Health Financial Systems BAPTIST	T HEALTH FLO	′D	In Lieu	ı of Form CMS-2552	2-10
This report is required by law (42 USC 1395g; 42 CFR 413.20(payments made since the beginning of the cost reporting period				FORM APPROVED OMB NO. 0938-005 EXPI RES 03-31-20	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFIAND SETTLEMENT SUMMARY	ICATION Prov	ider CCN: 15-0044	Period: From 09/01/2018 To 08/31/2019	Worksheet S Parts I-III Date/Time Prepar 9/21/2022 9:45 a	
PART I – COST REPORT STATUS	· · · ·				
Provider 1. [X] Electronically prepared cost report use only 2. [] Manually prepared cost report			Date:	Time:	
3.[1]If this is an amended report enter the 4.[F]Medicare Utilization. Enter "F" for fu	number of ti or "L" fo	mes the provider r rlow.	esubmitted this c	cost report	
Contractor use only5. [5]Cost Report Status (1) As Submitted6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N]Initial Report (3) Settled with Audit(3) Settled with Audit (4) Reopened (5) Amended9. [N]Final Report 9. [N]Final Report	eport for thi ort for this	s Provider CCN12. [ontractor's Vendo 0]If line 5, co	or Code: Lumn 1 is 4: Ente Wes reopened = 0-9	
PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMIN MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAIN ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECT ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.	NED IN THIS (L LAW. FURTH TLY OF A KICK	COST REPORT MAY BE I HERMORE, IF SERVICES BACK OR WERE OTHERN	S IDENTIFIED IN T	HIS REPORT WERE	
CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINIST	RATOR OF PROV	/IDER(S)			
I HEREBY CERTIFY that I have read the above certific: electronically filed or manually submitted cost repor Statement of Revenue and Expenses prepared by BAPTIS beginning 09/01/2018 and ending 08/31/2019 and to the are true, correct, complete and prepared from the boo applicable instructions, except as noted. I further regarding the provision of health care services, and provided in compliance with such laws and regulations	rt and submi T HEALTH FLO e best of my oks and reco certify that that the set s.	tted cost report an /D (15-0044) for knowledge and beli- rds of the provider I am familiar with	d the Balance She the cost reportin ef, this report a in accordance wi the laws and reg n this cost repor	eet and ng period nd statement th uulations	
SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		ELECTRONI C		
1	2	SIGN	ATURE STATEMENT		
1	l s	have read and agre tatement. I certify			1

	statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	
2 Signatory Printed Name		2
3 Signatory Title		3
4 Date		4

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-9, 264	-5, 166	C	1, 851, 716	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVI DER I						4.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	1		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	-9, 264	-5, 165	C	1, 851, 716	200.00

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

^{9/21/2022 9:45} am F:\Final Settlement\150044 08312019\150044.08312019.A1.mcax

SPI	TAL AND HOSPITAL HEALTH CARE COMPLEX		Provi d		15-0044	Period: From 09/01/ To 08/31/	2019	Part I Date/Ti 9/21/20		epare
	1.00	2.00		3.00		4	1.00			
00	Hospital and Hospital Health Care Co Street: 1850 STATE STREET	PO Box:								1.
00	City: NEW ALBANY	State: IN	Zip Cod	e [.] 47150	-4990 Coun	tv FLOYD				2.
00		Component Name	CCN	CBSA	Provi der		Pavme	nt Syst	tem (P.	
			Number	Number		Certified		0, or		
							V	XVIII	XIX	1
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Componer		-							
00	Hospi tal	BAPTIST HEALTH FLOYD	150044	31140	1	07/01/1966	N	P	0	3.
00	Subprovider - IPF									4.
00	Subprovider - IRF									5.
)0)0	Subprovider - (Other) Swing Beds - SNF									6.
0	5									8.
0	Swing Beds – NF Hospital-Based SNF									9
00	Hospital - Based NF									10.
00	Hospital -Based OLTC									111
00		BAPTIST HEALTH HOME	157152	31140		07/01/1985	Ν	P	N	12
		CARE FLOYD								
00	Separately Certified ASC									13.
00										14.
	Hospital-Based Health Clinic - RHC									15
00										16
00										17
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	Renal Dialysis Other									19
00	other		1			From:		Tc).	17
						1.00		2.0		1
00	Cost Reporting Period (mm/dd/yyyy)								10010	
00	COST Reporting Period (IIIII/dd/yyyy)					09/01/20	018	08/31	/2019	20
	Type of Control (see instructions)					09/01/20	018		/2019	
						2	018	08/31		
	Type of Control (see instructions)				1.00		018			
00	Type of Control (see instructions)	currently receiving na	wments fo	r		2	018	08/31		21.
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00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju	istment, in accordance w	ith 42 CF			2	018	08/31		21.
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00 00 01 02 03	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fof facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fof Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re- Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of the October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reporting neorting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reporting number of the cost reporting period occurring on or aft Does this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reporting period occurring on or aft Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reporting bost in shospital contain at least to be this hospital contain or a least Does this hospital contain or a least Does this hospital contain or a least Does this hospital contain at least	istment, in accordance w or yes or "N" for no. Is 5412.106(c)(2)(Pickle an or yes or "N" for no. iccompensated care paymer mm 1, "Y" for yes or "N eriod occurring prior to "for no for the portic crequires final uncompe port settlement? (see i "for no, for the porti- per 1. Enter in column 2 the cost reporting period nic reclassification fro ds for delineating stat column 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in column delineations for stati column 1, "Y" for yes of g period prior to Octob no for the portion of t column 1, "Y" for yes of delineations for stati column 1, "Y" for yes of the portion of t column 1, "Y" for yes of the portion of t column 1, "Y" for yes of the portion of t the portion of t	if th 42 CF this hendment ts for th o October on of the orructions) on of the orructions) on of the on on on of on on on of on	R is for 1. cost re ns) yes ter o reas no er as or o eas no er as	Y Y N	2 2.00 N Y N	018	08/31.	00	21. 22. 22. 22. 22. 22.
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00 00 01 02 03 04	Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fc facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fc Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me below? In column 1, enter 1 if date	istment, in accordance w or yes or "N" for no. Is 5412.106(c)(2)(Pickle an or yes or "N" for no. iccompensated care paymer mm 1, "Y" for yes or "N eriod occurring prior to "for no for the portion ere October 1. (see inst erequires final uncompe- port settlement? (see it" for no, for the portion per 1. Enter in column 2 ne cost reporting period ic reclassification fro ds for delineating stat column 1, "Y" for yes or ng period prior to Octob no for the portion of t ere October 1. (see inst column 1, "Y" for yes or ng period prior to Octob no for the portion of t cer October 1. (see inst 100 but not more than 4 2.105)? Enter in column ic reclassification fro 8 delineations for stati column 1, "Y" for yes co g period prior to Octob no for the portion of t ter October 1. (see inst 100 but not more than 4 2.105)? Enter in column adicaid days on lines 24 of admission, 2 if cens	if th 42 CF this hendment ts for th o October on of the oructions) ensated ca nstruction on of the t, "Y" for l on or af m urban to istical an "N" for ler 1. Entr he cost "Y" for a, "Y" for a, "Y" for or 1. Entr he cost "ructions) 99 beds (a, "Y" for l on or af m urban to stical any or "N" for er 1. Entr he cost ructions) 99 beds (a, "Y" for l on or af and/or 2 sus days, "	R is for 1. cost re ns) yes ter o reas no er as or er as or er as for 5 or 3	Y Y N	2.00 N Y N N	018	08/31.	00	20. 21. 22. 22. 22. 22. 22. 22. 22. 22. 22
00 00 01 02 03 04	Inpati ent PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fc facility subject to 42 CFR Section S hospital?) In column 2, enter "Y" fc Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aft boes this hospital receive a geograph rural as a result of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aft boes this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aft boes this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me	istment, in accordance w by yes or "N" for no. Is 5412.106(c)(2)(Pickle and or yes or "N" for no. iccompensated care paymer mm 1, "Y" for yes or "N eriod occurring prior to "for no for the portic crequires final uncompe- port settlement? (see i "for no, for the porti- per 1. Enter in column 2 ne cost reporting period nic reclassification fro ds for delineating stat tolumn 1, "Y" for yes or ng period prior to Octob no for the portion of t ter October 1. (see inst 2.105)? Enter in column delineations for stati column 1, "Y" for yes or g period prior to Octob no for the portion of t ter October 1. (see inst 100 but not more than 4 2.105)? Enter in column ic reclassification fro d g period prior to Octob no for the portion of t ter October 1. (see inst 100 but not more than 4 2.105)? Enter in column dicaid days on lines 24 of admission, 2 if cens of identifying the days	if th 42 CF this hendment ts for th for no o October on of the rructions) ensated ca nstructio on of the truction on of the truction on of the truction on of the truction on of the tructions (1) 10 on or af murban tr stical ar ructions) 99 beds (1) a, "Y" for murban tr stical ar- tructions) 99 beds (2) (1) and/or 2 us days, 1) (1) (1) (1) (1) (1) (1) (1) (R is for 1. cost re ns) yes ter o reas no er as or er as or er as for 5 or 3	Y Y N	2.00 N Y N N	018	08/31.	00	21 22 22 22 22 22 22 22 22

	ST HEALTH		N 45 0044		In Lieu			2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider CC	N: 15-0044	Period: From 09/0 To 08/3		Workshe Part I Date/Ti 9/21/20	ime Pre	epared:
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO day	ys Med	ther di cai d days	
24.00 If this provider is an IPPS hospital, enter the	1.00 1,086	2.00	3.00	4.00	5.00	482	5.00 110	24.00
 24.00 FT this provider is an FPPs hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 4. 	0	0			ς, ·	0		25. 00
				Urban/R	ural S	Date of	Geogr	
24.00 Enton your standard assarship -1: firsting (200) 0+-+-	ot the b	al pping -f	1. (00	2.	00	24.00
 26.00 Enter your standard geographic classification (not w. cost reporting period. Enter "1" for urban or "2" fo 27.00 Enter your standard geographic classification (not w. reporting period. Enter in column 1, "1" for urban o 	r rural. age) status	at the en	d of the co		1			26.00 27.00
as a sole community hospital (SCH), enter the effect in the cost reporting period.	ication in	column 2.		n	0			35.00
, strong the cost reporting period.				Begi nr		Endi		
36.00 Enter applicable beginning and ending dates of SCH s	tatus. Subs	cript line	36 for num	1. (Iber	0	2.	00	36.00
of periods in excess of one and enter subsequent date 37.00 If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	es.				0			37.00
 37.01 Is this hospital a former MDH that is eligible for thaccordance with FY 2016 OPPS final rule? Enter "Y" finstructions) 								37.01
 38.00 If line 37 is 1, enter the beginning and ending date: greater than 1, subscript this line for the number o enter subsequent dates. 								38.00
				Y/		Y/		
 39.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction), (İi), or the mileage ii)? Enter n adjustmen	(iii)? En requireme in column t? Enter "	ter in colu nts in 2 "Y" for y Y" for yes	imn ves or N		2. (N		39.00 40.00
"N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1			yes or "N"	for	V	XVIII	XIX	
					1.00		3.00	
45.00 Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions)	nt for disp	roporti ona	te share in	accordance	e N	Y	N	45.00
46.00 Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.					N	N	N	46.00
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS 48.00 Is the facility electing full federal capital paymen Teaching Hospitals			5		N N	N N	N N	47.00 48.00
56.00 Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the respons- was involved in training residents in approved GME p year, and are you are impacted by CR 11642 (or appli- Enter "Y" for yes; otherwise, enter "N" for no in co	e to column rograms in cable CRs)	1 is "Y", the prior	or if this year or pen	hospital Nultimate				56.00
57.00 If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I	period duri r yes or "N th of this Y", complet I, if appli	" for no i cost repor e Workshee cable.	n column 1. ting period t E-4. lf c	lf column I? Enter "Y column 2 is				57.00
58.00 If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes,			ans' servic	es as				58.00
59.00 Are costs claimed on line 100 of Worksheet A? If yes			, Pt. I.		N			59.00

Health Financial Systems BAPTI	ST HEA	LTH FLOYD		In Lieu	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ΑΤΑ	Provider CC		eriod: rom 09/01/2018 o 08/31/2019	Worksheet S-2 Part I Date/Time Pre 9/21/2022 9:4	pared:
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1.00	2.00	3.00	
60.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent 0 adjustement? Enter "Y" for yes or "N" for no in colu 60.01 If line 60 is yes, complete columns 2 and 3 for each	.85? (Lumn 1. CR) NAH umn 2.	see If column 1 E MA payment	Y	Y 23. 00	1	60.00
instructions)	Y/N	IME	Direct GME	IME	Direct GME	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	1.00 N	2.00	3.00	4.00	5.00 0.00	61.00
 61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
 61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 						61.03
 61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
61.10 Of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	4.00	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 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Se 62.00 Enter the number of FTE residents that your hospital				iod for which		62.00
your hospital received HRSA PCRE funding (see instruct 62.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	a Teach	ing Health Cen	• •	your hospital	0.00	62. 01
Teaching Hospitals that Claim Residents in Nonprovide 63.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this c			N	63.00

ealth Financial Systems IOSPITAL AND HOSPITAL HEALTH CARE COMPI		IST HEALTH FLOYD ATA Provider CO	CN: 15-0044 Pe	eriod:	u of Form CMS-2 Worksheet S-2	
				om 09/01/2018	Part I	pared:
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	··· FTF Desidents in N		1.00	2.00	3.00	
Section 5504 of the ACA Base Yea period that begins on or after J			-inis base year	is your cost	reporting	
4.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	yes, or your facili ber of unweighted no tations occurring in number of unweighte ur hospital. Enter i	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0. 00	0. 000000	64. OC
	Program Name	Program Code	Unweighted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 +	
			Nonprovi der	Hospi tal	col. 4))	
-	1.00	2.00	Si te 3.00	4.00	5.00	
55.00 Enter in column 1, if line 63 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)	1.00		Unweighted FTEs			65.00
			Nonprovider Site	Hospi tal	col. 2))	
Section 5504 of the ACA Current	Vear FTF Pesidente i	n Nonnrovider Sotting	1.00	2.00	<u>3.00</u>	
beginning on or after July 1, 20		n nonprovider Setting	gsEffective f			
66.00 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all nonp unweighted non-prima al. Enter in column	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
7.00 Enter in column 1, the program	1.00	2.00	3.00	4.00	5.00 0.000000	67.00
7.00 Enter In column 1, the program 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)				0.00		

Heal th	Financial Systems BAPTIST HEALTH FLOYD		In Lieu	of Form	n CMS-2	2552-10
HOSPI 1	TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-004			Workshe	et S-2	
		From 09/0 To 08/3		Part I Date/Ti	me Pre	pared:
				9/21/20	22 9:4	5 am
			1 00	2.00	3 00	
	Inpatient Psychiatric Facility PPS			12:00	0.00	
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an If	PF subprovi dei	~? N			70.00
71 00	Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching progra	m in the mos	.		0	71.00
/1.00	recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N'	for no. (see			0	/ 1. 00
	42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new					
	program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" Column 3: If column 2 is Y, indicate which program year began during this cost rep					
	(see instructions)	bi thig period				
	Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an	n IRF	N			75.00
76 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 progra	m in the mos	-		0	76.00
70.00	recent cost reporting period ending on or before November 15, 2004? Enter "Y" for				0	70.00
	no. Column 2: Did this facility train residents in a new teaching program in accor	dance with 42				
	CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 indicate which program year began during this cost reporting period. (see instruct	2 is Y,				
	Indicate which program year began during this cost reporting period. (see instruct	.10115)				
				1.0	0	
	Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. Is this a LTCH co-located within another hospital for part or all of the cost repo	nting poriod	Entor	N N		80.00 81.00
81.00	"Y" for yes and "N" for no.	n tring period	LIILEI	IN IN		81.00
	TEFRA Providers					
	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for	5	for no.	N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR	section				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under sec	ction		N		87.00
-	1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.					
		1.		XI > 2. 0		
	Title V and XIX Services		50	2.0	0	
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y"	for N		Y		90.00
01 00	yes or "N" for no in the applicable column.	in		Y		91.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either full or in part? Enter "Y" for yes or "N" for no in the applicable column.			Ŷ		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (se	e		Ν		92.00
~~ ~~	instructions) Enter "Y" for yes or "N" for no in the applicable column.					
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Er "Y" for yes or "N" for no in the applicable column.	nter M		N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	1	1	N		94.00
	applicable column.					
	If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the	0.		0. 0 N	0	95.00 96.00
90.00	applicable column.			IN		90.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.	00	0.0	0	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents po		,	Y		98.00
	stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no i column 1 for title V, and in column 2 for title XIX.	n				
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on	Wkst.	,	Y		98.01
	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2	2 for				
98 02	title XIX. Does title V or XIX follow Medicare (title XVIII) for the calculation of observati	on	,	Y		98.02
70.02	bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column					70.02
	for title V, and in column 2 for title XIX.					
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in col			N		98.03
	for title V, and in column 2 for title XIX.					
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of	1	I [Ν		98.04
	outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V,	and				
98 05	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowand	ce on N	,	Y		98.05
,0,00	Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, a					,0,00
	column 2 for title XIX.					
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. [Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in		, 	Y		98.06
	column 2 for title XIX.	1				
	Rural Providers					
	Does this hospital qualify as a CAH?	N mont				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of pa for outpatient services? (see instructions)	iyment N	·			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I		ı			107.00
	training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions	5)				
	Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)?					
	Enter "Y" for yes or "N" for no in column 2. (see instructions)					

Health Financial Systems BAPTIST HEAL	TH FLOYD		In Lieu	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	F	Period: From 09/01/2018 Fo 08/31/2019	Worksheet S-2 Part I Date/Time Pre 9/21/2022 9:4	epared:
			V 1.00	XI X 2.00	-
108.00 Is this a rural hospital qualifying for an exception to the	CRNA fee sche	edul e? See 42	N	2.00	108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati onal	Speech	Respi ratory	
	1.00	2.00	3.00	4.00	100.00
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00
	al Domonstrati	on project (S	1104	1.00 N	110.00
Demonstration) for the current cost reporting period? Enter ' complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	"Y" for yes or	"N" for no.	f yes,	N	110.00
			1.00	2.00	-
111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this constrained integration prong of the FCHIP demo in which this CAH is participated in the the the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of the term of term of the term of term	ost reporting olumn 1 is Y, rticipating ir	period? Enter enter the column 2.	N		111.00
		1.00	2.00	3.00	-
112.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital cear participation in the demonstration, if applicable.	period? s "Y", enter ne	N	2.00	3.00	112.00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or	r "N" for no	N		(0115.00
<pre>in column 1. If column 1 is yes, enter the method used (A, E in column 2. If column 2 is "E", enter in column 3 either "G for short term hospital or "98" percent for long term care of psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1. 116.00[s this facility classified as a referral center? Enter "Y"</pre>	93" percent (includes rs) based on	N			116.00
"N" for no.	5				
 117.00 Is this facility legally-required to carry malpractice insur "Y" for yes or "N" for no. 118.00 Is the malpractice insurance a claims-made or occurrence pol 		Y	1		117.00 118.00
if the policy is claim-made. Enter 2 if the policy is occurr	rence.	Premiums	Losses	Insurance	
			LUSSES	Thsu ance	
110 01 List success of released as successing and sold larger		1.00	2.00	3.00	1110 01
118.01 List amounts of malpractice premiums and paid losses:			0 98, 797	800, 122	4118.01
118.02 Are malpractice premiums and paid losses reported in a cost	center other	than the	1.00 N	2.00	118.02
Administrative and General? If yes, submit supporting scheo and amounts contained therein.					
119. 00 D0 NOT USE THIS LINE 120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no.	n column 1, "N ualifies for t	(" for yes or the Outpatient	Ν	Ν	119.00 120.00
121.00 Did this facility incur and report costs for high cost impla	antable device	es charged to	Y		121.00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included.			Ν		122.00
Transplant Center Information					
125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	or yes and "N"	tor no. If	N		125.00
126.00 If this is a Medicare certified kidney transplant center, er in column 1 and termination date, if applicable, in column 2		fication date			126.00
127.00 If this is a Medicare certified heart transplant center, en	ter the certif	ication date			127.00
in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, ent		fication date			128.00
in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.	2.				129.00

iter the cer in 2. enter the certifi opo number fined in CMS is, and home isee instruction for number.	ertificatio ication dat in column 1 Pub. 15-1, office cos tions)	To 08			
n 2. enter the ca n 2. the certif OPO number fined in CMS es, and home (see instruct nes 141 thro or number.	ertificatio ication dat in column 1 Pub. 15-1, office cos tions) ugh 143 the Contrac	n e ts e name an :tor's Nu	Y 3.00 d address		131. (132. (133. (134. (
n 2. enter the ca n 2. the certif OPO number fined in CMS es, and home (see instruct nes 141 thro or number.	ertificatio ication dat in column 1 Pub. 15-1, office cos tions) ugh 143 the Contrac	n e ts e name an :tor's Nu	Y 3.00 d address		131. 132. 133. 134.
enter the com 2. The certif OPO number ined in CMS es, and home isee instruct mes 141 thro or number.	ication dat in column 1 Pub. 15-1, office cos tions) pugh 143 the Contrac	e ts e name an :tor's Nu	3.00 d address	s of the home	132. 133. 134.
The certif OPO number Fined in CMS rs, and home (see instruction nes 141 thro or number.	in column 1 Pub. 15-1, office cos tions) Jugh 143 the Contrac	ts e name an :tor's Nu	3.00 d address	s of the home	133. 134.
fined in CMS es, and home (see instruc) hes 141 thro pr number.	Pub. 15-1, office cos tions) ugh 143 the Contrac	ts e name an tor's Nu	3.00 d address	s of the home	134.
es, and home (see instruc) nes 141 thro pr number.	office cos tions) bugh 143 the Contrac	e name an tor's Nu	3.00 d address	s of the home	140.
<u>see instruc</u> nes 141 thro or number.	tions) bugh 143 the Contrac	e name an tor's Nu	d address	s of the home	
or number.	Contrac	tor's Nu:	d address	s of the home	1
			mber: 1510		
)1	141.
	ZIP COC		4022		142.
		le:	4022	23	143.
				1.00	
				Y	144.
			1.00	2.00	1.45
or this cost	column 1 is reporting		Y	Y	145.
		lf	N		146
				1.00	
				N	147.
		or no.		N	140.
Part A	Part B			Title XIX	_
kemption fro	m the appli	cation o	f the low	ver of costs	
N	N		Ν	N	155.
N	N		N	N	156.
IN .	. IN		IN	IN IN	157.
N	N		Ν	Ν	159.
N					160.
	N		N	N	161.
				1.00	-
or more camp	uses in dif	ferent Cl	BSAs?	N	165.
•					
County 1 00			CBSA 4 00	FTE/Campus	-
1.00	2.00	3.00	4.00		0166.
					_
Recovery an	d Reinvestn	ent Act		1.00	-
for yes or	"N" for no.			Y	167.
ıl user (lin	e 167 is "Y				168.
or no. (see i	instruction	s)	•		168.
	Iumn 1. If r this cost y filed cos 2, chapter or "N" for es or "N" f r "Y" for y Part A 1.00 emption frc for Part A N N N N N N N N N N N N N N N N N N N	Lumn 1. If column 1 is r this cost reporting y filed cost report? 2, chapter 40, §4020) or "N" for no. es or "N" for no. r "Y" for yes or "N" f Part A Part B 1.00 2.00 emption from the appli for Part A and Part E N	Lumn 1. If column 1 is r this cost reporting y filed cost report? 2, chapter 40, §4020) If or "N" for no. es or "N" for no. r "Y" for yes or "N" for no. Part A Part B 1.00 2.00 emption from the application o for Part A and Part B. (See 4 N N N	Lumn 1. If column 1 is r this cost reporting y filed cost report? N y filed cost report? N 2, chapter 40, §4020) If N or "N" for no. es or "N" for no. r "Y" for yes or "N" for no. N Part A Part B Title V 1.00 2.00 3.00 emption from the application of the low for Part A and Part B. (See 42 CFR §4' N N	Lumn 1. If column 1 is r this cost reporting y filed cost report? N y filed cost report? N 2, chapter 40, §4020) If N x 1.00 or "N" for no. N es or "N" for no. N Part A Part B Title V Title XIX 1.00 2.00 and Part B Title V Title XIX 1.00 comption from the application of the lower of costs for Part A and Part B. (See 42 CFR §413.13) N N N

^{9/21/2022 9:45} am F: \Final Settlement\150044 08312019\150044.08312019. A1. mcax

Health Financial Systems B	APTIST HEALTH	FLOYD	In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATIO	N DATA		Period: From 09/01/2018		-
			To 08/31/2019	Date/Time Pr 9/21/2022 9:	
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date a period respectively (mm/dd/yyyy)	and ending dat	e for the reporting			170.00
			1.00	2.00	
171.00 If line 167 is "Y", does this provider have any c section 1876 Medicare cost plans reported on Wkst "Y" for yes and "N" for no in column 1. If column 1876 Medicare days in column 2. (see instructions	t. S-3, Pt. I, n 1 is yes, en	line 2, col. 6? Enter	n N		0171.00

^{9/21/2022 9:45} am F: \Final Settlement\150044 08312019\150044.08312019.A1.mcax

IOSPI TA	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	_TH FLOYD Provider C	CN: 15-0044	Period: From 09/01/2018	u of Form CMS Worksheet S- Part II	
				To 08/31/2019		
				Y/N	Date	
6				1.00	2.00	-
n	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	TOT ALL NU T	esponses. En	ter all dates in	the	-
	Provider Organization and Operation					-
. 00	Has the provider changed ownership immediately prior to the			N		1.0
	reporting period? If yes, enter the date of the change in c	olumn 2. (see		· · ·		_
			Y/N 1.00	Date 2.00	V/I 3.00	
. 00	Has the provider terminated participation in the Medicare F	Program? If	N 1.00	2.00	5.00	2.0
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary. Is the provider involved in business transactions, includir	n 3, "V" for	N			3. (
-	contracts, with individuals or entities (e.g., chain home c or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members c of directors through ownership, control, or family and othe relationships? (see instructions)	offices, drug ler or its of the board				0.1
			Y/N	Туре	Date	
			1.00	2.00	3.00	
. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava	for Compiled,	Y	A		4. (
. 00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5.
				Y/N	Legal Oper.	
17				1.00	2.00	_
. 00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column is the legal operator of the program?	2: If yes, i	s the provide	er N		6.
. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		wed during th	ne N		7. 8.
	Are costs claimed for Interns and Residents in an approved	graduate medi	cal education	n N		9.
0.00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated c		the current	Ν		10.
1.00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an Ap	proved	Ν		11.
					Y/N	_
F	Bad Debts				1.00	
2.00 3.00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.	s, see instruc policy change	tions. during this o	cost reporting	Y N	12. 13.
4.00	lf line 12 is yes, were patient deductibles and/or co-payme 3ed Complement	ents waived? I	fyes, see in	nstructions.	Ν	14.
-	Did total beds available change from the prior cost reporti		yes, see ins t A	structions. Par	N t B	15.
		Y/N	Date	Y/N	Date	
i.	PS&R Data	1.00	2.00	3.00	4.00	
5.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see	N		N		16.
7.00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	Y	01/04/2017	Y	01/04/2017	17.
3. 00	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	Ν		Ν		18.
	but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19.
	Report data for corrections of other PS&R Report					

SPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN	: 15-0044	Period: From 09/01/2018	Worksheet S Part II	S-2		
			To 08/31/2019				
	Descri p	tion	Y/N	Y/N	7.45 alli		
	0		1.00	3.00			
0.00 If line 16 or 17 is yes, were adjustments made to PS&R			N	Ν	20.0		
Report data for Other? Describe the other adjustments:	Y/N	Date	Y/N	Date			
	1.00	2.00	3.00	4.00			
.00 Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. (
	<u> </u>			1 00			
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS HO	SPI TALS)		1.00	_		
Capital Related Cost							
.00 Have assets been relifed for Medicare purposes? If yes, see	e instructions				22. (
Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to appraisa	ls made du	iring the cost		23.		
.00 Were new leases and/or amendments to existing leases entere If yes, see instructions	ed into during t	his cost r	reporting period?		24.		
.00 Have there been new capitalized leases entered into during instructions.	the cost report	ing period	l? If yes, see		25.		
 00 Were assets subject to Sec. 2314 of DEFRA acquired during the instructions. 	he cost reportin	g period?	lf yes, see		26.		
.00 Has the provider's capitalization policy changed during the	e cost reporting	period? I	fyes, submit		27.		
copy. Interest Expense							
8.00 Were new loans, mortgage agreements or letters of credit er period? If yes, see instructions.							
Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instr		t Service	Reserve Fund)		29.		
0.00 Has existing debt been replaced prior to its scheduled mature instructions.		ebt? If ye	es, see		30.		
.00 Has debt been recalled before scheduled maturity without is instructions.	ssuance of new d	ebt? If ye	es, see		31.		
Purchased Services 2.00 Have changes or new agreements occurred in patient care ser	rvi ces furni shed	through c	contractual		32.		
arrangements with suppliers of services? If yes, see instru- 1.00 If line 32 is yes, were the requirements of Sec. 2135.2 app	uctions.	-			33.		
no, see instructions. Provider-Based Physicians							
.00 Are services furnished at the provider facility under an ar If yes, see instructions.	rrangement with	provi der-b	based physicians?		34.		
6.00 If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in	isting agreement	s with the	e provider-based		35.		
physicians daring the cost reporting period: in yes, see in			Y/N	Date			
Home Office Costs			1.00	2.00			
0.00 Were home office costs claimed on the cost report?					36.		
1.00 If line 36 is yes, has a home office cost statement been pr If yes, see instructions.	repared by the h	ome office	?		37.		
2.00 <code>If</code> <code>line</code> 36 is yes , was the fiscal year end of the home off			of		38.		
 the provider? If yes, enter in column 2 the fiscal year end 00 If line 36 is yes, did the provider render services to other see instructions. 			9S,		39.		
0.00 If line 36 is yes, did the provider render services to the instructions.	home office? I	fyes, see	2		40.		
Cost Papart Preparar Contact Information	1.00)	2.	00			
Cost Report Preparer Contact Information .00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	SUSAN		FINK		41.		
					10		
respectively. 2.00 Enter the employer/company name of the cost report	BAPTI ST HEALTHC	ARE SYSTEM	,		42.		
2.00 Enter the employer/company name of the cost report preparer.	BAPTIST HEALTHC INC. 502-253-6162	ARE SYSTEM	, SUSAN. FI NK1@BH	SL.COM	42.		

Health Financial Systems BAPTIST HE	ALTH FLOYD	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CCN: 15-0044	Period: From 09/01/2018 To 08/31/2019		pared:
			, ,, _ ,, _ ,, _ ,, _ ,, _ ,, _ ,, _ ,	
	3.00			
Cost Report Preparer Contact Information				
41.00 Enter the first name, last name and the title/position	REIMBURSEMENT MANAGER			41.00
held by the cost report preparer in columns 1, 2, and 3,	ACCOUNTI NG			
respecti vel y.				
42.00 Enter the employer/company name of the cost report				42.00
preparer.				
43.00 Enter the telephone number and email address of the cost				43.00
report preparer in columns 1 and 2, respectively.				

		ST HEALTH FLOYD				Non-CMS HFS Wo	rksheet
HFS Su	upplemental Information	Provi c	ler CCN: 15-0044			9/21/2022 9:4	epared:
					Title V	Title XIX	
					1.00	2.00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE						
1.00	Do Title V or XIX follow Medicare (Title XVIII) for stepdown adjustments on W/S B, Part I, column 25? En and Y/N in column 2 for Title XIX. (see S-2, Part I,	ter Y/N in colum			Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for Part I (e.g. net of Physician's component)? Enter Y/ in column 2 for Title XIX. (see S-2, Part I, line 98	the reporting of N in column 1 fo			Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for Cost on W/S D-1, Part IV, line 89? Enter Y/N in colu 2 for Title XIX. (see S-2, Part I, line 98.02)	the cal cul ati on			Y	Y	3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?				N	Ν	3.01
3.02	Does Title XIX transfer managed care (HMO) days from sum of lines 2, 3, and 4 to Worksheet E-4, column 2,		Part I, column 7,			Υ	3. 02
					Inpati ent	Outpati ent	
					1.00	2.00	
	CRITICAL ACCESS HOSPITALS						
4.00	Does Title V follow Medicare (Title XVIII) for Critic reimbursed 101% of cost? Enter Y or N in column 1 fo for outpatient. (see S-2, Part I, lines 98.03 and 98	r inpatient and			N	Ν	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Cri reimbursed 101% of cost? Enter Y or N in column 1 fo for outpatient. (see S-2, Part I, lines 98.03 and 98	tical Access Hos r inpatient and			N	Ν	5.00
					Title V	Title XIX	
				Г	1.00	2.00	
	RCE DI SALLOWANCE						
6.00	Do Title V or XIX follow Medicare and add back the Recolumn 4? Enter Y/N in column 1 for Title V and Y/N S-2, Part I, line 98.05)				Y	Y	6.00
7.00	PASS THROUGH COST Do Title V or XIX follow Medicare when cost reimburst worksheets D, parts I through IV? Enter Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.06)			n	Y	Y	7.00
	RHC						
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16 Title V and Y/N in column 2 for Title XIX.	.04)? Enter Y/N	in column 1 for		N	N	8.00
0.00	FOHC	oonioo for Tit	a V and (an Title		N	N	0.00
9.00	For fiscal year beginning on/after 10/01/2014, use M XIX? Enter Y/N in column 1 for Title V and Y/N in co				N	Ν	9.00

10SPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C		Period: From 09/01/2018 To 08/31/2019		pared:
	0-month	Wardenat A		Dad Davis		I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30. 00	209	77,74	.5 0.00	0	1.00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider						2.00
1.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	
5.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		209	77,74	.5 0.00	0	7.00
3. 00	INTENSIVE CARE UNIT	31.00	16	5, 84	0.00	0	8.00
9.00	CORONARY CARE UNIT	32.00	0		0 0.00	0	9.0
0.00	BURN INTENSIVE CARE UNIT	33.00	0		0 0.00	0	10.0
1.00	SURGI CAL INTENSI VE CARE UNI T	34.00	0		0 0.00	0	
2.00	OTHER SPECIAL CARE (SPECIFY)						12.0
3.00	NURSERY	43.00				0	
4.00	Total (see instructions)		225	83, 58	0.00	-	
5.00	CAH visits	40.00	0		~	0	
6.00	SUBPROVIDER - IPF	40.00	0		0	0	
7.00 8.00	SUBPROVI DER – I RF SUBPROVI DER	41.00 42.00	0		0	0	
9.00	SKILLED NURSING FACILITY	42.00	0		0	0	
0.00	NURSING FACILITY	45.00	0		0	0	
1.00	OTHER LONG TERM CARE	46.00	0		0		21.0
2.00	HOME HEALTH AGENCY	101.00	0		0	0	
3.00	AMBULATORY SURGICAL CENTER (D. P.)	115.00					23.0
4.00	HOSPI CE	116.00	0		0		24.0
4.10	HOSPICE (non-distinct part)	30.00					24.1
5.00	CMHC - CMHC	99.00				0	25.0
5.10	CMHC - CORF	99.10				0	25.1
6.00	RURAL HEALTH CLINIC	88.00				0	26.0
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	
7.00	Total (sum of lines 14-26)		225				27.0
8.00	Observation Bed Days					0	
9.00	Ambul ance Trips						29.0
0.00	Employee discount days (see instruction)						30.0
1.00	Employee discount days - IRF		~		0		31.0
2.00	Labor & delivery days (see instructions) Total ancillary labor & delivery room		0		0		32.0
32. 01	outpatient days (see instructions)						32.0
33.00	LTCH non-covered days						33.0
13 01	LTCH site neutral days and discharges						33.

10SPI ⁻	FAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CO		eriod: rom 09/01/2018 o 08/31/2019		pared
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	-	6.00	7.00	Patients 8.00	& Residents 9.00	Payrol I 10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	21, 765	683	45, 689		10.00	1.0
	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	7, 421	6, 357				2.0
3.00	HMO I PF Subprovi der	7,421	0, 337				3.0
1. 00	HMO I RF Subprovi der	o	0				4.0
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.0
5.00	Hospital Adults & Peds. Swing Bed NF	Ű	0	0			6.0
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	21, 765	683	45, 689			7.0
. 00	INTENSIVE CARE UNIT	3, 841	286	5, 122			8.
. 00	CORONARY CARE UNI T	0	0	0			9.
0. 00	BURN INTENSIVE CARE UNIT	o	0	0			10.
1.00	SURGICAL INTENSIVE CARE UNIT	0	0	0			11.
2.00	OTHER SPECIAL CARE (SPECIFY)						12.
3.00	NURSERY		117	2, 428			13.
4.00	Total (see instructions)	25, 606	1, 086	53, 239	0.00	1, 559. 69	
5.00	CAH visits	0	0	0			15.
6.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	
7.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	
8.00	SUBPROVIDER		0	0	0.00	0.00	
9.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	
0.00	NURSING FACILITY		0	0	0.00	0.00	
1.00	OTHER LONG TERM CARE	01 000	0	0	0.00	0.00	
2.00	HOME HEALTH AGENCY	21, 930	0	32, 625	0.00	41.51	
3.00	AMBULATORY SURGICAL CENTER (D. P.)		0		0.00	0.00	
4.00		0	0	0	0.00	0.00	
4.10	HOSPICE (non-distinct part)	0	0	415	0.00	0.00	24.
5.00 5.10	CMHC - CMHC CMHC - CORF	0	0	0	0.00 0.00	0.00 0.00	
6.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	
6.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	
7.00	Total (sum of lines 14-26)	0	0	0	0.00	1, 601. 20	
8.00	Observation Bed Days		0	13, 523	0.00	1,001.20	27.
9.00	Ambulance Trips	0	0	15, 525			20.
0.00	Employee discount days (see instruction)	۲ ۲		0			30.
1.00	Employee discount days (see Histidetron)			0			31.
2.00	Labor & delivery days (see instructions)	o	119	303			32.
2.00	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.
3.00	LTCH non-covered days	o					33.
	LTCH site neutral days and discharges	0					33.

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	BAPTIST HEAL	Provi der C	CN: 15-0044	Peri od:	u of Form CMS-2 Worksheet S-3	
					From 09/01/2018 To 08/31/2019		pared:
		Full Time Equivalents		Di s	scharges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		C	6, 1	98 328	13, 965	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)			1 -	1 (10		2 00
2.00	HMO and other (see instructions)			1, 5			2.00
3.00	HMO I PF Subprovi der				0		3.00
4.00 5.00	HMO IRF Subprovider				0		4.00 5.00
6.00	Hospital Adults & Peds. Swing Bed SNF 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	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	C	6, 1	98 328	13, 965	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	C		0 0	0	16.00
17.00	SUBPROVIDER - IRF	0.00	C		0 0	0	17.00
18.00	SUBPROVI DER	0.00	C)	0	0	18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY	0.00					20.00
21.00	OTHER LONG TERM CARE	0.00				0	21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)	0.00					23.00
24.00	HOSPI CE	0.00					24.00
24.10	HOSPICE (non-distinct part)	0.00					24.10
25.00	CMHC - CMHC	0.00					25.00
25.10 26.00	CMHC - CORF	0.00					25.10 26.00
26.00	RURAL HEALTH CLINIC	0.00 0.00					26.00
20.25	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	0.00					20.25
27.00	Observation Bed Days	0.00					27.00
28.00	Ambulance Trips						28.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days (see first detron)						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.00	Total ancillary labor & delivery room						32.00
52.01	outpatient days (see instructions)						
33.00	LTCH non-covered days				0		33.00
	LTCH site neutral days and discharges			1	0		33.01

	Financial Systems AL WAGE INDEX INFORMATION		BAPTIST HEA	Provider C		eriod: rom 09/01/2018	u of Form CMS-2 Worksheet S-3 Part II	
					Te			
		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)	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	6.00	
	SALARI ES							
. 00	Total salaries (see instructions)	200.00	95, 663, 452	0	95, 663, 452	3, 244, 155. 75	29.49	1.0
2. 00	Non-physician anesthetist Part		0	0	0	0.00	0. 00	2.0
. 00	A Non-physician anesthetist Part		0	0	0	0.00	0. 00	3.0
. 00	B Physician-Part A -		0	0	0	0.00	0. 00	4.0
	Administrative		-	-				
. 01 . 00	Physicians - Part A - Teaching Physician and Non		0 0	0	-	0.00 0.00		
. 00	Physician-Part B Non-physician-Part B for		0	0	0	0.00	0.00	6.0
	hospital-based RHC and FQHC services		0	0	0	0.00	0.00	0.0
. 00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.0
. 01	Contracted interns and residents (in an approved		0	0	0	0.00	0.00	7.0
8. 00	programs) Home office and/or related organization personnel		0	0	0	0.00	0.00	8.0
. 00	SNĚ	44.00	0	0	0	0.00		
	Excluded area salaries (see instructions) OTHER WAGES & RELATED COSTS		3, 828, 657	9, 047	3, 837, 704	104, 563. 63	36. 70	10.0
1.00	Contract Labor: Direct Patient		2, 121, 361	0	2, 121, 361	23, 834. 40	89.00	11.0
2.00	Care Contract Labor: Top Level management and other management and administrative		0	0	0	0.00	0.00	12.0
3.00	services Contract Labor: Physician-Part		155, 038	0	155, 038	1, 155. 50	134. 17	13.0
4.00	A - Administrative Home office and/or related organization salaries and		0	0	0	0. 00	0.00	14.0
4. 01	wage-related costs Home office salaries		22, 606, 436	0	22, 606, 436	636, 033. 00	35.54	14.0
4.02 5.00	Related organization salaries Home office: Physician Part A		0	0	0	0.00 0.00		14.0 15.0
	- Administrative		0	0	0			
6.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.0
6. 01	Home office Physicians Part A		0	0	0	0.00	0.00	16. C
6. 02	- Teaching Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16. C
7.00	WAGE-RELATED COSTS Wage-related costs (core) (see		32, 006, 957	0	32, 006, 957			17.0
	instructions) Wage-related costs (other)		52,000,737	0	52,000,737			17.0
9.00	(see instructions) Excluded areas		190, 466	0	190, 466			19.0
	Non-physician anesthetist Part A		0	0	0			20.0
	Non-physician anesthetist Part B		0	0	0			21.0
2.00	Physician Part A - Administrative		0	0	0			22.0
	Physician Part A - Teaching		0	0	0			22.0
	Physician Part B Wage-related costs (RHC/FQHC)		0 0	0	0			23.0
	Interns & residents (in an approved program)		0	0	0			24.0
5.50	Home office wage-related (core)		4, 879, 940	0	4, 879, 940			25. 5
5. 51	Related organization wage-related (core)		0	0	0			25.5
5. 52	Home office: Physician Part A - Administrative -		0	0	0			25.5

Heal th	Financial Systems		BAPTIST HEA	LTH FLOYD		In Lie	u of Form CMS-2	2552-10
	AL WAGE INDEX INFORMATION			Provider C	F	Period: From 09/01/2018 Fo 08/31/2019	Worksheet S-3 Part II	pared:
		Wkst. A Line	Amount	Recl assi fi cat		Paid Hours	Average	
		Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.		(col. 4 ÷	
				(from Wkst. A-6)	3)	col. 4	col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A		0	0	(D		25.53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARI							
26.00	Employee Benefits Department	4.00	2, 111, 891	0				26.00
27.00	Administrative & General	5.00	4, 789, 140	-26, 929				27.00
28.00	Administrative & General under		719, 187	0	719, 187	7 7, 406. 97	97.10	28.00
00.00	contract (see inst.)	(00	0				0.00	00.00
29.00	Maintenance & Repairs	6.00	0	0	0 004 40	0.00		29.00
30.00	Operation of Plant	7.00	2, 294, 424	0	2, 294, 424			30.00
31.00	Laundry & Linen Service	8.00	100, 693		100, 693			31.00
32.00	Housekeepi ng	9.00	2,001,285	0	2,001,285			32.00
33.00	Housekeeping under contract (see instructions)		0	0		0.00	0.00	33.00
34.00	Dietary	10.00	2, 429, 457	-1, 453, 046	976, 41	1 55, 641. 59	17 55	34.00
34.00	Dietary under contract (see	10.00	2, 429, 437	-1, 455, 040	970,41	0,00		34.00 35.00
55.00	instructions)		0	0		0.00	0.00	33.00
36,00	Cafeteria	11.00	0	1, 453, 046	1, 453, 046	6 88, 859. 55	16 35	36.00
37.00	Maintenance of Personnel	12.00	0	1, 100, 010	1, 100, 010	0.00		37.00
38.00	Nursing Administration	13.00	0	0		0.00	0.00	
39.00	Central Services and Supply	14.00	514, 344	0	514, 344			39.00
40.00	Pharmacy	15.00	3, 785, 437	-9,047			43.90	
41.00	Medical Records & Medical	16.00	3, 593, 321	0	3, 593, 32			41.00
	Records Library	10100	2, 0, 0, 021		2,0,0,02		01107	
42.00	Social Service	17.00	0	0	0	0. 00	0.00	42.00
	Other General Service	18.00	0	0		0.00		43.00

Heal th	Financial Systems		BAPTIST HEA	LTH FLOYD		In Lie	u of Form CMS-2	2552-10
HOSPI	FAL WAGE INDEX INFORMATION			Provider C		Period: From 09/01/2018 To 08/31/2019		pared:
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.		(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
		1.00		A-6)		5.00	(
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		96, 382, 639	0	96, 382, 63	9 3, 251, 562. 72	29.64	1.00
	instructions)							
2.00	Excluded area salaries (see		3, 828, 657	9, 047	3, 837, 70	4 104, 563. 63	36. 70	2.00
	instructions)							
3.00	Subtotal salaries (line 1		92, 553, 982	-9, 047	92, 544, 93	5 3, 146, 999. 09	29. 41	3.00
4 00	minus line 2)		04 000 005		04 000 00		07 (4	4 00
4.00	Subtotal other wages & related		24, 882, 835	0	24, 882, 83	5 661, 022. 90	37.64	4.00
F 00	costs (see inst.)		24 004 007		24 004 00	7 0.00	20.04	F 00
5.00	Subtotal wage-related costs		36, 886, 897	0	36, 886, 89	7 0.00	39.86	5.00
(00	(see inst.) Total (sum of lines 3 thru 5)		154 202 714	0.047	154 214 44	7 2 000 021 00	40. 52	6.00
6.00			154, 323, 714					
7.00	Total overhead cost (see		22, 339, 179	-35, 976	22, 303, 20	3 777, 199. 24	28. 70	7.00
	instructions)			I				

Heal th	Financial Systems	BAPTI ST HEALTH	I FLOYD	In Lie	u of Form CMS-2	2552-10
	FAL WAGE RELATED COSTS		Provider CCN: 15-0044	Peri od: From 09/01/2018 To 08/31/2019		pared:
					Amount	
					Reported	
					1.00	
	PART IV - WAGE RELATED COSTS					
	Part A - Core List					
	RETIREMENT COST					
1.00	401K Employer Contributions				0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribu	iti on			2,802,416	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see i				-957	3.00
4.00	Qualified Defined Benefit Plan Cost (see inst	ructions)			0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External O	rgani zati on)				
5.00	401K/TSA Plan Administration fees				0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	1			0	6.00
7.00	Employee Managed Care Program Administration	Fees			72, 253	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				0	8.01
8.02	Health Insurance (Self Funded with a Third Pa	irty Administrato	ır)		0	8.02
8.03	Health Insurance (Purchased)				17, 741, 186	8.03
9.00	Prescription Drug Plan				0	9.00
10.00	Dental, Hearing and Vision Plan				0	10.00
11.00	Life Insurance (If employee is owner or benef				433, 061	
12.00	Accident Insurance (If employee is owner or b				0	
13.00	Disability Insurance (If employee is owner or				0	
14.00	Long-Term Care Insurance (If employee is owned	er or beneficiary	')		0	14.00
15.00	'Workers' Compensation Insurance				754, 661	
16.00	Retirement Health Care Cost (Only current yea	ir, not the extra	ordinary accrual requi	red by FASB 106.	0	16.00
	Non cumulative portion)					
47 00	TAXES					17.00
17.00	FICA-Employers Portion Only				10, 032, 900	
18.00	Medicare Taxes - Employers Portion Only				0	
19.00	Unemployment Insurance				70, 481	
20.00	State or Federal Unemployment Taxes				0	20.00
21.00	OTHER Executive Deferred Compensation (Other Than R	Retirement Cost R	eported on lines 1 thro	ough 4 above. (see	0	21.00
	instructions))				-	
22.00	Day Care Cost and Allowances				0	22.00
23.00	Tuition Reimbursement				291, 422	
24.00	Total Wage Related cost (Sum of Lines 1 -23)				32, 197, 423	24.00
05 00	Part B - Other than Core Related Cost					05.00
25.00	OTHER WAGE RELATED COSTS (SPECIFY)					25.00

Health F	-inancial Systems	BAPTIST HEALTH FLOYD	In Lie	u of Form CMS-2	2552-10
HOSPI TAI	L CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0044	Period: From 09/01/2018 To 08/31/2019		pared:
	Cost Center Description		Contract Labor	Benefit Cost	
			1.00	2.00	
P.	ART V - Contract Labor and Benefit Cost				
Н	lospital and Hospital-Based Component Identifi	cati on:			
1.00 T	Total facility's contract labor and benefit co	ost	2, 121, 361	32, 197, 423	1.00
2.00 H	Hospi tal		2, 121, 361	32, 197, 423	2.00
	SUBPROVIDER – IPF		0	0	3.00
	SUBPROVIDER – IRF		0	0	4.00
	Subprovider - (Other)		0	0	5.00
	Swing Beds - SNF		0	0	6.00
	Swing Beds – NF		0	0	7.00
	SKILLED NURSING FACILITY		0	0	8.00
	NURSING FACILITY		0	0	9.00
	OTHER LONG TERM CARE I			_	10.00
	Hospital-Based HHA		0	0	11.00
	AMBULATORY SURGICAL CENTER (D. P.) I		0	0	12.00
	Hospi tal -Based Hospi ce		0	0	13.00
	Hospital-Based Health Clinic RHC		0	0	14.00
	Hospital-Based Health Clinic FQHC		0	0	15.00
	Hospi tal -Based-CMHC		0	0	16.00
	Hospital-Based-CMHC 10		0	0	16.10
	RENAL DIALYSIS I		0	0	17.00
18.00 C	Other		I U	0	18.00

Heal th	Financial Systems	BAPTI ST HEAL	TH FLOYD		In Lie	u of Form CMS-:	2552-10
HOME H	IEALTH AGENCY STATI STI CAL DATA		Provider C Component	CN: 15-0044 CCN: 15-7152	Period: From 09/01/2018 To 08/31/2019	Worksheet S-4 Date/Time Pre 9/21/2022 9:4	pared:
					Home Health	PPS	
	· · · · · · · · · · · · · · · · · · ·				Agency I		
0.00	Country				1.	00	0.00
0.00	County	Title V	Title XVIII	Title XIX	Other	Total	0.00
	1	1.00	2.00	3.00	4.00	5.00	
1.00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	0	1, 915	-	79 933	2, 927	1.00
2.00	Unduplicated Census Count (see instructions)		1, 129. 00				
				Number of Em	ployees (Full Ti	me Equivalent)	
		Enter the numbe		Staff	Contract	Total	
		your normal	WOLK WEEK				
		0		1.00	2.00	3.00	
0.00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					0	0.05
3.00 4.00	Administrator and Assistant Administrator(s) Director(s) and Assistant Director(s)		0.00	9. (0. (9. 07 0. 00	3.00 4.00
5.00	Other Administrative Personnel			4.		4. 70	
6.00	Di rect Nursi ng Servi ce			13. 2			
7.00 8.00	Nursing Supervisor Physical Therapy Service			0.0		0. 00 8. 46	1
9.00	Physical Therapy Supervisor			0. (0.00	
10.00	Occupational Therapy Service			2. 5		2.50	
11.00 12.00	Occupational Therapy Supervisor Speech Pathology Service			0.0		0. 00 1. 17	1
13.00	Speech Pathology Supervisor			0.0		0.00	
14.00	Medical Social Service			0. 4		0. 92	
15.00 16.00	Medical Social Service Supervisor Home Health Aide			0.0		0. 00 1. 42	
17.00	Home Health Aide Supervisor			0.0		0.00	
18.00	Other (specify)			0. (0. 00		18.00
						CBSA Data 1.00	
	HOME HEALTH AGENCY CBSA CODES						
19.00 20.00	Enter in column 1 the number of CBSAs where List those CBSA code(s) in column 1 serviced					21140	19.00 20.00
20.00	first code).	i dui ng this co	streporting	period (inne	20 contains the	51140	20.00
20.01						99915	20.01
			sodes With Outliers	LUPA Episode	s PEP Only	Total (cols.	
		Outliers		•	Epi sodes	1-4)	
	PPS ACTIVITY DATA	1.00	2.00	3.00	4.00	5.00	
21.00	Skilled Nursing Visits	9, 328	452	30	07 120	10, 207	21.00
22.00	Skilled Nursing Visit Charges	1, 860, 830	90, 400			2, 036, 220	
23.00 24.00	Physical Therapy Visits Physical Therapy Visit Charges	6, 247 1, 436, 810	254 58, 420		98 139 40 31, 740	6, 738 1, 549, 510	
25.00	Occupational Therapy Visits	1, 736	141		25 65	1, 967	25.00
26.00 27.00	Occupational Therapy Visit Charges Speech Pathology Visits	362, 670 669	29, 610 70		50 13,650 8 40	411, 180 787	
28.00	Speech Pathology Visit Charges	147, 180	, 15, 400			173, 140	1
29.00	Medical Social Service Visits	212	13		3 10	238	29.00
30.00 31.00	Medical Social Service Visit Charges Home Health Aide Visits	50, 880 1, 811	3, 120 140		20 2, 400 6 36	57, 120 1, 993	
32.00	Home Heal th Aide Visit Charges	181, 100	14, 000		3, 600	199, 300	
33.00	Total visits (sum of lines 21, 23, 25, 27,	20, 003	1, 070	44	410	21, 930	33.00
34.00	29, and 31) Other Charges	0	0		0 0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28,	4, 039, 470	210, 950			4, 426, 470	1
36.00	30, 32, and 34) Total Number of Episodes (standard/non	1, 357		10	55 25	1, 547	36.00
30.00	outlier)	1, 357			25	1, 347	30.00
37.00	Total Number of Outlier Episodes	145 440	24		4	28	
38.UU	Total Non-Routine Medical Supply Charges	145, 418	13, 242	1, 30	08 184	160, 152	38.00

Heal th	Financial Systems BAPTIST HEALTH	FLOYD		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC	N: 15-0044	Peri od:	Worksheet S-1	0
				From 09/01/2018		
				To 08/31/2019	Date/Time Pre 9/21/2022 9:4	
					/ // 21/ 2022 /. 4	
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by li	ne 202 colum	n 8)	0. 169588	1.00
	Medicaid (see instructions for each line)				•	1
2.00	Net revenue from Medicaid				25, 180, 514	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 supplemer			ai d?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments f	rom Medicai	d		0	
6.00	Medicaid charges				199, 741, 335	
7.00	Medicaid cost (line 1 times line 6)				33, 873, 734	
8.00	Difference between net revenue and costs for Medicaid program	(line 7 min	nus sum of li	nes 2 and 5; if	8, 693, 220	8.00
	< zero then enter zero)	S				-
0.00	Children's Health Insurance Program (CHIP) (see instructions f	or each lin	ie)		0	0.00
9. 00 10. 00	Net revenue from stand-alone CHIP Stand-alone CHIP charges				0	
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	1
12.00	Difference between net revenue and costs for stand-alone CHIP	(line 11 mi	nus lino 0.	if < zero then		
12.00	enter zero)		nus rine 7,	II < Zero then	0	12.00
	Other state or local government indigent care program (see ins	structions f	or each line)		
13.00	Net revenue from state or local indigent care program (Not ind	cluded on li	nes 2, 5 or	9)	0	13.00
14.00	Charges for patients covered under state or local indigent car				0	
	10)					
15.00	State or local indigent care program cost (line 1 times line 1	14)			0	15.00
16.00	Difference between net revenue and costs for state or local ir	ndigent care	e program (li	ne 15 minus line	0	16.00
	13; if < zero then enter zero)					
	Grants, donations and total unreimbursed cost for Medicaid, CH	IP and stat	e/local indi	gent care progra	ams (see	
17 00	instructions for each line)	Sun all an an als are			0	17 00
	Private grants, donations, or endowment income restricted to f Government grants, appropriations or transfers for support of				0	
18.00	Total unreimbursed cost for Medicaid , CHIP and state and loca			s (sum of linos	8, 693, 220	
19.00	8, 12 and 16)	ai murgent	care program	s (suil of filles	0, 093, 220	19.00
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col. 2)	
			1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire fa	acility	768, 80	239, 231	1, 008, 031	20.00
	(see instructions)					
21.00	Cost of patients approved for charity care and uninsured disco	ounts (see	130, 37	239, 231	369, 610	21.00
22.00	instructions)			0		22.00
22.00	Payments received from patients for amounts previously writter charity care	i orr as		0 0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)		130, 37	239, 231	369, 610	23 00
23.00			130, 31	7 237,231	309,010	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patie	ent days bey	ond a length	of stay limit	N	24.00
	imposed on patients covered by Medicaid or other indigent care		0	3		
25.00	If line 24 is yes, enter the charges for patient days beyond t	the indigent	care progra	m's length of	0	25.00
	stay limit					
26.00	Total bad debt expense for the entire hospital complex (see in	,			21, 997, 729	1
27.00	Medicare reimbursable bad debts for the entire hospital comple				763, 483	
27.01	Medicare allowable bad debts for the entire hospital complex (see instruc	ctions)		1, 174, 589	
28.00	Non-Medicare bad debt expense (see instructions)		1	`	20, 823, 140	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt ex	kpense (see	INSTRUCTIONS)	3, 942, 461	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	ino 20)			4, 312, 071	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus l	1118 30)			13, 005, 291	31.00

RECLA	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider C	CN: 15-0044 Pe	eriod: rom 09/01/2018	Worksheet A	2552-10
				To			
	Cost Center Description	Sal ari es	Other	Total (col. 1	Reclassi fi cat	9/21/2022 9:4 Recl assi fi ed	5 am
		Sururres	other	+ col . 2)	i ons (See	Trial Balance	
					A-6)	(col. 3 +-	
		1.00	2.00	3.00	4.00	col. 4) 5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		0	0	5, 574, 631	5, 574, 631	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0	-	5, 726, 731	5, 726, 731	2.00
3.00 4.00	00300 OTHER CAP REL COSTS 00400 EMPLOYEE BENEFITS DEPARTMENT	2, 111, 891	0 729, 143	0 2, 841, 034	0 22, 955, 222	0 25, 796, 256	3.00
5.00	00500 ADMI NI STRATI VE & GENERAL	4, 789, 140	84, 725, 254		-12, 753, 164		5.00
6.00	00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	2, 294, 424 100, 693	5, 921, 066 921, 325		-552, 349 -24, 124	7, 663, 141 997, 894	7.00
9.00	00900 HOUSEKEEPI NG	2,001,285	1, 205, 568		-485, 082	2, 721, 771	9.00
10.00	01000 DI ETARY	2, 429, 457	1, 784, 848		-3, 094, 697	1, 119, 608	
11.00		0	0	0	2, 584, 970		
12.00 13.00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	0	0	0	0	0	12.00
14.00	01400 CENTRAL SERVICES & SUPPLY	514, 344	732, 112	1, 246, 456	-212, 547	1, 033, 909	•
15.00		3, 785, 437	13, 163, 404		-12, 614, 707	4, 334, 134	•
16.00	01600 MEDI CAL RECORDS & LI BRARY	3, 593, 321	965, 247		-864, 505	3, 694, 063	•
17.00 23.00		0 196, 949	0 59, 962	-	0 -22, 541	0 234, 370	17.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	170, 747	37,702	230, 711	22, 341	234, 370	23.00
30.00	03000 ADULTS & PEDIATRICS	26, 174, 906	11, 293, 574		-18, 525, 885		•
31.00		3, 285, 929	1, 663, 633	4, 949, 562	1, 654, 332	6, 603, 894	31.00
32.00 33.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	32.00 33.00
34.00		0	0	0	0	0	34.00
40.00	04000 SUBPROVI DER – I PF	0	0	0	0	0	40.00
41.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	0	0	0	0	0	41.00
42.00 43.00	04300 NURSERY	734, 155	189, 505	923, 660	68, 839	0 992, 499	42.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500 NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600 OTHER_LONG_TERM_CARE ANCI LLARY_SERVI CE_COST_CENTERS	0	0	0	0	0	46.00
50.00		9, 194, 966	26, 263, 639	35, 458, 605	-18, 357, 107	17, 101, 498	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	1, 326, 515	633, 229	1, 959, 744	-438, 715	1, 521, 029	
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 818, 730	5, 116, 189	9, 934, 919	-2, 609, 844	0 7, 325, 075	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	56.00
57.00 58.00		688, 983 417, 065	757, 794 415, 332		-237, 872 -157, 020		
59.00		3, 373, 092	10, 226, 255		-9, 765, 245	3, 834, 102	•
60.00	06000 LABORATORY	4, 628, 346	7, 895, 204	12, 523, 550	-1, 129, 371	11, 394, 179	60.00
60.01	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	60.01 61.00
61.00 62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	130, 790	130, 790	-65, 214	0 65, 576	
63.00		0	0	0	1, 192, 826	1, 192, 826	
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	5, 578, 562	5, 578, 562	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	2, 370, 349 3, 288, 911	1, 220, 550 1, 698, 815		-669, 700 -838, 511	2, 921, 199 4, 149, 215	•
67.00	06700 OCCUPATI ONAL THERAPY	0	1, 098, 815		-838, 511	4, 149, 215	67.00
68.00	06800 SPEECH PATHOLOGY	385, 297	120, 577		85, 333	591, 207	68.00
69.00		1, 963, 799	1,091,666		-815, 759	2, 239, 706	1
70.00 71.00		259, 416	1, 338, 496 0	1, 597, 912 0	-15, 037 13, 832, 359	1, 582, 875 13, 832, 359	1
72.00		0	0	0	16, 031, 475	16, 031, 475	1
73.00		0	0	0	11, 702, 047	11, 702, 047	73.00
74.00 75.00		0	411	411	240, 437	240, 848 0	1
76.00		0	0	0	0	0	76.00
76.97	07697 CARDI AC REHABI LI TATI ON	599, 851	244, 951	844, 802	-148, 127	696, 675	•
00.05	OUTPATIENT SERVICE COST CENTERS						
88.00 89.00		0	0	0	0	0	88.00 89.00
90.00		1, 456, 085	2,047,780	3, 503, 865	-364, 182	3, 139, 683	•
91.00	09100 EMERGENCY	5, 248, 408	2, 878, 729		-1, 636, 619		•
92.00							92.00
94.00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	94.00
/H. UU		0	-	-			•
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00

Health Financial Systems	BAPTI ST HEAL	TH FLOYD		In Lie	u of Form CMS-:	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC		eriod:	Worksheet A	
				rom 09/01/2018 o 08/31/2019	Date/Time Pre	nared
					9/21/2022 9:4	
Cost Center Description	Sal ari es	Other		Recl assi fi cat	Recl assi fi ed	
			+ col. 2)	ions (See	Trial Balance	
				A-6)	(col. 3 +-	
	1.00	2.00	3.00	4.00	<u>col. 4)</u> 5.00	
97.00 09700 DURABLE MEDI CAL EQUI P-SOLD	1.00	2.00	3.00		0	97.00
99. 00 09900 CMHC	0	0	(0	0	
99. 10 09910 CORF	0	0	(0	0	
100.0010000 I&R SERVICES-NOT APPRVD PRGM	0	0	(0	-	100.00
101.00 10100 HOME HEALTH AGENCY	2, 995, 533	1, 697, 274	4, 692, 807	-751,672	3, 941, 135	
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KI DNEY ACQUI SI TI ON	0	0	C	0 0	0	105.00
106.00 10600 HEART ACQUI SI TI ON	0	0	C	0 0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0	C	0	0	107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0	C	0	0	108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0	C	0 0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	C	0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	C	0 0		111.00
113.00 11300 INTEREST EXPENSE		0	C	0 0		113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0	C	0 0		114.00
115.00 11500 AMBULATORY SURGI CAL CENTER (D.P.)	0	0	C	0 0		115.00
116.00 11600 HOSPI CE	0	0	(0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	95, 027, 277	187, 132, 322	282, 159, 599	78, 168	282, 237, 767	118.00
NONREI MBURSABLE COST CENTERS	6, 771	110 005	117 10/	E 4 4	11/ 5/0	100.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 191. 00 19100 RESEARCH	89, 424	110, 335 21, 897			116, 562 89, 772	
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	89, 424 375, 144	21, 897 56, 001	111, 321 431, 145		422, 914	•
192. 01 19200 PHTSICIANS PRIVATE OFFICES	164, 836	4, 079, 382	4, 244, 218		4, 196, 374	•
192. 02 19201 DTHER NRCC	104, 030	4,017,302	4, 244, 210	-47,044		192.01
192. 00 19300 NONPALD WORKERS		0	(192.02
194. 00 07950 MARKETI NG	0	0	(194.00
200.00 TOTAL (SUM OF LINES 118 through 199)	95, 663, 452	191, 399, 937	287, 063, 389	0	287,063,389	
	,	,,,	,000,00,			

				 To 08/31/2019	Date/Time Pr 9/21/2022 9:	45 am
	Cost Center Description	Adjustments (See A-8)	Net Expenses For			
		6.00	Allocation 7.00			
C	GENERAL SERVICE COST CENTERS	· · · · ·				
	DO100 CAP REL COSTS-BLDG & FIXT	0				1.
	00200 CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAP REL COSTS	0				2
	00400 EMPLOYEE BENEFITS DEPARTMENT	-356, 325	-			4
	DO500 ADMINI STRATI VE & GENERAL	-19, 783, 577				5
	DO600 MAI NTENANCE & REPAI RS	0	0			6
	DO700 OPERATION OF PLANT	0	7, 663, 141			7
	DO800 LAUNDRY & LINEN SERVICE DO900 HOUSEKEEPING	0	997, 894 2, 721, 771			8
	D1000 DI ETARY	-1, 576, 637				10
	D1100 CAFETERI A	0	2, 584, 970			11
	D1200 MAINTENANCE OF PERSONNEL	0	0			12
	01300 NURSI NG ADMI NI STRATI ON	0	-			13
	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	-111, 925	.,			14
	D1600 MEDICAL RECORDS & LIBRARY	2, 855, 107				16
	D1700 SOCIAL SERVICE	0				17
	D2300 PARAMED ED PRGM-PHARMACY RESIDENCY	0	234, 370			23
	INPATIENT ROUTINE SERVICE COST CENTERS	253, 597	19, 196, 192			30
	D3100 INTENSIVE CARE UNIT	255, 597				31
	D3200 CORONARY CARE UNI T	0				32
	D3300 BURN INTENSIVE CARE UNIT	0	0			33
	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0			34
	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	0				40
	04200 SUBPROVI DER	0	0			42
00 0	D4300 NURSERY	0	992, 499			43
	04400 SKILLED NURSING FACILITY	0	0			44
	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0				45
	ANCI LLARY SERVICE COST CENTERS	0	0			- 40
	D5000 OPERATING ROOM	-1, 708, 323	15, 393, 175			50
	D5100 RECOVERY ROOM	0	U U			51
	D5200 DELI VERY ROOM & LABOR ROOM D5300 ANESTHESI OLOGY	-22, 766	1, 498, 263			52 53
	D5400 RADI OLOGY-DI AGNOSTI C	-184, 800	7, 140, 275			54
	05500 RADI OLOGY-THERAPEUTI C	0	0			55
	D5600 RADI OI SOTOPE	0	0			56
	05700 CT_SCAN 05800 MRI	0	1,200,700			57
	D5900 CARDI AC CATHETERI ZATI ON	-60, 853				58
	D6000 LABORATORY	-135, 982				60
. 01 0	D6001 BLOOD LABORATORY	0	0			60
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0			61
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS.	0	65, 576 1, 192, 826			62
	06400 I NTRAVENOUS THERAPY	-159, 284				64
	06500 RESPI RATORY THERAPY	0	2, 921, 199			65
	06600 PHYSI CAL THERAPY	-1, 658				66
	06700 OCCUPATI ONAL THERAPY	0	-			67
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY		591, 207 2, 239, 706			68
	D7000 ELECTROENCEPHALOGRAPHY	-1, 049, 378				70
. 00 0	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	-916, 407	12, 915, 952			71
	07200 IMPL. DEV. CHARGED TO PATIENTS	0				72
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	11, 702, 047 240, 848			73
	07500 ASC (NON-DI STI NCT PART)	0				75
	D3950 NUTRI TI ON/DI ABETES	0				76
	07697 CARDI AC REHABI LI TATI ON	-25, 581	671, 094			76
	DUTPATIENT SERVICE COST CENTERS					
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	1			88
	09000 CLINIC	-153, 461				90
. 00 0	D9100 EMERGENCY	-112, 385				91
	09200 OBSERVATION BEDS (NON-DISTINCT PART					92
	DTHER REIMBURSABLE COST CENTERS					
	09500 AMBULANCE SERVICES	0				94
	09600 DURABLE MEDICAL EQUIP-RENTED	0				96
	09700 DURABLE MEDICAL EQUIP-SOLD	0	. d			97

In Lieu of Form CMS-2552-10

9/21/2022 9:45 am F: \Final Settlement\150044 08312019\150044.08312019.A1.mcax

Health Financial Systems

Health Financial Systems	BAPTIST HEA	LTH FLOYD	In Lieu of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provider CCN: 15-0	
			From 09/01/2018 To 08/31/2019 Date/Time Prepared:
			9/21/2022 9:45 am
Cost Center Description	Adjustments	Net Expenses	
	(See A-8)	For	
		Allocation	
	6.00	7.00	
99.00 09900 CMHC	0	0	99.00
99.10 09910 CORF	0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	-1, 646	3, 939, 489	101.00
SPECIAL PURPOSE COST CENTERS	0	0	105.00
106. 00 10600 HEART ACQUISITION	0	0	105.00
107. 00 10700 LIVER ACQUISITION	0	0	108.00
108. 00 10800 LUNG ACQUISITION	0	0	107.00
109. 00 10900 PANCREAS ACQUI SI TI ON	0	0	109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	110.00
111. 00 11100 I SLET ACQUI SI TI ON	0	0	111.00
113.0011300 INTEREST EXPENSE	0	o	113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0	114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	115.00
116. 00 11600 HOSPI CE	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-23, 252, 284	258, 985, 483	118.00
NONREI MBURSABLE COST CENTERS			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	116, 562	190.00
191. 00 19100 RESEARCH	0	89, 772	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	422, 914	192.00
192. 01 19201 OTHER NRCC	0	4, 196, 374	192.01
192.02 19202 LTC	0	0	192.02
193.00 19300 NONPALD WORKERS	0	0	193.00
194.00 07950 MARKETING			194.00
200.00 TOTAL (SUM OF LINES 118 through 199)	-23, 252, 284	263, 811, 105	200.00

^{9/21/2022 9:45} am F: \Final Settlement\150044 08312019\150044.08312019.A1.mcax

ealth Financial Systems	BAPTI ST HEALTH FLOYE		In Lieu of Form	
COST CENTERS USED IN COST REPORT	Provi	der CCN: 15-0044	Period: Workshee From 09/01/2018	t Non-CMS
				e Prepare 2 9:45 am
Cost Center Description		CMS Code	Standard Label For	
			Non-Standard Codes	
GENERAL SERVICE COST CENTERS		1.00	2.00	
. 00 CAP REL COSTS-BLDG & FIXT		00100		1.
. 00 CAP REL COSTS-MVBLE EQUIP		00200		2.
. 00 OTHER CAP REL COSTS . 00 EMPLOYEE BENEFITS DEPARTMENT		00300 00400		3. 4.
. 00 ADMI NI STRATI VE & GENERAL		00400		5.
00 MAINTENANCE & REPAIRS		00600		6.
.00 OPERATION OF PLANT .00 LAUNDRY & LINEN SERVICE		00700 00800		7. 8.
00 HOUSEKEEPING		00900		9.
D. 00 DI ETARY		01000		10.
1.00 CAFETERIA 2.00 MAINTENANCE OF PERSONNEL		01100 01200		11. 12.
3. 00 NURSING ADMINISTRATION		01200		13.
4.00 CENTRAL SERVICES & SUPPLY		01400		14.
5. 00 PHARMACY 5. 00 MEDI CAL RECORDS & LI BRARY		01500 01600		15. 16.
7. 00 SOCIAL SERVICE		01700		17.
3. 00 PARAMED ED PRGM-PHARMACY RESIDENCY		02300		23.
D. 00 ADULTS & PEDIATRICS		03000		30.
1. 00 INTENSIVE CARE UNIT		03100		31.
2. 00 CORONARY CARE UNIT		03200		32.
3. 00 BURN INTENSIVE CARE UNIT 4. 00 SURGICAL INTENSIVE CARE UNIT		03300 03400		33. 34.
D. 00 SUBPROVIDER - IPF		04000		40.
I. 00 SUBPROVI DER – I RF		04100		41.
2. 00 SUBPROVI DER 3. 00 NURSERY		04200 04300		42.
4. 00 SKILLED NURSING FACILITY		04300		44.
5.00 NURSING FACILITY		04500		45.
6. 00 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS		04600		46.
D. 00 OPERATI NG ROOM		05000		50.
I. OO RECOVERY ROOM		05100		51.
2. 00 DELIVERY ROOM & LABOR ROOM 3. 00 ANESTHESIOLOGY		05200 05300		52. 53.
4. 00 RADI OLOGY-DI AGNOSTI C		05400		54.
5. 00 RADI OLOGY-THERAPEUTI C		05500		55.
5. 00 RADI OI SOTOPE 7. 00 CT SCAN		05600 05700		56. 57.
3. OO MRI		05800		58.
9. 00 CARDI AC CATHETERI ZATI ON		05900		59.
D. 00 LABORATORY D. 01 BLOOD LABORATORY		06000 06001		60. 60.
. 00 PBP CLINICAL LAB SERVICES-PRGM ONLY		06100		61.
2.00 WHOLE BLOOD & PACKED RED BLOOD CELL		06200		62.
3. 00 BLOOD STORING, PROCESSING & TRANS. 1. 00 INTRAVENOUS THERAPY		06300 06400		63. 64.
5. 00 RESPIRATORY THERAPY		06500		65.
5.00 PHYSICAL THERAPY		06600 06700		66. 67.
7. 00 OCCUPATIONAL THERAPY 3. 00 SPEECH PATHOLOGY		06700		67.
P. 00 ELECTROCARDI OLOGY		06900		69.
D. 00 ELECTROENCEPHALOGRAPHY		07000		70.
1.00 MEDICAL SUPPLIES CHARGED TO PATIENT 2.00 IMPL. DEV. CHARGED TO PATIENTS		07100 07200		71. 72.
8. 00 DRUGS CHARGED TO PATIENTS		07300		73.
. 00 RENAL DIALYSIS		07400		74.
5. 00 ASC (NON-DI STINCT PART) 5. 00 NUTRI TI ON/DI ABETES		07500 03950		75. 76.
0. 97 CARDI AC REHABI LI TATI ON		07697	CARDIAC REHABILITATION	76.
		00000		
3.00 RURAL HEALTH CLINIC 2.00 FEDERALLY QUALIFIED HEALTH CENTER		08800 08900		88. 89.
D. OO CLINIC		09000		90.
1.00 EMERGENCY		09100		91.
2. 00 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS		09200		92.
4. 00 HOME PROGRAM DI ALYSI S		09400		94.
5.00 AMBULANCE SERVICES		09500		95.
5.00 DURABLE MEDICAL EQUIP-RENTED 21/2022 9:45 am E:\Einal Settlement\150044 08		09600	1	96.

Health Financial Systems	BAPTIST HEALTH FLOYD	In Lieu of Form CMS-2552	2-10
COST CENTERS USED IN COST REPORT	Provider CCN: 15-0044	Period: Worksheet Non-CM	IS W
		From 09/01/2018 To 08/31/2019 Date/Time Prepare	·bd·
		9/21/2022 9:45 at	
Cost Center Description	CMS Code		
		Non-Standard Codes	
	1.00	2.00	
97.00 DURABLE MEDI CAL EQUI P-SOLD	09700	97	7.00
99.00 CMHC	09900	99	9.00
99. 10 CORF	09910	99	9.10
100.00 I&R SERVICES-NOT APPRVD PRGM	10000	100	0. 00
101.00 HOME HEALTH AGENCY	10100	101	I. 00
SPECIAL PURPOSE COST CENTERS			
105.00 KIDNEY ACQUISITION	10500		5.00
106.00 HEART ACQUISITION	10600		5.00
107.00 LIVER ACQUISITION	10700		7.00
108.00 LUNG ACQUI SI TI ON	10800		3.00
109.00 PANCREAS ACQUI SI TI ON	10900		9.00
110.00 INTESTINAL ACQUISITION	11000		0. 00
111.00 I SLET ACQUI SI TI ON	11100		. 00
113.00 INTEREST EXPENSE	11300		3.00
114.00 UTILIZATION REVIEW-SNF	11400		1.00
115.00 AMBULATORY SURGICAL CENTER (D. P.)	11500		5.00
	11600		5.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS			3. 00
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000	190), 00
191. 00 RESEARCH	19100		1.00
192. 00 PHYSI CLANS' PRI VATE OFFICES	19200		2.00
192. 01 OTHER NRCC	19201		2.01
192. 02 LTC	19202	192	2. 02
193. 00 NONPALD WORKERS	19300	193	3.00
194. OO MARKETI NG	07950	194	1.00
200.00 TOTAL (SUM OF LINES 118 through 199)		200	0.00

	FI NANCI AL SYSTEMS SIFI CATIONS		BAPIISI HEA	Provi der C	CN: 15-0044	Period: From 09/01	/2018	eet A-6
		Increases				To 08/31		ime Prepared: 022 9:45 am
	Cost Center	Li ne #	Salary	Other				
	2.00	3.00	4.00	5.00				
1.00	A - DRUGS DRUGS CHARGED TO PATIENTS	73.00	0	11, 702, 047				1.00
2.00	OTHER NRCC	192.01	О	97				2.00
3.00		0.00	0	0				3.00
4.00 5.00		0. 00 0. 00	0	0				4.00 5.00
6.00		0.00	0	0				6.00
7.00		0.00	0	0				7.00
8.00		0.00	0	0				8.00
9.00 10.00		0.00 0.00	0	0				9.00 10.00
	TOTALS			11, 702, 144				
1 00	B - IMPLANTS	70.00		1/ 001 475				1.00
1.00	I MPL. DEV. CHARGED TO PATI ENTS	72.00	0	16, 031, 475				1.00
	TOTALS			16,031,475				
	C - SUPPLIES	74.00						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	29, 863, 834				1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	84, 800				2.00
3.00		0.00	0	0				3.00
4.00 5.00		0.00 0.00	0 0	0				4.00
5.00 6.00		0.00	0	0				6.00
7.00		0.00	О	0				7.00
8.00		0.00	0	0				8.00
9.00 10.00		0.00 0.00	0 0	0				9.00 10.00
11.00		0.00	0	0				11.00
12.00		0.00	0	0				12.00
13.00		0.00	0 0	0 0				13.00
14.00 15.00		0.00 0.00	0	0				14.00 15.00
16.00		0.00	О	0				16.00
17.00		0.00	0	0				17.00
18.00 19.00		0.00 0.00	0 0	0				18.00 19.00
20.00		0.00	0	0				20.00
21.00		0.00	О	0				21.00
22.00		0.00	0	0				22.00
23.00 24.00		0.00 0.00	0 0	0				23.00
25.00		0.00	0	0				25.00
26.00		0.00	0	0				26.00
27.00	TOTALS		0	0 29, 948, 634				27.00
	D - MASSAGE		0	27, 740, 034				
1.00	PHYSICAL THERAPY	6600	26, 929	5, 498				1.00
	TOTALS E - PHARMACY RESIDENCY		26, 929	5, 498				
1.00	PARAMED ED PRGM-PHARMACY	23.00	9,047	16, 519				1.00
	RESI DENCY							
	TOTALS F - BENEFITS		9, 047	16, 519				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	22, 955, 222				1.00
2.00		0.00	0	0				2.00
3.00		0.00	0	0				3.00
4.00 5.00		0.00 0.00	0	0				4.00
6.00		0.00	0	0				6.00
7.00		0.00	0	0				7.00
8.00		0.00	0	0				8.00
9.00 10.00		0.00 0.00	0 0	0				9.0 10.0
11.00		0.00	0	0				11.00
12.00		0.00	0	0				12.0
13.00		0.00	0	0				13.0
14.00 15.00		0. 00 0. 00	0	0				14.0 15.0
16.00		0.00	0	0				16.0
17.00		0.00	0	0				17.0
18.00		0.00	0	0				18.0
19.00 20.00		0.00 0.00	0	0				19.00 20.00
	1)22 9·45 am E·\Einal Settlemen	· · ·	-					1 20.0

In Lieu of Form CMS-2552-10

9/21/2022 9:45 am F:\Final Settlement\150044 08312019\150044.08312019.A1.mcax

Health Financial Systems

In Lieu of Form CMS-2552-10

Heal th	Financial Systems		BAPTI ST HEA	LTH FLOYD		In Lieu	u of Form CMS	-2552-10
RECLASSI FI CATI ONS			Provider C	CN: 15-0044	Peri od:	Worksheet A-	6	
						From 09/01/2018		
						To 08/31/2019	Date/Time Pr 9/21/2022 9:	repared:
		Increases					9/21/2022 9.	
	Cost Center	Li ne #	Salary	Other				
	2.00	3.00	4.00	5.00				
21.00	2.00	0.00	0	0.00				21.00
22.00		0.00	0	0				22.00
23.00		0.00	0	0				23.00
24.00		0.00	0	0				24.00
24.00		0.00	0	0				25.00
26.00		0.00	0	0				26.00
27.00		0.00	0	0				27.00
28.00		0.00	0	0				28.00
28.00		0.00	0	0				28.00
30.00		0.00	0	0				30.00
30.00		0.00	0	0				30.00
32.00				0				31.00
32.00	TOTALS		<u>0</u>	22,955,222				32.00
	G - CAFETERIA RECLASS		U	22, 955, 222				-
1.00	CAFETERIA	11.00	1, 453, 046	1, 131, 924				1.00
1.00	TOTALS		1, 453, 046	1, 131, 924				1.00
	H - BLDG & FIXT DEPRECIATION		1, 455, 040	1, 131, 724				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5, 574, 631				1.00
1.00	TOTALS		— — — o	5, 574, 631				1.00
	I - MOVABLE DEPRECIATION	<u> </u>	<u>ч</u>	3, 374, 031				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5, 726, 731				1.00
1.00			— — — o	5, 726, 731				1.00
	J - IP ANCILLARY COST RECLASS	S		0,720,701				-
1.00	I NTENSI VE CARE UNI T	31.00	2, 256, 739	549, 976				1.00
2.00	NURSERY	43.00	194, 149	47, 447				2.00
3.00	OPERATING ROOM	50.00	205, 905	50, 603				3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	4, 993	1, 220				4.00
5.00	LABORATORY	60,00	11, 545	2, 822				5.00
6.00	BLOOD STORING, PROCESSING &	63.00	894, 155	219, 400				6.00
	TRANS.			,				
7.00	INTRAVENOUS THERAPY	64.00	58, 691	14, 345				7.00
8.00	RESPI RATORY THERAPY	65.00	4,606	1, 126				8.00
9.00	SPEECH PATHOLOGY	68, 00	148, 410	36, 269				9,00
10.00	ELECTROCARDI OLOGY	69.00	13, 182	3, 232				10.00
11.00	CLINIC	90.00	677	166				11.00
12.00	RENAL DIALYSIS	74.00	193, 281	47, 239				12.00
13.00	CLINIC	90.00	265, 576	64, 964				13.00
14.00	EMERGENCY	91.00	2, 576	630				14.00
	TOTALS		4, 254, 485	1,039,439				
	L - OP ANCILLARY COST RECLASS	S	., _== .,	.,				-
1.00	OPERATI NG ROOM	50.00	273, 180	66, 766				1.00
2.00	RADI OLOGY-DI AGNOSTI C	54.00	89	22				2.00
3.00	LABORATORY	60.00	177	43				3.00
4.00	BLOOD STORING, PROCESSING &	63.00	63, 703	15, 568				4.00
	TRANS.							
5.00	INTRAVENOUS THERAPY	64.00	4, 424, 280	1,081,246				5.00
6.00	RESPI RATORY THERAPY	65.00	166	41				6.00
7.00	PHYSI CAL THERAPY	66.00	105	26				7.00
8.00	CLINIC	90.00	1, 334	326				8.00
9.00	EMERGENCY	91.00	26, 442	6, 462				9.00
	TOTALS		4, 789, 476	1, 170, 500				
500.00	Grand Total: Increases		10, 532, 983	95, 302, 717				500.00
								·

Heal th	Fi nanci al	Systems
RECLAS	SI FI CATI ON	IS

In Lieu of Form CMS-2552-10 Worksheet A-6

Provider CCN: 15-0044

111 EI CO	
Peri od:	Worksheet A-6 Date/Time Prepared: 9/21/2022 9:45 am
From 09/01/2018	
To 08/31/2019	Date/Time Prepared:
	9/21/2022 9:45 am

							9/21/2022 9:	<u>45 am</u>
		Decreases				I		
	Cost Center	Line #	Salary		Wkst. A-7 Ref.			
	6.00 A - DRUGS	7.00	8.00	9.00	10.00			-
1.00	PHARMACY	15.00	0	11, 515, 318	0			1.00
2.00	ADULTS & PEDIATRICS	30.00	0	88, 936				2.00
3.00	OPERATI NG ROOM	50.00	0	36, 360				3.00
4.00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 985				4.00
5.00	MRI	58.00	0	765				5.00
6.00	CARDI AC CATHETERI ZATI ON	59.00	0	9,606	-			6.00
7.00	PHYSI CAL THERAPY	66.00	0	18				7.00
8.00	ELECTROCARDI OLOGY	69.00	0	45, 989				8.00
9.00	CARDIAC REHABILITATION	76.97	0	134	0			9.00
10.00	CLINIC	90.00	0	3, 033				10.00
	TOTALS			11, 702, 144				1
	B - IMPLANTS							1
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	16, 031, 475	0			1.00
	PATI ENT							
	TOTALS		0	16, 031, 475				
	C – SUPPLIES	,			1	1		
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	2, 619				1.00
2.00	OPERATION OF PLANT	7.00	0	11, 512				2.00
3.00	HOUSEKEEPING	9.00	0	409				3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	87,085				4.00
5.00		15.00	0	146, 437				5.00
6.00	ADULTS & PEDIATRICS	30.00	0	791, 413				6.00
7.00	I NTENSI VE CARE UNI T NURSERY	31.00	0	330, 339				7.00
8.00		43.00	-	1,443	0			8.00
9.00 10.00	OPERATING ROOM DELIVERY ROOM & LABOR ROOM	50.00 52.00	0	16, 694, 251	0			9.00 10.00
11.00	RADI OLOGY-DI AGNOSTI C	54.00	0	127, 367 1, 424, 660				11.00
12.00	CT SCAN	57.00	0	70, 389				12.00
13.00	MRI	58.00	0	50, 098				13.00
14.00	CARDI AC CATHETERI ZATI ON	59.00	0	8, 931, 922				14.00
15.00	LABORATORY	60.00	0	30, 254				15.00
16.00	WHOLE BLOOD & PACKED RED	62.00	0	65, 214				16.00
10.00	BLOOD CELL	02.00	Ű	00,211	0			10.00
17.00	RESPI RATORY THERAPY	65.00	0	128, 678	0			17.00
18.00	PHYSI CAL THERAPY	66.00	0	7, 849	0			18.00
19.00	SPEECH PATHOLOGY	68.00	0	7, 945				19.00
20.00	ELECTROCARDI OLOGY	69.00	0	303, 984	0			20.00
21.00	ELECTROENCEPHALOGRAPHY	70.00	0	5	0			21.00
22.00	CLINIC	90.00	0	628	0			22.00
23.00	RENAL DI ALYSI S	74.00	0	83	0			23.00
24.00	CARDIAC REHABILITATION	76.97	0	383				24.00
25.00	CLINIC	90.00	0	336, 563				25.00
26.00	EMERGENCY	91.00	0	397, 073				26.00
27.00	OTHER NRCC	<u> </u>	0	31				27.00
	TOTALS		0	29, 948, 634				_
1 00	D - MASSAGE	5.00	04 000	F 400	07			1 00
1.00	ADMI NI STRATI VE & GENERAL		- 26,929	<u>5, 498</u>				1.00
			26, 929	5, 498				-
1.00	E - PHARMACY RESIDENCY PHARMACY	15 00	0.047	14 510	0			1.00
1.00	TOTALS	<u>15.00</u>	<u> </u>	1 <u>6, 5</u> 19 16, 519				1.00
	F - BENEFITS		7,047	10, 319				-
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	1, 416, 756	0			1.00
2.00	OPERATION OF PLANT	7.00	0	540, 837				2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	24, 124				3.00
4.00	HOUSEKEEPING	9.00	0	484, 673				4.00
5.00	DI ETARY	10.00	0	509, 727				5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	125, 462				6.00
7.00	PHARMACY	15.00	0	927, 386				7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	864, 505				8.00
9.00	PARAMED ED PRGM-PHARMACY	23.00	0	48, 107	0			9.00
	RESI DENCY							
10.00	ADULTS & PEDIATRICS	30.00	0	6, 396, 787				10.00
11.00	INTENSIVE CARE UNIT	31.00	0	816, 893				11.00
12.00	NURSERY	43.00	0	171, 314				12.00
13.00	OPERATING ROOM	50.00	0	2, 222, 950				13.00
14.00	DELIVERY ROOM & LABOR ROOM	52.00	0	317, 561	0			14.00
15.00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 183, 310				15.00
16.00	CT SCAN	57.00	0	167, 483				16.00
17.00		58.00	0	106, 157				17.00
18.00	CARDI AC CATHETERI ZATI ON	59.00	0	823, 717				18.00
19.00		60.00 65.00	0	1, 113, 704				19.00
	RESPIRATORY THERAPY	65.00		546, 961	0			20.00
u/21/20)22 9:45 am E:\Final Settlemer	TTTLLUUAA 083120	1101150044 0831	UTU A1 meav				

Health Financial Systems RECLASSIFICATIONS

BAPTIST HEALTH FLOYD

In Lieu of Form CMS-2552-10

Provider CCN: 15-0044

Period: From 09/01/2018 To 08/31/2019 Date/Time Prepared: 9/21/2022 9: 45 am

						9/21/2022 9:	<u>45 am</u>
		Decreases					
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
21.00	PHYSI CAL THERAPY	66.00	0	863, 202			21.00
22.00	SPEECH PATHOLOGY	68.00	0	91, 401	0		22.00
23.00	ELECTROCARDI OLOGY	69.00	0	482, 200			23.00
24.00	ELECTROENCEPHALOGRAPHY	70.00	0	15, 032			24.00
25.00	HOME HEALTH AGENCY	101.00	0	751, 672			25.00
26.00	CARDIAC REHABILITATION	76.97	0	147, 610			26.00
27.00	CLINIC	90.00	0	357, 001	0		27.00
28.00	EMERGENCY	91.00	0	1, 275, 656			28.00
29.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	544			29.00
30.00	RESEARCH	191.00	0	21, 549			30.00
31.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	93, 031			31.00
32.00	OTHER NRCC	<u> </u>	0	47,910			32.00
	TOTALS		0	22, 955, 222			
	G - CAFETERIA RECLASS						
1.00	<u>DIETARY</u>		1, 453, 046	<u>1, 131, 9</u> 24			1.00
	TOTALS		1, 453, 046	1, 131, 924			
	H - BLDG & FIXT DEPRECIATION						_
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	<u>5, 574, 6</u> 31			1.00
	TOTALS		0	5, 574, 631			
	I - MOVABLE DEPRECIATION						-
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	5, 726, 731			1.00
	TOTALS			5, 726, 731			
1 00	J - I P ANCI LLARY COST RECLASS		4 05 4 405	4 000 400			1 00
1.00	ADULTS & PEDIATRICS	30.00	4, 254, 485	1, 039, 439			1.00
2.00		0.00	0	0			2.00
3.00		0.00	0	0			3.00
4.00		0.00	0	0			4.00
5.00		0.00	0	0	-		5.00
6.00		0.00	0	0			6.00
7.00		0.00	0	0			7.00
8.00 9.00		0.00	0	0			8.00 9.00
		0.00		0	-		
10. 00 11. 00		0.00 0.00	0	0			10.00
12.00		0.00	0	0			12.00
12.00		0.00	0	0			12.00
14.00		0.00	0	0			14.00
14.00	TOTALS	0.00	4, 254, 485	1,039,439	<u> </u>		14.00
	L - OP ANCILLARY COST RECLASS		4, 234, 403	1,037,437			-
1.00	ADULTS & PEDIATRICS	30.00	4, 785, 351	1, 169, 474	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	4, 703, 331	1, 109, 474			2.00
3.00	INTENSIVE CARE ON I	0.00	4, 125	1, 020			3.00
4.00		0.00	0	0			4.00
5.00		0.00	0	0			5.00
6.00		0.00	0	0	-		6.00
7.00		0.00	0	0			7.00
8.00		0.00	0	0	-		8.00
9.00		0.00	0	0	0		9.00
	TOTALS		4, 789, 476	1, 170, 500	├──── [─]		
500 00	Grand Total: Decreases		10, 532, 983	95, 302, 717			500.00
555.00		I	,, ,	, , , , , , , , , , , , , , , , , , , ,	1 1		1 2 8 8 . 8 8

Heal th F	i nanci al	Systems						
RECLASSI FI CATI ONS								

In Lieu of Form CMS-2552-10 Period: Worksheet A-6 From 09/01/2018 Non-CMS Worksheet To 08/31/2019 Date/Time Prepared: Provider CCN: 15-0044

1/2019	Date/Time	Prepared:
	9/21/2022	9.45 am

	Increases Decreases						15 am		
	Cost Center	Li ne #	Salary	Other	Cost Center	Li ne #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
1.00	A - DRUGS DRUGS CHARGED TO	73.00	0	11, 702, 047	PHARMACY	15.00	0	11, 515, 318	1.00
2.00	PATIENTS OTHER NRCC	192. 01	0	97	ADULTS & PEDIATRICS	30.00	0	88, 936	2.00
3.00		0.00	0		OPERATI NG ROOM	50.00	0	36, 360	3.00
4.00		0.00	0		RADI OLOGY-DI AGNOSTI C	54.00	0	1, 985	4.00
5.00 6.00		0.00 0.00	0		MRI CARDI AC	58.00 59.00	0	765 9, 606	5.00 6.00
					CATHETERI ZATI ON				
7.00 8.00		0.00	0		PHYSI CAL THERAPY ELECTROCARDI OLOGY	66.00 69.00	0	18 45, 989	7.00 8.00
9.00		0.00	Ō		CARDI AC	76.97	0	134	9.00
10.00		0.00	0	C	REHABI LI TATI ON CLI NI C	90.00	0	3, 033	10.00
	TOTALS			11, 702, 144				11, 702, 144	
1.00	B - IMPLANTS IMPL. DEV. CHARGED TO	72.00	0	16, 031, 475	MEDI CAL SUPPLI ES	71.00	0	16, 031, 475	1.00
	PATI ENTS			<u>16,031,4</u> 75	CHARGED TO PATIENT	<u> </u>	— — — _d	<u>16, 031, 4</u> 75	
	C - SUPPLIES		<u> </u>	10, 031, 475	TUTALS		0	10, 031, 475	
1.00	MEDI CAL SUPPLI ES CHARGED TO PATI ENT	71.00	0	29, 863, 834	ADMI NI STRATI VE & GENERAL	5.00	0	2, 619	1.00
2.00	PHYSI CLANS' PRI VATE	192.00	О	84, 800	OPERATION OF PLANT	7.00	о	11, 512	2.00
3.00	OFFICES	0.00	0	0	HOUSEKEEPING	9.00	0	409	3.00
4.00		0.00	0		CENTRAL SERVICES &	14.00	0	87, 085	4.00
5.00		0.00	0	0	SUPPLY PHARMACY	15.00	0	146, 437	5.00
6.00		0.00	0		ADULTS & PEDIATRICS	30.00	0	791, 413	6.00
7.00		0.00	0		INTENSIVE CARE UNIT	31.00	0	330, 339	7.00
8.00 9.00		0.00	0		NURSERY OPERATING ROOM	43.00 50.00	0	1, 443 16, 694, 251	8.00 9.00
10.00		0.00	0		DELIVERY ROOM & LABOR	52.00	0	127, 367	10.00
11.00		0.00	0	0	ROOM RADI OLOGY-DI AGNOSTI C	54.00	0	1, 424, 660	11.00
12.00		0.00	Ö		CT SCAN	57.00	0	70, 389	
13.00 14.00		0.00	0		MRI CARDI AC	58.00 59.00	0	50, 098	
14.00		0.00	0	U	CATHETERI ZATI ON	59.00	0	8, 931, 922	14.00
15. 00 16. 00		0.00 0.00	0			60.00 62.00	0	30, 254	15.00
16.00		0.00	0	U	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	0	65, 214	16.00
17.00		0.00	0		RESPI RATORY THERAPY	65.00	0	128, 678	
18.00 19.00		0.00	0		PHYSICAL THERAPY SPEECH PATHOLOGY	66.00 68.00	0	7, 849 7, 945	
20.00		0.00	Ō	C	ELECTROCARDI OLOGY	69.00	0	303, 984	20.00
21.00		0.00	0	C	ELECTROENCEPHALOGRAPH	70.00	0	5	21.00
22.00		0.00	0		CLINIC	90.00	0	628	
23.00 24.00		0.00	0		RENAL DIALYSIS CARDIAC	74.00 76.97	0	83 383	23.00 24.00
			S S		REHABI LI TATI ON		Ű		
25.00 26.00		0.00	0		CLINIC EMERGENCY	90.00 91.00	0	336, 563 397, 073	25.00 26.00
27.00		0.00	0		OTHER NRCC	192.01	0	377,073	27.00
	TOTALS			29, 948, 634	TOTALS		0	29, 948, 634	
1.00	D - MASSAGE PHYSI CAL THERAPY	66.00	26, 929	5, 498	ADMI NI STRATI VE &	5.00	26, 929	5, 498	1.00
			26, 929	<u> </u>	GENERAL	\vdash \dashv	26, 929		
	E - PHARMACY RESIDENCY		20, 727	3,470			20, 727		
1.00	PARAMED ED PRGM-PHARMACY	23.00	9, 047	16, 519	PHARMACY	15.00	9,047	16, 519	1.00
	RESI DENCY								
	TOTALS F - BENEFITS		9, 047	16, 519	TOTALS		9, 047	16, 519	
1.00	EMPLOYEE BENEFITS	4.00	0	22, 955, 222	ADMI NI STRATI VE &	5.00	0	1, 416, 756	1.00
2.00	DEPARTMENT	0.00	о	C	GENERAL OPERATION OF PLANT	7.00	о	540, 837	2.00
3.00		0.00	0		LAUNDRY & LINEN SERVICE	8.00	0	24, 124	3.00
4.00		0.00	О	C	HOUSEKEEPING	9.00	0	484, 673	4.00
5.00		0.00	О	C	DI ETARY	10.00	0	509, 727	5.00

Provider CCN: 15-0044 Period: Worksheet A-6 From 09/01/2018 Non-CMS Worksheet To 08/31/2019 Date/Time Prepared:

						'		Date/lime Pre <u>9/21/2022 9:4</u>	
		Incre	ases			Decre			
	Cost Center	Line #	Sal ary	Other	Cost Center	Line #	Sal ary	Other	
6.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	6.00
6.00		0.00	0	0	CENTRAL SERVICES & SUPPLY	14.00	0	125, 462	6.00
7.00		0.00	0	0	PHARMACY	15.00	0	927, 386	7.00
8.00		0.00	Ő		MEDI CAL RECORDS &	16.00	Ő	864, 505	8.00
					LI BRARY				
9.00		0.00	0	0	PARAMED ED	23.00	0	48, 107	9.00
					PRGM-PHARMACY				
10.00		0.00			RESI DENCY	20.00		(20(707	10.00
10. 00 11. 00		0.00 0.00	0		ADULTS & PEDIATRICS	30.00 31.00	0	6, 396, 787 816, 893	10. 00 11. 00
12.00		0.00	0		NURSERY	43.00	0	171, 314	12.00
13.00		0.00	0		OPERATI NG ROOM	50.00	o	2, 222, 950	13.00
14.00		0.00	0	0	DELIVERY ROOM & LABOR	52.00	0	317, 561	14.00
					ROOM				
15.00		0.00	0		RADI OLOGY-DI AGNOSTI C	54.00	0	1, 183, 310	15.00
16.00		0.00	0		CT SCAN	57.00	0	167, 483	16.00
17.00 18.00		0.00 0.00	0		MRI CARDI AC	58.00 59.00	0	106, 157 823, 717	17.00 18.00
10.00		0.00	0	0	CATHETERI ZATI ON	57.00	0	025,717	10.00
19.00		0.00	0	0	LABORATORY	60.00	0	1, 113, 704	19.00
20.00		0.00	0	0	RESPI RATORY THERAPY	65.00	О	546, 961	20.00
21.00		0.00	0		PHYSI CAL THERAPY	66.00	0	863, 202	21.00
22.00		0.00	0		SPEECH PATHOLOGY	68.00	0	91, 401	22.00
23.00		0.00	0		ELECTROCARDI OLOGY	69.00	0	482, 200	23.00
24.00		0.00	0	0	ELECTROENCEPHALOGRAPH	70.00	0	15, 032	24.00
25.00		0.00	0	0	HOME HEALTH AGENCY	101.00	0	751, 672	25.00
26.00		0.00	0		CARDI AC	76.97	o	147, 610	26.00
				_	REHABI LI TATI ON		-		
27.00		0.00	0	0	CLINIC	90.00	0	357, 001	27.00
28.00		0.00	0		EMERGENCY	91.00	0	1, 275, 656	28.00
29.00		0.00	0	0	GIFT, FLOWER, COFFEE	190. 00	0	544	29.00
30.00		0.00	0	0	SHOP & CANTEEN RESEARCH	191.00	0	21, 549	30.00
31.00		0.00	0		PHYSI CLANS' PRI VATE	192.00	0	93, 031	31.00
					OFFICES			,	
32.00		0.00	0		OTHER NRCC	192.01	0	4 <u>7, 9</u> 10	32.00
	TOTALS		0	22, 955, 222	TOTALS		0	22, 955, 222	
1.00	G - CAFETERIA RECLASS CAFETERIA	11.00	1, 453, 046	1, 131, 924		10.00	1, 453, 046	1, 131, 924	1.00
1.00	TOTALS	- 11.00	1, 453, 046	1, 131, 924		10.00	1, 453, 046	1, 131, 924	1.00
	H - BLDG & FIXT DEPREC	I ATI ON	.,	.,			.,,	.,	
1.00	CAP REL COSTS-BLDG &	1.00	0	5, 574, 631	ADMINISTRATIVE &	5.00	0	5, 574, 631	1.00
	FIXT				GENERAL				
	TOTALS I - MOVABLE DEPRECIATI		0	5, 574, 631	TOTALS		0	5, 574, 631	
1.00	CAP REL COSTS-MVBLE	2.00	0	5 726 731	ADMI NI STRATI VE &	5.00	0	5, 726, 731	1.00
1.00	EQUI P	2.00	0	5,720,751	GENERAL	5.00	Ŭ	3,720,731	1.00
	TOTALS		0	5, 726, 731			o	5, 726, 731	
	J - IP ANCILLARY COST								
1.00 2.00	I NTENSI VE CARE UNI T NURSERY	31.00 43.00	2, 256, 739 194, 149	549,976 47,447	ADULTS & PEDIATRICS	30.00 0.00	4, 254, 485	1, 039, 439 0	1.00 2.00
3.00	OPERATING ROOM	50.00	205, 905	50, 603		0.00	0	0	3.00
4.00	DELIVERY ROOM & LABOR	52.00	4, 993	1, 220		0.00	0	0	4.00
	ROOM	02.00	1,770	1,220		0.00	Ŭ	0	
5.00	LABORATORY	60.00	11, 545	2, 822		0.00	0	0	5.00
6.00	BLOOD STORING,	63.00	894, 155	219, 400		0.00	0	0	6.00
	PROCESSI NG & TRANS.		50 (01	11.015					
7.00	I NTRAVENOUS THERAPY	64.00	58, 691	14, 345		0.00	0	0	7.00
8.00 9.00	RESPI RATORY THERAPY SPEECH PATHOLOGY	65.00 68.00	4, 606 148, 410	1, 126 36, 269		0.00 0.00	0	0	8.00 9.00
10.00	ELECTROCARDI OLOGY	69.00	13, 182	3, 232		0.00	0	0	10.00
11.00	CLINIC	90.00	677	3, 232		0.00	0	0	11.00
12.00	RENAL DI ALYSI S	74.00	193, 281	47, 239		0.00	ő	0	12.00
13.00	CLINIC	90.00	265, 576	64, 964		0.00	0	0	13.00
14.00	EMERGENCY	91.00	<u> </u>	630		0.00	0	0	14.00
	TOTALS		4, 254, 485	1, 039, 439	TOTALS		4, 254, 485	1, 039, 439	
1.00	L - OP ANCILLARY COST OPERATING ROOM	RECLASS 50.00	273, 180	66 767	ADULTS & PEDIATRICS	30 00	1 705 251	1 160 171	1 00
1.00 2.00	RADI OLOGY-DI AGNOSTI C	50.00	273, 180 89		INTENSIVE CARE UNIT	30.00 31.00	4, 785, 351 4, 125	1, 169, 474 1, 026	1.00 2.00
3.00	LABORATORY	60.00	177	43	UNIT	0.00	4, 125	1, 020	3.00
4.00	BLOOD STORING,	63.00	63, 703	15, 568		0.00	0	0	4.00
	PROCESSING & TRANS.								
5.00	I NTRAVENOUS THERAPY	64.00	4, 424, 280	1, 081, 246		0.00	0	0	5.00

Health Financial Systems BAPTIST HE					ALTH FLOYD In Lieu of Form CMS			2552-10	
RECLASSI FI CATI ONS					Provider CCN: 15-0	1	Period: From 09/01/2018 To 08/31/2019		sheet epared:
		Incre	ases			Decr	eases		
	Cost Center	Line #	Sal ary	0ther	Cost Center	Line #	f Salary	0ther	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
6.00	RESPI RATORY THERAPY	65.00	166	41		0.00	0 0	0	6.00
7.00	PHYSI CAL THERAPY	66.00	105	26		0.00	0 0	0	7.00
8.00	CLINIC	90.00	1, 334	326		0.00	0 0	0	8.00
9.00	EMERGENCY	91.00	26, 442	6, 462		0.00	0	0	9.00
	TOTALS		4, 789, 476	1, 170, 500	TOTALS		4, 789, 476	1, 170, 500	
500.00	Grand Total:		10, 532, 983	95, 302, 717	Grand Total:		10, 532, 983	95, 302, 717	500.00
	Increases				Decreases				

Health Financial Systems	BAPTIST HEALTH FLOYD				In Lieu of Form CMS-2552-10				
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 15-0044			riod: om 09/01/2018 08/31/2019				
			Acqui si ti on	IS					
	Begi nni ng	Purchases	Donati on		Total	Disposals and			
	Bal ances					Retirements			
	1.00	2.00	3.00		4.00	5.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES								
1.00 Land	2, 197, 277	6, 375		0	6, 375	0	1.00		
2.00 Land Improvements	1, 133, 925	-699		0	-699	0	2.00		
3.00 Buildings and Fixtures	133, 336, 194	3, 504, 979		0	3, 504, 979	0	3.00		
4.00 Building Improvements	2, 030, 951	935, 698		0	935, 698	0	4.00		
5.00 Fixed Equipment	545, 884	446, 337		0	446, 337	0	5.00		
6.00 Movable Equipment	33, 649, 172	8, 370, 361		0	8, 370, 361	0	6.00		
7.00 HIT designated Assets	0	0		0	0	0	7.00		
8.00 Subtotal (sum of lines 1-7)	172, 893, 403	13, 263, 051		0	13, 263, 051	0	8.00		
9.00 Reconciling Items	0	0		0	0	0	9.00		
10.00 Total (line 8 minus line 9)	172, 893, 403	13, 263, 051		0	13, 263, 051	0	10.00		
	Endi ng	Ful I y							
	Bal ance	Depreci ated							
		Assets							
	6.00	7.00							
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE									
1.00 Land	2, 203, 652	0					1.00		
2.00 Land Improvements	1, 133, 226	0					2.00		
3.00 Buildings and Fixtures	136, 841, 173	0					3.00		
4.00 Building Improvements	2, 966, 649	0					4.00		
5.00 Fixed Equipment	992, 221	0					5.00		
6.00 Movable Equipment	42, 019, 533	0					6.00		
7.00 HIT designated Assets	0	0					7.00		
8.00 Subtotal (sum of lines 1-7)	186, 156, 454	0					8.00		
9.00 Reconciling Items	0	0					9.00		
10.00 Total (line 8 minus line 9)	186, 156, 454	0					10.00		

^{9/21/2022 9:45} am F: \Final Settlement\150044 08312019\150044.08312019. A1. mcax

Heal th	Financial Systems	BAPTIST HEA	LTH FLOYD		In Lieu of Form CMS-2552-10			
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0044	Period: From 09/01/2018 To 08/31/2019		pared:	
			SL	JMMARY OF CAP	ITAL			
	Cost Center Description	Depreciation	Lease	Interest	I nsurance (see i nstructi ons)	Taxes (see instructions)		
		9.00	10. 00	11.00	12.00	13.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU	MN 2, LINES 1	and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 0	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0 0	2.00	
3.00	Total (sum of lines 1-2)	0	0)	0 0	0	3.00	
		SUMMARY O	F CAPI TAL					
	Cost Center Description	0ther	Total (1)					
		Capi tal -Rel at	(sum of cols.					
		ed Costs (see	9 through 14)					
		instructions)						
		14.00	15.00					
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU	MN 2, LINES 1	and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00	
3.00	Total (sum of lines 1-2)	0	0				3.00	

Health Financial Systems	BAPTIST HEA	LTH FLOYD		In Lieu of Form CMS-2552-1			
RECONCILIATION OF CAPITAL COSTS CENTERS				Period: From 09/01/2018 To 08/31/2019	pared: 5 am		
	COMPUTATION OF RATIOS			ALLOCATION OF	OTHER CAPITAL		
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance		
		Leases	for Ratio	instructions)			
			(col. 1 - col. 2)				
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS C							
1.00 CAP REL COSTS-BLDG & FIXT	144, 136, 921		144, 136, 92		0	1.00	
2.00 CAP REL COSTS-MVBLE EQUIP	42, 019, 533		42, 019, 53		0	2.00	
3.00 Total (sum of lines 1-2)	186, 156, 454		186, 156, 45			3.00	
	ALLOCA	SUMMARY O	F CAPITAL				
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease		
		Capital-Relat					
		ed Costs	through 7)				
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS C 1.00 CAP REL COSTS-BLDG & FIXT	ENTERS	0		0 5, 574, 631	0	1.00	
2.00 CAP REL COSTS-BEDG & FIXT	0			0 5, 574, 631 0 5, 726, 731	0	2.00	
3.00 Total (sum of lines 1-2)	0			0 11, 301, 362	0	3.00	
		รเ	JMMARY OF CAPI		0	0.00	
Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)		
cost center bescription	interest	(see	i nstructi ons)				
		instructions)		ed Costs (see			
				instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS C							
1.00 CAP REL COSTS-BLDG & FIXT	0	0		0 0	5, 574, 631	1.00	
2.00 CAP REL COSTS-MVBLE EQUI P	0	0		0 0	5, 726, 731	2.00	
3.00 Total (sum of lines 1-2)	0	0	1	0 0	11, 301, 362	3.00	

Health Financial Systems

JUSTMENTS TO EXPENSES			Fi	eriod: rom 09/01/2018	Worksheet A-8	
			То	08/31/2019	Date/Time Pre 9/21/2022 9:4	
			Expense Classification on To/From Which the Amount is			
Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
cost center bescription	(2)				Ref.	
00 Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FLXT	4.00	5.00	1. (
COSTS-BLDG & FIXT (chapter 2)		-			-	
0 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.
0 Investment income - other (chapter 2)		0		0.00	0	3.
0 Trade, quantity, and time		0		0.00	0	4.(
discounts (chapter 8) 0 Refunds and rebates of		0		0.00	0	5.0
expenses (chapter 8)		0		0.00	0	
0 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6. (
0 Telephone services (pay stations excluded) (chapter 21)	A	-557, 232	ADMI NI STRATI VE & GENERAL	5.00	0	7.
0 Television and radio service	A	-130, 039	ADMI NI STRATI VE & GENERAL	5.00	0	8.
(chapter 21) 0 Parking lot (chapter 21)		0		0.00	0	9.
00 Provi der-based physi ci an adjustment	A-8-2	-4,073,768			0	10.
00 Sale of scrap, waste, etc.		0		0.00	0	11.
(chapter 23) D0 Related organization	A-8-1	7, 742, 859			0	12.
transactions (chapter 10)		0		0.00	0	
00 Laundry and linen service 00 Cafeteria-employees and guests	В	-1, 576, 637	DI ETARY	10.00	0	13. 14.
00 Rental of quarters to employee and others		0		0.00	0	15.
00 Sale of medical and surgical supplies to other than		0		0.00	0	16.
patients 00 Sale of drugs to other than		0		0.00	0	17.
patients 00 Sale of medical records and	В	0	MEDICAL RECORDS & LIBRARY	16.00	0	18.
abstracts	D	0	MEDICAL RECORDS & LIDRART			
00 Nursing and allied health education (tuition, fees,		0		0.00	0	19.
books, etc.)				0.00		
00 Vending machines 00 Income from imposition of		0 0		0.00 0.00	0 0	20. 21.
interest, finance or penalty charges (chapter 21)						
00 Interest expense on Medicare		0		0.00	0	22.
overpayments and borrowings to repay Medicare overpayments						
00 Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23.
therapy costs in excess of limitation (chapter 14)						
00 Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24.
limitation (chapter 14)						
00 Utilization review - physicians' compensation		0	UTILIZATION REVIEW-SNF	114.00		25.
(chapter 21)				1.00		~ (
00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	
00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.
00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28. (
00 Physicians' assistant 00 Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0.00 67.00	0	29. (30. (
therapy costs in excess of		0		37.00		55.0
<pre>limitation (chapter 14) 99 Hospice (non-distinct) (see</pre>	А	948, 063	ADULTS & PEDIATRICS	30.00		30. 9
i nstructi ons)		.,	-			

Heal th	Fi nan	ci al	l Systems
AD JUST	MENTS	TO	EXPENSES

	Financial Systems		BAPIISI HEA			u of Form CMS-2	
ADJUSI	MENTS TO EXPENSES				eriod: .om 09/01/2018	Worksheet A-8	
				To			pared:
						9/21/2022 9:4	5 am
				Expense Classification on			
				To/From Which the Amount is 1	to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
	cost center bescription	(2)	Allount	cost center		Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech	A-8-3		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	PERSONAL USE OF CAR DEPR	А		CAP REL COSTS-MVBLE EQUIP	2.00	9	33.00
33.01	PERSONAL USE OF CARE GAS	А	0	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	EMPLOYEE BENEFITS - MISC	В		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.02
	REVENUE						
33.03	A & G - MISC REVENUE	В	-298, 833	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	PLANT OPERATIONS - MISC	В	0	OPERATION OF PLANT	7.00	0	33.04
	REVENUE						
33.05	DIETARY - MISC REVENUE	В		DI ETARY	10.00	0	
33.06	CENTRAL SUPPLY - MISC REVENUE	В		CENTRAL SERVICES & SUPPLY	14.00	0	33.06
33.07	PHARMACY - MISC REVENUE	В		PHARMACY	15.00	0	
33.08	ADULTS AND PEDS - MISC REVENUE	В		ADULTS & PEDIATRICS	30.00	0	
33.09	SURGERY - MISC REVENUE	В	-	OPERATI NG ROOM	50.00	0	
33.10	LABOR AND DELIVERY - MISC	В	-2, 766	DELIVERY ROOM & LABOR ROOM	52.00	0	33.10
~~	REVENUE	5	0.700		54.00		
33.11	RADI OLOGY - MI SC REVENUE	В		RADI OLOGY-DI AGNOSTI C	54.00	0	
33.12	CARDIAC CATH - MISC REVENUE	В		CARDI AC CATHETERI ZATI ON	59.00	0	33.12
33.13	LABORATORY - MISC REVENUE	В			60.00	0	
33.14	IV THERAPY - MISC REVENUE	В		INTRAVENOUS THERAPY	64.00	0	
33.15	PHYSICAL THERAPY - MISC	В	0	PHYSI CAL THERAPY	66.00	0	33.15
33. 16	REVENUE SPEECH THERAPY - MISC REVENUE	В		SPEECH PATHOLOGY	68.00	o	33.16
33.10	CARDI OLOGY - MI SC REVENUE	В		ELECTROCARDI OLOGY	69.00	0	
33.17	CARDI OLOGT - MI SC REVENUE	В		CARDI AC REHABI LI TATI ON	76.97	0	
33.18	EMERGENCY DEPT - MISC REVENUE	B		EMERGENCY	91.00	0	
33. 20	INTEREST INCOME	В		CAP REL COSTS-BLDG & FIXT	1.00	11	1
33.20	LOBBYING DUES	A		ADMI NI STRATI VE & GENERAL	5.00	0	1
33. 22	EMPLOYEE BENEFITS -	A		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	
55. 22	ADVERTI SI NG	A	175	EWI EOTEE DENETTIS DELARTMENT	4.00	0	00.22
33. 23	ADMIN - ADVERTISING	А	-352, 156	ADMI NI STRATI VE & GENERAL	5.00	0	33.23
33.24	PHYSICAL THERAPY - ADVERTISING			PHYSICAL THERAPY	66.00	n	33.24
33.25		A		CLINIC	90.00	0	
33.26	ER- ADVERTI SI NG	A		EMERGENCY	91.00	0	
	EMPLOYEE BENEFITS - NON	A		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	
	ALLOWABLE EX					-	
33. 28	ADMIN - NONALLOWABLE EXPENSES	А	-41, 190	ADMI NI STRATI VE & GENERAL	5.00	0	33.28
33.29	HAF FEE - HOSPITAL	А		ADMI NI STRATI VE & GENERAL	5.00	0	
33.30	BAD DEBT EXPENSE	А		ADMI NI STRATI VE & GENERAL	5.00	0	
33.31	AMORTIZATION OF GOODWILL	А		ADMI NI STRATI VE & GENERAL	5.00	0	
33.32	ADVERTI SI NG-HHA	А		HOME HEALTH AGENCY	101.00	0	1
50.00	TOTAL (sum of lines 1 thru 49)		-23, 252, 284				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

(2) Basis for adjustment (see instructions).

(2) basis for adjustment (see first detroits).
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	BAPTI ST HE	ALTH FLOYD	eu of Form CMS-	2552-10				
	TATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 15-0044 Period: W								
OFFICE	To 08/31/2019 Date/Time Pre 9/21/2022 9:4								
	Line 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 OF	R CLAIMED HOME				
	OFFICE COSTS:								
1.00	16.00	MEDICAL RECORDS & LIBRARY		2, 855, 107	0	1.00			
2.00	5.00	ADMINISTRATIVE & GENERAL		44, 281, 907	38, 477, 748	2.00			
3.00	71.00	MEDICAL SUPPLIES CHARGED TO		-916, 407	0	3.00			
4.00	0.00			0	0	4.00			
5.00	TOTALS (sum of lines 1-4).			38, 477, 748	5.00				
	Transfer column 6, line 5 to								
	Worksheet A-8, column 2,								
	line 12.								

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 not been posted to Worksheet A columns 1 and/or 2 the amount allowable should be indicated in column 4 of this par

	nas not	been posted to worksheet A,	corumns r and/or 2,	the amount an	lowable sho	build be indicated in co	brumn 4 of this part				
					R	Related Organization(s)	and/or Home Office				
		Symbol (1)	Name	Perce	entage of	Name	Percentage of				
				Owr	nershi p		Ownershi p				
1		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	В	BHSI	100.00	BHSI	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				1	100.00
	non-financial) specify:				1	[

(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

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

Health Financial Systems BAPTIST HEALTH FLOYD In	In Lieu of Form CMS-2552-10			
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 15-0044 Period:	Worksheet A-8-1			
From 09/01/	2018			
To 08/310	2019 Date/Time Prepared:			

			9/21/20	22 9:45 am
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTI	MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	HOME
	OFFICE COSTS:			
1.00	2, 855, 107	0		1.00
2.00	5, 804, 159	0		2.00
3.00	-916, 407	0		3.00
4.00	0	0		4.00
5.00	7, 742, 859			5.00

* 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

nas not	been posted to worksheet A,		Ζ, ι	ne anount	arrowabre	Shourd be	- murcateu	i this part.	
	Related Organization(s)								
	and/or Home Office								
	Type of Business]							
	6.00	1							
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION	(S) AN	D/OR HOME	OFFLCE:				

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 XV/II

	sement under title XVIII.	
6.00	HEALTHCARE	6.00
7.00		7.00
8.00 9.00		8.00
9.00		9.00
10. 00 100. 00		10.00
100.00		100.00

(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 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.

Heal th	Financial Syste	ems	BAPTIST HE	ALTH FLOYD		In Lie	eu of Form CMS-	2552-10
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provider (Period:	Worksheet A-8	3-2
						From 09/01/2018		
						To 08/31/2019		
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	9/21/2022 9: 4 Physi ci an/Prov	
	WKSL A LINE #	I denti fi er	Remuneration	Component	Component	KCL AMOUNT	ider Component	
		ruentirrei	Remarker at ron	component	component		Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADULTS & PEDIATRICS	730, 038				456	1.00
2.00		OPERATING ROOM	1, 708, 323			246, 400	430	2.00
3.00		DELIVERY ROOM & LABOR ROOM	20,000			237, 100		3.00
4.00		RADI OLOGY-DI AGNOSTI C	181, 100			271,900	0	4.00
5.00		CARDI AC CATHETERI ZATI ON	60, 853			246,400	0	5.00
6.00		LABORATORY	97, 881			240, 400	0	6.00
7.00		ELECTROENCEPHALOGRAPHY	1, 049, 378			179,000	0	7.00
8.00		CLINIC	203, 895				588	8.00
9.00		EMERGENCY	148, 288				420	
10.00	0.00		140, 200			0	420	10.00
200.00	0.00		4, 199, 756	U U				200.00
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	200.00
	WKSL A LINE #	I denti fi er	Limit	Unadjusted RCE			of Malpractice	
		Tuentinei			Continuing	Share of col.	Insurance	
					Education	12	i fisul ance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADULTS & PEDIATRICS	39, 242			0 0		1.00
2.00		OPERATI NG ROOM	0,212	0				2.00
3.00		DELIVERY ROOM & LABOR ROOM		-			0	3.00
4.00		RADI OLOGY-DI AGNOSTI C		0			0	4.00
5.00		CARDI AC CATHETERI ZATI ON		0	(0	5.00
6.00		LABORATORY		0	(0	6.00
7.00		ELECTROENCEPHALOGRAPHY		0			0	7.00
8.00		CLINIC	50, 602	2, 530			0	8.00
9.00		EMERGENCY	36, 144				0	9.00
10.00	0.00		30, 144	1,007	(-	0	10.00
200.00	0.00		125, 988	U U				200.00
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
	WRSt. A LINC #	I denti fi er	Component	Limit	Di sal l owance	Adjustment		
			Share of col.	2	brourronanoo			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0		195, 358			1.00
2.00		OPERATING ROOM	0			1, 708, 323		2.00
3.00		DELIVERY ROOM & LABOR ROOM	0	0		20,000		3.00
4.00		RADI OLOGY-DI AGNOSTI C	0	0	(4.00
5.00		CARDI AC CATHETERI ZATI ON	0	0		60, 853		5.00
6.00		LABORATORY	0	0		97, 881		6.00
7.00		ELECTROENCEPHALOGRAPHY	0	0		1, 049, 378		7.00
8.00		CLINIC		50, 602	36, 398			8.00
9.00		EMERGENCY						9.00
10.00	0.00			00,144	10,27			10.00
200.00	1			125, 988	248, 050	4, 073, 768		200.00
200.00	1	1		.20,700	2.0,000	1, 0, 0, 700	I I	

Cost Center Description Cost Final Relation Costs Cost Service Costs Cost Service Costs Service Service Serv	Health Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS	BAPTI ST HEA	LTH FLOYD Provider C		eriod: com 09/01/2018	Date/Time Pre	pared:
Inc. Cost (1) Inc. Cos			CAPI TAL REL	ATED COSTS		972172022 9:4	
Inc. Cost (1) Inc. Cos							
Odd 7.0 2.00 4.00 4.00 0.00 07100 CAP FEL ODTS-AUDA A FIXT 5.174, 631 5.774, 731 1.00 0.00 07000 CAP FEL ODTS-AUDA A FIXT 2.499, 931 122, 948 6.73 25, 563, 552 4.00 0.00 00000 CAUSE LEED TTS BERNETHINT 25, 439, 931 122, 948 6.73 25, 563, 552 4.00 0.00 00000 CAUSE LEED TTS BERNETHINT 25, 439, 931 122, 948 7, 92 7, 565, 512, 665 7, 90 7, 90, 77, 92 7, 556, 512, 965 7, 90 7, 90, 77, 92 7, 515 1, 1, 1, 15, 999 8, 00 7, 90 0, 00 0, 00 7, 90 1, 1, 1, 15, 999 9, 00 0, 00 0, 00 1, 1, 1, 1, 15, 999 9, 00 1, 1, 1, 15, 999 1, 1, 1, 15, 199 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1	Cost Center Description	for Cost Allocation	BLDG & FIXT	MVBLE EQUIP	BENEFI TS	Subtotal	
DEFERSE CHERAL SERVICE COST CHTRES 1 0 00000 CLE RTL COST SWB F TOUTP NO B & FLXT 5, 574, 631 5, 774, 731 25, 563, 535 2, 00 0 00000 CLE RTL COST SWB F TOUTP NO B & FLXT 5, 774, 731 27, 563, 535 54, 644, 698 500 0 00000 CLE RTL COST SWB F TOUTP NOT 7, 663, 774, 731 27, 563, 535 54, 644, 698 500 0 00000 CLE RTL COST SWB F TOUTP NOT 7, 663, 774, 731 21, 503, 535 54, 644, 698 500 0 000000 CLE RTL COST SWB F TOUTP NOT 7, 663, 774, 731 21, 503, 535 54, 644, 698 500 0 000000 CLE RETTERS 0 07, 799 56, 64, 454 56, 664, 454 56, 664, 454 57, 574, 731 73, 575 11, 735, 797 66, 737, 731 75, 564, 733 75, 754, 731 75, 754, 731 75, 754, 731 75, 754, 731 75, 754, 731 75, 754, 731 75, 754, 731 75, 754, 731 75, 754, 731 75, 754, 731 75, 754, 731 75, 754, 731 75, 754, 731 75, 754, 731 75, 754, 731 75, 754, 731 75, 754, 731 75, 754, 731 75, 754, 7		col. 7)					
1.00 DOTION GAP FELL DOSTS-BUDG & FIAT 5, 574, 631 5, 726, 731 1.00 0.00 DOSTOR GAP FELL DOSTS-BUDG & FIAT 5, 726, 731 5, 726, 731 25, 563, 555 20 6 0.00 DOSTOR GAP FELL DOSTS-BUDG & FIAT 5, 726, 731 5, 726, 731 25, 563, 555 560, 70 0 6 0<	CENEDAL SEDVICE COST CENTEDS	0	1.00	2.00	4.00	4A	
2.00 DOUDD CAP ELL CORSTS-WINE LEDUP 5, 726, 731 5, 726, 731 5, 726, 731 5, 726, 731 2, 853, 853 5.00 DEDGO ADM MI STRUTY E METTEL TO HAVEL 56, 977, 653 729, 730 44, 817 2, 8, 83, 857 5.00 DEDGO ADM MI STRUTY E A CIPE FAUL 56, 977, 653 729, 730 44, 817 7, 97, 755 1, 105, 798, 460 700 0.00 DEDGO ADM MI STRUTY E METTEL TO TO PART 7, 63, 111 1, 279 72, 755 1, 105, 799 80, 07, 733, 799 564, 663 3, 284, 429 90 0.00 DEDGO LAMBERY & LINEW SERVICE 997, 1093 10, 60 977, 605, 610 1105, 713, 729 564, 663 1105, 713, 729 110, 60 110000 11000 11000 <td></td> <td>5 574 631</td> <td>5 574 631</td> <td></td> <td></td> <td></td> <td>1 00</td>		5 574 631	5 574 631				1 00
5.00 DENDROM JURNIN INTENSIVE A GIVE MAIL 56, 97, 63, 141 27, 64, 81, 51, 24, 40, 97, 71 66, 00 70, 00 00, 70, 00, 00, 00, 00, 00, 71, 72, 73 70, 63, 141 85, 91, 24, 40, 97, 71 70, 63, 74, 71 70, 70, 00, 00, 71, 74, 72 70, 70, 00, 00, 71, 74 70, 70, 70, 70, 70, 70, 70 70, 70, 70, 70, 70, 70 70, 70, 70, 70, 70, 70 70, 70, 70, 70, 70, 70, 70 70, 70, 70, 70, 70, 70 70, 70, 70, 70, 70, 70 70, 70, 70, 70, 70, 70 70, 70, 70, 70, 70 70, 70, 70, 70, 70, 70 70, 70, 70, 70, 70 70, 70, 70, 70, 70, 70 70, 70, 70, 70, 70 70, 70, 70, 70, 70 70, 70, 70, 70, 70, 70 70, 70, 70, 70, 70, 70, 70 70, 70, 70, 70, 70, 70, 70, 70, 70, 70,							
0.000 DOROD (M.NITEMORE & REPAIRS 0 <t< td=""><td>4.00 00400 EMPLOYEE BENEFITS DEPARTMENT</td><td>25, 439, 931</td><td>122, 948</td><td>673</td><td>25, 563, 552</td><td></td><td>4.00</td></t<>	4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	25, 439, 931	122, 948	673	25, 563, 552		4.00
7.00 DOTOD (DEFEAT ION OF PLANT 7. 6.63. 141 B3. 613 2. 409. 971 C.63. 965 10. 76.396 7. 70 0.00 DOBOD (DEFEAT ION OF PLANT 2. 771, 77 20. 042 5. 744 52. 759 773, 77 20. 042 5. 744 52. 744, 783 3. 944, 784, 784, 784, 78		56, 977, 653					
8.00 DOBCOD LANGENY & LINEN SERVICE 997, 894 79, 311 1, 279 27, 515 1, 105, 999 8, 20 9.00 DOSCOLUSERLEPIN 457, 029 30, 665 56, 454 03, 107 10.00 10.00 DETANY 457, 029 30, 665 56, 454 03, 109 10.00 10.00 DISING (METENANCE OF PERSONNEL 2.514, 171 20 0130 0130, 101, 100 10.00 1370, 005 1370, 100 1370, 005 1370, 100 1370, 001 13		7 662 141	-	-	-	-	1
9.00 00000 PULSEKCEP NIG 2, 721, 771 20, 0.43 5, 740 26, 645 3, 204, 422 9, 00 10, 00 0000 PETATY - 447, 702 9, 30, 658 5, 645 266, 61 -103, 710 10, 00 10, 00 CFTERIA - 25, 514, 970 173, 916 0, 939, 054 3, 155, 940 11, 00 10, 00 CFTERIA - 25, 1581 110 - 0 0 0 0 0, 2300 00 10, 00 CENTRAL SERVICES A SUPPLY 1, 10, 33, 909 107, 545 23, 153 140, 548 1, 395, 158 14, 00 0, 1000 CENTRAL SERVICES A SUPPLY - 2, 22, 209 40, 0, 668 171, 277 1, 0, 31, 927 3, 546, 06, 01 17, 00 0, 1700 0, 01, 000 CENTRAL SERVICES A SUPPLY - 2, 24, 270 0, 40, 0, 668 171, 277 1, 0, 31, 927 3, 546, 06, 01 17, 00 0, 00 0, 01, 400 CENTRAL SERVICES A SUPPLY - 2, 24, 370 5, 526, 520 - 0 0 0 0 0 0 0, 0 0, 01, 00 0, 000 CENTRAL SERVICES - 19, 196, 192 1, 775, 656 422, 221 4, 642, 222 4, 642, 643 10, 77, 00 0 0 0 0 0 0 0, 32, 00 0, 33, 00 0, 1011 NTNN VF CARF UNIT 0 0 0 0 0 0 0, 0, 34, 00 0, 32, 00 0, 3300 0, 1011 NTNN VF CARF UNIT 0 0 0 0 0 0, 0, 0, 34, 00 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0,							
10.00 01000 DETRY -477.29 30.658 56.454 266.10 -103.107 10.00 12.00 01220 MATERARCE OF PERSONNEL 0<							1
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13. 00 13.00 <t< td=""><td></td><td>2, 584, 970</td><td>173, 916</td><td>0</td><td>397, 054</td><td>3, 155, 940</td><td></td></t<>		2, 584, 970	173, 916	0	397, 054	3, 155, 940	
14.00 01400 CENTRAL SERVICES & SUPPLY 1.033,909 197,645 23,18 140,548 1,395,185 14.00 15.00 01500 NEECONDS & LIBRARY 6.549,170 88,909 13.01 91,897 7,620,116 16.00 23.00 OZ300 PARAMECY RESIDENCY 23.4,370 5,623 4,862 221 44.06,355 0.01 17.00 170,06 170,06 170,06 170,06 170,06 170,06 170,06 170,06 170,06 170,07 175,656 452,221 44.06,22,38 26,106,555 0.00 23.00 020,000 00 0 <t< td=""><td></td><td>0</td><td>0</td><td>0</td><td>0</td><td></td><td>1</td></t<>		0	0	0	0		1
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16. 00 01400 UEDICAL RECORDS & LIBRARY 6. 549, 170 88, 090 14.0 061, 877 7, 620, 116 16. 00 23. 00 02300 ARAMED ID PROX-PHARMACY RESIDENCY 234, 370 5, 623 4, 842 56, 290 301, 125 23.0 IMPATITAL INDUITINE SUPPORT 200, 03000 AULTS & WEDIATRIC COST CENES 10, 106, 192 1, 775, 666 452, 221 4, 662, 264 26, 106, 355 30, 00 40, 00 40, 00 40, 00 40, 00 40, 00 40, 00 40, 00 40, 00 40, 00 40, 00 42, 00 42, 00 42, 00 44, 00 40, 00 42, 00 44, 00 44, 00 44, 00 44, 00 44, 00 44, 00 44, 00							1
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32.00 03200 (COROMARY CARE UNIT 0 0 0 32.00 33.00 33.00 03300 (BAR) INTENSIVE CARE UNIT 0 0 0 33.00 34.00 03400 (SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 34.00 04.00 04000 (SURGICAL INTENSIVE CARE UNIT 0							
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34. 00 03400 SURGICAL INTENSIVE CARE UNIT 0 <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>-</td> <td></td>		0	0	0	0	-	
40.00 40000 SUBPROVIDER - IPF 0 0 0 0 <td></td> <td></td> <td></td> <td>0</td> <td>0</td> <td>-</td> <td></td>				0	0	-	
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45: 00 00 0 0 0 0 45: 00 46: 00 04600 01 0 0 0 0 0 46: 00 ANCI LLARY SERVICE COST CENTERS		992, 499	46, 654	10, 916	253, 665		
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50. 00 050000 0FEATI INC. ROM 15. 393. 175 526. 70 997. 107 2. 643. 492 19. 560. 344 50. 00 51. 00 051000 DECOVERY ROOM 1. 498. 263 314. 531 14. 358 363. 843 2. 190. 995 52. 00 53. 00 DS3000 DARSTHESI DLOGY 0 0 0 0 53. 00 54. 00 DAMESTHESI DLOGY 0 0 0 0 0 53. 00 55. 00 DS500 RADI OLGGY-THERAPEUTI C 7. 140, 275 345. 214 719. 717 1. 316. 771 9. 521. 977 54. 00 56. 00 DS500 RADI OLSTOPE 0 0 0 0 55. 00 57. 00 0 0 0 57. 00 50			0	0	0	0	40.00
52.00 05200 DELIVERY ROM & LABOR ROM 1,498,263 314,531 14,358 363,843 2,190,995 52.00 05300 05300 NST 53.00 53.00 53.00 53.00 53.00 53.00 0 0 0 53.00 53.00 0 53.00 53.00 0 0 0 0 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 55.00 56.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 5	50. 00 05000 OPERATI NG ROOM	15, 393, 175	526, 570	997, 107	2, 643, 492	19, 560, 344	50.00
53. 00 OS300 ARSTHESIOLOGY 0 0 53. 00 54. 00 54. 00 55. 00 56. 00 56. 00 56. 00 56. 00 60. 01 60. 01 60. 01 60. 01 60. 01 66. 00		0	0	0	0		
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56 00 00 0 0 0 0 0 0 0 0 0 0 0 56.00 57.00 55.00 CTSCAN 1,208,905 43,539 1,686 188,269 1,412,399 57.00 59.00 05900 CARDIAC CATHETERIZATION 3,773,249 136,362 166,105 921,718 4,997,434 59.00 60.01 60.01 60.01 Labord LABORATORY 11,258,197 21,887 23,357 1,267,926 12,762,367 60.00 60.01 61.00 62.00 62.00 60.01 60.01 60.01 65.00 60.01 65.00 60.01 65.00 60.01 65.00 60.01 65.00 60.01 65.00 6		7, 140, 273	0	, 1, , , , , , , , , , , , , , , , , ,	1, 310, 771		
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59:00 05900 CARDI AC CATHETERI ZATI ON 3, 773, 249 136, 362 166, 105 921, 718 4, 997, 434 59:00 60:00 DABORATORY 11, 258, 197 212, 887 23, 357 1, 267, 926 12, 762, 367 60:00 60:01 BLOOD LABORATORY 0 0 0 0 0 60:01 0		1, 208, 905	43, 539	1, 686	188, 269		57.00
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60.01 66.001 BLOOD LABORATORY 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
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Health Financial Systems	BAPTIST HEA	LTH FLOYD		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO	CN: 15-0044	Period: From 09/01/2018 To 08/31/2019	Worksheet B Part I Date/Time Pre 9/21/2022 9:4	epared:
		CAPI TAL REL	ATED COSTS		772172022 7	
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	BENEFI TS DEPARTMENT	Subtotal	
	0	1.00	2.00	4.00	4A	
95.00 09500 AMBULANCE SERVICES 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 99.00 09900 CMHC 99.10 09910 CORF 100.00 I & SERVICES-NOT APPRVD PRGM		0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		96.00 97.00 99.00
101.00 10100 HOME HEALTH AGENCY	3, 939, 489	0		0 818, 547	4, 758, 036	
SPECIAL PURPOSE COST CENTERS	0,707,107			0 010, 017	1, 700, 000	101.00
105. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 10600 HEART ACQUI SI TI ON 107. 00 10700 LI VER ACQUI SI TI ON 108. 00 10800 LUNG ACQUI SI TI ON	0 0 0 0	0 0 0 0		0 0 0 0 0 0 0 0 0 0	0	105.00 106.00 107.00 108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0		0 0	0	109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON 111. 00 11100 I SLET ACQUI SI TI ON 113. 00 11300 I NTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF	0	0 0		0 0 0 0		110. 00 111. 00 113. 00 114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0		115.00
116. 00 11600 HOSPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	258, 985, 483	5, 460, 857	5, 562, 43	25, 389, 714	258, 533, 575	118.00
NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	116, 562	0		0 1, 850	118, 412	
191.00 19100 RESEARCH	89, 772	0		0 24, 436	114, 208	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 01 19201 OTHER NRCC	422, 914 4, 196, 374	39, 516 55, 742		0 102, 510 6 45, 042	564, 940 4, 461, 454	
192. 01 19201 01HER NRCC 192. 02 19202 LTC	4, 196, 374	55, 742	164, 29	45,042		192.01
192. 02 19202 LTC 193. 00 19300 NONPALD WORKERS	0	0				192.02
194. 00 07950 MARKETI NG	0	18, 516				194.00
200.00 Cross Foot Adjustments		10, 510		0		200.00
201.00 Negative Cost Centers		0		0 0		200.00
202.00 TOTAL (sum lines 118 through 201)	263, 811, 105	5, 574, 631	5, 726, 73	25, 563, 552	263, 811, 105	202.00

COST A	Financial Systems ALLOCATION - GENERAL SERVICE COSTS	BAPTI ST HEA			eriod: rom 09/01/2018	u of Form CMS-2 Worksheet B Part I Date/Time Pre	
	Cost Contor Description					9/21/2022 9:4	5 am
	Cost Center Description	ADMI NI STRATI V <u>E & GENERAL</u> 5. 00	REPAIRS 6.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPI NG 9.00	
	GENERAL SERVICE COST CENTERS	5.00	0.00	7.00	8.00	9.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMI NI STRATI VE & GENERAL	58, 624, 698					4.00 5.00
6.00	00600 MAINTENANCE & REPAIRS	00,021,070	C				6.00
7.00	00700 OPERATION OF PLANT	3, 079, 509	C				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	315, 841	C			4 959 999	8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	940, 793	C	01,702	68, 998 70, 964	4, 358, 999 26, 874	9.00 10.00
11.00	01100 CAFETERI A	901, 245	C		0	152, 449	
12.00	01200 MAINTENANCE OF PERSONNEL	0	C	0	0	0	12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	C		0	0	13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	398, 424 1, 560, 935		539, 932 111, 153		173, 163 35, 648	
16.00	01600 MEDICAL RECORDS & LIBRARY	2, 176, 084	C			77, 935	
17.00	01700 SOCI AL SERVI CE	0	C	0	0	0	
23.00	02300 PARAMED ED PRGM-PHARMACY RESIDENCY	85, 993	C	15, 368	106	4, 929	23.00
20 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	7, 455, 184	C	1 052 004	002 005	1 664 400	20.00
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	7, 455, 184 2, 373, 765				1, 556, 489 140, 319	
32.00	03200 CORONARY CARE UNIT	2, 373, 703	C			0	
33.00	03300 BURN INTENSIVE CARE UNIT	0	C	0	0	0	33.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	C	0	0	0	34.00
40.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	0	C	0	0	0	40.00
41.00 42.00	04200 SUBPROVIDER - TRF	0		0	0	0	41.00
43.00	04300 NURSERY	372, 309	C	127, 514	23, 320	40, 895	
44.00	04400 SKILLED NURSING FACILITY	0	C		0	0	44.00
45.00	04500 NURSING FACILITY	0	C		0	0	
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	C	0	0	0	46.00
50.00	05000 OPERATING ROOM	5, 585, 867	C	1, 439, 223	179, 673	461, 576	50. OC
51.00	05100 RECOVERY ROOM	0	C	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	625, 685	C		0	275, 709	
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 2, 719, 200	C	0 943, 540	0 89, 289	0 302, 604	53.00 54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	2, 719, 200		0 943, 540	07,207	0	55.00
56.00	05600 RADI OI SOTOPE	0	C	0	0	0	56.00
57.00	05700 CT SCAN	411, 907	C			38, 165	
58.00		231, 389	C	,		17, 463	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	1, 427, 122 3, 644, 562				119, 531 186, 610	
60.01	06001 BLOOD LABORATORY	0,011,002	C	0 0	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	18, 727	C	0	0	0	
63.00 64.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	415, 382			0	0	
65.00	06500 RESPI RATORY THERAPY	1, 897, 413 1, 032, 951		78, 529	0	25, 185	
66.00	06600 PHYSI CAL THERAPY	1, 471, 104	C	10, 764		3, 452	
67.00	06700 OCCUPATI ONAL THERAPY	0	C	0	0	0	
68.00	06800 SPEECH PATHOLOGY	215, 066	C	19,044	14, 495	6, 108	
69.00 70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	850, 495 197, 303		299, 708 236, 481	0	96, 120 75, 842	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 688, 421		0 230, 481	0	0	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	4, 578, 124	C	o o	0	0	1
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 341, 765	C	0	0	0	
74.00	07400 RENAL DI ALYSI S	83, 862	C	0	0	0	
75.00 76.00	07500 ASC (NON-DI STINCT PART) 03950 NUTRI TI ON/DI ABETES	0				0	75.00 76.00
	07697 CARDI AC REHABI LI TATI ON	255, 744	C	-	0	38, 165	•
	OUTPATIENT SERVICE COST CENTERS		-	1			
88.00	08800 RURAL HEALTH CLINIC	0	C	-		0	
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0 1, 065, 136		0 302, 292	-	0 96, 949	89.00 90.00
90.00	09100 EMERGENCY	2, 341, 525					90.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	_, 5 , 520			2, .00		92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DI ALYSI S	0	C	0	0	0	
95.00 96.00	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED	0				0	
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	C	0	0	0	
	09900 CMHC	0	C	0	0	0	
	09910 CORF	1		0			99.10

Health Financial Systems	BAPTI ST HEAL	TH FLOYD		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period:	Worksheet B	
				rom 09/01/2018		
				To 08/31/2019	Date/Time Pre 9/21/2022 9:4	
Cost Center Description	ADMI NI STRATI V		OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
cost center bescription	E & GENERAL	REPAIRS	PLANT	LINEN SERVICE	HOUSEKEEFING	
	5.00	6.00	7.00	8.00	9,00	
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0	(100.00
101.00 10100 HOME HEALTH AGENCY	1, 358, 757	0	(0	0	101.00
SPECIAL PURPOSE COST CENTERS				·		
105.00 10500 KI DNEY ACQUI SI TI ON	0	0	(0 0	0	105.00
106.00 10600 HEART ACQUI SI TI ON	0	0	(0 0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0	(0 0	0	107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0	(0 0	0	108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0	(0 0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	(0 0	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	(0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	(0 0		115.00
116. 00 11600 H0SPI CE	0	0	(0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 57, 117, 589	0	13, 552, 230	1, 638, 614	4, 259, 267	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	33, 815	0	(0 0		190.00
191. 00 19100 RESEARCH	32, 614	0	(0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	161, 330	0	108, 006		34, 639	
192.01 19201 OTHER NRCC	1, 274, 062	0	152, 355	5 0	48, 862	•
192.02 19202 LTC	0	0	(0 0		192.02
193.00 19300 NONPALD WORKERS	0	0	(0 0		193.00
194.00 07950 MARKETI NG	5, 288	0	50, 608	3 0	16, 231	•
200.00 Cross Foot Adjustments		_			_	200.00
201.00 Negative Cost Centers	0	0	(0		201.00
202.00 TOTAL (sum lines 118 through 201)	58, 624, 698	0	13, 863, 199	1, 638, 614	4, 358, 999	202.00

Heal th	Financial Systems	BAPTI ST HEA	LTH FLOYD		In Lie	u of Form CMS-2	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 09/01/2018 To 08/31/2019	Date/Time Pre	pared:
	Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI O N	9/21/2022 9: 4 CENTRAL SERVI CES & SUPPLY	<u>s am</u>
		10.00	11.00	12.00	13.00	14.00	
1.00 2.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00 5.00 6.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS						4.00 5.00 6.00
7.00 8.00 9.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						7.00 8.00 9.00
10.00	01000 DI ETARY	78, 526	4 (04 001				10.00
11. 00 12. 00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL	0	4, 684, 981 0		0		11.00 12.00
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	0	0 53, 650		0 0 0 0	2, 560, 354	13.00 14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	0	152, 390 182, 529		0 0 0 0	0	15.00
17.00	01700 SOCI AL SERVI CE	0	0		0 0	0	17.00
23.00	02300 PARAMED ED PRGM-PHARMACY RESIDENCY INPATIENT ROUTINE SERVICE COST CENTERS	0	8, 807		0 0	0	23.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	71, 029 2, 932	1, 680, 719 195, 220		0 0 0 0	0	30.00 31.00
32.00	03200 CORONARY CARE UNI T	0	0		0 0	0	32.00
33.00 34.00	03300 BURN I NTENSI VE CARE UNI T 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		0 0 0 0	0 0	33.00 34.00
40.00 41.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	0	0		0 0	0	40.00 41.00
42.00	04200 SUBPROVI DER	0	0		0 0	0	42.00
43.00 44.00	04300 NURSERY 04400 SKILLED NURSING FACILITY	594 0	62, 941 0		0 0 0 0	0	43.00
45.00 46.00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0		0 0	0	45.00
40.00	ANCILLARY SERVICE COST CENTERS	-	0	1		0	40.00
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	53 0	525, 064 0		0 0 0 0	0 0	50.00 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 120	75, 939		0 0	0	52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	224	261, 380		0 0	0 0	53.00 54.00
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0		0 0 0 0	0	55.00 56.00
57.00	05700 CT SCAN	0	37, 332		0 0	0	57.00
58.00 59.00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	0 1, 177	22, 484 189, 460		0 0	0 0	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	316, 397 0		0 0	0 0	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0 0	62.00 63.00
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0 148, 341		0 0	0	64.00 65.00
66.00	06600 PHYSI CAL THERAPY	0	60, 838		0 0	0	66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0 17, 910		0 0	0	67.00 68.00
69.00 70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	87, 752 5, 164		0 0	0	69.00 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0,104		0 0	1, 185, 903	71.00
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	0	0		0 0 0 0	1, 374, 451 0	72.00
74.00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STINCT PART)	0	0		0 0	0	74.00 75.00
76.00	03950 NUTRI TI ON/DI ABETES	0	0		0 0	0	76.00
76.97	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0	23, 676		0 0	0	76.97
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	14	85, 878		0 0	0 0	89.00 90.00
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	383	337, 296		0 0	0	91.00 92.00
	OTHER REIMBURSABLE COST CENTERS	1		ı 1			
94.00 95.00	09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES	0	0		0 0 0 0	0 0	94.00 95.00
96.00 97.00	09600 DURABLE MEDICAL EQUIP-RENTED 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	96.00
97.00 99.00	09900 CMHC	0	0		0 0	0	
0 10 1 10		401 450044 0004					

Health Financial Systems	BAPTIST HEAL	TH FLOYD		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 09/01/2018 To 08/31/2019		
Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL	
			OF PERSONNEL	ADMI NI STRATI O	SERVICES &	
	10.00	11.00	10.00	N	SUPPLY	
99. 10 09910 CORF	10.00	11.00	12.00	13.00	14.00	00.10
	0	0		0 0	0	1 / /
100.00 10000 I &R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY	0	152.050		0 0		100.00 101.00
SPECIAL PURPOSE COST CENTERS	U	152, 959		0 0	0	101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0 0	0	105.00
106. 00 10600 HEART ACQUISITION	0	0				105.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0				107.00
108. 00 10800 LUNG ACQUI SI TI ON	0	0		0 0		108.00
109. 00 10900 PANCREAS ACQUI SI TI ON	0	0		0 0		109.00
110. 00 11000 INTESTINAL ACQUISITION	0	0		0 0		110.00
111. 00 11100 I SLET ACQUI SI TI ON	0	0		0 0		111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0	0	115.00
116. 00 11600 HOSPI CE	0	0		0 0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	78, 526	4, 684, 126		0 0	2, 560, 354	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	283		0 0		190.00
191. 00 19100 RESEARCH	0	0		0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
192.01 19201 OTHER NRCC	0	572		0 0		192.01
192. 02 19202 LTC	0	0		0 0		192.02
193. 00 19300 NONPALD WORKERS	0	0		0 0		193.00
194.00 07950 MARKETING	0	0		0 0	0	194.00
200.00 Cross Foot Adjustments		0			0	200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	0 78, 526	1 601 001		0 0		201.00
202.00 TOTAL (Sum TIMES THE INFOUGH 201)	18, 526	4, 684, 981	l	u U	2, 500, 354	202.00

	Financial Systems	BAPTIST HEA				u of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0044	Period: From 09/01/2018	Worksheet B Part I	
					To 08/31/2019	Date/Time Pre 9/21/2022 9:4	
	Cost Center Description	PHARMACY	MEDI CAL RECORDS &	SOCI AL SERVI CE	PARAMED ED PRGM-PHARMACY	Subtotal	
		15.00	LI BRARY	17 00	RESI DENCY	24.00	
	GENERAL SERVICE COST CENTERS	15.00	16.00	17.00	23.00	24.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
6.00	00600 MAI NTENANCE & REPAI RS						6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8.00 9.00
10.00	01000 DI ETARY						10.00
	01100 CAFETERI A						11.00
	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION						12.00 13.00
	01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY	7, 327, 309					15.00
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	10, 299, 670		0		16.00 17.00
	02300 PARAMED ED PRGM-PHARMACY RESIDENCY	0	0		0 0 416, 328		23.00
	INPATIENT ROUTINE SERVICE COST CENTERS	-	-				
	03000 ADULTS & PEDIATRICS	0	9, 178, 514		0 416, 328	52, 120, 749	
	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	0	0		0 0	11, 515, 730 0	1
33.00	03300 BURN INTENSIVE CARE UNIT	0	0		0 0	0	
	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		0 0	0	
	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	0	0		0 0	0	40.00
	04200 SUBPROVI DER	0	0		0 0	0	
	04300 NURSERY	0	0		0 0	1, 931, 307	1
	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0		0 0 0 0	0	
	04600 OTHER LONG TERM CARE	0	0		0 0	0	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	672, 693 0		0 0	28, 424, 493 0	
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	4, 030, 127	1
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0	37, 372 0		0 0	13, 875, 586	
	05600 RADI OLOGY - THERAPEUTIC	0	0		0 0	0	
	05700 CT SCAN	0	0		0 0	2,062,044	
58.00	05800 MRI	0	0		0 0	1, 152, 714	
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0		0 0	7, 186, 436 17, 491, 841	
	06001 BLOOD LABORATORY	0	0		0 0	0	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					0	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	84, 303	
	06400 I NTRAVENOUS THERAPY	0	0		0 0	1, 869, 948 8, 541, 690	
65.00	06500 RESPI RATORY THERAPY	0	52, 321		0 0	4, 954, 469	65.00
	06600 PHYSI CAL THERAPY	0	37, 372		0 0	6, 742, 982	1
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0			0 1, 025, 732	
	06900 ELECTROCARDI OLOGY	Ő	37, 372		0 0	4, 349, 673	
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	1, 205, 696	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	17, 790, 276 21, 984, 050	
	07300 DRUGS CHARGED TO PATIENTS	7, 327, 309	0		0 0	22, 371, 121	
	07400 RENAL DI ALYSI S	0	0		0 0	377, 525	
	07500 ASC (NON-DI STI NCT PART) 03950 NUTRI TI ON/DI ABETES	0	0		0 0	0	75.00 76.00
	07697 CARDI AC REHABI LI TATI ON	0	0		0 0	1, 332, 139	1
	OUTPATIENT SERVICE COST CENTERS	1]
	08800 RURAL HEALTH CLINIC	0	0		0 0	0	
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0 5, 280, 115	
	09100 EMERGENCY	0	284, 026		0 0	12, 644, 412	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
94.00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S		0		0 0	0	94.00
	09500 AMBULANCE SERVICES	0	0		0 0	0	
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	
	09700 DURABLE MEDICAL EQUIP-SOLD 09900 CMHC	0	0		0 0	0	
77.00			U		<u> </u>	0	77.00

Health Financial Systems	BAPTI ST HEAL	TH FLOYD		In Lieu of Form CMS-2552-10			
COST ALLOCATI ON - GENERAL SERVI CE COSTS		Provider CC	CN: 15-0044	Perio From To	od: 09/01/2018 08/31/2019		
Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	PRG	ARAMED ED M-PHARMACY ESI DENCY	Subtotal	
	15.00	16.00	17.00		23.00	24.00	
99. 10 09910 CORF	0	0		0	0	0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0	0		100.00
101.0010100 HOME HEALTH AGENCY	0	0		0	0	6, 269, 752	101.00
SPECIAL PURPOSE COST CENTERS							
105.00 10500 KI DNEY ACQUI SI TI ON	0	0		0	0	0	105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0		0	0		106.00
107.00 10700 LI VER ACQUI SI TI ON	0	0		0	0		107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0		0	0		108.00
109. 00 10900 PANCREAS ACQUI SI TI ON	0	0		0	0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0	0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0	0	0	111.00
113.00 11300 INTEREST EXPENSE							113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF							114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0	0		115.00
116. 00 11600 HOSPI CE	0	0		0	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	7, 327, 309	10, 299, 670		0	416, 328	256, 614, 910	118.00
NONREI MBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0	152, 510	•
191. 00 19100 RESEARCH	0	0		0	0	146, 822	•
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0	0	868, 915	
192.01 19201 OTHER NRCC	0	0		0	0	5, 937, 305	•
192. 02 19202 LTC	0	0		0	0		192.02
193. 00 19300 NONPALD WORKERS	0	0		0	0		193.00
194. 00 07950 MARKETI NG	0	0		0	0		194.00
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)	7, 327, 309	10, 299, 670		0	416, 328	263, 811, 105	202.00

	Financial Systems LOCATION - GENERAL SERVICE COSTS	BAPTIST HEAL	Provider CCN: 15-0044	In Lieu of Form CMS- Period: Worksheet B	-2552-10
				From 09/01/2018 Part I To 08/31/2019 Date/Time Pro	
	Cost Center Description	Intern &	Total	9/21/2022 9:	<u>45 am</u>
		Resi dents			
		Cost & Post			
		Stepdown Adjustments			
		25.00	26.00		
C	GENERAL SERVICE COST CENTERS	20100	20100		
	DO100 CAP REL COSTS-BLDG & FIXT				1.00
	DO200 CAP REL COSTS-MVBLE EQUIP				2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
	20500 ADMINI STRATI VE & GENERAL				5.00
	00600 MAI NTENANCE & REPAI RS 00700 OPERATI ON OF PLANT				6.00 7.00
	DO800 LAUNDRY & LINEN SERVICE				8.00
	DO900 HOUSEKEEPI NG				9.00
	D1000 DI ETARY				10.00
11.00	D1100 CAFETERI A				11.00
	D1200 MAINTENANCE OF PERSONNEL				12.00
	01300 NURSING ADMINISTRATION				13.00
	01400 CENTRAL SERVICES & SUPPLY				14.00
	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY				15.00
	01700 SOCIAL SERVICE				17.00
	D2300 PARAMED ED PRGM-PHARMACY RESIDENCY				23.00
-	NPATIENT ROUTINE SERVICE COST CENTERS		l		
30.00	D3000 ADULTS & PEDI ATRI CS	0	52, 120, 749		30.00
	D3100 I NTENSI VE CARE UNI T	0	11, 515, 730		31.00
	D3200 CORONARY CARE UNIT	0	0		32.00
	03300 BURN I NTENSI VE CARE UNI T	0	0		33.00
	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		34.00
	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	0	0		40.00
	04200 SUBPROVI DER	0	0		41.00
	D4300 NURSERY	0	1, 931, 307		43.00
	04400 SKILLED NURSING FACILITY	0	0		44.00
	D4500 NURSING FACILITY	0	o		45.00
	04600 OTHER LONG TERM CARE	0	0		46.00
	ANCI LLARY SERVICE COST CENTERS		20 424 402		
	D5000 OPERATING ROOM D5100 RECOVERY ROOM	0	28, 424, 493 0		50.00
	D5200 DELIVERY ROOM & LABOR ROOM	0	4, 030, 127		52.00
	D5300 ANESTHESI OLOGY	0	0		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	13, 875, 586		54.00
	05500 RADI OLOGY-THERAPEUTI C	0	0		55.00
	D5600 RADI OI SOTOPE	0	0		56.00
	D5700 CT SCAN	0	2,062,044		57.00
	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	0	1, 152, 714		58.00
	D6000 LABORATORY	0	7, 186, 436 17, 491, 841		59.00 60.00
	D6001 BLOOD LABORATORY	0	0		60.01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		O		61.00
62.00	D6200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	84, 303		62.00
	D6300 BLOOD STORING, PROCESSING & TRANS.	0	1, 869, 948		63.00
	06400 INTRAVENOUS THERAPY	0	8, 541, 690		64.00
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	4,954,469		65.00
	0600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY		6, 742, 982 0		66.00 67.00
	D6800 SPEECH PATHOLOGY	0	1, 025, 732		68.00
	D6900 ELECTROCARDI OLOGY	0	4, 349, 673		69.00
	07000 ELECTROENCEPHALOGRAPHY	0	1, 205, 696		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	17, 790, 276		71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	21, 984, 050		72.00
	07300 DRUGS CHARGED TO PATIENTS	0	22, 371, 121		73.00
	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0	377, 525 0		74.00
	03950 NUTRI TI ON/DI ABETES	0	0		75.00
	07697 CARDI AC REHABI LI TATI ON	0	1, 332, 139		76.97
C	DUTPATIENT SERVICE COST CENTERS				
	D8800 RURAL HEALTH CLINIC	0	0		88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
	09000 CLINIC	0	5, 280, 115		90.00
	D9100 EMERGENCY	0	12, 644, 412		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
	DTHER REIMBURSABLE COST CENTERS	0	0		94.00
	09500 AMBULANCE SERVICES	0	0		95.00
	09600 DURABLE MEDI CAL EQUI P-RENTED	0	o		96.00

Health Financial Systems	BAPTI ST HEAL	_TH FLOYD		In Lieu	of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-0044	Peri od:	Worksheet B
				From 09/01/2018	Part I
				To 08/31/2019	Date/Time Prepared: 9/21/2022 9:45 am
Cost Center Description	Intern &	Total			7/21/2022 9.45 alli
	Residents	lotal			
	Cost & Post				
	Stepdown				
	Adjustments				
	25.00	26.00			
97.00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0			97.00
99.00 09900 CMHC	0	0			99.00
99. 10 09910 CORF	0	0			99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	o			100.00
101.00 10100 HOME HEALTH AGENCY	0	6, 269, 752			101.00
SPECIAL PURPOSE COST CENTERS					
105.00 10500 KIDNEY ACQUISITION	0	0			105.00
106.00 10600 HEART ACQUI SI TI ON	0	0			106.00
107.00 10700 LIVER ACQUISITION	0	0			107.00
108.00 10800 LUNG ACQUI SI TI ON	0	o			108.00
109.00 10900 PANCREAS ACQUISITION	0	o			109.00
110.00 11000 INTESTINAL ACQUISITION	0	0			110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0			111.00
113.00 11300 INTEREST EXPENSE					113.00
114.00 11400 UTILIZATION REVIEW-SNF					114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0			115.00
116. 00 11600 HOSPI CE	0	0			116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	256, 614, 910			118.00
NONREI MBURSABLE COST CENTERS		· · · · ·			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	152, 510			190.00
191. 00 19100 RESEARCH	0	146, 822			191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	868, 915			192.00
192.01 19201 OTHER NRCC	0	5, 937, 305			192.01
192. 02 19202 LTC	0	o			192.02
193. 00 19300 NONPAI D WORKERS	0	o			193.00
194. 00 07950 MARKETI NG	0	90, 643			194.00
200.00 Cross Foot Adjustments	0	0			200.00
201.00 Negative Cost Centers	0	o			201.00
202.00 TOTAL (sum lines 118 through 201)	0	263, 811, 105			202.00

Heal th	Financial Systems	BAPTI ST HEALTH	I FLOYD		In Lieu	u of Form CMS-	-2552-10
COST A	LLOCATION STATISTICS		Provider C	CN: 15-0044	Peri od:	Worksheet No	n-CMS W
					From 09/01/2018 To 08/31/2019	Date/Time Pr 9/21/2022 9:	epared: 45 am
	Cost Center Description			Statistics Code	Statistics I	•	
				1.00	2.0	00	
	GENERAL SERVICE COST CENTERS						-
1.00	CAP REL COSTS-BLDG & FIXT			1	SQUARE FEET		1.00
2.00	CAP REL COSTS-MVBLE EQUIP			2	DOLLAR VALUE		2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT			S	GROSS SALARI ES		4.00
5.00	ADMINISTRATIVE & GENERAL			-1	ACCUM. COST		5.00
6.00	MAINTENANCE & REPAIRS			5	SQUARE FEET		6.00
7.00	OPERATION OF PLANT			1	SQUARE FEET		7.00
8.00	LAUNDRY & LINEN SERVICE			7	POUNDS OF LAUNE	ORY	8.00
9.00	HOUSEKEEPING			1	SQUARE FEET		9.00
10.00	DI ETARY			8	MEALS SERVED		10.00
11.00	CAFETERIA			9	PRODUCTI VE HOUR	RS	11.00
12.00	MAINTENANCE OF PERSONNEL			10	NUMBER HOUSED		12.00
13.00	NURSING ADMINISTRATION			11	DIRECT NRSING H	HRS	13.00
14.00	CENTRAL SERVICES & SUPPLY			12	COSTED REQUIS.		14.00
15.00	PHARMACY			13	COSTED REQUIS.		15.00
16.00	MEDI CAL RECORDS & LI BRARY			14	TIME SPENT		16.00
17.00	SOCI AL SERVI CE			15	ASSIGNED TIME		17.00
23.00	PARAMED ED PRGM-PHARMACY RESIDENCY			23	ASSI GNED TI ME		23.00

	Financial Systems TION OF CAPITAL RELATED COSTS	BAPTI ST HEA			Period: From 09/01/2018 Fo 08/31/2019	u of Form CMS-2 Worksheet B Part II Date/Time Pre	pared:
			CAPI TAL RE	LATED COSTS		9/21/2022 9:4	5 am
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		Related Costs	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS				2.11		
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	788	122, 948	67:	3 124, 409	124, 409	2.00
4.00 5.00	00500 ADMINI STRATI VE & GENERAL	6, 125, 152	295, 930			6, 334	5.00
6.00	00600 MAI NTENANCE & REPAI RS	0, 120, 102	0		0, 1, 0, 0, 1	0,001	6.00
7.00	00700 OPERATION OF PLANT	13, 934	83, 613			3, 052	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	79, 311			134	8.00
9.00	00900 HOUSEKEEPI NG	0 737	20, 043			2,662	9.00
10.00 11.00	01000 DI ETARY 01100 CAFETERI A	0	30, 658 173, 916		4 87, 849 0 173, 916	1, 299 1, 933	•
12.00	01200 MAINTENANCE OF PERSONNEL	0	0		0	0	12.00
13.00	01300 NURSING ADMINISTRATION	0	0	(0 0	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	197, 545			684	14.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	40, 668			5,023	•
16.00 17.00	01700 SOCIAL SERVICE	0	88, 909 0	1	0 89,049 0 0	4, 779 0	16.00
23.00	02300 PARAMED ED PRGM-PHARMACY RESIDENCY	0	5, 623		-	274	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00	03000 ADULTS & PEDIATRICS	7, 739	1, 775, 656			22, 775	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	160, 077			7, 366	31.00
32.00 33.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0			0	32.00 33.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0			0	34.00
40.00	04000 SUBPROVIDER - IPF	0	0		0 0	0	40.00
41.00	04100 SUBPROVI DER – I RF	0	0		0 0	0	41.00
42.00	04200 SUBPROVI DER	0	0	(0 0	0	42.00
43.00 44.00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0	46, 654	10, 91	5 57, 570	1, 235 0	43.00
44.00	04400 SKILLED NORSING FACILITY	0	0			0	44.00
46.00	04600 OTHER LONG TERM CARE	0	0		0 0	0	46.00
	ANCILLARY SERVICE COST CENTERS				1		1
50.00	05000 OPERATING ROOM	51, 838	526, 570			12, 866	
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	153	0 314, 531		0 0 3 329,042	0 1, 771	51.00 52.00
53.00	05300 ANESTHESI OLOGY	0	314, 331	14, 35	0 329,042	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	980, 557	345, 214	719, 71	2, 045, 488	6, 409	•
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
56.00	05600 RADI OI SOTOPE	0	0			0	
	05700 CT SCAN 05800 MRI	679	43, 539 19, 922				57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	136, 362			4, 486	
60.00	06000 LABORATORY	44, 546	212, 887			6, 171	
60.01	06001 BLOOD LABORATORY	0	0		0 0	0	•
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0		0	0	61.00
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS.	0	0			0 1, 274	
64.00	06400 I NTRAVENOUS THERAPY	0	0			5, 962	
65.00	06500 RESPI RATORY THERAPY	87, 910	28, 731	18, 19	134, 837	3, 159	
66.00	06600 PHYSI CAL THERAPY	558, 360	3, 938	93, 85	2 656, 150	4, 410	•
67.00	06700 OCCUPATI ONAL THERAPY	0	0			0	•
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	6, 968 109, 655			710	
	07000 ELECTROCARDI OLOGY	84, 294	109, 655 86, 522		282, 592 86, 522	2, 629 345	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	00, 022		0 0	0	•
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		o o	0	1
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
		0	0			257	•
75.00 76.00	07500 ASC (NON-DI STINCT PART) 03950 NUTRI TI ON/DI ABETES	0				0	•
	07697 CARDI AC REHABI LI TATI ON	36, 261	43, 539	17,00	5 96, 806	798	
	OUTPATIENT SERVICE COST CENTERS			1	1		1
	08800 RURAL HEALTH CLINIC	0	0		0	0	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0 1E2 647	110 400	140 00		0 2 2 2 2 2	
90.00 91.00	09000 CLINIC 09100 EMERGENCY	452, 647	110, 600 350, 328			2, 292 7, 019	
	09200 OBSERVATION BEDS (NON-DISTINCT PART		550, 520	20,07	0	7,019	92.00
	OTHER REIMBURSABLE COST CENTERS					-	1
94.00	09400 HOME PROGRAM DI ALYSI S	0	0	1	0 0	0	
	09500 AMBULANCE SERVICES	0	0		0 0		95.00

Health Financial Systems	BAPTI ST HEA	LTH FLOYD		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period: From 09/01/2018 To 08/31/2019		
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 99. 00 09900 CMHC	0 0	0 0		0 0 0 0 0 0	0 0 0	97.00
99. 10 09910 CORF	0	0		0 0	0	
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0 0	0	100.00
101.00 10100 HOME HEALTH AGENCY	5, 405	0		0 5,405		101.00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0 0	0	105.00
106.00 10600 HEART ACQUI SI TI ON	0	0		0 0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0		0 0	0	107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0		0 0		108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0		0 0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0	0	115.00
116. 00 11600 H0SPI CE	0	0		0 0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	8, 451, 000	5, 460, 857	5, 562, 43	19, 474, 292	123, 563	118.00
NONREI MBURSABLE COST CENTERS	тт					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
191. 00 19100 RESEARCH	0	0		0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	39, 516		0 39, 516		192.00
192.01 19201 OTHER NRCC	0	55, 742	164, 29	220, 038		192.01
192. 02 19202 LTC	0	0		0 0		192.02
193.00 19300 NONPAI D WORKERS	0	0		0 0		193.00
194. 00 07950 MARKETI NG	0	18, 516		0 18, 516	0	194.00
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	8, 451, 000	5, 574, 631	5, 726, 73	19, 752, 362	124, 409	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	BAPTI ST HEAL	Provi der		Fr	eriod: com 09/01/2018 o 08/31/2019	Date/Time Pre 9/21/2022 9:4	epared:
	Cost Center Description	ADMI NI STRATI V E & GENERAL 5. 00	MAI NTENANCE REPAI RS 6.00	& (OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPI NG 9.00	
	GENERAL SERVICE COST CENTERS	5.00	0.00		7.00	0.00	9.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT							1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT							2.00
4.00 5.00	00500 ADMINISTRATIVE & GENERAL	6, 477, 228						5.00
6.00	00600 MAINTENANCE & REPAIRS	0, 117, 220		0				6.00
7.00	00700 OPERATION OF PLANT	340, 247		0	2, 850, 817			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	34, 896		0	44, 577	160, 197	150 411	8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	103, 946		0	11, 265 17, 232	6, 746 6, 938	150, 411 927	
11.00	01100 CAFETERIA	99, 576		0	97, 750	0,700	5, 260	
12.00	01200 MAINTENANCE OF PERSONNEL	0		0	0	0	0	
13.00	01300 NURSI NG ADMI NI STRATI ON	0		0	0	0	0	
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	44, 021 172, 464		0	111, 031 22, 857	114	5, 975 1, 230	
16.00	01600 MEDI CAL RECORDS & LI BRARY	240, 430		0	49, 972	0	2, 689	
17.00	01700 SOCIAL SERVICE	0		0	0	0	0	
23.00	02300 PARAMED ED PRGM-PHARMACY RESIDENCY	9, 501		0	3, 160	10	170	23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	823, 643		0	998, 013	78, 493	53, 708	30.00
31.00	03100 I NTENSI VE CARE UNI T	262, 271		0	89, 972	5, 243	4, 842	
32.00	03200 CORONARY CARE UNI T	0		0	0	0	0	
33.00	03300 BURN INTENSIVE CARE UNIT	0		0	0	0	0	
34.00 40.00	03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	0		0	0	0	0	
41.00	04100 SUBPROVI DER – I RF	0		0	0	0	0	
42.00	04200 SUBPROVI DER	0		0	0	0	0	
43.00	04300 NURSERY	41, 135		0	26, 222	2, 280	1, 411	
44.00 45.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0		0	0 0	0	0	
46.00	04600 OTHER LONG TERM CARE	0		0	0	0	0	
101 00	ANCI LLARY SERVICE COST CENTERS			<u> </u>				
50.00	05000 OPERATING ROOM	617, 168		0	295, 961	17, 566	15, 927	
51.00	05100 RECOVERY ROOM	0		0	0	0	0	
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	69, 130 0		0	176, 784 0	0	9, 514 0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	300, 437		0	194, 029	8, 729	10, 442	
55.00	05500 RADI OLOGY-THERAPEUTI C	0		0	0	0	0	
56.00 57.00	05600 RADI OI SOTOPE 05700 CT SCAN	0 45, 511		0	0 24, 472	0 1, 294	0 1, 317	
58.00	05800 MRI	25, 566		0	24, 472	1, 294	603	1
59.00	05900 CARDI AC CATHETERI ZATI ON	157, 679		0	76, 643	7, 724	4, 125	
60.00	06000 LABORATORY	402, 678		0	119, 654	4	6, 439	
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0	0	60.0 [°] 61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	2,069		0	0	0	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	45, 894		0	0	0	0	
64.00	06400 I NTRAVENOUS THERAPY	209, 640		0	0	0	0	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	114, 128 162, 539		0	16, 149 2, 214	0 782	869 119	
67.00	06700 OCCUPATI ONAL THERAPY	102, 039		o	2, 214	0	0	
68.00	06800 SPEECH PATHOLOGY	23, 762		0	3, 916	1, 417	211	68.0
69.00	06900 ELECTROCARDI OLOGY	93, 969		0	61, 632	0	3, 317	
70.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	21, 799 407, 524		0	48, 630 0	0	2, 617 0	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	407, 524 505, 825		0	0	0	0	1
73.00	07300 DRUGS CHARGED TO PATIENTS	369, 223		0	Ō	Ő	0	73.0
74.00	07400 RENAL DI ALYSI S	9, 266		0	0	0	0	
75.00	07500 ASC (NON-DISTINCT PART) 03950 NUTRITI ON/DIABETES	0		0	0	0	0	
	07697 CARDI AC REHABI LI TATI ON	28, 256		0	24, 472	0	1, 317	1
	OUTPATIENT SERVICE COST CENTERS					-		
38.00	08800 RURAL HEALTH CLINIC	0		0	0	0	0	
39.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0 117, 684			0 62, 163	0	0 3, 345	
90.00 91.00	09100 EMERGENCY	258, 709		0	196, 903	21, 228	10, 596	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART							92.0
14 00	OTHER REIMBURSABLE COST CENTERS			0	~		-	
94.00 95.00	09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES	0		0	0	0	0	
	09600 DURABLE MEDICAL EQUIP-RENTED	0		õ	0	0	0	
97.00	09700 DURABLE MEDI CAL EQUI P-SOLD	0		0	0	0	0	97.00
	09900 CMHC	0		0	0	0	0	
1 9.10	09910 CORF	0		U	0	0	0	99.1

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0044 Period: From 09/01/2019 Worksheet B Provider CCN: 15-0044
To 08/31/2019 Date/Time Prepared: 9/21/2022 9:45 am Cost Center Description ADMI NI STRATI V E & GENERAL MAI NTENANCE & PLANT DPEANT V LINEN SERVICE LAUNDRY & LINEN SERVICE 100.00 10000 1 & R SERVI CES-NOT APPRVD PRGM 0 </td
Cost Center Description ADMI NI STRATI V E & GENERAL 5.00 MAI NTENANCE & REPAIRS OPERATI ON OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING 100.00 1000 1 & R SERVICES-NOT APPRVD PRGM 0 <t< td=""></t<>
Cost Center Description ADMINISTRATIV MAINTENANCE & OPERATION OF REPAIRS LAUNDRY & HOUSEKEEPING 100.00 1000 01 1& SERVICES-NOT APPRVD PRGM 0 <t< td=""></t<>
E & GENERAL REPAI RS PLANT LI NEN SERVI CE 100. 00 100.00 1& R SERVI CES-NOT APPRVD PRGM 0
5.00 6.00 7.00 8.00 9.00 100.00 10000 1& SERVICES-NOT APPRVD PRGM 0 <
100.00 10000 1 & R SERVICES-NOT APPRVD PRGM 0 0 0 0 0 100.00 101.00 HOME HEALTH AGENCY 150, 126 0
101.00 10100 HOME HEALTH AGENCY 150, 126 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 105.00 106.00 10600 HEART ACQUI SI TI ON 0 0 0 0 0 0 0 105.00 107.00 10700 LIVER ACQUI SI TI ON 0 0 0 0 0 107.00 107.00 0 0 0 107.00 0 0 0 107.00 107.00 0 0 0 107.00 107.00 0 0 0 0 108.00 108.00 108.00 0 0 0 0 0 0 109.00 108.00 108.00 109.00 0 0 0 109.00 109.00 0 0 0 109.00 110.00 1110.00 1110.00 1111.00 1111.00
SPECIAL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 105.00 106.01 10500 KI DNEY ACQUI SI TI ON 0
105.00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 0 105.00 106.00 10600 HEART ACQUI SI TI ON 0
106.00 106.00 HEART ACQUI SI TI ON 0 0 0 0 106.00 107.00 107.00 LI VER ACQUI SI TI ON 0<
107.00 10700 LI VER ACQUI SI TI ON 0 0 0 0 107.00 108.00 10800 LUNG ACQUI SI TI ON 0 0 0 0 0 108.00 109.00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 0 0 109.00 110.00 1NTESTI NAL ACQUI SI TI ON 0 0 0 0 0 109.00 111.00 INTEREST EXPENSE 0 0 0 0 0 111.00 113.00 INTOR EVI EW-SNF 114.00 114.00 114.00 115.00 0 0 0 0 115.00 115.00 11500 AMBULATORY SURGI CAL CENTER (D.P.) 0 0 0 0 116.00 116.00 116.00 10500 KGUM OF LINES 1 through 117) 6, 310, 712 0 2, 786, 870 160, 197 146, 970 118.00 NONREI MBURSABLE COST CENTERS 1 118.00 118.00 118.00 190.00 0 0 0 0 190.00 190.00 19000 GIFT, FLOWER, COFF
108.00 LUNG ACQUI SI TI ON 0 0 0 0 108.00 109.00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 0 109.00 110.00 1000 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 109.00 111.00 1NESTI NAL ACQUI SI TI ON 0 0 0 0 0 110.00 111.00 ISLET ACQUI SI TI ON 0 0 0 0 0 110.00 111.00 ISLET ACQUI SI TI ON 0 0 0 0 0 110.00 113.00 INTEREST EXPENSE 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 0 0 0 0 114.00 116.00 11600 HOSPI CE 0 0 0 0 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 118.00 118.00 118.00 0 0 0 0 118.00 190.00 19
109.00 PANCREAS ACQUISITION 0 0 0 0 109.00 110.00 INTESTINAL ACQUISITION 0 0 0 0 0 110.00 111.00 INTESTINAL ACQUISITION 0 0 0 0 0 0 110.00 111.00 INTEREST EXPENSE 0 0 0 0 0 113.00 114.00 INTEREST EXPENSE 114.00 115.00 11500 11500 115.00 114.00 114.00 114.00 115.00 116.00 0 0 0 0 115.00 115.00 116.00 116.00 116.00 0 0 0 0 115.00 116.00
110.00 INTESTI NAL ACQUI SI TI ON 0 0 0 0 110.00 111.00 ISLET ACQUI SI TI ON 0 0 0 0 0 110.00 111.00 ISLET ACQUI SI TI ON 0 0 0 0 0 111.00 113.00 INTEREST EXPENSE 113.00 111.00 113.00 114.00 111.12ATI ON REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGI CAL CENTER (D.P.) 0 0 0 0 115.00 116.00 11600 HOSPI CE 0 0 0 0 0 115.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 6, 310, 712 0 2, 786, 870 160, 197 146, 97 118.00 NONRELMBURSABLE COST CENTERS 114.00 0 2, 786, 870 160, 197 118.00 118.00 INTEREST LINES 1 through 117) 6, 310, 712 0 2, 786, 870 160, 197 118.00 1190.00 IPOTO GIFT, FLOWER, COFFEE SHOP & CANTEEN 3, 736 0 0 0 190.00 191.00 19100 RESEARC
111.00 1SLET ACQUISITION 0 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 113.00 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 114.00 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 0 0 0 0 116.00 11600 HOSPICE 0 0 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 6, 310, 712 0 2, 786, 870 160, 197 146, 970 118.00 NORREI MBURSABLE COST CENTERS 118.00 0 0 0 0 190.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 3, 736 0 0 0 190.00 191.00 19100 RESEARCH 3, 603 0 0 0 191.00
113.00 INTEREST EXPENSE 113.00 114.00 UTI LI ZATI ON REVI EW-SNF 114.00 115.00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 114.00 116.00 11500 HOSPI CE 0 0 0 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 6, 310, 712 0 2, 786, 870 160, 197 146, 970 118.00 NONREL MBURSABLE COST CENTERS 190.00 GFT, FLOWER, COFFEE SHOP & CANTEEN 3, 736 0 0 0 190.00 191.00 0 0 0 0 190.00
114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 0 0 0 0 115.00 116.00 11600 HOSPICE 0 0 0 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 6, 310, 712 0 2, 786, 870 160, 197 146, 970 118.00 NONREI MBURSABLE COST CENTERS 190.00 0 0 0 0 190.00 19000 0 0 190.00 191.00 191.00 0 0 0 0 0 191.00 0 0 0 0 191.00
115.00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 0 115.00 116.00 11600 HOSPI CE 0 0 0 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 6,310,712 0 2,786,870 160,197 146,970 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 3,736 0 0 0 190.00 191.00 19100 RESEARCH 3,603 0 0 0 191.00
116.00 HOSPI CE 0 0 0 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 6, 310, 712 0 2, 786, 870 160, 197 146, 970 118.00 NONREI MBURSABLE COST CENTERS 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 3, 736 0 0 0 190.00 190.00 191.00 0 0 0 191.00 0 0 191.00 0 0 0 191.00
SUBTOTALS (SUM OF LINES 1 through 117) 6, 310, 712 0 2, 786, 870 160, 197 146, 970 118. 00 NONREIMBURSABLE COST CENTERS
NONREI MBURSABLE COST CENTERS 190. 00 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 3, 736 0 0 0 190.00 191. 00 19100 RESEARCH 3, 603 0 0 0 0 191.00
190.00 O I FT, FLOWER, COFFEE SHOP & CANTEEN 3, 736 O O O 190.00 191.00 19100 RESEARCH 3, 603 O O 0 0 191.00
191.00 19100 RESEARCH 3, 603 0 0 0 191.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 17, 825 0 22, 210 0 1, 195 192. 00
192. 01 19201 OTHER NRCC 140, 768 0 31, 330 0 1, 686 192. 01
192. 02 19202 LTC 0 0 0 0 0 192. 02
193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 00
194. 00 07950 MARKETI NG 584 0 10, 407 0 560 194. 00
200.00 Cross Foot Adjustments 200.00
201.00 Negative Cost Centers 0 </td
202.00 TOTAL (sum lines 118 through 201) 6, 477, 228 0 2, 850, 817 160, 197 150, 411 202.00

<u>Heal th</u>	Financial Systems	BAPTI ST HEA	LTH FLOYD		In Lie	u of Form CMS-2	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provider C		Period: From 09/01/2018	Worksheet B Part II	
					To 08/31/2019		
	Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL	
				OF PERSONNEL	ADMI NI STRATI O N	SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4.00 5.00
6.00	00600 MAI NTENANCE & REPAI RS						6.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY	16, 751	270 425				10.00
11.00 12.00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL	0	378, 435 0		0		11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0		0 0		13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	4, 334 12, 310			386, 773 0	1
16.00	01600 MEDICAL RECORDS & LIBRARY	0	14, 744		0 0	0	1
17.00	01700 SOCIAL SERVICE	0	0		0 0	0	
23.00	02300 PARAMED ED PRGM-PHARMACY RESIDENCY	0	711		0 0	0	23.00
30.00	03000 ADULTS & PEDI ATRI CS	15, 151			0 0	0	
31.00 32.00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	626 0			0 0 0 0	0	
33.00	03300 BURN INTENSIVE CARE UNIT	0	0		0 0	0	
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		0 0	0	
40.00 41.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	0	0		0 0 0 0	0	40.00
42.00	04200 SUBPROVI DER	0	0		0 0	0	42.00
43.00 44.00	04300 NURSERY 04400 SKILLED NURSING FACILITY	127	5, 084			0	43.00
45.00	04500 NURSI NG FACI LI TY	0	0		0 0	0	1
46.00	04600 OTHER LONG TERM CARE	0	0		0 0	0	46.00
50.00	ANCI LLARY SERVICE COST CENTERS	11	42, 413		0 0	0	50.00
51.00	05100 RECOVERY ROOM	0	-		0 0	0	51.00
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	452 0				0	52.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	48			0 0	0	54.00
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0		0 0	0	
57.00	05700 CT SCAN	0	3, 016		0 0	0	
58.00	05800 MRI	0	1, 816		0 0	0	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	251	15, 304 25, 557			0	
60.01	06001 BLOOD LABORATORY	0	0		0 0	0	1
61.00 62.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	61.00 62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	1
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	11, 982 4, 914			0	65.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	1, 447 7, 088		0 0	0	68.00 69.00
	07000 ELECTROCARDI OLOGI	0	417		0 0	0	70.00
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0		0 0	179, 143	
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	0 0	0 0			207, 630 0	
74.00	07400 RENAL DI ALYSI S	0	0		0 0	0	74.00
75.00 76.00	07500 ASC (NON-DI STI NCT PART) 03950 NUTRI TI ON/DI ABETES	0	0		0 0	0	75.00 76.00
76.97	07697 CARDI AC REHABI LI TATI ON	0	1, 912		0 0	0	1
00.00	OUTPATIENT SERVICE COST CENTERS						00.00
88.00 89.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0 0	0 0		0 0 0 0	0	
90.00	09000 CLI NI C	3	6, 937		0 0	0	90.00
91.00	09100 EMERGENCY	82	27, 246		0 0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	l		1			92.00
94.00	09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	
95.00 96.00	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED	0	0			0	
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	97.00
99.00	09900 CMHC	0	0		0 0	0	99.00

Health Financial Systems	BAPTIST HEAL	TH FLOYD		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO	CN: 15-0044	Period: From 09/01/2018	Worksheet B Part II	
				To 08/31/2019		pared:
					9/21/2022 9:4	
Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE		CENTRAL	
			OF PERSONNE			
				N	SUPPLY	
	10.00	11.00	12.00	13.00	14.00	00.10
99.10 09910 CORF	0	0		0 0		99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0 0		100.00
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	12, 355		0 0	0	101.00
105. 00 10500 KI DNEY ACQUI SI TI ON		0		0 0	0	105.00
106. 00 10600 HEART ACQUISITION	0	0		0 0		105.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0		0 0		108.00
108. 00 10800 LUNG ACQUISITION	0	0				107.00
109. 00 10900 PANCREAS ACQUISITION	0	0		0 0		109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0 0		110.00
111. 00 11100 I SLET ACQUI SI TI ON	0	0		0 0		111.00
113. 00 11300 I NTEREST EXPENSE	-	-		-	-	113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0	0	115.00
116. 00 11600 HOSPI CE	0	0		0 0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	16, 751	378, 366		0 0	386, 773	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23		0 0		190.00
191. 00 19100 RESEARCH	0	0		0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
192.01 19201 OTHER NRCC	0	46		0 0		192.01
192. 02 19202 LTC	0	0		0 0		192.02
193. 00 19300 NONPAI D WORKERS	0	0		0 0		193.00
194.00 07950 MARKETI NG	0	0		0 0	0	194.00
200.00 Cross Foot Adjustments		_			_	200.00
201.00 Negative Cost Centers	97, 494	0		0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	114, 245	378, 435		0 0	386, 773	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	BAPTIST HEA	Provider CC	CN: 15-0044	Peri od:	u of Form CMS-2 Worksheet B Part LL	2002-10
					From 09/01/2018 To 08/31/2019	Date/Time Pre	
	Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	PARAMED ED PRGM-PHARMACY RESI DENCY	<u>9/21/2022 9:4</u> Subtotal	5 am
		15.00	16.00	17.00	23.00	24.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL						5.00
6.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						6.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY 01100 CAFETERI A						10.00
11.00 12.00	01200 MAINTENANCE OF PERSONNEL						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY	425, 883	101 (()				15.00
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	401, 663 0		0		16.00
	02300 PARAMED ED PRGM-PHARMACY RESIDENCY	0	0		0 24, 291		23.00
	INPATIENT ROUTINE SERVICE COST CENTERS	· · ·					
30.00	03000 ADULTS & PEDIATRICS	0	357, 943		0	4, 721, 105	30.00
31.00 32.00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	0	0		0	581, 101 0	31.00
33.00	03300 BURN I NTENSI VE CARE UNI T	0	0		0	0	32.00
	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		0	0	34.00
40.00	04000 SUBPROVI DER – I PF	0	0		0	0	
41.00	04100 SUBPROVIDER - IRF	0	0		0	0	41.00
42.00 43.00	04200 SUBPROVI DER 04300 NURSERY	0	0		0	0 135, 064	42.00
44.00	04400 SKILLED NURSING FACILITY	0	0		0	0	44.00
45.00	04500 NURSING FACILITY	0	0		0	0	45.00
46.00	04600 OTHER LONG TERM CARE	0	0		0	0	46.00
50,00	ANCI LLARY SERVICE COST CENTERS	ol	26, 233		0	2, 603, 660	50.00
51.00	05100 RECOVERY ROOM	0	20, 200		0	2,000,000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	592, 827	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0	0	53.00
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0	1, 457 0		0	2, 588, 152 0	54.00 55.00
56.00	05600 RADI OI SOTOPE	0	0		0	0	56.00
57.00	05700 CT SCAN	0	0		0	122, 430	57.00
58.00		0	0		0	62, 290	1
59.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0		0	568, 679 841, 293	
60. 00 60. 01	06001 BLOOD LABORATORY	0	0		0	041, 293	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	2,069	•
63.00 64.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0		0	47, 168 215, 602	•
	06500 RESPIRATORY THERAPY	0	2,040		0	283, 164	1
66.00	06600 PHYSI CAL THERAPY	0	1, 457		0	832, 585	
	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67.00
	06800 SPEECH PATHOLOGY	0			0	47, 526	
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	1, 457 0		0	452, 684 160, 330	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		ő	586, 667	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	713, 455	72.00
	07300 DRUGS CHARGED TO PATIENTS	425, 883	0		0	795, 106	•
	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0	0		0	9, 523 0	
	03950 NUTRI TI ON/DI ABETES	0	0		0	0	76.00
76.97	07697 CARDI AC REHABI LI TATI ON	0	0		0	153, 561	76.97
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0		0	0	
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0 917, 691	89.00 90.00
90.00 91.00	09100 EMERGENCY	0	11, 076		0	917, 091	•
	09200 OBSERVATION BEDS (NON-DISTINCT PART		,				92.00
04 55	OTHER REIMBURSABLE COST CENTERS						
	09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES	0	0		0	0	94.00 95.00
	09500 AMBULANCE SERVICES		0		0	0	95.00
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0	0	97.00
99.00	09900 CMHC	0	0		0	0	99.00

Health Financial Systems	BAPTI ST HEAL	TH FLOYD		In Lie	u of Form CMS-2	552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0044	Period: From 09/01/2018 To 08/31/2019		
Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	PARAMED ED PRGM-PHARMACY RESI DENCY	Subtotal	
	15.00	16.00	17.00	23.00	24.00	
99. 10 09910 CORF	0	0		0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0	171, 870	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0		0	0	105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0		0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0		0	0	107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0		0	0	108.00
109. 00 10900 PANCREAS ACQUI SI TI ON	0	0		0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0	0	115.00
116. 00 11600 HOSPI CE	o	0		0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	425, 883	401, 663		0 0	19, 117, 688	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	3, 768	190.00
191. 00 19100 RESEARCH	0	0		0	3, 722	191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0	81, 245	192.00
192.01 19201 OTHER NRCC	0	0		0	394, 087	192.01
192. 02 19202 LTC	0	0		0	0	192.02
193.00 19300 NONPALD WORKERS	0	0		0	0	193.00
194. 00 07950 MARKETI NG	0	0		0	30, 067	194.00
200.00 Cross Foot Adjustments				24, 291	24, 291	200.00
201.00 Negative Cost Centers	0	0		0 0	97, 494	201.00
202.00 TOTAL (sum lines 118 through 201)	425, 883	401, 663		0 24, 291	19, 752, 362	202.00

	nancial Systems ON OF CAPITAL RELATED COSTS	BAPTI ST HEAL	Provider CCN: 1	5-0044 Period:	Lieu of Form CMS-2552-10 Worksheet B
				From 09/01/2 To 08/31/2	2019 Date/Time Prepared:
	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments 25.00	Total 26. 00		9/21/2022 9:45 am
GE	NERAL SERVICE COST CENTERS	23.00	20.00		
$\begin{array}{cccccccccccccccccccccccccccccccccccc$	0100 CAP REL COSTS-BLDG & FIXT 0200 CAP REL COSTS-MVBLE EQUIP 0400 EMPLOYEE BENEFITS DEPARTMENT 0500 ADMINISTRATIVE & GENERAL 600 MAINTENANCE & REPAIRS 0500 OPERATION OF PLANT 000 DERATION OF PLANT 0800 LAUNDRY & LINEN SERVICE 000 DI ETARY 000 DI ETARY 200 MAINTENANCE OF PERSONNEL 300 NURSI NG ADMINISTRATION 400 CENTRAL SERVICES & SUPPLY 500 PHARMACY 600 MEDI CAL RECORDS & LI BRARY 700 SOCI AL SERVICE 200 PARAMED ED PRGM-PHARMACY RESI DENCY				1.00 2.00 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 23.00
30.00 03 31.00 03 32.00 03 33.00 03 34.00 03 40.00 04 41.00 04 42.00 04 45.00 04 46.00 04	ANTI ENT RECEIPTINE SERVICE COST CENTERS 3000 ADULTS & PEDIATRICS 3000 ADULTS & PEDIATRICS 3000 BURN INTENSIVE CARE UNIT 3000 BURN INTENSIVE CARE UNIT 3000 SUBPROVIDER - IPF 1000 SUBPROVIDER - IRF 3000 NURSERY 4000 SKILLED NURSING FACILITY 4000 SKILLED NURSING FACILITY 4000 SKILLED RERM CARE 4001 CHER LONG TERM CARE 4001 CHER SERVICE COST CENTERS		4, 721, 105 581, 101 0 0 0 0 0 135, 064 0 0 0		30.00 31.00 32.00 33.00 40.00 41.00 42.00 43.00 44.00 45.00 46.00
$\begin{array}{cccccccccccccccccccccccccccccccccccc$	5000 OPERATI NG ROOM 5100 RECOVERY ROOM 5200 DELI VERY ROOM & LABOR ROOM 5300 ANESTHESI OLOGY 5400 RADI OLOGY-DI AGNOSTI C 5500 RADI OLOGY-DI AGNOSTI C 5600 RADI OLOGY-THERAPEUTI C 5600 RADI AC CATHETERI ZATI ON 5000 LABORATORY 5000 BLOOD LABORATORY 5000 BLOOD STORI NG, PROCESSI NG & TRANS. 5000 BLOOD STORI NG, PROCESSI NG & TRANS. 5000 BLOOD STORY THERAPY 5000 BESPI RATORY THERAPY 5000 SEECH PATHOLOGY 5000 SECTROCARDI OLOGY		$\begin{array}{c} 2, 603, 660 \\ 0 \\ 592, 827 \\ 0 \\ 2, 588, 152 \\ 0 \\ 0 \\ 122, 430 \\ 62, 290 \\ 568, 679 \\ 841, 293 \\ 0 \\ 2, 069 \\ 47, 168 \\ 215, 602 \\ 283, 164 \\ 832, 585 \\ 0 \\ 47, 526 \\ 452, 684 \\ 160, 330 \\ 586, 667 \\ 713, 455 \\ 795, 106 \\ 9, 523 \\ 0 \\ 0 \\ 153, 561 \\ \end{array}$		50.00 51.00 52.00 53.00 54.00 55.00 56.00 57.00 58.00 59.00 60.01 61.00 62.00 63.00 64.00 65.00 63.00 64.00 65.00 70.00 71.00 72.00 73.00 74.00 73.00 74.00 75.00 76.97 88.00 76.97
89.00 08 90.00 09 91.00 09 92.00 09	8800 RURAL HEALTH CLINIC 8900 FEDERALLY QUALIFIED HEALTH CENTER 9000 CLINIC 9100 EMERGENCY 9200 OBSERVATION BEDS (NON-DISTINCT PART	0 0 0 0	0 0 917, 691 912, 086		88.00 89.00 90.00 91.00 92.00
94.00 09 95.00 09	HER REIMBURSABLE COST CENTERS 1400 HOME PROGRAM DI ALYSI S 1500 AMBULANCE SERVI CES 1600 DURABLE MEDI CAL EQUI P-RENTED	0 0 0	0 0 0		94. 00 95. 00 96. 00

ALLOCATION OF CAPITAL RELATED COSTS Provider CON: 15-0044 Period: From 09/01/2018 Period: Description Worksheet B Part II Cost Center Description Intern & Residents Cost & Post Stepdown Adjustments Total Total Worksheet B Part II Description 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 99.00 990.00 99.00 100.00 10	Health Financial Systems	BAPTI ST HEAI	LTH FLOYD		In Lieu	u of Form CMS-	2552-10
Residents Cost & Post Stepdown Adjustments 26.00 97.00 <td>ALLOCATION OF CAPITAL RELATED COSTS</td> <td></td> <td>Provider C</td> <td>CN: 15-0044</td> <td>From 09/01/2018</td> <td>Part II Date/Time Pro</td> <td>epared: 45 am</td>	ALLOCATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-0044	From 09/01/2018	Part II Date/Time Pro	epared: 45 am
97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 99.00 09900 CMHC 0 0 0 99.00 90.00 9	Cost Center Description	Residents Cost & Post Stepdown Adjustments					
99.00 09900 CMHC 0 99.00 100.00 100.00 100.00 100.00 100.00 100.00 105.00 105.00 105.00 105.00 105.00 105.00 106.00 107.00 0 0 0 101.00 108.00 109.00 101.00 109.00 101.00 101.00 101.00 101.00							
99.10 09910 CORF 0 0 99.10 100.00 10000 1&& SERVICES-NOT APPRVD PRGM 0 0 0 100.00 SPECIAL PURPOSE COST CENTERS 101.00 10000 107.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 109.00 110.00 110.00 108.00 109.00 111.0		0		1			
100.00 1000 L&R SERVICES-NOT APPRVD PRGM 0 0 100.00 101.00 10100 HME HEALTH AGENCY 0 171,870 101.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 0 105.00 106.00 106.00 10600 HEART ACQUISITION 0 0 106.00 106.00 107.00 LVER ACQUISITION 0 0 0 106.00 106.00 108.00 10800 LUNG ACQUISITION 0 0 0 108.00 109.00 10900 PANCREAS ACQUISITION 0 0 0 108.00 100.01 INTERST TINAL ACQUISITION 0 0 0 111.00		0	0				
1010.00 HOME HEALTH AGENCY 0 171,870 101.00 SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS 0 171,870 10 0 0 0 10 0 0 0 10 10 10 10 10 10 10 10 10 10 10 10 10		0	0				
SPECIAL PURPOSE COST CENTERS 105: 00 10500 KI DNEY ACQUI SI TI ON 0 0 105: 00 106: 0010600 HEART ACQUI SI TI ON 0 0 0 107: 00100 LI VER ACQUI SI TI ON 0 0 0 108: 0010800 LING ACQUI SI TI ON 0 0 0 109: 0010900 PANCREAS ACQUI SI TI ON 0 0 0 109: 0010900 PANCREAS ACQUI SI TI ON 0 0 0 110: 001 1000 INTESTI NAL ACQUI SI TI ON 0 0 0 111: 0011100 INTESTI NAL ACQUI SI TI ON 0 0 0 111: 0011100 INTERST EXPENSE 0 0 0 114: 0011400 UTL LI ZATI ON REVI EW-SNF 114: 00 115: 00 115: 00 116: 0011500 AMBULATORY SURGI CAL CENTER (D.P.) 0 0 0 118: 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 19, 117, 688 190: 00 190: 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 3, 768 190: 00 191: 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 81, 245 192: 00 192: 01 19200 INONPAI D		0	-				
105:00 KI DNEY ACQUI SI TI ON 0 0 105:00 106:00 HEART ACQUI SI TI ON 0 0 106:00 107:00 LI VER ACQUI SI TI ON 0 0 106:00 108:00 LIWG ACQUI SI TI ON 0 0 107:00 108:00 108:00 108:00 108:00 108:00 109:00 109:00 109:00 109:00 109:00 101:00 111:		0	1/1,8/0				101.00
106.00 106.00 HEART ACQUI SI TI ON 0 0 106.00 107.00 10700 LIVER ACQUI SI TI ON 0 0 107.00 108.00 LOBOD LIVER ACQUI SI TI ON 0 0 107.00 108.00 LOBOD PANCREAS ACQUI SI TI ON 0 0 108.00 108.00 109.00 PANCREAS ACQUI SI TI ON 0 0 0 109.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 110.00 110.00 110.00 110.00 110.00 111.00 111.00 111.00 111.00 111.00 111.00 111.00 111.00 111.00 111.00 113.00 114.00 115.00 115.00 115.00 115.00 115.00 115.00 115.00 115.00 116.00 115.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00<		0		1			105 00
107.00 LI VER ACQUI SI TI ON 0 0 107.00 108.00 LUNG ACQUI SI TI ON 0 0 108.00 109.00 PANCREAS ACQUI SI TI ON 0 0 109.00 100.00 INTESTI NAL ACQUI SI TI ON 0 0 109.00 110.00 INTESTI NAL ACQUI SI TI ON 0 0 110.00 111.00 INTESTI NAL ACQUI SI TI ON 0 0 111.00 111.00 INTEREST EXPENSE 113.00 113.00 111.00 111.00 114.00 ITAGO HAULATORY SURGI CAL CENTER (D.P.) 0 0 0 115.00 115.00 115.00 115.00 115.00 115.00 115.00 116.00 115.00 118.00 118.00 118.00 118.00 116.00 116.00 119.00 116.00 119.0		-					
108.00 10800 LUNG ACQUI SI TI ON 0 0 109.00 10900 PANCREAS ACQUI SI TI ON 0 0 110.00 11000 INTESTI NAL ACQUI SI TI ON 0 0 111.00 INTESTI NAL ACQUI SI TI ON 0 0 111.00 111.00 INTERST NAL ACQUI SI TI ON 0 0 111.00 113.00 INTERST EXPENSE 113.00 111.00 111.00 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114.00 115.00 115.00 116.00 11600 HOSPI CE 0 0 115.00 115.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 19.117, 688 118.00 NORREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 3, 768 190.00 191.00 19100 RESEARCH 0 3, 722 191.00 192.00 192.00 PHYSI CI ANS' PRI VATE OFFI CES 0 81, 245 192.00 192.00 192.02 LTC 0 0 0 192.02		0	0				
109:00 109:00 PANCREAS ACQUI SI TI ON 0 0 109:00 110:00 INTESTI NAL ACQUI SI TI ON 0 0 110:00 110:00 111:00 ISLET ACQUI SI TI ON 0 0 0 110:00 111:00 ISLET ACQUI SI TI ON 0 0 0 111:00 111:00 113:00 INTEREST EXPENSE 113:00 114:00 114:00 114:00 114:00 114:00 114:00 114:00 115:00 115:00 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 115:00 115:00 115:00 115:00 115:00 116:00		0	0				
110.00 11000 INTESTI NAL ACQUI SI TI ON 0 0 110.00 111.00 ISLET ACQUI SI TI ON 0 0 111.00 113.00 INTEREST EXPENSE 113.00 111.00 114.00 UTI LI ZATI ON REVI EW-SNF 114.00 115.00 11500 AMBULATORY SURGI CAL CENTER (D.P.) 0 0 116.00 11600 HOSPI CE 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 19, 117, 688 118.00 NONREL MEURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 3, 768 190.00 191.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 81, 245 192.00 192.01 19200 OTHER NRCC 0 394, 087 192.01 192.02 19202 LTC 0 0 193.00 193.00 194.00 7950 MARKETI NG 0 30, 067 193.00 194.00 7950 MARKETI NG 0 30, 067 194.00 200.00 Cross Foot Adj ustments 0 24, 291 200.00 <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td></td>		0	0				
111.00 1SLET ACQUISITION 0 0 111.00 113.00 1NTEREST EXPENSE 113.00 113.00 114.00 114.00 112ATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 116.00 11600 HOSPICE 0 0 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 19, 117, 688 118.00 NONREL MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 3, 768 190.00 191.00 19100 RESEARCH 0 3, 722 190.00 192.01 19200 OTHER NRCC 0 394, 087 192.01 192.02 19200 ITHEN NRCC 0 394, 087 192.02 193.00 19300 NONPKETNB 0 0 193.00 194.00 07950 MARKETING 0 0 192.02 193.00 19300 NONPAID WORKERS 0 0 193.00 194.00 07950 MARKETING 0 30		0	0				
113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114.00 115.00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 116.00 11600 HOSPI CE 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 19, 117, 688 118.00 NONREI MBURSABLE COST CENTERS 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 3, 768 190.00 191.00 19100 RESEARCH 0 3, 722 191.00 192.01 19200 PHYSI CI ANS' PRI VATE OFFICES 0 81, 245 192.00 192.01 19201 OTHER NRCC 0 394, 087 192.01 193.00 19300 NONPAI D WORKERS 0 0 193.00 194.00 07950 MARKETI NG 0 30, 067 193.00 194.00 Cross Foot Adj ustments 0 24, 291 200.00 200.00 Negati ve Cost Centers 0 97, 494 201.00		0	0				
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116.00 11600 HOSPI CE 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 19, 117, 688 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 3, 768 190.00 191.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 81, 245 192.00 192.01 19201 OTHER NRCC 0 394, 087 192.01 192.02 LTC 0 0 193.00 193.00 193.00 193.00 NONPAI D WORKERS 0 30, 067 194.00 194.00 200.00 Cross Foot Adj ustments 0 24, 291 200.00 201.00		0	0				
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NONREI MBURSABLE COST CENTERS 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 3, 768 190.00 191.00 19100 RESEARCH 0 3, 722 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 81, 245 192.00 192.01 19200 OTHER NRCC 0 394, 087 192.01 192.02 LTC 0 0 192.02 192.02 193.00 NONPAI D WORKERS 0 0 192.02 194.00 07950 MARKETI NG 0 30, 067 194.00 200.00 Cross Foot Adj ustments 0 24, 291 200.00 200.00 201.00 Negati ve Cost Centers 0 97, 494 201.00 201.00		-	19 117 688				
190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 3, 768 190.00 191.00 19100 RESEARCH 0 3, 722 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 81, 245 192.00 192.01 19201 OTHER NRCC 0 394, 087 192.01 192.02 LTC 0 0 192.02 192.02 193.00 NONPAI D WORKERS 0 0 192.02 192.02 194.00 07950 MARKETI NG 0 30, 067 194.00 200.00 Cross Foot Adj ustments 0 24, 291 200.00 201.00 Negati ve Cost Centers 0 97, 494 201.00		-1					
191.00 19100 RESEARCH 0 3,722 191.00 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 81,245 192.00 192.01 19201 OTHER NRCC 0 394,087 192.01 192.01 192.02 LTC 0 0 192.02 19		0	3, 768				190.00
192.01 19201 OTHER NRCC 0 394,087 192.01 192.02 19202 LTC 0 0 192.02 193.00 19300 NONPAI D WORKERS 0 0 193.00 194.00 07950 MARKETI NG 0 30,067 194.00 200.00 Cross Foot Adjustments 0 24,291 200.00 201.00 Negative Cost Centers 0 97,494 201.00	191. 00 19100 RESEARCH	0	3, 722				191.00
192.02 LTC 0 0 192.02 193.00 19300 NONPAI D WORKERS 0 0 193.00 194.00 07950 MARKETI NG 0 30,067 194.00 200.00 Cross Foot Adjustments 0 24,291 200.00 201.00 Negative Cost Centers 0 97,494 201.00	192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	81, 245				192.00
193.00 NONPAI D WORKERS 0 0 193.00 194.00 07950 MARKETI NG 0 30,067 200.00 Cross Foot Adjustments 0 24,291 200.00 201.00 Negative Cost Centers 0 97,494 201.00	192.01 19201 OTHER NRCC	0	394, 087				192.01
194.00 07950 MARKETI NG 0 30,067 194.00 200.00 Cross Foot Adjustments 0 24,291 200.00 201.00 Negative Cost Centers 0 97,494 201.00	192. 02 19202 LTC	0	0				192.02
200.00 Cross Foot Adjustments 0 24,291 200.00 201.00 Negative Cost Centers 0 97,494 201.00	193. 00 19300 NONPALD WORKERS	0	0				193.00
201.00 Negative Cost Centers 0 97,494 201.00	194. 00 07950 MARKETI NG	0	30, 067				194.00
		0					
202.00 TOTAL (sum lines 118 through 201) 0 19,752,362 202.00		0					
	202.00 TOTAL (sum lines 118 through 201)	0	19, 752, 362				202.00

	LLOCATION - STATISTICAL BASIS		Provider C	CN: 15-0044	Period:	Worksheet B-1	
					From 09/01/2018 Fo 08/31/2019	Date/Time Pre 9/21/2022 9:4	
		CAPI TAL REL	ATED COSTS			772172022 7.4	
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	Reconciliatio n	ADMI NI STRATI V E & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	460, 034					1 1 00
1.00 2.00	00200 CAP REL COSTS-BLDG & FIXT	400, 034	11, 271, 250				1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	10, 146		93, 551, 561	1		4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	24, 421	98, 040	4, 762, 21	-58, 624, 698		
6.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	6, 900	4, 743, 266	2, 294, 424		0 10, 783, 690	
8.00	00800 LAUNDRY & LI NEN SERVI CE	6, 545	2, 518	100, 693		1, 105, 999	
9.00	00900 HOUSEKEEPI NG	1, 654	11, 315	2, 001, 285		3, 294, 426	
10.00	01000 DI ETARY	2, 530	111, 112	976, 41		0	
11.00 12.00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL	14, 352	0	1, 453, 046		3, 155, 940 0	1
	01300 NURSI NG ADMI NI STRATI ON	0	0		0 0	0	
	01400 CENTRAL SERVICES & SUPPLY	16, 302	45, 628	514, 344		1, 395, 185	
	01500 PHARMACY	3, 356	336, 986	3, 776, 390		5, 466, 015	
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	7, 337	276	3, 593, 32		7, 620, 116	
	02300 PARAMED ED PRGM-PHARMACY RESIDENCY	464	9, 529	205, 996	-	301, 125	1
	INPATIENT ROUTINE SERVICE COST CENTERS	1					
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	146, 532	890, 053	17, 135, 070		26, 106, 355	
	03200 CORONARY CARE UNIT	13, 210	68, 758 0	5, 538, 543		8, 312, 346 0	31.00
	03300 BURN I NTENSI VE CARE UNI T	0	0		0 0	0	
	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		0 0	0	
40.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	0	0		0	0	
41.00 42.00	04200 SUBPROVIDER	0	0			0	
	04300 NURSERY	3, 850	21, 484	928, 304	4 0	1, 303, 734	
44.00	04400 SKILLED NURSING FACILITY	0	0	(-	0	
	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0		, ,	0	
40.00	ANCI LLARY SERVICE COST CENTERS	0	0			0	40.00
	05000 OPERATING ROOM	43, 454	1, 962, 489	9, 674, 051	1 0	19, 560, 344	
	05100 RECOVERY ROOM		0	1 221 500	0	0	
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	25, 956	28, 260 0	1, 331, 508	3 O	2, 190, 995 0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	28, 488	1, 416, 534	4, 818, 819	9 0	9, 521, 977	54.00
	05500 RADI OLOGY-THERAPEUTI C	0	0	(0	
	05600 RADI OI SOTOPE 05700 CT SCAN	03, 593	0 3, 318			0 1, 442, 399	
58.00	05800 MRI	1, 644	1, 972	417, 065		810, 267	
59.00	05900 CARDI AC CATHETERI ZATI ON	11, 253	326, 924	3, 373, 092	2 0	4, 997, 434	59.00
60.00		17, 568	45, 970	4, 640, 068	3 0	12, 762, 367	60.00
	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0			0	60.01 61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	(o o	65, 576	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	957, 858		1, 454, 566	
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0 35, 813	4, 482, 97		6, 644, 277	
	06600 PHYSI CAL THERAPY	2, 371 325	184, 717	2, 375, 12 ⁻ 3, 315, 945		3, 617, 142 5, 151, 449	
	06700 OCCUPATI ONAL THERAPY	0	0	(o o	0	
	06800 SPEECH PATHOLOGY	575	17, 901	533, 707		753, 109	
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	9,049	174, 466	1, 976, 98 [°] 259, 416		2, 978, 226 690, 906	
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	/, 140	0	239,410		12, 915, 952	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		o o	16, 031, 475	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	(0	11, 702, 047	
	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)			193, 28		293, 663 0	
	03950 NUTRI TI ON/DI ABETES	0	0			0	1
	07697 CARDI AC REHABI LI TATI ON	3, 593	33, 470	599, 851	0	895, 552	
00 00		^					00.00
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0 0			0	88.00 89.00
	09000 CLINIC	9, 127	318, 884	1, 723, 672	,	3, 729, 846	
91.00	09100 EMERGENCY	28, 910	56, 879	5, 277, 426	6 0	8, 199, 448	
~ ~ ~ ~	DODODODSLOVATION DEDS (NON DISTINCT DADT	1		1		1	92.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						

Health Fina	ancial Systems	BAPTIST HEA	LTH FLOYD		In Lie	u of Form CMS-2	2552-10
COST ALLOC	ATION - STATISTICAL BASIS		Provider CC	CN: 15-0044	Period:	Worksheet B-1	
					From 09/01/2018 To 08/31/2019		norod
						9/21/2022 9:4	
		CAPI TAL REL	ATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliatio	ADMI NI STRATI V	
	best best beschiption	(SQUARE FEET)	(DOLLAR	BENEFITS	n	E & GENERAL	
		(000,000,000,000,000,000,000,000,000,00	VALUE)	DEPARTMENT		(ACCUM. COST)	
				(GROSS			
				SALARI ES)			
		1.00	2.00	4.00	5A	5.00	
	O AMBULANCE SERVICES	0	0		0 0	0	
	O DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	-	
	DO DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	
		0	0		0 0	0	
	O CORF	0	0		0 0	0	
	0 I&R SERVICES-NOT APPRVD PRGM	0	0		0 0		100.00
	0 HOME HEALTH AGENCY	0	0	2, 995, 53	3 0	4, 758, 036	101.00
	I AL PURPOSE COST CENTERS	0	0		0 0	0	105.00
	0 HEART ACQUISITION	0	0		0 0		105.00
	0 LIVER ACQUISITION	0	0				107.00
	DO LUNG ACQUISITION	0	0				107.00
	O PANCREAS ACQUISITION	0	0				109.00
	O INTESTINAL ACQUISITION	0	0				110,00
	O I SLET ACQUI SI TI ON	0	0				111.00
	O I NTEREST EXPENSE	0	0		0	0	113.00
	OUTILIZATION REVIEW-SNF						114.00
	O AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0	0	115.00
116.001160		0	0		0 0		116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	450, 645	10, 947, 886	92, 915, 38	-58, 521, 591		
NONF	EI MBURSABLE COST CENTERS		., . ,	,			
190.001900	O GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	6, 77	1 0	118, 412	190.00
191.001910	0 RESEARCH	0	0	89, 42	4 O	114, 208	191.00
	0 PHYSICIANS' PRIVATE OFFICES	3, 261	0	375, 14	4 0	564, 940	192.00
192.01 1920	01 OTHER NRCC	4, 600	323, 364	164, 83	6 0	4, 461, 454	
192.02 1920		0	0		0 0		192.02
	O NONPAID WORKERS	0	0		0 0		193.00
	O MARKETI NG	1, 528	0		0 0	18, 516	194.00
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)	5, 574, 631	5, 726, 731	25, 563, 55	2	58, 624, 698	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	12. 117867	0. 508083			0. 285571	•
204.00	Cost to be allocated (per Wkst. B, Part II)			124, 40	9	6, 477, 228	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0. 00133	D	0. 031552	205.00
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

	IFINANCIAL SYSTEMS ALLOCATION - STATISTICAL BASIS	BAPTIST HEA			Period:	u of Form CMS-2 Worksheet B-1	
					rom 09/01/2018 o 08/31/2019		
	Cost Center Description	MAI NTENANCE & REPAI RS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	9/21/2022 9: 4 DI ETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
1 00	GENERAL SERVICE COST CENTERS						1 0 00
1.00 2.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY	425, 467 6, 900 6, 545 1, 654 2, 530	418, 567 6, 545 1, 654 2, 530	1, 620, 975 68, 255 70, 200	5 410, 368 2, 530	172, 834	1.00 2.00 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 23. 00	01100 CAFETERIA 01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 02300 PARAMED ED PRGM-PHARMACY RESI DENCY INPATI ENT ROUTI NE SERVI CE COST CENTERS	14, 352 0 16, 302 3, 673 7, 337 0 147	0 0 16, 302 3, 356 7, 337	0 C C C 1, 155 C C C	0 0 16, 302 3, 356 7, 337 0 0	0 0 0 0 0 0 0	11.00 12.00 13.00 14.00 15.00 16.00 17.00 23.00
30.00 31.00 32.00 33.00 34.00 40.00 41.00 42.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04200 NURSERY	146, 715 13, 210 0 0 0 0 0 0 0 0 0	13, 210 0 0 0 0 0 0 0 0 0 0 0	53, 048 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3 13, 210 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	156, 334 6, 454 0 0 0 0 0 0 0	30.00 31.00 32.00 33.00 34.00 40.00 41.00 42.00
43.00 44.00 45.00 46.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY 04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	3, 667 0 0 0				1, 308 0 0 0	44.00 45.00 46.00
50.00 51.00 52.00 53.00 54.00 55.00	05000 OPERATI NG ROOM 05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	43, 454 0 25, 956 0 28, 488 0	0 25, 956 0 28, 488	88, 328	0 0 25, 956 0 0 3 28, 488	116 0 4, 665 0 494 0	51.00
56.00 57.00 58.00 59.00 60.00 60.01 61.00	05600 RADI OI SOTOPE 05700 CT SCAN 05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY	0 3, 593 1, 644 11, 253 17, 568 0	3, 593 1, 644 11, 253	13, 096 16, 482 78, 156	3, 593 1, 644 11, 253	0 0 2, 591 0 0	59.00 60.00 60.01
61.00 62.00 63.00 64.00 65.00 67.00 68.00 69.00 70.00 71.00 71.00 73.00		0 0 2, 371 325 0 575 9, 049 7, 140 0 0	325 0 575 9, 049	7, 917 C 14, 339 C	0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	61.00 62.00 63.00 64.00 65.00 66.00 67.00 68.00 69.00 70.00 71.00 72.00 73.00
74.00 75.00 76.00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0 0 0 3, 593	0 0 0 0 3, 593		0 0 0 0 0 3,593	0 0 0 0	74.00 75.00 76.00
88.00 89.00 90.00 91.00 92.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0 0 9, 127 28, 910			0 0 9, 127 28, 910	0 0 30 842	89.00 90.00
95.00 96.00		000000000000000000000000000000000000000				0 0 0 0	95.00

Health Financial Systems	BAPTIST HEA	LTH FLOYD		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-	1
				rom 09/01/2018		
				Го 08/31/2019		
Cast Canton Deparintian	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	9/21/2022 9: 4 DI ETARY	45 am
Cost Center Description	REPAIRS	PLANT		(SQUARE FEET)	(MEALS	
	(SQUARE FEET)		(POUNDS OF	(SUUARE ILLI)	SERVED)	
	(SUUARE ILLI)	(SQUARE ILLI)	LAUNDRY)		JERVED)	
	6,00	7.00	8,00	9.00	10.00	
99.00 09900 CMHC	0.00) 0		99.00
99. 10 09910 CORF	0			0 0		99.10
100.0010000 I&R SERVICES-NOT APPRVD PRGM	0	-		0 0	-	100.00
101. 00 10100 HOME HEALTH AGENCY	0	-				101.00
SPECIAL PURPOSE COST CENTERS				<u> </u>		101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0 0	(105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0				106.00
107. 00 10700 LI VER ACQUI SI TI ON	0	, i i i i i i i i i i i i i i i i i i i				107.00
108. 00 10800 LUNG ACQUI SI TI ON	0					108.00
109. 00 10900 PANCREAS ACQUISITION	0					109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0					110,00
111. 00 11100 I SLET ACQUI SI TI ON	0	0				111.00
113. 00 11300 I NTEREST EXPENSE	0	0		0		113.00
114. 00 11400 UTI LI ZATI ON REVIEW-SNF					l .	114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0	· · · · ·	114.00
116. 00 11600 HOSPI CE	0	0		0) 116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	416, 078	409, 178	1, 620, 97	400, 979		118.00
NONREI MBURSABLE COST CENTERS	410,078	409, 176	1, 020, 973	400,979	172,034	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	(0 190.00
191. 00 19100 RESEARCH	0					190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	3, 261	, v		3, 261		192.00
192. 01 19201 OTHER NRCC	4, 600			4,600		192.00
192. 02 19202 LTC	4,000	4,000		4,000 0 0		192.01
193. 00 19300 NONPALD WORKERS	0	0				192.02
194. 00 07950 MARKETI NG	1, 528	1, 528		1,528		194.00
200.00 Cross Foot Adjustments	1, 520	1, 520		1, 520		200.00
201.00 Negative Cost Centers					l	200.00
202.00 Cost to be allocated (per Wkst. B,	0	12 042 100	1 4 20 41	1 1 250 000	70 52	201.00
Part I)	0	13, 863, 199	1, 638, 61	4, 358, 999	76, 520	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000	33. 120621	1.01088	10. 622171	0.454343	2203 00
204.00 Cost to be allocated (per Wkst. B,	0.000000					203.00
Part II)	0	2,050,017	100, 19	150,411	114, 240	204.00
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	6. 810898	0. 09882	0. 366527	0.096920	205 00
	0.000000	0. 010090	0.070020	0. 300327	0.070720	205.00
206.00 NAHE adjustment amount to be allocated					l	206.00
(per Wkst. B-2)						200.00
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						
	1	I	1	1		

	LLOCATION - STATISTICAL BASIS		Provider C	CN: 15-0044	Peri od:	Worksheet B-1	2552-
					From 09/01/2018 To 08/31/2019		
	Cost Center Description	CAFETERIA	MAI NTENANCE	NURSI NG	CENTRAL	9/21/2022 9:4 PHARMACY	<u>5 am</u>
	···· .	(PRODUCTI VE	OF PERSONNEL			(COSTED	
		HOURS)	(NUMBER HOUSED)	N (DI RECT	SUPPLY (COSTED	REQUIS.)	
			HOUSED	NRSI NG HRS)	REQUIS.)		
		11.00	12.00	13.00	14.00	15.00	
00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT			1			1.0
00	00200 CAP REL COSTS-MVBLE EQUIP						2.0
00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4.0
00 00	00600 MAINTENANCE & REPAIRS						5. 6.
00	00700 OPERATION OF PLANT						7.
00	00800 LAUNDRY & LINEN SERVICE						8.
00). 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.
	01100 CAFETERI A	2, 644, 817					10.
	01200 MAINTENANCE OF PERSONNEL	0	C				12.
	01300 NURSI NG ADMI NI STRATI ON	0	0		0		13.
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	30, 287 86, 029			0 29, 863, 834	100	14. 15.
	01600 MEDICAL RECORDS & LIBRARY	103, 043	0		0 0	0	
	01700 SOCIAL SERVICE	0	0		0 0	0	
3.00	02300 PARAMED ED PRGM-PHARMACY RESIDENCY	4, 972	0	1	0 0	0	23.
0. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	948, 817	C		0 0	0	30.
	03100 I NTENSI VE CARE UNI T	110, 208	0		0 0	0	
	03200 CORONARY CARE UNI T	0	0		0 0	0	
	03300 BURN I NTENSI VE CARE UNI T	0	0		0 0	0	
	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0				0	
	04100 SUBPROVI DER – I RF	0	0		0 0	0	
	04200 SUBPROVI DER	0	0		0 0	0	
	04300 NURSERY	35, 532	0		0 0	0	
	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0			0 0 0 0	0	
5.00	04600 OTHER LONG TERM CARE	0	0		0 0	0	
	ANCI LLARY SERVICE COST CENTERS	204 415	0	1	0 0	0	1 50
	05000 OPERATING ROOM 05100 RECOVERY ROOM	296, 415		1	0 0	0	
2.00	05200 DELIVERY ROOM & LABOR ROOM	42, 870	C		0 0	0	52.
	05300 ANESTHESI OLOGY	0	0		0 0	0	
	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	147, 557			0 0	0	
5.00	05600 RADI OI SOTOPE	0	0		0 0	0	
	05700 CT SCAN	21, 075	0		0 0	0	
		12, 693	0		0 0	0	
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	106, 956 178, 616				0	
	06001 BLOOD LABORATORY	0	0		0 0	0	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	
	06400 INTRAVENOUS THERAPY	0			0 0	0	
	06500 RESPI RATORY THERAPY	83, 743	0		0 0	0	65.
	06600 PHYSI CAL THERAPY	34, 345	0		0 0	0	
		10 111	0		0 0	0	
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	10, 111 49, 539			0 0	0	
	07000 ELECTROENCEPHALOGRAPHY	2, 915	0		0 0	0	1
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0		0 13, 832, 359	0	
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0			0 16,031,475	0 100	
	07400 RENAL DI ALYSI S	0	0		ŏ o	0	1
. 00	07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75.
	03950 NUTRI TI ON/DI ABETES	0	0		0 0	0	
. 97	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	13, 366	0	1	0 0	0	76.
. 00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.
. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89.
	09000 CLINIC	48, 481	0		0 0	0	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	190, 414	0		0	0	91. 92.
. 00	OTHER REIMBURSABLE COST CENTERS		l	1			72.
							-
	09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES	0	0		0 0	0	

Health Financial Systems	BAPTIST HEA	LTH FLOYD		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C	CN: 15-0044	Peri od:	Worksheet B-1	1
				From 09/01/2018		
				To 08/31/2019		epared:
	0.000000			05117541	9/21/2022 9: 4	15 am
Cost Center Description	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL	PHARMACY	
	(PRODUCTI VE	OF PERSONNEL			(COSTED	
	HOURS)	(NUMBER	N	SUPPLY	REQUIS.)	
		HOUSED)	(DI RECT	(COSTED		
	44.00	40.00	NRSING HRS)	REQUIS.)	15.00	
	11.00	12.00	13.00	14.00	15.00	07.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		0 0		
99.00 09900 CMHC	0	0		0 0		
99. 10 09910 CORF	0	0		0 0	C	
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		0 0		100.00
101.00 10100 HOME HEALTH AGENCY	86, 350	0		0 0	C	101.00
SPECIAL PURPOSE COST CENTERS			1	-	-	
105.00 10500 KI DNEY ACQUI SI TI ON	0	0		0 0		105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0		0 0	-	106.00
107.00 10700 LI VER ACQUI SI TI ON	0	0		0 0		107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0		0 0		108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0		0 0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	C	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0	C	115.00
116. 00 11600 HOSPI CE	0	0		0 0	C	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2, 644, 334	0		0 29, 863, 834	100	118.00
NONREI MBURSABLE COST CENTERS			-			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	160	0		0 0	C	190.00
191. 00 19100 RESEARCH	0	0		0 0	C	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0	C	192.00
192. 01 19201 OTHER NRCC	323	0		0 0	C	192.01
192.02 19202 LTC	0	0		0 0	C	192.02
193.00 19300 NONPALD WORKERS	0	0		0 0	C	193.00
194. 00 07950 MARKETI NG	0	0	1	0 0	c c	194.00
200.00 Cross Foot Adjustments			1			200.00
201.00 Negative Cost Centers			1			201.00
202.00 Cost to be allocated (per Wkst. B,	4, 684, 981	0	1	0 2, 560, 354	7, 327, 309	202.00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	1. 771382	0. 000000	0. 00000	0. 085734	73, 273. 090000	203.00
204.00 Cost to be allocated (per Wkst. B,	378, 435	0		0 386, 773	425, 883	204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 143086	0. 000000	0. 00000	0. 012951	4, 258. 830000	205.00
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)						
· · ·	•					

	n Financial Systems ALLOCATION - STATISTICAL BASIS	BAPTI ST HEAL		CCN: 15-0044	Peri od:	of Form CMS-2552-10 Worksheet B-1
					From 09/01/2018 To 08/31/2019	Date/Time Prepared:
	Cost Center Description	MEDI CAL RECORDS & LI BRARY (TI ME SPENT) 16.00	SOCI AL SERVI CE (ASSI GNED TI ME) 17. 00	PARAMED ED PRGM-PHARMAC RESI DENCY (ASSI GNED TI ME) 23.00	Y	9/21/2022 9:45 am
	GENERAL SERVICE COST CENTERS	10.00	17.00	23.00		
15.00	01100 CAFETERIA 01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	1, 378 0 0		0 10	00	1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 23.00
30.00		1, 228		0 10	00	30.00
30.00 31.00 32.00 33.00 40.00 41.00 42.00 43.00 44.00 45.00 46.00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	1,220 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 10 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00 44. 00 45. 00 46. 00
50.00	ANCI LLARY SERVI CE COST CENTERS	90		0	0	50.00
51.00 52.00 53.00 54.00 55.00 56.00	05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0 0 5 0 0			0 0 0 0 0	51.00 52.00 53.00 54.00 55.00 56.00
57.00	05700 CT SCAN	0		0	0	57.00
58.00 59.00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	0		0	0	58.00 59.00
60. 00 60. 01 61. 00 62. 00 63. 00	06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0 0 0			000	60. 00 60. 01 61. 00 62. 00 63. 00
64.00		0		0	0	64.00
65.00 66.00	06600 PHYSI CAL THERAPY	5		0	o	65.00 66.00
67.00 68.00		0		0	0	67.00 68.00
69.00	06900 ELECTROCARDI OLOGY	5		0	0	69.00
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	70.00 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DI ALYSI S	0		0	0	73.00 74.00
75.00 76.00		0		0	0	75.00 76.00
	07697 CARDI AC REHABI LI TATI ON	0		0	0	76. 97
88.00	OUTPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLINIC	0		0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	89.00
90.00 91.00	09100 EMERGENCY	38		0	0	90.00 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS					92.00
	09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES	0		0	0	94. 00 95. 00
95 111	107000 MIDDENNOL DENVIOLD	0		~I	<u> </u>	J 7J. UU

Health Financial Systems	BAPTI ST HEAL	_TH FLOYD		In Lieu of Form CMS	-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC	CN: 15-0044	Period: Worksheet B-	
				From 09/01/2018	
				To 08/31/2019 Date/Time Pr	
Cast Castar Description		COCLAL		9/21/2022 9:	<u>45 am</u>
Cost Center Description	MEDI CAL RECORDS &	SOCI AL SERVI CE	PARAMED ED PRGM-PHARMAC	1	
	LIBRARY	(ASSI GNED	RESI DENCY	T	
	(TIME SPENT)	TIME)	(ASSI GNED		
	(TIME SPENT)		TIME)		
	16.00	17.00	23.00	_	
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	10.00	0		0	97.00
99. 00 09900 CMHC	0	0		0	99.00
99. 10 09910 CORF	0	0		0	99.10
100.0010000 I &R SERVICES-NOT APPRVD PRGM	0	0		0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0	101.00
SPECIAL PURPOSE COST CENTERS	0	U U		0	
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0	105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0		0	106.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0		0	107.00
108. 00 10800 LUNG ACQUI SI TI ON	0	0		0	108.00
109. 00 10900 PANCREAS ACQUI SI TI ON	0	0		0	109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0	110.00
111. 00 11100 I SLET ACQUI SI TI ON	0	0		0	111.00
113. 00 11300 I NTEREST EXPENSE	0	0		0	113.00
114. 00 11400 UTILIZATION REVIEW-SNF					114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0	115.00
116. 00 11600 HOSPI CE	0	0		0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	U	0	10		118.00
NONREI MBURSABLE COST CENTERS	1, 570	V	10		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		o	190.00
191. 00 19100 RESEARCH	0	0		0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0	192.00
192. 01 19201 OTHER NRCC	0	0		0	192.01
192. 02 19202 LTC	0	0		0	192.02
193. 00 19300 NONPALD WORKERS	0	0		0	193.00
194. 00 07950 MARKETI NG	0	0		0	194.00
200.00 Cross Foot Adjustments	Ŭ	J. J. J. J. J. J. J. J. J. J. J. J. J. J			200.00
201.00 Negative Cost Centers					201.00
202.00 Cost to be allocated (per Wkst. B,	10, 299, 670	0	416, 32	8	202.00
Part I)	10/2///0/0	J	110,02		202100
203.00 Unit cost multiplier (Wkst. B, Part I)	7, 474. 361393	0. 000000	4, 163. 28000	0	203.00
204.00 Cost to be allocated (per Wkst. B,	401, 663	0	24, 29		204.00
Part II)		-			
205.00 Unit cost multiplier (Wkst. B, Part	291. 482583	0. 000000	242, 91000	0	205.00
206.00 NAHE adjustment amount to be allocated				0	206.00
(per Wkst. B-2)					
207.00 NAHE unit cost multiplier (Wkst. D,			0.00000	0	207.00
Parts III and IV)					

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	BAPTI ST HEA	ALTH FLOYD Provider C		In Lie Period: From 09/01/2018 To 08/31/2019		pared:
		Title	e XVIII	Hospi tal	9/21/2022 9:4 PPS	<u>5 am</u>
				Costs	115	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	52, 120, 749		52, 120, 74		52, 316, 107	30.00
31. 00 03100 I NTENSI VE CARE UNI T 32. 00 03200 CORONARY CARE UNI T	11, 515, 730		11, 515, 73		11, 515, 730	31.00 32.00
32. 00 03200 CORONARY CARE UNIT 33. 00 03300 BURN INTENSIVE CARE UNIT	0			0 0	0	32.00
34.00 03400 SURGI CAL I NTENSI VE CARE UNI T	0			0 0	0	34.00
40. 00 04000 SUBPROVIDER - IPF	0			0 0	0	40.00
41.00 04100 SUBPROVIDER - IRF	0			0 0	0	41.00
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY	1, 931, 307		1, 931, 30	0 0	0 1, 931, 307	42.00
44. 00 04400 SKILLED NURSING FACILITY	1, 931, 307		1, 931, 30	0 0	1, 931, 307	43.00
45. 00 04500 NURSI NG FACI LI TY	0			0 0	0	45.00
46.00 O4600 OTHER LONG TERM CARE	0			0 0	0	46.00
ANCI LLARY SERVICE COST CENTERS	20 424 402		20 424 40		20 424 402	50.00
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM	28, 424, 493		28, 424, 49	3 0 0 0	28, 424, 493 0	50.00 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	4, 030, 127		4, 030, 12		4, 030, 127	52.00
53. 00 05300 ANESTHESI OLOGY	0			0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	13, 875, 586		13, 875, 58		13, 875, 586	
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	0			0 0 0 0	0	55.00 56.00
57. 00 05700 CT SCAN	2,062,044		2, 062, 04		2, 062, 044	57.00
58.00 05800 MRI	1, 152, 714		1, 152, 71		1, 152, 714	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	7, 186, 436		7, 186, 43		7, 186, 436	59.00
60. 00 06000 LABORATORY	17, 491, 841		17, 491, 84		17, 491, 841	60.00
60.01 06001 BLOOD LABORATORY 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0 0 0 0	0	60.01 61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	84, 303		84, 30		84, 303	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	1, 869, 948		1, 869, 94		1, 869, 948	
64.00 06400 I NTRAVENOUS THERAPY	8, 541, 690		8, 541, 69		8, 541, 690	
65. 00 06500 RESPI RATORY THERAPY	4, 954, 469		4, 954, 46		4, 954, 469	1
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	6, 742, 982		6, 742, 98	2 0 0 0	6, 742, 982 0	66.00 67.00
68.00 06800 SPEECH PATHOLOGY	1, 025, 732	0	1, 025, 73		1, 025, 732	68.00
69.00 06900 ELECTROCARDI OLOGY	4, 349, 673		4, 349, 67		4, 349, 673	
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 205, 696		1, 205, 69		1, 205, 696 17, 790, 276	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	17, 790, 276 21, 984, 050		17, 790, 27 21, 984, 05		21, 984, 050	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	22, 371, 121		22, 371, 12		22, 371, 121	
74.00 07400 RENAL DI ALYSI S	377, 525		377, 52	5 0	377, 525	
75.00 07500 ASC (NON-DI STINCT PART)	0			0 0	0	
76. 00 03950 NUTRI TI ON/DI ABETES 76. 97 07697 CARDI AC REHABI LI TATI ON	1, 332, 139		1, 332, 13	0 0	0 1, 332, 139	76.00 76.97
OUTPATIENT SERVICE COST CENTERS	1,002,107		1,002,10		1,002,107	/0. //
88.00 08800 RURAL HEALTH CLINIC	0			0 0	0	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0 5, 280, 115		5, 280, 11	0 0 5 36, 398	0 5, 316, 513	89.00 90.00
91. 00 09100 EMERGENCY	12, 644, 412		12, 644, 41		12, 660, 706	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	11, 948, 111		11, 948, 11	1	11, 948, 111	
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DI ALYSI S 95. 00 09500 AMBULANCE SERVI CES	0			0 0	0	94.00 95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0			o o	0	95.00
97.00 09700 DURABLE MEDI CAL EQUI P-SOLD	0			0 0	0	97.00
99.00 09900 CMHC	0			0	0	99.00
99. 10 09910 CORF 100. 00 10000 I & SERVICES-NOT APPRVD PRGM	0			0	0	99.10 100.00
101.00 10100 HOME HEALTH AGENCY	6, 269, 752		6, 269, 75	2	6, 269, 752	
SPECIAL PURPOSE COST CENTERS	-,,02	r				
105. 00 10500 KI DNEY ACQUI SI TI ON	0			0		105.00
106. 00 10600 HEART ACQUI SI TI ON 107. 00 10700 LI VER ACQUI SI TI ON	0			0		106.00 107.00
108. 00 10800 LUNG ACQUISITION				0		107.00
109. 00 10900 PANCREAS ACQUI SI TI ON	0			ō		109.00
110.00 11000 INTESTINAL ACQUISITION	0			0	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	0			0	0	111.00
113. 00 11300 I NTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF						113.00 114.00
115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.)	0			0	0	115.00
116. 00 11600 HOSPI CE	0			0		116.00

Health Fina	ancial Systems	BAPTI ST HEALTH FLOYD				In Lieu of Form CMS-2552-10		
COMPUTATI O	N OF RATIO OF COSTS TO CHARGES			Provider CO		Period: From 09/01/2018		parad.
						To 08/31/2019	Date/Time Pre 9/21/2022 9:4	5 am
				Title	XVIII	Hospi tal	PPS	
						Costs		
	Cost Center Description	Total Cost	The	erapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.		Adj.		Di sal I owance		
		B, Part I,		-				
		col. 26)						
		1.00		2.00	3.00	4.00	5.00	
200.00	Subtotal (see instructions)	268, 563, 021		0	268, 563, 02	248, 050	268, 811, 071	200.00
201.00	Less Observation Beds	11, 948, 111			11, 948, 11	1	11, 948, 111	201.00
202.00	Total (see instructions)	256, 614, 910		0	256, 614, 91	0 248, 050	256, 862, 960	202.00

Health Financial Systems	BAPTI ST HEA	LTH FLOYD		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		eriod: rom 09/01/2018	Worksheet C Part I	
			Т	0 08/31/2019	Date/Time Pre 9/21/2022 9:4	pared: 5 am
			e XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Charges Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent	
	6.00	7.00	8.00	9.00	Rati o 10.00	
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	65, 251, 677 31, 847, 770		65, 251, 677 31, 847, 770			30.00 31.00
32. 00 03200 CORONARY CARE UNI T	0		0			32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0		0			33.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	0		0			34.00
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF	0					40.00
42. 00 04200 SUBPROVI DER	0		0			42.00
43. 00 04300 NURSERY	5, 379, 081		5, 379, 081			43.00
44. 00 04400 SKILLED NURSING FACILITY	0		0			44.00
45. 00 04500 NURSING FACILITY 46. 00 04600 OTHER LONG TERM CARE	0		0			45.00 46.00
ANCI LLARY SERVICE COST CENTERS						40.00
50.00 OPERATING ROOM	92, 780, 681	105, 069, 736	197, 850, 417	0. 143667	0. 000000	50.00
51.00 05100 RECOVERY ROOM	0	0	-		0.00000	•
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	6, 685, 037	1,063,265	7, 748, 302	0. 520130 0. 000000	0. 000000 0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	25, 986, 657	126, 999, 350	152, 986, 007	0. 090698	0.000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0. 000000	0. 000000	
56. 00 05600 RADI OI SOTOPE	0	0	0	0.00000	0.00000	
57. 00 05700 CT_SCAN 58. 00 05800 MRI	32, 127, 589 7, 951, 942	68, 291, 242 22, 254, 577		0. 020534 0. 038161	0. 000000 0. 000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	82, 145, 499	95, 218, 499			0.000000	
60. 00 06000 LABORATORY	68, 961, 747	93, 747, 844		0. 107503	0. 000000	•
60.01 06001 BLOOD LABORATORY	0	0			0.00000	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0 1, 097, 329	0 230, 402	-	0. 000000 0. 063494	0. 000000 0. 000000	•
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	4, 879, 898	330, 950			0.000000	•
64.00 06400 I NTRAVENOUS THERAPY	305, 325	22, 988, 458			0. 000000	
65. 00 06500 RESPIRATORY THERAPY	22, 468, 043	4, 023, 686			0.00000	
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	8, 975, 687 0	24, 364, 940	33, 340, 627		0. 000000 0. 000000	•
68. 00 06800 SPEECH PATHOLOGY	2, 983, 768	955, 340	-		0.000000	
69. 00 06900 ELECTROCARDI OLOGY	31, 004, 202	64, 178, 057			0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	448, 661	1, 686, 312			0.00000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	26, 035, 362 53, 044, 394	20, 233, 559 25, 063, 823		0. 384497 0. 281456	0. 000000 0. 000000	•
73. 00 07300 DRUGS CHARGED TO PATIENTS	54, 669, 496	41, 417, 695		0. 232821	0.000000	
74. 00 07400 RENAL DI ALYSI S	1, 632, 669	0		0. 231232	0. 000000	74.00
75. 00 07500 ASC (NON-DI STI NCT PART)	0	0	-		0.00000	
76. 00 03950 NUTRI TI ON/DI ABETES 76. 97 07697 CARDI AC REHABI LI TATI ON	0 1, 373	2, 172, 922	0 2, 174, 295			•
OUTPATIENT SERVICE COST CENTERS	1,070	2, 172, 722	2,111,270	0.012070	0.00000	10.77
88.00 08800 RURAL HEALTH CLINIC	0	0				88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0 1, 957, 759	0			0. 000000	89.00
91. 00 09100 EMERGENCY	25, 418, 879	16, 602, 182 84, 861, 620			0.000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	8, 410, 470	22, 643, 056			0. 000000	
OTHER REI MBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DI ALYSI S 95. 00 09500 AMBULANCE SERVI CES	0	0	0	0.000000 0.000000	0. 000000 0. 000000	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0.000000	0.000000	
97.00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0	0	0. 000000	0. 000000	•
99.00 09900 CMHC	0	0	0			99.00
99.10 09910 CORF 100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0				99.10 100.00
101. 00 10100 HOME HEALTH AGENCY	0	6, 321, 002	6, 321, 002			101.00
SPECIAL PURPOSE COST CENTERS				1		
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0				105.00
106. 00 10600 HEART ACQUI SI TI ON 107. 00 10700 LI VER ACQUI SI TI ON	0	0	0			106.00 107.00
108. 00 10800 LUNG ACQUISITION	0	0	0			107.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0	0			109.00
110. 00 11000 INTESTINAL ACQUISITION	0	0	0			110.00
111.00 11100 I SLET ACQUI SI TI ON 113.00 11300 I NTEREST EXPENSE	0	0				111.00 113.00
114. 00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0			115.00
116.00 11600 HOSPI CE	0	0				116.00
200.00 Subtotal (see instructions)	662, 450, 995	850, 718, 517	1, 513, 169, 512			200.00

Health Financial Systems BAPTIST HEALTH FLOYD					In Lieu of Form CMS-2552-10			
COMPUTATI O	N OF RATIO OF COSTS TO CHARGES			Period: From 09/01/2018	Worksheet C Part I			
					To 08/31/2019			
			Title	e XVIII	Hospi tal	PPS		
			Charges					
	Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA		
				+ col. 7)	Ratio	I npati ent		
						Rati o		
		6.00	7.00	8.00	9.00	10.00		
201.00	Less Observation Beds						201.00	
202.00	Total (see instructions)	662, 450, 995	850, 718, 517	1, 513, 169, 51	2		202.00	

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	Financial Systems ATION OF RATIO OF COSTS TO CHARGES	BAPTIST HEALT	H FLOYD Provider CCN: 15-0044	Period:	<u>i of Form CMS-2552-10</u> Worksheet C
				From 09/01/2018 To 08/31/2019	Part I Date/Time Prepared: 9/21/2022 9:45 am
			Title XVIII	Hospi tal	PPS
	Cost Center Description	PPS Inpatient Ratio			
		11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS	1			
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT				30.00 31.00
	03200 CORONARY CARE UNIT				32.00
	03300 BURN I NTENSI VE CARE UNI T				33.00
	03400 SURGI CAL I NTENSI VE CARE UNI T				34.00
	04000 SUBPROVIDER - IPF				40.00
41.00 42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER				41.00
	04300 NURSERY				43.00
	04400 SKILLED NURSING FACILITY				44.00
45.00	04500 NURSI NG FACI LI TY				45.00
46.00	04600 OTHER LONG TERM CARE				46.00
50.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	0. 143667			50.00
	05100 RECOVERY ROOM	0. 143887			51.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 520130			52.00
53.00	05300 ANESTHESI OLOGY	0. 000000			53.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 090698			54.00
	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0.000000			55.00 56.00
57.00	05700 CT SCAN	0. 020534			57.00
58.00	05800 MRI	0. 038161			58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 040518			59.00
	06000 LABORATORY	0. 107503			60.00
	06001 BLOOD LABORATORY	0. 000000			60.01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000 0. 063494			61.00 62.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 358857			63.00
	06400 I NTRAVENOUS THERAPY	0. 366694			64.00
65.00	06500 RESPI RATORY THERAPY	0. 187019			65.00
66.00	06600 PHYSI CAL THERAPY	0. 202245			66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0. 000000 0. 260397			67.00 68.00
	06900 ELECTROCARDI OLOGY	0. 045698			69.00
	07000 ELECTROENCEPHALOGRAPHY	0. 564736			70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 384497			71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 281456			72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0. 232821 0. 231232			73.00 74.00
	07500 ASC (NON-DISTINCT PART)	0. 000000			75.00
	03950 NUTRI TI ON/DI ABETES	0. 000000			76.00
76.97	07697 CARDI AC REHABI LI TATI ON	0. 612676			76. 97
00 00	OUTPATIENT SERVICE COST CENTERS				
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER				88.00 89.00
	09000 CLINIC	0. 286451			90.00
91.00	09100 EMERGENCY	0. 114805			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 384759			92.00
04 00	OTHER REIMBURSABLE COST CENTERS	0. 000000			94.00
	09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES	0. 000000			94.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			96.00
97.00	09700 DURABLE MEDI CAL EQUI P-SOLD	0. 000000			97.00
	09900 CMHC				99.00
	09910 CORF				99.10
	10000 I&R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY				100.00 101.00
101.00	SPECIAL PURPOSE COST CENTERS				
105.00	10500 KI DNEY ACQUI SI TI ON				105.00
	10600 HEART ACQUI SI TI ON				106.00
	10700 LIVER ACQUISITION				107.00
	10800 LUNG ACQUISITION 10900 PANCREAS ACQUISITION				108.00 109.00
	11000 INTESTINAL ACQUISITION				110.00
	11100 I SLET ACQUI SI TI ON				111.00
113.00	11300 INTEREST EXPENSE				113.00
	11400 UTI LI ZATI ON REVI EW-SNF				114.00
	11500 AMBULATORY SURGICAL CENTER (D.P.)				115.00
					111/ 00
116.00	11600 HOSPICE Subtotal (see instructions)				116.00 200.00
	Subtotal (see instructions)				116. 00 200. 00 201. 00

 202.00
 Total (see instructions)

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Health Financial Systems	BAPTIST HEA	LTH FLOYD		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	L COSTS	Provider C		Period: From 09/01/2018 To 08/31/2019		nared.
					9/21/2022 9:4	5 am
			× XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal Rel ated Cost	Swing Bed	Reduced Capital	Total Patient	Per Diem (col. 3 /	
	(from Wkst.	Adjustment	Related Cost	Days	col. 4)	
	B, Part II,		(col. 1 -		COI. 4)	
	col. 26)		col. 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 ADULTS & PEDIATRICS	4, 721, 105	0	1 1/121/10		79.73	•
31.00 INTENSIVE CARE UNIT	581, 101		581, 10		113.45	
32.00 CORONARY CARE UNIT 33.00 BURN INTENSIVE CARE UNIT	0			0 0	0.00 0.00	•
34. 00 SURGI CAL I NTENSI VE CARE UNI T	0				0.00	
40. 00 SUBPROVIDER - IPF	0	0		0 0	0.00	
41.00 SUBPROVIDER - IRF	0	0		0 0	0.00	•
42. 00 SUBPROVI DER	0	0		0 0	0.00	42.00
43. 00 NURSERY	135, 064		135, 06	2, 428		
44.00 SKILLED NURSING FACILITY	0			0 0		44.00
45.00 NURSING FACILITY	0		F 407 07	0 0	0.00	45.00
200.00 Total (lines 30 through 199) Cost Center Description	5, 437, 270 Inpati ent	Inpatient	5, 437, 27	66, 762		200.00
cost center bescription	Program days	Program				
	riogram days	Capital Cost				
		(col. 5 x				
		col. 6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS	04.7/5	1 705 000				
30. 00 ADULTS & PEDIATRICS 31. 00 INTENSIVE CARE UNIT	21, 765 3, 841	1, 735, 323 435, 761				30.00 31.00
32.00 CORONARY CARE UNIT	3, 841	435,761	1			32.00
33. 00 BURN INTENSIVE CARE UNIT	0	0				33.00
34.00 SURGI CAL I NTENSI VE CARE UNI T	0	0				34.00
40.00 SUBPROVIDER - IPF	0	0				40.00
41.00 SUBPROVIDER - IRF	0	0				41.00
42.00 SUBPROVI DER	0	0				42.00
43.00 NURSERY	0	0				43.00
44.00 SKILLED NURSING FACILITY 45.00 NURSING FACILITY	0	0				44.00
200.00 Total (lines 30 through 199)	25, 606	0				200.00
((((())))) = (((())))	20,000	2, , 001	1			

PPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI	FAL COSTS	Provider C		Period: From 09/01/2018 To 08/31/2019	Worksheet D Part II Date/Time Pre 9/21/2022 9:4	pared: 5 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)	5	· · · · ·	
	col. 26)		, · · · · · · · · · · · · · · · · · · ·			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS		````				
0.00 05000 OPERATING ROOM	2,603,660	197, 850, 417	0.01316	40, 544, 085	533, 560	1 50.00
1.00 05100 RECOVERY ROOM	0	0	0.00000		0	1
2.00 05200 DELIVERY ROOM & LABOR ROOM	592, 827	7, 748, 302			-	
3. 00 05300 ANESTHESI OLOGY	0,72,027	1,740,302	0.00000		0	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 588, 152	152, 986, 007			308, 653	
	2, 300, 132	152, 960, 007	0.01091			
	0				0	
6. 00 05600 RADI 0I SOTOPE	0	-	0100000		0	
7.00 05700 CT SCAN	122, 430		0.00121		16, 662	
8.00 05800 MRI	62, 290					
9. 00 05900 CARDI AC CATHETERI ZATI ON	568, 679					
0. 00 06000 LABORATORY	841, 293	162, 709, 591	0. 00517		183, 541	60.0
0.01 06001 BLOOD LABORATORY	0	0	0. 00000	0 0	0	60.0
1.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	2,069	1, 327, 731	0.00155	68 478, 803	746	62.00
3.00 06300 BLOOD STORING, PROCESSING & TRANS.	47, 168	5, 210, 848	0.00905	2, 641, 372	23, 910	63.00
4.00 06400 INTRAVENOUS THERAPY	215, 602			6 77, 081	713	64.00
5. 00 06500 RESPI RATORY THERAPY	283, 164	26, 491, 729	0. 01068	12, 421, 218	132, 770	65.00
6. 00 06600 PHYSI CAL THERAPY	832, 585					
7.00 06700 OCCUPATI ONAL THERAPY	0					
8. 00 06800 SPEECH PATHOLOGY	47, 526					
9. 00 06900 ELECTROCARDI OLOGY	452, 684				81, 122	
0. 00 07000 ELECTROENCEPHALOGRAPHY	160, 330				17, 245	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	586, 667	46, 268, 921	0.01268			
2. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	713, 455					
3. 00 07300 DRUGS CHARGED TO PATIENTS	795, 106					
4. 00 07400 RENAL DIALYSIS	9, 523					
5. 00 07500 ASC (NON-DI STINCT PART)	0	0	0.00000		0	
6. 00 03950 NUTRI TI ON/DI ABETES	0	-	0.00000		-	
6. 97 07697 CARDIAC REHABILITATION	153, 561	2, 174, 295	0. 07062	845	60	76.9
OUTPATIENT SERVICE COST CENTERS		-			-	
8.00 08800 RURAL HEALTH CLINIC	0	-			-	
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	-	0100000		0	
0. 00 09000 CLINIC	917, 691		0. 04944			
1.00 09100 EMERGENCY	912, 086					
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 078, 221	31, 053, 526	0. 03472	4, 724, 232	164, 030	92.00
OTHER REIMBURSABLE COST CENTERS			1			
4.00 09400 HOME PROGRAM DIALYSIS	0	0	0.00000	0 0	0	
5. 00 09500 AMBULANCE SERVICES						95.0
6.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0. 00000	0 0	0	96.0
7.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0.00000		0	97.00
00.00 Total (lines 50 through 199)	11 596 760	1, 404, 369, 982		274, 123, 197		

Health Financial Systems	BAPTI ST HEA	LTH FLOYD		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Provider C		eriod: rom 09/01/2018 o 08/31/2019		
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing Program	Nursing Program	Allied Health Post-Stepdown	Allied Health Cost	All Other Medical	
	Post-Stepdown Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 03000 ADULTS & PEDIATRICS	0	-		416, 328		
31.00 03100 INTENSIVE CARE UNIT	0	0	-	0	0	
32. 00 03200 CORONARY CARE UNIT	0	0	-	0	0	
33. 00 03300 BURN I NTENSI VE CARE UNI T	0	0	-	0	0	
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0	-	0	0	
40. 00 04000 SUBPROVIDER - IPF	0	0	-	0	0	
41.00 04100 SUBPROVIDER - IRF	0	0	0	0	0	
42. 00 04200 SUBPROVI DER	0	0	0	0	0	
43. 00 04300 NURSERY	0	0	0	0	0	
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0		44.00
45.00 04500 NURSING FACILITY	0	0	0	0	_	45.00
200.00 Total (lines 30 through 199)	0	0	0	110/020		200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem	Inpatient	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3, minus col. 4)		col. 6)		
	instructions) 4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	5.00	6.00	7.00	8.00	
30. 00 03000 ADULTS & PEDIATRICS	0	416, 328	59, 212	7.03	21, 765	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	410, 320				
32. 00 03200 CORONARY CARE UNIT		0				
33. 00 03300 BURN I NTENSI VE CARE UNI T				0.00	0	1
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T		0		0.00	-	
40. 00 04000 SUBPROVI DER – I PF	0	0	0	0.00		
41. 00 04100 SUBPROVI DER – I RF	0	0	0	0.00		•
42. 00 04200 SUBPROVI DER	0			0.00		•
43. 00 04300 NURSERY	0		2, 428			1
44.00 04400 SKILLED NURSING FACILITY		0				1
45. 00 04500 NURSING FACILITY				0.00		
200.00 Total (lines 30 through 199)		416, 328	0	0.00		200.00
Cost Center Description	I npati ent	PSA Adj. All	00,702		20,000	200.00
	Program	Other Medical				
	Pass-Through	Educati on				
	Cost (col. 7	Cost				
	x col. 8)					
	9.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 03000 ADULTS & PEDI ATRI CS	153, 008		1			30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
32.00 03200 CORONARY CARE UNIT	0	0				32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0		•			33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0				34.00
			•			
40. 00 04000 SUBPROVI DER – I PF	0	0				40.00
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF		0				40.00 41.00
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF 42. 00 04200 SUBPROVI DER	0	0 0 0				40.00 41.00 42.00
40.00 04000 SUBPROVI DER - I PF 41.00 04100 SUBPROVI DER - I RF 42.00 04200 SUBPROVI DER 43.00 04300 NURSERY	0 0 0	0 0 0 0				40.00 41.00 42.00 43.00
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF 42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY 44. 00 04400 SKI LLED NURSI NG FACI LI TY	0 0 0 0	0 0 0 0				40.00 41.00 42.00 43.00 44.00
40.00 04000 SUBPROVI DER - I PF 41.00 04100 SUBPROVI DER - I RF 42.00 04200 SUBPROVI DER 43.00 04300 NURSERY	0 0 0	0 0 0 0				40.00 41.00 42.00 43.00

Health Financial Systems	BAPTIST HEA				In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	ERVICE OTHER PAS					Date/Time Pre 9/21/2022 9:4	
			XVIII		Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	Allied Health	
	Anesthetist	Program	Program		Post-Stepdown		
	Cost	Post-Stepdown			Adjustments		
	1.00	Adjustments 2A	2.00		3A	3.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2A	2.00		ЪА	3.00	
50. 00 05000 OPERATING ROOM	0	0		0	0	0	50.00
51. 00 05100 RECOVERY ROOM	0	-		0	0	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0			0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	, s		0	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55.00
56. 00 05600 RADI OI SOTOPE	0	0		0	0	0	56.00
57.00 05700 CT SCAN	0	0		0	0	0	57.00
58. 00 05800 MRI	0	0		0	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00
60. 00 06000 LABORATORY	0	0		0	0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0		0	0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY							61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	-		0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0	, s		0	0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	-		0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	0	70.00 71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	73.00
74. 00 07400 RENAL DIALYSIS	0	0		0	0	0	74.00
75. 00 07500 ASC (NON-DI STINCT PART)	0	, o		0	0	0	75.00
76. 00 03950 NUTRI TI ON/DI ABETES	0	-		0	0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0			0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					-		
88.00 08800 RURAL HEALTH CLINIC	0	0		0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	0	89.00
90. 00 09000 CLINIC	0	0		0	0	0	90.00
91.00 09100 EMERGENCY	0	0		0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0		95, 083	92.00
OTHER REIMBURSABLE COST CENTERS	1	1					
94.00 09400 HOME PROGRAM DIALYSIS	0	0		0	0	0	94.00
95.00 09500 AMBULANCE SERVICES							95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0			0	0	0	96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0			0	0	0	97.00
200.00 Total (lines 50 through 199)	0	0		0	0	95, 083	200.00

PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHED DAG	TH FLOYD Provider CCN: 15-0044 P		Period:	u of Form CMS-2552-1 Worksheet D	
ROUGH COSTS	VICE OTHER PAS			From 09/01/2018 To 08/31/2019	Part IV Date/Time Pre 9/21/2022 9:4	
		Title	XVIII	Hospi tal	PPS	<u>o am</u>
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)	cols. 2, 3,	col. 8)	col. 7)	
			and 4)			
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVICE COST CENTERS						
D. 00 05000 OPERATING ROOM	0	0		0 197, 850, 417	0.000000	•
1.00 05100 RECOVERY ROOM	0	0		0 0	0.000000	
2. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 7, 748, 302	0.000000	
3. 00 05300 ANESTHESI OLOGY	0	0		0 0	0.000000	•
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 152, 986, 007	0.000000	
5. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0.000000	
5. 00 05600 RADI OI SOTOPE	0	0		0 0	0.000000	•
7. 00 05700 CT SCAN	0	0		0 100, 418, 831	0.000000	
3. 00 05800 MRI	0	0		0 30, 206, 519	0.000000	•
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 177, 363, 998	0.000000	•
D. 00 06000 LABORATORY	0	0		0 162, 709, 591	0.000000	•
D. 01 06001 BLOOD LABORATORY	0	0		0 0	0.000000	•
1.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 1, 327, 731	0.000000	
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 5, 210, 848	0.000000	•
4. 00 06400 I NTRAVENOUS THERAPY	0	0		0 23, 293, 783	0.000000	
5. 00 06500 RESPIRATORY THERAPY	0	0		0 26, 491, 729	0.000000	
6. 00 06600 PHYSI CAL THERAPY	0	0		0 33, 340, 627	0.000000	•
7. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0.000000	
3. 00 06800 SPEECH PATHOLOGY	0	0		0 3, 939, 108	0.000000	
9. 00 06900 ELECTROCARDI OLOGY	0	0		0 95, 182, 259	0.000000	•
0.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 2, 134, 973	0.000000	•
1. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0		0 46, 268, 921	0.000000	
2.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 78, 108, 217	0.000000	•
3. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 96, 087, 191	0.000000	•
4. 00 07400 RENAL DI ALYSI S	0	0		0 1, 632, 669	0.000000	•
5. 00 07500 ASC (NON-DI STI NCT PART)	0	0		0 0	0.000000	
5. 00 03950 NUTRI TI ON/DI ABETES	0	0		0 0 0 2.174.295	0.000000	
6. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	U	0		0 2, 174, 295	0. 000000	76.97
B. 00 08800 RURAL HEALTH CLINIC	0	0		0 0	0. 000000	88.00
9. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0.000000	
0. 00 099000 CLINIC	0	0		0 18, 559, 941	0.000000	
1. 00 09100 EMERGENCY	0	0		0 110, 280, 499	0.000000	•
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	95, 083			0.000000	•
OTHER REIMBURSABLE COST CENTERS	0	70,003	75,00	5 51,055,520	0.003002	72.00
4. 00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0. 000000	94.00
5. 00 09500 AMBULANCE SERVICES	0	0			0.000000	95.00
5. 00 09500 AMBBELANCE SERVICES 5. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0.000000	
7. 00 09700 DURABLE MEDICAL EQUIP-RENTED	0	0			0.000000	

Health Financial Systems	BAPTI ST HEALT	TH FLOYD		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	ERVICE OTHER PASS	Provider C		Period: From 09/01/2018 To 08/31/2019	Worksheet D Part IV Date/Time Pre 9/21/2022 9:4	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n 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	
ANCI LLARY SERVICE COST CENTERS			1			
50. 00 05000 OPERATI NG ROOM	0. 000000	40, 544, 085		0 31, 664, 174	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	27, 873		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	18, 244, 057		0 43, 826, 955	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	13, 668, 387		0 18, 153, 174	0	57.00
58.00 05800 MRI	0. 000000	3, 946, 883		0 6, 937, 205	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	39, 048, 559		0 38, 285, 569	0	59.00
60. 00 06000 LABORATORY	0. 000000	35, 494, 200		0 12, 386, 029	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	478, 803		0 95, 838	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	2, 641, 372		0 116, 605	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	77, 081		0 5, 374, 069	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	12, 421, 218		0 1, 312, 396	0	65.00
66.00 06600 PHYSI CAL THERAPY	0. 000000	4, 816, 670		0 201, 862	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	1, 364, 929		0 75, 242	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0. 000000	17, 056, 771		0 24,007,965	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	229, 637		0 368, 039	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	11, 300, 038		0 6, 434, 817	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	25, 445, 678		0 9, 366, 065	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	26, 798, 723		0 19, 867, 445	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	880, 814		0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0)	0 0	0	75.00
76.00 03950 NUTRI TI ON/DI ABETES	0. 000000	0)	0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	845		0 1, 182, 275	0	76.97
OUTPATIENT SERVICE COST CENTERS						1
88.00 08800 RURAL HEALTH CLINIC	0.000000	0		0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0 0	0	89.00
90. 00 09000 CLINIC	0. 000000	827, 567		0 5, 548, 975	0	90.00
91. 00 09100 EMERGENCY	0. 000000	14,084,775		0 17, 115, 180	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.003062	4, 724, 232		,,	18, 318	
OTHER REIMBURSABLE COST CENTERS		, _02	,		,	1
94. 00 09400 HOME PROGRAM DI ALYSI S	0.000000	0		0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES		0			Ũ	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0. 000000	0		0 0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0		0 0	0	97.00
200.00 Total (lines 50 through 199)	2.000000	274, 123, 197	14, 46			
	I I	2.1,120,177	1 17, 40	210,002,127	10, 510	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SI THROUGH COSTS	ERVICE OTHER PAS	S Provider C	CN: 15-0044	Period: From 09/01/2018 To 08/31/2019	Worksheet D Part IV Date/Time Pr 9/21/2022 9:	-2552-10 epared: 45 am
		Title	XVIII	Hospi tal	PPS	10 411
Cost Center Description	PSA Adj. Non	PSA Adj. All				
	Physi ci an	Other Medical				
	Anestheti st	Education				
	Cost	Cost				
	21.00	24.00				
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0				50.00
51.00 05100 RECOVERY ROOM	0	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	0	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
56. 00 05600 RADI OI SOTOPE	0	0				56.00
57.00 05700 CT SCAN	0	0				57.00
58. 00 05800 MRI	0	0				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
50. 00 06000 LABORATORY	0	0				60.00
50. 01 06001 BLOOD LABORATORY	0	0				60.01
51.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
22.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62.00
33. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
54.00 06400 INTRAVENOUS THERAPY	0					64.00
5. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
57.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
58.00 06800 SPEECH PATHOLOGY	0	0				68.00
59. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
2.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
74. 00 07400 RENAL DI ALYSI S	0	0				74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0				75.00
76. 00 03950 NUTRI TI ON/DI ABETES	0	0				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.97
OUTPATIENT SERVICE COST CENTERS						
38.00 08800 RURAL HEALTH CLINIC	0	0				88.00
39. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER	0	0				89.00
20. 00 09000 CLINIC	0	0				90.00
91.00 09100 EMERGENCY	0	0				91.00
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0				94.00
95. 00 09500 AMBULANCE SERVICES	1					95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0				96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0					97.00
200.00 Total (lines 50 through 199)	0					200.00

Health Financial Systems	BAPTIST HEA	LTH FLOYD		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES ANI	D VACCINE COST	Provi der C	CN: 15-0044	Period: From 09/01/2018	Worksheet D Part V	
				To 08/31/2019		pared:
		Title	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Services (see inst.)	Services Subject To	Services Not Subject To		
	Worksheet C, Part I, col.	inst.)	Ded. & Coins			
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS				-		
50. 00 05000 OPERATING ROOM	0. 143667		1	0 0		50.00
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000 0. 520130			0 0 0 0	0	51.00 52.00
53. 00 05300 ANESTHESI OLOGY	0. 020130			0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 090698			0 0	3, 975, 017	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 000000			0 0	0	56.00
57.00 05700 CT SCAN	0. 020534			0 0	372, 757	57.00
58. 00 05800 MRI	0. 038161	6, 937, 205		0 0	264, 731	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.040518			0 0	1, 551, 255	
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	0. 107503			0 0 0 0	1, 331, 535 0	60.00 60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000			0 0	0	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 063494	95, 838		0 0	6,085	62.00
63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0. 358857	116, 605		0 0	41, 845	63.00
64.00 06400 INTRAVENOUS THERAPY	0. 366694	5, 374, 069		0 0	1, 970, 639	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 187019			0 0	245, 443	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 202245		1	0 0	40, 826	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0. 260397 0. 045698	75, 242 24, 007, 965		0 0	19, 593 1, 097, 116	68.00 69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 564736			0 0	207, 845	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 384497			0 0	2, 474, 168	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 281456			0 0	2, 636, 135	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 232821	19, 867, 445		0 199, 918	4, 625, 558	73.00
74.00 07400 RENAL DIALYSIS	0. 231232			0 0	0	74.00
75. 00 07500 ASC (NON-DI STI NCT PART)	0. 000000			0 0	0	75.00
76. 00 03950 NUTRI TI ON/DI ABETES 76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000 0. 612676			0 0	0	76.00 76.97
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0.012070	1, 182, 275		0 0	724, 352	/0.9/
88.00 08800 RURAL HEALTH CLINIC						88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER						89.00
90. 00 09000 CLINIC	0. 284490	5, 548, 975		0 35	1, 578, 628	90.00
91. 00 09100 EMERGENCY	0. 114657			0 0		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 384759	5, 982, 248		0 0	2, 301, 724	92.00
0THER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DI ALYSI S	0.00000		1	0 0		94.00
95. 00 09500 AMBULANCE SERVICES	0.000000			0		94.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			0 0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000			0 0	0	97.00
200.00 Subtotal (see instructions)		248, 302, 127	27, 77	70 199, 953	31, 976, 724	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges		240 202 407	07 7	100 050	21 07/ 704	202.00
202.00 Net Charges (line 200 - line 201)	I	248, 302, 127	27,77	199, 953	31, 976, 724	202.00

Health Financial Systems	BAPTI ST HEAL				u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES	AND VACCINE COST	Provider C	CN: 15-0044	Period: From 09/01/2018 To 08/31/2019	Worksheet D Part V Date/Time Pre 9/21/2022 9:4	epared: 15 am
		Title	XVIII	Hospi tal	PPS	
	Cos	ts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
ANCI LLARY SERVI CE COST CENTERS	6.00	7.00				
50. 00 05000 OPERATING ROOM	0	0				50.00
51. 00 05100 RECOVERY ROOM	0	0				51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	0	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
56. 00 05600 RADI OLOGI - MERALEUTI C	0	0				56.00
57. 00 05700 CT SCAN	0	0				57.00
58. 00 05800 MRI	0	0				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	2, 985	0				60.00
60. 01 06001 BLOOD LABORATORY	2, ,00	0				60.01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0				61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0				64.00
65.00 06500 RESPIRATORY THERAPY	0	0				65.00
66.00 06600 PHYSI CAL THERAPY	0	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
69.00 06900 ELECTROCARDI OLOGY	0	0				69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	46, 545				73.00
74.00 07400 RENAL DIALYSIS	0	0				74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0				75.00
76. 00 03950 NUTRI TI ON/DI ABETES	0	0				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC						88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER						89.00
90. 00 09000 CLINIC	0	10				90.00
91.00 09100 EMERGENCY	0	0	•			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
OTHER REIMBURSABLE COST CENTERS		^				04.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0				94.00
95. 00 09500 AMBULANCE SERVICES	0	0				95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0				96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0 44 EEE				97.00
200.00 Subtotal (see instructions)	2, 985	46, 555				200.00
201.00 Less PBP Clinic Lab. Services-Progra	am O					201.00
Only Charges202.00Net Charges (line 200 - line 201)	2, 985	46, 555				202.00
202.00 Iner charges (The 200 - The 201)	2,900	40, 000	I			1202.00

MPUTA	Financial Systems BAPTIST HEALTH ATION OF INPATIENT OPERATING COST BAPTIST HEALTH	Provider CCN: 15-0044	Period:	Worksheet D-1		
			From 09/01/2018 To 08/31/2019	Date/Time Pre		
		Title XVIII	Hospi tal	9/21/2022 9:4 PPS	5 am	
	Cost Center Description					
[PART I – ALL PROVIDER COMPONENTS			1.00		
	INPATIENT DAYS			F0 010	1	
	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			59, 212 59, 212	1	
	Private room days (excluding private room days, excluding swing-		rivate room days,	07,212		
	do not complete this line.		J .			
	Semi-private room days (excluding swing-bed and observation b			45, 689	4	
	Total swing-bed SNF type inpatient days (including private ro reporting period	iom days) through Decemb	er 31 of the cost	0	5	
00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6	
	reporting period (if calendar year, enter 0 on this line)					
	Total swing-bed NF type inpatient days (including private roo reporting period	m days) through Decembe	r 31 of the cost	0	7	
	Total swing-bed NF type inpatient days (including private roo	m days) after December	31 of the cost	0	8	
	reporting period (if calendar year, enter 0 on this line)	allo boombor		0		
	Total inpatient days including private room days applicable t	o the Program (excludin	g swing-bed and	21, 765	9	
	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII c	nlv (including privato	room days)	0	10	
	through December 31 of the cost reporting period (see instruc		room days)	0		
00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private	room days) after	0	11	
	December 31 of the cost reporting period (if calendar year, e				10	
	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	x only (Including priva	te room days)	0	12	
	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	13	
	after December 31 of the cost reporting period (if calendar y					
	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0		
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0		
	SWING BED ADJUSTMENT			0		
	Medicare rate for swing-bed SNF services applicable to servic	es through December 31	of the cost	0.00	17	
	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost					
	reporting period Medicaid rate for swing-bed NF services applicable to service	s through December 31 c	f the cost	0.00	19	
	reporting period	5				
	Medicaid rate for swing-bed NF services applicable to service reporting period	s after December 31 of	the cost	0.00	20	
	Total general inpatient routine service cost (see instruction	s)		52, 316, 107	21	
	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost repor	ting period (line	0	22	
	5 x line 17)			0	0.00	
	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost report	ng period (line a	0	23	
00	Swing-bed cost applicable to NF type services through Decembe 7 x line 19)	er 31 of the cost report	ing period (line	0	24	
	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	a period (line 8	0	25	
	x line 20)		511111			
	Total swing-bed cost (see instructions)	(11		0		
	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(iine 21 minus line 26)		52, 316, 107	27	
	General inpatient routine service charges (excluding swing-be	d and observation bed c	harges)	0	28	
00	Private room charges (excluding swing-bed charges)		<u> </u>	0	29	
	Semi-private room charges (excluding swing-bed charges)			0		
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000		
	Average private room per diem charge (line 29 ÷ line 3)			0.00		
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00		
	Average per diem private room charge differential (line 32 mi		cuons)	0.00		
	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00		
	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	0 52, 316, 107		
	27 minus line 36)					
	PART II - HOSPITAL AND SUBPROVIDERS ONLY					
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			002 54	20	
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			883. 54 19, 230, 248		
	Medically necessary private room cost applicable to the Progr			17, 230, 248		
	,,,,,	+ line 40)		0	41	

	Financial Systems	BAPTI ST HEA				u of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C		eriod: rom 09/01/2018	Worksheet D-1	1
				T			epared
			Title	xviii	Hospi tal	9/21/2022 9:4 PPS	45 am
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpati ent	Inpatient	Diem (col. 1	0 9	(col. 3 x	
		Cost	Days	÷ col. 2)	4.00	<u>col. 4)</u>	
12.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.0
12.00	Intensive Care Type Inpatient Hospital Units	0	0	0.00	0	0	42.0
3.00	INTENSIVE CARE UNIT	11, 515, 730	5, 122	2, 248. 29	3, 841	8, 635, 682	2 43.0
4.00	CORONARY CARE UNI T	0	0			0	
	BURN INTENSIVE CARE UNIT	0	0			0	
6.00	SURGI CAL I NTENSI VE CARE UNI T	0	C	0.00	0	0	
1.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.0
						1.00	-
	Program inpatient ancillary service cost (Wks					40, 513, 406	48.0
9.00	Total Program inpatient costs (sum of lines 4	11 through 48)	(see instructi	ons)		68, 379, 336	49.0
0 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	tiont routing	annul and (fra	m Wkat D aum	of Dorto L one	2 224 002	2 50.0
0.00			Services (110	II WKSL. D, SUIII	UT PAILS I AND	2, 324, 092	50.0
51.00	Pass through costs applicable to Program inpa	atient ancilla	ry services (f	rom Wkst. D, si	um of Parts II	2, 509, 705	51.0
	and IV)		-				
52.00	Total Program excludable cost (sum of lines !					4, 833, 797	
3.00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line 5		erated, non-ph	ysician anesthe	etist, and	63, 545, 539	53.
	TARGET AMOUNT AND LIMIT COMPUTATION)					
4.00	Program di scharges					0	54.
5.00	Target amount per discharge					0.00	
6.00	Target amount (line 54 x line 55)				50)	0	
7.00 8.00	Difference between adjusted inpatient operati Bonus payment (see instructions)	ng cost and ta	arget amount (ine 56 minus i	ine 53)	0	
8.00 9.00	Lesser of lines 53/54 or 55 from the cost rep	orting period	ending 1996	undated and cor	nounded by the	-	
7.00	market basket	boi tring period	churng 1770,		ipounded by the	0.00	/ 37.
0.00	Lesser of lines 53/54 or 55 from prior year of	cost report, u	pdated by the	narket basket		0.00	60.
01. 00	If line 53/54 is less than the lower of lines					0) 61.
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		ts (lines 54 x	60), or 1% of	the target		
2.00	Relief payment (see instructions)	nstructrons)				0	62.
3.00	Allowable Inpatient cost plus incentive payme	ent (see instru	uctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST	•	*				
4.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost reportir	ng period (See	0	64.0
5.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	s after Decem	her 31 of the	cost reporting	neriod (See	0	65.0
0.00	instructions)(title XVIII only)			Just reporting		0	/ 00. (
6.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line	65)(title XVIII	only). For	0	66. (
	CAH (see instructions)			C 11			
57.00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	n December 31	of the cost rep	porting period	0	67.0
8 00	Title V or XIX swing-bed NF inpatient routine	e costs after [December 31 of	the cost repor	ting period	0	68.0
	(line 13 x line 20)			110 0001 10001	ang por ou	J. J. J. J. J. J. J. J. J. J. J. J. J. J	
9.00	Total title V or XIX swing-bed NF inpatient i					0	69.
0 00	PART III - SKILLED NURSING FACILITY, OTHER NU						
0.00 1.00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co	5		. ,			70.
2.00	Program routine service cost (line 9 x line 1			<i>∠</i>)			72.
3.00	Medically necessary private room cost applica		m (line 14 x l	ne 35)			73.
4.00	Total Program general inpatient routine servi	ce costs (line	e 72 + line 73)			74.
5.00	Capital-related cost allocated to inpatient i	routine service	e costs (from	Norksheet B, Pa	art II, column		75.
6.00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76.
7.00	Program capital -related costs (line 9 x line						77.
B. 00	Inpatient routine service cost (line 74 minus	· ·					78.
	Aggregate charges to beneficiaries for excess						79.
0.00	Total Program routine service costs for compa		cost limitatio	ו (line 78 minu	us line 79)		80.
1.00 2.00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (li		1)				81. 82.
2.00	Reasonable inpatient routine service cost (· · ·				82.
4.00	Program inpatient ancillary services (see ins						84.
5.00	Utilization review - physician compensation	(see instructio					85.
6.00	Total Program inpatient operating costs (sum		hrough 85)				86.
	PART IV - COMPUTATION OF OBSERVATION BED PASS					10 500	0 07
00 51	Total observation bed days (see instructions)	1				13, 523	8 87.0
37.00 38.00	Adjusted general inpatient routine cost per o	liem (line 27 -	÷line 2)			883.54	88.

Health Financial Systems	BAPTIST HEA	LTH FLOYD		In Lieu of Form CMS-2552			
COMPUTATION OF INPATIENT OPERATING COST		Provider CO	Provider CCN: 15-0044		Worksheet D-1		
				From 09/01/2018 To 08/31/2019			
		Title	XVIII	Hospi tal	PPS		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(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	4, 721, 105	52, 316, 107	0.09024	2 11, 948, 111	1, 078, 221	90.00	
91.00 Nursing Program cost	0	52, 316, 107	0.00000	0 11, 948, 111	0	91.00	
92.00 Allied health cost	416, 328	52, 316, 107	0.00795	8 11, 948, 111	95, 083	92.00	
93.00 All other Medical Education	0	52, 316, 107	0.00000	11, 948, 111	0	93.00	

Health Financial Systems BAPTIST HEALT	H FLOYD		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0044	Period:	Worksheet D-3	3
			From 09/01/2018 To 08/31/2019	Date/Time Pre	pared:
				9/21/2022 9:4	5 am
Cast Castas Danaistias		XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos To Charges	t Inpatient Program	Inpatient Program Costs	
			Charges	(col. 1 x	
			g	col. 2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1	04 570 744		1 00 00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T			34, 570, 741 15, 221, 565		30.00
32. 00 03200 CORONARY CARE UNIT			15, 221, 505		32.00
33. 00 03300 BURN I NTENSI VE CARE UNI T			0		33.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T			0		34.00
40. 00 04000 SUBPROVI DER – I PF			0		40.00
41. 00 04100 SUBPROVI DER – I RF			0		41.00
42. 00 04200 SUBPROVI DER			0		42.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM		0. 1436	67 40, 544, 085	5, 824, 847	50.00
51. 00 05100 RECOVERY ROOM		0.0000		5, 824, 847	
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 5201		14, 498	1
53. 00 05300 ANESTHESI OLOGY		0.0000	0 00	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 0906		1, 654, 699	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.0000		0	
56. 00 05600 RADI OI SOTOPE		0.0000		0	
57. 00 05700 CT SCAN 58. 00 05800 MRI		0. 0205		280, 667 150, 617	1
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0381		1, 582, 170	1
60. 00 06000 LABORATORY		0. 1075		3, 815, 733	
60. 01 06001 BLOOD LABORATORY		0.0000		0	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000	0 00	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.0634		30, 401	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 3588		947, 875	
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY		0.3666		28, 265	
66. 00 06600 PHYSI CAL THERAPY		0. 1870		2, 323, 004 974, 147	
67. 00 06700 OCCUPATI ONAL THERAPY		0.0000		0	1
68. 00 06800 SPEECH PATHOLOGY		0. 2603		355, 423	1
69. 00 06900 ELECTROCARDI OLOGY		0. 0456	98 17, 056, 771	779, 460	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY		0.5647		129, 684	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT		0. 3844		4, 344, 831	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2814		7, 161, 839 6, 239, 305	
74. 00 07400 RENAL DI ALYSI S		0. 2328		203, 672	
75. 00 07500 ASC (NON-DISTINCT PART)		0.0000		200, 072	
76. 00 03950 NUTRI TI ON/DI ABETES		0.0000		0	
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 6126	76 845	518	76.97
OUTPATIENT SERVICE COST CENTERS		T			
88. 00 08800 RURAL HEALTH CLINIC		0.0000		0	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC		0. 0000		0 237, 057	
91. 00 09100 EMERGENCY		0. 2804		1, 617, 003	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 3847		1, 817, 691	1
OTHER REIMBURSABLE COST CENTERS					
94. 00 09400 HOME PROGRAM DI ALYSI S		0.0000	0 00	0	
95. 00 09500 AMBULANCE SERVICES					95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0.0000		0	
97.00 09700 DURABLE MEDICAL EQUIP-SOLD		0.0000		0 40, 513, 406	
200.00Total (sum of lines 50 through 94 and 96 through 98)201.00Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		274, 123, 197	40, 513, 406	200.00
202.00 Net charges (line 200 minus line 201)			274, 123, 197		201.00
		1			,

	Financial Systems BAPTIST HEALTH ATLON OF RELMBURSEMENT SETTLEMENT	Provi der CCN: 15-0044	Period: From 09/01/2018	u of Form CMS-2 Worksheet E Part A	
		Title XVIII	To 08/31/2019 Hospi tal	Date/Time Pre 9/21/2022 9:4 PPS	
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurr instructions)	ring prior to October 1	(see	0 4, 616, 090	
1. 02	DRG amounts other than outlier payments for discharges occurr instructions)	ring on or after October	1 (see	53, 081, 922	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI f 1 (see instructions)	for di scharges occurri ng) prior to October	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCl f October 1 (see instructions)	for di scharges occurri ng	on or after	0	1.04
2.00 2.01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			3, 694, 999 0	2.00 2.01
2.02 3.00	Outlier payment for discharges for Model 4 BPCI (see instruct Managed Care Simulated Payments	ti ons)		0 0	2.02 3.00
4.00	Bed days available divided by number of days in the cost repo Indirect Medical Education Adjustment	orting period (see instr	ructions)	190. 81	4.00
5.00	FTE count for allopathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)	st recent cost reporting) period ending on	0.00	5.00
5.00	FTE count for allopathic and osteopathic programs that meet t new programs in accordance with 42 CFR 413.79(e)	the criteria for an add-	on to the cap for	0.00	6.00
7.00 7.01	MMA Section 422 reduction amount to the IME cap as specified ACA § 5503 reduction amount to the IME cap as specified under cost report straddles July 1, 2011 then see instructions.			0.00 0.00	7.00 7.01
8. 00	Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413. 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 sl report straddles July 1, 2011, see instructions.	ots under § 5503 of the	e ACA. If the cost	0.00	8. 0 [.]
3. 02	The amount of increase if the hospital was awarded FTE cap sl under § 5506 of ACA. (see instructions)	0.00	8.02		
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lir instructions)	nes (8, 8,01 and 8,02)	(see	0.00	9.00
0. 00 1. 00	FTE count for allopathic and osteopathic programs in the curr FTE count for residents in dental and podiatric programs.	rent year from your reco	ords		10.00
2.00	Current year allowable FTE (see instructions)				12.0
3.00 4.00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that year to the penultimate year if that year to the penultimate year if that year to be a set of the penultimate year if	ear ended on or after Se	eptember 30, 1997,		13.0 14.0
5.00	otherwise enter zero. Sum of lines 12 through 14 divided by 3.			0.00	15.0
	Adjustment for residents in initial years of the program				16.0
	Adjustment for residents displaced by program or hospital clo Adjusted rolling average FTE count	osure			17.0 18.0
9.00	Current year resident to bed ratio (line 18 divided by line 4	4).		0.000000	
	Prior year resident to bed ratio (see instructions)			0.000000	
1.00	Enter the lesser of lines 19 or 20 (see instructions)			0.00000	21.0
2.00	IME payment adjustment (see instructions)			0	
2. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 42	22 of the MMA		0	22.0
3. 00	Number of additional allopathic and osteopathic IME FTE resid (f)(1)(iv)(C).		CFR 412.105	0.00	23. C
4.00 5.00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -O-, then enter the	lower of line 23 or lin	ne 24 (see		24.0 25.0
6. 00	instructions) Resident to bed ratio (divide line 25 by line 4)			0. 000000	
7.00	IME payments adjustment factor. (see instructions)			0.000000	
3.00	IME add-on adjustment amount (see instructions)			0	
B. 01	IME add-on adjustment amount - Managed Care (see instructions	5)		0	
9. 00 9. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.0	01)		0	29.0 29.0
0. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A p	patient days (see instru	ictions)	4 78	30.0
1.00	Percentage of Medicaid patient days (see instructions)	Satisfit days (see fisting		14.12	
32.00				18.90	
33.00	Allowable disproportionate share percentage (see instructions	s)		5.04	
1 00	Disproportionate share adjustment (see instructions)			726, 995	34

CALCULA	Financial Systems BAPTIST HE ATION OF REIMBURSEMENT SETTLEMENT	ALTH FLOYD Provider CCN: 15-0044	Peri od:	u of Form CMS-2 Worksheet E	2002
			From 09/01/2018	Part A	naro
			To 08/31/2019	Date/Time Pre 9/21/2022 9:4	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
	Uncompensated Care Adjustment		1.00	2.00	
	Total uncompensated care amount (see instructions)		0	0	35.
	Factor 3 (see instructions)		0. 00000000	-	
5. 02	Hospital uncompensated care payment (If line 34 is zero,	enter zero on this line) (s	ee 1, 966, 458	2, 210, 426	35.
- 00	instructions)		1/1 /07	0 000 747	0.5
	Pro rata share of the hospital uncompensated care payment Total uncompensated care (sum of columns 1 and 2 on line		161, 627 2, 190, 374		35. 36.
0.00	Additional payment for high percentage of ESRD beneficiary	v discharges (lines 40 thro			30.
	Total Medicare discharges (see instructions)		0		40.
			Before 1/1	On/After 1/1	
1 00			1.00	1.01	11
	Total ESRD Medicare discharges (see instructions) Total ESRD Medicare covered and paid discharges (see inst	ructions)	0	-	
	Divide line 41 by line 40 (if less than 10%, you do not q		0.00	-	41
	Total Medicare ESRD inpatient days (see instructions)		0		43
I. 00	Ratio of average length of stay to one week (line 43 divi	ded by line 41 divided by 7	0.00000		44
	days)	• • • • •		0.00	4.5
	Average weekly cost for dialysis treatments (see instruct Total additional payment (line 45 times line 44 times line		0.00	0.00	45
	Subtotal (see instructions)	e 41.01)	64, 310, 380		47
	Hospital specific payments (to be completed by SCH and MD	H, small rural hospitals	0		48
	only. (see instructions)	-			
				Amount 1.00	-
9.00	Total payment for inpatient operating costs (see instruct	i ons)		64, 310, 380	49
	Payment for inpatient program capital (from Wkst. L, Pt.)	5, 094, 054	
	Exception payment for inpatient program capital (Wkst. L,			0	
	Direct graduate medical education payment (from Wkst. E-4	, line 49 see instructions)		0	
	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies			16, 490 0	
	Islet isolation add-on payment			0	
	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, li	ne 69)		0	
	Cost of physicians' services in a teaching hospital (see			0	
	Routine service other pass through costs (from Wkst. D, P		through 35).	153, 008	
. 00 . 00	Ancillary service other pass through costs from Wkst. D, Total (sum of amounts on lines 49 through 58)	Pt. IV, col. II line 200)		14, 466 69, 588, 398	
	Primary payer payments			37, 580	
	Total amount payable for program beneficiaries (line 59 m	inus line 60)		69, 550, 818	
	Deductibles billed to program beneficiaries			5, 703, 374	
	Coinsurance billed to program beneficiaries			116, 064	
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			391, 738 254, 630	
	Allowable bad debts for dual eligible beneficiaries (see	instructions)		56, 313	
	Subtotal (line 61 plus line 65 minus lines 62 and 63)			63, 986, 010	
. 00	Credits received from manufacturers for replaced devices			0	68
	Outlier payments reconciliation (sum of lines 93, 95 and 10 and 1	96).(For SCH see instruction	ins)	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pural Community Hospital Demonstration Project (\$4104 Dem	onstration) adjustment (cos	instructions)	0	
	Rural Community Hospital Demonstration Project (§410A Demonstration payment adjustment amount before sequestrat		instructions)	0	
	SCH or MDH volume decrease adjustment (contractor use onl)			0	
). 89	Pioneer ACO demonstration payment adjustment amount (see				70
	HSP bonus payment HVBP adjustment amount (see instruction			0	
	HSP bonus payment HRR adjustment amount (see instructions Bundled Model 1 discount amount (see instructions))		0	
). 91				0	70
0. 91 0. 92				_10 765	70
0. 91 0. 92 0. 93	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			-10, 765 -529, 667	

	ATION OF REIMBURSEMENT SETTLEMENT	Provider C		Period: From 09/01/2018		
				To 08/31/2019	Date/Time Pre 9/21/2022 9:4	
		Title	XVIII	Hospi tal	PPS	
			FFA FFA	(уууу) 0	Amount 1.00	
). 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column O		0		70.9
). 97	the corresponding federal year for the period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column O		0	0	70.9
J. 77	the corresponding federal year for the period ending on or af			0	0	/0. 7
0. 98	Low Volume Payment-3				0	70.9
). 99	HAC adjustment amount (see instructions)	(0 % 70)			0	
1.00 1.01	Amount due provider (line 67 minus lines 68 plus/minus lines Sequestration adjustment (see instructions)	69 & 70)			63, 445, 578 1, 268, 912	
1.01	Demonstration payment adjustment amount after sequestration				1, 200, 912	71.0
. 02	Sequestration adjustment-PARHM pass-throughs				0	71.0
2.00	Interim payments				62, 382, 546	
	Interim payments-PARHM				02, 302, 340	72.0
3.00	Tentative settlement (for contractor use only)				-196, 616	
3. 01	Tentative settlement-PARHM (for contractor use only)				170,010	73.0
. 00	Balance due provider/program (line 71 minus lines 71.01, 71.0)2 72 and			-9, 264	
	73)	2, ,2, and			,,201	/
. 01	Balance due provider/program-PARHM (see instructions)					74.0
5.00	Protested amounts (nonallowable cost report items) in accorda	ince with			0	75.0
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03			0	90.
	plus 2.04 (see instructions)					
. 00	Capital outlier from Wkst. L, Pt. I, line 2				267, 513	
	Operating outlier reconciliation adjustment amount (see instr				0	92.
	Capital outlier reconciliation adjustment amount (see instruc				0	93.
	The rate used to calculate the time value of money (see instr				0.00	
	Time value of money for operating expenses (see instructions)				0	
5. 00	Time value of money for capital related expenses (see instruc	, ti uns)			0	90.
				Prior to 10/1	On/After 10/1	
				Prior to 10/1 1.00	0n/After 10/1 2.00	
	HSP Bonus Payment Amount			1.00	2.00	
0. 00	HSP bonus amount (see instructions)				2.00	100.
	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			1.00	2.00	
1. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)			1.00 0.000000000	2.00 0 0.000000000	101.
1. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction	ls)		1.00	2.00 0 0.000000000	101.
1. 00 2. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment	ls)		1.00 0.00000000000000000000000000000000	2.00 0 0.000000000 0	101. 102.
1.00 2.00 3.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)	•		1.00 0.000000000 0 0.000000000000000000	2.00 0.0000000000 0.0000000000000000000	101. 102. 103.
1.00 2.00 3.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions	;)	istmont	1.00 0.00000000000000000000000000000000	2.00 0.0000000000 0.0000000000000000000	101. 102. 103.
1.00 2.00 3.00 4.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst	;) ration) Adju		1.00 0.000000000 0 0.000000000000000000	2.00 0.000000000 0 0.0000 0	101. 102. 103. 104.
1.00 2.00 3.00 4.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe	;) ration) Adju		1.00 0.000000000 0 0.000000000000000000	2.00 0.000000000 0 0.0000 0	101. 102. 103. 104.
1.00 2.00 3.00 4.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no.	;) ration) Adju		1.00 0.000000000 0 0.000000000000000000	2.00 0.000000000 0 0.0000 0	101. 102.
1.00 2.00 3.00 4.00 0.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	s) ration) Adju eriod under		1.00 0.000000000 0 0.000000000000000000	2.00 0.0000000000 0.0000 0.0000 0	101. 102. 103. 104.
1.00 2.00 3.00 4.00 0.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin	s) ration) Adju eriod under		1.00 0.000000000 0 0.000000000000000000	2.00 0.0000000000 0.0000 0.0000 0	101. 102. 103. 104. 200.
1.00 2.00 3.00 4.00 0.00 1.00 2.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions)	s) ration) Adju eriod under		1.00 0.000000000 0 0.000000000000000000	2.00 0.000000000 0 0.0000 0	101. 102. 103. 104. 200. 201. 202.
1.00 2.00 3.00 4.00 0.00 1.00 2.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin	nation) Adju riod under ne 49)	the 21st	1.00 0.000000000 0 0.0000 0 0.0000 0	2.00 0.00000000000000000000000000000000	101. 102. 103. 104. 200. 201. 202.
1.00 2.00 3.00 4.00 0.00 1.00 2.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)	nation) Adju riod under ne 49)	the 21st	1.00 0.000000000 0 0.0000 0 0	2.00 0.000000000 0.0000 0 0.0000 0	101. 102. 103. 104. 200. 201. 202. 203.
1.00 2.00 3.00 4.00 0.00 1.00 2.00 3.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	nation) Adju riod under ne 49)	the 21st	1.00 0.000000000 0 0.0000 0 0	2.00 0.000000000 0.0000 0.0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204.
1.00 2.00 3.00 4.00 0.00 1.00 2.00 3.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period)	nation) Adju riod under ne 49)	the 21st	1.00 0.000000000 0 0.0000 0 0	2.00 0.000000000 0.0000 0.0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204.
1. 00 2. 00 3. 00 4. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount	s) ration) Adju riod under ne 49) first year	the 21st	1.00 0.000000000 0 0.0000 0 0	2.00 0.0000000000 0.0000 0.0000 0	101. 103. 104. 200. 201. 202. 203. 204. 205.
1. 00 2. 00 3. 00 4. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 5. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	nation) Adju riod under ne 49) first year	the 21st	1.00 0.000000000 0 0.0000 0 0	2.00 0.0000000000 0.0000 0.0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206.
1. 00 2. 00 3. 00 4. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 5. 00 6. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst	ration) Adju riod under ne 49) first year	the 21st	1.00 0.000000000 0 0.0000 0 0	2.00 0.0000000000 0 0.0000 0 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207.
1. 00 2. 00 3. 00 4. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 5. 00 7. 00 3. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	ration) Adju riod under ne 49) first year	the 21st	1.00 0.000000000 0 0.0000 0 0	2.00 0.000000000 0.0000 0 0.0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 206. 207. 208.
1. 00 2. 00 3. 00 4. 00 5. 00 5. 00 5. 00 7. 00 3. 00 7. 00 3. 00 7. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions)	ration) Adju riod under ne 49) first year	the 21st	1.00 0.000000000 0 0.0000 0 0	2.00 0.000000000 0.0000 0 0.0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 206. 207. 208. 209.
1. 00 2. 00 4. 00 5. 00 5. 00 5. 00 7. 00 3. 00 7. 00 9. 00 0. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	ration) Adju riod under ne 49) first year	the 21st	1.00 0.000000000 0 0.0000 0 0	2.00 0.0000000000 0.0000 0 0.0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 209. 210.
1. 00 2. 00 4. 00 1. 00 2. 00 3. 00 4. 00 5. 00 5. 00 5. 00 7. 00 3. 00 9. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	ration) Adju riod under ne 49) first year	the 21st	1.00 0.000000000 0 0.0000 0 0	2.00 0.0000000000 0.0000 0 0.0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 209. 210.
1.00 2.00 3.00 4.00 0.00 1.00 2.00 3.00 5.00 5.00 7.00 3.00 9.00 1.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	ration) Adju riod under ne 49) first year ructions) line 59)	the 21st	1.00 0.000000000 0 0.0000 0 0	2.00 0.000000000 0.0000 0.0000 0 0.0000 0 0 0 0 0 0 0 0 0 0 0 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 211.
1. 00 2. 00 3. 00 4. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 5. 00 6. 00 7. 00 7. 00 0. 00 1. 00 2. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare Part A IPPS payments (from line	ration) Adju riod under ne 49) first year ructions) line 59)	the 21st	1.00 0.000000000 0 0.0000 0 0	2.00 0.000000000 0.0000 0 0 0 0 0 0 0 0 0 0 0 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 211.
1. 00 2. 00 3. 00 4. 00 0. 00 1. 00 5. 00 5. 00 5. 00 7. 00 3. 00 7. 00 7. 00 7. 00 3. 00 2. 00 3. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	ration) Adju riod under e 49) first year finst year line 59)	of the curre	1.00 0.000000000 0 0.0000 0 0	2.00 0.000000000 0.0000 0 0.0000 0 0 0 0 0 0 0 0 0 0 0 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 211.

CALCUL	ATION OF DSH PAYMENT PERCENTAGE		Provider CC	:N: 15-0044	Period: From 09/01/2018 To 08/31/2019	Worksheet DSH Date/Time Pre 9/21/2022 9:4	pared:
			Title	XVIII	Hospi tal	PPS	
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Overri de Val ue	Revi sed Val ue	
		1.00	2.00	3.00	4.00	5.00	
	CALCULATION OF THE DSH PAYMENT PERCENTAGE						
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line	4. 78	4. 78	4. 7	0.00	4. 78	1.00
2.00	30 - Revised from CMS) Percentage of Medicaid patient days to total days (From line 27)	14. 12	14. 12			14. 12	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	18.90	18.90			18. 90	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	Urban	Urban			Urban	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	190. 81	190. 81			190. 81	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	5.04	0.00			0.00	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes	Yes			Yes	7.00
8.00 9.00	S-2, Line 22 Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	Yes Yes	Yes Yes			Yes No	8.00 9.00
10.00	S-2, Line 45	Yes	Yes			Yes	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 geater than -0-)	Yes	Yes			Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7	4. 78	4. 78	4. 7	0.00	4. 78	12.00
13.00	- Revised from CMS) Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line	No	No			No	13.00
14.00	75, column 1 = "Y") Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0. (0.00	0.00	14.00
	CALCULATION OF THE PERCENTAGE OF MEDICAID DAY						
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	1, 086	1, 086			1, 086	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	714	714			714	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	82	82			82	17.00
18. 00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	79	79			79	18.00
18. 01 19. 00	N/A Medicaid HMO days (Worksheet S-2, line 24, column 5)	0 5, 482	0 5, 482			0 5, 482	
20. 00	Other Medicaid days (Worksheet S-2, line 24, column 6)	119	119			119	20. 00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	7, 562	7, 562			7, 562	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	53, 239	53, 239			53, 239	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	303	303			303	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5	O	0			0	25.00
26.00	and 6) Total Medicaid patient days for the DSH calculation (sum of lines 22–24, less line 25)	53, 542	53, 542			53, 542	26.00
27.00	-	14. 12	14. 12			14. 12	27.00

Health Financial Systems	BAPTI ST HEA	LTH FLOYD		In Lie	u of Form CMS-	2552-10
CALCULATION OF DSH PAYMENT PERCENTAGE		Provider C	CN: 15-0044	Period: From 09/01/2018 To 08/31/2019		epared:
		Title	XVIII	Hospi tal	PPS	
	Original .r	ncrx Values	Adj usted	.mcax Values	Revi sed	
	Condi ti on	Percentage	Condi ti on	Percentage	Condi ti on	
	1.00	2.00	3.00	4.00	5.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAG	Ε					
28.00 If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3		0.00		0.00		28.00
29.00 If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	6 True	5.03	True	5.03	True	29.00
30.00 Line 28 or 29 as applicable		5.03		5.03		30.00
31.00 If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		0.00		0.00		31.00
	Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	o Overri de Val ue	Revi sed Val ue	
	1.00	2.00	3.00	4.00	5.00	
DETERMINATION OF PROVIDER TYPE		•				
32.00 Does the hospital qualify under the Pickle ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	Fal se	Fal se			Fal se	32.00
33.00 Is This a Rural Referral Center? (Worksheet S-2, Part I, Line 116, column 1 = "Y")	Fal se	Fal se			Fal se	33.00
34.00 Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	Fal se	Fal se			Fal se	34.00
35.00 Is this a Sole Cummunity hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	Fal se	Fal se			Fal se	35.00
36.00 Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban	Urban			Urban	36.00

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Heal th Financia	l Systems	BAPTI ST HEALT	TH FLOYD	In Lieu	of Form CMS-	2552-10
CALCULATION OF	DSH PAYMENT PERCENTAGE		Provider CCN: 15-0044	Period:	Worksheet DSH	1
				From 09/01/2018 To 08/31/2019	Date/Time Pre 9/21/2022 9:4	
			Title XVIII	Hospi tal	PPS	
		Revi sed				
		Percentage				
		6.00				
CALCULATI	ON OF MAXIMUM DSH PAYMENT PERCENTAGI	E				
28.00 If line	3 is greater than 20.2% - 5.88% plus	0.00				28.00
82.5% of	the difference between 20.2% and					
line 3						
29.00 If line	3 is less than 20.2% - 2.5% plus 65%	5.03				29.00
of the d	ifference between 15% and line 3					
30.00 Line 28	or 29 as applicable	5.03				30.00
31.00 If Urban	and fewer than 100 beds, Rural and	0.00				31.00
fewer th	an 500 beds, or an SCH with less					
than 100	beds the lower of line 30 or .1200,					
if RRC, I	MDH or otherwise enter line 30.					
if RRC, I	MDH or otherwise enter line 30.					

W VC	DLUME CALCULATION EXHIBIT 4			Provider C	CN: 15-0044	Period: From 09/01/2018	Worksheet E Part A Exhibi	+ 4
						To 08/31/2019		pare
					XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
00	DRG amounts other than outlier payments	1.00	0	0		0 0	0	1.
01	DRG amounts other than outlier payments for discharges	1.01	4, 616, 090	0	4, 616, 09	0	4, 616, 090	1.
02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1.02	53, 081, 922	0		53, 081, 922	53, 081, 922	1.
03	1 DRG for Federal specific operating payment for Model 4 BPCL occurring prior to	1.03	O	0		0	0	1.
04	October 1 DRG for Federal specific operating payment for Model 4 BPCL occurring on or after	1.04	0	0		0	0	1.
00	October 1 Outlier payments for discharges (see instructions)	2.00	3, 694, 999	0	237, 92	29 3, 457, 070	3, 694, 999	2.
01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0		0 0	0	2.
00	Operating outlier reconciliation	2.01	0	0		0 0	0	3.
00	Managed care simulated payments	3.00	0	0		0 0	0	4.
	Indirect Medical Education Adju	ustment			1			
00	Amount from Worksheet E, Part	21.00	0. 000000	0. 000000	0.00000	0. 000000		5
00	A, line 21 (see instructions) IME payment adjustment (see instructions)	22.00	0	0		0 0	0	6
01	IME payment adjustment for managed care (see instructions)	22.01	0	0		0 0	0	6
	Indirect Medical Education Adj							
00	IME payment adjustment factor	27.00	0. 000000	0. 000000	0.00000	0.00000		7
00	(see instructions) IME adjustment (see instructions)	28.00	0	0		0 0	0	8
)1	IME payment adjustment add on for managed care (see instructions)	28.01	0	0		0 0	0	8
00	Total IME payment (sum of	29.00	0	0		0 0	0	9
01	lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and	29.01	0	0		0 0	0	9
	8.01) Disproportionate Share Adjustme	nt						
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0504	0. 0504	0. 050	0. 0504		10
00	Disproportionate share adjustment (see instructions)	34.00	726, 995	0	58, 16	668, 832	726, 995	11
01	Uncompensated care payments	36.00	2, 190, 374	0 di cobargos	161, 62	2, 028, 747	2, 190, 374	11
00	Additional payment for high per Total ESRD additional payment (see instructions)	46.00	0	di scharges 0		0 0	0	12
00 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47.00 48.00	64, 310, 380 0	0 0	5, 073, 80	9 59, 236, 571 0 0	64, 310, 380 0	
00	(see instructions) Total payment for inpatient operating costs (see instructions)	49.00	64, 310, 380	0	5, 073, 80	9 59, 236, 571	64, 310, 380	15
00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	5, 094, 054	0	5, 517, 60		5, 094, 054	
00	Special add-on payments for new technologies Net organ aquisition cost	54.00	0	U		0 0	0	17
. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0		0 0	0	

Heal th	Financial Systems		BAPTIST HEA	LTH FLOYD		In Lie	u of Form CMS-	2552-10
LOW VO	DLUME CALCULATION EXHIBIT 4			Provider C		Period: From 09/01/2018 To 08/31/2019	Date/Time Pre 9/21/2022 9:4	pared:
					XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	r Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0		0 0	0	
19.00	SUBTOTAL			0	10, 591, 4	18 58, 813, 016	69, 404, 434	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	4, 645, 385 0	0	5, 018, 29	97 -372, 912 0 0	4, 645, 385 0	
21. 00 21. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG	2.00 2.01	267, 499 0	0	303, 59	-36, 099	267, 499 0	
	outlier payments Indirect medical education	5. 00	0. 0000	0. 0000	0.000	0.0000	-	22.00
23.00	percentage (see instructions) Indirect medical education	6.00	0	0		0 0	C	23.00
24.00	adjustment (see instructions) Allowable disproportionate share percentage (see instructions)	10. 00	0. 0390	0. 0390	0. 03	0. 0390		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	181, 170	0	195, 7 ⁻	-14, 544	181, 170	25.00
26.00	Total prospective capital payments (see instructions)	12.00	5, 094, 054	0	5, 517, 60	-423, 555	5, 094, 054	26.00
		W/S E, Part A	(Amounts to					
		line	E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00 28.00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E,	70. 96			0. 00000	0.000000 0	C	27.00 28.00
29. 00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	O	29.00
100.00	adjustments to Wkst. E, Pt. A.		Ν					100.00

	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5			Period: From 09/01/2018 To 08/31/2019	Date/Time Prep 9/21/2022 9:4	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	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 01	4, 616, 090	4, 630, 26	8	4, 630, 268	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	53, 081, 922		52, 893, 330	52, 893, 330	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0		0	0	1.03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2. 00	Outlier payments for discharges (see instructions)	2.00	3, 694, 999	237, 92	.9 3, 361, 179	3, 599, 108	2.00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0		0 0	0	2.01
3.00	Operating outlier reconciliation	2. 01	0		0 0	0	3.00
4.00	Managed care simulated payments	3.00	0		0 0	0	4.00
	Indirect Medical Education Adjustment	1	1		_		
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0. 00000	0.00000		5.00
5.00	IME payment adjustment (see instructions)	22.00	0		0 0	0	6.00
5. 01	IME payment adjustment for managed care (see instructions)		0		0 0	0	6. 01
	Indirect Medical Education Adjustment for the						7 00
. 00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0.00000			7.00
3.00 3.01	IME adjustment (see instructions) IME payment adjustment add on for managed	28. 00 28. 01	0		0 0	0	8. 00 8. 01
5. 01	care (see instructions)	20.01	0		0 0	U	0.0
. 00	Total IME payment (sum of lines 6 and 8)	29.00	0		0 0	0	9.00
. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0		0 0	0	9.0
	Disproportionate Share Adjustment						
0.00	Allowable disproportionate share percentage	33.00	0. 0504	0. 050	0. 0504		10.00
1. 00	(see instructions) Disproportionate share adjustment (see instructions)	34.00	726, 995	58, 34	2 668, 653	726, 995	11.00
1.01	Uncompensated care payments	36.00	2, 190, 374	161, 62	2, 028, 747	2, 190, 374	11 0
1.01	Additional payment for high percentage of ES			101,02	2,020,141	2,170,374	11.0
2.00	Total ESRD additional payment (see instructions)	46.00	0		0 0	0	12.00
3.00	Subtotal (see instructions)	47.00	64, 310, 380	5, 088, 16	6 59, 222, 214	64, 310, 380	13.0
4.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	48.00	0		0 0	0	
5. 00	instructions) Total payment for inpatient operating costs (see instructions)	49.00	64, 310, 380	5, 088, 16	6 59, 222, 214	64, 310, 380	15.00
6. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	5, 094, 054	5, 517, 60	-423, 555	5, 094, 054	16.00
7.00 7.01	Special add-on payments for new technologies Net organ acquisition cost	54.00	0		0 0	0	17.00 17.01
7.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0	0	17.02
8. 00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		0 0	0	18.00
		1	1	1	1		

HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5	Provider CO		Period: From 09/01/2018 To 08/31/2019		pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	4, 645, 385	5, 018, 29	-372, 912	4, 645, 385	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0		0 0	0	20.01
	Capital DRG outlier payments	2.00	267, 499	303, 59	-36, 099	267, 499	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2. 01	0		0 0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6. 00	0		0 0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0390	0. 039	0 0. 0390		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	181, 170	195, 71	4 -14, 544	181, 170	25.00
26.00	Total prospective capital payments (see instructions)	12.00	5, 094, 054	5, 517, 60	-423, 555	5, 094, 054	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70. 96	0		0	0	28.00
29.00	Low volume adjustment on or after October 1	70. 97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70. 93	-10, 765	-2, 24	4 -8, 521	-10, 765	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-529, 667	-37, 75	-491, 908	-529, 667	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70. 99			0 0		32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Ν				100.00

Heal th	Financial Systems BAPTIST HEAL	.TH FLOYD	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0044	Period: From 09/01/2018 To 08/31/2019	Worksheet E Part B Date/Time Pre	pared:
		Title XVIII	Hospi tal	9/21/2022 9:4 PPS	5 am
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			49, 540	1.00
2.00	Medical and other services reimbursed under OPPS (see instru-	uctions)		31, 958, 406	2.00
3.00 4.00	OPPS payments Outlier payment (see instructions)			28, 883, 468 448, 014	3.00 4.00
4.01	Outlier reconciliation amount (see instructions)			0	4.01
5.00	Enter the hospital specific payment to cost ratio (see inst	ructions)		0.000	
6.00 7.00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0.00	6.00 7.00
8.00	Transitional corridor payment (see instructions)			0	8.00
9. 00 10. 00	Ancillary service other pass through costs from Wkst. D, Pt	. IV, col. 13, line 200		18, 318 0	1
	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			49, 540	
	COMPUTATION OF LESSER OF COST OR CHARGES			· ·	
12 00	Reasonable charges Ancillary service charges			227, 723	12 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4,	line 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13)			227, 723	14.00
15 00	Customary charges Aggregate amount actually collected from patients liable fo	r navment for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable			0	
17 00	had such payment been made in accordance with 42 CFR §413.1. Ratio of line 15 to line 16 (not to exceed 1.000000)	3(e)		0,000000	17 00
17.00 18.00	Total customary charges (see instructions)			0.000000	
19.00	Excess of customary charges over reasonable cost (complete	only if line 18 exceeds li	ne 11) (see	178, 183	
20.00	instructions) Excess of reasonable cost over customary charges (complete	only if line 11 exceeds li	ne 18) (see	0	20.00
21.00	instructions) Lesser of cost or charges (see instructions)			49, 540	21.00
	Interns and residents (see instructions)			0	
	Cost of physicians' services in a teaching hospital (see in:	-		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9 COMPUTATION OF REIMBURSEMENT SETTLEMENT)		29, 349, 800	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instruction	ons)		5, 772	25.00
26.00 27.00	Deductibles and Coinsurance amounts relating to amount on I Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26			5, 591, 577 23, 801, 991	26.00 27.00
27.00	instructions)	prus the sum of titles 22		23, 001, 991	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4,			0	
29.00 30.00	ESRD direct medical education costs (from Wkst. E-4, line 3 Subtotal (sum of lines 27 through 29)	8)		0 23, 801, 991	29.00 30.00
	Primary payer payments			35, 166	31.00
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERV			23, 766, 825	32.00
33.00	Composite rate ESRD (from Wkst. 1-5, line 11)	VICL3)		0	33.00
34.00	Allowable bad debts (see instructions)			782, 851	
35.00 36.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in:	structions)		508, 853 548, 213	
37.00	Subtotal (see instructions)			24, 275, 678	
38.00	MSP-LCC reconciliation amount from PS&R			767	38.00
39.00 39.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	ons)		0	39.00 39.50
39.97	Demonstration payment adjustment amount before sequestration			0	1
39.98	Partial or full credits received from manufacturers for rep	laced devices (see instruc	ctions)	10, 250	•
39.99 40.00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 24, 274, 911	
40.01	Sequestration adjustment (see instructions)			485, 498	
	Demonstration payment adjustment amount after sequestration			0	
40. 03 41. 00	Sequestration adjustment-PARHM pass-throughs Interim payments			24, 151, 542	40.03
41.01	Interim payments-PARHM			21,101,012	41.01
42.00	Tentative settlement (for contractors use only)			-356, 963	
42.01 43.00	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)			-5, 166	42.01 43.00
43.00	Balance due provider/program-PARHM (see instructions)			3, 100	43.00
44.00	Protested amounts (nonallowable cost report items) in accord §115.2	dance with CMS Pub. 15-2,	chapter 1,	0	44.00
90.00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			451, 586	90.00
	Outlier reconciliation adjustment amount (see instructions))		451, 580	1
92.00	The rate used to calculate the Time Value of Money			0.00	92.00
	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93.00 94.00
74.00				. 0	1 / 7.00

Health Financial Systems	BAPTI ST HEALTH	FLOYD	In Lieu	u of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0044	Period: From 09/01/2018	Worksheet E Part B	
			To 08/31/2019	Date/Time Pr	epared:
				9/21/2022 9:	45 am
		Title XVIII	Hospi tal	PPS	
				Overri des	
				1.00	
WORKSHEET OVERRIDE VALUES					
112.00 Override of Ancillary service charges (line 12))			(0 112.00
				1.00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					200.00

	Financial Systems BAPTIST HEA SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	LTH FLOYD Provider CO	°N· 15_0044	Period:	u of Form CMS-2 Worksheet E-1	
VAL I.	SIS OF FAIMENTS TO FROVIDERS FOR SERVICES RENDERED	FIOVIDEI CO	JN. 15-0044	From 09/01/2018	Part I	
				To 08/31/2019		
		Title	XVIII	Hospi tal	9/21/2022 9:4 PPS	5 ai
			t Part A		T B	
			A		A	
		mm/dd/yyyy 1.00	Amount 2.00		Amount 4.00	
00	Total interim payments paid to provider	1.00	62, 382, 54		24, 151, 542	1
00	Interim payments payable on individual bills, either		02,002,0	0	0	2
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
D1	ADJUSTMENTS TO PROVIDER			0	0	3
)2				0	0	
)3				0	0	3
)4				0	0	3
25				0	0	3
	Provider to Program	1		-		
50	ADJUSTMENTS TO PROGRAM			0	0	
51				0	0	
52 53				0	0	
53 54				0	0	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	
	3. 50-3. 98)			-	-	
00	Total interim payments (sum of lines 1, 2, and 3.99)		62, 382, 54	46	24, 151, 542	4
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate)					
0	TO BE COMPLETED BY CONTRACTOR	I				
0	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					1
	write "NONE" or enter a zero. (1)					
	Program to Provider					
)1	TENTATI VE TO PROVIDER	12/14/2021	46, 13	31	0	1
)2				0	0	Ę
)3				0	0	Ę
0	Provider to Program TENTATIVE TO PROGRAM	01/31/2020	242, 7	47 01/31/2020	356, 940	E
50 51	TENTATIVE TO PROGRAM	01/31/2020	242, 74	0 12/14/2021	356, 940	Į
52				0 12/14/2021	23	Į
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines		-196, 6		-356, 963	E
	5. 50-5. 98)				,	
00	Determined net settlement amount (balance due) based on					6
	the cost report. (1)					
D1	SETTLEMENT TO PROVIDER			0	0	6
22	SETTLEMENT TO PROGRAM		9,20		5, 166	6
00	Total Medicare program liability (see instructions)		62, 176, 60		23, 789, 413	
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1.00	2.00	

Heal th	Financial Systems BAPTIST HEALTH	+ FLOYD	In Lie	u of Form CMS	-2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0044	Peri od:	Worksheet E-	1
			From 09/01/2018		
			To 08/31/2019	Date/Time Pr 9/21/2022 9:	
		Title XVIII	Hospi tal	PPS	40 ulli
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.				1.00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and	8 through 12, and plus	for cost		2.00
	reporting periods beginning on or after 10/01/2013, line 32)				
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines	1, and 8 through 12, and	d plus for cost		4.00
	reporting periods beginning on or after 10/01/2013, line 32)				
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l				6.00
7.00	CAH only - The reasonable cost incurred for the purchase of c line 168	certified HII technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instructio	ns)		32.00
				Overri des	
				1.00	
	CONTRACTOR OVERRIDES				
108.00	Override of HIT payment				108.00

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C	F	eriod: rom 09/01/2018 o 08/31/2019	Worksheet G Date/Time Pre 9/21/2022 9:4	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
. 00	Cash on hand in banks	16, 512, 104	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
1.00	Accounts receivable	239, 109, 922		0	0	4.00
5.00	Other receivable	411, 328		0	0	5.00
5.00 7.00	Allowances for uncollectible notes and accounts receivable Inventory	-187, 737, 290 6, 601, 481		0	0	6.0 7.0
3.00	Prepai d expenses	0,001,401		0	0	8.0
9.00	Other current assets	1, 155, 485	-	0	0	9.0
0.00	Due from other funds	0	0	0	0	10.0
1.00	Total current assets (sum of lines 1-10)	76, 053, 030	0	0	0	11.0
	FI XED_ASSETS	0.000 (50				
2.00	Land	2, 203, 652			0	12.00
3.00	Land improvements Accumulated depreciation	1, 133, 226 -326, 867			0	13.00
	Buildings	136, 841, 173			0	14.0
	Accumulated depreciation	-12, 956, 511		0	0	16.0
	Leasehold improvements	2, 966, 649	-	0	0	17.0
8.00	Accumulated depreciation	-634, 283	0	0	0	18.0
	Fixed equipment	992, 221		0	0	19.0
	Accumulated depreciation	-327, 153			0	20.0
	Automobiles and trucks	24, 095			0	21.0
	Accumulated depreciation	-4, 016			0	22.0
	Major movable equipment	41, 995, 438			0	23.0
	Accumulated depreciation Minor equipment depreciable	-18, 878, 111	0	0	0	24.0 25.0
	Accumulated depreciation		0	0	0	26.0
	HIT designated Assets	0	0	0	0	27.0
	Accumulated depreciation	0	0	0	0	28.0
9.00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29.0
30.00	Total fixed assets (sum of lines 12-29)	153, 029, 513	0	0	0	30.0
	OTHER ASSETS					
	Investments	0			0	31.0
32.00 33.00	Deposits on leases Due from owners/officers	0	0	0	0	32.0 33.0
34.00	Other assets	10, 650, 872		0	0	34.0
35.00	Total other assets (sum of lines 31-34)	10, 650, 872		-	0	35.0
86.00	Total assets (sum of lines 11, 30, and 35)	239, 733, 415	0	0	0	36.0
	CURRENT LI ABI LI TI ES					
	Accounts payable	5, 710, 723			0	37.0
38.00	Salaries, wages, and fees payable	13, 012, 251			0	38.0
39.00	Payroll taxes payable	2, 176, 567	0	0	0	39.0
0.00	Notes and Loans payable (short term) Deferred income			0	0	
2.00	Accel erated payments			0	0	42.0
	Due to other funds	0	0	0	0	
	Other current liabilities	4, 342, 528	0		0	
5.00	Total current liabilities (sum of lines 37 thru 44)	25, 242, 069	0	0	0	45.0
	LONG TERM LIABILITIES					
6.00	Mortgage payable	0			0	
7.00	Notes payable	0	0	0	0	47.0
8.00	Unsecured Loans		0	0	0	48.0 49.0
9.00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	-3, 766, 354 -3, 766, 354		0	0	49.0 50.0
	Total liabilities (sum of lines 45 and 50)	21, 475, 715			0	51.0
1.00	CAPITAL ACCOUNTS	21,475,715		0	0	1 51.0
52.00	General fund balance	218, 257, 700				52. C
3.00	Specific purpose fund		0			53.0
64.00	Donor created - endowment fund balance - restricted			0		54.C
5.00	Donor created - endowment fund balance - unrestricted			0		55.0
6.00	Governing body created - endowment fund balance			0		56.0
7.00	Plant fund balance - invested in plant				0	57.0
8.00	Plant fund balance - reserve for plant improvement,				0	58. C
0 00	replacement, and expansion	210 257 700			0	59. C
9.00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	218, 257, 700 239, 733, 415		0	0	60.0
0.00						

Heal th	Financial Systems	BAPTI ST HEAL	TH FLOYD		In Lie	u of Form CMS-	2552-10
STATEM	IENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0044	Period: From 09/01/2018 To 08/31/2019	Worksheet G-1 Date/Time Pre 9/21/2022 9:4	epared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	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) 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	0 0 0 0 0 0 0 0 0 0 0 0 0	214, 692, 174 -14, 895, 714 199, 796, 460 0 199, 796, 460 199, 796, 460			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ \end{array}$
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund	_		
	1	6.00	7.00	8.00			
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 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	000	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
19.00	sheet (line 11 minus line 18)	0			0		19.00

. 00 . 00 . 00 . 00 . 00	Cost Center Description				To 08/31/2019		epared:
. 00 . 00 . 00 . 00 . 00	·			I npati ent	Outpati ent	9/21/2022 9:4 Total	
. 00 . 00 . 00 . 00 . 00	PART I – PATIENT REVENUES			1.00	2.00	3.00	
. 00 . 00 . 00 . 00 . 00							
. 00 . 00 . 00 . 00	General Inpatient Routine Services					I	4
. 00 . 00 . 00	Hospi tal			65, 251, 67		65, 251, 675	
. 00 . 00	SUBPROVIDER - I PF				0	0	
. 00	SUBPROVI DER – I RF SUBPROVI DER				0	0	
	Subprovider Swing bed - SNF				0	0	
. 00	Swing bed - NF				0	0	
	SKILLED NURSING FACILITY				0	0	
	NURSING FACILITY				0	0	
	OTHER LONG TERM CARE				0	0	9.0
0.00	Total general inpatient care services (sum of lines 1-9)			65, 251, 67	'5	65, 251, 675	10.0
	Intensive Care Type Inpatient Hospital Services				- F		
	INTENSIVE CARE UNIT			31, 847, 77	0	31, 847, 770	
	CORONARY CARE UNIT				0	0	
	BURN I NTENSI VE CARE UNI T				0	0	
	SURGI CAL I NTENSI VE CARE UNI T				0	0	
	OTHER SPECIAL CARE (SPECIFY) Total intensive care type inpatient hospital services (sum of	Lines		31, 847, 77	10	31, 847, 770	15.0
	11-15)	TTHES		31, 047, 77	0	31, 647, 770	10.0
	Total inpatient routine care services (sum of lines 10 and 16))		97, 099, 44	15	97, 099, 445	17.0
	Ancillary services	/		524, 185, 36		1, 244, 446, 017	
	Outpatient services			35, 787, 10			
	RURAL HEALTH CLINIC				0 0		
1.00	FEDERALLY QUALIFIED HEALTH CENTER				0 0	0	21.0
2.00	HOME HEALTH AGENCY				6, 321, 002	6, 321, 002	22.0
3.00	AMBULANCE SERVICES				0 0	0	23.0
	CMHC				0	0	
	CORF				0 0	0	
	AMBULATORY SURGICAL CENTER (D. P.)				0 0	0	
	HOSPI CE NURSERY			5, 379, 08	0 0 31 0	-	
	OTHER NRCC			3, 379, 08			
	PHYSI CI AN & PROFESSI ONAL			50	0 770, 915		
	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst		662, 451, 30		1, 513, 915, 122	
	G-3, line 1)			002, 101,00	001,100,022	1,010,10,122	2010
ſ	PART II - OPERATING EXPENSES						
	Operating expenses (per Wkst. A, column 3, line 200)				287,063,389		29.0
	ADD (SPECIFY)				0		30.0
	BHMG			18, 492, 45	51		31.0
2.00					0		32.0
3.00					0		33.0
4.00 5.00					0		34.0
	Total additions (sum of lines 30-35)				18, 492, 451		35.0
	DEDUCT (SPECIFY)				18, 492, 431		37.0
8.00					0		38.0
9.00					0		39.0
0.00					0		40.0
1.00					0		41.0
	Total deductions (sum of lines 37-41)				0		42.0
	Total operating expenses (sum of lines 29 and 36 minus line 42 to Wkst. G-3, line 4)	2)(transf	er		305, 555, 840		43.0

<u>Heal</u> th	Financial Systems	BAPTI ST HEALTH	FLOYD	In Lie	u of Form CMS-2	<u>2552-1</u> 0
STATEM	IENT OF REVENUES AND EXPENSES		Provider CCN: 15-0044	Period: From 09/01/2018 To 08/31/2019	Worksheet G-3 Date/Time Pre 9/21/2022 9:4	pared:
					1.00	
1.00	Total patient revenues (from Wkst. G-2,	Part L column 3 line	28)		1, 513, 915, 122	1.00
2.00	Less contractual allowances and discount				1, 226, 319, 318	2.00
3.00	Net patient revenues (line 1 minus line		5		287, 595, 804	3.00
4.00	Less total operating expenses (from Wkst		3)		305, 555, 840	
5.00	Net income from service to patients (lin				-17, 960, 036	
	OTHER I NCOME					
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				0	7.00
8.00	Revenues from telephone and other miscel	aneous communication :	servi ces		0	8.00
9.00	Revenue from television and radio servic				0	9.00
10.00	Purchase di scounts				0	10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00	Parking lot receipts				0	12.00
13.00	Revenue from Laundry and Linen service				0	13.00
14.00	Revenue from meals sold to employees and	guests			0	14.00
15.00	Revenue from rental of living quarters	-			0	15.00
16.00	Revenue from sale of medical and surgica	supplies to other the	an patients		0	16.00
17.00	Revenue from sale of drugs to other than	patients			0	17.00
18.00	Revenue from sale of medical records and	abstracts			0	18.00
19.00	Tuition (fees, sale of textbooks, unifor	ns, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shop	s, and canteen			0	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	MI SCELLANEOUS I NCOME				3, 064, 322	24.00
24.01	GRANT REVENUE				0	24.01
24.02	LOSS GAIN ON DISPOSAL OF ASSETS				0	24.02
24.50	COVI D-19 PHE Fundi ng				0	24.50
25.00	Total other income (sum of lines 6-24)				3, 064, 322	
26.00					-14, 895, 714	
27.00	OTHER EXPENSES (SPECIFY)				0	27.00
28.00	Total other expenses (sum of line 27 and	1 /			0	28.00
29.00	Net income (or loss) for the period (lin	e 26 minus line 28)			-14, 895, 714	29.00

IHA CON: 15-7122 From 69/01/2018 For 69/01/2018 Detect by 21 Image: Contracted product on the service of t	пеетн	WORKSneet H					0044	CNL 1E 00	Disso data a	`		Financial Systems	
Balaries Employee Benefits Transportatio n (see Instructions) Contracted/Pu erchased Services Other Costs costs Total costs 1.00 2.00 3.00 4.00 5.00 4 2.00 Capital Related - Bidg. & functional strative and General 0 0 0 0 3.00 Plant Operation & Maintenance 0 0 236, 633 0 0 0 4.00 Capital Related - Bidg. & functional strative and General 2.995, 533 0 71, 962 384, 149 885, 256 4.00 Capital Therapy 0 </th <th>Time Prepar</th> <th>Date/Time P</th> <th>Worksheet H Date/Time Pr</th> <th></th> <th></th> <th></th> <th>F</th> <th></th> <th></th> <th>b</th> <th>TH AGENCY COSTS</th> <th>SIS OF HOSPITAL-BASED HOME HEAL</th> <th>ANALYS</th>	Time Prepar	Date/Time P	Worksheet H Date/Time Pr				F			b	TH AGENCY COSTS	SIS OF HOSPITAL-BASED HOME HEAL	ANALYS
Sal aries Employee Benefits Transportatio (servections) Constructions/ (rchased) Other Costs Total (cols) 1.00 2.00 3.00 4.00 5.00 4 2.00 Capital Related - Bidg. & Fatures 0 0 0 0 0 0 2.00 Plant Operation & Maintenance 0 <th></th> <th>9/21/2022 9</th> <th>9/21/2022 9:</th> <th></th>		9/21/2022 9	9/21/2022 9:										
Benefits n (see Instructions) respective Services cols 1.00 2.00 3.00 4.00 5.00 0 1.00 Capital Related - Movable Faxtures 0 0 5.400 0 2.00 Capital Related - Movable Faxtures 0 0 0 0 0 0 0 4.00 Tant Operation 8 Maintenance 0	(sum of	Total (sum o	Total (sum o	Total (acted/Pu	Contrac	Transportatio	Employee	Salarios		
Incol 2.00 3.00 4.00 5.00 4 Capital Related - Bldg, & Fixtures	1 thru	cols. 1 thr	cols. 1 thru	cols. 1	00313		hased	rcha	n (see	Benefits	Sururres		
1.00 Capit tal Related - Bidg. & Fixtures 0 0 0 2.00 Capit tal Related - Movable Equipment 0 0 0 0 3.00 Plant Operation & Maintenance 0 0 236, 630 30 0 400 Transportation A Maintenance 0 0 236, 630 384, 149 885, 256 -00 Skilled Nursing Care 0 0 0 0 0 0 0 -00 Skilled Nursing Care 0	/	<u> </u>	,	/	00	5.00					1.00		
Fixtures Fixtures State 0 Capital Related - Novable Equipment 5,405 20 Capital Related - Novable Equipment 0 0 4.00 Transportation 8.01 intenance 0 0 4.00 Transportation 8.01 intenance 0 0 236,630 0 0 4.00 Transportation 8.01 intenance 0 0 236,630 0 0 0 60 Skilled Nursing Care 0	0			1				1	0				1 00
Equipment Addition Maintenance 0 </td <td>0</td> <td></td> <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td>0</td> <td></td> <td></td> <td>Fixtures</td> <td>1.00</td>	0				0				0			Fixtures	1.00
3.00 Plant Operation & Maintenance 0 <	5, 405 2	5,4	5,40		5, 405	5,40			C				2.00
5.00 Admin is trative and General 2,995,533 0 71,962 384,149 885,256	0 3			1		0	C		0		0	Plant Operation & Maintenance	
HHA RELIMBURSABLE SERVICES 7.00 Physical Therapy 0 <td>236, 630 , 336, 900</td> <td></td> <td></td> <td>•</td> <td>-</td> <td>~</td> <td></td> <td></td> <td></td> <td>-</td> <td>0 2, 995, 533</td> <td></td> <td></td>	236, 630 , 336, 900			•	-	~				-	0 2, 995, 533		
7.00 Physical Therapy 0		.,	.,,								T.	HHA REIMBURSABLE SERVICES	
9.00 Specic Pathology 0	0 6			1				•		-	0		
10.00 Medical Social Services 0 0 0 0 0 11.00 Home Health Aide 0 0 0 0 0 0 12.00 Supplies (see instructions) 0 <t< td=""><td>0</td><td></td><td></td><td></td><td>0</td><td>0</td><td>C</td><td></td><td>0</td><td>0</td><td>0</td><td>Occupational Therapy</td><td></td></t<>	0				0	0	C		0	0	0	Occupational Therapy	
11.00 Home Heal th Ai de 0 <td>0 9</td> <td></td> <td></td> <td></td> <td>0</td> <td>0</td> <td>C</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td></td>	0 9				0	0	C		0	0	0		
13.00 Drugs 0 0 0 0 0 0 0 0 14.00 DME 0	0 1	112.0	112 0	1	-	-	-		0	0	0	Home Health Aide	
HA NONRELINGURSABLE SERVICES 0	113, 872 12 0 13	113, 8	113, 87	1			-		0	0	0		
15:00 Home Dialysis Aide Services 0 <t< td=""><td>0 14</td><td></td><td></td><td></td><td>0</td><td>0</td><td>C</td><td>)</td><td>0</td><td>0</td><td>0</td><td></td><td>14.00</td></t<>	0 14				0	0	C)	0	0	0		14.00
17.00 Private Duty Nursing 0 </td <td>0 15</td> <td></td> <td></td> <td></td> <td>0</td> <td>0</td> <td>C</td> <td>)</td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td>15.00</td>	0 15				0	0	C)	0	0	0		15.00
18.00 Clinic 0 0 0 0 0 19.00 Health Promotion Activities 0 0 0 0 0 19.00 Health Promotion Activities 0 0 0 0 0 20.00 Day Care Program 0 0 0 0 0 0 21.00 Homemaker Service 0 0 0 0 0 0 23.00 All Others (specify) 0 0 0 0 0 0 23.00 Total (sum of lines 1-23) 2,995,533 0 308,592 384,149 1,004,533 0 24.00 Total (sum of lines 1-23) 2,995,533 0 308,592 384,149 1,004,533 0 24.00 Total (sum of lines 1-23) 2,995,533 0 308,592 384,149 1,004,533 0 20.01 Capital Related - Bldg. & frial Balance 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 16				-	-	-		-	0	0		
20.00 Day Care Program 0	0 18				0	-	-		0	0	0		
21.00 Home Delivered Meals Program Homemaker Service 0 <t< td=""><td>0 19</td><td></td><td></td><td></td><td>0</td><td>0</td><td>C</td><td></td><td>0</td><td>0</td><td>0</td><td></td><td></td></t<>	0 19				0	0	C		0	0	0		
23.00 All Others (specify) 0 10 0 10 0 10 0 10 0 10 0 10 10 10 10 10 10 10 10 10 10 10 10 10 10 10	0 21				0	0	C		0	0	0	Home Delivered Meals Program	
23. 50 Tel emedicine 0	0 22				0	0	C		0	0	0		
General Recl assi fi cat i on Recl assi fi ed ri al Bal ance (col. 6 + col. 7) Adj ustments Net Expenses for Al locati on (col. 8 + col. 9) 1.00 GENERAL SERVICE COST CENTERS 7.00 8.00 9.00 10.00 2.00 Capi tal Rel ated - Bl dg. & Fi xtures 0 0 0 0 0 2.00 Capi tal Rel ated - Movabl e Equipment 0 0 0 0 5,405 0 5,405 3.00 Pl ant Operati on & Maintenance 0 236,630 0 236,630 236,630 0 23	0 23				0	0	C		0	0	0	Tel emedi ci ne	23.50
ion Trial Balance (col. 6 + col. 7) for All ocation (col. 8 + col. 9) 7.00 8.00 9.00 10.00 GENERAL SERVICE COST CENTERS 7.00 8.00 9.00 10.00 Capital Related - Bldg. & Fixtures 0 0 0 0 2.00 Capital Related - Movable 0 5,405 0 5,405 Equipment 0 0 0 0 0 0 3.00 Plant Operation & Maintenance 0 0 236,630 0 236,630 5.00 Administrative and General -2,195,918 2,140,982 -753,317 1,387,665 HHA REIMBURSABLE SERVICES 600 Skilled Nursing Care 985,610 985,610 985,610 7.00 Speech Pathology 101,848 101,848 101,848 101,848 10.00 Medical Social Services 50,095 0 50,095 9.00 Speech Pathology 101,848 101,848 101,848 10.00 Home Heal th Ai de 40,520 40,5	, 692, 807 24	4, 692, 8	4, 692, 80	4,6	004, 533					0 Recl assi fi ed		Total (sum of lines 1-23)	24.00
Col. 7) (col. 8 + col. 9) 7.00 8.00 9.00 10.00 Capital Related - Bidg. & Fixtures 0 0 0 0 0 2.00 Capital Related - Movable 0 0 5,405 0 5,405 2.00 Capital Related - Movable 0 0 0 0 0 3.00 Plant Operation & Maintenance 0 0 0 0 0 3.00 Plant Operation & Maintenance 0 0 0 0 0 4.00 Transportation 0 236,630 0 236,630 0 236,630 5.00 Administrative and General -2,195,918 2,140,982 -753,317 1,387,665 HHA REIMBURSABLE SERVICES							for	fo	,	Trial Balance			
T.00 8.00 9.00 10.00 GENERAL SERVICE COST CENTERS													
GENERAL SERVICE COST CENTERS 1.00 Capital Related - Bldg. & 0 Fixtures 0 0 0 0 2.00 Capital Related - Movable 0 5,405 0 5,405 2.00 Capital Related - Movable 0 0 0 0 2.00 Capital Related - Movable 0 0 0 0 3.00 Plant Operation & Maintenance 0 0 0 0 4.00 Transportation 0 236,630 0 236,630 5.00 Administrative and General -2,195,918 2,140,982 -753,317 1,387,665 HHA REIMBURSABLE SERVICES 5 5 0 985,610 0 985,610 7.00 Physical Therapy 820,269 820,269 0 820,269 8.00 Occupational Therapy 197,575 0 197,575 9.00 Speech Pathology 101,848 101,848 0 101,848 0.00 Medical Social Services 50,095 0 5					-	_			9.00	8.00	7.00		
Fixtures Construction Construction Construction Construction 2.00 Capital Related - Movable 0 5,405 0 5,405 Equipment 0 0 0 0 0 3.00 Plant Operation & Maintenance 0 0 0 0 4.00 Transportation 0 236,630 0 236,630 5.00 Administrative and General -2,195,918 2,140,982 -753,317 1,387,665 HHA REIMBURSABLE SERVICES						-					T		
2.00 Capital Related - Movable Equipment 0 5,405 0 5,405 3.00 Plant Operation & Maintenance 0 0 0 0 4.00 Transportation 0 236,630 236,630 5.00 Administrative and General -2,195,918 2,140,982 -753,317 1,387,665 HHA REIMBURSABLE SERVICES 6.00 Skilled Nursing Care 985,610 985,610 9850,610 7.00 Physical Therapy 820,269 820,269 820,269 8.00 Occupational Therapy 197,575 197,575 197,575 9.00 Speech Pathology 101,848 101,848 101,848 10.00 Medical Social Services 50,095 50,095 0,095 11.00 Home Health Aide 40,520 40,520 40,520 40,520 12.00 Supplies (see instructions) 0 113,872 113,872 113,872						0	C		0	0	0		1.00
3.00 Plant Operation & Maintenance 0 0 0 0 4.00 Transportation 0 236,630 0 236,630 5.00 Administrative and General -2,195,918 2,140,982 -753,317 1,387,665 HHA REIMBURSABLE SERVICES HHA REIMBURSABLE SERVICES 6.00 Skilled Nursing Care 985,610 985,610 985,610 7.00 Physical Therapy 820,269 820,269 820,269 8.00 Occupational Therapy 197,575 197,575 197,575 9.00 Speech Pathology 101,848 101,848 0 101,848 10.00 Medical Social Services 50,095 50,095 0 50,095 11.00 Home Heal th Aide 40,520 40,520 40,520 40,520 12.00 Supplies (see instructions) 0 113,872 113,872 113,872						5	5,405		C	5, 405	0	Capital Related - Movable	2.00
5.00 Administrative and General -2,195,918 2,140,982 -753,317 1,387,665 HHA REIMBURSABLE SERVICES HHA REIMBURSABLE SERVICES 985,610 0 985,610 985,610 6.00 Skilled Nursing Care 985,610 985,610 0 985,610 7.00 Physical Therapy 820,269 820,269 0 820,269 8.00 Occupational Therapy 197,575 197,575 0 197,575 9.00 Speech Pathology 101,848 101,848 0 101,848 0.00 Medical Social Services 50,095 50,095 0 50,095 11.00 Home Health Aide 40,520 40,520 0 40,520 12.00 Supplies (see instructions) 0 113,872 0 113,872						0	C		0	о	0	Plant Operation & Maintenance	3.00
HHA REIMBURSABLE SERVICES 6.00 Skilled Nursing Care 985,610 985,610 985,610 7.00 Physical Therapy 820,269 820,269 820,269 8.00 Occupational Therapy 197,575 197,575 197,575 9.00 Speech Pathology 101,848 101,848 1011,848 0.00 Medical Social Services 50,095 50,095 50,095 11.00 Home Heal th Aide 40,520 40,520 40,520 12.00 Supplies (see instructions) 0 113,872 113,872	2								-		0 2 105 019	Transportati on	
7.00Physical Therapy820,269820,2690820,2698.00Occupational Therapy197,575197,5750197,5759.00Speech Pathology101,848101,8480101,84810.00Medical Social Services50,09550,095050,09511.00Home Heal th Ai de40,52040,520040,52012.00Supplies (see instructions)0113,8720113,872	Ì					-			-755, 517				5.00
8.00 Occupational Therapy 197, 575 197, 575 0 197, 575 9.00 Speech Pathology 101, 848 101, 848 0 101, 848 10.00 Medical Social Services 50, 095 50, 095 0 50, 095 11.00 Home Heal th Ai de 40, 520 40, 520 0 40, 520 12.00 Supplies (see instructions) 0 113, 872 0 113, 872													
10.00 Medical Social Services 50,095 50,095 0 50,095 11.00 Home Heal th Aide 40,520 40,520 0 40,520 12.00 Supplies (see instructions) 0 113,872 0 113,872	8					5	197, 575	1	0	197, 575		Occupational Therapy	8.00
11.00 Home Heal th Ai de 40,520 40,520 0 40,520 12.00 Supplies (see instructions) 0 113,872 0 113,872	10							1	0				
	11					0	40, 520	1	0	40, 520		Home Health Aide	11.00
	12						113, 872 C		0	113, 872 0	0	Supplies (see instructions) Drugs	12.00 13.00
14.00 DME 0 0 0	14					0	C)	0	0	0	DME	
HHA NONREI MBURSABLE SERVI CES 15.00 Home Dialysis Aide Services 0 0 0	15					0	C)	0	ol	0		15.00
16.00 Respiratory Therapy 0 0 0 0	16										0	Respiratory Therapy	16.00
17.00 Private Duty Nursing 0 0 0 0 18.00 Clinic 0 0 0 0 0	17					0	C		0	0	0		
19.00 Health Promotion Activities 0 0 0 0	19					0	C		0	0	0		
20.00 Day Care Program 0 0 0 0 21.00 Home Delivered Meals Program 0 0 0 0	2					0	C		0	0	0	5	
22.00 Homemaker Service 0 0 0 0 23.00 All Others (specify) 0 0 0 0	22					0	C		0	0	0		
23.50 Telemedicine 0 0 0 0	23					0	C		0	0	0	Tel emedi ci ne	23.50
24.00 Total (sum of lines 1-23) -1 4,692,806 -753,317 3,939,489	24					9	3, 939, 489	3,9	-753, 317	4, 692, 806	-1	Total (sum of lines 1-23)	24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable. 9/21/2022 9:45 am F: \Final Settlement\150044 08312019\150044.08312019. A1. mcax

Heal th	Financial Systems		BAPTI ST HEAL	_TH FLOYD			In Lie	u of Form CMS-2	2552-10
	LLOCATION - HHA GENERAL SERVICE	E COST		Provider CO	CN: 15-0044 15-7152	Peri From To		Worksheet H-1 Part I Date/Time Pre	pared:
							me Health	9/21/2022 9: 4 PPS	<u>5 am</u>
			Capital Rela	ated Costs			Agency I		
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	BI dgs & Fi xtures	Movable Equipment	Plant Operation & Maintenance	&	ansportatio n	Subtotal (col s. 0-4)	
	OFNEDAL CEDILLOF OOCT OFNEDO	0	1.00	2.00	3.00		4.00	4A. 00	
1.00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	0					0	1.00
2.00	Fixtures Capital Related - Movable	5, 405		5, 405				0	2.00
	Equi pment	5,405		5,405				0	
3.00 4.00	Plant Operation & Maintenance Transportation	0 236, 630	0	0		0	236, 630	0	3.00 4.00
4.00 5.00	Administrative and General	1, 387, 665	0	5, 405		0	230, 030	1, 393, 070	
6 00	HHA REIMBURSABLE SERVICES	095 410	0	0		0	100 000	1 005 509	6 00
6.00 7.00	Skilled Nursing Care Physical Therapy	985, 610 820, 269	0	0		0	109, 898 78, 659	1, 095, 508 898, 928	
8.00	Occupational Therapy	197, 575	0	0		0	20, 794	218, 369	
9. 00 10. 00	Speech Pathology Medical Social Services	101, 848 50, 095	0	0		0 0	8, 820 2, 423	110, 668 52, 518	
11.00	Home Health Aide	40, 520	0	0		0	16, 036	56, 556	11.00
12.00 13.00	Supplies (see instructions) Drugs	113, 872 0	0	0		0 0	0	113, 872 0	
14.00	DME	0	0	0		0	0	0	
15.00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0	0		0	0	0	15.00
16.00	Respiratory Therapy	0	0	0		0	0	0	16.00
17.00 18.00	Private Duty Nursing Clinic	0	0	0		0	0	0	17.00
18.00	Health Promotion Activities	0	0	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 22.00	Home Delivered Meals Program Homemaker Service	0	0	0		0	0	0	
23.00	All Others (specify)	0	0	0		0	0	0	23.00
23.50	Telemedicine Total (sum of lines 1-23)	0 3, 939, 489	0	0 5, 405		0 0	0 236, 630	0 3, 939, 489	23.50
24.00		Admi ni strati v	Total (cols.	5,405			230, 030	3, 737, 407	24.00
		e & General 5.00	<u>4A + 5)</u> 6.00						-
	GENERAL SERVICE COST CENTERS	3.00	0.00						
1.00	Capital Related - Bldg. & Fixtures								1.00
2.00	Capital Related - Movable								2.00
3.00	Equipment Plant Operation & Maintenance								3.00
4.00	Transportati on								4.00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	1, 393, 070							5.00
6.00	Skilled Nursing Care	599, 320	1, 694, 828						6.00
7.00 8.00	Physical Therapy Occupational Therapy	491, 777 119, 463	1, 390, 705 337, 832						7.00 8.00
8.00 9.00	Speech Pathology	60, 543	171, 211						9.00
10.00	Medical Social Services	28, 731	81, 249						10.00
11.00 12.00	Home Health Aide Supplies (see instructions)	30, 940 62, 296	87, 496 176, 168						11.00 12.00
13.00	Drugs	0	0						13.00
14.00	DME HHA NONREIMBURSABLE SERVICES	0	0						14.00
15.00	Home Dialysis Aide Services	0	0						15.00
16.00 17.00	Respiratory Therapy Private Duty Nursing	0	0						16.00 17.00
18.00	Clinic	0	0						18.00
19.00	Health Promotion Activities	0	0 0						19.00 20.00
20. 00 21. 00	Day Care Program Home Delivered Meals Program	0	0						20.00
22.00	Homemaker Service	0	0						22.00
	All Others (specify) Telemedicine	0	0 0						23.00 23.50
	Total (sum of lines 1-23)		3, 939, 489						24.00

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	Financial Systems		BAPTIST HEA	LTH FLOYD		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - HHA STATISTICAL BAS	SI S		Provider C HHA CCN:	CN: 15-0044 15-7152	Period: From 09/01/2018 To 08/31/2019		pared:
						Home Health	PPS	
		Capital Rel	ated Costs			Agency I		
		BIdgs &	Movabl e	Plant	Transportati	o Reconciliatio	Administrativ	-
		Fixtures (SQUARE FEET)	Equipment (DOLLAR	Operation & Maintenance	n (MILEAGE)	n	e & General (ACCUM. COST)	
			VALUE)	(SQUARE FEET)			. ,	
		1.00	2.00	3.00	4.00	5A. 00	5.00	
1 00	GENERAL SERVICE COST CENTERS							1 0 0
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable		5,405			0		2.00
2.00	Equipment		0, 100					2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see	0	0	0	32, 62	25		4.00
	instructions)			_				
5.00	Administrative and General	0	5, 405	0		0 -1, 393, 070	2, 546, 419	5.00
6.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	0	0	0	15, 15	52 0	1, 095, 508	6.00
7.00	Physical Therapy	0	0		10, 84		898, 928	
8.00	Occupational Therapy	0	0	0	2,86		218, 369	
9.00	Speech Pathology	0	0	0	1, 21		110, 668	
10.00	Medical Social Services	0	0	0	33	34 0	52, 518	10.00
11.00	Home Health Aide	0	0	0	2, 21	1 0		11.00
12.00	Supplies (see instructions)	0	0	0		0 0	113, 872	
13.00	Drugs	0	0	0		0	0	
14.00	DME HHA NONREIMBURSABLE SERVICES	0	0	0		0 0	0	14.00
15.00	Home Dialysis Aide Services	0	0	0		0 0	0	15.00
16.00	Respiratory Therapy	0	0	0		0 0	-	
17.00	Private Duty Nursing	0	0	0		0 0	0	
18.00	Clinic	0	0	0		0 0	0	
19.00	Health Promotion Activities	0	0	0		0 0	0	19.00
	Day Care Program	0	0	0		0 0	0	
	Home Delivered Meals Program	0	0	0		0 0	0	
	Homemaker Service	0	0	0		0 0	0	
	All Others (specify)	0	0	0		0 0	0	
23.50 24.00	Telemedicine Total (sum of lines 1-23)	0	0 5, 405		32, 62	0 25 -1, 393, 070	0 2, 546, 419	
24.00 25.00	Cost To Be Allocated (per	0	5,405		236, 63		1, 393, 070	
20.00	Worksheet H-1, Part I)		5,405		200,00		1, 0, 0, 0, 0	
	Unit Cost Multiplier	0. 000000	1.000000	0. 000000	7. 25302		0. 547070	

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	1 Financial Systems ATION OF GENERAL SERVICE COSTS ⁻	TO HHA COST CEN	BAPTI ST HEA ITERS	Provider C HHA CCN:	CN: 15-0044 15-7152	Period: From 09/01/2018 To 08/31/2019	u of Form CMS-2 Worksheet H-2 Part I Date/Time Pre 9/21/2022 9:4	pared:
						Home Health	PPS	
			CAPI TAL REL	ATED COSTS		Agency I		
	Cost Center Description	HHA Trial Balance (1)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI V E & GENERAL	
		0	1. 00	2.00	4.00	4A	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 50\\ 20.\ 00\\ 21.\ 00\\ \end{array}$	Tel emedi ci ne	0 1, 694, 828 1, 390, 705 337, 832 171, 211 81, 249 87, 496 176, 168 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		242, 1 269, 1 210, 1 50, 4 25, 2 8, 8 12, 6	$\begin{array}{c ccccccccccccccccccccccccccccccccccc$	69, 137 560, 862 457, 151 110, 874 56, 092 25, 721 28, 612 50, 308 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 10.00 11.00 12.00 13.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
		MAINTENANCE &		LAUNDRY &	HOUSEKEEPI N	G DI ETARY	CAFETERI A	
		REPAI RS 6. 00	PLANT 7.00	LINEN SERVICE 8.00	9.00	10.00	11.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 7.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 50\\ 20.\ 00\\ 21.\ 00\\ \end{array}$	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)		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50, 724 48, 938 31, 153 9, 220 4, 326 3, 385 5, 213 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 10.00 11.00 12.00 13.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 19.50

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.
9/21/2022 9:45 am F: \Final Settlement\150044 08312019\150044.08312019.A1.mcax

LLOCA	Financial Systems TION OF GENERAL SERVICE COSTS	FO HHA COST CEN	BAPTIST HEA ITERS	Provider C	CN: 15-0044	Period: From 09/01/2018	Worksheet H-2 Part I	2
				HHA CCN:	15-7152	To 08/31/2019	Date/Time Pre 9/21/2022 9:4	
						Home Health Agency I	PPS	
	Cost Center Description	MAI NTENANCE	NURSI NG	CENTRAL	PHARMACY	MEDICAL	SOCI AL	
		OF PERSONNEL	ADMI NI STRATI O	SERVICES & SUPPLY		RECORDS &	SERVI CE	
		12.00	N 13.00	14.00	15.00	LI BRARY 16. 00	17.00	
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy		0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 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. 3. 4. 5. 6. 7. 8. 9. 10. 11.
3.00 4.00 5.00 6.00 7.00 8.00 9.00 9.50 0.00 1.00	Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0				14. 15. 16. 17. 17. 18. 19. 19.
	Cost Center Description	PARAMED ED PRGM-PHARMACY RESIDENCY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		23.00	24.00	25.00	26.00	27.00	28.00	
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program		2, 573, 798 2, 089, 137 508, 348 256, 839 119, 173 134, 018 226, 476 0		2, 573, 7 2, 089, 1 508, 3 256, 8 119, 1 134, 0 226, 4	98 157, 693 37 127, 999 48 31, 146 39 15, 736 73 7, 302 18 8, 211	2, 217, 136 539, 494 272, 575 126, 475 142, 229 240, 352 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16.
2.00 3.00 9.00 9.50 9.00 .00	Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0 0 0 6, 269, 752	0 0 0 0 0		0 0 0 0 0 0 52 361, 963 0. 061269		18. 19. 19.

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.
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Health Financial Systems ALLOCATION OF GENERAL SERVICE CO:		BAPTIST HEA		CN: 15 0044	Do		u of Form CMS-2 Worksheet H-2	
BASIS	SIS TO HHA COST CEI	NIERS STATISTIC	CAL Provider C HHA CCN:	15-7152	Fr To	eriod: com 09/01/2018 o 08/31/2019	Part II	pared:
						Home Health	PPS	
	CAPI TAL RE	LATED COSTS				Agency I		
Cost Center Descript	on BLDG & FIXT (SQUARE FEET)	MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliati n		ADMI NI STRATI V E & GENERAL (ACCUM. COST)	MAI NTENANCE & REPAI RS (SQUARE FEET)	-
	1.00	2.00	4.00	5A		5.00	6.00	
 Administrative and General Administrative and General Skilled Nursing Care O Skilled Nursing Care O Ccupational Therapy O Occupational Therapy Supplies Interapy Medical Social Services O Home Health Aide O Supplies (see instructions O DHE O DME O Respiratory Therapy O Realth Promotion Activitie O Day Care Program O Home Delivered Meals Progr O All Others (specify) So Telemedicine O All Stress 1-19 			985, 048 768, 979 184, 524 92, 257 32, 270 46, 464 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			242, 102 1, 963, 998 1, 600, 833 388, 254 196, 421 90, 067 100, 193 176, 168 0 0 0 0 0 0 0 0 0 0 0 0 0		$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 50\\ 20.\ 00\\ \end{array}$
21.00 Total cost to be allocated		0	818, 547			1, 358, 757	0	
22.00 Unit cost multiplier Cost Center Descript	0. 000000 on 0PERATION 0F	0. 000000 LAUNDRY &	0. 273256 HOUSEKEEPI NG	DI ETARY		0. 285571 CAFETERI A	0. 000000 MAI NTENANCE	22.00
	PLANT (SQUARE FEET)	LI NEN SERVICE (POUNDS OF LAUNDRY)	(SQUARE FEET)	(MEALS SERVED)		(PRODUCTI VE HOURS)	OF PERSONNEL (NUMBER HOUSED)	
	7.00	8.00	9.00	10.00		11.00	12.00	
 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 Service 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activitie 16.00 Day Care Program 17.00 Home Delivered Meals Progr 18.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) 21.00 Unit cost multiplier 	rs 00 rs 00 rs 00 rs 00 ram 00 00 00 00 00 00 00 00 00 00 00 00 00					28, 635 27, 627 17, 587 5, 205 2, 442 1, 911 2, 943 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ \end{array}$

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Heal th	Financial Systems		BAPTI ST HEAL	TH FLOYD		In Lie	u of Form CMS-2	2552-10
	TION OF GENERAL SERVICE COSTS	TO HHA COST CEN	TERS STATISTICA	L Provider C	CN: 15-0044	Period:	Worksheet H-2	
BASI S				HHA CCN:	15-7152	From 09/01/2018 To 08/31/2019		narod
				TITA CON.	15-7152	10 00/31/2019	9/21/2022 9:4	
						Home Health	PPS	
						Agency I		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	PARAMED ED	
		ADMI NI STRATI O	SERVICES &	(COSTED	RECORDS &	SERVI CE	PRGM-PHARMACY	
		N	SUPPLY	REQUIS.)	LI BRARY	(ASSI GNED	RESI DENCY	
		(DI RECT	(COSTED		(TIME SPENT) TIME)	(ASSI GNED	
		NRSING HRS)	REQUIS.)	45.00	14.00	17.00	TIME)	
1 00		13.00	14.00	15.00	16.00	17.00	23.00	1.00
1.00	Administrative and General	0	0	0		0 0	0	1.00
2.00 3.00	Skilled Nursing Care	0	0	0		0 0	0	2.00
	Physical Therapy	0	0	0		0 0	0	3.00
4.00 5.00	Occupational Therapy Speech Pathology	0	0	0		0 0	0	4.00 5.00
5.00 6.00	Medical Social Services	0	0	0		0 0	0	6.00
8.00 7.00	Home Health Aide	0	0	0		0 0	0	7.00
8.00	Supplies (see instructions)	0	0	0		0 0	0	8.00
8.00 9.00	Drugs	0	0	0		0 0	0	9.00
9.00 10.00	DME	0	0	0		0 0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0		0 0	0	10.00
12.00	Respi ratory Therapy	0	0	0		0 0	0	
12.00	Private Duty Nursing	0	0	0			0	
14.00	Clinic	0	0	0			0	
15.00	Health Promotion Activities	0	0	0			0	
16.00	Day Care Program	0	0	0		0 0	0	16.00
17.00	Home Delivered Meals Program	0	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 0	0	19.00
19.50	Tel emedi ci ne	0	0	0		0 0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0		0 0	0	20.00
21.00	Total cost to be allocated	0	0	0		0 0	0	21.00
	Unit cost multiplier	0. 000000	0. 000000	0.000000	0.0000	0. 000000	0. 000000	

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PRORTI OMENT OF PATIENT SERVICE COSTS Provider COL 15-004 H4 COL Provider COL 15-004 From 89/01/2018 To 08/01/2018 To 08/01/201	Heal th	Financial Systems		BAPTI ST HEA	LTH FLOYD		In Lie	u of Form CMS-2	2552-10	
HAR COX 15-7152 TO 00/21/2012	APPORT	IONMENT OF PATIENT SERVICE COST	ΓS		Provider C	CN: 15-0044	Period:	Worksheet H-3		
Cost Center Description From, West. (c). 2 Part I. (c).							To 08/31/2019	Date/Time Pre 9/21/2022 9:4		
Cast Center Description From, Wist. H-2, Part I, Ol. 26, 11n Facility wist. H-2. Out (from Part I) Shared Casts (from Part I) Total Wist Is Casts (from Part I) Average Cast Part I) Average Cast Part I) Average Cast Part I) Average Cast Part I) Part II Average Cast Part I) Average Cast Part II Part II Average Cast Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII					Titl∈	e XVIII		PPS		
H=2, Part I. Costs (from Part I) Ancillary Part I) Costs (cols. Part I) Per Visit (col. 3) PART I - COMPUTATION OF LESSED OF AGREGATE PROGRAM COST. AGGREGATE OF THE PROGRAM LIMITATION COST. ON DUBLICIT ARY COST LIMITATION COST Per Visit Computation 3.00 4.00 6.00 0 0 OP Physical Therapy COST LIMITATION OF LESSED OF AGREGATE PROGRAM COST. AGGREGATE OF THE PROGRAM LIMITATION COST. ON DUBLICIT ARY COST Per Visit Computation 1.00 2.731.491 2.731.491 2.731.491 1.045 2.004.42 2.00 OD Physical Therapy COST Per Visit Computation 2.00 2.731.491 2.731.491 1.045 2.064.42 2.00 OD Physical Therapy COST Center Description 3.00 4.00 552.475 0 552.475 1.346.370.444 2.0 OD Home Health Aide 7.00 1.42.229 0 6.029.400 2.2625 7.00 OO Total (sum of Lines 1-6) 0 1.00 2.00 3.00 4.00 5.00 7.00 ON Physical Therapy Cost Center Description Cost Line 1's Cost Center Description Cost Line 1's Cost Center Description Cost Center Description 5.00 7.00 7.00 <td< td=""><td></td><td>Cost Center Description</td><td>From, Wkst.</td><td>Facility</td><td>Shared</td><td>Total HHA</td><td></td><td>Average Cost</td><td></td></td<>		Cost Center Description	From, Wkst.	Facility	Shared	Total HHA		Average Cost		
Part 1) Part 10 Col Col <th< td=""><td></td><td> p</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></th<>		p								
PART 1 - COMPUTATION OF LESSER OF AGGREGATE PORCIAU LOST. AGREGATE OF THE PROCRAM LIMITATION COST. OR BENEFICIARY COST LIMITATION 0 <th0< th=""> 0 0 <</th0<>			col. 28, line	Wkst. H-2,	Costs (from	1 + 2)		(col. 3 ÷		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION COST Per Visit Computation The PROGRAM LIMITATION COST, OR BENEFICIARY COST Per Visit Computation 00 Skilled Mursing Care 2.00 2,731,491 1,5152 180.27 1,00 00 Skilled Mursing Care 2.00 2,731,491 1,0455 206.44 2.00 00 Medical Social Services 6.00 126.475 0 727,575 1,716 224.16 4.00 00 Home Healt A ide 7.00 162,279 0 126.475 324 334.67 5.00 00 Home Healt A ide 7.00 6,029.400 0 6,029.400 0 6,029.400 0 6,029.400 0 6,029.400 0 6,029.400 0 6,029.400 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>										
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Ion Cocupational Thérapy 4.00 5.00 Cocupational Thérapy 4.00 5.00 272.575 0 272.575 0 272.575 0 272.575 0 272.575 0 272.575 0 126.475 1.216.475 2.21 4.00 0 0 0 126.475 1.216.475 3.34 378.67 5.00 0.00 Total (sum of lines 1-6) 0 6.029.400 0 6.029.400 32.625 7.00 0.01 Total (sum of lines 1-6) 0 1.00 2.00 3.00 4.00 5.00 0.01 Skilled Nursing Care 0 1.00 2.00 3.00 4.00 5.00 8.0 0.01 Skilled Nursing Care 99915 0 4.00 6.400 8.0 8.0 9.0 0.0 6.252 1.10 8.0 9.0 0.0 0.0 9.00 9.0 9.00 9.0 9.0 9.0 9.0 9.0 9.0 9.0 9.0 9.0 9.0 <td>2.00</td> <td></td> <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td>•</td>	2.00				0				•	
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0.00 bone Heal th Ai de 7.00 142,229 142,229 2,211 6.132,625 7.00 100 Total (sum of lines 1-6) 6.029,400 0 6.029,400 32,625 7.00 Cost Center Description Cost Limits CBSA No. (1) Part A Part B Subject Discover Subject Discover Deductibles Part B Subject Discover Subject Discover Both Subject Discover Both Subject Discover Part B Subject Discover Both Subject Discover	4.00		5.00		0	272, 57	1, 216	224.16	4.00	
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Cost Center Description Cost Limits CBSA No. (1) Program Visits Part A Part B 0 1.00 2.00 3.00 4.00 5.00 0.01 Skilled Nursing Care 9915 0 9.00 4.00 5.00 0.01 Skilled Nursing Care 99915 0 4.00 5.00 8.0 0.01 Skilled Nursing Care 99915 0 4.05 8.0 8.0 0.01 Occupational Therapy 31140 0 6.4.50 8.0 9.00 0.01 Occupational Therapy 31140 0 7.62 11.0 10.0 0.01 Occupational Therapy 31140 0 7.62 11.0 10.0 0.01 Occupational Therapy 31140 0 7.62 11.0 10.0 0.01 Occupational Therapy 9915 0 7.25 12.0 10.0 0.01 Ocst Genter Description From West. Facility Casts (from 1.3 1.2.0	6.00	Home Health Aide	7.00	142, 229		142, 22	29 2, 211	64.33	6.00	
Cost Center Description Cost Limits CBSA No. (1) Part A Part B Not Subject to Deductibles 0 1.00 2.00 3.00 4.00 5.00 0 5k111ed Mursing Care 9915 0 4.00 5.00 100 5k11ed Mursing Care 9915 0 4.00 5.00 101 5k11ed Mursing Care 9915 0 4.05 8.0 101 Sk11ed Mursing Care 9915 0 4.05 8.0 101 Sk11ed Mursing Care 9915 0 2.00 1.80 8.0 101 Sk11ed Surial Charagy 99915 0 2.28 9.0 10.0 101 Speech Pathol ogy 31140 0 76 10.0 12.0 2.00 Medical Social Services 99915 0 225 11.0 12.0 2.00 Medical Social Services 99915 0 1.3 12.0 12.0 3.00 Hoteleat h Aide 91140 0	7.00	Total (sum of lines 1-6)		6, 029, 400	0	6, 029, 40	32, 625		7.00	
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	^F inancial Systems ONMENT OF PATIENT SERVICE COS ⁻	ſS		Provider CO	CN: 15-0044	Peri od:	Worksheet H-3	
				HHA CCN:	15-7152	From 09/01/2018 To 08/31/2019	Part I Date/Time Pre 9/21/2022 9:4	parec
				Title	XVIII	Home Health Agency I	PPS	<u>5 ann</u>
	Cost Center Description	6.00	7.00	8.00	9.00	10.00	11.00	
L	imitation Cost Computation	0.00	7.00	0.00	7.00	10.00	11.00	
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3. 01 5	Skilled Nursing Care							8.
. OO F	Physical Therapy							9.
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0.00	Occupational Therapy							10.
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1.00 5	Speech Pathology							11.
	Speech Pathology							11.
	Medical Social Services							12.
	Medical Social Services							12.
	Home Health Aide							13.
	Home Health Aide							13.
4.00	Total (sum of lines 8-13)							14.
		Prog	ram Covered Char	rges	Cost of Servi ces			
			Part	В		Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
	· ·		to [Deductibles &		to	Deductibles &	
			Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
			Coi nsurance			Coi nsurance		
C	Supplies and Drugs Cost Comput	<u>6.00</u>	7.00	8.00	9.00	10.00	11.00	
	Cost of Medical Supplies		160, 151	0		0 259, 820	0	15.
	Cost of Drugs		0	0		0	0	
	Cost Center Description	Total Program				-		
		Cost (sum of						
		cols. 9-10)						
		12.00						
IP	PART I - COMPUTATION OF LESSER	OF AGGREGATE	PROGRAM COST. AO	JGREGAIE OF IF	HE PROGRAM L	IMITATION COST, C	R BENEFICIARY	
		0. //00//20///2						
С	COST LIMITATION							1
C	COST LIMITATION Cost Per Visit Computation	1, 840, 016						1.
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.00 S	COST LIMITATION Cost Per Visit Computation Skilled Nursing Care	1, 840, 016						2.
00 S 2.00 F 2.00 C	COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy	1, 840, 016 1, 377, 517						2. 3.
. 00 5 2. 00 F 3. 00 C 4. 00 S 5. 00 M	COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	1, 840, 016 1, 377, 517 370, 130						2. 3. 4.
C C C C C C C C C C C C C C C C C C C	COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	1, 840, 016 1, 377, 517 370, 130 176, 414 90, 123 128, 210						2. 3. 4. 5. 6.
C C C C C C C C C C C C C C C C C C C	COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Fotal (sum of lines 1-6)	1, 840, 016 1, 377, 517 370, 130 176, 414 90, 123						2. 3. 4. 5.
. 00 S . 00 F . 00 C . 00 C . 00 S . 00 M . 00 H	COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	1, 840, 016 1, 377, 517 370, 130 176, 414 90, 123 128, 210 3, 982, 410						2. 3. 4. 5. 6.
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C 00 5 00 F 00 C 00 C 00 S 00 N 00 H 00 T	COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Docupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description .imitation Cost Computation	1, 840, 016 1, 377, 517 370, 130 176, 414 90, 123 128, 210 3, 982, 410						2. 3. 4. 5. 6. 7. 8.
CONTRACTOR CONTRACTOR	COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care	1, 840, 016 1, 377, 517 370, 130 176, 414 90, 123 128, 210 3, 982, 410						2. 3. 4. 5. 6. 7. 8. 8.
. 00 S . 00 F . 00 C . 00 S . 00 M . 00 H . 00 T	COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care	1, 840, 016 1, 377, 517 370, 130 176, 414 90, 123 128, 210 3, 982, 410						2. 3. 4. 5. 6. 7. 8. 8. 8. 9.
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C 00 S . 00 F . 00 S . 00 M . 00 S . 00 H . 00 S . 01 S	COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Decupational Therapy	1, 840, 016 1, 377, 517 370, 130 176, 414 90, 123 128, 210 3, 982, 410						2. 3. 4. 5. 6. 7. 8. 8. 9. 9. 10. 10.
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C C C C C C C C C C C C C C	COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy Physical Therapy Decupational Therapy Decupational Therapy Speech Pathology Medical Social Services Medical Social Services Home Health Aide	1, 840, 016 1, 377, 517 370, 130 176, 414 90, 123 128, 210 3, 982, 410						2. 3. 4. 5. 6. 7. 8. 8. 8. 9. 9. 10. 10. 11. 11. 11. 12. 12. 13.
C 00 S 00 F 00 F 00 S 00 N 00 S 00 N 00 S 00 N 00 H 00 S 00 r>00 S 00	COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Decupational Therapy Speech Pathology Medical Social Services Medical Social Services	1, 840, 016 1, 377, 517 370, 130 176, 414 90, 123 128, 210 3, 982, 410						2. 3. 4. 5. 6. 7. 7. 8. 8. 8. 9. 9. 10. 10. 11. 11. 12. 12.

APPORTIONMENT OF PATIENT SERVICE COSTS Provider CCN: 15-004 HHA CCN: Period: 15-7152 Worksheet H-3 Part II Date/Time Prepared: 9/21/2022 9:45 am Image: Cost Center Description From Wkst. C, Part I, col. Cost to Part I, col. Total HHA Charge Ratio Total HHA Charge (from Provider HHA Shared Costs (col. 1 x col. 2) Transfer to Part I as Image: PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY 1.00 PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS Image: Col. 2, line 2.00 1.00 Image: Part I as 0 0.202245 0 0 0 1.00 Image: Cost of Medical Supplies 66.00 0.260397 0 0 0 1.00 2.00 3.00 1.00 2.00 Image: Cost of Medical Supplies 71.00 0.384497 0	Heal th	Financial Systems		BAPTIST HEA	LTH FLOYD		In Lie	u of Form CMS-2	2552-10
HHA CCN: 15-7152 To 08/31/2019 Date/Time Prepared: 9/21/2022 9: 45 am Title XVIII Home Heal th Agency I PPS Cost Center Description From Wkst. C, Part I, col. 9, line Cost to Charge Ratio Total HHA Charge (from provider records) HHA Shared Ancillary Costs (col. 1 x col. 2) Transfer to Part I as Indicated Part I as Indicated PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY 2.00 0 1.00 2.00 3.00 4.00 1.00 Physical Therapy 66.00 0.202245 0 0 1.00 2.00 2.00 Occupational Therapy 67.00 0.000000 0 0 0.20245 0 0 3.00 Speech Pathology 68.00 0.260397 0 0 0 2.00 3.00 4.00 Cost of Medical Supplies 71.00 0.384497 0 <td>APPORT</td> <td>IONMENT OF PATIENT SERVICE COS</td> <td>TS</td> <td></td> <td>Provider C</td> <td>CN: 15-0044</td> <td></td> <td></td> <td></td>	APPORT	IONMENT OF PATIENT SERVICE COS	TS		Provider C	CN: 15-0044			
Agency I Cost Center Description From Wkst. C, Part I, col. 9, line Cost to Charge Ratio Total HHA Charge (from provider records) HHA Shared Ancillary Costs (col. 1) Transfer to Part I as Indicated 0 1.00 2.00 3.00 4.00 PART 11 - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS 1.00 Physical Therapy 66.00 0.202245 0 0 cols. 2, line 2.00 1.00 2.00 Occupational Therapy 67.00 0.000000 0 0col. 2, line 3.00 2.00 3.00 Speech Pathology 68.00 0.260397 0 0col. 2, line 4.00 3.00 4.00 Cost of Medical Supplies 71.00 0.384497 0 0col. 2, line 15.00 4.00					HHA CCN:	15-7152		Date/Time Pre	pared: 5 am
Cost Center DescriptionFrom Wkst. C, Part I, col. 9, lineCost to Charge RatioTotal HHA Charge (from provider records)HHA Shared Ancillary Costs (col. 1 x col. 2)Transfer to Part I as IndicatedPART 11 - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS1.00Physical Therapy Occupational Therapy66.00 67.000.202245 000cols. 2, line 2.00 0 col. 2, line 3.001.00 2.002.00Speech Pathology 0 cost of Medical Supplies68.00 71.000.260397 00 0 col. 2, line 15.001.00 4.00					Titl∈	e XVIII	Home Health	PPS	
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PART 11 - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS 1.00 2.00 3.00 4.00 Physical Therapy 66.00 0.202245 0 0 1.00 2.00 2.00 Speech Pathology 66.00 0.202245 0 0 0 1.00 2.00 3.00 Speech Pathology 66.00 0.260397 0 0 0 2.11 ne 4.00 3.00 4.00 Cost of Medical Supplies 71.00 0.384497 0 0 0 0 2.1 ne 15.00 4.00			Part I, col.	Charge Ratio	Charge (from	Ancillary	Part I as		
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	3.00	Speech Pathology	68.00	0. 260397	0		Ocol. 2, line 4	. 00	3.00
	4.00	Cost of Medical Supplies	71.00	0. 384497	0		0 col. 2, line 1	5.00	4.00
5.00 Cost of Drugs 73.00 0.232821 0 0 col. 2, line 16.00 5.00	5.00	Cost of Drugs	73.00	0. 232821	0		0 col. 2, line 1	6. 00	5.00

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_CUL/	Financial Systems BAPTIST HEALTI ATION OF HHA REIMBURSEMENT SETTLEMENT BAPTIST HEALTI	Provider CC	CN: 15-0044	Peri od:	u of Form CMS-2 Worksheet H-4	
		HHA CCN:	15-7152	From 09/01/2018 To 08/31/2019		
		Title	XVIII	Home Health	PPS	+J 0
				Agency I		
			Dont A		t B	
			Part A	Not Subject to	Subject to Deductibles &	
				Deductibles &	Coi nsurance	
				Coi nsurance		
			1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUST	OMARY CHARGE	S			
	Reasonable Cost of Part A & Part B Services				0	
	Reasonable cost of services (see instructions)			0 0	0	
	Total charges Customary Charges			0 0	0	
	Amount actually collected from patients liable for payment for	or services		0 0	0	
	on a charge basis (from your records)	301 11 003		0 0	Ŭ	
00	Amount that would have been realized from patients liable for	payment		0 0	0	4
	for services on a charge basis had such payment been made in					1
	with 42 CFR §413.13(b)					
	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000		0.000000	
00	Total customary charges (see instructions) Excess of total customary charges over total reasonable cost	(complate		0 0	0	
	only if line 6 exceeds line 1)	Comprete		0	0	1
00	Excess of reasonable cost over customary charges (complete or	nly if line		0 0	0	1
	1 exceeds line 6)	J			Ū	
00	Primary payer amounts			0 8, 229	0	9
				Part A	Part B	
				Services 1.00	Services 2.00	-
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			1.00	2.00	
	Total reasonable cost (see instructions)			0	-8, 229	1 10
	Total PPS Reimbursement - Full Episodes without Outliers			0	3, 721, 190	
00	Total PPS Reimbursement - Full Episodes with Outliers			0	96, 019	1:
00	Total PPS Reimbursement - LUPA Episodes			0	70, 610	1:
	Total PPS Reimbursement - PEP Episodes			0	38, 477	14
	Total PPS Outlier Reimbursement - Full Episodes with Outliers	5		0	12, 600	
	Total PPS Outlier Reimbursement - PEP Episodes			0	947	
	Total Other Payments			0	0	
	DME Payments			0	0	
	Oxygen Payments			0	0	
	Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins	uranco)		0	0	
	Subtotal (sum of lines 10 thru 20 minus line 21)	sui ance)		0	3, 931, 614	
	Excess reasonable cost (from line 8)			0	3, 931, 014	
	Subtotal (line 22 minus line 23)			0	3, 931, 614	
	Coinsurance billed to program patients (from your records)				0, 751, 014	
	Net cost (line 24 minus line 25)			0	3, 931, 614	
	Reimbursable bad debts (from your records)			0	0	
	Reimbursable bad debts for dual eligible beneficiaries (see i	nstructions))	0	0	2
	Total costs - current cost reporting period (line 26 plus lir	ne 27)		0	3, 931, 614	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	0	
	Pioneer ACO demonstration payment adjustment (see instruction	is)		0	0	
	Demonstration payment adjustment amount before sequestration			0	0	
	Subtotal (see instructions)			0	3, 931, 614	
	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			0	78, 632	
01		structions)		0	0	
01 02	Sequestration adjustment for non claims based amounts (coo in	is i uc i UIIS)				
01 02 75	Sequestration adjustment for non-claims based amounts (see in Interim payments (see instructions)			()		
01 02 75 00	Interim payments (see instructions)			0	3, 852, 981	
01 02 75 00 00	Interim payments (see instructions) Tentative settlement (for contractor use only)	and 33)		0	0	33
01 02 75 00 00 00	Interim payments (see instructions)		S Pub. 15-2.			3

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Health Financial Systems BAPTIST HEALT ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 15-0044			ri od:	Worksheet H-5	
				To	om 09/01/2018 08/31/2019		
					Home Health	9/21/2022 9:45 ar PPS	
		Inpatient Part A			Agency I Par	t B	
	-	mm/dd/yyyy	Amount		mm/dd/yyyy	Amount	
		1.00	2.00		3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,			0 0		3, 852, 981 0	1. 2.
00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.
	Program to Provider		I				
01				0		0	3.
02				0		0	3.
03 04				0		0	3
04				0		0	3
	Provider to Program		л		1		
50				0		0	3
51				0		0	3
52 53				0		0	3
53 54				0		0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0		0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0		3, 852, 981	4
	TO BE COMPLETED BY CONTRACTOR		1		T		_
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5
	Program to Provider		1				
01 02				0 0		0	5
02				0		0	5
	Provider to Program			-	1		
50				0		0	5
51 52				0		0	5 5
52 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		0	5
	5. 50-5. 98)			Ŭ		0	
00	Determined net settlement amount (balance due) based on the cost report. (1)						6
01	SETTLEMENT TO PROVIDER			0		1	6
02	SETTLEMENT TO PROGRAM			0		2 952 092	6
00	Total Medicare program liability (see instructions)		l	0	Contractor	3,852,982 NPR Date	7
					Number	(Mo/Day/Yr)	
		0			1.00	2.00	
00	Name of Contractor Wi	sconsi n Phys	ician Servic	ces	08001		8

Health Financial Systems	Ith Financial Systems BAPTIST HEALTH FLOYD		
CALCULATION OF CAPITAL PAYMENT	Provi der CCN: 15-0044	Period: From 09/01/2018 To 08/31/2019	Worksheet L Parts I-III Date/Time Prepared: 9/21/2022 9:45 am
	Title XVIII	Hospi tal	PPS

1.01 Model 4 BPCI Capital DRG other than outlier 0 0.10 2.00 Capital DRG outlier payments 267,499 2.00 3.00 Total inpatient days divided by number of days in the cost reporting period (see instructions) 0 0.20 3.00 Total inpatient deucation percentage (see instructions) 0.00 4.00 4.00 Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01, see instructions) 0.600 7.00 Percentage of SI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 3.0) (see instructions) 14.12 8.00 8.00 Percentage of Medical dpatient days to total days (see instructions) 14.12 8.00 9.00 10.00 Disportionate share adjustment (see instructions) 3.90 10.00 3.90 10.00 10.00 Disportionate share adjust cost (see instructions) 5,094,054 12.00 11.00 Program inpatient anciliary capital cost (see instructions) 0 1.00 12.00 Program inpatient capital cost (see instructions) 0 1.00 12.00 Program inpatient anciliary capital cost (see instructions) 0 1.00 12.00 Program inp				HOSPILAI	PPS	
PART 1 - FULLY PROSPECTIVE METHOD CAPI TAL FEDERAL ANDUNT 1.00 Capital DRG other than outlier 4.645,385 1.00 1.01 Model 4 PRCI Capital DRG other than outlier 2.67,499 2.00 2.00 Capital DRG outlier payments 2.01 2.01 Addital DRG outlier payments 2.01 2.00 Ocapital DRG outlier payments 2.01 Addital DRG outlier payments 2.01 3.00 Total inpatient days divided by number of days in the cost reporting period (see instructions) 0.00 4.00 5.00 Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01, columns 1 and 1.01, (see instructions) 0.00 5.00 0.00 All Amage and the days to total days (see instructions) 14.12 8.00 9.00 Sum of lines 7 and 8 are percentage (see instructions) 1.90 3.90 1.00 3.90 1.00 1.00 All Amage and the days cost (see instructions) 1.00 1.00 2.00 7.04,451 2.00 3.90 1.00 1.00 Drotal inpatient propertionate share percentage (see instructions) 1.00				-	1 00	
CAPITAL FEDERAL ANOUNT Comparison 100 Capital DR6 other than outlier 4.645.385 1.01 Model 4 BPCI Capital DR6 outlier payments 26.7.497 2.01 Model 4 BPCI Capital DR6 outlier payments 26.7.497 2.01 Model 4 BPCI Capital DR6 outlier payments 26.7.497 2.01 Model 4 BPCI Capital DR6 outlier payments 26.7.497 2.01 Model 4 BPCI Capital DR6 outlier payments 26.7.497 2.01 Indirect medical education percentage (see instructions) 14.04 3.00 Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01, columns 1 and 1.01, columns 1 and 1.01, columns 1 and 1.01 0 3.00 Percentage of Medicaid patient days to Medicare Part A patient days (Worksheet E, part A line 3.0, 9.0, 0.0 3.00 3.00 Sum of lines 7 and 8 14.12 8.00 10.00 Dispropertionate share alystment (see instructions) 141.12 8.00 10.00 Dispropertionate share alystment (see instructions) 181.170 11.00 10.01 Percentage of Medicaid payments (see instructions) 0 2.00 1.00 Percentag		PART L - FULLY PROSPECTIVE METHOD	1.00			
1.00 Capital DRG other than outlier 4.645.385 1.00 1.01 Model A BPC Capital DRG other than outlier 9.01 2.00 Capital DRG outlier payments 9.02 2.00 Capital DRG outlier payments 9.01 2.00 0.01 1.00 2.01 0.01 1.01 2.01 0.01 1.01 2.01 0.01 1.01 0.01 1.01 0.02 1.00 0.00 4.01 3.00 0.00 4.00 3.00 0.00 4.00 3.00 0.00 4.00 0.00 4.00 0.00 4.00 0.00						
1.01 Model 4 BPCI Capital DRS outlier payments 0 1.01 2.00 Capital DRS outlier payments 2.07 3.00 Total Inpatient days divided by number of days in the cost reporting period (see instructions) 14.04 4.00 Number of Interns & residents (see instructions) 14.04 5.00 Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01, (see instructions) 0 7.00 Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 3.0 0 8.00 Percentage of Medicaid patient days to total days (see instructions) 14.12 8.00 9.00 Sum of lines 7 and 8 18.00 9.00 10.00 Dispropertionate share percentage (see instructions) 18.170 11.00 11.00 Dispropertionate share adjustment (see instructions) 14.12 8.00 11.00 Despropertionate share adjustment (see instructions) 14.12 8.00 12.00 Program inpatient routine capital cost (see instructions) 0 1.00 12.01 Program inpatient routile capital cost (see instructions) 0 2.00 1.00 Program inpatient capital cost (see instructions)	1.00					1.00
2:00 Capit tal DRG outlier payments 267,499 2.00 0<	1.01					1.01
2.01 Model 4 BPCI Capital DRG outlier payments 0 0 300 Total inpatient days divided by number of days in the cost reporting period (see instructions) 0 0.00 4.00 Number of interns & residents (see instructions) 0.00 4.00 5.00 Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01, columns 1 and 1.01, see instructions) 0.00 5.00 7.00 Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 3.0) (see instructions) 14.12 8.00 8.00 Percentage of Medical d patient days to total days (see instructions) 14.12 8.00 9.00 Sum of lines 7 and 8 3.90 10.00 18.90 0.01 All obable di sproportionate share percentage (see instructions) 18.17 11.00 10.00 Total prospective capital payments (see instructions) 1.00 10.00 10.00 Program inpatient ancillary capital cost (see instructions) 0 1.00 10.00 Program inpatient ancillary capital cost (see instructions) 0 1.00 10.00 Program inpatient ancillary capital cost (see instructions) 0 0 2.00 10.00	2.00				267, 499	2.00
3.00 Total inpatient days divided by number of days in the cost reporting period (see instructions) 140.04 3.00 0.0 Number of interns & residents (see instructions) 0.00 4.00 5.00 Indirect medical education percentage (see instructions) 0.00 6.00 0.0 Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 0 0.00 7.00 Percentage of Medical dapt in the sum of lines 1 and 1.01, columns 1 and 0 0.00 3.01 (see instructions) 14.12 8.00 9.00 Sum of lines 7 and 8 14.02 8.00 11.00 Percentage of Medical dapt int days to total days (see instructions) 14.12 8.00 9.00 Sum of lines 7 and 8 14.00 9.00 11.00 Percentage of Medical dapt instructions) 181.170 11.00 12.00 Total prospective capital payments (see instructions) 1.00 1.00 2.00 Program inpatient ancillary capital cost (see instructions) 0 1.00 2.00 Program inpatient capital cost (see instructions) 0 1.00 2.00 Program inpatient capital cost (see instructions) 0 0 0	2.01					2.01
4.00 Number of interns & residents (see instructions) 0.00 4.00 5.00 Indirect medical education percentage (see instructions) 0.00 5.00 6.00 Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01, columns 1 and 1.01, columns 1 and 1.01, columns 1 and 1.01, see instructions) 0.00 5.00 7.00 Percentage of SSI recipient patient days to total days (see instructions) 14.12 8.00 8.00 Percentage of Medical dpatient days to total days (see instructions) 14.12 8.00 9.00 Sum of lines 7 and 8 3.90 10.00 18.90 9.00 10.00 Disproportionate share adjustment (see instructions) 3.90 10.00 18.170 11.00 11.00 Total prospective capital payments (see instructions) 5.094.054 12.00 0 12.00 Total inpatient routine capital cost (see instructions) 0 1.00 2.00 1.00 2.00 Program inpatient acpital cost (line 1 plus line 2) 0 0 0 0 0 3.00 3.00 3.00 Total inpatient capital costs (line 3 x line 4) 0 0 0.00 0.00 0.00	3.00		period (see inst	tructions)	140.04	3.00
6.00 Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.00, columns 1 and 1.01, columns 1 and 1.01, columns	4.00			,	0.00	4.00
1.01) (see instructions) 1.01 7.00 Percentage of SI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions) 14.12 8.00 Percentage of SI recipient patient days to total days (see instructions) 14.12 8.00 Allowable disproportionate share apercentage (see instructions) 18.90 10.00 Allowable disproportionate share apercentage (see instructions) 18.90 10.00 Disproportionate share apument (see instructions) 5.094.054 12.00 Percentage of SI recipient actilary capital cost (see instructions) 5.094.054 12.00 Program inpatient ancillary capital cost (see instructions) 0 0 1.00 Program inpatient capital cost (see instructions) 0 0 0 2.00 Total inpatient program capital cost (line 3 x line 4) 0 5.00 1.00 Program inpatient capital costs (see instructions) 0 1.00 2.00 Program inpatient capital costs (line 3 x line 4) 0 5.00 1.00 Program inpatient capital costs (line 3 x line 4) 0 3.00 1.00 Program inpatient capital costs (line 3 x line 4) 0 3.00 1.00	5.00	Indirect medical education percentage (see instructions)			0.00	5.00
30) (see instructions) 1 <td>6.00</td> <td></td> <td>ines 1 and 1.01</td> <td>I, columns 1 and</td> <td>0</td> <td>6.00</td>	6.00		ines 1 and 1.01	I, columns 1 and	0	6.00
9.00 Sum of Lines 7 and 8 18.90 9.00 10.00 Allowable disproportionate share percentage (see instructions) 10.00 10.00 Disproportionate share adjustment (see instructions) 18.170 11.00 Tespective capital payments (see instructions) 18.170 12.00 Total prospective capital payments (see instructions) 5.094.054 12.00 PART 11 - PAYMENT UNDER REASONABLE COST 1.00 Program inpatient ancillary capital cost (see instructions) 0 2.00 2.00 Program inpatient ancillary capital cost (line 1 plus line 2) 0 3.00 4.00 Capital cost payment factor (see instructions) 0 1.00 5.00 Total inpatient capital costs (see instructions) 0 2.00 5.00 Total inpatient capital costs (see instructions) 0 2.00 5.00 Program inpatient capital costs (see instructions) 0 1.00 7.00 Program inpatient capital costs (see instructions) 0 2.00 7.00 Ref 111 - COMPUTATION OF EXCEPTION PAYMENTS 0 0 0 7.00 Apital cost for comparison to payments (line 3 x line 4) 0 0	7.00		ays (Worksheet E	E, part A line	4. 78	7.00
10.00 Allowable disproportionate share percentage (see instructions) 3.90 10.00 11.00 Disproportionate share adjustment (see instructions) 181,170 11.00 12.00 Total prospective capital payments (see instructions) 5,094,054 12.00 PART 11 - PAYMENT UNDER REASONABLE COST 1.00 1.00 Program inpatient routine capital cost (see instructions) 0 1.00 2.00 Total inpatient ancillary capital cost (see instructions) 0 2.00 3.00 Total inpatient program capital cost (line 1 plus line 2) 0 3.00 4.00 Capital cost payment factor (see instructions) 0 3.00 5.00 Total inpatient capital costs (see instructions) 0 5.00 7.00 Program inpatient capital costs (see instructions) 0 2.00 7.00 Program inpatient capital costs (see instructions) 0 2.00 7.00 Program inpatient capital costs (see instructions) 0 0 3.00 1.00 Program inpatient capital costs (line 1 minus line 2) 0 3.00 1.00 Applicable exception percentage (see instructions) 0.00 0 0 0<	8.00	Percentage of Medicaid patient days to total days (see instructions)			14. 12	8.00
11.00 Disproportionate share adjustment (see instructions) 11.00 12.00 Total prospective capital payments (see instructions) 5,094,054 12.00 Total prospective capital payments (see instructions) 10.00 PART II - PAYMENT UNDER REASONABLE COST 1.00 Program inpatient ancillary capital cost (see instructions) 0 2.00 Rotal inpatient program capital cost (line 1 plus line 2) 0 3.00 Total inpatient program capital cost (line 3 x line 4) 0 5.00 Total inpatient capital costs (see instructions) 0 7.00 Program inpatient capital costs (see instructions) 0 7.00 Program inpatient capital costs (see instructions) 0 7.00 Program inpatient capital costs (see instructions) 0 1.00 7.00 Program inpatient capital costs (see instructions) 0 2.00 9.00 Program inpatient capital costs (see instructions) 0 1.00 2.00 Program inpatient capital costs (see instructions) 0 2.00 0.00 Applicable exception percentage (see instructions) 0 3.00 0.00 Applicable exception percentage (see instructions)	9.00	Sum of lines 7 and 8			18.90	9.00
12.00 Total prospective capital payments (see instructions) 5, 094, 054 12.00 PART 11 - PAYMENT UNDER REASONABLE COST 1.00 Program inpatient ancillary capital cost (see instructions) 0 1.00 2.00 Program inpatient ancillary capital cost (see instructions) 0 1.00 2.00 Total inpatient ancillary capital cost (line 1 plus line 2) 0 3.00 3.00 Total inpatient program capital cost (line 1 plus line 2) 0 4.00 4.00 Capital cost payment factor (see instructions) 0 4.00 5.00 Total inpatient program capital cost (line 3 x line 4) 0 5.00 7.00 Program inpatient capital costs (see instructions) 0 1.00 7.00 Program inpatient capital costs (line 1 minus line 2) 0 0 1.00 Program inpatient capital costs (line 1 minus line 2) 0 0 0 1.00 Program inpatient capital costs (line 3 x line 4) 0	10.00	Allowable disproportionate share percentage (see instructions)			3.90	10.00
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 Total inpatient program capital cost (line 1 plus line 2) 0 4.00 Capital cost payment factor (see instructions) 0 5.00 Total inpatient program capital cost (line 3 x line 4) 0 7.00 Program inpatient capital costs (see instructions) 0 7.00 Program inpatient capital costs (see instructions) 0 7.00 Program inpatient capital costs (see instructions) 0 7.00 Program inpatient capital costs (line 1 minus line 2) 0 7.00 Applicable exception percentage (see instructions) 0 0 7.00 Applicable exception percentage (see instructions) 0 0 7.00 Adjustment to capital minum payment level for extraordinary circumstances (line 2 x line 6) 0 0 8.00 Capital minum payment level (line 5 plus line 7) 0 0 0 0 9.00 Current year capital may from Part I, line 12, as applicable) 0 0 0 0 0.00	11.00	Disproportionate share adjustment (see instructions)			181, 170	11.00
PART II - PAYMENT UNDER REASONABLE COST 0 1.00 Program inpatient routine capital cost (see instructions) 0 2.00 Program inpatient acapital cost (line 1 plus line 2) 0 3.00 Total inpatient program capital cost (line 1 plus line 2) 0 4.00 Capital cost payment factor (see instructions) 0 5.00 Total inpatient program capital cost (line 3 x line 4) 0 7 Program inpatient capital costs (see instructions) 0 7 Program inpatient capital costs (see instructions) 0 7 Program inpatient capital costs (see instructions) 0 8 Program inpatient capital costs (see instructions) 0 9 Program inpatient capital costs (line 1 minus line 2) 0 3.00 1.00 Net program inpatient capital costs (line 3 x line 4) 0 0 1.00 Percentage adjustment for extraordinary circumstances (see instructions) 0 0 1.00 Percentage adjustment for extraordinary circumstances (line 2 x line 6) 0 0 1.00 Capital cost or comparison of capital minimum payment level for extraordinary circumstances (line 8 less line 9) 0 0 1.00	12.00	Total prospective capital payments (see instructions)			5, 094, 054	12.00
PART II - PAYMENT UNDER REASONABLE COST 0 1.00 Program inpatient routine capital cost (see instructions) 0 2.00 Program inpatient acapital cost (line 1 plus line 2) 0 3.00 Total inpatient program capital cost (line 1 plus line 2) 0 4.00 Capital cost payment factor (see instructions) 0 5.00 Total inpatient program capital cost (line 3 x line 4) 0 7 Program inpatient capital costs (see instructions) 0 7 Program inpatient capital costs (see instructions) 0 7 Program inpatient capital costs (see instructions) 0 8 Program inpatient capital costs (see instructions) 0 9 Program inpatient capital costs (line 1 minus line 2) 0 3.00 1.00 Net program inpatient capital costs (line 3 x line 4) 0 0 1.00 Percentage adjustment for extraordinary circumstances (see instructions) 0 0 1.00 Percentage adjustment for extraordinary circumstances (line 2 x line 6) 0 0 1.00 Capital cost or comparison of capital minimum payment level for extraordinary circumstances (line 8 less line 9) 0 0 1.00				-	1 00	
1.00Program inpatient routine capital cost (see instructions)01.002.00Program inpatient ancillary capital cost (see instructions)02.003.00Total inpatient program capital cost (ine 1 plus line 2)03.004.00Capital cost payment factor (see instructions)03.005.00Total inpatient program capital cost (line 3 x line 4)05.007Program inpatient capital costs (see instructions)01.001.00Program inpatient capital costs (see instructions)01.002.00Program inpatient capital costs (see instructions)01.002.00Program inpatient capital costs (see instructions)02.003.00Net program inpatient capital costs (line 1 minus line 2)03.004.00Applicable exception percentage (see instructions)00.005.00Capital cost for comparison to payments (line 3 x line 4)05.006.00Percentage adjustment for extraordinary circumstances (see instructions)0.006.007.00Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)07.008.00Capital minimum payment level for extraordinary circumstances (line 8 less line 9)000.0010.00Current year comparison of capital minimum payment level to capital payment (from prior year010.0010.00Current year exception payment (if line 12 is positive, enter the amount on this line)013.0011.00Current year allowable		PART LL - PAYMENT LINDER REASONABLE COST			1.00	
2.00Program inpatient ancillary capital cost (see instructions)02.003.00Total inpatient program capital cost (line 1 plus line 2)03.004.00Capital cost payment factor (see instructions)04.005.00Total inpatient program capital cost (line 3 x line 4)05.00PART 111 - COMPUTATION OF EXCEPTION PAYMENTS1.00PART 111 - COMPUTATION OF EXCEPTION PAYMENTS1.00PART 111 - COMPUTATION OF EXCEPTION PAYMENTS001.00PART 111 - COMPUTATION OF EXCEPTION PAYMENTS1.001.00PART 111 - COMPUTATION OF EXCEPTION PAYMENTS001.002.00Program inpatient capital costs (for estraordinary circumstances (see instructions)0001.002.00Program inpatient capital costs (line 1 minus line 2)00000000000000000	1 00				0	1 00
3.00 Total inpatient program capital cost (line 1 plus line 2) 0 3.00 Capital cost payment factor (see instructions) 0 4.00 5.00 Total inpatient program capital cost (line 3 x line 4) 0 1.00 PART 111 - COMPUTATION OF EXCEPTION PAYMENTS 1.00 Program inpatient capital costs (see instructions) 0 2.00 Program inpatient capital costs (ine 1 minus line 2) 0 3.00 Applicable exception percentage (see instructions) 0 2.00 4.00 Applicable exception percentage (see instructions) 0 0 3.00 5.00 Capital cost for comparison to payments (line 3 x line 4) 0 0 0 0 0 0 3.00 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 0 0.00 4.00 0						2.00
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