This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0069 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/22/2024 3:00 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/22/2024 3:00 pm Manually prepared cost report use only If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by KINGS DAUGHTERS HOSPITAL (15-0069) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SIGNATURE STATEMENT	
1	Jo	hn Price	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	John Price			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			4

	·		Title	XVIII			
		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	-284, 603	-4, 417	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200. 00 TOTAL		0	-284, 603	-4, 417	0	0	200.00
The ob	nove amounts represent "due to" or "due from"	the engliceble	nrogram for t	he element of	the charge comp	lov indianted	

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

Health Financial Systems KINGS 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 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/22/2024 3:00 pm 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: 47250-2.00 City: MADISON County: JEFFERSON 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)
V XVIII XIX 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 KINGS DAUGHTERS 150069 99915 06/17/1966 Ν 3.00 HOSPI TAI Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 Hospital -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospital-Based HHA KINGS DAUGHTERS 157141 99915 03/08/1985 Ν Ρ Ν 12.00 HOSPITAL HHA 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce 14 00 KINGS DAUGHTERS 151535 99915 09/01/1995 14 00 15.00 Hospital-Based Health Clinic - RHC 15.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1 00 2 00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2023 12/31/2023 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 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. Did this hospital receive interim UCPs, including supplemental UCPs, for 22.01 this 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) 22.02 Is this a newly merged hospital that requires a final UCP to be N Ν 22.02 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 Ν N 22 03 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 counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no

for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)

Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.

23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

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

Health Financial Systems KINGS 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 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/22/2024 3:00 pm XVIII XIX 1. 00 2.00 3.00 58.00 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 58.00 Pt. I 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see 60 00 Υ instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. If line 60 is yes, complete columns 2 and 3 for each program. (see 23.00 60.01 1 instructions) Y/N LME Direct GME IME Direct GME 1.00 2.00 3.00 4. 00 5. 00 61.00 Did your hospital receive FTE slots under ACA 0 00 0.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)
61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary 61.05 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unwei ahted Unwei ahted IME FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0 00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 0.00 61.20 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 62.00 your hospital received HRSA PCRE funding (see instructions) 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 63.00 N

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

Health Financial Systems	KINGS D	DAUGHTERS HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP			r CCN: 15-0069	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I	pared:
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Cootion FEOA of the ACA Doos Vo	on FTF Dooldonto in N	annravi dan Cattini	1. 00	2.00	3.00	
Section 5504 of the ACA Base Year period that begins on or after a			JSIIIIS base yea	ii is your cost	reporting	
64.00 Enter in column 1, if line 63 is in the base year period, the numeresident FTEs attributable to resettings. Enter in column 2 the resident FTEs that trained in your of (column 1 divided by (column)	s yes, or your facilitable of unweighted nor obtains occurring in a number of unweighted bur hospital. Enter in 1 + column 2)). (see	ty trained resider n-primary care all nonprovider d non-primary care n column 3 the rat instructions)	e i o			64.00
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
			FTEs	FTEs in	3/ (col. 3 +	
			Nonprovi der Si te	Hospi tal	col. 4))	
	1. 00	2. 00	3. 00	4. 00	5. 00	
65.00 Enter in column 1, if line 63	1.00	2.00	0.0			65.00
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						85.00
			Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 +	
			Nonprovi der		col. 2))	
			Si te	'	,,	
			1. 00	2. 00	3. 00	
Section 5504 of the ACA Current		n Nonprovider Sett	tingsEffective	for cost report	ing periods	
beginning on or after July 1, 20			0.0	0.00	0.000000	// 00
66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 divided by (column 1 divided by (column 1 divided by	occurring in all nonpount unweighted non-priman cal. Enter in column 3	rovider settings. ry care resident 3 the ratio of	O. C	0.00	0. 000000	66.00
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
			FTEs Nonprovi don	FTEs in	3/ (col. 3 +	
			Nonprovi der Si te	Hospi tal	col. 4))	
	1. 00	2. 00	3. 00	4. 00	5. 00	
67.00 Enter in column 1, the program	1. 00	2.00	0. 0			67.00
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						

Health Financial Systems KINGS 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 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/22/2024 3:00 pm 1.00 Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) 68.00 68.00 For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)? 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 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 0 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 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 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for O 76.00 76.00 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) 1.00 Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. N 80.00 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter Ν 81.00 "Y" for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. N 85.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 87.00 N 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. Approved for Number of Permanent Approved Adiustment Permanent (Y/N)Adjustments 1.00 2.00 88. 00 88.00 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target Ν amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments Effecti ve Wkst. A Line Approved Date Permanent No. Adjustment Amount Per Di scharge 3. 00 2.00 1.00 89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number 0 00 0 89 00 on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per di scharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. XIX 1.00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for 90.00 Ν Υ yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. 91.00 Υ 91.00 Ν Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 92.00 Ν 92.00 93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. Ν Ν 93.00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the 94.00 Ν Ν applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 95.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the 96.00 Ν Ν 96.00 applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 97.00 0.00 0.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE	NTIFICATION DATA	Provi der Co	CN: 15-0069 F	Peri od:	Worksheet S-	S-2552-1 -2
IOST TIME THE HEALTH ONNE COM LEAT THE		Trovider of	F	From 01/01/2023 o 12/31/2023	Part I	
			'		5/22/2024 3:	
				V	XIX	4
8.00 Does title V or XIX follow Medicare (ti	itle VVIII) for the	intorns and ros	cidonte nost	1.00 Y	2. 00 Y	98. (
stepdown adjustments on Wkst. B, Pt. I, column 1 for title V, and in column 2 1	, col. 25? Enter "Y" for title XIX.	" for yes or "N"	for no in		·	
Does title V or XIX follow Medicare (ti C, Pt. I? Enter "Y" for yes or "N" for title XIX.				Y	Y	98.0
Des title V or XIX follow Medicare (ti bed costs on Wkst. D-1, Pt. IV, line 89 for title V, and in column 2 for title	9? Enter "Y" for yes			Y	Y	98.0
8.03 Does title V or XIX follow Medicare (ti reimbursed 101% of inpatient services of for title V, and in column 2 for title	itle XVIII) for a cr cost? Enter "Y" for			N N	N	98.0
28.04 Does title V or XIX follow Medicare (ti outpatient services cost? Enter "Y" for	itle XVIII) for a CA			N	N	98.0
in column 2 for title XIX. 18.05 Does title V or XIX follow Medicare (ti Wkst. C, Pt. I, col. 4? Enter "Y" for y					Υ	98. (
column 2 for title XIX. 18.06 Does title V or XIX follow Medicare (ti 19.16 Pts. I through IV? Enter "Y" for yes on 19.16 column 2 for title XIX.				Y	Y	98. (
Rural Providers				NI NI		105. (
05.00 Does this hospital qualify as a CAH? 06.00 f this facility qualifies as a CAH, ha		II-inclusive met	thod of paymen	t N		106.
for outpatient services? (see instructi 07.00 Column 1: If line 105 is Y, is this fac training programs? Enter "Y" for yes on	cility eligible for r "N" for no in colu	umn 1. (see ins	structi ons)	N		107.
Column 2: If column 1 is Y and line 70 approved medical education program in 1 Enter "Y" for yes or "N" for no in colu	the CAH's excluded umn 2. (see instruc	IPF and/or IRF ctions)	uni t(s)?			
07.01 If this facility is a REH (line 3, column reimbursement for I&R training programs instructions)						107.
08.00 Is this a rural hospital qualifying for CFR Section §412.113(c). Enter "Y" for						108.
		Physi cal 1.00	0ccupati onal 2.00	Speech	Respiratory 4.00	<u>/</u>
09.00 of this hospital qualifies as a CAH or therapy services provided by outside su for yes or "N" for no for each therapy.	upplier? Enter "Y"		N N	3. 00 N	N N	109.
					1.00	4
10.00 Did this hospital participate in the Ru Demonstration) for the current cost repo complete Worksheet E, Part A, lines 200	orting period? Enter	r "Y" for yes or	"N" for no.	lf yes,	1.00 N	110.
appl i cabl e.						
				1.00	0.00	
11 00 f this facility qualifies as a CAH di	d it participate in	n the Frontier (Communi ty	1. 00 N	2.00	111
11.00 f this facility qualifies as a CAH, di Health Integration Project (FCHIP) demo "Y" for yes or "N" for no in column 1. integration prong of the FCHIP demo in Enter all that apply: "A" for Ambulance for tele-health services.	onstration for this If the response to which this CAH is p	cost reporting column 1 is Y, participating in	period? Enter enter the oclumn 2.	1. 00 N	2.00	111.
Health Integration Project (FCHIP) demo "Y" for yes or "N" for no in column 1. integration prong of the FCHIP demo in Enter all that apply: "A" for Ambulance for tele-health services.	onstration for this If the response to which this CAH is p e services; "B" for	cost reporting column 1 is Y, participating ir additional beds	peri od? Enter enter the n col umn 2. s; and/or "C"		2.00	
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patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain head thacer related taxes as defined in \$1903(w) (3) of the ACT?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A 1 inter unuber where these taxes are included. 123.00 bid the Facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting tax preparation, bookkeeping, payroll, and/or progressor "N" for no enter or the services. From an unrelated organization? In column 1, enter "Y" for yes or "If no services expenses, i.e., greater than 50% of total professional services expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a C85A outside of the main hospital C85A? In column 2, enter "Y" for yes or "N" for no. Certified Transplant Center Information 125.00 Does this Facility operate a Medicare-certified transplant center? Enter "Y" for yes or "N" for no. "If yes, enter certification dates (smm/dd/yyyy) below. 126.00 of this is a Medicare-certified with the patient of the certification date in column 1 and termination date. If applicable, in column 2. 128.00 if this is a Medicare-certified learn transplant program, enter the certification date in column 1 and termination date. If applicable, in column 2. 129.00 if this is a Medicare-certified long transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 130.00 if this is a Medicare-certified long transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 131.00 if this is a Medicare-certified paper certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2. 132.00 if this is a hospital-based organ procurement organization (0P0), enter the Certification date in column 1 and termination date, if applicable, in column 2. 133.00 Remo	119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies f §3121 and applicable amendments? (see "N" for no. Is this a rural hospital w Hold Harmless provision in ACA §3121 a	instructions) Enter in ith < 100 beds that qua nd applicable amendment	column 1, "Y Hifies for t	" for yes or he Outpatien		Y	
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144.00 Are provider based physicians' costs included in Worksheet A? 1.00 1.00 2.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 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? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If						1. 00	
145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 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? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If	144.00 Are provider based physicians' costs i	ncluded in Worksheet A?	•				144. 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? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If					1.00	2. 00	
146.00 Has the cost allocation methodology changed from the previously filed cost report? N 146.00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If	inpatient services only? Enter "Y" for no, does the dialysis facility include	yes or "N" for no in c Medicare utilization f	olumn 1. If	column 1 is			145. 00
	146.00 Has the cost allocation methodology ch Enter "Y" for yes or "N" for no in col	anged from the previous umn 1. (See CMS Pub. 15					146. 00

Health Financial Systems	KINGS DAL	JGHTERS	HOSPI TAL			Li	n Lie	u of Form CMS-	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	A	Provi der CC	CN: 15-0069		riod: com 01/01/ 12/31/			epared:
								1.00	-
147.00Was there a change in the statist	ical basis? Enter "V"	for ve	es or "N" for	· no				1.00 N	147. 00
148.00 Was there a change in the order of								N N	148. 00
149.00 Was there a change to the simplif					for r	10.		N N	149.00
			Part A	Part		Title	V	Title XIX	
			1.00	2. 00		3. 00		4. 00	
Does this facility contain a prov or charges? Enter "Y" for yes or									
155. 00 Hospi tal			N	N		N		N	155.00
156.00 Subprovi der - IPF			N	N		N		N	156. 00
157. 00 Subprovi der - I RF			N	N		N		N	157. 00
158. 00 SUBPROVI DER									158.00
159. 00 SNF			N	N N		N		N	159.00
160.00HOME HEALTH AGENCY 161.00CMHC			N	N N		N N		N N	160. 00 161. 00
TO 1. OU CIWING				I IN		IN			161.00
Multicampus								1.00	
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that ha	as one	or more camp	uses in d	i ffere	ent CBSAs	?	N	165. 00
Enter 1 Tel years in Tel Hel	Name		County	State	Zip (Code CI	BSA	FTE/Campus	
	0		1. 00	2.00	3. (00 4.	.00	5. 00	1
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.0	0166.00
								1.00	
Health Information Technology (HI						Act			
167.00 s this provider a meaningful use 168.00 of this provider is a CAH (line 10 reasonable cost incurred for the	05 is "Y") and is a me	eani ngf	ful user (lin			enter the	е	Y	167. 00 168. 00
168.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	not a meaningful user,	, does	this provide			a hardshi _l	0		168. 01
169.00 If this provider is a meaningful transition factor. (see instruction	user (line 167 is "Y")					N"), ente	r the	9. 9	9169. 00
						Begi nni		Endi ng	
						1. 00		2. 00	
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	peginning date and end	ding da	ate for the r	eporti ng					170. 00
						1. 00	1	2.00	
171.00 If line 167 is "Y", does this prosection 1876 Medicare cost plans "Y" for yes and "N" for no in column 2. (s	reported on Wkst. S-3, umn 1. If column 1 is	, Pt. I	, line 2, co	I. 6? Ent		N			0 171. 00

	Financial Systems KINGS DAUGHTE AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0069	In Lie Period:	u of Form CMS- Worksheet S-2	
55111	AL AND HOSTITAL HEALTH CANE REIMBORGEMENT QUESTIONNAIRE	Trovider c		From 01/01/2023 To 12/31/2023	Part II Date/Time Pre	epared:
				Y/N	5/22/2024 3:0 Date	00 pm
				1.00	2. 00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURS General Instruction: Enter Y for all YES responses. Enter mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS			er all dates in	the	
	Provider Organization and Operation			_		
00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in			N	01/01/2022	1.00
	reporting period. It yes, enter the date of the change in	COT CHILT 2: (300	Y/N	Date	V/I	
			1. 00	2. 00	3. 00	
00	Has the provider terminated participation in the Medicare yes, enter in column 2 the date of termination and in colu voluntary or "I" for involuntary.	mn 3, "V" for	N			2.00
00	Is the provider involved in business transactions, includicontracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the proviofficers, medical staff, management personnel, or members of directors through ownership, control, or family and oth relationships? (see instructions)	offices, drug der or its of the board	N			3.00
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
00	Column 1: Were the financial statements prepared by a Cer Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date av column 3. (see instructions) If no, see instructions.	for Compiled, ailable in	N			4.00
00	Are the cost report total expenses and total revenues diff those on the filed financial statements? If yes, submit re		N			5.00
	These on the Third Thank a Statement The Jeep Sasmit To	9011011111111111		Y/N	Legal Oper.	
	la constant and the con			1. 00	2. 00	
00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column the legal operator of the program?	2: If yes, i	s the provide	r N		6.00
00	Are costs claimed for Allied Health Programs? If "Y" see i	nstructi ons.		Υ		7.00
00	Were nursing programs and/or allied health programs approv cost reporting period? If yes, see instructions.		Ü			8.00
00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instructio		cal education	N		9.00
. 00	Was an approved Intern and Resident GME program initiated		the current	N		10.00
. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than Teaching Program on Worksheet A? If yes, see instructions.	I & R in an Ap	proved	N		11.00
	, , , , , , , , , , , , , , , , , , ,			<u> </u>	Y/N	
	Dod Dobto				1. 00	
. 00	Bad Debts Is the provider seeking reimbursement for bad debts? If ye	s, see instruc	ti ons.		Y	12.00
	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			ost reporting	N	13.00
. 00	If line 12 is yes, were patient deductibles and/or coinsur instructions. Bed Complement	ance amounts w	aived? If yes,	see	N	14.00
5. 00	Did total beds available change from the prior cost report		yes, see ins		N N	15.0
		Y/N	Date	Y/N	Date	
	DCAD D. I.	1.00	2. 00	3. 00	4. 00	
. 00	PS&R Data Was the cost report prepared using the PS&R Report only?	l N	1	N		16. 00
. 00	If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)					
00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/04/2024	Y	04/04/2024	17.00
00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
. 00		N		N		19.00

Heal th	Financial Systems KINGS DAUGHTE	ERS HOSPITAL		In Lie	u of Form CMS	S-2552-10		
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der (CCN: 15-0069	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S Part II Date/Time P 5/22/2024 3	5-2 Prepared:		
			i pti on	Y/N	Y/N			
20.00	If line 14 or 17 is yes were adjustment and to DOOD		0	1. 00	3.00	20.00		
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00		
		Y/N	Date	Y/N	Date			
		1. 00	2.00	3. 00	4. 00			
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00		
					1.00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	1.00						
	Capital Related Cost		,					
22. 00	Have assets been relifed for Medicare purposes? If yes, se	e instructions	;		Υ	22. 00		
23. 00	Have changes occurred in the Medicare depreciation expense			ring the cost	N	23.00		
	reporting period? If yes, see instructions.			3				
24. 00	Were new leases and/or amendments to existing leases enter If yes, see instructions	ed into during	this cost r	eporting period?	N	24. 00		
25. 00	Have there been new capitalized leases entered into during	the cost repo	orting period	? If yes, see	N	25. 00		
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost report	ing period?	If yes, see	N	26. 00		
07.00	instructions.			6	.,	07.00		
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reporti	ng period? I	f yes, submit	N	27. 00		
	Interest Expense				l			
28. 00	Were new loans, mortgage agreements or letters of credit e period? If yes, see instructions.	ntered into du	ıring the cos	t reporting		28. 00		
29. 00	Did the provider have a funded depreciation account and/or	bond funds (ebt Service	Reserve Fund)		29.00		
27.00	treated as a funded depreciation account? If yes, see inst					27.00		
30.00	Has existing debt been replaced prior to its scheduled mat	urity with new	debt? If ye	s, see		30.00		
21 00	instructions.					21.00		
31. 00	Has debt been recalled before scheduled maturity without instructions.	ssuance or nev	dept? IT ye	s, see		31.00		
	Purchased Services							
32.00	Have changes or new agreements occurred in patient care se		ed through c	ontractual		32. 00		
	arrangements with suppliers of services? If yes, see instr							
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 ap	plied pertaini	ng to compet	itive bidding? If		33.00		
	no, see instructions. Provider-Based Physicians							
3/1 00	Were services furnished at the provider facility under an	arrangement wi	th provider-	hasad nhysicians	Υ	34.00		
34.00	If yes, see instructions.	arrangement wi	tii provider-	based physicians:	'	34.00		
35.00	If line 34 is yes, were there new agreements or amended ex		ents with the	provi der-based	N	35.00		
	physicians during the cost reporting period? If yes, see i	nstructions.		Y/N	Do+o			
				1.00	2. 00			
	Home Office Costs			1.00	2.00			
36. 00						36.00		
37. 00	If line 36 is yes, has a home office cost statement been p	repared by the	home office	?		37.00		
07.00	If yes, see instructions.	. opa. oa 23 :				07.00		
38. 00	If line 36 is yes , was the fiscal year end of the home of			f		38. 00		
	the provider? If yes, enter in column 2 the fiscal year en							
39. 00	If line 36 is yes, did the provider render services to othesee instructions.	er chain compo	onents? If ye	S,		39. 00		
40. 00	If line 36 is yes, did the provider render services to the	home office?	If yes, see			40.00		
	i nstructi ons.							
	1.00 2.							
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/position	LUCI A		GERBER		41.00		
	held by the cost report preparer in columns 1, 2, and 3,							
	respecti vel y.							
42.00	' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	BLUE & CO., LI		42.00				
42 00	preparer.	EO2 002 2524		I CEDDED ON LIEAN		42.00		
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		
	proport preparer in cordinas rand z, respectivery.	I		ı		Ш		

Heal th	Financial Systems	KINGS DAUGHTER	RS HOSPITAL		In Lieu of Form CMS-2552-10			
HOSPI T	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der (Peri From To	01/01/2023 12/31/2023	Worksheet S-2 Part II Date/Time Pre 5/22/2024 3:0	pared:
			3	. 00				
	Cost Report Preparer Contact Information			. 00		-		
41. 00	Enter the first name, last name and the title held by the cost report preparer in columns respectively.		SENIOR MANAGE	R				41. 00
42. 00	Enter the employer/company name of the cost repreparer.	report						42.00
43. 00	Enter the telephone number and email address report preparer in columns 1 and 2, respective							43.00

| Period: | Worksheet S-3 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared:
 Heal th Financial
 Systems
 KINGS
 DAUGHTERS
 HOSPITAL

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

					Т	o 12/31/2023	Date/Time Pre 5/22/2024 3:0	
							I/P Days /	O PIII
							0/P Visits /	
							Tri ps	
	Component	Worksheet A	No. of Bed	s Bed	Days	CAH/REH Hours	Title V	
		Li ne No.			abl e			
		1. 00	2. 00	3.	00	4. 00	5. 00	
	PART I - STATISTICAL DATA	00.00			00.010			
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		64	23, 360	0. 00	0	1.00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
2. 00	for the portion of LDP room available beds) 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	
6. 00	Hospital Adults & Peds. Swing Bed NF						0	
7. 00	Total Adults and Peds. (exclude observation			64	23, 360	0.00	0	
7.00	beds) (see instructions)				20,000	0.00	Ü	7.00
8.00	INTENSIVE CARE UNIT	31. 00		6	2, 190	0. 00	0	8.00
9. 00	CORONARY CARE UNIT							9.00
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGICAL INTENSIVE CARE UNIT							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY	43. 00					0	13.00
14.00	Total (see instructions)			70	25, 550	0. 00	0	14.00
15.00	CAH visits						0	15.00
15. 10	REH hours and visits					0. 00	0	15. 10
16. 00	SUBPROVIDER - IPF							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	101 00					0	21.00
22. 00 23. 00	HOME HEALTH AGENCY	101. 00					U	22. 00 23. 00
24.00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE	116. 00		1	365			24.00
24. 00	HOSPICE (non-distinct part)	30.00		'	300	,		24. 00
25. 00	CMHC - CMHC	30.00						25.00
26. 00	RURAL HEALTH CLINIC							26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	
27. 00	Total (sum of lines 14-26)	211.22		71				27. 00
28. 00	Observation Bed Days						0	ł
29. 00	Ambul ance Trips							29.00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31.00
32.00	Labor & delivery days (see instructions)			0	C)		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	00.55			_]	_	33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care	30. 00		0	C)	0	34.00

Provider CCN: 15-0069

Peri od: Worksheet S-3 From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/22/2024 3:00 pm

Title XVIII							5/22/2024 3:0	0 pm
PART I - STATISTICAL DATA		·	I/P Days	/ O/P Visits	/ Trips	Full Time E		
PART I - STATISTICAL DATA			,		•		•	
PART I - STATISTICAL DATA								
PART I - STATISTICAL DATA		Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
PART I - STATISTICAL DATA								
PART I - STATISTICAL DATA 1.00			6.00	7 00				
1.00		PART I - STATISTICAL DATA	0.00	7.00	0.00	7. 00	10.00	
8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2	1 00		3 032	1 241	8 068			1 00
Hospice days)(šee instructions for col. 2	1.00		3,032	1, 271	0,000			1.00
For the portion of LDP room avail able beds) 2, 00								
2.00 HMO and other (see instructions) 2,839 251								
3.00	2 00		2 020	251				2.00
4. 00 HMO IRF Subprovider			· · ·					
5.00			-1	-				
6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 11.00 10.00 UNGRICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 INTENSIVE CARE UNIT 10.00 UNRSERY 10.10 OUTHER SPECIAL CARE (SPECIFY) 13.00 OTHER SPECIAL CARE (SPECIFY) 14.00 Total (see instructions) 15.00 CAH visits 10.00 OUTHER SPECIAL CARE (SPECIFY) 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 18.00 OUTHER LONG TERM CARE 19.00 OTHER LONG TERM CARE 20.00 OUTHER LONG TERM CARE 21.00 OUTHER LONG TERM CARE 22.00 OUTHER LONG TERM CARE 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.10 HOSPICE (non-distinct part) 25.00 CAH visit conditions of the provided of the			1 -1	J.				
7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 3,032 1,241 8,068 8.00 NTENSIVE CARE UNIT 495 323 1,603 8.00 NTENSIVE CARE UNIT 9,00 10.00 BURN INTENSIVE CARE UNIT 10.00			O O	J.				
Beds) (see instructions)				0				
8. 00 INTENSIVE CARE UNIT 495 323 1,603 8. 00 0	7.00		3, 032	1, 241	8, 068			7.00
9. 00 CORONARY CARE UNIT 10. 00 BURN INTENSIVE CARE UNIT 11. 00 SURGICAL INTENSIVE CARE UNIT 11. 00 OTHER SPECIAL CARE (SPECIFY) 11. 00 11. 00 TOTHER LORGER OF TOTHER SPECIAL CARE (SPECIFY) 11. 00 11. 00 TOTHER LORGER OF TOTHER SPECIAL CARE OF TOTHER SPECIAL SPECIAL CARE OF TOTHER SPECIAL C								
10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 1			495	323	1, 603			
11. 00 SURGI CAL INTENSIVE CARE (UNIT 12. 00 12. 00 17.								
12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 14. 00 Total (see instructions) 13. 00 CAH visits 0 0 0 0 0 0 0 0 15. 10. REH hours and visits 0 0 0 0 0 0 0 0 15. 10. REH hours and visits 15. 10 SUBPROVIDER - IPF 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 CMRAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instructions) 31. 00 Employee discount days - IRF 30. 00 Total (ancillary labor & delivery room outpatient days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)								
13. 00 NURSERY								
14. 00 Total (see instructions) 3,527 2,059 10,480 0.00 720.33 14,00 15. 00 CAH visits 0 0 0 0 15.00 15. 10 REH hours and visits 0 0 0 0 15.00 16. 00 SUBPROVI DER - IPF 18.00 15.10 16.00 17. 00 SUBPROVI DER - IRF 18.00 18.00 19.00 19. 00 SKI LLED NURSI NG FACI LITY 20.00 19.00 20.00 19.00 20. 00 NURSI NG FACI LITY 20.00 20.00 20.00 21. 00 OTHER LONG TERM CARE 21.00 20.00 20.00 22. 00 HOME HEALTH AGENCY 1,917 199 5,352 0.00 12.30 22.00 23. 00 HOSPI CE 84 0 89 0.00 2.97 24.00 24. 10 HOSPI CE (non-distinct part) 25.00 26.00 26.00 27.00 27.00 25. 00 CMHC - CMHC 26.00 26.00 0.00 0.00 735.60 27.00 26. 05 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.00 735.60 27.00 28. 00 Observati on Bed Days <td< td=""><td>12.00</td><td>OTHER SPECIAL CARE (SPECIFY)</td><td></td><td></td><td></td><td></td><td></td><td>12.00</td></td<>	12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
15. 00 CAH visits CAH vis	13.00	NURSERY		495	809	1		13.00
15. 10 REH hours and visits 0 0 0 0 0 15. 10 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 18. 00 SUBPROVIDER - IRF 18. 00 19. 00 SVILLED NURSING FACILITY 19. 00 10. 00 THER LONG TERM CARE 19. 00 10. 00 THER LONG	14.00	Total (see instructions)	3, 527	2, 059	10, 480	0.00	720. 33	14.00
16. 00 SUBPROVI DER - I PF 16. 00 17. 00 SUBPROVI DER - I RF 18. 00 SUBPROVI DER 18. 00 17. 00 18. 00 19. 00 SKILLED NURSING FACILITY 19. 00	15.00	CAH visits	0	0	C	1		15.00
17. 00 SUBPROVI DER - I RF 17. 00 18. 00 18. 00 19. 00 SUBPROVI DER 19. 00 SUBPROVI DER 19. 00 19. 00 SUBLED NURSI NG FACILITY 19. 00 20. 00 19. 00 20. 0	15. 10	REH hours and visits	o	0	l	1		15. 10
18.00 SUBPROVI DER 18.00 19.00 SKI LLED NURSI NG FACI LITY 19.00 20.00 NURSI NG FACI LITY 20.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 1,917 199 5,352 0.00 12.30 22.00 23.00 AMBULATORY SURGI CAL CENTER (D. P.) 23.00 24.00 HOSPI CE 84 0 89 0.00 2.97 24.00 24.10 HOSPI CE (non-distinct part) 25.00 CMHC - CMHC 26.00 26.25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0.00 0.00 26.25 27.00 Total (sum of lines 14-26) 28.00 29.00 Ambul ance Trips 1,543 29.00 20.00 30.00 Empl oyee discount days (see instruction) 31.00 Empl oyee discount days (see instructions) 0 63 104 32.01 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 0 0 0 0 0 0 0 0 32.01 0 0 0 0 0 0 0 0 0	16.00	SUBPROVI DER - I PF						16.00
18.00 SUBPROVI DER 18.00 19.00 SKI LLED NURSI NG FACI LITY 19.00 20.00 NURSI NG FACI LITY 20.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 1,917 199 5,352 0.00 12.30 22.00 23.00 AMBULATORY SURGI CAL CENTER (D. P.) 23.00 24.00 HOSPI CE 84 0 89 0.00 2.97 24.00 24.10 HOSPI CE (non-distinct part) 25.00 CMHC - CMHC 26.00 26.25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0.00 0.00 26.25 27.00 Total (sum of lines 14-26) 28.00 29.00 Ambul ance Trips 1,543 29.00 20.00 30.00 Empl oyee discount days (see instruction) 31.00 Empl oyee discount days (see instructions) 0 63 104 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 0 0 0 0 0 0 0 0 32.01 0 0 0 0 0 0 0 0 0	17.00	SUBPROVI DER - I RF						17.00
19.00 SKILLED NURSING FACILITY 20.00 NURSING FACILITY 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 27.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instructions) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)	18.00	SUBPROVI DER						18.00
20. 00 NURSING FACILITY 20. 00 21. 00 21. 00 21. 00 22. 00 22. 00 23. 00 40ME HEALTH AGENCY 1,917 199 5,352 0. 00 12. 30 22. 00 23. 00 40MBULATORY SURGICAL CENTER (D.P.) 84 0 89 0. 00 2. 97 24. 00 40SPICE (non-distinct part) 24. 10 40SPICE (non-distinct part) 24. 10 40SPICE (non-distinct part) 24. 10 25. 00 26. 00 26. 25 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0. 00 0. 00 26. 25 26. 25 27. 00 70tal (sum of lines 14-26) 28. 00 29.	19.00							19.00
21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 3.00 AMBULATORY SURGICAL CENTER (D. P.) 24.00 HOSPICE 44.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 21.00 22.00 23.00 24.10 25.00 84								
22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 4.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 27.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 31.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)								
23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE HOSPICE (non-distinct part) CMHC - CMHC C6.00 RURAL HEALTH CLINIC 26.00 RURAL (sum of lines 14-26) CDServation Bed Days C9.00 Ambulance Trips Cmpl oyee discount days (see instruction) Cmpl oyee discount days (see instructions) Cm			1 917	100	5 352	0.00	12 30	
24. 00 HOSPICE (non-distinct part)			1, 717	177	3, 332	0.00	12. 30	1
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 Total (sum of lines 14-26) 27. 00 Observation Bed Days 29. 00 Ambulance Trips 31. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 00 Ambulance Trips 32. 00 Ambulance Trips 33. 00 Ambulance Trips 34. 10 Ambulance Trips 35. 00 Ambulance Trips 36. 00 Ambulance Trips 37. 00 Ambulance Trips 38. 00 Ambulance Trips 38. 00 Ambulance Trips 39. 00 Ambulance Trips 30. 00 Ambula			9.4	0	90	0.00	2 07	
25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0.00 0.00 26. 25 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)			04	O	0,	0.00	2. 71	1
26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0.00 0.00 26.25 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)								
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0.00 0.00 26. 25 27. 00 Total (sum of lines 14-26) 0.00 735. 60 27. 00 28. 00 Observation Bed Days 517 2, 822 28. 00 29. 00 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 0 0 31. 00 1 Total ancillary labor & delivery room outpatient days (see instructions) 0 32. 01 32. 01 Observation Bed Days 517 2, 822 28. 00 28. 00 29. 00								
27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Total (sum of lines 14-26) 27.00 28.00 28.00 29.00 29.00 30.00 31.00 31.00 31.00 31.00 32.01 32.01				0	_	0.00	0.00	
28.00 Observation Bed Days 28.00 29.00 Ambulance Trips 1,543 29.00 30.00 Employee discount days (see instruction) 83 30.00 31.00 29.00 31.00 32.00 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 0 32.01 32.01 32.01 33.00			U	U	_			
29.00 Ambulance Trips				F47	0.000		/35.60	
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 30.00 31.00 31.00 32.00 32.01		,	4 540	517	2, 822			
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 31.00 63 104 32.00 32.01			1, 543					
32.00 Labor & delivery days (see instructions) 0 63 104 32.00 Total ancillary labor & delivery room outpatient days (see instructions) 0 63 104 32.01								
32.01 Total ancillary labor & delivery room outpatient days (see instructions)								
outpatient days (see instructions)			0	63				
	32. 01				[C			32. 01
33 00 TCH non-covered days								
	33.00	LTCH non-covered days	0					33.00
33.01 LTCH site neutral days and discharges 0 33.01			· · · · · · · · · · · · · · · · · · ·					
34.00 Temporary Expansi on COVID-19 PHE Acute Care 0 0 0 34.00	34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	[C			34.00

| Period: | Worksheet S-3 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0069

				To	12/31/2023	Date/Time Prep 5/22/2024 3:00	
		Full Time		Di sch	arges	3/22/2024 3.0	O DIII
		Equi val ents			9		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	846	362	2, 284	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2 00	for the portion of LDP room available beds) HMO and other (see instructions)			510	58		2. 00
2. 00 3. 00	HMO IPF Subprovider			510	0		3. 00
4. 00	HMO IRF Subprovider				0		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF				o o		5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
7.00	beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						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						13.00
14.00	Total (see instructions)	0.00	0	846	362	2, 284	14.00
15. 00	CAH visits						15.00
15. 10	REH hours and visits						15. 10
16. 00	SUBPROVIDER - IPF						16. 00
17. 00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20. 00 21. 00	NURSING FACILITY OTHER LONG TERM CARE						20. 00 21. 00
21.00	HOME HEALTH AGENCY	0.00					21.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	0.00					23. 00
24. 00	HOSPICE	0.00					24.00
24. 10	HOSPICE (non-distinct part)	0.00					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	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
00.6-	outpatient days (see instructions)			_			
	LTCH non-covered days			0			33.00
33. 01	LTCH site neutral days and discharges			0			33. 01
34. UU	Temporary Expansion COVID-19 PHE Acute Care	ı l		1			34.00

	Financial Systems		KINGS DAUGHTE				u of Form CMS-2	
HOSPI T	AL WAGE INDEX INFORMATION			Provi der C	F	eriod: from 01/01/2023 fo 12/31/2023		pared:
		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA							
1. 00	SALARIES Total salaries (see	200.00	64, 589, 154	523, 709	65, 112, 863	1, 530, 053. 00	42. 56	1.00
	instructions)							
2. 00	Non-physician anesthetist Part A		0	C	0	0.00	0. 00	2. 00
3. 00	Non-physician anesthetist Part		335, 407	C	335, 407	2, 686. 00	124. 87	3.00
4. 00	Physician-Part A - Administrative		31, 816	C	31, 816	218. 00	145. 94	4. 00
4. 01	Physicians - Part A - Teaching		0	C	1		0.00	
5. 00	Physician and Non Physician-Part B		3, 935, 484	C	3, 935, 484	13, 979. 00	281. 53	5.00
6. 00	Non-physician-Part B for hospital-based RHC and FQHC		0	C	C	0. 00	0.00	6. 00
7. 00	services Interns & residents (in an	21. 00	0	C	0	0. 00	0. 00	7. 00
7. 01	approved program) Contracted interns and residents (in an approved		0	C	C	0. 00	0.00	7. 01
8. 00	programs) Home office and/or related		0	C	O	0. 00	0. 00	8. 00
9. 00	organization personnel SNF	44.00	0	C	0	0.00	0. 00	9. 00
10. 00	Excluded area salaries (see instructions)		23, 012, 403	91, 614	23, 104, 017	464, 921. 00	49. 69	10.00
11 00	OTHER WAGES & RELATED COSTS		7 000 417	0	7 000 /17	40 F27 00	117 10	11 00
11. 00	Contract Labor: Direct Patient Care		7, 088, 617	C	7, 088, 617	60, 537. 00	117. 10	11.00
12. 00	Contract labor: Top level management and other		0	C	C	0. 00	0. 00	12.00
13. 00	management and administrative services Contract Labor: Physician-Part		4, 741, 618	C	4, 741, 618	24, 941. 00	190. 11	13.00
14. 00	A - Administrative Home office and/or related organization salaries and		0	C	0	0. 00	0. 00	14. 00
	wage-related costs							
14. 01 14. 02	Home office salaries Related organization salaries		2, 501, 898 0	C	2, 501, 898	45, 286. 00 0. 00	55. 25 0. 00	14. 01 14. 02
15. 00	Home office: Physician Part A		Ö	C		0.00	0. 00	
16 00	- Administrative Home office and Contract		0	C		0.00	0.00	16. 00
	Physicians Part A - Teaching							
16. 01	Home office Physicians Part A - Teaching		0	C		0.00	0.00	16. 01
16. 02	Home office contract Physicians Part A - Teaching		0	C	O	0. 00	0. 00	16. 02
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		9, 699, 126	C	9, 699, 126			17. 00
	instructions)		,, 5, 7, 120		7,377,120			
18. 00	Wage-related costs (other) (see instructions)							18. 00
19.00	Excluded areas		5, 738, 623	C	5, 738, 623			19.00 20.00
20. 00	Non-physician anesthetist Part A Non-physician anesthetist Part		78, 195	C	78, 195			20.00
	В							
22. 00	Physician Part A - Administrative		7, 365	C	7, 365			22. 00
22. 01	Physician Part A - Teaching		0 887, 760	C	0 887, 760			22. 01 23. 00
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		007, 700	C	0			24.00
25. 00	Interns & residents (in an		0	C	0			25. 00
25. 50	approved program) Home office wage-related (core)		502, 555	C	502, 555			25. 50
25. 51	Related organization		0	C	C			25. 51
25. 52	wage-related (core) Home office: Physician Part A		0	C	0			25. 52
	- Administrative -							
	wage-related (core)				I			I

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0069 Peri od: Worksheet S-3 From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/22/2024 3:00 pm Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Sal ari es Related to Reported ion of Sal ari es (col. 2 ± col. Salaries in (from Wkst. 3) col. 4 A-6) 1.00 2.00 3.00 4.00 5.00 6.00 25.53 Home office: Physicians Part A 0 25. 53 0 - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 1, 113, 132 -1, 113, 132 0 0.00 0. 00 26.00 27.00 Administrative & General 5.00 7, 281, 920 1, 636, 841 8, 918, 761 243, 841. 94 36. 58 27.00 28. 00 338, 898 338, 898 1, 544. 00 219. 49 28.00 Administrative & General under contract (see inst.) 29.00 Maintenance & Repairs 6.00 0.00 0.00 29.00 30.00 Operation of Plant 7.00 716, 627 0 716, 627 22, 715. 77 31. 55 30.00 Laundry & Linen Service 8.00 32, 458 32, 458 2, 100. 85 15. 45 31.00 31.00 0 32.00 Housekeepi ng 48, 068. 54 17. 80 9.00 855, 725 C 855, 725 32.00 33.00 Housekeeping under contract 219, 714 219, 714 10, 433. 68 21.06 33.00 (see instructions) 34.00 Dietary 10.00 895, 864 -573, 032 322, 832 16, 309. 04 19. 79 34.00 Dietary under contract (see 35.00 C 0.00 0.00 35.00 instructions) 36.00 Cafeteri a 11.00 0 573, 032 573, 032 28, 948. 00 19.80 36.00 37.00 Maintenance of Personnel 12.00 0.00 0.00 37.00 0 Nursing Administration 13, 098. 43 49. 91 38.00 38.00 13.00 653, 719 Ω 653, 719 39.00 Central Services and Supply 14.00 78, 524 0 78, 524 4, 860. 40 16. 16 39.00 1, 062, 054 24, 944. 46 40.00 Pharmacy 15.00 0 1,062,054 42.58 40.00 Medical Records & Medical Records Library 41.00 16.00 802, 514 0 802, 514 29, 769. 97 26. 96 41. 00 42.00 Social Service 17.00 0 0 0 0.00 0.00 42.00

0

0

0.00

0.00 43.00

18.00

43.00 Other General Service

HOSPI T	DSPITAL WAGE INDEX INFORMATION					Period: From 01/01/2023	Worksheet S-3 Part III	
					_	To 12/31/2023	Date/Time Pre 5/22/2024 3:0	
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Pai d Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		60, 876, 875	523, 709	61, 400, 584	1, 525, 365. 68	40. 25	1.00
	instructions)							
2.00	Excluded area salaries (see		23, 012, 403	91, 614	23, 104, 01	464, 921. 00	49. 69	2.00
	instructions)							
3.00	Subtotal salaries (line 1		37, 864, 472	432, 095	38, 296, 56	1, 060, 444. 68	36. 11	3.00
	minus line 2)							
4.00	Subtotal other wages & related		14, 332, 133	0	14, 332, 133	130, 764. 00	109. 60	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		10, 209, 046	0	10, 209, 046	0.00	26. 66	5.00
	(coo i not)	I		1		1		

62, 837, 746

14, 574, 858

432, 095

523, 709

1, 191, 208. 68

446, 635. 08

52. 75

32. 63

6.00

7.00

62, 405, 651

14, 051, 149

6. 00

7.00

(see inst.)
Total (sum of lines 3 thru 5)
Total overhead cost (see

instructions)

Health Financial Systems	KINGS DAUGHTERS HOSPITAL	In Lieu	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0069	Peri od: From 01/01/2023	Worksheet S-3 Part IV
		To 12/21/2022	Dato/Timo Propared:

	To 12/31/2023	Date/Time Pre 5/22/2024 3:0	
		Amount	O piii
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	1, 862, 166	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	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)	7, 063, 958	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	2, 100, 618	
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	179, 344	
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15. 00	'Workers' Compensation Insurance	288, 895	
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Noncumulative portion)		
	TAXES		
	FICA-Employers Portion Only	4, 907, 436	
18. 00	Medicare Taxes - Employers Portion Only	0	18.00
19. 00	Unempl oyment Insurance	8, 653	
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21.00
	instructions))		
22. 00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24. 00		16, 411, 070	24.00
25 02	Part B - Other than Core Related Cost		25 00
Z5. UU	OTHER WAGE RELATED COSTS (SPECIFY)	1	25. 00

Health Financial Systems	KINGS DAUGHTERS HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part V Date/Time Pre 5/22/2024 3:0	pared:
Cost Center Description		Contract Labor	Benefit Cost	
		1. 00	2. 00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identif	i cati on:			
1.00 Total facility's contract labor and benefit of	cost	7, 088, 617	16, 411, 070	1.00

		Labor		
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	7, 088, 617	16, 411, 070	1.00
2.00	Hospi tal	7, 088, 617	16, 411, 070	2.00
3.00	SUBPROVI DER - I PF			3.00
4.00	SUBPROVI DER - I RF			4.00
5.00	Subprovi der - (0ther)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospi tal -Based HHA	0	0	11.00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I			12.00
13.00	Hospi tal -Based Hospi ce	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 I			17.00
18. 00	Other	0	0	18.00

Heal th	Financial Systems	KINGS DAUGHTEI	RS HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOME H	EALTH AGENCY STATISTICAL DATA		Provi der C		eriod: rom 01/01/2023	Worksheet S-4	
			Component	CCN: 15-7141 To		Date/Time Pre 5/22/2024 3:0	
					Home Health	PPS	<u> </u>
					Agency I		
0. 00	County				1. JEFFERSON	00	0.00
0.00	County	Title V	Title XVIII	Title XIX	Other	Total	0.00
	HOME HEALTH AGENCY STATISTICAL DATA	1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	Home Health Aide Hours	0	255	0	416	671	1. 00
2.00	Unduplicated Census Count (see instructions)	0.00	177. 00	0.00 Number of Empl			2.00
				Number of Empr	oyees (ruii ii	me Equi vai ent)	
		Enter the number		Staff	Contract	Total	
		your normal	work week				
		0		1.00	2. 00	3. 00	
2 22	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						2 22
3. 00 4. 00	Administrator and Assistant Administrator(s) Director(s) and Assistant Director(s)		40. 00	0. 00 0. 00	0. 00 0. 00	l e	3. 00 4. 00
5.00	Other Administrative Personnel			5. 03	0.00	l e	5.00
6. 00 7. 00	Direct Nursing Service Nursing Supervisor			4. 57 0. 00	0. 00 0. 00	l	6. 00 7. 00
8.00	Physical Therapy Service			2. 80	0. 00	2. 80	8. 00
9. 00 10. 00	Physical Therapy Supervisor Occupational Therapy Service			0. 00 0. 69	0. 00 0. 00		9. 00 10. 00
11. 00	Occupational Therapy Supervisor			0.00	0. 00	0. 00	11. 00
12. 00 13. 00	Speech Pathology Service Speech Pathology Supervisor			0. 03 0. 00	0. 00 0. 00	l e	12. 00 13. 00
14.00	Medical Social Service			0.00	0. 00	0.00	14. 00
15. 00 16. 00	Medical Social Service Supervisor Home Health Aide			0. 00 0. 32	0. 00 0. 00	l	15. 00 16. 00
17. 00	Home Health Aide Supervisor			0.00	0. 00	0. 00	17. 00
18.00	Other (specify)			0.00	0. 00	0.00 CBSA Data	18. 00
	LIGHT HEALTH ACTION ORGA COREC					1. 00	
19. 00	HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where	you provided se	ervices during	the cost repor	ting period.	1	19. 00
20. 00	List those CBSA code(s) in column 1 serviced					99915	20. 00
	first code).	Full Ep	i sodes				
		Without Outliers	With Outliers	LUPA Epi sodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4. 00	5. 00	
21. 00	PPS ACTIVITY DATA Skilled Nursing Visits	778	24	14	0	816	21.00
22. 00	Skilled Nursing Visit Charges	217, 120	6, 720	3, 920	0	227, 760	22. 00
23. 00 24. 00	Physical Therapy Visits Physical Therapy Visit Charges	794 199, 465	41 10, 338	•	0		23. 00 24. 00
25. 00	Occupational Therapy Visits	191	25	0	0	216	25. 00
26. 00 27. 00	Occupational Therapy Visit Charges Speech Pathology Visits	53, 034	6, 950 7	0	0		
28. 00	Speech Pathology Visit Charges	2, 574	2, 002	0	0	1	28. 00
29. 00 30. 00	Medical Social Service Visits Medical Social Service Visit Charges	0	0	1	0	0	29. 00 30. 00
31.00	Home Health Aide Visits	23	7	0	0	30	31.00
32. 00 33. 00	Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27,	3, 795 1, 795	1, 155 104		0		32. 00 33. 00
	29, and 31)						
34. 00 35. 00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	0 475, 988	0 27, 165	-	0		34.00 35.00
	30, 32, and 34)		27, 103				
36. 00	Total Number of Episodes (standard/non outlier)	203		14	0	217	36. 00
37.00	Total Number of Outlier Episodes	_	6		0	•	37.00
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	1 0	38. 00

Health Financial Systems		KINGS DAUGHTE	ERS HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED HOSPICE IDENTIFICATION	N DATA		Provi der C	CN: 15-0069	Peri od:	Worksheet S-9	
					From 01/01/2023	PARTS I THROU	IGH IV
			Hospi ce CC	N: 15-1535	To 12/31/2023		
					Hospi ce I	5/22/2024 3:0	o pm
	Unduplicated				поѕргсе г		
	Days						
	Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
	II ti c xviii	TI CIC XIX	Skilled	Nursing	All Other	col s. 1, 2 &	
			Nursi ng	Facility		5)	
			Facility			-,	
	1. 00	2. 00	3.00	4.00	5. 00	6. 00	
PART I - ENROLLMENT DAYS FOR (OST REPORTING	PERIODS BEGINN	ING BEFORE OCT	OBER 1, 2015	<u> </u>		
1.00 Hospice Continuous Home Care							1.00
2.00 Hospice Routine Home Care							2.00
3.00 Hospice Inpatient Respite Care							3.00
4.00 Hospice General Inpatient Care							4.00
5.00 Total Hospice Days							5.00
Part II - CENSUS DATA FOR COST	REPORTING PER	ODS BEGINNING	BEFORE OCTOBE	R 1, 2015			
6.00 Number of patients receiving							6.00
hospi ce care							
7.00 Total number of unduplicated							7. 00
Continuous Care hours billable							
to Medicare	_						
8.00 Average Length of Stay (line	9						8. 00
/ line 6)							9.00
9.00 Unduplicated census count							9.00
NOTE: Parts I and II, columns 1 and	2 also include	the days repor	ted in columns	3 and 4.			
			Title XVIII	Title XIX	0ther	Total (sum of	
						col s. 1	
						through 3)	
			1.00	2.00	3. 00	4. 00	
PART III - ENROLLMENT DAYS FOR	COST REPORTIN	G PERIODS BEGI	NNING ON OR AF	TER OCTOBER 1			1
10.00 Hospice Continuous Home Care			0		0	_	10.00
11.00 Hospice Routine Home Care			2, 372	1	16 64		11.00
12.00 Hospice Inpatient Respite Care			13		0		12. 00
13.00 Hospice General Inpatient Care	9		71	1	0		13.00
14. 00 Total Hospice Days	5.74 505 55	OT DEBODTING -	2, 456		16 64		14.00
PART IV - CONTRACTED STATISTIC		SI REPORTING P					45.00
15.00 Hospice Inpatient Respite Card			0		0 0		
16.00 Hospice General Inpatient Care	=		0	1	0 0	0	16. 00

Heal th	Financial Systems KINGS DAUGHTERS HOS	SPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA Pro	ovider CCN: 1		Period: From 01/01/2023 To 12/31/2023	Worksheet S-1 Parts I & II Date/Time Pre 5/22/2024 3:0	pared:
					1.00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				1.00	
	Uncompensated and Indigent Care Cost-to-Charge Ratio					
1.00	Cost to charge ratio (see instructions)				0. 273489	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				22, 575, 057	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		M. di	-: -10	Y	3. 00 4. 00
4. 00 5. 00	If line 3 is yes, does line 2 include all DSH and/or supplementa If line 4 is no, then enter DSH and/or supplemental payments from	1 2	rom wearca	ai d?	γ ο	5.00
6. 00	Medicald charges	iii wedi cai d			69, 331, 874	
7. 00	Medicaid cost (line 1 times line 6)				18, 961, 505	
8. 00	Difference between net revenue and costs for Medicaid program (s	ee instructio	ons)		0	
	Children's Health Insurance Program (CHIP) (see instructions for	each line)	-			1
9.00	Net revenue from stand-alone CHIP				0	9. 00
	Stand-alone CHIP charges				0	
11.00						
12.00	Difference between net revenue and costs for stand-alone CHIP (s			1	0	12.00
13. 00	Other state or local government indigent care program (see instructions for each line) Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) O 1				13.00	
14. 00						
	10)					
15.00	State or local indigent care program cost (line 1 times line 14)				0	
16. 00	Difference between net revenue and costs for state or local indi- Grants, donations and total unreimbursed cost for Medicaid, CHIP				0	16. 00
	instructions for each line)	and State/IC	ocai illuiç	jent care progra	allis (See	
17.00	Private grants, donations, or endowment income restricted to fun	ding charity	care		0	17.00
18.00	Government grants, appropriations or transfers for support of ho				0	1
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local	indigent care	e programs	s (sum of lines	0	19. 00
	8, 12 and 16)	Ur	ni nsured	Insured	Total (col. 1	
			atients	pati ents	+ col . 2)	
			1. 00	2.00	3. 00	
	Uncompensated care cost (see instructions for each line)					
20.00	Charity care charges and uninsured discounts (see instructions)		4, 321, 32			
21. 00	Cost of patients approved for charity care and uninsured discoun	ts (see	1, 181, 83	4 377, 223	1, 559, 057	21.00
22. 00	instructions) Payments received from patients for amounts previously written o	ff as		0 0	0	22. 00
22.00	charity care	11 43			Ĭ	22.00
23. 00	Cost of charity care (see instructions)		1, 181, 83	4 377, 223	1, 559, 057	23. 00
0.4.00			Land the second	2 . 1 1	1. 00	04.65
24. 00	Does the amount on line 20 col. 2, include charges for patient d		rength of	stay limit	N	24.00
25. 00	imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the		re nrogran	n's Lenath of	0	25.00
_5.00	ctav limit	. Har gerre car	. o prograi	o rongtii oi	I	20.00

656, 836 7, 605, 080 155, 857

7, 365, 300

2, 098, 252

3, 657, 309

3, 657, 309 31.00

239, 780

26.00

27.00

27.01

28.00

29.00

30.00

stay limit

26.00 Bad debt amount (see instructions)

Charges for insured patients' liability (see instructions)

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

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

27.00 | Medicare reimbursable bad debts (see instructions)

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

27.01 Medicare allowable bad debts (see instructions)

Hool +h	Financial Systems KINGS DAUGHTERS H	OSDI TAI		India	u of Form CMS-2	DEE2 10	
			CN: 15-0069	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-1 Parts I & II	0 pared:	
					1. 00		
	PART II - HOSPITAL DATA						
4 00	Uncompensated and Indigent Care Cost-to-Charge Ratio				0.040004	4 00	
1. 00	Cost to charge ratio (see instructions) Medicaid (see instructions for each line)				0. 269231	1.00	
2. 00	Net revenue from Medicaid					2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?				•	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemen			cai d?		4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments f	rom Medicai	i d			5.00	
6. 00 7. 00	Medicaid charges Medicaid cost (line 1 times line 6)					6. 00 7. 00	
8. 00	Difference between net revenue and costs for Medicaid program	(see instr	uctions)			8.00	
	Children's Health Insurance Program (CHIP) (see instructions for						
9. 00	Net revenue from stand-alone CHIP					9. 00	
10.00	Stand-alone CHIP charges					10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP	(soo instri	uctions)			11. 00 12. 00	
12.00	Other state or local government indigent care program (see ins			÷)		12.00	
13.00							
14.00	Charges for patients covered under state or local indigent care	e program	(Not include	d in lines 6 or		14.00	
45.00	10) 00 State or local indigent care program cost (line 1 times line 14)						
15. 00 16. 00							
10.00	00 Difference between net revenue and costs for state or local indigent care program (see instructions) 16 Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see						
	instructions for each line)			g pg			
17. 00	Private grants, donations, or endowment income restricted to f					17. 00	
18. 00 19. 00	Government grants, appropriations or transfers for support of			(- !		18. 00 19. 00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)	i inaigent	care prograi	iis (Suiii 01 1111eS		19.00	
	10, 12 and 10)		Uni nsured	Insured	Total (col. 1		
			pati ents	pati ents	+ col . 2)		
	Uncompanyed and and cost (and instructions for each line)		1.00	2. 00	3. 00		
20. 00	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions)	4, 321, 3	21 854, 422	5, 175, 743	20.00	
21. 00	Cost of patients approved for charity care and uninsured disco		1, 163, 4			ı	
	instructions)						
22. 00	Payments received from patients for amounts previously written	off as		0 0	0	22. 00	
23. 00	charity care Cost of charity care (see instructions)		1, 163, 4	34 374, 427	1, 537, 861	23. 00	
23.00	cost of charity care (see thistructions)		1, 103, 4	34 374, 427	1, 557, 601	23.00	
					1. 00		
24. 00	Does the amount on line 20 col. 2, include charges for patient		nd a Length	of stay limit	N	24.00	
25. 00	imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond the stay limit		t care progra	am's length of	0	25. 00	
25. 01	Charges for insured patients' liability (see instructions)				656, 836	25. 01	
26. 00					7, 605, 080		
27. 00	Medicare reimbursable bad debts (see instructions)				155, 857	27. 00	
27. 01	Medicare allowable bad debts (see instructions)				239, 780		
28. 00 29. 00	Non-Medicare bad debt amount (see instructions)	ounts (ccc	instruction	-)	7, 365, 300		
30.00	Cost of non-Medicare and non-reimbursable Medicare bad debt am Cost of uncompensated care (line 23, col. 3, plus line 29)	builts (500	THEFT UCTION) 	2, 066, 890 3, 604, 751	30.00	
	Total unreimbursed and uncompensated care cost (line 19 plus li	ine 30)			3, 604, 751		
		,		!		'	

Health Financial Systems	KINGS DAUGHTER	S HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der CO		Peri od:	Worksheet A	
				From 01/01/2023 To 12/31/2023	Date/Time Pre	narod:
				10 12/31/2023	5/22/2024 3:0	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	Recl assi fi ed	•
			+ col . 2)	i ons (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT		12, 598, 773	12, 598, 773		12, 987, 520	1.00
1. 01 00101 NEW CAP REL COSTS-BLDG & FLXT HHA/HO		0	(1, 435	1, 435	1.01
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP		0	(0	2.00
3. 00 00300 OTHER CAPITAL RELATED COSTS	1 110 100	14 0/4 /04	1/ 077 01/	1 502 214	0	3.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	1, 113, 132	14, 964, 684	16, 077, 816		14, 574, 502	4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	7, 281, 920	17, 719, 253	25, 001, 173		25, 703, 899	5.00
7.00 00700 0PERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE	716, 627	3, 247, 093	3, 963, 720	1	3, 963, 647	7. 00 8. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	32, 458 855, 725	320, 079 436, 949	352, 53 1, 292, 67		352, 537 1, 292, 674	9.00
10. 00 01000 DI ETARY	895, 864	390, 460	1, 286, 32	1	463, 537	10.00
11. 00 01100 CAFETERI A	075, 004	370, 400	1, 200, 32	822, 787	822, 787	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	653, 719	909	654, 628		654, 628	1
14. 00 01400 CENTRAL SERVICES & SUPPLY	78, 524	478	79, 002		79, 002	14.00
15. 00 01500 PHARMACY	1, 062, 054	12, 019, 705	13, 081, 759	1	1, 390, 857	1
16. 00 01600 MEDICAL RECORDS & LIBRARY	802, 514	157, 758	960, 272		960, 272	16.00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0		335, 407	335, 407	19.00
23. 00 02300 RADI OLOGY SCHOOL	159, 157	6, 110	165, 26		166, 334	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS				,		
30. 00 03000 ADULTS & PEDIATRICS	7, 706, 498	3, 071, 554	10, 778, 052	2 -2, 248, 922	8, 529, 130	30.00
31.00 03100 INTENSIVE CARE UNIT	1, 077, 772	1, 292, 977	2, 370, 749		2, 361, 867	31.00
43. 00 04300 NURSERY	0	0		744, 594	744, 594	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	3, 205, 841	10, 987, 107	14, 192, 948	-7, 399, 688	6, 793, 260	50.00
51.00 05100 RECOVERY ROOM	512, 505	373, 432	885, 937	7 -25, 919	860, 018	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	(985, 468	985, 468	52.00
53. 00 05300 ANESTHESI OLOGY	1, 845, 142	2, 626, 672	4, 471, 814	4 -466, 729	4, 005, 085	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 483, 423	1, 036, 706	4, 520, 129	-28, 692	4, 491, 437	54.00
54.01 03630 ULTRA SOUND	133, 818	44, 423	178, 24	1 -2, 296	175, 945	54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	86, 200	222, 612	308, 812	-121, 007	187, 805	54.02
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0	(0	0	55.00
55. 01 03480 0NC0L0GY	1, 201, 645	1, 539, 198	2, 740, 843		2, 638, 399	55. 01
57.00 05700 CT SCAN	300, 444	403, 005	703, 449		686, 770	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	242, 034	130, 445	372, 479	-1, 200	371, 279	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59.00
60. 00 06000 LABORATORY	1, 620, 934	3, 863, 565	5, 484, 499		3, 469, 947	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	308, 961	308, 96		308, 961	62.00
65. 00 06500 RESPI RATORY THERAPY	899, 639	224, 411	1, 124, 050			
66. 00 06600 PHYSI CAL THERAPY	1, 477, 001	128, 178	1, 605, 179		1, 519, 726	1
67. 00 06700 OCCUPATI ONAL THERAPY	282, 176	7, 997	290, 173		287, 776	
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	186, 533	3, 862	190, 39		188, 281	
69. 00 06900 ELECTROCARDI OLOGY 69. 01 03610 SLEEP LAB	0 208, 792	0 144, 331	353, 123	0 3 -17, 833	0 335, 290	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	200, 792	144, 331		3, 884, 333	3, 884, 333	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATTENTS 71. 01 07101 IV SOLUTIONS		0	(3, 004, 333	3, 664, 333	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0		5, 057, 108	5, 057, 108	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0		13, 768, 877	13, 768, 877	73.00
76. 00 03140 CARDI OLOGY	568, 376	141, 524	709, 900		683, 475	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	85, 503	5, 881	91, 38			
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	00,000	0, 001	71,00) 1, 100	0	77. 00
78. 00 07800 CAR T-CELL I MMUNOTHERAPY	o	0	(0	78.00
OUTPATIENT SERVICE COST CENTERS	<u> </u>			<u> </u>		1
90. 00 09000 CLI NI C	82, 419	1, 801	84, 220	0	84, 220	90.00
90. 01 09001 WOUND CARE CLINIC	395, 233	126, 740				90. 01
91. 00 09100 EMERGENCY	2, 482, 286	5, 957, 433	8, 439, 719			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	1, 994, 382	215, 773	2, 210, 15	-64, 291	2, 145, 864	95.00
101.00 10100 HOME HEALTH AGENCY	1, 089, 916	90, 981	1, 180, 89	-38, 677	1, 142, 220	101.00
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	(0		102.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE		0	(0	0	113.00
116. 00 11600 HOSPI CE	114, 463	76, 703				
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 44, 934, 669	94, 888, 523	139, 823, 192	-433, 232	139, 389, 960	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	(0		190.00
194. 00 07950 OTHER NON-REI MBURSABLE	0	0	(이		194.00
194. 01 07951 MOB	2, 749, 871	373, 702	3, 123, 573		3, 123, 573	
194. 02 07952 PHYSI CI AN CLI NI CS	5, 893, 679	1, 420, 361	7, 314, 040		7, 321, 044	
194. 03 07953 PHYS PRAC BUS OFC	888, 611	6, 441	895, 052		1, 551, 280	
194. 04 07954 MOB - MAIN CAMPUS	350, 465	5, 250	355, 71	1	355, 715	
194. 05 07955 ONCOLOGY - NONREI MBURSABLE	0	0	(0	0	194. 05

Health Financial Systems	KINGS DAUGHTERS	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provi der Co		Period: From 01/01/2023	Worksheet A	
				To 12/31/2023		
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
			+ col . 2)	i ons (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1. 00	2.00	3. 00	4. 00	5. 00	
194.06 07956 KDH - MC FAMILY PRACTICE	3, 107, 794	180, 769	3, 288, 56	3 -140, 000	3, 148, 563	194. 06
194.07 07957 KDH - MC ORTHOPEDICS	2, 859, 325	516, 768	3, 376, 09	3 0	3, 376, 093	194. 07
194.08 07958 KDH - MC GENERAL SURGERY	1, 499, 086	113, 059	1, 612, 14	5 0	1, 612, 145	194. 08
194. 09 07959 KDH - MC ENT	717, 538	31, 709	749, 24	7 -75, 000	674, 247	194. 09
194. 10 07960 KDH - MC UROLOGY	107, 479	407, 355	514, 83	4 0	514, 834	194. 10
194.11 07961 KDH - MC OB/GYN	1, 480, 637	878, 926	2, 359, 56	-15, 000	2, 344, 563	194. 11
200.00 TOTAL (SUM OF LINES 118 through 199)	64, 589, 154	98, 822, 863	163, 412, 01	7 0	163, 412, 017	200. 00

Health Financial Systems KINGS DAUGRECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provi der CCN: 15-0069 Peri od: Worksheet A From 01/01/2023 To 12/31/2023 Date/Time Prepared:

			To 12/31/2023 Date/lime Pre 5/22/2024 3:0	
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6. 00	7. 00		
GENERAL SERVICE COST CENTERS				
1. 00 00100 NEW CAP REL COSTS-BLDG & FLXT	715, 754	13, 703, 274		1.00
1. 01 00101 NEW CAP REL COSTS-BLDG & FLXT HHA/HO	0	1, 435 0		1.01
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP 3. 00 00300 OTHER CAPITAL RELATED COSTS	0	0		2. 00 3. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	-1, 438, 432	13, 136, 070		4.00
5. 00 00500 ADMINISTRATIVE & GENERAL	1, 179, 441	26, 883, 340		5.00
7. 00 00700 OPERATION OF PLANT	0	3, 963, 647		7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE	0	352, 537		8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	0	1, 292, 674 463, 537		9. 00 10. 00
11. 00 01100 CAFETERI A	-327, 104	495, 683		11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	654, 628		13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	79, 002		14.00
15. 00 01500 PHARMACY	0	1, 390, 857		15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	-2, 206	958, 066		16.00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS 23. 00 02300 RADI OLOGY SCHOOL	-335, 407 -39, 425	0 126, 909		19. 00 23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	37, 423	120, 707		25.00
30. 00 03000 ADULTS & PEDIATRICS	-1, 362, 476	7, 166, 654		30.00
31.00 03100 INTENSIVE CARE UNIT	0	2, 361, 867		31.00
43. 00 04300 NURSERY	0	744, 594		43.00
ANCILLARY SERVICE COST CENTERS 50.00 O5000 OPERATING ROOM	O	6, 793, 260		50.00
51. 00 05100 RECOVERY ROOM	0	860, 018		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	985, 468		52.00
53. 00 05300 ANESTHESI OLOGY	-4, 005, 085	0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-2, 258, 761	2, 232, 676		54.00
54. 01 03630 ULTRA SOUND 54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	175, 945 187, 805		54. 01 54. 02
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	187, 803		55.00
55. 01 03480 ONCOLOGY	-754, 504	1, 883, 895		55. 01
57.00 05700 CT SCAN	0	686, 770		57.00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	371, 279		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	221 407	2 240 450		59.00
60.00 06000 LABORATORY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	-221, 497 0	3, 248, 450 308, 961		60. 00 62. 00
65. 00 06500 RESPIRATORY THERAPY	0	982, 572		65.00
66. 00 06600 PHYSI CAL THERAPY	0	1, 519, 726		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	287, 776		67.00
68. 00 06800 SPEECH PATHOLOGY	0	188, 281		68.00
69. 00 06900 ELECTROCARDI OLOGY 69. 01 03610 SLEEP LAB	0	335, 290		69. 00 69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3, 884, 333		71.00
71. 01 07101 I V SOLUTIONS	0	0		71. 01
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	5, 057, 108		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	13, 768, 877		73.00
76. 00 03140 CARDI OLOGY 76. 97 07697 CARDI AC REHABI LI TATI ON	0	683, 475 90, 218		76. 00 76. 97
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	90, 218		77.00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	O	Ö		78.00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0	84, 220		90.00
90. 01 09001 WOUND CARE CLINIC 91. 00 09100 EMERGENCY	-2, 144, 671	452, 567 5, 960, 850		90. 01 91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	-2, 144, 071	5, 900, 650		92.00
OTHER REIMBURSABLE COST CENTERS				72.00
95. 00 09500 AMBULANCE SERVICES	-250, 355	1, 895, 509		95.00
101.00 10100 HOME HEALTH AGENCY	0	1, 142, 220		101.00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0		102.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE	O	0		113. 00
116. 00 11600 H0SPI CE	0	302, 909		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-11, 244, 728	128, 145, 232		118.00
NONREI MBURSABLE COST CENTERS				
190. 00 19000 GLFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
194. 00 07950 OTHER NON-REI MBURSABLE 194. 01 07951 MOB	0	2 122 572		194. 00 194. 01
194.01 07951 MOB 194.02 07952 PHYSLCLAN CLINICS	0	3, 123, 573 7, 321, 044		194.01
194. 03 07953 PHYS PRAC BUS OFC	ol	1, 551, 280		194. 02
194.04 07954 MOB - MAIN CAMPUS	0	355, 715		194. 04
194. 05 07955 ONCOLOGY - NONREI MBURSABLE	0	0		194. 05
194.06 07956 KDH - MC FAMILY PRACTICE	0	3, 148, 563		194. 06

Heal th Financial Systems KINGS DAUGHTERS HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 15-0069 From 01/01/2023 To 12/31/2023 Date/Time Prepared:

			5/2	22/2024 3:00 pm
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For		
		Allocation		
	6. 00	7. 00		
194.07 07957 KDH - MC ORTHOPEDICS	0	3, 376, 093		194. 07
194.08 07958 KDH - MC GENERAL SURGERY	0	1, 612, 145		194. 08
194.09 07959 KDH - MC ENT	0	674, 247		194. 09
194.10 07960 KDH - MC UROLOGY	0	514, 834		194. 10
194.11 07961 KDH - MC OB/GYN	0	2, 344, 563		194. 11
200.00 TOTAL (SUM OF LINES 118 through 199)	-11, 244, 728	152, 167, 289		200. 00

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/22/2024 3:00 pm Provider CCN: 15-0069

					5/22/2024 3:00 pm
	Cost Center	Increases Line #	Sal ary	Other	
	2. 00	3.00	4. 00	5. 00	
	A - CAFETERIA				
1. 00	CAFETERI A	1100	57 <u>3, 0</u> 32	24 <u>9, 7</u> 55 249, 755	1.00
	B - MEDICAL IMAGING TIME		573, 032	249, 755	
1.00	RADI OLOGY SCHOOL	23. 00	1, 544	0	1.00
2.00	PHYSICIAN CLINICS	<u> </u>	17, 004	0	2.00
	C - DEPRECIATION		18, 548	0	
1. 00	NEW CAP REL COSTS-BLDG &	1. 01	0	1, 435	1.00
	FIXT_HHA/HO				
	O D - NURSERY- L&D		0	1, 435	
1. 00	NURSERY	43.00	503, 614	240, 980	1.00
2. 00	DELIVERY ROOM & LABOR ROOM	52. 00	666, 531	318, 937	2. 00
	0		1, 170, 145	559, 917	
1. 00	E - CRNA EXPENSE NONPHYSICIAN ANESTHETISTS	19. 00	335, 407	0	1.00
1.00	0	17.00	335, 407	0	1.00
	F - EMPLOYEE BENEFITS				
1.00	ADMINISTRATIVE & GENERAL	5. 00	240, 000	0	1.00
2. 00 3. 00		0. 00 0. 00	0	0	2. 00 3. 00
4. 00		0. 00	Ö	$ \frac{0}{0}$	4.00
	0		240, 000	0	
1. 00	G - PHYSICIAN BILLING AND COL PHYS PRAC BUS OFC	_LECTI ONS 194. 03	0	656, 228	1.00
1.00	0	194.03	0	65 <u>6, 228</u> 656, 228	1.00
	I - MED/SURG SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	3, 884, 333	1.00
2. 00	PATIENTS ADMINISTRATIVE & GENERAL	5. 00	o	37, 441	2. 00
3. 00	ADMINISTRATIVE & GENERAL	0. 00	o	0	3.00
4.00		0. 00	0	0	4. 00
5.00		0.00	0	0	5.00
6. 00 7. 00		0. 00 0. 00	0	0	6. 00 7. 00
8. 00		0.00	Ö	O	8.00
9. 00		0.00	0	0	9. 00
10. 00 11. 00		0. 00 0. 00	0	0	10. 00 11. 00
12.00		0.00	0	0	12.00
13. 00		0.00	Ö	Ö	13.00
14.00		0.00	0	0	14.00
15. 00 16. 00		0. 00 0. 00	0	0	15. 00 16. 00
17. 00		0.00	0	0	17. 00
18.00		0. 00	0	0	18. 00
19.00		0.00	0	0	19.00
20. 00 21. 00	•	0. 00 0. 00	0	0	20. 00 21. 00
22. 00		0.00	0	0	22.00
23.00		0. 00	0	0	23. 00
24. 00		0. 00 0. 00	0	0	24. 00 25. 00
25. 00				00 3,921,774	25.00
	J - IV SOLUTIONS		<u> </u>	0/ /2 // / /	
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	80, 849	1.00
2. 00 3. 00		0. 00 0. 00	0	0	2. 00 3. 00
4. 00		0.00	0	0	4.00
5. 00		0. 00	O	0	5. 00
6. 00		0. 00	0	0	6. 00
7. 00 8. 00		0. 00 0. 00	0	0	7. 00 8. 00
9. 00		0.00	0	0	9. 00
	0			80, 849	
4 00	K - IMPLANTS	70.00		5 057 100	1.00
1. 00	IMPL. DEV. CHARGED TO PATIENTS	72. 00	0	5, 057, 108	1.00
	0	+		5, 057, 108	
	L - DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73. 00 0. 00	0	13, 688, 028	1.00
2. 00 3. 00		0.00	0	0	2. 00 3. 00
	1	3.30	٦	<u> </u>	1 2.00

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

Peri od: From 01/01/2023 To 12/31/2023 Worksheet A-6 Date/Time Prepared: 5/22/2024 3:00 pm

Increases						5/22/2024 3: 00 pm
1.00			Increases			
4.00		Cost Center	Li ne #	Sal ary	Other	
5. 00 6. 00 6. 00 7. 00 6. 00 7. 00 8. 00 9. 00 10.		2. 00	3. 00	4. 00	5. 00	
6. 00 7. 00 8. 00 9. 00 9. 00 10. 00 10. 00 11. 00	4.00		0.00	0	0	4.00
7. 00 8. 00 9. 00 0. 00	5.00		0.00	0	0	5. 00
8. 00 9. 00 10. 00 0. 00 0. 00 0. 00 0. 00 11. 00 11. 00 11. 00 11. 00 0 0. 00	6.00		0.00	0	0	6.00
9. 00 10. 00 10. 00 10. 00 11. 00 11. 00 11. 00 11. 00 10. 00 0	7.00		0.00	0	0	7.00
10.00 11.00 0 0 0 0 0 0 0 0 0 11.00 0 0 0 13,688,028 M - INSURANCE 1.00 NEW CAP REL COSTS-BLDG & 1.00 0 390, 182 FIXT 0 0 390, 182 N - HOME HEALTH DIRECTOR 1.00 HOME HEALTH AGENCY 101.00 73,066 0 0 0 0 1.00 0 - HOSPICE 110.00 111,743 0 0 1.00 0 - P - VACATI ON 1.00 ADMI NI STRATI VE & GENERAL 5.00 1,113,132 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8.00		0.00	o	0	8.00
11.00	9.00		0.00	o	0	9.00
1.00 NEW CAP REL COSTS-BLDG & 1.00 0 390, 182 1.00 1.00 1.00	10.00		0.00	o	0	10.00
M - INSURANCE	11.00		0.00	o	0	11.00
1. 00		0 = = = = = =			13, 688, 028	
FIXT		M - INSURANCE				
1.00 HOME HEALTH DIRECTOR 1.00 73,066 0 0 0 0 0	1.00	NEW CAP REL COSTS-BLDG &	1.00	0	390, 182	1.00
N - HOME HEALTH DIRECTOR 1. 00 HOME HEALTH AGENCY 101.00 73,066 0 0 73,066 0 0 - HOSPICE 1. 00 HOSPICE 116.00 111,743 0 0 P - VACATION 1. 00 ADMINISTRATIVE & GENERAL 5.00 1,113,132 0 0 - NORTON INTERCOMPANY SALARY 1. 00 ADMINISTRATIVE & GENERAL 5.00 283,709 0 0 - 283,709 0 0 1. 00		FIXT				
1. 00 HOME HEALTH AGENCY 101. 00 73, 066 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0		0	390, 182	
Too		N - HOME HEALTH DIRECTOR				
0 - HOSPI CE 1. 00 HOSPI CE	1.00	HOME HEALTH AGENCY	1 <u>01.</u> 00	7 <u>3, 0</u> 66	0	1.00
1. 00 HOSPICE 116. 00 111, 743 0 0 1. 00 0 1. 11, 743 0 0 1. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0		73, 066	0	
Text		0 - HOSPICE				
P - VACATION 1. 00 ADMINISTRATIVE & GENERAL 5. 00 1, 113, 132 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.00	HOSPI CE	1 <u>16.</u> 00		0	1.00
1. 00 ADMI NI STRATI VE & GENERAL 5. 00 1, 113, 132 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0		111, 743	0	
0						
Q - NORTON INTERCOMPANY SALARY 1. 00 ADMINISTRATIVE & GENERAL 5. 00 283, 709 0 0 283, 709 0	1.00	ADMINISTRATIVE & GENERAL			0	1.00
1. 00 ADMI NI STRATI VE & GENERAL 5. 00 283, 709 0 1. 00 1. 00		0		1, 113, 132	0	
0 283, 709 0						
	1.00	ADMI NI STRATI VE & GENERAL			0	1.00
500.00 Grand Total: Increases 3, 918, 782 24, 605, 276 500.00		0			0	
	500.00	Grand Total: Increases		3, 918, 782	24, 605, 276	500.00

Health Financial Systems RECLASSIFICATIONS Provi der CCN: 15-0069

					11	o 12/31/2023 Date/lime P 5/22/2024 3	
		Decreases		•		,	
	Cost Center	Li ne #	Sal ary	Other 0.00	Wkst. A-7 Ref.		
	6. 00 A - CAFETERI A	7. 00	8. 00	9. 00	10.00		
1. 00	DI ETARY	10. 00	573, 032	249, 755	0		1.00
	0		573, 032	249, 755			155
	B - MEDICAL IMAGING TIME						
1.00	RADI OLOGY-DI AGNOSTI C	54. 00	18, 548	0	1		1.00
2. 00		0.00	0	0			2.00
	C - DEPRECIATION		18, 548	0			_
1. 00	NEW CAP REL COSTS-BLDG &	1. 00	ol	1, 435	9		1.00
1.00	FIXT	1.00	ď	1, 433			1.00
	0			1, 435			
	D - NURSERY- L&D						
1. 00	ADULTS & PEDIATRICS	30. 00	1, 170, 145	559, 917			1.00
2. 00		0.00	0	0	9		2. 00
	E - CRNA EXPENSE		1, 170, 145	559, 917			_
1. 00	ANESTHESI OLOGY	53. 00	335, 407	0	0		1.00
1.00	0		335, 407	0			1.00
	F - EMPLOYEE BENEFITS				· · · · · · · · · · · · · · · · · · ·		
1.00	PHYSICIAN CLINICS	194. 02	0	10, 000			1.00
2. 00	KDH - MC FAMILY PRACTICE	194. 06	0	140, 000	1		2. 00
3.00	KDH - MC ENT	194. 09	0	75, 000	1		3.00
4. 00	KDH - MC OB/GYN	194. 11		1 <u>5, 0</u> 00 240, 000			4. 00
	G - PHYSICIAN BILLING AND COL	LECTIONS	<u> </u>	240, 000			
1. 00	ADMI NI STRATI VE & GENERAL	5. 00	0	656, 228	0		1.00
	0 — — — — — —			656, 228			
	I - MED/SURG SUPPLIES						
1. 00	OPERATION OF PLANT	7. 00	0	73			1.00
2.00	PHARMACY	15. 00	0	31, 853	1		2.00
3. 00 4. 00	RADI OLOGY SCHOOL ADULTS & PEDI ATRI CS	23. 00 30. 00	0	477 499, 414	1		3. 00 4. 00
5. 00	INTENSIVE CARE UNIT	31. 00	0	8, 882	- 1		5.00
6. 00	OPERATING ROOM	50.00	Ö	2, 306, 267	1		6.00
7. 00	RECOVERY ROOM	51.00	o	25, 110	1		7. 00
8.00	ANESTHESI OLOGY	53. 00	O	98, 068	0		8.00
9. 00	RADI OLOGY-DI AGNOSTI C	54. 00	0	7, 311	1		9. 00
10.00	ULTRA SOUND	54. 01	0	2, 032	1		10.00
11. 00	NUCLEAR MEDICINE - DIAGNOSTIC	54. 02	O	120, 872	0		11.00
12. 00	ONCOLOGY	55. 01	0	99. 386	0		12.00
13. 00	CT SCAN	57. 00	o	16, 679	1		13.00
14.00	MAGNETIC RESONANCE IMAGING	58. 00	o	1, 200	1		14.00
	(MRI)						
15. 00	LABORATORY	60.00	0	130, 776			15.00
16.00	RESPIRATORY THERAPY	65. 00	0	84, 842			16.00
17. 00 18. 00	PHYSICAL THERAPY OCCUPATIONAL THERAPY	66. 00 67. 00	0	7, 395 2, 397			17. 00 18. 00
19. 00	SPEECH PATHOLOGY	68. 00	Ö	2, 114			19.00
20.00	SLEEP LAB	69. 01	o	17, 833			20.00
21.00	CARDI OLOGY	76. 00	o	26, 425	0		21.00
22. 00	CARDI AC REHABI LI TATI ON	76. 97	0	1, 166	1		22.00
23.00	WOUND CARE CLINIC	90. 01	0	64, 555			23.00
24. 00 25. 00	EMERGENCY AMBULANCE SERVICES	91. 00 95. 00	0	317, 861	1		24. 00 25. 00
23.00	O SERVICES	95.00		4 <u>8, 7</u> 86 3, 921, 774			25.00
	J - IV SOLUTIONS		٥	5, 721, 774			
1.00	PHARMACY	15. 00	0	3, 235	0		1.00
2.00	ADULTS & PEDIATRICS	30. 00	O	19, 446			2. 00
3. 00	OPERATING ROOM	50. 00	O	36, 313	1		3.00
4.00	RECOVERY ROOM	51. 00	0	809	1		4.00
5. 00 6. 00	RADI OLOGY-DI AGNOSTI C ONCOLOGY	54. 00 55. 01	O	138 3, 058	1		5. 00 6. 00
7. 00	RESPI RATORY THERAPY	65. 00	0	3, 058	1		7.00
8. 00	EMERGENCY	91. 00	ol	16, 337	1		8.00
9. 00	AMBULANCE SERVI CES	95. 00	0		1		9. 00
	0 — — — — —		0	80, 849			
	K - IMPLANTS				,		
1. 00	OPERATI NG ROOM	50.00	0_	<u>5, 057, 108</u>			1.00
	U DRIICS		0	5, 057, 108	1		_
1. 00	L - DRUGS ADMINISTRATIVE & GENERAL	5. 00	0	31, 619	0		1.00
2. 00	PHARMACY	15. 00	o	11, 655, 814			2.00
3. 00	ANESTHESI OLOGY	53. 00	o	33, 254	1		3. 00

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

Peri od: Worksheet A-6 From 01/01/2023 To 12/31/2023 Date/Time Prepared:

							5/22/2024 3: OO pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
4.00	RADI OLOGY-DI AGNOSTI C	54.00	0	2, 695	0		4.00
5.00	ULTRA SOUND	54. 01	0	264	0		5.00
6. 00	NUCLEAR MEDICINE - DIAGNOSTIC	54. 02	0	135	0		6.00
7.00	LABORATORY	60.00	O	1, 883, 776	0		7. 00
8.00	RESPI RATORY THERAPY	65. 00	O	55, 968	0		8.00
9.00	PHYSI CAL THERAPY	66. 00	O	4, 992	0		9. 00
10.00	WOUND CARE CLINIC	90. 01	O	4, 851	0		10.00
11.00	AMBULANCE SERVICES	95.00	O	14, 660	0		11.00
	0 = = = = =			13, 688, 028			
	M - INSURANCE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	390, 182	12		1.00
	0 = = = = =			390, 182			
	N - HOME HEALTH DIRECTOR		<u> </u>				
1.00	PHYSI CAL THERAPY	66. 00	73, 066	0	0		1.00
	0 — — — — —		73, 066			1	
	0 - HOSPI CE						
1.00	HOME HEALTH AGENCY	101. 00	111, 743	0	0		1.00
	0 — — — — —	- $ +$	111, 743			1	
	P - VACATION						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	1, 113, 132	0	0)	1.00
	0 — — — — —		1, 113, 132	_		1	
	Q - NORTON INTERCOMPANY SALAF	RY					
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	283, 709	0)	1.00
			— — o	283, 709		1	
500.00	Grand Total: Decreases		3, 395, 073	25, 128, 985		1	500.00
	1	'			1	1	1

Provider CCN: 15-0069

					To 12/31/2023	Date/Time Pre	
				A ! +!	,	5/22/2024 3:0	U pm
		B	D	Acqui si ti ons		D:	
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances	0.00	2.00	4.00	Retirements	
	DART I ANALYCIC OF CHANGES IN CARLTAL ACCE	1.00	2. 00	3. 00	4. 00	5. 00	
4 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE					17.00/	
1.00	Land	5, 309, 781	0		0	17, 906	1
2. 00	Land Improvements	0	0		0	0	2.00
3.00	Buildings and Fixtures	84, 433, 611	491, 475		0 491, 475	0	3.00
4. 00	Building Improvements	0	0		0 0	0	4. 00
5.00	Fixed Equipment	0	0		0	0	5.00
6. 00	Movable Equipment	10, 607, 814	7, 241, 277		0 7, 241, 277	0	6.00
7. 00	HIT designated Assets	0	0		0	0	7.00
8.00	Subtotal (sum of lines 1-7)	100, 351, 206	7, 732, 752		0 7, 732, 752	17, 906	8.00
9.00	Reconciling Items	0	0		0 0	0	9. 00
10.00	Total (line 8 minus line 9)	100, 351, 206	7, 732, 752		0 7, 732, 752	17, 906	10.00
		Endi ng	Ful I y				
		Bal ance	Depreciated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	5, 291, 875	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	84, 925, 086	0				3.00
4.00	Building Improvements	o	0				4.00
5.00	Fixed Equipment	o	o				5.00
6.00	Movable Equipment	17, 849, 091	o				6.00
7. 00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	108, 066, 052	0				8.00
9. 00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	108, 066, 052	0				10.00
. 5. 66	1.000 (1.1.00)		٩	l			

Health Financial Systems	KINGS DAUGHTE	RS HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der CO		Peri od:	Worksheet A-7	
				From 01/01/2023 To 12/31/2023		narod:
				10 12/31/2023	5/22/2024 3:0	0 pm
		SU	JMMARY OF CAPI	TAL		
0	D				T /	
Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
				(see instructions)	instructions)	
	9, 00	10. 00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2	12.00	10.00	
1.00 NEW CAP REL COSTS-BLDG & FLXT	10, 900, 470	9, 104	1, 677, 85	5 0	11, 344	1.00
1.01 NEW CAP REL COSTS-BLDG & FLXT HHA/HO	0	0		0 0	0	1. 01
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0		0	0	2.00
3.00 Total (sum of lines 1-2)	10, 900, 470		1, 677, 85	5 0	11, 344	3.00
	SUMMARY O	F CAPITAL				
Cook Cooker Books at the	0+1	T-+-1 (1)				
Cost Center Description	Other Capi tal -Relat	Total (1)				
	ed Costs (see					
	instructions)	7 till ough 14)				
	14. 00	15. 00				
PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2			
1.00 NEW CAP REL COSTS-BLDG & FLXT	0	12, 598, 773				1.00

	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, CULUWIN	ız, LINES I a	nu z	
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	12, 598, 773		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	12, 598, 773		3.00

Provider CCN: 15-0069	Heal th	Financial Systems	KINGS DAUGHTE	RS HOSPITAL		In Lie	u of Form CMS-2	2552-10
Cost Center Description	RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		From 01/01/2023 To 12/31/2023	Part III Date/Time Prep 5/22/2024 3:00	pared:
Leases For Ratio (col. 1 - col. 2)			COMF	PUTATION OF RA	TI 0S	ALLOCATION OF	OTHER CAPITAL	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 90, 216, 961 0 90, 216, 961 0.834832 0 1.00		Cost Center Description	Gross Assets		for Ratio (col. 1 -		Insurance	
1.00			1. 00	2. 00	3.00	4. 00	5. 00	
1. 01								
2. 00 NEW CAP REL COSTS-MVBLE EQUIP 17,849,091 0 17,849,091 0 108,066,052 1.000000 0 3.00	1.00		90, 216, 961	0	90, 216, 96	0. 834832	0	1.00
Total (sum of lines 1-2) 108,066,052 0 108,066,052 1.000000 0 3.00			_	0	l .			
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL	2.00	NEW CAP REL COSTS-MVBLE EQUIP	17, 849, 091	0	17, 849, 09			2.00
Cost Center Description	3.00	Total (sum of lines 1-2)						3.00
Capital - Rel at ed Costs Cost Cost Capital - Reconciliation of Capital Costs Capital - Reconciliation of Capital Costs			ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY 0	F CAPITAL	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS		Cost Center Description			,	Depreciation	Lease	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS								
PART - RECONCILIATION OF CAPITAL COSTS CENTERS			6.00			0.00	10.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 0 10,899,035 -16,372 1.00		PART III - RECONCILIATION OF CAPITAL COSTS C		7.00	0.00	7.00	10.00	
1. 01 NEW CAP REL COSTS-BLDG & FIXT HHA/HO	1 00			0		10 899 035	-16 372	1 00
2.00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 0 0 0 0 2.00			0	0		· · · · ·		
Total (sum of lines 1-2)			0	0		1	1 - 1	
Cost Center Description			0	0		10 900 470	١	
Cost Center Description Interest Insurance (see instructions) Instructions Instructions Interest Insurance (see instructions) Interest Interest Insurance (see instructions) Interest	0.00	Total (Sam of Titles 1 2)		SI	IMMARY OF CAPI		10, 072	0.00
Capital - Related Costs (see instructions) Capital - Related Costs (see instructions) Capital - Related Costs (see instructions) PART III - RECONCILIATION OF CAPITAL COSTS CENTERS								
instructions ed Costs (see instructions 11.00 12.00 13.00 14.00 15.00		Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
instructions ed Costs (see instructions 11.00 12.00 13.00 14.00 15.00		·		(see	instructions)	Capi tal -Rel at	(sum of cols.	
11.00 12.00 13.00 14.00 15.00				instructions)				
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 1. 00 NEW CAP REL COSTS-BLDG & FIXT 1. 01 NEW CAP REL COSTS-BLDG & FIXT 1. 01 NEW CAP REL COSTS-BLDG & FIXT HHA/HO 0 0 0 0 1. 435 1. 01 2. 00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						instructions)		
1. 00 NEW CAP REL COSTS-BLDG & FIXT 1, 311, 585 390, 182 11, 344 1, 107, 500 13, 703, 274 1. 00 1. 01 NEW CAP REL COSTS-BLDG & FIXT HHA/HO 0 0 0 0 1, 435 1. 01 2. 00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 0 0 0 0 2. 00			11. 00	12. 00	13.00	14.00	15. 00	
1.01 NEW CAP REL COSTS-BLDG & FIXT HHA/HO 0 0 0 0 1,435 1.01 2.00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 0 0 0 2.00								
2.00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0 2.00			1, 311, 585	390, 182	11, 34	4 1, 107, 500		
			0	0	1			
3.00 Total (sum of Lines 1-2) 1.311.585 300.182 11.344 1.107.500 13.704.700 3.00			0	0		٠	1 - 1	
3. 00 10tal (3diii 01 111les 1-2) 1,311,303 370,102 11,344 1,107,300 13,704,707 3.00	3.00	Total (sum of lines 1-2)	1, 311, 585	390, 182	11, 34	4 1, 107, 500	13, 704, 709	3.00

From 01/01/2023 12/31/2023 Date/Time Prepared: 5/22/2024 3:00 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Cost Center Description Amount Wkst. A-7 (2) Ref. 1.00 2.00 3.00 4.00 5.00 1.00 Investment income - NEW CAP -366, 270 NEW CAP REL COSTS-BLDG & 1.00 11 1.00 REL COSTS-BLDG & FLXT (chapter lfi xt 1.01 Investment income - NEW CAP ONEW CAP REL COSTS-BLDG & 1.01 O 1.01 REL COSTS-BLDG & FIXT HHA/HO FIXT HHA/HO (chapter 2) 2.00 Investment income - NEW CAP ONEW CAP REL COSTS-MVBLE 2.00 2.00 REL COSTS-MVBLE EQUIP (chapter FOUL P 3.00 Investment income - other 0 0.00 O 3.00 (chapter 2) 4.00 Trade, quantity, and time 0.00 4.00 discounts (chapter 8) 5 00 Refunds and rebates of 0 00 5.00 expenses (chapter 8) 6.00 Rental of provider space by -25,476 NEW CAP REL COSTS-BLDG & 1.00 10 6.00 В suppliers (chapter 8) FLXT 7.00 Tel ephone services (pay -4, 078 ADMINISTRATIVE & GENERAL 7.00 5.00 Α stations excluded) (chapter 8.00 Tel evi si on and radi o servi ce Α -18, 740 ADMINISTRATIVE & GENERAL 5.00 8.00 (chapter 21) 9 00 Parking lot (chapter 21) 0.00 9.00 10.00 Provi der-based physici an -9, 977, 309 A-8-2 0 10.00 adj ustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 0 (chapter 23) 12.00 Related organization A-8-1 9, 971, 158 12.00 transactions (chapter 10) 13 00 Laundry and linen service 0 00 0 13 00 Cafeteria-employees and guests -327, 104 CAFETERI A 11.00 14.00 14.00 В 15.00 Rental of quarters to employee 0.00 15.00 and others Sale of medical and surgical 16,00 16.00 0 0.00 supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 17.00 0 pati ents 18.00 Sale of medical records and В -2. 206 MEDI CAL RECORDS & LI BRARY 16.00 18 00 abstracts Nursing and allied health 0 0.00 19.00 education (tuition, fees, books. etc.) 20 00 Vending machines 0.000 20.00 21.00 Income from imposition of 0.00 21.00 interest, finance or penalty charges (chapter 21) Interest expense on Medicare 22.00 0 22.00 0.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory ORESPIRATORY THERAPY 65.00 23.00 A-8-3 therapy costs in excess of limitation (chapter 14) Adjustment for physical OPHYSICAL THERAPY 24.00 A - 8 - 366,00 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) Depreciation - NEW CAP REL ONEW CAP REL COSTS-BLDG & 26.00 1.00 26.00 COSTS-BLDG & FLXT FLXT Depreciation - NEW CAP REL ONEW CAP REL COSTS-BLDG & 26.01 1.01 26.01 COSTS-BLDG & FLXT HHA/HO FIXT HHA/HO Depreciation - NEW CAP REL ONEW CAP REL COSTS-MVBLE 27 00 27 00 2 00 COSTS-MVBLE EQUIP FOUL P 28.00 Non-physician Anesthetist -335, 407 NONPHYSI CI AN ANESTHETI STS 19.00 28.00 29.00 Physicians' assistant -612, 576 ADULTS & PEDIATRICS 30.00 29.00

Heal th	Financial Systems		KINGS DAUGHTE	RS HOSPITAL	In Lie	u of Form CMS-:	2552-10
	MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					rom 01/01/2023		
				1	o 12/31/2023	Date/Time Pre 5/22/2024 3:0	
				Expense Classification on	Workshoot A	3/22/2024 3.0	lill Dill
				To/From Which the Amount is			
				TO THE SILL SILL SILL THIS GIVE TO	to bo haj dotod		
		D			"		
	Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2)	2. 00	3.00	4. 00	Ref. 5.00	
20.00	Adjustment for occupational	A-8-3		OCCUPATI ONAL THERAPY	4.00		30.00
30.00	therapy costs in excess of	A-0-3	0	CCCUPATIONAL THERAPT	07.00		30.00
	limitation (chapter 14)						
30. 99			0	ADULTS & PEDIATRICS	30.00		30. 99
	instructions)						
31.00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
	pathology costs in excess of						
	limitation (chapter 14)						
32.00	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		00.00
33. 01	AMBULANCE REVENUE	В		AMBULANCE SERVICES	95. 00		33. 01
33. 02 33. 03	ADVERTI SI NG SELF-I NSURANCE	A A	•	ADMINISTRATIVE & GENERAL EMPLOYEE BENEFITS DEPARTMENT	5. 00 4. 00	0	33. 02 33. 03
33. 04	HOSPITAL ASSOCIATION FEES	A	•	ADMINISTRATIVE & GENERAL	5. 00	1 0	
33. 04	HAF MEDICALD	A	•	ADMINISTRATIVE & GENERAL	5. 00		33.04
33. 06	PHYSI CLAN RECRUI TMENT	Ä	•	ADMINISTRATIVE & GENERAL	5. 00		
33. 07	PHYSICIAN LAB SALARY OFFSET	Ä	•	LABORATORY	60.00		
33. 08	PHYSICIAN LAB BENEFIT OFFSET	A	•	EMPLOYEE BENEFITS DEPARTMENT			
33. 09	CRNA BENEFIT OFFSET	A		EMPLOYEE BENEFITS DEPARTMENT			
33. 10	PA BENEFIT OFFSET	A	•	EMPLOYEE BENEFITS DEPARTMENT		0	33. 10
33. 11	DONATI ONS	A	-18, 288	ADMINISTRATIVE & GENERAL	5. 00	0	33. 11
33. 12	MISC REVENUE MGMT FEES	В	553, 993	ADMINISTRATIVE & GENERAL	5. 00	0	33. 12

-11, 244, 728

50.00

50.00 TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A, column 6, line 200.)

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

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

B. Amount Received - if cost cannot be determined.

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

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

Heal th	Financial Systems	KINGS DAUGHT	ERS HOSPITAL	In Lieu of Form CMS-2552-10		
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO		Period: From 01/01/2023	Worksheet A-8	3-1
OFFICE	COSTS			To 12/31/2023		
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED (ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:					
1.00	1.00	NEW CAP REL COSTS-BLDG & FIX	CAPITAL RELATED COSTS - BLD	296, 146	0	1.00
2.00	1.00	NEW CAP REL COSTS-BLDG & FIX	CAPITAL RELATED COSTS - MME	811, 354	0	2.00
3.00	5. 00	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE AND GENERAL	8, 863, 658	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			9, 971, 158	0	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					

The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

			Related Organization(s) and/or Home Office					
Symbol (1)	Name	Percentage of	Name	Percentage of				
		Ownershi p		Ownershi p				
1. 00	2. 00	3.00	4. 00	5. 00				
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:								

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6. 00 B	O. OO NORTON HEALTHCA	100.00	6. 00
7. 00	0.00	0.00	7. 00
8. 00	0.00	0.00	8. 00
9. 00	0.00	0.00	9. 00
10. 00	0.00	0.00	10.00
100.00 G. Other (financial or			100.00
non-financial) specify:			

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider. B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related
- E. Individual is director, officer, administrator, or key person of provider and related organization.

 F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

line 12.

Heal th	Financial Syste	ems	KINGS DAUGHTERS HOSPITAL			In Lieu of Form CMS-2552-					
		SERVICES FROM	RELATED ORGANI	ZATI ONS	AND HOME	Provi der	CCN:	15-0069	Peri od:	Worksheet	A-8-1
OFFICE	COSTS								From 01/01/2023 To 12/31/2023	Date/Time	Droporodi
									10 12/31/2023	5/22/2024	
	Net	Wkst. A-7 Ref.				•					
	Adjustments										
	(col. 4 minus										
	col. 5)*										
	6. 00	7. 00									
	A. COSTS INCURI	RED AND ADJUST	MENTS REQUIRED	AS A RES	SULT OF TR	ANSACTI ONS	S WITH	RELATED	ORGANI ZATI ONS OR	CLAIMED HON	1E
	OFFICE COSTS:										
1.00	296, 146	14									1.00
2.00	811, 354	14									2.00
3.00	8, 863, 658	0									3. 00
4.00	0	0									4.00
5.00	9, 971, 158										5. 00
* The	amounts on line	es 1-4 (and sul	bscripts as app	ropri ate	e) are tran	nsferred i	n det	ail to Wo	rksheet A, column	6, lines a	 S
appropr	iate. Positive a	amounts increas	se cost and neg	ative am	nounts decr	ease cost	. For	related o	rganization or ho	me office c	ost which
has not	been posted to	o Worksheet A,	columns 1 and/	or 2, th	ne amount a	allowable	shoul	d be indi	cated in column 4	of this pa	rt.
	Related Orga	ni zati on(s)									
	and/or Ho	me Office									
	Type of	Busi ness									

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	HOME OFFICE		6. 00
7.00			7.00
8.00			8.00
8. 00 9. 00			9.00
10.00			10.00
10. 00 100. 00		1	100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

6. 00

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.

 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in

PROVI DER BASED PHYSI CI AN ADJUSTMENT

Provi der CCN: 15-0069

Peri od: Worksheet A-8-2 From 01/01/2023 To 12/31/2023 Date/Time Prepared:

5/22/2024 3:00 pm Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov I denti fi er ider Component Remuneration Component Component Hours 1.00 2.00 4.00 3 00 5 00 6 00 7 00 5. 00 ADMI NI STRATI VE & GENERAL 1.00 12, 953 12, 953 211,500 26 1.00 2.00 30.00 ADULTS & PEDIATRICS 749, 900 749, 900 211, 500 0 2.00 53. 00 ANESTHESI OLOGY 3.00 4, 013, 947 4,000,579 13.368 239, 400 77 3.00 54. 00 RADI OLOGY-DI AGNOSTI C 2, 258, 761 271, 900 4 00 4 00 2, 258, 761 0 Ω 55. 01 ONCOLOGY 5.00 754, 504 754, 504 n 211, 500 0 5.00 6.00 60. 00 LABORATORY 150,000 150,000 260, 300 767 6.00 10, 383 7.00 69. 01 SLEEP LAB 10, 383 211, 500 111 7.00 91. OO EMERGENCY 8.00 4, 602, 748 4, 591, 618 11, 130 211, 500 24.174 8.00 9.00 95. 00 AMBULANCE SERVICES 980 980 211, 500 9.00 10.00 0.00 10.00 12, 554, 176 4, 779, 302 7.774.874 25, 164 200.00 200.00 Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Provi der Physician Cost Cost of I denti fi er Li mi t Unadjusted RCE Memberships & Component of Malpractice 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 5. OO ADMINISTRATIVE & GENERAL 1.00 2,644 132 0 1.00 2.00 30. 00 ADULTS & PEDIATRICS 0 0 0 2.00 53. 00 ANESTHESI OLOGY 3.00 0 0 3.00 8.862 443 0 0 0 54. 00 RADI OLOGY-DI AGNOSTI C 4 00 0 4 00 5.00 55. 01 ONCOLOGY 0 0 0 5.00 60. 00 LABORATORY 0 6.00 95, 986 4, 799 0 0 0 0 6.00 69. 01 SLEEP LAB 0 0 7 00 11, 287 7.00 564 91. 00 EMERGENCY 0 8.00 2, 458, 077 122, 904 0 8.00 9.00 95. 00 AMBULANCE SERVICES 915 0 9.00 46 0 10.00 0.00 0 0 0 10.00 2, 577, 771 o 200.00 128, 888 200.00 Wkst. A Line # Cost Center/Physician Provi der Adjusted RCE RCE Adjustment I denti fi er Component Li mi t Di sal I owance Share of col. 14 2.00 1.00 16.00 17.00 18.00 15.00 1.00 5. 00 ADMINISTRATIVE & GENERAL 0 2,644 10, 309 10, 309 1.00 30. 00 ADULTS & PEDIATRICS 749, 900 2.00 0 2.00 0 3.00 53. OO ANESTHESI OLOGY 8.862 4, 005, 085 3.00 4 506 2, 258, 761 54. 00 RADI OLOGY-DI AGNOSTI C 4.00 0 4.00 5.00 55. 01 ONCOLOGY 0 0 754, 504 5.00 6.00 60. 00 LABORATORY 0 95, 986 54,014 54,014 6.00 69. 01 SLEEP LAB 0 7 00 11 287 7 00 91. 00 EMERGENCY 0 8.00 2, 458, 077 2, 133, 541 2, 144, 671 8.00 9.00 95. 00 AMBULANCE SERVICES 915 9.00 0 10.00 0.00 10.00 0 9, 977, 309 2, 577, 771 2, 202, 435 200.00 200.00

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

				10	12/31/2023	Date/lime Pre 5/22/2024 3:0	
			CAP	TAL RELATED CO	STS	,	
	Cook Cooker Doored at lon	Nat Francisco	NEW DLDC 0	NEW DLDC 0	NEW ANIDLE	EMPL OVEE	
	Cost Center Description	Net Expenses for Cost	NEW BLDG & FLXT	NEW BLDG & FIXT HHA/HO	NEW MVBLE EQUIP	EMPLOYEE BENEFITS	
		Allocation	TIXI	TTXT TIHA/TIO	EQUIT	DEPARTMENT	
		(from Wkst A					
		col. 7)					
	CENEDAL CEDVICE COST CENTEDS	0	1. 00	1. 01	2. 00	4. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 NEW CAP REL COSTS-BLDG & FIXT	13, 703, 274	13, 703, 274				1.00
1. 01	00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO	1, 435	0				1. 01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	0			0		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	13, 136, 070	0	-	0	13, 136, 070	
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	26, 883, 340 3, 963, 647	1, 623, 274		0	1, 630, 529	1
8. 00	00800 LAUNDRY & LINEN SERVICE	352, 537	1, 514, 189 70, 576		0	149, 698 6, 780	1
9. 00	00900 HOUSEKEEPI NG	1, 292, 674	123, 711		Ö	178, 755	1
10.00	01000 DI ETARY	463, 537	233, 018		0	67, 437	1
11.00	01100 CAFETERI A	495, 683	94, 236		0	119, 702	1
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	654, 628 79, 002	75, 463 114, 639		0	136, 557 16, 403	1
15. 00	01500 PHARMACY	1, 390, 857	85, 202		0	221, 856	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	958, 066	6, 998		0	167, 640	1
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	-	0	0	
23. 00	02300 RADI OLOGY SCHOOL	126, 909	24, 476	0	0	33, 569	23. 00
30. 00	O3000 ADULTS & PEDIATRICS	7, 166, 654	1, 473, 791	O	0	1, 237, 435	30.00
31. 00	03100 NTENSIVE CARE UNIT	2, 361, 867	61, 985		0	225, 139	1
	04300 NURSERY	744, 594	72, 390		0	105, 201	
	ANCILLARY SERVICE COST CENTERS						
	1	6, 793, 260	682, 649		0	669, 678	1
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	860, 018 985, 468	50, 914 0		0	107, 059 139, 234	
53. 00	05300 ANESTHESI OLOGY	0	4, 814		0	315, 373	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 232, 676	401, 421	0	0	723, 788	1
54. 01	03630 ULTRA SOUND	175, 945	0	-	0	27, 954	
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	187, 805	17, 885		0	18, 007	
55. 00 55. 01	O5500 RADI OLOGY - THERAPEUTI C O3480 ONCOLOGY	1, 883, 895	0 453, 483	-	0	0 251, 015	55. 00 55. 01
57. 00	05700 CT SCAN	686, 770	33, 140		ő	62, 761	1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	371, 279	39, 990		0	50, 559	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	-	0	0	
60. 00 62. 00	O6000 LABORATORY O6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	3, 248, 450	231, 018	0	0	303, 616	60. 00 62. 00
65. 00	06500 RESPIRATORY THERAPY	308, 961 982, 572	10, 331 44, 323		0	0 187, 928	1
66.00	06600 PHYSI CAL THERAPY	1, 519, 726	459, 185		Ö	293, 272	1
67.00	06700 OCCUPATI ONAL THERAPY	287, 776	52, 580	0	0	58, 945	1
68.00	06800 SPEECH PATHOLOGY	188, 281	12, 441		0	38, 965	1
69.00	06900 ELECTROCARDI OLOGY 03610 SLEEP LAB	0 335, 290	0 31, 067	-	0	0 42 41E	69. 00 69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 884, 333	31,007		0	43, 613	1
	07101 IV SOLUTIONS	0,001,000	0	Ö	Ö	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	5, 057, 108	0	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	13, 768, 877	0	0	0	0	
	03140 CARDI OLOGY 07697 CARDI AC REHABI LI TATI ON	683, 475 90, 218	223, 909 26, 031		0	118, 730 17, 861	1
	07700 ALLOGENEIC HSCT ACQUISITION	90, 218	20, 031		0	17, 861	1
78. 00	07800 CAR T-CELL IMMUNOTHERAPY		0		Ö	0	1
	OUTPATIENT SERVICE COST CENTERS	,]
	09000 CLINIC	84, 220	28, 141		0	17, 217	1
	O9001 WOUND CARE CLINIC O9100 EMERGENCY	452, 567 5, 960, 850	4, 073 513, 913		0	82, 561 518, 532	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 400, 630	513, 713	o o	U	510, 552	92.00
	OTHER REIMBURSABLE COST CENTERS						1
	09500 AMBULANCE SERVICES	1, 895, 509	175, 217		0	416, 612	
	10100 HOME HEALTH AGENCY	1, 142, 220	0		0	219, 596	
102.00	10200 OPLOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	102. 00
113.00	11300 I NTEREST EXPENSE						113.00
	11600 HOSPI CE	302, 909	0	306	0	47, 253	116.00
118.00		128, 145, 232	9, 070, 473	1, 435	0	9, 026, 832	118.00
100.00	NONREI MBURSABLE COST CENTERS		27.0:5		5		100.00
) 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN) 07950 OTHER NON-REIMBURSABLE	0	27, 845 0		0		190. 00 194. 00
	07951 MOB	3, 123, 573	1, 948, 969		0	574, 429	1
	07952 PHYSICIAN CLINICS	7, 321, 044	1, 021, 753		0	1, 234, 700	194. 02
194. 03	07953 PHYS PRAC BUS OFC	1, 551, 280	36, 621	0	0	185, 625	194. 03
	<u> </u>						

Health Financial Systems	KINGS DAUGHTERS HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0069	Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/22/2024 3:00 pm

					5/22/2024 3:0	0 pm
		CAPI	TAL RELATED CO	STS		
Cost Center Description	Net Expenses	NEW BLDG &	NEW BLDG &	NEW MVBLE	EMPLOYEE	
	for Cost	FLXT	FLXT HHA/HO	EQUI P	BENEFITS	
	Allocation				DEPARTMENT	
	(from Wkst A					
	col. 7)					
	0	1. 00	1. 01	2. 00	4. 00	
194.04 07954 MOB - MAIN CAMPUS	355, 715	0	0	0	73, 210	194. 04
194. 05 07955 ONCOLOGY - NONREI MBURSABLE	0	0	0	0	0	194. 05
194.06 07956 KDH - MC FAMILY PRACTICE	3, 148, 563	1, 597, 613	0	0	649, 196	194. 06
194. 07 07957 KDH - MC ORTHOPEDICS	3, 376, 093	0	0	0	597, 293	194. 07
194.08 07958 KDH - MC GENERAL SURGERY	1, 612, 145	0	0	0	313, 149	194. 08
194.09 07959 KDH - MC ENT	674, 247	0	0	0	149, 889	194. 09
194. 10 07960 KDH - MC UROLOGY	514, 834	0	0	0	22, 452	194. 10
194.11 07961 KDH - MC OB/GYN	2, 344, 563	0	0	0	309, 295	194. 11
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	152, 167, 289	13, 703, 274	1, 435	0	13, 136, 070	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared: 5/22/2024 3:00 pm

			. ''		5/22/2024 3:0	
Cost Center Description	Subtotal	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	4A	E & GENERAL 5.00	PLANT 7. 00	8.00	9. 00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 NEW CAP REL COSTS-BLDG & FLXT					1	1.00
1. 01 O0101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO					ı	1.01
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					ı	2. 00 4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL	30, 137, 143	30, 137, 143			ı	5.00
7.00 00700 OPERATION OF PLANT	5, 627, 534				ı	7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	429, 893			582, 352	1	8. 00
9. 00 00900 HOUSEKEEPI NG	1, 595, 140			33, 332	2, 103, 557	9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	763, 992	1			3, 578 0	1
13. 00 01100 CAPETERTA 13. 00 01300 NURSI NG ADMI NI STRATI ON	709, 621 866, 648	175, 252 214, 032			0	11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	210, 044	1		ő	14, 314	14.00
15. 00 01500 PHARMACY	1, 697, 915	1		0	17, 296	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	1, 132, 704	279, 738	7, 092	0	0	16. 00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19.00
23. 00 02300 RADI OLOGY SCHOOL I NPATI ENT ROUTI NE SERVI CE COST CENTERS	184, 954	45, 677	16, 053	0	7, 753	23. 00
30. 00 03000 ADULTS & PEDIATRICS	9, 877, 880	2, 439, 491	929, 878	111, 110	654, 268	30.00
31. 00 03100 NTENSIVE CARE UNIT	2, 648, 991	654, 208			115, 705	31.00
43. 00 04300 NURSERY	922, 185	227, 747	47, 480	12, 201	7, 157	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	8, 145, 587				232, 602	50.00
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 017, 991 1, 124, 702			18, 396 16, 149	0 32, 803	51. 00 52. 00
53. 00 05300 ANESTHESI OLOGY	320, 187			10, 149	32, 803	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 357, 885				27, 435	54.00
54. 01 03630 ULTRA SOUND	203, 899			· · ·	10, 735	•
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	223, 697	55, 245	11, 730	1, 605	4, 771	54. 02
55. 00 O5500 RADI OLOGY - THERAPEUTI C	0	_	ı	0	0	55.00
55. 01 03480 0NCOLOGY 57. 00 05700 CT SCAN	2, 588, 393	1			76, 938	55. 01 57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	782, 671 461, 828	193, 292 114, 055			54, 274 0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0 114,033	0	2, 330	Ö	59.00
60. 00 06000 LABORATORY	3, 783, 084	934, 289	151, 523	O	39, 363	•
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	319, 292	78, 854		0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	1, 214, 823	1		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	2, 272, 183	1		29, 411	52, 485	1
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	399, 301 239, 687	98, 613 59, 194		0	0	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	237,007	37, 174	0, 100	0	0	69.00
69. 01 03610 SLEEP LAB	409, 972	101, 249	20, 376	2, 190	17, 296	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 884, 333	959, 294	0	0	0	71.00
71. 01 07101 I V SOLUTIONS	0	_	0	0	0	71.01
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS	5, 057, 108			0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS 76. 00 03140 CARDI OLOGY	13, 768, 877 1, 026, 114			20, 415	47, 117	73. 00 76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	134, 110					76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0			0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS	100 570		10.450			
90. 00 09000 CLINI C 90. 01 09001 WOUND CARE CLINI C	129, 578 539, 201		18, 458 39, 441		0 20, 875	90. 00 90. 01
91. 00 09100 EMERGENCY	6, 993, 295			2, 183 57, 697	20, 875 282, 701	90.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0, 770, 270		007,071	07,077	202, 701	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	2, 487, 338				0	95. 00
101. 00 10100 HOME HEALTH AGENCY	1, 362, 945	1				101.00
102. 00 10200 OPI 0I D TREATMENT PROGRAM SPECI AL PURPOSE COST CENTERS	0	0	0	0	0	102.00
113. 00 11300 I NTEREST EXPENSE	I					113. 00
116. 00 11600 HOSPI CE	350, 468	86, 553	18, 069	o	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)				l .	1, 727, 219	
NONREI MBURSABLE COST CENTERS	_					
190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	27, 845	6, 877	18, 263	0		190.00
194. 00 07950 OTHER NON-REI MBURSABLE	0	1 204 (04	1 270 214	0		194.00
194. 01 07951 MOB 194. 02 07952 PHYSI CI AN CLI NI CS	5, 646, 971 9, 577, 497	1, 394, 604 2, 365, 307			99, 005	194. 01 194. 02
194. 03 07953 PHYS PRAC BUS OFC	1, 773, 526					194. 02
194.04 07954 MOB - MAIN CAMPUS	428, 925					194. 04
194. 05 07955 ONCOLOGY - NONREI MBURSABLE	0	0	0	0		194. 05
194.06 07956 KDH - MC FAMILY PRACTICE	5, 395, 372				85, 287	
194.07 07957 KDH - MC ORTHOPEDICS 194.08 07958 KDH - MC GENERAL SURGERY	3, 973, 386 1, 925, 294			.,	39, 363 54, 870	
174. 00 0/730 NUTI - NIC GENERAL SUKGERY	1, 725, 294	1 4/5,480	1 0	1, 90/	54, 870	Į174. Uδ

Health Financial	Systems	KINGS DAUGHTERS	HOSPI TAL		In Lie	u of Form CMS-2552-10
COST ALLOCATION	- GENERAL SERVICE COSTS		Provi der	CCN: 15-0069	Peri od: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Prepared: 5/22/2024 3:00 pm

						0/22/2021 0.0	O PIII
	Cost Center Description	Subtotal	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
			E & GENERAL	PLANT	LINEN SERVICE		
		4A	5. 00	7. 00	8. 00	9. 00	
194. 09 07959	KDH - MC ENT	824, 136	203, 533	C	0	21, 471	194. 09
194. 10 07960	KDH - MC UROLOGY	537, 286	132, 691	0	1, 782	25, 646	194. 10
194. 11 07961	KDH - MC OB/GYN	2, 653, 858	655, 410	C	9, 872	44, 135	194. 11
200.00	Cross Foot Adjustments	0					200.00
201. 00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	152, 167, 289	30, 137, 143	7, 017, 338	582, 352	2, 103, 557	202.00

					5/22/2024 3:0	0 pm
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O	CENTRAL SERVI CES &	PHARMACY	
	10. 00	11. 00	N 13. 00	SUPPLY 14. 00	15. 00	
GENERAL SERVICE COST CENTERS	10.00	11.00	10.00	11.00	10.00	
1. 00	1, 109, 083 0 0 0 0 0 0 0	946, 682 16, 101 5, 974 30, 663 36, 595 0 5, 224	1, 146, 277 0 0	357, 397 439 196 0 20	2, 221, 522 0 0 0	1. 00 1. 01 2. 00 4. 00 5. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 19. 00 23. 00
30. 00 03000 ADULTS & PEDIATRICS	1, 025, 961	167, 353	462, 971	480	0	30.00
31.00 03100 NTENSI VE CARE UNI T 43.00 04300 NURSERY	83, 122	24, 207 14, 402	66, 967	6	0	31. 00 43. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM	0 0 0	102, 462 10, 168	28, 131	37, 691 29 0	0	50. 00 51. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0	19, 062 9, 154		34	0	52. 00 53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	66, 991	Ö	313	0	54.00
54. 01 03630 ULTRA SOUND	0	3, 497	0	o	0	54.01
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	2, 323		0	0	54.02
55. 00 05500 RADI OLOGY - THERAPEUTI C 55. 01 03480 ONCOLOGY	0	27 404	0	220	0	55. 00 55. 01
55. 01 03480 0NC0L0GY 57. 00 05700 CT SCAN	0	37, 404 11, 061		238	0	55.01
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	6, 938		ő	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	o	0	59.00
60. 00 06000 LABORATORY	0	76, 823		484	0	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	27, 747 49, 715	0	56 257	0	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	7, 716		237	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	5, 351		ő	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	o	0	69.00
69. 01 03610 SLEEP LAB	0	7, 711	0	8	0	69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	156, 522	0	71.00
71. 01 07101 IV SOLUTIONS 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 01
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		144, 612 4, 518	0 2, 221, 522	72. 00 73. 00
76. 00 03140 CARDI OLOGY	0	21, 174	l o	103	0	76. 00
76. 97 07697 CARDIAC REHABILITATION	0	4, 551		10	0	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	78. 00
90. 00 09000 CLINIC	0	2, 565	0	4	0	90.00
90. 01 09001 WOUND CARE CLINIC	0	11, 935		20	0	90. 01
91. 00 09100 EMERGENCY	0	76, 694	212, 172	357	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS 95. 00 O9500 AMBULANCE SERVICES	0	85, 121	l ol	140	0	95. 00
101.00 10100 HOME HEALTH AGENCY	0	03, 121		1, 142		101. 00
102.00 10200 OPIOID TREATMENT PROGRAM	0	0		O		102.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 NTEREST EXPENSE				4 000		113.00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0 1, 109, 083	946, 682	0 1, 146, 277	1, 020 348, 699		116.00
NONREI MBURSABLE COST CENTERS	1, 109, 003	940, 002	1, 140, 277	340, 099	2, 221, 322	116.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190. 00
194.00 07950 OTHER NON-REIMBURSABLE	0	0	0	o		194. 00
194. 01 07951 MOB	0	0	0	878		194. 01
194. 02 07952 PHYSI CI AN CLI NI CS	0	0	0	2, 864		194. 02
194. 03 07953 PHYS PRAC BUS OFC 194. 04 07954 MOB - MAIN CAMPUS	0	0	0	150 127		194. 03 194. 04
194.04 07954 MOB - MATN CAMPUS 194.05 07955 ONCOLOGY - NONREIMBURSABLE	0	0		12/ 0		194. 04 194. 05
194. 06 07956 KDH - MC FAMILY PRACTICE	0	0	o o	851		194. 06
194.07 07957 KDH - MC ORTHOPEDICS	o	0	1	1, 497		194. 07

Health Financial Systems	KINGS DAUGHTERS HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0069	Period: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

					5/22/2024 3:0	Ö pm
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI O	SERVICES &		
			N	SUPPLY		
	10. 00	11. 00	13.00	14.00	15. 00	
194.08 07958 KDH - MC GENERAL SURGERY	0	0	0	735	0	194. 08
194. 09 07959 KDH - MC ENT	0	0	0	312	0	194. 09
194. 10 07960 KDH - MC UROLOGY	0	0	0	529	0	194. 10
194.11 07961 KDH - MC OB/GYN	0	0	0	755	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, 109, 083	946, 682	1, 146, 277	357, 397	2, 221, 522	202.00

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

Cost Center Peace Pit Ion					10	5 12/31/2023	Date/lime Pre 5/22/2024 3:0	
Cost & Fost Stephen Cost & Fost Stephen Cost & Fost Stephen Cost & Fost		Cost Center Description				Subtotal	Intern &	
SERIOR SERVICE COST CENTERS				ANESTHETI STS	SCH00L			
CONTROL 100 19.00 23.00 24.00 28.0			LIBRARY					
DESCRIPTION CONTRIBUTIONS 16.00 19.00 23.00 24.00 25.00								
1.00 00000 MORE CAP PET COSTS BRIDG & PLYT 1.00			16. 00	19. 00	23. 00	24. 00		
1.01 DOTS NEW CAP REL COSTS -BULDS A FIXT HHW-/HO 2.00 DOTS OF ACAP CAP CEL COSTS -BURDS A FIXT HHW-/HO 3.00 DOTS OF CHAPTER STATE	4 00				T			
2.00 DOZOO INSE CAP REL CISTS—WRISE FOULP 4.00 DOZOO CHARDY SERVICE SERVICE SERVICE 5.00 DOZOO CHARDY SERVICE SERVICE 6.00 DOZOO CHARDY SERVICE SERVICE 7.00 DOZOO CHARDY SERV								•
4.00 OBADOLEMENT STATUT N. GOVERNOON A. DO DO DO DO STATUT OF PART A. DO DO DO DO DO STATUT OF PART A. DO DO DO DO DO STATUT OF PART A. DO								•
7. 00 00 0000 AUGUSTAN TO UT PLANT 1. 00 0000 AUGUSTAN TO UT PLANT 1. 00 0000 AUGUSTAN TO UT PLANT 1. 00 01 1000 AUGUSTAN TO UT PLANT								•
8.00 00800 AURIDRY & LINEN SERVICE 9.00 1000 107407 1100 1000 174747 1100 1000 1000 174747 1100								ł
9.00 0.0900 0.0900 0.0950 0.915		1 1						ł
10.00 0.000 DETARY		1 1						ł
13.00 01300 NURSHING ADMINISTRATION								ł
14.00 14.00 14.00 14.00 14.00 16.0								ł
15.00								ł
16. 00								•
19.00 1900 NOMPHYSICI AM AMESTHEIT ISTS 0 299.081 23.00 230 0230 RADI LOCKY SCHOOL 0 299.081 23.00 230 0200 2000		1 1	1, 456, 325					•
IMPATI ENT ROUTINE SERVICE COST CENTERS 3.5, 945 0 0 15, 705, 337 0 30 00 310 00 0			0	0				•
03.00 03.000 ADULTS & PEDIATRICS 35, 945 0 0 15, 705, 337 0 30.00 43.00 04.500 IMERSISY C ACE UNIT 14, 042 0 0 0, 12, 75, 455 0 43.00 43.00 ASOU MURSERY 4, 440 0 0 0 1, 275, 455 0 43.00 ASOU MURSERY 4, 440 0 0 0 1, 275, 455 0 43.00 ASOU MURSERY 4, 440 0 0 0 1, 275, 455 0 43.00 ASOU MURSERY 50.00 05000 (DEFLATIN IN ROMM 140, 906 0 0 1, 183, 326 0 1.00 52.00 05000 (DEFLATIN IN ROMM 140, 906 0 0 1, 283, 326 0 1.00 52.00 05000 (DEFLATIN IN ROMM 1, 285, 904 0 35.00 0.00 0.00 0.00 0 0 0.00	23. 00		0		259, 681			23. 00
31.00 03100 INTERSIVE CARE UNIT	20.00		25.045	0		15 705 227	0	20.00
43.00 04300 NURSERY 4,440 0 0 1,275,455 0 43.00								•
50.00								•
51.00								
52.00 05200 DELIVERY ROOM & LABOR ROOM 5,691 0								•
53.00 05500 ANESTHESI OLOGY 29, 158 0 0 440, 765 0 53.00 54.01 03630 ULTRA SOUND 7, 734 0 259, 681 4, 887, 866 0 54.01 54.02 03450 NUCLEAR MEDI CINE - DI AGNOSTI C 20, 270 0 0 0 379, 641 0 54.01 55.00 05500 RADIO LOCY - THERAPEUTI C 0 0 0 0 0 55.00 55.01 03460 NOCLEGAY MEDI CINE - DI AGNOSTI C 20, 270 0 0 0 0 55.00 57.00 05500 RADIO LOCY - THERAPEUTI C 0 0 0 0 3, 697, 735 0 55.00 57.00 05500 MADIO MAGNETI C RESOMANCE IMAGI NG (MRI) 18, 260 0 0 0 0 629, 848 0 58.00 58.00 05500 MAGNETI C RESOMANCE IMAGI NG (MRI) 18, 260 0 0 0 0 0 0 59.00 05500 LARDIA C CATHETERI ZATI ON 0 0 0 0 0 0 62.00 05500 LARDIA C CATHETERI ZATI ON 0 0 0 0 0 62.00 05500 LARDIA C CATHETERI ZATI ON 0 0 0 0 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 8, 222 0 0 413, 144 0 62, 20 66.00 06600 PHYSI CAL THERAPY 26, 986 0 0 1, 198, 702 0 65.00 66.00 06600 PHYSI CAL THERAPY 5, 823 0 0 545, 940 0 67.00 67.00 06700 CLECHTOCARBUIL LIGHT STATE ST			·					1
54 00 05400 ADDILOGY-DI AGNOSTIC 29, 476 0 259, 681 4, 857, 686 0 54, 00 0 154, 00 0 278, 611 0 54, 00 0 0 0 0 0 0 0 0 0			·		1			1
54. Q2 G3450 MUCLEAR MEDICINE - DIACNOSTIC 20, 270 0 0 319, 641 0 54, 02 055, 00 6550 ORADIOLOGY - THERAPEUTIC - DO	54.00	i i		0	259, 681	· ·		•
55.00 OSSOO RADIOLOGY - THERAPEUTIC 0 0 0 0 0 55.00 55.01 55.01 03480 ONCOLOGY 38, 134 0 0 3, 697, 735 0 55.01 57.00 OSTOO CT SCAN 86, 766 0 0 1, 163, 673 0 57.00 57.00 OSTOO CT SCAN 86, 766 0 0 0 0 0 0 0 0 58.00 OSSOO MAGNETIC RESONANCE IMAGING (MRI) 18, 260 0 0 0 0 0 0 0 0 59.00 OSSOO CARDIAL C CATHETERIZATION 0 0 0 0 0 0 0 59.00 OSSOO CARDIAL C CATHETERIZATION 0 0 0 0 0 0 0 0 0				0				•
55.00 03480 000 00 0 0 0 0 0 0			20, 270					1
57. 00 05700 CT SCAN S6. 00 0 0 1.163,673 0 57. 00			38. 134	0		O O		ł
59.00 0.05900 CARDIAC CATHETERIZATION 0 0 0 0 5 . 135, 411 0 0 60.00				0	0		0	1
60.00 06000 LABORATORY 149,845 0 0 5,135,411 0 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 8,222 0 0 413,144 0 62.00 65.00 06500 RESPIRATORY THERAPY 26,986 0 0 1,598,702 0 65.00 66.00 06600 PHYSI CAL THERAPY 31,557 0 0 3,297,934 0 0 60.00 67.00 06700 OCCUPATI ONAL THERAPY 5,823 0 0 545,940 0 67.00 68.00 06800 SPEECH PATHOLOGY 4,198 0 0 316,590 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 0 69.01 03600 SEPECH PATHOLOGY 0 0 0 0 0 0 0 0 0 69.01 03600 SEPECH PATHOLOGY 0 0 0 0 0 0 0 0 69.01 03600 SEPECH PATHOLOGY 0 0 0 0 0 0 0 0 69.01 03610 SLEEP LAB 9,395 0 0 508,197 0 69,101 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 60,934 0 0 500,10,83 0 71,00 71.01 07101 V SOLUTI ONS 0 0 0 0 0 0 0 71,00 72.00 07200 IMPL DEV CHARGED TO PATIENTS 445,001 0 0 6,541,185 0 72,00 72.00 07300 DRUGS CHARGED TO PATIENTS 445,001 0 0 19,840,318 0 73,00 76.00 03140 CARDIOLOGY 46,355 0 0 1,561,552 0 76,00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 78.00 08000 CAT T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 78.00 08000 CAT T-CELL ILMMUNOTHERAPY 0 0 0 0 0 78.00 08000 CAT T-CELL ILMMUNOTHERAPY 0 0 0 0 75,00 79.01 09001 WOUND CARE CLIN IC 11,294 0 0 0 75,00 79.01 09001 WOUND CARE CLIN IC 11,294 0 0 0 75,00 79.01 09000 0SERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 75,00 79.01 09000 0SERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 79.01 09000 0SERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 79.01 09000 0SERVATION SED			· ·			· ·		ł
62.00 06200 WOLLE BLOOD & PACKED RED BLOOD CELLS 8, 222 0 0 413, 144 0 62, 00 65.00 06500 RESPIRATORY THERAPY 31,557 0 0 3,297,934 0 66,00 66.00 06600 PHYSI CAL THERAPY 5,823 0 0 545,940 0 67.00 67.00 06700 COEUPATI ONAL THERAPY 5,823 0 0 545,940 0 67.00 69.00 06900 SPECCH PATHOLOGY 4,198 0 0 316,590 0 68.00 69.00 06900 SPECCH PATHOLOGY 0 0 0 0 56,940 0 69.00 69.00 06900 SELECTROCARDI OLOGY 0 0 0 0 56,940 0 69.00 71.00 07100 MEDIC AL SUPPLIES CHARGED TO PATIENTS 60,934 0 0 5,061,083 0 71.00 71.00 07100 MEDIC AL SUPPLIES CHARGED TO PATIENTS 60,934 0 0 0 0 0 0 0 0 71.01 07101 V SOLUTIONS 0 0 0 0 0 0 0 0 0 71.00 07200 MPL. DEV. CHARGED TO PATIENTS 90,536 0 0 6,541,185 0 72.00 73.00 07300 MEUS CHARGED TO PATIENTS 445,001 0 0 19,840,318 0 73.00 76.00 03140 RUSUS CHARGED TO PATIENTS 446,855 0 0 1,561,552 0 76.00 76.00 03140 RUSUS CHARGED TO PATIENTS 446,855 0 0 0 0 0 0 0 77.00 07700 ALLOGENEIC HIST CACOULSTITION 3,498 0 0 200,115 0 76.90 78.00 07800 CAR T-CELL IMMINOTHERAPY 0 0 0 0 0 0 0 77.00 77.00 07700 ALLOGENEIC HIST CACOULSTITION 0 0 0 0 0 0 78.00 78.00 07800 CAR T-CELL IMMINOTHERAPY 0 0 0 0 0 0 0 0 79.00 07800 CAR T-CELL IMMINOTHERAPY 0 0 0 0 0 0 0 79.00 07900 CLINIC SERVICE COST CENTERS 90.00 09000 CLINIC SERVICE SERVICES 23,016 0 0 3,339,458 0 90.00 79.00 07900 COSTIVATION 0 0 0 0 0 0 0 79.00 07900 COSTIVATION 0 0 0 0 0 0 0 79.00 07900 COSTIVATION 0 0 0 0 0 0 0 79.00 07900 COSTIVATION 0 0 0 0 0 0 0 79.00 07900 COSTIVATION 0 0 0 0 0 0 0 0 79.00 07900 COSTIVATION 0 0 0 0 0 0 0 79.00 07900 COSTIVATION 0 0 0 0 0 0 0 0 79.		1 1	O	_	-	_		ł
65.00 06500 RESPIRATORY THERAPY 26, 986 0 0 1, 598, 702 0 65.00 66.00 66.00 66.00 HASIS CAL THERAPY 31,557 0 0 3,297, 934 0 66.00 67.00 68.00 06800 PHSVIGAL THERAPY 5, 823 0 0 545, 940 0 67.00 68.00 06800 SPEECH PATHOLOGY 4, 198 0 0 316, 590 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 0 0				_	-			ł
66.00 06600 060000 060000 060000 060000 060000 0600000 06000000 0600000000				_	-			ł
68.00 06800 SPEECH PATHOLOGY 4, 198 0 0 316, 590 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 69.00 69.01 03610 SLEEP LAB 9, 395 0 0 568, 197 0 69.01 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 60, 934 0 0 5, 061, 083 0.71.00 71.01 07101 V SOLUTIONS 0 0 0 0 0 0 0 0 71.01 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 90, 536 0 0 6, 541, 185 0.72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 445, 001 0 0 19, 840, 318 0.73.00 74.00 03140 CARDI OLOGY 46, 355 0 0 1, 561, 552 0.76.00 74.07 07697 CARDI AC REHABI LI TATI ON 3, 498 0 0 200, 115 0.76.97 75.00 07700 ALLOGENEI CHEST ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	66.00		31, 557	0	0	3, 297, 934	0	66.00
69.00 06900 06900 06900 06900 06900 06900 06900 06900 0710				_	-			•
69. 01 03610 SLEEP LAB			4, 198	0	0	316, 590		•
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 5, 061, 083 0 71. 00 71. 01 07101 IV SOLUTIONS 0 0 0 0 0 0 0 0 0 0 0 0			9, 395	0	0	568. 197		•
72. 00 07200 MPL DEV. CHARGED TO PATIENTS 90,536 0 0 6,541,185 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 445,001 0 0 19,840,318 0 73. 00 03140 CARDI OLOGY 46,355 0 0 1,561,552 0 76. 00 76. 97 77. 90 07760 ALDGENEIC HSCT ACQUISITION 0 0 0 0 0 0 0 0 0		1 1	·	0	0	5, 061, 083	0	•
73. 00 07300 DRUGS CHARGED TO PATIENTS			0	_	_	_		•
76. 00 03140 CARDI OLOGY				0			_	
76. 97 07697 CARDI AC REHABILITATION 3,498 0 0 200,115 0 76. 97 77. 00 07700 ALLOGERIC HSCT ACQUI SITION 0 0 0 0 0 0 0 0 0		1 1		0				1
78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 0				0	0		0	
OUTPATIENT SERVICE COST CENTERS 200			0	0		-		1
90. 00	78.00		O	0	0	0	0	78.00
90. 01	90. 00		200	0	0	182, 806	0	90.00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 23, 016 0 0 3, 339, 458 0 95. 00 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 1, 767, 426 0 101. 00 102. 00 102. 00 102. 00 0 0 0 0 0 0 0 0 0				0	0		0	ı
OTHER REIMBURSABLE COST CENTERS 23,016 0 0 3,339,458 0 95.00			84, 834	0	0	9, 771, 920		1
95. 00	92.00						0	92.00
101. 00 10100 HOME HEALTH AGENCY 0 0 0 1, 767, 426 0 101. 00 102. 00 10200 OPI 0I D TREATMENT PROGRAM 0 0 0 0 0 0 102. 00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 0 0 456, 110 0 116. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 1, 456, 325 0 259, 681 107, 849, 576 0 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 52, 985 0 190. 00 194. 00 07950 OTHER NON-REI MBURSABLE 0 0 0 0 0 0 0 194. 00 194. 01 07951 MOB 0 0 0 0 8, 320, 769 0 194. 01 194. 01 07951 MOB 0 0 0 0 0 12, 737, 388 0 194. 01 194. 02 07952 PHYSI CI AN CLINI CS 0 0 0 0 0 2, 235, 694 0 194. 03 194. 04 07954 MOB - MAIN CAMPUS 0 0 0 0 541, 542 0 194. 04	95. 00		23, 016	0	0	3, 339, 458	0	95.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 0 456, 110 0 116.00 116.00 116.00 116.00 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 1, 456, 325 0 259, 681 107, 849, 576 0 118.00 NONREI MBURSABLE COST CENTERS		1 1	0				0	101.00
113. 00 116. 00 116. 00 116. 00 116. 00 116. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 1, 456, 325 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	102.00		0	0	0	0	0	102. 00
116. 00	112 00							112 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1,456,325 0 259,681 107,849,576 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 52,985 0 190.00 194.00 194.00 194.01 19700		1 1	0		0	456, 110		
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 0 52, 985 0 190. 00 194. 00 0 0 0 0 0 0 0 0 0			1, 456, 325	0				
194. 00 07950 OTHER NON-REIMBURSABLE 0 0 0 0 0 194. 00 194. 01 07951 MOB 0 0 8, 320, 769 0 194. 01 194. 02 07952 PHYSI CI AN CLI NI CS 0 0 0 12, 737, 388 0 194. 02 194. 03 07953 PHYS PRAC BUS OFC 0 0 0 2, 235, 694 0 194. 03 194. 04 07954 MOB - MAI N CAMPUS 0 0 0 541, 542 0 194. 04		NONREI MBURSABLE COST CENTERS						
194. 01 07951 MOB 0 0 8, 320, 769 0 194. 01 194. 02 07952 PHYSI CI AN CLI NI CS 0 0 0 12, 737, 388 0 194. 02 194. 03 07953 PHYS PRAC BUS OFC 0 0 0 2, 235, 694 0 194. 03 194. 04 07954 MOB - MAI N CAMPUS 0 0 0 541, 542 0 194. 04			0	0	0	52, 985		1
194. 02 07952 PHYSI CI AN CLI NI CS 0 0 12, 737, 388 0 194. 02 194. 03 07953 PHYS PRAC BUS OFC 0 0 2, 235, 694 0 194. 03 194. 04 07954 MOB - MAI N CAMPUS 0 0 0 541, 542 0 194. 04		1 1	0	0	0	0 220 760		
194. 03 07953 PHYS PRAC BUS 0FC 0 0 0 2, 235, 694 0 194. 03 194. 04 07954 MOB - MAI N CAMPUS 0 0 0 541, 542 0 194. 04		1 1	0	0				
	194. 03	07953 PHYS PRAC BUS OFC	0	0	0	2, 235, 694	0	194. 03
194. 05 01/955 0NCOLOGY - NONKETMBUKSABLE 0 0 0 0 0 194. 05			0	0				1
	194.05	DIO (ADDI ONCOTOR) - MONKEL WROKZARTE	O	0	1 0	O	0	1194.05

Health Financial Systems	KINGS DAUGHTERS HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0069	Peri od: From 01/01/2023 Part To 12/31/2023 Date/Time Prepared: 5/22/2024 3:00 pm

					5/22/2024 3:0	0 pm
Cost Center Description	MEDI CAL	NONPHYSI CI AN	RADI OLOGY	Subtotal	Intern &	
	RECORDS &	ANESTHETI STS	SCH00L		Resi dents	
	LI BRARY				Cost & Post	
					Stepdown	
					Adjustments	
	16. 00	19. 00	23. 00	24.00	25.00	
194.06 07956 KDH - MC FAMILY PRACTICE	0	0	0	7, 862, 175	0	194. 06
194.07 07957 KDH - MC ORTHOPEDICS	0	0	0	4, 997, 398	0	194. 07
194.08 07958 KDH - MC GENERAL SURGERY	0	0	0	2, 458, 346	0	194. 08
194.09 07959 KDH - MC ENT	0	0	0	1, 049, 452	0	194. 09
194.10 07960 KDH - MC UROLOGY	0	0	0	697, 934	0	194. 10
194.11 07961 KDH - MC OB/GYN	0	0	0	3, 364, 030	0	194. 11
200.00 Cross Foot Adjustments		0	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	o	0	201.00
202.00 TOTAL (sum lines 118 through 201)	1, 456, 325	o	259, 681	152, 167, 289	0	202.00

Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/22/2024 3:00 pm Provider CCN: 15-0069

			5/22/2024 3: 00	
	Cost Center Description	Total	372272024 3.00	O pili
	GENERAL SERVICE COST CENTERS	26. 00		
1. 00	00100 NEW CAP REL COSTS-BLDG & FLXT			1.00
1. 01	00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO			1. 01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500 ADMINISTRATIVE & GENERAL			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
	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON			11. 00 13. 00
	01400 CENTRAL SERVICES & SUPPLY			14.00
	01500 PHARMACY			15.00
	01600 MEDI CAL RECORDS & LI BRARY			16.00
	01900 NONPHYSICIAN ANESTHETISTS			19.00
	02300 RADI OLOGY SCHOOL			23.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	15, 705, 337		30.00
	03100 INTENSIVE CARE UNIT	3, 722, 110		31.00
43.00	04300 NURSERY	1, 275, 455		43.00
	ANCILLARY SERVICE COST CENTERS			
	05000 OPERATING ROOM	11, 490, 481		50.00
	05100 RECOVERY ROOM	1, 383, 326		51.00
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	1, 528, 904		52.00
	05400 RADI OLOGY-DI AGNOSTI C	440, 765 4, 857, 686		53. 00 54. 00
54. 01	03630 ULTRA SOUND	278, 611		54.00
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	319, 641		54.02
	05500 RADI OLOGY - THERAPEUTI C	0		55.00
	03480 ONCOLOGY	3, 697, 735		55. 01
57.00	05700 CT SCAN	1, 163, 673		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	629, 848		58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0		59.00
60.00	06000 LABORATORY	5, 135, 411		60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	413, 144		62.00
	06500 RESPI RATORY THERAPY	1, 598, 702		65.00
66.00	06600 PHYSI CAL THERAPY	3, 297, 934		66.00
	06700 OCCUPATI ONAL THERAPY	545, 940		67.00
68.00	06800 SPEECH PATHOLOGY	316, 590 0		68.00
	06900 ELECTROCARDI OLOGY 03610 SLEEP LAB	568, 197		69. 00 69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 061, 083		71.00
	07101 IV SOLUTIONS	0,001,000		71.01
	07200 IMPL. DEV. CHARGED TO PATIENTS	6, 541, 185		72.00
	07300 DRUGS CHARGED TO PATIENTS	19, 840, 318		73.00
76.00	03140 CARDI OLOGY	1, 561, 552		76.00
76. 97	07697 CARDIAC REHABILITATION	200, 115		76. 97
	07700 ALLOGENEIC HSCT ACQUISITION	0		77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0		78. 00
	OUTPATIENT SERVICE COST CENTERS			
	09000 CLINIC	182, 806		90.00
	09001 WOUND CARE CLINIC	758, 113		90.01
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	9, 771, 920		91.00
92. UU	OTHER REIMBURSABLE COST CENTERS			92.00
95 00	09500 AMBULANCE SERVICES	3, 339, 458		95.00
	10100 HOME HEALTH AGENCY	1, 767, 426		101.00
	10200 OPI OI D TREATMENT PROGRAM	1, 707, 420		102.00
. 52. 00	SPECIAL PURPOSE COST CENTERS	<u> </u>		1 00
113.00	11300 I NTEREST EXPENSE			113.00
116.00	11600 HOSPI CE	456, 110		116. 00
118.00		107, 849, 576		118. 00
	NONREI MBURSABLE COST CENTERS			
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	52, 985		190.00
	07950 OTHER NON-REI MBURSABLE	0		194.00
	07951 MOB	8, 320, 769		194. 01
	07952 PHYSI CI AN CLI NI CS	12, 737, 388		194. 02
	07953 PHYS PRAC BUS OFC	2, 235, 694		194.03
	07954 MOB - MAIN CAMPUS	541, 542		194. 04 194. 05
	OZOFE ONCOLOGY NONDELMBUIDGARIE			
194. 05	07955 ONCOLOGY - NONREIMBURSABLE	0 7 862 175		
194. 05 194. 06	07956 KDH - MC FAMILY PRACTICE	7, 862, 175		194. 06
194. 05 194. 06 194. 07		-1		194. 06 194. 07 194. 08

Health Financial Systems	KINGS DAUGHTER	S HOSPITAL	In Lieu	ı of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0069	Peri od: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Prepared: 5/22/2024 3:00 pm
Cost Center Description	Total			
	26. 00			
194.10 07960 KDH - MC UROLOGY	697, 934			194. 10
194.11 07961 KDH - MC OB/GYN	3, 364, 030			194. 11
200.00 Cross Foot Adjustments	0			200.00
201.00 Negative Cost Centers	0			201.00
202.00 TOTAL (sum lines 118 through 201)	152, 167, 289			202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | Pre Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0069

				Ic	12/31/2023	Date/lime Pre 5/22/2024 3:0	
			CAP	TAL RELATED CO	STS		
	Cost Center Description	Di rectly Assigned New Capital	NEW BLDG & FIXT	NEW BLDG & FIXT HHA/HO	NEW MVBLE EQUIP	Subtotal	
		Related Costs	1 00	1 01	2 00	2A	
	GENERAL SERVICE COST CENTERS	0 1	1. 00	1. 01	2. 00	ZA	
1. 00 1. 01 2. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO 00200 NEW CAP REL COSTS-MVBLE EQUIP						1. 00 1. 01 2. 00
4. 00 5. 00 7. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	811, 354 0	0 1, 623, 274 1, 514, 189	Ö	0 0 0	0 2, 434, 628 1, 514, 189	1
8. 00 9. 00	O0800 LAUNDRY & LI NEN SERVI CE O0900 HOUSEKEEPI NG	0 0	70, 576 123, 711	0 0	0 0	70, 576 123, 711	1
10.00	01000 DI ETARY	0	233, 018		0	233, 018	1
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	0	94, 236 75, 463		0 0	94, 236 75, 463	1
14.00	01400 CENTRAL SERVICES & SUPPLY	O	114, 639	0	0	114, 639	14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	85, 202 6, 998		0	85, 202 6, 998	
19. 00	01900 NONPHYSICIAN ANESTHETISTS	O	0	0	O	0	19. 00
23. 00	O2300 RADI OLOGY SCHOOL I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	24, 476	0	0	24, 476	23. 00
30. 00	03000 ADULTS & PEDIATRICS	0	1, 473, 791	0	0	1, 473, 791	30.00
31.00	03100 INTENSIVE CARE UNIT	0	61, 985		0	61, 985	1
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	72, 390	0	0	72, 390	43.00
50.00	05000 OPERATING ROOM	0	682, 649		0	682, 649	1
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELI VERY ROOM & LABOR ROOM	0	50, 914 0		0	50, 914 0	1
53. 00	05300 ANESTHESI OLOGY	0	4, 814		Ö	4, 814	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	401, 421 0	0	0	401, 421	54.00
54. 01 54. 02	03630 ULTRA SOUND 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	17, 885		0	0 17, 885	
55.00	05500 RADI OLOGY - THERAPEUTI C	0	0	-	0	0	55.00
55. 01 57. 00	03480 0NCOLOGY 05700 CT SCAN	0	453, 483 33, 140		0	453, 483 33, 140	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	39, 990		Ö	39, 990	
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0 231, 018	-	0	0 231, 018	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	10, 331	0	0	10, 331	1
65. 00	06500 RESPIRATORY THERAPY	0	44, 323		0	44, 323	1
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	459, 185 52, 580		0	459, 185 52, 580	1
68. 00	06800 SPEECH PATHOLOGY	0	12, 441	0	O	12, 441	68.00
69. 00 69. 01	06900 ELECTROCARDI OLOGY 03610 SLEEP LAB	0	0 31, 067	0	0	0 31, 067	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	Ö	o	0	1
	07101 IV SOLUTIONS	0	0	9	0	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	1
	03140 CARDI OLOGY	0	223, 909		0	223, 909	1
76. 97 77. 00	07697 CARDI AC REHABI LI TATI ON 07700 ALLOGENEI C HSCT ACQUI SI TI ON	0	26, 031 0		0	26, 031 0	1
	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0	0	1
90 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	0	28, 141	O	O	28, 141	90.00
90. 01	09001 WOUND CARE CLINIC	0	4, 073		Ö	4, 073	90. 01
	09100 EMERGENCY	0	513, 913	0	0	513, 913	1
92.00	O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS					0	92.00
	09500 AMBULANCE SERVICES	0	175, 217		0	175, 217	1
	10100 HOME HEALTH AGENCY 10200 OPIOID TREATMENT PROGRAM	0	0		0		101. 00 102. 00
	SPECIAL PURPOSE COST CENTERS	<u> </u>			<u> </u>	0	
	11300 INTEREST EXPENSE		0	204	0	204	113. 00 116. 00
118.00	3 /	811, 354	9, 070, 473	306 1, 435	0 0	9, 883, 262	1
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN		27, 845	l ol	ما	27, 845	190 00
194.00	07950 OTHER NON-REIMBURSABLE		27, 343	0	0		194.00
194.01	07951 MOB	0	1, 948, 969		0	1, 948, 969	
	07952 PHYSICIAN CLINICS 07953 PHYS PRAC BUS OFC		1, 021, 753 36, 621		0	1, 021, 753 36, 621	194. 02
	07954 MOB - MAIN CAMPUS	0	0		o		194. 04

Health Financial Systems	KINGS DAUGHTERS HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0069	Peri od: Worksheet B From 01/01/2023 Part II Date/Time Prepared: D

				12/31/2023	5/22/2024 3: 0	
		CAPI	TAL RELATED CO	STS		
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. 05 07955 ONCOLOGY - NONREI MBURSABLE	0	0	0	0	0	194. 05
194.06 07956 KDH - MC FAMILY PRACTICE	0	1, 597, 613	0	0	1, 597, 613	194. 06
194.07 07957 KDH - MC ORTHOPEDICS	0	0	0	0	0	194. 07
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)	811, 354	13, 703, 274	1, 435	0	14, 516, 063	202.00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-0069

				To	12/31/2023	Date/Time Pre 5/22/2024 3:0	
	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	y piii
		4. 00	5. 00	7. 00	8. 00	9. 00	
1. 00 1. 01 2. 00	GENERAL SERVICE COST CENTERS O0100 NEW CAP REL COSTS-BLDG & FIXT O0101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO O0200 NEW CAP REL COSTS-MVBLE EQUIP						1. 00 1. 01 2. 00
4. 00 5. 00 7. 00 8. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0 0	2, 434, 628 112, 275 8, 577	1, 626, 464 10, 729	89, 882		4. 00 5. 00 7. 00 8. 00
9. 00 10. 00 11. 00 13. 00	00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	0 0	31, 825 15, 242 14, 158 17, 290	35, 424 14, 326	5, 145 0 0 0	305 0	9. 00 10. 00 11. 00 13. 00
14. 00 15. 00 16. 00 19. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01900 NONPHYSICIAN ANESTHETISTS	0 0	4, 191 33, 875 22, 599 0	12, 952 1, 644	0 0 0 0	1, 476 0	14. 00 15. 00 16. 00 19. 00
23. 00	02300 RADIOLOGY SCHOOL INPATIENT ROUTINE SERVICE COST CENTERS	0	3, 690	3, 721	0	662	23. 00
30. 00 31. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04300 NURSERY ANCILLARY SERVICE COST CENTERS	0 0	52, 850	9, 423	17, 148 11, 453 1, 883	9, 873	30. 00 31. 00 43. 00
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	20, 310	7, 740	13, 637 2, 839	0	50. 00 51. 00
52. 00 53. 00 54. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 0	22, 439 6, 388 66, 993	732	2, 493 0 3, 602	0	52. 00 53. 00 54. 00
54. 01 54. 02 55. 00	03630 ULTRA SOUND 03450 NUCLEAR MEDICINE - DIAGNOSTIC 05500 RADIOLOGY - THERAPEUTIC	0	4, 068 4, 463 0	2, 719	369 248 0	407	54. 01 54. 02 55. 00
55. 01 57. 00 58. 00	03480 ONCOLOGY 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	51, 641 15, 615 9, 214		3, 079 2, 141 392	6, 565 4, 631	1
59. 00 60. 00 62. 00 65. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPI RATORY THERAPY	0 0	0 75, 476 6, 370 24, 237	35, 120 1, 571	0 0 0 0	3, 359 0	59. 00 60. 00 62. 00 65. 00
66. 00 67. 00 68. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	45, 332 7, 966 4, 782	69, 806 7, 993 1, 891	4, 539 0 0	4, 478 0	66. 00 67. 00 68. 00
69. 00 69. 01 71. 00 71. 01	06900 ELECTROCARDIOLOGY 03610 SLEEP LAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07101 IV SOLUTIONS	0 0	0 8, 179 77, 496 0	4, 723	0 338 0 0	1, 476 0	69. 00 69. 01 71. 00 71. 01
72. 00 73. 00 76. 00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03140 CARDI OLOGY	0	100, 894 274, 707 20, 472	0 0 34, 039	0 0 3, 151	0 0 4, 020	72. 00 73. 00 76. 00
76. 97 77. 00 78. 00	07697 CARDIAC REHABILITATION 07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY 0UTPATIENT SERVICE COST CENTERS	0 0	2, 676 0 0	0	0 0 0	0	77. 00
90. 00 90. 01 91. 00 92. 00	09000 CLINIC 09001 WOUND CARE CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 0	2, 585 10, 758 139, 523	9, 142	0 337 8, 905	1, 781	90.00 90.01 91.00 92.00
95. 00	OTHER REI MBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES	0	,		2, 259		95. 00
102.00	10100 HOME HEALTH AGENCY 10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	1		0	0	101. 00 102. 00
	11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0			83, 958	0	113. 00 116. 00 118. 00
194. 00 194. 01	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 07950 OTHER NON-REIMBURSABLE 07951 MOB	0	0 112, 663	0 296, 282	0 0 0	0	190. 00 194. 00 194. 01
194. 03 194. 04	07952 PHYSICIAN CLINICS 07953 PHYS PRAC BUS OFC 07954 MOB - MAIN CAMPUS 07955 ONCOLOGY - NONREIMBURSABLE	0 0	191, 081 35, 384 8, 557	5, 567 0	3, 481 0 0	0 560	194. 02 194. 03 194. 04 194. 05
194.06	07955 ONCOLOGY - NONRETHINDURSABLE 07956 KDH - MC FAMILY PRACTICE 07957 KDH - MC ORTHOPEDICS	0 0	107, 643 79, 273	242, 871	52 288	7, 277	194. 05 194. 06 194. 07

Health Financial Systems	KINGS DAUGHTERS HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0069	Peri od: Worksheet B From 01/01/2023 Part II Date/Time Prepared: D

					5/22/2024 3:0	O pm
Cost Center Description	EMPLOYEE	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	BENEFITS	E & GENERAL	PLANT	LINEN SERVICE		
	DEPARTMENT					
	4. 00	5. 00	7. 00	8. 00	9. 00	
194.08 07958 KDH - MC GENERAL SURGERY	0	38, 412	0	304	4, 682	194. 08
194.09 07959 KDH - MC ENT	0	16, 442	0	0	1, 832	194. 09
194.10 07960 KDH - MC UROLOGY	0	10, 719	0	275	2, 188	194. 10
194.11 07961 KDH - MC OB/GYN	0	52, 947	0	1, 524	3, 766	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	2, 434, 628	1, 626, 464	89, 882	179, 488	202.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | Pre

			10	12/31/2023	Date/lime Pre 5/22/2024 3:0	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMINISTRATIO N	SERVI CES & SUPPLY		
	10. 00	11. 00	13. 00	14.00	15. 00	
GENERAL SERVICE COST CENTERS						1 00
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.01 00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO	+					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 & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG						8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	283, 989					9. 00 10. 00
11. 00 01100 CAFETERI A	203, 707	122, 720				11.00
13.00 01300 NURSING ADMINISTRATION	0	2, 087	106, 312			13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	774	0	138, 253		14.00
15. 00 01500 PHARMACY	0	3, 975	0	170	137, 650	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	4, 744 0	0	76	0	16. 00 19. 00
23. 00 02300 RADI OLOGY SCHOOL	0	677	0	0 8	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	<u> </u>	<u> </u>	<u> </u>		20.00
30. 00 03000 ADULTS & PEDIATRICS	262, 705	21, 694	42, 939	186	0	30.00
31. 00 03100 INTENSIVE CARE UNIT	21, 284	3, 138		2	0	31.00
43. 00 O4300 NURSERY ANCI LLARY SERVICE COST CENTERS	0	1, 867	3, 695	0	0	43.00
50. 00 05000 OPERATING ROOM	0	13, 282	26, 289	14, 579	0	50.00
51. 00 05100 RECOVERY ROOM	o	1, 318		11	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	О	2, 471	4, 891	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	1, 187	0	13	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	8, 684	0	121	0	54.00
54. 01 03630 ULTRA SOUND 54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	453 301	0	0	0	54. 01 54. 02
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0	0	0	0	55.00
55. 01 03480 0NC0L0GY	o	4, 849	Ö	92	0	55. 01
57. 00 05700 CT SCAN	О	1, 434	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	899	0	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60. 00 06000 LABORATORY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	9, 959	0	187 0	0	60. 00 62. 00
65. 00 06500 RESPIRATORY THERAPY	0	3, 597	0	22	0	65.00
66. 00 06600 PHYSI CAL THERAPY	O	6, 445	O	100	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	1, 000	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	694	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	1 000	0	0	0	69.00
69. 01 03610 SLEEP LAB 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 000	0	60, 550	0	69. 01 71. 00
71. 01 07101 IV SOLUTIONS	0	0	0	00, 550	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	55, 938	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	1, 748	137, 650	73.00
76. 00 03140 CARDI OLOGY	0	2, 745	0	40	0	1 . 0. 00
76.97 07697 CARDIAC REHABILITATION 77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	590	0	4	0	76. 97 77. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION 78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS	<u> </u>		<u> </u>	<u> </u>		70.00
90. 00 09000 CLI NI C	0	333	0	2	0	90.00
90. 01 09001 WOUND CARE CLINIC	0	1, 547		8	0	90. 01
91. 00 09100 EMERGENCY	0	9, 942	19, 678	138	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
95. 00 09500 AMBULANCE SERVICES	0	11, 034	0	54	0	95.00
101. 00 10100 HOME HEALTH AGENCY	ő	0	Ö	442		101.00
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 INTEREST EXPENSE				205		113.00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0 283, 989	0 122, 720	104 212	395 134, 889	137, 650	116.00
NONREI MBURSABLE COST CENTERS	203, 909	122, 720	106, 312	134, 009	137, 630	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190. 00
194. 00 07950 OTHER NON-REI MBURSABLE	O	0	0	Ō		194.00
194. 01 07951 MOB	О	0	0	340		194. 01
194. 02 07952 PHYSI CI AN CLI NI CS	0	0	0	1, 108		194. 02
194. 03 07953 PHYS PRAC BUS OFC	0	0	0	58		194. 03
194. 04 07954 MOB - MAIN CAMPUS 194. 05 07955 ONCOLOGY - NONREI MBURSABLE	0	0		49		194. 04 194. 05
194.06 07956 KDH - MC FAMILY PRACTICE	0	0		329		194. 05
194. 07 07957 KDH - MC ORTHOPEDICS	0	0	0	579		194.00
			1	1		

Health Financial Systems	KINGS DAUGHTERS HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0069	Peri od: Worksheet B From 01/01/2023 Part II Date/Time Prepared: 5/23/2024 2:00 pm

					5/22/2024 3:00) pm
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI O	SERVICES &		
			N	SUPPLY		
	10. 00	11. 00	13.00	14.00	15. 00	
194.08 07958 KDH - MC GENERAL SURGERY	0	0	0	284	0	194.08
194.09 07959 KDH - MC ENT	0	0	0	121	0 1	194. 09
194. 10 07960 KDH - MC UROLOGY	0	0	0	204	0	194. 10
194.11 07961 KDH - MC OB/GYN	0	0	0	292	0	194. 11
200.00 Cross Foot Adjustments					[2	200.00
201.00 Negative Cost Centers	o	0	0	0	0 2	201.00
202.00 TOTAL (sum Lines 118 through 201)	283, 989	122, 720	106, 312	138, 253	137, 650	202.00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To 12/31/2023 | Date/Time Prepared: | Part | Part | Prepared: | Part | Par Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS KINGS DAUGHTERS HOSPITAL Provi der CCN: 15-0069

			To	12/31/2023	Date/Time Pre 5/22/2024 3:0	
Cost Center Description	MEDI CAL	NONPHYSI CI AN	RADI OLOGY	Subtotal	Intern &	
	RECORDS & LI BRARY	ANESTHETI STS	SCH00L		Residents Cost & Post	
	LIDRAKI				Stepdown	
	1/ 00	10.00	00.00	24.00	Adjustments	
GENERAL SERVICE COST CENTERS	16. 00	19. 00	23. 00	24. 00	25. 00	
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 01 00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO						1.01
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 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 11. 00 01100 CAFETERI A						10.00 11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00 01500 PHARMACY						15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	36, 061					16.00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS 23. 00 02300 RADI OLOGY SCHOOL	0	0	33, 234			19.00 23.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			33, 234			25.00
30. 00 03000 ADULTS & PEDIATRICS	891			2, 287, 777	0	30.00
31. 00 03100 INTENSIVE CARE UNIT	348			176, 567	0	31.00
43. 00 04300 NURSERY	110			109, 960	0	43.00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	3, 493			1, 040, 066	0	50.00
51. 00 05100 RECOVERY ROOM	590			86, 331	Ö	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	141			35, 234	0	52.00
53. 00 05300 ANESTHESI OLOGY	723			13, 857	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 03630 ULTRA SOUND	731 192		•	544, 918 5, 998		54. 00 54. 01
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	502			26, 525	0	54.01
55. 00 05500 RADI OLOGY - THERAPEUTI C	0			0	0	55.00
55. 01 03480 0NC0L0GY	945			589, 593	0	55. 01
57. 00 05700 CT SCAN	2, 151			64, 150		57.00
58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON	453 0			57, 027 0	0	58. 00 59. 00
60. 00 06000 LABORATORY	3, 714			358, 833	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	204			18, 476	0	62.00
65. 00 06500 RESPI RATORY THERAPY	669			79, 586	0	65.00
66. 00 06600 PHYSI CAL THERAPY	782			590, 667	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	144 104			69, 683 19, 912	0	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	0			0	Ö	69.00
69. 01 03610 SLEEP LAB	233			47, 019	0	69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 510			139, 556	0	71.00
71.01 07101 IV SOLUTIONS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0 2, 244			0 159, 076	0	71. 01 72. 00
73. 00 07300 DRUGS CHARGED TO PATTENTS	10, 993			425, 098		
76. 00 03140 CARDI OLOGY	1, 149			289, 525		
76. 97 07697 CARDI AC REHABI LI TATI ON	87			34, 007	0	
77.00 07700 ALLOGENEIC HSCT ACQUISITION 78.00 07800 CAR T-CELL IMMUNOTHERAPY	0			0		
OUTPATIENT SERVICE COST CENTERS	0			U	0	76.00
90. 00 09000 CLI NI C	5			35, 344	0	90.00
90. 01 09001 WOUND CARE CLINIC	280			27, 926		90. 01
91. 00 09100 EMERGENCY	2, 103			796, 450		91.00
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS					0	92.00
95. 00 09500 AMBULANCE SERVICES	570			265, 396	0	95.00
101.00 10100 HOME HEALTH AGENCY	0			44, 232		101.00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0			0	0	102.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	0			11, 881		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	36, 061	0	0	8, 450, 670	0	118.00
NONREI MBURSABLE COST CENTERS	-					100 0-
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 194.00 07950 OTHER NON-REIMBURSABLE	0			32, 634		190. 00 194. 00
194. 00 07950 0THER NON-RETMBORSABLE 194. 01 07951 M0B	0			2, 358, 254		194.00
194. 02 07952 PHYSI CI AN CLI NI CS	Ö			1, 381, 199		194. 02
194.03 07953 PHYS PRAC BUS OFC	0			77, 630	0	194. 03
194.04 07954 MOB - MAIN CAMPUS 194.05 07955 ONCOLOGY - NONREIMBURSABLE	0			9, 166 0		194. 04 194. 05
174. 00 0/900 UNCOLOGT - INDINKET MOUKSABLE	1 0		1	U	1 0	1174. 05

Health Financial Systems	KINGS DAUGHTERS HO	OSPI TAL	In Lieu	of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	P	Provider CO	From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/22/2024 3:00 pm

					5/22/2024 3:0	O pm
Cost Center Description	MEDI CAL	NONPHYSI CI AN	RADI OLOGY	Subtotal	Intern &	
	RECORDS &	ANESTHETI STS	SCH00L		Resi dents	
	LI BRARY				Cost & Post	
					Stepdown	
					Adjustments	
	16. 00	19. 00	23. 00	24. 00	25. 00	
194.06 07956 KDH - MC FAMILY PRACTICE	0			1, 955, 785	0	194.06
194.07 07957 KDH - MC ORTHOPEDICS	0			83, 499	0	194. 07
194.08 07958 KDH - MC GENERAL SURGERY	0			43, 682	0	194. 08
194.09 07959 KDH - MC ENT	0			18, 395	0	194. 09
194. 10 07960 KDH - MC UROLOGY	0			13, 386	0	194. 10
194. 11 07961 KDH - MC OB/GYN	0			58, 529	0	194. 11
200.00 Cross Foot Adjustments		0	33, 234	33, 234	0	200.00
201.00 Negative Cost Centers	0	0	0	o	0	201.00
202.00 TOTAL (sum lines 118 through 201)	36, 061	0	33, 234	14, 516, 063	0	202. 00

			/22/2024 3:00 pm
	Cost Center Description	Total	
	GENERAL SERVICE COST CENTERS	26. 00	
	00100 NEW CAP REL COSTS-BLDG & FLXT		1.00
1. 01	00101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO		1. 01
	00200 NEW CAP REL COSTS-MVBLE EQUIP		2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
	00500 ADMINISTRATIVE & GENERAL		5.00
	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE		7. 00 8. 00
	00900 HOUSEKEEPI NG		9.00
	01000 DI ETARY		10.00
	01100 CAFETERI A		11.00
	01300 NURSING ADMINISTRATION		13.00
	01400 CENTRAL SERVI CES & SUPPLY		14.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY		15. 00 16. 00
	01900 NONPHYSICIAN ANESTHETISTS		19.00
	02300 RADI OLOGY SCHOOL		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		
	03000 ADULTS & PEDIATRICS	2, 287, 777	30.00
	03100 INTENSIVE CARE UNIT	176, 567	31.00
	04300 NURSERY	109, 960	43.00
	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	1, 040, 066	50.00
	05100 RECOVERY ROOM	86, 331	51.00
	05200 DELIVERY ROOM & LABOR ROOM	35, 234	52.00
53.00	05300 ANESTHESI OLOGY	13, 857	53.00
	05400 RADI OLOGY-DI AGNOSTI C	544, 918	54.00
	03630 ULTRA SOUND	5, 998	54. 01
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	26, 525	54. 02
	05500 RADI OLOGY - THERAPEUTI C 03480 ONCOLOGY	0 589, 593	55. 00 55. 01
	05700 CT SCAN	64, 150	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	57, 027	58.00
	05900 CARDI AC CATHETERI ZATI ON	0	59.00
60.00	06000 LABORATORY	358, 833	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	18, 476	62.00
	06500 RESPI RATORY THERAPY	79, 586	65. 00
	06600 PHYSI CAL THERAPY	590, 667	66.00
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	69, 683 19, 912	67. 00 68. 00
	06900 ELECTROCARDI OLOGY	17, 712	69.00
	03610 SLEEP LAB	47, 019	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	139, 556	71.00
	07101 IV SOLUTIONS	0	71. 01
	07200 I MPL. DEV. CHARGED TO PATIENTS	159, 076	72.00
	07300 DRUGS CHARGED TO PATIENTS	425, 098	73.00
	03140 CARDI OLOGY 07697 CARDI AC REHABI LI TATI ON	289, 525 34, 007	76. 00 76. 97
	07700 ALLOGENEIC HSCT ACQUISITION	34,007	77.00
	07800 CAR T-CELL IMMUNOTHERAPY	o	78.00
	OUTPATIENT SERVICE COST CENTERS		
	09000 CLI NI C	35, 344	90.00
	09001 WOUND CARE CLINIC	27, 926	90. 01
	09100 EMERGENCY	796, 450	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS		92.00
	09500 AMBULANCE SERVICES	265, 396	95.00
	10100 HOME HEALTH AGENCY	44, 232	101.00
	10200 OPIOID TREATMENT PROGRAM	0	102.00
	SPECIAL PURPOSE COST CENTERS		
	11300 I NTEREST EXPENSE	11 001	113.00
118.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	11, 881 8, 450, 670	116. 00 118. 00
	NONREIMBURSABLE COST CENTERS	8, 430, 670	110.00
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	32, 634	190. 00
	07950 OTHER NON-REIMBURSABLE	0	194. 00
194.01	07951 MOB	2, 358, 254	194. 01
	07952 PHYSICIAN CLINICS	1, 381, 199	194. 02
	07953 PHYS PRAC BUS OFC	77, 630	194. 03
	07954 MOB - MAIN CAMPUS	9, 166	194. 04
	07955 ONCOLOGY - NONREI MBURSABLE	1 055 705	194. 05
	07956 KDH - MC FAMILY PRACTICE 07957 KDH - MC ORTHOPEDICS	1, 955, 785 83, 499	194. 06 194. 07
	07957 KDH - MC ORTHOPEDICS 07958 KDH - MC GENERAL SURGERY	43, 682	194. 07
	07959 KDH - MC GENERAL SURGERT	18, 395	194. 09
177.07	57757 ROTT INC LIFE	10, 373	174.07

Health Financial Systems	KINGS DAUGHTER	S HOSPITAL	In Lieu	of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0069	Peri od: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/22/2024 3:00 pm
Cost Center Description	Total			
	26. 00			
194. 10 07960 KDH - MC UROLOGY	13, 386			194. 10
194.11 07961 KDH - MC OB/GYN	58, 529			194. 11
200.00 Cross Foot Adjustments	33, 234			200. 00
201.00 Negative Cost Centers	0			201.00
202.00 TOTAL (sum lines 118 through 201)	14, 516, 063			202.00

	ALLOCATION - STATISTICAL BASIS	KINGS DAGGITE	Provi der Co	CN: 15-0069	Peri od:	Worksheet B-1	
					From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
		CAPI	TAL RELATED CO			5/22/2024 3:0	O pm
	Cost Center Description	NEW BLDG & FLXT	NEW BLDG & FIXT HHA/HO	NEW MVBLE EQUIP	EMPLOYEE BENEFITS	Reconciliatio n	
		(SQUARE	(SQUARE	(SQUARE	DEPARTMENT	"	
		FEET)	FEET)	FEET)	(GROSS		
		1. 00	1. 01	2. 00	SALARI ES) 4. 00	5A	
	GENERAL SERVICE COST CENTERS			2.00	1 00	G/.	
1. 00 1. 01	OO100 NEW CAP REL COSTS-BLDG & FIXT OO101 NEW CAP REL COSTS-BLDG & FIXT HHA/HO	370, 078 0	3, 492				1. 00 1. 01
2. 00	00200 NEW CAP REL COSTS-BLDG & FIXT HHAZHO		3, 492		0	•	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	o	0		0 62, 884, 264	1	4.00
5. 00 7. 00	OO5OO ADMINISTRATIVE & GENERAL OO7OO OPERATION OF PLANT	43, 839 40, 893	0		0 7, 805, 629 0 716, 627		1
8. 00	00800 LAUNDRY & LINEN SERVICE	1, 906	0		0 716, 627 0 32, 458	1	1
9. 00	00900 HOUSEKEEPI NG	3, 341	0	•	0 855, 725	0	9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	6, 293 2, 545	0		0 322, 832 0 573, 032	1	10.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	2, 038	0		0 573, 032 0 653, 719		
14.00	01400 CENTRAL SERVICES & SUPPLY	3, 096	0		0 78, 524	1	14.00
15.00	01500 PHARMACY	2, 301	0		0 1, 062, 054		
16. 00 19. 00	01600 MEDICAL RECORDS & LIBRARY 01900 NONPHYSICIAN ANESTHETISTS	189 0	0		0 802, 514 0 0	1	
	02300 RADI OLOGY SCHOOL	661	0		0 160, 701	1	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	20.000		Ī	5 000 77/		00.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	39, 802 1, 674	0		0 5, 923, 776 0 1, 077, 772		
	04300 NURSERY	1, 955	0	l .	0 503, 614		
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	10 424	0	1	0 3, 205, 841	0	E0 00
51.00	05100 RECOVERY ROOM	18, 436 1, 375	0	•	0 3, 205, 841 0 512, 505	1	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	•	0 666, 531	0	52.00
53.00	05300 ANESTHESI OLOGY	130	0		0 1, 509, 735	1	
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	10, 841	0		0 3, 464, 875 0 133, 818	1	
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	483	0		0 86, 200	1	1
55.00	05500 RADI OLOGY - THERAPEUTI C	0	0		0 0	0	
55. 01 57. 00	O3480 ONCOLOGY O5700 CT SCAN	12, 247 895	0		0 1, 201, 645 0 300, 444		00.0.
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 080	0	•	0 242, 034		1
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	•	0 0	0	
60. 00 62. 00	O6000 LABORATORY O6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	6, 239 279	0		0 1, 453, 451 0 0	0	
65.00	06500 RESPIRATORY THERAPY	1, 197	0		0 899, 639	1	1
66.00	06600 PHYSI CAL THERAPY	12, 401	0		0 1, 403, 935	1	66.00
67. 00 68. 00	O6700 OCCUPATI ONAL THERAPY O6800 SPEECH PATHOLOGY	1, 420 336	0		0 282, 176 0 186, 533	1	
	06900 ELECTROCARDI OLOGY	0	0		0 0	ő	69.00
	03610 SLEEP LAB	839	0		0 208, 792	1	
71. 00 71. 01	O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS O7101 V SOLUTIONS	0	0		0 0	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	ő	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73. 00
76. 00 76. 97	03140 CARDI OLOGY 07697 CARDI AC REHABI LI TATI ON	6, 047 703	0		0 568, 376 0 85, 503	1	76. 00 76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	703	0		0 0 0	1	1
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0	78. 00
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	760	0	1	0 82, 419	0	90.00
90. 01	09001 WOUND CARE CLINIC	110	0	1	0 395, 233		
91.00	09100 EMERGENCY	13, 879	0		0 2, 482, 286	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
95. 00	09500 AMBULANCE SERVICES	4, 732	0		0 1, 994, 382	0	95.00
	10100 HOME HEALTH AGENCY	0	2, 748	1	0 1, 051, 239		101.00
102.00	10200 OPIOI D TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	102.00
	11300 I NTEREST EXPENSE						113. 00
	11600 HOSPI CE	0	744		0 226, 206	1	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	244, 962	3, 492	<u> </u>	0 43, 212, 775	-30, 137, 143	Ji 18.00
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	752	0		0 0	•	190.00
	07950 OTHER NON-REIMBURSABLE 07951 MOB	0 52, 635	0		0 0 0 2, 749, 871		194. 00 194. 01
194. 01	07951 MOB 07952 PHYSI CLAN CLINICS	27, 594	0		0 2, 749, 871	•	194.01
	07953 PHYS PRAC BUS OFC	989	0		0 888, 611		194. 03

| Peri od: | Worksheet B-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

				'	3 12/31/2023	5/22/2024 3:0	
		CAPI	TAL RELATED CO	OSTS			
	Cost Center Description	NEW BLDG &	NEW BLDG &	NEW MVBLE	EMPLOYEE	Reconciliatio	
		FLXT	FIXT HHA/HO	EQUI P	BENEFI TS	n	
		(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	DEPARTMENT (GROSS		
		FEE1)	reei)	FEET)	SALARI ES)		
		1. 00	1. 01	2.00	4. 00	5A	
194. 04 07954	MOB - MAIN CAMPUS	0	0	0	350, 465	0	194. 04
194. 05 07955	ONCOLOGY - NONREI MBURSABLE	o	0	0	0	0	194. 05
194. 06 07956	KDH - MC FAMILY PRACTICE	43, 146	0	0	3, 107, 794	0	194. 06
1	KDH - MC ORTHOPEDICS	0	0	0	2, 859, 325		194. 07
-	KDH - MC GENERAL SURGERY	0	0	0	1, 499, 086	_	194. 08
	KDH - MC ENT	0	0	0	717, 538		194. 09
	KDH - MC UROLOGY	0	0	0	107, 479	_	194. 10
	KDH - MC OB/GYN	0	0	0	1, 480, 637		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)	13, 703, 274	1, 435	0	13, 136, 070		202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	37. 028070	0. 410939	0. 000000	0. 208893		203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)				0		204. 00
205. 00	Unit cost multiplier (Wkst. B, Part				0. 000000		205. 00
	11)						
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems KINGS DAUGHTERS HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0069 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/22/2024 3:00 pm Cost Center Description ADMINISTRATIV OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY LINEN SERVICE (HOURS OF (MEALS E & GENERAL PLANT (ACCUM. (SQUARE (POUNDS OF SERVICE) SERVED) LAUNDRY) COST) FFFT) 9. 00 10.00 5.00 7.00 8.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 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 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 122, 030, 146 5.00 7.00 00700 OPERATION OF PLANT 288, 941 5, 627, 534 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 429, 893 1, 906 641, 522 8.00 9 00 00900 HOUSEKEEPI NG 1, 595, 140 3, 341 36, 719 3,527 9 00 01000 DI ETARY 763, 992 6, 293 49, 115 10.00 10.00 0 2, 545 01100 CAFFTERI A 0 11.00 709, 621 0 0 11.00 13.00 01300 NURSING ADMINISTRATION 866, 648 2,038 0 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 210, 044 3,096 0 24 0 14.00 01500 PHARMACY 2, 301 1, 697, 915 0 29 15.00 0 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 1, 132, 704 292 0 0 16.00 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 19.00 0 02300 RADI OLOGY SCHOOL 23.00 184, 954 0 23.00 661 13 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 9, 877, 880 38, 288 122, 397 1, 097 45, 434 30.00 03100 INTENSIVE CARE UNIT 81, 747 3, 681 31.00 2, 648, 991 1,674 194 31.00 922, 185 04300 NURSERY 1, 955 43.00 43.00 13, 441 12 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 8, 145, 587 18, 436 97, 334 390 0 50.00 05100 RECOVERY ROOM 51.00 1,017,991 1, 375 20, 265 0 0 51.00 1, 124, 702 17, 790 52 00 05200 DELIVERY ROOM & LABOR ROOM 55 52 00 0 05300 ANESTHESI OLOGY 53.00 320, 187 130 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 3, 357, 885 10, 841 25, 707 0 54.00 46 54.01 03630 ULTRA SOUND 203.899 2, 633 18 0 54.01 C 03450 NUCLEAR MEDICINE - DIAGNOSTIC 54.02 223, 697 483 1, 768 8 0 54.02 55.00 05500 RADI OLOGY - THERAPEUTI C 0 0 55.00 03480 ONCOLOGY 55.01 2, 588, 393 12, 247 21, 977 129 0 55.01 57 00 05700 CT SCAN 782 671 895 15 283 91 0 57 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 461, 828 1,080 2,796 0 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 59.00 0 06000 LABORATORY 6, 239 60.00 3, 783, 084 0 66 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 319, 292 0 62 00 279 0 0 62 00 06500 RESPIRATORY THERAPY 0 65.00 1, 214, 823 1, 197 0 0 06600 PHYSI CAL THERAPY 12, 401 88 0 66.00 2, 272, 183 32, 399 66.00 67.00 06700 OCCUPATI ONAL THERAPY 399, 301 1, 420 0 0 0 06800 SPEECH PATHOLOGY 239, 687 68.00 68 00 336 0 69.00 06900 ELECTROCARDI OLOGY 0 0 69.01 03610 SLEEP LAB 409, 972 839 2, 413 29 0 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 3, 884, 333 0 71.00 0 07101 IV SOLUTIONS 71.01 C 0 0 71.01 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 5, 057, 108 C 0 0 0 73 00 07300 DRUGS CHARGED TO PATIENTS 13, 768, 877 0 0 0 03140 CARDI OLOGY 79 1,026,114 6,047 0 76.00 22, 489 76.00 07697 CARDIAC REHABILITATION 13 76.97 134, 110 703 0 0 76.97 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 129, 578 760 0 0 90.01 09001 WOUND CARE CLINIC 539, 201 1,624 2, 405 35 0 09100 EMERGENCY 63, 559 474 91.00 6, 993, 295 13, 879 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 2, 487, 338 4, 732 16, 122 0 101.00 10100 HOME HEALTH AGENCY 1, 362, 945 2, 748 C 0 102.00 10200 OPIOID TREATMENT PROGRAM 0 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 116. 00 11600 HOSPI CE 350, 468 01116.00 744 \cap 0 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 89, 266, 050 163, 825 599, 244 2,896 NONREI MBURSABLE COST CENTERS 190, 00 19000 GLFT, FLOWER, COFFEE SHOP, & CANTEEN 27,845 752 0 0

Health Financial Systems	KINGS DAUGHTERS HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0069	Peri od: Worksheet B-1

					1011 01/01/2023		
				Te	o 12/31/2023		
						5/22/2024 3:0	O pm
	Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		E & GENERAL	PLANT	LINEN SERVICE	(HOURS OF	(MEALS	
		(ACCUM.	(SQUARE	(POUNDS OF	SERVICE)	SERVED)	
		COST)	FEET)	LAUNDRY)			
		5. 00	7. 00	8. 00	9. 00	10.00	
194.070	7957 KDH - MC ORTHOPEDICS	3, 973, 386	0	2, 055	66	0	194. 07
194. 08 0	7958 KDH - MC GENERAL SURGERY	1, 925, 294	0	2, 167	92	0	194. 08
194. 09 0	7959 KDH - MC ENT	824, 136	0	0	36	0	194. 09
194. 10 0	7960 KDH - MC UROLOGY	537, 286	0	1, 963	43	0	194. 10
194. 11 0	7961 KDH - MC OB/GYN	2, 653, 858	0	10, 875	74	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,	30, 137, 143	7, 017, 338	582, 352	2, 103, 557	1, 109, 083	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 246965	24. 286404	0. 907766	596. 415367	22. 581350	203. 00
204.00	Cost to be allocated (per Wkst. B,	2, 434, 628	1, 626, 464	89, 882	179, 488	283, 989	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 019951	5. 629052	0. 140107	50. 889708	5. 782124	205. 00
	11)						
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

	Financial Systems	KINGS DAUGHTE				U OF FORM CMS-2	
COST A	NLLOCATION - STATISTICAL BASIS		Provi der CC	F	eriod: rom 01/01/2023 o 12/31/2023		pared:
	Coot Conton Decemintion	CAFFTEDIA	NUDCLNC	CENTRAL	DHADMACV	5/22/2024 3: 0	O pm
	Cost Center Description	CAFETERIA (MEALS	NURSI NG ADMI NI STRATI O	CENTRAL SERVICES &	PHARMACY (COSTED	MEDI CAL RECORDS &	
		SERVED)	N N	SUPPLY	REQUIS.)	LI BRARY	
		02.11123)	(DI RECT	(COSTED		(GROSS	
			NRŜI NG HRS)	REQUIS.)		CHARGES)	
		11. 00	13. 00	14. 00	15. 00	16. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT			<u> </u>			1 1 00
1. 00	00100 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	770 110					10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	770, 119 13, 098					11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	4, 860		11, 004, 405			14.00
15. 00	01500 PHARMACY	24, 944	o o	13, 524	l .		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	29, 770	0	6, 036	l .	388, 141, 008	
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	O	0	19.00
23.00	02300 RADI OLOGY SCHOOL	4, 250	0	620	0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS	10/ 100	407.400			0.500.007	
30.00	03000 ADULTS & PEDIATRICS	136, 138			0	9, 580, 327	•
31. 00 43. 00	03100 INTENSIVE CARE UNIT 04300 NURSERY	19, 692 11, 716	19, 692 11, 716	190 0	l .	3, 742, 454 1, 183, 282	
43.00	ANCI LLARY SERVI CE COST CENTERS	11,710	11,710		<u> </u>	1, 103, 202	43.00
50.00		83, 352	83, 352	1, 160, 500	0	37, 554, 849	50.00
51.00	05100 RECOVERY ROOM	8, 272	8, 272	882	0	6, 345, 776	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	15, 507	15, 507	0		1, 516, 744	1
53. 00	05300 ANESTHESI OLOGY	7, 447	0	1, 046		7, 771, 207	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	54, 497	0	9, 639	l .	7, 856, 091	1
54. 01 54. 02	03630 ULTRA SOUND 03450 NUCLEAR MEDICINE - DIAGNOSTIC	2, 845 1, 890		0 0	- I	2, 061, 313 5, 402, 489	1
55. 00	05500 RADI OLOGY - THERAPEUTI C	1,090	0	0		0, 402, 407	ı
55. 01	03480 ONCOLOGY	30, 428	ő	7, 320		10, 163, 718	1
57.00	05700 CT SCAN	8, 998	0	8		23, 125, 393	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	5, 644	0	0	· ·	4, 866, 839	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60. 00 62. 00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	62, 495	0	14, 917	0	39, 937, 235	1
65.00	06500 RESPIRATORY THERAPY	22, 572	0	1, 716	· ·	2, 191, 284 7, 192, 511	1
66. 00	06600 PHYSI CAL THERAPY	40, 443	Ö	7, 921	o	8, 410, 826	
67.00	06700 OCCUPATI ONAL THERAPY	6, 277	0	1	0	1, 551, 861	
68.00	06800 SPEECH PATHOLOGY	4, 353	0	0	0	1, 118, 879	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	
	03610 SLEEP LAB	6, 273			l .	2, 504, 053	69.01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07101 IV SOLUTIONS	0	0	4, 819, 550	0	16, 240, 373 0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	4, 452, 618	· ·	24, 130, 060	•
	07300 DRUGS CHARGED TO PATIENTS	o o	ő	139, 115	l .	118, 598, 045	
76.00	03140 CARDI OLOGY	17, 225	0	3, 158	0	12, 354, 685	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	3, 702	0	299	l .	932, 393	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	l .	0	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	78. 00
90. 00	09000 CLINIC	2, 087	0	135	O	53, 291	90.00
	09001 WOUND CARE CLINIC	9, 709	o o	623		3, 010, 249	1
91.00	09100 EMERGENCY	62, 390	1		l :	22, 610, 438	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	69, 245	1	4, 300	l .	6, 134, 343	
	10100 HOME HEALTH AGENCY 10200 OPIOID TREATMENT PROGRAM	0	0	35, 147 0			101. 00 102. 00
102.00	SPECIAL PURPOSE COST CENTERS	0	j o	0	l O	0	102.00
113.00	11300 I NTEREST EXPENSE						113.00
116.00	11600 HOSPI CE	0	0	31, 408	o	0	116. 00
118.00	9 /	770, 119	337, 067	10, 736, 667	100	388, 141, 008	118.00
400.55	NONREI MBURSABLE COST CENTERS	-	-	-	-1		100.05
	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	·		190.00
	07950 OTHER NON-REI MBURSABLE 07951 MOB	0		27, 032			194. 00 194. 01
	07951 MOB 07952 PHYSI CI AN CLI NI CS		n	88, 168	l .		194.01
	07953 PHYS PRAC BUS OFC	0	Ö	4, 608			194. 03
	07954 MOB - MAIN CAMPUS	0	0	3, 910	o		194. 04
194. 05	07955 ONCOLOGY - NONREI MBURSABLE	0	0	0	O	0	194. 05

				T T	o 12/31/2023	Date/Time Pre 5/22/2024 3:0	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	O DIII
	oost denter bescription	*	ADMI NI STRATI O	SERVICES &	(COSTED	RECORDS &	
		SERVED)	N	SUPPLY	REQUIS.)	LI BRARY	
			(DI RECT	(COSTED		(GROSS	
			NRŜING HRS)	REQUIS.)		CHARGES)	
		11. 00	13. 00	14.00	15. 00	16. 00	
	KDH - MC FAMILY PRACTICE	0	0	26, 208	0	0	194. 06
	KDH - MC ORTHOPEDICS	0	0	46, 085	0	0	194. 07
194. 08 07958	KDH - MC GENERAL SURGERY	0	0	22, 624	0	-	194. 08
194. 09 07959	KDH - MC ENT	0	0	9, 598	0	0	194. 09
•	KDH - MC UROLOGY	0	0	16, 273			194. 10
	KDH - MC OB/GYN	0	0	23, 232	0	- 1	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,	946, 682	1, 146, 277	357, 397	2, 221, 522	1, 456, 325	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	1. 229267	1		22, 215. 220000		
204. 00	Cost to be allocated (per Wkst. B,	122, 720	106, 312	138, 253	137, 650	36, 061	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 159352	0. 315403	0. 012563	1, 376. 500000	0. 000093	205.00
201 00	11)						00/ 00
206. 00	NAHE adjustment amount to be allocated						206. 00
207.00	(per Wkst. B-2)						207.00
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
ļ	Parts III and IV)						

Health Financial Systems

In Lieu of Form CMS-2552-10 KINGS DAUGHTERS HOSPITAL COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0069 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/22/2024 3:00 pm 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 1.00 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 5.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9 00 00900 HOUSEKEEPI NG 9 00 01000 DI ETARY 10.00 10.00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 02300 RADI OLOGY SCHOOL 23.00 100 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 0 30.00 03100 INTENSIVE CARE UNIT 0 31.00 0 31.00 04300 NURSERY 0 43.00 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 50.00 05100 RECOVERY ROOM 51.00 0000000000000000000000000000 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 52 00 05300 ANESTHESI OLOGY 53.00 Ω 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 100 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 55.01 0 55.01 57 00 05700 CT SCAN 0 57 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 06000 LABORATORY 60.00 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62 00 62 00 06500 RESPIRATORY THERAPY 65.00 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 67.00 06800 SPEECH PATHOLOGY 0 68 00 68 00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 69.01 03610 SLEEP LAB 0 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 71.00 07101 IV SOLUTIONS 71.01 0 71.01 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 03140 CARDI OLOGY 0 76.00 76.00 07697 CARDIAC REHABILITATION 76.97 0 76.97 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 O 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 90. 01 09001 WOUND CARE CLINIC 0 0 90.01 09100 EMERGENCY 0 91.00 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0 0 95.00 101.00 10100 HOME HEALTH AGENCY 101.00 0 0 102.00 10200 OPI OID TREATMENT PROGRAM 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE Ω 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 100 118.00 NONREI MBURSABLE COST CENTERS 190, 00 19000 GLFT, FLOWER, COFFEE SHOP, & CANTEEN 0 0 190.00 0 194. 00 07950 OTHER NON-REI MBURSABLE l194. 00 0 194. 01 07951 MOB 0 194.01 0 0 0 194. 02 07952 PHYSICIAN CLINICS 0 194.02 194. 03 07953 PHYS PRAC BUS OFC 0 194. 03

0

0

0

194.04

194.05

194.06

194. 04 07954 MOB - MAIN CAMPUS

194. 05 07955 ONCOLOGY - NONREI MBURSABLE

194.06 07956 KDH - MC FAMILY PRACTICE

Health Financial Systems	KINGS DAUGHTERS HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0069	Peri od: Worksheet B-1
		From 01/01/2023
		To 12/21/2022 Data/Time Dropared.

				10	5/22/2024 3	
	Cost Center Description	NONPHYSI CI AN	RADI OLOGY	<u> </u>		
	·	ANESTHETI STS	SCH00L			
		(ASSI GNED	(ASSI GNED			
		TIME)	TIME)			
		19. 00	23. 00			
194. 07 07957	KDH - MC ORTHOPEDICS	0	0			194. 07
194. 08 07958	KDH - MC GENERAL SURGERY	0	0			194. 08
194. 09 07959	KDH - MC ENT	0	0			194. 09
194. 10 07960	KDH - MC UROLOGY	0	0			194. 10
194. 11 07961	KDH - MC OB/GYN	0	0			194. 11
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202. 00	Cost to be allocated (per Wkst. B,	0	259, 681			202.00
	Part I)					
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	2, 596. 810000			203.00
204. 00	Cost to be allocated (per Wkst. B,	0	33, 234			204.00
	Part II)					
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	332. 340000			205.00
	11)					
206. 00	NAHE adjustment amount to be allocated		0			206. 00
	(per Wkst. B-2)					
207. 00	NAHE unit cost multiplier (Wkst. D,		0. 000000			207. 00
	Parts III and IV)					

			Ť	o 12/31/2023	Date/Time Pre 5/22/2024 3:0	pared:
		Title	XVIII	Hospi tal	PPS	<u>o p</u>
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	col . 26) 1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS	15, 705, 337		15, 705, 337	o	15, 705, 337	30.00
31. 00 03100 NTENSI VE CARE UNI T	3, 722, 110		3, 722, 110	0	3, 722, 110	
43. 00 04300 NURSERY	1, 275, 455		1, 275, 455	0	1, 275, 455	
ANCILLARY SERVICE COST CENTERS	1, 275, 455		1, 273, 433	<u> </u>	1, 273, 433	43.00
50. 00 05000 OPERATING ROOM	11, 490, 481		11, 490, 481	o	11, 490, 481	50.00
51. 00 05100 RECOVERY ROOM	1, 383, 326		1, 383, 326	l ő	1, 383, 326	
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 528, 904		1, 528, 904	l ő	1, 528, 904	1
53. 00 05300 ANESTHESI OLOGY	440, 765		440, 765	4, 506	445, 271	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 857, 686		4, 857, 686	0	4, 857, 686	
54. 01 03630 ULTRA SOUND	278, 611		278, 611	o	278, 611	
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	319, 641		319, 641	0	319, 641	
55. 00 05500 RADI OLOGY - THERAPEUTI C	0		0.7,011	o	0.7,511	55.00
55. 01 03480 0NCOLOGY	3, 697, 735		3, 697, 735	0	3, 697, 735	
57. 00 05700 CT SCAN	1, 163, 673		1, 163, 673	o	1, 163, 673	1
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	629, 848		629, 848	o	629, 848	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		0	o	0	59.00
60. 00 06000 LABORATORY	5, 135, 411		5, 135, 411	54, 014	5, 189, 425	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	413, 144		413, 144	0	413, 144	62.00
65. 00 06500 RESPIRATORY THERAPY	1, 598, 702	0	1, 598, 702	o	1, 598, 702	
66. 00 06600 PHYSI CAL THERAPY	3, 297, 934	0	3, 297, 934	o	3, 297, 934	
67. 00 06700 OCCUPATI ONAL THERAPY	545, 940	0	545, 940	o	545, 940	
68.00 06800 SPEECH PATHOLOGY	316, 590	0	316, 590	o	316, 590	68.00
69. 00 06900 ELECTROCARDI OLOGY	0		0	o	0	69.00
69. 01 03610 SLEEP LAB	568, 197		568, 197	0	568, 197	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 061, 083		5, 061, 083	o	5, 061, 083	71.00
71.01 07101 IV SOLUTIONS	0		0	0	0	71. 01
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	6, 541, 185		6, 541, 185	0	6, 541, 185	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	19, 840, 318		19, 840, 318	0	19, 840, 318	73.00
76. 00 03140 CARDI OLOGY	1, 561, 552		1, 561, 552	0	1, 561, 552	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	200, 115		200, 115	0	200, 115	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	182, 806		182, 806	0	182, 806	90.00
90. 01 09001 WOUND CARE CLINIC	758, 113		758, 113	0	758, 113	
91. 00 09100 EMERGENCY	9, 771, 920		9, 771, 920	2, 133, 541	11, 905, 461	
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 069, 832		4, 069, 832		4, 069, 832	92.00
OTHER REIMBURSABLE COST CENTERS	T					
95. 00 09500 AMBULANCE SERVICES	3, 339, 458		3, 339, 458	65	3, 339, 523	
101.00 10100 HOME HEALTH AGENCY	1, 767, 426		1, 767, 426		1, 767, 426	
102. 00 10200 OPI OI D TREATMENT PROGRAM	0		0		0	102.00
SPECIAL PURPOSE COST CENTERS						1110 00
113. 00 11300 INTEREST EXPENSE	457 440		45/ 410		457 440	113.00
116. 00 11600 HOSPI CE	456, 110	_	456, 110	0 400 401	456, 110	
200.00 Subtotal (see instructions)	111, 919, 408	0	111, 919, 408	2, 192, 126	114, 111, 534	
201.00 Less Observation Beds	4, 069, 832	0	4, 069, 832	2 102 124	4, 069, 832	
202.00 Total (see instructions)	107, 849, 576	O ₁	107, 849, 576	2, 192, 126	110, 041, 702	J2U2. UU

					To 12/31/2023		pared:
			Title	XVIII	Hospi tal	PPS	о рііі
			Charges	XVIII	nospi tui	110	
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	3031 3011101 30301 P 11 011	i inputi ont	output. o	+ col . 7)	Ratio	Inpatient	
				,		Ratio	
		6. 00	7.00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	9, 702, 672		9, 702, 672	2		30.00
31.00	03100 INTENSIVE CARE UNIT	3, 742, 454		3, 742, 454	1		31.00
43.00	04300 NURSERY	1, 183, 282		1, 183, 282	2		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	9, 297, 461	28, 257, 388	37, 554, 849	0. 305965	0. 000000	
51.00	05100 RECOVERY ROOM	1, 675, 537	4, 670, 239			0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 512, 288	4, 456			0.000000	
53.00	05300 ANESTHESI OLOGY	2, 694, 643	5, 076, 565			0.000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 452, 568	6, 403, 523			0. 000000	
54. 01	03630 ULTRA SOUND	192, 261	1, 869, 052	2, 061, 313		0. 000000	
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	200, 312	5, 202, 177	5, 402, 489		0. 000000	1
55.00	05500 RADI OLOGY - THERAPEUTI C	0	0	(0.000000	0. 000000	
55. 01	03480 ONCOLOGY	51, 259	10, 112, 459			0. 000000	
57.00	05700 CT SCAN	3, 205, 534	19, 920, 302			0. 000000	1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	382, 311	4, 484, 528	4, 866, 839		0. 000000	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	(0. 000000	0. 000000	1
60.00	06000 LABORATORY	5, 582, 676	34, 354, 558			0. 000000	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 135, 448	1, 055, 836			0. 000000	1
65.00	06500 RESPI RATORY THERAPY	4, 406, 828	2, 662, 895	7, 069, 723		0. 000000	1
66. 00	06600 PHYSI CAL THERAPY	904, 012	7, 506, 814			0. 000000	1
67. 00	06700 OCCUPATI ONAL THERAPY	430, 877	1, 120, 985			0. 000000	1
68. 00	06800 SPEECH PATHOLOGY	234, 667	884, 212			0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	0	0	(0.00000	0. 000000	
69. 01	03610 SLEEP LAB	0	2, 504, 053			0. 000000	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 613, 682	8, 626, 691	16, 240, 373		0. 000000	
71. 01	07101 IV SOLUTIONS	0	0	()	0.00000	0. 000000	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	9, 968, 198	14, 161, 862			0. 000000	1
73.00	07300 DRUGS CHARGED TO PATIENTS	30, 540, 551	88, 057, 494			0.000000	1
76.00	03140 CARDI OLOGY	1, 749, 586	10, 605, 099			0.000000	
76. 97	07697 CARDI AC REHABI LI TATI ON	907	931, 486			0.000000	
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	(0.000000	1
78. 00	07800 CAR T-CELL I MMUNOTHERAPY	l U	0	[(0. 000000	0. 000000	78. 00
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	1, 144	52, 147	53, 29	3. 430335	0. 000000	90.00
90.00	09001 WOUND CARE CLINIC	20, 180	2, 990, 069			0. 000000	1
91. 00	09100 EMERGENCY	3, 801, 931	18, 808, 508			0. 000000	1
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1 ' ' 1					1
92.00	OTHER REIMBURSABLE COST CENTERS	756, 674	3, 427, 324	4, 183, 998	0. 972714	0. 000000	92.00
05 00	09500 AMBULANCE SERVICES	l ol	6, 134, 343	4 124 24	0. 544387	0. 000000	95.00
	109300 AMBOLANCE SERVICES	0	1, 489, 816			0.000000	101.00
	10100 HOME HEALTH AGENCY		1, 469, 610	1, 409, 010			101.00
102.00	SPECIAL PURPOSE COST CENTERS	ı o	0		الــــــــــــــــــــــــــــــــــــ		102.00
113 00	11300 INTEREST EXPENSE						113. 00
	11600 HOSPI CE		532, 274	532, 274	1		116.00
200.00		102, 439, 943	291, 907, 155				200.00
201.00		102, 437, 743	271, 707, 133	374, 347, 070	1		201.00
202.00	1 1	102, 439, 943	291, 907, 155	394, 347, 098	3		202.00
202.00	1.11. (888 1.181 481 6.18)		_,,,,,,,,	37.,3.,,07.	-1 1		

Heal th Financial Systems KINGS DAUGHTERS HOSPITAL In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0069
From 01/01/2023
To 12/31/2023 Worksheet C
Part I
Date/Time Prepared: 5/22/2024 3:00 pm

				5/22/2024 3:0	00 pm
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>				
30. 00 03000 ADULTS & PEDIATRICS					30.00
31. 00 03100 I NTENSI VE CARE UNI T					31.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					43.00
	0.205045				F0 00
50. 00 05000 OPERATING ROOM	0. 305965				50.00
51. 00 05100 RECOVERY ROOM	0. 217992				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1. 008017				52.00
53. 00 05300 ANESTHESI OLOGY	0. 057298				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 618334				54.00
54. 01 03630 ULTRA SOUND	0. 135162				54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 059166				54.02
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 000000				55.00
55. 01 03480 ONCOLOGY	0. 363817				55. 01
57. 00 05700 CT SCAN	0. 050319				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 129416				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000				59.00
60. 00 06000 LABORATORY	0. 129940				60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 188540				62.00
65. 00 06500 RESPIRATORY THERAPY	0. 226134				65.00
	1				
66. 00 06600 PHYSI CAL THERAPY	0. 392106				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 351797				67.00
68. 00 06800 SPEECH PATHOLOGY	0. 282953				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
69. 01 03610 SLEEP LAB	0. 226911				69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 311636				71.00
71. 01 07101 IV SOLUTIONS	0. 000000				71.01
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 271080				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 167290				73.00
76. 00 03140 CARDI OLOGY	0. 126394				76.00
76. 97 07697 CARDIAC REHABILITATION	0. 214625				76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000				77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000				78.00
OUTPATIENT SERVICE COST CENTERS	<u>'</u>				
90. 00 09000 CLI NI C	3. 430335				90.00
90. 01 09001 WOUND CARE CLINIC	0. 251844				90.01
91. 00 09100 EMERGENCY	0. 526547				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 972714				92.00
OTHER REIMBURSABLE COST CENTERS	0. 7/2/14				1 72.00
	0. 544200				05 00
95. 00 09500 AMBULANCE SERVI CES	0. 544398				95.00
101.00 10100 HOME HEALTH AGENCY					101.00
102. 00 10200 OPI OI D TREATMENT PROGRAM					102. 00
SPECIAL PURPOSE COST CENTERS					
113. 00 11300 I NTEREST EXPENSE					113. 00
116. 00 11600 HOSPI CE					116. 00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

			Ť.	0 12/31/2023	Date/Time Pre 5/22/2024 3:0	
		Ti tl	e XIX	Hospi tal	Cost	o piii
				Costs		
Cost Center Description	(from Wkst. B, Part I,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	col . 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	15, 705, 337		15, 705, 337	0	15, 705, 337	30.00
31. 00 03100 INTENSIVE CARE UNIT	3, 722, 110		3, 722, 110		3, 722, 110	31.00
43. 00 04300 NURSERY	1, 275, 455		1, 275, 455	0	1, 275, 455	43. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	11 400 401		11 400 401	ol	11 400 401	50.00
	11, 490, 481		11, 490, 481		11, 490, 481	50.00
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 383, 326		1, 383, 326	0	1, 383, 326	
53. 00 05300 ANESTHESI OLOGY	1, 528, 904 440, 765		1, 528, 904 440, 765	4, 506	1, 528, 904 445, 271	52. 00 53. 00
54. 00 05400 RADI OLOGY 54. 00 05400 RADI OLOGY DI AGNOSTI C	4, 857, 686		4, 857, 686	4, 506	4, 857, 686	54.00
54. 00 03400 RADI OLOGI - DI AGNOSTI C 54. 01 03630 ULTRA SOUND	278, 611		278, 611		278, 611	54.00
54. 01 03830 DETRA 300ND 54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	319, 641		319, 641		319, 641	54.01
55. 00 05500 RADI OLOGY - THERAPEUTI C	317,041		317,041		317, 041	55.00
55. 01 03480 0NCOLOGY	3, 697, 735		3, 697, 735	0	3, 697, 735	55. 01
57. 00 05700 CT SCAN	1, 163, 673		1, 163, 673		1, 163, 673	57.00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	629, 848		629, 848		629, 848	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	027, 040		027, 040	0	027, 040	59.00
60. 00 06000 LABORATORY	5, 135, 411		5, 135, 411	54, 014	5, 189, 425	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	413, 144		413, 144	0	413, 144	62.00
65. 00 06500 RESPI RATORY THERAPY	1, 598, 702	0		l o	1, 598, 702	65.00
66. 00 06600 PHYSI CAL THERAPY	3, 297, 934	0		o	3, 297, 934	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	545, 940	0	545, 940	o	545, 940	67.00
68. 00 06800 SPEECH PATHOLOGY	316, 590	o o	316, 590	o	316, 590	68.00
69. 00 06900 ELECTROCARDI OLOGY	0.0,0,0	Ĭ	0.0,070	o	0	69.00
69. 01 03610 SLEEP LAB	568, 197		568, 197	o	568, 197	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 061, 083		5, 061, 083	o	5, 061, 083	71.00
71. 01 07101 I V SOLUTIONS	0		0	o	0	71. 01
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	6, 541, 185		6, 541, 185	o	6, 541, 185	
73.00 07300 DRUGS CHARGED TO PATIENTS	19, 840, 318		19, 840, 318	o	19, 840, 318	
76. 00 03140 CARDI OLOGY	1, 561, 552		1, 561, 552	0	1, 561, 552	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	200, 115		200, 115	o	200, 115	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0		0	o	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	182, 806		182, 806	0	182, 806	90.00
90. 01 09001 WOUND CARE CLINIC	758, 113		758, 113	0	758, 113	90. 01
91. 00 09100 EMERGENCY	9, 771, 920		9, 771, 920	2, 133, 541	11, 905, 461	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	4, 069, 832		4, 069, 832		4, 069, 832	92.00
95. 00 09500 AMBULANCE SERVICES	3, 339, 458	· · · · · · · · · · · · · · · · · · ·	3, 339, 458	65	3, 339, 523	95.00
101.00 10100 HOME HEALTH AGENCY	1, 767, 426		1, 767, 426		1, 767, 426	101.00
102.00 10200 OPIOID TREATMENT PROGRAM	0		0		0	102. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	456, 110		456, 110		456, 110	
200.00 Subtotal (see instructions)	111, 919, 408	0			114, 111, 534	
201.00 Less Observation Beds	4, 069, 832		4, 069, 832	l .	4, 069, 832	
202.00 Total (see instructions)	107, 849, 576	0	107, 849, 576	2, 192, 126	110, 041, 702	202. 00

					From 01/01/2023 To 12/31/2023	Date/Time Pre	
			Ti +I	e XIX	Hospi tal	5/22/2024 3: 0 Cost	о рііі
			Charges	e viv	nospi tai	COST	
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	9, 702, 672		9, 702, 67	2		30.00
31.00	03100 INTENSIVE CARE UNIT	3, 742, 454		3, 742, 45			31.00
43.00	04300 NURSERY	1, 183, 282		1, 183, 28	2		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	9, 297, 461	28, 257, 388			0. 000000	
51.00	05100 RECOVERY ROOM	1, 675, 537	4, 670, 239			0. 000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 512, 288	4, 456			0. 000000	
53.00	05300 ANESTHESI OLOGY	2, 694, 643	5, 076, 565			0. 000000	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 452, 568	6, 403, 523			0. 000000	1
54. 01	03630 ULTRA SOUND	192, 261	1, 869, 052			0. 000000	1
54. 02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	200, 312	5, 202, 177	5, 402, 48		0. 000000	1
55.00	05500 RADI OLOGY - THERAPEUTI C	0	0		0. 000000	0. 000000	
55. 01	03480 ONCOLOGY	51, 259	10, 112, 459			0. 000000	
57.00	05700 CT SCAN	3, 205, 534	19, 920, 302	23, 125, 83		0. 000000	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	382, 311	4, 484, 528			0. 000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0. 000000	0. 000000	
60.00	06000 LABORATORY	5, 582, 676	34, 354, 558			0. 000000	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 135, 448	1, 055, 836			0. 000000	1
65.00	06500 RESPI RATORY THERAPY	4, 406, 828	2, 662, 895			0. 000000	
66.00	06600 PHYSI CAL THERAPY	904, 012	7, 506, 814			0. 000000	1
67.00	06700 OCCUPATI ONAL THERAPY	430, 877	1, 120, 985			0.000000	1
68.00	06800 SPEECH PATHOLOGY	234, 667	884, 212	1, 118, 87		0.000000	1
69.00	06900 ELECTROCARDI OLOGY	0	0	0 504 05	0.000000	0.000000	1
69. 01	03610 SLEEP LAB	0	2, 504, 053			0.000000	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 613, 682	8, 626, 691	16, 240, 37		0.000000	1
71. 01	07101 IV SOLUTIONS	0.040.100	0	24 120 04	0.000000	0.000000	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	9, 968, 198	14, 161, 862	24, 130, 06		0.000000	1
73. 00 76. 00	07300 DRUGS CHARGED TO PATIENTS 03140 CARDI OLOGY	30, 540, 551	88, 057, 494 10, 605, 099			0. 000000 0. 000000	1
76. 00 76. 97	O7697 CARDI AC REHABI LI TATI ON	1, 749, 586 907				0. 000000	1
76. 97 77. 00	07700 ALLOGENEIC HSCT ACQUISITION	907	931, 486 0		0. 214625	0. 000000	1
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0. 000000	0. 000000	1
76.00	OUTPATIENT SERVICE COST CENTERS	U			J 0. 000000J	0.000000	76.00
90.00	09000 CLINIC	1, 144	52, 147	53, 29	1 3. 430335	0. 000000	90.00
90. 00	09001 WOUND CARE CLINIC	20, 180	2, 990, 069			0. 000000	1
91. 00	09100 EMERGENCY	3, 801, 931	18, 808, 508			0. 000000	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	756, 674	3, 427, 324	4, 183, 99		0. 000000	1
	OTHER REIMBURSABLE COST CENTERS	750, 674	3, 427, 324	4, 183, 99	0. 972714	0.000000	92.00
	09500 AMBULANCE SERVICES	0	6, 134, 343	6, 134, 34	0. 544387	0.000000	
	10100 HOME HEALTH AGENCY	0	1, 489, 816	1, 489, 81	5		101.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	(O		102.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113.00
	11600 H0SPI CE	0	532, 274				116. 00
200.00	,	102, 439, 943	291, 907, 155	394, 347, 09	3		200.00
201.00							201.00
202.00	Total (see instructions)	102, 439, 943	291, 907, 155	394, 347, 09	8		202. 00

Health Financial Systems KINGS DAUGHTERS HOSPITAL In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0069
From 01/01/2023
To 12/31/2023 Worksheet C
Part I
Date/Time Prepared: 5/22/2024 3:00 pm

				5/22/2024 3:0	00 pm
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
31. 00 03100 INTENSIVE CARE UNIT					31.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					1 .0.00
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. 00 03400 RADI 0L0GT-DI AGNOSTI C	0. 000000				54.00
54. 01 03636 DETRA SOUND 54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 000000				54.01
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 000000				
					55.00
55. 01 03480 0NCOLOGY	0. 000000				55. 01
57. 00 05700 CT SCAN	0. 000000				57.00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000				59.00
60. 00 06000 LABORATORY	0. 000000				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000				62.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
69. 01 03610 SLEEP LAB	0. 000000				69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
71. 01 07101 IV SOLUTIONS	0. 000000				71.01
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
76. 00 03140 CARDI OLOGY	0. 000000				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000				76. 97
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000				77.00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000				78.00
OUTPATIENT SERVICE COST CENTERS	0.000000				70.00
90. 00 09000 CLINIC	0. 000000				90.00
90. 01 09001 WOUND CARE CLINIC	0. 000000				90.01
91. 00 09100 EMERGENCY	0.000000				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
	0.000000				92.00
OTHER REIMBURSABLE COST CENTERS	0.000000				05.00
95. 00 09500 AMBULANCE SERVI CES	0. 000000				95.00
101. 00 10100 HOME HEALTH AGENCY					101.00
102. 00 10200 OPI OI D TREATMENT PROGRAM					102. 00
SPECIAL PURPOSE COST CENTERS					
113. 00 11300 I NTEREST EXPENSE					113.00
116. 00 11600 HOSPI CE					116. 00
200.00 Subtotal (see instructions)					200. 00
201.00 Less Observation Beds					201. 00
202.00 Total (see instructions)					202. 00

Health Financial Systems	KINGS DAUGHTE	RS HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2023 To 12/31/2023		narod:
				10 12/31/2023	5/22/2024 3:0	0 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			,			
30.00 ADULTS & PEDIATRICS	2, 287, 777	0	2, 287, 77			
31.00 INTENSIVE CARE UNIT	176, 567		176, 56			1
43. 00 NURSERY	109, 960		109, 96		135. 92	
200.00 Total (lines 30 through 199)	2, 574, 304		2, 574, 30	4 13, 302		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, 032					30.00
31.00 INTENSIVE CARE UNIT	495	54, 524				31.00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	3, 527	691, 487				200. 00

Health Financial Systems	KINGS DAUGHTERS HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY	SERVI CE CAPI TAL COSTS Provi der CCN: 15-0069	Period: Worksheet D

From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared: 5/22/2024 3:00 pm Title XVIII Hospi tal PPS Total Charges Capital Costs Cost Center Description Capi tal Ratio of Cost Inpati ent to Charges (column 3 x Related Cost (from Wkst. Program (from Wkst. C, Part I, (col. 1 ÷ Charges column 4) B, Part II, col. 8) col. 2) col. 26) 1. 00 5. 00 2.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50 00 50 00 05000 OPERATING ROOM 1,040,066 37, 554, 849 0.027695 2, 782, 320 77.056 6, 689 05100 RECOVERY ROOM 86, 331 6, 345, 776 0.013604 491, 711 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 35, 234 1, 516, 744 0.023230 5, 483 127 52.00 05300 ANESTHESI OLOGY 614, 215 53.00 13.857 7, 771, 208 0.001783 1.095 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 544, 918 7, 856, 091 0.069362 621, 337 43, 097 54.00 5, 998 76, 503 54.01 03630 ULTRA SOUND 2,061,313 0.002910 223 54.01 03450 NUCLEAR MEDICINE - DIAGNOSTIC 26, 525 5, 402, 489 0.004910 100, 172 492 54.02 54.02 0.000000 55 00 05500 RADI OLOGY - THERAPEUTI C Ω 55.00 55.01 03480 ONCOLOGY 589, 593 10, 163, 718 0.058010 51, 259 2, 974 55.01 57.00 05700 CT SCAN 64, 150 23, 125, 836 0.002774 1, 660, 200 4,605 57.00 174, 244 05800 MAGNETIC RESONANCE IMAGING (MRI) 57, 027 0.011717 2,042 58.00 4, 866, 839 58.00 05900 CARDI AC CATHETERI ZATI ON 59 00 0.000000 Ω 59.00 60.00 06000 LABORATORY 358, 833 39, 937, 234 0.008985 2, 526, 750 22, 703 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 18, 476 2, 191, 284 0.008432 468, 115 3, 947 62.00 06500 RESPIRATORY THERAPY 1, 793, 217 79.586 7, 069, 723 0.011257 65.00 20, 186 65.00 66.00 06600 PHYSI CAL THERAPY 590, 667 8, 410, 826 0.070227 393, 011 27,600 66.00 06700 OCCUPATI ONAL THERAPY 1, 551, 862 0.044903 67.00 69,683 176, 165 7, 910 67.00 06800 SPEECH PATHOLOGY 19, 912 1, 118, 879 0.017796 68.00 90.119 1,604 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 Ω 69.00 69.01 03610 SLEEP LAB 47,019 2,504,053 0.018777 0 O 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 139, 556 16, 240, 373 0.008593 2, 112, 106 18, 149 71.00 07101 IV SOLUTIONS 0.000000 71 01 0 71 01 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 159,076 24, 130, 060 0.006592 3, 773, 370 24,874 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 425, 098 118, 598, 045 0.003584 11, 015, 292 39, 479 73.00 76.00 03140 CARDI OLOGY 289, 525 12, 354, 685 0.023434 833, 347 19, 529 76.00 07697 CARDIAC REHABILITATION 76 97 34,007 932, 393 0.036473 76.97 0 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 78.00 78.00 0 OUTPATIENT SERVICE COST CENTERS 90 00 90 00 09000 CLI NI C 35, 344 53, 291 0.663226 1, 144 759 90.01 09001 WOUND CARE CLINIC 27, 926 3, 010, 249 0.009277 7, 391 69 90.01 09100 EMERGENCY 796, 450 0.035225 58, 291 91.00 22, 610, 439 1, 654, 818 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS 592, 848 4, 183, 998 0.141694 395, 041 <u>55</u>, 975 92.00 92.00 95. 00 09500 AMBULANCE SERVICES 95.00 200.00 Total (lines 50 through 199) 6, 147, 705 371, 562, 257 31, 817, 330 439, 475 200.00

Health Financial Systems	KINGS DAUGHTE	RS HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Provider C	1	Period: From 01/01/2023 Fo 12/31/2023	Worksheet D Part III Date/Time Pre 5/22/2024 3:0	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown Adjustments		Adjustments		Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30, 00 03000 ADULTS & PEDIATRICS	0	0	(0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
43. 00 04300 NURSERY	0	0		0	0	43.00
200.00 Total (lines 30 through 199)	0	0		0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem	I npati ent	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col . 6)		
		minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	10, 890		3, 032	
31. 00 03100 INTENSIVE CARE UNIT		0	1, 603		495	
43. 00 04300 NURSERY		0	809		0	
200. 00 Total (lines 30 through 199)		0	13, 302	2	3, 527	200.00
Cost Center Description	Inpati ent					
	Program Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9, 00					
INPATIENT ROUTINE SERVICE COST CENTERS	7. 00					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00 03100 INTENSIVE CARE UNIT	0					31.00
43. 00 04300 NURSERY	o					43.00
200.00 Total (lines 30 through 199)	0					200.00
, , ,	'					

Health Financial Systems	KINGS DAUGHTERS	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0069	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared:

					10 12/31/2023	5/22/2024 3: 0	
			Title	XVIII	Hospi tal	PPS	<u> </u>
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	·	Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0)	0	0	00.00
51.00	05100 RECOVERY ROOM	0	0)	0	0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0)	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	259, 681	54.00
54. 01	03630 ULTRA SOUND	0	0		0 0	0	54. 01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0)	0 0	0	54.02
55.00	05500 RADI OLOGY - THERAPEUTI C	0	0)	0 0	0	55.00
55. 01	03480 ONCOLOGY	0	0		0	0	55. 01
57.00	05700 CT SCAN	0	0		0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59.00
60.00	06000 LABORATORY	0	0)	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	0)	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0	0	69.00
69. 01	03610 SLEEP LAB	0	0		0	0	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71.00
71. 01	07101 IV SOLUTIONS	0	0		0	0	71. 01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
76.00	03140 CARDI OLOGY	0	0		0 0	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0	0	76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0)	0 0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0)	0 0	0	90.00
90. 01	09001 WOUND CARE CLINIC	0	0		0	0	90. 01
91.00	09100 EMERGENCY	0	0		0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)	0	0)	0 0	259, 681	200.00

Health Financial Systems	KINGS DAUGHTERS HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0069	Period: Worksheet D
THROUGH COSTS		From 01/01/2023 Part IV

THROUGH	1 COSTS				Fo 12/31/2023	Date/Time Pre 5/22/2024 3:0	epared:
			Title	XVIII	Hospi tal	PPS	о рііі
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
				and 4)		(see	
					7.00	instructions)	
	ANOLLI ADV. CEDVI OF COCT. CENTERS	4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM		0		37, 554, 849	0.000000	FO 00
	05100 RECOVERY ROOM	0	0			0.000000	
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0,0.0,7.0	0.000000	
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	0		1, 516, 744 7, 771, 208	0. 000000 0. 000000	
	05300 ANESTHESTOLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	259, 681	259, 68 ⁻		0. 033055	
	03630 ULTRA SOUND	0	239,001	239,00		0. 000000	1
	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	0		5, 402, 489	0. 000000	1
	05500 RADIOLOGY - THERAPEUTIC	0	0)	3,402,409	0. 000000	1
	03480 ONCOLOGY	0	0		10, 163, 718	0. 000000	1
	05700 CT SCAN	0	0			0. 000000	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			0. 000000	
	05900 CARDI AC CATHETERI ZATI ON	0	0			0. 000000	
1	06000 LABORATORY	0	0		-	0. 000000	1
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0			0. 000000	1
	06500 RESPI RATORY THERAPY	0	0			0. 000000	
	06600 PHYSI CAL THERAPY	0	0			0. 000000	1
	06700 OCCUPATI ONAL THERAPY	0	0			0.000000	1
	06800 SPEECH PATHOLOGY	0	0			0.000000	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	0			0.000000	69.00
69. 01	03610 SLEEP LAB	0	0		2, 504, 053	0.000000	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		16, 240, 373	0.000000	71.00
71. 01	07101 IV SOLUTIONS	0	0		0	0.000000	71. 01
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		24, 130, 060	0.000000	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		118, 598, 045	0.000000	73.00
	03140 CARDI OLOGY	0	0		12, 354, 685	0.000000	
	07697 CARDI AC REHABI LI TATI ON	0	0		932, 393	0.000000	76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0.000000	77. 00
	07800 CAR T-CELL IMMUNOTHERAPY	0	0	(0	0. 000000	78. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0		53, 291	0.000000	
	09001 WOUND CARE CLINIC	0	0		3, 010, 249	0. 000000	1
	09100 EMERGENCY	0	0		22, 610, 439	0. 000000	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		4, 183, 998	0. 000000	92.00
F	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES						95. 00
200. 00	Total (lines 50 through 199)	0	259, 681	259, 68°	371, 562, 257		200.00

Health Financial Systems	KINGS DAUGHTERS HOSPI	TAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Prov			Worksheet D
THROUGH COSTS			From 01/01/2023	Part IV

THROUGH COSTS				rom 01/01/2023 o 12/31/2023		
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷		Costs (col. 8		Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS	.					
50.00 05000 OPERATING ROOM	0. 000000	2, 782, 320	0	5, 968, 580	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	491, 711	0	896, 460	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	5, 483	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	614, 215	0	829, 295	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 033055	621, 337	20, 538	1, 129, 918	37, 349	54.00
54.01 03630 ULTRA SOUND	0. 000000	76, 503	0	311, 871	0	54.01
54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC	0. 000000	100, 172	0	1, 650, 558	0	54.02
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 000000	. 0	l o	0	ol	55.00
55. 01 03480 ONCOLOGY	0. 000000	51, 259	0	3, 305, 519	0	55. 01
57. 00 05700 CT SCAN	0. 000000	1, 660, 200		4, 480, 077	0	57.00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	174, 244			0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			0	59.00
60. 00 06000 LABORATORY	0. 000000	2, 526, 750	1	2, 265, 616	0	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	468, 115		330, 111	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	1, 793, 217		· ·	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	393, 011		· ·	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0.000000	176, 165		22, 054	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	90, 119		·	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	90, 119 0		1,020	0	69.00
69. 01 03610 SLEEP LAB	0. 000000	0	0	0	0	69.01
· · · · · · · · · · · · · · · · · · ·	0. 000000	2 112 104		_	0	71.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.01 07101 V SOLUTIONS	0.000000	2, 112, 106	0	1, 508, 625	0	71.00
		0 772 270		2 02/ 202	0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	3, 773, 370		3, 836, 303	-	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	11, 015, 292	0	20,001,071	0	73.00
76. 00 03140 CARDI OLOGY	0. 000000	833, 347	0	3, 610, 657	0	76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0. 000000	0		.2., 00.	0	76. 97
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	0		0	77.00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0	0	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS			1 _	_	_	
90. 00 09000 CLINIC	0. 000000	1, 144		_	0	90.00
90. 01 09001 WOUND CARE CLINIC	0. 000000	7, 391	0	,	0	90. 01
91. 00 09100 EMERGENCY	0. 000000	1, 654, 818		-,,	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	395, 041	0	469, 070	0	92.00
OTHER REIMBURSABLE COST CENTERS						05.00
95. 00 09500 AMBULANCE SERVICES		04 047 000	20 520	(1 ((0 040	27 242	95.00
200.00 Total (lines 50 through 199)	1	31, 817, 330	20, 538	61, 660, 349	37, 349	1200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0069 Peri od: Worksheet D From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 5/22/2024 3:00 pm Title XVIII Hospi tal **PPS** Charges Costs PPS Services Cost Center Description Cost to PPS Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) Services (see From Servi ces Services Not Worksheet C, inst.) Subject To Subject To Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 2.00 5.00 1.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0. 305965 5, 968, 580 691 1, 826, 177 50.00 05100 RECOVERY ROOM 0. 217992 0 51.00 177 51.00 896, 460 195, 421 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 1.008017 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0.056718 829, 295 0 47,036 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.618334 1, 129, 918 27 0 698, 667 54.00 0 311, 871 42, 153 54.01 03630 ULTRA SOUND 0.135162 15 54 01 0 54.02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0.059166 1,650,558 2 97,657 54.02 55.00 05500 RADIOLOGY - THERAPEUTIC 0.000000 0 55.00 03480 ONCOLOGY 0.363817 3, 305, 519 0 0 0 1, 202, 604 55.01 55.01 4, 480, 077 05700 CT SCAN 8 225, 433 57.00 0.050319 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.129416 1, 129, 191 146, 135 58.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 0.000000 0 0 0 59.00 291, 329 06000 LABORATORY 0 60 00 0 128587 2, 265, 616 60 00 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.188540 330, 111 62, 239 62.00 06500 RESPIRATORY THERAPY 0. 226134 463, 543 2 0 104, 823 65.00 65.00 0 66.00 06600 PHYSI CAL THERAPY 0.392106 40, 856 16,020 66.00 0 06700 OCCUPATIONAL THERAPY 0 0.351797 22, 054 7, 759 67 00 67 00 0 68.00 06800 SPEECH PATHOLOGY 0.282953 1,020 289 68.00 06900 ELECTROCARDI OLOGY 0.000000 0 69.00 69.00 0 69.01 03610 SLEEP LAB 0. 226911 0 0 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 508, 625 0 470, 142 71 00 0.311636 71 00 o 71.01 07101 IV SOLUTIONS 0.000000 0 71.01 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 271080 3, 836, 303 0 0 1, 039, 945 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 2, 818 4, 243, 242 73.00 0.167290 25, 364, 591 341 73.00 3, 610, 657 456, 365 03140 CARDI OLOGY 76.00 0.126394 0 76.00 76.97 07697 CARDIAC REHABILITATION 0. 214625 421, 807 0 0 90, 530 76.97 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 C 0 ol 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 0.000000 78.00 0 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 3. 430335 0 0 90.00 90.01 09001 WOUND CARE CLINIC 0. 251844 557.305 185 0 140.354 90.01 91.00 09100 EMERGENCY 91.00 0.432186 3, 067, 322 C 0 1, 325, 654 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 972714 469, 070 456, 271 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 95.00 0.544387200.00 Subtotal (see instructions) 61, 660, 349 1.448 2.818 13, 186, 245 200.00 201.00 Less PBP Clinic Lab. Services-Program 201.00

61, 660, 349

2, 818

1.448

13, 186, 245 202. 00

Only Charges

Net Charges (line 200 - line 201)

202.00

Health Financial Systems	KINGS DAUGHTERS	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 15-0069	Peri od: From 01/01/2023	Worksheet D Part V

12/31/2023 Date/Time Prepared: 5/22/2024 3:00 pm 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 05100 RECOVERY ROOM 51.00 39 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 52.00 53.00 05300 ANESTHESI OLOGY 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 17 0 54.00 03630 ULTRA SOUND 0 54.01 200000000000000000 54.01 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0 54.02 54.02 55.00 05500 RADI OLOGY - THERAPEUTI C 55.00 0 55.01 03480 ONCOLOGY 55.01 0 57.00 05700 CT SCAN 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 59.00 06000 LABORATORY 0 60 00 60 00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 65.00 06500 RESPIRATORY THERAPY 0 65.00 06600 PHYSI CAL THERAPY 66.00 66.00 06700 OCCUPATIONAL THERAPY 0 67 00 67 00 0 68.00 06800 SPEECH PATHOLOGY 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 0 69.01 03610 SLEEP LAB 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 71 00 71.01 07101 IV SOLUTIONS 0 71.01 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 07300 DRUGS CHARGED TO PATIENTS 57 73.00 73.00 76.00 03140 CARDI OLOGY 0 0 0 0 76.00 76. 97 07697 CARDIAC REHABILITATION 0 76.97 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 77.00 07800 CAR T-CELL I MMUNOTHERAPY 78.00 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 0 90.01 09001 WOUND CARE CLINIC 47 0 90.01 91.00 09100 EMERGENCY 91.00 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 373 200.00 471 200.00 Subtotal (see instructions) 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 373 471 202.00 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 15-0069 Peri od: Worksheet D From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 5/22/2024 3:00 pm Title XIX Hospi tal Cost Charges Costs PPS Services Cost Center Description Cost to PPS Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, Subject To Subject To inst.) Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 1. 00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0. 305965 7, 543, 054 50.00 05100 RECOVERY ROOM 0. 217992 0 51.00 0 1,006,110 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 1.008017 4, 456 0 52.00 53.00 05300 ANESTHESI OLOGY 0.056718 0 0 1, 080, 394 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.618334 0 1, 349, 806 0 54.00 03630 ULTRA SOUND 477, 756 54.01 0.135162 0 0 0 54.01 03450 NUCLEAR MEDICINE - DIAGNOSTIC 0 54.02 0.059166 0 511, 026 0 54.02 55.00 05500 RADI OLOGY - THERAPEUTI C 0.000000 0 55.00 03480 ONCOLOGY 0.363817 0 0 1, 137, 133 0 55.01 55.01 0 3, 682, 904 05700 CT SCAN 0.050319 0 57.00 57.00 0 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.129416 778, 689 0 58.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 0.000000 0 59.00 06000 LABORATORY 0 0 6, 892, 340 60 00 0 128587 0 60 00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.188540 0 115, 813 0 62.00 65.00 06500 RESPIRATORY THERAPY 0. 226134 0 415, 895 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.392106 910, 352 0 66.00 06700 OCCUPATIONAL THERAPY 0 67 00 0.351797 0 243, 149 67 00 0 0 68.00 06800 SPEECH PATHOLOGY 0.282953 0 383, 655 0 68.00 06900 ELECTROCARDI OLOGY 0.000000 0 69.00 69.00 69.01 03610 SLEEP LAB 0. 226911 0 0 463, 057 0 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.311636 0 0 71.00 71 00 84, 276 0 71.01 07101 IV SOLUTIONS 0.000000 0 0 71.01 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 271080 0 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 14, 567, 742 73.00 0.167290 0 73.00 0 03140 CARDI OLOGY 0. 126394 0 1, 360, 695 76.00 Ω 76.00 0 76. 97 07697 CARDIAC REHABILITATION 0. 214625 0 34, 944 0 76.97 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 0 77.00 07800 CAR T-CELL I MMUNOTHERAPY 0 78.00 0.000000 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 3. 430335 0 90.00 4, 430 09001 WOUND CARE CLINIC 90.01 0. 251844 0 0 270, 731 0 90.01 0 09100 EMERGENCY 0.432186 91.00 91.00 0 5, 233, 148 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 972714 1, 237, 528 0 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 0. 544387 0 95.00 200.00 0 200.00 Subtotal (see instructions) C 49, 789, 083

0

0

49, 789, 083

201.00

0 202.00

201.00

202.00

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Only Charges

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

					10 12/31/2023	5/22/2024 3:0	
			Ti tl	e XIX	Hospi tal	Cost	
		Cos			<u> </u>	<u> </u>	
	Cost Center Description	Cost	Cost	1			
	•	Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	2, 307, 911				50.00
51.00	05100 RECOVERY ROOM	0	219, 324				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	4, 492	2			52.00
53.00	05300 ANESTHESI OLOGY	0	61, 278	8			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	834, 631				54.00
54.01	03630 ULTRA SOUND	0	64, 574				54. 01
54.02	03450 NUCLEAR MEDICINE - DIAGNOSTIC	0	30, 235	5			54.02
55.00	05500 RADI OLOGY - THERAPEUTI C	0	C				55.00
55. 01	03480 ONCOLOGY	0	413, 708				55. 01
57.00	05700 CT SCAN	0	185, 320				57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	100, 775				58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	C				59.00
60.00	06000 LABORATORY	0	886, 265	5			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	21, 835	5			62.00
65.00	06500 RESPI RATORY THERAPY	0	94, 048	8			65.00
66.00	06600 PHYSI CAL THERAPY	0	356, 954				66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	85, 539)			67.00
68. 00	06800 SPEECH PATHOLOGY	0	108, 556)			68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	C)			69. 00
69. 01	03610 SLEEP LAB	0	105, 073	;			69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	26, 263				71.00
71. 01	07101 IV SOLUTIONS	0	C)			71. 01
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	C)			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2, 437, 038	3			73.00
	03140 CARDI OLOGY	0	171, 984				76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	7, 500)			76. 97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	C)			77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	C)			78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	15, 196)			90.00
90. 01	09001 WOUND CARE CLINIC	0	68, 182	2			90. 01
91.00	09100 EMERGENCY	0	2, 261, 693				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1, 203, 761				92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0					95. 00
200.00		0	12, 072, 135	i			200. 00
201.00	9	0					201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	0	12, 072, 135				202. 00

Health Financial Systems	KINGS DAUGHTERS HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Peri od: From 01/01/2023	Worksheet D-1	
			Date/Time Pre 5/22/2024 3:0	
	Title XVIII	Hospi tal	PPS	<u> </u>
Cost Center Description				

		Title XVIII	Hospi tal	5/22/2024 3: 00 PPS	0 pm	
	Cost Center Description	THE AVIII	поэрт саг	113		
				1. 00		
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS					
1. 00						
2.00	Inpatient days (including private room days, excluding swing-			10, 890	2. 00	
3. 00	Private room days (excluding swing-bed and observation bed da	ys). If you have only pr	rivate room days,	0	3. 00	
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	ned days)		8, 068	4. 00	
5. 00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost		5. 00	
	reporting period					
6. 00	Total swing-bed SNF type inpatient days (including private reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6. 00	
7. 00	Total swing-bed NF type inpatient days (including private roc	m davs) through December	31 of the cost	0	7. 00	
	reporting period	3 , 3				
8.00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	31 of the cost	0	8. 00	
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	o the Program (excluding	swing_bed and	3, 032	9. 00	
7. 00	newborn days) (see instructions)	o the mogram (exchading	3 Swifig-bed and	3, 032	7.00	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10. 00	
11. 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII of		coom days) after	0	11. 00	
11.00	December 31 of the cost reporting period (if calendar year, e		oom days) arter	U	11.00	
12.00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12.00	
40.00	through December 31 of the cost reporting period				40.00	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13.00	
14. 00	Medically necessary private room days applicable to the Progr			0	14.00	
15.00	Total nursery days (title V or XIX only)			0	15.00	
16. 00	Nursery days (title V or XIX only)			0	16. 00	
17 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	ros through Dosombor 21 o	of the cost	0.00	17. 00	
17.00	reporting period	es till ough becelliber 31 t	or the cost	0.00	17.00	
18.00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0. 00	18. 00	
40.00	reporting period	. Il	5.11	0.00	10.00	
19. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s through December 31 of	the cost	0.00	19. 00	
20. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of 1	he cost	0. 00	20. 00	
	reporting period					
21. 00 22. 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ing ported (line	15, 705, 337 9 0	21. 00 22. 00	
22.00	5 x line 17)	er 31 of the cost report	ing period (inte	U	22.00	
23. 00	,	31 of the cost reportin	ng period (line 6	0	23. 00	
0.4.00	x line 18)	04 - 6 11 1			04.00	
24. 00	Swing-bed cost applicable to NF type services through Decembe 7×1 ine 19)	r 31 of the cost reporti	ng period (line	0	24. 00	
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25. 00	
	x line 20)					
26.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(Line 21 minus Line 26)		0 15, 705, 337	26. 00 27. 00	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(TITIE 21 IIIITIUS TITIE 20)		15, 705, 337	27.00	
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	28. 00	
29. 00				0		
30.00	Semi-private room charges (excluding swing-bed charges)	· Line 20)		0. 000000		
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ 1111e 28)		0.000000		
33. 00	Average semi-private room per diem charge (Time 29 ÷ Time 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00		
34. 00	Average per diem private room charge differential (line 32 mi	nue lina 33)(ega inetru	rti one)	0.00		
35. 00	Average per diem private room cost differential (line 34 x li		, (1 0113)	0.00	35.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	31)		0.00	36.00	
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line		37.00	
200	27 minus line 36)					
	PART II - HOSPITAL AND SUBPROVIDERS ONLY					
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS				
	Adjusted general inpatient routine service cost per diem (see			1, 442. 18		
39. 00	Program general inpatient routine service cost (line 9 x line	•		4, 372, 690		
	Medically necessary private room cost applicable to the Progr Total Program general inpatient routine service cost (line 39			0 4, 372, 690	40.00	
- 1.00	Trotal Trogram general impatrent routine service cost (IIIIe 37			7, 312, 070	71.00	

20 00	Medicald rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20.00
20.00	report in a peri od	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	15, 705, 337	21 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	10, 700, 007	22. 00
22.00	5 x line 17)	ĭ	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	ol	23.00
	x line 18)		
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	o	24.00
	7 x line 19)		
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	o	25.00
	x line 20)		
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	15, 705, 337	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	o	29.00
30.00	Semi - pri vate room charges (excluding swing-bed charges)	o	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	o	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	15, 705, 337	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 442. 18	
39.00	Program general inpatient routine service cost (line 9 x line 38)	4, 372, 690	39.00
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)	4, 372, 690	41.00

Heal th	Financial Systems	KINGS DAUGHTE	RS HOSPLTAL		Inlie	u of Form CMS-2	2552-10
	TATION OF INPATIENT OPERATING COST	KINGO BRIGGINE			eriod: rom 01/01/2023	Worksheet D-1	
				T			
			Titl€	e XVIII	Hospi tal	5/22/2024 3: 0 PPS	<u>o pm</u>
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Di em (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00	5. 00	42.00
42.00	Intensive Care Type Inpatient Hospital Units			л <u>0.00</u>	O _I	0	42.00
43.00	INTENSIVE CARE UNIT	3, 722, 110	1, 603	2, 321. 97	495	1, 149, 375	1
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
10.00	·					1.00	10.00
48. 00 48. 01	Program inpatient ancillary service cost (Wk Program inpatient cellular therapy acquisiti			III. line 10.	column 1)	7, 478, 625 0	48. 00 48. 01
49. 00	Total Program inpatient costs (sum of lines					13, 000, 690	•
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	ationt routino	sorvices (fre	m Wkst D sum	of Parts L and	691, 487	50.00
30.00		attent routine	services (110	ill WKSt. D, Sull	OI Faits I allo	091, 407	30.00
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillar	ry services (f	rom Wkst. D, su	ım of Parts II	460, 013	51.00
52. 00	Total Program excludable cost (sum of lines	50 and 51)				1, 151, 500	52.00
53. 00	Total Program inpatient operating cost exclu		elated, non-ph	ysician anesthe	etist, and	11, 849, 190	53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54.00	Program di scharges					0	54.00
55. 00 55. 01	Target amount per discharge Permanent adjustment amount per discharge					0. 00 0. 00	•
55. 02	Adjustment amount per discharge (contractor	use only)				0. 00	1
56. 00 57. 00	Target amount (line 54 x sum of lines 55, 55 Difference between adjusted inpatient operat			lino E4 minus l	ino E2)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	ing cost and ta	arget amount (Title 56 IIITlus I	1116 55)	0	58.00
59. 00	Trended costs (lesser of line 53 ÷ line 54,		n the cost rep	orting period e	endi ng 1996,	0. 00	59. 00
60. 00	updated and compounded by the market basket) 50.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the						60. 00
61. 00							61.00
	55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x enter zero. (see instructions)						
62.00	Relief payment (see instructions)					0	
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mstrt	ictions)			0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	ember 31 of th	e cost reportir	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the	cost reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVIII	onl v): for	0	66.00
	CAH, see instructions	•	·	, ,	37.		
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	n December 31	of the cost rep	orting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after [December 31 of	the cost repor	ting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil						70.00
71. 00	Adjusted general inpatient routine service c		ine 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic	,	n (line 14 x l	ine 35)			72. 00 73. 00
74.00	Total Program general inpatient routine serv	ice costs (line	e 72 + line 73)			74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)		e costs (from	Worksheet B, Pa	ırt II, column		75.00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	,					76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu	s line 77)					78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				ıs line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limi		5051 111111 14110	(11116 76 1111116	13 11110 777		81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82.00
84. 00	Program inpatient ancillary services (see in		13)				83. 00 84. 00
85.00	Utilization review - physician compensation	(see instruction					85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		n ough 85)				86. 00
	Total observation bed days (see instructions)	line 2)			2, 822	1
გგ. UU	Adjusted general inpatient routine cost per	urem (IINE 27 -	- IIIIe 2)		l	1, 442. 18	88. UU

Health Financial Systems	KINGS DAUGHTE	RS HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023		pared: 0 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			4, 069, 832	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
				, i	instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	2, 287, 777	15, 705, 337	0. 14566	9 4, 069, 832	592, 848	90.00
91.00 Nursing Program cost	0	15, 705, 337	0. 00000	00 4, 069, 832	0	91.00
92.00 Allied health cost	0	15, 705, 337	0. 00000	00 4, 069, 832	0	92.00
93.00 All other Medical Education	0	15, 705, 337	0. 00000	00 4, 069, 832	0	93.00

Health Financial Systems	KINGS DAUGHTERS HOSPITAL		In Lieu	ı of Form CMS-2	552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN:		od: 01/01/2023	Worksheet D-1	
			12/31/2023	Date/Time Prep 5/22/2024 3:00	
	Title	XIX H	ospi tal	Cost	
Cost Center Description					
				1. 00	

Description			Title XIX	Hospi tal	5/22/2024 3:0 Cost	U pm
PART C. ALL PROVIDER COMPONENTS PART C. ALL PROVIDER COMPONENTS PART C. ALL PROVIDER COMPONENTS		Cost Center Description				
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41.00 Total Program general inpatient routine service cost (line 39 + line 40) 1,789,745 41.00		1 1				
	41. 00	lotal Program general inpatient routine service cost (line 39	+ line 40)		1, 789, 745	41.00

Heal th	Financial Systems	KINGS DAUGHTEI	RS HOSPITAL		In Lie	u of Form CMS-2	2552-10
	TATION OF INPATIENT OPERATING COST		Provi der Co		eriod: rom 01/01/2023	Worksheet D-1	
				T	12/31/2023	Date/Time Prep 5/22/2024 3:00	
	Cost Contor Description	Total	_	e XIX Average Per	Hospital Program Days	Cost Program Cost	•
	Cost Center Description	Total Inpatient	Total Inpatient	Diem (col. 1	Program bays	(col. 3 x	
		Cost	Days	÷ col . 2)	4.00	col . 4)	
42. 00	NURSERY (title V & XIX only)	1. 00 1, 275, 455	2.00	3. 00 1, 576. 58	4. 00 495	5. 00 780, 407	42. 00
40.00	Intensive Care Type Inpatient Hospital Units	0.700.440	1 (00	0.004.07	202	740.007	40.00
43. 00 44. 00	INTENSIVE CARE UNIT	3, 722, 110	1, 603	2, 321. 97	323	749, 996	43. 00 44. 00
45.00	BURN INTENSIVE CARE UNIT						45.00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description	L					47.00
48. 00	Program inpatient ancillary service cost (Wk	st D_3 col 3	R line 200)			1. 00 3, 699, 235	48. 00
48. 01	Program inpatient cellular therapy acquisiti			III, line 10,	column 1)	0	48. 01
49. 00	Total Program inpatient costs (sum of lines	41 through 48.0	01)(see instru	ctions)		7, 019, 383	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (from	m Wkst. D, sum	of Parts I and	0	50. 00
F4 00					C D I I I		E4 00
51. 00	Pass through costs applicable to Program inpland IV)	atient anciliar	ry services (Ti	rom WKST. D, SL	ım or Parts II	0	51.00
52.00	Total Program excludable cost (sum of lines					0	52.00
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line	9 1	elated, non-phy	ysician anesthe	etist, and	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54. 00 55. 00	Program discharges Target amount per discharge					0 0. 00	54. 00 55. 00
55. 01	Permanent adjustment amount per discharge					0.00	
55. 02	Adjustment amount per discharge (contractor					0.00	
56. 00 57. 00	Target amount (line 54 x sum of lines 55, 55 Difference between adjusted inpatient operat			line 56 minus l	ine 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	· ·			,	Ō	58.00
59. 00	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket)	or line 55 from	n the cost repo	orting period e	endi ng 1996,	0. 00	59. 00
60.00	60.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the						60.00
61. 00	market basket) 61.00 Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise						61. 00
62. 00	enter zero. (see instructions) Relief payment (see instructions)					0	62.00
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	·				0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	Ü		•			64.00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)					0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line	64 plus line (65)(title XVIII	only); for	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	n December 31 o	of the cost rep	porting period	0	67.00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after [December 31 of	the cost repor	ting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70.00	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	utine service o	cost (line 37)			70.00
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine /0 ÷ line	2)			71. 00 72. 00
73.00	Medically necessary private room cost applic	abĺe to Program	7	,			73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient				art II column		74. 00 75. 00
	26, line 45)		: CO313 (110III I	WOLKSHEET D, 12	irt II, corumii		
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu	s line 77)					78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				ıs line 79)		79. 00 80. 00
81.00	Inpatient routine service cost per diem limi	tati on		(.5 ,,		81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82. 00 83. 00
84. 00	Program inpatient ancillary services (see in		13)				84.00
85.00	Utilization review - physician compensation	(see instruction					85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ıı ougri 85)				86. 00
	Total observation bed days (see instructions)	ling 2)			2, 822	87.00
88.00	Adjusted general inpatient routine cost per	aiem (line 27 ÷	- iine 2)			1, 442. 18	88.00

Health Financial Systems	KINGS DAUGHTE	RS HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023		pared: 0 pm
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			4, 069, 832	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	2, 287, 777	15, 705, 337	0. 14566	4, 069, 832	592, 848	90.00
91.00 Nursing Program cost	0	15, 705, 337	0. 00000	00 4, 069, 832	0	91.00
92.00 Allied health cost	0	15, 705, 337	0. 00000	00 4, 069, 832	0	92.00
93.00 All other Medical Education	0	15, 705, 337	0. 00000	00 4, 069, 832	0	93.00

Health Financial Systems INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	KINGS DAUGHTERS HOSPITAL Provider (CCN: 15-0069	Peri od:	u of Form CMS-: Worksheet D-3	
	7.700.400	, , , , , , , , , , , , , , , , , , , ,	From 01/01/2023		
			To 12/31/2023	Date/Time Pre 5/22/2024 3:0	
	Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
		1.00	2.00	col . 2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			3, 601, 931		30.00
31. 00 03100 INTENSIVE CARE UNIT			1, 148, 269		31.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 3059		851, 293	
51. 00 05100 RECOVERY ROOM		0. 2179		107, 189	
52. 00 05200 DELIVERY ROOM & LABOR ROOM		1. 0080			
53. 00 05300 ANESTHESI OLOGY		0.0572		35, 193	
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 6183		384, 194	
54. 01 03630 ULTRA SOUND		0. 1351 0. 0591		10, 340	
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC 55. 00 05500 RADIOLOGY - THERAPEUTIC		0.0000	· ·	5, 927 0	1
55. 01 03480 ONCOLOGY		0. 3638		_	
57. 00 05700 CT SCAN		0. 0503		83, 540	
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 1294		22, 550	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000		0	1
60. 00 06000 LABORATORY		0. 1299		328, 326	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	S	0. 1885		88, 258	62.0
65. 00 06500 RESPIRATORY THERAPY		0. 2261	1, 793, 217	405, 507	65.0
66. 00 06600 PHYSI CAL THERAPY		0. 3921	393, 011	154, 102	66.0
67. 00 06700 OCCUPATI ONAL THERAPY		0. 3517		61, 974	
68. 00 06800 SPEECH PATHOLOGY		0. 2829		25, 499	
69. 00 06900 ELECTROCARDI OLOGY		0.0000		0	
69. 01 03610 SLEEP LAB	2	0. 2269		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.01 07101 IV SOLUTIONS	5	0. 3116			
		0.0000		1 022 005	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2710		1, 022, 885 1, 842, 748	
75. 00 07500 DRUGS CHARGED TO PATTENTS 76. 00 03140 CARDI OLOGY		0. 1672 0. 1263		1, 642, 746	
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 1203		105, 330	
77. 00 07700 ALLOGENEIC HSCT ACQUISITION		0.0000		0	
78. 00 07800 CAR T-CELL IMMUNOTHERAPY		0.0000		0	
OUTPATIENT SERVICE COST CENTERS		3. 3000			1
90. 00 09000 CLI NI C		3. 4303	35 1, 144	3, 924	90.0
90. 01 09001 WOUND CARE CLINIC		0. 2518		1, 861	
91. 00 09100 EMERGENCY		0. 5265	1, 654, 818	871, 339	91.0
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 9727	14 395, 041	384, 262	92.0
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVI CES		1			1 95 N

95.00

7, 478, 625 200. 00 201. 00 202. 00

31, 817, 330

31, 817, 330

95. 00 09500 AMBULANCE SERVICES

200.00

201. 00 202. 00 Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

Health Financial Systems	KINGS DAUGHTERS	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der C		Peri od:	Worksheet D-3	
				From 01/01/2023 To 12/31/2023	Date/Time Pre	narod:
				10 12/31/2023	5/22/2024 3:0	pareu. 10 pm
		Ti tl	e XIX	Hospi tal	Cost	-
Cost Center Description			Ratio of Cos	t Inpatient	I npati ent	
·			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col . 2)	
			1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						1
30. 00 03000 ADULTS & PEDI ATRI CS				2, 175, 097		30.00
31. 00 03100 I NTENSI VE CARE UNI T				743, 438		31.00
43. 00 04300 NURSERY				719, 320		43.00
ANCILLARY SERVICE COST CENTERS						1
50. 00 05000 OPERATING ROOM			0. 30596		952, 192	
51. 00 05100 RECOVERY ROOM			0. 21799		76, 642	
52.00 05200 DELI VERY ROOM & LABOR ROOM			1. 00801		846, 938	
53. 00 05300 ANESTHESI OLOGY			0. 05671		21, 549	
54. 00 05400 RADI OLOGY-DI AGNOSTI C			0. 61833		122, 827	1
54. 01 03630 ULTRA SOUND			0. 13516		4, 407	
54. 02 03450 NUCLEAR MEDICINE - DIAGNOSTIC			0. 05916		1, 481	
55. 00 05500 RADI OLOGY - THERAPEUTI C			0. 00000		0	
55. 01 03480 ONCOLOGY			0. 36381		0	
57. 00 05700 CT SCAN			0. 05031		27, 747	
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)			0. 12941		7, 053	
59. 00 05900 CARDI AC CATHETERI ZATI ON			0.00000		0	
60. 00 06000 LABORATORY			0. 12858		142, 029	1
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS			0. 18854		27, 009	
65. 00 06500 RESPI RATORY THERAPY			0. 22613		181, 881	
66. 00 06600 PHYSI CAL THERAPY			0. 39210		32, 776	
67. 00 06700 OCCUPATI ONAL THERAPY			0. 35179		12, 681	
68. 00 06800 SPEECH PATHOLOGY			0. 28295		10, 412	
69. 00 06900 ELECTROCARDI OLOGY			0.00000		0	
69. 01 03610 SLEEP LAB			0. 22691		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0. 31163		29, 988	
71. 01 07101 I V SOLUTIONS			0.00000		0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS			0. 27108		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS			0. 16729		966, 716	1
76. 00 03140 CARDI OLOGY			0. 12639		27, 918	1
76. 97 07697 CARDI AC REHABI LI TATI ON			0. 21462		0	
77. 00 07700 ALLOGENEIC HSCT ACQUISITION			0.00000		0	
78. 00 07800 CAR T-CELL IMMUNOTHERAPY			0.00000	00 0	0	78.00
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC			2 42022	15 0	0	00.00
90. 00 09000 CLINIC 90. 01 09001 WOUND CARE CLINIC			3. 43033 0. 25184		0	
91 ON OPION EMERGENCY			0. 25184		206 989	

0. 432186

0. 972714

478, 936

14, 329, 280

14, 329, 280

91.00

92.00

95.00

201. 00 202. 00

0

3, 699, 235 200. 00

206, 989

91.00

92.00

200.00

201.00 202. 00

09100 EMERGENCY

95. 00 09500 AMBULANCE SERVICES

09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS

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

Health Financial Systems	KINGS DAUGHTERS HOSPITAL	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0069	From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/22/2024 3:00 pm

	Title XVIII	Hospi tal	5/22/2024 3: 0 PPS	0 pm
			1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		1. 00	
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to October 1 instructions)	(see	0 5, 443, 259	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after Octobe instructions)	r 1 (see	2, 030, 899	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurrin 1 (see instructions)			1.03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurrin October 1 (see instructions)	g on or after	0	1.04
2.00	Outlier payments for discharges. (see instructions) Outlier reconciliation amount		0	2.00
2. 02 2. 03 2. 04	Outlier payment for discharges for Model 4 BPCI (see instructions) Outlier payments for discharges occurring prior to October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see instructions)		188, 799 265, 769	2. 02 2. 03 2. 04
3. 00 4. 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost reporting period (see inst	ructions)	5, 281, 958 62. 27	3.00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most recent cost reportin			5.00
5. 01	or before 12/31/1996. (see instructions) FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instruct		0.00	5. 01
6. 00	FTE count for allopathic and osteopathic programs that meet the criteria for an add new programs in accordance with 42 CFR 413.79(e)			6.00
6. 26	Rural track program FTE cap limitation adjustment after the cap-building window clothe CAA 2021 (see instructions)		0. 00	6. 26
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)		0. 00 0. 00	7. 00 7. 01
7. 02	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the hospital's rural track program FTE limitat track programs with a rural track for Medicare GME affiliated programs in accordance and 87 FR 49075 (August 10, 2022) (see instructions)	` '	0.00	7. 02
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic p affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26 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 report straddles July 1, 2011, see instructions.	e ACA. If the cost	0.00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teac under § 5506 of ACA. (see instructions)		0. 00	8. 02
8. 21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the instructions)	·	0.00	8. 21
9. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 a minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)		0. 00	9.00
11. 00 12. 00	FTE count for allopathic and osteopathic programs in the current year from your rec FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)	oi us	0. 00	11. 00 12. 00
13. 00	Total allowable FTE count for the prior year.			13. 00
14. 00	Total allowable FTE count for the penultimate year if that year ended on or after S otherwise enter zero.	eptember 30, 1997,	0. 00	14.00
15. 00 16. 00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program (see instructions)			15. 00 16. 00
17. 00 18. 00	Adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count		0. 00 0. 00	17. 00 18. 00
19. 00			0.000000	
20.00	Prior year resident to bed ratio (see instructions)		0.000000	
21. 00			0. 000000	
22. 00 22. 01	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)		0	22. 00 22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 (EVAL)	CFR 412. 105	0.00	23. 00
24. 00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)		0.00	1
25. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or li instructions)	ne 24 (see	0.00	
26. 00 27. 00	Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions)		0. 000000 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 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29. 00 29. 01
30. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient days (see instr	uctions)	4. 65	30.00
31. 00	Percentage of Medicaid patient days (see instructions)	actions,	22. 25	•
32. 00	Sum of lines 30 and 31		26. 90	•
33. 00	Allowable disproportionate share percentage (see instructions)		11. 41	33.00

	Financial Systems KINGS DAUG LATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0069	In Lie	u of Form CMS-2 Worksheet E	2552-1
CALCUI	ATTON OF REIMBORSEMENT SETTLEMENT	Provider CCN. 15-0009	From 01/01/2023 To 12/31/2023	Part A	pared:
		Title XVIII	Hospi tal	5/22/2024 3: 0 PPS)O pm
	·	Title AVIII	Hospi tal	PPS	
				1. 00	
34.00	Disproportionate share adjustment (see instructions)		Prior to 10/1	213, 201 On/After 10/1	34.00
			1.00	2.00	
	Uncompensated Care Payment Adjustment			5 000 004 757	
35. 00 35. 01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		6, 874, 403, 459 0. 000097909	5, 938, 006, 757 0. 000093319	
35. 02	Hospital UCP, including supplemental UCP (see instructions)	ons)	673, 066		
35. 03			503, 416		
36. 00	Total UCP adjustment (sum of columns 1 and 2 on line 35 Additional payment for high percentage of ESRD beneficial	i. 03)	642, 705		36.00
40. 00	Total Medicare discharges (see instructions)	ary discharges (Titles 40 tili)	0 Dugit 46)		40.00
41. 00	Total ESRD Medicare discharges (see instructions)		0		41.00
41. 01	Total ESRD Medicare covered and paid discharges (see in		0 00		41.0
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not Total Medicare ESRD inpatient days (see instructions)	quarity for adjustment)	0.00		42.00
44. 00	Ratio of average length of stay to one week (line 43 di	vided by line 41 divided by	7 0.000000		44. 0
45. 00	days) Average weekly cost for dialysis treatments (see instru	ictions)	0.00		45.00
46. 00	Total additional payment (line 45 times line 44 times l		0		46.0
47. 00 48. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and	MDH small rural bosnitals	8, 784, 632 8, 523, 367		47.00
40.00	only. (see instructions)	widit, siliari rurai nospitars	0, 323, 307		40.0
				Amount	
49. 00	Total payment for inpatient operating costs (see instru	uctions)		1. 00 8, 784, 632	49.0
50.00	Payment for inpatient program capital (from Wkst. L, Pt		e)	637, 225	
51.00	Exception payment for inpatient program capital (Wkst.			0	
52. 00 53. 00	Direct graduate medical education payment (from Wkst. E Nursing and Allied Health Managed Care payment	4, line 49 see instructions).	0 4, 321	
54. 00	Special add-on payments for new technologies			70, 535	
54. 01	Islet isolation add-on payment			0	1
55. 00 55. 01	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, Cellular therapy acquisition cost (see instructions)	line 69)		0	
56. 00	Cost of physicians' services in a teaching hospital (se	e intructions)		0	
57. 00	Routine service other pass through costs (from Wkst. D,	Pt. III, column 9, lines 30	through 35).	0	
58. 00 59. 00	Ancillary service other pass through costs from Wkst. D), Pt. IV, col. 11 line 200)		20, 538	
50.00	Total (sum of amounts on lines 49 through 58) Primary payer payments			9, 517, 251 0	
61. 00	Total amount payable for program beneficiaries (line 59	minus line 60)		9, 517, 251	61.0
52.00	Deductibles billed to program beneficiaries			967, 384	1
53. 00 54. 00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			5, 600 75, 736	1
	Adjusted reimbursable bad debts (see instructions)			49, 228	
66.00	, ,	e instructions)		12, 664	
57. 00 58. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced device	es for applicable to MS_DRGs	(see instructions)	8, 593, 495 0	1
59.00	Outlier payments reconciliation (sum of lines 93, 95 and	• •	,	0	1
0. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
70. 50 70. 75	Rural Community Hospital Demonstration Project (§410A D N95 respirator payment adjustment amount (see instruction		e instructions)	0	
70. 73	Demonstration payment adjustment amount before sequestra			0	
70. 88	SCH or MDH volume decrease adjustment (contractor use o	onl y)		0	70.8
70.89	Pioneer ACO demonstration payment adjustment amount (se			_	70.8
70. 90 70. 91	HSP bonus payment HVBP adjustment amount (see instruction HSP bonus payment HRR adjustment amount (see instruction)			0	1
	, ,			0	
70. 92					1
70. 92 70. 93 70. 94	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			0 -85, 959	

Heal th	Financial Systems KINGS DAUGHT	ERS HOSPITAL		In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CN: 15-0069	Peri od:	Worksheet E	
				From 01/01/2023 To 12/31/2023		narodi
				10 12/31/2023	5/22/2024 3:0	
		Ti tl e	XVIII	Hospi tal	PPS	<u>o p</u>
			FFY	(уууу)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Ent	er in column O	:	2023	604, 114	70. 96
	the corresponding federal year for the period prior to 10					
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Ent			2024	357, 594	70. 97
70.00	the corresponding federal year for the period ending on o	r after 10/1)				70.00
70. 98	Low Volume Payment-3			0	0	70. 98
70. 99	HAC adjustment amount (see instructions)	(0 0 70)			30, 402	
71.00	Amount due provider (line 67 minus lines 68 plus/minus li	nes 69 & 70)			9, 438, 842	
	Sequestration adjustment (see instructions)	0.0			188, 777	
	Demonstration payment adjustment amount after sequestration	on			0	71. 02 71. 03
	Sequestration adjustment-PARHM pass-throughs Interim payments				9, 534, 668	
	Interim payments Interim payments-PARHM				9, 334, 666	72.00
	Tentative settlement (for contractor use only)				0	
73. 00	Tentative settlement-PARHM (for contractor use only)				U	73.00
74. 00	Balance due provider/program (line 71 minus lines 71.01,	71 N2 72 and			-284, 603	
74.00	73)	71.02, 72, and			-204, 003	74.00
74. 01						74. 01
75. 00					1, 225, 090	1
70.00	CMS Pub. 15-2, chapter 1, §115.2	or dance in th			1,220,070	70.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or	sum of 2.03			0	90.00
	plus 2.04 (see instructions)					
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
	Operating outlier reconciliation adjustment amount (see i	,			0	
	Capital outlier reconciliation adjustment amount (see ins				0	
	The rate used to calculate the time value of money (see i	,			0. 00	
	Time value of money for operating expenses (see instruction	,			0	
96. 00	Time value of money for capital related expenses (see ins	tructions)			0	96.00
					On/After 10/1	
	HCD Day of Day of Asset			1.00	2. 00	
100 00	HSP Bonus Payment Amount			O	0] 100. 00
100.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			U U	U	100.00
101 00	HVBP adjustment factor (see instructions)			0. 0000000000	0. 0000000000	101 00
	HVBP adjustment amount for HSP bonus payment (see instruc	tions)		0.0000000000		101.00
102.00	HRR Adjustment for HSP Bonus Payment	ti ons)		<u> </u>	0	102.00
103 00	HRR adjustment factor (see instructions)			0. 0000	0. 0000	103 00
	HRR adjustment amount for HSP bonus payment (see instruct	ions)		0.0000		104.00
104.00	Rural Community Hospital Demonstration Project (§410A Demo		ustment	<u> </u>	0	1104.00
200 00	Is this the first year of the current 5-year demonstration					200. 00
_55.00	Century Cures Act? Enter "Y" for yes or "N" for no.	por roa anaoi	2.31			
	Cost Reimbursement					1
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II,	line 49)				201. 00
	Medicare discharges (see instructions)	,				202.00
	Case-mix adjustment factor (see instructions)					203. 00
	Computation of Demonstration Target Amount Limitation (N/)	Δ in first vear	of the curre	nt 5-vear demons		1

102.00 HVBP adjustment amount for HSP bonus payment (see instructions)	l O	ΟĮ	1102.00
HRR Adjustment for HSP Bonus Payment			
103.00 HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00 HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00 Is this the first year of the current 5-year demonstration period under the 21st			200.00
Century Cures Act? Enter "Y" for yes or "N" for no.			
Cost Reimbursement			
201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00 Medicare discharges (see instructions)			202.00
203.00 Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the curre	nt 5-year demons	trati on	
peri od)			
204.00 Medicare target amount			204.00
205.00 Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00 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 instructions)			207.00
208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00 Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00 Reserved for future use			210.00
211.00 Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparision of PPS versus Cost Reimbursement			l
212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00 Low-volume adjustment (see instructions)		ŀ	213.00
210 00 Not Madi care Dort A LDDC adjustment (difference between DDC and cost reimburgement)		ŀ	218.00
218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)			

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Peri od: Worksheet E From 01/01/2023 Part A Exhi bit 4 To 12/31/2023 Date/Time Prepared: Provi der CCN: 15-0069

							5/22/2024 3:0	O pm
		W/C E D. I A	A		XVIII	Hospi tal	PPS	
		W/S E, Part A line	E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After 10/01	Total (Col 2 through 4)	
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	DRG amounts other than outlier payments	1. 00	0	0	0	0	0	1.00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 01	5, 443, 259	0	5, 443, 259		5, 443, 259	1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	2, 030, 899	0		2, 030, 899	2, 030, 899	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1. 03	0	0	0		0	1.03
1. 04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00						2. 00
2. 01	Outlier payments for	2. 02	0	0	0	0	0	2. 01
2. 02	discharges for Model 4 BPCI Outlier payments for discharges occurring prior to	2. 03	188, 799	0	188, 799		188, 799	2. 02
2. 03	October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see	2.04	265, 769	0		265, 769	265, 769	2. 03
3. 00	instructions) Operating outlier	2. 01	0	0	0	0	0	3.00
4. 00	reconciliation Managed care simulated payments	3. 00	5, 281, 958	0	3, 811, 897	1, 470, 061	5, 281, 958	4. 00
	Indirect Medical Education Adj							
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5.00
6. 00	IME payment adjustment (see instructions)	22. 00	0	0	0	0	0	6.00
6. 01	IME payment adjustment for managed care (see instructions)	22. 01	0	0	0	0	0	6. 01
	Indirect Medical Education Adj							
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
8. 00	IME adjustment (see instructions)	28. 00	0	0	0	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	O	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. 00
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
	Di sproporti onate Share Adjustm	ent						
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 1141	0. 1141	0. 1141	0. 1141		10.00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	213, 201	0	155, 269	57, 932	213, 201	11.00
11. 01	Uncompensated care payments	36. 00	642, 705	0	503, 416	139, 289	642, 705	11. 01
10 00	Additional payment for high pe		RD beneficiary	di scharges	=1	_1	_	10 0-
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	0	0	0	
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47. 00 48. 00	8, 784, 632 0	0	6, 290, 743 0	2, 493, 889 0	8, 784, 632 0	ı
15. 00	(see instructions) Total payment for inpatient operating costs (see instructions)	49. 00	8, 784, 632	0	6, 290, 743	2, 493, 889	8, 784, 632	15. 00

LOW VC	LUME CALCULATION EXHIBIT 4			Provi der C		Period: From 01/01/2023 To 12/31/2023	5/22/2024 3:0	pared:
					XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After 10/01	Total (Col 2 through 4)	
		0	1. 00	2.00	3.00	4. 00	5. 00	
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	637, 225	O	443, 69	193, 531	637, 225	16.00
17. 00	Special add-on payments for new technologies	54. 00	70, 535	0	63, 74	6, 789	70, 535	17.00
17. 01 17. 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0		0 0	0	17. 01 17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)		0	0		0 0	0	18.00
19.00	SUBTOTAL			0	6, 798, 18	3 2, 694, 209	9, 492, 392	19.00
		W/S L, line	(Amounts from L)					
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
20. 00 20. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier	1. 00 1. 01	564, 631 0	0	,	0 156, 461 0 0	564, 631 0	1
21. 00 21. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments	2. 00 2. 01	72, 594 0	0	35, 52	4 37, 070 0 0	72, 594 0	21. 00 21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0. 000	0. 0000		22.00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0		0 0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0. 0000	0.000	0. 0000		24.00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	0		0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	637, 225	0	443, 69	4 193, 531	637, 225	26. 00
		W/S E, Part A	(Amounts to					
		line 0	E, Part A) 1.00	2. 00	3.00	4. 00	5. 00	
27. 00	Low volume adjustment factor	0	1.00	2.00	0. 08886		5.00	27. 00
28. 00	Low volume adjustment ractor (transfer amount to Wkst. E, Pt. A, Line)	70. 96			604, 11		604, 114	
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				357, 594	357, 594	29. 00
100.00	Transfer I ow volume adjustments to Wkst. E, Pt. A.		Y					100.00

HO251 I	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATTON EXHIBIT S		F	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/22/2024 3:0	pared:
				XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2. 00	3. 00	4. 00	
1. 00 1. 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 00 1. 01	5, 443, 259	5, 443, 259		5, 443, 259	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	2, 030, 899		2, 030, 899	2, 030, 899	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	0	C		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00					2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	(0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2. 03	188, 799			188, 799	2. 02
2. 03	Outlier payments for discharges occurring on or after October 1 (see instructions)		265, 769		265, 769		2.03
3. 00 4. 00	Operating outlier reconciliation Managed care simulated payments	2. 01 3. 00	5, 281, 958	3, 811, 897	0 1, 470, 061	5, 281, 958	3. 00 4. 00
5. 00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0.000000	0. 000000		5. 00
6. 00 6. 01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see	22. 00 22. 01	0	(0	6. 00 6. 01
	instructions) Indirect Medical Education Adjustment for the	o Add on for S	oction 422 of	the MMA			
7. 00	IME payment adjustment factor (see	27. 00	0. 000000		0. 000000		7.00
	instructions)						
8.00	IME adjustment (see instructions)	28. 00	0	(0	0	8. 00
8. 01	IME payment adjustment add on for managed	28. 01	0	(0	0	8. 01
0.00	care (see instructions)	29. 00		_		0	0.00
9. 00 9. 01	Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of	29. 00 29. 01	0		-	-	9. 00 9. 01
7.01	lines 6.01 and 8.01)	29.01			,		7.01
	Disproporti onate Share Adjustment	<u>I</u>					ĺ
10.00	Allowable disproportionate share percentage	33. 00	0. 1141	0. 1141	0. 1141		10.00
11. 00	(see instructions) Disproportionate share adjustment (see	34. 00	213, 201	155, 269	57, 932	213, 201	11. 00
11. 01	instructions) Uncompensated care payments	36. 00	642, 705	503, 416	139, 289	642, 705	11. 01
11.01	Additional payment for high percentage of ES			303, 410	137, 207	042, 703	11.01
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	(0	0	12.00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH	47. 00 48. 00	8, 784, 632 0	6, 290, 743 (2, 493, 889 0		
15. 00	and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs	49. 00	8, 784, 632	6, 290, 743	2, 493, 889	8, 784, 632	15. 00
13.00	(see instructions)	47.00	0,704,032	0,270,740	2, 475, 667	0, 704, 032	13.00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	637, 225	443, 694	193, 531	637, 225	16.00
17. 00 17. 01	Special add-on payments for new technologies Net organ acquisition cost		70, 535				17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	C	0	0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	(0	0	18. 00
19. 00	SUBTOTAL			6, 798, 183	2, 694, 209	9, 492, 392	19.00

Health Finan	cial Systems	KINGS DAUGHTE	DS HOSPITAI		In lie	u of Form CMS-:	2552_10
	DUIRED CONDITION (HAC) REDUCTION CALCUL			F	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Exhibi	t 5 epared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1. 00	2.00	3. 00	4. 00	
	al DRG other than outlier 4 BPCI Capital DRG other than outlier	1. 00 1. 01	564, 631 0	408, 170 (156, 461 0	564, 631 0	1
	al DRG outlier payments 4 BPCL Capital DRG outlier payments	2. 00 2. 01	72, 594 0	35, 524 (37, 070	72, 594 0	21.00
22. 00 I ndi r	ect medical education percentage (see uctions)	5. 00	0. 0000	0.0000	0.0000	_	22. 00
instr	ect medical education adjustment (see uctions)	6. 00	0	(0	0	23. 00
	able disproportionate share percentage instructions)	10. 00	0. 0000	0.0000	0.0000		24.00
	oportionate share adjustment (see uctions)	11. 00	0	(0	0	25. 00
	prospective capital payments (see uctions)	12. 00	637, 225	443, 694	193, 531	637, 225	26. 00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1. 00	2.00	3. 00	4. 00	
	olume adjustment prior to October 1	70. 96	604, 114			604, 114	
4	olume adjustment on or after October 1	70. 97	357, 594		357, 594		
	payment adjustment (see instructions)	70. 93	0	(0	0	00.00
	payment adjustment for HSP bonus	70. 90	0		0	0	30. 01

70. 94

70. 91

0

70. 99

-85, 959

1.00

Υ

-11, 614

30, 402

3.00

31.00

31.01

32.00

100.00

-85, 959

30, 402

(Amt. to Wkst. E, Pt. A) 4. 00

0

0

-74, 345

2.00

payment (see instructions)

32.00 HAC Reduction Program adjustment (see

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

instructions)

instructions)

31.00

31.01

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

Health Financial Systems	KINGS DAUGHTERS HOSPITAL	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0069	From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/22/2024 3:00 pm

			10 12/31/2023	5/22/2024 3:0	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			844	1.00
2.00	Medical and other services reimbursed under OPPS (see instruc	tions)		13, 148, 896	
3.00	OPPS or REH payments			11, 073, 152	3.00
4. 00	Outlier payment (see instructions)			98, 928	
4. 01	Outlier reconciliation amount (see instructions)	ati ana)		0 000	
5. 00 6. 00	Enter the hospital specific payment to cost ratio (see instru- Line 2 times line 5	CTI OIIS)		0.000	1
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0. 00	
8. 00	Transitional corridor payment (see instructions)			0.00	
9. 00	Ancillary service other pass through costs including REH dire	ct graduate medical educ	ation costs from		1
7. 00	Wkst. D, Pt. IV, col. 13, line 200	et graduate medicar educ	2011011 00313 11011	37, 347	7.00
10.00	Organ acquisitions			0	10.00
	Total cost (sum of lines 1 and 10) (see instructions)			844	1
	COMPUTATION OF LESSER OF COST OR CHARGES			<u> </u>	
	Reasonable charges				İ
12.00	Ancillary service charges			4, 266	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	1
	Total reasonable charges (sum of lines 12 and 13)			4, 266	14.00
	Customary charges			.,	
15.00	Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable fo			0	16.00
	had such payment been made in accordance with 42 CFR §413.13(e)			
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.00
18.00	Total customary charges (see instructions)			4, 266	18. 00
19.00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds li	ne 11) (see	3, 422	19. 00
	instructions)				
20. 00	Excess of reasonable cost over customary charges (complete on	ly if line 11 exceeds li	ne 18) (see	0	20.00
	instructions)				
21. 00	Lesser of cost or charges (see instructions)			844	1
	Interns and residents (see instructions)			0	22.00
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			11, 209, 429	24.00
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	-\		0	25 00
	Deductibles and coinsurance amounts (for CAH, see instruction:	•	untions)	0	
26.00	Deductibles and Coinsurance amounts relating to amount on line Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)]			2, 032, 014 9, 178, 259	
27.00	instructions)	prus the sum of filles 22	and 23] (See	9, 170, 239	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28. 00
	REH facility payment amount (see instructions)	THE 30)		O	28. 50
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	1
	Subtotal (sum of lines 27, 28, 28.50 and 29)			9, 178, 259	
	Primary payer payments			1, 874	1
	Subtotal (line 30 minus line 31)			9, 176, 385	1
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIO	CES)		, , , , , , , , , , , , , , , , , , , ,	
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	,		0	33.00
34.00	Allowable bad debts (see instructions)			164, 044	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			106, 629	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructi ons)		66, 780	36.00
37.00	Subtotal (see instructions)			9, 283, 014	37.00
38.00	MSP-LCC reconciliation amount from PS&R			-68	38. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)			39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)			0	
39. 97	Demonstration payment adjustment amount before sequestration			0	1
39. 98	Partial or full credits received from manufacturers for replan	cea devices (see instruc	CTI ONS)	0	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	
40.00	Subtotal (see instructions)			9, 283, 082	1
	Sequestration adjustment (see instructions)			185, 662	1
40. 02	Demonstration payment adjustment amount after sequestration			0	
40. 03	Sequestration adjustment-PARHM pass-throughs			0 101 027	40.03
	Interim payments Interim payments-PARHM			9, 101, 837	41. 00 41. 01
41.01	Tentative settlement (for contractors use only)			0	1
42. 00	Tentative settlement (for contractors use only)			U	42.00
43. 00	Balance due provider/program (see instructions)			-4, 417	1
43. 00	Balance due provider/program-PARHM (see instructions)			-4, 41/	43.00
44. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2	chapter 1	1, 334, 166	1
11.00	§115. 2	W. CII OMO 1 UD. 13-2,	5ap (5) 1,	1, 554, 100	55
	TO BE COMPLETED BY CONTRACTOR				1
90.00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	
92.00	The rate used to calculate the Time Value of Money			0.00	1
93.00	Time Value of Money (see instructions)			0	93.00
			<u>'</u>		

Health Financial Systems	KINGS DAUGHTERS	HOSPI TAL	In Lieu	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0069	Peri od:	Worksheet E	
			From 01/01/2023		
			To 12/31/2023	Date/Time Pre	epared:
				5/22/2024 3:0	00 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
94.00 Total (sum of lines 91 and 93)				0	94.00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200. 00

Peri od: Worksheet E-1 From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/22/2024 3:00 pm Provi der CCN: 15-0069

					5/22/2024 3: 0	O pm
			XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		9, 534, 668		9, 101, 837	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		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					
3. 50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3. 53			0		0	3. 53
3. 54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
	3. 50-3. 98)					
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		9, 534, 668		9, 101, 837	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
F 00	TO BE COMPLETED BY CONTRACTOR		I			F 00
5. 00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02	TENTATIVE TO PROVIDER		0		0	5. 02
5. 02			0		0	5. 02
5.05	Provider to Program				U	5.03
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51	TENTATI VE TO TROCKAW		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
J. 77	5. 50-5. 98)		0		O O	J. 77
6. 00	Determined net settlement amount (balance due) based on					6. 00
5. 55	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		0		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		284, 603		4, 417	6. 02
7. 00	Total Medicare program liability (see instructions)		9, 250, 065		9, 097, 420	7. 00
	(333 / 133 433 313)		., 255, 366	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8. 00	Name of Contractor					8. 00

Health Financial Systems KINGS DAUGHTERS HOSPITAL In Lieu					2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-0069	Peri od: From 01/01/2023	Worksheet E-	1
			To 12/31/2023		
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPOR				_
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCUL				
1.00	Total hospital discharges as defined in AARA §4102 from	Wkst. S-3, Pt. I col. 15 lin	e 14		1.00
2.00	Medicare days (see instructions)			2.00	
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days (see instructions)				4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 2	200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col			6.00	
7.00	CAH only - The reasonable cost incurred for the purchase	Wkst. S-2, Pt. I		7. 00	
	line 168				
8.00	Calculation of the HIT incentive payment (see instruction	ons)			8. 00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestra	ation (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions	s)			30.00
31.00	31.00 Other Adjustment (specify)				
32.00	32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)				

Health Financial Systems	KINGS DAUGHTERS HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0069	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/22/2024 3:00 pm
	Ti +I o VI V	Uocni tal	Cost

			10 12/31/2023	Date/lime Pre 5/22/2024 3:0	
-		Title XIX	Hospi tal	Cost	о рііі
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	RVICES FOR TITLES V OR XI		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	THE TOTAL THE PARTY OF THE	X 02.XV. 02.0		1
1. 00	Inpatient hospital/SNF/NF services		7, 019, 383		1.00
2. 00	Medical and other services		7,017,000	12, 072, 135	2.00
3. 00	Organ acquisition (certified transplant programs only)		0	12/0/2/100	3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		7, 019, 383	12, 072, 135	1
5. 00	Inpatient primary payer payments		0	12/0/2/100	5.00
6. 00	Outpatient primary payer payments			0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		7, 019, 383	12, 072, 135	1
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		7,017,000	12/0/2/100	7.00
	Reasonable Charges				İ
8.00	Routine service charges		0		8.00
9. 00	Ancillary service charges		14, 329, 280	49, 789, 083	9.00
10.00	Organ acquisition charges, net of revenue		O	., .,	10.00
	Incentive from target amount computation		o		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		14, 329, 280	49, 789, 083	
	CUSTOMARY CHARGES				İ
13.00	Amount actually collected from patients liable for payment for	r services on a charge	0	0	13.00
	basis	9			
14.00	Amounts that would have been realized from patients liable for	r payment for services or	0	0	14.00
	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	
16.00	Total customary charges (see instructions)		14, 329, 280	49, 789, 083	
17. 00	Excess of customary charges over reasonable cost (complete only	ly if line 16 exceeds	7, 309, 897	37, 716, 948	17. 00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete only	ly if line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	19.00
	Cost of physicians' services in a teaching hospital (see inst		0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line		7, 019, 383	12, 072, 135	21.00
22.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provid			22.00
	Other than outlier payments		0	0	
24. 00	Outlier payments		0	Ü	24.00
	Program capital payments Capital exception payments (see instructions)				25.00
26. 00	Routine and Ancillary service other pass through costs		0	0	1
	Subtotal (sum of lines 22 through 26)			0	
28. 00	Customary charges (title V or XIX PPS covered services only)			0	28.00
	Titles V or XIX (sum of lines 21 and 27)		7, 019, 383	12, 072, 135	
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		1,017,303	12,072,133	29.00
30. 00	Excess of reasonable cost (from line 18)			0	30.00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	7, 019, 383	12, 072, 135	
32. 00	Deductibles)	7, 017, 303	12, 072, 133	
33. 00	Coinsurance		0	0	02.00
	Allowable bad debts (see instructions)			0	34.00
35. 00	Utilization review			O	35.00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	d 33)	7, 019, 383	12, 072, 135	
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	a 55)	0	12, 072, 100	37.00
	Subtotal (line 36 ± line 37)		7, 019, 383	12, 072, 135	
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0	12/0/2/100	39.00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		7, 019, 383	12, 072, 135	
41. 00	Interim payments		7, 019, 383	12, 072, 135	
42. 00	Balance due provider/program (line 40 minus line 41)		0	0	
43. 00			o o	0	ł
	chapter 1, §115.2			· ·	
			'		'

Health Financial Systems KINGS DAUGHTERS HOSPITAL In Lieu		u of Form CMS-2	552-10		
OUTLI E	R RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0069	Peri od:	Worksheet E-5	
			From 01/01/2023 To 12/31/2023	Date/Time Prep 5/22/2024 3:00	
		Title XVIII		PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR				
1.00	instructions)	0	1.00		
2.00		0	2.00		
3.00 Operating outlier reconciliation adjustment amount (see instructions)					3.00
4.00 Capital outlier reconciliation adjustment amount (see instructions)					4.00
5.00 The rate used to calculate the time value of money (see instructions)					5.00
6.00 Time value of money for operating expenses (see instructions)					6.00
7.00 Time value of money for capital related expenses (see instructions)					7.00

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

Provi der CCN: 15-0069

Peri od: Worksheet G From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/22/2024 3:00 pm

37		General Fund	Speci fi c	Endowment	5/22/2024 3:0 Plant Fund	O pm
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	14, 398, 716	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	6, 540, 736 11, 445, 820	0	0	0	3. 00 4. 00
5. 00	Other receivable	-364, 066, 770	0	0	0	5.00
6. 00	Allowances for uncollectible notes and accounts receivable		0	0	0	6.00
7. 00	Inventory	2, 963, 074	0	Ö	0	7. 00
8.00	Prepai d expenses	498, 027	0	O	0	8. 00
9. 00	Other current assets	48, 600	0	0	0	9. 00
10.00	Due from other funds	0	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	-328, 171, 797	0	0	0	11.00
12. 00	Land	5, 291, 875	0	ol	0	12.00
13. 00	Land improvements	486, 345	0	Ö	0	13.00
14. 00	Accumulated depreciation	0	Ö	Ö	0	14.00
15. 00	Bui I di ngs	84, 438, 741	0	О	0	15.00
16. 00	Accumulated depreciation	-11, 924, 014	0	0	0	16.00
17. 00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19. 00 20. 00	Fixed equipment	0	0	0	0	19. 00 20. 00
21. 00	Accumulated depreciation Automobiles and trucks	0	0	0	0	20.00
22. 00	Accumulated depreciation	0	0	0	0	22.00
23. 00	Maj or movable equipment	17, 849, 091	Ö	Ö	0	23. 00
24. 00	Accumulated depreciation	-5, 255, 474	0	o	0	24.00
25.00	Mi nor equi pment depreci abl e	0	0	o	0	25. 00
26. 00	Accumulated 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	28. 00
29. 00 30. 00	Minor equipment-nondepreciable	00 994 544	0	0	0	29. 00 30. 00
30.00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	90, 886, 564	U	U	U	30.00
31. 00	Investments	0	0	ol	0	31.00
32.00	Deposits on leases	0	0	O	0	32.00
33.00	Due from owners/officers	0	0	O	0	33.00
34.00	Other assets	208, 977, 206	1	0	0	34.00
35. 00	Total other assets (sum of lines 31-34)	208, 977, 206	0	0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	-28, 308, 027	0	0	0	36.00
37. 00	Accounts payable	3, 140, 109	0	ol	0	37.00
38. 00	Salaries, wages, and fees payable	0, 110, 107	Ö	o	0	38.00
39. 00	Payrol I taxes payable	0	0	O	0	39.00
40.00	Notes and Loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42. 00	Accel erated payments	0		_	_	42.00
43.00	Due to other funds	15 (42 700	0	0	0	43.00
44. 00 45. 00	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	15, 643, 780 18, 783, 889	ا ما	0	0	44. 00 45. 00
43.00	LONG TERM LIABILITIES	10, 703, 007	0	<u>U</u>		43.00
46. 00	Mortgage payable	0	0	0	0	46. 00
47.00	Notes payable	0	0	O	0	47.00
48.00	Unsecured Loans	0	0	0	0	48. 00
49. 00	Other long term liabilities	1, 103, 551	0	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1, 103, 551		0	0	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	19, 887, 440	0	0	0	51.00
52. 00	CAPITAL ACCOUNTS General fund balance	-48, 195, 467				52. 00
53. 00	Specific purpose fund	-40, 173, 407	0			53.00
54. 00	Donor created - endowment fund balance - restricted			o		54.00
55. 00	Donor created - endowment fund balance - unrestricted			o		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	-48, 195, 467	0	0	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	-28, 308, 027	1	ol ol	0	60.00
	[59]			Ĭ	Ü	
			,	'		

Period: Worksheet G-1 From 01/01/2023 Provi der CCN: 15-0069

					To 12/31/2023	Date/Time Pre 5/22/2024 3:0	pared: O pm
		General	Fund	Special F	Purpose Fund	Endowment Fund	
		1. 00	2. 00	3.00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0 0 0 0	-42, 806, 901 -5, 388, 566 -48, 195, 467		0 0 0 0 0 0	0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0	0 -48, 195, 467 0 -48, 195, 467		0 0 0 0 0 0 0 0 0	0 0 0 0 0	9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
		Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8. 00	_		
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)	0 0	0 0 0 0 0		0 0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		19. 00

Health Financial Systems Kantement of Patlent Revenues and Operating Expenses Provider CCN: 15-0069

			0 12/31/2023	Date/IIme Pre 5/22/2024 3:0	
	Cost Center Description	Inpatient	Outpati ent	Total	, p
	<u> </u>	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	12, 779, 302	!	12, 779, 302	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF			0	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)	12, 779, 302		12, 779, 302	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	3, 895, 348		3, 895, 348	11. 00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL 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, 895, 348		3, 895, 348	16.00
	11-15)				
17.00	Total inpatient routine care services (sum of lines 10 and 16)	16, 674, 650		16, 674, 650	17. 00
18.00	Ancillary services	84, 036, 614	275, 269, 869	359, 306, 483	18. 00
19.00	Outpati ent servi ces	3, 509, 924	21, 060, 726	24, 570, 650	19.00
20.00	RURAL HEALTH CLINIC		0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		o	0	21.00
22.00	HOME HEALTH AGENCY		1, 489, 816	1, 489, 816	22.00
23.00	AMBULANCE SERVICES		6, 145, 701	6, 145, 701	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26.00	HOSPI CE		532, 274	532, 274	26.00
27. 00	OTHER OUTPATIENT		87, 532, 347	87, 532, 347	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	104, 221, 188		496, 251, 921	•
	G-3, line 1)		, ,	, ,	
	PART II - OPERATING EXPENSES	<u>'</u>	'		
29.00	Operating expenses (per Wkst. A, column 3, line 200)		163, 412, 017		29. 00
30.00	ADD (SPECIFY)				30.00
31.00					31.00
32.00					32.00
33. 00					33.00
34. 00			,		34.00
35. 00			,		35.00
36. 00	Total additions (sum of lines 30-35)		o		36.00
37. 00	DEDUCT (SPECIFY)		-		37.00
38. 00	SESSON (SESSINI)				38.00
39. 00					39.00
40. 00					40.00
41. 00					41.00
42. 00	Total deductions (sum of lines 37-41)				42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transf	er	163, 412, 017		43.00
73.00	to Wkst. G-3, line 4)	·	100, 412, 017		75.00
	10 1100 1	1	1 1		ı

		INGS DAUGHTERS HOSPITA			of Form CMS-2	
STATE	ENT OF REVENUES AND EXPENSES	Provi de	er CCN: 15-0069	Peri od:	Worksheet G-3	
				From 01/01/2023 To 12/31/2023	Date/Time Pre	pared.
				12,01,2020	5/22/2024 3:00	
					1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I,				496, 251, 921	1.00
2.00	Less contractual allowances and discounts on pa	atients' accounts			358, 691, 633	
3.00	Net patient revenues (line 1 minus line 2)				137, 560, 288	
4.00	Less total operating expenses (from Wkst. G-2,				163, 412, 017	
5. 00	Net income from service to patients (line 3 min	nus line 4)			-25, 851, 729	5.00
6. 00	OTHER INCOME				376, 404	6.00
7. 00	Contributions, donations, bequests, etc				3, 015, 081	
8. 00	Revenues from telephone and other miscellaneous	s communication convic	20		3,015,081	
9. 00	Revenue from television and radio service	s communication service	=5		0	
10.00	Purchase di scounts				0	
11. 00	Rebates and refunds of expenses				0	
12. 00	Parking Lot receipts				0	
	Revenue from Laundry and Linen service				ő	13.00
14. 00	Revenue from meals sold to employees and guests	5			327, 104	
15. 00	Revenue from rental of living quarters					15.00
16.00	Revenue from sale of medical and surgical suppl	ies to other than pati	ents		0	16.00
	Revenue from sale of drugs to other than patien				0	ı
	Revenue from sale of medical records and abstra				2, 206	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc	c.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and	canteen			o	20.00
21.00	Rental of vending machines				0	21.00
22.00	Rental of hospital space				0	22. 00
23.00	Governmental appropriations				0	23. 00
24.00	OTHER OPERATING INCOME				16, 742, 368	24.00
24.50	COVI D-19 PHE Fundi ng				0	24. 50
	Total other income (sum of lines 6-24)				20, 463, 163	25.00
	Total (line 5 plus line 25)				-5, 388, 566	
	OTHER EXPENSES (SPECIFY)				0	
	Total other expenses (sum of line 27 and subscr	. ,			0	28. 00
29. 00	Net income (or loss) for the period (line 26 mi	nus line 28)			-5, 388, 566	29.00

Heal th	Financial Systems		KINGS DAUGHTER	RS HOSPITAL		In Lie	u of Form CMS-2	2552-10
	ALLOCATION - HHA GENERAL SERVICE	COST		Provi der C		Period: From 01/01/2023	Worksheet H-1	
				HHA CCN:		To 12/31/2023	Date/Time Pre	pared:
						Home Health	5/22/2024 3: 0 PPS	U pm
			Capital Rela	ated Costs		Agency I		
			<u> </u>					
		Net Expenses for Cost	Bl dgs & Fi xtures	Movable Equipment	Plant Operation &	Transportatio n	Subtotal (cols. 0-4)	
		Allocation	TIXtures	Equi pilierri	Maintenance	"	(0013. 0-4)	
		(from Wkst. H, col. 10)						
		0	1. 00	2. 00	3. 00	4. 00	4A. 00	
1. 00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	0		I		0	1.00
1.00	Fixtures							1.00
2. 00	Capital Related - Movable Equipment	0		0			0	2. 00
3. 00	Plant Operation & Maintenance	450	0	0	450	0	0	3. 00
4. 00 5. 00	Transportation Administrative and General	0 366, 019	0	0	1	0 0	266 460	4. 00 5. 00
5.00	HHA REIMBURSABLE SERVICES	300,019	U _I	0	43	0	366, 469	3.00
6.00	Skilled Nursing Care Physical Therapy	400, 529	0	0	1	0 0	400, 529 263, 530	•
7. 00 8. 00	Occupational Therapy	263, 530 67, 608	0	0	1	0 0	67, 608	
9.00	Speech Pathology	3, 164	0	0		0	3, 164	
10. 00 11. 00	Medical Social Services Home Health Aide	0 11, 438	0	0		0 0	0 11, 438	
12.00	Supplies (see instructions)	28, 815	0	0		0	28, 815	12.00
13. 00 14. 00	Drugs DME	667 0	0	0	1	0 0	667 0	•
	HHA NONREIMBURSABLE SERVICES						<u> </u>	
15. 00 16. 00	Home Dialysis Aide Services Respiratory Therapy	0	0	0	l .	0 0	0	15. 00 16. 00
17. 00	Private Duty Nursing	Ö	ő	Ö	1	0 0	0	
18. 00 19. 00	Clinic Health Promotion Activities	0	0	0		0 0	0	18. 00 19. 00
20.00	Day Care Program	0	0	0		0 0	0	20.00
21.00	1	0	0	0		0	0	21.00
22. 00 23. 00	Homemaker Service All Others (specify)	0	0	0		0 0	0	22. 00 23. 00
23. 50	Tel emedi ci ne	0	0	0	1	0	0	23. 50
24.00	Total (sum of lines 1-23)	1, 142, 220 Admi ni strati v	Total (cols.	0	45	0 0	1, 142, 220	24. 00
		e & General	4A + 5)					
	GENERAL SERVICE COST CENTERS	5. 00	6. 00			<u>.</u>		
1. 00	Capital Related - Bldg. &							1. 00
2. 00	Fixtures Capital Related - Movable							2. 00
2 00	Equi pment							2 00
3. 00 4. 00	Plant Operation & Maintenance Transportation							3. 00 4. 00
5. 00	Administrative and General	366, 469						5. 00
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	189, 213	589, 742					6. 00
7.00	Physi cal Therapy	124, 493	388, 023					7. 00
8. 00 9. 00	Occupational Therapy Speech Pathology	31, 938 1, 495	99, 546 4, 659					8. 00 9. 00
10.00	Medical Social Services	0	0					10.00
11. 00 12. 00	Home Health Aide Supplies (see instructions)	5, 403 13, 612	16, 841 42, 427					11. 00 12. 00
13.00	Drugs	315	982					13.00
14. 00	DME HHA NONREI MBURSABLE SERVI CES	0	0					14. 00
15. 00	Home Dialysis Aide Services	0	0					15. 00
16. 00 17. 00		0	0					16. 00 17. 00
	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
	Day Care Program Home Delivered Meals Program	0	0					20. 00 21. 00
22.00	Homemaker Service	0	0					22. 00
	All Others (specify) Telemedicine	0	0					23. 00 23. 50
	Total (sum of lines 1-23)		1, 142, 220					24. 00

Heal th	Financial Systems		KINGS DAUGHTE	RS HOSPITAL		In Lie	u of Form CMS-	2552-10
	NLLOCATION - HHA STATISTICAL BAS	SIS		Provider C		Period: From 01/01/2023 To 12/31/2023	Worksheet H-1 Part II	pared:
						Home Health Agency I	PPS	
		Capi tal Rel	ated Costs			Agency		
		BI dgs & Fi xtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliatio n	Administrativ e & General (ACCUM. COST)	
		1. 00	2. 00	3.00	4.00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS					_		
1. 00	Capital Related - Bldg. & Fixtures	0				0		1.00
2. 00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	2, 748		0		3.00
4. 00	Transportation (see	0	0	0		0		4. 00
5. 00	instructions) Administrative and General	0	0	2, 748		0 -366, 469	775, 751	5. 00
	HHA REIMBURSABLE SERVICES				•	·	<u> </u>	1
6. 00	Skilled Nursing Care	0	0	0		0 0	400, 529	6.00
7. 00	Physical Therapy	0	0	0		0 0	263, 530	7.00
8. 00	Occupational Therapy	0	0	0		0 0	67, 608	8.00
9. 00	Speech Pathology	0	0	0		0 0	3, 164	9.00
10.00	Medical Social Services	0	0	0		0 0	0	10.00
11.00	Home Health Aide	0	0	0		0 0	11, 438	11.00
12.00	Supplies (see instructions)	0	0	0		0	·	12.00
13.00	Drugs	0	0	0		0	667	13.00
14.00	DME	0	0	0		0 0	0	14.00

0.000000

0.000000

0

0.000000

0

0

0

0

0

0

2,748

0. 163755

450

775, 751

366, 469

0. 472405 26. 00

0

-366, 469

15.00

16.00

17.00

18.00

19.00

20.00

21.00

22.00

23.00

23.50

24.00

25.00

15.00

16.00

17.00

18.00

19.00

20.00

21.00

22.00

23.00

23.50

24.00

25.00

HHA NONREIMBURSABLE SERVICES

Home Dialysis Aide Services

Health Promotion Activities

Home Delivered Meals Program

Total (sum of lines 1-23)

Cost To Be Allocated (per

Worksheet H-1, Part I)

Respiratory Therapy

Private Duty Nursing

Day Care Program

Homemaker Service

Tel emedi ci ne

26.00 Unit Cost Multiplier

All Others (specify)

Clinic

HHA CCN: 15-7141 From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared: 5/22/2024 3:00 pm

Home Health PPS Agency I CAPITAL RELATED COSTS NEW MVBLE NEW BLDG & NEW BLDG & **EMPLOYEE** HHA Trial Subtotal Cost Center Description Bal ance (1) FI XT FIXT HHA/HO EQUI P **BENEFITS** DEPARTMENT 0 1. 00 1. 01 2.00 4. 00 4A 1.00 Administrative and General 219, 596 220, 725 1.00 0 1.129 0 589, 742 0 2.00 Skilled Nursing Care 589, 742 2.00 Physical Therapy 388, 023 0 0 388, 023 3.00 00000000 0 3.00 Occupational Therapy 99, 546 0 0 99, 546 4.00 0 4.00 0 5.00 4,659 C 0 4, 659 Speech Pathology 5.00 0 6.00 Medical Social Services 0 0 6.00 7.00 Home Heal th Aide 16,841 0 0 16, 841 7.00 Supplies (see instructions) 0 0 0 42.427 8 00 42 427 8 00 0 9.00 Drugs 982 C 982 9.00 10.00 DMF 0 10.00 11.00 Home Dialysis Aide Services 0 0000000 0 0 0 0 11.00 0 Respiratory Therapy 0 0 12 00 12 00 13.00 Private Duty Nursing 0 0 13.00 14.00 0 0 14.00 Clinic 0 Health Promotion Activities 0 15.00 15.00 0 0 0 Day Care Program 16.00 16.00 Ω 17.00 Home Delivered Meals Program 0 0 0 0 17.00 0 0 18.00 Homemaker Service 0 0 0 18.00 All Others (specify) 0 0 o 19 00 19 00 Ω 19.50 Tel emedi ci ne 0 0 0 0 19.50 Total (sum of lines 1-19) (2) 1, 142, 220 1, 129 219, 596 1, 362, 945 20.00 20.00 21.00 Unit Cost Multiplier: column 0.000000 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places ADMINISTRATIV OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A Cost Center Description E & GENERAL PLANT LINEN SERVICE 11.00 10.00 8.00 9.00 5.00 7.00 1.00 Administrative and General 54, 511 66, 739 0 0 1.00 2.00 Skilled Nursing Care 145, 646 0 0 2.00 Physical Therapy 95, 828 0 0 0 0 0 3.00 3.00 0 0 4.00 Occupational Therapy 24 584 0 4 00 Speech Pathology 5.00 1, 151 0 5.00 6.00 Medical Social Services 0 0 0 0 0 0 0 0 0 0 0 6.00 0000000000 0 7.00 Home Health Aide 4.159 0 7.00 0 0 0 8.00 Supplies (see instructions) 10, 478 8.00 9.00 0 0 9.00 Drugs 243 10.00 DME 0 10.00 0 11.00 0 Home Dialysis Aide Services 0 0 11.00 12.00 Respiratory Therapy 0 0 0 12.00 13.00 Private Duty Nursing 13.00 14.00 0 0 Clinic 14.00 15.00 Health Promotion Activities 0 0 0 15.00 Day Care Program 0 0 0 0 16.00 16.00 0 0 17.00 Home Delivered Meals Program 0 0 17.00 Homemaker Service 0 18.00 0 0 0 18.00 0 19.00 All Others (specify) 0 0 0 19.00 19.50 19.50 Tel emedi ci ne 0 Total (sum of lines 1-19) (2) 66, 739 20.00 20.00 336,600 Unit Cost Multiplier: column 21.00 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to

6 decimal places.

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

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

							5/22/2024 3:0	ло рііі
						Home Health Agency I	PPS	
	Cost Center Description	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	NONPHYSI CI AN ANESTHETI STS	RADI OLOGY SCHOOL	
		13. 00	14. 00	15. 00	16. 00	19. 00	23. 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	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)	000000000000000000000000000000000000000	0 0 0 0 0 0 0 1, 142 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 11.00 115.00 15.00 16.00 17.00 17.00 18.00 19.00
	6 decimal places.							
	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs		
		24. 00	25. 00	26. 00	27. 00	28. 00		
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)	341, 975 735, 388 483, 851 124, 130 5, 810 0 21, 000 54, 047 1, 225 0 0 0 0 0 0 0 0 0 1, 767, 426	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	341, 975 735, 388 483, 851 124, 130 5, 810 0 21, 000 54, 047 1, 225 0 0 0 0 0 0 0 0 1, 767, 426	176, 424 116, 079 29, 780 1, 394 0 5, 038 12, 966 294 0 0 0 0 0	911, 812 599, 930 153, 910 7, 204 0 26, 038 67, 013 1, 519 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 13.00 14.00 15.00 16.00 17.00 18.00 19.50 20.00 21.00

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

BASIS HHA CCN: 15-7141

					Home Health Agency I	PPS	
	CAPI	TAL RELATED CO	STS		Agency 1		
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)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
	1. 00	1. 01	2.00	4.00	5A	5. 00	
1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 19.50 Tel emedicine 20.00 Total (sum of lines 1-19) 21.00 Total cost to be allocated 22.00 Unit cost multiplier Cost Center Description	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 748 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 051, 239 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	220, 725 589, 742 388, 023 99, 546	1. 00 2. 00 3. 00 4. 00 5. 00 6. 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 22. 00
	FEET)	LAUNDRY)	0.00	10.00	11.00	(DI RECT NRSI NG HRS)	
1.00 Administrative and General	7. 00 2, 748	8. 00	9. 00	10.00	11.00	13.00	1.00
2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) 21.00 Total cost to be allocated 22.00 Unit cost multiplier	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	000000000000000000000000000000000000000	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 20. 00 21. 00

Health Financial Systems	KINGS DAUGHTERS HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO H	HA COST CENTERS STATISTICAL Provider CCN: 15-0	
BASIS		From 01/01/2023 Part II
	HHA CCN: 15-	7141 To 12/31/2023 Date/Time Prepared

							5/22/2024 3:0	0 pm
						Home Health	PPS	
						Agency I		
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	NONPHYSI CI AN			
		SERVICES &	(COSTED	RECORDS &	ANESTHETI STS			
		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		1.00
2.00	Skilled Nursing Care	0	0	0)	0		2. 00
3.00	Physi cal Therapy	0	0	0)	0		3. 00
4.00	Occupational Therapy	0	0	0)	0		4. 00
5.00	Speech Pathology	0	0	0)	0		5.00
6.00	Medical Social Services	0	0	0)	0		6. 00
7.00	Home Health Aide	0	0	0)	0		7. 00
8.00	Supplies (see instructions)	35, 147	0	0)	0		8. 00
9.00	Drugs	0	0	0)	0		9. 00
10.00	DME	0	0	0)	0		10.00
11. 00	Home Dialysis Aide Services	0	0	0)	0		11. 00
12.00	Respiratory Therapy	0	0	0)	0		12.00
13.00	Private Duty Nursing	0	0	0)	0		13.00
14.00	Clinic	0	0	0)	0		14.00
15.00	Health Promotion Activities	0	0	0)	0		15. 00
16.00	Day Care Program	0	0	0)	0 0		16. 00
17.00	Home Delivered Meals Program	0	0	0)	0 0		17.00
18.00	Homemaker Service	0	0	0		0		18. 00
19.00	All Others (specify)	0	0	0		0		19.00
19. 50	Tel emedi ci ne	o	0	0)	0		19. 50
20.00	Total (sum of lines 1-19)	35, 147	o	0)	0 0		20.00
21.00	Total cost to be allocated	1, 142	o	0)	0 0		21.00
22.00	Unit cost multiplier	0. 032492	0. 000000	0. 000000	0.00000	0. 000000		22.00

Hool +h	Financial Systems		KINGS DAUGHTE	DC HOCDITAL		In Lie	u of Form CMS-2	2552 10
	TONMENT OF PATIENT SERVICE COST	rs .	KINGS DAUGITL	Provi der C	CN: 15-0069	Peri od:	Worksheet H-3	
711 7 6111	TOTALLE OF THE SERVICE GOST			HHA CCN:	15-7141	From 01/01/2023 To 12/31/2023	Part I	pared:
				Title	XVIII	Home Health Agency I	PPS	о рііі
	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2,	Shared Ancillary Costs (from	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷	
			Part I)	Part II)			col . 4)	
	DART 1 001017471 011 05 1 50050	0	1.00	2.00	3.00	4.00	5. 00	
	PART I - COMPUTATION OF LESSER COST LIMITATION	OF AGGREGATE	PROGRAM COST, A	AGGREGATE OF II	HE PROGRAM LI	MITATION COST, (JR BENEFICIARY	
	Cost Per Visit Computation			Г				
1.00	Skilled Nursing Care	2. 00			911, 8	12 2, 489		
2. 00	Physi cal Therapy	3. 00		l .				1
3. 00	Occupational Therapy	4. 00						1
4. 00	Speech Pathology	5.00		l	7, 20			
5.00	Medical Social Services	6. 00		l		0	1	
6.00	Home Health Aide	7.00			26, 03			
7. 00	Total (sum of lines 1-6)		1, 698, 894	0	.,			7. 00
					Program Visi	ts		
					Pa	art B		1
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject	Subject to		
	•		. ,		to	Deducti bl es		
					Deductibles	&		
					Coi nsurance	•		
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
	Limitation Cost Computation							
8. 00	Skilled Nursing Care		99915	0		16		8. 00
9. 00	Physi cal Therapy		99915	0		39		9. 00
10.00	Occupational Therapy		99915	0	2	16		10.00
11. 00	Speech Pathology		99915	0		16		11.00
12.00	Medical Social Services		99915	0		0		12.00
13.00	Home Health Aide		99915	0		30		13.00
14. 00				0	.,.			14.00
	Cost Center Description	From Wkst. H-2 Part I,	Facility Costs (from	Shared Ancillary	Total HHA Costs (cols	(from HHA	Ratio (col. 3 ÷ col. 4)	
		col. 28, line	Wkst. H-2, Part I)	Costs (from Part II)	1 + 2)	Records)		
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
	Supplies and Drugs Cost Comput							
	Cost of Medical Supplies Cost of Drugs	8. 00 9. 00						1
	-		Program Visits		Cost of Services			
			Pan	t B	oci vi ces	Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
	oost conten bescription	l lait /	to	Deductibles &	l rait X	to	Deductibles &	
			Deductibles &			Deductibles &		
			Coi nsurance	oor risur unce		Coi nsurance	oor risur unice	
		6. 00	7. 00	8. 00	9. 00	10.00	11.00	
	PART I - COMPUTATION OF LESSER							
	COST LIMITATION							1
1 00	Cost Per Visit Computation		014			0 200 022		1 00
1.00	Skilled Nursing Care	0		l e		0 298, 933		1.00
2.00	Physical Therapy		839	ł		0 228, 275		2.00
3.00	Occupational Therapy		216	ł		0 57, 817		3.00
4.00	Speech Pathology		16	ł		0 2,744	i e	4.00
5.00	Medical Social Services		0	l .		0 10.053		5.00
6.00	Home Health Aide Total (sum of lines 1-6)		30 1, 917			0 19, 052		6.00
7. 00	Total (Sum of Tilles 1-0)	ı	1, 917	I	I	0 606, 821	I	7.00

Hoal th	Financial Systems		KINGS DAUGHTE	INT IDSON 201		Inlia	u of Form CMS-2	2552_10
	TIONMENT OF PATIENT SERVICE COST	ΓS	KINGS DAGGITE	Provi der CO	CN: 15-0069 15-7141	Peri od: From 01/01/2023 To 12/31/2023	Worksheet H-3 Part I Date/Time Pre	pared:
				Ti +Lo	XVIII	Home Health	5/22/2024 3: 0 PPS	O pm
					AVIII	Agency I	FF3	
	Cost Center Description	6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
	Limitation Cost Computation	6.00	7.00	8.00	9.00	10.00	11.00	
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 8-13)							8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
		Progi	ram Covered Cha	arges	Cost of Services			
					00. 1. 000			
	Cost Center Description	Part A	Par Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Part B Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6. 00	7. 00	8.00	9. 00	10. 00	11. 00	
	Supplies and Drugs Cost Comput							
	Cost of Medical Supplies Cost of Drugs	0	0			0 0		
	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00						
	PART I - COMPUTATION OF LESSER COST LIMITATION	OF AGGREGATE	PROGRAM COST,	AGGREGATE OF TH	HE PROGRAM LI	MITATION COST, C	R BENEFICIARY	
1 00	Cost Per Visit Computation	200 022						1 00
1. 00 2. 00	Skilled Nursing Care Physical Therapy	298, 933 228, 275						1.00 2.00
3. 00	Occupational Therapy	57, 817						3.00
4. 00	Speech Pathology	2, 744						4. 00
5. 00 6. 00	Medical Social Services Home Health Aide	0 19, 052						5. 00 6. 00
7. 00	Total (sum of lines 1-6)	606, 821						7.00
	Cost Center Description	333732						
	T	12. 00						
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide							8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
14. 00	Total (sum of lines 8-13)	l						14.00

Heal th	Financial Systems		KINGS DAUGHTE	RS HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORT	TIONMENT OF PATIENT SERVICE COS	ΓS		Provi der C		Peri od:	Worksheet H-3	
				HHA CCN:	15-7141	From 01/01/2023 To 12/31/2023		nared·
				THIN CON.	13 7141	10 12/31/2023	5/22/2024 3: 0	
						Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Charge Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1. 00	2. 00	3. 00	4. 00		
	PART II - APPORTIONMENT OF COS	T OF HHA SERVI	CES FURNISHED I	BY SHARED HOSPI	ITAL DEPARTME	NTS		
1.00	Physi cal Therapy	66.00	0. 392106	0		0 col. 2, line 2	. 00	1.00
2.00	Occupational Therapy	67.00	0. 351797	0		0 col. 2, line 3	. 00	2.00
3.00	Speech Pathology	68.00	0. 282953	0		0 col. 2, line 4	. 00	3.00
4.00	Cost of Medical Supplies	71.00	0. 311636	0		0 col. 2, line 1	5. 00	4.00
4.01	Cost of Medical Supplies 1	71. 01	0. 000000	0		0 col. 2, line 1	5. 01	4. 01
5.00	Cost of Drugs	73.00	0. 167290	0		0 col. 2, line 1	6. 00	5. 00

	Financial Systems KINGS DAUGHTER ATION OF HHA REIMBURSEMENT SETTLEMENT	Provider C	CN: 15-0069	Peri od:	eu of Form CMS-2 Worksheet H-4	
		HHA CCN:	15-7141	From 01/01/202 To 12/31/202	3 Part I-II	pare
		Title	XVIII	Home Health Agency I	PPS	о рііі
			Part A		Subject to	
				to Deducti bl es Coi nsurance	Deductibles & Coinsurance	
			1.00	2. 00	3. 00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CU	STOMARY CHARGE	ES			-
0	Reasonable Cost of Part A & Part B Services Reasonable cost of services (see instructions)			0	0 0	1
0	Total charges				o o	
	Customary Charges					
00	Amount actually collected from patients liable for payment	for services		0	0	3
00	on a charge basis (from your records) Amount that would have been realized from patients liable for services on a charge basis had such payment been made i			0	0 0	4
	with 42 CFR §413.13(b)					
00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000		l	
)O)O	Total customary charges (see instructions) Excess of total customary charges over total reasonable cos	t (complete		0	0 0	
,0	only if line 6 exceeds line 1)	t (comprete		o e	٥	′
00	Excess of reasonable cost over customary charges (complete 1 exceeds line 6)	only if line		0	0	
0	Primary payer amounts				0 0	9
				Part A Services	Part B Services	
				1. 00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
	Total reasonable cost (see instructions)				0 0	
00	Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers				0 421, 923 0 11, 770	
00	Total PPS Reimbursement - LUPA Episodes				0 3,066	
00	Total PPS Reimbursement - PEP Episodes				0 0	1
00	Total PPS Outlier Reimbursement - Full Episodes with Outlie	rs			0 1, 752	15
00	Total PPS Outlier Reimbursement - PEP Episodes				0 0	16
00	Total Other Payments				0 0	
00	DME Payments				0	
00	Oxygen Payments				0	
00	Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coi	neuranea)			0 0	1 .
00	Subtotal (sum of lines 10 thru 20 minus line 21)	risui arice)			0 438, 511	
00	Excess reasonable cost (from line 8)				0 430, 311	1
00	Subtotal (line 22 minus line 23)				0 438, 511	
00	Coinsurance billed to program patients (from your records)				0	
00	Net cost (line 24 minus line 25)				0 438, 511	26
00	Allowable bad debts (from your records)				0	27
01	Adjusted reimbursable bad debts (see instructions)				0	
00	Allowable bad debts for dual eligible (see instructions)				0	
00	Total costs - current cost reporting period (see instruction	ns)			0 438, 511	
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction)	one)			0 0	
50 99	Demonstration payment adjustment before sequestration	,				
00	Subtotal (see instructions)	11			0 438, 511	
01	Sequestration adjustment (see instructions)				0 8,770	
02	Demonstration adjustment (see First detrois) Demonstration payment adjustment amount after sequestration				0 0,770	1
75	Sequestration adjustment for non-claims based amounts (see					
. 00	Interim payments (see instructions)				0 429, 741	
-	Tentative settlement (for contractor use only)				0 0	1
. 00						
. 00 . 00	Balance due provider/program (line 31 minus lines 31.01, 31	. 02, 31. 75, 32	2, and 33)		0 0	34

Health Financial Systems	KINGS DAUGHTERS	HOSPI TAL		In Lieu	of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED TO PROGRAM BENEFICIARIES	HHAS FOR SERVICES RENDERED	Provi der C	CN: 15-0069	Peri od: From 01/01/2023	Worksheet H-5
TO TROURAW BENEFICIARTES		HHA CCN:	15-7141		Date/Time Prepared:

5/22/2024 3:00 pm Home Health Agency I Inpatient Part A Part 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 429, 741 1.00 2.00 Interim payments payable on individual bills, either 0 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3. 01 3.01 3. 02 0 0 3.02 3.03 0 3.03 3.04 0 0 3.04 0 3.05 3.05 Provider to Program 3.50 0 0 3.50 3. 51 0 0 3.51 0 3.52 0 3.52 3.53 0 3.53 3.54 0 0 3.54 0 3. 99 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3. 50-3. 98) Total interim payments (sum of lines 1, 2, and 3.99) 4.00 429, 741 0 4.00 (transfer to Wkst. H-4, Part II, column as appropriate, line 32) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 0 n 5.01 0 0 5.02 5.02 5.03 0 0 5.03 Provider to Program 5.50 0 5.50 n 5. 51 0 0 5.51 5. 52 0 0 5.52 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 5. 50-5. 98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.01 0 0 6.02 SETTLEMENT TO PROGRAM 6.02 0 Total Medicare program liability (see instructions) n 429, 741 7.00 7.00 NPR Date Contractor Number (Mo/Day/Yr) 0 1.00 2.00 8.00 Name of Contractor 8. 00

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* 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.

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100.00 TOTAL

VOLUNTEER PROGRAM *

RESIDENTIAL CARE*

PALLIATIVE CARE PROGRAM*

OTHER PHYSICIAN SERVICES*

TELEHEALTH/TELEMONI TORI NG*

71.00 OTHER NONREIMBURSABLE (SPECIFY)*

NURSING FACILITY ROOM & BOARD*

HOSPICE/PALLIATIVE MEDICINE FELLOWS*

FUNDRAI SI NG*

ADVERTI SI NG*

THRIFT STORE*

				Hospi ce I	
		ADJUSTMENTS	TOTAL (col. 5		
			± col. 6)		
		6. 00	7. 00		
4 00	GENERAL SERVICE COST CENTERS		0	I	1.00
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	•	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	105.011		3.00
4.00	ADMI NI STRATI VE & GENERAL*	0	185, 861		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0		5.00
6.00	LAUNDRY & LI NEN SERVI CE*	0	0		6.00
7.00	HOUSEKEEPI NG*	0	0		7.00
8.00	DI ETARY*	0	0		8.00
9.00	NURSI NG ADMI NI STRATI ON*	0	0	•	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	18, 525		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	1, 891		13.00
14.00	PHARMACY*	0	25, 220		14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES*	0	0		15. 00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES DIRECT PATIENT CARE SERVICE COST CENTERS				17. 00
25. 00	INPATIENT CARE-CONTRACTED**	o	0		25. 00
26. 00	PHYSI CI AN SERVI CES**		0		26.00
27. 00	NURSE PRACTITIONER**	0	0		27.00
28. 00	REGI STERED NURSE**	o	5, 834		28.00
29. 00	LPN/LVN**	0	0,001		29.00
30.00	PHYSI CAL THERAPY**	o	649		30.00
31. 00	OCCUPATIONAL THERAPY**	0	373		31.00
32. 00	SPEECH/LANGUAGE PATHOLOGY**	o	0		32.00
33. 00	MEDICAL SOCIAL SERVICES**	o	16, 290		33.00
34.00	SPIRITUAL COUNSELING**	o	0		34.00
35.00	DI ETARY COUNSELI NG**	O	0		35.00
36.00	COUNSELING - OTHER**	o	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	16, 858		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	o	31, 408		38.00
39.00	PATI ENT TRANSPORTATI ON**	o	0		39.00
40.00	I MAGING SERVICES**	0	0		40.00
41.00	LABS & DI AGNOSTI CS**	0	0		41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0		42. 50
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		46. 00
	NONREI MBURSABLE COST CENTERS		_		
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0	l .	61.00
62.00	FUNDRAI SI NG*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65. 00
66.00	RESI DENTI AL CARE*	0	0		66.00
67.00	ADVERTI SI NG*	0	0		67.00
68.00	TELEHEALTH/TELEMONI TORI NG*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	202 000		71.00
100.00	/ IUIAL	<u> </u>	302, 909		100.00

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

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46. 00 OT	HER PATIENT CARE SERVICES (SPECIFY)	0	
100 00 TO	ITAL *	0	

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

		ADJUSTMENTS	TOTAL (col. 5	
			± col . 6)	
		6. 00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	I NPATI ENT CARE-CONTRACTED			25. 00
26.00	PHYSI CI AN SERVI CES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGI STERED NURSE	0	5, 634	28. 00
29. 00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	627	30.00
31.00	OCCUPATI ONAL THERAPY	0	360	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	15, 733	33.00
34.00	SPI RI TUAL COUNSELI NG	0	0	34.00
35.00	DI ETARY COUNSELI NG	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	16, 282	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	31, 408	38. 00
39. 00	PATI ENT TRANSPORTATION	0	0	39.00
40.00	I MAGI NG SERVI CES	0	0	40.00
41. 00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	42.00
42. 50	DRUGS CHARGED TO PATIENTS	0	0	42. 50
43.00	OUTPATIENT SERVICES	0	0	43.00
44. 00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0	45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46. 00
100.00	TOTAL *	0	70, 044	100.00

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

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DIETARY COUNSELING

COUNSELING - OTHER

IMAGING SERVICES

LABS & DIAGNOSTICS

OUTPATIENT SERVICES

PATIENT TRANSPORTATION

HOSPICE AIDE & HOMEMAKER SERVICES

DURABLE MEDICAL EQUIPMENT/OXYGEN

MEDICAL SUPPLIES-NON-ROUTINE

PALLIATIVE RADIATION THERAPY

DRUGS CHARGED TO PATIENTS

Health Financial Systems	KINGS DAUGHTER	RS HOSPITAL		In Li€	eu of Form CMS-	2552-10
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPI	CE INPATIENT	Provi der Co	CN: 15-0069	Peri od:	Worksheet 0-3	3
RESPITE CARE				From 01/01/2023		
		Hospi ce CCI	N: 15-1535	To 12/31/2023	Date/Time Pre 5/22/2024 3:0	
				Hospi ce I	3/22/2024 3.0	о рііі
	SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
	07.12.11.1.20	o men	(col. 1 +	CATIONS	000101712	
			col. 2)			
	1.00	2.00	3.00	4. 00	5. 00	
DIRECT PATIENT CARE SERVICE COST CENTERS	<u>'</u>			<u>'</u>		
25. 00 I NPATI ENT CARE-CONTRACTED		0		0 0	0	25. 00
26. 00 PHYSI CI AN SERVI CES	0	0		0 0	0	26.00
27. 00 NURSE PRACTITIONER	0	0		0 0	0	27. 00
28. 00 REGI STERED NURSE	0	0		0 31	31	28. 00
29. 00 LPN/LVN	0	0		0 0	0	
30. 00 PHYSI CAL THERAPY	0	0		0	3	30.00
31. 00 OCCUPATI ONAL THERAPY	0	0		0 2	2	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0		0	0	1
33.00 MEDICAL SOCIAL SERVICES	0	0		0 86	1	
34. 00 SPI RI TUAL COUNSELI NG	0	0		0 0	0	
35. 00 DI ETARY COUNSELI NG	0	0		0 0	0	
36. 00 COUNSELING - OTHER	0	0		0 0	0	1 00.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	0	0		0 89	89	
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		0 0	0	1 00.00
39. 00 PATIENT TRANSPORTATION	0	0		0	0	107.00
40. 00 I MAGI NG SERVI CES	0	0		0	0	1
41. 00 LABS & DI AGNOSTI CS	0	0		0	0	1
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0		0	0	1
42. 50 DRUGS CHARGED TO PATIENTS	0	0		0	0	42.50
43. 00 OUTPATIENT SERVICES	0	0		0	0	
44. 00 PALLI ATI VE RADI ATI ON THERAPY	0	0		0	0	1
45. 00 PALLIATIVE CHEMOTHERAPY	0	0		U C	0	1 .0.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		0 0	0	46.00

^{100.00} TOTAL * * Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5		
		6. 00	± col . 6) 7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS	0.00	7.00		
25. 00	I NPATI ENT CARE-CONTRACTED	0	0		25. 00
26. 00	PHYSI CI AN SERVI CES		0		26. 00
27. 00	NURSE PRACTITIONER		0		27. 00
28. 00	REGI STERED NURSE		31	l .	28. 00
29. 00	LPN/LVN	0	0		29. 00
30.00	PHYSI CAL THERAPY	0	3		30.00
31. 00	OCCUPATIONAL THERAPY	0	2		31.00
32. 00	SPEECH/LANGUAGE PATHOLOGY	0	ō		32.00
33. 00	MEDICAL SOCIAL SERVICES	0	86		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DI ETARY COUNSELI NG	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	89		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATI ENT TRANSPORTATION	0	0		39.00
40.00	I MAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATI ENT SERVI CES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	211	1	100.00

0 45.00 0 46.00 211 100.00

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

Haalah Firansial Customa	KINGS DAUGUTED	AC HOCDITAL		1 11	£ F CMC	2552 10
Health Financial Systems ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOS	KINGS DAUGHTER	Provider CCN	J: 15_0069	Period:	u of Form CMS-2 Worksheet 0-4	
INPATIENT CARE	THE GENERAL	Hospi ce CCN:		From 01/01/2023 To 12/31/2023		pared:
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
			(col. 1 +	CATI ONS		
			col . 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
DIRECT PATIENT CARE SERVICE COST CENTERS				_1		
25. 00 I NPATI ENT CARE-CONTRACTED		0		0	0	20.00
26. 00 PHYSI CI AN SERVI CES	0	0		0	0	26.00
27. 00 NURSE PRACTITIONER	0	0		0 0	0	27.00
28. 00 REGI STERED NURSE	0	0		0 169	169	28.00
29. 00 LPN/LVN	0	0		0	0	29.00
30. 00 PHYSI CAL THERAPY	0	0		0 19	19	30.00
31. 00 OCCUPATI ONAL THERAPY	0	0		0 11	11	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY 33.00 MEDICAL SOCIAL SERVICES	0	U		0 471	0	
	0	U		0 471	471	33.00
34. 00 SPIRITUAL COUNSELING 35. 00 DIETARY COUNSELING	0	U		0	0	
36. OO COUNSELING - OTHER		U O		0	0	36.00
37. 00 HOSPICE AIDE & HOMEMAKER SERVICES		0		0 487	487	37.00
38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN		U O		0 487	487 0	38.00
39. 00 PATIENT TRANSPORTATION		0		0	0	39.00
40.00 IMAGING SERVICES		0		0	0	40.00
41. 00 LABS & DI AGNOSTI CS		0		0	0	41.00
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE		0		0	0	42.00
42.50 DRUGS CHARGED TO PATIENTS		0			0	42.50
43. 00 OUTPATIENT SERVICES		0			o n	43.00
44. 00 PALLIATIVE RADIATION THERAPY		0		0 0	n	44.00
45. 00 PALLIATIVE CHEMOTHERAPY		0		0	j 0	45.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)		0		0 0	0	46.00
100. 00 TOTAL *	Ö	Ö		0 1, 157	1, 157	100.00

^{100.00} TOTAL * * Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6. 00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	0	25. 00
26.00	PHYSI CI AN SERVI CES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGI STERED NURSE	0	169	28. 00
29.00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	19	30.00
31.00	OCCUPATI ONAL THERAPY	0	11	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	471	33.00
34.00	SPI RI TUAL COUNSELI NG	0	0	34.00
35.00	DI ETARY COUNSELI NG	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	487	37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38. 00
39. 00	PATIENT TRANSPORTATION	0	0	39.00
40.00	I MAGING SERVICES	0	0	40.00
41.00	LABS & DI AGNOSTI CS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42. 50
43.00	OUTPATI ENT SERVI CES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0	45.00
46.00		0	0	46.00
100.00	TOTAL *	0	1, 157	100.00

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

Heal th	Financial Systems KINGS DAUGHTERS	S HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	_		Peri od:	Worksheet 0-5	
EXPENS	ES FOR ALLOCATION	Hospi ce CC		From 01/01/2023 To 12/31/2023		
				Hospi ce I		
	Descriptions	<u> </u>	HOSPI CE	GENERAL	TOTAL	
			DI RECT	SERVI CE	EXPENSES (sum	
			EXPENSES (see	EXPENSES FROM	of cols. 1 +	
			instructions)	WKST B PART I	2)	
				(see		
				instructions)		
			1.00	2. 00	3. 00	
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT			306	306	1.00
2.00	CAP REL COSTS-MVBLE EQUIP			0	0	2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT			47, 253		3.00
4. 00	ADMINISTRATIVE & GENERAL		185, 86	·		4.00
5. 00	PLANT OPERATION & MAINTENANCE			18, 069	18, 069	5.00
6.00	LAUNDRY & LINEN SERVICE			0	0	6.00
7. 00	HOUSEKEEPI NG			0	0	7.00
8. 00	DIETARY			0	0	8.00
9.00	NURSI NG ADMI NI STRATI ON			0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES			1, 020	1, 020	10.00
11.00	MEDI CAL RECORDS			0	0	11.00
12.00	STAFF TRANSPORTATION		18, 52	5	18, 525	12.00
13.00	VOLUNTEER SERVICE COORDINATION		1, 89	1	1, 891	13.00
14.00	PHARMACY		25, 22	0	25, 220	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES		(0	0	15.00
16.00	OTHER GENERAL SERVICE		(0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0	0	17.00
	LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	·		O	0	50.00
F4 00	HOODI OF BOUTINE HOME OADE		70.01	.1		

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51.00 HOSPICE ROUTINE HOME CARE

BEREAVEMENT PROGRAM

PALLIATIVE CARE PROGRAM

OTHER PHYSICIAN SERVICES

TELEHEALTH/TELEMONI TORI NG

70.00 NURSING FACILITY ROOM & BOARD

71.00 OTHER NONREIMBURSABLE (SPECIFY)

VOLUNTEER PROGRAM

RESIDENTIAL CARE

ADVERTI SI NG

THRIFT STORE

99.00 NEGATIVE COST CENTER

62. 00 FUNDRAI SI NG

HOSPICE INPATIENT RESPITE CARE

HOSPICE GENERAL INPATIENT CARE

HOSPICE/PALLIATIVE MEDICINE FELLOWS

NONREI MBURSABLE COST CENTERS

52.00

53.00

60.00

61.00

63.00

64.00

65.00

66.00

67.00

68.00

69.00

100. 00 TOTAL

Provider CCN: 15-0069 | Period: | Worksheet 0-6 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: | 5/2/2024 3:00 pm

						5/22/2024 3:0	O pm
					Hospi ce I		
	Descriptions	TOTAL	CAP REL BLDG	CAP REL MVBLE	EMPLOYEE	SUBTOTAL	
		EXPENSES	& FIX	EQUI P	BENEFI TS		
					DEPARTMENT		
		0	1. 00	2. 00	3. 00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	306	306				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	47, 253	0	0	47, 253		3.00
4.00	ADMINISTRATIVE & GENERAL	272, 414	306	0	30, 275	302, 995	4.00
5.00	PLANT OPERATION & MAINTENANCE	18, 069	0	0	0	18, 069	5. 00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6. 00
7.00	HOUSEKEEPI NG	0	0	0	o	0	7.00
8.00	DI ETARY	0	0	0	o	0	8.00
9.00	NURSI NG ADMI NI STRATI ON	0	0	0	o	0	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	1, 020	0	0	0	1, 020	10.00
11.00	MEDI CAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	18, 525	0	0	o	18, 525	12.00
13.00	VOLUNTEER SERVICE COORDINATION	1, 891	0	o	789	2, 680	13.00
14.00	PHARMACY	25, 220	0	o	0	25, 220	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	o	o	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	o	o	0	16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES		0	o		0	17.00
	LEVEL OF CARE	'					
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	70, 044			15, 635	85, 679	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	211	0	0	86	297	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1, 157	0	0	468	1, 625	53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAI SI NG	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESI DENTI AL CARE	0	0	0	0	0	66.00
67.00	ADVERTI SI NG	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	o	0	71.00
99.00	NEGATI VE COST CENTER	0	0	0	o		99. 00
100.00	TOTAL	456, 110	306	0	47, 253	456, 110	100.00

Provi der CCN: 15-0069 | Peri od: | Worksheet 0-6 | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: | Date/Time Prepared: | Part I | Date/Time Prepared: | Part I | Date/Time Prepared: | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Part I | Provi der CCN: 15-0069

					.0 .2,0.,2020	5/22/2024 3:	00 pm
					Hospi ce I		
	Descriptions	ADMI NI STRATI V	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	'	E & GENERAL	OPERATION &	LINEN SERVIC	Ξ		
			MAI NTENANCE				
		4. 00	5. 00	6.00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS			•	<u>'</u>		
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	302, 995					4.00
5.00	PLANT OPERATION & MAINTENANCE	35, 756	53, 825				5.00
6.00	LAUNDRY & LINEN SERVICE	l ol	. 0		0		6.00
7. 00	HOUSEKEEPI NG	ol	0		0		7.00
8. 00	DI ETARY	ol	0		0		0 8.00
9. 00	NURSI NG ADMI NI STRATI ON	0	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	2, 018	0	(0		10.00
11. 00	MEDI CAL RECORDS	_,	0		0		11.00
12. 00	STAFF TRANSPORTATION	36, 659	0		0		12.00
13. 00	VOLUNTEER SERVICE COORDINATION	5, 303	0		0		13.00
14. 00	PHARMACY	49, 907	0		0		14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	47, 707	0		0		15. 00
16. 00	OTHER GENERAL SERVICE		0		0		16.00
17. 00	PATI ENT/RESI DENTI AL CARE SERVI CES		0		0		17. 00
17.00	LEVEL OF CARE	<u> </u>		1			- 17.00
50.00	HOSPICE CONTINUOUS HOME CARE	O					50.00
51.00	HOSPICE ROUTINE HOME CARE	169, 548					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	588	8, 074		0 0		0 52.00
		3, 216	45, 751	1	0 0		0 53.00
00.00	NONREI MBURSABLE COST CENTERS	0,210	10, 701	l	<u> </u>		00.00
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61. 00	VOLUNTEER PROGRAM	أم	0		0		61.00
62. 00	FUNDRAI SI NG	أم	0		0		62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	أم	0		0		63.00
64. 00	PALLIATIVE CARE PROGRAM	أم	0		0		64.00
65. 00	OTHER PHYSICIAN SERVICES	أم	0		0		65.00
66. 00	RESI DENTI AL CARE		0		0 0		0 66.00
67. 00	ADVERTI SI NG		0		0		67.00
68. 00	TELEHEALTH/TELEMONI TORI NG		0		0		68.00
69. 00	THRI FT STORE		0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD		O				70.00
	OTHER NONREIMBURSABLE (SPECIFY)		0		0		0 71.00
	NEGATI VE COST CENTER		0		0 0		0 99.00
	TOTAL	302, 995	53, 825		o o		0 100.00
		332, 770	55, 626	I .	-1	l	- 1.00.00

Heal th Financial	Systems		KINGS DAUGHTERS	HOSPI TAL	In Lie	eu of Form CMS-2552-10
COST ALLOCATION	- HOSPI TAL-BASED	HOSPI CE GENERAL	SERVICE COSTS	Provi der CCN: 15-0069	Peri od:	Worksheet 0-6

From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared: Hospi ce CCN: 15-1535 5/22/2024 3:00 pm Hospi ce I NURSI NG ROUTI NE MEDI CAL VOLUNTEER Descriptions STAFF ADMI NI STRATI O MEDI CAL RECORDS TRANSPORTATI O SERVI CE COORDI NATI ON SUPPLI ES Ν N 11.00 9.00 10.00 12.00 13.00 GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT 1.00 1.00 2 00 CAP REL COSTS-MVBLE EQUIP 2.00 3.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 4.00 ADMINISTRATIVE & GENERAL 4.00 PLANT OPERATION & MAINTENANCE 5.00 5.00 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 HOUSEKEEPI NG 7.00 8.00 DI ETARY 8.00 NURSING ADMINISTRATION 9.00 9.00 000000 ROUTINE MEDICAL SUPPLIES 3,038 10.00 10.00 11.00 MEDICAL RECORDS 0 11.00 12.00 STAFF TRANSPORTATION 55, 184 12.00 VOLUNTEER SERVICE COORDINATION 7, 983 13.00 13.00 0 14.00 PHARMACY 0 0 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 15.00 0 OTHER GENERAL SERVICE 0 0 16.00 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 0 50.00 0 0 50.00 0 0 51.00 HOSPICE ROUTINE HOME CARE 2, 937 53, 355 7,717 51.00 52.00 HOSPICE INPATIENT RESPITE CARE 16 283 42 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 0 85 0 1,546 224 53.00 NONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM VOLUNTEER PROGRAM 60.00 0 0 0 0 0 0 0 0 60.00 0 61.00 0 61.00 62.00 FUNDRAI SI NG 62.00 0 0 0 0 HOSPICE/PALLIATIVE MEDICINE FELLOWS 63.00 0 63.00 PALLIATIVE CARE PROGRAM 64.00 0 64.00 65.00 OTHER PHYSICIAN SERVICES 0 65.00 RESIDENTIAL CARE 0 66.00 0 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 0 0 0 71.00 0 0 99. 00 NEGATI VE COST CENTER 0 99.00 100.00 TOTAL 3, 038 55, 184 7, 983 100.00

Health FinancialSystemsKINGS DAUGHTERS HOSPITALCOST ALLOCATION- HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTSProvider Provider CCN: 15-0069 | Period: | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: | 5/22/2024 3:00 pm

			·			5/22/2024 3:0	O pm
					Hospi ce I		
	Descriptions	PHARMACY	PHYSI CI AN	OTHER GENERAL	PATI ENT/	TOTAL	
			ADMI NI STRATI V	SERVI CE	RESI DENTI AL		
			E SERVICES		CARE SERVICES		
	T	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	HOUSEKEEPI NG						7. 00
8. 00	DI ETARY						8. 00
9. 00	NURSI NG ADMI NI STRATI ON						9. 00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11. 00	MEDI CAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14. 00	PHARMACY	75, 127	_				14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0					16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES				0		17. 00
FO 00	LEVEL OF CARE	0	0	ı ,	\	0	FO 00
	HOSPICE CONTINUOUS HOME CARE HOSPICE ROUTINE HOME CARE	72, 640	0	(0 391, 876	
51. 00 52. 00	HOSPICE ROUTINE HOME CARE HOSPICE INPATIENT RESPITE CARE	384	0			· ·	
	HOSPICE THPATTENT RESPITE CARE	2, 103	0				
53. 00	NONREI MBURSABLE COST CENTERS	2, 103	U	1) 0	54, 550	53.00
60. 00	BEREAVEMENT PROGRAM	0			\	0	60.00
61.00	VOLUNTEER PROGRAM	0				0	61.00
62. 00	FUNDRAI SI NG	0				0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0				0	63.00
64. 00	PALLIATIVE CARE PROGRAM	0				0	64.00
65. 00	OTHER PHYSICIAN SERVICES	0				0	65.00
66. 00	RESIDENTIAL CARE	0	0		ó	_	66.00
67. 00	ADVERTI SI NG	0				0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	0				0	68.00
69.00	THRIFT STORE	0				0	69.00
70.00				ì		0	70.00
	OTHER NONREIMBURSABLE (SPECIFY)	0	0	1	0	0	71.00
99.00	NEGATI VE COST CENTER	0	n	l à	o o	0	99.00
100.00		75, 127	Ö		o o	_	
	i .			'	1		

Health Financial Systems	KINGS DAUGHTERS	HOSPI TAL	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPIC STATISTICAL BASIS	E GENERAL SERVICE COSTS	Provi der CCN: Hospi ce CCN:	 From 01/01/2023	Worksheet 0-6 Part II Date/Time Prepared: 5/22/2024 3:00 pm

			nospi ce co	N. 13-1333	10 12/31/2023	5/22/2024 3: 0	
					Hospi ce I		
	Cost Center Descriptions	CAP REL BLDG	CAP REL MVBLE	EMPLOYEE		ADMI NI STRATI V	
	'	& FIX	EQUI P	BENEFI TS	N	E & GENERAL	
		(SQUARE FEET)	(DOLLAR	DEPARTMENT		(ACCUMULATED	
		(,	VALUE)	(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	1		า		3.00
4. 00	ADMI NI STRATI VE & GENERAL	744	1	72, 52		153, 115	1
5. 00	PLANT OPERATION & MAINTENANCE	, , ,	١	72,02	1 002, 770	18, 069	5.00
6. 00	LAUNDRY & LINEN SERVICE					0	
7. 00	HOUSEKEEPI NG					0	1
8. 00	DI ETARY					0	1
9. 00	NURSING ADMINISTRATION					0	
10. 00	ROUTINE MEDICAL SUPPLIES					1, 020	1
	MEDICAL RECORDS					1,020	1
12. 00	STAFF TRANSPORTATION					_	
				1, 89	1	18, 525	1
	VOLUNTEER SERVICE COORDINATION	0				2, 680	1
14.00	PHARMACY	0	0		0	25, 220	1
	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0	0	
	OTHER GENERAL SERVICE	0	1		0	0	
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17. 00
	LEVEL OF CARE		1			1	
50. 00	HOSPICE CONTINUOUS HOME CARE				0	0	00.00
	HOSPICE ROUTINE HOME CARE			37, 45		,	1
	HOSPICE INPATIENT RESPITE CARE	0					52.00
53. 00	HOSPICE GENERAL INPATIENT CARE	0	0	1, 12	1 0	1, 625	53.00
	NONREI MBURSABLE COST CENTERS	+			_		
60.00	BEREAVEMENT PROGRAM	0	0		0	0	00.00
61. 00	VOLUNTEER PROGRAM	0	0		0	0	61.00
62.00	FUNDRAI SI NG	0	0		0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	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	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0	0	68. 00
69.00	THRI FT STORE	0	0		0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0	0	71.00
	NEGATI VE COST CENTER						99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	306	0	47, 25	3	302, 995	100.00
	UNIT COST MULTIPLIER	0. 411290	0. 000000			1. 978872	
	!	1	•	•	1		1

Health Financial Systems	KINGS DAUGHTE	RS HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	RVI CE COSTS	Provi der CO		Peri od:	Worksheet 0-6	
STATISTICAL BASIS		Hospi ce CCN		From 01/01/2023 To 12/31/2023	Date/Time Pre	
				Hospi ce I	5/22/2024 3:0) pm
Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI NO		NURSI NG	

			nospi ce co	N. 15-1555	0 12/31/2023	5/22/2024 3: 0	
					Hospi ce I		
	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
	'	OPERATION &	LINEN SERVICE	(SQUARE FEET)	(IN-FACILITY	ADMI NI STRATI O	
		MAI NTENANCE	(IN-FACILITY	(DAYS)	N	
		(SQUARE FEET)	DAYS)			(DI RECT NURS.	
		(**************************************	,			HRS.)	
		5. 00	6.00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & 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	100					5.00
6. 00	LAUNDRY & LINEN SERVICE	100	0				6.00
7. 00	HOUSEKEEPI NG	0		1			7.00
8. 00	DI ETARY				0		8.00
9. 00	NURSING ADMINISTRATION				O	0	1
10.00	ROUTINE MEDICAL SUPPLIES	0				0	10.00
11. 00	MEDICAL RECORDS	0		0		0	11.00
12. 00	STAFF TRANSPORTATION	0				0	12.00
		0		0		_	
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16. 00	OTHER GENERAL SERVICE	0		0		0	16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17. 00
	LEVEL OF CARE	1	1	1		1	
50.00	HOSPICE CONTINUOUS HOME CARE					0	
51. 00	HOSPICE ROUTINE HOME CARE					0	
52.00	HOSPICE INPATIENT RESPITE CARE	15				0	
53.00	HOSPICE GENERAL INPATIENT CARE	85	0	0	0	0	53.00
	NONREI MBURSABLE COST CENTERS				i .		
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	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	0	1
99. 00	NEGATI VE COST CENTER	1		1			99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	53, 825	0	0	0	0	100.00
	UNIT COST MULTIPLIER	538. 250000		0. 000000	0. 000000		

	Financial Systems ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	KINGS DAUGHTER		CN: 15-0069	Peri od:	u of Form CMS-2 Worksheet 0-6	
	STICAL BASIS	SERVICE COSTS	Frovider C		From 01/01/2023	Part II	
			Hospi ce CC	N: 15-1535	To 12/31/2023	Date/Time Pre 5/22/2024 3:0	pared:
					Hospi ce I	3/22/2024 3.0	о рііі
	Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
		MEDI CAL	RECORDS	TRANSPORTATI ((CHARGES)	
		SUPPLI ES	(PATI ENT	N .	COORDI NATI ON		
		(PATI ENT	DAYS)	(MI LEAGE)	(HOURS OF		
		DAYS)			SERVICE)		
	DENERAL DEPUT OF COOT DENTERO	10. 00	11. 00	12. 00	13. 00	14. 00	
1 00	GENERAL SERVICE COST CENTERS			I	1		1 00
1.00	CAP REL COSTS-BLDG & FLXT CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT	+					3.00
4. 00	ADMINISTRATIVE & GENERAL	1					4.00
5. 00	PLANT OPERATION & MAINTENANCE						5.00
6. 00	LAUNDRY & LINEN SERVICE						6.00
7. 00	HOUSEKEEPI NG			•			7.00
8. 00	DI ETARY						8.00
9. 00	NURSI NG ADMI NI STRATI ON						9. 00
10.00	ROUTI NE MEDI CAL SUPPLI ES	2, 536					10.00
11.00	MEDI CAL RECORDS		C				11.00
12.00	STAFF TRANSPORTATION			18, 13	2		12.00
13.00	VOLUNTEER SERVICE COORDINATION				0 1, 891		13.00
14.00	PHARMACY				0 0	25, 220	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						17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	C		0 0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	2, 452	C	,		24, 385	
52.00	HOSPICE INPATIENT RESPITE CARE	13	C	1		129	52.00
53. 00	HOSPI CE GENERAL I NPATI ENT CARE	71	C	50	8 53	706	53.00
	NONREI MBURSABLE COST CENTERS			1			,, ,,
60.00	BEREAVEMENT PROGRAM			l .	0 0	0	60.00
61.00	VOLUNTEER PROGRAM				0 0	0	61.00
62.00	FUNDRAL SI NG				0 0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS				0 0	0	63.00
64. 00 65. 00	PALLIATIVE CARE PROGRAM OTHER PHYSICIAN SERVICES	1			0 0	0	64. 00 65. 00
66.00	RESIDENTIAL CARE					0	66.00
67.00	ADVERTI SI NG	1				0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG					0	68.00
60.00	TUDI ET CTODE			1		0	40.00

3, 038 1. 197950

0.000000

0

75, 127 100. 00 2. 978866 101. 00

0

7, 983

4. 221576

55, 184 3. 043459

69. 00 70. 00

71.00

99.00

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

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

Health Financial Systems	KINGS DAUGHTERS H	IOSPI TAL		In Lieu	of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOS STATISTICAL BASIS		Provider CCN: 15-0 Hospice CCN: 15-	From	01/01/2023	Worksheet 0-6 Part II Date/Time Prepared:

							5/22/2024 3:0	OO pm
						Hospi ce I		
		Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/			
		·	ADMI NI STRATI V	SERVI CE	RESI DENTI AL			
			E SERVICES	(SPECI FY	CARE SERVICES			
			(PATI ENT	BASIS)	(IN-FACILITY			
			DAYS)		DAYS)			
			15. 00	16. 00	17. 00			
_		GENERAL SERVICE COST CENTERS	10.00	10.00	17.00			
1	. 00	CAP REL COSTS-BLDG & FLXT						1.00
	. 00	CAP REL COSTS-BEDG & TTAT						2.00
		EMPLOYEE BENEFITS DEPARTMENT						1
	. 00							3.00
	. 00	ADMI NI STRATI VE & GENERAL						4.00
	. 00	PLANT OPERATION & MAINTENANCE						5.00
	. 00	LAUNDRY & LINEN SERVICE						6. 00
	. 00	HOUSEKEEPI NG						7. 00
8	. 00	DI ETARY						8. 00
9	. 00	NURSING ADMINISTRATION						9. 00
1	0. 00	ROUTINE MEDICAL SUPPLIES						10.00
1	1. 00	MEDI CAL RECORDS						11.00
1	2. 00	STAFF TRANSPORTATION						12.00
		VOLUNTEER SERVICE COORDINATION						13.00
		PHARMACY						14.00
		PHYSICIAN ADMINISTRATIVE SERVICES	C					15.00
				΄ Ι				1
		OTHER GENERAL SERVICE			1			16.00
ı	7. 00	PATIENT/RESIDENTIAL CARE SERVICES			0			17. 00
_		LEVEL OF CARE	_		.1			
		HOSPICE CONTINUOUS HOME CARE	C	1	1			50.00
		HOSPICE ROUTINE HOME CARE	C		1			51.00
5.	2. 00	HOSPICE INPATIENT RESPITE CARE	C					52.00
5	3.00	HOSPICE GENERAL INPATIENT CARE	C) C	0			53.00
		NONREI MBURSABLE COST CENTERS						
6	0. 00	BEREAVEMENT PROGRAM		C				60.00
6	1. 00	VOLUNTEER PROGRAM						61.00
6	2. 00	FUNDRAI SI NG						62.00
6	3. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS						63.00
		PALLIATIVE CARE PROGRAM						64.00
		OTHER PHYSICIAN SERVICES						65.00
		RESI DENTI AL CARE		1	ól			66.00
		ADVERTI SI NG		1	Ί "			67.00
								68.00
		TELEHEALTH/TELEMONI TORI NG	1		()			
		THRIFT STORE			ή			69.00
		NURSING FACILITY ROOM & BOARD	_	_				70.00
		OTHER NONREI MBURSABLE (SPECIFY)	C)	0	1		71.00
		NEGATI VE COST CENTER						99. 00
		COST TO BE ALLOCATED (per Wkst. 0-6, Part I)) () 0			100.00
1	01. 00	UNIT COST MULTIPLIER	0. 000000	0. 000000	0. 000000	1		101. 00

Health Financial Systems	KINGS DAUGHTERS	HOSPI TAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF HOSPITAL-BASED HOSPICE LEVEL OF CARE	SHARED SERVICE COSTS BY	Provider CCN: 15-0069	From 01/01/2023	
		Hospi ce CCN: 15-1535		Date/Time Prepared: 5/22/2024 3:00 pm

		Hospi ce CCI	N: 15-1535 To	o 12/31/2023	Date/Time Pre 5/22/2024 3:0	
				Hospi ce I		
			Charges by L	.OC (from Provi	der Records)	
				`	Í	
Cost Center Descriptions	From Wkst. C.	Cost to	HCHC	HRHC	HI RC	
, , , , , , , , , , , , , , , , , , ,	Part I, Col.	Charge Ratio				
	9 line	J				
	0	1. 00	2. 00	3. 00	4. 00	
ANCILLARY SERVICE COST CENTERS						
1. 00 PHYSI CAL THERAPY	66.00	0. 392106	0	0	0	1.00
2. 00 OCCUPATI ONAL THERAPY	67.00		0	0	0	2.00
3. 00 SPEECH PATHOLOGY	68.00	0. 282953	_	0	·	1
4. 00 DRUGS CHARGED TO PATIENTS	73.00	0. 167290		0	0	4.00
5. 00 DURABLE MEDICAL EQUIP-RENTED	96.00	0. 107270		O	٥	5.00
6. 00 LABORATORY	60.00	0. 128587	0	0	0	1
7. 00 MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		-	0	0	
				0		
7. 01 IV SOLUTIONS	71. 01	0. 000000	0	U	0	1
8. 00 OTHER OUTPATIENT SERVICE COST CENTER	93. 00					8.00
9. 00 RADI OLOGY - THERAPEUTI C	55.00		0	0	1	
9. 01 ONCOLOGY	55. 01	0. 363817	0	0	0	
10. 00 CARDI OLOGY	76.00			0	0	
10. 97 CARDI AC REHABI LI TATI ON	76. 97	0. 214625	0	0	0	10. 97
11.00 Totals (sum of lines 1-11)						11.00
	Charges by		Shared Service	Costs by LOC		
	LOC (from					
	Provi der					
	Records)					
Cost Center Descriptions	HGI P	HCHC (col. 1	HRHC (col. 1	HIRC (col. 1	HGIP (col. 1	
		x col. 2)	x col. 3)	x col. 4)	x col. 5)	
	5. 00	6. 00	7. 00	8. 00	9. 00	
ANCILLARY SERVICE COST CENTERS						
1. 00 PHYSI CAL THERAPY	0	0	0	0	0	1.00
2. 00 OCCUPATI ONAL THERAPY	0	0	0	0	0	2.00
3. 00 SPEECH PATHOLOGY	0	0	0	0	0	3.00
4. 00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5. 00 DURABLE MEDICAL EQUIP-RENTED						5.00
6. 00 LABORATORY	0	0	0	0	0	1
7. 00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	n	0	0	0	
7. 01 IV SOLUTIONS	1 0	0	·	0	1	7. 01
8. 00 OTHER OUTPATIENT SERVICE COST CENTER				O		8.00
9. 00 RADI OLOGY - THERAPEUTI C	0	0	0	0	0	1
9. 01 ONCOLOGY		0	_	0	0	
10. 00 CARDI OLOGY		0	_	0	0	
10. 97 CARDI AC REHABI LI TATI ON		0	_	0	0	
		0		0	1	1
11.00 Totals (sum of lines 1-11)	1	0	0	0	0	11. 00

Health Financial Systems	KINGS DAUGHTERS HOSPITAL		In Lieu	of Form CMS-2552-10
CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST	Provider CCN	N: 15-0069		Worksheet 0-8
	Haari aa CCN	15 1525	From 01/01/2023	Data/Time Drangrad

Date/Time Prepared: 5/22/2024 3:00 pm Hospi ce CCN: 15-1535 12/31/2023 Hospi ce I TITLE XVIII TITLE XIX TOTAL MEDI CARE MEDI CAI D 3.00 1.00 2.00 HOSPICE CONTINUOUS HOME CARE Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, 1.00 1.00 line 11) 2 00 Total unduplicated days (Wkst. S-9, col. 4, line 10) 2 00 0 3.00 Total average cost per diem (line 1 divided by line 2) 0.00 3.00 Unduplicated program days (Wkst. S-9 col. as appropriate, line 10) 4.00 4.00 5.00 Program cost (line 3 times line 4) 0 5.00 HOSPICE ROUTINE HOME CARE 6.00 Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, 391, 876 6.00 line 11) 7.00 Total unduplicated days (Wkst. S-9, col. 4, line 11) 2, 452 7.00 8.00 Total average cost per diem (line 6 divided by line 7) 159.82 8.00 9.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 11) 2, 372 16 9.00 10.00 Program cost (line 8 times line 9) 379, 093 2, 557 10.00 HOSPICE INPATIENT RESPITE CARE Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, 9, 684 11.00 11.00 line 11) 12.00 Total unduplicated days (Wkst. S-9, col. 4, line 12) 12.00 13 Total average cost per diem (line 11 divided by line 12) 13.00 744.92 13.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 12) 14.00 13 0 14.00 15.00 Program cost (line 13 times line 14) 9,684 0 15.00 HOSPICE GENERAL INPATIENT CARE Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, 54, 550 16.00 16, 00 line 11) Total unduplicated days (Wkst. S-9, col. 4, line 13) 17.00 71 17.00 18.00 Total average cost per diem (line 16 divided by line 17) 768.31 18.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 19.00 71 0 19.00 Program cost (line 18 times line 19)
TOTAL HOSPICE CARE 20.00 54, 550 20.00 0 Total cost (sum of line 1 + line 6 + line 11 + line 16) 456, 110 21.00 22.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 2, 536 22.00 23.00 Average cost per diem (line 21 divided by line 22) 179. 85 23. 00

Hool +h	Financial Systems KINGS DAUGHTERS	LATINOON O	In Lio	u of Form CMS-2	DEE2 10		
	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0069	Peri od: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III	pared:		
		Title XVIII	Hospi tal	PPS	о рііі		
				1. 00			
	PART I - FULLY PROSPECTIVE METHOD						
	CAPITAL FEDERAL AMOUNT						
1.00	Capital DRG other than outlier			564, 631			
1. 01	Model 4 BPCI Capital DRG other than outlier			0			
2.00	Capital DRG outlier payments			72, 594			
2. 01	Model 4 BPCI Capital DRG outlier payments			0			
3.00	Total inpatient days divided by number of days in the cost r	eporting period (see ins	tructions)	27. 01	3.00		
4.00	Number of interns & residents (see instructions)			0.00			
5. 00 6. 00	Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by th	o sum of lines 1 and 1 0	1 columns 1 and	0.00			
	1.01)(see instructions)						
7. 00	Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions)	patient days (Worksheet	E, part A line	0. 00	7.00		
8.00	Percentage of Medicaid patient days to total days (see instr	ructions)		0.00	8.00		
9.00	Sum of lines 7 and 8			0.00			
10.00	Allowable disproportionate share percentage (see instruction	ns)		0.00	10.00		
11.00	Disproportionate share adjustment (see instructions)			0			
12.00	Total prospective capital payments (see instructions)			637, 225	12.00		
				1. 00			
4 00	PART II - PAYMENT UNDER REASONABLE COST						
1.00	Program inpatient routine capital cost (see instructions)			0			
2.00	Program inpatient ancillary capital cost (see instructions)			0			
3. 00 4. 00	Total inpatient program capital cost (line 1 plus line 2) Capital cost payment factor (see instructions)			0			
4. 00 5. 00	Total inpatient program capital cost (line 3 x line 4)			0			
5.00	Total impatrent program capital cost (Title 3 x Title 4)			U	3.00		
	DADT LLL COMPUTATION OF EVOEDTION DAVIENTS			1. 00			
1 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS			0	1 00		
1. 00 2. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan	uses (see i petrusti and)		0			
3. 00	Net program inpatient capital costs for extraordinary circumstant	ices (see Histi uctions)		0			
4. 00	Applicable exception percentage (see instructions)			0.00			
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0.00			
6. 00	Percentage adjustment for extraordinary circumstances (see i	nstructions)		0.00			
7. 00	Adjustment to capital minimum payment level for extraordinar	,	x line 6)	0.00			
8. 00	Capital minimum payment level (line 5 plus line 7)	y crrcumstances (rine 2	X 11116 0)	Ö			
9. 00	Current year capital payments (from Part I, line 12, as appl	i cable)		Ö			
10.00	Current year comparison of capital minimum payment level to	,	less line 9)	Ö			
11. 00	Carryover of accumulated capital minimum payment level over			0			
	Worksheet L, Part III, line 14)	, h. 2 (2 b.	<i>y</i>				
12.00	Net comparison of capital minimum payment level to capital p	payments (line 10 plus li	ne 11)	0	12.00		
13.00	Current year exception payment (if line 12 is positive, ente			0	1		
14.00	Carryover of accumulated capital minimum payment level over			0	14.00		
	(if line 12 is negative, enter the amount on this line)	· · ·	٠.				
15.00	Current year allowable operating and capital payment (see in	structions)		0	15.00		
	Current year operating and capital costs (see instructions)			0			
17. 00	Current year exception offset amount (see instructions)			0	17.00		