near th i maner	ar bystems relation memorara	_ 11001 1 1/1L	111	2 01 101111 0WO 2002 10
This report is	required by law (42 USC 1395g; 42 CFR 413.20(b)). Fa	ilure to report can re	sult in all interim	FORM APPROVED
payments made	since the beginning of the cost reporting period being	g deemed overpayments	(42 USC 1395g).	OMB NO. 0938-0050
				EXPIRES 03-31-2022
HOSPITAL AND H	IOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION	Provider CCN: 15-1305		Worksheet S
AND SETTLEMENT	SUMMARY		From 10/01/2018	
			To 09/30/2019	Date/Time Prepared: 2/25/2020 4:33 pm
PART I - COST	REPORT STATUS			
Provi der	1. [X] Electronically filed cost report		Date: 2/25/20	20 Time: 4:33 pm
use only	2. [] Manually submitted cost report			
	3. [0]If this is an amended report enter the number 4. [F]Medicare Utilization. Enter "F" for full or " $^{\circ}$		resubmitted this o	cost report
Contractor	5. [1]Cost Report Status 6. Date Received:	10). NPR Date:	
use only	(1) Ås Submitted 7. Contractor No.	11	I. Contractor's Vendo	or Code: 4
,	(2) Settled without Audit 8. [N] Initial Report f	or this Provider CCN 12	2.[0]If line 5, cc	olumn 1 is 4: Enter
	(3) Settled with Audit 9. [N] Final Report for	this Provider CCN		nes reopened = 0-9.
	(4) Reopened			
	(E) Amondod			

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PULASKI MEMORIAL HOSPITAL (15-1305) for the cost reporting period beginning 10/01/2018 and ending 09/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	276, 343	-537, 120	0	102, 544	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	156, 676	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	1		0	9.00
10.00	RURAL HEALTH CLINIC I	0		24, 319		0	10.00
10.01	RURAL HEALTH CLINIC II	0		-51, 845		0	10. 01
10.02	RURAL HEALTH CLINIC III	0		16, 319		0	10. 02
200.00	Total	0	433, 019	-548, 326	0	102, 544	200.00

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

Health Financial Systems PULASKI MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1305 Peri od: Worksheet S-2 From 10/01/2018 Part I 09/30/2019 Date/Time Prepared: 2/25/2020 4:33 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: 1.00 Street: 616 FAST 13TH PO Box: 1.00 State: IN 2.00 City: WINAMAC Zi p Code: 46996-County: PULASKI 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 PULASKI MEMORIAL 151305 99915 10/01/2000 Ν 0 0 3.00 HOSPI TAI Subprovi der - IPF 4.00 4.00 Subprovi der - IRF 5.00 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF Р PULASKI MEMORIAL 157305 99915 10/01/2000 N 0 7.00 7 00 HOSPI TAI 8.00 Swing Beds - NF 8.00 9.00 Hospital -Based SNF 9.00 Hospital -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospital -Based HHA PULASKI MEMORIAL 157078 99915 10/14/1982 Ρ Ν 12.00 HOSPI TAL Separately Certified ASC 13.00 13 00 14.00 Hospi tal -Based Hospi ce 14.00 15.00 Hospital -Based Health Clinic - RHC PULASKI MEMORIAL RHC -158512 99915 08/21/2014 0 Ν 15.00 Ν WI NAMAC Hospital-Based Health Clinic - RHC PULASKI MEMORIAL RHC -158527 99915 Ν 15.01 15.01 03/14/2018 0 Ν NORTH JUDSON PULASKI MEMORIAL RHC -15.02 15.02 Hospital-Based Health Clinic - RHC 158528 99915 03/15/2018 N 0 N $\Pi\Pi$ FRANCESVI LLE Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To 2 00 1 00 09/30/2019 20.00 Cost Reporting Period (mm/dd/yyyy) 10/01/2018 20.00 21.00 Type of Control (see instructions) 21.00 2.00 1 00 3 00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Ν N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this Ν Ν 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care Ν Ν 22.02 payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to N N 22 03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for ves or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 2 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

Health Financial Systems PULASKI MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1305 Peri od: Worksheet S-2 From 10/01/2018 Part I 09/30/2019 Date/Time Prepared: 2/25/2020 4:33 pm In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d paid days eligible Medi cai d Medi cai d days unpai d paid days el i gi bl e days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6. 00 24.00 If this provider is an IPPS hospital, enter the 0 24.00 \cap n 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 0 0 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 2.00 1.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26, 00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. 35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in 0 35.00 effect in the cost reporting period. Begi nni ng: Endi ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates. 36 00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 0 37.00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in 37.01 accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38.00 | If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39.00 Ν hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν N 40.00 "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX V 1. 00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance N N 45.00 Ν with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances 46.00 Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through 47 00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N 47.00 48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. Ν N Ν 48.00 Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes 56.00 Ν 56.00 or "N" for no. If line 56 is yes, is this the first cost reporting period during which residents in approved 57.00 57.00 GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. If line 56 is yes, did this facility elect cost reimbursement for physicians' services as 58.00

N

59.00

defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.

Health Financial Systems PULASKI	MEMORI	AL HOSPITAL		Inlie	u of Form CMS-2)552 <u>-</u> 10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provi der Co	Fi	eriod: rom 10/01/2018	Worksheet S-2 Part I Date/Time Prep 2/25/2020 4:3	pared:
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
	(1.1.1.1 -)		1.00	2. 00	3. 00	
60.00 Are you claiming nursing and allied health education any programs that meet the criteria under §413.85? (costs for structions)	N			60.00
	Y/N	IME	Direct GME	I ME	Direct GME	
	1. 00	2. 00	3. 00	4. 00	5. 00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	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
	Pr	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
(1.10 Of the FTF- in Line (1.05 and for each new grants)		1. 00	2. 00	3. 00	4.00	(1.10
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61. 10
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 Sel 62.00 Enter the number of FTE residents that your hospital				ind for which	0.00	62. 00
your hospital received HRSA PCRE funding (see instruction of the funding of the funding of the funding in this cost reporting period of HRSA THC programmer.)	ctions) a Teach	ing Health Cer	nter (THC) into			62. 01
Teaching Hospitals that Claim Residents in Nonprovide 63.00 Has your facility trained residents in nonprovider se	er Sett	tings		period? Enter	N	63. 00
"Y" for yes or "N" for no in column 1. If yes, comple					Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Base Year FTE Residents in No			1. 00	2.00 is your cost	3.00 reporting	
period that begins on or after July 1, 2009 and before 64.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	re June ty trai n-prima all no d non-p n colum	e 30, 2010. ned residents ary care anprovider orimary care an 3 the ratio	0.00			64.00

	4)). (see instructions)								
						1.00	2.00	3.00	
	Inpatient Psychiatric Facility F	PPS							
70.00	Is this facility an Inpatient Ps	sychiatric Facility (IPF), or does it cont	ain an IPF sub	provi der?	N			70.00
	Enter "Y" for yes or "N" for no).							
71.00	If line 70 is yes: Column 1: Did	d the facility have a	n approved GME teachi	ng program in	the most			0	71.00
	recent cost report filed on or k	oefore November 15, 2	004? Enter "Y" for y	es or "N" for	no. (see				
	42 CFR 412. 424(d)(1)(iii)(c)) Co								
	program in accordance with 42 CF	R 412.424 (d)(1)(iii)(D)? Enter "Y" for y	es or "N" for	no.				
	Column 3: If column 2 is Y, indi	cate which program y	ear began during this	cost reportin	g period.				
	(see instructions)								
	Inpatient Rehabilitation Facili	ty PPS							
75.00	Is this facility an Inpatient Re		y (IRF), or does it c	ontain an IRF		N			75.00
	subprovider? Enter "Y" for yes	and "N" for no.							

5, the ratio of (column 3 divided by (column 3 + column

ealth Financial Systems PULASKI MEMORIAL				of For		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CCN: 15-1305	Period: From 10/01/ To 09/30/	2018	Workshe Part I Date/Ti 2/25/20	me Pre	epared:
						- Pill
76.00 If line 75 is yes: Column 1: Did the facility have an approved recent cost reporting period ending on or before November 15, no. Column 2: Did this facility train residents in a new teach CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. (indicate which program year began during this cost reporting p	2004? Enter "Y" for yes ning program in accordan Column 3: If column 2 is	or "N" for ce with 42 Y,	1.00	2.00	3.00	76.0
				1. C	00	
Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes a strict of the str		ng period? I	Inter	N N		80. 0 81. 0
TEFRA Providers 35.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 7 36.00 Did this facility establish a new Other subprovider (excluded			no.	N		85. 0 86. 0
\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 1s this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	classified under section	n		N		87.0
		V 1. 00		XI :		
Title V and XIX Services 00.00 Does this facility have title V and/or XIX inpatient hospital	services? Enter "Y" for			Y		90.0
yes or "N" for no in the applicable column. 21.00 Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the application.	e cost report either in	N		Y		91.0
22.00 Are title XIX NF patients occupying title XVIII SNF beds (dual instructions) Enter "Y" for yes or "N" for no in the applicabl	certification)? (see			N		92.0
P3.00 Does this facility operate an ICF/IID facility for purposes of "Y" for yes or "N" for no in the applicable column.	f title V and XIX? Enter	N		N		93.0
P4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, ar applicable column.		N		N		94.0
05.00 If line 94 is "Y", enter the reduction percentage in the application possible column. 15 If line 94 is "Y", enter the reduction percentage in the application percentage in the app		0. 00 N		O. C N		95. 0 96. 0
07.00 If line 96 is "Y", enter the reduction percentage in the appli 08.00 Does title V or XIX follow Medicare (title XVIII) for the inte stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for column 1 for title V, and in column 2 for title XIX.	erns and residents post	0. 00 Y		0. C Y		97. 0 98. 0
08.01 Does title V or XIX follow Medicare (title XVIII) for the report. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title title XIX.				Υ		98.0
Does title V or XIX follow Medicare (title XVIII) for the calcount bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or for title V, and in column 2 for title XIX.		Y		Υ		98.0
Descritle V or XIX follow Medicare (title XVIII) for a critic reimbursed 101% of inpatient services cost? Enter "Y" for yes				N		98.0
for title V, and in column 2 for title XIX. 8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH recoupation a control of the co		d N		N		98.0
in column 2 for title XIX. 18.05 Does title V or XIX follow Medicare (title XVIII) and add back Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in col				Υ		98.0
column 2 for title XIX. 8.06 Does title V or XIX follow Medicare (title XVIII) when cost represented by the column of the column 2 for title XIX. Purel Providers		Y		Y		98. 0
Rural Providers 05.00 Does this hospital qualify as a CAH?		Y				105.0
06.00 If this facility qualifies as a CAH, has it elected the all-ir for outpatient services? (see instructions)	. ,					106. 0
07.00 f this facility qualifies as a CAH, is it eligible for cost r training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. 2	1. (see instructions) If					107.0
reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 Is this a rural hospital qualifying for an exception to the CF CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	RNA fee schedule? See 4	2 N				108.0

Health Financial Systems PULASKI MEMORIA HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der C	F	Period: From 10/01/ To 09/30/	2018	Worksheet S Part I Date/Time P 2/25/2020 4	-2 repared:
	Physi cal	Occupati onal	Speech	ı	Respi ratory	
109.00 f 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.	1. 00 N	2. 00 N	3. 00 N		4.00 N	109.0
					1. 00	
110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter 'complete Worksheet E, Part A, lines 200 through 218, and Wowapplicable.	'Y" for yes o	"N" for no. I	f yes,		N	110. 0
			1.00		2. 00	
111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this conformal structure (FCHIP) demonstration for this conformal structure (FCHIP) demonstration properties to conformal structure (FCHIP) demonstration properties (FCHIP) demonstration properties (FCHIP) demonstration (FCHIP) demon	ost reporting olumn 1 is Y, rticipating in	period? Enter enter the n column 2.	N			111.0
Missallanana Cost Danatina Lafanatina				1. 00	2.00 3.0	0
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1.	If column 2 nt for long to rs) based on	is "E", enter erm care (inclu the definition	in column udes	N	0	
116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insurance.			"N" for	N Y		116. C
118.00 s the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	icy? Enter 1	if the policy	is	1		118.0
		Premi ums	Losses	5	Insurance	
		1.00	2.00		3. 00	
118.01 List amounts of malpractice premiums and paid losses:		163, 86		0	3.00	0118.0
			1.00		2. 00	
Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 119.00 DO NOT USE THIS LINE			N		2.00	118. (
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 qualifies provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	n column 1, "` ualifies for	d" for yes or the Outpatient	N		N	120. (
121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	antable devic	es charged to	Y	•		121. (
122.00 Does the cost report contain healthcare related taxes as det Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included.			N			122. (
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for	or yes and "N'	' for no. If	N			125. (
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 f this is a Medicare certified kidney transplant center, en	nter the certi	fication date				126. (
in column 1 and termination date, if applicable, in column 27.00 If this is a Medicare certified heart transplant center, en	ter the certi	fication date				127. (
in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, en	ter the certi	fication date				128. (
in column 1 and termination date, if applicable, in column 2 29.00 If this is a Medicare certified lung transplant center, enterpolyment and termination date, if applicable in column 1		cation date in	ו			129. (
column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in col		rti fi cati on				130.
31.00 f this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in col	r, enter the o	certi fi cati on				131.
		fication date				132. (
132.00 <mark>lf this is a Medicare certified islet transplant center, en</mark>	2. ter the certi 2.					133. (134. (

Health Financial Systems	PULASKI ME	MORIAL HOSPITAL			In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DATA	Provi der CC	CN: 15-1305	From 1	: 0/01/2018 9/30/2019		epared:
		<u>'</u>		<u> </u>			
140.00 Are there any related organization chapter 10? Enter "Y" for yes or are claimed, enter in column 2 th	"N" for no in column 1.	. If yes, and home	office c	1,	1. 00 N	2.00	140.00
1.00		2. 00		<u>'</u>	3. 00	·	
If this facility is part of a cha office and enter the home office	contractor name and co	ntractor number.				of the home	
141.00 Name: 142.00 Street:	Contractor's Name PO Box:	e:	Contr	actor's Nu	ımber:		141. 00
143. 00 Ci ty:	State:		Zip C	ode:		T	143. 00
						1. 00	-
144.00 Are provider based physicians' co	sts included in Worksh	eet A?				Υ	144.00
					1. 00	2. 00	-
145.00 If costs for renal services are of inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N" 146.00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no iyes, enter the approval date (mm/	" for yes or "N" for no nclude Medicare utiliza for no in column 2. ngy changed from the pro n column 1. (See CMS Po	o in column 1. If tion for this cost eviously filed cos	column 1 reporting t report?	9	N		145. 00
						1.00	
147.00Was there a change in the statist	ical hasis? Enter "Y"	for ves or "N" for	no			1. 00 N	147. 00
148.00 Was there a change in the order o	of allocation? Enter "Y	" for yes or "N" f	or no.			N	148. 0
149.00Was there a change to the simplif	ied cost finding metho					N	149.00
		Part A 1.00	Part 2.00		itle V 3.00	Title XIX 4.00	_
Does this facility contain a prov		r an exemption fro	m the app	lication c	of the low	er of costs	
or charges? Enter "Y" for yes or 155.00 Hospi tal	"N" for no for each co	mponent for Part A	and Part	B. (See 4	12 CFR §41 N	3. 13) N	 155. 00
56.00Subprovi der - IPF		N	N N		N	N N	156. 0
57. 00 Subprovi der - I RF		N	N		N	N	157. 0
58. 00 SUBPROVI DER 59. 00 SNF		N	l N		N	N	158. 0 159. 0
60.00HOME HEALTH AGENCY		N	N N		N	N N	160. 0
61. 00 CMHC			N		N	N	161. 0
						1. 00	
Mul ti campus							
65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that has	s one or more camp	uses in d	fferent C	BSAs?	N	165. 00
	Name	County	State	Zi p Code	CBSA	FTE/Campus	
66.00 f line 165 is yes, for each	0	1. 00	2.00	3. 00	4. 00	5. 00	0166.0
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.0	0 100. 0
						1. 00	
Health Information Technology (HI	T) incentive in the Am	erican Recovery an	nd Rei nves	tment Act			
					r the	Y	167. 00 168. 00
68.00 If this provider is a CAH (line 1						1	1
168.00 If this provider is a CAH (line 1 reasonable cost incurred for the	HIT assets (see instru	ctions)	r qualify	for a har	dshi p	N	168.01
168.00 If this provider is a CAH (line 1 reasonable cost incurred for the 168.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii) 169.00 If this provider is a meaningful	HIT assets (see instruction of a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y")	ctions) does this provide "N" for no. (see	instructi	ons)	•		
168.00 If this provider is a CAH (line 1 reasonable cost incurred for the 168.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	HIT assets (see instruction of a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y")	ctions) does this provide "N" for no. (see	instructi	ons) is "N"),	•		168. 01
168.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii) 169.00 If this provider is a meaningful	HIT assets (see instruction of a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons)	ctions) does this provide "N" for no. (see and is not a CAH	instructi (line 105	ons) is "N"),	enter the	O. C	

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL		In Lieu	of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENT	TIFICATION DATA	Provider CCN: 15-1305			Worksheet S-2	
				10/01/2018	Part I Date/Time Pre	norod.
			To	09/30/2019	2/25/2020 4: 3	
					2/23/2020 4.3	S PIII
				1. 00	2. 00	
171.00 If line 167 is "Y", does this provider ha	ave any days for indiv	viduals enrolled in		N	0	171.00
section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter						
"Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section			on			
1876 Medicare days in column 2. (see ins	tructions)					

Heal th Fi	nancial Systems PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	-2552-10
	AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Peri od:	Worksheet S-	
				From 10/01/2018 To 09/30/2019		epared:
				Y/N	2/25/2020 4:	33 pm
				1.00	2. 00	
	eneral Instruction: Enter Y for all YES responses. Enter N	N for all NO re	esponses. Ent			
	n/dd/yyyy format. MPLETED BY ALL HOSPITALS					
	rovider Organization and Operation					
1.00 Ha	as the provider changed ownership immediately prior to the			N		1.00
re	eporting period? If yes, enter the date of the change in o	column 2. (see			\/ /I	
			1. 00	2. 00	V/I 3. 00	
	as the provider terminated participation in the Medicare I		N N	2.00	0.00	2.00
	es, enter in column 2 the date of termination and in colum	mn 3, "V" for				
	oluntary or "I" for involuntary. s the provider involved in business transactions, includio	na management	l N			3.00
	ontracts, with individuals or entities (e.g., chain home of					3.00
or	medical supply companies) that are related to the provi	der or its				
	fficers, medical staff, management personnel, or members of directors through ownership, control, or family and other					
	elationships? (see instructions)	er Sillirai				
			Y/N	Туре	Date	
F:	noncial Data and Danasta		1.00	2. 00	3. 00	
	nancial Data and Reports Dlumn 1: Were the financial statements prepared by a Cer	tified Public	Y	A		4.00
	ccountant? Column 2: If yes, enter "A" for Audited, "C"			,		
	"R" for Reviewed. Submit complete copy or enter date ava	ailable in				
	olumn 3. (see instructions) If no, see instructions. re the cost report total expenses and total revenues diffo	erent from	l N			5. 00
	nose on the filed financial statements? If yes, submit rec					0.00
				Y/N	Legal Oper.	
Δn	proved Educational Activities			1.00	2. 00	
	olumn 1: Are costs claimed for nursing school? Column 2:	If yes, is t	he provider i:	s N		6.00
	ne legal operator of the program?					
	re costs claimed for Allied Health Programs? If "Y" see in ere nursing school and/or allied health programs approved		d during the	N N		7. 00 8. 00
	ost reporting period? If yes, see instructions.	and/or renewer	a durring the	IN		0.00
9. 00 Ar	re costs claimed for Interns and Residents in an approved		cal education	N		9. 00
	rogram in the current cost report? If yes, see instruction as an approved Intern and Resident GME program initiated o		the current	N		10.00
	ost reporting period? If yes, see instructions.	or renewed in	the current	IN		10.00
11. 00 Ar	re GME cost directly assigned to cost centers other than I	I & R in an Ap	proved	N		11.00
Te	eaching Program on Worksheet A? If yes, see instructions.				Y/N	
					1.00	
	nd Debts					
	s the provider seeking reimbursement for bad debts? If yes				Y	12.00
	fline 12 is yes, did the provider's bad debt collection period? If yes, submit copy.	policy change	during this c	ost reporting	N	13. 00
	fline 12 is yes, were patient deductibles and/or co-paymo	ents waived? I	fyes, see in:	structions.	N	14.00
	ed Complement					
15. 00 Di	d total beds available change from the prior cost reporti		yes, see ins		t B	15. 00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
	S&R Data as the cost report prepared using the PS&R Report only?	Y	01/22/2020	Y	01/22/2020	14 00
	f either column 1 or 3 is yes, enter the paid-through	ī	01/22/2020	ı	01/22/2020	16. 00
da	ate of the PS&R Report used in columns 2 and 4 .(see					
	nstructions)	N.		N.		17.00
	as the cost report prepared using the PS&R Report for otals and the provider's records for allocation? If	N		N		17.00
	ther column 1 or 3 is yes, enter the paid-through date					
	n columns 2 and 4. (see instructions)					10.00
	fline 16 or 17 is yes, were adjustments made to PS&R eport data for additional claims that have been billed	N		N		18. 00
	ut are not included on the PS&R Report used to file this					
	ost report? If yes, see instructions.	,.				10.00
	f line 16 or 17 is yes, were adjustments made to PS&R eport data for corrections of other PS&R Report	N		N		19.00
	nformation? If yes, see instructions.					

Heal th	Financial Systems PULASKI MEMOR	I AL HOSPITAL		In Lie	u of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-1305	Peri od: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part II	epared:
			iption	Y/N	Y/N	
20.00	LE Line 1/ au 17 in the property and to DCOD		0	1. 00	3.00	20, 00
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
	report data for other. Beserve the other day astments.	Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS	HOSPI TALS)			
	Capital Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, se				N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense	e due to apprai	sals made dur	ing the cost	N	23. 00
24. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases enter If yes, see instructions	red into during	this cost re	eporting period?	N	24. 00
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repo	rting period?	Plf yes, see	N	25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during tinstructions.	the cost report	ing period? I	f yes, see	N	26. 00
27. 00	Has the provider's capitalization policy changed during th copy.	ne cost reporti	ng period? If	fyes, submit	N	27. 00
28. 00	Interest Expense Were new loans, mortgage agreements or letters of credit e	entered into du	ring the cost	reporting	N	28. 00
29. 00						
30. 00						
31. 00	instructions. Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					
32. 00	Purchased Services Have changes or new agreements occurred in patient care se		ed through co	ontractual	N	32.00
33. 00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.		ng to competi	tive bidding? If		33. 00
	Provi der-Based Physi ci ans					
34. 00		arrangement wit	h provider-ba	ised physicians?	Υ	34.00
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i		nts with the	provi der-based	N	35.00
	physicians during the cost reporting period? If yes, see i	IISTI UCTI OIIS.		Y/N	Date	
				1. 00	2. 00	
	Home Office Costs					
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	prepared by the	home office?	N		36. 00 37. 00
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of			=		38. 00
39. 00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth see instructions.			5,		39. 00
40. 00	If line 36 is yes, did the provider render services to the instructions.	e home office?	If yes, see			40.00
		1.	00	2.	00	
41. 00	Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	MI CHAEL		ALESSANDRI NI		41.00
42. 00	respectively. Enter the employer/company name of the cost report	BLUE AND CO.,	LLC			42.00
	preparer.					
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317. 713. 7959		MALESSANDRI NI @	BLUEANDCO. COM	43.00

Health Financial Systems PULASKI M	EMORIAL HOSPITAL	In Lieu of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CCN: 15-1305	Peri od: From 10/01/2018 To 09/30/2019 Date/Time Pri 2/25/2020 4:	epared:
	3.00	_	
Cost Report Preparer Contact Information	3.00		
41.00 Enter the first name, last name and the title/position			41.00
held by the cost report preparer in columns 1, 2, and	3,		
respecti vel y.			10.00
42.00 Enter the employer/company name of the cost report			42.00
preparer.			40.00
43.00 Enter the telephone number and email address of the co	ost		43.00
report preparer in columns 1 and 2, respectively.	I		1

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 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provi der CCN: 15-1305

						To 09/30/2019	Date/Time Pre 2/25/2020 4:3	
							1/P Days /	J pili
							0/P Visits /	
							Tri ps	
	Component	Worksheet A	No	. of Beds	Bed Days	CAH Hours	Title V	
		Line Number 1.00		2. 00	Available 3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		2.00			5.00	1.00
1.00	8 exclude Swing Bed, Observation Bed and	00.00		20	/, 12	10, 712.00	Ŭ	1.00
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2. 00	HMO and other (see instructions)							2.00
3.00	HMO I PF Subprovi der							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						0	
7. 00	Total Adults and Peds. (exclude observation			25	9, 12	5 45, 912. 00	0	
7.00	beds) (see instructions)			20	/, 12	10, 712.00	Ŭ	7.00
8.00	INTENSIVE CARE UNIT	31.00		0		0.00	0	8. 00
9.00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)	42.00						12.00
13. 00 14. 00	NURSERY Total (see instructions)	43. 00		25	9, 12	5 45, 912. 00	0	
15. 00	CAH visits			25	7, 12	45, 912.00	0	1
16. 00	SUBPROVI DER - I PF							16.00
17. 00	SUBPROVI DER - I RF							17. 00
18.00	SUBPROVI DER							18.00
19.00	SKILLED NURSING FACILITY							19.00
20.00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE	101 00						21.00
22.00	HOME HEALTH AGENCY	101. 00					0	
23. 00 24. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE	116. 00		0		0		23. 00 24. 00
24. 00	HOSPICE (non-distinct part)	30.00		U	'			24. 00
25. 00	CMHC - CMHC	00.00						25.00
26.00	RURAL HEALTH CLINIC	88. 00					0	26.00
26. 01	RURAL HEALTH CLINIC II	88. 01					0	26. 01
26. 02	RURAL HEALTH CLINIC III	88. 02					0	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	
27. 00	Total (sum of lines 14-26)			25				27.00
28. 00 29. 00	Observation Bed Days Ambulance Trips						0	28. 00 29. 00
30.00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days - IRF							31.00
32.00	Labor & delivery days (see instructions)			0		0		32.00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33.00	LTCH non-covered days							33.00
33.01	LTCH site neutral days and discharges				l	T		33. 01

Peri od: Worksheet S-3 From 10/01/2018 Part I To 09/30/2019 Date/Time Prepared: 2/25/2020 4:33 pm

						2/25/2020 4: 3	3 pm
	·	I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	'			Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 038	29	1, 913	3		1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	82	94				2.00
3.00	HMO IPF Subprovider	o	0				3.00
4.00	HMO IRF Subprovider	o	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	692	0	692			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	198	3		6.00
7.00	Total Adults and Peds. (exclude observation	1, 730	29	2, 803	3		7.00
	beds) (see instructions)	·					
8.00	INTENSIVE CARE UNIT	l ol	0	1 0			8.00
9. 00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		102	158	8		13.00
14. 00	Total (see instructions)	1, 730	131			178. 85	
15. 00	CAH visits	0	0				15. 00
16.00	SUBPROVIDER - IPF						16.00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	2, 860	874	6, 369	0.00	9. 39	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	_, -,					23. 00
24. 00	HOSPI CE	0	0	1	0.00	0.00	
24. 10	HOSPICE (non-distinct part)	١	ŭ	1		0.00	24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	7, 336	336	24, 138	0.00	50. 56	
26. 01	RURAL HEALTH CLINIC II	2, 031	16			l	1
26. 02	RURAL HEALTH CLINIC III	510	26				
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0			l e	
27. 00	Total (sum of lines 14-26)	٩	Ü		0.00		
28. 00	Observation Bed Days		0	338		2 10. 00	28.00
29. 00	Ambulance Trips	0	Ü				29.00
30.00	Employee discount days (see instruction)	١		1 0	1		30.00
31. 00	Employee discount days (see Thisti detroit)						31.00
32. 00	Labor & delivery days (see instructions)	0	0	1			32.00
32. 00	Total ancillary labor & delivery room	٩	O				32.00
JZ. U1	outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days	o					33.00
	LTCH site neutral days and discharges	o					33. 01
55. 51	12.5 5. to hour at days and discharges	١		ı	T.	I	1 30.01

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 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider CCN: 15-1305

Perio	od:	Worksheet	S-3
From	10/01/2018	Part I	
To	09/30/2019	Date/lime	Prepared:
		2/25/2020	4:33 pm

				11	0 09/30/2019	2/25/2020 4:3	
		Full Time		Di sch	arges	2,20,2020 110	<u> </u>
		Equi val ents			3		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	•	Workers				Pati ents	
		11. 00	12. 00	13.00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	282	12	543	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			17	39		2.00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	0.00	0	202	10	F 42	13.00
14.00	Total (see instructions)	0. 00	0	282	12	543	
15.00	CAH visits						15.00
16. 00 17. 00	SUBPROVIDER - IPF SUBPROVIDER - IRF						16. 00 17. 00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY			•			20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	0.00					22. 00
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	CWHC - CWHC						25. 00
26. 00	RURAL HEALTH CLINIC	0.00					26.00
26. 01	RURAL HEALTH CLINIC II	0.00					26. 01
26. 02	RURAL HEALTH CLINIC III	0.00					26. 02
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32. 00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days			0			33.00
33. 01	LTCH site neutral days and discharges			0			33. 01

Heal th	Financial Systems	PULASKI MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
	EALTH AGENCY STATISTICAL DATA		Provi der C	CN: 15-1305 CCN: 15-7078	Peri od: From 10/01/2018 To 09/30/2019	Worksheet S-4	pared:
					Home Health	PPS	о рііі
					Agency I		
0.00	County				1.	00	0.00
0.00	County	Title V	Title XVIII	Title XIX	Other	Total	0.00
		1. 00	2. 00	3.00	4. 00	5. 00	
1. 00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	O	C	nl	0 0	0	1.00
2. 00	Unduplicated Census Count (see instructions)	0.00	116.00	0. (0.00	0.00	
				Number of Em	ployees (Full Ti	me Equivalent)	
				01.66			
		Enter the numbe your normal		Staff	Contract	Total	
		your norman	WOLK WOOK				
		0		1.00	2. 00	3. 00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3. 00 4. 00	Administrator and Assistant Administrator(s) Director(s) and Assistant Director(s)		40.00	0. (•	
5. 00	Other Administrative Personnel			1.		l	
6.00	Direct Nursing Service			3. !		•	6. 00
7. 00 8. 00	Nursing Supervisor Physical Therapy Service			0.0		l	
9. 00	Physical Therapy Supervisor			0. 0		•	
10.00	Occupational Therapy Service			0. :		l	
11.00	Occupational Therapy Supervisor			0.0		1	
12. 00 13. 00	Speech Pathology Service Speech Pathology Supervisor			0. (
14. 00	Medical Social Service			0. (0. 00	0.00	
15.00	Medical Social Service Supervisor			0. (l	
16. 00 17. 00	Home Health Aide Home Health Aide Supervisor			2. 0. 0		l	
18. 00	Other			0. 3			
40.00	HOME HEALTH AGENCY CBSA CODES			1	-1		10.00
19. 00	Enter in column 1 the number of CBSAs where you provided services during the cost				1		19.00
	reporting period.						
20. 00	List those CBSA code(s) in column 1 serviced			99915			20.00
	during this cost reporting period (line 20 contains the first code).						
		Full Epi					
		Without V	With Outliers	LUPA Epi sode	PEP Only Epi sodes	Total (cols. 1-4)	
		1. 00	2.00	3. 00	4. 00	5. 00	
21. 00	PPS ACTIVITY DATA Skilled Nursing Visits	994	21		32 23	1, 070	21.00
22. 00	Skilled Nursing Visit Charges	237, 876	5, 041				
23. 00	Physical Therapy Visits	723	12		10 1	746	23. 00
24.00	Physical Therapy Visit Charges Occupational Therapy Visits	189, 096 208	3, 142 C		19 262 0 0	195, 119 208	
25. 00 26. 00	Occupational Therapy Visit Charges	54, 438	C	•	0 0	l	1
27. 00	Speech Pathology Visits	67	C	I .	0 0	67	27. 00
28. 00	Speech Pathology Visit Charges	17, 500	C	1	0 0		
29. 00 30. 00	Medical Social Service Visits Medical Social Service Visit Charges	0	C	1	0 0	0 0	29. 00 30. 00
31.00	Home Health Aide Visits	746	15	;	1 7	769	31.00
32.00	Home Health Aide Visit Charges	82, 524	1, 662	1	11 776	1	
33. 00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2, 738	48	ή ΄	43 31	2, 860	33.00
34.00	Other Charges	О	C		0 0	0	
35. 00	Total Charges (sum of lines 22, 24, 26, 28, 20, 22, and 24)	581, 434	9, 845	10, 4	12 6, 552	608, 243	35.00
36. 00	30, 32, and 34) Total Number of Episodes (standard/non	152			17 3	172	36.00
	outlier)	.52		1			
	Total Number of Outlier Episodes	24 007	1 221	2 21	50 1 272	1 31, 049	
30.00	Total Non-Routine Medical Supply Charges	26, 087	1, 331	2, 3	59 1, 272	1 31,049	J 30. 00

Health Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1305	Peri od:	Worksheet S-8	3
		Component	CCN: 15-8512	From 10/01/2018 To 09/30/2019		
				RHC I	Cost	, p
Clinic Address and Identification					00	_
1.00 Street				540 HOSPITAL D	RIVE	1.00
		Ci	ty	State	ZIP Code	
			00	2. 00	3. 00	
2.00 City, State, ZIP Code, County		WI NI MAC		IN	46996-	2.00
					1.00	
3.00 HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rura	al or "U" for	urban		0	3.00
			Grai	nt Award	Date	
				1. 00	2. 00	
Source of Federal Funds 4.00 Community Health Center (Section 330(d), PHS	Act)		I		T	4.00
5.00 Migrant Health Center (Section 329(d), PHS A						5.00
6.00 Health Services for the Homeless (Section 34)						6.00
7.00 Appalachian Regional Commission						7. 00
8. 00 Look-Alikes						8.00
9.00 OTHER (SPECIFY)						9.00
				1. 00	2. 00	
10.00 Does this facility operate as other than a hyes or "N" for no in column 1. If yes, indicate 2. (Enter in subscripts of line 11 the type of		0	10.00			
hours.)	Sund	day	T N	Monday	Tuesday	
	from	to	from	to	from	
	1. 00	2. 00	3. 00	4.00	5. 00	
Facility hours of operations (1)			I	1.=	1	
11. 00 CLINIC			08: 00	17: 00	08: 00	11.00
				1. 00	2.00	
12.00 Have you received an approval for an exception	on to the produ	uctivity stand	ard?	N		12.00
13.00 Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	umn 1. If yes,	enter in colu	mn 2 the	N	0	13.00
numbers below.			Prov	ider name	CCN number	
				1. 00	2.00	
14.00 RHC/FQHC name, CCN number	V (2)		V2 ** • •	V/1.V/	T. I. I. M	14.00
	Y/N 1. 00	V 2. 00	3. 00	XI X 4. 00	Total Visits 5.00	
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and		2.00	3.00	4.00	5.00	15. 00
4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.						
(see instructions)						
			inty			
2.00 City, State, ZIP Code, County		PULASKI	00			2.00
2. 55 State, 211 Code, County	Tuesday	sday	2.00			
	to	from	esday to	from	to	
	6. 00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1) 11.00 CLINIC	17. 20	00.00	10.00	00.00	10.00	11 00
11.00 JOLINIC	17: 30	08: 00	19: 00	08: 00	19: 00	11.00

Health Financial Systems	PULASKI MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der (CCN: 15-1305	Peri od:	Worksheet S-8	
		Component	CCN: 15-8512	From 10/01/2018 To 09/30/2019	Date/Time Pre 2/25/2020 4:3	
				RHC I	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14.00		
Facility hours of operations (1)			_			
11. 00 CLINIC	08: 00	16: 30	08: 00	12: 00		11.00

Health Financial Systems	PULASKI MEMORI	IAL HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1305	Peri od: From 10/01/2018	Worksheet S-8	3
		Component	CCN: 15-8527	To 09/30/2019		
				RHC II	Cost	
				1.	00	
Clinic Address and Identification				NORTH LANE OF	FFT	1
1.00 Street		Ci	ty	NORTH LANE STR State	ZIP Code	1.00
			00	2. 00	3.00	
2.00 City, State, ZIP Code, County		NORTH JUDSON			46366-1226	2.00
					1.00	
3.00 HOSPITAL-BASED FQHCs ONLY: Designation - Ento	er "R" for rur	al or "U" for	urban		1.00	3.00
				nt Award	Date	
				1. 00	2. 00	
Source of Federal Funds 4.00 Community Health Center (Section 330(d), PHS	Act)					4.00
5.00 Migrant Health Center (Section 329(d), PHS A						5.00
6.00 Health Services for the Homeless (Section 34)						6.00
7.00 Appal achi an Regi onal Commi ssi on						7.00
8. 00 Look-Alikes 9. 00 OTHER (SPECIFY)						8. 00 9. 00
7.00 OTILIX (SECTED)						7.00
				1. 00	2. 00	
10.00 Does this facility operate as other than a house or "N" for no in column 1. If yes, indicate 2. (Enter in subscripts of line 11 the type of hours.)	ate number of	other operatio	ns in column		0	10.00
(Hour of)	Sun	day	N	Monday	Tuesday	
	from	to	from	to	from	
Eacility hours of operations (1)	1. 00	2. 00	3.00	4. 00	5. 00	
Facility hours of operations (1) 11.00 CLINIC			08: 00	17: 00	08: 00	11.00
		<u> </u>				
12.00 Have you received an approval for an exception	on to the prod	uctivity stand	lard?	1.00	2. 00	12.00
13.00 Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in coll number of providers included in this report. numbers below.	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	N	o	1
			Prov	ider name	CCN number	
14.00 5040				1. 00	2. 00	
14.00 RHC/FOHC name, CCN number	Y/N	V	XVIII	XIX	Total Visits	14.00
	1. 00	2. 00	3.00	4.00	5. 00	
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the						15.00
number of total visits for this provider.						
(see instructions)		Col	l unty			
			00			
2.00 City, State, ZIP Code, County			2.00			
	Tuesday		esday		sday	
	to 6. 00	7.00	8. 00	9.00	to 10.00	
Facility hours of operations (1)	0.00	7.00	3.00	7.00	10.00	
	17: 00	08: 00	17: 00	08: 00	17: 00	11.00

Health Financial Systems	PULASKI MEM	IORI AL	HOSPI TAL			In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provi der	CCN: 15-1		Peri od:	Worksheet S-8	
						From 10/01/2018		
			Component	: CCN: 15-	8527	To 09/30/2019		
							2/25/2020 4: 3	3 pm
						RHC II	Cost	
	F	ri day			Sa	turday		
	from		to	fi	^om	to		
	11. 00		12.00	13	. 00	14. 00		
Facility hours of operations (1)								
11. 00 CLINIC	08: 00	17:	00					11.00

Health Financial Systems	PULASKI MEMORI	IAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1305	Peri od:	Worksheet S-8	3
		Component	CCN: 15-8528	From 10/01/2018 To 09/30/2019	Date/Time Pre	
				RHC III	2/25/2020 4: 3 Cost	33 piii
				100 111	0031	
				1.	00	
Clinic Address and Identification						1
1.00 Street		1 0:	±	112 E MONTGOME		1.00
			00	State 2.00	ZIP Code 3.00	
2.00 City, State, ZIP Code, County		FRANCESVI LLE	00		47946-8087	2.00
					1.00	
3.00 HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for			0	3.00
			Gra	nt Award 1.00	Date 2.00	
Source of Federal Funds				1.00	2.00	
4.00 Community Health Center (Section 330(d), PHS	Act)					4.00
5.00 Migrant Health Center (Section 329(d), PHS A						5.00
6.00 Health Services for the Homeless (Section 34)	O(d), PHS Act)					6.00
7.00 Appalachian Regional Commission 8.00 Look-Alikes						7.00
9. 00 OTHER (SPECIFY)						9.00
7. 00 OTTER (OF EOTT)						7.00
				1. 00	2.00	
10.00 Does this facility operate as other than a hyes or "N" for no in column 1. If yes, indicate 2. (Enter in subscripts of line 11 the type of hours.)	ate number of	other operatio	ns in column		0	10.00
mour 5.)	Sun	day	l N	londay	Tuesday	
	from	to	from	to	from	
	1. 00	2.00	3. 00	4. 00	5. 00	
Facility hours of operations (1)		I	00.00	17.00	00.00	11 00
11. 00 CLINI C			08: 00	17: 00	09: 00	11.00
				1. 00	2.00	
12.00 Have you received an approval for an exception 13.00 Is this a consolidated cost report as define					0	12.00
30.8? Enter "Y" for yes or "N" for no in col- number of providers included in this report.	umn 1. If yes,	enter in colu	mn 2 the	N N		13.00
numbers below.			Dn=	idor nome	CCN primbor	
			Prov	ider name 1.00	CCN number 2.00	
14.00 RHC/FQHC name, CCN number				50	2.00	14.00
	Y/N	V	XVIII	XIX	Total Visits	
	1. 00	2. 00	3. 00	4. 00	5. 00	
15.00 Have you provided all or substantially all						15. 00
GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and						
4 the number of program visits performed by						
Intern & Residents for titles V, XVIII, and						
XIX, as applicable. Enter in column 5 the						
number of total visits for this provider.						
(see instructions)		Col	l inty			
			00			
2.00 City, State, ZIP Code, County		PULASKI				2.00
	Tuesday	Wedn	esday	Thur	sday	
	to	from	to	from	to	
Encility hours of coaretions (1)	6. 00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1) 11.00 CLINIC	19: 00	08: 00	16: 00	08: 00	16: 00	11.00
33 35 10	1. 7. 00	100.00	1.5.00	150. 00	1.0.00	1

Health Financial Systems	PULASKI MEM	ORI AL	HOSPI TAL			In Lieu	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provi der	CCN:	15-1305	Peri od:	Worksheet S-8	
			Component	t CCN	N: 15-8528	From 10/01/2018 To 09/30/2019		
						RHC III	Cost	
	F	ri day	1		Sa	turday		
	from		to		from	to		
	11. 00		12. 00		13.00	14. 00		
Facility hours of operations (1)								
11. 00 CLINIC								11. 00

Heal th	Financial Systems PULASKI MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10			
		Provi der Co	CN: 15-1305	Peri od:	Worksheet S-1				
				From 10/01/2018 To 09/30/2019	Doto/Time Dro	narad.			
				To 09/30/2019	Date/Time Pre 2/25/2020 4:3	pareu. 3 pm			
					1. 00				
4 00	Uncompensated and indigent care cost computation		200	2)	0.404074				
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di Medicaid (see instructions for each line)	vraea by ri	ne 202 colur	in 8)	0. 491271	1.00			
2. 00	Net revenue from Medicaid				265, 956	2. 00			
3. 00	Did you receive DSH or supplemental payments from Medicaid?		203, 730 Y	3.00					
4. 00	If line 3 is yes, does line 2 include all DSH and/or supplemen	tal payment	ts from Medio	ai d?	N	4.00			
5.00	If line 4 is no, then enter DSH and/or supplemental payments f	rom Medicai	d		235, 830	5.00			
6.00	Medi cai d charges				8, 059, 271	6. 00			
7.00	Medicaid cost (line 1 times line 6)			0 15 16	3, 959, 286				
8. 00	Difference between net revenue and costs for Medicaid program	(line 7 mir	nus sum of li	nes 2 and 5; if	3, 457, 500	8. 00			
	<pre>< zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions f</pre>	or each lir	ne)						
9. 00	Net revenue from stand-alone CHIP	or each iii	10)		0	9. 00			
10.00	Stand-alone CHIP charges				0	10.00			
11. 00	Stand-alone CHIP cost (line 1 times line 10)				0	11.00			
12. 00	Difference between net revenue and costs for stand-alone CHIP	(line 11 mi	nus line 9;	if < zero then	0	12. 00			
	enter zero) Other state or local government indigent care program (see ins	tructions f	For each line	.)					
13. 00	Other state or local government indigent care program (see ins Net revenue from state or local indigent care program (Not inc				0	13. 00			
14. 00	Charges for patients covered under state or local indigent car				0	14.00			
	10)	. 3	•						
15.00	State or local indigent care program cost (line 1 times line 1				0	15.00			
16. 00	Difference between net revenue and costs for state or local in	digent 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	te/local indi	gent care progra	ıms (see				
	instructions for each line)								
17.00	1				0				
18. 00 19. 00	Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and loca			ns (sum of lines	3, 457, 500				
17.00	8, 12 and 16)	i illai gent	care program	is (sum of filles	3, 437, 300	17.00			
			Uni nsured	Insured	Total (col. 1				
			pati ents	pati ents	+ col . 2)				
	Uncompensated Care (see instructions for each line)		1.00	2. 00	3. 00				
20. 00	Charity care charges and uninsured discounts for the entire fa	cility	180, 5	72 323, 277	503, 849	20.00			
20.00	(see instructions)		.55,5	020,277	000,017	20.00			
21.00	Cost of patients approved for charity care and uninsured disco	unts (see	88, 7	10 323, 277	411, 987	21.00			
	instructions)	66							
22. 00	Payments received from patients for amounts previously written charity care	off as		0 0	0	22. 00			
23. 00	Cost of charity care (line 21 minus line 22)		88, 7	10 323, 277	411, 987	23 00			
20.00	poset of sharry sairs (rins 21 minus 1116 22)		00, 1	020/277	1117707	20.00			
					1. 00				
24. 00	Does the amount on line 20 column 2, include charges for patie		yond a Length	n of stay limit	N	24. 00			
25 00	imposed on patients covered by Medicaid or other indigent care	. 5	t cara progr	m's longth of	0	25 00			
23.00	<pre>If line 24 is yes, enter the charges for patient days beyond t stay limit</pre>	ne margen	care progra	illi S Ferigtii oi	0	25. 00			
26. 00									
27. 00	Medicare reimbursable bad debts for the entire hospital comple	,			31, 269				
27. 01	Medicare allowable bad debts for the entire hospital complex (see instru	ctions)		48, 106				
28. 00	Non-Medicare bad debt expense (see instructions)			`	1, 274, 505	•			
29. 00 30. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt ex Cost of uncompensated care (line 23 column 3 plus line 29)	pense (see	instructions	5)	642, 964 1, 054, 951	•			
	Total unreimbursed and uncompensated care cost (line 19 plus I	ine 30)			4, 512, 451	•			
	, and the second	,		Į.	., 5.2, .01				

Heal th	Fi nar	ncial Systems	PULASKI MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
		ATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der C		eri od:	Worksheet A	
						From 10/01/2018		
					T	To 09/30/2019 Date/Time Pro		pared:
				2.1			2/25/2020 4: 3	3 pm
		Cost Center Description	Sal ari es	0ther		Recl assi fi cat	Recl assi fi ed	
					+ col. 2)	i ons (See	Trial Balance	
						A-6)	(col. 3 +-	
							col. 4)	
			1. 00	2. 00	3. 00	4. 00	5. 00	
	GENER	RAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1, 590, 557	1, 590, 557	39, 454	1, 630, 011	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	o	5, 610, 235	5, 610, 235	0	5, 610, 235	4.00
5.00		ADMINISTRATIVE & GENERAL	2, 295, 283	3, 151, 241	5, 446, 524	268, 353	5, 714, 877	5.00
7. 00	1	OPERATION OF PLANT	340, 428	541, 233		0	881, 661	7. 00
8. 00		LAUNDRY & LINEN SERVICE	16, 040	50, 533		_	66, 573	8. 00
9. 00	1	HOUSEKEEPI NG	202, 243	107, 447			309, 690	9. 00
10.00	1	DI ETARY	194, 950	183, 810			378, 760	10.00
13. 00	1	NURSING ADMINISTRATION						13. 00
			401, 647	26, 900			428, 547	
14.00		CENTRAL SERVICES & SUPPLY	42, 621	25, 673			68, 294	14.00
15.00		PHARMACY	0	0		_	0	15.00
16.00		MEDICAL RECORDS & LIBRARY	359, 446	36, 374			395, 820	16.00
17. 00		SOCIAL SERVICE	73, 626	405	74, 031	0	74, 031	17. 00
		TENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2, 153, 485	94, 542	2, 248, 027	30, 041	2, 278, 068	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	27, 890	4, 705	32, 595	36, 904	69, 499	43.00
	ANCI L	LARY SERVICE COST CENTERS	•		,			
50.00		OPERATING ROOM	484, 838	85, 187	570, 025	409, 268	979, 293	50.00
52.00		DELIVERY ROOM & LABOR ROOM	28, 569	3, 372			78, 071	52.00
53. 00	1	ANESTHESI OLOGY	20,007	603, 475			603, 475	53. 00
54. 00		RADI OLOGY-DI AGNOSTI C	814, 768	475, 398			1, 290, 166	
60.00		LABORATORY	668, 205	681, 222			1, 349, 427	60.00
60. 00		BLOOD LABORATORY	000, 203	001, 222			1, 349, 427	60.00
			0			_	-	
63.00		BLOOD STORING, PROCESSING & TRANS.	200 140	68, 865			68, 865	63.00
65.00		RESPI RATORY THERAPY	308, 140	35, 720			343, 860	65.00
66. 00		PHYSI CAL THERAPY	1, 018, 597	34, 516		0	1, 053, 113	
67.00		OCCUPATI ONAL THERAPY	143, 117	794		0	143, 911	67.00
68. 00		SPEECH PATHOLOGY	74, 262	5, 348	79, 610	0	79, 610	68.00
69.00	06900	ELECTROCARDI OLOGY	5, 733	13, 470	19, 203	0	19, 203	69.00
69. 01	06901	CARDIAC REHABILITATION	65, 183	3, 117	68, 300	0	68, 300	69. 01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	o	503, 826	503, 826	-151, 715	352, 111	71.00
72.00		IMPL. DEV. CHARGED TO PATIENTS	o	0			151, 715	72.00
73.00		DRUGS CHARGED TO PATIENTS	24, 303	2, 224, 756	2, 249, 059		2, 249, 059	73. 00
76. 00		ONCOLOGY	114, 465	32, 255			146, 720	76. 00
70.00		TIENT SERVICE COST CENTERS	111, 100	02, 200	1 10, 720	· ·	110,720	70.00
88. 00		RURAL HEALTH CLINIC	4, 906, 658	416, 856	5, 323, 514	-778, 590	4, 544, 924	88. 00
88. 01		RURAL HEALTH CLINIC II	552, 228	78, 640			660, 240	
88. 02		RURAL HEALTH CLINIC III	207, 106	30, 122				88. 02
90.00		CLINIC	85, 995	235, 153			321, 148	90.00
		EMERGENCY	991, 129	1, 343, 470	2, 334, 599	0	2, 334, 599	91.00
92.00		OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	554, 478	95, 566	650, 044	-76, 529	573, 515	101.00
	SPECI	AL PURPOSE COST CENTERS						
116.00	11600	HOSPI CE	0	0	0	0	0	116.00
118.00)	SUBTOTALS (SUM OF LINES 1 through 117)	17, 155, 433	18, 394, 783	35, 550, 216	16, 546	35, 566, 762	118. 00
	NONRE	IMBURSABLE COST CENTERS	•					
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
		HOMECARE	ol	0				190. 01
		PHYSICIANS' PRIVATE OFFICES	112, 595	34, 869			159, 882	
		KNOX RHC	.12,070	180				192. 01
		MARKETI NG	55, 183	137, 913			164, 132	
200.00		TOTAL (SUM OF LINES 118 through 199)	17, 323, 211	18, 567, 745			35, 890, 956	
∠∪U. UU	' I	TIVIAL (SUM OF LINES 118 (III OUGH 199)	17, 323, 211	10, 007, 745	J 30, 890, 956	ı O	30, 890, 956	200.00

Peri od: From 10/01/2018 To 09/30/2019 Date/Ti me Prepared: 2/25/2020 4: 33 pm

				2/25/2020 4: 3	33 pm
	Cost Center Description	Adjustments	Net Expenses		
	'	(See A-8)	For		
		(000 // 0)	Allocation		
		/ 00			
		6. 00	7. 00		_
	GENERAL SERVICE COST CENTERS			,	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-13, 691	1, 616, 320		1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	5, 610, 235		4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	-1, 277, 754	4, 437, 123		5.00
7.00	00700 OPERATION OF PLANT	-278	881, 383		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	66, 573		8.00
9.00	00900 HOUSEKEEPI NG	0	309, 690		9.00
10.00	01000 DI ETARY	_	307, 046		10.00
		-71, 714			
13.00	01300 NURSING ADMINISTRATION	0	428, 547		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	-11, 328	56, 966		14.00
15.00	01500 PHARMACY	0	0		15.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	-9, 349	386, 471		16.00
17. 00	01700 SOCI AL SERVI CE	0	74, 031		17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-425, 413	1, 852, 655		30.00
31. 00	03100 I NTENSI VE CARE UNI T	0		l .	31.00
43.00	04300 NURSERY	0	69, 499		43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-409, 268	570, 025		50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0			52. 00
53.00	05300 ANESTHESI OLOGY	-592, 497	10, 978		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 290, 166		54.00
60.00	06000 LABORATORY	-2, 243	1, 347, 184		60.00
60. 01	06001 BLOOD LABORATORY	0	0	•	60. 01
			1	l .	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0			63.00
65.00	06500 RESPI RATORY THERAPY	0	343, 860		65.00
66.00	06600 PHYSI CAL THERAPY	0	1, 053, 113		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	143, 911		67. 00
		_			
68.00	06800 SPEECH PATHOLOGY	0	79, 610		68.00
69.00	06900 ELECTROCARDI OLOGY	-5, 719	13, 484		69.00
69. 01	06901 CARDI AC REHABI LI TATI ON	0	68, 300		69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
		_	1		
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	352, 111		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	151, 715		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	-53, 440	2, 195, 619		73.00
76. 00	03020 ONCOLOGY	0	l		76. 00
70.00		0	140, 720		70.00
	OUTPATIENT SERVICE COST CENTERS				
88. 00	08800 RURAL HEALTH CLINIC	-1, 763	4, 543, 161		88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	660, 240		88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0			88. 02
90.00	09000 CLI NI C	0	321, 148		90.00
91.00	09100 EMERGENCY	0	2, 334, 599		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
	OTHER REIMBURSABLE COST CENTERS				
101 00			F70 F1F		101 00
101.00	0 10100 HOME HEALTH AGENCY	0	573, 515		101.00
	SPECIAL PURPOSE COST CENTERS				
116.00	0 11600 H0SPI CE	0	0		116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-2, 874, 457	32, 692, 305		118.00
110.00	NONREI MBURSABLE COST CENTERS	2,071,107	02,072,000		1110.00
400 -		_	-	1	1.00 0-
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190.00
190. 01	1 19001 HOMECARE	0	0		190. 01
	19200 PHYSICIANS' PRIVATE OFFICES	0	159, 882		192.00
	1 19201 KNOX RHC		l .	•	192.01
		0	180	•	
	07950 MARKETI NG	0			194. 00
200.00	TOTAL (SUM OF LINES 118 through 199)	-2, 874, 457	33, 016, 499		200.00
	· · · · · · · · · · · · · · · · · · ·	· ·			

Health Financial Systems	PULASKI MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
RECLASSI FI CATI ONS	Provider CCN: 15-1305	Period: Worksheet A-6

						From 10/01/2018 To 09/30/2019	Date/Time Pr	epared:
					1		2/25/2020 4:	33 pm
		Increases						
	Cost Center	Li ne #	Sal ary	0ther				
	2.00	3. 00	4. 00	5. 00				
	A - PROPERTY I NSURANCE	4 00		00.454				4
1.00	NEW CAP REL COSTS-BLDG &	1. 00	0	39, 454				1.00
	FIXT	+						
	B - MARKETING RECLASS		U	39, 454				
1. 00		E 00	8, 277	20 (07				1.00
1.00	ADMI NI STRATI VE & GENERAL		$\frac{8,277}{8,277}$	2 <u>0, 6</u> 87 20, 687				1.00
	C - IMPLANTABLE DEVICES		8, 211	20, 687				
1. 00	I MPL. DEV. CHARGED TO	72. 00	0	151, 715				1.00
1.00	PATI ENTS	72.00	٩	151, 715				1.00
	0	+		 151, 715				
	D - PHYSICIAN SALARIES		<u> </u>	101,710				
1. 00	ADULTS & PEDIATRICS	30.00	113, 075	0				1.00
2. 00	OPERATI NG ROOM	50.00	409, 268	0				2.00
3. 00	RURAL HEALTH CLINIC II	88. 01	631	0				3.00
4.00	PHYSICIANS' PRIVATE OFFICES	192. 00	12, 418	0				4.00
			535, 392	0				
	E - RHC PHYSICIAN COSTS							
1.00	RURAL HEALTH CLINIC	88. 00	0	12, 807				1.00
	0		0	12, 807				
	F - BILLER RECLASS							
1.00	ADMI NI STRATI VE & GENERAL		7 <u>6, 5</u> 29	0				1.00
	0		76, 529	0				
	G - PATIENT ACCOUNTS RECLASS							
1. 00	ADMINISTRATIVE & GENERAL		21 <u>5, 1</u> 21	0				1.00
	0		215, 121					
	H - RHC DEPT 175 RECLASS				T			
1.00	RURAL HEALTH CLINIC II	88. 01	0	28, 741				1.00
2. 00	RURAL HEALTH CLINIC III	8802		1 <u>2, 7</u> 74				2.00
	O DN CALABLES		0	41, 515				
1 00	I - RN SALARIES	42.00	27, 004					1 00
1.00	NURSERY	43.00	36, 904	0				1.00
2. 00	DELIVERY ROOM & LABOR ROOM	5200	4 <u>6, 1</u> 30					2.00
500.00	O Grand Total: Increases		83, 034 918, 353	266, 178	1			500.00
300.00	poraniu rotar. Tricreases	1	910, 333	200, 178				1 300. 00

			10 09/30/2019	Date/Time Pro 2/25/2020 4:3	
			T- 00 /20 /2010	D-+- /T! D	
			From 10/01/2018		
 					-
IIICAIIUNS	rioviuei (JUN. 13-1303 I	FELLOU.	I MOLVOLIGE F M-1	

Cost Center							0 09/30/2019	2/25/2020 4:33 pm
A - PROPERTY INSURANCE			Decreases		_			
A - PROPERTY I NSURANCE		Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
1.00 ADMINISTRATIVE & GENERAL 5.00 0 39,454 12 0 39,454 12 0 39,454 12 0 39,454 12 0 39,454 12 0 39,454 12 0 39,454 12 0 39,454 12 0 39,454 12 0 39,454 12 0 39,454 12 0 39,454 12 0 39,454 12 0 39,454 12 0 39,454 12 0 0 39,454 12 0 0 10 0 10 0 10 0 10 0		6. 00	7. 00	8. 00	9. 00	10.00		
1.00		A - PROPERTY INSURANCE						
B - MARKETING RECLASS MARKETING 194.00 8,277 20.687 0 0 0 1.00	1.00	ADMINISTRATIVE & GENERAL	5. 00	0	39, 454	12		1.00
1.00 MARKETING 194.00 8.277 20.687 0 0 8.277 20.687 0 1.00 MEDICAL SUPPLIES CHARGED TO 71.00 0 151.715 0 D - PHYSICIAN SALARIES 1.00 RURAL HEALTH CLINIC 88.00 534, 761 0 0 0 1.00 2.00 RURAL HEALTH CLINIC 111 88.02 631 0 0 0 2.00 3.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0		0	39, 454			
1.00 NEDICAL SUPPLIES CHARGED TO 71.00 0 151,715 0 0 151,715 0 0 0 151,715 0 0 0 0 151,715 0 0 0 0 0 0 0 0 0		B - MARKETING RECLASS						
C - IMPLANTABLE DEVICES MEDICAL SUPPLIES CHARGED TO	1.00	MARKETI NG	194. 00	8, 277	20, 687	0		1.00
1.00 MEDICAL SUPPLIES CHARGED TO 71.00 0 151,715 0 0 0 1 1 0 0 0 1 1 0 0 0 0 1 1 0		0		8, 277	20, 687	7		
PATI ENTS								
1.00 PHYSI CI AN SALARI ES	1.00		71. 00	0	151, 715	0		1.00
D - PHYSICIAN SALARIES 1.00 2.00 38.00 534,761 0 0 0 2.00 3.00 3.00 4.00 0 0 0 0 0 0 3.00 4.00 0 0 0 0 0 0 0 0 0		PATI ENTS						
1. 00 RURAL HEALTH CLINIC		0		0	151, 715	5		
2. 00 3. 00 3. 00 4. 00 0. 00								
3.00 4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					C	0		
4.00 0		RURAL HEALTH CLINIC III		631	C	0		1
The image is a second color of the image is a second color o				0	C	0		3.00
E - RHC PHYSICI AN COSTS 1.00 ADMI NI STRATI VE & GENERAL 5.00 0 12,807 0 1.00	4.00		000	0	0	00		4.00
1. 00 ADMI NI STRATI VE & GENERAL 5. 00 0 12, 807 0 1. 00 0 12, 807		0		535, 392	C)		
1.00 HOME HEALTH AGENCY 101.00 76,529 0 0 0 0 0 0 0 0 0								
F - BI LLER RECLASS 1. 00 HOME HEALTH AGENCY 101.00 76,529 0 0 1.00 G - PATI ENT ACCOUNTS RECLASS 1. 00 RURAL HEALTH CLINIC 88.00 215,121 0 0 1.00 H - RHC DEPT 175 RECLASS 1. 00 RURAL HEALTH CLINIC 88.00 0 41,515 0 1.00 2. 00 0 0 0 0 0 2.00 O ADDITION OF THE PROPERTY OF THE PROP	1.00	ADMINISTRATIVE & GENERAL		0				1.00
1. 00 HOME HEALTH AGENCY 101. 00 76, 529 0 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0		0	12, 807	'		
Total Tota								
G - PATIENT ACCOUNTS RECLASS RURAL HEALTH CLINIC 88.00 215, 121 0 0 0 1.00 H - RHC DEPT 175 RECLASS 1. 00 RURAL HEALTH CLINIC 88.00 0 41, 515 0 1.00 2. 00 0 0 0 0 0 0 2.00 I - RN SALARIES 1. 00 ADULTS & PEDIATRICS 30.00 83, 034 0 0 0 2.00 0 83, 034 0 0 0 2.00 0 83, 034 0 0 0 2.00	1.00	HOME HEALTH AGENCY	1 <u>01.</u> 00					1.00
1. 00 RURAL HEALTH CLINIC 88. 00 215, 121 0 0 1 1. 00		0		76, 529	C)		
1.00 RURAL HEALTH CLINIC 88.00 0 41,515 0 0 2.00 0 41,515 0 0 2.00 0 0 0 0 0 0 0 0 0								
H - RHC DEPT 175 RECLASS 1. 00 RURAL HEALTH CLINIC 0. 00 0 41,515 1 - RN SALARIES 1. 00 ADULTS & PEDIATRICS 30. 00 83,034 0 0 1. 00 2. 00 0 83,034 0 0 0 2. 00 0 0 83,034 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 00	RURAL HEALTH CLINIC			0	<u> </u>		1.00
1. 00		0		215, 121	C)		
2. 00								
1. 00		RURAL HEALTH CLINIC		0	41, 515	0		
1. 00 ADULTS & PEDIATRICS 30. 00 83, 034 0 0 1. 00 2. 00 0 0 2. 00 0 0 2. 00 0 0 0 0 0	2. 00		000	•	0	0 0		2. 00
1. 00 ADULTS & PEDIATRICS 30. 00 83, 034 0 0 1. 00 2. 00 0 0 2. 00 0 0 0 2. 00 0 0 0 0		0		0	41, 515	5		
2. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
0 83,034 0		ADULTS & PEDIATRICS		83, 034	C	0		1
	2.00		000	0	C	00		2.00
500.00 Grand Total: Decreases 918, 353 266, 178 500.00		0			C)		
	500.00	Grand Total: Decreases		918, 353	266, 178	3		500.00

Peri od: Worksheet A-7
From 10/01/2018 Part I
To 09/30/2019 Date/Time Prepared:

				11	0 09/30/2019	Date/lime Pre 2/25/2020 4:3	
				Acqui si ti ons		1. 0	O PIII
		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	T BALANCES					
1.00	Land	348, 302	0	0	0	152, 777	1.00
2.00	Land Improvements	432, 594	0	0	0	0	2.00
3.00	Buildings and Fixtures	13, 232, 909	20, 129	0	20, 129	0	3. 00
4.00	Building Improvements	187, 055	0	0	0	0	4.00
5.00	Fi xed Equi pment	7, 434, 636	0	0	0	0	5.00
6.00	Movable Equipment	8, 699, 714	214, 507	0	214, 507	0	6. 00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	30, 335, 210	234, 636	0	234, 636	152, 777	
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	30, 335, 210	234, 636	0	234, 636	152, 777	10.00
		Endi ng	Fully				
		Bal ance	Depreciated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1. 00	Land	195, 525	0				1. 00
2.00	Land Improvements	432, 594	0				2.00
3.00	Buildings and Fixtures	13, 253, 038	0				3.00
4.00	Building Improvements	187, 055	0				4. 00
5.00	Fixed Equipment	7, 434, 636	0				5. 00
6.00	Movable Equipment	8, 914, 221	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8. 00	Subtotal (sum of lines 1-7)	30, 417, 069	0				8. 00
9. 00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	30, 417, 069	0				10.00

Heal th	Health Financial Systems PULASKI MEMORIAL HOSPITAL In Lieu of Form CMS-255									
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od: From 10/01/2018	Worksheet A-7 Part II				
						Date/Time Pre 2/25/2020 4:3				
			Sl	JMMARY OF CAPI	TAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see				
					(see	instructions)				
					instructions)					
		9. 00	10. 00	11. 00	12. 00	13. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU	MN 2, LINES 1	and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1, 311, 052	0	279, 50	05	0	1.00			
3.00	Total (sum of lines 1-2)	1, 311, 052	0	279, 50	05	0	3.00			
		SUMMARY O	F CAPITAL							
	Cost Center Description	Other	Total (1)	1						
		Capi tal -Rel at	(sum of cols.							
		ed Costs (see	9 through 14)							
		instructions)								
		14. 00	15. 00	1						
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	MN 2, LINES 1	and 2						
1.00	NEW CAP REL COSTS-BLDG & FLXT	0	1, 590, 557	'			1.00			
3. 00	Total (sum of lines 1-2)	0	1, 590, 557	•			3.00			

Health Financial Systems	PULASKI MEMORI	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		eri od:	Worksheet A-7	
				From 10/01/2018 To 09/30/2019		arod:
			'	0 09/30/2019	2/25/2020 4: 33	3 pm
	COMF	COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPIT				
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 -			
			col . 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C				1 000000		
1.00 NEW CAP REL COSTS-BLDG & FLXT	30, 417, 069	l .				1.00
3.00 Total (sum of lines 1-2)	30, 417, 069 0 30, 417, 069 ALLOCATION OF OTHER CAPITAL				3. 00	
	ALLUCA	IION OF OTHER (CAPITAL	SUMMARY C	OF CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
cost center bescription		Capi tal -Rel at		Depi eci ati on	Lease	
		ed Costs	through 7)			
	6, 00	7. 00	8.00	9, 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS O			5.55			
1.00 NEW CAP REL COSTS-BLDG & FLXT	0	0	C	1, 308, 251	0	1.00
3.00 Total (sum of lines 1-2)	0	0	l c	1, 308, 251	o	3.00
		Sl	JMMARY OF CAPI	ΓAL		
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
		(see	instructions)	Capi tal -Rel at		
		instructions)		ed Costs (see	9 through 14)	
	11.00	10.00	40.00	instructions)	45.00	
DART III DECONCILIATION OF CARLTAL COCTE O	11. 00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CONTROL NEW CAP REL COSTS-BLDG & FIXT		20.454			1 (1(220	1 00
3.00 Total (sum of lines 1-2)	268, 615		•			1. 00 3. 00
3.00 Total (Suill Of TitleS 1-2)	268, 615	39, 454	1	0 ار	1,010,320	3.00

					o 09/30/2019		
				Expense Classification on		2/25/2020 4: 3	3 pm
				To/From Which the Amount is	to be Adjusted		
		D!-/C!-	A ±	Cook Conton	1: "	WI+ A 7	
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1. 00	Investment income - NEW CAP	1. 00	2. 00	3. 00 NEW CAP REL COSTS-BLDG &	4. 00	5. 00 0	1.00
1.00	REL COSTS-BLDG & FLXT (chapter		Ö	FIXT	1.00	0	1.00
2. 00	Investment income - CAP REL		0	*** Cost Center Deleted ***	2. 00	0	2.00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0. 00	0	3.00
4. 00	(chapter 2) Trade, quantity, and time		0		0. 00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0. 00	0	7. 00
	stations excluded) (chapter 21)						
8. 00	Television and radio service (chapter 21)		0		0.00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-840, 838		0. 00	0	
11. 00	adjustment Sale of scrap, waste, etc.	0 2	0.0,000		0. 00	0	
12. 00	(chapter 23) Rel ated organi zati on	A-8-1	0		0.00	0	
	transactions (chapter 10)	A-0-1					
13. 00 14. 00			0		0. 00 0. 00	0	
15. 00	Rental of quarters to employee and others		0		0. 00	0	15. 00
16. 00			0		0. 00	0	16. 00
17 00	patients Sale of drugs to other than		0		0. 00	0	17. 00
18. 00	patients		0		0. 00	0	
	abstracts		0				
19. 00	Nursing and allied health education (tuition, fees,		U		0.00	0	19.00
20. 00	books, etc.) Vending machines		0		0.00	0	20.00
21. 00	Income from imposition of interest, finance or penalty		0		0. 00	0	21.00
22. 00	charges (chapter 21) Interest expense on Medicare		0		0. 00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
24 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24.00
24.00	therapy costs in excess of	H-0-3	0	FITTSI CAL THERAFT	00.00		24.00
25. 00			0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG &	1.00	0	
27. 00	COSTS-MVBLE EQUIP			*** Cost Center Deleted ***	2.00	0	
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19. 00 0. 00	0	28. 00 29. 00
	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00	O	30.00
30 00	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
JU. 77	instructions)			ALDIAINICS	30.00		30. 77

Heal th	Financial Systems		PULASKI MEMORI	IAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
	MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 10/01/2018		
					To 09/30/2019	Date/Time Pre	
				Evnence Classification or	Workshoot A	2/25/2020 4: 3	3 pm
				Expense Classification or To/From Which the Amount is			
				TO/FION WINCH THE AMOUNT IS	to be Aujusteu		
	Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	'	(2)				Ref.	
		1. 00	2. 00	3.00	4. 00	5. 00	
31.00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
	pathology costs in excess of						
	limitation (chapter 14)						
32.00		Α	-2, 801	NEW CAP REL COSTS-BLDG &	1.00	9	32.00
	Depreciation and Interest			FLXT			
33.00	INVEST INC/UNRESTRIC- INT EXP	В		NEW CAP REL COSTS-BLDG &	1.00	11	33.00
				FLXT			
	OTHER NONOPER REV	В	· ·	ADMINISTRATIVE & GENERAL	5. 00	0	0 00
35.00	OTHER SERVICES -OTHER REV	В		ADMINISTRATIVE & GENERAL	5. 00	0	35.00
36.00	POB/RENT INCOME	В		ADMINISTRATIVE & GENERAL	5. 00	0	36.00
37.00	CAFETERIA VENDING - OTHER REV	В		DI ETARY	10. 00	0	37.00
38.00		В		CENTRAL SERVICES & SUPPLY	14. 00	0	00.00
40.00	REBATES & REFUNDS - OTHER REV	В		CENTRAL SERVICES & SUPPLY	14. 00	0	40.00
43.00	MEDICAL RECORDS FEES -OTHER	В	-9, 349	MEDICAL RECORDS & LIBRARY	16. 00	0	43.00
	REV						
44.00		В		ADULTS & PEDI ATRI CS	30.00	0	
45.00	LAB REV	В		LABORATORY	60. 00	0	45.00
45. 01	EMPLOYEE RX PROGRAM -OTHER REV			DRUGS CHARGED TO PATIENTS	73. 00	0	45. 01
45. 02	OTHER REVENUE RHC- OTHER REV	В		RURAL HEALTH CLINIC	88. 00	0	45. 02
45. 03	1	A		OPERATION OF PLANT	7. 00	0	45. 03
45. 04	LOBBYING EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	45.04
45. 05	CRNA	A		ANESTHESI OLOGY	53. 00	0	45.05
45.06	HAF EXPENSE	Α		ADMINISTRATIVE & GENERAL	5. 00	0	45.06
45. 07	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	45. 07
FO 00	(3)		2 074 457				F0 00
50. 00	TOTAL (sum of lines 1 thru 49)		-2, 874, 457				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).

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.

| Peri od: | Worksheet A-8-2 | From 10/01/2018 | To 09/30/2019 | Date/Time Prepared:

West							0 09/30/2019	2/25/2020 4:3	
Identifier Remuneration Component Component Identifier Remuneration Component Identifier Remuneration Component Identifier Identifier Remuneration Remuneratio		Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount		
1.00							1102 711104111		
1.00									
2.00		1. 00	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	
3.00 90.00 CLINIC 36.000 0 36.000 0 0 3.00	1. 00	91. 00	EMERGENCY	1, 232, 616	0	1, 232, 616	0	0	1.00
3.00 90.00 CLINIC 36.000 0 36.000 0 0 3.00	2.00	60. 00	LABORATORY	5, 926	450	5, 476	0	0	2.00
S. 00	3. 00	90. 00	CLINIC			36,000	0	0	3.00
Continuing Con	4. 00	30. 00	ADULTS & PEDIATRICS	312, 326	312, 326	0	0	0	4.00
Continuing Con	5. 00	69. 00	ELECTROCARDI OLOGY	5, 719	5, 719	0	0	0	5.00
8.00	6. 00	30. 00	ADULTS & PEDIATRICS				0	0	6.00
9,00	7. 00	50. 00	OPERATING ROOM	409, 268	409, 268	0	0	0	7. 00
9,00				0	0	0	0	0	1
1.00		0. 00		0	0	0	0	0	9.00
Number Cost Center/Physician Cost Center/Physician Identifier Cost Center/P				0	0	0	0	0	1
Wkst. A Line # Cost Center/Physician I dentifier Linit Unadjusted RCE Linit Component Share of col. 12. Unit Component Share of col. Unit Component Unit Component Share of col. Unit Component Unit Component Unit				2, 114, 930	840, 838	1, 274, 092	_	0	1
Identifier		Wkst. A Line #	Cost Center/Physician				Provi der	Physician Cost	
1.00						Memberships &	Component		
1.00									
1.00									
2. 00 60. 00 LABORATORY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1. 00	2.00	8. 00	9. 00		13. 00	14.00	
3. 00	1. 00	91. 00	EMERGENCY	0	0	0	0	0	1.00
4. 00	2. 00	60. 00	LABORATORY	0	0	0	0	0	2.00
S. 00	3.00	90. 00	CLINIC	0	0	0	0	0	3.00
6. 00 30. 00 ADULTS & PEDIATRICS 0 0 0 0 0 0 0 0 0 7. 00 8. 00 9.	4.00	30. 00	ADULTS & PEDIATRICS	0	0	0	0	0	4.00
7.00	5. 00	69. 00	ELECTROCARDI OLOGY	0	0	0	0	0	5. 00
8.00	6. 00	30. 00	ADULTS & PEDIATRICS	0	0	0	0	0	6.00
9. 00	7. 00	50. 00	OPERATING ROOM	0	0	0	0	0	7.00
10.00	8. 00	0. 00		0	0	0	0	0	8.00
Number Cost Center/Physician Cost Center/Physician Identifier Component Share of col. 14	9. 00	0. 00		0	0	0	0	0	9.00
Wkst. A Line # Cost Center/Physician I dentifier Provider Component Share of col. 14	10.00	0. 00		0	0	0	0	0	10.00
Identifier Component Share of col. Li mi t Share	200.00			0	0	0	0	0	200.00
Identifier Component Share of col. Li mi t Share		Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
14			I denti fi er	Component	Limit	Di sal I owance	,		
1. 00 2. 00 15. 00 16. 00 17. 00 18. 00 1. 00 91. 00 EMERGENCY 0 0 0 0 0 1. 00 2. 00 60. 00 LABORATORY 0 0 0 450 2. 00 3. 00 90. 00 CLI NI C 0 0 0 0 0 3. 00 4. 00 30. 0ADULTS & PEDI ATRI CS 0 0 0 312, 326 4. 00 5. 00 69. 00 ELECTROCARDI OLOGY 0 0 0 5. 719 5. 00 6. 00 30. 00 ADULTS & PEDI ATRI CS 0 0 0 113, 075 6. 00 7. 00 50. 00 OPERATI NG ROOM 0 0 0 409, 268 7. 00 8. 00 0 0 0 0 0 9. 00 9. 00 0 0 0 0 9. 00 10. 00 0 0 0 0 9. 00				Share of col.					
1. 00 91. 00 EMERGENCY 0 0 0 0 0 1. 00 2. 00 60. 00 LABORATORY 0 0 0 450 2. 00 3. 00 90. 00 CLI NI C 0 0 0 0 0 3. 00 4. 00 30. 00 ADULTS & PEDI ATRI CS 0 0 0 312, 326 4. 00 5. 00 69. 00 ELECTROCARDI OLOGY 0 0 0 5, 719 5. 00 6. 00 30. 00 ADULTS & PEDI ATRI CS 0 0 0 113, 075 6. 00 7. 00 50. 00 OPERATI NG ROOM 0 0 0 409, 268 7. 00 8. 00 0. 00 0 0 0 0 9. 00 9. 00 0. 00 0 0 0 0 9. 00 10. 00 0 0 0 0 0 9. 00									
2. 00 60. 00 LABORATORY 0 0 450 2. 00 3. 00 90. 00 CLI NI C 0 0 0 0 3. 00 4. 00 30. 00 ADULTS & PEDI ATRI CS 0 0 0 312, 326 4. 00 5. 00 69. 00 ELECTROCARDI OLOGY 0 0 0 5, 719 5. 00 6. 00 30. 00 ADULTS & PEDI ATRI CS 0 0 0 113, 075 6. 00 7. 00 50. 00 OPERATI NG ROOM 0 0 0 409, 268 7. 00 8. 00 0. 00 0 0 0 0 8. 00 9. 00 0. 00 0 0 0 0 9. 00 10. 00 0. 00 0 0 0 0 0 0				15. 00	16. 00	17. 00			
3. 00 90. 00 CLINIC 0 0 0 0 3. 00 4. 00 30. 00 ADULTS & PEDIATRICS 0 0 0 0 312, 326 4. 00 5. 00 69. 00 ELECTROCARDI OLOGY 0 0 0 5, 719 5. 00 6. 00 30. 00 ADULTS & PEDIATRICS 0 0 0 113, 075 6. 00 7. 00 50. 00 OPERATING ROOM 0 0 0 409, 268 7. 00 8. 00 0 0 0 0 0 8. 00 9. 00 0 0 0 9. 00 9. 00 10. 00 0 0 0 0 10. 00 10. 00 10. 00 10. 00 10. 00		91. 00	EMERGENCY	0	0	0			1.00
4. 00 30. 00 ADULTS & PEDI ATRI CS 0 0 312, 326 4. 00 5. 00 69. 00 ELECTROCARDI OLOGY 0 0 5, 719 5. 00 6. 00 30. 00 ADULTS & PEDI ATRI CS 0 0 0 113, 075 6. 00 7. 00 50. 00 OPERATI NG ROOM 0 0 0 409, 268 7. 00 8. 00 0. 00 0 0 0 0 0 8. 00 9. 00 0. 00 0 0 0 0 9. 00 10. 00 0. 00 0 0 0 0 0 10. 00	2.00	60. 00	LABORATORY	0	0	0	450		2.00
5. 00 69. 00 ELECTROCARDI OLOGY 0 0 5,719 5. 00 6. 00 30. 00 ADULTS & PEDI ATRI CS 0 0 0 113,075 6. 00 7. 00 50. 00 OPERATI NG ROOM 0 0 0 409,268 7. 00 8. 00 0. 00 0 0 0 0 0 8. 00 9. 00 0. 00 0 0 0 0 9. 00 10. 00 0. 00 0 0 0 0 10. 00				0	0	0			3.00
6. 00 30. 00 ADULTS & PEDIATRICS 0 0 0 113, 075 6. 00 7. 00 50. 00 OPERATING ROOM 0 0 0 409, 268 7. 00 8. 00 0 0 0 0 0 8. 00 9. 00 0 0 0 9. 00 9. 00 10. 00 0 0 0 10. 00 10. 00	4. 00			0	0	0	312, 326		4.00
7. 00	5. 00	69. 00	ELECTROCARDI OLOGY	0	0	0			5.00
8. 00 0. 00 9. 00 0. 00 10. 00 0. 00	6. 00	30. 00	ADULTS & PEDIATRICS	0	0	0			6.00
9. 00 0. 00 0 0 0 0 9. 00 10. 00 0 10. 00 0 10. 00	7. 00	50. 00	OPERATING ROOM	0	0	0	409, 268		7.00
10.00 0.00 0 0 0 10.00	8. 00	0. 00		0	0	0	0		8.00
	9. 00			0	0	0	0		9. 00
200. 00 0 0 840, 838 200. 00		0. 00		0	0	0	0		
	200.00			0	0	0	840, 838		200.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 10/01/2018 | Part I | To 09/30/2019 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-1305

				T	o 09/30/2019		
			CAPI TAL			2/25/2020 4: 3	3 pm
			RELATED COSTS				
	Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMINISTRATIV	
		for Cost	FLXT	BENEFITS		E & GENERAL	
		Allocation		DEPARTMENT			
		(from Wkst A					
		col. 7)	1.00	4.00	4.4	F 00	
	GENERAL SERVICE COST CENTERS	0	1. 00	4. 00	4A	5. 00	
1. 00	00100 NEW CAP REL COSTS-BLDG & FLXT	1, 616, 320	1, 616, 320				1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	5, 610, 235	23, 856				4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	4, 437, 123	281, 611		5, 562, 785	5, 562, 785	5. 00
7.00	00700 OPERATION OF PLANT	881, 383	153, 224				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	66, 573		5, 217	85, 199	17, 263	8. 00
9.00	00900 HOUSEKEEPI NG	309, 690					9. 00
10.00	01000 DI ETARY	307, 046					1
13.00	01300 NURSI NG ADMI NI STRATI ON	428, 547	14, 411	130, 629			13.00
14. 00 15. 00	O1400 CENTRAL SERVI CES & SUPPLY O1500 PHARMACY	56, 966 0		13, 862			1
16. 00	01600 MEDICAL RECORDS & LIBRARY	386, 471	17, 262 35, 304				1
17. 00	01700 SOCIAL SERVICE	74, 031	0			19, 852	17.00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	74,031		25, 740	71, 711	17,032	17.00
30.00	03000 ADULTS & PEDIATRICS	1, 852, 655	194, 475	710, 157	2, 757, 287	558, 693	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0			0	31.00
43.00	04300 NURSERY	69, 499	3, 586	21, 073	94, 158	19, 079	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	570, 025	118, 142		· ·	198, 361	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	78, 071	13, 721	24, 295		23, 522	1
53.00	05300 ANESTHESI OLOGY	10, 978	690		,		1
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	1, 290, 166	107, 205			336, 834	54. 00 60. 00
60. 00	06001 BLOOD LABORATORY	1, 347, 184	31, 340 0			323, 357 0	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	68, 865	936			14, 143	1
65. 00	06500 RESPI RATORY THERAPY	343, 860		100, 218			
66.00	06600 PHYSI CAL THERAPY	1, 053, 113	39, 403				1
67.00	06700 OCCUPATI ONAL THERAPY	143, 911	0	46, 547	190, 458	38, 591	67.00
68.00	06800 SPEECH PATHOLOGY	79, 610	0				1
69.00	06900 ELECTROCARDI OLOGY	13, 484	0	1, 865			1
69. 01	06901 CARDI AC REHABI LI TATI ON	68, 300	9, 979				69. 01
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	352, 111	0	0		0 71, 346	70. 00 71. 00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	151, 715	0				1
73. 00	07300 DRUGS CHARGED TO PATIENTS	2, 195, 619	0	_			73.00
	03020 ONCOLOGY	146, 720				39, 818	1
	OUTPATIENT SERVICE COST CENTERS	·				·	
	08800 RURAL HEALTH CLINIC	4, 543, 161	228, 087				
88. 01	08801 RURAL HEALTH CLINIC II	660, 240					88. 01
88. 02	08802 RURAL HEALTH CLINIC III	249, 371	0	,			1
90.00	09000 CLINIC	321, 148		27, 968			90.00
91.00	09100 EMERGENCY	2, 334, 599	137, 208	322, 349		l	
92.00	O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS				0		92.00
101 00	10100 HOME HEALTH AGENCY	573, 515	17, 196	155, 445	746, 156	151, 189	101 00
101.00	SPECIAL PURPOSE COST CENTERS	070,010	17, 170	100, 110	7 10, 100	101, 107	101.00
116.00	11600 HOSPI CE	0	0	0	0	0	116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	32, 692, 305	1, 606, 274	5, 578, 178	32, 626, 346	5, 483, 731	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10, 046		· ·		190.00
	19001 HOMECARE	0	0	_		l e	190. 01
	19200 PHYSI CLANS' PRI VATE OFFI CES	159, 882	0	40, 658			192.00
	19201 KNOX RHC 07950 MARKETI NG	180 164, 132		15, 255	180 179, 387		192. 01 194. 00
200.00		104, 132		10, 200	179, 387	1	200.00
201.00			n	0	_	l .	201.00
202.00		33, 016, 499	1, 616, 320				
	,			•		•	

				To	09/30/2019	Date/Time Pre 2/25/2020 4:3	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	3 pili
	oust denter beschiptron	PLANT	LINEN SERVICE	HOUSEREEFFING	DIEMMI	ADMI NI STRATI O	
						N	
		7. 00	8. 00	9. 00	10.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT	1, 377, 397					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	12, 390					8. 00
9. 00	00900 HOUSEKEEPI NG	7, 595	ŀ	,			9. 00
10.00	01000 DI ETARY	61, 436	l e		608, 818		10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	13, 316	l e	4, 749	0	707, 874	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	18, 565		6, 621	0	0	14.00
15.00	01500 PHARMACY	15, 951	0	-,	0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	32, 622	0		0	0	16.00
17. 00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	17. 00
30. 00	03000 ADULTS & PEDIATRICS	179, 697	32, 513	64, 085	608, 818	400, 899	30.00
31.00	03100 INTENSIVE CARE UNIT	177,077	32, 313		008,818	400, 899	31.00
43. 00	04300 NURSERY	3, 314	2, 212		0		43.00
10.00	ANCILLARY SERVICE COST CENTERS	0,011	2,212	1, 102		11,702	10.00
50.00	05000 OPERATING ROOM	109, 164	22, 443	38, 931	0	78, 050	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	12, 678	0	4, 521	0	17, 077	52.00
53.00	05300 ANESTHESI OLOGY	638	0	228	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	99, 059	16, 131	35, 327	0	0	54.00
60.00	06000 LABORATORY	28, 958	350	10, 327	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	864	0		0	0	63.00
65. 00	06500 RESPI RATORY THERAPY	16, 115	0	-,	0	19, 327	65.00
66. 00	06600 PHYSI CAL THERAPY	48, 655	l ·		0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	·	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	1	0	0	68.00
69. 00 69. 01	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHABI LI TATI ON	9, 221	0	0 3, 288	0	0	69. 00 69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	9, 221	0	3, 200	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	Ö	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020 ONCOLOGY	11, 608	40	4, 140	0	49, 589	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	229, 648	582	81, 902	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	80, 350		28, 655	0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	33, 795	l		0	0	88. 02
90.00	09000 CLI NI C	37, 355	l		0	16, 395	90.00
91.00	09100 EMERGENCY	126, 782	19, 649	45, 214	0	111, 755	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
101 00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	15, 889	0	5, 666	0	0	101. 00
101.00	SPECIAL PURPOSE COST CENTERS	10,009	0	3, 666	0	0	101.00
116.00	11600 HOSPI CE	0	0	0	0	0	116. 00
118.00	1 1	1, 205, 665	113, 623	422, 849	608, 818		
	NONREI MBURSABLE COST CENTERS				·	·	
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	9, 282	0	3, 310	0	0	190. 00
	19001 HOMECARE	0	0	0	0		190. 01
	19200 PHYSI CI ANS' PRI VATE OFFI CES	162, 450	1, 229	42, 865	0		192.00
	19201 KNOX RHC	0	0	0	0		192. 01
	07950 MARKETING	0	0	0	0		194. 00 200. 00
200. 00 201. 00		_	_		0		200. 00 201. 00
201.00		1, 377, 397	114, 852	469, 024	608, 818		
202.00	, 1.01/12 (34m 11/103 110 till bugil 201)	1, 377, 377	1 117,002	1 707, 024	300, 010	101,014	_02.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1305

	2/25/2020 4:33 pm
Cost Center Description CENTRAL PHARMACY MEDICAL SOC	OCLAL Subtotal
	RVICE
SUPPLY LI BRARY	
	7. 00 24. 00
GENERAL SERVICE COST CENTERS 1. 00 OO100 NEW CAP REL COSTS-BLDG & FLXT	1.00
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	1.00
5. 00 00500 ADMINISTRATIVE & GENERAL	5.00
7. 00 00700 OPERATI ON OF PLANT	7.00
8.00 JOSBOO LAUNDRY & LINEN SERVICE	8.00
9. 00 00900 HOUSEKEEPI NG	9.00
10. 00 01000 DI ETARY	10.00
13.00 O1300 NURSING ADMINISTRATION	13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 134, 527	14.00
15. 00 01500 PHARMACY 0 42, 399	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 0 0 692, 084	16.00
17. 00 01700 SOCIAL SERVICE 0 0 0	117, 829 17. 00
INPATIENT ROUTINE SERVICE COST CENTERS	
30. 00 03000 ADULTS & PEDI ATRI CS 0 0 26, 759	109, 964 4, 738, 715 30. 00
31. 00 03100 I NTENSI VE CARE UNI T	0 31.00
43. 00 04300 NURSERY 0 0 1, 108	0 135, 835 43.00
ANCI LLARY SERVI CE COST CENTERS 0 05000 0PERATI NG ROOM 0 54, 135	7, 865 1, 487, 910 50. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 4, 814	0 178, 699 52. 00
53. 00 05300 ANESTHESI OLOGY	0 23, 018 53. 00
54. 00 05400 RADI 0L0GY-DI AGNOSTI C 0 145, 048	0 2, 294, 760 54. 00
60. 00 06000 LABORATORY 0 131, 445	0 2,090,284 60.00
60. 01 06001 BLOOD LABORATORY 0 0	0 60.01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 2,714	0 87, 830 63. 00
65. 00 06500 RESPI RATORY THERAPY 0 0 13, 546	0 609, 769 65. 00
66. 00 06600 PHYSI CAL THERAPY 0 31, 393	0 1, 828, 356 66. 00
67. 00 06700 0CCUPATI ONAL THERAPY 0 0 4, 859	0 233, 908 67. 00
68. 00 06800 SPEECH PATHOLOGY 0 1, 702	0 126, 490 68. 00
69. 00 06900 ELECTROCARDI OLOGY 0 5, 612	0 24, 071 69. 00
69. 01 06901 CARDI AC REHABI LI TATI ON 0 2, 016	0 134, 161 69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0 0 70.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 119, 840 0 23, 604 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 14, 687 0 2, 893	0 566, 901 71. 00 0 200, 036 72. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 14, 687 0 2, 893 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 42, 399 104, 166	0 200, 036 72. 00 0 2, 796, 575 73. 00
76. 00 03020 0NCOLOGY	0 303, 904 76. 00
OUTPATIENT SERVICE COST CENTERS	0 303, 704 70.00
88. 00 08800 RURAL HEALTH CLINIC 0 49, 201	0 7, 725, 203 88. 00
88. 01 08801 RURAL HEALTH CLINIC II 0 0 7, 009	0 1, 127, 288 88. 01
88. 02 08802 RURAL HEALTH CLINIC III 0 0 2, 312	0 428, 848 88. 02
90. 00 09000 CLI NI C 0 0 8, 047	0 543, 593 90. 00
91. 00 09100 EMERGENCY 0 50, 636	0 3, 714, 355 91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS	
101. 00 10100 HOME HEALTH AGENCY 0 0 8, 747	0 927, 647 101. 00
SPECIAL PURPOSE COST CENTERS 116.00 11600 HOSPI CF 0 0 0	0 116 00
116.00 11600 10321CE	0 0 110.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 134, 527 42, 399 692, 084 NONREI MBURSABLE COST CENTERS	117, 829 32, 328, 156 118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0	0 24, 674 190. 00
190. 0119001 HOMECARE 0 0	0 0 190.01
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0	0 447, 718 192. 00
192. 01 19201 KNOX RHC 0 0 0	0 216 192. 01
194. 00 07950 MARKETI NG 0 0 0	0 215, 735 194. 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) 134,527 42,399 692,084	117, 829 33, 016, 499 202. 00

Health Financial Systems PULASKI MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1305 Period: Worksheet B

From 10/01/2018 Part I 09/30/2019 Date/Time Prepared: 2/25/2020 4:33 pm Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 4, 738, 715 30.00 03100 INTENSIVE CARE UNIT 31.00 0 31.00 C 04300 NURSERY 135, 835 43.00 43.00 0 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0 1, 487, 910 50.00 05200 DELIVERY ROOM & LABOR ROOM 0000000000000000 52.00 178.699 52.00 05300 ANESTHESI OLOGY 23, 018 53.00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 2, 294, 760 54.00 06000 LABORATORY 60.00 2, 090, 284 60.00 60 01 06001 BLOOD LABORATORY Ω 60 01 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 87,830 63.00 65. 00 06500 RESPIRATORY THERAPY 609, 769 65.00 06600 PHYSI CAL THERAPY 66.00 1,828,356 66.00 06700 OCCUPATI ONAL THERAPY 67 00 233, 908 67 00 06800 SPEECH PATHOLOGY 68.00 126, 490 68.00 24, 071 06900 ELECTROCARDI OLOGY 69.00 69.00 69.01 06901 CARDIAC REHABILITATION 134, 161 69.01 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 566, 901 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 200,036 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 796, 575 73.00 03020 ONCOLOGY 0 303, 904 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 7, 725, 203 88.00 08801 RURAL HEALTH CLINIC II 0 1, 127, 288 88.01 88.01 08802 RURAL HEALTH CLINIC III 88.02 428, 848 88 02 90.00 09000 CLI NI C 0 543, 593 90.00 09100 EMERGENCY 0 91.00 3, 714, 355 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 927, 647 101.00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 0 116,00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 32, 328, 156 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 24,674 190.00 190. 01 19001 HOMECARE 0 r 190.01 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 447, 718 192.00 0 0 0 192. 01 19201 KNOX RHC 216 192.01 194. 00 07950 MARKETI NG 194. 00 215, 735 200.00 Cross Foot Adjustments C 200.00 Negative Cost Centers 0 201.00 201.00 33, 016, 499 202.00 TOTAL (sum lines 118 through 201) 202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-1305

				Τ̈́	o 09/30/2019		
			CAPI TAL			2/25/2020 4: 3	3 pm
			RELATED COSTS				
	Cost Center Description	Di rectly	NEW BLDG &	Subtotal	EMPLOYEE	ADMINISTRATIV	
	'	Assigned New	FLXT		BENEFI TS	E & GENERAL	
		Capi tal			DEPARTMENT		
		Related Costs					
		0	1.00	2A	4. 00	5. 00	
	AL SERVICE COST CENTERS						
	NEW CAP REL COSTS-BLDG & FIXT			00.05/	00.05/		1.00
	EMPLOYEE BENEFITS DEPARTMENT	0	23, 856			1	4.00
4	ADMINISTRATIVE & GENERAL	0	281, 611				5.00
4	OPERATION OF PLANT	0	153, 224				7.00
4	LAUNDRY & LINEN SERVICE HOUSEKEEPING	0	13, 409			885	8. 00 9. 00
	DIETARY	0	8, 219 66, 488				10.00
4	NURSING ADMINISTRATION	0	14, 411				13. 00
4	CENTRAL SERVICES & SUPPLY	0	20, 091	20, 091		944	14.00
	PHARMACY	0	17, 262			179	15. 00
4	MEDICAL RECORDS & LIBRARY	0	35, 304		_		16. 00
	SOCI AL SERVI CE	0	0			1, 018	17. 00
	TENT ROUTINE SERVICE COST CENTERS					,	
	ADULTS & PEDIATRICS	0	194, 475	194, 475	3, 007	28, 643	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	C	0	0	31.00
43.00 04300	NURSERY	0	3, 586	3, 586	89	978	43.00
	LARY SERVICE COST CENTERS						
	OPERATING ROOM	0				10, 169	50.00
	DELIVERY ROOM & LABOR ROOM	0	13, 721	13, 721			52.00
	ANESTHESI OLOGY	0	690				53.00
	RADI OLOGY-DI AGNOSTI C	0	107, 205				54.00
	LABORATORY	0	31, 340				60.00
	BLOOD LABORATORY	0	0 936	-		0	60. 01
	BLOOD STORING, PROCESSING & TRANS. RESPIRATORY THERAPY	0	17, 441	17, 441		725 4, 794	63. 00 65. 00
	PHYSI CAL THERAPY	0	39, 403				66.00
	OCCUPATIONAL THERAPY	0	0 37, 403			1, 978	67.00
	SPEECH PATHOLOGY	0	0	1		1, 078	68. 00
	ELECTROCARDI OLOGY	0	0		_	159	69.00
	CARDI AC REHABI LI TATI ON	0	9, 979			1, 033	69. 01
	ELECTROENCEPHALOGRAPHY	0	0	l .,		0	70.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	l c	0	3, 658	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	1, 576	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	C	33	22, 890	73.00
	ONCOLOGY	0	12, 563	12, 563	158	2, 041	76. 00
	TIENT SERVICE COST CENTERS						
	RURAL HEALTH CLINIC	0			1	63, 606	88. 00
	RURAL HEALTH CLINIC II	0	0			8, 726	88. 01
	RURAL HEALTH CLINIC III	0	0	10 10		3, 288	88. 02
	CLINIC	0	40, 427				90.00
	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	0	137, 208	137, 208		29, 026	91. 00 92. 00
	REIMBURSABLE COST CENTERS				,		92.00
	HOME HEALTH AGENCY	0	17, 196	17, 196	658	7 751	101. 00
	AL PURPOSE COST CENTERS		17, 170	17,170	, 030	7,731	101.00
116. 00 11600	HOSPI CF	0	0	С	0	0	116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0	l e				
	I MBURSABLE COST CENTERS		,			,	
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10, 046	10, 046	0	104	190.00
190. 01 19001		0	0			o l	190. 01
	PHYSICIANS' PRIVATE OFFICES	0	0	C	172	2, 083	192. 00
192. 01 19201		0	0	C	0	1	192. 01
194.00 07950		0	0	C	65		194. 00
200. 00	Cross Foot Adjustments			C			200. 00
201. 00	Negative Cost Centers		0	C	_		201. 00
202. 00	TOTAL (sum lines 118 through 201)	0	1, 616, 320	1, 616, 320	23, 856	285, 185	202.00

Provider CCN: 15-1305

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 10/01/2018 Part II
To 09/30/2019 Date/Time Prepared: 2/25/2020 4:33 pm

				0 97 307 2019	2/25/2020 4: 3	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	- Ja
	PLANT	LINEN SERVICE			ADMI NI STRATI O	
					N	
	7. 00	8. 00	9.00	10.00	13.00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 NEW CAP REL COSTS-BLDG & FLXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT	165, 591					7.00
8. 00 00800 LAUNDRY & LINEN SERVICE	1, 490	15, 806				8.00
9. 00 00900 HOUSEKEEPI NG	913		13, 396			9. 00
10. 00 01000 DI ETARY	7, 386		626	79, 307		10.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	1, 601	0	136	0	22, 659	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	2, 232	0	189	0	0	14.00
15. 00 01500 PHARMACY	1, 918		162	0	Ö	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	3, 922		332	0	Ö	16. 00
17. 00 01700 SOCI AL SERVI CE	0, 722		0	0		17. 00
INPATIENT ROUTINE SERVICE COST CENTERS			<u> </u>			17.00
30. 00 03000 ADULTS & PEDIATRICS	21, 603	4, 475	1, 830	79, 307	12, 833	30.00
31. 00 03100 NTENSI VE CARE UNI T	21,009		1, 030	77, 307	12,033	31.00
43. 00 04300 NURSERY	398		34	0		43. 00
ANCI LLARY SERVI CE COST CENTERS	370	304] 34		473	43.00
50. 00 05000 OPERATING ROOM	13, 124	3, 089	1, 112	0	2, 498	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 524	0,007	129	0	1	52.00
53. 00 05300 ANESTHESI OLOGY	77	0	6	0	0	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	11, 909	2, 220		0	ĺ	54.00
60. 00 06000 LABORATORY	3, 481	48		0	ĺ	60.00
60. 01 06001 BLOOD LABORATORY	0, 401		0	0	ĺ	60. 01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	104	0	9	0	Ö	63.00
65. 00 06500 RESPIRATORY THERAPY	1, 937	0	164	0	619	65.00
66. 00 06600 PHYSI CAL THERAPY	5, 849	2, 568		0	017	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	3, 047	2, 300	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	1, 108	0	94	0	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 100	0	0	0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	ĺ	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
76. 00 03020 0NC0L0GY	1, 396	6	118	0		76.00
OUTPATIENT SERVICE COST CENTERS	1, 370		110		1,307	70.00
88. 00 08800 RURAL HEALTH CLINIC	27, 607	80	2, 341	0	0	88. 00
88. 01 08801 RURAL HEALTH CLINIC II	9, 660			0	Ö	88. 01
88. 02 08802 RURAL HEALTH CLINIC III	4, 063		344	0	0	88. 02
90. 00 09000 CLINIC	4, 491	0	380	0	525	90.00
91. 00 09100 EMERGENCY	15, 242	2, 704	1, 291	0	3, 577	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	15, 242	2, 704	1, 271	O	3,377	92.00
OTHER REIMBURSABLE COST CENTERS						72.00
101. 00 10100 HOME HEALTH AGENCY	1, 910	0	162	0	0	101.00
SPECIAL PURPOSE COST CENTERS	1, 710		102			101.00
116. 00 11600 HOSPI CE	0	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	144, 945			79, 307		
NONREI MBURSABLE COST CENTERS	111,710	10,007	12,077	77,007	22,007	110.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	1, 116	0	95	0	0	190. 00
190. 01 19001 HOMECARE	0	0		0		190. 01
192.00 19200 PHYSICIANS' PRIVATE OFFICES	19, 530	_	1	0		192.00
192. 01 19201 KNOX RHC	17,550	1 0	1, 224	0		192. 01
194. 00 07950 MARKETI NG			n	0	l e	194. 00
200.00 Cross Foot Adjustments				O		200.00
201.00 Negative Cost Centers	0	0	n	0		201.00
202.00 TOTAL (sum lines 118 through 201)	165, 591	15, 806	13, 396	79, 307		
[.00,071			, 501	1 22,007	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1305

				To	09/30/2019	Date/Time Pre 2/25/2020 4:3	
	Cost Center Description	CENTRAL SERVI CES &	PHARMACY	MEDI CAL RECORDS &	SOCI AL SERVI CE	Subtotal	ээ рш
		SUPPLY 14. 00	15. 00	LI BRARY 16. 00	17. 00	24.00	
	GENERAL SERVICE COST CENTERS			10.00	171.00	21100	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
13. 00	01300 NURSING ADMINISTRATION						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	23, 515					14.00
15.00	01500 PHARMACY	0	19, 521				15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		4 440		16.00
17. 00	01700 SOCI AL SERVI CE	0	0	0	1, 119		17. 00
20 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	O	0	1 744	1 044	240 002	20.00
30. 00 31. 00	03100 INTENSIVE CARE UNIT		0		1, 044 0	348, 983 0	
	04300 NURSERY		0		0	-	1
.0.00	ANCILLARY SERVICE COST CENTERS	<u> </u>			<u> </u>	0,700	10.00
50.00	05000 OPERATING ROOM	0	0	3, 572	75	153, 012	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	318	0	17, 548	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0		1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	9, 550	0	150, 284	1
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	0	8, 674 0	0	61, 336 0	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	179	0	1, 953	1
65. 00	06500 RESPIRATORY THERAPY		0	894	0	26, 273	1
66.00	06600 PHYSI CAL THERAPY	O	0	2, 072	0	66, 581	1
67.00	06700 OCCUPATI ONAL THERAPY	O	0	321	0	2, 496	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	112	0	1, 292	1
69. 00	06900 ELECTROCARDI OLOGY	0	0	370	0	537	1
69. 01	06901 CARDI AC REHABI LI TATI ON	0	0	133	0	12, 437	1
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	20, 948	0	0 1, 558	0	0 26, 164	
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	2, 567	0	1, 556	0		1
73. 00	07300 DRUGS CHARGED TO PATIENTS	2,007	19, 521	6, 874	ő		1
	03020 ONCOLOGY	0	0		0		1
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0		0		1
88. 01	08801 RURAL HEALTH CLINIC II	0	0	462	0	20, 566	1
88. 02 90. 00	08802 RURAL HEALTH CLINIC III 09000 CLINIC	0	0	153	0	8, 136	1
90.00	09100 EMERGENCY	0	0	531 3, 341	0	50, 519 193, 754	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		O	3, 341	O I	173, 734	92.00
72.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>					72.00
101.00	10100 HOME HEALTH AGENCY	0	0	577	0	28, 254	101.00
	SPECIAL PURPOSE COST CENTERS						
	11600 HOSPI CE	0	0		0		116. 00
118.00		23, 515	19, 521	45, 649	1, 119	1, 579, 851	1118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				٥	11 241	190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1	0		190.00
	19200 PHYSICIANS' PRIVATE OFFICES		0		0		192.00
	19201 KNOX RHC	l ől	0	Ö	ő		192.01
	07950 MARKETI NG	o	0	0	o	1, 928	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	23, 515	19, 521	45, 649	1, 119	1, 616, 320	202.00

Health Financial Systems PULASKI MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1305 Period: Worksheet B

From 10/01/2018 Part II 09/30/2019 Date/Time Prepared: 2/25/2020 4:33 pm Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 25. 00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 348, 983 30.00 03100 INTENSIVE CARE UNIT 0 31.00 C 31.00 04300 NURSERY 0 5, 935 43.00 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0 153, 012 50.00 05200 DELIVERY ROOM & LABOR ROOM 0000000000000000 52.00 17.548 52.00 05300 ANESTHESI OLOGY 1, 430 53.00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 150, 284 54.00 06000 LABORATORY 60.00 61, 336 60.00 60 01 06001 BLOOD LABORATORY Ω 60 01 06300 BLOOD STORING, PROCESSING & TRANS. 1, 953 63.00 63.00 65. 00 06500 RESPIRATORY THERAPY 26, 273 65.00 06600 PHYSI CAL THERAPY 66.00 66, 581 66.00 06700 OCCUPATI ONAL THERAPY 67 00 2.496 67 00 06800 SPEECH PATHOLOGY 68.00 1, 292 68.00 06900 ELECTROCARDI OLOGY 537 69.00 69.00 69.01 06901 CARDIAC REHABILITATION 12, 437 69.01 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 26, 164 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 4, 334 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 49, 318 73.00 03020 ONCOLOGY 0 18,014 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 330, 695 88.00 0 08801 RURAL HEALTH CLINIC II 88.01 20, 566 88.01 08802 RURAL HEALTH CLINIC III 88.02 8, 136 88 02 90.00 09000 CLI NI C 0 50, 519 90.00 09100 EMERGENCY 0 91.00 193, 754 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 28, 254 101.00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 0 116,00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 1, 579, 851 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 00 11, 361 190.00 190. 01 19001 HOMECARE 190.01 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 23, 178 192.00 00000 192. 01 19201 KNOX RHC 192.01 194. 00 07950 MARKETI NG 194. 00 1.928 200.00 Cross Foot Adjustments C 200.00 Negative Cost Centers 201.00 201.00 202.00 TOTAL (sum lines 118 through 201) 202.00 1,616,320

	LLOCATION - STATISTICAL BASIS	TOLASKI WEWOKI	Provi der C	CN: 15-1305 F	Peri od:	Worksheet B-1	
				T	rom 10/01/2018 o 09/30/2019	Date/Time Pre	pared:
		CAPI TAL				2/25/2020 4: 3	3 pm
	Cost Center Description	NEW BLDG & FIXT	EMPLOYEE BENEFITS	Reconciliatio n	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT	
		(SQUARE FEET)	DEPARTMENT (GROSS		(ACCUM. COST)	(SQUARE FEET)	
		1. 00	4. 00	5A	5. 00	7. 00	
4 00	GENERAL SERVICE COST CENTERS	70.5/5					1 00
1. 00 4. 00	OO100 NEW CAP REL COSTS-BLDG & FIXT OO400 EMPLOYEE BENEFITS DEPARTMENT	72, 565 1, 071	17, 323, 211				1. 00 4. 00
5. 00	00500 ADMINI STRATI VE & GENERAL	12, 643	2, 595, 210		27, 453, 714		5.00
7.00	00700 OPERATION OF PLANT	6, 879	340, 428			66, 924	1
8.00	00800 LAUNDRY & LI NEN SERVI CE	602	16, 040	1		602	
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	369 2, 985	202, 243 194, 950			369 2, 985	1
	01300 NURSING ADMINISTRATION	647	401, 647			2, 483	1
	01400 CENTRAL SERVICES & SUPPLY	902	42, 621			902	
	01500 PHARMACY	775	0	1		775	1
	01600 MEDI CAL RECORDS & LI BRARY	1, 585	359, 446				
17. 00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	73, 626) <u> </u>	97, 977	0	17. 00
30.00	03000 ADULTS & PEDIATRICS	8, 731	2, 183, 526	C	2, 757, 287	8, 731	30.00
	03100 INTENSIVE CARE UNIT	0	0	1 ~		0	
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	161	64, 794	· C	94, 158	161	43.00
50. 00	05000 OPERATING ROOM	5, 304	894. 106	, C	978, 961	5, 304	50.00
	05200 DELIVERY ROOM & LABOR ROOM	616	74, 699			616	1
53.00	05300 ANESTHESI OLOGY	31	0	1	,	31	1
	05400 RADI OLOGY-DI AGNOSTI C	4, 813	814, 768	1		4, 813	1
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	1, 407	668, 205 0	1		1, 407 0	1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	42	0		_	42	1
65.00	06500 RESPIRATORY THERAPY	783	308, 140		461, 519	783	65.00
	06600 PHYSI CAL THERAPY	1, 769	1, 018, 597				1
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	143, 117 74, 262	1	,	0	
69. 00	06900 ELECTROCARDI OLOGY		5, 733	1		0	1
69. 01	06901 CARDI AC REHABI LI TATI ON	448	65, 183	1		448	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	C		0	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			0	
73.00	07300 DRUGS CHARGED TO PATIENTS		24, 303			0	1
	03020 ONCOLOGY	564	114, 465			564	1
	OUTPATIENT SERVICE COST CENTERS	10.040		1		44.450	
88. 00 88. 01	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II	10, 240	4, 156, 776 552, 859			11, 158 3, 904	88. 00 88. 01
	08802 RURAL HEALTH CLINIC III		206, 475				88. 02
	09000 CLI NI C	1, 815	85, 995	c c	389, 543		90.00
	09100 EMERGENCY	6, 160	991, 129	C	2, 794, 156	6, 160	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
101. 00	10100 HOME HEALTH AGENCY	772	477, 949	C	746, 156	772	101.00
	SPECIAL PURPOSE COST CENTERS						1
	11600 HOSPI CE	72 114	17 151 202				116. 00 118. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	72, 114	17, 151, 292	-5, 562, 785	27, 063, 561	38, 380]118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	451	0) C	10, 046	451	190. 00
	19001 HOMECARE	0	0	0	-		190. 01
	19200 PHYSICIANS' PRIVATE OFFICES 19201 KNOX RHC	0	125, 013	C	200, 540 180		192. 00 192. 01
	07950 MARKETI NG		46, 906		179, 387		194.00
200. 00			,			_	200.00
201.00	3						201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	1, 616, 320	5, 634, 091		5, 562, 785	1, 377, 397	202.00
203. 00		22. 274099	0. 325234		0. 202624	20. 581510	203. 00
204.00			23, 856	1	285, 185	165, 591	
	Part II)		0 004077		0.010000		
205. 00	Unit cost multiplier (Wkst. B, Part		0. 001377	1	0. 010388	2. 474314	205.00
206. 00	NAHE adjustment amount to be allocated						206. 00
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207. 00
, ,	Parts III and IV)			1			

	FINANCIAL SYSTEMS	PULASKI WEWUKI		N 45 4005 D		u or Form CMS	
COST A	LLOCATION - STATISTICAL BASIS		Provi der Co	F	eriod: rom 10/01/2018 o 09/30/2019	Worksheet B-1 Date/Time Pre	
						2/25/2020 4: 3	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	CENTRAL SERVICES &	
		LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(MEALS SERVED)	ADMI NI STRATI O N	SUPPLY	
		LAUNDRY)		02.1125)	(DI RECT	(100%)	
		·			NRSI NG HRS)		
	OFNEDAL CEDITION OF COST OFNITEDS	8. 00	9. 00	10.00	13. 00	14. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE	119, 121	,,,,,,,				8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	63, 900 2, 985	100			9.00
13. 00	01300 NURSING ADMINISTRATION	0	2, 903	0	78, 968		13. 00
	01400 CENTRAL SERVI CES & SUPPLY	o o	902	Ö	0	2, 519, 433	1
15.00	01500 PHARMACY	0	775	0	O	0	15. 00
	01600 MEDICAL RECORDS & LIBRARY	0	1, 585	0	0	0	
17. 00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	17. 00
30.00	03000 ADULTS & PEDIATRICS	33, 720	8, 731	100	44, 723	0	30.00
31. 00	03100 I NTENSI VE CARE UNI T	0	0	0		0	1
43.00	04300 NURSERY	2, 294	161	0	1, 649	0	43.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	23, 277	5, 304			0	
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	616	0	1, 905 0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	16, 731	4, 813	Ö	Ö	0	1
60.00	06000 LABORATORY	363	1, 407	Ō	Ö	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	O	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	42	0	0	0	63.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	19, 356	783	0	2, 156	0	65. 00 66. 00
	06700 OCCUPATI ONAL THERAPY	19, 330	2, 364	0	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	o o	ő	ő	o	0	1
69.00	06900 ELECTROCARDI OLOGY	0	0	0	o	0	69. 00
69. 01	06901 CARDI AC REHABI LI TATI ON	0	448	0	0	0	
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	2, 244, 377 275, 056	
	07300 DRUGS CHARGED TO PATIENTS	o o	ő	ő	o	0	73.00
76.00	03020 ONCOLOGY	42	564	0	5, 532	0	76.00
00.00	OUTPATIENT SERVICE COST CENTERS	(0.4	44.450		٥		00.00
88. 00 88. 01	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II	604 1, 049	11, 158 3, 904			0	
88. 02	08802 RURAL HEALTH CLINIC III	31	1, 642		0	0	
90.00	09000 CLI NI C	0	1, 815	Ō	1, 829	0	1
	09100 EMERGENCY	20, 379	6, 160	0	12, 467	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
101 00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0	772	0	ol	0	101.00
101.00	SPECIAL PURPOSE COST CENTERS	0	112	0	U	0	1101.00
116.00	11600 HOSPI CE	0	0	0	0	0	116.00
118. 00	, ,	117, 846	57, 609	100	78, 968	2, 519, 433	118. 00
100.00	NONREI MBURSABLE COST CENTERS		451		٥		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 HOMECARE	0	451	0 0			190. 00 190. 01
	19200 PHYSICIANS' PRIVATE OFFICES	1, 275	5, 840		0		192.00
	19201 KNOX RHC	0	0	Ō	Ö		192. 01
	07950 MARKETI NG	0	0	0	0	0	194. 00
200.00							200.00
201. 00 202. 00	1 1	114, 852	469, 024	608, 818	707, 874	134, 527	201.00
202.00	Part 1)	114,032	407, 024	000, 010	707, 074	134, 327	202.00
203.00		0. 964162	7. 339969	6, 088. 180000	8. 964061	0. 053396	203.00
204.00	1 7	15, 806	13, 396	79, 307	22, 659	23, 515	204. 00
205 00	Part II)	0.122/00	0.200740	702 070000	0.204020	0.000000	205 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 132689	0. 209640	793. 070000	0. 286939	0. 009333	200.00
206.00	NAHE adjustment amount to be allocated						206. 00
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207. 00
201.00	Parts III and IV)						207.00

PULASKI MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | From 10/01/2018 | To 09/30/2019 | Date/Time Prepared: Provider CCN: 15-1305

				To	09/30/2019 Date/Time F 2/25/2020 4	
	Cost Center Description	PHARMACY	MEDI CAL	SOCI AL	27 207 2020	1. 00 piii
		(100%)	RECORDS &	SERVI CE		
			LI BRARY (GROSS	(ALLOCATION OF TIME)		
			CHARGES)	OI IIWL)		
		15. 00	16. 00	17. 00		
	ENERAL SERVICE COST CENTERS					1 00
	0100 NEW CAP REL COSTS-BLDG & FIXT 0400 EMPLOYEE BENEFITS DEPARTMENT					1.00 4.00
1	0500 ADMINISTRATIVE & GENERAL					5. 00
7.00 0	0700 OPERATION OF PLANT					7. 00
	0800 LAUNDRY & LINEN SERVICE					8. 00
	0900 HOUSEKEEPI NG 1000 DI ETARY					9. 00 10. 00
	1300 NURSING ADMINISTRATION					13.00
	1400 CENTRAL SERVICES & SUPPLY					14.00
	1500 PHARMACY	100				15. 00
1	1600 MEDI CAL RECORDS & LI BRARY	0	65, 805, 098			16.00
	1700 SOCIAL SERVICE NPATIENT ROUTINE SERVICE COST CENTERS	0	0	9, 888		17. 00
	3000 ADULTS & PEDI ATRI CS	0	2, 544, 339	9, 228		30.00
	3100 INTENSIVE CARE UNIT	0	0	_		31.00
	4300 NURSERY	0	105, 386	0		43. 00
	NCILLARY SERVICE COST CENTERS 5000 OPERATING ROOM	0	5, 147, 352	660		50.00
	5200 DELIVERY ROOM & LABOR ROOM	o	457, 711			52.00
	5300 ANESTHESI OLOGY	0	772, 129			53.00
1	5400 RADI OLOGY-DI AGNOSTI C	0	13, 790, 810			54.00
	6000 LABORATORY	0	12, 498, 302			60.00
	6001 BLOOD LABORATORY 6300 BLOOD STORING, PROCESSING & TRANS.	0	0 258, 045			60. 01 63. 00
1	6500 RESPI RATORY THERAPY	o	1, 287, 989			65. 00
66.00 0	6600 PHYSI CAL THERAPY	0	2, 984, 992			66. 00
	6700 OCCUPATI ONAL THERAPY	0	461, 996			67. 00
1	6800 SPEECH PATHOLOGY 6900 ELECTROCARDI OLOGY	0	161, 824 533, 602			68. 00 69. 00
1	6901 CARDI AC REHABILITATION	0	191, 719			69. 01
	7000 ELECTROENCEPHALOGRAPHY	0	0			70.00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 244, 377			71. 00
	7200 I MPL. DEV. CHARGED TO PATIENTS	0	275, 056			72.00
	7300 DRUGS CHARGED TO PATIENTS 3020 ONCOLOGY	100	9, 904, 506 208, 955			73. 00 76. 00
	UTPATIENT SERVICE COST CENTERS	<u> </u>	200, 733	J 0 ₁		70.00
88. 00 0	8800 RURAL HEALTH CLINIC	0	4, 678, 204	0		88. 00
	8801 RURAL HEALTH CLINIC II	0	666, 421	0		88. 01
	8802 RURAL HEALTH CLINIC III 9000 CLINIC	0	219, 824	0		88. 02 90. 00
	9100 EMERGENCY	0	765, 111 4, 814, 712			90.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	<u> </u>	1,011,712			92.00
	THER REIMBURSABLE COST CENTERS	-1				
	0100 HOME HEALTH AGENCY PECIAL PURPOSE COST CENTERS	0	831, 736	0		101.00
	1600 HOSPI CE	0	0	0		116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	100	65, 805, 098	9, 888		118. 00
	ONREI MBURSABLE COST CENTERS					100.00
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 9001 HOMECARE	0	0			190. 00 190. 01
	9200 PHYSI CI ANS' PRI VATE OFFI CES	0	0			192. 00
192. 01 1	9201 KNOX RHC	0	0	0		192. 01
	7950 MARKETI NG	0	0	0		194. 00
200.00	Cross Foot Adjustments					200. 00 201. 00
201. 00 202. 00	Negative Cost Centers Cost to be allocated (per Wkst. B,	42, 399	692, 084	117, 829		201.00
202.00	Part I)	12, 377	372, 304	117,027		
203. 00	Unit cost multiplier (Wkst. B, Part I)	423. 990000	0. 010517			203. 00
204.00	Cost to be allocated (per Wkst. B,	19, 521	45, 649	1, 119		204. 00
205. 00	Part II) Unit cost multiplier (Wkst. B, Part	195. 210000	0. 000694	0. 113167		205. 00
200.00	II)	175. 210000	0. 000074	0.113107		200.00
206. 00	NAHE adjustment amount to be allocated					206. 00
207.00	(per Wkst. B-2)					207.00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207. 00
Ţ	,	Ţ				1

Health Financial Systems	PULASKI MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1305	Peri od: Worksheet C From 10/01/2018 Part I To 09/30/2019 Date/Time Prepared:

Title XVIII
Total Cost Center Description Total Cost Cfrom Wkst. R. Part I. Col. 26) Disal I owance Disa
NPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 30.00 3
B, Part I, col . 26) 1.00 2.00 3.00 4.00 5.00
INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00
INPATIENT ROUTI NE SERVICE COST CENTERS 1,00 2,00 3,00 4,00 5,00 5,00
NPATIENT ROUTINE SERVICE COST CENTERS 4,738,715 0 0 0 30.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
30. 00 03000 ADULTS & PEDIATRICS 4,738,715 0 0 30. 00 31. 00 31. 00 30. 00 1 NTENSI VE CARE UNIT 0 0 0 0 0 31. 00 31. 00 31. 00 0 0 0 0 0 0 31. 00 0 0 0 0 0 0 0 0 0
31.00 03100 INTENSIVE CARE UNIT 0 135,835 0 0 0 31.00
43.00 04300 NURSERY 135, 835 135, 835 0 0 0 43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OFERATI NG ROOM 1, 487, 910 1, 487, 910 0 0 50. 00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 178, 699 178, 699 0 0 52. 00 53. 00 05300 ANESTHESI OLOGY 23, 018 23, 018 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 2, 294, 760 0 0 54. 00 60. 00 06000 LABORATORY 2, 090, 284 2, 090, 284 0 0 60. 00 60. 01 06001 BLOOD LABORATORY 0 0 0 0 60. 01 63. 00 06300 BLOOD STORI NG PROCESSI NG & TRANS. 87, 830 87, 830 0 0 63. 00 65. 00 06500 RESPI RATORY THERAPY 609, 769 0 609, 769 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 1, 828, 356 0 1, 828, 356 0 0 67. 00 66. 00 06600 SPEECH PATHOLOGY 126, 490 0 126, 490 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 24, 071 24, 071 0 0 69. 00 69. 01 06901 CARDI AC REHABI LITATI ON 134, 161 134, 161 0 0 69. 01 70. 00 07000 ELECTROCEPHALOGRAPHY 0 0 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 566, 901 566, 901 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 200, 036 200, 036 0 0 72. 00 76. 00 03020 ONCOLOGY 303, 904 303, 904 0 0 76. 00 76. 00 03020 ONCOLOGY 303, 904 303, 904 0 0 76. 00 76. 00 03020 ONCOLOGY 303, 904 303, 904 0 0 76. 00 76. 00 03020 ONCOLOGY 303, 904 303, 904 0 0 76. 00 77. 00 07000 0000000000000000000000000
50. 00 05000 OPERATI NG ROOM 1, 487, 910 0 0 50. 00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 178, 699 0 0 52. 00 53. 00 05300 ANESTHESI OLOGY 23, 018 23, 018 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 2, 294, 760 2, 294, 760 0 0 54. 00 60. 00 06000 LABORATORY 2, 090, 284 2, 090, 284 0 0 60. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 87, 830 87, 830 0 0 63. 00 65. 00 06500 RESPI RATORY THERAPY 609, 769 0 609, 769 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 1, 828, 356 0 1, 828, 356 0 1, 828, 356 0 0 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 233, 908 0 233, 908 0 0 67. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 178, 699 0 0 52. 00 53. 00 05300 ANESTHESI OLOGY 23, 018 23, 018 0 0 53. 00 54. 00 05400 RADI OLOGY - DI AGNOSTI C 2, 294, 760 2, 294, 760 0 0 54. 00 60. 00 06000 LABORATORY 2, 090, 284 2, 090, 284 0 0 0 60. 01 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 87, 830 87, 830 0 0 0 60. 01 65. 00 06500 RESPI RATORY THERAPY 609, 769 0 609, 769 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 1, 828, 356 0 1, 828, 356 0 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 233, 908 0 233, 908 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 126, 490 0 126, 490 0 69. 00 69. 01 06900 CARDI AC REHABI LI TATI ON 134, 161 134, 1
53. 00 05300 ANESTHESI OLOGY 23, 018 23, 018 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 2, 294, 760 2, 294, 760 0 0 54. 00 60. 00 06000 LABORATORY 2, 090, 284 0 <td< td=""></td<>
54. 00 05400 RADI OLOGY-DI AGNOSTI C 2, 294, 760 2, 294, 760 0 0 54. 00 60. 00 06000 LABORATORY 2, 090, 284 2, 090, 284 0 <t< td=""></t<>
60. 00
60. 01
63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 87, 830 87, 830 0 63. 00 65. 00 65. 00 665. 00 665. 00 665. 00 666. 00
65. 00 06500 RESPIRATORY THERAPY 609, 769 0 609, 769 0 0 65. 00 66. 00 66. 00 06600 PHYSI CAL THERAPY 1,828, 356 0 1,828, 356 0 0 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 233, 908 0 233, 908 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 126, 490 0 126, 490 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 24, 071 24, 071 0 0 69. 00 69. 01 06901 CARDI AC REHABI LI TATI ON 134, 161 134, 161 0 0 69. 01 70. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
66. 00 06600 PHYSI CAL THERAPY 1,828,356 0 1,828,356 0 0 66. 00 67. 00 67. 00 06700 0CCUPATI ONAL THERAPY 233,908 0 233,908 0 0 67. 00 68. 00 68. 00 06800 SPECH PATHOLOGY 126,490 0 126,490 0 0 68. 00 69. 00
67. 00 06700 0CCUPATI ONAL THERAPY 233, 908 0 233, 908 0 0 67. 00 068. 00 06800 SPEECH PATHOLOGY 126, 490 0 126, 490 0 069. 00 06900 ELECTROCARDI OLOGY 24, 071 24, 071 0 069. 00 069. 00 069. 00 070. 00 07
68. 00 06800 SPEECH PATHOLOGY 126, 490 0 126, 490 0 0 68. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 01 69. 0
69. 00 06900 ELECTROCARDI OLOGY 24, 071 24, 071 0 0 69. 00 69. 01 06901 CARDI AC REHABI LI TATI ON 134, 161 134, 161 0 0 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 566, 901 566, 901 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 200, 036 200, 036 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 2, 796, 575 2, 796, 575 0 73. 00 76. 00 03020 ONCOLOGY 303, 904 303, 904 0 0 76. 00
69. 01 06901 CARDI AC REHABI LI TATI ON 134, 161 134, 161 0 0 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 566, 901 566, 901 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 200, 036 200, 036 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 2, 796, 575 2, 796, 575 0 0 73. 00 76. 00 03020 ONCOLOGY 303, 904 303, 904 0 0 76. 00 0 76. 00 0 0 0 0 0 0 0 0 0
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 70. 00 0 71. 00 0 0 71. 00 0 0 0 0 0 0 0 0 0
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 566, 901 566, 901 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 200, 036 200, 036 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 2, 796, 575 2, 796, 575 0 0 73. 00 74. 00 75. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 200, 036 200, 036 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 2, 796, 575 2, 796, 575 0 0 73. 00 74. 00 03020 0NCOLOGY 303, 904 303, 904 0 0 76. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 2, 796, 575 2, 796, 575 0 0 73. 00 76. 00 03020 0NCOLOGY 303, 904 303, 904 0 0 76. 00
76. 00 03020 0NCOLOGY 303, 904 0 0 76. 00
91. 00 09100 EMERGENCY 3,714,355 3,714,355 0 91. 00 91. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 541,300 541,300 0 92. 00
OTHER REIMBURSABLE COST CENTERS
101. 00 10100 HOME HEALTH AGENCY 927, 647 927, 647 0 101. 00
SPECIAL PURPOSE COST CENTERS
116. 00 11600 HOSPI CE 0 116. 00
200. 00 Subtotal (see instructions) 32,869,456 0 32,869,456 0 0 200. 00
201. 00 Less Observation Beds 541, 300 541, 300 0 201. 00
202.00 Total (see instructions) 32, 328, 156 0 0 202.00

Health Financial Systems	PULASKI MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1305	Period: Worksheet C From 10/01/2018 Part I
		To 09/30/2019 Date/Time Prepared

				o 09/30/2019	Date/Time Pre 2/25/2020 4:3	pared: 3 pm
		Title	: XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Ratio	
	6. 00	7. 00	8. 00	9. 00	10. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	,					
30. 00 03000 ADULTS & PEDI ATRI CS	2, 233, 044		2, 233, 044	ŀ	ļ	30.00
31.00 03100 INTENSIVE CARE UNIT	0		[C			31.00
43. 00 04300 NURSERY	105, 386		105, 386			43.00
ANCILLARY SERVICE COST CENTERS	,					
50.00 05000 OPERATING ROOM	700, 686	4, 446, 666			0. 000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	306, 096	151, 615			0.000000	52.00
53. 00 05300 ANESTHESI OLOGY	96, 932	675, 197			0. 000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 323, 025	12, 467, 785			0.000000	54.00
60. 00 06000 LABORATORY	2, 400, 133	10, 098, 169			0. 000000	60.00
60. 01 06001 BLOOD LABORATORY	0	0	_		0. 000000	60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	135, 197	122, 848			0.000000	63.00
65. 00 06500 RESPI RATORY THERAPY	999, 478	288, 511			0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	436, 820	2, 548, 172	2, 984, 992		0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	182, 681	279, 315			0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	43, 320	118, 504			0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	36, 760	496, 842	533, 602		0.000000	69. 00
69. 01 06901 CARDI AC REHABI LI TATI ON	0	191, 719	191, 719		0.000000	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	(0.00000	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	800, 546	1, 443, 831	2, 244, 377		0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	148, 215	126, 841	275, 056		0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 982, 386	4, 922, 120			0.000000	73.00
76. 00 03020 0NC0L0GY	345	208, 610	208, 955	1. 454399	0.000000	76. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	4, 678, 204				88. 00
88.01 08801 RURAL HEALTH CLINIC II	0	666, 421	666, 421			88. 01
88.02 08802 RURAL HEALTH CLINIC III	0	219, 824				88. 02
90. 00 09000 CLI NI C	0	765, 111	•		0.000000	90.00
91. 00 09100 EMERGENCY	235, 228	4, 579, 484			0.000000	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	0	311, 295	311, 295	1. 738865	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	831, 736	831, 736			101.00
SPECIAL PURPOSE COST CENTERS						
116. 00 11600 H0SPI CE	0	0	C	1	l	116. 00
200.00 Subtotal (see instructions)	15, 166, 278	50, 638, 820	65, 805, 098	3		200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	15, 166, 278	50, 638, 820	65, 805, 098	3		202. 00

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-1305	From 10/01/2018	Worksheet C Part I Date/Time Prepared: 2/25/2020 4:33 pm

				2/25/2020 4:33 pm
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31. 00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 000000			50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
60. 00 06000 LABORATORY	0. 000000			60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			60.01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
	0. 000000			69.00
69. 01 06901 CARDI AC REHABI LI TATI ON				
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
76. 00 03020 0NC0L0GY	0. 000000			76. 00
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC				88.00
88. 01 08801 RURAL HEALTH CLINIC II				88. 01
88. 02 08802 RURAL HEALTH CLINIC III				88. 02
90. 00 09000 CLI NI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202.00

Health Financial Systems	PULASKI MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 1	5-1305 Peri od: Worksheet C From 10/01/2018 Part To 09/30/2019 Date/Time Prepared: Date/Time Pre

Title XIX Hospital Cost
Cost Center Description Total Cost (from Wkst. B, Part I, col. 26) 1.00 Costs Therapy Limit Total Costs RCE Disallowance Disallowance Industry Disallowance D
Cost Center Description Total Cost (from Wkst. B, Part I, col. 26) Therapy Limit Adj. Total Costs Disallowance Disallowance Disallowance 2.00 3.00 4.00 5.00
(from Wkst. Adj. Di sal I owance B, Part I, col. 26) 1.00 2.00 3.00 4.00 5.00
col . 26) 00 1.00 2.00 3.00 4.00 5.00
1.00 2.00 3.00 4.00 5.00
INPATIENT ROUTINE SERVICE COST CENTERS
30. 00 03000 ADULTS & PEDI ATRI CS 4, 738, 715 4, 738, 715 0 4, 738, 715 30. 0
31.00 03100 INTENSIVE CARE UNIT 0 0 0 31.0
43. 00 <u>04300 NURSERY 135, 835</u> 0 135, 835 43. 0
ANCILLARY SERVICE COST CENTERS
50. 00 05000 0PERATI NG ROOM 1, 487, 910 1, 487, 910 0 1, 487, 910 50. 0
52. 00 05200 DELI VERY ROOM & LABOR ROOM 178, 699 178, 699 0 178, 699 52. 0
53. 00 05300 ANESTHESI OLOGY 23, 018 23, 018 0 23, 018 53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 2, 294, 760 2, 294, 760 0 2, 294, 760 54. 0
60. 00 06000 LABORATORY 2, 090, 284 2, 090, 284 0 2, 090, 284 60. 0
60. 01 06001 BLOOD LABORATORY 0 0 60. C
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 87, 830 87, 830 0 87, 830 63. 0
65. 00 06500 RESPI RATORY THERAPY 609, 769 0 609, 769 0 609, 769 65. 0
66. 00 06600 PHYSI CAL THERAPY 1,828,356 0 1,828,356
67. 00 06700 0CCUPATI ONAL THERAPY 233, 908 0 233, 908 0 233, 908 67. 0
68. 00 06800 SPEECH PATHOLOGY 126, 490 0
69. 00 06900 ELECTROCARDI OLOGY 24, 071 0 24, 071 0 24, 071 0 134 17
69. 01 06901 CARDI AC REHABI LI TATI ON 134, 161 0 134, 161 0 134, 161 0 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 70. 0
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 200, 036 200, 036 0 200, 036 72. 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 2, 796, 575 2, 796, 575 0 2, 796, 575 73. 0
75. 00 07300 DROGS CHARGED TO PATTENTS 2, 796, 375 2, 796, 375 0 2, 796, 375 75. 0 76. 00 03020 0NCOLOGY 303, 904 0 303, 904 76. 0
OUTPATIENT SERVICE COST CENTERS
88. 00 08800 RURAL HEALTH CLINIC 7, 725, 203 7, 725, 203 0 7, 725, 203 88. 0
88. 01 08801 RURAL HEALTH CLINIC II
88. 02 08802 RURAL HEALTH CLINIC 11 428, 848 428, 848 0 428, 848 88. 0
90. 00 09000 CLI NI C 543, 593 0 5243, 593 90. 0
91. 00 09100 EMERGENCY 3, 714, 355 3, 714, 355 0 3, 714, 355 91. 0
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 541,300 541,300 541,300 541,300
OTHER REIMBURSABLE COST CENTERS
101. 00 10100 HOME HEALTH AGENCY 927, 647 927, 647 927, 647 927, 647
SPECIAL PURPOSE COST CENTERS
116. 00 11600 HOSPI CE 0 0 116. 0
200.00 Subtotal (see instructions) 32,869,456 0 32,869,456 0 32,869,456 0 32,869,456
201. 00 Less Observation Beds 541, 300 541, 300 541, 300 541, 300
202. 00 Total (see instructions) 32, 328, 156 0 32, 328, 156 0 32, 328, 156 202. 0

Health Financial Systems	PULASKI MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1305	Period: Worksheet C From 10/01/2018 Part I
		To 09/30/2019 Date/Time Prepared

				o 09/30/2019	Date/Time Pre 2/25/2020 4:3	pared: 3 pm
		Ti tl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Rati o	
	6. 00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	2, 233, 044		2, 233, 044		 -	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0		(31.00
43. 00 04300 NURSERY	105, 386		105, 386			43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	700, 686	4, 446, 666			0. 000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	306, 096	151, 615			0. 000000	52.00
53. 00 05300 ANESTHESI OLOGY	96, 932	675, 197			0. 000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 323, 025	12, 467, 785			0.000000	54.00
60. 00 06000 LABORATORY	2, 400, 133	10, 098, 169	12, 498, 302		0. 000000	60.00
60. 01 06001 BL00D LABORATORY	0	0	1	0.00000	0.000000	60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	135, 197	122, 848			0. 000000	63.00
65. 00 06500 RESPI RATORY THERAPY	999, 478	288, 511	1, 287, 989		0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	436, 820	2, 548, 172	2, 984, 992	0. 612516	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	182, 681	279, 315	461, 996	0. 506299	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	43, 320	118, 504	161, 824	0. 781652	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	36, 760	496, 842	533, 602	0. 045110	0.000000	69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	0	191, 719	191, 719	0. 699779	0.000000	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	C	0.000000	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	800, 546	1, 443, 831	2, 244, 377	0. 252587	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	148, 215	126, 841	275, 056	0. 727256	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 982, 386	4, 922, 120	9, 904, 506	0. 282354	0.000000	73.00
76. 00 03020 ONCOLOGY	345	208, 610	208, 955	1. 454399	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	4, 678, 204	4, 678, 204	1. 651318	0.000000	88. 00
88.01 08801 RURAL HEALTH CLINIC II	0	666, 421	666, 421	1. 691555	0.000000	88. 01
88.02 08802 RURAL HEALTH CLINIC III	0	219, 824	219, 824	1. 950870	0.000000	88. 02
90. 00 09000 CLI NI C	0	765, 111	765, 111	0. 710476	0.000000	90.00
91. 00 09100 EMERGENCY	235, 228	4, 579, 484	4, 814, 712	0. 771459	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	311, 295	311, 295	1. 738865	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	831, 736	831, 736			101.00
SPECIAL PURPOSE COST CENTERS						
116. 00 11600 HOSPI CE	0	0	C			116. 00
200.00 Subtotal (see instructions)	15, 166, 278	50, 638, 820	65, 805, 098	3	ļ	200.00
201.00 Less Observation Beds					ļ	201. 00
202.00 Total (see instructions)	15, 166, 278	50, 638, 820	65, 805, 098	3		202. 00

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL			In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 15-	1305	Peri od: From 10/01/2018 To 09/30/2019	Worksheet C Part I Date/Time Prepared: 2/25/2020 4:33 pm
		Ti	tla VIV		Hospi tal	Cost

				2/25/2020 4:33 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 000000			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
60. 00 06000 LABORATORY	0. 000000			60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	0. 000000			69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
76. 00 03020 0NC0L0GY	0. 000000			76.00
OUTPATIENT SERVICE COST CENTERS	<u> </u>			
88. 00 08800 RURAL HEALTH CLINIC	0. 000000			88.00
88. 01 08801 RURAL HEALTH CLINIC II	0. 000000			88. 01
88.02 08802 RURAL HEALTH CLINIC III	0. 000000			88. 02
90. 00 09000 CLI NI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS				
116. 00 11600 HOSPI CE				116.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00

Cost Center Description	Health Financial Systems	PULASKI MEMORI	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
Cost Center Description	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C				
Cost Center Description							narodi
Cost Center Description					10 09/30/2019		
Related Cost (from Wkst. C, Part I, col. 1 + col. 2) Col. 1 + col. 2) Col. 2			Title	xVIII	Hospi tal		
ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00	Cost Center Description		Total Charges	Ratio of Cos	t Inpatient		
B, Part II, Col. 8) Col. 2) RANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 RANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 RANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 RANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 RANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 RANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 RANCILLARY SERVICE COST CENTERS 1.00 3.00 3.00 4.00 5.00 8.00 6.364 50.00 5.00 5.00 6.364 50.00 5.00 5.00 6.364 5.00 6.364 5.00 6.364 5.00 6.364 5.00 6.364 5.00 6.364 5.00 6.364 6.00 6.364 6.00 6.364 6.00 6.			(from Wkst.		Program	(column 3 x	
COL _ 26)					Charges	column 4)	
NOTE Service			col. 8)	col . 2)			
ANCILLARY SERVICE COST CENTERS							
50. 00 05000 OPERATI NG ROOM 153, 012 5, 147, 352 0, 029726 214, 096 6, 364 50. 00		1. 00	2. 00	3. 00	4. 00	5. 00	
52. 00 05200 DELI VERY ROOM & LABOR ROOM 17, 548 457, 711 0.038339 2, 562 98 52. 00 53.00 05300 ANESTHESI OLOGY 1, 430 772, 129 0.001852 23, 833 44 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 150, 284 13, 790, 810 0.010897 492, 881 5, 371 54.00 06.00 06000 LABORATORY 61, 336 12, 498, 302 0.004908 705, 149 3, 461 60.00 60.01 06001 BLOOD LABORATORY 0 0.000000 0 0.000000 0 0.6000 0.00000 0.00000 0.000000 0.0000000 0.00000000							
53. 00 05300 ANESTHESI OLOGY 1,430 772, 129 0.001852 23,833 44 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 150,284 13,790,810 0.010897 492,881 5,371 54.00 60. 00 06000 LABORATORY 61,336 12,498,302 0.004908 705,149 3,461 60.00 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 1,953 258,045 0.007568 59,938 454 63.00 65. 00 06500 RESPI RATORY THERAPY 26,273 1,287,989 0.020398 455,472 9,291 65.00 66. 00 06600 PHYSI CAL THERAPY 66,581 2,984,992 0.022305 109,525 2,443 66.00 67. 00 06700 OCCUPATI ONAL THERAPY 2,496 461,996 0.005403 29,413 159,670 68. 00 06900 SELECTROCARDI OLOGY 537 533,602 0.010006 28,764 29,69.00 69. 01 06901 CARDI AC REHABI LI TATI ON 12,437 191,719 0.064871 0 0 0							
54. 00 05400 RADI OLOGY-DI AGNOSTI C 150, 284 13, 790, 810 0.010897 492, 881 5, 371 54. 00 60. 00 06000 LABORATORY 61, 336 12, 498, 302 0.004908 705, 149 3, 461 60. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 1, 953 258, 045 0.007568 59, 938 454 63. 00 65. 00 06500 RESPI RATORY THERAPY 26, 273 1, 287, 989 0.020398 455, 472 9, 291 65. 00 66. 00 06600 PHYSI CAL THERAPY 66, 581 2, 984, 992 0.022305 109, 525 2, 443 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 2, 496 461, 996 0.005403 29, 413 159 67. 00 68. 00 06900 ELECTROCARDI OLOGY 1, 292 161, 824 0.007984 9, 575 76 68. 00 69. 00 06900 ELECTROCARDI OLOGY 537 533, 602 0.001006 28, 764 29 69. 00 69. 01 06901 CARDI AC REHABI LI TATI ON 12, 437 191, 719 0.064871 0 0 69. 01 71. 00 07000 ELECTROCARDI OLOGY 0 0 0 0.000000 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 26, 164 2, 244, 377 0.011658 232, 229 2, 707 71. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 4, 334 275, 056 0.015757 69, 644 1, 097 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 49, 318 9, 904, 506 0.004979 1, 859, 337 9, 258 73. 00 74. 00 03020 ONCOLOGY 18, 014 208, 955 0.086210 102 9 76. 00 00 00 00 00 00 00 00							
60. 00 06000 LABORATORY 61, 336 12, 498, 302 0. 004908 705, 149 3, 461 60. 00 60. 01 80.00 LABORATORY 0 0 0. 0000000 0 0 0. 0000000 0 0 0. 0000000 0 0 0. 0000000 0 0 0. 00000000		1					
60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0		•					
63. 00							
65. 00		_				-	
66. 00 06600 PHYSI CAL THERAPY 66, 581 2, 984, 992 0. 022305 109, 525 2, 443 66. 00 67. 00 06700 0cCUPATI ONAL THERAPY 2, 496 461, 996 0. 005403 29, 413 159 67. 00 68. 00 06800 SPECH PATHOLOGY 1, 292 161, 824 0. 007984 9, 575 76 68. 00 69. 00 6900 ELECTROCARDI OLOGY 537 533, 602 0. 001006 28, 764 29 69. 00 69. 01 69. 01 6901 CARDI AC REHABI LITATI ON 12, 437 191, 719 0. 064871 0 0 69. 01 70. 00 70. 00 70. 00 ELECTROENCEPHALOGRAPHY 0 0 0. 000000 0 0 70. 00 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 26, 164 2, 244, 377 0. 011658 232, 229 2, 707 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 4, 334 275, 056 0. 015757 69, 644 1, 097 72. 00 73. 00 DRUGS CHARGED TO PATI ENTS 49, 318 9, 904, 506 0. 004979 1, 859, 337 9, 258 73. 00 73. 00 O3020 ONCOLOGY 18, 014 208, 955 0. 086210 102 9 76. 00 0017PATI ENT SERVICE COST CENTERS 4, 678, 204 0. 030860 0 0 88. 01 08801 RURAL HEALTH CLINIC 11 8, 136 219, 824 0. 037011 0 0 88. 01 08802 RURAL HEALTH CLINIC 11 8, 136 219, 824 0. 037011 0 0 88. 02 90. 00 09000 CLINIC 50, 519 765, 111 0. 066028 0 0 90. 00 90. 00 90. 00 09000 CLINIC 193, 754 4, 814, 712 0. 040242 31, 890 1, 283 91. 00 92. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 39, 864 311, 295 0. 128059 0 0 92. 00 92. 00 92. 00 09200 08SERVATION BEDS (NON-DISTINCT PART) 39, 864 311, 295 0. 128059 0 0 92. 0							
67. 00		1		1		· ·	
68. 00							
69. 00 06900 ELECTROCARDI OLOGY 537 533, 602 0.001006 28, 764 29 69. 00 69. 01 06901 CARDI AC REHABI LI TATI ON 12, 437 191, 719 0.064871 0 0 69. 01 0.000000 0 0 0.000000 0 0	67. 00 06700 OCCUPATI ONAL THERAPY						
69. 01 06901 CARDIAC REHABILITATION 12, 437 191, 719 0.064871 0 0 69. 01 70. 00 71. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0.000000 0 0 70. 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 26, 164 2, 244, 377 0.011658 232, 229 2, 707 71. 00 72. 00 72. 00 1MEDICAL SUPPLIES CHARGED TO PATIENTS 4, 334 275, 056 0.015757 69, 644 1, 097 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 49, 318 9, 904, 506 0.004979 1, 859, 337 9, 258 73. 00 03020 ONCOLOGY 18, 014 208, 955 0.086210 102 9 76. 00 00000000000000000000000000000000							
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0.000000 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 26, 164 2, 244, 377 0.011658 232, 229 2, 707 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 4, 334 275, 056 0.015757 69, 644 1, 097 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 49, 318 9, 904, 506 0.004979 1, 859, 337 9, 258 73. 00 76. 00 03020 ONCOLOGY 18, 014 208, 955 0.086210 102 9 76. 00 0UTPATI ENT SERVI CE COST CENTERS 88. 01 08800 RURAL HEALTH CLINIC 330, 695 4, 678, 204 0.070688 0 0 88. 00 88. 01 08801 RURAL HEALTH CLINIC II 20, 566 666, 421 0.030860 0 0 88. 01 90. 00 09000 CLINIC 50, 519 765, 111 0.066028 0 0 90.00 91. 00 09200 OBS						29	
71. 00	69. 01 06901 CARDI AC REHABI LI TATI ON	12, 437	191, 719	0. 06487	71 0	0	69. 01
72. 00 07200 1 MPL. DEV. CHARGED TO PATIENTS 4, 334 275, 056 0. 015757 69, 644 1, 097 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 49, 318 9, 904, 506 0. 004979 1, 859, 337 9, 258 73. 00 03020 ONCOLOGY 18, 014 208, 955 0. 086210 102 9 76. 00 00000000000000000000000000000000	70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000	0 0	0	70.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 49, 318 9, 904, 506 0.004979 1, 859, 337 9, 258 73. 00 76. 00 03020 ONCOLOGY 0.004979 0.086210 0.004979 102 9 76. 00 00000000000000000000000000000000	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	26, 164	2, 244, 377	0. 01165	8 232, 229	2, 707	71.00
76. 00 03020 ONCOLOGY 18, 014 208, 955 0. 086210 102 9 76. 00		4, 334	275, 056	0. 01575	69, 644	1, 097	72.00
SECTION SURVICE COST CENTERS SECTION SURVICE COST CENTERS SECTION	73.00 07300 DRUGS CHARGED TO PATIENTS	49, 318	9, 904, 506	0. 00497	1, 859, 337	9, 258	73.00
88. 00 08800 RURAL HEALTH CLINIC 330, 695 4, 678, 204 0. 070688 0 0 88. 00 88. 01 88. 01 88. 02 08802 RURAL HEALTH CLINIC III 20, 566 666, 421 0. 030860 0 0 88. 01 88. 02 09000 CLINIC 111 8, 136 219, 824 0. 037011 0 0 88. 02 09000 CLINIC 50, 519 765, 111 0. 066028 0 0 90. 00 09100 EMERGENCY 193, 754 4, 814, 712 0. 040242 31, 890 1, 283 91. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 39, 864 311, 295 0. 128059 0 0 92. 00 0 92. 00 0 0 0 0 0 0 0 0 0		18, 014	208, 955	0. 08621	0 102	9	76. 00
88. 01 08801 RURAL HEALTH CLINIC II 20, 566 666, 421 0.030860 0 0 88. 01 88. 02 08802 RURAL HEALTH CLINIC III 8, 136 219, 824 0.037011 0 0 88. 02 90. 00 09000 CLINIC 50, 519 765, 111 0.066028 0 0 90. 00 91. 00 91. 00 09100 EMERGENCY 193, 754 4, 814, 712 0.040242 31, 890 1, 283 91. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 39, 864 311, 295 0.128059 0 0 92. 00 0 92. 00 0 0 0 0 0 0 0 0 0							
88. 02 08802 RURAL HEALTH CLINIC III 8, 136 219, 824 0. 037011 0 0 88. 02 90. 00 09000 CLINIC 50, 519 765, 111 0. 066028 0 0 90. 00 91. 00 91. 00 09100 EMERGENCY 193, 754 4, 814, 712 0. 040242 31, 890 1, 283 91. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 39, 864 311, 295 0. 128059 0 0 92. 00 0 92. 00 0 0 0 0 0 0 0 0 0				0. 07068	88 0	0	
90. 00 09000 CLINIC 50, 519 765, 111 0.066028 0 0 90.00 91.00 09100 EMERGENCY 193, 754 4, 814, 712 0.040242 31, 890 1, 283 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 39, 864 311, 295 0.128059 0 0 92.00						0	
91. 00 09100 EMERGENCY 193, 754 4,814,712 0.040242 31,890 1,283 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 39,864 311,295 0.128059 0 0 92.00						0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 39,864 311,295 0.128059 0 0 92.00	90. 00 09000 CLI NI C	50, 519	765, 111	0. 06602	.8	0	90.00
						1, 283	
200.00 Total (lines 50 through 199) 1,236,543 62,634,932 4,324,410 42,144 200.00		1		1	0	-	
	200.00 Total (lines 50 through 199)	1, 236, 543	62, 634, 932		4, 324, 410	42, 144	200. 00

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1305	Peri od:	Worksheet D
TUDOUCU COCTC			From 10/01/2018	Dart IV

THROUGH COSTS To 09/30/2019 Date/Time Prepared: 2/25/2020 4:33 pm Title XVIII Hospi tal Cost Cost Center Description Non Physician Nursi ng Nursi ng Allied Health Allied Health Anestheti st School Post-Stepdown School Post-Stepdown Cost Adjustments Adjustments 1. 00 2.00 ЗА 3.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0 0 0 0 54.00 06000 LABORATORY 0 60.00 60.00 0 06001 BLOOD LABORATORY 60.01 0 0 60.01 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 63.00 06500 RESPIRATORY THERAPY 0 0 0 0 65.00 0 65.00 01 06600 PHYSI CAL THERAPY Ω 66.00 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 68.00 0 69.00 06900 ELECTROCARDI OLOGY 0 69.00 0 06901 CARDIAC REHABILITATION 0 69.01 69.01 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 0 72.00 0 0 72.00 73.00 0 0 73.00 76.00 03020 ONCOLOGY 0 0 0 0 0 76.00 OUTPATIENT SERVICE COST CENTERS 88. 00 0 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 0 0 88.01 08801 RURAL HEALTH CLINIC II 0 0 88.01 08802 RURAL HEALTH CLINIC III 88.02 88.02 0 0 0 0 0 0 0 0 90.00 09000 CLI NI C Ω 90.00 91.00 09100 EMERGENCY 0 91.00 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 0 0 200.00 200.00 Total (lines 50 through 199) ol

THROUGH COSTS

			'	0 09/30/2019	2/25/2020 4: 3	
		Title	xVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)			
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS	1 _1	_	1			
50. 00 05000 OPERATING ROOM	0	0		5, 147, 352		
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		457, 711	0. 000000	1
53. 00 05300 ANESTHESI OLOGY	0	0		772, 129		1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		13, 790, 810		
60. 00 06000 LABORATORY	0	0	9	12, 498, 302		1
60. 01 06001 BL00D LABORATORY	0	0	9	0	0. 000000	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	9	258, 045		
65. 00 06500 RESPI RATORY THERAPY	0	0	9	1, 287, 989		1
66. 00 06600 PHYSI CAL THERAPY	0	0	9	2, 984, 992	0. 000000	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(461, 996		1
68. 00 06800 SPEECH PATHOLOGY	0	0	(161, 824		
69. 00 06900 ELECTROCARDI OLOGY	0	0	(533, 602		
69. 01 06901 CARDIAC REHABILITATION	0	0	(191, 719		1
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	(0	0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(2, 244, 377	0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(275, 056		1
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(9, 904, 506	0. 000000	1
76. 00 03020 ONCOLOGY	0	0	(208, 955	0. 000000	76. 00
OUTPATIENT SERVICE COST CENTERS	,					
88.00 08800 RURAL HEALTH CLINIC	0	0	(4, 678, 204	0. 000000	
88.01 08801 RURAL HEALTH CLINIC II	0	0	(666, 421	0. 000000	
88.02 08802 RURAL HEALTH CLINIC III	0	0	(219, 824		1
90. 00 09000 CLI NI C	0	0	(765, 111	0. 000000	
91. 00 09100 EMERGENCY	0	0	(4, 814, 712		1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(311, 295		
200.00 Total (lines 50 through 199)	0	0	() C	62, 634, 932		200. 00

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	ı of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1305	Peri od:	Worksheet D

From 10/01/2018 Part IV To 09/30/2019 Date/Time Prepared: THROUGH COSTS 2/25/2020 4:33 pm Title XVIII Hospi tal Cost Cost Center Description Outpati ent I npati ent I npati ent Outpati ent Outpati ent Ratio of Cost Program Program Program Program to Charges Pass-Through Pass-Through Charges Charges (col. 6 ÷ col. 7) Costs (col. 8 Costs (col. x col. 12) 13.00 x col. 10) 9. 00 10.00 11. 00 12.00 ANCILLARY SERVICE COST CENTERS 50 00 0.000000 214, 096 50 00 05000 OPERATING ROOM 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 2, 562 0 52.00 0 0 0 0 0 0 0 0 0 0 0 05300 ANESTHESI OLOGY 0.000000 23, 833 0 53.00 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 492, 881 0 0.000000 54.00 0 54.00 60.00 06000 LABORATORY 0.000000 705, 149 0 60.00 60.01 06001 BLOOD LABORATORY 0.000000 0 0 60.01 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 59, 938 0 63.00 06500 RESPIRATORY THERAPY 455, 472 0 65.00 0.000000 0 65.00 06600 PHYSI CAL THERAPY 66.00 0.000000 109, 525 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 29, 413 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 0.000000 9, 575 0 68.00 0 69.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 28, 764 0 69.01 06901 CARDIAC REHABILITATION 0.000000 0 69.01 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0.000000 0 0 0 70.00 0 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 232, 229 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 69, 644 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 1, 859, 337 0 0 0 73.00 73.00 0 03020 ONCOLOGY 0.000000 0 0 76.00 76.00 102 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 88.00 0 08801 RURAL HEALTH CLINIC II 0.000000 88.01 88. 01 0 0 0 0 0 88 02 08802 RURAL HEALTH CLINIC III 0.000000 0 Ω 88.02 0 0.000000 90.00 90. 00 | 09000 | CLI NI C C 0 91. 00 09100 EMERGENCY 0.000000 31, 890 0 91.00 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 0.000000 0 0 4, 324, 410 200.00 Total (lines 50 through 199) 0 200.00

From 10/01/2018 Part V 09/30/2019 Date/Time Prepared: 2/25/2020 4:33 pm Title XVIII Hospi tal Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Part I, col. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 455, 596 50.00 0. 289063 05200 DELIVERY ROOM & LABOR ROOM 0 0.390419 52.00 0 1, 394 52.00 0 05300 ANESTHESI OLOGY 0. 029811 229, 311 53.00 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.166398 4, 761, 326 0 0 0 0 0 0 0 0 0 0 54.00 60.00 06000 LABORATORY 0. 167245 4, 863, 233 0 60.00 06001 BLOOD LABORATORY 60.01 0.000000 0 60.01 0 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0.340367 77, 224 0 63.00 65.00 06500 RESPIRATORY THERAPY 0. 473427 182, 872 0 65.00 06600 PHYSI CAL THERAPY 0.612516 892, 776 0 66.00 66.00 06700 OCCUPATI ONAL THERAPY 0.506299 67.00 84, 409 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.781652 3,063 0 68.00 06900 ELECTROCARDI OLOGY 0.045110 203, 703 0 69.00 69.00 06901 CARDIAC REHABILITATION 0.699779 69.01 69 01 88.664 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 252587 0 418, 522 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0. 727256 0 45, 525 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 122 73 00 0 282354 2, 419, 921 Ω 73 00 03020 ONCOLOGY 76.00 1. 454399 101, 594 0 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 88.00 08801 RURAL HEALTH CLINIC II 0.000000 0 88.01 88.01 08802 RURAL HEALTH CLINIC III 88.02 0.000000 0 88.02 90.00 09000 CLI NI C 0.710476 739, 896 0 90.00 09100 EMERGENCY 0. 771459 1, 454, 926 91.00 91.00 0 0 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1. 738865 92.00 0 96, 225 Ω 200.00 Subtotal (see instructions) 0 18, 120, 180 122 0 200.00 Less PBP Clinic Lab. Services-Program 201.00 C 0 201.00 Only Charges

0

18, 120, 180

122

0 202.00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	PULASKI MEMORIA	L HOSPI TAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1305	Period: Worksheet D From 10/01/2018 Part V

				To 09/30/2019		
		Title	XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	420, 759	0				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	544	0				52.00
53. 00 05300 ANESTHESI OLOGY	6, 836	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	792, 275	0				54.00
60. 00 06000 LABORATORY	813, 351	0				60.00
60. 01 06001 BL00D LABORATORY	0	0				60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	26, 285	0				63.00
65. 00 06500 RESPI RATORY THERAPY	86, 577	0				65.00
66. 00 06600 PHYSI CAL THERAPY	546, 840	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	42, 736	0				67.00
68.00 06800 SPEECH PATHOLOGY	2, 394	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	9, 189	0				69. 00
69. 01 06901 CARDI AC REHABI LI TATI ON	62, 045	0				69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	105, 713	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	33, 108	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	683, 274	34				73.00
76. 00 03020 ONCOLOGY	147, 758	0				76. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0				88. 00
88.01 08801 RURAL HEALTH CLINIC II	0	0				88. 01
88.02 08802 RURAL HEALTH CLINIC III	0	0				88. 02
90. 00 09000 CLI NI C	525, 678	0				90.00
91. 00 09100 EMERGENCY	1, 122, 416	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	167, 322	0				92.00
200.00 Subtotal (see instructions)	5, 595, 100	34				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	5, 595, 100	34				202. 00

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 15-1305	Peri od: From 10/01/2018	Worksheet D Part V

Provider CCN: 15-1305 | Period: | Worksheet D | From 10/01/2018 | To 09/30/2019 | Date/Time Prepared: | 2/25/2020 4: 33 pm

			Component	LCN: 15-Z305 I	0 09/30/2019	2/25/2020 4:3	parea: 3 pm
			Title	XVIII Sv	ving Beds - SNF		
			<u> </u>	Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	·	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not	,	
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.	, i	Ded. & Coins.	Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1. 00	2.00	3.00	4. 00	5. 00	
ANCI	ILLARY SERVICE COST CENTERS						
50.00 0500	OO OPERATING ROOM	0. 289063	0	0	0	0	50.00
52.00 0520	OO DELIVERY ROOM & LABOR ROOM	0. 390419	0	0	0	0	52.00
53.00 0530	00 ANESTHESI OLOGY	0. 029811	0	0	o	0	53.00
54.00 0540	00 RADI OLOGY-DI AGNOSTI C	0. 166398	0	0	o	0	54.00
60.00 0600	00 LABORATORY	0. 167245	0	0	o	0	60.00
60. 01 0600	01 BLOOD LABORATORY	0. 000000	0	0	o	0	60. 01
63.00 0630	OO BLOOD STORING, PROCESSING & TRANS.	0. 340367	0	0	o	0	63.00
65. 00 0650	00 RESPIRATORY THERAPY	0. 473427	0	l 0	ol	0	65.00
	00 PHYSI CAL THERAPY	0. 612516	0	0	o	0	66.00
	OO OCCUPATI ONAL THERAPY	0. 506299	0	0	0	0	67.00
	00 SPEECH PATHOLOGY	0. 781652	0	0	0	0	68.00
69.00 0690	00 ELECTROCARDI OLOGY	0. 045110	0	0	0	0	69.00
	O1 CARDI AC REHABI LI TATI ON	0. 699779	0	0	0	0	69. 01
	OO ELECTROENCEPHALOGRAPHY	0. 000000	0	0	o	0	70.00
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 252587	0	0	o	0	71.00
	00 IMPL. DEV. CHARGED TO PATIENTS	0. 727256	0	0	o	0	72.00
	OO DRUGS CHARGED TO PATIENTS	0. 282354	0	0	o	0	73.00
	20 ONCOLOGY	1. 454399	0	0	o	0	76.00
	PATIENT SERVICE COST CENTERS						
	OO RURAL HEALTH CLINIC	0. 000000				0	88. 00
	01 RURAL HEALTH CLINIC II	0. 000000				0	88. 01
	02 RURAL HEALTH CLINIC III	0. 000000				0	88. 02
	OO CLI NI C	0. 710476	0	0	o	0	90.00
	OO EMERGENCY	0. 771459	0	0	o	0	91.00
	OO OBSERVATION BEDS (NON-DISTINCT PART)	1. 738865	0	0	ام	0	92.00
200. 00	Subtotal (see instructions)		0	l	ام	_	200. 00
201. 00	Less PBP Clinic Lab. Services-Program		0	١	ا		201.00
201.00	Only Charges			I	j Y		
202. 00	Net Charges (line 200 - line 201)		0	0	О	0	202. 00
	3 ()	'	_		-1	_	

Health Financial Systems	5	PULAS	KI MEMORI	AL HOSPITAL			Ιn	Li e	u of Form CMS-2	552-10
APPORTIONMENT OF MEDICA	L, OTHER HEALTH SERVICE	S AND VACC	NE COST		CCN: 15-1305 CCN: 15-Z305		10/01/2		Worksheet D Part V Date/Time Pre 2/25/2020 4:33	
				Title	e XVIII	Swi ng	Beds -	SNF	Cost	
·			Cos	ts						
Cost Center	Description	Rei r Ser	Cost nbursed rvi ces	Cost Reimbursed Services Not						

			Title	XVIII	Swing Beds - SNF	Cost	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0	1		50	0. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0			52	2. 00
53.00	05300 ANESTHESI OLOGY	0	0			53	3. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0			54	1.00
60.00	06000 LABORATORY	0	0			60	0. 00
60. 01	06001 BLOOD LABORATORY	0	0			60	0. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	1		63	3. 00
65.00	06500 RESPI RATORY THERAPY	0	0	1		65	5. 00
66.00	06600 PHYSI CAL THERAPY	0	0)		66	. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0			67	7. 00
68. 00	06800 SPEECH PATHOLOGY	0	0)		68	3. 00
69.00	06900 ELECTROCARDI OLOGY	0	0)		69	9. 00
69. 01	06901 CARDI AC REHABI LI TATI ON	0	0	1		69	0. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0)		70	0. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71	. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			72	2. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0			73	3. 00
76.00	03020 ONCOLOGY	0	0			76	. 00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0			88	3. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	0			88	3. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	0			88	3. 02
90.00	09000 CLI NI C	0	0			90	0. 00
91.00	09100 EMERGENCY	0	0			91	. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92	2. 00
200.00	Subtotal (see instructions)	0	0			200	0. 00
201.00	Less PBP Clinic Lab. Services-Program	0				201	. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	0	0	1		202	. 00

Health Financial Systems	PULASKI MEMORIAL	. HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1305	Peri od: From 10/01/2018	Worksheet D-1	
			To 09/30/2019	Date/Time Pre 2/25/2020 4:3	
		Title XVIII	Hospi tal	Cost	
Cost Center Description					

All PROVIDER COMPONENTS 1.00	-		Title XVIII	Hospi tal	2/25/2020 4: 3 Cost	3 pm
New Tite ALL PROVIDER COMPONENTS		Cost Center Description		110061 101	3331	
MPATIENT IMAS					1. 00	
Inpatient days (including private room days and swing-bed days, excluding nesborn)						
1. Injustient days (including private room days, excluding swing-bed and newborn days) 1. Provided for common days (coulding swing-bed and observation bed days). 1. Provided for the cost of th	1. 00		s. excluding newborn)		3. 141	1.00
do not complete this line. 4. 00 Sein-private room days (sectualing swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 7. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 7. 00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if callendar year, enter 0 on this line) 8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 9. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 10. 00 Sking-bed SNF type inpatient days applicable to the Program (excluding swing-bed and next of the cost reporting period (is callendar) and the cost reporting period (is callendar year, enter 0 on this line) 12. 00 Sking-bed NF type inpatient days applicable to title SV or XIX only (including private room days) 13. 00 Sking-bed NF type inpatient days applicable to title SV or XIX only (including private room days) 14. 00 Sking-bed NF type inpatient days applicable to title SV or XIX only (including private room days) 15. 00 NF or observable of NF type inpatient days applicable to service safet December 31 of the cost reporting period (including period (including private room days) 15. 00 NF or observable of NF type inpatient days applicable to services after December 31 of the cost reporting period (including private room days) 16. 00 NF or observable of NF type inpati						
	3.00		ys). If you have only pr	ivate room days,	0	3.00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (If calledary sear, enter 0 on this line)		•				
reporting period (if callendar year, enter 0 on this line) 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.0				or 21 of the cost		
Total swing-bad SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total swing-bad NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total swing-bad NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total swing-bad NF type inpatient days (and using private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total swing-bad SNF type inpatient days applicable to the Program (excluding swing-bad and newborn days) Total swing-bad SNF type inpatient days applicable to title XVIII only (including private room days) Total SNF type applicable to title XVIII only (including private room days) Total SNF type applicable to title XVIII only (including private room days) Total SNF type applicable to title XVIII only (including private room days) Total SNF type applicable to title SVIII only (including private room days) Total SNF type applicable to title SVIII only (including private room days) Total SNF type applicable to title SVIII only (including private room days) Total SNF type applicable to title SVIII only (including private room days) Total SNF type applicable to title SVIII only (including private room days) Total SNF type applicable to title SVIII only (including private room days) Total SNF type applicable to title SVIII only (including private room days) Total SNF type applicable to the Program (excluding swing-bad days) Total SNF type applicable to services after December 31 of the cost reporting period (including sNF type applicable to services after December 31 of the cost Total SNF type applicable to services after December 31 of the cost Total SNF type applicable to services after December 31 of the cost Total SNF type services after December 31 of th	5.00		oni days) trii odgii becembe	i 31 of the cost	101	3.00
Total swing-bed NF type inpatient days (including private room days) afrong becember 31 of the cost reporting period of Total swing-bed NF type inpatient days (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and through becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.0 Seing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and through becember 31 of the cost reporting period (see instructions) 11.0 Swing-bed SNF type inpatient days applicable to the title XVII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after becember 31 of the cost reporting period to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 15.00 Total unresery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 18.00 Nursery days (title V or XIX only) 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including period medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days) 18.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days) 18.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days) 18.00 Medicare rate for swing-bed NF services samplicable to serv	6.00		om days) after December	31 of the cost	531	6. 00
reporting period 7. Total inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7. Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 8. Sing-bed SNBr 13 of the cost reporting period (is extended to the program (excluding swing-bed and newborn days) 10. Swing-bed SNBr 13 of the cost reporting period (is extended to the program (excluding private room days) after 10. Swing-bed SNBr 13 of the cost reporting period (is extended to the swing-bed SNBr 13 of the cost reporting period (is extended to the swing-bed SNBr 13 of the cost reporting period (is ealendar year, enter 0 on this line) 12. OS Swing-bed SNB type inpatient days applicable to titles V or XIX only (including private room days) after 13. OS Swing-bed SNB type inpatient days applicable to titles V or XIX only (including private room days) 15. OS Swing-bed SNB type inpatient days applicable to titles V or XIX only (including private room days) 15. OS Swing-bed SNB type inpatient days applicable to titles V or XIX only (including private room days) 15. OS Swing-bed SNB type inpatient days applicable to titles V or XIX only (including private room days) 15. OS Swing-bed SNB (it it V or XIX only V or XIX only (including swing-bed days) 15. OS Swing-bed SNB (it it V or XIX only V o						
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if Calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) Total inpatient days including private room days applicable to the Program (excluding private room days) Total inpatient days applicable to Will only (including private room days) after so wing-bed SNF type inpatient days applicable to the Program (and this line) Swing-bed SNF type inpatient days applicable to the Program (and this line) 30 Swing-bed SNF type inpatient days applicable to the Program (and this line) 13.00 Swing-bed SNF type inpatient days applicable to the Program (excluding private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medical care rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (incer rate for swing-bed NF services applicable to services after December 31 of the cost 129.14 to Medical drafter for swing-bed NF services applicable to services after December 31 of the cost 129.00 Medical drafter for swing-bed NF services applicable to services after December 31 of the cost 129.14 total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 8 x 11ne 19) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 8 x 11ne 19) 24.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 8 x 11ne 30) 25.	7. 00		m days) through December	31 of the cost	50	7.00
reporting period (if Calendar year, enter 0 on this line) 10.00 Sing bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (see instructions) 12.00 Swing-bed NF type inpatient days applicable to title SV III only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (line of verying period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line reporting period Medical rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line reporting period Medical rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line reporting period NF services after December 31 of the cost reporting period (line Ary 38,715 21,00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line Ary 38,715 21,00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line Ary 38,715 21,00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting peri	8 00		m davs) after December 3	1 of the cost	148	8 00
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24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6, 457 24.00 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 19, 113 25.00 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 29.00 Semi-private room charges (excluding swing-bed charges) 29.00 Average per diem private room per diem charge (line 29 + line 3) 30.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 30.00 Average per diem private room cost differential (line 3 x line 35) 20.00 Average per diem private room cost differential (line 3 x line 35) 20.00 Average per diem private room cost differential (line 3 x line 35) 20.00 Average per diem private room cost differential (line 3 x line 35) 20.00 Average per diem private room cost differential (line 3 x line 35) 20.00 Average per diem private room cost differential (line 3 x line 35) 20.00 Average per diem private room cost differential (line 3 x line 35) 20.00 Average per diem private room cost differential (line 3 x line 35) 20.00 Average per diem private room cost differential (line 3 x line 35) 20.00 Average per diem private room cost differential (line 3 x line 35) 20.00 Average per diem private room cost differential (line 3 x line 35) 20.00 Average per diem private room cost differential (line 3 x line 35) 20.00 Average per diem private room cost differential (line 3 x line 35) 20.00 Average per diem private room cost differential (line 3 x line 35) 20.00 Average per diem private room cost differential (line 3 x line 35) 20.00 Average per diem private room cost differential (line 3 x line 35) 20.00 Average per diem private room cost differential (line 3 x l	23.00		31 of the cost reportin	g period (line 6	0	23. 00
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25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 604, 921) 37.00 Average per diem private room cost differential dipustment (line 3 x line 35) 38.00 Ajusted general inpatient routine service cost per diem (see instructions) 38.00 Ajusted general inpatient routine service cost per diem (see instructions) 38.00 Ajusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	24. 00	1 3 11 31	r 31 of the cost reporti	ng period (line	6, 457	24.00
X line 20 Total swing-bed cost (see instructions) 1, 133, 794 26. 00 27. 00 27. 00 28. 00 27. 00 28. 00 28. 00 28. 00 29.	25 00	· · · · · · · · · · · · · · · · · · ·	31 of the cost reporting	period (line 8	19 113	25 00
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 3,604,921 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			ar ar arra again a par ar ng	, , , , , , , , , , , , , , , , , , , ,	,	
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 9.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-pri vate room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average pri vate room per diem charge (line 29 ÷ line 3) 33.00 Average semi-pri vate room per diem charge (line 30 ÷ line 4) 34.00 Average per diem pri vate room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem pri vate room cost differential (line 34 x line 31) 36.00 Pri vate room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and pri vate room cost differential (line 3, 604, 921) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 9.00 Program general inpatient routine service cost (line 9 x line 38) 1,662,336 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 28.00 28.00 29.00 20.00 20.00 31.00 20.00 32.00 33.00 34.00 35.00 Average per diem private room cost differential (line 33 kine 33) 0.00 35.00 36.00 37.00 27 minus line 36) PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,662,336 39.00		, ,				
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 30.00 Average private room per diem charge (line 29 ÷ line 3) 30.00 Average semi-private room per diem charge (line 30 ÷ line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Private room cost differential adjustment (line 3 x line 35) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 604, 921) 30.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 30.00 Adjusted general inpatient routine service cost per diem (see instructions) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 30.01 Average per diem private room cost applicable to the Program (line 14 x line 35) 30.01 Average per diem private room cost applicable to the Program (line 14 x line 35)	27. 00		(IIne 21 minus line 26)		3, 604, 921	27. 00
29.00 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room per diem charge ratio (line 27 ÷ line 28) 30.00 Average private room per diem charge (line 29 ÷ line 3) 30.00 Average semi-private room per diem charge (line 30 ÷ line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Private room cost differential adjustment (line 3 x line 35) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 604, 921) 30.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 30.00 Adjusted general inpatient routine service cost (line 9 x line 38) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 30.00 Value of the private room charge (line 27 ± line 28) 30.00 Value of the private room cost differential (line 3, 00) 31.00 Value of the private room cost differential (line 3, 00) 32.00 Value of the private room cost differential (line 3, 00) 33.00 Value of the private room cost differential (line 3, 00) 34.00 Value of the private room cost differential (line 3, 00) 35.00 Value of the private room cost differential (line 3, 00) 36.00 Value of the private room cost differential (line 3, 00) 37.00 Value of the private room cost differential (line 3, 00) 38.00 Value of the private room cost differential (line 3, 00) 39.00 Value of the private room charge (line 29 ± line 28) 39.00 Value of the private room cost differential (line 27 ± line 28) 39.00	28 00		d and observation hed ch	arnes)	0	28 00
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32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 604, 921) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30.00				0	
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3,604,921) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 33.00 0.00 34.00 36.00 37.00 General inpatient routine service cost and private room cost differential (line 3,604,921) 37.00 Algusted general inpatient routine service cost per diem (see instructions) 1,601.48 38.00 1,662,336 39.00 40.00		i i	÷ line 28)			
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35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 604, 921) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			nus line 33)(see instruc	tions)		
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 604, 921 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 36.00 37.00 Additional control of the program (line 14 x line 35) 0 40.00		9 '	, ,			
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,601.48 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 1,662,336 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	36.00	Private room cost differential adjustment (line 3 x line 35)	•		0	36. 00
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,601.48 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 1,662,336 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	37. 00	,	and private room cost di	fferential (line	3, 604, 921	37. 00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,601.48 38.00 Program general inpatient routine service cost (line 9 x line 38) 1,662,336 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,601.48 38.00 Program general inpatient routine service cost (line 9 x line 38) 1,662,336 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			USTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,662,336 39.00 40.00	38. 00				1, 601. 48	38.00
		,	•			39. 00
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 1,662,336 41.00		, , , , , , , , , , , , , , , , , , , ,	•		-	
	41.00	Trotal Program general impatrent routine service cost (ITNe 39	+ ITTIE 40)	ا	1,002,336	41.00

	Financial Systems	PULASKI MEMORIA		20N 1F 120F		u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C		Period: From 10/01/2018 To 09/30/2019	Date/Time Pre	pared:
			Ti +I /	e XVIII	Hospi tal	2/25/2020 4: 3	3 pm
	Cost Center Description	Total I npati ent Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1. 00	2.00	3.00	4. 00	5. 00	
42.00	NURSERY (title V & XIX only)	0	(0.0	0 0	0	42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	(0.0	0 0	0	43.00
44.00	CORONARY CARE UNIT) 0.0		Ĭ	44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description	'		•	-		
48. 00	Program inpatient ancillary service cost (Wk	st D 2 col 2	Line 200)			1. 00 1, 249, 386	48. 00
	Total Program inpatient costs (sum of lines			ons)		2, 911, 722	1
	PASS THROUGH COST ADJUSTMENTS	9 , ,		,			
50. 00	Pass through costs applicable to Program inp	atient routine s	ervices (fro	om Wkst. D, sur	n of Parts I and	0	50.00
51.00	Pass through costs applicable to Program inp	atient ancillary	services (f	rom Wkst. D, s	sum of Parts II	0	51.00
F2 00	and IV)	EO and E1)				0	E2 00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ated, non-ph	ysician anesth	netist, and	0	
	medical education costs (line 49 minus line	9 1					
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)				>	0	
57.00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and tar	get amount (line 56 minus	line 53)	0	
59.00	Lesser of lines 53/54 or 55 from the cost re	porting period e	ndi ng 1996,	updated and co	ompounded by the	_	
	market basket					0.00	(0.00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0.00	1
011.00	which operating costs (line 53) are less tha	n expected costs					000
42.00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62.00
62. 00 63. 00	Allowable Inpatient cost plus incentive paym	ent (see instruc	tions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of th	ie cost reporti	ng period (See	257, 838	64.00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	r 31 of the	cost reporting	g period (See	850, 386	65.00
44 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	no costo (lino (4 nlug ling	/E)/+:+!	l only) For	1 100 224	44 00
66. 00	CAH (see instructions)	THE COSTS (TITHE O	4 prus rine	os)(title xvii	i diliy). Foi	1, 108, 224	66.00
67. 00	9 '	e costs through	December 31	of the cost re	eporting period	0	67.00
68. 00	<pre>(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin</pre>	e costs after De	cember 31 of	the cost repo	orting period	0	68. 00
00.00	(line 13 x line 20)	c costs arter be	comber or or	the cost rept	or tring period	Ĭ	00.00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00
70. 00	Skilled nursing facility/other nursing facil)		70.00
71.00	Adjusted general inpatient routine service c		ne 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic	•	(line 14 x l	ine 35)			72. 00 73. 00
74.00	Total Program general inpatient routine serv						74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from	Worksheet B, F	Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line	,					77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces	,	ovider recor	·ds)			78. 00 79. 00
80.00	Total Program routine service costs for comp	, ,		,	nus line 79)		80.00
81.00	Inpatient routine service cost per diem limi						81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs ()				82. 00 83. 00
84.00	Program inpatient ancillary services (see in	structions)					84.00
85.00	Utilization review - physician compensation	•					85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		ougn 85)			<u> </u>	86.00
87. 00	Total observation bed days (see instructions)				338	1
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	line 2)			1, 601. 48 541, 300	
57.00	1555. Valion bod cost (Time of A Time oo) (Se	o mon denons)				1 571, 300	1 57.00

Health Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 10/01/2018 To 09/30/2019	Date/Time Pre 2/25/2020 4:3	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	348, 983	4, 738, 715	0. 07364	5 541, 300	39, 864	90.00
91.00 Nursing School cost	0	4, 738, 715	0.00000	0 541, 300	ol	91.00
92.00 Allied health cost	o	4, 738, 715	0.00000	0 541, 300	0	92.00
93.00 All other Medical Education	o	4, 738, 715	0.00000	0 541, 300	0	93.00

Health Financial Systems	PULASKI MEMORIAL I	HOSPI TAL	In Lieu	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1305	Peri od: From 10/01/2018	Worksheet D-1	
				Date/Time Pre	
		Title XIX	Hospi tal	2/25/2020 4: 3 Cost	3 pm
Cost Center Description					

		Title XIX	Hospi tal	2/25/2020 4: 3 Cost	3 pm
	Cost Center Description	THE XIX	1103pr tur	0031	
	DADT I ALL DDOVI DED COMPONENTO			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day	rs, excluding newborn)		3, 141	1.00
2.00	Inpatient days (including private room days, excluding swing-			2, 251	2.00
3. 00	Private room days (excluding swing-bed and observation bed da	ys). If you have only pr	rivate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	ned days)		1, 913	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost		5. 00
	reporting period	3 .			
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	692	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7. 00
7.00	reporting period	iii days) tiii dagii beceiibei	31 Of the cost	O	7.00
8.00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	31 of the cost	198	8. 00
	reporting period (if calendar year, enter 0 on this line)			0.0	
9. 00	Total inpatient days including private room days applicable t newborn days)	the Program (excluding	g swing-bed and	29	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	room days)	0	10.00
	through December 31 of the cost reporting period (see instruc				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12. 00
12.00	through December 31 of the cost reporting period	A only (Therauling privat	le room days)	O	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13.00
44.00	after December 31 of the cost reporting period (if calendar y				44.00
14. 00 15. 00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0 158	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			102	
	SWI NG BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	of the cost		17. 00
18. 00	reporting period	os after December 21 of	the cost		18. 00
18.00	Medicare rate for swing-bed SNF services applicable to service reporting period	es arter becember 31 or	the cost		18.00
19.00					19. 00
	reporting period				
20. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s after December 31 of t	the cost	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instruction	s)		4, 738, 715	21. 00
22. 00	Swing-bed cost applicable to SNF type services through Decemb		ing period (line		22. 00
	5 x line 17)			_	
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	ng period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	na period (line	0	24. 00
	7 x line 19)		3 1 1		
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			1, 114, 231	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 624, 484	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	•		0. 00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	
34.00	Average per diem private room charge differential (line 32 mi		ctions)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	116 J1)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line		
	27 minus line 36)	· 	,		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	LICTMENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see		T	1, 610. 16	38. 00
39. 00	Program general inpatient routine service cost per drem (see	•		46, 695	
40. 00	Medically necessary private room cost applicable to the Progr	•		0	
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		46, 695	41.00

Provider COL 13-130 Peri od (2007/2006)	Heal th	Financial Systems PULASKI MEMORIAL HOSPITAL In Lie	u of Form CMS-2	2552-10			
To 04/30/2013 Salar/Time Preparent Total Total Nortice Total Nortice Program Days Cost Cost Center Description Inpatient Inp		FATION OF INPATIENT OPERATING COST Provider CCN: 15-1305 Period:		1002 10			
Cost Centure Description							
Cost Center Description		Title VIV Hospital		3 pm			
Cost							
1.00 2.00 2.00 3.00 4.00 5.00 8.671 42.00 3.00 4.00 5.00 8.671 42.00 3.00 1.00 5.00 4.00 5.0			•				
NESSERY (LITL V & XIX only)							
HitPISSIVE CARE UNIT	42. 00	NURSERY (title V & XIX only) 135, 835 158 859.72 102		42.00			
44.00 CORRINARY CARE UNIT	42.00		0	42.00			
64.00 SURCICAL INTERSIVE CARE UNIT			U				
47.00 OTHER SPECIAL CARE (SPECIFY)							
Cost Center Description							
Both Program Inpati ent and Illary service cost (Wist D-3, col. 3, 11 ne 200) 33, 074 40, 00 Total Program Inpati ent costs (com of Illare 4, 41 through 48) (see instructions) 167, 460 40, 00 Pass THROUGH COST ADJUSTMENTS 167, 460 40, 00 Pass THROUGH COST ADJUSTMENTS 05, 00 Pass through costs applicable to Program inpatient routine services (From Wist, D, sum of Parts I and 05, 00 David Through costs applicable to Program inpatient and Illary services (From Wist, D, sum of Parts II and 19) 10, 100 10 10 10 10 10 10	47.00			47.00			
49.00 PROSE THROUGH COST ADUSTNEMTS 100.00	10.00			10.00			
PASS THROUGH COST ADJUSTNEMTS 50.00 Plass through costs applicable to Program inpatient routine services (from West. D. sum of Parts I and 50.00 plass through costs applicable to Program inpatient ancillary services (from West. D. sum of Parts II 51.00 plass through costs applicable to Program inpatient ancillary services (from West. D. sum of Parts II 51.00 plass through costs applicable to Program inpatient costs (sum of lines, 50 and 51) 52.00 archive Program excludable cost (sum of lines, 50 and 51) 53.00 medical education costs (tine 49 minus lines, 50 and 51) 53.00 medical education costs (tine 49 minus lines, 50 and 51) 53.00 medical education costs (tine 49 minus lines, 50 and 51) 54.00 program discharges 0.54.00 program discharges 0.55.00 Target amount (line 54 x line 55) 0.55.00 Discharges 0.55.0							
III) Sas through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts II of 51.00 and IV) Science	17.00		107, 100	17.00			
51.00 pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II of 10 of 11 of 11 of 11 of 10 of 11 o	50.00		0	50.00			
and IV) 52.00 Total Program excludable cost (sum of lines 50 and 51) 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 55.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 56.00 Program discharge 57.00 Target amount (line 54 kine 15) 58.00 Program discharge 58.00 Target amount (line 54 kine 15) 58.00 Target amount (line 56 kine 16 kine	51. 00	,	0	51.00			
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and ended education costs (line 49 minus line 52) 54.00 Program discharges 54.00 Program discharges 56.00 Target amount per discharge 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58.00 Donus payment (see lins fructions) 59.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the compounded by the lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 59.00 Clesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 59.00 Clesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 59.00 Clesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 59.00 Clesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 59.00 Clesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 59.00 Clesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 59.00 Clesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 59.00 Clesser of lines 53/54 or 55 from prior year costs from 50 fro		and IV)					
medical education costs (line 49 minus line 52)							
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1.00 Target amount per discharge 0.00 55.00 0.00							
56.00 Target amount (IIne 54 x Ine 55) 0.56.00 0.57.00 0.58.00 0.59.00			-				
S8. 00 Bonus payment (see instructions) 0 58. 00							
Section Lesser of lines \$3/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 0.00 0.00							
market basket 0.00 Color							
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 62.00 Rel lef payment (see instructions) 63.00 Allowable inpatient cost plus incentive payment (see instructions) 64.00 Medic are swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 65.00 Medic are swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) (title XVIII only) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 70.00 Skilled nursing facility/other nursing facility/fi/Fi/ID routine service cost (line 37) 70.00 Adjusted general inpatient routine service costs (line 70 + line 2) 71.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 72.00 Program capital -related costs (line 9 x line 76) 73.00 Total Program general inpatient routine service costs (from provider records) 74.00 Program capital -related costs (line 75 + line 2) 75.00 Program capital -related costs (line 9 x line 76) 76.00 Program capital -related costs (line 9 x line 76) 77.00 Program capital -related costs (line 9 x line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider rec	37.00		0.00	37.00			
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71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 74 minus line 77) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient routine services (see instructions) 84.00 Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 71.00 72.00 73.00 74.00 75.00 76.00 77.00 76.00 77.00 78.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 79.00 70.0	70.00			70 00			
73.00 74.00 75.00 76.00 76.00 77.00 78.00 79.00 70							
Total Program general inpatient routine service costs (line 72 + line 73) 74.00 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76) 77.00 78.00 Inpatient routine service cost (line 74 minus line 77) 78.00 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 74.00 75.00 75.00 76.00 77.00 77.00 78.00 78.00 79.00 80.00 80.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		, ,					
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 1 Inpatient routine service cost (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Reasonable inpatient routine services (see instructions) 83.00 Program inpatient ancillary services (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1, 610.17 88.00							
76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Route Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 76.00 77.00 77.00 78.00 78.00 78.00 78.00 79.00 88.00							
77.00 78.00 1npatient routine service cost (line 9 x line 76) 78.00 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 1npatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 1npatient routine service cost per diem limitation 82.00 1npatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,610.17 88.00	76 00			76 00			
79.00 80.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00		· · · · · · · · · · · · · · · · · · ·					
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00							
81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00							
83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine service costs (see instructions) 84.00 84.00 85.00 85.00 85.00 85.00 85.00 85.00 85.00 86.00 86.00 86.00 87.00 88.00 87.00 88.00 87.00 88.00 87.00 88.00							
84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00							
85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)							
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,610.17 88.00	85.00	Utilization review - physician compensation (see instructions)		85.00			
87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 338 87.00 1,610.17 88.00	86. 00			86.00			
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,610.17 88.00	87. 00		338	87. 00			
89.00 Observation bed cost (line 87 x line 88) (see instructions) 544,237 89.00	88. 00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1, 610. 17	88. 00			
	89. 00	Ubservation bed cost (line 87 x line 88) (see instructions)	544, 237	89. 00			

Health Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 10/01/2018 To 09/30/2019	Date/Time Pre 2/25/2020 4:3	
		Title	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	348, 983	4, 738, 715	0. 07364	5 544, 237	40, 080	90.00
91.00 Nursing School cost	0	4, 738, 715	0.00000	0 544, 237	0	91.00
92.00 Allied health cost	o	4, 738, 715	0.00000	0 544, 237	0	92.00
93.00 All other Medical Education	o	4, 738, 715	0.00000	0 544, 237	0	93.00

Health Financial Systems PULASKI MEMORIA	L HOSPITAL		In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1305	Peri od:	Worksheet D-3	
			From 10/01/2018 To 09/30/2019	Date/Time Pre 2/25/2020 4:3	
	Title	e XVIII	Hospi tal	Cost	
Cost Center Description	<u> </u>	Ratio of Cos	st Inpatient	Inpatient	
·		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
			Ŭ	col . 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			1, 035, 338		30.00
31.00 03100 INTENSIVE CARE UNIT			0		31.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM		0. 2890	63 214, 096	61, 887	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 3904	19 2, 562	1, 000	52.00
53. 00 05300 ANESTHESI OLOGY		0. 0298	11 23, 833	710	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1663	98 492, 881	82, 014	54.00
60. 00 06000 LABORATORY		0. 1672	45 705, 149	117, 933	60.00
60. 01 06001 BLOOD LABORATORY		0.0000	00 0	0	60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 3403	67 59, 938	20, 401	63.00
65. 00 06500 RESPI RATORY THERAPY		0. 4734	27 455, 472	215, 633	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 6125	16 109, 525	67, 086	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 5062	99 29, 413	14, 892	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 7816	52 9, 575	7, 484	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 0451	10 28, 764	1, 298	69. 00
69. 01 06901 CARDI AC REHABI LI TATI ON		0. 6997	79 0	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000	00 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2525	87 232, 229	58, 658	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 7272		50, 649	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 2823	54 1, 859, 337	524, 991	73.00
76. 00 03020 ONCOLOGY		1. 4543	99 102	148	76.00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		0.0000		0	88. 00
88. 01 08801 RURAL HEALTH CLINIC II		0.0000	00	0	88. 01
88. 02 08802 RURAL HEALTH CLINIC III		0.0000		0	88. 02
90. 00 09000 CLI NI C		0. 7104			90.00
91. 00 09100 EMERGENCY		0. 7714		24, 602	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 7388		0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)			4, 324, 410	1, 249, 386	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			4, 324, 410		202.00

ealth Financial Systems PULASKI MEMORIAL NPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-1305	Peri od:	u of Form CMS- Worksheet D-3	
NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN. 15-1505	From 10/01/2018	Worksheet D-3)
	•	CCN: 15-Z305	To 09/30/2019	Date/Time Pre 2/25/2020 4:3	
	Titl∈		Swing Beds - SNF		
Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
0. 00 03000 ADULTS & PEDI ATRI CS			0		30.
1. 00 03100 I NTENSI VE CARE UNI T			0	l	31.
3. 00 04300 NURSERY					43.
ANCILLARY SERVICE COST CENTERS		1			
0.00 05000 OPERATING ROOM		0. 28906	4, 901	1, 417	50.
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 39041		0	
3. 00 05300 ANESTHESI OLOGY		0. 02981		l e	
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 16639			
D. 00 06000 LABORATORY		0. 16724	1		
0. 01 06001 BLOOD LABORATORY		0.00000			
3.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 34036		1, 376	
5. 00 06500 RESPIRATORY THERAPY		0. 47342			
5. 00 06600 PHYSI CAL THERAPY		0. 61251			
7. 00 06700 OCCUPATI ONAL THERAPY		0. 50629		46, 742	
8. 00 06800 SPEECH PATHOLOGY 9. 00 06900 ELECTROCARDI OLOGY		0. 78165	1		1
P. 00 06900 ELECTROCARDI OLOGY P. 01 06901 CARDI AC REHABI LI TATI ON		0. 04511 0. 69977			
0. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000			1 .
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 25258			1
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 72725	1	1	1
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 28235			
5. 00 03020 0NC0L0GY		1. 45439			1
OUTPATIENT SERVICE COST CENTERS					
3. 00 08800 RURAL HEALTH CLINIC		0.00000	00	0	88.
3.01 08801 RURAL HEALTH CLINIC II		0.00000	00	0	88.
3.02 08802 RURAL HEALTH CLINIC III		0.00000	00	0	88.
0. 00 09000 CLI NI C		0. 71047	76 0	0	90.
1. 00 09100 EMERGENCY		0. 77145	59 2, 198	1, 696	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 73886	0 0	0	
00.00 Total (sum of lines 50 through 94 and 96 through 98)			760, 281	308, 349	
D1.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0	l	201.
02.00 Net charges (line 200 minus line 201)			760, 281		202.

Heal th	n Financial Systems	PULASKI MEMORIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
I NPAT	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1305	Peri od: From 10/01/2018	Worksheet D-3	3
				To 09/30/2019	Date/Time Pre 2/25/2020 4:3	
		Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	9	Program Costs	
				Charges	(col . 1 x	
			1.00	0.00	col . 2)	
	INDATI ENT POUTINE CEDVI CE COCT CENTERC		1.00	2. 00	3. 00	
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS		1	10.057		30.00
30.00	03100 INTENSIVE CARE UNIT			12, 857 0		30.00
43.00	1			7, 922		
43.00	04300 NURSERY ANCILLARY SERVICE COST CENTERS			1,922		43.00
50. 00			0. 2890	63 12, 269	3, 547	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 3904		5, 879	
53.00	05300 ANESTHESI OLOGY		0. 0298		72	1
54. 00	1		0. 1663		1, 920	
60.00	06000 LABORATORY		0. 1672		4, 229	
60. 01	06001 BLOOD LABORATORY		0.0000	·	0	1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		0. 3403	67 1, 783	607	63.00
65. 00	06500 RESPIRATORY THERAPY		0. 4734	27 3, 111	1, 473	65.00
66. 00	06600 PHYSI CAL THERAPY		0. 6125	16 487	298	66.00
67. 00			0. 5062		142	67.00
68. 00	06800 SPEECH PATHOLOGY		0. 7816		974	
69. 00			0. 0451		5	
69. 01	06901 CARDI AC REHABI LI TATI ON		0. 6997		0	69. 01
70.00			0.0000		0	
71.00			0. 2525	·	2, 263	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 7272		0 000	1
73. 00 76. 00	07300 DRUGS CHARGED TO PATIENTS 03020 ONCOLOGY		0. 2823 1. 4543		8, 099 10	
76.00	OUTPATIENT SERVICE COST CENTERS		1. 4343	79 7	10	, 76. UC
88. 00			1. 6513	18 0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II		1. 6915		0	
88. 02			1. 9508		0	
90. 00	09000 CLINIC		0. 7104		0	
91. 00	09100 EMERGENCY		0. 7714			
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 7388		0	
200. 0	1 1	96 through 98)		115, 848	33, 074	
201.0		rogram only charges (line 61)		0		201.00
202.0	Net charges (line 200 minus line 201)			115, 848		202.00

ealth Financial Systems	PULASKI MEMORIAL				u of Form CMS-	
NPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider C	CN: 15-1305	Peri od: From 10/01/2018	Worksheet D-3	3
		Component	CCN: 15-Z305	To 09/30/2019	Date/Time Pre 2/25/2020 4:3	epared:
		Ti tl	e XIX	Swing Beds - SNF		,
Cost Center Description			Ratio of Cos		I npati ent	
			To Charges		Program Costs	
				Charges	(col . 1 x	
			1.00	2.00	col . 2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			1.00	2. 00	3.00	
30. 00 03000 ADULTS & PEDIATRICS				0		30.00
81. 00 03100 NTENSI VE CARE UNI T				0		31.00
13. 00 04300 NURSERY				o o		43. 0
ANCILLARY SERVICE COST CENTERS						1
50. 00 05000 OPERATING ROOM			0.0000	00 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM			0.0000	00	0	52.0
33. 00 05300 ANESTHESI OLOGY			0.0000		0	53.0
64. 00 05400 RADI OLOGY-DI AGNOSTI C			0.0000		0	
00. 00 06000 LABORATORY			0. 0000		0	
00. 01 06001 BLOOD LABORATORY			0.0000		0	
53. 00 06300 BLOOD STORING, PROCESSING & TRANS.			0.0000		0	
55. 00 06500 RESPIRATORY THERAPY			0.0000		0	
66. 00 06600 PHYSI CAL THERAPY			0.0000		0	
57.00 06700 OCCUPATIONAL THERAPY 58.00 06800 SPEECH PATHOLOGY			0. 0000 0. 0000		0	1
99. 00 06900 SPEECH PATHOLOGY			0.0000		0	1
99. 01 06901 CARDI AC REHABI LI TATI ON			0.0000		0	
70. 00 07000 ELECTROENCEPHALOGRAPHY			0.0000		0	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0. 0000		o o	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS			0.0000		0	72.0
3.00 07300 DRUGS CHARGED TO PATIENTS			0.0000	00 0	0	73.0
6. 00 03020 ONCOLOGY			0.0000	00	0	76.0
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC			0. 0000			
8.01 08801 RURAL HEALTH CLINIC II			0. 0000		0	
38. 02 08802 RURAL HEALTH CLINIC III			0.0000		0	
00. 00 09000 CLINIC			0.0000		0	
01. 00 09100 EMERGENCY			0.0000		0	
02.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 100.00 Total (sum of lines 50 through 94 and	04 through 00\		0.0000	00 0	0	1
200.00 Total (sum of lines 50 through 94 and 201.00 Less PBP Clinic Laboratory Services-Pr		(lino 61)		0	0	200. 0 201. 0
202.00 Net charges (line 200 minus line 201)	ogram om y charges	(11116 01)	1	0		201.00

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1305	Peri od: From 10/01/2018 To 09/30/2019	Worksheet E Part B Date/Time Prepared: 2/25/2020 4:33 pm

MRCT B - MEDICAL MID OTHER HEALTH SERVICES 1.00				10 09/30/2019	2/25/2020 4:3	pared:
Description			Title XVIII	Hospi tal		о рііі
Description						
Medical and other services (see instructions)		DART R. MEDICAL AND OTHER HEALTH CERVICOES			1. 00	
Medical and other services reinfluxed under OPPS (see Instructions) 0 2	1 00				5 505 124	1.00
0.00 OoPS payments 0.0 3.	2. 00	·	etions)		1	1
0.00 Dutilier payment (see instructions)	3.00		,			•
Comparison Com	4.00				0	4.00
100 Line 2 times 1 ine 5 0 0 0 0 0 0 0 0 0	4. 01	1			1	1
March Company March Ma	5.00			l		
0.00 Organ acquisitions 0.00	8. 00				l .	
0.00 Organ acquisistions	9. 00	1	IV, col. 13, line 200		1	
Computation of Lesser or cost or expenses of the cost	10.00	Organ acqui si ti ons			0	10.0
Reasonable charges 2.00 Ancil Tary service charges 3.00 Organ acquisition charges (sum of lines 12 and 13) 3.00 Organ acquisition charges (sum of lines 12 and 13) 4.00 Total reasonable charges (sum of lines 12 and 13) 5.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 6.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis 7.00 Aggregate amount actually collected from patients liable for payment for services on a chargebasis 8.00 Aggregate amount actually collected from patients liable for payment for services on a chargebasis 9.01 Excess of customary charges (see instructions) 9.02 Excess of customary charges (see instructions) 9.03 Total customary charges (see instructions) 9.04 Excess of customary charges (see instructions) 9.05 Excess of customary charges (see instructions) 1.00 Exce	11. 00				5, 595, 134	11.0
2.00 Ancillary service charges 0 12.						1
1.00 Total reasonable charges (Sum of lines 12 and 13) 0 14.	12 00				1	12 0
1-00 10 10 10 10 10 10 1			ine 69)			1
Costonarry charges Costona			07)			
Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR \$413.13(e) 16. had such payment been made in accordance with 42 CFR \$413.13(e) 0.000000 17. No. 17 Total customary charges (see instructions) 0.18. No. 17 Total customary charges (see instructions) 0.18. No. 17 Total customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 0.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 17. No. 17 Total customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 17. No. 17 Total customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 17. No. 17 Total customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 17. No. 17 Total customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 17. No. 17 Total customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 17. No. 17 Total customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 17. No. 17 Total customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 17. No. 17 Total customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 17. No. 17 Total customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 17. No. 17 Total customary charges over reasonable cost (see instructions) 17. No. 17 Total customary charges (see instructions) 17. No. 17 Total customary charges of customary customary charges of customary charges of customary customary customary customary customary cus]
had such payment been made in accordance with 42 CFR §413.13(e)	15.00	, 00 0	. 3	•		
Nation of Line 15 to line 16 (not to exceed 1.000000)	16. 00			on a chargebasis	0	16.0
0 18.	17 00		(e)		0 000000	17.0
19.						
0.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 5, 651,085 21. 20 Interna and residents (see instructions) 0.22, 3.00 Cost of physicians' services in a teaching hospital (see instructions) 0.23, 3.00 Cost of physicians' services in a teaching hospital (see instructions) 0.24, 3.00 Cost of physicians' services in a teaching hospital (see instructions) 0.24, 3.00 Cost of physicians' services in a teaching hospital (see instructions) 74, 651 25, 600 Deductibles and coinsurance amounts (For CAH, see instructions) 74, 651 25, 600 Deductibles and coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 2, 678, 046 26, 70. 00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 0.28, 90. ESRO direct medical education payments (from Wkst. E-4, line 36) 0.29, 90. 00 Subtotal (sum of lines 27 through 29 2, 898, 388 30, 90. Primary payer payments 5, 506 30, 90. Primary pa	19. 00		ly if line 18 exceeds li	ne 11) (see	0	19.0
Instructions 1.00 Lesser of cost or charges (see instructions 5, 651,085 21.						
Lesser of cost or charges (see instructions) 5, 651,085 21, 20 Interns and residents (see instructions) 0 22, 3, 20 Cost of physicians' services in a teaching hospital (see instructions) 0 23, 3, 20 Cost of physicians' services in a teaching hospital (see instructions) 0 24, 25, 25, 25, 26, 26, 26, 27, 27, 28, 28, 28, 27, 28, 28, 28, 28, 28, 28, 28, 28, 28, 28	20. 00		ly if line 11 exceeds li	ne 18) (see	0	20.0
Interns and residents (see instructions) 0 22.	21 00				E 4E1 00E	21 0
Cost of physicians' services in a teaching hospital (see instructions)		,				
COMPUTATION OF REIMBURSEMENT SETTLEMENT 74,651 25		1	ructions)			1
Deductibles and coinsurance amounts (for CAH, see instructions) 74, 651 25, 600 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 2, 678, 046 26, 700 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 0 28, 898, 388 27.	24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	ŕ		0	24.0
Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 2,678,046 26,700 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 0 28, 898,388 27.						
2,898,388 27.	25.00		•			1
instructions						1
SRD direct medical education costs (from Wkst. E-4, line 36) 29, 2, 898, 388 30, 100 Subtotal (sum of lines 27 through 29) 2, 898, 388 30, 100 Primary payer payments 5,506 31, 2,892,882 32, 32, 32, 32, 33, 34, 35, 36, 36, 37, 37, 38, 39, 39, 39, 39, 39, 39, 39, 39, 39, 39	27.00	,	prus the sum of fines 22	2 414 25] (300	2,070,300	27.0
0.00 Subtotal (sum of lines 27 through 29) 2,898,388 30. 5,506 31. 32. 30.	28. 00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28.0
1.00					1	1
Subtotal (line 30 minus line 31)		,			1	1
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)						1
Composite rate ESRD (from Wkst. I-5, line 11)	32.00		CFS)		2,072,002	32.0
Adjusted reimbursable bad debts (see instructions) 0 35.	33. 00		,		0	33.0
Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Pomonstration payment adjustment emount before sequestration Partial or full credits received from manufacturers for replaced devices (see instructions) PRECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration 1.00 Interim payments Tentative settlement (for contractors use only) Bal ance due provider/program (see instructions) Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{1}{5}\$ 15. 2. To BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) Original outlier amount (see instructions) The rate used to calculate the Time Value of Money Time Value of Money (see instructions) O 93.					0	
7. 00 Subtotal (see instructions) 8. 00 MSP-LCC reconciliation amount from PS&R 9. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 9. 50 Pioneer ACO demonstration payment adjustment (see instructions) 9. 97 Demonstration payment adjustment amount before sequestration 9. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 9. 99 Partial or full credits received from manufacturers for replaced devices (see instructions) 9. 90 No Subtotal (see instructions) 9. 90 Subtotal (see instructions) 9. 91 Sequestration adjustment (see instructions) 9. 92 Demonstration payment adjustment amount after sequestration 9. 90 Demonstration adjustment amount (see instructions) 9. 91 Demonstration adjustment amount (see instructions) 9. 91 Demonstration adjustment amount (see instructions) 9. 92 Demonstration adjustment amount (see instructions) 9. 90 Demonstration adjustment amount after sequestration 9. 90 Demonstration adjustment amount after sequestration 9. 90 Demonstration adjustment amount after seq					·	
8.00 MSP-LCC reconciliation amount from PS&R 0 38. 9.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 9.50 Pioneer ACO demonstration payment adjustment (see instructions) 39. 9.97 Demonstration payment adjustment amount before sequestration 0 39. 9.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 9.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 0.00 Subtotal (see instructions) 2, 892, 882 40. 0.01 Sequestration adjustment (see instructions) 5,7858 40. 0.02 Demonstration payment adjustment amount after sequestration 0 40. 1.00 Interim payments 3,372,144 41. 2.00 Tentative settlement (for contractors use only) 3,372, 144 41. 2.00 Balance due provider/program (see instructions) 5,37,120 43. 4.00 Potested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 0. 0.01 Outlier reconciliation adjustment amount (see instructions) 0 90. 0.01 Outlier reconciliation adjustment amount (see instructions) 0 91. 0.02 The rate used to calculate the Time Value of Money (see instructions) 0 93.		· ·	ructions)			
9.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 9.50 Pioneer ACO demonstration payment adjustment (see instructions) 9.97 Demonstration payment adjustment amount before sequestration 9.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 9.99 RECOVERY OF ACCELERATED DEPRECIATION 0.00 Subtotal (see instructions) 0.01 Sequestration adjustment (see instructions) 0.02 Demonstration payment adjustment amount after sequestration 0.02 Demonstration payment adjustment amount after sequestration 0.01 Interim payments 0.00 Interim payments 0.00 Protested amounts (for contractors use only) 0.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0.01 Outlier reconciliation adjustment amount (see instructions) 0.02 Outlier reconciliation adjustment amount (see instructions) 0.039. 0.04 Additional outlier amount (see instructions) 0.05 Outlier reconciliation adjustment amount (see instructions) 0.06 Outlier reconciliation adjustment amount (see instructions) 0.07 Outlier reconciliation adjustment amount (see instructions) 0.08 Outlier reconciliation adjustment amount (see instructions) 0.09 Outlier reconciliation adjustment amount (see instructions) 0.00 Outlier of Money (see instructions)	38.00	1				
9.97 Demonstration payment adjustment amount before sequestration 9.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 9.99 RECOVERY OF ACCELERATED DEPRECIATION 0.00 Subtotal (see instructions) 0.01 Sequestration adjustment (see instructions) 0.02 Demonstration payment adjustment amount after sequestration 1.00 Interim payments 1.00 Interim payments 1.00 Balance due provider/program (see instructions) 1.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, spi15. 2 1.00 Demonstration payment (see instructions) 1.00 Original outlier amount (see instructions) 1.00 Outlier reconciliation adjustment amount (see instructions) 1.00 Outlier reconciliation adjustment amount (see instructions) 1.00 The rate used to calculate the Time Value of Money 1.00 Time Value of Money (see instructions)	39. 00				l	1
9.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 9.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 0.00 Subtotal (see instructions) 2,892,882 40. 0.01 Sequestration adjustment (see instructions) 0 2,892,882 40. 1.00 Demonstration payment adjustment amount after sequestration 1.00 Interim payments 1.00 Interim payments 1.00 Balance due provider/program (see instructions) 1.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 1.00 Doriginal outlier amount (see instructions) 1.00 Original outlier amount (see instructions) 1.00 Outlier reconciliation adjustment amount (see instructions) 1.00 The rate used to calculate the Time Value of Money 3.00 Time Value of Money (see instructions) 0 93.	39. 50	1	ıs)			39.5
9.99 RECOVERY OF ACCELERATED DEPRECIATION 0.00 Subtotal (see instructions) 0.01 Sequestration adjustment (see instructions) 0.02 Demonstration payment adjustment amount after sequestration 0.02 Demonstration payments 0.03 Jet 1	39. 97				l	1
Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, s115.2 TO BE COMPLETED BY CONTRACTOR Outlier reconciliation adjustment amount (see instructions) 1.00 Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money Time Value of Money (see instructions) 2, 892, 882 40. 4.00 57, 858 40. 40. 40. 40. 40. 51. 52. 64. 64. 65. 66. 67. 68. 69. 69. 69. 69. 69. 69. 69	39. 98	·	iced devices (see instrud	ctions)	1	
Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, s115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money Time Value of Money (see instructions) 57,858 40. 40. 40. 40. 41. 41. 57,858 40. 42. 42. 43. 43. 44. 45. 45. 45. 46. 47. 47. 47. 48. 49. 49. 49. 49. 40. 40. 40. 40						1
0.02 Demonstration payment adjustment amount after sequestration 0 40. 1.00 Interim payments 3, 372, 144 41. 2.00 Tentative settlement (for contractors use only) 0 42. 3.00 Balance due provider/program (see instructions) -537, 120 43. 4.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 0 Original outlier amount (see instructions) 0 90. 1.00 Outlier reconciliation adjustment amount (see instructions) 0 91. 2.00 The rate used to calculate the Time Value of Money 0 93. 1.00 Time Value of Money (see instructions) 0 93.						1
1.00 Interim payments 2.00 Tentative settlement (for contractors use only) 3.00 Balance due provider/program (see instructions) 4.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{\sqrt{115.2}}{\sqrt{10 BE COMPLETED BY CONTRACTOR}}\$ 0.00 Original outlier amount (see instructions) 0.01 Outlier reconciliation adjustment amount (see instructions) 0.02 The rate used to calculate the Time Value of Money 0.03 Time Value of Money (see instructions) 0.04 42. 41. 41. 41. 41. 41. 41. 41. 42. 43. 43. 44. 45. 45. 45. 46. 45. 47. 47. 47. 47. 47. 47. 47. 47. 47. 47	40. 02	, ,			l .	
2.00 Tentative settlement (for contractors use only) 3.00 Balance due provider/program (see instructions) 4.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2 TO BE COMPLETED BY CONTRACTOR 0.00 Original outlier amount (see instructions) 1.00 Outlier reconciliation adjustment amount (see instructions) 2.00 The rate used to calculate the Time Value of Money 3.00 Time Value of Money (see instructions) 0 42.		1				
4.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR 0.00 Original outlier amount (see instructions) 0 90. Outlier reconciliation adjustment amount (see instructions) 0 91. Outlier returned to calculate the Time Value of Money 0.00 92. Time Value of Money (see instructions) 0 93.		``				
\$115.2 TO BE COMPLETED BY CONTRACTOR 0.00 Original outlier amount (see instructions) 1.00 Outlier reconciliation adjustment amount (see instructions) 2.00 The rate used to calculate the Time Value of Money 3.00 Time Value of Money (see instructions) 0 93.	43.00			-1	l	
TO BE COMPLETED BY CONTRACTOR 0.00 Original outlier amount (see instructions) 1.00 Outlier reconciliation adjustment amount (see instructions) 2.00 The rate used to calculate the Time Value of Money 3.00 Time Value of Money (see instructions) 0 90. 0 91. 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	44. 00	,	ince with CMS Pub. 15-2,	cnapter 1,	0	44.0
0.00 Original outlier amount (see instructions) 1.00 Outlier reconciliation adjustment amount (see instructions) 2.00 The rate used to calculate the Time Value of Money 3.00 Time Value of Money (see instructions) 0 90. 0 91. 0 92. 0 93.						1
1.00 Outlier reconciliation adjustment amount (see instructions) 2.00 The rate used to calculate the Time Value of Money 3.00 Time Value of Money (see instructions) 0 91. 0.00 92. 0.00 93.	90. 00				0	90.0
2.00 The rate used to calculate the Time Value of Money 3.00 Time Value of Money (see instructions) 0.00 92.						
		· ·			0.00	92.0
4.00 Total (sum of lines 91 and 93) 0 94.		,				
	94.00	liotai (sum of lines 91 and 93)			1 0	94.0

Health Financial Systems PULA:
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 10/01/2018 | Part | To 09/30/2019 | Date/Time Prepared: Provi der CCN: 15-1305

				10 09/30/2019	2/25/2020 4: 3	
-		Title	XVIII	Hospi tal	Cost	-
		I npati en	it Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		2, 227, 39	5	3, 372, 144	1. 00
2.00	Interim payments payable on individual bills, either)	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER	04/11/2019	92, 400		0	3. 01
3. 01	ADJUSTMENTS TO PROVIDER	04/11/2019				3.01
3. 02						3. 02
3. 04						3. 04
3. 05						3. 05
3. 03	Provider to Program		<u> </u>	71	0	3.03
3. 50	ADJUSTMENTS TO PROGRAM				0	3.50
3. 51	7.5556 THERE OF THE TROUBLE		•		0	3. 51
3. 52					l ol	3. 52
3. 53					0	3. 53
3.54				o l	l ol	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		92, 400)	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 319, 79	5	3, 372, 144	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR		T	1		
5. 00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		1		0	5. 01
5. 02	TENTATIVE TO TROVIDER				0	5. 02
5. 03					l ol	5. 03
	Provider to Program			-1	_	
5.50	TENTATI VE TO PROGRAM		()	0	5. 50
5. 51)	0	5. 51
5.52				D	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			D	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		276, 34	3	0	6. 01
6. 02	SETTLEMENT TO PROVIDER		270, 34,		537, 120	6. 02
7. 00	Total Medicare program liability (see instructions)		2, 596, 13	3	2, 835, 024	7. 00
7.00	10 tal modical opiogram i rabitity (see instructions)		2, 370, 130	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00

		Component	CCN: 15-Z305 1	0 09/30/2019	2/25/2020 4:3	
		Title	XVIII Sv	ving Beds - SNF		о рііі
		I npati en	it Part A	Par	t B	
					1	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1 00	Transfer to the state of the second to the s	1.00	2.00	3. 00	4. 00	4 00
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either		1, 227, 191 0		0	
2.00	submitted or to be submitted to the contractor for		0		0	2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
0.01	Program to Provider	I	1 0			0.01
3. 01 3. 02	ADJUSTMENTS TO PROVIDER		0 0		0 0	3. 01 3. 02
3. 02						
3. 04			0		0	3.04
3. 05			0		0	
0.00	Provider to Program					0.00
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3. 51
3. 52			0		0	
3. 53			0		0	
3. 54			0		0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 227, 191		0	4.00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		1, 227, 171			4.00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
5. 01	Program to Provider TENTATIVE TO PROVIDER		0		0	5. 01
5. 02	TENTATIVE TO PROVIDER				0	
5. 02			0			
0.00	Provi der to Program					1 0.00
5.50	TENTATI VE TO PROGRAM		0		0	5.50
5. 51			0		0	5. 51
5. 52			0		0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6. 01	SETTLEMENT TO PROVIDER		156, 676		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		130, 070			
7. 00	Total Medicare program liability (see instructions)		1, 383, 867		0	
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
	To the second se	()	1. 00	2. 00	
8.00	Name of Contractor					8.00

Heal th	Financial Systems PULASKI MEMO	ORIAL HOSPITAL	In Lie	u of Form CMS-	2552-10	
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1305 Period:					
			From 10/01/2018 To 09/30/2019		narod:	
			10 09/30/2019	2/25/2020 4: 3		
		Title XVIII	Hospi tal	Cost		
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORT				1	
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULA				1.00	
	1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12					
2.00		2.00				
3.00		3.00				
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines				4. 00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 2	00			5.00	
6.00	Total hospital charity care charges from Wkst. S-10, col	. 3 line 20			6.00	
7.00	CAH only - The reasonable cost incurred for the purchase	of certified HIT technology	Wkst. S-2, Pt. I		7. 00	
	line 168					
8.00	Calculation of the HIT incentive payment (see instruction	ns)			8. 00	
9.00	9.00 Sequestration adjustment amount (see instructions)					
10.00	10.00 Calculation of the HIT incentive payment after sequestration (see instructions)					
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00	
31.00	31.00 Other Adjustment (specify)					
32.00	Balance due provider (line 8 (or line 10) minus line 30	and line 31) (see instructio	ns)		32.00	
	•		·		•	

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWI NG BEDS	Provider CCN: 15-1305		Worksheet E-2
			From 10/01/2018	
		Component CCN: 15-Z305	To 09/30/2019	Date/Time Prepared:
		·		2/25/2020 4:33 pm
		Ti +l o YVIII	Swing Rode - SNE	Cost

				2/25/2020 4:3	3 pm
		Title XVIII S	wing Beds - SNF	Cost	
			Part A	Part B	
	T		1.00	2. 00	
4 00	COMPUTATION OF NET COST OF COVERED SERVICES		1 110 00/	0	4 00
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1, 119, 306	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	and aum of What D	211 422	0	2.00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instruc		311, 432	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching p	-		0. 00	4.00
4.00	instructions)	rogram (see		0.00	4.00
5. 00	Program days		692	0	5. 00
6. 00	Interns and residents not in approved teaching program (see instru	ctions)	1	0	6.00
7. 00	Utilization review - physician compensation - SNF optional method	•	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	,	1, 430, 738	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9. 00
10.00	Subtotal (line 8 minus line 9)		1, 430, 738	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable	to physician	4, 044	0	11.00
	professional services)				
12.00	Subtotal (line 10 minus line 11)		1, 426, 694	0	12.00
13. 00	Coinsurance billed to program patients (from provider records) (ex	cl ude coi nsurance	14, 585	0	13. 00
	for physician professional services)			_	
14.00	80% of Part B costs (line 12 x 80%)		4 440 400	0	14.00
	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		1, 412, 109	0	15.00
16.00			0	0	16.00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions) Rural community hospital demonstration project (§410A Demonstratio	n) normant			16.50
16. 55	adjustment (see instructions)	n) payment			16. 55
16. 99	Demonstration payment adjustment amount before sequestration		0	0	16. 99
	Allowable bad debts (see instructions)			0	17. 00
17. 00	Adjusted reimbursable bad debts (see instructions)		0	0	17. 01
	Allowable bad debts for dual eligible beneficiaries (see instructi	ons)	0	0	18.00
	Total (see instructions)	01.0)	1, 412, 109	0	19.00
	Sequestration adjustment (see instructions)		28, 242	0	19. 01
	Demonstration payment adjustment amount after sequestration)		0	0	19. 02
	Interim payments		1, 227, 191	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 2	1)	156, 676	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance w	ith CMS Pub. 15-2,	0	0	23.00
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonstration				
200. 00	Is this the first year of the current 5-year demonstration period	under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.				
201 00	Cost Reimbursement	D 1 D+ 11 1:	T T		201 00
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst.	D-1, Pt. 11, Tine			201. 00
202 00	66 (title XVIII hospital)) Medicare swing-bed SNF inpatient ancillary service costs (from Wks	t D 2 col 2 line			202.00
202.00	200 (title XVIII swing-bed SNF))	t. D-S, COL. S, TITLE			202.00
203 00	Total (sum of lines 201 and 202)				203. 00
	Medicare swing-bed SNF discharges (see instructions)				204.00
201.00	Computation of Demonstration Target Amount Limitation (N/A in firs	t vear of the curren	t 5-vear demonst		201.00
	peri od)	. ,	,		
205.00	Medicare swing-bed SNF target amount				205.00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 times	line 204)			206. 00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursemen	t			
207.00	Program reimbursement under the §410A Demonstration (see instructi				207. 00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, co	I. 1, sum of lines 1			208. 00
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instruction	s)			209. 00
210.00	Reserved for future use				210. 00
	Comparision of PPS versus Cost Reimbursement				
215. 00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 p	lus line 210) (see			215. 00
	instructions)		1		l

Health Financial Systems	PULASKI MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 15-1305		Worksheet E-2
			From 10/01/2018	
		Component CCN: 15-Z305	To 09/30/2019	Date/Time Prepared:
		·		2/25/2020 4:33 pm
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				2/25/2020 4:33 pm
		Title XIX S	wing Beds - SNF	PPS
			Part A	Part B
			1.00	2. 00
1 00	COMPUTATION OF NET COST OF COVERED SERVICES			1.00
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)		0	2.00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instru		0	3.00
4.00	Per diem cost for interns and residents not in approved teaching	-	0.00	4.00
4.00	instructions)	program (see	0.00	4.00
5. 00	Program days		0	5.00
6. 00	Interns and residents not in approved teaching program (see inst	ructions)	o	6.00
7. 00	Utilization review - physician compensation - SNF optional method	•	O	7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	3	0	8.00
9.00	Primary payer payments (see instructions)		0	9.00
10.00	Subtotal (line 8 minus line 9)		0	10.00
11. 00	Deductibles billed to program patients (exclude amounts applicable	e to physician	0	11.00
	professional services)			
12.00	Subtotal (line 10 minus line 11)		0	12.00
13. 00	Coinsurance billed to program patients (from provider records) (exclude coinsurance	0	13.00
14 00	for physician professional services)			14.00
14.00	80% of Part B costs (line 12 x 80%) Subtotal (enter the lesser of line 12 minus line 13, or line 14)		0	14. 00 15. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	16.00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16. 55	Rural community hospital demonstration project (§410A Demonstrati	on) navment		16. 55
10. 55	adjustment (see instructions)	on) payment		10.33
16. 99	Demonstration payment adjustment amount before sequestration		o	16. 99
17.00	Allowable bad debts (see instructions)		O	17.00
17. 01	Adjusted reimbursable bad debts (see instructions)		0	17. 01
18.00	Allowable bad debts for dual eligible beneficiaries (see instruc	ti ons)	0	18.00
	Total (see instructions)		0	19.00
	Sequestration adjustment (see instructions)		0	19. 01
	Demonstration payment adjustment amount after sequestration)		0	19. 02
	Interim payments		0	20.00
	Tentative settlement (for contractor use only)	24)	0	21.00
22. 00	Balance due provider/program (line 19 minus lines 19.01, 20, and	•	0	22.00
23. 00	Protested amounts (nonallowable cost report items) in accordance	WITH CMS Pub. 15-2,	0	23. 00
	<pre>chapter 1, §115.2 Rural Community Hospital Demonstration Project (§410A Demonstration)</pre>	on) Adiustment		
200 00	Is this the first year of the current 5-year demonstration period			200. 00
200.00	Century Cures Act? Enter "Y" for yes or "N" for no.	a under the 21st		200.00
	Cost Reimbursement		<u> </u>	
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wks	t. D-1, Pt. II, line		201.00
	66 (title XVIII hospital))			
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from W	kst. D-3, col. 3, line		202.00
	200 (title XVIII swing-bed SNF))			
	Total (sum of lines 201 and 202)			203. 00
204. 00	Medicare swing-bed SNF discharges (see instructions)			204. 00
	Computation of Demonstration Target Amount Limitation (N/A in fi	st year of the curren	t 5-year demonst	ration
205 00	period) Medicare swing-bed SNF target amount		T	205 00
	Medicare swing-bed SNF target amount Medicare swing-bed SNF inpatient routine cost cap (line 205 time:	s Line 204)		205. 00 206. 00
200.00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburseme			208.00
207 00	Program reimbursement under the §410A Demonstration (see instruction)			207. 00
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2,	•		208. 00
200.00	and 3)	Jon 1, Juni Di Tillico I		200.00
209. 00	Adjustment to Medicare swing-bed SNF PPS payments (see instruction	ons)		209.00
	Reserved for future use	,		210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209	plus line 210) (see		215. 00
	instructions)			

Heal th	Financial Systems	PULASKI MEMORIAL	HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15	-1305		Worksheet E-3 Part V Date/Time Prep 2/25/2020 4:33	pared: 3 pm
			Title XVII	l	Hospi tal	Cost	
						1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEM	MENT FOR MEDICARE	PART A SERVICES	- COST	Γ REI MBURSEMENT		
1.00	Inpatient services					2, 911, 722	1.00
2.00	Nursing and Allied Health Managed Care paymen	nt (see instruction	ons)			0	2.00
3.00	Organ acquisition					o	3.00
4.00	4.00 Subtotal (sum of lines 1 through 3)					2, 911, 722	4.00
5.00	Primary payer payments					2, 492	5.00
6.00	Total cost (line 4 less line 5). For CAH (see	e instructions)				2, 938, 347	6.00

1. 00 I 2. 00 N 3. 00 0 4. 00 S 5. 00 P 6. 00 T	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT Inpatient services Nursing and Allied Health Managed Care payment (see instructions) Organ acquisition	1. 00 2, 911, 722 0	1.00
1. 00 I 2. 00 N 3. 00 0 4. 00 S 5. 00 P 6. 00 T	Inpatient services Nursing and Allied Health Managed Care payment (see instructions)		1 00
2. 00 N 3. 00 0 4. 00 S 5. 00 P 6. 00 T	Nursing and Allied Health Managed Care payment (see instructions)		1 1 00
3. 00 0 4. 00 S 5. 00 P 6. 00 T			
4. 00 S 5. 00 P 6. 00 T	Organ acquisition	U	
5. 00 P 6. 00 T		0	3.00
5. 00 P 6. 00 T	Subtotal (sum of lines 1 through 3)	2, 911, 722	4.00
6.00 T	Primary payer payments	2, 492	
	Total cost (line 4 less line 5). For CAH (see instructions)	2, 938, 347	
	COMPUTATION OF LESSER OF COST OR CHARGES	,	
	Reasonable charges		
7. 00 R	Routine service charges	0	7.00
1	Ancillary service charges	0	
	Organ acquisition charges, net of revenue	0	
	Total reasonable charges	0	10.00
	Customary charges	-	
	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
	Amounts that would have been realized from patients liable for payment for services on a charge basis	0	
	had such payment been made in accordance with 42 CFR 413.13(e)	-	
	Ratio of line 11 to line 12 (not to exceed 1.000000)	0. 000000	13.00
	Total customary charges (see instructions)	0	1
	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see	0	
	instructions)	ŭ	
1	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see	0	16.00
	instructions)	-	
	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	-	
	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
	Cost of covered services (sum of lines 6, 17 and 18)	2, 938, 347	19.00
	Deductibles (exclude professional component)	320, 496	
	Excess reasonable cost (from line 16)	0	1
	Subtotal (line 19 minus line 20 and 21)	2, 617, 851	
	Coi nsurance	0	
	Subtotal (line 22 minus line 23)	2, 617, 851	
	Allowable bad debts (exclude bad debts for professional services) (see instructions)	48, 106	
	Adjusted reimbursable bad debts (see instructions)	31, 269	1
	Allowable bad debts for dual eligible beneficiaries (see instructions)	48, 106	
	Subtotal (sum of lines 24 and 25, or line 26)	2, 649, 120	1
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	2, 047, 120	1
1	Pioneer ACO demonstration payment adjustment (see instructions)	0	
	Demonstration payment adjustment amount before sequestration	0	
	Subtotal (see instructions)	2, 649, 120	
	Sequestration adjustment (see instructions)	52, 982	
	Demonstration payment adjustment amount after sequestration	0	
	Interim payments	2, 319, 795	
	Tentative settlement (for contractor use only)	2, 314, 743	
	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	276, 343	
	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	270, 343	
	§115. 2	٥	34.00

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-1305	Peri od: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part VII Date/Time Prepared: 2/25/2020 4:33 pm

			10 09/30/2019	2/25/2020 4:3	
		Title XIX	Hospi tal	Cost	, p
			Inpatient	Outpati ent	
			1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		167, 460		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		o		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		167, 460	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		167, 460	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				1
8.00	Routi ne servi ce charges		20, 779		8.00
9.00	Ancillary service charges		115, 848	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		136, 627	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
	basi s				
14.00	Amounts that would have been realized from patients liable for		ا ا	0	14.00
	a charge basis had such payment been made in accordance with 42	CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	
16.00	Total customary charges (see instructions)		136, 627	0	
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	0	0	17. 00
	line 4) (see instructions)			_	
18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	30, 833	0	18. 00
10.00	16) (see instructions)			0	10.00
19.00	Interns and Residents (see instructions)	-+!>	0	0	
20.00	Cost of physicians' services in a teaching hospital (see instru		0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 16		167, 460	0	21.00
22 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be continuous than outlier payments	ompreted for PPS provid	0	0	22.00
23. 00	Outlier payments		0	0	
	Program capital payments		0	U	24.00
	Capital exception payments (see instructions)		0		25.00
26.00			0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)			0	
29.00	Titles V or XIX (sum of lines 21 and 27)		167, 460	0	
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		107, 400		1 27.00
30.00	Excess of reasonable cost (from line 18)		30, 833	0	30.00
31.00	1		167, 460	0	
	Deductibles		0	0	1
33. 00	Coinsurance		o o	0	
34. 00	Allowable bad debts (see instructions)		o o	0	
	Utilization review		o o	Ü	35.00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		167, 460	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
	, , , , ,		167, 460	0	1
			0	_	39.00
	Total amount payable to the provider (sum of lines 38 and 39)		167, 460	0	40.00
41.00	Interim payments		64, 916	0	41.00
	Balance due provider/program (line 40 minus line 41)		102, 544	0	42.00
42.00					1
42. 00 43. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2,	0	0	43.00

Health Financial Systems

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

Provi der CCN: 15-1305 Pe

Peri od: Worksheet G From 10/01/2018 To 09/30/2019 Date/Ti me Prepared: 2/25/2020 4:33 pm

J 37		General Fund	Specific Purpose Fund	Endowment Fund	2/25/2020 4:3 Plant Fund	3 pm
		1.00	2.00	3. 00	4. 00	
	CURRENT ASSETS			_1		
1. 00 2. 00	Cash on hand in banks Temporary investments	863, 898	0	0	0	1. 00 2. 00
3. 00	Notes receivable	0	0	0	0	3.00
4. 00	Accounts receivable	9, 026, 436	0	ō	0	4. 00
5.00	Other receivable	0	0	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable		1	0	0	6.00
7. 00 8. 00	Inventory Prepai d expenses	496, 331 48, 558	0	O O	0	7. 00 8. 00
9. 00	Other current assets	2, 780, 261		0	0	9.00
10.00	Due from other funds	0	0	o	0	10.00
11. 00	Total current assets (sum of lines 1-10)	7, 495, 921	0	0	0	11.00
12.00	FI XED ASSETS	105 525		ol	-	10.00
12. 00 13. 00	Land Land improvements	195, 525 432, 594		0	0	12. 00 13. 00
14. 00	Accumulated depreciation	-384, 269	1	Ö	0	14.00
15. 00	Bui I di ngs	13, 253, 038		ō	0	15.00
16. 00	Accumulated depreciation	-7, 864, 573	1	0	0	16.00
17.00	Leasehold improvements	187, 055	1	0	0	17.00
18. 00 19. 00	Accumulated depreciation Fixed equipment	-182, 961 7, 434, 637	0	0	0	18. 00 19. 00
20. 00	Accumulated depreciation	-5, 473, 038	1	0	0	20.00
21. 00	Automobiles and trucks	0	Ö	Ö	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23. 00	Major movable equipment	8, 918, 074	1	0	0	23. 00
24. 00	Accumulated depreciation	-8, 118, 449	0	0	0	24.00
25. 00 26. 00	Minor equipment depreciable Accumulated depreciation	0		0	0	25. 00 26. 00
27. 00	HIT designated Assets	0	0	0	0	27.00
28. 00	Accumulated depreciation	0	0	ō	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	o	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	8, 397, 633	0	0	0	30.00
31. 00	OTHER ASSETS Investments	1 0	O	ol	0	31.00
32. 00	Deposits on Leases	0	0	ő	0	32.00
33.00	Due from owners/officers	0	0	o	0	33.00
34.00	Other assets	4, 819, 471	1	0	0	34.00
35. 00	Total other assets (sum of lines 31-34)	4, 819, 471	1	0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	20, 713, 025	U U	0	0	36. 00
37.00	Accounts payable	443, 176	0	0	0	37.00
38. 00	Salaries, wages, and fees payable	1, 552, 981	0	o	0	38. 00
39.00	Payroll taxes payable	0	0	0	0	39.00
40. 00 41. 00	Notes and Loans payable (short term) Deferred income	548, 694	0	0	0	40. 00 41. 00
42.00	Accel erated payments	0		ď	O	42.00
43.00	Due to other funds	0	0	О	0	43.00
44.00	Other current liabilities	518, 803		0	0	44. 00
45. 00	Total current liabilities (sum of lines 37 thru 44)	3, 063, 654	0	0	0	45.00
46. 00	LONG TERM LIABILITIES Mortgage payable	1	O	ol	0	46.00
47. 00	Notes payable	2, 889, 143		Ö	0	47.00
48.00	Unsecured Loans	0	0	o	0	48. 00
49.00	Other long term liabilities	2, 678, 586	1	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	5, 567, 729	1	0	0	50.00
51. 00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	8, 631, 383	0	0	0	51.00
52.00	General fund balance	12, 081, 642				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56. 00 57. 00	Governing body created - endowment fund balance Plant fund balance - invested in plant			۷	0	56. 00 57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58.00
	replacement, and expansion				, and a	
59. 00	Total fund balances (sum of lines 52 thru 58)	12, 081, 642	1	0	0	59.00
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	20, 713, 025	0	0	0	60.00
	<i>~'/</i>	I	ı I	ı		I

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

Peri od: Wo From 10/01/2018 Provi der CCN: 15-1305

					To 09/30/2019	Date/Time Pre 2/25/2020 4:3	pared: 3 pm
		General	Fund	Special F	Purpose Fund	Endowment Fund	
		1. 00	2.00	3. 00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0 0 0	11, 402, 853 678, 789 12, 081, 642		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0	5. 00 6. 00 7. 00 8. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0 0	0 12, 081, 642 0 12, 081, 642		0 0 0 0 0 0 0 0	0 0 0 0 0	10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
	Isheet (The IT minds The Te)	Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8. 00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 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) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0	000000000000000000000000000000000000000	5. 55	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 deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	0 0 0 0		0 0		13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

Health Financial Systems PRISTATEMENT OF PATLENT REVENUES AND OPERATING EXPENSES Provi der CCN: 15-1305

			To 09/30/2019	Date/Time Pre 2/25/2020 4:3	
	Cost Center Description	Inpati ent	Outpati ent	Total	J piii
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	•			
	General Inpatient Routine Services				
1.00	Hospi tal	2, 338, 43	0	2, 338, 430	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF		0	0	5.00
6.00	Swing bed - NF		0	0	6.00
7. 00	SKILLED NURSING FACILITY				7. 00
8. 00	NURSI NG FACI LI TY				8. 00
9. 00	OTHER LONG TERM CARE				9.00
10. 00	Total general inpatient care services (sum of lines 1-9)	2, 338, 43	0	2, 338, 430	10.00
	Intensive Care Type Inpatient Hospital Services	T	al 1		
11.00	INTENSIVE CARE UNIT		0	0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)			0	15.00
16. 00	Total intensive care type inpatient hospital services (sum of lines 11-15)	'	0	0	16. 00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	2, 338, 43		2, 338, 430	17. 00
18. 00	Ancillary services	12, 592, 62		51, 179, 365	
19. 00	Outpatient services	235, 22		5, 891, 118	
20. 00	RURAL HEALTH CLINIC		0 5, 564, 449	5, 564, 449	•
20. 00	RURAL HEALTH CLINIC II	•	0 3, 304, 447	0, 304, 447	20.00
20. 01	RURAL HEALTH CLINIC III			0	20.02
21. 00	FEDERALLY QUALIFIED HEALTH CENTER			0	21.00
22. 00	HOME HEALTH AGENCY		831, 736	831, 736	
23. 00	AMBULANCE SERVICES		001,700	001,700	23.00
24. 00	CMHC				24.00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE	50	0 64, 404	64, 904	
27. 00	PHYSI CI AN FEES	351, 65	·	351, 651	27.00
28. 00	Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst.	15, 518, 42	9 50, 703, 224	66, 221, 653	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		35, 890, 956		29. 00
30.00	ADD (SPECIFY)	1	0		30.00
31. 00		1	0		31.00
32.00		1	0		32.00
33. 00		1	0		33.00
34.00			0		34.00
35. 00			0		35.00
36. 00	Total additions (sum of lines 30-35)		0		36.00
37. 00	DEDUCT (SPECIFY)		0		37.00
38. 00		•	0		38.00
39.00			0		39.00
40. 00 41. 00		1	0		40. 00 41. 00
41.00	Total deductions (sum of lines 37-41)				41.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		35, 890, 956		42.00
43.00	to Wkst. G-3, line 4)		33, 670, 730		43.00
	100 1100 17	1	1		1

∐oal +h	Financial Systems	PULASKI MEMORIAL HO	SDI TAI	In Lie	u of Form CMS-2	0552 10
	ENT OF REVENUES AND EXPENSES		ovider CCN: 15-1305	Peri od:	Worksheet G-3	
				From 10/01/2018		
				To 09/30/2019	Date/Time Prep 2/25/2020 4:33	
					2/23/2020 4. 3	5 piii
					1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part	I, column 3, line 2	8)		66, 221, 653	1. 00
2.00	Less contractual allowances and discounts or	patients' accounts			30, 917, 870	2.00
3.00	Net patient revenues (line 1 minus line 2)				35, 303, 783	3.00
4.00	Less total operating expenses (from Wkst. G-				35, 890, 956	
5.00	Net income from service to patients (line 3	minus line 4)			-587, 173	5.00
	OTHER INCOME					
6. 00	Contributions, donations, bequests, etc				0	6. 00
7. 00	Income from investments				0	7. 00
8. 00	Revenues from telephone and other miscellane	eous communication se	ervi ces		0	8. 00
9.00	Revenue from television and radio service				0	,, 00
10.00	Purchase di scounts				0	
	Rebates and refunds of expenses				0	11.00
	Parking lot receipts				0	12.00
	Revenue from Laundry and Linen service				0	13.00
	Revenue from meals sold to employees and gue	ests			0	14.00
	Revenue from rental of living quarters				0	15.00
	Revenue from sale of medical and surgical su		patrents		0	16. 00 17. 00
	Revenue from sale of drugs to other than pat Revenue from sale of medical records and abs				0	18.00
	Tuition (fees, sale of textbooks, uniforms,				0	19.00
	Revenue from gifts, flowers, coffee shops, a	,			0	20.00
	Rental of vending machines	ind Carreen			0	21.00
	Rental of hospital space				0	
	Governmental appropriations				0	
	OTHER INCOME				1, 098, 997	
24. 00	RENTAL INCOME				14, 022	
24. 02					152, 943	
	Total other income (sum of lines 6-24)				1, 265, 962	
	Total (line 5 plus line 25)				678, 789	
	OTHER EXPENSES (SPECIFY)				0.0,707	
	Total other expenses (sum of line 27 and sub	oscri pts)			ő	28. 00
	Net income (or loss) for the period (line 26				678, 789	
	,			,	2.2/.2.1	

	Financial Systems IS OF HOSPITAL-BASED HOME HEALT	H AGENCY COSTS	PULASKI MEMORIA	Provi der CCI	N: 15-1305	Peri od:	u of Form CMS-2 Worksheet H	2552-10
				HHA CCN:	15-7078	From 10/01/2018 To 09/30/2019	Date/Time Pre	
						Home Health	2/25/2020 4: 3 PPS	3 pm
						Agency I		
		Sal ari es		ransportati o		u Other Costs	Total (sum of	
			Benefits i	n (see nstructions)	rchased Servi ces		cols. 1 thru 5)	
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
1. 00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &			ol		O	0	1.00
1.00	Fixtures			٥			U	1.00
2. 00	Capital Related - Movable			0		0	0	2. 00
3. 00	Equipment Plant Operation & Maintenance	0	0	0			0	3.00
4. 00	Transportation	0	Ö	Ö		0 0	0	4.00
5. 00	Administrative and General	110, 326	0	71, 349		0 24, 216	205, 891	5.00
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	256, 658	O	O		0 0	256, 658	6. 00
7. 00	Physical Therapy	72, 590	Ö	o			72, 590	
8. 00	Occupational Therapy	19, 834	О	0		0 0	19, 834	•
9.00	Speech Pathology	6, 746	0	0		0 0	6, 746	•
10. 00 11. 00	Medical Social Services Home Health Aide	0 88, 325	0	O			0 88, 325	10.00 11.00
12. 00	Supplies (see instructions)	00, 323	Ö	o			00, 323	12.00
13. 00	Drugs	0	О	0		0 0	0	13.00
14. 00	DME	0	0	0		0 0	0	14.00
15. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	ol	ol		ol ol	0	 15. 00
16. 00	Respiratory Therapy	0	Ö	ő			0	16.00
17. 00	Private Duty Nursing	0	О	0		0 0	0	17.00
18. 00	Clinic	0	0	0		0 0	0	18.00
19. 00 20. 00	Health Promotion Activities Day Care Program	0	0	0		0 0	0	19. 00 20. 00
20.00	Home Delivered Meals Program	0	0	0			0	21.00
22. 00	Homemaker Service	0	Ö	o		o o	0	22.00
	All Others (specify)	0	O	0		0 0	0	23.00
23. 50	Tel emedi ci ne	0	0	71 240		0 0 24, 216	(50.044	23.50
24. 00	Total (sum of lines 1-23)	554, 479 Recl assi fi cat	Recl assi fi ed	71, 349 Adjustments	Net Expenses		650, 044	24.00
		i on	Tri al Balance	, ag de time. Te	for			
			(col. 6 +		All ocation			
			col . 7)		(col. 8 + col. 9)			
		7. 00	8. 00	9. 00	10.00			
	GENERAL SERVICE COST CENTERS							
1. 00	Capital Related - Bldg. &	0	0	0		0		1.00
2. 00	Fixtures Capital Related - Movable	0	0	0		0		2.00
2.00	Equi pment	Ö	٩	9				2.00
3. 00	Plant Operation & Maintenance	0	o	0		0		3.00
4. 00 5. 00	Transportation	74 520	120 262	0	120 24	0		4.00 5.00
3.00	Administrative and General HHA REIMBURSABLE SERVICES	-76, 529	129, 362	U	129, 30	02		5.00
6. 00	Skilled Nursing Care	0	256, 658	0	256, 65	58		6.00
7. 00	Physi cal Therapy	0	72, 590	0	72, 59			7. 00
8. 00	Occupational Therapy	0	19, 834	0	19, 83			8.00
9. 00 10. 00	Speech Pathology Medical Social Services	0	6, 746	0	6, 74	10		9. 00 10. 00
11. 00	Home Heal th Aide	0	88, 325	Ö	88, 32	25		11.00
12.00	Supplies (see instructions)	0	0	0		0		12.00
13.00	Drugs	0	0	0		0		13.00
	DME	0	0	0		0		14.00
14. 00								
	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0	0		0		15.00
14. 00 15. 00 16. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy	0	0 0	0		0		16.00
14. 00 15. 00 16. 00 17. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing		l l	- 1				16. 00 17. 00
14. 00 15. 00 16. 00 17. 00 18. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic		l l	- 1				16. 00 17. 00 18. 00
14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities		l l	- 1				16. 00 17. 00 18. 00 19. 00
14. 00 15. 00 16. 00 17. 00 18. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic		l l	- 1				16. 00 17. 00 18. 00 19. 00 20. 00
14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service		l l	- 1				16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00
14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program		l l	- 1				15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 23. 50

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

Heal th	Financial Systems		PULASKI MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	ALLOCATION - HHA GENERAL SERVICE	COST		Provi der C	CN: 15-1305	Peri od: From 10/01/2018	Worksheet H-1	
				HHA CCN:	15-7078	To 09/30/2019	Date/Time Pre 2/25/2020 4:3	pared:
						Home Health	PPS	5 рііі
			Capital Rela	ated Costs		Agency I		
		Not Eyponsos	Bl dgs &	Movabl e	PI ant	Transportatio	Subtotal	
		Net Expenses for Cost	Fi xtures	Equi pment	Operation 8	Transportatio n	(col s. 0-4)	
		Allocation (from Wkst.			Maintenance	2		
		Ĥ, col. 10)						
	GENERAL SERVICE COST CENTERS	0	1. 00	2. 00	3.00	4. 00	4A. 00	
1. 00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2. 00	Capital Related - Movable	0		0			0	2.00
3. 00	Equipment Plant Operation & Maintenance	0	0	0		0	0	3.00
4.00	Transportati on	0	O	0	1	0 0	_	4.00
5. 00	Administrative and General HHA REIMBURSABLE SERVICES	129, 362	0	0		0 0	129, 362	5.00
6.00	Skilled Nursing Care	256, 658	0	0	1	0 0	256, 658	
7. 00 8. 00	Physical Therapy Occupational Therapy	72, 590 19, 834	0	0		0 0	72, 590 19, 834	
9. 00 10. 00	Speech Pathology Medical Social Services	6, 746 0	0	0		0 0	6, 746 0	
11. 00	Home Health Aide	88, 325	o	0		0 0		11.00
12. 00 13. 00	Supplies (see instructions) Drugs	0	0	0		0 0	0	
14. 00	DME	0	0	0	1	0 0	0	1
15. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	O	0	0		0 0	0	15. 00
16.00	Respi ratory Therapy	0	0	0		0 0	0	
17. 00 18. 00	Private Duty Nursing Clinic	0	0	0	l .	0 0	0	
19. 00 20. 00	Health Promotion Activities Day Care Program	0	0	0	1	0 0	0	
21. 00	Home Delivered Meals Program	0	0	0		0 0	0	21.00
22. 00 23. 00	Homemaker Service All Others (specify)	0	0	0		0 0	0	
23. 50	Tel emedi ci ne	Ö	o	0	1	0 0	0	23. 50
24. 00	Total (sum of lines 1-23)	573, 515 Admi ni strati v	Total (cols.	0		0 0	573, 515	24.00
		e & General 5.00	4A + 5) 6.00					
	GENERAL SERVICE COST CENTERS	5.00	6.00					
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 5. 00	Transportation Administrative and General	129, 362						4. 00 5. 00
5.00	HHA REIMBURSABLE SERVICES	127, 302						3.00
6. 00 7. 00	Skilled Nursing Care Physical Therapy	74, 753 21, 142	331, 411 93, 732					6. 00 7. 00
8.00	Occupational Therapy	5, 777	25, 611					8. 00
9. 00 10. 00	Speech Pathology Medical Social Services	1, 965 0	8, 711 0					9. 00 10. 00
11.00	Home Health Aide	25, 725	114, 050					11.00
12. 00 13. 00	Supplies (see instructions) Drugs	0	0					12. 00 13. 00
14. 00	DME HHA NONREI MBURSABLE SERVI CES	0	0					14.00
15.00	Home Dialysis Aide Services	0	0					15. 00
16. 00 17. 00		0	0					16. 00 17. 00
18.00	Clinic	0	O					18. 00
19. 00 20. 00	Health Promotion Activities Day Care Program	0	0					19. 00 20. 00
21. 00 22. 00	Home Delivered Meals Program	0	0					21. 00 22. 00
23. 00	All Others (specify)	0	O					23.00
23. 50 24. 00	Telemedicine Total (sum of lines 1-23)	0	0 573, 515					23. 50 24. 00
00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ı	3.0,010					00

	Financial Systems LLOCATION - HHA STATISTICAL BAS	212	PULASKI MEMOR		CN: 15-1305	In Lie Period:	u of Form CMS-2 Worksheet H-1	
C031 F	RECOGNITION - THIN STATISTICAL DA.	51.5		HHA CCN:		From 10/01/2018 To 09/30/2019	Part II	pared:
						Home Health	PPS	3 piii
						Agency I		
		Capital Rel	ated Costs					
		BI dgs &	Movabl e	PI ant	Transportation	Reconciliatio	Administrativ	-
		Fixtures (SQUARE FEET)	Equi pment (DOLLAR	Operation & Maintenance	n (MI LEAGE)	n	e & General (ACCUM. COST)	
		1. 00	2. 00	(SQUARE FEET) 3.00	4.00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	JA. 00	5.00	
1. 00	Capital Related - Bldg. &	0				0		1.00
2. 00	Capital Related - Movable Equipment		C)		0		2. 00
3.00	Plant Operation & Maintenance	O	C			0		3.00
4.00	Transportation (see	0	C	o c		О		4.00
	instructions)							
5. 00	Administrative and General	0	C) <u> </u>)	0 -129, 362	444, 153	5.00
	HHA REIMBURSABLE SERVICES	1 0		\			05/ /50	
6. 00 7. 00	Skilled Nursing Care Physical Therapy	0	C		l .	0 0	256, 658 72, 590	1
8. 00	Occupational Therapy					0	19, 834	
9. 00	Speech Pathology					0	6, 746	
10.00	Medical Social Services					0	0, 740	1
11. 00	Home Heal th Aide		Č	ól ő		0 0	88, 325	
12. 00	Supplies (see instructions)	l o	C			o o	0	12.00
13. 00	Drugs	0	C			0	0	13.00
14.00	DME	0	C) c)	0 0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15. 00	Home Dialysis Aide Services	0	C) c		0	0	1
16. 00	Respi ratory Therapy	0	C	0)	0	0	16. 00
17. 00	Private Duty Nursing	0	C	0)	0	0	17. 00
18. 00	Clinic	0	C	0)	0	0	18.00
19.00	Health Promotion Activities	0	C)	0	0	19.00
20.00	Day Care Program	0	(0		20.00
21. 00 22. 00	Home Delivered Meals Program Homemaker Service		((0		21. 00 22. 00
22. 00	All Others (specify)		(0	0	22.00
23. 50	Tel emedicine		(0 0		23.50
24. 00	Total (sum of lines 1-23)		(0 -129, 362	444, 153	1
25. 00	Cost To Be Allocated (per		(0 127, 302	129, 362	
_0.00	Wester to be All to Best 1)	ı		i i		-	1 .27,002	1 -0.00

0.000000

0. 000000

0.000000

0.000000

0. 291255 26. 00

24.00 Total (sum of lines 1-23)
25.00 Cost To Be Allocated (per Worksheet H-1, Part I)
26.00 Unit Cost Multiplier

Peri od: Worksheet H-2
From 10/01/2018 Part I
To 09/30/2019 Date/Time Prepared: 2/25/2020 4:33 pm

Home Heal th PPS HHA CCN: 15-7078

						Home Health Agency I	PPS	
			CAPI TAL			, in the second		
	Cost Center Description	HHA Trial	RELATED COSTS NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI V	OPERATION OF	
		Bal ance (1)	FLXT	BENEFITS DEPARTMENT		E & GENERAL	PLANT	
		0	1. 00	4. 00	4A	5. 00	7. 00	
1.00	Administrative and General	0	17, 196	155, 445	172, 641	34, 981	15, 889	1.00 2.00
2. 00 3. 00	Skilled Nursing Care Physical Therapy	331, 411 93, 732	0	0	331, 411 93, 732	67, 153 18, 992	0	1
4.00	Occupational Therapy	25, 611	o	0	25, 611	5, 189	0	
5. 00 6. 00	Speech Pathology Medical Social Services	8, 711	0	0	8, 711 0	1, 765 0	0	
7. 00	Home Heal th Ai de	114, 050		0	114, 050		0	7. 00
8.00	Supplies (see instructions)	0	0	0	0	0	0	
9. 00 10. 00	Drugs DME		0	0		0	0	9. 00 10. 00
11.00	Home Dialysis Aide Services	0	O	0	0	0	0	
12. 00 13. 00	Respiratory Therapy Private Duty Nursing	0	0	0	0	0	0	12. 00 13. 00
14.00	Clinic	0	Ö	0	Ö	0	Ō	14.00
15. 00 16. 00	Health Promotion Activities Day Care Program	0	0	0	0	0	0	
17. 00	Home Delivered Meals Program		0	0	0	0	0	
18.00	Homemaker Service	0	0	0	0	0	0	
19. 00 19. 50	All Others (specify) Telemedicine		0	0	0	0	0	19. 00 19. 50
20.00	Total (sum of lines 1-19) (2)	573, 515	17, 196	155, 445		151, 189	15, 889	20.00
21. 00	Unit Cost Multiplier: column 26, line 1 divided by the sum				0. 000000			21.00
	of column 26, line 20 minus							
	column 26, line 1, rounded to 6 decimal places.							
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	CENTRAL	PHARMACY	
		LINEN SERVICE			ADMI NI STRATI O N	SERVI CES & SUPPLY		
1.00	Induiting and Consul	8. 00	9. 00	10.00	13. 00	14. 00	15. 00	1 00
1. 00 2. 00	Administrative and General Skilled Nursing Care	0	5, 666 0	0	0	0	0	
3.00	Physi cal Therapy	0	О	0	0	0	0	
4. 00 5. 00	Occupational Therapy Speech Pathology	0	0	0	0	0	0	1
6. 00	Medical Social Services	Ö	o	0	ő	0	0	
7. 00 8. 00	Home Health Aide Supplies (see instructions)	0	0	0	0	0	0	
9. 00	Drugs		0	0	0	0	0	1
10.00	DME	0	0	0	0	0	0	
11. 00 12. 00	Home Dialysis Aide Services Respiratory Therapy		0	0	0 0	0	0	
13.00	Private Duty Nursing	0	0	0	0	0	0	
14. 00 15. 00	Clinic Health Promotion Activities	0	0	0	0	0	0	
16.00	Day Care Program	0	ō	0	Ō	0	0	16. 00
17. 00 18. 00	Home Delivered Meals Program Homemaker Service	0	0	0	0	0	0	17. 00 18. 00
	All Others (specify)	Ö	o	0	ő	0	0	
19.50	Telemedicine Total (sum of lines 1-19) (2)	0	0 5, 666	0	0	0	0	19. 50 20. 00
21. 00	Unit Cost Multiplier: column		3, 000	O		J	O	21.00
	26, line 1 divided by the sum							
	of column 26, line 20 minus column 26, line 1, rounded to							

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

	Cost Center Description	Total HHA		
		Costs		
		28. 00		
1.00	Administrative and General			1.00
2.00	Skilled Nursing Care	536, 050		2.00
3.00	Physi cal Therapy	151, 609		3.00
4.00	Occupational Therapy	41, 425		4.00
5.00	Speech Pathology	14, 090		5.00
6.00	Medical Social Services	0		6.00
7.00	Home Health Aide	184, 473		7.00
8.00	Supplies (see instructions)	0		8. 00
9.00	Drugs	0		9. 00
10.00	DME	0		10.00
11. 00	Home Dialysis Aide Services	0		11.00
12.00	Respiratory Therapy	0		12.00
13.00	Private Duty Nursing	0		13.00
14.00	Clinic	0		14.00
15.00	Health Promotion Activities	0		15.00
16.00	Day Care Program	0		16.00
17.00	Home Delivered Meals Program	0		17.00
18.00	Homemaker Service	0		18. 00
19.00	All Others (specify)	0		19. 00
19. 50	Tel emedi ci ne	0		19. 50
20.00	Total (sum of lines 1-19) (2)	927, 647		20.00
21. 00	Unit Cost Multiplier: column			21.00
	26, line 1 divided by the sum			
	of column 26, line 20 minus			l
	column 26, line 1, rounded to			l
	6 decimal places.			I

0. 344956

21.00

Unit Cost Multiplier: column

6 decimal places.

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

21.00

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

2/25/2020 4:33 pm

Home Health PPS Agency I CAPI TAL RELATED COSTS **EMPLOYEE** ADMI NI STRATI V OPERATION OF LAUNDRY & Reconciliatio Cost Center Description NEW BLDG & FI XT **BENEFITS** E & GENERAL **PLANT** LINEN SERVICE (SQUARE DEPARTMENT (ACCUM (SQUARE (POUNDS OF LAUNDRY) FEET) (GROSS COST) FEET) SALARIES) 1.00 8.00 4.00 5A 5.00 7.00 1.00 Administrative and General 772 477, 949 172, 641 772 1.00 C 2.00 Skilled Nursing Care 0 0 331, 411 0 2.00 0 93, 732 0 3.00 3 00 0 0 Physical Therapy 0 0 0 0 4.00 Occupational Therapy 0 25, 611 4.00 Speech Pathology 0 5.00 0 0 8,711 0 5.00 0 0 6.00 Medical Social Services 0 0 0 6.00 0 0 0 7 00 Home Health Aide Ω 114,050 7 00 8.00 Supplies (see instructions) 0 8.00 9.00 0 0 9.00 Drugs 0000 0 0 0 10.00 10.00 DMF 0 0 0 0 0 0 11.00 Home Dialysis Aide Services 0 11.00 12.00 Respiratory Therapy 0 0 0 12.00 Private Duty Nursing 0 13.00 13.00 0 0 0 0 0 0 14.00 Clinic 14.00 0 15.00 Health Promotion Activities 0 0 15 00 0 16.00 Day Care Program 16.00 17.00 Home Delivered Meals Program 0 0 0 0 17.00 0 0 0 Homemaker Service 18.00 0 0 18.00 0 0 19.00 All Others (specify) C 19.00 19.50 0 0 0 19.50 Tel emedi ci ne 0 746, 156 20.00 Total (sum of lines 1-19) 772 477.949 772 20.00 21.00 Total cost to be allocated 17, 196 155, 445 151, 189 15,889 21.00 22.00 Unit cost multiplier 22. 274611 0.325233 0.202624 20. 581606 0.000000 22.00 HOUSEKEEPI NG NURSI NG CENTRAL PHARMACY MEDI CAL Cost Center Description DI ETARY (SQUARE (MEALS ADMI NI STRATI O SERVICES & (100%)RECORDS & LI BRARY SERVED) SUPPLY FEET) (DI RECT (100%)(GROSS NRSING HRS) CHARGES) 9.00 10. 00 13.00 14.00 15.00 16.00 Administrative and General 1.00 772 0 831, 736 1.00 00000000000000 0 2.00 Skilled Nursing Care 0 C 2 00 0 o 3.00 Physical Therapy 0 0 3.00 4.00 Occupational Therapy 0 0 0 4.00 0 0 0 Speech Pathology 0 0 5.00 5.00 0 0 0 6.00 Medical Social Services 6.00 7.00 Home Heal th Aide 0 0 0 7.00 0 0 0 0 0 8.00 Supplies (see instructions) 0 8.00 0 0 Drugs 9.00 0 0 9.00 10.00 DMF C 0 10.00 11.00 Home Dialysis Aide Services 0 11.00 0 0 Respiratory Therapy 0 0 12.00 12.00 0 13.00 Private Duty Nursing C 0 13.00 0 14.00 0 14.00 Clinic 0 0 15.00 Health Promotion Activities 0 0 0 0 0 15.00 0 0 16,00 Day Care Program 0 16,00 17.00 Home Delivered Meals Program 0 17.00 0 Homemaker Service 0 0 0 o 18.00 18.00 All Others (specify) 0 o 0 0 19.00 19.00 0 Tel emedi ci ne 0 0 o 19.50 C 19.50 20.00 Total (sum of lines 1-19) 772 0 C 0 0 831, 736 20.00 8, 747 21.00 Total cost to be allocated 21.00 5,666

7 339378

0.000000

0.000000

0.000000

0.000000

0.010517 22.00

22.00 Unit cost multiplier

Health Financial Systems		PULAS	SKI MEMORIAL	HOSPI TAL			In Lie	u of Form CMS-2	2552-10
ALLOCATION OF GENERAL SERVICE COSTS T	O HHA COST (CENTERS	STATI STI CAL	Provi der	CCN:		Peri od: From 10/01/2018	Worksheet H-2	
0.000				HHA CCN:		15-7078		Date/Time Prep 2/25/2020 4:33	
							Home Health	PPS	
							Agency I		
Cost Center Description	SOCI AL								
	SERVI CE								
	(ALLOCATIO	N							
	OF TIME)								

				Agency I	
	Cost Center Description	SOCI AL			
		SERVI CE			
		(ALLOCATION			
		OF TIME)			
		17. 00			
1.00	Administrative and General	0			1.00
2.00	Skilled Nursing Care	0			2.00
3.00	Physi cal Therapy	0			3.00
4.00	Occupational Therapy	0			4.00
5.00	Speech Pathology	0			5.00
6.00	Medical Social Services	0			6.00
7.00	Home Health Aide	0			7.00
8.00	Supplies (see instructions)	0			8.00
9.00	Drugs	0			9.00
10.00	DME	0			10.00
11.00	Home Dialysis Aide Services	0			11.00
12.00	Respiratory Therapy	0			12.00
13.00	Private Duty Nursing	0			13.00
14.00	Clinic	0			14.00
15.00	Health Promotion Activities	0			15.00
16.00	Day Care Program	0			16.00
17.00	Home Delivered Meals Program	0			17.00
18.00	Homemaker Service	0			18.00
19.00	All Others (specify)	0			19.00
19. 50	Tel emedi ci ne	0			19.50
20.00	Total (sum of lines 1-19)	0			20.00
21.00	Total cost to be allocated	0			21.00
22.00	Unit cost multiplier	0. 000000			22.00

	h Financial Systems		PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPOR	TIONMENT OF PATIENT SERVICE COST	rs		Provi der C	CN: 15-1305	Peri od:	Worksheet H-3	
						From 10/01/2018		
				HHA CCN:	15-7078	To 09/30/2019	Date/Time Pre 2/25/2020 4:3	
				Title	XVIII	Home Health	PPS	о рііі
	Cost Center Description	From, Wkst.	Facility	Shared	Total HHA	Agency I Total Visits	Average Cost	
	good gomes, pood, i per on	H-2, Part I,	Costs (from	Ancillary	Costs (cols		Per Visit	
		col. 28, line		Costs (from	1 + 2)		(col. 3 ÷	
			Part I)	Part II)	ĺ		col. 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE						
	COST LIMITATION		,					
	Cost Per Visit Computation							1
1.00	Skilled Nursing Care	2.00	536, 050		536, 0	50 2, 575	208. 17	1.00
2.00	Physi cal Therapy	3.00		0				
3. 00	Occupational Therapy	4.00		0			120. 42	1
4. 00	Speech Pathology	5.00		0			120. 43	1
5. 00	Medical Social Services	6.00		O	14,0	0 0	0.00	
	l control of the cont				404.4	-		1
6.00	Home Health Aide	7.00			184, 4		88. 95	
7. 00	Total (sum of lines 1-6)		927, 647	0	72.70			7.00
					Program Visi	ts		
						art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject	Subject to		
					to	Deducti bl es		
					Deducti bl es	&		
					Coi nsurance	:		
		0	1. 00	2. 00	3.00	4. 00	5. 00	
	Limitation Cost Computation				•			
8.00	Skilled Nursing Care		99915	0	1, 0	70		8.00
9.00	Physi cal Therapy		99915	0		46		9.00
10.00			99915	0		08		10.00
11.00			99915	0		55 57		11.00
12.00			99915	0		0		12.00
				-				
13.00	1		99915	0		69		13.00
14.00	Total (sum of lines 8-13)			0	-1 -			14.00
	Cost Center Description	From Wkst.	Facility	Shared	Total HHA		Ratio (col. 3	
		H-2 Part I,	Costs (from	Ancillary	Costs (cols	7	÷ col. 4)	
		col. 28, line	Wkst. H-2,	Costs (from	1 + 2)	Records)		
			Part I)	Part II)				
		0	1. 00	2. 00				
	Supplies and Drugs Cost Comput			2.00	3. 00	4. 00	5. 00	
	Cost of Medical Supplies	8. 00	0	0		0 0	0. 000000	1
		8. 00 9. 00	0				0. 000000	1
	Cost of Medical Supplies	8. 00 9. 00	0	0		0 0	0. 000000	1
	Cost of Medical Supplies	8. 00 9. 00	0	0		0 0	0. 000000	1
	Cost of Medical Supplies	8. 00 9. 00	0	0	Cost of	0 0	0. 000000	1
	Cost of Medical Supplies Cost of Drugs	8. 00 9. 00	0 0 Program Visits	0 0	Cost of Services	0 0 0 0 0 0 Part B	0. 000000 0. 000000	1
	Cost of Medical Supplies	8. 00 9. 00	0 0 Program Visits Par Not Subject	0 0 t B Subject to	Cost of	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0. 000000 0. 000000 Subj ect to	1
	Cost of Medical Supplies Cost of Drugs	8. 00 9. 00	0 0 Program Visits Par Not Subject to	0 0 t B Subject to Deductibles &	Cost of Services	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0.000000 0.000000 Subject to Deductibles &	1
	Cost of Medical Supplies Cost of Drugs	8. 00 9. 00	0 0 Program Visits Par Not Subject to Deductibles &	0 0 t B Subject to Deductibles &	Cost of Services	Part B Not Subject to Deductibles &	0.000000 0.000000 Subject to Deductibles &	1
	Cost of Medical Supplies Cost of Drugs	8.00 9.00 Part A	Program Visits Par Not Subject to Deductibles & Coinsurance	0 0 t B Subject to Deducti bles & Coi nsurance	Cost of Services Part A	Part B Not Subject to Deducti bl es & Coi nsurance	0. 000000 0. 000000 Subject to Deductibles & Coinsurance	1
	Cost of Medical Supplies Cost of Drugs Cost Center Description	8.00 9.00 Part A	Program Visits Par Not Subject to Deductibles & Coinsurance 7.00	t B Subject to Deductibles & Coinsurance 8.00	Cost of Services Part A	Part B Not Subject to Deducti bles & Coi nsurance 10.00	0.000000 0.000000 Subject to Deductibles & Coinsurance	1
	Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER	8.00 9.00 Part A	Program Visits Par Not Subject to Deductibles & Coinsurance 7.00	t B Subject to Deductibles & Coinsurance 8.00	Cost of Services Part A	Part B Not Subject to Deducti bles & Coi nsurance 10.00	0.000000 0.000000 Subject to Deductibles & Coinsurance	1
	Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION	8.00 9.00 Part A	Program Visits Par Not Subject to Deductibles & Coinsurance 7.00	t B Subject to Deductibles & Coinsurance 8.00	Cost of Services Part A	Part B Not Subject to Deducti bles & Coi nsurance 10.00	0.000000 0.000000 Subject to Deductibles & Coinsurance	1
16.00	Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation	8.00 9.00 Part A 6.00 OF AGGREGATE	Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A	t B Subject to Deductibles & Coinsurance 8.00	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance 10.00 MITATION COST, C	0.000000 0.000000 Subject to Deductibles & Coinsurance	16.00
1. 00	Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care	8.00 9.00 Part A 6.00 OF AGGREGATE	Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A	t B Subject to Deductibles & Coinsurance 8.00	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance 10.00 MITATION COST, C	0.000000 0.000000 Subject to Deductibles & Coinsurance	1.00
1. 00 2. 00	Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy	8.00 9.00 Part A 6.00 OF AGGREGATE	Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A	t B Subject to Deductibles & Coinsurance 8.00	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance 10.00 MITATION COST, CO 0 222,742 0 89,833	0.000000 0.000000 Subject to Deductibles & Coinsurance	1. 00
1. 00	Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care	8.00 9.00 Part A 6.00 OF AGGREGATE	Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A	t B Subject to Deductibles & Coinsurance 8.00	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance 10.00 MITATION COST, C	0.000000 0.000000 Subject to Deductibles & Coinsurance	1. 00
1. 00 2. 00	Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy	8.00 9.00 Part A 6.00 OF AGGREGATE	Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A	t B Subject to Deductibles & Coinsurance 8.00	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance 10.00 MITATION COST, CO 0 222,742 0 89,833	0.000000 0.000000 Subject to Deductibles & Coinsurance	1. 00 2. 00 3. 00
1. 00 2. 00 3. 00	Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy	8.00 9.00 Part A 6.00 OF AGGREGATE 0 0 0	Program Vi si ts Par Not Subj ect to Deducti bl es & Coi nsurance 7.00 PROGRAM COST, A 1,070 746 208 67	t B Subject to Deductibles & Coinsurance 8.00	Cost of Services Part A	Part B Not Subject to Deducti bl es & Coi nsurance 10.00 MI TATI ON COST, CO 89,833 0 25,047	0.000000 0.000000 Subject to Deductibles & Coinsurance	1. 00 2. 00 3. 00 4. 00
1. 00 2. 00 3. 00 4. 00 5. 00	Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	8.00 9.00 Part A 6.00 OF AGGREGATE 0 0 0 0 0	Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A 1,070 746 208 67	t B Subject to Deductibles & Coinsurance 8.00	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance 10.00 MITATION COST, CO 0 222,742 0 89,833 0 25,047 0 8,069 0 0	0.000000 0.000000 Subject to Deductibles & Coinsurance	1. 00 2. 00 3. 00 4. 00 5. 00
1. 00 2. 00 3. 00 4. 00	Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	8.00 9.00 Part A 6.00 OF AGGREGATE 0 0 0 0	Program Visits Par Not Subject to Deductibles & Coinsurance 7.00 PROGRAM COST, A 1,070 746 208 67 0 769	t B Subject to Deductibles & Coinsurance 8.00	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance 10.00 MITATION COST, CO 0 222,742 0 89,833 0 25,047 0 8,069	0.000000 0.000000 Subject to Deductibles & Coinsurance 11.00 R BENEFICIARY	16.00

Heal th	Financial Systems		PULASKI MEMOR	IAI HOSPITAI		Inlie	u of Form CMS-	2552-10
	TONMENT OF PATIENT SERVICE COST	ΓS	TOERON MEMON	Provi der Co	CN: 15-1305 15-7078	Peri od: From 10/01/2018 To 09/30/2019	Worksheet H-3 Part I Date/Time Pre	Phared:
				TITIA CON.	13 7070	10 077 307 2017	2/25/2020 4: 3	33 pm
				Title	XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description		7.00	0.00	0.00	10.00	44.00	
		6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
8. 00	Limitation Cost Computation Skilled Nursing Care							8.00
9. 00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11. 00	Speech Pathology			•				11.00
12. 00	Medical Social Services							12.00
13. 00	Home Heal th Aide							13.00
	Total (sum of lines 8-13)							14.00
		Progr	ram Covered Cha	arges	Cost of			
				Ü	Servi ces			
				t B		Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
			to	Deductibles &		to	Deductibles &	
			Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
		6, 00	Coi nsurance	0.00	0.00	Coi nsurance	11 00	
	Supplies and Drugs Cost Comput		7. 00	8. 00	9. 00	10.00	11.00	
15. 00	Cost of Medical Supplies	0	31, 049	0		0 0	C	15.00
	Cost of Drugs		0	l .				
	Cost Center Description	Total Program	-	-			_	
	'	Cost (sum of						
		col s. 9-10)						
		12. 00						
	PART I - COMPUTATION OF LESSER COST LIMITATION	OF AGGREGATE	PROGRAM COST, A	AGGREGATE OF TH	HE PROGRAM LI	MITATION COST, C	R BENEFICIARY	
	Cost Per Visit Computation							1
1. 00	Skilled Nursing Care	222, 742						1.00
2.00	Physi cal Therapy	89, 833						2.00
3.00	Occupational Therapy	25, 047						3.00
4. 00 5. 00	Speech Pathology Medical Social Services	8, 069 0						4. 00 5. 00
	Home Health Aide	-						
6. 00 7. 00	4	68, 403						6. 00 7. 00
7.00	Total (sum of lines 1-6) Cost Center Description	414, 094						7.00
	cost center bescription	12. 00						1
	Limitation Cost Computation	12.00						
8. 00	Skilled Nursing Care							8.00
9. 00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11. 00	Speech Pathology							11.00
12.00	Medi cal Soci al Servi ces							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

Heal th	Financial Systems		PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APP0R1	TIONMENT OF PATIENT SERVICE COS	ΓS		Provi der C	CN: 15-1305	Peri od:	Worksheet H-3	
				HHA CCN:	15-7078	From 10/01/2018 To 09/30/2019	Date/Time Pre	
				T: +1 -		Hama Haal Ab	2/25/2020 4: 3	<u>3 pm</u>
				litie	× XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Charge Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1. 00	2. 00	3.00	4. 00		
	PART II - APPORTIONMENT OF COS	T OF HHA SERVI	CES FURNISHED E	BY SHARED HOSP	ITAL DEPARTME	NTS		
1.00	Physi cal Therapy	66.00	0. 612516	0		0 col. 2, line 2	. 00	1.00
2.00	Occupational Therapy	67.00	0. 506299	0		Ocol. 2, line 3	. 00	2.00
3.00	Speech Pathology	68.00	0. 781652	0		0 col. 2, line 4	. 00	3.00
4.00	Cost of Medical Supplies	71.00	0. 252587	0)	0 col. 2, line 1	5. 00	4.00
5.00	Cost of Drugs	73.00	0. 282354	0)	0 col. 2, line 1	6. 00	5.00

	Financial Systems PULASKI MEMORIAL ATION OF HHA REIMBURSEMENT SETTLEMENT	Provider Co	CN: 15-1305	Peri od:	worksheet H-4	
		HHA CCN:	15-7078	From 10/01/2018 To 09/30/2019		
		Title	XVIII	Home Health Agency I	PPS	
			D+ A		t B Subject to	
			Part A	Not Subject to	Deductibles &	
				Deductibles &	Coi nsurance	
			1.00	Coi nsurance 2.00	3. 00	-
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUS-	TOMARY CHARGE		2.00] 3.00	
	Reasonable Cost of Part A & Part B Services					
00	Reasonable cost of services (see instructions)			0 0	1	1
00	Total charges Customary Charges			0 0	0	2
00	Amount actually collected from patients liable for payment for	or services		0 0	0	3
	on a charge basis (from your records)					
00	Amount that would have been realized from patients liable for for services on a charge basis had such payment been made in with 42 CFR §413.13(b)			0 0	0	4
00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 0000	0. 000000	l e	
00	Total customary charges (see instructions)	(0 0	0	
00	Excess of total customary charges over total reasonable cost only if line 6 exceeds line 1)	(complete		0 0	0	7
00	Excess of reasonable cost over customary charges (complete of 1 exceeds line 6)	nlyifline		0 0	0	8
00	Primary payer amounts			0 0		9
				Part A Services	Part B Services	
				1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
. 00	Total reasonable cost (see instructions)			0		
. 00	Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers			0	400, 360 3, 984	
. 00	Total PPS Reimbursement - LUPA Episodes			0	6, 649	
. 00	Total PPS Reimbursement - PEP Episodes			0	3, 433	14
. 00	Total PPS Outlier Reimbursement - Full Episodes with Outlier	S		0	543	
. 00	Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments			0	0	
. 00	DME Payments			0	0	1
00	Oxygen Payments			0	0	1
00	Prosthetic and Orthotic Payments			0		
. 00	, ,	surance)			0	
. 00 . 00	Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8)			0	414, 969 0	
. 00	Subtotal (line 22 minus line 23)			0	414, 969	
. 00					0	
. 00	Net cost (line 24 minus line 25)			0	414, 969	
. 00	, , ,					27
. 00	Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin)	0	414, 969	28
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	110 27)		Ö	1	
. 50	Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	l	1
. 99	Demonstration payment adjustment amount before sequestration			0		
. 00	Subtotal (see instructions)			0		
. 01 . 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			0		1
. 02	Interim payments (see instructions)			0	l e	
	in the state of th					
2. 00	Tentative settlement (for contractor use only)			0	0	33
2. 00	Balance due provider/program (line 31 minus lines 31.01, 32,			0		34

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL		In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED	HHAS FOR SERVICES RENDERED	Provi der	CCN: 15-1305	Peri od: From 10/01/2018	Worksheet H-5
TO PROGRAM BENEFICIARIES		HHA CCN:	15-7078		Date/Time Prepared:

2/25/2020 4: 33 pm Home Health Agency I Inpatient Part A Part B mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 1.00 406, 669 2.00 0 2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3. 01 3.01 0 3.02 0 3.02 3.03 0 3.03 3.04 0 0 3.04 0 3.05 3.05 Provider to Program 3.50 0 0 3.50 3. 51 0 0 3.51 0 3.52 0 3.52 3.53 0 3.53 3.54 0 0 3.54 0 3. 99 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3. 50-3. 98) Total interim payments (sum of lines 1, 2, and 3.99) 4.00 0 406, 669 4.00 (transfer to Wkst. H-4, Part II, column as appropriate, line 32) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after 5.00 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 0 n 5.01 0 0 5.02 5.02 5.03 0 0 5.03 Provider to Program 5.50 0 5.50 n 5. 51 0 0 5.51 5. 52 0 0 5.52 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 5. 50-5. 98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.01 0 6.02 SETTLEMENT TO PROGRAM 6.02 0 Total Medicare program liability (see instructions) n 406, 670 7.00 7.00 NPR Date Contractor Number (Mo/Day/Yr) 0 1.00 2.00

8. 00

8.00 Name of Contractor

		DIN AGAI MEMODI				6.5	10
	Financial Systems IS OF HOSPITAL-BASED RHC/FOHC COSTS	PULASKI MEMORI	Provider C	ON. 1E 120E	In Lie Period:	u of Form CMS-2 Worksheet M-1	
ANALTS	OF HUSPITAL-BASED KHC/FUNC CUSTS		Provider Co	UN. 13-1303	From 10/01/2018		
			Component	CCN: 15-8512	To 09/30/2019		
					RHC I	Cost	
		Compensation	Other Costs		1 Reclassi fi cat	Reclassified	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
		1. 00	2. 00	3.00	4.00	col . 4) 5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	5.00	
1. 00	Physician	2, 992, 450	47, 000	3, 039, 45	-480, 473	2, 558, 977	1.00
2. 00	Physician Assistant	2, 772, 430	47,000	3, 037, 43	0 -400, 473	2, 330, 777	
3.00	Nurse Practitioner	494, 374	25, 400	519, 77	٥	465, 487	3.00
4. 00	Visiting Nurse	0	20, 100	017,77	0 01,207	0	
5. 00	Other Nurse	169, 856	0	169, 85	6 0	169, 856	
6. 00	Clinical Psychologist	0	0	151,55	0 0	0	6.00
7. 00	Clinical Social Worker	0	0		0 0	0	7.00
8. 00	Laboratory Techni ci an	0	0		0 0	0	1
9.00	Other Facility Health Care Staff Costs	615, 558	0	615, 55	8 0	615, 558	9.00
10.00	Subtotal (sum of lines 1 through 9)	4, 272, 238	72, 400	4, 344, 63	-534, 760	3, 809, 878	10.00
11.00	Physician Services Under Agreement	0	67, 040	67, 04	0 -11, 569	55, 471	11.00
12.00	Physician Supervision Under Agreement	0	0		0 0	0	12.00
13.00	Other Costs Under Agreement	0	0		0 0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	67, 040	67, 04	0 -11, 569	55, 471	14.00
15.00	Medical Supplies	0	36, 194	36, 19	-5, 102	31, 092	
16.00	Transportation (Health Care Staff)	0	0		0	0	16.00
17. 00	Depreciation-Medical Equipment	0	0		0	0	17. 00
18. 00	Professional Liability Insurance	0	0		0	0	18. 00
19.00		0	0		0	0	
20.00	Allowable GME Costs		07.404	0, 40	F 400	24 000	20.00
21. 00	Subtotal (sum of lines 15 through 20)	4 272 220	36, 194		· ·	31, 092	1
22. 00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	4, 272, 238	175, 634	4, 447, 87	-551, 431	3, 896, 441	22. 00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	ol	0		0 0	0	23.00
24. 00	Dental	Ö	0		0 0	Ö	
25. 00	Optometry	0	0		0 0	Ö	
25. 01	Tel eheal th	0	0		0 0	Ö	
25. 02	Chronic Care Management	o	0		0 0	0	25. 02
26. 00	All other nonreimbursable costs	0	0		0 0	0	26.00
27. 00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	28. 00
	through 27)						
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	138, 809		· ·		
30.00	Administrative Costs	634, 420	102, 410				
31.00	Total Facility Overhead (sum of lines 29 and	634, 420	241, 219	875, 63	-227, 156	648, 483	31.00
	(30)			1	1	l .	i .

4, 906, 658

416, 853

-778, 587

4, 544, 924

32.00

5, 323, 511

32.00 Total facility costs (sum of lines 22, 28 and 31)

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CCN: 15-1305	Peri od: From 10/01/2018	Worksheet M-1
		Component CCN: 15-8512	To 09/30/2019	Date/Time Prepared: 2/25/2020 4:33 pm
			RHC I	Cost

						2/25/2020 4:3	3 pm
					RHC I	Cost	
		Adjustments	Net Expenses				
		-	for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6. 00	7. 00				
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	2, 558, 977				1.00
2.00	Physician Assistant	0	0				2.00
3.00	Nurse Practitioner	0	465, 487				3.00
4.00	Visiting Nurse	0	0				4.00
5.00	Other Nurse	0	169, 856				5.00
6.00	Clinical Psychologist	0	0				6. 00
7.00	Clinical Social Worker	0	0				7. 00
8.00	Laboratory Techni ci an	0	0				8. 00
9.00	Other Facility Health Care Staff Costs	0	615, 558				9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	3, 809, 878				10.00
11. 00	Physician Services Under Agreement	0	55, 471				11.00
12.00	Physician Supervision Under Agreement	0	0				12.00
13.00	Other Costs Under Agreement	0	0				13.00
14.00	Subtotal (sum of lines 11 through 13)	0	55, 471				14.00
15.00	Medical Supplies	0	31, 092				15.00
16.00	Transportation (Health Care Staff)	0	0				16.00
17.00	Depreciation-Medical Equipment	0	0				17.00
18.00	Professional Liability Insurance	0	0				18. 00
19.00	Other Health Care Costs	0	0				19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	31, 092				21.00
22.00	Total Cost of Health Care Services (sum of	0	3, 896, 441				22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0				23.00
24.00	Dental	0	0				24.00
25.00	Optometry	0	0				25.00
25. 01	Tel eheal th	0	0				25. 01
25. 02	Chronic Care Management	0	0)			25. 02
26.00	All other nonreimbursable costs	0	0)			26. 00
27.00	Nonallowable GME costs						27. 00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0	1			28. 00
	through 27)						
	FACILITY OVERHEAD						
	Facility Costs	0	118, 341				29. 00
30.00	Administrative Costs	-1, 763	528, 379	1			30.00
31. 00	Total Facility Overhead (sum of lines 29 and	-1, 763	646, 720	1			31.00
	30)	_					
32. 00	Total facility costs (sum of lines 22, 28	-1, 763	4, 543, 161				32. 00
	and 31)	ļ		I			

	Financial Systems	PULASKI MEMORI				u of Form CMS-2	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co		Peri od:	Worksheet M-1	
			Component (From 10/01/2018 To 09/30/2019	Date/Time Pre	nared.
			Component	3014. 10 0027	10 077 007 2017	2/25/2020 4: 3	3 pm
					RHC II	Cost	
		Compensation	Other Costs		Recl assi fi cat	Recl assi fi ed	
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
		1. 00	2.00	2.00	4.00	col . 4) 5.00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3. 00	4. 00	5.00	
1. 00	Physician	269, 829	25, 481	295, 31	0	295, 310	1.00
2. 00	Physician Assistant	207, 027	25, 401			273, 310	1
3. 00	Nurse Practitioner	73, 956	0	73, 95	٠	74, 587	3.00
4. 00	Visiting Nurse	73, 730 N	0	73, 73	031	74, 387	4.00
5. 00	Other Nurse	40, 304	0	40, 30	4 0	40, 304	
6. 00	Clinical Psychologist	40, 304 N	0	40, 30		10,304	6.00
7. 00	Clinical Social Worker	0	o o			o o	1
8. 00	Laboratory Techni ci an	0	0		0 0	o o	8.00
9. 00	Other Facility Health Care Staff Costs	95, 695	o o	95, 69	5 0	95, 695	
10.00	Subtotal (sum of lines 1 through 9)	479, 784	25. 481	505, 26		505, 896	
11. 00	Physician Services Under Agreement	0	0	333, 23	8,009	8, 009	1
12. 00	Physician Supervision Under Agreement	0	0		0 0	0	12.00
13.00	Other Costs Under Agreement	0	0		0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		8, 009	8, 009	14.00
15.00	Medical Supplies	0	12, 936	12, 93	6 3, 532	16, 468	15.00
16.00	Transportation (Health Care Staff)	0	0		0	0	16.00
17.00	Depreciation-Medical Equipment	0	0		0 0	0	17.00
18.00	Professional Liability Insurance	0	0		0 0	0	18.00
19.00	Other Health Care Costs	0	0	(0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	12, 936	12, 93	6 3, 532	16, 468	21.00
22. 00	Total Cost of Health Care Services (sum of	479, 784	38, 417	518, 20	1 12, 172	530, 373	22. 00
	lines 10, 14, and 21)]
	COSTS OTHER THAN RHC/FQHC SERVICES				_		
23. 00	Pharmacy	0	0		0	0	
24. 00	Dental	0	0		0	0	24. 00
25. 00	Optometry	0	0	,	0	0	
25. 01	Tel eheal th	0	0	(0	0	25. 01
25. 02	Chronic Care Management	0	0	'	0	0	25. 02
26. 00	All other nonreimbursable costs	0	0	1	0	0	26.00
27. 00	Nonallowable GME costs	_	_			_	27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0	1	0	0	28. 00
	through 27)						1
20.00	FACILITY OVERHEAD	^	20.004	20.00	1 1 170	44.074	20.00
	Facility Costs Administrative Costs	0 72 444		30, 80 81, 86			29. 00 30. 00
.5() ()()	LAGIII DE STEATE VE. COSTS	1/ 444	. 9471	ı 81.86	or 3.028	ı 84 893	1.50 (10)

72, 444

72, 444

552, 228

30, 804 9, 421 40, 225

78, 642

14, 170 3, 028 17, 198

29, 370

81, 865

112, 669

630, 870

44, 974 84, 893

129, 867

660, 240

30.00

31.00

32.00

30.00 Administrative Costs

31.00

32.00

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28 and 31)

Health Financial Systems	PULASKI MEMORIAL HO	OSPI TAL	In Lieu	of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Pr		Peri od: From 10/01/2018	Worksheet M-1
	Со	omponent CCN: 15-8527	To 09/30/2019	

2.00 Physician Assistant 0 0 0 3.00 Nurse Practitioner 0 74,587	
FACILITY HEALTH CARE STAFF COSTS Physician Assistant 0 295, 310 0 0 0 0 0 0 0 0 0	
Allocation (col. 5 + col. 6) 6.00 7.00	
Col. 5 + col. 6) 6.00 7.00 FACILITY HEALTH CARE STAFF COSTS 0 295, 310 2.00 Physician Assistant 0 0 0 0 0 0 0 0 0	
Col. 6 6.00 7.00	
6. 00 7. 00 FACILITY HEALTH CARE STAFF COSTS 1. 00 Physician 0 295, 310 2. 00 Physician Assistant 0 0 3. 00 Nurse Practitioner 0 74, 587	
FACILITY HEALTH CARE STAFF COSTS 1.00 Physician 0 295, 310 2.00 Physician Assistant 0 0 0 3.00 Nurse Practitioner 0 74, 587	
1.00 Physi ci an 0 295, 310 2.00 Physi ci an Assi stant 0 0 3.00 Nurse Practi ti oner 0 74, 587	
2.00 Physician Assistant	
3.00 Nurse Practitioner 0 74,587	1.00
	2.00
4.00 Visiting Nurse	3.00
	4.00
	5.00
	6.00
	7.00
	8.00
9.00 Other Facility Health Care Staff Costs 0 95,695	9.00
	0.00
	1.00
12.00 Physician Supervision Under Agreement 0 0 1	2.00
13.00 Other Costs Under Agreement 0 0 1	3.00
14.00 Subtotal (sum of lines 11 through 13) 0 8,009 1	4.00
15.00 Medical Supplies 0 16,468 1	5.00
16.00 Transportation (Health Care Staff) 0 0 1	6.00
17.00 Depreciation-Medical Equipment 0 0 1	7.00
18.00 Professional Liability Insurance 0 0 1	8.00
19.00 Other Health Care Costs 0 0 1	9.00
20.00 Allowable GME Costs	0.00
21.00 Subtotal (sum of lines 15 through 20) 0 16,468 2	1.00
22.00 Total Cost of Health Care Services (sum of 0 530, 373 2	2.00
lines 10, 14, and 21)	
COSTS OTHER THAN RHC/FQHC SERVICES	
23.00 Pharmacy 0 0 2	3.00
24. 00 Dental 0 0 2	4.00
25.00 Optometry 0 0	5.00
	5. 01
25. 02 Chroni c Care Management 0 0 2	5.02
26.00 All other nonreimbursable costs 0 0 2	6.00
	7.00
28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 2	8.00
through 27)	
FACILITY OVERHEAD	
	9.00
	0.00
	1.00
30)	
	2.00
and 31)	

	Financial Systems	PULASKI MEMORI				u of Form CMS-2	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 15-1305	Period: From 10/01/2018	Worksheet M-1	
			Component	CCN: 15-8528	To 09/30/2019	Date/Time Pre 2/25/2020 4:3	pared: 3 pm
					RHC III	Cost	
		Compensation	Other Costs	,	1 Recl assi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
		1. 00	2. 00	3. 00	4. 00	col . 4) 5.00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	5.00	
1. 00	Physi ci an	0	0		0 0	0	1.00
2. 00	Physician Assistant	0	0		0 0		
3. 00	Nurse Practitioner	117, 084	12, 000	129, 0	-	128, 453	
4. 00	Visiting Nurse	0	0	, -	0 0	0	•
5. 00	Other Nurse	0	0		0 0	0	5.00
6. 00	Clinical Psychologist	0	0		0 0	0	6.00
7. 00	Clinical Social Worker	0	0		0 0	0	7.0
3. 00	Laboratory Techni ci an	0	0		0 0	0	8.0
9. 00	Other Facility Health Care Staff Costs	63, 856	0	63, 8	56 0	63, 856	9.0
10.00	Subtotal (sum of lines 1 through 9)	180, 940	12, 000	192, 9		192, 309	1
11. 00	Physician Services Under Agreement	0	0		0 3, 560		
12.00	Physician Supervision Under Agreement	0	0		0	0	
13.00	Other Costs Under Agreement	0	0		0 0	0	
14.00	Subtotal (sum of lines 11 through 13)	0	0	4 2	0 3, 560		
15. 00 16. 00	Medical Supplies Transportation (Health Care Staff)	0	4, 374	4, 3	74 1, 570	5, 944 0	1
17. 00		0	0			0	
18.00	1 '	0	0			0	18.0
19. 00		0	0			0	
20. 00	Allowable GME Costs	J				Ĭ	20.0
21. 00	Subtotal (sum of lines 15 through 20)	0	4, 374	4, 3	74 1, 570	5, 944	
22. 00	Total Cost of Health Care Services (sum of	180, 940	16, 374		· ·	·	
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	1	0	0		0	1	
24. 00	Dental	0	0		0	1	24.0
25. 00	Optometry	0	0		0	0	
25. 01	Tel eheal th	0	0		0	0	
25. 02	9	0	0		0	0	
26. 00	All other nonreimbursable costs	O	0		0	0	26.0
27. 00 28. 00	Nonallowable GME costs Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	27. 0
20.00	through 27)	U					20.00
	FACILITY OVERHEAD						1
29. 00	Facility Costs	0	8, 941	8. 9	41 6, 298	15, 239	29.00
	Administrative Costs	26, 166	· ·	- /			
	Total Facility Overhead (sum of lines 29 and	·	· ·				

26, 166

207, 106

Total Facility Overhead (sum of lines 29 and

32.00 Total facility costs (sum of lines 22, 28 and 31)

13, 748

30, 122

39, 914

237, 228

7, 644

12, 143

47, 558

249, 371

31.00

32.00

Health Financial Systems	PULASKI MEMORIAL HOSPITAL		In Lieu	of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der	CCN: 15-1305	Peri od: From 10/01/2018	Worksheet M-1
	Component		To 09/30/2019	Date/Time Prepared: 2/25/2020 4:33 pm
			DUC III	Coot

			Component	JN. 15-6526	10 09/30/2019	2/25/2020 4: 3	
					RHC III	Cost	
		Adjustments	Net Expenses				
		.,	for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6. 00	7.00				
	FACILITY HEALTH CARE STAFF COSTS	0.00	71.00				
1.00	Physi ci an	٥	0				1.00
2. 00	Physician Assistant	ol Ol	0				2.00
3.00	Nurse Practitioner	0	128, 453				3.00
4. 00	Visiting Nurse		120, 433				4.00
5. 00	Other Nurse		0				5.00
6. 00	Clinical Psychologist	0	0				6.00
7. 00	Clinical Social Worker	o O	0				7.00
	1	o o	0				1
8.00	Laboratory Technician	U	-1				8.00
9.00	Other Facility Health Care Staff Costs	O O	63, 856				9.00
10.00	Subtotal (sum of lines 1 through 9)	0	192, 309				10.00
11. 00	Physician Services Under Agreement	O	3, 560				11.00
12. 00	Physician Supervision Under Agreement	0	0				12.00
13.00	,	O	0				13.00
14.00	Subtotal (sum of lines 11 through 13)	0	3, 560				14.00
15. 00	1 ''	0	5, 944				15. 00
16. 00	, , ,	0	0				16.00
17. 00	, '	0	0				17.00
18.00	Professional Liability Insurance	0	0				18.00
19.00	Other Health Care Costs	0	0				19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	5, 944				21.00
22.00	Total Cost of Health Care Services (sum of	0	201, 813				22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0				23. 00
24.00	Dental	0	0				24.00
25.00	Optometry	0	0				25.00
25. 01	Tel eheal th	0	0				25. 01
25. 02	Chronic Care Management	0	0				25. 02
26.00	All other nonreimbursable costs	0	0				26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	o	O				28. 00
	through 27)						
	FACILITY OVERHEAD						
29.00	Facility Costs	0	15, 239				29. 00
30.00		o	32, 319				30.00
31. 00	Total Facility Overhead (sum of lines 29 and	ol	47, 558				31.00
	30)	Ĭ	, 230				
32.00	Total facility costs (sum of lines 22, 28	ol	249, 371				32.00
	and 31)	[
	'	'	'				•

Heal th	Financial Systems	PULASKI MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 10/01/2018 To 09/30/2019	Date/Time Pre 2/25/2020 4:3	
					RHC I	Cost	
		Number of FTE	Total Visits	Producti vi ty		Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1. 00	Physi ci an	5. 51					1.00
2.00	Physician Assistant	0.00					2.00
3.00	Nurse Practitioner	3. 84					3.00
4.00	Subtotal (sum of lines 1 through 3)	9. 35			31, 206	31, 206	4. 00
5.00	Visiting Nurse	0.00				0	
6.00	Clinical Psychologist	0.00				0	0.00
7.00	Clinical Social Worker	0.00	l .			0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	l .			0	7. 01
7. 02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8. 00	Total FTEs and Visits (sum of lines 4	9. 35	23, 993			31, 206	8. 00
0.00	through 7)		4.5			4.45	0.00
9. 00	Physician Services Under Agreements		145			145	9.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASI	ED RHC/FQHC SEI	RVICES			
10.00	Total costs of health care services (from Wk	kst. M-1, col.	7, line 22)			3, 896, 441	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line	28)			0	11.00
12.00	Cost of all services (excluding overhead) (s	sum of lines 10	and 11)			3, 896, 441	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I	ine 10 divided	by line 12)			1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (fr	om Worksheet.	M-1, col. 7, li	ine 31)		646, 720	14.00
15.00	Parent provider overhead allocated to facili	ty (see instru	ctions)			3, 182, 042	15.00
16.00	Total overhead (sum of lines 14 and 15)	•				3, 828, 762	16.00
17.00	Allowable GME overhead (see instructions)					0	17. 00
18.00	Enter the amount from line 16					3, 828, 762	18.00
19.00	Overhead applicable to hospital-based RHC/FC	DHC services (Ι	ine 13 x line	18)		3, 828, 762	19.00
	Total allowable cost of hospital-based RHC/F	OUC 2000 1 200 (E ! 1/	2 1 10)		7, 725, 203	1 20 00

	Financial Systems	PULASKI MEMORI	I AL_HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od: From 10/01/2018	Worksheet M-2	
			Component		To 09/30/2019	Date/Time Pre 2/25/2020 4:3	
					RHC II	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)	,	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons		T				
1. 00	Physi ci an	0. 82		1			1.00
2.00	Physician Assistant	0.00			0 0		2.00
3.00	Nurse Practitioner	0. 56			· ·		3. 00
4. 00	Subtotal (sum of lines 1 through 3)	1. 38	•	1	4, 620	4, 620	
5.00	Visiting Nurse	0.00	l e			0	5. 00
6. 00	Clinical Psychologist	0.00				0	6. 00
7. 00	Clinical Social Worker	0.00				0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
	onl y)						
8. 00	Total FTEs and Visits (sum of lines 4	1. 38	3, 485			4, 620	8. 00
	through 7)		_			_	
9. 00	Physician Services Under Agreements		0			0	9. 00
						4 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOCDITAL DACI	ED DUC/FOUR CEI	DVII CEC		1. 00	
	Total costs of health care services (from Wk			RVICES		530, 373	10 00
	Total nonreimbursable costs (from Wkst. M-1,					030, 373	
12. 00	Cost of all services (excluding overhead) (s					530, 373	
12.00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	
14. 00	Total hospital-based RHC/FQHC overhead - (fr			ino 21)		129, 867	
15. 00	Parent provider overhead allocated to facili			The 31)		467, 048	
16. 00	Total overhead (sum of lines 14 and 15)	ty (see Instru	Ctrons)			596, 915	
17. 00	Allowable GME overhead (see instructions)					0 390, 915	
	Enter the amount from line 16					596, 915	
	Overhead applicable to hospital-based RHC/FQ	NUC sorvices (1)	ino 12 y lino	10\		596, 915 596, 915	
	Total allowable cost of hospital-based RHC/F					1, 127, 288	
20.00	Tiotal allowable cost of hospital-based knc/r	CITO SELVICES (Julii OI IIIICS I	0 anu 17)	ı	1, 121, 200	20.00

	Financial Systems	PULASKI MEMORI	AL_HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 10/01/2018 To 09/30/2019	Date/Time Pre 2/25/2020 4:3	
					RHC III	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)	,	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						_
4 00	Posi ti ons	0.00		1			4 00
1.00	Physician	0.00		1	0		1.00
2. 00 3. 00	Physician Assistant Nurse Practitioner	0. 00 0. 67	0 1, 549		0 1, 407		2.00 3.00
4. 00	Subtotal (sum of lines 1 through 3)	0.67	1, 549		1, 407	1, 549	
5. 00	Visiting Nurse	0. 07	1, 349		1, 407	1, 549	1
6. 00	Clinical Psychologist	0.00	0			0	
7. 00	Clinical Social Worker	0.00	0			0	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
7.02	only)	0.00				ŭ	/. 02
8.00	Total FTEs and Visits (sum of lines 4	0. 67	1, 549			1, 549	8.00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T			RVI CES			
	Total costs of health care services (from Wk					201, 813	
	Total nonreimbursable costs (from Wkst. M-1,					0	
12.00	Cost of all services (excluding overhead) (s					201, 813	
13.00	Ratio of hospital -based RHC/FQHC services (I			: 21)		1. 000000	
14. 00 15. 00	Total hospital-based RHC/FQHC overhead - (fr Parent provider overhead allocated to facili			rne 31)		47, 558 179, 477	
16. 00	Total overhead (sum of lines 14 and 15)	ty (see mstruc	Ctions)			227, 035	
	Allowable GME overhead (see instructions)					227, 035	1
	Enter the amount from line 16					227, 035	
	Overhead applicable to hospital-based RHC/FQ	HC services (Li	ne 13 x line	18)		227, 035	
	Total allowable cost of hospital-based RHC/F					428, 848	
-		(-		. ,	'	,	

Heal th	Financial Systems PULASKI MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provi der CCN: 15-1305	Peri od:	Worksheet M-3	
SERVI C	ES	Component CCN: 15-8512	From 10/01/2018 To 09/30/2019	Date/Time Pre 2/25/2020 4:3	
		Title XVIII	RHC I	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst. M-2, line 20)		7, 725, 203	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, li	ne 15)		84, 992	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			7, 640, 211	3.00
4. 00 5. 00	Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		31, 206 145	4. 00 5. 00
6. 00	Total adjusted visits (line 4 plus line 5)	7)		31, 351	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			243. 70	7. 00
			Calculation	of Limit (1)	
			Pri or to Jan.	On or After	
			1 (Rate	Jan. 1 (Rate	
			Peri od 1) 1.00	Peri od 2) 2.00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00	0.00	8. 00
9.00	Rate for Program covered visits (see instructions)		243. 70	243. 70	9. 00
40.00	CALCULATION OF SETTLEMENT			7.000	10.00
10. 00 11. 00	Program covered visits excluding mental health services (from Program cost excluding costs for mental health services (line		0	7, 280 1, 774, 136	1
12.00	Program covered visits for mental health services (from contr		0	1, 774, 130	1
13. 00	Program covered cost from mental health services (line 9 x li	•	0	13, 647	
14. 00	Limit adjustment for mental health services (see instructions		0	13, 647	14.00
15.00	Graduate Medical Education Pass Through Cost (see instruction	•		1 707 700	15.00
16. 00 16. 01	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 Total program charges (see instructions)(from contractor's re	•	0	1, 787, 783 959, 316	•
16. 02	Total program preventive charges (see instructions)(from prov			21, 262	•
16. 03	Total program preventive costs ((line 16.02/line 16.01) times			39, 624	1
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		1, 314, 440	16. 04
16. 05	(Titles V and XIX see instructions.) Total program cost (see instructions)		0	1, 354, 064	16. 05
17. 00	Primary payer amounts		J	1, 334, 004	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		105, 109	1
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		166, 589	19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)			1, 354, 064	20.00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		34, 861	21.00
22. 00	Total reimbursable Program cost (line 20 plus line 21)			1, 388, 925	1
23. 00 23. 01	Allowable bad debts (see instructions)			0	23. 00 23. 01
24. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	24.00
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	. 451. 51.57		0	25.00
25. 50		s)		0	25. 50
	Demonstration payment adjustment amount before sequestration			1 200 025	1
26. 00 26. 01	Net reimbursable amount (see instructions) Sequestration adjustment (see instructions)			1, 388, 925 27, 779	
26. 02	Demonstration payment adjustment amount after sequestration			0	26. 02
	Interim payments			1, 336, 827	
28. 00	Tentative settlement (for contractor use only)	00 07 1 77		0	28.00
29. 00 30. 00	Balance due component/program (line 26 minus lines 26.01, 26. Protested amounts (nonallowable cost report items) in accorda			24, 319 0	29. 00 30. 00
	chapter I, §115.2				

Heal th	Financial Systems PULASKI MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Peri od:	Worksheet M-3	
SERVI (SERVI CES Component CCN: 15-8527 From 10/01/2018 To 09/30/2019				
		Title XVIII	RHC II	2/25/2020 4: 3 Cost	<u> </u>
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst. M-2, line 20)		1, 127, 288	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, li	ne 15)		27, 896	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1, 099, 392	
4. 00 5. 00	Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		4, 620 0	4. 00 5. 00
6. 00	Total adjusted visits (line 4 plus line 5)	1111e 7)		4, 620	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			237. 96	7. 00
			Cal cul ati on	of Limit (1)	
			Pri or to Jan.	On or After	
			1 (Rate	Jan. 1 (Rate	
			Peri od 1) 1.00	Peri od 2) 2.00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00	0.00	8. 00
9. 00	Rate for Program covered visits (see instructions)		237. 96	237. 96	9.00
10.00	CALCULATION OF SETTLEMENT			2 021	10.00
10. 00 11. 00	Program covered visits excluding mental health services (from Program cost excluding costs for mental health services (line		0	2, 031 483, 297	
12.00	Program covered visits for mental health services (from contr		0	403, 277	12.00
13.00	Program covered cost from mental health services (line 9 x li	ne 12)	0	0	13. 00
14.00	Limit adjustment for mental health services (see instructions	•	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instruction	•	0	402 207	15.00
16. 00 16. 01	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 Total program charges (see instructions)(from contractor's re	•	U	483, 297 244, 704	1
16. 02	Total program preventive charges (see instructions) (from prov			8, 054	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	*		15, 907	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		351, 926	16. 04
16. 05	(Titles V and XIX see instructions.) Total program cost (see instructions)		0	367, 833	16. 05
17. 00	Primary payer amounts			0	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		27, 483	18. 00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		41, 834	19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)			367, 833	20.00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		15, 150	21.00
22. 00	Total reimbursable Program cost (line 20 plus line 21)			382, 983	
23. 00 23. 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	23. 00 23. 01
24. 00		ructions)		0	24.00
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	. 401. 66)		0	
25. 50		s)		0	25. 50
	Demonstration payment adjustment amount before sequestration			303 003	
26. 00 26. 01	Net reimbursable amount (see instructions) Sequestration adjustment (see instructions)			382, 983 7, 660	1
26. 02	Demonstration payment adjustment amount after sequestration			7,000	
	Interim payments			427, 168	
28.00	Tentative settlement (for contractor use only)	00 07 1 77		0	28.00
29. 00 30. 00	Balance due component/program (line 26 minus lines 26.01, 26. Protested amounts (nonallowable cost report items) in accorda			-51, 845 0	1
50.00	chapter I, §115. 2	ince with ows rub. 19-11	' [U] 30.00

Heal th	Financial Systems PULASKI MEMORIAL	HOSPI TAI	In lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Peri od:	Worksheet M-3	
SERVI (SERVI CES Component CCN: 15-8528 From 10/01/2018 To 09/30/2019				
		Title XVIII	RHC III	2/25/2020 4: 3 Cost	<u> </u>
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro			428, 848	
2.00	Cost of vaccines and their administration (from Wkst. M-4, li	ne 15)		9, 035	
3. 00 4. 00	Total allowable cost excluding vaccine (line 1 minus line 2) Total Visits (from Wkst. M-2, column 5, line 8)			419, 813 1, 549	
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5. 00
6.00	Total adjusted visits (line 4 plus line 5)	,		1, 549	6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)		0.1	271. 02	7.00
			Cal cul ati on	of Limit (1)	
			Pri or to Jan.	On or After	
			1 (Rate	Jan. 1 (Rate	
			Peri od 1) 1.00	Peri od 2) 2.00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00	0.00	8. 00
9. 00	Rate for Program covered visits (see instructions)		271. 02	271. 02	9. 00
10 00	CALCULATION OF SETTLEMENT Program covered visits excluding mental health services (from	contractor records)	O	510	10.00
10. 00 11. 00	Program cost excluding costs for mental health services (line	-	0	138, 220	
12.00	Program covered visits for mental health services (from contr		ő	0	12.00
13.00	Program covered cost from mental health services (line 9 x li	ne 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions	•	0	0	14.00
15. 00 16. 00	Graduate Medical Education Pass Through Cost (see instruction Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	138, 220	15. 00 16. 00
16. 00	Total program charges (see instructions) (from contractor's re	*		54, 877	
16. 02	Total program preventive charges (see instructions) (from prov	•		11, 019	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	•		27, 754	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0 (Titles V and XIX see instructions.)	3 and 18) times .80)		82, 486	16. 04
16. 05	Total program cost (see instructions)		0	110, 240	16. 05
17.00	Pri mary payer amounts			0	17. 00
18.00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		7, 358	18. 00
19. 00	records) Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		7, 300	19. 00
20. 00	records) Net Medicare cost excluding vaccines (see instructions)			110, 240	20.00
21.00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		6, 269	
22. 00	Total reimbursable Program cost (line 20 plus line 21)			116, 509	
23. 00	Allowable bad debts (see instructions)			0	23.00
23. 01 24. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	23. 01 24. 00
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructions)		0	
25. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	25. 50
	Demonstration payment adjustment amount before sequestration			0	
26. 00 26. 01	Net reimbursable amount (see instructions) Sequestration adjustment (see instructions)			116, 509 2, 330	1
26. 01	Demonstration payment adjustment amount after sequestration			2, 330	
	Interim payments			97, 860	
28.00	,	00 07 1		0	28.00
.50 UU	Balance due component/program (line 26 minus lines 26.01, 26.			16, 319	
30.00	Protested amounts (nonallowable cost report items) in accorda			0	

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FOHC PNEUM VACCINE COST	MOCOCCAL AND INFLUENZA	Provi der CCN: 15-1305	Peri od: From 10/01/2018	Worksheet M-4	
VACCINE COST		Component CCN: 15-8512			
		Title XVIII	RHC I	Cost	
			Pneumococcal	I nfl uenza	

		Title XVIII	RHC I	Cost	<u> </u>
			Pneumococcal	I nfl uenza	
			1. 00	2. 00	
1. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		3, 809, 878	3, 809, 878	1. 00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tot	al health care staff time	0. 000485	0. 001909	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (li	ne 1 x line 2)	1, 848	7, 273	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (f	rom your records)	19, 634	14, 113	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plu	s line 4)	21, 482	21, 386	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksh	eet M-1, col. 7, line 22)	3, 896, 441	3, 896, 441	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		3, 828, 762	3, 828, 762	7. 00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0. 005513	0. 005489	8. 00
	divided by line 6)				l
9. 00	Overhead cost - pneumococcal and influenza vaccine (line 7 x	line 8)	21, 108	21, 016	9. 00
10.00	Total pneumococcal and influenza vaccine cost and its (their)	administration (sum of	42, 590	42, 402	10.00
	lines 5 and 9)				l
11. 00	Total number of pneumococcal and influenza vaccine injections		201		11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 1	0/line 11)	211. 89	53. 54	12.00
13.00	Number of pneumococcal and influenza vaccine injections admin	istered to Program	68	382	13.00
	benefi ci ari es				l
14. 00	Program cost of pneumococcal and influenza vaccine and its (t	heir) administration	14, 409	20, 452	14.00
	(line 12 x line 13)				l
15. 00	Total cost of pneumococcal and influenza vaccine and its (the			84, 992	15. 00
	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3				
16. 00	Total Program cost of pneumococcal and influenza vaccine and	,		34, 861	16. 00
	administration (sum of cols. 1 and 2, line 14) (transfer this	amount to Wkst. M-3,			
	line 21)				J

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC P	PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-1305	Peri od: From 10/01/2018	Worksheet M-4
VACCINE COST		Component CCN: 15-8527	To 09/30/2019	
		Title XVIII	RHC II	Cost

				2/23/2020 4.3.	o piii
		Title XVIII	RHC II	Cost	
			Pneumococcal	I nfl uenza	
			1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		505, 896	505, 896	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tot	al health care staff tim	e 0. 001524	0. 004723	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (li	ne 1 x line 2)	771	2, 389	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (f	rom your records)	6, 045	3, 920	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plu	s line 4)	6, 816	6, 309	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksh	eet M-1, col. 7, line 22	530, 373	530, 373	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		596, 915	596, 915	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0. 012851	0. 011895	8.00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x	line 8)	7, 671	7, 100	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their)	administration (sum of	14, 487	13, 409	10.00
	lines 5 and 9)				
11.00	Total number of pneumococcal and influenza vaccine injections	(from your records)	71	220	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 1	0/line 11)	204. 04	60. 95	12.00
13.00	Number of pneumococcal and influenza vaccine injections admin	istered to Program	39	118	13.00
	benefi ci ari es	-			
14.00	Program cost of pneumococcal and influenza vaccine and its (t	heir) administration	7, 958	7, 192	14.00
	(line 12 x line 13)				
15.00	Total cost of pneumococcal and influenza vaccine and its (the	ir) administration (sum		27, 896	15.00
	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3	, line 2)			
16.00	Total Program cost of pneumococcal and influenza vaccine and	its (their)		15, 150	16.00
	administration (sum of cols. 1 and 2, line 14) (transfer this	amount to Wkst. M-3,			
	line 21)				

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC	PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-1305	Peri od: From 10/01/2018	Worksheet M-4	
VACCINE COST		Component CCN: 15-8528			
		Title XVIII	RHC III	Cost	
			Pneumococcal	I nfl uenza	

				2/25/2020 4:3.	3 pm
		Title XVIII	RHC III	Cost	
			Pneumococcal	I nfl uenza	
			1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		192, 309	192, 309	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tot	al health care staff tim	e 0. 001028	0. 004570	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (li	ne 1 x line 2)	198	879	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (f	rom your records)	1, 758	1, 417	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plu	s line 4)	1, 956	2, 296	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksh	eet M-1, col. 7, line 22	201, 813	201, 813	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		227, 035	227, 035	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0. 009692	0. 011377	8.00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x	line 8)	2, 200	2, 583	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their)	administration (sum of	4, 156	4, 879	10.00
	lines 5 and 9)				
11. 00	Total number of pneumococcal and influenza vaccine injections	(from your records)	18	80	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 1	0/line 11)	230. 89	60. 99	12.00
13.00	Number of pneumococcal and influenza vaccine injections admin	istered to Program	15	46	13.00
	benefi ci ari es				
14.00	Program cost of pneumococcal and influenza vaccine and its (t	heir) administration	3, 463	2, 806	14.00
	(line 12 x line 13)				
15.00	00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum			9, 035	15.00
	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3				
16.00	Total Program cost of pneumococcal and influenza vaccine and			6, 269	16.00
	administration (sum of cols. 1 and 2, line 14) (transfer this	amount to Wkst. M-3,			
	line 21)				

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL		In Lieu	ı of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED R SERVICES RENDERED TO PROGRAM BENEFICIARI			CCN: 15-1305	Peri od: From 10/01/2018	
		Component	t CCN: 15-8512	To 09/30/2019	Date/Time Prepared: 2/25/2020 4:33 pm
				RHC I	Cost

		Component CCN. 13-0312	10 097 307 2019	2/25/2020 4: 3:	
			RHC I	Cost	
				rt B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
. 00	Total interim payments paid to hospital-based RHC/FQHC			1, 266, 427	1.
2. 00	Interim payments payable on individual bills, either submit			0	2.
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
3. 00	List separately each retroactive lump sum adjustment amount				3.
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
. 01	· ·		04/30/2019	70, 400	3.
. 02				0	3.
. 03				o	3.
. 04				0	3.
. 05				o	3.
	Provider to Program				ĺ
50				0	3
51				o	3
52				ol	3
53				0	3
54				0	3
. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		70, 400	3
. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans		,	1, 336, 827	4
	27)	,		.,,	
	TO BE COMPLETED BY CONTRACTOR		<u> </u>	'	İ
. 00	List separately each tentative settlement payment after des	sk review. Also show date o	f		5.
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider		-	,	1
. 01				0	5.
02				ol	5
03				0	5
	Provider to Program		<u>'</u>		1
50	-			0	5
51				ol	5
52				o	5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		o	5
00	Determined net settlement amount (balance due) based on the				6
01	SETTLEMENT TO PROVIDER			24, 319	6
	SETTLEMENT TO PROGRAM			0	6
02				1, 361, 146	
	Trotal Medicare program Hability (see Instructions)				<u> </u>
	Total Medicare program liability (see instructions)		Contractor	NPR Date	
	Total Medicare program Hability (see Instructions)				
6. 02 7. 00	Total Medicare program Hability (see Instructions)	0	Contractor Number 1.00	NPR Date (Mo/Day/Yr) 2.00	

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RH SERVICES RENDERED TO PROGRAM BENEFICIARIE		Provider CCN: 15-1305	Peri od: From 10/01/2018	Worksheet M-5
		Component CCN: 15-8527	To 09/30/2019	Date/Time Prepared: 2/25/2020 4:33 pm
			D110 11	

				2/25/2020 4: 33	3 pm
			RHC II	Cost	
			Par	Part B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
. 00	Total interim payments paid to hospital-based RHC/FQHC			369, 168	1. (
. 00	Interim payments payable on individual bills, either submit	ted or to be submitted to		0	2. (
	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 amount based on subsequent				3.
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
01			04/30/2019	58, 000	3.
02				0	3.
03				0	3.
04				0	3.
05				0	3.
	Provider to Program		<u>'</u>	•	
50				0	3.
51				0	3.
52				0	3.
53				0	3.
54				0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		58, 000	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	fer to Worksheet M-3, line		427, 168	4.
	27)				
	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after des	k review. Also show date o	f		5.
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
01				0	5.
02				0	5.
03				0	5.
	Provider to Program				
50				0	5.
51				0	5.
52				0	5.
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.
00	Determined net settlement amount (balance due) based on the cost report. (1)				6.
) 1	SETTLEMENT TO PROVI DER			0	6.
02	SETTLEMENT TO PROGRAM			51, 845	6.
00	Total Medicare program liability (see instructions)			375, 323	7.
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	
00	Name of Contractor				8.

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED I SERVICES RENDERED TO PROGRAM BENEFICIAR		Provider CCN: 15-130	From 10/01/2018	Worksheet M-5 Date/Time Prepared:
		Component Con. 13-032	0 10 077 307 2017	2/25/2020 4: 33 pm
			DUO LLI	0

		Component CCN: 15-8528	10 09/30/2019	2/25/2020 4: 33	
			RHC III	Cost	-
	· · · · · · · · · · · · · · · · · · ·		Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
. 00	Total interim payments paid to hospital-based RHC/FQHC			97, 860	1. 0
. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.0
00	List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period. payment. If none, write "NONE" or enter a zero. (1) Program to Provider				3. C
01	1 rogram to 1 rovider			0	3.0
. 02				ő	3.0
. 03				Ö	3. 0
. 03				0	3. (
. 05				0	3. (
. 05	Provider to Program			U	3. (
50	Provider to Program			0	3.
51				0	3.
52				0	3.
				0	
53				0	3. 3.
54	Cultural (cum of lines 2 01 2 40 minus cum of lines 2 50 2 4	00)		0	3. 3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3. Total interim payments (sum of lines 1, 2, and 3.99) (trans			-	
00		Ter to worksheet M-3, Tine	=	97, 860	4.
	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after des	k raviow. Also show data s	s€		5.
00	each payment. If none, write "NONE" or enter a zero. (1)	k review. Also show date t	וו		5.
	Program to Provider			_	_
01				0	5.
02				0	5.
03				0	5.
	Provider to Program		T		
50				0	5.
51				0	5.
52				0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.
00	Determined net settlement amount (balance due) based on the	cost report. (1)			6.
01	SETTLEMENT TO PROVI DER			16, 319	6.
02	SETTLEMENT TO PROGRAM			0	6.
00	Total Medicare program liability (see instructions)			114, 179	7.
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	