3. 98)					
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		13, 498, 62	8	9, 763, 359	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after		I			5. 00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			o	0	5. 01
5.02				o	o	5. 02
5.03				0	0	5.03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER			o	4, 695	6. 01
6. 02	SETTLEMENT TO PROGRAM		201, 81	1	0	6. 02
7. 00	Total Medicare program liability (see instructions)		13, 296, 81		9, 768, 054	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
)	1. 00	2.00	
8.00	Name of Contractor					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		Provi der CCN: 15-0069	Peri od:	Worksheet E-1	
				From 01/01/2017		
				To 12/31/2017		
			T: +1 o V/// / /	Hooni tol	5/23/2018 1:1	2 pm
			Title XVIII	Hospi tal	PPS	
					1.00	
	TO BE COMPLETED BY CONTRACTOR FOR MONOTANIDA	DD AACT DEDADTS			1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDA					1
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION					1.00
1.00						
2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12						2.00
3. 00	Medicare HMO days from Wkst. S-3, Pt. I, co					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	the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168					
8.00	Calculation of the HIT incentive payment (s	ee instructions)				8. 00
9. 00	Sequestration adjustment amount (see instru	ctions)				9. 00
10.00	Calculation of the HIT incentive payment af	ter sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS	& CAH				1
30.00	Initial/interim HIT payment adjustment (see	instructions)				30.00
31.00						
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)						
				•		•

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL		In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der C	CCN: 15-0069		Worksheet E-3 Part VII Date/Time Prepared: 5/23/2018 1:12 pm
		T: ::			-

DIRT VII - CALCILATION OF RETINBUSSIENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				To 12/31/2017	Date/Time Pre 5/23/2018 1:1:		
Inpati ent			Title XIX	Hospi tal		_ p	
PART VII - CALCULATION OF REINBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES							
COMPUTATION OF NET COST OF COVERED SERVICES 1.00 1.0							
COMPUTATION OF NET COST OF COVERED SERVICES 1.00 1.0		PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XI	X SERVICES			
Inpatient hospital/SNF/NF services 3.62, 166 6.093, 842 1.00							
Medical and other services 6,093,842 2.00 3.00 Organ acquisition (certified transplant centers only) 3,622,166 6,093,842 4.00 5.00 Inpatient primary payer payments 0 0 0.00	1.00			3, 622, 166		1.00	
Organ acquistion (certified transplant centers only)	2.00	Medical and other services			6, 093, 842	2.00	
Subtotal (sum of lines 1, 2 and 3) 3,622,166 6,093,842 4,00	3.00	Organ acquisition (certified transplant centers only)		0		3.00	
0.00 Outpatient primary payer payments 0.00 0.00	4.00	Subtotal (sum of lines 1, 2 and 3)		3, 622, 166	6, 093, 842	4.00	
0.00 0.00	5.00	Inpatient primary payer payments					
2,00 Subtotal (line 4 less sum of lines 5 and 6) 3,622,166 6,093,842 7,00	6.00				0	6.00	
Reasonable Charges 8.00 Routine service charges 10,056,122 32,612,026 9.00 Ancillary service charges 10,056,122 32,612,026 9.00 10.00 Incentive from target amount computation 10,00 10,056,122 32,612,026 10.00 11.00 10,056,122 32,612,026 10.00 11.00 10,056,122 32,612,026 10.00 11.00 10,056,122 32,612,026 10.00 11.00 10,056,122 32,612,026 10.00 10,001 10,056,122 32,612,026 10.00 10,001 10,056,122 32,612,026 10.00 10,001 10,001 10,056,122 32,612,026 10.00 10,001 10,	7.00			3, 622, 166	6, 093, 842	7. 00	
Routine service charges 0 0 32, 612,026 6, 00 0.00		COMPUTATION OF LESSER OF COST OR CHARGES					
9,00 Ancillary service charges 10,056.122 32,612,02 9,00 10.00 10.00 Incentive from target amount computation 10,00 10,006.122 32,612,026 10,00 10,006.122 32,612,026 10,00 10,006.122 32,612,026 10,006.122 32,612,026 10,006.122 32,612,026 10,006.122 32,612,026 10,006.122 32,612,026 10,006.122 32,612,026 10,006.122 32,612,026 10,006.122 32,612,026 10,006.122 32,612,026 10,006.122 32,612,026 10,006.122 32,612,026 10,006.122 32,612,026 10,006.122 32,612,026 10,006.122 32,612,026 10,006.122 32,612,026 10,006.123 32,612,02		Reasonable Charges					
10.00 Organ acquisition charges, net of revenue 0 10.0	8.00	Routine service charges		0		8.00	
11.00	9.00			10, 056, 122	32, 612, 026	9. 00	
12.00 Total reasonable charges (sum of lines 8 through 11) 10,056,122 32,612,026 12.00 12.00 13.00 13.00 13.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 15.				0		10.00	
CUSTOWARY CHARGES				0			
13. 00 Amount actually collected from patients liable for payment for services on a charge basis 14. 00 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR \$413.13(e) 0.000000 0.000000 15. 00 16. 00 10.056, 122 32. 612, 026 16. 00 10.056, 122 32. 612, 026 16. 00 10.056, 122 32. 612, 026 16. 00 10.056, 122 32. 612, 026 16. 00 10.056, 122 32. 612, 026 16. 00 10.056, 122 32. 612, 026 16. 00 10.056, 122 32. 612, 026 16. 00 10.056, 122 32. 612, 026 16. 00 10.056, 122 32. 612, 026 16. 00 10.056, 122 32. 612, 026 16. 00 10.056, 122 32. 612, 026 16. 00 10.056, 122 32. 612, 026 16. 00 10.056, 122 32. 612, 026 16. 00 10.056, 122 32. 612, 026 16. 00 10.056, 122 32. 612, 026 16. 00 10.056, 122 32. 612, 026 16. 00 10.056, 122 32. 612, 026 16. 00 10.056, 122 32. 612, 026 16. 00	12. 00			10, 056, 122	32, 612, 026	12. 00	
basis							
14.00 Amounts that would have been realized from patients I lable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 0.000000 0.000000 15.00 16.00 Total customary charges (see instructions) 10.056,122 32,612,026 16.00 10.00000 10.00000 10.00000 10.00000 10.00000 10.00000 10.00000 10.00000 10.00000 10.00000 10.00000 10.00000 10.00000 10.000000 10.000000 10.000000 10.0000000 10.000000 10.0000000 10.0000000 10.0000000 10.0000000000	13. 00		services on a charge	0	0	13. 00	
a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 15. 00 Ratio of line 13 to line 14 (not to exceed 1.000000) 10. 000000 10. 000000 10. 000000 10. 000000 10. 0056, 122 32, 612, 026 10. 00 10. 056, 122 32, 612, 026 10. 00 10. 056, 122 32, 612, 026 10. 00 10. 056, 122 32, 612, 026 10. 00 10. 056, 122 32, 612, 026 10. 00 10. 056, 122 32, 612, 026 10. 00 10. 056, 122 32, 612, 026 10. 00 10. 056, 122 32, 612, 026 10. 00 10. 056, 122 32, 612, 026 10. 00 10. 056, 122 32, 612, 026 10. 00	4					44.00	
15.00	14.00			ן ו	0	14.00	
16.00 Total customary charges (see instructions) 10,056,122 32,612,026 16.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 10,056,122 26,518,184 17.00 11 10 16 10 10 10 10	15 00		2 CFR §413. 13(e)	0.000000	0.000000	15 00	
17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 6, 433, 956 26, 518, 184 17.00							
18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 0 0 0 18.00 10 (see instructions) 0 0 19.00 10 10 10 10 10 10 10			if line 14 exceeds				
18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) 19.00 18.00 19.00 10.00	17.00		7 IT TITLE TO exceeds	0, 433, 930	20, 310, 104	17.00	
16) (see instructions) 19.00 1 19.00 1 19.00 1 10.00 1 19.00 1 10.	18 00		, if line 4 exceeds line	7	0	18 00	
19.00 Interins and Resi dents' (see instructions) 0 0 19.00 20.00	10.00		TT TITLE 4 CACCCUS TITLE		O	10.00	
20. 00 Cost of physicians' services in a teaching hospital (see instructions) 0 0 0 0 0 0 0 0 0	19 00			0	0	19 00	
21.00			ıcti ons)	0	-		
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				3, 622, 166	6, 093, 842		
22.00 Other than outlier payments 0 0 22.00					., ,		
24.00 Program capital payments 0 24.00 25.00 Capital exception payments (see instructions) 0 25.00 26.00 Routine and Ancillary service other pass through costs 0 0 26.00 27.00 Subtotal (sum of lines 22 through 26) 0 0 27.00 28.00 Customary charges (title V or XIX PPS covered services only) 0 0 28.00 29.00 Titles V or XIX (sum of lines 21 and 27) 3,622,166 6,093,842 29.00 20.00 ComPUTATION OF REIMBURSEMENT SETTLEMENT 8 0 0 0 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 3,622,166 6,093,842 31.00 32.00 Deductibles 0 0 0 32.00 33.00 Allowable bad debts (see instructions) 0 0 33.00 34.00 Allowable bad debts (see instructions) 0 0 34.00 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 3,622,166 6,093,842 36.00 37.00 ZERO SETTLEMENT -3,622,166 -6,093,842	22.00				0	22. 00	
25. 00 Capital exception payments (see instructions) 26. 00 Routine and Ancillary service other pass through costs 27. 00 Subtotal (sum of lines 22 through 26) 28. 00 Customary charges (title V or XIX PPS covered services only) 29. 00 Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT 30. 00 Excess of reasonable cost (from line 18) 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32. 00 Deductibles 33. 00 Coinsurance 34. 00 Allowable bad debts (see instructions) 35. 00 Utilization review 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37. 00 ZERO SETTLEMENT 38. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 40. 00 Uniterim payments 40. 00	23.00	Outlier payments		0	0	23.00	
26. 00 Routine and Ancillary service other pass through costs 27. 00 Subtotal (sum of lines 22 through 26) 28. 00 Customary charges (title V or XIX PPS covered services only) 29. 00 Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT 30. 00 Excess of reasonable cost (from line 18) 30. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 30. 00 Deductibles 30. 00 Allowable bad debts (see instructions) 31. 00 Allowable bad debts (see instructions) 32. 00 Utilization review 33. 00 Utilization review 34. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 35. 00 Utilization review 36. 00 Subtotal (line 36 ± line 37) 37. 00 ZERO SETTLEMENT 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 40. 00 Bal ance due provider/program (line 40 minus line 41) 41. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	24.00	Program capital payments		0		24.00	
27. 00 Subtotal (sum of lines 22 through 26) 0 0 27. 00 28. 00 Customary charges (title V or XIX PPS covered services only) 3, 622, 166 6, 093, 842 29. 00 Titles V or XIX (sum of lines 21 and 27) 3, 622, 166 6, 093, 842 30. 00 Ecomputation of Reimbursement Settlement 30. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 3, 622, 166 6, 093, 842 31. 00 Deductibles 0 0 0 32. 00 32. 00 Outlibles 0 0 0 33. 00 34. 00 Allowable bad debts (see instructions) 0 0 0 34. 00 35. 00 Utilization review 0 0 35. 00 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 3, 622, 166 6, 093, 842 37. 00 ZERO SETTLEMENT -3, 622, 166 6, 093, 842 38. 00 Subtotal (line 36 ± line 37) 0 0 38. 00 39. 00 Direct graduate medical education payments (from Wkst. E-4) 0 39. 00 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 0 0 0 40. 00 41. 00 Hortim payments 0 0 0 42. 00 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43. 00	25.00	Capital exception payments (see instructions)		0		25.00	
28. 00 Customary charges (title V or XIX PPS covered services only) 7	26.00	Routine and Ancillary service other pass through costs		0	0	26.00	
29.00 Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 3, 622, 166 6, 093, 842 31.00 32.00 Coinsurance 30.00 Allowable bad debts (see instructions) 31.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 ZERO SETTLEMENT 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	27.00	Subtotal (sum of lines 22 through 26)		0	0	27. 00	
COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 0 0 30.00 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 3,622,166 6,093,842 31.00 32.00 33.00 Coinsurance 0 0 0 32.00 33.00 Allowable bad debts (see instructions) 0 0 0 34.00 35.00 Utilization review 0 0 35.00 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 3,622,166 6,093,842 36.00 37.00 ZERO SETTLEMENT -3,622,166 -6,093,842 37.00 38.00 Subtotal (line 36 ± line 37) 0 0 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 0 39.00 41.00 Interim payments 0 0 41.00 Interim payments 0 0 42.00 Balance due provider/program (line 40 minus line 41) 0 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00	28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00	
30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 32.00 Coi nsurance 33.00 Allowable bad debts (see instructions) 35.00 Utilization review 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 ZERO SETTLEMENT 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	29. 00			3, 622, 166	6, 093, 842	29. 00	
31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 3.622, 166 32.00 Deductibles 3.622, 166 3.622							
32.00 Deductibles 0 0 32.00 33.00 34.00 34.00 34.00 34.00 35.00 Utilization review 0 0 35.00 35.00 Utilization review 0 0 35.00 35.00 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 3,622,166 6,093,842 36.00 37.00 2ERO SETTLEMENT -3,622,166 -6,093,842 37.00 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 40.00 41.00 Total amount payable to the provider (sum of lines 38 and 39) 0 40.00 41.00 42.00 Balance due provider/program (line 40 minus line 41) 0 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00				0			
33.00 Coinsurance 0 0 33.00 34.00 34.00 35.00 Utilization review 0 35.00 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 3,622,166 6,093,842 36.00 37.00 ZERO SETTLEMENT -3,622,166 -6,093,842 37.00 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 39.00 1.00 Interim payments 0 0 40.00 41.00 Interim payments 0 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) 0 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00				3, 622, 166			
34.00 Allowable bad debts (see instructions) 0 34.00 35.00 Utilization review 0 35.00 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 3,622,166 6,093,842 36.00 37.00 ZERO SETTLEMENT -3,622,166 -6,093,842 37.00 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 0 40.00 1nterim payments 0 41.00 1nterim payments 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00				0	- 1		
35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 3,622,166 6,093,842 36.00 37.00 ZERO SETTLEMENT 5,622,166 -6,093,842 37.00 Subtotal (line 36 ± line 37) 0 0 38.00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 Total amount payable to the provider (sum of lines 38 and 39) 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				0	-		
36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 3, 622, 166 -3, 622, 166 -3, 622, 166 -6, 093, 842 37.00 38.00 Subtotal (line 36 ± line 37) 0 0 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 0 Total amount payable to the provider (sum of lines 38 and 39) 0 1 nterim payments 0 0 41.00 0 Balance due provider/program (line 40 minus line 41) 0 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00		,		0	0		
37. 00 ZERO SETTLEMENT 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 41. 00 Balance due provider/program (line 40 minus line 41) 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 37. 00 38. 00 39. 00 39. 00 40. 00 41. 00 42. 00 43. 00			22)	0			
38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 38.00 39.00 0 40.00 0 41.00 0 42.00							
39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 39.00 0 40.00 0 41.00 0 42.00 0 43.00							
40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 40.00 0 40.00 0 41.00 0 42.00 43.00				0			
41.00 Interim payments 0 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) 0 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00			_	0			
42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 42.00 43.00			-	-			
43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00			٩	-			
				- 1			
10.00p.co. 1, 3.10.2	75.00		WI CII ONO I UD 13-2,		U	75.00	
		- -		'	ı	•	

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: From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/23/2018 1:12 pm

oni y)				12,01,201,	5/23/2018 1: 1	2 pm
		General Fund	Specific	Endowment	Plant Fund	
		1. 00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS					
1. 00 2. 00	Cash on hand in banks	16, 303, 840	0	0	0	1.00 2.00
3.00	Temporary investments Notes receivable	0		0	0	3.00
4. 00	Accounts receivable	10, 370, 400	_	0	0	4.00
5.00	Other recei vable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	
7.00	Inventory	2, 497, 096	1	0	0	7.00
8. 00 9. 00	Prepaid expenses Other current assets	2, 917, 927 210, 357	1	0	0	8. 00 9. 00
10.00	Due from other funds	210, 337		0	0	10.00
11.00	Total current assets (sum of lines 1-10)	32, 299, 620		0	0	11.00
	FIXED ASSETS					
12.00	Land	4, 045, 918	1	0	0	
13. 00 14. 00	Land improvements Accumulated depreciation	0	0	0	0	13.00
15. 00	Buildings	118, 000, 503	- 1	0	0	15.00
16. 00	Accumulated depreciation	-30, 916, 975		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	Fixed equipment	0	0	0	0	19.00
20. 00 21. 00	Accumulated depreciation Automobiles and trucks	1, 253, 908		0	0	20.00
22.00	Accumulated depreciation	-1, 253, 1 08		0	0	22.00
23. 00	Major movable equipment	62, 399, 767		0	0	23. 00
24.00	Accumul ated depreciation	-46, 686, 777	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 Accumulated depreciation	0		0	0	27.00
29. 00	Mi nor equi pment-nondepreci abl e	0		0	0	
30.00	Total fixed assets (sum of lines 12-29)	107, 005, 759	0	0	0	
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32. 00 33. 00	Deposits on leases Due from owners/officers) 	0	0	0	32. 00 33. 00
34.00	Other assets	137, 600, 992	Ö	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	137, 600, 992	1	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	276, 906, 371	0	0	0	36.00
27 00	CURRENT LIABILITIES	2 025 220		0	0	27 00
37. 00 38. 00	Accounts payable Salaries, wages, and fees payable	2, 035, 338	0	0	0	37. 00 38. 00
39. 00	Payrol I taxes payable	Ö		0	0	39.00
40.00	Notes and Loans payable (short term)	461, 761	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0				42.00
43. 00 44. 00	Due to other funds Other current liabilities	11, 809, 545		0	0	
45.00	Total current liabilities (sum of lines 37 thru 44)	14, 306, 644	·	0		
	LONG TERM LIABILITIES	,	-1			
46.00	Mortgage payable	0	0	0	0	
47.00	Notes payable	92, 316, 785		0	0	
48.00	Unsecured Loans Other Long term Liabilities	1 220 270	0	0	0	48. 00 49. 00
49. 00 50. 00	Total long term liabilities (sum of lines 46 thru 49)	1, 328, 270 93, 645, 055		0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	107, 951, 699		0	0	
	CAPITAL ACCOUNTS					
52.00	General fund balance	168, 954, 672				52.00
53.00	Specific purpose fund		0	0		53.00
54. 00 55. 00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		54. 00 55. 00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant			Ĭ	0	
58.00	Plant fund balance - reserve for plant improvement,				0	58.00
FO 00	replacement, and expansion	1/0 054 /30			_	F0 00
59. 00 60. 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	168, 954, 672 276, 906, 371	1	0	0	59. 00 60. 00
50.00	[59]	270,700,371		U		00.00
	1 /	•		· ·	ı	

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES KING'S DAUGHTERS' HOSPITAL

Provi der CCN: 15-0069

					To 12/31/201	7 Date/Time Pro 5/23/2018 1:	epared: 12 pm
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
	I -	1. 00	2.00	3. 00	4. 00	5. 00	
1.00	Fund balances at beginning of period		148, 855, 645	1		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		20, 099, 027	1		0	2. 00 3. 00
3. 00 4. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)		168, 954, 672		0	u (
5. 00	Additions (credit adjustments) (specify)				0		
6. 00					Ö		
7. 00		ol			o		
8. 00		o			0		
9.00		o			0		9.00
10.00	Total additions (sum of line 4-9)		0			o	10.00
11. 00	Subtotal (line 3 plus line 10)		168, 954, 672			0	11.00
12.00	Deductions (debit adjustments) (specify)	0			0		
13.00		0			0		
14.00		0			0		
15. 00 16. 00		0			0		
16.00					0		
18.00	Total deductions (sum of lines 12-17)		0		O .		18.00
19. 00	Fund balance at end of period per balance		168, 954, 672			0	19.00
171.00	sheet (line 11 minus line 18)		100,701,072				
		Endowment	PI ant	Fund		•	
		Fund		1			
		6. 00	7. 00	8.00			
1.00	Fund balances at beginning of period	0			0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3. 00	Total (sum of line 1 and line 2)	0	_		0		3. 00
4.00	Additions (credit adjustments) (specify)		0	1			4.00
5. 00 6. 00			0				5.00
7. 00			0				6. 00 7. 00
8. 00			0				8.00
9. 00			0				9.00
10.00	Total additions (sum of line 4-9)	0	· ·		0		10.00
11. 00	Subtotal (line 3 plus line 10)	o			0		11.00
12.00	Deductions (debit adjustments) (specify)		0	1			12.00
13.00			0	(13.00
14.00			0				14.00
15.00			0				15. 00
16. 00			0	1			16.00
17.00	T	_	0	1			17.00
18.00	Total deductions (sum of lines 12-17)	0			0		18.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)				O		19.00

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

			IC	12/31/201/	5/23/2018 1:1:	
	Cost Center Description	Inpati en	t	Outpati ent	Total	z piii
		1.00		2. 00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>				
	General Inpatient Routine Services					
1.00	Hospi tal	13, 088,	777		13, 088, 777	1.00
2.00	SUBPROVIDER - IPF					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)	13, 088,	777		13, 088, 777	10.00
	Intensive Care Type Inpatient Hospital Services					
11. 00	INTENSIVE CARE UNIT	2, 422,	631		2, 422, 631	11.00
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)	0.400	. 04		0 400 (04	15.00
16. 00	Total intensive care type inpatient hospital services (sum of lines	2, 422,	631		2, 422, 631	16. 00
17 00	11-15)	15 511	400		15 511 400	17 00
17. 00 18. 00	Total inpatient routine care services (sum of lines 10 and 16) Ancillary services	15, 511, 80, 749,		270 110 510	15, 511, 408 359, 859, 633	17. 00 18. 00
19. 00	Outpatient services	00, 749,	0	279, 110, 510 0	339, 639, 633	19. 00
20.00	RURAL HEALTH CLINIC		0	0	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21.00
22. 00	HOME HEALTH AGENCY		U	1, 841, 795	1, 841, 795	22.00
23. 00	AMBULANCE SERVICES	4	556	4, 657, 275	4, 663, 831	23. 00
24. 00	CMHC	0,	330	4,037,273	4, 003, 031	24.00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)					25. 00
26. 00	HOSPI CE		0	388, 825	388, 825	26.00
27. 00	OTHER (SPECIFY)		0	000, 020	000, 020	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wk	st. 96, 267,	087	285, 998, 405	382, 265, 492	28. 00
20.00	G-3, line 1)	70,207,	00.	200, 770, 100	002/200/ 1/2	20.00
	PART II - OPERATING EXPENSES	'	•			
29.00	Operating expenses (per Wkst. A, column 3, line 200)			123, 624, 971		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			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			0			41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tra	insfer		123, 624, 971		43.00
	to Wkst. G-3, line 4)	I	I	I		

	ncial Systems	KING'S DAUGHTERS'			u of Form CMS-2	
STATEMENT (F REVENUES AND EXPENSES		Provider CCN: 15-0069	Peri od: From 01/01/2017	Worksheet G-3	
				To 12/31/2017	Date/Time Pre	pared:
					5/23/2018 1:1	
	(6)		00)		1.00	1 0
	I patient revenues (from Wkst. G-2, Part				382, 265, 492	
4	contractual allowances and discounts on	n patrents' accoun	ts		255, 270, 324	
	patient revenues (line 1 minus line 2)	0 0 1 11 11 11	40)		126, 995, 168	
	total operating expenses (from Wkst. G-		43)		123, 624, 971	
	income from service to patients (line 3 R INCOME	minus iine 4)			3, 370, 197	5.0
	ributions, donations, beguests, etc				49, 724	6.0
	me from investments				2, 666, 798	
	nues from telephone and other miscellane	ous communication	servi ces		2, 000, 770	
	nue from television and radio service	ous communication	30. 1. 003		0	1
	hase di scounts				0	10.0
	tes and refunds of expenses				0	1
	ing lot receipts				0	
	nue from Laundry and Linen service				0	13.0
	nue from meals sold to employees and que	ests			366, 454	14.0
	nue from rental of living quarters				0	ı
	nue from sale of medical and surgical su	upplies to other t	han patients		171	16.0
7.00 Reve	nue from sale of drugs to other than pat	ients	·		0	17.0
8.00 Reve	nue from sale of medical records and abs	stracts			127	18.0
9. 00 Tui t	ion (fees, sale of textbooks, uniforms,	etc.)			0	19.0
0.00 Reve	nue from gifts, flowers, coffee shops, a	and canteen			0	20.0
21.00 Rent	al of vending machines				0	21.0
2.00 Rent	al of hospital space				0	22.0
3.00 Gove	rnmental appropriations				49, 055	23.0
4.00 OTHE	R OPERATING INCOME				13, 596, 501	24.0
4. 01 GAIN	/LOSS ON SALE				0	24.0
4. 02 OTHE	R NONOPERATING REVENUE				0	24.0
	l other income (sum of lines 6-24)				16, 728, 830	
26. 00 Tota	l (line 5 plus line 25)				20, 099, 027	26.0
	R EXPENSES (SPECIFY)				0	
28. 00 Tota	I other expenses (sum of line 27 and sub	scri pts)			0	28.0
29.00 Net	income (or loss) for the period (line 26	minus line 28)			20, 099, 027	29.0

	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 01/01/2017 To 12/31/2017	Date/Time Pre	pared:
						Home Health	5/23/2018 1: 1 PPS	
						Agency I		
		Sal ari es	Benefits	Transportatio n (see instructions)	Contracted/P rchased Services	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	0	1.00
1.00	Fixtures							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	918, 972	88	946		0 10,000	930, 006	
	HHA REIMBURSABLE SERVICES			00.004			00.00/	
6. 00 7. 00	Skilled Nursing Care Physical Therapy	0	0	33, 236 27, 362		0 0	33, 236 27, 362	
8. 00	Occupational Therapy	0	o	0		0 0	0	1
9. 00	Speech Pathology	0	0	0		0 0	0	
10. 00 11. 00	Medical Social Services Home Health Aide	0	0	0 3, 727		0 0	0	10.00
12. 00	Supplies (see instructions)		0	3, 727		0 19, 179	3, 727 19, 179	1
13. 00	Drugs	0	Ö	Ö		0 702	702	
14.00	DME	0	0	0		0 0	0	14.00
15. 00	HHA NONREI MBURSABLE SERVI CES Home Dialysis Aide Services	0	0	ol		0 0	0	15. 00
16. 00	Respiratory Therapy		0	0		0 0		1
17. 00	Private Duty Nursing	0	0	ō		0 0	Ō	17.00
18. 00	Clinic	0	0	0		0 0	0	
19.00	Health Promotion Activities	0	0	0		0 0	0	19.00
20. 00 21. 00	Day Care Program Home Delivered Meals Program		0	0			0	20.00
22. 00	Homemaker Service	l ő	Ö	o		0 0	Ö	22.00
23. 00	All Others (specify)	0	0	О		0 0	0	23. 00
23. 50	Tel emedi ci ne	0	0	(5.271		0 0	0	23.50
24. 00	Total (sum of lines 1-23)	918, 972 Recl assi fi cat	88 Recl assi fi ed	65, 271 Adjustments	Net Expenses	0 29, 881	1, 014, 212	24.00
		i on	Trial Balance	riaj ao timorreo	for			
			(col. 6 +		All ocation			
			col . 7)		(col. 8 + col. 9)			
		7. 00	8. 00	9. 00	10.00			1
	GENERAL SERVICE COST CENTERS							
1. 00	Capital Related - Bldg. &	0	0	0		0		1.00
2. 00	Fixtures Capital Related - Movable	0	0	0		0		2. 00
3. 00	Equipment Plant Operation & Maintenance	0	0	0		0		3.00
4. 00	Transportati on	0	0	Ō		0		4.00
5. 00	Administrative and General	-328, 875	601, 131	0	601, 13	31		5.00
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	26, 025	59, 261	ol	59, 20	51		6.00
7. 00	Physical Therapy	215, 391	242, 753	o	242, 7			7. 00
8.00	Occupational Therapy	58, 464	58, 464	0	58, 40			8.00
9. 00	Speech Pathology	4, 953	4, 953	0	4, 9	53		9.00
10.00	Medical Social Services Home Health Aide	0	27 740	0	27, 70	0		10.00
11. 00 12. 00	Supplies (see instructions)	24, 042	27, 769 19, 179	0	19, 1			12.00
13. 00	Drugs	0	702	ō	7(13.00
14.00	DME	0	0	0		0		14.00
15. 00	HHA NONREI MBURSABLE SERVI CES	0	0	0		0		15. 00
16. 00	Home Dialysis Aide Services Respiratory Therapy		0	0		0		16.00
17. 00	Private Duty Nursing	0	Ö	ő		Ö		17.00
18. 00	Clinic	0	0	o		0		18.00
19. 00 20. 00	Health Promotion Activities Day Care Program	0	0	0		0		19. 00 20. 00
21. 00	Home Delivered Meals Program		0	ol Ol		0		20.00
22. 00	Homemaker Service	0	ő	ő		0		22. 00
23. 00	All Others (specify)	0	0	0		0		23.00
23. 50 24. 00	Telemedicine Total (sum of lines 1-23)	0	0 1, 014, 212	0	1, 014, 2	U		23. 50 24. 00
Z4. UU	Total (Suii OI TITIES 1-23)	ı	1,014,212	υĮ	1,014,2	14		1 24.00

Heal th	Financial Systems		KING'S DAUGHTER	S' HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - HHA GENERAL SERVICE	COST		Provi der C	CN: 15-0069	Peri od: From 01/01/2017	Worksheet H-1 Part I	
				HHA CCN:	15-7141	To 12/31/2017		pared:
						Home Health	PPS	2 piii
			Capital Rela	ated Costs		Agency I		
		Not Evnences	·	Movabl e	Dlont	Transpartatio	Subtotal	
		Net Expenses for Cost	Bl dgs & Fi xtures	Equi pment	Plant Operation 8	Transportation n	(col s. 0-4)	
		Allocation (from Wkst.			Mai ntenance	9		
		H, col. 10)						
	GENERAL SERVICE COST CENTERS	0	1. 00	2.00	3. 00	4. 00	4A. 00	
1. 00	Capital Related - Bldg. &	0	0				0	1.00
2. 00	Fixtures Capital Related - Movable	0		0			0	2.00
3. 00	Equipment Plant Operation & Maintenance	0	0	0		0	0	3. 00
4. 00	Transportation	0	0	0		0 0	0	4.00
5. 00	Administrative and General HHA REIMBURSABLE SERVICES	601, 131	0	0		0 0	601, 131	5.00
6. 00	Skilled Nursing Care	59, 261	0	0		0 0	59, 261	6.00
7. 00 8. 00	Physical Therapy Occupational Therapy	242, 753 58, 464	0	0	•	0 0	242, 753 58, 464	
9. 00	Speech Pathology	4, 953	Ö	0	1	0 0	4, 953	
10. 00 11. 00	Medical Social Services Home Health Aide	0 27, 769	0	0		0 0	0 27 769	10.00 11.00
12.00	Supplies (see instructions)	19, 179	Ö	0	•	0 0	19, 179	12.00
13. 00 14. 00	Drugs DME	702 0	0	0		0 0		13. 00 14. 00
	HHA NONREIMBURSABLE SERVICES		- 1		· 			
15. 00 16. 00	Home Dialysis Aide Services Respiratory Therapy	0	0	0	l .	0 0	0	
17.00	Private Duty Nursing	0	0	0	1	0 0	0	17.00
18. 00 19. 00	Clinic Health Promotion Activities	0	0	0	1	0 0	0	
20.00	Day Care Program	0	0	0		0 0	0	
21. 00 22. 00	Home Delivered Meals Program Homemaker Service	0	0	0		0 0	0	
23.00	All Others (specify) Telemedicine	0	0	0		0 0	0	23. 00 23. 50
23. 50 24. 00	Total (sum of lines 1-23)	1, 014, 212	0	0		0 0	0 1, 014, 212	
		Administrativ e & General	Total (cols. 4A + 5)					
		5. 00	6.00					
1. 00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &							1.00
	Fixtures							
2. 00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4. 00 5. 00	Transportation Administrative and General	601, 131						4. 00 5. 00
6 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	86, 239	145, 500					6. 00
6. 00 7. 00	Physical Therapy	353, 262	596, 015					7. 00
8. 00 9. 00	Occupational Therapy Speech Pathology	85, 079 7, 208	143, 543 12, 161					8. 00 9. 00
10.00	Medical Social Services	0	0					10.00
11. 00 12. 00	Home Health Aide Supplies (see instructions)	40, 411 27, 910	68, 180 47, 089					11. 00 12. 00
13.00	Drugs	1, 022	1, 724					13.00
14. 00	DME HHA NONREI MBURSABLE SERVI CES	0	0					14.00
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 19. 00	Clinic	0	0					18.00
20. 00	Health Promotion Activities Day Care Program	0	0					19. 00 20. 00
21. 00 22. 00	Home Delivered Meals Program Homemaker Service	0	0					21. 00 22. 00
23.00	All Others (specify)	0	0					23. 00
	Telemedicine Total (sum of lines 1-23)	0	0 1, 014, 212					23. 50 24. 00
_ 1. 00	1.1.10. (30 01 111103 1 20)	!	., 0 . , 2 . 2					, 21.00

	Financial Systems		KING'S DAUGHTE				u of Form CMS-2	
COST A	LLOCATION - HHA STATISTICAL BAS	SIS		Provi der C		Period: From 01/01/2017	Worksheet H-1	
				HHA CCN:		To 12/31/2017		
						Home Health	PPS	
						Agency I		
		Capi tal Rel	ated Costs					
		51.1.0		<u>.</u>				
		Bl dgs &	Movabl e	Plant		Reconciliatio		
		Fi xtures	Equi pment	Operation &	n (MILEAGE)	n	e & General	
		(SQUARE FEET)	(DOLLAR	Mai ntenance			(ACCUM. COST)	
		1.00	VALUE)	(SQUARE FEET)	4.00	FA 00	F 00	
	CENEDAL CEDVICE COCT CENTEDS	1. 00	2. 00	3. 00	4. 00	5A. 00	5. 00	
1 00	GENERAL SERVICE COST CENTERS	0			I	0	I	1.00
1. 00	Capital Related - Bldg. & Fixtures	0				0		1.00
2. 00	Capital Related - Movable		0			0		2.00
2.00	Equipment		U			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4. 00	Transportation (see	0	0	0		0		4.00
4.00	instructions)	0	0	0	·	O .		4.00
5. 00	Administrative and General	0	0	0		0 -601, 131	413, 081	5. 00
3.00	HHA REIMBURSABLE SERVICES					0 001, 131	413,001	3.00
6. 00	Skilled Nursing Care	0	0	0		0 0	59, 261	6.00
7. 00	Physi cal Therapy	0	0			o o	242, 753	
8. 00	Occupational Therapy	0	0			0	58, 464	1
9.00	Speech Pathology	O	0	0		o o	4, 953	
10.00	Medical Social Services	0	0	0		o o	0	1
11.00	Home Health Aide	0	0	0		o o	27, 769	11.00
12.00	Supplies (see instructions)	0	0	0		o o	19, 179	12.00
13.00	Drugs	o	0	O		0	702	13.00
14.00	DME	0	0			0 0		1
	HHA NONREIMBURSABLE SERVICES			<u> </u>	•		•	
15.00	Home Dialysis Aide Services	0	0	0		0 0	0	15. 00
16.00	Respi ratory Therapy	O	0	0		0 0	0	16.00
17.00	Private Duty Nursing	o	0	0		0 0	0	17.00
18.00	Clinic	0	0	0		0 0	0	18.00
19.00	Health Promotion Activities	0	0	0		0 0	0	19.00
20.00	Day Care Program	0	0	0		0 0	0	20.00
21.00	Home Delivered Meals Program	0	0	0		0 0	0	21.00
22.00	Homemaker Service	0	0	0		0 0	0	22. 00
23.00	All Others (specify)	0	0	0		0 0	0	23.00
23. 50	Tel emedi ci ne	0	0	0		0 0	0	23. 50
24.00	Total (sum of lines 1-23)	0	0	0		-601, 131		
25.00	Cost To Be Allocated (per	0	0	0		0	601, 131	25. 00
	Worksheet H-1, Part I)							
26. 00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0.00000	0	1. 455238	26.00

Home Health PPS

						Home Health Agency I	PPS	
			CAPI	TAL RELATED CO	OSTS	Agency I		
	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. 50 20. 00 21. 00	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	0 145, 500 596, 015 143, 543 12, 161 0 68, 180 47, 089 1, 724 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0	221, 047 145, 500 596, 015 143, 543 12, 161 0 68, 180 47, 089 1, 724 0 0 0 0 0 0 0 0 1, 235, 259 0. 0000000	5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00
	Cost Center Description	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		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 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00	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)	39, 182 25, 791 105, 649 25, 444 2, 156 0 12, 085 8, 347 306 0 0 0 0 0 0 0 0 218, 960	49, 554 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0		000000000000000000000000000000000000000	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00

⁽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

0

0

0

0

1, 504, 578

13.00

14.00

15.00

16.00

17.00

18.00

19.00

19.50

20.00

21.00

309, 783

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1, 504, 578

0

0 0 0

0

13.00

14.00

15.00

16.00

17.00

18.00

19.00

19.50

20 00

21.00

Clinic

Private Duty Nursing

Day Care Program

Homemaker Service

6 decimal places.

Tel emedi ci ne

All Others (specify)

Health Promotion Activities

Home Delivered Meals Program

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

Unit Cost Multiplier: column

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

⁽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.

Health Financial Systems KING ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS KING'S DAUGHTERS' HOSPITAL In Lieu of Form CMS-2552-10 Worksheet H-2 Part I Date/Time Prepared: 5/23/2018 1:12 pm Provi der CCN: 15-0069 Peri od: From 01/01/2017 To 12/31/2017 HHA CCN: 15-7141 Home Health PPS

				Home Hear th	110	
				Agency I		
	Cost Center Description	Total HHA				
		Costs				
	,	28. 00	 			
1.00	Administrative and General					1.00
2.00	Skilled Nursing Care	215, 703				2.00
3.00	Physi cal Therapy	883, 590				3.00
4.00	Occupational Therapy	212, 801				4. 00
5.00	Speech Pathology	18, 029				5.00
6.00	Medical Social Services	0				6.00
7.00	Home Health Aide	101, 076				7. 00
8.00	Supplies (see instructions)	70, 823				8.00
9.00	Drugs	2, 556				9. 00
10.00	DME	0				10.00
11.00	Home Dialysis Aide Services	0				11.00
12.00	Respiratory Therapy	0				12.00
13.00	Private Duty Nursing	0				13.00
14.00	Clinic	0				14.00
15.00	Health Promotion Activities	0				15.00
16.00	Day Care Program	0				16.00
17.00	Home Delivered Meals Program	0				17.00
18.00	Homemaker Service	0				18. 00
19.00	All Others (specify)	0				19. 00
19. 50	Tel emedi ci ne	0				19. 50
20.00	Total (sum of lines 1-19) (2)	1, 504, 578				20. 00
21.00	Unit Cost Multiplier: column					21. 00
	26, line 1 divided by the sum					
	of column 26, line 20 minus					
	column 26, line 1, rounded to					
	6 decimal places.					

⁽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.

5/23/2018 1:12 pm

0.000000

22 00

Home Health PPS Agency I CAPITAL RELATED COSTS NEW BLDG & NEW BLDG & NEW MVBLE **EMPLOYEE** Reconciliatio ADMINISTRATIV Cost Center Description FIXT HHA/HO EQUI P **BENEFITS** E & GENERAL FI XT n (SQUARE (SQUARE (SQUARE DEPARTMENT (ACCUM. FEET) FEET) FEET) (GROSS COST) SALARIES) 1.00 5.00 1.01 2.00 4.00 5A 1.00 Administrative and General 0 2, 748 2, 748 919, 060 0 221, 047 1.00 2.00 Skilled Nursing Care 0 0 0 145, 500 2.00 Physical Therapy 0 0 0 0 3.00 3 00 596, 015 Ω 0 0 0 4.00 Occupational Therapy 0 143, 543 4.00 Speech Pathology 0 5.00 0 0 0 0 12, 161 5.00 0 0 0 6.00 Medical Social Services 0 0 0 6.00 0 0 0 68, 180 7 00 Home Health Aide Ω 7 00 8.00 Supplies (see instructions) 0 0 47,089 8.00 9.00 0 0000 0 0 1, 724 9.00 Drugs 0 0 10.00 10.00 DMF 0 0 0 0 11.00 11.00 Home Dialysis Aide Services 0 0 12.00 Respiratory Therapy 0 0 0 12.00 Private Duty Nursing 0 13.00 13.00 0 0 0 0 0 0 14.00 Clinic 0 14.00 15.00 Health Promotion Activities C 0 15 00 16.00 Day Care Program 16.00 17.00 Home Delivered Meals Program 0 0 0 0 17.00 0 0 0 Homemaker Service 18.00 C 0 18.00 0 0 19.00 All Others (specify) C 19.00 0 0 19.50 19.50 Tel emedi ci ne 0 Total (sum of lines 1-19) 0 2, 748 919, 060 20.00 2,748 1, 235, 259 20.00 218, 960 21.00 Total cost to be allocated 6, 214 214, 833 21.00 22.00 Unit cost multiplier 0.000000 2. 261281 0.000000 0.233753 0.177258 22.00 OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG Cost Center Description **PLANT** LINEN SERVICE (HOURS OF (MEALS (MEALS ADMI NI STRATI O (POUNDS OF (SOUARE SERVICE) SERVED) SERVED) (DI RECT FEET) LAUNDRY) NRSING HRS) 7.00 8. 00 9.00 10.00 11. 00 13.00 Administrative and General 2, 748 1.00 1.00 00 0 0 0 0 2.00 Skilled Nursing Care 0 C 0 2 00 3.00 Physical Therapy 0 0000000000000000 0 3.00 4.00 Occupational Therapy 0 0 0 0 0 4.00 0 Speech Pathology 0 0 5.00 0 5.00 0 0 6.00 Medical Social Services 6.00 7.00 Home Heal th Aide 0 0 0 0 0 0 7.00 0 0 8.00 Supplies (see instructions) 0 8.00 0 0 Drugs 0 9.00 0 9.00 10.00 DMF C 0 10.00 11.00 Home Dialysis Aide Services 11.00 0 0 0 0 Respiratory Therapy 0 12.00 12.00 0 13.00 Private Duty Nursing C 0 13.00 14.00 0 14.00 Clinic 0 0 15.00 Health Promotion Activities 0 0 0 15.00 0 0 16,00 Day Care Program 0 16,00 17.00 Home Delivered Meals Program 0 17.00 0 Homemaker Service 0 0 0 o 18.00 18.00 All Others (specify) o 0 0 0 19.00 19.00 0 Tel emedi ci ne 0 0 o 19.50 19.50 C 20.00 Total (sum of lines 1-19) 2,748 0 C 0 0 20.00 21.00 Total cost to be allocated 49, 554 21.00

18. 032751

0.000000

0.000000

0.000000

0.000000

22.00 Unit cost multiplier

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL Provider CCN: 15-0069

BASIS

HOSPITAL In Lieu of Form CMS-2552-10

Period: Worksheet H-2

From 01/01/2017 Part II

HHA CCN: 15-7141 12/31/2017 Date/Time Prepared: 5/23/2018 1:12 pm Home Health PPS Agency I CENTRAL PHARMACY SOCI AL NONPHYSI CI AN RADI OLOGY Cost Center Description MEDI CAL SERVICES & **ANESTHETI STS** (COSTED RECORDS & SERVI CE SCHOOL REQUIS.) (TIME (ASSI GNED SUPPLY LI BRARY (ASSI GNED (COSTED (GROSS SPENT) TIME) TIME) REQUIS.) CHARGES) 17.00 19. 00 23.00 14. 00 15. 00 16. 00 Administrative and General 1.00 0 00 0 0 1.00 2.00 Skilled Nursing Care C 2.00 3.00 Physical Therapy 0 0 0 3.00 0000000000000000000 0 0 0 Occupational Therapy 0 0 0 4.00 4.00 0 0 Speech Pathology 0 5.00 5.00 0 0 6.00 Medical Social Services 0 6.00 7.00 Home Health Aide 0 0 0 0 0 0 7.00 23, 895 0 0 8.00 8 00 Supplies (see instructions) 0 0 0 9.00 Drugs 0 9.00 10.00 DMF 0 0 10.00 0 0 11.00 Home Dialysis Aide Services 0 0 0 11.00 0 Respiratory Therapy 0 0 12 00 12 00 13.00 Private Duty Nursing 0 13.00 14.00 Clinic 0 0 0 14.00 0 0 0 Health Promotion Activities 0 15.00 0 0 15.00 0 0 Day Care Program 0 16.00 16.00 17.00 Home Delivered Meals Program 0 0 17.00 Homemaker Service 0 0 o 18.00 0 18.00 All Others (specify) 0 0 0 19 00 0 ol 19 00 0 0 0 19.50 Tel emedi ci ne C 19.50 Total (sum of lines 1-19) 23, 895 0 0 0 20.00 20.00 21.00 Total cost to be allocated 805 0 0 0 21.00 0.000000 0. 033689 0.000000 0.000000 Unit cost multiplier 0.000000 0.000000 22.00 22.00 Cost Center Description HUB SITE 3RD YEAR MED STUDENTS (ASSI GNED TIME) 23.01 1.00 Administrative and General 0 1.00 2.00 Skilled Nursing Care 0 0 0 2.00 Physi cal Therapy 3.00 3 00 4.00 Occupational Therapy 4.00 Speech Pathology 5.00 0 5.00 6.00 Medical Social Services 6.00 0 0 0 7.00 Home Health Aide 7.00 8.00 Supplies (see instructions) 8.00 9.00 0 0 0 9.00 Drugs 10.00 DMF 10.00 11.00 Home Dialysis Aide Services 11.00 Respiratory Therapy 0 0 0 0 0 0 0 12.00 12.00 Private Duty Nursing 13.00 13.00 14.00 Clinic 14.00 15.00 Health Promotion Activities 15.00 Day Care Program 16.00 16.00 Home Delivered Meals Program 17.00 17.00 18 00 Homemaker Service 18.00 19.00 All Others (specify) 19.00 0 19.50 Tel emedi ci ne 19.50 Total (sum of lines 1-19) 0 20.00 20.00 0 21.00 Total cost to be allocated 21.00 22.00 Unit cost multiplier 0.000000 22.00

Heal th	Financial Systems		KING'S DAUGHTE	RS' HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	TONMENT OF PATIENT SERVICE COS	TS		Provi der C	CN: 15-0069	Peri od:	Worksheet H-3	
				HHA CCN:		From 01/01/2017 To 12/31/2017	Part I Date/Time Prep 5/23/2018 1:12	
				Title	e XVIII	Home Health Agency I	PPS	
	Cost Center Description	From, Wkst.	Facility	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I,	Costs (from	Ancillary	Costs (cols.		Per Visit	
		col. 28, line	Wkst. H-2, Part I)	Costs (from Part II)	1 + 2)		(col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
	PART I - COMPUTATION OF LESSER							
	COST LIMITATION Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	215, 703		215, 70	3, 918	55. 05	1. 00
2. 00	Physical Therapy	3.00		0			290. 08	2. 00
3. 00	Occupational Therapy	4.00		0			275. 29	3. 00
4.00	Speech Pathology	5.00		0	1		305. 58	4.00
5.00	Medical Social Services	6. 00	0			0 3	0. 00	5.00
6.00	Home Health Aide	7.00	101, 076		101, 07	76 388	260. 51	6.00
7. 00	Total (sum of lines 1-6)		1, 431, 199	0	1, 10 1, 11			7.00
					Program Visit	:S		
					Pá	nrt B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject			
					to	Deducti bl es		
					Deducti bl es			
		0	1. 00	2. 00	Coi nsurance 3.00	4. 00	5. 00	
	Limitation Cost Computation	0	1.00	2.00	3.00	4.00	3.00	
8.00	Skilled Nursing Care		31140	0	1	5		8.00
8. 01	Skilled Nursing Care		99915	0	2, 27	' 1		8. 01
9.00	Physi cal Therapy		31140	0	2	24		9.00
9. 01	Physi cal Therapy		99915	0	_, -,	96		9. 01
10.00	Occupational Therapy		31140	0		4		10.00
10. 01	Occupational Therapy		99915	0	1			10.01
11.00	Speech Pathology		31140	0	1	0		11.00
11. 01 12. 00	Speech Pathology Medical Social Services		99915 31140	0	1	0		11. 01 12. 00
12.00	Medical Social Services		99915	0	1	1		12.00
13. 00	Home Heal th Ai de		31140	0		9		13. 00
13. 01	Home Heal th Ai de		99915	0	1			13. 01
	Total (sum of lines 8-13)			0	1			14.00
	Cost Center Description	From Wkst.	Facility	Shared	Total HHA	Total Charges	Ratio (col. 3	
		H-2 Part I,	Costs (from	Ancillary	Costs (cols.		÷ col. 4)	
		col. 28, line	Wkst. H-2,	Costs (from	1 + 2)	Records)		
		0	Part I)	Part II)	2.00	4.00	Г 00	
	Supplies and Drugs Cost Comput	0 ations	1. 00	2. 00	3. 00	4. 00	5. 00	
	Cost of Medical Supplies	8. 00		0				
16. 00	Cost of Drugs	9. 00				66 0	0. 000000	16.00
			Program Visits		Cost of			
			Don	+ D	Servi ces	Dort D		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Part B Not Subject	Subject to	
	cost center bescription	rait A	to	Deductibles &		to	Deductibles &	
				Coinsurance		Deductibles &	Coi nsurance	
			Deductibles & l					
			Deducti bl es & Coi nsurance	oor risur unce		Coi nsurance		
		6. 00	Coi nsurance 7. 00	8. 00	9.00	10.00	11. 00	
	PART I - COMPUTATION OF LESSER		Coi nsurance 7. 00	8. 00		10.00		
	PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation		Coi nsurance 7. 00	8. 00		10.00		
1.00	COST LIMITATION Cost Per Visit Computation Skilled Nursing Care		Coi nsurance 7.00 PROGRAM COST, A	8.00 AGGREGATE OF TI	HE PROGRAM LI	10. 00 MI TATI ON COST, C 0 125, 844	R BENEFICIARY	1.00
2.00	COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy	OF AGGREGATE	Coinsurance 7.00 PROGRAM COST, A 2,286 2,120	8.00 AGGREGATE OF TI	HE PROGRAM LI	10.00 MI TATI ON COST, C 0 125,844 0 614,970	R BENEFICIARY	2.00
2. 00 3. 00	COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy	OF AGGREGATE	Coinsurance 7.00 PROGRAM COST, A 2,286 2,120 537	8.00 AGGREGATE OF TI	HE PROGRAM LI	10. 00 MITATION COST, CO 0 125, 844 0 614, 970 0 147, 831	R BENEFICIARY	2. 00 3. 00
2. 00 3. 00 4. 00	COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	OF AGGREGATE	Coinsurance 7.00 PROGRAM COST, A 2,286 2,120 537 40	8.00 AGGREGATE OF TI	HE PROGRAM LI	10. 00 MITATION COST, CO 0 125, 844 0 614, 970 0 147, 831 0 12, 223	R BENEFICIARY	2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00	COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	OF AGGREGATE	Coinsurance 7.00 PROGRAM COST, A 2,286 2,120 537 40	8.00 AGGREGATE OF TI	HE PROGRAM LI	10.00 MITATION COST, COS	R BENEFICIARY	2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00	COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	OF AGGREGATE	Coinsurance 7.00 PROGRAM COST, A 2,286 2,120 537 40	8.00 AGGREGATE OF TI	HE PROGRAM LI	10. 00 MITATION COST, CO 0 125, 844 0 614, 970 0 147, 831 0 12, 223	R BENEFICIARY	2. 00 3. 00 4. 00

	ı Financial Systems FLONMENT OF PATLENT SERVICE COS	TS	KING'S DAUGHTE	Provi der CO	CN: 15-0069	Peri od:	u of Form CMS- Worksheet H-3	
				HHA CCN:	15-7141	From 01/01/2017 To 12/31/2017	Part I Date/Time Pre 5/23/2018 1:1	
				Title	XVIII	Home Health Agency I	PPS	ız piii
	Cost Center Description	6. 00	7. 00	8. 00	9. 00	10.00	11.00	
	Limitation Cost Computation	0.00	7.00	8.00	7.00	10.00	11.00	
8. 00 8. 01 9. 00 9. 01 10. 00 10. 01 11. 00 12. 01 13. 00 13. 01 14. 00	Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Medical Social Services Home Health Aide Home Health Aide Total (sum of lines 8-13)							8. 00 8. 01 9. 00 9. 01 10. 00 11. 01 12. 00 12. 01 13. 00 13. 01 14. 00
	Tretar (eam er rriies e ie)	Progr	ram Covered Cha	arges	Cost of			1 11 00
					Servi ces			
			Par	t B		Part B		
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
15 00	Supplies and Drugs Cost Comput Cost of Medical Supplies	ations o				0 0		15.00
15. 00 16. 00	Cost of Drugs		0			0 0	C	1
	Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION	Total Program Cost (sum of cols. 9-10) 12.00 OF AGGREGATE	PROGRAM COST, A	AGGREGATE OF TH	HE PROGRAM L	IMITATION COST, C	R BENEFICIARY	
1 00	Cost Per Visit Computation	125, 844						1 1 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	125, 844 614, 970 147, 831 12, 223 0 85, 447						1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
7. 00	Total (sum of lines 1-6)	986, 315						7.00
	Cost Center Description	12.00						-
	Limitation Cost Computation	12. 00						
8. 00 8. 01 9. 00 9. 01 10. 00	Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology							8. 00 8. 01 9. 00 9. 01 10. 00 10. 01 11. 00

Heal th	Financial Systems	KING'S DAUGHTE	ERS' HOSPITAL In Lieu 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 01/01/2017 To 12/31/2017		pared:
							5/23/2018 1:1	
				Title	: XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Charge Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1. 00	2. 00	3. 00	4. 00		
	PART II - APPORTIONMENT OF COS	T OF HHA SERVI	CES FURNISHED E	BY SHARED HOSP	TAL DEPARTME	NTS		
1.00	Physi cal Therapy	66.00	0. 312700	0		0 col. 2, line 2	. 00	1.00
2.00	Occupational Therapy	67.00	0. 000000	0		0 col. 2, line 3	. 00	2.00
3.00	Speech Pathology	68.00	0. 000000	0		0 col. 2, line 4	. 00	3.00
4.00	Cost of Medical Supplies	71.00	0. 367370	0		0 col. 2, line 1	5. 00	4.00
4.01	Cost of Medical Supplies 1	71. 01	0. 058362	0		0 col. 2, line 1	5. 01	4. 01
5.00	Cost of Drugs	73.00	0. 187969	0		0 col. 2, line 1	6. 00	5.00

	Financial Systems KING'S DAUGHTERS ATION OF HHA REIMBURSEMENT SETTLEMENT	Provi der C	^N· 15_0060	In Lie	u of Form CMS-2 Worksheet H-4	
ALCUL	ATTOM OF THE RETWINDURSEWEINT SETTLEWEINT	HHA CCN:	15-7141	From 01/01/2017 To 12/31/2017	Part I-II	
		Title	XVIII	Home Health	5/23/2018 1:1 PPS	2 pm
				Agency I	t B	
			Part A	Not Subject	Subject to	
				to Deductibles &	Deductibles & Coinsurance	
			1.00	Coi nsurance 2.00	3. 00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUST	TOMARY CHARGI				
00	Reasonable Cost of Part A & Part B Services		<u> </u>		0	1
00	Reasonable cost of services (see instructions) Total charges			0 0	0	1. 2.
00	Customary Charges			0 0	0	
00	Amount actually collected from patients liable for payment for	or services		0 0	0	3.
00	on a charge basis (from your records)					١.
.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	Total customary charges (see instructions)			0 0	0	6.
00	Excess of total customary charges over total reasonable cost only if line 6 exceeds line 1)	(complete		0 0	0	7.
00	Excess of reasonable cost over customary charges (complete of 1 exceeds line 6)	nlyifline		0 0	0	8.
00	Primary payer amounts			0 0	0	9.
				Part A	Part B	
				Servi ces 1.00	Servi ces 2. 00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
	Total reasonable cost (see instructions)			0	0	1
1. 00 2. 00	Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers			0	902, 568 15, 583	
3. 00	Total PPS Reimbursement - LUPA Episodes			0	25, 650	1
. 00	Total PPS Reimbursement - PEP Epi sodes			0	11, 436	1
5. 00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	S		0	5, 628	
. 00	Total PPS Outlier Reimbursement - PEP Episodes			0	0	16
. 00	Total Other Payments			0	0	17
. 00	DME Payments			0	0	18
. 00	Oxygen Payments			0	0	19
. 00	Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins	suranco)		0	0	20
. 00	Subtotal (sum of lines 10 thru 20 minus line 21)	sui ance)		0	960, 865	
. 00	Excess reasonable cost (from line 8)			0	0	23
. 00	Subtotal (line 22 minus line 23)			0	960, 865	24
. 00	Coinsurance billed to program patients (from your records)				0	25
	Net cost (line 24 minus line 25)			0	960, 865	26
	Reimbursable bad debts (from your records)					27
. 00	Reimbursable bad debts for dual eligible beneficiaries (see i)		0/0 0/5	28
. 00	Total costs - current cost reporting period (line 26 plus lin OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ne 27)		0	960, 865 0	1
. 50	Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	0	
. 99	Demonstration payment adjustment amount before sequestration	,		0	0	30
. 00	Subtotal (see instructions)			0	960, 865	
I. 01	Sequestration adjustment (see instructions)			0	19, 217	31
1. 02	Demonstration payment adjustment amount after sequestration			0	0	31
2.00	Interim payments (see instructions)			0	941, 648	
3. 00	Tentative settlement (for contractor use only)	and 22)		0	0	
	Balance due provider/program (line 31 minus lines 31.01, 32,	anu 33)		0	0	34.
4. 00 5. 00	Protested amounts (nonallowable cost report items) in accorda	ance with CM	S Dub 15 2	0	0	35

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: Worksnee: Strom 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/23/2018 1:12 pm PPS TO PROGRAM BENEFICIARIES HHA CCN: 15-7141

					5/23/2018 1: 1.	2 pm
				Home Health	PPS	
				Agency I		
		Inpatien	t Part A	Par	⁻t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
. 00	Total interim payments paid to provider			0	941, 648	1.0
. 00	Interim payments payable on individual bills, either			0	0	2.0
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3. (
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
. 01				0	0	3. (
02				0	0	3.
03				0	0	3.
04				0	0	3.
. 05				0	0	3.
	Provider to Program	•		<u> </u>		
50				0	0	3.
51				0	0	3.
52				0	0	3.
53				0	0	3.
54				0	0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3.
	3. 50-3. 98)					
. 00	Total interim payments (sum of lines 1, 2, and 3.99)			0	941, 648	4.
	(transfer to Wkst. H-4, Part II, column as appropriate,					
	line 32)					
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					5.
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider	I		_	_	_
01				0	0	5.
02				0	0	5.
03	Dravi dan ta Dragnam			0	0	5.
50	Provi der to Program			ol	0	5.
50 51				0		5. 5.
52				0		5. 5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		5. 5.
77	5. 50-5. 98)			O O	0	٥.
00	Determined net settlement amount (balance due) based on					6.
50	the cost report. (1)					0.
01	SETTLEMENT TO PROVIDER			0	o	6.
02	SETTLEMENT TO PROGRAM			0		6.
00	Total Medicare program liability (see instructions)			0	941, 648	7.
00	Total medicale program frability (see instructions)			Contractor	NPR Date	/.
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
00	Name of Contractor			1.00	2.00	8.

	Financial Systems SIS OF HOSPITAL-BASED HOSPICE COSTS	KING'S DAUGHTERS	S' HOSPITAL Provi der C	CN: 15-0069	Period:	u of Form CMS-2 Worksheet O	2552-10
7110/12/13	NO OF HOOFF ME BROLD HOOFF OF GOOTS		Hospi ce CCI		From 01/01/2017 To 12/31/2017		narod:
			nospi ce coi	N. 15-1555	10 12/31/2017	Date/Time Pre 5/23/2018 1:1	2 pm
		041.451.50	OTHER	OURTOTAL	Hospi ce I	OUDTOTAL	
		SALARI ES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSI FI - CATI ONS	SUBTOTAL	
		1.00	2. 00	3.00	4. 00	5. 00	
4 00	GENERAL SERVICE COST CENTERS	1		I			
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT* CAP REL COSTS-MVBLE EQUIP*		0		0 0	0	1
3. 00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		0 0	0	
4. 00	ADMI NI STRATI VE & GENERAL*	55, 293	4, 096	59, 38	-45, 297	14, 092	4. 00
5.00	PLANT OPERATION & MAINTENANCE*	0	0		0 0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		0	0	
7.00	HOUSEKEEPI NG*	0	0		0	0	1
8. 00 9. 00	DI ETARY* NURSI NG ADMI NI STRATI ON*	0	0		0	0	
10.00	ROUTINE MEDICAL SUPPLIES*		0			0	
11. 00	MEDI CAL RECORDS*		0		0 0	0	11.00
12. 00	STAFF TRANSPORTATION*	o	391	39	91 0	391	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0		0 1, 497	1, 497	13.00
14.00	PHARMACY*	0	14, 674	14, 67	74 0	14, 674	14.00
15. 00	PHYSI CI AN ADMI NI STRATI VE SERVI CES*	0	0		0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0		0	0	16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES DIRECT PATIENT CARE SERVICE COST CENTERS						17. 00
25. 00	I NPATI ENT CARE -CONTRACTED**		0		0 0	0	25.00
26. 00	PHYSI CI AN SERVI CES**		0		0 0	Ö	26.00
27. 00	NURSE PRACTITIONER**	0	0		0 0	0	27.00
28. 00	REGI STERED NURSE**	0	6, 619	6, 61	19 39, 033	45, 652	28.00
29. 00	LPN/LVN**	0	0		0 0	0	29.00
30.00	PHYSI CAL THERAPY**	0	535	53		568	1
31. 00 32. 00	OCCUPATIONAL THERAPY** SPEECH/LANGUAGE PATHOLOGY**		0		0 0	0	31.00
33. 00	MEDICAL SOCIAL SERVICES**		1, 188	1, 18	38 0	1, 188	
34. 00	SPIRITUAL COUNSELING**		0	., .,	0 0	0	1
35.00	DI ETARY COUNSELI NG**	o	0		0 0	0	35.00
36.00	COUNSELING - OTHER**	0	0		0 0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	2, 060	2, 06		6, 794	37.00
38.00	DURABLE MEDI CAL EQUI PMENT/OXYGEN**	0	36, 082 0	36, 08	32 0	36, 082 0	1
39. 00 40. 00	PATIENT TRANSPORTATION** I MAGING SERVICES**		0			0	
41. 00	LABS & DI AGNOSTI CS**		0		0 0	0	
42. 00	MEDICAL SUPPLIES-NON-ROUTINE**	o	0		0 0	0	
42.50	DRUGS CHARGED TO PATIENTS**	0	0		0 0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0		0 0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		0	0	
45.00	PALLIATIVE CHEMOTHERAPY** OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		0 0	0	
46. 00	NONREI MBURSABLE COST CENTERS	J U	0		0 0	0	46. 00
60. 00	BEREAVEMENT PROGRAM *	0	0		0 0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0		0 0	0	
62.00	FUNDRAI SI NG*	0	0		0 0	0	
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		0	0	
64.00	PALLIATIVE CARE PROGRAM*	0	0		0	0	
65. 00 66. 00	OTHER PHYSICIAN SERVICES* RESIDENTIAL CARE*		0			0	
67.00	ADVERTI SI NG*		0			0	1
68. 00	TELEHEALTH/TELEMONI TORI NG*		0		o o	0	
69. 00	THRI FT STORE*		0		0 0	0	
70.00	NURSING FACILITY ROOM & BOARD*	0	0		0 0	0	
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0			0 0	0	
100 00	TOTAL	55, 293	65, 645	120, 93	38 0	120, 938	1100.00

^{*} 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	: 1	
		ADJUSTMENTS	TOTAL (col. 5			
			± col. 6)			
		6. 00	7. 00			
	GENERAL SERVICE COST CENTERS	. 1				
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*	0	14, 092			4.00
5. 00	PLANT OPERATION & MAINTENANCE*	0	0			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			8.00
9. 00	NURSI NG ADMI NI STRATI ON*	0	0			9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0			10.00
11. 00	MEDI CAL RECORDS*	0	0			11.00
12.00	STAFF TRANSPORTATION*	0	391			12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	1, 497			13.00
14.00	PHARMACY*	0	14, 674			14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0			15.00
16. 00	OTHER GENERAL SERVI CE*	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	45, 652			28.00
29. 00	LPN/LVN**	0	0			29.00
30.00	PHYSI CAL THERAPY**	0	568			30.00
31.00	OCCUPATIONAL THERAPY**	0	0			31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	1 100			32.00
33.00	MEDICAL SOCIAL SERVICES**	0	1, 188			33.00
34. 00 35. 00	SPIRITUAL COUNSELING** DIETARY COUNSELING**	0	0			34. 00 35. 00
36.00	COUNSELING - OTHER**	0	0			36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0 0	6, 794			37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0				38.00
39. 00	PATIENT TRANSPORTATION**		36, 082 0			39.00
40. 00	IMAGING SERVICES**	o	0			40.00
41. 00	LABS & DI AGNOSTI CS**	0	0			41.00
42. 00	MEDICAL SUPPLIES-NON-ROUTINE**		0			42.00
42. 50	DRUGS CHARGED TO PATIENTS**		0			42.50
43. 00	OUTPATIENT SERVICES**	o	0			43.00
44. 00	PALLIATIVE RADIATION THERAPY**	o	0			44. 00
45. 00	PALLIATIVE CHEMOTHERAPY**	o	0			45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	o	0			46.00
10.00	NONREI MBURSABLE COST CENTERS	<u> </u>	J			10.00
60.00	BEREAVEMENT PROGRAM *	0	0			60.00
61. 00	VOLUNTEER PROGRAM *	o	0			61.00
62. 00	FUNDRAI SI NG*	o	0			62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	o	0			63.00
64.00	PALLIATIVE CARE PROGRAM*	o	0			64.00
65. 00	OTHER PHYSICIAN SERVICES*	Ö	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*	o	0			68.00
69. 00	THRIFT STORE*		0			69.00
70.00	NURSING FACILITY ROOM & BOARD*		0			70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	o	0			71.00
100.00		o	120, 938			100.00
+ T	1 · · · · · · · · · · · · · · · · · · ·	· · · · · ·	.20, .00	1	<u></u>	

^{*} 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

307

0

0

46, 307

0

43, 058

0

0

89, 365 100. 00

45.00

46.00

^{100.00|}TOTAL * 0|

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

		ADJUSTMENTS	TOTAL (col. 5	
			± col . 6)	
		6. 00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS	I		
25. 00	I NPATI ENT 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	44, 877	28. 00
29. 00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	559	30.00
31. 00	OCCUPATI ONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	1, 168	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	6, 679	37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	36, 082	38. 00
39. 00	PATIENT TRANSPORTATION	0	0	39.00
40.00	I MAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	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	OUTPATI ENT SERVI CES	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	89, 365	100.00

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

45.00

PALLIATIVE CHEMOTHERAPY

46.00 OTHER PATIENT CARE SERVICES (SPECIFY)

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	E INPATIENT	Provi der CC	N: 15-0069	Peri od:	Worksheet 0-3	
RESPITE CARE		Hospi ce CCN	l: 15-1535	From 01/01/2017 To 12/31/2017	Date/Time Pre 5/23/2018 1:1	
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSI FI - CATI ONS	SUBTOTAL	
	1. 00	2.00	3. 00	4. 00	5. 00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25. 00 I NPATI ENT CARE-CONTRACTED		0		0	0	25.00
26. 00 PHYSI CI AN SERVI CES	0	0		0	0	26.00
27. 00 NURSE PRACTITIONER	0	0		0	0	27. 00
28. 00 REGI STERED NURSE	0	64	(375	439	
29. 00 LPN/LVN	0	0		0	0	29. 00
30. 00 PHYSI CAL THERAPY	0	5		5 0	5	30.00
31. 00 OCCUPATIONAL THERAPY	0	0		0 0	0	31.00
32. 00 SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	32.00
33. 00 MEDICAL SOCIAL SERVICES	0	11		11 0	11	33.00
34. 00 SPIRITUAL COUNSELING	0	0		0 0	0	34.00
35. 00 DI ETARY COUNSELI NG	0	0		0 0	0	35. 00
36. 00 COUNSELING - OTHER	0	0		0 0	0	36. 00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	0	20	:	20 45	65	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 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	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	46. 00
100.00 TOTAL *	0	100	10	00 420	520	100.00

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

ADJUSTMENTS TOTAL (Col 5 ± col 6 6 6 6 6 6 6 6 6					
DIRECT PATIENT CARE SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			ADJUSTMENTS	TOTAL (col. 5	
DIRECT PATIENT CARE SERVICE COST CENTERS				± col. 6)	
25. 00 INPATIENT CARE-CONTRACTED			6. 00	7.00	
26. 00 PHYSI CI AN SERVI CES		DIRECT PATIENT CARE SERVICE COST CENTERS			
27. 00 NURSE PRACTITIONER 0 0 0 27. 00 28. 00 REGISTERED NURSE 0 439 29. 00 LPN/LVN 0 0 0 0 30. 00 PHYSI CAL THERAPY 0 5 30. 00 31. 00 OCCUPATIONAL THERAPY 0 0 0 5 32. 00 SPEECH/LANGUAGE PATHOLOGY 31. 00 33. 00 MEDI CAL SOCI AL SERVI CES 0 11 33. 00 34. 00 SPIRI TUAL COUNSELING 0 0 0 35. 00 DI ETARY COUNSELING 0 0 0 36. 00 COUNSELING 0 0 0 33. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 65 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 65 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 0 38. 00 40. 00 OUNSELING 0 0 0 0 38. 00 41. 00 LABS & DI AGNOSTI CS 0 0 0 0 41. 00 42. 00 MEDI CAL SUPLIES-NON-ROUTI NE 0 0 0 0 42. 50 43. 00 OUTPATIENT SERVI CES 0 0 45. 00 44. 00 PALLI ATIVE RADI ATION THERAPY 0 0 0 44. 00 44. 00 PALLI ATIVE CHEMOTHERAPY 0 0 0 0 45. 00 65. 00 OTHER PATIENT CARE SERVI CES 0 0 0 0 44. 00 66. 00 OTHER PATIENT CARE SERVI CES 0 0 0 0 44. 00 66. 00 OTHER PATIENT CARE SERVI CES 0 0 0 0 44. 00 66. 00 OTHER PATIENT CARE SERVI CES 0 0 0 0 44. 00 67. 00 OTHER PATIENT CARE SERVI CES 0 0 0 0 44. 00 68. 00 OTHER PATIENT CARE SERVI CES (SPECI FY) 0 0 0 45. 00	25.00	I NPATI ENT CARE-CONTRACTED	0	0	25. 00
28. 00 REGISTERED NURSE 0 439 28. 00 29. 00 LPN/LVN 0 0 29. 00 30. 00 PHYSI CAL THERAPY 0 5 30. 00 31. 00 OCCUPATI ONAL THERAPY 0 0 31. 00 32. 00 SPEECH/LANGUAGE PATHOLOGY 0 0 32. 00 33. 00 MEDI CAL SCI AL SERVI CES 0 11 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 COUNSELI NG - OTHER 0 0 36. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 65 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 39. 00 40. 00 IMAGI NG 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. 50	26.00	PHYSI CI AN SERVI CES	0	0	26.00
29. 00 LPN/LVN	27.00	NURSE PRACTITIONER	0	0	27.00
30. 00 PHYSI CAL THERAPY 0 0 5 30. 00 31. 00 OCCUPATI ONAL THERAPY 0 0 0 31. 00 32. 00 SPEECH/LANGUAGE PATHOLOGY 0 0 0 32. 00 33. 00 MEDI CAL SOCI AL SERVI CES 0 11 33. 00 34. 00 SPI RI TUAL COUNSELI NG 0 0 0 34. 00 35. 00 DI ETARY COUNSELI NG 0 0 0 35. 00 36. 00 COUNSELI NG 0 0 0 36. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 65 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 39. 00 40. 00 IMAGI NG SERVI CES 0 0 0 40. 00 41. 00 LABS & DI AGNOSTI CS 0 0 0 41. 00 42. 50 DRUGS CHARGED TO PATI ENTS 0 0 0 42. 50 43. 00 OUTPATI ENT SERVI CES 0 0 0 42. 00 44. 00 PALLI ATI VE RADI ATION THERAPY 0 0 0 0 45. 00 46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY) 0 0 46. 00	28.00	REGI STERED NURSE	0	439	28. 00
31. 00 OCCUPATI ONAL THERAPY 0 0 0 32. 00 32. 00 SPEECH/LANGUAGE PATHOLOGY 0 0 0 32. 00 33. 00 MEDI CAL SOCI AL SERVI CES 0 11 33. 00 34. 00 SPI RI TUAL COUNSELI NG 0 0 0 34. 00 35. 00 DI ETARY COUNSELI NG 0 0 0 35. 00 36. 00 COUNSELI NG - OTHER 0 0 0 0 36. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 65 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 0 39. 00 40. 00 I MAGI NG SERVI CES 0 0 0 0 40. 00 41. 00 LABS & DI AGNOSTI CS 0 0 0 41. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 0 42. 00 42. 50 DRUGS CHARGED TO PATI ENTS 0 0 0 42. 50 43. 00 OUTPATI ENT SERVI CES 0 0 0 43. 00 44. 00 PALLI ATI VE RADI ATI ON THERAPY 0 0 0 45. 00 46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY) 0 0 0 46. 00	29.00	LPN/LVN	0	0	29. 00
32.00 SPEECH/LANGUAGE PATHOLOGY 33.00 MEDI CAL SOCI AL SERVI CES 31.00 MEDI CAL SOCI AL SERVI CES 32.00 SPIRI TUAL COUNSELI NG 33.00 DI ETARY COUNSELI NG 35.00 DI ETARY COUNSELI NG 36.00 COUNSELI NG O O 36.00 COUNSELI NG O O 36.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 37.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 39.00 PATI ENT TRANSPORTATI ON 40.00 I MAGI NG SERVI CES 40.00 MEDI CAL SUPPLI ES-NON-ROUTI NE 42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE 42.00 DRUGS CHARGED TO PATI ENTS 43.00 OUTPATI ENT SERVI CES 44.00 PALLI ATI VE RADI ATI ON THERAPY 45.00 PALLI ATI VE RADI ATI ON THERAPY 46.00 OTHER PATI ENT CARE SERVI CES (SPECI FY) 46.00 OTHER PATI ENT CARE SERVI CES (SPECI FY)	30.00	PHYSI CAL THERAPY	0	5	30.00
33. 00 MEDI CAL SOCI AL SERVI CES 34. 00 SPI RI TUAL COUNSELI NG 35. 00 DI ETARY COUNSELI NG 36. 00 COUNSELI NG 36. 00 COUNSELI NG 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 39. 00 PATI ENT TRANSPORTATI ON 40. 00 IMAGI NG SERVI CES 40. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 41. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 42. 50 DRUGS CHARGED TO PATI ENTS 43. 00 OUTPATI ENT SERVI CES 44. 00 PALLI ATI VE RADI ATI ON THERAPY 45. 00 PALLI ATI VE CHEMOTHERAPY 46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY) 46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY)	31.00	OCCUPATI ONAL THERAPY	0	0	31.00
34. 00 SPIRITUAL COUNSELING 0 0 0 35. 00 35. 00 DI ETARY COUNSELING 0 0 0 35. 00 36. 00 COUNSELING - OTHER 0 0 0 36. 00 37. 00 HOSPICE AIDE & HOMEMAKER SERVICES 0 65 37. 00 38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN 0 0 38. 00 39. 00 PATIENT TRANSPORTATION 0 0 0 39. 00 40. 00 IMAGING SERVICES 0 0 0 0 41. 00 41. 00 LABS & DIAGNOSTICS 0 0 0 42. 00 42. 00 MEDICAL SUPPLIES-NON-ROUTINE 0 0 0 42. 00 42. 50 DRUGS CHARGED TO PATIENTS 0 0 0 42. 50 43. 00 OUTPATIENT SERVICES 0 0 0 42. 50 44. 00 PALLIATIVE RADIATION THERAPY 0 0 44. 00 45. 00 PALLIATIVE CHEMOTHERAPY 0 0 0 46. 00 46. 00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 0 46. 00	32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
35. 00 DI ETARY COUNSELING 0 0 0 35. 00 36. 00 COUNSELING - OTHER 0 0 0 36. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 65 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 39. 00 40. 00 I MAGI NG SERVI CES 0 0 0 40. 00 41. 00 LABS & DI AGNOSTI CS 0 0 0 41. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 0 42. 50 42. 50 DRUGS CHARGED TO PATI ENTS 0 0 0 42. 50 43. 00 OUTPATI ENT SERVI CES 0 0 0 43. 00 44. 00 PALLI ATI VE CHEMOTHERAPY 0 0 45. 00 46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY) 0 0 0 46. 00	33.00	MEDICAL SOCIAL SERVICES	0	11	33.00
36. 00 COUNSELING - OTHER 0 0 0 37. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 65 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 0 39. 00 1 MAGI NG SERVI CES 0 0 0 40. 00 41. 00 LABS & DI AGNOSTI CS 0 0 0 41. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 42. 00 42. 50 DRUGS CHARGED TO PATI ENTS 0 0 0 42. 50 OUTPATI ENT SERVI CES 0 0 0 42. 50 44. 00 PALLI ATI VE RADI ATI ON THERAPY 0 0 0 44. 00 PALLI ATI VE RADI ATI ON THERAPY 0 0 0 46. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	34.00	SPIRITUAL COUNSELING	0	0	34.00
37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 0 65 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 39. 00 40. 00 I MAGI NG 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 PATI ENTS 0 0 42. 50 43. 00 OUTPATI ENT SERVI CES 0 0 43. 00 44. 00 PALLI ATI VE RADI ATI ON THERAPY 0 0 44. 00 45. 00 PALLI ATI VE CHEMOTHERAPY 0 0 45. 00 46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY) 0 0 46. 00	35.00	DI ETARY COUNSELI NG	0	0	35.00
38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 0 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 0 40. 00 I MAGI NG SERVI CES 0 0 0 41. 00 LABS & DI AGNOSTI CS 0 0 0 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 0 42. 50 DRUGS CHARGED TO PATI ENTS 0 0 0 43. 00 OUTPATI ENT SERVI CES 0 0 0 43. 00 44. 00 PALLI ATI VE RADI ATI ON THERAPY 0 0 0 45. 00 PALLI ATI VE CHEMOTHERAPY 0 0 0 46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY) 0 0 0	36.00	COUNSELING - OTHER	0	0	36.00
39. 00 PATI ENT TRANSPORTATION 0 0 0 40. 00 1 MAGI NG SERVI CES 0 0 0 0 41. 00 1 MAGI NG SERVI CES 0 0 0 0 41. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 0 42. 00 DRUGS CHARGED TO PATI ENTS 0 0 0 42. 50 UTPATI ENT SERVI CES 0 0 0 43. 00 44. 00 PALLI ATI VE RADI ATI ON THERAPY 0 0 0 44. 00 PALLI ATI VE CHEMOTHERAPY 0 0 0 0 45. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	65	37.00
40. 00	38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
41. 00 LABS & DI AGNOSTI CS 0 0 0 42. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 0 42. 50 42. 50 DRUGS CHARGED TO PATI ENTS 0 0 0 42. 50 43. 00 OUTPATI ENT SERVI CES 0 0 0 43. 00 44. 00 PALLI ATI VE CHEMOTHERAPY 0 0 0 45. 00 46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY) 0 0 0 46. 00	39.00	PATIENT TRANSPORTATION	0	0	39.00
42.00 MEDICAL SUPPLIES-NON-ROUTINE 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	40.00	I MAGING SERVICES	0	0	40.00
42.50 DRUGS CHARGED TO PATIENTS 0 0 0 42.50 43.00 OUTPATIENT SERVICES 0 0 0 43.00 44.00 PALLIATIVE RADIATION THERAPY 0 0 0 44.00 45.00 PALLIATIVE CHEMOTHERAPY 0 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 0	41.00	LABS & DIAGNOSTICS	0	0	41.00
43.00 OUTPATIENT SERVICES 0 0 0 0 43.00 44.00 PALLIATIVE RADIATION THERAPY 0 0 0 45.00 PALLIATIVE CHEMOTHERAPY 0 0 0 45.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 0 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 0 0 0 0 0 0 0 0	42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
44.00 PALLIATIVE RADIATION THERAPY 0 0 0 44.00 45.00 PALLIATIVE CHEMOTHERAPY 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 46.00	42.50	DRUGS CHARGED TO PATIENTS	0	0	42. 50
45.00 PALLIATIVE CHEMOTHERAPY 0 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 46.00	43.00	OUTPATIENT SERVICES	0	0	43.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 46.00	44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
	45.00	PALLI ATI VE CHEMOTHERAPY	0	0	45.00
100. 00 TOTAL * 0 520 100. 00	46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
	100.00	TOTAL *	0	520	100.00

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

Heal th	Financial Systems	KING'S DAUGHTERS'	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	SIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC	CE GENERAL	Provider CO	CN: 15-0069	Peri od:	Worksheet 0-4	
I NPATI	ENT CARE		Hospi ce CCN	N: 15-1535	From 01/01/2017 To 12/31/2017	Date/Time Pre 5/23/2018 1:1	pared: 2 pm
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI - CATIONS	SUBTOTAL	
		1. 00	2.00	3.00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	I NPATI ENT CARE-CONTRACTED		0		0 0	0	25.00
26.00	PHYSI CI AN SERVI CES	0	0		0 0	0	26.00
27. 00	NURSE PRACTITIONER	0	0		0 0	0	27.00
28.00	REGI STERED NURSE	0	49		49 287	336	28. 00
29. 00	LPN/LVN	0	0		0 0	0	29. 00
30.00	PHYSI CAL THERAPY	0	4		4 0	4	30.00
31.00	OCCUPATI ONAL THERAPY	0	0		0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	9		9 0	9	33.00
34.00	SPI RI TUAL COUNSELI NG	0	0		0	0	34.00
35.00	DI ETARY COUNSELI NG	0	0		0	0	35.00
36.00		0	0		0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	15		15 35	50	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		0	0	38. 00
39. 00	PATI ENT TRANSPORTATION	0	0		0	0	39.00
40.00	I MAGING SERVICES	0	0		0	0	40.00
41.00	LABS & DIAGNOSTICS	0	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		0 0	0	42. 50
43.00	OUTPATI ENT SERVI CES	0	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
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		0	0	46. 00
100.00	TOTAL *	0	77		77 322	399	100.00

^{45.00} PALLIATIVE CHEMOTHERAPY
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)
100.00 TOTAL *

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

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6. 00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT 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	336	28. 00
29.00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	4	30.00
31.00	OCCUPATI ONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	9	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	50	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	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATI ENT SERVI CES	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		0	0	46. 00
100.00	TOTAL *	0	399	100.00

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

	ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET SES FOR ALLOCATION	Provi der Co		Peri od: From 01/01/2017	Worksheet 0-5	
		Hospi ce CCI	N: 15-1535	To 12/31/2017	Date/Time Pre 5/23/2018 1:1	
	·		1	Hospi ce I		
	Descri pti ons		HOSPI CE DI RECT	GENERAL SERVI CE	TOTAL EXPENSES (sum	
				e EXPENSES FROM	of cols. 1 +	
			,) WKST B PART I	2)	
				(see	·	
				instructions)		
	OFNEDAL CEDILOF COST OFNEDO		1.00	2. 00	3. 00	
1. 00	GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT			0 1, 683	1, 683	1.00
2. 00	CAP REL COSTS-BLDG & FIXT			0 1, 683	1, 683	2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT			0 12, 925	12, 925	
4. 00	ADMINISTRATIVE & GENERAL		14, 0		38, 119	
5. 00	PLANT OPERATION & MAINTENANCE		1, 5	0 13, 416	13, 416	
6.00	LAUNDRY & LINEN SERVICE			0 0	0	6.00
7.00	HOUSEKEEPI NG			0 0	0	7.00
8.00	DI ETARY			0 0	0	8.00
9.00	NURSI NG ADMI NI STRATI ON			0	0	
10.00	ROUTINE MEDICAL SUPPLIES			0 0	0	
11.00	MEDICAL RECORDS			0 0	0	
12. 00 13. 00	STAFF TRANSPORTATION VOLUNTEER SERVICE COORDINATION		3 ¹		391 1, 497	12. 00 13. 00
14. 00			14, 6		1, 497	
15. 00	PHYSI CI AN ADMI NI STRATI VE SERVI CES		14,0	0	0	15.00
16. 00	OTHER GENERAL SERVICE			o o	Ö	
17. 00				0	0	
	LEVEL OF CARE					
50.00				0	0	
51.00	HOSPICE ROUTINE HOME CARE		89, 3		89, 365	
52.00				20	520	
53. 00	HOSPICE GENERAL INPATIENT CARE] 3'	99	399	53.00
60. 00	NONREI MBURSABLE COST CENTERS BEREAVEMENT PROGRAM			O	0	60.00
61. 00	VOLUNTEER PROGRAM			0	0	
62.00	FUNDRALSING			o	0	62.00
63.00				0	0	
64.00	PALLIATIVE CARE PROGRAM			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	65.00
66.00				0	0	66.00
67. 00	ADVERTI SI NG			0	0	67.00
68.00				0	0	68.00
69. 00 70. 00				0	0	
70.00				0	0	
	NEGATIVE COST CENTER			0	0	99.00
99 nn						

			nospi ce cc	N. 13-1333	10 12/31/2017	5/23/2018 1:1	
					Hospi ce I	0, 20, 2010 111	_ p
	Descriptions	TOTAL	CAP REL BLDG	CAP REL MVBL		SUBTOTAL	
	'	EXPENSES	& FIX	EQUI P	BENEFI TS		
					DEPARTMENT		
		0	1.00	2.00	3. 00	3A	
	GENERAL SERVICE COST CENTERS				<u>.</u>		
1.00	CAP REL COSTS-BLDG & FIXT	1, 683	1, 683				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	o			0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	12, 925	0		0 12, 925		3.00
4.00	ADMINISTRATIVE & GENERAL	38, 119	1, 683		0 2, 337	42, 139	4.00
5.00	PLANT OPERATION & MAINTENANCE	13, 416	0		0 0	13, 416	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0 0	0	6. 00
7.00	HOUSEKEEPI NG	o	0		0 0	0	7. 00
8.00	DI ETARY	o	0		0 0	0	8. 00
9.00	NURSI NG ADMI NI STRATI ON	o	0		0 0	0	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	o	0		0 0	0	10.00
11. 00	MEDI CAL RECORDS	o	0		0 0	0	11.00
12. 00	STAFF TRANSPORTATION	391	0		0 0	391	12.00
13. 00	VOLUNTEER SERVICE COORDINATION	1, 497	0		0 350	1, 847	13.00
14. 00	PHARMACY	14, 674	0		0 0	14, 674	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	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				<u> </u>		17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51. 00	HOSPICE ROUTINE HOME CARE	89, 365			10, 065	99, 430	51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	520	0		0 98		52.00
53. 00	HOSPICE GENERAL INPATIENT CARE	399	0		0 75		53.00
00.00	NONREI MBURSABLE COST CENTERS	37,1			<u>0</u>	.,,,	00.00
60.00	BEREAVEMENT PROGRAM	0	0		0 0	0	60.00
61.00	VOLUNTEER PROGRAM	o	0		0 0	0	61.00
62.00	FUNDRAI SI NG	l ol	0		0 0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	o	0		0 0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	o	0		0 0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	o	0		0 0	0	65.00
66.00	RESI DENTI AL CARE	o	0		0 0	0	66.00
67. 00	ADVERTI SI NG	o	0		0 0	0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	o	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)	l ol	Ω		0 0	Ö	71.00
	NEGATI VE COST CENTER		0		0 0		99.00
	TOTAL	172, 989	1, 683		0 12, 925	172, 989	
	1 .		., 555	ı		1, 707	

Provi der CCN: 15-0069

			nospi ce co	N. 13-1333	10 12/31/2017	5/23/2018 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	i					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	i					3.00
4.00	ADMINISTRATIVE & GENERAL	42, 139					4.00
5. 00	PLANT OPERATION & MAINTENANCE	4, 321	17, 737				5.00
6.00	LAUNDRY & LINEN SERVICE	0	. 0)		6. 00
7. 00	HOUSEKEEPI NG	0	0		0		7.00
8. 00	DI ETARY	0	0		0		0 8.00
9. 00	NURSING ADMINISTRATION	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	126	0		0		12.00
13. 00	VOLUNTEER SERVICE COORDINATION	595	0		0		13.00
14. 00	PHARMACY	4, 726	0		0		14.00
15. 00	PHYSI CLAN ADMINI STRATI VE SERVI CES	4, 720	0		0		15.00
16. 00	OTHER GENERAL SERVICE		0		0		16.00
	PATIENT/RESIDENTIAL CARE SERVICES		0		0		17.00
17.00	LEVEL OF CARE				0		17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51. 00	HOSPICE ROUTINE HOME CARE	32, 019					51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	199	10, 110		o		0 52.00
	HOSPICE GENERAL INPATIENT CARE	153	7, 627		0		0 53.00
00.00	NONREI MBURSABLE COST CENTERS	100	7,027	`	<u> </u>		00.00
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61. 00	VOLUNTEER PROGRAM	0	0		0		61.00
62. 00	FUNDRAI SI NG	0	0		0		62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64. 00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65. 00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66. 00	RESI DENTI AL CARE	0	0		o o		0 66.00
67. 00	ADVERTI SI NG	0	0	· ·	0		67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	0	0		0		68.00
69. 00	THRIFT STORE		0		n		69.00
70. 00	NURSING FACILITY ROOM & BOARD		O				70.00
	OTHER NONREI MBURSABLE (SPECIFY)	0	0		0		0 71.00
99.00			0				0 99.00
100.00		42, 139	17, 737				0 100.00
100.00	1.02	12, 137	17,737	'	-1	l	o ₁ .00.00

Health Financial	Systems		KING'S DAUGHTERS'	HOSPI TAL	In	Lieu of Form CMS-2552-10
COST ALLOCATION -	HOSPI TAL-BASED	HOSPICE GENERAL	SERVICE COSTS	Provi der CCN: 15-0069	Peri od:	Worksheet 0-6

From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: Hospi ce CCN: 15-1535 5/23/2018 1:12 pm Hospi ce I NURSI NG ROUTI NE MEDI CAL VOLUNTEER Descriptions STAFF ADMI NI STRATI O MEDI CAL RECORDS SERVI CE TRANSPORTATI O 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 517 12.00 VOLUNTEER SERVICE COORDINATION 13.00 2,442 13.00 0 14.00 PHARMACY 0 0 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 15.00 0 OTHER GENERAL SERVICE 0 16.00 0 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 17.00 LEVEL OF CARE 50.00 HOSPICE CONTINUOUS HOME CARE 0 50.00 0 0 0 0 2, 401 HOSPICE ROUTINE HOME CARE 508 51.00 51.00 0 52.00 HOSPICE INPATIENT RESPITE CARE 0 23 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 0 0 4 18 53.00 NONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM VOLUNTEER PROGRAM 60.00 0 0 0 0 0 0 0 0 0 60.00 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 OTHER NONREIMBURSABLE (SPECIFY) 71 00 0 0 0 Ω 71.00 0

0

0

2, 442 100.00

99.00

99.00 NEGATIVE COST CENTER

100.00 TOTAL

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

Heal th FinancialSystemsKING'S DAUGHCOST ALLOCATION- HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

			Hospi ce cc	N: 15-1535 I	0 12/31/2017	5/23/2018 1:1	
					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						
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						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	19, 400					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	o	0				15.00
16.00	OTHER GENERAL SERVICE	ol		1 0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						1
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	C)	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	19, 072	0	(153, 430	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	186	0	d c	0	11, 141	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	142	0	ol c	0	8, 418	53.00
	NONREI MBURSABLE COST CENTERS						1
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	o		(0	65.00
66.00	RESI DENTI AL CARE	o	0	(0	0	66.00
67.00	ADVERTI SI NG	o		(0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	o		l c		0	68. 00
69.00	THRI FT STORE	o		(0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	o	0	d c	0	0	71.00
99.00	NEGATI VE COST CENTER	o	0	ı c	0	0	99.00
100.00	TOTAL	19, 400	0	d	0	172, 989	100.00
	•	•		•	*		•

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE STATISTICAL BASIS	GENERAL SERVICE COSTS	Provider CCN: Hospice CCN:		Worksheet 0-6 Part II Date/Time Prepared: 5/23/2018 1:12 pm

			Hospi ce (JCN: 15-15	35 1	0 12/31/2017	5/23/2018 1:1	
-						Hospi ce I	0, 20, 2010 111	_ p
	Cost Center Descriptions	CAP REL BLDG	CAP REL MVBL	E EMPLO	YEE	RECONCI LI ATI O	ADMI NI STRATI V	
		& FIX	EQUI P	BENEF		N	E & GENERAL	
		(SQUARE FEET)	(DOLLAR	DEPART			(ACCUMULATED	
		(040/11/2 / 22/)	VALUE)	(GRO			COSTS)	
			17.202)	SALARI			555.57	
		1. 00	2.00	3. 0		4A	4. 00	
	GENERAL SERVICE COST CENTERS	1				<u>'</u>		
1.00	CAP REL COSTS-BLDG & FLXT	744						1.00
2.00	CAP REL COSTS-MVBLE EQUIP			o				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	i	ol !	55, 293	3		3.00
4. 00	ADMINISTRATIVE & GENERAL	744		0	9, 996		130, 850	1
5. 00	PLANT OPERATION & MAINTENANCE	0		0	. (0	13, 416	5.00
6. 00	LAUNDRY & LINEN SERVICE	0	j	ol	(0	0	1
7. 00	HOUSEKEEPI NG			o	(0	
8. 00	DI ETARY			o	(o o	Ö	
9. 00	NURSING ADMINISTRATION			o	(o o	0	
10.00	ROUTINE MEDICAL SUPPLIES			0			0	10.00
	MEDICAL RECORDS						0	11.00
	STAFF TRANSPORTATION			0			391	12.00
13. 00				0	1, 497	7		13.00
	VOLUNTEER SERVICE COORDINATION			-			1, 847	
	PHARMACY	0)	0	(1	14, 674	14.00
	PHYSI CI AN ADMI NI STRATI VE SERVI CES	0	1	0	C	0	0	15.00
	OTHER GENERAL SERVICE	0	•	0	(0	0	16.00
17. 00	PATI ENT/RESI DENTI AL CARE SERVI CES	0)	0		0	0	17. 00
	LEVEL OF CARE						_	
50. 00	HOSPICE CONTINUOUS HOME CARE				C	9	0	
	HOSPICE ROUTINE HOME CARE			1	43, 058		99, 430	1
	HOSPICE INPATIENT RESPITE CARE	0		0	420		618	
53. 00	HOSPICE GENERAL INPATIENT CARE	0)	0	322	2 0	474	53.00
	NONREIMBURSABLE COST CENTERS							
	BEREAVEMENT PROGRAM	0	l .	0	C		0	60.00
61. 00	VOLUNTEER PROGRAM	0)	0	C		0	61. 00
	FUNDRAI SI NG	0)	0	C	,	0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0)	0	C	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0)	0	C	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0)	0	C	0	0	65.00
66.00	RESI DENTI AL CARE	0)	0	C	0	0	66.00
67.00	ADVERTI SI NG	0)	0	C	0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0)	o	C	0	0	68.00
69.00	THRI FT STORE	0		0	C	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0		70.00
	OTHER NONREIMBURSABLE (SPECIFY)	0		o	C	0	0	1
	NEGATI VE COST CENTER							99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I	1, 683	:	0	12, 925	5	42, 139	100.00
	UNIT COST MULTIPLIER	2. 262097		•	233755		0. 322041	
	1		1 2.2000		, , , , ,	1		, ,

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lieu	ı of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE STATISTICAL BASIS		Provider CC Hospice CCN	From 01/01/2017 To 12/31/2017	Worksheet 0-6 Part II Date/Time Prepared: 5/23/2018 1:12 pm
			Hospi ca I	3/23/2010 1. 12 pill

0171110	THORE BROTO		Hospi ce CC	N: 15-1535 T	o 12/31/2017	Date/Time Pre 5/23/2018 1:1	
					Hospi ce I		
	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
		OPERATION &	LINEN SERVICE	(SQUARE FEET)	(IN-FACILITY	ADMI NI STRATI O	
		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						
1.00	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	o	0				6.00
7.00	HOUSEKEEPI NG	o		0			7.00
8. 00	DI ETARY	ol		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	o o		0		0	
12. 00	STAFF TRANSPORTATION	0		0		l o	
13. 00	VOLUNTEER SERVICE COORDINATION	0				0	
14. 00	PHARMACY	0				0	
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0					
16. 00	OTHER GENERAL SERVICE	0				0	
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0				١	17. 00
17.00	LEVEL OF CARE	<u> </u>				L	17.00
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51. 00	HOSPICE ROUTINE HOME CARE					0	
52. 00	HOSPICE INPATIENT RESPITE CARE	57	0	0	0		
53. 00	HOSPICE GENERAL INPATIENT CARE	43	0				
33.00	NONREI MBURSABLE COST CENTERS	+5		,			33.00
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61. 00	VOLUNTEER PROGRAM	0		0		0	
62. 00	FUNDRAI SI NG	0				0	
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0				0	
64. 00	PALLIATIVE CARE PROGRAM	0				0	
65. 00	OTHER PHYSICIAN SERVICES	0				0	
66. 00	RESI DENTI AL CARE	0	0		0	0	
67. 00	ADVERTI SI NG	0	0	,	0	0	
68. 00	TELEHEALTH/TELEMONI TORI NG	0				0	
69. 00	THRIFT STORE					0	
70. 00	NURSING FACILITY ROOM & BOARD	U				0	70.00
70.00	OTHER NONREIMBURSABLE (SPECIFY)	0	_		_	0	
99.00	NEGATIVE COST CENTER	١	0	ή	l 0		99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	17 707	0		_		100.00
	UNIT COST MULTIPLIER	17, 737 177. 370000	0. 000000	0. 000000	0. 000000		
101.00	JUNIT COST MULTIPLIER	177.370000	0. 000000	η υ. υυυυυυ	0.00000	1 0.000000	1101.00

	Financial Systems	KING'S DAUGHTERS				u of Form CMS-2	
	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL STICAL BASIS	SERVICE COSTS	Provi der C	CN: 15-0069	Peri od: From 01/01/2017	Worksheet 0-6	
SIAIIS	STICAL DASIS		Hospi ce CC	N: 15-1535	To 12/31/2017		pared:
					Hospi ce I	5/23/2018 1: 1	2 piii
	Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
		MEDI CAL	RECORDS	TRANSPORTATION		(CHARGES)	
		SUPPLI ES	(PATI ENT	N N	COORDI NATI ON		
		(PATI ENT	DAYS)	(MI LEAGE)	(HOURS OF		
		DAYS) 10, 00	11. 00	12.00	SERVI CE) 13. 00	14. 00	
	GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	13.00	14.00	
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						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	0					10.00
11.00	MEDI CAL RECORDS		0				11.00
12. 00 13. 00	STAFF TRANSPORTATION VOLUNTEER SERVICE COORDINATION			10, 40	0 14, 674		12. 00 13. 00
14. 00	PHARMACY				0 14, 674	19, 832	
15. 00	PHYSI CI AN ADMI NI STRATI VE SERVI CES				0	17, 032	•
16. 00	OTHER GENERAL SERVICE				0	0	
17. 00	PATIENT/RESIDENTIAL CARE SERVICES					Ü	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0 0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	10, 22	14, 426	19, 497	51.00
52.00		0	0			190	1
53. 00	HOSPICE GENERAL INPATIENT CARE	0	0	7	6 107	145	53.00
	NONREI MBURSABLE COST CENTERS	1 -		1			
60.00	BEREAVEMENT PROGRAM				0 0	0	60.00
61. 00 62. 00	VOLUNTEER PROGRAM FUNDRALSING				0 0	0	61.00 62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS					0	63.00
64. 00	PALLIATIVE CARE PROGRAM				0	0	64.00
65.00	OTHER PHYSICIAN SERVICES					0	65.00
66. 00						0	66.00
67. 00	ADVERTI SI NG				ol ol	Ö	67.00
68.00	TELEHEALTH/TELEMONI TORI NG				o o	0	68.00
69. 00	THRI FT STORE				0 0	0	69.00
70 00	NUDCING FACILITY DOOM & DOADD	1 1		I	1		70 00

0.000000

0.000000

0. 049702

99.00

0 69.00 70.00 71.00

19, 400 100. 00 0. 978217 101. 00

2, 442

0. 166417

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

Health Financial Systems	KING'S DAUGHTERS' F	HOSPI TAL	In Lieu	of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOS STATISTICAL BASIS		Provider CCN: 15 Hospice CCN: 15	From 01/01/2017 To 12/31/2017	Worksheet 0-6 Part II Date/Time Prepared:

						5/23/2018 1:12 pm
					Hospi ce I	
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/		
		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					
1. 00	CAP REL COSTS-BLDG & FLXT					1.0
2. 00	CAP REL COSTS-MVBLE EQUIP					2.0
3. 00	EMPLOYEE BENEFITS DEPARTMENT					3.0
4. 00	ADMINISTRATIVE & GENERAL					4.0
5. 00	PLANT OPERATION & MAINTENANCE					5.0
6. 00	LAUNDRY & LINEN SERVICE					6.0
7. 00	HOUSEKEEPI NG					7.0
8. 00	DI ETARY					8.0
9. 00	NURSING ADMINISTRATION					9.0
	ROUTINE MEDICAL SUPPLIES					10.0
	MEDICAL RECORDS					11.0
	STAFF TRANSPORTATION					12.0
	VOLUNTEER SERVICE COORDINATION					13. 0
	PHARMACY					14. 0
		0				•
	PHYSICIAN ADMINISTRATIVE SERVICES	0				15. 0
	OTHER GENERAL SERVICE		0			16.0
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES				0	17. 0
	LEVEL OF CARE			ı	1	F0.0
	HOSPICE CONTINUOUS HOME CARE	0	-			50.0
	HOSPICE ROUTINE HOME CARE	0	_			51.0
	HOSPICE INPATIENT RESPITE CARE	0	0		0	52.0
53.00	HOSPICE GENERAL INPATIENT CARE	0	0		0	53.0
,	NONREI MBURSABLE COST CENTERS					
	BEREAVEMENT PROGRAM		0			60.0
	VOLUNTEER PROGRAM		0			61.0
	FUNDRAI SI NG		0			62.0
	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.0
	PALLIATIVE CARE PROGRAM		0			64.0
65. 00	OTHER PHYSICIAN SERVICES		0			65.0
66. 00	RESI DENTI AL CARE	0	0		0	66.0
67. 00	ADVERTI SI NG		0			67.0
68. 00	TELEHEALTH/TELEMONI TORI NG		0			68.0
59. 00	THRI FT STORE		0			69. 0
	NURSING FACILITY ROOM & BOARD					70. C
70. 00				I	o	71. C
	OTHER NONREIMBURSABLE (SPECIFY)	0	0		U	/ 1. 0
71. 00	OTHER NONREIMBURSABLE (SPECIFY) NEGATIVE COST CENTER	0	0			•
71. 00 99. 00			0		0	99. 0 100. 0

	Francis I Control	KINOLO BAHOUTE	CDCL LIOCDI TAL			G F OHG .	2550 40
	Financial Systems	KING'S DAUGHTE		011 45 00/0 5		u of Form CMS-2	
	FIONMENT OF HOSPITAL-BASED HOSPICE SHARED SE	RVICE COSTS BY	Provi der Co	CN: 15-0069	Period: From 01/01/2017	Worksheet 0-7	
LEVEL	OF CARE		Hospi ce CCI		Tolli 01/01/2017 To 12/31/2017		nared:
			nospi ce coi	10 1000	12/01/201/	5/23/2018 1: 1	2 pm
					Hospi ce I		
	·			Charges by	LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C,	Cost to	HCHC	HRHC	HI RC	
		Part I, Col.	Charge Ratio				
		9 line					
		0	1.00	2.00	3. 00	4. 00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSI CAL THERAPY	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 PATIENTS	73. 00		(0	0	1
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5. 00
6.00	LABORATORY	60.00			0	0	
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00			0	0	1
7. 01	IV SOLUTIONS	71. 01	0. 058362	(0	0	7. 01
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	ONCOLOGY	55. 00	0. 418464	C	0	0	9.00
10.00	CARDI OLOGY	76.00	0. 110439	C	0	0	10.00
10. 97	CARDIAC REHABILITATION	76. 97	0. 261366	C	0	0	10. 97
11. 00	Totals (sum of lines 1-11)						11.00
		Charges by		Shared Service	e Costs by LOC		
		LOC (from					
		Provi der					
		Records)					
	Cost Center Descriptions	HGI P	HCHC (col. 1	HRHC (col. 1	,	HGIP (col. 1	
			x col. 2)	x col. 3)	x col. 4)	x col. 5)	

		Records)					
	Cost Center Descriptions	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						
1.00	PHYSI CAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATI ONAL THERAPY	0	0	0	0	0	2.00
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	ol	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	ol	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
7. 01	IV SOLUTIONS	0	0	0	0	0	7. 01
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	ONCOLOGY	0	0	0	0	0	9.00
10.0	CARDI OLOGY	0	0	0	0	0	10.00
10. 9	7 CARDIAC REHABILITATION	0	0	0	0	0	10. 97
11. 0	Totals (sum of lines 1-11)		0	0	0	0	11.00
	•	•	•	•			

Health Financial Systems	KING'S DAUGHTERS	HOSPI TAL		In Lie	u of Form CMS-2552-10
CALCULATION OF HOSPITAL-BASED HOSPICE PER	DIEM COST	Provider CCN:	15-0069	Peri od: From 01/01/2017	Worksheet 0-8
		Hospi ce CCN:	15-1535		Date/Time Prepared:

		nospi ce con	. 10 1000 10	12/01/2017	5/23/2018 1: 1	
				Hospi ce I		
			TITLE XVIII	TITLE XIX	TOTAL	
			MEDI CARE	MEDICAID		
			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, line	10)	0	0		4.00
5.00	Program cost (line 3 times line 4)		0	0		5.00
	HOSPICE ROUTINE HOME CARE					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7	', col. 7,			153, 430	6.00
	line 11)					
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				1, 741	7.00
8.00	Total average cost per diem (line 6 divided by line 7)				88. 13	
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, lir	ne 11)	1, 500	111		9.00
10. 00	Program cost (line 8 times line 9)		132, 195	9, 782		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,			11, 141	11. 00
	line 11)					
	Total unduplicated days (Wkst. S-9, col. 4, line 12)					12.00
	Total average cost per diem (line 11 divided by line 12)				655. 35	
	Unduplicated program days (Wkst. S-9, col. as appropriate, lir	ne 12)	17	0		14.00
15. 00	Program cost (line 13 times line 14)		11, 141	0		15.00
	HOSPICE GENERAL INPATIENT CARE		ı			
16. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7	', col. 9,			8, 418	16.00
47.00	line 11)				4.0	47.00
	Total unduplicated days (Wkst. S-9, col. 4, line 13)					17.00
	Total average cost per diem (line 16 divided by line 17)	10)	4.0		647. 54	
	Unduplicated program days (Wkst. S-9, col. as appropriate, lir	ie 13)	13	0		19.00
20.00	Program cost (line 18 times line 19)		8, 418	O		20. 00
	TOTAL HOSPICE CARE				470.000	04 00
	Total cost (sum of line 1 + line 6 + line 11 + line 16)				172, 989	
	Total unduplicated days (Wkst. S-9, col. 4, line 14)				1, 771	
23.00	Average cost per diem (line 21 divided by line 22)				97.68	23.00

UMLUUL	Financial Systems KING'S DAUGHTERS ATION OF CAPITAL PAYMENT	' HOSPITAL Provider CCN: 15-0069	Peri od:	u of Form CMS-2 Worksheet L	2002 10
	ATTOM OF CAPITAL PATWENT	Provider CCN. 15-0009	From 01/01/2017 To 12/31/2017	Parts I-III Date/Time Pre	pared:
		Title XVIII	Hospi tal	5/23/2018 1: 1: PPS	2 pm
	DADT I FILLY PROCRECTIVE METHOD			1. 00	
	PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT				1
1. 00	Capital DRG other than outlier			1, 015, 100	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2. 00	Capital DRG outlier payments			39, 368	
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00	Total inpatient days divided by number of days in the cost re	eporting period (see ins	tructions)	32. 37	3.00
4.00	Number of interns & residents (see instructions)			0. 00	
5.00	Indirect medical education percentage (see instructions)			0. 00	
6. 00	Indirect medical education adjustment (multiply line 5 by the	1, columns 1 and	0	6.00	
7. 00	1.01)(see instructions) Percentage of SSI recipient patient days to Medicare Part A p	0. 00	7.00		
7.00	30) (see instructions)	L, part A TITIE	0.00	7.00	
8. 00	Percentage of Medicaid patient days to total days (see instructions)				8.00
9.00	Sum of lines 7 and 8				9.00
10.00					10.00
11. 00	DO Disproportionate share adjustment (see instructions)				
12.00	Total prospective capital payments (see instructions)			1, 054, 468	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST			1.00	
1. 00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)			0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3.00
4.00	Capital cost payment factor (see instructions)			0	
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5.00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			11.00	
1. 00	Program inpatient capital costs (see instructions)			0	1.00
2.00	Program inpatient capital costs for extraordinary circumstand	ces (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)				
4.00	Applicable exception percentage (see instructions)			0. 00	
5. 00 6. 00	Capital cost for comparison to payments (line 3 x line 4)			0	
7. 00	Percentage adjustment for extraordinary circumstances (see instructions) Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)			0. 00 0	
8. 00	Capital minimum payment level (line 5 plus line 7)	y circumstances (irme 2	x iiile 0)	0	
9. 00	Current year capital payments (from Part I, line 12, as applicable)			0	
10.00				0	
11. 00	Carryover of accumulated capital minimum payment level over of Worksheet L, Part III, line 14)	capital payment (from pr	ior year	0	11.00
12.00	Net comparison of capital minimum payment level to capital pa			0	12.00
40 00	Current year exception payment (if line 12 is positive, enter			0	13.00
13.00	Carryover of accumulated capital minimum payment level over of	capital payment for the	following period	0	14.00
14. 00	(if line 12 is negative, enter the amount on this line)				
14. 0015. 00		structions)		0	