This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0069 Worksheet S Peri od: From 01/01/2020 Parts I-III AND SETTLEMENT SUMMARY 12/31/2020 Date/Time Prepared: 5/24/2021 11:00 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 5/24/2021 Time: 11:00 am ] Manually prepared cost report use only ] If this is an amended report enter the number of times the provider resubmitted this cost report ] Medicare Utilization. Enter "F" for full or "L" for low. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[11] 12. Contractor's Vendor Code:
[12] 13. NPR Date:
[13] 14. Contractor's Vendor Code:
[14] 15. Contractor's Vendor Code:
[15] 16. NPR Date:
[16] 17. Contractor's Vendor Code:
[17] 17. Contractor's Vendor Code:
[18] 18. Contractor's Vendor Code:
[18] 19. NPR Date:
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[18] 19. NPR Date:
[18] 19. NPR Date:
[19] 19. NPR Date Contractor use only

PART II - CERTIFICATION

(3) Settled with Audit

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by KING'S DAUGHTERS' HOSPITAL (15-0069) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

> JOHN PRICE (Si aned) Officer or Administrator of Provider(s) CF0 Title

> > (Dated when report is electronically signed.) Date

number of times reopened = 0-9.

			Title XVIII				
Cost Center Description		Title V	Part A	Part B	HI T	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-94, 543	1, 886	0	0	1. 00
2.00	Subprovi der - I PF	0	0	0		0	2. 00
3.00	Subprovi der - I RF	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	-94, 543	1, 886	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 01/01/2020 Part I Date/Time Prepared: 12/31/2020 5/24/2021 11:00 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1373 EAST SR 62 1.00 PO Box: 1.00 State: IN Zi p Code: 47250-County: JEFFERSON 2.00 City: MADISON 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N) Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal KING'S DAUGHTERS' 150069 99915 06/17/1966 3.00 HOSPI TAL Subprovi der - IPF 4.00 4 00 5.00 Subprovider - 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 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA KING'S DAUGHTERS' 157141 99915 03/08/1985 N Ρ Ν 12.00 HOSPITAL HHA Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce KING'S DAUGHTERS' 151535 99915 09/01/1995 14.00 14 00 Hospital-Based Health Clinic - RHC 15.00 15.00 16.00 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) 01/01/2020 12/31/2020 20.00 21.00 Type of Control (see instructions) 21.00 2 1. 00 2. 00 3 00 Inpatient PPS Information 22. 00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22.01 Did this hospital receive interim uncompensated care payments for this Υ Υ 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care Ν Ν 22.02 payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1 22.03 Did this hospital receive a geographic reclassification from urban to 22 03 N Ν N rural as a result 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

	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	Medi cai d	Other	
		Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
		paid days	eligible	Medi cai d	Medi cai d		days	
			unpai d	pai d days	eligible			
			days		unpai d			
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	1
24. 00	If this provider is an IPPS hospital, enter the	276	287	143	30	1, 511	95	24. 00
	in-state Medicaid paid days in column 1, in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid paid days in column 3,							
	out-of-state Medicaid eligible unpaid days in column							
	4, Medicaid HMO paid and eligible but unpaid days in							
	column 5, and other Medicaid days in column 6.							
	<u> </u>							

Ν

23.00

counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for

below? In column 1, enter 1 if date of admission, 2 if census days, or 3

Which method is used to determine Medicaid days on lines 24 and/or 25

yes or "N" for no.

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 01/01/2020 Part I Date/Time Prepared: 12/31/2020 5/24/2021 11:00 am In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days unpai d paid days el i gi bl e days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6.00 25.00 If this provider is an IRF, enter the in-state 25, 00  $\cap$ Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 1.00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the 26. 00 cost reporting period. Enter "1" for urban or "2" for rural. Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 10/01/2020 27.00 enter the effective date of the geographic reclassification in column 2. If this is a sole community hospital (SCH), enter the number of periods SCH status in 35.00 effect in the cost reporting period. Endi ng: Begi nni ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number 01/01/2020 12/31/2020 36 00 of periods in excess of one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 37.00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see 37 01 instructions) 38.00 | If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39.00 hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 | Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν N 40.00 "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX 1. 00 2. 00 3 00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance Ν Ν 45.00 with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances 46.00 Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III. 47.00 | Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. Ν Ν Ν 47.00 48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no N Ν 48.00 Ν Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA Ν 56.00 GME payment reduction? Enter "Y" for yes or "N" for no in column 2. If line 56 is yes, is this the first cost reporting period during which residents in approved 57.00 57.00 GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as 58.00 defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, 59.00 Pt. NAHE 413.85 Pass-Through Worksheet A Y/N Line # Qual i fi cati on Criterion Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60.00 any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustement? Enter "Y" for yes or "N" for no in column 2. 60.01 If line 60 is yes, complete columns 2 and 3 for each program. (see 23.00 1 60.01 instructions)

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 01/01/2020 Part I Date/Time Prepared: 12/31/2020 5/24/2021 11:00 am Y/N IME Direct GME IME Direct GME 1. 00 2.00 3. 00 4.00 5.00 0.00 61.00 61.00 Did your hospital receive FTE slots under ACA 0 00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA \$5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unweighted IME Unweighted Program Name FTE Count Direct GME FTE Count 3.00 1.00 2.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 01 6

02.00	were beginning to the control of the	. oper tring peri	04 .0 0	0.09	02.00
(2.01	your hospital received HRSA PCRE funding (see instructions)	ton (TUC) into	vous boonital	0.00	(2.01
62. 01	Enter the number of FTE residents that rotated from a Teaching Health Cent		your nospital	0.00	62. 01
	during in this cost reporting period of HRSA THC program. (see instruction	18)			
	Teaching Hospitals that Claim Residents in Nonprovider Settings				
63. 00	Has your facility trained residents in nonprovider settings during this co			N	63.00
	"Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 6		ctions)		
		Unwei ghted	Unwei ghted	Ratio (col. 1/	
		FTEs	FTEs in	(col. 1 + col.	
		Nonprovi der	Hospi tal	2))	
		Si te	·		
		1. 00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings	This base year	is your cost n	eporting	
	period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents	0.00	0. 00	0. 000000	64.00
	in the base year period, the number of unweighted non-primary care				
	resident 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)				
	of (cordinar ran videa by (cordinar r cordinar 2)). (see firstructions)				

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 01/01/2020 Part I Date/Time Prepared: 12/31/2020 5/24/2021 11:00 am Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) 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. 00 0. 00 0.000000 65.00 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/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) 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 66.00 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 Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der Co	CN: 15-0069	Peri od: From 01/01/2020 To 12/31/2020		epared:
					1. 00	
	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes Is this a LTCH co-located within another hospital for part o "Y" for yes and "N" for no.			ng period? Enter	N N	80. 00
	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) Did this facility establish a new Other subprovider (exclude §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85. 00 86. 00
37. 00	Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	al classified	under sectio	n	N	87. 00
				V 1. 00	XI X 2. 00	
0. 00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospita	al services? Fi	nter "Y" for	N	Y	90.00
	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through t	the cost repor	t either in	N	Y	91.00
2. 00	full or in part? Enter "Y" for yes or "N" for no in the appl Are title XIX NF patients occupying title XVIII SNF beds (du	ual certificat			N	92. 0
3. 00	instructions) Enter "Y" for yes or "N" for no in the applica Does this facility operate an ICF/IID facility for purposes		d XIX? Enter	N	N	93. 00
4. 00	"Y" for yes or "N" for no in the applicable column.  Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for n	in the	N	N	94. 0
	0 l'fline 94 is "Y", enter the reduction percentage in the applicable column. 0 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the				0. 00 N	95. 0 96. 0
	stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in					97. 0 98. 0
8. 01	column 1 for title V, and in column 2 for title XIX.  Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst.  C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for				Y	98. 0
8. 02	title XIX. Does title V or XIX follow Medicare (title XVIII) for the ca bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes o			Y	Y	98. 0
8. 03	for title V, and in column 2 for title XIX.  Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for ye				N	98. 0
8. 04	for title V, and in column 2 for title XIX.  Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in			N d	N	98. 0
8. 05	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c				Y	98. 0
98. 06	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			Y	Y	98. 0
05.00	Rural Providers Does this hospital qualify as a CAH?			N		105. 00
	If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)	inclusive met	nod of payme	nt N		106. 00
07. OC	Column 1: If line 105 is Y, is this facility eligible for cotraining programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded IP	n 1. (see ins you train L&R: PF and/or LRF :	tructions) s in an	N		107. 0
08. 00	Enter "Y" for yes or "N" for no in column 2. (see instructi Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		dul e? See 4	2 N		108. 0
		Physi cal 1.00	Occupati on 2.00	al Speech 3.00	Respi ratory 4.00	-
	If this hospital qualifies as a CAH or a cost provider, are	N	N N	N N	N	109. 00

	1. 00	
110.00Did this hospital participate in the Rural Community Hospital Demonstration project (§410A	N	110. 00
Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes,		
complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as		
appl i cabl e.		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	VI. 1E 00(0 D		eu of Form CMS	
		eriod: rom 01/01/2020 o 12/31/2020	Date/Time Pr	epared:
			5/24/2021 11	: 00 am
I11.00 If this facility qualifies as a CAH, did it participate in the Frontier Co Health Integration Project (FCHIP) demonstration for this cost reporting p "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, en integration prong of the FCHIP demo in which this CAH is participating in a Enter all that apply: "A" for Ambulance services; "B" for additional beds; for tele-health services.	eriod? Enter nter the column 2.	1. 00 N	2.00	111.00
	1. 00	2. 00	3. 00	+
112.00 Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period?  Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information	N			112.00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 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.	N			0115.00
16.00   Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116. 00
17.00  Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117. 00
118.00 is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0			118. 00
	Premi ums	Losses	Insurance	
10.01 List amounts of malarastics are minus and said Lassas.	1. 00	2.00	3.00	0110 0
18.01   List amounts of mal practice premiums and paid losses:	963, 805		J	0 118. 0
   118.02  Are malpractice premiums and paid losses reported in a cost center other t	han tha	1. 00 N	2. 00	118. 0
Administrative and General? If yes, submit supporting schedule listing co- and amounts contained therein.  19.00 DO NOT USE THIS LINE  20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov §3121 and applicable amendments? (see instructions) Enter in column 1, "Y"  "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instru	st centers ision in ACA for yes or e Outpatient	Y	Y	119. 0
		1		
Enter in column 2, "Y" for yes or "N" for no. 21.00Did this facility incur and report costs for high cost implantable devices	charged to	Y		121. 0
Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defined in §1903(nact?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.	w)(3) of the	Y Y	5. 00	
Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defined in §1903(Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter	w)(3) of the in column 2  for no. If ication date cation date ation date in ification rtification cation date		5.00	121. 0 122. 0 125. 0 126. 0 127. 0 128. 0 129. 0 130. 0 131. 0 132. 0 134. 0

Health Financial Systems KING'S DAUGHTERS' HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0069 Peri od: Worksheet S-2

From 01/01/2020 Part I Date/Time Prepared: To 12/31/2020 5/24/2021 11:00 am 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 00 Name: Contractor's Name: Contractor's Number: 141 00 142.00 Street: PO Box: 142.00 143. 00 Ci ty: 143. 00 State: Zip Code: 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 γ 1. 00 2.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145 00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν N 148 00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no N 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal 155.00 Ν N 156.00 Subprovi der - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν 159. 00 Ν 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 167 00 168.00 of this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the 168.00 reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 168.01 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 9. 99169. 00 transition factor. (see instructions) Begi nni ng Endi ng 1.00 2.00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 170. 00 period respectively (mm/dd/yyyy) 1.00 2.00 171.00|If line 167 is "Y", does this provider have any days for individuals enrolled in 0171.00 N section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section

1876 Medicare days in column 2. (see instructions)

	Financial Systems KING'S DAUGHTE		011 45 55		u of Form CMS-	
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provi der C	CN: 15-0069	Peri od: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Pro 5/24/2021 11	epared:
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N	l for all NO ro	enoncoe Ent	1.00	2. 00	
	mm/dd/yyyy format.  COMPLETED BY ALL HOSPITALS	I TOT ALL NO TE	sponses. Enti	er arr dates in t	TIE .	
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the			N		1. 00
	reporting period? If yes, enter the date of the change in o	column 2. (see	Y/N	) Date	V/I	
			1.00	2. 00	3. 00	
2. 00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.00
3. 00	s the provider involved in business transactions, including management ontracts, with individuals or entities (e.g., chain home offices, drug r medical supply companies) that are related to the provider or its fficers, medical staff, management personnel, or members of the board f directors through ownership, control, or family and other similar elationships? (see instructions)					3.00
			Y/N	Type	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
4. 00 5. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avaccolumn 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues difference.	for Compiled, ailable in	Y	A	05/19/2021	4.00
0.00	those on the filed financial statements? If yes, submit rec		l N			3.00
				Y/N	Legal Oper.	
	la let i lairie			1. 00	2. 00	
. 00	Approved Educational Activities  Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	s N		6. 00		
'. 00 3. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	N N		7. 00 8. 00		
. 00	Are costs claimed for Interns and Residents in an approved		cal education	N		9. 00
0. 00	program in the current cost report? If yes, see instruction Was an approved Internal and Resident GME program initiated of		the current	N		10.00
1. 00	cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11. 00
				•	Y/N 1. 00	
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			ost reporting	Y N	12. 00 13. 00
4. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	yes, see in:	structi ons.	N	14.00
5. 00	Did total beds available change from the prior cost reporti				N	15. 00
		Y/N	Tt A Date	Par Y/N	<u>t в</u> Date	
		1.00	2.00	3. 00	4. 00	
6. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	N		N		16. 00
7. 00	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 totals and the provider's records for allocation? If	Y	04/26/2021	Y	04/26/2021	17. 00
3. 00	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
0 00	Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		10.0
9. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. 00

Heal th	Financial Systems KING'S DAUGHTER	RS' HOSPITAL		In Lie	u of Form CM	S-2552-10		
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0069	Peri od: From 01/01/2020 To 12/31/2020		repared:		
		Descr	pti on	Y/N	Y/N	1.00 am		
			)	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		
	The port data for other. Beson to the other day astments.	Y/N	Date	Y/N	Date			
21 00	Was the seek second solver in the second deal of	1.00	2.00	3.00	4. 00	21.00		
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00		
					1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCER	PT CHILDRENS H	OSPI TALS)					
	Capital Related Cost							
22. 00	Have assets been relifed for Medicare purposes? If yes, see					22. 00		
23. 00	Have changes occurred in the Medicare depreciation expense of reporting period? If yes, see instructions.	due to apprais	als made dur	ing the cost		23. 00		
24. 00	Were new leases and/or amendments to existing leases entered If yes, see instructions	d into during	this cost re	porting period?		24. 00		
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	If yes, see		25. 00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the	f yes, see		26. 00				
27. 00	instructions. Has the provider's capitalization policy changed during the	yes, submit		27. 00				
	copy. Interest Expense							
28. 00	Were new Loans, mortgage agreements or Letters of credit entered into during the cost reporting period? If yes, see instructions.							
29. 00	00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)							
30. 00	treated as a funded depreciation account? If yes, see instructions  Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see							
31. 00	instructions. Has debt been recalled before scheduled maturity without is: instructions.		31. 00					
32. 00	Purchased Services Have changes or new agreements occurred in patient care services	vi ces furni she	d through co	ntractual		32. 00		
33. 00	arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applino, see instructions.		g to competi	tive bidding? If		33. 00		
	Provi der-Based Physi ci ans							
34. 00	Are services furnished at the provider facility under an arm	rangement with	provi der-ba	sed physicians?	Y	34. 00		
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exis		its with the	provi der-based	N	35. 00		
	physicians during the cost reporting period? If yes, see in	STructions.		Y/N	Date			
				1.00	2. 00			
	Home Office Costs			00	2.00			
	Were home office costs claimed on the cost report?					36.00		
37. 00	If line 36 is yes, has a home office cost statement been prolef yes, see instructions.	epared by the	home office?	'		37. 00		
38. 00	If line 36 is yes, was the fiscal year end of the home offi the provider? If yes, enter in column 2 the fiscal year end					38. 00		
39. 00	If line 36 is yes, did the provider render services to other			i,		39. 00		
40. 00	see instructions. If line 36 is yes, did the provider render services to the linstructions.	home office?	If yes, see			40. 00		
			00		00			
	Cost Donort Dronaror Contact Information	1.	00	2.	00			
41. 00	held by the cost report preparer in columns 1, 2, and 3,	LUCI A		GERBER		41.00		
42. 00	respectively. Enter the employer/company name of the cost report	BLUE & CO., LL	С			42. 00		
42.00	preparer.	-02 002 2524		L CEDDED-DI UE	DCO COM	40.00		
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	502. 992. 3524		LGERBER@BLUEAN	DCO. COM	43. 00		

Heal th	Financial Systems	KING'S DAUGHTERS	' HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	ESTI ONNAI RE	Provi der CCN:	1	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Pre 5/24/2021 11:	pared:
		_	3.00	1	_		
	Cost Report Preparer Contact Information		3.00	·			
41. 00	Enter the first name, last name and the title held by the cost report preparer in columns respectively.	· ·	NI OR MANAGER				41. 00
42. 00	Enter the employer/company name of the cost preparer.	report					42. 00
43. 00	Enter the telephone number and email address report preparer in columns 1 and 2, respective						43. 00

| Peri od: | Worksheet S-3 | From 01/01/2020 | Part | To 12/31/2020 | Date/Time Prepared: | 11/202 | Part | Prepared: | Part | P Health Financial Systems KING'S DHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0069

					0 12/31/2020	5/24/2021 11:0	
						I/P Days / 0/P	JO UIII
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
	35pariarit	Line Number		Avai I abl e	57 III 110 GI 0		
		1.00	2. 00	3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	55	20, 130	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		55	20, 130	0.00	0	7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31. 00	6	2, 196	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)						12.00
13.00	NURSERY	43. 00				0	13.00
14.00	Total (see instructions)		61	22, 326	0.00	0	14.00
15. 00	CAH visits					0	15.00
16. 00	SUBPROVI DER - I PF						16.00
17. 00	SUBPROVI DER - I RF						17.00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	101. 00				0	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23. 00
24. 00	HOSPI CE	116. 00		366			24. 00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)		62				27. 00
28. 00	Observation Bed Days					0	28. 00
29. 00	Ambul ance Tri ps						29. 00
30. 00	Employee discount days (see instruction)						30. 00
31. 00	Employee di scount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)		0	(	)		32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33. 00
33.01	LTCH site neutral days and discharges			I		ı l	33. 01

In Lieu of Form CMS-2552-10

Period:	Worksheet S-3
From 01/01/2020	Part
To 12/31/2020	Date/Time Prepared:
5/24/2021	11:00 am

						5/24/2021 11:	00 am
		I/P Days	o/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	3, 866	1, 086	8, 142			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)	1, 733	674				2. 00
3.00	HMO IPF Subprovider	1, 733	0/4				3.00
4. 00	HMO IRF Subprovider	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF		0	0			5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF	Ĭ	0	0			6.00
7. 00	Total Adults and Peds. (exclude observation	3, 866	1, 086	8, 142			7.00
7.00	beds) (see instructions)	0,000	1,000	0, 112			7.00
8.00	INTENSIVE CARE UNIT	692	229	1, 473			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)						12. 00
13.00	NURSERY		258	990			13. 00
14.00	Total (see instructions)	4, 558	1, 573	10, 605	0.00	726. 24	14. 00
15. 00	CAH visits	0	0	C			15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE			, ,==		40.54	21.00
22. 00	HOME HEALTH AGENCY	3, 693	658	6, 657	0.00	13. 51	
23. 00	AMBULATORY SURGICAL CENTER (D. P. )	27			0.00	2.25	23. 00
24. 00	HOSPICE	27	0	55	0.00	2. 35	24. 00 24. 10
24. 10 25. 00	HOSPICE (non-distinct part) CMHC - CMHC			C			25. 00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	o	C	0.00	0.00	26. 25
27. 00	Total (sum of lines 14-26)	ď	Ŭ		0.00	l	
28. 00	Observation Bed Days		500	2, 898		742.10	28. 00
29. 00	Ambulance Trips	1, 838	500	2,070			29. 00
30. 00	Employee discount days (see instruction)	., 555		82			30.00
31. 00	Employee discount days - IRF			0			31.00
32. 00	Labor & delivery days (see instructions)	o	95	157			32. 00
32. 01	Total ancillary labor & delivery room		, 9	0			32. 01
	outpatient days (see instructions)			_			
33.00	LTCH non-covered days	o					33. 00
33. 01	LTCH site neutral days and discharges	o					33. 01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Peri od: Worksheet S-3 From 01/01/2020 Part I Date/Time Prepared: To 12/31/2020

5/24/2021 11:00 am Full Time Di scharges Equi val ents Title XVIII Total All Component Nonpai d Title V Title XIX Workers Pati ents 12.00 13.00 11.00 14.00 15.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 1, 208 359 2, 692 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 377 2 00 184 HMO IPF Subprovider 3.00 3.00 HMO IRF Subprovider 4.00 0 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 6.00 7.00 Total Adults and Peds. (exclude observation 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 CORONARY CARE UNIT 9.00 9.00 BURN INTENSIVE CARE UNIT 10.00 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 OTHER SPECIAL CARE (SPECIFY) 12.00 12.00 NURSERY 13.00 13.00 2, 692 14.00 Total (see instructions) 0.00 0 1, 208 359 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 0.00 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23.00 HOSPI CE 0 00 24.00 24 00 HOSPICE (non-distinct part) 24. 10 24. 10 25. 00 CMHC - CMHC 25.00 26.00 RURAL HEALTH CLINIC 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0.00 26, 25 27.00 Total (sum of lines 14-26) 0.00 27.00 28.00 Observation Bed Days 28.00 29.00 29.00 Ambul ance Trips 30 00 Employee discount days (see instruction) 30.00 31.00 Employee discount days - IRF 31.00 32.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room 32.00 32.01 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 33.01 LTCH site neutral days and discharges 33.01

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

| Period: | Worksheet S-3 | From 01/01/2020 | Part II | To 12/31/2020 | Date/Time Prepared:

PART II - WAGE DAT SALARIES  1.00 Total salaries (seinstructions) 2.00 Non-physician anes A 3.00 Non-physician anes B 4.00 Physician-Part A Administrative	ethetist Part	Wkst. A Line Number 1.00	Amount Reported  2.00  50,841,221  0  380,325		(col . 2 ± col . 3) 4.00	Related to Salaries in col. 4 5.00	5/24/2021 11:( Average Hourly Wage (col. 4 ÷ col. 5) 6.00	
SALARIES  1.00 Total salaries (seinstructions)  2.00 Non-physician anes A  3.00 Non-physician anes B  4.00 Physician-Part A-Administrative	e thetist Part thetist Part		50, 841, 221	A-6) 3.00 270,969	4.00	col . 4 5.00		
SALARIES  1.00 Total salaries (seinstructions)  2.00 Non-physician anes A  3.00 Non-physician anes B  4.00 Physician-Part A-Administrative	e thetist Part thetist Part		50, 841, 221	270, 969				
SALARIES  1.00 Total salaries (seinstructions)  2.00 Non-physician anes A  3.00 Non-physician anes B  4.00 Physician-Part A-Administrative	e thetist Part thetist Part	200.00	0		51, 112, 190	1, 543, 577. 00	20.11	
i nstructions) 2.00 Non-physician anes A 3.00 Non-physician anes B 4.00 Physician-Part A - Administrative	thetist Part	200. 00	0		51, 112, 190	1, 543, 577. 00		
2.00 Non-physician anes A 3.00 Non-physician anes B 4.00 Physician-Part A - Administrative	thetist Part		_	0			33. 11	1. 00
B Physician-Part A - Administrative			380, 325		0	0. 00	0. 00	2. 00
Admi ni strati ve				0	380, 325	3, 317. 00	114. 66	3. 00
	A - Teaching		44, 474	0	44, 474	197. 00	225. 76	4. 00
4.01 Physicians - Part 5.00 Physician and Non			0 2, 961, 147	0	-	0. 00 21, 640. 00	0. 00 136. 84	4. 01 5. 00
Physician-Part B 6.00 Non-physician-Part hospital-based RHC			0	0	0	0. 00	0. 00	6. 00
services 7.00 Interns & resident		21. 00	0	0	0	0. 00	0. 00	7. 00
approved program) 7.01 Contracted interns residents (in an a			0	О	0	0. 00	0. 00	7. 01
programs) 8.00 Home office and/or	related		0	0	0	0. 00	0. 00	8. 00
organization perso 9.00 SNF	nnel	44. 00	0	0	О	0.00	0. 00	9. 00
10.00 Excluded area sala instructions) OTHER WAGES & RELA	·		19, 804, 361	78, 043	19, 882, 404	476, 652. 00	41. 71	10. 00
11.00 Contract Labor: Di			478, 902	0	478, 902	4, 151. 00	115. 37	11. 00
Care 12.00 Contract Labor: To management and oth management and adm	ier		0	0	0	0.00	0. 00	12. 00
services 13.00 Contract Labor: Ph	ysi ci an-Part		1, 439, 982	o	1, 439, 982	8, 534. 00	168. 73	13. 00
A - Administrative Home office and/or organization salar	related ies and		0	0	0	0. 00	0. 00	14. 00
wage-related costs			0	0	0	0.00	0.00	14. 01
14. 02 Related organizati			0	Ö	Ö	0.00	0. 00	
15.00 Home office: Physi	cian Part A		0	0	0	0. 00	0. 00	15. 00
16.00 Home office and Co			0	0	0	0.00	0. 00	16. 00
16.01 Home office Physic			0	0	0	0.00	0. 00	16. 01
- Teaching 16.02 Home office contra Physicians Part A			0	0	0	0.00	0. 00	16. 02
WAGE-RELATED COSTS								
17.00 Wage-related costs instructions)			7, 469, 884	0	7, 469, 884			17. 00
18.00 Wage-related costs (see instructions)								18. 00
19.00 Excluded areas 20.00 Non-physician anes	thetist Part		4, 850, 922 0	0	4, 850, 922 0			19. 00 20. 00
21.00 Non-physician anes	thetist Part		81, 758	0	81, 758			21. 00
22.00 Physician Part A - Administrative			9, 510	0	9, 510			22. 00
22.01 Physician Part A - 23.00 Physician Part B	Teachi ng		632, 921	0	0 632, 921			22. 01 23. 00
24.00 Wage-related costs 25.00 Interns & resident approved program)			0	0	0 0			24. 00 25. 00
25.50 Home office wage-r	el ated		0	0	0			25. 50
(core) 25. 51 Related organizati			0	0	0			25. 51
wage-related (core 25.52 Home office: Physi - Administrative - wage-related (core	cian Part A		0	0	0			25. 52

| Period: | Worksheet S-3 | From 01/01/2020 | Part II | To 12/31/2020 | Date/Time Prepared:

					T	o 12/31/2020	Date/Time Prep 5/24/2021 11:0	
		Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number		on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4	, i	
		1.00	2.00	3.00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARIE							
26.00	Employee Benefits Department	4. 00	0	0	0			26. 00
27. 00	Administrative & General	5. 00	6, 407, 684	270, 969	6, 678, 653	252, 017. 00	26. 50	27. 00
28. 00	Administrative & General under		1, 005, 203	0	1, 005, 203	12, 485. 00	80. 51	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0. 00		29. 00
30.00	Operation of Plant	7. 00	549, 520		549, 520			
31. 00	Laundry & Linen Service	8. 00	28, 203		28, 203			
32.00	Housekeepi ng	9. 00	673, 450	0	673, 450		13. 55	32. 00
33.00	Housekeeping under contract		214, 096	0	214, 096	10, 548. 00	20. 30	33. 00
	(see instructions)							
34.00	Di etary	10. 00	710, 613	-190, 617	519, 996	32, 179. 00	16. 16	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	190, 617	190, 617			36. 00
37. 00	Maintenance of Personnel	12. 00	0	0	0	0. 00		
38. 00	Nursing Administration	13. 00	440, 930	0	440, 930	11, 678. 00	37. 76	38. 00
39. 00	Central Services and Supply	14. 00	85, 043	0	85, 043	5, 591. 00	15. 21	39. 00
40.00	Pharmacy	15. 00	735, 040	0	735, 040	19, 763. 00	37. 19	40. 00
41.00	Medical Records & Medical	16. 00	532, 261	0	532, 261	23, 956. 00	22. 22	41. 00
	Records Li brary							
42.00	Soci al Servi ce	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

					11	0 12/31/2020	5/24/2021 11:0	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number		on of Salaries	,		Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
PART III - HOSPITAL WAGE INDEX SUMMARY								
1.00	Net salaries (see		48, 719, 048	270, 969	48, 990, 017	1, 541, 653. 00	31. 78	1.00
	instructions)							
2.00	Excluded area salaries (see		19, 804, 361	78, 043	19, 882, 404	476, 652. 00	41. 71	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		28, 914, 687	192, 926	29, 107, 613	1, 065, 001. 00	27. 33	3. 00
	minus line 2)			_				
4.00	Subtotal other wages & related		1, 918, 884	0	1, 918, 884	12, 685. 00	151. 27	4. 00
	costs (see inst.)		7 470 004				05.70	
5.00	Subtotal wage-related costs		7, 479, 394	0	7, 479, 394	0. 00	25. 70	5. 00
	(see inst.)		00 040 045	400.007	00 505 004	4 077 (0/ 00	05.70	, 00
6. 00	Total (sum of lines 3 thru 5)		38, 312, 965					
7. 00	Total overhead cost (see		11, 382, 043	270, 969	11, 653, 012	451, 928. 00	25. 79	7. 00
	instructions)							

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lie	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS		Provider CCN: 15-0069	From 01/01/2020	Worksheet S-3 Part IV Date/Time Prepared:

		To 12/31/2020	Date/Time Pre 5/24/2021 11:	
			Amount	
			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		0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		1, 955, 716	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees		0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan		0	6. 00
7.00	Employee Managed Care Program Administration Fees		0	7. 00
	HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)		0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	)	0	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		4, 493, 650	8. 02
8.03	Heal th Insurance (Purchased)		0	8. 03
9.00	Prescription Drug Plan		2, 787, 796	9. 00
10.00	Dental, Hearing and Vision Plan		0	1
11.00	Life Insurance (If employee is owner or beneficiary)		0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		171, 946	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14. 00
15.00	'Workers' Compensation Insurance		210, 008	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordin	nary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)	, ,		
	TAXES			
17.00	FICA-Employers Portion Only		3, 240, 867	17. 00
18.00	Medicare Taxes - Employers Portion Only		0	18. 00
19.00	Unemployment Insurance		185, 012	19. 00
20.00	State or Federal Unemployment Taxes		0	20. 00
	OTHER		•	
21.00	Executive Deferred Compensation (Other Than Retirement Cost Report	ted on lines 1 through 4 above. (see	0	21. 00
	instructions))	· ·		
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)		13, 044, 995	24. 00
	Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	·		25. 00

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0069	Peri od:	Worksheet S-3
			From 01/01/2020	Part V

		0 12/31/2020	Date/IIMe Prep   5/24/2021 11:0						
	Cost Center Description	Contract Labor		JO alli					
		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	478, 902	13, 044, 995	1.00					
2.00	Hospi tal	478, 902	13, 044, 995	2.00					
3.00	Subprovi der - IPF			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					
17. 00	Renal Dialysis			17.00					
18. 00	Other	0	0	18.00					

Country	Heal th	Financial Systems	KING'S DAUGHTER	S' HOSPITAL		In Lie	eu of Form CMS-:	2552-10
1.00				Provider C		Period: From 01/01/2020	Worksheet S-4 Date/Time Pre	pared:
Description   County						Home Health		oo alii
MOME HEALTH AGENCY - NUMBER OF EMPLOYES   1.00   3.00   0.00   1.00   0.00						Agency I		
Filt   V						1.	00	
HOWE HEALTH AGENCY STATISTICAL DATA	0.00	County						0.00
Mary   HALTH ACENCY STATISTICAL BATA   Color   Home Health Aide Hours   South   South   Halth Halth Aide Hours   South   Halth Halth   Halth								
Description   Contract   Contra		HOME HEALTH AGENCY STATISTICAL DATA	1.00	2.00	3.00	4.00	3.00	
Enter the number of hours in your normal work week   Staff   Contract   Total	1.00	Home Health Aide Hours	1		1			1
Enter the number of hours in your normal work week	2.00	Unduplicated Census Count (see instructions)	0.00	320. 00				2. 00
					Number of Em	iproyees (Furi II	me Equi vai ent)	
			Enter the number	r of hours in	Staff	Contract	Total	
HOME HEALTH ACRICY - NUMBER OF EMPLOYEES					Starr	Contract	Total	
HOME HEALTH ACRICY - NUMBER OF EMPLOYEES								
HOME HEALTH ACRICY - NUMBER OF EMPLOYEES								
Admin istrator and Assistant Admin istrator(s)   40.00   0.00			0		1.00	2. 00	3. 00	
0.00   Director(s) and Assistant Director(s)   0.00   0.	2.00			40.00		20 22	2.22	
1.00   Other Administrative Personnel	3. 00 4. 00			40. 00			<b>l</b>	1
1.00   Nursing Supervisor	5. 00				1		<b>l</b>	
1.00   Physical Therapy Service     2.83   0.00   2.83   8.00   0.00   Physical Therapy Supervisor     0.00   0.	6. 00				1		l .	1
0.00   0.00	7.00				1		l .	1
1.00   Occupational Therapy Supervisor   0.00   0.00   0.00   0.00   1.00   0	9. 00				1		l	1
2.00   Speech Pathology Service   0.04   0.00   0.04   12.00   0.00	10.00							•
Speech Pathology Supervisor   0.00   0.00   0.00   0.00   13.00   0.00   0.00   0.00   13.00   0.0	11.00				1		•	1
Medical Social Service   0.00   0.00   0.00   14.00	13. 00				1		l	
Home Heal th Aide	14. 00	Medical Social Service			1		1	
No   Home Health Aide Supervisor   0,00   0,00   0,00   0,00   18.00	15.00	· ·			1		l	1
0.00   Other (specify)   HOME HEALTH AGENCY CBSA CODES	17. 00				1		1	1
19.00	18. 00	Other (specify)			1		1	1
you provided services during the cost reporting period.   20.00   20					1	-1		
Peps Activity DATA	19.00					1		19.00
Skilled Nursing Visits   1,767   72   53   1   1,893   1,893   1,000   1,000   1,000   1,767   1,767   1,7874   13,128   248   468,777   22.00   1,0		reporting period.						
Full Episodes   Without   With Outliers   LUPA Episodes   PEP Only   Episodes   1-4)	20. 00	` '			99915			20. 00
Full Episodes								
PPS ACTIVITY DATA   1,00   2,00   3,00   4,00   5,00			<del></del>					
PPS ACTIVITY DATA   1.00   2.00   3.00   4.00   5.00				With Outliers	LUPA Epi sode	,	7	
PPS ACTIVITY DATA    1.00   Skilled Nursing Visits   1,767   72   53   1   1,893   21.00				2. 00	3.00		,	
22.00   Skilled Nursing Visit Charges   437,527   17,874   13,128   248   468,777   22.00								
1, 242   26   43   4   1, 315   23.00     24.00   Physical Therapy Visits   274,706   5,758   9,522   886   290,872   24.00     25.00   Occupational Therapy Visits   305   29   7   0   341   25.00     26.00   Occupational Therapy Visits   305   29   7   0   341   25.00     27.00   Speech Pathology Visits   25   0   0   0   0     28.00   Speech Pathology Visits   25   0   0   0   0     29.00   Medical Social Service Visits   0   0   0   0     29.00   Medical Social Service Visits   0   0   0   0     29.00   Medical Social Service Visit Charges   0   0   0   0     29.00   Model Health Aide Visits   113   5   1   0     20.00   Home Health Aide Visit Charges   16,396   726   145   0     31.00   Total Visits (sum of lines 21, 23, 25, 27, 29, and 31)   31.00     34.00   Other Charges   0   0   0   0   0     35.00   Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)   31,498   31,498   24,518   1,134   867,068   35.00     36.00   Total Number of Episodes (standard/non outlier)   5   37.00   5   37.00     37.00   Total Number of Outlier Episodes   5   0   0   5   37.00     37.00   Total Number of Outlier Episodes   5   0   0   5   37.00     37.00   Total Number of Outlier Episodes   5   0   0   0     38.817   24.00   25.00   27.00			1					1
24.00   Physical Therapy Visit Charges   274,706   5,758   9,522   886   290,872   24.00   25.00   0   0   0   0   341   25.00   0   0   0   0   0   0   0   0   0	23. 00							
26.00     Occupational Therapy Visit Charges     74,954     7,140     1,723     0     83,817     26.00       27.00     Speech Pathology Visits     25     0     0     0     25     27.00       28.00     Speech Pathology Visit Charges     6,335     0     0     0     0     6,335     28.00       29.00     Medical Social Service Visits     0     0     0     0     0     0     0     29.00       20.00     Medical Social Service Visit Charges     0     17,267     32.00     0	24. 00	Physical Therapy Visit Charges	274, 706			22 886	290, 872	24. 00
27.00   Speech Pathology Visits   25   0   0   0   25   27.00     28.00   Speech Pathology Visit Charges   6,335   0   0   0   0     29.00   Medical Social Service Visits   0   0   0   0     29.00   Medical Social Service Visit Charges   0   0   0     29.00   Medical Social Service Visit Charges   0   0   0     29.00   Medical Social Service Visit Charges   0   0   0     29.00   0   0   0   0     29.00   0   0   0   0     29.00   0   0   0   0     29.00   0   0   0     29.00   0   0   0     29.00   0   0   0     29.00   0   0   0     29.00   0   0   0     29.00   0   0   0     20.00   0   0   0     20.00   0     20.00   0   0     20.00   0	25. 00		1			1		1
18.00   Speech Pathology Visit Charges   6,335   0   0   0   6,335   28.00     19.00   Medical Social Service Visits   0   0   0   0     10.00   Home Health Aide Visits   113   5   1   0     11.00   Home Health Aide Visit Charges   16,396   726   145   0     17.267   32.00     18.00   Total Visits (sum of lines 21, 23, 25, 27, 29, and 31)   10   10     18.00   Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)   36.00     18.00   Total Number of Episodes (standard/non outlier)   10   10   10     18.00   Total Number of Outlier Episodes   5   0   5   37.00     18.00   Total Number of Outlier Episodes   5   0   5   37.00     18.00   Total Number of Outlier Episodes   5   0   5   37.00     18.00   Total Number of Outlier Episodes   5   0   5   37.00     18.00   Total Number of Outlier Episodes   5   0   5   37.00     18.00   Total Number of Outlier Episodes   5   0   5   37.00     18.00   Total Number of Outlier Episodes   5   0   5   37.00     18.00   Total Number of Outlier Episodes   5   0   5   37.00     18.00   Total Number of Outlier Episodes   5   0   5   37.00     18.00   Total Number of Outlier Episodes   5   0   5   37.00     18.00   Total Number of Outlier Episodes   5   0   0   0     18.00   Total Number of Outlier Episodes   5   0   0   0     18.00   Total Number of Outlier Episodes   5   0   0   0     18.00   Total Number of Outlier Episodes   5   0   0   0     18.00   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   0     18.00   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   0     18.00   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   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   0     18.00   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   0     18.00   0	27. 00							1
No.00   Medical Social Service Visit Charges   0   0   0   0   30.00	28. 00	Speech Pathology Visit Charges			1	0 0		
Home Health Aide Visits Home Health Aide Visits Home Health Aide Visit Charges Home Home Health Aide Visit Charges Home Home Health Aide Visit Charges Home Health Aide Visit Charges Home Home Health Aide Visit Charges	29. 00		0		1		l	1
12.00 Home Health Aide Visit Charges 16,396 726 145 0 17,267 32.00 13.00 Total visits (sum of lines 21, 23, 25, 27, 29, and 31) 0 0 0 0 0 0 0 0 34.00 15.00 Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34) 30, 32, and 34) 16.00 Total Number of Episodes (standard/non outlier) 17.00 Total Number of Outlier Episodes 5 0 5 37.00 15.00 Total Number of Outlier Episodes 5 0 5 37.00 15.00 Total Number of Outlier Episodes	31. 00		-				l	1
29, and 31) 44.00 Other Charges 0 0 0 0 0 0 34.00 15.00 Total Charges (sum of lines 22, 24, 26, 28, 809, 918 31, 498 24, 518 1, 134 867, 068 35.00 16.00 Total Number of Episodes (standard/non outlier) 17.00 Total Number of Outlier Episodes	32. 00		l l	726	1.		17, 267	32. 00
0 0 0 0 0 34.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	33. 00		3, 452	132	10	5 5	3, 693	33. 00
75.00 Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34) 75.00 Total Number of Episodes (standard/non outlier) 75.00 Total Number of Outlier Episodes 55.00 Total Number of Outlier Episodes	34. 00		0	0	,	0 0	0	34.00
30, 32, and 34) 16.00 Total Number of Episodes (standard/non outlier) 17.00 Total Number of Outlier Episodes 5 0 5 37.00	35. 00	Total Charges (sum of lines 22, 24, 26, 28,	1	31, 498	24, 5 <sup>-</sup>		l .	1
outlier) 17.00 Total Number of Outlier Episodes 5 0 5 37.00	26 00	30, 32, and 34)	247				404	26 00
17.00 Total Number of Outlier Episodes 5 37.00	აu. UU	l · · · · · · · · · · · · · · · · · · ·	36/			ادر ا	421	30.00
18.00   Total Non-Routine Medical Supply Charges   0  0  0  0  0  0   38.00	37. 00	Total Number of Outlier Episodes						
	38. 00	Total Non-Routine Medical Supply Charges	0	0	1	0	0	38.00

Hool +h	Financial Systems		KING'S DAUGHTE	EDC! HOCDITAL		In Lia	u of Form CMS-2	neen 10
	AL-BASED HOSPICE IDENTIFICATION	Ι ΠΔΤΔ	KING 3 DAUGITE	Provi der C	CN: 15_0069	Peri od:	Worksheet S-9	
1103111	AL BASED HOSTIGE TRENTITION TON	DATA				From 01/01/2020	PARTS I THROU	GH IV
				Hospi ce CC	N: 15-1535	To 12/31/2020		
						Hospi ce I	5/24/2021 11:	oo am_
		Unduplicated				поѕргсе г		
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		cols. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility				
	_	1. 00	2.00	3. 00	4. 00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS FOR CO	OST REPORTING F	PERI ODS BEGINNI	NG BEFORE OCTO	BER 1, 2015			
1.00	Hospice Continuous Home Care							1.00
2. 00 3. 00	Hospice Routine Home Care Hospice Inpatient Respite Care							2. 00 3. 00
4. 00	Hospice General Inpatient Care							4.00
5.00	Total Hospice Days							5.00
5.00	Part II - CENSUS DATA FOR COST	REPORTING PERI	ODS BEGLNNING	BEFORE OCTOBER	1 2015			3.00
6. 00	Number of patients receiving	KEI OKTTNO TEKI	ODS BESTAINTING	DEFORE GOTOBER	1, 2010			6.00
0.00	hospi ce care							0.00
7.00	Total number of unduplicated							7. 00
	Continuous Care hours billable							
	to Medicare		4					
8.00	Average Length of Stay (line 5							8. 00
	/ line 6)							
9.00	Unduplicated census count							9. 00
NOIE:	Parts I and II, columns 1 and 2	also include	the days repor	ted in columns	3 and 4.			
				Title XVIII	Title XIX	Other	Total (sum of	
							col s. 1	
							through 3)	
				1.00	2.00	3. 00	4. 00	
10.00	PART III - ENROLLMENT DAYS FOR	COST REPORTING	G PERLODS BEGLA	NNING ON OR AFT	ER OCTOBER 1	· ·		40.00
10.00	Hospi ce Conti nuous Home Care			2 200	1	0 0	_	10.00
11.00	Hospice Routine Home Care Hospice Inpatient Respite Care			2, 308	1	26 13 0 0		11.00
12. 00 13. 00				22		0 0	5	12. 00 13. 00
14. 00	1 .			2. 335	1	26 13		14. 00
14.00	PART IV - CONTRACTED STATISTICA	AL DATA FOR COS	ST REPORTING PE					14.00
15. 00			J. ALI OKTINO TE	C C		0 0		15. 00
	Hospice General Inpatient Care					0 0		16. 00
				•	•	1	'	

	. UNCOMPENSATED AND INDIGENT CARE DATA Provi	ider CCN: 15-0069	Peri od:	u of Form CMS-2 Worksheet S-1			
0011171	. UNCOMPENSATED AND INDIGENT CARE DATA FIOVE	Tuel CCN. 15-0009	From 01/01/2020	WOLKSHEET 3-1	J		
			To 12/31/2020	Date/Time Pre 5/24/2021 11:			
					50 ai		
11-				1. 00			
	ncompensated and indigent care cost computation ost to charge ratio (Worksheet C, Part I line 202 column 3 divided	l by Line 202 colum	n 0)	0. 250394	1.		
	edicaid (see instructions for each line)	a by Title 202 Corull	III 0 <i>)</i>	0. 230394	1.		
	et revenue from Medicaid			12, 208, 309	2.		
	id you receive DSH or supplemental payments from Medicaid?			Υ Υ	3.		
	fline 3 is yes, does line 2 include all DSH and/or supplemental p	payments from Medic	ai d?	Υ	4.		
.00   11	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid						
	edi cai d charges			47, 671, 629	6.		
	edicaid cost (line 1 times line 6)	7 ' 61'	0 15 16	11, 936, 690			
	ifference between net revenue and costs for Medicaid program (line zero then enter zero)	e / minus sum of ii	nes 2 and 5; IT	0	8.		
	nildren's Health Insurance Program (CHIP) (see instructions for ea	nch line)					
_	et revenue from stand-alone CHIP	,		0	9.		
0. 00 S	tand-alone CHIP charges			0	10.		
	tand-alone CHIP cost (line 1 times line 10)			0	11. 12.		
	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then						
_	nter zero)	ions for each line	)				
	ther state or local government indigent care program (see instruct et revenue from state or local indigent care program (Not included			0	13.		
	harges for patients covered under state or local indigent care pro				14.		
	0)	ogram (Not Therauce					
5. 00 S	tate or local indigent care program cost (line 1 times line 14)			0	15.		
	ifference between net revenue and costs for state or local indigen	nt care program (li	ne 15 minus line	0	16.		
	3; if < zero then enter zero) rants, donations and total unreimbursed cost for Medicaid, CHIP an	nd atata/lagal indi	acut como program	. (000			
	ants, donations and total univermodised cost for medicald, chir an astructions for each line)	iu state/rocai riiui	gent care program	is (See			
	rivate grants, donations, or endowment income restricted to fundin				17.		
	Government grants, appropriations or transfers for support of hospital operations						
9.00 To			( ( )	0	18.		
	otal unreimbursed cost for Medicaid , CHIP and state and local ind		s (sum of lines	0	18.		
	otal unreimbursed cost for Medicaid , CHIP and state and local ind , 12 and 16)		·	_	18.		
		Uni nsured pati ents	I nsured pati ents	Total (col. 1 + col. 2)	18.		
8,	, 12 and 16)	di gent care program  Uni nsured	Insured	Total (col. 1	18.		
8, Ur	ncompensated Care (see instructions for each line)	Uni nsured pati ents	Insured patients 2.00	Total (col. 1 + col. 2) 3.00	18. 19.		
8, Ur 0. 00 Ct	ncompensated Care (see instructions for each line) harity care charges and uninsured discounts for the entire facilit	Uni nsured pati ents	Insured patients 2.00	Total (col. 1 + col. 2) 3.00	18. 19.		
0. 00 CH	ncompensated Care (see instructions for each line)	Uni nsured pati ents 1.00	Insured patients 2.00 283,607	0 Total (col. 1 + col. 2) 3.00 2,848,375	18. 19. 20.		
0. 00 CH	ncompensated Care (see instructions for each line) harity care charges and uninsured discounts for the entire facilit see instructions) ost of patients approved for charity care and uninsured discounts instructions)	Uni nsured pati ents 1.00  Ty 2,564,7 (see 642,2	Insured patients 2.00  283,607 283,607	0 Total (col. 1 + col. 2) 3.00 2,848,375 925,810	18. 19. 20. 21.		
0. 00 Cl (5 1. 00 Cc i i 2. 00 Pa	ncompensated Care (see instructions for each line) harity care charges and uninsured discounts for the entire facilit see instructions) ost of patients approved for charity care and uninsured discounts instructions) ayments received from patients for amounts previously written off	Uni nsured pati ents 1.00  Ty 2,564,7 (see 642,2	Insured patients 2.00	0 Total (col. 1 + col. 2) 3.00 2,848,375 925,810	18. 19. 20. 21.		
0. 00 Cl (3 1. 00 Cd i i 2. 00 Pa	ncompensated Care (see instructions for each line) harity care charges and uninsured discounts for the entire facilit see instructions) ost of patients approved for charity care and uninsured discounts nstructions) ayments received from patients for amounts previously written off harity care	Uninsured patients 1.00  Ty 2,564,7  (see 642,2	Insured patients 2.00 283,607 0 0	0 Total (col. 1 + col. 2) 3.00 2,848,375 925,810 0	18. 19. 20. 21. 22.		
0. 00 Ct (5 1. 00 Cc i i 2. 00 Pa	ncompensated Care (see instructions for each line) harity care charges and uninsured discounts for the entire facilit see instructions) ost of patients approved for charity care and uninsured discounts instructions) ayments received from patients for amounts previously written off	Uni nsured pati ents 1.00  Ty 2,564,7 (see 642,2	Insured patients 2.00 283,607 0 0	0 Total (col. 1 + col. 2) 3.00 2,848,375 925,810	18. 19. 20. 21. 22.		
8, 0. 00 Ct 1. 00 Cc i i 2. 00 Pa	ncompensated Care (see instructions for each line) harity care charges and uninsured discounts for the entire facilit see instructions) ost of patients approved for charity care and uninsured discounts nstructions) ayments received from patients for amounts previously written off harity care	Uninsured patients 1.00  Ty 2,564,7  (see 642,2	Insured patients 2.00 283,607 0 0	0 Total (col. 1 + col. 2) 3.00 2,848,375 925,810 0	18. 19. 20. 21. 22.		
8, 0.00 CC 1.00 CC 1.00 Pc 3.00 CC	ncompensated Care (see instructions for each line) harity care charges and uninsured discounts for the entire facilit see instructions) ost of patients approved for charity care and uninsured discounts instructions) ayments received from patients for amounts previously written off harity care ost of charity care (line 21 minus line 22)	Uni nsured pati ents 1.00  Ey 2,564,7  (see 642,2  as 642,2	Insured patients 2.00  68 283,607  0 283,607  0 283,607	0 Total (col. 1 + col. 2) 3.00 2,848,375 925,810 0 925,810	18. 19. 20. 21. 22. 23.		
8,   00   00   Cl   (5,   1. 00   Cc   1. 00   Cc   1. 00   Cc   1. 00   Cc	ncompensated Care (see instructions for each line) harity care charges and uninsured discounts for the entire facilit see instructions) ost of patients approved for charity care and uninsured discounts instructions) ayments received from patients for amounts previously written off harity care ost of charity care (line 21 minus line 22)  oes the amount on line 20 column 2, include charges for patient da mposed on patients covered by Medicaid or other indigent care prog	Uninsured patients 1.00  Ty 2,564,7  (see 642,2  as 642,2  ays beyond a length gram?	Insured patients 2.00  68 283,607  0 283,607  0 0  003 283,607	0 Total (col. 1 + col. 2) 3.00 2,848,375 925,810 0 925,810 1.00 N	18. 19. 20. 21. 22. 23.		
8, D. 00 CC (1.00 CC in	ncompensated Care (see instructions for each line) harity care charges and uninsured discounts for the entire facilit see instructions) ost of patients approved for charity care and uninsured discounts nstructions) ayments received from patients for amounts previously written off harity care ost of charity care (line 21 minus line 22)  oes the amount on line 20 column 2, include charges for patient da mposed on patients covered by Medicaid or other indigent care prog f line 24 is yes, enter the charges for patient days beyond the in	Uninsured patients 1.00  Ty 2,564,7  (see 642,2  as 642,2  ays beyond a length gram?	Insured patients 2.00  68 283,607  0 283,607  0 0  003 283,607	0 Total (col. 1 + col. 2) 3.00  2,848,375 925,810 0 925,810	18. 19. 20. 21. 22. 23.		
8, 0.00 CC (3, 1.00 CC 1.00 CC 1.00 CC 1.00 CC 1.00 CC	ncompensated Care (see instructions for each line) harity care charges and uninsured discounts for the entire facilit see instructions) ost of patients approved for charity care and uninsured discounts nstructions) ayments received from patients for amounts previously written off harity care ost of charity care (line 21 minus line 22)  oes the amount on line 20 column 2, include charges for patient da mposed on patients covered by Medicaid or other indigent care prog f line 24 is yes, enter the charges for patient days beyond the in tay limit	Uninsured patients 1.00  ty 2,564,7  (see 642,2  as 642,2  ays beyond a length gram? ndigent care program	Insured patients 2.00  68 283,607  0 283,607  0 0  003 283,607	0 Total (col. 1 + col. 2) 3.00 2,848,375 925,810 0 925,810 1.00 N	20. 21. 22. 23. 24.		
8, 0.00 Cr (3 1.00 Cr ii 22.00 Pr ct 3.00 Cr iii 5.00 In 5.00 In 6.00 Tr 6.00 Tr	ncompensated Care (see instructions for each line) harity care charges and uninsured discounts for the entire facilit see instructions) ost of patients approved for charity care and uninsured discounts nstructions) ayments received from patients for amounts previously written off harity care ost of charity care (line 21 minus line 22)  oes the amount on line 20 column 2, include charges for patient da mposed on patients covered by Medicaid or other indigent care prog f line 24 is yes, enter the charges for patient days beyond the in	Uninsured patients 1.00  Ty 2,564,7  (see 642,2  as 642,2	Insured patients 2.00  68 283,607  0 283,607  0 0  003 283,607	0 Total (col. 1 + col. 2) 3.00 2,848,375 925,810 0 925,810 1.00 N	20. 21. 22. 23. 24. 25.		
8,   Ur   O. 00   Cr   (3   1. 00   Cr   Cr   Cr   Cr   Cr   Cr   Cr	ncompensated Care (see instructions for each line) harity care charges and uninsured discounts for the entire facilit see instructions) ost of patients approved for charity care and uninsured discounts nstructions) asyments received from patients for amounts previously written off harity care ost of charity care (line 21 minus line 22)  oes the amount on line 20 column 2, include charges for patient da mposed on patients covered by Medicaid or other indigent care prog f line 24 is yes, enter the charges for patient days beyond the in tay limit otal bad debt expense for the entire hospital complex (see instruc	Uni nsured pati ents 1.00  Ey 2,564,7  (see 642,2  as 642,2  ays beyond a length gram? ndi gent care program ettions) ee instructions)	Insured patients 2.00  68 283,607  0 283,607  0 0  003 283,607	0 Total (col. 1 + col. 2) 3.00 2,848,375 925,810 0 925,810 1.00 N 0 7,467,758	20. 21. 22. 23. 24.		
8,  D. 00 Ci (s)  1. 00 Cc ir 2. 00 Pr cc ct 3. 00 Cc  4. 00 Dc ir 5. 00 I1 Sr 6. 00 Tc 7. 00 Mc 7. 01 Ma 3. 00 Nc	ncompensated Care (see instructions for each line) harity care charges and uninsured discounts for the entire facilit see instructions) ost of patients approved for charity care and uninsured discounts nstructions) ayments received from patients for amounts previously written off harity care ost of charity care (line 21 minus line 22)  oes the amount on line 20 column 2, include charges for patient da mposed on patients covered by Medicaid or other indigent care prog f line 24 is yes, enter the charges for patient days beyond the in tay limit otal bad debt expense for the entire hospital complex (see instruct edicare reimbursable bad debts for the entire hospital complex (see edicare allowable bad debt expense (see instructions)	Uninsured patients 1.00  Ty 2,564,7  (see 642,2  as 642,2  ays beyond a length gram? ndigent care program etions) ee instructions) nstructions)	Insured patients   2.00	0 Total (col. 1 + col. 2) 3.00  2,848,375 925,810 0 925,810 1.00 N 0 7,467,758 261,372	20. 21. 22. 23. 24. 25. 26. 27. 27.		
8,  D. 00 CC  1. 00 CC  1. 00 CC  1. 00 CC  2. 00 Pc  cc  cc  1. 00 CC  1. 00 CC  4. 00 Dc  ir  5. 00 In  Si  To  To  To  To  To  To  To  To  To  T	ncompensated Care (see instructions for each line) harity care charges and uninsured discounts for the entire facilit see instructions) ost of patients approved for charity care and uninsured discounts nstructions) ayments received from patients for amounts previously written off harity care ost of charity care (line 21 minus line 22)  oes the amount on line 20 column 2, include charges for patient da mposed on patients covered by Medicaid or other indigent care prog f line 24 is yes, enter the charges for patient days beyond the in tay limit otal bad debt expense for the entire hospital complex (see instruct edicare reimbursable bad debts for the entire hospital complex (see edicare allowable bad debts for the entire hospital complex (see ion-Medicare bad debt expense (see instructions) ost of non-Medicare and non-reimbursable Medicare bad debt expense	Uninsured patients 1.00  Ty 2,564,7  (see 642,2  as 642,2  ays beyond a length gram? ndigent care program etions) ee instructions) nstructions)	Insured patients   2.00	0 Total (col. 1 + col. 2) 3.00  2,848,375 925,810 0 925,810 1.00 N 0 7,467,758 261,372 402,111 7,065,647 1,909,935	20. 21. 22. 23. 24. 25. 26. 27. 28. 29.		
8, 1. 00 CC 1. 00 CC 2. 00 P2 3. 00 CC 4. 00 DC 1. S 6. 00 TC 7. 01 Mc 8. 00 Mc 9. 00 CC	ncompensated Care (see instructions for each line) harity care charges and uninsured discounts for the entire facilit see instructions) ost of patients approved for charity care and uninsured discounts nstructions) ayments received from patients for amounts previously written off harity care ost of charity care (line 21 minus line 22)  oes the amount on line 20 column 2, include charges for patient da mposed on patients covered by Medicaid or other indigent care prog f line 24 is yes, enter the charges for patient days beyond the in tay limit otal bad debt expense for the entire hospital complex (see instruct edicare reimbursable bad debts for the entire hospital complex (see edicare allowable bad debt expense (see instructions)	Uninsured patients 1.00  Ty 2,564,7  (see 642,2  Ty 642,	Insured patients   2.00	0 Total (col. 1 + col. 2) 3.00 2,848,375 925,810 0 925,810 1.00 N 0 7,467,758 261,372 402,111 7,065,647	20. 21. 22. 23. 24. 25. 26. 27. 27. 28. 29. 30.		

Health Financial Systems	KING'S DAUGHTERS		N. 15 0040 D		u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	IF EXPENSES	Provider CC		eriod: rom 01/01/2020	Worksheet A	
			Т	o 12/31/2020	Date/Time Pre	
Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	5/24/2021 11: Recl assi fi ed	OU am
oost contor bescription	54141165	o their	+ col . 2)	ons (See A-6)	Trial Balance	
			Í	, ,	(col. 3 +-	
					col. 4)	
OFNEDAL CEDIU OF COCT OFNEDO	1.00	2. 00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS  1.00   O0100   NEW CAP REL COSTS-BLDG & FIXT		13, 619, 374	13, 619, 374	338, 387	13, 957, 761	1.00
1. 01   00101   NEW CAP REL COSTS-BLDG & FIXT HHA/HO		13, 017, 374	13, 017, 374	6, 879	6, 879	
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP		O	0	0	0	2. 00
3.00 00300 OTHER CAPITAL RELATED COSTS		0	0	0	0	3. 00
4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT	0	12, 869, 327	12, 869, 327		12, 431, 363	4. 00
5.00   00500   ADMINISTRATIVE & GENERAL 7.00   00700   OPERATION OF PLANT	6, 407, 684 549, 520	12, 075, 434	18, 483, 118		18, 067, 070	5. 00 7. 00
8. 00   00800 LAUNDRY & LINEN SERVICE	28, 203	2, 810, 292 337, 100	3, 359, 812 365, 303		3, 342, 273 365, 303	
9. 00   00900   HOUSEKEEPI NG	673, 450	405, 409	1, 078, 859		1, 076, 059	
10. 00 01000 DI ETARY	710, 613	393, 560	1, 104, 173		807, 986	
11. 00   01100   CAFETERI A	0	0	0	,	296, 187	
13. 00   01300   NURSI NG ADMI NI STRATI ON	440, 930	1, 339	442, 269	I	442, 269	
14. 00   01400   CENTRAL SERVI CES & SUPPLY 15. 00   01500   PHARMACY	85, 043 735, 040	1, 808 8, 041, 602	86, 851 8, 776, 642		86, 851 1, 487, 603	
16. 00 01600 MEDI CAL RECORDS & LI BRARY	532, 261	272, 880	805, 141		805, 141	
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	I	380, 325	1
23. 00 02300 RADI OLOGY SCHOOL	128, 283	7, 586	135, 869	0	135, 869	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS 31. 00   03100   INTENSI VE CARE UNI T	5, 092, 774	1, 217, 491	6, 310, 265 1, 128, 304		4, 813, 066	1
43. 00   04300   NURSERY	1, 118, 906	9, 398 0	1, 128, 304		1, 127, 082 458, 917	31. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS	<u> </u>	<u> </u>		430, 717	430, 717	73.00
50. 00 05000 OPERATING ROOM	2, 004, 045	5, 434, 021	7, 438, 066	-4, 703, 844	2, 734, 222	50.00
51.00 05100 RECOVERY ROOM	283, 341	31, 395	314, 736	-26, 363	288, 373	51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	0	0	0	020,0.0	626, 678	1
53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY-DI AGNOSTI C	1, 629, 419 2, 985, 379	679, 349	2, 308, 768		1, 836, 349	
54. 00   05400   RADI OLOGY-DI AGNOSTI C 54. 01   03630   ULTRA SOUND	115, 617	1, 020, 826 55, 600	4, 006, 205 171, 217		3, 985, 165 167, 198	
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	74, 293	157, 912	232, 205		230, 933	
55. 00   05500 RADI OLOGY - THERAPEUTI C	0	0	0	O	0	55. 00
55. 01 03480 ONCOLOGY	897, 772	1, 431, 587	2, 329, 359		2, 270, 937	55. 01
57. 00   05700   CT   SCAN	146, 597	271, 983	418, 580		404, 901	
58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI) 59. 00   05900   CARDIAC CATHETERIZATION	149, 282	130, 686	279, 968 0		278, 967 0	58. 00 59. 00
60. 00   06000 LABORATORY	1, 584, 532	3, 689, 312	5, 273, 844	١	3, 731, 241	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	254, 004	254, 004		254, 004	
65. 00 06500 RESPI RATORY THERAPY	670, 926	157, 383	828, 309	-118, 024	710, 285	
66. 00   06600   PHYSI CAL THERAPY	1, 297, 315	33, 030	1, 330, 345		1, 251, 892	
67. 00   06700   0CCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY	211, 488	6, 297 2, 709	217, 785		215, 663	1
69. 00   06900   SPEECH PATHOLOGY	130, 314	2, 709	133, 023 0		131, 885 0	1
69. 01   03610   SLEEP LAB	115, 994	73, 637	189, 631	-	183, 247	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		2, 503, 948	
71. 01  07101   I V SOLUTI ONS	0	0	0		93, 644	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	-,,	3, 336, 352	72.00
73. 00   07300   DRUGS CHARGED TO PATIENTS 76. 00   03140   CARDI OLOGY	456, 035	219, 138	675, 173	-,,	8, 808, 157 652, 161	73. 00 76. 00
76. 97   07697   CARDI OLOGT	66, 501	4, 174	70, 675		70, 399	76. 97
OUTPATIENT SERVICE COST CENTERS	23, 33.	.,,	,	:-1		1
90. 00 09000 CLI NI C	59, 982	2, 880	62, 862		61, 663	90.00
90. 01   09001   WOUND CARE CLINIC	83, 509	92, 039	175, 548		154, 532	1
91. 00   09100   EMERGENCY	1, 700, 095	1, 579, 689	3, 279, 784	-241, 630	3, 038, 154	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
95. 00 09500 AMBULANCE SERVICES	1, 642, 252	195, 922	1, 838, 174	-49, 854	1, 788, 320	95. 00
101.00 10100 HOME HEALTH AGENCY	935, 604	93, 178	1, 028, 782		1, 036, 713	
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 INTEREST EXPENSE	00.000	0	0	0		113.00
116.00   11600   HOSPI CE 118.00   SUBTOTALS (SUM OF LINES 1 through 117)	82, 800 33, 825, 799	72, 654 67, 752, 005	155, 454 101, 577, 804		210, 889 101, 144, 876	
NONREI MBURSABLE COST CENTERS	33, 623, 744	07, 732, 003	101, 377, 804	-432, 720	101, 144, 670	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	Ol	0	ol	0	190. 00
194.00 07950 OTHER NON-REIMBURSABLE	112, 305	21, 562	133, 867	O	133, 867	194. 00
194. 01 07951 MOB	2, 792, 615	288, 417	3, 081, 032	I	3, 081, 032	
194. 02 07952 PHYSI CI AN CLI NI CS	4, 723, 206	1, 433, 010	6, 156, 216	I	6, 155, 224	
194. 03 07953  PHYS PRAC BUS OFC 194. 04 07954  MOB - MAIN CAMPUS	631, 957 371, 139	10, 880 -4, 960	642, 837 366, 179		1, 277, 036 366, 179	1
194. 05 07955 ONCOLOGY - NONREI MBURSABLE	371, 139	-4, 700 N	300, 179	l .		194. 04
194. 06 07956 KDH - MC FAMILY PRACTICE	2, 530, 606	242, 297	2, 772, 903	-	2, 649, 615	
194.07 07957 KDH - MC ORTHOPEDICS	2, 407, 148	306, 283	2, 713, 431	1, 406	2, 714, 837	194. 07
194.08 07958 KDH - MC GENERAL SURGERY	1, 109, 222	387, 313	1, 496, 535	0	1, 496, 535	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 C	F EXPENSES	Provider CO		Peri od:	Worksheet A	
			From 01/01/2020 Fo 12/31/2020		pared: 00 am	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fied	
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
194.09 07959 KDH - MC ENT	604, 081	27, 167	631, 24	-65, 220	566, 028	194. 09
194. 10 07960 KDH - MC UROLOGY	91, 823	373, 064	464, 88	7 0	464, 887	194. 10
194.11 07961 KDH - MC OB/GYN	1, 641, 320	608, 962	2, 250, 28:	-13, 177	2, 237, 105	194. 11
200.00 TOTAL (SUM OF LINES 118 through 199)	50, 841, 221	71, 446, 000	122, 287, 22	0	122, 287, 221	200. 00

Peri od: Worksheet A From 01/01/2020 Date/Time Prepared: 5/24/2021 11:00 am

Supplement   Cost Center Description   Adjustments   Cost Annual Cost					10	5/24/2021 11:	
	Cost Cente	er Description	,				
COMPANY SERVICE COST CENTERS   1							
1.00	GENERAL SERVICE	COST CENTERS	6.00	7.00			
2 00 00000 MINE CAPI REL COSIS-WINEL DOUBLY 5 00 00000 ADMINISTRATION A CRIFFORM 5 00 00000 ADMINISTRATION A CRIFFORM 6 00 00000 ADMINISTRATION A CRIFFORM 7 00 00000 ADMINISTRATION A CRIFFORM 7 00 00000 ADMINISTRATION A CRIFFORM 7 00 00000 ADMINISTRATION 6 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			-4, 503, 412	9, 454, 349			1.00
3.00 DOSIGO INTER CAPIT IZE RELIED COSIS   0   0   0   0   0   0   0   0   0			1	6, 879			1
0.0400   MARCHATE SHERT IS DEPARTMENT   -7, 149, 579   11, 281, 784   5.0				0			1
5.00   0.0500   ADMINISTRATIVE & CENERAL   -3.788.282   14.283.788   5.00     5.00   0.0700   CERRATION OF PLANTE   -2.156   3.200.747   7.70     5.00   0.0700   CERRATION OF PLANTE   -2.156   3.200.747   7.70     5.00   0.0500   CAMDRAY & LIKEN SERVICE   -2.156   3.200.747   7.70     5.00   0.00   0.00   0.00   0.00   0.00     5.00   0.00   0.00   0.00   0.00     5.00   0.00   0.00   0.00   0.00     5.00   0.00   0.00   0.00   0.00     5.00   0.00   0.00   0.00   0.00     5.00   0.00   0.00   0.00   0.00     5.00   0.00   0.00   0.00   0.00     5.00   0.00   0.00   0.00   0.00     5.00   0.00   0.00   0.00   0.00     5.00   0.00   0.00   0.00   0.00     5.00   0.00   0.00   0.00   0.00     5.00   0.00   0.00   0.00   0.00     5.00   0.00   0.00   0.00   0.00     5.00   0.00   0.00   0.00     5.00   0.00   0.00   0.00   0.00     5.00   0.00   0.00   0.00     5.00   0.00   0.00   0.00     5.00   0.00   0.00   0.00     5.00   0.00   0.00   0.00     5.00   0.00   0.00   0.00     5.00   0.00   0.00   0.00     5.00   0.00   0.00   0.00     5.00   0.00   0.00   0.00     5.00   0.00   0.00   0.00     5.00   0.00   0.00   0.00     5.00   0.00   0.00   0.00     5.00   0.00   0.00   0.00     5.00				11 201 704			1
2.00 00000 (AURION SERVICE SERVICE SERVICE)  0.00 00000 (AURION SERVICE)  1.00 0 10000 (AURION SERVI	1 1						1
0.00   0.000   DANJON S LINEN SERVICE   0   3.05 302   9.0 0   0.000   DIE FARY   9.0 0   0.000   DIE FARY   9.0 0   10.000   DIE FARY   9.0 0   DI							1
10.00   01000   DETARY   0   807, 996   10.00   11.0			1				1
11.00 0 1100 (CAFETERIA   -215,240 -1-19,058   11.00		NG	0	1, 076, 059			9. 00
13.00   0.1300   NURSIEN A ADMINISTRATION   0   44.2   269   13.00			-				1
14 00 0 1400 CENTRAL SERVICES & SUPPLY 0 1, 487, 603 115, 00 1500 DISCO PERMANCY 0 7, 4487, 603 115, 00 1500 DISCO PERMANCY 0 1, 4877, 603 115, 00 1500 DISCO PERMANCY SERVICES 1, 4877, 603 115, 00 1500 DISCO PERMANCY SERVICES 1, 4877, 603 115, 00 1500 DISCO PERMANCY SERVICES 1, 497, 602 13, 00 1500 DISCO PERMANCY SERVICES 1, 497, 602 13, 00 1500 DISCO PERMANCY SERVICES 1, 497, 602 13, 00 1500 DISCO PERMANCY SERVICES 1, 497, 602 13, 00 1500 DISCO PERMANCY SERVICES 1, 497, 602 13, 00 1500 DISCO PERMANCY SERVICES 1, 497, 602 14, 287, 297, 297, 297, 297, 297, 297, 297, 29	1 1	MALAU CEDATI ON	1				1
15.00   01500   PHASMACY   0   1,497,603   15.00   10.00   1	1 1		· ·				1
16.00     10.00     MFDI CAL RECORDS & I BRARY   9-64   20.00		RVICES & SUFFEI	· ·				
19. 00   01900   NOPIPMYSIC IAN AMESTHETISTS   -380, 225   0   0.900   19. 00   19		CORDS & LI BRARY	1				
INDITED   TOTAL   TO			-380, 325				19. 00
30.00	-		-49, 425	86, 444			23. 00
31.00			4 040 040	0.7/4.00/			00.00
A3. 00   ASSO NURSERY   A3. 00   A56, 917   A56, 917   A57, 920   A56, 917   A57, 920							1
MICLITARY SERVICE COST COMM   0   2,734,222   50.00	1 1	CARE UNI I	l .				1
50.00		CE COST CENTERS	<u> </u>	430, 717			1 .0.00
S200   05200   DELIVERY ROOM & LABOR ROOM	50. 00 05000 OPERATI NG	ROOM	0	2, 734, 222			50.00
1.55.0   0.5300   AMSTHESI OLOGY			1				
1.5.   0.   0.6400   RADI LOGY-DI AGNOSTI C	1 1		- I				1
19.4   0.   0.3630   ULTER SOUND   0   16.7, 198   54. 01	1 1						1
54.02   03450   NUCLEAR MEDICINE - DIAGNOSTIC   0   230, 933   54.02   05.00   055.00   03500   RADIOLOGY - THERAPUTIC   0   0   05.00   05.00   05.00   RADIOLOGY - THERAPUTIC   0   0   0.00   0.000   0.000   RADIOLOGY - THERAPUTIC   0   0   0.00   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.000   0.0000   0.			i i i				1
55.00   05500   RADIOLOGY - THERAPEUTIC   0   0   55.01     57.00   05700   CT SCAN   55.01   1,674,436   55.01     57.00   05700   CT SCAN   58.00   05900   MAGNETIC RESONANCE IMAGING (WRI)   0   0   59.00     59.00   05900   CARDIAL C CATHETERIZATION   0   0   59.00     59.00   05900   CARDIAL C CATHETERIZATION   0   0   59.00     60.00   05900   LABORATORY   9-96,521   3,634,720   60.00     60.00   05900   RESPIRATORY THERAPY   0   2710,285   65.00     60.00   05900   RESPIRATORY THERAPY   0   710,285   65.00     60.00   05900   RESPIRATORY THERAPY   0   1,251,892   66.00     60.00   05600   RESPIRATORY   1,251,893   1,251,893   1,251,893     60.00   05600   RESPIRATORY   1,251,893   1,251,893   1,251,893     60.00   05600   RESPIRATORY   1,251,893   1,251,893   1,251,893   1,251,893   1,251,893     60.00   05600   RESPIRATORY   1,251,893	1 1		· ·				1
55.00   03480   ONCOLOGY			0				
57.00   05700   CT SCAN   0   404, 901   57.00   58.00   58.00   05900   CARDITIC RESONANCE I IMAGING (MRI)   0   278, 967   58.00   59.00   05900   CARDITIC RESONANCE I IMAGING (MRI)   0   0   0   0   0   0   0   0   0		THERAI EUTTO	-596, 501				1
59. 00   05900   CARDIAC CATHETER ZATION   0   0   0   0   0   0   0   0   0			1				1
60. 00   06000   LABORATORY   0.0   0.0   0.2   0.0		RESONANCE IMAGING (MRI)	0				58. 00
Color   Colo			0	0			59. 00
65. 00 66.00 66.00 66.00 67.00							1
66. 00 66.00 66.00 67. 00 66.00 67. 00 68.00 69.00 71.10 00 710.00 00 010 010 010 010 010 010 010 010			· ·				1
67.00   06700   05CUPATIONAL THERAPY   0   215, 663   68, 00   69. 00   069.00   069			· ·				1
68. 00   06800   SPEECH PATHOLOGY   0   131,885   68. 00   69. 00			· ·				1
69. 00   06900   ELECTROCARDIOLOGY   0   0   69, 00   69. 01   03610   SLEEP LAB   69. 01   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   2, 503, 948   71. 00   70710   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   93, 644   71. 01   07101   V SOLUTI ONS   0   93, 644   71. 00   707200   IMPL. DEV. CHARGED TO PATIENTS   0   3, 36, 352   72. 00   7300   DRUGS CHARGED TO PATIENTS   0   8, 808, 157   73. 00   7300   DRUGS CHARGED TO PATIENTS   0   652, 161   76. 00   03140   CARDIOLOGY   0   652, 161   76. 00   03140   CARDIOLOGY   0   652, 161   76. 97   07697   CARDI AC REHABILITATION   0   70, 399   76. 97   000   09000   CLINIC   0   61, 663   90. 00   90000   CLINIC   0   61, 663   91. 00   90000   CLINIC   0   71, 327   91. 00   99.00   09200   DRESERVATI ON BEDS (NON-DISTINCT PART)   92. 00   92. 00   09200   08SERVATI ON BEDS (NON-DISTINCT PART)   92. 00   95. 00   09500   AMBULANCE SERVI CES   -50, 175   1, 738, 145   95. 00   101. 00   10100   HOME HEALTH AGENCY   0   1, 036, 713   116. 00   116. 00   11600   HOSPI CE   118. 00   118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   -16, 062, 337   85, 082, 539   118. 00   110. 00   10900   GIFT, FLOWER, COFFE SHOP, & CANTEEN   0   133, 867   194. 00   194. 00   07950   PHYSI CIAN CLINICS   0   1, 277, 036   194. 01   194. 02   07952   PHYSI CIAN CLINICS   0   1, 277, 036   194. 01   194. 02   07952   PHYSI CIAN CLINICS   0   6, 155, 224   194. 02   194. 03   07954   MOB - MAIN CAMPUS   0   1, 277, 036   194. 03   194. 04   07955   CNICLOGY - NONREI MBURSABLE   0   1, 277, 036   194. 03   194. 05   07955   CNICLOGY - NONREI MBURSABLE   0   1, 277, 036   194. 03   194. 05   07955   CNICLOGY - NONREI MBURSABLE   0   1, 277, 036   194. 03   194. 06   079578   MOB - MC CAMTLESN   0   2, 714, 837   194. 06   194. 06   079578   MOB - MC CAMTLESN   0   2, 714, 837   194. 06   194. 06   079578   MOB - MC CAMTLESN   0   2, 714, 837   194. 06   194. 06   079578   KOH - MC CENTAL SURGERY   0   1, 496, 535   194. 08   194. 09   07959   KOH - MC CENTAL SURG							1
69. 01   03610   SLEEP LAB	1 1		1				1
71. 00   07100   INFO CALL SUPPLIES CHARGED TO PATIENTS   0   2,503,948   71. 00   71. 01   07101   IV SOLUTI ONS   0   07200   MPL. DEV. CHARGED TO PATIENTS   0   3,336,352   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   8,808,157   73. 00   76. 00   03140   CARDI OLOGY   0   0   652, 161   76. 00   07. 079   07	1 1	.51.02001	1				1
72.00   07200   IMPL DEV. CHARGED TO PATIENTS   0   3,336,3552   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   0   8,808,157   75.00   03140   CARDI OLOGY   0   0   652,161   76.00   03140   CARDI OLOGY   0   0   652,161   76.00   76.97   000   0	1 1	JPPLIES CHARGED TO PATIENTS	0				1
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   8,808,157   76.00   7			0	93, 644			71. 01
76. 07 76. 96 90. 01 90. 00 90. 00			1				1
76. 97							1
OUTPATLENT SERVICE COST CENTERS   O			-				
90. 00   09000   CLINIC   0   61, 663   90. 00   90. 01   90001   WOUND CARE CLINIC   -1, 327   153, 205   90. 01   90. 01   90. 01   WOUND CARE CLINIC   -578, 468   2, 459, 686   91. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   92. 00   07500   ABULANCE SERVI CES   -50, 175   1, 738, 145   95. 00   10100   HOME HEALTH AGENCY   0   1, 036, 713   101. 00   10100   HOME HEALTH AGENCY   0   1, 036, 713   101. 00   113. 00   113.00   11300   INTEREST EXPENSE   0   210, 889   116. 00   116. 00   11600   HOSPI CE   0   210, 889   116. 00   11600   HOSPI CE   SUBTOTALS (SUM OF LINES 1 through 117)   -16, 062, 337   85, 082, 539   118. 00   19000   GIFT, FLOWER, COFFEE SHOP, & CANTEEN   0   133, 867   194. 00   194. 00   07950   OTHER NON-REI MBURSABLE   0   133, 867   194. 01   07951   MOB   194. 00   194. 00   07952   PHYSI CI AN CLINICS   0   6, 155, 224   194. 02   194. 03   07953   PHYS PRAC BUS OFC   0   1, 277, 036   194. 03   194. 04   07954   MOB   MONREI MISSABLE   0   0   0   0   0   194. 03   07955   NONREI MISURSABLE   0   0   0   0   0   0   0   0   0			U	70, 399			76.97
90. 01 09001 WOUND CARE CLINIC -1, 327 153, 205 91.00 09100 EMERGENCY -578, 468 91.00 992.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 00 09500 AMBULANCE SERVICES -50, 175 1, 738, 145 95. 00 10100 HOME HEALTH AGENCY 0 1, 036, 713 101.00 1000 HOME HEALTH AGENCY 0 1, 036, 713 101.00 11300 INTEREST EXPENSE 0 210, 889 116. 00 11600 HOSPICE 0 210, 889 116. 00 11600 HOSPICE 0 0 210, 889 116. 00 11800 HOSPICE 0 0 210, 889 116. 00 1900 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 133, 867 194. 01 194. 01 197951 MOB 0 1, 07951 MOB 0 1,		CE COST CENTERS	0	61, 663			90.00
92. 00 OP200 OBSERVATI ON BEDS (NON-DISTINCT PART) OTHER REI MBURSABLE COST CENTERS  95. 00 101.00 OP500 AMBULANCE SERVI CES		CLINIC	-1, 327				1
OTHER REIMBURSABLE COST CENTERS   95.00   09500   AMBULANCE SERVI CES   -50,175   1,738,145   95.00   10100   HOME HEALTH AGENCY   0   1,036,713   101.00   101.00   HOME HEALTH AGENCY   0   1,036,713   101.00   101.00   HOME HEALTH AGENCY   0   1,036,713   101.00   101.00   101.00   HOME HEALTH AGENCY   0   1,036,713   101.00   101.			-578, 468	2, 459, 686			91. 00
95. 00 101. 00 10100   HOME   HEALTH   AGENCY   0   1, 036, 713   101. 00   SPECIAL   PURPOSE   COST   CENTERS   0   0   0   113.00   113.00   113.00   113.00   115.00   116.		. ,					92. 00
101.00   10100   HOME HEALTH AGENCY   0   1,036,713     101.00			E0 475	4 700 445			05.00
SPECIAL PURPOSE COST CENTERS   13. 00   11300   INTEREST EXPENSE   0   210, 889   116. 00   118. 00   118. 00   118. 00   210, 889   118. 00   210, 889   118. 00   210, 889   118. 00   210, 889   118. 00   210, 889   118. 00   210, 889   210, 899   21							
113. 00 116. 00 116. 00 116. 00 116. 00 116. 00 118. 00  SUBTOTALS (SUM OF LINES 1 through 117)  NONREI MBURSABLE COST CENTERS  190. 00 194. 00 07950 0716FR NON-REI MBURSABLE 070707957 070957			l O	1, 030, 713			1101.00
116. 00 118. 0			0	0			113. 00
NONREI MBURSABLE COST CENTERS   190. 00   1900   1975   190. 00							
190. 00 190. 0	118. 00 SUBTOTALS	(SUM OF LINES 1 through 117)	-16, 062, 337				
194. 00   07950   07HER NON-REI MBURSABLE   0   133, 867   194. 00   194. 01   194. 01   194. 02   194. 02   194. 03   194. 03   194. 03   194. 04   194. 05   194. 06   19750   194. 06   19750   194. 06   19750   194. 06   19750   194. 06   19750   194. 07   19750   194. 08   19750   19750   194. 08   19750	NONREI MBURSABLE	COST CENTERS					1
194. 01   07951   MOB   0   3, 081, 032   194. 01   194. 02   194. 02   194. 03   194. 03   194. 04   194. 04   194. 05   194. 06   1975   KDH - MC GENERAL SURGERY   0   566, 028   194. 09   194. 09   194. 09   1979   KDH - MC ENT   0   566, 028   194. 09							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 194. 09 194. 09 194. 09 194. 09 194. 09	194. 00 07950 OTHER NON-	REIMBURSABLE					
194. 03 07953 PHYS PRAC BUS OFC 0 1, 277, 036 194. 04 194. 05 194. 05 07955 ONORLI MBURSABLE 0 2, 649, 615 194. 07 07957 KDH - MC GENERAL SURGERY 0 1,408 07958 KDH - MC ENT 0 1,566, 028 194. 09 194. 09		CLINICS	1				
194. 04 07954 MOB - MAIN CAMPUS 0 366, 179 194. 05 07955 ONCOLOGY - NONREI MBURSABLE 0 0 0 194. 06 07956 KDH - MC FAMI LY PRACTI CE 0 2, 649, 615 194. 07 07957 KDH - MC ORTHOPEDI CS 0 2, 714, 837 194. 08 07958 KDH - MC GENERAL SURGERY 0 1, 496, 535 194. 09 07959 KDH - MC ENT 0 566, 028							1
194. 05 07955 ONCOLOGY - NONREI MBURSABLE 0 0 194. 05 194. 06 194. 06 194. 07 07957 KDH - MC ORTHOPEDI CS 0 1,496, 535 194. 08 07958 KDH - MC GENERAL SURGERY 0 566, 028 194. 09							1
194. 06 07956 KDH - MC FAMI LY PRACTI CE 0 2, 649, 615 194. 07 07957 KDH - MC ORTHOPEDI CS 0 2, 714, 837 194. 08 07958 KDH - MC GENERAL SURGERY 0 1, 496, 535 194. 09 07959 KDH - MC ENT 0 566, 028 194. 09				330, 179 N			
194. 07 07957 KDH - MC ORTHOPEDI CS 0 2, 714, 837 194. 07 194. 08 07958 KDH - MC GENERAL SURGERY 0 1, 496, 535 194. 09 07959 KDH - MC ENT 0 566, 028 194. 09	194.06 07956 KDH - MC F	FAMILY PRACTICE	l ől	2, 649, 615			
194. 08 07958 KDH - MC GENERAL SURGERY 0 1, 496, 535 194. 09 07959 KDH - MC ENT 0 566, 028 194. 09	194. 07 07957 KDH - MC C	ORTHOPEDI CS	ol				1
	194.08 07958 KDH - MC G	GENERAL SURGERY					
194. 10 0/960 KDH - MC UROLOGY   0  464, 887    194. 10			- 1				
	194. 10 07960 KDH - MC L	JKULUGY	0	464, 887			1194. 10

Health Financial Systems		KING'S DAUGHTE	RS' HOSPI TAL		In	Lieu of Form	CMS-2	552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL	BALANCE O	F EXPENSES	Provi der Co	CN: 15-0069	Period: From 01/01/2	Worksheet	Α	
						020 Date/Time 5/24/2021		
Cost Center Description		Adiustments	Net Expenses					

			5/24/2021 1	1:00 am_
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6. 00	7.00		
194. 11 07961 KDH - MC OB/GYN	0	2, 237, 105		194. 11
200.00 TOTAL (SUM OF LINES 118 through 199)	-16, 062, 337	106, 224, 884		200. 00

| Peri od: | Worksheet A-6 | From 01/01/2020 | To 12/31/2020 | Date/Time Prepared: Provider CCN: 15-0069

					Date/lime Prepared: 5/24/2021 11:00 am
		Increases			
	Cost Center	Li ne #	Sal ary	Other 5.00	
	2. 00 A - CAFETERI A	3. 00	4. 00	5. 00	
1. 00	CAFETERIA	11. 00	190, 617	105, 570	1.00
1.00	0		190, 617	105, 570	1.00
	B - MEDICAL IMAGING TIME		170,017	103, 370	
1.00	PHYSICIAN CLINICS	194. 02	14, 677	0	1. 00
	0		14, 677	0	
	C - DEPRECIATION	· · · · · · · · · · · · · · · · · · ·	., .		
1.00	NEW CAP REL COSTS-BLDG &	1. 01	0	6, 879	1.00
	FIXT_HHA/HO				
	0		0	6, 879	
	D - NURSERY- L&D				
1. 00	NURSERY	43. 00	446, 255	12, 662	1.00
2.00	DELIVERY ROOM & LABOR ROOM	<u>52.</u> 00	60 <u>9, 3</u> 87	1 <u>7, 2</u> 91	2. 00
	0		1, 055, 642	29, 953	
	E - CRNA EXPENSE	40.00	222 225		
1. 00	NONPHYSI CI AN ANESTHETI STS		380, 325	0	1. 00
	U F DUVELCIAN BLLLING AND COLL	LECTIONS	380, 325	U	
1 00	F - PHYSICIAN BILLING AND COLI PHYS PRAC BUS OFC	194. 03	٥	634, 199	1 00
1. 00	PHYS PRAC BUS OFC	194.03	0	63 <u>4, 1</u> 99 634, 199	1.00
	G - EMPLOYEE BENEFITS			034, 199	
1.00	ADMINISTRATIVE & GENERAL	5.00	178, 271	37, 677	1.00
2. 00	KDH - MC ORTHOPEDICS	194. 07	170, 271	1, 406	2. 00
3. 00	RDIT - WIG ORTHOLEDICS	0.00	0	0	3. 00
4. 00		0.00	0	0	4. 00
4.00			178, 271	39, 083	4.00
	I - MED/SURG SUPPLIES		170, 271	07,000	
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	2, 503, 948	1. 00
	PATI ENTS			_,,	
2.00		0.00	0	0	2. 00
3.00		0.00	0	0	3.00
4.00		0.00	O	O	4. 00
5.00		0.00	0	0	5. 00
6.00		0.00	o	0	6. 00
7.00		0.00	O	0	7. 00
8.00		0.00	O	0	8. 00
9.00		0.00	O	0	9. 00
10.00		0.00	O	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12. 00
13.00		0.00	0	0	13. 00
14.00		0.00	0	0	14. 00
15.00		0.00	0	0	15. 00
16.00		0.00	0	0	16. 00
17.00		0.00	0	0	17. 00
18.00		0.00	0	0	18. 00
19.00		0.00	0	0	19. 00
20.00		0.00	0	0	20.00
21. 00		0.00	0	0	21.00
22. 00		0. 00	0	0	22. 00
23. 00		0. 00	0	0	23. 00
24. 00		0. 00	0	0	24. 00
25. 00		0. 00	0	0	25. 00
26. 00		0. 00	0	0	26. 00
27. 00		0.00		0	27. 00
	0		0	2, 503, 948	
	J - IV SOLUTIONS	1	_1		
1.00	IV SOLUTIONS	71. 01	0	93, 644	1. 00
2.00		0.00	0	0	2.00
3.00		0.00	O O	U	3.00
4.00		0.00	O	U	4.00
5.00		0.00	O O	U	5.00
6. 00 7. 00		0. 00 0. 00	O O	U	6. 00 7. 00
			0	0	
8. 00 9. 00		0. 00 0. 00	0	0	8. 00 9. 00
7. UU		— <u> </u>	- — — <del>} </del>	93, 644	9.00
	K - IMPLANTS		U	93, 044	
1. 00	IMPL. DEV. CHARGED TO	72. 00	0	3, 336, 352	1. 00
1.00	PATIENTS	72.00	٩	3, 330, 332	1.00
	0	+		3, 336, 352	
	1-	I	٩	5, 555, 552	I I

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

Period: Worksheet A-6 From 01/01/2020 To 12/31/2020 Date/Time Prepared: 5/24/2021 11:00 am

					 5/24/2021 11:00	am_
		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, 808, 157	1	1. 00
2.00		0.00	0	0	2	2. 00
3.00		0.00	0	0	3	3. 00
4.00		0.00	o	0	4	4. 00
5.00		0.00	o	0	5	5. 00
6.00		0.00	o	0	6	6. 00
7.00		0.00	o	0	7	7. 00
8.00		0.00	o	0	8	8. 00
9.00		0.00	О	0	9	9. 00
10.00		0.00	О	0	10	0. 00
11.00		0.00	О	0	11	1. 00
	0 = = = = =			8, 808, 157		
	M - INSURANCE	•				
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	345, 266	1	1. 00
	FLXT			·		
		$+$		345, 266		
	N - HOME HEALTH DIRECTOR	<u>'</u>				
1.00	HOME HEALTH AGENCY	101.00	63, 366	0	1	1. 00
			63, 366			
	0 - HOSPICE	· · · · · · · · · · · · · · · · · · ·		-		
1.00	HOSPI CE	116.00	55, 435	0	1	1. 00
	0		55, 435			
	P - VACATION	' ' '		-		
1.00	ADMI NI STRATI VE & GENERAL	5. 00	92, 698	0	1	1. 00
	TOTALS		92, 698			
500.00	Grand Total: Increases		2, 031, 031	15, 903, 051	500	0. 00
	1	1	, ,		1	

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2020 | To 12/31/2020 | Date/Time Prepared: Provider CCN: 15-0069

					Ic	) 12/31/2020 Date/lime Pr   5/24/2021 11	
		Decreases					
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
	6. 00 A - CAFETERI A	7. 00	8. 00	9. 00	10. 00		
1. 00	DI ETARY	10.00	190, 617	105, 570	0		1.00
1.00	0		190, 617	105, 570			1.00
	B - MEDICAL IMAGING TIME		1707017	. 00, 0, 0			
1.00	RADI OLOGY-DI AGNOSTI C	54.00	14, 677	0	0		1.00
	0		14, 677	0			
	C - DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG &	1. 00	0	6, 879	9		1. 00
	FIXT						
	O LUDGERY LAR		0	6, 879			
4 00	D - NURSERY- L&D	20.00	4 055 (40	00.050			1 00
1. 00 2. 00	ADULTS & PEDIATRICS	30. 00 0. 00	1, 055, 642	29, 953	0		1.00
2.00		<u> </u>	1, 055, 642	<u> 0</u> 29, 953	— — — Ч		2.00
	E - CRNA EXPENSE		1, 000, 042	27, 755			
1. 00	ANESTHESI OLOGY	53.00	380, 325	0	0		1.00
1.00	0		380, 325	0	— — <u> </u>		1.00
	F - PHYSICIAN BILLING AND COL	LECTI ONS		-1	<u>'</u>		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	634, 199	0		1.00
	0		0	634, 199			
	G - EMPLOYEE BENEFITS						
1.00	PHYSICIAN CLINICS	194. 02	0	15, 669	0		1. 00
2.00	KDH - MC FAMILY PRACTICE	194. 06	0	123, 288	0		2. 00
3.00	KDH - MC ENT	194. 09	0	65, 220	0		3. 00
4. 00	KDH - MC OB/GYN	1 <u>94.</u> 1 <u>1</u>		1 <u>3, 1</u> 77	0		4. 00
	I - MED/SURG SUPPLIES		0	217, 354			_
1. 00	ADMI NI STRATI VE & GENERAL	5, 00	ol	59, 449	0		1.00
2.00	OPERATION OF PLANT	7.00	o	17, 539	0		2. 00
3. 00	HOUSEKEEPI NG	9. 00	Ö	2, 800	ő		3. 00
4. 00	PHARMACY	15. 00	o	10, 291	o		4. 00
5.00	ADULTS & PEDIATRICS	30.00	0	393, 318	0		5. 00
6.00	INTENSIVE CARE UNIT	31.00	0	1, 222	0		6. 00
7.00	OPERATING ROOM	50.00	0	1, 349, 209	0		7. 00
8.00	RECOVERY ROOM	51.00	0	25, 732	0		8. 00
9.00	ANESTHESI OLOGY	53.00	0	66, 166	0		9. 00
10. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 451	0		10. 00
11. 00	ULTRA SOUND	54. 01	0	2, 996	0		11. 00
12. 00	NUCLEAR MEDICINE -	54. 02	0	1, 013	0		12. 00
13. 00	DI AGNOSTI C ONCOLOGY	55. 01	0	56, 664	0		13. 00
14. 00	CT SCAN	57. 00	0	13, 679	0		14. 00
15. 00	MAGNETIC RESONANCE I MAGING	58.00	0	1, 001	0		15. 00
	(MRI)	33. 33	Ĭ	.,			10.00
16.00	LABORATORY	60.00	O	91, 320	О		16. 00
17.00	RESPIRATORY THERAPY	65. 00	O	74, 774	0		17. 00
18.00	PHYSI CAL THERAPY	66. 00	0	9, 603	0		18. 00
19. 00	OCCUPATI ONAL THERAPY	67. 00	0	2, 122	0		19. 00
20. 00	SPEECH PATHOLOGY	68. 00	0	1, 138	0		20. 00
21. 00	SLEEP LAB	69. 01	0	6, 384	0		21. 00
22. 00	CARDI OLOGY	76.00	0	23, 012	0		22. 00
23. 00	CARDIAC REHABILITATION	76. 97 90. 00	0	276	0		23. 00
24. 00 25. 00	CLINIC WOUND CARE CLINIC	90.00	0	1, 199 20, 275	0		24. 00 25. 00
26. 00	EMERGENCY	91.00	0	230, 674	0		26. 00
27. 00	AMBULANCE SERVICES	95.00	o	40, 641	0		27. 00
27.00	0		-	2, 503, 948			27.00
	J - IV SOLUTIONS		-1	,			
1.00	PHARMACY	15. 00	0	42, 836	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	18, 286	0		2. 00
3.00	OPERATING ROOM	50.00	0	18, 283	0		3. 00
4.00	RECOVERY ROOM	51.00	0	631	0		4. 00
5.00	RADI OLOGY-DI AGNOSTI C	54.00	0	150	0		5. 00
6.00	ONCOLOGY	55. 01	0	1, 758	0		6. 00
7.00	RESPIRATORY THERAPY	65.00	ol	119	0		7. 00
8.00	EMERGENCY	91. 00 95. 00	0	10, 956	0		8.00
9. 00	AMBULANCE SERVICES	95.00	0	<u>625</u> 93, 644	9		9. 00
	K - IMPLANTS		U	73, 044			
1. 00	OPERATING ROOM	50.00	0	3, 336, 352	0		1.00

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

Peri od: Worksheet A-6 From 01/01/2020 To 12/31/2020 Date/Time Prepared:

						5/24/2021 11:00	) am
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	L - DRUGS						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	31, 046	0		1.00
2.00	PHARMACY	15. 00	О	7, 235, 912	2 o		2.00
3.00	ANESTHESI OLOGY	53.00	O	25, 928	o o		3.00
4.00	RADI OLOGY-DI AGNOSTI C	54.00	o	4, 762	2 o		4.00
5.00	ULTRA SOUND	54. 01	О	1, 023	o o		5.00
6.00	NUCLEAR MEDICINE -	54.02	O	259	ol		6.00
	DI AGNOSTI C						
7.00	LABORATORY	60.00	0	1, 451, 283	8 o		7.00
8.00	RESPIRATORY THERAPY	65.00	О	43, 131	o		8.00
9.00	PHYSI CAL THERAPY	66.00	О	5, 484	ı o		9.00
10.00	WOUND CARE CLINIC	90. 01	О	741	o		10.00
11.00	AMBULANCE SERVICES	95.00	О	8, 588	ol ol		11.00
				8, 808, 157	,		
	M - INSURANCE	'		· · · · · ·	<u>'</u>		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	345, 266	12		1.00
				345, 266			
	N - HOME HEALTH DIRECTOR	'	<u>'</u>	·	<u>'</u>		
1.00	PHYSI CAL THERAPY	66.00	63, 366	C	0		1.00
			63, 366				
	O - HOSPICE	'			<u>'</u>		
1.00	HOME HEALTH AGENCY	101.00	55, 435	C	0		1.00
			55, 435				
	P - VACATION	'			'		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	92, 698	0		1.00
	TOTALS			92, 698	3 - 1		
500.00	Grand Total: Decreases		1, 760, 062	16, 174, 020		50	00.00
		,			1	1 -	

					То	12/31/2020	Date/Time Prep 5/24/2021 11:0	
				Acqui si ti ons			0,21,2021 111	- Can
		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 ASSET	Γ BALANCES						
1.00	Land	3, 493, 206	0		0	0	0	1.00
2.00	Land Improvements	496, 350	0		0	0	0	2.00
3.00	Buildings and Fixtures	118, 503, 603	352, 853		0	352, 853	144, 865	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	61, 834, 115	2, 255, 430		0	2, 255, 430	523, 544	6.00
7.00	HIT designated Assets	0	0		0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	184, 327, 274	2, 608, 283		0	2, 608, 283	668, 409	8. 00
9.00	Reconciling Items	0	0		0	0	0	9. 00
10.00	Total (line 8 minus line 9)	184, 327, 274	2, 608, 283		0	2, 608, 283	668, 409	10.00
		Endi ng Bal ance	Fully					
			Depreci ated					
			Assets					
		6.00	7. 00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	3, 493, 206	0					1. 00
2.00	Land Improvements	496, 350	0					2. 00
3.00	Buildings and Fixtures	118, 711, 591	0					3. 00
4.00	Building Improvements	0	0					4. 00
5.00	Fi xed Equipment	0	0					5. 00
6.00	Movable Equipment	63, 566, 001	0					6. 00
7.00	HIT designated Assets	0	0					7. 00
8.00	Subtotal (sum of lines 1-7)	186, 267, 148	0					8. 00
9.00	Reconciling Items	0	0					9. 00
10.00	Total (line 8 minus line 9)	186, 267, 148	0					10. 00

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lie	u of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 15-0069	Peri od: From 01/01/2020 To 12/31/2020	Worksheet A-7 Part II Date/Time Prepared:

			T	o 12/31/2020	Date/Time Prep 5/24/2021 11:0	
		SL	JMMARY OF CAPIT	AL		
Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
				instructions)	instructions)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
PART II - RECONCILIATION OF AMOUNTS FROM	WORKSHEET A, COLUM	IN 2, LINES 1 a	nd 2			
1.00 NEW CAP REL COSTS-BLDG & FIXT	8, 436, 098	31, 538	5, 132, 129	0	19, 609	1. 00
1.01 NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	0	0	0	0	1. 01
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2. 00
3.00 Total (sum of lines 1-2)	8, 436, 098	31, 538	5, 132, 129	0	19, 609	3. 00
	SUMMARY 0	F CAPITAL				
Cost Center Description		Total (1) (sum				
	Capi tal -Rel ate					
	d Costs (see	through 14)				
	instructions)	45.00				
	14. 00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM	WORKSHEET A, COLUN					
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	13, 619, 374				1. 00
1. 01 NEW CAP REL COSTS-BLDG & FIXT HHA/HO	0	0				1. 01
2. 00 NEW CAP REL COSTS-MVBLE EQUIP	0	0				2. 00
3.00  Total (sum of lines 1-2)	0	13, 619, 374				3. 00

Heal th	Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2020	Worksheet A-7 Part III	
					o 12/31/2020	Date/Time Prep	pared:
		1			T	5/24/2021 11:0	00 am
		COM	PUTATION OF RA	1108	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col . 2)			
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	122, 701, 147	C	122, 701, 147		0	1. 00
1.01	NEW CAP REL COSTS-BLDG & FLXT HHA/HO	0	0	)	0.00000		1. 01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	63, 566, 001	0	63, 566, 001			2.00
3.00	Total (sum of lines 1-2)	186, 267, 148		186, 267, 148			3. 00
		ALLOCA	TION OF OTHER (	CAPITAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
	·		Capi tal -Relate	cols. 5	•		
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE		1				
1.00	NEW CAP REL COSTS-BLDG & FLXT	0	0		8, 429, 219		1. 00
1.01	NEW CAP REL COSTS-BLDG & FLXT HHA/HO	0	0		6, 879	0	1. 01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	)	0 407 000	0	2.00
3. 00	Total (sum of lines 1-2)	0		IMMADY OF CARL	8, 436, 098	10, 998	3. 00
			50	JMMARY OF CAPI	IAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
					d Costs (see	through 14)	
					instructions)		
	DART LLL DECONOLILATION OF CARLEY COOTS OF	11.00	12.00	13. 00	14. 00	15. 00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS CE		245.244	10.404	\	0.454.040	1 00
1.00	NEW CAP REL COSTS BLDG & FLXT	649, 257	345, 266	19, 609	0	9, 454, 349	1.00
1. 01 2. 00	NEW CAP REL COSTS-BLDG & FIXT HHA/HO NEW CAP REL COSTS-MVBLE EQUIP	0			0	6, 879	1. 01 2. 00
2. 00 3. 00	Total (sum of lines 1-2)	649, 257	345, 266	19, 609		0 9, 461, 228	2. 00 3. 00
3.00	Total (Suii Of TITIES 1-2)	049, 257	J 340, 200	17, 009	'  0	7, 401, 228	3.00

| Peri od: | Worksheet A-8 | From 01/01/2020 | To 12/31/2020 | Date/Time Prepared:

				T	o 12/31/2020		pared:
				Expense Classification on	Worksheet A	5/24/2021 11:0	00 am
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center	Line #	Wkst. A-7 Ref.	
1. 00	Investment income - NEW CAP	1. 00 B	2.00	3.00 NEW CAP REL COSTS-BLDG &	4. 00	5. 00	1. 00
1.00	REL COSTS-BLDG & FIXT (chapter			FIXT	1.00	''	1.00
1. 01	2) Investment income - NEW CAP		0	NEW CAP REL COSTS-BLDG &	1. 01	0	1. 01
1.01	REL COSTS-BLDG & FLXT HHA/HO			FIXT HHA/HO	1.01		1.01
2. 00	(chapter 2) Investment income - NEW CAP		0	NEW CAP REL COSTS-MVBLE	2.00	0	2. 00
2.00	REL COSTS-MVBLE EQUIP (chapter			EQUI P	2.00		2.00
3. 00	2) Investment income - other		0		0.00	0	3. 00
3.00	(chapter 2)		0		0.00		3.00
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0. 00	0	4. 00
5. 00	Refunds and rebates of		0		0. 00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by	В	-20 540	NEW CAP REL COSTS-BLDG &	1.00	10	6. 00
	suppliers (chapter 8)			FIXT			
7. 00	Telephone services (pay stations excluded) (chapter	A	-1, 662	ADMINISTRATIVE & GENERAL	5. 00	0	7. 00
	21)						
8. 00	Television and radio service (chapter 21)	A	-21, 526	OPERATION OF PLANT	7. 00	0	8. 00
9. 00	Parking Lot (chapter 21)		0		0.00		9. 00
10. 00	Provider-based physician adjustment	A-8-2	-5, 287, 190			0	10. 00
11. 00	Sale of scrap, waste, etc.		0		0.00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	0			0	12. 00
40.00	transactions (chapter 10)				0.00		40.00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В	-315, 240	CAFETERI A	0. 00 11. 00	l	
15. 00	Rental of quarters to employee		0		0. 00	0	15. 00
16. 00	and others Sale of medical and surgical		0		0.00	0	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than		0		0.00	0	17. 00
18. 00	patients Sale of medical records and	В	-964	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
	abstracts						
19. 00	Nursing and allied health education (tuition, fees,		0		0.00	0	19. 00
	books, etc.)						
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00		
	interest, finance or penalty						
22. 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to						
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - NEW CAP REL			NEW CAP REL COSTS-BLDG &	1.00	0	26. 00
26. 01	COSTS-BLDG & FIXT Depreciation - NEW CAP REL			FLXT 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	27. 00
	COSTS-MVBLE EQUIP			EQUI P			
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant	A A		NONPHYSICIAN ANESTHETISTS ADULTS & PEDIATRICS	19. 00 30. 00		28. 00 29. 00
30. 00	Adjustment for occupational	A-8-3		OCCUPATI ONAL THERAPY	67. 00		30.00
	therapy costs in excess of limitation (chapter 14)						
	V 1	. '			•		•

				To	12/31/2020	Date/Time Prep 5/24/2021 11:0	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	cost center bescription	1.00	2. 00	3.00	4. 00	5. 00	
30. 99	Hospice (non-distinct) (see	1.00		ADULTS & PEDIATRICS	30.00	5.00	30. 99
30. 77	instructions)		0	ADDETS & LEDIATRICS	30.00		30. 77
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	CAH HIT Adjustment for		0		0.00	0	32.00
	Depreciation and Interest						
33.00	RADI OLOGY TUITI ON	В	· ·	RADI OLOGY SCHOOL	23. 00	0	33.00
33. 01	AMBULANCE REVENUE	В		AMBULANCE SERVICES	95. 00	0	33. 01
33. 02	ADVERTI SI NG	Α		ADMINISTRATIVE & GENERAL	5. 00	0	33. 02
33. 03	SELF-I NSURANCE	A	· ·	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 03
33. 04	HOSPITAL ASSOCIATION FEES	A	· ·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 04
33. 05	HAF MEDICAID	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 05
33. 06	PHYSICIAN RECRUITMENT	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 06
33. 07	PHYSICIAN LAB SALARY OFFSET	Α		LABORATORY	60. 00	0	33. 07
33. 08	PHYSICIAN LAB BENEFIT OFFSET	Α	· ·	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 08
33. 09	CRNA BENEFIT OFFSET	Α	·	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 09
33. 10	PA BENEFIT OFFSET	Α	· ·	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 10
33. 11	DONATIONS	A	· ·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 11
33. 12	REALIZED GAIN/LOSS	В		NEW CAP REL COSTS-BLDG &	1. 00	11	33. 12
22 12	MISC REVENUE MGMT FEES	В		FIXT ADMINISTRATIVE & GENERAL	5. 00	0	33. 13
33. 13	TOTAL (sum of lines 1 thru 49)	_	-16, 062, 337		5.00	U	50.00
50. 00	(Transfer to Worksheet A,		-10,002,337				SU. UU
	column 6, line 200.)						
	[COT UIIII 6, TTTIE 200.)			0110 0 1 15 1			<u></u>

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

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

B. Amount Received - if cost cannot be determined.

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

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

Peri od: Worksheet A-8-2 From 01/01/2020 To 12/31/2020 Date/Time Prepared:

						5/24/2021 11:		00 am
	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	5. 00	ADMINISTRATIVE & GENERAL	16, 830	4, 896	11, 934	211, 500	26	1. 00
2.00	30.00	ADULTS & PEDIATRICS	610, 001	610, 001	0	211, 500	0	2. 00
3.00	53. 00 ANESTHESI OLOGY		1, 569, 132	1, 545, 714	23, 418	239, 400	27	3. 00
4.00	54.00	RADI OLOGY-DI AGNOSTI C	1, 920, 264	1, 920, 264	0	271, 900	0	4. 00
5.00	55. 01 ONCOLOGY		606, 669	587, 919	18, 750	211, 500	100	5. 00
6.00	60. 00 LABORATORY		150, 000		150, 000	260, 300	1, 621	6. 00
7.00	69. 01 SLEEP LAB		13, 056				126	7. 00
8. 00	90, 01	WOUND CARE CLINIC	4, 377	1 0	4, 377	211, 500	30	8. 00
9. 00	91. OO EMERGENCY		1, 271, 232					9. 00
10.00	95. 00 AMBULANCE SERVICES		582					10.00
200.00			6, 162, 143				8, 747	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	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	5. 00	ADMINISTRATIVE & GENERAL	2, 644	132	0	0	0	1. 00
2.00	30.00 ADULTS & PEDIATRICS		0	C	_	0	0	2. 00
3.00	53. 00 ANESTHESI OLOGY		3, 108	155	0	0	0	3. 00
4.00	54. 00 RADI OLOGY-DI AGNOSTI C		0	C	_	0	0	4. 00
5.00		ONCOLOGY	10, 168	508	0	0	0	5. 00
6.00	60.00	LABORATORY	202, 859	10, 143	0	0	0	6. 00
7.00	69. 01 SLEEP LAB		12, 812	641	0	0	0	7. 00
8.00	90. 01	WOUND CARE CLINIC	3, 050	153	0	0	0	8. 00
9.00	91. 00	EMERGENCY	692, 764	34, 638	0	0	0	9. 00
10.00	95. 00	AMBULANCE SERVICES	407	20	0	0	0	10.00
200.00			927, 812			0	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	2, 644				1. 00
2.00		ADULTS & PEDIATRICS	0			0.0,00.		2. 00
3.00		ANESTHESI OLOGY	0	0,.00	· ·			3. 00
4.00		RADI OLOGY-DI AGNOSTI C	0	1		1, 920, 264		4. 00
5.00		ONCOLOGY	0					5. 00
6.00		LABORATORY	0	,		0	ı	6. 00
7. 00		SLEEP LAB	0	12, 812				7. 00
8.00		WOUND CARE CLINIC	0	-,				8. 00
9.00		EMERGENCY	0	0,2,,0,				9. 00
10. 00	95. 00	AMBULANCE SERVICES	0	407				10. 00
200.00			0	927, 812	618, 396	5, 287, 190		200. 00

| Peri od: | Worksheet B | From 01/01/2020 | Part | | To | 12/31/2020 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0069

			To	12/31/2020	Date/Time Pre 5/24/2021 11:	
		CAPI	TAL RELATED CO	STS	372472021 11.	oo aiii
Cost Center Description	Net Expenses	NEW BLDG &	NEW BLDG &	NEW MVBLE	EMPLOYEE	
	for Cost Allocation	FIXT	FIXT HHA/HO	EQUI P	BENEFITS DEPARTMENT	
	(from Wkst A				DEPARTMENT	
	col. 7) 0	1. 00	1. 01	2. 00	4. 00	
GENERAL SERVICE COST CENTERS	0	1.00	1.01	2.00	4.00	
1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT	9, 454, 349	9, 454, 349	( 070			1.00
1.01 O0101 NEW CAP REL COSTS-BLDG & FLXT F 2.00 O0200 NEW CAP REL COSTS-MVBLE EQUIP	IHA/H0 6, 879	U	6, 879	0		1. 01 2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	11, 281, 784	0	0	0	11, 281, 784	4. 00
5. 00   00500   ADMI NI STRATI VE & GENERAL 7. 00   00700   OPERATI ON OF PLANT	14, 283, 788 3, 320, 747	1, 111, 648 1, 050, 361	0	0	1, 470, 082 122, 660	5. 00 7. 00
8.00   00800 LAUNDRY & LINEN SERVICE	365, 303	48, 692	Ö	0	6, 295	8. 00
9. 00   00900  HOUSEKEEPI NG 10. 00   01000  DI ETARY	1, 076, 059 807, 986	85, 352 160, 767	0	0	150, 323 116, 070	9. 00 10. 00
11. 00   01100   CAFETERI A	-19, 053	65, 017	0	0	42, 548	11.00
13. 00 01300 NURSING ADMINISTRATION	442, 269	52, 065	0	0	98, 421	13.00
14. 00   01400   CENTRAL SERVICES & SUPPLY   15. 00   01500   PHARMACY	86, 851 1, 487, 603	79, 093 58, 783	0	0	18, 983 164, 070	14. 00 15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	804, 177	7, 460	0	0	118, 808	16. 00
19. 00   01900   NONPHYSICIAN ANESTHETISTS 23. 00   02300   RADIOLOGY SCHOOL	0 86, 444	0 16, 887	0	0	0 28, 634	19. 00 23. 00
INPATIENT ROUTINE SERVICE COST CENTER						20.00
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   NTENSIVE CARE UNIT	3, 764, 006 1, 127, 082	966, 107 42, 766	0	0	901, 141 249, 754	30. 00 31. 00
43. 00   04300   NURSERY	458, 917	49, 944	0	0		43. 00
ANCILLARY SERVICE COST CENTERS	2 724 222	470.000	٥	0	447 220	F0 00
50. 00   05000   OPERATING ROOM 51. 00   05100   RECOVERY ROOM	2, 734, 222 288, 373	470, 983 35, 127	0	0	447, 329 63, 245	50. 00 51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	626, 678	0	0	0	136, 023	52. 00
53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY-DI AGNOSTI C	270, 325 2, 064, 901	3, 321 276, 954	0	0	278, 814 663, 099	53. 00 54. 00
54.01 03630 ULTRA SOUND	167, 198	0	Ö	0	25, 807	54. 01
54. 02   03450   NUCLEAR MEDICINE - DIAGNOSTIC 55. 00   05500   RADIOLOGY - THERAPEUTIC	230, 933	12, 339	0	0	16, 583 0	54. 02 55. 00
55. 01   03480   ONCOLOGY	1, 674, 436	312, 873	0	0	200, 394	55. 00
57. 00 05700 CT SCAN	404, 901	22, 864	0	0	32, 722	57. 00
58. 00   05800   MAGNETI C RESONANCE I MAGING (MRI 59. 00   05900   CARDI AC   CATHETERI ZATI ON	278, 967	27, 591 0	0	0	33, 322 0	58. 00 59. 00
60. 00 06000 LABORATORY	3, 634, 720	159, 387	0	0	332, 143	60.00
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD 65. 00   06500   RESPIRATORY THERAPY	CELLS 254, 004 710, 285	7, 128 30, 580	0	0	0 149, 759	62. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 251, 892	316, 807	Ō	0	275, 433	66. 00
67. 00   06700   OCCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY	215, 663 131, 885	36, 277 8, 584	0	0	47, 207 29, 088	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0, 304	Ö	0	27,000	69. 00
69. 01   03610   SLEEP LAB 71. 00   07100   MEDICAL SUPPLIES CHARGED TO PAT	183, 003 TENTS 2, 503, 948	21, 434	0	0	25, 891	69. 01 71. 00
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PAT	93, 644	0	0	0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	3, 336, 352	0	0	0	0	72.00
73. 00   07300   DRUGS CHARGED TO PATIENTS 76. 00   03140   CARDI OLOGY	8, 808, 157 652, 161	0 154, 482	0	0	0 101, 793	73. 00 76. 00
76. 97 07697 CARDI AC REHABILITATION	70, 399	17, 959	0	0	14, 844	76. 97
90. 00 O9000 CLINIC	61, 663	19, 416	0	0	13, 389	90. 00
90. 01 09001 WOUND CARE CLINIC	153, 205	53, 521	0	0	18, 640	90. 01
91. 00   09100   EMERGENCY 92. 00   09200   OBSERVATION   BEDS (NON-DISTINCT	2, 459, 686	354, 566	0	0	379, 483	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS	PARI)					92.00
95. 00 09500 AMBULANCE SERVICES	1, 738, 145	120, 888		0		95. 00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	1, 036, 713	0	5, 413	0	210, 609	101. 00 
113. 00 11300 I NTEREST EXPENSE						113. 00
116.00 11600 HOSPI CE 118.00 SUBTOTALS (SUM OF LINES 1 throu	210, 889 ligh 117) 85, 082, 539	0 6, 258, 023	1, 466 6, 879	0	•	
NONREI MBURSABLE COST CENTERS	igii 117)   05,002,557	0, 230, 023	0, 07 7	J	7, 400, 444	1110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CA 194.00 07950 OTHER NON-REIMBURSABLE	1	19, 211	0	0	0 25, 068	190.00
194. 01 07950 OTHER NON-RETMBURSABLE 194. 01 07951 MOB	133, 867 3, 081, 032	1, 344, 661	0	0	623, 348	
194. 02 07952 PHYSI CLAN CLINICS	6, 155, 224	704, 941	0	0	1, 057, 557	
194.03 07953 PHYS PRAC BUS OFC 194.04 07954 MOB - MAIN CAMPUS	1, 277, 036 366, 179	25, 266 0	0	0	141, 061 82, 843	
194.05 07955 ONCOLOGY - NONREI MBURSABLE	o	0	0	0	0	194. 05
194.06 07956 KDH - MC FAMILY PRACTICE	2, 649, 615	1, 102, 247	0	O	564, 864	194. 06

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	Peri od: From 01/01/2020 To 12/31/2020	Worksheet B Part I Date/Time Prepared: 5/24/2021 11:00 am

					5/24/2021 11:	00 am_
		CAPI	TAL RELATED C	OSTS		
	<u>-</u>	NEW BLBC 4	LIEW BL BO &	115111 111 151 5	5454 0V55	
Cost Center Description	Net Expenses	NEW BLDG & FLXT	NEW BLDG & FIXT HHA/HO	NEW MVBLE	EMPLOYEE	
	for Cost Allocation	FIXI	FIXI HHA/HU	EQUI P	BENEFITS DEPARTMENT	
	(from Wkst A				DEPARTMENT	
	col. 7)					
	0	1. 00	1. 01	2. 00	4. 00	
194.07 07957 KDH - MC ORTHOPEDICS	2, 714, 837	0	C	0	537, 307	194. 07
194.08 07958 KDH - MC GENERAL SURGERY	1, 496, 535	0	C	0	247, 593	194. 08
194.09 07959 KDH - MC ENT	566, 028	0	C	0	134, 839	194. 09
194.10 07960 KDH - MC UROLOGY	464, 887	0	C	0	20, 496	194. 10
194.11 07961 KDH - MC OB/GYN	2, 237, 105	0	(	0	366, 364	194. 11
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		0	(	0		201. 00
202.00   TOTAL (sum lines 118 through 201)	106, 224, 884	9, 454, 349	6, 879	0	11, 281, 784	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0069

Peri od: Worksheet B From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared:

5/24/2021 11:00 am Cost Center Description ADMI NI STRATI VE OPERATION OF LAUNDRY & HOUSEKEEPI NG Subtotal & GENERAL **PLANT** LINEN SERVICE 4A 5.00 9.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO 1.01 1.01 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 16, 865, 518 16, 865, 518 5.00 00700 OPERATION OF PLANT 5, 341, 913 7.00 4, 493, 768 848, 145 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 420, 290 79, 325 35, 238 534, 853 8.00 00900 HOUSEKEEPI NG 247, 574 61, 768 1, 621, 076 9.00 1.311.734 9 00 1, 084, 823 1, 306 10.00 01000 DI ETARY 204, 747 116, 344 10.00 11.00 01100 CAFETERI A 88, 512 16, 706 47,052 0 Ω 11.00 01300 NURSING ADMINISTRATION 37, 678 592 755 111.875 0 13 00 13 00 0 14.00 01400 CENTRAL SERVICES & SUPPLY 184, 927 34, 903 57, 239 0 8,708 14.00 15.00 01500 PHARMACY 1, 710, 456 322, 828 42, 541 0 23, 512 15.00 01600 MEDICAL RECORDS & LIBRARY 5, 398 0 16, 00 930, 445 16, 00 175, 610 0 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 0 0 19.00 23.00 02300 RADI OLOGY SCHOOL 131, 965 24, 907 12, 221 4, 209 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 699, 157 510, 690 30.00 5, 631, 254 1,062,832 193, 199 03100 INTENSIVE CARE UNIT 267, 933 31.00 1, 419, 602 30, 949 53, 816 31 00 04300 NURSERY <u>36</u>, 144 43.00 608, 471 114, 842 6, 096 43.00 ANCILLARY SERVICE COST CENTERS 3, 652, 534 245, 889 05000 OPERATING ROOM 50.00 689, 372 340.843 85, 274 50.00 51.00 05100 RECOVERY ROOM 386, 745 72, 993 25, 421 13, 617 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 762, 701 143, 951 14, 131 18, 479 52.00 05300 ANESTHESI OLOGY 552, 460 104, 270 2, 403 53.00 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 3, 004, 954 54.00 567, 149 200, 427 36.448 20, 261 54.00 54.01 03630 ULTRA SOUND 193,005 36, 427 4,024 7,634 54.01 C 03450 NUCLEAR MEDICINE - DIAGNOSTIC 1, 480 54.02 259, 855 49,045 8, 930 2, 110 54.02 05500 RADI OLOGY - THERAPEUTI C 55.00 C 0 55.00 03480 ONCOLOGY 2, 187, 703 412, 903 50, 780 55.01 226, 421 18, 268 55.01 57.00 05700 CT SCAN 460, 487 86, 911 16, 547 18, 855 3, 106 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 339, 880 64, 148 19, 967 3,605 7,692 58.00 05900 CARDIAC CATHETERIZATION 59 00 59 00 C 0 06000 LABORATORY 60.00 4, 126, 250 778, 780 115, 346 0 27, 198 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 261, 132 49, 286 0 62.00 62.00 5. 158 0 65.00 06500 RESPIRATORY THERAPY 890.624 168, 095 22, 130 65.00 0 06600 PHYSI CAL THERAPY 229, 268 66.00 1, 844, 132 348, 058 15, 791 19, 715 66.00 67.00 56, 460 26, 253 06700 OCCUPATI ONAL THERAPY 299, 147 0 67.00 06800 SPEECH PATHOLOGY 68.00 169, 557 32,002 6, 212 0 0 68.00 69 00 06900 ELECTROCARDI OLOGY 69 00 0 0 C 03610 SLEEP LAB 69.01 230, 328 43, 472 15, 511 1, 284 12,017 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2, 503, 948 472, 590 71.00 0 71.00 71.01 07101 IV SOLUTIONS 93,644 17, 674 0 71.01 0 0 07200 IMPL. DEV. CHARGED TO PATIENTS 3, 336, 352 629, 696 0 72 00 72 00 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 8, 808, 157 1, 662, 444 0 73.00 111, 796 76.00 03140 CARDI OLOGY 908.436 171, 456 24, 752 29, 939 76.00 07697 CARDIAC REHABILITATION 103, 202 19, 478 8, 273 76. 97 12, 997 76. 97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 94, 468 17, 830 14, 051 1, 626 90.00 09001 WOUND CARE CLINIC 1.051 90.01 225, 366 42, 535 38, 732 4, 180 90.01 09100 EMERGENCY 184, 207 91.00 91.00 3, 193, 735 602, 779 256, 594 85, 427 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92 00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 2, 225, 605 420, 056 87, 485 8, 238 95.00 101.00 10100 HOME HEALTH AGENCY 1, 252, 735 236, 439 50,805 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116.00 11600 HOSPI CE 243, 211 45, 903 13, 755 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS <u>526,</u> 074 11, 554, 429 118.00 78, 084, 873 3, 028, 781 1, 250, 813 118. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 19, 211 3, 626 13, 903 0 190. 00 194. 00 07950 OTHER NON-REI MBURSABLE 29, 997 0 194.00 158, 935 0 194. 01 07951 MOB 5, 049, 041 952, 946 973.110 1, 217 0 194. 01 194. 02 07952 PHYSICIAN CLINICS 7, 917, 722 1, 494, 375 2, 478 101, 920 194. 02 510, 155 194. 03 07953 PHYS PRAC BUS OFC 1, 443, 363 272, 417 18, 285 1, 509 194. 03 0 2, 612 194. 04 194. 04 07954 MOB - MAIN CAMPUS 449,022 84, 748 C 0 194. 05 07955 ONCOLOGY - NONREI MBURSABLE 0 0 0 194. 05 194.06 07956 KDH - MC FAMILY PRACTICE 4, 316, 726 814, 730 57 81, 955 194. 06 797, 679 194. 07 07957 KDH - MC ORTHOPEDICS 3, 252, 144 613, 803 0 775 48, 185 194. 07 194.08 07958 KDH - MC GENERAL SURGERY 1, 744, 128 36, 650 194. 08 329, 183 0 1, 228 194.09 07959 KDH - MC ENT 700,867 132, 280 0 21, 799 194. 09 194. 10 07960 KDH - MC UROLOGY 33, 950 194. 10 485, 383 91,610 0 194. 11 07961 KDH - MC OB/GYN 0 3.024 41, 683 194. 11 2 603 469 491, 374

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	Peri od: From 01/01/2020	Worksheet B Part I Date/Time Prepared:

						5/24/2021 11:	oo am_
	Cost Center Description	Subtotal	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
			& GENERAL	PLANT	LINEN SERVICE		
		4A	5. 00	7. 00	8. 00	9. 00	
200. 00	Cross Foot Adjustments	0					200.00
201.00	Negative Cost Centers	0	0	C	0	0	201. 00
202.00	TOTAL (sum Lines 118 through 201)	106 224 884	16 865 518	5 341 913	534 853	1 621 076	202 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2020 | Part I | To 12/31/2020 | Date/Time Prepared: | 5/24/2021 | 11: 00 am

Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	5/24/2021 11: 00 a	
OFNEDAL CEDIUSE COCT CENTEDO	10. 00	11. 00	13. 00	14. 00	15. 00	
GENERAL SERVICE COST CENTERS  1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT					1	. 00
1. 01 00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO 2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL 7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING 10. 00 01000 DIETARY 11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION 14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDICAL RECORDS & LIBRARY 19. 00 01900 NONPHYSICIAN ANESTHETISTS 23. 00 02300 RADIOLOGY SCHOOL	1, 407, 220 0 0 0 0 0 0 0 0	152, 270 2, 296 1, 099 3, 886 4, 710 0 802	744, 604 0 0 0 0	286, 876 1, 034 242 0 52	1 2 4 5 7 7 8 8 9 10 11 13 14 2, 104, 257 0 16 0 19	1. 01 2. 00 1. 01 2. 00 1. 00 3. 00 7. 00 3. 00 0. 00 1. 00 3. 00 1. 00 5. 00 5. 00 6. 00 6. 00 6. 00 7. 00 8. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS  30. 00   03000   ADULTS & PEDI ATRI CS	1, 303, 219	29, 097	311, 250	6, 821	0 30	0. 00
31.00 03100 INTENSIVE CARE UNIT	104, 001	5, 894	1	36	0 31	. 00
43. 00   04300   NURSERY	0	2, 937	31, 414	0	0 43	3. 00
ANCI LLARY SERVI CE COST CENTERS		14 114	150,005	7 440	0 50	
50. 00   05000   OPERATI NG ROOM   51. 00   05100   RECOVERY ROOM   52. 00   05200   DELI VERY ROOM & LABOR ROOM   53. 00   05300   ANESTHESI OLOGY   54. 00   05400   RADI OLOGY-DI AGNOSTI C   54. 01   03630   ULTRA SOUND   54. 02   03450   NUCLEAR MEDI CI NE - DI AGNOSTI C   55. 00   05500   RADI OLOGY - THERAPEUTI C   55. 01   03480   ONCOLOGY   57. 00   05700   CT SCAN   58. 00   05800   MAGNETI C RESONANCE   MAGI NG (MRI )   59. 00   05900   CARDI AC CATHETERI ZATI ON   60. 00   06000   LABORATORY   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   65. 00   06500   RESPI RATORY THERAPY   66. 00   06600   PHYSI CAL THERAPY   67. 00   06700   OCCUPATI ONAL THERAPY   68. 00   06800   SPEECH PATHOLOGY   69. 01   03610   SLEEP LAB   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   71. 01   07101   IV SOLUTI ONS   72. 00   07200   IMPL DEV. CHARGED TO PATI ENTS   73. 00   07300   DRUGS CHARGED TO PATI ENTS   74. 00   07400   CARDI OLOGY   76. 97   07697   CARDI AC REHABI LI TATI ON   0UTPATI ENT SERVI CE COST CENTERS   90. 00   09000   CLI NI C   90. 01   09001   WOUND CARE CLI NI C   90. 01   09001   WOUND CARE CLI NI C   90. 01   09001   WOUND CARE CLI NI C	000000000000000000000000000000000000000	14, 116 1, 552 4, 010 1, 241 11, 629 575 414 0 5, 357 1, 026 794 0 14, 485 0 4, 577 8, 024 993 632 0 0 575 0 0 0 3, 345 523	16, 599 42, 900 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7, 442 147 0 498 1, 785 1, 041 39 0 1, 551 4, 713 679 0 1, 571 0 102 323 9 2 0 29 101, 998 3, 815 135, 911 1, 833 193 20	0 51 0 52 0 53 0 54 0 54 0 54 0 55 0 55 0 57 0 60 0 62 0 65 0 66 0 67 0 68 0 69 0 69 0 71 0 71 0 72 2, 104, 257 73 0 76	0. 00 1. 00 2. 00 3. 00 4. 00 4. 00 4. 00 5. 00 6. 01 7. 00 9.
91. 00   09100   EMERGENCY 92. 00   09200   OBSERVATION   BEDS (NON-DISTINCT PART)	0	12, 003	128, 398	2, 011		. 00 2. 00
OTHER REIMBURSABLE COST CENTERS		44.040		252	0 05	- 00
95. 00   09500   AMBULANCE   SERVI CES 101. 00   10100   HOME   HEALTH   AGENCY	0	14, 812 0		258 1, 236	0 95 0 101	. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>		1 0	1, 250	0 101	. 00
113. 00 11300 I NTEREST EXPENSE					113	3. 00
116. 00 11600 H0SPI CE	0	0	0	5	0 116	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 407, 220	152, 270	744, 604	275, 662	2, 104, 257 118	3. 00
NONREI MBURSABLE COST CENTERS	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	0 29 1, 129 3, 315 349 248 0 1, 159 1, 681 1, 439 345	0 190 0 194 0 194 0 194 0 194 0 194 0 194 0 194 0 194 0 194	I. 00 I. 01 I. 02 I. 03 I. 04 I. 05 I. 06 I. 07 I. 08 I. 09
194. 10 07960 KDH - MC UROLOGY	0	0	0	614	0 194	1. 10

Heal th Financial	Systems	KING'S DAUGHTERS	' HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION	- GENERAL SERVICE COSTS		Provi der (	CCN: 15-0069	Peri od: From 01/01/2020 To 12/31/2020	Worksheet B Part I Date/Time Pre 5/24/2021 11:	
Cost	Center Description	DIFTARY	CAFFTERLA	NURSI NG	CENTRAL	PHARMACY	

						5/24/2021 11:	<u>00 am</u>
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
				ADMI NI STRATI ON	SERVICES &		
					SUPPLY		
		10.00	11. 00	13.00	14. 00	15. 00	
194. 11 07961	KDH - MC OB/GYN	0	0	0	906	0	194. 11
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers	0	0	0	0	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	1, 407, 220	152, 270	744, 604	286, 876	2, 104, 257	202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2020 | Part | To 12/31/2020 | Date/Time Prepared: | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/2021 | 14/202

				11	3 12/31/2020	Date/lime Pre 5/24/2021 11:	
	Cost Center Description	MEDI CAL	NONPHYSI CI AN	RADI OLOGY	Subtotal	Intern &	
		RECORDS & LI BRARY	ANESTHETI STS	SCH00L		Residents Cost & Post	
		Erbitati				Stepdown	
		16 00	10.00	22.00	24. 00	Adjustments	
	GENERAL SERVICE COST CENTERS	16. 00	19. 00	23. 00	24.00	25. 00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
1.01	00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO						1. 01
2. 00 4. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A						10. 00 11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13.00
14. 00	01400 CENTRAL SERVI CES & SUPPLY						14. 00
15. 00	01500 PHARMACY						15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 116, 405					16. 00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0				19.00
23. 00	02300 RADI OLOGY SCHOOL I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0		174, 156			23. 00
30. 00	03000 ADULTS & PEDIATRICS	34, 321	0	0	9, 781, 840	0	30.00
31. 00	03100   NTENSI VE CARE UNI T	13, 731	0		1, 959, 010	ő	31.00
43.00	04300 NURSERY	5, 201	0	0	805, 105	0	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	99, 734	0	0	5, 286, 199	0	50.00
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	18, 461 6, 970	0	0	535, 535 993, 142	0	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	21, 357	0	ľ	856, 385	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	25, 724	Ö	0	3, 868, 377	0	54.00
54. 01	03630 ULTRA SOUND	7, 077	0	0	249, 783	0	54. 01
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	18, 287	0		340, 160	0	54. 02
55. 00	O5500   RADI OLOGY - THERAPEUTI C	0	0	0	0 024 574	0	55. 00 55. 01
55. 01 57. 00	03480 ONCOLOGY 05700 CT SCAN	23, 593 62, 511	)   0	] 0 0	2, 926, 576 654, 156	0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	13, 905	0	0	450, 670	Ö	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60.00	06000 LABORATORY	129, 609	0	0	5, 193, 239	0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	7, 857	0	_	323, 433	0	62. 00
65. 00	06500 RESPI RATORY THERAPY	23, 380	0	_	1, 108, 908	0	65.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	30, 663 4, 662	)   0	0	2, 495, 974 387, 524	0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	2, 136	0	0	210, 541	ő	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
69. 01	03610 SLEEP LAB	5, 318	0	0	308, 534	0	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	39, 649	0	0	3, 118, 185	0	71.00
71. 01	07101 IV SOLUTIONS   07200 IMPL. DEV. CHARGED TO PATIENTS	12, 194 52, 811	0		127, 327 4, 154, 770	0	71. 01 72. 00
	07300 DRUGS CHARGED TO PATIENTS	301, 817	0	0	12, 878, 508		73.00
76. 00	03140 CARDI OLOGY	40, 294	0	0	1, 290, 211	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	1, 354	0	0	145, 847	0	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS	200			400 540		00.00
90.00	09000 CLINIC 09001 WOUND CARE CLINIC	202 1, 154	0		128, 560 313, 767	0	90. 00 90. 01
91. 00	09100 EMERGENCY	91, 384	0	0	4, 556, 538		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	, , , , , ,			1, 000, 000	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	21, 049					95. 00
101.00	10100 HOME HEALTH AGENCY   SPECIAL PURPOSE COST CENTERS	0	0	0	1, 541, 215	0	101. 00
113 00	11300 INTEREST EXPENSE						113. 00
	11600 HOSPI CE	0		0	302, 874	0	116.00
118.00	1 1	1, 116, 405	0	174, 156			118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	36, 740		190.00
	07950 OTHER NON-REIMBURSABLE 07951 MOB	0	0	0	188, 961 6, 977, 443		194. 00 194. 01
	2 07951 MOB 2 07952 PHYSI CI AN CLI NI CS	0	0	0	10, 029, 965		194. 01
	07953 PHYS PRAC BUS OFC	0	o o	0	1, 735, 923		194. 03
	07954 MOB - MAIN CAMPUS	0	0	0	536, 630		194. 04
	07955 ONCOLOGY - NONREI MBURSABLE	0	0	0	0		194. 05
	07956 KDH - MC FAMILY PRACTICE 707957 KDH - MC ORTHOPEDICS	0	0	0	6, 012, 306		194. 06 194. 07
	807958 KDH - MC GENERAL SURGERY	0	0	0	3, 916, 588 2, 112, 628		194. 07
	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	<u>.                                    </u>	<u> </u>		=,2, 020	<u> </u>	

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CCN: 15-0069	From 01/01/2020 To 12/31/2020	Worksheet B Part I Date/Time Prepared:

			'	0 12/31/2020	5/24/2021 11:0	
Cost Center Description	MEDI CAL	NONPHYSI CI AN	RADI OLOGY	Subtotal	Intern &	
	RECORDS &	ANESTHETI STS	SCH00L		Residents Cost	
	LI BRARY				& Post	
					Stepdown	
					Adjustments	
	16. 00	19. 00	23.00	24.00	25. 00	
194.09 07959 KDH - MC ENT	0	0	0	855, 291	0	194. 09
194.10 07960 KDH - MC UROLOGY	0	0	0	611, 557	0	194. 10
194.11 07961 KDH - MC OB/GYN	0	0	0	3, 140, 456	0	194. 11
200.00 Cross Foot Adjustments		0	0	0	0	200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 116, 405	0	174, 156	106, 224, 884	0	202. 00

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 01/01/2020 Part I | To 12/31/2020 Date/Time Prepared: 5/24/2021 11: 00 am Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0069

		5/24/2021 11:00 am
Cost Center Description	Total	372472021 11.00 dill
	26. 00	
GENERAL SERVICE COST CENTERS		4.00
1.00   00100   NEW CAP REL COSTS-BLDG & FIXT 1.01   00101   NEW CAP REL COSTS-BLDG & FIXT HHA/HO		1. 00 1. 01
2.00   00200   NEW CAP REL COSTS-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 & 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   NURSI NG ADMINI STRATI ON 14. 00   01400   CENTRAL SERVI CES & SUPPLY		13. 00 14. 00
15. 00   01500   PHARMACY		15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY		16.00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS		19.00
23. 00   02300   RADI OLOGY   SCHOOL		23.00
INPATIENT ROUTINE SERVICE COST CENTERS		
30. 00   03000   ADULTS & PEDI ATRI CS	9, 781, 840	30.00
31. 00   03100   I NTENSI VE CARE UNI T	1, 959, 010	31.00
43. 00 04300 NURSERY	805, 105	43. 00
ANCI LLARY SERVI CE COST CENTERS  50. 00   05000   OPERATI NG ROOM	5, 286, 199	50.00
51. 00   05100   RECOVERY   ROOM	5, 286, 199	51.00
52. 00   05100 RECOVERT ROOM   52. 00   05200 DELIVERY ROOM & LABOR ROOM	993, 142	51.00
53. 00 05300 ANESTHESI OLOGY	856, 385	53.00
54. 00   05400 RADI OLOGY-DI AGNOSTI C	3, 868, 377	54.00
54. 01   03630   ULTRA   SOUND	249, 783	54. 01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	340, 160	54. 02
55. 00   05500   RADI OLOGY - THERAPEUTI C	0	55. 00
55. 01   03480   ONCOLOGY	2, 926, 576	55. 01
57. 00 05700 CT SCAN	654, 156	57. 00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI) 59.00   05900   CARDIAC CATHETERIZATION	450, 670 0	58. 00 59. 00
60. 00   06000   LABORATORY	5, 193, 239	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	323, 433	62.00
65. 00 06500 RESPIRATORY THERAPY	1, 108, 908	65. 00
66. 00   06600 PHYSI CAL THERAPY	2, 495, 974	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	387, 524	67. 00
68. 00 06800 SPEECH PATHOLOGY	210, 541	68.00
69. 00   06900   ELECTROCARDI OLOGY	0	69.00
69. 01   03610   SLEEP LAB	308, 534	69. 01
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   71. 01   07101   IV SOLUTIONS	3, 118, 185	71. 00 71. 01
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	127, 327 4, 154, 770	71.01
73. 00 07300 DRUGS CHARGED TO PATIENTS	12, 878, 508	73.00
76. 00   03140   CARDI OLOGY	1, 290, 211	76.00
76. 97 07697 CARDIAC REHABILITATION	145, 847	76. 97
OUTPATIENT SERVICE COST CENTERS		
90. 00   09000   CLI NI C	128, 560	90.00
90. 01   09001   WOUND CARE CLINIC	313, 767	90. 01
91. 00 09100 EMERGENCY	4, 556, 538	91.00
92.00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   OTHER REIMBURSABLE COST CENTERS		92. 00
95. 00 09500 AMBULANCE SERVICES	2, 777, 503	95.00
101. 00 10100 HOME HEALTH AGENCY	1, 541, 215	101.00
SPECIAL PURPOSE COST CENTERS	.,	
113. 00 11300   I NTEREST EXPENSE		113. 00
116. 00 11600 HOSPI CE	302, 874	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	70, 070, 396	118. 00
NONREI MBURSABLE COST CENTERS	2	
190. 00 19000 GLFT, FLOWER, COFFEE SHOP, & CANTEEN	36, 740	190.00
194. 00 07950 0THER NON-REI MBURSABLE 194. 01 07951 MOB	188, 961 6, 977, 443	194. 00 194. 01
194.01 07951 MOB 194.02 07952 PHYSICIAN CLINICS	10, 029, 965	194. 01
194. 03 07953 PHYS PRAC BUS OFC	1, 735, 923	194. 02
194. 04 07954 MOB - MAIN CAMPUS	536, 630	194. 04
194. 05 07955 ONCOLOGY - NONREI MBURSABLE	0	194. 05
194.06 07956 KDH - MC FAMILY PRACTICE	6, 012, 306	194. 06
194. 07 07957 KDH - MC ORTHOPEDICS	3, 916, 588	194. 07
194.08 07958 KDH - MC GENERAL SURGERY	2, 112, 628	194. 08
194. 09 07959 KDH - MC ENT	855, 291	194. 09
194. 10 07960 KDH - MC UROLOGY	611, 557	194. 10
194.11 07961 KDH - MC OB/GYN 200.00  Cross Foot Adjustments	3, 140, 456 0	194. 11 200. 00
200.00 Cross Foot Adjustments	U	200.00

Health Fina	ancial Systems	KING'S DAUGHTERS'	HOSPI TAL		In Lie	u of Form CMS-	-2552-10
COST ALLOCA	ATION - GENERAL SERVICE COSTS		Provi der CC	CN: 15-0069	Peri od: From 01/01/2020 To 12/31/2020	Worksheet B Part I Date/Time Pro 5/24/2021 11:	
	Cost Center Description	Total 26.00				0,21,2021 11	
201. 00 202. 00	Negative Cost Centers TOTAL (sum lines 118 through 201)	0 106, 224, 884					201. 00 202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2020 Part II
To 12/31/2020 Date/Time Prepared:
5/24/2021 11:00 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0069

Cert Centure Reserription						12/31/2020	5/24/2021 11:	
April   Pix   Pi				CAPI	ITAL RELATED CO	STS		
Assignment Now   Cognition   FixT   FixT   FixT   HIA/HID   FOULP		Cost Center Description	Directly	NEW BLDG &	NEW BLDG &	NEW MVBLE	Subtotal	
PRIFIES   SERVICE COST CIVITES								
GENERAL STRVICE COST CENTERS								
FREMENT SERVICE DOST CENTERS   1.00				1 00	1 01	2 00	2A	
1.01   0.011   NEW CAPP ELL COSTS - MULE 1.001   0.01		GENERAL SERVICE COST CENTERS		1.00	1.01	2. 00	211	
2.00								
0.000   0.004   0.00								1
0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000000			0	0	0	0	0	
0.00   0.000   CAMIDIENY & LINEN SERVICE   0   48,692   0   0   49,692   8.0   0   10.00   0.000   0			1	1, 111, 648		o		
9.00   0.9900   MUSEREPT NO	7.00		0			О		7. 00
10.00   01000   DETARY			0			0		1
11.00   01100  CAFFERIA   0   6.5.017   0   0   6.5.017   11.00   13.0			0			0		1
13.00   01300   MURSI NC ADMINISTRATION   0   52,005   0   0   52,005   13.00   15.0			0	•		0		•
15.00   01500  PINATMICY   0   58, 783   0   0   59, 783   15, 00   19, 0		1	0			o		•
16.00   01000   MEDICAL, RECORDS & LIBRARY   0   7, 400   0   0   7, 400   10   0   0   0   0   0   0   0   0	14.00		0			О		•
19.00   01900   MORPHYSIC IAN AMESTHETISTS   0   0   16,887   0   0   16,887   23.00   200   ROPEN   ROPE   ROPEN		1	1			0		•
23.00   02500  RADIOLOGY SCHOOL   0   16,887   23.00			1	7, 460		0		
INPATI ENT ROUTI NE SERVICE COST CENTERS			1	16 887		-1		•
31.00   0.3100   INTERSI VE CARE UNIT	20.00		<u> </u>	10,007	<u> </u>		.0,00.	20.00
143.00   04300 NURSERY   0   49,944   0   0   49,944   49,00			· •			- 1		1
MODELLARY SERVICE COST CENTERS			· •	· ·		- 1		1
50.00   050000   0FEATH INC ROOM   0   0   470, 983   0   0   470, 983   0   0   370, 983   50.00   0   0   0   0   0   52.00   52.00   05200   0FLUFRY ROOM & LABOR ROOM   0   0   0   0   0   0   52.00   0   0   0   0   0   0   0   0   0	43.00		0	49, 944	0	0	49, 944	43.00
15.1 0.0   05100  RECOVERY ROOM   0   35.127   0   0   35.127   51.00   052.00   05200   0ELIVERY ROOM   0   0   0   0   0   0   0   0   0	50. 00		0	470. 983	0	0	470, 983	50.00
1.53		1	0			o		1
54.00			0	0	1	0		1
54.00					1	0		•
54.02   0.3450   MUCLEAR MEDICINE - DIAGNOSTIC   0   12, 339   0   0   0   12, 339   54.02     55.00   0.550.00   RADIOLOGY - THERAPEUTIC   0   0   0   0   0   55.00     55.00   0.3400   0.000   CADIOLOGY   0   312, 873   0   0   312, 873   55.01     57.00   0.570.00   CTS CAN   0   22, 864   0   0   22, 864   67.00     57.00   0.570.00   CTS CAN   0   0   22, 864   0   0   22, 864   67.00     58.00   0.5800   MAGNETIC RESONANCE IMAGING (MRI)   0   27, 591   0   0   0   22, 591   88.00     59.00   0.5900   CARDIA CCATHETERIZATION   0   0   0   0   0   0   0   0     69.00   0.5900   CARDIA CCATHETERIZATION   0   159, 387   0   0   159, 387   0   0   0   0     69.00   0.5900   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   7, 128   0   0   7, 128   0   0   7, 128   0   0   7, 128   0   0   7, 128   0   0   7, 128   0   0   7, 128   0   0   0     65.00   0.6500   PRESIPRATORY THERAPY   0   30, 580   0   0   316, 807   0   0   316, 807   0   0   316, 807   0   0   316, 807   0   0   0   0   0   0   0   0   0		1 1		276, <del>9</del> 54 0		0		•
55.00   05500   RADI OLOGY - THERAPEUTI C				12, 339	-	o		
57.00   05700   CT SCAN   S0   0   22,864   0   0   22,864   0   0   27,591   S0   059.00   05900	55.00		0	0	0	О		
SBS 00   OSBOO   MAGNETIC RESONANCE I MACING (MRI)   0   27, 591   0   0   0   0   59, 00			0			0		•
59.00   05900   CARDIAC CATHETRIZATION   0   159, 387   0   0   0   0   0   0   0   0   0			0			0		•
60.0 0 6000 LABORATORY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 65.00 06500 RESPIRATORY THERAPY 66.00 06600 RESPIRATORY THERAPY 70 0 30,580 0 0 316,807 0 0 316,807 66.00 0 0 316,807 65.00 0 0 316,807 67.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				27,371	_	Ö		•
65.00   06500   RESPI RATORY THERAPY   0   30, 580   0   0   30, 580   65, 00   66.00   06600   PHYSI CAL THERAPY   0   316, 807   0   0   316, 807   66, 00   67.00   06700   0CCUPATI ONAL THERAPY   0   316, 807   0   0   36, 277   67, 00   68.00   06800   SPEECH PATHOLOGY   0   8, 584   0   0   8, 584   68, 00   69.00   06900   ELECTROCARDI OLOGY   0   0   0   0   0   0   0   69.01   03600   ELECTROCARDI OLOGY   0   0   0   0   0   0   0   69.01   03600   ELECTROCARDI OLOGY   0   0   0   0   0   0   0   69.01   03600   ELECTROCARDI OLOGY   0   0   0   0   0   0   0   69.01   03610   SLEEP LAB   0   21, 434   0   0   21, 434   69, 01   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   0   71.10   07101   VI SOLUTI ONS   0   0   0   0   0   0   0   71.20   07200   MPL DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   0   72.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   154, 482   0   0   154, 482   76. 00   76.97   07697   CARDI ACRE CHABI LITATION   0   17, 959   0   0   17, 959    00   07900   00000   00000   0   0   0   0   17, 959    00   07900   0000   00000   0   0   0   0   0		1	0	159, 387	0	o	159, 387	60.00
66.00   06600   PHYSICAL THERAPY   0   316,807   0   0   316,807   66.00   67.00   06700   0CCUPATI ONAL THERAPY   0   36,277   0   0   36,277   67.00   68.00   06800   SPEECH PATHOLOGY   0   0   0   0   0   8,584   68.00   69.00   06900   ELECTROCARDI OLOGY   0   0   0   0   0   0   0   69.00   69.01   03610   SLEEP LAB   0   0   21,434   69.01   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   0   0   71.01   07101   V SOLUTI ONS   0   0   0   0   0   0   0   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0   76.00   03140   CARDI OLOGY   0   154,482   0   0   154,482   76.00   76.07   07697   CARDI AC REHABI LI TATI ON   0   17,959   0   0   17,959   76.97   007474   INTERT ENTIFE COST CENTERS   0   0   19,416   0   0   19,416   90.00   90.00   09000   CLI NI C   0   0   0   354,566   0   0   354,566   91.00   91.00   09100   EMERGENCY   0   0   0   0   354,456   91.00   91.00   09100   EMERGENCY   0   0   0   0   0   14,466   110.00   91.00   09100   EMERGENCY   0   0   0   0   0   14,466   110.00   91.00   09100   EMERGENCY   0   0   0   0   0   14,466   110.00   91.00   09100   EMERGENCY   0   0   0   0   0   0   0   14,466   110.00   91.00   09100   EMERGENCY   0   0   0   0   0   0   0   0   0		1	0			0		•
67.00   06700   05CUPATIONAL THERAPY   0   36,277   0   0   36,277   67,00   68.00   06800   SPEECH PATHOLOGY   0   8,584   0   0   8,584   68.00   69.01   03610   SLEEP LAB   0   0   0   0   0   0   0   69.01   03610   SLEEP LAB   0   21,434   0   0   21,434   69.00   69.01   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   71.01   07101   IV SOLUTIONS   0   0   0   0   0   0   0   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   74.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   75.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   76.00   03140   CARDI OLOGY   0   154,482   0   0   154,482   76.00   76.97   07697   CARDI AC REHABEL LITATION   0   17,959   0   0   17,959   76.97   07697   CARDI AC REHABEL LITATION   0   17,959   0   0   17,959   76.97   07697   CARDI AC REHABEL LITATION   0   19,416   0   0   19,416   90.00   79.01   09000   USUNDI CARE CLINIC   0   53,521   0   0   53,521   0   0   79.00   07900   WOUND CARE CLINIC   0   535,521   0   0   354,566   91.00   79.00   07900   WOUND CARE CLINIC   0   354,566   0   0   354,566   91.00   79.00   07900   WOUND CARE CLINIC   0   54,43   0   5,413   0   70   07900   WOUND CARE CLINIC   0   0   0   5,413   0   5,413   0   70   07900   WOUND CARE CLINIC   0   0   0   0   0   1,466   0   1,466   116.00   70   08000   WOUND   WOUND			-1			0		•
68.00   06800   SPEECH PATHOLOGY   0   8,584   0   0   8,584   68.00   69.01   03610   SLEET LAB   0   0   0   0   0   0   69.01   03610   SLEET LAB   0   0   0   0   0   71.00   07100   MEDI CAL. SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   71.01   07101   IV SOLUTIONS   0   0   0   0   0   0   71.01   07101   IV SOLUTIONS   0   0   0   0   0   0   72.00   07200   IMPL DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   76.00   03140   CARDIOLOGY   0   154, 482   0   0   154, 482   0   76.07   07697   CARDI AC REHABILLITATION   0   17, 959   0   0   17, 959   76.07   07697   CARDI AC REHABILLITATION   0   17, 959   0   0   17, 959   79.00   09000   CLI NI C   0   0   0   0   0   0   19, 416   90.00   79.01   09001   WOUND CARE CLI NI C   0   53, 521   0   0   53, 521   90.01   79.00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   0   0   354, 566   0   0   354, 566   79.00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   0   0   5, 413   0   5, 413   79.00   09500   AMBULANCE SERVI CES   0   120, 888   0   0   120, 888   95.00   79.01   ONDITE REI MBURSABLE COST CENTERS   0   0   0   5, 413   0   5, 413   79.00   19000   GIFT, FLOWER, COFFEE SHOP, & CANTEEN   0   0   0   1, 466   0   1, 466   110.00   79.01   ONDITE REI MBURSABLE COST CENTERS   0   0   0   0   0   0   0   0   0   79.01   ONDITE REI MBURSABLE COST CENTERS   0   0   0   0   0   0   0   0   0			-			0		
69.01   03610   SLEEP LAB   0   21,434   0   0   21,434   69.01     71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0     71.01   07101   IV SOLUTIONS   0   0   0   0   0   0     72.00   07200   IMPL DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   0     73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0     76.00   03140   CARDI OLOGY   0   154,482   0   0   154,482   76.00     76.97   07697   CARDI AC REHABILITATION   0   17,959   0   0   17,959     70.00   07000   CLI NI C   0   19,416   0   0   19,416   90.00     90.00   09000   CLI NI C   0   53,521   0   0   53,521   90.01     90.01   09000   O9000   OSSERVATION BEDS (NON-DISTINCT PART)   0   354,566   0   0   354,566   91.00     91.00   09500   AMBULANCE SERVI CES   0   120,888   0   0   120,888   95.00     101.00   09500   AMBULANCE SERVI CES   0   0   0   5,413   0   5,413     113.00   11300   INTEREST EXPENSE   113.00   11466   0   1,466   0   1,466   116.00     116.00   11600   HOSPICE   0   0   0   5,286,023   6,879   0   6,264,902     118.00   SUBSTOTALS (SUM OF LINES 1 through 117)   0   6,258,023   6,879   0   6,264,902     119.00   07950   OTHER NON-REI MBURSABLE   0   0   0   0   0   1,344,661   194.01     194.02   07955   MOB   MILNACE SERVI CES   0   0   0   0   0   0   0   1,466   0     194.01   07951   MOB   0   0   0   0   0   0   0   0   1,466   0   0   0     194.00   07950   OTHER NON-REI MBURSABLE   0   0   0   0   0   0   0   0   0			1			Ö		
71. 00	69. 00		0	0	0	o	0	
71. 01   07101   IV SOLUTIONS   0   0   0   0   0   71. 01   72. 00   07200   MPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   0			0	21, 434	0	0		
72. 00 07200   IMPL. DEV. CHARGED TO PATIENTS		1	0	0	0	0		
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 73. 00 76. 00 03140 CARDI OLOGY 0 154, 482 0 0 154, 482 76. 00 76. 97 07697 CARDI AC REHABILITATION 0 17, 959 0 0 17, 959 76. 97  OUTPATIENT SERVICE COST CENTERS  90. 00 09000 CLINIC 0 19, 416 0 0 19, 416 0 0 53, 521 0 0 0 354, 566 91. 00 91. 00 19001 WOUND CARE CLINIC 0 354, 521 0 0 0 354, 566 91. 00 92. 00 09200 DESERVATION BEDS (NON-DISTINCT PART) 0 0 0 354, 566 0 0 354, 566 91. 00 92. 00 09200 DESERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 120, 888 0 0 0 120, 888 95. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 54, 413 101. 00 SPECIAL PURPOSE COST CENTERS  113. 00 11300 INTEREST EXPENSE 1 0 0 1, 466 0 1, 466 116. 00 116. 00 11600 HOSPI CE SERVICES 0 0 1, 466 10 1, 466 116. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 6, 258, 023 6, 879 0 6, 264, 902 118. 00  NONREE MBURSABLE COST CENTERS  190. 00 17950 OTHER NON-REI MBURSABLE 0 0 0 1, 344, 661 0 0 1, 344, 661 194. 01 194. 01 07951 MOB 0 07952 PHYSI CI AN CLINIC S 0 0 0 0 0 0 0 0 194. 00 194. 01 07951 MOB 0 0 0 0 0 0 0 0 0 0 0 0 194. 00 194. 01 07954 MOB - MAIN CAMPUS 0 0 0 0 0 0 0 0 0 0 0 194. 00 194. 04 07954 MOB - MAIN CAMPUS 0 0 0 0 0 0 0 0 0 194. 00 194. 04 07956 (NOR - MORE) MORE IMBURSABLE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 194. 00 194. 04 07956 (NOR - MORE) MORE IMBURSABLE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1		0	0	o		
76. 97   07697   CARDI AC REHABILITATION   0   17, 959   0   0   17, 959   76. 97		07300 DRUGS CHARGED TO PATIENTS	0	0	0	o		
OUTPATIENT SERVICE COST CENTERS   O			1			0		
90. 00	76. 97		0	17, 959	0	0	17, 959	76. 97
90. 01	90. 00		0	19. 416	0	0	19, 416	90.00
92. 00			0			ō		1
OTHER REIMBURSABLE COST CENTERS   O			0	354, 566	0	0		
95. 00	92. 00						0	92.00
101. 00   10100   HOME   HEALTH   AGENCY   SPECIAL   PURPOSE   COST   CENTERS	95 00		0	120 888	0	O	120 888	95.00
SPECIAL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   113. 00   11300   INTEREST EXPENSE   113. 00   11466   0   1, 466   116. 00   1600   1								
116. 00		SPECIAL PURPOSE COST CENTERS						
118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   0   6, 258, 023   6, 879   0   6, 264, 902   118. 00								
NONREI MBURSABLE COST CENTERS  190. 00 19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 194. 00 07950 OTHER NON-REI MBURSABLE 0 0 0 0 0 194. 00 194. 00 194. 01 194. 01 07951 MOB 0 1, 344, 661 0 0 1, 344, 661 194. 01 194. 02 07952 PHYSI CI AN CLI NI CS 0 704, 941 0 0 0 704, 941 0 0 0 704, 941 194. 02 194. 03 07953 PHYS PRAC BUS OFC 0 25, 266 0 0 25, 266 194. 04 07954 MOB - MAI N CAMPUS 0 0 0 0 0 0 0 194. 04 194. 05 07955 ONCOLOGY - NONREI MBURSABLE 0 0 0 0 0 0 0 1, 102, 247 194. 06 194. 06 07956 KDH - MC FAMI LY PRACTI CE 0 1, 102, 247 194. 06				( 250 022		- 1		
190. 00   19000   GIFT, FLOWER, COFFEE SHOP, & CANTEEN   0   19, 211   0   0   19, 211   190. 00   194. 00   194. 00   1950   0   0   0   0   0   194. 00   194. 00   194. 01   194. 01   194. 02   194. 02   194. 03   194. 04   194. 05   194. 04   194. 05   194. 05   194. 06   194. 06   194. 06   194. 06   196. 07956   194. 06   196. 08	118.00		<u> </u>	6, 258, 023	6,879	U	6, 264, 902	] 118.00
194. 00     07950     OTHER NON-REI MBURSABLE     0     0     0     194. 00       194. 01     07951     MOB     0     1, 344, 661     0     0     1, 344, 661     194. 01       194. 02     07952     PHYSI CI AN CLI NI CS     0     704, 941     0     0     704, 941     194. 02       194. 03     07953     PHYS PRAC BUS OFC     0     25, 266     0     0     25, 266     194. 03       194. 04     07954     MOB - MAI N CAMPUS     0     0     0     0     194. 04       194. 06     07956     KDH - MC FAMI LY PRACTI CE     0     1, 102, 247     0     0     1, 102, 247     194. 06	190.00		0	19, 211	0	0	19, 211	190. 00
194. 02 07952 PHYSI CI AN CLI NI CS 0 704, 941 0 0 704, 941 194. 02 194. 03 07953 PHYS PRAC BUS OFC 0 25, 266 0 0 25, 266 194. 03 194. 04 07954 MOB - MAI N CAMPUS 0 0 0 0 0 194. 04 194. 05 07955 ONCOLOGY - NONREI MBURSABLE 0 0 0 0 0 194. 05 194. 06 07956 KDH - MC FAMI LY PRACTI CE 0 1, 102, 247 0 0 1, 102, 247 194. 06	194.00	07950 OTHER NON-REIMBURSABLE	1	0		ō	0	194. 00
194. 03     07953     PHYS PRAC BUS OFC     0     25, 266     0     0     25, 266     194. 03       194. 04     07954     MOB - MAI N CAMPUS     0     0     0     0     194. 04       194. 05     07955     ONCOLOGY - NONREI MBURSABLE     0     0     0     0     194. 05       194. 06     07956     KDH - MC FAMI LY PRACTI CE     0     1, 102, 247     0     0     1, 102, 247     194. 06		1	0			O		
194. 04 07954 MOB - MAIN CAMPUS 0 0 0 0 194. 04 194. 05 07955 ONCOLOGY - NONREI MBURSABLE 0 0 0 0 0 194. 05 194. 06 07956 KDH - MC FAMILY PRACTICE 0 1, 102, 247 0 0 1, 102, 247 194. 06					1	0		
194. 05 07955 ONCOLOGY - NONREI MBURSABLE 0 0 0 0 194. 05 194. 06 07956 KDH - MC FAMI LY PRACTI CE 0 1, 102, 247 0 0 1, 102, 247 194. 06				∠5, ∠66 ∩		0		
194. 06 07956 KDH - MC FAMILY PRACTICE 0 1, 102, 247 0 0 0 1, 102, 247 194. 06		1		0		o	0	194. 05
194. 07 07957 KDH - MC ORTHOPEDICS   0  0  0  0  194. 07			1	1, 102, 247	1	o		
	194. 0	7 07957 KDH - MC ORTHOPEDICS	0	0	0	이	0	194. 07

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 01/01/2020 To 12/31/2020	Worksheet B Part II Date/Time Prepared:

					5/24/2021 11:	00 am
		CAPI TAL RELATED COSTS				
Cost Center Description	Di rectly	NEW BLDG &	NEW BLDG &	NEW MVBLE	Subtotal	
	Assigned New	FLXT	FIXT HHA/HO	EQUI P		
	Capi tal					
	Related Costs					
	0	1.00	1. 01	2. 00	2A	
194.08 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)	0	9, 454, 349	6, 879	0	9, 461, 228	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2020 Part II
To 12/31/2020 Date/Time Prepared:
5/24/2021 11:00 am

Description					0 12/31/2020	5/24/2021 11:	
Company	Cost Center Description					HOUSEKEEPI NG	
ENTIRED SEPOND CHAT CHUTTES   1.09   5.99   7.90   8.00   9.90			& GENERAL	PLAN I	LINEN SERVICE		
1.00   00100/REX CAP HEL COSTS-PLEUX & FIXT MAY-MO   1.00   00100/REX CAP EL COSTS-PLEUX & FIXT MAY-MO   1.00			5. 00	7.00	8. 00	9. 00	
1.00   00100  IMPRI CAP BIT COSTS, BIRD & FIXT HAVAID   0.00   00000  CAPPE (CYFE PERFEIT S DEPARTMENT   0.00   0.0000  CAPPE (CYFE PERFEIT S CYFE PERFEIT S DEPARTMENT   0.00   0.0000  CAPPE (CYFE PERFEIT S CYFE PERFEIT S CY							
2.00							1
4.00   00000   MARIN SINGTIVE & DELPISIMEN   0   1,111,680   1,100,225   1,000,200   1,100,200   1,0							1
5.00   DOSEDIAL MINISTRATIVE & GENERAL   0   1.111, 648   1.00				•			•
2.00   DOTORD DEPENTED NO PLANES   0.00			1, 111, 648				
9.00   0.0000   NUSERCEPT NG				1			•
0.000   OLFTARY   0		(		1			•
11.00 0 1100 CAFETERIA 0 1,101 9,744 0 0 113.00 13.10 13.00		(		l			1
13.00   01300   MIRSTRAT ABUNIN STRATION   0   7,374   7,903   0   0   13.00				l			1
14 00   01400  CENTRAL SERVICES & SUPPLY   0   2,000   11,884   0   1.60   15,00   15,	1 1	-		l	0		•
15.00   01500   PHARMACY   0   21,278   8,101   0   0   16.00   10.0	1 1	1		l	0		1
19.00   01900   NOMPHYSICIAN AMESTHETISTS   0   0   0   0   0   0   0   0   0	· · · · · · · · · · · · · · · · · · ·			1	0		1
23 00   03000   ADD ILLORY SCHOOL   0   1,642   2,531   0   27   23 00	· •		11, 575	1, 118	0		1
NAME   MARCH	1 1			_	0		1
30.00		(	) 1, 642	2, 531	0	297	23.00
31.00   03100   INTENSIVE CARE UNIT   0   17, 660   6, 400   0   3,800   31.00   34.00   03.00   03400   03.			70.053	144 789	22 110	36.059	30 00
0   0.4300   NUBSERY   0   7, 569   7, 485   0   4.30   4.30		1	1	1			
50.00			1	1	0		1
15.00   05100 RECOVERY ROOM   0   4,811   5,244   1,559   0   51,05   52,00   52,00   05200 DELIVERY ROOM   0   9,488   0   1,617   1,305   52,00   52,00   05300 ANESTHESI OLOGY   0   6,873   498   0   0,0   53,00   52,00   05300 ANESTHESI OLOGY   0   37,382   41,507   4,172   1,431   54,00   40,00   55,00   65,00							
52 00   05200   DELIVERY ROOM & LABOR ROOM   0   9,488   0   1,617   1,305   52. 00   53. 00   53.00   05300   MESTHESI OLGY   0   6.873   448   0   0   53. 00   53. 00   53.00   05300   MESTHESI OLGY   0   37. 382   41,507   4,172   1,431   54. 00   0   54. 01   03450   MUTEA SOUNDED   0   20   0   0   0   0   0   0   0				1			
53 00   085300   ARESTHESI OLOGY   0   6,873   498   0   0   53 00				l			
1.4		-		1	.,		•
54. 01   03630   ULTRA SOUND   0   2, 401   0   461   539   54. 01   54. 02   03650   NUCLEAR MEDI CINE - DI AGNOSTIC   0   3, 233   1, 849   242   105   54. 02   55. 00   05500   NUCLEAR MEDI CINE - DI AGNOSTIC   0   0   0   0   0   0   55. 00   55. 00   05500   NUCLEAR MEDI CINE - DI AGNOSTIC   0   27.215   46, 890   2, 091   3, 586   55. 01   03480   NOCLOGY   1, 288   219   57. 00   05700   CT SCAN   1, 288   219   57. 00   0   0   0   0   0   0   0   0   0				1			
54 02   03450   NUCLEAR MEDICINE - DIAGNOSTIC   0   3, 233   1, 849   242   105   54. 02   055. 00   0550. 00   0500   0   0   0   0   0   0   0		-					
55.00   03480   ONCOLOCY   O   27,215   46,890   2,091   3,586   55.01				1			•
57.00   05700   CT SCAN   0   5.728   3.427   2.158   219   57.00     58.00   05800   MAGNETIC RESONANCE I IMAGI NS (MRI )	55. 00   05500   RADI OLOGY - THERAPEUTI C		0	0	0	0	55. 00
S8 00   OSBOO   MAGNETIC RESOMANCE IMAGINO (MRI)   0   4,228   4,135   413   543   58.0   059.00   0590   0   0   0   0   0   0   0   0   0		(		l			•
S9-00   OSPOOL CARDIAC CATHETER ZATION   0   0   0   0   0   0   59-00		(		l			•
60.00   0.0000   LABORATORY   0					413		•
Color   Colo		-	-	1 ~	0		•
65.00   06500   RESPIRATORY THERAPY   0   11,079   4,583   0   0   65.00	1 1			l	0		•
66.00   06600   PHYSI CAL THERAPY   0   22, 941   47, 479   1, 807   1, 302   66.00   67.00   06700   06700   06700   06700   06700   06700   06700   06700   06700   06700   06700   06800   06900   06900   06900   06900   06900   06900   06900   0   0   0   0   0   0   0   0   0	1 1	-		l			•
68.00   06800   SPECCH PATHOLOGY   0   2, 109   1,286   0   0   68.00   0   09.00   069.00   06900   ELCTROCARDIOLOGY   0   0   0   0   0   0   0   0   0	1 1			l		1, 392	1
69.00   06900   ELECTROCARDI OLOGY   0   0   0   0   0   0   0   0   0	67.00 06700 OCCUPATIONAL THERAPY		3, 721	5, 437	0	0	67. 00
69.01   03410   SLEEP LAB   0   2, 865   3, 212   147   849   69, 01   71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   31, 149   0   0   0   0   71. 00   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   41, 504   0   0   0   0   72. 00   73. 00   073. 00   073. 00   073. 00   073. 00   073. 00   073. 00   073. 00   073. 00   073. 00   073. 00   075. 00   0	1 1	(	2, 109	1	0		1
71. 00   07100   MCDI CAL. SUPPLIES CHARGED TO PATIENTS   0   31, 149   0   0   0   0   71, 00   710, 00   710, 01	1 1		0		0		1
71.01   07101   V SOLUTIONS   0   1,165   0   0   0   71.01     72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   41,504   0   0   0   0   72.00     73.00   07300   DRUGS CHARGED TO PATIENTS   0   109,592   0   0   0   0   73.00     76.00   03140   CARDI OLOGY   0   11,301   23,152   2,833   2,114   76.00     76.97   O7697   CARDI AC REHABILITATI ON   0   1,284   2,692   0   584     76.97   O7697   CARDI AC REHABILITATI ON   0   1,284   2,692   0   584     76.97   O7697   CARDI AC REHABILITATI ON   0   1,175   2,910   0   115     90.01   09000   CLINI C   0   2,804   8,021   120   295   90.01     90.01   09000   WOUND CARE CLINI C   0   39,730   53,138   9,778   13,007   91.00     91.00   09100   EMERGENCY   0   39,730   53,138   9,778   13,007   91.00     92.00   09520   AMBULANCE SERVI CES   0   27,687   18,117   943   0   95.00     07500   AMBULANCE SERVI CES   0   27,687   18,117   943   0   95.00     101.00   10100   HOME HEALTH AGENCY   0   15,584   10,521   0   0   0110.00     SPECIAL PURPOSE COST CENTERS   113.00     113.00   11300   11300   INTRERST EXPRISE   113.00     110.00   1000   HOME HEALTH AGENCY   0   761,587   627,234   60,211   88,319     110.00   1000   HOME HBURSABLE COST CENTERS   110,000     110.00   1000   HOME HBURSABLE COST CENTERS   110,000     110.00   1000   HOME HBURSABLE COST CENTERS   10,000   10,000     110.00			_, _, _,	1	147		1
72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0 41,504 0 0 0 72. 00 73. 00 73. 00 73.00 074.00 0				i	0		1
73.00   07300   DRUGS CHARGED TO PATIENTS   0   109, 592   0   0   0   73.00   76.00   03140   CARDI OLOGY   0   11.301   23, 152   2,833   2,114   76.00   76.97   07697   CARDI OLOGY   0   1,284   2,692   0   584   76.97   07697   CARDI OLOGY   0   1,284   2,692   0   584   76.97   07697   CARDI OLOGY   0   0   1,284   2,692   0   584   76.97   07697   CARDI OLOGY   0   0   1,284   2,692   0   584   76.97   07697   CARDI OLOGY   0   0   1,15   90.00   0900   UNIO CARE CLINIC   0   2,804   8,021   120   295   90.01   91.00   92.00   08ERGENCY   0   39,730   53,138   9,778   13,007   91.00   92.00   08ERGENCY   0   39,730   53,138   9,778   13,007   91.00   92.00   08ERGENCY   0   0716   0   0   0   0   0   0   0   0   0	1 1			1	0		1
76. 97				1	0	0	
OUTPATIENT SERVICE COST CENTERS   OUTPATIENT SERVICES   OU							
90. 00   09000   CLINIC   0   1,175   2,910   0   115   90. 00   90. 01   09001   wound care clinic   0   2,804   8,021   120   295   90. 01   91. 00   09100   EMERGENCY   0   39,730   53,138   9,778   13,007   91. 00   91. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   92. 00   09500   AMBULANCE SERVICES   0   27,687   18,117   943   0   95. 00   101. 00   10100   HOME HEALTH AGENCY   0   15,584   10,521   0   0   101. 00   10100   HOME HEALTH AGENCY   0   15,584   10,521   0   0   101. 00   113. 00   113.00   113.00   11300   INTEREST EXPENSE   113.00   11600   HOSPICE   0   3,026   2,849   0   0   116. 00		(	1, 284	2, 692	0	584	76. 97
90. 01   09001   WOUND CARE CLINIC   0   2,804   8,021   120   295   90. 01   91. 00   92.00   DESERVATION BEDS (NON-DISTINCT PART)   92. 00   09200   BSERVATION BEDS (NON-DISTINCT PART)   92. 00   079200   DESERVATION BEDS (NON-DISTINCT PART)   943   0   95. 00   07950   DESERVATION BEDS (NON-DISTINCT PART)   943   0   95. 00   07950   DESERVATION BEDS (NON-DISTINCT PART)   943   0   95. 00   07950   DESERVATION BEDS (NON-DISTINCT PART)   943   0   95. 00   07950   DESERVATION BEDS (NON-DISTINCT PART)   943   0   95. 00   07950   DESERVATION BEDS (NON-DISTINCT PART)   943   0   95. 00   07950   DESERVATION BEDS (NON-DISTINCT PART)   943   0   95. 00   07950   DESERVATION BEDS (NON-DISTINCT PART)   943   0   95. 00   07950   DESERVATION BEDS (NON-DISTINCT PART)   943   0   95. 00   07950   DESERVATION BEDS (NON-DISTINCT PART)   943   0   95. 00   07950   DESERVATION BEDS (NON-DISTINCT PART)   943   0   95. 00   07950   DESERVATION BEDS (NON-DISTINCT PART)   943   0   95. 00   0   0   0   0   0   0   0   0   0		1 /	1 175	2.010	0	115	00.00
91. 00   09100   EMERGENCY   0   39, 730   53, 138   9, 778   13, 007   91. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   0   20. 00   0   0   0   0   0   0   0   0							
92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   070   0			1				
95. 00 101. 00		1	07,700	30,100	,,	10,007	
101.00   10100   HOME   HEALTH AGENCY   0   15,584   10,521   0   0   101.00							
SPECIAL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   0   3, 026   2, 849   0   0   116. 0							
113. 00		(	15, 584	10, 521	0	0	101. 00
116. 00   116000   11600   11600   11600   11600   11600   11600   11600   11600   11600   11600   11600   1		1		1			112 00
118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   0   761, 587   627, 234   60, 211   88, 319   118. 00   NONREI MBURSABLE COST CENTERS   190. 00   190. 00   190. 00   194.			3 026	2 849	0	n	
NONRE   MBURSABLE   COST   CENTERS     CENTERS     CENTERS   CENTERS   COST   CENTERS   CENTER							
194. 00 07950 OTHER NON-REIMBURSABLE 0 1, 977 0 0 0 194. 00 194. 01 194. 01 194. 01 194. 02 17951 MOB 0 62, 810 201, 522 139 0 194. 01 194. 02 17952 PHYSI CI AN CLI NI CS 0 98, 496 105, 649 284 7, 196 194. 02 194. 03 19795 PHYSI CI AN CLI NI CS 0 17, 955 3, 787 0 107 194. 03 194. 04 07954 MOB - MAI N CAMPUS 0 5,586 0 0 184 194. 04 194. 05 07955 ONCOLOGY - NONREI MBURSABLE 0 0 0 0 0 194. 05 194. 05 194. 06 19795 ONCOLOGY - NONREI MBURSABLE 0 0 53,700 165, 192 7 5,787 194. 06 194. 07 19795 KDH - MC FAMI LY PRACTI CE 0 40,457 0 89 3, 402 194. 07 194. 08 19795 KDH - MC GENERAL SURGERY 0 21,697 0 141 2,588 194. 08 194. 09 19795 KDH - MC ENT				5=17=51		22/21/	
194. 01 07951 MOB  194. 02 07952 PHYSI CI AN CLI NI CS  194. 03 07953 PHYS PRAC BUS OFC  194. 04 07954 MOB - MAI N CAMPUS  194. 05 07955 ONCOLOGY - NONREI MBURSABLE  194. 06 07956 KDH - MC FAMI LY PRACTI CE  194. 07 07957 KDH - MC ORTHOPEDI CS  194. 09 07958 KDH - MC GENERAL SURGERY  194. 09 07959 KDH - MC ENT  0 62, 810 201, 522 139 0 194. 01  194. 01  194. 02  194. 03  195. 649  195. 649  195. 649  196. 649  197. 955  3, 787  0 107, 195. 03  195. 649  197. 00  198. 496  197. 195. 649  198. 00  199. 01  199. 01  199. 01  199. 01  199. 01  199. 01  199. 02  199. 03  199. 03  199. 01  199. 01  199. 02  199. 03  199. 03  199. 01  199. 02  199. 03  199. 03  199. 03  199. 05  199. 05  199. 05  199. 07  199. 08  199. 09  199. 0	190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	(	239	2, 879	0		
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 194. 09 07959 KDH - MC ENT 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  0 0 5, 586  0 0 0 184 194. 05  194. 06 07956 KDH - MC FAMI LY PRACTI CE  0 53, 700  194. 07 07957 KDH - MC ORTHOPEDI CS  194. 08 07958 KDH - MC GENERAL SURGERY  194. 09 07959 KDH - MC ENT  0 17, 955  3, 787  0 0 0 184 194. 09  194. 09  195. 09  196. 09  197. 09  198. 09  198. 09  199. 09	· · · · · · · · · · · · · · · · · · ·	(		1			
194. 04 07954 MOB - MAIN 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. 05 07955 ONCOLOGY - NONREI MBURSABLE 0 0 53,700 165, 192 7 5,787 194. 06 194. 07 07957 KDH - MC ORTHOPEDI CS 0 21,697 0 141 2,588 194. 08 194. 09 07958 KDH - MC ENT 0 8,719 0 0 1,539 194. 09				1			
194. 06 07956 KDH - MC FAMILY PRACTICE 0 53, 700 165, 192 7 5, 787 194. 06 194. 07 07957 KDH - MC ORTHOPEDICS 0 40, 457 0 89 3, 402 194. 07 194. 08 07958 KDH - MC GENERAL SURGERY 0 21, 697 0 141 2, 588 194. 08 194. 09 07959 KDH - MC ENT 0 8, 719 0 0 1, 539 194. 09		-		1	n		
194. 07 07957 KDH - MC ORTHOPEDICS 0 40, 457 0 89 3, 402 194. 07 194. 08 07958 KDH - MC GENERAL SURGERY 0 21, 697 0 141 2, 588 194. 08 194. 09 07959 KDH - MC ENT 0 8, 719 0 0 1, 539 194. 09		-	-	165, 192	7		
194. 09 07959 KDH - MC ENT 0 8, 719 0 0 1, 539 194. 09	194.07 07957 KDH - MC ORTHOPEDICS			1		3, 402	194. 07
				1		2, 588	194. 08
194. TU U/96U KUH - MC URULUGY   0  6, 038  0  0  2, 397   194. 10					_	1, 539	194. 09
	194. TUJU / 960 KDH - MC URULOGY	(	ار 6, 038	0	0	2, 397	1194. 10

Health Financial Systems	KING'S DAUGHTE	RS'	HOSPI TAL			In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		1	Provider CO	N: 15-0069	Peri od:		Worksheet B	
					From 01/0	1/2020	Part II	
					To 12/3	1/2020	Date/Time Pre	pared:
							5/24/2021 11:	00 am
Cost Center Description	EMPLOYEE	ADMI	NI STRATI VE	OPERATION O	F LAUND	RY &	HOUSEKEEPI NG	
	BENEFITS	&	GENERAL	PLANT	LINEN S	ERVI CE		

						5/24/2021 11:	<u>uu aiii </u>
	Cost Center Description	EMPLOYEE	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		BENEFITS	& GENERAL	PLANT	LINEN SERVICE		
		DEPARTMENT					
		4. 00	5. 00	7. 00	8. 00	9. 00	
194. 11 07961	KDH - MC OB/GYN	0	32, 387	0	346	2, 943	194. 11
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers	0	0	0	0	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	0	1, 111, 648	1, 106, 263	61, 217	114, 462	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2020 Part II
To 12/31/2020 Date/Time Prepared:
5/24/2021 11:00 am

					12/31/2020	5/24/2021 11:	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
				ADMI NI STRATI ON	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 2. 00	00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.01
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY	198, 448					10. 00
11. 00	01100 CAFETERI A	0	67, 425				11. 00
13. 00	01300 NURSING ADMINISTRATION	0	1, 017				13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	487		94, 349	02 502	14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	1, 721 2, 086		340 80	92, 592 0	15. 00 16. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	2,000	1	0	0	1
23. 00	02300 RADI OLOGY SCHOOL	l ol	355	1	17	0	1
	INPATIENT ROUTINE SERVICE COST CENTERS	,		, · · · · · · · · · · · · · · · · · · ·	,		
30.00	03000 ADULTS & PEDIATRICS	183, 782	12, 882	28, 532	2, 243	0	30. 00
31.00	03100 INTENSIVE CARE UNIT	14, 666	2, 610		12	0	
43.00	04300 NURSERY	0	1, 300	2, 880	0	0	43. 00
FO 00	ANCILLARY SERVICE COST CENTERS		, 050	10.040	0.447		50.00
50. 00 51. 00	05000 OPERATING ROOM	0	6, 250		2, 447	0	50.00 51.00
52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	687 1, 776		48 0	0	52.00
53. 00	05300 ANESTHESI OLOGY	0	549		164	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	o	5, 150		587	0	
54. 01	03630 ULTRA SOUND	0	255		343	0	1
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	183	0	13	0	54. 02
55.00	05500 RADI OLOGY - THERAPEUTI C	0	0	-	0	0	55. 00
55. 01	03480 ONCOLOGY	0	2, 372		510	0	55. 01
57. 00	05700 CT SCAN	0	454		1, 550	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	352	1	223	0	58.00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	6, 414	'l "I	0  517	0	59. 00 60. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0, 414		0	0	62.00
65. 00	06500 RESPI RATORY THERAPY	o	2, 026	·	34	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	o	3, 553		106	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	O	440	0	3	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	280	0	1	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	1	0	0	69. 00
69. 01	03610 SLEEP LAB	0	255		10	0	
71. 00 71. 01	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07101 V SOLUTIONS	0	0		33, 545 1, 255	0	
71.01	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		1, 255 44, 697	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	o o	0		603	92, 592	1
76. 00	03140 CARDI OLOGY	o	1, 481		64	0	1
76. 97	07697 CARDIAC REHABILITATION	0	232		6	0	
	OUTPATIENT SERVICE COST CENTERS						
90.00		0	165		4	0	
90. 01	09001 WOUND CARE CLINIC	0	219		84	0	
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	5, 315	11, 770	661	0	91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS						92.00
95. 00	09500 AMBULANCE SERVICES	0	6, 559	0	85	0	95. 00
	10100 HOME HEALTH AGENCY	Ö	0,000		407		101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113. 00
	11600 H0SPI CE	0	0	0	2		116. 00
118.00	, ,	198, 448	67, 425	68, 259	90, 661	92, 592	118. 00
100.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN		0	ol	ol	0	190. 00
	07950 OTHER NON-REIMBURSABLE	0	0		10		190.00
	07951 MOB		0		371		194. 00
	07952 PHYSI CI AN CLI NI CS	o	0	o o	1, 090		194. 02
	07953 PHYS PRAC BUS OFC		0	ol ol	115		194. 03
194. 04	07954 MOB - MAIN CAMPUS	o	0	0	82		194. 04
	07955 ONCOLOGY - NONREI MBURSABLE	0	0	0	o		194. 05
	07956 KDH - MC FAMILY PRACTICE	0	0	0	381		194. 06
	7 07957 KDH - MC ORTHOPEDICS	0	0	0	553		194. 07
194.08	07958 KDH - MC GENERAL SURGERY 07959 KDH - MC ENT	0	0		473		194. 08 194. 09
	007959 KDH - MC ENT 007960 KDH - MC UROLOGY	0	0	1	113 202		194. 09
174.10	NO OKOLOGI	<u>ı</u> 9		. <sub>1</sub>	202	0	1177.10

Health Financial Systems	KING'S DAUGHTER	RS' HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CC		Period: From 01/01/2020 To 12/31/2020	Worksheet B Part II Date/Time Pre 5/24/2021 11:	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	

						5/24/2021 11:	00 am_
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
				ADMI NI STRATI ON	SERVICES &		
					SUPPLY		
		10.00	11. 00	13. 00	14. 00	15. 00	
194. 11 07961	KDH - MC OB/GYN	0	0	0	298	0	194. 11
200. 00	Cross Foot Adjustments						200.00
201. 00	Negative Cost Centers	0	8, 437	0	0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	198, 448	75, 862	68, 259	94, 349	92, 592	202.00

| Peri od: | Worksheet B | From 01/01/2020 | Part | I | To | 12/31/2020 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0069

					To 12/31/2020	Date/Time Pre 5/24/2021 11:	
	Cost Center Description	MEDI CAL	NONPHYSI CI AN	RADI OLOGY	Subtotal	Intern &	
		RECORDS &	ANESTHETI STS	SCH00L		Residents Cost & Post	
		LI BRARY				Stepdown	
						Adjustments	
	OFNEDAL CEDIU OF COCT OFNEDO	16. 00	19. 00	23. 00	24. 00	25. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT			<u> </u>			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 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPING						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							14. 00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	22, 319					15. 00 16. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	22, 319	0				19.00
23. 00	1 1	Ö		21, 72	9		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	1 1	690			1, 467, 247	0	
31. 00	1 1	276	l e		93, 979	0	1
43. 00	04300 NURSERY ANCI LLARY SERVICE COST CENTERS	105			69, 713	0	43.00
50. 00		2,006			638, 674	0	50.00
51. 00		371			49, 389	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	140	l e		18, 259	0	
53. 00	· ·	430			11, 835	0	
54. 00	1 1	517			367, 700	0	1
54. 01 54. 02	03630 ULTRA SOUND 03450 NUCLEAR MEDICINE - DIAGNOSTIC	142 368			4, 141 18, 332	0	
55. 00	05500 RADI OLOGY - THERAPEUTI C	0			10, 332	0	
55. 01	03480 ONCOLOGY	475			396, 012	Ō	
57.00	05700 CT SCAN	1, 257			37, 657	0	
58. 00		280			37, 765	0	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0			0	0	
60. 00 62. 00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2, 607 158			246, 063 11, 602	0	
65. 00	06500 RESPIRATORY THERAPY	470	l .		48, 772	Ö	
66. 00	06600 PHYSI CAL THERAPY	617			394, 702	Ō	
67. 00	06700 OCCUPATI ONAL THERAPY	94			45, 972	0	
68. 00	06800 SPEECH PATHOLOGY	43			12, 303	0	1
69. 00	06900 ELECTROCARDI OLOGY	0			0	0	
69. 01 71. 00	03610 SLEEP LAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	107 797			28, 879 65, 491	0 0	1
71. 00	1 1	245			2, 665	l	
72. 00	1 1	1, 062			87, 263	l	1
73.00	07300 DRUGS CHARGED TO PATIENTS	5, 937			208, 724		
76. 00		810			196, 237	0	
76. 97	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	27			22, 784	0	76. 97
90. 00		4			23, 789	0	90.00
90. 01	1 1	23			65, 087	Ö	
91.00	1 1	1, 838			489, 803	0	91.00
92. 00						0	92. 00
05.00	OTHER REIMBURSABLE COST CENTERS	400	I		474 700		05.00
95.00	09500 AMBULANCE SERVICES 0 10100 HOME HEALTH AGENCY	423 0	l e		174, 702 31, 925		95. 00 101. 00
101.00	SPECIAL PURPOSE COST CENTERS	0			31, 923	0	1101.00
113.00	0 11300   NTEREST EXPENSE						113. 00
	11600 HOSPI CE	0			7, 343		116. 00
118.00		22, 319	0		0 5, 374, 809	0	118. 00
100.04	NONREIMBURSABLE COST CENTERS D 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0			22.220	^	190. 00
	007950 OTHER NON-REIMBURSABLE	0	l .		22, 329 1, 987		194. 00
	1 07951 MOB	0	l		1, 609, 503		194. 00
	2 07952 PHYSI CI AN CLI NI CS	Ö			917, 656	l	194. 02
	3 07953 PHYS PRAC BUS OFC	0			47, 230	0	194. 03
194.0	4 07954 MOB - MAIN CAMPUS	0			5, 852		194. 04
194. 0	5 07955 ONCOLOGY - NONREI MBURSABLE	0			0		194. 05
	607956 KDH - MC FAMILY PRACTICE 707957 KDH - MC ORTHOPEDICS	0	l .		1, 327, 314		194. 06 194. 07
	BO7958 KDH - MC GENERAL SURGERY	0	l e		44, 501 24, 899		194. 07
. , 1. 00	alaria de la concenti	<u> </u>	1	1	27,077	1 0	1.,1.00

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	From 01/01/2020	Worksheet B Part II Date/Time Prepared:

				10 12/31/2020	5/24/2021 11:	
Cost Center Description	MEDI CAL	NONPHYSI CI AN	RADI OLOGY	Subtotal	Intern &	
	RECORDS &	ANESTHETI STS	SCH00L		Residents Cost	
	LI BRARY				& Post	
					Stepdown	
					Adjustments	
	16. 00	19. 00	23. 00	24.00	25. 00	
194.09 07959 KDH - MC ENT	0			10, 371	0	194. 09
194.10 07960 KDH - MC UROLOGY	0			8, 637	0	194. 10
194.11 07961 KDH - MC OB/GYN	0			35, 974	0	194. 11
200.00 Cross Foot Adjustments		0	21, 729	9 21, 729	0	200. 00
201.00 Negative Cost Centers	0	0	(	8, 437	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	22, 319	0	21, 72	9, 461, 228	0	202. 00

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 01/01/2020 Part II | To 12/31/2020 Date/Time Prepared: 5/24/2021 11: 00 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0069

		5/24/2021 11:00 am	
Cost Center Description	Total	372472021 11. 00 dill	
	26. 00		
GENERAL SERVICE COST CENTERS			00
1.00   00100   NEW CAP REL COSTS-BLDG & FIXT		1.0	
2.00   00200   NEW CAP REL COSTS-MVBLE EQUIP		2.0	
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT		4.0	
5. 00 00500 ADMINISTRATIVE & GENERAL		5. 0	
7.00 00700 OPERATION OF PLANT		7.0	00
8.00   00800 LAUNDRY & LINEN SERVICE		8.0	00
9. 00   00900   HOUSEKEEPI NG		9.0	
10. 00   01000   DI ETARY		10.0	
11. 00   01100   CAFETERI A		11. (	
13. 00   01300   NURSI NG ADMI NI STRATI ON 14. 00   01400   CENTRAL   SERVI CES & SUPPLY		13. 0	
14. 00   01400   CENTRAL SERVI CES & SUPPLY 15. 00   01500   PHARMACY		14. C   15. C	
16. 00   01600   MEDI CAL RECORDS & LI BRARY		16. 0	
19. 00 01900 NONPHYSI CI AN ANESTHETI STS		19. 0	
23. 00   02300   RADI OLOGY   SCHOOL		23.0	
INPATIENT ROUTINE SERVICE COST CENTERS			
30. 00 03000 ADULTS & PEDI ATRI CS	1, 467, 247	30. C	00
31.00 03100 INTENSIVE CARE UNIT	93, 979	31.0	
43. 00   04300   NURSERY	69, 713	43. 0	00
ANCILLARY SERVICE COST CENTERS	(20 (74	50.6	00
50. 00   05000   0PERATING ROOM 51. 00   05100   RECOVERY ROOM	638, 674 49, 389	50. C 51. C	
52. 00   05100   RECOVERY ROOM	18, 259	52.0	
53. 00   05300   ANESTHESI OLOGY	11, 835	53.0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	367, 700	54. 0	
54. 01   03630 ULTRA SOUND	4, 141	54. 0	
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	18, 332	54. 0	02
55. 00   05500   RADI OLOGY - THERAPEUTI C	0	55. C	
55. 01   03480   0NC0L0GY	396, 012	55. C	
57. 00   05700   CT   SCAN	37, 657	57. 0	
58. 00   05800   MAGNETI C RESONANCE I MAGING (MRI)	37, 765	58. 0	
59. 00   05900   CARDI AC CATHETERI ZATI ON 60. 00   06000   LABORATORY	0 246, 063	59. C	
62. 00   06200   LABORATORY   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS	11, 602	62.0	
65. 00 06500 RESPIRATORY THERAPY	48, 772	65. 0	
66. 00   06600   PHYSI CAL THERAPY	394, 702	66.0	
67. 00 06700 OCCUPATI ONAL THERAPY	45, 972	67.0	
68.00 06800 SPEECH PATHOLOGY	12, 303	68.0	00
69. 00 06900 ELECTROCARDI OLOGY	0	69.0	
69. 01   03610   SLEEP LAB	28, 879	69.0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	65, 491	71. 0	
71. 01   07101   IV SOLUTIONS 72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS	2, 665 87, 263	71. C   72. C	
73. 00 07300 DRUGS CHARGED TO PATIENTS	208, 724	72. 0	
76. 00 03140 CARDI OLOGY	196, 237	76.0	
76. 97 07697 CARDI AC REHABI LI TATI ON	22, 784	76.9	
OUTPATIENT SERVICE COST CENTERS			
90. 00 09000 CLI NI C	23, 789	90. 0	
90. 01   09001   WOUND CARE CLINIC	65, 087	90.0	
91. 00   09100   EMERGENCY	489, 803	91. 0	
92. 00   09200   0BSERVATI ON BEDS (NON-DI STINCT PART)		92.0	JU
OTHER REI MBURSABLE COST CENTERS  95. 00 09500 AMBULANCE SERVI CES	174, 702	95. 0	$\cap$
101.00 10100 HOME  HEALTH AGENCY	31, 925	101.0	
SPECIAL PURPOSE COST CENTERS	51, 725	101. 0	55
113. 00 11300   NTEREST EXPENSE		113. 0	00
116. 00 11600 HOSPI CE	7, 343	116. 0	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	5, 374, 809	118. C	00
NONREI MBURSABLE COST CENTERS			
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	22, 329	190. C	
194. 00 07950 OTHER NON-REI MBURSABLE	1, 987	194. 0	
194. 01 07951 MOB	1, 609, 503	194. 0	
194. 02 07952 PHYSI CLAN CLINI CS	917, 656	194. C 194. C	
194. 03 07953 PHYS PRAC BUS OFC 194. 04 07954 MOB - MAIN CAMPUS	47, 230 5, 852	194. C   194. C	
194. 04 07954 MOB - MAIN CAMPUS 194. 05 07955 ONCOLOGY - NONREI MBURSABLE	5, 852	194. (	
194. 06 07956 KDH - MC FAMILY PRACTICE	1, 327, 314	194. 0	
194. 07 07957 KDH - MC ORTHOPEDICS	44, 501	194. 0	
194. 08 07958 KDH - MC GENERAL SURGERY	24, 899	194. 0	
194. 09 07959 KDH - MC ENT	10, 371	194. 0	
194.10 07960 KDH - MC UROLOGY	8, 637	194. 1	
194. 11 07961 KDH - MC OB/GYN	35, 974	194. 1	
200.00 Cross Foot Adjustments	21, 729	200. 0	<u>00</u>

Health Fin	ancial Systems	KING'S DAUGHTERS'	HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATI ON	I OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0069	Peri od: From 01/01/2020 To 12/31/2020	Worksheet B Part II Date/Time Pre 5/24/2021 11:	
	Cost Center Description	Total	'				
		26. 00					
201.00	Negative Cost Centers	8, 437					201. 00
202. 00	TOTAL (sum lines 118 through 201)	9, 461, 228					202. 00

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

					To 12/31/202	0 Date/lime Pre 5/24/2021 11:	
		CAPI	TAL RELATED CO	STS			
	Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	NEW BLDG & FIXT HHA/HO (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
		1.00	1. 01	2.00	4. 00	5A	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT	370, 078					1.00
1. 01 2. 00	OO101   NEW CAP REL COSTS-BLDG & FLXT HHA/HO   OO200   NEW CAP REL COSTS-MVBLE EQUIP	O	3, 492	1	0		1. 01 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0		0 50, 542, 64	7	4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	43, 514	0		0 6, 585, 95	•	5. 00
7.00	00700 OPERATION OF PLANT	41, 115	0		0 549, 52	l .	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 906	0		0 28, 20	I	8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	3, 341 6, 293	0		0 673, 45 0 519, 99	I	9. 00 10. 00
11. 00	01100 CAFETERI A	2, 545	0		0 190, 61	I	11. 00
13.00	01300 NURSING ADMINISTRATION	2, 038	0		0 440, 93	0 0	13. 00
14.00	01400 CENTRAL SERVI CES & SUPPLY	3, 096	0	•	0 85, 04	I	14. 00
15.00	01500 PHARMACY	2, 301	0		0 735, 04	1	15.00
16. 00 19. 00	O1600   MEDICAL RECORDS & LIBRARY   O1900   NONPHYSICIAN ANESTHETISTS	292	0		0 532, 26 0	1 0	16. 00 19. 00
23. 00	02300 RADI OLOGY SCHOOL	661	0		0 128, 28	-	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	37, 817	0		0 4, 037, 13	I	30. 00
31. 00 43. 00	03100 I NTENSI VE CARE UNIT 04300 NURSERY	1, 674 1, 955	0		0 1, 118, 90 0 446, 25	l e e e e e e e e e e e e e e e e e e e	31. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	1, 755	U		0 440, 20	5  0	43.00
50.00	05000 OPERATING ROOM	18, 436	0		0 2, 004, 04	5 0	50. 00
51. 00	05100 RECOVERY ROOM	1, 375	0		0 283, 34	I	51. 00
52. 00 53. 00	05200   DELI VERY ROOM & LABOR ROOM   05300   ANESTHESI OLOGY	0 130	0		0 609, 38 0 1, 249, 09		52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	10, 841	0		0 2, 970, 70		54. 00
54. 01	03630 ULTRA SOUND	0	0		0 115, 61		54. 01
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	483	0		0 74, 29	l e	54. 02
55. 00	O5500   RADI OLOGY - THERAPEUTI C   O3480   ONCOLOGY	12 247	0		-	0	55. 00 55. 01
55. 01 57. 00	05700 CT SCAN	12, 247 895	0	ŀ	0 897, 77 0 146, 59		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 080	0		0 149, 28	l .	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0 0	59. 00
60.00	06000 LABORATORY	6, 239	0		0 1, 488, 01	I	60.00
62. 00 65. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPIRATORY THERAPY	279 1, 197	0	•	0 0 670, 92	0 0	62. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	12, 401	0	•	0 1, 233, 94		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 420	0		0 211, 48	8 0	67. 00
68. 00	06800 SPEECH PATHOLOGY	336	0		0 130, 31		68. 00
69. 00 69. 01	06900  ELECTROCARDI OLOGY   03610  SLEEP LAB	0 839	0		0 115, 99	0 0	69. 00 69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	000	0		0	0 0	71. 00
71. 01	07101 IV SOLUTIONS	0	0		0	0 0	71. 01
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
73. 00 76. 00	O7300   DRUGS CHARGED TO PATIENTS   O3140   CARDI OLOGY	6, 047	0		0 456, 03	0 0	73. 00 76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	703	0		0 66, 50		76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	760	0		0 59, 98		90.00
	O9001   WOUND CARE CLINIC   O9100   EMERGENCY	2, 095 13, 879			0 83, 50 0 1, 700, 09		90. 01 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	13, 679	0		1, 700, 09	5	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	4, 732			0 1, 642, 25		95. 00
101.00	10100 HOME HEALTH AGENCY   SPECIAL PURPOSE COST CENTERS	0	2, 748		0 943, 53	5 0	101. 00
113.00	11300 INTEREST EXPENSE						113. 00
	11600 H0SPI CE	0	744		0 138, 23	5 0	116. 00
118.00		244, 962	3, 492		0 33, 512, 54	8 -16, 865, 518	118. 00
100 00	NONREIMBURSABLE COST CENTERS   19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	752	0		0	ol o	190. 00
	07950 OTHER NON-REIMBURSABLE	752	0		0 112, 30	l .	190.00
194. 01	07951 MOB	52, 635	0		0 2, 792, 61	5 0	194. 01
194. 02	07952 PHYSI CI AN CLI NI CS	27, 594	0		0 4, 737, 88		194. 02
	07953 PHYS PRAC BUS OFC 07954 MOB - MAIN CAMPUS	989	0		0 631, 95 0 371, 13		194. 03 194. 04
	07955 ONCOLOGY - NONREI MBURSABLE	0	0		0 371, 13		194. 04
	07956 KDH - MC FAMILY PRACTICE	43, 146	Ö		0 2, 530, 60		194. 06

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 01/01/2020	Worksheet B-1

			T.	o 12/31/2020	Date/Time Pre 5/24/2021 11:	
	CAPI	TAL RELATED CO	STS			
	NEW BLBC &	NEW DI DO A	NEW MADE	511D1 0\155		
Cost Center Description	NEW BLDG & FLXT	NEW BLDG & FLXT HHA/HO	NEW MVBLE	-	Reconciliation	
	(SQUARE	(SQUARE	EQUI P (SQUARE	BENEFITS DEPARTMENT		
	FEET)	FEET)	FEET)	(GROSS		
	1 221)	1 221)	1 LL1)	SALARI ES)		
	1.00	1. 01	2.00	4. 00	5A	
194. 07 07957 KDH - MC ORTHOPEDICS	0	0	0	2, 407, 148	0	194. 07
194.08 07958 KDH - MC GENERAL SURGERY	0	0	0	1, 109, 222	0	194. 08
194.09 07959 KDH - MC ENT	0	0	0	604, 081	_	194. 09
194.10 07960 KDH - MC UROLOGY	0	0	0	91, 823		194. 10
194.11 07961 KDH - MC OB/GYN	0	0	0	1, 641, 320	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)	9, 454, 349	6, 879	0	11, 281, 784		202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	25. 546909	1. 969931	0.000000	0. 223213		203. 00
204.00 Cost to be allocated (per Wkst. B,				0		204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part				0. 000000		205. 00
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2)						207.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00
raits iii allu iv)	I I					

| Period: | Worksheet B-1 | From 01/01/2020 | To 12/31/2020 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0069

				0 12/31/2020	Date/Time Pre 5/24/2021 11:	
Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG (HOURS OF	DI ETARY (MEALS	JO alli
	(ACCUM.	(SQUARE	(POUNDS OF	SERVICE)	SERVED)	
	5. 00	FEET) 7. 00	LAUNDRY) 8. 00	9. 00	10.00	
GENERAL SERVI CE COST CENTERS						
1.00   00100 NEW CAP REL COSTS-BLDG & FIXT 1.01   00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO						1. 00 1. 01
2. 00   00200   NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	00.350.377					4. 00
5.00   00500   ADMINISTRATIVE & GENERAL 7.00   00700   OPERATION OF PLANT	89, 359, 366 4, 493, 768	288, 941				5. 00 7. 00
8.00   00800 LAUNDRY & LINEN SERVICE	420, 290	1, 906	344, 933	1		8. 00
9. 00   00900   HOUSEKEEPI NG 10. 00   01000   DI ETARY	1, 311, 734 1, 084, 823	3, 341 6, 293	0	,	46, 749	9. 00 10. 00
11. 00  01100   CAFETERI A	88, 512	2, 545		I	40, 749	11. 00
13.00 01300 NURSING ADMINISTRATION	592, 755	2, 038	0	0	0	13. 00
14. 00   01400   CENTRAL SERVI CES & SUPPLY 15. 00   01500   PHARMACY	184, 927 1, 710, 456	3, 096 2, 301	0	1, 500 4, 050	0	14. 00 15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	930, 445	292	ő	0	0	16. 00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS	0	0	0	0	0	19.00
23. 00   02300   RADI OLOGY SCHOOL   I NPATI ENT ROUTI NE SERVI CE COST CENTERS	131, 965	661	0	725	0	23. 00
30. 00 03000 ADULTS & PEDIATRICS	5, 631, 254	37, 817	124, 595		43, 294	30. 00
31. 00   03100   I NTENSI VE CARE UNI T 43. 00   04300   NURSERY	1, 419, 602 608, 471	1, 674 1, 955	0		3, 455 0	31. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS	000, 471	1, 755		1, 030	0	43.00
50. 00 05000 OPERATING ROOM	3, 652, 534	18, 436	54, 994		0	50. 00
51.00   05100   RECOVERY ROOM 52.00   05200   DELIVERY ROOM & LABOR ROOM	386, 745 762, 701	1, 375 0	8, 782 9, 113		0	51. 00 52. 00
53. 00   053200   DEET VERT   ROOM & EABOR ROOM	552, 460	130		0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 004, 954	10, 841	23, 506		0	54. 00
54. 01   03630   ULTRA SOUND 54. 02   03450   NUCLEAR   MEDICINE - DIAGNOSTIC	193, 005 259, 855	0 483	2, 595 1, 361	1, 315 255	0	54. 01 54. 02
55. 00   05500   RADI OLOGY - THERAPEUTI C	0	0	0	0	0	55. 00
55. 01   03480   ONCOLOGY	2, 187, 703	12, 247			0	55. 01
57.00   05700   CT SCAN 58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	460, 487 339, 880	895 1, 080	12, 160 2, 325	1	0	57. 00 58. 00
59. 00   05900 CARDI AC CATHETERI ZATI ON	0	0	0	o	0	59. 00
60. 00   06000   LABORATORY 62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS	4, 126, 250 261, 132	6, 239 279		4, 685	0	60. 00 62. 00
65. 00   06500   RESPIRATORY THERAPY	890, 624	1, 197	Ö	o	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 844, 132	12, 401	10, 184	3, 396	0	66. 00
67. 00   06700   0CCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY	299, 147 169, 557	1, 420 336		0	0	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	Ö	Ö	0	69. 00
69. 01 03610 SLEEP LAB	230, 328	839	828	2, 070	0	69. 01
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS 71.01   07101   IV SOLUTIONS	2, 503, 948 93, 644	0		0	0	71. 00 71. 01
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 336, 352	0	0	O	0	72. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS 76. 00   03140   CARDI OLOGY	8, 808, 157 908, 436	0 6, 047			0	73. 00 76. 00
76. 97 07697 CARDI GEOGT	103, 202	703		1, 425	0	76. 97
OUTPATIENT SERVICE COST CENTERS	04.440	7/0		000		00.00
90. 00   09000   CLINI C 90. 01   09001   WOUND CARE CLINI C	94, 468 225, 366	760 2, 095			0	90. 00 90. 01
91. 00   09100   EMERGENCY	3, 193, 735	13, 879			0	91. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92. 00
95. 00 09500 AMBULANCE SERVICES	2, 225, 605	4, 732	5, 313	ol	0	95. 00
101.00 10100 HOME HEALTH AGENCY	1, 252, 735	2, 748		1	0	101. 00
SPECIAL PURPOSE COST CENTERS  113. 00 11300   NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	243, 211	744		o		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	61, 219, 355	163, 825	339, 271	215, 455	46, 749	118. 00
NONREI MBURSABLE COST CENTERS  190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	19, 211	752	0	ol	0	190. 00
194.00 07950 OTHER NON-REIMBURSABLE	158, 935	0	0			194. 00
194. 01 07951 MOB 194. 02 07952 PHYSI CLAN CLINI CS	5, 049, 041 7, 917, 722	52, 635 27, 594				194. 01 194. 02
194. 03 07953 PHYS PRAC BUS OFC	1, 443, 363	989				194. 02
194. 04 07954 MOB - MAIN CAMPUS	449, 022	0	0			194. 04
194. 05 07955  ONCOLOGY - NONREIMBURSABLE 194. 06 07956  KDH - MC FAMILY PRACTICE	0 4, 316, 726	0 43, 146	0 37			194. 05 194. 06
194.07 07957 KDH - MC ORTHOPEDICS	3, 252, 144	.5, . +0	500	8, 300	0	194. 07
194.08 07958 KDH - MC GENERAL SURGERY 194.09 07959 KDH - MC ENT	1, 744, 128 700, 867	0				194. 08 194. 09
177. 07 07 707 NDIT - MC LINT	700, 667	U	1 0	3, 755	0	174.07

Health Financial S	Systems	KING'S DAUGHTERS'	HOSPI TAL		In Lieu	of Form CMS-2552-10
COST ALLOCATION -	STATISTICAL BASIS		Provi der	CCN: 15-0069	Peri od: From 01/01/2020	Worksheet B-1

				T T	o 12/31/2020	Date/Time Pre	
			005047101105		HOHOEKEEDING	5/24/2021 11:0	ou am
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& 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	485, 383	0	0	5, 848	0	194. 10
194. 11	07961 KDH - MC OB/GYN	2, 603, 469	0	1, 950	7, 180	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, 865, 518	5, 341, 913	534, 853	1, 621, 076	1, 407, 220	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 188738	18. 487902	1. 550600	5. 805439	30. 101606	203. 00
204.00	Cost to be allocated (per Wkst. B,	1, 111, 648	1, 106, 263	61, 217	114, 462	198, 448	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 012440	3. 828681	0. 177475	0. 409914	4. 244968	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
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0069

Cost Center Description CAFETERIA NURSING CENTRAL PHARMACY MEDICAL	11:00 am &
(MEALS ADMINISTRATION SERVICES & (COSTED RECORDS SERVED) SUPPLY REQUIS.) LIBRAR' (GROSS NRSING HRS) REQUIS.) CHARGES	
11.00 13.00 14.00 15.00 16.00	
GENERAL SERVICE COST CENTERS  1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT	1 00
1. 00    00100   NEW CAP REL COSTS-BLOG & FIXT	1. 00 1. 01 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 893 0 19. 00 23. 00
30. 00 03000 ADULTS & PEDIATRICS 147, 987 147, 987 167, 455 0 8, 418	102 30.00
31. 00   03100   I NTENSI VE CARE UNI T   29, 977   29, 977   894   0 3, 367   43. 00   04300   NURSERY   14, 936   14, 936   0 0 1, 275	
43. 00   04300   NURSERY   14, 936   14, 936   0   0   1, 275   ANCI LLARY SERVI CE COST CENTERS	811 43.00
50. 00         05000         0PERATING ROOM         71, 792         71, 792         182, 681         0         24, 462           51. 00         05100         RECOVERY ROOM         7, 892         7, 892         3, 617         0         4, 528	063 51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM   20, 397   20, 397   0   0   1, 709   53. 00   05300   ANESTHESI OLOGY   6, 310   0   12, 227   0   5, 238	
53. 00   05300   ANESTREST DEDGT   6, 310   0   12, 227   0   5, 238   54. 00   05400   RADI OLOGY - DI AGNOSTI C   59, 147   0   43, 825   0   6, 309	
54. 01   03630   ULTRA SOUND   2, 924   0   25, 567   0   1, 735	
54. 02   03450   NUCLEAR MEDICINE - DIAGNOSTIC   2, 104   0   965   0   4, 485   055. 00   05500   RADIOLOGY - THERAPEUTIC   0   0   0   0   0	311 54.02 0 55.00
55. 01   03480   0NCOLOGY   27, 246   0   38, 065   0   5, 786	1
57. 00 05700 CT SCAN 5, 218 0 115, 688 0 15, 332	
58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI)	645 58.00 0 59.00
60. 00   06000   LABORATORY   73, 671   0   38, 562   0   31, 790	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 1,927	
65. 00   06500   RESPI RATORY THERAPY   23, 276   0   2, 505   0   5, 734   66. 00   06600   PHYSI CAL THERAPY   40, 809   0   7, 918   0   7, 520	
67. 00   06700   0CCUPATI ONAL THERAPY   5, 050   0   230   0   1, 143	
	829 68.00
69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0	0 69.00
69. 01   03610   SLEEP LAB 2, 924 0 710 0 1, 304 71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 2, 503, 948 0 9, 725	
	998 71.01
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 3, 336, 352 0 12, 953	
73. 00   07300   DRUGS CHARGED TO PATIENTS   0 0 44,989 100 74,019 76. 00   03140   CARDI OLOGY 17,010 0 4,746 0 9,883	
	060 76.97
OUTPATIENT SERVICE COST CENTERS	
	626 90.00 038 90.01
91. 00   09100   EMERGENCY   61, 048   61, 048   49, 373   0   22, 414	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	92. 00
OTHER REI MBURSABLE COST CENTERS         75, 331         0         6, 336         0         5, 162	906 95.00
101. 00 10100 HOME HEALTH AGENCY 0 0 30, 345 0 5, 102	0 101.00
SPECIAL PURPOSE COST CENTERS	
113. 00 11300   NTEREST EXPENSE	113.00
116.00 11600 HOSPICE 0 0 120 0 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 774,438 354,029 6,767,100 100 273,819	0 116.00 893 118.00
NONREI MBURSABLE COST CENTERS	
190. 00   19000   GIFT, FLOWER, COFFEE SHOP, & CANTEEN   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 190.00
194. 00 07950 0THER NON-REI MBURSABLE 0 0 720 0 194. 01 07951 MOB 0 27, 713 0	0 194. 00
194. 02 07952 PHYSI CI AN CLI NI CS 0 81, 389 0	0 194. 02
194. 03 07953 PHYS PRAC BUS OFC 0 0 8, 571 0	0 194. 03
194. 04 07954 MOB - MAIN CAMPUS 0 0 6, 099 0 194. 05 07955  ONCOLOGY - NONREI MBURSABLE 0 0 0 0	0 194. 04 0 194. 05
194. 06 07956 KDH - MC FAMILY PRACTICE 0 0 28, 458 0	0 194. 06
194. 07 07957 KDH - MC ORTHOPEDICS 0 0 41, 256 0	0 194. 07
194. 08 07958 KDH - MC GENERAL SURGERY   0  0  35, 336  0	0 194. 08

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

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0069 Period: From 01/01/2020 Worksheet B-1

12/31/2020 Date/Time Prepared: 5/24/2021 11:00 am Cost Center Description CAFETERI A NURSI NG CENTRAL PHARMACY MEDI CAL (MEALS ADMI NI STRATI ON SERVICES & (COSTED RECORDS & SERVED) SUPPLY REQUIS.) LI BRARY (DI RECT (COSTED (GROSS NRSING HRS) CHARGES) REQUIS.) 11.00 15.00 13.00 14.00 16.00 194.09 07959 KDH - MC ENT 8, 458 0 194. 09 194. 10 07960 KDH - MC UROLOGY 0 15, 083 0 0 194. 10 194. 11 07961 KDH - MC OB/GYN 0 22, 236 0 0 194. 11 200. 00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 201. 00 202.00 Cost to be allocated (per Wkst. B, 152, 270 744, 604 286, 876 2, 104, 257 1, 116, 405 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 2. 103229 0.040735 21, 042. 570000 0.004077 203.00 0.196620 204.00 Cost to be allocated (per Wkst. B, 75, 862 68, 259 94, 349 92, 592 22, 319 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0. 087063 0. 192806 0.013397 925. 920000 0. 000082 205. 00  $\Pi$ 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 01/01/2020 12/31/2020 Date/Time Prepared: 5/24/2021 11:00 am Cost Center Description NONPHYSI CI AN RADI OLOGY ANESTHETI STS SCH00L (ASSI GNED (ASSI GNED TIME) TIME) 19.00 23.00 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 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 02300 RADI OLOGY SCHOOL 23.00 1,000 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 30.00 31.00 03100 INTENSIVE CARE UNIT 0 0 31.00 43.00 04300 NURSERY 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 50.00 05100 RECOVERY ROOM 51.00 00000000000000000000000000 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 Ω 52 00 05300 ANESTHESI OLOGY 53.00 1,000 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 54.01 03630 ULTRA SOUND 0 54.01 03450 NUCLEAR MEDICINE - DIAGNOSTIC 54 02 0 54 02 55.00 05500 RADI OLOGY - THERAPEUTI C 0 55.00 03480 ONCOLOGY 0 55.01 55.01 57.00 05700 CT SCAN 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 06000 LABORATORY 60.00 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 06500 RESPIRATORY THERAPY 0 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 68.00 06900 ELECTROCARDI OLOGY 0 69.00 69.00 69.01 03610 SLEEP LAB 0 69.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 07101 IV SOLUTIONS 71.01 71.01 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 73.00 03140 CARDI OLOGY 0 76.00 76.00 07697 CARDIAC REHABILITATION 0 76.97 0 76.97 OUTPATIENT SERVICE COST CENTERS 0 90.00 09000 CLI NI C 0 90.00 09001 WOUND CARE CLINIC 0 90.01 0 90.01 91.00 09100 EMERGENCY 0 Ω 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 0 Λ 95 00 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 1,000 118.00 NONREI MBURSABLE COST CENTERS 190, 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0000000000 190 00 194. 00 194. 00 07950 OTHER NON-REIMBURSABLE 0 194. 01 07951 MOB 0 194. 01 194. 02 07952 PHYSICIAN CLINICS 0 194.02 194.03 07953 PHYS PRAC BUS OFC 0 194 03 194. 04 07954 MOB - MAIN CAMPUS 0 194.04 194. 05 07955 ONCOLOGY - NONREI MBURSABLE 194. 05 194.06 07956 KDH - MC FAMILY PRACTICE 0 194. 06 194. 07 07957 KDH - MC ORTHOPEDICS 194. 07 0 194.08 07958 KDH - MC GENERAL SURGERY 0 194. 08

194.09

194.09 07959 KDH - MC ENT

Health Financial Systems	KING'S DAUGHTERS' HO	OSPI TAL	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Pr	rovider CCN: 15-0069	From 01/01/2020	
				Date/Time Prepared:

					'	0 12/31/2020	5/24/2021 11: 00 am
		Cost Center Description	NONPHYSI CI AN	RADI OLOGY			
			ANESTHETI STS	SCH00L			
			(ASSI GNED	(ASSI GNED			
			TIME)	TIME)			
			19. 00	23. 00			
194. 1	0 07960	KDH - MC UROLOGY	0	0			194. 10
194. 1	1 07961	KDH - MC OB/GYN	0	0			194. 11
200.0	00	Cross Foot Adjustments					200. 00
201.0	00	Negative Cost Centers					201. 00
202.0	00	Cost to be allocated (per Wkst. B,	0	174, 156			202. 00
		Part I)					
203.0	00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	174. 156000			203. 00
204.0	00	Cost to be allocated (per Wkst. B,	0	21, 729			204. 00
		Part II)					
205.0	00	Unit cost multiplier (Wkst. B, Part	0. 000000	21. 729000			205. 00
		[11]					
206.0	00	NAHE adjustment amount to be allocated		0			206. 00
		(per Wkst. B-2)					
207.0	00	NAHE unit cost multiplier (Wkst. D,		0. 000000			207. 00
		Parts III and IV)					

				To 12/31/2020	Date/Time Pre 5/24/2021 11:	pared:
		Title	: XVIII	Hospi tal	PPS	00 4111
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
oost content possin per en	(from Wkst. B,	Adj.	l rotal ocoto	Di sal I owance	.014. 00010	
	Part I, col.	7.69		Di dai i diidiido		
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	11.00	2.00	0.00		0.00	
30. 00 03000 ADULTS & PEDIATRICS	9, 781, 840		9, 781, 840	ol	9, 781, 840	30.00
31. 00   03100   NTENSI VE CARE UNI T	1, 959, 010	ł .	1, 959, 010		1, 959, 010	31. 00
43. 00   04300   NURSERY	805, 105	ł .	805, 10			43. 00
ANCI LLARY SERVI CE COST CENTERS	000, 100		000, 10	<u> </u>	000, 100	10.00
50. 00 05000 OPERATI NG ROOM	5, 286, 199		5, 286, 19	ol ol	5, 286, 199	50. 00
51. 00   05100   RECOVERY   ROOM	535, 535		535, 53		535, 535	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	993, 142		993, 142		993, 142	52.00
53. 00   05300   ANESTHESI OLOGY	856, 385		856, 38		876, 695	53. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	3, 868, 377		3, 868, 37		3, 868, 377	54.00
54. 01   03630   ULTRA SOUND	249, 783		249, 78		249, 783	54. 01
54. 02   03450 NUCLEAR MEDICINE - DIAGNOSTIC	340, 160		340, 160		340, 160	54. 01
55. 00   05500   RADI OLOGY - THERAPEUTI C	340, 100				340, 100	55. 00
55. 00   05500   RADI 0LOGY - THERAPEUTI C	2, 926, 576		2, 926, 57	1 1	2, 935, 158	55. 00
		l e				
57. 00 05700 CT SCAN	654, 156		654, 15		654, 156	57. 00
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI)	450, 670		450, 670		450, 670	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0	0	59. 00
60. 00 06000 LABORATORY	5, 193, 239		5, 193, 23		5, 193, 239	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	323, 433		323, 43		323, 433	62.00
65. 00 06500 RESPI RATORY THERAPY	1, 108, 908	•	,		1, 108, 908	65. 00
66. 00 06600 PHYSI CAL THERAPY	2, 495, 974	1	2, 495, 97		2, 495, 974	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	387, 524	0			387, 524	67. 00
68. 00 06800 SPEECH PATHOLOGY	210, 541	0	210, 54		210, 541	68. 00
69. 00   06900   ELECTROCARDI OLOGY	0			-	0	69. 00
69. 01  03610  SLEEP LAB	308, 534		308, 53		308, 778	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 118, 185		3, 118, 18		3, 118, 185	71. 00
71. 01  07101 IV SOLUTIONS	127, 327		127, 32		127, 327	71. 01
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	4, 154, 770		4, 154, 770		4, 154, 770	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	12, 878, 508		12, 878, 50		12, 878, 508	73. 00
76. 00   03140   CARDI OLOGY	1, 290, 211		1, 290, 21	이	1, 290, 211	76. 00
76. 97 O7697 CARDIAC REHABILITATION	145, 847		145, 84	7 0	145, 847	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000  CLI NI C	128, 560		128, 560	이	128, 560	90. 00
90. 01  09001 WOUND CARE CLINIC	313, 767		313, 76	1, 327	315, 094	90. 01
91. 00   09100   EMERGENCY	4, 556, 538		4, 556, 53	578, 468	5, 135, 006	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 567, 744		2, 567, 74	1	2, 567, 744	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	2, 777, 503		2, 777, 50	175	2, 777, 678	95. 00
101.00 10100 HOME HEALTH AGENCY	1, 541, 215		1, 541, 21	5	1, 541, 215	101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300   NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	302, 874		302, 87	ı	302, 874	116. 00
200.00 Subtotal (see instructions)	72, 638, 140				73, 247, 246	
201.00 Less Observation Beds	2, 567, 744		2, 567, 74		2, 567, 744	
202.00 Total (see instructions)	70, 070, 396	0	70, 070, 39	609, 106	70, 679, 502	202. 00

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0069	Peri od: From 01/01/2020	Worksheet C Part I

To 12/31/2020 Date/Time Prepared: 5/24/2021 11:00 am Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 8, 418, 102 8, 418, 102 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 3, 367, 864 3, 367, 864 31.00 1, 275, 811 43.00 43.00 04300 NURSERY 1, 275, 811 ANCILLARY SERVICE COST CENTERS 50.00 18, 929, 778 24, 462, 581 0.216093 0.000000 50.00 05000 OPERATING ROOM 5. 532. 803 51.00 05100 RECOVERY ROOM 1,053,587 3, 474, 476 4, 528, 063 0.118270 0.000000 51.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 1, 695, 691 13, 794 1, 709, 485 0.580960 0.000000 52 00 05300 ANESTHESI OLOGY 1.855.955 3, 382, 497 5, 238, 452 0.163481 0.000000 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 1, 208, 929 5, 100, 519 6, 309, 448 0.613109 0.000000 54 00 54.01 03630 ULTRA SOUND 173, 733 1, 562, 158 1, 735, 891 0.143893 0.000000 54.01 54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 234, 093 4, 251, 218 4, 485, 311 0.075839 0.000000 54.02 05500 RADI OLOGY - THERAPEUTI C 55.00 0.000000 0.000000 55.00 55.01 03480 ONCOLOGY 48, 736 5, 738, 038 5, 786, 774 0.505735 0.000000 55.01 57.00 05700 CT SCAN 2, 458, 939 12, 873, 616 15, 332, 555 0.042665 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 265, 786 3, 144, 859 3, 410, 645 0.132136 0.000000 58.00 05900 CARDIAC CATHETERIZATION 59 00 0.000000 0.000000 59 00 60.00 06000 LABORATORY 5, 410, 581 26, 379, 672 31, 790, 253 0.163359 0.000000 60.00 1, 070, 382 856, 761 1, 927, 143 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.167830 0.000000 62.00 06500 RESPIRATORY THERAPY 3, 965, 748 1, 768, 940 0.193368 5.734.688 0.000000 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 706, 893 6, 814, 012 7, 520, 905 0.331871 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 352, 283 791, 175 1, 143, 458 0.338905 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 96,004 427, 825 523, 829 0.401927 0.000000 68.00 06900 ELECTROCARDI OLOGY 0 0.000000 0 000000 69 00 69 00 69.01 03610 SLEEP LAB 1, 304, 505 1, 304, 505 0.236514 0.000000 69.01 9, 725, 130 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 4, 628, 898 5, 096, 232 0. 320632 0.000000 71.00 71.00 71.01 07101 IV SOLUTIONS 1, 687, 244 1, 303, 754 2, 990, 998 0.042570 0.000000 71.01 07200 IMPL. DEV. CHARGED TO PATIENTS 12, 953, 322 72.00 5, 976, 141 6, 977, 181 0.320749 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 20, 218, 653 53, 800, 726 74, 019, 379 0.173988 0.000000 73.00 76.00 03140 CARDI OLOGY 1, 743, 500 8, 139, 736 9, 883, 236 0.130545 0.000000 76.00 76 97 07697 CARDIAC REHABILITATION 783 331, 277 332, 060 0.439219 0.000000 76 97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 49, 626 49, 626 2.590578 0.000000 90.00 90. 01 09001 WOUND CARE CLINIC 181 282, 857 283, 038 1. 108568 0.000000 90.01 09100 EMERGENCY 3, 880, 809 22, 414, 435 0. 203286 0 000000 91 00 91 00 18, 533, 626 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 92.00 436,024 3, 459, 194 3, 895, 218 0.659204 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES Э 5, 162, 906 5, 162, 906 0. 537973 0.000000 95.00 101.00 10100 HOME HEALTH AGENCY 1, 658, 702 1, 658, 702 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 466, 938 466, 938 116, 00 200.00 Subtotal (see instructions) 77. 764. 153 202, 076, 598 279, 840, 751 200. 00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 77, 764, 153 202, 076, 598 279, 840, 751 202.00

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
Form 01/01/2020
To 12/31/2020
To 12/31/2020
Date/Time Prepared: 5/24/2021 11:00 am

			T: +1 o V/// / /	Hooni tol	5/24/2021 11: 00	o ani
	Cost Contor Doscription	DDC Innotiont	Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient Ratio				
		11. 00				
INDA	TIENT ROUTINE SERVICE COST CENTERS	11.00				
	O ADULTS & PEDIATRICS					30. 00
	O INTENSIVE CARE UNIT					31. 00
	O NURSERY					43. 00
	LLARY SERVICE COST CENTERS					43.00
	O OPERATING ROOM	0. 216093				50. 00
	O RECOVERY ROOM	0. 218270				51. 00
	O DELIVERY ROOM & LABOR ROOM	0. 580960				52. 00
	O ANESTHESI OLOGY	0. 167358				53. 00
	O RADI OLOGY-DI AGNOSTI C	0. 613109			l l	54. 00
	O ULTRA SOUND	0. 013104				54. 00
	O NUCLEAR MEDICINE - DIAGNOSTIC	0. 143893			l l	54. 01
		1			l l	
	O RADI OLOGY - THERAPEUTI C	0. 000000				55. 00
	O ONCOLOGY	0. 507218				55. 01
	O CT SCAN	0. 042665				57. 00
	O MAGNETIC RESONANCE IMAGING (MRI)	0. 132136				58.00
	O CARDI AC CATHETERI ZATI ON	0.000000				59.00
	O LABORATORY	0. 163359				60.00
	O WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 167830				62.00
	O RESPI RATORY THERAPY	0. 193368				65. 00
	O PHYSI CAL THERAPY	0. 331871				66.00
	O OCCUPATI ONAL THERAPY	0. 338905				67.00
	O SPEECH PATHOLOGY	0. 401927				68. 00
	O ELECTROCARDI OLOGY	0.000000				69.00
	O SLEEP LAB	0. 236701				69. 01
71.00 07100	O MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 320632				71.00
	1 I V SOLUTIONS	0. 042570				71. 01
	O IMPL. DEV. CHARGED TO PATIENTS	0. 320749				72.00
	O DRUGS CHARGED TO PATIENTS	0. 173988				73.00
	O CARDI OLOGY	0. 130545				76. 00
	7 CARDI AC REHABI LI TATI ON	0. 439219				76. 97
	ATIENT SERVICE COST CENTERS	0.500570				
90.00 09000		2. 590578				90.00
	1 WOUND CARE CLINIC	1. 113257			l l	90. 01
	O EMERGENCY	0. 229094				91.00
	O OBSERVATION BEDS (NON-DISTINCT PART)	0. 659204				92. 00
	R REIMBURSABLE COST CENTERS					
	O AMBULANCE SERVICES	0. 538007				95. 00
	O HOME HEALTH AGENCY				1	101. 00
	IAL PURPOSE COST CENTERS					
	O I NTEREST EXPENSE					113. 00
116. 00 11600	•					116. 00
200. 00	Subtotal (see instructions)					200. 00
201. 00	Less Observation Beds					201. 00
202. 00	Total (see instructions)				2	202. 00

					10 12/31/2020	5/24/2021 11:	
			Ti tl	e XIX	Hospi tal	Cost	
			<u> </u>		Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	·	(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3. 00	4. 00	5. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDIATRICS	9, 781, 840		9, 781, 84			
	3100 INTENSIVE CARE UNIT	1, 959, 010		1, 959, 01			31. 00
	4300 NURSERY	805, 105		805, 10	5 0	805, 105	43. 00
	NCILLARY SERVICE COST CENTERS				_		
	5000 OPERATING ROOM	5, 286, 199		5, 286, 19			
	5100 RECOVERY ROOM	535, 535		535, 53			
	5200 DELIVERY ROOM & LABOR ROOM	993, 142		993, 14		1	52.00
	5300 ANESTHESI OLOGY	856, 385		856, 38			1
	5400 RADI OLOGY-DI AGNOSTI C	3, 868, 377		3, 868, 37		3, 868, 377	1
	3630 ULTRA SOUND	249, 783		249, 78		,	
	3450 NUCLEAR MEDICINE - DIAGNOSTIC	340, 160		340, 16	0 0	340, 160	
	5500 RADI OLOGY - THERAPEUTI C	0			0	0	55. 00
	3480 ONCOLOGY	2, 926, 576		2, 926, 57	· ·	2, 935, 158	1
	5700 CT SCAN	654, 156		654, 15		654, 156	
	5800 MAGNETIC RESONANCE IMAGING (MRI)	450, 670		450, 67			
	5900 CARDI AC CATHETERI ZATI ON	0			0	0	59. 00
	6000 LABORATORY	5, 193, 239		5, 193, 23		5, 193, 239	
	6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	323, 433		323, 43		323, 433	62. 00
	6500 RESPI RATORY THERAPY	1, 108, 908	0			1, 108, 908	1
	6600 PHYSI CAL THERAPY	2, 495, 974	0			_,,	66. 00
	6700 OCCUPATI ONAL THERAPY	387, 524	0	387, 52		387, 524	67. 00
	6800 SPEECH PATHOLOGY	210, 541	0	210, 54			68. 00
	6900 ELECTROCARDI OLOGY	0			0	0	69. 00
1	3610 SLEEP LAB	308, 534		308, 53		308, 778	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 118, 185		3, 118, 18			1
	7101 I V SOLUTI ONS	127, 327		127, 32			
	7200 I MPL. DEV. CHARGED TO PATIENTS	4, 154, 770		4, 154, 77		.,	
	7300 DRUGS CHARGED TO PATIENTS	12, 878, 508		12, 878, 50		12, 878, 508	
	3140 CARDI OLOGY	1, 290, 211		1, 290, 21		1, 290, 211	76.00
	7697 CARDI AC REHABI LI TATI ON	145, 847		145, 84	.7 0	145, 847	76. 97
	UTPATIENT SERVICE COST CENTERS	100 5/0		100 5/		100 5/0	
	9000 CLI NI C	128, 560		128, 56			
	9001 WOUND CARE CLINIC	313, 767		313, 76		315, 094	90. 01
	9100 EMERGENCY	4, 556, 538		4, 556, 53			91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 567, 744		2, 567, 74	4	2, 567, 744	92. 00
	THER REIMBURSABLE COST CENTERS	0 777 500		0 777 50	.0 475	0 777 /70	05.00
	9500 AMBULANCE SERVICES	2, 777, 503		2, 777, 50			
	0100 HOME HEALTH AGENCY	1, 541, 215		1, 541, 21	5	1, 541, 215	101.00
	PECIAL PURPOSE COST CENTERS						112 00
	1300 I NTEREST EXPENSE	202 074		202.07	4	202 074	113.00
	1600 HOSPI CE	302, 874	^	302, 87		302, 874	
200.00	Subtotal (see instructions)	72, 638, 140	0	,			
201.00	Less Observation Beds	2, 567, 744	^	2, 567, 74		2, 567, 744	
202.00	Total (see instructions)	70, 070, 396	0	70, 070, 39	609, 106	70, 679, 502	1202. UU

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0069	Peri od: From 01/01/2020	Worksheet C Part I

To 12/31/2020 Date/Time Prepared: 5/24/2021 11:00 am Title XIX Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 8, 418, 102 8, 418, 102 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 3, 367, 864 3, 367, 864 31.00 1, 275, 811 43.00 43.00 04300 NURSERY 1, 275, 811 ANCILLARY SERVICE COST CENTERS 50.00 50.00 18, 929, 778 24, 462, 581 0.216093 0.000000 05000 OPERATING ROOM 5. 532. 803 51.00 05100 RECOVERY ROOM 1, 053, 587 3, 474, 476 4, 528, 063 0.118270 0.000000 51.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 1, 695, 691 13, 794 1, 709, 485 0.580960 0.000000 52 00 05300 ANESTHESI OLOGY 1.855.955 3, 382, 497 5, 238, 452 0.163481 0.000000 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 1, 208, 929 5, 100, 519 6, 309, 448 0.613109 0.000000 54 00 54.01 03630 ULTRA SOUND 173, 733 1, 562, 158 1, 735, 891 0.143893 0.000000 54.01 54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 234, 093 4, 251, 218 4, 485, 311 0.075839 0.000000 54.02 05500 RADI OLOGY - THERAPEUTI C 55.00 0.000000 0.000000 55.00 55.01 03480 ONCOLOGY 48, 736 5, 738, 038 5, 786, 774 0.505735 0.000000 55.01 57.00 05700 CT SCAN 2, 458, 939 12, 873, 616 15, 332, 555 0.042665 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 265, 786 3, 144, 859 3, 410, 645 0.132136 0.000000 58.00 05900 CARDIAC CATHETERIZATION 59 00 0.000000 0.000000 59 00 60.00 06000 LABORATORY 5, 410, 581 26, 379, 672 31, 790, 253 0.163359 0.000000 60.00 1, 070, 382 856, 761 1, 927, 143 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.167830 0.000000 62.00 06500 RESPIRATORY THERAPY 3, 965, 748 1, 768, 940 0.193368 5.734.688 0.000000 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 706, 893 6, 814, 012 7, 520, 905 0.331871 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 352, 283 791, 175 1, 143, 458 0.338905 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 96,004 427, 825 523, 829 0.401927 0.000000 68.00 06900 ELECTROCARDI OLOGY 0 0.000000 0 000000 69 00 69 00 69.01 03610 SLEEP LAB 1, 304, 505 1, 304, 505 0.236514 0.000000 69.01 9, 725, 130 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 4, 628, 898 5, 096, 232 0.320632 0.000000 71.00 71.00 71.01 07101 IV SOLUTIONS 1, 687, 244 1, 303, 754 2, 990, 998 0.042570 0.000000 71.01 07200 IMPL. DEV. CHARGED TO PATIENTS 12, 953, 322 72.00 5, 976, 141 6, 977, 181 0.320749 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 20, 218, 653 53, 800, 726 74, 019, 379 0.173988 0.000000 73.00 76.00 03140 CARDI OLOGY 1, 743, 500 8, 139, 736 9, 883, 236 0.130545 0.000000 76.00 76 97 07697 CARDIAC REHABILITATION 783 331, 277 332, 060 0.439219 0.000000 76 97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 49, 626 49, 626 2.590578 0.000000 90.00 90. 01 09001 WOUND CARE CLINIC 181 282, 857 283, 038 1. 108568 0.000000 90.01 09100 EMERGENCY 3, 880, 809 22, 414, 435 0. 203286 0 000000 91 00 91 00 18, 533, 626 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 92.00 436,024 3, 459, 194 3, 895, 218 0.659204 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES Э 5, 162, 906 5, 162, 906 0. 537973 0.000000 95.00 101.00 10100 HOME HEALTH AGENCY 1, 658, 702 1, 658, 702 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 466, 938 466, 938 116, 00 200.00 Subtotal (see instructions) 77. 764. 153 202, 076, 598 279, 840, 751 200. 00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 77, 764, 153 202, 076, 598 279, 840, 751 202.00

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 01/01/2020 | Part I | To 12/31/2020 | Date/Time Prepared: 5/24/2021 11:00 am

				5/24/2021 11:00 am
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00   03000   ADULTS & PEDI ATRI CS				30.00
31.00  03100   INTENSIVE CARE UNIT				31.00
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. 0
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 000000			54. 02
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 000000			55. 00
55. 01 03480 ONCOLOGY	0. 000000			55. 0
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. 0
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 00
71. 01   07101   IV SOLUTIONS	0. 000000			71. 0
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	0.000000			70. 47
90. 00   09000   CLI NI C	0. 000000			90.00
90. 01   09001   WOUND CARE CLINIC	0. 000000			90.00
91. 00   09100   EMERGENCY	0. 000000			91.00
	· ·			
	0. 000000			92. 00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES	0.000000			0F 00
95. 00   09500   AMBULANCE SERVICES 101. 00   10100   HOME HEALTH AGENCY	0. 000000			95. 00 101. 00
				101.00
SPECIAL PURPOSE COST CENTERS				110.00
113. 00 11300 INTEREST 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)	1			202. 00

Health Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2020		narad.
				To 12/31/2020	Date/Time Pre 5/24/2021 11:	
		Title	xVIII	Hospi tal	PPS	00 4111
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 467, 247	0	1, 467, 24	7 11, 040	132. 90	30. 00
31.00 INTENSIVE CARE UNIT	93, 979		93, 97	9 1, 473	63. 80	31.00
43. 00 NURSERY	69, 713		69, 71	3 990	70. 42	43.00
200.00 Total (lines 30 through 199)	1, 630, 939		1, 630, 93	9 13, 503		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	3, 866	513, 791				30. 00
31.00 INTENSIVE CARE UNIT	692	44, 150				31. 00
43. 00 NURSERY	0	0				43. 00
200.00 Total (lines 30 through 199)	4, 558	557, 941				200. 00

Health Financial Systems	KING'S DAUGHT	ERS' HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERV	ICE CAPITAL COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2020 To 12/31/2020		
		Ti tl e	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	Inpati ent	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4. 00	5. 00	

Capital   Capi			Title	XVIII	Hospi tal	PPS	00 4
Related Cost   From Wisst.   Related Cost   From Wisst.   Part   , col.	Cost Center Description	Cani tal					
ANCILLARY SERVICE COST CENTERS   Part I, col.   Col. 1 col.   Col. 1 col.   Col. 1 col.   C	oust delited besoft per on						
Part II, col							
ANCILLARY SERVICE COST CENTERS   1.00   2.00   3.00   4.00   5.00					onal ges	cor anni 1)	
ANCILLARY SERVICE COST CENTERS				2)			
ANCILLARY SERVICE COST CENTERS   S. 0.0			2 00	3 00	4 00	5 00	
50.00	ANCILLARY SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
51.00   05100   RECOVERY ROOM & LABOR ROOM   18, 259   1, 709, 485   0.010681   2, 2895   31   52.00		638 674	24 462 581	0.026108	2 352 124	61 409	50 00
52.00   05200   DELI VERY ROOM & LABOR ROOM   18, 259   1, 709, 485   0. 010681   2, 895   31   52, 00							
53.00   05300   AMESTHESI OLOGY   11, 835   5, 238, 452   0, 002259   492, 654   1, 113   53, 00   54.00   05400   RADIOLOGY-DI AGNOSTI C   367, 700   6, 309, 448   0, 058278   695, 173   40, 513   54, 00   54.01   03630   ULTRA SOUND   4, 141   1, 735, 891   0, 002386   688, 477   163   54, 01   54.02   03450   NUCLEAR MEDI CI NE - DI AGNOSTI C   18, 332   4, 485, 311   0, 004087   163, 061   666   54, 02   55.00   05500   RADIOLOGY - THERAPEUTI C   0   0   0, 0000000   0   0, 55, 00   55.01   03480   0NCOLOGY   396, 012   5, 786, 774   0, 068434   28, 327   1, 939   55, 01   57.00   05700   CT SCAN   37, 657   15, 332, 555   0, 002456   1, 310, 190   3, 218   57, 00   58.00   05800   MADRETI C RESONANCE I MAGI NG (MRI )   37, 765   33, 410, 645   0, 011073   139, 767   1, 548   58, 00   59.00   05900   CARDIAC CATHETERI ZATI ON   0   0, 000000   0   0   0, 59, 00   60.00   06200   MHOLE BLOOD & PACKED RED BLOOD CELLS   11, 602   11, 927, 143   0, 006020   548, 928   3, 305   62, 00   66.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   11, 602   1, 927, 143   0, 006020   548, 928   3, 305   62, 00   66.00   06600   CABDRATORY   48, 772   5, 734, 688   0, 008505   2, 060, 998   17, 529   65, 00   67.00   06900   CABDRATIONAY   THERAPY   48, 772   5, 734, 688   0, 008505   2, 060, 998   17, 529   65, 00   68.00   06600   SPEECH PATHOLOGY   12, 303   523, 829   0, 0023467   57, 412   1, 348   68, 00   69.00   06900   ELECTROCARDI OLOGY   0   0, 000000   0   0, 000000   0   0							
54. 00   05400   RADIOLOCY-DIAGNOSTIC   367,700   6,309,448   0.088278   695,173   40,513   54,00   54. 01   03630   ULTRA SOUND   4,141   1,735,891   0.002386   68,477   163   54,01   55. 00   03450   NUCLEAR MEDICINE - DIAGNOSTIC   18,332   4,485,311   0.004087   163,061   666   54,02   55. 00   05500   RADIOLOGY - THERAPEUTIC   0   0   0.000000   0   0.55,00   55. 01   03480   ONCOLOGY   396,012   5,786,774   0.068434   28,327   1,939   55,01   57. 00   05700   CT SCAN   37,657   15,332,555   0.002456   1,310,190   3,218   57,00   58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI)   37,755   3,410,645   0.011073   139,767   1,548   58,00   59. 00   05900   CARDIA C CATHETERI ZATION   0   0   0.000000   0   0,59,00   60. 00   06000   LABORATORY   246,063   31,790,253   0.007740   2,694,171   20,853   62,00   62. 00   06500   RESPIRATORY THERAPY   48,772   5,734,688   0.008505   2,060,998   17,529   65. 00   06600   PHYSICAL THERAPY   394,702   7,520,905   0.052481   379,112   19,896   66.00   66.00   06600   PHYSICAL THERAPY   48,772   1,143,458   0.00244   177,750   7,146   67.00   69. 01   03600   SEEPL PATHOLOGY   12,303   69.00   0.000000   0   0   0.000000   69. 01   03610   SLEEP LAB   28,879   1,304,505   0.022188   0   0   0   0.000000   69. 01   03610   SLEEP LAB   28,879   1,304,505   0.00218   0.00673   1,801,836   12,134   71.00   71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   26,5491   9,725,130   0.00673   2,747,698   18,511   72.00   72. 00   07200   IMPL DEV. CHARGED TO PATIENTS   28,727   9,883,236   0.10985   973,156   19,323   76.00   74. 00   07300   DRUGS CHARGED TO PATIENTS   28,789   49,626   0.479366   0   0.00891   760,148   677   71.00   75. 00   07300   DRUGS CHARGED TO PATIENTS   28,789   49,626   0.479366   0   0   0.009000   0.00900   0.00900   0.00900   0.00900   0.00900							
54. 01   03630   ULTRA SOUND   4   141   1   735,891   0   0   0   0   0   0   0   0   0							
54. 02   03450   NUCLEAR MEDICINE - DIAGNOSTIC   18, 332   4, 485, 311   0.004087   163, 061   666   54, 02							
55. 00   05500   RADI OLOGY - THERAPEUTI C   0   0   0   0.000000   0   0   55. 00							
55. 01   03480   0NCOLOGY   396, 012   5, 786, 774   0.068434   28, 327   1, 939   55. 01			1		103, 001		
57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 59. 00 05900 CARDIA C CATHETERI ZATION 60. 00 06000 LABORATORY 60. 00 06000 LABORATORY 61. 00 06000 LABORATORY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 63. 00 06500 (RESPI RATORY THERAPY 64. 072 1, 227, 143 65. 00 06600 PHYSI CAL THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATIONAL THERAPY 68. 00 06700 OCCUPATIONAL THERAPY 69. 00 06700 OCCUPATIONAL THERAPY 69. 00 06900 ELECTROCARDIOLOGY 69. 00 06900 ELECTROCARDIOLOGY 69. 01 03610 SLEEP LAB 69. 00 06900 ELECTROCARDIOLOGY 69. 01 03610 SLEEP LAB 69. 00 06900 MEDI CAL SUPPLIES CHARGED TO PATIENTS 65. 491 P. 725, 130 67. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 67. 01 07101 IV SOLUTIONS 78. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 78. 00 07300 DRUGS CHARGED TO PATIENTS 78. 00 07300 DRUGS CHARGED TO PATIENTS 78. 00 07400 DRUGS CHARGED TO PATIENTS 78. 00 07500 DRUGS CHARGED TO PATIENTS 78. 00 07500 DRUGS CHARGED TO PATIENTS 78. 00 07500 DRUGS CHARGED TO PATIENTS 79. 00 07500 DRUGS CHARGED			1		20 227	-	
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 37, 765 3, 410, 645 0.011073 139, 767 1, 548 58. 00 5900 (ARDIAC CATHETERIZATION 0 0.000000 0 0.590. 00 0.000000 0 0.000000 0 0.000000 0 0.000000							
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0.000000 0 0.000000 0 0 59. 00 60.00 06000 LABORATORY 246, 063 31, 790, 253 0.007740 2, 694, 171 20, 853 60. 00 650 0 6500 RESPI RATORY THERAPY 48, 772 5, 734, 688 0.008505 2, 060, 998 17, 529 65. 00 6600 PHYSI CAL THERAPY 394, 702 7, 520, 905 0.052481 379, 112 19, 896 66. 00 6600 PHYSI CAL THERAPY 45, 972 1, 143, 458 0.040204 177, 750 7, 146 67. 00 6700 0CCUPATI ONAL THERAPY 45, 972 1, 143, 458 0.040204 177, 750 7, 146 67. 00 68. 00 68600 SPEECH PATHOLOGY 12, 303 523, 829 0.023487 57, 412 1, 348 68. 00 69. 00 69. 01 03610 SLEEP LAB 28, 879 1, 304, 505 0.022138 0 0 69. 01 03610 SLEEP LAB 28, 879 1, 304, 505 0.022138 0 0 69. 01 70.100 MEDIC ALL SUPPLIES CHARGED TO PATI ENTS 65, 491 9, 725, 130 0.006734 1, 801, 836 12, 134 71. 00 71.001 V SOLUTI ONS 2, 665 2, 990, 998 0.000891 760, 148 677 71. 01 72. 00 72000 IMPL. DEV. CHARGED TO PATI ENTS 87, 263 12, 953, 322 0.006737 2, 747, 698 18, 511 72. 00 7300 DRUGS CHARGED TO PATI ENTS 208, 724 74, 019, 379 0.002820 8, 527, 153 24, 047 73. 00 7300 DRUGS CHARGED TO PATI ENTS 208, 724 74, 019, 379 0.002820 8, 527, 153 24, 047 73. 00 7300 DRUGS CHARGED TO PATI ENTS 208, 724 74, 019, 379 0.002820 8, 527, 153 24, 047 73. 00 7300 DRUGS CHARGED TO PATI ENTS 208, 724 74, 019, 379 0.002820 8, 527, 153 24, 047 73. 00 7300 DRUGS CHARGED TO PATI ENTS 208, 724 74, 019, 379 0.002820 8, 527, 153 24, 047 73. 00 76. 07 07007 MEDIT ENT SERVI CE COST CENTERS 90.00 09000 CLI NI C 23, 789 49, 626 0.479366 0 0 0.90.00 90.01 90.00 90.00 90.00 DRUGS CHARGED TO BEDS (NON-DISTINCT PART) 385, 154 3, 895, 218 0.098879 293, 102 28, 982 92. 00 00 00 DESERVATI ON BEDS (NON-DISTINCT PART) 385, 154 3, 895, 218 0.098879 293, 102 28, 982 92. 00 00 DESERVATI ON BEDS (NON-DISTINCT PART) 385, 154 3, 895, 218 0.098879 293, 102 28, 982 92. 00 00 DESERVATI ON BEDS (NON-DISTINCT PART) 385, 154 3, 895, 218 0.098879 293, 102 28, 982 92. 00 00 DESERVATI ON BEDS (NON-DISTINCT PART) 385, 154 3, 895, 218 0.098879 293, 102 28, 982 92. 00 00 DESERVATI ON BEDS (NON-DISTINCT PAR							
60.00 06000 LABORATORY 246,063 31,790,253 0.007740 2,694,171 20,853 60.00 6200 WHOLE BLOOD & PACKED RED BLOOD CELLS 11,602 1,927,143 0.006020 548,928 3,305 62.00 65.00 06500 RESPI RATORY THERAPY 48,772 5,734,688 0.008505 2,060,998 17,529 65.00 66.00 06600 PHYSI CAL THERAPY 394,702 7,520,905 0.052481 379,112 19,896 66.00 67.00 06700 0CCUPATI ONAL THERAPY 45,972 1,143,458 0.040204 177,750 7,146 67.00 68.00 06800 SPEECH PATHOLOGY 12,303 523,829 0.023487 57,412 1,348 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0.000000 0 0 0 69.00 17.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 65,491 9,725,130 0.006734 1,801,836 12,134 71.00 71.01 07101 IV SOLUTI ONS 2,665 2,990,998 0.000891 760,148 677 71.01 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 87,263 12,953,322 0.006737 2,747,698 18,511 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 208,724 74,019,379 0.002820 8,527,153 24,047 73.00 76.00 03140 CARDI OLOGY 196,237 9,883,236 0.019856 973,156 19,323 76.00 76.97 CARDI AC REHABI LI TATI ON 22,784 332,060 0.068014 161 11 76.97 0.000000 0.000000					139, 767		
62. 00					0 (04 474	-	
65. 00 06500 RESPIRATORY THERAPY 48, 772 5, 734, 688 0. 008505 2, 060, 998 17, 529 65. 00 660. 00 06500 PHYSI CAL THERAPY 394, 702 7, 520, 905 0.052481 379, 112 19, 896 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 45, 972 1, 143, 458 0. 040204 177, 750 7, 146 67. 00 6800 SPEECH PATHOLOGY 12, 303 523, 829 0. 023487 57, 412 1, 348 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0.000000 0 0 0 69. 01 03610 SLEEP LAB 28, 879 1, 304, 505 0. 022138 0 0 0 69. 01 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 65, 491 9, 725, 130 0. 006734 1, 801, 836 12, 134 71. 00 7100 INPL. DEV. CHARGED TO PATI ENTS 87, 263 12, 953, 322 0. 006737 2, 747, 698 18, 511 72. 00 07300 DRUGS CHARGED TO PATI ENTS 208, 724 74, 019, 379 0. 002820 8, 527, 153 24, 047 73. 00 07409 INPL. DEV. CHARGED TO PATI ENTS 208, 724 74, 019, 379 0. 002820 8, 527, 153 24, 047 73. 00 07409 INPL. DEV. CHARGED TO PATI ENTS 208, 724 74, 019, 379 0. 002820 8, 527, 153 24, 047 73. 00 07409 INPL. DEV. CHARGED TO PATI ENTS 208, 724 74, 019, 379 0. 002820 8, 527, 153 24, 047 73. 00 074097 CARDI AC REHABI LI TATI ON 22, 784 332, 060 0. 068614 161 11 00000000000000000000000000000							
66. 00   06600   PHYSI CAL THERAPY   394, 702   7,520,905   0.052481   379,112   19,896   66. 00   67. 00   06700   OCCUPATI ONAL THERAPY   45,972   1,143,458   0.040204   177,750   7,146   67. 00   68. 00   06800   SPECH PATHOLOGY   12,303   523,829   0.023487   57,412   1,348   68. 00   69. 00   ELECTROCARDI OLOGY   0 0 0.000000   0 0   69. 00   0.000000   0 0   0.000000   0 0   0.000000   0 0   0.000000   0 0   0.000000   0 0   0.000000   0 0   0.000000   0 0   0.000000   0 0   0.000000   0 0   0.0000000   0 0   0.000000   0 0   0.000000   0 0   0.000000   0 0   0.000000   0 0   0.000000   0 0   0.000000   0 0   0.000000   0 0   0.000000   0 0   0.000000   0 0   0.000000   0 0   0.000000   0 0   0.000000   0 0   0.0000000   0 0   0.0000000   0 0   0.0000000   0 0   0.0000000   0 0   0.0000000   0 0   0.0000000   0 0   0.0000000   0 0   0.0000000   0 0   0.0000000   0 0   0.0000000   0 0   0.0000000   0 0   0.0000000   0 0   0.00000000							
67. 00   06700   0CCUPATI ONAL THERAPY   45, 972   1, 143, 458   0. 040204   177, 750   7, 146   67. 00   68. 00   06800   SPEECH PATHOLOGY   12, 303   523, 829   0. 023487   57, 412   1, 348   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   0   0. 000000   0   0   69. 01   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   65, 491   9, 725, 130   0. 006734   1, 801, 836   12, 134   71. 00   71. 01   1 V SOLUTI ONS   2, 665   2, 990, 998   0. 000891   760, 148   677   71. 01   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   87, 263   12, 953, 322   0. 006737   2, 747, 698   18, 511   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   208, 724   74, 019, 379   0. 002820   8, 527, 153   24, 047   73. 00   73. 00   07697   CARDI AC REHABI LI TATI ON   22, 784   332, 060   0. 068614   161   11   76. 97   0. 007697   0							
68. 00   06800   SPEECH PATHOLOGY   12, 303   523, 829   0. 023487   57, 412   1, 348   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   0   0. 0000000   0   0   0   69. 00   69. 01   03610   SLEEP LAB   28, 879   1, 304, 505   0. 022138   0   0   69. 01   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   65, 491   9, 725, 130   0. 006734   1, 801, 836   12, 134   71. 00   71. 01   1V SOLUTI ONS   2, 665   2, 990, 998   0. 000891   760, 148   677   71. 01   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   87, 263   12, 953, 322   0. 006737   2, 747, 698   18, 511   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   208, 724   74, 019, 379   0. 002820   8, 527, 153   24, 047   73. 00   76. 00   03140   CARDI OLOGY   196, 237   9, 883, 236   0. 019856   973, 156   19, 323   76. 00   76. 97   0. 002800   CARDI AC REHABI LI TATI ON   22, 784   332, 060   0. 068614   161   11   76. 97   0. 002800   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000   0. 00000							
69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   0   0   0   0   0							
69. 01 03610 SLEEP LAB 28,879 1,304,505 0.022138 0 0 69. 01 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 65,491 9,725,130 0.006734 1,801,836 12,134 71. 00 71. 01 07101 I V SOLUTI ONS 2,665 2,990,998 0.000891 760,148 677 71. 01 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 87,263 12,953,322 0.006737 2,747,698 18,511 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 208,724 74,019,379 0.002820 8,527,153 24,047 73. 00 76. 00 03140 CARDI OLOGY 196,237 9,883,236 0.019856 973,156 19,323 76. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 22,784 332,060 0.068614 161 11 76. 97 00TPATI ENT SERVI CE COST CENTERS  90. 00 09000 CLI NI C 23,789 49,626 0.479366 0 0 0 90.00 90.01 09001 WOUND CARE CLI NI C 65,087 283,038 0.229959 0 0 90.01 91. 00 09100 EMERGENCY 489,803 22,414,435 0.021852 2,099,623 45,881 91.00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 385,154 3,895,218 0.098879 293,102 28,982 92.00 0THER REI MBURSABLE COST CENTERS			1		57, 412	· ·	
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   65, 491   9, 725, 130   0.006734   1, 801, 836   12, 134   71. 00   71. 01   07101   IV SOLUTIONS   2, 665   2, 990, 998   0.000891   760, 148   677   71. 01   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   87, 263   12, 953, 322   0.006737   2, 747, 698   18, 511   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   208, 724   74, 019, 379   0.002820   8, 527, 153   24, 047   73. 00   03140   CARDI OLOGY   196, 237   9, 883, 236   0.019856   973, 156   19, 323   76. 00   76. 97   07697   CARDI AC REHABI LI TATI ON   22, 784   332, 060   0.068614   161   11   76. 97   0.002820   0.0068014   0.0068		_			0		
71. 01   07101   IV SOLUTIONS   2, 665   2, 990, 998   0. 000891   760, 148   677   71. 01   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   87, 263   12, 953, 322   0. 006737   2, 747, 698   18, 511   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   208, 724   74, 019, 379   0. 002820   8, 527, 153   24, 047   73. 00   76. 00   03140   CARDI OLOGY   196, 237   9, 883, 236   0. 019856   973, 156   19, 323   76. 00   07697   CARDI AC REHABILITATI ON   22, 784   332, 060   0. 068614   161   11   76. 97   000000					0		
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   87, 263   12, 953, 322   0.006737   2, 747, 698   18, 511   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   208, 724   74, 019, 379   0.002820   8, 527, 153   24, 047   73. 00   76. 00   03140   CARDI OLOGY   196, 237   9, 883, 236   0.019856   973, 156   19, 323   76. 00   76. 97   07697   CARDI AC REHABI LI TATI ON   22, 784   332, 060   0.068614   161   11   76. 97   00000   CLI NI C   23, 789   49, 626   0.479366   0   0.008820   0		65, 491	9, 725, 130		1, 801, 836	12, 134	71. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS   208, 724   74, 019, 379   0.002820   8, 527, 153   24, 047   73. 00   76. 00   03140   CARDI OLOGY   196, 237   9, 883, 236   0.019856   973, 156   19, 323   76. 00   76. 97   07697   CARDI AC REHABI LI TATI ON   22, 784   332, 060   0.068614   161   11   76. 97   00000   CLI NI C   23, 789   49, 626   0.479366   0   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000000	71.01  07101 IV SOLUTIONS	2, 665	2, 990, 998	0. 000891	760, 148	677	71. 01
76. 00 03140 CARDI OLOGY 196, 237 9, 883, 236 0. 019856 973, 156 19, 323 76. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 22, 784 332, 060 0. 068614 161 11 76. 97  OUTPATI ENT SERVI CE COST CENTERS  90. 00 09000 CLI NI C 23, 789 49, 626 0. 479366 0 0 0 0 90. 00 90. 01 09001 WOUND CARE CLI NI C 65, 087 283, 038 0. 229959 0 0 0 90. 01 91. 00 09100 EMERGENCY 489, 803 22, 414, 435 0. 021852 2, 099, 623 45, 881 91. 00 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 385, 154 3, 895, 218 0. 098879 293, 102 28, 982 92. 00  OTHER REI MBURSABLE COST CENTERS	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	87, 263	12, 953, 322	0.006737	2, 747, 698	18, 511	72. 00
76. 97 O7697 CARDIAC REHABILITATION 22, 784 332, 060 0.068614 161 11 76. 97 OUTPATIENT SERVICE COST CENTERS  90. 00 09000 CLINIC 23, 789 49, 626 0.479366 0 0 0 90.00 90.01 09001 WOUND CARE CLINIC 65, 087 283, 038 0.229959 0 0 90.01 91.00 09100 EMERGENCY 489, 803 22, 414, 435 0.021852 2, 099, 623 45, 881 91. 00 92.00 0958ERVATION BEDS (NON-DISTINCT PART) 385, 154 3, 895, 218 0.098879 293, 102 28, 982 92. 00 OTHER REIMBURSABLE COST CENTERS	73.00 07300 DRUGS CHARGED TO PATIENTS	208, 724	74, 019, 379	0. 002820	8, 527, 153	24, 047	73.00
OUTPATIENT SERVICE COST CENTERS  90. 00	76. 00 03140 CARDI OLOGY	196, 237	9, 883, 236	0. 019856	973, 156	19, 323	76. 00
90. 00   09000   CLI NI C   23,789   49,626   0.479366   0   0   90.00   09001	76. 97 07697 CARDI AC REHABI LI TATI ON	22, 784	332, 060	0. 068614	161	11	76. 97
90. 00   09000   CLI NI C   23,789   49,626   0.479366   0   0   90.00   09001	OUTPATIENT SERVICE COST CENTERS						
91. 00   09100   EMERGENCY   489, 803   22, 414, 435   0. 021852   2, 099, 623   45, 881   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART)   385, 154   3, 895, 218   0. 098879   293, 102   28, 982   92. 00   OTHER REI MBURSABLE COST CENTERS		23, 789	49, 626	0. 479366	0	0	90.00
91. 00   09100   EMERGENCY   489, 803   22, 414, 435   0. 021852   2, 099, 623   45, 881   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART)   385, 154   3, 895, 218   0. 098879   293, 102   28, 982   92. 00   OTHER REI MBURSABLE COST CENTERS					0	0	
92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART)   385, 154   3, 895, 218   0. 098879   293, 102   28, 982   92. 00   OTHER REI MBURSABLE COST CENTERS					2, 099, 623	45, 881	91.00
OTHER REI MBURSABLE COST CENTERS							
					-,=	-, -=	
95. 00 1095001 AMBULANCE SERVI CES	95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199) 3, 915, 054 259, 490, 428 28, 801, 715 334, 909 200.00		3, 915, 054	259, 490, 428		28, 801, 715	334, 909	

Health Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	PASS THROUGH COST	rs Provider C		Period: From 01/01/2020 To 12/31/2020		pared: 00 am
		Ti tl e	XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdowr Adjustments		All Other Medical Education 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	
31. 00   03100   I NTENSI VE CARE UNI T	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		Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
		minus col. 4)	/ 00	7.00	0.00	
INPATIENT ROUTINE SERVICE COST CENTERS	4. 00	5. 00	6. 00	7. 00	8. 00	
30. 00 03000 ADULTS & PEDIATRICS	0		11, 04	0.00	3, 866	30.00
31. 00   03100   NTENSI VE CARE UNI T	0	0	1, 47			
43. 00   04300   NURSERY		0	99			
200.00 Total (lines 30 through 199)		0	1			200. 00
Cost Center Description	Inpatient	0	13, 30	J <sub> </sub>	4, 330	200.00
oost conten boscii peron	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 I NTENSI VE 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'	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0069	Peri od: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared:

			'	0 12/31/2020	5/24/2021 11:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
· ·	Anestheti st	Post-Stepdown	Ŭ	Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0	C	0	0	50.00
51.00   05100   RECOVERY ROOM	0	0	C	0	0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	C	0	0	52. 00
53. 00   05300   ANESTHESI OLOGY	0	0	C	0	174, 156	53. 00
54. 00   05400 RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	54.00
54. 01   03630   ULTRA SOUND	0	0	l c	0	0	54. 01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	C	0	0	54. 02
55. 00   05500 RADI OLOGY - THERAPEUTI C	0	0	l c	0	0	55. 00
55. 01   03480   ONCOLOGY	0	0	l c	0	0	55. 01
57. 00  05700 CT SCAN	0	0	l c	0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	l c	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	l c	0	0	59. 00
60. 00 06000 LABORATORY	0	0	l c	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	l c	0	0	62. 00
65. 00 06500 RESPIRATORY THERAPY	0	0	l c	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	l c	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	l c	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	l c	0	0	69. 00
69. 01   03610   SLEEP LAB	0	0	l c	0	0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	l c	0	0	71. 00
71. 01 07101 IV SOLUTIONS	0	0	l c	0	0	71. 01
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	l c	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	l c	0	0	73. 00
76. 00 03140 CARDI OLOGY	0	0	l c	0	0	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	C	0	0	90.00
90. 01   09001   WOUND CARE CLINIC	0	0	l d	0	0	
91. 00   09100   EMERGENCY	0	0	l d	0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	_	i o	)	0	1
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVI CES						95. 00
200.00 Total (lines 50 through 199)	0	0	l c	0	174, 156	
	١			1	, 100	,_ 50. 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	Peri od: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 5/24/2021 11:00 am
		Title XVIII	Hospi tal	PPS

	000.10			Т	o 12/31/2020	Date/Time Pre 5/24/2021 11:	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4.00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0	C		0. 000000	1
51. 00	05100 RECOVERY ROOM	0	0	C	.,		
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C	., ,		
53.00	05300 ANESTHESI OLOGY	0	174, 156	174, 156			
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	[ C	-,,		
54. 01	03630 ULTRA SOUND	0	0	C	1, 735, 891	0. 000000	1
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0	C	4, 485, 311	0.000000	54. 02
55.00	05500   RADI OLOGY - THERAPEUTI C	0	0	C	0	0.000000	55. 00
55. 01	03480 ONCOLOGY	0	0	C	5, 786, 774	0.000000	55. 01
57.00	05700 CT SCAN	0	0	C	15, 332, 555	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	C	3, 410, 645	0.000000	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	C	0	0.000000	59. 00
60.00	06000 LABORATORY	0	0	C	31, 790, 253	0.000000	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	C	1, 927, 143	0.000000	62. 00
65.00	06500 RESPI RATORY THERAPY	0	0	C	5, 734, 688	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	l c	7, 520, 905	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	o	0	l	1, 143, 458	0. 000000	67. 00
68.00	06800 SPEECH PATHOLOGY	o	0	l	523, 829		68. 00
69.00	06900 ELECTROCARDI OLOGY	o	0	l	0	0.000000	69. 00
69. 01	03610 SLEEP LAB	o	0	l	1, 304, 505	0.000000	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0	l c	9, 725, 130	0. 000000	71.00
71. 01	07101 I V SOLUTIONS	o	0	l	2, 990, 998	0. 000000	71. 01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	l			
73.00	07300 DRUGS CHARGED TO PATIENTS	o	0	l	74, 019, 379	0. 000000	73. 00
76. 00	03140 CARDI OLOGY	o	0	l	9, 883, 236	0. 000000	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	o	0				76. 97
	OUTPATIENT SERVICE COST CENTERS	'		•			1
90.00	09000 CLI NI C	0	0	C	49, 626	0.000000	90.00
90. 01	09001 WOUND CARE CLINIC	o	0	C	283, 038	0. 000000	90. 01
91.00	09100 EMERGENCY	o	0	l c	22, 414, 435	0. 000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	o	0	l	3, 895, 218	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS	,					1
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)	o	174, 156	174, 156	259, 490, 428		200. 00

Health Financial Systems	KING'S DAUGHTER	S' HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILL	ARY SERVICE OTHER PASS	Provi der Co		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2020	Part IV	
				To 12/31/2020	Date/Time Pre	pared:
					5/24/2021 11:	00 am
		Title	: XVIII	Hospi tal	PPS	
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	n Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	

			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	2, 352, 124	0	5, 446, 008	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	427, 799	0	933, 103	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	2, 895	0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 033246	492, 654	16, 379	712, 766	23, 697	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	695, 173	0	1, 264, 921	0	54.00
54. 01	03630 ULTRA SOUND	0. 000000	68, 477	0	330, 811	0	54. 01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 000000	163, 061	0	1, 680, 645	0	54. 02
55.00	05500 RADI OLOGY - THERAPEUTI C	0. 000000	0	0	0	0	55. 00
55. 01	03480 ONCOLOGY	0. 000000	28, 327	0	2, 766, 099	0	55. 01
57.00	05700 CT SCAN	0. 000000	1, 310, 190	0	3, 742, 576	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	139, 767	0	995, 149	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0	0	0	0	59. 00
60.00	06000 LABORATORY	0. 000000	2, 694, 171	0	2, 487, 444	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	548, 928	0	179, 725	0	62. 00
65.00	06500 RESPIRATORY THERAPY	0. 000000	2, 060, 998	0	434, 644	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	379, 112	0	53, 602	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	177, 750	0	36, 120	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 000000	57, 412	0	907	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	359, 524	0	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1, 801, 836	0	1, 016, 278	0	71. 00
71. 01	07101 IV SOLUTIONS	0. 000000	760, 148	0	263, 308	0	71. 01
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	2, 747, 698	0	2, 249, 555	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	8, 527, 153	0	23, 617, 797	0	73. 00
76.00	03140 CARDI OLOGY	0. 000000	973, 156	0	3, 272, 225	0	76. 00
76. 97	07697 CARDIAC REHABILITATION	0. 000000	161	0	123, 430	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 000000	0	0	4, 979	0	90.00
90. 01	09001 WOUND CARE CLINIC	0. 000000	0	0	116, 677	0	90. 01
91.00	09100 EMERGENCY	0. 000000	2, 099, 623	0	3, 650, 520	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	293, 102	0	824, 759	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)		28, 801, 715	16, 379	56, 563, 572	23, 697	200. 00

| Peri od: | Worksheet D | From 01/01/2020 | Part V | To | 12/31/2020 | Date/Time Prepared: | Date/Time Prepar

					0 12/31/2020	5/24/2021 11:	
			Title	xVIII	Hospi tal	PPS	oo aiii
				Charges	noopi tui	Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	oost center bescription	9	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	(300 11.01.)	
		Part I, col. 9	,	Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2. 00	3.00	4. 00	5. 00	
ANCI L	LARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0. 216093	5, 446, 008	(	0	1, 176, 844	50.00
51.00 05100	RECOVERY ROOM	0. 118270		(	0	110, 358	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0. 580960	0		0	0	52. 00
53.00 05300	ANESTHESI OLOGY	0. 163481	712, 766		0	116, 524	53. 00
54.00 05400	RADI OLOGY-DI AGNOSTI C	0. 613109	1, 264, 921		0	775, 534	54. 00
54. 01 03630	ULTRA SOUND	0. 143893	330, 811		0	47, 601	54. 01
54. 02 03450	NUCLEAR MEDICINE - DIAGNOSTIC	0. 075839	1, 680, 645		0	127, 458	54. 02
	RADIOLOGY - THERAPEUTIC	0. 000000	0	1	0	0	55. 00
55. 01 03480	ONCOLOGY	0. 505735	2, 766, 099		0	1, 398, 913	55. 01
57.00 05700	CT SCAN	0. 042665	3, 742, 576		0	159, 677	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0. 132136	995, 149		0	131, 495	
	CARDI AC CATHETERI ZATI ON	0. 000000	0		0	0	59.00
	LABORATORY	0. 163359	2, 487, 444	3, 400	0	406, 346	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 167830				30, 163	62.00
65.00 06500	RESPI RATORY THERAPY	0. 193368	434, 644		0	84, 046	
	PHYSI CAL THERAPY	0. 331871	53, 602		0	17, 789	66.00
67.00 06700	OCCUPATIONAL THERAPY	0. 338905			0	12, 241	
68. 00 06800	SPEECH PATHOLOGY	0. 401927	907	1	0	365	68. 00
	ELECTROCARDI OLOGY	0. 000000	0		0	0	
69. 01 03610	SLEEP LAB	0. 236514	359, 524		0	85, 032	69. 01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 320632	1, 016, 278		0	325, 851	71.00
	I I V SOLUTIONS	0. 042570			0	11, 209	
	IMPL. DEV. CHARGED TO PATIENTS	0. 320749		1	0	721, 543	1
	DRUGS CHARGED TO PATIENTS	0. 173988			82, 093	4, 109, 213	1
	CARDI OLOGY	0. 130545		1		427, 173	1
	CARDIAC REHABILITATION	0. 439219		l .		54, 213	
	ATIENT SERVICE COST CENTERS						
	CLINIC	2. 590578	4, 979	(	0	12, 898	90.00
90. 01 09001	WOUND CARE CLINIC	1. 108568	116, 677		0	129, 344	90. 01
	EMERGENCY	0. 203286		1	39	742, 100	
	OBSERVATION BEDS (NON-DISTINCT PART)	0. 659204	824, 759	1		543, 684	
	R REIMBURSABLE COST CENTERS					2.07.00	
	AMBULANCE SERVICES	0. 537973					95. 00
200.00	Subtotal (see instructions)		56, 563, 572	3, 400	82, 132	11, 757, 614	
201. 00	Less PBP Clinic Lab. Services-Program		,,		0	,	201. 00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)		56, 563, 572	3, 400	82, 132	11, 757, 614	202. 00

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 15-0069	Peri od: From 01/01/2020	Worksheet D Part V

12/31/2020 Date/Time Prepared: To 5/24/2021 11:00 am Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 7.00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 51.00 05100 RECOVERY ROOM 000000000000 0 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 0 53.00 05300 ANESTHESI OLOGY 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0 54. 01 03630 ULTRA SOUND 54.01 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0 54.02 54.02 55.00 05500 RADIOLOGY - THERAPEUTIC 0 55.00 03480 ONCOLOGY 0 55.01 55.01 05700 CT SCAN 0 57 00 57 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 555 60.00 06000 LABORATORY 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 000000000000 0 62.00 62.00 65.00 06500 RESPIRATORY THERAPY 0 65.00 66.00 06600 PHYSI CAL THERAPY 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 03610 SLEEP LAB 0 69.01 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 71.00 07101 IV SOLUTIONS 0 71.01 71.01 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 14, 283 73.00 76.00 03140 CARDI OLOGY 0 76.00 07697 CARDIAC REHABILITATION 76.97 0 76.97 OUTPATIENT SERVICE COST CENTERS 0 90.00 09000 CLI NI C 0 90.00 09001 WOUND CARE CLINIC 0 90.01 90.01 0 91.00 09100 EMERGENCY 8 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 95.00 200.00 Subtotal (see instructions) 555 14, 291 200.00 201.00 Less PBP Clinic Lab. Services-Program 201. 00 Only Charges Net Charges (line 200 - line 201) 202.00 555 202.00 14, 291

| Peri od: | Worksheet D | From 01/01/2020 | Part V | To | 12/31/2020 | Date/Time Prepared: | Date/Time Prepar

					10 12/31/2020	5/24/2021 11:	
			Ti tl	e XIX	Hospi tal	Cost	00 4111
				Charges	noopi tui	Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	0001 0011101 20001 1 pt. 011	9	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	(000 111011)	
		Part I, col. 9	,	Subject To	Subject To		
		,		Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 216093	0		0 3, 039, 675	0	50.00
51.00	D5100 RECOVERY ROOM	0. 118270	0		0 1, 000, 678	0	51.00
52.00	D5200 DELIVERY ROOM & LABOR ROOM	0. 580960	0		0 6, 937	0	52. 00
53.00	D5300 ANESTHESI OLOGY	0. 163481	0		0 787, 949	0	53.00
54.00	D5400 RADI OLOGY-DI AGNOSTI C	0. 613109	0		0 1, 012, 774	0	54.00
54. 01	03630 ULTRA SOUND	0. 143893	0		0 327, 627	0	54. 01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 075839	0		0 459, 504	0	54. 02
	D5500 RADI OLOGY - THERAPEUTI C	0. 000000	0		0 0	0	55.00
55. 01	D3480 ONCOLOGY	0. 505735	0		0 465, 707	0	55. 01
57.00	D5700 CT SCAN	0. 042665	0		0 2, 342, 355	0	57.00
58.00	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0. 132136	0		0 470, 253	0	58. 00
	D5900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
	06000 LABORATORY	0. 163359	0		0 5, 491, 358	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 167830	0		0 39, 772	0	62. 00
	06500 RESPIRATORY THERAPY	0. 193368	0		0 328, 330	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 331871	0		0 1, 039, 731	0	66. 00
67. 00	06700 OCCUPATIONAL THERAPY	0. 338905	0		0 0	0	67. 00
68.00	D6800 SPEECH PATHOLOGY	0. 401927	0		0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	0		0	0	69. 00
69. 01	03610 SLEEP LAB	0. 236514	0		0	0	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 320632	0		0 1, 165, 676	0	71. 00
71. 01	07101 IV SOLUTIONS	0. 042570	0		0 321, 689	0	71. 01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 320749	0		0 1, 124, 659	0	72. 00
73.00	D7300 DRUGS CHARGED TO PATIENTS	0. 173988	0		0 5, 357, 959	0	73. 00
76.00	03140 CARDI OLOGY	0. 130545	0		0 1, 386, 281	0	76. 00
76. 97	D7697 CARDIAC REHABILITATION	0. 439219	0		0 26, 242	0	76. 97
C	DUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLI NI C	2. 590578	0		0 9, 018	0	90.00
90. 01	D9001 WOUND CARE CLINIC	1. 108568	0		0 0	0	90. 01
91.00	D9100 EMERGENCY	0. 203286	0		0 5, 682, 614	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 659204	0		0 737, 984	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0. 537973	0		0		95. 00
200.00	Subtotal (see instructions)		0		0 32, 624, 772	0	200. 00
201.00	Less PBP Clinic Lab. Services-Program				0		201. 00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)		0		0 32, 624, 772	0	202. 00

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST		Peri od: From 01/01/2020	Worksheet D Part V

12/31/2020 Date/Time Prepared: To 5/24/2021 11:00 am Title XIX Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 656, 852 50.00 51.00 05100 RECOVERY ROOM 0 0 0 118, 350 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 4,030 52 00 53.00 05300 ANESTHESI OLOGY 128, 815 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 620, 941 54.00 54. 01 03630 ULTRA SOUND 0000000000000000000000 47, 143 54.01 03450 NUCLEAR MEDICINE - DIAGNOSTIC 54.02 34, 848 54.02 55.00 05500 RADIOLOGY - THERAPEUTIC 55.00 03480 ONCOLOGY 55.01 235, 524 55.01 05700 CT SCAN 99, 937 57 00 57 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 62, 137 58.00 59.00 05900 CARDIAC CATHETERIZATION 59.00 60.00 06000 LABORATORY 897, 063 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 6, 675 62.00 65.00 06500 RESPIRATORY THERAPY 63, 489 65.00 06600 PHYSI CAL THERAPY 345, 057 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 67.00 0 06800 SPEECH PATHOLOGY 68.00 0 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 03610 SLEEP LAB 69.01 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 373, 753 71.00 07101 IV SOLUTIONS 71.01 13, 694 71.01 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 360, 733 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 932, 221 73.00 03140 CARDI OLOGY 180, 972 76.00 76.00 07697 CARDIAC REHABILITATION 76.97 11, 526 76.97 OUTPATIENT SERVICE COST CENTERS 0 90.00 09000 CLI NI C 23, 362 90.00 09001 WOUND CARE CLINIC 0 90.01 90.01 0 91.00 09100 EMERGENCY 1, 155, 196 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 486, 482 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 95.00 0 200.00 Subtotal (see instructions) 6, 858, 800 200.00 201.00 Less PBP Clinic Lab. Services-Program 201. 00 Only Charges Net Charges (line 200 - line 201) o 202.00 202.00 6.858.800

Health Financial Systems	KING'S DAUGHTERS' F	HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	F	Provider CCN: 15-0069	Peri od: From 01/01/2020	
			To 12/31/2020	Date/Time Prepared: 5/24/2021 11:00 am
		Title XVIII	Hospi tal	PPS

		Title XVIII	Hospi tal	5/24/2021 11: PPS	00 am
	Cost Center Description	THE AVIII	nospi tai		
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			11, 040	1. 00
2.00	Inpatient days (including private room days, excluding swing-l			11, 040	2.00
3.00	Private room days (excluding swing-bed and observation bed day do not complete this line.	(S). If you have only pr	ivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		8, 142	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	5. 00
/ 00	reporting period	d) - <del></del>	24 - 5 - 1	0	
6. 00	Total swing-bed SNF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)	om days) arter becember	31 OF the Cost	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private roor	n days) through December	31 of the cost	0	7. 00
0.00	reporting period		4 6 11		0.00
8. 00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	n days) after December 3	or the cost	0	8. 00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	3, 866	9. 00
	newborn days) (see instructions)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruc-		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom davs) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, en	nter O on this line)	,		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including private	e 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)	Conty (including private	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye	ear, enter O on this lin	e)		
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14.00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15. 00 16. 00
10.00	SWING BED ADJUSTMENT				10.00
17. 00					
18. 00	reporting period	os after December 21 of	the cost	0.00	18. 00
16.00	O Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				16.00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period	a after December 21 of t	ha aaat	0.00	20. 00
20.00	Medicaid rate for swing-bed NF services applicable to services reporting period	s arter becember 31 or t	ne cost	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions			9, 781, 840	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 173	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	31 of the cost reporting	a period (line 6	0	23. 00
	x line 18)		9		
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)		p		
26. 00	Total swing-bed cost (see instructions)	(1: 04 : 1: 04)		0 701 010	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost   PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		9, 781, 840	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi - pri vate room charges (excluding swing-bed charges)	1: 20)		0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 ÷ line 3)	: II ne 28)		0. 000000 0. 00	31. 00 32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)				34. 00
35. 00 36. 00					35. 00 36. 00
36.00					37.00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			886. 04	38. 00
39. 00	Program general inpatient routine service cost per drem (see	*		3, 425, 431	ı
40.00	Medically necessary private room cost applicable to the Progra			0	40.00
41. 00	Total Program general inpatient routine service cost (line 39	3, 425, 431	41. 00		

	Financial Systems	KING'S DAUGHTER		CN: 1E 00/0		workshoot D 1	
COMPUI	ATION OF INPATIENT OPERATING COST		Provi der C	UN: 15-0069	Peri od: From 01/01/2020		
					To 12/31/2020	Date/Time Pre 5/24/2021 11:	
			_	XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Costl	Total	Average Per	3	Program Cost (col. 3 x col.	
		Impatrent costi	mpatrent bays	col . 2)		4)	
42.00	MUDGEDY (+; +1 - V o VIV1)	1.00	2.00	3.00	4. 00	5. 00	12.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	C	0.	00 0	0	42.00
43.00	INTENSIVE CARE UNIT	1, 959, 010	1, 473	1, 329.	95 692	920, 325	43. 00
44.00	CORONARY CARE UNIT						44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)			1. 00 6, 096, 449	48. 00
	Total Program inpatient costs (sum of lines			ons)		10, 442, 205	
F0 00	PASS THROUGH COST ADJUSTMENTS			W/ 1 D	6.0.1.1.1	557.044	F0 00
50. 00	Pass through costs applicable to Program inp	oatient routine s	services (from	n Wkst. D, sui	m of Parts I and	557, 941	50.00
51.00	Pass through costs applicable to Program inp	atient ancillary	services (fr	om Wkst. D,	sum of Parts II	351, 288	51.00
F2 00	and IV)	FO F1)				000 000	F2 00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ated non-phy	sician anesti	netist and	909, 229 9, 532, 976	
00.00	medical education costs (line 49 minus line					7,002,770	]
F4 00	TARGET AMOUNT AND LIMIT COMPUTATION					1 0	   <sub> </sub>
	Program discharges Target amount per discharge					0.00	54. 00 55. 00
56. 00	Target amount (line 54 x line 55)						56. 00
57. 00	57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						
58.00	8.00  Bonus payment (see instructions) 9.00  Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the						
	market basket		o .	•			59. 00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0.00	60.00
01.00	which operating costs (line 53) are less than						01.00
	amount (line 56), otherwise enter zero (see		•	,	3		
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ont (soo instru	rtions)			0	
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST	ient (see mistruc	, tr 0113)				03.00
64. 00		sts through Decem	nber 31 of the	cost report	ng period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	sts after Decembe	er 31 of the d	ost reportin	neriod (See	0	65. 00
	instructions) (title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line 6	64 plus line 6	5)(title XVI	II only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing	ne costs through	December 31 c	of the cost r	eporting period	0	67. 00
	(line 12 x line 19)						
68.00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	ie costs after De	ecember 31 or	the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs (I	ine 67 + line	e 68)		0	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER N				<u> </u>	I	70.00
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of				)		70.00
72. 00	Program routine service cost (line 9 x line	71)					72. 00
73.00	Medically necessary private room cost applic						73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•			Part II. column		74. 00 75. 00
	26, line 45)						
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	, ,						78.00
79. 00	Aggregate charges to beneficiaries for exces						79. 00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		st limitation	ı (line 78 mi	nus line 79)		80. 00 81. 00
82. 00	Inpatient routine service cost per drem from						82.00
83. 00	Reasonable inpatient routine service costs (	see instructions					83. 00
84. 00 85. 00	Program inpatient ancillary services (see in		ne)				84. 00 85. 00
86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST	<i>J/</i>				
87.00	Total observation bed days (see instructions	•	lino 2)			2, 898	
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	11110 2)			2, 567, 744	88. 00 89. 00
57.00	(1110 07 X 1110 00) (30					2,007,744	, 57. 50

Health Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2020 To 12/31/2020	Date/Time Pre 5/24/2021 11:0	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 467, 247	9, 781, 840	0. 14999	7 2, 567, 744	385, 154	90.00
91.00 Nursing School cost	0	9, 781, 840	0.00000	2, 567, 744	0	91.00
92.00 Allied health cost	0	9, 781, 840	0.00000	2, 567, 744	0	92.00
93.00 All other Medical Education	0	9, 781, 840	0.00000	2, 567, 744	0	93.00

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0069	From 01/01/2020	Worksheet D-1 Date/Time Prepared: 5/24/2021 11:00 am
•		Title XIX	Hospi tal	Cost

PART I - ALL PROVIDER COMPONENTS    PART I - ALL PROVIDER COMPONENTS			Title XIX	Hospi tal	5/24/2021 11:0 Cost	00 am
Impatient days (Including private room days and saring-bed days, excluding newborn)   11,000   1,000		Cost Center Description	THE XIX	позрі саі	0031	
MATTERN DAYS					1. 00	
Impatient days (including private room days and sering-bed days, excluding nestorn)   11,040   1.0						
Impatient days (including private room days, excluding seing-bed and neeborn days)   11,040   2.00   3.00   Private room days (secularing swing-bed and observation bed days). If you have not not private room days.   3.00   3.00   2.00   3	1.00		s, excluding newborn)		11, 040	1. 00
do not complete this line.  4. 00 Semi-private room days (excluding saxing-bed and observation bed days)  Total saxing-bed SNF type inpatient days (including private room days) after December 31 of the cost open reporting period (if calendar year, enter 0 on this line)  7. 00 Iotal saxing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  8. 00 Iotal saxing-bed NF type inpatient days (including private room days) after December 31 of the cost of reporting period (if calendar year, enter 0 on this line)  9. 00 Iotal saxing-bed NF type inpatient days (including private room days) after December 31 of the cost of reporting period (if calendar year, exter 0 on this line)  10. 00 Sxing-bed SNF type inpatient days applicable to the Program (excluding saing-bed and next-ordinal days) (see instructions)  10. 00 Sxing-bed SNF type inpatient days applicable to the Program (excluding saing-bed and next-ordinal days) (see instructions)  10. 00 Sxing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after on through December 31 of the cost reporting period (see Instructions)  10. 00 Sxing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after on through December 31 of the cost reporting period (see Instructions)  10. 00 Sxing-bed SNF type inpatient days applicable to title SV or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  10. 00 Sxing-bed SNF type inpatient days applicable to title SV or XIX only (including private room days)  10. 00 Total nursery days (title V or XIX only)  10. 00 Total nursery days (title V or XIX only)  10. 00 Total nursery days (title V or XIX only)  10. 00 Total nursery days (title V or XIX only)  10. 00 Total nursery days (title V or XIX only)  10. 00 Total calendar to for swing-bed SNF services applicable to services through December 31 of the cos	2.00	Inpatient days (including private room days, excluding swing-k	ped and newborn days)		11, 040	
Semi-private room days (excluding swing-ted and observation bed days) through December 31 of the cost reporting period of saving-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period of it call ender year, enter 0 on this line)   Total saving-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days applicable to services after December 31 of the cost reporting period (inclu	3.00		ys). If you have only pri	vate room days,	0	3. 00
Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost of Potal Institute private (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line)  7.00 period period (if callendar year, enter 0 on this line)  8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line)  9.01 Total inpatient days including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line)  10.02 Swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line)  10.03 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  10.03 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  10.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days)  10.00 Swing-bed SNF type inpatient days applicable to services XVIII only (including private room days)  10.00 Swing-bed SNF type inpatient days applicable to services XVIII only (including private room days)  10.00 Swing-bed SNF type inpatient days applicable to services XVIII only (including private room days)  10.00 Swing-bed SNF type inpatient days applicable to services through December 31 of the cost on this line)  10.00 Swing-bed SNF type inpatient days applicable to services through December 31 of the cost on the services of the services after December 31 of the cost of the cost of the cost of the services after December 31	4 00		ad days)		0 142	4 00
reporting period (1 real real real real real real real real				r 31 of the cost		
reporting period (if cal endar year, enter 0 on this line)  7. 00 Total sing-bed NF type inpatient days (including private room days) after December 31 of the cost 1 on the single single period 1 on the sin	0.00		siii aaye, tiii eagii beesiiibe	0. 0. 1 0001	ا	0.00
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24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  Private room charges (excluding swing-bed and observation bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average per diem private room per diem charge (line 30 + line 4)  33.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  34.00 Average per diem private room cost differential (line 34 x line 31)  35.00 Average per diem private room cost differential (line 3 x line 35)  26.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 781, 840)  37.00 Program general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	23. 00	l	31 of the cost reporting	g period (line 6	0	23. 00
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x line 20)  26. 00  Total swing-bed cost (see instructions)  27. 00  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00  General inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)  30. 00  Semi-private room charges (excluding swing-bed charges)  30. 00  Semi-private room charges (excluding swing-bed charges)  30. 00  General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  Average private room per diem charge (line 29 ÷ line 3)  31. 00  Average semi-private room per diem charge (line 30 ÷ line 4)  Average per diem private room cost differential (line 32 minus line 33) (see instructions)  Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  O General inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 781, 840)  PRIVATE ROOM DIFFERENTIAL ADD SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00  Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40. 00  Medically necessary private room cost applicable to the Program (line 14 x line 35)	25 00	l	31 of the cost reporting	neriod (line 8	ام	25 00
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 9, 781, 840 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 28. 00 Private room charges (excluding swing-bed charges) 0 29. 00 30. 00 Semi-private room charges (excluding swing-bed charges) 0 30. 00 General inpatient routine service cost/charge ratio (line 27 ± line 28) 0.000000 31. 00 32. 00 Average private room per diem charge (line 29 + line 3) 0.00 32. 00 Average semi-private room per diem charge (line 30 ± line 4) 0.00 32. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00 34. 00 Average per diem private room cost differential (line 34 x line 31) 0.00 35. 00 Average per diem private room cost differential (line 34 x line 35) 0 36. 00 Frivate room cost differential djustment (line 3 x line 35) 0 36. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 781, 840 37. 00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 886. 04 Adjusted general inpatient routine service cost (line 9 x line 38) 9.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00	20.00		or the cost reporting	perred (Trie 6	ا	20.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  9.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  31.00 Average private room per diem charge (line 29 ÷ line 3)  32.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 781, 840)  37.00 General inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  9.00 Program general inpatient routine service cost (line 9 x line 38)  9.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28.00  28.00  29.00  29.00  20.00  20.00  20.00  30.00		,				
28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  31. 00 Average private room per diem charge (line 29 ÷ line 3)  32. 00 Average semi-private room per diem charge (line 30 ÷ line 4)  33. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  34. 00 Average per diem private room cost differential (line 34 x line 31)  35. 00 Average per diem private room cost differential (line 3 x line 35)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 781, 840)  Adjusted general inpatient routine service cost per diem (see instructions)  38. 00 Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28. 00 29. 00 29. 00 30. 00 0 30. 00 0 0. 0000000 31. 00 0. 00 32. 00 0. 00 32. 00 33. 00 0. 00 34. 00 35. 00 36. 00 37. 00 36. 00 37. 00 37. 00 38. 00 38. 00 39. 00 40. 00	27. 00		(line 21 minus line 26)		9, 781, 840	27. 00
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 31.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 781, 840) 27 minus line 36)  PART II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 29.00 30.00 30.00 0.00 30.00 0.000000 31.00 31.00 0.000000 31.00 32.00 32.00 0.00 32.00 32.00 0.00 32.00 32.00 0.00 32.00 32.00 0.00	28 00		d and observation had ch	arges)	0	28 00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 781, 840)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  886.04 38.00 97.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 10.00 0.00 0.00 0.00 0.00 0.00 0.00 0			a and observation bed che	ai ges)		
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33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 781, 840)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 33.00  0.00 34.00  37.00 9, 781,840  37.00 886.04  38.00 962,239  962,239  90.00	31.00	General inpatient routine service cost/charge ratio (line 27 -	: line 28)		0. 000000	31.00
34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 781, 840)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 34.00  9, 781, 840  9, 781, 840  9, 781, 840  9, 781, 840  9, 781, 840  9, 781, 840  9, 781, 840  9, 781, 840  9, 781, 840  9, 781, 840  9, 781, 840  9, 781, 840  9, 781, 840  9, 781, 840  17.00						
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 9, 781, 840)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		, , , , , , , , , , , , , , , , , , , ,	nuc lino 22)(coo inctruo	tions)		•
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 781, 840)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 36.00 9, 781, 840 9, 781, 840 37.00 38.00 9, 781, 840				ti ons)		
37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37. 00  9, 781, 840  37. 00  886. 04  38. 00  962, 239  962, 239  40. 00			3.,			
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  886.04 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38)  962,239 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	37. 00		and private room cost di	fferential (line	9, 781, 840	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  886.04 38.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  886.04 38.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  886.04 38.00 962,239 39.00			ICTMENTS			
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40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
41.00   Total Program general inpatient routine service cost (line 39 + line 40) 962,239   41.00		, , , , , , , , , , , , , , , , , , , ,	-		l I	
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		962, 239	41.00

Provider COR: 15 0009   Service: To 107/12/200   Service: To 107/12/2	Heal th	Financial Systems	KING'S DAUGHTERS	S' HOSPLTAL		In lie	eu of Form CMS-2	2552-10	
Cost Center Description			KING 5 DAGGITEK		N: 15-0069			2002 10	
Cost Center Description									
Total   Tota						10 12/31/2020			
Name				Title	e XIX	Hospi tal		00 4111	
2.00		Cost Center Description	Total	Total	Average Per	Program Days			
1.00   2.00   3.00   4.00   5.00   5.00   10.00   5.00			Inpatient Cost I	npatient Days		÷	<b>C</b>		
			1.00	2.00		4.00			
Intensive Care Type Input ent Respital Units  1,959,010   1,473   1,329.95   229   30,595   43.00   60.00   80.00   10.00   60	42.00	NUDSERV (+i +l o V & VI V onl v)						42.00	
1.47.0	42.00		803, 103	770	013. 2	4 230	209, 810	42.00	
44.00   CREMARY CARE UNIT   45.00   SURCI CALL NITERSIVE CARE UNIT   45.00   SURCI CALL NITERSIVE CARE UNIT   45.00   SURCI CALL NITERSIVE CARE UNIT   45.00   CREATER POPULATION CONTROL CARE CARE CONTROL CARE CONTROL CARE CARE CARE CARE CARE CARE CARE CARE	43.00		1, 959, 010	1, 473	1, 329, 9	5 229	304, 559	43. 00	
45.00   BURRAL INTENSIVE CARE UNIT   45.00   46.00   SURCIAL INTENSIVE CARE UNIT   46.00   SURCIAL INTENSIVE CARE UNIT   46.00   47.00   61.				,	,				
47.00   OTHER SPECIAL CARE (SPECIFY)	45.00	BURN INTENSIVE CARE UNIT						45. 00	
Cost Centrer Description	46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00	
1.00	47. 00							47. 00	
18.00   Program Inpatrient ancillary service cost (Wistr. D-3. col. 3. 11ne 200)   2, 449.500   48.00   Program Inpatrient costs (come of lines. 4.1 through 48) (cost Instructions)   3, 926, 114   99.00   Program Inpatrient costs (come of lines. 4.1 through 48) (cost Instructions)   3, 926, 114   99.00   Program Inpatrient costs (cost Instructions)   0.50.00   Program Inpatrient program Inpatrient costs (cost Instructions)   0.50.00   Program Inpatrient program Inpatrient program Inpatrient (cost Instructions)   0.50.00   Program Inpatrient program Inpatrient (cost Instructions)   0.50.00   0.50.00   Program Inpatrient (cost Instructions)   0.50.00   Program Inpatrient (cost Instructions)   0.50.00   Program Inpatrien		Cost Center Description					1.00		
49.00	48 00	Program innatient ancillary service cost (Wk	st D-3 col 3	line 200)				48 00	
PASS TIRROUGH COST ADJUSTMENTS					ns)				
50.00   Pass through costs applicable to Program inpatient routine services (from West. D., sum of Parts II and III)   51.00   Pass through costs applicable to Program inpatient ancillary services (from West. D., sum of Parts II and IV)   51.00   32.00	171.00		11 till ough 10) (0				0,720,111	17.00	
51.00   Pass through costs applicable to Program Inpatient ancillary services (from Wkst. D. sum of Parts II   0   51.00   25.00   101al Program excludable cost (sum of lines 50 and 51)   0   52.00   101al Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (tine 40 minus line 52)   0   54.00   0   55.00   0   55.00   0   55.00   0   55.00   0   55.00   0   55.00   0   55.00   0   55.00   0   55.00   0   55.00   0   55.00   0   55.00   0   55.00   0   55.00   0   55.00   0   55.00   0   55.00   0   55.00   0   55.00   0   0   55.00   0   0   55.00   0   0   0   0   0   0   0   0   0	50.00		atient routine s	ervices (from	Wkst. D, sum	of Parts I and	0	50. 00	
and IV)  52.00 Total Program excludable cost (sum of lines 50 and 51)  53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and  55.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and  55.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and  56.00 Program discharges  57.00 Program discharges  58.00 Program discharges  58.00 Diarget amount (line 54 x line 55)  58.00 Diarget amount (line 55 x line 51 x line 51)  58.00 Diarget amount (line 55 x line 51 x line 51)  59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket  59.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket  59.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket  59.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket  59.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket  59.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket  59.00 Lesser of lines 53/54 or 55 from prior year cost report prior year cost prior year cost prior year cost report prior year cost prior year cost report prior year cost prior year year year year year year year yea		1 *							
Total Program excludable cost (sum of lines 50 and 51)	51.00		atient ancillary	services (fro	om Wkst. D, s	um of Parts II	0	51.00	
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (fine 49 minus line 52)  FARCET ANDURT AND LIMIT COMPUTATION  54.00 Program discharge 54.00 Program discharge 56.00 Target amount per discharge 56.00 Target amount per discharge 56.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58.00 Dous payment (see instructions) 59.00 Lesser of Ilnes 33/54 or 55 from prior year cost report, updated by the market basket 59.00 Clesser of Ilnes 33/54 or 55 from prior year cost report, updated by the market basket 59.00 Clesser of Ilnes 33/54 or 55 from prior year cost report, updated by the market basket 59.00 Clesser of Ilnes 33/54 or 55 from prior year cost report, updated by the market basket 59.00 Clesser of Ilnes 33/54 or 55 from prior year cost report, updated by the market basket 59.00 Relief payment (see instructions) 59.00 Clesser of Ilnes 33/54 or 55 from prior year cost report, updated by the market basket 59.00 Relief payment (see instructions) 59.00 Relief payment (see instructions) 59.00 Relief payment (see instructions) 59.00 Allowable Inpatient costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see Instructions) 59.00 Relief payment (see instructions) 59.00 Relief payme	52 00		50 and 51)				0	52 00	
medical education costs (line 49 intus line 52)		,	,	ated, non-phys	sician anesth	etist, and			
54.00   Program discharges   0.0   54.00   55.00   Target amount per discharge   0.00   55.00   Target amount per discharge   0.00   55.00   Target amount (line 54 x line 55)   0.0   55.00   56.00   57.00				. , ,					
55.00   Target amount per discharge   0.00   55.00   10   10   10   10   15   10   10									
56.00   Target amount (line 54 x line 55)   0.55.00   55.00   50.00									
57.00   Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)   0   57.00   58.00   Bosso payment (see instructions)   0   58.00   Esser of lines \$3/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket   0.00   59.00									
S8. 00   Bonus payment (see instructions)   0   58. 00		, ,	ing cost and tar	net amount (Li	ine 56 minus	line 53)			
Sy 00   Lesser of lines \$3/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket   0.00   59.00		, , , , , , , , , , , , , , , , , , , ,	ring cost and tary	get amount (1)	1110 30 1111 1103	11110 33)			
0.00   Lesser of Lines 53/54 or 55 from prior year cost report, updated by the market basket   0.00   60.00   61.00		, , , , , , , , , , , , , , , , , , , ,							
1.00   If									
which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)  0. 62.00  Relief payment (see instructions)  0. 63.00  Allowable Inpatient cost plus incentive payment (see instructions)  64.00  Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  65.00  Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  66.00  CAH (see instructions) (title XVIII only)  67.00  CAH (see instructions)  67.00  Title V or XIX swing-bed NF inpatient routine costs (line 64 plus line 65) (title XVIII only). For Oche (see instructions)  68.00  Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (see instructions)  69.00  Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (see instructions)  69.00  Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (see instructions)  69.00  Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (see instructions)  69.00  Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00  PART III — SXILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICE/IID ONLY  70.00  SKIII of nursing facility/other nursing facility/ICE/IID routine service cost (line 37)  71.00  72.00  72.00  73.00  Medicarly necessary private routine service costs (line 70 + line 70)  73.00  74.00  Total Program general inpatient routine service costs (fine 70 + line 70)  75.00  76.00  77.00  78									
amount (line 56), otherwise enter zero (see instructions)   0   62.00	61.00					•	0	61.00	
62.00 Relief payment (see instructions) 63.00 All lowable Inpast ent cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only). For CAH (see instructions) (title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per dien (line 10 x line 35) 71.00 Adjusted general inpatient routine service costs (line 72 + line 73) 72.00 Valus Program routine service cost (line 9 x line 71) 73.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 74.00 Per diem capital -related costs (line 75 + line 2) 75.00 Per diem capital -related costs (line 75 + line 2) 76.00 Per diem capital -related costs (line 75 + line 2) 77.00 Per diem capital -related costs (line 75 + line 2) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service cost film intation (line 9 x									
63.00   Allowable   Inpatient cost plus incentive payment (see instructions)   0   03.00	62. 00								
PROGRAM INPATIENT ROUTINE SWING BED COST									
Instructions) (Title XVIII only)   Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)   66.00   Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)   67.00   Total Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (I ine 12 x line 19)   68.00   Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (I ine 12 x line 20)   69.00   Total litle V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (I ine 13 x line 20)   69.00   Total litle V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)									
66.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (1tite XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (See instructions)  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICE/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICE/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  71.00 Program routine service cost (line 9 x line 71)  72.00 Program general inpatient routine service costs (fine 72 + line 73)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  75.00 Per diem capital-related costs (line 75 + line 2)  77.00 Program capital-related costs (line 75 + line 2)  77.00 Program capital-related costs (line 9 x line 76)  78.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79)  80.00 Total Program routine service cost (see instructions)  81.00 No Reasonable inpatient routine service (see instructions)  82.00 Inpatient routine service cost (see instructions)  83.00 William to total Program inpatient coperating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	64. 00	i i	ts through Decem	ber 31 of the	cost reporti	ng period (See	0	64. 00	
instructions) (title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  70.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  71.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  72.00 Total Program eneral inpatient routine service costs (fine 72 + line 73)  73.00 Total Program eneral inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  74.00 Program capital -related costs (line 75 + line 2)  75.00 Program capital -related costs (line 75 + line 2)  77.00 Program capital -related costs (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service costs (see instructions)  81.00 Reasonable inpatient routine service costs (see instructions)  82.00 Inpatient routine service costs (see instructions)  83.00 Adjusted general inpatient routine costs (see instructions)  84.00 Program inpatient accillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient routine cost (see instructions)  87.00 Total Program inpatient routine cost (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)	65 00		ts after Decembe	r 31 of the co	nst renorting	neriad (See	0	65 00	
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 70.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Program capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 75 + line 2) 77.00 Aggregate charges to beneficiaries for excess costs (from provider records) 78.00 Total Program routine service cost from worksheet R, Part II, column 26, line 45) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service cost (line 74 x line 81) 80.00 Total Program routine service cost per diem limitation (line 78 minus line 79) 81.00 Inpatient routine service cost (see instructions) 82.00 Inpatient routine service cost (see instructions) 83.00 Reasonable inpatient routine service (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient poperating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 886.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)	03.00	i i	ts arter becombe	31 01 116 6	ost reporting	perrou (see		03.00	
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(line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  70.01 Total ritle V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  70.02 RAT III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.03 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  70.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  71.00 Program routine service cost (line 9 x line 71)  72.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  75.00 Per diem capital -related costs (line 75 + line 2)  77.00 Program capital -related costs (line 75 + line 2)  78.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  82.00 Inpatient routine service costs (see instructions)  83.00 Reasonable inpatient ancillary services (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)  88.00 Adjusted general inpatient routine cost service cost per diem (line 27 + line 2)							_		
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Cline 13 x line 20)   Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)   PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY	68 00		e costs after De	rember 31 of	the cost reno	rting period	0	68 00	
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)  72.00 Program routine service cost (line 9 x line 71)  73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)  74.00 Total Program general inpatient routine service costs (line 72 + line 73)  75.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Program capital -related costs (line 75 ÷ line 2)  77.00 Program capital -related costs (line 74 minus line 77)  78.00 Inpatient routine service cost (line 74 minus line 77)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  81.00 Reasonable inpatient routine service costs (see instructions)  82.00 Willization review - physician compensation (see instructions)  83.00 Utilization review - physician compensation (see instructions)  84.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  70.00 PASS ON Adjusted general inpatient routine cost per diem (line 27 + line 2)  886.04 88.00	00.00		c costs arter be	comper or or	the cost repo	reing period		00.00	
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75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital-related costs (line 75 ÷ line 2)  77.00 Program capital-related costs (line 9 x line 76)  1 Inpatient routine service cost (line 74 minus line 77)  78.00 Aggregate charges to beneficiaries for excess costs (from provider records)  80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  82.00 Inpatient routine service cost limitation (line 9 x line 81)  83.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  886.04									
76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 886.04 88.00	75.00				orksheet B, P	art II, column		75. 00	
77. 00 Program capital-related costs (line 9 x line 76) 78. 00 Inpatient routine service cost (line 74 minus line 77) 79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 79. 00 80. 00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80. 00 81. 00 Inpatient routine service cost per diem limitation 81. 00 Inpatient routine service cost limitation (line 9 x line 81) 82. 00 83. 00 Reasonable inpatient routine service costs (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions) 87. 00 88. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88. 00		1	->						
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 886.04 88.00									
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  1 Inpatient routine service cost per diem limitation  1 Inpatient routine service cost per diem limitation  1 Inpatient routine service cost limitation (line 9 x line 81)  1 Reasonable inpatient routine service costs (see instructions)  1 Program inpatient ancillary services (see instructions)  1 Itilization review - physician compensation (see instructions)  1 Inpatient routine service costs (see instructions)  1 Itilization review - physician compensation (see instructions)  1 Inpatient routine service costs (see instructions)  1 Itilization review - physician compensation (see instructions)  2 Inpatient routine service cost limitation  3 Inpatient routine service cost limitation  4 Inpatient routine service cost limitation  5 Inpatient routine service cost limitation  8 Inpatient routine 79)  8 Inpatient routine 79)  8 Inpatient routine 79)  8 Inpatient routine 79)  8 Inpatient routine 79  8 Inpat		, , ,	,						
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 886.04 88.00		1 .		ovi der records	5)				
81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 886.04 88.00		1				us line 79)			
83.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  886.04  88.00 Reasonable inpatient routine service costs (see instructions)  85.00 85.00 85.00 85.00 86.00		Inpatient routine service cost per diem limi	tati on						
84.00 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions) 87.00 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 84.00 85.00 86.00 87.00 88.00 88.00		1 .							
85.00 Utilization review - physician compensation (see instructions)  86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  886.04 88.00		1		)					
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  886.00 88.00				s)					
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  886.04 88.00		1							
87.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  2,898 87.00 886.04 88.00									
		Total observation bed days (see instructions	)						
89.00 Judservation ded cost (line 87 x line 88) (see instructions) 2,567,744 89.00				line 2)					
	U7. UU	longer various new cost (Title 0/ X Title 88) (Se	e mstructions)				2, 307, 744	07.00	

Health Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2020	Worksheet D-1	
				To 12/31/2020	Date/Time Prep 5/24/2021 11:0	pared: 30 am
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 467, 247	9, 781, 840	0. 14999	7 2, 567, 744	385, 154	90.00
91.00 Nursing School cost	0	9, 781, 840	0.00000	2, 567, 744	0	91.00
92.00 Allied health cost	0	9, 781, 840	0.00000	2, 567, 744	0	92.00
93.00 All other Medical Education	0	9, 781, 840	0.00000	2, 567, 744	0	93.00

Health Financial Systems	KING'S DAUGHTERS'				u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der C	CN: 15-0069	Peri od:	Worksheet D-3	
				From 01/01/2020 To 12/31/2020	Date/Time Pre	nared·
					5/24/2021 11:	
		Ti tl e	e XVIII	Hospi tal	PPS	
Cost Center Description			Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2. 00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS				4, 081, 873		30.00
31. 00   03100   NTENSI VE CARE UNI T				1, 427, 059		31.00
43. 00   04300   NURSERY				1, 127, 007		43. 00
ANCILLARY SERVICE COST CENTERS						1
50. 00 05000 OPERATING ROOM			0. 21609	2, 352, 124	508, 278	50.00
51. 00   05100   RECOVERY ROOM			0. 11827	0 427, 799	50, 596	51.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM			0. 58096	2, 895	1, 682	52.00
53. 00   05300   ANESTHESI OLOGY			0. 16735	492, 654	82, 450	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C			0. 61310		426, 217	
54.01   03630   ULTRA SOUND			0. 14389		9, 853	
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC			0. 07583		12, 366	
55. 00   05500   RADI OLOGY - THERAPEUTI C			0.00000		0	55.00
55. 01   03480   ONCOLOGY			0. 50721		14, 368	
57. 00   05700   CT SCAN			0.04266		55, 899	
58. 00   05800   MAGNETI C RESONANCE I MAGING (MRI)			0. 13213		18, 468	
59. 00   05900   CARDI AC   CATHETERI ZATI ON 60. 00   06000   LABORATORY			0. 00000 0. 16335		0	59. 00 60. 00
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS			0. 16783		440, 117 92, 127	
65. 00 06500 RESPIRATORY THERAPY			0. 19336			
66. 00   06600   PHYSI CAL THERAPY			0. 17330		125, 816	
67. 00 06700 OCCUPATI ONAL THERAPY			0. 33890			
68. 00   06800   SPEECH PATHOLOGY			0. 40192		23, 075	
69. 00 06900 ELECTROCARDI OLOGY			0.00000		0	69. 00
69. 01   03610   SLEEP LAB			0. 23670		Ö	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0. 32063			
71. 01   07101   I V SOLUTIONS			0. 04257			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS			0. 32074			
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 17398	8, 527, 153	1, 483, 622	
76. 00   03140   CARDI OLOGY			0. 13054		127, 041	
76. 97 O7697 CARDI AC REHABI LI TATI ON			0. 43921	9 161	71	76. 97
OUTPATIENT SERVICE COST CENTERS						
au uu luauuul ci ini c			2 59057	'8 n	Λ.	I an nn

2. 590578

1.113257

0. 229094

0. 659204

2, 099, 623 293, 102

28, 801, 715

28, 801, 715

91.00

92.00

95.00

201. 00

202.00

0 90.00

0 90.01

6, 096, 449 200. 00

481, 011

193, 214

76. 97 90.00

90.01

91.00

92.00

95.00

200.00

201.00

202.00

09000 CLI NI C

09100 EMERGENCY

09001 WOUND CARE CLINIC

09500 AMBULANCE SERVICES

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Net charges (line 200 minus line 201)

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

OTHER REIMBURSABLE COST CENTERS

Heal th	Financial Systems	KING'S DAUGHTERS'	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der 0	CCN: 15-0069	Peri od:	Worksheet D-3	
					From 01/01/2020 To 12/31/2020		namad.
					To 12/31/2020	Date/Time Pre 5/24/2021 11:	pareu: 00 am
			Ti t	le 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)	
				1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS				1, 332, 918		30. 00
31.00	03100 INTENSIVE CARE UNIT				468, 301		31. 00
43.00	04300 NURSERY				785, 610		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM			0. 21609	93 887, 756	191, 838	50. 00
51. 00	05100 RECOVERY ROOM			0. 1182	70 236, 151	27, 930	51. 00

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der (	CCN: 15-0069	Peri od: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 5/24/2021 11:00 am

		Title XVIII	Hospi tal	5/24/2021 11: PPS	00 am
		THE XVIII	nospi tai	•	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1. 00	
1. 00	DRG Amounts Other than Outlier Payments			0	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurring prinstructions)	or to October 1 (s	see	6, 312, 410	1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on instructions)	or after October 1	1 (see	2, 781, 306	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for disc 1 (see instructions)	charges occurring p	orior to October	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discontinuous (See instructions)	charges occurring o	on or after	0	1. 04
2.00	Outlier payments for discharges. (see instructions)			0	2. 00
2. 01 2. 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instructions)			0	2. 01 2. 02
2. 02	Outlier payments for discharges occurring prior to October 1 (see in	netructions)		100, 186	2. 02
2. 03	Outlier payments for discharges occurring prior to october 1 (see 1)	· ·		11, 894	2. 03
3. 00	Managed Care Simulated Payments	5 Thistructrons)		0	3. 00
4. 00	Bed days available divided by number of days in the cost reporting	period (see instruc	ctions)	53. 08	4. 00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most recei			0.00	5. 00
5.00	or before 12/31/1996. (see instructions)	it cost reporting p	berroa enaring on	0.00	5.00
6. 00	FTE count for allopathic and osteopathic programs that meet the crinew programs in accordance with 42 CFR 413.79(e)	teria for an add-or	n to the cap for	0. 00	6. 00
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified under ACA § 5503 reduction amount to the IME cap as specified under 42 CFI			0. 00 0. 00	7. 00 7. 01
	cost report straddles July 1, 2011 then see instructions.	,,,,,			
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic all affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(1998), and 67 FR 50069 (August 1, 2002).			0.00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0. 00	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)		0. 00	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 linstructions)		0.00	9. 00	
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			0. 00	
11. 00	FTE count for residents in dental and podiatric programs.				11. 00
12. 00	Current year allowable FTE (see instructions)				12.00
13.00	Total allowable FTE count for the prior year.			0.00	13.00
14. 00	Total allowable FTE count for the penultimate year if that year end	ed on or atter Sept	tember 30, 1997,	0. 00	14. 00
15. 00	otherwise enter zero. Sum of lines 12 through 14 divided by 3.			0.00	15. 00
16. 00	Adjustment for residents in initial years of the program				16. 00
17. 00	Adjustment for residents displaced by program or hospital closure				17. 00
18. 00	Adjusted rolling average FTE count				18. 00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000	19. 00
20.00	Prior year resident to bed ratio (see instructions)			0.000000	20. 00
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	21. 00
22. 00	, , , , , , , , , , , , , , , , , , , ,			0	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)			0	22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 of the Number of additional allopathic and osteopathic IME FTE resident cal		FR 412. 105	0.00	23. 00
24. 00	(f)(1)(iv)(C).			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 lower of the country of the	of line 23 or line	24 (see	0. 00 0. 00	24. 00 25. 00
26. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	26. 00
27. 00	IME payments adjustment factor. (see instructions)			0. 000000	27. 00
28. 00	IME add-on adjustment amount (see instructions)			0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01
29. 00	Total IME payment ( sum of lines 22 and 28)			0	29. 00
29. 01				0	29. 01
30. 00	Percentage of SSI recipient patient days to Medicare Part A patient	days (see instruct	tions)	4.66	30. 00
31. 00	Percentage of Medicaid patient days (see instructions)	(300 111311 001	,	21. 60	31. 00
32. 00	Sum of lines 30 and 31			26. 26	32. 00
33.00	Allowable disproportionate share percentage (see instructions)			10. 88	33. 00
34. 00	Disproportionate share adjustment (see instructions)			247, 350	34. 00

High In Financial Systems							
Price   1071/2020   Part A.   Properties   Price   1071/2020   Part A.   Price   Part Part Part Part Part Part Part Part	Heal th	Financial Systems KING'S DAUGHTERS'	HOSPI TAL	In Lie	u of Form CMS-2	2552-10	
Discomponentated Care Adjustment   Prior to 19/1   Display   Dis	CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0069	From 01/01/2020	Part A Date/Time Pre		
Incorporated Care Adjustment			Title XVIII	Hospi tal		00 4111	
Incompensated Care Adjustment   See Instructions   8,360,599,066   8,290,014,571   35.00   See Instructions   1,600,000175732   0,00009755   35.01   Septicial uncompensated care anount (see instructions)   0,000175732   0,00009755   35.01   Septicial uncompensated care payment (If Fine 34 is zero, enter zero on this line) (see   1,47,465   8,260,701   35.02   Septicial uncompensated care payment amount (see instructions)   1,008,594   208,442   35.03   35.03   35.01   Septicial uncompensated care (sum of columns 1 and 2 on line 35.03   1,008,594   208,442   35.03   36.00   Total charges of columns 1 and 2 on line 35.03   1,008,594   208,442   36.00   Total charges excluding MS-DRGs 05.00   26.00   1,000   1				Prior to 10/1	On/After 10/1		
15.00   Total uncompensated care amount (see instructions)				1. 00	2. 00		
35.01   Eactor 3 (see instructions)	05.00			0.050.500.007	0.000.044.504	05.00	
Sespital uncompensated care payment (IF I in 34 is zero, enter zero on this line) (see   1,467,465   826,970   35.02   instructions)   1,098,594   208,442   35.03   35.03   Total compensated care (sum of columns 1 and 2 on line 35.03)   1,098,594   208,442   35.03   35.03   10   Total uncompensated care (sum of columns 1 and 2 on line 35.03)   1,098,594   208,442   35.03   35.04   35.03   35.0							
35.03   Pro Trafa share of the hospit tal uncompensated care payment amount (see instructions)   1,098,594   208,442   35.03   208,000   Total uncompensated care (sum or columns 1 and 2 on line 35.03)   208,000   2		Hospital uncompensated care payment (If line 34 is zero, ente	r zero on this line) (see				
40.00   Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see   0   141.00   17.00		Pro rata share of the hospital uncompensated care payment amou	,				
Instructions   1							
1.00	40. 00		84 and 685. (see	0		40. 00	
1.01   Total ESRO Medicare covered and paid discharges excluding MS-DRCs 652, 682, 683, 684   0   0   0   0   0   0   0   0   0	41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 68	83, 684 an 685. (see	0		41. 00	
42.00   Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)   0.00   42.00   43.00   Total Medicare ESRD inpatient days excluding MS-DMSs 652, 682, 683, 684 an 685. (see   0   1nstructions)   44.00   Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7   0.000000   44.00   44.00   Ratio of average weekly cost for dialysis treatments (see instructions)   0.00   45.00   46.00   Total additional payment (line 45 times line 44 times line 41.01)   0   46.00	41. 01	Total ESRD Médicare covered and paid discharges excluding MS-1	DRGs 652, 682, 683, 684	0		41. 01	
44.00   Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7   0.000000   44.00   45.00   46.00   Average weekly cost for dialysis treatments (see instructions)   0.00   46.00   0.00   46.00   0.00   46.00   0.00   46.00   0.00   46.00   0.00   0.00   46.00   0.				1			
45.00   Average weekly cost for dialysis treatments (see instructions)   0.00   46.00   0.00   0.00   46.00   0.	44. 00	Ratio of average length of stay to one week (line 43 divided l	by line 41 divided by 7	0. 000000		44. 00	
46. 00   Total additional payment (line 45 times line 44 times line 41.01)	45.00		)	0.00		45.00	
47.00   Subtotal (see instructions)   48.00   Hospital specific payments (to be completed by SCH and MDH, small rural hospitals   10,760,182   48.00		, ,	•	0.00			
A8.00   Hospi tal specific payments (to be completed by SCH and MDH, small rural hospitals   10,343,295     48.00			,	10, 760, 182			
Anount	48. 00		mall rural hospitals			48. 00	
1.00		only. (see instructions)					
49.00   Total payment for inpatient operating costs (see instructions)   10,760,182   49.00   Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)   726,313   50.00   50.0							
50 00         Payment for inpatient program capital (From Wkst. L, Pt. I and Pt. II, as applicable)         726, 313 50.00           51.00         Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)         0 51.00           52.00         Direct graduate medical education payment (From Wkst. E-4, line 49 see instructions).         0 52.00           53.00         Nursing and Allied Health Managed Care payment         2, 639 53.00           54.01         Special add-on payments for new technologies         35, 871 54.00           55.00         Islet isolation add-on payment for new technologies         35, 871 54.00           56.00         Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)         0 52.00           57.00         Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).         0 55.00           58.00         Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11 line 200)         16,379 58.00           59.00         Total (sum of amounts on lines 49 through 58)         11,541,384 59.00           60.00         Primary payer payments         5,937 60.00           61.00         Total amount payable for program beneficiaries (line 59 minus line 60)         11,541,340 61.00           62.00         Deductibles billed to program beneficiaries (see instructions)         145,097 64.00           64.00         Al	49 00	Total payment for impatient operating costs (see instructions)	)			49 00	
St. costion payment for inpatient program capital (Wkst. L, Pt. III, see instructions)							
53.00         Nursing and Allied Health Managed Care payment         2,639         53.00           54.00         Special add-on payments for new technologies         35,871         54.00           54.01         Islet isolation add-on payment         0,54.01         55.00         0         Cost of physicians' services in a teaching hospital (see intructions)         0,55.00         55.00         55.00         Cost of physicians' services in a teaching hospital (see intructions)         0,56.00         55.00         55.00         60.00         60.00         60.01         60.00         6							
54.00         Special add-on payments for new technologies         35,871         54.00           54.01         Islet isolation add-on payment         0         54.01           55.00         Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)         0         55.00           56.00         Cost of physicians' services in a teaching hospital (see intructions)         0         56.00           57.00         Routine service other pass through costs (from Wkst. D, Pt. III, col. 11 line 200)         16,379         58.00           59.00         Total (sum of amounts on lines 49 through 58)         11,541,384         59.00           60.00         Primary payer payments         5,937         60.00           61.00         Total amount payable for program beneficiaries (line 59 minus line 60)         11,541,384         59.00           61.00         Total amount payable for program beneficiaries         11,541,347         61.00           62.00         Coinsurance billed to program beneficiaries         11,541,406         62.00           64.00         All lowable bad debts (see instructions)         145,097         64.00           65.00         All lowable bad debts (see instructions)         48,246         66.00           66.00         All lowable bad debts for dual eligible beneficiaries (see instructions)         10,367,180         70.	52.00	Direct graduate medical education payment (from Wkst. E-4, li	ne 49 see instructions).		0	52. 00	
54.01       Islet isolation add-on payment       0       54.01         55.00       Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)       0       55.00         56.00       Cost of physicians's services in a teaching hospital (see intructions)       0       55.00         57.00       Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).       0       57.00         58.00       Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)       11,541,384       59.00         60.00       Total (sum of amounts on lines 49 through 58)       11,541,384       59.00         60.00       Primary payer payments       5,937       60.00         61.00       Total amount payable for program beneficiaries (line 59 minus line 60)       11,541,460       62.00         63.00       Coinsurance billed to program beneficiaries       1,241,460       62.00         63.00       Allowable bad debts (see instructions)       145,097       64.00         64.00       Allowable bad debts (see instructions)       94,313       65.00         66.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       48,246       66.00         67.00       Subtotal (line 61 plus line 65 minus lines 62 and 63)       0       10,367,180       67.00		, ,					
55.00         Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)         0         55.00           56.00         Cost of physicians' services in a teaching hospital (see intructions)         0         55.00           57.00         Routine service other pass through costs (from Wkst. D, Pt. IV, col. 11 line 200)         16,379         58.00           58.00         Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)         11,541,384         59.00           59.00         Total (sum of amounts on lines 49 through 58)         11,541,384         59.00           60.00         Primary payer payments         5,937         60.00           61.00         Total amount payable for program beneficiaries (line 59 minus line 60)         11,531,447         61.00           62.00         Deductibles billed to program beneficiaries         1,241,460         62.00           63.00         Coinsurance billed to program beneficiaries         221,120         63.00           64.00         All owable bad debts (see instructions)         145,097         64.00           65.00         Adjusted reimbursable bad debts (see instructions)         48,246         66.00           66.00         All owable bad debts for dual eligible beneficiaries (see instructions)         10,367,180         67.00           68.00         Credits received from manufa		, ,					
56.00         Cost of physicians' services in a teaching hospital (see intructions)         0         56.00           57.00         Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).         0         57.00           58.00         Ancillary service other pass through costs from Wkst. D, Pt. III, column 9, lines 30 through 35).         16, 379         58.00           59.00         Total (sum of amounts on lines 49 through 58)         11, 541, 384         59.00           60.00         Primary payer payments         5, 937         60.00           61.00         Total amount payable for program beneficiaries (line 59 minus line 60)         11, 541, 384         59.00           62.00         Deductibles billed to program beneficiaries         11, 241, 460         62.00           63.00         Coinsurance billed to program beneficiaries         12, 41, 460         62.00           64.00         Allowable bad debts (see instructions)         21, 120         63.00           65.00         Adjusted reimbursable bad debts (see instructions)         94, 313         65.00           66.00         Allowable bad debts for dual eligible beneficiaries (see instructions)         10, 367, 180         67.00           68.00         Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)         10, 367, 180         68.00 <td></td> <td>, ,</td> <td>0)</td> <td></td> <td></td> <td></td>		, ,	0)				
57. 00         Routine service other pass through costs (From Wkst. D, Pt. III, column 9, lines 30 through 35).         0         57. 00           58. 00         Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)         16, 379 58.00           59. 00         Total (Sum of amounts on lines 49 through 58)         11, 541, 384 59.00           60. 00         Primary payer payments         5, 937 60.00           61. 00         Total amount payable for program beneficiaries (line 59 minus line 60)         11, 541, 384 59.00           62. 00         Deductibles billed to program beneficiaries         11, 541, 384 59.00           63. 00         Coinsurance billed to program beneficiaries         11, 541, 384 59.00           64. 00         Allowable bad debts (see instructions)         12, 211, 460 62.00           64. 00         Allowable bad debts (see instructions)         145, 097 64.00           65. 00         Allowable bad debts for dual eligible beneficiaries (see instructions)         94, 313 65.00           66. 00         Allowable bad debts for dual eligible beneficiaries (see instructions)         10, 367, 180 67.00           68. 00         Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)         0           69. 00         Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)         0         69.00					-		
58.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)  59.00 Total (sum of amounts on lines 49 through 58)  11, 541, 384 59.00  60.00 Primary payer payments  61.00 Total amount payable for program beneficiaries (line 59 minus line 60)  62.00 Deductibles billed to program beneficiaries  63.00 Coinsurance billed to program beneficiaries  64.00 Allowable bad debts (see instructions)  65.00 Adjusted reimbursable bad debts (see instructions)  66.00 Allowable bad debts for dual eligible beneficiaries (see instructions)  67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63)  68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)  69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)  70.50 Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)  70.87 Demonstration payment adjustment amount before sequestration  70.88 SCH or MDH volume decrease adjustment (contractor use only)  70.90 HSP bonus payment HVRP adjustment amount (see instructions)  70.91 HSP bonus payment HRR adjustment amount (see instructions)  70.92 Bundled Model 1 discount amount (see instructions)  70.93 HRR adjustment amount (see instructions)  70.94 HRR adjustment amount (see instructions)  70.94 HRR adjustment amount (see instructions)  70.95 Jone Payment adjustment amount (see instructions)  70.90 HRR adjustment amount (see instructions)		, ,	•	rough 35)			
59.00         Total (sum of amounts on lines 49 through 58)         11,541,384         59.00           60.00         Primary payer payments         5,937         60.00           61.00         Total amount payable for program beneficiaries (line 59 minus line 60)         11,535,447         61.00           62.00         Deductibles billed to program beneficiaries         1,241,460         62.00           63.00         Coinsurance billed to program beneficiaries         21,120         63.00           64.00         Allowable bad debts (see instructions)         94,313         65.00           65.00         Adjusted reimbursable bad debts (see instructions)         94,313         65.00           66.00         Allowable bad debts for dual eligible beneficiaries (see instructions)         48,246         66.00           67.00         Subtotal (line 61 plus line 65 minus lines 62 and 63)         10,367,180         70.00           68.00         Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)         0         68.00           69.00         Othler ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)         0         70.00           70.87         Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)         0         70.87           70.89         Pioneer ACO demonstration payment adj				rough 33).	-		
60.00 Primary payer payments 61.00 Total amount payable for program beneficiaries (line 59 minus line 60) 62.00 Deductibles billed to program beneficiaries 62.00 Coinsurance billed to program beneficiaries 63.00 Coinsurance billed to program beneficiaries 64.00 Allowable bad debts (see instructions) 65.00 Adjusted reimbursable bad debts (see instructions) 66.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63) 68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) 69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) 69.00 THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 70.50 Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions) 70.87 Demonstration payment adjustment amount before sequestration 70.88 SCH or MDH volume decrease adjustment amount (see instructions) 70.90 HSP bonus payment HVRP adjustment amount (see instructions) 70.91 HSP bonus payment HRR adjustment amount (see instructions) 70.92 HVBP payment adjustment amount (see instructions) 70.94 HRR adjustment amount (see instructions) 70.95 For SCH or MDH volume decrease adjustment amount (see instructions) 70.91 HVBP payment adjustment amount (see instructions) 70.92 HVBP payment adjustment amount (see instructions) 70.93 HVBP payment adjustment amount (see instructions) 70.94 HRR adjustment amount (see instructions) 70.95 For SCH or MDH volume decrease adjustment amount (see instructions) 70.90 For SCH or MDH volume decrease adjustment amount (see instructions) 70.91 For SCH or MDH volume decrease adjustment amount (see instructions) 70.92 For SCH or MDH volume decrease adjustment amount (see instructions) 70.93 For SCH or MDH volume decrease adjustment amount (see instructions) 70.94 For SCH or MDH			,				
Total amount payable for program beneficiaries (line 59 minus line 60)  62.00 Deductibles billed to program beneficiaries  63.00 Coinsurance billed to program beneficiaries  64.00 Allowable bad debts (see instructions)  65.00 Adjusted reimbursable bad debts (see instructions)  66.00 Allowable bad debts for dual eligible beneficiaries (see instructions)  67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63)  68.00 Ottler payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)  69.00 Ottler ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  70.50 Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)  70.87 Pioneer ACO demonstration payment adjustment amount (see instructions)  70.90 HSP bonus payment HVBP adjustment amount (see instructions)  70.91 HVBP payment adjustment amount (see instructions)  81, 241, 460 62.00  11, 241, 460 62.00  145, 097 64.00  145, 097 64.00  148, 246 66.00  10, 367, 180 67.00  10, 367, 180 67.00  10, 367, 180 67.00  10, 367, 180 67.00  10, 367, 180 67.00  10, 367, 180 67.00  10, 368.00  10, 367, 180 67.00  10, 368.00  10, 367, 180 67.00  10, 368.00  10, 367, 180 67.00  10, 368.00  10, 367, 180 67.00  10, 368.00  10, 367, 180 67.00  10, 367, 180 67.00  10, 367, 180 67.00  10, 367, 180 67.00  10, 367, 180 67.00  10, 367, 180 67.00  10, 367, 180 67.00  10, 367, 180 67.00  10, 367, 180 67.00  10, 368.00  10, 367, 180 67.00  10, 367, 180 67.00  10, 368, 20  10, 367, 180 67.00  10, 367, 180 67.00  10, 367, 180 67.00  10, 368, 20  10, 367, 180 67.00  10, 368, 20  10, 367, 180 67.00  10, 368, 20  10, 367, 180 67.00  10, 367, 180 67.00  10, 367, 180 67.00  10, 368, 20  10, 367, 180 67.00  10, 367, 180 67.00  10, 368, 20  10, 367, 180 67.00  10, 367, 180 67.00  10, 367, 180 67.00  10, 367, 180 67.00  10, 368, 20  10, 367, 180 67.00  10, 368, 20  10, 367, 180 67.00  10, 368, 20  10, 367, 180 67.00  10, 368, 20  10, 367, 180 67.00  10, 368, 20  10, 367, 180 67.00  10, 368, 20  10, 368, 20  10, 368, 20  10, 368, 20  10, 368, 20  10,		, , , , , , , , , , , , , , , , , , , ,					
Coinsurance billed to program beneficiaries  Allowable bad debts (see instructions)  Adjusted reimbursable bad debts (see instructions)  Adjusted reimbursable bad debts (see instructions)  Allowable bad debts for dual eligible beneficiaries (see instructions)  Subtotal (line 61 plus line 65 minus lines 62 and 63)  Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)  Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)  Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)  OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  Demonstration payment adjustment amount before sequestration  SCH or MDH volume decrease adjustment (contractor use only)  Pioneer ACO demonstration payment adjustment amount (see instructions)  Demonstration payment HVRP adjustment amount (see instructions)  HSP bonus payment HVRP adjustment amount (see instructions)  HSP bonus payment HRR adjustment amount (see instructions)  HSP payment adjustment amount (see instructions)  HKRP adjustment amount (see instructions)  HRR adjustment amount (see instructions)  Allowable bad debts (see instructions)  10, 43, 797 70. 93  10, 94 HRR adjustment amount (see instructions)  21, 120 63. 00  145, 097 64. 00  145, 097 64. 00  10, 367, 180 67. 0	61.00	Total amount payable for program beneficiaries (line 59 minus	line 60)		11, 535, 447	61. 00	
Allowable bad debts (see instructions)  Adjusted reimbursable bad debts (see instructions)  Allowable bad debts for dual eligible beneficiaries (see instructions)  Allowable bad debts for dual eligible beneficiaries (see instructions)  Subtotal (line 61 plus line 65 minus lines 62 and 63)  Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)  Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)  Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)  Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)  Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)  Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)  Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)  Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)  Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)  Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)  Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)  Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)  Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)  Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)  Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)  Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)  Outlier payment sum sum (see instructions)  Outlier payment debte 93, 95 and 96). (For SCH see instructions)  Outlier payment (see instructions)  Outlier payment debte 93, 95 and 96). (For SCH see instructions)  Outlier payment (see instructions)  Outlier payment (see instructions)  Outli							
Adjusted reimbursable bad debts (see instructions)  61. 00 Allowable bad debts for dual eligible beneficiaries (see instructions)  62. 00 Allowable bad debts for dual eligible beneficiaries (see instructions)  63. 00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)  64. 00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)  65. 00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)  66. 00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)  67. 00 OUTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  68. 00 Outlier payments (SEE INSTRUCTIONS) (SPECIFY)  69. 00 OUTHER ADJUSTMENTS (SEE INSTRUCTIONS)  60 OUTHER ADJUSTMENTS (		1 9					
66.00 Allowable bad debts for dual eligible beneficiaries (see instructions)  67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63)  68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)  69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)  70.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  70.50 Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)  70.87 Demonstration payment adjustment amount before sequestration  70.88 SCH or MDH volume decrease adjustment (contractor use only)  70.90 HSP bonus payment HVBP adjustment amount (see instructions)  70.91 HSP bonus payment HVBP adjustment amount (see instructions)  70.92 Bundled Model 1 discount amount (see instructions)  70.93 HVBP payment adjustment amount (see instructions)  70.94 HRR adjustment amount (see instructions)  70.95 Add (see instructions)  848, 246 66.00  10, 367, 180 67.00  68.00  69.00  70.70.50  70.70.50  70.80  70.81  70.82  70.83  70.89  70.90  70.91  70.91  70.92  70.93  70.94  70.94							
67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63) 68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) 69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) 70.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 70.50 Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions) 70.87 Demonstration payment adjustment amount before sequestration 70.88 SCH or MDH volume decrease adjustment (contractor use only) 70.90 HSP bonus payment HVBP adjustment amount (see instructions) 70.91 HSP bonus payment HRR adjustment amount (see instructions) 70.92 Bundled Model 1 discount amount (see instructions) 70.93 HVBP payment adjustment amount (see instructions) 70.94 HRR adjustment amount (see instructions) 70.95 A3, 979 70.96 PARR ADJUSTMENTS 70.97 A3, 979 70.99 HRR adjustment amount (see instructions) 70.90 A3, 979 70.91		• · · · · · · · · · · · · · · · · · ·				1	
68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)  69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)  70.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  70.50 Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)  70.87 Demonstration payment adjustment amount before sequestration  70.88 SCH or MDH volume decrease adjustment (contractor use only)  70.99 HSP bonus payment HVBP adjustment amount (see instructions)  70.91 HSP bonus payment HVBP adjustment amount (see instructions)  70.92 Bundled Model 1 discount amount (see instructions)  70.93 HVBP payment adjustment amount (see instructions)  70.94 HRR adjustment amount (see instructions)  90 68.00  68.00  69.00  70.50  70.50  70.50  70.87  70.88  70.89  70.90  70.91  70.91  70.91  70.91  70.92  70.93  70.94			ructions)				
69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)  70.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  70.50 Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)  70.87 Demonstration payment adjustment amount before sequestration  70.88 SCH or MDH volume decrease adjustment (contractor use only)  70.99 Pioneer ACO demonstration payment adjustment amount (see instructions)  70.90 HSP bonus payment HVBP adjustment amount (see instructions)  70.91 HSP bonus payment HVBP adjustment amount (see instructions)  80 70.91  70.92 Bundled Model 1 discount amount (see instructions)  90 70.93 HVBP payment adjustment amount (see instructions)  91 70.94 HRR adjustment amount (see instructions)  92 70.93 HVBP payment adjustment amount (see instructions)  93 70.94 HRR adjustment amount (see instructions)  943,979 70.93			annlicable to MS_DDCs (so	e instructions)		1	
70.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  70.50 Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)  70.87 Demonstration payment adjustment amount before sequestration  70.88 SCH or MDH volume decrease adjustment (contractor use only)  70.89 Pioneer ACO demonstration payment adjustment amount (see instructions)  70.90 HSP bonus payment HVBP adjustment amount (see instructions)  70.91 HSP bonus payment HRR adjustment amount (see instructions)  70.92 Bundled Model 1 discount amount (see instructions)  70.93 HVBP payment adjustment amount (see instructions)  70.94 HRR adjustment amount (see instructions)  70.95 Payment adjustment amount (see instructions)  70.96 Payment adjustment amount (see instructions)  70.97 Payment adjustment amount (see instructions)  70.98 Payment adjustment amount (see instructions)  70.99 Payment adjustment amount (see instructions)  70.90 Payment adjustment amount (see instructions)  70.91 Payment adjustment amount (see instructions)  70.92 Payment adjustment amount (see instructions)  70.90 Payment adjustment amount (see instructions)  70.91 Payment adjustment amount (see instructions)		•					
Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)  70. 87 Demonstration payment adjustment amount before sequestration  SCH or MDH volume decrease adjustment (contractor use only)  70. 89 Pioneer ACO demonstration payment adjustment amount (see instructions)  70. 90 HSP bonus payment HVBP adjustment amount (see instructions)  70. 91 HSP bonus payment HRR adjustment amount (see instructions)  80 70. 92 Bundled Model 1 discount amount (see instructions)  90 70. 93 HVBP payment adjustment amount (see instructions)  90 70. 94 HRR adjustment amount (see instructions)  90 70. 95 91 92 93 943, 979 95 96 97 97 98 99 90 90 90 90 90 90 90 90 90 90 90 90			C. I. Son Soo Frider doct one	,			
70. 87 Demonstration payment adjustment amount before sequestration 0 70. 87 70. 88 SCH or MDH volume decrease adjustment (contractor use only) 0 70. 88 70. 89 Pioneer ACO demonstration payment adjustment amount (see instructions) 70. 89 70. 90 HSP bonus payment HVBP adjustment amount (see instructions) 0 70. 91 70. 91 Bundled Model 1 discount amount (see instructions) 0 70. 92 70. 93 HVBP payment adjustment amount (see instructions) 43,979 70. 94 HRR adjustment amount (see instructions) -9,015 70. 94		, , , , ,	ration) adjustment (see i	nstructions)			
70. 89 Pi oneer ACO demonstration payment adjustment amount (see instructions) 70. 90 HSP bonus payment HVBP adjustment amount (see instructions) 70. 91 HSP bonus payment HRR adjustment amount (see instructions) 70. 92 Bundled Model 1 discount amount (see instructions) 70. 93 HVBP payment adjustment amount (see instructions) 70. 94 HRR adjustment amount (see instructions) 70. 99 70. 91 HVBP payment adjustment amount (see instructions) 70. 92 70. 93 HVBP payment adjustment amount (see instructions) 70. 99 70. 91 HRR adjustment amount (see instructions) 70. 90 70. 91 HVBP payment adjustment amount (see instructions) 70. 90 70. 91 HVBP payment adjustment amount (see instructions) 70. 90 70. 91 HVBP payment adjustment amount (see instructions) 70. 90 70. 91 HVBP payment adjustment amount (see instructions) 70. 90 70. 91 HVBP payment adjustment amount (see instructions) 70. 90 70. 91 HVBP payment adjustment amount (see instructions) 70. 90 70. 91 HVBP payment adjustment amount (see instructions) 70. 90 70. 91 HVBP payment adjustment amount (see instructions) 70. 92				,	0		
70. 90 HSP bonus payment HVBP adjustment amount (see instructions)  70. 91 HSP bonus payment HRR adjustment amount (see instructions)  80 70. 91  70. 92 Bundled Model 1 discount amount (see instructions)  90 70. 91  70. 92 HVBP payment adjustment amount (see instructions)  90 70. 92  70. 93 HVBP payment adjustment amount (see instructions)  90 70. 90  91 70. 92  92 70. 93  93 70. 94 HRR adjustment amount (see instructions)  91 70. 90  92 70. 93  93 70. 94	70. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	70. 88	
70. 91 HSP bonus payment HRR adjustment amount (see instructions)  0 70. 91  70. 92 Bundled Model 1 discount amount (see instructions)  1 70. 92 HVBP payment adjustment amount (see instructions)  1 70. 93 HVBP payment adjustment amount (see instructions)  2 70. 94 HRR adjustment amount (see instructions)  3 70. 94 HRR adjustment amount (see instructions)			ructions)				
70. 92 Bundled Model 1 discount amount (see instructions)  70. 93 HVBP payment adjustment amount (see instructions)  70. 94 HRR adjustment amount (see instructions)  9 70. 92 43, 979 70. 93 70. 94		, , , , , , , , , , , , , , , , , , , ,					
70. 93 HVBP payment adjustment amount (see instructions) 43, 979 70. 93 70. 94 HRR adjustment amount (see instructions) -9, 015 70. 94		, , , , , , , , , , , , , , , , , , , ,					
70. 94 HRR adjustment amount (see instructions) -9,015 70. 94		· · · · · · · · · · · · · · · · · · ·					
		, , , , , , , , , , , , , , , , , , , ,					
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Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0069	Peri od:	Worksheet E
			From 01/01/2020	

				From 01/01/2020 To 12/31/2020	Date/Time Pre 5/24/2021 11:	
		Title	XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in co	- Lump 0	,	02020	1. 00 444, 247	70. 96
70. 90	the corresponding federal year for the period prior to 10/1)	Ji ullili U	1	2020	444, 247	70.90
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in c	olumn O		2021	208, 312	70. 97
	the corresponding federal year for the period ending on or after					
70. 98	Low Volume Payment-3				0	70. 98
	HAC adjustment amount (see instructions)				0	70. 99
	Amount due provider (line 67 minus lines 68 plus/minus lines 69	§ 70)			11, 054, 703	
71. 01	Sequestration adjustment (see instructions)				72, 961	1
	Demonstration payment adjustment amount after sequestration				0	1
	Sequestration adjustment-PARHM pass-throughs Interim payments				11, 076, 285	71.03
	Interim payments  Interim payments-PARHM				11, 070, 203	72.00
73. 00	Tentative settlement (for contractor use only)				0	1
73. 01	Tentative settlement-PARHM (for contractor use only)				Ŭ	73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02,	72, and			-94, 543	1
	73)					
74. 01	Balance due provider/program-PARHM (see instructions)					74. 01
75.00	Protested amounts (nonallowable cost report items) in accordance	wi th			386, 573	75. 00
	CMS Pub. 15-2, chapter 1, §115.2					
90. 00	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)	2 02	I		0	00.00
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of plus 2.04 (see instructions)	2. 03			0	90.00
91. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
	Operating outlier reconciliation adjustment amount (see instruct	ions)			0	1
	Capital outlier reconciliation adjustment amount (see instruction	,			0	
94.00					0.00	94.00
95.00	Time value of money for operating expenses (see instructions)				0	95.00
96. 00	Time value of money for capital related expenses (see instruction	ns)			0	96. 00
				Prior to 10/1 1.00	0n/After 10/1 2.00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment					
	HVBP adjustment factor (see instructions)			0. 0000000000	0. 0000000000	
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	0	102. 00
100.00	HRR Adjustment for HSP Bonus Payment			0.0000	0.0000	100.00
	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions)			0.0000		103. 00 104. 00
104.00	Rural Community Hospital Demonstration Project (§410A Demonstrati	on) Adiu	stment	<u> </u>	0	104.00
200 00	Is this the first year of the current 5-year demonstration period					200. 00
200.00	Century Cures Act? Enter "Y" for yes or "N" for no.	a aa	2.101			200.00
	Cost Reimbursement					
	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 4	9)				201. 00
	Medicare discharges (see instructions)					202. 00
203.00	Case-mix adjustment factor (see instructions)		6 11			203. 00
	Computation of Demonstration Target Amount Limitation (N/A in fi	rst year	of the currer	τ 5-year demonsτ	ration	
204 00	period) Medicare target amount					204. 00
	Case-mix adjusted target amount (line 203 times line 204)					205. 00
	Medicare inpatient routine cost cap (line 202 times line 205)					206. 00
	Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instruc	tions)				207. 00
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, li	ne 59)				208. 00
	Adjustment to Medicare IPPS payments (see instructions)					209. 00
	Reserved for future use					210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)					211. 00
212 00	Comparision of PPS versus Cost Reimbursement  Total adjustment to Medicare Part A LDDS payments (from Line 211)	\				212 00
	Total adjustment to Medicare Part A IPPS payments (from line 211) Low-volume adjustment (see instructions)	)				212. 00 213. 00
	Net Medicare Part A IPPS adjustment (difference between PPS and	cost reim	hursement)			218. 00
210.00	(line 212 minus line 213) (see instructions)		Joinotti			[
	, , , , , , , , , , , , , , , , , , , ,			. '		•

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0069

					10	5 12/31/2020	Date/lime Prep   5/24/2021 11:0	
				Title	XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Peri od Pri or	Peri od	Total (Col 2	
		line 0	E, Part A) 1.00	Entitlement 2.00	to 10/01 3.00	0n/After 10/01 4.00	through 4) 5.00	
1.00	DRG amounts other than outlier	1. 00	1.00	2.00		4.00	0	1. 00
1. 01	payments DRG amounts other than outlier	1. 01	6, 312, 410	0			6, 312, 410	
	payments for discharges occurring prior to October 1							
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	2, 781, 306	0		2, 781, 306	2, 781, 306	1. 02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	0		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00						2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to	2. 03	100, 186	0	100, 186		100, 186	2. 02
2. 03	October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see instructions)	2. 04	11, 894	0		11, 894	11, 894	2. 03
3.00	Operating outlier reconciliation	2. 01	0	0	0	0	0	3. 00
4. 00	Managed care simulated payments	3. 00	0	0	0	0	0	4. 00
	Indirect Medical Education Adju							
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
6. 00	IME payment adjustment (see instructions)	22. 00	0	0	0	0	0	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	0	0	0	0	0	6. 01
	instructions) Indirect Medical Education Adju	istmont for the	Add on for So	otion 122 of t	bo MMA			
7. 00	IME payment adjustment factor	27.00	0. 000000	0. 000000		0. 000000		7. 00
8. 00	(see instructions) IME adjustment (see	28. 00	0	0		0	0	8. 00
	instructions)							
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	0	0	0	0	0	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	0	0	0	
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	0	0	0	9. 01
10.00	Disproportionate Share Adjustme		0.4000	0.4000	0.4000	0.4000		10.00
10.00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 1088	0. 1088	0. 1088	0. 1088		10. 00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	247, 350	0	171, 698	75, 652	247, 350	11. 00
11. 01	Uncompensated care payments  Additional payment for high per	36.00 centage of ESF	1,307,036 RD beneficiary	0 di scharges	1, 098, 594	208, 442	1, 307, 036	11. 01
12. 00	Total ESRD additional payment	46.00	0	0	0	0	0	12. 00
13. 00 14. 00	(see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH,	47. 00 48. 00	10, 760, 182 0	0	7, 682, 888 0	3, 077, 294 0	10, 760, 182 0	13. 00 14. 00
15. 00	small rural hospitals only.) (see instructions) Total payment for inpatient	49. 00	10, 760, 182	0	7, 682, 888	3, 077, 294	10, 760, 182	15. 00
16. 00	operating costs (see instructions) Payment for inpatient program capital (from Wkst. L, Pt. I,	50. 00	726, 313	0	518, 546	207, 767	726, 313	16. 00
	if applicable)							

					Ī	o 12/31/2020	Date/Time Pre 5/24/2021 11:	pared:
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A		Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
17.00		0	1.00	2.00	3.00	4. 00	5. 00	47.00
17. 00	Special add-on payments for new technologies	54.00	35, 871	0	(	35, 871	35, 871	17. 00
17. 01	Net organ aquisition cost							17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	C	0	0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0	C	0	0	18. 00
19.00	SUBTOTAL			0	8, 201, 434	3, 320, 932	11, 522, 366	19. 00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4. 00	5. 00	
20. 00	Capital DRG other than outlier	1. 00	703, 218	0	498, 743	204, 475	703, 218	20. 00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0	(	0	0	20. 01
21. 00	Capital DRG outlier payments	2. 00	23, 095	0	19, 803	3, 292	23, 095	
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	C	0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0.0000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0	(	0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0.0000	0.0000	0.0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	0	C	0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	726, 313	0	518, 54 <i>6</i>	207, 767	726, 313	26. 00
		W/S E, Part A						
		line	Part A)					
	I	0	1. 00	2. 00	3.00	4. 00	5. 00	
27. 00 28. 00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			0. 054167 444, 247		444, 247	27. 00 28. 00
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				208, 312	208, 312	29. 00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

| Peri od: | Worksheet E | From 01/01/2020 | Part A Exhibit 5 | To 12/31/2020 | Date/Time Prepared: 
 Heal th Financial
 Systems
 KING'S DAUGHTER

 HOSPITAL
 ACQUIRED
 CONDITION (HAC)
 REDUCTION CALCULATION EXHIBIT 5
 Provider CCN: 15-0069

West   Pt					To	12/31/2020	Date/Time Prep 5/24/2021 11:0	
A   1 inc   Wkst, E, Pt   10/01   arter 10/01   and 3				Title	XVIII	Hospi tal		<u> </u>
1.00   DRG amounts other than outlier payments   1.00   1.00   2.00   3.00   4.00   1.00			•					
1.00   BRG amounts other than outlier payments for   1.00   6.312.410   6.312.410   8.312.410   1.00   1.			A, line		10/01	after 10/01	and 3)	
1.00   DRG amounts other than outli er payments   1.00   6.312,410   6.312,410   0.10			0		2 00	3 00	4 00	
1.01   DNS amounts other than out if ir payments for discharges cocurring prior to 0 totober 1   1.02   2,781,306   2,781,306   2,781,306   2,781,306   1.02   3,781,306   3	1. 00	DRG amounts other than outlier payments		1.00	2.00	0.00	1. 00	1. 00
1.02   DNS amounts other than out I en payments for discharges occurring on or after October 1   1.03   0   0   0   0   0   1.03   0   0   1.03   0   0   0   0   0   0   0   0   0	1.01		1. 01	6, 312, 410	6, 312, 410		6, 312, 410	1. 01
1.03	1. 02	DRG amounts other than outlier payments for	1. 02	2, 781, 306		2, 781, 306	2, 781, 306	1. 02
For Model 4 BPCI occurring on or after   0ctober 1	1. 03	DRG for Federal specific operating payment	1. 03	0	0		0	1. 03
2.00   OutFler payments for discharges (see   2.00   OutFler payments for discharges for Model 4   2.02   OutFler payments for discharges for Model 4   2.02   OutFler payments for discharges for Model 4   2.03   100,186   100,186   100,186   100,186   2.03   101,186   100,186   100,186   2.03   101,186	1. 04	for Model 4 BPCI occurring on or after	1. 04	О		0	0	1. 04
2.01   Outlier payments for discharges for Model 4   2.02   0   0   0   0   0   0   2.01	2.00	Outlier payments for discharges (see	2. 00					2. 00
2.02   0utilier payments for discharges occurring prior to October 1 (see instructions)   2.03   100, 186   100, 186   100, 186   2.02   2.03   0utilier payments for discharges occurring on 0 2.04   11,894   11,894   11,894   11,894   2.03   0perating outilier reconciliation   2.01   0   0   0   0   0   0   0   0   0	2. 01	Outlier payments for discharges for Model 4	2. 02	0	0	0	0	2. 01
2.03   0util er payments for discharges occurring on or after October 1 (see instructions)   2.01   0   0   0   0   0   0   3.00   3.00   Operating outil er reconcil lation   2.01   0   0   0   0   0   0   0   0   0	2.02	Outlier payments for discharges occurring	2.03	100, 186	100, 186		100, 186	2. 02
Operating outlier reconciliation   2.01   0   0   0   0   3.00   0   0   0   0   4.00   10   10   10   10   10   10   10	2.03	Outlier payments for discharges occurring on	2.04	11, 894		11, 894	11, 894	2. 03
Indirect Medical Education Adjustment		Operating outlier reconciliation			-	-		3. 00 4. 00
5.00   Amount from Worksheet E, Part A, Line 21   21.00   0.0000000   0.00000000	00		2.00	<u> </u>	<u> </u>	<u> </u>		00
6.00   IME payment adjustment (see instructions)   22.00   0   0   0   0   0   0   0   0   0	5. 00		21. 00	0. 000000	0. 000000	0. 000000		5. 00
Instructions   National   Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA	6.00	IME payment adjustment (see instructions)	22. 00	0	0	0	0	6. 00
7. 00   ME payment adjustment factor (see   27. 00   0.00000   0.000000   0.000000   0.000000   0.000000   0.000000   0.00000   0.000000   0.0000000   0.00000000	6. 01	instructions)				0	0	6. 01
Instructions   1ME adjustment (see instructions)   28.00   0   0   0   0   0   0   0   8.00	7.00					0.00000		7 00
8.00   IME adjustment (see instructions)   28.00   0   0   0   0   0   8.00	7.00		27.00	0.000000	0.000000	0.000000		7.00
Care (see instructions)	8. 00		28. 00	0	0	0	0	8. 00
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 34.00 247,350 171,698 75,652 247,350 11.00 instructions)  11.01 Uncompensated care payments 36.00 1,307,036 8,019 328,323 336,342 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)  14.00 Hospital specific payments (completed by SCH 48.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8. 01		28. 01	0	0	0	0	8. 01
Lines 6.01 and 8.01)   Disproportionate Share Adjustment   10.00   All lowable of instructions   11.00   Disproportionate share adjustment (see   34.00   247,350   171,698   75,652   247,350   11.00   11.00   Disproportionate share adjustment (see   34.00   247,350   171,698   75,652   247,350   11.00   11.01   Uncompensated care payments   36.00   1,307,036   8,019   328,323   336,342   11.01   Additional payment for high percentage of ESRD beneficiary discharges   46.00   0   0   0   0   12.00   13.00   Subtotal (see instructions)   47.00   10,760,182   7,563,007   3,197,175   10,760,182   13.00   14.00   14.00   14.00   15.00				0	0	0		9. 00
10.00   Allowable disproportionate share percentage (see instructions)   11.00   Disproportionate share adjustment (see   34.00   247,350   171,698   75,652   247,350   11.00   instructions)   11.01   Uncompensated care payments   36.00   1,307,036   8,019   328,323   336,342   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   10,760,182   7,563,007   3,197,175   10,760,182   13.00   14.00   14.00   14.00   15.0	9. 01	lines 6.01 and 8.01)	29. 01	0	0	0	0	9. 01
11.00   Disproportionate share adjustment (see   34.00   247,350   171,698   75,652   247,350   11.00   11.01   Instructions)   Incompensated care payments   36.00   1,307,036   8,019   328,323   336,342   11.01   Additional payment for high percentage of ESRD beneficiary discharges   12.00   Total ESRD additional payment (see   46.00   0   0   0   0   0   12.00   13.00   Subtotal (see instructions)   47.00   10,760,182   7,563,007   3,197,175   10,760,182   13.00   14.00   Hospital specific payments (completed by SCH   48.00   0   0   0   0   0   14.00   14.00   14.00   15.00   Total payment for inpatient operating costs   49.00   10,760,182   7,563,007   3,197,175   10,760,182   15.00   16.00   Payment for inpatient operating costs   49.00   10,760,182   7,563,007   3,197,175   10,760,182   15.00   16.00   Payment for inpatient program capital (from   50.00   726,313   518,546   207,767   726,313   16.00   17.01   17.01   17.01   17.02   Credits received from manufacturers for replaced devices for applicable MS-DRGs   18.00   0   0   0   0   0   0   0   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   19.0	10.00		22.00	0 1000	0.1000	0.1000		10 00
11. 00   Disproportionate share adjustment (see instructions)   11. 00   Uncompensated care payments   36. 00   1, 307, 036   8, 019   328, 323   336, 342   11. 01	10.00		33.00	0. 1088	0. 1088	0. 1088		10.00
11. 01   Uncompensated care payments   36. 00   1, 307, 036   8, 019   328, 323   336, 342   11. 01	11. 00	Di sproporti onate share adjustment (see	34.00	247, 350	171, 698	75, 652	247, 350	11. 00
Additional payment for high percentage of ESRD beneficiary discharges   Total ESRD additional payment (see   46.00   0   0   0   0   0   12.00	11. 01	· ·	36.00	1, 307, 036	8, 019	328, 323	336, 342	11. 01
13.00   Subtotal (see instructions)   47.00   10,760,182   7,563,007   3,197,175   10,760,182   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   10,760,182   7,563,007   3,197,175   10,760,182   15.00   15.00   70   10,760,182   15.00   10,760,182   15.00   10,760,182   10,760,18			D beneficiary	di scharges				
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 35,871 0 35,871 35,871 17.00 Credits received from manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment amount (see instructions)  10.760,182 7,563,007 3,197,175 10,760,182 15.00 763,007 3,197,175 10,760,182 15.00 760,182 7,563,007 3,197,175 10,760,182 15.00 760,182 7,563,007 3,197,175 10,760,182 15.00 760,182 7,563,007 3,197,175 10,760,182 15.00 760,182 7,563,007 3,197,175 10,760,182 15.00 760,182 7,563,007 3,197,175 10,760,182 15.00 760,182 7,563,007 3,197,175 10,760,182 15.00 760,182 7,563,007 3,197,175 10,760,182 15.00 760,182 7,563,007 3,197,175 10,760,182 15.00 760,182 7,563,007 3,197,175 10,760,182 15.00 760,182 7,563,007 3,197,175 10,760,182 15.00 760,182 7,563,007 3,197,175 10,760,182 7,563,007 3	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 35,871 0 35,871 35,871 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)	13 00		47 00	10 760 182	7 563 007	3 107 175	10 760 182	13 00
15.00 Total payment for inpatient operating costs (see instructions)  16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)  17.00 Special add-on payments for new technologies  17.01 Net organ acquisition cost  17.02 Credits received from manufacturers for replaced devices for applicable MS-DRGs  18.00 Capital outlier reconciliation adjustment amount (see instructions)  10, 760, 182 7, 563, 007 3, 197, 175 10, 760, 182 15.00 726, 313 518, 546 7207, 767 726, 313 16.00 726, 313		Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see						
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 35,871 0 35,871 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) 50.00 726,313 518,546 207,767 726,313 16.00 726,313 518,546 207,767 726,313 16.00 726,313 518,546 207,767 726,313 16.00 726,313 72	15. 00	Total payment for inpatient operating costs	49. 00	10, 760, 182	7, 563, 007	3, 197, 175	10, 760, 182	15. 00
17. 00 Special add-on payments for new technologies 54. 00 35, 871 0 35, 871 17. 00 Net organ acquisition cost 17. 01 Credits received from manufacturers for replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see instructions) 54. 00 35, 871 0 35, 871 17. 00 17. 00 0 0 0 0 17. 00 17. 00 0 18. 00	16. 00	Payment for inpatient program capital (from	50. 00	726, 313	518, 546	207, 767	726, 313	16. 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 0 0 17. 02  0 0 0 0 0 18. 00		Special add-on payments for new technologies	54.00	35, 871	0	35, 871	35, 871	
18.00 Capital outlier reconciliation adjustment 93.00 0 0 0 18.00 amount (see instructions)		Credits received from manufacturers for	68. 00	0	0	0	0	17. 01 17. 02
	18. 00	Capital outlier reconciliation adjustment	93. 00	О	0	0	0	18. 00
	19. 00	,			8, 081, 553	3, 440, 813	11, 522, 366	19. 00

Health Financial Systems	KING'S DAUGHTE	RS' HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) R	REDUCTION CALCULATION EXHIBIT 5	Provider Co		From 01/01/2020	Worksheet E Part A Exhibit Date/Time Prep 5/24/2021 11:0	pared:
		Title	XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from				
		Wkst. L)				
	0	1.00	2.00	3. 00	4. 00	

						5/24/2021 11:	00 am_
			Title	: 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	703, 218	498, 74	3 204, 475	703, 218	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	23, 095	19, 80	3, 292	23, 095	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	726, 313	518, 54	6 207, 767	726, 313	26. 00
		Wkst. E, Pt. A, line	(Amt. from 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	444, 247	444, 24	7	444, 247	28. 00
29.00	Low volume adjustment on or after October 1	70. 97	208, 312		208, 312	208, 312	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	43, 979	45, 42	5 -1, 446	43, 979	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	-9, 015		-9, 015	-9, 015	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0	0	31. 01
						(Amt. to Wkst. E, Pt. A)	
		0	1. 00	2, 00	3. 00	4. 00	
32. 00	HAC Reduction Program adjustment (see instructions)	70. 99	00		0 0		32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0069	Peri od: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 5/24/2021 11:00 am

		Title XVIII	Hospi tal	5/24/2021 11: PPS	00 am
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			14, 846	
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		11, 733, 917 11, 349, 291	
3. 00 4. 00	OPPS payments Outlier payment (see instructions)			46, 751	3. 00 4. 00
4. 01	Outlier reconciliation amount (see instructions)			0	1
5.00	Enter the hospital specific payment to cost ratio (see instruc-	tions)		0. 000	1
6.00	Line 2 times line 5			0	
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	1
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. 1	V. col. 13. line 200		23, 697	1
10.00	Organ acqui si ti ons	.,,		0	1
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			14, 846	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				-
12. 00	Reasonable charges Ancillary service charges			85, 532	12 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Iii	ne 69)		0	1
14.00	Total reasonable charges (sum of lines 12 and 13)			85, 532	14. 00
15.00	Customary charges			0	15.00
15. 00 16. 00	Aggregate amount actually collected from patients liable for paramounts that would have been realized from patients liable for	3	•	0	
10.00	had such payment been made in accordance with 42 CFR §413.13(e)		i a chargebasi s		10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
	Total customary charges (see instructions)	1011 10 111	44) (	85, 532	
19. 00	Excess of customary charges over reasonable cost (complete only instructions)	y if line 18 exceeds lir	ne 11) (see	70, 686	19. 00
20. 00	Excess of reasonable cost over customary charges (complete only	v if line 11 exceeds lin	ne 18) (see	0	20. 00
	instructions)	,	, (		
	Lesser of cost or charges (see instructions)			14, 846	1
	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instru	ictions)		0	22. 00 23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	de (1 diis)		11, 419, 739	1
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)			0	25. 00
26. 00 27. 00	Deductibles and Coinsurance amounts relating to amount on line Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl			2, 145, 741 9, 288, 844	
27.00	instructions)	us the sum of filles 22	and 23] (See	9, 200, 044	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30.00	Subtotal (sum of lines 27 through 29) Primary payer payments			9, 288, 844 2, 057	
	Subtotal (line 30 minus line 31)			9, 286, 787	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	ES)			
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			257, 014 167, 059	
	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)		149, 723	
	Subtotal (see instructions)	,		9, 453, 846	1
	MSP-LCC reconciliation amount from PS&R			-18	
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00 39. 50
39. 97	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration	)		0	1
39. 98	Partial or full credits received from manufacturers for replace	ed devices (see instruct	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	
40. 00	Subtotal (see instructions)			9, 453, 864	1
40. 01 40. 02	Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration			62, 396 0	1
40. 03	1			Ŭ	40. 03
41.00	Interim payments			9, 389, 582	41. 00
41. 01	Interim payments-PARHM				41. 01
42. 00 42. 01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			0	42. 00 42. 01
43. 00	Balance due provider/program (see instructions)			1, 886	ı
43. 01	Balance due provider/program-PARHM (see instructions)				43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub. 15-2, o	chapter 1,	1, 402, 496	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				-
90. 00	Original outlier amount (see instructions)			0	90.00
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money				92. 00
93.00	Time Value of Money (see instructions)			0	93. 00 94. 00
74. UU	Total (sum of lines 91 and 93)			ı	74.00

In Lieu of Form CMS-2552-10

Period:	Worksheet E-1
From 01/01/2020	Part
To 12/31/2020	Date/Time Prepared:
5/24/2021	11:00 am Health Financial Systems KING ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0069

					5/24/2021 11:0	00 am
			XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		11, 076, 28	5	9, 389, 582	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	ADJUST MENTS TO TROVIDER			Ö	0	3. 02
3. 03				o	0	3. 03
3. 04				o	l ol	3. 04
3. 05				o	0	3. 05
0.00	Provider to Program			<u> </u>		0.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3.51				O	0	3. 51
3.52				o	0	3. 52
3.53				o	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)		11, 076, 28	5	9, 389, 582	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
5. 00	TO BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after					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	0	5. 02
5.03				O	o	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			0	0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
. 01	the cost report. (1)				1 00/	/ 01
6. 01	SETTLEMENT TO PROVIDER			0	1, 886	6. 01
6. 02	SETTLEMENT TO PROGRAM		94, 54		0 201 469	6. 02
7. 00	Total Medicare program liability (see instructions)		10, 981, 74	Contractor	9, 391, 468 NPR Date	7. 00
				Number	(Mo/Day/Yr)	
			)	1. 00	2. 00	
8. 00	Name of Contractor			00	2.00	8. 00
5. 50	1			T.	ı	5.00

Heal th	Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCUL	From 01/01/2020   To 12/31/2020			Worksheet E-1 Part II Date/Time Pre 5/24/2021 11:	pared:	
			Title XVIII	Hospi tal	PPS	
					1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDA					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION					1
1.00   Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14						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, col. 6. line 2						3. 00 4. 00
	4.00   Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12					
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 ce	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168					
8. 00	Calculation of the HIT incentive payment (s					8. 00
9. 00	Sequestration adjustment amount (see instru					9. 00
10. 00	Calculation of the HIT incentive payment af		(see instructions)			10. 00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00  Initial/interim HIT payment adjustment (see instructions)						30. 00
	31.00 Other Adjustment (specify)					31. 00
32. 00	Balance due provider (line 8 (or line 10) m	inus line 30 and li	ne 31) (see instruction	ıs)		32.00

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der	CCN: 15-0069	Peri od: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VII Date/Time Prepared: 5/24/2021 11:00 am

			To 12/31/2020	Date/Time Pre 5/24/2021 11:	
		Title XIX	Hospi tal	Cost	00 4
			Inpatient	Outpati ent	
			1, 00	2, 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XIX	SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		3, 926, 114		1.00
2.00	Medical and other services			6, 858, 800	2. 00
3.00	Organ acquisition (certified transplant centers only)		o		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		3, 926, 114	6, 858, 800	4. 00
5.00	Inpatient primary payer payments		o		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		3, 926, 114	6, 858, 800	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routine service charges		0		8. 00
9.00	Ancillary service charges		10, 761, 078	32, 624, 772	9. 00
10.00	Organ acquisition charges, net of revenue		0		10. 00
11. 00	Incentive from target amount computation		0		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		10, 761, 078	32, 624, 772	12. 00
	CUSTOMARY CHARGES		, , , , , , , , , , , , , , , , , , , ,		
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basis			_	
14. 00	Amounts that would have been realized from patients liable for		0	0	14. 00
15 00	a charge basis had such payment been made in accordance with 4	2 CFR §413.13(e)	0.000000	0.000000	15 00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15. 00 16. 00
16.00	Total customary charges (see instructions)  Excess of customary charges over reasonable cost (complete only	v if line 1/ evenede	10, 761, 078	32, 624, 772	17. 00
17. 00	line 4) (see instructions)	y II IIIle 16 exceeds	6, 834, 964	25, 765, 972	17.00
18. 00	Excess of reasonable cost over customary charges (complete only	0	0	18. 00	
10.00	16) (see instructions)	y II IIIle 4 exceeds IIIle		O	10.00
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instr	uctions)		0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		3, 926, 114	6, 858, 800	21.00
200	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			0,000,000	200
22. 00	Other than outlier payments		0	0	22. 00
23. 00	Outlier payments		0	0	23. 00
24.00	Program capital payments		o		24. 00
25.00	Capital exception payments (see instructions)		o		25. 00
26.00	Routine and Ancillary service other pass through costs		o	0	26. 00
27.00	Subtotal (sum of lines 22 through 26)		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, 926, 114	6, 858, 800	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30. 00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		3, 926, 114	6, 858, 800	31.00
32. 00	Deducti bl es		0	0	32. 00
33. 00	Coinsurance		0	0	33. 00
34.00	Allowable bad debts (see instructions)	0	0	34.00	
35. 00	Utilization review	0		35. 00	
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	3, 926, 114	6, 858, 800	36. 00	
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0 3, 926, 114	0	37. 00	
38. 00	Subtotal (line 36 ± line 37)			6, 858, 800	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)	0	, 050 000	39.00	
40. 00	Total amount payable to the provider (sum of lines 38 and 39)	3, 926, 114	6, 858, 800	40.00	
41.00	Interim payments		3, 926, 114	6, 858, 800	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 accordan	ce with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2		1 I		I

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

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

Provider CCN: 15-0069 | Period: From 01/01/2

oni y)					5/24/2021 11:	00 am
		General Fund		Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	26, 915, 057	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2. 00
3.00	Notes recei vabl e	0	0	0	0	
4. 00 E. 00	Accounts recei vable	10, 759, 153	0	0	0	
5. 00 6. 00	Other receivable Allowances for uncollectible notes and accounts receivable	0		0	0	
7. 00	Inventory	3, 056, 386		0		1
8. 00	Prepai d expenses	1, 752, 074		0	Ö	
9.00	Other current assets	294, 463	0	0	0	9. 00
10. 00	Due from other funds	0	1	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	42, 777, 133	0	0	0	11. 00
10.00	FI XED ASSETS	4 020 252	1			12.00
12. 00 13. 00	Land Land improvements	4, 039, 252	1	0	0	1
14. 00	Accumulated depreciation	-2, 348, 701		0	0	
15. 00	Bui I di ngs	118, 741, 847	1	0	Ö	1
16. 00	Accumulated depreciation	-43, 891, 241	1	0	Ö	1
17. 00	Leasehold improvements	0	0	0	0	17. 00
18. 00	Accumul ated depreciation	0	0	0	0	18. 00
19. 00	Fi xed equipment	0	0	0	0	1
20.00	Accumulated depreciation	0	0	0	0	
21. 00	Automobiles and trucks	1, 248, 285	1	0	0	
22. 00 23. 00	Accumulated depreciation Major movable equipment	-1, 000, 664 62, 237, 765	1	0	0	
24. 00	Accumulated depreciation	-48, 932, 719		0		24. 00
25. 00	Mi nor equipment depreciable	0	o o	o	Ö	25. 00
26. 00	Accumul ated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	90, 093, 824	0	0	0	30. 00
31. 00	Investments	0	0	O	0	31. 00
32. 00	Deposits on Leases			0	Ö	32. 00
33. 00	Due from owners/officers	0	Ō	0	Ö	
34.00	Other assets	193, 482, 395	0	0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	193, 482, 395		0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	326, 353, 352	2 0	0	0	36. 00
27.00	CURRENT LI ABI LI TI ES	1 441 240		ام		27.00
37. 00 38. 00	Accounts payable Salaries, wages, and fees payable	1, 441, 340 0		0	0	1
39. 00	Payroll taxes payable			0	0	1
40. 00	Notes and Loans payable (short term)	265, 024	Ö	ő	o o	40.00
41. 00	Deferred income	0	Ö	0	Ö	1
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	0	0	0	0	
44. 00	Other current liabilities	9, 910, 334	1	1		
45. 00	Total current liabilities (sum of lines 37 thru 44)	11, 616, 698	0	0	. 0	45. 00
46. 00	LONG TERM LIABILITIES  Mortgage payable		0	O	0	46. 00
47. 00	Notes payable	87, 366, 804	1	0	0	
48. 00	Unsecured Loans	0	o o	o	Ö	1
49.00	Other long term liabilities	758, 144	0	0	0	
50.00	Total long term liabilities (sum of lines 46 thru 49)	88, 124, 948	0	0	0	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	99, 741, 646	0	0	0	51. 00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	226, 611, 706				52.00
53. 00 54. 00	Specific purpose fund Donor created - endowment fund balance - restricted		0	0		53. 00 54. 00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			o		56. 00
57. 00	Plant fund balance - invested in plant				0	1
58. 00	Plant fund balance - reserve for plant improvement,				0	
	repl acement, and expansi on					
59.00	Total fund balances (sum of lines 52 thru 58)	226, 611, 706		0	0	1
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	326, 353, 352				60.00
	I ~ ' /	I	ı			I

Provider CCN: 15-0069

					То	12/31/2020	Date/Time Prep 5/24/2021 11:0	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	30 diii
		1.00	2. 00	3.00		4. 00	5. 00	
1.00	Fund balances at beginning of period	1.00	194, 630, 464			4.00		1. 00
2. 00	Net income (loss) (from Wkst. G-3, line 29)		31, 981, 242			· ·		2. 00
3.00	Total (sum of line 1 and line 2)		226, 611, 706			0		3. 00
4.00	Additions (credit adjustments) (specify)	o	, , ,		0		0	4. 00
5.00		0			0		0	5.00
6.00		0			0		0	6.00
7.00		0			0		0	7. 00
8.00		0			0		0	8.00
9.00		0			0		0	9. 00
10. 00	Total additions (sum of line 4-9)		0			0		10. 00
11. 00	Subtotal (line 3 plus line 10)	_	226, 611, 706		_	0	_	11. 00
12.00	Deductions (debit adjustments) (specify)	0			0		0	
13.00		0			0		0	13. 00 14. 00
14. 00 15. 00		0			0		0	14. 00 15. 00
16. 00					0			16. 00
17. 00					0			17. 00
18. 00	Total deductions (sum of lines 12-17)		0		J	0	o l	18. 00
19. 00	Fund balance at end of period per balance		226, 611, 706			0		19. 00
	sheet (line 11 minus line 18)		,,			_		
		Endowment Fund	PI ant	Fund				
		/ 00	7.00	0.00				
1. 00	Fund balances at beginning of period	6.00	7. 00	8.00	0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)	0			U			2. 00
3.00	Total (sum of line 1 and line 2)	0			0			3. 00
4. 00	Additions (credit adjustments) (specify)		0					4. 00
5. 00	(		0					5. 00
6.00			0					6. 00
7.00			0					7.00
8.00			0					8. 00
9.00			0					9. 00
10.00	Total additions (sum of line 4-9)	0			0			10.00
11. 00	Subtotal (line 3 plus line 10)	0	_		0			11. 00
12.00	Deductions (debit adjustments) (specify)		0					12.00
13.00			0					13.00
14. 00 15. 00			0					14. 00 15. 00
16. 00			0					16. 00
17. 00			0					17. 00
18. 00	Total deductions (sum of lines 12-17)		U		0			18. 00
19. 00	Fund balance at end of period per balance				O			19. 00
	sheet (line 11 minus line 18)							
		·					•	

Health Financial Systems K STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0069

	5/24/2021 11:0	)O am
Cost Center Description   Inpatient   Outpatient	Total	
1.00 2.00	3.00	
PART I - PATIENT REVENUES		
General Inpatient Routine Services		
1. 00 Hospi tal 11, 321, 694	11, 321, 694	1.00
2. 00 SUBPROVI DER - I PF		2.00
3. 00 SUBPROVIDER - I RF		3.00
4. 00 SUBPROVI DER		4. 00
5.00 Swing bed - SNF	o	5. 00
6.00 Swing bed - NF	0	6. 00
7.00 SKILLED NURSING FACILITY		7. 00
8.00 NURSING FACILITY		8. 00
9. 00 OTHER LONG TERM CARE		9. 00
10.00 Total general inpatient care services (sum of lines 1-9)  11,321,694	11, 321, 694	10.00
Intensive Care Type Inpatient Hospital Services	11, 321, 074	10.00
11. 00   INTENSIVE CARE UNIT   3, 277, 172	3, 277, 172	11. 00
12. OO CORONARY CARE UNIT	0,277,172	12.00
13. 00 BURN INTENSIVE CARE UNIT		13. 00
14. 00 SURGI CAL INTENSIVE CARE UNIT		14. 00
15. 00 OTHER SPECIAL CARE (SPECIFY)		15. 00
16.00 Total intensive care type inpatient hospital services (sum of lines 3,277,172)	3, 277, 172	16. 00
11-15)	3, 211, 112	10.00
17.00 Total inpatient routine care services (sum of lines 10 and 16)  14,598,866	14, 598, 866	17. 00
18. 00   Ancillary services   64, 356, 530   203, 664, 40		18. 00
19. 00   Outpatient services   0   68, 696, 75		19. 00
	0 00, 090, 754	
		20.00
		21. 00
22. 00 HOME HEALTH AGENCY 1, 658, 70		22. 00
23. 00   AMBULANCE SERVI CES	2 5, 183, 782	23. 00
24. 00 CMHC		24. 00
25. 00   AMBULATORY SURGI CAL CENTER (D. P. )	4// 000	25. 00
26. 00 HOSPI CE 0 466, 93		26.00
27. 00 OTHER OUTPATIENT 0 339, 87		27. 00
28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. 78,955,396 280,010,45	8 358, 965, 854	28. 00
G-3, line 1)		
PART II - OPERATING EXPENSES	1	20.00
29. 00 Operating expenses (per Wkst. A, column 3, line 200) 122, 287, 22 30. 00 ADD (SPECIFY)	1	29. 00
		30.00
		31.00
52. 55		32.00
33.00		33. 00
34.00		34. 00
35. 00		35. 00
36.00 Total additions (sum of lines 30-35)	U	36. 00
37. 00 DEDUCT (SPECIFY) 0		37. 00
38. 00		38. 00
39. 00		39. 00
40. 00		40.00
41.00	_	41.00
42.00 Total deductions (sum of lines 37-41)	U	42.00
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 122, 287, 22	η	43.00
to Wkst. G-3, line 4)	1	

	L. Coratana	KINGLO DALIGHTEDOL	HOCDITAL	1-11-	£ F OMC 3	NEED 10
Heal th Financi	EVENUES AND EXPENSES	KING'S DAUGHTERS'	Provider CCN: 15-0069	Period:	u of Form CMS-2 Worksheet G-3	2552-10
STATEMENT OF T	EVENUES AND EAR ENGES		Trovider con. 10 ccc	From 01/01/2020 To 12/31/2020	Date/Time Prep 5/24/2021 11:0	
					1. 00	
	atient revenues (from Wkst. G-2, Part				358, 965, 854	1. 00
	ntractual allowances and discounts or	n patients' account	S		239, 702, 833	2.00
	ent revenues (line 1 minus line 2)				119, 263, 021	
	tal operating expenses (from Wkst. G-		3)		122, 287, 221	
	ome from service to patients (line 3	minus line 4)			-3, 024, 200	5.00
OTHER II						
	utions, donations, bequests, etc				379, 312	6. 00
	from investments				3, 419, 259	
	s from telephone and other miscellane	eous communication	servi ces		0	
	from television and radio service				0	
	e di scounts				0	
	and refunds of expenses				0	11. 00
	lot receipts				0	
•	from laundry and linen service				0	13.00
	from meals sold to employees and gue	ests			315, 240	
	from rental of living quarters				0	
	from sale of medical and surgical su		an patients		0	
	from sale of drugs to other than pat				0	
	from sale of medical records and abs					18.00
	(fees, sale of textbooks, uniforms,				0	19.00
l l	from gifts, flowers, coffee shops, a	and canteen			0	20.00
	of vending machines				0	
22.00 Rental	of hospital space				0	22.00
23.00 Governm	ental appropriations				53, 235	23.00
	PERATING INCOME				17, 516, 852	24.00
	PHE Funding				13, 320, 580	
	ther income (sum of lines 6-24)				35, 005, 442	
	ine 5 plus line 25)				31, 981, 242	
	KPENSES (SPECIFY)				0	
	ther expenses (sum of line 27 and sub				0	28. 00
29.00 Net inc	ome (or loss) for the period (line 26	ś minus line 28)			31, 981, 242	29. 00

Heal th	Financial Systems		KING'S DAUGHTE	RS' HOSPITAL		In Lie	eu of Form CMS-:	2552-10
ANALYS	IS OF HOSPITAL-BASED HOME HEALT	TH AGENCY COSTS		Provider CC	CN: 15-0069	Peri od:	Worksheet H	
				HHA CCN:	15-7141	From 01/01/2020 To 12/31/2020		pared:
							5/24/2021 11:	00 am
						Home Health	PPS	
		Sal ari es	Employee	Transportati on	Contracted/Pu	Agency I ur Other Costs	Total (sum of	
		Sur ur res	Benefits	(see	chased	ii other oosts	col s. 1 thru	
				instructions)	Servi ces		5)	
	I	1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
4 00	GENERAL SERVICE COST CENTERS	I		ام		1	1 0	1 1 00
1. 00	Capital Related - Bldg. & Fixtures			U		0	0	1. 00
2.00	Capital Related - Movable			0		0	0	2. 00
	Equi pment							
3.00	Plant Operation & Maintenance	0	0	0		0 0	0	3. 00
4.00	Transportation	0	0	0		0 0	0	4.00
5.00	Administrative and General	935, 604	0	478		0 14, 685	950, 767	5. 00
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	0	0	28, 819		0 0	28, 819	6. 00
7. 00	Physical Therapy	0	0	21, 594			21, 594	•
8. 00	Occupational Therapy	0	0	0		0 0	0	1
9.00	Speech Pathology	0	0	0		0 0	0	9. 00
10.00	Medical Social Services	0	0	35		0 0	35	
11. 00	Home Heal th Aide	0	0	2, 205		0 0	2, 205	•
12. 00 13. 00	Supplies (see instructions) Drugs	0	0	0		0 24, 810 0 552		
14. 00	DME	0	0	0		0 552	0	1
14.00	HHA NONREI MBURSABLE SERVI CES		O O	U		0 0		14.00
15.00	Home Dialysis Aide Services	0	0	0		0 0	0	15. 00
16. 00	Respiratory Therapy	0	0	0		0 0	0	16. 00
17. 00	Private Duty Nursing	0	0	0		0	0	17. 00
18.00	Clinic	0	0	0		0 0	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	0				21.00
22. 00	Homemaker Service	0	0	Ö		0 0	Ö	22. 00
23. 00	All Others (specify)	0	0	0		0 0	0	23. 00
23. 50	Tel emedi ci ne	0	0	0		0 0	0	23. 50
24. 00	Total (sum of lines 1-23)	935, 604	0	53, 131		0 40, 047	1, 028, 782	24. 00
		Recl assi fi cati on	Reclassified Trial Balance	Adjustments	Net Expenses for Allocation			
		OII	(col. 6 +		(col. 8 + col			
			col . 7)		9)			
		7. 00	8. 00	9. 00	10.00			
4 00	GENERAL SERVICE COST CENTERS	1		٥				1 00
1. 00	Capital Related - Bldg. & Fixtures	0	0	O		0		1. 00
2.00	Capital Related - Movable	0	0	0		0		2.00
2.00	Equi pment		Ü	Ŭ				2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3. 00
4.00	Transportation	0	0	0		0		4. 00
5. 00	Administrative and General	-643, 038	307, 729	0	307, 72	29		5. 00
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	357, 520	386, 339	n	386, 33	39		6.00
7. 00	Physical Therapy	216, 041	237, 635	0	237, 63			7. 00
8. 00	Occupational Therapy	58, 949	58, 949	o	58, 94			8. 00
9.00	Speech Pathology	3, 862	3, 862	0	3, 86	52		9. 00
10.00	Medical Social Services	0	35	0		35		10.00
11. 00	Home Health Aide	14, 597	16, 802	0	16, 80			11.00
12. 00 13. 00	Supplies (see instructions) Drugs	0	24, 810 552	0	24, 81 55			12. 00 13. 00
14. 00	DME		0	0	50	0		14. 00
11.00	HHA NONREI MBURSABLE SERVI CES		<u> </u>	<u> </u>		<u> </u>		1 1. 00
15. 00	Home Dialysis Aide Services	0	0	0		0		15. 00
16. 00	Respiratory Therapy	0	0	0		0		16. 00
17. 00	Private Duty Nursing	0	0	0		0		17. 00
18.00	Clinic	0	0	0		0		18.00
19. 00 20. 00	Health Promotion Activities Day Care Program		0	0		0		19. 00 20. 00
21. 00	Home Delivered Meals Program		n	n		Ö		21. 00
22. 00	Homemaker Service	Ö	0	ő		0		22. 00
23. 00	All Others (specify)	0	0	O		0		23. 00
23. 50	Tel emedi ci ne	0	0	0		0		23. 50
24. 00	Total (sum of lines 1-23)	7, 931	1, 036, 713	0	1, 036, 71	3		24. 00

Provider CDI 15-0007	Heal th	Financial Systems		KING'S DAUGHTER	S' HOSPI TAL		In Lie	u of Form CMS-2	2552-10
Net   Expense   September						CN: 15-0069	Peri od:	Worksheet H-1	
Next Expenses   Part   Part   Page					HHA CCN:	15-7141		Date/Time Pre	
Capital Related - Bidg							Home Health		oo am
Net Engenesis   Net Engenesi				C: +-  D-		1	Agency I		
Prof.   Cost   Flatures   Flatu				Capitai kera	itea Costs				
Al Location   Crom Wist III.   Col. 107									
Col. 10				Fixtures	Equi pment			(COIS. U-4)	
Capital Related - Bidg &			•						
Description   Comparison   Co				1. 00	2.00	3.00	4. 00	4A. 00	
Fixtures									
Capit tal Related = Movable   Sequipment	1. 00	, ,	0	0				0	1.00
Pint Operation & Maintenance	2.00	Capital Related - Movable	0		0			0	2. 00
1.00	3 00		0	0	0		0	0	3 00
HAR PENBURSARIE SERVICES   0   0   0   386,339   0   0   0   0   386,339   6   0   0   0   0   386,339   6   0   0   0   0   386,339   6   0   0   0   0   386,339   6   0   0   0   0   386,339   6   0   0   0   0   386,339   6   0   0   0   0   386,339   7   0   0   0   0   0   386,339   7   0   0   0   0   0   0   0   0   0		Transportation	Ö	-	Ö		0 0	0	
SKIT   Led Nursing Care   386, 339   0   0   0   386, 339   6, 00   0   237, 635   6, 00   0   0   237, 635   6, 00   0   0   237, 635   6, 00   0   0   237, 635   6, 00   0   0   237, 635   6, 00   0   0   237, 635   6, 00   0   0   0   237, 635   6, 00   0   0   0   237, 635   6, 00   0   0   0   0   237, 635   6, 00   0   0   0   0   0   0   0   386, 69   0   0   0   0   0   386, 69   0   0   0   0   0   386, 69   0   0   0   0   386, 69   0   0   0   0   386, 69   0   0   0   0   386, 69   0   0   0   0   386, 69   0   0   0   0   386, 69   0   0   0   0   0   0   386, 69   0   0   0   0   0   0   0   0   0	5.00		307, 729	0	0		0 0	307, 729	5. 00
8.00   Occupational Therapy   58,949   0   0   0   0   88,949   8.00	6. 00		386, 339	0	0	ı	0 0	386, 339	6. 00
9.00   Speech Pathology   3,862   0,0   0   0   3,862   9,0   11,00   Medical Social Services   35   0,0   0   0   0,3   10,00   11,00   Medical Social Services   35   0,0   0   0   0   0,0   16,802   11,00   11,00   12,00   12,00   12,00   12,00   12,00   12,00   12,00   12,00   12,00   12,00   14,00				-		1			
10.00   Medical Social Services   55   0   0   0   0   35   10.00					0		0 0		1
12.00   Suppl   les (see instructions)   24,810   0   0   0   0   552   13.00   14.00	10.00	Medical Social Services	35	- 1	0		0 0	35	10.00
13.00   Drugs		1		-	0		0 0		
HAN NONE IMBURSABLE SERVICES				-	ŭ		-		1
15.00	14. 00		0	0	0		0 0	0	14. 00
17.00	15. 00		0	0	0		0 0	0	15. 00
18.00   Clinic			0	-	0				1
19.00   Heal th Promotion Activities   0   0   0   0   0   0   0   0   0			0	-	0		٦ ١	-	1
21.00   Home Delivered Meals Program   0   0   0   0   0   0   0   0   22.00	19. 00	Health Promotion Activities	0	٦	0		0 0	-	19. 00
22.00   Homemaker Service		1 3	0	-	-	1	٦ ١		1
23.50   Telemedicine		Homemaker Service	Ö	o	-	1	ŭ ŭ	-	
24.00   Total (sum of lines 1-23)   1,036,713   0   0   0   1,036,713   24.00			0	٦	ŭ		٦ ١	-	
Seneral   4A + 5)   5.00   6.00		1	1, 036, 713	0		1		-	
S.00   6.00									
1.00									-
Fixtures	1 00								1.00
Equi pment	1.00								1.00
3.00	2.00	•							2. 00
4.00	3. 00	1 · ·							3. 00
HHA REIMBURSABLE SERVICES			007.700						1
6. 00       Skilled Nursing Care       163,087       549,426       6. 00         7. 00       Physical Therapy       100,314       337,949       7. 00         8. 00       Occupati onal Therapy       24,884       83,833       8.00         9. 00       Speech Pathol ogy       1,630       5,492       9. 00         10. 00       Medical Social Services       15       50       10. 00         11. 00       Home Health Aide       7,093       23,895       11. 00         12. 00       Supplies (see instructions)       10,473       35,283       12. 00         13. 00       Drugs       233       785       13. 00         14. 00       DME       0       0       14. 00         HHA NONREIMBURSABLE SERVICES       0       0       15. 00         15. 00       Respiratory Therapy       0       0       15. 00         17. 00       Private Duty Nursing       0       0       17. 00         18. 00       Clinic       0       0       18. 00         19. 00       Health Promotion Activities       0       0       18. 00         20. 00       Day Care Program       0       0       20. 00         21. 00 <t< td=""><td>5.00</td><td></td><td>307, 729</td><td></td><td></td><td></td><td></td><td></td><td>5.00</td></t<>	5.00		307, 729						5.00
8.00     Occupational Therapy     24,884     83,833     8.00       9.00     Speech Pathology     1,630     5,492     9.00       10.00     Medical Social Services     15     50     10.00       11.00     Home Heal th Aide     7,093     23,895     11.00       12.00     Supplies (see instructions)     10,473     35,283     12.00       13.00     Drugs     233     785     13.00       14.00     ME     0     0     14.00       HHA NONREI MBURSABLE SERVI CES     15.00     15.00     16.00       15.00     Respiratory Therapy     0     0     15.00       16.00     Respiratory Therapy     0     0     17.00       17.00     Private Duty Nursing     0     0     17.00       18.00     Clinic     0     0     18.00       19.00     Health Promotion Activities     0     0     18.00       19.00     Day Care Program     0     0     20.00       21.00     Home Delivered Meals Program     0     0     21.00       22.00     Homemaker Service     0     0     22.00       23.00     All Others (specify)     0     0     23.00       21.00     Tel emedicine		Skilled Nursing Care							1
9.00     Speech Pathology     1,630     5,492       10.00     Medical Social Services     15     50       11.00     Home Health Aide     7,093     23,895     11.00       12.00     Supplies (see instructions)     10,473     35,283     12.00       13.00     Drugs     233     785     13.00       14.00     HHA NONREI MBURSABLE SERVI CES     14.00     14.00       15.00     Home Dialysis Aide Services     0     0     15.00       16.00     Respiratory Therapy     0     0     15.00       18.00     Clinic     0     0     17.00       19.00     Health Promotion Activities     0     0     18.00       19.00     Day Care Program     0     0     19.00       20.00     Home Delivered Meals Program     0     0     20.00       21.00     Homemaker Service     0     0     22.00       23.00     All Others (specify)     0     0     23.00       23.50     Tel emedicine     0     0     0		1 3							
11.00   Home Heal th Ai de   7,093   23,895   12.00   12.00   10,473   35,283   12.00   13.00   14.00		Speech Pathology		5, 492					9. 00
12.00   Supplies (see instructions)   10,473   35,283   12.00   13.00   14.00		·							
14. 00     DME     0     0       HHA NONREI MBURSABLE SERVI CES       15. 00     Home Dialysis Aide Services     0     0       16. 00     Respiratory Therapy     0     0       17. 00     Private Duty Nursing     0     0       18. 00     Clinic     0     0       19. 00     Heal th Promotion Activities     0     0       20. 00     Day Care Program     0     0       21. 00     Home Delivered Meals Program     0     0       22. 00     Homemaker Service     0     0       23. 00     All Others (specify)     0     0       23. 50     Tel emedicine     0     0		·							
HHA NONREI MBURSABLE SERVI CES									
15. 00       Home Dialysis Aide Services       0       0       15. 00         16. 00       Respiratory Therapy       0       0       16. 00         17. 00       Private Duty Nursing       0       0       17. 00         18. 00       Clinic       0       0       18. 00         19. 00       Heal th Promotion Activities       0       0       19. 00         20. 00       Day Care Program       0       0       20. 00         21. 00       Home Dialysis Aide Service       0       0       20. 00         21. 00       Home Dialysis Aide Service       0       0       20. 00         22. 00       Home Dialysis Aide Services       0       0       20. 00         22. 00       Home Dialysis Aide Services       0       0       0         22. 00       Home Dialysis Aide Services       0       0       0         22. 00       Home Dialysis Aide Services       0       0       0         23. 00       All Others (specify)       0       0       0         23. 50       Tel emedicine       0       0       0	14.00		1 0	U					14.00
17. 00     Private Duty Nursing     0     0       18. 00     Clinic     0     0       19. 00     Health Promotion Activities     0     0       20. 00     Day Care Program     0     0       21. 00     Home Delivered Meals Program     0     0       22. 00     Homemaker Service     0     0       23. 00     All Others (specify)     0     0       23. 50     Tel emedicine     0     0		Home Dialysis Aide Services							
18.00     Clinic     0     0       19.00     Health Promotion Activities     0     0       20.00     Day Care Program     0     0       21.00     Home Delivered Meals Program     0     0       22.00     Homemaker Service     0     0       23.00     All Others (specify)     0     0       23.50     Tel emedicine     0     0		1							
20. 00       Day Care Program       0       0       0         21. 00       Home Delivered Meals Program       0       0       21. 00         22. 00       Homemaker Service       0       0       22. 00         23. 00       All Others (specify)       0       0       23. 00         23. 50       Tel emedicine       0       0       23. 50	18. 00	Clinic		0					18. 00
21.00       Home Delivered Meals Program       0       0         22.00       Homemaker Service       0       0         23.00       All Others (specify)       0       0         23.50       Tel emedicine       0       0			0	- 1					
23. 00 All Others (specify) 0 0 23. 50 Tel emedicine 0 0 23. 50		, ,							1
23. 50 Tel emedi ci ne 0 0 23. 50									
		1 3/		- 1					
				1, 036, 713					1

	Financial Systems	21.0	KING'S DAUGHTE		ON 45 00/0		u of Form CMS-2	
COST A	LLOCATION - HHA STATISTICAL BAS	51.5		Provi der Co	UN: 15-0069	Peri od: From 01/01/2020	Worksheet H-1 Part II	
				HHA CCN:	15-7141	To 12/31/2020		pared: 00 am
						Home Health	PPS	
		Capital Pol	ated Costs			Agency I		
		Capital Kei	ateu costs					
		BI dgs &	Movabl e	PI ant	Transportati	onReconciliation	Admi ni strati ve	1
		Fixtures	Equi pment	Operation &	(MI LEAGE)		& General	
		(SQUARE FEET)	(DOLLAR VALUE)	Maintenance (SQUARE FEET)			(ACCUM. COST)	
		1.00	2.00	3. 00	4. 00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS						2.22	
1.00	Capital Related - Bldg. &	0				0		1.00
	Fixtures							
2. 00	Capital Related - Movable Equipment		0			0		2. 00
3.00	Plant Operation & Maintenance		0	0		0		3.00
4. 00	Transportation (see	0	0	0		0		4.00
00	instructions)							
5.00	Administrative and General	0	0	0		0 -307, 729	728, 984	5.00
	HHA REIMBURSABLE SERVICES							
6. 00	Skilled Nursing Care	0		0		0 0	386, 339	
7.00	Physi cal Therapy	0	0	0		0 0	237, 635	
8.00	Occupational Therapy	0	0	0		0 0	58, 949	
9.00	Speech Pathology	0	0	0		0 0	3, 862	
10.00	Medical Social Services	0	0	0		0 0	35	1
11.00	Home Health Aide	0	0	0		0 0	16, 802	1
12.00	Supplies (see instructions)	0	0	0		0	24, 810	1
13.00	Drugs DME	0	0	0		0 0	552 0	
14. 00	HHA NONREI MBURSABLE SERVI CES		0			0 0	U	14. 00
15. 00	Home Dialysis Aide Services	l 0	0	0		0 0	0	15. 00
16. 00	Respiratory Therapy	l o	Ö	0		0 0	0	
17. 00	Private Duty Nursing	0	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	Ö	19.00
20. 00	Day Care Program	1 0	0	0		0	0	20.00
21. 00	Home Delivered Meals Program	0	0	0		0 0	Ô	21.00
22. 00	Homemaker Service	ا م	ا م	l o		0 0	, o	22. 00
23. 00	All Others (specify)	l n	l n	n		0 0	ő	
23. 50	Tel emedi ci ne	ا م	ا م	l o		0 0	ő	
24. 00	Total (sum of lines 1-23)	ا م	ا م	1 0		0 -307, 729	728, 984	
25. 00	Cost To Be Allocated (per	l o	Ö	Ö		0	307, 729	1
<del>-</del>	Worksheet H-1, Part I)	]	_	_				
	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0.0000	00	0. 422134	26 00

HHA CCN: 15-7141 Home Health PPS

						Agency I		
			CAPI	TAL RELATED CO	STS			
	Cost Center Description	HHA Trial Balance (1)	NEW BLDG & FLXT	NEW BLDG & FIXT HHA/HO	NEW MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
			1.00	4.04	0.00	DEPARTMENT	4.0	
1. 00	Administrative and General	0	1.00	1. 01 5, 413	2.00	4. 00 210, 609	4A 216, 022	1. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00 17. 00 18. 00 17. 00 19. 50 20. 00 21. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to	0 549, 426 337, 949 83, 833 5, 492 50 23, 895 35, 283 785 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0 0 0 0 0 0 0 0 0 0	216, 022 549, 426 337, 949 83, 833 5, 492 50 23, 895 35, 283 785 0 0 0 0 0 0 0 0 0 0 0 1, 252, 735 0. 0000000	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 19. 00 19. 00 19. 00 20. 00 21. 00
	6 decimal places.  Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		& GENERAL 5.00	PLANT 7.00	LINEN SERVICE 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 10. 00 11. 00 12. 000 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 10 mus column 26, line 1, rounded to 6 decimal places.	40, 772 103, 698 63, 784 15, 822 1, 037 9 4, 510 6, 659 148 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50, 805	0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00 21. 00

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

0

0

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0

1, 541, 215

0

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0

307, 599

0.249347

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C

1, 541, 215

0

14.00

15.00

16.00

17.00

18.00

19.00

19.50

20.00

21.00

(1) Column O, line 20 must agree with Wkst. A, column 7, line 101.

0

0

0

0

0

1, 541, 215

14.00

15.00

16.00

17.00

18.00

19.00

19.50

20.00

21.00

Clinic

Day Care Program

6 decimal places.

Tel emedi ci ne

Homemaker Service All Others (specify)

Health Promotion Activities

Home Delivered Meals Program

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

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

Unit Cost Multiplier: column

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

5/24/2021 11:00 am

21.00

22.00

0.000000

Home Health PPS Agency I CAPITAL RELATED COSTS NEW BLDG & NEW MVBLE **EMPLOYEE** Reconciliation ADMINISTRATIVE NEW BLDG & Cost Center Description FLXT FIXT HHA/HO FOUL P BENEFITS & GENERAL (SQUARE (SQUARE (SQUARE DEPARTMENT (ACCUM. FEET) FEET) FEET) (GROSS COST) SALARI ES) 1.00 2.00 5.00 1.01 5A 4.00 1.00 Administrative and General 0 2,748 943, 535 0 216, 022 1.00 0 2.00 Skilled Nursing Care 0 549, 426 2.00 3.00 Physical Therapy 0 0 0 0 337, 949 3.00 0 Occupational Therapy 0 0 0 0 83, 833 4.00 4.00 0 5.00 Speech Pathology 5, 492 5.00 6.00 Medical Social Services 0 00000000 0 0 50 6.00 0 0 0 0 7.00 Home Health Aide 0 23, 895 7.00 0 0 35, 283 8.00 8.00 Supplies (see instructions) 0 9.00 Drugs C 0 785 9.00 10.00 DMF 10.00 0 0 0 0 11.00 Home Dialysis Aide Services 0 0 11.00 0 0 12.00 Respiratory Therapy 0 12.00 0 13.00 Private Duty Nursing 13.00 0 0 14.00 Clinic 0 0 0 0 0 0 0 0 14.00 Health Promotion Activities 0 15.00 0 0 15.00 0 16.00 Day Care Program 0 16.00 17.00 17.00 Home Delivered Meals Program 0 0 0 0 0 Homemaker Service 0 18.00 18.00 0 0 0 19.00 All Others (specify) 19.00 0 19.50 Tel emedi ci ne 0 C 0 19.50 Total (sum of lines 1-19) 20.00 2,748 943, 535 1, 252, 735 20.00 21.00 Total cost to be allocated 5.413 210, 609 236, 439 21.00 1. 969796 0. 223213 0. 188738 22.00 Unit cost multiplier 0.000000 0.000000 22.00 Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG PLANT LINEN SERVICE (HOURS OF (MEALS (MEALS ADMI NI STRATI ON (SQUARE (POUNDS OF SERVICE) SERVED) SERVED) LAUNDRY) (DI RECT FEET) NRSING HRS) 8.00 7.00 9.00 10.00 11.00 13.00 1.00 Administrative and General 2, 748 0 1. 00 0 2.00 Skilled Nursing Care 0 000000000000000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 2.00 0 0 0 0 3 00 Physical Therapy 3 00 O 4.00 Occupational Therapy 0 0 4.00 5.00 Speech Pathology 0 5.00 0 6 00 Medical Social Services 0 0 6 00 O 7.00 Home Heal th Aide 0 0 7.00 8.00 Supplies (see instructions) 0 0 8.00 Drugs 0 0 9.00 0 9.00 0 0 10.00 DMF Ω 10 00 0 11.00 Home Dialysis Aide Services 0 11.00 Respiratory Therapy 0 12.00 12.00 0 13.00 Private Duty Nursing 0 0 13.00 0 0 14.00 Ω Clinic 14.00 0 15.00 Health Promotion Activities 0 0 15.00 Day Care Program 16.00 16.00 0 0 0 17.00 Home Delivered Meals Program 17.00 0 0 18.00 Homemaker Service 0 18.00 0 19.00 All Others (specify) 0 0 0 0 19.00 19.50 Tel emedi ci ne 0 0 C 0 0 19.50 Total (sum of lines 1-19) 2.748 0 20.00 20.00 0 0 C

50.805

0.000000

0.000000

0.000000

0.000000

18. 487991

21.00

22.00

Total cost to be allocated

Unit cost multiplier

Health Financial Systems		KING'S DAUGHTER	RS' HOSPITAL		In Lie	u of Form CMS-2	552-10
ALLOCATION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS STATISTICA	L Provider C		Peri od: From 01/01/2020	Worksheet H-2 Part II	
			HHA CCN:	15-7141	To 12/31/2020	Date/Time Prep 5/24/2021 11:0	
					Home Health Agency I	PPS	
Cost Center Description	CENTRAL SERVI CES &	PHARMACY (COSTED	MEDI CAL RECORDS &	NONPHYSI CI AN ANESTHETI STS			

						nome near tri	PP3	
						Agency I		
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	NONPHYSICI AN	RADI OLOGY		
		SERVICES &	(COSTED	RECORDS &	ANESTHETI STS	SCH00L		
		SUPPLY	REQUIS.)	LI BRARY	(ASSI GNED	(ASSI GNED		
		(COSTED		(GROSS	TIME)	TIME)		
		REQUIS.)		CHARGES)				
		14. 00	15. 00	16. 00	19. 00	23. 00		
1.00	Administrative and General	0	0	0	0	0		1. 00
2.00	Skilled Nursing Care	0	0	0	0	0		2. 00
3.00	Physical Therapy	0	0	0	0	0		3. 00
4.00	Occupational Therapy	0	0	0	0	0		4. 00
5.00	Speech Pathology	0	0	0	0	0		5. 00
6.00	Medical Social Services	0	0	0	0	0		6. 00
7.00	Home Health Aide	0	0	0	0	0		7. 00
8.00	Supplies (see instructions)	30, 345	0	0	0	o		8. 00
9.00	Drugs	0	0	0	0	o		9. 00
10.00	DME	O	o	0	0	o		10.00
11. 00	Home Dialysis Aide Services	O	o	0	0	o		11. 00
12.00	Respiratory Therapy	l o	o	0	0	o		12. 00
13.00	Private Duty Nursing	O	o	0	0	o		13. 00
14.00	Clinic	O	o	0	0	o		14. 00
15.00	Health Promotion Activities	O	o	0	0	o		15. 00
16.00	Day Care Program	O	o	0	0	ol		16. 00
17.00	Home Delivered Meals Program	l o	o	0	0	ol		17. 00
18.00	Homemaker Service	l o	o	0	0	ol		18. 00
19. 00	All Others (specify)	l ol	o	0	0	ol		19. 00
19. 50	Tel emedi ci ne	l ol	o	0	0	ol		19. 50
20.00	Total (sum of lines 1-19)	30, 345	o	0	o	ol		20. 00
21. 00	Total cost to be allocated	1, 236	o	0	0	ol		21. 00
	Unit cost multiplier	0. 040732	0. 000000	0. 000000	0. 000000	0. 000000		22. 00

неат тг	Financial Systems		KING'S DAUGHTE	RS' HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APP0R	FIONMENT OF PATIENT SERVICE COST	ſS		Provi der C		Peri od:	Worksheet H-3	
				HHA CCN:		From 01/01/2020 To 12/31/2020		pared:
							5/24/2021 11:	
				Ti tl e	e XVIII	Home Health	PPS	
	Cost Center Description	From, Wkst.	Facility Costs	Shared	Total HHA	Agency I Total Visits	Average Cost	
	cost center beserver on	H-2, Part I,	(from Wkst.	Ancillary	Costs (cols.		Per Vi si t	
		col. 28, line	,	Costs (from	+ 2)		(col. 3 ÷ col.	
				Part II)			4)	
	DADT I COMPUTATION OF LEGGED	0	1.00	2.00	3.00	4.00	5. 00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TE	IE PROGRAM LIN	ITATION COST, OF	₹	
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	815, 978		815, 97	'8 3, 584	227. 67	1.00
2.00	Physi cal Therapy	3. 00	501, 904	C	501, 90	2, 284	219. 75	2.00
3.00	Occupational Therapy	4. 00	1	C			217. 66	
4.00	Speech Pathology	5. 00	1	C	7			
5. 00 6. 00	Medical Social Services Home Health Aide	6. 00 7. 00			35, 48	1 172	74. 00 205. 13	
7.00	Total (sum of lines 1-6)	7.00	35, 488 1, 486, 105	c			205. 13	7.00
7.00	Total (suil of Triles 1-0)		1, 400, 103		Program Visit			7.00
						nrt B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject t	o Subject to		
					Deducti bl es	& Deductibles		
			1.00	0.00	Coi nsurance	4.00	F 00	
	Limitation Cost Computation	0	1.00	2. 00	3. 00	4. 00	5. 00	
8. 00	Skilled Nursing Care		99915	C	1, 89	13		8.00
9. 00	Physical Therapy		99915	Ċ	1			9.00
10.00	Occupational Therapy		99915	C	34			10.00
11.00	Speech Pathology		99915	C	) 2	!5		11.00
12.00	Medical Social Services		99915	C		0		12.00
13.00	Home Heal th Ai de		99915	C				13.00
14. 00		From Wkot II 2	Facility Coata	Shared	3, 69 Total HHA		Datia (aal 2	14.00
	Cost Center Description	From Wkst. H-2 Part I, col.	(from Wkst.	Ancillary	Costs (col s.	Total Charges 1 (from HHA	Ratio (col. 3 ÷ col. 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Records)	. 601. 4)	
			, , ,	Part II)	<u> </u>	,		
		0	1.00	2. 00	3. 00	4. 00	5. 00	
15 00	Supplies and Drugs Cost Comput		F2 044		T2 0/	F2 221	1 022004	1 15 00
15. 00 16. 00	Cost of Medical Supplies Cost of Drugs	8. 00 9. 00			1		1. 032994 0. 000000	
16. 00	cost of brugs		Program Visits		Cost of	0	0.000000	16.00
			Trogram vrarta		Servi ces			
			Par	t B		Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to		
			Deductibles &			Deductibles &	Deductibles &	
		6.00	Coi nsurance 7.00	Coi nsurance 8.00	9.00	Coi nsurance 10.00	Coi nsurance 11.00	
	PART I - COMPUTATION OF LESSER							
	BENEFICIARY COST LIMITATION	JONEONTE T						
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0				0 430, 979		1.00
2.00	Physi cal Therapy	0				0 288, 971		2.00
3.00	Occupational Therapy	0	341			0 74, 222		3.00
4. 00 5. 00	Speech Pathology Medical Social Services		25 0			0 4, 743		4. 00 5. 00
6.00	Home Health Aide	0				0 24, 410		6.00
	Total (sum of lines 1-6)	0	1			0 823, 325		7. 00
7.00	Cost Center Description		2,370			525, 326		
7. 00	cost center bescription		7. 00	8. 00	9. 00	10.00	11. 00	
7. 00		6. 00	7.00					
7.00	Limitation Cost Computation	6.00	7.00					1 -
8. 00	Limitation Cost Computation Skilled Nursing Care	6.00	7.00					
8. 00 9. 00	Limitation Cost Computation Skilled Nursing Care Physical Therapy	6.00	7.00					8. 00 9. 00
8. 00 9. 00 10. 00	Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy	6.00	7.00					9. 00 10. 00
8. 00 9. 00 10. 00 11. 00	Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	6.00	7.00					9. 00 10. 00 11. 00
8. 00 9. 00 10. 00	Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy	6.00	7.00					9. 00 10. 00

	Financial Systems		KING'S DAUGHTE			In Lie	u of Form CMS-	2552-10
APPORT	IONMENT OF PATIENT SERVICE COST	TS .		Provider CO	CN: 15-0069 15-7141	Peri od: From 01/01/2020 To 12/31/2020		pared:
				Title	XVIII	Home Health	PPS	
		Drog	nam Cayarad Cha	2500	Cost of	Agency I		
		Prog	ram Covered Cha	ai ges	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		
		6. 00	7.00	8. 00	9. 00	10.00	11. 00	
	Supplies and Drugs Cost Comput							
15. 00	Cost of Medical Supplies	C	_	_		0 0	0	1 .0.00
16. 00	Cost of Drugs Cost Center Description	Total Program	0	0		0	0	16. 00
	cost center bescription	Cost (sum of cols. 9-10)	-					-
	PART I - COMPUTATION OF LESSER		PROGRAM COST, A	AGGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	}	
	BENEFICIARY COST LIMITATION							1
1 00	Cost Per Visit Computation	430, 979						1.00
1. 00 2. 00	Skilled Nursing Care Physical Therapy	288, 971						2.00
3.00	Occupational Therapy	74, 222						3.00
4. 00	Speech Pathology	4, 743						4.00
5. 00	Medical Social Services	1, 7, 10						5.00
6.00	Home Health Aide	24, 410						6.00
7. 00	Total (sum of lines 1-6)	823, 325						7. 00
	Cost Center Description							
		12. 00						
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8. 00
9.00	Physi cal Therapy							9. 00
10.00	Occupational Therapy							10.00
11. 00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Heal th Ai de	1						13.00
14.00	Total (sum of lines 8-13)							14. 00

Heal th	Financial Systems		KING'S DAUGHTE	RS' HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APP0R1	TIONMENT OF PATIENT SERVICE COST	S		Provider Co		Peri od:	Worksheet H-3	
					15-7141	From 01/01/2020 To 12/31/2020		
				Title	· XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
		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 COST	T OF HHA SERVIC	ES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	ITS		
1.00	Physi cal Therapy	66. 00	0. 331871	0		0 col. 2, line 2	. 00	1. 00
2.00	Occupational Therapy	67. 00	0. 338905	0		0 col. 2, line 3	. 00	2. 00
3.00	Speech Pathology	68. 00	0. 401927	0		Ocol. 2, line 4	. 00	3. 00
4.00	Cost of Medical Supplies	71. 00	0. 320632	0		0 col. 2, line 1	5. 00	4. 00
4.01	Cost of Medical Supplies 1	71. 01	0. 042570	0		0 col. 2, line 1	5. 01	4. 01
5.00	Cost of Drugs	73. 00	0. 173988	0		0 col. 2, line 1	6. 00	5. 00

	Financial Systems KING'S DAUGHTERS' ATION OF HHA REIMBURSEMENT SETTLEMENT	Provi der CC	CN: 15-0069	Peri od:	u of Form CMS-2 Worksheet H-4	2552-10
CALCOLI	ATTON OF THE RETWIDORSEMENT SETTLEMENT	Trovider co				
		HHA CCN:	15-7141	From 01/01/2020 To 12/31/2020	Part I-II	
					5/24/2021 11:0	
		Title	XVIII	Home Health Agency I	PPS	
					t B	
			Part A	Not Subject to Deductibles &		
				Coi nsurance	Coi nsurance	
			1.00	2. 00	3. 00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTO Reasonable Cost of Part A & Part B Services	MARY CHARGES	S			1
	Reasonable cost of services (see instructions)			0 0	0	1.00
	Total charges			0 0	0	2. 00
	Customary Charges			ol ol	0	2 00
3. 00	Amount actually collected from patients liable for payment for on a charge basis (from your records)	services		0	ا	3. 00
4.00	Amount that would have been realized from patients liable for			0 0	0	4. 00
	for services on a charge basis had such payment been made in a	iccordance				
	with 42 CFR §413.13(b) Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 0000	0. 000000	0. 000000	5. 00
	Total customary charges (see instructions)		0.0000	0 0	0	6. 00
7. 00	Excess of total customary charges over total reasonable cost (	complete		0 0	0	7. 00
8. 00	only if line 6 exceeds line 1) Excess of reasonable cost over customary charges (complete onl	vifline		0	0	8.00
0.00	1 exceeds line 6)	y 11 1111C			,	0.00
9. 00	Primary payer amounts			0 0	0	9. 00
				Part A Servi ces	Part B Servi ces	
				1.00	2. 00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
1	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers			0	0 718, 837	
	Total PPS Reimbursement - Full Episodes without outliers			o o	10, 611	
1	Total PPS Reimbursement - LUPA Episodes			0	17, 018	
14.00	Total PPS Reimbursement - PEP Episodes			0	765	
15. 00 16. 00	Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes			0	2, 177 0	1
	Total Other Payments			Ö	0	
1	DME Payments			0	0	
	Oxygen Payments Prosthetic and Orthotic Payments			0	0	19. 00 20. 00
	Part B deductibles billed to Medicare patients (exclude coinsu	ırance)			0	
	Subtotal (sum of lines 10 thru 20 minus line 21)	,		0	749, 408	
1	Excess reasonable cost (from line 8)			0	7.40, 400	23. 00
1	Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records)			0	749, 408 0	24. 00 25. 00
1	Net cost (line 24 minus line 25)			0	749, 408	
	Reimbursable bad debts (from your records)					27. 00
1	Reimbursable bad debts for dual eligible beneficiaries (see in				740 400	28. 00
	Total costs - current cost reporting period (line 26 plus line ZERO OUT SETTLEMENT	: 27)		0	749, 408 -1	29. 00 30. 00
	Pioneer ACO demonstration payment adjustment (see instructions	5)		0	0	30. 50
1	Demonstration payment adjustment amount before sequestration			0	0	
1	Subtotal (see instructions) Sequestration adjustment (see instructions)			0	749, 407	
1	Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration			0	4, 815 0	
	Interim payments (see instructions)			Ö	744, 592	
32. 00				ا ما		33.00
33. 00	Tentative settlement (for contractor use only)			0	0	
33. 00 34. 00	Tentative settlement (for contractor use only) Balance due provider/program (line 31 minus lines 31.01, 32, a Protested amounts (nonallowable cost report items) in accordance.		Dub 15 2	0	0	34. 00

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

Peri od: From 01/01/2020 To 12/31/2020 Date/Ti me Prepared: 5/24/2021 11:00 am Provider CCN: 15-0069 TO PROGRAM BENEFICIARIES HHA CCN: 15-7141

				Home Health Agency I	PPS	
		I npati en	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	744, 592 0	1. 00 2. 00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider					3. 00
3. 01				0	0	3. 01
3.02				0	0	3. 02
3.03				0	0	3. 03
3.04				0	0	3. 04
3.05				0	0	3. 05
	Provider to Program	T		al		
3.50				0	0 0	3. 50
3. 51 3. 52				0		3. 51 3. 52
3. 52				0		3. 52
3. 54				0		3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			Ö	0	3. 99
0. , ,	3. 50-3. 98)					0. ,,
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0	744, 592	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
E 01	Program to Provider				0	F 01
5. 01 5. 02				0	0	5. 01 5. 02
5. 02				0		5. 02
0.00	Provider to Program			<u> </u>		0.00
5.50	- contract of the gram			0	0	5. 50
5. 51				o	0	5. 51
5.52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER			o	o	6. 01
6. 02	SETTLEMENT TO PROGRAM			Ö	o o	6. 02
7. 00	Total Medicare program liability (see instructions)			O	744, 592	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
	In the second second	(	)	1. 00	2. 00	
8. 00	Name of Contractor	I			I I	8. 00

Provi der CCN: 15-0069 Peri od: Worksheet 0 From 01/01/2020 To 12/31/2020 Date/Time Prepared: 5/24/2021 11:00 am Hospi ce CCN: 15-1535

						5/24/2021 11:	00 am_
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
		1.00	0.00	1 pl us col . 2)	CATI ONS	F 00	
	CENEDAL CEDALCE COCT CENTEDO	1.00	2. 00	3. 00	4. 00	5. 00	
1 00	GENERAL SERVICE COST CENTERS				٥	0	1 00
1.00	CAP REL COSTS-BLDG & FIXT* CAP REL COSTS-MVBLE EQUIP*		(		0	0	1.00
2.00			(		0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	02 000	4 520	07 220	27 015	115 153	3.00
4.00	ADMINISTRATIVE & GENERAL*	82, 800	4, 538	87, 338	27, 815	115, 153	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	(		0	0	5. 00
6.00	LAUNDRY & LINEN SERVICE*	0	(		U	0	6.00
7.00	HOUSEKEEPI NG*	0	(		0	0	7. 00
8.00	DI ETARY*	0	(		U	0	8. 00
9.00	NURSI NG ADMINI STRATI ON*	0	(	0	0	0	9. 00
10.00	ROUTINE MEDICAL SUPPLIES*	0	(	0	0	0	10.00
11.00	MEDI CAL RECORDS*	0	(	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	209	209	0	209	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	)	0	412	412	13.00
14. 00	PHARMACY*	0	9, 263	9, 263	0	9, 263	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	(	0	0	0	15. 00
16.00	OTHER GENERAL SERVICE*	0	(	)  0	0	0	16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
05.00	DIRECT PATIENT CARE SERVICE COST CENTERS				ام		05 00
25. 00	I NPATI ENT CARE-CONTRACTED**		(		0	0	25. 00
26. 00	PHYSI CI AN SERVI CES**	0	(	0	U	0	26. 00
27. 00	NURSE PRACTITIONER**	0	0.210	0 210	000	0 113	27. 00
28. 00	REGISTERED NURSE**	0	8, 310	8, 310	803	9, 113	28. 00
29. 00	LPN/LVN**	0	4 754	0	0 540	0	29. 00
30.00	PHYSI CAL THERAPY**	0	1, 751	1, 751	2, 540	4, 291	30.00
31.00	OCCUPATIONAL THERAPY**	0	(		339	339	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0.04=	0	7 224	0	32.00
33. 00	MEDICAL SOCIAL SERVICES**	0	2, 047	2, 047	7, 394	9, 441	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	COUNSELING - OTHER**	0	2 0 1	0	1 1 1 2 2	0	36.00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	3, 865		16, 133	19, 998	37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	42, 550	42, 550	0	42, 550	38. 00
39. 00	PATIENT TRANSPORTATION**	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	0	41.00
42. 00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	120	120	0	120	42.00
42. 50	DRUGS CHARGED TO PATI ENTS**	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
(0.00	NONREI MBURSABLE COST CENTERS				ام	0	(0.00
60.00	BEREAVEMENT PROGRAM *	0	(	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	(	0	0	0	61.00
62.00	FUNDRAL SI NG*	0	(	0	0	0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	(	0	0	0	63.00
	PALLIATIVE CARE PROGRAM*	0	(	0	0	0	64.00
65. 00	OTHER PHYSI CI AN SERVI CES*	0	(		0	0	65.00
66.00	RESI DENTI AL CARE*	0	(		0	0	66.00
67. 00	ADVERTI SI NG*	0	(		0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG*	0	(	j o	0	0	68. 00
69. 00	THRIFT STORE*	0	(		0	0	69.00
	NURSING FACILITY ROOM & BOARD*	0	(	j o	0	0	70.00
	OTHER NONREIMBURSABLE (SPECIFY)*	02 020	70 (5	1 1 1 1 1 1	0 EE 434	210,000	71.00
100.00	TOTAL	82, 800	72, 653	155, 453	55, 436	210, 889	100.00

<sup>\*</sup> 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.

ADJUSTMENTS   DIAL Cost   Second   Cost   Centers				·		5/24/2021 11	:00 am_
STINERAL SERVICE COST CENTERS   6.00   7.00					Hospi ce I		
CAP REL COSTS -BLOC & FIXT"			ADJUSTMENTS	,			
GENERAL SERVICE COST CENTERS							
1.00   CAP REL COSTS-RINGE & FLAT"   0   0   0   2.00   0   2.00   0   2.00   0   2.00   0   2.00   0   2.00   0   2.00   0   3.00   4.00   3.00   3.00   4.00   3.00   3.00   4.00   3.00   3.00   4.00   3.00   3.00   4.00   3.00		CENEDAL CEDALOE COCT CENTEDO	6.00	7.00			
2.00   CAP REL COSTS-MAYBLE EQUIP"   0   0   0   3.00	1 00		1 0				1 00
ADDITION   CONTROL BENEFITS DEPARTMENT*   0   0   15,153   4,00   ADM INSTRATIVE & GENERAL*   0   15,153   4,00   ADM INSTRATIVE & GENERAL*   0   0   0   6,00   CALDON & LINENS EXPRICE*   0   0   0   0   6,00   CALDON & LINENS EXPRICE*   0   0   0   0   0   6,00   CALDON & LINENS EXPRICE*   0   0   0   0   0   0   0   0   0		l control of the cont	-				•
A.00   ADMIN STRATIVE & CENERAL*   0   115, 153   4.00   5.00   ADMIN STRATIVE & CENERAL*   0   0   5.00   6.00   6.00   7.00   00   6.00   7.00   00   6.00   7.00   00   6.00   7.00   00   6.00   7.00   00   6.00   7.00   00   6.00   7.00   00   6.00   7.00   00   6.00   7.00   00   6.00   7.00   00   6.00   7.00   00   7.00   00   7.00   00				1			•
DIANT OPERATION & MAINTENANCE*   0				1			
AUMDRY & LINEN SERVICE*		l control of the cont		113, 133			
MOUSEKEEPING*							•
B. 00   DETARY*   0   0   0   9.00   0   0   0   0   0   0   0   0   0							•
9.00   0.00   0.00   0.00   0.00   0.00   11.00   10.00   11.0							
11.00   MEDI CAL RECORDS*   0 0   11.00   12.00   13.00   13.00   13.00   13.00   13.00   14.00   13.00   14							
11.00   MEDI CAL RECORDS*   0 0   11.00   12.00   13.00   13.00   13.00   13.00   13.00   14.00   13.00   14							
13.00   VOLUNTEER SERVICE COORDINATION*   0   412   13.00     14.00   PHASICIAN ADMINISTRATIVE SERVICES*   0   0   0   15.00     15.00   PHASICIAN ADMINISTRATIVE SERVICES*   0   0   0   15.00     16.00   OTHER GENERAL SERVICES*   0   0   0   16.00     17.00   DIRECT PATIENT CARE SERVICES   0   0   0     25.00   DIRATIENT CARE-CONTRACTED**   0   0   2.50     27.00   NURSE PRACTI II ONER**   0   0   0   2.50     28.00   ROST CARE SERVICES*   0   0   0   2.50     29.00   NURSE PRACTI II ONER**   0   0   0   2.50     29.00   LPATLVIN**   0   0   0   3.30     31.00   OCCUPATI ONAL THERAPY**   0   3.39   3.10     32.00   SPECHL'AURGUAGE PATHOLOGY**   0   0   3.30     33.00   MEDI CAL SOCIAL SERVICES**   0   9.441   33.00     34.00   SPIT II TUAL COUNSELI ING**   0   0   0   3.50     35.00   DIETARY COUNSELI ING**   0   0   0   3.50     36.00   DIABLE LING**   0   0   0   3.50     37.00   HOSPICE ALDE & HOMEMARER SERVICES**   0   19.998   37.00     38.00   DIABLE LING*   0   0   0   0   0     39.00   PATIENT TRANSPORTATION**   0   0   0   0     40.00   MIGNISEL WIGH SERVICES**   0   0   0   0   0     40.00   PATIENT TRANSPORTATION**   0   0   0   0     40.00   DIABLE LINGT SERVICES**   0   0   0   0     40.00   PATHENT TRANSPORTATION**   0   0   0   0     40.00   PATHENT TRANSPORTATION**   0   0   0   0     40.00   PATHENT TRANSPORTATION**   0   0	11. 00	MEDI CAL RECORDS*	C	ol ol			11. 00
14.00   PHARMACY*   0   9,263   14.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   17.0	12.00	STAFF TRANSPORTATION*	C	209			12. 00
15.00   PhYSICIAN ADMINISTRATIVE SERVICES*   0   0   16.00   16.00   17.00	13.00	VOLUNTEER SERVICE COORDINATION*	C	412			13. 00
16. 00   OTHER GENERAL SERVICES	14.00	PHARMACY*	C	9, 263			14. 00
17. 00   PATI ENT / RES DENTI AL CARE SERVI CES	15. 00	PHYSICIAN ADMINISTRATIVE SERVICES*	C	0			15. 00
DIRECT PATIENT CARE SERVICE COST CENTERS	16. 00	OTHER GENERAL SERVICE*	C	0			16. 00
25. 00   INPATIENT CARE-CONTRACTED**   0 0 0   26. 00	17. 00						17. 00
26. 00							
27. 00   NURSE PRACTITIONER*   0 0 0   9,113   28. 00     29. 00   LPN/LVM**   0 0 0   9,113   28. 00     29. 00   LPN/LVM**   0 0 0   4, 291   30. 00     29. 00   PHYSI CAL THERAPY**   0 0 4, 291   30. 00     29. 00   SPECH/LANGUAGE PATHOLOGY**   0 0 0   339   31. 00     20. 00   SPECH/LANGUAGE PATHOLOGY**   0 0 0   32. 00     30. 00   MIDICAL SOCIAL SERVICES**   0 9, 441   33. 00     30. 00   MIDICAL SOCIAL SERVICES**   0 9, 441   33. 00     30. 00   SPIRI TUAL COUNSELING**   0 0 0   35. 00     30. 00   COUNSELING * 0 10   0   35. 00     30. 00   COUNSELING * 0 11   0   0   0   0     30. 00   OUNSELING * 0 11   0   0   0     30. 00   OUNSELING * 0 11   0   0   0     30. 00   OUNSELING * 0 0   0   0     40. 00   OUNSELING * 0 0   0   0			1	1			•
28.00   REGISTERE NURSE**   0   9,113   28.00   29.0			C	0			•
29. 00   PHYLVIN*			C	0			
30.00   OR-YSI CAL THERAPY**   0   4,291   30.00   31.00   OCCUPATI ONAL THERAPY**   0   33.9   31.00   32.00   OCCUPATI ONAL THERAPY**   0   0   0   32.00   32.00   SPECCH/LANGUAGE PATHOLOGY**   0   0   0   32.00   32.00   MEDI CAL SCCI AL SERVI CES**   0   9,441   33.00   34.00   SPIE TI TUAL COUNSELI NG**   0   0   0   35.00   0   0   35.00   0   0   0   35.00   0   0   0   35.00   0   0   0   0   35.00   0   0   0   0   0   0   0   0   0				9, 113			
31.00   OCCUPATI ONAL THERAPY**   0   339   31.00		I control of the cont		1 201			•
32.00   SPECHLANGUAGE PATHOLOGY**   0 0 0   32.00     MEDI CAL SOCI AL SERVI CES**   0 9, 441   33.00     33.00   SPIRITUAL 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 19, 998   37.00     38.00   DURABLE MEDI CAL EQUI PMENT/OXYGEN**   0 42,550   38.00     39.00   PATI LENT TRANSPORTATI ION**   0 0   39.00     40.00   IMAGI NG SERVI CES**   0 0 0   39.00     41.00   LABS & DI AGNOSTI CS**   0 0 0   42.00     42.00   MEDI CAL SUPPLI ES-NON-ROUTI NE**   0 0 0   42.00     42.50   DRUGS CHARGED TO PATI ENTS**   0 0 0   42.00     43.00   OUTPATI ENT SERVI CES**   0 0 0   43.00     44.00   PALLI ATI VE CHEMOTHERAPY**   0 0 0   44.00     45.00   PALLI ATI VE CHEMOTHERAPY**   0 0 0   46.00     MONREI MBURSABLE COST CENTERS   0 0 0   66.00     61.00   VOLUNTEER PROGRAM *   0 0 0   66.00     63.00   HOSPI CEPALLI ATI VE MEDI CI NE FELLOWS*   0 0 0   66.00     64.00   OTHER PATI ENT CARE SERVI CES*   0 0 0   66.00     65.00   OTHER PATIS IN G*   0 0   66.00     66.00   RESI DENTI AL CARE*   0 0 0   66.00     67.00   OTHER PHYSI CI AN SERVI CES*   0 0 0   66.00     67.00   OTHER PHYSI CI AN SERVI CES*   0 0 0   66.00     67.00   OTHER PHYSI CI AN SERVI CES*   0 0 0   66.00     67.00   OTHER PHYSI CI AN SERVI CES*   0 0 0   66.00     67.00   OTHER NONREI MBURSABLE (SPECI FY)*   0 0 0     67.00   OTHER NONREI MBURSABLE (SPECI FY)*   0 0 0     67.00   OTHER NONREI MBURSABLE (SPECI FY)*   0 0 0     0 0 THER FORDRAM * 0 0 0 0 0     0 0 THER FORDRAM * 0 0 0 0 0 0     0 0 THER FORDRAM * 0 0 0 0 0 0 0     0 0 THER FORDRAM * 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1				
33.00   MEDICAL SOCIAL SERVICES**   0   9,441   33.00     34.00   SPIRITUAL COUNSELING**   0   0   0     35.00   ODETARY COUNSELING**   0   0   0     36.00   OCUNSELING - OTHER**   0   0   0     37.00   HOSPICE AIDE & HOMEMAKER SERVICES**   0   19,998   37.00     38.00   DURABLE MEDICAL EQUIPMENT/OXYGEN**   0   42,550   38.00     39.00   PATIENT TRANSPORTATION**   0   0   0     41.00   LABS & DIAGNOSTICS**   0   0   0     42.00   MEDICAL SUPPLIES-NON-ROUTINE**   0   120   42.00     42.50   OUTPATIENT SERVICES**   0   0   0     43.00   OUTPATIENT SERVICES**   0   0   0     44.00   PALLIATIVE RADIATION THERAPY**   0   0   0     45.00   PALLIATIVE CHEMOTHERAPY**   0   0   0     46.00   OTHER PATIENT CARE SERVICES (SPECIFY)**   0   0     46.00   OTHER PATIENT CARE SERVICES (SPECIFY)**   0   0     46.00   OTHER PATIENT CARE SERVICES*   0   0   0     46.00   PALLIATIVE CARE PROGRAM   0   0   0     46.00   OTHER PATIENT CARE SERVICES (SPECIFY)**   0   0     46.00   PALLIATIVE CARE PROGRAM   0   0   0     46.00   OTHER PATIENT CARE SERVICES (SPECIFY)**   0   0     46.00   OTHER PATIENT CARE SERVICES (SPECIFY)*   0   0     46.00   OTHER NONREINIUM SABALE (SPECIFY)*   0   0     46.00   OTHER NONREINIUM SABALE (SPECIFY)*   0   0     46.00   OTHER NONREINIUM SABALE (SPECIFY)*   0   0     46.00   OTHER NONREINIUM SABAL			-	1			•
34. 00   SPIRITUAL COUNSELING**							
35. 00 DI ETARY COUNSELING** 0 0 0 36. 00 COUNSELING* OTHER** 0 0 0 0 0 36. 00 COUNSELING - OTHER** 0 0 0 0 0 36. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES** 0 19.998 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN** 0 42.550 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN** 0 0 0 0 39. 00 40. 00 1 MAGGI NG SERVI CES** 0 0 0 0 42.550 39. 00 41. 00 LABS & DI AGNOSTI CS** 0 0 0 0 40. 00 1 MAGGI NG SERVI CS** 0 0 0 0 40. 00 41. 00 LABS & DI AGNOSTI CS** 0 0 0 0 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE** 0 120 42. 00 DRUGS CHARGED TO PATI ENTS** 0 0 0 0 42. 50 DRUGS CHARGED TO PATI ENTS** 0 0 0 0 42. 50 43. 00 0UTPATI ENT SERVI CES** 0 0 0 0 44. 00 PALLI ATI VE RADI ATI ON THERAPY** 0 0 0 0 44. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 44. 00 THER PATI ENT CARE SERVI CES (SPECI FY) ** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				1			
36. 00 COUNSELING - OTHER** 0 0 0 37. 00 HOSPICE AIDE & HOMEMAKER SERVICES** 0 19, 998 37. 00 37. 00 HOSPICE AIDE & HOMEMAKER SERVICES** 0 42, 550 38. 00 39. 00 PATIENT TRANSPORTATION** 0 42, 550 39. 00 40. 00 IMAGING SERVICES** 0 0 0 0 41. 00 41. 00 LABS & DIAGNOSTICS** 0 0 0 0 41. 00 42. 00 MEDICAL SUPPLIES-NON-ROUTINE** 0 120 42. 50 42. 50 DRUGS CHARGED TO PATIENTS** 0 0 0 0 42. 50 43. 00 UTPATIENT SERVICES** 0 0 0 0 43. 00 44. 00 PALLIATIVE RADIATION THERAPY** 0 0 0 0 44. 00 45. 00 PALLIATIVE RADIATION THERAPY** 0 0 0 0 0 44. 00 46. 00 PALLIATIVE CHEMOTHERAPY** 0 0 0 0 0 0 45. 00 46. 00 PALLIATIVE CHEMOTHERAPY** 0 0 0 0 0 0 66. 00 67. 00 BEREAVEMENT PROGRAM * 0 0 0 0 67. 00 68. 00 HOSPICE/PALLIATIVE MEDICINE FELLOWS* 0 0 0 0 66. 00 67. 00 OTHER PATIENT CARE SERVICES* 0 0 0 0 66. 00 67. 00 OTHER PHYSICIAN SERVICES* 0 0 0 0 66. 00 68. 00 THER PHYSICIAN SERVICES* 0 0 0 0 66. 00 69. 00 THER PHYSICIAN SERVICES* 0 0 0 0 66. 00 69. 00 THER FORGRAM * 0 0 0 0 66. 00 69. 00 THER FORGRAM * 0 0 0 0 66. 00 69. 00 THER FINSING* 0 0 0 0 66. 00 69. 00 THER FINSING* 0 0 0 0 66. 00 69. 00 THER FINSING* 0 0 0 0 66. 00 69. 00 THER FORGRAM * 0 0 0 0 66. 00 69. 00 THER FORGRAM * 0 0 0 0 66. 00 69. 00 THER FINSING* 0 0 0 0 0 66. 00 69. 00 THER FORGRAM * 0 0 0 0 0 0 66. 00 69. 00 THER FORGRAM * 0 0 0 0 0 0 66. 00 69. 00 THER FORGRAM * 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		l control of the cont					
37. 00 HOSPICE AIDE & HOMEMAKER SERVICES** 0 19,998 38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN** 0 42,550 38. 00 40. 00 IMAGI NG SERVICES** 0 0 0 41. 00 IMAGI NG SERVICES** 0 0 0 41. 00 LABS & DI AGNOSTICS** 0 120 42. 00 42. 50 MEDICAL SUPPLIES-NON-ROUTINE** 0 120 42. 00 42. 50 DRUGS CHARGED TO PATIENTS** 0 0 0 0 42. 50 43. 00 OUTPATIENT SERVICES** 0 0 0 0 44. 00 44. 00 PALLI ATIVE RADIATION THERAPY** 0 0 0 0 44. 00 45. 00 PALLI ATIVE RADIATION THERAPY** 0 0 0 0 0 44. 00 46. 00 PALLI ATIVE CHEMOTHERAPY** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		l control of the cont					
38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN** 0 42,550 39. 00 PATIENT TRANSPORTATION** 0 0 0 39. 00 40. 00 41. 00 42. 00 41. 00 42. 00 41. 00 485 & DI AGNOSTICS** 0 0 0 0 41. 00 41. 00 42. 00 MEDICAL SUPPLIES-NON-ROUTINE** 0 120 42. 00 MEDICAL SUPPLIES-NON-ROUTINE** 0 120 42. 50 DRUGS CHARGED TO PATIENTS** 0 0 0 0 43. 00 0UTPATIENT SERVICES** 0 0 0 0 43. 00 0UTPATIENT SERVICES** 0 0 0 0 44. 00 PALLIATIVE RADIATION THERAPY** 0 0 0 0 45. 00 0 46. 00 OTHER PATIENT CARE SERVICES (SPECIFY)** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				19, 998			
39. 00 PATIENT TRANSPORTATION** 0 0 0 40. 00 40. 00 40. 00 1 MAGI NG SERVI CES** 0 0 0 0 40. 00 41. 00 42. 00 MEDI CAL SUPPLIES-NON-ROUTI NE** 0 120 42. 00 MEDI CAL SUPPLIES-NON-ROUTI NE** 0 120 42. 50 DRUGS CHARGED TO PATIENTS** 0 0 0 42. 50 DRUGS CHARGED TO PATIENTS** 0 0 0 44. 00 PALLI ATI VE RADI ATI ON THERAPY** 0 0 0 0 44. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 44. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 46. 00 OTHER PATIENT CARE SERVI CES (SPECI FY) ** 0 0 0 0 46. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							•
41. 00	39.00		l c				39. 00
42. 00 42. 00 42. 50 DRUGS CHARGED TO PATIENTS** 0 0 0 0 0 0 UTPATIENT SERVI CES** 0 0 0 0 43. 00 44. 00 PALLIATIVE RADIATION THERAPY** 0 0 0 45. 00 PALLIATIVE CHEMOTHERAPY** 0 0 0 46. 00 OTHER PATIENT CARE SERVICES (SPECIFY)** NONNEI MBURSABLE COST CENTERS  60. 00 FUNDRAI SI NG* 0 0 0 61. 00 FUNDRAI SI NG* 0 0 0 63. 00 64. 00 PALLIATIVE CARE PROGRAM * 0 0 0 65. 00 CARES DENTIAL CARE PROGRAM* 0 0 0 CARES DENTIAL CARE CARES* 0 0 0 CARES DENTIAL CARES DENTIAL CARES* 0 0 0 CARES DENTIAL CARES	40.00	I MAGI NG SERVI CES**	C	o			40.00
42. 50 43. 00 0UTPATIENT SERVICES** 0 0 0UTPATIENT SERVICES** 0 0 0 44. 00 44. 00 PALLIATIVE RADIATION THERAPY** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	41.00	LABS & DIAGNOSTICS**	C	o o			41.00
43. 00	42.00	MEDICAL SUPPLIES-NON-ROUTINE**	C	120			42.00
44. 00 PALLI ATI VE RADI ATI ON THERAPY** 0 0 0 0 45. 00 45. 00 OTHER PATIENT CARE SERVICES (SPECIFY)** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	42. 50	DRUGS CHARGED TO PATI ENTS**	C	0			42. 50
45. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 46. 00  TO STREET PATI ENT CARE SERVI CES (SPECI FY) ** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			C	0			
46. 00 OTHER PATIENT CARE SERVICES (SPECIFY)** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			C				•
NONREIMBURSABLE COST CENTERS			1				•
60. 00 BEREAVEMENT PROGRAM * 0 0 0 0 61. 00 61. 00 62. 00 FUNDRAI SI NG* 0 0 0 62. 00 FUNDRAI SI NG* 0 0 0 63. 00 64. 00 9ALLI ATI VE MEDI CI NE FELLOWS* 0 0 0 64. 00 65. 00 OTHER PHYSI CI AN SERVI CES* 0 0 0 0 66. 00 66. 00 67. 00 ADVERTI SI NG* 0 0 0 66. 00 67. 00 ADVERTI SI NG* 0 0 0 67. 00 68. 00 67. 00 THEI FT STORE* 0 0 0 0 68. 00 69. 00 NURSI NG FACI LI TY ROOM & BOARD* 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	46. 00	,	C	0			46. 00
61. 00							
62. 00 FUNDRAI SI NG* 0 0 0 63. 00 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS* 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1	1			
63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS* 0 0 0 64. 00 65. 00 PALLI ATI VE CARE PROGRAM* 0 0 0 0 66. 00 65. 00 0 66. 00 0 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 67. 00 68. 00 THER PHYSI CI AN SERVI CES* 0 0 0 66. 00 66. 00 67. 00 68. 00 THER FITS TORE* 0 0 0 69. 00 69. 00 69. 00 69. 00 69. 00 70. 00 NURSI NG FACI LITY ROOM & BOARD* 0 0 71. 00 OTHER NONREI MBURSABLE (SPECI FY)* 0 0 0 71. 00			1	1			
64. 00 PALLI ATI VE CARE PROGRAM*  0 0 0 0 65. 00  65. 00 OTHER PHYSI CI AN SERVI CES*  0 0 0 0 66. 00  66. 00 RESI DENTI AL CARE*  0 0 0 0 66. 00  67. 00 ADVERTI SI NG*  0 0 0 67. 00  68. 00 THRI FT STORE*  0 0 0 0 68. 00  70. 00 NURSI NG FACI LI TY ROOM & BOARD*  71. 00 OTHER NONREI MBURSABLE (SPECI FY)*  0 0 0 64. 00  66. 00  67. 00  68. 00  71. 00  71. 00  71. 00			1	1			
65. 00 OTHER PHYSI CI AN SERVI CES* 0 0 0 66. 00 66. 00 66. 00 67. 00 0 0 66. 00 67. 00 0 67. 00 68. 00 1 67. 00 68. 00 1 68. 00			-	1			
66. 00 RESI DENTI AL CARE* 0 0 0 67. 00 67. 00 ADVERTI SI NG* 0 0 0 68. 00 TELEHEALTH/TELEMONI TORI NG* 0 0 0 68. 00 THRI FT STORE* 0 0 0 0 69. 00 70. 00 NURSI NG FACILITY ROOM & BOARD* 0 0 0 THER NONREI MBURSABLE (SPECI FY)* 0 0 0 0 71. 00 THER NONREI MBURSABLE (SPECI FY)*			1	1			
67. 00   ADVERTI SI NG*   0 0 0   68. 00   68. 00   69. 00   0 0   68. 00   69. 00   0 0   68. 00   69. 00   0 0   69. 00   69. 00   0   0 0   0 0   0 0   0 0   0 0   0 0   0 0   0 0   0 0   0 0   0   0 0   0 0   0 0   0 0   0 0   0 0   0 0   0 0   0 0   0 0   0   0 0   0 0   0 0   0 0   0 0   0 0   0 0   0 0   0 0   0 0   0   0 0   0 0   0 0   0 0   0 0   0 0   0 0   0 0   0 0   0 0   0   0 0   0 0   0 0   0 0   0 0   0 0   0 0   0 0   0 0   0 0   0			-				
68.00   TELEHEALTH/TELEMONI TORI NG*   0 0 0   68.00   69.00   THRI FT STORE*   0 0 0   70.00   NURSI NG FACILITY ROOM & BOARD*   0 0   71.00   OTHER NONREI MBURSABLE (SPECI FY)*   0 0   71.00   0   0   0   71.00   0   0   0   71.00   0							
69.00 THRI FT STORE* 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
70.00   NURSING FACILITY ROOM & BOARD*   0   0   70.00   71.00   OTHER NONREIMBURSABLE (SPECIFY)*   0   0   0   71.00			1	1			
71.00 OTHER NONREIMBURSABLE (SPECIFY)* 0 0 71.00		l control of the cont	1	1			
				1			
	100.00		C	210, 889	 		

<sup>\*</sup> 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.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

Provider CCN: 15-0069 Hospi ce CCN: 15-1535

To

Peri od: Worksheet 0-2 From 01/01/2020 12/31/2020

Date/Time Prepared:

5/24/2021 11:00 am Hospi ce I SUBTOTAL (col SALARI ES OTHER RECLASSI FI -SUBTOTAL 1 + col . CATI ONS 2) 1.00 2.00 5. 00 3 00 4.00 DIRECT PATIENT CARE SERVICE COST CENTERS 25.00 INPATIENT CARE-CONTRACTED 25.00 PHYSICIAN SERVICES 0 26.00 0 26.00 NURSE PRACTITIONER 27.00 0 27.00 0 0 28.00 REGISTERED NURSE 8, 214 8, 214 793 9,007 28.00 29.00 LPN/LVN 29.00 30.00 PHYSI CAL THERAPY 1,731 2.511 4.242 30.00 1,731 OCCUPATIONAL THERAPY 31.00 C 335 335 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 32.00 33.00 MEDICAL SOCIAL SERVICES 2, 024 2,024 7, 308 9, 332 33.00 SPIRITUAL COUNSELING 34.00 0 0 34.00 35.00 DIETARY COUNSELING 0 0 35.00 36.00 COUNSELING - OTHER 36.00 HOSPICE AIDE & HOMEMAKER SERVICES 3, 821 19, 767 37.00 3.821 15, 946 37.00 DURABLE MEDICAL EQUIPMENT/OXYGEN 38.00 38.00 42, 550 42, 550 0 42, 550 39.00 PATIENT TRANSPORTATION 0 39.00 40.00 I MAGING SERVICES 0 40.00 0 0 41.00 LABS & DIAGNOSTICS 0 C 41.00 0 MEDICAL SUPPLIES-NON-ROUTINE 42.00 119 0 119 42.00 42.50 DRUGS CHARGED TO PATIENTS 0 42.50 OUTPATIENT SERVICES 0 0 43.00 0 0 43.00 PALLIATIVE RADIATION THERAPY 44.00 C 0 0 44.00 45.00 PALLIATIVE CHEMOTHERAPY C 0 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 46.00 100.00 TOTAL \* 58, 459 26, 893 85, 352 100. 00 58. 459

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

	AD ILICTMENTS	TOTAL (agl E	
	ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
	6, 00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS	0.00	7.00	
25. 00 INPATIENT CARE-CONTRACTED			25. 00
26. 00 PHYSI CLAN SERVI CES	0		26. 00
27. 00 NURSE PRACTITIONER	0		27. 00
28. 00 REGISTERED NURSE	0	9, 007	28. 00
29. 00 LPN/LVN	0	7,007	29.00
30. 00 PHYSI CAL THERAPY	0	4, 242	30.00
31. 00 OCCUPATIONAL THERAPY	0	335	31. 00
32. 00 SPEECH/LANGUAGE PATHOLOGY	0	0	32. 00
33. 00 MEDICAL SOCIAL SERVICES	0	9, 332	33. 00
34. 00 SPIRITUAL COUNSELING	0	7, 552	34.00
35. 00 DI ETARY COUNSELING	0		35. 00
36. 00 COUNSELING - OTHER	0		36. 00
37. 00 HOSPICE AIDE & HOMEMAKER SERVICES	0	19, 767	37. 00
38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	42, 550	38. 00
39. 00 PATIENT TRANSPORTATION	0	1 42, 330	39.00
40. 00 I MAGI NG SERVI CES	0		40. 00
41. 00 LABS & DIAGNOSTICS	0		41. 00
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	119	42. 00
42. 50 DRUGS CHARGED TO PATIENTS	0	1	42. 50
43. 00 OUTPATIENT SERVICES	0		43. 00
44. 00 PALLIATIVE RADIATION THERAPY			44. 00
45. 00 PALLI ATI VE CHEMOTHERAPY			45. 00
46. 00 OTHER PATIENT CARE SERVICES (SPECIFY)			46. 00
100. 00 TOTAL *	0	85, 352	100.00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

RESPITE CARE

Peri od: From 01/01/2020 To 12/31/2020 Date/Time Prepared: 5/24/2021 11:00 am Hospi ce CCN: 15-1535

					Hospi ce i		
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
				1 + col . 2)	CATI ONS		
		1.00	2.00	3. 00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT 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	18	18	2	20	28. 00
29. 00	LPN/LVN	0	0	0	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	4	4	5	9	30. 00
31.00	OCCUPATI ONAL THERAPY	0	0	0	1	1	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32. 00
33.00	MEDICAL SOCIAL SERVICES	0	4	4	16	20	33. 00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DI ETARY COUNSELING	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	8	8	35	43	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38. 00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39. 00
40.00	I MAGING SERVICES	0	0	0	0	0	40. 00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
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	0	44. 00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	o	0	0	0	0	46. 00
100.00	TOTAL *	0	34	34	59	93	100. 00
* Tron	efor the amount in column 7 to Wkst O.E. colu	ımp 1 lino E2					

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5	
		ADJUSTINIENTS	± col. 6)	
		6, 00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS	0.00	7.00	
25. 00	INPATIENT CARE-CONTRACTED	0	0	25. 00
26.00	PHYSI CI AN SERVI CES	0	ol	26. 00
27.00	NURSE PRACTITIONER	0	ol	27. 00
28.00	REGI STERED NURSE	0	20	28. 00
29.00	LPN/LVN	0	o	29. 00
30.00	PHYSI CAL THERAPY	0	9	30.00
31.00	OCCUPATI ONAL THERAPY	0	1	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	o	32. 00
33.00	MEDICAL SOCIAL SERVICES	0	20	33. 00
34.00	SPIRITUAL COUNSELING	0	o	34. 00
35.00	DI ETARY COUNSELING	0	o	35. 00
36.00	COUNSELING - OTHER	0	o	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	43	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	o	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	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
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	O	46. 00
100.00	TOTAL *	0	93	100. 00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

INPATIENT CARE

Hospi ce CCN: 15-1535

Peri od: Worksheet 0-4 From 01/01/2020 To 12/31/2020

Date/Time Prepared: 5/24/2021 11:00 am

					0, 2 1, 2021 111	00 4
				Hospi ce I		
	SALARIES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
			1 + col . 2)	CATI ONS		
	1.00	2. 00	3. 00	4. 00	5. 00	
DIRECT PATIENT CARE SERVICE COST C	ENTERS					
25. 00 INPATIENT 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	78	78	8	86	28. 00
29. 00 LPN/LVN	0	0	0	0	0	29. 00
30. 00 PHYSI CAL THERAPY	0	16	16	24	40	30. 00
31. 00 OCCUPATIONAL THERAPY	0	0	0	3	3	31. 00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32. 00
33.00 MEDICAL SOCIAL SERVICES	0	19	19	70	89	33. 00
34. 00 SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35. 00 DIETARY COUNSELING	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	36	36	152	188	37. 00
38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38. 00
39.00 PATIENT TRANSPORTATION	0	0	0	0	0	39. 00
40.00 IMAGING SERVICES	0	0	0	0	0	40. 00
41.00 LABS & DIAGNOSTICS	0	0	0	0	0	41. 00
42.00 MEDICAL SUPPLIES-NON-ROUTINE	0	1	1	0	1	42. 00
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	0	44.00
45.00 PALLIATIVE CHEMOTHERAPY	O	0	0	0	0	45.00
46.00 OTHER PATIENT CARE SERVICES (SPECI	FY) 0	o	0	o	0	46. 00
100. 00 TOTAL *	0	150	150	257	407	100.00
* Transfer the amount in religion 7 to What	0.51 1 1: 52					

<sup>\*</sup> 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	86	28. 00
29.00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	40	30.00
31.00	OCCUPATIONAL THERAPY	0	3	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32. 00
33.00	MEDICAL SOCIAL SERVICES	0	89	33. 00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DI ETARY COUNSELING	0	0	35. 00
36.00	COUNSELING - OTHER	0	0	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	188	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 & DIAGNOSTICS	0	0	41. 00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	1	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	407	100. 00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

	Financial Systems KING'S DAUGHTERS'				eu of Form CMS-2	
	ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provider Co		Period: From 01/01/2020	Worksheet 0-5	
EXPENS	SES FOR ALLOCATION	Hospi ce CCI		To 12/31/2020	Date/Time Pre 5/24/2021 11:	
				Hospi ce I		
	Descriptions		HOSPICE DIREC		TOTAL EXPENSES	
			EXPENSES (see		(sum of cols.	
			instructions)	EXPENSES FROM	1 + 2)	
				WKST B PART I		
				(see		
			1.00	instructions) 2.00	3. 00	
	GENERAL SERVICE COST CENTERS		1.00	2.00	3.00	
1.00	CAP REL COSTS-BLDG & FLXT			0 1, 466	1, 466	1.00
2.00	CAP REL COSTS-MVBLE EQUIP			0 0	0	2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT			0 30, 856	30, 856	•
4. 00	ADMINISTRATIVE & GENERAL		115, 15		161, 056	
5.00	PLANT OPERATION & MAINTENANCE			0 13, 755	13, 755	
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	0	9. 00
10.00	ROUTINE MEDICAL SUPPLIES			0 5	5	10.00
11. 00	MEDI CAL RECORDS			0	0	11. 00
12.00	STAFF TRANSPORTATION		20		209	12. 00
13.00	VOLUNTEER SERVICE COORDINATION		41		412	1
14. 00	PHARMACY		9, 26		., =	•
15. 00				0	0	15. 00
16. 00	OTHER GENERAL SERVI CE			0	0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES			0	0	17. 00
FO 00	LEVEL OF CARE		<u> </u>	ol		
50. 00 51. 00	HOSPICE CONTINUOUS HOME CARE HOSPICE ROUTINE HOME CARE		85, 35	0	0 85, 352	
51.00	HOSPICE INPATIENT RESPITE CARE		9 85, 35		93	51. 00 52. 00
53. 00			40		407	1
55.00	NONREI MBURSABLE COST CENTERS		1 40	/	407	33.00
60.00	BEREAVEMENT PROGRAM			o	0	60.00
61. 00	VOLUNTEER PROGRAM			0	0	61. 00
62. 00	FUNDRAI SI NG			ō	ĺ	62. 00
63. 00	HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS			O	Ö	63.00
64. 00	PALLIATIVE CARE PROGRAM			o	0	64. 00
65.00	OTHER PHYSI CI AN SERVI CES			o	0	65. 00
66.00	RESI DENTI AL CARE			o	0	66. 00
67.00	ADVERTI SI NG			o	0	67. 00
68 00	TELEBEALTH/TELEMONI TODI NO		I	0	۸ ا	60 00

91, 985

210, 889

68. 00

0 69.00 0 70.00

0 71.00 0 99.00

302, 874 100. 00

68. 00 | TELEHEALTH/TELEMONI TORI NG

100. 00 TOTAL

69.00 THELEHEALTH TELEMONTTORING
69.00 THRIFT STORE
70.00 NURSING FACILITY ROOM & BOARD
71.00 OTHER NONREIMBURSABLE (SPECIFY)
99.00 NEGATIVE COST CENTER

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERA	L SERVICE COSTS	Provider CCN: 15-0069	Peri od:	Worksheet 0-6

From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared: 5/24/2021 11:00 am Hospi ce CCN: 15-1535 Hospi ce I Descriptions TOTAL EXPENSES CAP REL BLDG & CAP REL MVBLE EMPLOYEE SUBTOTAL FIX EQUI P **BENEFITS** DEPARTMENT 1.00 2.00 3. 00 0 ЗА GENERAL SERVICE COST CENTERS
CAP REL COSTS-BLDG & FIXT 1.00 1, 466 1, 466 1.00 2.00 2. 00 CAP REL COSTS-MVBLE EQUIP 0 0 0 0 3.00 EMPLOYEE BENEFITS DEPARTMENT 30, 856 30, 856 3.00 4.00 ADMINISTRATIVE & GENERAL 161, 056 1, 466 20, 563 183, 085 4.00 5.00 PLANT OPERATION & MAINTENANCE 13, 755 13, 755 5. 00

5.00	I LANT OF ENATION & WATNIENANCE	13,733	٠	U	Ч	13, 733	3.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6. 00
7.00	HOUSEKEEPI NG	0	0	0	0	0	7. 00
8.00	DI ETARY	0	0	0	0	0	8. 00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	5	0	0	0	5	10. 00
11. 00	MEDI CAL RECORDS	0	0	0	0	0	11. 00
12.00	STAFF TRANSPORTATION	209	0	0	0	209	12. 00
13.00	VOLUNTEER SERVICE COORDINATION	412	0	0	154	566	13. 00
14.00	PHARMACY	9, 263	0	0	0	9, 263	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15. 00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16. 00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
	HOSPICE ROUTINE HOME CARE	85, 352			10, 022	95, 374	51.00
	HOSPICE INPATIENT RESPITE CARE	93	0	0	22		52. 00
	HOSPICE GENERAL INPATIENT CARE	407	0	0	95	502	53. 00
	NONREI MBURSABLE COST CENTERS						
	BEREAVEMENT PROGRAM	0	0	0	0	0	00.00
61. 00		0	0	0	0	0	61. 00
62. 00		0	0	0	0	0	62. 00
	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63. 00
	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64. 00
	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65. 00
66. 00		0	0	0	0	0	66. 00
	ADVERTI SI NG	0	0	0	0	0	67. 00
	TELEHEALTH/TELEMONI TORI NG	0	0	0	0	0	00.00
	THRI FT STORE	0	0	0	0	0	07.00
	NURSING FACILITY ROOM & BOARD	0				0	70. 00
	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71. 00
	NEGATIVE COST CENTER	0	0	0	0		99. 00
100.00	TOTAL	302, 874	1, 466	0	30, 856	302, 874	100. 00

			nospi ce cc	N. 15-1555	10 12/31/2020	5/24/2021 11	
					Hospi ce I	0,21,202111	- <del> </del>
	Descriptions	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	OPERATION &	LINEN SERVIC	E		
			MAI NTENANCE				
		4. 00	5. 00	6. 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	CAP REL COSTS-BLDG & FIXT						1. 00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL	183, 085					4. 00
5.00	PLANT OPERATION & MAINTENANCE	21, 023	34, 778	8			5. 00
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 ADMINI STRATI ON	0	0	)	0		9. 00
10.00	ROUTINE MEDICAL SUPPLIES	8	0	)	0		10. 00
11. 00	MEDI CAL RECORDS	0	0	)	0		11. 00
12.00	STAFF TRANSPORTATION	319	0	)	0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	865	0	)	0		13. 00
14.00	PHARMACY	14, 158	0	)	0		14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	)	0		15. 00
16.00	OTHER GENERAL SERVICE	0	0	)	0		16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50. 00
51.00	HOSPICE ROUTINE HOME CARE	145, 769					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	176	6, 608		0	(	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	767	28, 170	)	0 0	(	53.00
	NONREI MBURSABLE COST CENTERS						
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		0 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	THRI FT STORE	0	0	)	0		69. 00
70.00	NURSING FACILITY ROOM & BOARD						70. 00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0 0	(	71.00
99. 00	NEGATIVE COST CENTER	0	0		0	'	99. 00
100.00	TOTAL	183, 085	34, 778	3	0 0	(	100.00

Heal th Financial	Systems		KING'S DAUGHTERS	HOSPI TAL	Li	n Lieu of Form CMS-2552-10
COST ALLOCATION	- HOSPI TAL-BASED	HOSPI CE GENERAL	SERVICE COSTS	Provider CCN: 15-0069	Peri od:	Worksheet 0-6

From 01/01/2020 Part I
To 12/31/2020 Date/Time Prepared: Hospi ce CCN: 15-1535 5/24/2021 11:00 am Hospi ce I NURSI NG ROUTI NE MEDI CAL VOLUNTEER Descriptions STAFF MEDI CAL RECORDS ADMI NI STRATI ON TRANSPORTATI ON SERVI CE COORDI NATI ON **SUPPLIES** 9. 00 11. 00 12.00 10.00 13.00 GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FLXT 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 5.00 PLANT OPERATION & MAINTENANCE 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 0 0 0 0 0 ROUTINE MEDICAL SUPPLIES 10.00 13 10.00 11.00 MEDICAL RECORDS 11.00 12.00 STAFF TRANSPORTATION 528 12.00 VOLUNTEER SERVICE COORDINATION 1, 431 13.00 0 13.00 14.00 PHARMACY 0 0 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 15.00 OTHER GENERAL SERVICE 16.00 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 17.00 LEVEL OF CARE 50.00 HOSPICE CONTINUOUS HOME CARE 50.00 0 0 0 HOSPICE ROUTINE HOME CARE 0 51.00 13 522 1, 414 51.00 HOSPICE INPATIENT RESPITE CARE 0 52.00 C 3 52.00 0 53.00 HOSPICE GENERAL INPATIENT CARE 5 14 53.00 NONREI MBURSABLE COST CENTERS BEREAVEMENT PROGRAM 60.00 n 60.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 VOLUNTEER PROGRAM 61.00 0 61.00 62.00 FUNDRAI SI NG 0 62.00 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 66.00 0 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 71.00 0 0 0 0 99.00 NEGATIVE COST CENTER 99.00 0 0

13

528

1, 431 100. 00

100.00 TOTAL

Provider CCN: 15-0069 | Period: | Worksheet 0-6 | From 01/01/2020 | Part | Hospice CCN: 15-1535 | To 12/31/2020 | Date/Time Prepared:

			nospi ce cci	N. 13-1333   1	0 12/31/2020	5/24/2021 11:	
					Hospi ce I		
	Descriptions	PHARMACY	PHYSI CI AN	OTHER GENERAL	PATI ENT/	TOTAL	
		Α	ADMI NI STRATI VE	SERVI CE	RESI DENTI AL		
			SERVI CES		CARE SERVICES		
		14. 00	15. 00	16. 00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT						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	HOUSEKEEPING						7. 00
8.00	DI ETARY						8. 00
9.00	NURSING ADMINISTRATION						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	23, 421					14. 00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	o	0				15. 00
16.00	OTHER GENERAL SERVICE	l ol		l c			16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES				0		17. 00
	LEVEL OF CARE					•	1
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	C		C	50.00
51.00	HOSPICE ROUTINE HOME CARE	23, 166	0	l c		266, 258	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	48	0	l c	0	6, 951	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	207	0	l c	0	29, 665	53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		C		C	60.00
61.00	VOLUNTEER PROGRAM	0		[ c		C	61.00
62.00	FUNDRAI SI NG	0		l c		(	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		[ c		(	63.00
64.00	PALLIATIVE CARE PROGRAM	o		l c			64.00
65.00	OTHER PHYSICIAN SERVICES	o		1 0			65. 00
66.00	RESI DENTI AL CARE	o	0		0		66. 00
67.00	ADVERTI SI NG	o		l c		l	67. 00
68.00	TELEHEALTH/TELEMONI TORI NG	o		l			68. 00
69.00	THRI FT STORE	o					69. 00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	o	0	C	0		71. 00
99. 00	NEGATIVE COST CENTER	o	0	C	0	(	99. 00
100.00	TOTAL	23, 421	0	c	0	302, 874	100.00
	•			•		•	•

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GEI STATISTICAL BASIS	NERAL SERVICE COSTS	Provider CCN: Hospice CCN:	Peri od: From 01/01/2020 To 12/31/2020	Worksheet 0-6 Part II Date/Time Prepared:

			Hospi ce cui	: 15-1535   1	0 12/31/2020	5/24/2021 11:	
					Hospi ce I	0,21,2021 111	<u> </u>
	Cost Center Descriptions	CAP REL BLDG & C.	AP REL MVBLE	EMPLOYEE	RECONCI LI ATI ON	ADMI NI STRATI VE	
	·	FLX	EQUI P	BENEFITS		& GENERAL	
		(SQUARE FEET) (D	OOLLAR VALUE)	DEPARTMENT		(ACCUMULATED	
				(GROSS		COSTS)	
				SALARI ES)			
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	744					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	82, 799			3. 00
4.00	ADMINISTRATIVE & GENERAL	744	0	55, 181	-183, 085	119, 789	4. 00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	13, 755	5. 00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6. 00
7.00	HOUSEKEEPI NG	0	0	0	0	0	7. 00
8.00	DI ETARY	0	0	0	0	0	8. 00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	5	10.00
11.00	MEDI CAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	209	12.00
13.00	VOLUNTEER SERVICE COORDINATION	o	0	412	o	566	13.00
14.00	PHARMACY	o	0	0	o	9, 263	14. 00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	o	0	0	o	0	15. 00
16.00	OTHER GENERAL SERVICE	o	0	0	o	0	16. 00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	o	0		o	0	17. 00
	LEVEL OF CARE	<u> </u>			<u>'</u>		1
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50. 00
51.00	HOSPICE ROUTINE HOME CARE			26, 892	o	95, 374	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	o	0	58	o	115	52. 00
53.00	HOSPICE GENERAL INPATIENT CARE	o	0	256	o	502	53.00
	NONREI MBURSABLE COST CENTERS	<u> </u>	'		<u>'</u>		1
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	o	O	0	o	0	61.00
62.00	FUNDRAI SI NG	o	0	0	o	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	o	0	0	o	0	63.00
64.00	PALLIATIVE CARE PROGRAM	l o	0	0	o	0	64.00
65.00	OTHER PHYSICIAN SERVICES	o	0	0	o	0	65. 00
66.00	RESI DENTI AL CARE	o	0	0	o	0	66.00
67.00	ADVERTI SI NG	o	0	0	o	0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	o	o	0	o	0	68. 00
69. 00	THRI FT STORE	o	o	0	o	0	1
70. 00	NURSING FACILITY ROOM & BOARD				o		70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	l	ol	0	ol	0	
99. 00	NEGATIVE COST CENTER		٦	_	]	_	99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	1, 466	ol	30, 856		183, 085	
	UNIT COST MULTIPLIER	1. 970430	0. 000000	0. 372662		1. 528396	
		· ·					

Health Financial Systems	KING'S DAUGHTERS' HOSPITAL	In Lie	eu of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE STATISTICAL BASIS	GENERAL SERVICE COSTS Provider Hospice C	CCN: 15-0069   Peri od: From 01/01/2020 To 12/31/2020	Worksheet 0-6 Part II Date/Time Prepared:

SIAIIS	TICAL BASIS		Hospi ce CCI	N: 15-1535	To 12/31/2020	Date/Time Pre 5/24/2021 11:	
-					Hospi ce I	3/24/2021 11.	oo aiii
	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSI NG ADMI NI STRATI ON (DI RECT NURS. HRS.)	
		5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT						1. 00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMI NI STRATI VE & GENERAL	400					4. 00
5.00	PLANT OPERATION & MAINTENANCE	100	•				5. 00
6. 00 7. 00	LAUNDRY & LINEN SERVICE	0	0	1			6.00
8. 00	HOUSEKEEPI NG DI ETARY	0			0		7. 00 8. 00
9.00	NURSING ADMINISTRATION				J	0	
10.00	ROUTI NE MEDI CAL SUPPLI ES	0			) )	0	
11. 00	MEDI CAL RECORDS	0			Ö	0	11. 00
12. 00	STAFF TRANSPORTATION	0			0	0	12. 00
13.00	VOLUNTEER SERVICE COORDINATION	0			Ö	0	13. 00
14.00	PHARMACY	0			O	0	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15. 00
16.00	OTHER GENERAL SERVICE	0			O	0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0			O		17. 00
	LEVEL OF CARE						
50. 00	HOSPICE CONTINUOUS HOME CARE					0	
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	19	0	1	0		
53. 00	HOSPICE GENERAL INPATIENT CARE NONREIMBURSABLE COST CENTERS	81	0		0	0	53. 00
60. 00	BEREAVEMENT PROGRAM	0			0	1 0	60.00
61. 00	VOLUNTEER PROGRAM	0			0	0	61. 00
62. 00	FUNDRAI SI NG	0			5	0	62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	i o			0	l ő	63. 00
64. 00	PALLIATIVE CARE PROGRAM	0			Ö	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		1	0	0	65. 00
66.00	RESI DENTI AL CARE	0	0		0	0	66. 00
67.00	ADVERTI SI NG	0			C	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	0			O	0	68. 00
69. 00	THRI FT STORE	0		1	O	0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD		_			_	70. 00
	OTHER NONREIMBURSABLE (SPECIFY)	0	0	'	0	0	7 00
	NEGATIVE COST CENTER	04 770	_			_	99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I) UNIT COST MULTIPLIER	34, 778 347. 780000	0. 000000	0. 00000	J 0 000000		100.00
101.00	UNIT COST MULTIPLIER	347. /80000	0.000000	J 0.00000	0.000000	U. 000000	1101.00

Health Financial Systems	KING'S DAUGHTERS' HOSPITAL	In Lie	eu of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE STATISTICAL BASIS	GENERAL SERVICE COSTS Provider Hospice C	CCN: 15-0069   Peri od: From 01/01/2020 To 12/31/2020	Worksheet 0-6 Part II Date/Time Prepared:

			Hospi ce CCI	N: 15-1535 T	o 12/31/2020	Date/Time Prep 5/24/2021 11:0	
					Hospi ce I	0,21,2021 111	00 4
	Cost Center Descriptions	ROUTI NE MEDI CAL SUPPLI ES (PATI ENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MI LEAGE)	VOLUNTEER SERVI CE COORDI NATI ON (HOURS OF SERVI CE)	PHARMACY (CHARGES)	
		10.00	11. 00	12.00	13. 00	14.00	
	GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	10.00	11.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL PLANT OPERATION & MAINTENANCE LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY NURSING ADMINISTRATION ROUTINE MEDICAL SUPPLIES MEDICAL RECORDS STAFF TRANSPORTATION VOLUNTEER SERVICE COORDINATION PHARMACY PHYSICIAN ADMINISTRATIVE SERVICES OTHER GENERAL SERVICE	2, 474	0	15, 973 0 0 0	413 0 0	9, 262 0 0	15. 00
50. 00	HOSPI CE CONTI NUOUS HOME CARE	0	0	0	O	0	50.00
51. 00	HOSPICE ROUTINE HOME CARE	2, 447	Ö	· ·		9, 161	51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	5	Ö		l .	19	52. 00
53.00	HOSPICE GENERAL INPATIENT CARE	22	0	1		82	53.00
	NONREI MBURSABLE COST CENTERS						
99. 00	BEREAVEMENT PROGRAM VOLUNTEER PROGRAM FUNDRAI SI NG HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS PALLI ATI VE CARE PROGRAM OTHER PHYSI CI AN SERVI CES RESI DENTI AL CARE ADVERTI SI NG TELEHEALTH/TELEMONI TORI NG THRI FT STORE NURSI NG FACI LI TY ROOM & BOARD OTHER NONREI MBURSABLE (SPECI FY) NEGATI VE COST CENTER COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	13	0	0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	99. 00
	UNIT COST MULTIPLIER	0. 005255	0. 000000	1		2. 528719	

Health Financial Systems	KING'S DAUGHTERS'	HOSPI TAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE STATISTICAL BASIS	GENERAL SERVICE COSTS	Provi der CCN: Hospi ce CCN:	Peri od: From 01/01/2020 To 12/31/2020	Worksheet 0-6 Part II Date/Time Prepared:

			nospi ce coi	N. 15-1555	10 12/31/2020	5/24/2021 11	
					Hospi ce I		
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/			
		ADMI NI STRATI VE		RESI DENTI AL			
		SERVI CES	(SPECI FY	CARE SERVICE	S		
		(PATIENT DAYS)	,	(IN-FACILIT			
		( ,		DAYS)			
		15. 00	16.00	17. 00			
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2. 00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4. 00	ADMI NI STRATI VE & GENERAL						4.00
5. 00	PLANT OPERATION & MAINTENANCE						5.00
6. 00	LAUNDRY & LINEN SERVICE						6. 00
7. 00	HOUSEKEEPI NG						7. 00
8.00	DIETARY						8.00
9.00							9.00
	NURSI NG ADMINI STRATI ON						
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						14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0					15. 00
16. 00	OTHER GENERAL SERVICE		0	1			16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES				0		17. 00
	LEVEL OF CARE						
	HOSPICE CONTINUOUS HOME CARE	0	l .	1			50. 00
51. 00	HOSPICE ROUTINE HOME CARE	0	0	1			51. 00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0		0		52. 00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0		0		53. 00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM		0				60. 00
61.00	VOLUNTEER PROGRAM		0	)			61. 00
62.00	FUNDRAI SI NG		0	)			62. 00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0	)			63. 00
64.00	PALLIATIVE CARE PROGRAM		0	1			64. 00
65. 00	OTHER PHYSICIAN SERVICES		0	)			65. 00
66. 00	RESI DENTI AL CARE	0	0	)	0		66. 00
67. 00	ADVERTI SI NG		0	,			67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG		0	,			68. 00
69. 00	THRI FT STORE		1	,			69. 00
	NURSING FACILITY ROOM & BOARD						70.00
	OTHER NONREIMBURSABLE (SPECIFY)	0	_	,	0		71.00
	NEGATIVE COST CENTER		Ĭ	1			99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		_	J	0		100.00
	UNIT COST MULTIPLIER	0. 000000	0. 000000	0. 0000	20		101.00
101.00	JOHN 1 0001 MIDELLI ELEK	0.00000	0.00000	0.0000	33		1101.00

Health Financial Systems	KING'S DAUGHTERS	' HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED	SERVICE COSTS BY	Provider CCN	N: 15-0069	Peri od: From 01/01/2020	Worksheet 0-7	
LEVEL OF CARE		Hospi ce CCN:	15-1535	To 12/31/2020		
				Hospi ce I		
			Charges by	/ LOC (from Provi	der Records)	

LLVLL	or once		Hospi ce CCN	N: 15-1535	To 12/31/2020	Date/Time Prep 5/24/2021 11:0	pared: 00 am
					Hospi ce I		
	·			Charges by	LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C, C	ost to Charge	HCHC	HRHC	HI RC	
		Part I, Col. 9	Ratio				
		line					
		0	1.00	2.00	3. 00	4. 00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSI CAL THERAPY	66. 00	0. 331871		0 0	0	1.00
2.00	OCCUPATIONAL THERAPY	67. 00	0. 338905		0 0	0	2. 00
3.00	SPEECH PATHOLOGY	68. 00	0. 401927		0 0	0	3. 00
4.00	DRUGS CHARGED TO PATIENTS	73. 00	0. 173988		0 0	0	4. 00
5.00	DURABLE MEDICAL EQUIP-RENTED	96. 00					5. 00
6.00	LABORATORY	60.00	0. 163359		0 0	0	6. 00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71. 00	0. 320632		0 0	0	7. 00
7. 01	IV SOLUTIONS	71. 01	0. 042570		0 0	0	7. 01
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93. 00					8. 00
9.00	RADI OLOGY - THERAPEUTI C	55. 00	0. 000000		0 0	0	9. 00
9. 01	ONCOLOGY	55. 01	0. 505735		0 0	0	9. 01
10.00	CARDI OLOGY	76. 00	0. 130545		0 0	0	10. 00
10. 97	CARDI AC REHABI LI TATI ON	76. 97	0. 439219		0 0	0	10. 97
11. 00	Totals (sum of lines 1-11)						11. 00
		Charges by LOC		Shared Servi	ce Costs by LOC		
		(from Provider			·		
		Records)					
	Cost Center Descriptions	HGI P H			xHIRC (col. 1 x		
			col . 2)	col. 3)	col . 4)	col . 5)	
		5. 00	6. 00	7. 00	8. 00	9. 00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSI CAL THERAPY	0	0		0		
2.00	OCCUPATI ONAL THERAPY	0	0		0		2. 00
3.00	SPEECH PATHOLOGY	0	0		0	0	3. 00
4.00	DRUGS CHARGED TO PATIENTS	0	0		0	0	4. 00
5. 00	DURABLE MEDICAL EQUIP-RENTED						5. 00
6.00	LABORATORY	0	0		0 0	0	6. 00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	7. 00
7. 01	IV SOLUTIONS	0	0		0	0	7. 01
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8. 00
9.00	RADI OLOGY - THERAPEUTI C	0	0		0	0	9. 00
9. 01	ONCOLOGY	0	0		0	0	
10.00	CARDI OLOGY	0	0		0	0	10.00
10. 97	CARDI AC REHABILI TATI ON	0	0		0	-	10. 97
11. 00	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: Hospice CCN:	Peri od: From 01/01/2020 To 12/31/2020	Worksheet 0-8  Date/Time Prepared:
		·		5/24/2021 11:00 am

					5/24/2021 11:0	00 am
				Hospi ce I		
			TITLE XVIII	TITLE XIX	TOTAL	
			MEDI CARE	MEDI CAI D		
			1.00	2. 00	3. 00	
	HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7,	col . 6.			0	1.00
	line 11)	.,				
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				o	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)	l c	0		4.00
5. 00	Program cost (line 3 times line 4)	/		0		5. 00
0.00	HOSPI CE ROUTI NE HOME CARE					0.00
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7,	col 7			266, 258	6.00
0.00	line 11)	00,			200, 200	0.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				2, 447	7. 00
8.00	Total average cost per diem (line 6 divided by line 7)				108, 81	8. 00
9. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, line	11)	2, 308	126		9. 00
10. 00	Program cost (line 8 times line 9)	, , , ,	251, 133			10.00
10.00	HOSPICE INPATIENT RESPITE CARE		251, 155	13, 710		10.00
11. 00	Total cost (Wkst. 0-6, Part I, col. 18, Line 52 plus Wkst. 0-7,	col 8			6, 951	11. 00
11.00	line 11)	COI . O,			0, 751	11.00
12. 00	Total unduplicated days (Wkst. S-9, col. 4, line 12)				5	12. 00
13. 00	Total average cost per diem (line 11 divided by line 12)				1, 390. 20	1
14. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, line	12)	5	0	1,070.20	14. 00
15. 00	Program cost (line 13 times line 14)	, (2)	6. 951	0		15. 00
13.00	HOSPICE GENERAL INPATIENT CARE		0, 751			13.00
16. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7,	col 9			29, 665	16. 00
10.00	line 11)	001. 7,			27,000	10.00
17. 00	Total unduplicated days (Wkst. S-9, col. 4, line 13)				22	17. 00
18. 00	Total average cost per diem (line 16 divided by line 17)				1, 348. 41	
19. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, line	13)	22	0	1,010.11	19. 00
20. 00	Program cost (line 18 times line 19)	, 13)	29, 665			20.00
20.00	TOTAL HOSPICE CARE		27,000	0		20.00
21. 00					302, 874	21. 00
21.00					2, 474	1
	Average cost per diem (line 21 divided by line 22)				122. 42	1
23.00	Paverage cost per drelli (Title 21 divided by Title 22)		l	1	122.42	23.00

Hoal +h	Financial Systems KING'S DAUGHTERS'	HOSDI TAI	In Lie	eu of Form CMS-2	DEE2 10
	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0069	Peri od:	Worksheet L	2332-10
CALCUL	ATION OF CAPITAL PAINENT	Frovider Con. 13-0007	From 01/01/2020 To 12/31/2020	Parts I-III	
		Title XVIII	Hospi tal	PPS	00 4
				1.00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			703, 218	1. 00
1.01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			23, 095	2. 00
2.01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00	Total inpatient days divided by number of days in the cost re	porting period (see inst	ructions)	26. 92	3. 00
4.00	Number of interns & residents (see instructions)			0.00	4. 00
5.00	Indirect medical education percentage (see instructions)			0.00	5. 00
6. 00	Indirect medical education adjustment (multiply line 5 by the 1.01) (see instructions)	sum of lines 1 and 1.01	, columns 1 and	0	6. 00
7. 00	Percentage of SSI recipient patient days to Medicare Part A p. 30) (see instructions)	0.00	7. 00		
8.00	Percentage of Medicaid patient days to total days (see instru	0.00	8. 00		
9.00	Sum of lines 7 and 8	0.00	9. 00		
10.00	Allowable disproportionate share percentage (see instructions		0.00	10.00	
11. 00	Disproportionate share adjustment (see instructions)			0	11. 00
12.00	Total prospective capital payments (see instructions)			726, 313	12. 00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)			O	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)			O	3. 00
4.00	Capital cost payment factor (see instructions)			ol	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	1. 00
2.00	Program inpatient capital costs for extraordinary circumstance	es (see instructions)		0	2. 00
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	3. 00
4.00	Applicable exception percentage (see instructions)	0.00	4. 00		
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	5. 00
6.00	Percentage adjustment for extraordinary circumstances (see in			0.00	6. 00
7.00	Adjustment to capital minimum payment level for extraordinary	circumstances (line 2 x	line 6)	0	7. 00
8.00	Capital minimum payment level (line 5 plus line 7)			0	8. 00
9.00	Current year capital payments (from Part I, line 12, as appli			0	9. 00
10.00	Current year comparison of capital minimum payment level to c			0	10. 00
11. 00	Carryover of accumulated capital minimum payment level over c.	apital payment (from pri	or year	0	11. 00

Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)

Current year exception payment (if line 12 is positive, enter the amount on this line)

Carryover of accumulated capital minimum payment level over capital payment for the following period

13.00 0

14.00

0 12.00

0

0 15.00

0 16.00 0 17.00

Worksheet L, Part III, line 14)

(if line 12 is negative, enter the amount on this line)

15.00 Current year allowable operating and capital payment (see instructions)
16.00 Current year operating and capital costs (see instructions)
17.00 Current year exception offset amount (see instructions)

13.00

14.00