This report is	s required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can	result in all interin	n FORM APPROVED
payments made	e since the beginning of the cost reporting period being deemed overpayment	rs (42 USC 1395g).	OMB NO. 0938-0050
			EXPIRES 05-31-2019
HOSPITAL AND I	HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-13		Worksheet S
AND SETTLEMEN	IT SUMMARY	From 10/01/2017	
		To 09/30/2018	
			7/31/2019 3:12 pm
PART I - COST	r report status		
Provi der	1.[X]Electronically filed cost report	Date: 7/31/20	19 Time: 3:12 pm
use only	2. [] Manually submitted cost report		
	3. [1] If this is an amended report enter the number of times the provid 4. [F] Medicare Utilization. Enter "F" for full or "L" for low.	der resubmitted this d	cost report
Contractor	5. [1] Cost Report Status 6. Date Received:	10. NPR Date:	
use only	(1) Ås Submitted 7. Contractor No.	11. Contractor's Vende	or Code: 4
	(2) Settled without Audit 8. [N] Initial Report for this Provider CCN	12.[0]Ifline 5, co	olumn 1 is 4: Enter
	(3) Settled with Audit 9. [N] Final Report for this Provider CCN		nes 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 10/01/2017 and ending 09/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	213, 584	189, 508	0	15, 006	1.00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovi der - I RF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	42, 229	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	o	1		0	9.00
10.00	RURAL HEALTH CLINIC - WINAMAC I	0		170, 069		0	10.00
10. 01	RURAL HEALTH CLINIC - NORTH JUDSON II	0		59, 990		0	10. 01
10. 02	RURAL HEALTH CLINIC - FRANCESVILLE III	0		21, 896		0	10. 02
200.00	Total	0	255, 813	441, 464	0	15, 006	200.00

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

Health Financial Systems PULASKI MEMORIAL HOSPITAL
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1305 Period: Worksheet S-2

From 10/01/2017 Part I 09/30/2018 Date/Time Prepared: 7/31/2019 3:12 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: 1.00 Street: 616 EAST 13TH PO Box: 1.00 State: IN 2.00 City: WINAMAC Zi p Code: 46996-County: PULASKI 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 PULASKI MEMORIAL 151305 99915 10/01/2000 N 0 0 3.00 HOSPI TAI Subprovi der - IPF 4.00 4.00 Subprovi der - IRF 5.00 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF Р PULASKI MEMORIAL 157305 99915 10/01/2000 N 0 7.00 7 00 HOSPI TAI 8.00 Swing Beds - NF 8.00 9.00 Hospital -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospital -Based HHA PULASKI MEMORIAL 157078 99915 10/14/1982 Ρ Ν 12.00 HOSPI TAL Separately Certified ASC 13.00 13 00 14.00 Hospi tal -Based Hospi ce 14.00 15.00 Hospital -Based Health Clinic - RHC PULASKI MEMORIAL RHC -158512 99915 08/21/2014 0 Ν 15.00 Ν WI NAMAC Hospital-Based Health Clinic - RHC PULASKI MEMORIAL RHC -158527 99915 0 Ν 15.01 15.01 03/14/2018 Ν NORTH JUDSON PULASKI MEMORIAL RHC -158528 99915 15.02 15.02 Hospital-Based Health Clinic - RHC 03/15/2018 N 0 N $\Pi\Pi$ FRANCESVI LLE Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To 2 00 1 00 09/30/2018 20.00 Cost Reporting Period (mm/dd/yyyy) 10/01/2017 20.00 21.00 Type of Control (see instructions) 21.00 1.00 2.00 3 00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Ν N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this Ν N 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care Ν Ν 22.02 payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to N N 22 03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for ves or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 2 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

Health Financial Systems PULASKI MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1305 Peri od: Worksheet S-2 From 10/01/2017 Part I 09/30/2018 Date/Time Prepared: 7/31/2019 3:12 pm In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days unpai d paid days el i gi bl e days unpai d 1.00 2. 00 3.00 4. 00 5. 00 6. 00 24.00 If this provider is an IPPS hospital, enter the 0 24.00 \cap n in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 2.00 1.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26, 00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. 35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in 0 35.00 effect in the cost reporting period. Begi nni ng: Endi ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates. 36 00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 37.00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in 37.01 accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38.00 | If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39.00 Ν hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν N 40.00 "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX V 1. 00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance Ν N Ν 45.00 with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances 46.00 Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N 47.00 48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. Ν N Ν 48.00 Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes 56.00 Ν 56.00 or "N" for no. If line 56 is yes, is this the first cost reporting period during which residents in approved 57.00 57.00 GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. If line 56 is yes, did this facility elect cost reimbursement for physicians' services as 58.00 defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.

N

59.00

59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.

Health Financial Systems PULASKI	MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provi der CC		eriod: rom 10/01/2017	Worksheet S-2 Part I	pared:
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
60.00 Are you claiming nursing and allied health education	(MAHE)	costs for	1. 00 N	2. 00	3. 00	60.00
		structions)	IN IN			
	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2. 00	3. 00	4. 00	5. 00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0. 00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding 0B/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61. 04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61. 06
	Pr	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
41 10 Of the ETEs in Line 41 OF specify each new program		1.00	2. 00	3. 00	4.00	41 10
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61. 10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0. 00	61. 20
					1. 00	
ACA Provisions Affecting the Health Resources and Se 62.00 Enter the number of FTE residents that your hospital				ind for which	0.00	62. 00
your hospital received HRSA PCRE funding (see instru Enter the number of FTE residents that rotated from during in this cost reporting period of HRSA THC pro	ctions) a Teach	ing Health Cen	nter (THC) into			62. 01
Teaching Hospitals that Claim Residents in Nonprovider s Has your facility trained residents in nonprovider s "Y" for yes or "N" for no in column 1. If yes, compl	<u>er Sett</u> ettings	ings during this o	cost reporting		N	63. 00
, i io. yes or iv ioi no in corumii i. ii yes, compi	313 7111	SS 01 till bugil	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Page Very ETE Posidents in N	opprovid	der Sattings	1.00	2. 00	3.00	
Section 5504 of the ACA Base Year FTE Residents in N period that begins on or after July 1, 2009 and befo 64.00 Enter in column 1, if line 63 is yes, or your facili in the base year period, the number of unweighted no resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighter resident FTEs that trained in your hospital. Enter if of (column 1 divided by (column 1 + column 2)). (see	re June ty trai n-prima all no d non-p n colum	e 30, 2010. ned residents ry care nprovider orimary care in 3 the ratio	O. 00			64.00

	4)). (see instructions)								
						1.00	2.00	3.00	
	Inpatient Psychiatric Facility F	PPS							
70.00	Is this facility an Inpatient Ps	sychiatric Facility (IPF), or does it cont	ain an IPF sub	provi der?	N			70.00
	Enter "Y" for yes or "N" for no	o.							
71.00	\mid lf line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the mos							0	71.00
	recent cost report filed on or b								
	42 CFR 412. 424(d)(1)(iii)(c)) Co								
	program in accordance with 42 CF								
	Column 3: If column 2 is Y, indi	cate which program y	ear began during this	cost reportin	g period.				
	(see instructions)								
	Inpatient Rehabilitation Facili	7							
75. 00	Is this facility an Inpatient Re		y (IRF), or does it c	ontain an IRF		N			75. 00
	subprovider? Enter "Y" for yes	and "N" for no.							

divided by (column 3 + column

Ith Financial Systems PULASKI MEMORIAL				of For		
SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CCN: 15-1305	Peri od: From 10/01/2 To 09/30/2	017	Workshe Part I Date/Ti 7/31/20	me Pre	pare
		-	1. 00	2.00	3. 00	
OO If line 75 is yes: Column 1: Did the facility have an approve recent cost reporting period ending on or before November 15, no. Column 2: Did this facility train residents in a new teach CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Indicate which program year began during this cost reporting	2004? Enter "Y" for yes hing program in accordan Column 3: If column 2 is	n the most or "N" for ce with 42 Y,		2.00	0	76.
T 0 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				1.0	00	
Long Term Care Hospital PPS Oo Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. TEFRA Providers		ng period? Er	nter	N N		80. 81.
00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 00 Did this facility establish a new Other subprovider (excluded §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			no.	N		85. 86.
00 Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	classified under sectio	n		N		87.
		V 1.00		XI :		
Title V and XIX Services Oo Does this facility have title V and/or XIX inpatient hospital	services? Enter "Y" for	N		Y		90.
yes or "N" for no in the applicable column. 100 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 applicable.		N	•	Υ		91
OO Are title XIX NF patients occupying title XVIII SNF beds (dual instructions) Enter "Y" for yes or "N" for no in the applicab	l certification)? (see			N		92
OD Does this facility operate an ICF/IID facility for purposes on "Y" for yes or "N" for no in the applicable column.		N		N		93
00 Does title V or XIX reduce capital cost? Enter "Y" for yes, all applicable column.	nd "N" for no in the	N		N		94
00 If line 94 is "Y", enter the reduction percentage in the appl 00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.		0. 00 N		O. C N	00	95
00	erns and residents post	0. 00 Y		0. C Y		97 98
O1 Does title V or XIX follow Medicare (title XVIII) for the rep C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for tit title XIX.				Υ		98
O2 Does title V or XIX follow Medicare (title XVIII) for the call bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or for title V, and in column 2 for title XIX.		Y		Υ		98
03 Does title V or XIX follow Medicare (title XVIII) for a critic reimbursed 101% of inpatient services cost? Enter "Y" for yes				N		98
for title V, and in column 2 for title XIX. O4 Does title V or XIX follow Medicare (title XVIII) for a CAH reoutpatient services cost? Enter "Y" for yes or "N" for no in a		N d		N		98
in column 2 for title XIX. O5 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 column column.				Υ		98
column 2 for title XIX. 06 Does title V or XIX follow Medicare (title XVIII) when cost representation of the property of the		Y		Υ		98
Rural Providers 5.00 Does this hospital qualify as a CAH?		Y				105
6.00 f this facility qualifies as a CAH, has it elected the all-infor outpatient services? (see instructions)	. 3					106
7.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col.:	1. (see instructions) If					107
reimbursed. If yes complete Wkst. D-2, Pt. II. B.OO Is this a rural hospital qualifying for an exception to the Cl	RNA fee schedule? See 4	2 N				108

ealth Financial Systems PULASKI MEMORI OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		F	eriod: rom 10/01/ o 09/30/	2017	of Form (Worksheet Part I Date/Time	S-2 Prepared
	Physi cal	Occupati onal	Speec	h	7/31/2019 Respi rate	
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.	1. 00 N	2. 00 N	3. 00 N		4. 00 N	109.0
					1. 00	
10.00 Did this hospital participate in the Rural Community Hospit. Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	"Y" for yes o	r "N" for no. I	f yes,	5	N	110. 0
			1.00		2. 00	
11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this construction for the construction for the construction properties of the FCHIP demonstration for the FCHIP demonstration for the formal construction of the FCHIP demonstrates and the formal construction of the FCHIP demonstrates and the formal construction of the formal const	ost reporting olumn 1 is Y, rticipating i	period? Enter enter the n column 2.	N			111. (
Miscellaneous Cost Reporting Information				1. 00	2.00 3	. 00
15.00 Is this an all-inclusive rate provider? Enter "Y" for yes o is yes, enter the method used (A, B, or E only) in column 2 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provide Pub. 15-1, chapter 22, §2208.1.	. If column 2 nt for long t rs) based on	is "E", enter erm care (inclu the definition	in column des	N		0 115.0
16.00 s this facility classified as a referral center? Enter "Y" 17.00 s this facility legally-required to carry malpractice insu no.	,		"N" for	N Y		116. (117. (
18.00 s the malpractice insurance a claims-made or occurrence po claim-made. Enter 2 if the policy is occurrence.	licy? Enter 1	if the policy	İs	1		118.
		Premi ums	Losse	S	Insuran	ce
		1. 00	2. 00		3. 00	
18.01 List amounts of malpractice premiums and paid losses:		139, 682		0		0118.
			1.00		2. 00	
18.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche- and amounts contained therein. 19.00 DO NOT USE THIS LINE			N			118. 119.
20.00 Is this a SCH or EACH that qualifies for the Outpatient Holes \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	n column 1, " ualifies for	Y" for yes or the Outpatient	N		N	120.
21.00 Did this facility incur and report costs for high cost implipatients? Enter "Y" for yes or "N" for no.	antable devic	es charged to	Y			121.
22.00 Does the cost report contain healthcare related taxes as de Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included.			N			122.
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for	or yes and "N	" for no. If	N			125.
yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, e	nter the cert	ification date				126
in column 1 and termination date, if applicable, in column 27.00. If this is a Medicare certified heart transplant center, en	ter the certi	fication date				127.
in column 1 and termination date, if applicable, in column 18.00 f this is a Medicare certified liver transplant center, en	ter the certi	fication date				128.
in column 1 and termination date, if applicable, in column 19.00 f this is a Medicare certified lung transplant center, ent		ication date in				129
column 1 and termination date, if applicable, in column 2. 0.00 of this is a Medicare certified pancreas transplant center, the in column 1 and termination date in column 1 and termination date if applicable in column 1.		rti fi cati on				130
date in column 1 and termination date, if applicable, in co 1.00 If this is a Medicare certified intestinal transplant cente date in column 1 and termination date, if applicable, in co	r, enter the	certi fi cati on				131
water in column rang reimination date it applicable in co		fication date				132.
32.00 f this is a Medicare certified islet transplant center, en						
32.00 If this is a Medicare certified islet transplant center, en in column 1 and termination date, if applicable, in column 33.00 If this is a Medicare certified other transplant center, en in column 1 and termination date, if applicable, in column 3.00 If this is a Medicare certified other transplant center, en in column 1 and termination date, if applicable, in column 3.00 If this is a Medicare certified other transplant center, en in column 3.00 If this is a Medicare certified other transplant center, en in column is a medicare certified other transplant center, en in column is a medicare certified other transplant center, en in column is a medicare certified other transplant center, en in column is a medicare certified other transplant center.	2. ter the certi	fication date				133.

Health Financial Systems	PULASKI M	EMORIAL HOSPITAL			In Lie	u of Form CMS-	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DATA	A Provider C	CN: 15-1305	From 1	l: 0/01/2017 9/30/2018	Worksheet S- Part I Date/Time Pr 7/31/2019 3:	epared:
		<u> </u>					- <u>-</u> -
140.00 Are there any related organization chapter 10? Enter "Y" for yes or are claimed, enter in column 2 th	"N" for no in column ?	1. If yes, and home	e office c		1. 00 N	2.00	140.00
1. 00		2. 00			3. 00		
If this facility is part of a cha office and enter the home office	contractor name and co	ontractor number.				of the home	
141.00 Name: 142.00 Street:	Contractor's Nam PO Box:	ne:	Contr	actor's N	umber:		141. 00 142. 00
142.003t1 eet. 143.00 Ci ty:	State:		Zi p C	ode:			143.00
						1.00	-
144.00 Are provider based physicians' co	sts included in Worksh	heet A?				Y	144.00
					1. 00	2.00	+
145.00 If costs for renal services are of inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N" 146.00 Has the cost allocation methodoloc Enter "Y" for yes or "N" for no iyes, enter the approval date (mm/	" for yes or "N" for r clude Medicare utiliza for no in column 2. gy changed from the p n column 1. (See CMS F	no in column 1. If ation for this cos reviously filed cos	column 1 t reportin st report?	g	N		145. 00
	7777					1.00	
147.00Was there a change in the statist	ical basis? Enter "Y"	for ves or "N" for	- no.			1. 00 N	147.00
48.00 Was there a change in the order o	f allocation? Enter "\	Y" for yes or "N" 1	for no.			N	148. 0
149.00 Was there a change to the simplif	ied cost finding metho	od? Enter "Y" for y Part A	yes or "N" Part		Γitle V	N Title XIX	149.00
		1.00	2. 00		3. 00	4. 00	
Does this facility contain a provor charges? Enter "Y" for yes or							
155. 00 Hospi tal	N TOT THE TOT CACT C	N	N N	D. (See	N N	N N	155. 0
56. 00 Subprovi der - IPF		N	N		N	N	156.0
57. 00 Subprovi der - IRF 58. 00 SUBPROVI DER		N	N		N	N	157. 0 158. 0
59. 00 SNF		N	N		N	N	159. 0
160.00HOME HEALTH AGENCY 161.00CMHC		N	N N		N N	N N	160. 0
01. 00 0mm		I	14		11		101.0
Multicampus						1. 00	
165.00 Is this hospital part of a Multic	ampus hospital that ha	as one or more camp	ouses in d	ifferent (CBSAs?	N	165.00
Enter "Y" for yes or "N" for no.	Name	County	State	Zi p Code	CBSA	FTE/Campus	
166.00 f ine 165 is yes, for each	0	1. 00	2.00	3. 00	4. 00	5.00	0166.0
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.0	0 100. 0
						1.00	+
Health Information Technology (HI	T) incentive in the A	merican Recovery a	nd Rei nves	tment Act			4
67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 1	05 is "Y") and is a me	eaningful user (lir			er the	Y	167. 00 0168. 00
reasonable cost incurred for the 68.01 If this provider is a CAH and is			er qualify	for a ha	rdshi p	N	168. 0°
exception under §413.70(a)(6)(ii) 169.00 If this provider is a meaningful transition factor. (see instructi	? Enter "Y" for yes or user (line 167 is "Y")	r "N" for no. (see	instructi	ons)	·	0.0	0169. 00
transition factor. (See Instructi	uiis)			Ве	egi nni ng	Endi ng	
170.00 Enter in columns 1 and 2 the EHR	heainning date and end	ding date for the	renorti na	10	1.00 /03/2017	2. 00 12/31/2017	170.00
period respectively (mm/dd/yyyy)	bogining date and en	aring date for tile i	opor tring	10	, 55, 2017	12/31/201/	70.00

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lie	eu of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE	NTIFICATION DATA	Provider CCN: 15-1305	Peri od:	Worksheet S-2	2
			From 10/01/2017 To 09/30/2018	B Date/Time Pre	narod:
			10 04/30/2010	7/31/2019 3: 1	
			1. 00	2.00	
171.00 If line 167 is "Y", does this provider	have any days for indiv	viduals enrolled in	N	(171.00
section 1876 Medicare cost plans report					
"Y" for yes and "N" for no in column 1.	on				
1876 Medicare days in column 2. (see in	istructi ons)				

Heal th	Financial Systems PULASKI MEMOR	IAI HOSPITAI		Inlie	u of Form CMS-	2552-10
	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Peri od:	Worksheet S-2	
				From 10/01/2017 Fo 09/30/2018	Part II Date/Time Pre	epared:
					7/31/2019 3: 1	
				Y/N 1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter	N for all NO re	esponses. Ente			
	mm/dd/yyyy format.					
	COMPLETED BY ALL HOSPITALS					
1 00	Provider Organization and Operation		46	N.		1 00
1. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in			N		1.00
	Troporting portion in your onter the date of the change in	20. diii. 2. (200	Y/N	Date	V/I	
			1. 00	2. 00	3. 00	
2. 00	Has the provider terminated participation in the Medicare		N			2.00
	yes, enter in column 2 the date of termination and in coluvoluntary or "I" for involuntary.	mn 3, V Tor				
3. 00	Is the provider involved in business transactions, includi	ng management	l N			3.00
	contracts, with individuals or entities (e.g., chain home	offices, drug				
	or medical supply companies) that are related to the provi					
	officers, medical staff, management personnel, or members of directors through ownership, control, or family and oth					
	relationships? (see instructions)	er Similar				
	Transfer (add that dott one)		Y/N	Type	Date	
			1. 00	2. 00	3. 00	
	Financial Data and Reports		1	T .		
4. 00	Column 1: Were the financial statements prepared by a Cer Accountant? Column 2: If yes, enter "A" for Audited, "C"		Y	Α		4.00
	or "R" for Reviewed. Submit complete copy or enter date av					
	column 3. (see instructions) If no, see instructions.	arrabre in				
5.00	Are the cost report total expenses and total revenues diff		N			5.00
	those on the filed financial statements? If yes, submit re	conciliation.) (A)		
				Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
6.00	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is t	he provider is	N N		6.00
	the legal operator of the program?					
7.00	Are costs claimed for Allied Health Programs? If "Y" see i		d d	N		7.00
8. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	and/or renewe	a during the	N		8.00
9. 00	Are costs claimed for Interns and Residents in an approved	graduate medi	cal education	N		9.00
	program in the current cost report? If yes, see instruction					
10. 00	Was an approved Intern and Resident GME program initiated	or renewed in	the current	N		10.00
11. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than	I & Pin an An	nroved	N		11.00
11.00	Teaching Program on Worksheet A? If yes, see instructions.	i a k ili ali Ap	proved	IN IN		11.00
					Y/N	
					1. 00	
12 00	Bad Debts	0 000 notruo	+i ono		V	12.00
	Is the provider seeking reimbursement for bad debts? If ye If line 12 is yes, did the provider's bad debt collection			st renorting	Y N	12.00
13.00	period? If yes, submit copy.	porrey change	during this co	ost reporting	14	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-paym	ents waived? I	fyes, see ins	tructions.	N	14.00
	Bed Complement		<u> </u>			
15. 00	Did total beds available change from the prior cost report		_yes, see inst t A		t B	15.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
	PS&R Data					
16. 00	Was the cost report prepared using the PS&R Report only?	Y	01/17/2019	Υ	01/17/2019	16.00
	If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see					
	instructions)					
17.00	Was the cost report prepared using the PS&R Report for	N		N		17.00
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date					
18. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18.00
10.00	Report data for additional claims that have been billed	IN		IN		10.00
	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
19. 00	, , , , , , , , , , , , , , , , , , ,	N		N		19.00
	Report data for corrections of other PS&R Report information? If yes, see instructions.					
	1	1	1	1	•	1

Heal th	Financial Systems PULASKI MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-1305	Peri od: From 10/01/2017	Worksheet S-2 Part II Date/Time Pre 7/31/2019 3:1	epared:
	<u> </u>		i pti on	Y/N	Y/N	
20.00	LE Line 1/ au 17 in the property and to DCOD		0	1. 00	3.00	20, 00
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
	report data for other. Beserve the other day astments.	Y/N	Date	Y/N	Date	
		1. 00	2.00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS	HOSPI TALS)			
	Capital Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, se				N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense	due to apprai	sals made dur	ing the cost	N	23. 00
24. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases enter If yes, see instructions	red into during	this cost re	eporting period?	N	24. 00
25. 00	Have there been new capitalized leases entered into during instructions.	, the cost repo	rting period?	Plf yes, see	N	25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during tinstructions.	he cost report	ing period? I	f yes, see	N	26. 00
27. 00	Has the provider's capitalization policy changed during th copy.	ne cost reporti	ng period? If	fyes, submit	N	27. 00
28. 00	Interest Expense Were new loans, mortgage agreements or letters of credit e	entered into du	ring the cost	reporting	N	28. 00
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	N	29. 00			
30. 00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat instructions.	N	30.00			
31. 00	Has debt been recalled before scheduled maturity without i instructions.	N	31.00			
32. 00	Purchased Services Have changes or new agreements occurred in patient care se		ed through co	ontractual	N	32.00
33. 00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.		ng to competi	tive bidding? If		33. 00
	Provi der-Based Physi ci ans					
34. 00		ırrangement wit	h provider-ba	ised physicians?	Υ	34.00
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended explains during the sector of t		nts with the	provi der-based	N	35.00
	physicians during the cost reporting period? If yes, see i	nati ucti una.		Y/N	Date	
				1. 00	2. 00	
	Home Office Costs					
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	prepared by the	home office?	N		36. 00 37. 00
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of			=		38. 00
39. 00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth see instructions.			5,		39. 00
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see			40. 00
	1.00 2.0					
41. 00	Cost Report Preparer Contact Information Enter the first name, last name and the title/position	MI CHAEL		ALESSANDRI NI		41.00
42.00	held by the cost report preparer in columns 1, 2, and 3, respectively.	DITIE VND CO	11.0			42.00
42. 00	Enter the employer/company name of the cost report preparer.	BLUE AND CO.,	LLC			42.00
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317. 713. 7959		MALESSANDRI NI @	BLUEANDCO. COM	43.00

Health Finan	cial Systems	PULASKI ME	MORI AL	HOSPI TAL			In Lieu	u of Form CMS-	2552-10
HOSPITAL AND) HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE		Provi der	CCN: 15-1305		eriod: rom 10/01/2017 o 09/30/2018	Worksheet S-2 Part II Date/Time Pro 7/31/2019 3:	epared:
					3. 00				
Cost	Report Preparer Contact Information								
41.00 Enter	the first name, last name and the	title/position	SEN	II OR MANAG	ER				41.00
	by the cost report preparer in colu	mns 1, 2, and 3	3,						
1 '	cti vel y.								
42.00 Enter	the employer/company name of the c	ost report							42.00
prepa									
	the telephone number and email add		st						43.00
repor	t preparer in columns 1 and 2, resp	ecti vel y.				l			

| Period: | Worksheet S-3 | From 10/01/2017 | Part | To 09/30/2018 | Date/Time Prepared:
 Heal th Financial
 Systems
 PULASKI

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

						То	09/30/2018	Date/Time 7/31/2019		
								I/P Days		_ piii
								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		25	48, 360. 00		0	1. 00
	8 exclude Swing Bed, Observation Bed and									
	Hospice days) (see instructions for col. 2									
	for the portion of LDP room available beds)									
2.00	HMO and other (see instructions)									2.00
3. 00 4. 00	HMO IPF Subprovider HMO IRF Subprovider									3. 00 4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF								0	5.00
6. 00	Hospital Adults & Peds. Swing Bed NF								0	6. 00
7. 00	Total Adults and Peds. (exclude observation			25	9, 12	25	48, 360. 00		ő	7. 00
	beds) (see instructions)						,		- [
8.00	INTENSIVE CARE UNIT	31. 00		0		0	0. 00		0	8.00
9.00	CORONARY CARE UNIT									9.00
10.00	BURN INTENSIVE CARE UNIT									10.00
11. 00	SURGICAL INTENSIVE CARE UNIT									11.00
12.00	OTHER SPECIAL CARE (SPECIFY)	42.00								12.00
13. 00 14. 00	NURSERY	43. 00		25	9, 12) E	48, 360. 00		0	13. 00 14. 00
15. 00	Total (see instructions) CAH visits			25	9, 12	23	46, 360. 00		0	15.00
16. 00	SUBPROVI DER - I PF								٠	16. 00
17. 00	SUBPROVI DER - I RF									17. 00
18.00	SUBPROVI DER									18.00
19.00	SKILLED NURSING FACILITY									19.00
20.00	NURSING FACILITY									20.00
21. 00	OTHER LONG TERM CARE									21.00
22. 00	HOME HEALTH AGENCY	101. 00							0	22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	444.00								23.00
24. 00	HOSPI CE	116.00		0		0				24.00
24. 10 25. 00	HOSPICE (non-distinct part) CMHC - CMHC	30. 00								24. 10 25. 00
26. 00	RURAL HEALTH CLINIC - WINAMAC	88. 00							0	26.00
26. 01	RURAL HEALTH CLINIC - NORTH JUDSON	88. 01							0	26. 01
26. 02	RURAL HEALTH CLINIC - FRANCESVILLE	88. 02							ol	26. 02
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00							ō	26. 25
27.00	Total (sum of lines 14-26)			25						27.00
28.00	Observation Bed Days								0	28.00
29. 00	Ambul ance Trips									29.00
30.00	Employee discount days (see instruction)									30.00
31.00	Employee discount days - IRF									31.00
32. 00	Labor & delivery days (see instructions)			0		0				32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)									32. 01
33. 00	LTCH non-covered days									33.00
	LTCH site neutral days and discharges									33. 01
	,	ļ	'		'	1	1		'	

Provider CCN: 15-1305

Peri od: Worksheet S-3
From 10/01/2017 Part I
To 09/30/2018 Date/Time Prepared: 7/31/2019 3:12 pm

						7/31/2019 3: 1	2 pm
		I/P Days	/ O/P Visits	/ Tri ps	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 057	20	2, 015			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)	200	278				2.00
3.00	HMO IPF Subprovider	0	0				3. 00
4. 00	HMO IRF Subprovider	0	0				4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	897	0	949			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0				6.00
7.00	Total Adults and Peds. (exclude observation	1, 954	20	3, 232			7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT	0	0	0			8. 00
9.00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY		0	147			13.00
14.00	Total (see instructions)	1, 954	20	3, 379	0. 00	175. 88	ł
15. 00	CAH visits	0	0	0			15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE					40.04	21.00
22. 00	HOME HEALTH AGENCY	2, 928	659	3, 607	0. 00	10. 31	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)		_	_			23.00
24. 00	HOSPI CE	0	0			0.00	1
24. 10	HOSPICE (non-distinct part)			0			24. 10
25.00	CMHC - CMHC	, , , , , ,	005	00.000	0.00	45.05	25.00
26.00	RURAL HEALTH CLINIC - WINAMAC	6, 297	235	· ·		45. 85	
26. 01	RURAL HEALTH CLINIC - NORTH JUDSON	903	16	· ·		l e	•
26. 02	RURAL HEALTH CLINIC - FRANCESVILLE	223	12	896		3. 58	1
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		l e	•
27. 00	Total (sum of lines 14-26)		0	221	0. 00	240. 52	1
28. 00	Observation Bed Days	0	0	331			28.00
29.00	Ambulance Trips	٩		_			29.00
30.00	Employee discount days (see instruction)			0 0			30.00
31.00	Employee discount days - IRF		0				31.00
32.00	Labor & delivery days (see instructions)	0	0	39 0			32.00
32. 01	Total ancillary labor & delivery room						32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days						33.00
	LTCH non-covered days LTCH site neutral days and discharges	0					33.00
33.01	Lion of the neutral days and discharges	١		I	I	I	1 33.01

Provi der CCN: 15-1305

				Ť	09/30/2018	Date/Time Pre 7/31/2019 3:1	
		Full Time		Di sch	arges	770172017 0. 1	Z piii
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
	I	11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2		0	293	6	585	1.00
2 00	for the portion of LDP room available beds)			2.4	00		2 00
2.00	HMO and other (see instructions)			24	89 0		2.00
3.00	HMO IPF Subprovi der				0		3.00
4. 00 5. 00	HMO IRF Subprovider				U		4. 00 5. 00
	Hospital Adults & Peds. Swing Bed SNF						6.00
6. 00 7. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation						7.00
7.00	beds) (see instructions)						7.00
8. 00	INTENSIVE CARE UNIT						8.00
9. 00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	0.00	0	293	6	585	
15. 00	CAH visits	0.00	Ŭ	273	S S	505	15.00
16. 00	SUBPROVI DER - I PF						16.00
17. 00	SUBPROVI DER - I RF						17.00
18. 00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE	0.00					24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC - WINAMAC	0. 00					26.00
26. 01	RURAL HEALTH CLINIC - NORTH JUDSON	0. 00					26. 01
26. 02	RURAL HEALTH CLINIC - FRANCESVILLE	0. 00					26. 02
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32. 00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)			_			22.00
33.00	LTCH non-covered days			0			33.00
33. UI	LTCH site neutral days and discharges		l	0	ı I		33. 01

SOME HEALTH AGENCY STATISTICAL DATA	Heal th	Financial Systems	PULASKI MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
	HOME H	EALTH AGENCY STATISTICAL DATA				Peri od: From 10/01/2017	Worksheet S-4 Date/Time Pre	pared:
1.00 Country								<u></u>
11 11 12 11 11 12 13 13					,	Agency I		
HOME HEALTH AGENCY STATISTICAL DATA	0.00	Country				1.	00	0.00
NUMBER HEALTH AGENCY STATISTICAL DATA 1.00 2.00 3.00 4.00 5.00 1.00	0.00	County	Title V	Title XVIII	Title XIX	Other	Total	0.00
1.00 Unduplicated Census Count (see Instructions)								
Number of Employees (Full Time Equivalent) Number of Employees (Full Time Equivalent)	1 00				ı		1 0	1 00
NOWE HEALTH AGENCY - NUMBER OF EMPLOYEES	2. 00		1		1			
NOME HEALTH AGENCY - NUMBER OF EMPLOYEES					Number of Em	ployees (Full Ti	me Equivalent)	
NOME HEALTH AGENCY - NUMBER OF EMPLOYEES								
NOME HEALTH AGENCY - NUMBER OF EMPLOYEES								
Note HEALTH AGENCY - NUMBER OF EMPLOYEES					Staff	Contract	Total	
NOME_HEALTH ACENCY = NUMBER OF EMPLOYEES 40.00			your norman	work week				
NOME_HEALTH ACENCY = NUMBER OF EMPLOYEES 40.00								
NOME_HEALTH ACENCY = NUMBER OF EMPLOYEES 40.00			0		1 00	2 00	3, 00	
0.00 Director(s) and Assistant Director(s) 0.00 0.								
Other Administrative Personnel 0.00 0.	3.00			40. 00	1			1
Nursing Supervisor 0.00	5. 00				1			1
Physical Therapy Service 0.84 0.00 0.84 8.0	6.00				1			
Physical Therapy Supervisor	7.00				1			
10.00 Occupational Therapy Service 0.29 0.00 0.29 10.0	9. 00				1			1
12.00 Speech Pathology Service 0.04 0.00 0.00 0.04 12.00 13.00 Speech Pathology Supervisor 0.00 0.00 0.00 0.00 0.00 13.00 14.00 Medical Social Service 0.00 0.00 0.00 0.00 15.00 15.00 Medical Social Service 0.00 0.00 0.00 0.00 15.00 15.00 Medical Social Service 0.00 0.00 0.00 0.00 15.00 15.00 Medical Social Service Supervisor 0.00 0.00 0.00 0.00 15.00 16.00 Medical Social Services 0.00 0.00 0.00 0.00 15.00 15.00 Medical Social Services 0.00 0.00 0.00 0.00 0.00 0.00 15.00 16.00 Medical Social Services 0.00 0.00 0.00 0.00 0.00 15.00 16.00 Medical Social Services Supervisor 0.00 0.00 0.00 0.00 0.00 15.00 16.00	10.00				1			
13.00 Speech Pathology Supervisor	11.00				1			
14.00 Medical Social Service 0.00 0.00 0.00 14.0	12.00				1			1
	14. 00				0.0	0. 00		
	15.00				1			
Ne Home Health Agency CBSA codes					1			1
International Column 1 the number of CBSAs where you provided services during the cost reporting period. 20.00 2	18. 00	MEDI CAL TECH			1			
You provided services during the cost reporting period. 20.00 List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code). Full Episodes Without Outliers With Outliers LUPA Episodes PEP Only Episodes 1-4) 1.00 2.00 3.00 4.00 5.00 1.40 5.00 1.00 2.00 3.00 4.00 5.00 1.40	10.00		I		I	1	ı	10.00
Per 19.00					1		19.00	
PREACTIVITY DATA PRESENTING PRIVITY DATA PRESENTING VISITS PRESENTANCE VISITS PRESENTING VISITS PRESENTANCE								
Full Episodes	20. 00				99915			20.00
Without Outliers With Outliers LUPA Episodes PEP Only Fpisodes 1-4)								
PPS ACTIVITY DATA Total Number of Episodes 1-4) PPS ACTIVITY DATA Total Number of Episodes 1-4) PPS ACTIVITY DATA Total Number of Episodes 1.00 2.00 3.00 4.00 5.00					LUDA Enicodo	DED Only	Total (cols	
PPS ACTIVITY DATA				with outliers	LUFA Epi soue			
21.00 Skilled Nursing Visits		DDC AOTHWEN DATA	1. 00	2. 00	3.00	4. 00	5. 00	
22.00 Skilled Nursing Visit Charges 223,783 47,078 6,526 0 277,387 22.00 23.00 Physical Therapy Visits 601 55 7 0 663 23.00 24.00 Physical Therapy Visits 25.00 Cocupational Therapy Visits 201 32 0 0 233 25.00 25.00 Occupational Therapy Visit Charges 51,038 8,136 0 0 233 25.00 27.00 Speech Pathology Visits 5 31 0 0 36 27.00 27.00 Speech Pathology Visit Charges 1,271 7,882 0 0 9,153 28.00 29.00 Medical Social Service Visits 0 0 0 0 0 0 0 0 0	21. 00		962	202		28 0	1, 192	21.00
24.00 Physical Therapy Visit Charges 152,671 13,969 1,772 0 168,412 24.00 25.00 Occupational Therapy Visits 201 32 0 0 233 25.0 26.00 Occupational Therapy Visit Charges 51,038 8,136 0 0 59,174 26.0 27.00 Speech Pathology Visits 5 31 0 0 36.27.0 28.00 Speech Pathology Visit Charges 1,271 7,882 0 0 9,153 28.0 29.00 Medical Social Service Visits 0 0 0 0 0 9,153 28.0 29.00 Medical Social Service Visits 0<	22. 00	Skilled Nursing Visit Charges	223, 783	47, 078	6, 5	26 0	277, 387	22.00
25. 00 Occupational Therapy Visits 201 32 0 0 233 25.00 26.00 Occupational Therapy Visit Charges 51,038 8,136 0 59,174 26.00 27.00 Speech Pathology Visit S 5 31 0 0 36 27.00 28.00 Speech Pathology Visit Charges 1,271 7,882 0 0 9,153 28.00 Medical Social Service Visit S 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23. 00		1					1
26. 00 Occupational Therapy Visit Charges 51,038 8,136 0 0 59,174 26.00 27.00 Speech Pathology Visits 5 31 0 0 36 27.00 28.00 Speech Pathology Visit Charges 1,271 7,882 0 0 9,153 28.00 29.00 Medical Social Service Visits 0 0 0 0 0 0 0 29.00 30.00 Medical Social Service Visit Charges 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00	Occupational Therapy Visits						
28. 00 Speech Pathology Visit Charges 1,271 7,882 0 0 9,153 28.00 29.00 Medical Social Service Visits 0 0 0 0 0 29.00 30.00 Medical Social Service Visit Charges 0 0 0 0 0 30.00 31.00 Home Health Aide Visits 700 102 2 0 804 31.00 32.00 Home Health Aide Visit Charges 75,186 10,972 215 0 86,373 32.00 33.00 Total Visits (sum of lines 21, 23, 25, 27, 2,469 422 37 0 2,928 33.00 29, and 31) 34.00 Other Charges 0 0 0 0 0 0 34.00 35.00 Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34) 36.00 Total Number of Episodes (standard/non outlier) 37.00 Total Number of Outlier Episodes 9 0 9 37.00 9 37.00 37.00 Total Number of Outlier Episodes 9 0 9 37.00 0 0 0 0 0 0 0 0 0	26.00	Occupational Therapy Visit Charges	1	8, 136			59, 174	26.00
29.00 Medical Social Service Visits 0 0 0 0 0 0 0 30.00 30.00 Medical Social Service Visit Charges 0 0 0 0 0 0 0 30.00 31.00 Home Heal th Aide Visits 700 102 2 0 804 31.0 32.00 Home Heal th Aide Visit Charges 75,186 10,972 215 0 86,373 32.0 Total visits (sum of lines 21, 23, 25, 27, 2,469 422 37 0 2,928 33.0 29, and 31) 34.00 Other Charges 0 0 0 0 0 0 0 0 34.0 35.00 Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34) 36.00 Total Number of Episodes (standard/non outlier) 139 0 105 0 9 37.00 Total Number of Outlier Episodes			1 271					
31.00 Home Health Aide Visits 700 102 2 0 804 31.00 32.00 Home Health Aide Visit Charges 75,186 10,972 215 0 86,373 32.0 33.00 Total visits (sum of lines 21, 23, 25, 27, 2,469 422 37 0 2,928 33.0 34.00 Other Charges 0 0 0 0 0 0 34.0 35.00 Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34) 88,037 8,513 0 600,499 35.0 Total Number of Episodes (standard/non outlier) 37.00 Total Number of Outlier Episodes 9 0 9 37.0	29. 00	,	1 .1		1			1
32.00 Home Health Aide Visit Charges 75, 186 10, 972 215 0 86, 373 32.00 33.00 Total visits (sum of lines 21, 23, 25, 27, 2, 469 422 37 0 2, 928 33.00 34.00 Other Charges 0 0 0 0 0 0 34.0 35.00 Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34) 36.00 Total Number of Episodes (standard/non outlier) 37.00 Total Number of Outlier Episodes 9 0 9 37.00	30.00		1		1			1
33. 00 Total visits (sum of lines 21, 23, 25, 27, 2, 469 422 37 0 2, 928 33. 00 2, 928 33. 00 34. 00 Other Charges 0 0 0 0 0 0 34. 00 35. 00 Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34) 36. 00 Total Number of Episodes (standard/non outlier) 37. 00 Total Number of Outlier Episodes 9 0 9 37. 00			1		1			
34.00 Other Charges 0 0 0 0 0 0 34.00 35.00 Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34) 88,037 8,513 0 600,499 35.00 Total Number of Episodes (standard/non outlier) 37.00 Total Number of Outlier Episodes 9 0 9 37.00	33. 00	Total visits (sum of lines 21, 23, 25, 27,	1		1			1
35.00 Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34) 36.00 Total Number of Episodes (standard/non outlier) 37.00 Total Number of Outlier Episodes 9 0 9 37.00	24 00			^			_	24.00
30, 32, and 34) 36.00 Total Number of Episodes (standard/non outlier) 37.00 Total Number of Outlier Episodes 9 0 9 37.00	34.00			88. 037	8.5			
outlier) 37.00 Total Number of Outlier Episodes 9 0 9 37.0		30, 32, and 34)		22, 30.				
37.00 Total Number of Outlier Episodes 9 9 0 9 37.0	36. 00		139			16 0	155	36.00
38.00 Total Non-Routine Medical Supply Charges 30,891 9,148 2,188 0 42,227 38.0	37. 00			9		0		
	38. 00	Total Non-Routine Medical Supply Charges	30, 891	9, 148	2, 18	88 0	42, 227	38.00

Health Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1305	Peri od:	Worksheet S-8	3
		Component	CCN: 15-8512	From 10/01/2017 To 09/30/2018		
				RHC I	Cost	
				1.	00	
Clinic Address and Identification						
1.00 Street			-	540 HOSPITAL D		1.00
			ty	State	ZIP Code	
2.00 City State 7LD Code County		1. WINIMAC	00	2. 00	3. 00 46996-	2.00
2.00 City, State, ZIP Code, County		WINIWAC		IN	40990-	2.00
					1. 00	
3.00 HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rura	al or "U" for	urban		0	3.00
			Gra	nt Award	Date	
				1. 00	2. 00	
Source of Federal Funds	A = # \		1		T	4 00
4.00 Community Health Center (Section 330(d), PHS 5.00 Migrant Health Center (Section 329(d), PHS A					-	4. 00 5. 00
6.00 Health Services for the Homeless (Section 34						6.00
7.00 Appalachian Regional Commission	-(-),					7. 00
8. 00 Look-Alikes						8.00
9. 00 OTHER (SPECIFY)						9.00
				1 00	2.00	
10.00 Does this facility operate as other than a h	osni tal _hasod [PHC or FOHC2 F	nter "V" for	1. 00 N	2.00	10.00
yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)	ate number of o	other operatio	ns in column			10.00
Thouse of y	Sun	day	N	londay	Tuesday	
	from	to	from	to	from	
	1. 00	2. 00	3. 00	4. 00	5. 00	
Facility hours of operations (1) 11.00 CLINIC			08: 00	17: 00	08: 00	11.00
TI. 00 CLINIC			06.00	17.00	06.00	11.00
				1. 00	2. 00	
12.00 Have you received an approval for an excepti	on to the produ	uctivity stand	ard?	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 number of providers included in this report.	umn 1. If yes,	enter in colu	mn 2 the	N	0	13.00
numbers below.			Prov	ider name	CCN number	
			1100	1. 00	2. 00	
14.00 RHC/FQHC name, CCN number						14. 00
	Y/N	V	XVIII	XIX	Total Visits	
15 00	1. 00	2. 00	3. 00	4. 00	5. 00	15.00
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in						15.00
column 1. If yes, enter in columns 2, 3 and						
4 the number of program visits performed by						
Intern & Residents for titles V, XVIII, and						
XIX, as applicable. Enter in column 5 the						
number of total visits for this provider.						
(see instructions)		Col	l Inty			
			00			
2.00 City, State, ZIP Code, County		PULASKI				2.00
	Tuesday	Wedn	esday	Thur	sday	
	to	from	to	from	to	
Facility hours of secretical (1)	6. 00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1) 11.00 CLINIC	17: 30	08: 00	19: 00	08: 00	19: 00	11.00
11. 00 OLINI C	117.30	00.00	J1 7. UU	μο. ου	117.00	1 11.00

Health Financial Systems	PULASKI MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Peri od:	Worksheet S-8	
				From 10/01/2017		
		Component	CCN: 15-8512	To 09/30/2018	Date/lime Pre 7/31/2019 3:1	
			_	RHC I	Cost	
	Fri	day	Sa ⁻	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	16: 30	08: 00	12: 00		11. 00

Health Financial Systems	PULASKI MEMORI	IAL HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1305	Peri od:	Worksheet S-8	3
		Component	CCN: 15-8527	From 10/01/2017 To 09/30/2018	Date/Time Pre 7/31/2019 3:1	
				RHC II	Cost	
				1.	00	
Clinic Address and Identification						
1.00 Street		1		NORTH LANE STR		1.00
			ty	State	ZIP Code	
2.00 City, State, ZIP Code, County		NORTH JUDSON	00	2. 00	3. 00 46366-1226	2.00
2.00 City, State, ZIP code, county		INOKIH JUDSUN		I IV	40300-1220	2.00
					1. 00	
3.00 HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for			0	3.00
			Gra	nt Award	Date	
Causas of Fadamal Funda				1. 00	2. 00	
Source of Federal Funds 4.00 Community Health Center (Section 330(d), PHS	Act)		I		I	4.00
5.00 Migrant Health Center (Section 329(d), PHS A						5.00
6.00 Health Services for the Homeless (Section 34)						6.00
7.00 Appalachian Regional Commission						7. 00
8. 00 Look-Alikes						8. 00
9. 00 OTHER (SPECIFY)						9.00
				1.00	2.00	
10.00 Does this facility operate as other than a he	ospi tal -based	RHC or FQHC? E	nter "Y" for		0	10.00
yes or "N" for no in column 1. If yes, indic. 2. (Enter in subscripts of line 11 the type of hours.)	ate number of	other operatio	ns in column			
modi 5.)	Sun	day	N	Monday	Tuesday	
	from	to	from	to	from	
	1. 00	2.00	3. 00	4. 00	5. 00	
Facility hours of operations (1) 11.00 CLINIC			08: 00	17: 00	08: 00	11.00
TI. 00 CETNIC			06.00	17.00	06.00	11.00
				1. 00	2.00	
12.00 Have you received an approval for an exception	on to the prod	uctivity stand	ard?			12.00
13.00 Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	umn 1. If yes,	enter in colu	mn 2 the	N	0	13.00
numbers below.			Prov	ider name	CCN number	
			1100	1. 00	2.00	
14.00 RHC/FQHC name, CCN number						14.00
	Y/N	V	XVIII	XIX	Total Visits	
15 00 Have you provided all as substantially all	1. 00	2. 00	3. 00	4. 00	5. 00	15 00
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in						15. 00
column 1. If yes, enter in columns 2, 3 and						
4 the number of program visits performed by						
Intern & Residents for titles V, XVIII, and						
XIX, as applicable. Enter in column 5 the						
number of total visits for this provider. (see instructions)						
(See Thati detions)		Col	l inty			
			00			
2.00 City, State, ZIP Code, County		PULASKI				2.00
	Tuesday		esday		sday	
	to	from	to	from	to	
Facility hours of operations (1)	6. 00	7. 00	8. 00	9. 00	10.00	
	17: 00	08: 00	17: 00	08: 00	17: 00	11.00
32 0	1	1 00	1	100.00	,	, 55

Health Financial Systems	PULASKI MEM	MORI AL	HOSPI TAL			In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provi der	CCN: 1		Peri od:	Worksheet S-8	
						From 10/01/2017		
			Component	CCN:	15-8527	To 09/30/2018	Date/Time Pre	pared:
							7/31/2019 3:1	2 pm
						RHC II	Cost	
	F	Fri day			Sa	turday		
	from		to		from	to		
	11. 00		12. 00		13.00	14.00		
Facility hours of operations (1)								
11. 00 CLINIC	08: 00	17:	00					11.00

ากรอเว	Financial Systems	PULASKI MEMORIAL				eu of Form CMS-	
100111	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1305	Peri od: From 10/01/201	Worksheet S-8	3
			Component	CCN: 15-8528	To 09/30/2018		
					RHC III	Cost	
					1	. 00	-
	Clinic Address and Identification					. 00	
. 00	Street			-	112 E MONTGOM		1. (
				ty	State	ZIP Code	
	City State 7LD Code County	rn.		00	2.00	3.00	1 2 /
. 00	City, State, ZIP Code, County	ĮFK.	ANCESVI LLE			N 47946-8087	2.0
						1.00	
. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rural	or "U" for			C	3. (
					it Award 1.00	Date 2.00	
	Source of Federal Funds				1.00	2.00	
. 00	Community Health Center (Section 330(d), PHS	Act)					4.0
00	Migrant Health Center (Section 329(d), PHS A						5.
00	Health Services for the Homeless (Section 34)	O(d), PHS Act)					6.
00	Appalachian Regional Commission Look-Alikes						7. 8.
00	OTHER (SPECIFY)						9.
	To make (or correspond	,					1
	Tanaharan arang				1. 00	2. 00	
0. 00	Does this facility operate as other than a hoyes or "N" for no in column 1. If yes, indic. 2. (Enter in subscripts of line 11 the type of hours.)	ate number of oth	her operatio	ns in column	N	C	10.
	(110di 3.)	Sunda	У	Mo	onday	Tuesday	
		from	to	from	to	from	
	<u></u>	1. 00	2. 00	3. 00	4. 00	5. 00	
1 00	Facility hours of operations (1)			08: 00	17: 00	09: 00	11.
. 00	OEI W.O			00.00	17.00	07.00	1 1 1 .
					1.00	2.00	
	Have you received an approval for an exceptils this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below.	d in CMS Pub. 100 umn 1. If yes, er	0-04, chapte nter in colu	r 9, section mn 2 the	1.00 N	2. 00 C	
	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu	d in CMS Pub. 100 umn 1. If yes, er	0-04, chapte nter in colu	r 9, section mn 2 the ders and		CCN number	
3. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below.	d in CMS Pub. 100 umn 1. If yes, er	0-04, chapte nter in colu	r 9, section mn 2 the ders and	N	C	13.
3. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	d in CMS Pub. 100 umn 1. If yes, er List the names o	0-04, chapte nter in colu of all provi	r 9, section mn 2 the ders and Provi	N der name	CCN number	13.
3. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below.	d in CMS Pub. 100 umn 1. If yes, er List the names o	0-04, chapte nter in colu of all provi V	r 9, section mn 2 the ders and Provi	N der name	CCN number 2.00 Total Visits	13.
1. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and	d in CMS Pub. 100 umn 1. If yes, er List the names o	0-04, chapte nter in colu of all provi	r 9, section mn 2 the ders and Provi	N der name	CCN number	13.
. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the	d in CMS Pub. 100 umn 1. If yes, er List the names o	0-04, chapte nter in colu of all provi V	r 9, section mn 2 the ders and Provi	N der name	CCN number 2.00 Total Visits	13.
. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in colonumber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	d in CMS Pub. 100 umn 1. If yes, er List the names o	0-04, chapte nter in colu of all provi V	r 9, section mn 2 the ders and Provi	N der name	CCN number 2.00 Total Visits	13.
. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the	d in CMS Pub. 100 umn 1. If yes, er List the names o	0-04, chapte nter in colu of all provi V 2.00	r 9, section mn 2 the ders and Provi	N der name	CCN number 2.00 Total Visits	13.
1. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	d in CMS Pub. 100 umn 1. If yes, er List the names o	0-04, chapte nter in colu of all provi V 2.00	r 9, section mn 2 the ders and Provi XVIII 3.00	N der name	CCN number 2.00 Total Visits	13.
1.00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in colonumber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	Y/N 1.00	0-04, chapte nter in colu of all provi V 2.00 Cou	r 9, section mn 2 the ders and Provi XVIII 3.00	N der name 1. 00 XIX 4. 00	CCN number 2.00 Total Visits 5.00	13.
4.00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	Y/N 1.00 Tuesday	O-04, chapte nter in colu of all provi V 2.00 Cou 4. LASKI Wedn	r 9, section mn 2 the ders and Provi XVIII 3.00 unty 00 esday	N der name 1. 00 XIX 4. 00	CCN number 2.00 Total Visits 5.00	13.
	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	Y/N 1.00	0-04, chapte nter in colu of all provi V 2.00 Cou	r 9, section mn 2 the ders and Provi XVIII 3.00	N der name 1. 00 XIX 4. 00	CCN number 2.00 Total Visits 5.00	12. () 13. () 15. ()

Health Financial Systems	PULASKI MEMOR	RIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA					Peri od:	Worksheet S-8	
			Component	CCN: 15-8528	From 10/01/2017 To 09/30/2018	Date/Time Pre 7/31/2019 3:1	pared:
					RHC III	Cost	z piii
	Fr	i day		Sa	turday		
	from		to	from	to		
	11. 00		12. 00	13. 00	14. 00		
Facility hours of operations (1)		_					
11. 00 CLI NI C							11. 00

OSPI T	Financial Systems PULASKI MEMORIAL HOSPI AL UNCOMPENSATED AND INDIGENT CARE DATA Provi	der CCN: 15-1305	Period		u of Form CMS- Worksheet S-1	
331111	THE UNCOME ENOUGH AND THE GENT OAKE BATA	uci coli. 15 1505		0/01/2017	WOLKSHEET 3 1	10
			To C	9/30/2018	Date/Time Pre 7/31/2019 3:1	
						IZ PIII
	Uncompensated and indigent care cost computation		· ·		1.00	
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided	l by line 202 co	Lumn 8)		0. 501715	1.
	Medicaid (see instructions for each line)	1 by 11110 202 00	r dillir 0)		0.001710	Ή ''
00	Net revenue from Medicaid				1, 435, 838	2.
00	Did you receive DSH or supplemental payments from Medicaid?				Υ	3.
00	If line 3 is yes, does line 2 include all DSH and/or supplemental p		di cai d?		N	4.
00	If line 4 is no, then enter DSH and/or supplemental payments from N	ledi cai d			235, 830	
00	Medicaid charges				9, 945, 362	
00	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program (line	7 minus sum of	Lines 2	and 5: if	4, 989, 737 3, 318, 069	
00	zero then enter zero)	: / IIII IIUS SUIII OI	TITIES 2	anu o, m	3, 310, 009	′ °.
	Children's Health Insurance Program (CHIP) (see instructions for ea	ch line)				
00	Net revenue from stand-alone CHIP				0	
. 00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)				0	
	Difference between net revenue and costs for stand-alone CHIP (line	11 minus line	9·if < 7	ero then	0	
00	enter zero)	, ii iii iida iiii i	,, 11 、 2	ero then		´ '-
	Other state or local government indigent care program (see instruct	ions for each I	i ne)			
. 00	Net revenue from state or local indigent care program (Not included				0	
. 00	Charges for patients covered under state or local indigent care pro	ogram (Not inclu	ded in li	nes 6 or	0	14
. 00	10) State or local indigent care program cost (line 1 times line 14)				0	15
	Difference between net revenue and costs for state or local indiger	nt care program	(line 15	minus line		
	13; if < zero then enter zero)	. 0	•			
	Grants, donations and total unreimbursed cost for Medicaid, CHIP an instructions for each line)	d state/local i	ndigent c	are progra	ams (see	
. 00	Private grants, donations, or endowment income restricted to funding	ng charity care			0	17.
	Government grants, appropriations or transfers for support of hospi				0	18.
9. 00	Total unreimbursed cost for Medicaid, CHIP and state and local inc 8, 12 and 16)	ligent care prog	rams (sum	of lines	3, 318, 069	19.
	6, 12 and 10)	Uni nsur	ed I	nsured	Total (col. 1	
		patient	is pa	nti ents	+ col . 2)	-
	Uncompensated Care (see instructions for each line)	1.00		2. 00	3.00	
. 00	Charity care charges and uninsured discounts for the entire facilit	y 265	, 522	0	265, 522	20.
	(see instructions)					
. 00	Cost of patients approved for charity care and uninsured discounts	(see 133	3, 216	0	133, 216	21.
	instructions) Payments received from patients for amounts previously written off		0	0	0	
2. 00	charity care	as	U	U	0	22.
. 00	Cost of charity care (line 21 minus line 22)	133	3, 216	0	133, 216	23
					1. 00	+
. 00	Does the amount on line 20 column 2, include charges for patient da	ys beyond a Len	gth of st	ay limit	N N	24.
	imposed on patients covered by Medicaid or other indigent care prog	ram?		-		
. 00	If line 24 is yes, enter the charges for patient days beyond the instay limit	ndigent care pro	gram's le	ngth of	0	25.
. 00	Total bad debt expense for the entire hospital complex (see instruc	ctions)			1, 486, 179	26
. 00	Medicare reimbursable bad debts for the entire hospital complex (see	•			243, 112	
	Medicare allowable bad debts for the entire hospital complex (see i				374, 018	
		•			1, 112, 161	1
. 01	Non-Medicare bad debt expense (see instructions)				1, 112, 101	
7. 01 3. 00 9. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense	e (see instructi	ons)		688, 894	29.
7. 01 8. 00 9. 00 0. 00	, ,	•	ons)			29.

Health Financial Systems	PULASKI MEMORIAL	_ HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC		eri od:	Worksheet A	
				rom 10/01/2017 o 09/30/2018	Date/Time Pre	pared:
					7/31/2019 3:1	2 pm
Cost Center Description	Sal ari es	0ther		Reclassificat	Reclassified	
			+ col. 2)	i ons (See A-6)	Trial Balance (col. 3 +-	
				7, 6)	col . 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 NEW CAP REL COSTS-BLDG & FLXT		1, 692, 348	1, 692, 348		1, 721, 684	1.00
4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT 5.00 O0500 ADMINISTRATIVE & GENERAL	0 2, 135, 210	5, 606, 397	5, 606, 397		5, 606, 397 4, 969, 150	4. 00 5. 00
7. 00 00700 OPERATION OF PLANT	338, 260	2, 427, 307 537, 337	4, 562, 517 875, 597		4, 969, 130 875, 597	7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE	19, 908	53, 571	73, 479		73, 479	8. 00
9. 00 00900 HOUSEKEEPI NG	174, 367	90, 722	265, 089		265, 089	9. 00
10. 00 01000 DI ETARY	164, 816	184, 389	349, 205		349, 205	10.00
13.00 01300 NURSING ADMINISTRATION	443, 514	15, 064	458, 578		458, 578	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	42, 584	56, 148	98, 732		98, 732	14.00
15. 00 01500 PHARMACY	215 412	[1 000]	247 401	0	0 247 401	15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY 17. 00 01700 SOCIAL SERVICE	315, 413 46, 636	51, 988 348	367, 401 46, 984	0	367, 401 46, 984	16. 00 17. 00
INPATIENT ROUTINE SERVICE COST CENTERS	40, 030	340	40, 704	<u> </u>	40, 704	17.00
30. 00 03000 ADULTS & PEDI ATRI CS	2, 058, 241	142, 608	2, 200, 849	17, 153	2, 218, 002	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43. 00 04300 NURSERY	17, 687	3, 962	21, 649	30, 727	52, 376	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	502, 220	94, 938	597, 158		961, 382	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	19, 019 0	5, 791 574, 353	24, 810 574, 353		63, 218 574, 353	52. 00 53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	803, 769	319, 322	1, 123, 091		1, 123, 091	54.00
60. 00 06000 LABORATORY	651, 328	827, 709	1, 479, 037		1, 479, 037	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0		0	60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	62, 861	62, 861	O	62, 861	63.00
65. 00 06500 RESPI RATORY THERAPY	316, 729	31, 747	348, 476	0	348, 476	65.00
66. 00 06600 PHYSI CAL THERAPY	903, 810	37, 658	941, 468	0	941, 468	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	142, 166	1, 174	143, 340		143, 340	67.00
68. 00 06800 SPEECH PATHOLOGY	61, 265	3, 548	64, 813		64, 813	68.00
69. 00 06900 ELECTROCARDI OLOGY	10, 624	14, 695	25, 319		25, 319	69.00
69. 01 06901 CARDI AC REHABI LI TATI ON 70. 00 07000 ELECTROENCEPHALOGRAPHY	53, 063 0	1, 443	54, 506	0	54, 506 0	69. 01 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	557, 029	557, 029	-100, 869	456, 160	70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	337, 027	337,027	100, 869	100, 869	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	2, 338, 836	2, 338, 836		2, 338, 836	73. 00
76. 00 03020 ONCOLOGY	103, 182	35, 175	138, 357		138, 357	76.00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC - WINAMAC	4, 606, 101	416, 155	5, 022, 256			88. 00
88. 01 08801 RURAL HEALTH CLINIC - NORTH JUDSON	373, 047	87, 680	460, 727		381, 981	88. 01
88. 02 08802 RURAL HEALTH CLINIC - FRANCESVILLE 90. 00 09000 CLINIC	195, 045	42, 608	237, 653 372, 869		203, 841	88. 02 90. 00
91. 00 09100 EMERGENCY	84, 282 933, 406	288, 587 1, 314, 784			372, 869 2, 248, 190	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	733, 400	1, 314, 704	2, 240, 170		2, 240, 170	92.00
OTHER REIMBURSABLE COST CENTERS						72.00
101.00 10100 HOME HEALTH AGENCY	608, 487	106, 341	714, 828	-73, 950	640, 878	101. 00
SPECIAL PURPOSE COST CENTERS						
116. 00 11600 HOSPI CE	0	0				116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	16, 124, 179	18, 024, 623	34, 148, 802	-69, 265	34, 079, 537	118. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	O	ol	0		0	190. 00
190. 00 19000 GTFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	162, 476	40, 539	203, 015	97, 465	300, 480	
194. 00 07950 MARKETI NG	68, 156	119, 847	188, 003		159, 803	
200.00 TOTAL (SUM OF LINES 118 through 199)	16, 354, 811	18, 185, 009				

Provi der CCN: 15-1305

Peri od: From 10/01/2017 To 09/30/2018 Worksheet A Date/Time Prepared: 7/31/2019 3:12 pm

				7/31/2019 3: 12	pm
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For		
			Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-13, 105	1, 708, 579		1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	5, 606, 397		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-893, 388	4, 075, 762		5.00
7.00	00700 OPERATION OF PLANT	-278	875, 319		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	73, 479		8.00
9.00	00900 HOUSEKEEPI NG	0	265, 089		9.00
10.00	01000 DI ETARY	-67, 054	282, 151		10.00
13. 00	01300 NURSING ADMINISTRATION	0	458, 578		13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	-10, 148			14. 00
15. 00	01500 PHARMACY	0	0		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	-8, 601	358, 800		16. 00
17. 00	01700 SOCI AL SERVI CE	0,001	46, 984		17. 00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS		10, 701		17.00
30. 00	03000 ADULTS & PEDIATRICS	-397, 428	1, 820, 574		30. 00
31.00	03100 INTENSIVE CARE UNIT	0	0		31.00
43. 00	04300 NURSERY	0			43.00
10.00	ANCILLARY SERVICE COST CENTERS		02,010		10.00
50.00	05000 OPERATING ROOM	-364, 224	597, 158	F	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	001,221	63, 218		52.00
53. 00	05300 ANESTHESI OLOGY	-554, 438			53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0 0	1, 123, 091		54.00
60.00	06000 LABORATORY	-1, 824	1, 477, 213	1	50.00
60.00	06001 BLOOD LABORATORY	-1, 024	1,477,213		50. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	1	1	53. 00
65. 00	06500 RESPIRATORY THERAPY	0	348, 476	1	55. 00 55. 00
66.00	06600 PHYSI CAL THERAPY	-234	941, 234		56. 00
67. 00	06700 OCCUPATI ONAL THERAPY	-234	143, 340		56. 00 57. 00
68. 00	06800 SPEECH PATHOLOGY	0	64, 813		57. 00 58. 00
69.00	06900 ELECTROCARDI OLOGY	_			
		-5, 663 0	19, 656		69.00
69. 01 70. 00	06901 CARDI AC REHABI LI TATI ON	0	54, 506 0		59. 01 70. 00
	07000 ELECTROENCEPHALOGRAPHY		1		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	456, 160		71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	01 010			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	-81, 019			73.00
76. 00	03020 ONCOLOGY OUTPATIENT SERVICE COST CENTERS	0	138, 357		76. 00
88. 00	08800 RURAL HEALTH CLINIC - WINAMAC	12 001	4 220 027		38. 00
88. 00		-13, 081	4, 239, 937		38. 00 38. 01
	08801 RURAL HEALTH CLINIC - NORTH JUDSON	0	381, 981	1	
88. 02	08802 RURAL HEALTH CLINIC - FRANCESVILLE	0			38. 02
90.00	09000 CLINIC	0	372, 869		90.00
91.00	09100 EMERGENCY	0	2, 248, 190		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
404 0	OTHER REIMBURSABLE COST CENTERS		/ 40, 070	100	24 00
101.00	10100 HOME HEALTH AGENCY	0	640, 878		01.00
11/ 0	SPECIAL PURPOSE COST CENTERS	0		11	1/ 00
	11600 HOSPI CE	0		1	16.00
118. 00		-2, 410, 485	31, 669, 052		18. 00
100 0	NONREI MBURSABLE COST CENTERS	_	_		20.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	l e		90.00
	1 19001 HOMECARE	0	l e		90.01
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0		1	92.00
	0 07950 MARKETI NG	0	,	1	94.00
200.00	TOTAL (SUM OF LINES 118 through 199)	-2, 410, 485	32, 129, 335		00.00

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

					From 10/01/2017 To 09/30/2018	Date/Time Pr 7/31/2019 3:	
		Increases			<u> </u>	1/31/2019 3:	TZ DII
	Cost Center	Li ne #	Sal ary	Other			
	2.00	3.00	4. 00	5. 00			
	A - PROPERTY INSURANCE	0.00	1. 00	0.00			
00	NEW CAP REL COSTS-BLDG &	1.00	0	29, 336			1 1.
,0	FIXT	1.00	٩	27,000			'
		+		29, 336			
	B - MARKETING RECLASS		<u> </u>	27,000			
00	ADMINISTRATIVE & GENERAL	5. 00	10, 223	17, 977			1
	0	+	10, 223	17, 977			1
	C - IMPLANTABLE DEVICES		.0,220	,			
00	IMPL. DEV. CHARGED TO	72. 00	O	100, 869			1
	PATIENTS	72.00	٦	.00,007			
	0	+		100, 869			
	D - PHYSICIAN SALARIES		<u> </u>	.00,007			
00	ADULTS & PEDIATRICS	30, 00	86, 288	0			٦ 1
00	OPERATI NG ROOM	50. 00	364, 224	Ö			2
00	RURAL HEALTH CLINIC -	88. 00	147, 495	0			3
	WI NAMAC	00.00	, . , . , . ,	Ğ			
00	RURAL HEALTH CLINIC - NORTH	88. 01	13, 606	0			4
	JUDSON	00.0.	.0,000	ŭ			
00	RURAL HEALTH CLINIC -	88. 02	9, 562	0			5
	FRANCESVI LLE	55.52	7,002	Ğ			
00	PHYSICIANS' PRIVATE OFFICES	192. 00	97, 465	0			6
	0	``+	718, 640	0			
	E - RHC PHYSICIAN COSTS			- 1			
00	RURAL HEALTH CLINIC -	88. 00	0	19, 665			1
	WI NAMAC						
		+		19, 665			
	F - BILLER RECLASS	<u> </u>		,			
00	ADMINISTRATIVE & GENERAL	5. 00	73, 950	0			7 1
	0	+	73, 950	0			
	G - PATIENT ACCOUNTS RECLASS	<u>'</u>		-1			
00	ADMINISTRATIVE & GENERAL	5. 00	353, 484	0			1
	0		353, 484	0			
	H - RHC DEPT 175 RECLASS	<u>'</u>		-1			
00	RURAL HEALTH CLINIC - NORTH	88. 01	0	18, 023			1
	JUDSON			., .			
00	RURAL HEALTH CLINIC -	88. 02	o	7, 639			2
	FRANCESVI LLE						
		+		25, 662			
	I - RN SALARIES	<u>'</u>	- '				
00	NURSERY	43.00	30, 727	0			1
00	DELIVERY ROOM & LABOR ROOM	52. 00	38, 408	0			2
	0	+	69, 135	ō			1
<u> </u>	Grand Total: Increases		1, 225, 432	193, 509			500

From 10/01/2017 To 09/30/2018 Date/Time Prepared: 7/31/2019 3:12 pm Decreases Cost Center 0ther Wkst. A-7 Ref. Li ne # Sal ary 10.00 6. 00 7.00 8.00 9.00 A - PROPERTY INSURANCE 1.00 ADMINISTRATIVE & GENERAL 5.00 29, 336 12 1.00 29, 336 B - MARKETING RECLASS 1.00 MARKETI NG 194.00 10, 223 17, 977 0 1.00 17, 977 10, 223 C - IMPLANTABLE DEVICES MEDICAL SUPPLIES CHARGED TO 100, 869 1.00 71.00 0 1.00 PATI ENTS ō 100, 869 D - PHYSICIAN SALARIES RURAL HEALTH CLINIC -88. 00 1.00 557, 252 0 0 1.00 WL NAMAC 2.00 RURAL HEALTH CLINIC - NORTH 88.01 110, 375 0 0 2.00 JUDSON RURAL HEALTH CLINIC -3.00 88. 02 51, 013 0 0 3.00 FRANCESVI LLE 4.00 0.00 0 0 4.00 5.00 0.00 0 0 5.00 0. 00 6.00 6.00 0 0 718, 640 0 RHC PHYSICIAN COSTS 1.00 ADMINISTRATIVE & GENERAL 5.00 19, 665 0 1.00 19, 665 F - BILLER RECLASS 1.00 HOME HEALTH AGENCY 1<u>01.</u> 00 73, 950 0 1.00 73, 950 0 G - PATIENT ACCOUNTS RECLASS 1.00 RURAL HEALTH CLINIC -1.00 88.00 353, 484 0 0 WI NAMAC 353, 484 0 H - RHC DEPT 175 RECLASS RURAL HEALTH CLINIC -1.00 88.00 25, 662 0 1.00 WI NAMAC 2.00 0.00 0 2.00

ō

69, 135

69, 135

1, 225, 432

30.00

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25, 662

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2.00

500.00

I - RN SALARIES

500.00 Grand Total: Decreases

ADULTS & PEDIATRICS

1.00

2.00

Provi der CCN: 15-1305

					o 09/30/2018	Date/Time Pre	pared:
						7/31/2019 3: 1	2 pm
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	12, 288, 972	943, 937	0	943, 937	0	1.00
2.00	Land Improvements	432, 594	0	0	0	0	2.00
3.00	Buildings and Fixtures	195, 525	152, 777	0	152, 777	0	3.00
4.00	Building Improvements	187, 055	0	0	0	0	4.00
5.00	Fixed Equipment	8, 514, 633	183, 037	0	183, 037	0	5.00
6.00	Movable Equipment	7, 874, 656	150, 661	0	150, 661	588, 637	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	29, 493, 435	1, 430, 412	0	1, 430, 412	588, 637	8.00
9.00	Reconciling Items	0	0	0	0	ol	9.00
10.00	Total (line 8 minus line 9)	29, 493, 435	1, 430, 412	0	1, 430, 412	588, 637	10.00
		Endi ng	Ful I y				
		Bal ance	Depreciated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	13, 232, 909	0				1.00
2.00	Land Improvements	432, 594	0				2.00
3.00	Buildings and Fixtures	348, 302	0				3.00
4.00	Building Improvements	187, 055	0				4.00
5.00	Fi xed Equi pment	8, 697, 670	0				5.00
6.00	Movable Equipment	7, 436, 680	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	30, 335, 210	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	30, 335, 210	0				10.00
			'	•		'	

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-1305 Period: From 10/01/2017 To 09/30/2018 Period: Port II Date/Time Prep	
7/31/2019 3: 12	
SUMMARY OF CAPITAL	
Cost Center Description Depreciation Lease Interest Insurance (see instructions) instructions)	
9.00 10.00 11.00 12.00 13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2	
1. 00 NEW CAP REL COSTS-BLDG & FIXT 1, 424, 822 0 267, 526 0 0	1.00
3.00 Total (sum of lines 1-2) 1,424,822 0 267,526 0 0	3.00
SUMMARY OF CAPITAL	
Cost Center Description Other Total (1)	
Capital-Relat (sum of cols.	
ed Costs (see 9 through 14)	
instructions)	
14. 00 15. 00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2	
1. 00 NEW CAP REL COSTS-BLDG & FIXT 0 1, 692, 348	1.00
3.00 Total (sum of lines 1-2) 0 1,692,348	3.00

Health Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10	
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od:	Worksheet A-7		
				From 10/01/2017 o 09/30/2018	Part III Date/Time Pre	narod:	
			'	0 077 307 2010	7/31/2019 3: 12		
	COMF	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL		
			1 -				
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance		
		Leases	for Ratio	instructions)			
			(col. 1 - col. 2)				
	1. 00	2.00	3.00	4. 00	5. 00		
PART III - RECONCILIATION OF CAPITAL COSTS (2.00	0.00	1.00	0.00		
1. 00 NEW CAP REL COSTS-BLDG & FIXT	30, 335, 333	0	30, 335, 333	1.000000	0	1.00	
3.00 Total (sum of lines 1-2)	30, 335, 333	0	30, 335, 333	1.000000	0	3.00	
	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL						
			I=				
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease		
		Capi tal -Rel at					
	6, 00	ed Costs 7.00	through 7) 8.00	9. 00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS (7.00	0.00	7.00	10.00		
1. 00 NEW CAP REL COSTS-BLDG & FLXT	0	0		1, 415, 164	0	1.00	
3.00 Total (sum of lines 1-2)	o o	Ö		1, 415, 164		3. 00	
		SL	JMMARY OF CAPI				
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)		
		(see	instructions)				
		instructions)		ed Costs (see	9 through 14)		
	11. 00	12. 00	13.00	instructions)	15. 00		
PART III - RECONCILIATION OF CAPITAL COSTS (12.00	13.00	14.00	15.00		
1.00 NEW CAP REL COSTS-BLDG & FLXT	264, 079	29, 336		0	1, 708, 579	1. 00	
3.00 Total (sum of lines 1-2)	264, 079		1		1, 708, 579		

0 *** Cost Center Deleted ***

FIXT 0 *** Cost Center Deleted ***

0 *** Cost Center Deleted ***

O OCCUPATIONAL THERAPY

OADULTS & PEDIATRICS

ONEW CAP REL COSTS-BLDG &

114.00

1.00

2.00

19 00

67.00

30.00

0.00

25.00

26.00

27.00

28 00

29.00

30.00

30.99

25.00

26.00

27.00

28.00

29.00

30.00

30.99

limitation (chapter 14)

physicians' compensation

Depreciation - NEW CAP REL

Non-physician Anesthetist

Adjustment for occupational

therapy costs in excess of limitation (chapter 14)

Hospice (non-distinct) (see

A-8-3

Utilization review -

COSTS-BLDG & FIXT

COSTS-MVBLE EQUIP

Depreciation - CAP REL

Physicians' assistant

(chapter 21)

instructions)

∐oal +h	Financial Systems		PULASKI MEMOR	IAI HOSDITAI	In Lin	u of Form CMS-2	0552 10
	MENTS TO EXPENSES		FULASKI WILWOK		Peri od:	Worksheet A-8	
7100001	MENTO TO EXILENSES				rom 10/01/2017		
					Γo 09/30/2018	Date/Time Pre	
				Expense Classification on	Worksheet A	7/31/2019 3: 1	2 piii
				To/From Which the Amount is			
	C+ C+ D	D! - /CI-	A	0+ 0+	1: //	Wkst. A-7	
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Ref.	
		1. 00	2. 00	3.00	4. 00	5. 00	
31. 00	Adjustment for speech	A-8-3		SPEECH PATHOLOGY	68. 00	3.00	31.00
01100	pathology costs in excess of	,, o o			00.00		01100
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for	Α	-9, 658	NEW CAP REL COSTS-BLDG &	1.00	9	32.00
	Depreciation and Interest			FIXT			
33.00	INVEST INC/UNRESTRIC- INT EXP	В	·	NEW CAP REL COSTS-BLDG &	1. 00	11	33.00
				FIXT			
34.00	OTHER NONOPER REV	В		ADMINISTRATIVE & GENERAL	5. 00	0	
35.00	OTHER SERVICES -OTHER REV	В		ADMINISTRATIVE & GENERAL	5. 00	0	00.00
36.00	POB/RENT I NCOME	B B		ADMINISTRATIVE & GENERAL	5. 00	0	00.00
37. 00 38. 00	CAFETERIA VENDING - OTHER REV	В		DI ETARY CENTRAL SERVI CES & SUPPLY	10. 00 14. 00	0	07.00
40. 00	REBATES & REFUNDS - OTHER REV	В		CENTRAL SERVICES & SUPPLY	14. 00	0	
43. 00	MEDICAL RECORDS FEES -OTHER	В		MEDICAL RECORDS & LIBRARY	16. 00	0	
43.00	REV	Ь	-0,001	MEDICAL RECORDS & EIBRART	10.00	O	43.00
44. 00	I CG - OTHER REV	В	-2, 106	ADULTS & PEDIATRICS	30.00	0	44.00
45.00	ATHLETIC TRAIN SUPP -OTHER REV	В		PHYSI CAL THERAPY	66. 00	0	45.00
45.01	EMPLOYEE RX PROGRAM -OTHER REV	В		DRUGS CHARGED TO PATIENTS	73. 00	0	45. 01
45.02	OTHER REVENUE RHC- OTHER REV	В		RURAL HEALTH CLINIC -	88. 00	0	45. 02
				WI NAMAC			
45.03	TELEVI SI ON	Α		OPERATION OF PLANT	7. 00	0	1 .0.00
45.04	PHYSICIAN RECRUITMENT- ADMIN	Α		ADMINISTRATIVE & GENERAL	5. 00	0	10.01
45. 05	LOBBYING EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	1 .0.00
45.06	CRNA	A		ANESTHESI OLOGY	53.00	0	1 .0.00
45. 07	HAF EXPENSE	А		ADMINISTRATIVE & GENERAL	5. 00	0	45. 07
50. 00	TOTAL (sum of lines 1 thru 49)		-2, 410, 485	1			50.00

column 6, line 200.) (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(Transfer to Worksheet A,

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

Provider CCN: 15-1305

| Peri od: | Worksheet A-8-2 | From 10/01/2017 | To 09/30/2018 | Date/Time Prepared:

						10 09/30/2018	7/31/2019 3:	epared: 12 pm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		l denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1.00	2. 00	3. 00	4.00	5. 00	6. 00	7. 00	
1. 00	91. 00	EMERGENCY	1, 233, 116	0	1, 233, 116	C	0	1.00
2.00	60.00	LABORATORY	24, 000	1, 824	22, 176	C	0	2.00
3.00	90. 00	CLINIC	35, 400	0	35, 400	C	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	309, 034	309, 034	0	C	0	4.00
5.00	69. 00	ELECTROCARDI OLOGY	656	656	0	C	0	5.00
6.00	69. 00	ELECTROCARDI OLOGY	5, 007	5, 007	0	C	0	6. 00
7.00	30.00	ADULTS & PEDIATRICS	86, 288	86, 288	0	C	0	7. 00
8. 00	50.00	OPERATING ROOM	364, 224	364, 224	0	C	0	8. 00
9.00	0.00		0	0	0	l c	0	9. 00
10.00	0.00		0	0	0	l c	0	10.00
200.00			2, 057, 725	767, 033	1, 290, 692		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14.00	
1. 00		EMERGENCY	0	-		1		
2.00		LABORATORY	0	0	0	C	1	
3. 00		CLINIC	0	0	0	C	0	3.00
4. 00		ADULTS & PEDIATRICS	0	0	0	C	0	4.00
5. 00		ELECTROCARDI OLOGY	0	0	0	C	0	5.00
6. 00		ELECTROCARDI OLOGY	0	0	0	C	0	
7. 00		ADULTS & PEDIATRICS	0	0	0	C	0	
8. 00		OPERATING ROOM	0	0	0	[C	0	
9. 00	0.00		0	0	0	[C	0	,
10. 00	0. 00		0	0	0	[C	0	
200.00			0	0	0	C	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		ldenti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	14 15. 00	16.00	17. 00	18. 00	-	
1. 00	1.00	EMERGENCY	15.00				\	1.00
2. 00		LABORATORY		1	_	1, 824	I .	2.00
3.00		CLINIC			0	1,024		3.00
4. 00		ADULTS & PEDIATRICS			0	309, 034	1	4.00
5. 00		ELECTROCARDI OLOGY			0	656	•	5.00
6. 00		ELECTROCARDI OLOGY			0	5, 007		6.00
		ADULTS & PEDIATRICS		0	0	86, 288		7.00
7. 00 8. 00		OPERATING ROOM			0	364, 224	•	8.00
			0	0	0	i .	1	
9. 00	0. 00 0. 00				0	C		9.00
10.00	0.00			0	0	767, 033		10. 00 200. 00
200. 00	1		1	ı U	ı	107,033	'I	₁ 200.00

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

				Fr To	om 10/01/2017 0 09/30/2018	Date/Time Pre	
			CAPI TAL			7/31/2019 3:1	2 piii
		=	RELATED COSTS				
	Cost Center Description	Net Expenses for Cost	NEW BLDG &	EMPLOYEE	Subtotal	ADMINISTRATIV	
		Allocation	FLXT	BENEFITS DEPARTMENT		E & GENERAL	
		(from Wkst A		DELYMENT			
		col. 7)					
	GENERAL SERVICE COST CENTERS	0	1. 00	4. 00	4A	5. 00	
1. 00	00100 NEW CAP REL COSTS-BLDG & FLXT	1, 708, 579	1, 708, 579				1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	5, 606, 397	25, 396				4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	4, 075, 762	240, 113		5, 201, 844		5. 00
7.00	00700 OPERATION OF PLANT	875, 319	176, 041		1, 167, 840		7.00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	73, 479 265, 089	14, 275 8, 750		94, 609 333, 882		8. 00 9. 00
10. 00	01000 DI ETARY	282, 151	70, 782		409, 688		10.00
13.00	01300 NURSING ADMINISTRATION	458, 578	16, 741		628, 043		13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	88, 584	24, 566		127, 814		14.00
15.00	01500 PHARMACY	0	18, 377		18, 377	3, 550	15.00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	358, 800 46, 984	34, 762 0		502, 175 63, 043		16. 00 17. 00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	40, 704	0	10,037	03, 043	12, 177	17.00
30.00	03000 ADULTS & PEDIATRICS	1, 820, 574	204, 900	714, 664	2, 740, 138	529, 340	30. 00
31.00	03100 INTENSIVE CARE UNIT	0	0	· ·	0	1	31.00
43. 00	04300 NURSERY	52, 376	3, 818	16, 671	72, 865	14, 076	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	597, 158	125, 771	298, 361	1, 021, 290	197, 293	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	63, 218	13, 279		96, 272		52. 00
53.00	05300 ANESTHESI OLOGY	19, 915	735		20, 650	3, 989	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 123, 091	114, 128		1, 513, 998		54.00
60.00	06000 LABORATORY	1, 477, 213	32, 960 0		1, 734, 458		60.00
60. 01 63. 00	O6001 BLOOD LABORATORY O6300 BLOOD STORING, PROCESSING & TRANS.	62, 861	996	· · · · · · · · · · · · · · · · · · ·	0 63, 857	-	60. 01 63. 00
65. 00	06500 RESPIRATORY THERAPY	348, 476	18, 567		476, 109		65.00
66.00	06600 PHYSI CAL THERAPY	941, 234	56, 056	311, 228	1, 308, 518	252, 780	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	143, 340	0		192, 295		67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	64, 813 19, 656	0	21, 097 3, 658	85, 910 23, 314		68. 00 69. 00
69. 01	06901 CARDI AC REHABILI TATI ON	54, 506	10, 623		83, 401	16, 111	69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	1	0		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	456, 160	0	0	456, 160		71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	100, 869	0	0	100, 869		72.00
73. 00 76. 00	07300 DRUGS CHARGED TO PATIENTS 03020 ONCOLOGY	2, 257, 817 138, 357	0 13, 374		2, 257, 817 187, 262		73. 00 76. 00
70.00	OUTPATIENT SERVICE COST CENTERS	130, 337	15, 574	33, 331	107, 202	30, 173	70.00
88. 00	08800 RURAL HEALTH CLINIC - WINAMAC	4, 239, 937	265, 462	1, 323, 292	5, 828, 691	1, 125, 976	88. 00
88. 01	08801 RURAL HEALTH CLINIC - NORTH JUDSON	381, 981	0		477, 118		88. 01
88. 02 90. 00	08802 RURAL HEALTH CLINIC - FRANCESVILLE 09000 CLINIC	203, 841 372, 869	0 43, 038	,	256, 731 444, 930	49, 595 85, 952	88. 02 90. 00
	09100 EMERGENCY	2, 248, 190	146, 069		2, 715, 678		
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2/2:0/:/0	0, 00,	02.7.1.7	0		92.00
	OTHER REIMBURSABLE COST CENTERS						
101. 00	10100 HOME HEALTH AGENCY	640, 878	15, 461	184, 068	840, 407	162, 350	101. 00
116 00	SPECIAL PURPOSE COST CENTERS 11600 HOSPI CE	0	0	0	0	0	116. 00
118.00		31, 669, 052			31, 546, 053		
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10, 694		10, 694		190. 00
	19001 HOMECARE 19200 PHYSICIANS'PRIVATE OFFICES	0 300, 480	2, 845 0		2, 845 389, 991		190. 01
	07950 MARKETING	159, 803	0		179, 752		
200.00					0		200. 00
201.00			0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	32, 129, 335	1, 708, 579	5, 631, 793	32, 129, 335	5, 201, 844	202.00

Provider CCN: 15-1305

Peri od: Worksheet B From 10/01/2017 Part I To 09/30/2018 Date/Ti me Prepared: 7/31/2019 3:12 pm

					077 307 2010	7/31/2019 3: 1	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
	'	PLANT	LINEN SERVICE			ADMI NI STRATI O	
						N	
		7. 00	8. 00	9.00	10.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL						5.00
7. 00	00700 OPERATION OF PLANT	1, 393, 443					7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	13, 382	l e				8.00
9. 00	00900 HOUSEKEEPI NG	8, 202	120, 200				9.00
			0		E74 040		
10.00		66, 352	0	19, 665	574, 849	l .	10.00
13.00	l l	15, 693	0	4, 651	U	769, 712	13.00
14. 00		23, 029	0	6, 825	0	0	14.00
15. 00		17, 227	0	5, 106	0	0	15. 00
16. 00		32, 587	0	9, 658	0	0	16. 00
17. 00		0	0	0	0	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	192, 077	46, 930	56, 927	574, 849	408, 630	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300 NURSERY	3, 579	2, 266	1, 061	0	22, 306	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	117, 900	20, 051	34, 943	0	92, 132	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	12, 448	0	3, 689	0	32, 422	52.00
53.00	05300 ANESTHESI OLOGY	689	0	204	0	0	53.00
54.00	1 1	106, 986	ł		0	19, 339	54.00
60.00	1	30, 898		9, 157	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	l e	0	0	Ö	60. 01
63. 00	1	934	i o	277	0	Ö	63.00
65. 00	1 1	17, 405	l o	5, 158	0	18, 317	65.00
66. 00	1 1	52, 548			0	10, 317	66.00
67. 00	1	J2, J40	14,030	13, 374	0	0	67.00
68. 00	1 1	0		0	0	0	68.00
	1	0	0	0	0	0	
69. 00	l i		0	2 051	0		69.00
69. 01	06901 CARDI AC REHABI LI TATI ON	9, 958	0	2, 951	0	0	69. 01
70.00	l i	0	0	0	0	0	70.00
71.00	l i	0	0	0	Ü	0	71.00
72. 00		0	0	0	0	0	72.00
73.00		0	0	0	0	0	73.00
76. 00		12, 537	40	3, 716	0	43, 588	76. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00		253, 963		75, 266	0		88. 00
88. 01		35, 255	l .		0	0	88. 01
88. 02		19, 761	32	5, 857	0	0	88. 02
90.00		40, 345	0	11, 957	0	16, 048	90.00
91.00	09100 EMERGENCY	136, 928	26, 252	40, 582	0	116, 930	91.00
92.00							92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	0 10100 HOME HEALTH AGENCY	14, 493	0	4, 295	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	0 11600 HOSPI CE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 235, 176	125, 951	359, 676	574, 849	769, 712	118.00
	NONREI MBURSABLE COST CENTERS		· ·	· · · · · · · · · · · · · · · · · · ·	·	· · · · · · · · · · · · · · · · · · ·	
190. 0	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	10, 025	0	2, 971	0	0	190. 00
	1 19001 HOMECARE	2, 667			0		190. 01
	019200 PHYSI CLANS' PRI VATE OFFI CES	145, 575			n		192.00
	007950 MARKETI NG	n	l 01,7	0,110	0		194.00
200.00	1				O	l .	200.00
201.00		0	n	n	^		201.00
202.00		1, 393, 443	126, 268	406, 583	574, 849		
202.00	of Trotal (Sum Times The Uniough 201)	1, 373, 443	120, 200	1 400, 505	314,049	107,112	202.00

Period: Worksheet B
From 10/01/2017 Part I Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-1305

				To	09/30/2018	Date/Time Pre 7/31/2019 3:1	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	Subtotal	Z piii
		SERVICES &		RECORDS &	SERVI CE		
		SUPPLY		LI BRARY			
		14. 00	15. 00	16.00	17. 00	24.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL						5.00
7. 00	00700 OPERATION OF PLANT						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 01400 CENTRAL SERVI CES & SUPPLY	102 250					13.00
14. 00 15. 00	01500 PHARMACY	182, 359	44 240				14. 00 15. 00
16. 00		0	44, 260 0				16.00
17. 00	01700 SOCIAL SERVICE		0		75, 222		17.00
17.00	I NPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	<u> </u>	U U	15, 222		17.00
30. 00	03000 ADULTS & PEDIATRICS	0	0	24, 813	70, 201	4, 643, 905	30.00
31. 00			Ö		70, 201	4, 043, 703	31.00
43. 00	1 I		0		o	117, 132	
10.00	ANCILLARY SERVICE COST CENTERS	<u> </u>	<u> </u>	,,,,	<u> </u>	117, 102	10.00
50.00		0	0	55, 555	5, 021	1, 544, 185	50.00
52.00	1	o	0		0	166, 782	1
53.00		o	0	8, 711	O	34, 243	
54.00	05400 RADI OLOGY-DI AGNOSTI C	o	0	132, 050	o	2, 110, 418	
60.00	06000 LABORATORY	o	0	121, 745	o	2, 231, 585	
60. 01	06001 BLOOD LABORATORY	o	0	0	0	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	2, 547	o	79, 951	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	13, 790	0	622, 754	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	32, 593	0	1, 676, 669	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	5, 039	0	234, 482	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	1, 241	0	103, 747	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	5, 202	0	33, 020	69.00
69. 01	06901 CARDI AC REHABI LI TATI ON	0	0	939	0	113, 360	69. 01
70.00		0	0	0	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	168, 701	0	23, 277	0	736, 259	
72. 00		13, 658	0	1, 885	0	135, 898	
73. 00		0	44, 260		0	2, 833, 740	
76. 00	03020 ONCOLOGY	0	0	2, 066	0	285, 384	76. 00
88. 00	OUTPATIENT SERVICE COST CENTERS	0	0	47, 929	ام	7 222 422	00 00
88. 00	08800 RURAL HEALTH CLINIC - WINAMAC 08801 RURAL HEALTH CLINIC - NORTH JUDSON	0	0	47, 929 4, 148	0	7, 333, 422 619, 140	
88. 02	08802 RURAL HEALTH CLINIC - NORTH SUBSON	0	0	2, 208	0	334, 184	1
90.00			0	3, 520	0	602, 752	1
91.00	09100 EMERGENCY		0	44, 055	0	3, 605, 040	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	١	O.	44, 033	J	3, 003, 040	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
101.00	10100 HOME HEALTH AGENCY	0	0	8, 287	0	1, 029, 832	101.00
	SPECIAL PURPOSE COST CENTERS	<u> </u>			'	· · · ·	
116.00	11600 H0SPI CE	0	0	0	0		116. 00
118.00		182, 359	44, 260	641, 430	75, 222	31, 227, 884	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	1 19001 HOMECARE	0	0	0	0		190. 01
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0	654, 366	1
	07950 MARKETI NG	0	0	0	0	214, 476	
200.00	, ,						200.00
201.00		100 250	44 24	(41 420	75 222		201.00
202. 00	TOTAL (sum lines 118 through 201)	182, 359	44, 260	641, 430	75, 222	32, 129, 335	J2U2. UU

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

From 10/01/2017 Part I To 09/30/2018 Date/Time Prepared: 7/31/2019 3:12 pm Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 25. 00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14.00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 4, 643, 905 30.00 03100 INTENSIVE CARE UNIT 0 31.00 C 31.00 04300 NURSERY 0 43.00 43.00 117, 132 ANCILLARY SERVICE COST CENTERS 1, 544, 185 05000 OPERATING ROOM 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0000000000000000 166, 782 52.00 52.00 05300 ANESTHESI OLOGY 53.00 53.00 34, 243 54.00 05400 RADI OLOGY-DI AGNOSTI C 2, 110, 418 54.00 06000 LABORATORY 60.00 2, 231, 585 60.00 60 01 06001 BLOOD LABORATORY Ω 60 01 06300 BLOOD STORING, PROCESSING & TRANS. 79, 951 63.00 63.00 65.00 06500 RESPIRATORY THERAPY 622, 754 65.00 66.00 06600 PHYSI CAL THERAPY 1,676,669 66.00 06700 OCCUPATI ONAL THERAPY 67 00 234, 482 67 00 06800 SPEECH PATHOLOGY 68.00 103, 747 68.00 69.00 06900 ELECTROCARDI OLOGY 33, 020 69.00 69.01 06901 CARDIAC REHABILITATION 113, 360 69.01 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 736, 259 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 135, 898 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 833, 740 73.00 03020 ONCOLOGY 0 285, 384 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC - WINAMAC 08801 RURAL HEALTH CLINIC - NORTH JUDSON 88.00 0 7, 333, 422 88.00 0 619, 140 88.01 88.01 08802 RURAL HEALTH CLINIC - FRANCESVILLE 88 02 334, 184 88 02 90.00 09000 CLI NI C 0 602, 752 90.00 09100 EMERGENCY 0 91.00 3,605,040 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 1, 029, 832 101.00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 31, 227, 884 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 00 25, 756 190.00 190. 01 19001 HOMECARE 6,853 190. 01 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 654, 366 192.00 0 194. 00 07950 MARKETI NG 194.00 214, 476 200.00 200.00 Cross Foot Adjustments Ω 201.00 Negative Cost Centers 0 201.00 TOTAL (sum lines 118 through 201) 32, 129, 335 202.00 202.00

| Period: | Worksheet B | From 10/01/2017 | Part II | To 09/30/2018 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-1305

				Ť	o 09/30/2018		
			CAPI TAL			7/31/2019 3: 1	2 piii
			RELATED COSTS				
	Cost Center Description	Di rectly	NEW BLDG &	Subtotal	EMPLOYEE	ADMI NI STRATI V	
	·	Assigned New	FLXT		BENEFITS	E & GENERAL	
		Capi tal			DEPARTMENT		
		Related Costs					
	CENEDAL CEDVICE COCT CENTERS	0	1.00	2A	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT			I			1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	25, 396	25, 396	25, 396		4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	0	240, 113				5. 00
7. 00	00700 OPERATION OF PLANT	0	176, 041	176, 041			7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	14, 275			858	8.00
9.00	00900 HOUSEKEEPI NG	0	8, 750			3, 027	9.00
10.00	01000 DI ETARY	0	70, 782	70, 782	256	3, 714	10.00
13.00	01300 NURSING ADMINISTRATION	0	16, 741	16, 741	689	5, 693	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	24, 566	24, 566	66	1, 159	14.00
15. 00	01500 PHARMACY	0	18, 377			167	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	34, 762				16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	72	571	17. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0	204, 900	204, 900	3, 223	24, 839	30.00
	03100 INTENSIVE CARE UNIT	0	204, 900	1		24, 639	31.00
	04300 NURSERY	0	· -				43. 00
.0.00	ANCILLARY SERVICE COST CENTERS		0,0.0	0,010	1		10.00
50.00	05000 OPERATI NG ROOM	0	125, 771	125, 771	1, 346	9, 258	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	13, 279	13, 279	89	873	52.00
53.00	05300 ANESTHESI OLOGY	0	735	735	0	187	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	114, 128				54.00
60.00	06000 LABORATORY	0	32, 960			15, 723	60.00
60. 01	06001 BLOOD LABORATORY	0	0			0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	996			579	63.00
65.00	06500 RESPIRATORY THERAPY	0	18, 567			4, 316	65.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	56, 056 0			11, 862 1, 743	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	1		779	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0				69.00
69. 01	06901 CARDI AC REHABI LI TATI ON	0	10, 623	1		756	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	Ō	l c	0	4, 135	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	O.	0	914	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	20, 467	73.00
76.00	03020 ONCOLOGY	0	13, 374	13, 374	160	1, 698	76. 00
	OUTPATIENT SERVICE COST CENTERS		0/5 //0	1 0/5 4/0		50.040	
88. 00	08800 RURAL HEALTH CLINIC - WINAMAC	0		1		52, 849	88. 00
88. 01 88. 02	08801 RURAL HEALTH CLINIC - NORTH JUDSON 08802 RURAL HEALTH CLINIC - FRANCESVILLE	0	0	0			88. 01 88. 02
90.00	09000 CLINIC	0	43, 038			2, 327 4, 033	90.00
91.00	09100 EMERGENCY	0	146, 069				91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		140,007	140,007		24,010	92.00
,2,00	OTHER REIMBURSABLE COST CENTERS				1		72.00
101.00	10100 HOME HEALTH AGENCY	0	15, 461	15, 461	830	7, 618	101.00
	SPECIAL PURPOSE COST CENTERS						
	11600 H0SPI CE	0					116. 00
118.00		0	1, 695, 040	1, 695, 040	24, 902	238, 822	118. 00
100.00	NONREI MBURSABLE COST CENTERS		10 (04	10 (04		07	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10, 694				190.00
	19001 HOMECARE 19200 PHYSICIANS' PRIVATE OFFICES		2, 845 0				190. 01 192. 00
	07950 MARKETING		0			•	194. 00
200.00							200.00
201.00			n				201.00
202.00		0	1, 708, 579		_		
	, , , , , , , , , , , , , , , , , , , ,	•	•	•	•	•	•

Provider CCN: 15-1305

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 10/01/2017 | Part II | To 09/30/2018 | Date/Time Prepared: | Part |

			10	09/30/2018	7/31/2019 3: 1	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
	PLANT	LINEN SERVICE			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 & FLXT						1. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	4					4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT	187, 152					7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	1, 797	16, 961				8.00
9. 00 00900 HOUSEKEEPI NG	1, 102	0	13, 150			9. 00
10. 00 01000 DI ETARY	8, 912	0	636	84, 300		10.00
13.00 O1300 NURSING ADMINISTRATION	2, 108	0	150	0	25, 381	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	3, 093	0	221	0	0	14.00
15. 00 01500 PHARMACY	2, 314	0	165	0	0	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	4, 377	0	312	0	0	16.00
17. 00 01700 SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	25, 798	6, 305	1, 841	84, 300	13, 474	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43. 00 04300 NURSERY	481	304	34	0	736	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	15, 835	2, 693	1, 130	0	3, 038	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 672	0	119	0	1, 069	52.00
53. 00 05300 ANESTHESI OLOGY	93	0	7	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	14, 369	1, 862	1, 026	0	638	54.00
60. 00 06000 LABORATORY	4, 150	35		0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0	O	0	0	60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	125	0	9	0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	2, 338	0	167	0	604	65.00
66. 00 06600 PHYSI CAL THERAPY	7, 058			0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	o	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	o	0	0	69. 00
69. 01 06901 CARDI AC REHABI LI TATI ON	1, 338	0	95	0	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	Ö	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	l o	0	l o	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	l o	0	Ö	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	1	73.00
76. 00 03020 0NC0L0GY	1, 684	5	120	0		76. 00
OUTPATIENT SERVICE COST CENTERS	1,7001		120		., ., .,	70.00
88. 00 08800 RURAL HEALTH CLINIC - WINAMAC	34, 106	215	2, 435	0	0	88. 00
88.01 08801 RURAL HEALTH CLINIC - NORTH JUDSON	4, 735	l .	338	0	0	88. 01
88. 02 08802 RURAL HEALTH CLINIC - FRANCESVILLE	2, 654	4	189	0	0	88. 02
90. 00 09000 CLINIC	5, 419	0	387	0	529	90.00
91. 00 09100 EMERGENCY	18, 391	3, 526		0	3, 856	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	10,071	0,020	1,010	ŭ	0,000	92.00
OTHER REIMBURSABLE COST CENTERS						72.00
101. 00 10100 HOME HEALTH AGENCY	1, 947	0	139	0	0	101. 00
SPECIAL PURPOSE COST CENTERS	1, 717		107			101.00
116. 00 11600 HOSPI CE	0	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	165, 896		_	84, 300		
NONREI MBURSABLE COST CENTERS	100,070	10, 710	11,000	01,000	20,001	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 346	0	96	0	0	190. 00
190. 01 19001 HOMECARE	358			0		190. 01
192. 00 19200 PHYSICIANS' PRIVATE OFFICES	19, 552			0		192. 00
194. 00 07950 MARKETI NG	17, 332	l e	1, 373	0		194. 00
200.00 Cross Foot Adjustments				O		200.00
201.00 Negative Cost Centers	0	0	n	n	0	201.00
202.00 TOTAL (sum lines 118 through 201)	187, 152		13, 150	84, 300		202.00
	1 .5., 102	1 .5, 701		5.,000	, 25,001	

Health Financial Systems PULASKI MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1305 Peri od: Worksheet B From 10/01/2017 Part II 09/30/2018 Date/Time Prepared: 7/31/2019 3:12 pm Cost Center Description CENTRAL PHARMACY MEDI CAL SOCI AL Subtotal SERVICES & RECORDS & SERVI CE SUPPLY LI BRARY 15. 00 17.00 24.00 14 00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10 00 13.00 01300 NURSING ADMINISTRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 29, 105 14.00 01500 PHARMACY 21,023 15.00 15.00 0 01600 MEDICAL RECORDS & LIBRARY 16.00 0 44, 493 16.00 17.00 01700 SOCIAL SERVICE 0 0 643 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 0 0 1.722 600 367,002 31.00 03100 INTENSIVE CARE UNIT 0 0 0 31.00 04300 NURSERY 43.00 0 0 68 0 6, 177 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 3.855 43 162, 969 05200 DELIVERY ROOM & LABOR ROOM 0 17, 334 52.00 233 05300 ANESTHESI OLOGY o 53.00 0000000000 0 604 1,626 05400 RADI OLOGY-DI AGNOSTI C 9.149 0 156, 144 54.00 0 60.00 06000 LABORATORY 0 8, 447 0 62,623 60.01 06001 BLOOD LABORATORY 0 0 0 0 0 06300 BLOOD STORING, PROCESSING & TRANS. 0 177 1,886 63.00 0 06500 RESPIRATORY THERAPY 65.00 0 957 27, 441 0 66.00 06600 PHYSI CAL THERAPY 0 2, 261 81, 114 06700 OCCUPATI ONAL THERAPY o 2, 314 67.00 350 0 68.00 06800 SPEECH PATHOLOGY 0 960 86 06900 ELECTROCARDI OLOGY 0 69.00 361 588 0 69. 01 06901 CARDIAC REHABILITATION 0 0 65 12, 959 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0 0 0 0 0 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 26, 925 Ω 1,615 32 675 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 2, 180 131 3, 225 73.00 07300 DRUGS CHARGED TO PATIENTS 0 21, 023 0 48, 116 6.626 03020 ONCOLOGY 76.00 0 143 ol 18, 621 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC - WINAMAC 88.00 0 0 3, 326 0 364, 357 08801 RURAL HEALTH CLINIC - NORTH JUDSON 0 0 288 10, 115 88 02 08802 RURAL HEALTH CLINIC - FRANCESVILLE 0 0 153 0 5.566 0 90.00 09000 CLI NI C C 244 0 53, 781 09100 EMERGENCY 0 3, 057 0 202, 280 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS

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

From 10/01/2017 Part II 09/30/2018 Date/Time Prepared: 7/31/2019 3:12 pm Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 367, 002 30.00 03100 INTENSIVE CARE UNIT 0 31.00 C 31.00 04300 NURSERY 43.00 0 43.00 6, 177 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0 162, 969 50.00 05200 DELIVERY ROOM & LABOR ROOM 0000000000000000 17, 334 52.00 52.00 05300 ANESTHESI OLOGY 1, 626 53.00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 156, 144 54.00 06000 LABORATORY 60.00 62,623 60.00 60 01 06001 BLOOD LABORATORY Ω 60.01 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 1,886 63.00 65.00 06500 RESPIRATORY THERAPY 27, 441 65.00 06600 PHYSI CAL THERAPY 66.00 81, 114 66.00 06700 OCCUPATIONAL THERAPY 67 00 67 00 2, 314 06800 SPEECH PATHOLOGY 68.00 960 68.00 06900 ELECTROCARDI OLOGY 588 69.00 69.00 69.01 06901 CARDIAC REHABILITATION 12, 959 69.01 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 Ω 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 32, 675 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 3, 225 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 48. 116 73.00 03020 ONCOLOGY 0 18,621 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC - WINAMAC 08801 RURAL HEALTH CLINIC - NORTH JUDSON 88.00 0 364, 357 88.00 0 88.01 10, 115 88.01 08802 RURAL HEALTH CLINIC - FRANCESVILLE 88 02 5, 566 88 02 90.00 09000 CLI NI C 0 53, 781 90.00 09100 EMERGENCY 0 91.00 202, 280 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 26, 570 101.00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 0 116. 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 1,666,443 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 00 12, 233 190. 01 19001 HOMECARE 3, 255 190. 01 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 24, 929 192.00 0 194. 00 07950 MARKETI NG 1, 719 194.00 200.00 200.00 Cross Foot Adjustments Ω 201.00 Negative Cost Centers 0 C 201.00 TOTAL (sum lines 118 through 201) 202.00 1, 708, 579 202.00

	-inancial Systems LOCATION - STATISTICAL BASIS	PULASKI MEMORI		CN: 15-1305 P	eriod:	wof Form CMS-2 Worksheet B-1	
	ECONTION - STATISTICAL BASIS		Trovider c	F	rom 10/01/2017	Date/Time Pre 7/31/2019 3:1	pared:
	Cost Center Description	CAPI TAL RELATED COSTS NEW BLDG & FIXT (SOUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	n	ADMI NI STRATI V E & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SOUARE FEET)	
	ENEDAL SEDVICE COST CENTERS	1. 00	4. 00	5A	5. 00	7. 00	
1.00 C	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	72, 054 1, 071 10, 126	16, 354, 811 2, 572, 867	1	26, 927, 491		1. 00 4. 00 5. 00
8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	7, 424 602	338, 260 19, 908	0	94, 609	62, 687 602	
	00900 H0USEKEEPI NG 01000 DI ETARY	369 2, 985	174, 367 164, 816	1	,	369 2, 985	1
13. 00 C	01300 NURSING ADMINISTRATION	706	443, 514	· O	628, 043	706	13.00
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	1, 036 775	42, 584	1		1, 036 775	•
	01600 MEDICAL RECORDS & LIBRARY	1, 466	315, 413			1, 466	1
17. 00 C	01700 SOCIAL SERVICE	0	46, 636			0	1
	NPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	8, 641	2, 075, 394	1 0	2, 740, 138	8, 641	30.00
	03100 INTENSIVE CARE UNIT	0, 041	2,075,394			0,041	1
_	04300 NURSERY	161	48, 414	1 0	72, 865	161	43.00
	NCILLARY SERVICE COST CENTERS D5000 OPERATING ROOM	5, 304	866, 444	1 0	1, 021, 290	5, 304	50.00
	05200 DELIVERY ROOM & LABOR ROOM	560	57, 427			560	1
	05300 ANESTHESI OLOGY	31	0	′I		31	
	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	4, 813 1, 390	803, 769 651, 328	1		4, 813 1, 390	
	06001 BLOOD LABORATORY	0	031, 320	.1		1, 390	1
	06300 BLOOD STORING, PROCESSING & TRANS.	42	0	′l	,	42	1
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	783 2, 364	316, 729 903, 810		,	783 2, 364	1
	06700 OCCUPATI ONAL THERAPY	2, 304	142, 166	1		2, 304	1
	06800 SPEECH PATHOLOGY	O	61, 265	1		0	
	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHABI LI TATI ON	0 448	10, 624	1	,	0 448	
	07000 ELECTROENCEPHALOGRAPHY	0	53, 063 0			0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	О	0	0		0	
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		,	0	72. 00 73. 00
	03020 ONCOLOGY	564	103, 182			564	1
C	OUTPATIENT SERVICE COST CENTERS]
	08800 RURAL HEALTH CLINIC - WINAMAC 08801 RURAL HEALTH CLINIC - NORTH JUDSON	11, 195 0	3, 842, 860 276, 278	1		11, 425 1, 586	1
	08802 RURAL HEALTH CLINIC - NORTH JUDSON	0	276, 276 153, 594				88. 02
	09000 CLI NI C	1, 815	84, 282		444, 930		90.00
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 160	933, 406	0	2, 715, 678	6, 160	91. 00 92. 00
	THER REIMBURSABLE COST CENTERS						72.00
_	0100 HOME HEALTH AGENCY	652	534, 537	0	840, 407	652	101.00
_	PECIAL PURPOSE COST CENTERS	l ol	0	0	0	0	116. 00
118. 00 N	SUBTOTALS (SUM OF LINES 1 through 117) IONREIMBURSABLE COST CENTERS	71, 483	16, 036, 937		26, 344, 209	55, 567	118. 00
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 9001 HOMECARE	451 120	0		· ·		190. 00 190. 01
	9200 PHYSICIANS' PRIVATE OFFICES	0	259, 941	•	· ·		190.01
194.000	07950 MARKETI NG	0	57, 933	1			194. 00
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	1, 708, 579	5, 631, 793	3	5, 201, 844	1, 393, 443	
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	23. 712480	0. 344351 25, 396	1	0. 193180 244, 109	22. 228580 187, 152	
205. 00	Unit cost multiplier (Wkst. B, Part		0. 001553	3	0. 009065	2. 985499	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

COST A	LLOCATION - STATISTICAL BASIS	. 02/10/1120111	Provider C	CN: 15 1205 D		Worksheet B-1	
CUST A	LLUCATION - STATISTICAL DASIS		Provider Co	F	eriod: rom 10/01/2017 o 09/30/2018		
						7/31/2019 3:1	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DIETARY	NURSI NG	CENTRAL	
		LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(MEALS SERVED)	ADMI NI STRATI O N	SERVI CES & SUPPLY	
		LAUNDRY)		0225)	(DI RECT	(100%)	
		0.00	0.00	10.00	NRSI NG HRS)	11.00	
	GENERAL SERVICE COST CENTERS	8. 00	9.00	10.00	13. 00	14. 00	
1. 00	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	163, 809					7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	0					9.00
10.00	01000 DI ETARY	0	2, 985		I		10.00
	01300 NURSI NG ADMI NI STRATI ON	0	706		82, 784	2 441 /5/	13.00
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	1, 036 775		0	2, 441, 656 0	1
	01600 MEDICAL RECORDS & LIBRARY	0	•		o	0	
17. 00	01700 SOCI AL SERVI CE	0	0	0	0	0	17. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	40.002	0 (41	100	42.040	0	20.00
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	60, 882		100		0	
	04300 NURSERY	2, 940				0	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	26, 013		0		0	
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	560 31	0	-,:	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	17, 985				0	
60.00	06000 LABORATORY	342			0	0	
60. 01	06001 BLOOD LABORATORY	0	-		-	0	
63. 00 65. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06500 RESPIRATORY THERAPY	0	42 783	0	0 1, 970	0	
66. 00	06600 PHYSI CAL THERAPY	19, 014			1, 470	0	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	d	ō	0	•
68. 00	06800 SPEECH PATHOLOGY	0	0	O	0	0	•
69. 00 69. 01	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHABI LI TATI ON	0	0 448		0	0	
	07000 ELECTROENCEPHALOGRAPHY	0	0			0	•
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	o	2, 258, 783	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	O	0	182, 873	
	07300 DRUGS CHARGED TO PATIENTS 03020 ONCOLOGY	52	0 564	0		0	•
70.00	OUTPATIENT SERVICE COST CENTERS	J2	304		4, 000	0	70.00
	08800 RURAL HEALTH CLINIC - WINAMAC	2, 072	11, 425	C	0	0	88.00
	08801 RURAL HEALTH CLINIC - NORTH JUDSON	0	,			0	
88. 02 90. 00	08802 RURAL HEALTH CLINIC - FRANCESVILLE 09000 CLINIC	41	889			0	1
	09100 EMERGENCY	34, 057	1, 815 6, 160		.,	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	.,	5, 155		,		92.00
	OTHER REIMBURSABLE COST CENTERS	_		1 -			ļ
101. 00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	652	0	0	0	101.00
116. 00	11600 HOSPI CE	0	0		ol	0	116.00
118.00		163, 398	54, 596	100	82, 784	2, 441, 656	
460 =	NONREI MBURSABLE COST CENTERS				.1		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 HOMECARE	0		0			190. 00 190. 01
	19200 PHYSICIANS' PRIVATE OFFICES	411	6, 549	•			190.01
	07950 MARKETI NG	0	0	d	ō		194.00
200.00	,						200.00
201.00	1 3	124 240	404 503	F74 040	7/0 712	102 250	201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	126, 268	406, 583	574, 849	769, 712	182, 359	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 770825	6. 587967	5, 748. 490000	9. 297835	0. 074687	203.00
204.00	Cost to be allocated (per Wkst. B,	16, 961	13, 150	1		29, 105	
205 22	Part II)	0 100541	0.010070	042 00000	0.20/502	0.011000	205 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 103541	0. 213073	843. 000000	0. 306593	0. 011920	205.00
204 00	NAHE adjustment amount to be allocated	1					206.00
206. 00		1	I				
	(per Wkst. B-2)		ŀ	•	1		laa-
207. 00	1 "						207. 00

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

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1305 Peri od: Worksheet B-1 From 10/01/2017 09/30/2018 Date/Time Prepared: 7/31/2019 3:12 pm Cost Center Description **PHARMACY** MEDI CAL SOCI AL SERVI CE (100%)RECORDS & LI BRARY (ALLOCATION (GROSS OF TIME) CHARGES) 15. 00 16.00 17.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 100 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 62, 242, 330 16.00 01700 SOCIAL SERVICE 0 17.00 17.00 9.888 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 2, 407, 849 9, 228 30.00 03100 INTENSIVE CARE UNIT 31.00 0 0 31.00 04300 NURSERY 95,027 43.00 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 5, 391, 079 660 50.00 0 05200 DELIVERY ROOM & LABOR ROOM 325, 418 52.00 52.00 0 05300 ANESTHESI OLOGY 0 53.00 845, 273 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 12, 811, 828 0 54.00 00000000000 06000 LABORATORY 60.00 11, 814, 129 0 60.00 0 60 01 06001 BLOOD LABORATORY 60 01 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 247, 206 63.00 0 06500 RESPIRATORY THERAPY 1, 338, 190 65.00 65.00 0 66.00 06600 PHYSI CAL THERAPY 3, 162, 876 66.00 0 06700 OCCUPATI ONAL THERAPY 67 00 488.962 67 00 06800 SPEECH PATHOLOGY 68.00 120, 399 68.00 06900 ELECTROCARDI OLOGY 504, 852 0 69.00 69.00 69.01 06901 CARDIAC REHABILITATION 91, 154 0 69.01 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70 00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2, 258, 783 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 182, 873 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 100 9, 267, 200 0 73.00 103020 ONCOLOGY 200, 507 0 76.00 0 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC - WINAMAC 0 4, 651, 066 0 88.00 08801 RURAL HEALTH CLINIC - NORTH JUDSON 0 402, 519 0 88.01 88.01 0 08802 RURAL HEALTH CLINIC - FRANCESVILLE 0 88.02 214, 284 88 02 90.00 09000 CLI NI C 0 341, 592 0 90.00 09100 EMERGENCY 0 91.00 0 91.00 4, 275, 087 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 804, 177 0 101.00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 0 0 116,00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 100 62, 242, 330 9,888 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190.00 190. 01 19001 HOMECARE 0 C 0 190.01 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 C 0 192.00 194. 00 07950 MARKETI NG 0 0 194.00 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 44, 260 641, 430 75, 222 202.00 Part I) 203 00 Unit cost multiplier (Wkst. B, Part I) 442 600000 0.010305 7 607403 203 00 44, 493 204.00 Cost to be allocated (per Wkst. B, 21,023 643 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 210. 230000 0.000715 0.065028 205.00 11) NAHE adjustment amount to be allocated 206. 00 206.00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00

Parts III and IV)

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-1305	From 10/01/2017	Worksheet C Part I Date/Time Prepared: 7/31/2019 3:12 pm

					To 09/30/2018	Date/Time Pre 7/31/2019 3:1	epared: 2 pm
			Title	XVIII	Hospi tal	Cost	
			<u>'</u>		Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	·	(from Wkst.	Adj .		Di sal I owance		
		B, Part I,	·				
		col. 26)					
		1. 00	2.00	3. 00	4. 00	5. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	4, 643, 905		4, 643, 90		0	
	03100 INTENSIVE CARE UNIT	0			0	l	
	04300 NURSERY	117, 132		117, 13	2 0	0	43.00
	ANCILLARY SERVICE COST CENTERS	,					
	05000 OPERATING ROOM	1, 544, 185		1, 544, 18		l e	1
	D5200 DELIVERY ROOM & LABOR ROOM	166, 782		166, 78		-	1 02.00
	D5300 ANESTHESI OLOGY	34, 243		34, 24		0	
	D5400 RADI OLOGY-DI AGNOSTI C	2, 110, 418		2, 110, 41		0	
	06000 LABORATORY	2, 231, 585		2, 231, 58		0	
	06001 BLOOD LABORATORY	0			0 0	0	
	06300 BLOOD STORING, PROCESSING & TRANS.	79, 951	_	79, 95		0	
	06500 RESPI RATORY THERAPY	622, 754	0	622, 75		0	65.00
	06600 PHYSI CAL THERAPY	1, 676, 669	0	1, 676, 66		0	
	06700 OCCUPATI ONAL THERAPY	234, 482	0	234, 48		0	01.00
	06800 SPEECH PATHOLOGY	103, 747	0	103, 74		0	
	06900 ELECTROCARDI OLOGY	33, 020		33, 02		0	
	06901 CARDI AC REHABI LI TATI ON	113, 360		113, 36		0	69. 01
	07000 ELECTROENCEPHALOGRAPHY	727 250			0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	736, 259		736, 25		1	
	07200 IMPL. DEV. CHARGED TO PATIENTS	135, 898		135, 89		0	
	D7300 DRUGS CHARGED TO PATIENTS D3020 ONCOLOGY	2, 833, 740 285, 384		2, 833, 74		0	1
	DUTPATIENT SERVICE COST CENTERS	285, 384		285, 38	4 0	U	76.00
	D8800 RURAL HEALTH CLINIC - WINAMAC	7, 333, 422		7, 333, 42	2 0	0	88. 00
	08801 RURAL HEALTH CLINIC - NORTH JUDSON	619, 140		619, 14		0	
	08802 RURAL HEALTH CLINIC - FRANCESVILLE	334, 184		334, 18		0	1
	09000 CLINIC	602, 752		602, 75		0	1
	09100 EMERGENCY	3, 605, 040		3, 605, 04		0	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	462, 331		462, 33		0	
	OTHER REIMBURSABLE COST CENTERS	402, 331		+02, 30	1		/2.00
	10100 HOME HEALTH AGENCY	1, 029, 832		1, 029, 83	2	0	101.00
	SPECIAL PURPOSE COST CENTERS	., 02., 002		1,027,00	_		1.000
	11600 HOSPI CE	0			0	0	116. 00
200.00	Subtotal (see instructions)	31, 690, 215	0	31, 690, 21	5 0		200.00
201.00	Less Observation Beds	462, 331		462, 33		0	201.00
202.00	Total (see instructions)	31, 227, 884	0	31, 227, 88	4 0	0	202.00
				-			

eu of Form CMS-2552-10
Worksheet C 7 Part I 8 Date/Time Prepared:

				Τ̈́	o 09/30/2018	Date/Time Pre 7/31/2019 3:1	
			Title	: XVIII	Hospi tal	Cost	2 piii
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	, and the second			+ col. 7)	Ratio	Inpati ent	
						Rati o	
		6. 00	7. 00	8.00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	'					
30.00	03000 ADULTS & PEDIATRICS	2, 164, 044		2, 164, 044			30.00
31.00	03100 INTENSIVE CARE UNIT	0		l			31.00
43.00	04300 NURSERY	95, 027		95, 027	1		43.00
	ANCILLARY SERVICE COST CENTERS	, , , ,			'		
50.00	05000 OPERATING ROOM	871, 352	4, 519, 727	5, 391, 079	0. 286433	0. 000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	208, 133	117, 285	325, 418	0. 512516	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	119, 669	725, 604			0.000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 375, 366	11, 436, 462			0.000000	
60.00	06000 LABORATORY	2, 259, 971	9, 554, 158			0. 000000	
60. 01	06001 BLOOD LABORATORY	0	0			0. 000000	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	117, 194	130, 012	247, 206		0. 000000	
65. 00	06500 RESPIRATORY THERAPY	987, 286	350, 904			0. 000000	
66. 00	06600 PHYSI CAL THERAPY	549, 083	2, 613, 793			0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	221, 709	267, 253			0. 000000	
68. 00	06800 SPEECH PATHOLOGY	39, 813	80, 586			0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	39, 665	465, 187			0. 000000	
	06901 CARDI AC REHABI LI TATI ON	0	91, 154			0. 000000	
	07000 ELECTROENCEPHALOGRAPHY		,,,,,,,	,,,,,,		0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	766, 210	1, 492, 573		1	0. 000000	
	07200 I MPL. DEV. CHARGED TO PATIENTS	63, 291	119, 582		l l	0. 000000	
	07300 DRUGS CHARGED TO PATIENTS	4, 765, 298	4, 501, 902			0. 000000	
	03020 ONCOLOGY	1, 921	198, 586		1	0. 000000	
70.00	OUTPATIENT SERVICE COST CENTERS	1, 721	170,000	200,007	1. 120012	0.00000	70.00
88. 00	08800 RURAL HEALTH CLINIC - WINAMAC	0	4, 651, 066	4, 651, 066			88. 00
	08801 RURAL HEALTH CLINIC - NORTH JUDSON		402, 519		1		88. 01
	08802 RURAL HEALTH CLINIC - FRANCESVILLE		214, 284				88. 02
90.00	09000 CLINIC		341, 592			0. 000000	
	09100 EMERGENCY	294, 864	3, 980, 223			0. 000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	274,004	243, 805			0. 000000	
72.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>	243,003	243,000	1.070313	0.000000	72.00
101 00	10100 HOME HEALTH AGENCY	l	804, 177	804, 177			101.00
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	004, 177	004, 177			1101.00
116 00	11600 HOSPI CE		0				116. 00
200.00		14, 939, 896	47, 302, 434	_			200.00
200.00	· · · · · · · · · · · · · · · · · · ·	14, 737, 070	47, 302, 434	02, 242, 330			201.00
201.00		14, 939, 896	47, 302, 434	62, 242, 330			202.00
202.00	Total (See Histiactions)	14, 737, 070	41, 302, 434	1 02, 242, 330	η J		1202.00

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-1305	From 10/01/2017	Worksheet C Part I Date/Time Prepared: 7/31/2019 3:12 pm

			10 07/30/2010	7/31/2019 3: 12 pm
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient		 	
· ·	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 000000			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
60. 00 06000 LABORATORY	0. 000000			60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS	0. 000000			63.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
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 PATIE	NTS 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				
88.00 08800 RURAL HEALTH CLINIC - WINAMAC				88. 00
88. 01 08801 RURAL HEALTH CLINIC - NORTH JUDSO	N			88. 01
88. 02 08802 RURAL HEALTH CLINIC - FRANCESVILL	E			88. 02
90. 00 09000 CLI NI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PA	ART) 0. 000000			92. 00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS				
116. 00 11600 HOSPI CE				116.00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202. 00

Health Financial Systems	PULASKI MEMORIA	L HOSPITAL		In Lie	ı of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C	CN: 15-1305	Peri od: From 10/01/2017 To 09/30/2018	Worksheet C Part I Date/Time Pre 7/31/2019 3:1:	
		Ti tl	e XIX	Hospi tal	Cost	
				Costs		

					10 09/30/2018	7/31/2019 3:1	
			Ti tl	e XIX	Hospi tal	Cost	
			,		Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	·	(from Wkst.	Ādj .		Di sal I owance		
		B, Part I,					
		col. 26)					
		1. 00	2. 00	3. 00	4.00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDI ATRI CS	4, 643, 905		4, 643, 90	5 0	4, 643, 905	
	03100 INTENSIVE CARE UNIT	0			0	0	31.00
43.00	04300 NURSERY	117, 132		117, 13	2 0	117, 132	43.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	1, 544, 185		1, 544, 18		1, 544, 185	50.00
	05200 DELIVERY ROOM & LABOR ROOM	166, 782		166, 78		166, 782	52.00
53.00	05300 ANESTHESI OLOGY	34, 243		34, 24		34, 243	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 110, 418		2, 110, 41		2, 110, 418	1
	06000 LABORATORY	2, 231, 585		2, 231, 58		2, 231, 585	1
60. 01	06001 BLOOD LABORATORY	0		1	0	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	79, 951		79, 95		79, 951	63.00
	06500 RESPI RATORY THERAPY	622, 754	0	,		622, 754	65.00
66. 00	06600 PHYSI CAL THERAPY	1, 676, 669	0	1, 676, 66		1, 676, 669	66. 00
	06700 OCCUPATI ONAL THERAPY	234, 482	0	234, 48		234, 482	67.00
68. 00	06800 SPEECH PATHOLOGY	103, 747	0	103, 74		103, 747	68. 00
69. 00	06900 ELECTROCARDI OLOGY	33, 020		33, 02		33, 020	69.00
	06901 CARDI AC REHABI LI TATI ON	113, 360		113, 36		113, 360	69. 01
	07000 ELECTROENCEPHALOGRAPHY	0			0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	736, 259		736, 25		736, 259	
	07200 I MPL. DEV. CHARGED TO PATIENTS	135, 898		135, 89		135, 898	
	07300 DRUGS CHARGED TO PATIENTS	2, 833, 740		2, 833, 74		2, 833, 740	
76. 00	03020 ONCOLOGY	285, 384		285, 38	1 0	285, 384	76.00
	OUTPATIENT SERVICE COST CENTERS	7 000 100		7 000 40		7 000 100	
	08800 RURAL HEALTH CLINIC - WINAMAC	7, 333, 422		7, 333, 42		7, 333, 422	88.00
	08801 RURAL HEALTH CLINIC - NORTH JUDSON	619, 140		619, 14		619, 140	1
	08802 RURAL HEALTH CLINIC - FRANCESVILLE	334, 184		334, 18		334, 184	88. 02
90.00	09000 CLI NI C	602, 752		602, 75		602, 752	90.00
	09100 EMERGENCY	3, 605, 040		3, 605, 04		3, 605, 040	•
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	462, 331		462, 33		462, 331	92.00
404.00	OTHER REIMBURSABLE COST CENTERS	4 000 000		4 000 00		4 000 000	101 00
101.00	10100 HOME HEALTH AGENCY	1, 029, 832		1, 029, 83	<u> </u>	1, 029, 832	[101.00
11/ 00	SPECIAL PURPOSE COST CENTERS			1		0	114 00
		0	0) 5 0		116.00
200.00		31, 690, 215	0				
201. 00 202. 00		462, 331 31, 227, 884	0	462, 33 31, 227, 88		462, 331 31, 227, 884	
202. UC	Trotal (see Histructions)	31, 221, 884	ı	31, 221, 88	1 0	31, 221, 884	202.00

Health Financial Systems	PULASKI MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1305	Peri od: Worksheet C From 10/01/2017 Part I To 09/30/2018 Date/Time Prepared:

				-	Го 09/30/2018	Date/Time Pre 7/31/2019 3:1	
			Ti tl	e XIX	Hospi tal	Cost	2 piii
			Charges				
	Cost Center Description	Inpatient	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	, , , , , , , , , , , , , , , , , , ,			+ col. 7)	Ratio	I npati ent	
				,		Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	NPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	2, 164, 044		2, 164, 04	1		30.00
31.00	03100 INTENSIVE CARE UNIT	o		(31.00
43.00	04300 NURSERY	95, 027		95, 02	7		43.00
7	ANCILLARY SERVICE COST CENTERS						1
	05000 OPERATING ROOM	871, 352	4, 519, 727	5, 391, 079	0. 286433	0. 000000	50.00
	D5200 DELIVERY ROOM & LABOR ROOM	208, 133	117, 285	325, 418	0. 512516	0.000000	
53.00	D5300 ANESTHESI OLOGY	119, 669	725, 604	845, 273	0. 040511	0.000000	53.00
	D5400 RADI OLOGY-DI AGNOSTI C	1, 375, 366	11, 436, 462	12, 811, 828	0. 164724	0.000000	54.00
60.00	06000 LABORATORY	2, 259, 971	9, 554, 158	11, 814, 129	0. 188891	0.000000	60.00
60. 01	06001 BLOOD LABORATORY	0	0	(0. 000000	0.000000	60. 01
63.00	D6300 BLOOD STORING, PROCESSING & TRANS.	117, 194	130, 012	247, 200	0. 323419	0.000000	63.00
65.00	06500 RESPIRATORY THERAPY	987, 286	350, 904	1, 338, 190	0. 465370	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	549, 083	2, 613, 793	3, 162, 876	0. 530109	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	221, 709	267, 253	488, 962	0. 479551	0.000000	67.00
68. 00	06800 SPEECH PATHOLOGY	39, 813	80, 586	120, 399	0. 861693	0.000000	68.00
69. 00	06900 ELECTROCARDI OLOGY	39, 665	465, 187	504, 852	0. 065405	0.000000	69.00
69. 01	D6901 CARDIAC REHABILITATION	0	91, 154	91, 154	1. 243610	0.000000	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	(0.000000	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	766, 210	1, 492, 573	2, 258, 783	0. 325954	0.000000	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	63, 291	119, 582	182, 873	0. 743128	0.000000	
73.00	D7300 DRUGS CHARGED TO PATIENTS	4, 765, 298	4, 501, 902	9, 267, 200	0. 305782	0.000000	73.00
	D3020 ONCOLOGY	1, 921	198, 586	200, 50	1. 423312	0. 000000	76.00
	DUTPATIENT SERVICE COST CENTERS						
	D8800 RURAL HEALTH CLINIC - WINAMAC	0	4, 651, 066			0. 000000	
	08801 RURAL HEALTH CLINIC - NORTH JUDSON	0	402, 519			0. 000000	
	08802 RURAL HEALTH CLINIC - FRANCESVILLE	0	214, 284	214, 28	1. 559538	0. 000000	
	09000 CLI NI C	0	341, 592			0. 000000	
	D9100 EMERGENCY	294, 864	3, 980, 223			0. 000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	243, 805	243, 80	1. 896315	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
	10100 HOME HEALTH AGENCY	0	804, 177	804, 17	7		101.00
	SPECIAL PURPOSE COST CENTERS						1
	11600 HOSPI CE	0	0		-		116.00
200.00	Subtotal (see instructions)	14, 939, 896	47, 302, 434	62, 242, 330			200. 00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	14, 939, 896	47, 302, 434	62, 242, 330)		202.00

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-1305	To 09/30/2018	Worksheet C Part I Date/Time Prepared: 7/31/2019 3:12 pm
		T		<u> </u>

				7/31/2019 3:12 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
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 BL00D LABORATORY	0. 000000			60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	0. 000000			69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
76. 00 03020 0NC0L0GY	0. 000000			76.00
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC - WINAMAC	0. 000000			88. 00
88. 01 08801 RURAL HEALTH CLINIC - NORTH JUDSON	0. 000000			88. 01
88. 02 08802 RURAL HEALTH CLINIC - FRANCESVILLE	0. 000000			88. 02
90. 00 09000 CLI NI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS				
116. 00 11600 HOSPI CE			-	116.00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202.00

Health Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der Co		Peri od:	Worksheet D	
				From 10/01/2017		norod.
				To 09/30/2018	Date/Time Pre 7/31/2019 3:1	pared: 2 nm
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	162, 969				8, 702	1
52.00 05200 DELIVERY ROOM & LABOR ROOM	17, 334	325, 418			0	52.00
53. 00 05300 ANESTHESI OLOGY	1, 626			•	66	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	156, 144				· ·	54.00
60. 00 06000 LABORATORY	62, 623				3, 486	
60. 01 06001 BL00D LABORATORY	0	_				60. 01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	1, 886					1
65. 00 06500 RESPI RATORY THERAPY	27, 441	1, 338, 190			· ·	1
66. 00 06600 PHYSI CAL THERAPY	81, 114				· ·	
67. 00 06700 OCCUPATI ONAL THERAPY	2, 314	488, 962				1
68.00 06800 SPEECH PATHOLOGY	960					68.00
69. 00 06900 ELECTROCARDI OLOGY	588	504, 852			30	69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	12, 959	91, 154	0. 14216	6 0	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	32, 675	2, 258, 783				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 225	182, 873	0. 01763	5 30, 977	546	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	48, 116	9, 267, 200			8, 836	
76. 00 03020 ONCOLOGY	18, 621	200, 507	0. 09287	1, 066	99	76. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC - WINAMAC	364, 357	4, 651, 066	0. 07833	8 0	0	88. 00
88.01 08801 RURAL HEALTH CLINIC - NORTH JUDSON	10, 115	402, 519	0. 02512	9 0	0	88. 01
88. 02 08802 RURAL HEALTH CLINIC - FRANCESVILLE	5, 566	214, 284	0. 02597	5 0	0	88. 02
90. 00 09000 CLI NI C	53, 781	341, 592	0. 15744	2 0	0	90.00
91. 00 09100 EMERGENCY	202, 280	4, 275, 087	0. 04731	6 44, 795	2, 120	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	36, 538	243, 805	0. 14986	6 0	0	92.00
200.00 Total (lines 50 through 199)	1, 303, 232	59, 179, 082		4, 214, 036	46, 391	200. 00

Health Financial Systems	PULASKI MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1305	Peri od: Worksheet D
THROUGH COSTS		From 10/01/2017 Part IV

THROUG	H COSTS				o 09/30/2018	Date/Time Pre 7/31/2019 3:1	pared:
			Title	xVIII	Hospi tal	Cost	<u> 2 piii </u>
	Cost Center Description	Non Physician		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 OPERATING ROOM	0	0	C	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	ol c	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	ol c	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	ol c	0	0	54.00
60.00	06000 LABORATORY	0	0	ol c	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	c c	0	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	d c	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	d c	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	d c	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	C	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	C	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	C	0	0	69.00
69. 01	06901 CARDI AC REHABI LI TATI ON	0	0	C	0	0	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	C	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	73.00
76.00	03020 ONCOLOGY	0	0	C	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC - WINAMAC	0	0	C	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC - NORTH JUDSON	0	0	C	0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC - FRANCESVILLE	0	0	C	0	0	88. 02
90.00	09000 CLI NI C	0	0	C	0	0	90.00
91.00	09100 EMERGENCY	0	0	(0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		[C)	0	92.00
200.00	Total (lines 50 through 199)	0	0	d c	0	0	200. 00

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1305	Peri od:	Worksheet D
THROUGH COSTS			From 10/01/2017	Part IV

THROUGH COSTS				o 09/30/2018		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)			
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS			1	5 004 070	0.00000	
50. 00 05000 OPERATING ROOM	0	0	0	5, 391, 079		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		325, 418		
53. 00 05300 ANESTHESI OLOGY	0	0		845, 273	1	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	0	0	12,011,020		
60. 00 06000 LABORATORY	0	0		11, 814, 129		
60. 01 06001 BLOOD LABORATORY	0	0		0	0.000000	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		247, 206		
65. 00 06500 RESPIRATORY THERAPY	0	0		1, 338, 190		
66. 00 06600 PHYSI CAL THERAPY	0	0		3, 162, 876		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		488, 962		
68. 00 06800 SPEECH PATHOLOGY	0	0		120, 399		
69. 00 06900 ELECTROCARDI OLOGY	0	0		504, 852		
69. 01 06901 CARDI AC REHABI LI TATI ON	0	0		91, 154	1	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 050 700	0. 000000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		2, 258, 783	1	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		182, 873	1	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0				
76. 00 03020 ONCOLOGY	0	0	0	200, 507	0. 000000	76. 00
OUTPATIENT SERVICE COST CENTERS			1	4 (51 0((0.000000	00.00
88. 00 08800 RURAL HEALTH CLINIC - WINAMAC	0	0		4, 651, 066		
88. 01 08801 RURAL HEALTH CLINIC - NORTH JUDSON	0	0		402, 519		88. 01
88. 02 08802 RURAL HEALTH CLINIC - FRANCESVILLE	0	0		214, 284		88. 02
90. 00 09000 CLI NI C	0	0		341, 592		90.00
91. 00 09100 EMERGENCY		0		4, 275, 087		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	1	,		
200.00 Total (lines 50 through 199)	0	0	0	59, 179, 082	ı .	200. 00

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENTHROUGH COSTS	NT ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-1305	From 10/01/2017	Worksheet D Part IV Date/Time Prepared:

THROUG	SH COSTS				To 09/30/2018	Date/Time Pre	pared:
-			Title	· XVIII	Hospi tal	7/31/2019 3:1 Cost	<u> 2 pm</u>
	Cost Center Description	Outpati ent	Inpatient	Inpatient	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷	J	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	287, 862		0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	34, 427		0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	574, 493		0 0	0	54.00
60.00	06000 LABORATORY	0. 000000	657, 617		0	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0		0	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	37, 777		0	0	63.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	437, 139		0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	107, 389		0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	42, 184		0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	6, 658		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	25, 333		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	224, 419		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	30, 977		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 701, 900		0 0	0	73.00
76.00	03020 ONCOLOGY	0. 000000	1, 066		0 0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC - WINAMAC	0. 000000	0		0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC - NORTH JUDSON	0. 000000	0		0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC - FRANCESVILLE	0. 000000	0		0	0	88. 02
90.00	09000 CLI NI C	0. 000000	0		0	0	90.00
91. 00	09100 EMERGENCY	0. 000000	44, 795		0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0	0	92.00
200.00	Total (lines 50 through 199)		4, 214, 036		0 0	0	200. 00

Health Financial Systems	PULASKI MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 1	15-1305

					rom 10/01/2017		
				7	To 09/30/2018		epared:
			Ti +Lc	· XVIII	Hospi tal	7/31/2019 3: 1 Cost	2 pm
			11110	Charges	1103pi tai	Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	COST CONTON DESCRIPTION	Charge Ratio	Reimbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Servi ces Not	(300 11131.)	
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.	,	Ded. & Coins.	Ded. & Coins.		
		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. 286433	0	1, 505, 365	0	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 512516	0	(0	0	52.00
53. 00	05300 ANESTHESI OLOGY	0. 040511	0	224, 215	0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 164724	0	4, 217, 169	0	0	54.00
60.00	06000 LABORATORY	0. 188891	0	3, 995, 525	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0	(0	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 323419	0	47, 106	0	0	63.00
65.00	06500 RESPI RATORY THERAPY	0. 465370	0	242, 469	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 530109	0	936, 929	0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 479551	0	65, 497	7 0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 861693	0	7, 07	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 065405	0	186, 413	0	0	69. 00
	06901 CARDIAC REHABILITATION	1. 243610	0	40, 768	0	0	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	(0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 325954	0	379, 780	0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 743128	0	40, 748		0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 305782	0	., , =		0	
	03020 ONCOLOGY	1. 423312	0	83, 857	7 0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC - WINAMAC	0. 000000				0	00.00
	08801 RURAL HEALTH CLINIC - NORTH JUDSON	0. 000000				0	88. 01
	08802 RURAL HEALTH CLINIC - FRANCESVILLE	0. 000000				0	00.02
	09000 CLI NI C	1. 764538	0			0	
	09100 EMERGENCY	0. 843267	0	., ,		0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 896315	0	74, 523		0	, ,
200.00	,		0	15, 527, 062	276	0	200.00
201. 00				(0		201. 00
000 00	Only Charges			45 507 07			000 00
202. 00	Net Charges (line 200 - line 201)		0	15, 527, 062	276	1 0	202.00

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	ı of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH	SERVICES AND VACCINE COST	Provi der CCN: 15-1305	Peri od: From 10/01/2017 To 09/30/2018	Worksheet D Part V Date/Time Prepared: 7/31/2019 3:12 pm
'		Title XVIII	Hospi tal	Cost

				10 09/30/2018	7/31/2019 3:	eparea: 12 pm
		Title	XVIII	Hospi tal	Cost	·- p····
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7.00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	431, 186	0				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	9, 083	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	694, 669	0				54.00
60. 00 06000 LABORATORY	754, 719	0				60.00
60. 01 06001 BLOOD LABORATORY	0	0				60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	15, 235	o				63.00
65. 00 06500 RESPIRATORY THERAPY	112, 838	o				65.00
66. 00 06600 PHYSI CAL THERAPY	496, 674	l ol				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	31, 409	l ol				67.00
68. 00 06800 SPEECH PATHOLOGY	6, 093	l ol				68.00
69. 00 06900 ELECTROCARDI OLOGY	12, 192	l ol				69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	50, 699	l ol				69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	l ol				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	123, 791	l ol				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	30, 281	l ol				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	599, 729	84				73.00
76. 00 03020 0NC0L0GY	119, 355	l ol				76.00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC - WINAMAC	0	0				88. 00
88.01 08801 RURAL HEALTH CLINIC - NORTH JUDSON	0	o				88. 01
88. 02 08802 RURAL HEALTH CLINIC - FRANCESVILLE	0	o				88. 02
90. 00 09000 CLI NI C	539, 130	o				90.00
91. 00 09100 EMERGENCY	1, 022, 711	o				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	141, 319	o				92.00
200.00 Subtotal (see instructions)	5, 191, 113	84				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	5, 191, 113	84				202.00

Health Financial Systems	PULASKI MEMORIAL F	HOSPI TAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1305	Peri od: From 10/01/2017	Worksheet D
		Component CCN: 15-7305		

			Component		From 10/01/2017 To 09/30/2018		
			Title	XVIII S	wing Beds - SNF		<u> </u>
				Charges		Costs	
Cost (Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	·	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins.	Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ERVICE COST CENTERS						
50. 00 05000 OPERAT		0. 286433	0	(0	0	50.00
	ERY ROOM & LABOR ROOM	0. 512516	0	(0	0	52.00
53. 00 05300 ANESTH	HESI OLOGY	0. 040511	0	(0	0	53.00
54. 00 05400 RADI OL	_OGY-DI AGNOSTI C	0. 164724	0	(0	0	54.00
60. 00 06000 LABORA	ATORY	0. 188891	0	(0	0	60.00
60. 01 06001 BL00D	LABORATORY	0. 000000	0	(0	0	60. 01
63. 00 06300 BL00D	STORING, PROCESSING & TRANS.	0. 323419	0	(0	0	63.00
65. 00 06500 RESPIF	RATORY THERAPY	0. 465370	0	(0	0	65.00
66. 00 06600 PHYSI (CAL THERAPY	0. 530109	0	(0	0	66.00
67. 00 06700 OCCUPA	ATIONAL THERAPY	0. 479551	0	(0	0	67.00
68. 00 06800 SPEECH	H PATHOLOGY	0. 861693	0	(0	0	68.00
69. 00 06900 ELECTE	ROCARDI OLOGY	0. 065405	0	(0	0	69.00
69. 01 06901 CARDI A	AC REHABILITATION	1. 243610	0	(0	0	69. 01
70. 00 07000 ELECTE	ROENCEPHALOGRAPHY	0. 000000	0	(0	0	70.00
71.00 07100 MEDICA	AL SUPPLIES CHARGED TO PATIENTS	0. 325954	0	(0	0	71.00
72.00 07200 I MPL.	DEV. CHARGED TO PATIENTS	0. 743128	0	(0	0	72.00
73. 00 07300 DRUGS	CHARGED TO PATIENTS	0. 305782	0	(0	0	73.00
76. 00 03020 ONCOLO	OGY	1. 423312	0	(0	0	76.00
OUTPATI ENT :	SERVICE COST CENTERS						
88. 00 08800 RURAL	HEALTH CLINIC - WINAMAC	0. 000000				0	88. 00
88. 01 08801 RURAL	HEALTH CLINIC - NORTH JUDSON	0. 000000				0	88. 01
88. 02 08802 RURAL	HEALTH CLINIC - FRANCESVILLE	0. 000000				0	88. 02
90. 00 09000 CLINI		1. 764538	0		o	0	90.00
91.00 09100 EMERGE	ENCY	0. 843267	0		o	0	91.00
92. 00 09200 OBSER\	/ATION BEDS (NON-DISTINCT PART)	1. 896315	0		o	0	92.00
200. 00 Subtot	tal (see instructions)		0		o	0	200.00
	PBP Clinic Lab. Services-Program				o	I	201.00
	Charges					I	
202.00 Net Ch	narges (line 200 - line 201)		0		o	0	202. 00

Health Financial Systems	PULASKI MEMOR	I AL HOSPI TAL		In Lieu	of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	ID VACCINE COST		CN: 15-1305 CCN: 15-Z305	Period: From 10/01/2017 To 09/30/2018		narod
		Component	CCN. 15-2305	10 09/30/2018	Date/Time Pre 7/31/2019 3:1:	2 pm
	_	Title	XVIII	Swing Beds - SNF	Cost	
	Co	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(!+)	(!+)				

Cost Center Description	Cost	Cost		
	Rei mbursed	Rei mbursed		
	Servi ces	Servi ces Not		
	Subject To	Subject To		
	Ded. & Coins.	Ded. & Coins.		
	(see inst.)	(see inst.)		
	6. 00	7. 00		
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0	0		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 STORING, PROCESSING & TRANS.	0	0		63.00
65. 00 06500 RESPIRATORY THERAPY	0	0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	0	0		69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
76. 00 03020 ONCOLOGY	0	0		76.00
OUTPATIENT SERVICE COST CENTERS		•		
88.00 08800 RURAL HEALTH CLINIC - WINAMAC	0	0		88. 00
88. 01 08801 RURAL HEALTH CLINIC - NORTH JUDSON	0	0		88. 01
88. 02 08802 RURAL HEALTH CLINIC - FRANCESVILLE	0	0		88. 02
90. 00 09000 CLI NI C	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		200.00
201.00 Less PBP Clinic Lab. Services-Program	0			201.00
Only Charges				
202.00 Net Charges (line 200 - line 201)	0	0		202.00
	'	1	1	

Health Financial Systems	PULASKI MEMORIAL	_ HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1305	Peri od: From 10/01/2017	Worksheet D-1	
				Date/Time Pre 7/31/2019 3:1	
		Title XVIII	Hospi tal	Cost	
Cost Center Description					
·				1. 00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAVS					

Title XVIII Hospital	Cost	
Cost Center Description	1. 00	
PART I - ALL PROVIDER COMPONENTS	1.00	
I NPATI ENT DAYS		l
1.00 Inpatient days (including private room days and swing-bed days, excluding newborn)	3, 563	
2.00 Inpatient days (including private room days, excluding swing-bed and newborn days) 3.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days,	2, 346 0	2. 00 3. 00
do not complete this line.	U	3.00
4.00 Semi-private room days (excluding swing-bed and observation bed days)	2, 015	4.00
5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	207	5.00
reporting period 6.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	742	6.00
reporting period (if calendar year, enter 0 on this line)	772	0.00
7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	63	7. 00
reporting period 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	205	8. 00
8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	205	8.00
9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and	1, 057	9.00
newborn days)	007	10.00
10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	207	10.00
11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	690	11.00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)		1
12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
through December 31 of the cost reporting period 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	_	
14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only)	0	15. 00 16. 00
SWING BED ADJUSTMENT	U	10.00
17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17. 00
reporting period		10.00
18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18. 00
19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	155. 02	19.00
reporting period		
20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	155. 02	20.00
	4, 643, 905	21.00
22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22.00
5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	U	23.00
24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	9, 766	24.00
7 x line 19)	04 770	05.00
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	31, 779	25.00
	1, 367, 080	26.00
	3, 276, 825	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	0	28. 00
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges)	0	29.00
30. 00 Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32.00 Average private room per diem charge (line 29 + line 3)	0.00	
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00 0. 00	
35. 00 Average per diem private room cost differential (line 34 x line 31)	0.00	
36.00 Private room cost differential adjustment (line 3 x line 35)	0	36.00
	3, 276, 825	37.00
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY		
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00 Adjusted general inpatient routine service cost per diem (see instructions)	1, 396. 77	38.00
	1, 476, 386	
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 41.00 Total Program general inpatient routine service cost (line 39 + line 40)	0 1, 476, 386	40.00
The potential rings and general impatrion routine service cost (Time 37 + Time 40)	., +,0,500	- 1.00

MCRI F32	-	15. (6. 1	166.	3

Heal th	Financial Systems PULASKI MEMORIAL HOSPITAL In	Lieu of Form CMS-2	2552-10
	TATION OF INPATIENT OPERATING COST Provider CCN: 15-1305 Period:	Worksheet D-1	
	From 10/01/2 To 09/30/2		pared:
		7/31/2019 3:1	
	Title XVIII Hospital Cost Center Description Total Total Average Per Program Da	ys Program Cost	
	Inpatient Inpatient Diem (col. 1	(col. 3 x	
	Cost Days ÷ col. 2) 1.00 2.00 3.00 4.00	col . 4)	
42.00	1.00 2.00 3.00 4.00 NURSERY (title V & XIX only) 0 0 0.00	5. 00	42.00
	Intensive Care Type Inpatient Hospital Units		
43.00		0 0	
44. 00 45. 00	BURN INTENSIVE CARE UNIT		44. 00 45. 00
46. 00			46.00
47. 00	OTHER SPECIAL CARE (SPECIFY)		47. 00
	Cost Center Description	1.00	
48. 00		1, 258, 770	48. 00
49. 00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2, 735, 156	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I	and 0	50.00
51. 00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00		0	53.00
	medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program di scharges	0	54.00
55.00		0.00	1
56.00		0	56.00
57. 00 58. 00		0	57. 00 58. 00
59. 00		-	
07.00	market basket		07.00
60.00		0.00	•
61. 00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target	оу 0	61.00
	amount (line 56), otherwise enter zero (see instructions)		
62.00		0	
63. 00	Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST	0	63.00
64.00		See 289, 131	64.00
4F 00	instructions)(title XVIII only)	0/2 771	4F 00
65. 00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (Section instructions) (title XVIII only)	963, 771	65. 00
66. 00		1, 252, 902	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting peri	od 0	67. 00
07.00	(line 12 x line 19)	ou o	07.00
68. 00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period	0 1	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69. 00
07.00	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		07.00
70.00			70.00
71. 00 72. 00			71. 00 72. 00
72.00			73.00
74.00			74.00
75. 00		ımn	75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ line 2)		76. 00
77. 00			77. 00
78.00	,		78.00
79. 00 80. 00			79. 00 80. 00
81. 00			81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00			83.00
84. 00 85. 00			84. 00 85. 00
	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00		331	1
88. 00 89. 00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) Observation bed cost (line 87 x line 88) (see instructions)	1, 396. 77 462, 331	1
		, , , , , , , , , , , , , , , , , , , ,	

Health Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 10/01/2017 To 09/30/2018	Date/Time Pre 7/31/2019 3:1	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	367, 002	4, 643, 905	0. 07902	9 462, 331	36, 538	90.00
91.00 Nursing School cost	0	4, 643, 905	0.00000	0 462, 331	0	91.00
92.00 Allied health cost	0	4, 643, 905	0.00000	0 462, 331	0	92.00
93.00 All other Medical Education	o	4, 643, 905	0.00000	0 462, 331	0	93.00

Health Financial Systems	PULASKI	MEMORI AL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provi der CCN: 15-1305	Period: From 10/01/2017	Worksheet D-1	
				To 09/30/2018	Date/Time Pre 7/31/2019 3:1	pared: 2 pm
			Title XIX	Hospi tal	Cost	
Cost Center Description						
					1. 00	
PART I - ALL PROVIDER COMPONENTS						
I NPATI ENT DAYS						
			1 11 1		0 5 (0	4 00

	Cost Contar Decoription Title XIX Hospital	Cost	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS		
1 00	I NPATI ENT DAYS	2 5/2	1 0
1. 00 2. 00	Inpatient days (including private room days and swing-bed days, excluding newborn) Inpatient days (including private room days, excluding swing-bed and newborn days)	3, 563 2, 346	1. 0 2. 0
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	2, 340	3. 0
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 the cost reporting period	2, 015 0	4. 0 5. 0
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	949	6. 0
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7. 0
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	268	8. 0
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	20	9. 0
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10. 0
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.0
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.0
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	
14. 00 15. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days) Total nursery days (title V or XIX only)	0 147	14. 0 15. 0
16. 00	Nursery days (title V of XIX only) SWING BED ADJUSTMENT	0	
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17. 0
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18. 0
19. 00	Medical d rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0. 00	19. 0
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0. 00	20. 0
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	4, 643, 905 0	21. 0 22. 0
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23. 0
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7×1 ine 19)	0	24. 0
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.0
26. 00 27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1, 337, 502 3, 306, 403	
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 0
	Pri vate room charges (excluding swing-bed charges)	Ö	29. 0
	Semi -pri vate room charges (excluding swing-bed charges)	0	30.0
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31.0
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	32.0
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	33.0
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.0
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	35. C
36. 00	Private room cost differential adjustment (line 3 x line 35)	0	36.0
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3, 306, 403	37.0
	DART II HOCDITAL AND CURRENCY ONLY		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1 400 00	20.5
38.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions)	1, 409. 38	
38. 00 39. 00 40. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1, 409. 38 28, 188 0	

6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	949	6.00
	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 the cost	0	7. 00
	reporting period		
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	268	8. 00
	reporting period (if calendar year, enter 0 on this line)		
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	20	9. 00
	newborn days)	_	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)	_	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	_	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period	_	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
44.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	
15. 00	Total nursery days (title V or XIX only)	147	
16. 00	Nursery days (title V or XIX only)	0	16. 00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17. 00
40.00	reporting period		40.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18. 00
40.00	reporting period	0.00	40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19.00
	reporting period	0.00	
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
04 00	reporting period	4 (40 005	04 00
21.00	Total general inpatient routine service cost (see instructions)	4, 643, 905	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	. 0	22.00
	5 x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
04.00	x line 18)	0	04.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
25 00	7 x line 19)	0	25 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
24 00	X line 20)	1 227 502	26. 00
26.00	Total swing-bed cost (see instructions)	1, 337, 502	
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	3, 306, 403	27. 00
20.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
28. 00 29. 00		0	
30.00	Pri vate room charges (excluding swing-bed charges)	0	
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00 0. 00	
	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	0.00	
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	0	
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	3, 306, 403	37. 00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1 100 00	20.00
	Adjusted general inpatient routine service cost per diem (see instructions)	1, 409. 38	
	Program general inpatient routine service cost (line 9 x line 38)	28, 188	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	28, 188	41.00

Heal th	Financial Systems PULASKI MEMORIAL HOSPITAL In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST Provider CCN: 15-1305 Period:	Worksheet D-1	10
	From 10/01/2017 To 09/30/2018		
	Ti tl e XIX Hospi tal	7/31/2019 3: 1 Cost	2 pm
	Cost Center Description Total Total Average Per Program Days	Program Cost	
	Inpatient Inpatient Diem (col. 1	(col . 3 x	
	Cost Days ÷ col . 2) 1.00 2.00 3.00 4.00	col . 4) 5.00	
42.00	NURSERY (title V & XIX only) 117, 132 147 796.82 0	0	42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT O 0 0.00 0	0	43. 00
44. 00	CORONARY CARE UNIT		44. 00
	BURN INTENSIVE CARE UNIT		45.00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)		46. 00 47. 00
	Cost Center Description		
48. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1. 00 31, 426	48 00
	Total Program inpatient costs (sum of lines 41 through 48) (see instructions)	59, 614	
FO 00	PASS THROUGH COST ADJUSTMENTS		F0 00
50. 00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines 50 and 51)	0	52. 00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and	0	53.00
	medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0. 00	
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	0	58.00
59. 00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0. 00	60. 00
61. 00		0	61.00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target		
62. 00	amount (line 56), otherwise enter zero (see instructions) Relief payment (see instructions)	0	62. 00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See	0	64. 00
/ F 00	instructions)(title XVIII only)		/F 00
65. 00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66. 00
67. 00	· · · · · · · · · · · · · · · · · · ·	0	67. 00
69 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period	0	68. 00
00.00	(line 13 x line 20)		08.00
69. 00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY	0	69. 00
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70. 00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72. 00 73. 00	Program routine service cost (line 9 x line 71) Medically necessary private room cost applicable to Program (line 14 x line 35)		72. 00 73. 00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75. 00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75. 00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76. 00
77.00	Program capital -related costs (line 9 x line 76)		77.00
78. 00 79. 00	Inpatient routine service cost (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records)		78. 00 79. 00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limitation		81. 00 82. 00
83.00	Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions)		82.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85. 00 86. 00	Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85)		85. 00 86. 00
50.00	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	331	
88. 00 89. 00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) Observation bed cost (line 87 x line 88) (see instructions)	1, 409. 38 466, 505	

Health Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 10/01/2017 To 09/30/2018		
		Ti tl	e XIX	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	367, 002	4, 643, 905	0. 07902	9 466, 505	36, 867	90.00
91.00 Nursing School cost	0	4, 643, 905	0.00000	0 466, 505	0	91.00
92.00 Allied health cost	0	4, 643, 905	0.00000	0 466, 505	0	92.00
93.00 All other Medical Education	0	4, 643, 905	0.00000	0 466, 505	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1305	Peri od: From 10/01/2017 To 09/30/2018	Worksheet D-3 Date/Time Pre 7/31/2019 3:1	epared
	Titl∈	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		,			
30. 00 03000 ADULTS & PEDI ATRI CS			939, 168		30.0
31.00 03100 INTENSIVE CARE UNIT			0		31.0
43. 00 04300 NURSERY					43.0
ANCILLARY SERVICE COST CENTERS					٠
50. 00 05000 OPERATING ROOM		0. 2864		82, 453	
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 5125		0	
53. 00 05300 ANESTHESI OLOGY		0.0405	·	1, 395	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY		0. 16472	·	94, 633	
60. 01 06000 LABORATORY		0. 1888 0. 0000		124, 218 0	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 3234		12, 218	
65. 00 06500 RESPIRATORY THERAPY		0. 4653		203, 431	
66. 00 06600 PHYSI CAL THERAPY		0. 53010		56, 928	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 4795!		20, 229	
68. 00 06800 SPEECH PATHOLOGY		0. 8616		5, 737	
69. 00 06900 ELECTROCARDI OLOGY		0. 06540	·	1, 657	
69. 01 06901 CARDI AC REHABI LI TATI ON		1. 2436		0	69.0
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000	00 0	0	70.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3259!	54 224, 419	73, 150	71.0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 74312		23, 020	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 30578			
76. 00 03020 ONCOLOGY		1. 4233	12 1, 066	1, 517	76.0
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC - WINAMAC		0. 00000		0	
38. 01 08801 RURAL HEALTH CLINIC - NORTH JUDSON		0. 00000		0	
38. 02 08802 RURAL HEALTH CLINIC - FRANCESVILLE		0.00000		0	
90. 00 09000 CLI NI C		1. 76453		0	1
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 84320	·	37, 774	
	augh 09)	1. 8963		1 250 770	
200.00 Total (sum of lines 50 through 94 and 96 through 201.00 Less PBP Clinic Laboratory Services-Program			4, 214, 036	1, 258, 770	
zui. ooj = Less PBP Cliffic Laboratory Services-Program (only charges (Tine 61)	1	1 0		201. 0 202. 0

Heal th	Financial Systems	PULASKI N	MEMORI AL	HOSPI TAL			In Lie	u of Form CMS-2	2552-10
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT			Provi der C	CN: 15-1305	Peri od:		Worksheet D-3	
						From 10/			
				Component	CCN: 15-Z305	To 09/	′30/2018	Date/Time Pre 7/31/2019 3:1	pared:
				Ti +l c	e XVIII	Swing Bed	de - SNE	7/31/2019 3. 1 Cost	2 μιι
	Cost Center Description			11 (16	Ratio of Cos		tient	I npati ent	
	oost center beson per on				To Charges			Program Costs	
					l o onal goo		rges	(col. 1 x	
							. 9	col . 2)	
					1.00	2.	00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000 ADULTS & PEDIATRICS						0		30.00
	03100 INTENSIVE CARE UNIT						0		31.00
43.00	04300 NURSERY								43.00
	ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM				0. 2864		13, 171	3, 773	•
52.00	05200 DELIVERY ROOM & LABOR ROOM				0. 5125		0	0	52.00
53.00	05300 ANESTHESI OLOGY				0. 0405		638	26	•
54. 00	05400 RADI OLOGY-DI AGNOSTI C				0. 1647		64, 009	10, 544	
60.00	06000 LABORATORY				0. 1888		159, 809	30, 186	1
60. 01	06001 BLOOD LABORATORY				0.0000		0	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.				0. 3234		10, 991	3, 555	•
65.00	06500 RESPI RATORY THERAPY				0. 4653		145, 154	67, 550	1
66.00	06600 PHYSI CAL THERAPY				0. 5301		278, 196	147, 474	1
67.00	06700 OCCUPATI ONAL THERAPY				0. 4795		108, 254	51, 913	
68.00	06800 SPEECH PATHOLOGY				0. 8616		7, 657	6, 598	
69.00	06900 ELECTROCARDI OLOGY				0.0654		3, 073	201	69.00
69. 01 70. 00	O6901 CARDI AC REHABI LI TATI ON O7000 ELECTROENCEPHALOGRAPHY				1. 2436 0. 0000		0	0	69. 01 70. 00
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				0. 3259		53, 803		
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS				0. 3259		53, 803	17, 537 0	71.00
	07300 DRUGS CHARGED TO PATIENTS				0. 7431.		175, 753	53, 742	
	03020 ONCOLOGY				1. 4233		49	70	1
70.00	OUTPATIENT SERVICE COST CENTERS				1.4233	12	47	70	70.00
88. 00	08800 RURAL HEALTH CLINIC - WINAMAC				0.0000	20		0	88. 00
88. 01	08801 RURAL HEALTH CLINIC - NORTH JUDSON				0.0000			0	88. 01
88. 02	08802 RURAL HEALTH CLINIC - FRANCESVILLE				0. 0000			0	
90.00	09000 CLINIC				1. 7645		0	0	90.00
91. 00	09100 EMERGENCY				0. 8432		6, 246	5, 267	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				1. 8963		0, 2 10	0, 20,	
200.00		96 through	98)				026, 803	398, 436	
201.00				s (line 61)		.,	0	2.2, 100	201.00
202.00	1 1	- J / J	900	. (21)		1.	026, 803		202.00
					•				•

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Health Fir	nancial Systems PU	ILASKI MEMORIAL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
Title XIX To O9/30/2018 Bate/Time Prepared: To O9/30/2018 Bate/Time Prepared: To O9/30/2018 Bate/Time Prepared: To Obspirate Cost Center Description				CN: 15-1305		_	
NPATI ENT ROUTH NE SERVICE COST CENTERS 1.00 2.00 3.00					From 10/01/2017 To 09/30/2018	B Date/Time Pre	
NPATIENT ROUTINE SERVICE COST CENTERS			Ti tl	e XIX	Hospi tal		
INPATI ENT ROUTI NE SERVICE COST CENTERS		Cost Center Description	· ·	Ratio of Cos	t Inpatient	I npati ent	
INPATI ENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00		·		To Charges	Program	Program Costs	
IMPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3					Charges	(col. 1 x	
INPATIENT ROUTI NE SERVICE COST CENTERS 14,666 30.00 31.00 30.00 3							
14,666 30,00 3000 ADULTS & PEDLATRICS 14,666 31,00 31 31,00				1.00	2. 00	3. 00	
31.00 03100 INTENSIVE CARE UNIT 31.00 04300 NURSERY 3.744 43.00 04300 NURSERY 3.744 43.00 04300 NURSERY 3.744 43.00 04300 NURSERY 3.744 43.00 04300 NURSERY 3.745 3.74							
43.00					14, 666		
ANCILLARY SERVICE COST CENTERS					_	1	
SOLOD					3, 744		43.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 0.512516 7, 335 3, 759 52.00							
53.00 05300 ANESTHESI OLOGY 0.040511 1,965 80 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.164724 8,949 1,474 54.00 60.00 06000 LABORATORY 0.188891 16,963 3,204 60.00 60.01 06001 BLOOD LABORATORY 0.000000 0 0 60.01 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.323419 1,186 384 63.00 65.00 06500 RESPIRATORY THERAPY 0.465370 5,718 2,661 66.00 66.00 06600 PHYSI CAL THERAPY 0.530109 850 451 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.479551 291 140 67.00 68.00 ORBORO SPEECH PATHOLOGY 0.861693 690 595 68.00 68000 PEECTROCARDI OLOGY 0.479551 291 14 69.00 69.01 06901 CARDI AC REHABI LI TATI ON 1.243610 0 0				0. 2864			50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 164724 8, 949 1, 474 54.00 60.00 06000 LABORATORY 0. 1888971 16, 963 3, 204 60.00 60.01 06001 BLOOD LABORATORY 0. 000000 0 0 06.01 63.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0. 323419 1, 186 384 63.00 65.00 06500 RESPI RATORY THERAPY 0. 465370 5,718 2,661 65.00 66.00 06600 PHYSI CAL THERAPY 0. 5330109 850 451 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0. 479551 291 140 67.00 68.00 08600 SEECH PATHOLOGY 0. 861693 690 595 68.00 69.01 06900 ELECTROCARDI OLOGY 0. 065405 219 14 69.00 69.01 06901 CARDI AC REHABI LI TATI ON 1. 243610 0 0 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 325954 9,028 2,943 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 325954 9,028 2,943 71.00							
60. 00 06000 LABORATORY 0. 188891 16, 963 3, 204 60. 00 60. 01 06001 BLOOD LABORATORY 0. 0000000 0 0 06. 01 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0. 323419 1, 186 384 63. 00 06500 RESPI RATORY THERAPY 0. 465370 5, 718 2, 661 65. 00 06600 PHYSI CAL THERAPY 0. 530109 850 451 66. 00 06700 OCCUPATI ONAL THERAPY 0. 479551 291 140 67. 00 06800 SPECH PATHOLOGY 0. 861693 690 595 68. 00 06800 SPECH PATHOLOGY 0. 861693 690 595 68. 00 06900 ELECTROCARDI OLOGY 0. 065405 219 14 69. 00 69. 01 06900 ELECTROCARDI OLOGY 0. 065405 219 14 69. 00 070000 070000 070000 070000 070000 0700000							53.00
60. 01 06001 BLOOD LABORATORY 0.000000 0 0 0 0 0 0 0						1, 474	54.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.323419 1,186 384 63.00 65.00 65.00 RESPIRATORY THERAPY 0.465370 5,718 2,661 65.00 66.00 06600 PHYSI CAL THERAPY 0.530109 850 451 66.00 67.00 06000 PHYSI CAL THERAPY 0.479551 291 140 67.00 68.00 06600 PHYSI CAL THERAPY 0.479551 291 140 67.00 68.00 06800 SPEECH PATHOLOGY 0.861693 690 595 68.00 69.00 69.00 ELECTROCARDI OLOGY 0.065405 219 144 69.00 69.01 06901 CARDI AC REHABI LI TATI ON 1.243610 0 0 69.01 70.00 70.00 ELECTROENCEPHALOGRAPHY 0.000000 0 0 70.00 70.00 70.00 T.000 T.00				0. 1888	91 16, 963	3, 204	60.00
65. 00 06500 RESPIRATORY THERAPY 0.465370 5,718 2,661 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.530109 850 451 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0.479551 291 140 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.861693 690 595 68. 00 690 ELECTROCARDI OLOGY 0.065405 219 14 69. 00 69. 01 06901 CARDI AC REHABI LITATI ON 1.243610 0 0.6901 0.00000 0 0.00000 0 0.000000 0						1	60. 01
66. 00 06600 PHYSI CAL THERAPY 0.530109 850 451 66. 00 6700 0CCUPATI ONAL THERAPY 140 67. 00 68. 00 68. 00 68. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 01 69. 00 69. 01 69. 00 69. 01 69. 00 69. 01 69. 0				0. 3234	1, 186	384	63.00
67. 00 06700 0CCUPATI ONAL THERAPY 0. 479551 291 140 67. 00 68. 00 SPEECH PATHOLOGY 0. 86. 00 SPEECH PATHOLOGY 0. 86. 00 SPEECH PATHOLOGY 0. 86. 00 SPEECH PATHOLOGY 0. 065405 219 14 69. 00 06900 ELECTROCARDI OLOGY 0. 0. 65405 219 14 69. 00 07000 ELECTROCARDI AC REHABI LI TATI ON 0. 0. 000000 0. 0. 0. 0. 0. 0. 0. 0. 0.							65.00
68. 00 06800 SPEECH PATHOLOGY 0. 861693 690 595 68. 00 690 06900 ELECTROCARDI OLOGY 0. 065405 219 14 69. 00 69. 01 06901 CARDI AC REHABI LI TATI ON 1. 243610 0 0 69. 01 07. 00 07.000 ELECTROENCEPHALOGRAPHY 0. 0. 000000 0 0 0 0 0. 07. 00 07.	66.00 066	500 PHYSI CAL THERAPY		0. 5301	09 850	451	66.00
69. 00							
69. 01 06901 CARDI AC REHABILITATION 1. 243610 0 0 69. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 000000 0 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 325954 9, 028 2, 943 71. 00 72. 00 07200 MPL. DEV. CHARGED TO PATI ENTS 0. 743128 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 305782 29, 816 9, 117 73. 00 76. 00 03020 ONCOLOGY 0. 123312 0 0 0 76. 00 0017PATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C - WI NAMAC 1. 576719 0 0 88. 00 88. 01 08801 RURAL HEALTH CLINI C - NORTH JUDSON 1. 538163 0 0 88. 01 88. 02 08802 RURAL HEALTH CLINI C - FRANCESVI LLE 1. 559538 0 0 88. 02 90. 00 09000 CLINI C 1. 764538 0 0 90. 00 91. 00 09100 EMERGENCY 0. 843267 4, 275 3, 605 91. 00 920. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 0 92. 00 200. 00 Total (sum of lines 50 through 94 and 96 through 98) 97, 755 31, 426 200. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00							68.00
70. 00 07000 CLECTROENCEPHALOGRAPHY 0.000000 0 0 70.00				0. 0654	05 219	14	
71. 00						0	69. 01
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 743128 0 0. 72. 00 0. 7300 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0.							
73. 00 07300 DRUGS CHARGED TO PATIENTS 0.305782 29,816 9,117 73.00 76.00 03020 ONCOLOGY 1.423312 0 0 0 76.00 000						2, 943	
76. 00 03020 ONCOLOGY 1.423312 0 0 76. 00							
88.00 08800 RURAL HEALTH CLINIC - WINAMAC 1.576719 0 0 88.00 88.01 RURAL HEALTH CLINIC - NORTH JUDSON 1.538163 0 0 88.01 88.02 08802 RURAL HEALTH CLINIC - FRANCESVILLE 1.559538 0 0 88.02 90.00 09000 CLINIC 1.764538 0 0 90.00 91.00 EMERGENCY 0.843267 4,275 3,605 91.00 92.00 095200 0BSERVATION BEDS (NON-DISTINCT PART) 1.896315 0 0 92.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00						9, 117	73.00
88. 00				1. 4233	12 C	0	76. 00
88. 01 08801 RURAL HEALTH CLINIC - NORTH JUDSON 1.538163 0 0 88. 01 88. 02 08802 RURAL HEALTH CLINIC - FRANCESVILLE 1.559538 0 0 0 88. 02 09000 CLINIC 1.764538 0 0 90. 00 91. 00 91. 00 9200 08SERVATION BEDS (NON-DISTINCT PART) 0.843267 4,275 3,605 91. 00 9200 09200							
88. 02 08802 RURAL HEALTH CLINIC - FRANCESVILLE 1.559538 0 0 88. 02 90. 00 09000 CLINIC 1.764538 0 0 90. 00 91. 00 09100 EMERGENCY 0.843267 4, 275 3, 605 91. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 1.896315 0 0 92. 00 201. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00 201. 00 201. 00 0 0 0 0 0 0 0 0 0						0	
90. 00 09000 CLINIC 1.764538 0 0 90. 00 91. 00 09100 EMERGENCY 0.843267 4,275 3,605 91. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 1.896315 0 0 92. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00 201. 00 0 0 0 0 0 0 0 0 0				1. 5381	63 C	0	88. 01
91. 00	88. 02 088	302 RURAL HEALTH CLINIC - FRANCESVILLE				0	
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 1.896315 0 92. 00 200. 00 Total (sum of lines 50 through 94 and 96 through 98) 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00				1. 7645		1	
200.00 Total (sum of lines 50 through 94 and 96 through 98) 97,755 31,426 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00						3, 605	
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00				1. 8963	15 C	1	
					97, 755	31, 426	200.00
202.00 Net charges (line 200 minus line 201) 97,755 202.00			am only charges (line 61)		C)	
	202. 00	Net charges (line 200 minus line 201)			97, 755	5	202.00

111 46	Figure 1 Contains	DILLACKI MEMODI AL LIOCDI	T A I			la lia		2552 10
	Financial Systems ENT ANCILLARY SERVICE COST APPORTIONMENT	PULASKI MEMORIAL HOSPI		CN: 15-1305	Do	ri od:	u of Form CMS-: Worksheet D-3	
INPAII	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi	der C	CN: 15-1305		om 10/01/2017	worksneet D-3	
		Compo	nent	CCN: 15-Z305	То		Date/Time Pre 7/31/2019 3:1	
			Ti tl	e XIX	Swi	ng Beds - SNF		
	Cost Center Description			Ratio of Cos	st	I npati ent	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							
30. 00	03000 ADULTS & PEDIATRICS					0		30.00
31. 00	03100 INTENSIVE CARE UNIT					0		31.00
43. 00	04300 NURSERY					0		43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM			0.0000		0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM			0.0000		0	0	52.00
53.00	05300 ANESTHESI OLOGY			0.0000		0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C			0.0000		0	0	54.00
60.00	06000 LABORATORY			0.0000		0	0	60.00
60. 01	06001 BLOOD LABORATORY			0.0000		0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.			0.0000		0	0	63.00
65.00	06500 RESPI RATORY THERAPY			0.0000		0	0	65.00
66.00	06600 PHYSI CAL THERAPY			0.0000		0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY			0.0000		0	0	67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY			0. 0000 0. 0000		0	0	68. 00 69. 00
69. 00	06901 CARDI AC REHABI LI TATI ON			0.0000		0	0	69.00
	07000 ELECTROENCEPHALOGRAPHY			0.0000		0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0.0000		0	0	71.00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS			0.0000		0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS			0.0000		o	0	73.00
76.00	03020 ONCOLOGY			0.0000		Ö	0	76.00
70.00	OUTPATIENT SERVICE COST CENTERS			0.0000	00	<u> </u>		70.00
88 00	08800 RURAL HEALTH CLINIC - WINAMAC			0.0000	00	ol	0	88.00
88. 01	08801 RURAL HEALTH CLINIC - NORTH JUDSON			0.0000		ol	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC - FRANCESVILLE			0.0000		o	0	88. 02
90.00	09000 CLINIC			0.0000		ol	0	90.00
91.00	09100 EMERGENCY			0.0000		ol	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)			0.0000		o	0	1
200.00	1 1	96 through 98)				o	-	200.00
201.00			e 61)			Ö		201.00
202.00	1 1	3 3 4 (,			o		202.00
				•		-1		

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-1305	From 10/01/2017	Worksheet E Part B Date/Time Prepared: 7/31/2019 3:12 pm
		Ti +1 o V\/I I I	Hospi tal	Cost

		10 09/30/2018	7/31/2019 3: 1	
		Title XVIII Hospital	Cost	
	· · · · · · · · · · · · · · · · · · ·			
			1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1. 00	Medical and other services (see instructions)		5, 191, 197	1
2. 00	Medical and other services reimbursed under OPPS (see instruc	tions)	0	
3. 00	OPPS payments		0	
4.00	Outlier payment (see instructions)		0	
4. 01	Outlier reconciliation amount (see instructions)		0	
5.00	Enter the hospital specific payment to cost ratio (see instru	ctions)	0.000	1
6.00	Line 2 times line 5		0	
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	1
9. 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt.	IV col 12 line 200	0	1
10.00	Organ acquisitions	1 V, COI. 13, 1111e 200	0	
11. 00	Total cost (sum of lines 1 and 10) (see instructions)		5, 191, 197	
11.00	COMPUTATION OF LESSER OF COST OR CHARGES		0, 171, 177	11.00
	Reasonable charges			
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)	0	1
14.00	Total reasonable charges (sum of lines 12 and 13)	,	0	14.00
	Customary charges			
15.00	Aggregate amount actually collected from patients liable for	payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable fo	r payment for services on a chargebasis	0	16.00
	had such payment been made in accordance with 42 CFR §413.13(e)		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0. 000000	1
18. 00	Total customary charges (see instructions)		0	
19. 00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds line 11) (see	0	19. 00
20.00	instructions)	l., i.f. line 11	0	20.00
20. 00	Excess of reasonable cost over customary charges (complete on	Ty IT Time IT exceeds Time 18) (see	0	20.00
21. 00	instructions) Lesser of cost or charges (see instructions)		5, 243, 109	21 00
22. 00	Interns and residents (see instructions)		0, 243, 107	1
23. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)	0	1
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	1 40 (1 5115)	0	1
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
25. 00	Deductibles and coinsurance amounts (for CAH, see instruction	s)	66, 533	25. 00
26.00	Deductibles and Coinsurance amounts relating to amount on lin		2, 328, 605	1
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	plus the sum of lines 22 and 23] (see	2, 847, 971	27.00
	instructions)			
28. 00	Direct graduate medical education payments (from Wkst. E-4, I		0	
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	
30.00	Subtotal (sum of lines 27 through 29)		2, 847, 971	1
31.00	Primary payer payments		2, 096	1
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	(FC)	2, 845, 875	32.00
33 00	Composite rate ESRD (from Wkst. I-5, line 11)	(63)	0	33.00
34. 00	Allowable bad debts (see instructions)		325, 802	
35. 00	Adjusted reimbursable bad debts (see instructions)		211, 771	1
36.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)	290, 849	1
	Subtotal (see instructions)	, and the second	3, 057, 646	1
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		39. 50
39. 97	Demonstration payment adjustment amount before sequestration		0	39. 97
39. 98	Partial or full credits received from manufacturers for repla	ced devices (see instructions)	0	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION		0	
40.00	Subtotal (see instructions)		3, 057, 646	1
40. 01	Sequestration adjustment (see instructions)		61, 153	1
40. 02	Demonstration payment adjustment amount after sequestration		0	
41. 00 42. 00	Interim payments Tentative settlement (for contractors use only)		2, 806, 985 0	1
43. 00	Balance due provider/program (see instructions)		189, 508	1
44. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2 chanter 1	0	1
44.00	\$115. 2	rice with Gwo rub. 13-2, Chapter 1,	O	44.00
	TO BE COMPLETED BY CONTRACTOR			1
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0. 00	92.00
93.00	Time Value of Money (see instructions)		0	1
94. 00	Total (sum of lines 91 and 93)		0	94.00

| Peri od: | Worksheet E-1 | From 10/01/2017 | Part I | | Part I | | Date/Time Prepared: | 2/10/10/2018 | 2/10/10/2018 | 2/10/10/2018 | 2/10/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | 2/10/2018 | Provi der CCN: 15-1305

			'	0 09/30/2018	7/31/2019 3:1:	
		Title XVIII Inpatient Part A		Hospi tal	Cost	_ p
	<u> </u>			Part B		
		/- - /	A	/ - - /	A +	
		mm/dd/yyyy 1.00	Amount 2.00	mm/dd/yyyy 3.00	Amount 4.00	
1. 00	Total interim payments paid to provider	1.00	2, 190, 229		2, 667, 685	1. 00
2. 00	Interim payments para to provider		2, 190, 229		2,007,083	2.00
2.00	submitted or to be submitted to the contractor for					2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
2 01	Program to Provider ADJUSTMENTS TO PROVIDER			05 /14 /2010	120, 200	2.01
3. 01 3. 02	ADJUSTMENTS TO PROVIDER		l C		139, 300 0	3. 01 3. 02
3. 02						3. 02
3. 04						3. 04
3. 05						3. 05
	Provider to Program		_	1		
3.50	ADJUSTMENTS TO PROGRAM		C)	0	3. 50
3. 51			C)	0	3. 51
3. 52			C		0	3. 52
3. 53			C		0	3. 53
3. 54			C		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		C)	139, 300	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 190, 229		2, 806, 985	4.00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		2, 170, 227		2,000,703	4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
F 01	Program to Provider	l				F 01
5. 01 5. 02	TENTATI VE TO PROVI DER		C		0	5. 01 5. 02
5. 02						5. 02
5. 05	Provider to Program			1		3.00
5.50	TENTATI VE TO PROGRAM		C)	0	5. 50
5. 51			C)	0	5. 51
5. 52			C		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		C)	0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER		212 504		189, 508	6. 01
6. 01	SETTLEMENT TO PROVIDER		213, 584		189, 508	6. 01
7. 00	Total Medicare program liability (see instructions)		2, 403, 813		2, 996, 493	7. 00
	Trotal modification program readering (300 reader dott only)		2, 100, 010	Contractor	NPR Date	7.50
				Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8. 00	Name of Contractor					8. 00

		Component	JUN. 13-Z303 11	3 09/30/2016	7/31/2019 3: 1:	
		Title	XVIII Sw	ving Beds - SNF		
	<u> </u>	Inpatient Part A		Par	Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1 00	Takal interior as marks as in the annuither	1.00	2.00	3. 00	4.00	1. 00
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either		1, 532, 470 0		0	2.00
2.00	submitted or to be submitted to the contractor for		U		U	2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER	05/14/2018	29, 900		0	3. 01
3. 01	ADJUSTIMENTS TO PROVIDER	03/14/2016	29, 900			3. 01
3. 02						3. 02
3. 04			0		0	3. 04
3. 05			Ö		0	3. 05
	Provider to Program		-,			
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3. 53			0		0	3. 53
3. 54			0		0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		29, 900		0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 562, 370		0	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		1, 302, 370		U	4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR	•				
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
F 04	Program to Provider					F 04
5. 01 5. 02	TENTATIVE TO PROVIDER		0		0	5. 01 5. 02
5. 02			0			5. 02
5.05	Provider to Program		<u> </u>		0	3.03
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			Ö		Ö	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
. 01	the cost report. (1)		40.000			/ 01
6. 01 6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		42, 229 0		0	6. 01 6. 02
6. 02 7. 00	Total Medicare program liability (see instructions)		1, 604, 599			7.00
7.00	Trotal modicals program frability (see instructions)		1,004,077	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00

Health Financial Systems PULASKI MEMORIAL HO		L HOSPITAL	HOSPITAL In Lie			
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provi der CCN: 15-1305	Peri od:	Worksheet E-1		
			From 10/01/2017		nonod.	
			To 09/30/2018	Date/Time Pre 7/31/2019 3:1		
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		1.00			
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1,		2.00			
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3. 00			
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,		4. 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		6.00			
7.00	, , , , , , , , , , , , , , , , , , ,					
	line 168					
8. 00	Calculation of the HIT incentive payment (see instructions)		8. 00			
9. 00	Sequestration adjustment amount (see instructions)		9. 00 10. 00			
10. 00	The same and the s					
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
	Initial/interim HIT payment adjustment (see instructions)				30.00	
	Other Adjustment (specify)		31.00			
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instruction	ns)		32.00	

Health Financial Systems	PULASKI	MEMORI AL	HOSPI TAL	In Lie	u of Form CMS-2	552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS		Provider CCN: 15-1305	Peri od: From 10/01/2017	Worksheet E-2	
			Component CCN: 15-Z305	To 09/30/2018	Date/Time Prep 7/31/2019 3:12	
			Title XVIII	Swing Beds - SNF	Cost	

				7/31/2019 3: 1	2 pm
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES		1	_	
00	Inpatient routine services - swing bed-SNF (see instructions)		1, 265, 431	0	1.00
00	Inpatient routine services - swing bed-NF (see instructions)	. A D	400, 400	0	2.00
00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part		402, 420	0	3. 00
00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see ins			0. 00	4.00
00	Per diem cost for interns and residents not in approved teachi instructions)	ng program (see		0.00	4.00
00	Program days		897	0	5.00
00	Interns and residents not in approved teaching program (see in	nstructions)	077	0	6.00
00	Utilization review - physician compensation - SNF optional met		0	o .	7.00
00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1, 667, 851	0	8.00
00	Primary payer payments (see instructions)		0	0	9.00
0. 00	Subtotal (line 8 minus line 9)		1, 667, 851	0	10.00
. 00	Deductibles billed to program patients (exclude amounts applic	cable to physician	10, 991	0	11.00
	professional services)	py	,	_	
2. 00	Subtotal (line 10 minus line 11)		1, 656, 860	0	12.00
3. 00	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	19, 514	0	13.00
	for physician professional services)	•	·		
. 00	80% of Part B costs (line 12 x 80%)			0	14.00
. 00	Subtotal (enter the lesser of line 12 minus line 13, or line 1	4)	1, 637, 346	0	15.00
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)			16. 50
. 55	Rural community hospital demonstration project (§410A Demonstr	ration) payment	0		16. 55
	adjustment (see instructions)				
. 99	Demonstration payment adjustment amount before sequestration		0	0	16. 99
. 00	Allowable bad debts (see instructions)		0	0	17.00
. 01	Adjusted reimbursable bad debts (see instructions)		0	0	17. 01
. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	0	0	18. 00
. 00	Total (see instructions)		1, 637, 346	0	19.00
. 01	Sequestration adjustment (see instructions)		32, 747	0	19. 01
0. 02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
0.00	Interim payments		1, 562, 370	0	20.00
	Tentative settlement (for contractor use only)		42, 220	0	21.00
. 00	Balance due provider/program (line 19 minus lines 19.01, 20, a	•	42, 229	0	22.00
. 00	Protested amounts (nonallowable cost report items) in accordar	ice with CMS Pub. 15-2,	0	0	23.00
	<pre>chapter 1, §115.2 Rural Community Hospital Demonstration Project (§410A Demonstr</pre>	cation) Adjustment			
0 00	Is this the first year of the current 5-year demonstration per				200. 00
0. 00	Century Cures Act? Enter "Y" for yes or "N" for no.	Tod drider the 21st			200.00
	Cost Reimbursement				
1. 00	Medicare swing-bed SNF inpatient routine service costs (from V	/kst. D-1. Pt. II. line			201. 00
	66 (title XVIII hospital))				
2.00	Medicare swing-bed SNF inpatient ancillary service costs (from	n Wkst. D-3. col. 3. lin	e		202. 00
	200 (title XVIII swing-bed SNF))				
3. 00	Total (sum of lines 201 and 202)				203.00
	Medicare swing-bed SNF discharges (see instructions)				204.00
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-year demons	trati on	
	peri od)				
	Medicare swing-bed SNF target amount				205.00
6.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti				206. 00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				
7.00	Program reimbursement under the §410A Demonstration (see instr	ructions)			207. 00
8.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	2, col. 1, sum of lines	1		208. 00
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	ctions)			209. 00
0. 00	Reserved for future use				210. 00
	Comparision of PPS versus Cost Reimbursement				
5.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 2	209 plus line 210) (see			215. 00
	instructions)		1		l

Health Financial Systems	PULASKI MEMORIA	L HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWI NG BEDS	Provider CCN: 15-1305		Worksheet E-2
			From 10/01/2017	
		Component CCN: 15-Z305	To 09/30/2018	Date/Time Prepared:
				7/31/2019 3:12 pm
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				7/31/2019 3:12 pm
		Title XIX S	wing Beds - SNF	PPS
			Part A	Part B
			1.00	2. 00
4 00	COMPUTATION OF NET COST OF COVERED SERVICES			1.00
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	and aum of West D	0	2.00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instru			3.00
4. 00	Per diem cost for interns and residents not in approved teaching	-	0.00	4.00
4.00	instructions)	program (see	0.00	4.00
5. 00	Program days		0	5.00
6. 00	Interns and residents not in approved teaching program (see inst	ructions)	o	6.00
7. 00	Utilization review - physician compensation - SNF optional method	•	0	7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	,	0	8.00
9.00	Primary payer payments (see instructions)		0	9.00
10.00	Subtotal (line 8 minus line 9)		0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable	e to physician	0	11.00
	professional services)			
12.00	Subtotal (line 10 minus line 11)		0	12. 00
13. 00	Coinsurance billed to program patients (from provider records) (exclude coinsurance	0	13.00
4	for physician professional services)			
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		0	15.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	16.00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions)	an) normant		16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstration adjustment (see instructions)	on) payment		16. 55
16. 99	Demonstration payment adjustment amount before sequestration		0	16. 99
	Allowable bad debts (see instructions)			17. 00
	Adjusted reimbursable bad debts (see instructions)			17.00
	Allowable bad debts for dual eligible beneficiaries (see instructions)	tions)	0	18.00
	Total (see instructions)		0	19.00
	Seguestration adjustment (see instructions)		o	19. 01
	Demonstration payment adjustment amount after sequestration)		0	19. 02
	Interim payments		0	20.00
	Tentative settlement (for contractor use only)		0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and	21)	0	22. 00
23.00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	0	23.00
	chapter 1, §115.2			
	Rural Community Hospital Demonstration Project (§410A Demonstrati	on) Adjustment		
200.00	Is this the first year of the current 5-year demonstration period	d under the 21st		200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.			
004 00	Cost Reimbursement	D 4 DI II II		201.00
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wks	t. D-I, Pt. II, IIne		201. 00
202.00	66 (title XVIII hospital))	est D 2 col 2 lino		202.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from WI 200 (title XVIII swing-bed SNF))	St. D-3, Col. 3, Tille		202. 00
303 00	Total (sum of lines 201 and 202)			203. 00
	Medicare swing-bed SNF discharges (see instructions)			204.00
204.00	Computation of Demonstration Target Amount Limitation (N/A in fir	est year of the curren	t 5-vear demonst	
	period)	or year or the current	t o year demonst	il del on
205.00	Medicare swing-bed SNF target amount			205. 00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 time:	s line 204)		206. 00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburseme		·	
207.00	Program reimbursement under the §410A Demonstration (see instruc			207. 00
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2,	•		208. 00
	and 3)			
	Adjustment to Medicare swing-bed SNF PPS payments (see instruction	ons)		209. 00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215. 00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209	plus line 210) (see		215. 00
	instructions)			1

		ASKI MEMORIAL			u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-1305	Peri od: From 10/01/2017 To 09/30/2018		pared:
			Title XVIII	Hospi tal	Cost	
					1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT	FOR MEDICARE	PART A SERVICES - COS	T REIMBURSEMENT		
1. 00	Inpatient services				2, 735, 156	
2.00	Nursing and Allied Health Managed Care payment (s	see instructi	ons)		0	
3. 00	Organ acquisition				0	
4. 00	Subtotal (sum of lines 1 through 3)				2, 735, 156	
5.00	Primary payer payments				0	0.00
6. 00	Total cost (line 4 less line 5). For CAH (see ins	structions)			2, 762, 508	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES					1
7 00	Reasonable charges Routine service charges					7 00
7. 00 8. 00					0	
9. 00	Ancillary service charges Organ acquisition charges, net of revenue				0	
10.00	Total reasonable charges				0	
10.00	Customary charges				0	10.00
11. 00	Aggregate amount actually collected from patients	s liable for	navment for services on	a charge hasis	0	11.00
12. 00	Amounts that would have been realized from patier					
12.00	had such payment been made in accordance with 42			on a charge basis	·	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.0000		,		0.000000	13.00
14.00	Total customary charges (see instructions)	,			0	14.00
	Excess of customary charges over reasonable cost	(complete on	ly if line 14 exceeds I	ine 6) (see	0	15.00
	instructions)	` '	,	, ,		
16.00	Excess of reasonable cost over customary charges	(complete on	ly if line 6 exceeds li	ne 14) (see	0	16.00
	instructions)					
17.00	Cost of physicians' services in a teaching hospit	tal (see inst	ructi ons)		0	17. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT					
	Direct graduate medical education payments (from		4, line 49)		0	
	Cost of covered services (sum of lines 6, 17 and	18)			2, 762, 508	
	Deductibles (exclude professional component)				340, 503	1
	Excess reasonable cost (from line 16)				0	
22. 00	Subtotal (line 19 minus line 20 and 21)				2, 422, 005	
23. 00	Coinsurance				0	
	Subtotal (line 22 minus line 23)				2, 422, 005	
	Allowable bad debts (exclude bad debts for profes		ces) (see instructions)		47, 484	1
	Adjusted reimbursable bad debts (see instructions	,			30, 865	1
	Allowable bad debts for dual eligible beneficiari	ies (see inst	ructions)		38, 008	
	Subtotal (sum of lines 24 and 25, or line 26)				2, 452, 870	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		->		0	

29.50 Pioneer ACO demonstration payment adjustment (see instructions)

33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)

34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,

29.99 Demonstration payment adjustment amount before sequestration

30.02 Demonstration payment adjustment amount after sequestration

Sequestration adjustment (see instructions)

Tentative settlement (for contractor use only)

30.00 Subtotal (see instructions)

31.00 | Interim payments

§115. 2

30.01

29. 50

29.99 0

30.00

30.01

30.02

31.00

32.00

33.00

0

0 2, 190, 229

0

0 34.00

2, 452, 870

49, 057

213, 584

Health Financial Systems	PULASKI MEMORIAL H	OSPI TAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	P	Provider CCN: 15-1305	Peri od: From 10/01/2017 To 09/30/2018	Worksheet E-3 Part VII Date/Time Prepared: 7/31/2019 3:12 pm
		T1 11 1/11/		-

			09/30/2018	Date/lime Pre 7/31/2019 3:1	
		Title XIX	Hospi tal	Cost	_ p
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	VICES FOR TITLES V OR XI			
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		59, 614		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		59, 614	0	4.00
5.00	Inpatient primary payer payments		o		5.00
6.00	Outpati ent pri mary payer payments			0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		59, 614	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routine service charges		18, 409		8. 00
9.00	Ancillary service charges		97, 755	0	9. 00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		116, 164	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
	basi s				
14. 00	Amounts that would have been realized from patients liable for		0	0	14. 00
	a charge basis had such payment been made in accordance with 4	2 CFR §413.13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	
16. 00	Total customary charges (see instructions)		116, 164	0	16.00
17. 00	Excess of customary charges over reasonable cost (complete only	y if line 16 exceeds	56, 550	0	17. 00
40.00	line 4) (see instructions)	1611		0	40.00
18. 00	Excess of reasonable cost over customary charges (complete only	y it line 4 exceeds line	0	0	18. 00
10.00	16) (see instructions)		0	0	10 00
19. 00 20. 00	Interns and Residents (see instructions)	uati ana)	0	0	19. 00 20. 00
21. 00	Cost of physicians' services in a teaching hospital (see instructions of covered services (enter the lesser of line 4 or line 1).		59, 614	0	20.00
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be		' ' '	U	21.00
22 00	Other than outlier payments	compreted for FF3 provid	0	0	22.00
	Outlier payments		0	0	23.00
24. 00				U	24.00
	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs			0	26.00
	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
	Titles V or XIX (sum of lines 21 and 27)		59, 614	0	
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		07/011		27.00
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		59, 614	0	31.00
32.00	Deducti bl es		o	0	32.00
33.00	Coinsurance		o	0	33.00
34.00	Allowable bad debts (see instructions)		o	0	34.00
35.00	Utilization review		O		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	59, 614	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,	o	0	37.00
38.00	Subtotal (line 36 ± line 37)		59, 614	0	38. 00
39.00	Direct graduate medical education payments (from Wkst. E-4)		o		39.00
40.00			59, 614	0	40.00
41.00	Interim payments		44, 608	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		15, 006	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				

Health Financial Systems

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

Provi der CCN: 15-1305

Peri od: Worksheet G
From 10/01/2017
To 09/30/2018 Date/Time Prepared: 7/31/2019 3:12 pm

UIII y)					7/31/2019 3:1	2 pm
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	0.00	1. 00	
1.00	Cash on hand in banks	2, 994, 321	0	0	0	1.00
2.00	Temporary investments	0	0	0		2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts recei vable	10, 096, 049	0	0	0	1
5. 00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable			0	0	1
7. 00 8. 00	Inventory Prepai d expenses	514, 315		0	0	7. 00 8. 00
9. 00	Other current assets	8, 863 2, 641, 522		0	0	
10.00	Due from other funds	2,041,322		0	0	
11. 00	Total current assets (sum of lines 1-10)	10, 091, 016	-	0		11.00
	FIXED ASSETS	, , , , , , , , , , , , , , , , , , , ,	, - <u>-</u> 1	-		
12.00	Land	348, 302	! 0	0	0	12.00
13.00	Land improvements	432, 594	0	0	0	13.00
14.00	Accumulated depreciation	-366, 250		0	0	14.00
15. 00	Bui I di ngs	13, 232, 909		0	0	15.00
16.00	Accumulated depreciation	-7, 415, 148		0	0	16.00
17.00	Leasehold improvements	187, 055		0	0	17.00
18. 00 19. 00	Accumulated depreciation Fixed equipment	-176, 932 7, 434, 636		0	0	18. 00 19. 00
20.00	Accumulated depreciation	-4, 948, 389		0	0	20.00
21. 00	Automobiles and trucks	1 -4, 740, 307		0	0	21.00
22. 00	Accumulated depreciation			0	ő	22.00
23. 00	Major movable equipment	8, 699, 714	Ö	0	0	23. 00
24.00	Accumulated depreciation	-7, 805, 520		0	0	24.00
25.00	Mi nor equi pment depreci abl e	0	0	0	0	25. 00
26.00	Accumulated depreciation	0	0	0	0	26.00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	9, 622, 971	0	0	0	30.00
31. 00	OTHER ASSETS Investments	1	ol ol	0	0	31.00
32.00	Deposits on Leases			0	0	32.00
33. 00	Due from owners/officers	0		0	ő	33.00
34.00	Other assets	3, 451, 344	Ö	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3, 451, 344	. 0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	23, 165, 331	0	0	0	36.00
	CURRENT LIABILITIES	1				
37. 00	Accounts payable	1, 075, 443		0	-	37.00
38. 00	Sal ari es, wages, and fees payable	1, 657, 835	0	0	0	38.00
39.00	Payroll taxes payable (chart tarm)	/ OF 122		0	0	1
40. 00 41. 00	Notes and Loans payable (short term) Deferred income	685, 123		0	0	40. 00 41. 00
42.00	Accel erated payments			U	U	42.00
43. 00	Due to other funds			0	0	43.00
44. 00	Other current liabilities	326, 848	o o	0	Ö	
45.00	Total current liabilities (sum of lines 37 thru 44)	3, 745, 249		0		1
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	
47.00	Notes payable	5, 399, 438	0	0	0	
48. 00	Unsecured Loans	0	0	0		1
49. 00	Other long term liabilities	2, 617, 785		0	0	
50.00	Total long term liabilities (sum of lines 46 thru 49)	8, 017, 223		0		50.00
51. 00	Total liabilities (sum of lines 45 and 50)	11, 762, 472	! 0	0	0	51.00
52. 00	CAPITAL ACCOUNTS General fund balance	11, 402, 859	,			52.00
53. 00	Specific purpose fund	11, 402, 639				53.00
54.00	Donor created - endowment fund balance - restricted			n		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant				0	
58.00	Plant fund balance - reserve for plant improvement,				0	58. 00
	replacement, and expansion					
59.00	Total fund balances (sum of lines 52 thru 58)	11, 402, 859		0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	23, 165, 331	0	0	0	60.00
	197)	I	1	ļ	I	I

Provider CCN: 15-1305

Peri od: Worksheet G-1 From 10/01/2017 To 09/30/2018 Date/Time Prepared:

					10	09/30/2018	7/31/2019 3:1	
		General	Fund	Speci al	Pui	rpose Fund	Endowment	<u> </u>
				'		'	Fund	
		1. 00	2. 00	3. 00		4. 00	5. 00	
1. 00	Fund balances at beginning of period		11, 804, 441			0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-401, 582					2. 00
3.00	Total (sum of line 1 and line 2)		11, 402, 859			0		3. 00
4. 00	Additions (credit adjustments) (specify)	0			0		0	
5.00		0			0		0	
6.00		0			0		0	
7.00		0			0		0	
8. 00 9. 00		0			0		0	
10.00	Total additions (sum of line 4-9)	۷	0		U	0	U	10.00
11. 00	Subtotal (line 3 plus line 10)		11, 402, 859			0		11.00
12. 00	Deductions (debit adjustments) (specify)	0	11, 402, 037		0	U	0	
13. 00	beddetrons (debrt day dstillents) (speerry)				0		0	1
14. 00		ol			0		0	1
15. 00		o			0		0	
16.00		o			0		0	1
17.00		o			0		0	17. 00
18.00	Total deductions (sum of lines 12-17)		0			0		18.00
19.00	Fund balance at end of period per balance		11, 402, 859			0		19. 00
	sheet (line 11 minus line 18)							
		Endowment	PI ant	Fund				
		Fund						
		6. 00	7. 00	8. 00				
1. 00	Fund balances at beginning of period	0			0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)							2.00
3.00	Total (sum of line 1 and line 2)	0			0			3.00
4.00	Additions (credit adjustments) (specify)		0					4. 00
5. 00			0					5.00
6.00			0					6.00
7.00			0					7.00
8. 00 9. 00			0					8. 00 9. 00
10.00	Total additions (sum of line 4-9)	0	U		0			10.00
11. 00	Subtotal (line 3 plus line 10)	0			0			11.00
12. 00	Deductions (debit adjustments) (specify)		0		٥			12.00
13. 00	beddetrons (debrt day dstillerits) (speerry)		0					13.00
14. 00			0					14.00
15. 00			0					15.00
16. 00			0					16.00
17.00			0					17.00
18.00	Total deductions (sum of lines 12-17)	0			0			18. 00
19. 00	Fund balance at end of period per balance	0			0			19. 00
	sheet (line 11 minus line 18)			l				I
16. 00 17. 00 18. 00	·	0	0 0					16. 00 17. 00 18. 00

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

		Т	o 09/30/2018	Date/Time Pre 7/31/2019 3:1	
	Cost Center Description	Inpati ent	Outpati ent	Total	2 0111
	······································	1.00	2.00	3. 00	
	PART I - PATIENT REVENUES	•			
	General Inpatient Routine Services				
1.00	Hospi tal	2, 259, 071		2, 259, 071	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6. 00
7. 00	SKILLED NURSING FACILITY				7. 00
8. 00	NURSI NG FACI LI TY				8. 00
9. 00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	2, 259, 071		2, 259, 071	10.00
	Intensive Care Type Inpatient Hospital Services	1	T	_	
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)			0	15.00
16. 00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16. 00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	2, 259, 071		2, 259, 071	17. 00
18. 00	Ancillary services	12, 385, 961		49, 050, 729	18.00
19. 00	Outpatient services	294, 864		4, 860, 484	
20. 00	RURAL HEALTH CLINIC - WINAMAC	274,004		4, 651, 066	20.00
20. 01	RURAL HEALTH CLINIC - NORTH JUDSON			402, 519	20. 00
20. 01	RURAL HEALTH CLINIC - FRANCESVILLE			214, 284	
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		211,201	0	21.00
22. 00	HOME HEALTH AGENCY	Ĭ	804, 177	804, 177	22. 00
23. 00	AMBULANCE SERVICES		001,177	001, 177	23. 00
24. 00	CMHC				24.00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE	0	0	0	26. 00
27. 00	PROFESSI ONAL FEES	325, 077	59, 317	384, 394	27. 00
28.00	Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst.	15, 264, 973	47, 361, 751	62, 626, 724	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		34, 539, 820		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 42. 00	Total deductions (sum of lines 37-41)				41. 00 42. 00
42.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		34, 539, 820		42.00
43.00	to Wkst. G-3, line 4)		34, 337, 620		43.00
	10 mot. 0 0, 11110 T/	1			'

Heal th	Financial Systems PULASKI MEMORIAL	. HOSPI TAL	In Lieu	ı of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-1305	Peri od:	Worksheet G-3	
			From 10/01/2017	Doto/Time Dro	narad.
			To 09/30/2018	Date/Time Pre 7/31/2019 3:1	
				770172017 0. 1.	2 piii
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, lir	ne 28)		62, 626, 724	1.00
2.00	Less contractual allowances and discounts on patients' accour	nts		29, 732, 088	
3.00	Net patient revenues (line 1 minus line 2)			32, 894, 636	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		34, 539, 820	4.00
5.00	Net income from service to patients (line 3 minus line 4)			-1, 645, 184	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 miscellaneous communication	n 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 guests			0	14.00
15. 00	J 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			0	15.00
16.00		than patients		0	16.00
17. 00				0	17.00
18. 00				0	18.00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21. 00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	OTHER I NCOME			993, 053	24.00
24. 01	INVESTMENT INCOME			35, 423	24. 01
24. 02	OTHER NON-OP			215, 126	
25.00	Total other income (sum of lines 6-24)			1, 243, 602	25.00
26.00	Total (line 5 plus line 25)			-401, 582	26.00
	OTHER EXPENSES (SPECIFY)			0	27.00
	Total other expenses (sum of line 27 and subscripts)			0	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 28)			-401, 582	29. 00

Billion Code 15 - 7078 Force 10/041/2017 Reterral tree Proposed (PM 20/2017) Reterral tree Propose		Financial Systems IS OF HOSPITAL-BASED HOME HEALT	TH AGENCY COSTS	PULASKI MEMORI	AL HOSPITAL Provider Co	°N: 15-1305	In Lie Period:	u of Form CMS-2 Worksheet H	2552-10
Salari es	71171213	TO OF HOSE TIME SHOED HOME HEALT	THE MODING!	,			From 10/01/2017	Date/Time Pre	
Sail art ices	-						Home Health		2 pm
Seminary							Agency I		
SCHERAL SERVICE COST CENTERS			Sal ari es	' '	n (see	rchased	Oul Other Costs	cols. 1 thru	
Capital Related - Bidg. 5 Flatures Capital Related - Bidg. 5 Flatures Capital Related - Movable Capital Related - Bidg. 5 Capital Related - Bidg. 6 Capital Related - Bidg. 7 Capital Related - Bidg. 6 Capital Related - Bidg. 6 Capital Related - Bidg. 7 Capital Related - Capital Related			1. 00	2. 00			5. 00		
2 1 1 1 1 1 1 1 1 1	1 00				0			0	1 00
Sepi primorn Sepi		Fixtures			U		U	_	
1.00 Albam instrative and General 133.712 0 0 0 0 0 0 270.053 5.00	2. 00	•			0		0	0	2.00
## After Business Author Services ## Aft			0	0	0		-	0	3. 00 4. 00
Skilled Nursing Care 277, 613 0 0 0 277, 613 6.08		Administrative and General	133, 712		68, 950		-	240, 053	
7.00 Physical Therapy 76, 331 0 0 0 76, 321 7.00 8.00 Coupstional Therapy 26, 011 0 0 0 0 0 9.00 Speech Pathology 3, 308 0 0 0 0 0 9.00 Speech Pathology 3, 308 0 0 0 0 0 9.01 Medical Social Social Services 0 0 0 0 0 9.02 Speech Pathology 3, 308 0 0 0 0 0 9.03 Speech Pathology 3, 308 0 0 0 0 0 9.04 Olivor 10 0 0 0 0 9.05 Speech Pathology 3, 308 0 0 0 0 0 9.06 Speech Pathology 3, 308 9.00 9.07 Speech Pathology 3, 308 9.00 0 0 0 9.08 Speech Pathology 9, 308 9.00 9.09 Speech Pathology 9, 308 9.00 9.00 Speech Pathology 9, 308 9, 00 9.00 Speech Pathology 9, 308 9.00 Speech Pathology 9, 308 9.00 Speech Patho	6. 00		277, 613	O	0		0 0	277, 613	6.00
9.00 Speech Pathology 3,308 0 0 0 0 3,308 9.00 0 0 0 0 0 1.00		Physical Therapy							1
10.00 Medical Social Services 0 0 0 0 0 0 0 0 0					0		٥		
11.00			3, 308	1	0		٥		
12.00 Supplies (see instructions)			91, 522	١	0		٥	_	
14.00			0	1	0		0 0	0	12.00
Hish NonRELIMBURSABLE SERVICES			1		- 1			-	
15.00	14.00		0	0	O		0 0	0	14.00
17.00	15. 00		0	0	0		0 0	0	15.00
18.00 Clinic 0 0 0 0 0 0 0 0 18.00			0		0			_	
19.00 Health Promotion Activities 0 0 0 0 0 0 0 19.00			0	0	0		0 0	-	
20.00 Day Care Program			0	0	0		0 0	_	
			Ö	o	0		0 0	0	20.00
23.00 All Others (specify) 0 0 0 0 0 0 0 0 0		,	0	O	0		0 0	0	21.00
23.50 Telemedicine			0	0	0		0 0	0	22.00
24.00 Total (sum of lines 1-23) 608, 487 0 68, 950 0 37, 391 714, 828 24.00			0	0	0		0 0	0	
Ion			608, 487	Ö			0 37, 391	_	
Col. 6 + Col. 7)					Adjustments		S		
COL.7 COL.8 + COL.9			I on						
7.00									
Capital Related - Bidg. & 0 0 0 0 0 0 0 0 0			7.00	0.00	0.00		_		-
1.00		GENERAL SERVICE COST CENTERS	7.00	8.00	9.00	10.00		<u> </u>	
Capital Related - Movable Capital Related - Capital Rela	1.00		0	0	0		0		1.00
Equi pment									
3.00	2.00	•	0	O O	Ü		0		2.00
Administrative and General -73,950 166,103 0 166,103 HHA REI INBURSABLE SERVI CES		Plant Operation & Maintenance		l .			0		3.00
HHA REIMBURSABLE SERVICES						166 1			5.00
7. 00 Physical Therapy 0 76, 321 0 76, 321 7. 00 8. 00 Occupational Therapy 0 26, 011 0 26, 011 8. 00 9. 00 Speech Pathology 0 3, 308 0 3, 308 9. 00 10. 00 Medical Social Services 0 0 0 0 0 11. 00 Home Health Aide 0 91, 522 0 91, 522 11. 00 12. 00 Supplies (see instructions) 0 0 0 0 0 13. 00 Drugs 0 0 0 0 0 12. 00 14. 00 DME 0 0 0 0 0 0 13. 00 14. 00 HHA NONREIMBURSABLE SERVICES 0 0 0 0 0 15. 00 16. 00 Respiratory Therapy 0 0 0 0 0 15. 00 17. 00 Private Duty Nursing 0 0 0	0.00		70,700	100, 100		100, 1	50		0.00
8. 00		g .		· · · · · · · · · · · · · · · · · · ·	0				6.00
9.00 Speech Pathology 0 3,308 0 3,308 9.00 10.00 Medical Social Services 0 0 0 0 0 10.00 11.00 Home Heal th Aide 0 91,522 0 91,522 11.00 12.00 Supplies (see instructions) 0 0 0 0 0 0 12.00 13.00 Drugs 0 0 0 0 0 0 13.00 0 0 0 13.00 0 0 13.00 0 0 0 13.00 0 0 0 13.00 0 0 0 13.00 0 0 0 13.00 0 0 13.00 0 0 0 13.00 0 0 0 14.00 0 0 14.00 0 0 0 14.00 0 0 0 15.00 0 0 0 15.00 0 0 0 0					0				
10.00 Medical Social Services 0 0 0 0 10.00 11.00 Home Heal th Aide 0 91,522 0 91,522 11.00 12.00 Supplies (see instructions) 0 0 0 0 0 13.00 Drugs 0 0 0 0 0 0 14.00 DME 0 0 0 0 0 0 0 13.00 14.00 DME 0 0 0 0 0 0 0 0 13.00 14.00 0 0 0 14.00 0 0 0 0 15.00 15.00 15.00 0 0 0 0 15.00 16.00 16.00 0 0 0 0 16.00 17.00 16.00 0 0 0 0 17.00 17.00 18.00 0 0 0 17.00 18.00 0 0 0 0		1 1			0				9.00
12.00 Supplies (see instructions) 0 0 0 0 0 12.00 13.00 Drugs 0 0 0 0 0 14.00 DME HHA NONREIMBURSABLE SERVICES			Ö	0	0	2, 2	0		10.00
13.00 Drugs 0 0 0 0 0 13.00 14.00 HHA NONREIMBURSABLE SERVICES 0 0 0 0 15.00 Respiratory Therapy 0 0 0 0 16.00 Private Duty Nursing 0 0 0 0 18.00 Clinic 0 0 0 0 19.00 Health Promotion Activities 0 0 0 20.00 Day Care Program 0 0 0 0 21.00 Home Delivered Meals Program 0 0 0 22.00 Homemaker Service 0 0 0 23.00 All Others (specify) 0 0 0 23.50 Telemedicine 0 0 0 13.00 0 0 0 14.00 14.00 14.00 15.00 15.00 0 0 0 15.00 0 0 16.00 0 0 17.00 0 0 18.00 0 0 19.00 0 0 20.00 0 0			0	91, 522	0	91, 5	22		11.00
14.00 DME 0 0 0 0 0 HHA NONREIMBURSABLE SERVICES 15.00 Home Dialysis Aide Services 0 0 0 0 0 16.00 Respiratory Therapy 0 0 0 0 0 17.00 Private Duty Nursing 0 0 0 0 0 18.00 Clinic 0 0 0 0 18.00 19.00 Health Promotion Activities 0 0 0 0 19.00 20.00 Day Care Program 0 0 0 0 0 20.00 21.00 Home Delivered Meals Program 0 0 0 0 0 21.00 22.00 Homemaker Service 0 0 0 0 0 22.00 23.00 All Others (specify) 0 0 0 0 0 23.00 23.50 Tel emedicine 0 0 0 0 0			0	0	0		0		1
HHA NONREIMBURSABLE SERVICES 15.00 Home Dialysis Aide Services 0 0 0 0 0 15.00		g .			-				14.00
16.00 Respiratory Therapy 0 0 0 0 0 16.00 17.00 Private Duty Nursing 0 0 0 0 0 17.00 18.00 Clinic 0 0 0 0 0 18.00 19.00 Heal th Promotion Activities 0 0 0 0 0 19.00 20.00 Day Care Program 0 0 0 0 0 20.00 0 20.00 20.00 0 0 0 20.00 0 21.00 22.00 0 0 0 0 22.00 23.00 23.00 23.00 23.00 23.00 0 0 0 0 0 23.00 23.50 23.50 0 0 0 0 0 0 23.50 0 <td></td> <td>HHA NONREIMBURSABLE SERVICES</td> <td>_</td> <td>-</td> <td></td> <td></td> <td></td> <td></td> <td>1</td>		HHA NONREIMBURSABLE SERVICES	_	-					1
17. 00 Private Duty Nursing 0 0 0 0 17. 00 18. 00 Clinic 0 0 0 0 0 18. 00 19. 00 Heal th Promotion Activities 0 0 0 0 19. 00 20. 00 Day Care Program 0 0 0 0 0 21. 00 Home Deli vered Meals Program 0 0 0 0 21. 00 22. 00 Homemaker Service 0 0 0 0 0 23. 00 All Others (specify) 0 0 0 0 0 23. 50 Tel emedicine 0 0 0 0 0				l					15.00
18.00 Clinic 0 0 0 0 0 19.00 Health Promotion Activities 0 0 0 0 0 20.00 Day Care Program 0 0 0 0 0 21.00 Home Delivered Meals Program 0 0 0 0 22.00 Homemaker Service 0 0 0 0 23.00 All Others (specify) 0 0 0 23.50 Tel emedicine 0 0 0			0		0				
19.00 Health Promotion Activities 0 0 0 0 20.00 Day Care Program 0 0 0 0 21.00 Home Delivered Meals Program 0 0 0 0 22.00 Homemaker Service 0 0 0 0 23.00 All Others (specify) 0 0 0 0 23.50 Tel emedicine 0 0 0 0		, ,	0		0		o		18.00
21.00 Home Delivered Meals Program 0 0 0 0 0 21.00 22.00 Homemaker Service 0 0 0 0 0 22.00 23.00 All Others (specify) 0 0 0 0 0 23.00 23.50 Tel emedicine 0 0 0 0 0 23.50	19. 00	Health Promotion Activities	Ö	o	O		0		19.00
22.00 Homemaker Service 0 0 0 0 23.00 All Others (specify) 0 0 0 0 23.50 Tel emedicine 0 0 0 0		, ,	0	0	0		0		20.00
23.00 All Others (specify) 0 0 0 0 23.50 Tel emedicine 0 0 0 0 23.50			0	0	0		0		21.00
23. 50 Tel emedi ci ne 0 0 0 23. 50			0		0		o		23. 00
24.00 Total (sum of lines 1-23) -73,950 640,878 0 640,878 24.00	23.50	Tel emedi ci ne			-		-		23. 50
	24. 00	Total (sum of lines 1-23)	-73, 950	640, 878	0	640, 8	78		24.00

Heal th	Financial Systems		PULASKI MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
	ALLOCATION - HHA GENERAL SERVICE	COST		Provi der C	CN: 15-1305	Peri od: From 10/01/2017	Worksheet H-1 Part I	
				HHA CCN:	15-7078		Date/Time Pre 7/31/2019 3:1	pared:
						Home Health	PPS	Ζ μιι
			Capital Rela	ated Costs		Agency I		
		Net Expenses for Cost Allocation (from Wkst.	BI dgs & Fi xtures	Movable Equipment	Plant Operation & Maintenance		Subtotal (cols. 0-4)	
		H, col. 10)	1 00	2.00	2.00	4.00	4A. 00	
	GENERAL SERVICE COST CENTERS	0	1. 00	2. 00	3.00	4. 00	4A. 00	
1. 00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2. 00	Capital Related - Movable	0		0			0	2.00
3. 00	Equipment Plant Operation & Maintenance	0	0	0		0	0	3.00
4.00	Transportati on	o o	o	Ö	1	0 0	_	4.00
5. 00	Administrative and General HHA REIMBURSABLE SERVICES	166, 103	0	0		0 0	166, 103	5.00
6. 00	Skilled Nursing Care	277, 613	0	0		0 0	277, 613	6.00
7.00	Physical Therapy Occupational Therapy	76, 321 26, 011	0	0	1	0 0	76, 321 26, 011	
8. 00 9. 00	Speech Pathology	3, 308	0	0	1	0 0	3, 308	
10.00	Medical Social Services	0	0	0		0 0	01 500	
11. 00 12. 00	Home Health Aide Supplies (see instructions)	91, 522	0	0		0 0	91, 522	11. 00 12. 00
13.00	Drugs	0	0	0	1	0	0	13.00
14. 00	HHA NONREI MBURSABLE SERVI CES	0	0	0		0 0	0	14.00
15. 00	Home Dialysis Aide Services	0	0	0	1	0 0	0	
16. 00 17. 00	Respiratory Therapy Private Duty Nursing	0	0	0		0 0	0	16. 00 17. 00
18. 00	Clinic	o o	Ö	Ö		0 0	Ö	1
19. 00 20. 00	Health Promotion Activities Day Care Program	0	0	0		0 0	0	
21. 00		o o	0	Ö		0 0	Ö	
22. 00 23. 00	Homemaker Service All Others (specify)	0	0	0		0 0	0	22. 00 23. 00
23. 50	Telemedicine	0	0	0		0 0	0	
24.00	Total (sum of lines 1-23)	640, 878 Admi ni strati v	0 Tatal (asl s	0		0 0	640, 878	24.00
		e & General	4A + 5)					
	GENERAL SERVICE COST CENTERS	5. 00	6. 00					
1. 00	Capital Related - Bldg. &							1.00
2. 00	Fixtures Capital Related - Movable							2.00
2.00	Equi pment							2.00
3. 00 4. 00	Plant Operation & Maintenance Transportation							3. 00 4. 00
5. 00	Administrative and General	166, 103						5.00
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	97, 125	374, 738					6.00
7.00	Physi cal Therapy	26, 701	103, 022					7. 00
8.00	Occupational Therapy	9, 100	35, 111					8.00
9. 00 10. 00	Speech Pathology Medical Social Services	1, 157 0	4, 465 0					9. 00 10. 00
11.00	Home Heal th Ai de	32, 020	123, 542					11.00
12. 00 13. 00	Supplies (see instructions) Drugs	0	0					12. 00 13. 00
14. 00	DME	0	0					14. 00
15. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0					15. 00
16.00	Respi ratory Therapy	0	О					16. 00
17. 00 18. 00		0	0					17. 00 18. 00
19.00	Health Promotion Activities	0	0					19. 00
20. 00 21. 00] 3	0	0					20. 00 21. 00
22.00	Homemaker Service	0	О					22.00
	All Others (specify) Telemedicine	0	0					23. 00 23. 50
	Total (sum of lines 1-23)		640, 878					24.00

Heal th	Financial Systems		PULASKI MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST A	ALLOCATION - HHA STATISTICAL BAS	SIS		Provi der C	CN: 15-1305	Peri od: From 10/01/2017	Worksheet H-1	
				HHA CCN:	15-7078	To 09/30/2018		
						Home Health	PPS	
		Carrital Dal	-+ 0+-			Agency I		
		Capital Rel	ated Costs					
		BI dgs &	Movabl e	PI ant	Transportati	o Reconciliatio	Administrativ	
		Fi xtures	Equi pment	Operation &	n (MI LEAGE)	n	e & General	
		(SQUARE FEET)	(DOLLAR	Mai ntenance			(ACCUM. COST)	
		1.00	2. 00	(SQUARE FEET) 3.00	4. 00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5A. 00	5.00	
1.00	Capital Related - Bldg. &	0				0		1.00
	Fixtures							
2. 00	Capital Related - Movable		0			0		2.00
3. 00	Equipment Plant Operation & Maintenance	0	0	0		0		3. 00
4. 00	Transportation (see	Ö	0	Ö		0		4.00
	instructions)							
5. 00	Administrative and General	0	0	0		0 -166, 103	474, 775	5.00
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	0	0	Ιο	1	0 0	277, 613	6.00
7. 00	Physical Therapy		0		•	0 0	76, 321	1
8. 00	Occupational Therapy	Ö	0	Ö		0 0	26, 011	1
9. 00	Speech Pathology	0	0	0		0 0	3, 308	9. 00
10.00	Medical Social Services	0	0	0		0 0	0	
11. 00 12. 00	Home Health Aide Supplies (see instructions)	0	0	0		0 0	91, 522 0	ı
13. 00	Drugs	0	0			0	0	
14. 00	DME	l ő	0			0 0	0	
	HHA NONREIMBURSABLE SERVICES							
15. 00	Home Dialysis Aide Services	0	0			0 0	0	
16.00	Respiratory Therapy	0	0	0		0 0	0	16.00
17. 00 18. 00	Private Duty Nursing Clinic	0	0	0			0	17. 00 18. 00
19. 00	Health Promotion Activities	ĺ	0	ĺ			0	19.00
20.00	Day Care Program	0	0	0		0 0	0	20.00
21. 00	3	0	0	0		0	0	21.00
22.00	Homemaker Service	0	0	0		0	0	
23. 00	All Others (specify) Telemedicine		0			0	0	23. 00 23. 50
24. 00	Total (sum of lines 1-23)		0	0		0 -166, 103	474, 775	
25. 00	Cost To Be Allocated (per	O	0	O		0	166, 103	
	Walliaharak II 4 Dalak IN	1		I	I	1		1

0.000000

0. 000000

0.000000

0.000000

0. 349856 26. 00

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

Peri od: Worksheet H-2
From 10/01/2017 Part I
To 09/30/2018 Date/Time Prepared: 7/31/2019 3:12 pm
Home Heal th PPS HHA CCN: 15-7078

						Home Health Agency I	PPS	
			CAPI TAL			Agency 1		
	Cost Center Description	HHA Trial	RELATED COSTS NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI V	OPERATION OF	
	cost center bescription	Balance (1)	FIXT	BENEFITS	Subtotal	E & GENERAL	PLANT	
				DEPARTMENT				
1.00		0	1. 00	4.00	4A	5. 00	7. 00	1.00
1. 00 2. 00	Administrative and General Skilled Nursing Care	0 374, 738	15, 461 0	184, 068	199, 529 374, 738		14, 493 0	1. 00 2. 00
3. 00	Physical Therapy	103, 022	o	0	103, 022		0	3.00
4.00	Occupational Therapy	35, 111	0	0	35, 111		0	4.00
5. 00	Speech Pathology	4, 465	0	0	4, 465	863	0	5.00
6. 00 7. 00	Medical Social Services Home Health Aide	0 123, 542	0	0	0 123, 542	0 23, 866	0	6. 00 7. 00
8. 00	Supplies (see instructions)	123, 342	0	0	123, 542	23, 600	0	8.00
9. 00	Drugs	Ö	Ö	0	Ö	Ö	0	9. 00
10.00	DME	0	0	0	0	0	0	10.00
11. 00 12. 00	Home Dialysis Aide Services Respiratory Therapy	0	0	0	0	0	0	11. 00 12. 00
13. 00	Pri vate Duty Nursing		0	0	0	0	0	13.00
14. 00	Clinic	Ö	0	0	Ö	0	0	14.00
15. 00	Health Promotion Activities	0	0	0	0	0	0	15.00
16. 00 17. 00	Day Care Program Home Delivered Meals Program	0	0	0	0	0	0	16. 00 17. 00
18. 00	Homemaker Service		0	0		0	0	18.00
19. 00	All Others (specify)	Ö	Ö	0	Ö	0	0	19.00
19. 50	Tel emedi ci ne	0	0	0	0	0	0	19. 50
20. 00 21. 00	Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	640, 878	15, 461	184, 068	840, 407 0. 000000		14, 493	20. 00 21. 00
21.00	26, line 1 divided by the sum				0.00000			21.00
	of column 26, line 20 minus							
	column 26, line 1, rounded to 6 decimal places.							
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	CENTRAL	PHARMACY	
		LINEN SERVICE			ADMI NI STRATI O	SERVICES &		
		8. 00	9. 00	10. 00	N 13.00	SUPPLY 14. 00	15. 00	
1. 00	Administrative and General	0.00	4, 295	0			0	1. 00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3. 00 4. 00	Physical Therapy	0	0	0	0	0	0	3.00
5. 00	Occupational Therapy Speech Pathology		0	0		0	0	4. 00 5. 00
6. 00	Medical Social Services	Ö	0	0	Ö	0	0	6. 00
7. 00	Home Health Aide	0	0	0	0	0	0	7. 00
8. 00 9. 00	Supplies (see instructions) Drugs	0	0	0	0	0	0	8. 00 9. 00
10.00	DME		o	0		0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11. 00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13. 00 14. 00	Private Duty Nursing	0	0	0		0	0	13. 00 14. 00
15. 00		Ö	O	0	Ö	Ö	0	15. 00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17. 00 18. 00	Home Delivered Meals Program Homemaker Service	0	0	0	0	0	0	17. 00 18. 00
19. 00	All Others (specify)		0	0		0	0	19.00
19. 50	Tel emedi ci ne	0	0	0	0	0	0	19. 50
20.00	Total (sum of lines 1-19) (2)	0	4, 295	0	0	0	0	20.00
21. 00	Unit Cost Multiplier: column 26, line 1 divided by the sum							21. 00
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.		1					

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

0 11.00 Home Dialysis Aide Services 11.00 12.00 Respiratory Therapy 12.00 13.00 Private Duty Nursing 13.00 14.00 0 14.00 Clinic 15.00 Health Promotion Activities 15.00 Day Care Program 16.00 16.00 0 17.00 Home Delivered Meals Program 17.00 Homemaker Service 0 18.00 18.00 0 19.00 All Others (specify) 19.00 Tel emedi ci ne 19.50 19.50 Total (sum of lines 1-19) (2) 1,029,832 20.00 20.00 Unit Cost Multiplier: column 21.00 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.

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

Health Financial Systems	PULASKI MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO	HHA COST CENTERS STATISTICAL Provider CCN: 15-1305	Peri od: Worksheet H-2
BASIS		From 10/01/2017 Part II
	HHA CCN: 15-7078	
		7/31/2019 3: 12 pm

Home Health Agency I CAPI TAL RELATED COSTS **EMPLOYEE** Reconciliatio ADMI NI STRATI V OPERATION OF LAUNDRY & Cost Center Description NEW BLDG & FI XT **BENEFITS** E & GENERAL **PLANT** LINEN SERVICE (SQUARE DEPARTMENT (ACCUM. (SQUARE (POUNDS OF LAUNDRY) FEET) (GROSS COST) FEET) SALARIES) 8.00 1.00 5A 5.00 7.00 4.00 1.00 Administrative and General 652 534, 537 199, 529 652 1.00 0 2.00 Skilled Nursing Care 0 374, 738 0 2.00 0 103, 022 0 3.00 3 00 0 0 0 O Physical Therapy 4.00 Occupational Therapy 0 35, 111 4.00 Speech Pathology 0 5.00 0 4, 465 0 5.00 0 6.00 Medical Social Services 000000000000 0 0 0 6.00 0 7 00 Home Health Aide Ω 123, 542 7 00 8.00 Supplies (see instructions) 0 0 8.00 9.00 0 0 0 9.00 Drugs 0 0 0 0 DME. 0 0 10.00 10.00 0 0 0 0 11.00 0 Home Dialysis Aide Services 11.00 12.00 Respiratory Therapy 0 0 12.00 Private Duty Nursing 13.00 13.00 0 0 0 0 0 14.00 Clinic 14.00 0 15.00 Health Promotion Activities 0 15 00 16.00 Day Care Program 16.00 17.00 Home Delivered Meals Program 0 0 0 17.00 0 0 0 0 Homemaker Service 0 18.00 C 18.00 0 19.00 All Others (specify) C 19.00 Tel emedi ci ne 0 0 0 19.50 19.50 0 Total (sum of lines 1-19) 840, 407 20.00 20.00 652 534, 537 652 184, 068 162, 350 14, 493 21.00 Total cost to be allocated 15, 461 21.00 22.00 Unit cost multiplier 23. 713190 0.344350 0.193180 22. 228528 0.000000 22.00 HOUSEKEEPI NG NURSI NG CENTRAL PHARMACY MEDI CAL Cost Center Description DI ETARY RECORDS & (SQUARE (MEALS ADMI NI STRATI O SERVICES & (100%)SERVED) SUPPLY LI BRARY FEET) (DI RECT (GROSS (100%)NRSING HRS) CHARGES) 9. 00 10. 00 13. 00 14.00 15. 00 16.00 1. 00 1.00 Administrative and General 0 804. 177 652 00000000000000000000 0 2.00 Skilled Nursing Care 0 C 2 00 0 3.00 Physical Therapy 0 0 3.00 4.00 Occupational Therapy 0 0 0 0 0 0 0 0 0 0 0 4.00 0 Speech Pathology 0 0 5.00 0 5.00 0 6.00 Medical Social Services 6.00 7.00 Home Heal th Ai de 0 0 0 7.00 0 8.00 Supplies (see instructions) 0 0 0 0 8.00 0 Drugs 0 9.00 9.00 10.00 DMF C 10.00 11.00 Home Dialysis Aide Services 11.00 0 0 12.00 Respiratory Therapy 0 12.00 0 0 13.00 Private Duty Nursing 0 13.00 0 14.00 14.00 0 0 15.00 Health Promotion Activities 0 0 0 15.00 0 16,00 Day Care Program 0 16,00 0 17.00 Home Delivered Meals Program 17.00 0 Homemaker Service 0 0 0 18.00 18.00 All Others (specify) 0 19.00 0 0 19.00 0 19.50 Tel emedi ci ne 0 C 0 0 19.50 20.00 Total (sum of lines 1-19) 652 0 C 0 0 804, 177 20.00 Total cost to be allocated 21.00 4, 295 8, 287 21.00 22.00 Unit cost multiplier 6 587423 0.000000 0.000000 0.000000 0.000000 0.010305 22.00

Health Financial Systems		PULA	SKI MEMORIAL	HOSPI TAL				In Lieu	of Form CMS-2	2552-10
ALLOCATION OF GENERAL SERVICE COSTS T	O HHA COST CI	ENTERS	STATI STI CAL	Provi der	CCN:	15-1305	Peri From	od: 10/01/2017	Worksheet H-2 Part II	
BA313				HHA CCN:		15-7078			Date/Time Pre 7/31/2019 3:1	
							Но	me Health	PPS	
								Agency I		
Cost Center Description	SOCI AL									
	SERVI CE									
	(ALLOCATION									
	OF TIME)									

				Agency I		
	Cost Center Description	SOCI AL		·		
		SERVI CE				
		(ALLOCATION				
		OF TIME)				
		17. 00				
1.00	Administrative and General	0				1.00
2.00	Skilled Nursing Care	0				2.00
3.00	Physi cal Therapy	0				3.00
4.00	Occupational Therapy	0				4.00
5.00	Speech Pathology	0				5.00
6.00	Medical Social Services	0				6.00
7.00	Home Health Aide	0				7.00
8.00	Supplies (see instructions)	0				8.00
9.00	Drugs	0				9.00
10.00	DME	0			'	10.00
11.00	Home Dialysis Aide Services	0			'	11. 00
12.00	Respiratory Therapy	0			'	12.00
13.00	Private Duty Nursing	0			'	13.00
14.00	Clinic	0			'	14.00
15.00	Health Promotion Activities	0			'	15. 00
16.00	Day Care Program	0			'	16. 00
17.00	Home Delivered Meals Program	0			'	17. 00
18.00	Homemaker Service	0			'	18. 00
19.00	All Others (specify)	0			'	19. 00
19. 50	Tel emedi ci ne	0				19. 50
20.00	Total (sum of lines 1-19)	0				20. 00
21.00	Total cost to be allocated	0			2	21. 00
22. 00	Unit cost multiplier	0. 000000			2	22. 00

Health Financial Systems	Hool +h	Financial Systems		DIII ASKI MEMODI	IAI HOSDITAI		In Lio	u of Form CMS 3	DEE2 10
HNA_COL_ 15-707 From 10/01/2017 From Wast_ Facility Facility From Wast_ Facility			rs .	FULASKI WILWOKI		CN: 15-1305			
Cost Center Description	711 1 01(1	TONNELLY OF TANTENT SERVICE GOST					From 10/01/2017	Part I Date/Time Pre	pared:
H-2, Part I, Col 28, Ine Part I) Cost (Services Part I) Part I) Part II Pa					Title	XVIII			<u> 2 piii </u>
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST. AGGREGATE OF THE PROGRAM LIMITATION COST. OR BENEFICIARY COST LIMITATION COST. COST CONTROL PROGRAM LIMITATION COST. OR BENEFICIARY COST. AGGREGATE OF THE PROGRAM LIMITATION COST. OR BENEFICIARY COST. AGGREGATE OF THE PROGRAM LIMITATION COST. OR BENEFICIARY COST. AGGREGATE OF THE PROGRAM LIMITATION COST. OR BENEFICIARY COST. AGGREGATE OF THE PROGRAM LIMITATION COST. OR BENEFICIARY COST. AGGREGATE OF THE PROGRAM LIMITATION COST. OR BENEFICIARY COST. AGGREGATE PROGRAM COST. AGGREGATE OF THE PROGRAM LIMITATION COST. OR BENEFICIARY COST. AGGREGATE PROGRAM COST. AGGREGATE OF THE PROGRAM LIMITATION COST. OR BENEFICIARY COST. AGGREGATE PROGRAM COST. AGGREGATE OF THE PROGRAM LIMITATION COST. OR BENEFICIARY COST. AGGREGATE PROGRAM COST. AGGREGATE OF THE PROGRAM LIMITATION COST. OR BENEFICIARY COST. AGGREGATE PROGRAM COST. AGGREGATE PROGRAM LIMITATION COST. OR BENEFICIARY COST. AGGREGATE PROGRAM COST. AGGREGATE OF THE PROGRAM LIMITATION COST. OR BENEFICIARY COST. AGGREGATE PROGRAM COST. AGGREGATE OF THE PROGRAM LIMITATION COST. OR BENEFICIARY COST. AGGREGATE PROGRAM COST. AGGREGATE PROGRAM LIMITATION COST. OR BENEFICIARY COST. AGGREGATE PROGRAM COST. AGGREGATE OF THE PROGRAM LIMITATION COST. OR BENEFICIARY COST. AGGREGATE PROGRAM COST. AGGREGATE OF THE PROGRAM LIMITATION COST. OR BENEFICIARY COST. AGGREGATE PROGRAM COST. AGGREGATE OF THE PROGRAM LIMITATION COST. OR BENEFICIARY COST. AGGREGATE PROGRAM COST. AGGREGATE OF THE PROGRAM LIMITATION COST. OR BENEFICIARY COST. AGGREGATE PROGRAM COST. AGGREGATE OF THE PROGRAM LIMITATION COST. OR BENEFICIARY COST. AGGREGATE PROGRAM COST. AGGREGATE OF THE PROGRAM LIMITATION COST. OR BENEFICIARY COST. AGGREGATE PROGRAM COST. AGGREGATE OF THE PROGRAM LIMITATION COST. OR BENEFICIARY COST. AGGREGATE PROGRAM COST. AGGREGATE OF THE PROGRAM LIMITATION COST. OR BENEFICIARY COST. AGGREGATE PROGRAM COST. AGGREGATE OF THE PROGRAM LIMITATION COST. AGGREGATE OF THE PROGRAM LIMITATION COST. AGGREGATE OF THE PROGRAM LIMITATION COST. OR BE		Cost Center Description	H-2, Part I,	Costs (from Wkst. H-2,	Ancillary Costs (from	Costs (cols	Total Visits	Per Visit (col. 3 ÷	
Description Part			0			2.00	4.00		
Cost Per VIsit Computation									
1.00 Skilled Nursing Care 2.00 602, 169 602, 169 1.299 463.56 1.00									
2.00 Physical Therapy	1 00		2 00	602 160		602 1	60 1 200	163 56	1 00
1.00									
1.00 Speech Pathology 5.00 7,175 0 7,175 0 0 0 0 0 0 0 0 0					l e				
Solid Medical Social Services 6.00 0 0 0.00 5.00 6.00						,			
Note Home Heal th Aide					l	/, '			
Total (sum of lines 1-6)		N .				100 E			
Program Visits			7.00		_			143.00	
Cost Center Description Cost Limits CBSA No. (1) Part A Not Subject to beductibles Coloration Cost Limits CBSA No. (1) Part A Not Subject to to beductibles Coloration Cost Center Description Cost Limits CBSA No. (1) Part A Not Subject to to beductibles Coloration Cost Center Description Cost	7.00	Total (Sull of Titles 1-6)		1,029,832	0				7.00
Cost Center Description Cost Limits CBSA No. (1) Part A Not Subject to beductible s Coinsurance Cost Center Description Cost Limits CBSA No. (1) Part A Not Subject to beductible s Coinsurance Cost Center Description Cost Cen						Program VISI	ts		
Cost Center Description Cost Limits CBSA No. (1) Part A Not Subject to beductible s Coinsurance Cost Center Description Cost Limits CBSA No. (1) Part A Not Subject to beductible s Coinsurance Cost Center Description Cost Cen						D	art D		
Limitation Cost Computation 0		Cost Contor Dossription	Cost Limits	CDCA No. (1)	Dort A		 		
Limitation Cost Computation		cost center bescription	COST LIMITS	CBSA NO. (1)	Part A				
Limitation Cost Computation Skilled Nursing Care 99915 0 3.00 4.00 5.00									
Supplies and Drugs Cost Computations Supplies Supplie									
Limitation Cost Computation			0	1 00	2 00			5.00	
Skilled Nursing Care		Limitation Cost Computation	0	1.00	2.00	3.00	4.00	3.00	
9,00	8 00			00015	0	1 10	92		8 00
10.00					1				
11.00 Speech Pathology 99915 0 36 0 11.00 12.00 Medical Social Services 99915 0 0 0 13.00 Home Health Aide 99915 0 804 12.00 14.00 Total (sum of lines 8-13) Cost Center Description From Wkst. H-2 Part I, col. 28, line Wkst. H-2, Part I) 0 1.00 2.00 3.00 4.00 5.00 15.00 Cost of Medical Supplies 8.00 0 0 0 0 0 0.000000 15.00 Cost of Medical Supplies 9.00 9.00 0 0 0 0.000000 15.00 Cost Center Description Part A Part B Not Subject to Deductibles & Coinsurance Coinsuranc					1				
12.00 Medical Social Services 99915 0 0 804 12.00 13.00 14.00 Total (sum of lines 8-13)					1				
13.00 Home Heal th Aide 99915 0 804 13.00 14.00 Total (sum of lines 8-13) Cost Center Description From Wkst. H-2 Part I, col. 28, line Wkst. H-2, Part II) Costs (from Part II) Costs (from Part II) Costs (from Part II) Cost (from Part II) Costs (from Part II) Cos					1				
14.00 Total (sum of lines 8-13) Cost Center Description From Wkst. H-2 Part I, col. 28, line Wkst. H-2, Part II) O 1.00 2.00 3.00 4.00 5.00					1		-		
Cost Center Description From Wkst. H-2 Part I Costs (from Ancillary Costs (costs (from HHA Records) H-2 Part I Costs (from Part II) O 1.00 2.00 3.00 4.00 5.00				77713	1				
H-2 Part I, col . 28, line Costs (from Wkst. H-2, Part I) Dol . 2.00 Stock (from HHÅ Records) Form Part II) Dol . 1.00 Dol . 0 Dol	14.00		From Wkst	Facility				Patio (col 3	14.00
Supplies and Drugs Cost Computations Supplies and Drugs Cost Computations		odst denter bescription	H-2 Part I,	Costs (from Wkst. H-2,	Ancillary Costs (from	Costs (cols	. (from HHĀ		
Supplies and Drugs Cost Computations			0			3, 00	4, 00	5. 00	
15.00 Cost of Medical Supplies 8.00 9.00 0 0 0 0 0 0 0 0 0		Supplies and Drugs Cost Comput	ati ons			•			
Program Visits Cost of Services Part B Not Subject to Deductibles & Coinsurance Coinsuranc	15.00			0	0		0 0	0. 000000	15. 00
Part B	16.00	Cost of Drugs	9. 00	0	0		0 0	0. 000000	16.00
Cost Center Description				Program Visits					
To Deductibles & Coinsurance Deductibles & Coinsuran				Par	t B		Part B		
Deducti bl es & Coi nsurance Deducti bl es & Coi nsurance Coi nsurance		Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
Coi nsurance Coi nsurance		·		to			to	Deductibles &	
Coi nsurance Coi nsurance				Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION COST COST LIMITATION COST, OR BENEFICIARY COST COST COST COST COST COST COST COST				Coi nsurance			Coi nsurance		
COST LIMITATION Cost Per Visit Computation 1. 00 Skilled Nursing Care 0 1, 192 0 552, 564 1.00 2. 00 Physical Therapy 0 663 0 164, 059 2.00 3. 00 Occupational Therapy 0 233 0 57, 658 3.00 4. 00 Speech Pathology 0 36 0 8,907 4.00 5. 00 Medical Social Services 0 0 0 5.00 6. 00 Home Heal th Ai de 0 804 0 115, 495 6.00			6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
1. 00 Skilled Nursing Care 0 1, 192 0 552, 564 1. 00 2. 00 Physical Therapy 0 663 0 164, 059 2.00 3. 00 Occupational Therapy 0 233 0 57, 658 3. 00 4. 00 Speech Pathology 0 36 0 8, 907 4. 00 5. 00 Medical Social Services 0 0 0 5.00 6. 00 Home Health Aide 0 804 0 115, 495 6. 00		COST LIMITATION	OF AGGREGATE	PROGRAM COST, A	AGGREGATE OF TI	HE PROGRAM LI	MITATION COST, C	R BENEFICIARY	
2. 00 Physical Therapy 0 663 0 164,059 2.00 3. 00 Occupational Therapy 0 233 0 57,658 3.00 4. 00 Speech Pathology 0 36 0 8,907 4.00 5. 00 Medical Social Services 0 0 0 0 5.00 6. 00 Home Health Aide 0 804 0 115,495 6.00									
3. 00 Occupational Therapy 0 233 0 57,658 3.00 4. 00 Speech Pathology 0 36 0 8,907 4.00 5. 00 Medical Social Services 0 0 0 0 5.00 6. 00 Home Heal th Ai de 0 804 0 115,495 6.00		9	0		l e				
4. 00 Speech Pathology 0 36 0 8,907 4.00 5. 00 Medical Social Services 0 0 0 0 5.00 6. 00 Home Heal th Ai de 0 804 0 115,495 6.00			0						
5. 00 Medical Social Services 0 0 0 0 5.00 6. 00 Home Heal th Ai de 0 804 0 115, 495 6.00			0						
6.00 Home Heal th Ai de 0 804 0 115, 495 6.00			0	1	ł				
			0		l .				
7.00 Iotal (sum of lines 1-6) 0 2,928 0 898,683 7.00	6.00		0						

Heal th	Financial Systems		PULASKI MEMOR	ΙΔΙ ΗΩΩΡΙΤΔΙ		Inlie	u of Form CMS-:	2552_10
	TIONMENT OF PATIENT SERVICE COST	ΓS	TOLASKI WEWOK	Provi der C	CN: 15-1305	Peri od:	Worksheet H-3	
				HHA CCN:	15-7078	From 10/01/2017 To 09/30/2018		
				Title	XVIII	Home Health	PPS	
	Cook Cook on Donor inting					Agency I		
	Cost Center Description	6. 00	7. 00	8.00	9. 00	10.00	11. 00	
	Limitation Cost Computation	0.00	7.00	0.00	9.00	10.00	11.00	
8. 00	Skilled Nursing Care							8.00
9. 00	Physical Therapy							9.00
10.00	Occupational Therapy						•	10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00
		Progi	ram Covered Ch	arges	Cost of			
					Servi ces			
				. 5				
	Cook Cooks Doors at a	D+ A		t B	D+ A	Part B	Culti and the	
	Cost Center Description	Part A	Not Subject	Subject to Deductibles &	Part A	Not Subject	Subject to Deductibles &	
			to Deductibles &			to Deductibles &	Coinsurance	
			Coinsurance	Corrisul ance		Coi nsurance	Corrisul ance	
		6, 00	7. 00	8.00	9. 00	10.00	11. 00	
	Supplies and Drugs Cost Comput							
15.00	Cost of Medical Supplies	0	C	0		0 0	0	15. 00
16.00	Cost of Drugs		C	0		0	0	16.00
	Cost Center Description	Total Program						
		Cost (sum of						
		col s. 9-10)						-
	PART I - COMPUTATION OF LESSER	12. 00	DDOCDAM COST	ACCDECATE OF TH	IE DDOCDAM I	IMITATION COCT (D DENEELCLARY	
	COST LIMITATION	OF AGGREGATE	PRUGRAWI CUST,	AGGREGATE OF TE	HE PRUGRAM L	IMITATION COST, C	JR BENEFICIARY	
	Cost Per Visit Computation							1
1. 00	Skilled Nursing Care	552, 564						1.00
2. 00	Physical Therapy	164, 059						2.00
3.00	Occupational Therapy	57, 658						3.00
4.00	Speech Pathology	8, 907						4.00
5.00	Medical Social Services	0						5.00
6.00	Home Health Aide	115, 495						6.00
7. 00	Total (sum of lines 1-6)	898, 683						7.00
	Cost Center Description							
	1	12. 00						
	Limitation Cost Computation	T						
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11. 00 12. 00	Speech Pathology Medical Social Services							11. 00 12. 00
12.00	Home Health Aide							12.00
	Total (sum of lines 8-13)							14.00
1 1. 00	1.5tal (5am 51 111165 6 15)	I	l					1 00

Heal th	Financial Systems		PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APP0R1	TIONMENT OF PATIENT SERVICE COS	ΓS		Provi der C	CN: 15-1305	Peri od:	Worksheet H-3	
				HHA CCN:	15-7078	From 10/01/2017 To 09/30/2018		
				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 FURNISHED E	BY SHARED HOSP	TAL DEPARTME	INTS		
1.00	Physi cal Therapy	66.00	0. 530109	0		0 col. 2, line 2	. 00	1.00
2.00	Occupational Therapy	67.00	0. 479551	0		0 col. 2, line 3	. 00	2.00
3.00	Speech Pathology	68.00	0. 861693	0		0 col. 2, line 4	. 00	3.00
4.00	Cost of Medical Supplies	71.00	0. 325954	0		0 col. 2, line 1	5. 00	4.00
5.00	Cost of Drugs	73.00	0. 305782	0		0 col. 2, line 1	6. 00	5.00

	Financial Systems PULASKI MEMORI. ATION OF HHA REIMBURSEMENT SETTLEMENT	AL HOSPITAL Provider C	CN: 15-1305	Peri od:	u of Form CMS-2 Worksheet H-4	
		HHA CCN:	15-7078	From 10/01/2017 To 09/30/2018	Part I-II	pare
		Title	XVIII	Home Health Agency I	PPS	Ζ μιιι
			Part A		t B Subject to	
			Ture A	to Deductibles &	Deductibles & Coinsurance	
			1. 00	Coi nsurance 2. 00	3. 00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CU	STOMARY CHARG				
00	Reasonable Cost of Part A & Part B Services Reasonable cost of services (see instructions)			0 0	0	1.
. 00	Total charges			0 0	0	1
. 00	Customary Charges			0		
. 00	Amount actually collected from patients liable for payment on a charge basis (from your records)	for services		0 0	0	3.
. 00	Amount that would have been realized from patients liable f for services on a charge basis had such payment been made i with 42 CFR §413.13(b)			0 0	0	4.
. 00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 0000			1
. 00 . 00	Total customary charges (see instructions) Excess of total customary charges over total reasonable cos	t (complete		0 0	0	
. 00	only if line 6 exceeds line 1) Excess of reasonable cost over customary charges (complete	only if line		0 0	0	8.
. 00	1 exceeds line 6) Primary payer amounts			0 0	0	9.
. 00	in many payor amounts			Part A	Part B	/.
				Servi ces 1.00	Servi ces 2. 00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
	Total reasonable cost (see instructions)			0	0	
1. 00 2. 00	Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers			0	347, 787 29, 446	1
3. 00	Total PPS Reimbursement - LUPA Episodes			0	5, 313	1
4. 00	Total PPS Reimbursement - PEP Episodes			0	0	1
5. 00	Total PPS Outlier Reimbursement - Full Episodes with Outlie	ers		0	7, 965	15
. 00	Total PPS Outlier Reimbursement - PEP Episodes			0	0	
. 00	Total Other Payments			0	0	
. 00	DME Payments			0	0	
. 00	Oxygen Payments Prosthetic and Orthotic Payments			0	0	
. 00	Part B deductibles billed to Medicare patients (exclude coi	nsurance)			0	1
. 00	Subtotal (sum of lines 10 thru 20 minus line 21)	nour unice)		0	390, 511	
. 00	Excess reasonable cost (from line 8)			0	0	
. 00	Subtotal (line 22 minus line 23)			0	390, 511	24
. 00	Coinsurance billed to program patients (from your records)				0	25
6. 00	Net cost (line 24 minus line 25)			0	390, 511	26
. 00	Reimbursable bad debts (from your records)					27
3. 00	Reimbursable bad debts for dual eligible beneficiaries (see)			28
. 00	Total costs - current cost reporting period (line 26 plus l	ine 27)		0	390, 511	
0.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	>		0	0	
). 50). 99	Prioneer ACO demonstration payment adjustment (see instructi	*		0	0	
1. 00	Demonstration payment adjustment amount before sequestration Subtotal (see instructions)	/I I		0	0 390, 511	30
1. 01	Sequestration adjustment (see instructions)			0	7, 810	1
1. 02	Demonstration adjustment (see histractions) Demonstration payment adjustment amount after sequestration	1		0	7,010	1
2. 00	Interim payments (see instructions)			0	382, 700	
3. 00	Tentative settlement (for contractor use only)			0	0	1
	Balance due provider/program (line 31 minus lines 31.01, 32	and 33)		0	1	34
4. 00	barance due provider/program (Trie 31 milius Tries 31.01, 32	i, and oo)				1 0 .

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL		In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED	HHAS FOR SERVICES RENDERED	Provi der	CCN: 15-1305	Peri od: From 10/01/2017	Worksheet H-5
TO PROGRAM BENEFICIARIES		HHA CCN:	15-7078		Date/Time Prepared:

7/31/2019 3:12 pm Home Health Agency I Inpatient Part A Part B mm/dd/yyyy Amount mm/dd/yyyy Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 382, 700 1.00 2.00 Interim payments payable on individual bills, either 0 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3. 01 3.01 3. 02 0 0 3.02 3.03 0 3.03 3.04 0 0 3.04 0 3.05 3.05 Provider to Program 3.50 0 0 3.50 3. 51 0 0 3.51 0 3.52 0 3.52 3.53 0 3.53 3.54 0 0 3.54 0 3. 99 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3. 50-3. 98) Total interim payments (sum of lines 1, 2, and 3.99) 4.00 0 382, 700 4.00 (transfer to Wkst. H-4, Part II, column as appropriate, line 32) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 0 n 5.01 0 0 5.02 5.02 5.03 0 0 5.03 Provider to Program 5.50 0 5.50 n 5. 51 0 0 5.51 5. 52 0 0 5. 52 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 5, 50-5, 98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.01 0 6.02 SETTLEMENT TO PROGRAM 6.02 0 Total Medicare program liability (see instructions) 382, 701 7.00 7.00 NPR Date Contractor Number (Mo/Day/Yr) 0 1.00 2.00

8. 00

8.00 Name of Contractor

ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 15-1305	Peri od:	Worksheet M-1	
			Component	CCN: 15-8512	From 10/01/2017 To 09/30/2018	Date/Time Pre 7/31/2019 3:1	
					RHC I	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
		1.00	0.00	2.00	4.00	col . 4)	
	FACILITY HEALTH CARE STAFF COSTS	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	Physician	2, 743, 540	47, 500	2, 791, 04	-358, 024	2, 433, 016	1.00
2. 00	Physician Assistant	2, 743, 340	47, 500	2, 191, 02	0 -336, 024	2, 433, 010	1
3. 00	Nurse Practitioner	518, 771	12, 800	531, 57	٥	479, 838	
4. 00	Vi si ti ng Nurse	510, 771	12, 800	331, 37	-51, 733	479, 636	4.00
5. 00	Other Nurse	102, 821	0	102, 82	21 0	102, 821	
6. 00	Clinical Psychologist	102, 021	0	102, 02	0 0	102, 021	
7. 00	Clinical Social Worker	0	0		0	0	
8. 00	Laboratory Techni ci an	0	0		0 0	0	
9. 00	Other Facility Health Care Staff Costs	493, 271	0	493, 27	71 0	493, 271	9.00
10.00	Subtotal (sum of lines 1 through 9)	3, 858, 403	60, 300			3, 508, 946	
11. 00	Physician Services Under Agreement	0	49, 306			43, 587	
12.00	Physician Supervision Under Agreement	0	0		0 0	0	1
13.00	Other Costs Under Agreement	0	0		0 0	0	13.00
14. 00	Subtotal (sum of lines 11 through 13)	0	49, 306	49, 30	-5, 719	43, 587	14.00
15. 00	Medical Supplies	0	33, 807	33, 80		30, 384	15.00
16.00	Transportation (Health Care Staff)	0	0		0 0	0	16.00
17. 00	Depreciation-Medical Equipment	0	0		0 0	0	17.00
18. 00	Professional Liability Insurance	0	0		0 0	0	
19. 00	Other Health Care Costs	0	0		0 0	0	
20. 00	Allowable GME Costs						20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	33, 807			30, 384	
22. 00	Total Cost of Health Care Services (sum of	3, 858, 403	143, 413	4, 001, 81	-418, 899	3, 582, 917	22.00
	lines 10, 14, and 21)						
22 00	COSTS OTHER THAN RHC/FQHC SERVICES	ما					1 22 00
23.00	Pharmacy	0	0		0 0	0	
24. 00 25. 00	Dental	0	0		0 0	0	
25. 00 25. 01	Optometry Tel eheal th	0	0		0	0	
25. 01	· I	0	0		0	0	
26. 00	All other nonreimbursable costs	0	0			0	
27. 00	Nonallowable GME costs	U	0			U	27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	
20.00	through 27)	O	0			O	20.00
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	102, 295	102, 29	95 -11, 898	90, 397	29.00
30.00	Administrative Costs	747, 698	170, 447			579, 704	
31.00	Total Facility Overhead (sum of lines 29 and	·	272, 742			670, 101	31.00
	30)		•			•	
32.00	Total facility costs (sum of lines 22, 28	4, 606, 101	416, 155	5, 022, 25	-769, 238	4, 253, 018	32.00
	and 31)						1

Health Financial Systems	PULASKI MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der	CCN: 15-1305	Peri od: From 10/01/2017	Worksheet M-1	
		Component	CCN: 15-8512	To 09/30/2018		
				RHC I	Cost	
	Adjustments	Net Expenses	5			
		for				

Adj ustments				30p00t		7,7 00,7 20,10	7/31/2019 3: 1	12 pm
FACILITY HEALTH CARE STAFF COSTS						RHC I	Cost	
FACILITY HEALTH CARE STAFF COSTS			Adjustments	Net Expenses				
CCOL 5 + COL 6 COL				for				
FACILITY HEALTH CARE STAFF COSTS								
FACILITY HEALTH CARE STAFF COSTS								
FACILITY HEALTH CARE STAFF COSTS								
1. 00 Physician 0 2,433,016 1.00 2. 00 Physician Assistant 0 0 0 3. 00 Nurse Practitioner 0 479,838 3.00 4. 00 Visiting Nurse 0 0 4.00 5. 00 Other Nurse 0 102,821 5.00 6. 00 Clinical Psychologist 0 0 6.00 7. 00 Clinical Social Worker 0 0 7.00 8. 00 Laboratory Technician 0 0 8.00 9. 00 Other Facility Health Care Staff Costs 0 493,271 9.00 10. 00 Subtotal (sum of lines 1 through 9) 0 3,508,946 10.00 11. 00 Physician Services Under Agreement 0 43,587 11.00 12. 00 Other Costs Under Agreement 0 0 13.00 14. 00 Subtotal (sum of lines 11 through 13) 0 43,587 14.00 15. 00 Medical Supplies 0 30,384 15.00 17. 00 Depreciation-Medical Equipment 0 0			6. 00	7. 00				
2.00 Physician Assistant 0 0 0 2.00 3.00 Nurse Practitioner 0 479,838 3.00 4.00 Visiting Nurse 0 0 4.00 5.00 Other Nurse 0 102,821 5.00 6.00 Clinical Psychologist 0 0 6.00 7.00 Laboratory Technician 0 0 8.00 9.00 Other Facility Health Care Staff Costs 0 493,271 9.00 10.00 Subtotal (sum of lines 1 through 9) 0 3,508,946 10.00 11.00 Physician Services Under Agreement 0 43,587 11.00 12.00 Physician Supervision Under Agreement 0 0 12.00 13.00 Other Costs Under Agreement 0 0 13.00 14.00 Subtotal (sum of lines 11 through 13) 0 43,587 14.00 15.00 Transportation (Health Care Staff) 0 0 15.00 17.00 Depreciation-Medical Equipment 0 0 17.00 18.00 Other Health Care Costs </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
3. 00 Nurse Practitioner 0 479,838 3.00 4. 00 Visiting Nurse 0 0 4.00 5. 00 Other Nurse 0 102,821 5.00 6. 00 Clinical Psychologist 0 0 6.00 7. 00 Clinical Social Worker 0 0 7.00 8. 00 Laboratory Technician 0 0 8.00 9. 00 Other Facility Health Care Staff Costs 0 493,271 9.00 10. 00 Subtotal (sum of lines 1 through 9) 0 3,508,946 10.00 11. 00 Physician Supervision Under Agreement 0 0 43,587 11.00 12. 00 Physician Supervision Under Agreement 0 0 0 13.00 14. 00 Subtotal (sum of lines 11 through 13) 0 43,587 14.00 15. 00 Medical Supplies 0 30,384 15.00 17. 00 Depreciation-Medical Equipment 0 0 17.00 18. 00 Professional Liability Insurance 0 0 18.00 19. 00			0		1			
4. 00 Visiting Nurse 0 0 4.00 5. 00 Other Nurse 0 102,821 5.00 6. 00 Clinical Psychologist 0 0 6.00 7. 00 Clinical Social Worker 0 0 7.00 8. 00 Laboratory Technician 0 0 8.00 9. 00 Other Facility Health Care Staff Costs 0 493,271 9.00 10. 00 Subtotal (sum of lines 1 through 9) 0 3,508,946 10.00 11. 00 Physician Services Under Agreement 0 43,587 11.00 12. 00 Physician Supervision Under Agreement 0 0 13.00 14. 00 Other Costs Under Agreement 0 0 13.00 14. 00 Subtotal (sum of lines 11 through 13) 0 43,587 14.00 15. 00 Medical Supplies 0 30,384 15.00 17. 00 Depreciation-Medical Equipment 0 0 16.00 17. 00 Depreciation-Medical Equipment 0 0 18.00 19. 00 Other Health Care Costs			0		1			
5. 00 Other Nurse 0 102,821 5.00 6. 00 Clinical Psychologist 0 0 6.00 7. 00 Clinical Social Worker 0 0 7.00 8. 00 Laboratory Technician 0 0 8.00 9. 00 Other Facility Health Care Staff Costs 0 493, 271 9.00 10. 00 Subtotal (sum of lines 1 through 9) 0 3, 508, 946 10.00 11. 00 Physician Services Under Agreement 0 43, 587 11.00 12. 00 Physician Supervision Under Agreement 0 0 13.00 14. 00 Other Costs Under Agreement 0 0 13.00 14. 00 Subtotal (sum of lines 11 through 13) 0 43, 587 14.00 15. 00 Medical Supplies 0 30, 384 15.00 16. 00 Transportation (Health Care Staff) 0 0 16.00 17. 00 Depreciation-Medical Equipment 0 0 17.00 18. 00 Professional Liability Insurance 0 0 18.00 19. 00 <td< td=""><td></td><td>1</td><td>0</td><td>479, 838</td><td></td><td></td><td></td><td></td></td<>		1	0	479, 838				
6. 00 Clinical Psychologist 0 0 6.00 7. 00 Clinical Social Worker 0 0 7.00 8. 00 Laboratory Technician 0 0 8.00 9. 00 Other Facility Health Care Staff Costs 0 493, 271 9.00 10. 00 Subtotal (sum of lines 1 through 9) 0 3,508, 946 10.00 11. 00 Physician Services Under Agreement 0 43,587 11.00 12. 00 Physician Supervision Under Agreement 0 0 12.00 13. 00 Other Costs Under Agreement 0 0 13.00 14. 00 Subtotal (sum of lines 11 through 13) 0 43,587 14.00 15. 00 Medical Supplies 0 30,384 15.00 17. 00 Depreciation-Medical Equipment 0 0 16.00 17. 00 Professional Liability Insurance 0 0 18.00 19. 00 Other Health Care Costs 0 0 19.00		1	0	0				
7. 00 Clinical Social Worker 0 0 7. 00 8. 00 Laboratory Technician 0 0 8. 00 9. 00 Other Facility Health Care Staff Costs 0 493, 271 9. 00 10. 00 Subtotal (sum of lines 1 through 9) 0 3, 508, 946 10. 00 11. 00 Physician Services Under Agreement 0 43, 587 11. 00 12. 00 Physician Supervision Under Agreement 0 0 12.00 13. 00 Other Costs Under Agreement 0 0 13. 00 14. 00 Subtotal (sum of lines 11 through 13) 0 43, 587 14. 00 15. 00 Medical Supplies 0 30, 384 15. 00 16. 00 Transportation (Health Care Staff) 0 0 16. 00 17. 00 Depreciation-Medical Equipment 0 0 17. 00 18. 00 Professional Liability Insurance 0 0 18. 00 19. 00 Other Health Care Costs 0 0 19. 00		1	0	102, 821				1
8. 00 Laboratory Technician 0 0 8. 00 9. 00 Other Facility Health Care Staff Costs 0 493, 271 9. 00 10. 00 Subtotal (sum of lines 1 through 9) 0 3, 508, 946 10. 00 11. 00 Physician Services Under Agreement 0 43, 587 11. 00 12. 00 Physician Supervision Under Agreement 0 0 12. 00 13. 00 Other Costs Under Agreement 0 0 13. 00 14. 00 Subtotal (sum of lines 11 through 13) 0 43, 587 14. 00 15. 00 Medical Supplies 0 30, 384 15. 00 16. 00 Transportation (Health Care Staff) 0 0 16. 00 17. 00 Depreciation-Medical Equipment 0 0 17. 00 18. 00 Professional Liability Insurance 0 0 18. 00 19. 00 Other Health Care Costs 0 0 19. 00			0	-				1
9. 00 Other Facility Health Care Staff Costs 0 493, 271 9.00 10. 00 Subtotal (sum of lines 1 through 9) 0 3, 508, 946 10.00 11. 00 Physician Services Under Agreement 0 43, 587 11.00 12. 00 Physician Supervision Under Agreement 0 0 12.00 13. 00 Other Costs Under Agreement 0 0 13.00 14. 00 Subtotal (sum of lines 11 through 13) 0 43, 587 14.00 15. 00 Medical Supplies 0 30, 384 15.00 16. 00 Transportation (Health Care Staff) 0 0 16.00 17. 00 Depreciation-Medical Equipment 0 0 17.00 18. 00 Professional Liability Insurance 0 0 18.00 19. 00 Other Health Care Costs 0 0 19.00			0	0				
10.00 Subtotal (sum of lines 1 through 9) 0 3,508,946 10.00 11.00 Physician Services Under Agreement 0 43,587 11.00 12.00 Physician Supervision Under Agreement 0 0 12.00 13.00 Other Costs Under Agreement 0 0 13.00 14.00 Subtotal (sum of lines 11 through 13) 0 43,587 14.00 15.00 Medical Supplies 0 30,384 15.00 16.00 Transportation (Heal th Care Staff) 0 0 16.00 17.00 Depreciation-Medical Equipment 0 0 17.00 18.00 Professional Liability Insurance 0 0 18.00 19.00 Other Health Care Costs 0 0 19.00			0	0				
11. 00 Physician Services Under Agreement 0 43,587 11. 00 12. 00 Physician Supervision Under Agreement 0 0 12. 00 13. 00 Other Costs Under Agreement 0 0 13. 00 14. 00 Subtotal (sum of lines 11 through 13) 0 43, 587 14. 00 15. 00 Medical Supplies 0 30, 384 15. 00 16. 00 Transportation (Heal th Care Staff) 0 0 16. 00 17. 00 Depreciation-Medical Equipment 0 0 17. 00 18. 00 Professional Liability Insurance 0 0 18. 00 19. 00 Other Heal th Care Costs 0 0 19. 00	9. 00		0	•				
12.00 Physician Supervision Under Agreement 0 0 13.00 Other Costs Under Agreement 0 0 14.00 Subtotal (sum of lines 11 through 13) 0 43,587 14.00 15.00 Medical Supplies 0 30,384 15.00 16.00 Transportation (Heal th Care Staff) 0 0 16.00 17.00 Depreciation-Medical Equipment 0 0 17.00 18.00 Professional Liability Insurance 0 0 18.00 19.00 Other Heal th Care Costs 0 0 19.00			0		1			
13.00 Other Costs Under Agreement 0 0 13.00 14.00 Subtotal (sum of lines 11 through 13) 0 43,587 14.00 15.00 Medical Supplies 0 30,384 15.00 16.00 Transportation (Health Care Staff) 0 0 16.00 17.00 Depreciation-Medical Equipment 0 0 17.00 18.00 Professional Liability Insurance 0 0 18.00 19.00 Other Health Care Costs 0 0 19.00			0	43, 587				
14.00 Subtotal (sum of lines 11 through 13) 0 43,587 14.00 15.00 Medical Supplies 0 30,384 15.00 16.00 Transportation (Health Care Staff) 0 0 16.00 17.00 Depreciation-Medical Equipment 0 0 17.00 18.00 Professional Liability Insurance 0 0 18.00 19.00 Other Health Care Costs 0 0 19.00			0		1			
15.00 Medical Supplies 0 30,384 15.00 16.00 Transportation (Health Care Staff) 0 0 16.00 17.00 Depreciation-Medical Equipment 0 0 17.00 18.00 Professional Liability Insurance 0 0 18.00 19.00 Other Health Care Costs 0 0 19.00			0		1			1
16.00 Transportation (Health Care Staff) 0 0 16.00 17.00 Depreciation-Medical Equipment 0 0 17.00 18.00 Professional Liability Insurance 0 0 18.00 19.00 Other Health Care Costs 0 0 19.00	14.00		0	43, 587				
17. 00 Depreciation-Medical Equipment 0 0 17. 00 18. 00 Professional Liability Insurance 0 0 18. 00 19. 00 Other Health Care Costs 0 0 19. 00	15.00		0	30, 384				
18.00 Professional Liability Insurance 0 0 18.00 19.00 Other Health Care Costs 0 0 19.00	16.00	Transportation (Health Care Staff)	0	0				16. 00
19.00 Other Health Care Costs 0 0 19.00	17.00	Depreciation-Medical Equipment	0	0				
	18.00	Professional Liability Insurance	0	0				
	19.00	Other Health Care Costs	0	0				
	20.00	Allowable GME Costs						20.00
21.00 Subtotal (sum of lines 15 through 20) 0 30,384 21.00	21.00		0	•				
22.00 Total Cost of Health Care Services (sum of 0 3,582,917 22.00	22.00		0	3, 582, 917				22. 00
lines 10, 14, and 21)								
COSTS OTHER THAN RHC/FQHC SERVICES								4
23. 00 Pharmacy 0 0 23. 00		1 -	0		1			
24. 00 Dental 0 0 24. 00		1	0		1			
25. 00 Optometry 0 0 25. 00		1'	0	-	1			
25. 01 Tel eheal th 0 0 25. 01		4	0		1			
25. 02 Chroni c Care Management 0 0 25. 02			0	-				
26.00 All other nonreimbursable costs 0 0 26.00		4	0	0				
27.00 Nonallowable GME costs 27.00								
28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 28.00	28. 00		0	0)			28. 00
through 27)								1
FACILITY OVERHEAD			.1					4
29. 00 Facility Costs 0 90, 397 29. 00								
30. 00 Administrative Costs -13, 081 566, 623 30. 00								
31.00 Total Facility Overhead (sum of lines 29 and -13,081 657,020 31.00	31. 00	i i	-13, 081	657, 020	1			31.00
30)	00.05	1 '	10.05	4 000 5==				00.00
32.00 Total facility costs (sum of lines 22, 28 -13,081 4,239,937 32.00	32.00		-13, 081	4, 239, 937				32.00
and 31)		Tanu 31)	I		I			I

ANALYS	IS OF HOSPITAL-BASED RHC/FOHC COSTS		Provi der C	CN: 15-1305	Peri od:	Worksheet M-1	
			Component	CCN: 15-8527	From 10/01/2017 To 09/30/2018	Date/Time Pre 7/31/2019 3:1	pared: 2 pm
					RHC II	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
		1 00	2.00	2.00	4.00	col . 4)	
	FACILITY HEALTH CARE STAFF COSTS	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	Physi ci an	216, 517	0	216, 5	17 -110, 375	106, 142	1.00
2. 00	Physician Assistant	210, 317	0		0 -110, 373	100, 142	2.00
3. 00	Nurse Practitioner	0	0		0 13, 606	13, 606	
4. 00	Visiting Nurse	0	0		0 0	0	4.00
5. 00	Other Nurse	74, 959	0	74, 95	59 0	74, 959	
6.00	Clinical Psychologist	0	0		0 0	0	6.00
7.00	Clinical Social Worker	0	0		0 0	0	7. 00
8.00	Laboratory Techni ci an	O	0		0 0	0	8.00
9.00	Other Facility Health Care Staff Costs	47, 363	0	47, 30		47, 363	9. 00
10.00	Subtotal (sum of lines 1 through 9)	338, 839	0	338, 83		242, 070	
11. 00	Physician Services Under Agreement	0	0		0 4, 017	4, 017	11.00
12.00	Physician Supervision Under Agreement	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	0		0 4, 017	4, 017	14.00
15.00	Medical Supplies	0	9, 976	9, 9	76 2, 404	12, 380	
16. 00 17. 00	Transportation (Health Care Staff)	0	0		0	0	16.00
17.00	Depreciation-Medical Equipment Professional Liability Insurance	0	0		0	0	17. 00 18. 00
19.00	Other Health Care Costs	0	0		0	0	19.00
20.00	Allowable GME Costs	O ₁	0			U	20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	9, 976	9, 9	76 2, 404	12, 380	
22. 00	Total Cost of Health Care Services (sum of	338, 839	9, 976		·	258, 467	22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0		0 0	0	23. 00
24.00	Dental	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	25. 01
25. 02	Chronic Care Management	0	0		0	0	25. 02
26.00	All other nonreimbursable costs	0	0		0	0	26.00
27. 00	Nonallowable GME costs		0		0	0	27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		U	0	28. 00
	FACILITY OVERHEAD						
29. 00	Facility Costs	ol	70, 934	70, 93	34 8, 356	79, 290	29. 00
30.00	Admi ni strati ve Costs	34, 208	6, 770		·	44, 224	30.00
31.00	Total Facility Overhead (sum of lines 29 and	34, 208	77, 704			123, 514	1
	30)	, ====	,		, , , , , ,	-,	

373, 047

87, 680

460, 727

-78, 746

381, 981

32.00

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

Health Financial Systems	PULASKI	MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS			Provi der	CCN: 15-1305	Peri od: From 10/01/2017	Worksheet M-1	
			Component	t CCN: 15-8527	To 09/30/2018	Date/Time Pre 7/31/2019 3:1	
					RHC II	Cost	
	A 11 . 1		M - 1				

					1	7/31/2019 3: 1	2 pm
				_	RHC II	Cost	
		Adjustments	Net Expenses				
			for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6. 00	7. 00				
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	106, 142	2			1.00
2.00	Physician Assistant	0	()			2.00
3.00	Nurse Practitioner	0	13, 606				3. 00
4. 00	Visiting Nurse	0	C)			4.00
5.00	Other Nurse	0	74, 959	9			5.00
6.00	Clinical Psychologist	0	()			6. 00
7. 00	Clinical Social Worker	0	C	•			7.00
8.00	Laboratory Techni ci an	0	C	•			8.00
9.00	Other Facility Health Care Staff Costs	0	47, 363				9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	242, 070				10.00
11. 00	Physician Services Under Agreement	0	4, 017	1			11.00
12.00	Physician Supervision Under Agreement	0	C	•			12.00
13. 00	Other Costs Under Agreement	0	(1			13.00
14.00	Subtotal (sum of lines 11 through 13)	0	4, 017				14.00
15.00	Medical Supplies	0	12, 380)			15.00
16.00	Transportation (Health Care Staff)	0	()			16.00
17.00	Depreciation-Medical Equipment	0	()			17.00
18.00	Professional Liability Insurance	0	()			18. 00
19.00	Other Health Care Costs	0	()			19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	12, 380)			21.00
22.00	Total Cost of Health Care Services (sum of	0	258, 467	<u>'</u>			22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	1	0	(1			23.00
24. 00	Dental	0	(•			24.00
25. 00	Optometry	0	C	1			25.00
25. 01	Tel eheal th	0	C	1			25. 01
25. 02	Chronic Care Management	0	C	1			25. 02
26. 00	All other nonreimbursable costs	0	C)			26. 00
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	C				28. 00
	through 27)						
	FACILITY OVERHEAD	_1	70	,			
	Facility Costs	0	79, 290				29.00
30.00	Administrative Costs	0	44, 224				30.00
31. 00	Total Facility Overhead (sum of lines 29 and	이	123, 514	1			31.00
22.00	30)		201 201				22.00
32. 00	Total facility costs (sum of lines 22, 28	O	381, 981				32.00
	and 31)	I		I			I

111 44	Financial Conton	DIII ACKI, MEMODI	AL HOCDITAL		1-11-	£ F CMC /	2552 10
	Financial Systems IS OF HOSPITAL-BASED RHC/FOHC COSTS	PULASKI MEMORI	Provider C	ON. 1E 120E	Period:	u of Form CMS-2 Worksheet M-1	
ANALYS	13 OF HOSPITAL-BASED RHC/FUHC COSTS		Provider C	JN: 15-1305	From 10/01/2017	worksneet w-i	
			Component	CCN: 15-8528	To 09/30/2018	Date/Time Pre 7/31/2019 3:1	
					RHC III	Cost	
		Compensation	Other Costs		1 Reclassi fi cat	Recl assi fi ed	
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
		1.00			4 00	col . 4)	
	FACILITY HEALTH CARE CTAFE COCTO	1. 00	2. 00	3. 00	4. 00	5. 00	
4 00	FACILITY HEALTH CARE STAFF COSTS				0 5/0	0.5/0	1 00
1.00	Physician	0	0		9, 562	9, 562	1.00
2.00	Physician Assistant	100 (42	0	100 (0 0	0	
3. 00 4. 00	Nurse Practitioner	100, 643	20, 000	120, 64	-51, 014	69, 629 0	1
5. 00	Visiting Nurse Other Nurse	0	0		0		1
6. 00	Clinical Psychologist	0	0			0	
7. 00	Clinical Social Worker	0	0			0	
8. 00	Laboratory Techni ci an	0	0			0	
9. 00	Other Facility Health Care Staff Costs	67, 599	0	67, 59	٥	67, 599	1
10.00	Subtotal (sum of lines 1 through 9)	168, 242	20, 000	188, 24		146, 790	1
11. 00	Physician Services Under Agreement	0	20, 000	100, 2	0 1, 703	1, 703	
12. 00	Physician Supervision Under Agreement	0	0		0 0	0	12.00
13. 00	Other Costs Under Agreement	0	0		0 0	Ō	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0 1, 703	1, 703	14.00
15.00	Medi cal Supplies	0	4, 571	4, 57	71 1, 019	5, 590	15.00
16.00	Transportation (Health Care Staff)	0	0		0 0	0	16.00
17.00	Depreciation-Medical Equipment	0	0		0 0	0	17.00
18.00	Professional Liability Insurance	0	0		0 0	0	18. 00
19. 00	Other Health Care Costs	0	0		0	0	1
20.00	Allowable GME Costs						20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	4, 571	4, 57		5, 590	
22. 00	Total Cost of Health Care Services (sum of	168, 242	24, 571	192, 81	-38, 730	154, 083	22. 00
	lines 10, 14, and 21)						
22 00	COSTS OTHER THAN RHC/FQHC SERVICES						22.00
23. 00 24. 00	Pharmacy Dental	0	0		0 0	0	1
25.00	Optometry	0	0		0		25.00
25. 00	Tel eheal th	0	0		0		
25. 01	Chronic Care Management	0	0			0	
26. 00	All other nonreimbursable costs	0	0			0	1
27. 00	Nonallowable GME costs	O	U			0	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	1
20.00	through 27)	J	O				20.00
	FACILITY OVERHEAD						1
29. 00	Facility Costs	0	12, 240	12, 24	10 3, 542	15, 782	29. 00
30.00	Administrative Costs	26, 803	5, 797	32, 60	· ·	33, 976	1
31. 00	Total Facility Overhead (sum of lines 29 and		18, 037	44, 84	· ·	49, 758	1
	30)						

195, 045

42, 608

237, 653

203, 841

32.00

-33, 812

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

Health Financial Systems	PULASKI	MEMORI A	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS			Provi der	CCN: 15-1305	Peri od: From 10/01/2017	Worksheet M-1	
			Component	CCN: 15-8528	To 09/30/2018	Date/Time Pre 7/31/2019 3:1	
					RHC III	Cost	
	Adiustm	onte	Nat Evnancas				

						7/31/2019 3: 1	2 pm
					RHC III	Cost	
		Adjustments	Net Expenses				
			for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6. 00	7. 00	1			
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	O	9, 562				1.00
2. 00	Physician Assistant	ol Ol	7, 002	1			2.00
3. 00	Nurse Practitioner	0	69, 629	1			3.00
4. 00	Vi si ti ng Nurse	0	07, 027				4.00
5. 00	Other Nurse	0	C				5.00
	1	o o		1			1
6.00	Clinical Psychologist	U	-	1			6.00
7. 00	Clinical Social Worker	O O	C	1			7.00
8.00	Laboratory Techni ci an	0	(7.500	1			8.00
9. 00	Other Facility Health Care Staff Costs	O	67, 599				9. 00
10. 00	Subtotal (sum of lines 1 through 9)	0	146, 790				10.00
11. 00	Physician Services Under Agreement	이	1, 703	1			11. 00
12.00	Physician Supervision Under Agreement	0	C)			12.00
13.00	Other Costs Under Agreement	0	C)			13.00
14.00	Subtotal (sum of lines 11 through 13)	0	1, 703	s			14.00
15.00	Medical Supplies	0	5, 590				15.00
16.00	Transportation (Health Care Staff)	o	C				16.00
17.00	Depreciation-Medical Equipment	ol	C				17.00
18.00	1 ' '	ol	C	ol .			18.00
19.00	Other Health Care Costs	0	C				19.00
20.00	Allowable GME Costs	-	_				20.00
21. 00	Subtotal (sum of lines 15 through 20)	٥	5, 590				21.00
22. 00	Total Cost of Health Care Services (sum of	Ö	154, 083				22.00
22.00	lines 10, 14, and 21)	ď	134, 003	'			22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
22 00	Pharmacy	O	C	VI.			23. 00
24. 00	Dental	0	C	1			24.00
25.00	1	ol ol		()			25.00
	Optometry	ol ol		()			25.00
25. 01	Tel eheal th	U	C	<u>'</u>			
25. 02	Chronic Care Management	O ₀	C	<u>'</u>			25. 02
26.00	All other nonreimbursable costs	٥	C	7			26.00
27. 00	Nonallowable GME costs	_	_				27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	C	9			28. 00
	through 27)						
	FACILITY OVERHEAD	1					
	Facility Costs	0	15, 782	•			29.00
30.00	Administrative Costs	0	33, 976	1			30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	49, 758	 			31.00
	30)						
32.00	, ,	0	203, 841				32.00
	and 31)						

Heal th	Financial Systems	PULASKI MEMORI	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 10/01/2017 To 09/30/2018	Date/Time Pre 7/31/2019 3:1	
					RHC I	Cost	
			Total Visits			Greater of	
		Personnel		Standard (1)	,	col. 2 or	
						col. 4	
		1. 00	2.00	3.00	4. 00	5. 00	
			1	T			
1. 00							1.00
2.00	1 3						2.00
3. 00		1					3.00
4.00		1			28, 896	28, 896	
5. 00		1	l .			0	5. 00
6. 00						0	6. 00
7.00						0	7. 00
7. 01						0	7. 01
7. 02		0.00	0			0	7. 02
			00.70/			20.00/	
8. 00		8.81	22, /36			28, 896	8. 00
0.00			202			202	0.00
9. 00	Physician Services under Agreements		203			203	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPITAL-BASI	ED RHC/FOHC SEL	RVICES		1.00	
						3, 582, 917	10.00
						0,002,717	
12.00						3, 582, 917	
13.00						1. 000000	
14. 00				ine 31)		657, 020	
15. 00						3, 093, 485	
16.00		.,	,			3, 750, 505	
	·					0	
	Number of FTE Personnel Number of FTE Personnel Number of FTE Personnel Number of FTE Personnel Number of FTE Standard (1) Nisits (col. 1 x col. 3)						
	Nurse Practitioner Subtotal (sum of lines 1 through 3) Substiting Nurse Clinical Psychologist O.00 Clinical Social Worker Medical Nutrition Therapist (FOHC only) Diabetes Self Management Training (FOHC Only) Total FTEs and Visits (sum of lines 4 through 7) Physician Services Under Agreements DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES Total costs of health care services (from Wkst. M-1, col. 7, line 22) Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) Cost of all services (excluding overhead) (sum of lines 10 and 11) Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) Parent provider overhead allocated to facility (see instructions) Total overhead (sum of lines 14 and 15) Allowable GME overhead (see instructions) Enter the amount from line 16 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18)						
						3, 750, 505 7, 333, 422	
	· '	•		·	·	•	•

Number of FTE Personnel Total Visits Productivity Standard (1) Visits (col. 2 or col. 4 Visits (col. 1) Visits (col. 2 or col. 4 Visits (c		Financial Systems	PULASKI MEMORI	I AL_HOSPI TAL		In Lie	u of Form CMS-2	2552-10
Number of FTE Personnel Number of FTE Standard (1) Number of FTE Standard (1) Number of FTE Number of FTE Standard (1) Number of FTE Number of FTE Standard (1) Number of FTE Number of FTE Number of FTE Number of FTE Number of Number	ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C			Worksheet M-2	
Number of FTE Personnel				Component				
Personnel Standard (1) Visits (col. col. 2 or					RHC II			
Note				Total Visits				
1.00 2.00 3.00 4.00 5.00			Personnel		Standard (1)	,		
VISITS AND PRODUCTIVITY								
Positions			1. 00	2. 00	3. 00	4. 00	5. 00	
1.00 Physician								
2. 00 Physician Assistant			1		1			
3.00 Nurse Practitioner 0.11 459 2,100 231 3.00 4.00 Subtotal (sum of lines 1 through 3) 0.47 2,114 1,743 2,114 4.00 5.00 Visiting Nurse 0.00 0 0 5.00 6.00 Clinical Psychologist 0.00 0 0 0 0 7.00 Clinical Social Worker 0.00 0 0 0 0 7.01 Medical Nutrition Therapist (FOHC only) 0.00 0 0 0 7.01 7.02 Diabetes Self Management Training (FOHC 0.00 0 0 0 0 8.00 Total FTEs and Visits (sum of lines 4 0.47 2,114 2,114 2,114 8.00 9.00 Physician Services Under Agreements 0 0 0 11.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 258,467 10.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 11.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 258,467 12.00 13.00 Ratio of hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 12) 1.000 15.00 Total nospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 237,159 15.00 16.00 Total overhead (sum of lines 14 and 15) 330,673 16.00 17.00 All owable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 360,673 19.00 19.00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18) 360,673 19.00 19.00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18) 360,673 19.00 19.00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18) 360,673 19.00 19.00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18) 360,673 19.00 19.00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18) 360,673 19.00								
4.00 Subtotal (sum of lines 1 through 3) 0.47 2,114 1,743 2,114 4.00				l e				
5.00 Visiting Nurse 0.00 0 0 0 0 0 0 0 0				l e				
Clinical Psychologist				•		1, 743		
7. 00 Clinical Social Worker 0. 00 0 0 7. 00 7. 00 7. 01 Medical Nutrition Therapist (FOHC only) 0. 00 0 0 7. 01 0. 00 0 0 0 0 0 0 0 0				l e			-	
7. 01 Medical Nutrition Therapist (FQHC only)							-	
7. 02 Di abetes Sel f Management Training (FQHC 0.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							ū	
onl y) 8. 00 Total FTEs and Visits (sum of lines 4							ū	
8.00 Total FTEs and Visits (sum of lines 4 through 7) 9.00 Physician Services Under Agreements 0 0 9.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 11.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 12.00 Cost of hospital-based RHC/FOHC services (line 10 divided by line 12) 13.00 Ratio of hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18) 360,673 19.00	7. 02		0.00	0			0	7.02
through 7) Physician Services Under Agreements 0 9.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 360, 673 19.00	0.00		0.47	2 114			2 114	0.00
9. 00 Physician Services Under Agreements 0 0 9. 00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10. 00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 258, 467 10. 00 11. 00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 11. 00 12. 00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 258, 467 12. 00 13. 00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 1. 000000 13. 00 14. 00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 123, 514 14. 00 15. 00 Parent provider overhead allocated to facility (see instructions) 237, 159 15. 00 16. 00 Total overhead (sum of lines 14 and 15) 360, 673 16. 00 17. 00 Allowable GME overhead (see instructions) 0 17. 00 18. 00 Enter the amount from line 16 360, 673 19. 00 19. 00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18) 360, 673 19. 00	6.00		0.47	2, 114			2, 114	0.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 258, 467 10.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 11.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 258, 467 12.00 13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 1.000000 13.00 14.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 123, 514 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 237, 159 15.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 360, 673 18.00 19.00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18) 360, 673 19.00	0 00			0			0	0 00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 258, 467 10.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 11.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 258, 467 12.00 13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 1.000000 13.00 14.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 123, 514 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 237, 159 15.00 16.00 Total overhead (sum of lines 14 and 15) 360, 673 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 360, 673 18.00 19.00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18) 360, 673 19.00 19.	7.00	Friysi ci ali Sei vi ces under Agreements					0	7.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 258, 467 10.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 11.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 258, 467 12.00 13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 1.000000 13.00 14.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 123, 514 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 237, 159 15.00 16.00 Total overhead (sum of lines 14 and 15) 360, 673 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 360, 673 18.00 19.00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18) 360, 673 19.00 19.							1 00	
10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 258, 467 10.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 11.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 258, 467 12.00 13.00 Ratio of hospital -based RHC/FQHC services (line 10 divided by line 12) 1.000000 13.00 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 123, 514 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 237, 159 15.00 16.00 Total overhead (sum of lines 14 and 15) 360, 673 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 360, 673 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 360, 673 19.00		DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPITAL-BASE	FD_RHC/FOHC_SE	RVLCES		1.00	
11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 0 11.00 12.00 1.000000 1.000 1.000 237, 159 360, 673 18.00 360, 673 19.00					020		258, 467	10.00
12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 258, 467 12.00 1.000000 13.00 123, 514 14.00 123, 514 14.00 123, 514 14.00 123, 514 14.00 123, 514 14.00 123, 514 14.00 123, 514 14.00 123, 514 14.00 123, 514 14.00 123, 514 14.00 123, 514 14.00 123, 514 14.00 124, 00 125, 467 12.00 120, 00 120, 00 13.00 123, 514 14.00 15.00 16.00 17.00 17.00 18.00 19.00							· ·	
13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 11.000000 123,514 14.00 237,159 15.00 360,673 16.00 17.00 360,673 18.00							258. 467	12.00
14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 123,514 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 237,159 15.00 16.00 Total overhead (sum of lines 14 and 15) 360,673 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 360,673 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 360,673 19.00								
15.00 Parent provider overhead allocated to facility (see instructions) 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 237, 159	14.00				i ne 31)		123, 514	14.00
16.00 Total overhead (sum of lines 14 and 15) 360, 673 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 360, 673 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 360, 673 19.00	15. 00				,			
18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 360, 673 18.00 360, 673 19.00	16.00	Total overhead (sum of lines 14 and 15)	,	•			360, 673	16.00
19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 360,673 19.00	17.00	Allowable GME overhead (see instructions)					0	17.00
		, , ,					360, 673	
	19.00	Overhead applicable to hospital-based RHC/FQ	HC services (I	ine 13 x line	18)		360, 673	19.00
	20.00	Total allowable cost of hospital-based RHC/F	QHC services (sum of lines 1	0 and 19)		619, 140	20.00

2. 00 Physician Assistant	Heal th	Financial Systems	PULASKI MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
Component CCN: 15-8528 To 09/30/2018 Date/Time Prepared: 7/31/2019 3:12 pm	ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der C			Worksheet M-2	
Number of FTE Total Visits Productivity Mininum Greater of col. 2 or col. 4				Component				
Personnel Standard (1) Visits (col. col. 2 or col. 4						RHC III		
Note			Number of FTE	Total Visits				
1.00 2.00 3.00 4.00 5.00			Personnel		Standard (1)	Visits (col.	col. 2 or	
VISITS AND PRODUCTIVITY								
Positions			1. 00	2. 00	3. 00	4. 00	5. 00	
1.00 Physician								
2.00 Physician Assistant			_					
3.00 Nurse Practitioner 0.36 837 2,100 756 3.00		1 3						1.00
4.00 Subtotal (sum of lines 1 through 3)								
5.00 Visiting Nurse 0.00 0 0 0 0 0 0 0 0								
6.00 Clinical Psychologist 0.00 0 0 0 0 0 0 0 0						1, 050	1, 050	
7. 00 Clinical Social Worker 0. 00 0 0 7. 00 7. 00 7. 01 Medical Nutrition Therapist (FQHC only) 0. 00 0 0 7. 01 0 7. 01 0 0 0 0 0 0 0 0 0					1		_	
7. 01 Medical Nutrition Therapist (FQHC only)								
7. 02 Di abetes Sel f Management Training (FQHC 0.00 0 0 0 1)			1	l .	1			
only) 8.00 Total FTEs and Visits (sum of lines 4 0.43 896 1,050 8.00 9.00 Physician Services Under Agreements 0 9.00 1.00 1.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 154,083 10.00 11.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 154,083 10.00 13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 1.000000 13.00 14.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 49,758 14.00 Parent provider overhead allocated to facility (see instructions) 130,343 15.00 16.00 Total overhead (see instructions) 180,00 Enter the amount from line 16 180,101 18.00 19.00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18) 180,101 19.00		' ' '	1	l .				
8.00 Total FTEs and Visits (sum of lines 4 0.43 896 1,050 8.00 9.00 Physician Services Under Agreements 0 0 9.00 1.00 1.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 154,083 10.00 11.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 154,083 12.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 1.000000 13.00 14.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 49,758 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 130,343 15.00 16.00 Total overhead (sum of lines 14 and 15) 180,101 16.00 Allowable GME overhead (see instructions) 0 17.00 Allowable GME overhead (see instructions) 180,101 18.00 Enter the amount from line 16 180,101 19.00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18) 180,101 19.00	7. 02		0.00	0			0	7. 02
through 7) Physician Services Under Agreements 0 0 9.00	0 00		0.42	004			1 050	0.00
9.00 Physician Services Under Agreements 0 0 9.00	8.00		0.43	890	1		1, 050	8.00
1.00	0.00			,			0	0.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES	9.00	Prhysician services under Agreements			1		U	9.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							1 00	
10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 154,083 10.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 11.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 154,083 12.00 13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 1.000000 13.00 15.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 49,758 14.00 15.00 Total overhead (sum of lines 14 and 15) 130,343 15.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 180,101 180,001 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 180,101 19.00		DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASI	ED RHC/FOHC SE	RVLCES			
11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 11.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 154,083 12.00 13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 1.000000 13.00 15.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 49,758 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 130,343 15.00 16.00 Total overhead (sum of lines 14 and 15) 180,101 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 180,101 180,001 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 180,101 19.00							154, 083	10.00
12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 154,083 12.00 1.000000 13.00 1.000000 13.00 1.000000 17.00 180,101 16.00								
13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 1.000000 13.00 15.00 Parent provider overhead allocated to facility (see instructions) 15.00 Allowable GME overhead (see instructions) 16.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 1.000000 13.00 49,758 14.00 130,343 15.00 180,101 16.00 180,101 18.00	12.00						154, 083	12.00
14.00Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)49,75814.0015.00Parent provider overhead allocated to facility (see instructions)130,34315.0016.00Total overhead (sum of lines 14 and 15)180,10116.0017.00Allowable GME overhead (see instructions)017.0018.00Enter the amount from line 16180,101180,00119.00Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)180,10119.00							•	
15.00 Parent provider overhead allocated to facility (see instructions) 130,343 15.00 16.00 17.00 180,101 16.00 180,101 180,001 180,001 180,001 180,001 180,001 180,001 180,001 180,001 180,001 180,001 180,001 190,000 1	14.00				i ne 31)			
16.00 Total overhead (sum of lines 14 and 15) 180, 101 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 180, 101 180, 101 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 180, 101 19.00	15.00				,			
17.00Allowable GME overhead (see instructions)017.0018.00Enter the amount from line 16180,10118.0019.00Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)180,10119.00			J (- /				
18.00 Enter the amount from line 16 180,101 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 180,101 180,00	17. 00						· ·	•
19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 180,101 19.00							180, 101	
			MC services (I	ine 13 x line	18)		•	
							•	

	Financial Systems PULASKI MEMORIAL		In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1305	Peri od: From 10/01/2017	Worksheet M-3	
SERVIC	ES	Component CCN: 15-8512	To 09/30/2018	Date/Time Pre 7/31/2019 3:1	
		Title XVIII	RHC I	Cost	-
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst. M-2, line 20)		7, 333, 422	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, li	ne 15)		94, 624	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			7, 238, 798	
4. 00 5. 00	Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		28, 896 203	4.00 5.00
6. 00	Total adjusted visits (line 4 plus line 5)			29, 099	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			248. 76	7. 00
			Cal cul ati on	of Limit (1)	
			Pri or to Jan.	On or After	
			1 (Rate	Jan. 1 (Rate	
			Peri od 1) 1.00	Peri od 2) 2.00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00	0.00	8. 00
9. 00	Rate for Program covered visits (see instructions)		248. 76	248. 76	9. 00
10 00	CALCULATION OF SETTLEMENT	contractor records)		4 244	10.00
10. 00 11. 00	Program covered visits excluding mental health services (from Program cost excluding costs for mental health services (line	•	0	6, 264 1, 558, 233	1
12. 00	Program covered visits for mental health services (from contr	•	0	1, 330, 233	12.00
13.00	Program covered cost from mental health services (line 9 x li		0	8, 209	
14.00	Limit adjustment for mental health services (see instructions	•	0	8, 209	14.00
15.00	Graduate Medical Education Pass Through Cost (see instruction	•		4 5// 440	15.00
16. 00 16. 01	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 Total program charges (see instructions)(from contractor's re		0	1, 566, 442 800, 496	•
16. 02	Total program preventive charges (see instructions) (from prov	*		23, 570	•
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	•		46, 122	•
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		1, 145, 943	16. 04
1/ 05	(Titles V and XIX see instructions.)		0	1 100 0/5	14 05
16. 05 17. 00	Total program cost (see instructions) Primary payer amounts		U	1, 192, 065 0	16. 05 17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		87, 891	18.00
	records)				
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		137, 807	19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)			1, 192, 065	•
21.00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		41, 909	
22. 00 23. 00	Total reimbursable Program cost (line 20 plus line 21) Allowable bad debts (see instructions)			1, 233, 974 732	ł
23. 00	Adjusted reimbursable bad debts (see instructions)			476	
24. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	24.00
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	•		0	25. 00
25. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	25. 50
	Demonstration payment adjustment amount before sequestration			1 224 450	
26. 00 26. 01	Net reimbursable amount (see instructions) Sequestration adjustment (see instructions)			1, 234, 450 24, 689	
26. 02	, ,			0	
	Interim payments			1, 039, 692	
28. 00	,			0	
29.00				170, 069	
JU. UU	Protested amounts (nonallowable cost report items) in accorda chapter I, §115.2	TICE WITH CMS PUB. 15-11	'	0	30.00

	Financial Systems PULASKI MEMORIAL		In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1305	Peri od: From 10/01/2017	Worksheet M-3	
SERVI (ieS	Component CCN: 15-8527	To 09/30/2018	Date/Time Pre 7/31/2019 3:1	
		Title XVIII	RHC II	Cost	-
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst. M-2, line 20)		619, 140	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, li	ne 15)		5, 883	2.00
3. 00 4. 00	Total allowable cost excluding vaccine (line 1 minus line 2) Total Visits (from Wkst. M-2, column 5, line 8)			613, 257 2, 114	3. 00 4. 00
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		2, 114	5.00
6. 00	Total adjusted visits (line 4 plus line 5)			2, 114	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			290. 09	7. 00
			Cal cul ati on	of Limit (1)	
			Pri or to Jan.	On or After	
			1 (Rate	Jan. 1 (Rate	
			Peri od 1) 1.00	Peri od 2) 2.00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	. 6 or your contractor)	0.00	0.00	8.00
9. 00	Rate for Program covered visits (see instructions)		290. 09	290. 09	9.00
	CALCULATION OF SETTLEMENT			200	
10. 00 11. 00	Program covered visits excluding mental health services (from		0	903	10.00 11.00
12. 00	Program cost excluding costs for mental health services (line Program covered visits for mental health services (from contr	•	0	261, 951 0	12.00
13. 00	Program covered cost from mental health services (line 9 x li	•	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions	•	0	0	14.00
15. 00	Graduate Medical Education Pass Through Cost (see instruction	•			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	261, 951	16.00
16. 01 16. 02	Total program charges (see instructions)(from contractor's re Total program preventive charges (see instructions)(from prov	•		102, 993 3, 905	1
16. 02	Total program preventive charges (see histractions) (from prov Total program preventive costs ((line 16.02/line 16.01) times	•		9, 932	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0			198, 414	16.04
	(Titles V and XIX see instructions.)				
16. 05	Total program cost (see instructions)		0	208, 346	
17. 00 18. 00	Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		4, 001	17. 00 18. 00
10.00	records)	(110m contractor		4,001	10.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		19, 017	19.00
20. 00	Net Medicare cost excluding vaccines (see instructions)			208, 346	20.00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		2, 036	
22. 00	Total reimbursable Program cost (line 20 plus line 21)			210, 382	1
23. 00 23. 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	23.00
24. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	24.00
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,		0	25.00
25. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	25. 50
	Demonstration payment adjustment amount before sequestration			210, 202	
26. 00 26. 01	Net reimbursable amount (see instructions) Sequestration adjustment (see instructions)			210, 382 4, 208	
26. 01	, ,			4, 200	
	Interim payments			146, 184	
28. 00	Tentative settlement (for contractor use only)			0	28.00
29. 00				59, 990	
30.00	Protested amounts (nonallowable cost report items) in accorda chapter I, §115.2	nce with CMS Pub. 15-II	ı	0	30.00

Heal th	Financial Systems PULASKI MEMORIAL	HOSPI TAI	In lie	u of Form CMS-2	2552_10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provi der CCN: 15-1305	Peri od:	Worksheet M-3	
SERVI (ES	Component CCN: 15-8528	From 10/01/2017 To 09/30/2018	Date/Time Pre 7/31/2019 3:1	
		Title XVIII	RHC III	Cost	Ζ μιιι
	DETERMINATION OF DATE FOR HOCKLIAL DACED BUC /FOUR CED// OFC			1. 00	
1. 00	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst M ₋ 2 line 20)		334, 184	1.00
2. 00	Cost of vaccines and their administration (from Wkst. M-4, li			0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			334, 184	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1, 050	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0 1, 050	5. 00 6. 00
6. 00 7. 00	Total adjusted visits (line 4 plus line 5) Adjusted cost per visit (line 3 divided by line 6)			318. 27	7.00
7.00	That district of the order of the order of the order		Cal cul ati on		7.00
			Pri or to Jan.	On or After	
			1 (Rate Period 1)	Jan. 1 (Rate Period 2)	
			1.00	2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00	0. 00	8. 00
9. 00	Rate for Program covered visits (see instructions)		318. 27	318. 27	9. 00
10.00	CALCULATION OF SETTLEMENT Program covered visits excluding mental health services (from	contractor records)	0	223	10.00
10. 00 11. 00	Program cost excluding costs for mental health services (line		0	70, 974	•
12. 00	Program covered visits for mental health services (from contr	,	0	75, 774	12.00
13.00	Program covered cost from mental health services (line 9 x li		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions	•	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instruction	•		70.074	15.00
16. 00 16. 01	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 Total program charges (see instructions)(from contractor's re	-	0	70, 974 23, 616	•
16. 01	Total program preventive charges (see instructions)(from prov	•		2, 320	•
16. 03	Total program preventive costs ((line 16.02/line 16.01) times			6, 972	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		49, 534	16. 04
4. 05	(Titles V and XIX see instructions.)			5, 50,	4, 65
16. 05 17. 00	Total program cost (see instructions) Primary payer amounts		0	56, 506 0	16. 05 17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		2, 085	•
	records)	(1. om ooner doto.		2, 555	
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		3, 842	19.00
20. 00	Net Medicare cost excluding vaccines (see instructions)			56, 506	•
21.00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		0	21.00
22. 00 23. 00	Total reimbursable Program cost (line 20 plus line 21) Allowable bad debts (see instructions)			56, 506 0	22. 00 23. 00
23. 00	Adjusted reimbursable bad debts (see instructions)			0	23.00
24. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25. 00
25. 50		s)		0	
25. 99	Demonstration payment adjustment amount before sequestration			0 56 506	1
26. 00 26. 01	Net reimbursable amount (see instructions) Sequestration adjustment (see instructions)			56, 506 1, 130	1
26. 02	Demonstration adjustment (see First detrois) Demonstration payment adjustment amount after sequestration			0	26. 02
27. 00	Interim payments			33, 480	
28. 00	Tentative settlement (for contractor use only)			0	28.00
29.00		•		21, 896	
30. 00	Protested amounts (nonallowable cost report items) in accorda chapter I, §115.2	iice with two Pub. 15-11	'	0	30.00
	O. I. O. I		ı I		ı

Heal th	Financial Systems PULASKI MEMORIAL	. HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF HOSPITAL-BASED RHC/FOHC PNEUMOCOCCAL AND INFLUENZA E COST		Peri od: From 10/01/2017	Worksheet M-4	
V/10011	2 3001	Component CCN: 15-8512	To 09/30/2018	Date/Time Pre 7/31/2019 3:1:	
		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)		3, 508, 946	3, 508, 946	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tot	al health care staff tim	e 0. 000821	0. 002022	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (li	ne 1 x line 2)	2, 881	7, 095	3.00
4 00	Medical supplies cost - preumococcal and influenza vaccine (f	from vour records)	23 924	12 331	4 00

		Pneumococcal	I nfl uenza	
		1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	3, 508, 946	3, 508, 946	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0. 000821	0. 002022	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	2, 881	7, 095	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	23, 924	12, 331	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	26, 805	19, 426	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3, 582, 917	3, 582, 917	
7.00	Total overhead (from Wkst. M-2, line 19)	3, 750, 505	3, 750, 505	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5	0. 007481	0. 005422	8.00
	divided by line 6)			i
9. 00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	28, 058	20, 335	
10. 00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of	54, 863	39, 761	10.00
	lines 5 and 9)			i
11. 00	Total number of pneumococcal and influenza vaccine injections (from your records)	281		11. 00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	195. 24	57. 46	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program	119	325	13.00
	benefi ci ari es			i e
14. 00	Program cost of pneumococcal and influenza vaccine and its (their) administration	23, 234	18, 675	14. 00
	(line 12 x line 13)			i
15. 00			94, 624	15. 00
	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			i
16. 00	Total Program cost of pneumococcal and influenza vaccine and its (their)		41, 909	16. 00
	administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,			i
	line 21)		l	

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	PNEUMOCOCCAL AND INFLUENZA	Provi der CCN: 15-1305	Peri od: From 10/01/2017	Worksheet M-4	
VACCINE GOST		Component CCN: 15-8527	To 09/30/2018	Date/Time Pre 7/31/2019 3:1	
		Title XVIII	RHC II	Cost	
			Pneumococcal	Influenza	

-		Title XVIII	RHC II	Cost	2 p
		TITLE XVIII	Pneumococcal	I nfl uenza	
			1. 00	2. 00	
1. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		242, 070		1. 00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tot	al health care staff time	0.000999	0.000000	2.00
3.00			242	0	3.00
4.00	.00 Medical supplies cost - pneumococcal and influenza vaccine (from your records)		2, 214	0	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plu	s line 4)	2, 456	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksh	eet M-1, col. 7, line 22)	258, 467	258, 467	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		360, 673	360, 673	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0. 009502	0.000000	8.00
	divided by line 6)				
9. 00	Overhead cost - pneumococcal and influenza vaccine (line 7 x	line 8)	3, 427	0	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their)	administration (sum of	5, 883	0	10.00
	lines 5 and 9)				
11. 00	Total number of pneumococcal and influenza vaccine injections		26	0	
12. 00	Cost per pneumococcal and influenza vaccine injection (line 1		226. 27	0. 00	12.00
13. 00	Number of pneumococcal and influenza vaccine injections admin	istered to Program	9	0	13.00
	benefi ci ari es				
14. 00	Program cost of pneumococcal and influenza vaccine and its (t	heir) administration	2, 036	0	14.00
	(line 12 x line 13)				
15. 00	Total cost of pneumococcal and influenza vaccine and its (the			5, 883	15. 00
	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3				
16. 00	Total Program cost of pneumococcal and influenza vaccine and	,		2, 036	16. 00
	administration (sum of cols. 1 and 2, line 14) (transfer this	amount to Wkst. M-3,			
	line 21)				

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL		In Lieu	of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED R SERVICES RENDERED TO PROGRAM BENEFICIARI		Provider CCN: 15-1		From 10/01/2017	
		Component CCN: 15-	-8512		Date/Time Prepared: 7/31/2019 3:12 pm
				RHC I	Cost

		Component Con. 13-8312	077 307 2010	7/31/2019 3: 1:	
			RHC I	Cost	
			Pai	rt B	
			mm/dd/yyyy	Amount	
			1.00	2.00	
00	Total interim payments paid to hospital-based RHC/FQHC			1, 039, 692	1.
00	Interim payments payable on individual bills, either submit	tted or to be submitted to		0	2.
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero	•			
0	List separately each retroactive lump sum adjustment amount	t based on subsequent			3
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider		<u> </u>		
1				0	3
2				0	3
3				0	3
4				0	3
5				0	3
	Provi der to Program				
0				0	3
1				0	3
2				0	3
3				0	3
4				0	3
9	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		0	3
0	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line)	1, 039, 692	4
	27)				
	TO BE COMPLETED BY CONTRACTOR				
0	List separately each tentative settlement payment after des	sk review. Also show date o	of		5
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider		T		
1				0	5
2				0	5
3				0	5
	Provider to Program				_
0				0	5
1				0	5
2		00)		0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	5
0	Determined net settlement amount (balance due) based on the	e cost report. (I)		470.040	6
1	SETTLEMENT TO PROVIDER			170, 069	6
2	SETTLEMENT TO PROGRAM			0	6
0	Total Medicare program liability (see instructions)		01	1, 209, 761	7
			Contractor	NPR Date	
		0	Number	(Mo/Day/Yr)	
	Name of Contractor	0	1. 00	2. 00	
00	Name of Contractor				8

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED F		Provi der CCN: 15-1305	Peri od: From 10/01/2017	Worksheet M-5
SERVICES REIDERED TO FROSIVIII BEILE FORMIN		Component CCN: 15-8527	To 09/30/2018	Date/Time Prepared: 7/31/2019 3:12 pm
			DUC 11	0+

		Component CCN: 15-8527	10 09/30/2018	7/31/2019 3: 12	
			RHC II	Cost	
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			146, 184	1.00
2. 00	Interim payments payable on individual bills, either submit the contractor for services rendered in the cost reporting "NONE" or enter a zero			0	2.00
3. 00	List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period. payment. If none, write "NONE" or enter a zero. (1)				3.00
	Program to Provider				
3. 01	g			0	3.0
3. 02				0	3. 02
3. 03				0	3. 03
3.04				0	3.04
3.05				0	3. 0!
	Provider to Program				
3.50				0	3.50
3. 51				0	3. 5
3. 52				0	3. 5
3.53				0	3. 5
3.54				0	3.5
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			0	3. 9
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans 27)	sfer to Worksheet M-3, line	9	146, 184	4.00
	TO BE COMPLETED BY CONTRACTOR				
5. 00	List separately each tentative settlement payment after deseach payment. If none, write "NONE" or enter a zero. (1)	sk review. Also show date o	of		5. 00
	Program to Provider				
5. 01				0	5.0
5.02				0	5.0
5.03				0	5.03
	Provider to Program				
5. 50				0	5. 50
5. 51				0	5.5
5. 52				0	5. 5.
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	5. 9
6.00	Determined net settlement amount (balance due) based on the	e cost report. (1)			6.0
6. 01	SETTLEMENT TO PROVIDER			59, 990	6. 0
6. 02	SETTLEMENT TO PROGRAM			0	6. 02
7. 00	Total Medicare program liability (see instructions)			206, 174	7. 00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	
8. 00	Name of Contractor		,		8. 00

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	ı of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAR		Provider CCN: 15-1305 Component CCN: 15-8528	From 10/01/2017	Worksheet M-5 Date/Time Prepared: 7/31/2019 3:12 pm
			RHC III	Cost

		Component CCN: 15-8528	10 09/30/2018	7/31/2019 3: 12	
			RHC III	Cost	
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1. 00	Total interim payments paid to hospital-based RHC/FQHC			33, 480	1.00
2. 00	Interim payments payable on individual bills, either submit the contractor for services rendered in the cost reporting "NONE" or enter a zero			0	2.00
3. 00	List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period. payment. If none, write "NONE" or enter a zero. (1)				3.00
	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	Dec 1 Les Le Bresses			0	3. 0
3. 50	Provider to Program			0	3. 50
3. 51				0	3. 5
3. 52				0	3. 52
3. 53				0	3. 53
3. 54				ő	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		o	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans 27)		е	33, 480	4. 00
	TO BE COMPLETED BY CONTRACTOR				
5. 00	List separately each tentative settlement payment after deseach payment. If none, write "NONE" or enter a zero. (1)	sk review. Also show date o	of		5. 00
	Program to Provider				
5. 01				0	5.0
5. 02				0	5. 02
5. 03				0	5. 03
F F0	Provider to Program				
5. 50				0	5. 50 5. 51
5. 51 5. 52				0	5. 52
5. 99				0	5. 9
6. 00					6. 00
6. 01	SETTLEMENT TO PROVIDER			21, 896	6. 0
6. 02	SETTLEMENT TO PROGRAM			0	6. 02
7. 00	Total Medicare program liability (see instructions)			55, 376	7. 00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1.00	2. 00	
					8. 00