PULASKI MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 05-31-2019 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-1305 Worksheet S Peri od. From 10/01/2016 Parts I-III AND SETTLEMENT SUMMARY 09/30/2017 Date/Time Prepared: То 2/27/2018 12:02 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically filed cost report Date: 2/27/2018 Time: 12:02 pm use only Manually submitted cost report 2. []If this is an amended report enter the number of times the provider resubmitted this cost report]Medicare Utilization. Enter "F" for full or "L" for low. 3 0 Ē 4

 [1] Cost Report Status
 6. Date Received:

 [1] As Submitted
 7. Contractor No.

 (2) Settled without Audit 8.
 [N] Initial Report for this Provider CCN

 (3) Settled with Audit
 9.

 [N] Final Report for this Provider CCN
 10. NPR Date:

 (11. Contractor's Vendor Code:
 4

 (12. Settled with Audit
 9.

 [N] Final Report for this Provider CCN
 11. Contractor's Code:

 (13. Settled with Audit
 9.

 [N] Final Report for this Provider CCN
 11.

 [N] Final Report for this Provider CCN
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 [N] Final Report for this Provider CCN
 10.

 [N] Final Report for this Provider CCN
 10.

 [N] Contractor 5. use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT. CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S) I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PULASKI MEMORIAL HOSPITAL (15-1305) for the cost reporting period beginning 10/01/2016 and ending 09/30/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.]I have read and agree with the above certification statement. I certify that I intend my electronic Γ signature on this certification statement to be the legally binding equivalent of my original signature. (Signed) Officer or Administrator of Provider(s) Title Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	13, 220	242, 587	0	22, 928	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	73, 235	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	-1		0	9.00
10.00	RURAL HEALTH CLINIC I	0		65, 379		0	10.00
200.00	Total	0	86, 455	307, 965	0	22, 928	200.00

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

	AL AND HOSPITAL HEALTH CARE COMPLEX	PULASKI MEMOR		ler CCN: 1		Period: From 10/01		Workshe	et S-2	
							/2017			
	1.00	2.00		3.00			4.00		510 12.	
00	Hospital and Hospital Health Care Co Street: 616 EAST 13TH	PO Box:								1.
00 00	City: WINAMAC	State: IN	Zip Cod	e: 46996-	Count	ty: PULASKI				2.
		Component Name	CCN	CBSA	Provi der			ent Syst		
			Number	Number	Туре	Certi fi ed		F, O, or XVIII	N) XIX	-
		1.00	2.00	3.00	4.00	5.00	6. 00		8.00	+
	Hospital and Hospital-Based Componer		-							
0	Hospi tal	PULASKI MEMORIAL HOSPITAL	151305	99915	1	10/01/2000	N C	0	0	3.
0	Subprovider - IPF	HUSFTIAL								4.
0	Subprovider - IRF									5.
0	Subprovi der - (Other)		157005	00045		1.0 (0.1 (0.0.0)				6.
0	Swing Beds - SNF	PULASKI MEMORIAL HOSPITAL	15Z305	99915		10/01/2000	N C	0	P	7.
0	Swing Beds - NF	HOSTTAL								8.
0	Hospital-Based SNF									9.
00	Hospital -Based NF									10.
00 00	Hospital-Based OLTC Hospital-Based HHA	PULASKI MEMORIAL	157078	99915		10/14/1982	2 N	P	N	11. 12.
00		HOSPI TAL	107070	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						12.
00	Separately Certified ASC									13.
00	Hospital-Based Hospice	PULASKI MEMORIAL HOSPICE	151550	99915		09/01/1997	/			14.
00	Hospital-Based Health Clinic - RHC	PULASKI MEMORIAL RHC	158512	99915		08/21/2014	4 N	0	N	15.
00	Hospital-Based Health Clinic - FQHC									16.
00	Hospital-Based (CMHC) I									17.
00 00	Renal Dialysis Other									18. 19.
00				1	1	From	1:	То):	17.
						1.00		2. (
00 00	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)					10/01/2	2016	09/30	/2017	20.
00	Inpatient PPS Information					2				21.
00	Does this facility qualify and is it	currently receiving pa	ayments fo	r di sprop	portionate	e N		N		22.
	share hospital adjustment, in accord									
	for yes or "N" for no. Is this facil amendment hospital?) In column 2, en			12. 106(C)) (2) (РІ СКІ	е				
D1	Did this hospital receive interim un			is cost r	reporting	N		N	l	22.
	period? Enter in column 1, "Y" for y									
	reporting period occurring prior to			2						
	for no for the portion of the cost r (see instructions)	eporting period occurr	ng on or	arter uci	LUDEI I.					
02	Is this a newly merged hospital that	requires final uncompo	ensated ca	re paymer	nts to be	N		N	l	22.
	determined at cost report settlement									
	or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for									
	or after October 1.		the cost	. spor criti	9 001 00 0					
	Did this hospital receive a geograph	is real assification fr		o rurol d		t N		N	l	22.
03										
03	of the OMB standards for delineating	statistical areas ado	oted by CM	S in FY20	015? Enter					
03		statistical areas ado no for the portion of	oted by CM the cost r	S in FY20 eporting	015? Enter period	-				
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alth Financial Systems PULASKI DSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	MEMORIAL H	Provider CC	N: 15-1305	Peri od:			rkshee		
				From 10 To 09	9/30/20	017 Da			pared: 01 pm
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	d HMC	li cai d) days	Otl Medi	ner cai d lys	
	1.00	2.00	3.00	4.00		5.00	6.	00	
5.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	Urbar	0 VRural	C S Dat		Geogr	25.0
					1.00		2.00		
 6.00 Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for 7.00 Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi 5.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period. 	r rural. age) status r "2" for r ication in	at the end ural. If ap column 2.	d of the co pplicable,	st		2 2 0			26.00 27.00 35.00
erreet in the cost reporting perrou.					i nni ng	:	Endi n	g:	
6.00 Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date		cript line	36 for num		1.00		2.00)	36.0
7.00 If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		er of perio	ds MDH stat	us		0			37.0
7.01 Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)					Ν				37.0
8.00 If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.									38.0
					Y/N		Y/N		
9.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) for yes or "N" for no. Does the facility meet the mil with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column instructions)) or (ii)? Leage requi	Enter in co rements in	olumn 1 "Y" accordance	ume	<u>1.00</u> N		2.00 N)	39.0
 0.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1. 	ber 1. Ente	er "Y" for y			N		N		40.0
								XI X 3. 00	1
Prospective Payment System (PPS)-Capital									
 5.00 Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) 6.00 Is this facility eligible for additional payment excert 					nce	N N	N N	N N	45.0
pursuant to 42 CFR §412.348(f)? If yes, complete Wks1 Pt. III.	t. L, Pt. I	II and Wks ⁻	t. L-1, Pt.	l throu					
7.00 Is this a new hospital under 42 CFR §412.300(b) PPS of 8.00 Is the facility electing full federal capital payment Teaching Hospitals						N N	N N	N N	47.0 48.0
6.00 Is this a hospital involved in training residents in or "N" for no.	approved G	ME programs	s? Enter "	Y" for ye	es	N			56.0
7.00 If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for	r yes or "N th of this	l" for no in cost repor e Workshee	n column 1. ting period	lf colur ? Enter	nn 1 "Y"				57.0
is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "N "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	l, if appli				1				58.0
is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II 8.00 If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	l, if appli bursement f complete W	°or physicia /kst. D-5.		es as		N			- FO
is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "\ "N", complete Wkst. D, Parts III & IV and D-2, Pt. II 8.00 If line 56 is yes, did this facility elect cost reimb	l, if appli bursement f complete W	°or physicia /kst. D-5.		35 Work	ksheet i ne #	Qua	ss-Thr alific Criter	ation ion	59.0
is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II 8.00 If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	l, if appli bursement f complete W	°or physicia /kst. D-5.	<u>, Pt. I.</u> NAHE 413.8	35 Work L		A Pa Qua	al i fi c	ation ion	

OSPI	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provider CC		eriod: com 10/01/2016 o 09/30/2017		pared
		Y/N	IME	Direct GME	I ME	Direct GME	
	1	1.00	2.00	3.00	4.00	5.00	
1.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in				0.00	0.00	61.0
	column 1. (see instructions)						
1. 01	Enter the average number of unweighted primary care		0.00	0.00			61.0
	FTEs from the hospital's 3 most recent cost reports						
	ending and submitted before March 23, 2010. (see instructions)						
1. 02	Enter the current year total unweighted primary care		0.00	0.00			61.0
	FTE count (excluding OB/GYN, general surgery FTEs,						
	and primary care FTEs added under section 5503 of ACA). (see instructions)						
1.03	Enter the base line FTE count for primary care		0.00	0.00			61.0
	and/or general surgery residents, which is used for						
	determining compliance with the 75% test. (see						
1 04	instructions) Enter the number of unweighted primary care/or		0.00	0.00			61.0
1.04	surgery allopathic and/or osteopathic FTEs in the		0.00	0.00			01.0
	current cost reporting period. (see instructions).						
1. 05	Enter the difference between the baseline primary		0.00	0.00			61.0
	and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						
	61.04 minus line 61.03). (see instructions)						
1. 06	Enter the amount of ACA §5503 award that is being		0.00	0.00			61.0
	used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						
	care of general surgery. (see this full to its)	Pro	ogram Name	Program Code	Unweighted	Unweighted	
					IME FTE Count	Direct GME	
			1.00	2.00	3.00	FTE Count 4.00	-
1.10	Of the FTEs in line 61.05, specify each new program		1.00	2.00	0.00		61.
	specialty, if any, and the number of FTE residents						
	for each new program. (see instructions) Enter in						
	column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE						
	unweighted count. Enter in column 4, the direct GME						
	FTE unweighted count.						
1. 20	Of the FTEs in line 61.05, specify each expanded				0.00	0.00	61.2
	program specialty, if any, and the number of FTE residents for each expanded program. (see						
	instructions) Enter in column 1, the program name.						
	Enter in column 2, the program code. Enter in column						
	3, the IME FTE unweighted count. Enter in column 4,						
	the direct GME FTE unweighted count.						
	<u></u>					1.00	1
2. 00	ACA Provisions Affecting the Health Resources and Sen Enter the number of FTE residents that your hospital				iod for which	0.00	62.0
	your hospital received HRSA PCRE funding (see instruc			r opor tring por]
2. 01	Enter the number of FTE residents that rotated from a				your hospital	0.00	62.0
	during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide			ns)			1
3.00	Has your facility trained residents in nonprovider se			ost reporting	period? Enter	N	63.0
	"Y" for yes or "N" for no in column 1. If yes, comple	ete lin	es 64 through				
				Unweighted	Unweighted	Ratio (col.	
				FTEs Nonprovider	FTEs in Hospital	1/ (col . 1 + col . 2))	
				Site	noopi tui	2,7,7	
				1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor			This base year	is your cost	reporting	
. 00	Enter in column 1, if line 63 is yes, or your facilit	ty trai	ned residents	0.00	0.00	0. 000000	64.0
	in the base year period, the number of unweighted nor	n-prima	ry care				
	resident FTEs attributable to rotations occurring in	all no	nprovi der				
	settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in	d non-p	rimary care				

	EX IDENTIFICATION D	ATA Provider C	Fr	eriod: com 10/01/2016	Worksheet S-2 Part I	
			To	09/30/2017	Date/Time Pre 2/27/2018 12:	epare
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
-	1.00	2.00	3.00	4.00	5.00	1
00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column			0.00	0.00	0. 000000	, 65.
5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unweighted FTEs	Unweighted FTEsin	Ratio (col. 1/ (col. 1 +	
			Nonprovider Site	Hospi tal	col . 2))	
Section 5504 of the ACA Current	Voar ETE Docidort- :	n Nonnrouidor Cattin	1.00	2.00	3.00	
beginning on or after July 1, 20		n Nonprovider Settin	ysLitective i	u cust repurt	ing perious	
					0.00000	
	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column	provider settings. ary care resident 3 the ratio of	0.00	0.00	0. 000000	66.
00 Enter in column 1 the number of a FTEs attributable to rotations of Enter in column 2 the number of a FTEs that trained in your hospita	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column	provider settings. ary care resident 3 the ratio of	0.00 Unweighted FTEs Nonprovider Site	0.00 Unweighted FTEs in Hospital	0.000000 Ratio (col. 3/ (col. 3 + col. 4))	
<pre>00 Enter in column 1 the number of of FTEs attributable to rotations of Enter in column 2 the number of of FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program</pre>	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column column 2)). (see ir	provider settings. ary care resident 3 the ratio of astructions)	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	_
00 Enter in column 1 the number of o FTEs attributable to rotations of Enter in column 2 the number of o FTEs that trained in your hospita (column 1 divided by (column 1 +	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column column 2)). (see ir Program Name	provider settings. ary care resident 3 the ratio of astructions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	
 OD Enter in column 1 the number of the FTEs attributable to rotations of Enter in column 2 the number of the FTEs that trained in your hospital (column 1 divided by (column 1 + OO 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 3 divided by (column 3 + column 4)). (see instructions) 	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name <u>1.00</u>	provider settings. ary care resident 3 the ratio of astructions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Rati o (col . 3/ (col . 3 + col . 4)) 5.00 0.000000	
 OD Enter in column 1 the number of of FTEs attributable to rotations of Enter in column 2 the number of of FTEs that trained in your hospita (column 1 divided by (column 1 + OD 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 3 divided by (column 3 + column 4)). (see instructions) 	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column column 2)). (see ir Program Name 1.00 1.00	Provi der settings. Ary care resident 3 the ratio of Instructions) Program Code 2.00	Unwei ghted FTEs Nonprovi der Si te 3.00 0.00	Unwei ghted FTEs in Hospi tal 4.00 0.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000	
 OD Enter in column 1 the number of of FTEs attributable to rotations of Enter in column 2 the number of of FTEs that trained in your hospita (column 1 divided by (column 1 + OO 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 3 divided primary care resident FTEs that trained in your hospital. Enter in column 3 divided by (column 3 + column 4)). (see instructions) 	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column column 2)). (see ir Program Name 1.00 1.00 1.00 2.00 2.00 2.00 2.00 2.00	provi der settings. ary care resident 3 the ratio of istructions) Program Code 2.00 2.00 (IPF), or does it con approved GME teach 2004? Enter "Y" for ility train resident)(D)? Enter "Y" for	Unweighted FTEs Nonprovider Site 3.00 0.00 tain an IPF subp ing program in f yes or "N" for r s in a new teach	Unwei ghted FTEs in Hospi tal 4.00 0.00 0.00 1.00 provi der? N the most no. (see ni ng no.	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000	0 67.

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1305	Period: From 10/01/2016 To 09/30/2017		repared
		1.0	0 2.00 3.00	5
b. 00 If line 75 is yes: Column 1: Did the facility have an approved recent cost reporting period ending on or before November 15, 2 no. Column 2: Did this facility train residents in a new teachi CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Co indicate which program year began during this cost reporting period.	2004? Enter "Y" for yes ng program in accordar blumn 3: If column 2 is	n the most s or "N" for nce with 42 s Y,	0	76.0
Long Term Care Hospital PPS			1.00	_
 0.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes ar 1.00 Is this a LTCH co-located within another hospital for part or a "Y" for yes and "N" for no. 		ng period? Ente	~ N	80. 0 81. 0
 TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TE Did this facility establish a new Other subprovider (excluded u §413.40(f)(1)(i)? Enter "Y" for yes and "N" for no. 	3		N	85. 0 86. 0
7.00 Is this hospital a "subclause (II)" LTCH classified under secti for yes or "N" for no.	on 1886(d)(1)(B)(iv)(I	I)? Enter "Y"	N	87.0
		V	XIX	_
Title V and XIX Services		1.00	2.00	
0.00 Does this facility have title V and/or XIX inpatient hospital s yes or "N" for no in the applicable column.	services? Enter "Y" for	- N	Y	90.0
1.00 Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the applica	able column.	Ν	Y	91.0
2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual instructions) Enter "Y" for yes or "N" for no in the applicable			N	92.0
B. OD Does this facility operate an ICF/IID facility for purposes of "Y" for yes or "N" for no in the applicable column.		- N	N	93.0
.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and applicable column.		N	N	94.
 00 If line 94 is "Y", enter the reduction percentage in the applic 00 Does title V or XIX reduce operating cost? Enter "Y" for yes or applicable column. 		0. 00 N	0. 00 N	95.0
C.00 If line 96 is "Y", enter the reduction percentage in the applic Does title V or XIX follow Medicare (title XVIII) for the inter stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for column 1 for title V, and in column 2 for title XIX.	rns and residents post	0. 00 Y	0. 00 Y	97.0
8.01 Does title V or XIX follow Medicare (title XVIII) for the report C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title title XIX.			Y	98.
B. 02 Does title V or XIX follow Medicare (title XVIII) for the calcubed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "for title V, and in column 2 for title XIX.		Y	Y	98.
.03 Does title V or XIX follow Medicare (title XVIII) for a critical reimbursed 101% of inpatient services cost? Enter "Y" for yes of for title V, and in column 2 for title XIX.			N	98.
.04 Does title V or XIX follow Medicare (title XVIII) for a CAH rei outpatient services cost? Enter "Y" for yes or "N" for no in co in column 2 for title XIX.		N N	N	98.
.05 Does title V or XIX follow Medicare (title XVIII) and add back Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in colu column 2 for title XIX.			Y	98.
.06 Does title V or XIX follow Medicare (title XVIII) when cost rei Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 column 2 for title XIX. Rural Providers		Y	Y	98.
5.00Does this hospital qualify as a CAH? 6.00 f this facility qualifies as a CAH, has it elected the all-inc	clusive method of pavme	Y ent N		105.
for outpatient services? (see instructions) 7.00 If this facility qualifies as a CAH, is it eligible for cost re training programs? Enter "Y" for yes or "N" for no in column 1. yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25	eimbursement for I&R (see instructions) I1	- N		107.
reimbursed. If yes complete Wkst. D-2, Pt. II. 8.00 s this a rural hospital qualifying for an exception to the CRN				108.

	Provider C		<u>In</u> eriod: rom 10/01/2		Workshe Part I		
		Т	o 09/30/	2017	Date/Ti 2/27/20		
	Physi cal	Occupati onal	Speech	ן ו	Respi r		
	1.00	2.00	3.00		4. ()0	
09.00 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.	N	N	N		N		109.00
					1. (
10.00 Did this hospital participate in the Rural Community Hospita Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	"Y" for yes o	"N" for no. I	f yes,		N		110.00
			1.00		2.0	00	
11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this construction for yes or "N" for no in column 1. If the response to construct on prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for a construction for tele-health services.	ost reporting olumn 1 is Y, rticipating in	period? Enter enter the column 2.	N				111.00
				1.00	2.00	3.00	
 Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percer psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1. 16.00 Is this facility classified as a referral center? Enter "Y" 	. If column 2 nt for long to rs) based on [.]	is "E", enter erm care (inclu the definition	in column des	N		0	115.00
17.00 Is this facility legally-required to carry malpractice insur no.			"N" for	Y			117.00
18.00 Is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	licy? Enter 1			1			118.00
		Premi ums	Losses	5	Insur	ance	
		1.00	2.00		3.0		
18.01 List amounts of malpractice premiums and paid losses:		124, 679	9	0		(0118.0
			1.00		2.0)0	
Administrative and General? If yes, submit supporting scheo and amounts contained therein.			1.00 N		2. (0	118.0
Administrative and General? If yes, submit supporting scheo and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Holo §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment	dule listing o d Harmless pro n column 1, "` ualifies for	cost centers ovision in ACA (" for yes or the Outpatient			2. C		118.0 119.0 120.0
Administrative and General? If yes, submit supporting scheo and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no.	dule listing o d Harmless pro n column 1, " ualifies for nts? (see ins	cost centers ovision in ACA (" for yes or the Outpatient tructions)	N				119. 0 120. 0 121. 0
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 Administrative and General? If yes, submit supporting sched and amounts contained therein. 19.00 D0 NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for 	dule listing of d Harmless pro- n column 1, "" ualifies for - nts? (see ins antable device fined in §1903 1 is "Y", ento	cost centers poision in ACA (" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2	N N Y				119. 0 120. 0 121. 0 122. 0
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 Administrative and General? If yes, submit supporting sched and amounts contained therein. 19.00 D0 NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain heal thcare related taxes as defined Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified heart transplant center, entin column 1 and termination date, if applicable, in column 2 	dule listing of d Harmless pro- n column 1, "Y ualifies for nts? (see ins antable device fined in §1903 1 is "Y", ent or yes and "N" nter the certi- ter the certi- 2. ter the certi-	cost centers poision in ACA (" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 	N N Y N				119. 0 120. 0 121. 0 122. 0 125. 0 126. 0 127. 0
 Administrative and General? If yes, submit supporting sched and amounts contained therein. 19.00 D0 NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implatients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2 27.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2 28.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2 29.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2 29.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2 29.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2 	dule listing of d Harmless pro- n column 1, "" ualifies for nts? (see ins antable device fined in §1900 1 is "Y", ento or yes and "N" nter the certi- ter the certi- 2. ter the certi- 2. er the certi-	cost centers ovision in ACA (" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 ' for no. If fication date fication date fication date in	N N Y N				119. 0 120. 0 121. 0 122. 0 125. 0 126. 0 127. 0 128. 0 129. 0
 Administrative and General? If yes, submit supporting sched and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain heal there related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2 27.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2 29.00 If this is a Medicare certified pancreas transplant center, entin column 1 and termination date, if applicable, in column 2 30.00 If this is a Medicare certified pancreas transplant center, entin column 1 and termination date, if applicable, in column 2 30.00 If this is a Medicare certified pancreas transplant center, enter column 1 and termination date, if applicable, in column 2 30.00 If this is a Medicare certified pancreas transplant center, enter column 1 and termination date, if applicable, in column 2 30.00 If this is a Medicare certified pancreas transplant center, enter column 1 and termination date, if applicable, in column 2 	dule listing of d Harmless pro- n column 1, "Y ualifies for nts? (see ins antable device fined in §1903 1 is "Y", ento or yes and "N" nter the certi- 2. ter the certi- 2. er the certi- 2. er the certi- 1. enter the certi- 1. enter the certi- 1.	cost centers by ision in ACA (" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 ' for no. If fication date fication date fication date in rtification	N N Y N				119. C 120. C 121. C 122. C 125. C 126. C 127. C 128. C 129. C 130. C
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 and amounts contained therein. 19.00 D0 NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA \$3121 and applicable amendmemer Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implatients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A Line number where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified heart transplant center, entin column 1 and termination date, if applicable, in column 2 27.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2 29.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2 30.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2 30.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2 30.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2 30.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2 30.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2 	dule listing of h column 1, "Y ualifies for nts? (see ins antable device fined in §1903 1 is "Y", ento or yes and "N" nter the certifient ter the certifient enter the certifient enter the certifient iumn 2. r, enter the certifient ter the certifient con 2. ter the certifient ter the certifient ter the certifient con 2.	cost centers by ision in ACA (" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 ' for no. If fication date fication date fication date cation date in rtification certification fication date	N N Y N				119. 0 120. 0 121. 0

Health Financial Systems	PULASKI MEMOR	REAL HOSPETAL			In L	ieu of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ID	ENTIFICATION DATA	Provider CC	N: 15-130		i od:	Worksheet S-	2
				To	m 10/01/20 09/30/20		epared:
						2/27/2018 12	
					1.00	2.00	-
140.00 Are there any related organization or	home office costs as	defined in CMS	Pub. 15-	1,	N	2.00	140.00
chapter 10? Enter "Y" for yes or "N" f				osts			
are claimed, enter in column 2 the hom		e <u>r. (see instruc</u> 00	tions)		3.00		
If this facility is part of a chain or			ugh 143 t	the name		ess of the home	
office and enter the home office contr	actor name and contr		-				
141.00Name:	Contractor's Name:		Contr	ractor's	s Number:		141.00
142.00 Street: 143.00 City:	PO Box: State:		Zip C	ode:			142.00 143.00
	otatoi						
						1.00	
144.00 Are provider based physicians' costs i	ncluded in Worksheet	A?				Y	144.00
				-	1.00	2.00	-
145.00 If costs for renal services are claime							145.00
inpatient services only? Enter "Y" for							
no, does the dialysis facility include period? Enter "Y" for yes or "N" for		n for this cost	reportin	ig			
146.00 Has the cost allocation methodology ch		ously filed cos	t report?	,	Ν		146.00
Enter "Y" for yes or "N" for no in col		15-2, chapter 4	40, §4020)) If			
yes, enter the approval date (mm/dd/yy	yy) in column 2.						
						1.00	-
147.00 Was there a change in the statistical						N	147.00
148.00 Was there a change in the order of all				6		N	148.00
149.00 Was there a change to the simplified c	ost finding method?	Part A	es or "N" Part		Title V	N Title XIX	149.00
		1.00	2.00		3.00	4.00	-
Does this facility contain a provider							
or charges? Enter "Y" for yes or "N" f 155.00 Hospi tal	for no for each compo	nent for Part A		t B. (S∈		§413.13) N	155.00
155.00 Subprovi der – TPF		N	N N		N N	N N	155.00
157.00 Subprovider - IRF		N	N		N	N	157.00
158. 00 SUBPROVI DER							158.00
159.00 SNF 160.00 HOME_HEALTH_AGENCY		N	N		N N	N	159.00 160.00
161. OO CMHC		14	N		N	N	161.00
				·			
Multicompue						1.00	
Multicampus 165.00Is this hospital part of a Multicampus	hospital that has o	ne or more camp	uses in d	li fferen	nt CBSAs?	N	165.00
Enter "Y" for yes or "N" for no.	·····						
	Name	County	State	Zip Co			-
166.00 fline 165 is yes, for each	0	1.00	2.00	3.00	0 4.00		0166.00
campus enter the name in column						0.0	100.00
0, county in column 1, state in							
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in							
column 5 (see instructions)							
Health Information Tachnology (ULT) in	contine in the Ameri		d Doi pyor	stmont /	Act.	1.00	-
Health Information Technology (HIT) in 167.00 Is this provider a meaningful user und	er §1886(n)? Enter	"Y" for ves or '	"N" for n	IO.	ACI	Y	167.00
168.00 If this provider is a CAH (line 105 is					enter the		0168.00
reasonable cost incurred for the HIT a				6			
168.01 If this provider is a CAH and is not a exception under §413.70(a)(6)(ii)? Ent					nardsni p	N	168.01
169.00 If this provider is a meaningful user					'), enter t	.he 0.0	0169.00
transition factor. (see instructions)							
				_	Begi nni ng 1. 00	Endi ng 2. 00	-
170.00 Enter in columns 1 and 2 the EHR begin	ning date and ending	date for the re	eporti na		10/03/2016		170.00
period respectively (mm/dd/yyyy)	- 0						

Health Financial Systems PL	JLASKI MEMORIAL	HOSPI TAL	In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICAT	ION DATA	Provider CCN: 15-1305	Period: From 10/01/2016	Worksheet S-	-2
			To 09/30/2017	Date/Time Pr 2/27/2018 12	repared: 2:01 pm
			1.00	2.00	
171.00 If line 167 is "Y", does this provider have any section 1876 Medicare cost plans reported on Wk "Y" for yes and "N" for no in column 1. If colu 1876 Medicare days in column 2. (see instruction	st. S-3, Pt. I, mn 1 is yes, en	line 2, col. 6? Enter	on		0171.00

OSPI T	Financial Systems PULASKI MEMORI AL AND HOSPI TAL HEALTH CARE REIMBURSEMENT QUESTI ONNAI RE	AL HOSPITAL Provider C	CN: 15-1305	In Lie Period:	Worksheet S	
				From 10/01/2016 To 09/30/2017		repare
				Y/N	Date	<u>2.01 p</u>
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	lfor all NO re	esponses. En	ter all dates in	the	
	Provider Organization and Operation					_
. 00	Has the provider changed ownership immediately prior to the			N		1.
	reporting period? If yes, enter the date of the change in c	column 2. (see		· · ·		_
			Y/N 1.00	Date 2.00	V/I 3.00	
. 00	Has the provider terminated participation in the Medicare P	Program? If	N 1.00	2.00	3.00	2.
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	nn 3, "V" for				
. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other	offices, drug der or its of the board	N			3.
	relationships? (see instructions)		Y/N	Туре	Date	_
			1.00	2.00	3.00	
	Financial Data and Reports					
. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	for Compiled,	Y	A		4.
. 00	Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit reconcisional statements of the statement of the stateme		N			5.
	Approved Educational Activities			Y/N 1.00	Legal Oper. 2.00	
. 00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	lf ves, is t	he provider i	is N	1	6.
	the legal operator of the program?					_
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved		d during the	N N		7. 8.
00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal educatio	n N		9.
0. 00	Was an approved Intern and Resident GME program initiated c cost reporting period? If yes, see instructions.		the current	Ν		10.
1.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11.
	Dad Debto				Y/N 1.00	
	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	s, see instruc	ti ons.		Y	12.
3.00	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.	oolicy change o	during this o		N	13.
4.00	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? I	fyes, see in	nstructions.	N	14.
5 00	Bed Complement Did total beds available change from the prior cost reporti	na period? [f	ves see in	structions	N	15.
			rt A		t B	
	_	Y/N	Date	Y/N	Date	_
	PS&R Data	1.00	2.00	3.00	4.00	-
5. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	Y	10/18/2017	Y	10/18/2017	16.
7.00	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	Ν		Ν		17.
3. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	Ν		Ν		18.
	but are not included on the PS&R Report used to file this cost report? If yes, see instructions.					
9.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		N		19.

Heal th	Fi nanci al	Systems

	Financial Systems PULASKI MEMORI AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CC	V· 15_1305	Period:	Worksheet S	
	AL AND HUSPITAL HEALTH GARE REIMBURGEMENT QUESTIONNALKE	Provider CC	1. 13-1305	From 10/01/2016 To 09/30/2017	Part II Date/Time P	repare
	· · · · · · · · · · · · · · · · · · ·	Deceriu	tion	Y/N	2/27/2018 1: Y/N	2:01 pr
		Descri		1.00	3.00	
0 00	If line 16 or 17 is yes, were adjustments made to PS&R	0		1.00	N 3.00	20.
0.00	Report data for Other? Describe the other adjustments:			IN	IN IN	20.
	Report data for other beserve the other adjustments.	Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
1.00	Was the cost report prepared only using the provider's	N	2.00	N	1.00	21.
	records? If yes, see instructions.					
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	OSPI TALS)			
	Capital Related Cost					
2.00	Have assets been relifed for Medicare purposes? If yes, see	e instructions			N	22.
3.00	Have changes occurred in the Medicare depreciation expense	e due to apprais	als made du	ring the cost	N	23.
	reporting period? If yes, see instructions.					
4.00	Were new leases and/or amendments to existing leases enter	red into during	this cost r	eporting period?	N	24.
	lf yes, see instructions					
5.00	Have there been new capitalized leases entered into during	g the cost repor	ting period	?lfyes, see	N	25.
	instructions.					
5.00	Were assets subject to Sec. 2314 of DEFRA acquired during the	he cost reporti	ng period?	If yes, see	N	26.
7 00	instructions.			£		07
7.00	Has the provider's capitalization policy changed during the	ne cost reportin	g period? I	r yes, submit	N	27.
	copy. Interest Expense				<u> </u>	_
3. 00	Were new Loans, mortgage agreements or letters of credit e	ntorod into dur	ing the cos	t roporting	N	28.
5. 00	period? If yes, see instructions.		ing the cos	t reporting	IN IN	20.
. 00	Did the provider have a funded depreciation account and/or	bond funds (De	nt Service	Reserve Fund)	N	29.
. 00	treated as a funded depreciation account? If yes, see inst		St Service	Reserve runu)	IN IN	27.
0. 00	Has existing debt been replaced prior to its scheduled mat	urity with new	debt?lfve	s see	N	30.
. 00	instructions.		debt. If ye	5, 500		00.
I. 00	Has debt been recalled before scheduled maturity without is	ssuance of new	debt?lf ve	s. see	N	31.
	instructions.		5			
	Purchased Services					
2.00	Have changes or new agreements occurred in patient care se	ervi ces furni she	d through c	ontractual	N	32.
	arrangements with suppliers of services? If yes, see instru	ructions.	-			
3.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap	plied pertainin	g to compet	itive bidding? If	ŧ	33.
	no, see instructions.					
	Provi der-Based Physi ci ans					
4. 00	Are services furnished at the provider facility under an a	arrangement with	provi der-b	ased physicians?	Y	34.
	Are services furnished at the provider facility under an a If yes, see instructions.	Ū.				
	Are services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended ex	kisting agreemen			Y N	
	Are services furnished at the provider facility under an a If yes, see instructions.	kisting agreemen		provi der-based	N	
	Are services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended ex	kisting agreemen		provi der-based	N Date	
	Are services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see in	kisting agreemen		provi der-based	N	
. 00	Are services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see in Home Office Costs	kisting agreemen		provi der-based Y/N 1.00	N Date	35.
5. 00 5. 00	Are services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report?	kisting agreemen nstructions.	ts with the	provi der-based Y/N 1.00	N Date	35.
5. 00	Are services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	kisting agreemen nstructions.	ts with the	provi der-based Y/N 1.00	N Date	35.
5. 00 5. 00 7. 00	Are services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p If yes, see instructions.	isting agreemen nstructions.	ts with the	Provi der-based Y/N 1.00 N	N Date	35. 36. 37.
5. 00 5. 00 7. 00	Are services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p If yes, see instructions. If line 36 is yes , was the fiscal year end of the home office for the home offi	kisting agreemen nstructions. prepared by the fice different	ts with the	Provi der-based Y/N 1.00 N	N Date	35. 36. 37.
5. 00 6. 00 7. 00 3. 00	Are services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p If yes, see instructions.	kisting agreemen nstructions. prepared by the ffice different nd of the home o	ts with the nome office from that o ffice.	provi der-based Y/N 1.00 N f	N Date	35. 36. 37. 38.
5. 00 5. 00 7. 00 3. 00	Are services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end	kisting agreemen nstructions. prepared by the ffice different nd of the home o	ts with the nome office from that o ffice.	provi der-based Y/N 1.00 N f	N Date	35. 36. 37. 38.
5. 00 5. 00 7. 00 3. 00 9. 00	Are services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other	isting agreemen nstructions. orepared by the ffice different ad of the home o her chain compon	nome office from that o ffice. ents? If ye	provi der-based <u>Y/N</u> <u>1.00</u>	N Date	35. 36. 37. 38. 39.
5. 00 5. 00 7. 00 3. 00 9. 00	Are services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions.	isting agreemen nstructions. orepared by the ffice different ad of the home o her chain compon	nome office from that o ffice. ents? If ye	provi der-based <u>Y/N</u> <u>1.00</u>	N Date	35. 36. 37. 38. 39.
5. 00 5. 00 7. 00 3. 00 9. 00	Are services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the	disting agreemen nstructions. prepared by the fice different d of the home o her chain compon- e home office?	ts with the nome office from that o ffice. ents? If ye If yes, see	provi der-based Y/N 1.00 N f s,	N Date 2.00	35. 36. 37. 38. 39.
5. 00 5. 00 7. 00 3. 00 9. 00	Are services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions.	isting agreemen nstructions. orepared by the ffice different ad of the home o her chain compon	ts with the nome office from that o ffice. ents? If ye If yes, see	provi der-based Y/N 1.00 N f s,	N Date	35. 36. 37. 38. 39.
5. 00 5. 00 7. 00 3. 00 9. 00 0. 00	Are services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions. If line 36 is yes, did the provider render services to the instructions.	sting agreemen nstructions. orepared by the fice different ad of the home o her chain compon- home office?	ts with the nome office from that o ffice. ents? If ye If yes, see	Provi der-based Y/N 1.00 N f S, 2.	N Date 2.00	35. 36. 37. 38. 39.
5. 00 5. 00 7. 00 3. 00 9. 00 0. 00	Are services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position	disting agreemen nstructions. prepared by the fice different d of the home o her chain compon- e home office?	ts with the nome office from that o ffice. ents? If ye If yes, see	provi der-based Y/N 1.00 N f s,	N Date 2.00	35. 36. 37. 38. 39. 40.
5. 00 5. 00 7. 00 3. 00 9. 00 0. 00	Are services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	sting agreemen nstructions. orepared by the fice different ad of the home o her chain compon- home office?	ts with the nome office from that o ffice. ents? If ye If yes, see	Provi der-based Y/N 1.00 N f S, 2.	N Date 2.00	35. 36. 37. 38. 39. 40.
5. 00 5. 00 5. 00 7. 00 3. 00 9. 00 1. 00	Are services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions. If line 36 is yes, did the provider render services to the instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	cisting agreemen nstructions. prepared by the ffice different d of the home o her chain compon e home office? 1.0 MI CHAEL	ts with the nome office from that o ffice. ents? If ye If yes, see	Provi der-based Y/N 1.00 N f S, 2.	N Date 2.00	35. 36. 37. 38. 39. 40. 41.
5.00 6.00 7.00 8.00 9.00 0.00 1.00	Are services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report	sting agreemen nstructions. orepared by the fice different ad of the home o her chain compon- home office?	ts with the nome office from that o ffice. ents? If ye If yes, see	Provi der-based Y/N 1.00 N f S, 2.	N Date 2.00	35. 36. 37. 38. 39. 40. 41.
5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00	Are services furnished at the provider facility under an a If yes, see instructions. If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see in Home Office Costs Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to other instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer.	cisting agreemen nstructions. prepared by the ffice different d of the home o her chain compon e home office? 1.0 MI CHAEL	ts with the nome office from that o ffice. ents? If ye If yes, see	Provi der-based Y/N 1.00 N f S, 2.	N <u>Date</u> 2.00	34. 35. 36. 37. 38. 39. 40. 41. 41. 42. 1.

ancial Systems PULAS	SKI MEMORIA	AL HOSPITAL	In Lieu	u of Form CMS-2	2552-10
ND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTION	NAI RE	Provider CCN: 15-1	eriod: rom 10/01/2016 o 09/30/2017	Date/Time Pre	pared:
		3.00			
t Report Preparer Contact Information					
er the first name, last name and the title/pos		ENIOR MANAGER			41.00
d by the cost report preparer in columns 1, 2,	and 3,				
pecti vel y.					
er the employer/company name of the cost repor	t				42.00
parer.					
	he cost				43.00
ort preparer in columns 1 and 2, respectively.					
er the first name, last name and the title/pos d by the cost report preparer in columns 1, 2, pectively. er the employer/company name of the cost repor	and 3, t				01 pm 41.0

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	<u>PULASKI MEMORI</u> AL DATA	Provider C	CN: 15-1305	Period: From 10/01/2016		
					To 09/30/2017	Date/Time Pre 2/27/2018 12:	
						I/P Days /	
						0/P Visits /	
						Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number 1.00	2.00	Available 3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	25			0.00	1.0
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.0
8.00 .00	HMO IPF Subprovider HMO IRF Subprovider						3.0 4.0
. 00	Hospital Adults & Peds. Swing Bed SNF					0	4.0 5.0
. 00	Hospital Adults & Peds. Swing Bed SN Hospital Adults & Peds. Swing Bed NF					0	6.0
. 00	Total Adults and Peds. (exclude observation		25	9, 12	47, 664. 00	0	7.0
	beds) (see instructions)		20	77.12		0	
. 00	INTENSIVE CARE UNIT	31.00	0		0 0.00	0	8.
. 00	CORONARY CARE UNIT						9.
0. 00	BURN INTENSIVE CARE UNIT						10.
1.00	SURGI CAL I NTENSI VE CARE UNI T						11.
2.00	OTHER SPECIAL CARE (SPECIFY)						12.
3.00	NURSERY	43.00				0	
4.00	Total (see instructions)		25	9, 12	47, 664. 00	0	
5.00 6.00	CAH visits SUBPROVIDER - IPF					0	15. 16.
7.00	SUBPROVIDER - IRF						17.
8.00	SUBPROVI DER						17.
9.00	SKILLED NURSING FACILITY						19.
0.00	NURSING FACILITY						20.
1.00	OTHER LONG TERM CARE						21.
2.00	HOME HEALTH AGENCY	101.00				0	22.
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23.
4.00	HOSPI CE	116.00	0		0		24.
4.10	HOSPICE (non-distinct part)	30.00					24.
5.00	CMHC - CMHC						25.
6.00	RURAL HEALTH CLINIC	88.00				0	
6.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00	05			0	26.
7.00 8.00	Total (sum of lines 14-26)		25			0	27.
9.00	Observation Bed Days Ambulance Trips					0	20.
9.00).00	Employee discount days (see instruction)						30.
1.00	Employee discount days (see fisting the fi						31.
2.00	Labor & delivery days (see instructions)		0		0		32.
2.01	Total ancillary labor & delivery room						32.
	outpatient days (see instructions)						
3.00	LTCH non-covered days						33.
3. 01	LTCH site neutral days and discharges						33.

OSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-1305	Period: From 10/01/2016 To 09/30/2017	Worksheet S-3 Part I Date/Time Pre 2/27/2018 12:	pared
		I/P Days	/ O/P Visits	/ Trips	Full Time E		
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
. 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)	1, 065	32	1, 98	36		1.
. 00 . 00	HMO and other (see instructions) HMO IPF Subprovider	118 0	255 0				2. 3.
. 00	HMO I RF Subprovider	0 910	0	91	0		4.
. 00 . 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF	910	0	91	-		5. 6.
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 975	32	3, 09			7.
. 00 . 00 0. 00 1. 00	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T	0	O		0		8. 9. 10. 11.
2.00	OTHER SPECIAL CARE (SPECIFY)						12.
3.00	NURSERY	4 075	0	23		10/ 00	13.
1.00 5.00	Total (see instructions) CAH visits	1, 975 0	32 0	3, 33	0.00	186.02	14 15
b. 00	SUBPROVIDER - IPF	0	0		0		16
. 00	SUBPROVIDER - IRF						17
. 00	SUBPROVI DER						18
. 00	SKILLED NURSING FACILITY						19
. 00	NURSING FACILITY						20
. 00	OTHER LONG TERM CARE	2, 386	o	2 45	0.00	10. 75	21
. 00 . 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.)	2, 380	0	3, 47	0.00	10.75	22
. 00	HOSPI CE	0	0		0 0.00	0.00	
. 10	HOSPICE (non-distinct part)	0	0		0		24
. 00	CMHC - CMHC						25
. 00	RURAL HEALTH CLINIC	5, 920	279	22, 97		45.93	
. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00	0.00	
. 00	Total (sum of lines 14-26)		0	42	0.00	242.70	27
. 00	Observation Bed Days Ambulance Trips	0	0	42	0		20
. 00	Employee discount days (see instruction)	0			0		30
. 00	Employee discount days - IRF				0		31
. 00	Labor & delivery days (see instructions)	0	0		3		32
2. 01	Total ancillary labor & delivery room				0		32
	outpatient days (see instructions)						
3.00	LTCH non-covered days	0					33

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	PULASKI MEMORIAL	Provider C	°N· 15_1305	Period:	u of Form CMS-2 Worksheet S-3	2552-10
1103FT I	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC		FIOVICEI CO	50. 15-1505	From 10/01/2016 To 09/30/2017		
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers 11.00	12.00	13.00	14.00	Patients 15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12.00		03 14	582	1.00
2.00 3.00 4.00 5.00	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider		-		27 90 0 0		2.00 3.00 4.00 5.00
5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	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) NURSERY						5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00
13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE	0.00	0	3(03 14	582	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 26.00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	0.00					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	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambul ance 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 0.00					26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01
33. 00 33. 01	LTCH non-covered days LTCH site neutral days and discharges				0		33. 00 33. 01

Heal th	Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
HOME H	IEALTH AGENCY STATI STI CAL DATA				Period: From 10/01/2016 Fo 09/30/2017		
			component	CCN. 13-7070	Home Health	2/27/2018 12: PPS	
					Agency I	rr J	
	1				1.	00	
0.00	County	Title V	Title XVIII	Title XIX	Other	Total	0.00
		1.00	2.00	3.00	4.00	5.00	
1.00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	0	0		0 0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	111.00		0.00 Loyees (Full Ti		2.00
					royees (run n		
		Enter the numb your normal		Staff	Contract	Total	
		your norman	WOLK WEEK				
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	()	1.00	2.00	3.00	
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00 5.00	Director(s) and Assistant Director(s) Other Administrative Personnel			0. 5 [°] 0. 0 [°]			4.00 5.00
6.00	Direct Nursing Service			4.1	0.00	4.11	6.00
7.00 8.00	Nursi ng Supervi sor Physi cal Therapy Servi ce			0.00			
9.00	Physical Therapy Supervisor			0.00			
10.00	Occupational Therapy Service			0.1			
11.00 12.00	Occupational Therapy Supervisor Speech Pathology Service			0.00			•
13.00	Speech Pathology Supervisor			0.00			
14.00 15.00	Medical Social Service Medical Social Service Supervisor			0.00			
16.00	Home Health Aide			3. 08	0.00	3.08	16.00
17.00 18.00	Home Health Aide Supervisor OTHER			0.00			
	HOME HEALTH AGENCY CBSA CODES				0.00	0.07	
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost				1		19.00
~~~~~	reporting period.			00015			
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20			99915			20.00
	contains the first code).	Full Er	al codoc				
		Wi thout	With Outliers	LUPA Epi sodes		Total (cols.	
		Outliers 1.00	2.00	3.00	Epi sodes 4.00	<u> </u>	
21.00	PPS ACTIVITY DATA			1			21.00
21.00 22.00	Skilled Nursing Visits Skilled Nursing Visit Charges	944 213, 180				1, 023 231, 056	1
23.00	Physical Therapy Visits	522	12	-	7 0	541	23.00
24.00 25.00	Physical Therapy Visit Charges Occupational Therapy Visits	128, 656 113			1 U 3 0	133, 329 134	1
26.00	Occupational Therapy Visit Charges	27, 836	4, 443			33, 020	26.00
27.00 28.00	Speech Pathology Visits Speech Pathology Visit Charges	8 1, 975				8 1, 975	•
29.00	Medical Social Service Visits	0	0		0 0	0	29.00
30.00 31.00	Medical Social Service Visit Charges Home Health Aide Visits	0 637	0 42			0 680	•
32.00	Home Health Aide Visit Charges	66, 380	4, 386	104		70, 870	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2, 224	108	54	¹ 0	2, 386	33.00
34.00	Other Charges	0	0	1		0	
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	438, 027	19, 937	12, 280	0	470, 250	35.00
36.00	Total Number of Episodes (standard/non outlier)	142		20	0 0	162	36.00
37.00	Total Number of Outlier Episodes		2	4 40	0		
38.00	Total Non-Routine Medical Supply Charges	35, 506	6, 488	4,400	6 0	46, 400	38.00

Heal th	Financial Systems	PULASKI MEMOR	I AL HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period:	Worksheet S-8	3
			Component		From 10/01/2016 To 09/30/2017		epared: 01 pm
					RHC I	Cost	
					1	. 00	-
	Clinic Address and Identification				1.	00	
1.00	Street		-		540 HOSPITAL D		1.00
				ty	State	ZIP Code	
2.00	City, State, ZIP Code, County		UNIMAC	00	2.00	3.00 46996	2.00
2.00	orty, state, zri code, county						2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for		t Award	0	3.00
					t Award .00	Date 2.00	
	Source of Federal Funds					2100	
4.00	Community Health Center (Section 330(d), PHS						4.00
5.00 6.00	Migrant Health Center (Section 329(d), PHS A Health Services for the Homeless (Section 34)						5.00 6.00
7.00	Appal achi an Regi onal Commi ssi on	U(U), FIIS ACT)					7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECI FY)						9.00
					1.00	2.00	
10.00	Does this facility operate as other than a h	ospi tal -based	RHC or FQHC? E	nter "Y" for	N	0	10.00
	yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o						
	hours.)	Sur	nday	Mo	nday	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
11 00	Facility hours of operations (1)		1	60.00	17.00		111 00
11.00	Clinic			08: 00	17:00	08: 00	11.00
					1.00	2.00	
	Have you received an approval for an exception				N		12.00
13.00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col	umn 1. If yes,	enter in colu	mn 2 the	N	0	13.00
	number of providers included in this report. numbers below.	LIST THE Name	es or all provi	ders and			
					der name	CCN number	
11.00				1	. 00	2.00	11.00
14.00	RHC/FQHC name, CCN number	Y/N	V	XVIII	XIX	Total Visits	14.00
		1.00	2.00	3.00	4.00	5. 00	
15.00	Have you provided all or substantially all						15.00
	GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and						
	4 the number of program visits performed by						
	Intern & Residents for titles V, XVIII, and						
	XIX, as applicable. Enter in column 5 the number of total visits for this provider.						
	(see instructions)						
				inty			
2.00	City State 71D Cade County			00			2.00
2.00	City, State, ZIP Code, County	Tuesday	PULASKI Wedn	esday	Thu	rsday	2.00
		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		10. 30	100.00	117.00	00.00	110. 30	11.00

Health Financial Systems	PULASKI MEMO	RI AL	HOSPI TAL		In Lieu	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provi der	CCN: 15-1305	Period:	Worksheet S-8	3
			Component	CCN: 15-8512	From 10/01/2016 To 09/30/2017	Date/Time Pre 2/27/2018 12:	epared: 01 pm
		_			RHC I	Cost	
	Fr	ri day	1	Sa	turday		
	from		to	from	to		
	11.00		12.00	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 MEMORIAL H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI 1	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN		Period:	Worksheet S-1	0
				rom 10/01/2016 o 09/30/2017		pared:
					2/27/2018 12:	
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	vided by lir	ne 202 column	8)	0. 458433	1.00
	Medicaid (see instructions for each line)	3		,		
2.00	Net revenue from Medicaid				1, 640, 666	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		с и н		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement	1 5		1 d?	N 590 577	4.00
5.00 6.00	If line 4 is no, then enter DSH and/or supplemental payments fr Medicaid charges	rom medicald	1		589, 577 10, 557, 002	5.00 6.00
7.00	Medicaid cost (line 1 times line 6)				4, 839, 678	
8.00	Difference between net revenue and costs for Medicaid program (	(line 7 minu	us sum of lin	es 2 and 5: if	2, 609, 435	8.00
	< zero then enter zero)					
	Children's Health Insurance Program (CHIP) (see instructions fo	or each line	e)			
9.00	Net revenue from stand-al one CHIP				0	9.00
	Stand-alone CHIP charges				0	10.00 11.00
	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (	(line 11 mir	us lino 0 i	f < zero then		12.00
12.00	enter zero)		ius i i i e 🧃 i		0	12.00
	Other state or local government indigent care program (see inst	tructions fo	or each line)		I	
13.00	Net revenue from state or local indigent care program (Not incl	uded on lir	nes 2, 5 or 9	)	0	13.00
14.00		e program (N	lot included	in lines 6 or	0	14.00
15 00	10) State on Local indigent care program post (Line 1 times Line 1)	4)			0	15 00
	State or local indigent care program cost (line 1 times line 14 Difference between net revenue and costs for state or local ind		program (lin	o 15 minus line	0	15.00 16.00
10.00	13; if < zero then enter zero)	argent care				10.00
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state	e∕local indig	ent care progra	ams (see	
	instructions for each line)		-		-	
	Private grants, donations, or endowment income restricted to fu				0	17.00 18.00
	Government grants, appropriations or transfers for support of H Total unreimbursed cost for Medicaid, CHIP and state and local			(sum of lines	2, 609, 435	
17.00	8, 12 and 16)	i indigent d		(Suil Of TITIES	2,007,433	19.00
			Uni nsured	Insured	Total (col. 1	
		_	patients	patients	+ col . 2)	
	Uncompanyated Care (see instructions for each line)		1.00	2.00	3.00	
20.00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fac	cility	282, 063	3 0	282, 063	20 00
20.00	(see instructions)	Shrity	202,000		202,000	20.00
21.00	Cost of patients approved for charity care and uninsured discouinstructions)	unts (see	129, 307	0	129, 307	21.00
22.00	Payments received from patients for amounts previously written charity care	off as	(	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)		129, 307	0	129, 307	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patier	nt davs bevo	ond a length	of stav limit	1.00	24.00
	imposed on patients covered by Medicaid or other indigent care	program?		•		
25.00	If line 24 is yes, enter the charges for patient days beyond the stay limit	ne indigent	care program	's length of	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see ins				1, 894, 866	
27.00	Medicare reimbursable bad debts for the entire hospital complex	•			401, 684	
27.01	Medicare allowable bad debts for the entire hospital complex (s	see instruct	(ions)		617, 975	
28.00 29.00		nansa (soci	nstructions)		1, 276, 891 801, 660	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	50136 (366 I	13 ti uc ti 0115)		930, 967	30.00
	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			3, 540, 402	

4.00         00400         EMPLOYEE BENEFITS DEPARTMENT         0         5, 216, 386         5, 216, 386         0         5, 216, 386         4, 00           5.00         00500         ADMIN IS TRATI ON OF PLANT         2, 67, 823         550, 358         818, 181         0         818, 181         7.00           0.00         OPERATI ON OF PLANT         2, 67, 823         550, 358         818, 181         0         818, 181         7.00           0.00         OPOOD (HOUSEKEPPING         160, 061         79, 628         239, 689         0         239, 689         9.00           13.00         01300         NURSI NG ADMINI STRATI ON         441, 531         17, 09         458, 630         0         458, 630         10.00           14.00         01400 CENTRAL SERVICES & SUPPLY         42, 106         53, 456         95, 556         0         95, 556         14.00         15.00           15.00         01500         PLARMACY         0         0         0         0         15.00           16.00         01600         MEDICAL SERVICE MERTICS         2,078, 555         131,738         2,210,293         41,128         2,251,421         30.00           17.00         01700 SOIAL SERVI CE COST CENTERS         24,612         9,527 </th <th>Health Financial Systems</th> <th>PULASKI MEMORIAL</th> <th>HOSPI TAL</th> <th></th> <th>In Lie</th> <th>u of Form CMS-2</th> <th>2552-10</th>	Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10	
Cost Center Description         Salaries         Other         Total         Coll         Reclase in cat (cons. 6)         Pace (coll)         Reclase in cat (cons. 6)           1.00         0.00         3.00         4.00         5.00           1.00         0.000 NW CAP REL         COSTS -BLO & FLXT         1.00         1.00         1.00         1.00         3.00         4.00         5.00           1.00         0.0000 AW CAP REL         COSTS -BLO & FLXT         1.700, 836         1.700, 836         1.700, 836         1.99,74         1.720, 810         1.00           5.00         0.00000 AUMINISTAR THE & CHEREAL         1.960 035         2.013, 228         3.022, 814         400,962         4.381, 220         5.00           0.000000 AUMINEST KE SERVICE         2.02,72         42,744         7.700,814         5.00         4.383, 229         1.00           1.00         10300 MURSING AUMINESTRATION         441,531         17,099         488,630         0         458,830         13.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00 <td>RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O</td> <td>F EXPENSES</td> <td>Provider C</td> <td>CN: 15-1305</td> <td>Period:</td> <td>Worksheet A</td> <td></td>	RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C	CN: 15-1305	Period:	Worksheet A		
Cost Center Description         Salaries         Other         Total         Coll         Reclase in cat (cons. 6)         Pace (coll)         Reclase in cat (cons. 6)           1.00         0.00         3.00         4.00         5.00           1.00         0.000 NW CAP REL         COSTS -BLO & FLXT         1.00         1.00         1.00         1.00         3.00         4.00         5.00           1.00         0.0000 AW CAP REL         COSTS -BLO & FLXT         1.700, 836         1.700, 836         1.700, 836         1.99,74         1.720, 810         1.00           5.00         0.00000 AUMINISTAR THE & CHEREAL         1.960 035         2.013, 228         3.022, 814         400,962         4.381, 220         5.00           0.000000 AUMINEST KE SERVICE         2.02,72         42,744         7.700,814         5.00         4.383, 229         1.00           1.00         10300 MURSING AUMINESTRATION         441,531         17,099         488,630         0         458,830         13.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00 <td></td> <td></td> <td></td> <td></td> <td>To 09/30/2017</td> <td>Date/Time Pre</td> <td></td>					To 09/30/2017	Date/Time Pre		
Line         + col. 2)         Lons (See A)         Tri al Bal ance Col. 4)           1.00         2.00         3.00         4.00         5.00           1.00         2.00         3.00         4.00         5.00           1.00         0000 (RE) CAP REL COSTS-BLO & FLYT         1.700, 830         1.700, 830         1.700, 830         1.700, 830         1.700, 810         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.383, 920         5.03         5.03         5.03         5.03         5.04         4.00         4.00         4.833, 920         4.833, 920         4.833, 920         4.833, 920         4.836, 920         4.836, 920         4.836, 920         4.836, 920         4.836, 920         4.836, 920         4.836, 920         4.836, 920         4.836, 920         4.836, 920         4.836, 920         4.836, 920         4.836, 930         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00 </td <td>Cost Conton Deparintian</td> <td>Calarian</td> <td>Othor</td> <td></td> <td>-</td> <td>2/27/2018 12:</td> <td>01 pm</td>	Cost Conton Deparintian	Calarian	Othor		-	2/27/2018 12:	01 pm	
Image: service cost centers         1.00         2.00         3.00         4.00         5.00           1.00         2.00         3.00         4.00         5.00         5.00           1.00         0.000 (NEW CPC COST CENTES DEP & FIT         0.700 (NEW CPC COST CENTERS DEP & FIT </td <td>Cost center bescription</td> <td>Salaries</td> <td>Uther</td> <td></td> <td></td> <td></td> <td></td>	Cost center bescription	Salaries	Uther					
Image: constraint of the service cost centers         Image: constraint of the service cost centers         Image: constraint of the service cost centers           0.000000         Centers         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 736         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 836         1, 700, 736         1, 180, 736         1, 180, 736         1, 180, 736								
ENCRAL_SERVICE_COST_CENTERS         1.00         2.00         3.00         4.00         5.00           1.00         00100 [NEW CAP REL_COST_S-BLG & FIXT         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.700, 836         1.710, 1.710, 1.710, 1.710, 1.710, 1.								
1.00       ODION NEW CAP REL COSTS-BLOG & FLXT       1.700, 836       19,974       1,720, 836       19,974       1,720, 816       1.00         5.00       ODSOD AMMINSTRATIVE & GENERAL       1.969,030       2,013,928       3,982,998       400,962       4,882,920       5.00         0.00       ODSOD CPEATION OF PLANT       267,823       550,356       818,181       181,181       7.00         0.00       ODSOD CPEATION OF PLANT       207,222       49,274       69,546       0.69,546       8.00         0.00       ODSOD CAMURY & LINEN SERVICE       20,272       49,274       69,546       0.358,629       10.00         0.00       ODSOD CAMURSING AMMINISTRATION       441,531       17,009       458,633       0       458,643       13.00         1.00       OIGOD CHENTAN LESCRVICE SE SUPPLY       42,106       53,450       95,556       0       95,56       10       0       15.00         1.00       OIGOD CHARAMACY       29,445       44,169       0.0       14.00       0       17.002       17.002       17.002       17.002       17.002       17.002       17.002       17.002       17.002       17.002       17.002       17.002       17.002       17.002       17.002       17.002       17.002		1.00	2.00	3.00	4.00			
4.00         00400         EMPLOYEE         ENERTISE         0         5.216.386         0         5.216.386         4.00         5.216.386         4.00.962         4.383.292         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00				-	_			
5.00         00500         ADMI MISTRATIVE & GENERAL         1,969,030         2,013,928         3,929,958         400,962         4,383,920         5.00           8.00         00800         LAUNDRY & LINEN SERVICE         20,272         40,274         40,9546         0         818,181         7.00           8.00         00800         LAUNDRY & LINEN SERVICE         20,272         40,274         40,9546         0         808,99,00           9.00         00900         DURSINE ADMINI STRATION         411,5117,002         187,427         338,429         0         358,429         0         358,429         0         458,630         458,630         0         458,630         0         458,630         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0					6 19, 974	1, 720, 810	1.00	
7.00         00700         OPERATION OF PLANT         267, 823         550, 358         Bil, 181         0         Distant         Sign 140         Sign 140         Sign 140         Sign 143         Sign 143         Bil, 181         10         Bil, 181         0         Bil, 181         Distant         Bil, 181	4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-						
8.00         000600         LAUNDRY & LINEN SERVICE         20,272         49,274         69,546         0         69,069         0.200         00200         DISENCE PUNC         160,061         79,628         239,669         0.238,6429         0         338,429         0         338,429         0         338,429         0         338,429         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
9.00 00900 HOUSEKEEPING 100,001 T79,028 239,689 0 239,689 0 239,689 0 01300 NURSING ADMINISTRATION 441,531 17,999 458,630 0 458,630 0 458,630 0 458,630 0 10300 NURSING ADMINISTRATION 441,531 17,999 458,630 0 458,630 0 556 14.00 10.00 01500 (PARAMACY CST & SUPPLY 42,106 53,450 95,556 0 0 5,56 14.00 15.00 0 1500 (PARAMACY CST & SUPPLY 42,106 53,450 95,556 0 0 31.00 0 1500 (PARAMACY CST & SUPPLY 42,106 53,450 95,556 0 0 31.00 0 1500 (PARAMACY CST & SUPPLY 42,106 53,450 95,556 0 0 0 31.00 0 1700 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
10. 00         01000         DIETRAY         171,002         187,427         358,429         0         338,429         10.00           13. 00         01300         NRSING ADMINSTRATION         441,531         17,099         458,630         13.00         01300         16.00         95,566         0         95,566         0         95,566         0         95,566         0         16.00         0         0         0         0         0         16.00         0         0         0         16.00         0         0         16.00         16.00         0         0         16.00         0         0         16.00         0         0         0         16.00         0         0         10.00         0         0         0         16.00         0         0         16.00         0         0         0         30.0         10.00         0         0         0         0         0         17.00         17.00         17.00         17.00         17.00         17.00         17.00         18.00         0         30.0         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00         13.00<							•	
13. 00       01300, NURSI NG, ADMI NI STRATI ON       441, 521       17, 00       458, 630       0.0       458, 630       15. 00       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0								
14. 00       01400 CENTRAL SERVICES & SUPPLY       42. 106       53. 450       95. 556       0       95. 556       0       95. 556       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0								
15. 00       01500 PHARMACY       0       0       0       0       0       0       0       15.00         16. 00       01600 MEDICAL SERVICE       49,804       105       49,909       0       49,909       0       49,909       0       49,909       0       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00								
16. 00       01400 MEDICAL RECORDS & LIBRARY       293, 445       48, 245       341, 690       0       341, 690       16. 00         10.00       01700 DILTS & FRVICE       049, 909       17. 00         0100       0300 INTERSIVE CARE UNIT       2, 078, 555       131, 738       2, 210, 293       41, 128       22, 14, 21       30. 00         0100       03100 INTERSIVE CARE UNIT       24, 612       9, 527       34, 139       45, 438       79, 577         0100       05000 OFERATING ROOM       545, 952       104, 781       650, 733       355, 147       1, 005, 880       50. 00         01000 ODELIVERY ROM & LABOR ROOM       77, 922       5, 548       633, 419       0       83, 470       52. 00         01000 ODELIVERY ROM & LABOR ROOM       77, 922       5, 548       631, 449       0       630, 144       53. 00       60. 00       600       1, 516, 393       0       1, 516, 393       0       1, 516, 393       0       1, 516, 393       54. 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       60. 00       60. 00							•	
17.00         001700         SOCIAL SERVICE         49,004         105         49,009         0         49,090         17.00           0.00         03000         AULTS & PEDIATRICS         2,078,555         131,738         2,210,293         41,128         2,251,421         30.00           0.0300         INTENSIVE CARE UNIT         24,612         9,527         34,139         45,438         79,577         43.00           0.00         05200         DEFRATING ROOM         77,922         5,548         83,470         0         83,470         55.00         65.00         630,149         630,149         630,149         630,149         630,149         630,149         630,149         630,149         630,149         630,149         630,149         660,00         60.00         60.00         1,381,406         0         1,381,406         60.00         60.00         60.00         1,381,406         0         1,381,406         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         60.00         60.00         60.00         60.00		°,	-			-	•	
INPATIENT ROUTINE SERVICE COST CENTERS         Image and the service of the ser								
30. 00         03000 ADULTS & PEDIATRICS         2.078,555         131,738         2.202,293         41,128         2.251,421         30.00           43. 00         04300 NITERSI VE CARE UNIT         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0		49, 004	105	49,90	9 0	49,909	17.00	
31. 00       031.00       INTENSIVE CARE UNIT       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 <t< td=""><td></td><td>2 078 555</td><td>131 738</td><td>2 210 29</td><td>3 41 128</td><td>2 251 421</td><td>30 00</td></t<>		2 078 555	131 738	2 210 29	3 41 128	2 251 421	30 00	
43. 00         04300 NURSERY         24, 612         9, 527         34, 139         45, 438         79, 577         43. 00           NALLLARY SERVICE COST CENTERS         50.00         05000 DERATING ROOM         77, 922         5, 548         83, 470         0         83, 470         0         83, 470         50.00         83, 470         0         83, 470         52.00         06300 ANESTHESI OLOGY         0         630, 144         630, 144         630, 144         630, 144         53.00           54. 00         0.5400 RADI DLOGY -DI AGNOSTI C         761, 764         754, 629         1, 516, 393         0         1, 516, 393         66.00         60.01         630, 144         630, 149         60.00         660.00           0.00         0.000 LABORATORY         638, 227         743, 179         1, 381, 406         60.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         68.00         62.928         54, 928         69.02         61.43, 292         67.00         66.00           0.00 6600 CUCLAPIA INAL THERAPY         789, 320         50.61, 73         34, 130         62.372         68.00         68.							•	
ANCI LLARY SERVICE COST CENTERS           ANCI LLARY SERVICE COST CENTERS           0.00         05000         OPERATING ROM         545, 952         104, 781         650, 733         355, 147         1, 005, 880         52. 00           52.00         D5300         DELIVERY ROM & LABOR ROM         77, 922         5, 548         83, 470         0         630, 149         53. 00         630, 149         630, 149         630, 149         630, 149         53. 00         60. 00         6300         RADOR RADIOLOGY DI AGNOSTI C         761, 764         754, 629         1, 516, 393         0         1, 516, 393         0         1, 516, 393         0         1, 516, 393         0         1, 516, 393         0         1, 516, 393         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0		-	-			-	•	
50. 00         05000         DEELVERY         ROM         545, 952         104, 781         650, 733         355, 147         1, 055, 880         50. 00           52. 00         05200         DELLVERY         ROM         ALABOR ROM         77, 922         5, 548         83, 470         0         83, 470         53. 00           53. 00         05300         ANESTHESI OLOGY         0         630, 149         630, 149         0         1, 516, 393         0         1, 516, 393         54. 00         630, 149         0         1, 516, 393         54. 00         660. 0         1, 516, 393         54. 00         60. 0         1, 516, 393         54. 00         660. 0         1, 516, 393         65. 00         660. 0         1, 516, 393         65. 00         660. 0         54. 928         54, 928         63. 00         54. 928         54, 928         63. 00         54. 928         63. 00         560. 0         6600         PHYSICAL         148, 262         20. 9         143. 292         0         143. 292         61. 00         66. 00         6600         5600         960. 00         690. 00         690. 00         690. 00         690. 00         690. 00         690. 00         690. 00         690. 00         690. 00         69. 01         68. 00		21,012	7,027	01,10	10,100	17,011	10.00	
52. 00         OS200         DELI VERY ROM & LABOR ROM         77, 922         5,548         83,470         0         83,470         52. 00           53. 00         05300         ANESTHESI OLGGY         0         630, 149         630, 149         630, 149         630, 149         630, 149         630, 149         630, 149         630, 149         630, 149         630, 149         630, 149         630, 149         630, 149         630, 149         630, 149         630, 149         630, 149         630, 149         630, 149         630, 149         630, 149         630, 149         630, 149         630, 149         630, 149         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60         60 <td></td> <td>545, 952</td> <td>104, 781</td> <td>650, 73</td> <td>3 355, 147</td> <td>1,005,880</td> <td>50.00</td>		545, 952	104, 781	650, 73	3 355, 147	1,005,880	50.00	
53. 00         IOS300         ARESTHESIOLOGY         0         630, 149         630, 149         630, 149         630, 149         630, 149         630, 149         630, 149         53, 00           54. 00         05400         RADIOLOGY-DI AGNOSTI C         761, 764         754, 629         1, 516, 393         0         1, 516, 393         40         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0								
54.00       054.00       RADIOLOCY-DIAGNOSTIC       761,764       754,629       1,516,393       0       1,516,393       54.00       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0							•	
60.000         060000         LABORATORY         638,227         743,179         1,381,406         0         1,381,406         60.00         60.00           60.01         06001         BLOOD LABORATORY         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	54. 00 05400 RADI OLOGY-DI AGNOSTI C	761, 764				1, 516, 393	54.00	
63.00         IG300         BLOOD STORING, PROCESSING & TRANS.         0         54,928         54,928         54,928         63.00           65.00         06500         RESPIRATORY THERAPY         291,255         27,782         319,037         0         319,037         65.00           66.00         06600         PHYSICAL THERAPY         789,320         50,057         839,377         0         839,377         66.00           67.00         06600         SPEECH PATHOLOGY         59,930         2,442         62,372         0         62,372         68.00           68.00         06600         ELECTROCARDIOLOGY         18,363         9,971         28,334         0         28,334         69.00           69.01         06901         CARDI AC REHABILI TATION         63,197         2,703         65,900         0         70.00         70.00           0000         DECTROCRENCPHALOGRAPHY         0         0         0         0         72.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00			743, 179					
65.00       06500       RESPI RATORY THERAPY       291, 255       27, 782       319, 037       0       319, 037       65.00         66.00       06600       PHYSI CAL THERAPY       789, 320       50, 057       839, 377       0       839, 377       66.00         67.00       06700       0CCUPATI ONAL THERAPY       141, 263       2, 029       143, 292       0       62.372       68.00         68.00       06900       ELECTROCARDI OLOGY       18, 363       9, 971       28, 334       0       28, 334       69.00         06901       CARDI AC REHABI LI TATI ON       63, 197       2, 703       65, 900       0       69.01       0       0       0       70.00       70.00       656, 193       566, 193       -146, 922       419, 271       71.00       70.00       70.00       126, 922       72.00       72.00       72.00       73.00       0       0       0       0       70.00       70.00       146, 922       146, 922       146, 922       72.00       73.00       73.00       073.00       0       146, 922       146, 922       74.00       73.00       73.00       0       146, 922       146, 922       146, 922       72.00       73.00       0       73.00       0	60.01 06001 BLOOD LABORATORY	0	0		0 0	0	60.01	
66.00       06600       PHYSI CAL THERAPY       789, 320       50, 057       839, 377       0       839, 377       66.00         67.00       0CCUPATI ONAL THERAPY       111, 263       2, 029       113, 292       0       113, 292       67.00         68.00       06800       SPEECH PATHOLOGY       59, 930       2, 442       62, 372       68.00       69.00         69.01       06900       ELECTROCARDI OLOGY       18, 363       9, 971       28, 334       0       28, 334       69.00         69.00       06901       CARDI AC REHABI LI TATI ON       63, 197       2, 703       65, 900       0       69.00       70.00       70.00       71.00       0       0       0       0       0       0       70.00       71.00       70.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       74.65, 751       396, 417       4, 453, 168       -787, 928       3, 665, 240       88.00       88.00       88.00       88.00       90.00       90.00       144, 921       144, 921       144, 921       90.00       90.00       2, 055, 244       0       2, 055, 244       90.00       90.00	63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	54, 928	54, 92	8 0	54, 928	63.00	
67.00       06700       0CCUPATI ONAL THERAPY       141, 263       2, 029       143, 292       0       143, 292       67.00         68.00       06800       SPECH PATHOLOGY       59, 930       2, 442       62, 372       0       62, 372       68.00         69.00       06900       LECTROCARDI OLOGY       18, 363       9, 971       28, 334       0       28, 334       69.00         69.01       06901       CARDIAC REHABILI TATI ON       63, 197       2, 703       65, 900       0       69.01         0       0       0       0       0       0       0       0       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00	65. 00 06500 RESPI RATORY THERAPY	291, 255	27, 782	319, 03	7 0	319, 037	65.00	
68.00         06800         SPEECH         PATHOLOGY         59,930         2,442         62,372         0         62,372         68.00           69.01         06900         ELECTROCARDIOLOGY         18,363         9,971         28,334         0         28,334         0         28,334         0         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         69.00         70.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00         0.0         0         0         2,041,030         0         2,041,030         0         2,041,030         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         74.44,922         44.92.74         76.00         78.31         144,021         0         2.041,030         2.05.244         0		789, 320	50, 057	839, 37	7 0	839, 377	66.00	
69:00       06900       ELECTROCARDI OLOGY       18,363       9,971       28,334       0       28,334       69.00         69:01       06901       CARDI AC       REHABI LI TATI ON       63,197       2,703       65,900       0       69.01         70:00       07000       ELECTROCENCEPHALOGRAPHY       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       <		141, 263	2, 029	143, 29	2 0	143, 292	67.00	
69.01       06901       CARDIAC REHABILITATION       63,197       2,703       65,900       0       65,900       69.01         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0	68.00 06800 SPEECH PATHOLOGY	59, 930	2, 442			62, 372	68.00	
70.00         07000         ELECTROENCEPHALOGRAPHY         0         0         0         0         0         70.00         70.00           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATIENTS         0         566, 193         -146, 922         419, 271         71.00           72.00         07300         DRUGS CHARGED TO PATIENTS         0         0         146, 922         146, 922         146, 922         146, 922         146, 922         146, 922         146, 922         146, 922         146, 922         146, 922         146, 922         146, 922         146, 922         146, 922         146, 922         146, 922         146, 922         146, 922         146, 922         146, 922         146, 922         146, 922         146, 922         146, 922         146, 922         146, 922         146, 922         146, 922         146, 922         146, 922         146, 922         146, 923         72.00         73.00         0         0         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.01         73.03         73.1144, 021         0         74.00         74.00         74.05, 751         78.04, 453, 168         787.928         3, 665, 240 </td <td>69. 00 06900 ELECTROCARDI OLOGY</td> <td></td> <td>9, 971</td> <td>28, 33</td> <td>4 0</td> <td>28, 334</td> <td>69.00</td>	69. 00 06900 ELECTROCARDI OLOGY		9, 971	28, 33	4 0	28, 334	69.00	
71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       566, 193       -146, 922       419, 271       71.00         72.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       146, 922       146, 922       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       2, 041, 030       2, 041, 030       0       2, 041, 030       76.00         00202       ONCOLOGY       106, 190       37, 831       144, 021       0       144, 021       76.00         001PATI ENT SERVICE COST CENTERS       0       2, 041, 030       2, 041, 030       2, 041, 030       78.31       144, 021       0       144, 021       76.00         00100       BURGENCY       903, 073       1, 151, 871       2, 055, 244       0       2, 84, 588       0       284, 588       90.00         91.00       09000       CLINIC       903, 373       1, 151, 871       2, 055, 244       0       2, 055, 244       92.00       92.055, 244       92.05, 244       92.00       92.00       92.00       905EVATI ON BEDS (NON-DI STI NCT PART)       92.00       10100       HOME HEALTH AGENCY       585, 707       105, 782       691, 489       -68, 589       622, 900       101.00       10.00		63, 197	2, 703	65, 90	0 0	65, 900	69.01	
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       0       146,922       146,922       72.00       73.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       2,041,030       2,041,030       0       2,041,030       73.00         76.00       03020       ONCOLOGY       106,190       37,831       144,021       0       144,021       74.00       74.00         00UTPATIENT SERVICE COST CENTERS       0       37,831       144,021       0       144,021       74.00       74.00       76.00         90.00       09000       CLINIC       4,056,751       396,417       4,453,168       -787,928       3,665,240       88.00       80.00         90.00       09000       CLINIC       92,593       191,995       284,588       0       2,84,588       90.00         92.00       0BERGENCY       903,373       1,151,871       2,055,244       0       2,055,244       91.00         92.00       0BERVATION BEDS (NON-DISTINCT PART)       903,373       1,151,871       2,055,244       0       2,055,244       91.00         91.00       10100       HOME HEALTH AGENCY       585,707       105,782       691,489       -68,589       622,900		0	0				70.00	
73.00       07300       DRUGS CHARGED TO PATIENTS       0       2,041,030       2,041,030       0       2,041,030       73.00         76.00       03020       ONCOLOGY       106,190       37,831       144,021       0       144,021       76.00         0UTPATIENT SERVICE COST CENTERS		0	566, 193				•	
76. 00         03020         ONCOLOGY         106, 190         37, 831         144, 021         0         144, 021         76. 00           0UTPATI ENT SERVICE COST CENTERS         0         0.44, 021         0         144, 021         0         144, 021         0         144, 021         76. 00           88. 00         08800         RURAL HEALTH CLINIC         4, 056, 751         396, 417         4, 453, 168         -787, 928         3, 665, 240         88. 00           90. 00         09000         CLINIC         92, 593         191, 995         284, 588         0         284, 588         90. 00           91. 00         09100         EMERGENCY         903, 373         1, 151, 871         2, 055, 244         0         2, 055, 244         91. 00           92. 00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART)         0         0         2, 055, 244         92. 00         92. 00           09200         OBSERVATI ON BEDS (SUM OF LINES 1 CENTERS         585, 707         105, 782         691, 489         -68, 589         622, 900         101. 00           116. 00         I1600         HOSPI CE         0         0         0         0         16, 937, 318         31, 587, 366         6, 132         31, 593, 498         18		°,	0				•	
OUTPATI ENT SERVICE COST CENTERS           88.00         08800         RURAL HEALTH CLINIC         4,056,751         396,417         4,453,168         -787,928         3,665,240         88.00           90.00         09000         CLINIC         92,593         191,995         284,588         0         284,588         90.00           91.00         09100         EMERGENCY         903,373         1,151,871         2,055,244         0         2,055,244         91.00           92.00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART)         903,373         1,151,871         2,055,244         0         2,055,244         92.00           01100         HOME HEALTH AGENCY         585,707         105,782         691,489         -68,589         622,900         101.00           116.00         11600         HOSPI CE         0         0         0         0         116.00           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         14,650,048         16,937,318         31,587,366         6,132         31,593,498         18.00           190.00         19000         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         0         190.00           190.00         19000         GIFT, FLOWER, CO		-					•	
88.00       08800       RURAL HEALTH CLINIC       4,056,751       396,417       4,453,168       -787,928       3,665,240       88.00         90.00       09000       CLINIC       92,593       191,995       284,588       0       284,588       90.00         91.00       09100       EMERGENCY       903,373       1,151,871       2,055,244       0       2,055,244       91.00         92.00       OBSERVATION BEDS (NON-DISTINCT PART)       903,373       1,151,871       2,055,244       0       2,055,244       92.00         01.00       IONE HEALTH AGENCY       585,707       105,782       691,489       -68,589       622,900       101.00         101.00       HOME HEALTH AGENCY       585,707       105,782       691,489       -68,589       622,900       101.00         116.00       11600       HOSPICE       0       0       0       0       116.00         118.00       SUBTOTALS (SUM OF LINES 1 through 117)       14,650,048       16,937,318       31,587,366       6,132       31,593,498       18.00         190.00       190001       HOMESABLE COST CENTERS       0       0       0       0       190.00         190.00       190001       HOMECARE       0 <td< td=""><td></td><td>106, 190</td><td>37, 831</td><td>144, 02</td><td>1 0</td><td>144, 021</td><td>76.00</td></td<>		106, 190	37, 831	144, 02	1 0	144, 021	76.00	
90. 00       09000       CLINIC       92, 593       191, 995       284, 588       0       284, 588       90. 00         91. 00       09100       EMERGENCY       903, 373       1, 151, 871       2, 055, 244       0       2, 055, 244       91. 00         92. 00       09200       OBSERVATION BEDS (NON-DISTINCT PART)       903, 373       1, 151, 871       2, 055, 244       0       2, 055, 244       91. 00         92. 00       OBSERVATION BEDS (NON-DISTINCT PART)       0       0       0       10100       10100       HOME HEALTH AGENCY       585, 707       105, 782       691, 489       -68, 589       622, 900       101. 00         SPECIAL PURPOSE COST CENTERS         116.00       11600       HOSPI CE       0       0       0       0       116. 00         SUBTOTALS (SUM OF LINES 1 through 117)       14, 650, 048       16, 937, 318       31, 587, 366       6, 132       31, 593, 498       118. 00         NONREI MBURSABLE COST CENTERS         190. 00       190001       GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       190. 00       190. 00       190. 01       190. 01       190. 00       190. 01       190. 00       190. 01       190. 00		4 05 4 751	20/ 417	4 450 17	0 707 000	2 ( ( 5 240		
91.00       09100       EMERGENCY       903, 373       1, 151, 871       2, 055, 244       0       2, 055, 244       91.00         92.00       OBSERVATI ON BEDS (NON-DI STI NCT PART)       0       0       92.00       92.00       000000000000000000000000000000000000								
92. 00         09200         0BSERVATI ON BEDS (NON-DI STINCT PART)         92. 00           OTHER         REI MBURSABLE         COST CENTERS         92. 00           101. 00         10100         HOME HEALTH AGENCY         585, 707         105, 782         691, 489         -68, 589         622, 900         101. 00           SPECI AL PURPOSE COST CENTERS           116. 00         10000         0         0         0         0         101. 00           SPECI AL PURPOSE COST CENTERS           116. 00         10000         0         0         0         0         0         0         0         0         0         0         0         0         0         106. 00         108. 00         108. 00         108. 00         108. 00         108. 00         109. 00         109. 00         109. 00         109. 00         0         0         0 <th 2"2"2"2"2"2"2"2"2"2"2"2"2"2"2<="" colspa="2" td=""><td></td><td></td><td>,</td><td></td><td></td><td></td><td>•</td></th>	<td></td> <td></td> <td>,</td> <td></td> <td></td> <td></td> <td>•</td>			,				•
OTHER         REI MBURSABLE         COST         CENTERS           101.00         10100         HOME         HEALTH         AGENCY         585, 707         105, 782         691, 489         -68, 589         622, 900         101.00           SPECIAL         PURPOSE         COST         CENTERS         0         0         0         0         116.00           116.00         11600         HOSPI CE         0         0         0         0         116.00           118.00         SUBTOTALS         (SUM OF LINES 1 through 117)         14, 650, 048         16, 937, 318         31, 587, 366         6, 132         31, 593, 498         118.00           NONREI         MBURSABLE         COST         CENTERS         0         0         0         0         190.00         190.00         190.00         190.00         190.00         190.00         190.00         190.00         190.00         190.00         190.00         190.00         190.00         190.00         190.00         190.00         190.00         190.00         190.00         190.00         190.00         190.00         190.00         190.00         190.00         190.00         190.00         190.00         190.00         190.00         190.00         190		903, 373	1, 151, 871	2,055,24	4 0	2,055,244		
101.00         10100         HOME HEALTH AGENCY         585,707         105,782         691,489         -68,589         622,900         101.00           SPECIAL PURPOSE COST CENTERS         SUBTOTALS (SUM OF LINES 1 through 117)         14,650,048         0         0         0         0         116.00         116.00           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         14,650,048         16,937,318         31,587,366         6,132         31,593,498         118.00           118.00         NONREI MBURSABLE COST CENTERS         NONREI MBURSABLE COST CENTERS         116.00         100.01         190.00         6,132         31,593,498         118.00           190.00         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         0         190.00         190.00         190.00         190.01         190.00         190.01         190.01         190.00         0         0         0         190.01         190.00         190.01         190.00         190.01         190.00         190.00         190.01         190.01         190.00         190.01         190.01         190.00         190.01         190.00         190.00         190.01         190.00         190.00         190.01         190.00         190.00         190.01         190							72.00	
SPECIAL PURPOSE COST CENTERS           SPECIAL PURPOSE COST CENTERS           116.00         11600         HOSPICE         0         0         0         0         116.00           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         14,650,048         16,937,318         31,587,366         6,132         31,593,498         118.00           NONREI MBURSABLE COST CENTERS         NONREI MBURSABLE COST CENTERS         0         0         0         190.00         19000         GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         190.00         1900.01         1900.01         1900.01         1900.01         1900.01         1900.01         1900.01         190.01         190.00         190.01         190.01         190.01         190.01         190.01         190.01         190.01         190.01         190.01         190.01         190.01         190.01         190.01         190.01         190.01         190.01         190.01         190.01         190.01         190.01         190.01         190.01         190.01         190.01         190.01         190.01         190.01         190.01         190.01         190.01         190.01         190.01         190.01         190.01         190.01         190.01         190.01		585 707	105 782	691 48	9 -68 589	622 900	101 00	
116.00       11600       HOSPICE       0       0       0       0       116.00         118.00       SUBTOTALS (SUM OF LINES 1 through 117)       14,650,048       16,937,318       31,587,366       6,132       31,593,498       118.00         NONREI MBURSABLE COST CENTERS         190.00       19000       GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       190.00       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       1900.01       190.01       190.00       190.01       190.01       190.01       190.01       190.00       190.01       190.01       190.01       190.01       190.01       190.01       190.01       190.01       190.01       190.01		000,707	100,702	071,40	. 00, 307	022,700		
118.00         SUBTOTALS (SUM OF LINES 1 through 117)         14,650,048         16,937,318         31,587,366         6,132         31,593,498         118.00           NONREI MBURSABLE         COST CENTERS                       118.00                    118.00             31,593,498         118.00 <td< td=""><td></td><td>ol</td><td>0</td><td></td><td>0 0</td><td>0</td><td>116.00</td></td<>		ol	0		0 0	0	116.00	
NONREI MBURSABLE COST CENTERS           190.00         19000         GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         190.00           190.01         19001         HOMECARE         0         0         0         0         190.01           192.00         19200         PHYSI CI ANS' PRI VATE OFFICES         1,000,268         438,455         1,438,723         32,619         1,471,342         192.00           194.00         07950         MARKETI NG         94,050         164,289         258,339         -38,751         219,588         194.00								
190.00         19000         GI FT,         FLOWER,         COFFEE         SHOP & CANTEEN         0         0         0         0         190.00           190.01         19001         HOMECARE         0         0         0         0         190.01         190.01           192.00         19200         PHYSI CI ANS'         PRI VATE         0FFI CES         1,000,268         438,455         1,438,723         32,619         1,471,342         192.00           194.00         07950         MARKETI NG         94,050         164,289         258,339         -38,751         219,588         194.00		, 250, 010	,		5,102	2., 6, 6, 1, 0	1	
190. 0119001HOMECARE000190. 01192. 0019200PHYSI CI ANS'PRI VATE OFFICES1,000,268438,4551,438,72332,6191,471,342194. 0007950MARKETI NG94,050164,289258,339-38,751219,588194.00		0	0		0 0	0	190.00	
192.0019200PHYSI CI ANS'PRI VATEOFFI CES1,000,268438,4551,438,72332,6191,471,342192.00194.0007950MARKETI NG94,050164,289258,339-38,751219,588194.00								
194. 00 07950 MARKETI NG 94, 050 164, 289 258, 339 -38, 751 219, 588 194. 00			-					

ECLASSI	Financial Systems IFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	OF EXPENSES	Provider CCN:	15-1305	Peri od:	of Form C Worksheet	
					From 10/01/2016 To 09/30/2017	Date/Time	
	Cost Costos Description		Nat Emeran			2/27/2018	<u>12:01 r</u>
	Cost Center Description	Adjustments (See A-8)	Net Expenses For				
		(See A-0)	Allocation				
		6.00	7.00				
G	ENERAL SERVICE COST CENTERS	0.00	7.00				
	00100 NEW CAP REL COSTS-BLDG & FIXT	-11, 123	1, 709, 687				1
	0400 EMPLOYEE BENEFITS DEPARTMENT	11, 125	5, 216, 386				4
	0500 ADMINI STRATI VE & GENERAL	-499, 693	3, 884, 227				5
	00700 OPERATION OF PLANT	-278	817, 903				7
	00800 LAUNDRY & LINEN SERVICE	0	69, 546				8
	00900 HOUSEKEEPI NG	0	239, 689				9
	1000 DI ETARY	-68, 978	289, 451				10
	1300 NURSI NG ADMI NI STRATI ON	00, 770	458, 630				13
	1400 CENTRAL SERVICES & SUPPLY	-31, 743	63, 813				14
	1500 PHARMACY	01,710	00,010				15
	1600 MEDI CAL RECORDS & LI BRARY	-7, 714	333, 976				16
	1700 SOCIAL SERVICE	0	49, 909				17
	NPATIENT ROUTINE SERVICE COST CENTERS		17,707				
	3000 ADULTS & PEDIATRICS	-397, 213	1, 854, 208				30
	3100 I NTENSI VE CARE UNI T	0	0				31
	4300 NURSERY	0	79, 577				43
_	NCI LLARY SERVICE COST CENTERS	U0	17, 511				
	05000 OPERATING ROOM	-355, 147	650, 733				50
	5200 DELIVERY ROOM & LABOR ROOM	0	83, 470				52
	05300 ANESTHESI OLOGY	-612, 919	17, 230				53
	05400 RADI OLOGY-DI AGNOSTI C	012, 717	1, 516, 393				54
	6000 LABORATORY	0	1, 381, 406				60
	06001 BLOOD LABORATORY	0	0				60
	06300 BLOOD STORING, PROCESSING & TRANS.	0	54, 928				63
	06500 RESPIRATORY THERAPY	0	319, 037				65
	06600 PHYSI CAL THERAPY	0	839, 377				66
	06700 OCCUPATI ONAL THERAPY	0	143, 292				67
	06800 SPEECH PATHOLOGY	0	62, 372				68
	6900 ELECTROCARDI OLOGY	-6, 396	21, 938				69
	06901 CARDI AC REHABI LI TATI ON	0	65, 900				69
. 00 0	7000 ELECTROENCEPHALOGRAPHY	0	0				70
. 00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-191	419,080				71
. 00 0	7200 IMPL. DEV. CHARGED TO PATIENTS	0	146, 922				72
. 00 0	7300 DRUGS CHARGED TO PATIENTS	-91, 608	1, 949, 422				73
. 00 0	03020 ONCOLOGY	0	144, 021				76
0	UTPATIENT SERVICE COST CENTERS						
. 00 0	08800 RURAL HEALTH CLINIC	-8, 128	3, 657, 112				88
. 00 0	99000 CLINIC	0	284, 588				90
. 00 0	09100 EMERGENCY	0	2,055,244				91
. 00 0	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92
0	THER REIMBURSABLE COST CENTERS						
1.001	0100 HOME HEALTH AGENCY	0	622, 900				101
	PECIAL PURPOSE COST CENTERS						
	1600 HOSPI CE	0	0				116
8. 00	SUBTOTALS (SUM OF LINES 1 through 117)	-2, 091, 131	29, 502, 367				118
N	ONREI MBURSABLE COST CENTERS						
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190
	9001 HOMECARE	0	o				190
2.001	9200 PHYSICIANS' PRIVATE OFFICES	0	1, 471, 342				192
	07950 MARKETI NG	0	219, 588				194
0.00	TOTAL (SUM OF LINES 118 through 199)	-2,091,131	31, 193, 297				200

	Financial Systems SIFICATIONS		PULASKI MEMORIA	Provider C	CN. 15 1205	Period:	ı of Form CMS-2552 Worksheet A-6
ULAS.	STFTCATTONS			Provider Co	UN: 15-1305	From 10/01/2016	WORKSheet A-0
						To 09/30/2017	Date/Time Prepare 2/27/2018 12:01 p
		Increases					
	Cost Center	Line #	Sal ary	Other			
	2.00	3.00	4.00	5.00			
	A - PROPERTY INSURANCE			·			
00	NEW CAP REL COSTS-BLDG &	1.00	0	19, 974			1.
	FIXT						
	0		0	19, 974			
	B - MARKETING RECLASS						
00	ADMI NI STRATI VE & GENERAL	5.00	14, 108	24, 643			1.
	0		14, 108	24, 643			
	C - IMPLANTABLE DEVICES						
00	IMPL. DEV. CHARGED TO	72.00	0	146, 922			1.
	PATIENTS						
	0	T	0	146, 922			
	D - PHYSICIAN SALARIES						
00	ADULTS & PEDIATRICS	30.00	86, 566	0			1.
00	OPERATING ROOM	50.00	355, 147	0			2.
00	PHYSICIANS' PRIVATE OFFICES	192.00	74, 230	0			3.
			515, 943	0			
	E - RHC PHYSICIAN COSTS						
00	RURAL HEALTH CLINIC	88.00	0	11, 524			1.
			0	11, 524			
	F - BILLER RECLASS						
00	ADMI NI STRATI VE & GENERAL	5.00	68, 589	0			1.
			68, 589	0			
	G - PATIENT ACCOUNTS RECLASS						
00	ADMI NI STRATI VE & GENERAL	5.00	325, 120	0			1.
			325, 120	0			
	H - RHC SALARIES RECLASS	· · ·					
00	RURAL HEALTH CLINIC	88.00	41, 611	0			1.
	TOTALS		41,611	ō			
	I - RN SALARIES						
00	NURSERY	43.00	45, 438	0			1.
	TOTALS	+	45, 438	ō			
	Grand Total: Increases		1,010,809	203, 063			500.

	Financial Systems SIFICATIONS		PULASKI MEMORIAI		CCN: 15-1305	Peri od:	u of Form CN Worksheet	
						From 10/01/2016		
						To 09/30/2017	Date/Time 2/27/2018	Prepared: 12:01 pm
		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	<u> </u>		2		1.0
	0		0	19, 974	1			
	B - MARKETING RECLASS							
. 00	MARKETING	<u> </u>	<u> </u>	2 <u>4, 6</u> 43	3	<u>0</u>		1.0
	0		14, 108	24, 643	3			
	C - IMPLANTABLE DEVICES							
. 00	MEDICAL SUPPLIES CHARGED TO	71.00	0	146, 922	2	0		1.0
	PATI ENTS							
	0		0	146, 922	2			
	D - PHYSICIAN SALARIES							
. 00	RURAL HEALTH CLINIC	88.00	515, 943	C	D	0		1.0
. 00		0.00	0	C	D	0		2.0
. 00		0.00	0	C	)	0		3.0
	0	T	515, 943			7		
	E - RHC PHYSICIAN COSTS	·						
. 00	ADMI NI STRATI VE & GENERAL	5.00	0	11, 524	1	0		1.0
	0	†	0	11, 524	1	7		
	F - BILLER RECLASS	·						
. 00	HOME HEALTH AGENCY	101.00	68, 589	C	)	0		1.0
	0	+	68, 589			1		
	G - PATIENT ACCOUNTS RECLASS	· · ·						
. 00	RURAL HEALTH CLINIC	88.00	325, 120	C		0		1.0
	0		325, 120			1		
	H - RHC SALARI ES RECLASS							
. 00	PHYSICIANS' PRIVATE OFFICES	192.00	41, 611	0	)	0		1.0
	TOTALS		41,611		<u> </u>	1		
	I - RN SALARIES		.,	-	- <u> </u>			
. 00	ADULTS & PEDIATRICS	30.00	45, 438	(		0		1.0
	TOTALS		45, 438			1		
00 00	Grand Total: Decreases		1,010,809	203, 063	2	-		500. C

PECONCILIATION OF CAPITAL COSTS CENTERS         Provider CCN: 15-1305         Period: From 10/01/2016 To 09/30/2017         Worksheet A-7 Part I Date/Time Prepared: Date/Time Prepared: Disposal s and Retirements           PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 <th>Health Financial Systems</th> <th>PULASKI MEMORI</th> <th></th> <th></th> <th></th> <th></th> <th>u of Form CMS-2</th> <th>2552-10</th>	Health Financial Systems	PULASKI MEMORI					u of Form CMS-2	2552-10
To         09/30/2017         Date/Time Prepared: 2/27/2018 12:01 pm 2/27/2018 12:01 pm 2/27/2018 12:01 pm 2/27/2018 12:01 pm           PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES         Donation         Total         Disposal s and Retirements           1.00         2.00         3.00         4.00         5.00           2.00         Land         0         0         0         0           2.00         Land         195,525         0         0         0         0         2.00           3.00         Buildings and Fixtures         10,748,465         1,540,507         0         1,540,507         0         3.00           0.00         Building Improvements         187,056         0         0         0         2.00         3.00         4.00         5.00           0.00         Fixed Equipment         9,180,370         1,365,251         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-1305				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES         Purchases         Donation         Total         Disposal s and Retirements           1.00         2.00         3.00         4.00         5.00           2.00         Land         0         0         0         0         0           2.00         Land         1.00         2.00         3.00         4.00         5.00           2.00         Land         Improvements         195,525         0         0         0         0         0         2.00           3.00         Buildings and Fixtures         10,748,465         1,540,507         0         1.00         2.00         3.00         4.00         5.00         0         0         0         0         2.00         3.00         4.00         5.00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>narad</td>								narad
PART I         - Acquisitions         - Acquisitions           1.00         2.00         3.00         4.00         5.00           1.00         2.00         3.00         4.00         5.00           1.00         2.00         3.00         4.00         5.00           1.00         2.00         3.00         4.00         5.00           1.00         2.00         3.00         4.00         5.00           1.00         2.00         3.00         4.00         5.00           1.00         2.00         3.00         4.00         5.00           2.00         Land         Improvements         195,525         0         0         0         0         2.00           3.00         Building Improvements         187,056         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0					10	09/30/2017	2/27/2018 12:	01 pm
PART I         - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES         Retirements           1.00         2.00         3.00         4.00         5.00           2.00         Land         195,525         0         0         0         0         2.00           2.00         Land Improvements         432,594         0         0         0         2.00         3.00         4.00         5.00           2.00         Land Improvements         10,748,465         1,540,507         0         1,540,507         0         3.00           4.00         Buil ding Improvements         10,748,465         1,684,396         0         0         0         4.00           5.00         Fixed Equipment         5,714,668         1,684,396         0         5.00         6.00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 <t< td=""><td></td><td></td><td></td><td>Acqui si ti on</td><td>IS</td><td></td><td></td><td><u> </u></td></t<>				Acqui si ti on	IS			<u> </u>
PART I         - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES           Land         195, 525         0         0         0         0         0         2.00           2.00         Land Improvements         432, 594         0         0         0         0         2.00           3.00         Buil dings and Fixtures         10, 748, 465         1, 540, 507         0         1, 540, 507         0         0         0         0         2.00           3.00         Buil ding improvements         187, 056         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         <		Begi nni ng	Purchases	Donati on		Total	Disposals and	
PART I         - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES           1.00         Land         195,525         0         0         0         0         1.00           2.00         Land Improvements         432,594         0         0         0         0         2.00           3.00         Buil dings and Fixtures         10,748,465         1,540,507         0         1,540,507         0         3.00           4.00         Buil ding Improvements         187,056         0         0         0         0         4.00           5.00         Fixed Equipment         5,714,668         1,684,396         0         1,365,251         1,540,507         6.00           6.00         Movable Equipment         9,180,370         1,365,251         0         1,540,507         8.00           7.00         HIT designated Assets         0         0         0         0         0         7.00           8.00         Subtotal (sum of lines 1-7)         26,458,678         4,590,154         0         4,590,154         1,540,507         10.00           10.00         Total (line 8 minus line 9)         26,458,678         4,590,154         0         4,590,154         1,540,507         10.00           2.00		Bal ances					Retirements	
1.00         Land         195,525         0         0         0         0         0         0         1.00           2.00         Land Improvements         432,594         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0		1.00	2.00	3.00		4.00	5.00	
2.00         Land Improvements         432,594         0         0         0         0         2.00           3.00         Buildings and Fixtures         10,748,465         1,540,507         0         1,540,507         0         3.00           4.00         Building Improvements         187,056         0         0         0         0         4.00           5.00         Fixed Equipment         5,714,668         1,684,396         0         1,684,396         0         5.00           6.00         Movable Equipment         9,180,370         1,365,251         0         1,540,507         6.00           7.00         HI designated Assets         0         0         0         0         7.00           8.00         Subtotal (sum of lines 1-7)         26,458,678         4,590,154         0         4,590,154         1,540,507         8.00           9.00         Reconciling Items         0         0         0         0         0         9.00           10.00         Total (line 8 minus line 9)         26,458,678         4,590,154         0         4,590,154         1,540,507         10.00           10.00         Land         Inprovements         432,594         0         4,590,154								
3.00       Buildings and Fixtures       10,748,465       1,540,507       0       1,540,507       0       3.00         4.00       Building Improvements       187,056       0       0       0       0       0       4.00         5.00       Fixed Equipment       5,714,668       1,684,396       0       1,365,251       1,540,507       6.00         6.00       Movable Equipment       9,180,370       1,365,251       0       1,365,251       1,540,507       6.00         7.00       HIT designated Assets       0       0       0       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       26,458,678       4,590,154       0       4,590,154       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0		195, 525	0		0	0	0	
4.00       Building Improvements       187,056       0       0       0       0       4.00         5.00       Fixed Equipment       5,714,668       1,684,396       0       1,684,396       0       5.00       5.00       5.00       1,540,507       5.00       5.00       6.00       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0			0		0	0	0	
5.00       Fixed Equipment       5,714,668       1,684,396       0       1,684,396       0       5.00         6.00       Movable Equipment       9,180,370       1,365,251       0       1,365,251       1,540,507       6.00         7.00       HIT designated Assets       0       0       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       26,458,678       4,590,154       0       4,590,154       0       9.00         9.00       Reconciling Items       0       0       0       0       0       9.00         10.00       Total (line 8 minus line 9)       26,458,678       4,590,154       0       4,590,154       0       9.00         10.00       Total (line 8 minus line 9)       26,458,678       4,590,154       0       4,590,154       1,540,507       10.00         Fully Balance         Balance       Perciated       Assets       1       1.00       2.00       2.00       2.00       2.00       2.00       3.00       3.00       3.00       3.00       3.00       2.00       3.00       432,594       0       4.00       4.00       4.00       4.00       4.00       4.00       4.00       4.00       4.00			1, 540, 507		0	1, 540, 507	0	
6.00       Movable Equipment       9,180,370       1,365,251       0       1,365,251       1,540,507       6.00         7.00       HIT designated Assets       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 <t< td=""><td></td><td>187, 056</td><td>0</td><td></td><td>0</td><td>0</td><td>0</td><td>4.00</td></t<>		187, 056	0		0	0	0	4.00
7.00       HIT designated Assets       0       0       0       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       26,458,678       4,590,154       0       4,590,154       1,540,507       8.00         9.00       Reconciling Items       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       <		5, 714, 668	1, 684, 396		0		0	5.00
8.00       Subtotal (sum of lines 1-7)       26, 458, 678       4, 590, 154       0       4, 590, 154       1, 540, 507       8.00         9.00       Reconciling Items       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0		9, 180, 370	1, 365, 251		0	1, 365, 251	1, 540, 507	6.00
9.00         Reconciling Items         0         0         0         0         0         0         9.00           10.00         Total (line 8 minus line 9)         26,458,678         4,590,154         0         4,590,154         1,540,507         10.00           Image: Construct Struct St		0	0		0	0	0	
10.00         Total (line 8 minus line 9)         26,458,678         4,590,154         0         4,590,154         1,540,507         10.00           Ending         Fully         Balance         Depreciated         Assets         6.00         7.00         7.00           PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES         195,525         0         1.00         1.00           2.00         Land         195,525         0         2.00         2.00         3.00         8uildings and Fixtures         12,288,972         0         3.00         3.00         4.00         5.00         5.00         4.00         5.00         5.00         4.00         5.00         5.00         4.00         5.00         5.00         4.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00		26, 458, 678	4, 590, 154		0	4, 590, 154	1, 540, 507	
Ending         Fully           Balance         Depreciated           Assets         6.00           6.00         7.00           PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES         6.00           1.00         Land           2.00         Land Improvements           3.00         Buildings and Fixtures           12,288,972         0           3.00         Building Improvements           187,056         0           6.00         7,399,064           0         0           6.00         9,005,114           0         0           0         0           8.00         Subtotal (sum of lines 1-7)           29,508,325         0           9.00         Reconciling Items		0	0		0	0	0	
Bal ance         Depreciated Assets           6.00         7.00           PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES         6.00           1.00         Land         195,525         0           2.00         Land Improvements         432,594         0         2.00           3.00         Building Improvements         12,288,972         0         3.00           4.00         Building Improvements         187,056         0         4.00           5.00         Fixed Equipment         7,399,064         0         5.00           6.00         Movable Equipment         9,005,114         0         6.00           7.00         HIT designated Assets         0         0         7.00         7.00           9.00         Reconciling Items         0         0         0         9.00	10.00 Total (line 8 minus line 9)				0	4, 590, 154	1, 540, 507	10.00
PART I         ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES         1.00         1.00         Land         1.00         1.00         2.00         Land         1.00         2.00         Status         1.00         2.00         Status         1.00         2.00         Status         1.00         2.00         3.00         Buildings and Fixtures         12,288,972         0         1.00         3.00         4.00         Status         3.00         4.00         5.00         Fixed Equipment         7,399,064         0         4.00         5.00         Fixed Equipment         9,005,114         0         5.00         Fixed Equipment         7.00         8.00         Subtotal (sum of lines 1-7)         29,508,325         0         0         0         9.00         9.00								
6.00         7.00           PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES         1.00           Land         195,525         0           2.00         Land Improvements         432,594         0           3.00         Buildings and Fixtures         12,288,972         0         3.00           4.00         Building Improvements         187,056         0         4.00           5.00         Fixed Equipment         7,399,064         0         5.00           6.00         Movable Equipment         9,005,114         0         6.00           7.00         HIT designated Assets         0         0         8.00         8.00           9.00         Reconciling Items         0         0         0         9.00		Bal ance						
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         12, 288, 972         0         3.00           4.00         Building Improvements         187, 056         0         4.00           5.00         Fixed Equipment         7, 399, 064         0         5.00           6.00         Movable Equipment         9, 005, 114         0         6.00           7.00         HIT designated Assets         0         0         7.00           8.00         Subtotal (sum of Lines 1-7)         29, 508, 325         0         8.00           9.00         Reconciling Items         0         0         9.00								
1.00       Land       195,525       0       1.00         2.00       Land Improvements       432,594       0       2.00         3.00       Buildings and Fixtures       12,288,972       0       3.00         4.00       Building Improvements       187,056       0       4.00         5.00       Fixed Equipment       7,399,064       0       5.00         6.00       Movable Equipment       9,005,114       0       6.00         7.00       HIT designated Assets       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       29,508,325       0       8.00         9.00       Reconciling Items       0       0       9.00			7.00					
2.00       Land Improvements       432,594       0       2.00         3.00       Buildings and Fixtures       12,288,972       0       3.00         4.00       Building Improvements       187,056       0       4.00         5.00       Fixed Equipment       7,399,064       0       5.00         6.00       Movable Equipment       9,005,114       0       6.00         7.00       HIT designated Assets       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       29,508,325       0       8.00         9.00       Reconciling Items       0       0       9.00								
3.00       Buildings and Fixtures       12,288,972       0       3.00         4.00       Building Improvements       187,056       0       4.00         5.00       Fixed Equipment       7,399,064       0       5.00         6.00       Movable Equipment       9,005,114       0       6.00         7.00       HIT designated Assets       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       29,508,325       0       8.00         9.00       Reconciling Items       0       0       9.00			0					
4.00       Building Improvements       187,056       0       4.00         5.00       Fixed Equipment       7,399,064       0       5.00         6.00       Movable Equipment       9,005,114       0       6.00         7.00       HIT designated Assets       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       29,508,325       0       8.00         9.00       Reconciling Items       0       0       9.00			0					
5.00         Fixed Equipment         7, 399, 064         0         5.00           6.00         Movable Equipment         9, 005, 114         0         6.00           7.00         HIT designated Assets         0         0         7.00           8.00         Subtotal (sum of lines 1-7)         29, 508, 325         0         8.00           9.00         Reconciling Items         0         0         9.00			0					
6.00       Movable Equipment       9,005,114       0       6.00         7.00       HIT designated Assets       0       0       7.00         8.00       Subtotal (sum of lines 1-7)       29,508,325       0       8.00         9.00       Reconciling Items       0       0       9.00			0					
7.00         HIT designated Assets         0         0         7.00           8.00         Subtotal (sum of lines 1-7)         29,508,325         0         8.00         8.00           9.00         Reconciling Items         0         0         0         9.00			0					
8.00         Subtotal (sum of lines 1-7)         29,508,325         0         8.00         8.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00		9, 005, 114	0					
9.00 Reconciling Items 0 0 9.00		0	0					
5		29, 508, 325	0					
10.00   Total (line 8 minus line 9)   29,508,325   0   10.00		0	0					
	10.00  Total (line 8 minus line 9)	29, 508, 325	0					10.00

Health Financial Systems	PULASKI MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-:	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period:	Worksheet A-7	
				From 10/01/2016 To 09/30/2017		pared:
					2/27/2018 12:	
		SUMMARY OF CAPITAL				
Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
				(see instructions)	instructions)	
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WOR						
1.00 NEW CAP REL COSTS-BLDG & FIXT	1, 521, 113	0	179, 72	.3 0	0	1.00
3.00 Total (sum of lines 1-2)	1, 521, 113	0	179, 72	.3 0	0	3.00
	SUMMARY OF	F CAPI TAL				
Cost Center Description	0ther	Total (1)				
	Capi tal -Rel at	(sum of cols.				
	ed Costs (see	9 through 14)				
	instructions)					
	14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	NN 2, LINES 1 a	and 2			
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	1, 700, 836				1.00
3.00  Total (sum of lines 1-2)	0	1, 700, 836				3.00

Provider       CCN: 15-1305       Period: For 00/01/2017       Period: Part 111 Date/Time Prepared: 2/2/2018 12:01 pm 09/30/2017       Period: Part 111 Date/Time Prepared: 2/21/2018 12:01 pm 00/30/2017         Cost Center Description       Gross Assets       Capitalized Leases       Gross Assets       Ratio (see instructions)       Insurance         PART 111 - RECONCILIATION OF CAPITAL 0.00       2.00       3.00       4.00       5.00         1.00       New CAP REL COSTS-BLDG & FIXT 0.00       29,508,325       0       29,508,325       1.000000       0       1.00         3.00       Total (sum of lines 1-2)       29,508,325       0       29,508,325       1.000000       0       3.00         Cost Center Description       Taxes       Other Capital-Relat ed Costs       Total (sum of col s. 5       Depreciation       Lease       Lease         New CAP REL COSTS-BLDG & FIXT 0       0       0       0       1.511,377       0       1.00         New CAP REL COSTS-BLDG & FIXT 0       0       0       0       1.511,377       0       3.00         1.00       New CAP REL COSTS-BLDG & FIXT 0       0       0       0       1.511,377       0       3.00         1.00       New CAP REL COSTS-BLDG & FIXT 0       0       0       0       1.511,377       0 <t< th=""><th>Health Financial Systems</th><th>PULASKI MEMORI</th><th>AL HOSPI TAL</th><th></th><th>In Lie</th><th>u of Form CMS-2</th><th>2552-10</th></t<>	Health Financial Systems	PULASKI MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
Cost Center Description         COMPUTATION OF RATIOS         ALLOCATION OF OTHER CAPITAL           Gross Assets         Capitalized Leases         Gross Assets for Ratio (col. 1 - col. 2)         Ratio (see instructions)         Insurance           PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS         1.00         2.00         3.00         4.00         5.00           1.00         NEW CAP REL COSTS-BLDG & FIXT         29, 508, 325         0         29, 508, 325         1.000000         0         1.00           3.00         Total (sum of lines 1-2)         29, 508, 325         0         29, 508, 325         1.000000         0         3.00           Cost Center Description         Taxes         Other Capital-Relation         Total (sum of Depreciation cols. 5 through 7)         Lease         29, 508, 325         1.000         1.00           NEW CAP REL COSTS-BLDG & FIXT         0         0         7.00         8.00         9.00         10.00           0         0         7.00         8.00         9.00         10.00         3.00         1.00.00           1.00         NEW CAP REL COSTS-BLDG & FIXT         0         0         0         1.511, 377         0         1.00           3.00         Total (sum of lines 1-2)         0         0         0         1.	RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		From 10/01/2016	Part III Date/Time Pre	pared:
PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS         O         29, 508, 325         0         29, 508, 325         1.00000         0         1.00         2.000         3.00         4.00         5.00           1.00         NEW CAP REL COSTS-BLDG & FIXT         29, 508, 325         0         29, 508, 325         1.000000         0         1.00         3.00           3.00         Total (sum of lines 1-2)         29, 508, 325         0         29, 508, 325         1.000000         0         3.00         3.00           Cost Center Description         Taxes         Other capital-Relat ed Costs         Total (sum of cols. 5 through 7)         Depreciation         Lease           New CAP REL COSTS-BLDG & FIXT         0         0         0         1.00         1.00           New CAP REL COSTS-BLDG & FIXT         0         0         0         1.511,377         0         3.00           New CAP REL COSTS-BLDG & FIXT         0         0         0         1.511,377         0         3.00           3.00         Total (sum of lines 1-2)         0         0         0         1.00         3.00         1.00         3.00           3.00         Total (sum of lines 1-2)         0         0         0         0         0		COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITAL					
I. 00         2. 00         3. 00         4. 00         5. 00           I. 00         NEW CAP REL CONCILIATION OF CAPITAL COSTS CENTERS         0         29, 508, 325         0         29, 508, 325         1. 00000         0         1. 00           3. 00         Total (sum of lines 1-2)         29, 508, 325         0         29, 508, 325         1. 000000         0         3. 00           ALLOCATION OF OTHER CAPITAL           Cost Center Description         Taxes         Other Capital-Relat ed Costs         Depreciation         Lease           1. 00         NEW CAP REL COSTS-BLDG & FIXT         0         0         7.00         8.00         9.00         10.00           0         0         7.00         8.00         9.00         10.00         1.00           SUMMARY OF CAPITAL           0         0         0         1.511, 377         0         1.00           3. 00         Total (sum of lines 1-2)         0         0         0         1.511, 377         0         1.00           3. 00         Total (sum of lines 1-2)         0         0         0         1.511, 377         0         3.00           SUMMARY OF CAPITAL	Cost Center Description	Gross Assets		for Ratio (col. 1 -		Insurance	
1.00       NEW CAP REL COSTS-BLDG & FIXT       29, 508, 325       0       29, 508, 325       1.00000       0       1.00         3.00       Total (sum of lines 1-2)       29, 508, 325       0       29, 508, 325       1.000000       0       3.00         ALLOCATION OF OTHER CAPITAL       SUMMARY OF CAPITAL       SUMMARY OF CAPITAL       SUMMARY OF CAPITAL         Cost Center Description       Taxes       Other       Total (sum of cols. 5       Depreciation       Lease         6.00       7.00       8.00       9.00       10.00       0       1.00         1.00       NEW CAP REL COSTS-BLDG & FIXT       0       0       0       1.00       1.00         1.00       Total (sum of lines 1-2)       0       0       0       1.00       1.00         1.00       SUMMARY OF CAPITAL COSTS CENTERS       0       0       0       1.00       1.00         3.00       Total (sum of lines 1-2)       0       0       0       1.511, 377       0       3.00         3.00       Total (sum of lines 1-2)       0       0       0       0       1.00       3.00         3.00       Total (sum of lines 1-2)       0       0       0       1.511, 377       0       3.00		1.00	2.00	3.00	4.00	5.00	
3.00       Total (sum of lines 1-2)       29, 508, 325       0       29, 508, 325       1.000000       0       3.00         ALLOCATION OF OTHER CAPITAL         Cost Center Description         Taxes       Other Capital -Relat ed Costs       Total (sum of cols. 5 through 7)       Depreciation       Lease         1.00       PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS       0       0       1.00       1.00         3.00       Total (sum of lines 1-2)       0       0       0       1.511, 377       0       1.00         3.00       Total (sum of lines 1-2)       0       0       0       1.01, 511, 377       0       3.00         SUMWARY OF CAPITAL         Cost Center Description       Interest       Insurance instructions)       Taxes (see instructions)       Other capital -Relat ed Costs (see instructions)       Total (2) (sum of col s. 9 through 14)	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS					
ALLOCATION OF OTHER CAPITAL       SUMMARY OF CAPITAL         Cost Center Description       Taxes       Other       Total (sum of cols. 5         Cost Center Description       Taxes       Other       Total (sum of cols. 5         MEW CAP REL COSTS-BLDG & FIXT       0       0       0       1.00         SUMMARY OF CAPITAL COSTS CENTERS       0       0       1.511,377       0         Cost Center Description       Interest       Insurance (see instructions)       Taxes (see instructions)       Other         Total (sum of Lines 1-2)       11.00       12.00       13.00       Other       Total (2) (sum of cols. 9							
Cost Center Description       Taxes       Other Capital -Rel at ed Costs       Total (sum of col s. 5 through 7)       Depreciation       Lease         1.00       PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS         1.00       NEW CAP REL COSTS-BLDG & FIXT       0       0       0       1.511,377       0       1.00         3.00       Total (sum of lines 1-2)       0       0       0       1,511,377       0       3.00         SUMMARY OF CAPITAL         Cost Center Description       Interest       Insurance (see instructions)       Taxes (see instructions)       Other Capital -Rel at ed Costs       Other (sum of col s. e)       Total (2) (sum of col s. e)       Other (sum of col s. e)       Total (2)         11.00       12.00       13.00       14.00       15.00	3.00 Total (sum of lines 1-2)						3.00
Capital -Relat ed Costs         col s. 5 through 7)         col s. 5 through 7)         col s. 5 through 7)           PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS         6.00         7.00         8.00         9.00         10.00           NEW CAP REL COSTS-BLDG & FIXT         0         0         0         1,511,377         0         1.00           3.00         Total (sum of lines 1-2)         0         0         0         1,511,377         0         3.00           Cost Center Description           Interest         Insurance (see instructions)         Taxes (see instructions)         Other Capital -Relat (sum of col s. ed Costs (see instructions)         Total (2) (sum of col s. ed Costs (see instructions)         9 through 14)           11.00         12.00         13.00         14.00         15.00         15.00		ALLOCAT	FION OF OTHER (	CAPI TAL	SUMMARY C	F CAPITAL	
I.OO         PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS         6.00         7.00         8.00         9.00         10.00           3.00         Total (sum of lines 1-2)         0         0         0         1,511,377         0         1.00           SUMMARY OF CAPITAL COSTS CENTERS           Cost Center Description         0         0         0         1,511,377         0         1.00         3.00           Cost Center Description         Interest         Insurance (see instructions)         Taxes (see instructions)         Other Capital-Relat instructions)         Total (2) (sum of cols. 9         (sum of cols. 9         9         11.00         12.00         13.00         14.00         15.00	Cost Center Description	Taxes			Depreciation	Lease	
6.00         7.00         8.00         9.00         10.00           PART 111 - RECONCILIATION OF CAPITAL COSTS CENTERS         0         0         1,511,377         0         1.00           3.00         Total (sum of lines 1-2)         0         0         0         1,511,377         0         3.00           Cost Center Description           Interest         Insurance (see instructions)         Taxes (see instructions)         Other Capital -Relat ed Costs (see instructions)         Total (2) (sum of cols. 9 through 14) instructions)							
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS         1.00       NEW CAP REL COSTS-BLDG & FIXT       0       0       0       1,511,377       0       1.00         3.00       Total (sum of lines 1-2)       0       0       0       0       1,511,377       0       3.00         SUMMARY OF CAPI TAL         Cost Center Description       Taxes (see (see instructions)       Taxes (see of costs (s							
1.00       NEW CAP REL COSTS-BLDG & FIXT       0       0       0       1,511,377       0       1.00         3.00       Total (sum of lines 1-2)       0       0       0       0       1,511,377       0       3.00         SUMMARY OF CAPI TAL         Cost Center Description         Taxes (see (see instructions)       0       0       0       0       0       0       3.00         11.00       12.00       13.00       14.00       15.00			7.00	8.00	9.00	10.00	
3.00         Total (sum of lines 1-2)         0         0         0         0         1,511,377         0         3.00           SUMMARY OF CAPI TAL           Cost Center Description           Taxes (see (see instructions)         Taxes (see instructions)         Other Cost (sum of cols. ed Costs (see instructions)         Total (2) (sum of cols. ed Costs (see instructions)           11.00         12.00         13.00         14.00         15.00				1			
Summary of CAPITAL         Cost Center Description       Interest       Insurance (see instructions)       Taxes (see instructions)       Other       Total (2) (sum of cols. ed Costs (see instructions)         11.00       12.00       13.00       14.00       15.00		-	-				
Cost Center DescriptionInterestInsurance (see instructions)Taxes (see instructions)OtherTotal (2) (sum of cols. ed Costs (see instructions)11.0012.0013.0014.0015.00	3.00  Total (sum of lines 1-2)	0	0			0	3.00
(see instructions)instructions)Capital -Relat ed Costs (see 9 through 14) instructions)(sum of cols. ed Costs (see 9 through 14) instructions)11.0012.0013.0014.0015.00			SL	JMMARY OF CAPI	TAL		
instructions)         ed Costs (see 9 through 14) instructions)           11.00         12.00         13.00         14.00         15.00	Cost Center Description	Interest					
instructions           11.00         12.00         13.00         14.00         15.00				instructions)			
			instructions)			9 through 14)	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT 178, 336 19, 974 0 0 1, 709, 687 1.00	1.00 NEW CAP REL COSTS-BLDG & FIXT	178, 336	19, 974		0 0	1, 709, 687	1.00
3.00 Total (sum of lines 1-2) 178, 336 19, 974 0 0 1, 709, 687 3.00	3.00  Total (sum of lines 1-2)	178, 336	19, 974		0 0	1, 709, 687	3.00

nanci al	Systems

Health Financial Systems ADJUSTMENTS TO EXPENSES

ADJUST	MENTS TO EXPENSES			Provider CCN: 15-1305	Period:	Worksheet A-8	
					From 10/01/2016 To 09/30/2017	Date/Time Pre 2/27/2018 12:	
				Expense Classification o			
				To/From Which the Amount is	s to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
		(2)	2.00	3.00	4.00	Ref. 5.00	
1.00	Investment income - NEW CAP	1.00	0	NEW CAP REL COSTS-BLDG &	1.00	0	1.00
	REL COSTS-BLDG & FIXT (chapter 2)			FIXT			
2.00	Investment income - CAP REL		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3.00
	(chapter 2)						
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by		0		0.00	0	6.00
7.00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7.00
7.00	stations excluded) (chapter				0.00	0	/.00
8.00	21) Television and radio service		0		0.00	0	8.00
	(chapter 21)						
9.00 10.00	Parking lot (chapter 21) Provider-based physician	A-8-2	0 -756, 796		0.00	0	
	adjustment						
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00			0		0.00	0	
14.00 15.00	Cafeteria-employees and guests Rental of quarters to employee		0		0.00	0	
	and others		0				
16.00	Sale of medical and surgical supplies to other than		0		0.00	0	16.00
17 00	patients						17 00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19. 00	Nursing and allied health		0		0.00	0	19.00
	education (tuition, fees, books, etc.)						
	Vending machines		0		0.00	0	
21.00	Income from imposition of interest, finance or penalty		0		0.00	0	21.00
22.00	charges (chapter 21)						22.00
22.00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
22 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
23.00	therapy costs in excess of	A-0-3	0	RESFIRATORT HIERAFT	05.00		23.00
24 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
21100	therapy costs in excess of						200
25.00	limitation (chapter 14) Utilization review –		0	*** Cost Center Deleted ***	114.00		25.00
	physicians' compensation						
26.00	(chapter 21) Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-BLDG &	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL			FIXT *** Cost Center Deleted ***	2.00	0	27.00
	COSTS-MVBLE EQUIP					0	
28.00 29.00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19.00 0.00	0	28.00 29.00
	Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	67.00	0	30.00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
	instructions)		I	l	Ι	I	I

Heal th	Fi nanc	ial S	Systems
ADJUST	MENTS T	OEX	PENSES

Health Financial Systems	Pl	JLASKI MEMORIA	AL HUSPITAL	In Lie	U OT FORM CMS-∠	2552-10
ADJUSTMENTS TO EXPENSES				Peri od:	Worksheet A-8	
				From 10/01/2016		
				To 09/30/2017	Date/Time Pre 2/27/2018 12:	
			Expense Classification or	Workshoot A	2/2//2010 12.	
		IT.	o/From Which the Amount is			
		'	over one will che the Anodite 13	to be haj usted		
Cost Center Description   Basis	s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	2)				Ref.	
	. 00	2.00	3.00	4.00	5.00	
31.00 Adjustment for speech A-	8-3	0 S	PEECH PATHOLOGY	68.00		31.00
pathology costs in excess of						
limitation (chapter 14)						
32.00 CAH HIT Adjustment for	A	-9, 736 N	IEW CAP REL COSTS-BLDG &	1.00	9	32.00
Depreciation and Interest		F	I XT			
33.00 CAFETERIA VENDING - OTHER REV	В	-68, 978 D	I ETARY	10.00	0	33.00
34.00 EMPLOYEE RX PROGRAM -OTHER REV	В	-91, 608 D	RUGS CHARGED TO PATIENTS	73.00	0	34.00
35.00 MEDICAL RECORDS FEES -OTHER	В	-7, 714 M	IEDI CAL RECORDS & LI BRARY	16.00	0	35.00
REV						
36.00 SALE OF SCRAP -OTHER REV	В	-1,009C	ENTRAL SERVICES & SUPPLY	14.00	0	36.00
37.00 REBATES & REFUNDS - OTHER REV	В		ENTRAL SERVICES & SUPPLY	14.00	0	37.00
38.00 BABY PHOTO - OTHER REV	В		DMINISTRATIVE & GENERAL	5.00	0	38.00
40.00 MED SUPPLY SALES -OTHER REV	В		IEDI CAL SUPPLI ES CHARGED TO	71.00	0	40.00
			ATI ENTS			
43.00 OTHER SERVICES -OTHER REV	В		DMINISTRATIVE & GENERAL	5.00	0	
44.00 ICG - OTHER REV	В		DULTS & PEDIATRICS	30.00	0	
45.00 INVEST INC/UNRESTRIC- INT EXP	В		IEW CAP REL COSTS-BLDG &	1.00	11	45.00
	_		I XT			
45.01 OTHER REVENUE RHC- OTHER REV	В		URAL HEALTH CLINIC	88.00	0	
45.02 POB/RENT I NCOME	В		DMINISTRATIVE & GENERAL	5.00	0	45.02
45. 03 TELEVI SI ON	A		PERATION OF PLANT	7.00	0	45.03
45.04 PHYSICIAN RECRUITMENT- ADMIN	A		DMINISTRATIVE & GENERAL	5.00	0	45.04
	A		DMI NI STRATI VE & GENERAL	5.00	0	45.05
	A		NESTHESI OLOGY	53.00	0	45.06
45. 07 HAF EXPENSE	A		DMINISTRATIVE & GENERAL	5.00	0	45.07
50.00 TOTAL (sum of lines 1 thru 49)		-2, 091, 131				50.00
(Transfer to Worksheet A,						
column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(2) Herris and the distribution for the second basis of the second second

(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	REAL HOSPETAL		In Lie	eu of Form CMS-	2552-10
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provider (		Peri od:	Worksheet A-8	3-2
						From 10/01/2016 To 09/30/2017	7 Date/Time Pre	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	2/27/2018 12: Physi ci an/Prov	
	WKSL A LINE #	I denti fi er	Remuneration	Component	Component	RCE AIIIOUTT	ider Component	
		rdentifier	Reliuneration	component	component		Hours	
	1 00	2.00	2.00	4.00	F 00	6.00	7.00	
1 00	1.00	2.00	3.00	4.00	5.00	6.00		1.00
1.00		EMERGENCY	1, 095, 775		.,		-	
2.00		LABORATORY	24,000				-	
3.00		CLINIC	36,000				°,	3.00
4.00		RESPI RATORY THERAPY	0	-			0	4.00
5.00		ADULTS & PEDIATRICS	308, 687	308, 687		°	0	5.00
6.00	69.00	ELECTROCARDI OLOGY	6, 396	6, 396	(	0 0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	86, 566	86, 566	(	0 0	0	7.00
8.00	50.00	OPERATING ROOM	355, 147	355, 147	(	0 0	0	8.00
9.00	0.00		0	0	(	0 0	0	9.00
10.00	0.00		0	0	(	ol o	0	10.00
200.00			1, 912, 571	756, 796	1, 155, 775	5	0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er		Unadjusted RCE			of Malpractice	
				Limit	Continuing	Share of col.	Insurance	
					Education	12	i nour unoc	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		EMERGENCY	0					1.00
2.00		LABORATORY	0					
3.00		CLINIC	0				-	
4.00		RESPIRATORY THERAPY	0		(		0	4.00
5.00		ADULTS & PEDIATRICS	0			°	0	5.00
		ELECTROCARDI OLOGY				°	0	
6.00			0	0			0	6.00
7.00		ADULTS & PEDIATRICS	0	0	(		0	7.00
8.00		OPERATING ROOM	0	0		-	0	0.00
9.00	0.00		0	-		-	0	9.00
10.00	0.00		0			-	-	
200.00			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.					
			14				-	
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		EMERGENCY	0	-		-		1.00
2.00		LABORATORY	0					2.00
3.00		CLINIC	0	0		-		3.00
4.00		RESPI RATORY THERAPY	0	-		0 0		4.00
5.00		ADULTS & PEDIATRICS	0	0	(	308, 687		5.00
6.00	69.00	ELECTROCARDI OLOGY	0	0	(	6, 396		6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	(	86, 566		7.00
8.00	50.00	OPERATING ROOM	0	0	(			8.00
9.00	0.00		0					9.00
10.00	0.00		0			-		10.00
200.00	0.00		0	-		-		200.00
200.00	1	1				, , , , , , , , , , , , , , , , , , , ,	1	

Health Financial Systems	PULASKI MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-1305 F	eri od:	Worksheet B	
				rom 10/01/2016 0 09/30/2017		nared
					2/27/2018 12:	
		CAPI TAL				
Cost Center Description	Net Expenses	RELATED COSTS NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI V	
	for Cost	FLXT	BENEFITS	Subtotui	E & GENERAL	
	Allocation		DEPARTMENT			
	(from Wkst A					
	col. 7)	1.00	4.00	4.0	F 00	
GENERAL SERVICE COST CENTERS	0	1.00	4.00	4A	5.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	1, 709, 687	1, 709, 687				1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	5, 216, 386	22, 348	5, 238, 734			4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	3, 884, 227	343, 145	790, 865		5, 018, 237	5.00
7.00 00700 OPERATION OF PLANT	817, 903	177, 174	89, 115		207, 859	7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	69, 546	12, 561	6,745		17,035	8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	239, 689 289, 451	7, 700 62, 285	53, 258 56, 899		57, 639 78, 343	9.00 10.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	458, 630	14, 731	146, 914		118, 918	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	63, 813	20, 282	14, 010		18, 808	
15.00 01500 PHARMACY	0	16, 171	C	16, 171	3, 100	15.00
16.00 01600 MEDI CAL RECORDS & LI BRARY	333, 976	30, 590	97,640			
17.00 01700 SOCI AL SERVI CE	49, 909	0	16, 572	66, 481	12, 746	17.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	1, 854, 208	181, 848	705, 297	2, 741, 353	525, 567	30.00
31. 00 03100 INTENSIVE CARE UNIT	1, 654, 206	101, 040	105, 291	2, 741, 303	0 525, 567	31.00
43. 00 04300 NURSERY	79, 577	3, 359	23, 308	106, 244	20, 369	
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	650, 733	110, 674	299, 829	1, 061, 236	203, 458	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	83, 470	10, 141	25, 928		22, 918	
53. 00 05300 ANESTHESI OLOGY	17, 230	647	050 4/7	,	3, 427	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	1, 516, 393 1, 381, 406	78, 498 29, 004	253, 467 212, 362		354, 363 311, 115	54.00 60.00
60. 01 06000 LABORATORY	1, 361, 400	29,004	212, 302		0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	54, 928	876	C	-	10, 699	63.00
65.00 06500 RESPI RATORY THERAPY	319, 037	16, 338	96, 911		82, 877	65.00
66. 00 06600 PHYSI CAL THERAPY	839, 377	49, 328	262, 636		220, 733	66.00
67.00 06700 OCCUPATI ONAL THERAPY	143, 292	0	47,003		36, 483	67.00
68. 00 06800 SPEECH PATHOLOGY	62, 372	0	19, 941		15, 781	68.00
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHABI LI TATI ON	21, 938 65, 900	9, 348	6, 110 21, 028		5, 377 18, 458	69.00 69.01
70. 00 07000 ELECTROENCEPHALOGRAPHY	03, 900	⁹ , 340	21, 020	0,270	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	419, 080	0	C	419,080	80, 345	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	146, 922	0	C	146, 922	28, 168	
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 949, 422	0	C		373, 739	
76.00 03020 ONCOLOGY	144, 021	11, 768	35, 333	191, 122	36, 642	76.00
0UTPATI ENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	2 457 112	171, 061	1, 083, 824	4, 911, 997	941, 725	
90. 00 09000 CLINIC	3, 657, 112 284, 588	37, 872	30, 809			
91. 00 09100 EMERGENCY	2, 055, 244	110, 611	300, 586		472, 861	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	_,,	,	,	0		92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	622, 900	13, 605	172, 064	808, 569	155, 017	101.00
SPECIAL PURPOSE COST CENTERS	-		-	-	-	
116.00 11600 HOSPI CE				-		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	29, 502, 367	1, 541, 965	4, 868, 454	28, 964, 365	4, 590, 911	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9, 411	C	9, 411	1.804	190.00
190. 01 19001 HOMECARE	0	2, 504	C			190.01
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 471, 342	155, 807	343, 680		377, 843	192.00
194.0007950 MARKETI NG	219, 588	0	26,600		47, 199	
200.00 Cross Foot Adjustments		_	-	0	-	200.00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201)	21 102 207	1 700 407	E 220 724	-		201.00
202.00   TOTAL (sum lines 118 through 201)	31, 193, 297	1, 709, 687	5, 238, 734	31, 193, 297	5, 018, 237	1202.00

Health Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 10/01/2016 To 09/30/2017	Worksheet B Part I Date/Time Pre	
Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	2/27/2018 12: NURSI NG ADMI NI STRATI O N	
	7.00	8.00	9.00	10.00	13.00	
GENERAL SERVICE COST CENTERS				1		
1.00       00100       NEW CAP REL COSTS-BLDG & FIXT         4.00       00400       EMPLOYEE BENEFITS DEPARTMENT         5.00       00500       ADMI NI STRATI VE & GENERAL         7.00       00700       OPERATI ON OF PLANT         8.00       00800       LAUNDRY & LI NEN SERVI CE         9.00       009000       HOUSEKEEPI NG         10.00       01000       DI ETARY         13.00       01300       NURSI NG ADMI NI STRATI ON         14.00       01400       CENTRAL         9.00       01500       PHARMACY         15.00       01500       PHARMACY         16.00       01600       MEDI CAL         17.00       SOCI AL       SERVI CE         INPATI ENT ROUTI NE       SERVI CE       COST CENTERS	1, 292, 051 13, 907 8, 525 68, 958 16, 310 22, 455 17, 904 33, 867 0	119, 794 0 0 0 0 0 0 0 0 0	366, 81 19, 92 4, 71 6, 48 5, 17 9, 78	3 575, 859 2 0 8 0 3 0	760, 215 0 0 0 0 0	14.00
30. 00 03000 ADULTS & PEDIATRICS	201, 332	43, 549	58, 16	6 575, 859	395, 355	30.00
31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY	0 3, 719	0 2, 552		0 0	0 39, 694	31.00 43.00
ANCILLARY SERVICE COST CENTERS				-1		
50.00       05000       OPERATI NG ROOM         52.00       05200       DELI VERY ROOM & LABOR ROOM         53.00       05300       ANESTHESI OLOGY         54.00       05400       RADI OLOGY-DI AGNOSTI C         60.00       06000       LABORATORY         60.01       06000       LABORATORY         63.00       06300       BLOOD STORI NG, PROCESSI NG & TRANS.         65.00       06500       RESPI RATORY THERAPY         66.00       06600       PHYSI CAL THERAPY         67.00       06700       OCCUPATI ONAL THERAPY         68.00       06800       SPEECH PATHOLOGY         69.01       06900       ELECTROCARDI OLOGY         69.01       06900       ELECTROCARDI OLOGY         69.01       06700       CLECTROCARDI OLOGY         69.01       06900       ELECTROCARDI OLOGY         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         72.00       07200       IMPL.       DEV. CHARGED TO PAT	122, 531 11, 227 716 86, 908 32, 111 0 970 18, 089 54, 612 0 0 10, 350 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	19, 626 0 11, 679 316 0 0 12, 428 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 24 20 25, 10 9, 27 28 5, 22 15, 77 2, 99	4       0         7       0         9       0         7       0         0       0         6       0         8       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0	92, 716 16, 429 0 17, 817 0 0 17, 517 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 52.\ 00\\ 53.\ 00\\ 54.\ 00\\ 60.\ 01\\ 63.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 01\\ 70.\ 00\\ 71.\ 00\\ 72.\ 00\\ \end{array}$
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
76. 00 03020 ONCOLOGY OUTPATI ENT SERVICE COST CENTERS	13, 029	64	3, 76	4 0	44, 465	76.00
88. 00 08800 RURAL HEALTH CLINIC 90. 00 09000 CLINIC 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0THER REIMBURSABLE COST CENTERS	189, 387 41, 929 122, 462	1, 288 0 27, 835	12, 11	4 0	0 17, 560 102, 404	
101.00 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	15, 062	0	4, 35	2 0	0	101.00
116. 00 11600 HOSPICE 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0 1, 106, 360	0 119, 337		0 0 2 575, 859	0 743, 957	116. 00 118. 00
190.00       GI FT, FLOWER, COFFEE SHOP & CANTEEN         190.01       19001         HOMECARE       192.00         192.00       PHYSICIANS' PRIVATE OFFICES         194.00       07950         MARKETING       Cross Foot Adjustments         201.00       Negative Cost Centers         202.00       TOTAL (sum Lines 118 through 201)	10, 419 2, 772 172, 500 0 1, 292, 051	0 0 457 0 119, 794	80 49, 83	1 0 8 0 0 0 0 0	0 16, 258 0 0	190.00 190.01 192.00 194.00 200.00 201.00 202.00
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Heal th	Financial Systems	PULASKI MEMORIA	L HOSPI TAL		In Lieu	u of Form CMS-	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-1305	Period: From 10/01/2016 To 09/30/2017	Worksheet B Part I Date/Time Pre 2/27/2018 12:	epared:
	Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	Subtotal	
		14.00	15.00	16.00	17.00	24.00	
	GENERAL SERVICE COST CENTERS	ГГ		I	TT		
	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4.00 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
	01000 DI ETARY						10.00
13.00	01300 NURSING ADMINISTRATION						13.00
	01400 CENTRAL SERVICES & SUPPLY	145, 856					14.00
	01500 PHARMACY	0	42, 348				15.00
	01600 MEDICAL RECORDS & LIBRARY	0	0				16.00
17.00	01700 SOCIAL SERVICE	0	0		0 79, 227		17.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0	22.20		4 (27 400	20.00
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	0 0		30 73, 939 0 0	4, 637, 400 0	
	04300 NURSERY	0	0			175, 088	
43.00	ANCI LLARY SERVICE COST CENTERS	0	0	1,4,	<u> </u>	175,000	43.00
50.00	05000 OPERATING ROOM	0	0	53, 9	5, 288	1, 594, 243	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0			177, 397	
53.00	05300 ANESTHESI OLOGY	0	0	9, 3	65 0	31, 592	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	120, 40	0 0	2, 464, 640	54.00
	06000 LABORATORY	0	0	113, 6	78 0	2, 089, 269	60.00
	06001 BLOOD LABORATORY	0	0		0 0	0	
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	1, 9		69, 668	
	06500 RESPIRATORY THERAPY	0	0	11, 9		567, 971	
	06600 PHYSI CAL THERAPY	0	0	28, 4		1, 483, 340	
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	3, 90		230, 742 99, 145	
	06900 ELECTROCARDI OLOGY	0	0	4, 5		38, 017	
	06901 CARDI AC REHABI LI TATI ON	0	0	1, 4		129, 526	
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	131, 537	0	23, 5	78 0	654, 540	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	14, 319	0	2, 50	67 0	191, 976	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	42, 348	90, 5	21 0	2, 456, 030	73.00
76.00	03020 ONCOLOGY	0	0	2, 5	70 0	291, 656	76.00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0			6, 138, 688	
	09000 CLINIC	0	0			501, 249	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	40, 78	36 0	3, 268, 170	91.00
	OTHER REIMBURSABLE COST CENTERS						92.00
	10100 HOME HEALTH AGENCY	0	0	7,6	37 0	990, 637	101 00
101.00	SPECIAL PURPOSE COST CENTERS	0	0	7,0		770,007	
116.00	11600 HOSPI CE	0	0		0 0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	145, 856	42, 348	594, 4	71 79, 227	28, 280, 984	
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	24, 644	190.00
	19001 HOMECARE	0	0		0 0		190.01
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0	2, 587, 725	
	07950 MARKETI NG	0	0		0 0	293, 387	
200.00			0				200.00
201.00 202.00		145 054	0 42, 348	594, 4	0 0 71 79, 227	0 31, 193, 297	201.00
202.00	TOTAL (Sum TITES TTO LITUUYIT 201)	145, 856	42, 348	I 394, 4	19,227	51, 195, 297	1202.00

Health Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-1305	Peri od:	Worksheet B	
				From 10/01/2016		
				To 09/30/2017	Date/Time Pre 2/27/2018 12:	01 pm
Cost Center Description	Intern &	Total		-L .		
	Residents					
	Cost & Post					
	Stepdown					
	Adjustments	04.00				
GENERAL SERVICE COST CENTERS	25.00	26.00				
1.00 00100 NEW CAP REL COSTS-BLDG & FLXT		1				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						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY						10.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY						15.00
16.00 01600 MEDICAL RECORDS & LIBRARY						16.00
17.00 01700 SOCIAL SERVICE						17.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		4 ( 27 400				1 20 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	0	4, 637, 400				30.00
31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY	0	0 175, 088				31.00 43.00
ANCI LLARY SERVICE COST CENTERS	0	175,000				43.00
50. 00 05000 OPERATING ROOM	0	1, 594, 243				50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	177, 397				52.00
53. 00 05300 ANESTHESI OLOGY	0	31, 592				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	2, 464, 640				54.00
60. 00 06000 LABORATORY	0	2,089,269				60.00
60. 01 06001 BLOOD LABORATORY	0	0				60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	69, 668				63.00
65. 00 06500 RESPI RATORY THERAPY	0	567, 971				65.00
66. 00 06600 PHYSI CAL THERAPY	0	1, 483, 340				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	230, 742				67.00
68.00 06800 SPEECH PATHOLOGY	0	99, 145				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	38, 017				69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	0	129, 526				69.01
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	664 640				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	654, 540 191, 976				71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	2, 456, 030				73.00
76. 00 03020 ONCOLOGY	0	291,656				76.00
OUTPATI ENT SERVICE COST CENTERS		2717000				10100
88.00 08800 RURAL HEALTH CLINIC	0	6, 138, 688				88.00
90. 00 09000 CLI NI C	0	501, 249				90.00
91.00 09100 EMERGENCY	0	3, 268, 170				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	990, 637				101.00
SPECIAL PURPOSE COST CENTERS	1	. 1				447
116.00 11600 HOSPI CE	0	0				116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	28, 280, 984				118.00
NONREI MBURSABLE COST CENTERS		24 444				190.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190. 01 19001 HOMECARE	0	24,644				190.00
190. 01 1900 [ HOMECARE 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES		6, 557 2, 587, 725				190.01
192.00 19200 PHTSTCTANS PRIVATE OFFICES		2, 387, 725				192.00
200.00 Cross Foot Adjustments	0	273, 307				200.00
201.00 Negative Cost Centers	0	o				201.00
202.00 TOTAL (sum lines 118 through 201)	0	31, 193, 297				202.00
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Health Financial Systems	PULASKI MEMOR	LAL HOSPITAL		Inlie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-1305 F	Period [.]	Worksheet B	
				From 10/01/2016	Part II	norod.
			1	o 09/30/2017	Date/Time Pre 2/27/2018 12:	Darea: 01 pm
		CAPI TAL				
		RELATED COSTS				
Cost Center Description	Di rectl y	NEW BLDG &	Subtotal	EMPLOYEE	ADMI NI STRATI V	
	Assigned New	FLXT		BENEFI TS	E & GENERAL	
	Capi tal			DEPARTMENT		
	Related Costs		24	4.00	E 00	
GENERAL SERVICE COST CENTERS	0	1.00	2A	4.00	5.00	
1.00 00100 NEW CAP REL COSTS-BLDG &	FLXT					1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTM		22, 348	22, 348	22, 348		4.00
5. 00 00500 ADMINI STRATI VE & GENERAL			343, 145		346, 518	5.00
7.00 00700 OPERATION OF PLANT	C		177, 174		14, 353	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	C	12, 561	12, 561		1, 176	8.00
9.00 00900 HOUSEKEEPI NG	0	7, 700	7,700	227	3, 980	9.00
10. 00 01000 DI ETARY	0	62, 285	62, 285	5 243	5, 410	10.00
13.00 01300 NURSING ADMINISTRATION	0		14, 731		8, 211	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY		20, 282	20, 282		1, 299	14.00
15.00 01500 PHARMACY			16, 171		214	15.00
16.00 01600 MEDI CAL RECORDS & LI BRAR			30, 590		6, 119	16.00
17.00 01700 SOCIAL SERVICE		0 0	C	) 71	880	17.00
30. 00 03000 ADULTS & PEDIATRICS	CENTERS	101 040	101 040	2 000	26, 200	20.00
30. 00  03000  ADULTS & PEDI ATRI CS 31. 00  03100  I NTENSI VE CARE UNI T			181, 848		36, 290 0	30.00 31.00
43. 00 04300 NURSERY			3, 359	° °	1, 406	
ANCI LLARY SERVICE COST CENTERS		5,007	3, 337	, , , , , , , , , , , , , , , , , , , ,	1,400	45.00
50. 00 05000 OPERATI NG ROOM		110, 674	110, 674	1, 279	14, 049	50.00
52.00 05200 DELIVERY ROOM & LABOR ROO	DM MC		10, 141		1, 582	•
53.00 05300 ANESTHESI OLOGY	C	647	647	0	237	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	78, 498	78, 498	1, 081	24, 469	54.00
60. 00 06000 LABORATORY	0	29, 004	29, 004	906	21, 482	60.00
60.01 06001 BLOOD LABORATORY	0	0 0	C	-	0	60.01
63.00 06300 BLOOD STORING, PROCESSING	G & TRANS.	0.0	876		739	63.00
65.00 06500 RESPI RATORY THERAPY	0	16, 338	16, 338		5, 723	65.00
66.00 06600 PHYSI CAL THERAPY		49, 328	49, 328		15, 241	66.00
67.00 06700 OCCUPATIONAL THERAPY			C		2, 519	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY		0			1, 090 371	68.00 69.00
69. 01 06901 CARDI AC REHABI LI TATI ON		9, 348	9, 348		1, 275	
70. 00 07000 ELECTROENCEPHALOGRAPHY		y, 340	9, 340		1, 273	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED	TO PATIENTS	0	C	-	5, 548	
72.00 07200 I MPL. DEV. CHARGED TO PA		0	C	0	1, 945	
73.00 07300 DRUGS CHARGED TO PATIENTS		0	C		25, 806	
76.00 03020 ONCOLOGY	0	11, 768	11, 768	3 151	2, 530	
OUTPATIENT SERVICE COST CENTER	S					
88.00 08800 RURAL HEALTH CLINIC	0		171, 061		65, 035	
90. 00 09000 CLINIC	0		37, 872	2 131	4, 677	
91.00 09100 EMERGENCY	C	110, 611	110, 611		32, 651	
92.00 09200 OBSERVATION BEDS (NON-DI			C	)		92.00
OTHER REIMBURSABLE COST CENTER		10 (05	10 (05	704	10 704	101 00
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS		13, 605	13, 605	5 734	10, 704	101.00
116. 00 11600 HOSPI CE		0	C	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES					317, 011	
NONREI MBURSABLE COST CENTERS		1, 341, 703	1, 541, 705	20,707	517,011	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP	P & CANTEEN C	9, 411	9, 411	0	125	190.00
190. 01 19001 HOMECARE			2, 504			190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFIC			155, 807		26, 090	
194.0007950 MARKETI NG		0	C	113		194.00
200.00 Cross Foot Adjustments			C			200.00
201.00 Negative Cost Centers		0	C	0		201.00
202.00 TOTAL (sum lines 118 thro	bugh 201) (	1, 709, 687	1, 709, 687	22, 348	346, 518	202.00

Heal th	n Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
ALLOC.	ATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-1305	Period: From 10/01/2016 To 09/30/2017		
	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPINO	G DI ETARY	NURSI NG ADMI NI STRATI O N	
		7.00	8.00	9.00	10.00	13.00	
	GENERAL SERVICE COST CENTERS	1		1			1 4 4 4
$\begin{array}{c} 1. \ 00 \\ 4. \ 00 \\ 5. \ 00 \\ 7. \ 00 \\ 8. \ 00 \\ 9. \ 00 \\ 10. \ 00 \\ 13. \ 00 \\ 14. \ 00 \\ 15. \ 00 \\ 16. \ 00 \\ 17. \ 00 \end{array}$	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	191, 907 2, 066 1, 266 10, 242 2, 422 3, 335 2, 659 5, 030 0	15, 832 0 0 0 0 0 0 0 0 0 0 0	13, 17 71 16 23 18 35	15     78, 895       59     0       33     0       36     0	26, 160 0 0 0 0 0	14.00 15.00 16.00
30.00		29, 907	5, 757	2,09	78, 895	13, 606	30.00
31.00		27, 707	3,737		0 70,073	0	
43.00		552	337	3	39 0	1, 366	
	ANCILLARY SERVICE COST CENTERS			1	- 1		
50.00 52.00 53.00 54.00 60.00	05200 DELIVERY ROOM & LABOR ROOM	18, 199 1, 668 106 12, 908	2, 594 0 0 1, 543	11 90	16 0 7 0 02 0	3, 190 565 0 613 0	52.00 53.00 54.00
60.00	06000 LABORATORY	4, 769 0	42 0	1	0 0	0	60.00
63.00		144	0		0 0	0	
65.00	06500 RESPI RATORY THERAPY	2, 687	0			603	
66.00		8, 112	1, 642	56		0	
67.00		0	0		0 0	0	
68.00 69.00		0	0		0 0	0	
69.00	06901 CARDI AC REHABI LI TATI ON	1, 537	0	10		0	69.00
70.00		0	0		0 0	0	
71.00		0	0		0 0	0	
72.00		0	0		0 0	0	
73.00 76.00		1, 935	0		0 0 35 0	0 1, 530	
70.00	OUTPATIENT SERVICE COST CENTERS	1, 700	0	1 10	0	1,000	/0.00
88.00		28, 129	170	1, 96	55 0	0	88.00
90.00		6, 228	0			604	
91.00 92.00		18, 189	3, 679	1, 27	0 0	3, 524	91.00 92.00
92.00	OTHER REIMBURSABLE COST CENTERS						92.00
101.0	SPECIAL PURPOSE COST CENTERS	2, 237	0	15	0	0	101.00
116. 0 118. 0	D 11600 HOSPICE D SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0 164, 327	0 15, 772		0 0 16 78, 895		116.00 118.00
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 547	0				190.00
		412	0		29 0		190.01
	D 19200 PHYSI CLANS' PRI VATE OFFI CES D 07950 MARKETI NG	25, 621	60	1, 79	0 0 0 0		192.00 194.00
200.0		0	0		0	0	200.00
201.0	D Negative Cost Centers	0	0		0 0	0	201.00
202.0	D TOTAL (sum lines 118 through 201)	191, 907	15, 832	13, 17	73 78, 895	26, 160	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	PULASKI MEMORIAL	Provider CC	CN: 15-1305	Period: From 10/01/2016 To 09/30/2017	u of Form CMS- Worksheet B Part II Date/Time Pre	
						2/27/2018 12:	
	Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	Subtotal	
		14.00	15.00	16.00	17.00	24.00	
	GENERAL SERVICE COST CENTERS	1 1		<b>F</b>	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 7.00
7.00 B.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00 9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
	01300 NURSING ADMINISTRATION						13.00
	01400 CENTRAL SERVICES & SUPPLY	25, 209					14.00
15.00	01500 PHARMACY	0	19, 230				15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0	42, 50	06		16.00
17.00	01700 SOCI AL SERVI CE	0	0		0 951		17.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1					
30.00	03000 ADULTS & PEDIATRICS	0	0	1, 59		353, 882	
	03100 INTENSIVE CARE UNIT	0	0	1	0 0	0	
43.00	04300 NURSERY	0	0	[](	03 0	7, 261	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	0	0	3, 8	60 63	155, 179	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0		89 0	14, 472	
	05300 ANESTHESI OLOGY	Ő	0		70 0	1, 667	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	8, 6		128, 624	
	06000 LABORATORY	o	0	8, 1		64, 664	
50. 01	06001 BLOOD LABORATORY	0	0		0 0	0	60.01
53.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	1:	37 0	1, 906	63.00
65.00	06500 RESPI RATORY THERAPY	0	0	8!	56 0	26, 808	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	2, 0	34 0	78, 044	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		83 0	3, 002	
	06800 SPEECH PATHOLOGY	0	0		75 0	1, 250	
	06900 ELECTROCARDI OLOGY	0	0		28 0	725	
69.01	06901 CARDI AC REHABI LI TATI ON	0	0	1	04 0	12, 461	
	07000 ELECTROENCEPHALOGRAPHY		0	1 / 1	0 0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	22, 734 2, 475	0	1, 6	86 0 84 0	29, 968 4, 604	
	07300 DRUGS CHARGED TO PATIENTS	2,475	19, 230	6, 4		51, 508	
	03020 ONCOLOGY	0	0		84 0	18, 241	
	OUTPATIENT SERVICE COST CENTERS				31 31	10/211	
38.00	08800 RURAL HEALTH CLINIC	0	0	2,8	30 0	273, 817	88.00
90.00	09000 CLINIC	0	0	6	18 0	50, 565	90.00
91.00	09100 EMERGENCY	0	0	2, 9	16 0	174, 123	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS	· · · · ·					
101.00	10100 HOME HEALTH AGENCY	0	0	5.	46 0	27, 982	101.00
	SPECIAL PURPOSE COST CENTERS						
	11600 HOSPI CE	0	0	10 5	0 0		116.00
118.00		25, 209	19, 230	42, 50	06 951	1, 480, 753	
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	11 101	190.00
	19001 HOMECARE	0	0		0 0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	2, 978	
		0	0		-		
192.00	07950 MARKETING	0	0		0 0	.3.377	1194 00
192.00 194.00	07950 MARKETING Cross Foot Adjustments	0	0		0 0		200.00
192.00	Cross Foot Adjustments	0	0 0 19, 230		0 0	0	200.00

Health Financial Systems	PULASKI MEMORIA	I HOSPI TAI	In Lieu of Form CMS-	-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-130	5 Period: Worksheet B	
			From 10/01/2016 Part II	
			To 09/30/2017 Date/Time Pro 2/27/2018 12	
Cost Center Description	Intern &	Total		
	Resi dents			
	Cost & Post			
	Stepdown			
	Adjustments	24.00		
GENERAL SERVICE COST CENTERS	25.00	26.00		
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5. 00 00500 ADMINI STRATI VE & GENERAL				5.00
7.00 00700 OPERATION OF PLANT				7.00
8.00 00800 LAUNDRY & LINEN SERVICE				8.00
9. 00 00900 HOUSEKEEPI NG				9.00
10. 00 01000 DI ETARY				10.00
13.00 01300 NURSI NG ADMI NI STRATI ON				13.00
14.00 01400 CENTRAL SERVICES & SUPPLY				14.00
15.00 01500 PHARMACY				15.00
16.00 01600 MEDI CAL RECORDS & LI BRARY				16.00
17.00 01700 SOCIAL SERVICE				17.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		252,000		
30. 00 03000 ADULTS & PEDIATRICS	0	353, 882		30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0		31.00
43. 00 04300 NURSERY	0	7, 261		43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0	155, 179		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	14, 472		52.00
53. 00 05300 ANESTHESI OLOGY	0	1, 667		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	128, 624		54.00
60. 00 06000 LABORATORY	Ő	64, 664		60.00
60. 01 06001 BLOOD LABORATORY	0	0		60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	1, 906		63.00
65. 00 06500 RESPI RATORY THERAPY	0	26, 808		65.00
66. 00 06600 PHYSI CAL THERAPY	0	78, 044		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	3, 002		67.00
68.00 06800 SPEECH PATHOLOGY	0	1, 250		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	725		69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	0	12, 461		69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	29, 968		71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS	0	4,604		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03020 ONCOLOGY	0	51, 508 18, 241		73.00 76.00
OUTPATIENT SERVICE COST CENTERS	0	10, 241		/0.00
88.00 08800 RURAL HEALTH CLINIC	0	273, 817		88.00
90. 00 09000 CLINIC	0	50, 565		90.00
91. 00 09100 EMERGENCY	0	174, 123		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
OTHER REIMBURSABLE COST CENTERS	11	1		
101.00 10100 HOME HEALTH AGENCY	0	27, 982		101.00
SPECIAL PURPOSE COST CENTERS				
116. 00 11600 HOSPI CE	0	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	1, 480, 753		118.00
NONREI MBURSABLE COST CENTERS	11			_
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11, 191		190.00
190. 01 19001 HOMECARE	0	2, 978		190.01
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	211, 393		192.00
194.00 07950 MARKETING	0	3, 372		194.00
200.00Cross Foot Adjustments201.00Negative Cost Centers	0	0		200. 00 201. 00
201.00 Negative cost centers 202.00 TOTAL (sum lines 118 through 201)	0	1, 709, 687		201.00
		1, 107, 007		1202.00

	Financial Systems	PULASKI MEMORI		ON 15 1005 5		u of Form CMS-	
COST A	LLOCATION - STATISTICAL BASIS		Provider C		eriod: rom 10/01/2016	Worksheet B-1	
					09/30/2017	Date/Time Pre	
		CAPI TAL				2/27/2018 12:	01 pm
		RELATED COSTS					
	Cost Center Description	NEW BLDG &	EMPLOYEE	Reconciliatio	ADMI NI STRATI V	OPERATION OF	
		FLXT	<b>BENEFITS</b>	n	E & GENERAL	PLANT	
		(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	
		FEET)	(GROSS		COST)	FEET)	
		1.00	SALARIES) 4.00	5A	5.00	7.00	
	GENERAL SERVICE COST CENTERS	1.00	4.00	JA	5.00	7.00	-
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	81, 936					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 071	15, 744, 366				4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	16, 445	2, 376, 847				5.00
7.00	00700 OPERATION OF PLANT	8, 491	267, 823		1, 084, 192	55, 929	
8.00	00800 LAUNDRY & LINEN SERVICE	602	20, 272		88, 852	602	
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	369 2, 985	160, 061 171, 002	0	300, 647 408, 635	369 2, 985	1
	01300 NURSI NG ADMI NI STRATI ON	2, 985	441, 531			706	
	01400 CENTRAL SERVICES & SUPPLY	972	42, 106		98, 105	972	
	01500 PHARMACY	775	C			775	1
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 466	293, 445	0		1, 466	16.00
17.00	01700 SOCIAL SERVICE	0	49, 804	0	66, 481	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS			-			
	03000 ADULTS & PEDIATRICS	8, 715	2, 119, 683			8, 715	
	03100 I NTENSI VE CARE UNI T 04300 NURSERY	161	70, 050	0		0	31.00 43.00
43.00	ANCI LLARY SERVICE COST CENTERS	101	70,050	<u> </u>	100, 244	101	43.00
50.00	05000 OPERATING ROOM	5, 304	901.099	0	1, 061, 236	5, 304	50.00
	05200 DELIVERY ROOM & LABOR ROOM	486	77, 922		1	486	1
53.00	05300 ANESTHESI OLOGY	31	C			31	53.00
	05400 RADI OLOGY-DI AGNOSTI C	3, 762	761, 764	0	1, 848, 358	3, 762	54.00
	06000 LABORATORY	1, 390	638, 227	0	1, 622, 772	1, 390	
	06001 BLOOD LABORATORY	0	C	-	0	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	42	201 255	0	55, 804	42	1
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	783 2, 364	291, 255 789, 320			783 2, 364	
	06700 OCCUPATI ONAL THERAPY	2, 304	141, 263		190, 295	2,304	
	06800 SPEECH PATHOLOGY	0	59, 930		82, 313	0	
69.00	06900 ELECTROCARDI OLOGY	0	18, 363		28, 048	0	69.00
	06901 CARDI AC REHABI LI TATI ON	448	63, 197	0	96, 276	448	69.01
	07000 ELECTROENCEPHALOGRAPHY	0	C	0	0	0	
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	C	0	419,080	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0		0		0	
	03020 ONCOLOGY	564	106, 190			564	1
70.00	OUTPATIENT SERVICE COST CENTERS	504	100, 170	10	171, 122		70.00
88.00	08800 RURAL HEALTH CLINIC	8, 198	3, 257, 299	0	4, 911, 997	8, 198	88.00
	09000 CLINIC	1, 815			353, 269	1, 815	90.00
	09100 EMERGENCY	5, 301	903, 373	0	2, 466, 441	5, 301	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
101 00	OTHER REIMBURSABLE COST CENTERS	(50)	F17 110		000 5/0	(52	101 00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	652	517, 118	0	808, 569	652	101.00
116 00	11600 HOSPI CE	0	C	0	0	0	116.00
118.00		73, 898	14, 631, 537				118.00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	451	C	0	9, 411	451	190.00
	19001 HOMECARE	120	C	0			190. 01
	19200 PHYSI CLANS' PRI VATE OFFI CES	7,467	1, 032, 887				192.00
	07950 MARKETI NG	0	79, 942	0	246, 188	0	194.00
200.00 201.00							200.00
201.00	5	1, 709, 687	5, 238, 734		5, 018, 237	1, 292, 051	
202.00	Part I)	1, 707, 007	5,250,754		5,010,237	1, 272, 031	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	20. 866127	0. 332737		0. 191718	23. 101629	203.00
204.00	Cost to be allocated (per Wkst. B,		22, 348		346, 518		
	Part II)						
205.00			0. 001419		0. 013238	3. 431261	205.00
	11)	ļ l		1	l	l	1

Health Financial Systems	PULASKI MEMORI	AL HOSPITAL		Inlie	u of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Period:	Worksheet B-1	
				From 10/01/2016 To 09/30/2017		pared:
				NUDGLNG	2/27/2018 12:	
Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG (SQUARE	DI ETARY (MEALS	NURSI NG ADMI NI STRATI O	CENTRAL SERVICES &	
	(POUNDS OF	FEET)	SERVED)	N	SUPPLY	
	LAUNDRY)			(DI RECT	(100%)	
	8.00	9.00	10.00	NRSING HRS) 13.00	14.00	
GENERAL SERVICE COST CENTERS	0.00	7.00	10.00	10.00	11.00	
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 7. 00 00700 OPERATI ON OF PLANT						5.00 7.00
8.00 00800 LAUNDRY & LI NEN SERVI CE	169, 904					8.00
9.00 00900 HOUSEKEEPI NG	0	54, 958				9.00
10.00 01000 DI ETARY	0	2, 985				10.00
13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY	0	706 972		0 88,750 0 0		13.00 14.00
15. 00 01500 PHARMACY	0	775		0 0	0	
16.00 01600 MEDICAL RECORDS & LIBRARY	0	1, 466		0 0	0	
17.00 01700 SOCIAL SERVICE	0	0		0 0	0	17.00
30. 00 03000 ADULTS & PEDIATRICS	61, 766	8, 715	10	0 46, 155	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	01,700	0, 713		0 40, 133		
43. 00 04300 NURSERY	3, 619	161		0 4, 634	0	
ANCI LLARY SERVICE COST CENTERS			1		-	
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	27, 836 0	5, 304 486		0 10, 824 0 1, 918		
53. 00   05300   ANESTHESI OLOGY	0	480		0 1,910	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	16, 564	3, 762		2, 080	0	•
60. 00 06000 LABORATORY	448	1, 390		0 0	0	
60. 01 06001 BLOOD LABORATORY	0	0		0 0	0	
63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 65. 00 06500 RESPI RATORY THERAPY	0	42 783		0 2,045	0	
66. 00 06600 PHYSI CAL THERAPY	17, 626	2, 364		0 0	0	
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	
69. 00  06900  ELECTROCARDI OLOGY 69. 01  06901  CARDI AC REHABI LI TATI ON	0	448			0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	2, 446, 861	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	266, 365	
73. 00 07300 DRUGS CHARGED TO PATI ENTS 76. 00 03020 ONCOLOGY	91	0 564		0 5, 191	0	
OUTPATIENT SERVICE COST CENTERS	71	001		0,171		/0.00
88.00 08800 RURAL HEALTH CLINIC	1, 827	8, 198		0 0	-	
90. 00 09000 CLINIC	0	1,815		0 2,050		
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	39, 479	5, 301		0 11, 955	0	91.00 92.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>					92.00
101.00 10100 HOME HEALTH AGENCY	0	652		0 0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0 169, 256	0 46, 920		0 0 0 86, 852		116.00
NONREI MBURSABLE COST CENTERS	109, 230	40, 720	10	0 00,032	2,713,220	1110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	451		0 0	0	190.00
190. 01 19001 HOMECARE	0	120		0 0		190.01
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 194. 00 07950 MARKETI NG	648	7,467		0 1,898		192.00
200.00 Cross Foot Adjustments	0	0		0	0	194.00 200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	119, 794	366, 811	575, 85	9 760, 215	145, 856	202.00
Part I)	0 7050/0	L (74000		0 0 646000	0 052757	202 00
203.00Unit cost multiplier (Wkst. B, Part I)204.00Cost to be allocated (per Wkst. B,	0. 705069 15, 832	6. 674388 13, 173				203.00
Part II)	13, 032	15, 175	70,07	20,100	23, 209	207.00
205.00 Unit cost multiplier (Wkst. B, Part	0. 093182	0. 239692	788. 95000	0 0. 294761	0. 009291	205.00
11)			l		I	I

Heal th	Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lieu	of Form CMS-2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provider C		Period: W From 10/01/2016	Vorksheet B-1
					To 09/30/2017 [	Date/Time Prepared: 2/27/2018 12:01 pm
	Cost Center Description	PHARMACY (100%)	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES)	SOCI AL SERVI CE (ALLOCATI ON OF TI ME)		72772010 12. 01 pm
		15.00	16.00	17.00	-	
	GENERAL SERVICE COST CENTERS			1		
14.00 15.00 16.00	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 DI ETARY 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	100 0 0	61, 690, 568 0		В	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	03000 ADULTS & PEDIATRICS	0	2, 312, 196	9, 22	8	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0	(	D	31.00
43.00	04300 NURSERY	0	148, 945	(		43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	0	5, 602, 639	660		50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	419, 273			52.00
	05300 ANESTHESI OLOGY	0	971, 886		D	53.00
	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	12, 493, 320 11, 797, 196			54.00 60.00
	06001 BLOOD LABORATORY	0	0			60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	198, 753		D	63.00
	06500 RESPIRATORY THERAPY	0	1, 242, 806			65.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	2, 952, 303 411, 381			66.00 67.00
	06800 SPEECH PATHOLOGY	0	109, 107			68.00
	06900 ELECTROCARDI OLOGY	0	476, 527		D	69.00
	06901 CARDI AC REHABI LI TATI ON 07000 ELECTROENCEPHALOGRAPHY	0	150, 656 0			69.01 70.00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 446, 862			70.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	266, 365		D	72.00
	07300 DRUGS CHARGED TO PATIENTS	100	9, 393, 998		D	73.00
76.00	03020 ONCOLOGY OUTPATIENT SERVICE COST CENTERS	0	266, 688	[(		76.00
88.00	08800 RURAL HEALTH CLINIC	0	4, 106, 911		כ	88.00
	09000 CLINIC	0	897, 542		D	90.00
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	4, 232, 673	(		91.00 92.00
92.00	OTHER REIMBURSABLE COST CENTERS	I				92.00
101.00	10100 HOME HEALTH AGENCY	0	792, 541	(	D	101.00
11/ 00	SPECIAL PURPOSE COST CENTERS					11/ 00
116.00 118.00		0 100	0 61, 690, 568		2 3	116. 00 118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			190.00
	19001 HOMECARE	0	0		5 D	190.01
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		D	192.00
194.00 200.00	07950 MARKETING Cross Foot Adjustments	0	0	(	D	194.00 200.00
200.00	5					200.00
202.00		42, 348	594, 471	79, 22	7	202.00
203.00 204.00	Unit cost multiplier (Wkst. B, Part I)	423. 480000 19, 230	0. 009636 42, 506			203.00 204.00
205.00	Part II)	192. 300000	0. 000689			205.00
	11)					

Heal th Financial	Systems	PULASKI MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF R	RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1305	Period: From 10/01/2016 To 09/30/2017		epared:
			Title	XVIII	Hospi tal	Cost	
					Costs		
Cost	t Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	ROUTINE SERVICE COST CENTERS	1					
	TS & PEDIATRICS	4, 637, 400		4, 637, 40		0	
	ENSIVE CARE UNIT	0		175 0	0 0	0	
43.00 04300 NURS	SERVICE COST CENTERS	175, 088		175, 08	38 0	0	43.00
	SERVICE COST CENTERS	1, 594, 243		1, 594, 24	13 0	0	50.00
	VERY ROOM & LABOR ROOM	1, 394, 243		1, 394, 24		-	
	STHESI OLOGY	31, 592		31, 59	-	0	
	OLOGY-DI AGNOSTI C	2, 464, 640		2, 464, 64		0	
60.00 06000 LABC		2, 089, 269		2, 089, 26		0	
	DD LABORATORY	0		2,00,720	0 0	0	60.01
	DD STORING, PROCESSING & TRANS.	69, 668		69,66	58 0	0	1
	PIRATORY THERAPY	567, 971	0			0	1
66.00 06600 PHYS	SI CAL THERAPY	1, 483, 340	0			0	66.00
67.00 06700 0CCL	JPATI ONAL THERAPY	230, 742	0	230, 74	12 0	0	67.00
68.00 06800 SPEE	ECH PATHOLOGY	99, 145	0	99, 14	15 0	0	68.00
	CTROCARDI OLOGY	38, 017		38, 01	17 0	0	69.00
69.01 06901 CARE	DI AC REHABI LI TATI ON	129, 526		129, 52	26 0	0	69.01
70.00 07000 ELEC	CTROENCEPHALOGRAPHY	0			0 0	0	70.00
	CAL SUPPLIES CHARGED TO PATIENTS	654, 540		654, 54	10 0	0	
	DEV. CHARGED TO PATIENTS	191, 976		191, 97		0	
	GS CHARGED TO PATIENTS	2, 456, 030		2, 456, 03		0	
76.00 03020 ONCC		291, 656		291, 65	56 0	0	76.00
	T SERVICE COST CENTERS				-	-	
	AL HEALTH CLINIC	6, 138, 688		6, 138, 68		0	
90.00 09000 CLIN		501, 249		501, 24		0	
91.00 09100 EMER		3, 268, 170		3, 268, 17		0	
	ERVATION BEDS (NON-DISTINCT PART)	591, 877		591, 87	//	0	92.00
	MBURSABLE COST CENTERS	000 (07		000 (/		2	101 00
101.00 10100 HOME	_ HEALTH AGENCY URPOSE COST CENTERS	990, 637		990, 63	57	0	101.00
116.00 11600 HOSE		0			0	0	116.00
	total (see instructions)	28, 872, 861	0	28, 872, 86	-		200.00
	s Observation Beds	28, 872, 861	0	28, 872, 80			200.00
	al (see instructions)	28, 280, 984	0				201.00
202.00 1012		20, 200, 904	0	20,200,90	0	0	202.00

COMPUTA	TION OF RATIO OF COSTS TO CHARGES						
					Period: From 10/01/2016 To 09/30/2017		epared: 01 pm
				XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpatient	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
	NPATIENT ROUTINE SERVICE COST CENTERS			1			
	D3000 ADULTS & PEDIATRICS	2, 010, 881		2, 010, 88	31		30.00
31.00	D3100 INTENSIVE CARE UNIT	0			0		31.00
	D4300 NURSERY	148, 945		148, 94	45		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	D5000 OPERATING ROOM	705, 933	4, 896, 706	5, 602, 63	0. 284552	0. 000000	50.00
52.00	D5200 DELIVERY ROOM & LABOR ROOM	269, 361	149, 912	419, 27	0. 423106	0. 000000	52.00
53.00	D5300 ANESTHESI OLOGY	117, 618	854, 268	971, 88	0. 032506	0.00000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 193, 842	11, 299, 478	12, 493, 32	0. 197277	0. 000000	54.00
60.00	06000 LABORATORY	1, 941, 418	9, 855, 778	11, 797, 19	0. 177099	0. 000000	60.00
60.01	06001 BLOOD LABORATORY	0	0		0 0.000000	0. 000000	60.01
63.00	D6300 BLOOD STORING, PROCESSING & TRANS.	85, 790	112, 963	198, 75	0. 350526	0. 000000	63.00
	06500 RESPI RATORY THERAPY	937, 083	305, 723			0, 000000	
	D6600 PHYSI CAL THERAPY	456, 483	2, 495, 820				
	06700 OCCUPATI ONAL THERAPY	238, 867	172, 514			0. 000000	
	D6800 SPEECH PATHOLOGY	44, 636	64, 471			0, 000000	
	06900 ELECTROCARDI OLOGY	28, 312	448, 215			0. 000000	
	06901 CARDI AC REHABI LI TATI ON	0	150, 656			0. 000000	
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0.000000	0, 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	883, 834	1, 563, 028			0. 000000	
	07200 I MPL. DEV. CHARGED TO PATIENTS	99,069	167, 296			0.000000	
	07300 DRUGS CHARGED TO PATIENTS	3, 886, 918	5, 507, 080			0.000000	
	D3020 ONCOLOGY	541	266, 147			0.000000	
	DUTPATI ENT SERVI CE COST CENTERS	J 341	200, 147	200, 00	1.075025	0.000000	/0.00
	D8800 RURAL HEALTH CLINIC	0	4, 106, 911	4, 106, 91	1		88.00
	DODOO CLINIC	0	897, 542			0. 000000	
	D9100 EMERGENCY	216, 088	4, 016, 585				
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	210,000	4,018,385			0. 000000	•
	OTHER REIMBURSABLE COST CENTERS	0	301, 313	301, 3	1. 904313	0.00000	92.00
	10100 HOME HEALTH AGENCY		702 541	702 5/	11		101 00
		0	792, 541	792, 54	+1		101.00
	SPECIAL PURPOSE COST CENTERS			1	0		1114 00
		12 2/5 /10	0		0		116.00
200.00	Subtotal (see instructions)	13, 265, 619	48, 424, 949	61, 690, 56	δQ		200.00
201.00	Less Observation Beds	10 0/5 /10	40 404 040	(1 (00 5)			201.00
202.00	Total (see instructions)	13, 265, 619	48, 424, 949	61, 690, 56	אמ		202.00

Health Financial Systems	PULASKI MEMORIAL	_ HOSPI TAL	In Lieu	」of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1305	Period: From 10/01/2016 To 09/30/2017	Worksheet C Part I Date/Time Pre 2/27/2018 12:	epared: 01 pm
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
43.00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.000000				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
53.00 05300 ANESTHESI OLOGY	0. 000000				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60. 00 06000 LABORATORY	0. 000000				60.00
60.01 06001 BLOOD LABORATORY	0. 000000				60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66.00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	0. 000000				69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72. 00 07200 I MPL. 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
OUTPATIENT SERVICE COST CENTERS	0.000000				10100
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 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000				92.00
OTHER REIMBURSABLE COST CENTERS	0.000000				/2.00
101.00 10100 HOME HEALTH AGENCY					101.00
SPECIAL PURPOSE COST CENTERS					101.00
116. 00 11600 H0SPI CE					116.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					200.00
202.00 Total (see instructions)					201.00
	I I				202.00

Health Financial Systems	PULASKI MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period:	Worksheet C	
				From 10/01/2016 To 09/30/2017	Part I Date/Time Pre	pared:
					2/27/2018 12:	01 pm
		Titl	e XIX	Hospi tal	Cost	
	TALL OF A	<b>T</b> I	Talah Quala	Costs		
Cost Center Description	Total Cost (from Wkst.	Therapy Limit	Total Costs	RCE Di sal I owance	Total Costs	
	B, Part I,	Adj .		DISALLOWALICE		
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	4, 637, 400		4, 637, 40	0 0	4, 637, 400	30.00
31.00 03100 INTENSIVE CARE UNIT	0			0 0	0	31.00
43. 00 04300 NURSERY	175, 088		175, 08	38 0	175, 088	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1, 594, 243		1, 594, 24		1, 594, 243	•
52.00 05200 DELIVERY ROOM & LABOR ROOM	177, 397		177, 39		177, 397	•
53.00 05300 ANESTHESI OLOGY	31, 592		31, 59		31, 592	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 464, 640		2, 464, 64		2, 464, 640	
60. 00 06000 LABORATORY	2, 089, 269		2, 089, 26		2,089,269	
60. 01 06001 BLOOD LABORATORY	0			0 0	0	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	69, 668	0	69,66		69, 668	
65. 00 06500 RESPI RATORY THERAPY	567, 971	0			567, 971	•
66. 00 06600 PHYSI CAL THERAPY	1, 483, 340	0	.,		1, 483, 340	•
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	230, 742 99, 145	0	230, 74 99, 14		230, 742 99, 145	•
69. 00 06900 ELECTROCARDI OLOGY	38, 017	0	38, 01		38, 017	
69. 01 06901 CARDI AC REHABI LI TATI ON	129, 526		129, 52		129, 526	
70. 00 07000 ELECTROENCEPHALOGRAPHY	127, 320			0 0	127, 320	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		654, 54	-	654, 540	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	191, 976		191, 97		191, 976	
73. 00 07300 DRUGS CHARGED TO PATIENTS	2, 456, 030		2, 456, 03		2, 456, 030	
76. 00 03020 ONCOLOGY	291, 656		291, 65		291, 656	
OUTPATIENT SERVICE COST CENTERS				<u> </u>		
88.00 08800 RURAL HEALTH CLINIC	6, 138, 688		6, 138, 68	38 0	6, 138, 688	88.00
90. 00 09000 CLINIC	501, 249		501, 24	19 0	501, 249	90.00
91.00 09100 EMERGENCY	3, 268, 170		3, 268, 17	0 0	3, 268, 170	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	591, 877		591, 87	7	591, 877	92.00
OTHER REIMBURSABLE COST CENTERS						
101.0010100 HOME HEALTH AGENCY	990, 637		990, 63	37	990, 637	101.00
SPECIAL PURPOSE COST CENTERS			1			
116.00 11600 HOSPI CE	0	-		0		116.00
200.00 Subtotal (see instructions)	28, 872, 861	0			28, 872, 861	
201.00 Less Observation Beds	591,877	~	591, 87		591, 877	
202.00  Total (see instructions)	28, 280, 984	0	28, 280, 98	34 0	28, 280, 984	202.00

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CH		PULASKI MEMORI	Provi der C	CN: 15-1305	Peri od:	worksheet C	2002 1
	WINGED			. 10 1000	From 10/01/2016	Part I	
					To 09/30/2017	Date/Time Pre	epared:
						2/27/2018 12:	01 pm
				e XIX	Hospi tal	Cost	
Cost Conton Decerinti er		Inpatient	Charges	Total (asl	( Coot on Other	TEFRA	
Cost Center Description	1	Inpatient	Outpati ent	$+ \operatorname{col}. 7$	6 Cost or Other Ratio	Inpati ent	
				+ COL. 7)	Ratio		
	-	6.00	7.00	8.00	9,00	Rati o 10.00	
INPATIENT ROUTINE SERVICE CO	ST CENTERS	0.00	7.00	0.00	9.00	10.00	
30. 00 03000 ADULTS & PEDI ATRI CS	DI CENTERS	2,010,881		2, 010, 88	21		30.00
31. 00 03100 INTENSIVE CARE UNIT		2,010,001		2,010,00	0		31.00
43. 00 04300 NURSERY		148, 945		148, 94	-		43.00
ANCI LLARY SERVICE COST CENTER	20	140, 745		140, 74	+5		43.00
50. 00 05000 OPERATING ROOM	()	705, 933	4, 896, 706	5, 602, 63	0. 284552	0. 000000	50.00
52.00 05200 DELIVERY ROOM & LABOR F	POOM	269, 361	4, 090, 700				
53. 00 05300 ANESTHESI OLOGY		117, 618	854, 268				
54. 00 05400 RADI OLOGY - DI AGNOSTI C		1, 193, 842	11, 299, 478				
60. 00 06000 LABORATORY		1, 941, 418	9, 855, 778				
60. 01 06000 EABORATORY		1, 941, 410	9, 655, 778		0 0. 000000		
63. 00 06300 BLOOD STORING, PROCESSI	NC & TDANS	85, 790	112, 963				
65. 00 06500 RESPI RATORY THERAPY	NG & IKANS.	937, 083	305, 723				
		456, 483	2, 495, 820				
67.00 06700 OCCUPATI ONAL THERAPY		238, 867	172, 514				
68.00 06800 SPEECH PATHOLOGY		44, 636	64, 471				
69.00 06900 ELECTROCARDI OLOGY		28, 312	448, 215				
69. 01 06901 CARDI AC REHABI LI TATI ON		0	150, 656				
70.00 07000 ELECTROENCEPHALOGRAPHY		0	0		0 0.00000		
71.00 07100 MEDICAL SUPPLIES CHARGE		883, 834	1, 563, 028				
72.00 07200 I MPL. DEV. CHARGED TO F		99, 069	167, 296				
73.00 07300 DRUGS CHARGED TO PATIEN	IIS	3, 886, 918	5, 507, 080				
76.00 03020 ONCOLOGY		541	266, 147	266, 68	38 1.093623	0. 000000	76.00
OUTPATIENT SERVICE COST CENTI	ERS	-					
88.00 08800 RURAL HEALTH CLINIC		0	4, 106, 911				
90. 00 09000 CLI NI C		0	897, 542				
91.00 09100 EMERGENCY		216, 088	4, 016, 585				
92.00 09200 OBSERVATION BEDS (NON-E		0	301, 315	301, 31	1. 964313	0. 000000	92.00
OTHER REIMBURSABLE COST CENTI	ERS					1	
101.00 10100 HOME HEALTH AGENCY		0	792, 541	792, 54	41		101.00
SPECIAL PURPOSE COST CENTERS				1		1	-
116.00 11600 HOSPI CE		0	0		0		116.00
200.00 Subtotal (see instructi	ons)	13, 265, 619	48, 424, 949	61, 690, 50	58		200.00
201.00 Less Observation Beds							201.00
202.00 Total (see instructions	5)	13, 265, 619	48, 424, 949	61, 690, 56	58		202.0

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1305	Period: From 10/01/2016 To 09/30/2017	Worksheet C Part I Date/Time Pre 2/27/2018 12:	pared: 01 pm
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	· · · · ·				
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS	· · ·				
50.00 05000 OPERATING ROOM	0. 000000				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60. 00 06000 LABORATORY	0. 000000				60.00
60. 01 06001 BLOOD LABORATORY	0. 000000				60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000				68.00
69.00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	0. 000000				69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
76.00 03020 ONCOLOGY	0. 000000				76.00
OUTPATIENT SERVICE COST CENTERS					1
88.00 08800 RURAL HEALTH CLINIC	0. 000000				88.00
90. 00 09000 CLINIC	0. 000000				90.00
91.00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
OTHER REIMBURSABLE COST CENTERS					1
101.00 10100 HOME HEALTH AGENCY					101.00
SPECIAL PURPOSE COST CENTERS	1 1				
116. 00 11600 HOSPI CE					116.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00
	1 I				

Health Financial Systems	PULASKI MEMOR	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provider C		Period: From 10/01/2016 To 09/30/2017	Date/Time Pre 2/27/2018 12:	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	155, 179	5, 602, 639				
52.00 05200 DELIVERY ROOM & LABOR ROOM	14, 472					
53.00 05300 ANESTHESI OLOGY	1, 667	971, 886	0. 00171	5 33, 095	57	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	128, 624	12, 493, 320	0. 01029	5 402, 373	4, 142	54.00
60. 00 06000 LABORATORY	64, 664	11, 797, 196	0. 00548	1 623, 059	3, 415	60.00
60.01 06001 BLOOD LABORATORY	0	0	0. 00000	0 0	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	1, 906	198, 753	0. 00959	0 48, 777	468	63.00
65. 00 06500 RESPI RATORY THERAPY	26, 808	1, 242, 806	0. 02157	1 444, 805	9, 595	65.00
66. 00 06600 PHYSI CAL THERAPY	78, 044	2, 952, 303	0. 02643	5 90, 713	2, 398	66.00
67.00 06700 OCCUPATI ONAL THERAPY	3, 002	411, 381	0.00729	7 39, 789	290	67.00
68.00 06800 SPEECH PATHOLOGY	1, 250	109, 107	0. 01145	7 5, 637	65	68.00
69. 00 06900 ELECTROCARDI OLOGY	725	476, 527	0. 00152	1 23, 622	36	69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	12, 461	150, 656	0. 08271	2 0	0	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0. 00000	0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	29, 968	2, 446, 862	0. 01224	8 209, 208	2, 562	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	4,604	266, 365	0. 01728	5 55, 032	951	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	51, 508	9, 393, 998	0.00548	3 1, 545, 918	8, 476	73.00
76.00 03020 ONCOLOGY	18, 241	266, 688	0. 06839	8 0	0	76.00
OUTPATIENT SERVICE COST CENTERS	· · · · ·					
88.00 08800 RURAL HEALTH CLINIC	273, 817	4, 106, 911	0. 06667	2 0	0	88.00
90. 00 09000 CLINIC	50, 565	897, 542	0. 05633	7 0	0	90.00
91.00 09100 EMERGENCY	174, 123			8 16, 198	666	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	45, 166				0	92.00
200.00   Total (lines 50 through 199)	1, 136, 794			3, 807, 319	40, 596	200.00

Health Financial Systems	PULASKI MEMORI	AL HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PAS	S Provider C	CN: 15-1305	Period: From 10/01/2016 To 09/30/2017		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS			•			
50.00 05000 OPERATI NG ROOM	0	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
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	o o	63.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	0	0		0 0	0	69.01
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	0	73.00
76.00 03020 ONCOLOGY	0	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS					. · · ·	
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		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92.00
200.00 Total (lines 50 through 199)	0	0		0 0	-	200.00
				1	-	

Health Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PAS	S Provider C		Period: From 10/01/2016 To 09/30/2017		
		Title	e XVIII	Hospi tal	Cost	•
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of col 1	Outpati ent	(from Wkst.	to Charges	
	Educati on	through col.	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col. 2, 3 and	l col. 8)	col. 7)	
			4)			
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		5, 602, 639	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 419, 273	0.000000	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		971, 886	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		12, 493, 320	0.000000	54.00
60. 00 06000 LABORATORY	0	0		0 11, 797, 196	0.000000	60.00
60.01 06001 BLOOD LABORATORY	0	0		0 C	0.000000	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		D 198, 753	0. 000000	63.00
65. 00 06500 RESPI RATORY THERAPY	0	0		1, 242, 806	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		2, 952, 303	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		D 411, 381	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 109, 107	0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		476, 527	0. 000000	69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	0	0		0 150, 656	0. 000000	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0. 000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		2, 446, 862	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		266, 365	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		9, 393, 998	0.000000	73.00
76.00 03020 ONCOLOGY	0	0		266, 688	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS						1
88.00 08800 RURAL HEALTH CLINIC	0	0		4, 106, 911	0. 000000	88.00
90. 00 09000 CLINIC	0	0		897, 542		
91.00 09100 EMERGENCY	0	0		4, 232, 673	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		301, 315	0. 000000	92.00
200.00   Total (lines 50 through 199)	0	0		58, 738, 201		200.00

Health Financial Systems	PULASKI MEMORIA	- HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	Provider CC	CN: 15-1305	Period: From 10/01/2016 To 09/30/2017		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	265, 776		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	3, 317		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	33, 095		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	402, 373		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	623, 059		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. 000000	48, 777		0 0	0	63.00
65.00 06500 RESPI RATORY THERAPY	0. 000000	444, 805		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	90, 713		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	39, 789		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	5, 637		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	23, 622		0 0	0	69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	209, 208		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	55, 032		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 545, 918		0 0	0	73.00
76.00 03020 ONCOLOGY	0. 000000	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS	· ·					
88.00 08800 RURAL HEALTH CLINIC	0.000000	0		0 0	0	88.00
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
91.00 09100 EMERGENCY	0. 000000	16, 198		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)		3, 807, 319		0 0	0	200.00
· · · · ·						

Health Financial Systems	PULASKI MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C		Peri od:	Worksheet D	
				From 10/01/2016		
				To 09/30/2017	Date/Time Pre 2/27/2018 12:	on pared:
		Title XVIII		Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not	. ,	
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.	í í	Ded. & Coi ns			
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 284552	0	1, 838, 75	7 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 423106	0	4, 23	6 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 032506	0	300, 06	0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 197277	0	3, 969, 98	4 0	0	54.00
60. 00 06000 LABORATORY	0. 177099	0	4, 274, 64	8 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. 350526	0	88, 10	0 0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0. 457007	0	129, 98	7 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 502435	0	898, 56	1 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 560896	0	42, 52	0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 908695	0	6, 10	7 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 079779	0	180, 35	4 0	0	69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	0. 859747	0	93, 67	3 0	0	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 267502	0	553, 30	8 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 720725	0	77,67	5 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 261447	0	2, 394, 81	0 76	0	73.00
76.00 03020 ONCOLOGY	1.093623	0	121, 90	8 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	88.00
90. 00 09000 CLINIC	0. 558469	0	761, 40	3 0	0	90.00
91. 00 09100 EMERGENCY	0. 772129	0	1, 281, 64	4 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.964313	0	96, 38		0	12.00
200.00 Subtotal (see instructions)		0	17, 114, 12	4 76	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	17, 114, 12	4 76	0	202.00

ANCI LLARY SERVICE COST CENTERS         Solution         Solution <t< th=""><th>Cost Cost Reimbursed Services Subject To</th><th></th><th>XVIII</th><th>Peri od: From 10/01/2016 To 09/30/2017 Hospi tal</th><th>Worksheet D Part V Date/Time Pre 2/27/2018 12: Cost</th><th></th></t<>	Cost Cost Reimbursed Services Subject To		XVIII	Peri od: From 10/01/2016 To 09/30/2017 Hospi tal	Worksheet D Part V Date/Time Pre 2/27/2018 12: Cost	
ANCI LLARY SERVICE COST CENTERS ANCI LLARY SERVICE COST CENTERS	Cost Reimbursed Services Subject To	cost	XVIII	Hospi tal		
ANCI LLARY SERVICE COST CENTERS ANCI LLARY SERVICE COST CENTERS	Cost Reimbursed Services Subject To	cost	XVIII	nospi tai		<u> </u>
ANCI LLARY SERVICE COST CENTERS ANCI LLARY SERVICE COST CENTERS	Cost Reimbursed Services Subject To	Cost	1		CUST	
ANCI LLARY SERVICE COST CENTERS ANCI LLARY SERVICE COST CENTERS	Reimbursed Services Subject To					
ANCI LLARY SERVICE COST CENTERS         Solution         Solution <t< td=""><td>Servi ces Subj ect To</td><td></td><td></td><td></td><td></td><td></td></t<>	Servi ces Subj ect To					
ANCI LLARY SERVICE COST CENTERS 0.00 05000 0PERATI NG ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY 54.00 05400 RADI OLOGY-DI AGNOSTI C 50.00 06000 LABORATORY 50.01 06001 BLOOD LABORATORY 53.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	Subject To	Servi ces Not				
De ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( (		Subject To				
ANCI LLARY SERVICE COST CENTERS           50.00         05000         0PERATI NG ROOM           52.00         05200         DELI VERY ROOM & LABOR ROOM           53.00         05300         ANESTHESI OLOGY           54.00         05400         RADI OLOGY-DI AGNOSTI C           50.00         06000         LABORATORY           50.01         06001         BLOOD LABORATORY           53.00         06300         BLOOD STORI NG, PROCESSI NG & TRANS.		Ded. & Coins.				
ANCI LLARY         SERVI CE         COST         CENTERS           50. 00         05000         OPERATI NG         ROOM           52. 00         05200         DELI VERY         ROOM           53. 00         05300         ANESTHESI OLOGY           54. 00         05400         RADI OLOGY-DI AGNOSTI C           00. 00         06000         LABORATORY           00. 01         06001         BLOOD           053. 00         06300         BLOOD	(see inst.)	(see inst.)				
50.00         05000         OPERATING         ROOM           52.00         05200         DELIVERY         ROOM & LABOR         ROOM           53.00         05300         ANESTHESI OLOGY         State         State         State           54.00         05400         RADI OLOGY-DI AGNOSTI C         State	6.00	7.00				
50.00         05000         OPERATING         ROOM           52.00         05200         DELIVERY         ROOM & LABOR         ROOM           53.00         05300         ANESTHESI OLOGY         State         State         State           54.00         05400         RADI OLOGY-DI AGNOSTI C         State	0.00					
52.00         05200         DELIVERY         ROOM & LABOR         ROOM           53.00         05300         ANESTHESI OLOGY         54.00         654.00         RADI OLOGY-DI AGNOSTI C         50.00         66000         LABORATORY         50.01         66001         BLOOD LABORATORY         53.00         66300         BLOOD STORING, PROCESSI NG & TRANS.         50.01         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00	523, 222	0				50.00
33.00         05300         ANESTHESI OLOGY           64.00         05400         RADI OLOGY-DI AGNOSTI C           50.00         06000         LABORATORY           50.01         06001         BLOOD LABORATORY           53.00         06300         BLOOD STORING, PROCESSI NG & TRANS.	1, 792	0	1			52.00
54.00         05400         RADI OLOGY-DI AGNOSTI C           50.00         06000         LABORATORY           50.01         06001         BLOOD           53.00         06300         BLOOD           50.01         06300         BLOOD	9, 754	o	1			53.00
00.00         06000         LABORATORY           00.01         06001         BLOOD         LABORATORY           03.00         06300         BLOOD         STORI NG, PROCESSI NG & TRANS.	783, 187	0	1			54.00
00. 01 06001 BLOOD LABORATORY 03. 00 06300 BLOOD STORING, PROCESSING & TRANS.	757,036	o	1			60.00
3.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	1			60.01
	30, 881	0	1			63.00
5. 00 06500 RESPIRATORY THERAPY	59, 405	0	1			65.00
66.00 06600 PHYSI CAL THERAPY	451, 468	0	1			66.00
57. 00 06700 OCCUPATI ONAL THERAPY	23, 849	0	1			67.00
58. 00 06800 SPEECH PATHOLOGY	5, 549	o	1			68.00
9. 00 06900 ELECTROCARDI OLOGY	14, 388	0	1			69.00
9. 01 06901 CARDI AC REHABI LI TATI ON	80, 535	0	1			69.01
0.00 07000 ELECTROENCEPHALOGRAPHY	0	0	1			70.00
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	148, 011	0	1			71.00
2.00 07200 I MPL. DEV. CHARGED TO PATIENTS	55, 982	0	1			72.00
3.00 07300 DRUGS CHARGED TO PATIENTS	626, 116	20	1			73.00
76.00 03020 ONCOLOGY	133, 321	o				76.00
OUTPATIENT SERVICE COST CENTERS						1
38.00 08800 RURAL HEALTH CLINIC	0	0				88.00
00.00 09000 CLINIC	425, 220	0				90.00
01.00 09100 EMERGENCY	989, 595	0				91.00
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	189, 338	0				92.00
200.00 Subtotal (see instructions)	5, 308, 649	20				200.00
201.00 Less PBP Clinic Lab. Services-Program	0		4			
Only Charges		I	1			201.00
202.00 Net Charges (line 200 - line 201)						201.00

Health Financial Systems		PULASKI MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEA	LTH SERVICES AND	VACCINE COST	Provi der C		Peri od:	Worksheet D	
					From 10/01/2016		
			Component	CCN: 15-Z305	To 09/30/2017	Date/Time Pre 2/27/2018 12:	pared: 01 pm
			Title	Title XVIII S			
				Charges	Swing Beds - SNF	Costs	
Cost Center Description		Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
		From	Services (see		Services Not		
		Worksheet C.	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins.			
		9		(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTER	S					•	
50.00 05000 OPERATI NG ROOM		0. 284552	0		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR R	OOM	0. 423106	0		0 0	0	52.00
53.00 05300 ANESTHESI OLOGY		0. 032506	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 197277	0		0 0	0	54.00
60. 00 06000 LABORATORY		0. 177099	0		0 0	0	60.00
60.01 06001 BLOOD LABORATORY		0. 000000	0		0 0	0	60.01
63.00 06300 BLOOD STORING, PROCESSI	NG & TRANS.	0. 350526	0		0 0	0	63.00
65.00 06500 RESPI RATORY THERAPY		0. 457007	0		0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY		0. 502435	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 560896	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY		0. 908695	0		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY		0. 079779	0		0 0	0	69.00
69.01 06901 CARDIAC REHABILITATION		0. 859747	0		0 0	0	69.01
70.00 07000 ELECTROENCEPHALOGRAPHY		0. 000000	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGE	D TO PATIENTS	0. 267502	0		0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO P	ATI ENTS	0. 720725	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIEN	TS	0. 261447	0		0 0	0	73.00
76.00 03020 ONCOLOGY		1. 093623	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTE	RS						
88.00 08800 RURAL HEALTH CLINIC		0. 000000				0	88.00
90. 00 09000 CLINIC		0. 558469	0		0 0	0	90.00
91.00 09100 EMERGENCY		0. 772129	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-D		1. 964313	0		0 0	0	1 2.00
200.00 Subtotal (see instructi	ons)		0		0 0	0	200.00
201.00 Less PBP Clinic Lab. Se	rvices-Program				0 0		201.00
Only Charges							
202.00 Net Charges (line 200 -	line 201)		0		0 0	0	202.00

Health Financial Systems	PULASKI MEMORIA	AL HOSPI TAL		In Lieu	u of Form CMS-255	52-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-1305	Peri od:	Worksheet D	
		Comment	CON 15 7005	From 10/01/2016	Part V	
		component	CCN: 15-Z305	To 09/30/2017	Date/Time Prepa 2/27/2018 12:01	
		Title	× XVIII	Swing Beds - SNF		
	Cost			10		
Cost Center Description	Cost	Cost	1			
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
		(see inst.)	-			
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS			1			
50. 00 05000 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
60. 00 06000 LABORATORY	0	0				60.00
60. 01 06001 BLOOD LABORATORY	0	0				60.01
63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0	0				63.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	0				65.00 66.00
	0	0				
67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	0	0				67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
69. 01 069001 CARDI AC REHABI LI TATI ON	0	0				69.00 69.01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72. 00 107200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
76. 00 03020 ONCOLOGY	0	0				76.00
OUTPATIENT SERVICE COST CENTERS		0	1		· · · · · · · · · · · · · · · · · · ·	0.00
88. 00 08800 RURAL HEALTH CLINIC	0	0			8	88.00
90. 00 09000 CLINIC	0	0			-	90.00
91. 00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	0	0				00.00
201.00 Less PBP Clinic Lab. Services-Program	0	0				01.00
Only Charges					20	
202.00 Net Charges (line 200 - line 201)	0	0			20	02.00

	h Financial Systems PULASKI MEMORIAL HOSPITAL TATION OF INPATIENT OPERATING COST Provider CCN: 15-1305 Period:	In Lieu of Form		2552-1
		/01/2016 /30/2017 Date/Tin 2/27/201		
	Cost Center Description		Cost	
	· · · · · · · · · · · · · · · · · · ·	1.00	)	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3, 524	1.0
2.00 3.00	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private ro		2, 414 0	2.0 3.0
	do not complete this line.		1 00/	
4.00 5.00	Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) through December 31 of		1, 986 295	4.0 5.0
6.00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of t	ne cost	623	6.0
	reporting period (if calendar year, enter 0 on this line)			
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of reporting period	the cost	8	7.C
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of th	e cost	184	8.C
9.00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-	bed and	1, 065	9.0
10.00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room day	-)	0	10. 0
10.00	through December 31 of the cost reporting period (see instructions)	5)	0	10.0
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room day December 31 of the cost reporting period (if calendar year, enter 0 on this line)	s) after	910	11.0
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room	days)	0	12.0
13.00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room	days)	0	13. C
14.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Medically necessary private room days applicable to the Program (excluding swing-bed days)		o	14. C
	Total nursery days (title V or XIX only)		0	14. C
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT		0	16. C
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the c	ost		17. C
18.00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cos	t		18. C
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the co	st   1	37. 30	19. C
20 00	reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	1	55. 02	20. C
	reporting period			
	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting per		7, 400 0	21.0 22.0
	5 x line 17)		0	
22 00	ISWING-DED COST ADDITCADLE TO SNE TYDE SELVICES ATTEL DECEMPER 31 OF THE COST LEDOFTING DEFIO			22 C
23.00	x line 18)	d (line 6	0	23.0
	x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting peri-		0 1, 098	
23.00 24.00 25.00	x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting perior 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period	od (line		23.0 24.0 25.0
24. 00 25. 00	<pre>x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period x line 20)</pre>	od (line (line 8 2	1, 098 8, 524	24.0 25.0
24.00 25.00 26.00	<pre>x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting periot 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)</pre>	od (line (line 8 2 1,29	1, 098	24. 0 25. 0 26. 0
24.00 25.00 26.00 27.00	<pre>x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</pre>	od (line (line 8 2 1,29	1, 098 8, 524 9, 115	24. 0 25. 0 26. 0 27. 0
24.00 25.00 26.00 27.00 28.00 29.00	<pre>x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges)</pre>	od (line (line 8 2 1,29	1, 098 8, 524 9, 115 <u>8, 285</u> 0 0	24. 0 25. 0 26. 0 27. 0 28. 0 29. 0
<ol> <li>24.00</li> <li>25.00</li> <li>26.00</li> <li>27.00</li> <li>28.00</li> <li>29.00</li> <li>30.00</li> </ol>	<pre>x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)</pre>	d (line (line 8 2 1,29 3,33	1, 098 8, 524 9, 115 <u>8, 285</u> 0 0 0	24. 0 25. 0 26. 0 27. 0 28. 0 29. 0 30. 0
4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00	<pre>x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting periot 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 + line 28)</pre>	d (line (line 8 2 1,29 3,33	1, 098 8, 524 9, 115 8, 285 0 0 0 0 00000	24. ( 25. ( 26. ( 27. ( 28. ( 29. ( 30. ( 31. (
4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00	<pre>x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3)</pre>	d (line (line 8 2 1,29 3,33	1, 098 8, 524 9, 115 8, 285 0 0 0 00000 0.00	24. ( 25. ( 26. ( 27. ( 28. ( 29. ( 30. ( 31. ( 32. (
<ul> <li>4. 00</li> <li>5. 00</li> <li>6. 00</li> <li>7. 00</li> <li>8. 00</li> <li>9. 00</li> <li>00 00</li> <li>1. 00</li> <li>2. 00</li> <li>3. 00</li> </ul>	<pre>x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 + line 28) Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4)</pre>	d (line (line 8 2 1,29 3,33	1, 098 8, 524 9, 115 8, 285 0 0 0 0 00000	24. ( 25. ( 26. ( 27. ( 28. ( 29. ( 30. ( 31. ( 32. ( 33. (
24.00         25.00         26.00         27.00         28.00         29.00         30.00         31.00         32.00         33.00         34.00	<pre>x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 + line 28) Average private room per diem charge (line 29 + line 3) Average per diem private room per diem charge differential (line 32 minus line 33)(see instructions)</pre>	d (line (line 8 2 1,29 3,33	1, 098 8, 524 9, 115 8, 285 0 0 00000 0, 00 0, 00 0, 00	24. ( 25. ( 26. ( 27. ( 28. ( 29. ( 30. ( 31. ( 32. ( 33. ( 34. (
24.00         25.00         26.00         27.00         28.00         29.00         30.00         31.00         32.00         33.00         34.00         35.00	<pre>x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 + line 28) Average private room per diem charge (line 30 + line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35)</pre>	0d (line (line 8 2 1, 29 3, 33	1, 098 8, 524 9, 115 8, 285 0 0 00000 0, 00 0, 00 0, 00 0, 00	24. ( 25. ( 26. ( 27. ( 28. ( 29. ( 30. ( 31. ( 32. ( 33. ( 33. ( 35. (
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	<pre>x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 + line 28) Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 34 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 35)</pre>	od (line (line 8 2 1, 29 3, 33	1, 098 8, 524 9, 115 8, 285 0 0 0 00000 0, 00 0, 00 0, 00 0, 00 0, 00 0, 00	24. ( 25. ( 26. ( 27. ( 28. ( 29. ( 30. ( 31. ( 32. ( 33. ( 34. ( 35. ( 36. (
24.00 25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00	<pre>x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 + line 28) Average private room per diem charge (line 29 + line 3) Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost different AT adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost different AT adjustment (line 3 x line 35) PART 11 - HOSPITAL AND SUBPROVIDERS ONLY</pre>	od (line (line 8 2 1, 29 3, 33	1, 098 8, 524 9, 115 8, 285 0 0 00000 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	24. ( 25. ( 26. ( 27. ( 28. ( 29. ( 30. ( 31. ( 32. ( 33. ( 34. ( 35. ( 36. (
24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 31. 00 33. 00 34. 00 35. 00 36. 00 37. 00	<pre>x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 + line 28) Average private room per diem charge (line 29 + line 3) Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost different 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</pre>	od (line (line 8 2 1, 29 3, 33 0. 0	1, 098 8, 524 9, 115 8, 285 0 0 0 00000 0, 00 0, 00000000	24. ( 25. ( 26. ( 27. ( 28. ( 29. ( 30. ( 31. ( 33. ( 33. ( 35. ( 37. (
24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00	x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average per diem private room cost differential (line 30 ÷ line 4) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential 27 minus line 36) PART 11 - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions)	d (line (line 8 2 1, 29 3, 33 0. 0	1, 098 8, 524 9, 115 8, 285 0 0 0 00000 0, 00 0, 00000000	24. ( 25. ( 26. ( 27. ( 29. ( 30. ( 31. ( 33. ( 33. ( 35. ( 37. ( 37. ( 38. ( 38. (
24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 31. 00 33. 00 34. 00 35. 00 36. 00 37. 00	x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 + line 28) Average private room per diem charge (line 29 + line 3) Average per diem private room charge differential (line 32 minus line 33) (see instructions) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost different 27 minus line 36) PART 11 - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost (line 9 x line 38)	d (line (line 8 2 1, 29 3, 33 0. 0	1, 098 8, 524 9, 115 8, 285 0 0 0 00000 0, 00 0, 00000000	24. ( 25. ( 26. ( 27. ( 29. ( 30. ( 31. ( 33. ( 33. ( 35. ( 37. ( 37. ( 38. ( 38. (

MPUTATION OF INPATIENT OPERAT			Provider (	CN: 15-1305	Peri od:	Worksheet D-1	1
					From 10/01/2016 To 09/30/2017	Date/Time Pre	anaro
						2/27/2018 12:	
Cost Center Descrip	ation	Total	Ti tl Total	e XVIII Average Per	Hospital Program Days	Cost Program Cost	
cost center beschi		Inpatient	Inpatient	Diem (col.		(col. 3 x	
		Cost	Days	÷ col. 2)		col. 4)	
		1.00	2.00	3.00	4.00	5.00 0	42.
.00 NURSERY (title V & XIX o Intensive Care Type Inpa				0.0	0	0	42.
. 00 INTENSIVE CARE UNIT		0	(	0. (	0 00	0	43.
. OO CORONARY CARE UNI T							44.
. 00 BURN INTENSIVE CARE UNIT							45.
. 00 SURGICAL INTENSIVE CARE . 00 OTHER SPECIAL CARE (SPEC							46. 47.
Cost Center Descrip							
00 0		(WI				1.00	10
.00 Program inpatient ancill .00 Total Program inpatient				005)		1, 075, 416 2, 548, 194	
PASS THROUGH COST ADJUST			see mistracti	013)		2, 340, 174	47.
.00 Pass through costs appli		inpatient routine	services (fro	om Wkst. D, su	m of Parts I and	0	50.
							5
.00 Pass through costs appli and IV)	cable to Program	inpatient ancillar	y services (1	rom Wkst. D,	sum of Parts II	0	51.
. 00 Total Program excludable	cost (sum of li	nes 50 and 51)				0	52.
.00 Total Program inpatient			lated, non-ph	nysician anest	hetist, and	0	53.
medical education costs		ine 52)					-
. 00 Program di scharges	COMPUTATION					0	54.
. 00 Target amount per discha	irge					0.00	
.00 Target amount (line 54 x						0	
7.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							57.
i8.00 Bonus payment (see instructions) i9.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by th							) 58. ) 59.
market basket		t reporting period	churng 1990,	apaarea ana e	inpounded by the	0.00	
.00 Lesser of lines 53/54 or						0.00	
.00 If line 53/54 is less th which operating costs (I						0	61.
amount (line 56), otherw			S (THES 54 )	( 00), 01 1% U	n the target		
.00 Relief payment (see inst	ructions)					0	
. 00 Allowable Inpatient cost		payment (see instru	ctions)			0	63.
. 00 Medicare swing-bed SNF i		costs through Dece	mber 31 of th	e cost report	ing period (See	0	64.
instructions) (title XVII		costs through beec			ing period (see	Ū	
.00 Medicare swing-bed SNF i		costs after Decemb	er 31 of the	cost reportin	g period (See	1, 258, 430	65.
.00 Total Medicare swing-bed		outine costs (line	64 nlus line	65) (ti tha XV/I	LL only) For	1, 258, 430	66
CAH (see instructions)		outifie costs (iffie	o4 prus rine	05)(11118 XVI	TT OHLY). TO	1, 200, 400	00.
.00 Title V or XIX swing-bed	INF inpatient ro	utine costs through	December 31	of the cost r	eporting period	0	67.
(line 12 x line 19)		uting and offer D		·		0	
.00 Title V or XIX swing-bed (line 13 x line 20)	i we impatrent ro	utine costs after D	ecember 31 01	the cost rep	orting period	0	68.
. 00 Total title V or XIX swi	ng-bed NF inpati	ent routine costs (	line 67 + lir	ne 68)		0	69.
PART III - SKILLED NURSI							
.00 Skilled nursing facility .00 Adjusted general inpatie					)		70.
. 00 Program routine service			ine /0 ÷ inie	; 2)			72.
.00 Medically necessary priv	•		(line 14 x l	ine 35)			73.
.00 Total Program general in	•	•					74.
.00 Capital-related cost all 26, line 45)	ocated to inpati	ent routine service	costs (from	Worksheet B,	Part II, column		75.
. 00 Per diem capital-related	costs (line 75	÷line 2)					76.
.00 Program capital -related	•	,					77.
.00 Inpatient routine servic		· ·					78.
.00 Aggregate charges to ben .00 Total Program routine se					nus line 70)		80.
. 00 Inpatient routine servic		•			143 IIIC /7)		80.
. 00 Inpatient routine service	•		)				82
.00 Reasonable inpatient rou		•	s)				83.
. 00 Program inpatient ancill			20)				84.
.00 Utilization review - phy .00 Total Program inpatient	•	•					85. 86.
PART IV - COMPUTATION OF							- 00.
						428	87.
.00 Total observation bed da .00 Adjusted general inpatie	5 .					1, 382. 89	

Health Financial Systems	PULASKI MEMORI	AL_HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	
				From 10/01/2016 To 09/30/2017		pared: 01 pm
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	353, 882	4,637,400	0. 07631	0 591, 877	45, 166	90.00
91.00 Nursing School cost	0	4,637,400	0.00000	0 591, 877	0	91.00
92.00 Allied health cost	0	4,637,400	0.00000	0 591, 877	0	92.00
93.00 All other Medical Education	0	4,637,400	0.00000	0 591, 877	0	93.00

	Financial Systems PULASKI MEMORIAL HOSP			of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST Prov	ider CCN: 15-1305	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Pre 2/27/2018 12:0	
		Title XIX	Hospi tal	Cost	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
1.00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days, ex	cluding newborn)		3, 524	1.00
2.00 3.00	Inpatient days (including private room days, excluding swing-bed a Private room days (excluding swing-bed and observation bed days).		rivate room days,	2, 414 0	2.00 3.00
4.00 5.00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed da Total swing-bed SNF type inpatient days (including private room da	<i>J</i> /	er 31 of the cost	1, 986 0	4.00 5.00
	reporting period			-	
6.00	Total swing-bed SNF type inpatient days (including private room da reporting period (if calendar year, enter 0 on this line)	<b>.</b> .		918	6.00
7.00	Total swing-bed NF type inpatient days (including private room day reporting period	s) through Decembe	r 31 of the cost	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room day reporting period (if calendar year, enter 0 on this line)	s) after December	31 of the cost	192	8.00
9.00	Total inpatient days including private room days applicable to the newborn days)	0 1		32	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only ( through December 31 of the cost reporting period (see instructions	)	5	0	10.00
	Swing-bed SNF type inpatient days applicable to title XVIII only ( December 31 of the cost reporting period (if calendar year, enter	0 on this line)	5	0	
	Swing-bed NF type inpatient days applicable to titles V or XIX onl through December 31 of the cost reporting period	5 . 5 .	5 1	0	12.00
	Swing-bed NF type inpatient days applicable to titles V or XIX onl after December 31 of the cost reporting period (if calendar year,	enter 0 on this li	ne)	0	13.00
	Medically necessary private room days applicable to the Program (e Total nursery days (title V or XIX only)	xcl udi ng swi ng-bed	days)	0 236	14.00 15.00
	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16.00
17.00	Medicare rate for swing-bed SNF services applicable to services th reporting period	rough December 31	of the cost		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services af reporting period	ter December 31 of	the cost		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services thr reporting period	ough December 31 o	f the cost	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services aft reporting period	er December 31 of	the cost	0.00	20. 00
	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31	of the cost repor	ting period (line	4, 637, 400 0	21.00 22.00
	S x line 17) Swing-bed cost applicable to SNF type services after December 31 o		51 (	0	23.00
	x line 18)				
24.00	Swing-bed cost applicable to NF type services through December 31 7 x line 19)		51 (	0	24.00
	Swing-bed cost applicable to NF type services after December 31 of x line 20)	tne cost reportin	g period (line 8	0	25.00
26.00 27.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line	21 minus line 26)		1, 277, 654 3, 359, 746	
28.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and	observation bed c	harges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
	Semi-private room charges (excluding swing-bed charges)	a 20)		0	30.00
	General inpatient routine service cost/charge ratio (line 27 ÷ lin Average private room per diem charge (line 29 ÷ line 3)	E 20)		0. 000000 0. 00	31.00 32.00
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 minus l	ine 33)(see instru	ctions)	0.00	
	Average per diem private room cost differential (line 34 x line 31			0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	niveto norre aral 1	fforonti-1 (1)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and p 27 minus line 36)	iivale room cost d	iiierentiai (line	3, 359, 746	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTME	NTS			
38.00	Adjusted general inpatient routine service cost per diem (see inst			1, 391. 78	38.00
	Program general inpatient routine service cost (line 9 x line 38)			44, 537	39.00
	Medically necessary private room cost applicable to the Program (I Total Program general inpatient routine service cost (line 39 + li			0 44, 537	40.00
4 I. UU	Trotar i rogram general inpatrent routine service cost (ITHE 39 + IT	116 40)	I	44, 537	41.00

OMPUT	Financial Systems	PULASKI MEMORI	Provi der C	CN: 15-1305	Period:	u of Form CMS- Worksheet D-1	
01111 01				. 10 1000	From 10/01/2016		
					To 09/30/2017	Date/Time Pre 2/27/2018 12:	
			Ti tl	e XIX	Hospi tal	Cost	<u>.</u>
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient	Inpatient	Diem (col. 1		(col. 3 x	
		<u>Cost</u> 1.00	Days 2.00	÷ col. 2) 3.00	4.00	<u>col. 4)</u> 5.00	-
2.00	NURSERY (title V & XIX only)	175,088	236			0	42.
	Intensive Care Type Inpatient Hospital Unit						
8.00	INTENSIVE CARE UNIT	0	0	0.0	0 0	0	
. 00	CORONARY CARE UNIT						44.
5.00 5.00							45.
	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description	-L - I		1			
						1.00	
. 00	Program inpatient ancillary service cost (W			222)		22, 631	
. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(	see instruction	505)		67, 168	49.
. 00	Pass through costs applicable to Program in	patient routine	services (fro	n Wkst. D, su	m of Parts I and	0	50.
. 00	Pass through costs applicable to Program in	patient ancillar	y services (f	rom Wkst. D,	sum of Parts II	0	51.
2. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52.
3.00	Total Program inpatient operating cost excl		lated non-ph	vsician anest	hetist and	0	
	medical education costs (line 49 minus line		i a coa, non pri	jor of all alloot	lotrot, and	c c	
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program di scharges					0	
. 00	Target amount per discharge Target amount (line 54 x line 55)					0. 00 0	
	5	ting cost and ta	raet amount (	line 56 minus	line 53)	0	
. 00							
. 00	Lesser of lines 53/54 or 55 from the cost r	eporting period	endi ng 1996, i	updated and c	ompounded by the	0.00	59
~ ~	market basket						
. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of lin					0. 00 0	
. 00	which operating costs (line 53) are less th					0	0
	amount (line 56), otherwise enter zero (see				the target		
						0	
. 00		ment (see instru	icti ons)			0	63.
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine co	sts through Dece	mber 31 of th	e cost report	ing period (See	0	64.
. 00	instructions)(title XVIII only)	sts through bood				0	
5.00	Medicare swing-bed SNF inpatient routine co	sts after Decemb	er 31 of the o	cost reportin	g period (See	0	65.
00	instructions)(title XVIII only)		(A. 1)				
o. 00	Total Medicare swing-bed SNF inpatient rout CAH (see instructions)	ine costs (line	64 plus line (	55)(title XVI	II ONLY). FOr	0	66.
. 00	, , ,	ne costs through	December 31	of the cost r	eporting period	0	67.
	(line 12 x line 19)					-	
8.00	Title V or XIX swing-bed NF inpatient routi	ne costs after D	ecember 31 of	the cost rep	orting period	0	68.
00	(line 13 x line 20)	routino costo (	line (7 . lin	- (Q)		0	
. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER					0	69.
. 00	Skilled nursing facility/other nursing faci				)		70.
. 00	Adjusted general inpatient routine service	cost per diem (l					71.
. 00	Program routine service cost (line 9 x line		/// · · · · · · · ·				72
. 00 . 00	Medically necessary private room cost appli Total Program general inpatient routine ser						73
. 00	Capital -related cost allocated to inpatient				Part II column		75
	26, line 45)				,		
. 00	Per diem capital-related costs (line 75 ÷ l						76
. 00	Program capital -related costs (line 9 x lin						77
00 00	Inpatient routine service cost (line 74 min Aggregate charges to beneficiaries for exce	,	rovider recor	ds)			78
00	Total Program routine service costs for com	• •			nus line 79)		80
00	Inpatient routine service cost per diem lim	•					81
00	Inpatient routine service cost limitation (						82
. 00	Reasonable inpatient routine service costs	•	s)				83
. 00 . 00	Program inpatient ancillary services (see i		ne)				84
	Utilization review - physician compensation Total Program inpatient operating costs (su						85
	PART IV - COMPUTATION OF OBSERVATION BED PA						1 55
. 00	Total observation bed days (see instruction	s)				428	
· • •	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 391. 78	88.
. 00	Observation bed cost (line 87 x line 88) (s	and the state of t				595, 682	1 00

Health Financial Systems	PULASKI MEMORI	AL_HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
				From 10/01/2016 To 09/30/2017	Date/Time Pre 2/27/2018 12:	pared: 01 pm
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	353, 882	4,637,400	0. 07631	0 595, 682	45, 456	90.00
91.00 Nursing School cost	0	4,637,400	0.00000	0 595, 682	0	91.00
92.00 Allied health cost	0	4,637,400	0.00000	0 595, 682	0	92.00
93.00 All other Medical Education	0	4,637,400	0. 00000	0 595, 682	0	93.00

Health Financial Systems PULASKI	MEMORIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1305	Period:	Worksheet D-3	3
			From 10/01/2016 To 09/30/2017	Date/Time Pre	-nared
			10 077 307 2017	2/27/2018 12:	
	Title	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1			
30. 00 03000 ADULTS & PEDIATRICS			907, 501		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVICE COST CENTERS		0.0045		75 (07	
50. 00 05000 OPERATING ROOM		0. 28455			
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 42310			
53. 00 05300 ANESTHESI OLOGY		0. 03250			
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY		0. 1972			
60. 00  06000  LABORATORY 60. 01  06001  BLOOD_LABORATORY		0. 00000		110, 343 0	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 35052		17, 098	
65. 00 06500 RESPIRATORY THERAPY		0. 35052			
66. 00 06600 PHYSI CAL THERAPY		0. 50243			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 56089			
68. 00 06800 SPEECH PATHOLOGY		0. 90869			•
69. 00 06900 ELECTROCARDI OLOGY		0. 0797			
69. 01 06901 CARDI AC REHABI LI TATI ON		0.85974		0	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	•
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 26750		-	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 72072			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 2614			
76.00 03020 ONCOLOGY		1.09362			
OUTPATIENT SERVICE COST CENTERS				`	
88.00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88.00
90. 00 09000 CLINIC		0. 55840		0	
91.00 09100 EMERGENCY		0. 77212	29 16, 198	12, 507	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 9643		0	
200.00 Total (sum of lines 50 through 94 and 96 through			3, 807, 319	1, 075, 416	200.00
201.00 Less PBP Clinic Laboratory Services-Program on	y charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			3, 807, 319		202.00

Health Financial Systems PULASKI MEMORIAL	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1305	Peri od:	Worksheet D-3	3
	Component	CCN: 15-Z305	From 10/01/2016 To 09/30/2017		parad
	component	CCN: 15-2305	To 09/30/2017	2/27/2018 12:	
	Title	XVIII	Swing Beds - SNI		<u> </u>
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges		Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1			
30. 00 03000 ADULTS & PEDIATRICS			C		30.00
31.00 03100 I NTENSI VE CARE UNI T			C		31.00
43.00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS		0.0015		1 107	
50. 00 05000 OPERATING ROOM		0. 2845			
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 4231			
53. 00 05300 ANESTHESI OLOGY		0.0325		0 0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1972			
60. 00 06000 LABORATORY		0. 1770			
60. 01 06001 BLOOD LABORATORY 63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 0000 0. 3505		-	
63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 65. 00 06500 RESPI RATORY THERAPY		0. 3505			
66. 00 06600 PHYSI CAL THERAPY		0.4370			
67. 00 06700 OCCUPATI ONAL THERAPY		0.5608			
68. 00 06800 SPEECH PATHOLOGY		0. 9086			
69. 00 06900 ELECTROCARDI OLOGY		0. 0797			
69. 01 06901 CARDI AC REHABI LI TATI ON		0.8597			
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000		-	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2675		-	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 7207			
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 2614			
76. 00 03020 ONCOLOGY		1.0936			
OUTPATIENT SERVICE COST CENTERS				. · · ·	
88.00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88.00
90. 00 09000 CLINIC		0. 5584		0	90.00
91.00 09100 EMERGENCY		0. 7721		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1.9643		0	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			965, 819	381, 336	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		C		201.00
202.00 Net charges (line 200 minus line 201)			965, 819		202.00

Health Financial Systems PULASKI MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1305	Period:	Worksheet D-3	3
			From 10/01/2016 To 09/30/2017		parod
			10 09/30/2017	2/27/2018 12:	
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1			
30. 00 03000 ADULTS & PEDI ATRI CS			10, 805		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
43.00 04300 NURSERY			5, 822		43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM		0. 2845	52 8, 690	2, 473	50,00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 2845			
53. 00 05300 ANESTHESI OLOGY		0. 03250			
54. 00  05400 RADI OLOGY-DI AGNOSTI C		0. 1972			
60. 00 06000 LABORATORY		0. 1770			
60. 01 06001 BLOOD LABORATORY		0. 00000			1
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 3505			1
65. 00 06500 RESPI RATORY THERAPY		0. 4570			
66. 00 06600 PHYSI CAL THERAPY		0. 5024			
67.00 06700 OCCUPATI ONAL THERAPY		0. 5608			
68.00 06800 SPEECH PATHOLOGY		0. 9086	95 755	686	68.00
69. 00 06900 ELECTROCARDI OLOGY		0.0797	79 177	14	69.00
69. 01 06901 CARDI AC REHABI LI TATI ON		0. 8597	47 0	0	69.01
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000	0 00	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 26750	7, 894	2, 112	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 7207:	25 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2614		5, 677	
76. 00 03020 ONCOLOGY		1. 09362	23 0	0	76.00
OUTPATI ENT SERVI CE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		1. 49472		-	
90. 00 09000 CLINIC		0. 5584		0	
91.00 09100 EMERGENCY		0. 77212			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 9643		0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)			80, 125	22, 631	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		0 105		201.00
202.00 Net charges (line 200 minus line 201)		I	80, 125	I	202.00

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider C	CN: 15-1305	Peri od:	Worksheet D-3	3
			001 45 7005	From 10/01/2016		
		Component	CCN: 15-Z305	To 09/30/2017	Date/Time Pre 2/27/2018 12:	
		Ti +1	e XIX	Swing Beds - SNI		<u>or pili</u>
Cost Center Description		1 11 11	Ratio of Cos		Inpatient	
cost center bescription			To Charges		Program Costs	
			10 ondriges	Charges	(col. 1 x	
				ondriges	col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS				C	)	30.00
31.00 03100 INTENSIVE CARE UNIT				C		31.00
43.00 04300 NURSERY				C		43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM			0. 2845	52 C	0 0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM			0. 4231	06 C	0	52.00
53.00 05300 ANESTHESI OLOGY			0. 0325	06 C	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C			0. 1972	77 C	0	54.00
60.00 06000 LABORATORY			0. 1770	99 C	0	60.00
60.01 06001 BLOOD LABORATORY			0.0000	00 C	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.			0. 3505	26 C	0	63.00
65. 00 06500 RESPI RATORY THERAPY			0. 4570	07 C	0	65.00
66. 00 06600 PHYSI CAL THERAPY			0. 5024	35 C	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY			0. 5608	96 C	0	67.00
68.00 06800 SPEECH PATHOLOGY			0. 9086	95 C	0	68.00
69. 00 06900 ELECTROCARDI OLOGY			0. 0797	79 C	0	69.00
69. 01 06901 CARDI AC REHABI LI TATI ON			0.8597		0	
70.00 07000 ELECTROENCEPHALOGRAPHY			0.0000		0	1 1 0 1 0 0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0. 2675	02 C	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS			0. 7207		0	
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 2614			
76.00 03020 ONCOLOGY			1. 0936	23 C	0	76.00
OUTPATIENT SERVICE COST CENTERS					1	
88.00 08800 RURAL HEALTH CLINIC			1. 4947			
90. 00 09000 CLINIC			0. 5584			
91.00 09100 EMERGENCY			0. 7721		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			1. 9643	13 C	0	
200.00 Total (sum of lines 50 through 94 and				C	0	200.00
201.00 Less PBP Clinic Laboratory Services-P	rogram only charges	s (line 61)		C		201.00
202.00 Net charges (line 200 minus line 201)				C		202.00

	Financial Systems PULASKI MEMORIAL I ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1305	Peri od:	u of Form CMS-2 Worksheet E	≤00Z-T
			From 10/01/2016 To 09/30/2017	Part B	nared·
				2/27/2018 12:	
		Title XVIII	Hospi tal	Cost	
				1.00	
1.00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			5, 308, 669	1.00
2.00	Medical and other services (see Histiderions) Medical and other services reimbursed under OPPS (see instruct	i ons)		0	2.00
3.00	OPPS payments			0	3.00
4.00 4.01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			0	4.0
5.00	Enter the hospital specific payment to cost ratio (see instruc	tions)		0.000	5.0
6.00	Line 2 times line 5			0	6.0
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.0
8.00 9.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. I	V. col. 13. line 200		0	8.0 9.0
10.00	Organ acqui si ti ons	1, 3011 10, 1110 200		0	10.0
11.00	Total cost (sum of lines 1 and 10) (see instructions)			5, 308, 669	11.0
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
12.00	Ancillary service charges			0	12.0
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, li	ne 69)		0	13.0
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14.0
15.00	Customary charges Aggregate amount actually collected from patients liable for p	avment for services on	a charge basis	0	15.0
16.00	Amounts that would have been realized from patients liable for	5	0	0	16.0
	had such payment been made in accordance with 42 CFR §413.13(e	)	-		
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 0	17.0 18.0
19.00	Excess of customary charges over reasonable cost (complete onl	vifline 18 exceeds l	ine 11) (see	0	19.0
	instructions)	-			
20.00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds l	ine 18) (see	0	20.0
21.00	instructions) Lesser of cost or charges (line 11 minus line 20) (see instruc	tions)		5, 361, 756	21.0
	Interns and residents (see instructions)			0	22.0
	Cost of physicians' services in a teaching hospital (see instr	uctions)		0	23.0
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24.0
25.00	Deductibles and coinsurance (for CAH, see instructions)			65, 763	25.0
26.00	Deductibles and Coinsurance relating to amount on line 24 (for			2, 594, 076	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p instructions)	lus the sum of lines 2	2 and 23] (see	2, 701, 917	27.0
28.00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	28.0
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	,		0	29.0
	Subtotal (sum of lines 27 through 29)			2, 701, 917	
31.00 32.00	Primary payer payments Subtotal (line 30 minus line 31)			2, 432 2, 699, 485	
02100	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	ES)		210771100	02.0
	Composite rate ESRD (from Wkst. I-5, line 11)				33.0
34.00 35.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			572, 744 372, 284	34.0 35.0
	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		547,869	
	Subtotal (see instructions)	,		3, 071, 769	
	MSP-LCC reconciliation amount from PS&R			0	38.0
39.00 39.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	<b>\</b>		0	39.0
39.30 39.97	Pioneer ACO demonstration payment adjustment (see instructions Demonstration payment adjustment amount before sequestration	)		0	39.5 39.9
39.98	Partial or full credits received from manufacturers for replac	ed devices (see instru	ctions)	0	39.9
	RECOVERY OF ACCELERATED DEPRECIATION			0	39.9
	Subtotal (see instructions)			3,071,769	40.0
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			61, 435 0	40.0 40.0
	Interim payments			2, 767, 747	41.0
42.00	Tentative settlement (for contractors use only)			0	42.0
43.00 44.00	Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordan	Cewith CMS Dub 15 2	chanter 1	242, 587 0	43.0 44.0
	§115. 2	ce wrth GWB FUD. 19-2,		0	+4.0
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0	91.0 92.0
92.00 93.00	Time Value of Money (see instructions)			0.00	
	Total (sum of lines 91 and 93)			0	94.0

ANALY	n Financial Systems PULASKI MEMORI SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	AL HOSPITAL Provider Co	CN: 15-1305	In Lie Period: From 10/01/2016 To 09/30/2017		pared:
		Title	XVIII	Hospi tal	2/2//2018 12: Cost	UT pili
			t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00 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, 192, 9	13 0	2, 767, 747 0	1.00 2.00 3.00
	payment. If none, write "NONE" or enter a zero. (1)					
0 01	Program to Provider	05 (00 (0017	24.44			
3. 01 3. 02 3. 03 3. 04 3. 05	ADJUSTMENTS TO PROVIDER	05/22/2017	31, 40	0 0 0 0	0 0 0 0	3.01 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 3.50-3.98)		31, 40		0 0 0 0 0	3.50 3.51 3.52 3.53 3.54 3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2, 224, 31	13	2, 767, 747	4.0
	TO BE COMPLETED BY CONTRACTOR		[	- 1		
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) Program to Provider					5.00
5.01	TENTATI VE TO PROVI DER			0	0	5.01
5.02 5.03				0	0	5.02
	Provider to Program			1		
5.50 5.51 5.52 5.99	TENTATIVE TO PROGRAM Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0 0 0 0	0 0 0	5.50 5.51 5.52 5.99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6. 01 6. 02 7. 00	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		13, 22 2, 237, 53	0	242, 587 0 3, 010, 334	6.0 ² 6.02 7.00
			•	Contractor Number	NPR Date (Mo/Day/Yr)	
	Name of Contractor	(	)	1.00	2.00	8.00

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	Title		mm/dd/yyyy 3.00	2/27/2018 12:	eparec 01 pr
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 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate	Inpatier	t Part A Amount 2.00 1,534,546	Par mm/dd/yyyy 3.00	Cost T B Amount 4.00	
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 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate	mm/dd/yyyy	Amount 2.00 1,534,546	mm/dd/yyyy 3.00	Amount 4.00	
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 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate		2.00 1,534,546	3.00	4.00	
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 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate		2.00 1,534,546	3.00	4.00	
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 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate				0	
00           	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate		0	1		) 1.(
00             	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			1	0	2.
00   ; ; F	write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					
00     -     	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					
; - F	amount based on subsequent revision of the interim rate					3.
· J						3.
F	for the cost reporting period. Also show date of each					
F	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		1		1	
D1 /	ADJUSTMENTS TO PROVIDER		0	,	0	) 3
02			0	1	0	-
03			0	1	0	) 3
04			0		0	-
D5 🗋			0	1	0	) 3
	Provider to Program					4
	ADJUSTMENTS TO PROGRAM		0		0	
51			0		0	-
52			0		0	-
53 54					0	-
	Subtotal (sum of lines 3.01-3.49 minus sum of lines					-
	3. 50-3. 98)		0		0	
	Total interim payments (sum of lines 1, 2, and 3.99)		1, 534, 546		0	4
	(transfer to Wkst. E or Wkst. E-3, line and column as		.,		-	
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
	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 TENTATIVE TO PROVIDER				0	
01 ¹ 02 1	TENTATIVE TO PROVIDER		0		0	
03			0		0	
	Provider to Program				<u> </u>	-
	TENTATI VE TO PROGRAM		0	)	0	5
51			0	J	0	5
52			0	1	0	-
	Subtotal (sum of lines 5.01–5.49 minus sum of lines		0	j.	0	) 5
	5. 50-5. 98)					
	Determined net settlement amount (balance due) based on					6
	the cost report. (1)		70.005			
	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		73, 235	1	0	
	Total Medicare program liability (see instructions)		1, 607, 781			
00			1,007,701	Contractor	NPR Date	$+^{\prime}$
				Number	(Mo/Day/Yr)	
			о С	1.00	2.00	1

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT       Provider CCN: 15-1305       Period: From 10/01/2016 To 09/30/2017       Worksheet E-1 Part II Do 9/30/2017         Title XVIII       Hospital       Cost         1.00         To be completed by contractor for nonstandard cost reports HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION         1.00       Total hospital discharges as defined in AARA \$4102 from Wkst. S-3, Pt. I col. 15 line 14       1.00         2.00       Medicare days from Wkst. S-3, Pt. I, col. 6 line 2       3.00         3.00       Medicare HMO days from Wkst. S-3, Pt. I, col. 6 line 2       4.00         5.00       Total hospital charges from Wkst. C, Pt. I, col. 8 line 200       5.00         6.00       Total hospital charges from Wkst. C, Pt. I, col. 3 line 20       6.00         7.00       CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168       7.00         8.00       Calculation of the HIT incentive payment (see instructions)       9.00         9.00       Sequestration adjustment amount (see instructions)       9.00         9.00       Initia /interim HIT payment adjustment (see instructions)       9.00         9.00       Initia /interim HIT payment adjustment (see instructions)       30.00         9.00       Balance due provider (line 8 (or line 10) minus line 30 and line 31) (se	Heal th	Financial Systems PULASKI MEMOR	TAL HOSPITAL	In Lie	u of Form CMS	-2552-10
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS         HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION         1.00         Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14         2.00         Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12         3.00         Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2         4.00         Total inpatient days from Wkst C, Pt. I, col. 8 line 200         5.00         Total hospital charges from Wkst C, Pt. I, col. 3 line 20         6.00         7.00         CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I         Ine 168         8.00         Calculation of the HIT incentive payment (see instructions)         9.00         Calculation of the HIT incentive payment after sequestration (see instructions)         9.00         INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH         30.00         31.00	CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-1305	From 10/01/2016	Part II Date/Time Pr	epared:
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION1.00Total hospital discharges as defined in AARA \$4102 from Wkst. S-3, Pt. I col. 15 line 141.002.00Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-122.003.00Medicare HMO days from S-3, Pt. I, col. 6. Line 23.004.00Total inpatient days from S-3, Pt. I, col. 8 sum of lines 1, 8-124.005.00Total hospital charges from Wkst C, Pt. I, col. 8 line 2005.006.00Total hospital charity care charges from Wkst. S-10, col. 3 line 205.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I7.008.00Calculation of the HIT incentive payment (see instructions)8.009.00Sequestration adjustment amount (see instructions)9.0010.00IniPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH10.0030.0031.00Other Adjustment (specify)30.00			Title XVIII	Hospi tal	Cost	
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION1.00Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 141.002.00Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-122.003.00Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 23.004.00Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-123.005.00Total hospital charges from Wkst C, Pt. I, col. 8 line 2004.006.00Total hospital charges from Wkst S, S-10, col. 3 line 2006.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I7.001 line 1688.00Calculation of the HIT incentive payment (see instructions)9.009.00Sequestration adj ustment amount (see instructions)9.0010.00INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH30.0031.00Other Adj ustment (specify)31.00					1.00	
1.00Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 141.002.00Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-122.003.00Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 23.004.00Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-124.005.00Total hospital charges from Wkst C, Pt. I, col. 8 line 2005.006.00Total hospital charity care charges from Wkst. S-10, col. 3 line 205.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I7.008.00Calculation of the HIT incentive payment (see instructions)8.009.00Sequestration adjustment amount (see instructions)9.0010.00Calculation of the HIT incentive payment after sequestration (see instructions)9.0010.00Initial/interim HIT payment adjustment (see instructions)10.0031.00Other Adjustment (specify)30.00		TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS	i			
2.00Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-122.003.00Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 23.004.00Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-124.005.00Total hospital charges from Wkst C, Pt. I, col. 8 line 2005.006.00Total hospital charity care charges from Wkst. S-10, col. 3 line 205.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I7.008.00Calculation of the HIT incentive payment (see instructions)8.009.00Sequestration adjustment amount (see instructions)9.0010.00InPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH30.0031.00Other Adjustment (specify)31.00		HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULAT	T ON			
3.00Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 23.004.00Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-124.005.00Total hospital charges from Wkst C, Pt. I, col. 8 line 2005.006.00Total hospital charity care charges from Wkst. S-10, col. 3 line 205.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I6.008.00Calculation of the HIT incentive payment (see instructions)8.009.00Sequestration adjustment amount (see instructions)9.0010.00INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH10.0031.00Other Adjustment (specify)30.00	1.00	Total hospital discharges as defined in AARA §4102 from Wk	st. S-3, Pt. I col. 15 lin	ne 14		1.00
4.00Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-124.005.00Total hospital charges from Wkst C, Pt. I, col. 8 line 2005.006.00Total hospital charity care charges from Wkst. S-10, col. 3 line 206.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I7.001 ine 1688.00Cal culation of the HIT incentive payment (see instructions)8.009.00Sequestration adjustment amount (see instructions)9.0010.00INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH10.0030.0031.00Other Adjustment (specify)30.00	2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1	, 8-12			2.00
5.00       Total hospital charges from Wkst C, Pt. I, col. 8 line 200       5.00         6.00       Total hospital charity care charges from Wkst. S-10, col. 3 line 20       6.00         7.00       CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I       7.00         8.00       Calculation of the HIT incentive payment (see instructions)       8.00         9.00       Sequestration adjustment amount (see instructions)       9.00         10.00       INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH       10.00         30.00       Initial/interim HIT payment adjustment (see instructions)       30.00         31.00       Other Adjustment (specify)       31.00	3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
6.00Total hospital charity care charges from Wkst. S-10, col. 3 line 206.007.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 1687.008.00Calculation of the HIT incentive payment (see instructions)8.009.00Sequestration adjustment amount (see instructions)9.0010.00Calculation of the HIT incentive payment after sequestration (see instructions)9.0010.00INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH30.0031.00Other Adjustment (specify)31.00	4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1	, 8-12			4.00
7.00       CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168       7.00         8.00       Calculation of the HIT incentive payment (see instructions)       8.00         9.00       Sequestration adjustment amount (see instructions)       9.00         10.00       Calculation of the HIT incentive payment after sequestration (see instructions)       9.00         10.00       INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH       10.00         30.00       Initial/interim HIT payment adjustment (see instructions)       30.00         31.00       Other Adjustment (specify)       31.00	5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	)			5.00
1 i ne 1688.009.00Sequestration adj ustment amount (see instructions)9.0010.00Cal cul ation of the HIT incentive payment after sequestration (see instructions)10.0010.0010.0110.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.0010.00<	6.00	Total hospital charity care charges from Wkst. S-10, col.	3 line 20			6.00
9.00       Sequestration adjustment amount (see instructions)       9.00         10.00       Calculation of the HIT incentive payment after sequestration (see instructions)       10.00         1NPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH       30.00         30.00       Initial/interim HIT payment adjustment (see instructions)       30.00         31.00       Other Adjustment (specify)       31.00	7.00		of certified HIT technology	/Wkst. S-2, Pt. I		7.00
10.00       Calculation of the HIT incentive payment after sequestration (see instructions)       10.00         INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH       30.00         30.00       Initial/interim HIT payment adjustment (see instructions)       30.00         31.00       Other Adjustment (specify)       31.00	8.00	Calculation of the HIT incentive payment (see instructions	5)			8.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH         30.00       Initial/interim HIT payment adjustment (see instructions)       30.00         31.00       Other Adjustment (specify)       31.00	9.00	Sequestration adjustment amount (see instructions)				9.00
30.00Initial/interim HIT payment adjustment (see instructions)30.0031.00Other Adjustment (specify)31.00	10.00	Calculation of the HIT incentive payment after sequestrati	on (see instructions)			10.00
31.00 Other Adjustment (specify) 31.00		INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
	30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) 32.00	31.00	Other Adjustment (specify)				31.00
	32.00	Balance due provider (line 8 (or line 10) minus line 30 an	nd line 31) (see instructio	ons)		32.00

ALCUL/	TION OF REIMBURSEMENT SETTLEMENT - SWING BEDS P	rovider CCN: 15-1305	Peri od:	Worksheet E-2	-
	c	component CCN: 15-Z305	From 10/01/2016 To 09/30/2017	Date/Time Pre 2/27/2018 12:	
		Title XVIII	Swing Beds - SNF		<u> </u>
			Part A	Part B	
			1.00	2.00	
C	COMPUTATION OF NET COST OF COVERED SERVICES				
	npatient routine services - swing bed-SNF (see instructions)		1, 271, 014	0	1.
	npatient routine services - swing bed-NF (see instructions)				2.
	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part		, 385, 149	0	3.
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see inst				
	Per diem cost for interns and residents not in approved teachin	g program (see		0.00	4
	nstructions) Program days		910	0	5
	Interns and residents not in approved teaching program (see ins	tructions)	710	0	
	Jtilization review - physician compensation - SNF optional meth		0	0	7
	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1, 656, 163	0	
	Primary payer payments (see instructions)		0	0	
	Subtotal (line 8 minus line 9)		1, 656, 163	0	
00	Deductibles billed to program patients (exclude amounts applica	ble to physician	1, 524	0	11
	professional services)				
	Subtotal (line 10 minus line 11)		1, 654, 639	0	12
	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	14, 046	0	13
	for physician professional services)				
	30% of Part B costs (line 12 x 80%)	、 、	1 ( 10 500	0	
	Subtotal (enter the lesser of line 12 minus line 13, or line 14	)	1, 640, 593	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Pioneer ACO demonstration payment adjustment (see instructions) Rural community hospital demonstration project (§410A Demonstra		0	0	16
	adjustment (see instructions)	tron) payment	0		
	Demonstration payment adjustment amount before sequestration		0	0	16
	Allowable bad debts (see instructions)		0	0	
	Adjusted reimbursable bad debts (see instructions)		0	0	17
. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)	0	0	18
. 00	Total (see instructions)		1, 640, 593	0	19
	Sequestration adjustment (see instructions)		32, 812	0	
	Demonstration payment adjustment amount after sequestration)		0	0	
	nterim payments		1, 534, 546	0	
	Tentative settlement (for contractor use only)		0	0	
	Balance due provider/program (line 19 minus lines 19.01, 20, an		73, 235	0	
	Protested amounts (nonallowable cost report items) in accordanc	e with CMS Pub. 15-2,	0	0	23
	chapter 1, §115.2 Rural Community Hospital Demonstration Project (§410A Demonstra	tion) Adjustment			1
	s this the first year of the current 5-year demonstration peri				200
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	Cost Reimbursement				1
	Medicare swing-bed SNF inpatient routine service costs (from Wk	st. D-1, Pt. II, line			201
	56 (title XVIII hospital))				
	Medicare swing-bed SNF inpatient ancillary service costs (from	Wkst. D-3, col. 3, li	ne		202
	200 (title XVIII swing-bed SNF))				203
	Total (sum of lines 201 and 202) Medicare swing-bed SNF discharges (see instructions)				203
	Computation of Demonstration Target Amount Limitation (N/A in f	irst year of the curr	ent 5-vear demons		204
	period)		one o goar aomono		
	Medicare swing-bed SNF target amount				205
5.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 tim	es line 204)			206
	djustment to Medicare Part A Swing-Bed SNF Inpatient Reimburse				
	Program reimbursement under the §410A Demonstration (see instru				207
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2,	col. 1, sum of lines	1		208
	and 3) Adjustment to Medicero quing had SNE DDS normante (acc instruct	(ana)			000
	Adjustment to Medicare swing-bed SNF PPS payments (see instruct Recorved for future use	rons)			209 210
	Reserved for future use Comparision of PPS versus Cost Reimbursement		I		1210
	For adjustment to Medicare swing-bed SNF PPS payment (line 20				215

ALCULA	FION OF REIMBURSEMENT SETTLEMENT - SWING BEDS PI	rovider CCN: 15-1305	Peri od:	Worksheet E-2
	C	omponent CCN: 15-Z305	From 10/01/2016 To 09/30/2017	Date/Time Prepa 2/27/2018 12:01
		Title XIX	Swing Beds - SNF	
			Part A	Part B
			1.00	2.00
С	OMPUTATION OF NET COST OF COVERED SERVICES			
00 I	npatient routine services - swing bed-SNF (see instructions)		0	
00   I	npatient routine services - swing bed-NF (see instructions)		0	
00 A	ncillary services (from Wkst. D-3, col. 3, line 200, for Part /	A, and sum of Wkst. D	, 0	
	art V, cols. 6 and 7, line 202, for Part B) (For CAH, see inst			
	er diem cost for interns and residents not in approved teaching	g program (see	0.00	
	nstructions)			
	rogram days	tt!	0	
	nterns and residents not in approved teaching program (see ins		0	
	tilization review - physician compensation - SNF optional method	od oni y	0	
	ubtotal (sum of lines 1 through 3 plus lines 6 and 7)		0	
	rimary payer payments (see instructions)		0	
	ubtotal (line 8 minus line 9) eductibles billed to program patients (exclude amounts applical	blo to physician	0	
	rofessional services)	bre to physician	0	
	ubtotal (line 10 minus line 11)		0	
	oinsurance billed to program patients (from provider records)	(exclude coinsurance	0	
	for physician professional services)		0	
	0% of Part B costs (line 12 x 80%)		0	
	ubtotal (enter the lesser of line 12 minus line 13, or line 14)	)	0	
	THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	·	0	
	ioneer ACO demonstration payment adjustment (see instructions)		0	
	ural community hospital demonstration project (§410A Demonstra	tion) payment		
a	djustment (see instructions)			
. 99 C	emonstration payment adjustment amount before sequestration		0	
	llowable bad debts (see instructions)		0	
. 01 A	djusted reimbursable bad debts (see instructions)		0	
	llowable bad debts for dual eligible beneficiaries (see instru	ctions)	0	
	otal (see instructions)		0	
	equestration adjustment (see instructions)		0	
	emonstration payment adjustment amount after sequestration)		0	
	nterim payments		0	
	entative settlement (for contractor use only)	1.01)	0	
	alance due provider/program (line 19 minus lines 19.01, 20, and		0	
	rotested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	0	
	hapter 1, §115.2 ural Community Hospital Demonstration Project (§410A Demonstrat	tion) Adjustmont		
	s this the first year of the current 5-year demonstration perio			2
	entury Cures Act? Enter "Y" for yes or "N" for no.			2
	ost Rei mbursement			
	edicare swing-bed SNF inpatient routine service costs (from Wk	st. D-1, Pt. II, line		2
	6 (title XVIII hospital))			
	edicare swing-bed SNF inpatient ancillary service costs (from N	Wkst. D-3, col. 3, li	ne	2
	00 (title XVIII swing-bed SNF))			
3. 00 T	otal (sum of lines 201 and 202)			2
	edicare swing-bed SNF discharges (see instructions)			2
	omputation of Demonstration Target Amount Limitation (N/A in fi	rst year of the curr	ent 5-year demons	tration
	eriod)		1	
	edicare swing-bed SNF target amount			2
	edicare swing-bed SNF inpatient routine cost cap (line 205 time			2
	djustment to Medicare Part A Swing-Bed SNF Inpatient Reimburser			
	rogram reimbursement under the §410A Demonstration (see instruc		1	2
	edicare swing-bed SNF inpatient service costs (from Wkst. E-2,	cor. r, sum or rines		2
	nd 3) djustment to Medicare swing-bed SNF PPS payments (see instructi	ions)		2
	eserved for future use	101137		2
	omparision of PPS versus Cost Reimbursement			2
	otal adjustment to Medicare swing-bed SNF PPS payment (line 20			

	Financial Systems PULASKI MEMORIA			u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1305	Peri od:	Worksheet E-3	
			From 10/01/2016 To 09/30/2017	Part V   Date/Time Pre	narod
			10 07/30/2017	2/27/2018 12:	
		Title XVIII	Hospi tal	Cost	
				1.00	
1 00	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICAR	E PART A SERVICES - COS	T REIMBURSEMENT	0 540 404	1 1 00
1.00	Inpatient services	:)		2, 548, 194	1.00
2.00 3.00	Nursing and Allied Health Managed Care payment (see instruct Organ acquisition	Tons)		0	
3.00 4.00	Subtotal (sum of lines 1 through 3)			2, 548, 194	
4.00 5.00	Primary payer payments			2, 546, 194	
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2, 573, 676	
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			2, 373, 070	0.00
	Reasonable charges				1
7.00	Routi ne servi ce charges			0	7.00
8.00	Ancillary service charges			0	8.00
9.00	Organ acquisition charges, net of revenue			0	9.00
10.00	Total reasonable charges			0	10.00
	Customary charges				
11.00	Aggregate amount actually collected from patients liable for			0	
12.00	Amounts that would have been realized from patients liable f	1 5	on a charge basis	0	12.00
40.00	had such payment been made in accordance with 42 CFR 413.13(	e)		0 00000	10.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	
14.00	Total customary charges (see instructions)	nly if line 14 evenede l	(no. () (no.	0	
15.00	Excess of customary charges over reasonable cost (complete o instructions)	ni y 11 11në 14 exceeds 1	The b) (See	0	15.00
16.00	Excess of reasonable cost over customary charges (complete o	nlvifline 6 exceeds li	ne 14) (see	0	16.00
10.00	instructions)			Ū	10.00
17.00	Cost of physicians' services in a teaching hospital (see ins	tructions)		0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
18.00	Direct graduate medical education payments (from Worksheet E	-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			2, 573, 676	19.00
20.00	Deductibles (exclude professional component)			319, 666	
21.00	Excess reasonable cost (from line 16)			0	
22.00	Subtotal (line 19 minus line 20 and 21)			2, 254, 010	
23.00	Coinsurance			0	
24.00	Subtotal (line 22 minus line 23)			2, 254, 010	•
25.00	Allowable bad debts (exclude bad debts for professional serv	ices) (see instructions)		44, 903	
26.00	Adjusted reimbursable bad debts (see instructions)	t		29, 187	
27.00 28.00	Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (sum of lines 24 and 25, or line 26)	tructions)		38, 340 2, 283, 197	
28.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			2, 283, 197	
29.00 29.50	Pioneer ACO demonstration payment adjustment (see instructio	ns)		0	
29.99	Demonstration payment adjustment amount before sequestration			0	
30.00	Subtotal (see instructions)			2, 283, 197	
30.01	Sequestration adjustment (see instructions)			45, 664	•
30.02	Demonstration payment adjustment amount after sequestration			0	
31.00	Interim payments			2, 224, 313	
32.00	Tentative settlement (for contractor use only)			0	
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.	02, 31, and 32)		13, 220	33.00
34.00	Protested amounts (nonallowable cost report items) in accord	ance with CMS Pub. 15-2,	chapter 1,	0	34.00
54.00	§115. 2	and write owo rub. $10^{-2}$ ,		0	

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES           COMPUTATION OF NET COST OF COVERED SERVICES           1.00         Inpatient hospital/SMF/NF services           2.00         Medical and other services           3.00         Organ acquisition (certified transplant centers only)           4.00         Subtotal (sum of lines 1, 2 and 3)           5.00         Inpatient primary payer payments           6.00         Outpatient primary payer payments           7.00         Subtotal (line 4 less sum of lines 5 and 6)           COMPUTATION OF LESSER OF COST OR CHARGES           Reasonable charges           8.00         Routine service charges           9.00         Ancillary service charges           9.00         Ancillary service charges           11.00         Incentive from target amount computation           12.00         Total reasonable charges (sum of lines 8 through 11)           CUSTOMARY CHARGES           13.00         Amount actually collected from patients liable for payment for service basis           14.00         Amount sthat would have been realized from patients liable for payment a charge basis had such payment been made in accordance with 42 CFR §           15.00         Ratio of line 13 to line 14 (not to exceed 1.000000)           16.00         Excess of reasonable cost over customary charges (co	itle XIX		2/27/2018 12:0	epared: 01 pm
COMPUTATION OF NET COST OF COVERED SERVICES           1         Inpatient hospital/SNF/NF services           2.00         Medical and other services           3.00         Organ acquisition (certified transplant centers only)           4.00         Subtotal (sum of lines 1, 2 and 3)           5.01         Inpatient primary payer payments           6.00         Outpatient primary payer payments           6.01         Subtotal (line 4 less sum of lines 5 and 6)           COMPUTATION OF LESSER OF COST OR CHARGES           Reasonable Charges           8.00         Routine service charges           9.00         Ancillary service charges (sum of lines 8 through 11)           CUSTOMARY CHARGES           13.00         Amount actually collected from patients liable for payment for service basis           14.00         Ancounts that would have been realized from patients liable for payment a charge basis had such payment been made in accordance with 42 CFR §r           15.00         Ratio of line 13 to line 14 (not to exceed 1.000000)           16.00         Total customary charges over reasonable cost (complete only if line 16) (see instructions)           17.00         Excess of reasonable cost over customary charges (complete only if line 16) (see instructions)           17.00         Excess of reasonable cost over customary charges (complete only if line 16) (see instructions)		Hospi tal	Cost	- <u>-</u>
COMPUTATION OF NET COST OF COVERED SERVICES           1.00         Inpatient hospital/SNF/NF services           2.00         Medical and other services           3.00         Organ acquisition (certified transplant centers only)           4.01         Subtotal (sum of lines 1, 2 and 3)           5.00         Inpatient primary payer payments           6.00         Outpatient primary payer payments           6.00         Subtotal (line 4 less sum of lines 5 and 6)           COMPUTATION OF LESSER OF COST OR CHARGES           Reasonable Charges           8.00         Routine service charges           9.00         Ancillary service charges (sum of lines 8 through 11)           CUSTOMARY CHARGES           13.00         Amount actually collected from patients liable for payment for service basis           14.00         Amount studily collected from patients liable for payment a charge basis had such payment been made in accordance with 42 CFR §r           15.00         Ratio of line 13 to line 14 (not to exceed 1.00000)           16.00         Total customary charges (see instructions)           17.00         Excess of reasonable cost over customary charges (complete only if line 16)           18.00         Excess of reasonable cost over customary charges (must only be complete only 2000)           10.01         Inters and Residents (see instructions)		I npati ent	Outpati ent	
COMPUTATION OF NET COST OF COVERED SERVICES           1.00         Inpatient hospital/SNF/NF services           2.00         Medical and other services           3.00         Organ acquisition (certified transplant centers only)           4.01         Subtotal (sum of lines 1, 2 and 3)           5.00         Inpatient primary payer payments           6.00         Outpatient primary payer payments           6.00         Subtotal (line 4 less sum of lines 5 and 6)           COMPUTATION OF LESSER OF COST OR CHARGES           Reasonable Charges           8.00         Routine service charges           9.00         Ancillary service charges (sum of lines 8 through 11)           CUSTOMARY CHARGES           13.00         Amount actually collected from patients liable for payment for service basis           14.00         Anounts that would have been realized from patients liable for payment a charge basis had such payment been made in accordance with 42 CFR §r           15.00         Ratio of line 13 to line 14 (not to exceed 1.000000)           16.00         Total customary charges over reasonable cost (complete only if line 16) (see instructions)           17.00         Excess of reasonable cost over customary charges (complete only if line 16) (see instructions)           17.00         Excess of reasonable cost over customary charges (complete only if line 16) (see instructions)		1.00	2.00	
<ul> <li>1.00 Inpatient hospital/SNF/NF services</li> <li>Medical and other services</li> <li>Wedical and other services</li> <li>Organ acquisition (certified transplant centers only)</li> <li>Subtotal (sum of lines 1, 2 and 3)</li> <li>Inpatient primary payer payments</li> <li>Outpatient primary payer payments</li> <li>Outpatient primary payer payments</li> <li>Subtotal (line 4 less sum of lines 5 and 6)</li> <li>COMPUTATION OF LESSER OF COST OR CHARGES</li> <li>Reasonable Charges</li> <li>Routine service charges</li> <li>On Arcuisition charges, net of revenue</li> <li>Organ acquisition charges, net of revenue</li> <li>Incentive from target amount computation</li> <li>Total reasonable charges (sum of lines 8 through 11)</li> <li>CUSTOMARY CHARGES</li> <li>Amount actually collected from patients liable for payment for service basis</li> <li>Amounts that would have been realized from patients liable for payment for service basis</li> <li>Manunts that would have been realized from patients liable for payment for service basis</li> <li>Matio of line 13 to line 14 (not to exceed 1.000000)</li> <li>Total customary charges over reasonable cost (complete only if line 4) (see instructions)</li> <li>Excess of reasonable cost over customary charges (complete only if line 16) (see instructions)</li> <li>Cost of physicians' services (net rthe lesser of line 4 or line 16) PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be complete 22.00 Other than outlier payments</li> <li>Outrie and Ancillary service other pass through costs</li> <li>Outine and Ancillary service other pass through costs</li> <li>COMPUTATION OF REIMBURSEMENT SETTLEMENT</li> <li>COMPUTATION OF REIMBURSEMENT SET</li></ul>	DR TITLES V OR X	(IX SERVICES		
<ul> <li>2.00 Medical and other services</li> <li>3.00 Organ acquisition (certified transplant centers only)</li> <li>4.00 Subtotal (sum of lines 1, 2 and 3)</li> <li>Inpatient primary payer payments</li> <li>6.00 Outpatient primary payer payments</li> <li>7.00 Subtotal (line 4 less sum of lines 5 and 6)</li> <li>COMPUTATION OF LESSER OF COST OR CHARGES</li> <li>Reasonable Charges</li> <li>8.00 Routine service charges</li> <li>9.00 Ancillary service charges (sum of lines 8 through 11)</li> <li>CUSTOMARY CHARGES</li> <li>11.00 Incentive from target amount computation</li> <li>12.00 Total reasonable charges (sum of lines 8 through 11)</li> <li>CUSTOMARY CHARGES</li> <li>13.00 Amount actually collected from patients liable for payment for service basis</li> <li>14.00 Amounts that would have been realized from patients liable for payment a charge basis had such payment been made in accordance with 42 CFR §r</li> <li>15.00 Ration of line 13 to line 14 (not to exceed 1.000000)</li> <li>16.00 Total customary charges (see instructions)</li> <li>17.00 Excess of reasonable cost over customary charges (complete only if line 1) (see instructions)</li> <li>18.00 Excess of reasonable cost over customary charges (complete only if line 1) (see instructions)</li> <li>19.00 Interns and Residents (see instructions)</li> <li>10.01 Covered services (enter the lesser of line 4 or line 16)</li> <li>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed of the payments</li> <li>20.00 Cajtal exception payments (see instructions)</li> <li>20.00 Customary charges (title V or XIX PPS covered services only)</li> <li>20.01 Ther XIX (sum of lines 21 and 27)</li> <li>COMPUTATION OF REIMBURSEMENT SETTLEMENT</li> <li>20.00 Customary charges (title V or XIX PPS covered services only)</li> <li>20.01 The XV (x) (sum of lines 19 and 20, plus 29 minus lines 5 and 6)</li> <li>20.02 Deductibles</li> <li>21.00 Deductibles</li> <li>22.00 Other ADUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> </ul>				
<ul> <li>Organ acquisition (certified transplant centers only)</li> <li>Subtotal (sum of lines 1, 2 and 3)</li> <li>Subtotal (sum of lines 1, 2 and 3)</li> <li>Olipatient primary payer payments</li> <li>Subtotal (line 4 less sum of lines 5 and 6)</li> <li>COMPUTATION OF LESSER OF COST OR CHARGES</li> <li>Reasonable Charges</li> <li>Routine service charges</li> <li>Anounts that would have been realized from patients liable for payment for service basis</li> <li>Amounts that would have been realized from patients liable for payment for service basis</li> <li>Ratio of line 13 to line 14 (not to exceed 1.00000)</li> <li>Total customary charges (see instructions)</li> <li>Excess of customary charges (see instructions)</li> <li>Excess of reasonable cost over customary charges (complete only if line 14 (not to exceed 1.000000)</li> <li>Interns and Residents (see instructions)</li> <li>Excess of reasonable cost over customary charges (complete only if line 4) (see instructions)</li> <li>Cost of physicians' services (enter the lesser of line 4 or line 16)</li> <li>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be complete</li> <li>Otarier payments</li> <li>Outifier payments</li> <li>Outi</li></ul>		67, 168		1.00
1.00       Subtotal (sum of lines 1, 2 and 3)         1.01       Inpatient primary payer payments         0.01       Uptatient primary payer payments         0.01       Subtotal (line 4 less sum of lines 5 and 6)         COMPUTATION OF LESSER OF COST OR CHARGES         Reasonable Charges         0.00       Program acquisition charges, net of revenue         11.00       Organ acquisition charges, net of revenue         11.00       Incentive from target amount computation         12.00       Total reasonable charges (sum of lines 8 through 11)         CUSTOMARY CHARGES         13.00       Amount actually collected from patients liable for payment for service basis         14.00       Amounts that would have been realized from patients liable for payment a charge basis had such payment been made in accordance with 42 CFR §.         15.00       Ratio of line 13 to line 14 (not to exceed 1.000000)         16.00       Total customary charges (see instructions)         16.00       Excess of reasonable cost over customary charges (complete only if line 16) (see instructions)         17.00       Excess of reasonable cost over customary charges of line 4 or line 16)         19.00       Interns and Residents (see instructions)         10.01       forer shard reasonable cost over customary charges complete only if line 16)         10.01       forer shard rea			0	
<ul> <li>Inpatient primary payer payments</li> <li>Outpatient primary payer payments</li> <li>COMPUTATION OF LESSER OF COST OR CHARGES</li> <li>Reasonable Charges</li> <li>Reasonable Charges</li> <li>Reasonable charges</li> <li>On Ancillary service charges</li> <li>On Incentive from target amount computation</li> <li>Total reasonable charges (sum of lines 8 through 11)</li> <li>CUSTOMARY CHARGES</li> <li>Ound mount actually collected from patients liable for payment for service basis</li> <li>Anounts that would have been realized from patients liable for payment a charge basis had such payment been made in accordance with 42 CFR §-</li> <li>Ratio of line 13 to line 14 (not to exceed 1.000000)</li> <li>Total customary charges (see instructions)</li> <li>Excess of customary charges over reasonable cost (complete only if line 16) (see instructions)</li> <li>Excess of reasonable cost over customary charges (complete only if line 16) (see instructions)</li> <li>Cost of physicians' services in a teaching hospital (see instructions)</li> <li>Cast of covered services (enter the lesser of line 4 or line 16)</li> <li>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be complete</li> <li>Outlier payments</li> <li>Capital exception payments (see instructions)</li> <li>Cast of covers (title V or XIX PPS covered services only)</li> <li>Titles V or XIX (sum of lines 21 and 27)</li> <li>COMPUTATION OF REIMBURSEMENT SETTLEMENT</li> <li>Excess of reasonable cost (from line 18)</li> <li>Outlier advented (see instructions)</li> <li>Coinsurance</li> <li>Allowable bad debts (see instructions)</li> <li>Outliels as of reasonable cost (from line 18)</li> <li>Outliels of reasonable cost (from line 18)</li> <li>Outliels as of reasonable cost (from line 18)</li> <li>Outher ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li></ul>		0	_	3.00
<ul> <li>Outpatient primary payer payments</li> <li>Subtotal (line 4 less sum of lines 5 and 6)</li> <li>COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges</li> <li>Ancuit e service charges</li> <li>On Ancillary service charges (sum of lines 8 through 11)</li> <li>CUSTOMARY CHARGES</li> <li>Amount actually collected from patients liable for payment for service basis</li> <li>Amount stat would have been realized from patients liable for payment for service basis</li> <li>Amounts that would have been realized from patients liable for payment for service basis</li> <li>Amounts that would have been realized from patients liable for payment for service basis</li> <li>Total customary charges (see instructions)</li> <li>Excess of customary charges over reasonable cost (complete only if line 14 (not to exceed 1.000000)</li> <li>Excess of reasonable cost over customary charges (complete only if line 16) (see instructions)</li> <li>Excess of reasonable cost over customary charges (complete only if line 16) (see instructions)</li> <li>Cost of physicians' services in a teaching hospital (see instructions)</li> <li>Cost of covered services (enter the lesser of line 4 or line 16) PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed</li> <li>Coutine and Ancillary service other pass through costs</li> <li>Coutine and Ancillary service other pass through costs</li> <li>Coutomary charges (title V or XIX PPS covered services only)</li> <li>Titles V or XIX (sum of lines 21 and 27)</li> <li>COMPUTATION OF REIMBURSEMENT SETTLEMENT</li> <li>Computation of lines 19 and 20, plus 29 minus lines 5 and 6)</li> <li>Coutonsurance</li> <li>Allowable bad debts (see instructions)</li> <li>Coutorsurance</li> <li>Allowable bad debts (see instructions)</li> <li>Couting and fines 31, 34 and 35 minus sum of lines 32 and 33)</li> <li>OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> </ul>		67, 168	0	
Subtotal (line 4 jess sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges           00         Routine service charges           00         Routine service charges           00         Organ acquisition charges, net of revenue           1.00         Incentive from target amount computation           2.00         Total reasonable charges (sum of lines 8 through 11)           CUSTOMARY CHARGES           3.00         Amount actually collected from patients liable for payment for service basis           4.00         Amounts that would have been realized from patients liable for payment a charge basis had such payment been made in accordance with 42 CFR §-           5.00         Ratio of line 13 to line 14 (not to exceed 1.000000)           6.01         Total customary charges (see instructions)           7.00         Excess of customary charges over reasonable cost (complete only if line 16) (see instructions)           8.00         Excess of reasonable cost over customary charges (complete only if line 16) (see instructions)           9.00         Interns and Residents (see instructions)           0.00         Cost of physicians' services in a teaching hospital (see instructions)           0.00         Prospective PAYMENT AMOUNT - Lines 22 through 26 must only be complete           0.01         Inter than outlier payments           0.02         Cost of physicians' service other pass thro		0		5.00
COMPUTATION OF LESSER OF COST OR CHARGES         Reasonable Charges         0.00       Routine service charges         0.01       Ancillary service charges         0.02       Organ acquisition charges, net of revenue         1.00       Incentive from target amount computation         2.00       Total reasonable charges (sum of lines 8 through 11)         CUSTOMARY CHARGES         3.00       Amounts that would have been realized from patients liable for payment a charge basis had such payment been made in accordance with 42 CFR §-         5.00       Ratio of line 13 to line 14 (not to exceed 1.000000)         6.00       Total customary charges (see instructions)         7.00       Excess of reasonable cost over customary charges (complete only if line 16) (see instructions)         8.00       Excess of reasonable cost over customary charges (complete only if line 16) (see instructions)         0.01       Interns and Residents (see instructions)         0.02       Cost of physicians' services in a teaching hospital (see instructions)         0.03       Cost of covered services (enter the lesser of line 4 or line 16)         PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be complete         0.04       Therm and Ancillary service other pass through costs         7.00       Subtotal (sum of lines 22 through 26)         0.00		(7.1(0	0	
Reasonable Charges         .00       Routine service charges         .00       Organ acquisition charges, net of revenue         1.00       Incentive from target amount computation         2.00       Total reasonable charges (sum of lines 8 through 11)         CUSTOMARY CHARGES         3.00       Amount actually collected from patients liable for payment for service basis         4.00       Amounts that would have been realized from patients liable for payment a charge basis had such payment been made in accordance with 42 CFR §-         5.00       Ratio of line 13 to line 14 (not to exceed 1.000000)         6.00       Total customary charges (see instructions)         7.00       Excess of customary charges over reasonable cost (complete only if line 1) (see instructions)         8.00       Excess of reasonable cost over customary charges (complete only if line 1) (see instructions)         9.00       Interns and Residents (see instructions)         0.01       Cost of covered services (net the lesser of line 4 or line 16)         PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed         0.02       Capital exception payments (see instructions)         0.03       Customary charges (title V or XIX PPS covered services only)         0.04       Frequents         0.00       Customary charges (title V or XIX PPS covered services only)         <		67, 168	0	7.00
<ul> <li>Routine service charges</li> <li>Ancillary service charges</li> <li>Organ acquisition charges, net of revenue</li> <li>Incentive from target amount computation</li> <li>Total reasonable charges (sum of lines 8 through 11)</li> <li>CUSTOMARY CHARGES</li> <li>Amount actually collected from patients liable for payment for service basis</li> <li>Amounts that would have been realized from patients liable for payment for service basis</li> <li>Amounts that would have been realized from patients liable for payment a charge basis had such payment been made in accordance with 42 CFR 5.</li> <li>Ratio of line 13 to line 14 (not to exceed 1.000000)</li> <li>Total customary charges (see instructions)</li> <li>Excess of customary charges over reasonable cost (complete only if line 4) (see instructions)</li> <li>Excess of reasonable cost over customary charges (complete only if line 4) (see instructions)</li> <li>Cost of physicians' services in a teaching hospital (see instructions)</li> <li>Cost of covered services (enter the lesser of line 4 or line 16)</li> <li>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed</li> <li>Outlier payments</li> <li>Outlier payments</li> <li>Outlier payments</li> <li>Cost of reasonable cost (see instructions)</li> <li>Cost of covered services (ther pass through costs</li> <li>Capital exception payments (see instructions)</li> <li>Coutine and Ancillary service other pass through costs</li> <li>Customary charges (title V or XIX PPS covered services only)</li> <li>Titles V or XIX (sum of lines 21 and 27)</li> <li>COMPUTATION OF REIMBURSEMENT SETTLEMENT</li> <li>Computation of lines 19 and 20, plus 29 minus lines 5 and 6)</li> <li>Deductibles</li> <li>Coinsurance</li> <li>Allowable bad debts (see instructions)</li> <li>Outline and cost (see instructions)</li> <li>Outline rew</li> &lt;</ul>				-
<ul> <li>Ancillary service charges</li> <li>Organ acquisition charges, net of revenue</li> <li>Incentive from target amount computation</li> <li>Total reasonable charges (sum of lines 8 through 11)</li> <li>CUSTOMARY CHARGES</li> <li>Amount actually collected from patients liable for payment for service basis</li> <li>Amounts that would have been realized from patients liable for payment a charge basis had such payment been made in accordance with 42 CFR §-</li> <li>Ratio of line 13 to line 14 (not to exceed 1.00000)</li> <li>Total customary charges (see instructions)</li> <li>Excess of customary charges over reasonable cost (complete only if line 4) (see instructions)</li> <li>Excess of reasonable cost over customary charges (complete only if line 16) (see instructions)</li> <li>Cost of physicians' services in a teaching hospital (see instructions)</li> <li>Cost of covered services (enter the lesser of line 4 or line 16)</li> <li>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be complete</li> <li>Other than outlier payments</li> <li>Outlier payments</li> <li>Outlier and Ancillary service other pass through costs</li> <li>Subtotal (sum of lines 22 through 26)</li> <li>Customary charges (title V or XIX PPS covered services only)</li> <li>Titles V or XIX (sum of lines 12 and 27)</li> <li>COMPUTATION OF RELMBURSEMENT SETTLEMENT</li> <li>Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)</li> <li>Deductibles</li> <li>O Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)<td></td><td>16, 627</td><td></td><td>8.00</td></li></ul>		16, 627		8.00
<ul> <li>0.00 Organ acquisition charges, net of revenue <ul> <li>Incentive from target amount computation</li> <li>Total reasonable charges (sum of lines 8 through 11)</li> <li>CUSTOMARY CHARGES</li> </ul> </li> <li>3.00 Amount actually collected from patients liable for payment for service basis <ul> <li>4.00 Amounts that would have been realized from patients liable for payment a charge basis had such payment been made in accordance with 42 CFR §.</li> <li>5.00 Ratio of line 13 to line 14 (not to exceed 1.000000)</li> <li>6.00 Total customary charges (see instructions)</li> <li>7.00 Excess of customary charges over reasonable cost (complete only if line 4) (see instructions)</li> <li>8.00 Excess of reasonable cost over customary charges (complete only if line 16) (see instructions)</li> <li>9.00 Interns and Residents (see instructions)</li> <li>0.00 Cost of physicians' services in a teaching hospital (see instructions)</li> <li>9.00 Other than outlier payments</li> <li>0.00 Other than outlier payments</li> <li>0.00 Cast of covered services (enter the lesser of line 4 or line 16) <ul> <li>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be complete</li> </ul> </li> <li>0.00 Utilier payments</li> <li>0.00 Customary charges (title V or XIX PPS covered services only)</li> <li>0.01 Titles V or XIX (sum of lines 21 and 27) <ul> <li>COMPUTATION OF REIMBURSEMENT SETTLEMENT</li> </ul> </li> <li>0.00 Excess of reasonable cost (from line 18)</li> <li>1.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)</li> <li>00 Deductibles</li> <li>0.00 Coinsurance</li> <li>0.01 Allowable bad debts (see instructions)</li> <li>0.02 Coinsurance</li> <li>0.03 Allowable bad debts (see instructions)</li> <li>0.04 Allowable bad debts (see instructions)</li> <li>05.00 Cuitization review</li> <li>0.00 Allowable bad debts (SEE INSTRUCTIONS) (SPECIFY)</li> </ul> </li> </ul>		80, 125	0	
<ul> <li>Incentive from target amount computation Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES</li> <li>Amount actually collected from patients liable for payment for service basis</li> <li>Amounts that would have been realized from patients liable for payment a charge basis had such payment been made in accordance with 42 CFR §. Ratio of line 13 to line 14 (not to exceed 1.000000)</li> <li>Total customary charges (see instructions)</li> <li>Excess of customary charges over reasonable cost (complete only if lin line 4) (see instructions)</li> <li>Excess of reasonable cost over customary charges (complete only if lin 16) (see instructions)</li> <li>O Excess of reasonable cost over customary charges (complete only if lin 16) (see instructions)</li> <li>O Cost of physicians' services in a teaching hospital (see instructions)</li> <li>Cost of covered services (enter the lesser of line 4 or line 16) PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be complete 0 Other than outlier payments</li> <li>O Capi tal exception payments (see instructions)</li> <li>Coutine and Ancillary service other pass through costs</li> <li>Subtotal (sum of lines 22 through 26) Customary charges (title V or XIX PPS covered services only)</li> <li>Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT</li> <li>Excess of reasonable cost (from line 18)</li> <li>Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)</li> <li>Deductibles</li> <li>O Cai nsurance</li> <li>Alowable bad debts (see instructions)</li> <li>O Allowable bad debts (see instructions)</li> <li>O Ther ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> </ul>		00, 125	U	10.00
<ul> <li>Total reasonable charges (sum of lines 8 through 11) CUSTOMARY CHARGES</li> <li>Amount actually collected from patients liable for payment for service basis</li> <li>Amounts that would have been realized from patients liable for payment a charge basis had such payment been made in accordance with 42 CFR §. Ratio of line 13 to line 14 (not to exceed 1.00000)</li> <li>OTatal customary charges (see instructions)</li> <li>Excess of customary charges over reasonable cost (complete only if line 16) (see instructions)</li> <li>Excess of reasonable cost over customary charges (complete only if line 16) (see instructions)</li> <li>Excess of reasonable cost over customary charges (complete only if line 16) (see instructions)</li> <li>Interns and Residents (see instructions)</li> <li>Cost of physicians' services in a teaching hospital (see instructions)</li> <li>Cost of covered services (enter the lesser of line 4 or line 16)</li> <li>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be complete</li> <li>Outlier payments</li> <li>Outlier payments</li> <li>Cost of lines 22 through 26)</li> <li>Customary charges (title V or XIX PPS covered services only)</li> <li>Titles V or XIX (sum of lines 21 and 27)</li> <li>COMPUTATION OF REIMBURSEMENT SETTLEMENT</li> <li>Dou Excess of reasonable cost (from line 18)</li> <li>Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)</li> <li>Deductibles</li> <li>Coinsurance</li> <li>And Allowable bad debts (see instructions)</li> <li>Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)</li> <li>OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> </ul>		0		11.0
CUSTOMARY CHARGES         3.00       Amount actually collected from patients liable for payment for service basis         Amounts that would have been realized from patients liable for payment a charge basis had such payment been made in accordance with 42 CFR §.         5.00       Ratio of line 13 to line 14 (not to exceed 1.000000)         5.00       Total customary charges (see instructions)         7.00       Excess of customary charges over reasonable cost (complete only if line 14) (see instructions)         8.00       Excess of reasonable cost over customary charges (complete only if line 16) (see instructions)         9.00       Interns and Residents (see instructions)         0.00       Cost of physicians' services in a teaching hospital (see instructions)         0.00       Cost of covered services (enter the lesser of line 4 or line 16)         PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed         0.01       Other than outlier payments         0.00       Cost of lines 22 through 26 must only be completed         0.01       Other than outlier payments         0.00       Customary charges (title V or XIX PPS covered services only)         10       Decess of reasonable cost (from line 18)         0.00       Customary charges (title V or XIX PPS covered services only)         11       Titles V or XIX (sum of lines 21 and 27)         COMPUTATION OF REIMBURSE		96, 752	0	
<ul> <li>Amount actually collected from patients liable for payment for service basis</li> <li>Amounts that would have been realized from patients liable for payment a charge basis had such payment been made in accordance with 42 CFR §. Ratio of line 13 to line 14 (not to exceed 1.000000)</li> <li>Total customary charges (see instructions)</li> <li>Excess of customary charges over reasonable cost (complete only if line 4) (see instructions)</li> <li>Excess of reasonable cost over customary charges (complete only if line 16) (see instructions)</li> <li>Cost of physicians' services in a teaching hospital (see instructions)</li> <li>Other than outlier payments</li> <li>Outlier payments</li> <li>Outlier payments</li> <li>Outlier payments</li> <li>Capital exception payments (see instructions)</li> <li>Cost of line 31 apyments</li> <li>Capital exception payments (see instructions)</li> <li>Customary charges (title V or XIX PPS covered services only)</li> <li>Titles V or XIX (sum of lines 21 and 27)</li> <li>COMPUTATION OF REIMBURSEMENT SETTLEMENT</li> <li>Cost of insurance</li> <li>Auto of lines 19 and 20, plus 29 minus lines 5 and 6)</li> <li>Customary charges (see instructions)</li> <li>Customary charges (see instructions)</li> <li>Customary charges (title V or XIX PPS covered services only)</li> <li>Titles V or XIX (sum of lines 19 and 20, plus 29 minus lines 5 and 6)</li> <li>Cubtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)</li> <li>Customar ceive</li> <li>Customar (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)</li> <li>OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> </ul>		70,702		1 12.0
<ul> <li>basis</li> <li>Amounts that would have been realized from patients liable for payment a charge basis had such payment been made in accordance with 42 CFR §- 5.00 Ratio of line 13 to line 14 (not to exceed 1.00000)</li> <li>6.00 Total customary charges (see instructions)</li> <li>7.00 Excess of customary charges over reasonable cost (complete only if line line 4) (see instructions)</li> <li>8.00 Excess of reasonable cost over customary charges (complete only if line 16) (see instructions)</li> <li>9.00 Interns and Residents (see instructions)</li> <li>0.00 Cost of physicians' services in a teaching hospital (see instructions)</li> <li>9.00 Interns and Residents (see instructions)</li> <li>0.00 Cost of covered services (enter the lesser of line 4 or line 16)</li> <li>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be complete</li> <li>0.00 Other than outlier payments</li> <li>0.00 Capital exception payments (see instructions)</li> <li>6.00 Routine and Ancillary service other pass through costs</li> <li>7.00 Subtotal (sum of lines 22 through 26)</li> <li>8.00 Customary charges (title V or XIX PPS covered services only)</li> <li>9.00 Titles V or XIX (sum of lines 21 and 27)</li> <li>COMPUTATION OF REIMBURSEMENT SETTLEMENT</li> <li>0.00 Excess of reasonable cost (from line 18)</li> <li>1.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)</li> <li>2.00 Deductibles</li> <li>3.00 Coinsurance</li> <li>4.00 Allowable bad debts (see instructions)</li> <li>5.00 Utilization review</li> <li>6.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)</li> <li>7.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> </ul>	es on a charge	0	0	13.00
<ul> <li>4.00 Amounts that would have been realized from patients liable for payment a charge basis had such payment been made in accordance with 42 CFR §-0. Ratio of line 13 to line 14 (not to exceed 1.000000)</li> <li>6.00 Total customary charges (see instructions)</li> <li>7.00 Excess of customary charges over reasonable cost (complete only if line 4) (see instructions)</li> <li>8.00 Excess of reasonable cost over customary charges (complete only if line 16) (see instructions)</li> <li>9.00 Interns and Residents (see instructions)</li> <li>0.00 Cost of physicians' services in a teaching hospital (see instructions)</li> <li>1.00 Cost of covered services (enter the lesser of line 4 or line 16)</li> <li>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be complete</li> <li>2.00 Other than outlier payments</li> <li>3.00 Outlier payments</li> <li>5.00 Capital exception payments (see instructions)</li> <li>6.00 Routine and Ancillary service other pass through costs</li> <li>7.00 Subtotal (sum of lines 21 through 26)</li> <li>8.00 Customary charges (title V or XIX PPS covered services only)</li> <li>9.00 Titles V or XIX (sum of lines 21 and 27)</li> <li>COMPUTATION OF REIMBURSEMENT SETTLEMENT</li> <li>0.00 Excess of reasonable cost (from line 18)</li> <li>1.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)</li> <li>2.00 Coin surance</li> <li>4.00 Allowable bad debts (see instructions)</li> <li>6.01 Kuitarian review</li> <li>6.02 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)</li> <li>7.03 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> </ul>			-	
<ul> <li>Ratio of line 13 to line 14 (not to exceed 1.000000)</li> <li>Total customary charges (see instructions)</li> <li>Excess of customary charges over reasonable cost (complete only if line 4) (see instructions)</li> <li>Excess of reasonable cost over customary charges (complete only if line 16) (see instructions)</li> <li>Cole Excess of reasonable cost over customary charges (complete only if line 16) (see instructions)</li> <li>Cole Excess of reasonable cost over customary charges (complete only if line 16) (see instructions)</li> <li>Cole Excess of reasonable cost over customary charges (complete only if line 16) (see instructions)</li> <li>Cole Cost of physicians' services in a teaching hospital (see instructions)</li> <li>Cost of covered services (enter the lesser of line 4 or line 16) (see instructions)</li> <li>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed of the noutlier payments</li> <li>Cole Copital exception payments (see instructions)</li> <li>Cole Copital exception payments (see instructions)</li> <li>Cole Customary charges (title V or XIX PPS covered services only)</li> <li>Computation of Lines 19 and 20, plus 29 minus lines 5 and 6)</li> <li>Cole Deductibles</li> <li>Cole Coinsurance</li> <li>Allo Wable bad debts (see instructions)</li> <li>Cole Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)</li> <li>OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> </ul>	t for services (	on 0	0	14.0
<ul> <li>Total customary charges (see instructions)</li> <li>Excess of customary charges over reasonable cost (complete only if line 4) (see instructions)</li> <li>Excess of reasonable cost over customary charges (complete only if line 16) (see instructions)</li> <li>Interns and Residents (see instructions)</li> <li>Cost of physicians' services in a teaching hospital (see instructions)</li> <li>Cost of covered services (enter the lesser of line 4 or line 16)</li> <li>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be complete</li> <li>Other than outlier payments</li> <li>Outlier payments</li> <li>Outlier payments</li> <li>Capital exception payments (see instructions)</li> <li>Customary charges (title V or XIX PPS covered services only)</li> <li>Titles V or XIX (sum of lines 21 and 27)</li> <li>COMPUTATION OF RELINBURSEMENT SETTLEMENT</li> <li>Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)</li> <li>Deductibles</li> <li>Consurance</li> <li>Allowable bad debts (see instructions)</li> <li>Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)</li> <li>OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> </ul>				
<ul> <li>Excess of customary charges over reasonable cost (complete only if line line 4) (see instructions)</li> <li>Excess of reasonable cost over customary charges (complete only if line 16) (see instructions)</li> <li>Interns and Residents (see instructions)</li> <li>Cost of physicians' services in a teaching hospital (see instructions)</li> <li>Cost of covered services (enter the lesser of line 4 or line 16)</li> <li>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be complete</li> <li>O Other than outlier payments</li> <li>O Capital exception payments (see instructions)</li> <li>Compare capital payments (see instructions)</li> <li>Customary charges (title V or XIX PPS covered services only)</li> <li>Titles V or XIX (sum of lines 21 and 27)</li> <li>COMPUTATION OF RELIMBURSEMENT SETTLEMENT</li> <li>Excess of reasonable cost (from line 18)</li> <li>O Coin surance</li> <li>Allowable bad debts (see instructions)</li> <li>O Utilization review</li> <li>Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)</li> <li>O OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> </ul>		0.000000	0. 000000	15.0
<pre>line 4) (see instructions) 3.00 Excess of reasonable cost over customary charges (complete only if lin 16) (see instructions) 9.00 Interns and Residents (see instructions) 0.00 Cost of physicians' services in a teaching hospital (see instructions) 1.00 Cost of covered services (enter the lesser of line 4 or line 16) PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be complete 2.00 Other than outlier payments 3.00 Outlier payments 4.00 Program capital payments 5.00 Capital exception payments (see instructions) 5.00 Capital exception payments (see instructions) 6.00 Customary charges (title V or XIX PPS covered services only) 7.00 Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETLEMENT 9.00 Excess of reasonable cost (from line 18) 1.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 2.00 Deductibles 3.00 Coinsurance 4.00 Allowable bad debts (see instructions) 5.00 Utilization review 5.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 7.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) </pre>		96, 752	0	16.0
<ul> <li>Excess of reasonable cost over customary charges (complete only if line 16) (see instructions)</li> <li>Interns and Residents (see instructions)</li> <li>Cost of physicians' services in a teaching hospital (see instructions)</li> <li>Cost of covered services (enter the lesser of line 4 or line 16)</li> <li>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed</li> <li>Other than outlier payments</li> <li>Outlier payments</li> <li>O Capital exception payments (see instructions)</li> <li>Cost of reasonable cost (if e V or XIX PPS covered services only)</li> <li>O Customary charges (title V or XIX PPS covered services only)</li> <li>COMPUTATION OF RELMBURSEMENT SETTLEMENT</li> <li>Computationable cost (from line 18)</li> <li>O Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)</li> <li>Deductibles</li> <li>Coinsurance</li> <li>Allowable bad debts (see instructions)</li> <li>Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)</li> <li>OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> </ul>	ne 16 exceeds	29, 584	0	17.0
<ul> <li>16) (see instructions)</li> <li>16) (see instructions)</li> <li>17) Interns and Residents (see instructions)</li> <li>18) Cost of physicians' services in a teaching hospital (see instructions)</li> <li>19) Cost of covered services (enter the lesser of line 4 or line 16)</li> <li>10) PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed</li> <li>10) Other than outlier payments</li> <li>10) Outlier payments</li> <li>10) Capital exception payments (see instructions)</li> <li>10) Customary charges (title V or XIX PPS covered services only)</li> <li>11) COMPUTATION OF REIMBURSEMENT SETTLEMENT</li> <li>10) Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)</li> <li>11) Deductibles</li> <li>10) Coinsurance</li> <li>11) O Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)</li> <li>11) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> </ul>				
<ul> <li>9.00 Interns and Residents (see instructions)</li> <li>0.00 Cost of physicians' services in a teaching hospital (see instructions)</li> <li>0.00 Cost of covered services (enter the lesser of line 4 or line 16)</li> <li>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be complete</li> <li>0.00 Other than outlier payments</li> <li>0.00 Program capital payments</li> <li>0.00 Capital exception payments (see instructions)</li> <li>0.00 Routine and Ancillary service other pass through costs</li> <li>0.00 Subtotal (sum of lines 22 through 26)</li> <li>0.00 Customary charges (title V or XIX PPS covered services only)</li> <li>0.00 Excess of reasonable cost (from line 18)</li> <li>0.00 Deductibles</li> <li>0.00 Coinsurance</li> <li>0.01 Allowable bad debts (see instructions)</li> <li>0.02 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)</li> <li>0.03 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> </ul>	ne 4 exceeds lir	ne 0	0	18.0
<ul> <li>Cost of physicians' services in a teaching hospital (see instructions) Cost of covered services (enter the lesser of line 4 or line 16) PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be complete Other than outlier payments</li> <li>Outlier payments</li> <li>Outlier payments</li> <li>Outrine and Ancillary service other pass through costs</li> <li>Cost of reasonable cost (from line 18)</li> <li>ComPUTATION OF REIMBURSEMENT SETLEMENT</li> <li>Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)</li> <li>Deductibles</li> <li>Coinsurance</li> <li>Allowable bad debts (see instructions)</li> <li>Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)</li> <li>OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> </ul>				
<ul> <li>1.00 Cost of covered services (enter the lesser of line 4 or line 16) PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be complete Other than outlier payments 0.01 ier payments 0.00 Program capital payments 0.00 Capital exception payments (see instructions) 0.00 Routine and Ancillary service other pass through costs 0.00 Customary charges (title V or XIX PPS covered services only) 0.00 Customary charges (title V or XIX PPS covered services only) 1.100 Subtotal (sum of lines 22 through 26) 1.00 Excess of reasonable cost (from line 18) 1.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 2.00 Deductibles 0.00 Eixenance 4.00 Allowable bad debts (see instructions) 5.00 Utilization review 6.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 0.00 THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> </ul>		0	0	
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be complete         2.00       Other than outlier payments         3.00       Outlier payments         4.00       Program capital payments         5.00       Capital exception payments (see instructions)         6.00       Routine and Ancillary service other pass through costs         7.00       Subtotal (sum of lines 22 through 26)         8.00       Customary charges (title V or XIX PPS covered services only)         9.00       Titles V or XIX (sum of lines 21 and 27)         COMPUTATION OF REIMBURSEMENT SETTLEMENT         0.00       Excess of reasonable cost (from line 18)         1.00       Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)         2.00       Deductibles         3.00       Coinsurance         4.00       Allowable bad debts (see instructions)         5.00       Utilization review         6.00       Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)         7.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	)	0	0	
<ul> <li>2.00 Other than outlier payments</li> <li>3.00 Outlier payments</li> <li>4.00 Program capital payments</li> <li>5.00 Capital exception payments (see instructions)</li> <li>6.00 Routine and Ancillary service other pass through costs</li> <li>7.00 Subtotal (sum of lines 22 through 26)</li> <li>8.00 Customary charges (title V or XIX PPS covered services only)</li> <li>7.10 Titles V or XIX (sum of lines 21 and 27)</li> <li>COMPUTATION OF REIMBURSEMENT SETTLEMENT</li> <li>0.00 Excess of reasonable cost (from line 18)</li> <li>1.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)</li> <li>0.00 Deductibles</li> <li>3.00 Coinsurance</li> <li>4.00 Allowable bad debts (see instructions)</li> <li>5.00 Utilization review</li> <li>6.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)</li> <li>7.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> </ul>		67, 168	0	21.0
<ul> <li>3.00 Outlier payments</li> <li>4.00 Program capital payments</li> <li>5.00 Capital exception payments (see instructions)</li> <li>6.00 Routine and Ancillary service other pass through costs</li> <li>7.00 Subtotal (sum of lines 22 through 26)</li> <li>8.00 Customary charges (title V or XIX PPS covered services only)</li> <li>7.11 Titles V or XIX (sum of lines 21 and 27)</li> <li>COMPUTATION OF REIMBURSEMENT SETTLEMENT</li> <li>0.00 Excess of reasonable cost (from line 18)</li> <li>1.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)</li> <li>2.00 Deductibles</li> <li>3.00 Coinsurance</li> <li>4.00 Allowable bad debts (see instructions)</li> <li>5.00 Utilization review</li> <li>6.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)</li> <li>7.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> </ul>	<u>ea for PPS provi</u>			1 22 0
<ul> <li>4.00 Program capital payments</li> <li>5.00 Capital exception payments (see instructions)</li> <li>6.00 Routine and Ancillary service other pass through costs</li> <li>7.00 Subtotal (sum of lines 22 through 26)</li> <li>8.00 Customary charges (title V or XIX PPS covered services only)</li> <li>9.00 Titles V or XIX (sum of lines 21 and 27)</li> <li>COMPUTATION OF REIMBURSEMENT SETTLEMENT</li> <li>0.00 Excess of reasonable cost (from line 18)</li> <li>1.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)</li> <li>2.00 Deductibles</li> <li>3.00 Coinsurance</li> <li>4.00 Allowable bad debts (see instructions)</li> <li>5.00 Utilization review</li> <li>6.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)</li> <li>7.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> </ul>		0	0	
<ul> <li>5.00 Capital exception payments (see instructions)</li> <li>6.00 Routine and Ancillary service other pass through costs</li> <li>7.00 Subtotal (sum of lines 22 through 26)</li> <li>8.00 Customary charges (title V or XIX PPS covered services only)</li> <li>9.00 Titles V or XIX (sum of lines 21 and 27)</li> <li>COMPUTATION OF REIMBURSEMENT SETLEMENT</li> <li>0.00 Excess of reasonable cost (from line 18)</li> <li>1.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)</li> <li>2.00 Deductibles</li> <li>3.00 Coinsurance</li> <li>4.00 Allowable bad debts (see instructions)</li> <li>5.00 Utilization review</li> <li>6.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)</li> <li>7.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> </ul>		0	U	23.0
<ul> <li>6.00 Routine and Ancillary service other pass through costs</li> <li>7.00 Subtotal (sum of lines 22 through 26)</li> <li>8.00 Customary charges (title V or XIX PPS covered services only)</li> <li>9.00 Titles V or XIX (sum of lines 21 and 27)</li> <li>COMPUTATION OF REIMBURSEMENT SETLEMENT</li> <li>9.00 Excess of reasonable cost (from line 18)</li> <li>1.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)</li> <li>2.00 Deductibles</li> <li>3.00 Coinsurance</li> <li>4.00 Allowable bad debts (see instructions)</li> <li>5.00 Utilization review</li> <li>6.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)</li> <li>7.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> </ul>		0		24.0
<ul> <li>7.00 Subtotal (sum of lines 22 through 26)</li> <li>8.00 Customary charges (title V or XIX PPS covered services only)</li> <li>7.00 Titles V or XIX (sum of lines 21 and 27)</li> <li>COMPUTATION OF REIMBURSEMENT SETTLEMENT</li> <li>0.00 Excess of reasonable cost (from line 18)</li> <li>1.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)</li> <li>2.00 Deductibles</li> <li>3.00 Coinsurance</li> <li>4.00 Allowable bad debts (see instructions)</li> <li>5.00 Utilization review</li> <li>6.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)</li> <li>7.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> </ul>		0	0	
<ul> <li>8.00 Customary charges (title V or XIX PPS covered services only)</li> <li>9.00 Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT</li> <li>0.00 Excess of reasonable cost (from line 18)</li> <li>1.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)</li> <li>2.00 Deductibles</li> <li>3.00 Coinsurance</li> <li>4.00 Allowable bad debts (see instructions)</li> <li>5.00 Utilization review</li> <li>6.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)</li> <li>7.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> </ul>		0	0	
<ul> <li>9.00 Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT</li> <li>0.00 Excess of reasonable cost (from line 18)</li> <li>1.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)</li> <li>0.00 Deductibles</li> <li>3.00 Coinsurance</li> <li>4.00 Allowable bad debts (see instructions)</li> <li>0.00 Utilization review</li> <li>6.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)</li> <li>7.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> </ul>		0	0	
COMPUTATION OF REIMBURSEMENT SETTLEMENT0.00Excess of reasonable cost (from line 18)1.00Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)2.00Deductibles3.00Coinsurance4.00Allowable bad debts (see instructions)5.00Utilization review6.00Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)7.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		67, 168	Ő	
<ul> <li>0.00 Excess of reasonable cost (from line 18)</li> <li>1.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)</li> <li>2.00 Deductibles</li> <li>3.00 Coinsurance</li> <li>4.00 Allowable bad debts (see instructions)</li> <li>5.00 Utilization review</li> <li>6.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)</li> <li>7.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> </ul>		0,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
<ol> <li>Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)</li> <li>Deductibles</li> <li>Coinsurance</li> <li>Allowable bad debts (see instructions)</li> <li>Utilization review</li> <li>Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)</li> <li>OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> </ol>		0	0	30.0
<ul> <li>2.00 Deductibles</li> <li>3.00 Coinsurance</li> <li>4.00 Allowable bad debts (see instructions)</li> <li>5.00 Utilization review</li> <li>6.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)</li> <li>7.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> </ul>		67, 168	0	
<ul> <li>4.00 Allowable bad debts (see instructions)</li> <li>5.00 Utilization review</li> <li>6.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)</li> <li>7.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> </ul>		0	0	
<ul> <li>4.00 Allowable bad debts (see instructions)</li> <li>5.00 Utilization review</li> <li>6.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)</li> <li>7.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</li> </ul>		0	0	
5.00 Utilization review 6.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 7.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
7.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		35.0
		67, 168	0	36.0
8.00 Subtotal (line $36 \pm 1$ ine $37$ )		0	0	37.0
		67, 168	0	38.0
9.00 Direct graduate medical education payments (from Wkst. E-4)		0		39.0
0.00 Total amount payable to the provider (sum of lines 38 and 39)		67, 168	0	40.0
1.00 Interim payments		44, 240	0	
2.00 Balance due provider/program (line 40 minus line 41)			0	42.0
3.00 Protested amounts (nonallowable cost report items) in accordance with chapter 1, §115.2		22, 928	0	43.0

	Financial Systems PULASKI MEMORI E SHEET (If you are nonproprietary and do not maintain was accounting pagarda complete the Capacal Fund column	Provider C		eriod: rom 10/01/2016	u of Form CMS-2 Worksheet G	
una-t nl y)	ype accounting records, complete the General Fund column		T		Date/Time Pre 2/27/2018 12:	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
. 00	Cash on hand in banks	3, 047, 236	0	0	0	1.
. 00	Temporary investments	0	0	0	0	
. 00	Notes receivable	0	0	0	0	3.
. 00 . 00	Accounts receivable Other receivable	8, 582, 344	0	0	0	4. 5.
00	Allowances for uncollectible notes and accounts receivable	-4, 560, 455	-	0	0	
00	Inventory	753, 278		0	0	
00	Prepai d expenses	-10, 458	0	0	0	8.
00	Other current assets	2, 115, 093	0	0	0	
	Due from other funds	0 007 000	0	0	0	10.
1.00	Total current assets (sum of lines 1-10) FIXED ASSETS	9,927,038	0	0	0	11.
2.00	Land	195, 525	0	0	0	12.
3.00	Land improvements	432, 594	0	0	0	13.
	Accumulated depreciation	-348, 137	0	0	0	
	Buildings	12, 288, 972	0	0	0	15
	Accumulated depreciation Leasehold improvements	-6, 955, 812 187, 055	0	0	0	16
	Accumul ated depreciation	-170, 821	0	0	0	18
	Fi xed equi pment	7, 384, 556	°	0	0	19
	Accumulated depreciation	-4, 419, 372	0	0	0	20
	Automobiles and trucks	0	0	0	0	21
	Accumulated depreciation	0	0	0	0	
	Major movable equipment Accumulated depreciation	9, 004, 733 -7, 393, 276		0	0	23
	Minor equipment depreciable	-1, 393, 210	0	0	0	24
	Accumulated depreciation	0	0	0	0	26
	HIT designated Assets	0	0	0	0	27
	Accumulated depreciation	0	0	0	0	28
	Minor equipment-nondepreciable	0	0	0	0	29
. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	10, 206, 017	0	0	0	30
. 00	Investments	0	0	0	0	31
	Deposits on Leases	0		0	0	32
	Due from owners/officers	0	0	0	0	33
	Other assets	3, 419, 387	0	0	0	34
	Total other assets (sum of lines 31-34)	3, 419, 387	0	0	0	35
. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	23, 552, 442	0	0	0	30
. 00	Accounts payable	1, 154, 490	0	0	0	37
	Salaries, wages, and fees payable	1, 532, 658		0	0	
	Payroll taxes payable	0	0	0	0	
	Notes and Loans payable (short term) Deferred income	903, 575	0	0	0	40
	Accel erated payments	0	0	0	0	42
	Due to other funds	0	0	0	0	
	Other current liabilities	261, 576		0	0	
. 00	Total current liabilities (sum of lines 37 thru 44)	3, 852, 299	0	0	0	45
00	LONG TERM LI ABI LI TI ES				0	
	Mortgage payable Notes payable	4, 903, 586	0	0	0	
	Unsecured Loans	4, 703, 500	0	0	0	
	Other long term liabilities	2, 826, 366	0	0	0	49
. 00	Total long term liabilities (sum of lines 46 thru 49)	7, 729, 952	0	0	0	50
. 00	Total liabilities (sum of lines 45 and 50)	11, 582, 251	0	0	0	51
00	CAPITAL ACCOUNTS General fund balance	11 070 101				1 6 2
	Specific purpose fund	11, 970, 191	0			52 53
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		55
. 00	Governing body created - endowment fund balance			0		56
	Plant fund balance - invested in plant				0	57
. 00	Plant fund balance - reserve for plant improvement,				0	58
. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	11, 970, 191	0	0	0	59
	Total liabilities and fund balances (sum of lines 51 and	23, 552, 442		0	0	
	59)	20,002, 142	ı v	0	0	1 00

Health Financial Systems STATEMENT OF CHANGES IN FUND BALANCES	PULASKI MEMORIAI	Provider CC	N: 15-1305	Period: From 10/01/2016 To 09/30/2017	u of Form CMS- Worksheet G- Date/Time Pro	1
	General	Fund	Speci al	Purpose Fund	2/27/2018 12 Endowment Fund	
	1.00	2.00	3.00	4.00	5.00	
1.00Fund balances at beginning of period2.00Net income (loss) (from Wkst. G-3, line 29)3.00Total (sum of line 1 and line 2)4.00Additions (credit adjustments) (specify)5.006.007.008.009.00Total additions (sum of line 4-9)11.00Subtotal (line 3 plus line 10)12.00Deductions (debit adjustments) (specify)13.0014.0015.0015.0016.00Total deductions (sum of lines 12-17)19.00Fund balance at end of period per balance		2: 00 11, 856, 036 114, 155 11, 970, 191 0 11, 970, 191 0 11, 970, 191	3.00	4.00           0           0           0           0           0           0           0           0           0           0           0           0           0           0           0           0           0           0           0           0           0           0           0           0           0           0           0           0           0           0           0           0           0           0           0           0           0           0           0      0           0           0           0           0           0           0           0           0           0		5.00           6.00           7.00           8.00           9.00           10.00           11.00           12.00           13.00           14.00           15.00           16.00
sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
	6.00	7.00	8.00			
1.00Fund balances at beginning of period2.00Net income (loss) (from Wkst. G-3, line 29)3.00Total (sum of line 1 and line 2)4.00Additions (credit adjustments) (specify)5.006.007.008.009.009.00	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 10.00 Total additions (sum of line 4-9) 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) (specify) 13.00 14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 12-17)	00	0 0 0 0 0 0		0		9.00           10.00           11.00           12.00           13.00           14.00           15.00           16.00           17.00           18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)	0			ō		19.00

STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	HOSPITAL Provider C	CN: 15-1305	Peri od:	eu of Form CMS- Worksheet G-2	
				From 10/01/201 To 09/30/201	6 Parts I & II	epared:
	Cost Center Description		I npati ent	Outpati ent	Total	
			1.00	2.00	3.00	<u> </u>
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					1
1.00	Hospi tal		2, 159, 8	26	2, 159, 826	1.00
2.00	SUBPROVIDER - IPF					2.00
3.00	SUBPROVIDER - IRF					3.00
4.00	SUBPROVIDER					4.00
5.00	Swing bed - SNF		1	0	0	5.00
6.00	Swing bed - NF		1	0	0	6.00
7.00	SKILLED NURSING FACILITY		1			7.00
8.00	NURSING FACILITY		1			8.00
9.00	OTHER LONG TERM CARE		1			9.00
10.00	Total general inpatient care services (sum of lines 1-9)		2, 159, 8	26	2, 159, 826	10.00
	Intensive Care Type Inpatient Hospital Services					
11.00	I NTENSI VE CARE UNI T			0	0	11.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGICAL INTENSIVE CARE UNIT					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines		0	0	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16	)	2, 159, 8	26	2, 159, 826	17.00
18.00	Ancillary services		10, 889, 7	05 38, 310, 05	5 49, 199, 760	18.00
19.00	Outpatient services		216, 0	87 9, 322, 35	9, 538, 441	19.00
20.00	RURAL HEALTH CLINIC			0	0 0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0 0	21.00
22.00	HOME HEALTH AGENCY			792, 54	1 792, 541	22.00
23.00	AMBULANCE SERVICES					23.00
24.00	СМНС					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPI CE			0	0 0	26.00
27.00	PHYSI CI AN SERVI CES		342, 1	69 1, 294, 26	1, 636, 431	27.00
27.01	OTHER (SPECIFY)			0	0 0	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	13, 607, 7	87 49, 719, 21	2 63, 326, 999	28.00
	G-3, line 1)					
	PART II – OPERATING EXPENSES				-	
29.00	Operating expenses (per Wkst. A, column 3, line 200)			33, 284, 42	28	29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)				0	36.00
37.00	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)				0	42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 4	2)(transfer		33, 284, 42	28	43.00
	to Wkst. G-3, line 4)				1	1

Heal th	Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES		Provider CCN: 15-1305	Period: From 10/01/2016 To 09/30/2017	Worksheet G-3 Date/Time Prep 2/27/2018 12:0	pared:
				-	1.00	
1.00	Total patient revenues (from Wkst. G-2, Pa	rt I, column 3, lin	e 28)		63, 326, 999	1.00
2.00	Less contractual allowances and discounts	on patients' accoun	its		31, 149, 181	2.00
3.00	Net patient revenues (line 1 minus line 2)	1			32, 177, 818	3.00
4.00	Less total operating expenses (from Wkst.	G-2, Part II, line	43)		33, 284, 428	4.00
5.00	Net income from service to patients (line	3 minus line 4)			-1, 106, 610	5.00
	OTHER INCOME					
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				0	7.00
8.00	Revenues from telephone and other miscella	neous communication	servi ces		0	8.00
9.00	Revenue from television and radio service				0	9.00
10.00	Purchase di scounts				0	10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00	Parking lot receipts				0	12.00
13.00	Revenue from Laundry and Linen service				0	13.00
14.00	Revenue from meals sold to employees and g	juests			0	14.00
15.00	Revenue from rental of living quarters				0	15.00
16.00	Revenue from sale of medical and surgical	supplies to other t	han patients		0	16.00
17.00	Revenue from sale of drugs to other than p	atients			0	17.00
	Revenue from sale of medical records and a				0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms	s, etc.)			0	
	Revenue from gifts, flowers, coffee shops,	and canteen			0	
21.00	Rental of vending machines				0	21.00
22.00	Rental of hospital space				0	
	Governmental appropriations				0	
	OTHER INCOME				971, 511	
24.01	INVESTMENT INCOME				24, 788	24.01
24.02	OTHER NON OP				224, 466	
	Total other income (sum of lines 6-24)				1, 220, 765	
	Total (line 5 plus line 25)				114, 155	
	OTHER EXPENSES (SPECIFY)				0	
	Total other expenses (sum of line 27 and s				0	
29.00	Net income (or loss) for the period (line	26 minus line 28)			114, 155	29.00

	Financial Systems		PULASKI MEMORI	AL_HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ANALYS	SIS OF HOSPITAL-BASED HOME HEALT	TH AGENCY COSTS	i	Provider C HHA CCN:	F	eriod: rom 10/01/2016 o 09/30/2017	Worksheet H Date/Time Pre	pared:
						Home Health	2/27/2018 12: PPS	
				<u> </u>		Agency I		
		Sal ari es	Employee Benefits	n (see instructions)	Contracted/Pu rchased Servi ces	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
1.00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. & Fixtures			C		0	0	1.00
2.00	Capital Related - Movable Equipment			O		0	0	2.00
3.00 4.00	Plant Operation & Maintenance Transportation	0 0	0	0	0	-	0	
5.00	Administrative and General HHA REIMBURSABLE SERVICES	119, 982	0	70, 468	0	35, 313	225, 763	
6.00	Skilled Nursing Care	275, 465	0	0	0	0	275, 465	6.00
7.00	Physical Therapy	61, 788	0	0	-	-	61, 788	•
8.00 9.00	Occupational Therapy Speech Pathology	16, 469 861	0	0	0	-	16, 469 861	
10.00	Medical Social Services	0	0	0	0	0	0	
11.00	Home Health Aide	111, 143	0	0	0	-	111, 143	•
12.00 13.00	Supplies (see instructions) Drugs	0	0		-		0	
14.00	DME	0	0	0	0	0	0	
15.00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respi ratory Therapy	0	0	0			0	
17.00	Private Duty Nursing	0	0	0	-	-	0	
18.00 19.00	Clinic Health Promotion Activities	0	0	0	0	-	0	
20.00	Day Care Program	0	0	0	0	-	0	
21.00	Home Delivered Meals Program	0	0	0	0	-	0	
22.00 23.00	Homemaker Service All Others (specify)	0	0	0	0	-	0	
23.50	Tel emedi ci ne	0	0	0	0	-	0	
24.00	Total (sum of lines 1-23)	585, 708 Recl assi fi cat	0 Recl assi fi ed	70, 468		35, 313	691, 489	24.00
		ion	Trial Balance	Adjustments	Net Expenses for			
			(col. 6 +		Allocation			
			col . 7)		(col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
1.00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	0	0	0			1.00
	Fixtures							
2.00	Capital Related - Movable Equipment	0	0	U	0			2.00
3.00 4.00	Plant Operation & Maintenance Transportation	0	0	0				3.00 4.00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	-68, 589	157, 174	C	157, 174			5.00
6.00	Skilled Nursing Care	0	275, 465					6.00
7.00 8.00	Physical Therapy Occupational Therapy	0	61, 788 16, 469		61, 788 16, 469			7.00 8.00
9.00	Speech Pathol ogy	0	861	0				9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00 12.00	Home Health Aide Supplies (see instructions)	0	111, 143 0	0				11.00 12.00
13.00	Drugs	0	0	0	-			13.00
14.00		0	0	0	0			14.00
15.00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00 18.00		0	0	0	0			17.00 18.00
18.00 19.00		0	0	0				18.00
20.00	Day Care Program	0	0	O	-			20.00
21.00 22.00	e e e e e e e e e e e e e e e e e e e	0	0	0	0			21.00 22.00
	All Others (specify)	0	0	0	0			23.00
23.00						1		00 50
23.50	Telemedicine Total (sum of lines 1-23)	0 -68, 589	0 622, 900		622, 900			23.50 24.00

Heal th	Financial Systems		PULASKI MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
	LLOCATION - HHA GENERAL SERVICE	E COST			CN: 15-1305	Period: From 10/01/2016	Worksheet H-1 Part I	
				HHA CCN:	15-7078	To 09/30/2017	Date/Time Pre 2/27/2018 12:	pared:
						Home Health	PPS	
			Capital Rela	ited Costs		Agency I		
		Net Expenses for Cost	BI dgs & Fi xtures	Movabl e	Pl ant	Transportatio	Subtotal	-
		Allocation (from Wkst.	FIXIULES	Equi pment	Operation & Maintenance	n	(col s. 0-4)	
		H, col. 10) 0	1.00	2.00	3.00	4.00	4A. 00	
	GENERAL SERVICE COST CENTERS			2.00	3.00	4.00		
1.00	Capital Related - Bldg. & Fixtures	0	0				C	1.00
2.00	Capital Related - Movable	0		0			C	2.00
3.00	Equipment Plant Operation & Maintenance	0	0	C		D	C	3.00
4.00	Transportation	0	0	0		0 0	157 174	4.00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	157, 174	0	0	1	0 0	157, 174	5.00
6.00	Skilled Nursing Care Physical Therapy	275, 465 61, 788	0	0			275, 465	•
7.00 8.00	Occupational Therapy	16, 469	0	0		0 0	61, 788 16, 469	•
9. 00 10. 00	Speech Pathology Medical Social Services	861 0	0	0			861 0	
11.00	Home Heal th Ai de	111, 143	0	0		0 0	111, 143	
12.00 13.00	Supplies (see instructions) Drugs	0	0	0			0	
14.00	DME	0	0	0	1	0 0	0	
15.00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0	0		o o	0	15.00
16.00	Respiratory Therapy	0	0	0		0 0	0	16.00
17.00 18.00	Private Duty Nursing Clinic	0	0	0			0	
19.00	Health Promotion Activities	0	0	0		0 0	0	19.00
20.00 21.00	Day Care Program Home Delivered Meals Program	0	0	0			0	20.00 21.00
22.00	Homemaker Service	0	0	0		0 0	C	22.00
23.00 23.50	All Others (specify) Telemedicine	0	0	0		0 0 0 0	0	23.00 23.50
24.00	Total (sum of lines 1-23)	622, 900		0		0 0	622, 900	24.00
		Administrativ e & General	Total (cols. 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
	Equi pment							
3.00 4.00	Plant Operation & Maintenance Transportation							3.00 4.00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	157, 174						5.00
6.00	Skilled Nursing Care	92, 964	368, 429					6.00
7.00 8.00	Physical Therapy Occupational Therapy	20, 852 5, 558						7.00 8.00
9.00	Speech Pathology	291	1, 152					9.00
10.00 11.00	Medical Social Services Home Health Aide	0 37, 509	0 148, 652					10.00
12.00	Supplies (see instructions)	0	0					12.00
13.00 14.00	Drugs DME	0	0					13.00
	HHA NONREI MBURSABLE SERVI CES							
15.00 16.00	Home Dialysis Aide Services Respiratory Therapy	0	0					15.00 16.00
17.00	Private Duty Nursing	0	0					17.00
18. 00 19. 00	Clinic Health Promotion Activities	0	0					18.00 19.00
20.00	5 5	0	0					20.00 21.00
21.00 22.00	Home Delivered Meals Program Homemaker Service	0	0					21.00
23.00 23.50	All Others (specify) Telemedicine	0	0					23.00 23.50
	Total (sum of lines 1-23)		622, 900					23.50

	Financial Systems		PULASKI MEMORI		ON 15 1005		u of Form CMS-2	
COSTA	ALLOCATION - HHA STATISTICAL BAS	515		Provider C HHA CCN:	UN: 15-1305 15-7078	Period: From 10/01/2016 To 09/30/2017		pared:
						Home Health	PPS	<u>or pii</u>
						Agency I		
		Capital Rel	ated Costs					
		BIdgs &	Movabl e	PI ant	Transportati	o Reconciliatio	Administrativ	1
		Fixtures	Equipment	Operation &	n (MI LEAGE)	n	e & General	
		(SQUARE FEET)	(DOLLAR	Mai ntenance			(ACCUM. COST)	
		()	VALUE)	(SQUARE FEET)			(	
		1.00	2.00	3.00	4.00	5A. 00	5.00	
	GENERAL SERVICE COST CENTERS				•			
1.00	Capital Related - Bldg. &	0				0		1.0
	Fixtures							
2.00	Capital Related - Movable		0			0		2.0
	Equipment			_				
3.00	Plant Operation & Maintenance	0	0	0		0		3.0
4.00	Transportation (see	0	0	0		0		4.0
F 00	instructions)	0	0	0		0 157 174	4/5 70/	
5.00	Administrative and General HHA REIMBURSABLE SERVICES	0	0	0		0 -157,174	465, 726	5.C
6.00	Skilled Nursing Care	0	0	0		0 0	275, 465	6.0
7.00	Physical Therapy	0	0	0		0 0	61, 788	
8.00	Occupational Therapy	0	0	0		0 0	16, 469	
9.00	Speech Pathol ogy	0	0	0		0 0	861	
10.00	Medical Social Services	0	0	0		0 0	0	
11.00	Home Heal th Ai de	0	0	0		0 0	111, 143	
12.00	Supplies (see instructions)	0	0	0		0 0	0	
13.00	Drugs	0	0	0		0	-	
14.00	DME	0	0	0		0 0		
	HHA NONREI MBURSABLE SERVI CES		0			<u> </u>	°	1
15.00	Home Dialysis Aide Services	0	0	0		0 0	0	15. C
16.00	Respiratory Therapy	0	0	0		0 0	0	16.0
17.00	Private Duty Nursing	0	0	0		0 0	0	17.0
18.00	Clinic	0	0	0		0 0	0	18.0
19.00	Health Promotion Activities	0	0	0		0 0	0	19.0
20. 00	Day Care Program	0	0	0		0 0	0	20.0
21.00	Home Delivered Meals Program	0	0	0		0 0	0	21.0
22.00	Homemaker Service	0	0	0		0 0	0	
23.00	All Others (specify)	0	0	0		0 0	0	
23.50	Tel emedi ci ne	0	0	0		0 0	0	
24.00	Total (sum of lines 1-23)	0	0	0		0 -157, 174		
25.00	Cost To Be Allocated (per	0	0	0		0	157, 174	25.0
	Worksheet H-1, Part I)		0 000	0.000				
26.00	Unit Cost Multiplier	0. 000000	0. 000000	0.000000	0.00000	00	0. 337482	26. 0

LUCA	TION OF GENERAL SERVICE COSTS 7	FO HHA COST CEN	ITERS	Provider C	CN: 15-1305	Period:	Worksheet H-2	)
				HHA CCN:	15-7078	From 10/01/2016 To 09/30/2017		eparec 01 pr
						Home Health Agency I	PPS	
			CAPI TAL			Agency		
	Cost Center Description	HHA Trial Balance (1)	RELATED COSTS NEW BLDG & FI XT	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	ADMI NI STRATI V E & GENERAL	OPERATION OF PLANT	-
		0	1.00	4.00	4A	5.00	7.00	
00	Administrative and General	0	13, 605	172, 064	185, 60	69 35, 596	15, 062	1. (
00	Skilled Nursing Care	368, 429		0	368, 42		0	
00	Physical Therapy	82, 640	0	0	82, 64		0	
00 00	Occupational Therapy Speech Pathology	22, 027	0	0	22, 02		0	1
00 00	Medical Social Services	1, 152	0	0	1, 15	52 221 0 0	0	
00	Home Health Aide	148, 652	0	0	148, 65	-	0	
00	Supplies (see instructions)	0	0	0		0 0	0	
00	Drugs	0	0	0		0 0	0	
00	DME	0	0	0		0 0	0	10.
00	Home Dialysis Aide Services	0	0	0		0 0	0	
00	Respiratory Therapy	0	0	0		0 0	0	
00	Private Duty Nursing	0	0	0		0 0	0	
00 00	Clinic Health Promotion Activities	0	0	0		0 0	0	
00	Day Care Program		0	0			0	
00	Home Delivered Meals Program	0	0	0		0 0	0	
00	Homemaker Service	0	0	0		0 0	0	
00	All Others (specify)	0	0	0		0 0	0	
50	Tel emedi ci ne	0	0	0		0 0	0	19.
00	Total (sum of lines 1-19) (2)	622, 900	13, 605	172, 064	808, 50	69 155, 017	15, 062	20.
00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to				0. 00000	00		21.
	<u>6 decimal places.</u> Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	NURSI NG ADMI NI STRATI	CENTRAL 0 SERVICES &	PHARMACY	
					N	SUPPLY		
)0		8.00	9.00	10.00	13.00	0 0	15.00	
0	Administrative and General Skilled Nursing Care		4, 332	0		0 0	0	
0	Physical Therapy	0	0	0		0 0	0	
0	Occupational Therapy	0	0	0		0 0	0	
0	Speech Pathology	0	0	0		0 0	0	5
0	Medical Social Services	0	0	0		0 0	0	
0	Home Health Aide	0	0	0		0 0	0	
0	Supplies (see instructions)	0	0	0		0 0	0	
0 00	Drugs DME	0	0	0		0 0	0	
00	Home Dialysis Aide Services		0	0			0	
00	Respiratory Therapy	0	0	0		0 0	0	
00	Private Duty Nursing	0	Ő	0		0 0	0	
	Clinic	0	0	0		0 0	0	
00	Health Promotion Activities	0	0	0		0 0	0	15
	Day Care Program	0	0	0		0 0	0	
00	Home Delivered Meals Program	0	0	0		0 0	0	
00	Homemaker Service		0	0		0 0	0	
	All Others (specify)	0	0	0		0 0	0	
50 00	Telemedicine Total (sum of lines 1–19) (2)		0 4, 352	0			0	
00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to		4, 352	0		0	0	20.

(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.

LOCATION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS	Provider CO	CN: 15-1305	Period: From 10/01/2016	Worksheet H-2 Part I	
			HHA CCN:	15-7078	To 09/30/2017	Date/Time Pre 2/27/2018 12:	pare 01 p
					Home Health Agency I	PPS	
Cost Center Description	MEDI CAL	SOCI AL	Subtotal	Intern &	Subtotal	Allocated HHA	
	RECORDS & LI BRARY	SERVI CE		Residents Cost & Post	+	A&G (see Part	
	LI DKAKT			Stepdown		11)	
				Adjustments			
00 Administrative and Conserve	16.00	17.00	24.00	25.00	26.00	27.00	1
00 Administrative and General 00 Skilled Nursing Care	7, 637 0	0	248, 316 439, 063		0 248, 316 0 439, 063		1. 2.
00 Physical Therapy	0	0	98, 484		0 98, 484		
00 Occupational Therapy	0	0	26, 250		0 26, 250		
00 Speech Pathology	0	0	1, 373		0 1, 373 0 0		
00 Medical Social Services 00 Home Health Aide	0	0	0 177, 151		0 177, 151	-	
00 Supplies (see instructions)	0	0	0		0 0		
00 Drugs	0	0	0		0 0	-	
0.00 DME	0	0	0		0 0	-	
.00 Home Dialysis Aide Services 2.00 Respiratory Therapy	0	0	0		0 0 0 0	0	11. 12.
8.00 Private Duty Nursing	0	0	0		0 0	-	
. 00 Clinic	0	0	0		0 0	-	
5.00 Health Promotion Activities	0	0	0		0 0	-	-
.00 Day Care Program .00 Home Delivered Meals Program	0	0	0 0		0 0 0 0	0	
8.00 Homemaker Service	0	0	0		0 0		
.00 All Others (specify)	0	0	0		0 0	0	
9.50 Tel emedicine	0	0	0		0 0		19.
0.00 Total (sum of lines 1–19) (2) 1.00 Unit Cost Multiplier: column	7,637	0	990, 637		0 990, 637	248, 316 0. 334513	
26, line 1 divided by the sum						0. 334513	21.
of column 26, line 20 minus							
column 26, line 1, rounded to							
<u>6 decimal places.</u> Cost Center Description	Total HHA			<u> </u>			
	Costs						
	28.00						
00 Administrative and General 00 Skilled Nursing Care	585, 936						1. 2.
00 Physical Therapy	131, 428						3.
00 Occupational Therapy	35, 031						4.
00 Speech Pathology	1, 832						5.
00 Medical Social Services 00 Home Health Aide	0 236, 410						6. 7.
00 Supplies (see instructions)	230, 410						8.
00 Drugs	0						9.
. OO DME	0						10.
.00 Home Dialysis Aide Services .00 Respiratory Therapy	0						11. 12.
. 00 Private Duty Nursing	0						12.
. 00 Clinic	0						14.
.00 Health Promotion Activities	0						15.
. 00 Day Care Program	0						16.
.00 Home Delivered Meals Program .00 Homemaker Service	0						17. 18.
0.00 All Others (specify)	0						19.
7.50 Tel emedi ci ne	0						19.
0.00 Total (sum of lines 1-19) (2)	990, 637						20.
I.00 Unit Cost Multiplier: column 26, line 1 divided by the sum							21.
of column 26, line 20 minus							
column 26, line 1, rounded to							

(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.

Health Financial Systems		PULASKI MEMORI				u of Form CMS-	
ALLOCATION OF GENERAL SERVICE COSTS T BASIS	O HHA COST CEN	TERS STATISTIC	CAL Provider C HHA CCN:	CN: 15-1305 15-7078	Period: From 10/01/2016 To 09/30/2017		epared:
					Home Health Agency I	PPS	
Cost Center Description	CAPI TAL RELATED COSTS NEW BLDG & FI XT (SQUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	Reconci I i ati o n	ADMI NI STRATI E & GENERAL (ACCUM. COST)	V OPERATION OF	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	-
	1.00	4.00	5A	5.00	7.00	8.00	
<ol> <li>Administrative and General</li> <li>O Skilled Nursing Care</li> <li>O Physical Therapy</li> <li>O Occupational Therapy</li> <li>O Occupational Therapy</li> <li>O Ospeech Pathology</li> <li>O Medical Social Services</li> <li>O Home Health Aide</li> <li>Sou Supplies (see instructions)</li> <li>O Drugs</li> <li>O ME</li> <li>O Home Dialysis Aide Services</li> <li>O Respiratory Therapy</li> <li>O Clinic</li> <li>O Ay Care Program</li> <li>O Home Belivered Meals Program</li> <li>O Home Belivered Meals Program</li> <li>O All Others (specify)</li> <li>O Telemedicine</li> </ol>	652 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	517, 118 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		368, 4 82, 6 22, 0 1, 1 148, 6	29       0         40       0         27       0         52       0         52       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 13.00 14.00 15.00 17.00 18.00 19.50
20.00 Total (sum of lines 1-19) 21.00 Total cost to be allocated 22.00 Unit cost multiplier Cost Center Description	652 13, 605 20. 866564 HOUSEKEEPI NG (SQUARE FEET)	517, 118 172, 064 0. 332736 DI ETARY (MEALS SERVED)	NURSI NG ADMI NI STRATI O N	808, 5 155, 0 0. 1917 CENTRAL SERVI CES & SUPPLY	17 15, 062 18 23. 101227 PHARMACY	0 0. 000000 MEDI CAL RECORDS & LI BRARY	
			(DI RECT NRSI NG HRS)	(100%)		(GROSS CHARGES)	
	9.00	10.00	13.00	14.00	15.00	16.00	
<ol> <li>Administrative and General</li> <li>O Skilled Nursing Care</li> <li>O Physical Therapy</li> <li>O Occupational Therapy</li> <li>O Occupational Therapy</li> <li>Seech Pathology</li> <li>O Medical Social Services</li> <li>O Home Health Aide</li> <li>O Supplies (see instructions)</li> <li>O Drugs</li> <li>O DME</li> <li>O Respiratory Therapy</li> <li>O Respiratory Therapy</li> <li>O Private Duty Nursing</li> <li>O Day Care Program</li> <li>O Home Delivered Meals Program</li> <li>O Home Service</li> <li>O All Others (specify)</li> <li>O Telemedicine</li> <li>O Total cost to be allocated</li> <li>O Unit cost multiplier</li> </ol>	652 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0	792, 541 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.

Health Financial Systems		PULASKI MEMORIAL	HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
ALLOCATION OF GENERAL SERVICE COSTS	TO HHA COST CEN	ITERS STATI STI CAL	Provi der	CCN: 15-1305	Period:	Worksheet H-2	
BASIS			HHA CCN:	15-7078	From 10/01/2016 To 09/30/2017	Part II Date/Time Pre	pared:
						2/27/2018 12:	
					Home Health	PPS	
	C001 A1				Agency I		
Cost Center Description	SOCI AL SERVI CE						
	(ALLOCATION						
	OF TIME)						
	17.00				-		
1.00 Administrative and General	0						1.00
2.00 Skilled Nursing Care	0						2.00
3.00 Physical Therapy	0						3.00
4.00 Occupational Therapy	0						4.00
5.00 Speech Pathology	0						5.00
6.00 Medical Social Services	0						6.00
7.00 Home Health Aide	0						7.00
8.00 Supplies (see instructions) 9.00 Drugs	0						8.00 9.00
9. 00 Drugs 10. 00 DME	0						9.00
11.00 Home Dialysis Aide Services							11.00
12. 00 Respiratory Therapy	0						12.00
13.00 Private Duty Nursing	0						13.00
14.00 Clinic	0						14.00
15.00 Health Promotion Activities	0						15.00
16.00 Day Care Program	0						16.00
17.00 Home Delivered Meals Program	0						17.00
18.00 Homemaker Service	0						18.00
19.00 All Others (specify)	0						19.00
19.50 Telemedicine	0						19.50
20.00 Total (sum of lines 1-19) 21.00 Total cost to be allocated							20.00 21.00
22.00 Unit cost multiplier	0. 000000						21.00
	0.00000						22.00

Heal th	Financial Systems		PULASKI MEMORI	I AL HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORT	IONMENT OF PATIENT SERVICE COS	ſS		Provider C		Peri od:	Worksheet H-3	
				HHA CCN:		From 10/01/2016 To 09/30/2017		pared: 01 pm
				Title	e XVIII	Home Health Agency I	PPS	<u>or piii</u>
	Cost Center Description	From, Wkst.	Facility	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I,	Costs (from	Ancillary	Costs (cols.		Per Visit	
		col. 28, line	Wkst. H-2,	Costs (from	1 + 2)		(col. 3 ÷	
			Part I)	Part II)			col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE	PROGRAM COST, A	AGGREGATE OF T	HE PROGRAM LI	MITATION COST, C	DR BENEFICIARY	
	COST LIMITATION							
	Cost Per Visit Computation							1
1.00	Skilled Nursing Care	2.00	585, 936		585, 93	6 1, 197	489.50	1.00
2.00	Physical Therapy	3.00	131, 428	l o	131, 42	8 574	228.97	2.00
3.00	Occupational Therapy	4.00						1
4.00	Speech Pathology	5.00						
5.00	Medical Social Services	6.00				0 0		
6.00	Home Heal th Ai de	7.00			236, 41			
		7.00						
7.00	Total (sum of lines 1-6)		990, 637	0	990, 63			7.00
					Program Visit	S		
			1		D	unt D		-
			0000 11 (1)		-	irt B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject	Subject to		
					to	Deducti bl es		
					Deductibles a	Š.		
					Coi nsurance			
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation		L		1	-	1	
8.00	Skilled Nursing Care		99915	0				8.00
9.00	Physi cal Therapy		99915	0	54	1		9.00
10.00	Occupational Therapy		99915	0	13	4		10.00
11.00	Speech Pathology		99915	0	)	8		11.00
12.00	Medical Social Services		99915	0		0		12.00
13.00	Home Health Aide		99915	0	68	0		13.00
14.00	Total (sum of lines 8-13)			0	2, 38	6		14.00
	Cost Center Description	From Wkst.	Facility	Shared	Total HHA	Total Charges	Ratio (col. 3	
		H-2 Part I,	Costs (from	Ancillary	Costs (cols.	(from HHĂ	÷ col. 4)	
		col. 28, line		Costs (from	1 + 2)	Records)		
			Part I)	Part II)				
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Comput	ations						
15.00	Cost of Medical Supplies	8.00	0	0		0 0	0.000000	15 00
16.00	Cost of Drugs	9.00		-		0 0		
	]		Program Visits	-	Cost of	-		
			riogram troiteo		Servi ces			
			Par	t B	00.11000	Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
	obst center bescription		to	Deductibles &		to	Deductibles &	
			Deductibles &			Deductibles &		
			Coi nsurance	corrisul ance			corrisul ance	
		6.00		8.00	9.00	Coi nsurance 10.00	11.00	
	PART I - COMPUTATION OF LESSER	6.00	7.00					
	COST LIMITATION	OF AGGREGATE	I ROURAW CUST, I	NUORLOATE UF I	IL FROGRAW LI	WITATION COST, C	JA DENELTUTARY	
	Cost Per Visit Computation							1
1.00	Skilled Nursing Care	0	1,023			0 500, 759		1.00
2.00	Physical Therapy					0 500, 759		2.00
3.00	Occupational Therapy	0				0 30, 681		3.00
4.00	Speech Pathology	0				0 1,832		4.00
5.00	Medical Social Services	0				0 0		5.00
6.00	Home Health Aide	0				0 104, 054		6.00
7.00	Total (sum of lines 1-6)	0	2, 386			0 761, 199	1	7.00

	Financial Systems		PULASKI MEMOR				u of Form CMS-	
APPORT	FIONMENT OF PATIENT SERVICE COST	S		Provider C HHA CCN:	CN: 15-1305 15-7078	Period: From 10/01/2016 To 09/30/2017	Worksheet H-3 Part I Date/Time Pre 2/27/2018 12:	epared:
				Title	e XVIII	Home Health Agency I	PPS	
	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
8.00	Limitation Cost Computation Skilled Nursing Care			1				8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00								12.00
13.00	Home Health Aide							13.00
	Total (sum of lines 8-13)							14.00
		Prog	ram Covered Cha	arges	Cost of			
		5		5	Servi ces			
			Par	rt B		Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
			to	Deductibles &		to	Deductibles &	
			Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
			Coi nsurance			Coi nsurance		
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Comput		-	-	1		-	
15.00	Cost of Medical Supplies	0	-			0 0	C	
16.00	Cost of Drugs	TILL DI	0	0		0	0	16.00
	Cost Center Description	Total Program						
		Cost (sum of						
		col s. 9-10) 12.00						-
	PART I - COMPUTATION OF LESSER		DDOCDAM COST					
	COST LIMITATION	UF AGGREGATE	PROGRAW CUST,	AGGREGATE OF T	TE PROGRAM L	IMITATION COST, O	K DENEFICIARI	
	Cost Per Visit Computation							-
1.00	Skilled Nursing Care	500, 759						1.00
2.00	Physical Therapy	123, 873						2.00
3.00	Occupational Therapy	30, 681						3.00
4.00	Speech Pathol ogy	1, 832						4.00
5.00	Medical Social Services	1,032						5.00
6.00	Home Heal th Ai de	104,054						6.00
7.00	Total (sum of lines 1-6)	761, 199						7.00
7.00	Cost Center Description	701,177						7.00
	best conter beschiption	12.00						1
	Limitation Cost Computation	.2.00	1					
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathol ogy							11.00
12.00	Medical Social Services							12.00
13.00	Home Heal th Aide							13.00
	Total (sum of lines 8-13)							14.00
14.00	Tiorai (Sulli Di Titles o-13)		I					14.

Health Financial Systems		PULASKI MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF PATIENT SERVICE COST	TS		Provider C	CN: 15-1305	Period:	Worksheet H-3	
			HHA CCN:	15-7078	From 10/01/2016 To 09/30/2017		
			Title	XVIII	Home Health	PPS	•
					Agency I		
Cost Center Description	From Wkst. C,	Cost to	Total HHA	HHA Shared	Transfer to		
	Part I, col.	Charge Ratio	Charge (from	Ancillary	Part I as		
	9, line		provi der	Costs (col.	1 Indicated		
			records)	x col. 2)			
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COS	T OF HHA SERVI	CES FURNI SHED	BY SHARED HOSP	TAL DEPARTME	INTS		
1.00 Physical Therapy	66.00	0. 502435	0		0 col. 2, line 2	. 00	1.00
2.00 Occupational Therapy	67.00	0. 560896	0		Ocol. 2, line 3	. 00	2.00
3.00 Speech Pathology	68.00	0. 908695	0		0 col. 2, line 4	. 00	3.00
4.00 Cost of Medical Supplies	71.00	0. 267502	0		0 col. 2, line 1	5.00	4.00
5.00 Cost of Drugs	73.00	0. 261447	0		0 col. 2, line 1	6.00	5.00
-							

	Financial Systems PULASKI MEMORIAL		N. 15 1005		eu of Form CMS-2	
CALCUL	ATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CC	CN: 15-1305	Period: From 10/01/2016	Worksheet H-4  Part I-II	
		HHA CCN:	15-7078	To 09/30/2017		
		Title	XVIII	Home Health	PPS	•
				Agency I		
			Part A	Not Subject	rt B Subject to	
			Part A	to	Deductibles &	
				Deductibles &		
				Coi nsurance		
			1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUST	FOMARY CHARGE	S			
. 00	Reasonable Cost of Part A & Part B Services Reasonable cost of services (see instructions)			0 0	0	1 1.0
. 00	Total charges					
. 00	Customary Charges				/	
. 00	Amount actually collected from patients liable for payment for	or services		0 0	0	3.0
	on a charge basis (from your records)					
1.00	Amount that would have been realized from patients liable for			0 0	0	4.0
	for services on a charge basis had such payment been made in	accordance				
. 00	with 42 CFR §413.13(b) Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	0. 000000	0. 000000	5.0
o. 00 o. 00	Total customary charges (see instructions)		0.0000	0 0.00000		
. 00	Excess of total customary charges over total reasonable cost	(complete		0 0	-	
	only if line 6 exceeds line 1)	(				
. 00	Excess of reasonable cost over customary charges (complete or	nlyifline		0 0	0	8. (
. 00	1 exceeds line 6) Primary payer amounts			0 0	0	9.
		1		Part A	Part B	
				Servi ces	Servi ces	
				1.00	2.00	
0.00	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT Total reasonable cost (see instructions)			0		10.0
1.00	Total PPS Reimbursement - Full Episodes without Outliers					
2.00	Total PPS Reimbursement - Full Episodes with Outliers			C	8, 231	
3.00	Total PPS Reimbursement - LUPA Episodes			C	7, 695	13.
4.00	Total PPS Reimbursement - PEP Episodes			C	0	
5.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	5		C	2, 524	
6.00	Total PPS Outlier Reimbursement - PEP Episodes			0	0	
7.00 8.00	Total Other Payments DME Payments					
9.00	Oxygen Payments					
0.00	Prosthetic and Orthotic Payments			C	o o	
1.00	Part B deductibles billed to Medicare patients (exclude coins	surance)			0	21.
2.00	Subtotal (sum of lines 10 thru 20 minus line 21)			C	348, 600	22.
3.00	Excess reasonable cost (from line 8)			C	0	
4.00	Subtotal (line 22 minus line 23)			C	348, 600	
5.00	Coinsurance billed to program patients (from your records)				0	
	Net cost (line 24 minus line 25)			C	348, 600	
7.00	Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see i	nstructions)				27. 28.
	<b>3</b>			C	348, 600	
8.00	LIGTAL COSTS - CUFFERT COST FEDOLLING DEFLOG (LINE 26 DIUS LIF	10 21)				
8.00 9.00	Total costs - current cost reporting period (line 26 plus lir OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				o o	
8.00 9.00 0.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	ns)			/	
8.00 9.00 0.00 0.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ns)		0	0	30.
8.00 9.00 0.00 0.50 0.99 1.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Subtotal (see instructions)	าร)			0 0 348, 600	31.
8.00 9.00 0.00 0.50 0.99 1.00 1.01	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Subtotal (see instructions) Sequestration adjustment (see instructions)	าร)			0 348, 600 6, 972	31. 31.
8.00 9.00 0.00 0.50 0.99 1.00 1.01 1.01	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration	ns)			0 348, 600 6, 972 0	31. 31. 31.
8.00 9.00 0.00 0.50 0.99 1.00 1.01 1.02 2.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Interim payments (see instructions)	ns)			0 348, 600 6, 972 0 341, 629	31. 31. 31. 32.
28.00           29.00           30.00           30.50           30.99           31.00           31.02           32.00           33.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Interim payments (see instructions) Tentative settlement (for contractor use only)			C	0 348,600 6,972 0 341,629 0	31.0 31.0 31.0 32.0 33.0
8.00         9.00         0.00         0.50         0.99         1.00         1.01         1.02         2.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Interim payments (see instructions)	and 33)	6 Pub. 15-2		0 348,600 6,972 0 341,629 0	31.0 31.0 31.0 32.0 33.0 34.0

	SIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED	Provider C	CN: 15-1305		eriod:	Worksheet H-5	
PR(	OGRAM BENEFI CI ARI ES	HHA CCN:	15-7078	T	rom 10/01/2016 p 09/30/2017	Date/Time Prep 2/27/2018 12:0	
					Home Health Agency I	PPS	
		Inpatien	t Part A		Par	t B	
		mm/dd/yyyy 1.00	Amount 2.00		mm/dd/yyyy 3.00	Amount 4.00	
00	Total interim payments paid to provider	1.00	2.00	0	3.00	341, 629	1.
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,			0		0	2.
00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3
	Program to Provider						
)1				0		0	3
)2 )3				0 0		0	3
)4				0		0	3
)5				0		0	3
0	Provider to Program			0		0	3
1				0		0	3
2				0		0	3
53				0		0	3
54 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0		0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32) TO BE COMPLETED BY CONTRACTOR			0		341, 629	4
0	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)						
)1	Program to Provider			0		0	5
)2				0		0	5
)3	Dravidar to Dragnam			0		0	5
0	Provider to Program			0		0	5
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) Determined net settlement amount (balance due) based on			0		0	5
	the cost report. (1)						
)1 )2	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM			0 0		0	6
)2 )0	Total Medicare program liability (see instructions)			0		341, 628	7
			·		Contractor Number	NPR Date (Mo/Day/Yr)	
		(	C		1.00	2.00	

	Financial Systems	PULASKI MEMORI	AL_HOSPI TAL				u of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1305		eriod:	Worksheet M-1	
			Component	CCN: 15-8512	+ I   T (	rom 10/01/2016 o 09/30/2017	Date/Time Pre	pared:
							2/27/2018 12:	01 pm
					L	RHC I	Cost	
		Compensati on	Other Costs		1	Recl assi fi cat	Recl assi fi ed	
				+ col. 2)		i ons	Trial Balance	
							(col. 3 +	
		1.00	2.00	3.00		4.00	<u>col. 4)</u> 5.00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	5.00		4.00	5.00	
1.00	Physician	2, 567, 833	40, 594	2, 608, 4	27	-433, 429	2, 174, 998	1.00
2.00	Physician Assistant	2, 307, 033	40, 374		27	-433, 427	2, 174, 770	2.00
3.00	Nurse Practitioner	228, 406	-		06	-40, 904	187, 502	3.00
4.00	Visiting Nurse	220, 400	0		00	40, 704	0	4.00
5.00	Other Nurse	129, 610	-		10	0	129, 610	5.00
6.00	Clinical Psychologist	127,010	0	127,0	0	0	0	6.00
7.00	Clinical Social Worker	0	0		0	0	0	7.00
8.00	Laboratory Techni ci an	0	0		0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	496, 771	0	496.7	71	0	496, 771	9.00
10.00	Subtotal (sum of lines 1 through 9)	3, 422, 620	40, 594			-474, 333	2, 988, 881	10.00
11.00	Physician Services Under Agreement	0	68, 667	68, 6		0	68, 667	11.00
12.00	Physician Supervision Under Agreement	0	0		0	0	0	12.00
13.00	Other Costs Under Agreement	0	0		0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	68, 667	68, 6	67	0	68, 667	14.00
15.00	Medical Supplies	0	32, 509	32, 5	09	0	32, 509	15.00
16.00	Transportation (Health Care Staff)	0	0		0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	1	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	1	0	0	0	18.00
19.00	Other Health Care Costs	0	0	1	0	0	0	19.00
20.00	Allowable GME Costs							20.00
21.00	Subtotal (sum of lines 15 through 20)	0	32, 509	32, 5	09	0	32, 509	21.00
22.00	Total Cost of Health Care Services (sum of	3, 422, 620	141, 770	3, 564, 3	90	-474, 333	3, 090, 057	22.00
	lines 10, 14, and 21)							
	COSTS OTHER THAN RHC/FQHC SERVICES			1				
23.00	Pharmacy	0	-		0	0	0	23.00
24.00	Dental	0	0		0	0	0	24.00
25.00	Optometry	0	0		0	0	0	25.00
25.01	Tel eheal th	0	0		0	0	0	25.01
25.02	Chronic Care Management	0	0		0	0	0	25.02
26.00	All other nonreimbursable costs	0	0		0	0	0	26.00
27.00	Nonallowable GME costs				~	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	0	28.00
	through 27) FACILITY OVERHEAD							
29.00	FACILITY OVERHEAD Facility Costs	0	115, 440	115, 4	40	0	115, 440	29.00
30.00	Administrative Costs	634, 132				-313, 596	459, 745	30.00
30.00	Total Facility Overhead (sum of lines 29 and					-313, 596		31.00
51.00	30)	007, 102	237,047	000,7	51	515, 570	373,103	51.00
32.00	Total facility costs (sum of lines 22, 28	4,056,752	396, 419	4, 453, 1	71	-787,929	3, 665, 242	32.00
	and 31)	.,,,	,,	.,		, /2/	-,,	
	and 31)							

llool th	Financial Systems					u of Form CNC	2552 10
	Financial Systems	PULASKI MEMORI	Provider C	CNI 15 1205	Peri od:	u of Form CMS- Worksheet M-1	
ANALIS	IS OF HUSPITAL-DASED RHC/FUHC CUSIS		Provider C	CN. 15-1505	From 10/01/2016	WOLKSHEEL M-	I
			Component	CCN: 15-8512	To 09/30/2017	Date/Time Pre	
						2/27/2018 12:	01 pm
					RHC I	Cost	
		Adjustments	Net Expenses				
			for				
			Allocation				
			(col. 5 +				
		( 00	col. 6)	-			
		6. 00	7.00				-
1.00	FACILITY HEALTH CARE STAFF COSTS Physician	0	2, 174, 998	1			1.00
2.00	Physician Assistant	0	2, 174, 990	1			2.00
2.00	Nurse Practitioner	0	187, 502	1			2.00
3.00 4.00	Visiting Nurse	0	167, 502				4.00
4.00 5.00	Other Nurse	0	129, 610				5.00
6.00	Clinical Psychologist	0	129,010	1			6.00
7.00	Clinical Social Worker	0	0				7.00
7.00 8.00	Laboratory Technician	0	0	1			8.00
9.00	Other Facility Health Care Staff Costs	0	496, 771				9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2, 988, 881				10.00
11.00	Physician Services Under Agreement	0	68, 667				11.00
12.00	Physician Supervision Under Agreement	0	08,007				12.00
	Other Costs Under Agreement	0	0				12.00
14.00	Subtotal (sum of lines 11 through 13)	0	68, 667				14.00
	Medical Supplies	0	32, 509				14.00
	Transportation (Health Care Staff)	0	32, 509	1			16.00
	Depreciation-Medical Equipment	0	0	1			17.00
	Professional Liability Insurance	0	0				18.00
	Other Heal th Care Costs	0	0				19.00
	Allowable GME Costs	0	0				20.00
	Subtotal (sum of lines 15 through 20)	0	32, 509				21.00
	Total Cost of Health Care Services (sum of	0	3, 090, 057	•			22.00
22.00	lines 10, 14, and 21)	0	0,070,007				22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			1			
23.00	Pharmacy	0	0	)			23.00
24.00	Dental	0	0				24.00
25.00	Optometry	0	0				25.00
25.01	Tel eheal th	0	0				25.01
25.02	Chronic Care Management	0	0				25.02
26.00	All other nonreimbursable costs	0	0				26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0				28.00
	through 27)						
	FACILITY OVERHEAD						
	Facility Costs	0	115, 440	1			29.00
30.00	Administrative Costs	-8, 130	451, 615	1			30.00
31.00	Total Facility Overhead (sum of lines 29 and	-8, 130	567,055				31.00
	30)						0.0.77
32.00	Total facility costs (sum of lines 22, 28	-8, 130	3, 657, 112				32.00
	and 31)			1			I

Health Financial Systems	PULASKI MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-2	2552-1
ALLOCATION OF OVERHEAD TO HOSPITAL-BASE	RHC/FQHC SERVICES	Provider C		Period:	Worksheet M-2	
		Component		rom 10/01/2016 0 09/30/2017		nared
		component		0775072017	2/27/2018 12:	
		_	_	RHC I	Cost	
	Number of FTE	Total Visits	Producti vi ty	Mi ni mum	Greater of	
	Personnel		Standard (1)	Visits (col.	col. 2 or	
				1 x col. 3)	col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Posi ti ons		1			1	
. 00 Physi ci an	4.98					1.0
.00 Physician Assistant	0.00					2.0
.00 Nurse Practitioner	2.68					3.0
.00 Subtotal (sum of lines 1 through			1	26, 544		4.0
.00 Visiting Nurse	0.00				0	5.0
00 Clinical Psychologist	0.00				0	6.
.00 Clinical Social Worker	0.00				0	7.(
.01 Medical Nutrition Therapist (FQH					0	1
. 02 Diabetes Self Management Training	(FQHC 0.00				0	7.0
only)		00.700			04 544	
5.00 Total FTEs and Visits (sum of lin	ies 4 7.66	22, 702			26, 544	8.0
through 7) 2.00 Physician Services Under Agreeme	+	272			272	9.0
.00 Physician Services Under Agreemen	ls	212			272	9.0
					1.00	
DETERMINATION OF ALLOWABLE COST A	PPLICABLE TO HOSPITAL-BAS	ED RHC/FQHC SE	RVI CES			
0.00 Total costs of health care servio	es (from Wkst. M-1, col.	7, line 22)			3, 090, 057	1 10.0
1.00 Total nonreimbursable costs (from	Wkst. M-1, col. 7, line	28)			0	11.0
2.00 Cost of all services (excluding (	verhead) (sum of lines 10	) and 11)			3, 090, 057	12. (
3.00 Ratio of hospital-based RHC/FQHC	services (line 10 divided	l by line 12)			1.000000	13.0
4.00 Total hospital-based RHC/FQHC over	rhead - (from Worksheet.	M-1, col. 7, I	ine 31)		567, 055	14.0
5.00 Parent provider overhead allocate	d to facility (see instru	icti ons)			2, 481, 576	15.0
6.00 Total overhead (sum of lines 14 a	nd 15)				3, 048, 631	16.0
7.00 Allowable GME overhead (see inst	uctions)				0	17.0
8.00 Enter the amount from line 16					3, 048, 631	18.
9.00 Overhead applicable to hospital-I	ased RHC/FQHC services (I	ine 13 x line	18)		3, 048, 631	19.0
20 00 Total allowable cost of bospital	hased RHC/FOHC services (	sum of lines 1	0 and 19)		6 138 688	20 0

20.00Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)6,138,68820.00

	Financial Systems PULASKI MEMORIAL			u of Form CMS-2	
CALCUL SERVI (	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1305	Period: From 10/01/2016	Worksheet M-3	
SERVIC	'ES	Component CCN: 15-8512	To 09/30/2017	Date/Time Pre	pared:
				2/27/2018 12:	01 pm
		Title XVIII	RHC I	Cost	
				1.00	
	DETERMINATION OF DATE FOR HOSPITAL PACED DUC/FOUR SERVICES			1.00	
1.00	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES Total Allowable Cost of hospital-based RHC/FOHC Services (fro	www.kst M 2 line 20)		6, 138, 688	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, li			165, 692	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			5, 972, 996	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			26, 544	
5.00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		272	
6.00	Total adjusted visits (line 4 plus line 5)			26, 816	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			222.74	7.00
			Cal cul ati on	of Limit (1)	
			Prior to Jan.	On or After	
			1 (Rate	Jan. 1 (Rate	
			Period 1)	Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	0.6 or your contractor)	0.00	0.00	
9.00	Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		222.74	222.74	9.00
10.00	Program covered visits excluding mental health services (from	contractor records)	0	5, 875	10.00
11.00	Program cost excluding costs for mental health services (line		0	1, 308, 598	
12.00	Program covered visits for mental health services (from contr	,	0	45	
13.00	Program covered cost from mental health services (line 9 x li		0	10, 023	13.00
14.00	Limit adjustment for mental health services (see instructions	<b>)</b>	0	10, 023	14.00
15.00	Graduate Medical Education Pass Through Cost (see instruction				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	-	0	1, 318, 621	
16.01	Total program charges (see instructions) (from contractor's re			684, 285	
16.02	Total program preventive charges (see instructions) (from prov			21, 360	
16.03 16.04	Total program preventive costs ((line 16.02/line 16.01) times Total Program non-preventive costs ((line 16 minus lines 16.0			41, 161 965, 203	16.03 16.04
10.04	(Titles V and XIX see instructions.)	s and to) trilles . bo)		903, 203	10.0
16.05	Total program cost (see instructions)		0	1,006,364	16.05
17.00	Primary payer amounts			0	
18.00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		70, 956	18.00
	records)				
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructio records)	ns) (from contractor		118, 394	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			1,006,364	20.00
21.00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		77, 983	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			1, 084, 347	22.00
23.00	Allowable bad debts (see instructions)			328	
	Adjusted reimbursable bad debts (see instructions)			213	
24.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		89	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration	15)		0	
	Net reimbursable amount (see instructions)			1,084,560	
26.01	Sequestration adjustment (see instructions)			21, 691	
26.02				0	
	Interim payments			997, 490	
	Tentative settlement (for contractor use only)			0	
29.00	Balance due component/program (line 26 minus lines 26.01, 26.	· · · · ·		65, 379	
30.00	Protested amounts (nonallowable cost report items) in accorda chapter I, §115.2	nce with CMS Pub. 15-II	1	0	30.0

Health Financial Systems PULASKI MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	Provider CCN: 15-1305	Period:	Worksheet M-4	
VACCI NE COST	Component CCN: 15-8512	From 10/01/2016 To 09/30/2017	Date/Time Pre 2/27/2018 12:	pared: 01 pm
	Title XVIII	RHC I	Cost	
		Pneumococcal	I nfl uenza	
		1.00	2.00	
1.00 Health care staff cost (from Wkst. M-1, col. 7, line 10)		2, 988, 881	2, 988, 881	1.00
2.00 Ratio of pneumococcal and influenza vaccine staff time to tota			0. 002152	
3.00 Pneumococcal and influenza vaccine health care staff cost (lir	,	4, 095	6, 432	3.00
4.00 Medical supplies cost - pneumococcal and influenza vaccine (fr		61, 863	11, 016	
5.00 Direct cost of pneumococcal and influenza vaccine (line 3 plus	,	65, 958	17, 448	
6.00 Total direct cost of the hospital-based RHC/FQHC (from Workshe	eet M-1, col. 7, line 22		3, 090, 057	6.00
7.00 Total overhead (from Wkst. M-2, line 19)		3, 048, 631	3, 048, 631	7.00
8.00 Ratio of pneumococcal and influenza vaccine direct cost to tot	tal direct cost (line 5	0. 021345	0. 005646	8.00
divided by line 6)				
9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x l		65, 073	17, 213	
10.00 Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9)	administration (sum of	131, 031	34, 661	10.00
11.00 Total number of pneumococcal and influenza vaccine injections	(from your records)	404	636	11.00
12.00 Cost per pneumococcal and influenza vaccine injection (line 10	D/line 11)	324.33	54.50	12.00
13.00 Number of pneumococcal and influenza vaccine injections admini beneficiaries	stered to Program	186	324	13.00
14.00 Program cost of pneumococcal and influenza vaccine and its (th (line 12 x line 13)	neir) administration	60, 325	17, 658	14.00
15.00 Total cost of pneumococcal and influenza vaccine and its (thei of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3,			165, 692	15.00
16.00 Total Program cost of pneumococcal and influenza vaccine and i administration (sum of cols. 1 and 2, line 14) (transfer this line 21)	ts (their)		77, 983	16.00

Heal th	Financial Systems PULASKI MEMOR	I AL HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	IS OF PAYMENTS TO HOSPITAL-BASED RHC/FOHC PROVIDER FOR	Provider CCN: 15-1305	Peri od:	Worksheet M-5	
	ES RENDERED TO PROGRAM BENEFICIARIES		From 10/01/2016		
		Component CCN: 15-8512	To 09/30/2017		
				2/27/2018 12:0	01 pm
			RHC I	Cost	
				t B	
			mm/dd/yyyy	Amount	
		· · · · · · · · · · · · · · · · · · ·	1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			997, 490	1.00
2.00	Interim payments payable on individual bills, either submi			0	2.00
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
3.00	List separately each retroactive lump sum adjustment amoun	t based on subsequent			3.00
	revision of the interim rate for the cost reporting period	. Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
	Provider to Program				
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3	98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (tran			997, 490	4.00
	27)			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after de	sk review. Also show date o	f		5.00
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider		-		
5.01				0	5.01
5.02				0	5.02
5.03				0	5.03
	Provider to Program				
5.50				0	5.50
5.51				0	5.51
5.52				0	5.52
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5	98)		0	5.99
6.00	Determined net settlement amount (balance due) based on th			Ŭ	6.00
6.01	SETTLEMENT TO PROVIDER			65, 379	6.01
6.02	SETTLEMENT TO PROGRAM			03, 377	6.02
7.00	Total Medicare program liability (see instructions)			1,062,869	7.00
7.00			Contractor	NPR Date	7.00
			Number	(Mo/Day/Yr)	
		0	1,00	2.00	
8,00	Name of Contractor	0	1.00	2.00	8.00
5.00		I	I	I I	0.00