i i i i i i i i i i i i i i i i i i i					u of Form CMS-2552-10
This report is	required by law (42 USC 1395g;	42 CFR 413.20(b)). Failu	ire to report can resul	t in all interim	FORM APPROVED
payments made	since the beginning of the cost	t reporting period being c	leemed overpayments (42	2 USC 1395g).	OMB NO. 0938-0050
AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX COS SUMMARY	ST REPORT CERTIFICATION	Provider CCN: 151305	Period: From 10/01/2013 To 09/30/2014	Worksheet S Parts I-III Date/Time Prepared: 3/30/2015 4:02 pm
PART I - COST	REPORT STATUS				
Provi der	1. [X] Electronically filed c			Date: 3/30/20	15 Time: 4:02 pm
use only	2. [] Manually submitted cos	t report			
	3. [1] If this is an amended 4. [F] Medicare Utilization.			esubmitted this co	ost report
Contractor use only	 (1) As Submitted (2) Settled without Audit 	 Date Received: Contractor No. [N] Initial Report for [N] Final Report for the second second	this Provider CCN 12.		or Code: 4 lumn 1 is 4: Enter es reopened = 0-9.
PART II - CERT	I FI CATI ON				
ADMI NI STRATI VE PROVI DED OR PR	ION OR FALSIFICATION OF ANY INF ACTION, FINE AND/OR IMPRISONME OCURED THROUGH THE PAYMENT DIRE ACTION, FINES AND/OR IMPRISONM	ENT UNDER FEDERAL LAW. FL	IRTHERMORE, IF SERVICES	S IDENTIFIED IN TH	IS REPORT WERE

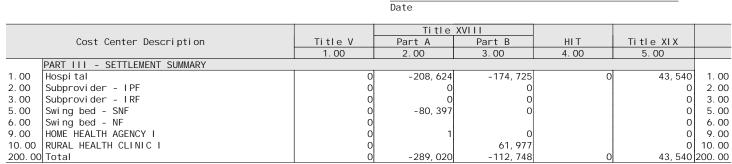
CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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 (151305) for the cost reporting period beginning 10/01/2013 and ending 09/30/2014 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.

(Signed)

Title

Officer or Administrator of Provider(s)



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.

OSPI T	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DA			ider CCN	l: 151305	Period: From 10/01, To 09/30,	/2013 /2014	of For Workshe Part I Date/Ti 3/30/20	et S-2 me Pre	pared:
	1.00		00		3.00			4.00			
	Hospital and Hospital Health Care Co Street: 616 EAST 13TH City: WINAMAC	mplex Address: P0 Box: State: I	N 7i	in Code	e: 46996-	Cour	nty: PULASKI				1.00
. 00	erty. Writewie	Component Na	ame	CCN umber	CBSA Number	Provi de			nt Syst 0, or XVIII		2.00
		1.00	2	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
. 00	Hospital and Hospital-Based Componen Hospital	PULASKI MEMORIAL		51305	99915	1	10/01/2000	N	0	0	3. 00
. 00 . 00 . 00 . 00	Subprovider - IPF Subprovider - IRF Subprovider - (Other) Swing Beds - SNF	HOSPITAL PULASKI MEMORIAL HOSPITAL	15	5Z305	99915		10/01/2000	N	0	Ρ	4.00 5.00 6.00 7.00
1. 00	Swing Beds - NF Hospital-Based SNF Hospital-Based NF Hospital-Based OLTC Hospital-Based HHA	PULASKI MEMORIAL HOSPITAL	15	57078	99915		10/14/1982	N	Р	N	8.00 9.00 10.00 11.00 12.00
	Separately Certified ASC Hospital-Based Hospice	PULASKI MEMORIAL HOSPICE	15	51550	99915		09/01/1997				13.00 14.00
5.00	Hospital-Based Health Clinic – RHC	PULASKI MEMORIAL HOSPITAL	15	58512	99915		08/21/2014	N	0	N	15.00
7.00 8.00	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I Renal Dialysis Other										16.00 17.00 18.00 19.00
							From		То		
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)						1.00		2.0 09/30/		20.00 21.00
	Inpatient PPS Information Does this facility qualify and is it share hospital adjustment, in accord for yes or "N" for no. Is this facil amendment hospital?) In column 2, en Did this hospital receive interim un period? Enter in column 1, "Y" for y reporting period occurring prior to no for the portion of the cost repor	ance with 42 CFR ity subject to 42 ter "Y" for yes o compensated care es or "N" for no October 1. Enter	§412.106? CFR Section "N" for payments f for the po in column	In co on §41 no. or thi ortion 2 "Y"	lumn 1, 2.06(c)(s cost r of the c for yes	enter "Y (2)(Pickl reporting cost or "N" f	" e or		N		22. 00
3. 00	instructions) Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per	dicaid days on li f census days, or is cost reporting	nes 24 and 3 if date period di	l/or 25 of di fferen	below? scharge. t from t	In colum Is the the metho	n d	2	N		23.00
			In-State Medicaid paid days	In-S Medio eligi unpa dag	tate (caid ible Me aid pa ys	Out-of State edicaid nid days	Out-of M State H Medicaid eligible unpaid	Medicai MO day	ys Mec c	ther li cai d lays	
	If this provider is an IPPS hospital in-state Medicaid paid days in col. Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter th Medicaid paid days in col. 1, the in eligible unpaid days in col. 2, out- Medicaid days in col. 3, out-of-stat eligible unpaid days in col. 4, Medi and eligible but unpaid days in col. Medicaid days in col. 6.	1, in-state 2, 3, 4 days in col. t unpaid days in column 6. e in-state -state Medicaid of-state e Medicaid caid HMO paid	<u> 1.00 0</u> 0		0	<u>3.00</u> 0 0	4.00 0 0	5.00	0	<u>. 00</u> C	24.00

			AL HOSPITAL		1	n Lieu	u of Form	n CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	ΑΤΑ	Provi der	F	eriod: rom 10/01/ o 09/30/		Workshe Part I Date/Ti 3/30/20	me Pre	pared:
					Urban/Run 1.00			Geogr	
26.00	Enter your standard geographic classification (not w	age) sta	atus at the beg	jinning of the	1.00	2	2.0	0	26.00
27.00	cost reporting period. Enter "1" for urban or "2" fo Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o	age) sta r "2" fo	atus at the enc or rural. If ap			2			27.00
35.00	enter the effective date of the geographic reclassif If this is a sole community hospital (SCH), enter th effect in the cost reporting period.			CH status in		0			35.00
					Begi nni 1.00		Endi r 2. 0	0	
36.00	Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent dat		Subscript line	36 for number					36.00
	If this is a Medicare dependent hospital (MDH), ente in effect in the cost reporting period.	r the nu				o			37.00
38.00	Enter applicable beginning and ending dates of MDH s of periods in excess of one and enter subsequent dat		Subscript line	38 FOF NUMBER					38.00
					Y/N 1.00	1	Y/N 2.0		
	Does this facility qualify for the inpatient hospita hospitals in accordance with 42 CFR §412.101(b)(2)(i or "N" for no. Does the facility meet the mileage re CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes	i)? Ente quiremen	er in column 1 nts in accordar	"Y" for yes nce with 42					39.00
						V 1.00	XVIII 2.00	XI X 3.00	
	Prospective Payment System (PPS)-Capital	nt for	di oproporti opot	a ahara in aa					45.00
	Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc	eption 1	for extraordina	ary circumstan	ces	N N	N N	N N	45.00 46.00
47.00	pursuant to 42 CFR §412.348(f)? If yes, complete Wor III. Is this a new hospital under 42 CFR §412.300 PPS cap			·	5	N	N	N	47.00
	Is the facility electing full federal capital paymen					N N	N	N	47.00
56.00	Teaching Hospitals Is this a hospital involved in training residents in	approve	ed GME programs	? Enter "Y"	for yes	N			56.00
	or "N" for no. If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is "	r yes ou th of th	r "N" for no ir his cost report	n column 1. lf ing period?	column 1 Enter "Y"				57.00
58.00	"N", complete Worksheet D, Part III & IV and D-2, Pa If line 56 is yes, did this facility elect cost reim	bursemen	nt for physicia	ans' services a	as				58.00
59.00	defined in CMS Pub. 15-1, section 2148? If yes, comp Are costs claimed on line 100 of Worksheet A? If ye			D-2, Part I.		N			59.00
	Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"	costs	for a program t	hat meets the	ctions)	N			60.00
		Y/N	IME	Direct GME	IME		Di rect	GME	
		1.00	2.00	3.00	4.00		5.0		
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in					0.00		0.00	61.00
61.01	column 1. (see instructions) 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		O. OC	0.0	o				61.01
61. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs,		0.00	0.0	o				61. 02
61. 03	and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care		0.00	0.0	d				61. 03
	and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)								
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost concrines period (see instructions)		0.00	0.0	0 				61.04
	current cost reporting period. (see instructions). 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		O. OC	0.0	o				61.05
61.06	61.04 minus line 61.03). (see instructions) 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)		0.00	0.0	o				61.06

HOSPITAL AND	HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DA	TA	Provi der	F	eriod: rom 10/01/2013 o 09/30/2014	Worksheet S-2 Part I Date/Time Pre 3/30/2015 3:5	pared:
			Program	Name	Program Code	Unweighted IME FTE Count		
			1. (0	2.00	3.00	4.00	
special for eac column program unweigh FTE unw 61.20 Of the program resider instruc enter i 3 the I	FTEs in line 61.05, speci ty, if any, and the numbe ch new program. (see instr 1 the program name, enter n code, enter in column 3 nted count and enter in co veighted count. FTEs in line 61.05, speci n specialty, if any, and t tts for each expanded prog tions) Enter in column 1 n column 2 the program co ME FTE unweighted count a	r of FTE residents uctions) Enter in in column 2 the the IME FTE lumn 4 direct GME fy each expanded ne number of FTE ram. (see the program name, de, enter in column				0.00		61. 1
urrect	GME FTE unweighted count.							
							1.00	
	ovisions Affecting the Hea					od for whiteh	0.00	(2.0.0)
	he number of FTE resident: Spital received HRSA PCRE			this cost	reporting per	od for which	0.00	62.00
52.01 Énter t during	he number of FTE resident in this cost reporting pe	s that rotated from a riod of HRSA THC prog	a Teaching ⊢ gram. (see i	nstructio		your hospital	0.00	62. 0'
53.00 Has you	ng Hospitals that Claim Re Ir facility trained reside Yes or "N" for no in col	nts in non-provider s	settings dur	ing this		period? Enter	N	63.00
					Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
					1.00	2.00	3.00	1
	1 5504 of the ACA Base Yea that begins on or after J				This base year	is your cost r	reporting	
54.00 Enter i in the resider setting resider	n column 1, if line 63 is base year period, the num it FTEs attributable to ro is. Enter in column 2 the it FTEs that trained in yo umn 1 divided by (column	yes, or your facilit ber of unweighted nor tations occurring in number of unweightec ur hospital. Enter in	ty trained r p-primary ca all non-pro non-primar n column 3 t	esidents re vider y care he ratio	0.00	0.00	0. 000000	64.00
		Program Name	Program	Code	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2. (0	Si te 3. 00	4.00	5.00	-
is yes, trained year pe associa FTEs fo program resider the pro column unweigt resider rotatio non-pro column unweigt resider	n column 1, if line 63 or your facility d residents in the base eriod, the program name thed with primary care or each primary care in which you trained ots. Enter in column 2 ogram code, enter in 3 the number of oted primary care FTE ots attributable to ons occurring in all ovider settings. Enter in 4 the number of the primary care ot FTEs that trained in ospital. Enter in column atio of (column 3				0.00	0.00	0. 000000	65.00

	Financial Systems		MEMORIAL HOSP				n Lieu	u of Form CMS	
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DA	.TA Pr	ovi der		Period: From 10/01/ To 09/30/		Worksheet S- Part I Date/Time Pr 3/30/2015 3:	epared:
					Unwei ghted FTEs Nonprovi der Si te		n al	Ratio (col. 1 (col. 1 + col 2))	
	Section 5504 of the ACA Current	Year FTE Residents in	n Nonprovider s	settina	1.00 sEffective	2.00 for cost rei		3.00 na periods	
((00	<u>beginning on or after July 1, 20</u>	10	•		0.0				0 66.00
00.00	Enter in column 1 the number of a FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospits	ccurring in all non-p unweighted non-primar al. Enter in column 3	provider settin ry care resider 3 the ratio of	ngs.	0.0		0.00	0.00000	0 00.00
	(column 1 divided by (column 1 +	Column 2)). (see ins Program Name	Program Co	ode	Unweighted	Unwei ght	ted	Ratio (col. 3	3/
		-			FTĔs Nonprovi der Si te	FTEs i Hospita		(col. 3 + col 4))	
(7.00	Enter in column 1 the program	1.00	2.00		3.00	4.00		5.00	0 (7 00
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				0.0		0.00	0.00000	00 67.00
							1.00	2.00 3.00)
70 00	Inpatient Psychiatric Facility P Is this facility an Inpatient Ps		PE) or does i	t conta	ain an IDE sul	oprovi der2	N		70.00
	Enter "Y" for yes or "N" for no If line 70 yes: Column 1: Did the recent cost report filed on or be Column 2: Did this facility train §412.424 (d)(1)(iii)(D)? Enter "	e facility have an ap efore November 15, 20 n residents in a new Y" for yes or "N" for	pproved GME tea 004? Enter "Y' teaching progr no. Column 3:	aching p 'for ye ramin a lf col	program in the es or "N" for accordance wi umn 2 is Y, e	e most no. th 42 CFR enter 1, 2		0	71.00
	or 3 respectively in column 3. (beginning of the fourth year, en the new teaching program in exis	ter 4 in column 3, or tence, enter 5. (see	rif the 5th or						
75.00	Inpatient Rehabilitation Facilit Is this facility an Inpatient Re		/ (IRF), or doe	esit co	ontain an IRF		N		75.00
76.00	subprovider? Enter "Y" for yes a If line 75 yes: Column 1: Did the recent cost reporting period end no. Column 2: Did this facility CFR §412.424 (d)(1)(iii)(D)? Enter 1, 2 or 3 respectively in column beginning of the fourth year, en the new teaching program in exist	e facility have an ap ing on or before Nove train residents in a er "Y" for yes or "N" 3. (see instructions ter 4 in column 3, or	mber 15, 2004 new teaching p for no. Colum s) If this cost if the 5th or	? Enter program nn 3: lf t report	"Y" for yes (in accordance column 2 is ting period co	or "N" for e with 42 Y, enter overs the		0	76.00
								1.00	-
80.00	Long Term Care Hospital PPS Is this a long term care hospita	(ITCH)2 Entor "\"	for yes and "M	" for "	20				80.00
	TEFRA Providers		.					N	
	Is this a new hospital under 42 (Did this facility establish a new §413.40(f)(1)(ii)? Enter "Y" for	w Other subprovider ((excluded unit)			on	no.	N	85.00 86.00
						V 1.00		XI X 2.00	-
00.00	Title V and XIX Services		hoonit-1 '	aa-2 5					00.00
	Does this facility have title V a yes or "N" for no in the applical	ole column.	·			N		Y	90.00
91.00	Is this hospital reimbursed for full or in part? Enter "Y" for ye					N		Y	91.00
92.00	Are title XIX NF patients occupy	ing title XVIII SNF b	beds (dual cert	ti fi cati				Ν	92.00
	instructions) Enter "Y" for yes Does this facility operate an IC "Y" for yes or "N" for no in the	F\MR facility for pur applicable column.	poses of title	e V and		N		N	93.00
	Does title V or XIX reduce capita applicable column.		-			N		N	94.00
95.00	If line 94 is "Y", enter the red	uction percentage in	the applicable	e columr	۱.		0.00	0.0	95.00

	I AL HOSPITAL		In	Lieu of Form CMS	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der		eriod: rom 10/01/20 o 09/30/20		
			V	3/30/2015 3 XI X	
			1.00	2.00	
 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yeapplicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 			N 0	N 0. 00 0.	96.00 00 97.00
Rural Providers 105.00 Does this hospital qualify as a Critical Access Hospital (C	·VH) 2		Y		105.00
106.00 If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)		hod of payment	Ň		106.00
107.00 Column 1: If this facility qualifies as a CAH, is it eligi for I &R training programs? Enter "Y" for yes or "N" for r instructions) If yes, the GME elimination would not be on W 25 and the program would be cost reimbursed. If yes complet Column 2: If this facility is a CAH, do I&Rs in an approve train in the CAH's excluded IPF and/or IRF unit? Enter "Y column 2. (see instructions)	no in column 1. Norksheet B, Pan The Worksheet D-2 Ed medical educa " for yes or "1	(see rt I, column 2, Part II. ation program N" for no in	N		107.00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physical	dule? See 42	N Speech	Respiratory	108.00
	1.00	2.00	3.00	4.00	
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y Y	N	Y	N	109.00
		1	1	1.00 2.00 3.0	0
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes c enter the method used (A, B, or E only) in column 2. If col either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospital provider	umn 2 is "E", e for long term	enter in columr care (includes	3	N 0	115.00
15-1, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insu			N" for	N Y	116. 00 117. 00
118.00 Is the malpractice insurance a claims-made or occurrence po	olicy? Enter 1 i	if the policy i	s	1	118.00
claim-made. Enter 2 if the policy is occurrence.		Premi ums	Losses	I nsurance	
			200000	i nour unee	
		1.00	2.00	3.00	_
118.01 List amounts of malpractice premiums and paid losses:		1.00		3.00	0 118. 01
		75, 769	1.00		0118.01
118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche and amounts contained therein.		75,769 than the		0	0118.01
 118. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheard amounts contained therein. 119. 00 DO NOT USE THIS LINE 120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that or Hold Harmless provision in ACA §3121 and applicable amendments? 	dule listing co d Harmless prov n column 1 "Y" Jualifies for th	75,769 than the ost centers vision in ACA for yes or he Outpatient	1.00	0	0118.01
 118. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche and amounts contained therein. 119. 00 D0 NOT USE THIS LINE 120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendmente Enter in column 2 "Y" for yes or "N" for no. 121. 00 Did this facility incur and report costs for high cost implication patients? Enter "Y" for yes or "N" for no. 	dule listing co d Harmless prov n column 1 "Y" µualifies for th nnts? (see instr	75,769 than the post centers vision in ACA for yes or he Outpatient ructions)	1.00 N	0 2.00	0118.01
 118. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche and amounts contained therein. 119. 00 D0 NOT USE THIS LINE 120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that or Hold Harmless provision in ACA §3121 and applicable amendments? 121. 00 Did this facility incur and report costs for high cost implicable 	dule listing co d Harmless prov n column 1 "Y" gualifies for th ents? (see instr antable devices	75,769 than the ost centers vision in ACA for yes or he Outpatient ructions) s charged to	1.00 N	0 2.00	0118.01 118.02 119.00 120.00
 118. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche and amounts contained therein. 119. 00 D0 NOT USE THIS LINE 120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that or Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter i column 2 "Y" for yes or "N" for no. 121. 00 Did this facility incur and report costs for high cost implications? Enter "Y" for yes or "N" for no. 125. 00 Does this facility operate a transplant center? Enter "Y" fyes, enter certification date(s) (mm/dd/yyyy) below. 126. 00 If this is a Medicare certified kidney transplant center, ein column 1 and termination date, if applicable, in column 	d Harmless prov n column 1 "Y" jualifies for th ents? (see instr antable devices for yes and "N" enter the certif 2.	75,769 than the ost centers vision in ACA for yes or he Outpatient ructions) s charged to for no. If fication date	1.00 N N	0 2.00	0 118. 01 118. 02 119. 00 120. 00 121. 00 125. 00 126. 00
 118. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheand amounts contained therein. 119. 00 D0 NOT USE THIS LINE 120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendments? Inter in column 2 "Y" for yes or "N" for no. 121. 00 Did this facility incur and report costs for high cost impletion patients? Enter "Y" for yes or "N" for no. 125. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126. 00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 127. 00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 	d Harmless prov n column 1 "Y" gualifies for the ents? (see instr antable devices for yes and "N" enter the certifi 2. ther the certifi 2.	75,769 than the ost centers vision in ACA for yes or he Outpatient ructions) s charged to for no. If fication date ication date	1.00 N N	0 2.00	0 118. 01 118. 02 119. 00 120. 00 121. 00 125. 00 126. 00 127. 00
 118. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheand amounts contained therein. 119. 00 D0 NOT USE THIS LINE 120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter i "N" for no. 121. 00 Did this facility incur and report costs for high cost implications? Enter "Y" for yes or "N" for no. 125. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126. 00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 127. 00 If this is a Medicare certified heart transplant center, enter in column 1 and termination transplant center in center, enter in column 1 and termination transplant center in column 1 and termination transplant center in column 1 and termination transplant center in the conter in column 1 and termination transplant center in column 1 and termination transplant center in the conter in the conter in the conter i	d Harmless prov n column 1 "Y" ualifies for th antable devices for yes and "N" enter the certifi 2. ther the certifi 2.	75,769 than the ost centers vision in ACA for yes or he Outpatient ructions) s charged to for no. If fication date ication date ication date	1.00 N N	0 2.00	0 118. 01 118. 02 119. 00 120. 00 121. 00 125. 00 126. 00
 118. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheand amounts contained therein. 119. 00 D0 NOT USE THIS LINE 120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this facility incur and report costs for high cost implications? Enter "Y" for yes or "N" for no. 121. 00 Did this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 125. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126. 00 If this is a Medicare certified heart transplant center, entin column 1 and termination date, if applicable, in column 127. 00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 128. 00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 129. 00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 129. 00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 129. 00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 129. 00 If this is a Medicare certified liver transplant center, entin column 1 and termination date,	d Harmless prov n column 1 "Y" gualifies for the ents? (see instr antable devices for yes and "N" enter the certifi 2. ther the certifi 2. er the certific enter the certific	75,769 than the ost centers vision in ACA for yes or he Outpatient ructions) s charged to for no. If fication date ication date ication date cation date in	1.00 N N	0 2.00	0 118. 01 118. 02 119. 00 120. 00 121. 00 125. 00 126. 00 127. 00 128. 00
 118. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche and amounts contained therein. 119. 00 D0 NOT USE THIS LINE 120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that center in column 2 "Y" for yes or "N" for no. 121. 00 Did this facility incur and report costs for high cost implication that center? Enter "Y" for yes or "N" for no. 125. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126. 00 If this is a Medicare certified kidney transplant center, entification date, if applicable, in column 127. 00 If this is a Medicare certified liver transplant center, entification 1 and termination date, if applicable, in column 128. 00 If this is a Medicare certified liver transplant center, entification 1 and termination date, if applicable, in column 128. 00 If this is a Medicare certified liver transplant center, entification 1 and termination date, if applicable, in column 128. 00 If this is a Medicare certified liver transplant center, entification 1 and termination date, if applicable, in column 129. 00 If this is a Medicare certified liver transplant center, entified tities transplant center, entified liver transplant center	d Harmless prov n column 1 "Y" ualifies for the antable devices for yes and "N" enter the certifi 2. ther the certifi 2. ther the certifi 2. enter the certifi	75,769 than the ost centers vision in ACA for yes or he Outpatient ructions) s charged to for no. If fication date ication date ication date ication date in tification	1.00 N N	0 2.00	0 118. 01 118. 02 119. 00 120. 00 121. 00 125. 00 126. 00 127. 00 128. 00 129. 00
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 118. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche and amounts contained therein. 119. 00 D0 NOT USE THIS LINE 120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that co Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter i column 2 "Y" for yes or "N" for no. 121. 00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no. 125. 00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below. 126. 00 If this is a Medicare certified kidney transplant center, entification date, if applicable, in column 127. 00 If this is a Medicare certified liver transplant center, entification 1125. 00 If this is a Medicare certified liver transplant center, entification 127. 00 If this is a Medicare certified liver transplant center, entification 1125. 00 If this is a Medicare certified heart transplant center, entification 1125. 00 If this is a Medicare certified liver transplant center, entification 1126. 00 If this is a Medicare certified liver transplant center, entified liver transplant center, entifie	d Harmless prov n column 1 "Y" ualifies for the ents? (see instru- antable devices for yes and "N" enter the certifi 2. ther the certifi 2. ther the certifi 2. enter the certifi 2.	75,769 than the ost centers vision in ACA for yes or he Outpatient ructions) s charged to for no. If fication date ication date ication date cation date in tification ertification ication date ication date	1.00 N N	0 2.00	 0 118. 01 118. 02 119. 00 120. 00 121. 00 121. 00 125. 00 126. 00 127. 00 128. 00 129. 00 130. 00 131. 00

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL			In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE			CCN: 151305			Worksheet S-: Part I Date/Time Pro 3/30/2015 3:	2 epared:
						37 307 2013 3.3	
					1.00	2.00	
All Providers 140.00 Are there any related organization chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the	N" for no in column 1. If ye	es, and home	office cos	ts	N		140. 00
1.00	2.00				3.00		
If this facility is part of a chai home office and enter the home off				name an	d address	of the	
141.00 Name:	Contractor's Name:		Contrad	ctor's N	umber:		141.00
142. 00 Street: 143. 00 Ci ty:	PO Box: State:		Zip Cod	de ·			142.00 143.00
110.00 01 29.	otate.		210 000				
	to included in Wenteboot AO					1.00	144.00
144.00 Are provider based physicians' cos 145.00 If costs for renal services are cl services only? Enter "Y" for yes c	aimed on Worksheet A, line 3	74, are they	costs for	i npati en	t	Y N	144. 00 145. 00
	we also made from the mount and				1.00	2.00	14(00
146.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir enter the approval date (mm/dd/yyy	column 1. (See CMS Pub. 15-			s,	Ν		146. 00
147.00 Was there a change in the statisti	cal basis? Enter "Y" for yes	s or "N" for	no.		Ν		147.00
148.00 Was there a change in the order of 149.00 Was there a change to the simplifi				or	N N		148.00 149.00
no.	ed cost finding method? Ente	en i ron ye	501 11 11		IN .		149.00
		Part A	Part B		Title V	Title XIX	_
Does this facility contain a provi							
or charges? Enter "Y" for yes or " 155.00Hospital	<u>N" for no for each componen</u>	<u>t for Part A</u> N	and Part B	. (See 4	2 CFR §413 N	3. 13) N	155.00
156.00 Subprovider - IPF		N	N		N	N	156.00
157.00 Subprovi der – IRF		Ν	N		Ν	N	157.00
158. 00 SUBPROVI DER 159. 00 SNF		Ν	N		N	N	158.00 159.00
160.00 HOME HEALTH AGENCY		N	N		N	N	160.00
161.00 CMHC			N		N	N	161.00
						1.00	
Multicampus 165.00 s this hospital part of a Multica	mous bospital that has one of	or more campi	ises in dif	ferent C	RSAs?	N	165.00
Enter "Y" for yes or "N" for no.	· · ·						
	Name 0	County 1.00	State 2 2.00	Zip Code 3.00	CBSA 4.00	FTE/Campus 5.00	_
166.00 If line 165 is yes, for each	0	1.00	2.00	3.00	4.00		0166.00
campus enter the name in column O, county in column 1, state in							
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in							
column 5							
Health Information Technology (HI) incentive in the American	Recovery and	1 Reinvestm	ent Act		1.00	
167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10	under Section §1886(n)? Er	nter "Y" for	yes or "N"	for no.	r the	N	167. 00 0168. 00
reasonable cost incurred for the H 169.00 If this provider is a meaningful u	IT assets (see instructions) ser (line 167 is "Y") and is)				0.0	0169. 00
transition factor. (see instructio	INS)			Be	egi nni ng	Endi ng	
					1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR b period respectively (mm/dd/yyyy)	eginning date and ending dat	te for the re	eporti ng	10	/01/2013	09/30/2014	170.00

SPI T.	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der	CCN: 151305	Period: From 10/01/2013 To 09/30/2014	Date/Time Pr	epared
					Y/N	3/30/2015 3: Date	55 pm
					1.00	2.00	
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	oonses. Enter N for	all NO re	esponses. Ente	er all dates in	the	
00	<u>Provider Organization and Operation</u> Has the provider changed ownership immediatel reporting period? If yes, enter the date of t	y prior to the beg	inning of	the cost	N		1.
	reporting period? IT yes, enter the date of t	the change th corun	III Z. (See	Y/N	Date	V/I	
				1.00	2.00	3.00	
00	Has the provider terminated participation in yes, enter in column 2 the date of termination			N			2.
00	voluntary or "I" for involuntary. Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or f relationships? (see instructions)	, chain home offic d to the provider c , or members of th	es, drug or its e board	N			3.
				Y/N	Туре	Date	
	Financial Data and Reports			1.00	2.00	3.00	_
00	Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see instr	Audited, "C" for C enter date availab	ompiled,	Y	A		4.
00	Are the cost report total expenses and total			N			5.
	those on the filed financial statements? If y	yes, submit reconci	TTation.		Y/N	Legal Oper.	
					1.00	2.00	
00	Approved Educational Activities Column 1: Are costs claimed for nursing scho the legal operator of the program?	ool?Column 2: If	yes, is th	ne provider is	s N		6
00 00	Are costs claimed for Allied Health Programs? Were nursing school and/or allied health proc			during the	N N		7.
00	cost reporting period? If yes, see instruction Are costs claimed for Intern-Resident program		urrent cos	st report? If	N		9
00	yes, see instructions. Was an Intern-Resident program been initiated period? If yes, see instructions.	d or renewed in the	e current c	cost reporting) N		10
00	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see		in an App	proved	Ν		11.
						Y/N 1.00	
	Bad Debts					1	
	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det				ost reporting	Y N	12.
	period? If yes, submit copy. <u>If line 12 is yes, were patient deductibles a</u> Bed Complement	and/or co-payments	waived? If	[°] yes, see ins	structions.	N	14
	Did total beds available change from the pric	or cost reporting p	eriod?lf	yes, see inst	ructions.	N	15.
		Description			art A	Part B	_
		Descriptio 0		Y/N 1.00	Date 2.00	Y/N 3.00	
	PS&R Data						
00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see			Y	02/19/2015	Y	16
00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns			N		N	17
00	2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file			Ν		Ν	18.
00	this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see			N		N	19.
00	instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N		Ν	20.

Heal th	Financial Systems	PULASKI MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE			F	Period: From 10/01/2013 Fo 09/30/2014	Worksheet S-2 Part II	pared:
				Par	rt A	Part B	
		Descri	ption	Y/N	Date	Y/N	
		0		1.00	2.00	3.00	
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 HOSPIT Capital Related Cost	ALS ONLY (EXCE	PT CHILDRENS H	IOSPI TALS)		1.00	-
22.00	Have assets been relifed for Medicare purpose	es? If yes, see	instructions			N	22.00
	Have changes occurred in the Medicare depreci			als made durir	ng the cost	Ν	23.00
	reporting period? If yes, see instructions.	·			0		
	Were new leases and/or amendments to existing If yes, see instructions		Ũ		0.1	N	24.00
25.00	Have there been new capitalized leases entered instructions.	ed into during	the cost repor	rting period? I	f yes, see	N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acqu instructions.	uired during th	e cost reporti	ng period? If	yes, see	Ν	26.00
27.00	Has the provider's capitalization policy char copy.	nged during the	cost reportin	ng period?lfy	ves, submit	Ν	27.00
~~ ~~	Interest Expense	<u> </u>				••	
28.00	Were new loans, mortgage agreements or letter period? If yes, see instructions.	rs of credit en	tered into dur	ring the cost r	eporting	N	28.00
29.00	Did the provider have a funded depreciation a treated as a funded depreciation account? If			ebt Service Res	erve Fund)	Ν	29.00
30.00	Has existing debt been replaced prior to its			debt? If yes,	see	N	30.00
	instructions.						
31.00	Has debt been recalled before scheduled matur instructions.	rity without is	suance of new	debt? If yes,	see	N	31.00
	Purchased Services						
32.00	Have changes or new agreements occurred in pa	atient care ser	vi ces furni she	ed through cont	ractual	N	32.00
	arrangements with suppliers of services? If y			0			
33.00	If line 32 is yes, were the requirements of S	Sec. 2135.2 app	lied pertainin	ng to competiti	ve bidding? If		33.00
	no, see instructions.						
3/ 00	Provider-Based Physicians Are services furnished at the provider facili	ty under an ar	rangement with	nrovi der-base	d physicians?	Y	34.00
54.00	If yes, see instructions.	ty under an ar	rangement with			I	54.00
35.00	If line 34 is yes, were there new agreements	or amended exi	sting agreemen	nts with the pr	ovi der-based	Ν	35.00
	physicians during the cost reporting period?	lfyes, see in	structions.				
					Y/N	Date	
	llama Offi an Canto				1.00	2.00	
	Home Office Costs Were home office costs claimed on the cost re	port2			N		36.00
	If line 36 is yes, has a home office cost sta		epared by the	home office?	in in		37.00
38.00	If yes, see instructions. If line 36 is yes , was the fiscal year end o	of the home off	ice different	from that of			38.00
	the provider? If yes, enter in column 2 the f						
39.00	If line 36 is yes, did the provider render se see instructions.	ervices to othe	r chain compon	nents? If yes,			39.00
40.00	If line 36 is yes, did the provider render se instructions.	ervices to the	home office?	lf yes, see			40.00
			1.	00	2.	00	
	Cost Report Preparer Contact Information	· · · · ·					
41.00	Enter the first name, last name and the title	•	MICHAEL		ALESSANDRI NI		41.00
	held by the cost report preparer in columns 7 respectively.	i, 2, and 3,					
42.00	Enter the employer/company name of the cost r	report	BLUE AND CO.,	LLC			42.00
	preparer.						
43.00	Enter the telephone number and email address report preparer in columns 1 and 2, respective		317. 713. 7959		MALESSANDRI NI @I	BLUEANDCO. COM	43.00

	Financial Systems	PULASKI MEMOR				In Lieu	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE		Provi d	er CCN: 15130	F	eriod: rom 10/01/2013 o 09/30/2014	Worksheet S-2 Part II Date/Time Pre 3/30/2015 3:5	epared:
		Part B						
		Date						
		4.00						
	PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	02/19/2015						16.00
17.00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns							17.00
18.00	2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file							18. 00
19.00	this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.							19.00
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:							20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.							21.00
				3.00				
	Cost Report Preparer Contact Information			0.00				
41.00	Enter the first name, last name and the title held by the cost report preparer in columns respectively.		SENI OR MANAG	GER				41.00
42.00	Enter the employer/company name of the cost i	report						42.00
43.00	preparer. Enter the telephone number and email address report preparer in columns 1 and 2, respectiv							43.00

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	PULASKI MEMORI			CCN: 151305	D	eri od:	u of Form CMS- Worksheet S-3	
HUSPII	AL AND HUSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	F	r ovi der	CCN: 151305		rom 10/01/2013	Part I Date/Time Pre 3/30/2015 3:5	epared
								1/P Days / 0/F	
								<u>Visits / Trips</u>	\$
	Component	Worksheet A	NO. O	of Beds	Bed Days		CAH Hours	Title V	
		Line Number 1.00	2	. 00	Avai I abl e 3. 00		4.00	5.00	+
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		25	<u> </u>	25	45, 744. 00	5.00) 1.0
1.00	8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	00.00		20	7, 1	20	10, 7 11.00		
2.00	HMO and other (see instructions)								2.0
3.00	HMO IPF Subprovider								3.0
4.00	HMO IRF Subprovider								4.0
5.00	Hospital Adults & Peds. Swing Bed SNF							(5.0
6.00	Hospital Adults & Peds. Swing Bed NF							(6.0
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)			25	9, 1		45, 744. 00	(
8.00	INTENSIVE CARE UNIT	31.00		0		0	0.00	(
9.00	CORONARY CARE UNI T								9.0
10.00	BURN INTENSIVE CARE UNIT								10.0
11.00	SURGICAL INTENSIVE CARE UNIT								11. C
12.00	OTHER SPECIAL CARE (SPECIFY)								12.0
13.00	NURSERY	43.00						(
14.00	Total (see instructions)			25	9, 1	25	45, 744. 00	(
15.00	CAH visits							(
16.00	SUBPROVIDER - IPF								16.0
17.00	SUBPROVIDER - IRF								17.0
18.00 19.00									18.0
20.00	SKILLED NURSING FACILITY NURSING FACILITY								20.0
20.00	OTHER LONG TERM CARE								20.0
21.00	HOME HEALTH AGENCY	101.00						(
23.00	AMBULATORY SURGICAL CENTER (D. P.)	101.00						(23.0
24.00	HOSPICE	116.00		0		0			24.0
24.10	HOSPICE (non-distinct part)	30.00	•	Ű		Ŭ			24.1
25.00	CMHC - CMHC	00.00							25.0
26.00	RURAL HEALTH CLINIC	88.00						(
26.25	FEDERALLY QUALIFIED HEALTH CENTER								26.2
27.00	Total (sum of lines 14-26)			25					27.0
28.00	Observation Bed Days							(28.0
29.00	Ambul ance Trips								29.0
30.00	Employee discount days (see instruction)								30.0
31.00	Employee discount days - IRF								31.0
32.00	Labor & delivery days (see instructions)			0		0			32.0
32.01	Total ancillary labor & delivery room								32.0
	outpatient days (see instructions)								
33.00	LTCH non-covered days								33.0

IOSPI TAL AN	D HOSPITAL HEALTH CARE COMPLEX STATISTIC				Period: From 10/01/2013 To 09/30/2014	Worksheet S-3 Part I Date/Time Pre 3/30/2015 3:5	pared
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	·	6.00	7.00	8.00	9.00	10.00	
	tal Adults & Peds. (columns 5, 6, 7 and clude Swing Bed, Observation Bed and	974	146			10100	1.
Hospi	ce days) (see instructions for col. 2						
	the portion of LDP room available beds)	110	224				2.
	and other (see instructions) PF Subprovider	0	236 0				2.
	RF Subprovider	0	0				4.
	tal Adults & Peds. Swing Bed SNF	762	0	77	0		5.
	tal Adults & Peds. Swing Bed NF	/02	0		6		6.
.00 Total	Adults and Peds. (exclude observation (see instructions)	1, 736	146				7.
	NSI VE CARE UNI T	0	0		0		8.
	VARY CARE UNI T	Ŭ	0		0		9.
1	INTENSIVE CARE UNIT						10
	CAL INTENSIVE CARE UNIT						11
	R SPECIAL CARE (SPECIFY)						12
3. 00 NURSE	. ,		0	25	4		13.
	(see instructions)	1, 736	146			163.68	
1	/i si ts	0	0	_,	0		15
	ROVIDER – IPF		-		-		16
	ROVIDER – IRF						17
	ROVIDER						18
	ED NURSING FACILITY						19
). 00 NURSI	NG FACILITY						20
. OO OTHEF	R LONG TERM CARE						21.
2.00 HOME	HEALTH AGENCY	3, 509	0	4, 63	7 0.00	8.85	22.
3. OO AMBUL	_ATORY SURGICAL CENTER (D. P.)						23.
1. 00 HOSPI	CE	0	0		0.00	1.02	24.
1. 10 HOSPI	CE (non-distinct part)	0	0		0		24.
5.00 CMHC	- CMHC						25.
5. 00 RURAL	_ HEALTH CLINIC	471	0	1, 84	2 0.00	29.08	26.
	RALLY QUALIFIED HEALTH CENTER						26.
	(sum of lines 14-26)				0.00	202.63	
3. 00 Obser	rvation Bed Days		0	30	3		28.
	ance Trips	0					29.
	oyee discount days (see instruction)				0		30.
	oyee discount days - IRF				0		31
	<pre>^ & delivery days (see instructions)</pre>	0	0		0		32.
outpa	ancillary labor & delivery room atient days (see instructions)				0		32.
3.00 LTCH	non-covered days	0					33

HOSPI 1	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	CCN: 151305	Period: From 10/01/2013 To 09/30/2014	Worksheet S-3 Part I Date/Time Prep 3/30/2015 3:55	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0		50 38		1.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)				22 108		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 20.00 21.00	NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE	0.00	0	2	50 38	567	13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00
22.00 23.00 24.00 24.10 25.00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC	0.00					22.00 23.00 24.00 24.10 25.00
26.00 26.25 27.00 28.00 29.00 30.00 31.00 32.00 32.01	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0.00					26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01

Heal th	Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
	IEALTH AGENCY STATI STI CAL DATA			CCN: 151305	Period: From 10/01/2013		
			Component	t CCN: 157078	To 09/30/2014	Date/Time Pre 3/30/2015 3:5	
					Home Health Agency I	PPS	
						00	
0.00	County				PULASKI	00	0.00
		Title V 1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	Total 5.00	
1 00	HOME HEALTH AGENCY STATISTICAL DATA					1	1.00
1.00 2.00	Home Health Aide Hours Unduplicated Census Count (see instructions)	0.00			0 0 0.00		
				Number of Em	ployees (Full Ti	me Equivalent)	
		Enter the numb	er of hours in	Staff	Contract	Total	
		your normal	work week				
)	1.00	2.00	3.00	
3.00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)		0.00	0.0	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.0	0. 00	0.00	4.00
5.00 6.00	Other Administrative Personnel Direct Nursing Service			0.0			
7.00 8.00	Nursi ng Supervi sor Physi cal Therapy Servi ce			0.0			
8.00 9.00	Physical Therapy Supervisor			0.0			
10.00 11.00	Occupational Therapy Service Occupational Therapy Supervisor			0.0			
12.00	Speech Pathology Service			0.0	0. 00	0.00	12.00
13.00 14.00	Speech Pathology Supervisor Medical Social Service			0.0			
15.00 16.00	Medical Social Service Supervisor Home Health Aide			0.0			
17.00	Home Health Aide Supervisor			0.0	0. 00	0.00	17.00
18.00	Other (specify) HOME HEALTH AGENCY CBSA CODES			0.(0.00	0.00	18.00
19.00	Enter in column 1 the number of CBSAs where				2		19.00
	you provided services during the cost reporting period.						
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20			99915			20.00
20.01	contains the first code).			22044			20.01
20. 01		Full Ep		23844			20.01
		Without Outliers	With Outliers	LUPA Epi sode	s PEP Only Epi sodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
21.00	PPS ACTIVITY DATA Skilled Nursing Visits	1, 269	96	1	08 19	1, 492	21.00
22.00 23.00	Skilled Nursing Visit Charges Physical Therapy Visits	226, 065 724			74 3, 173 9 12		
24.00	Physical Therapy Visit Charges	152, 568	5, 100			161, 995	24.00
25.00 26.00	Occupational Therapy Visits Occupational Therapy Visit Charges	160 34, 338		8	4 6 55 1, 298	170 36, 501	
27.00	Speech Pathology Visits	44	0		2 0	46	27.00
28. 00 29. 00	Speech Pathology Visit Charges Medical Social Service Visits	9, 519 0	0	2	16 0 0 0	9, 735 0	
30.00 31.00	Medical Social Service Visit Charges Home Health Aide Visits	0772	0 33		0 0 9 8	0 822	
32.00	Home Health Aide Visit Charges	68, 869	2, 977	6	41 732	73, 219	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2, 969	154	1:	32 45	3, 300	33.00
34.00 35.00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	0 491, 359	0 26, 605		0 0 27 7, 799	0 544, 090	
	30, 32, and 34)						
36.00	Total Number of Episodes (standard/non outlier)	163		:	37 3	203	36.00
37.00	Total Number of Outlier Episodes	17 525	3 2, 907	4, 2	0 92 304	55 038	37.00 38.00
38.00	Total Non-Routine Medical Supply Charges	47, 535	2,907	1 4, 2	72 ₁ 304	1 55, 038	J 30. UU

Heal th	Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
	AL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	IED HEALTH CENT	TER Provi der	CCN: 151305	Peri od:	Worksheet S-8	3
STATI S	TICAL DATA		Componen	t CCN: 158512	From 10/01/2013 To 09/30/2014		
					Rural Health Clinic (RHC) I	Cost	
					1.	00	_
	Clinic Address and Identification						
1.00	Street		C	+	540 HOSPITAL D State		1.00
		·		i ty . 00	2.00	Zip Code 3.00	
2.00	City, State, Zip Code, County		WINIMAC			46996	2.00
						1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural	l or "U" for ur	ban			0	3.00
					Grant Award	Date	
					1.00	2.00	
4 00	Source of Federal Funds Community Health Center (Section 330(d), PHS	(Act)					1 4 00
4.00 5.00	Migrant Health Center (Section 330(d), PHS A				0		4.00 5.00
6.00	Health Services for the Homeless (Section 329(d), Fils A				0		6.00
7.00	Appal achi an Regi onal Commi ssi on				0)	7.00
8.00	Look-Alikes				0)	8.00
9.00	OTHER (SPECIFY)				0)	9.00
10.00					1.00	2.00	10.00
10. 00	Does this facility operate as other than an I no in column 1. If yes, indicate number of o subscripts of line 11 the type of other opera	ther operations	in column 2.	(Enter in	N	0	10.00
	Isobserripts of the tritle type of other opera	Sun	¥		onday	Tuesday	
		from	to	from	to	from	
		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
					1.00	2.00	
12.00	Have you received an approval for an exception	on to the produ	ctivity stand	ard?	N		12.00
	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu	d in CMS Pub. 1 umn 1. If yes,	00-04, chapte enter in colu	r 9, section mn 2 the	N	0	13.00
	number of providers included in this report. numbers below.	LIST THE Hames					
					der name	CCN number	
				· · · · · · · · · · · · · · · · · · ·	1. 00	2.00	
14.00	Provider name, CCN number)/ /N	M		VIV		14.00
		Y/N 1.00	V 2.00	XVIII 3.00	4. 00	Total Visits 5.00	
15.00	Have you provided all or substantially all	N 1.00		3.00	0 0		15.00
10.00	GME cost? Enter "Y" for yes or "N" for no in				0		10.00
	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)						
			Co	unty		1	
				. 00			
2.00	City, State, Zip Code, County		PULASKI				2.00
		Tuesday	Wedr	iesday	Thur	rsday	
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
11 00	Facility hours of operations (1) Clinic	18: 30	08: 00	17:00	08:00	18: 30	111 00
11.00	lor mic	10.30	00.00	µ7.00	00.00	10.30	11.00

Health Financial Systems	PULASKI MEMOR	IAL HOSPI	TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	IED HEALTH CEN	TER Pro	ovider (Peri od:	Worksheet S-8	
STATI STI CAL DATA		Com	nponent		From 10/01/2013 To 09/30/2014		
				Rural Health	Cost		
					Clinic (RHC) I		
	Fri	day		Sa	turday		
	from	to		from	to		
	11.00	12.0	00	13.00	14.00		
Facility hours of operations (1)							
11. 00 Cl i ni c	08: 00	16: 30					11.00

Heal th	Financial Systems		PULASKI MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	AL IDENTIFICATION DATA			Provi der	CCN: 151305	Peri od:	Worksheet S-9	
						From 10/01/2013		
				Component	CCN: 151550	To 09/30/2014		
						Hospi ce I	3/30/2015 3:55	s pm
	· · · · · · · · · · · · · · · · · · ·	Unduplicated				nospi ce i		
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
		II LIE AVIII	II LIE XIX	Skilled	Nursing	ALL OTHER	col s. 1, 2 &	
				Nursing	Facility		5)	
				Facility	l		0)	
		1.00	2.00	3,00	4.00	5, 00	6,00	
	PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0		0 0	0	1.00
2.00	Routine Home Care	180	0	9		0 34	214	2.00
3.00	Inpatient Respite Care	0	0	0		0 0	0	3.00
4.00	General Inpatient Care	0	0	0		0 0	0	4.00
5.00	Total Hospice Days	180	0	9		0 34	214	5.00
	Part II - CENSUS DATA							
6.00	Number of Patients Receiving	0	0	0		0 0	0	6.00
	Hospi ce Care							
7.00	Total Number of Unduplicated	0.00		0.00				7.00
	Continuous Care Hours Billable							
	to Medicare							
8.00	Average Length of Stay (line	0.00	0.00	0.00	0.0	0.00	0.00	8.00
	5/line 6)							
9.00	Unduplicated Census Count	12	0	3		0 11	23	9.00

Heal th	Financial Systems PULASKI MEMORIAL HOS	SPI TAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN:		Peri od:	Worksheet S-1	0
				From 10/01/2013		
				To 09/30/2014	Date/Time Pre 3/30/2015 3:5	epared:
					373072013 3. 3	
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	led by line 20	02 column	8)	0. 400268	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				1, 095, 969	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental p	payments from	Medi cai d'	?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from M	ledi cai d			402, 077	5.00
6.00	Medi cai d charges				4, 912, 751	6.00
7.00	Medicaid cost (line 1 times line 6)				1, 966, 417	7.00
8.00	Difference between net revenue and costs for Medicaid program (li	ne 7 minus su	um of line	es 2 and 5; if	468, 371	8.00
	< zero then enter zero)					
	State Children's Health Insurance Program (SCHIP) (see instructio	ons for each l	ine)			
9.00	Net revenue from stand-alone SCHIP				0	
10.00					0	
11.00	Stand-alone SCHIP cost (line 1 times line 10)				0	1
12.00	Difference between net revenue and costs for stand-alone SCHIP (I	ine 11 minus	line 9; i	if < zero then	0	12.00
	enter zero)					
	Other state or local government indigent care program (see instru					
13.00	Net revenue from state or local indigent care program (Not includ				C	
14.00	Charges for patients covered under state or local indigent care p	program (Not i	ncl uded i	in lines 6 or	C	14.00
	10)					1
15.00	State or local indigent care program cost (line 1 times line 14)		<i>.</i>	45 1 11	0	
16.00	Difference between net revenue and costs for state or local indig	gent care prog	gram (line	e 15 minus line	0	16.00
	13; if < zero then enter zero)					
17 00	Uncompensated care (see instructions for each line) Private grants, donations, or endowment income restricted to fund	ling charity o	2250		0	17.00
17.00 18.00	Government grants, appropriations or transfers for support of hos					
18.00	Total unreimbursed cost for Medicaid, SCHIP and state and local			cum of lines	468, 371	
19.00	8, 12 and 16)	rndigent care	e program:	s (sum of fines	408, 371	19.00
		Uni	i nsured	Insured	Total (col. 1	
			atients	patients	+ col . 2)	
			1.00	2.00	3.00	
20.00			341, 55	3 0	341, 553	20.00
	charges excluding non-reimbursable cost centers) for the entire f					
21.00	Cost of initial obligation of patients approved for charity care	(line 1	136, 71	3 0	136, 713	21.00
	times line 20)					
22.00	Partial payment by patients approved for charity care			0 0		
23.00	Cost of charity care (line 21 minus line 22)		136, 71	3 0	136, 713	23.00
					1.00	
24.00	Does the amount in line 20 column 2 include charges for patient d		length o	f stay limit	N	24.00
	imposed on patients covered by Medicaid or other indigent care pr			<u> </u>		
	If line 24 is "yes," charges for patient days beyond an indigent		n's lengti	n of stay limit	0	
26.00					2, 347, 043	
27.00	Medicare bad debts for the entire hospital complex (see instructi	,	>		297, 518	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line			2.2)	2,049,525	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expen	nse (line 1 ti	mes line	28)	820, 359	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				957, 072	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line	e 30)			1, 425, 443	31.00

LASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der	CCN: 151305	Peri od:	Worksheet A
				From 10/01/2013 To 09/30/2014	Date/Time Pre
				_	3/30/2015 3:5
Cost Center Description	Sal ari es	Other		1 Recl assi fi cati	Recl assi fi ed
			+ col. 2)	ons (See A-6)	Trial Balance
					(col. 3 +-
	1.00		0.00	1.00	<u>col. 4)</u>
	1.00	2.00	3.00	4.00	5.00
GENERAL SERVICE COST CENTERS	1	4 004 750	4 004 75	0 00 457	1 0 10 01 (
0 00100 NEW CAP REL COSTS-BLDG & FIXT		1, 221, 759			1, 242, 216
0 00400 EMPLOYEE BENEFITS DEPARTMENT	0	3, 770, 648			3, 770, 648
0 00500 ADMINISTRATIVE & GENERAL	1, 586, 461	1, 712, 796			3, 336, 740
0 00700 OPERATION OF PLANT	246, 400	493, 444			739, 844
0 00800 LAUNDRY & LINEN SERVICE	22, 035	48, 898			70, 933
0 00900 HOUSEKEEPI NG	129, 839	67, 257			197, 096
00 01000 DI ETARY	155, 196	159, 772			314, 968
00 01300 NURSING ADMINISTRATION	339, 628	22, 414			362, 042
00 01400 CENTRAL SERVICES & SUPPLY	45, 370	37, 291	82, 66	0	82, 661
00 01500 PHARMACY	0	0		0 0	0
00 01600 MEDICAL RECORDS & LIBRARY	237, 205	49, 547	286, 75	52 0	286, 752
00 01700 SOCIAL SERVICE	45, 583	0	45, 58	33 0	45, 583
INPATIENT ROUTINE SERVICE COST CENTERS					
00 03000 ADULTS & PEDI ATRI CS	1, 450, 804	126, 498	1, 577, 30	02 0	1, 577, 302
00 03100 INTENSIVE CARE UNIT	0	0		0 0	0
00 04300 NURSERY	93, 729	9, 329	103, 05	58 0	103, 058
ANCI LLARY SERVICE COST CENTERS				<u> </u>	
00 05000 0PERATING ROOM	447, 272	124, 574	571, 84	6 0	571, 846
00 05200 DELIVERY ROOM & LABOR ROOM	55, 910	6, 061			61, 971
00 05300 ANESTHESI OLOGY	0	590, 098			590, 098
00 05400 RADI OLOGY-DI AGNOSTI C	608, 496	754, 220			1, 362, 716
00 05900 CARDI AC CATHETERI ZATI ON	000, 470	104, 220	1, 302, 7	0 0	0
00 06000 LABORATORY	502, 272	550, 245	1, 052, 51		1, 052, 517
01 06001 BLOOD LABORATORY	502, 272	00, 243		0 0	1,052,517
	0	-		-	
00 06300 BLOOD STORING, PROCESSING & TRANS.	S S	70, 536			70, 536
	178, 140	19, 238			197, 378
00 06600 PHYSI CAL THERAPY	387, 148	37, 141			424, 289
00 06700 OCCUPATI ONAL THERAPY	71, 947	306			72, 253
00 06800 SPEECH PATHOLOGY	91, 552	8, 723			100, 275
00 06900 ELECTROCARDI OLOGY	52, 865	2, 429	55, 29		55, 294
00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	643, 521	643, 52		
00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 107, 325	107, 325
00 07300 DRUGS CHARGED TO PATIENTS	0	1, 634, 788	1, 634, 78	38 0	1, 634, 788
00 03020 ONCOLOGY	80, 625	41, 950	122, 57	75 0	122, 575
01 03021 CARDI AC REHAB	73, 399	2, 178	75, 57	7 0	75, 577
OUTPATIENT SERVICE COST CENTERS					
00 08800 RURAL HEALTH CLINIC	2, 658, 285	423, 641	3, 081, 92	26 -2, 455, 965	625, 961
00 09000 CLINIC	67, 364	219, 665	287, 02	29 0	287, 029
00 09100 EMERGENCY	774, 266	732, 221			1, 506, 487
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REI MBURSABLE COST CENTERS			•		
. 00 10100 HOME HEALTH AGENCY	459, 417	100, 211	559, 62	28 0	559, 628
SPECIAL PURPOSE COST CENTERS	107,117	.00,211		0	007,020
. 00 11600 HOSPI CE	46, 534	18, 387	64, 92	21 0	64, 921
. 00 SUBTOTALS (SUM OF LINES 1-117)	10, 907, 742	13, 699, 786			22, 209, 503
NONREI MBURSABLE COST CENTERS	10, 707, 742	13, 077, 700	24,007,02	-2, 370, 023	22, 207, 303
			1	0	
. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0
01 19001 HOMECARE	58, 575	14, 423			72, 998
. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 020, 598	329, 849			
. 00 07950 MARKETI NG	89, 964	296, 301			328, 325
.00 TOTAL (SUM OF LINES 118-199)	12, 076, 879	14, 340, 359	26, 417, 23	38 0	26, 417, 238

	n Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lieu	u of Form CMS-2	552-10
RECLA	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	OF EXPENSES	Provi der	CCN: 151305	Peri od:	Worksheet A	
					From 10/01/2013 To 09/30/2014	Date/Time Prep	pared:
						3/30/2015 3:55	
	Cost Center Description		Net Expenses				
			<u>For Allocation</u>	4			
		6.00	7.00				
1 00	GENERAL SERVICE COST CENTERS	10.005	1 000 411	1			1 00
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-18, 805	1, 223, 411	1			1.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	0 -540, 105	3, 770, 648 2, 796, 635	1			4.00
7.00	00700 OPERATION OF PLANT	-340, 103	2, 790, 035 739, 566				5.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	-278	70, 933				8.00
9.00	00900 HOUSEKEEPING	0	197, 096				9.00
10.00	01000 DI ETARY	-62, 889	252, 079				10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	362, 042				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	-30,660	52,001				14.00
15.00		0	C	1			15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-4, 627	282, 125				16.00
17.00	01700 SOCIAL SERVICE	0	45, 583	1			17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	1, 577, 302				30.00
31.00	03100 I NTENSI VE CARE UNI T	0	C				31.00
43.00	04300 NURSERY	0	103, 058				43.00
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	571, 846	•			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	61, 971				52.00
53.00	05300 ANESTHESI OLOGY	-568, 926	21, 172				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 362, 716				54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	C				59.00
60.00	06000 LABORATORY	0	1, 052, 517				60.00
60.01	06001 BLOOD LABORATORY	0	0				60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	70, 536	1			63.00
65.00	06500 RESPI RATORY THERAPY	0	197, 378	1			65.00
66.00	06600 PHYSI CAL THERAPY	0	424, 289	1			66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	72, 253				67.00
68.00	06800 SPEECH PATHOLOGY	U E 410	100, 275				68.00
69.00	06900 ELECTROCARDI OLOGY	-5, 412	49, 882 0	1			69.00
70.00 71.00		0	536, 196	1			70.00 71.00
72.00		0	107, 325				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	-100, 861	1, 533, 927				73.00
76.00		0	122, 575				76.00
76.01	03021 CARDI AC REHAB	0	75, 577	1			76.01
70.01	OUTPATIENT SERVICE COST CENTERS	0	15, 511	I			70.01
88.00		0	625, 961				88.00
90.00		-27, 750	259, 279	1			90.00
91.00		0	1, 506, 487	1			91.00
92.00		_	.,				92.00
	OTHER REIMBURSABLE COST CENTERS	1 1		1			
101.0	0 10100 HOME HEALTH AGENCY	0	559, 628			1	101. 00
	SPECIAL PURPOSE COST CENTERS	1					
116.0	D 11600 HOSPI CE	0	64, 921			1	116. 00
118.0		-1, 360, 313	20, 849, 190	1			118.00
	NONREI MBURSABLE COST CENTERS						
	D 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C			1	190. 00
190.0	1 19001 HOMECARE	0	72, 998				190. 01
192.0	0 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	3, 806, 412				192.00
				1			
	DO7950 MARKETI NG	0	328, 325				194. 00 200. 00

Heal th	Financial Systems		PULASKI MEMOR	IAL HOSPITAL		In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provi der	CCN: 151305	Peri od:	Worksheet A-	6
						From 10/01/2013 To 09/30/2014	Date/Time Pr 3/30/2015 3:	
		Increases						
	Cost Center	Line #	Salary	Other				
	2.00	3.00	4.00	5.00				
	A - PROPERTY INSURANCE							
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	20, 457				1.00
	FI XT							
	0		o	20, 457				1
	B - MARKETING RECLASS							1
1.00	ADMI NI STRATI VE & GENERAL	5.00	13, 495	44, 445				1.00
	0		13, 495	44, 445				
	C - IMPLANTABLE DEVICES							1
1.00	IMPL. DEV. CHARGED TO	72.00	0	107, 325				1.00
	PATI ENTS							
	0		0	107, 325				
	D - NON-RHC EXPENSE RECLASS							1
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	2, 339, 570	116, 395				1.00
	TOTALS		2, 339, 570	116, 395				1
500.00	Grand Total: Increases		2, 353, 065	288, 622				500.00

Heal th	Financial Systems		PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS	-2552-10
RECLASS	SEFECATIONS			Provi der	CCN: 151305	Peri od:	Worksheet A-	6
						From 10/01/2013 To 09/30/2014	Date/Time Pr 3/30/2015 3:	
		Decreases						
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref	· .		
	6.00	7.00	8.00	9.00	10.00			
	A - PROPERTY INSURANCE							
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	20, 457	1	2		1.00
	0		0	20, 457				
	B - MARKETING RECLASS							
1.00	MARKETING	194.00	13, 495	44, 445		0		1.00
	0		13, 495	44, 445				
	C - IMPLANTABLE DEVICES							
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	107, 325		0		1.00
	PATI ENTS							
	0		0	107, 325				
	D - NON-RHC EXPENSE RECLASS							
1.00	RURAL_HEALTH_CLINIC	<u> </u>	2, 339, 570	<u>116, 3</u> 95		Ō		1.00
	TOTALS		2, 339, 570	116, 395				
500.00	Grand Total: Decreases		2, 353, 065	288, 622				500.00

Heal th	Financial Systems	PULASKI MEMORI	AL HOSPITAL		_	In Lie	u of Form CMS-2	2552-10
RECON	LIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 151305		d: 10/01/2013 09/30/2014		pared:
				Acqui si ti ons			373072013 3.3	
		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 ASSET	BALANCES						
1.00	Land	195, 525	0		0	0	0	1.00
2.00	Land Improvements	357, 251	75, 343		0	75, 343	0	2.00
3.00	Buildings and Fixtures	9, 770, 624	653, 478		0	653, 478	0	3.00
4.00	Building Improvements	160, 930	0		0	0	0	4.00
5.00	Fixed Equipment	5, 411, 222	58, 120		0	58, 120	0	5.00
6.00	Movable Equipment	6, 582, 421	1, 111, 300		0	1, 111, 300	0	6.00
7.00	HIT designated Assets	209, 807	73, 375		0	73, 375	0	7.00
8.00	Subtotal (sum of lines 1-7)	22, 687, 780	1, 971, 616		0	1, 971, 616	0	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	22, 687, 780	1, 971, 616		0	1, 971, 616	0	10.00
		Ending Balance	Fully					
		-	Depreciated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES						
1.00	Land	195, 525	0					1.00
2.00	Land Improvements	432, 594	0					2.00
3.00	Buildings and Fixtures	10, 424, 102	0					3.00
4.00	Building Improvements	160, 930	0					4.00
5.00	Fixed Equipment	5, 469, 342	0					5.00
6.00	Movable Equipment	7, 693, 721	0					6.00
7.00	HIT designated Assets	283, 182	0					7.00
8.00	Subtotal (sum of lines 1-7)	24, 659, 396	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	24, 659, 396	0					10.00

Heal th	Financial Systems	PULASKI MEMOR	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10	
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 10/01/2013 To 09/30/2014		pared:	
		SUMMARY OF CAPITAL						
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see i nstructi ons)		
		9.00	10.00	11.00	12.00	13.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	N 2, LINES 1 a	nd 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1, 051, 555	0	170, 20	4 0	0	1.00	
3.00	Total (sum of lines 1-2)	1, 051, 555	0	170, 20	4 0	0	3.00	
		SUMMARY O	F CAPITAL					
	Cost Center Description	Other	Total (1) (sum					
		Capi tal -Rel ate	of cols. 9					
		d Costs (see	through 14)					
		instructions)						
		14.00	15.00					
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1, 221, 759				1.00	
3.00	Total (sum of lines 1-2)	0	1, 221, 759				3.00	

Health Financial Systems	PULASKI MEMOR	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der	F	Period: From 10/01/2013 To 09/30/2014		pared:
	COMI	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col.	Ratio (see instructions)	Insurance	
	1.00	2.00	2)	4,00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		2.00	3.00	4.00	5.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0	(1.000000	0	1.00
3.00 Total (sum of lines 1-2)	0	0	(1.000000		3.00
	ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	Other Capi tal -Rel ate	Total (sum of cols. 5	Depreciation	Lease	
		d Costs	through 7)			
	6.00	7.00	8, 00	9,00	10,00	
PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0	(1, 035, 714	0	1.00
3.00 Total (sum of lines 1-2)	0	Ů	(1, 035, 714	0	3.00
		SL	JMMARY OF CAPI ⁻			
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)	Capital -Relate		
				d Costs (see instructions)	through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		.2.00				
1.00 NEW CAP REL COSTS-BLDG & FIXT	167, 240	20, 457	(0 0	1, 223, 411	1.00
3.00 Total (sum of lines 1-2)	167, 240			0 0		3.00

	Financial Systems MENTS TO EXPENSES				eriod: rom 10/01/2013	u of Form CMS-2 Worksheet A-8 Date/Time Prep 3/30/2015 3:55	pared:
				Expense Classification on To/From Which the Amount is			
	Cost Center Description		Amount	Cost Center	Line #	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
	REL COSTS-BLDG & FIXT (chapter 2)			FIXT			
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
. 00	Investment income - other		0		0.00	0	3.00
. 00	(chapter 2) Trade, quantity, and time		0		0.00	0	4.00
. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.00
. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.00
	suppliers (chapter 8)		-				
. 00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
3. 00	Television and radio service (chapter 21)		0		0.00	0	8.00
0. 00 0. 00	Parking lot (chapter 21) Provider-based physician adjustment	A-8-2	0 -33, 162		0.00	0 0	9. 00 10. 00
1.00	Sale of scrap, waste, etc.		0		0.00	0	11.00
2.00	(chapter 23) Related organization transactions (chapter 10)	A-8-1	0			0	
3.00 4.00	Laundry and linen service Cafeteria-employees and guests		0		0.00 0.00	0	13.00 14.00
5.00	Rental of quarters to employee and others		0		0.00	0	15.00
6. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16.00
7.00	patients Sale of drugs to other than		0		0.00	0	17.00
8. 00	patients Sale of medical records and		0		0.00	0	18.00
9.00	abstracts Nursing school (tuition, fees,		0		0.00	0	19.00
	books, etc.)		-				
0. 00 1. 00	Vending machines Income from imposition of interest, finance or penalty		0 0		0.00 0.00	0	20. 00 21. 00
2. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22. 00
3. 00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
4.00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
5.00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25. 00
6. 00	(chapter 21) Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-BLDG &	1.00	0	26. 00
7.00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	FIXT *** Cost Center Deleted ***	2.00	0	27.00
8. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
9. 00 0. 00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	0.00 67.00		29. 00 30. 00
0. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
1. 00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
2. 00	limitation (chapter 14) CAH HIT Adjustment for	A	-15, 841	NEW CAP REL COSTS-BLDG &	1.00	9	32.00
3 00	Depreciation and Interest CAFETERIA VENDING - OTHER REV	В	-62 880	FI XT DI ETARY	10.00	0	33.00

Heal th	Financial Systems		PULASKI MEMOR	I AL HOSPI TAL	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES			Provi der CCN: 151305	Period: From 10/01/2013 To 09/30/2014	Worksheet A-8 Date/Time Pre 3/30/2015 3:5	pared:
				Expense Classification of			
				To/From Which the Amount i	s to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
34.00	EMPLOYEE RX PROGRAM -OTHER REV	В	-100, 861	DRUGS CHARGED TO PATIENTS	73.00	0	34.00
35.00	MEDICAL RECORDS FEES -OTHER	В	-4, 627	MEDICAL RECORDS & LIBRARY	16.00	0	35.00
	REV						
36.00	SALE OF SCRAP -OTHER REV	В		CENTRAL SERVICES & SUPPLY	14.00		00.00
37.00	REBATES & REFUNDS - OTHER REV	В		CENTRAL SERVICES & SUPPLY	14.00		37.00
38.00	BABY PHOTO - OTHER REV	В		ADMI NI STRATI VE & GENERAL	5.00	0	00.00
40.00	OTHER SERVICES -OTHER REV	В		ADMINISTRATIVE & GENERAL	5.00		1 101 00
41.00	ICG - OTHER REV	В		ADMINISTRATIVE & GENERAL	5.00		
43.00	INVEST INC/UNRESTRIC- INT EXP	A	-2, 964	NEW CAP REL COSTS-BLDG &	1.00	11	43.00
44.00	NONOPERATING - OTHER EXP	А	13, 405	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00	BANK FEES -OTHER EXP	А		ADMI NI STRATI VE & GENERAL	5.00	0	45.00
45.01	MISC	В	3	ADMI NI STRATI VE & GENERAL	5.00	0	45.01
45.02	TELEVI SI ON	А	-278	OPERATION OF PLANT	7.00	0	45.02
45.03	PHYSICIAN RECRUITMENT - ADMIN	A	-37, 586	ADMINI STRATI VE & GENERAL	5.00	0	45.03
45.04	LOBBYING EXPENSE	A	-3, 016	ADMI NI STRATI VE & GENERAL	5.00	0	45.04
45.05	CRNA	A	-568, 926	ANESTHESI OLOGY	53.00	0	45.05
45.06	HOSPITAL ASSESSMENT FEE EXPENSE	A	-542, 344	ADMI NI STRATI VE & GENERAL	5.00	0	45.06
45.07	ENTENDE		0		0.00	0	45.07
45.08			0		0.00		
45.09			0		0.00		
45.10			0		0.00		45.10
45.11			0		0.00		45.11
50.00	TOTAL (sum of lines 1 thru 49)		-1, 360, 313		0100		50.00
	(Transfer to Worksheet A,		.,, 010				
	column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Syste	ems	PULASKI MEMOF	RIAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
	R BASED PHYSIC				CCN: 151305	Period: From 10/01/2013 To 09/30/2014	Worksheet A-8	3-2 epared:
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Prov ider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	694, 328	0	694, 32	8 0	0	1.00
2.00	60.00	LABORATORY	24, 000	0	24,00	o 0	0	2.00
3.00	69.00	ELECTROCARDI OLOGY	5, 412	5, 412		o 0	0	3.00
4.00	90.00	CLINIC	27, 750	27, 750		0 0	0	4.00
5.00	0.00		0	0		0 0	0	5.00
6.00	0.00		0	0		o 0	0	6.00
7.00	0.00		0	0		o 0	0	7.00
8.00	0.00		0	0		o 0	0	8.00
9.00	0.00		0	0		o 0	0	9.00
10.00	0.00		0	0		o o	0	10.00
200.00			751, 490	33, 162	718, 32	8	0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		Identifier	Limit	Unadjusted RCE	Memberships &	Component	of Mal practi ce	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		EMERGENCY	0	0		0 0	-	
2.00		LABORATORY	0	0		0 0	0	2.00
3.00		ELECTROCARDI OLOGY	0	0		0 0	0	
4.00		CLINIC	0	0		0 0	0	
5.00	0.00		0	0		0 0	0	
6.00	0.00		0	0		0 0	0	
7.00	0.00		0	0		0 0	0	7.00
8.00	0.00		0	0		0 0	0	
9.00	0.00		0	0		0 0	0	9.00
10.00	0.00		0	0		0 0	, s	
200.00			0	0		0 0	0	200.00
	Wkst. A Line #	, , , , , , , , , , , , , , , , , , ,	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	14	1/ 00	17.00	10.00		
1 00	1.00	2.00	15.00	16.00	17.00	18.00		1.00
1.00			0	0		0 0 0 0		1.00
2.00			0					2.00
3.00		ELECTROCARDI OLOGY	0	0		0 5, 412		3.00
4.00		CLINIC	0	0		0 27,750		4.00
5.00	0.00		0	0		0 0		5.00
6.00	0.00		0	0		0 0		6.00
7.00	0.00		0	0		0 0		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		10.00
200.00			0	0		0 33, 162		200. 00

	NABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	FURNI SHED BY	Provi der	CCN: 151305	Period: From 10/01/2013 To 09/30/2014		pared:
					Physical Therapy		
	PART I - GENERAL INFORMATION					1.00	
1.00	Total number of weeks worked (excluding aides	s) (see instruc	tions)			13	1.00
2.00	Line 1 multiplied by 15 hours per week					195	
3.00 4.00	Number of unduplicated days in which supervis Number of unduplicated days in which therapy					65	
4.00	nor therapist was on provider site (see inst		Sil provider si		ier supervisor	0	4.0
5.00	Number of unduplicated offsite visits - super					0	
6.00	Number of unduplicated offsite visits - thera assistant and on which supervisor and/or the					0	6.0
	instructions)	apist was not	bi esent during	the visit(s	(366		
7.00	Standard travel expense rate					0.00	
8.00	Optional travel expense rate per mile	Supervi sors	Therapi sts	Assi stants	Ai des	0.00 Trai nees	8.00
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	400.05	0.	00 0.00	0.00	
10.00	AHSEA (see instructions)	0.00	77.39		00 0.00	0.00	
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3,	38. 70	38. 70	0.	00		11.00
	one-half of column 3, line 10)						
12.00	Number of travel hours (provider site)	0	0		0		12.00
12.01 13.00	Number of travel hours (offsite) Number of miles driven (provider site)	0	0		0		12.0
13.01	Number of miles driven (offsite)	0	0		0		13.0
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00	
14.00		line 10)				0	14.0
15.00	Therapists (column 2, line 9 times column 2,					30, 960	
16.00	Assistants (column 3, line 9 times column 3,		natary, therapy	on Linco 1/	1/ for all	0	
17.00	Subtotal allowance amount (sum of lines 14 ar others)	id is for respi	ratory therapy	or times 12		30, 960	17.0
18.00	Aides (column 4, line 9 times column 4, line					0	18.0
19.00				47 44		0	
20. 00	Total allowance amount (sum of lines 17-19 for If the sum of columns 1 and 2 for respiratory						20. 0
	occupational therapy, line 9, is greater than						
	the amount from line 20. Otherwise complete				4 1 0 11 0	0.00	
21.00	Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3,			m of columns	and 2, line 9	0.00	21.00
22.00	Weighted allowance excluding aides and traine					0	22.00
23. 00	Total salary equivalency (see instructions)					20.060	
		ANCE AND TRAVE	_ EXPENSE COMPI		OVIDER SLIE	30, 900	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW			JIAIION - FR	OVIDER OTTE		23.00
24.00	Standard Travel Allowance Therapists (line 3 times column 2, line 11)						23.00
25. 00	Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)					2, 516	24. 00 25. 00
25. 00 26. 00	Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or		4 and 25 for a	II others)		2, 516 0 2, 516	24. 00 25. 00 26. 00
25. 00	Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)		4 and 25 for a	II others)		2, 516	24. 00 25. 00 26. 00
25. 00 26. 00	Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard	for respirator	4 and 25 for a y therapy or s	ll others) um of lines	3 and 4 for all	2, 516 0 2, 516 0	24. 00 25. 00 26. 00 27. 00
25. 00 26. 00 27. 00	Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27)	for respirator	4 and 25 for a y therapy or s	ll others) um of lines	3 and 4 for all	2, 516 0 2, 516 0	24. 00 25. 00 26. 00 27. 00
25. 00 26. 00 27. 00	Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel	for respirator travel expense Expense	4 and 25 for a y therapy or s at the provid	ll others) um of lines	3 and 4 for all	2, 516 0 2, 516 0	24. 00 25. 00 26. 00 27. 00 28. 00
25.00 26.00 27.00 28.00 28.00 29.00 30.00	Standard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 4, line 10, line 10	for respiratory travel expense Expense of columns 1 and line 12)	4 and 25 for a y therapy or s at the provid d 2, line 12)	ll others) um of lines er site (sum	3 and 4 for all	2, 516 0 2, 516 0 2, 516 0 2, 516	24. 00 25. 00 26. 00 27. 00 28. 00 28. 00 30. 00
 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 	Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or	for respirator travel expense Expense of columns 1 and line 12) sum of lines 2	4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a	II others) um of lines er site (sum II others)	3 and 4 for all of lines 26 and	2, 516 0 2, 516 0 2, 516 0 2, 516 0 0 0 0 0	24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00
25.00 26.00 27.00 28.00 28.00 29.00 30.00	Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns)	for respirator travel expense Expense of columns 1 and line 12) sum of lines 2	4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a	II others) um of lines er site (sum II others)	3 and 4 for all of lines 26 and	2, 516 0 2, 516 0 2, 516 0 2, 516	24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00
 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 	Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or	for respirator travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 2 s 1 and 2, line	4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respire	II others) um of lines er site (sum II others)	3 and 4 for all of lines 26 and	2, 516 0 2, 516 0 2, 516 0 2, 516 0 0 0 0 0	24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00
 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 	Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel	for respirator: travel expense <u>Expense</u> of columns 1 an- line 12) sum of lines 2' s 1 and 2, line expense (line expense (sum	4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an	II others) um of lines er site (sum II others) atory therap d 31)	3 and 4 for all of lines 26 and	2, 516 0 2, 516 0 2, 516 0 2, 516 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00
 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 	Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel	for respirator travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum	4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir. 28) of lines 27 an of lines 31 an	II others) um of lines er site (sum II others) atory therap d 31) d 32)	3 and 4 for all of lines 26 and y or sum of	2, 516 0 2, 516 0 2, 516 0 2, 516 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 33. 00 34. 00
 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 	Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel	for respirator travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum	4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir. 28) of lines 27 an of lines 31 an	II others) um of lines er site (sum II others) atory therap d 31) d 32)	3 and 4 for all of lines 26 and y or sum of	2, 516 0 2, 516 0 2, 516 0 2, 516 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 33. 00 34. 00
 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 	Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWE Standard Travel Expense Therapists (line 5 times column 2, line 11)	for respirator travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum	4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir. 28) of lines 27 an of lines 31 an	II others) um of lines er site (sum II others) atory therap d 31) d 32)	3 and 4 for all of lines 26 and y or sum of	2, 516 0 2, 516 2, 516 0 2, 516 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 31. 00 32. 00 33. 00 34. 00 35. 00
 25. 00 26. 00 27. 00 28. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 	Standard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum ofAssistants (column 3, line 10 times column 3,Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard travelColumns 1-3, line 13 for all others)Standard travel allowance and standard travelOptional travel allowance and standard travelOptional travel allowance and standard travelStandard travel allowance and standard travelDitional travel allowance and standard travelDiti	for respirator travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum	4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir. 28) of lines 27 an of lines 31 an	II others) um of lines er site (sum II others) atory therap d 31) d 32)	3 and 4 for all of lines 26 and y or sum of	2, 516 0 2, 516 0 2, 516 0 2, 516 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00	Standard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum ofAssistants (column 3, line 10 times column 3,Subtotal (line 29 for respiratory therapy orOptional travel expense (line 8 times column 3,Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard travelOptional travel allowance and standard travelOptional travel allowance and standard travelOptional travel allowance and standard travelPart IV - STANDARD AND OPTIONAL TRAVEL ALLOWAStandard Travel ExpenseTherapists (line 5 times column 3, line 11)Assistants (line 6 times column 3, line 11)Subtotal (sum of lines 36 and 37)	for respirator: travel expense <u>Expense</u> of columns 1 an- line 12) sum of lines 2' s 1 and 2, line expense (line expense (sum NCE AND TRAVEL	4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU	II others) um of lines er site (sum II others) atory therap d 31) d 32)	3 and 4 for all of lines 26 and y or sum of	2, 516 0 2, 516 0 2, 516 0 2, 516 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 35. 00 36. 00 37. 00 38. 00
 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 	Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)	for respirator: travel expense Expense of columns 1 and line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum NCE AND TRAVEL	4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU	II others) um of lines er site (sum II others) atory therap d 31) d 32)	3 and 4 for all of lines 26 and y or sum of	2, 516 0 2, 516 0 2, 516 0 2, 516 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	24. 0 25. 0 26. 0 27. 0 28. 0 30. 0 31. 0 32. 0 33. 0 34. 0 35. 0 34. 0 35. 0 34. 0 35. 0 36. 0 37. 0 38. 0
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 31. 00 322. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00	Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum 0 Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 2, line 11) Subtotal (sum of lines 36 and 37) Standard travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0	for respirator travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 2 5 1 and 2, line expense (line expense (sum NCE AND TRAVEL	4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU	II others) um of lines er site (sum II others) atory therap d 31) d 32)	3 and 4 for all of lines 26 and y or sum of	2, 516 0 2, 516 0 2, 516 0 2, 516 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	24. 0 25. 0 26. 0 27. 0 28. 0 29. 0 30. 0 31. 0 32. 0 33. 0 34. 0 35. 0 36. 0 37. 0 38. 0 39. 0 40. 0
 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 	Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel allowance and standard travel Optional travel allowance and optional travel Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (colum 3, line 12.01 times column	for respirator travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 2 5 1 and 2, line expense (line expense (sum NCE AND TRAVEL	4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU	II others) um of lines er site (sum II others) atory therap d 31) d 32)	3 and 4 for all of lines 26 and y or sum of	2, 516 0 2, 516 0 2, 516 0 2, 516 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00
25.00 26.00 27.00 28.00 29.00 30.00 31.00 31.00 32.00 33.00 33.00 33.00 34.00 35.00 36.00 37.00 38.00 37.00 38.00 37.00 38.00 37.00 38.00 37.00 38.00 37.00	Standard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum ofAssistants (column 3, line 10 times column 3,Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard travelColumns 1-3, line 13 for all others)Standard travel allowance and standard travelOptional travel allowance and standard travelOptional travel allowance and standard travelPart IV - STANDARD AND OPTIONAL TRAVEL ALLOWAStandard Travel ExpenseTherapists (line 5 times column 3, line 11)Subtotal (sum of lines 36 and 37)Standard travel Allowance and Optional TravelTherapists (sum of columns 1 and 2, line 12.0Assistants (column 3, line 2.01 times columnSubtotal (sum of lines 40 and 41)	for respirator: travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 2 s 1 and 2, line expense (sum expense (sum NCE AND TRAVEL n of lines 5 and Expense 1 times column n 3, line 10)	4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU d 6) 2, line 10)	II others) um of lines er site (sum II others) atory therap d 31) d 32)	3 and 4 for all of lines 26 and y or sum of	2, 516 0 2, 516 0 2, 516 0 2, 516 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	24. 0 25. 0 26. 0 27. 0 28. 0 29. 0 30. 0 31. 0 32. 0 33. 0 34. 0 35. 0 36. 0 37. 0 38. 0 39. 0 40. 0 41. 0 42. 0
 25. 00 26. 00 27. 00 28. 00 29. 00 29. 00 20. 00 21. 00 22. 00 33. 00 44. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 44. 00 45. 00 46. 00 47. 00 48. 00 49. 00 49. 00 40. 00 41. 00 41. 00 42. 00 44. 00 45. 00 46. 00 47. 00 48. 00 49. 00 49. 00 40. 00 40. 00 40. 00 40. 00 40. 00 40. 00 41. 00 42. 00 	Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel allowance and standard travel Optional travel allowance and optional travel Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (colum 3, line 12.01 times column	for respirator: travel expense Expense of columns 1 an- line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum NCE AND TRAVEL n of lines 5 an- Expense 1 times column a 3, line 10) n of columns 1-	4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU d 6) 2, line 10) 3, line 13.01)	II others) um of lines er site (sun ll others) atory therap d 31) d 32) TATION - SEF	3 and 4 for all n of lines 26 and ny or sum of WICES OUTSIDE PRO	2, 516 0 2, 516 0 2, 516 0 2, 516 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	24. 0 25. 0 26. 0 27. 0 28. 0 29. 0 30. 0 31. 0 32. 0 33. 0 34. 0 35. 0 36. 0 37. 0 38. 0 37. 0 38. 0 39. 0 40. 0 41. 0 42. 0
25.00 26.00 27.00 28.00 29.00 30.00 31.00 31.00 32.00 33.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00	Standard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum ofAssistants (column 3, line 10 times column 3,Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard travelOptional travel allowance and standard travelPart IV - STANDARD AND OPTIONAL TRAVEL ALLOW/Standard travel expenseTherapists (line 5 times column 3, line 11)Assistants (line 6 times column 3, line 11)Subtotal (sum of lines 36 and 37)Standard travel expense (line 7 times the surOptional Travel Allowance and Optional TravelTherapists (sum of columns 1 and 2, line 12.0Assistants (column 3, line 40 and 41)Optional travel expense (line 8 times column	for respirator: travel expense Expense of columns 1 and line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum NCE AND TRAVEL n of lines 5 and Expense 1 times column n 3, line 10) n of columns 1- offsite Services	4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir. 28) of lines 27 an of lines 27 an of lines 31 an EXPENSE COMPU d 6) 2, line 10) 3, line 13.01) 5; Complete on	II others) um of lines er site (sum II others) atory therap d 31) d 32) TATION - SEF	3 and 4 for all of lines 26 and by or sum of VICES OUTSIDE PRO	2, 516 0 2, 516 0 2, 516 0 2, 516 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	24. 0 25. 0 26. 0 27. 0 28. 0 29. 0 30. 0 31. 0 32. 0 33. 0 34. 0 35. 0 36. 0 37. 0 38. 0 39. 0 40. 0 41. 0 42. 0

	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	<u>PULASKI MEMORIA</u> FURNI SHED BY		CCN: 151305	Peri od: From 10/01/2013 To 09/30/2014	u of Form CMS-2 Worksheet A-8 Parts I-VI Date/Time Prep 3/30/2015 3:55	-3 pared:
					Physical Therapy		
						1.00	
6.00	Optional travel allowance and optional travel	expense (sum o	flines 42 an	d 43 - see ir	nstructions)		46.00
		Therapists	Assi stants	Ai des	Trainees	Total	
	PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	5.00	
	Overtime hours worked during reporting	0.00	0.00	0.0	0.00	0.00	47.0
/. 00	period (if column 5, line 47, is zero or	0.00	0.00		0.00	0.00	17.0
	equal to or greater than 2,080, do not						
	complete lines 48-55 and enter zero in each						
	column of line 56)						
	Overtime rate (see instructions)	0.00	0.00				48.0
9.00	Total overtime (including base and overtime	0. 00	0.00	0. (0. 00		49.0
	allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT						
0. 00	Percentage of overtime hours by category	0.00	0.00	0.0	0.00	0.00	50.0
0.00	(divide the hours in each column on line 47	0.00	0.00	0.1	0.00	0.00	00.0
	by the total overtime worked - column 5,						
	line 47)						
1.00	Allocation of provider's standard work year	0. 00	0.00	0.0	0.00	0.00	51.0
	for one full-time employee times the						
	percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE						
2.00	Adjusted hourly salary equivalency amount	77.39	0.00	0.0	0.00		52.0
2.00	(see instructions)	,,,	0.00		0.00		02.0
3.00	Overtime cost limitation (line 51 times line	0	0		0 0		53.0
	52)						
4.00	Maximum overtime cost (enter the lesser of	0	0		0 0		54.0
F 00	line 49 or line 53)						
5.00	Portion of overtime already included in hourly computation at the AHSEA (multiply	0	0		0 0		55.0
	line 47 times line 52)						
6.00	Overtime allowance (line 54 minus line 55 -	О	0		0 0	0	56.0
	if negative enter zero) (Enter in column 5						
	the sum of columns 1, 3, and 4 for						
	respiratory therapy and columns 1 through 3						
	for all others.)						
						1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT			1.00	
7.00	Salary equivalency amount (from line 23)					30, 960	57.0
8.00	Travel allowance and expense - provider site	(from lines 33,	34, or 35))			0	58.0
	Travel allowance and expense - Offsite service	ces (from lines	44, 45, or 46)		0	
	Overtime allowance (from column 5, line 56)					0	
	Equipment cost (see instructions)					0	
	Supplies (see instructions)					0	02.0
	Total allowance (sum of lines 57-62) Total cost of outside supplier services (from	vour records)				30, 960 28, 004	
	Excess over limitation (line 64 minus line 63		enter zero)				65.0
0.00	LINE 33 CALCULATION	, in negative,					00.0
00.00	Line 26 = line 24 for respiratory therapy or	sum of lines 24	and 25 for a	II others		2, 516	100. C
00.01	Line 27 = line 7 times line 3 for respiratory	/ therapy or sum	of lines 3 a	nd 4 for all	others		100. 0
00.02	Line 33 = line 28 = sum of lines 26 and 27					2, 516	100. 0
	LINE 34 CALCULATION						
	Line 27 = line 7 times line 3 for respiratory				others		101.0
	Line 31 = line 29 for respiratory therapy or	sum of lines 29	and 30 for a	II others			101.0
01.02	Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION					0	101.0
		sum of lines 20	and 30 for a	11 others		0	102.0
02 00						0	1102.0
	Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2. line				umns 1-3, line	0	102.0
	Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line 13 for all others				umns 1-3, line	0	102. 0

	VABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	PULASKI MEMORI / FURNI SHED BY		CCN: 151305	Period: From 10/01/2013 To 09/30/2014		-3 pared:
					Speech Pathology		
						1.00	
	PART I - GENERAL INFORMATION					-	
1.00 2.00	Total number of weeks worked (excluding aides Line 1 multiplied by 15 hours per week	s) (see instruct	ions)			8	1.00 2.00
3.00	Number of unduplicated days in which supervis	sor or therapist	was on provi	der site (se	e instructions)	9	3.00
4.00	Number of unduplicated days in which therapy	assistant was c				0	4.00
F 00	nor therapist was on provider site (see instr		niata (asa in			0	F 00
5.00 6.00	Number of unduplicated offsite visits - super Number of unduplicated offsite visits - thera	anv assistants (include only	visits made	by therapy	0	5.00 6.00
	assistant and on which supervisor and/or the					_	
7.00	instructions)					0.00	7.00
8.00	Standard travel expense rate Optional travel expense rate per mile					0.00	
		Supervi sors	Therapi sts	Assi stants		Trai nees	
9.00	Total hours worked	1.00	2.00	3.00	<u>4.00</u> 00 0.00	5.00	9.00
9.00 10.00	AHSEA (see instructions)	0.00	70. 52		00 0.00		
11.00	Standard travel allowance (columns 1 and 2,	35. 26	35.26	0.	00		11.00
	one-half of column 2, line 10; column 3,						
12.00	one-half of column 3, line 10) Number of travel hours (provider site)	О	0		0		12.00
12. 01	Number of travel hours (offsite)	0	0		0		12.01
13.00	Number of miles driven (provider site)	0	0		0		13.00
13.01	Number of miles driven (offsite)	0	0		0		13.01
						1.00	
14 00	Part II - SALARY EQUIVALENCY COMPUTATION	Lino 10)				0	1 1 4 00
14.00 15.00	Supervisors (column 1, line 9 times column 1, Therapists (column 2, line 9 times column 2,					3, 561	14.00 15.00
16.00	Assistants (column 3, line 9 times column 3,					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 ar	nd 15 for respir	atory therapy	or lines 14	-16 for all	3, 561	17.00
18.00	others) Aides (column 4, line 9 times column 4, line	10)				0	18.00
19.00	Trainees (column 5, line 9 times column 5, li					0	19.00
20. 00	Total allowance amount (sum of lines 17-19 for					3, 561	20.00
	If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than						
	the amount from line 20. Otherwise complete	lines 21-23.				11110 25	
21.00	Weighted average rate excluding aides and tra	inoos (lino 17					
				m of columns	1 and 2, line 9	70. 51	21.00
	for respiratory therapy or columns 1 thru 3,	line 9 for all	others)	m of columns	1 and 2, line 9		
22. 00 23. 00		line 9 for all	others)	m of columns	1 and 2, line 9	70. 51 8, 461 8, 461	22.00
22. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	line 9 for all ees (line 2 time	others) s line 21)			8, 461	22.00
22. 00 23. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	line 9 for all ees (line 2 time	others) s line 21)			8, 461 8, 461	22. 00 23. 00
22. 00 23. 00 24. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	line 9 for all ees (line 2 time	others) s line 21)			8, 461 8, 461	22. 00 23. 00 24. 00
22. 00 23. 00 24. 00 25. 00 26. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	line 9 for all ees (line 2 time /ANCE AND TRAVEL sum of lines 24	others) s line 21) EXPENSE COMP and 25 for a	UTATION - PR	OVI DER SI TE	8, 461 8, 461 317 0 317	22. 00 23. 00 24. 00 25. 00 26. 00
22. 00 23. 00 24. 00 25. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3	line 9 for all ees (line 2 time /ANCE AND TRAVEL sum of lines 24	others) s line 21) EXPENSE COMP and 25 for a	UTATION - PR	OVI DER SI TE	8, 461 8, 461 317 0	22. 00 23. 00 24. 00 25. 00
22. 00 23. 00 24. 00 25. 00 26. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	line 9 for all ees (line 2 time ANCE AND TRAVEL sum of lines 24 for respiratory	others) s line 21) EXPENSE COMP and 25 for a therapy or s	UTATION - PR Il others) um of lines	OVIDER SITE 3 and 4 for all	8, 461 8, 461 317 0 317	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00
22.00 23.00 24.00 25.00 26.00 27.00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27)	line 9 for all ees (line 2 time /ANCE AND TRAVEL sum of lines 24 for respiratory travel expense	others) s line 21) EXPENSE COMP and 25 for a therapy or s	UTATION - PR Il others) um of lines	OVIDER SITE 3 and 4 for all	8, 461 8, 461 317 0 317 0	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel	line 9 for all ees (line 2 time ANCE AND TRAVEL sum of lines 24 for respiratory travel expense Expense	others) s line 21) EXPENSE COMP and 25 for a therapy or s at the provid	UTATION - PR Il others) um of lines	OVIDER SITE 3 and 4 for all	8, 461 8, 461 317 0 317 0 317	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00
22.00 23.00 24.00 25.00 26.00 27.00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27)	line 9 for all ees (line 2 time VANCE AND TRAVEL sum of lines 24 for respiratory travel expense <u>Expense</u> of columns 1 and	others) s line 21) EXPENSE COMP and 25 for a therapy or s at the provid	UTATION - PR Il others) um of lines	OVIDER SITE 3 and 4 for all	8, 461 8, 461 317 0 317 0	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 28. 00 29. 00 30. 00 31. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or	line 9 for all ees (line 2 time ANCE AND TRAVEL sum of lines 24 for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29	others) s line 21) EXPENSE COMP and 25 for a therapy or s at the provid 2, line 12) and 30 for a	UTATION - PR II others) um of lines er site (sum II others)	OVIDER SITE 3 and 4 for all of lines 26 and	8, 461 8, 461 317 0 317 0 317 0 317 0 0 0 0 0 0	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 28. 00 30. 00 31. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum 0, Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns)	line 9 for all ees (line 2 time ANCE AND TRAVEL sum of lines 24 for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29	others) s line 21) EXPENSE COMP and 25 for a therapy or s at the provid 2, line 12) and 30 for a	UTATION - PR II others) um of lines er site (sum II others)	OVIDER SITE 3 and 4 for all of lines 26 and	8, 461 8, 461 317 0 317 0 317 0 317 0 0 0 0	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 28. 00 30. 00 31. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 28. 00 29. 00 30. 00 31. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or	line 9 for all ees (line 2 time ANCE AND TRAVEL sum of lines 24 for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29 s 1 and 2, line	others) s line 21) EXPENSE COMP and 25 for a therapy or s at the provid 2, line 12) and 30 for a 13 for respir	UTATION - PR II others) um of lines er site (sum II others)	OVIDER SITE 3 and 4 for all of lines 26 and	8, 461 8, 461 317 0 317 0 317 0 317 0 317 0 0 0 0 0	22. 00 23. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel	line 9 for all ees (line 2 time ANCE AND TRAVEL sum of lines 24 for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum of	others) s line 21) EXPENSE COMP and 25 for a therapy or s at the provid 2, line 12) and 30 for a 13 for respir 28) f lines 27 an	UTATION - PR II others) um of lines er site (sum II others) atory therap d 31)	OVIDER SITE 3 and 4 for all of lines 26 and	8, 461 8, 461 317 0 317 0 317 0 317 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 25. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and optional travel	line 9 for all ees (line 2 time ANCE AND TRAVEL sum of lines 24 for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum c expense (sum c	others) s line 21) EXPENSE COMP and 25 for a therapy or s at the provid 2, line 12) and 30 for a 13 for respir 28) f lines 27 an f lines 31 an	UTATION - PR II others) um of lines er site (sum II others) atory therap d 31) d 32)	OVIDER SITE 3 and 4 for all of lines 26 and y or sum of	8, 461 8, 461 317 0 317 0 317 0 317 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 25. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel	line 9 for all ees (line 2 time ANCE AND TRAVEL sum of lines 24 for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum c expense (sum c	others) s line 21) EXPENSE COMP and 25 for a therapy or s at the provid 2, line 12) and 30 for a 13 for respir 28) f lines 27 an f lines 31 an	UTATION - PR II others) um of lines er site (sum II others) atory therap d 31) d 32)	OVIDER SITE 3 and 4 for all of lines 26 and y or sum of	8, 461 8, 461 317 0 317 0 317 0 317 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 25. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11)	line 9 for all ees (line 2 time ANCE AND TRAVEL sum of lines 24 for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum c expense (sum c	others) s line 21) EXPENSE COMP and 25 for a therapy or s at the provid 2, line 12) and 30 for a 13 for respir 28) f lines 27 an f lines 31 an	UTATION - PR II others) um of lines er site (sum II others) atory therap d 31) d 32)	OVIDER SITE 3 and 4 for all of lines 26 and y or sum of	8, 461 8, 461 317 0 317 0 317 0 317 0 317 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)	line 9 for all ees (line 2 time ANCE AND TRAVEL sum of lines 24 for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum c expense (sum c	others) s line 21) EXPENSE COMP and 25 for a therapy or s at the provid 2, line 12) and 30 for a 13 for respir 28) f lines 27 an f lines 31 an	UTATION - PR II others) um of lines er site (sum II others) atory therap d 31) d 32)	OVIDER SITE 3 and 4 for all of lines 26 and y or sum of	8, 461 8, 461 317 0 317 0 317 0 317 0 317 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)	line 9 for all ees (line 2 time ANCE AND TRAVEL sum of lines 24 for respiratory travel expense Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum c expense (sum c	others) s line 21) EXPENSE COMP and 25 for a therapy or s at the provid 2, line 12) and 30 for a 13 for respir 28) f lines 27 an f lines 31 an EXPENSE COMPU	UTATION - PR II others) um of lines er site (sum II others) atory therap d 31) d 32)	OVIDER SITE 3 and 4 for all of lines 26 and y or sum of	8, 461 8, 461 317 0 317 0 317 0 317 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 25. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)	line 9 for all ees (line 2 time ANCE AND TRAVEL sum of lines 24 for respiratory travel expense Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum contexpense (sum contexpense) NCE AND TRAVEL	others) s line 21) EXPENSE COMP and 25 for a therapy or s at the provid 2, line 12) and 30 for a 13 for respir 28) f lines 27 an f lines 31 an EXPENSE COMPU	UTATION - PR II others) um of lines er site (sum II others) atory therap d 31) d 32)	OVIDER SITE 3 and 4 for all of lines 26 and y or sum of	8, 461 8, 461 317 0 317 0 317 0 317 0 317 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 25. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0	line 9 for all ees (line 2 time ANCE AND TRAVEL sum of lines 24 for respiratory travel expense Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum co expense (sum co	others) s line 21) EXPENSE COMP and 25 for a therapy or s at the provid 2, line 12) and 30 for a 13 for respir 28) f lines 27 an f lines 31 an EXPENSE COMPU	UTATION - PR II others) um of lines er site (sum II others) atory therap d 31) d 32)	OVIDER SITE 3 and 4 for all of lines 26 and y or sum of	8, 461 8, 461 317 0 317 0 317 0 317 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of column 3, line 12, line 12, 0 Standard travel expense (line 7 times the sum	line 9 for all ees (line 2 time ANCE AND TRAVEL sum of lines 24 for respiratory travel expense Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum co expense (sum co	others) s line 21) EXPENSE COMP and 25 for a therapy or s at the provid 2, line 12) and 30 for a 13 for respir 28) f lines 27 an f lines 31 an EXPENSE COMPU	UTATION - PR II others) um of lines er site (sum II others) atory therap d 31) d 32)	OVIDER SITE 3 and 4 for all of lines 26 and y or sum of	8, 461 8, 461 317 0 317 0 317 0 317 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.00 Standard travel Allowance and Attavel Optional Travel Allowance and Optional Travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense	line 9 for all ees (line 2 time ANCE AND TRAVEL sum of lines 24 for respiratory travel expense Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum c expense (sum c expense (sum c expense s and NCE AND TRAVEL	others) s line 21) EXPENSE COMP and 25 for a therapy or s at the provid 2, line 12) and 30 for a 13 for respir 28) f lines 27 an f lines 31 an EXPENSE COMPU 6) 2, line 10)	UTATION - PR II others) um of lines er site (sum II others) atory therap d 31) d 32)	OVIDER SITE 3 and 4 for all of lines 26 and y or sum of	8, 461 8, 461 317 0 317 0 317 0 317 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00
22. 00 23. 00 23. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 41. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum Total Travel Allowance and Travel Expense - C	line 9 for all ees (line 2 time ANCE AND TRAVEL sum of lines 24 for respiratory travel expense Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (sum c expense (s	others) s line 21) EXPENSE COMP and 25 for a therapy or s at the provid 2, line 12) and 30 for a 13 for respir 28) f lines 27 an f lines 27 an f lines 27 an f lines 31 an EXPENSE COMPU 6) 2, line 10) , line 13.01)	UTATION - PR II others) um of lines er site (sum ll others) atory therap d 31) d 32) TATION - SER	OVIDER SITE 3 and 4 for all of lines 26 and y or sum of VICES OUTSIDE PRO	8, 461 8, 461 317 0 317 0 317 0 317 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 41. 00 43. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns, Standard travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 3, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.07 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum	line 9 for all ees (line 2 time ANCE AND TRAVEL sum of lines 24 for respiratory travel expense Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum co expense (sum co INCE AND TRAVEL n of lines 5 and Expense 1 times column n 3, line 10) n of columns 1-3 offsite Services	others) s line 21) EXPENSE COMP and 25 for a therapy or s at the provid 2, line 12) and 30 for a 13 for respir 28) f lines 27 an f lines 13 an EXPENSE COMPU 6) 2, line 10) ; Complete on	UTATION - PR II others) um of lines er site (sum II others) atory therap d 31) d 32) TATION - SER	OVIDER SITE 3 and 4 for all of lines 26 and y or sum of VICES OUTSIDE PRO Lowing three line	8, 461 8, 461 317 0 317 0 317 0 317 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00

OUTSIE	IABLE COST DETERMINATION FOR THERAPY SERVICES IE SUPPLIERS	PULASKI MEMORIA FURNI SHED BY		CCN: 151305	Period: From 10/01/2013 To 09/30/2014	u of Form CMS-2 Worksheet A-8 Parts I-VI Date/Time Pre 3/30/2015 3:5	-3 pared:
	· · · · · · · · · · · · · · · · · · ·				Speech Pathology	Cost	
						1.00	
46.00	Optional travel allowance and optional travel						46.00
		Therapists	Assistants	Ai des	Trai nees	Total	
	PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	5.00	
7.00	Overtime hours worked during reporting	0.00	0.00	0.0	0.00	0.00	47.00
7.00	period (if column 5, line 47, is zero or	0.00	0.00	0.0	0.00	0.00	47.00
	equal to or greater than 2,080, do not						
	complete lines 48-55 and enter zero in each						
	column of line 56)						
8.00	Overtime rate (see instructions)	0.00	0.00	0.0	0.00		48.00
9.00	Total overtime (including base and overtime	0.00	0.00	0.0	0.00		49.00
	allowance) (multiply line 47 times line 48)						
	CALCULATION OF LIMIT						
D. 00	Percentage of overtime hours by category	0.00	0.00	0.0	0. 00	0.00	50.00
	(divide the hours in each column on line 47						
	by the total overtime worked - column 5,						
	line 47)						
1.00	Allocation of provider's standard work year	0.00	0.00	0.0	0.00	0.00	51.00
	for one full-time employee times the						
	percentages on line 50) (see instructions)						
	DETERMINATION OF OVERTIME ALLOWANCE	70 50	0.00	0.0			
2.00	Adjusted hourly salary equivalency amount (see instructions)	70. 52	0.00	0.0	0.00		52.00
3. 00	Overtime cost limitation (line 51 times line	0	0		0 0		53.0
3.00	52)	0	0		0 0		55.00
4.00	Maximum overtime cost (enter the lesser of	0	0		0 0		54.00
Ŧ. 00	line 49 or line 53)	0	0		0		54.0
5.00	Portion of overtime already included in	0	0		0 0		55.00
	hourly computation at the AHSEA (multiply		-				
	line 47 times line 52)						
6.00	Overtime allowance (line 54 minus line 55 -	0	0	1	0 0	0	56.00
	if negative enter zero) (Enter in column 5						
	the sum of columns 1, 3, and 4 for						
	respiratory therapy and columns 1 through 3						
	for all others.)						
						1 00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EVCESS COST				1.00	
		IND EXCLOSE OUSE A	ADJUSTMENT			8, 461	57.0
7 00						0,401	58.0
7.00	Salary equivalency amount (from line 23)	(from lines 33	34 or 35))				
8.00	Travel allowance and expense - provider site)			59 0
8.00 9.00	Travel allowance and expense - provider site Travel allowance and expense - Offsite servid)		0	
8.00 9.00 0.00	Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56))		0	60.0
8.00 9.00 0.00 1.00	Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions))		0 0 0	60. 0 61. 0
8.00 9.00 0.00 1.00 2.00	Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions))		0 0 0	60. 0 61. 0 62. 0
8.00 9.00 0.00 1.00 2.00 3.00	Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62)	ces (from lines)		0 0 0 8, 461	60. 0 61. 0 62. 0 63. 0
8.00 9.00 0.00 1.00 2.00 3.00 4.00	Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from	n your records)	44, 45, or 46)		0 0 0 8, 461 2, 879	60.00 61.00 62.00 63.00 64.00
8.00 9.00 0.00 1.00 2.00 3.00 4.00	Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63	n your records)	44, 45, or 46)		0 0 0 8, 461	60.00 61.00 62.00 63.00 64.00
8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00	Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 62 LINE 33 CALCULATION	es (from lines n your records) 3 - if negative,	44, 45, or 46			0 0 0 8, 461 2, 879 0	60.00 61.00 62.00 63.00 64.00 65.00
8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00	Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 65 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or	your records) - if negative, sum of lines 24	44, 45, or 46 enter zero) and 25 for a	II others	others	0 0 0 8, 461 2, 879 0 317	64. 00 65. 00 100. 00
8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 00.00 00.00	Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 62 LINE 33 CALCULATION	your records) - if negative, sum of lines 24	44, 45, or 46 enter zero) and 25 for a	II others	others	0 0 0 8, 461 2, 879 0 317 0	60.00 61.00 62.00 63.00 64.00 65.00 100.00
8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 00.00	Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory	your records) - if negative, sum of lines 24	44, 45, or 46 enter zero) and 25 for a	II others	others	0 0 0 8, 461 2, 879 0 317 0	60.00 61.00 62.00 63.00 64.00 65.00
8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 00.00 00.00	Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27	es (from lines n your records) 3 - if negative, sum of lines 24 / therapy or sum	44, 45, or 46 enter zero) and 25 for a of lines 3 a	II others nd 4 for all		0 0 0 8, 461 2, 879 0 317 0 317	60. 0 61. 0 62. 0 63. 0 64. 0 65. 0 100. 0 100. 0
8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 00.00 00.01 00.02 01.00	Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION	your records) - if negative, sum of lines 24 / therapy or sum	44, 45, or 46 enter zero) and 25 for a of lines 3 a of lines 3 a	II others nd 4 for all nd 4 for all		0 0 0 8, 461 2, 879 0 317 0 317	60. 0 61. 0 62. 0 63. 0 64. 0 65. 0 100. 0 100. 0 100. 0
8.00 9.00 1.00 2.00 3.00 4.00 5.00 00.00 00.01 00.02 01.00	Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory	your records) - if negative, sum of lines 24 / therapy or sum	44, 45, or 46 enter zero) and 25 for a of lines 3 a of lines 3 a	II others nd 4 for all nd 4 for all		0 0 0 8, 461 2, 879 0 317 0 317 0 317	60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 100. 00 100. 00 100. 00 101. 00
8.00 9.00 1.00 2.00 3.00 4.00 5.00 00.00 00.01 00.02 01.00	Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 65 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 33 = line 7 times line 3 for respiratory LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or	your records) - if negative, sum of lines 24 / therapy or sum	44, 45, or 46 enter zero) and 25 for a of lines 3 a of lines 3 a	II others nd 4 for all nd 4 for all		0 0 0 8, 461 2, 879 0 317 0 317 0 317	60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 100. 00 100. 00 100. 00 101. 00
8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 00.01 00.02 01.00 01.01	Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31	your records) - if negative, sum of lines 24 (therapy or sum sum of lines 29	44, 45, or 46 enter zero) and 25 for a of lines 3 a of lines 3 a and 30 for a	II others nd 4 for all nd 4 for all II others		0 0 0 8, 461 2, 879 0 317 0 317 0 317 0 0 0 0 0 0	60.00 61.00 62.00 63.00 64.00 65.00 100.00
8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 00.01 00.02 01.00 01.01 01.02	Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 62 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION	sum of lines 24 therapy or sum sum of lines 24 therapy or sum sum of lines 29 sum of lines 29	44, 45, or 46 enter zero) and 25 for a of lines 3 a of lines 3 a and 30 for a and 30 for a	II others nd 4 for all nd 4 for all II others	others	0 0 0 8, 461 2, 879 0 317 0 317 0 317 0 0 0 0 0 0 0 0 0	60. 0 61. 0 62. 0 63. 0 64. 0 65. 0 100. 0 100. 0 100. 0 101. 0 101. 0
8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 00.01 00.02 01.00 01.01 01.02	Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 65 LINE 33 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION Line 31 = line 29 for respiratory therapy or	sum of lines 24 therapy or sum sum of lines 24 therapy or sum sum of lines 29 sum of lines 29	44, 45, or 46 enter zero) and 25 for a of lines 3 a of lines 3 a and 30 for a and 30 for a	II others nd 4 for all nd 4 for all II others	others	0 0 0 8, 461 2, 879 0 317 0 317 0 317 0 0 0 0 0 0 0 0 0	60. 0 61. 0 62. 0 63. 0 64. 0 65. 0 100. 0 100. 0 100. 0 101. 0 101. 0 101. 0 101. 0

Heal th	Financial Systems	PULASKI MEMOR	IAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 151305	Period: From 10/01/2013 To 09/30/2014		
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL RELATED COSTS NEW BLDG & FI XT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI VE & GENERAL	
		0	1.00	4.00	4A	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	1, 223, 411	1, 223, 411	1			1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	3, 770, 648		3, 787, 81	5		4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	2, 796, 635				3, 562, 301	5.00
7.00	00700 OPERATION OF PLANT	739, 566				151, 724	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	70, 933					8.00
9.00	00900 HOUSEKEEPI NG	197, 096	5, 944	40, 72	23 243, 763	40, 399	9.00
10.00	01000 DI ETARY	252, 079	48, 391	48, 67	76 349, 146	57, 864	10.00
13.00	01300 NURSING ADMINISTRATION	362, 042					
14.00	01400 CENTRAL SERVICES & SUPPLY	52,001	15, 742	14, 23			
15.00	01500 PHARMACY	0	12, 551		0 12, 551	2, 080	
16.00	01600 MEDI CAL RECORDS & LI BRARY	282, 125	24, 989			63, 228	
17.00	01700 SOCIAL SERVICE	45, 583	0	14, 29	97 59, 880	9, 924	17.00
30, 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	1, 577, 302	121, 075	455, 03	2, 153, 410	356, 885	30.00
30.00	03100 I NTENSI VE CARE UNI T	1, 577, 302	121, 075	455, 03	0 2, 155, 410	350, 885	31.00
	04300 NURSERY	103, 058	2,607	29, 39	135,062	22, 384	
10.00	ANCI LLARY SERVI CE COST CENTERS	100,000	2,007	27,07	100,002	22,001	10.00
50.00	05000 OPERATING ROOM	571, 846	87, 437	140, 28	799, 566	132, 512	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	61, 971	28, 325		107, 832		52.00
53.00	05300 ANESTHESI OLOGY	21, 172	1, 668		0 22, 840	3, 785	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 362, 716	58, 157	190, 85	50 1, 611, 723	267, 111	54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60.00	06000 LABORATORY	1, 052, 517	22, 511	157, 53		204, 273	60.00
60.01	06001 BLOOD LABORATORY	0	0		0 0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	70, 536			0 71, 216		63.00
65.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	197, 378		55, 87		44,073	65.00
66.00 67.00	06700 OCCUPATIONAL THERAPY	424, 289 72, 253	28, 649	121, 42 22, 56			66.00 67.00
68.00	06800 SPEECH PATHOLOGY	100, 275	-	22, 30			68.00
69.00	06900 ELECTROCARDI OLOGY	49, 882		16, 58		11,015	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	10,00	0 0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	536, 196	0		0 536, 196		
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	107, 325	0		0 107, 325		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 533, 927	0		0 1, 533, 927	254, 218	73.00
76.00	03020 ONCOLOGY	122, 575	10, 122	25, 28	37 157, 984	26, 183	76.00
76.01	03021 CARDI AC REHAB	75, 577	7, 255	23, 02	105, 853	17, 543	76.01
00.00	OUTPATIENT SERVICE COST CENTERS	(OF 0/1	44.510	00.01	0 740	400 717	00.00
	08800 RURAL HEALTH CLINIC 09000 CLINIC	625, 961					
90.00 91.00	09100 EMERGENCY	259, 279 1, 506, 487		21, 12 242, 84			
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 500, 467	63, 630	242, 04	1, 030, 1/9	304, 144	91.00 92.00
72.00	OTHER REIMBURSABLE COST CENTERS				0		72.00
101.00	10100 HOME HEALTH AGENCY	559, 628	8, 486	144, 09	712, 206	118, 034	101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	11600 HOSPI CE	64, 921	3, 093	14, 59	95 82, 609	13, 691	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	20, 849, 190	1, 001, 603	2, 691, 57	70 19, 531, 137	2, 646, 517	118.00
	NONREI MBURSABLE COST CENTERS		1				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7, 304		0 7, 304		190.00
	19001 HOMECARE	72, 998					
	19200 PHYSI CLANS' PRI VATE OFFI CES	3, 806, 412		1, 053, 88			
	07950 MARKETING	328, 325	0	23, 98		58, 388	194.00
200.00 201.00			_		0 0		200. 00 201. 00
201.00		25, 056, 925	1, 223, 411	3, 787, 81			
202.00		1 20,000,720	1 1,223,411	1 5,707,01	20,000,720	1 0,002,001	-02.00

Health Financial Systems	PULASKI MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		eriod: rom 10/01/2013		
			T	09/30/2014	Date/Time Prep 3/30/2015 3:55	
Cost Center Description	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
	PLANT	LINEN SERVICE			ADMI NI STRATI ON	
GENERAL SERVICE COST CENTERS	7.00	8.00	9.00	10.00	13.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT	1,067,215					7.00
8.00 00800 LAUNDRY & LINEN SERVICE	11, 824					8.00
9. 00 00900 HOUSEKEEPI NG	7, 208		,			9.00
10. 00 01000 DI ETARY 13. 00 01300 NURSI NG ADMI NI STRATI ON	58, 687		16, 314 3, 855		577, 270	10.00 13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	19,091		5, 307		3, 648	
15. 00 01500 PHARMACY	15, 222		4, 231		0,010	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	30, 306		8, 424		0	16.00
17.00 01700 SOCIAL SERVICE	0	0	C	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	146, 836				322, 132	30.00
31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY	2 142	-		-	0 22 E12	31.00 43.00
ANCI LLARY SERVI CE COST CENTERS	3, 162	3, 286	0/9	0	22, 512	43.00
50. 00 05000 OPERATI NG ROOM	106, 042	26, 925	29, 477	0	78, 882	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	34, 352				13, 654	52.00
53. 00 05300 ANESTHESI OLOGY	2, 023	0	562	0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	70, 531		19, 606		0	54.00
59.00 05900 CARDI AC CATHETERI ZATI ON	0	-	-	-	0	59.00
	27, 301			0	0	60.00
60. 01 06001 BLOOD LABORATORY 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	825	-	-	0	0	60.01 63.00
65. 00 06500 RESPIRATORY THERAPY	15, 379				0	65.00
66.00 06600 PHYSI CAL THERAPY	46, 431				0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	C	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	C	0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0	0	C	0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0		0	0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS				0	0	73.00
76. 00 03020 ONCOLOGY	12, 276	-	3, 412	0	25, 049	
76. 01 03021 CARDI AC REHAB	8, 799					
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	17, 638					88.00
90. 00 09000 CLINIC	0			0	0	90.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	104, 117	20, 187	28, 942	0	88, 810	91.00 92.00
00100000000000000000000000000000000000						92.00
101.00 10100 HOME HEALTH AGENCY	10, 292	0	2, 861	0	0	101.00
SPECIAL PURPOSE COST CENTERS		1				
116. 00 11600 HOSPI CE	3, 751					116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	765, 960	112, 193	207, 628	482, 011	577, 270	118.00
NONREI MBURSABLE COST CENTERS	0.050		0.44			100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,858					190.00 190.01
190. 01 19001 HOMECARE 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	2, 357 290, 040					190.01
194. 00 07950 MARKETING	2 70, 040	1, 741	00,020	0		192.00
200.00 Cross Foot Adjustments		Ĭ				200.00
201.00 Negative Cost Centers	0	0	c	0	0	201.00
202.00 TOTAL (sum lines 118-201)	1, 067, 215	113, 934	291, 370	482, 011	577, 270	202.00

1.00	LLOCATION - GENERAL SERVICE COSTS		11001dei		Period: From 10/01/2013	Worksheet B Part I	
1.00 4.00	Cost Center Description						
1.00 4.00	Cost Center Description				To 09/30/2014	Date/Time Pre 3/30/2015 3:5	pared:
1.00 4.00		CENTRAL	PHARMACY	MEDI CAL	SOCI AL SERVI CE	Subtotal	
1.00 4.00		SERVICES &		RECORDS &			
1.00 4.00		SUPPLY	15.00	LIBRARY	17.00		
1.00 4.00	GENERAL SERVICE COST CENTERS	14.00	15.00	16.00	17.00	24.00	
4.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
5.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
	00800 LAUNDRY & LINEN SERVICE						8.00
	00900 HOUSEKEEPI NG						9.00
	01000 DI ETARY						10.00
	01300 NURSING ADMINISTRATION						13.00
	01400 CENTRAL SERVICES & SUPPLY	123, 604					14.00
	01500 PHARMACY	0	34, 084	100.14			15.00
	01600 MEDICAL RECORDS & LIBRARY	0	0	483, 46			16.00
	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	0		0 69, 804		17.00
	03000 ADULTS & PEDIATRICS	0	0	20, 07	5 64, 408	3, 617, 846	30.00
	03100 I NTENSI VE CARE UNI T	0	0	20, 07	0 04,400	3, 017, 040	
	04300 NURSERY	0	0	1, 50	-	188, 792	
	ANCI LLARY SERVICE COST CENTERS			1,00	<u>, </u>	100,772	10.00
	05000 OPERATI NG ROOM	0	0	51, 41	7 4, 607	1, 229, 428	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	3, 98		190, 329	
	05300 ANESTHESI OLOGY	0	0	7, 94	8 0	37, 158	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	105, 85	4 0	2, 091, 264	54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	(0 0	0	59.00
	06000 LABORATORY	0	0	87, 83	7 0	1, 560, 037	60.00
	06001 BLOOD LABORATORY	0	0	(0 0	0	
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	2, 88		86, 954	
	06500 RESPI RATORY THERAPY	0	0	11, 60		341, 260	
	06600 PHYSI CAL THERAPY	0	0	15, 83		754, 963	
	06700 OCCUPATI ONAL THERAPY	0	0	2, 87		113, 408	
	06800 SPEECH PATHOLOGY	0	0	2, 35		152, 721	1
	06900 ELECTROCARDI OLOGY	0	0	3, 49	2 0	80, 970	
	07000 ELECTROENCEPHALOGRAPHY	112 017	0	24 72	0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	112, 817 10, 787	0	26, 73		764, 611 138, 455	
	07300 DRUGS CHARGED TO PATIENTS	10, 787	34, 084	2, 55 80, 08		1, 902, 313	
	03020 ONCOLOGY	0	34, 084	1, 84		226, 896	1
	03021 CARDI AC REHAB	0	0	1, 33		158, 559	
	OUTPATIENT SERVICE COST CENTERS			1,00		100,007	1 / 0. 01
	08800 RURAL HEALTH CLINIC	0	0	3, 87	5 0	889, 732	88.00
90.00	09000 CLINIC	0	0	2, 41		329, 292	
91.00	09100 EMERGENCY	0	0	38, 71	9 0	2, 420, 098	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
[OTHER REIMBURSABLE COST CENTERS			r			
	10100 HOME HEALTH AGENCY	0	0	7, 55	9 0	850, 952	101.00
	SPECIAL PURPOSE COST CENTERS		-				4
	11600 HOSPI CE	0	0			102, 577	
118.00		123, 604	34, 084	483, 46	9 69, 804	18, 228, 615	1118.00
	NONREI MBURSABLE COST CENTERS		0			10.004	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
	19001 HOMECARE 19200 PHYSI CLANS' PRI VATE OFFI CES		0			111, 790 6, 285, 989	
	07950 MARKETING		0			6, 285, 989 410, 697	
200.00		0	0				200.00
		0	0				200.00
201.00	TOTAL (sum lines 118-201)	123, 604	34, 084	483, 46	69, 804	25, 056, 925	

Heal th	Financial Systems	PULASKI MEMORIA	L HOSPITAL		In Lieu d	of Form CMS-2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 151305	From 10/01/2013 Pa To 09/30/2014 Da	orksheet B art I ate/Time Prepared: /30/2015 3:55 pm
	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		<u> </u>	<u>/30/2013/3.35 plit</u>
		25.00	26.00			
	GENERAL SERVICE COST CENTERS	, , , , , , , , , , , , , , , , , , ,	1			
4.00 5.00 7.00 8.00 9.00 10.00 13.00 14.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY					1.00 4.00 5.00 7.00 8.00 9.00 10.00 13.00 14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY					16.00
	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS					17.00
	03000 ADULTS & PEDIATRICS	0	3, 617, 846			30.00
43.00	03100 INTENSIVE CARE UNIT 04300 NURSERY ANCI LLARY SERVICE COST CENTERS	0 0	0 188, 792			31.00 43.00
	05000 OPERATING ROOM	0	1, 229, 428			50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	190, 329			52.00
	05300 ANESTHESI OLOGY	0	37, 158			53.00
	05400 RADI OLOGY-DI AGNOSTI C 05900 CARDI AC CATHETERI ZATI ON	0	2, 091, 264			54.00 59.00
	06000 LABORATORY	0	1, 560, 037			60.00
	06001 BLOOD LABORATORY	0	0			60.01
	06300 BLOOD STORING, PROCESSING & TRANS.	0	86, 954			63.00
	06500 RESPI RATORY THERAPY	0	341, 260			65.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	754, 963			66.00 67.00
	06800 SPEECH PATHOLOGY	0	113, 408 152, 721			68.00
	06900 ELECTROCARDI OLOGY	0	80, 970			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0			70.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	764, 611			71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	138, 455			72.00
	07300 DRUGS CHARGED TO PATIENTS 03020 ONCOLOGY	0	1, 902, 313 226, 896			73.00 76.00
	03021 CARDI AC REHAB	0	158, 559			76.01
	OUTPATIENT SERVICE COST CENTERS					
	08800 RURAL HEALTH CLINIC	0	889, 732			88.00
	09000 CLINIC	0	329, 292			90.00
92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	2, 420, 098			91.00 92.00
101.00	10100 HOME HEALTH AGENCY	0	850, 952			101.00
	SPECIAL PURPOSE COST CENTERS 11600 HOSPI CE	0	102, 577			116.00
118.00		0	18, 228, 615			118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19, 834			190.00
	19001 HOMECARE	0	111, 790			190. 01
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	6, 285, 989			192.00
	07950 MARKETI NG	0	410, 697			194.00
200.00 201.00		0	0			200. 00 201. 00
201.00		0	25, 056, 925			201.00
202.00	1.51/12 (Sum 111105 110 201)	, y	20,000,720			1202.00

Heal th	Financial Systems	PULASKI MEMOR	IAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	TION OF CAPITAL RELATED COSTS			CCN: 151305	Period: From 10/01/2013	Worksheet B	
					To 09/30/2014		pared:
			CAPI TAL			373072013 3.3	
	Cost Center Description	Di rectl y	RELATED COSTS NEW BLDG &	Subtotal	EMPLOYEE	ADMI NI STRATI VE	
		Assigned New	FLXT	Subtotal	BENEFITS	& GENERAL	
		Capital			DEPARTMENT		
		Related Costs 0	1.00	2A	4.00	5.00	
	GENERAL SERVICE COST CENTERS			1			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	0	17 1/7	17 1/	7 17 1/7		1.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL			17, 16 263, 85		266, 127	4.00 5.00
7.00	00700 OPERATION OF PLANT	0	98, 644				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	9, 749			1, 084	8.00
9.00	00900 HOUSEKEEPI NG	0	5, 944			3, 018	
	01000 DI ETARY	0	48, 391	48, 39		4, 323	
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	11, 434			5, 943	
	01500 PHARMACY		15, 742 12, 551	15, 74 12, 55		1,015	
	01600 MEDICAL RECORDS & LIBRARY	0				4, 723	16.00
	01700 SOCIAL SERVICE	0			0 65	741	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS		1	1	1	1	
	03000 ADULTS & PEDIATRICS	0				26, 661	30.00
	03100 I NTENSI VE CARE UNI T 04300 NURSERY	0		2,60	0 0 07 133	0 1, 672	31.00 43.00
43.00	ANCI LLARY SERVICE COST CENTERS	0	2,007	2,00	133	1,072	43.00
50.00	05000 OPERATING ROOM	0	87, 437	87, 43	7 636	9, 899	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0				1, 335	52.00
	05300 ANESTHESI OLOGY	0	.,			283	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	58, 157	58, 15		19, 955	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0			0 0 1 714	15 240	59.00 60.00
	06001 BLOOD LABORATORY		22, 511	22, 51	0 0	15, 260 0	60.00
63.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0	680	68	0	882	63.00
65.00	06500 RESPI RATORY THERAPY	0	12, 681	12, 68	1 253	3, 292	65.00
66.00	06600 PHYSI CAL THERAPY	0	28, 649	28, 64		7, 111	66.00
	06700 OCCUPATI ONAL THERAPY	0	0		0 102	1, 174	
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0			0 130 0 75	1, 597 823	68.00 69.00
	07000 ELECTROEARDIOLOGI	0			0 0	023	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	6, 639	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	1, 329	
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	18, 992	73.00
	03020 ONCOLOGY	0					
76. 01		0	7, 255	7, 25	5 104	1, 311	76.01
88.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	14, 543	14, 54	3 453	9 168	88.00
	09000 CLINIC	0			0 96		90.00
91.00	09100 EMERGENCY	0	85, 850	85, 85	0 1, 100		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	OTHER REIMBURSABLE COST CENTERS					0.010	
101.00	10100 HOME HEALTH AGENCY	0	8, 486	8, 48	6 653	8, 818	101.00
116 00	SPECIAL PURPOSE COST CENTERS 11600 HOSPI CE	0	3, 093	3, 09	3 66	1 023	116.00
118.00		0					
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190. 00
	19001 HOMECARE	0					190.01
	19200 PHYSI CLANS' PRI VATE OFFI CES 07950 MARKETI NG	0	212, 561	212, 56			192.00
194.00 200.00		0	0		0 109	4, 362	194. 00 200. 00
200.00		1	0		0 0	0	200.00
202.00		0	1, 223, 411	1, 223, 41	1 17, 167		

Health Financial Systems	PULASKI MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		eriod: com 10/01/2013 o 09/30/2014		
Cost Center Description	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	3/30/2015 3:5 NURSI NG	5 pm
	PLANT	LINEN SERVICE			ADMI NI STRATI ON	
	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 ADMI NI STRATI VE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT	110, 329					7.00
8.00 00800 LAUNDRY & LINEN SERVICE	1, 222	12, 086				8.00
9.00 00900 HOUSEKEEPI NG	745		,,,,,			9.00
	6,067	0		59, 556	10 105	10.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	1,434		131 180	0	19, 425	13.00
14. 00 01400 CENTRAL_SERVICES & SUPPLY 15. 00 01500 PHARMACY	1, 974 1, 574		180	0	123 0	14.00 15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	3, 133		286	0	0	16.00
17. 00 01700 SOCIAL SERVICE	0		1	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	15, 180	3, 646	1, 281	59, 556	10, 840	30.00
31.00 03100 I NTENSI VE CARE UNI T	0	-	-	0	0	31.00
43. 00 04300 NURSERY	327	349	30	0	758	43.00
ANCI LLARY SERVICE COST CENTERS	10.042	2 954	1,001	0	2 454	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	10, 963 3, 551	2, 856		0	2, 654 459	52.00
53. 00 05300 ANESTHESI OLOGY	209	-		0	437	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	7, 292			0	0	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0	0	59.00
60. 00 06000 LABORATORY	2, 822	50	258	0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	-	-	0	0	60. 01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	85		-	0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	1, 590			0	0	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	4,800			0	0	66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	0	-		0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	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 ONCOLOGY	1, 269			0	843	76.00
76. 01 03021 CARDI AC REHAB	910	0	83	0	760	76.01
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC	1, 823	14	166	0	0	88.00
90. 00 09000 CLINIC	1, 023			0	0	90.00
91.00 09100 EMERGENCY	10, 764	-		o	2, 988	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS		1	1			
101.00 10100 HOME HEALTH AGENCY	1, 064	0	97	0	0	101.00
SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE	388		25	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	79, 186			0 59, 556	19, 425	
NONREI MBURSABLE COST CENTERS	79,100	11, 901	7,050	57, 550	17, 425	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	916	0	84	0	0	190. 00
190. 01 19001 HOMECARE	244			0	0	190. 01
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	29, 983	185	2, 736	0		192.00
194. 00 07950 MARKETI NG	0	0	0	0		194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	-	0	0		201.00
202.00 TOTAL (sum lines 118-201)	110, 329	12, 086	9, 892	59, 556	19, 425	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	PULASKI MEMORIA		CCN: 151305	Period:	u of Form CMS-: Worksheet B	2052-10
ALLUCA	TTON OF CAPITAL RELATED COSTS		Provider	CCN. 151505	From 10/01/2013	Part II	
					To 09/30/2014	Date/Time Pre 3/30/2015 3:5	pared:
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	Subtotal	
		SERVICES &		RECORDS &			
		SUPPLY	15.00	LIBRARY	17.00	24.00	
	GENERAL SERVICE COST CENTERS	14.00	15.00	16.00	17.00	24.00	
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						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00							10.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	19, 098					13.00
14.00	01500 PHARMACY	19, 098	14, 424				15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	14, 424	33, 46	8		16.00
17.00	01700 SOCI AL SERVICE	0	0		0 806		17.00
	INPATIENT ROUTINE SERVICE COST CENTERS	· ·	-				
30.00	03000 ADULTS & PEDIATRICS	0	0	1, 39	0 744	242, 435	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0		0 0	0	31.00
43.00	04300 NURSERY	0	0	10	4 0	5, 980	43.00
	ANCI LLARY SERVICE COST CENTERS	-	-				
50.00	05000 OPERATING ROOM	0	0	3, 56		119, 059	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	27		34, 454	1
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	0	55 7, 32		2, 729 96, 004	
54.00 59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	90, 004 0	1
60.00	06000 LABORATORY	0	0	6, 08		47,696	1
60.01	06001 BLOOD LABORATORY	0	0		0 0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	19	9 0	1, 854	1
65.00	06500 RESPI RATORY THERAPY	0	0	80	3 0	18, 764	1
66.00	06600 PHYSI CAL THERAPY	0	0	1, 09	6 0	43, 730	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	19	9 0	1, 475	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	16		1, 890	
69.00	06900 ELECTROCARDI OLOGY	0	0	24		1, 140	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	17, 431	0	1, 85		25, 921	
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	1, 667	0 14, 424	17		3, 173	
76.00	03020 ONCOLOGY	0	14, 424	5, 54 12		38, 961 14, 564	1
76.01	03021 CARDI AC REHAB	0	0	9		10, 515	
70.01	OUTPATIENT SERVICE COST CENTERS	<u> </u>		,	2 0	10,010	1 / 0. 01
88.00	08800 RURAL HEALTH CLINIC	0	0	26	8 0	26, 435	88.00
90.00	09000 CLINIC	0	0	16	7 0	3, 735	
91.00	09100 EMERGENCY	0	0	2, 68	1 0	129, 228	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS	TT			.I		
101.00	10100 HOME HEALTH AGENCY	0	0	52	3 0	19, 641	101.00
11/ 0/	SPECIAL PURPOSE COST CENTERS		0	4		4 (/2	111/ 00
118.00		0 19, 098	0 14, 424	4 33, 46	8 9 8 806	4, 002 894, 045	116.00
110.00	NONREIMBURSABLE COST CENTERS	19,090	14, 424	55,40	0 000	074, 045	1110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	8 394	190.00
	19001 HOMECARE	0	0		0 0		190.01
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	313, 054	
	07950 MARKETI NG	0	0		0 0		194.00
194.00					1 1		000000
200.00							200.00
	Negative Cost Centers	0 19, 098	0 14, 424	33, 46	0 0 8 806		201.00

Heal th	Financial Systems	PULASKI MEMORIA	AL HOSPITAL		In Lieu	of Form CMS-2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der	CCN: 151305	From 10/01/2013 F To 09/30/2014 E	Vorksheet B Part II Date/Time Prepared: 3/30/2015 3:55 pm
	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total			7.3072013-3.35 pm
		25.00	26.00			
16.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE					1.00 4.00 5.00 7.00 8.00 9.00 10.00 13.00 14.00 15.00 16.00 17.00
30. 00 31. 00 43. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 04300 NURSERY	0 0	242, 435 0 5, 980			30. 00 31. 00 43. 00
$\begin{array}{c} 50. \ 00\\ 52. \ 00\\ 53. \ 00\\ 54. \ 00\\ 59. \ 00\\ 60. \ 01\\ 63. \ 00\\ 65. \ 00\\ 65. \ 00\\ 67. \ 00\\ 67. \ 00\\ 70. \ 00\\ 71. \ 00\\ 71. \ 00\\ 72. \ 00\\ 73. \ 00\\ 76. \ 01\\ \end{array}$	ANCI LLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTIC 05900 CARDI AC CATHETERI ZATION 06000 LABORATORY 06000 BLOOD STORING, PROCESSING & TRANS. 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06600 SPECH PATHOLOGY 06900 ELECTROCARDI OLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03020 ONCOLOGY 03021 CARDIAC REHAB 0UTPATIENT SERVICE COST CENTERS		119, 059 34, 454 2, 729 96, 004 0 47, 696 0 1, 854 18, 764 43, 730 1, 475 1, 890 1, 140 0 25, 921 3, 173 38, 961 14, 564 10, 515			50. 00 52. 00 53. 00 54. 00 59. 00 60. 01 63. 00 65. 00 66. 00 67. 00 68. 00 68. 00 69. 00 70. 00 71. 00 71. 00 72. 00 73. 00 76. 01
91.00	08800 RURAL HEALTH CLINIC 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0THER REIMBURSABLE COST CENTERS	0 0 0 0	26, 435 3, 735 129, 228			88. 00 90. 00 91. 00 92. 00
101.00	10100 HOME HEALTH AGENCY	0	19, 641			101. 00
116.00 118.00	SPECIAL PURPOSE COST CENTERS 11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	0	4, 662 894, 045			116. 00 118. 00
190. 01 192. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 HOMECARE 19200 PHYSICIANS' PRIVATE OFFICES 07950 MARKETING Cross Foot Adjustments Negative Cost Centers		8, 394 3, 447 313, 054 4, 471 0 0 1, 223, 411			190. 00 190. 01 192. 00 194. 00 200. 00 201. 00 202. 00

	Financial Systems LOCATION - STATISTICAL BASIS	PULASKI MEMORI		CCN- 1E120E		u of Form CMS-2 Worksheet B-1	
CUST AL	LUCATION - STATISTICAL BASIS		Provi der	CCN: 151305	Period: From 10/01/2013		
					To 09/30/2014	Date/Time Pre	pared:
	· · · ·	CAPI TAL				3/30/2015 3:5	5 pm
		RELATED COSTS					
	Cost Center Description	NEW BLDG &	EMPLOYEE	Reconciliatio	on ADMI NI STRATI VE	OPERATION OF	
		FLXT	BENEFITS		& GENERAL	PLANT	
		(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	
		FEET)	(GROSS SALARI ES)		COST)	FEET)	
		1.00	4. 00	5A	5.00	7.00	
C	GENERAL SERVICE COST CENTERS	1.00	4.00	5/	3.00	7.00	
	DO100 NEW CAP REL COSTS-BLDG & FIXT	75, 542					1.00
4.00 0	DO400 EMPLOYEE BENEFITS DEPARTMENT	1,060	12, 076, 879				4.00
	DO5OO ADMI NI STRATI VE & GENERAL	16, 292	1, 599, 956	-3, 562, 30	01 21, 494, 624		5.00
	DO700 OPERATION OF PLANT	6, 091	246, 400		0 915, 491	54, 336	
	DO800 LAUNDRY & LINEN SERVICE	602	22, 035		0 87, 593	602	8.00
	DO900 HOUSEKEEPI NG	367	129, 839		0 243, 763	367	9.00
	D1000 DI ETARY D1300 NURSI NG ADMI NI STRATI ON	2, 988 706	155, 196		0 349, 146 0 479, 998	2, 988	
	D1400 CENTRAL SERVICES & SUPPLY	972	339, 628 45, 370		0 479,998	706 972	
	D1500 PHARMACY	775	43, 370		0 12, 551	775	
	D1600 MEDI CAL RECORDS & LI BRARY	1, 543	237, 205		0 381, 511	1, 543	
	D1700 SOCIAL SERVICE	0	45, 583		0 59, 880	0	
	NPATIENT ROUTINE SERVICE COST CENTERS				-1		
	D3000 ADULTS & PEDIATRICS	7,476	1, 450, 804		0 2, 153, 410	7, 476	30.00
	D3100 INTENSIVE CARE UNIT	0	0		0 0	0	31.00
	04300 NURSERY	161	93, 729		0 135, 062	161	43.00
	ANCI LLARY SERVICE COST CENTERS	F 000	447.070		0 700 5//	5 000	50.00
	D5000 OPERATING ROOM D5200 DELIVERY ROOM & LABOR ROOM	5, 399	447, 272		0 799, 566 0 107, 832	5, 399	50.00 52.00
	D5300 ANESTHESI OLOGY	1, 749 103	55, 910		0 22, 840	1, 749	
	05400 RADI OLOGY-DI AGNOSTI C	3, 591	608, 496		0 1, 611, 723	3, 591	54.00
	D5900 CARDI AC CATHETERI ZATI ON	0,0,1	000, 170		0 0	0,0,1	59.00
	D6000 LABORATORY	1, 390	502, 272		0 1, 232, 562	1, 390	
60.01	D6001 BLOOD LABORATORY	0	0		0 0	0	60.01
	D6300 BLOOD STORING, PROCESSING & TRANS.	42	0		0 71, 216	42	63.00
	06500 RESPI RATORY THERAPY	783	178, 140		0 265, 931	783	65.00
	D6600 PHYSI CAL THERAPY	1, 769	387, 148		0 574, 364	2, 364	66.00
	06700 OCCUPATI ONAL THERAPY	0	71, 947		0 94, 819	0	67.00
	06800 SPEECH PATHOLOGY	0	91, 552		0 128, 990	0	68.00
	D6900 ELECTROCARDI OLOGY D7000 ELECTROENCEPHALOGRAPHY	0	52, 865		0 66, 463	0	69.00 70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 536, 196	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 107, 325	0	72.00
	D7300 DRUGS CHARGED TO PATIENTS	0	0		0 1, 533, 927	0	73.00
	D3020 ONCOLOGY	625	80, 625		0 157, 984	625	
	D3021 CARDI AC REHAB	448	73, 399		0 105, 853	448	
	DUTPATIENT SERVICE COST CENTERS	r					
	D8800 RURAL HEALTH CLINIC	898			0 740, 466		
	09000 CLINIC	0	67, 364		0 280, 407	0	
	D9100 EMERGENCY	5, 301	774, 266		0 1, 835, 179	5, 301	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	10100 HOME HEALTH AGENCY	524	459, 417		0 712, 206	524	101.00
	SPECIAL PURPOSE COST CENTERS	524	437,417		712,200	524	101.00
	11600 HOSPI CE	191	46, 534		0 82,609	191	116. OC
118.00	SUBTOTALS (SUM OF LINES 1-117)	61, 846					
٩	NONREI MBURSABLE COST CENTERS	· · · · · ·					1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	451	0		0 7, 304		190. 00
	19001 HOMECARE	120	58, 575		0 93, 313		190. 01
	19200 PHYSI CLANS' PRI VATE OFFI CES	13, 125	3, 360, 168		0 5, 072, 862	14, 767	
	07950 MARKETING	0	76, 469		0 352, 309	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	1 222 411	3 707 015		2 542 201	1 047 015	201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1, 223, 411	3, 787, 815		3, 562, 301	1, 067, 215	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	16. 195110	0. 313642		0. 165730	19. 641030	203 00
203.00	Cost to be allocated (per Wkst. B,		17, 167		266, 127	110, 329	
	Part II)		, 107		200, 121		
205.00	Unit cost multiplier (Wkst. B, Part		0. 001421		0.012381	2.030495	205.00
		1		1	1		

ealth Financial Systems OST ALLOCATION - STATISTICAL BASIS	PULASKI MEMORIA		CCN: 151305	Peri od:	u of Form CMS-: Worksheet B-1	
				From 10/01/2013 To 09/30/2014		pare
Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HRS)	CENTRAL	
	8.00	9.00	10.00	13.00	14.00	
GENERAL SERVICE COST CENTERS .00 00100 NEW CAP REL COSTS-BLDG & FIXT .00 00400 EMPLOYEE BENEFITS DEPARTMENT .00 00500 ADMINISTRATIVE & GENERAL .00 .00 00700 OPERATION OP LANT .00 00700 OPERATION OP LANT .00 .00000 LAUNDRY & LINEN SERVICE .00 00900 HOUSEKEEPING .00 .0000 DIETARY 3.00 01300 NURSING ADMINISTRATION 4.00 .01400 CENTRAL SERVICES & SUPPLY 5.00 01500 PHARMACY .00 .01600 MEDICAL RECORDS & LIBRARY	108, 412 0 0 0 0 0 0 0 0	53, 367 2, 988 706 972 775 1, 543		00 0 72, 801 0 460 0 0 0 0	2, 759, 058 0 0	15.
7. 00 01700 SOCI AL SERVI CE	0	0		0 0	0	17.
INPATI ENT ROUTI NE SERVI CE COST CENTERS 0.00 03000 ADULTS & PEDI ATRI CS 1.00 03100 INTENSI VE CARE UNI T 3.00 04300 NURSERY	32, 695 0 3, 127	6, 910 0 161		00 40, 625 0 0 0 2, 839	0 0 0	31.
ANCILLARY SERVICE COST CENTERS 0.00 05000 OPERATING ROOM	25, 620	5, 399		0 9, 948	0	50.
2. 00 05200 DELIVERY ROOM & LABOR ROOM 3. 00 05300 ANESTHESI OLOGY	0 0	2, 315 103		0 1,722 0 0	0 0	52. 53.
4. 00 05400 RADI OLOGY-DI AGNOSTI C 9. 00 05900 CARDI AC CATHETERI ZATI ON	15, 642	3, 591 0		0 0	0	
D. 00 06000 LABORATORY D. 01 06001 BLOOD LABORATORY 3. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	452 0 0	1, 390 0 42		0 0 0 0 0 0	0	60. 60. 63.
5. 00 06500 RESPI RATORY THERAPY 5. 00 06600 PHYSI CAL THERAPY 7. 00 06700 0CCUPATI ONAL THERAPY	0 9,745 0	783 2, 364 0		0 0 0 0 0 0	0 0 0	66. 67.
3. 00 06800 SPEECH PATHOLOGY 9. 00 06900 ELECTROCARDI OLOGY 9. 00 07000 ELECTROENCEPHALOGRAPHY	000000000000000000000000000000000000000	0 0 0		0 0 0 0 0 0	0 0 0	69. 70.
0.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 2.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 3.00 07300 DRUGS CHARGED TO PATI ENTS	0 0 0	0 0 0		0 0 0 0 0 0	2, 518, 277 240, 781 0	72 73
00 03020 0NC0L0GY 03021 CARDI AC REHAB 0UTPATI ENT SERVI CE COST CENTERS	138 0	625 448		0 3, 159 0 2, 848		
3. 00 08800 RURAL HEALTH CLINIC 0. 00 09000 CLINIC 1. 00 09100 EMERGENCY	127 0 19, 209	898 0 5, 301		0 0 0 0 0 11,200	0	90
2. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS						92
11. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	524		0 0	0	101
6. 00 11600 H0SPI CE 8. 00 SUBTOTALS (SUM OF LINES 1-117)	0 106, 755	191 38, 029		0 0 00 72, 801	0 2, 759, 058	116 118
NONREI MBURSABLE COST CENTERS 0. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0. 01 19001 HOMECARE 2. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 4. 00 07950 MARKETI NG 0. 00 Concer East Adjustments	0 0 1, 657 0	451 120 14, 767 0		0 0 0 0 0 0 0 0 0 0	0 0	190 190 192 194
0.00 Cross Foot Adjustments 1.00 Negative Cost Centers 2.00 Cost to be allocated (per Wkst. B, Part L)	113, 934	291, 370	482, 01	1 577, 270	123, 604	200 201 202
Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	1. 050935 12, 086	5. 459741 9, 892				
05.00 Unit cost multiplier (Wkst. B, Part II)	0. 111482	0. 185358	595. 56000	0. 266823	0. 006922	205

	Financial Systems LLOCATION - STATISTICAL BASIS	PULASKI MEMORI		CCN: 151305	In Lie Period:	u of Form CMS-2552-10 Worksheet B-1
CUST P	LEUCATION - STATISTICAL BASIS		PLOVEDEL	CCN. 151305	From 10/01/2013	
					To 09/30/2014	Date/Time Prepared: 3/30/2015 3:55 pm
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVI	CE	
		(100%)	RECORDS &			
			LI BRARY (GROSS	(ALLOCATION OF TIME)		
			CHARGES)			
		15.00	16.00	17.00		
	GENERAL SERVICE COST CENTERS	1 1		1		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT					5.00
8.00	00800 LAUNDRY & LINEN SERVICE					8.00
9.00	00900 HOUSEKEEPING					9.00
10.00	01000 DI ETARY					10.00
13.00	01300 NURSING ADMINISTRATION					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY					14.00
15.00	01500 PHARMACY	100				15.00
	01600 MEDI CAL RECORDS & LI BRARY	0	45, 541, 068		24	16.00
17.00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	0	10, 00		17.00
30.00	03000 ADULTS & PEDIATRICS	0	1, 891, 013	9, 2	28	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	1, 071, 013		0	31.00
43.00	04300 NURSERY	0	141, 975		0	43.00
	ANCILLARY SERVICE COST CENTERS			•		
50.00	05000 OPERATING ROOM	0	4, 843, 387	6	60	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	375, 024		0	52.00
53.00	05300 ANESTHESI OLOGY	0	748, 666		0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	9, 970, 711		0	54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0			0	59.00
60.00 60.01	06000 LABORATORY 06001 BLOOD LABORATORY	0	8, 274, 058		0	60. 00 60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	271, 366		0	63.00
65.00	06500 RESPI RATORY THERAPY	0	1, 092, 841		0	65.00
66.00	06600 PHYSI CAL THERAPY	0	1, 491, 202		0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	270, 798	8	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	221, 684		0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	328, 975		0	69.00
	07000 ELECTROENCEPHALOGRAPHY	0			0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	2, 518, 277 240, 781		0	71.00
	07300 DRUGS CHARGED TO PATIENTS	100	7, 543, 748		0	73.00
76.00	03020 ONCOLOGY	0	173, 945		0	76.00
	03021 CARDI AC REHAB	0	125, 724		0	76.01
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	364, 968		0	88.00
	09000 CLI NI C	0	227, 260		0	90.00
	09100 EMERGENCY	0	3, 647, 202		0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS					92.00
101 00	10100 HOME HEALTH AGENCY	0	712, 054		0	101.00
101.00	SPECIAL PURPOSE COST CENTERS	0	712,034		0	101.00
116.00	11600 HOSPI CE	0	65, 409) 1 [.]	13	116.00
118.00		100	45, 541, 068			118.00
	NONREI MBURSABLE COST CENTERS					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	190. 00
	19001 HOMECARE	0	0	1	0	190.01
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0	192.00
	07950 MARKETING Cross Foot Adjustments	0	C		0	194.00
200.00 201.00						200. 00 201. 00
201.00		34, 084	483, 469	69,80	04	201.00
00	Part I)	54,004	100, 107	0,0		202.00
203.00		340. 840000	0. 010616	6. 97970	02	203.00
204.00		14, 424	33, 468		06	204.00
	Part II)					
205.00		144. 240000	0. 000735	0. 0805	92	205.00
		1		1		

Health Fi	nancial Systems	PULASKI MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATI	ON OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 151305	Peri od:	Worksheet C	
					From 10/01/2013	Part I	
					To 09/30/2014	Date/Time Pre	pared:
			T: +1	e XVIII	Hospi tal	3/30/2015 3:5	5 pm
			1111		Costs	Cost	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	cost center bescription	(from Wkst. B,	Adj.		Di sal I owance	TOTAL COSTS	
		Part I, col.	Auj .		DI Sal I Owalice		
		26)					
		1.00	2.00	3.00	4.00	5.00	
LN	PATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
	000 ADULTS & PEDIATRICS	3, 617, 846		3, 617, 8	46 0	0	30.00
	100 I NTENSI VE CARE UNI T	0,017,010		0,017,0	0 0	0	
	300 NURSERY	188, 792		188, 7		0	
	CI LLARY SERVICE COST CENTERS	100,772		100, 7			10.00
	DOO OPERATING ROOM	1, 229, 428		1, 229, 4	28 0	0	50.00
	200 DELIVERY ROOM & LABOR ROOM	190, 329		190, 3		0	
	300 ANESTHESI OLOGY	37, 158		37, 1		0	
1	400 RADI OLOGY-DI AGNOSTI C	2, 091, 264		2,091,2		0	
	900 CARDI AC CATHETERI ZATI ON	2,071,201		2,071,2	0 0	0	
	000 LABORATORY	1, 560, 037		1, 560, 0	-	0	1
	001 BLOOD LABORATORY	1,000,007		1,000,0	0 0	0	
	300 BLOOD STORING, PROCESSING & TRANS.	86, 954		86, 9	-	0	1
	500 RESPI RATORY THERAPY	341, 260				0	
	600 PHYSI CAL THERAPY	754, 963		754, 9		0	1
	700 OCCUPATI ONAL THERAPY	113, 408		113, 4		0	
	BOO SPEECH PATHOLOGY	152, 721		152, 7		0	
	900 ELECTROCARDI OLOGY	80, 970		80, 9		0	
	000 ELECTROENCEPHALOGRAPHY	00,770		00, 7	0 0	0	07.00
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	764, 611		764, 6	-	0	
	200 IMPL. DEV. CHARGED TO PATIENTS	138, 455		138, 4		0	•
	300 DRUGS CHARGED TO PATIENTS	1, 902, 313		1, 902, 3		0	
	D20 ONCOLOGY	226, 896		226, 8		0	
	021 CARDI AC REHAB	158, 559		158, 5		0	
	TPATIENT SERVICE COST CENTERS	130, 337		100, 0		0	/0.01
	BOO RURAL HEALTH CLINIC	889, 732		889, 7	32 0	0	88.00
	DOO CLINIC	329, 292		329, 2		0	
	100 EMERGENCY	2, 420, 098		2, 420, 0		0	
	200 OBSERVATION BEDS (NON-DISTINCT PART)	367, 372		367, 3		0	
	HER REIMBURSABLE COST CENTERS	007,072		007,0			72.00
	100 HOME HEALTH AGENCY	850, 952		850, 9	52	0	101.00
	ECIAL PURPOSE COST CENTERS	000,702		000, 7			
	600 HOSPI CE	102, 577		102, 5	77	0	116.00
200.00	Subtotal (see instructions)	18, 595, 987					200.00
201.00	Less Observation Beds	367, 372		367, 3			201.00
202.00	Total (see instructions)	18, 228, 615					202.00
202.00		1 .0, 220, 010		, 220, 0	· -1 01	0	- 52. 00

73.00 07300 DRUGS CHARGED TO PATIENTS 3,017,509 4,526,239 7,543,748 0.252171 0.000000 73.0 76.00 03020 ONCOLOGY 4,699 169,246 173,945 1.304412 0.000000 76.0 03021 CARDI AC REHAB 0 125,724 125,724 1.261167 0.000000 76.0 0UTPATIENT SERVICE COST CENTERS 0 364,968 88.0 88.0 88.0 88.0 90.00 09000 CLINIC 0 227,260 2.4420 1.448966 0.000000 90.00 91.00 9200 0BSERVATION BEDS (NON-DI STINCT PART) 0 224,420 224,420 1.636984 0.000000 92.0 92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART) 0 712,054 712,054 0 92.0 92.00 0.663549 0.000000 92.0 0101.00 10100 HOME HEALTH AGENCY 0 712,054 712,054 10.00 92.0 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00	Health Fina	ancial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
Cost Center Description Inpatient Inpatient Outpatient Outpatient Total (col. + col. 7) Cost or Other Ratio TEFRA Inpatient Ratio INPATIENT ROUTINE SERVICE COST CENTERS 6.00 7.00 8.00 9.00 10.00 30.00 03000 ADULTS & PEDIATRICS 1.666.593 1.666.593 30.0 31.00 03000 INVESERV 141.975 30.0 33.00 30.00 33.00 30.00 30.00 30.00 33.00 30.00 30.00 33.00 30.00 33.00 30.00 33.00 30.00 33.00 30.00 33.00 30.00 33.00 30.00 33.00 30.00 33.00 30.00 33.00 30.00 33.00 30.00 33.00 30.00 30.00 30.00 30.00 30.00 30.00 33.00 30.00 <td>COMPUTATI O</td> <td>N OF RATIO OF COSTS TO CHARGES</td> <td></td> <td>Provi der</td> <td>CCN: 151305</td> <td>From 10/01/2013</td> <td>Part I Date/Time Pre</td> <td>pared: 5 pm</td>	COMPUTATI O	N OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 151305	From 10/01/2013	Part I Date/Time Pre	pared: 5 pm
Cost Center Description Inpatient Outpatient Total (col. 6) + col. 7) Cost or other Ratio TEFRA Inpatient Ratio 1000 000000000000UTS & PEDIATRICS 1.666.593 1.666.593 1.666.593 30.0 30.00 03000 INTENSIVE CARE UNIT 0 141.975 141.975 30.0 43.00 04300 DELIVERY ROW & LABOR ROM 882.601 3.960.786 4.843.387 0.253836 0.000000052.2 50.00 05000 DELIVERY NOM & LABOR ROM 283.012 125.013 623.663 748.666 0.049623 0.000000 55.2 50.00 05000 DELIVERY NOM & LABOR ROM 283.012 125.013 623.663 748.666 0.049632 0.000000 55.0 50.00 05000 LABOR RAD CLOCY-DIARNSTIC 938.192 9.032.519 9.90.711 0.000000 55.0 50.00 05000 LABORATORY 1.279.536 6.994.522 8.274.058 0.304631 0.000000 60.0 60.00 06000 DELIVERY NEAPPY 282.955 269.866 0.304631 0.000000 63.0 65.00 0.0000000 63.				Ti tl	e XVIII	Hospi tal		
Impart ENT ROUTINE SERVICE COST CENTERS 6.00 7.00 8.00 9.00 10.00 30.00 03000 ADULTS & PEDIATRICS 1,666,593 1,666,593 30.0 30.0 31.00 03100 INTENSIVE CARE UNIT 0 0 0 0 0 30.0 31.00 03000 INDRESEY 141,975 141,975 30.0 31.0 ANCI LLARY SERVICE COST CENTERS 141,975 0.9,000 (PERATINE ROM 230,127 144,497 375,024 0.507512 0.0000000 52.0 52.00 05200 DELIVERY ROM& LABOR ROM 230,127 144,497 375,024 0.507512 0.000000 52.0 53.00 05300 MESTHESI DLOGY 125,013 623,653 746,666 0.049632 0.000000 54.0 59.00 05900 CARDIA CATHETERI ZATI ON 0 0 0 0.000000 60.00000 60.00000 60.000000 60.000000 60.000000 60.0000000 60.0000000 60.0000000 60.00000000000 60.000000000000000 65.0 66.00 66.000 RESPI RATORY THERAPY 228,9				Charges				
INPATIENT ROUTINE SERVICE COST CENTERS Ratio 1000 7.00 8.00 9.00 10.00 31:00 023000 ADULTS & PEDIATRICS 1,666,593 1,666,593 31.00 31:00 03000 INTENSIVE CARE UNIT 0 141,975 141,975 31.00 43:00 05000 (DELIVERY NOM & LABOR ROOM 282,011 3,960,786 4,843,387 0.253836 0.000000 55.0 50:00 05000 (DELIVERY NOM & LABOR ROOM 283,127 144,897 375,024 0.507512 0.000000 55.0 53:00 05300 (RADICATES YENDIA CATHETERI ZATION 0 0 0 0.000000 55.0 59:00 05900 (LABOR TORY 1,279,536 6,994,522 82,740,058 0.188546 0.000000 55.0 60:00 06000 LABORATORY 1,279,536 6,994,522 271,366 0.32431 0.000000 65.0 60:00 06000 PHYSICAL THERAPY 288,917 1,202,285 1,491,202 0.502,78 0.000000 65.0 60:00 06000 PHYSICAL THERAPY 288,917 1,202,285 1,491,202 0.502,78 0.		Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other		
IMPATE ENT ROUTINE SERVICE COST CENTERS 6.00 7.00 8.00 9.00 10.00 30.00 03000 ADULTS & PEDIATRICS 1,666,593 1,666,593 30.0 30.0 31.00 03100 INTENSIVE CARE UNIT 0 0 0 30.0 31.0					+ col. 7)	Rati o		
INPATI ENT. ROUTINE SERVICE COST CENTERS 1 666, 593 30.00								
30.00 03000 AULTS & PEDIATRICS 1,666,593 1,666,593 31.00 0 0 31.00 0 0 0 31.00 0 0 31.00 0 0 31.00 0 0 31.00 0 0 31.00 0 0 0 31.00 0 0 30.00 A3.00 A3.00 <td></td> <td></td> <td>6.00</td> <td>7.00</td> <td>8.00</td> <td>9.00</td> <td>10.00</td> <td></td>			6.00	7.00	8.00	9.00	10.00	
31 00 03100 INTENSIVE CARE UNIT 100 111,975 111,975 141,975 141,975 141,975 143,00 ANCILLARY SERVICE COST CENTERS 141,975 141,975 141,975 43,00 S0.00 05000 DELIVERY ROOM & LABOR ROOM 230,127 144,897 375,024 0.50751,00 0.000000 52,0 S2.00 05200 DELIVERY ROOM & LABOR ROOM 230,127 144,897 375,024 0.50751,00 0.000000 52,0 S3.00 ORSON CARDIAC CATHETERI ZATI ON 0 0 0.000000 0.000000 0.000000 60,00 0.000000 0.000000 60,00 0.000000 0.000000 60,00 0.000000 0.000000 60,00 0.000000 60,00 0.000000 60,00 0.000000 60,00 0.000000 60,00 0.000000 60,00 0.000000 60,00 0.000000 60,00 0.000000 60,00 60,00 60,00 60,00 60,00 60,00 60,00 60,00 60,00 60,00 60,00 60,00 60,00 60,00 60,00 60,00 60,00 60,00 60,00			4 (() 500					
43.00 04300 NURSERY 141,975 141,975 43.0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 230,127 144,897 375,024 0.507512 0.000000 52.00 50.00 05000 OPERATING ROOM 230,127 144,897 375,024 0.507512 0.000000 52.00 51.00 05000 CARDIA C. CATHETERI ZATION 938,192 9,032,519 9,970,711 0.209741 0.000000 54.00 50.00 06000 LABORATORY 1,279,536 6,994,522 8,274,058 0.188546 0.000000 60.000000 60.000000 60.000000 60.000000 60.000000 60.000000 60.000000 60.000000 60.000000 60.000000 60.000000 60.00 60.0000000 60.000000 60.0000000 60.0000000 60.0000000 60.00 60.000 60.0000000 60.0000000 60.0000000 60.0000000 60.000 60.0000000 60.00 60.0000000 60.0000000 60.00 60.0000000 60.000 60.000 60.0000000 60.0000000 60.0000000 60.00000000 60.0000000 60.0000000					1, 666, 59			•
ANCILLARY SERVICE COST CENTERS Image: Cost Centers 50.00 05000 OPERATING ROOM 882,601 3,960,786 4,843,387 0.253836 0.000000 55.0 53.00 05200 DELLVERY ROOM & LABOR ROOM 230,127 144,897 375,024 0.507512 0.000000 53.0 54.00 05400 RADICORY-DIAGNOSTIC 938,192 9,032,519 9,07711 0.209741 0.000000 53.0 59.00 05900 CARDIAC CATHETERIZATION 0 0 0.000000 0.000000 60.00 60.01 06001 BLODD LABORATORY 1,279,536 6,994,522 8,274,058 0.188546 0.000000 60.00000 0.000000 63.0 65.00 06500 RESPI RATORY THERAPY 822,955 269,886 1.092,841 0.31229 0.000000 66.00 66.00 06000 SPECEL PATORY THERAPY 288,917 1,202,285 1,491,202 0.56278 0.000000 67.0 67.00 06700 CEUPATIONAL THERAPY 288,917 1,202,285 1,491,202 0.566278 0.0000000 60.0000000 60.0000000			-			-		
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92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0 224, 420 1.636984 0.000000 92.0 OTHER REI MBURSABLE COST CENTERS 0 712, 054 712, 054 101.00 101.00 SPECIAL PURPOSE COST CENTERS 0 65, 409 65, 409 116.00 1060 HOSPICE 100.964, 544 34, 576, 524 45, 541, 068 200.00 201.00 Less Observation Beds 201.00 201.00 10, 964, 544 34, 576, 524 45, 541, 068 201.00 201.00 201.00 201.00 10, 964, 544 34, 576, 524 45, 541, 068 201.00								
OTHER REI MBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 712,054 712,054 101.0 SPECIAL PURPOSE COST CENTERS 116.0 1000 HOSPI CE 116.0 116.00 1000 HOSPI CE 110,964,544 34,576,524 45,541,068 200.00 201.00 Less 0bservation 201.00 201.								
101.00 10100 HOME HEALTH AGENCY 0 712,054 712,054 101.0 SPECIAL PURPOSE COST CENTERS 116.00 11600 HOSPI CE 0 65,409 116.0 116.0 200.00 Subtotal (see instructions) 10,964,544 34,576,524 45,541,068 200.0 201.00 201.00 201.00 10,964,544 34,576,524 45,541,068 201.00			<u> </u>	221, 120	221,12	1.000701	0.00000	12.00
SPECIAL PURPOSE COST CENTERS 116.00 11600 HOSPI CE 0 65, 409 116.0 200.00 Subtotal (see instructions) 10, 964, 544 34, 576, 524 45, 541, 068 200.0 201.00 Less Observation Beds 201.00 <td< td=""><td></td><td></td><td>0</td><td>712 054</td><td>712 05</td><td>54</td><td></td><td>101.00</td></td<>			0	712 054	712 05	54		101.00
116.00 11600 HOSPI CE 0 65, 409 116.0 200.00 Subtotal (see instructions) 10, 964, 544 34, 576, 524 45, 541, 068 200.0 201.00 Less Observation Beds 201.00				, .2, 301	, , , , , , , , , , , , , , , , , , , ,	· .		1
200. 00 Subtotal (see instructions) 10,964,544 34,576,524 45,541,068 200. 0 201. 00 Less Observation Beds 201. 0 <td></td> <td></td> <td>0</td> <td>65, 409</td> <td>65.40</td> <td>)9</td> <td></td> <td>116.00</td>			0	65, 409	65.40)9		116.00
201.00 Less Observation Beds 201.0			10, 964, 544					200.00
								201.00
202.00 Total (see instructions) 10,964,544 34,576,524 45,541,068 202.0	202.00	Total (see instructions)	10, 964, 544	34, 576, 524	45, 541, 06	68		202.00

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151305	Period: From 10/01/2013 To 09/30/2014	Worksheet C Part I Date/Time Prepared: 3/30/2015 3:55 pm
		Title XVIII	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
ANCI LLARY SERVI CE COST CENTERS				
50. 00 05000 OPERATI NG 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
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
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 OCCUPATIONAL THERAPY	0.000000			67.00
	0.000000			
68. 00 06800 SPEECH PATHOLOGY				68.00
69. 00 06900 ELECTROCARDI OLOGY	0.000000			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	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 ONCOLOGY	0. 000000			76.00
76. 01 03021 CARDI AC REHAB	0. 000000			76. 01
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC				88.00
90. 00 09000 CLINIC	0. 000000			90.00
91.00 09100 EMERGENCY	0. 000000			91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS				
116. 00 11600 H0SPI CE				116.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00

Heal th F	Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
	TION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 151305	Peri od:	Worksheet C	
					From 10/01/2013	Part I	
					To 09/30/2014	Date/Time Pre 3/30/2015 3:5	epared:
							5 pm
			111	le XIX	Hospi tal	Cost	
		.			Costs	T I I O I	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)	2.00	2.00	1.00	F 00	
		1.00	2.00	3.00	4.00	5.00	
	NPATIENT ROUTINE SERVICE COST CENTERS					0 (17 0)	
	03000 ADULTS & PEDIATRICS	3, 617, 846		3, 617, 84			
	03100 INTENSIVE CARE UNIT	0			0 0	0	
	04300 NURSERY	188, 792		188, 79	02 0	188, 792	43.00
	ANCI LLARY SERVI CE COST CENTERS	1	1	1	. [
	D5000 OPERATING ROOM	1, 229, 428		1, 229, 42		1, 229, 428	
	D5200 DELIVERY ROOM & LABOR ROOM	190, 329		190, 32		190, 329	•
	05300 ANESTHESI OLOGY	37, 158		37, 15		37, 158	
	05400 RADI OLOGY-DI AGNOSTI C	2, 091, 264		2, 091, 26	04 0	2, 091, 264	
	05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	
	06000 LABORATORY	1, 560, 037		1, 560, 03	37 0	1, 560, 037	60.00
	06001 BLOOD LABORATORY	0			0 0	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	86, 954		86, 95	64 0	86, 954	63.00
65.00 0	06500 RESPI RATORY THERAPY	341, 260	0	341, 26	0 0	341, 260	65.00
66.00 0	D6600 PHYSI CAL THERAPY	754, 963	0	754, 96	03 0	754, 963	66.00
67.00	06700 OCCUPATI ONAL THERAPY	113, 408	0	113, 40	0 8	113, 408	67.00
68.00 0	06800 SPEECH PATHOLOGY	152, 721	0	152, 72	21 0	152, 721	68.00
69.00	06900 ELECTROCARDI OLOGY	80, 970		80, 97	0 0	80, 970	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	764, 611		764, 61	1 0	764, 611	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	138, 455		138, 45	5 0	138, 455	72.00
	07300 DRUGS CHARGED TO PATIENTS	1,902,313		1, 902, 3		1, 902, 313	
	03020 ONCOLOGY	226, 896		226, 89		226, 896	
	03021 CARDI AC REHAB	158, 559		158, 55		158, 559	
	DUTPATIENT SERVICE COST CENTERS			,			1
	D8800 RURAL HEALTH CLINIC	889, 732		889, 73	32 0	889, 732	88.00
	09000 CLINIC	329, 292		329, 29		329, 292	
	D9100 EMERGENCY	2, 420, 098		2, 420, 09		2, 420, 098	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	367, 372		367, 37		367, 372	
	THER REIMBURSABLE COST CENTERS	307,372		307, 31	2	307, 372	/2.00
	10100 HOME HEALTH AGENCY	850, 952		850, 95	:2	850, 952	1101 00
	SPECIAL PURPOSE COST CENTERS	030, 732		050, 7		050, 752	101.00
	11600 HOSPI CE	102, 577		102, 57	7	102, 577	1116 00
200.00	Subtotal (see instructions)	18, 595, 987	0				•
200.00	Less Observation Beds	367, 372		367, 37		367, 372	
201.00	Total (see instructions)	18, 228, 615					
202.00		10,220,013	1 0	1 10, 220, 0	5	10, 220, 010	202.00

Health Financ	cial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION	OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 151305	Period: From 10/01/2013 To 09/30/2014	Worksheet C Part I Date/Time Pre 3/30/2015 3:5	pared: 5 pm
				le XIX	Hospi tal	Cost	
			Charges	-			
	Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
				+ col. 7)	Rati o	Inpati ent	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
	ENT ROUTINE SERVICE COST CENTERS						
	ADULTS & PEDIATRICS	1, 666, 593		1, 666, 59			30.00
	INTENSIVE CARE UNIT	0			0		31.00
	NURSERY	141, 975		141, 97	75		43.00
	ARY SERVICE COST CENTERS						
	OPERATING ROOM	882, 601	3, 960, 786			0.000000	
	DELIVERY ROOM & LABOR ROOM	230, 127	144, 897			0.000000	
	ANESTHESI OLOGY	125, 013	623, 653			0.000000	
	RADI OLOGY-DI AGNOSTI C	938, 192	9, 032, 519	9, 970, 71		0.00000	54.00
	CARDI AC CATHETERI ZATI ON	0	0		0 0.000000	0.00000	
	LABORATORY	1, 279, 536	6, 994, 522	8, 274, 05		0.000000	60.00
	BLOOD LABORATORY	0	0		0 0.000000	0.000000	60.01
	BLOOD STORING, PROCESSING & TRANS.	97, 104	174, 262	271, 36		0.000000	63.00
65.00 06500	RESPI RATORY THERAPY	822, 955	269, 886	1, 092, 84	0. 312269	0.000000	65.00
66.00 06600	PHYSI CAL THERAPY	288, 917	1, 202, 285	1, 491, 20	0. 506278	0.00000	66.00
67.00 06700	OCCUPATIONAL THERAPY	132, 401	138, 397	270, 79	0. 418792	0.000000	67.00
68.00 06800	SPEECH PATHOLOGY	49, 725	171, 959	221, 68	0. 688913	0.000000	68.00
69.00 06900	ELECTROCARDI OLOGY	19, 334	309, 641	328, 97	0. 246128	0.000000	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0		0 0.000000	0.000000	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 013, 220	1, 505, 057	2, 518, 27	0. 303625	0.000000	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	121, 272	119, 509	240, 78	0. 575025	0.000000	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	3, 017, 509	4, 526, 239	7, 543, 74	18 0. 252171	0.000000	73.00
76.00 03020	ONCOLOGY	4, 699	169, 246	173, 94	1. 304412	0.000000	76.00
76.01 03021	CARDI AC REHAB	0	125, 724	125, 72	1. 261167	0.000000	76.01
OUTPAT	TIENT SERVICE COST CENTERS			·			1
88.00 08800	RURAL HEALTH CLINIC	0	364, 968	364, 96	2. 437836	0.000000	88. 00
90.00 09000	CLINIC	0	227, 260	227, 26	50 1. 448966	0.000000	90.00
91.00 09100	EMERGENCY	133, 371	3, 513, 831	3, 647, 20	0. 663549	0.000000	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	224, 420	224, 42	1. 636984	0.000000	92.00
	REIMBURSABLE COST CENTERS	1					
	HOME HEALTH AGENCY	0	712,054	712, 05	54		101.00
	AL PURPOSE COST CENTERS	1	,	_, _, _,			1
116.0011600		0	65, 409	65, 40)9		116.00
	Subtotal (see instructions)	10, 964, 544	34, 576, 524				200.00
	Less Observation Beds	,,	,, 02 .				201.00
		10, 964, 544			1		1-0.1.00

MPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151305	Peri od:	Worksheet C
			From 10/01/2013 To 09/30/2014	Part I Date/Time Prepared
			10 07/30/2014	3/30/2015 3:55 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
D. 00 03000 ADULTS & PEDIATRICS				30. C
1.00 03100 INTENSIVE CARE UNIT				31.0
3. 00 04300 NURSERY				43.0
ANCILLARY SERVICE COST CENTERS				
D. 00 05000 OPERATING ROOM	0. 000000			50. C
2.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.0
3. 00 05300 ANESTHESI OLOGY	0. 000000			53.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54. C
9. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59. C
D. 00 06000 LABORATORY	0. 000000			60. C
D. 01 06001 BLOOD LABORATORY	0. 000000			60. 0
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.0
5. 00 06500 RESPI RATORY THERAPY	0. 000000			65.0
6. 00 06600 PHYSI CAL THERAPY	0. 000000			66.0
7. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.0
B. 00 06800 SPEECH PATHOLOGY	0. 000000			68.0
9. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.0
D. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			70.0
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			71.0
3. 00 07200 TMPL. DEV. CHARGED TO PATTENTS 3. 00 07300 DRUGS CHARGED TO PATTENTS	0.000000			72.0
6. 00 03020 ONCOLOGY	0.000000			76.0
6. 01 03020 ONCOLOGY 6. 01 03021 CARDI AC REHAB	0.000000			76.0
OUTPATIENT SERVICE COST CENTERS	0.00000			/0.0
B. 00 08800 RURAL HEALTH CLINIC	0. 000000			88.0
2. 00 08800 RURAL HEALTH CLINIC 2. 00 09000 CLINIC	0.000000			90.0
1.00 09100 EMERGENCY	0. 000000			91.0
2. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	0. 000000			92.0
OTHER REIMBURSABLE COST CENTERS				101
01.00 10100 HOME HEALTH AGENCY				101.0
SPECIAL PURPOSE COST CENTERS				11/
16. 00 11600 HOSPI CE				116.0
00.00 Subtotal (see instructions)				200. 0
01.00 Less Observation Beds				201. C
02.00 Total (see instructions)				202.0

Health Financial Systems	PULASKI MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS			Period: From 10/01/2013 To 09/30/2014	Date/Time Pre 3/30/2015 3:5	
			e XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	1	1	-	- F		
50. 00 05000 OPERATI NG ROOM	119, 059					
52.00 05200 DELIVERY ROOM & LABOR ROOM	34, 454				311	52.00
53. 00 05300 ANESTHESI OLOGY	2,729	748, 666				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	96,004	9, 970, 711			3, 725	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.0000	0 0	0	59.00
60. 00 06000 LABORATORY	47,696	8, 274, 058	0.00576	452, 771	2, 610	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0.0000	0 0	0	60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	1,854	271, 366	0. 00683	89, 026	608	63.00
65. 00 06500 RESPI RATORY THERAPY	18, 764	1, 092, 841	0.01717	0 135, 901	2, 333	65.00
66. 00 06600 PHYSI CAL THERAPY	43, 730	1, 491, 202	0. 02932	5 56, 166	1, 647	66.00
67.00 06700 OCCUPATI ONAL THERAPY	1, 475	270, 798	0.00544	7 22, 598	123	67.00
68.00 06800 SPEECH PATHOLOGY	1, 890	221, 684	0. 00852	14, 441	123	68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 140	328, 975	0.00346	5 17, 052	59	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.0000	0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	25, 921	2, 518, 277	0. 01029	546, 490	5, 625	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 173	240, 781	0.01317	90, 387	1, 191	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	38, 961	7, 543, 748	0.00516	5 1, 302, 313	6, 726	73.00
76.00 03020 ONCOLOGY	14, 564	173, 945	0.08372	.8 0	0	76.00
76. 01 03021 CARDI AC REHAB	10, 515	125, 724	0. 08363	6 0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	26, 435	364, 968	0.07243	1 0	0	88.00
90. 00 09000 CLI NI C	3, 735				0	90.00
91. 00 09100 EMERGENCY	129, 228				281	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	33, 254		1		0	92.00
200.00 Total (lines 50-199)	654, 581			3, 475, 309	33, 162	

Health Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	6 Provi der	CCN: 151305	Period: From 10/01/2013	Worksheet D Part IV	
				To 09/30/2014		
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursing School	Allied Healt		Total Cost	
	Anestheti st	0		Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS			1			
50.00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
59.00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0		0 0	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67. 00 06700 OCCUPATIONAL THERAPY	0	0		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	72.00 73.00
73.00 07300 DR0GS CHARGED TO PATTENTS 76.00 03020 0NC0L0GY	0	0		0 0	0	76.00
76. 01 03020 0NC0L0GY 76. 01 03021 CARDI AC REHAB	0	0			0	76.00
OUTPATIENT SERVICE COST CENTERS	0	0	1	0 0	0	70.01
88. 00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0				0	90.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0 0	0	92.00
200.00 Total (lines 50-199)	0			0 0		200.00
			1	-1 0	, v	

Health Financial Systems	PULASKI MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	S Provi der		Period:	Worksheet D	
THROUGH COSTS				From 10/01/2013 To 09/30/2014		norod.
				10 09/30/2014	Date/Time Pre 3/30/2015 3:5	
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Total	Total Charges	Ratio of Cos	t Outpatient	I npati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col	. to Charges	Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS	1		1		r	
50.00 05000 OPERATING ROOM	0	.,				•
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	375, 024				
53. 00 05300 ANESTHESI OLOGY	0	748, 666				•
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	9, 970, 711	0.00000			54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000	0.00000	0	59.00
60. 00 06000 LABORATORY	0	8, 274, 058	0.00000	0.00000	452, 771	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0.00000	0.00000	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	271, 366	0.00000	0.00000	89, 026	63.00
65. 00 06500 RESPI RATORY THERAPY	0	1, 092, 841	0.00000	0. 000000	135, 901	65.00
66. 00 06600 PHYSI CAL THERAPY	0	1, 491, 202	0.00000	0. 000000	56, 166	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	270, 798	0.00000	0. 000000	22, 598	67.00
68.00 06800 SPEECH PATHOLOGY	0	221, 684	0.00000	0. 000000	14, 441	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	328, 975	0.00000	0. 000000	17, 052	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0. 00000	0. 000000	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 518, 277	0. 00000	0. 000000	546, 490	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	240, 781	0.00000	0. 000000	90, 387	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	7, 543, 748	0. 00000	0. 000000	1, 302, 313	73.00
76.00 03020 ONCOLOGY	0	173, 945	0.00000	0. 000000	0	76.00
76. 01 03021 CARDI AC REHAB	0	125, 724	0.00000	0. 000000	0	76.01
OUTPATIENT SERVICE COST CENTERS					•	1
88.00 08800 RURAL HEALTH CLINIC	0	364, 968	0.00000	0.00000	0	88.00
90. 00 09000 CLINIC	0	227, 260	0. 00000	0. 000000	0	90.00
91.00 09100 EMERGENCY	0	3, 647, 202	0. 00000	0. 000000	7, 927	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	224, 420	0. 00000	0. 000000	0	92.00
200.00 Total (lines 50-199)	0	42, 955, 037			3, 475, 309	200. 00

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	PULASKI MEMORI RVICE OTHER PASS		CCN: 151305	Peri od:	Worksheet D	5-2552-10
THROUGH COSTS				From 10/01/201	3 Part IV	
				To 09/30/201		repared:
		Ti +1	e XVIII	Hospi tal	3/30/2015 3: Cost	
Cost Center Description	I npati ent	Outpatient	Outpatient			
cost center bescription	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug	h		
	Costs (col. 8	onar ges	Costs (col.			
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	()	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0		52.00
53. 00 05300 ANESTHESI OLOGY	0	C		0		53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0		54.OC
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0		59.00
60. 00 06000 LABORATORY	0	C		0		60.00
60. 01 06001 BLOOD LABORATORY	0	C		0		60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C		0		63.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	C		0		67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	C		0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0		73.00
76.00 03020 ONCOLOGY	0	C		0		76.00
76. 01 03021 CARDI AC REHAB	0	C)	0		76. 01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	C		0		88.00
90. 00 09000 CLINIC	0	C		0		90.00
91. 00 09100 EMERGENCY	0	C		0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C		0		92.00
200.00 Total (lines 50-199)	0	C		0		200.00

Health Financial Systems	PULASKI MEMOR			In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 151305	Peri od:	Worksheet D	
				From 10/01/2013 To 09/30/2014	Part V Date/Time Pre	narod
				10 09/30/2014	3/30/2015 3:5	
		Ti tl	e XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge		Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	1					
50.00 O5000 OPERATING ROOM	0. 253836		.,		0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 507512		.,		0	
53. 00 05300 ANESTHESI OLOGY	0. 049632	0			0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 209741	0	3, 042, 36	0 8	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	
60. 00 06000 LABORATORY	0. 188546	0	3, 143, 85	57 0	0	
60.01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 320431	0	85, 65	51 0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 312269	0	67, 69	95 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 506278		448, 74	15 0	0	
67.00 06700 OCCUPATI ONAL THERAPY	0. 418792		47, 90	01 0	0	
68.00 06800 SPEECH PATHOLOGY	0. 688913	0	13, 91	3 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 246128	0	134, 69	07 0	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 303625	0	629, 98	35 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 575025	0	71, 25	52 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 252171	0	2, 131, 96	51 33	0	
76. 00 03020 ONCOLOGY	1. 304412	0	74, 59	95 0	0	76.00
76. 01 03021 CARDI AC REHAB	1. 261167	0	102, 10	0 8	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	88.00
90. 00 09000 CLINIC	1. 448966	0	202, 12	29 0	0	90.00
91.00 09100 EMERGENCY	0. 663549	0	999, 44	1 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 636984	0	81, 51		0	
200.00 Subtotal (see instructions)		0	12, 801, 41	9 33	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
0nl y Charges 202.00 Net Charges (line 200 +/- line 201)		0	12, 801, 41	9 33	0	202.00

Heal th	Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTI	ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 151305	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part V Date/Time Pre 3/30/2015 3:5	
			Ti tl	e XVIII	Hospi tal	Cost	
		Cos	sts				
	Cost Center Description	Cost	Cost]			
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
	ANCI LLARY SERVI CE COST CENTERS						_
	05000 OPERATING ROOM	331, 575					50.00
	05200 DELIVERY ROOM & LABOR ROOM	779	0				52.00
	05300 ANESTHESI OLOGY	10, 711	0				53.00
	05400 RADI OLOGY-DI AGNOSTI C	638, 109	0				54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
	06000 LABORATORY	592, 762	0				60.00
60. 01	06001 BLOOD LABORATORY	0	0				60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	27, 445	0				63.00
65.00	06500 RESPI RATORY THERAPY	21, 139	0				65.00
66.00	06600 PHYSI CAL THERAPY	227, 190	0				66.00
67.00	06700 OCCUPATI ONAL THERAPY	20, 061	0				67.00
68.00	06800 SPEECH PATHOLOGY	9, 585	0				68.00
69.00	06900 ELECTROCARDI OLOGY	33, 153	0				69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	191, 279	0				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	40, 972	0				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	537, 619	8				73.00
76.00	03020 ONCOLOGY	97, 303	0				76.00
76.01	03021 CARDI AC REHAB	128, 775	0				76.01
0	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	1			88.00
90.00	09000 CLINIC	292, 878	0				90.00
91.00	09100 EMERGENCY	663, 178	0				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	133, 437	0				92.00
200.00	Subtotal (see instructions)	3, 997, 950	8				200.00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)	3, 997, 950	8				202.00

Health Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 151305	Peri od:	Worksheet D	
		Component	CCN: 15Z305	From 10/01/2013 To 09/30/2014		
		T: +1		Curline Dede CNE	3/30/2015 3:5	5 pm
		111	e XVIII Charges	Swing Beds - SNF	Cost Costs	
Cast Contar Description	Cost to Charge	DDS Doimburcod		Cost	PPS Services	
Cost Center Description		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Servi ces Not	(see mst.)	
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 253836	0		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 507512	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 049632	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 209741	0		0 0	0	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 188546	0		0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 320431	0		0 0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0. 312269	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 506278	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 418792	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 688913	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 246128	0		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 303625	0	1	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 575025	0	1	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 252171	0	1	0 0	0	73.00
76.00 03020 ONCOLOGY	1. 304412	0		0 0	0	76.00
76. 01 03021 CARDI AC REHAB	1. 261167	0		0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS			-			
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	88.00
90. 00 09000 CLINIC	1. 448966	0		0 0	0	
91.00 09100 EMERGENCY	0. 663549	0		0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 636984	0		0 0	0	
200.00 Subtotal (see instructions)		0		0 0	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges		-			-	000 00
202.00 Net Charges (line 200 +/- line 201)	1	0	I	0 0	0	202.00

Health Financial Systems	PULASKI MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 151305	Peri od:	Worksheet D	
				From 10/01/2013	Part V	
		Component	CCN: 15Z305	To 09/30/2014	Date/Time Pre 3/30/2015 3:5	
		Ti +1	e XVIII	Swing Beds - SNF		o pili
	Cos			Jowing Deus - Jin	0031	
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS			-			
50.00 O5000 OPERATING ROOM	0	0				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	0	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	0	0				60.00
60. 01 06001 BLOOD LABORATORY	0	0				60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
76.00 03020 0NC0L0GY	0	0				76.00
76. 01 03021 CARDI AC REHAB	0	0				76.01
OUTPATIENT SERVICE COST CENTERS			1			
88. 00 08800 RURAL HEALTH CLINIC	0	0				88.00
90. 00 09000 CLINIC	0	0				90.00
91.00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges		0				202.00
202.00 Net Charges (line 200 +/- line 201)	0	0	I			202.00

	Financial Systems PULASKI MEMORIAL HC ATION OF INPATIENT OPERATING COST	Provider CCN: 151305	Period: From 10/01/2013 To 09/30/2014	u of Form CMS-2 Worksheet D-1 Date/Time Prep 3/30/2015 3:55	pare
	Cost Center Description	Title XVIII	Hospi tal	Cost	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
00 00	Inpatient days (including private room days and swing-bed days, Inpatient days (including private room days, excluding swing-bed			3, 025 2, 209	1
00	Private room days (excluding swing-bed and observation bed days)	5,	ivate room davs.	2,209	
	do not complete this line.	i i jou navo oni j pi	i vato i com adjo,	J.	
00 00	Semi-private room days (excluding swing-bed and observation bed		- 01 -6 +6+	1, 906	4
00	Total swing-bed SNF type inpatient days (including private room reporting period	days) through becembe	r 31 OF the COSt	185	
00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	585	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room d	ave) through December	21 of the cost	20	-
00	reporting period	ays) through becember	ST OF THE COST	20	'
00	Total swing-bed NF type inpatient days (including private room d	ays) after December 3	1 of the cost	26	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to t	bo Program (oveluding	swing bod and	974	Ģ
00	newborn days)	The Trogram (excluding	Swing-bed and	774	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days)	183	10
. 00	through December 31 of the cost reporting period (see instructio Swing-bed SNF type inpatient days applicable to title XVIII only		oom days) after	579	11
. 00	December 31 of the cost reporting period (if calendar year, ente		oom days) arter	577	
. 00	5 51 1 5 11	nly (including privat	e room days)	0	12
. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX o	nlv (including privat	e room days)	0	13
	after December 31 of the cost reporting period (if calendar year	, enter 0 on this lin	e)		
	Medically necessary private room days applicable to the Program	(excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost		17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost		18
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to services t reporting period	hrough December 31 of	the cost	129.14	19
. 00	Medicaid rate for swing-bed NF services applicable to services a	fter December 31 of t	he cost	129. 14	20
00	reporting period Total general inpatient routine service cost (see instructions)			3, 617, 846	21
	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	0,017,040	22
	5 x line 17)				
. 00	Swing-bed cost applicable to SNF type services after December 31 x line 18)	or the cost reportin	g period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through December 3	1 of the cost reporti	ng period (line	2, 583	24
00	7 x line 19) Swing bod cost applicable to NE type services after December 21	of the cost reporting	poriod (lipo 9	3, 358	2
. 00	Swing-bed cost applicable to NF type services after December 31 x line 20)	or the cost reporting		3, 300	25
	Total swing-bed cost (see instructions)			939, 535	
. 00	General inpatient routine service cost net of swing-bed cost (li PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ne zi minus line 26)		2, 678, 311	27
. 00	General inpatient routine service charges (excluding swing-bed a	nd observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)			0	
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ l	ine 28)		0 0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 minus Average per diem private room cost differential (line 34 x line		tions)	0.00 0.00	
	Private room cost differential adjustment (line 3 x line 35)	~.,		0.00	36
. 00	General inpatient routine service cost net of swing-bed cost and	private room cost di	fferential (line	2, 678, 311	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	MENTS			
00	Adjusted general inpatient routine service cost per diem (see in			1, 212. 46	
				1, 180, 936	39
. 00	Program general inpatient routine service cost (line 9 x line 38 Medically necessary private room cost applicable to the Program	-		0	

	Cost Center Description				From 10/01/2013 To 09/30/2014		nore
					1	3/30/2015 3:5	
				e XVIII	Hospi tal	Cost	
		Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	NURSERY (title V & XIX only)	0	(0.	00 0	0	42.
	Intensive Care Type Inpatient Hospital Units	0			00 0	0	43.
	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	(0.	00 0	0	43.
	BURN INTENSIVE CARE UNIT						45.
	SURGI CAL INTENSI VE CARE UNI T						46.
. 00	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1.00	
. 00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3,	line 200)			923, 801	48.
. 00	Total Program inpatient costs (sum of lines 4			ons)		2, 104, 737	49.
	PASS THROUGH COST ADJUSTMENTS				<u> </u>		1 50
	Pass through costs applicable to Program inpa III)	atient routine s	services (Tror	N WKST. D, SU	m of Parts I and	0	50.
	Pass through costs applicable to Program inpa	atient ancillary	/ services (fi	om Wkst. D,	sum of Parts II	0	51.
	and IV)	5					
	Total Program excludable cost (sum of lines s		- +			0	
	Total Program inpatient operating cost exclud medical education costs (line 49 minus line 5		ated, non-phy	/sician anest	netist, and	0	53.
	TARGET AMOUNT AND LIMIT COMPUTATION	52)				1	
	Program di scharges					0	
	Target amount per discharge					0.00	
	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	na cost and tar	aet amount (l	ing 56 minus	line 53)	0	
. 00 Bonus payment (see instructions)							58
	Lesser of lines 53/54 or 55 from the cost rep	porting period e	ending 1996, เ	updated and c	ompounded by the	0.00	59
	market basket						
	Lesser of lines 53/54 or 55 from prior year of lines 53/54 is less than the lower of lines				the amount by	0.00	
	which operating costs (line 53) are less than					0	
	amount (line 56), otherwise enter zero (see i				5		
	Relief payment (see instructions)					0	
	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see Instruc	ctions)			0	63.
	Medicare swing-bed SNF inpatient routine cost	ts through Decem	ber 31 of the	e cost report	ing period (See	221, 880	64.
	instructions)(title XVIII only)	-					
	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	ts after Decembe	er 31 of the o	cost reportin	g period (See	702, 014	65.
	Total Medicare swing-bed SNF inpatient routin	ne costs (line 6	54 plus line 6	5)(title XVI	ll only). For	923, 894	66.
	CAH (see instructions)	, i i i i i i i i i i i i i i i i i i i			J ,		
	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 d	of the cost r	eporting period	0	67.
	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	e costs after De	cember 31 of	the cost ren	orting period	0	68.
	(line 13 x line 20)			the cost rep	bitting period	0	00.
-	Total title V or XIX swing-bed NF inpatient n			,		0	69.
	PART III - SKILLED NURSING FACILITY, OTHER NU						1 70
	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co						70.
	Program routine service cost (line 9 x line 1						72
	Medically necessary private room cost applica						73
	Total Program general inpatient routine servi	•	,				74
	Capital-related cost allocated to inpatient 1 26, line 45)	out ne service	COSTS (TION V	WIKSNeet B,	Part II, corumn		75
1	Per diem capital-related costs (line 75 ÷ lin	ne 2)					76
	Program capital-related costs (line 9 x line	· · · · · · · · · · · · · · · · · · ·					77
	Inpatient routine service cost (line 74 minus	,	oulder	10)			78
	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa				nus line 79)		79
	Inpatient routine service cost per diem limit			. (81
. 00	Inpatient routine service cost limitation (li	ne 9 x line 81)					82
	Reasonable inpatient routine service costs (s		5)				83
	Program inpatient ancillary services (see ins Utilization review - physician compensation ()				84
	Total Program inpatient operating costs (sum	•	•				86
	PART IV - COMPUTATION OF OBSERVATION BED PASS						1
	Total observation bed days (see instructions)					303	
	Adjusted general inpatient routine cost per o Observation bed cost (line 87 x line 88) (see	•	line 2)			1, 212. 45 367, 372	

Health Financial Systems	PULASKI MEMOR	AL HOSPITAL		In Lieu of Form CMS-2552-		
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 10/01/2013	Worksheet D-1	
				To 09/30/2014		
		Titl	e XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	242, 435	2, 678, 311	0. 09051	8 367, 372	33, 254	90.00
91.00 Nursing School cost	0	2, 678, 311	0.00000	0 367, 372	0	91.00
92.00 Allied health cost	0	2, 678, 311	0.00000	0 367, 372	0	92.00
93.00 All other Medical Education	0	2, 678, 311	0. 00000	0 367, 372	0	93.00

	ATION OF INPATIENT OPERATING COST	Provider CCN: 151305	Period: From 10/01/2013	Worksheet D-1	
			To 09/30/2014	Date/Time Prep 3/30/2015 3:55	
	Cost Center Description	Title XIX	Hospi tal	Cost	
	PART I – ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				1
00	Inpatient days (including private room days and swing-bed days			3, 025	
00 00	Inpatient days (including private room days, excluding swing-b Private room days (excluding swing-bed and observation bed day		ivate room days,	2, 209 0	
~~	do not complete this line.	5 51	J .	1.00/	
00 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	1, 906 0	
00	reporting period Total swing-bed SNF type inpatient days (including private roc	m davs) after December	31 of the cost	770	6
50	reporting period (if calendar year, enter 0 on this line)	•		770	`
00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	46	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	146	9
. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII or	oly (including private r	nom davs)	0	10
	through December 31 of the cost reporting period (see instruct	tions)	5		
. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er		oom days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	<pre>< only (including privat</pre>	e room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13
. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14
. 00	Total nursery days (title V or XIX only)		-	254	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost		17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20
00	reporting period	->		2 (17 04)	
. 00 . 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ing period (line	3, 617, 846 0	
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	a period (line 6	0	23
	x line 18)				
. 00	Swing-bed cost applicable to NF type services through December 7×1 (ine 19)	⁻ 31 of the cost reporti	ng period (line	0	24
. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25
. 00	Total swing-bed cost (see instructions)			935, 126	
. 00	General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		2, 682, 720	27
. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28
. 00	Private room charges (excluding swing-bed charges)			0	
. 00 . 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷	Line 28)		0 0. 000000	
. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
. 00	Average per diem private room charge differential (line 32 min		tions)	0.00	
. 00	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)		Committee (1)	0	
. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	ilerential (line	2, 682, 720	3
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				1
					1 00
	Adjusted general inpatient routine service cost per diem (see			1, 214. 45	
. 00 . 00 . 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progra	38)		1, 214. 45 177, 310 0	39

OMPUTATION OF INPATIENT OF	PERATING COST		HOSPI TAL Provi der	CCN: 151305	Peri od:	eu of Form CMS- Worksheet D-1	
					From 10/01/2013 To 09/30/2014		
				le XIX	Hospi tal	Cost	-
Cost Center De	scription	Total Inpatient CostIn	Total patient Days	Average Per Diem (col. 1		Program Cost (col. 3 x col.	
		1.00	2.00	<u>col.2)</u> 3.00	4.00	4) 5.00	
2.00 NURSERY (title V & X	IX only)	188, 792	254				42.
Intensive Care Type	Inpatient Hospital Uni						
3. 00 INTENSIVE CARE UNIT		0	0	0.	0 00	0	
4.00 CORONARY CARE UNIT 5.00 BURN INTENSIVE CARE							44.
5. 00 SURGI CAL I NTENSI VE C							46.
7.00 OTHER SPECIAL CARE (1		L	47.
Cost Center De	scription					1.00	
3.00 Program inpatient ar	cillary service cost (Wkst. D-3, col. 3,	line 200)			148, 793	48.
9.00 <u>Total Program inpati</u>	ent costs (sum of line			ns)		326, 103	49.
D. 00 PASS THROUGH COST AD	JUSTMENTS pplicable to Program i	nationt routing co	ruless (from	Wkct D cu	n of Dorte L and	0	50.
III)	ppricable to program i	npatrent routine se	rvices (iroli	WKSL. D, SU	n of Parts I and		50.
	pplicable to Program i	npatient ancillary	services (fr	om Wkst. D, s	sum of Parts II	0	51.
and IV) 2.00 Total Program exclud	able cost (cum of lite	c 50 and 51				0	52.
	able cost (sum of line ent operating cost exc		ted non-phy	sician anestl	netist and		
	sts (line 49 minus lin		tou, non phy				
TARGET AMOUNT AND LI	MIT COMPUTATION						
.00 Program discharges .00 Target amount per di	scharge					0.00	
.00 Target amount (line						0.00	
	djusted inpatient oper	ating cost and targ	et amount (I	ine 56 minus	line 53)	0	
8.00 Bonus payment (see i		reporting period on	ding 100/	ndated and a	manundad by the	0	
2.00 Lesser of lines 53/5 market basket	4 or 55 from the cost	reporting period en	aing 1996, u	poated and co	ompounded by the	0.00	59
	4 or 55 from prior yea	r cost report, upda	ted by the m	arket basket		0.00	60.
	s than the lower of li					0	61.
	s (line 53) are less t herwise enter zero (se		(lines 54 x	60), or 1% of	r the target		
2.00 Relief payment (see						0	62.
	cost plus incentive pa	yment (see instruct	i ons)			0	63.
PROGRAM INPATIENT RO . 00 Medicare swing-bed S	NF inpatient routine c	osts through Decemb	er 31 of the	cost reporti	na period (See	0	64.
instructions) (title		osts thi ough become			ng period (bee	Ĭ	
	NF inpatient routine c	osts after December	31 of the c	ost reporting	g period (See	0	65.
instructions)(title 5.00 Total Medicare swind	XVIII only) -bed SNF inpatient rou	tine costs (line 64	nlus line 6	5)(title XVI)	lonly) For	0	66.
CAH (see instruction	•					Ĭ	
	-bed NF inpatient rout	ine costs through D	ecember 31 c	f the cost re	eporting period	0	67.
(line 12 x line 19) B.OO Title V or XIX swing	-bed NF inpatient rout	ine costs after Dec	ember 31 of	the cost ren	orting period		68.
(line 13 x line 20)				the cost rep	bitting period	Ĭ	/ 00.
	swing-bed NF inpatien			,		0	69.
	<u>JRSING FACILITY, OTHER</u> lity/other nursing fac						70.
5	atient routine service						71.
	ice cost (line 9 x lin			,			72.
	private room cost appl						73
5 5	<pre>I inpatient routine se allocated to inpatien</pre>	•	,		Part II column		74.
26, line 45)	an ocated to impation						,
	ated costs (line 75 ÷						76.
5	ted costs (line 9 x li rvice cost (line 74 mi	· · · · · · · · · · · · · · · · · · ·					77
	beneficiaries for exc		vider record	s)			79
.00 Total Program routir	e service costs for co				nus line 79)		80
	rvice cost per diem li						81
	rvice cost limitation routine service costs	• . • .					82
	cillary services (see					1	84
5.00 Utilization review -	physician compensatio	n (see instructions					85
	ent operating costs (s		ugh 85)			L	86.
	N OF OBSERVATION BED P. d days (see instructio					303	8 87.
	atient routine cost pe		ine 2)			1, 214. 45	
n oo magaabaa ganarar mp							

Health Financial Systems	PULASKI MEMOR	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1	
				From 10/01/2013 To 09/30/2014		
		Tit	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	242, 435	2, 682, 720	0. 09036	9 367, 978	33, 254	90.00
91.00 Nursing School cost	0	2, 682, 720	0.00000	0 367, 978	0	91.00
92.00 Allied health cost	0	2, 682, 720	0.00000	0 367, 978	0	92.00
93.00 All other Medical Education	0	2, 682, 720	0. 00000	0 367, 978	0	93.00

Health Financial Systems PULASKI MEMORIA INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	L HOSPITAL Provider	CCN: 151305	Peri od:	u of Form CMS- Worksheet D-3	
INFAILENT ANGLEEART SERVICE COST AFFORTIONWENT	FIOVICE	CCN. 151505	From 10/01/2013	WULKSHEEL D-3)
			To 09/30/2014		
				3/30/2015 3:5	55 pm
	Titl	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs (col. 1 x col.	
			Charges	(COI. 1 X COI. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			748, 257		30. 00
31. 00 03100 INTENSIVE CARE UNIT			0		31.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 2538			
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 5075			52.00
53. 00 05300 ANESTHESI OLOGY		0. 0496			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2097		81, 136	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000		0	
60. 00 06000 LABORATORY		0. 1885		85, 368	
60. 01 06001 BLOOD LABORATORY		0.0000		0	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 3204			
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY		0. 3122		42, 438	
66. 00 06600 PHYSI CAL_THERAPY 67. 00 06700 0CCUPATI 0NAL_THERAPY		0. 5062			
68.00 06800 SPEECH PATHOLOGY		0. 4187		9, 464 9, 949	
69. 00 06900 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY		0. 8889			
70. 00 07000 ELECTROCARDIOLOGT		0. 2461		4, 197	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.3036			
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 5750			
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 2521			
76. 00 03020 ONCOLOGY		1. 3044		0	
76. 01 03021 CARDI AC REHAB		1. 2611		0	
OUTPATIENT SERVICE COST CENTERS		1.2011	0/ 0		/ /0.0
88. 00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88. 00
90. 00 09000 CLINIC		1. 4489		0	
91.00 09100 EMERGENCY		0. 6635		5, 260	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)		1.6369		0	
200.00 Total (sum of lines 50-94 and 96-98)			3, 475, 309	923, 801	
201.00 Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)	,		3, 475, 309		202.00

Health Financial Systems Pl	JLASKI MEMORIAL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151305	Peri od:	Worksheet D-3	
			From 10/01/2013		
	Component	t CCN: 15Z305	To 09/30/2014		
	Ti +1	e XVIII	Swing Beds - SNF	3/30/2015 3:5 Cost	5 pili
Cost Center Description		Ratio of Cos		Inpatient	
cost center bescription		To Charges	Program	Program Costs	
		10 charges	Charges	$(col. 1 \times col.)$	
			charges	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS				•	1
50. 00 05000 OPERATI NG ROOM		0. 2538	36 5, 689	1, 444	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 5075	12 0	0	52.00
53. 00 05300 ANESTHESI OLOGY		0.0496	32 1, 723	86	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2097	41 45,039	9, 447	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000			59.00
60. 00 06000 LABORATORY		0. 1885		18, 066	60.00
60. 01 06001 BLOOD LABORATORY		0.0000	0 00	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 3204	2, 450	785	63.00
65. 00 06500 RESPI RATORY THERAPY		0. 3122	59 53, 728	16, 778	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 5062			
67.00 06700 OCCUPATI ONAL THERAPY		0. 4187			
68.00 06800 SPEECH PATHOLOGY		0. 6889			
69. 00 06900 ELECTROCARDI OLOGY		0. 2461			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000			•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3036			
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 5750		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2521			
76. 00 03020 ONCOLOGY		1. 3044			
76. 01 03021 CARDI AC REHAB		1. 2611			76.01
OUTPATIENT SERVICE COST CENTERS		1.2011	0		70.01
88.00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88.00
90. 00 09000 CLINIC		1. 4489		-	
91. 00 09100 EMERGENCY		0. 6635		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 6369		0	
200.00 Total (sum of lines 50-94 and 96-98)		1.0007	679, 771	-	
201.00 Less PBP Clinic Laboratory Services-Progra	am only charges (line 61)		0,7,77	20,,,,00	200.00
202.00 Net Charges (line 200 minus line 201)	an only ond gos (The Of)		679, 771		201.00
		I	0,7,771	I	1-02.00

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151305	Peri od:		Worksheet D-3	
			From 10/01/2			
			To 09/30/2	014	Date/Time Pre 3/30/2015 3:5	
	Ti t	le XIX	Hospi tal			5 pili
Cost Center Description		Ratio of Cos	t Inpatient	:	Inpati ent	
		To Charges	Program		Program Costs	
			Charges	((col. 1 x col.	
					2)	
		1.00	2.00		3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1		107		
30. 00 03000 ADULTS & PEDIATRICS			71,			30.0
31. 00 03100 I NTENSI VE CARE UNI T				0		31.0
43. 00 04300 NURSERY			32,	121		43.0
		0.0520	24 42	140	14 025	50.0
50. 00 05000 OPERATING ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 2538			16, 035 23, 750	
53. 00 05200 ANESTHESI OLOGY		0. 5075				52.0
54. 00 05300 RADI OLOGY-DI AGNOSTI C		0. 0498			577 9, 644	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.2097		9/9	9,044	59.0
50. 00 06000 LABORATORY		0. 1885		-	13, 105	
50. 01 06000 LABORATORY		0. 1885		0	13, 105	60.0
53. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 3204		829	1, 547	63.0
55. 00 06500 RESPIRATORY THERAPY		0. 3122			8,059	65.0
56. 00 06600 PHYSI CAL THERAPY		0.5062		101	1,064	
57. 00 06700 OCCUPATI ONAL THERAPY		0. 4187		940	394	
58. 00 06800 SPEECH PATHOLOGY		0. 6889		439	3, 058	
59. 00 06900 ELECTROCARDI OLOGY		0. 2461		895	220	69.0
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	0	70.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3036		472	19, 272	71.0
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 5750		0	0	72.0
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2521		798	41, 557	73.0
76.00 03020 ONCOLOGY		1. 3044		0	0	76.0
76. 01 03021 CARDI AC REHAB		1. 2611		0	0	76.0
OUTPATIENT SERVICE COST CENTERS						1
38.00 08800 RURAL HEALTH CLINIC		2.4378	36	0	0	88. 0
90. 00 09000 CLINIC		1.4489	66	0	0	90.0
91. 00 09100 EMERGENCY		0. 6635	49 15,	840	10, 511	91.0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 6369	84	0	0	92.0
200.00 Total (sum of lines 50-94 and 96-98)			520,	194	148, 793	200. 0
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)			0		201.0
202.00 Net Charges (line 200 minus line 201)			520,	194		202.0

Heal th Financi	al Systems	PULASKI MEMORIAL	HOSPI TAL			In Lie	u of Form CMS-:	2552-10
INPATIENT ANCI	ILLARY SERVICE COST APPORTIONMENT		Provi der	CCN: 151305	Peri od	:	Worksheet D-3	
						0/01/2013		
			Component	t CCN: 15Z305	To 0	9/30/2014		
			Ti +	le XIX	Swing [Beds - SNF	3/30/2015 3:5 PPS	s pili
C	ost Center Description		III	Ratio of Cos		patient	Inpati ent	
	ost center bescription			To Charges		rogram	Program Costs	
				10 charges			$(col. 1 \times col.$	
						nai ges	2)	
				1.00		2.00	3.00	
I NPATI E	NT ROUTINE SERVICE COST CENTERS					2.00	0100	
30.00 03000 AI	DULTS & PEDIATRICS					0		30.00
31.00 03100 11	NTENSIVE CARE UNIT					0		31.00
43.00 04300 NI	URSERY					0		43.00
ANCI LLA	RY SERVICE COST CENTERS							
50.00 05000 0I	PERATING ROOM			0. 2538	36	0	0	50.00
52.00 05200 DI	ELIVERY ROOM & LABOR ROOM			0. 5075	12	0	0	52.00
53.00 05300 AI	NESTHESI OLOGY			0. 0496	32	0	0	53.00
54.00 05400 R/	ADI OLOGY-DI AGNOSTI C			0. 2097	41	0	0	54.00
59.00 05900 C/	ARDI AC CATHETERI ZATI ON			0.0000	00	0	0	59.00
60.00 06000 L	ABORATORY			0. 1885	46	0	0	60.00
60. 01 06001 BI	LOOD LABORATORY			0.0000	00	0	0	60. 01
63.00 06300 BI	LOOD STORING, PROCESSING & TRANS.			0. 3204	31	0	0	63.00
65.00 06500 RI	ESPI RATORY THERAPY			0. 3122	69	0	0	65.00
66.00 06600 PI	HYSI CAL THERAPY			0. 5062	78	0	0	66.00
67.00 06700 00	CCUPATIONAL THERAPY			0. 4187	92	0	0	67.00
68.00 06800 SI	PEECH PATHOLOGY			0. 6889	13	0	0	68.00
69.00 06900 EI	LECTROCARDI OLOGY			0. 2461	28	0	0	69.00
70.00 07000 EI	LECTROENCEPHALOGRAPHY			0.0000	00	0	0	70.00
71.00 07100 MI	EDICAL SUPPLIES CHARGED TO PATIENTS			0. 3036	25	0	0	71.00
72.00 07200 11	MPL. DEV. CHARGED TO PATIENTS			0. 5750	25	0	0	72.00
73.00 07300 DI	RUGS CHARGED TO PATIENTS			0. 2521	71	0	0	73.00
76.00 03020 01	NCOLOGY			1. 3044	12	0	0	76.00
76.01 03021 C/	ARDI AC REHAB			1. 2611	67	0	0	76.01
OUTPATI	ENT SERVICE COST CENTERS							
88.00 08800 RI	URAL HEALTH CLINIC			2. 4378	36	0	0	88.00
90. 00 09000 CI	LINIC			1. 4489	66	0	0	90.00
91.00 09100 EI	MERGENCY			0.6635	49	0	0	91.00
92.00 09200 01	BSERVATION BEDS (NON-DISTINCT PART)			1. 6369	84	0	0	92.00
	otal (sum of lines 50-94 and 96-98)					0	0	200.00
	ess PBP Clinic Laboratory Services-Pro	ogram only charges	(line 61)			0		201.00
	et Charges (line 200 minus line 201)					0		202.00

	Financial Systems PULASKI MEMORIAL HO ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 151305	Period: From 10/01/2013 To 09/30/2014	u of Form CMS-2 Worksheet E Part B Date/Time Pre 3/30/2015 3:55	pared:
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)	nc)		3, 997, 958	1.00
2.00 3.00	Medical and other services reimbursed under OPPS (see instruction PPS payments	115)		0	2.00 3.00
4.00	Outlier payment (see instructions)			0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instruction	ons)		0. 000	5.00
5.00 7.00	Line 2 times line 5 Sum of line 3 plus line 4 divided by line 6			0 0.00	6.00 7.00
3.00	Transitional corridor payment (see instructions)			0.00	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Par	t IV, column 13, line	200	0	9.00
10.00	Organ acquisitions			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			3, 997, 958	11.00
	Reasonable charges				
12.00	Ancillary service charges			0	
	Organ acquisition charges (from Worksheet D-4, Part III, line 69	, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			0	14.00
15.00	Aggregate amount actually collected from patients liable for pay	ment for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for p	ayment for services o	n a chargebasis	0	16.00
17 00	had such payment been made in accordance with 42 CFR 413.13(e)			0.000000	17 00
17.00 18.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0.000000	18.00
19.00	Excess of customary charges over reasonable cost (complete only	ifline 18 exceeds li	ne 11) (see	0	19.00
	instructions)			_	
20.00	Excess of reasonable cost over customary charges (complete only instructions)	ne 18) (see	0	20.00	
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see in	4, 037, 938	21.00		
	Interns and residents (see instructions)			0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instruc	tions)		0	23.00 24.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24.00
25.00	Deductibles and coinsurance (for CAH, see instructions)			31, 922	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for C			1, 956, 605	
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the see instructions)	e sum of lines 22 and	23} (TOP CAH,	2, 049, 411	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4,	line 50)		0	28.00
	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00 31.00	Subtotal (sum of lines 27 through 29) Primary payer payments			2, 049, 411 2, 021	
	Subtotal (line 30 minus line 31)			2,021	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES))			
	Composite rate ESRD (from Worksheet I-5, line 11)				33.00
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			366, 990 278, 912	
36.00	Allowable bad debts for dual eligible beneficiaries (see instruc	tions)		329, 932	36.00
37.00	Subtotal (see instructions)			2, 326, 302	37.00
38.00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	38.00
39.00 39.98	Partial or full credits received from manufacturers for replaced	devices (see instruc	tions)	0	39.00 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40.00	Subtotal (see instructions)			2, 326, 302	40.00
40.01 41.00	Sequestration adjustment (see instructions)		46, 526 2, 454, 501		
41.00 42.00	Interim payments Tentative settlement (for contractors use only)		2, 454, 501	41.00 42.00	
43.00	Balance due provider/program (see instructions)			-174, 725	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	chapter 1,	0	44.00
	§115.2 TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92.00	The rate used to calculate the Time Value of Money			0.00	92.00 93.00
	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 151305	Period: From 10/01/2013 To 09/30/2014		pared:
		Ti tl	e XVIII	Hospi tal	Cost	
		Inpati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00 3.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each		2, 065, 6	32 0	2, 454, 501 0	1.00 2.00 3.00
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01 3.02 3.03 3.04 3.05	ADJUSTMENTS TO PROVIDER			0 0 0 0	0 0 0 0	3.0 ² 3.02 3.03 3.04 3.04
	Provider to Program					
3.50 3.51 3.52 3.53 3.54 3.99	ADJUSTMENTS TO PROGRAM Subtotal (sum of lines 3.01-3.49 minus sum of lines			0 0 0 0 0 0	0 0 0 0 0	3.5(3.5 ² 3.52 3.52 3.54 3.54
4.00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2, 065, 6	32	2, 454, 501	4.0
5.00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5.0
5.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.00
5. 01	TENTATI VE TO PROVIDER			0	0	5. 0 ²
5. 02				0	0	
5.03				0	0	5.03
5.50	Provider to Program TENTATIVE TO PROGRAM			0	0	5.50
5.50 5.51 5.52 5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0 0 0	0 0 0	5.5 5.52
5.00	5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
5. 01 5. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		208, 6	0 24	0 174, 725	6. 0 [.] 6. 0.
7.00	Total Medicare program liability (see instructions)		1, 857, 0	Contractor	2,279,776 NPR Date	7.0
			`	Number	(Mo/Day/Yr)	
	Name of Contractor	()	1.00	2.00	8.0

NALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		F	Period: From 10/01/2013 To 09/30/2014		pared
		Ti tl	e XVIII S	wing Beds - SNF		<u>o p</u>
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00	Total interim payments paid to provider		1, 209, 458	3	0	1.C
. 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		(D	0	2.0
. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3. C
	Program to Provider	1		1		
. 01	ADJUSTMENTS TO PROVIDER		(0	
. 02 . 03			(0	
03 04			(0	
04			(0	
	Provider to Program	1		-		
50	ADJUSTMENTS TO PROGRAM		(0	3.
51			(0	
52			(0	
53			(0	
54 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		(0	
99	3. 50-3. 98)		(0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1, 209, 458	3	0	4.
	TO BE COMPLETED BY CONTRACTOR			1		
00	List separately each tentative settlement payment after					5.
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
01	TENTATI VE TO PROVI DER		(0	0	5.
02			(0	
03			(0	5.
	Provider to Program	1				
50	TENTATI VE TO PROGRAM		(0	5.
51 52			(0	5. 5.
5∠ 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		(-	0	
//	5, 50-5, 98)				0	
00	Determined net settlement amount (balance due) based on the cost report. (1)					6.
01	SETTLEMENT TO PROVIDER		(1	0	
02	SETTLEMENT TO PROGRAM		80, 397		0	
00	Total Medicare program liability (see instructions)		1, 129, 061		0	7.
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1.00	2.00	

Heal th	Financial Systems PULASKI MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10	
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 151305 Period: From 10/01/2013 To 09/30/2014					
		Title XVIII	Hospi tal	Cost		
				1.00		
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			567	1.00	
1.00						
	2.00 Medicare days from Wkst S-3, Part I, column 6 sum of Lines 1, 8-12					
	3.00 Medicare HMO days from Wkst S-3, Part I, column 6. line 2					
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1,	8-12		1, 906	4.00	
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			45, 541, 068	5.00	
6.00	Total hospital charity care charges from Wkst S-10, column 3 l			341, 553	6.00	
7.00	CAH only - The reasonable cost incurred for the purchase of ce Part I line 168	ertified HIT technology	Worksheet S-2,	0	7.00	
8.00	Calculation of the HIT incentive payment (see instructions)			0	8.00	
9.00	Sequestration adjustment amount (see instructions)			0	9.00	
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		0	10.00	
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30.00	
31.00	Other Adjustment (specify)			0	31.00	
32.00	Balance due provider (line 8 (or line 10) minus line 30 and li	ne 31) (see instruction	s)	0	32.00	

Heal th	Financial Systems	PULASKI MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING	BEDS	Provider CCN: 1513 Component CCN: 15Z		Period: From 10/01/2013 To 09/30/2014	Worksheet E-2 Date/Time Pre	pared:
			Title XVIII		Swing Beds - SNF	3/30/2015 3:5 Cost	5 pm
					Part A	Part B	
					1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				1.00	2.00	
1.00	Inpatient routine services - swing bed-SNF				933, 133	0	1.00
2.00	Inpatient routine services - swing bed-NF (-	2.00
3.00	Ancillary services (from Wkst. D-3, column		t A, and sum of Wks [.]	t.D,	242, 366	0	3.00
	Part V, columns 6 and 7, line 202 for Part						
4.00	Per diem cost for interns and residents not	t in approved teachir	ng program (see			0.00	4.00
	instructions)						
5.00	Program days				762	0	5.00
6.00	Interns and residents not in approved teach					0	6.00
7.00	Utilization review - physician compensation		nod only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lir	nes 6 and 7)			1, 175, 499	0	8.00
9.00	Primary payer payments (see instructions)				0	0	9.00
10.00	Subtotal (line 8 minus line 9)				1, 175, 499	0	10.00
11.00	Deductibles billed to program patients (exc professional services)	clude amounts applica	able to physician		0	0	11.00
12.00	Subtotal (line 10 minus line 11)				1, 175, 499	0	12.00
13.00	Coinsurance billed to program patients (fro for physician professional services)	om provider records)	(exclude coinsurand	се	23, 396	0	13.00
14.00	80% of Part B costs (line 12 x 80%)					0	14.00
15.00	Subtotal (enter the lesser of line 12 minus	-	4)		1, 152, 103	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECI	FY)			0	0	
16.50	RURAL DEMONSTRATION PROJECT				0		16.50
17.00	Allowable bad debts (see instructions)				0	0	17.00
17.01	Adjusted reimbursable bad debts (see instru				0	0	
18.00	Allowable bad debts for dual eligible benef	ficiaries (see instru	uctions)		0	0	
19.00	Total (see instructions)				1, 152, 103	0	
19.01	Sequestration adjustment (see instructions))			23, 042	0	
20.00	Interim payments				1, 209, 458	0	20.00
21.00	Tentative settlement (for contractor use or				0	0	21.00
22.00	Balance due provider/program line 19 minus				-80, 397	0	22.00
23.00	Protested amounts (nonallowable cost report section 115.2	t items) in accordanc	ce with CMS Pub. 15	-2,	0	0	23.00

Heal th	Financial Systems P	PULASKI MEMORIAL H	IOSPI TAL	In Lie	u of Form CMS-	-2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	;	Provider CCN: 151305	Peri od:	Worksheet E-	2
				From 10/01/2013		
			Component CCN: 15Z305	To 09/30/2014	Date/Time Pro 3/30/2015 3:	epared:
			Title XIX	Swing Beds - SNF		55 piii
				Part A	Part B	
				1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (se	e 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, column 3,	line 200 for Part	A, and sum of Wkst. [), 0		3.00
	Part V, columns 6 and 7, line 202 for Part B)					
4.00	Per diem cost for interns and residents not in	approved teachin	g program (see	0.00		4.00
	instructions)					
5.00	Program days			0		5.00
6.00	Interns and residents not in approved teaching			0		6.00
7.00	Utilization review - physician compensation -		od only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines	6 and 7)		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 (exclud	e amounts applica	ble to physician	0		11.00
12.00	professional services) Subtotal (line 10 minus line 11)			0		12.00
12.00	Coinsurance billed to program patients (from p	rovidor recorde)	(avaluda, cai pouranca	0		12.00
13.00	for physician professional services)	rovider records)	(exclude collisulance	0		13.00
14.00	80% of Part B costs (line 12 x 80%)			0		14.00
15.00	Subtotal (enter the lesser of line 12 minus li	ne 13. or line 14)	0		15.00
16,00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		, ,	0		16.00
16.50	RURAL DEMONSTRATION PROJECT			0		16.50
17.00	Allowable bad debts (see instructions)			0		17.00
17.01	Adjusted reimbursable bad debts (see instruction	ons)		0		17.01
18.00	Allowable bad debts for dual eligible benefici	aries (see instru	ctions)	0		18.00
19.00	Total (see instructions)			0		19.00
19.01	Sequestration adjustment (see instructions)			0		19.01
20.00	Interim payments			0		20.00
21.00	Tentative settlement (for contractor use only)			0		21.00
22.00	Balance due provider/program line 19 minus lin	es 19.01, 20 and	21	0		22.00
23.00	Protested amounts (nonallowable cost report it	ems) in accordanc	e with CMS Pub. 15-2,	0		23.00
	section 115.2					

	TION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151305	Peri od:	Worksheet E-3	
_					
			From 10/01/2013	Part V	
			To 09/30/2014	Date/Time Pre	
			lloonital	3/30/2015 3:5 Cost	5 pm
	· · · · · · · · · · · · · · · · · · ·	Title XVIII	Hospital	COST	
				1.00	
P	ART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE F	PART A SERVICES - COST	RELMBURSEMENT	1.00	
	npatient services			2, 104, 737	1.00
	lursing and Allied Health Managed Care payment (see instruction	n)		0	2.00
	Organ acquisition	,		0	3,00
4.00 S	Subtotal (sum of lines 1 thru 3)			2, 104, 737	4.00
5.00 P	Primary payer payments			8, 581	5.00
6.00 T	otal cost (line 4 less line 5). For CAH (see instructions)			2, 117, 203	6.00
C	OMPUTATION OF LESSER OF COST OR CHARGES				
R	easonabl e charges				
7.00 R	Routi ne servi ce charges			0	7.00
8.00 A	ncillary service charges			0	8.00
9.00 0)rgan acquisition charges, net of revenue			0	9.00
10.00 T	otal reasonable charges			0	10.00
	ustomary charges				
11.00 A	Aggregate amount actually collected from patients liable for pa	ayment for services on	a charge basis	0	11.00
	mounts that would have been realized from patients liable for	payment for services o	n a charge basis	0	12.00
	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)			0.00000	
	otal customary charges (see instructions)			0	14.00
	excess of customary charges over reasonable cost (complete only	y if line 14 exceeds li	ne 6) (see	0	15.00
	nstructions)			0	1/ 00
	excess of reasonable cost over customary charges (complete only	y IT line 6 exceeds lin	e 14) (see	0	16.00
	nstructions)	uctions)		0	17.00
	Cost of physicians' services in a teaching hospital (see instru OMPUTATION OF REIMBURSEMENT SETTLEMENT			0	17.00
	Direct graduate medical education payments (from Worksheet E-4,	line (19)		0	18.00
	Cost of covered services (sum of lines 6, 17 and 18)	, THE 47)		2, 117, 203	
	Deductibles (exclude professional component)			2, 117, 203	
	Excess reasonable cost (from line 16)			231,703	21.00
	Subtotal (line 19 minus line 20 and 21)			1, 885, 420	
	Coinsurance				23.00
	Subtotal (line 22 minus line 23)			1, 876, 300	
	Nlowable bad debts (exclude bad debts for professional service	es) (see instructions)		24, 481	
	djusted reimbursable bad debts (see instructions)			18, 606	
	Nlowable bad debts for dual eligible beneficiaries (see instru	uctions)		18, 074	
	Subtotal (sum of lines 24 and 25, or line 26)	· · · · · · · · · · · · · · · · · · ·		1, 894, 906	
	THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29.00
29.99 R	Recovery of Accelerated Depreciation			0	29, 99
	Subtotal (line 28, plus or minus lines 29)			1, 894, 906	30.00
	Sequestration adjustment (see instructions)			37, 898	30. 01
31.00 I	nterim payments			2,065,632	31.00
	entative settlement (for contractor use only)			0	32.00
33.00 B	Balance due provider/program line 30 minus lines 30.01, 31, and	d 32		-208, 624	33.00
34.00 P	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub. 15-2,	chapter 1,	0	34.00
S	115. 2				

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT P	rovider CCN: 151305	Period: From 10/01/2013 To 09/30/2014	Worksheet E-3 Part VII Date/Time Pre 3/30/2015 3:5	parec
		Title XIX	Hospi tal	Cost	
			Inpatient	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICI	S FOR TITLES V OR X	IX SERVICES		-
00	COMPUTATION OF NET COST OF COVERED SERVICES		226 102		1 1.0
00	Inpatient hospital/SNF/NF services Medical and other services		326, 103	0	2.0
00	Organ acquisition (certified transplant centers only)		0	0	3.0
00	Subtotal (sum of lines 1, 2 and 3)		326, 103	0	
00	Inpatient primary payer payments		0	-	5.0
00	Outpatient primary payer payments			0	6.1
00	Subtotal (line 4 less sum of lines 5 and 6)		326, 103	0	7.0
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
00	Routi ne servi ce charges		103, 317	-	8.
00	Ancillary service charges		520, 194	0	
D. 00 1. 00	Organ acquisition charges, net of revenue Incentive from target amount computation		0		10.
2.00	Total reasonable charges (sum of lines 8 through 11)		623, 511	0	
2.00	CUSTOMARY CHARGES		023, 311	0	12.
3. 00	Amount actually collected from patients liable for payment for se	rvices on a charge	0	0	13.
	basi s				
4.00	Amounts that would have been realized from patients liable for pa	yment for services o	in 0	0	14.
	a charge basis had such payment been made in accordance with 42 C	FR §413.13(e)			
5.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.00000	
5.00	Total customary charges (see instructions)	.	623, 511	0	16.
7.00	Excess of customary charges over reasonable cost (complete only i	f line 16 exceeds	297, 408	0	17.
3. 00	line 4) (see instructions)	Elina 4 avaaada lin		0	18.
5. 00	Excess of reasonable cost over customary charges (complete only i 16) (see instructions)	I ITTIE 4 exceeds ITTI	ue U	0	10.
9.00	Interns and Residents (see instructions)		0	0	19.
). 00). 00	Cost of physicians' services in a teaching hospital (see instruct	ions)	0	0	20.
1.00	Cost of covered services (enter the lesser of line 4 or line 16)		326, 103	0	21.
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be com	oleted for PPS provi			
2.00	Other than outlier payments	•	0	0	22.
3.00	Outlier payments		0	0	23.
4.00	Program capital payments		0		24.
5.00	Capital exception payments (see instructions)		0		25
5.00	Routine and Ancillary service other pass through costs		0	0	
7.00	Subtotal (sum of lines 22 through 26)		0	0	27.
3.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.
9.00	Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT		326, 103	0	29.
D. 00	Excess of reasonable cost (from line 18)		0	0	30.
1.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		326, 103	0	
2.00	Deducti bl es		020,100	0	
3.00			0	0	
1.00	Allowable bad debts (see instructions)		0	0	34.
5.00	Utilization review		0		35.
6. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	326, 103	0	36.
7.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.
3.00	Subtotal (line 36 ± line 37)		326, 103	0	
. 00	Direct graduate medical education payments (from Wkst. E-4)		0	-	39
0.00	Total amount payable to the provider (sum of lines 38 and 39)		326, 103	0	
. 00	Interim payments		282, 563	0	
2.00	Balance due provider/program (line 40 minus line 41)	with CMS Dub 15 0	43, 540	0	42
3.00	Protested amounts (nonallowable cost report items) in accordance chapter 1, §115.2	WI LII UWO FUD IO-2,	0	0	43

ALANCE S	nancial Systems PULASKI MEMORI SHEET (If you are nonproprietary and do not maintain e accounting records, complete the General Fund column onl	Provi der		Period: From 10/01/2013	u of Form CMS- Worksheet G	
una-type	e accounting records, comprete the General Fund corumn on	y)		To 09/30/2014	Date/Time Pre 3/30/2015 3:5	
		General Fund	Specific Purpose Fund	Endowment Fund		
CU	RRENT ASSETS	1.00	2.00	3.00	4.00	
	ash on hand in banks	2, 588, 706	(0 0	0	1
	emporary investments	500, 000		0 0	0	
00 No	otes receivable	0	(0 0	0	3
	counts receivable	4, 458, 278	(0 0	0	
	ther receivable	0		0	0	
	lowances for uncollectible notes and accounts receivable nventory	774, 598			0	
	repaid expenses	0			0	
	ther current assets	224, 168	(0 0	0	
). 00 Du	ue from other funds	0		0 0	0	10
	otal current assets (sum of lines 1–10)	8, 545, 750	(0 0	0	11
	XED ASSETS	400.075				1 4 6
	and and improvements	488, 375			0	
	ccumulated depreciation				0	
1	uildings	9, 053, 874	(0 0	0	
	ccumulated depreciation	0	(0 0	0	
1	easehold improvements	0		0 0	0	
	ccumulated depreciation	0		0 0	0	
	xed equipment ccumulated depreciation				0	
	itomobiles and trucks				0	21
1	ccumul ated depreciation	0		0 0	0	
	ajor movable equipment	0	(0 0	0	
I. 00 Ac	ccumulated depreciation	0	(0 0	0	24
	nor equipment depreciable	0		0 0	0	
	ccumulated depreciation	0		0 0	0	
	T designated Assets ccumulated depreciation				0	
	nor equi pment-nondepreci abl e				0	
	otal fixed assets (sum of lines 12-29)	9, 542, 249		0	0	
OT	HER ASSETS					
	nvestments	0		0 0	0	
	eposits on leases	0		0 0	0	
	ue from owners/officers :her assets				0	
	otal other assets (sum of lines 31-34)				0	
	otal assets (sum of lines 11, 30, and 35)	18, 087, 999		0 0	0	
	RRENT LI ABI LI TI ES					
	ccounts payable	1, 863, 579		0 0	0	
	alaries, wages, and fees payable	1, 438, 563		0 0	0	
	ayroll taxes payable	400.027			0	
	otes and loans payable (short term) eferred income	490, 837			0	
1	ccelerated payments	0		0	0	42
	ue to other funds	0	(o o	0	
1	ther current liabilities	919, 549		0 0	0	
	otal current liabilities (sum of lines 37 thru 44)	4, 712, 528	(0 0	0	45
	NG TERM LIABILITIES	0			0	
	ortgage payable otes payable	0			0	
	nsecured Loans	0			0	
	cher long term liabilities	3, 739, 159		0 0	0	
). 00 To	otal long term liabilities (sum of lines 46 thru 49	3, 739, 159	(o o	0	50
	otal liabilites (sum of lines 45 and 50)	8, 451, 687		0 0	0	51
	PITAL ACCOUNTS	0 (0) 010		1 1		
	eneral fund balance becific purpose fund	9, 636, 312				52
	poor created - endowment fund balance - restricted			0		54
	phor created - endowment fund balance - unrestricted			0		55
	overning body created - endowment fund balance			0		56
7.00 PI	ant fund balance - invested in plant				0	
	ant fund balance - reserve for plant improvement,				0	58
	eplacement, and expansion	0 (0) 010			~	
	otal fund balances (sum of lines 52 thru 58) otal liabilities and fund balances (sum of lines 51 and	9, 636, 312 18, 087, 999			0	
J. UU IU))	10,007,999	'	- U	0	יו טע

Heal th	Financial Systems	PULASKI MEMORIA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
STATEN	IENT OF CHANGES IN FUND BALANCES		Provi der	CCN: 151305	Period: From 10/01/2013 To 09/30/2014		pared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3,00	4.00	E 00	
$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ 17.00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)		2:00 10,788,201 -1,151,889 9,636,312 0 9,636,312		4.00 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 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 9, 636, 312		0		18. 00 19. 00
		Endowment Fund	PI ant	Fund			
	r	6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0 0 0 0 0			0 0 0 0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

To 09/30/2014 District in 3/30/2014 PART I - PATIENT REVENUES Inpatient Outpatient Energial Inpatient Routine Services 1.00 2.00 3/0 1.00 Hospital 1.808.568 1.808.568 1.808.568 1.00 SUBROVIDER - IFF 1.808.568 1.808.568 1.808.568 1.00 Subrovide Response 0 0 0 5.00 Subrovide Response 0 0 0 5.00 Subrovide Response 0 0 0 5.00 Subrovide Response 0 0 0 0 5.00 Subrovide Response 0 0 0 0 0 5.00 Subrovide Response 0 <th></th> <th>Financial Systems PULASKI MEMORIAL I IENT OF PATIENT REVENUES AND OPERATING EXPENSES</th> <th></th> <th>CCN: 151305</th> <th>Peri od:</th> <th>u of Form CMS-2 Worksheet G-2</th> <th></th>		Financial Systems PULASKI MEMORIAL I IENT OF PATIENT REVENUES AND OPERATING EXPENSES		CCN: 151305	Peri od:	u of Form CMS-2 Worksheet G-2	
Cost Center Description Inpatient Outpatient Total PART I - PATLENT REVENUES 0 2.00 3.00 Ceneral Inpatient Routine Services 1.00 400,556 1.00 Mospital 1.00 1.00 1.00 2.00 SUBPROVIDER - IPF 1.908,568 1.90 1.90 SUBPROVIDER - IPF 0 0 0 0 SUBPROVIDER - INF 0 0 1.808,568 1.808 OWINSING FACILITY 0 0 1.808,568 1.808 Intensive Care Type Inpatient Hospital Services (sum of lines 10 and 16) 1.808,568 1.808 10 10 Thressive Care UNIT 0 3.406,5511 4.00 10 0 0 1.808,568 1.808,568 1.808,568					From 10/01/2013	Parts I & II	pared:
PART I - PATIENT REVENUES General Inpatient Routine Services 1.00 Mospital 0000 0000 0000 00000 00000000 000000000000000000000000000000000000		Cost Center Description				Total	
General Inpatient Routine Services 1.00 Hospital 1,808,568 1,808,568 2.00 SUBPROVIDER - IPF 0 1,808,568 1,80 4.00 SUBPROVIDER - IPF 0 0 0 0 5.00 Swing bed - SWF 0 0 0 0 6.00 Swing bed - SWF 0 0 0 0 7.00 SkitLeb NURSING FACILITY 0 0 0 1,808,568 1,80 10.00 Total general inpatient Hospital Services 0 0 0 0 11.00 Total general inpatient routine care services (sum of lines 1-9) 1,808,568 1,80 11.00 Total Intensive Care type inpatient hospital services (sum of lines 10 and 16) 1,808,568 1,80 12.00 CRRMARY CARE UNIT T 0 0 0 0 13.00 Untensive care type inpatient hospital services (sum of lines 10 and 16) 1,808,568 1,80 19.00 Outpatient services 0 0 0 10.00 RE				1.00	2.00	3.00	
1.00 Hospital 1,808,568 1,808,568 1,808,568 2.00 SUBPROVIDER - IRF 0 0 3.00 SUBPROVIDER - IRF 0 0 5.00 Swing bed - SWF 0 0 6.00 Swing bed - SWF 0 0 7.00 SKILLED NURSING FACILITY 0 0 8.00 NURSING FACILITY 0 0 7.00 SKILLED NURSING FACILITY 0 0 8.00 NURSING FACILITY 0 0 9.00 Ottpartisely Care Type Inpattent Hospital Services 0 0 11.00 Intensive Care Type Inpattent Hospital Services (sum of lines 0 0 10.00 Ottal Intensive Care Spriphetient services 13.3.371 3,965,551 4,00 10.00 ORDEALLY OUALITED EMERTH CENTER 0 0 0 0 11.15 0 Total adultinth crite OETER (D.P.) 0							-
2:00 SUBPROVIDER - IPF 00 SUBPROVIDER - IFF 0.00 SUPROVIDER - IFF 0.00 SUPROVIDER - SWF 0.00 Swing bed - SWF 0.00 Swing bed - SWF 0.00 Swing bed - SWF 0.00 Sking bed - SWF 0.00 Theres Net Call TY 0.00 Total general inpatient Hospital Services 11.00 Intensive Care Type Inpatient Hospital Services 11.00 BURN INTERSIVE CARE UNIT 12.00 CORONARY CARE UNIT 13.00 BURN INTENSIVE CARE UNIT 14.00 SURCIAL INTENSIVE CARE UNIT 15.00 Total intensi ve care type inpatient hospital services (sum of lines 10 and 16) 11.15) Instruct Care Services (sum of lines 10 and 16) 11.150 Instruct Services 11.10 Inpatient routine care services (sum of lines 10 and 16) 12.00 RORONARC CARE UNIT 12.00 RORONARC CARE UNIT 13.30 30 11.40 SURCIAL INFERSIVE CARE UNIT 11.00 Instruct Services				1 000 5	(a)	1 000 5/0	1
3.00 SUBPROVIDER - IRF 0 JUNE 0 JUNE 0 JUNE 0 JUNE 0 JUNE 0 0 JUNE 0 0 JUNE 0 JUNE 0 JUNE 0 JUNE 0 JUNE J				1, 808, 5	68	1, 808, 568	
4.00 SUBPROVIDER 0 50 Sking bed - NF 0 500 Sking bed - NF 0 0 6.00 Sking bed - NF 0 0 7.00 SkilleD NURSING FACILITY 0 0 9.00 OTHER LONG TERM CARE 1,808,568 1,800 100 Thremsive Care Type inpatient care services (sum of lines 1-9) 1,808,568 1,800 11.00 ORNENVIC CARE UNIT 0 0 0 12.00 CORONARY CARE UNIT 0 0 0 0 11.00 INTENSIVE CARE CARE (SPECIFY) 0 0 1,808,568 1,808 11.15) 0 THER SPECIAL CARE (SPECIFY) 0 1.808,568 1,807 10.00 TRENS VE CARE (SPECIFY) 13,371 3,665,511 4,09 10.00 THER SPECIAL CARE (SPECIFY) 133,371 3,665,511 4,09 10.00 RUBLATORY SURGICAL CENTER 9,00,022,605 29,468,852,511 4,09 11.00 FEDERALLY OUALIFIED HEALTH CENTER 0 3							2.0
5.00 Swing bed - SNF 0 00 Swing bed - SNF 0 00 SKILLED NURSING FACILITY 0 10.00 Total general inpatient care services (sum of lines 1-9) 1, 808, 568 1, 80 11.00 Total general inpatient Hospital Services 0 1, 808, 568 1, 80 11.00 INTENSIVE CARE UNIT 0 0 0 1, 808, 568 1, 80 12.00 CORONARY CARE UNIT 0 0 0 0 0 13.00 BURN INTENSIVE CARE UNIT 0 0 1, 808, 568 1, 80 1115 Total intensive care type inpatient hospital services (sum of lines 10 and 16) 1, 808, 568 1, 80 1115 Total intensive care type inpatient cervices 133, 371 3, 965, 511 4, 09 00 REALTH ACREVY SURGICAL CENTER 0							3.0
6.00 Swing bed - NF 0 0 00 SkilleD NURSING FACILITY 0 0 0.00 Total general inpatient care services (sum of lines 1-9) 1, 808, 568 1, 808 10.00 Total general inpatient care services (sum of lines 1-9) 1, 808, 568 1, 808 11.00 INTENSIVE CARE UNIT 0 0 0 12.00 CORONARY CARE UNIT 0 0 0 13.00 BURN INTENSIVE CARE UNIT 0 0 1.1.5) 0 11.10 TOTAL intensive care type inpatient hospital services (sum of lines 10 and 16) 1, 808, 568 1, 808 11.00 Total inpatient routine care services (sum of lines 10 and 16) 1, 808, 568 1, 808 11.11 Tarty services 133, 371 3, 965, 511 4, 00 0.00 RURAL HEALTH CLNIC 14, 00 364, 968 362 11.00 HEALTH ACENCY 0 0 712, 054 711 200 HOME HEALTH ACENCY 0 65, 409 6 712, 054 712 200					0	0	4.0
7.00 SkillED MURSING FACILITY 1,808,568 1,80 8.00 NURSING FACILITY 1,808,568 1,80 10.00 Total general inpatient care services (sum of lines 1-9) 1,808,568 1,80 11.00 INTERSIVE CARE UNIT 0 1,808,568 1,80 11.00 UNRARY CARE UNIT 0 0 0 0 13.00 BURN INTENSIVE CARE UNIT 0 0 0 0 14.00 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 11.15) OTAtal intensive care type inpatient hospital services (sum of lines 10 and 16) 1,808,568 29,468,582 38,49 11.00 Outpatient services 133,371 3,965,511 4,09 364,968 36 00 REDRALLY QUALIFIED HEALTH CENTER 0 0 712,054 71 20.0 HOME KAENY 0 0 65,409 6 12.00 MURLATORY SURGICAL CENTER (D. P.) 0 65,409 6 388,936,489 50,14 20.0 HOME LATTH					-	0	
8.00 NURSING FACILITY 9.00 OTHER LONG TERM CARE 1.808,568 1.80 10.00 Total general inpatient care services (sum of lines 1-9) 1.808,568 1.80 11.00 INTENSIVE CARE UNIT 0 0 0 12.00 CORONARY CARE UNIT 0 0 0 14.00 SURGICAL INTENSIVE CARE UNIT 0 0 0 10.00 Total intensive care type inpatient hospital services (sum of lines 10 and 16) 1.808,568 1.80 11.05 Ottal intensive care services (sum of lines 10 and 16) 1.808,568 1.80 11.01 Optatient services 9.022,605 29,468,582 38,49 10.00 RURAL HEALTH CLINIC 0 344,968 36 0.00 RURAL HEALTH CLINIC 0 344,968 36 0.00 RURAL HEALTH CLINIC CES 0 344,968 36 0.00 RURAL HEALTH AGENCY 0 0 0 0 21.00 ROBERALLY OUALTHEATH AGENCY 0 0 0		5			0	0	7.0
9.00 OTHER LONG TERM CARE 1.808,568 1.808,568 10.00 Total general inpatient care services (sum of lines 1-9) 1.808,568 1.800 11.00 INTENSI VE CARE UNIT 0 0 12.00 CORONARY CARE UNIT 0 0 13.00 BURN INTENSI VE CARE UNIT 0 0 14.00 SURG CAL INTENSI VE CARE UNIT 0 0 15.00 OTTAL inpatient routine care services (sum of lines 10 and 16) 1.808,568 1.800 17.10 Total inpatient routine care services (sum of lines 10 and 16) 1.808,568 1.800 0.00 RURAL HEALTH CLINIC 0 364,968 360 10.00 REDERALLY QUALIFIED HEALTH CENTER 0 364,968 360 10.00 RUBULANCE SERVICES 0 65,409 6 22.00 HOME HEALTH AGENCY 0 712,054 711 24.00 CMMC 229,270 4,359,659 4,58 25.00 AMBULATORY SURGICAL CENTER (D.P.) 0 65,409 6 26.01							8.0
10.00 Total general inpatient care services (sum of lines 1-9) 1, 808, 568 1, 808, 568 11.00 INTENSIVE CARE UNIT 0 0 12.00 CORONARY CARE UNIT 0 0 13.00 BURN INTENSIVE CARE UNIT 0 0 14.00 SURGICAL INTENSIVE CARE UNIT 0 0 15.00 Total inpatient routine care services (sum of lines 10 and 16) 1, 808, 568 1, 808 17.00 Total inpatient routine care services (sum of lines 10 and 16) 1, 808, 568 29, 468, 582 38, 49 10.00 RURAL HEALTH CLINIC 13, 371 3, 965, 511 4, 90 00 RURAL HEALTH CLINIC 13, 371 3, 965, 511 4, 90 01.00 RURAL HEALTH CLINIC 13, 371 3, 965, 511 4, 90 01.00 RURAL HEALTH CLINIC 13, 371 3, 965, 511 4, 90 01.00 RURAL HEALTH CLINIC 12, 864 366 11, 206, 578 38, 93 21.00 HOBE HEALTH ACENTER 0 0 65, 409 6 11, 206, 578 38, 936, 489 50, 14 22.00 OMHC HALTH ACENCY							9.0
Intensive Care Type Inpatient Hospital Services Control 11.00 INTENSIVE CARE UNIT 0 12.00 COROMARY CARE UNIT 0 13.00 BURN INTENSIVE CARE UNIT 0 14.00 SURG CAL INTENSIVE CARE UNIT 0 15.00 OTHER SPECIAL CARE (SPECI FY) 0 16.00 Total inpatient routine care services (sum of lines 10 and 16) 1, 808, 568 1, 800 17.00 Total inpatient routine care services (sum of lines 10 and 16) 1, 808, 568 9, 0022, 605 29, 468, 582 38, 49 19.00 Outpatient services 133, 371 3, 965, 511 4, 90 10.00 Total inpatient counces 13, 371 3, 965, 511 4, 90 10.00 REPERALLY QUALIFIED HEALTH CENTER 0 364, 968 36 20.00 RURAL HEALTH CAENCY 0 65, 409 6 21.00 HBULANCE SERVICES 29, 270 4, 39, 66, 458 22.00 HOME HEALTH ACENCY 0 65, 409 6 22.00 HEALTH ACENCY 0 65, 409 6				1, 808, 5	68	1, 808, 568	
11.00 INTENSIVE CARE UNIT 12.00 CORONARY CARE UNIT 12.00 SURGICAL INTENSIVE CARE UNIT 14.00 SURGICAL INTENSIVE CARE UNIT 15.00 THER SPECIAL CARE (SPECIFY) 16.00 Total inpatient routine care services (sum of lines 10 and 16) 1, 808, 568 17.00 Total inpatient routine care services (sum of lines 10 and 16) 1, 808, 568 1, 800 17.00 Total inpatient services 9, 022, 605 29, 468, 582 38, 49 19.00 Outpatient services 133, 371 3, 965, 511 4, 00 00 RURAL HEALTH CLINIC 364, 968 36 36 10.00 FEDERALLY QUALIFIED HEALTH CENTER 0 364, 968 36 11.00 AMBULATORY SURGICAL CENTER (D. P.) 0 65, 409 6 21.00 FEDERALLY QUALIFIED HEALTH CENTER 229, 270 4, 359, 659 4, 58 12.00 AMBULATORY SURGICAL CENTER (D. P.) 0 65, 409 6 23.00 AMBULATORY SURGICAL CENTER (D. P.) 0 11, 206, 678 38, 936, 489 50, 14 24.00 GMHC 26, 417, 238 0	10.00			1,000,0	00	1,000,011	1 10
12:00 CORONARY CARE UNIT 13:00 BURN INTENSIVE CARE UNIT 13:00 BURN INTENSIVE CARE UNIT 14:00 SURGICAL INTENSIVE CARE UNIT 15:00 OTHER SPECIAL CARE (SPECIFY) 16:00 Total intensive care type inpatient hospital services (sum of lines 0 11:15) 0 11:15) 00 Ottal intensive care services (sum of lines 10 and 16) 1.808.668 1.80 11:00 0 0.0142 intensive care services 9,022,605 29,468.582 38,49 19:00 Outpatient services 9,022,605 29,468.582 38,49 19:00 Outpatient services 0 364.968 36 20:00 RURAL HEALTH AGENCY 0 364.968 36 21:00 OME HEALTH AGENCY 0 65,409 6 22:00 HOWE HEALTH AGENCY 0 65,409 6 21:00 OMBULATORY SURGICAL CENTER (D.P.) 0 65,409 6 22:00 HOWE SICIAN PROFESSIONAL FEES 11,206,678 38,936,489 50,14 28:00 Operating expenses (per Wkst. A, column 3, line 200) 0<	11.00			I	0	0	111.0
13:00 BURN INTENSIVE CARE UNIT 14:00 SURGICAL INTENSIVE CARE UNIT 14:00 SURGICAL INTENSIVE CARE UNIT 14:00 SURGICAL INTENSIVE CARE UNIT 15:00 OTHER SPECIAL CARE (SPECIFY) 16:00 Total intensive care type inpatient hospital services (sum of lines 10 and 16) 1,808,568 17:00 Total inpatient routine care services (sum of lines 10 and 16) 1,808,568 1,80 18:00 Ancillary services 9,022,605 29,468,582 38,49 20:00 RURAL HEALTH CLINIC 0 364,968 36 20:00 RURAL HEALTH CLINIC 0 364,968 36 21:00 HOME HEALTH ACENCY 712,054 71 23:00 AMBULANCE SERVICES 712,054 71 24:00 CMHC 0 65,409 6 27:00 PHYSICIANS' PRIVATE OFFICE 229,270 4,359,659 4,58 27:00 PHYSICIANS' PRIVATE OFFICE 229,270 4,359,659 4,58 26:01 PHYSICIANS' PRIVATE OFFICE 229,270 4,359,659 4,58 27:01 PHYSICIANS' PRIVATE OFFICE 229,27					-	-	12.0
15.00 OTHER SPECIAL CARE (SPECIFY) Intensive care type inpatient hospital services (sum of lines 10 and 16) Intensive care type inpatient not the care services (sum of lines 10 and 16) Intensive care type inpatient not the care services (sum of lines 10 and 16) Intensive care type inpatient not the care services (sum of lines 10 and 16) Intensive care type inpatient not the care services (sum of lines 10 and 16) Intensive care type inpatient not the care services (sum of lines 10 and 16) Intensive care type inpatient not the care services (sum of lines 10 and 16) Intensive care type inpatient not the care services (sum of lines 10 and 16) Intensive care type inpatient not the care services (sum of lines 10 and 16) Intensive care type inpatient not the care services (sum of lines 10 and 16) Intensive care type inpatient not the care services (sum of lines 10 and 16) Intensive care type inpatient not the care services (sum of lines 10 and 16) Intensive care type inpatient not the care services (sum of lines 10 and 16) Intensive care type inpatient not the care services (sum of lines 10 and 16) Intensive care type inpatient not the care services (sum of lines 10 and 16) Intensive care type inpatient not the care services (sum of lines 10 and 16) Intensive care type inpatient not the care services (sum of lines 10 and 16) Intensive care type inpatient not the care services (sum of lines 17-27) (transfer column 3 to Wkst. Intensive care type inpatient not the care services (services and the care services and the care services (services and the care services and	13.00	BURN INTENSIVE CARE UNIT					13.0
16.00 Total intensive care type inpatient hospital services (sum of lines 10 and 16) 1, 808, 568 1, 807, 808, 568 17.00 Total inpatient routine care services (sum of lines 10 and 16) 1, 808, 568 29, 468, 582 38, 49 19.00 Outpatient services 13, 371 3, 965, 511 4, 09 19.00 Outpatient Accency 133, 371 3, 965, 511 4, 09 21.00 FEDERALLY OUALIFIED HEALTH CENTER 0 0 0 0 22.00 HOME HEALTH ACENCY 712, 054 712, 054 71 23.00 AMBULATORY SURGICAL CENTER (D. P.) 0 65, 409 6 24.00 CMHC 229, 270 4, 359, 659 4, 58 25.00 MBULATORY SURGICAL CENTER (D. P.) 0 65, 409 6 26.00 HOSPICE 229, 270 4, 359, 659 4, 58 27.00 PHYSICIAN PROFESSIONAL FEES 11, 206, 678 38, 936, 489 50, 14 27.01 PHYSICIAN PROFESSIONAL FEES 229, 270 4, 359, 659 4, 58 29.00 Operating expenses (per Wkst. A, column 3, line 200) 0 0 0 30.	14.00						14.0
11-15) Total inpatient routine care services (sum of lines 10 and 16) 1, 808, 568 1, 80 17.00 Total inpatient routine care services (sum of lines 10 and 16) 1, 808, 568 9, 002, 605 29, 468, 582 38, 49 19.00 Outpatient services 133, 371 3, 965, 511 4, 09 20.00 RURAL HEALTH CLINIC 0 364, 968 36 21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 22.00 HOME HEALTH AGENCY 712, 054 71 23.00 AMBULATORY SURGICAL CENTER (D. P.) 0 65, 409 6 24.00 CMHC 229, 270 4, 359, 659 4, 58 25.00 AMBULATORY SURGICAL CENTER (D. P.) 0 65, 409 6 26.00 HOSPICE 229, 270 4, 359, 659 4, 58 27.01 PHYSICIAN PROFESSIONAL FEES 11, 206, 678 38, 936, 489 50, 14 0 0 0 0 0 0 11, 206, 678 38, 936, 489 50, 14 0 0 0 0 0 0 0 0 0 0 <t< td=""><td>15.00</td><td>OTHER SPECIAL CARE (SPECIFY)</td><td></td><td></td><td></td><td></td><td>15.0</td></t<>	15.00	OTHER SPECIAL CARE (SPECIFY)					15.0
17.00 Total inpatient routine care services (sum of lines 10 and 16) 1,808,568 1,80 18.00 Ancillary services 9,022,605 29,468,582 38,49 19.00 Qutpatient services 133,371 3,965,511 4,09 20.00 RURAL HEALTH CLINIC 0 364,968 366 21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 22.00 HOWE HEALTH AGENCY 712,054 712 71 23.00 AMBULANCE SERVICES 0 65,409 6 24.00 CMHC 229,270 4,359,659 4,58 25.00 AMBULATORY SURGICAL CENTER (D.P.) 0 65,409 6 26.00 HOSPICE 229,270 4,359,659 4,58 27.01 PHYSICI AN SURGICAL FEES 12,864 306 11 26.01 Inter revenues (sum of lines 17-27) (transfer column 3 to Wkst. 11,206,678 38,936,489 50,14 G-3, line 1) - - - - - - 20.00 AbD (SPECIFY) 0 0 0 - - -	16.00	Total intensive care type inpatient hospital services (sum of I	i nes		0	0	16.0
18.00 Ancillary services 9,022,605 29,468,582 38,49 19.00 Outpatient services 133,371 3,965,511 4,09 00.00 RURAL HEALTH CLINIC 0 0 364,968 36 21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 22.00 HOME HEALTH AGENCY 712,054 711 712 054 711 23.00 AMBULATORY SURGICAL CENTER (D.P.) 0 0 0 0 0 0 0 0 24.00 CMHC 0		11-15)					
19.00 Outpatient services 133,371 3,965,511 4,09 20.00 RURAL HEALTH CLINIC 0 364,968 36 21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 22.00 HOME HEALTH AGENCY 0 712,054 71 23.00 AMBULANCE SERVICES 0 65,409 6 24.00 CMHC 229,270 4,359,659 4,58 25.00 AMBULATORY SURGICAL CENTER (D.P.) 0 65,409 6 26.00 HOSPICE 0 65,409 6 27.00 PHYSICIANS' PRIVATE OFFICE 229,270 4,359,659 4,58 28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. 11,206,678 38,936,489 50,14 G-3, line 1) 0 0 0 0 0 0 29.00 Operating expenses (per Wkst. A, column 3, line 200) 0 0 0 0 0 31.00 0 0 0 0 0 0 0 0 32.00 0 0 0 0						1, 808, 568	17.0
20.00 RURAL HEALTH CLINIC 364,968 364 21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 22.00 HOME HEALTH AGENCY 711 300 AMBULANCE SERVICES 712,054 711 24.00 CMHC 0 65,409 6 25.00 AMBULATORY SURGICAL CENTER (D. P.) 0 65,409 6 26.01 PHYSICIANS' PRIVATE OFFICE 229,270 4,359,659 4,58 27.01 PHYSICIANS' PRIVATE OFFICE 12,864 306 1 28.00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 11,206,678 38,936,489 50,14 6-3, line 1) PART 11 - OPERATING EXPENSES 0 0 33,00 33,00 30,00 30,00 0 0 33,00 33,00 30,00 30,00 0 0 0 33,00 30,00 30,00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <		5				38, 491, 187	18.0
21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 22.00 HOME HEALTH AGENCY 712,054 71 23.00 AMBULANCE SERVICES 712,054 71 24.00 CMHC 712,054 71 25.00 AMBULATORY SURGICAL CENTER (D. P.) 0 65,409 66 26.00 HOSPICE 0 65,409 6 27.00 PHYSICIANS' PRIVATE OFFICE 229,270 4,359,659 4,585 27.01 PHYSICIANS' PRIVATE OFFICE 12,864 306 1 28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. 11,206,678 38,936,489 50,14 9.01 PART 11 - OPERATING EXPENSES 0 0 0 0 9.00 Operating expenses (per Wkst. A, column 3, line 200) 0 0 0 0 30.00 ADD (SPECIFY) 0 0 0 0 0 0 30.00 ADD O 0 0 0 0 0 0 0 0 0 30.00 DUCYCI (SPECIFY) 0 0				133, 3		4, 098, 882	
22.00 HOME HEALTH AGENCY 712,054 71 23.00 AMBULANCE SERVICES 712,054 71 24.00 CMHC 0 65,409 6 25.00 AMBULATORY SURGICAL CENTER (D. P.) 0 65,409 6 26.00 HOSPICE 0 65,409 6 27.00 PHYSICIANS' PRIVATE OFFICE 229,270 4,359,659 4,58 28.00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 11,206,678 38,936,489 50,14 6-3, line 1) PART II - OPERATING EXPENSES 26,417,238 0 1 90.00 Operating expenses (per Wkst. A, column 3, line 200) 0 26,417,238 0 31.00 30.00 ADD (SPECIFY) 0 0 0 0 0 33.00 30.00 ADD (SPECIFY) 0						364, 968	
23.00 AMBULANCE SERVICES 24.00 CMHC 25.00 AMBULATORY SURGICAL CENTER (D. P.) 46.00 HOSPICE 0 POPE 0 PHYSICIANS' PRIVATE OFFICE 27.00 PHYSICIANS' PRIVATE OFFICE 27.01 PHYSICIAN PROFESSIONAL FEES 27.01 PHYSICIAN PROFESSIONAL FEES 28.00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. G-3, line 1) PART II - OPERATING EXPENSES 29.00 Operating expenses (per Wkst. A, column 3, line 200) ADD (SPECIFY) 0 33.00 0 34.00 0 35.00 0 0 0 35.00 0 0 0 36.00 0 37.00 DEDUCT (SPECIFY) 0 0 38.00 0 39.00 0 40.00 0					-	0	21.0
24.00 CMHC 25.00 AMBULATORY SURGICAL CENTER (D. P.) 26.00 HOSPICE 0 65,409 6 27.00 PHYSICIANS' PRIVATE OFFICE 229,270 4,359,659 4,58 27.01 PHYSICIAN PROFESSIONAL FEES 12,864 306 1 28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. 11,206,678 38,936,489 50,14 0 ABT II - OPERATING EXPENSES 0 26,417,238 0 29.00 Operating expenses (per Wkst. A, column 3, line 200) 0 26,417,238 30.00 ADD (SPECIFY) 0 0 0 31.00 0 0 0 0 32.00 0 0 0 0 33.00 0 0 0 0 0 36.00 0 0 0 0 0 0 38.00 0 0 0 0 0 0 38.00 0 0 0 0 0 0 38.00 0 0 0 0 0					712, 054	712, 054	
25.00 AMBULATORY SURGICAL CENTER (D. P.) 0 65,409 6 26.00 HOSPICE 0 65,409 6 27.00 PHYSICIANS' PRIVATE OFFICE 229,270 4,359,659 4,58 27.01 PHYSICIANS' PRIVATE OFFICE 12,864 306 1 28.00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 11,206,678 38,936,489 50,14 G-3, line 1) PART II - OPERATING EXPENSES 26,417,238 0 0 90.00 Operating expenses (per Wkst. A, column 3, line 200) 0 0 0 30.00 ADD (SPECIFY) 0 0 0 0 35.00 Total additions (sum of lines 30-35) 0 0 0 0 38.00 0 0 0 0 0 0 36.00 Total additions (sum of lines 30-35) 0 0 0 0 0 38.00 0 0 0 0 0 0 0 0 38.00 0 0 0 0 0 0 0 0 0							23.0
26.00 HOSPICE 0 65,409 6 27.00 PHYSICLANS' PRIVATE OFFICE 229,270 4,359,659 4,58 27.01 PHYSICLAN PROFESSIONAL FEES 12,864 306 1 28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. 11,206,678 38,936,489 50,14 G-3, line 1) PART IL - OPERATING EXPENSES 26,417,238 50,14 90.00 Operating expenses (per Wkst. A, column 3, line 200) 0 26,417,238 33.00 0 0 0 0 33.00 0 0 0 0 33.00 0 0 0 0 34.00 0 0 0 0 35.00 Total additions (sum of lines 30-35) 0 0 0 38.00 0 0 0 0 0 38.00 0 0 0 0 0 38.00 0 0 0 0 0 38.00 0 0 0 0 0 38.00 0 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>24.0</td>							24.0
27.00 PHYSICIANS' PRIVATE OFFICE 229,270 4,359,659 4,58 27.01 PHYSICIAN PROFESSIONAL FEES 12,864 306 1 28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. 11,206,678 38,936,489 50,14 G-3, line 1) PART 11 - OPERATING EXPENSES 26,417,238 0 0 9.00 Operating expenses (per Wkst. A, column 3, line 200) 0 26,417,238 0 30.00 ADD (SPECIFY) 0 0 0 0 0 0 0 33.00 33.00 36.00 0 <td></td> <td></td> <td></td> <td></td> <td>0 (5.400</td> <td>(5.400</td> <td>25.0</td>					0 (5.400	(5.400	25.0
27. 01 PHYSICIAN PROFESSIONAL FEES 12,864 306 1 28. 00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 11,206,678 38,936,489 50,14 G-3, line 1) PART II - OPERATING EXPENSES 26,417,238 26,417,238 0 90. 00 Operating expenses (per Wkst. A, column 3, line 200) 0 26,417,238 0 31. 00 ADD (SPECI FY) 0 0 0 0 0 33. 00 30.00 100 0 0 0 0 0 35. 00 0				220.2		65, 409	
28.00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 11, 206, 678 38, 936, 489 50, 14 G-3, line 1) PART II - OPERATING EXPENSES 29.00 Operating expenses (per Wkst. A, column 3, line 200) 26, 417, 238 30.00 ADD (SPECI FY) 0 31.00 0 0 32.00 0 0 33.00 0 0 34.00 0 0 35.00 0 0 36.00 Total additions (sum of lines 30-35) 0 0 0 0 38.00 0 0 39.00 0 0 40.00 0 0 41.00 0 0							
G-3, line 1) PART II - OPERATING EXPENSES 29.00 Operating expenses (per Wkst. A, column 3, line 200) ADD (SPECIFY) 0 31.00 0 32.00 0 33.00 0 34.00 0 35.00 0 36.00 Total additions (sum of lines 30-35) 0 0 38.00 0 39.00 0 40.00 0 41.00 0			o What			13, 170 50, 143, 167	27.0
PART 11 - OPERATING EXPENSES 29.00 Operating expenses (per Wkst. A, column 3, line 200) ADD (SPECIFY) 0 31.00 0 32.00 0 33.00 0 34.00 0 35.00 0 36.00 Total additions (sum of lines 30-35) 0 0 38.00 0 39.00 0 40.00 0 41.00 0	26.00		U WKSL.	11, 200, 0	10 30, 930, 409	50, 143, 107	20.0
29.00 Operating expenses (per Wkst. A, column 3, line 200) 26, 417, 238 30.00 ADD (SPECIFY) 0 31.00 0 0 32.00 0 0 33.00 0 0 34.00 0 0 35.00 0 0 36.00 Total additions (sum of lines 30-35) 0 38.00 0 0 39.00 0 0 41.00 0 0				1			1
30. 00 ADD (SPECIFY) 0 31. 00 0 32. 00 0 33. 00 0 34. 00 0 35. 00 0 36. 00 Total additions (sum of lines 30-35) 0 37. 00 DEDUCT (SPECIFY) 0 38. 00 0 0 39. 00 0 0 40. 00 0 0	29.00				26, 417, 238		29.0
31.00 0 32.00 0 33.00 0 34.00 0 35.00 0 36.00 Total additions (sum of lines 30-35) 0 37.00 DEDUCT (SPECI FY) 0 38.00 0 0 39.00 0 0 40.00 0 0							30.0
33.00 0 34.00 0 35.00 0 35.00 0 36.00 Total additions (sum of lines 30-35) 0 37.00 DEDUCT (SPECIFY) 0 38.00 0 0 39.00 0 0 40.00 0 0 41.00 0 0							31.0
34.00 0 35.00 0 36.00 Total additions (sum of lines 30-35) 0 37.00 DEDUCT (SPECIFY) 0 38.00 0 0 39.00 0 0 40.00 0 0 41.00 0 0							32.0
35.00 0 36.00 Total additions (sum of lines 30-35) 0 37.00 DEDUCT (SPECIFY) 0 38.00 0 0 39.00 0 0 41.00 0 0	33.00				0		33.0
36.00 Total additions (sum of lines 30-35) 0 37.00 DEDUCT (SPECIFY) 0 38.00 0 0 39.00 0 0 40.00 0 0 41.00 0 0	34.00				0		34.0
37.00 DEDUCT (SPECI FY) 0 38.00 0 0 39.00 0 0 40.00 0 0 41.00 0 0	35.00				0		35.0
38.00 0 39.00 0 40.00 0 41.00 0	36.00	Total additions (sum of lines 30-35)			0		36.0
39.00 0 40.00 0 41.00 0	37.00	DEDUCT (SPECIFY)			0		37.0
40.00 41.00 0					0		38.0
41.00 0							39.0
	40.00						40. C
					0		41.0
	42.00	Total deductions (sum of lines 37-41)			0		42.0
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 26, 417, 238 to Wkst. G-3, line 4)	43.00		(transfer		26, 417, 238		43.0

Heal th	Financial Systems	PULASKI MEMORIAL H	OSPI TAL	In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES		Provider CCN: 151305	Period: From 10/01/2013	Worksheet G-3	
				To 09/30/2014	Date/Time Prep 3/30/2015 3:55	
	La				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part		28)		50, 143, 167	1.00
2.00	Less contractual allowances and discounts on	patients' accounts			25, 642, 650	2.00
3.00	Net patient revenues (line 1 minus line 2)				24, 500, 517	3.00
4.00	Less total operating expenses (from Wkst. G-)		26, 417, 238	
5.00	Net income from service to patients (line 3	minus line 4)			-1, 916, 721	5.00
(00	OTHER I NCOME					(00
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments	aug communication o			0	7.00
8.00 9.00	Revenues from telephone and other miscellane	ous communication se	ervices		0	8.00 9.00
	Revenue from television and radio service				0	9.00 10.00
10.00	Purchase di scounts				0	10.00
11. 00 12. 00	Rebates and refunds of expenses				0	12.00
12.00	Parking lot receipts Revenue from laundry and linen service				0	12.00
13.00	Revenue from meals sold to employees and que	ete			0	13.00
14.00	Revenue from rental of living quarters	515			0	14.00
16.00	Revenue from sale of medical and surgical su	police to other the	a pationto		0	16.00
17.00	Revenue from sale of drugs to other than pat		i patrents		0	17.00
18.00	Revenue from sale of medical records and abs				0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms,				0	19.00
20.00	Revenue from gifts, flowers, coffee shops, a				0	20.00
20.00	Rental of vending machines	na canteen			0	20.00
22.00	Rental of hospital space				0	22.00
23.00	Governmental appropriations				0	23.00
24.00	OTHER REVENUE				710, 373	
24.00	TOTAL NONOPERATING REVENUE (EXPENSE)				54, 459	
25.00	Total other income (sum of lines 6-24)				764, 832	
26.00	Total (line 5 plus line 25)				-1, 151, 889	
27.00	OTHER EXPENSES (SPECIFY)				0	27.00
28.00	Total other expenses (sum of line 27 and sub	scripts)			0	28.00
	Net income (or loss) for the period (line 26				-1, 151, 889	

	Financial Systems		PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ANALYS	IS OF PROVIDER-BASED HOME HEAL	TH AGENCY COSTS		Provider HHA CCN:	1	Period: From 10/01/2013 To 09/30/2014	Worksheet H Date/Time Pre	
						Home Health Agency I	3/30/2015 3:5 PPS	5 pm
		Sal ari es	Employee Benefits	Transportation (see	chased		Total (sum of cols. 1 thru	
		1.00	2.00	instructions) 3.00	Services 4.00	5.00	5) 6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0 0	0	3.00
4.00 5.00	Transportation Administrative and General	0 80, 606	0	0 66, 191		0 0 34,020	0 180, 817	4.00 5.00
5.00	HHA REI MBURSABLE SERVI CES	80,000	0	00, 171		5 54, 020	100, 017	5.00
6.00	Skilled Nursing Care	212, 510				0 0	212, 510	
7.00	Physical Therapy	49, 403	0	-		0 0	49, 403	1
8.00 9.00	Occupational Therapy Speech Pathology	11, 122	0	0			11, 122 2, 910	
10.00	Medical Social Services	0	0	0		0 0	0	10.00
11.00	Home Health Aide	102, 866	0	0		0 0	102, 866	
12.00	Supplies (see instructions)	0	0	0		0 0	0	
13.00 14.00	Drugs DME	0	0	0			0	
11.00	HHA NONREI MBURSABLE SERVI CES				· · · · · · · · · · · · · · · · · · ·			11.00
15.00	Home Dialysis Aide Services	0	0		1	0 C	0	
16.00 17.00	Respiratory Therapy	0	0	0			0	
17.00	Private Duty Nursing Clinic		0			0	0	17.00
19.00	Health Promotion Activities	0	0	0		0 0	0	19.00
20. 00	Day Care Program	0	0	0		0 0	0	20.00
21.00	Home Delivered Meals Program	0	0	0		0 0	0	
22.00 23.00	Homemaker Service All Others (specify)	0	0				0	22.00 23.00
24.00		459, 417	0	66, 191		34, 020		1
		Recl assi fi cati		Adjustments	Net Expenses			
		on	Trial Balance (col. 6 +		for Allocation (col. 8 + col.			
			col . 7)		9)			
	CENERAL CERVILOE COCT CENTERC	7.00	8.00	9.00	10.00			
1.00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	0	0				1.00
1.00	Fixtures		0					1.00
2.00	Capital Related - Movable	0	0	0		D		2.00
3.00	Equipment Plant Operation & Maintenance	0	0	0		o		3.00
4.00	Transportati on	0	0	0		D D		4.00
5.00	Administrative and General	0	180, 817	0	180, 81	7		5.00
6.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	0	212, 510	0	212, 510			6.00
7.00	Physical Therapy	0	49, 403					7.00
8.00	Occupational Therapy	0	11, 122					8.00
9.00	Speech Pathol ogy	0	2, 910					9.00
10.00	Medical Social Services	0	102.0((0		0		10.00
11.00 12.00	Home Health Aide Supplies (see instructions)	0	102, 866 0	0				11.00 12.00
13.00	Drugs	0	0	0		D D		13.00
4 4 00	DME	0	0	0) (C		14.00
14.00	HHA NONREI MBURSABLE SERVI CES	0	0	0				15.00
	Home Dialveis Aide Services		0	-		5		16.00
15.00	Home Dialysis Aide Services Respiratory Therapy	0	0					
15. 00 16. 00	Respiratory Therapy		0	0)	C		17.00
15.00 16.00 17.00 18.00	Respiratory Therapy Private Duty Nursing Clinic		0 0 0	0		C		18.00
15.00 16.00 17.00 18.00 19.00	Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities		0 0 0 0	0 0 0		D D		18.00 19.00
15.00 16.00 17.00 18.00 19.00 20.00	Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program		0 0 0 0 0	0 0 0 0		0 0 0		18.00 19.00 20.00
15.00 16.00 17.00 18.00 19.00 20.00	Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program		0 0 0 0 0 0 0 0 0 0	0 0 0		D D		18.00 19.00
15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00	Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)		0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0		ว ว ว		18.00 19.00 20.00 21.00
15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00	Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service		0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0		D D D D D D		18.00 19.00 20.00 21.00 22.00

Heal th	Financial Systems		PULASKI MEMORI	αι μοςρίται		Inlie	eu of Form CMS-	2552-10
	LLOCATION - HHA GENERAL SERVICE	COST			CCN: 151305	Peri od:	Worksheet H-1	
				HHA CCN:	157078	From 10/01/2013 To 09/30/2014	Date/Time Pre	
						Home Health	3/30/2015 3:5 PPS	<u>15 pm</u>
			Conital Dal	atad Casta		Agency I		
			Capital Rela					
		Net Expenses for Cost	BI dgs & Fi xtures	Movable Equipment	Plant Operation &	Transportati on	Subtotal (cols. 0-4)	
		Allocation	Tratures	Equi pillerit	Maintenance		(COIS. 0-4)	
		(from Wkst. H, col. 10)						
		0	1.00	2.00	3.00	4.00	4A. 00	
1.00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	0		1	1	C	1.00
1.00	Fixtures	0	0					1.00
2.00	Capital Related - Movable Equipment	0		0			C	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	C	3.00
4.00 5.00	Transportation Administrative and General	0 180, 817	0	0		0 0		4.00 5.00
5.00	HHA REI MBURSABLE SERVI CES						100,017	5.00
6.00 7.00	Skilled Nursing Care Physical Therapy	212, 510 49, 403	0	0		0 0	212, 510 49, 403	
8.00	Occupational Therapy	11, 122	0	0		0 0	11, 122	8.00
9. 00 10. 00	Speech Pathology Medical Social Services	2, 910	0	0		0 0	2, 910 C	
11.00	Home Health Aide	102, 866	0	0		0 0	102, 866	
12.00	Supplies (see instructions)	0	0	0		0 0	C	
13.00 14.00	Drugs DME	0	0	0		0 0		
15 00	HHA NONREI MBURSABLE SERVI CES							15 00
15.00 16.00	Home Dialysis Aide Services Respiratory Therapy	0	0	0 0		0 0 0 0		
17.00	Private Duty Nursing	0	0	0		0 0	C	
18.00 19.00	Clinic Health Promotion Activities	0	0	0		0 0		
20.00	Day Care Program	0	0	0		0 0	C	
21.00 22.00	Home Delivered Meals Program Homemaker Service	0	0	0		0 0		
	All Others (specify)	0	0	0	•	0 0	C	
24.00	Total (sum of lines 1-23)	559,628 Administrative	Total (cols.	0	1	0 0	559, 628	3 24.00
		& General	4A + 5)					_
	GENERAL SERVICE COST CENTERS	5.00	6.00					
1.00	Capital Related - Bldg. &							1.00
2.00	Fixtures Capital Related - Movable							2.00
3.00	Equipment Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	180, 817						5.00
6.00	Skilled Nursing Care	101, 437	313, 947					6.00
7.00 8.00	Physical Therapy Occupational Therapy	23, 581 5, 309	72, 984 16, 431					7.00
9.00	Speech Pathol ogy	1, 389	4, 299					9.00
10.00 11.00	Medical Social Services Home Health Aide	0 49, 101	0 151, 967					10.00
12.00	Supplies (see instructions)	49,101	0					12.00
13.00 14.00	Drugs DME	0	0					13.00 14.00
14.00	HHA NONREI MBURSABLE SERVI CES		0					14.00
15. 00 16. 00	Home Dialysis Aide Services Respiratory Therapy	0	0					15.00
	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
	Health Promotion Activities Day Care Program	0	0					19.00 20.00
21.00	Home Delivered Meals Program	0	0					21.00
22. 00 23. 00	Homemaker Service All Others (specify)	0	0 0					22.00 23.00
24.00	Total (sum of lines 1-23)		559, 628					24.00

	Financial Systems		PULASKI MEMORI				u of Form CMS-2	
COST A	LLOCATION - HHA STATISTICAL BAS	il S		Provider HHA CCN:	CCN: 151305 157078	Period: From 10/01/2013 To 09/30/2014	Worksheet H-1 Part II Date/Time Pre 3/30/2015 3:5	pared:
						Home Health	PPS	
		Capital Rel	ated Costs			Agency I		
		. ,	Movable Equipment (DOLLAR VALUE)	(SQUARE FEET)	(MI LEAGE)	onReconciliation	& General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A. 00	5.00	
	GENERAL SERVICE COST CENTERS				1			1 00
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
	Transportation (see	0	0	0		0		4.00
5.00	instructions) Administrative and General	0	0	0		0 -180, 817	378, 811	5.00
	HHA REIMBURSABLE SERVICES	0	0	0		-100, 017	570,011	5.00
	Skilled Nursing Care	0	0	0		0 0	212, 510	6.00
	Physical Therapy	0	0	0		0 0	49, 403	
	Occupational Therapy	0	0	0		0 0	11, 122	8.00
9.00	Speech Pathology	0	0	0		0 0	2, 910	9.00
	Medical Social Services	0	0	0		0 0	0	10.00
11.00	Home Health Aide	0	0	0		0 0	102, 866	11.00
	Supplies (see instructions)	0	0	0		0 0	0	12.00
	Drugs	0	0	0		0	0	
	DME	0	0	0		0 0	0	14.00
	HHA NONREI MBURSABLE SERVI CES				1			1 4 5 4 4
	Home Dialysis Aide Services	0	0	0		0 0	0	
	Respiratory Therapy Private Duty Nursing	0	0	0		0 0	0	
	Clinic	0	0	0		0 0	0	
	Health Promotion Activities		0	0		0 0	0	
	Day Care Program		0	0		0 0	0	1
	Home Delivered Meals Program	0	0	0		0 0	0	
	Homemaker Service	0	0	0		0 0	0	1
	All Others (specify)	0	0	0		0 0	0	1
24.00	Total (sum of lines 1-23)	0	0	0		0 -180, 817	378, 811	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0		0	180, 817	25.00
26.00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0.0000	00	0. 477328	26.00

	TION OF GENERAL SERVICE COSTS 1	O HHA COST CEN	TERS	Provi der	CCN: 151305	Peri od:	Worksheet H-2	
				HHA CCN:		From 10/01/2013 To 09/30/2014	Part I Date/Time Pre 3/30/2015 3:5	
						Home Health Agency I	PPS	
	Cost Center Description	HHA Trial Balance (1)	CAPI TAL RELATED COSTS NEW BLDG & FI XT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	_
		0	1.00	4.00	4A	5.00	7.00	
.00 .	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to 6 decimal places.	0 313, 947 72, 984 16, 431 4, 299 0 151, 967 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		144, 092 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	313, 94 72, 98 16, 43 4, 29 151, 96	7 52,031 14 12,096 11 2,723 12 712 0 0 0	10, 292 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.0 3.0 4.0 5.0 6.0 7.0 8.0 10.0 11.0 12.0 14.0 15.0 14.0 15.0 17.0 18.0 19.0 19.0 10.0 11.0 12.0 13.0 14.0 15.0 17.0 18.0 19.0
	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	NURSI NG ADMI NI STRATI C	CENTRAL N SERVI CES & SUPPLY	PHARMACY	
00	Administrative and General	8.00	9.00 2,861	10.00	13.00	14.00 0 0	15.00 0) 1.
00 00 00 00 00 00 00 00 00 00 00 00 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs		0 0 0 0 0 0 0 0 0 0					2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 14. 15. 14. 15. 14. 15. 14. 15. 14. 15. 14. 15. 14. 15. 14. 15. 14. 15. 14. 15. 14. 14. 14. 14. 14. 14. 14. 14. 14. 14

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

LLOCATION OF GENERAL SERVICE COSTS T	O HHA COST CENT	TERS	Provider HHA CCN:		Period: From 10/01/2013 To 09/30/2014	Date/Time Pre	pare
					Home Health	3/30/2015 3:55 PPS	5 pm
Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments		Allocated HHA A&G (see Part II)	
	16.00	17.00	24.00	25.00	26.00	27.00	
 Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs O Home Dialysis Aide Services O Respiratory Therapy O Clinic O Home Delivered Meals Program O Home Delivered Meals Program O Home Delivered Meals Program O Total (sum of lines 1-19) (2) O Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to 	7, 559 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	198, 577 365, 978 85, 080 19, 154 5, 011 0 177, 152 0 0 177, 152 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 198, 577 0 365, 978 0 85, 080 0 19, 154 0 5, 011 0 0 0 177, 152 0 0	111, 401 25, 898 5, 830 1, 525 0 53, 923 0 53, 923 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4 5 6 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20.
6 decimal places. Cost Center Description	Total HHA Costs						
 Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME OME Home Dialysis Aide Services Respiratory Therapy OR Private Duty Nursing OCIninc OBAY Care Program OHome Delivered Meals Program OHome Delivered Service OAII Others (specify) OUTatal (sum of lines 1-19) (2) OUTA (sum of lines 1-19) (2) OUTA (sum of line 1, rounded to 6 decimal places. 	28.00 477,379 110,978 24,984 6,536 0 231,075 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 20. 21.

⁽¹⁾ Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Heal th	Financial Systems		PULASKI MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOC/ BASI S	ATION OF GENERAL SERVICE COSTS 1	O HHA COST CEN	TERS STATISTIC	AL Provider HHA CCN:	CCN: 151305 157078	Period: From 10/01/2013 To 09/30/2014	Worksheet H-2 Part II Date/Time Pre 3/30/2015 3:5	pared:
						Home Health	PPS	
		CAPI TAL				Agency I		
	Cost Center Description	RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI & GENERAL (ACCUM. COST)	/E OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVICE (POUNDS OF LAUNDRY)	
1 00		1.00	4.00	5A	5.00	7.00	8.00	1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) Total cost to be allocated Unit cost multiplier	524 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	459, 417 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		313, 94 72, 94 16, 4 4, 24 151, 94 151, 94 151, 94 151, 94 0, 157 CENTRAL	47 0 34 0 31 0 99 0 0 0 <	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 2, 00\\ 3, 00\\ 4, 00\\ 5, 00\\ 6, 00\\ 7, 00\\ 8, 00\\ 9, 00\\ 10, 00\\ 11, 00\\ 12, 00\\ 13, 00\\ 14, 00\\ 15, 00\\ 16, 00\\ 17, 00\\ 18, 00\\ 19, 00\\ 20, 00\\ 21, 00\\ \end{array}$
			SERVED)	(DI RECT NRSI NG HRS)	(100%)		(GROSS CHARGES)	
1 00		9.00	10.00	13.00	14.00	15.00	16.00	1.00
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ \end{array}$	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) Total cost to be allocated Unit cost multiplier	524 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ \end{array}$

Health Financial System	s		PULASKI MEMORIAL	HOSPI TAL			In Lie	u of Form CMS-2	2552-10
ALLOCATION OF GENERAL S	SERVICE COSTS TO	O HHA COST CENT	FERS STATI STI CAL	Provi der	CCN: 151	305	Period:	Worksheet H-2	
BASIS				HHA CCN:	15	7078	From 10/01/2013 To 09/30/2014	Part II Date/Time Pre	hared
					15	1010	10 07/30/2014	3/30/2015 3:5	
							Home Health	PPS	<u> </u>
							Agency I		
Cost Center	Description	SOCIAL SERVICE							
		(ALLOCATI ON							
		OF TIME)							
		17.00							
1.00 Administrative a		0							1.00
2.00 Skilled Nursing		0							2.00
3.00 Physical Therapy		0							3.00
4.00 Occupational The		0							4.00
5.00 Speech Pathol ogy		0							5.00
6.00 Medical Social S		0							6.00
7.00 Home Health Aide		0							7.00
8.00 Supplies (see in	structions)	0							8.00
9.00 Drugs		0							9.00
10.00 DME		0							10.00
11.00 Home Dialysis Ai		0							11.00
12.00 Respiratory Ther		0							12.00
13.00 Private Duty Nur	sing	0							13.00
14.00 Clinic	A = + !! +!	0							14.00
15.00 Heal th Promotion		0							15.00
16.00 Day Care Program 17.00 Home Delivered M		0							16. 00 17. 00
17.00 Home Delivered M 18.00 Homemaker Servic		0							17.00
19.00 All Others (spec		0							18.00
20.00 Total (sum of li		0						-	19.00 20.00
21.00 Total cost to be		0							20.00
22.00 Unit cost to be		0. 000000							21.00
22.00 joint cost multip		0.000000						1	22.00

Heal th	n Financial Systems		PULASKI MEMORI	I AL HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
	TIONMENT OF PATIENT SERVICE COST	S			CCN: 151305	Peri od:	Worksheet H-3	
				HHA CCN:	157078	From 10/01/2013 To 09/30/2014		
				Ti tl	e XVIII	Home Health Agency I	PPS	
	Cost Center Description	From, Wkst.	Facility Costs	Shared	Total HHA	Total Visits	Average Cost	
	p	H-2, Part I,	(from Wkst.	Ancillary	Costs (cols.		Per Visit	
		col. 28, line	H-2, Part I)	Costs (from	+ 2)		(col. 3 ÷ col.	
			1.00	Part II)	2.00	4.00	4)	
	PART I - COMPUTATION OF LESSER		1.00	2.00	3.00		5.00	
	BENEFICIARY COST LIMITATION	OF AGGREGATE P	RUGRAM COST, A	GOREGATE OF T		ITATION COST, O	`	
	Cost Per Visit Computation	1	r	1	1	- 1	1	
1.00	Skilled Nursing Care	2.00			477, 3			1.00
2.00	Physical Therapy Occupational Therapy	3.00				-		
3.00 4.00	Speech Pathol ogy	4. 00 5. 00			24,9 0 6,5			
4.00 5.00	Medical Social Services	6. 00			0, 5	0 0		
6.00	Home Heal th Ai de	7.00			231, 0			•
7.00	Total (sum of lines 1-6)		850, 952					7.00
					Program Visi			
					P	art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject Deductibles			
					Coi nsurance			
		0	1.00	2.00	3.00	4.00	5.00	
8.00	Limitation Cost Computation Skilled Nursing Care		99915	106	1, 3	26		8.00
8.00 8.01	Skilled Nursing Care		23844			0		8.00
9.00	Physical Therapy		99915	45		25		9.00
9.01	Physical Therapy		23844	(0		9.01
10.00	Occupational Therapy		99915	e	5 1	64		10.00
10.01	Occupational Therapy		23844	0		0		10.01
11.00	Speech Pathology		99915	0		46		11.00
11.01	1 35		23844	0	D	0		11.01
12.00			99915	0		0		12.00
12.01	Medical Social Services		23844	(0		12.01
13.00			99915	52		70		13.00
13.01	Home Heal th Ai de		23844	(0		13.01
14.00	Total (sum of lines 8-13) Cost Center Description	From Wkst. H-2	Facility Costs	209 Shared	7 3,0 Total HHA	Total Charges	Ratio (col. 3	14.00
	cost center bescription	Part I, col.	(from Wkst.	Ancillary	Costs (col s.		÷ col. 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Record)		
				Part II)				
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Comput		-		.1			
15.00		8.00						
16.00	Cost of Drugs	9.00	Program Visits		Cost of	0 0	0. 000000	16.00
					Servi ces			
			Par	t B		Part B		
	Cost Center Description	Part A	Not Subject to	Subject to	Part A	Not Subject to	Subject to	
			Deductibles &	Deductibles &		Deductibles &		
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
		6.00	7.00		9.00		11.00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	UF AGGREGATE F	KUGRAM CUSI, A	IGGREGATE UF I	1E PRUGRAM LI	MITATION COST, O	τ	
1 00	Cost Per Visit Computation	101	1 00/	1	24.5	10 477 000		1 00
1.00	Skilled Nursing Care	106			36, 5			1.00
2.00	Physical Therapy Occupational Therapy	45			6, 5			2.00
3.00 4.00	Speech Pathology	6			8	72 23, 823 0 6, 681		3.00 4.00
4.00 5.00	Medical Social Services	0				0 0,081		4.00 5.00
5.00 6.00	Home Heal th Ai de	52			5, 2			6.00
7.00	Total (sum of lines 1-6)	209			49, 2			7.00
		207	0,071	1		27.7001	1	

Cost Center Description Limitation Cost Computation Skilled Nursing Care			HHA CCN:	157078	From 10/01/2013 To 09/30/2014	Date/Time Pre	pared
Limitation Cost Computation Skilled Nursing Care						3/30/2015 3:5	5 nm
Limitation Cost Computation Skilled Nursing Care			Ti tl	e XVIII	Home Health Agency I	PPS	<u>o piii</u>
Skilled Nursing Care	6.00	7.00	8.00	9.00	10.00	11.00	
Skilled Nursing Care	0.00	7.00	8.00	9.00	10.00	11.00	
Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Medical Social Services							8. (8. (9. (10. (10. (11. (11. (12. (12. (
							13.0
							13.0
Inter (sum of Times 6-13)	Prog	ram Covered Cha	rges	Cost of Services			14.0
Cost Center Description	Part A	Not Subject to	Subject to Deductibles &	Part A	Part B Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	6.00	7.00	8.00	9.00	10.00	11.00	
	ations						
			0				15.0
Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00						
	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	2	
Cost Per Visit Computation		-					
Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	111, 851 24, 695						1. (2. (3. (4. (
Medical Social Services Home Health Aide Total (sum of Lipos 1.6)	83, 680						5. 6. 7.
Cost Center Description							- /.
Limitation Cost Computation	12.00						-
Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy							8. 8. 9. 9. 10.
Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Medical Social Services Home Health Aide							10. 10. 11. 11. 12. 12. 13. 13.
	Occupational Therapy Speech Pathology Medical Social Services Medical Social Services Home Heal th Aide Total (sum of lines 8-13) Cost Center Description Cost Center Description Cost of Medical Supplies Cost of Drugs Cost Center Description PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Heal th Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Physical Therapy Occupational Therapy Speech Pathology Physical Therapy Physical Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Medical Social Services	Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 8-13) Prog Cost Center Description Cost Center Description Cost of Medical Supplies Cost of Medical Supplies Cost of Drugs Cost Center Description Total Program Cost Center Description Total Program Cost Center Description Cost Center Description Total Program Cost Center Description Total Program Cost Center Description Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Kedical Social Services Medical Social Services Medical Social Services Home Health Aide Total (sum of lines 1-6) Total (sum of lines 1-6) Total (sum of lines 1-6) Total (sum of lines 2-6) Total (sum of lines 2-6) Total (sum of lines 2-6) Total (sum of lines 2-6) <td>Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Home Heal th Aide Total (sum of lines 8-13) Part A Cost Center Description Cost Center Description Supplies and Drugs Cost Computations Cost of Medical Supplies Cost Center Description Cost Center Description Cost Center Description Cost of Medical Supplies Cost Center Description Cost Per Visit Computation Skilled Nursing Care Physical Therapy Dithitation Cost Computation Skilled Nursing Care Physical Therapy <!--</td--><td>Occupational Therapy Speech Pathol ogy Medical Social Services Medical Social Services Mem Health Aide Total (sum of lines 8-13) Cost Center Description Cost Center Description Cost of Medical Supplies Cost of Medical Supplies Cost of Medical Supplies Cost Center Description Cost Center Description Skilled Nursing Care Physical Therapy Speech Pathol ogy Medical Social Services Killed Nursing Care Skilled Nursing Care Skilled</td><td>Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Home Health Aide Total (sum of Lines 8-13) Program Covered Charges Cost Center Description Part A Part A Part A Not Subject to s Cost Center Description Cost Pervisit Computations Skilled Nursing Care Physical Therapy Cuptal Charles 118,890 Physical Therapy Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description</td><td>Occupational Therapy Speech Pathology Image: Construct of the second second</td><td>Occupational Therapy Speech Pathology Image: Construct on the second second</td></td>	Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Home Heal th Aide Total (sum of lines 8-13) Part A Cost Center Description Cost Center Description Supplies and Drugs Cost Computations Cost of Medical Supplies Cost Center Description Cost Center Description Cost Center Description Cost of Medical Supplies Cost Center Description Cost Per Visit Computation Skilled Nursing Care Physical Therapy Dithitation Cost Computation Skilled Nursing Care Physical Therapy </td <td>Occupational Therapy Speech Pathol ogy Medical Social Services Medical Social Services Mem Health Aide Total (sum of lines 8-13) Cost Center Description Cost Center Description Cost of Medical Supplies Cost of Medical Supplies Cost of Medical Supplies Cost Center Description Cost Center Description Skilled Nursing Care Physical Therapy Speech Pathol ogy Medical Social Services Killed Nursing Care Skilled Nursing Care Skilled</td> <td>Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Home Health Aide Total (sum of Lines 8-13) Program Covered Charges Cost Center Description Part A Part A Part A Not Subject to s Cost Center Description Cost Pervisit Computations Skilled Nursing Care Physical Therapy Cuptal Charles 118,890 Physical Therapy Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description</td> <td>Occupational Therapy Speech Pathology Image: Construct of the second second</td> <td>Occupational Therapy Speech Pathology Image: Construct on the second second</td>	Occupational Therapy Speech Pathol ogy Medical Social Services Medical Social Services Mem Health Aide Total (sum of lines 8-13) Cost Center Description Cost Center Description Cost of Medical Supplies Cost of Medical Supplies Cost of Medical Supplies Cost Center Description Cost Center Description Skilled Nursing Care Physical Therapy Speech Pathol ogy Medical Social Services Killed Nursing Care Skilled	Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Home Health Aide Total (sum of Lines 8-13) Program Covered Charges Cost Center Description Part A Part A Part A Not Subject to s Cost Center Description Cost Pervisit Computations Skilled Nursing Care Physical Therapy Cuptal Charles 118,890 Physical Therapy Cost Center Description Cost Center Description Cost Center Description Cost Center Description Cost Center Description	Occupational Therapy Speech Pathology Image: Construct of the second	Occupational Therapy Speech Pathology Image: Construct on the second

Heal th	Financial Systems		PULASKI MEMORI	AL H	OSPI TAL		_	In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF PATIENT SERVICE COST	S			Provi der	CCN: 151305	Peri		Worksheet H-3	
					HHA CCN:	157078		m 10/01/2013 09/30/2014	Part II Date/Time Pre 3/30/2015 3:5	
					Ti tl	e XVIII		ome Health	PPS	
								Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge	То	tal HHA	HHA Shared	Т	Fransfer to		
		Part I, col.	Ratio	Char	ge (from	Ancillary		Part I as		
		9, line		pr	ovi der	Costs (col.	1	Indi cated		
				re	ecords)	x col. 2)				
		0	1.00		2.00	3.00		4.00		
	PART II - APPORTIONMENT OF COS	T OF HHA SERVIC	CES FURNI SHED B	Y SHA	ARED HOSPI	TAL DEPARTME	NTS			
1.00	Physical Therapy	66.00	0. 506278		0)	0co	ol. 2, line 2	. 00	1.00
2.00	Occupational Therapy	67.00	0. 418792		0)	0co	ol. 2, line 3	. 00	2.00
3.00	Speech Pathology	68.00	0. 688913		0)	0co	ol. 2, line 4	. 00	3.00
4.00	Cost of Medical Supplies	71.00	0. 303625		0		0 co	ol. 2, line 1	5. 00	4.00
5.00	Cost of Drugs	73.00	0. 252171		0		0co	ol. 2, line 1	6. 00	5.00

	ATION OF HHA REIMBURSEMENT SETTLEMENT	Provi der	CCN: 151305	Peri od:		Worksheet H-4	
		HHA CCN:	157078	From 10/0 To 09/3	01/2013 30/2014	Part I-II Date/Time Pre 3/30/2015 3:5	
		Ti tl	e XVIII	Home He Agenc		PPS	
					Par		
			Part A		bles &	Deductibles &	
			1.00	Coi nsu 2.0		Coi nsurance 3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMA	RY CHARGE		2.	00]	3.00	
	Reasonable Cost of Part A & Part B Services						1
00	Reasonable cost of services (see instructions)			0	0	0	1 1
00	Total charges			0	0	0	
	Customary Charges						
00	Amount actually collected from patients liable for payment for s on a charge basis (from your records)	servi ces		0	0	0	3
00	Amount that would have been realized from patients liable for pa	avment		0	0	0	4
	for services on a charge basis had such payment been made in acc with 42 CFR 413.13(b)			Ū	0	Ű	
00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	00 0	. 000000	0,000000	5
00	Total customary charges (see instructions)			0	0	0	6
00	Excess of total customary charges over total reasonable cost (co only if line 6 exceeds line 1)	omplete		0	0	0	7
00	Excess of reasonable cost over customary charges (complete only 1 exceeds line 6)	ifline		0	0	0	8
00	Primary payer amounts			0	0	0	q
			1	Par	t A	Part B	
				Serv		Servi ces	
				1. (00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				0	0	1 10
00	Total reasonable cost (see instructions)				0		
00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers				24, 526	384, 441	1
00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers				-	384, 441 5, 905	11
00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers				24, 526 2, 847	384, 441	11 12 13
. 00 . 00 . 00 . 00 . 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes				24, 526 2, 847	384, 441 5, 905 11, 795	11 12 13 14
00 00 00 00 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes				24, 526 2, 847 0 0	384, 441 5, 905 11, 795 2, 459	11 12 13 14 14
. 00 . 00 . 00 . 00 . 00 . 00 . 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments				24, 526 2, 847 0 0 78	384, 441 5, 905 11, 795 2, 459 2, 066	11 12 14 14 14 14 16
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments				24, 526 2, 847 0 0 78	384, 441 5, 905 11, 795 2, 459 2, 066 0 0	11 12 13 14 15 16 17 18
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments				24, 526 2, 847 0 0 78 0 0 0 0 0 0	384, 441 5, 905 11, 795 2, 459 2, 066 0 0 0 0	11 12 14 14 14 14 16 17 18 16
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments				24, 526 2, 847 0 0 78	384, 441 5, 905 11, 795 2, 459 2, 066 0 0 0 0 0 0 0	1 1 1 1 1 1 1 1 1 1 1 1 1 1 2 0
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Qutlier Reimbursement - Full Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsura	ance)			24, 526 2, 847 0 0 78 0 0 0 0 0 0 0 0 0	384, 441 5, 905 11, 795 2, 459 2, 066 0 0 0 0 0 0 0 0 0 0 0 0 0	11 12 13 14 15 16 17 18 16 17 20 21
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - Full Episodes Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsura Subtotal (sum of lines 10 thru 20 minus line 21)	ance)			24, 526 2, 847 0 0 78 0 0 0 0 0 0	384, 441 5, 905 11, 795 2, 459 2, 066 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	111 12 14 15 16 17 18 19 20 21 21
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsura Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8)	ance)			24, 526 2, 847 0 0 78 0 0 0 0 0 0 27, 451 0	384, 441 5, 905 11, 795 2, 459 2, 066 0 0 0 0 0 406, 666	111 122 133 144 155 166 177 188 199 200 211 222 233
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsura Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23)	ance)			24, 526 2, 847 0 0 78 0 0 0 0 0 0 0 0 0	384, 441 5, 905 11, 795 2, 459 2, 066 0 0 0 0 406, 666	111 122 13 14 15 16 17 18 19 20 21 22 23 24
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsura Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records)	ance)			24, 526 2, 847 0 0 78 0 0 0 0 0 27, 451 0 27, 451	384, 441 5, 905 11, 795 2, 459 2, 066 0 0 0 0 0 406, 666 0	111 122 133 144 155 166 177 188 199 200 211 222 233 244 255
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsura Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25)	ance)			24, 526 2, 847 0 0 78 0 0 0 0 0 0 27, 451 0	384, 441 5, 905 11, 795 2, 459 2, 066 0 0 0 0 406, 666	111 122 13 14 15 16 17 18 19 20 21 22 23 24 25 26
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsura Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records)				24, 526 2, 847 0 0 78 0 0 0 0 0 27, 451 0 27, 451	384, 441 5, 905 11, 795 2, 459 2, 066 0 0 0 0 0 406, 666 0	111 122 133 144 155 166 177 186 197 200 211 222 233 244 255 246 256 266 277
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsura Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records)	ructions))		24, 526 2, 847 0 0 78 0 0 0 0 0 27, 451 27, 451 27, 451	384, 441 5, 905 11, 795 2, 459 2, 066 0 0 0 0 0 406, 666 0	111 122 133 144 155 166 177 186 199 200 211 222 233 244 255 266 277 286
. 00 . 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsura Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records)	ructions))		24, 526 2, 847 0 0 78 0 0 0 0 0 27, 451 0 27, 451	$\begin{array}{c} 384,441\\ 5,905\\ 11,795\\ 2,459\\ 2,066\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\$	111 122 133 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 27 28 29
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsura Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts for dual eligible beneficiaries (see inst Total costs - current cost reporting period (line 26 plus line 27)	ructions))		24, 526 2, 847 0 0 78 0 0 0 0 0 27, 451 27, 451 27, 451	384, 441 5, 905 11, 795 2, 459 2, 066 0 0 0 0 406, 666 406, 666 406, 666	111 12 13 14 15 16 17 18 20 21 22 23 24 25 26 27 28 29 30
. 00 . 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsura Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see inst Total costs - current cost reporting period (line 26 plus line 20 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructions))		24, 526 2, 847 0 0 78 0 0 0 0 27, 451 27, 451 27, 451 0	384, 441 5, 905 11, 795 2, 459 2, 066 0 0 0 0 406, 666 0 406, 666 406, 666	111 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
. 00 . 00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsura Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see inst Total costs - current cost reporting period (line 26 plus line 27) Subtotal (line 29 plus/minus line 30)	ructions))		24, 526 2, 847 0 0 78 0 0 0 0 0 27, 451 27, 451 27, 451 27, 451 0 27, 451	384, 441 5, 905 11, 795 2, 459 2, 066 0 0 0 0 406, 666 0 406, 666 0 406, 666	111 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 31
1.00 .00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsura Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts for dual eligible beneficiaries (see inst Total costs - current cost reporting period (line 26 plus line 27 Subtotal (line 29 plus/minus line 30) Sequestration adjustment (see instructions)	ructions))		24, 526 2, 847 0 0 78 0 0 0 0 27, 451 27, 451 27, 451 27, 451 0 27, 451 0 27, 451	$\begin{array}{c} 384, 441\\ 5, 905\\ 11, 795\\ 2, 459\\ 2, 066\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\$	122 13 14 15 16 17 18 20 21 22 23 24 25 26 27 28 29 30 31 31 32 33
0.00 1.00 2.00 3.00 4.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 6.00 7.00 3.00 4.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsura Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts for dual eligible beneficiaries (see inst Total costs - current cost reporting period (line 26 plus line 20 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Subtotal (line 29 plus/minus line 30) Sequestration adjustment (see instructions) Interim payments (see instructions)	ructions) 27) 33			24, 526 2, 847 0 0 78 0 0 0 0 27, 451 27, 451 27, 451 27, 451 27, 451 27, 451	$\begin{array}{c} 384, 441 \\ 5, 905 \\ 11, 795 \\ 2, 459 \\ 2, 066 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0 \\ 0$	111 122 133 144 155 166 177 188 199 200 211 222 233 244 255 266 277 288 299 300 311 312 333 34

	SIS OF PAYMENTS TO PROVIDER-BASED HHAS FOR SERVICES RENDERED TO AM BENEFICIARIES	Provider HHA CCN:	CCN: 151305 157078	Period: From 10/01/2013 To 09/30/2014	Date/Time Prep	
				Home Health	3/30/2015 3:55 PPS	5 pm
		Inpatier	nt Part A	Agency I Par	T B	
	m	nm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)		26, 9	01	398, 533 0	1 2 3
)1	Program to Provider		1	0	0	3
12 13 14				0 0 0	000000000000000000000000000000000000000	3 3 3 3 3
	Provider to Program		1			
50 51 52 53				0 0 0	0 0 0	3333
4 9	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0 0	0.03
0	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		26, 9	01	398, 533	4
0	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after		1			5
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
)1	Program to Provider		1	0	0	5
)2				0	0	5
3				0	0	5
~	Provider to Program		1	0		
0 1				0	0	5
2				0	0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5
)0)1	Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER			1	0	6
)2	SETTLEMENT TO PROGRAM			0	0	6
00	Total Medicare program liability (see instructions)		26, 9		398, 533	7
			0	Contractor Number 1.00	NPR Date (Mo/Day/Yr) 2.00	
00	Name of Contractor		0	1.00	2.00	8

Heal th	Financial Systems	PULASKI MEMORIAL	- HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ANALYS	IS OF PROVIDER-BASED HOSPICE COSTS		Provi der	CCN: 151305	Peri od:	Worksheet K	
					From 10/01/2013		
			Hospi ce C	CN: 151550	To 09/30/2014	Date/Time Pre 3/30/2015 3:5	
					Hospi ce I	373072013 3.3	<u>5 piii</u>
		Salaries (from	Employee	Transportati		Other	
			nefits (from				
			Wkst. K-2)	. ,	Wkst. K-3)		
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.				0	0	1.00
2.00	Capital Related Costs-Movable Equip.				0	0	2.00
3.00	Plant Operation and Maintenance	0	0		0 0	0	3.00
4.00	Transportation - Staff	0	0		0 0	0	4.00
5.00	Volunteer Service Coordination	0	0		0 0	0	5.00
6.00	Administrative and General	4, 484	0	4	46 0	17, 941	6.00
	I NPATI ENT_CARE_SERVI CE						
7.00	Inpatient - General Care	0	0		0 0	0	7.00
8.00	Inpatient - Respite Care	0	0		0 0	0	8.00
0.00	VI SI TI NG SERVI CES						0.00
9.00	Physician Services	0	0		0 0	0	9.00
10.00	Nursing Care	23, 294	0		0 0	0	10.00
11.00	Nursing Care-Continuous Home Care	0 17, 910	0		0 0	0	11.00 12.00
12.00 13.00	Physical Therapy Occupational Therapy	17, 910	0		0 0	0	12.00
13.00	Speech/ Language Pathol ogy	0	0		0 0	0	14.00
14.00	Medi cal Soci al Servi ces	0	0		0 0	0	14.00
16.00	Spiritual Counseling	0	0		0 0	0	16.00
17.00	Dietary Counseling	0	0		0 0	0	17.00
18.00	Counseling - Other	0	0		0 0	0	18.00
19.00	Home Health Aide and Homemaker	846	0		0 0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	20.00
21.00	Other	0	0		0 0	0	21.00
21.00	OTHER HOSPICE SERVICE COSTS				0		21100
22.00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	22.00
23.00	Anal gesi cs	0	0		0 0	0	23.00
24.00	Sedatives / Hypnotics	0	0		0 0	0	24.00
25.00	Other - Specify	0	0		0 0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	26.00
27.00	Patient Transportation	0	0		0 0	0	27.00
28.00	Imaging Services	0	0		0 0	0	28.00
29.00	Labs and Diagnostics	0	0		0 0	0	29.00
30.00	Medical Supplies	0	0		0 0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	31.00
32.00	Radiation Therapy	0	0		0 0	0	32.00
33.00	Chemotherapy	0	0		0 0	0	33.00
34.00	Other	0	0		0 0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE	1					
35.00	Bereavement Program Costs	0	0		0 0	0	35.00
36.00	Volunteer Program Costs	0	0		0 0	0	36.00
37.00	Fundrai si ng	0	0		0 0	0	37.00
38.00	Other Program Costs	44 524	0	4	0 0	0	38.00
37.00	Total (sum of lines 1 thru 38)	46, 534	0	44	46 0	17, 941	39.00

Heal th	Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
ANALYS	IS OF PROVIDER-BASED HOSPICE COSTS		Provi der	CCN: 151305	Period:	Worksheet K	
			Hospi ce (CCN: 151550	From 10/01/2013 To 09/30/2014		
						3/30/2015 3:5	5 pm
					Hospi ce I		
			Recl assi fi cati			Total (col. 8	
		1-5)	on	$6 \pm col. 7$		± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
1 00	GENERAL SERVICE COST CENTERS	0	-		0 0	0	1 1 00
1.00	Capital Related Costs-Bldg and Fixt.		C	1	0 0		
2.00	Capital Related Costs-Movable Equip.	0	C		0 0	0	
3.00	Plant Operation and Maintenance	0	C		0 0	0	
4.00	Transportation - Staff	0	C		0 0	0	
5.00	Volunteer Service Coordination	0	C		0 0	0	
6.00	Administrative and General	22, 871	C	22, 8	71 0	22, 871	6.00
	I NPATI ENT_CARE_SERVI CE			1			
7.00	Inpatient - General Care	0	C		0 0		
8.00	Inpatient - Respite Care	0	C		0 0	0	8.00
	VI SI TI NG SERVI CES						
9.00	Physi ci an Servi ces	0	C		0 0	0	1
10.00	Nursing Care	23, 294	C	/		23, 294	1
11.00	Nursing Care-Continuous Home Care	0	C		0 0	0	
12.00	Physical Therapy	17, 910	C			17, 910	1
13.00	Occupational Therapy	0	C		0 0	0	
14.00	Speech/ Language Pathol ogy	0	C		0 0	0	
15.00	Medical Social Services	0	C		0 0	0	15.00
16.00	Spiritual Counseling	0	C		0 0	0	16.00
17.00	Dietary Counseling	0	C		0 0	0	17.00
18.00	Counseling - Other	0	C		0 0	0	18.00
19.00	Home Health Aide and Homemaker	846	C	8	46 0	846	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	C		0 0	0	20.00
21.00	Other	0	C		0 0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	C		0 0	0	22.00
23.00	Anal gesi cs	0	C)	0 0	0	23.00
24.00	Sedatives / Hypnotics	0	C)	0 0	0	24.00
25.00	Other - Specify	0	C		0 0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	C		0 0	0	26.00
27.00	Patient Transportation	0	C		0 0	0	27.00
28.00	Imaging Services	0	C		0 0	0	28.00
29.00	Labs and Diagnostics	0	C)	0 0	0	29.00
30.00	Medical Supplies	0	C		0 0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	C		0 0	0	31.00
32.00	Radiation Therapy	0	C		0 0	0	32.00
33.00	Chemotherapy	0	C		0 0	0	
34.00	Other	0	C		0 0		
	HOSPICE NONREIMBURSABLE SERVICE	-	-	1	-		
35.00	Bereavement Program Costs	0	C		0 0	0	35.00
36.00	Volunteer Program Costs	0	C		0 0	0	
37.00	Fundrai si ng	0	C.		0 0	0	
38.00	Other Program Costs	0	C.		0 0	0	
	Total (sum of lines 1 thru 38)	64, 921	C	64, 9	-		39.00
2	······································						

Heal th	Financial Systems	PULASKI MEMORIA	AL HOSPITAL			In Lie	u of Form CMS-2	2552-10
	E COMPENSATION ANALYSIS SALARIES AND WAGES			CCN: 151305	Pe	eri od:	Worksheet K-1	
1100111				CN: 151550		om 10/01/2013	Date/Time Pre	pared:
							3/30/2015 3:5	
						Hospice I		
		Admi ni strator	Di rector	Soci al		Supervi sors	Nurses	
		1.00	2.00	Services 3.00		4.00	5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00		4.00	5.00	
1.00	Capital Related Costs-Bldg and Fixt.							1.00
2.00	Capital Related Costs Movable Equip.							2.00
3.00	Plant Operation and Maintenance	0	0		0	0	0	3.00
4.00	Transportation - Staff	0	0		0	0	0	4.00
5.00	Volunteer Service Coordination	0	0		0	0	0	5.00
6.00	Administrative and General	4, 484	0		0	0	0	6.00
0.00	I NPATI ENT CARE SERVI CE	1,101			-			0.00
7.00	Inpatient - General Care	0	0		0	0	0	7.00
8.00	Inpatient - Respite Care	0	0		0	ō	0	8,00
	VI SI TI NG SERVI CES				-			
9.00	Physi ci an Servi ces	0	0		0	0	0	9.00
10.00	Nursing Care	0	0		0	0	23, 294	10.00
11.00	Nursing Care-Continuous Home Care	0	0		0	0	0	11.00
12.00	Physical Therapy	0	0		0	0	0	12.00
13.00	Occupational Therapy	0	0		0	0	0	13.00
14.00	Speech/ Language Pathology	0	0		0	0	0	14.00
15.00	Medical Social Services	0	0		0	0	0	15.00
16.00	Spiritual Counseling	0	0		0	o	0	16.00
17.00	Di etary Counsel i ng	0	0		0	o	0	17.00
18.00	Counseling - Other	0	0		0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0		0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	0	20.00
21.00	Other	0	0		0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy							22.00
23.00	Anal gesi cs							23.00
24.00	Sedatives / Hypnotics							24.00
25.00	Other - Specify							25.00
26.00	Durable Medical Equipment/Oxygen							26.00
27.00	Patient Transportation	0	0		0	0	0	27.00
28.00	Imaging Services	0	0		0	0	0	28.00
29.00	Labs and Diagnostics	0	0		0	0	0	29.00
30.00	Medical Supplies	0	0		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		0	0	0	31.00
32.00	Radiation Therapy	0	0		0	0	0	32.00
33.00	Chemotherapy	0	0		0	0	0	33.00
34.00	Other	0	0		0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE	-ii-						
35.00	Bereavement Program Costs	0	0		0	0	0	35.00
36.00	Volunteer Program Costs	0	0		0	0	0	36.00
37.00	Fundraising	0	0		0	0	0	37.00
38.00	Other Program Costs	0	0		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	4, 484	0		0	0	23, 294	39.00

Heal th	Financial Systems	PULASKI MEMORIAL	L HOSPI TAL		In Lie	u of Form CMS-	2552-10
	E COMPENSATION ANALYSIS SALARIES AND WAGES			CCN: 151305	Peri od:	Worksheet K-1	
					From 10/01/2013		
			Hospi ce CO	CN: 151550	To 09/30/2014	Date/Time Pre	
						3/30/2015 3:5	5 pm
		T 1 1			Hospi ce I		
		Total	Ai des	All-Other	Total (1)		
		Therapists 6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS	0.00	7.00	8.00	9.00		
1.00	Capital Related Costs-Bldg and Fixt.						1 1.00
2.00	Capital Related Costs-Brug and Trxt.						2.00
3.00	Plant Operation and Maintenance		0		0 0		3.00
4.00	Transportation - Staff		0		0 0		4.00
5.00	Volunteer Service Coordination		0		0 0		5.00
6.00	Administrative and General		0		0 4,484		6.00
0.00	I NPATI ENT_CARE_SERVI CE		<u> </u>		4, 404		0.00
7.00	Inpatient - General Care		0		0 0		7.00
8.00	Inpatient - Respite Care		0		0 0		8.00
0.00	VI SI TI NG SERVI CES		<u> </u>		0		0.00
9.00	Physician Services		0		0 0		9.00
10,00	Nursi ng Care		0		0 23, 294		10.00
11.00	Nursing Care-Continuous Home Care		0		0 23, 274		11.00
12.00	Physical Therapy	17, 910	0		0 17,910		12.00
12.00	Occupational Therapy	17, 710	0		0 17, 710		13.00
14.00	Speech/ Language Pathology	0	0		0 0		14.00
15.00	Medi cal Soci al Servi ces	Ŭ	0		0 0		15.00
16.00	Spiritual Counseling		0		0 0		16.00
17.00	Di etary Counsel i ng		0		0 0		17.00
18.00	Counseling - Other		0		0 0		18.00
19.00	Home Health Aide and Homemaker		846		0 846		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		010		0 0		20.00
21.00	Other		o		0 0		21.00
21.00	OTHER HOSPICE SERVICE COSTS				0		21.00
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Anal gesi cs						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0		0 0		27.00
28.00	I magi ng Servi ces		0		0 0		28.00
29.00	Labs and Diagnostics		o		0 0		29.00
30.00	Medical Supplies		o		0 0		30,00
31.00	Outpatient Services (including E/R Dept.)		0		0 0		31.00
32.00	Radiation Therapy		0		0 0		32.00
33.00	Chemotherapy		0		0 0		33.00
34.00	Other		o		0 0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	1	0		0 0		35.00
36.00	Volunteer Program Costs		0		0 0		36.00
37.00	Fundrai si ng		o		0 0		37.00
38.00	Other Program Costs		0		0 0		38.00
	Total (sum of lines 1 thru 38)	17, 910	846		0 46, 534		39.00
							•

Heal th	Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	LLOCATION - HOSPICE GENERAL SERVICE COST			CCN: 151305	Peri od:	Worksheet K-4	
			Hospi ce (CN: 151550	From 10/01/2013 To 09/30/2014	Part I Date/Time Pre	pared [.]
					10 07/00/2011	3/30/2015 3:5	
					Hospi ce I		
			CAPI TAL RE	LATED COST			
		NET EXPENSES	BUI LDI NGS &	MOVABLE	PLANT	TRANSPORTATI ON	
		FOR COST	FIXTURES	EQUI PMENT	OPERATION &		
		ALLOCATI ON			MALNT.		
		0	1.00	2.00	3.00	4.00	
1 00	GENERAL SERVICE COST CENTERS			[1 00
1.00 2.00	Capital Related Costs-Bldg and Fixt. Capital Related Costs-Movable Equip.	0	0		0		1.00 2.00
2.00	Plant Operation and Maintenance	0	0		0 0		3.00
3.00 4.00	Transportation - Staff	0	0		0 0	0	4.00
4.00 5.00	Volunteer Service Coordination	0	0		0 0	0	5.00
6.00	Administrative and General	22, 871	0		0 0		6.00
0.00	I NPATI ENT_CARE_SERVI CE	22,071	0		0 0	0	0.00
7.00	Inpatient - General Care	0	0		0 0	0	7.00
8.00	Inpatient - Respite Care	0	0		0 0		8.00
	VI SI TI NG SERVI CES						
9.00	Physi ci an Servi ces	0	0		0 0	0	9.00
10.00	Nursing Care	23, 294	0		0 0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0		0 0	0	11.00
12.00	Physical Therapy	17, 910	0		0 0	0	12.00
13.00	Occupational Therapy	0	0		0 0	0	13.00
14.00	Speech/ Language Pathol ogy	0	0		0 0	0	14.00
15.00	Medical Social Services	0	0		0 0	0	15.00
16.00	Spiritual Counseling	0	0		0 0	0	16.00
17.00	Dietary Counseling	0	0		0 0	-	17.00
18.00	Counseling - Other	0	0		0 0	0	18.00
19.00	Home Health Aide and Homemaker	846	0		0 0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0		20.00
21.00		0	0		0 0	0	21.00
22.00	OTHER HOSPICE SERVICE COSTS Drugs, Biological and Infusion Therapy	0	0		0 0	0	22.00
22.00	Anal gesi cs	0	0		0 0		22.00
24.00	Sedatives / Hypnotics	0	0		0 0		24.00
24.00	Other - Specify	0	0		0 0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0		0 0		26.00
27.00	Pati ent Transportati on	0	0		0 0		27.00
28.00	Imaging Services	0	0		0 0	0	28.00
29.00	Labs and Diagnostics	0	0		0 0	0	29.00
30.00	Medical Supplies	0	0		0 0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	31.00
32.00	Radiation Therapy	0	0		0 0	0	32.00
33.00	Chemotherapy	0	0		0 0	0	33.00
34.00	Other	0	0		0 0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0		0 0		35.00
36.00	Volunteer Program Costs	0	0		0 0	-	36.00
37.00	Fundraising	0	0		0 0		37.00
38.00	Other Program Costs	0	0		0 0		38.00
39.00	Total (sum of lines 1 thru 38)	64, 921	0		0 0	0	39.00

	Financial Systems	PULASKI MEMOR		0.011 454055		u of Form CMS-	
COST A	LLOCATION - HOSPICE GENERAL SERVICE COST		Provi der	CCN: 151305	Period: From 10/01/2013	Worksheet K-4 Part I	4
			Hospi ce	CCN: 151550		Date/Time Pre	
					Hospi ce I	3/30/2015 3:5	<u>55 pili</u>
		VOLUNTEER	SUBTOTAL	ADMI NI STRATI	VETOTAL (col. 5A		
		SERVI CES COORDI NATOR	(cols. 0 - 5)	& GENERAL	± col. 6)		
		5.00	5A	6.00	7.00		
4 00	GENERAL SERVICE COST CENTERS			1			1
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance						3.00
4.00 5.00	Transportation - Staff Volunteer Service Coordination	0					4.00
5.00 6.00	Administrative and General		22 07	1 22, 8	71		6.00
0.00	I NPATI ENT CARE SERVI CE		22, 87	1 22, 0	71		0.00
7.00	Inpatient - General Care	0		b	0 0		7.00
8.00	Inpatient - Respite Care	0			0 0		8.00
0.00	VI SI TI NG SERVI CES		· · · · ·	5	0 0		0.00
9.00	Physician Services	0		2	0 0		9.00
10.00	Nursi ng Care	0	23. 29	4 12,6	-		10.00
11.00	Nursing Care-Continuous Home Care	0))	0 0		11.00
12.00	Physical Therapy	0	17, 910	9,7	41 27, 651		12.00
13.00	Occupational Therapy	0) O	0 0		13.00
14.00	Speech/ Language Pathology	0		b	0 0		14.00
15.00	Medical Social Services	0		b	0 0		15.00
16.00	Spiritual Counseling	0		b	0 0		16.00
17.00	Dietary Counseling	0	(C	0 0		17.00
18.00	Counseling - Other	0	(C	0 0		18.00
19.00	Home Health Aide and Homemaker	0	84	6 4	60 1, 306		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0			0 0		20.00
21.00	Other	0	(0	0 0		21.00
	OTHER HOSPICE SERVICE COSTS	-		-			
22.00	Drugs, Biological and Infusion Therapy	0	(-	0 0		22.00
23.00	Analgesics	0			0 0		23.00
24.00	Sedatives / Hypnotics	0			0 0		24.00
25.00	Other - Specify	0			0 0		25.00
26.00	Durable Medical Equipment/Oxygen				0 0		26.00
27.00 28.00	Patient Transportation Imaging Services	0			0 0		27.00
28.00	Labs and Diagnostics	0			0 0		29.00
30.00	Medical Supplies	0			0 0		30.00
31.00	Outpatient Services (including E/R Dept.)				0 0		31.00
32.00	Radiation Therapy				0 0		32.00
33.00	Chemotherapy	0			0 0		33.00
34.00	Other	0		-	0 0		34.00
	HOSPICE NONREIMBURSABLE SERVICE	-		-1			
35.00	Bereavement Program Costs	0	(D	0 0		35.00
36.00	Volunteer Program Costs	0		D	0 0		36.00
37.00	Fundrai si ng	0	(C	0 0		37.00
38.00	Other Program Costs	0		C	0 0		38.00
20 00	Total (sum of lines 1 thru 38)	0	64, 92	1	64, 921		39.00

Heal th	Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der	CCN: 151305	Period: From 10/01/2013	Worksheet K-4	ļ
			Hospi ce	CCN: 151550	To 09/30/2014		
					Hospi ce I		
		CAPI TAL RE	LATED COST				
		BUILDINGS &	MOVABLE	PLANT	TRANSPORTATI ON	VOLUNTEER	
		FIXTURES (SQ.	EQUIPMENT (\$	OPERATION 8		SERVI CES	
		FT.)	VALUE)	MAINT. (SQ. FT.)		COORDI NATOR (HOURS)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS			-			
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
2.00	Capital Related Costs-Movable Equip.	0					2.00
3.00	Plant Operation and Maintenance	0		C	0		3.00
4.00	Transportation - Staff	0		D	0 0		4.00
5.00	Volunteer Service Coordination	0			0 0		
6.00	Administrative and General	0			0 0	0	6.00
7.00	INPATIENT CARE SERVICE	0			0 0	0	7.00
7.00 8.00	Inpatient - General Care Inpatient - Respite Care	0					
0.00	VI SI TI NG SERVI CES	0		J	0 0	0	0.00
9.00	Physi ci an Servi ces	0		b	0 0	0	9.00
10.00	Nursi ng Care	0			0 0		
11.00	Nursing Care-Continuous Home Care	0			0 0		
12.00	Physical Therapy	0		b	0 0	0	12.00
13.00	Occupational Therapy	0		b	0 0	0	13.00
14.00	Speech/ Language Pathol ogy	0	(C	0 0	0	14.00
15.00	Medical Social Services	0		C	0 0		
16.00	Spiritual Counseling	0		C	0 0		
17.00	Dietary Counseling	0		C	0 0		1
18.00	Counseling - Other	0			0 0	-	1
19.00	Home Health Aide and Homemaker	0		D	0 0	-	
20.00	HH Aide & Homemaker - Cont. Home Care	0			0 0		
21.00	Other OTHER HOSPICE SERVICE COSTS	0		D	0 0	0	21.00
22.00	Drugs, Biological and Infusion Therapy	0		b	0 0	0	22.00
22.00	Anal gesi cs	0			0 0		
24.00	Sedatives / Hypnotics	0			0 0		
25.00	Other - Specify	0			0 0		
26.00	Durable Medical Equipment/Oxygen	0			0 0	0	
27.00	Patient Transportation	0		b	0 0	0	27.00
28.00	Imaging Services	0		D	0 0	0	28.00
29.00	Labs and Diagnostics	0		C	0 0	0	29.00
30.00	Medical Supplies	0	(C	0 0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0		C	0 0	-	
32.00	Radiation Therapy	0		C	0 0		
33.00	Chemotherapy	0		C	0 0		
34.00		0		0	0 0	0	34.00
25 22	HOSPICE NONREIMBURSABLE SERVICE				0	-	05 00
35.00	Bereavement Program Costs	0			0 0		
36.00 37.00	Volunteer Program Costs	0			0 0	0	
37.00	Fundraising Other Program Costs	0					
38.00 39.00	Cost to be Allocated (per Wkst. K-4, Part I)	0				0	
	Unit Cost Multiplier	0. 000000			0		
	I sur s sees and s priva		0.0000	-1 0.0000		1 0.00000	1 .0.00

Heal th	Financial Systems	PULASKI MEMORIAI	L HOSPITAL		In Lie	u of Form CMS	-2552-10
COST A	ALLOCATION - STATISTICAL BASIS		Provider CCN: 1	51305	Period:	Worksheet K-	4
			Hospi ce CCN:	151550	From 10/01/2013 To 09/30/2014	Part II Date/Time Pro	
					Hospi ce I	3/30/2015 3:	55 pm
		RECONCILIATION AD	MINI STRATI VE		lospice i		
			& GENERAL				
			(ACC. COST)				
		6A	6.00				
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
2.00	Capital Related Costs-Movable Equip.	0					2.00
3.00	Plant Operation and Maintenance	0					3.00
4.00	Transportation - Staff	0					4.00
5.00	Volunteer Service Coordination						5.00
6.00	Administrative and General	-22, 871	42, 050				6.00
	INPATIENT CARE SERVICE	· · ·					
7.00	Inpatient - General Care	0	0				7.00
8.00	Inpatient - Respite Care	0	0				8.00
	VISITING SERVICES	1					
9.00	Physician Services	0	0				9.00
10.00	Nursing Care	0	23, 294				10.00
11.00	Nursing Care-Continuous Home Care	0	0				11.00
12.00	Physical Therapy	0	17, 910				12.00
13.00	Occupational Therapy	0	0				13.00
14.00	Speech/ Language Pathol ogy	0	0				14.00
15.00	Medical Social Services	0	0				15.00
16.00	Spiritual Counseling	0	0				16.00
17.00	Di etary Counsel i ng	0	0				17.00
18.00	Counseling - Other	0	0				18.00
19.00	Home Health Aide and Homemaker	0	846				19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0				20.00
21.00		0	0				21.00
22.00	OTHER HOSPICE SERVICE COSTS Drugs, Biological and Infusion Therapy	0	0				22.00
22.00	Anal gesi cs	0	0				22.00
23.00	Sedatives / Hypnotics	0	0				23.00
24.00	Other - Specify	0	0				24.00
26.00	Durable Medical Equipment/Oxygen	0	0				25.00
27.00	Pati ent Transportati on	0	0				27.00
28.00	I maging Services	0	0				28.00
29.00	Labs and Diagnostics	0	0				29.00
30.00	Medical Supplies	0	0				30.00
31.00	Outpatient Services (including E/R Dept.)	0	0				31.00
32.00	Radiation Therapy	0	0				32.00
33.00	Chemotherapy	0	o				33.00
34.00	Other	0	o				34.00
	HOSPI CE NONREI MBURSABLE SERVI CE	<u> </u>	<u> </u>				
35.00	Bereavement Program Costs	0	0				35.00
36.00	Volunteer Program Costs	0	Ö				36.00
37.00	Fundrai si ng	0	Ö				37.00
38.00	Other Program Costs	0	Ö				38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		22, 871				39.00

ALLOCATI ON	OF GENERAL SERVICE COSTS TO HOSPICE COST						
		CENTERS	Provi der Hospi ce (CCN: 151305 CCN: 151550	Period: From 10/01/2013 To 09/30/2014	Worksheet K-5 Part I Date/Time Pre 3/30/2015 3:5	pared:
					Hospi ce I		
	Cost Center Description	Hospi ce Tri al	CAPITAL RELATED COSTS NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
	cost center beschiptron	Bal ance (1)	FIXT	BENEFITS DEPARTMENT	Subtotal	& GENERAL	
		0	1.00	4.00	4A	5.00	
1.00 Admir	nistrative and General		3, 093	14, 5	95 17, 688	2, 931	1.00
2.00 Inpat	itient - General Care	0	0		0 0	0	2.00
3.00 Inpat	itient - Respite Care	0	0		0 0	0	3.00
4.00 Physi	si ci an Servi ces	0	0		0 0	0	4.00
5.00 Nursi	sing Care	35, 964	0		0 35, 964	5, 961	5.00
6.00 Nursi	sing Care-Continuous Home Care	0	0		0 0	0	6.00
7.00 Physi	si cal Therapy	27, 651	0		0 27,651	4, 583	7.00
8.00 Occur	ipational Therapy	0	0		0 0	0	8.00
9.00 Speed	ech/ Language Pathol ogy	0	0		0 0	0	9.00
10.00 Medi (cal Social Services	0	0		0 0	0	10.00
11. 00 Spi ri	itual Counseling	0	0		0 0	0	11.00
12.00 Dieta	ary Counseling	0	0		0 0	0	12.00
13.00 Couns	nseling - Other	0	0		0 0	0	13.00
14.00 Home	e Health Aide and Homemaker	1, 306	0		0 1, 306	216	14.00
15.00 HH Ai	ide & Homemaker - Cont. Home Care	0	0		0 0	0	15.00
16.00 Other	r	0	0		0 0	0	16.00
17.00 Drugs	s, Biological and Infusion Therapy	0	0		0 0	0	17.00
	gesi cs	0	0		0 0	0	18.00
19.00 Sedat	itives / Hypnotics	0	0		0 0	0	19.00
20.00 Other	er - Specify	0	0		0 0	0	20.00
21.00 Durat	ble Medical Equipment/Oxygen	0	0		0 0	0	21.00
	ent Transportation	0	0		0 0	0	22.00
23.00 I magi	jing Services	0	0		0 0	0	23.00
	and Diagnostics	0	0		0 0	0	24.00
	cal Supplies	0	0		0 0	0	25.00
	atient Services (including E/R Dept.)	0	0		0 0	0	26.00
	ation Therapy	0	0		0 0	0	27.00
	notherapy	0	0		0 0	0	28.00
29.00 Other		0	0		0 0	0	29.00
30.00 Berea	avement Program Costs	0	0		0 0	0	30,00
	inteer Program Costs	0	0		0 0	0	31.00
	Iraising	0	0		0 0	0	32.00
	er Program Costs	0	0		0 0	0	33.00
	I (sum of lines 1 thru 33) (2)	64, 921	3, 093	14, 5	95 82, 609	-	34.00
	Cost Multiplier (see instructions)		2, 370		0. 000000		35.00

Heal th	Financial Systems	PULASKI MEMOR	IAL H	OSPI TAL				In Lie	eu of Form CMS-2	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS		Provi der	CCN: 1	51305		ri od:	Worksheet K-5	
						454550		om 10/01/2013		
				Hospi ce C	CN:	151550	10	09/30/2014	Date/Time Pre 3/30/2015 3:5	
								Hospi ce I	5/ 50/ 2015 5.5	
	Cost Center Description	OPERATION OF	LA	UNDRY &	HOUSE	EKEEPING	3	DI ETARY	NURSI NG	
	···· · · · · · · · · · · · · · · · · ·	PLANT	LINE	N SERVICE					ADMI NI STRATI ON	
		7.00		8.00	9	9.00		10.00	13.00	
1.00	Administrative and General	3, 751		0		1, 04	43	0	0	1.00
2.00	Inpatient - General Care	0		0			0	0	0	
3.00	Inpatient - Respite Care	0		0			0	0	0	3.00
4.00	Physician Services	0		0			0	0	0	
5.00	Nursing Care	0		0			0	0	0	
6.00	Nursing Care-Continuous Home Care	0		0			0	0	0	6.00
7.00	Physical Therapy	0		0			0	0	0	
8.00	Occupational Therapy	0		0			0	0	0	
9.00	Speech/ Language Pathology	0		0			0	0	0	9.00
10.00	Medical Social Services	0		0			0	0	0	
11.00	Spiritual Counseling	0		0			0	0	0	
12.00	Dietary Counseling	0		0			0	0	0	12.00
13.00	Counseling - Other	0		0			0	0	0	
14.00	Home Health Aide and Homemaker	0		0			0	0	0	
15.00	HH Aide & Homemaker - Cont. Home Care	0		0			0	0	0	15.00
16.00	Other	0		0			0	0	0	
17.00	Drugs, Biological and Infusion Therapy	0		0			0	0	0	
18.00	Anal gesi cs	0		0			0	0	0	18.00
19.00	Sedatives / Hypnotics	0		0			0	0	0	
20.00	Other - Specify	0		0			0	0	0	
21.00	Durable Medical Equipment/Oxygen	0		0			0	0	0	21.00
22.00	Patient Transportation	0		0			0	0	0	
23.00 24.00	I maging Services	0		0			0	0	0	23.00 24.00
24.00 25.00	Labs and Diagnostics Medical Supplies	0		0			0	0	0	
25.00 26.00	Outpatient Services (including E/R Dept.)	0		0			0	0		
28.00	Radiation Therapy	0		0			0	0		27.00
27.00	Chemotherapy	0		0			0	0	0	
28.00	Other	0		0			0	0		
30,00	Bereavement Program Costs	0		0			0	0	0	30.00
30.00	Volunteer Program Costs	0		0			0	0	0	
32.00	Fundrai si ng	0		0			0	0	0	
33.00	Other Program Costs	0		0			0	0	0	
34.00	Total (sum of lines 1 thru 33) (2)	3, 751		0		1, 04	~	0	0	
35.00	Unit Cost Multiplier (see instructions)	5,751		0		1, 04		0		35.00
00.00		I	I	I	1		I		I	1 30.00

Heal th	Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Li	eu of Form CMS-2	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS		CCN: 151305 CCN: 151550	Period: From 10/01/2013 To 09/30/2014		pared:
					Hospi ce I		
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	Subtotal	
		SERVICES &		RECORDS &		(col s. 4A-23)	
		SUPPLY		LI BRARY			
		14.00	15.00	16.00	17.00	24.00	
1.00	Administrative and General	0	C		94 789		1.00
2.00	Inpatient - General Care	0	C		0 (2.00
3.00	Inpatient - Respite Care	0	C		0	ol o	3,00
4.00	Physi ci an Servi ces	0	- (0		4.00
5.00	Nursi ng Care	0	C		0	41, 925	5.00
6.00	Nursing Care-Continuous Home Care	0	C		0	0 0	6.00
7.00	Physical Therapy	0				32, 234	7.00
8.00	Occupational Therapy	0				0 52,234	8.00
9.00	Speech/ Language Pathol ogy	0			0		9.00
10.00	Medical Social Services	0			0		10.00
11.00	Spiritual Counseling	0					11.00
		0				-	
12.00	Dietary Counseling	0	C		0	0	12.00
13.00	Counseling - Other	0	Ĺ		0	0	13.00
14.00	Home Health Aide and Homemaker	0	C)	0 0	.,	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	C)	0 (0 0	15.00
16.00	Other	0	C)	0	0 0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	C)	0 (°	17.00
18.00	Anal gesi cs	0	C)	0 (0 0	18.00
19.00	Sedatives / Hypnotics	0	C)	0 (°	19.00
20.00	Other - Specify	0	C)	0 (0 0	20.00
21.00	Durable Medical Equipment/Oxygen	0	C)	0 (0 0	21.00
22.00	Patient Transportation	0	C)	0 0	°	22.00
23.00	I magi ng Servi ces	0	C)	0 0	0 0	23.00
24.00	Labs and Diagnostics	0	C)	0 0	0 0	24.00
25.00	Medical Supplies	0	C		0 (0 0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	C		0 0	0 0	26.00
27.00	Radiation Therapy	0	C		0 0	0 0	27.00
28.00	Chemotherapy	0	C)	0 (0 0	28.00
29.00	Other	0	C)	0 0	0 0	29.00
30.00	Bereavement Program Costs	0	C		0 (0 0	30.00
31.00	Volunteer Program Costs	0	C		0 0	0 0	31.00
32.00	Fundrai si ng	0	C)	0 0	o o	32.00
33.00	Other Program Costs	0	C		0 (0 0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	C	6	94 789	102, 577	34.00
	Unit Cost Multiplier (see instructions)						35.00
							•

	Financial Systems TION OF GENERAL SERVICE COSTS TO HOSPICE COST	PULASKI MEMORI CENTERS		CCN: 151305	In Lie Period:	Worksheet K-5
				CCN: 151550	From 10/01/2013	Part I
						3/30/2015 3:55 pm
					Hospi ce I	
	Cost Center Description	Intern &	Subtotal	Allocated	Total Hospice	
		Residents Cost	(cols. 24 ±	Hospi ce A&C		
		& Post	25)	(See Part II) 26 ± 27)	
		Stepdown				
		Adjustments	24.00	27.00	20.00	
00	Administrative and General	25.00	26.00	27.00	28.00	1.
. 00		0	0		0	
2.00 8.00	Inpatient - General Care Inpatient - Respite Care	0	0		0 0	2.
	Physician Services	0	0		0 0	
. 00 . 00	Nursing Care	0	41, 925	14, 8		4.
. 00	Nursing Care-Continuous Home Care	0	41, 925	14, 8	99 56, 824	5.
. 00 . 00	Physical Therapy	0	32, 234	11 4		6. 7.
. 00	Occupational Therapy	0	32, 234	11, 4	56 43, 690	8.
. 00	Speech/ Language Pathol ogy	0	0		0 0	9.
0.00	Medical Social Services	0	0		0 0	10.
1.00	Spiritual Counseling	0	0		0 0	10.
2.00	Dietary Counseling	0	0		0 0	11.
3.00	Counseling - Other	0	0		0 0	12.
4.00	Home Health Aide and Homemaker	0	1, 522	5	41 2,063	13.
4.00 5.00	HH Aide & Homemaker - Cont. Home Care	0	1, 522	5	41 2,003	14.
6.00	Other	0	0		0 0	15.
7.00	Drugs, Biological and Infusion Therapy	0	0		0 0	18.
8.00	Anal gesi cs	0	0		0 0	17.
9.00	Sedatives / Hypnotics	0	0		0 0	10.
0.00	Other - Specify	0	0		0 0	20.
1.00	Durable Medical Equipment/Oxygen	0	0		0 0	20.
2.00	Pati ent Transportati on	0	0		0 0	21.
3.00	Imaging Services	0	0			22.
4.00	Labs and Di agnosti cs	0	0			23.
5.00	Medi cal Supplies	0	0		0 0	25.
b. 00	Outpatient Services (including E/R Dept.)	0	0			25.
7.00	Radi ati on Therapy	0	0			20.
3.00	Chemotherapy	0	0			27.
9.00	Other	0	0		0 0	20.
). 00	Bereavement Program Costs	0	0			30.
1.00	Volunteer Program Costs	0	0			31.
2.00	Fundrai si ng	0	0			31.
3.00	Other Program Costs	0	0			33.
4.00	Total (sum of lines 1 thru 33) (2)	0	102, 577		102, 577	33.
5.00	Unit Cost Multiplier (see instructions)	0	102, 377	0. 3553		35.

Heal th	Financial Systems	PULASKI MEMORI	AL HOSPITAL			In Lie	u of Form CMS-2	2552-10
	TION OF GENERAL SERVICE COSTS TO HOSPICE COST TICAL BASIS	CENTERS	Provi der Hospi ce (CCN: 151305 CCN: 151550	Fr	eriod: com 10/01/2013 o 09/30/2014		
						Hospi ce I		•
		CAPI TAL RELATED COSTS						
	Cost Center Description	NEW BLDG & FLXT	EMPLOYEE BENEFITS	Reconciliati	on/	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	
		(SQUARE FEET)	DEPARTMENT (GROSS			(ACCUM. COST)	(SQUARE FEET)	
		1.00	SALARIES)	54		5.00	7.00	
1.00	Administrative and General	1.00	4.00		0	5.00	7.00	1.00
2.00	Inpatient - General Care	0	40, 534		0	17,000	0	2.00
2.00	Inpatient - Respite Care	0	0		0	0	0	2.00
4.00	Physi ci an Servi ces	0		,	0	0	0	4.00
5.00	Nursi ng Care	0		,	0	35, 964	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0		0	03, 704	0	6.00
7.00	Physical Therapy	0	C		0	27, 651	0	7.00
8.00	Occupational Therapy	0	C		0	27,001	0	8.00
9.00	Speech/ Language Pathology	0	C		0	0	0	9.00
10.00	Medical Social Services	0	C		0	0	0	10.00
11.00	Spiritual Counseling	0	C		0	0	0	11.00
12.00	Di etary Counsel i ng	0	C		0	0	0	12.00
13.00	Counseling - Other	0	C		0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	C		0	1, 306	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	C)	0	0	0	15.00
16.00	Other	0	C		0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	C		0	0	0	17.00
18.00	Anal gesi cs	0	C		0	0	0	18.00
19.00	Sedatives / Hypnotics	0	C		0	0	0	19.00
20.00	Other - Specify	0	C		0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	C		0	0	0	21.00
22.00	Patient Transportation	0	C)	0	0	0	22.00
23.00	Imaging Services	0	C)	0	0	0	23.00
24.00	Labs and Diagnostics	0	C		0	0	0	24.00
25.00	Medical Supplies	0	C		0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	C		0	0	0	26.00
27.00	Radiation Therapy	0	C		0	0	0	27.00
28.00	Chemotherapy	0	C		0	0	0	28.00
29.00	Other	0	C		0	0	0	29.00
30.00	Bereavement Program Costs	0	C		0	0	0	30.00
31.00	Volunteer Program Costs	0	C		0	0	0	31.00
32.00	Fundrai si ng	0	C	2	0	0	0	32.00
33.00	Other Program Costs	0	C	2	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	191	46, 534	•		82, 609	191	34.00
35.00 36.00	Total cost to be allocated	3, 093	14, 595			13, 691	3, 751	35.00
	Unit Cost Multiplier (see instructions)	16. 193717	0. 313642	71		0. 165733	19.638743	

Heal th	Financial Systems	PULASKI MEMOR	I AL HOSPITAL		Inlie	u of Form CMS-2	2552-10
	TION OF GENERAL SERVICE COSTS TO HOSPICE COST			r CCN: 151305	Peri od:	Worksheet K-5	
STATI S	TI CAL BASI S				From 10/01/2013	Part II	
			Hospi ce	CCN: 151550	To 09/30/2014	Date/Time Pre	
					Hospi ce I	3/30/2015 3:5	5 pm
	Cost Center Description	LAUNDRY &	HOUSEKEEPING	DI ETARY	NURSING	CENTRAL	
	cost center bescription	LINEN SERVICE	(SQUARE	(MEALS	ADMI NI STRATI ON	SERVICES &	
		(POUNDS OF	FEET)	SERVED)		SUPPLY	
		LAUNDRY)			(DI RECT	(100%)	
		, í			NRSING HRS)	. ,	
		8.00	9.00	10.00	13.00	14.00	
1.00	Administrative and General	0	19	91	0 0	0	1.00
2.00	Inpatient - General Care	0		0	0 0	0	2.00
3.00	Inpatient - Respite Care	0		0	0 0	0	3.00
4.00	Physi ci an Servi ces	0		0	0 0	0	4.00
5.00	Nursing Care	0		0	0 0	0	5.00
6.00	Nursing Care-Continuous Home Care	0		0	0 0	0	
7.00	Physical Therapy	0		0	0 0	0	
8.00	Occupational Therapy	0		0	0 0	0	
9.00	Speech/ Language Pathology	0		0	0 0	0	
10.00	Medical Social Services	0		0	0 0	0	10.00
11.00	Spiritual Counseling	0		0	0 0	0	11.00
12.00	Di etary Counsel i ng	0		0	0 0	0	12.00
13.00	Counseling - Other	0		0	0 0	0	13.00
14.00	Home Health Aide and Homemaker	0		0	0 0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0		0	0 0	0	15.00
16.00	Other	0		0	0 0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0		0		0	17.00
18. 00 19. 00	Anal gesi cs Sedati ves / Hypnoti cs	0			0 0	0	18.00 19.00
20.00	Other - Specify	0			0 0	0	20.00
20.00	Durable Medical Equipment/Oxygen	0			0 0	0	20.00
21.00	Patient Transportation	0		0	0 0	0	21.00
23.00	I magi ng Servi ces	0		0	0 0	0	
24.00	Labs and Diagnostics	0		0	0 0	0	24.00
25.00	Medi cal Supplies	0		0	0 0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0		0	0 0	0	26.00
27.00	Radi ati on Therapy	0		0	0 0	0	27.00
28.00	Chemotherapy	0		o	0 0	0	28.00
29.00	Other	0		0	0 0	0	29.00
30.00	Bereavement Program Costs	0		0	0 0	0	30.00
31.00	Volunteer Program Costs	0		0	0 0	0	31.00
32.00	Fundrai si ng	0		0	0 0	0	32.00
33.00	Other Program Costs	0		0	0 0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	19	91	0 0	0	34.00
35.00	Total cost to be allocated	0	1, 04	3	0 0	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0. 000000	5. 46073	0. 0000	0. 000000	0.000000	36.00

Heal th	Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2552-10
	TION OF GENERAL SERVICE COSTS TO HOSPICE COST			CCN: 151305	Peri od:	Worksheet K-5
STATI S	STICAL BASIS				From 10/01/2013	
			Hospi ce	CCN: 151550	To 09/30/2014	
					Hospi ce I	3/30/2015 3:55 pm
	Cost Center Description	PHARMACY	MEDI CAL	SOCI AL SERVI		
	cost center bescription	(100%)	RECORDS &	SUCIAL SERVI		
		(100%)	LI BRARY	(ALLOCATION	J	
			(GROSS	OF TIME)		
			CHARGES)			
		15.00	16.00	17.00		
1.00	Administrative and General	0	65, 409	7 1	13	1.00
2.00	Inpatient - General Care	0	(C	0	2.00
3.00	Inpatient - Respite Care	0	(D	0	3.00
4.00	Physician Services	0	(D	0	4.00
5.00	Nursing Care	0	(D	0	5.00
6.00	Nursing Care-Continuous Home Care	0		D	0	6.00
7.00	Physical Therapy	0		D	0	7.00
8.00	Occupational Therapy	0	(C	0	8.00
9.00	Speech/ Language Pathol ogy	0	(D	0	9.00
10.00	Medical Social Services	0		D	0	10.00
11.00	Spiritual Counseling	0			0	11.00
12.00	Di etary Counsel i ng	0			0	12.00
13.00	Counseling - Other	0			0	13.00
14.00	Home Health Aide and Homemaker	0			0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0			0	15.00
16.00	Other	0			0	16.00 17.00
17.00 18.00	Drugs, Biological and Infusion Therapy Analgesics	0			0	18.00
19.00	Sedatives / Hypnotics	0			0	19.00
20.00	Other - Specify	0			0	20.00
20.00	Durable Medical Equipment/Oxygen	0			0	21.00
22.00	Patient Transportation	0			0	22.00
23.00	I maging Services	Ő			0	23.00
24.00	Labs and Diagnostics	0			0	24.00
25.00	Medical Supplies	0	(b	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	(b	0	26.00
27.00	Radiation Therapy	0	(b	0	27.00
28.00	Chemotherapy	0	(C	0	28.00
29.00	Other	0	(C	0	29.00
30.00	Bereavement Program Costs	0	(D	0	30.00
31.00	Volunteer Program Costs	0	(D	0	31.00
32.00	Fundrai si ng	0	(D	0	32.00
33.00	Other Program Costs	0	(D	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	65, 409		13	34.00
35.00	Total cost to be allocated	0	694		89	35.00
30.00	Unit Cost Multiplier (see instructions)	0. 000000	0. 010610	6. 9823	υų	36.00

Heal th	Financial Systems	PULASKI MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF TOTAL HOSPICE SHARED COSTS		Provi der Hospi ce	CCN: 151305 CCN: 151550	Period: From 10/01/2013 To 09/30/2014		pared:
					Hospi ce I		
	Cost Center Description		t. C, Part col. 11 line	Cost to Char Ratio	ge Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
			0	1.00	2.00	3.00	
	ANCILLARY SERVICE COST CENTERS				-		
1.00	PHYSI CAL THERAPY		66.00			0	1.00
2.00	OCCUPATIONAL THERAPY		67.00			0	2.00
3.00	SPEECH PATHOLOGY		68.00			0	3.00
4.00	DRUGS CHARGED TO PATIENTS		73.00		71 0	0	4.00
4.01	DRUGS CHARGED TO PATIENTS		73.01				4.01
5.00	DURABLE MEDICAL EQUIP-RENTED		96.00	1			5.00
6.00	LABORATORY		60.00		46 0	0	6.00
6.01	BLOOD LABORATORY		60. 01	0.0000	00 0	0	6. 01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		71.00	0. 3036	25 0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER		93.00				8.00
9.00	RADI OLOGY-THERAPEUTI C		55.00				9.00
10.00	ONCOLOGY		76.00	1. 3044	12 0	0	10.00
10.01	CARDI AC REHAB		76.01	1. 2611	67 0	0	10.01
11.00	Totals (sum of lines 1–10)					0	11.00

Health Financial Systems PULASKI MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
CALCULATION OF HOSPICE PER DIEM COST	Provi der	CCN: 151305	Period:	Worksheet K-6	
	Hospi ce (CCN: 151550	From 10/01/2013 To 09/30/2014		
			Hospi ce I		
	Title XVIII	Title XIX	Other	Total	
	1.00	2.00	3.00	4.00	
1.00 Total cost (see instructions)				102, 577	1.00
2.00 Total Unduplicated Days (Worksheet S-9, column 6, line 5)				214	2.00
3.00 Average cost per diem (line 1 divided by line 2)				479.33	3.00
4.00 Upduplicated Medicare Days (Worksheet S-9, column 1, line 5)	180				4.00
5.00 Aggregate Medicare cost (line 3 time line 4)	86, 279				5.00
6.00 Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)			0		6.00
7.00 Aggregate Medicaid cost (line 3 time line 60)			0		7.00
8.00 Upduplicated SNF Days (Worksheet S-9, column 3, line 5)	9	•			8.00
9.00 Aggregate SNF cost (line 3 time line 8)	4, 314				9.00
10.00 Unduplicated NF Days (Worksheet S-9, column 4, line 5)			0		10.00
11.00 Aggregate NF cost (line 3 times line 10)			0		11.00
12.00 Other Unduplicated days (Worksheet S-9, column 5, line 5)			34		12.00
13.00 Aggregate cost for other days (line 3 times line 12)			16, 297		13.00

	Financial Systems	PULASKI MEMORI				u of Form CMS-:	
	SIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDE	RALLY QUALIFIED) Provi der	CCN: 151305	Peri od:	Worksheet M-1	
HEALTH	I CENTER COSTS		0	- CON 150510	From 10/01/2013	Data (Time Dura	
			Componen	CCN: 158512	To 09/30/2014	Date/Time Pre 3/30/2015 3:5	
					Rural Health	Cost	5 pii
					Clinic (RHC) I	0031	
		Compensati on	Other Costs	Total (col.	1 Recl assi fi cati	Recl assi fi ed	
		oomportou er orr	00000	+ col. 2	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	213, 008	1, 339	214, 3	47 -44, 636	169, 711	1.00
2.00	Physician Assistant	0	C		0 0		2.00
3.00	Nurse Practitioner	15, 680	C	15, 6	80 0	15, 680	3.00
4.00	Visiting Nurse	0	C		0 0	0	4.00
5.00	Other Nurse	14, 937	C	14, 9	37 0	14, 937	5.00
6.00	Clinical Psychologist	0	C		0 0	0	6.00
7.00	Clinical Social Worker	0	C		0 0	0	7.00
8.00	Laboratory Techni ci an	0	0		0 0	0	8.00
9.00	Other Facility Health Care Staff Costs	67, 916	1, 388	69, 3	04 0	69, 304	9.00
10.00	Subtotal (sum of lines 1-9)	311, 541	2, 727				
11.00	Physician Services Under Agreement	011,011	2, 727	011,2	0 0	0	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 11-13)	0	0		0 0	0	14.00
15.00	Medical Supplies	0	2, 234	2,2	0	2, 234	
16.00	Transportation (Health Care Staff)	0	2, 234	2,2	0 0	0	16.00
17.00	Depreciation-Medical Equipment	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	19.00
20.00	Allowable GME Costs	0	0		0 0	0	20.00
20.00	Subtotal (sum of lines 15-20)	0	2, 234	2, 2	0	2, 234	•
22.00	Total Cost of Health Care Services (sum of	311, 541	4, 961	316, 5			
22.00	lines 10, 14, and 21)	511, 541	4, 901	510, 5	-44,030	271,000	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS			1			
23.00	Pharmacy	0	C		0 0	0	23.00
24.00	Dental	0	0		0 0	0	24.00
25.00	Optometry	0	0			0	25.00
26.00	All other nonreimbursable costs	0	0		0 44, 636		
27.00	Nonal I owable GME costs	0	0		0 44,030	0	
28.00	Total Nonreimbursable Costs (sum of lines	0	0		0 44,636	-	
20.00	23-27)	U	0			44,000	20.00
	FACILITY OVERHEAD			1			
29.00	Facility Costs	0	113, 278	113, 2	78 0	113, 278	29.00
30.00	Administrative Costs	7, 174	189, 007				30.00
31.00	Total Facility Overhead (sum of lines 29 and	7, 174	302, 285				•
00	30)	,,,,,	002,200	007,4	-		
	Total facility costs (sum of lines 22, 28	318, 715	307, 246	625, 9	61 0	625, 961	32.00
32.00	IULAI IACIIILY CUSIS (SUII UI IIILES 22, 20	510,715	307,240	020.7	010 0	023,701	

IEALTH . 00 2. 00 3. 00	S OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDER CENTER COSTS	ALLY QUALIFIED		CCN: 151305	Period: From 10/01/2013	Worksheet M-	1
. 00 2. 00 3. 00			Componer		FIUII 10/01/2013		
. 00 2. 00 3. 00				t CCN: 158512	To 09/30/2014	Date/Time Pr 3/30/2015 3:	
. 00 2. 00 3. 00					Rural Health	Cost	
. 00 2. 00 3. 00					Clinic (RHC) I		_
. 00 2. 00 3. 00			Net Expenses				
. 00 2. 00 3. 00			for Allocatio				
. 00 2. 00 3. 00		0	(col. 5 + col				
. 00 2. 00 3. 00		6.00	<u> </u>	_			
. 00 2. 00 3. 00	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00				
2.00 3.00	Physi ci an	0	169, 71	1			1.00
3.00	Physician Assistant	0	-	0			2.0
	Nurse Practitioner	0	15, 68	-			3.00
1.00	Visiting Nurse	0	.0,00				4.00
	Other Nurse	0	14, 93	7			5.00
	Clinical Psychologist	0		0			6.00
	Clinical Social Worker	0		ol			7.0
	Laboratory Techni ci an	0		0			8.0
	Other Facility Health Care Staff Costs	0	69, 30	-			9.0
	Subtotal (sum of lines 1-9)	0	269, 63				10.0
	Physician Services Under Agreement	0		0			11.0
	Physician Supervision Under Agreement	0		o			12.0
	Other Costs Under Agreement	0		0			13.0
	Subtotal (sum of lines 11-13)	0		0			14.0
	Medical Supplies	0	2, 23	-			15.0
	Transportation (Health Care Staff)	0		0			16.0
	Depreciation-Medical Equipment	0		0			17.0
	Professional Liability Insurance	0					18.0
	Other Health Care Costs	0		0			19.0
	Allowable GME Costs	0					20.0
	Subtotal (sum of lines 15-20)	0	2, 23	4			21.0
	Total Cost of Health Care Services (sum of	0	271,86				22.0
	lines 10, 14, and 21)	-		-			
6	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0		0			23. 0
24.00	Dental	О		o			24.0
25.00	Optometry	0		o			25.0
26.00	All other nonreimbursable costs	0	44, 63	6			26.0
27.00	Nonallowable GME costs	0		0			27.0
28.00	Total Nonreimbursable Costs (sum of lines	0	44, 63	6			28.0
	23-27)						
	FACILITY OVERHEAD						
	Facility Costs	0	113, 27				29.0
	Administrative Costs	0	196, 18				30.0
	Total Facility Overhead (sum of lines 29 and	0	309, 45	9			31.0
	30)						
	Total facility costs (sum of lines 22, 28 and 31)	0	625, 96	1			32.0

Health Financial Systems		PULASKI MEMORIAL HOSPITAL				eu of Form CMS-2		
ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES				Provi der	CCN: 151305	Peri od:	Worksheet M-2	
				Component	CCN: 158512	From 10/01/2013 To 09/30/2014		
						Rural Health	Cost	•
		Number of FTE	Total	Vi si ts	Productivity	<u>Clinic (RHC) I</u> Minimum Visits	Greater of	
		Personnel	TOLA	VISILS) (col. 1 x col.		
		i ci sonner				3)	4	
		1.00		2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY	1	•					
	Posi ti ons							1
1.00	Physi ci an	0. 62		1, 343	4, 20	2, 604		1.00
2.00	Physician Assistant	0.00		0	2, 10	0 00		2.00
3.00	Nurse Practitioner	0. 22		499	2, 10	0 462		3.00
4.00	Subtotal (sum of lines 1-3)	0.84		1, 842		3, 066	3, 066	4.00
5.00	Visiting Nurse	0.00	1	0			0	
6.00	Clinical Psychologist	0.00	1	0			0	
7.00	Clinical Social Worker	0.00	1	0			0	
7.01	Medical Nutrition Therapist (FQHC only)	0.00	1	0			0	
7.02	Diabetes Self Management Training (FQHC	0.00		0			0	7.02
	only)							
8.00	Total FTEs and Visits (sum of lines 4-7)	0.84		1, 842			3, 066	
9.00	Physician Services Under Agreements			0			0	9.00
							1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T		U CES				1.00	
10.00				7 line 2	2)		271, 866	10.00
11.00	Total nonreimbursable costs (from Worksheet				2)		44, 636	
12.00								12.00
13.00								
14.00 Total facility overhead - (from Worksheet M-1, column 7, line 31)							0. 858971 309, 459	
5.00 Parent provider overhead allocated to facility (see instructions)							263, 771	
6.00 Total overhead (sum of lines 14 and 15)							573, 230	
17.00 Allowable GME overhead (see instructions)							0	1
18.00	Subtract line 17 from line 16						573, 230	18.00
19.00	Overhead applicable to RHC/FQHC services (li	ne 13 x line 18	3)				492, 388	19.00
	Total allowable cost of RHC/FQHC services (s						764, 254	1

Heal th	Financial Systems PULASKI MEMORIAL I	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 151305	Peri od:	Worksheet M-3	
		Component CCN: 158512	From 10/01/2013 To 09/30/2014	Date/Time Pre 3/30/2015 3:55	
		Title XVIII	Rural Health Clinic (RHC) I	Cost	
				1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			7/1.05/	
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2,			764, 254	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4,	line 15)		0	2.00
3.00 4.00	Total allowable cost excluding vaccine (line 1 minus line 2) Total Visits (from Worksheet M-2, column 5, line 8)			764, 254 3, 066	3.00 4.00
4.00 5.00	Physicians visits under agreement (from Worksheet M-2, column 5	5 line 0)		3,000	4.00 5.00
6.00	Total adjusted visits (line 4 plus line 5)	5, TTHE 9)		3, 066	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			249.27	7.00
			Cal cul ati on		
			Prior to	On on After	
			January 1	January 1	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6	6 or your contractor)	79.17	79.80	8.00
9.00	Rate for Program covered visits (see instructions)		249.27	249.27	9.00
10.00	CALCULATION OF SETTLEMENT		0	471	10.00
10.00	Program covered visits excluding mental health services (from c	471 117, 406	10. 00 11. 00		
11.00 12.00	5				12.00
12.00					13.00
14.00	5				14.00
15.00					15.00
16.00	5 ,				
16.01	Total program charges (see instructions)(from contractor's reco			117, 406 117, 390	
16. 02	Total program preventive charges (see instructions)(from provid			0	16. 02
16. 03	Total program preventive costs ((line 16.02/line 16.01) times I	ine 16)		0	16. 03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03	and 18) times .80)		93, 925	16.04
	(Titles V and XIX see instructions.)				
16.05	Total program cost (see instructions)			93, 925	
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (records)	(Trom contractor		0	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions records)	s) (from contractor		0	19. 00
20.00	Net Medicare cost excluding vaccines (see instructions)			93, 925	20,00
21.00	Program cost of vaccines and their administration (from Wkst. N	1-4, line 16)		,3, ,23	21.00
22.00	5				
23.00	Allowable bad debts (see instructions)			93, 925 0	23.00
23. 01	Adjusted reimbursable bad debts (see instructions)			0	23. 01
24.00	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)		0	
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 93, 925	25.00
26.00					
26.01					26.01
27.00	Interim payments	30, 069			
28.00	Tentative settlement (for contractor use only)	0	28.00		
29.00 30.00	Balance due component/program line 26 minus lines 26.01, 27 and			61, 977 0	29.00 30.00
30.00	Protested amounts (nonallowable cost report items) in accordance chapter I, section 115.2	Le with CMS Pub. 15-11,		0	30.00
	100000 1, 3000000 113.2		1		I

Heal th	Financial Systems PULASKI MEMORIAI	_ HOSPI TAL	In Lie	u of Form CMS-2	2552-10		
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES Provider CC			Peri od:	Worksheet M-5			
RENDERED TO PROGRAM BENEFICIARIES		Component CCN: 158512	From 10/01/2013 To 09/30/2014	Date/Time Pre 3/30/2015 3:55			
			Rural Health	Cost			
			Clinic (RHC) I	_			
				t B			
			mm/dd/yyyy	Amount			
1 00	Total interim payments paid to provider		1.00	2.00	1.00		
1.00 2.00	Interim payments payable on individual bills, either submitte the contractor for services rendered in the cost reporting per "NONE" or enter a zero			30, 089 0	2.00		
3.00	List separately each retroactive lump sum adjustment amount b revision of the interim rate for the cost reporting period. A payment. If none, write "NONE" or enter a zero. (1)			3. 00			
	Program to Provider						
3.01 3.02 3.03 3.04				0 0 0	3. 01 3. 02 3. 03 3. 04		
3.05				0	3.05		
	Provider to Program						
3.50 3.51 3.52 3.53 3.54				0 0 0 0	3.50 3.51 3.52 3.53 3.54		
3. 99 4. 00	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) (transfe	·		0 30, 069	3. 99 4. 00		
	27) TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						
F 04	Program to Provider				F 01		
5. 01 5. 02 5. 03				0 0 0	5. 01 5. 02 5. 03		
	Provider to Program						
5.50 5.51 5.52 5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98	3)		0 0 0 0	5.50 5.51 5.52 5.99		
6. 00 6. 01 6. 02	SETTLEMENT TO PROVIDER						
7.00	Total Medicare program liability (see instructions)			0 92, 046	6. 02 7. 00		
			Contractor Number	NPR Date (Mo/Day/Yr)			
0.00		0	1.00	2.00	0.00		
8.00	Name of Contractor				8.00		