This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-1305 Worksheet S Peri od: From 10/01/2021 Parts I-III AND SETTLEMENT SUMMARY 09/30/2022 Date/Time Prepared: 2/23/2023 4: 28 pm PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 2/23/2023 4: 28 pm ] Manually prepared cost report use only ] If this is an amended report enter the number of times the provider resubmitted this cost report ] Medicare Utilization. Enter "F" for full or "L" for low. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(5) Amended

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 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 10/01/2021 and ending 09/30/2022 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.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SIGNATURE STATEMENT	
1	Gre	gg Malott	l t	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Gregg Malott			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			4

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-81	69, 485	0	16, 652	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	22, 165	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		37, 894		0	10.00
10.01	RURAL HEALTH CLINIC II	0		15, 818		0	10. 01
10.02	RURAL HEALTH CLINIC III	0		9, 353		0	10. 02
10.03	RURAL HEALTH CLINIC IV	0		2, 464		0	10.03
200.00	Total	0	22, 084	135, 014	0	16, 652	200.00
The ab	ove amounts represent "due to" or "due from"	the applicable	program for t	he element of	the above compl	ex indicated.	

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1305 Peri od: Worksheet S-2 From 10/01/2021 Part I 09/30/2022 Date/Time Prepared: 2/23/2023 4:28 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 Ν 0 0 3.00 HOSPI TAI Subprovi der - IPF 4.00 4.00 Subprovi der - IRF 5.00 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF Р PULASKI MEMORIAL 157305 99915 10/01/2000 N 0 7.00 7.00 HOSPI TAI 8.00 Swing Beds - NF 8.00 9.00 Hospital -Based SNF 9.00 Hospital -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospital -Based HHA 12.00 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce 14 00 14 00 15.00 Hospital-Based Health Clinic - RHC PULASKI MEMORIAL RHC -158512 99915 08/21/2014 N 0 Ν 15.00 WI NAMAC PULASKI MEMORIAL RHC -Hospital-Based Health Clinic - RHC 158527 99915 03/14/2018 0 15.01 15.01 NORTH JUDSON PULASKI MEMORIAL RHC -Hospital - Based Health Clinic - RHC 158528 99915 03/15/2018 0 N 15.02 15.02 N 1111 FRANCESVILLE Hospital-Based Health Clinic - RHC PULASKI MEMORIAL RHC -158554 99915 07/06/2020 15.03 15.03 0 KNOX MEDICAL 16.00 Hospital-Based Health Clinic - FQHC 16.00 Hospital-Based (CMHC) I 17.00 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 10/01/2021 09/30/2022 20.00 21.00 Type of Control (see instructions) 21.00 2 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for N 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. 22. 01 Did this hospital receive interim uncompensated care payments for this 22.01 Ν Ν 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 N 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 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas 22.03 Ν Ν Ν 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 yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to Ν Ν Ν 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? 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 yes or "N" for no.

	Financial Systems PULASKI MEM AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			CN: 15-1305	Period: From 10/0 To 09/3	In Lieu 01/2021 80/2022	of For Worksho Part I Date/Ti 2/23/20	et S-2 me Pre	pared:
				1.00	2.	00	3. (	00	
	Which method is used to determine Medicaid days on lines below? In column 1, enter 1 if date of admission, 2 if co if date of discharge. Is the method of identifying the da reporting period different from the method used in the pr reporting period? In column 2, enter "Y" for yes or "N"	ensus da ays in rior cos for no.	ays, or 3 this cost st		2 N	I			23. 00
	Med pai d	State li cai d d days	In-State Medicaid eligible unpaid days 2.00	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	ys Med	ther li cai d lays	
25. 00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state	0	0	0	0		0	O	24. 00 25. 00
	Medicaid eligible unpaid days in column 4, Medicaid								
	HMO paid and eligible but unpaid days in column 5.				Urban/R	Rural S	Date of	Geogr	
04.00					1.	00	2. (		04.00
	Enter your standard geographic classification (not wage) cost reporting period. Enter "1" for urban or "2" for ru		at the be	ginning of	the	2			26. 00
27. 00	Enter your standard geographic classification (not wage) reporting period. Enter in column 1, "1" for urban or "2' enter the effective date of the geographic reclassificati	status " for ru ion in o	ural. If a <sub>l</sub> column 2.	ppl i cabl e,		2			27. 00
	If this is a sole community hospital (SCH), enter the nur effect in the cost reporting period.	mber of	peri ods S	CH status i	n	0			35.00
					Begi n		Endi		
36. 00	Enter applicable beginning and ending dates of SCH status	s. Subso	cript line	36 for num	ber 1.	00	2. (	)()	36.00
	of periods in excess of one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), enter the is in effect in the cost reporting period.					0			37.00
37. 01	Is this hospital a former MDH that is eligible for the MI accordance with FY 2016 OPPS final rule? Enter "Y" for ye instructions)								37. 01
	If line 37 is 1, enter the beginning and ending dates of greater than 1, subscript this line for the number of perenter subsequent dates.								38.00
					1.		Y/ 2. (		-
	Does this facility qualify for the inpatient hospital pay hospitals in accordance with 42 CFR §412.101(b)(2)(i), (i 1 "Y" for yes or "N" for no. Does the facility meet the r accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? or "N" for no. (see instructions)	ii), or mileage	(iii)? En	ter in colu nts in	ume N mn		N.		39.00
40. 00	Is this hospital subject to the HAC program reduction adj "N" for no in column 1, for discharges prior to October on no in column 2, for discharges on or after October 1. (se	1. Entei	r "Y" for				Nauti		40.00
						1. 00	2. 00		-
	Prospective Payment System (PPS)-Capital	on -!!		+0 0	000				45.00
	Does this facility qualify and receive Capital payment for with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception	•	•			N N	N N	N N	45. 00 46. 00
	pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS capi				0	N	N	N	47.00
48. 00	ls the facility electing full federal capital payment? I Teaching Hospitals	Enter "\	for yes	or "N" for	no.	N	N	N	48. 00
	Is this a hospital involved in training residents in apportant for no in column 1. For column 2, if the response to was involved in training residents in approved GME prograyear, and are you are impacted by CR 11642 (or applicable Enter "Y" for yes; otherwise, enter "N" for no in column	column ams in <sup>.</sup> e CRs) M 2.	1 is "Y", the prior y MA direct	or if this year or pen GME payment	hospital ultimate reduction?				56.00
	If line 56 is yes, is this the first cost reporting period GME programs trained at this facility? Enter "Y" for yes is "Y" did residents start training in the first month of for yes or "N" for no in column 2. If column 2 is "Y", o "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if	s or "N' f this c complete	' for no i cost repor e Workshee	n column 1. ting period	If column ? Enter "\	/"			57.00

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 10/01/2021 Part I 09/30/2022 Date/Time Prepared: 2/23/2023 4: 28 pm | XVIII | XIX 1. 00 2.00 3.00 58.00 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 58.00 Pt. I 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see 60 00 N instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustement? Enter "Y" for yes or "N" for no in column 2 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 0.00 0.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61 02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions). 61.05 Enter the difference between the baseline primary 61.05 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) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unwei ghted Unwei ghted IME FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 0.00 61.10 61.10 Of the FTEs in line 61.05, specify each new program 0. 00 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. 61. 20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 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 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 63.00 "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

Health Financial Systems	PIJI ASKI	MEMORIAL HOSPITAL		In lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP				eriod: com 10/01/2021	Worksheet S-2 Part I Date/Time Pre 2/23/2023 4:2	pared:
			Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	<u> </u>
			Si te 1.00	2. 00	3. 00	
Section 5504 of the ACA Base Yea						
period that begins on or after of the following seriod in the base year period, the number resident FTEs attributable to resettings. Enter in column 2 the resident FTEs that trained in your of (column 1 divided by (column 1)	yes, or your facili ber of unweighted non tations occurring in number of unweighted ur hospital. Enter in	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0. 00	0. 000000	64.00
or (ser anni ) ar vi asa z) (ser anni	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
			FTEs Nonprovi der Si te	FTEs in Hospital	3/ (col. 3 + col. 4))	
	1. 00	2.00	3. 00	4. 00	5. 00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
			FTEs Nonprovider Site	FTEs in Hospital	1/ (col . 1 + col . 2))	
			1. 00	2. 00	3. 00	
Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Setting	ysEffective f	or cost report	ing periods	
66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-prima ccurring in all nonpounweighted non-prima al. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	66. 00
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
			FTEs Nonprovi der	FTEs in Hospital	3/ (col. 3 + col. 4))	
			Si te	'	,,	
67.00 Enter in column 1, the program	1. 00	2. 00	3. 00	4. 00	5. 00 0. 000000	67.00
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.00000	67. 00

09/30/2022 Date/Time Prepared: 2/23/2023 4:28 pm 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 70.00 | Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75 00 N 75 00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 1.00 Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 N 80.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter Ν 81.00 Y" for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 85.00 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00  $\S413.40(f)(1)(ii)$ ? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section Ν 87.00 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. V XIX 1. 00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for 90 00 Ν yes or "N" for no in the applicable column. is this hospital reimbursed for title V and/or XIX through the cost report either in Ν Υ 91.00 full or in part? Enter "Y" for yes or "N" for no in the applicable column. 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. Ν 92.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 93.00 Ν N 93.00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the Ν Ν 94.00 applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 95.00 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the Ν N 96.00 applicable column. 97.00 | If line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 97.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post Υ 98.00 stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. 98.01 98.01 C,Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V,and in column 2 for title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation 98.02 bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) 98.03 Ν reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and 98.04 N N 98.04 in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on 98.05 Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Υ 98.06 Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers 105.00 Does this hospital qualify as a CAH? 105 00 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment 106.00 Ν for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) N 107.00 Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)

Health Financial Systems PULASKI MEMORIA HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	_	CN: 15-1305 Pe	In Lie	Worksheet S-	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	Fr	om 10/01/2021	Part I	
		To		Date/Time Pro 2/23/2023 4:	
			V 1. 00	2. 00	_
108.00 is this a rural hospital qualifying for an exception to the	CRNA fee sche	edul e? See 42	N N	2.00	108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati onal	Speech	Respi ratory	
	1. 00	2. 00	3. 00	4.00	
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109. 00
			101	1.00	110.00
110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "complete Worksheet E, Part A, lines 200 through 218, and Worlapplicable.	Y" for yes or	r "N" for no. I	f yes,	N	110.00
			1. 00	2. 00	
111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this con "Y" for yes or "N" for no in column 1. If the response to contegration prong of the FCHIP demonstration which this CAH is particle all that apply: "A" for Ambulance services; "B" for additional for tele-health services.	st reporting lumn 1 is Y, ticipating in	period? Enter enter the n column 2.	N		111. 00
		1.00	2. 00	3.00	+
112.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital cear participation in the demonstration, if applicable.	peri od? "Y", enter e	N	2.33	5.00	112.00
Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or	"N" for no	N			 0115. 00
in column 1. If column 1 is yes, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1.	, or E only) 3" percent includes				
116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	N			116. 00
117.00 s this facility legally-required to carry malpractice insur-	ance? Enter	Y			117. 00
"Y" for yes or "N" for no.  118.00 Is the mal practice insurance a claims-made or occurrence pol	icy? Enter 1	1			118.00
if the policy is claim-made. Enter 2 if the policy is occurred	ence.	Premi ums	Losses	Insurance	
		PI eiiii uiiis	LOSSES	Trisurance	
110 01 ist amounts of malarastics promitime and said lesses.		1. 00	2. 00	3. 00	0110 01
118.01 List amounts of malpractice premiums and paid losses:		198, 283		0	0118.01
110 00 Are malarentiae aremiume and acid league reported in a cost	aantan athan	than the	1. 00 N	2. 00	118. 02
118. 02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedland amounts contained therein. 119. 00 D0 NOT USE THIS LINE			N		119. 00
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no.	column 1, "\alifies for t	Y" for yes or the Outpatient	N	N	120. 00
121.00 Did this facility incur and report costs for high cost implaination patients? Enter "Y" for yes or "N" for no.	ntable device	es charged to	Υ		121. 00
122.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.  Transplant Center Information			N		122. 00
125.00 Does this facility operate a transplant center? Enter "Y" fo	r yes and "N'	for no. If	N		125. 00
yes, enter certification date(s) (mm/dd/yyyy) below.  126.00 If this is a Medicare certified kidney transplant center, en		fication date			126. 00
in column 1 and termination date, if applicable, in column 2		fication date			127. 00
127.00  f this is a Medicare certified heart transplant center, ent- in column 1 and termination date, if applicable, in column 2 128.00  f this is a Medicare certified liver transplant center, ent-		fication date			128. 00

ealth Financial Systems	PULASKI MEMORI		N 45 4005	15		u of Form CMS	
OSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENIIFICATION DATA	Provi der CC	: 15-1305	Period:	0/01/2021	Worksheet S- Part I	-2
					9/30/2022	Date/Time Pr	
						2/23/2023 4:	28 pm
					1. 00	2.00	
30.00 If this is a Medicare certified pa			ti fi cati on				130. (
date in column 1 and termination of 31.00 If this is a Medicare certified in	ntestinal transplant cente	r, enter the c	erti fi cati oı	n			131. (
date in column 1 and termination of this is a Medicare certified is			ication date	_			132.
in column 1 and termination date,			reatron date				132.
33.00 Removed and reserved 44.00 If this is an organ procurement o	rganization (OPO), enter t	he OPO number	in column 1				133. 134.
and termination date, if applicable All Providers							
0.00 Are there any related organization				to	N		140.
chapter 10? Enter "Y" for yes or are claimed, enter in column 2 the	<u>e home office chain number</u>	. (see instruc		ıs			
1.00 If this facility is part of a cha	2.0 in organization, enter on		ugh 143 the	name ar	3.00 nd address	of the home	
office and enter the home office		nctor number.					
11. 00 Name:	Contractor's Name: PO Box:		Contrac	tor's Nu	mber:		141.
12.00  Street: 13.00  City:	State:		Zi p Cod	е.			142. 143.
5. 50 51 ty.	otate.		21 p 000	<u>.                                    </u>			110.
						1. 00	
14.00 Are provider based physicians' co	sts included in Worksheet	A?				Y	144.
					1. 00	2. 00	-
15.00 If costs for renal services are c							145.
inpatient services only? Enter "Y' no, does the dialysis facility in period? Enter "Y" for yes or "N"	clude Medicare utilization						
6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o	n column 1. (See CMS Pub.			lf	N		146.
						1.00	4
17.00Was there a change in the statist	ical hasis? Enter "V" for	ves or "N" for	no			1. 00 N	147.
48.00 Was there a change in the order o						N	148.
19.00Was there a change to the simplif	ied cost finding method? E					N	149.
		Part A 1.00	Part B 2.00		itle V 3.00	Title XIX 4.00	-
Does this facility contain a prov	ider that qualifies for an			cation c			
or charges? Enter "Y" for yes or	"N" for no for each compon	ent for Part A		. (See 4			
55. 00 Hospi tal		N	N		N	N	155.
66.00 Subprovider - IPF 67.00 Subprovider - IRF		N N	N N		N N	N N	156.
58. OO SUBPROVI DER		14	''		14	14	1157
59. 00 SNF		N	N		N	N	158.
O. OO HOME HEALTH AGENCY		N N	N		N	N	158. 159. 160.
O. OO HOME HEALTH AGENCY							158. 159. 160.
50.00 HOME HEALTH AGENCY 51.00 CMHC			N		N	N	158. 159. 160.
69.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC  Multicampus 65.00 Is this hospital part of a Multicampus 65.00 Finder "Y" for year or "N" for pa	ampus hospital that has on	N	N N	ferent C	N N	N N	157. 158. 159. 160. 161.
00.00 HOME HEALTH AGENCY 11.00 CMHC	Name	N e or more camp County	N N uses in dif	ip Code	N N BSAs?	N N N 1.00 N FTE/Campus	158. 159. 160. 161.
0.00 HOME HEALTH AGENCY 1.00 CMHC  Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.		N e or more camp	N N uses in dif		N N BSAs?	N N N 1.00 N FTE/Campus 5.00	158. 159. 160. 161.
0.00 HOME HEALTH AGENCY 1.00 CMHC  Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.  6.00 If line 165 is yes, for each 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	Name	N e or more camp County	N N uses in dif	ip Code	N N BSAs?	N N N 1.00 N FTE/Campus 5.00	158. 159. 160. 161.
0.00 HOME HEALTH AGENCY 1.00 CMHC  Multicampus 5.00 Is this hospital part of a Multicampus Enter "Y" for yes or "N" for no.  6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,	Name	N e or more camp County	N N uses in dif	ip Code	N N BSAs?	N N N 1.00 N FTE/Campus 5.00	158. 159. 160. 161.
0.00 HOME HEALTH AGENCY 1.00 CMHC  Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.  6.00 If line 165 is yes, for each 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	Name	N e or more camp County	N N uses in dif	ip Code	N N BSAs?	N N N 1.00 N FTE/Campus 5.00	158. 159. 160. 161.
Multicampus  5.00 Is this hospital part of a Multicampus Enter "Y" for yes or "N" for no.  6.00 If line 165 is yes, for each 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)	Name 0  T) incentive in the Americ	e or more camp  County 1.00	uses in dif	i p Code 3.00	N N BSAs?	N N N 1.00 N FTE/Campus 5.00 0.0	158. 159. 160. 161. 165.
Multicampus  5.00 Is this hospital part of a Multicampus  Enter "Y" for yes or "N" for no.  6.00 If line 165 is yes, for each 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)  Health Information Technology (HI 7.00 Is this provider a meaningful user	Name 0  T) incentive in the Americ runder §1886(n)? Enter "	e or more camp  County 1.00  can Recovery an Y" for yes or	uses in diff	ip Code 3.00	BSAS?  CBSA  4.00	N N 1.00 N FTE/Campus 5.00 0.0	158. 159. 160. 161. 165. 00 166.
Multicampus  55.00 Ship of the state of the	Name  O  T) incentive in the Americ r under \$1886(n)? Enter "  O5 is "Y") and is a meanin	e or more camp  County 1.00  can Recovery an Y" for yes or gful user (lin	uses in diff	ip Code 3.00	BSAS?  CBSA  4.00	N N N 1.00 N FTE/Campus 5.00 0.0	158. 159. 160. 161.
Multicampus 05.00   Multicampus 05.00   Is this hospital part of a Multicampus 05.00   Is this hospital part of a Multicampus 06.00   If line 165 is yes, for each 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)	Name  0  T) incentive in the Americ r under §1886(n)? Enter " 05 is "Y") and is a meanin HIT assets (see instructio	e or more camp  County 1.00  can Recovery an Y" for yes or gful user (lin	uses in diff	ent Act	BSAs?  CBSA 4.00	N N N 1.00 N FTE/Campus 5.00 0.0	158. 159. 160. 161. 165. 00 166.
0.00 HOME HEALTH AGENCY 1.00 CMHC  Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.  6.00 If line 165 is yes, for each 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)  Health Information Technology (HI 7.00 Is this provider a meaningful user 8.00 If this provider is a CAH (line 10 reasonable cost incurred for the Information Technology (HI 1) as this provider is a CAH (line 10 reasonable cost incurred for the Information Technology (HI 1) as this provider is a CAH (line 10 reasonable cost incurred for the Information Technology (HI 1) as this provider is a CAH (line 10 reasonable cost incurred for the Information Technology (HI 1) as this provider is a CAH (line 10 reasonable cost incurred for the Information Technology (HI 1) as this provider is a CAH (line 10 reasonable cost incurred for the Information Technology (HI 1) as this provider is a CAH (line 10 reasonable cost incurred for the Information Technology (HI 1) as the control of the Information Technology (HI 1) as the control of the Information Technology (HI 1) as the control of the Information Technology (HI 1) as the control of the Information Technology (HI 1) as the control of the Information Technology (HI 1) as the control of the Information Technology (HI 1) as the control of the Information Technology (HI 1) as the control of the Information Technology (HI 1) as the control of the Information Technology (HI 1) and the control of the Information Technology (HI 1) and the control of the Information Technology (HI 1) and the control of the Information Technology (HI 1) and the control of the Information Technology (HI 1) and the control of the Information Technology (HI 1) and the control of the Information Technology (HI 1) and the control of the Information Technology (HI 1) and the control of the Information Technology (HI 1) and the control of the Information Technology (HI 1) and the control of the I	Name  O  T) incentive in the Americ r under §1886(n)? Enter " O5 is "Y") and is a meanin HIT assets (see instructio not a meaningful user, doe ? Enter "Y" for yes or "N"	e or more camp  County 1.00  can Recovery an Y" for yes or gful user (lin ns) s this provide for no. (see	uses in diff	ent Act '), ente	BSAS?  CBSA 4.00  r the	N N N N N N N N N N N N N N N N N N N	158. 159. 160. 161. 165. 200 166.

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE	NTIFICATION DATA	Provider CCN: 15-1305	Peri od:	Worksheet S-2	
			From 10/01/2021 To 09/30/2022	Part     Date/Time Pre	narod:
			10 09/30/2022	2/23/2023 4: 2	8 pm
	Begi nni ng	Endi ng			
			1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beginn period respectively (mm/dd/yyyy)			170. 00		
			1. 00	2. 00	
171.00 If line 167 is "Y", does this provider			N	0	171. 00
section 1876 Medicare cost plans report					
"Y" for yes and "N" for no in column 1.		nter the number of secti	on		
1876 Medicare days in column 2. (see in	structions)				

	Financial Systems PULASKI MEMORI AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		ON: 1E 120E		u of Form CMS-	
HUSPI I	AL AND HUSPITAL HEALTH CAKE KEIMBUKSEMENT QUESTIUNNAIRE	Provi der C		Peri od: From 10/01/2021 To 09/30/2022		epared:
				Y/N	2/23/2023 4:: Date	28 pm
				1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	l for all NO re	esponses. Ent	er all dates in	the	
	COMPLETED BY ALL HOSPITALS					
1. 00	Provider Organization and Operation  Has the provider changed ownership immediately prior to the	hoginning of	the cost	N		1.00
1.00	reporting period? If yes, enter the date of the change in c					1.00
		,	Y/N	Date	V/I	
0.00	lucción de la contraction de l	2	1.00	2. 00	3. 00	0.00
2. 00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.00
3. 00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home cor medical supply companies) that are related to the providences, medical staff, management personnel, or members of			3. 00		
	of directors through ownership, control, or family and other	er similar				
	relationships? (see instructions)		Y/N	Type	Date	
			1.00	2.00	3. 00	
	Financial Data and Reports					
4. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions.	for Compiled,	Y	A		4.00
5. 00	Are the cost report total expenses and total revenues diffe		N			5.00
	those on the filed financial statements? If yes, submit rec	conciliation.		V /N	Logal Open	
				Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
6. 00	Column 1: Are costs claimed for a nursing program? Column	2: If yes, is	s the provide	r N		6. 00
7. 00	is the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in	etructions		N		7.00
8. 00	Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		wed during th			8.00
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	N		9. 00
10. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.	or renewed in	the current	N		10.00
11. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	oroved	N		11.00
	Treaching Frogram on worksheet A: Tr yes, see Thistractions.				Y/N	
					1. 00	
12 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	coo instruc	tions		Y	12.00
	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			ost reporting	N N	13. 00
14. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? I	fyes, see in	structi ons.	N	14. 00
15. 00	Did total beds available change from the prior cost reporti				N t B	15.00
		Y/N	t A Date	Y/N	Date	
		1. 00	2.00	3. 00	4. 00	
4 / 00	PS&R Data		40 (00 (0000		10 /00 /0000	1, 00
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)	Υ	12/30/2022	Y	12/30/2022	16. 00
17. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	N		N		17. 00
18. 00	in columns 2 and 4. (see instructions)  If line 16 or 17 is yes, were adjustments made to PS&R  Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. 00
19. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. 00

Heal th	Financial Systems PULASKI MEMOR	I AL HOSPITAL		In Lie	u of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-1305	Peri od: From 10/01/2021 To 09/30/2022	Worksheet S-2 Part II	epared:
	<u> </u>		i pti on	Y/N	Y/N	
20.00	1611 46 47 17 18 18 18 18 18 18 18 18 18 18 18 18 18		0	1.00	3. 00	00.00
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	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.	? If yes, see	N	25. 00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during tinstructions.	the cost report	ing period? I	f yes, see	N	26. 00
27. 00	Has the provider's capitalization policy changed during th copy.	ne cost reporti	ng period? If	fyes, submit	N	27. 00
28. 00	Interest Expense Were new loans, mortgage agreements or letters of credit e	entered into du	ring the cost	t reporting	N	28. 00
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		ebt Service F	Reserve Fund)	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.	s, see	N	30.00		
31. 00	Has debt been recalled before scheduled maturity without i instructions.	s, see	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		arrangement wit	h provider-ba	ased physicians?	Υ	34.00
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i		nts with the	provi der-based	N	35.00
	physicians during the cost reporting period? If yes, see i	IISTI UCTI OIIS.		Y/N	Date	
				1. 00	2. 00	
	Home Office Costs					
	Were home office costs claimed on the cost report?  If line 36 is yes, has a home office cost statement been p	prepared by the	home office?	N ?		36. 00 37. 00
38. 00	If yes, see instructions.  If line 36 is yes, was the fiscal year end of the home of			=		38. 00
39. 00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth see instructions.			5,		39. 00
40. 00	If line 36 is yes, did the provider render services to the instructions.	e home office?	If yes, see			40.00
		1.	00	2.	00	
41. 00	Cost Report Preparer Contact Information  Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	MI CHAEL		ALESSANDRI NI		41.00
42. 00	respectively.  Enter the employer/company name of the cost report	BLUE AND CO.,	LLC			42.00
	preparer.					
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317. 713. 7959		MALESSANDRI NI @	BLUEANDCO. COM	43.00

Heal th Financ	cial Systems	PULASKI MEMOR	RIAL HOSPITA	۸L		In Lieu	of Form CMS-	2552-10
HOSPI TAL AND	HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi de	er CCN: 15-1305		riod: om 10/01/2021 09/30/2022	Worksheet S-2 Part II Date/Time Pre 2/23/2023 4:2	pared:
				3.00				
Cost R	eport Preparer Contact Information			3.00				
	the first name, last name and the		DI RECTOR					41.00
	by the cost report preparer in colur	nns 1, 2, and 3,						
1 '	cti vel y.		1					40.00
	the employer/company name of the co	ost report						42.00
prepar	er. the telephone number and email addu	socc of the cost	+					43.00
	preparer in columns 1 and 2, respe							43.00
Ti opoi t	proparer in corumns rana 2, respe	seti vei y.			,			I

Heal th FinancialSystemsPULASKIHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Peri od: | Worksheet S-3 | From 10/01/2021 | Part | To 09/30/2022 | Date/Time Prepared: Provi der CCN: 15-1305

				[7	To 09/30/2022	Date/Time Pre 2/23/2023 4:2	
						1/P Days /	O pili
						0/P Visits /	
						Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1. 00	2. 00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	25	9, 125	26, 088. 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	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						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, 125	26, 088. 00	0	7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT	31. 00	0	(	0.00	0	8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					_	12.00
13. 00	NURSERY	43. 00	l e			0	13.00
14. 00	Total (see instructions)		25	9, 125	26, 088. 00	l e	14.00
15.00						0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00 22. 00	OTHER LONG TERM CARE HOME HEALTH AGENCY	101. 00				0	21. 00 22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )	101.00				U	23.00
24. 00	HOSPICE	116. 00	0				24.00
24. 00	HOSPICE (non-distinct part)	30.00	l				24. 00
25. 00	CMHC - CMHC	30.00					25.00
26. 00	RURAL HEALTH CLINIC	88. 00				0	26.00
26. 01	RURAL HEALTH CLINIC II	88. 01				0	26.00
26. 02	RURAL HEALTH CLINIC III	88. 02				ĺ	26.02
26. 03	RURAL HEALTH CLINIC IV	88. 03	l e			Ö	26. 03
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00	l e			0	26. 25
27. 00		07.00	25			Ĭ	27. 00
28. 00	Observation Bed Days					0	28. 00
29. 00	Ambul ance Trips					_	29.00
30. 00	· ·						30.00
31. 00	. 3						31.00
32.00			0	(			32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00							33. 00
33. 01	LTCH site neutral days and discharges						33. 01

Provider CCN: 15-1305

Peri od: Worksheet S-3 From 10/01/2021 To 09/30/2022 Date/Ti me Prepared: 2/23/2023 4:28 pm

					1	2/23/2023 4: 2	8 pm
		I/P Days	/ O/P Visits	/ Tri ps	Full Time I	Equi val ents	
			T				
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
		/ 00	7.00	Pati ents	& Residents	Payrol I	
1 00	Harrital Adulta & Dada (asluma E. ( 7 and	6. 00	7.00	8.00	9. 00	10.00	1.00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	485	/	1, 087			1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)	140	56				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4. 00	HMO IRF Subprovider	o o	0				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	287	0	287			5.00
6. 00	Hospital Adults & Peds. Swing Bed NF		0	333			6.00
7. 00	Total Adults and Peds. (exclude observation	772	7	1, 707			7.00
	beds) (see instructions)		•	.,			
8.00	INTENSIVE CARE UNIT	o	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	23			13.00
14.00	Total (see instructions)	772	7	1, 730	0. 00	176. 24	14.00
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	_	_	_			21.00
22. 00	HOME HEALTH AGENCY	0	0	0	0. 00	0.00	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	_	_	_			23.00
24.00	HOSPI CE	0	0	_		0.00	
24. 10	HOSPICE (non-distinct part)			0			24. 10
25.00	CMHC - CMHC	4 757	0.4.4	04 040	0.00	47.00	25.00
26.00	RURAL HEALTH CLINIC	4, 757	244			47. 82	1
26. 01	RURAL HEALTH CLINIC II	1, 784	16			l e	1
26. 02	RURAL HEALTH CLINIC III	304	12		0.00	l e	l .
26. 03	RURAL HEALTH CLINIC IV	1, 070	19			l	1
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		l e	26. 25 27. 00
27. 00 28. 00	Total (sum of lines 14-26) Observation Bed Days		32	536	0.00	230. 42	28.00
29.00	Ambulance Trips	0	32	330			29.00
30.00	Employee discount days (see instruction)	١		0			30.00
31.00	Employee discount days (see l'istruction)						31.00
32.00	Labor & delivery days (see instructions)	0	0				32.00
32. 00	Total ancillary labor & delivery room	١	0	0			32.00
JZ. UI	outpatient days (see instructions)						JZ. U1
33.00	LTCH non-covered days	n					33.00
	LTCH site neutral days and discharges	o					33. 01
		١		1	I .	ı	

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

				10	09/30/2022	2/23/2023 4: 2	
		Full Time Equivalents		Di sch	arges	, _, _, _, _, _, _,	<b>F</b>
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	Component	Workers	II LIE V	II the Aviii	II LIE XIX	Patients	
		11. 00	12. 00	13.00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12.00		14.00	278	1. 00
1.00	8 exclude Swing Bed, Observation Bed and			121	'l	270	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			33	13		2.00
3.00	HMO IPF Subprovider				o		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	0. 00	C	124	1	278	14.00
15. 00	CAH visits						15. 00
16. 00	SUBPROVIDER - I PF						16. 00
17. 00	SUBPROVIDER - IRF						17. 00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00 22. 00	OTHER LONG TERM CARE	0.00					21. 00 22. 00
23. 00	HOME HEALTH AGENCY	0.00					22.00
24. 00	AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE	0.00					24.00
24. 00	HOSPICE (non-distinct part)	0.00					24. 00
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	0. 00					26.00
26. 01	RURAL HEALTH CLINIC II	0.00					26. 01
26. 02	RURAL HEALTH CLINIC III	0. 00					26. 02
26. 03	RURAL HEALTH CLINIC IV	0.00					26. 03
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days			0			33.00
33. 01	LTCH site neutral days and discharges			0			33. 01

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 10/01/2021 To 09/30/2022		
				RHC I	Cost	
				1	00	-
Clinic Address and Identification					00	
1.00 Street				540 HOSPITAL D	RI VE	1.00
			ty	State	ZIP Code	
			00	2. 00	3.00	
2.00 City, State, ZIP Code, County		WI NI MAC		I N	46996-	2.00
					1. 00	
3.00 HOSPITAL-BASED FQHCs ONLY: Designation - Ent.	er "R" for rura	al or "U" for	urban		0	3.00
				nt Award	Date	
				1. 00	2. 00	
Source of Federal Funds						
4.00 Community Health Center (Section 330(d), PHS						4.00
5.00 Migrant Health Center (Section 329(d), PHS A 6.00 Health Services for the Homeless (Section 34						5.00
7.00 Appal achi an Regional Commission	U(u), FIIS ACT)					7.00
8. 00 Look-Alikes						8.00
9. 00 OTHER (SPECIFY)						9.00
40.00 0 111 6 1111		501100 5	. "\" 6	1. 00	2.00	10.00
10.00 Does this facility operate as other than a h 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		0	10.00
(modi oi )	Sun	day	l N	Monday	Tuesday	
	from	to	from	to	from	
	1. 00	2. 00	3. 00	4. 00	5. 00	
Facility hours of operations (1)			00.00	17. 00	100.00	11 00
11. 00   CLINI C			08: 00	17: 00	08: 00	11.00
				1. 00	2. 00	
12.00 Have you received an approval for an excepti	on to the produ	uctivity stand	ard?	Y	2100	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. numbers below.	d in CMS Pub. 1 umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	N	0	13.00
Trumber 3 below.			Prov	i der name	CCN number	
				1. 00	2. 00	
14.00 RHC/FQHC name, CCN number						14. 00
	Y/N	V 2.00	XVIII	XIX	Total Visits	
15.00 Have you provided all or substantially all	1. 00	2. 00	3. 00	4. 00	5. 00	15.00
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)			L			
			inty			
2.00 City, State, ZIP Code, County		PULASKI	00			2.00
2. 55   State, 211 Code, County	Tuesday		esday	Thur	sday	2.00
	to	from	to	from	to	
	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

Health Financial Systems	PULASKI MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C		Peri od:	Worksheet S-8	
				From 10/01/2021		
		Component	CCN: 15-8512	To 09/30/2022		
		· ·			2/23/2023 4: 2	8 pm
				RHC I	Cost	
	Fri	day	Sat	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

Heal th	n Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
H0SPI	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1305	Peri od:	Worksheet S-8	3
			Component	CCN: 15-8527	From 10/01/2021 To 09/30/2022	Date/Time Pre 2/23/2023 4:2	
					RHC II	Cost	о рііі
					1.	00	
1. 00	Clinic Address and Identification Street				NORTH LANE STR	CCT	1.00
1.00	311 ee t		Ci	ty	State	ZIP Code	1.00
				00	2. 00	3. 00	
2.00	City, State, ZIP Code, County		NORTH JUDSON		IN	46366-1226	2.00
						1 00	
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	or "D" for rur	al or "II" for	urhan		1. 00 0	3.00
3.00	THOSE THE BASED TUTIOS ONET. Designation - Ent	er k for fula	al 01 0 101		nt Award	Date	3.00
					1. 00	2. 00	
	Source of Federal Funds						
4. 00	Community Health Center (Section 330(d), PHS						4. 00
5.00	Migrant Health Center (Section 329(d), PHS A						5.00
6. 00 7. 00	Health Services for the Homeless (Section 34 Appalachian Regional Commission	ω(α), PHS ACT)					6. 00 7. 00
8. 00	Look-Alikes						8.00
9. 00	OTHER (SPECIFY)						9.00
					1. 00	2. 00	
10. 00	j 1					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.)	other operati	ron(3) and the	operatring			
		Sun	day	l N	londay	Tuesday	
		from	to	from	to	from	
		1. 00	2. 00	3.00	4. 00	5. 00	
11 00	Facility hours of operations (1)			08: 00	17: 00	08: 00	11.00
11.00	CLINIC			08.00	17.00	08.00	11.00
					1. 00	2. 00	
12.00	Have you received an approval for an excepti	on to the produ	uctivity stand	ard?	Y		12.00
13.00					N	0	13.00
	30. 8? Enter "Y" for yes or "N" for no in col						
	number of providers included in this report. numbers below.	LIST the names	s or arr provi	ders and			
	Trainbor & Borowi			Prov	ider name	CCN number	
					1. 00	2. 00	
14. 00	RHC/FQHC name, CCN number	) / (b)	.,	20111	VIV	<b>-</b>	14.00
		Y/N 1. 00	V 2. 00	3. 00	XI X 4. 00	Total Visits 5.00	
15. 00	Have you provided all or substantially all	1.00	2.00	3.00	4.00	5.00	15.00
13.00	GME cost? Enter "Y" for yes or "N" for no in	1					13.00
	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)						
		•		inty			
	Taxania and a same and			00			
2. 00	City, State, ZIP Code, County		PULASKI	anday.	TI	e dov	2.00
		Tuesday to	from	esday to	from	sday to	
		6. 00	7.00	8. 00	9. 00	10. 00	
	Facility hours of operations (1)	0.00		3.00	,,,,,,	10.00	
11. 00	CLINIC	17: 00	08: 00	17: 00	08: 00	17: 00	11.00

Health Financial Systems	PULASKI MEN	MORI AL	HOSPI TAL			In Lie	eu of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provi der	CCN: 1		Peri od:	Worksheet S-8	
						From 10/01/2021		
			Component	CCN:	15-8527	To 09/30/2022		
			•				2/23/2023 4: 2	8 pm
						RHC II	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	17:	00					11.00

Health Financial Systems	PULASKI MEMORI	IAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1305	Peri od:	Worksheet S-8	3
		Component	CCN: 15-8528	From 10/01/2021 To 09/30/2022	Date/Time Pre 2/23/2023 4:2	
				RHC III	Cost	
				1	00	-
Clinic Address and Identification					00	
1.00 Street				112 E MONTGOME	RY STREET	1.00
			ty	State	ZIP Code	
			00	2. 00	3.00	
2.00 City, State, ZIP Code, County		FRANCESVI LLE		IN	47946-8087	2.00
					1. 00	
3.00 HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for			0	3.00
			Gra	nt Award	Date	
Source of Federal Funds				1. 00	2. 00	
4.00 Community Health Center (Section 330(d), PHS	Act)		I			4.00
5.00 Migrant Health Center (Section 329(d), PHS A						5.00
6.00 Health Services for the Homeless (Section 34	O(d), PHS Act)					6.00
7.00 Appalachian Regional Commission						7.00
8.00 Look-Alikes 9.00 OTHER (SPECIFY)						8. 00 9. 00
9.00 OTHER (SPECIFY)						9.00
				1. 00	2.00	
10.00 Does this facility operate as other than a h 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		0	10.00
	Sun	day	N	londay	Tuesday	
	from	to	from	to	from	
<u></u>	1. 00	2.00	3. 00	4. 00	5. 00	
Facility hours of operations (1) 11.00 CLINIC		I	08: 00	17: 00	09: 00	11.00
11.00 CEINIC			00.00	17.00	07.00	11.00
				1. 00	2.00	
12.00 Have you received an approval for an excepti 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. numbers below.	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	Y N	0	12. 00 13. 00
			Prov	ider name	CCN number	
44.00 DU0/F01/0				1. 00	2. 00	14.05
14.00 RHC/FOHC name, CCN number	Y/N	V	XVIII	XIX	Total Visits	14.00
	1. 00	2.00	3.00	4.00	5. 00	
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.		2. 00	3. 00		3.00	15.00
(see instructions)		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	
	19: 00	08: 00	16: 00	08: 00	16: 00	11.00

Health Financial Systems	PULASKI	MEMORI AL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provi der	CCN: 15-1305	Peri od:	Worksheet S-8	
			Component	CCN: 15_8528	From 10/01/2021 To 09/30/2022	Date/Time Pre	nared:
			Component	CON. 15 0320	10 077 307 2022	2/23/2023 4: 2	8 pm
				_	RHC III	Cost	
		Fri day	/	Sa	turday		
	fro	m	to	from	to		
	11. 0	00	12. 00	13.00	14. 00		
Facility hours of operations (1)							
11. 00   CLI NI C							11. 00

	ED RHC/FQHC STATISTICAL DATA			CN: 15-1305	Peri od: From 10/01/2021	Worksheet S-	8
CI i ni c			1				
Clinic			Component	CCN: 15-8554	To 09/30/2022	Date/Time Pro 2/23/2023 4:	
CI i ni c					RHC I V	Cost	
Clinic					1	00	+
	Address and Identification					00	
1.00 Street		1			2 S. PEARL STR		1.00
		-		00	State 2.00	ZIP Code 3. 00	
2.00 Ci ty,	State, ZIP Code, County		KNOX	00	2.00 I N	46534	2.00
3. 00 HOSPI T.	AL-BASED FQHCs ONLY: Designation - Ente	or "D" for rurs	al or "II" for	urhan		1. 00	3.00
3. 00   HUSPI I	AL-BASED FUNCS UNLT. Designation - Ente	er K TOLTULA	1 01 0 101		nt Award	Date	3.00
					1. 00	2. 00	
	of Federal Funds			T			
	nity Health Center (Section 330(d), PHS at Health Center (Section 329(d), PHS Ad						4. 00 5. 00
	Services for the Homeless (Section 340						6. 0
	nchian Regional Commission						7.00
8. 00 Look-A 9. 00 OTHER	llikes (SPECIFY)						9.00
9. 00   OTTLK	(SFECITI)						7.0
					1. 00	2. 00	
yes or	this facility operate as other than a hore. "N" for no in column 1. If yes, indicater in subscripts of line 11 the type of N	ate number of d	other operatio	ns in column		(	10.00
mour 3.	,	Sund	day	l N	Monday	Tuesday	
		from	to	from	to	from	
Facili	ty hours of energtions (1)	1. 00	2. 00	3.00	4. 00	5. 00	
11. 00 CLINIC	ty hours of operations (1)			08: 00	19: 00	08: 00	11.0
		'		1			
12.00 Have y	you received an approval for an exception	on to the produ	ictivity stand	lard?	1. 00 Y	2. 00	12.00
13.00 Is this 30.8?	our received an approval for an exception is a consolidated cost report as defined Enter "Y" for yes or "N" for no in colustion of providers included in this report.	d in CMS Pub. 1 umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the		(	13.00
number	s below.			1 5		2211	
				Prov	ider name 1.00	CCN number 2.00	
14.00 RHC/FQ	NHC name, CCN number				1. 00	2.00	14.0
		Y/N	V	XVIII	XI X	Total Visits	
15.00 Have y	you provided all or substantially all	1. 00	2. 00	3.00	4. 00	5. 00	15. 00
	ost? Enter "Y" for yes or "N" for no in						15.0
col umn	1. If yes, enter in columns 2, 3 and						
	number of program visits performed by a & Residents for titles V, XVIII, and						
	is applicable. Enter in column 5 the						
number	of total visits for this provider.						
(see i	nstructions)		Cou	10.414			
		-		unty 00			
2.00 Ci ty,	State, ZIP Code, County						2.00
			esday		sday		
		to 6. 00	from	to	from	to	
			7. 00	8.00	9. 00	10.00	

Health Financial Systems	PULASKI	MEMORI AL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provi der		Peri od: From 10/01/2021	Worksheet S-8	
			Component		To 09/30/2022	Date/Time Pre 2/23/2023 4:2	
					RHC IV	Cost	
		Fri da	У	Saturday			
	fror	n	to	from	to		
	11. 0	10	12. 00	13. 00	14.00		
Facility hours of operations (1)							
11. 00 CLINIC	08: 00	16	: 00	08: 00	12: 00		11. 00

กรคเา	Financial Systems PULASKI MEMORIAL HOS TAL UNCOMPENSATED AND INDIGENT CARE DATA Pro		CCN: 15-	1305	Peri od:	u of Form CMS-2 Worksheet S-1	
JJFTT	AL UNCOMPENSATED AND INDIGENT CARE DATA	ovidei	CCIV. 13-		From 10/01/2021	WOLKSHEET 3-1	U
					To 09/30/2022	Date/Time Pre 2/23/2023 4:2	
						1.00	
	Uncompensated and indigent care cost computation						
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ded by	line 202	2 column	8)	0. 496129	1.
	Medicaid (see instructions for each line)						
00	Net revenue from Medicaid					1, 153, 864	2.
00	Did you receive DSH or supplemental payments from Medicaid?  If line 3 is yes, does line 2 include all DSH and/or supplemental	l navmo	nts from	n Modica	i d2	Y N	3. 4.
00	If line 4 is no, then enter DSH and/or supplemental payments from			ii weui ca	i u :	235, 830	•
00	Medicaid charges	iii wcai c	ui u			10, 011, 625	
00	Medicaid cost (line 1 times line 6)					4, 967, 057	
00	Difference between net revenue and costs for Medicaid program (li	ine 7 m	inus sum	m of lin	es 2 and 5; if	3, 577, 363	8.
	< zero then enter zero)						
	Children's Health Insurance Program (CHIP) (see instructions for	each I	i ne)				
00	Net revenue from stand-alone CHIP					0	
0.00	Stand-alone CHIP charges   Stand-alone CHIP cost (line 1 times line 10)					0	10.
2. 00	1	ine 11	minus li	ne 9: i	f < zero then	Ö	ı
00	enter zero)			, .	20.0		
	Other state or local government indigent care program (see instru	uctions	for eac	ch line)			
. 00	Net revenue from state or local indigent care program (Not includ					l e	13.
. 00	Charges for patients covered under state or local indigent care p	program	(Not ir	ncl uded	in lines 6 or	0	14.
- 00	[10]					0	15.
5.00	State or local indigent care program cost (line 1 times line 14) Difference between net revenue and costs for state or local indig	aent ca	re nroar	com (Lin	Δ 15 minus line		ı
5. 00							
	13: if < zero then enter zero)	90 04	re progr	alli (IIII	0 10 1111103 11110	Ĭ	10.
	13; if < zero then enter zero)  Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)			· · · · · · · · · · · · · · · · · · ·			10.
7. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)	and sta	ate/I oca	al indig			
3. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)  Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos	and sta	ate/loca arity ca	al indig are ons	ent care progra	ams (see	17. 18.
3. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)  Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos	and sta	ate/loca arity ca	al indig are ons	ent care progra	ams (see	17. 18.
3. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)  Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i	and sta	ate/loca arity ca operation	al indig are ons	ent care progra	0 0,3,577,363	17. 18.
3. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)  Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i	and sta	ate/loca arity ca operatic t care p	al indig are ons orograms onsured ients	ent care progra  (sum of lines  Insured patients	0 0 3,577,363 Total (col. 1 + col. 2)	17. 18.
3. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16)	and sta	ate/loca arity ca operatic t care p	al indigare ons orograms	ent care progra	0 0,3,577,363	17. 18.
3. 00 9. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)  Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16)  Uncompensated Care (see instructions for each line)	and sta ding ch spital indigen	ate/loca arity ca operatic t care p	are ons or	(sum of lines  Insured patients 2.00	0 0 3,577,363 Total (col. 1 + col. 2) 3.00	17. 18. 19.
3. 00 9. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16)	and sta ding ch spital indigen	ate/loca arity ca operatic t care p	al indig are ons orograms onsured ients	(sum of lines  Insured patients 2.00	0 0 3,577,363 Total (col. 1 + col. 2) 3.00	17. 18. 19.
3. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)  Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facil (see instructions)  Cost of patients approved for charity care and uninsured discount	and stading chespital indigen	arity ca operation t care publication	are ons or	ent care progra (sum of lines Insured patients 2.00	Total (col. 1 + col. 2) 3.00	17. 18. 19.
3. 00 9. 00 0. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)  Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facil (see instructions)  Cost of patients approved for charity care and uninsured discount instructions)	and standing chespital indigen	arity ca operation t care publication	al indig are ons orograms orograms ients .00	(sum of lines Insured patients 2.00 137,721	Total (col. 1 + col. 2) 3.00 173,292 155,369	17. 18. 19. 20.
3. 00 9. 00 0. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)  Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facil (see instructions)  Cost of patients approved for charity care and uninsured discount instructions)  Payments received from patients for amounts previously written of	and standing chespital indigen	arity ca operation t care publication	are ons orograms orograms ients .00	(sum of lines Insured patients 2.00 137,721	Total (col. 1 + col. 2) 3.00	17. 18. 19. 20. 21.
3. 00 2. 00 3. 00 3. 00 4. 00 2. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)  Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facil (see instructions)  Cost of patients approved for charity care and uninsured discount instructions)  Payments received from patients for amounts previously written of charity care	and standing chespital indigen	arity ca operation t care publication	al indig are ons orograms nsured ients .00	(sum of lines Insured patients 2.00 137,721 3 137,721	Total (col. 1 + col. 2) 3.00 173,292 155,369	17. 18. 19. 20. 21.
0.00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)  Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facil (see instructions)  Cost of patients approved for charity care and uninsured discount instructions)  Payments received from patients for amounts previously written of charity care	and standing chespital indigen	arity ca operation t care publication	al indig are ons orograms orograms ients .00	(sum of lines Insured patients 2.00 137,721 3 137,721	Total (col. 1 + col. 2) 3.00 173,292 155,369	17. 18. 19. 20. 21.
. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)  Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facil (see instructions)  Cost of patients approved for charity care and uninsured discount instructions)  Payments received from patients for amounts previously written of charity care  Cost of charity care (line 21 minus line 22)	and standing chaspital indigen	arity caarity caarity care poperation of the	al indig are ons orograms nsured ients .00 35,57 17,648	(sum of lines     Insured patients 2.00     137,721     137,721     0     137,721	Total (col. 1 + col. 2) 3.00 173,292 155,369	17. 18. 19. 20. 21.
0.00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)  Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facil (see instructions)  Cost of patients approved for charity care and uninsured discount instructions)  Payments received from patients for amounts previously written of charity care  Cost of charity care (line 21 minus line 22)	and standing chaspital indigen	arity caarity capperation to care pure unit pat 1	al indig are ons orograms nsured ients .00 35,57 17,648	(sum of lines     Insured patients 2.00     137,721     137,721     0     137,721	Total (col. 1 + col. 2) 3.00  173,292  155,369	17. 18. 19. 20. 21. 22.
. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)  Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facil (see instructions)  Cost of patients approved for charity care and uninsured discount instructions)  Payments received from patients for amounts previously written of charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care pr If line 24 is yes, enter the charges for patient days beyond the	and standing chaspital indigen  lity  ts (see ff as days b rogram?	arity carapritical arity care properation of the carepritical arithmetical arithmetical arithmetical carepritical arithmetical arith	al indig are ons orograms nsured ients .00 35,57' 17,648	(sum of lines Insured patients 2.00 137,721 3 137,721 0 137,721 of stay limit	Total (col. 1 + col. 2) 3.00 173, 292 155, 369 0 1.00 N	20. 21. 22. 23.
3. 00 0. 00 0. 00 0. 00 2. 00 3. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)  Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facil (see instructions)  Cost of patients approved for charity care and uninsured discount instructions)  Payments received from patients for amounts previously written of charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care provided in the stay limit.	and standing chaspital indigen	arity care properation of the	al indig are ons orograms nsured ients .00 35,57' 17,648	(sum of lines Insured patients 2.00 137,721 3 137,721 0 137,721 of stay limit	Total (col. 1 + col. 2) 3.00  173, 292  155, 369  0  1.00  N	20. 21. 22. 23.
3. 00 3. 00 3. 00 3. 00 4. 00 4. 00 5. 00 5. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)  Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facil (see instructions)  Cost of patients approved for charity care and uninsured discount instructions)  Payments received from patients for amounts previously written of charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care proposed in the patient of the charges for patient days beyond the stay limit  Total bad debt expense for the entire hospital complex (see instructions)	and standing chespital indigen	ate/loca arity capperation to care p Unir pat 1  eyond a nt care s)	al indig are ons orograms nsured ients .00 35,57 17,648 (1ength program	(sum of lines Insured patients 2.00 137,721 3 137,721 0 137,721 of stay limit	Total (col. 1 + col. 2) 3.00  173, 292  155, 369  1.00  N  0  1,002,849	20. 21. 22. 23. 24. 25.
33.00 30.00 30.00 30.00 30.00 41.00 41.00 41.00 41.00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)  Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facil (see instructions)  Cost of patients approved for charity care and uninsured discount instructions)  Payments received from patients for amounts previously written of charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care pr If line 24 is yes, enter the charges for patient days beyond the stay limit  Total bad debt expense for the entire hospital complex (see instructions)	and standing chespital indigen  lity  ts (see  ff as  days b  rogram?  indige  ruction (see in	ate/loca arity ca poperation t care p Unir pat 1  eyond a nt care s) struction	al indig are ons orograms nsured ients .00 35,57 17,648 ( 17,648 I ength program	(sum of lines Insured patients 2.00 137,721 3 137,721 0 137,721 of stay limit	Total (col. 1 + col. 2) 3.00  173, 292  155, 369  1.00  N  0  1,002,849 137,499	20. 21. 22. 23. 24. 25. 26. 27.
33.00 3.00 3.00 3.00 3.00 3.00 4.00 5.00 6.00 7.00 7.01	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)  Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facil (see instructions)  Cost of patients approved for charity care and uninsured discount instructions)  Payments received from patients for amounts previously written of charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care pr If line 24 is yes, enter the charges for patient days beyond the stay limit  Total bad debt expense for the entire hospital complex (see instructions)  Medicare reimbursable bad debts for the entire hospital complex (see	and standing chespital indigen  lity  ts (see  ff as  days b  rogram?  indige  ruction (see in	ate/loca arity ca poperation t care p Unir pat 1  eyond a nt care s) struction	al indig are ons orograms nsured ients .00 35,57 17,648 ( 17,648 I ength program	(sum of lines Insured patients 2.00 137,721 3 137,721 0 137,721 of stay limit	Total (col. 1 + col. 2) 3.00  173, 292  155, 369  1.00  N  0  1,002, 849 137, 499 211, 536	20. 21. 22. 23. 24. 25. 26. 27. 27.
33.00 9.00 1.00 1.00 4.00 5.00 7.00 7.01 33.00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)  Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facil (see instructions)  Cost of patients approved for charity care and uninsured discount instructions)  Payments received from patients for amounts previously written of charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care pr If line 24 is yes, enter the charges for patient days beyond the stay limit  Total bad debt expense for the entire hospital complex (see instrudedicare reimbursable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions)	and standing chaspital indigen  lity  ts (see ff as days b rogram? indige ruction (see in str	eyond a nt care ss) struction occurrence of the care struction occurrence occ	al indig are ons orograms sured ients .00 35,57' 17,648 length program	ent care progra  (sum of lines  Insured patients 2.00  137,721  0 137,721  of stay limit 's length of	1, 002, 849 1, 002, 849 1, 002, 849 211, 536 791, 313	20. 21. 22. 23. 24. 25. 26. 27. 27. 28.
9. 00 0. 00 1. 00 2. 00 3. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)  Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16)  Uncompensated Care (see instructions for each line)  Charity care charges and uninsured discounts for the entire facil (see instructions)  Cost of patients approved for charity care and uninsured discount instructions)  Payments received from patients for amounts previously written of charity care  Cost of charity care (line 21 minus line 22)  Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care pr If line 24 is yes, enter the charges for patient days beyond the stay limit  Total bad debt expense for the entire hospital complex (see instructions)  Medicare reimbursable bad debts for the entire hospital complex (see	and standing chaspital indigen  lity  ts (see ff as days b rogram? indige ruction (see in str	eyond a nt care ss) struction occurrence of the care struction occurrence occ	al indig are ons orograms sured ients .00 35,57' 17,648 length program	ent care progra  (sum of lines  Insured patients 2.00  137,721  0 137,721  of stay limit 's length of	Total (col. 1 + col. 2) 3.00  173, 292  155, 369  1.00  N  0  1,002, 849 137, 499 211, 536	20. 21. 22. 23. 24. 25. 26. 27. 27. 28. 29.

Health Financial Systems	L HOSPITAL		In Lieu of Form CMS-2552-10			
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O		Provi der Co		Peri od:	Worksheet A	
				From 10/01/2021 Fo 09/30/2022	Date/Time Pre 2/23/2023 4:2	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	Reclassi fied	O pili
F			+ col . 2)	ions (See	Trial Balance	
				A-6)	(col. 3 +-	
					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, 693, 515				1. 00
4.00   00400   EMPLOYEE BENEFITS DEPARTMENT	0	4, 676, 696			4, 676, 696	4. 00
5. 00   00500   ADMI NI STRATI VE & GENERAL	3, 384, 118	3, 955, 729				5.00
7.00 O0700 OPERATION OF PLANT	425, 905	611, 628			1, 037, 533	7. 00
8.00   00800 LAUNDRY & LINEN SERVICE	9, 522	69, 455			78, 977	8. 00
9. 00   00900   HOUSEKEEPI NG	209, 477	137, 263			346, 740	9. 00
10. 00   01000   DI ETARY	223, 188	165, 845			389, 033	10.00
13.00 01300 NURSING ADMINISTRATION	373, 141	242, 857			615, 998	13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	20, 629	93, 073			113, 702	14.00
15. 00   01500   PHARMACY	0	0	(	-	0	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	315, 721	43, 134	358, 855		358, 855	16.00
17. 00 01700 SOCIAL SERVICE	40, 864	164	41, 028	3 0	41, 028	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS	4 004 404	040 400		1.0.001	0 004 (07	
30. 00 03000 ADULTS & PEDI ATRI CS	1, 921, 184	218, 122	2, 139, 306	1	2, 301, 607	30.00
31. 00 03100 INTENSIVE CARE UNIT	0	0	(	,	0	31.00
43. 00   04300   NURSERY	2, 162	2, 077	4, 239	9 10, 307	14, 546	43.00
ANCILLARY SERVICE COST CENTERS	/40 000	00.700	740 (0)	0.45 0.40	4 557 000	F0 00
50. 00   05000   OPERATING ROOM	610, 892	99, 799			1, 556, 003	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	12, 201	4, 379				52.00
53. 00 05300 ANESTHESI OLOGY	0	510, 424	510, 424		510, 424	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	899, 754	572, 524	1, 472, 278		1, 472, 278	54.00
60. 00   06000   LABORATORY	739, 084	731, 170 0	1, 470, 254		1, 470, 254	60.00
60. 01   06001   BLOOD LABORATORY	0	ŭ	1	٠	0	60.01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	-1	45, 364	45, 364		45, 364	63.00
65. 00 06500 RESPI RATORY THERAPY	365, 491	45, 006			410, 497	65.00
66. 00   06600   PHYSI CAL THERAPY 67. 00   06700   OCCUPATI ONAL THERAPY	967, 349	42, 859			1, 010, 208	66.00
	183, 585	891	184, 476		184, 476	67.00
68. 00   06800   SPEECH   PATHOLOGY   69. 00   06900   ELECTROCARDI OLOGY	120	45 13, 195	165		165	68. 00 69. 00
1	-1				13, 195 73, 580	69.00
69. 01   06901   CARDI AC REHABI LI TATI ON 70. 00   07000   ELECTROENCEPHALOGRAPHY	71, 063	2, 517	73, 580		1	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	E02 023	E02 02	124 140	0 457 004	70. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	582, 033	582, 033		l	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	81, 628	2, 159, 905	١ `			73.00
76. 00   03020   0NCOLOGY	146, 674				1	76.00
OUTPATIENT SERVICE COST CENTERS	140, 074	34, 062	100, 730	<u> </u>	100, 730	76.00
88. 00 08800 RURAL HEALTH CLINIC	5, 262, 581	437, 912	5, 700, 493	-1, 375, 839	4, 324, 654	88. 00
88. 01   08801 RURAL HEALTH CLINIC II	684, 728	110, 359			912, 848	88. 01
88. 02 08802 RURAL HEALTH CLINIC III	206, 240	29, 788			292, 489	88. 02
88. 03   08803   RURAL HEALTH CLINIC IV	555, 918	78, 299			l '	88. 03
90. 00   09000   CLINIC	61, 862	238, 249			300, 111	
91. 00   09100   EMERGENCY	1, 214, 721	1, 368, 544			2, 583, 265	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 211, 721	1,000,011	2,000,200	]	2,000,200	92.00
OTHER REIMBURSABLE COST CENTERS						72.00
101. 00 10100 HOME HEALTH AGENCY	0	0		0	0	101. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>			<u>,                                     </u>		
116. 00 11600 HOSPI CE	0	0	(	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	18, 989, 802	19, 016, 882		-		
NONREI MBURSABLE COST CENTERS	.0/ /0// 002	. , , 0 . 0 , 0 0 2	00/000/00		00/012/010	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	n	(	0	n	190. 00
190. 01 19001 HOMECARE	Ö	0		o o		190. 01
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	333, 176	64, 377			397, 553	
192. 01 19201 KNOX RHC	0	0	(	ol o		192. 01
194. 00 07950 MARKETI NG	81, 041	158, 664	239, 705	-35, 956		
200.00 TOTAL (SUM OF LINES 118 through 199)	19, 404, 019	19, 239, 923				
			•	•	•	-

Peri od: Worksheet A From 10/01/2021 To 09/30/2022 Date/Time Prepared: 2/23/2023 4:28 pm

				2/23/2023 4:2	28 pm
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For		
			Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS	40.000	4 707 005	T	4
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT	-12, 338		•	1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	.,		4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	-1, 406, 772		•	5.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	-278	1, 037, 255 78, 977		7. 00 8. 00
9. 00	00900 HOUSEKEEPING	0	346, 740	•	9.00
10.00	01000 DI ETARY	-54, 903			10.00
13. 00	01300 NURSING ADMINISTRATION	-34, 703	615, 998	•	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	-3, 916		•	14.00
15. 00	01500 PHARMACY	0, 7.0	0	•	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	-5, 762	1	1	16.00
	01700 SOCIAL SERVICE	0		•	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-579, 403	1, 722, 204		30.00
31.00	03100 INTENSIVE CARE UNIT	0			31.00
43.00	04300 NURSERY	0	14, 546		43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-990, 980	565, 023		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	29, 463		52.00
53.00	05300 ANESTHESI OLOGY	-500, 000		•	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 472, 278		54.00
60.00	06000 LABORATORY	0	1, 470, 254		60.00
60. 01	06001 BLOOD LABORATORY	0	0	•	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	45, 364	•	63.00
65.00	06500 RESPIRATORY THERAPY	0	410, 497	•	65.00
66.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	1, 010, 208		66.00
67. 00 68. 00	06800 SPEECH PATHOLOGY	0	184, 476 165	•	67. 00 68. 00
69.00	06900 ELECTROCARDI OLOGY	-4, 294	8, 901		69.00
69. 01	06901 CARDI AC REHABI LI TATI ON	-4, 2,4 O	73, 580		69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	73, 300	•	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-1	457, 883	•	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		•	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	o o	2, 241, 533		73.00
76. 00	03020 ONCOLOGY	-30,000		•	76.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	4, 324, 654		88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	912, 848		88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	292, 489		88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	0	718, 310		88. 03
90.00	09000 CLI NI C	0	300, 111		90.00
91. 00	09100 EMERGENCY	0	2, 583, 265		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
	OTHER REIMBURSABLE COST CENTERS	_	_		
101.00	10100 HOME HEALTH AGENCY	0	0		101.00
444 00	SPECIAL PURPOSE COST CENTERS				111 00
	11600 HOSPI CE	0		l .	116.00
118. 00	3 7	-3, 588, 647	34, 453, 993		118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0		190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	•	190.00
	1900   HOMECARE 19200   PHYSI CLANS' PRI VATE OFFI CES		397, 553	l .	190.01
	19201 KNOX RHC		347, 333	1	192.00
	07950 MARKETI NG	O	203, 749	l .	194.00
200.00	1 1	-3, 588, 647			200.00
	, (: -: oug. 1//)	2,000,017	1, 555, 275	1	,

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

KLULA	STITCATIONS			Frovider	JCIN. 13-1303	From 10/01/2021	WOLKSHEET A-0
						To 09/30/2022	Date/Time Prepared: 2/23/2023 4: 28 pm
		Increases					
	Cost Center	Li ne #	Sal ary	0ther			
	2. 00	3. 00	4. 00	5. 00			
	A - PROPERTY INSURANCE RECLAS						
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	46, 058			1.00
	FI XT						
	0		0	46, 058			
	B - MARKETING RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5. 00	1 <u>2, 1</u> 56	23, 800			1.00
	0		12, 156	23, 800			
	C - IMPLANTABLE DEVICE RECLAS	SS					
1.00	IMPL. DEV. CHARGED TO	72. 00	0	124, 149			1.00
	PATI ENTS						
	0		0	124, 149			
	D - PHYSICIAN SALARIES RECLAS	SS					
1.00	ADULTS & PEDIATRICS	30. 00	185, 491	0			1.00
2.00	OPERATING ROOM	50.00	845, 312	0			2.00
3.00	RURAL HEALTH CLINIC II	88. 01	75, 666	0			3.00
4.00	RURAL HEALTH CLINIC III	88. 02	44, 288	0			4.00
5.00	RURAL HEALTH CLINIC IV	88. 03	48, 222	0			5.00
			1, 198, 979				
	E - PATIENT ACCOUNTS RECLASS	<u>.</u>					
1.00	ADMINISTRATIVE & GENERAL	5. 00	86, 721	0			1.00
			86, 721				
	F - RHC DEPT 175 RECLASS	<u> </u>					
1.00	RURAL HEALTH CLINIC II	88. 01	0	47, 339			1.00
2.00	RURAL HEALTH CLINIC III	88. 02	O	12, 173			2.00
3.00	RURAL HEALTH CLINIC IV	88. 03	o	35, 871			3.00
				95, 383			
	G - RN SALARIES RECLASS		-1	.,			
1.00	NURSERY	43.00	10, 307	0			1.00
2. 00	DELIVERY ROOM & LABOR ROOM	52. 00	12, 883	0			2.00
	0	— — — <del>`</del>	23, 190		1		
500 00	Grand Total: Increases		1, 321, 046	289, 390	1		500.00
200.00	1-	1	., 52., 5.10	207,070	1		1 200. 00

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

 RECLASSIFICATIONS
 Provider CCN: 15-1305
 Period: Worksheet A-6

From 10/01/2021 To 09/30/2022 Date/Time Prepared: 2/23/2023 4: 28 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 RECLASS 1.00 ADMINISTRATIVE & GENERAL 5.00 46,058 12 1.00 46, 058 B - MARKETING RECLASS 1.00 MARKETI NG 194.00 12, 156 23,800 0 1.00 12, 156 23, 800 C - IMPLANTABLE DEVICE RECLASS MEDICAL SUPPLIES CHARGED TO 1.00 124, 149 71.00 0 1.00 PAT I ENTS 124, 149 D - PHYSICIAN SALARIES RECLASS RURAL HEALTH CLINIC 1, 193, 735 1.00 1.00 88.00 0 0 2.00 RURAL HEALTH CLINIC II 88.01 5, 244 0 0 2.00 3.00 0.00 0 0 0 3.00 4.00 0.00 0 0 4.00 0 5.00 0.00 5.00 0 0 1, 198, 979 Ō - PATIENT ACCOUNTS RECLASS 86, 721 1.00 RURAL HEALTH CLINIC 88. 00 1.00 0 0 86, 721 F - RHC DEPT 175 RECLASS 1.00 RURAL HEALTH CLINIC 88. 00 95, 383 0 1.00 0 0 2.00 0.00 0 0 2.00 3.00 0.00 0 3.00 o 95, 383 G - RN SALARIES RECLASS 1.00 ADULTS & PEDIATRICS 30.00 23, 190 0 0 1.00 2.00 0.00 0 2.00 23, 190

1, 321, 046

289, 390

500.00

500.00 Grand Total: Decreases

Provider CCN: 15-1305

				10	09/30/2022	2/23/2023 4: 2	
				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	195, 525	0	0	0	0	1.00
2. 00	Land Improvements	432, 594	0	0	0	0	2.00
	Buildings and Fixtures	13, 253, 038	0	0	0	0	3.00
	Building Improvements	187, 055	0	0	0	0	4.00
	Fixed Equipment	7, 468, 798	79, 265	0	79, 265	0	5.00
	Movable Equipment	12, 398, 914	3, 153, 346	0	3, 153, 346	0	6.00
	HIT designated Assets	0	0	0	0	0	7.00
	Subtotal (sum of lines 1-7)	33, 935, 924	3, 232, 611	0	3, 232, 611	0	8.00
	Reconciling Items	0	0	0	0	0	,
10. 00	Total (line 8 minus line 9)	33, 935, 924	3, 232, 611	0	3, 232, 611	0	10.00
		Endi ng	Fully				
		Bal ance	Depreciated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		_1				
1. 00	Land	195, 525	0				1.00
	Land Improvements	432, 594	0				2.00
	Buildings and Fixtures	13, 253, 038	0				3.00
	Building Improvements	187, 055	0				4.00
	Fi xed Equi pment	7, 548, 063	0				5.00
	Movable Equipment	15, 552, 260	0				6. 00
	HIT designated Assets	0	0				7. 00
	Subtotal (sum of lines 1-7)	37, 168, 535	0				8. 00
	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	37, 168, 535	0				10.00

Heal th	Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od:	Worksheet A-7	
					From 10/01/2021 To 09/30/2022		pared:
				,		2/23/2023 4: 2	8 pm
			SI	UMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see	instructions)	
					instructions)		
		9. 00	10. 00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	MN 2, LINES 1	and 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	1, 372, 053	(	321, 46	2 0	0	1.00
3.00	Total (sum of lines 1-2)	1, 372, 053	C	321, 46	2 0	0	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	0ther	Total (1)				
		Capi tal -Rel at	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	MN 2, LINES 1	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1, 693, 515	5			1.00
3.00	Total (sum of lines 1-2)	0	1, 693, 515	5			3.00

Health Financial Systems	PULASKI MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		eri od:	Worksheet A-7	
				rom 10/01/2021 o 09/30/2022	Part III   Date/Time Pre	nared·
				0 077 007 2022	2/23/2023 4: 28	
	COM	PUTATION OF RA	TI 0S	ALLOCATION OF	OTHER CAPITAL	
Cook Conton Boominting	C A	C: +-1:	Gross Assets	D-+: - (	1	
Cost Center Description	Gross Assets	Capi tal i zed Leases	for Ratio	Ratio (see instructions)	Insurance	
		Leases	(col. 1 -	Tristructions)		
			col . 2)			
	1. 00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS (	ENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT	37, 168, 535	0	37, 168, 535			1.00
3.00 Total (sum of lines 1-2)	37, 168, 535		37, 168, 535			3.00
	ALLOCA <sup>-</sup>	TION OF OTHER (	CAPI TAL	SUMMARY O	F CAPITAL	
0	T	011	T. I. I. ( 6	D	1	
Cost Center Description	Taxes	Other	Total (sum of cols. 5	Depreciation	Lease	
		Capi tal -Relat ed Costs	through 7)			
	6. 00	7.00	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, 371, 320	0	1.00
3.00 Total (sum of lines 1-2)	0	0	(	1, 371, 320	o	3.00
		Sl	JMMARY OF CAPI	ΓAL		
Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
		(see	instructions)			
		instructions)		ed Costs (see	9 through 14)	
	11. 00	12. 00	13. 00	instructions) 14.00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS (		12.00	13.00	14.00	13.00	
1.00 NEW CAP REL COSTS-BLDG & FLXT	309, 857	46, 058		) 0	1, 727, 235	1. 00
3.00 Total (sum of lines 1-2)	309, 857				1, 727, 235	

					From 10/01/2021 To 09/30/2022	Date/Time Pre	
			·	Expense Classification or To/From Which the Amount is		2/23/2023 4: 2	8 pm
					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1. 00	2. 00	3. 00	4.00	5. 00	
1. 00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2. 00	0	2.00
3. 00	Investment income - other (chapter 2)		0		0.00	0	3. 00
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4. 00
5. 00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6. 00
7. 00	Telephone services (pay stations excluded) (chapter		0		0.00	0	7. 00
8. 00	21) Tellevision and radio service (chapter 21)		0		0.00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -1, 604, 677		0.00	0	
11. 00	adjustment Sale of scrap, waste, etc.		0		0. 00	0	11. 00
12. 00	(chapter 23) Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests		0		0. 00 0. 00	0	
15. 00	Rental of quarters to employee		0		0.00	0	
16. 00	and others Sale of medical and surgical supplies to other than		0		0. 00	0	16. 00
17. 00	patients Sale of drugs to other than		0		0. 00	0	17. 00
18. 00	patients Sale of medical records and		0		0. 00	0	18. 00
19. 00	abstracts Nursing and allied health education (tuition, fees,		0		0. 00	0	19. 00
	books, etc.) Vending machines		0		0.00	0	0.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25. 00
26. 00	(chapter 21) Depreciation - NEW CAP REL			NEW CAP REL COSTS-BLDG &	1. 00	0	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP			*** Cost Center Deleted ***	2. 00	0	27. 00
28. 00	Non-physician Anesthetist		o	*** Cost Center Deleted ***	19. 00		28.00
29.00	Physicians' assistant	A 0 2	o	OCCUDATIONAL TUEDADY	0.00	0	
30. 00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30.00
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30. 99

					0 09/30/2022	2/23/2023 4:2	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is			
					•		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2)				Ref.	
	T	1. 00	2. 00	3. 00	4. 00	5. 00	
31. 00	.,	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
	pathology costs in excess of						
	limitation (chapter 14)						
32. 00			0		0. 00	0	32.00
00.00	Depreciation and Interest		44 (05	NEW OAR REL COCTO RIPO O	4 00	4.4	00.00
33. 00	INVEST INC/UNRESTRIC- INT EXP	В		NEW CAP REL COSTS-BLDG & FLXT	1. 00	11	33.00
33. 01	OTHER SERVICES -OTHER REV	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 01
33. 02	CAFETERIA VENDING - OTHER REV	В	-54, 903		10. 00	0	
33. 02	A Company of the Comp	В		CENTRAL SERVICES & SUPPLY	14. 00	0	
33. 03		В		MEDICAL RECORDS & LIBRARY	14.00	0	
33. 04	REV	D	-5, 702	WEDICAL RECORDS & LIBRARY	10.00	U	33.04
33. 05	MED SUPPLY SALES -OTHER REV	В	1	MEDICAL SUPPLIES CHARGED TO	71. 00	0	33. 05
33.03	WIED SUFFET SALES -OTTIER REV	ь		PATIENTS	71.00	U	33.03
33. 08	TELEVI SI ON	А		OPERATION OF PLANT	7. 00	0	33. 08
33. 09	PHYSICIAN RECRUITMENT- ADMIN	A		ADMI NI STRATI VE & GENERAL	5. 00	0	
33. 10	LOBBYI NG EXPENSE	A	·	ADMINISTRATIVE & GENERAL	5. 00	0	
33. 11	CRNA	A		ANESTHESI OLOGY	53. 00	0	
33. 12	A Company of the Comp	A		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 13	-	A	· ·	NEW CAP REL COSTS-BLDG &	1. 00	9	33. 13
	PAYMENT			FIXT			
50.00	TOTAL (sum of lines 1 thru 49)		-3, 588, 647				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

<sup>(2)</sup> 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 BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-1305

Peri od: Worksheet A-8-2 From 10/01/2021 09/30/2022 Date/Time Prepared:

1, 604, 677

200.00

2/23/2023 4:28 pm Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov I denti fi er der Component Remuneration Component Component Hours 1.00 2.00 3. 00 5. 00 4 00 6 00 7 00 30.00 ADULTS & PEDIATRICS 1.00 579, 403 579, 403 0 1.00 2.00 50.00 OPERATING ROOM 990, 980 990, 980 0 0 0 2.00 60. 00 LABORATORY 3.00 5, 957 0 5, 957 0 0 0 0 3.00 0 4.00 69. 00 ELECTROCARDI OLOGY 4, 294 4, 294 4.00 Ω 76. 00 ONCOLOGY 5.00 30,000 30,000 0 5.00 6.00 90. 00 CLI NI C 34, 400 34, 400 6.00 0 91. 00 EMERGENCY 7.00 1, 251, 744 0 1, 251, 744 0 7.00 0.00 8.00 0 8.00 0 Ω 0 9.00 0.00 0 9.00 10.00 0.00 0 10.00 1, 292, 101 2, 896, 778 1,604,677 200.00 200.00 Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Provi der Physician Cost Cost of I denti fi er Li mi t Unadjusted RCE Memberships & Component of Malpractice Limit Conti nui ng Share of col Insurance Education 12.00 1.00 2.00 8. 00 9.00 13.00 14. 00 30.00 ADULTS & PEDIATRICS 1.00 0 0 1.00 2.00 50.00 OPERATING ROOM 0 0 0 0 2.00 60. 00 LABORATORY 3.00 0 0 0 0 3.00 0 0 69. 00 ELECTROCARDI OLOGY 0 0 4.00 0 4 00 5.00 76. 00 ONCOLOGY 0 0 0 5.00 0 90. 00 CLI NI C 0 6.00 0 0 0 0 6.00 91. 00 EMERGENCY 0 0 7 00 7.00 0 0 0 0 8.00 0.00 0 8.00 9.00 0.00 0 0 9.00 0 10.00 0.00 0 0 0 C 10.00 o 200.00 200.00 Wkst. A Line # Cost Center/Physician Provi der Adjusted RCE RCE Adjustment I denti fi er Component Limit Di sal I owance Share of col. 14 2.00 1.00 15.00 16.00 17.00 18.00 1.00 30. 00 ADULTS & PEDIATRICS 0 0 0 579, 403 1.00 50. 00 OPERATING ROOM 0 0 0 990, 980 2.00 2.00 0 3.00 60. 00 LABORATORY 0 0 3.00 0 69. 00 ELECTROCARDI OLOGY 0 4, 294 4.00 4.00 5.00 76. 00 ONCOLOGY 0 0 0 30,000 5.00 6.00 90. 00 CLI NI C 0 0 0 6.00 91. 00 EMERGENCY 0 0 0 7.00 7 00 0 0.00 0 8.00 0 0 8.00 9.00 0.00 0 0 9.00 0 0 10.00 0.00 0 10.00 C

200.00

| Period: | Worksheet B | From 10/01/2021 | Part | To 09/30/2022 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-1305

				To	09/30/2022		
			CAPI TAL			2/23/2023 4: 2	8 piii
			RELATED COSTS				
	Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI V	
	·	for Cost	FLXT	BENEFI TS		E & GENERAL	
		Allocation		DEPARTMENT			
		(from Wkst A					
		col. 7)					
	OFNEDAL CEDIUSE OCCT OFNEDO	0	1. 00	4. 00	4A	5. 00	
1 00	GENERAL SERVICE COST CENTERS O0100 NEW CAP REL COSTS-BLDG & FIXT	1 707 005	1 707 005				1 00
1. 00 4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 727, 235 4, 676, 696					1.00 4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	6, 009, 694			7, 170, 310	7, 170, 310	5.00
7. 00	00700 OPERATION OF PLANT	1, 037, 255		103, 118	1, 293, 414	332, 587	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	78, 977	14, 913		96, 195		8. 00
9. 00	00900 HOUSEKEEPI NG	346, 740			406, 637	104, 562	9. 00
10.00	01000 DI ETARY	334, 130			462, 928		10.00
13.00	01300 NURSING ADMINISTRATION	615, 998	11, 000	90, 343	717, 341	184, 456	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	109, 786	23, 255	4, 995	138, 036	35, 494	14.00
15.00	01500 PHARMACY	0	19, 072		19, 072		15.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	353, 093		76, 441	467, 505		16. 00
17. 00	01700 SOCI AL SERVI CE	41, 028	0	9, 894	50, 922	13, 094	17. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	1 700 004	227 424	FO4 44F	2 454 002	(21.040	20.00
30.00	03000 ADULTS & PEDIATRICS	1, 722, 204	227, 434		2, 454, 083		30.00
31. 00 43. 00	03100 I NTENSI VE CARE UNI T 04300 NURSERY	14, 546	0 3, 962	0 3, 019	0 21, 527	0 5, 535	31.00 43.00
43.00	ANCI LLARY SERVICE COST CENTERS	14, 540	3, 702	3,017	21, 527	5, 555	43.00
50. 00	05000 OPERATING ROOM	565, 023	130, 525	352, 570	1, 048, 118	269, 512	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	29, 463			38, 194		52.00
53. 00	05300 ANESTHESI OLOGY	10, 424	763		11, 187	2, 877	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 472, 278			1, 808, 565		54.00
60.00	06000 LABORATORY	1, 470, 254	34, 181	178, 944	1, 683, 379		60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	45, 364	1, 501	0	46, 865	12, 051	63.00
65.00	06500 RESPI RATORY THERAPY	410, 497	19, 269		518, 257	133, 264	65.00
66. 00	06600 PHYSI CAL THERAPY	1, 010, 208			1, 287, 952	331, 183	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	184, 476	0		228, 925		67.00
68. 00	06800 SPEECH PATHOLOGY	165	0	29 0	194		68.00
69. 00 69. 01	06900  ELECTROCARDI OLOGY   06901  CARDI AC REHABI LI TATI ON	8, 901 73, 580	11, 025	_	8, 901 101, 810	2, 289 26, 179	69. 00 69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	73,300	11,023		101, 810	20, 179	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	457, 883	0	ő	457, 883	_	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	124, 149	Ö	ő	124, 149		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 241, 533	0	19, 763	2, 261, 296		73.00
76. 00	03020 ONCOLOGY	150, 736		35, 512	200, 127		76. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	4, 324, 654			5, 540, 794		88. 00
88. 01	08801 RURAL HEALTH CLINIC II	912, 848		,	1, 095, 682		88. 01
88. 02	08802 RURAL HEALTH CLINIC III	292, 489		60, 657	353, 146		88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	718, 310		146, 272	864, 582		88. 03
90.00	09000 CLINIC	300, 111	44, 665		359, 754	· ·	
	09100   EMERGENCY   09200   OBSERVATION BEDS (NON-DISTINCT PART)	2, 583, 265	130, 451	294, 103	3, 007, 819 0	773, 428	91.00
92.00	OTHER REIMBURSABLE COST CENTERS				0		92.00
101 00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
101.00	SPECIAL PURPOSE COST CENTERS		0				101.00
116. 00	11600 HOSPI CE	0	0	0	0	0	116. 00
118.00		34, 453, 993	1, 716, 136		34, 345, 549		
	NONREI MBURSABLE COST CENTERS				· · · · · · · · · · · · · · · · · · ·		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11, 099	0	11, 099		190. 00
	19001 HOMECARE	0	0	0	0		190. 01
	19200 PHYSICIANS' PRIVATE OFFICES	397, 553	0	80, 667	478, 220	122, 969	192.00
	19201 KNOX RHC	0	0	0	0	0	192. 01
	07950 MARKETI NG	203, 749	0	16, 678	220, 427	56, 680	
200.00	, ,				0		200.00
201.00		35, 055, 295	1 727 225	4 400 033	0 DEE 20E		201.00
202.00	p   TOTAL (Sum Fines 110 through 201)	35, 055, 295	1, 727, 235	4, 698, 032	35, 055, 295	1, 170, 310	<sub> </sub> 202.00

Provider CCN: 15-1305

Peri od: Worksheet B From 10/01/2021 Part I To 09/30/2022 Date/Ti me Prepared:

			10	0 77 307 2022	2/23/2023 4: 2	
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 O0100 NEW CAP REL COSTS-BLDG & FLXT						1.00
4.00   00400   EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00   00500   ADMINISTRATIVE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT	1, 626, 001					7.00
8.00   00800   LAUNDRY & LINEN SERVICE	15, 204	136, 134				8.00
9. 00 00900 HOUSEKEEPI NG	9, 358	0	520, 557			9.00
10. 00 01000 DI ETARY	76, 220	0	25, 599	683, 784		10.00
13.00 01300 NURSING ADMINISTRATION	11, 215		3, 767	0	916, 779	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	23, 709		7, 963	0	0	14.00
15. 00 01500 PHARMACY	19, 444	0	6, 530	0	0	15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	38, 712	0	13, 002	0	0	16.00
17. 00   01700   SOCI AL   SERVI CE	0		0	0		17. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	231, 870	29, 458	77, 875	683, 784	517, 331	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0		0	0		31.00
43. 00   04300   NURSERY	4, 039		1, 357	0		43.00
ANCILLARY SERVICE COST CENTERS	1,007	072	1,007		1, 127	10.00
50. 00 05000 OPERATING ROOM	133, 071	30, 622	44, 693	0	115, 628	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 710		910	0	4, 244	52.00
53. 00   05300   ANESTHESI OLOGY	778		261	0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	120, 752			0	0	54.00
60. 00   06000   LABORATORY	34, 848			0	0	60.00
60. 01   06001   BLOOD   LABORATORY	34, 646		11, 704	0	0	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	1, 530	-	514	0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	19, 644		6, 598	0	21, 835	65.00
66. 00   06600 PHYSI CAL THERAPY	59, 310			0	21, 633	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	37, 310	24, 102	17, 720	0	0	67.00
68.00   06800   SPEECH PATHOLOGY		0	0	0	0	68.00
69. 00   06900   ELECTROCARDI OLOGY		0	0	0	0	69.00
· · · · · · · · · · · · · · · · · · ·	_	-	~	0		1
69. 01   06901   CARDI AC REHABI LI TATI ON 70. 00   07000   ELECTROENCEPHALOGRAPHY	11, 240		3, 775	0	0	69.01
· · · · · · · · · · · · · · · · · · ·			0	0	0	70. 00 71. 00
· · · · · · · · · · · · · · · · · · ·			0	0	0	•
72.00   07200   IMPL. DEV. CHARGED TO PATIENTS 73.00   07300   DRUGS CHARGED TO PATIENTS			0	0	1	72. 00 73. 00
75. 00 07500 DRUGS CHARGED TO PATTENTS  76. 00 03020 ONCOLOGY	14 150	0 27	4 750	0		76.00
OUTPATIENT SERVICE COST CENTERS	14, 150		4, 752	0	38, 868	76.00
88. 00   08800   RURAL HEALTH CLINIC	256, 908	2, 298	86, 283	0	0	88. 00
88. 01   08801   RURAL HEALTH CLINIC   I	97, 946			0	0	88. 01
· · · · · · · · · · · · · · · · · · ·				0		ł
88. 02   08802   RURAL HEALTH CLINIC III	41, 196		13, 836	0	0	88. 02
88. 03   08803   RURAL HEALTH CLINIC IV	53, 966		18, 125	0	1	88. 03
90. 00   09000   CLI NI C 91. 00   09100   EMERGENCY	45, 536		15, 294	0	20, 777	90.00
	132, 995	26, 893	44, 668	U	193, 969	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
101.00 10100 HOME HEALTH AGENCY	1	0	O	0	1 0	101 00
SPECIAL PURPOSE COST CENTERS	0	0	U	0	0	101.00
	1 0	1 0			1 0	11/ 00
116. 00 11600 HOSPI CE	0 1, 456, 351	_	400.070	402 704		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 450, 351	135, 420	480, 878	683, 784	910, 779	1118.00
NONREI MBURSABLE COST CENTERS	11 215	1 0	2 000	0	1 0	100 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	11, 315	0	3, 800	-		190. 00 190. 01
190. 01 19001 HOMECARE	150 225	700	25 070	0		
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	158, 335	708	35, 879	0		192.00
192. 01 19201 KNOX RHC			0	0		192.01
194. 00 07950 MARKETI NG	0	1	0	0		194.00
200.00 Cross Foot Adjustments	_	_		^	_	200.00
201.00 Negative Cost Centers	1 404 001	124 124	E20 E53	402 704		201.00
202.00   TOTAL (sum lines 118 through 201)	1, 626, 001	136, 134	520, 557	683, 784	916, 779	12U2. UU

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 10/01/2021 | Part I | To 09/30/2022 | Date/Time Prepared: Provider CCN: 15-1305

COSE CENTER   SERVICE   COSE CENTERS   SUPPLY   14.00   15.00   16.00   17.00   24.00					10	09/30/2022	2/23/2023 4: 2	
SUPPLY		Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL		<u> </u>
CENERAL SERVICE COST CENTERS		·	SERVICES &		RECORDS &	SERVI CE		
ENTRAIL SERVICE COST CENTERS			SUPPLY		LI BRARY			
1.00   1.00			14. 00	15. 00	16. 00	17. 00	24. 00	
0.000   DADIO BINDLOYER ENDERITS DEPARTMENT								
0.0000   ADMIN STRATIVE & GENERAL								•
7. 00 00700 (DPERATION OF PLANT								•
8.00								ł
9.00   0.0900   HOUSEKEEPING     9.00   10.00   13.00	1	•						ł
10.00   01000   ILETARY								1
13.0 0   01300 NURSING ADMINISTRATION		•						ł
14. 00   10400   CENTRAL SERVICES & SUPPLY   205, 202     14. 00   16. 00   17. 00   17. 00   17. 00   17. 00   17. 00   17. 00   17. 00   18. 00   17. 00   18. 00	1	•						ł
15.00   10500   PHARMACY   0   0   0   639, 433   64, 016   16.00   17.00   MEDICAL SERVICE   0   0   0   0   639, 433   64, 016   17.00   17.00   17.00   SOCIAL SERVICE   0   0   0   0   0   0   0   0   0			205, 202					ł
16. 00   01600   MEDICAL RECORDS & LIBRARY   0   0   6.39, 433   0   64, 016   17.00   1700   01700   0500   61, 185   187   17.00   1700   01700			0	49, 950				1
17. 00   01700   SCI AL SERVICE   0   0   0   0   64,016   17. 00	16.00 0160	OO MEDICAL RECORDS & LIBRARY	o		639, 433			16.00
30.00			0	0	0	64, 016		17.00
31.00   03100   INTERSIVE CARE UNIT   0   0   0   0   37, 329   43.00	I NPA	TIENT ROUTINE SERVICE COST CENTERS						
ABOUG   ABOU			0		17, 026	59, 743	4, 702, 210	•
ANCIL LARY SERVICE COST CENTERS   50.00		•	· ·			- 1		•
SOLIC   GOSDO   GEPEATING ROOM   CO   CO   CO   CO   CO   CO   CO			0]	0	152	0]	37, 329	43.00
S2 00   05200   05200   05200   05200   05200   0530				ما	F/ 2F1	4 070	1 700 1/0	
53.00   08300   ABSTHESI DLOGY   0 0 7,560   0 2,2643   53.00			0					1
SALON   OSAGO   RADIO LOGY-DIAGNOSTIC   0 0 143, 429 0 2, 599, 031 54, 00			0			- 1		1
60.00   0.0000   LABORATORY   0   0   128, 181   0   2, 291, 294   60.00			0			0		1
60.01   06001   06001   06000   1200		•		0		0		1
63.00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   1, 653   0   62, 613   63.00   65.00   06500   RESPIRATORY THERAPY   0   0   0   6,045   0   705,643   65.00   66.00   06600   PHYSI CAL THERAPY   0   0   0   27,693   0   1,750,160   66.00   67.00   06700   06700   06700   06700   06800   0			o o	0		Ö		1
65.00   06500   RESPI RATORY THERAPY   0   0   0   6,045   0   705,643   65.00   66.00   06600 PHYSI CAL THERAPY   0   0   0   27,693   0   1,750,160   66.00   67.00   06700   0CCUPATI ONAL THERAPY   0   0   0   5,515   0   293,306   67.00   68.00   06800   SPEECH PATHOLOGY   0   0   5,515   0   293,306   67.00   68.00   06800   SPEECH PATHOLOGY   0   0   5,911   0   17,101   69.01   06900   ELCETROCARDI OLOGY   0   0   5,911   0   17,101   69.01   06900   ELCETROCARDI OLOGY   0   0   0   0   0   0   69.01   06901   CARDI ACR REHABI LITATI ON   0   0   0   0   0   0   0   69.01   06901   CARDI ACR REHABI LITATI ON   0   0   0   0   0   0   0   69.01   07000   07000   ELCETROCHEPHALOGRAPHY   0   0   0   0   0   0   0   69.01   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   176,600   0   28,913   0   781,136   71.00   69.01   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   28,602   0   49,950   84,196   0   2,976,990   73.00   73.00   07300   DRUGS CHARGED TO PATI ENTS   0   49,950   84,196   0   2,976,990   73.00   74.00   03020   ONCOLOGY   0   0   0   3,644   0   313,028   76.00   68.00   08000   RURAL HEALTH CLINIC II   0   0   6,514   0   1,515,219   88.01   88.01   08802   RURAL HEALTH CLINIC II   0   0   6,514   0   1,515,219   88.01   88.02   08802   RURAL HEALTH CLINIC II   0   0   6,514   0   1,516,219   88.03   88.03   08803   RURAL HEALTH CLINIC II   0   0   0   0   1,541   18   88.03   99.00   09000   CLINIC   0   0   0   0   0   0   0   0   99.00   09000   CLINIC   0   0   0   0   0   0   0   99.00   09000   0BSERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   0   010   0100   HOWE HEALTH AGENCY   0   0   0   0   0   0   0   0   010   0100   HOWE HEALTH AGENCY   0   0   0   0   0   0   0   0   010   0100   HOWE HEALTH AGENCY   0   0   0   0   0   0   0   0   010   0100   0100   HOWE AGRE   0   0   0   0   0   0   0   0   0   010   0100   0100   HOWE AGRE   0   0   0   0   0   0   0   0   0			o	0		o		•
66.00   06600   PHYSI CAL THERAPY   0   0   27,693   0   1,750,160   66.00   67.00   06700   COUPDATI ONAL THERAPY   0   0   0   5,515   0   293,30   67.00   68.00   06800   SPEECH PATHOLOGY   0   0   5,515   0   293,30   67.00   69.01   06901   CARDIAC REHABELLITATION   0   0   5,911   0   17,101   69.00   70.00   07000   CLECTROCARDIOLOGY   0   0   0   0   0   0   0   70.00   07000   CARDIAC REHABELLITATION   0   0   0   0   0   0   0   71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   176,600   0   28,913   0   781,136   71.00   71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   176,600   0   28,913   0   781,136   71.00   71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   28,602   0   4,683   0   189,358   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   0   49,950   84,196   0   2,976,909   73.00   73.00   07300   DRUGS CHARGED TO PATIENTS   0   49,950   84,196   0   2,976,909   73.00   73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   3,644   0   313,028   76.00   74.00   003020   ONCOLOGY   0   0   0   3,444   0   313,028   76.00   75.00   07000   NUTPATIENT SERVICE COST CENTERS   0   0   0   43,440   0   7,354,470   88.00   75.00   08800   RURAL HEALTH CLINIC   1   0   0   6,514   0   1,515,219   88.01   75.00   08801   RURAL HEALTH CLINIC   1   0   0   6,514   0   1,515,219   88.01   75.00   07000   DRUGSCHARGED COST CENTERS   0   0   0   0   0   0   0   75.00   07000   DRUGSCHARGED COST CENTERS   0   0   0   0   0   0   0   75.00   07000   DRUGSCHARGED COST CENTERS   0   0   0   0   0   0   0   0   75.00   07000   DRUGSCHARGED COST CENTERS   0   0   0   0   0   0   0   0   75.00   07000   DRUGSCHARGED COST CENTERS   0   0   0   0   0   0   0   0   0			o	0		O		1
68.00   06800   SPEECH PATHOLOGY   0   0   52   0   296   68.00   69.01   06901   ELECTROCARDIOLOGY   0   0   0   5, 911   0   17, 101   69.00   69.01   06901   CARDIA C. REHABI LITATION   0   0   0   2, 526   0   145, 530   70.00   07000   ELECTROENCEPHALOGRAPHY   0   0   0   0   0   0   71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   176, 600   0   28, 913   0   781, 136   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   28, 602   0   4, 683   0   189, 358   72.00   73.00   07300   RUGS CHARGED TO PATIENTS   0   49, 950   84, 196   0   2, 976, 909   73.00   73.00   07300   DRUGS CHARGED TO PATIENTS   0   49, 950   84, 196   0   2, 976, 909   73.00   73.00   07300   DRUGS CHARGED TO PATIENTS   0   49, 950   84, 196   0   2, 976, 909   73.00   74.00   03020   DNCOLOGY   0   0   0   43, 440   0   313, 028   76.00   75.00   03020   DNCOLOGY   0   0   0   43, 440   0   7, 354, 470   88.00   75.00   08800   RURAL HEALTH CLINIC II   0   0   0   6, 514   0   1, 515, 219   88.01   75.00   08801   RURAL HEALTH CLINIC II   0   0   0   5, 190   0   1, 64, 181   88.03   75.00   09000   CLINIC   0   0   0   0   0   0   0   0   75.00   09000   CLINIC   0   0   0   0   0   0   0   75.00   09000   DRIFFORM   0   0   0   0   0   0   0   75.00   09000   DRIFFORM   0   0   0   0   0   0   0   75.00   09000   DRIFFORM   0   0   0   0   0   0   0   75.00   09000   DRIFFORM   0   0   0   0   0   0   0   75.00   09000   DRIFFORM   0   0   0   0   0   0   0   0   75.00   09000   DRIFFORM   0   0   0   0   0   0   0   0   75.00   090			o	0		О		1
69.00   06900   LECTROCARDIOLOGY   0   0   5,911   0   17,101   69.00	67.00 0670	O OCCUPATIONAL THERAPY	o	0	5, 515	0	293, 306	67.00
69.01   06901   CARDI AC REHABILITATION   0   0   2,526   0   145,530   69.01   70.00   07000   ELECTROENCEPHALOGRAPHY   0   0   0   0   0   0   0   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   176,600   0   28,913   0   781,136   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   176,600   0   28,913   0   781,136   71.00   07300   DRUGS CHARGED TO PATIENTS   28,602   0   4,683   0   189,358   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   0   49,950   84,196   0   2,976,909   73.00   07300   DRUGS CHARGED TO PATIENTS   0   49,950   84,196   0   2,976,909   74.00   03020   ONCOLOGY   0   0   0   3,644   0   313,028   75.00   07300   DRUGS CHARGED TO PATIENTS   0   49,950   75.00   03020   ONCOLOGY   0   0   0   75.00   03020   ONCOLOGY   0   0   0   75.00   03020   ONCOLOGY   0   0   0   75.00   03020   ONCOLOGY   0   0   75.00   03020   ONCOLOGY   0   0   0   75.00   03020   ONCOLOGY   0   0   75.00   03020   ONCOLOGY   0   0   75.00   03020   ONCOLOGY   0   0   0   75.00   03020   ONCOLOGY   0   0   75.00   03020   ONCOLOGY   0   0   0   0   0   75.00   03020   ONCOLOGY   0   0   0   0   75.00   03020   00020	68. 00 0680	OO SPEECH PATHOLOGY	0	0	52	0	296	68. 00
70.00   07000   ELECTROENCEPHALOGRAPHY   0   0   0   0   0   0   70.00			0	0	5, 911	0	17, 101	69. 00
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   176,600   0   28,913   0   781,136   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   28,602   0   4,683   0   189,358   72. 00   73			0	0		0		1
72. 00   07200   IMPL DEV CHARGED TO PATIENTS   28,602   0   4,683   0   189,358   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   49,950   84,196   0   2,976,909   73. 00   76. 00   03020   ONCOLOGY   0   0   0   3,644   0   313,0026   76. 00   00   00   00   00   00   00   00		•	0	0	-	0		ł
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   49,950   84,196   0   2,976,909   73. 00   76. 00   03020   ONCOLOGY   0   0   0   3,644   0   313,028   76. 00   00000000000000000000000000000000	1	•				0		1
76. 00   03020   ONCOLOGY   O   O   O   O   O   O   O   O   O						-1		1
SB. 00   OBBOOR RURAL HEALTH CLINIC   O   O   43, 440   O   7, 354, 470   88. 00			-1					1
88. 00			ı o		3, 044	<u> </u>	313, 020	70.00
88. 01 08801 RURAL HEALTH CLINIC III 0 0 0 6,514 0 1,515,219 88. 01 88. 02 08802 RURAL HEALTH CLINIC III 0 0 0 1,571 0 500,557 88. 02 88. 03 08803 RURAL HEALTH CLINIC IV 0 0 0 5,190 0 1,164,181 88. 03 0803 RURAL HEALTH CLINIC IV 0 0 0 5,190 0 1,164,181 88. 03 0800 RURAL HEALTH CLINIC IV 0 0 0 5,190 0 1,164,181 88. 03 0800 RURAL HEALTH CLINIC IV 0 0 0 0 5,190 0 1,164,181 88. 03 0800 RURAL HEALTH CLINIC IV 0 0 0 0 5,190 0 1,164,181 88. 03 0800 RURAL HEALTH CLINIC IV 0 0 0 0 0 5,190 0 1,164,181 88. 03 08 0 1,164,181 88. 03 08 0 1,164,181 88. 03 08 0 1,164,181 88. 03 08 0 1,164,181 88. 03 08 0 1,164,181 88. 03 08 0 1,164,181 88. 03 09 09,100 PURCHER FOR FOR FOR FOR FOR FOR FOR FOR FOR FO			0	0	43 440	0	7 354 470	88 00
88. 02 08802 RURAL HEALTH CLINIC III 0 0 0 1,571 0 500,557 88. 02 88. 03 08803 RURAL HEALTH CLINIC IV 0 0 0 5,190 0 1,164,181 88. 03 90. 00 09000 CLINIC 0 0 0 3,508 0 537,376 90. 00 9100 EMERGENCY 0 0 0 55,011 0 4,234,783 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			o					1
88. 03		•	o	0		o		•
91. 00			o	0		O		•
92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   92. 00   0THER REI MBURSABLE COST CENTERS   101. 00   10100   HOME HEALTH AGENCY   0   0   0   0   0   101. 00   0   0   101. 00   0   0   0   0   0   0   0   0   116. 00   0   0   0   0   0   0   0   0   0	90.00 0900	OO CLI NI C	o	0	3, 508	O	537, 376	90.00
OTHER REIMBURSABLE COST CENTERS   O O O O O O O O O O O O O O O O O O	91.00 0910	OO EMERGENCY	0	0	55, 011	0	4, 234, 783	91.00
101.00   10100   HOME   HEALTH   AGENCY   0   0   0   0   0   0   101.00		,						92.00
SPECIAL PURPOSE COST CENTERS   116.00   11600   HOSPI CE   SUBTOTALS (SUM OF LINES 1 through 117)   205, 202   49, 950   639, 433   64, 016   33, 953, 009   118.00   NONREI MBURSABLE COST CENTERS			. 1		-	.1		
116. 00 116. 00 118. 00  SUBTOTALS (SUM OF LINES 1 through 117)  NONREI MBURSABLE COST CENTERS  190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN  190. 01 19001 HOMECARE  192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES  192. 01 19201 KNOX RHC  194. 00 07950 MARKETI NG  205. 202  0 0 0 0 0 0 0 29, 068 190. 00  192. 01 19200 PHYSI CI ANS' PRI VATE OFFI CES  0 0 0 0 0 0 796, 111 192. 00  192. 01 19200 KNOX RHC  0 0 0 0 0 0 0 192. 01  194. 00 07950 MARKETI NG  0 0 0 0 0 0 277, 107 194. 00  200. 00  Cross Foot Adjustments  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0]	0	0]	0	101.00
118.00   SUBTOTALS (SUM OF LINES 1 through 117)   205, 202   49, 950   639, 433   64, 016   33, 953, 009   118.00			ما	٥		ما	0	114 00
NONREI MBURSABLE COST CENTERS   190. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   29, 068   190. 00   190. 01   19001   HOMECARE   0   0   0   0   0   0   190. 01   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   0   0   0   0   796, 111   192. 00   192. 01   192.01   192.01   KNOX RHC   0   0   0   0   0   0   192. 01   194. 00   07950   MARKETI NG   0   0   0   0   277, 107   194. 00   200. 00   Cross Foot Adjustments   0   0   0   0   0   0   0   201. 00			l I			l l		
190. 00			203, 202	49, 930	039, 433	64,010	33, 933, 009	1110.00
190. 01 19001 HOMECARE 0 0 0 0 0 0 190. 01 192. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 796, 111 192. 00 192. 01 19201 KNOX RHC 0 0 0 0 0 0 192. 01 194. 00 07950 MARKETI NG 0 0 0 0 277, 107 194. 00 200. 00 Cross Foot Adjustments 0 Negative Cost Centers 0 0 0 0 0 0 0 0 201. 00			0	0	0	0	29 068	190 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 796, 111 192. 00 192. 01 19201 KNOX RHC 0 0 0 0 0 192. 01 194. 00 07950 MARKETI NG 0 0 0 0 277, 107 194. 00 200. 00 Cross Foot Adjustments 0 Negative Cost Centers 0 0 0 0 0 0 0 201. 00			ol			- 1		
194. 00 07950 MARKETING 0 0 0 277, 107 194. 00 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 201. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			o			o		
200.00   Cross Foot Adjustments   0 200.00   201.00   Negative Cost Centers   0 0 0 0 0 0 0 201.00		•	o	o	0	o	·	1
201.00   Negative Cost Centers   0   0   0   0   201.00			0	O	0	О		
202.00   TOTAL (sum lines 118 through 201)   205,202  49,950  639,433  64,016  35,055,295 202.00			0	0	0	0		
	202. 00	IUIAL (sum lines 118 through 201)	205, 202	49, 950	639, 433	64, 016	35, 055, 295	202. 00

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

From 10/01/2021 Part I 09/30/2022 Date/Time Prepared: 2/23/2023 4:28 pm Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 4, 702, 210 30.00 03100 INTENSIVE CARE UNIT 31.00 0 31.00 04300 NURSERY 37, 329 43.00 43.00 0 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0 1, 702, 168 50.00 05200 DELIVERY ROOM & LABOR ROOM 0000000000000000 52.00 52.00 56, 648 05300 ANESTHESI OLOGY 53.00 22,663 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 2, 599, 031 54.00 06000 LABORATORY 60.00 2, 291, 294 60.00 60 01 06001 BLOOD LABORATORY Ω 60 01 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 62,613 63.00 65.00 06500 RESPIRATORY THERAPY 705, 643 65.00 06600 PHYSI CAL THERAPY 66.00 1, 750, 160 66.00 06700 OCCUPATI ONAL THERAPY 67 00 293, 306 67 00 06800 SPEECH PATHOLOGY 68.00 296 68.00 06900 ELECTROCARDI OLOGY 17, 101 69.00 69.00 69.01 06901 CARDIAC REHABILITATION 145, 530 69.01 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 781, 136 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 189, 358 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 976, 909 73.00 03020 ONCOLOGY 0 76.00 313, 028 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 7, 354, 470 88.00 08801 RURAL HEALTH CLINIC II 0 88.01 1, 515, 219 88.01 08802 RURAL HEALTH CLINIC III 88.02 500, 557 88 02 88.03 08803 RURAL HEALTH CLINIC IV 0 1, 164, 181 88.03 0 09000 CLI NI C 90.00 537.376 90.00 09100 EMERGENCY 91.00 91.00 4, 234, 783 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 116.00 0 SUBTOTALS (SUM OF LINES 1 through 117) 33, 953, 009 118.00 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 29,068 190. 00 190. 01 19001 HOMECARE 0 190.01 192.00 19200 PHYSICIANS' PRIVATE OFFICES 796, 111 0 0 192.00 192. 01 19201 KNOX RHC 192.01 194. 00 07950 MARKETI NG 277, 107 194.00 200.00 Cross Foot Adjustments 0 200.00 0 201.00 201.00 Negative Cost Centers C 35, 055, 295 202.00 TOTAL (sum lines 118 through 201) 202.00

| Peri od: | Worksheet B | From 10/01/2021 | Part II | To 09/30/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1305

				To	09/30/2022	Date/Time Pre 2/23/2023 4:2	
	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIV E & GENERAL	o piii
		0	1. 00	2A	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS			'			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	21, 336		21, 336		4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	0	317, 327		3, 831	321, 158	5. 00
7.00	00700 OPERATION OF PLANT	0	153, 041		468		1
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	14, 913 9, 179		10 230		8. 00 9. 00
10.00	01000 DI ETARY	0	74, 761		246		1
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	11, 000		410		1
14.00	01400 CENTRAL SERVICES & SUPPLY	0	23, 255		23		1
15.00	01500 PHARMACY	0	19, 072	19, 072	0	220	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	37, 971	1	347	5, 384	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	45	586	17. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS		227 424	227 424	2 202	20.274	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	227, 434 0		2, 292 0	28, 264 0	30.00 31.00
	04300 NURSERY		_		14	248	
43.00	ANCI LLARY SERVI CE COST CENTERS		5, 702	3, 702		240	1 43.00
50.00	05000 OPERATING ROOM	0	130, 525	130, 525	1, 602	12, 071	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	2, 658		28		52.00
53.00	05300 ANESTHESI OLOGY	0	763	1	0		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	118, 442		990		
60.00	06000 LABORATORY	0	34, 181		813	•	60.00
60. 01 63. 00	06001 BLOOD LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	0	1 501		0		60. 01 63. 00
65.00	06500 RESPIRATORY THERAPY	0	1, 501 19, 269		402	5, 969	1
66. 00	06600 PHYSI CAL THERAPY	0	43, 533		1, 064		1
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		202		67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	0	0	103	69. 00
69. 01	06901 CARDI AC REHABI LI TATI ON	0	11, 025		78	1	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	5, 273	1
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0 90	1, 430 26, 043	1
	03020 ONCOLOGY	0	13, 879		161	2, 305	1
70.00	OUTPATIENT SERVICE COST CENTERS		10,077	10,077	101	2,000	70.00
88.00	08800 RURAL HEALTH CLINIC	0	251, 993	251, 993	4, 372	63, 819	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	0	0	831	12, 619	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	0	0	276		1
88. 03	08803 RURAL HEALTH CLINIC IV	0	0	0	665	9, 957	88. 03
90.00	09000   CLI NI C   09100   EMERGENCY	0	44, 665		68	4, 143	1
		0	130, 451	130, 451 0	1, 336	34, 641	91.00
92.00	O9200   OBSERVATION BEDS (NON-DISTINCT PART)   OTHER REIMBURSABLE COST CENTERS			l o			92.00
101 00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS	_	-	-1	-		
116.00	11600 HOSPI CE	0	0	0	0	0	116.00
118.00		0	1, 716, 136	1, 716, 136	20, 894	312, 983	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11, 099		0		190. 00
	19001 HOMECARE		0	0	0		190. 01
	19200 PHYSICIANS' PRIVATE OFFICES  19201 KNOX RHC		0	0	366 0		192. 00 192. 01
	1920   KNOX   KHC   07950   MARKETI NG		0	0	76		194. 00
200.00					70		200.00
201.00	1 1		О	Ö	0		201.00
202.00		0	1, 727, 235	1, 727, 235	21, 336		
	· · · · · · · · · · · · · · · · · · ·			'			

Provider CCN: 15-1305

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 10/01/2021 Part II
To 09/30/2022 Date/Time Prepared: 2/23/2023 4:28 pm

				'`	0 77 307 2022	2/23/2023 4: 2	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
	'	PLANT	LINEN SERVICE			ADMINISTRATIO	
						N	
		7. 00	8. 00	9. 00	10.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	168, 405					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 575	17, 606				8.00
9.00	00900 HOUSEKEEPI NG	969	0	15, 061			9.00
10.00	01000 DI ETARY	7, 894	0	741	88, 974		10.00
13.00	01300 NURSING ADMINISTRATION	1, 162	0	109	. 0	20, 943	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	2, 456	0	230	0	0	14.00
15. 00	01500 PHARMACY	2, 014	0	189	0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	4, 009	0		0	0	16.00
	01700 SOCIAL SERVICE	0	0		0	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			-1			
30.00	03000 ADULTS & PEDIATRICS	24, 015	3, 810	2, 253	88, 974	11, 818	30.00
31. 00	03100 I NTENSI VE CARE UNI T	0	0		0	l	31.00
	04300 NURSERY	418	77	39	0		43.00
	ANCILLARY SERVICE COST CENTERS			0,1			10.00
50.00	05000 OPERATING ROOM	13, 782	3, 959	1, 293	0	2, 641	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	281	0	26	0	97	52.00
53. 00	05300 ANESTHESI OLOGY	81	0	8	0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	12, 506	2, 674		0	0	54.00
60.00	06000 LABORATORY	3, 609	41	339	0	o o	60.00
60. 01	06001 BLOOD LABORATORY	0,007	0		0	Ö	60.01
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	159	0	15	0	o o	63.00
65. 00	06500 RESPIRATORY THERAPY	2, 035	0		0	499	65.00
66. 00	06600 PHYSI CAL THERAPY	6, 143	3, 117	576	0	1,7	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0, 110	0,117	0	0	o o	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	,	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	n	0	0	,	69.00
69. 01	06901 CARDI AC REHABI LI TATI ON	1, 164	0		0	o o	69. 01
	07000 ELECTROENCEPHALOGRAPHY	1, 101	0	0	0	o o	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	l o	0	l ĭ	0	Ö	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
	03020 ONCOLOGY	1, 466	4	137	0	1	76.00
70.00	OUTPATIENT SERVICE COST CENTERS	1, 100		107		000	70.00
88. 00	08800 RURAL HEALTH CLINIC	26, 606	297	2, 499	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	10, 144	57	952	0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	4, 267	0		0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	5, 589	0	524	0	0	88. 03
90. 00	09000 CLINIC	4, 716	0	442	0	475	90.00
91. 00	09100 EMERGENCY	13, 774	3, 478		0	4, 431	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	15,774	3, 470	1, 272	O	4, 451	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
101 00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
101.00	SPECIAL PURPOSE COST CENTERS	0	0	<u> </u>			1101.00
116 00	11600 HOSPI CE	0	0	O	0	0	116. 00
118.00		150, 834	17, 514		88, 974	20 043	118.00
110.00	NONREI MBURSABLE COST CENTERS	130,034	17, 314	13, 713	00, 774	20, 743	1110.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 172	0	110	0	0	190. 00
	19001 HOMECARE	1, 1/2	0		0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	16, 399	92	-	0		190.01
	19200 PHYSICIANS PRIVATE OFFICES	10, 399	92		0		192.00
	07950 MARKETI NG	0	0		0		194. 00
200.00			1	ا	U		200.00
200.00		_	0		^	_	200.00
201.00		168, 405	_	-	88, 974		201.00
202.00	TOTAL (Sum TIMES TTO LINOUGH 201)	100, 405	17,000	15,001	00, 9/4	20, 943	1202. UU

Period: Worksheet B From 10/01/2021 Part II Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-1305

				1	09/30/2022	Date/Time Pre 2/23/2023 4:2	
	Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	Subtotal	26 pili
		14. 00	15. 00	16. 00	17. 00	24.00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1. 00 4. 00	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
4. 00 5. 00	OO400	+					4. 00 5. 00
7. 00	00700 OPERATION OF PLANT						7.00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
13.00	01300 NURSING ADMINISTRATION						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	27, 554					14.00
15. 00	01500 PHARMACY	0	21, 495				15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	0				16.00
17. 00	01700 SOCIAL SERVICE	0	0	0	631		17. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS		0	1 201	F00	200 720	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	0		589 0		
43. 00	04300 NURSERY	0	0	-	0		1
43.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	0		<u> </u>	4,003	43.00
50.00	05000 OPERATING ROOM	0	0	4, 232	42	170, 147	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	58	0		1
53.00	05300 ANESTHESI OLOGY	0	0	569	0	1, 550	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	10, 771	0	167, 385	54.00
60.00	06000 LABORATORY	0	0	9, 644	0	68, 014	1
60. 01	06001 BLOOD LABORATORY	0	0	0	· ·	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	124		2, 339	1
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0	455 2, 083	l .	28, 820 71, 349	
67.00	06700 OCCUPATI ONAL THERAPY	0	0	415	l i	3, 254	1
68. 00	06800 SPEECH PATHOLOGY	0	0	413	0	3, 234	1
69. 00	06900 ELECTROCARDI OLOGY	o	0	445	_	548	1
69. 01	06901 CARDI AC REHABI LI TATI ON	o	0	190	l .	13, 739	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	23, 713	0	2, 175	0	31, 161	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3, 841	0	352		5, 623	1
73.00	07300 DRUGS CHARGED TO PATIENTS	0	21, 495				1
76. 00	03020 ONCOLOGY	0	0	274	0	19, 114	76. 00
88. 00	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC	O	0	3, 268	O	352, 854	88. 00
88. 01	08801 RURAL HEALTH CLINIC	0	0				1
88. 02	08802 RURAL HEALTH CLINIC III	0	0	118		9, 128	1
88. 03	08803 RURAL HEALTH CLINIC IV	0	0	390		17, 125	1
90.00	09000 CLI NI C	o	0	264	o	54, 773	1
91.00	09100 EMERGENCY	0	0	4, 139	0		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS						144,00
	11600 HOSPI CE	0	0				116.00
118.00		27, 554	21, 495	48, 087	631	1, 688, 708	]118.00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	0	0	12 500	190. 00
	19001 HOMECARE	0	0		l .		190.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0				192.00
	19201 KNOX RHC	ol	Ō	Ö	· ·		192. 01
	07950 MARKETI NG	o	0	0	O	2, 615	194.00
200.00	Cross Foot Adjustments						200.00
201.00		O	0	0			201.00
202.00	TOTAL (sum lines 118 through 201)	27, 554	21, 495	48, 087	631	1, 727, 235	202.00

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

From 10/01/2021 Part II 09/30/2022 Date/Time Prepared: 2/23/2023 4:28 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 0 390, 730 30.00 03100 INTENSIVE CARE UNIT 0 31.00 31.00 C 04300 NURSERY 0 4, 863 43.00 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0 170, 147 50.00 05200 DELIVERY ROOM & LABOR ROOM 0000000000000000 52.00 3,588 52.00 1, 550 05300 ANESTHESI OLOGY 53.00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 167, 385 54.00 06000 LABORATORY 60.00 68, 014 60.00 60 01 06001 BLOOD LABORATORY Ω 60 01 06300 BLOOD STORING, PROCESSING & TRANS. 2, 339 63.00 63.00 65.00 06500 RESPIRATORY THERAPY 28, 820 65.00 06600 PHYSI CAL THERAPY 66.00 71, 349 66.00 06700 OCCUPATI ONAL THERAPY 67 00 3, 254 67 00 06800 SPEECH PATHOLOGY 68.00 68.00 06900 ELECTROCARDI OLOGY 548 69.00 69.00 69.01 06901 CARDIAC REHABILITATION 13, 739 69.01 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 31, 161 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 5, 623 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 53, 963 73.00 03020 ONCOLOGY 0 19, 114 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 352, 854 88.00 0 08801 RURAL HEALTH CLINIC II 88.01 88.01 25.093 08802 RURAL HEALTH CLINIC III 88.02 9, 128 88 02 88.03 08803 RURAL HEALTH CLINIC IV 0 0 17, 125 88.03 09000 CLI NI C 90.00 54.773 90.00 09100 EMERGENCY 91.00 91.00 193, 542 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 116.00 0 SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 118.00 0 1, 688, 708 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 12, 509 190. 00 190. 01 19001 HOMECARE 0 190.01 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0000 23, 403 192.00 192. 01 19201 KNOX RHC 192.01 194. 00 07950 MARKETI NG 2,615 194.00 200.00 Cross Foot Adjustments 200.00 201.00 201.00 Negative Cost Centers C 202.00 TOTAL (sum lines 118 through 201) 1, 727, 235 202.00

	Financial Systems LOCATION - STATISTICAL BASIS	PULASKI MEMORI	Provider C	CN: 15-1305 P	In Lie eriod:	u of Form CMS-: Worksheet B-1	
0001 AE	ESSATION STATISTICAL BIOLO		Trovider o	F	rom 10/01/2021 o 09/30/2022	Date/Time Pre	pared:
	Cost Center Description	CAPI TAL RELATED COSTS NEW BLDG & FI XT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	28 pm
		1. 00	4. 00	5A	5. 00	7. 00	
	ENERAL SERVICE COST CENTERS						
4. 00 0 5. 00 0 7. 00 0 8. 00 0 9. 00 0	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY	70, 188 867 12, 895 6, 219 606 373 3, 038	19, 404, 019 3, 482, 995 425, 905 9, 522 209, 477 223, 188	-7, 170, 310 0 0 0 0	1, 293, 414 96, 195 406, 637	64, 810 606 373 3, 038	8. 00 9. 00
13. 00 0 14. 00 0 15. 00 0 16. 00 0 17. 00 0	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	447 945 775 1, 543	373, 141 20, 629 0 315, 721 40, 864	0 0	717, 341 138, 036 19, 072 467, 505	447 945 775 1, 543 0	13.00 14.00 15.00 16.00
30. 00 0 31. 00 0	NPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04300 NURSERY	9, 242 0 161	2, 083, 485 0 12, 469	0	0	9, 242 0 161	31.00
50. 00 0	NOTILLARY SERVICE COST CENTERS 15000 OPERATING ROOM 15200 DELIVERY ROOM & LABOR ROOM	5, 304	1, 456, 204 25, 084		1, 048, 118	5, 304 108	50.00
54. 00 0 60. 00 0 60. 01 0	195300 ANESTHESI OLOGY 195400 RADI OLOGY-DI AGNOSTI C 196000 LABORATORY 196001 BLOOD LABORATORY 196300 BLOOD STORI NG, PROCESSI NG & TRANS.	31 4, 813 1, 389 0 61	0 899, 754 739, 084 0	0	1, 808, 565 1, 683, 379 0	31 4, 813 1, 389 0 61	54. 00 60. 00 60. 01
65. 00 0 66. 00 0 67. 00 0 68. 00 0	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	783 1, 769 0 0	365, 491 967, 349 183, 585 120		518, 257 1, 287, 952 228, 925 194	783 2, 364 0 0	65. 00 66. 00 67. 00 68. 00
69. 01 0 70. 00 0 71. 00 0 72. 00 0	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHABILI TATI ON 077000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	0 448 0 0 0	0 71, 063 0 0 0 81, 628	0 0	101, 810 0 457, 883 124, 149	0 448 0 0 0	69. 01 70. 00 71. 00 72. 00
76.00 0	03020 ONCOLOGY	564	146, 674	•		564	1
O	UTPATIENT SERVICE COST CENTERS						
88. 01 0 88. 02 0 88. 03 0 90. 00 0 91. 00 0	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II 08802 RURAL HEALTH CLINIC III 08803 RURAL HEALTH CLINIC IV 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	10, 240 0 0 0 1, 815 5, 301	3, 982, 125 755, 150 250, 528 604, 140 61, 862 1, 214, 721	0 3 0 0 0 2	1, 095, 682 353, 146 864, 582 359, 754	2, 151	88. 01 88. 02 88. 03 90. 00
	THER REIMBURSABLE COST CENTERS	1					92.00
101.001	0100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
116. 00 1 118. 00	PECIAL PURPOSE COST CENTERS  1600 HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117)	0 69, 737	0 19, 001, 958				116. 00 118. 00
190. 00 1 190. 01 1 192. 00 1 192. 01 1	ONREIMBURSABLE COST CENTERS 9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN HOMECARE 9200 PHYSICIANS' PRIVATE OFFICES 9201 KNOX RHC NOY SHOP MARKETING Cross Foot Adjustments	451 0 0 0 0	0 333, 176 0 68, 885	0 0	0	0 6, 311 0	190. 00 190. 01 192. 00 192. 01 194. 00 200. 00
201. 00 202. 00	Negative Cost Centers Cost to be allocated (per Wkst. B, Part I)	1, 727, 235	4, 698, 032	2	7, 170, 310	1, 626, 001	201.00
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	24. 608694	0. 242116 21, 336	1	0. 257139 321, 158	25. 088736 168, 405	
205. 00 206. 00	Unit cost multiplier (Wkst. B, Part		0. 001100	b	0. 011517	2. 598442	205. 00 206. 00
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00
							-

COST A	LLOCATION - STATISTICAL BASIS		Provi der CC		eri od:	Worksheet B-1	
					rom 10/01/2021 o 09/30/2022		
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	2/23/2023 4: 2 CENTRAL	8 pm
	cost center bescription	LINEN SERVICE	(SQUARE	(MEALS	ADMI NI STRATI O	SERVICES &	
		(POUNDS OF	FEET)	SERVED)	N	SUPPLY	
		LAUNDRY)			(DI RECT	(100%)	
		8. 00	9. 00	10. 00	NRSI NG HRS) 13.00	14. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
7. 00	00700 OPERATION OF PLANT						7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	99, 537					8.00
9. 00	00900 HOUSEKEEPI NG	0	61, 778				9. 00
	01000 DI ETARY 01300 NURSI NG ADMI NI STRATI ON	0	3, 038 447	100 0			10.00 13.00
	01400 CENTRAL SERVICES & SUPPLY	0	945	0	70, 031	3, 595, 470	14.00
	01500 PHARMACY	0	775	0	0	0	15. 00
	01600 MEDICAL RECORDS & LIBRARY	0	1, 543	0		0	16.00
17. 00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	17. 00
30. 00	03000 ADULTS & PEDIATRICS	21, 539	9, 242	100	44, 495	0	30.00
31.00	03100 INTENSIVE CARE UNIT	0	o	0	0	0	31.00
43.00	04300 NURSERY	433	161	0	355	0	43.00
50. 00	ANCILLARY SERVICE COST CENTERS  05000 OPERATING ROOM	22, 389	5, 304	0	9, 945	0	50.00
	05200 DELIVERY ROOM & LABOR ROOM	22, 369	108	0		0	52.00
	05300 ANESTHESI OLOGY	0	31	0		0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	15, 118		0	0	0	54.00
60. 00 60. 01	06000   LABORATORY   06001   BLOOD   LABORATORY	234	1, 389 0	0	0	0	60. 00 60. 01
	06300 BLOOD STORING, PROCESSING & TRANS.	0	61	0	0	0	63.00
65.00	06500 RESPI RATORY THERAPY	0	783	0	1, 878	0	65. 00
	06600 PHYSI CAL THERAPY	17, 623		0	0	0	66.00
	O6700   OCCUPATI ONAL THERAPY   O6800   SPEECH PATHOLOGY	0	0	0	0	0	67. 00 68. 00
	06900 ELECTROCARDI OLOGY	0	l o	0	o	0	69.00
69. 01	06901 CARDIAC REHABILITATION	0	448	0	0	0	69. 01
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	٥	0	0	3, 094, 308 501, 162	71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	Ö	0	Ö	001, 102	73.00
76. 00	03020 ONCOLOGY	20	564	0	3, 343	0	76. 00
88. 00	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC	1, 680	10, 240	0	O	0	88. 00
	08801 RURAL HEALTH CLINIC II	320		0		0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	1, 642	0	0	0	88. 02
	08803 RURAL HEALTH CLINIC IV	0	2, 151	0	0	0	88. 03
	09000 CLI NI C 09100 EMERGENCY	19, 663	1, 815 5, 301	0	1, 787 16, 683	0	90. 00 91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	19,003	5, 301	0	10, 003		92.00
	OTHER REIMBURSABLE COST CENTERS						
101. 00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
116 00	SPECIAL PURPOSE COST CENTERS  11600 HOSPI CE	0	ol	0	O	0	116. 00
118. 00	l l	99, 019		100			
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 HOMECARE	0	451	0	0		190. 00 190. 01
	19200 PHYSICIANS' PRIVATE OFFICES	518	4, 258	0	0		190.01
192.01	19201 KNOX RHC	0	0	0	0		192. 01
	07950 MARKETI NG	0	0	0	0	0	194.00
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
201.00	Cost to be allocated (per Wkst. B,	136, 134	520, 557	683, 784	916, 779		
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	1. 367672	1	6, 837. 840000			
204.00	Cost to be allocated (per Wkst. B, Part II)	17, 606	15, 061	88, 974	20, 943	27, 554	204.00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 176879	0. 243792	889. 740000	0. 265602	0. 007664	205. 00
201 25	II)						20/ 65
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	1 1 2					 	207. 00
	Parts III and IV)					 	

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

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1305 

				10		Date/lime Prepared: 2/23/2023 4:28 pm
	Cost Center Description	PHARMACY	MEDI CAL	SOCI AL	, I	1, 20, 2020 11 20 piii
		(100%)	RECORDS & LI BRARY	SERVICE (ALLOCATION		
			(GROSS	OF TIME)		
			CHARGES)	,		
	CENEDAL CEDVICE COCT CENTEDS	15. 00	16. 00	17. 00		
1. 00	GENERAL SERVICE COST CENTERS O0100 NEW CAP REL COSTS-BLDG & FIXT					1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500 ADMINISTRATIVE & GENERAL					5. 00
7. 00 8. 00	00700 OPERATION OF PLANT					7.00
9. 00	OO8OO  LAUNDRY & LI NEN SERVI CE   OO9OO  HOUSEKEEPI NG					8. 00 9. 00
10.00	01000 DI ETARY					10.00
	01300 NURSING ADMINISTRATION					13. 00
14. 00 15. 00	01400   CENTRAL SERVI CES & SUPPLY   01500   PHARMACY	100				14. 00 15. 00
	01600 MEDICAL RECORDS & LIBRARY	0	68, 435, 904			16. 00
	01700 SOCI AL SERVI CE	O	0			17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 31. 00	03000   ADULTS & PEDIATRICS   03100   INTENSIVE CARE UNIT	0	1, 822, 080 0			30. 00 31. 00
	04300 NURSERY	0	16, 275	-		43.00
	ANCILLARY SERVICE COST CENTERS	-	,	_		
	05000 OPERATING ROOM	0	6, 020, 045			50.00
52.00	05200   DELIVERY ROOM & LABOR ROOM   05300   ANESTHESIOLOGY	0	82, 348			52.00
53. 00 54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	809, 070 15, 353, 051	0		53. 00 54. 00
60.00	06000 LABORATORY	o	13, 718, 049	-		60.00
60. 01	06001 BLOOD LABORATORY	O	0			60. 01
	06300 BLOOD STORING, PROCESSING & TRANS.	0	176, 855			63.00
65. 00 66. 00	06500  RESPI RATORY THERAPY   06600  PHYSI CAL THERAPY	0	646, 961 2, 963, 720	0		65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	590, 270			67. 00
68.00	06800 SPEECH PATHOLOGY	0	5, 573			68. 00
	06900 ELECTROCARDI OLOGY	0	632, 637			69.00
69. 01 70. 00	06901   CARDI AC   REHABI LI TATI ON   07000   ELECTROENCEPHALOGRAPHY	0	270, 372 0			69. 01 70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3, 094, 308	-		71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	501, 162			72.00
	07300 DRUGS CHARGED TO PATIENTS	100	9, 010, 703			73.00
76. 00	03020 ONCOLOGY OUTPATIENT SERVICE COST CENTERS	0	389, 973	0		76. 00
88. 00	08800 RURAL HEALTH CLINIC	0	4, 649, 023	0		88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	697, 170			88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	168, 149			88. 02
88. 03 90. 00	08803  RURAL HEALTH CLINIC IV   09000  CLINIC	0	555, 385 375, 448			88. 03 90. 00
91. 00	09100 EMERGENCY	o	5, 887, 277			91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					92.00
101 00	OTHER REIMBURSABLE COST CENTERS  10100 HOME HEALTH AGENCY	0	0	O		101. 00
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	0	0		101.00
	11600 HOSPI CE	0	0			116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	100	68, 435, 904	9, 888		118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190. 00
	19001 HOMECARE	0	0			190. 01
	19200 PHYSICIANS' PRIVATE OFFICES	0	0			192. 00
	19201   KNOX RHC   07950   MARKETI NG	0	0	0		192. 01 194. 00
200.00			Ü	J		200. 00
201.00	, ,					201. 00
202. 00	,,	49, 950	639, 433	64, 016		202. 00
203. 00	Part I)   Unit cost multiplier (Wkst. B, Part I)	400 500000	0. 009344	6 474110		202 00
203.00		499. 500000 21, 495	0. 009344 48, 087			203. 00 204. 00
	Part II)		.5, 557			201.00
205. 00	, , , , , , , , , , , , , , , , , , , ,	214. 950000	0. 000703	0. 063815		205. 00
206. 00						206. 00
200.00	(per Wkst. B-2)					200.00
207. 00						207. 00
	Parts III and IV)	ı I		I I		I

Health Financial Systems	PULASKI MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1305	Period: Worksheet C From 10/01/2021 Part I
		To 09/30/2022 Date/Time Prepared

					To 09/30/2022	Date/Time Pre 2/23/2023 4:2	
			Title	XVIII	Hospi tal	Cost	
			<u> </u>		Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1. 00	2.00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	4, 702, 210		4, 702, 21	0 0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	l			ol ol	0	31.00
43.00	04300 NURSERY	37, 329		37, 32	9 0	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 702, 168		1, 702, 16	8 0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	56, 648		56, 64		0	52.00
	05300 ANESTHESI OLOGY	22, 663		22, 66		0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	2, 599, 031		2, 599, 03		0	54.00
	06000 LABORATORY	2, 291, 294		2, 291, 29		0	60.00
60. 01	06001 BLOOD LABORATORY	0				0	60. 01
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	62, 613		62, 61	3 0	0	63.00
	06500 RESPI RATORY THERAPY	705, 643	0	705, 64		0	65.00
66. 00	06600 PHYSI CAL THERAPY	1, 750, 160	0	1, 750, 16		0	66.00
	06700 OCCUPATI ONAL THERAPY	293, 306	0	293, 30		0	67.00
68. 00	06800 SPEECH PATHOLOGY	296	0	29		0	68.00
69. 00	06900 ELECTROCARDI OLOGY	17, 101	ŭ	17, 10		0	69.00
	06901 CARDI AC REHABI LI TATI ON	145, 530		145, 53		0	69. 01
	07000 ELECTROENCEPHALOGRAPHY	0				0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	781, 136		781, 13	-	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	189, 358		189, 35		0	72.00
	07300 DRUGS CHARGED TO PATIENTS	2, 976, 909		2, 976, 90		0	73.00
	03020 ONCOLOGY	313, 028		313, 02		0	76.00
70.00	OUTPATIENT SERVICE COST CENTERS	313, 020		313, 02	<u> </u>	0	70.00
88 00	08800 RURAL HEALTH CLINIC	7, 354, 470		7, 354, 47	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	1, 515, 219		1, 515, 21		0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	500, 557		500, 55		0	88. 02
	08803 RURAL HEALTH CLINIC IV	1, 164, 181		1, 164, 18		0	88. 03
	09000 CLINIC	537, 376		537, 37		0	90.00
	09100 EMERGENCY	4, 234, 783		4, 234, 78		0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 297, 978		1, 297, 97		0	92.00
72.00	OTHER REIMBURSABLE COST CENTERS	1, 277, 770		1, 271, 71	3	U	92.00
101 00	10100 HOME HEALTH AGENCY	ol			o	0	101.00
101.00	SPECIAL PURPOSE COST CENTERS	ı v		'	J	U	1101.00
116 00	11600 HOSPI CE					0	116. 00
200.00	1	35, 250, 987	0				200.00
200.00		1, 297, 978	Ü	1, 297, 97			200.00
201.00		33, 953, 009	^				201.00
202. UL	Trotal (See Fristructions)	33, 953, 009	0	J 33, 933, 00°	기 이	0	12U2. UU

Health Financial Systems	PULASKI MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1305	Period: Worksheet C From 10/01/2021 Part I
		To 09/30/2021 Part 1

					From 10/01/2021 To 09/30/2022	Part I Date/Time Pre 2/23/2023 4:2	
			Title	: XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	1, 364, 429		1, 364, 42			30.00
	03100 INTENSIVE CARE UNIT	0		1	0		31.00
	04300 NURSERY	16, 275		16, 27	5		43.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	725, 910	5, 294, 135				
	05200 DELIVERY ROOM & LABOR ROOM	66, 197	16, 151				52.00
	05300 ANESTHESI OLOGY	65, 121	743, 949			0. 000000	53.00
	05400 RADI OLOGY-DI AGNOSTI C	973, 890	14, 379, 161			0. 000000	
	06000 LABORATORY	1, 727, 227	11, 990, 822			0.000000	60.00
	06001 BLOOD LABORATORY	0	0	l .	0.000000	0. 000000	
	06300 BLOOD STORING, PROCESSING & TRANS.	61, 656	115, 199			0. 000000	1
	06500 RESPIRATORY THERAPY	263, 072	383, 889			0. 000000	65.00
	06600 PHYSI CAL THERAPY	391, 381	2, 572, 339			0. 000000	66.00
	06700 OCCUPATI ONAL THERAPY	206, 508	383, 762			0. 000000	67.00
	06800 SPEECH PATHOLOGY	4, 795	778			0.000000	68.00
	06900 ELECTROCARDI OLOGY	25, 940	606, 697			0.000000	
	06901 CARDI AC REHABI LI TATI ON	0	270, 372			0.000000	69. 01
	07000 ELECTROENCEPHALOGRAPHY	1 107 105	0		0.000000	0.000000	
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	1, 187, 125	1, 907, 183				
	07200 IMPL. DEV. CHARGED TO PATIENTS	113, 405	387, 757			0.000000	
	07300 DRUGS CHARGED TO PATIENTS	4, 664, 072	4, 346, 631				73.00
	03020 ONCOLOGY	2, 417	387, 556	389, 97	0. 802691	0. 000000	76.00
	OUTPATIENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC		4 (40 000	4 (40 02	2		00.00
	08801 RURAL HEALTH CLINIC	0	4, 649, 023				88. 00 88. 01
		0	697, 170				
	08802 RURAL HEALTH CLINIC III	0	168, 149				88. 02
	08803 RURAL HEALTH CLINIC IV 09000 CLINIC	0	555, 385			0. 000000	88. 03 90. 00
	09100 EMERGENCY	242 424	375, 448				
		262, 626	5, 624, 651			0.000000	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	4, 000	453, 651	457, 65	1 2. 836174	0.000000	92.00
	10100 HOME HEALTH AGENCY	O	0	I	0		101. 00
	SPECIAL PURPOSE COST CENTERS	U <sub>I</sub>	0		U		1101.00
	11600 HOSPI CE	0	0		0		116. 00
200. 00	Subtotal (see instructions)	12, 126, 046	56, 309, 858		-		200.00
200.00		12, 120, 040	JU, JU7, 858	00, 433, 90	*		200.00
	l	12 124 044	E4 200 050	40 425 00	4		
202. 00	Total (see instructions)	12, 126, 046	56, 309, 858	68, 435, 90	4		202. 00

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1305	From 10/01/2021	Worksheet C Part I Date/Time Prepared:

			10 09/30/2022	2/23/2023 4: 28 pm
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient		<u> </u>	
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00   03000   ADULTS & PEDIATRICS				30.00
31. 00   03100   I NTENSI VE CARE UNI T				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 CARDIAC REHABILITATION	0. 000000			69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
76. 00   03020   ONCOLOGY	0. 000000			76.00
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC				88.00
88. 01   08801 RURAL HEALTH CLINIC II				88. 01
88.02 08802 RURAL HEALTH CLINIC III				88. 02
88. 03   08803 RURAL HEALTH CLINIC IV				88. 03
90. 00   09000   CLI NI C	0. 000000			90.00
91. 00   09100   EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS				
116. 00 11600 HOSPI CE				116.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1305	From 10/01/2021	Worksheet C Part I Date/Time Prepared:

					To 09/30/2022	Date/Time Pre 2/23/2023 4:2	
			Ti tl	e XIX	Hospi tal	Cost	
	·				Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1. 00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	4, 702, 210		4, 702, 21	0 0	4, 702, 210	30.00
31.00	03100 INTENSIVE CARE UNIT	o			0 0	0	31.00
43.00	04300 NURSERY	37, 329		37, 32	9 0	37, 329	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 702, 168		1, 702, 16	8 0	1, 702, 168	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	56, 648		56, 64	8 0	56, 648	52.00
53.00	05300 ANESTHESI OLOGY	22, 663		22, 66	3 0	22, 663	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 599, 031		2, 599, 03	1 0	2, 599, 031	54.00
60.00	06000 LABORATORY	2, 291, 294		2, 291, 29	4 0	2, 291, 294	60.00
60. 01	06001 BLOOD LABORATORY	o			0 0	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	62, 613		62, 61	3 0	62, 613	63.00
65.00	06500 RESPI RATORY THERAPY	705, 643	0	705, 64	3 0	705, 643	65.00
66.00	06600 PHYSI CAL THERAPY	1, 750, 160	0	1, 750, 16	0 0	1, 750, 160	66.00
67.00	06700 OCCUPATI ONAL THERAPY	293, 306	0	293, 30	6 0	293, 306	67.00
68.00	06800 SPEECH PATHOLOGY	296	0	29	6 0	296	68. 00
69.00	06900 ELECTROCARDI OLOGY	17, 101		17, 10	1 0	17, 101	69.00
69. 01	06901 CARDI AC REHABI LI TATI ON	145, 530		145, 53	0 0	145, 530	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	o			0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	781, 136		781, 13	6 0	781, 136	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	189, 358		189, 35	8 0	189, 358	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 976, 909		2, 976, 90	9 0	2, 976, 909	73.00
76.00	03020 ONCOLOGY	313, 028		313, 02	8 0	313, 028	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	7, 354, 470		7, 354, 47	0 0	7, 354, 470	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	1, 515, 219		1, 515, 21	9 0	1, 515, 219	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	500, 557		500, 55	7 0	500, 557	
88. 03	08803 RURAL HEALTH CLINIC IV	1, 164, 181		1, 164, 18	1 0	1, 164, 181	88. 03
	09000 CLI NI C	537, 376		537, 37		537, 376	
91.00	09100 EMERGENCY	4, 234, 783		4, 234, 78	3 0	4, 234, 783	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 297, 978		1, 297, 97		1, 297, 978	1
	OTHER REIMBURSABLE COST CENTERS	, , ,					
	10100 HOME HEALTH AGENCY	0			0	0	101.00
	SPECIAL PURPOSE COST CENTERS			<u>'</u>			
116.00	11600 H0SPI CE	0			0	0	116. 00
200.00	Subtotal (see instructions)	35, 250, 987	0	35, 250, 98	7 0	35, 250, 987	200.00
201.00	Less Observation Beds	1, 297, 978		1, 297, 97	8	1, 297, 978	201.00
202.00	Total (see instructions)	33, 953, 009	0	33, 953, 00	9 0	33, 953, 009	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 10/01/2021 Part I

					To 09/30/2022	Date/Time Pre 2/23/2023 4:2	pared: 8 pm
				e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Rati o	I npati ent	
			7.00		0.00	Rati o	
	LNDATI ENT. DOUTLINE CEDIULOE COCT. CENTEDO	6. 00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	4 0 (4 400		4 0/4 40/			1 00 00
	03000 ADULTS & PEDIATRICS	1, 364, 429		1, 364, 429			30.00
	03100 INTENSIVE CARE UNIT	0		( ( ) ( )	-		31.00
	04300 NURSERY	16, 275		16, 275			43.00
	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	725 010	F 204 12F	/ 020 045	0.202750	0.000000	FO 00
		725, 910	5, 294, 135			0.000000	
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	66, 197	16, 151 743, 949			0. 000000 0. 000000	
	05300  ANESTHESTOLOGY 05400  RADI OLOGY-DI AGNOSTI C	65, 121 973, 890				0. 000000	
	06000 LABORATORY		14, 379, 161			0. 000000	
	06001 BLOOD LABORATORY	1, 727, 227	11, 990, 822 0			0. 000000	1
	06300 BLOOD STORING, PROCESSING & TRANS.	61, 656	115, 199			0.000000	
	06500 RESPIRATORY THERAPY	263, 072	383, 889			0. 000000	
	06600 PHYSI CAL THERAPY	391, 381	2, 572, 339			0. 000000	
	06700 OCCUPATI ONAL THERAPY	206, 508	383, 762			0. 000000	
	06800 SPEECH PATHOLOGY	4, 795	363, 762 778			0. 000000	
	06900  SPEECH PATHOLOGY	25, 940	606, 697			0.000000	1
	06901 CARDI AC REHABI LI TATI ON	23, 740	270, 372			0. 000000	
	07000 ELECTROENCEPHALOGRAPHY	0	270, 372			0. 000000	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 187, 125	1, 907, 183			0. 000000	
	07200 IMPL. DEV. CHARGED TO PATIENTS	113, 405	387, 757			0. 000000	
	07300 DRUGS CHARGED TO PATIENTS	4, 664, 072	4, 346, 631			0. 000000	
	03020 ONCOLOGY	2, 417	387, 556			0. 000000	
	OUTPATIENT SERVICE COST CENTERS	2, 417	307, 330	307, 773	0.002071	0.000000	70.00
	08800 RURAL HEALTH CLINIC	0	4, 649, 023	4, 649, 023	1. 581939	0. 000000	88. 00
	08801 RURAL HEALTH CLINIC II	0	697, 170			0. 000000	
	08802 RURAL HEALTH CLINIC III	0	168, 149			0. 000000	
	08803 RURAL HEALTH CLINIC IV	0	555, 385			0. 000000	1
	09000 CLINI C	0	375, 448			0. 000000	
	09100 EMERGENCY	262, 626	5, 624, 651			0. 000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 000	453, 651	457, 65		0. 000000	
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	0	(			101.00
	SPECIAL PURPOSE COST CENTERS	'					1
	11600 HOSPI CE	0	0	(			116. 00
200.00	Subtotal (see instructions)	12, 126, 046	56, 309, 858	68, 435, 904	1		200.00
201.00	Less Observation Beds						201.00
202. 00	Total (see instructions)	12, 126, 046	56, 309, 858	68, 435, 904	1		202. 00

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1305	From 10/01/2021	Worksheet C Part I Date/Time Prepared:

			10 07/30/2022	2/23/2023 4: 28 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient		<u> </u>	
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00   03000   ADULTS & PEDIATRICS				30.0
31.00 03100 INTENSIVE CARE UNIT				31.0
43. 00 04300 NURSERY				43.0
ANCILLARY SERVICE COST CENTERS				
50.00   05000   OPERATING ROOM	0. 000000			50.0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.0
53. 00   05300   ANESTHESI OLOGY	0. 000000			53.0
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000			54.0
60. 00  06000 LABORATORY	0. 000000			60.0
60. 01   06001   BL00D   LABORATORY	0. 000000			60.0
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.0
65. 00 06500 RESPI RATORY THERAPY	0. 000000			65.0
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.0
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.0
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68.0
69. 00   06900   ELECTROCARDI OLOGY	0. 000000			69.0
69. 01   06901   CARDI AC   REHABI LI TATI ON	0. 000000			69.0
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.0
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.0
76. 00 03020 0NC0L0GY	0. 000000			76. 0
OUTPATIENT SERVICE COST CENTERS				
88. 00   08800 RURAL HEALTH CLINIC	0. 000000			88.0
88.01 08801 RURAL HEALTH CLINIC II	0. 000000			88.0
88.02 08802 RURAL HEALTH CLINIC III	0. 000000			88.0
88.03   08803   RURAL HEALTH CLINIC IV	0. 000000			88.0
90. 00  09000  CLI NI C	0. 000000			90.0
91. 00   09100   EMERGENCY	0. 000000			91.0
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 0
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101. (
SPECIAL PURPOSE COST CENTERS				
116. 00 11600 HOSPI CE				116. (
200.00 Subtotal (see instructions)				200. 0
201.00 Less Observation Beds				201. 0
202.00   Total (see instructions)				202.0

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	l r	n Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLAR	RY SERVICE CAPITAL COSTS	Provider CCN: 15-1305	Peri od:	Worksheet D

Health Financial Systems	PULASKI MEMORI	I AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der Co		Period: From 10/01/2021	Worksheet D Part II	
				To 09/30/2022	Date/Time Pre	
		<b>T.</b>	\0.41.1		2/23/2023 4: 2	8 pm
01 01 D	0		XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost (from Wkst.	(from Wkst. C, Part I,	to Charges (col. 1 ÷	Program	(column 3 x column 4)	
	B, Part II,	c, Part 1,	col. 1 ÷	Charges	COLUMN 4)	
	col . 26)	COI. 6)	(01. 2)			
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00 05000 OPERATING ROOM	170, 147	6, 020, 045	0. 02826	3 241, 408	6, 823	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	3, 588				0	1
53. 00   05300   ANESTHESI OLOGY	1, 550				45	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	167, 385	15, 353, 051	0. 01090	2 201, 739	2, 199	54.00
60. 00   06000   LABORATORY	68, 014	13, 718, 049	0. 00495	327, 330	1, 623	60.00
60. 01   06001   BLOOD LABORATORY	0	0	0. 00000	0	0	60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	2, 339	176, 855	0. 01322	6 13, 750	182	63.00
65. 00 06500 RESPIRATORY THERAPY	28, 820	646, 961	0. 04454	7 90, 718	4, 041	65.00
66. 00 06600 PHYSI CAL THERAPY	71, 349	2, 963, 720	0. 02407	4 65, 111	1, 567	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	3, 254	590, 270	0. 00551	3 33, 629	185	67.00
68. 00   06800   SPEECH PATHOLOGY	6	5, 573			0	00.00
69. 00   06900   ELECTROCARDI OLOGY	548				12	69. 00
69. 01   06901   CARDI AC   REHABI LI TATI ON	13, 739	270, 372	0. 05081		0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0. 00000		0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	31, 161	3, 094, 308			3, 681	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	5, 623				698	
73.00 07300 DRUGS CHARGED TO PATIENTS	53, 963				2, 919	73.00
76. 00 03020 ONCOLOGY	19, 114	389, 973	0. 04901	4 0	0	76.00
OUTPATIENT SERVICE COST CENTERS				_	_	
88. 00 08800 RURAL HEALTH CLINIC	352, 854				0	88. 00
88. 01   08801   RURAL HEALTH CLINIC II	25, 093				0	88. 01
88. 02 08802 RURAL HEALTH CLINIC III	9, 128				0	88. 02
88. 03   08803 RURAL HEALTH CLINIC IV	17, 125				0	88. 03
90. 00   09000   CLI NI C	54, 773				0	90.00
91.00   09100   EMERGENCY 92.00   09200   0BSERVATION   BEDS (NON-DISTINCT PART)	193, 542				927 869	
92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART) 200.00   Total (lines 50 through 199)	107, 855 1, 400, 970					
200.00   Total (Titles 50 through 199)	1, 400, 970	07,000,200		1, 957, 877	25, //11	<sub>1</sub> ∠00.00

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	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 10/01/2021	Part IV

THROUGH COSTS 09/30/2022 Date/Time Prepared: To 2/23/2023 4:28 pm Title XVIII Hospi tal Cost Cost Center Description Non Physician Nursi ng Nursi ng Allied Health Allied Health Program Anesthetist Post-Stepdown Program Post-Stepdown Cost Adjustments Adjustments 1. 00 2.00 ЗА 3.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 0 50.00 50.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 0 54.00 0 06000 LABORATORY 0 60.00 60.00 0 60.01 06001 BLOOD LABORATORY 0 0 60.01 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 63.00 06500 RESPIRATORY THERAPY 0 0 65.00 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 0 66.00 0 67.00 06700 OCCUPATI ONAL THERAPY 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 68.00 0 06900 ELECTROCARDI OLOGY 0 69.00 69.00 0 06901 CARDIAC REHABILITATION 0 69.01 69.01 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 0 72.00 0 0 72.00 73.00 0 0 73.00 76.00 03020 ONCOLOGY 0 0 0 0 0 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 0 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 0 0 0 88.01 08801 RURAL HEALTH CLINIC II 0 0 88.01 08802 RURAL HEALTH CLINIC III 0 88.02 88.02 0 0 0 0 0 0 0 88 03 08803 RURAL HEALTH CLINIC IV Ω 88.03 0 90. 00 09000 CLI NI C 0 90.00 0 91.00 09100 EMERGENCY 0 0 91.00 92.00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 0 0 Total (lines 50 through 199) 0 0 200.00 200.00

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	Period: Worksheet D
THROUGH COSTS		From 10/01/2021   Part IV

TTIKOOO				Γ	o 09/30/2022	Date/Time Pre 2/23/2023 4: 2	
			Title	xVIII	Hospi tal	Cost	<u> </u>
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	·	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0	(	6, 020, 045		
	05200 DELIVERY ROOM & LABOR ROOM	0	0	(	82, 348		1
53.00	05300 ANESTHESI OLOGY	0	0	C	809, 070	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	C	15, 353, 051	0.000000	54.00
60.00	06000 LABORATORY	0	0	C	13, 718, 049	0.000000	60.00
60. 01	06001 BLOOD LABORATORY	0	0	C	0	0.000000	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(	176, 855	0.000000	63.00
65.00	06500 RESPI RATORY THERAPY	0	0	(	646, 961	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	(	2, 963, 720	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	(	590, 270	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	ı c	5, 573	0.000000	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	ı c	632, 637	0.000000	69.00
69. 01	06901 CARDI AC REHABI LI TATI ON	0	0	ı c	270, 372	0.000000	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	ı c	0	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	ı c	3, 094, 308	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	501, 162	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(	9, 010, 703	0.000000	73.00
76.00	03020 ONCOLOGY	0	0	ı c	389, 973	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	C	4, 649, 023	0.000000	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	0	(	697, 170	0.000000	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	0	C	168, 149	0.000000	88. 02
	08803 RURAL HEALTH CLINIC IV	0	0	(	555, 385		
90.00	09000 CLI NI C	0	0	(	375, 448	0.000000	90.00
	09100 EMERGENCY	0	0	(	5, 887, 277		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	C	457, 651	0. 000000	92.00
200.00	Total (lines 50 through 199)	0	0	) c	67, 055, 200		200. 00

Health Financial Systems	PULASKI MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider Co	CN: 15-1305   Period:   Worksheet D
THROUGH COSTS		From 10/01/2021 Part IV

THROUGH COSTS				From 10/01/2021 Fo 09/30/2022	Part IV   Date/Time Pre	parad.
				09/30/2022	2/23/2023 4: 2	8 pm
		Title	XVIII	Hospi tal	Cost	<u> </u>
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷		Costs (col. 8		Costs (col. 9	
	col . 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0. 000000	241, 408	1	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	23, 547		0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000	201, 739		0	0	54.00
60. 00   06000   LABORATORY	0. 000000	327, 330	(	0	0	60.00
60. 01   06001   BL00D   LABORATORY	0. 000000	0	(	0	0	60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	13, 750		0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	90, 718		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	65, 111		0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	33, 629		0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0	(	0	0	68. 00
69. 00  06900  ELECTROCARDI OLOGY	0. 000000	13, 576	(	0	0	69.00
69. 01   06901   CARDI AC REHABI LI TATI ON	0. 000000	0	(	0	0	69. 01
70. 00   07000   ELECTROENCEPHALOGRAPHY	0. 000000	0	(	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	365, 495		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	62, 247		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	487, 445		0	0	73.00
76. 00 03020 ONCOLOGY	0. 000000	0	(	0	0	76. 00
OUTPATIENT SERVICE COST CENTERS						
88.00   08800   RURAL HEALTH CLINIC	0. 000000	0	(	0	0	88. 00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000	0	(	0	0	88. 01
88.02   08802   RURAL HEALTH CLINIC III	0. 000000	0	(	0	0	88. 02
88.03   08803   RURAL HEALTH CLINIC IV	0. 000000	0	(	0	0	88. 03
90. 00  09000  CLI NI C	0. 000000	0	(	0	0	90.00
91. 00   09100   EMERGENCY	0. 000000	28, 193		0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	3, 689	•	0	0	1 ,2.00
200.00   Total (lines 50 through 199)		1, 957, 877	(	0	0	200. 00

| Peri od: | Worksheet D | From 10/01/2021 | Part V | To | 09/30/2022 | Date/Time | Prepared: Provider CCN: 15-1305

					10 09/30/2022	2/23/2023 4: 2	
-			Title	XVIII	Hospi tal	Cost	
			·	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	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0. 282750	0	.,,		0	50.00
	D5200 DELIVERY ROOM & LABOR ROOM	0. 687910	0	578		0	52.00
	D5300 ANESTHESI OLOGY	0. 028011	0	193, 091		0	53.00
	D5400 RADI OLOGY-DI AGNOSTI C	0. 169284	0	4, 001, 802		0	54.00
	06000 LABORATORY	0. 167028	0	3, 851, 580	0	0	60.00
	06001 BLOOD LABORATORY	0. 000000	0	(	-	0	60. 01
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 354036	0	58, 208		0	63.00
	06500 RESPI RATORY THERAPY	1. 090704	0	91, 855		0	65.00
	06600 PHYSI CAL THERAPY	0. 590528	0	916, 559	9 0	0	66.00
	06700 OCCUPATI ONAL THERAPY	0. 496901	0	110, 053	0	0	67.00
	06800 SPEECH PATHOLOGY	0. 053113	0	(	0	0	68.00
	06900 ELECTROCARDI OLOGY	0. 027031	0	182, 736	6 0	0	69.00
	D6901 CARDIAC REHABILITATION	0. 538258	0	94, 484	1 0	0	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	(	0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 252443	0	711, 037	7 0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 377838	0	85, 328		0	72.00
	D7300 DRUGS CHARGED TO PATIENTS	0. 330375	0	3, 375, 040	420	0	73.00
	03020 ONCOLOGY	0. 802691	0	199, 312	0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS				_		
	08800 RURAL HEALTH CLINIC						88. 00
	08801 RURAL HEALTH CLINIC II						88. 01
	08802 RURAL HEALTH CLINIC III						88. 02
	08803 RURAL HEALTH CLINIC IV						88. 03
	09000 CLI NI C	1. 431293	0	251, 659		0	90.00
	09100 EMERGENCY	0. 719311	0	1, 288, 769		0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2. 836174	0	146, 945		0	92.00
200.00	Subtotal (see instructions)		0	16, 929, 494	64, 886		200. 00
201.00	Less PBP Clinic Lab. Services-Program			(	0		201. 00
	Only Charges		_			_	
202. 00	Net Charges (line 200 - line 201)		0	16, 929, 494	64, 886	0	202. 00

Health Financial Systems	PULASKI MEMORI	AL HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 15-1305	Period: Worksheet D From 10/01/2021 Part V To 09/30/2022 Date/Time Prepared:

				From 10/01/2021 To 09/30/2022	Part V Date/Time Pre 2/23/2023 4:2	
		Title	XVIII	Hospi tal	Cost	LO PIII
	Cos	sts		<u> </u>		
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	387, 497	0				50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	398	0				52.00
53. 00   05300   ANESTHESI OLOGY	5, 409	0				53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	677, 441	0				54.00
60. 00   06000   LABORATORY	643, 322	0				60.00
60. 01   06001   BL00D   LABORATORY	0	0				60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	20, 608	0				63.00
65. 00 06500 RESPIRATORY THERAPY	100, 187	0				65.00
66. 00 06600 PHYSI CAL THERAPY	541, 254	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	54, 685	0				67. 00
68.00 06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00   06900   ELECTROCARDI OLOGY	4, 940					69. 00
69. 01 06901 CARDI AC REHABI LI TATI ON	50, 857	0				69. 01
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	179, 496	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	32, 240		1			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 115, 029		1			73.00
76. 00 03020 0NC0L0GY	159, 986	0				76. 00
OUTPATIENT SERVICE COST CENTERS			T			
88. 00 08800 RURAL HEALTH CLINIC						88.00
88. 01   08801   RURAL HEALTH CLINIC II						88. 01
88. 02 08802 RURAL HEALTH CLINIC III						88. 02
88. 03   08803 RURAL HEALTH CLINIC IV	0/0 400					88. 03
90. 00   09000   CLI NI C	360, 198					90.00
91. 00 09100 EMERGENCY	927, 026					91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	416, 762	0				92.00
200.00 Subtotal (see instructions)	5, 677, 335	46, 510				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges (Line 200 Line 201)	E 477 225	// E10				202 00
202.00   Net Charges (line 200 - line 201)	5, 677, 335	46, 510	l			202.00

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-	-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-1305	Peri od: From 10/01/2021 To 09/30/2022	Worksheet D-1  Date/Time Prepare	
				2/23/2023 4: 28 pm	<u> </u>
		Title XVIII	Hospi tal	Cost	

PART   - ALL PROVIDER COMPONENTS   1.00			Title XVIII	Hospi tal	2/23/2023 4: 2 Cost	8 pm
INPATED LANS   INPA		Cost Center Description	THE AVIII	1103pi tai	0031	
INPARTENT DAYS   100   Impatient days (including private room days and swing-bed days, excluding swing-bed and mosborn days)   1,00		DADT I ALL DDOVI DED COMPONENTO			1. 00	
Impattient days (including private room days and swing-bed days, excluding newborn)   2,243   1,00						
A cooperation of adays (excluding swing-bed and observation bed days). If you have only private room days, do do not complete this line.  4.00 do not complete this line.  4.00 Semi-private room days (excluding swing-bed and observation bed days).  5.00 Total swing-bed SWF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line).  7.00 Total swing-bed WF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line).  7.00 Total swing-bed WF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line).  7.00 Total swing-bed WF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line).  7.00 Swing-bed WF type inpatient days applicable to the Program (excluding saing-bed and newborn days) (see Instructions) was period (if calendary year, enter 0 on this line).  7.00 Swing-bed SWF type inpatient days applicable to SWF type inpatient days applicable to the Program (excluding private room days) after becamber 31 of the cost reporting period (if calendary year, enter 0 on this line).  7.00 Swing-bed SWF type inpatient days applicable to SWF type swing-bed SWF services applicable	1. 00		rs, excluding newborn)		2, 243	1. 00
do not complete this line.  4. 00 Semi-private room days (excelleding swing-bed and observation bed days)  1. 1. 087  1. 087	2.00	Inpatient days (including private room days, excluding swing-	bed and newborn days)		1, 623	2.00
Semi-private room days (excluding swing-bed and observation bed days)  Total swing-bed SWF type inpatient days (including private room days) after December 31 of the cost reporting period of the swing-bed SWF type inpatient days (including private room days) after December 31 of the cost reporting period of the swing-bed SWF type inpatient days (including private room days) after December 31 of the cost reporting period of (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (i	3.00		ys). If you have only pr	rivate room days,	0	3.00
Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) through December 31 of the cost reporting period (including private room days) through December 31 of the cost reporting period (including private room days) after December 31 of the cost system of the private room days after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including pr	4 00				4 007	4 00
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed SWT type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days after December 31 of the cost 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 newborn days) (see Instructions) 10.00 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after become of the cost reporting period (see instructions) 11.00 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after brown days applicable to title XVIII only (including private room days) after swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 15.00 Note the cost of the cost reporting period (if calendar year, enter 0 on this line) 16.00 Note the cost of the cost reporting period (if calendar year, enter 0 on this line) 17.00 Note the period (if the cost reporting period (if the cost rep				or 21 of the cost	· ·	
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reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period 8.00 Total inpatient days including private room days after December 31 of the cost reporting period 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and neaborn days) (see instructions) 10.00 Swing-bed SNF type Inpatient days applicable to title XVIII only (including private room days) after period (including private room days) after 30 of through December 31 of the cost reporting period (including private room days) after period private room days applicable to title XVIII only (including private room days) after period (including private room days) after period (including period to the cost reporting period (including private room days) after period (including period to the XVIII only (including private room days) after period (including period to the XVIII only (including private room days) after period (including period to the XVIII only (including private room days) after period (including period to the XVIII only (including private room days) after December 31 of the cost reporting period (inclendar year, enter 0 on this line) after December 31 of the cost reporting period (inclendar year, enter 0 on this line) after December 31 of the cost reporting period (inclendar year, enter 0 on this line) after December 31 of the cost reporting period (inclendar year, enter 0 on this line) after December 31 of the cost reporting period (inclendar year, enter 0 on this line) after December 31 of the cost reporting period (inclendar year, enter 0 on this line) after December 31 of the cost reporting period (inclendar year, enter 0 on this line) after December 31 of the cost reporting period (inclendar year, enter 0 on this line) after December 31 of the cost reporting period (inclendar year, enter 0 on this line) after December 31 of the cost reporting period (inclendar year) after December	6.00		om days) after December	31 of the cost	197	6. 00
reporting period  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)  9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see Instructions)  10. 00 Suling-bed SNF type inpatient days applicable to title XVIII only (including private room days) after period (including room period (includi			,			
rotal swing-bed NF type inpatient days (including private room days) arter December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7.00 For a protection of the private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  7.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after protection of the cost reporting period (see instructions)  7.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after protection of the cost reporting period (see instructions)  7.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after protection of the cost reporting period (see instructions)  7.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after protection of the cost reporting period (see instructions)  7.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions)  7.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions)  8.00 Swing-bed SNF type days (title V or XIX only)  8.00 Swing-bed SNF type days (title V or XIX only)  8.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (see instructions)  8.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (see instructions)  8.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (see instructions)  8.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 8 x I ine 17)  8.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 8 x I ine 18)  8.0	7.00		m days) through December	31 of the cost	35	7. 00
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10.00   Swing-bed SMF Type inpatitent days applicable to tittle XVIII only (including private room days)   00   10.00	8.00		m days) after becember .	si or the cost	298	8.00
newborn days) (see Instructions)   90   10. 00	9. 00		o the Program (excluding	swing-bed and	485	9. 00
through December 31 of the cost reporting period (see instructions)  1.00 Swing-bed SNF type inpatient days applicable to title XVII only (including private room days) after period (if calendar year, enter 0 on this line)  1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.00 Nedically incessary private room days applicable to the Program (excluding swing-bed days)  1.00 Nedically incessary private room days applicable to the Program (excluding swing-bed days)  1.00 Nedical room of the Victor of th				,		
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) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 18.00 Nursery days (title V or XIX only) 19.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 19.00 Nursery days (title V or XIX only) 19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (local days applicable to services after December 31 of the cost reporting period (local days applicable to services after December 31 of the cost reporting period (local days applicable to services after December 31 of the cost 231.10 19.00 Medical days applicable to services applicable to services after December 31 of the cost 231.10 19.00 Nurserving period (local days applicable to SNF type services after December 31 of the cost 231.10 19.00 Nurserving period (local days applicable to SNF type services after December 31 of the cost reporting period (line 6 x x line 17) 19.00 Medical days applicable to SNF type services after December 31 of the cost reporting period (line 6 x x line 18) 19.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x x line 19) 19.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x x line 19) 19.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x x line	10.00			room days)	90	10.00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.2.0 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.3.0 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.4.00 Medical pracessary private room days applicable to titles V or XIX only (including private room days)  1.5.00 Total nursery days (title V or XIX only)  1.5.00 Total nursery days (title V or XIX only)  1.5.00 Total nursery days (title V or XIX only)  1.5.00 No Modicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including period)  1.5.00 Nedicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  1.5.00 Nedicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  1.5.00 Nedical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period  1.5.00 Nedical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period  2.5.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line size in the cost reporting period (line size in the cost	11 00				107	11 00
12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) of through December 31 of the cost reporting period (including private room days) of through December 31 of the cost reporting period (if call endary perior, enter 0 on this line) of the program (excluding swing-bed days) of the cost reporting period (if call endary perior) of the cost reporting perior (including swing-bed days) of the cost reporting period (including swing-bed cost applicable to services after December 31 of the cost reporting period (line for swing-bed cost applicable to swing-bed swing-bed swing-bed cost applicable to swing-bed swing-bed cost applicable to swing-bed swing-bed cost applicable to swing-bed cost reporting period (line for x line 18) for swing-bed cost applicable to SWF type services through December 31 of the cost reporting period (line for x line 19) for swing-bed cost applicable to SWF type services after December 31 of the cost reporting period (line for x line 19) for swing-bed cost applicable to SWF type services after December 31 of the cost reporting period (line for x line 29) for swing-bed cost applicable to SWF type services after December 31 of the cost reporting period (line for x line 29) for swing-bed cost applicable to SWF type services after December 31 of the cost reporting period (line for x line 29) for swing-bed cost (see instructions) for swing-bed cost (see instructions) for	11.00			room days) arter	197	11.00
through December 31 of the cost reporting period  13.00 Swing-bed NT type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  16.00 Norsery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to the Program (excluding swing-bed days)  18.00 Norsery days (title V or XIX only)  18.00 Norsery days (title V or XIX only)  19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting period reporting period services applicable to services after December 31 of the cost reporting period reporting period reporting period services applicable to services after December 31 of the cost reporting period reporting period services applicable to services after December 31 of the cost reporting period reporting period services applicable to services after December 31 of the cost reporting period reporting period services applicable to services after December 31 of the cost reporting period reporting period services applicable to services after December 31 of the cost reporting period (line services in services)  18.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line services in services)  18.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line services)  18.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line services)  18.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line services)  18.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line services)  18.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line services)  18.00 Swing-bed cost applicable to NF type services	12.00			te room days)	0	12.00
after December' 31 of the cost reporting period (if calendar year, enter 0 on this line)  14. 00  15. 00  Total nursery days (title V or XIX only)  16. 00  Norsery days (title V or XIX only)  17. 00  SWING BED ADJUSTMENT  18. 00  Mich care rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (line dare)  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  19. 00  20. 00  2					_	
14.00   Modically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00   0   15.00   16.00   Nursery days (title V or XIX only)   0   15.00   16.00   Nursery days (title V or XIX only)   0   15.00   16.00   Nursery days (title V or XIX only)   0   15.00   16.00   Nursery days (title V or XIX only)   16.00   Nursery days (title V or XIX only)   16.00   16.00   Nursery days (title V or XIX only)   16.00	13.00				0	13.00
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16.00 Nursery days (title v or XIX only)			am (excluding swing-bed	days)	-	
SW NG BED ADJUSTMENT  17. 00  18. 00  18. 00  18. 00  18. 00  18. 00  19. 00						
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reporting period Medicald rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 231.10 20.00 reporting period 7.00 Total general inpatient routine service cost (see instructions) 7.00 All swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 8.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 18) 8.00 Average per journal for the cost reporting period (line 8 x line 20) 8.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20) 8.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20) 8.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 8.00 Swing-bed cost (see instructions) 8.00 Swing-bed cost (see instructions) 9.00 Total swing-bed cost (see instructions) 9.00 Total swing-bed cost (see instructions) 9.00 Total swing-bed cost (see instructions) 9.00 Fixer Power of the cost reporting period (line 8 x line 20) 9.00 Private room charges (excluding swing-bed cost (line 21 minus line 26) 9.00 Private room charges (excluding swing-bed charges) 9.00 Swing-bed charges) 9.00 Swing-bed charges (excluding swing-bed charges) 9.00 Swing-bed charges) 9.00 Swing-bed charges (line 29 + line 30) 9.00 Average per journal room per diem charge (line 29 + line 30) 9.00 Average per journal room per diem charge (line 29 + line 30) 9.00 Average per journal room per diem charge (line 30 + line 4) 9.00 9.00 9.00 9.00 9.00 9.00 9.00 9.0	40.00					40.00
19.00 Medicald rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 4.702.210 21.00 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.10 Swing-bed cost (line 20) 27.00 Seneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 3.930.254 27.00 Private room charges (excluding swing-bed charges) 0.28.00 Private room charges (excluding swing-bed charges) 0.29.00 Swing-private room per diem charge (line 29 + line 3) 0.00 Swing-private room per diem charge (line 29 + line 3) 0.00 Swing-private room per diem charge (line 30 + line 4) 0.00 33.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00 34.00 Average per diem private room charge differential (line 34 x line 31) 0.00 35.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00 35.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00 35.00 Average per diem private room charge differential (line 34 x line 31) 0.00 35.00 Average per	18.00		es after December 31 of	the cost		18.00
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reporting period Total general inpatient routine service cost (see instructions)  22.00  22.00  23.00  24.702,210  25.00  26.00  27.00  28.00  28.00  28.00  29.00  29.00  20.00			-			
21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 19)  25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 19)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  36.00 Private room cost differential (line 3 x line 31)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3 y 30.025)  37.00 Provate room cost differential (line 3 x line 35)  38.00 Average per diem private room cost differential (line 3 x line 35)  38.00 Adjusted general inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  4, 702, 210  22.00 23.00  23.00 24.00  24.00 25.00  25.00 26.00 27.00  26.00 27.00 27.00  27.00 27.00 27.00  28.00 29.00  29.00 29.00  29.00 29.00  20.00 29.00  20.00 29.00  20.00 29.00  20.00 29.00  20.00 29.00  20.00 29.00  20.00 29.00  20.00 29.00  20.00 29.00  20.00 29.00  20.00 29.00  20.00 29.00  20.00 29.00  20.00 29.00  20.00 29.00  20.00 29.	20. 00		s after December 31 of t	the cost	231. 10	20. 00
22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x 8,089 24.00 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x 8,089 24.00 7 x line 19)  25.00 Total swing-bed cost (see instructions)  27.00 Total swing-bed cost (see instructions)  28.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  29.00 Private room charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average perivate room per diem charge (line 29 * line 3)  30.00 Average semi-private room per diem charge (line 29 * line 3)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Private room cost differential adjustment (line 3 x line 35)  30.00 Private room cost differential adjustment (line 3 x line 35)  30.00 Private room cost differential adjustment (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Private room cost differential adjustment (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  3	21. 00	1 1 3 1	as)		4. 702. 210	21. 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 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8, 089 24.00 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 68, 868 25.00 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  27.00 General inpatient routine service cost net of swing-bed and observation bed charges)  28.00 General inpatient routine service charges (excluding swing-bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average private room per diem charge (line 29 + line 3)  33.00 Average semi-private room per diem charge (line 29 + line 3)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 930, 254 27 minus line 36)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost per diem (see instructions)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				ting period (line		
x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8, 089 24.00 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 68, 868 25.00 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service charges (line 27 + line 28)  32.00 Average private room per diem charge (line 29 + line 3)  33.00 Average semi-private room per diem charge (line 30 + line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room charge differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 930,254)  28.00 Average per diem private room cost differential (line 37 x line 31)  38.00 Average per diem private room cost differential (line 3 x line 31)  39.00 Provate room cost differential adjustment (line 3 x line 35)  40.00 Provate room cost differential routine service cost net of swing-bed cost and private room cost differential (line 3, 930,254)  27.00 Provate room cost differential routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)						
24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8	23. 00		31 of the cost reporting	ng period (line 6	0	23. 00
7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 68, 868 25.00 x line 20)  26.00 Total swing-bed cost (see instructions) Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average private room per diem charge (line 29 ÷ line 3)  30.00 Average per diem private room per diem charge (line 29 ÷ line 3)  30.00 Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 930, 254)  Adjusted general inpatient routine service cost (line 9 x line 38)  Adjusted general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  O 40.00  Medically necessary private room cost applicable to the Program (line 14 x line 35)	24 00	·	r 31 of the cost reporti	na period (line	8 089	24 00
x line 20)  26. 00 Total swing-bed cost (see instructions)  27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  27. 00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  31. 00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32. 00 Average private room per diem charge (line 29 + line 3)  33. 00 Average semi-private room per diem charge (line 30 + line 4)  34. 00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  35. 00 Average per diem private room cost differential (line 3 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 930, 254)  27. minus line 36)  28. 00  29. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20. 00  20					2, 221	
26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  28.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  30.00 Average private room per diem charge (line 29 + line 3)  30.00 Average semi-private room per diem charge (line 30 + line 4)  30.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 930, 254)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 930, 254)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  38.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	25. 00		31 of the cost reporting	g period (line 8	68, 868	25.00
27. 00   General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)   3, 930, 254   27. 00     PRI VATE ROOM DIFFERENTIAL ADJUSTMENT   28. 00   General inpatient routine service charges (excluding swing-bed and observation bed charges)   0   28. 00     29. 00   Pri vate 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   31. 00     32. 00   Average private room per diem charge (line 29 ÷ line 3)   0. 00   32. 00     33. 00   Average semi-private room per diem charge (line 30 ÷ line 4)   0. 00   33. 00     34. 00   Average per diem private room charge differential (line 32 minus line 33) (see instructions)   0. 00   34. 00     35. 00   Average per diem private room cost differential (line 34 x line 31)   0. 00   35. 00     36. 00   Private room cost differential adjustment (line 3 x line 35)   0. 36. 00     37. 00   General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 930, 254     27. minus line 36)   2, 421. 60     PART II - HOSPITAL AND SUBPROVIDERS ONLY   PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS   2, 421. 60     38. 00   Program general inpatient routine service cost per diem (see instructions)   2, 421. 60   39. 00     40. 00   Medically necessary private room cost applicable to the Program (line 14 x line 35)   0   40. 00	26 00	1			771 056	26 00
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  9. 00  Pri vate room charges (excluding swing-bed charges)  30. 00  Semi-pri vate room charges (excluding swing-bed charges)  General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  30. 00  31. 00  Average pri vate room per diem charge (line 29 ÷ line 3)  Average semi-pri vate room per diem charge (line 30 ÷ line 4)  Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions)  Average per diem pri vate room cost differential (line 34 x line 31)  Average per diem pri vate room cost differential (line 3 x line 31)  Pri vate room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and pri vate room cost differential (line 3, 930, 254)  The program of the program general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary pri vate room cost applicable to the Program (line 14 x line 35)  0 28. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  20. 00  20. 00  30. 00			(line 21 minus line 26)			
29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 930, 254)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 930, 254)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0.00 000 00.00			d and observation bed ch	narges)		
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 930, 254)  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)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 000 32.00  31.00  32.00  32.00  34.00  35.00  36.00  37.00  36.00  37.00  37.00  38.00  39.00 Average per diem private room cost differential (line 3, 930, 254)  37.00  38.00 Average per diem private room cost differential (line 3, 930, 254)  38.00 Average per diem private room cost per diem (see instructions)  38.00 Average per diem private room cost applicable to the Program (line 14 x line 35)  0.00 34.00  37.00 34.00  38.00  39.00 Average per diem private room cost differential (line 3, 930, 254)  39.00 Average per diem private room cost differential (line 3, 930, 254)  39.00 Average per diem private room cost differential (line 3, 930, 254)  39.00 Average per diem private room cost differential (line 3, 930, 254)  39.00 Average per diem private room cost differential (line 3, 930, 254)  39.00 Average per diem private room cost differential (line 3, 930, 254)  39.00 Average per diem private room cost differential (line 3, 930, 254)  39.00 Average per diem private room cost differential (line 3, 930, 254)  39.00 Average per diem private room cost differential (line 3,						
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 930, 254) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			- line 28)		-	
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 930, 254)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 33.00  37.00 35.00  37.00 35.00  38.00 36.00  39.00 Average per diem private room cost differential (line 3, 930, 254)  37.00 36.00  38.00 37.00  39.00 Average per diem private room cost differential (line 3, 930, 254)  39.00 Average per diem private room cost differential (line 3, 930, 254)  39.00 Average per diem private room cost differential (line 34 x line 31)  39.00 Average per diem private room cost differential (line 34 x line 31)  39.00 Average per diem private room cost differential (line 34 x line 31)  39.00 Average per diem private room cost differential (line 34 x line 31)  39.00 Average per diem private room cost differential (line 34 x line 31)  39.00 Average per diem private room cost differential (line 34 x line 31)  39.00 Average per diem private room cost differential (line 34 x line 31)  39.00 Average per diem private room cost differential (line 34 x line 31)  39.00 Average per diem private room cost differential (line 34 x line 31)  39.00 Average per diem private room cost differential (line 34 x line 31)  39.00 Average per diem private room cost differential (line 34 x line 31)  39.00 Average per diem private room cost differential (line 34 x line 31)  39.00 Average per diem private room cost differenti		,	+ 111le 20)			
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 930, 254)  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)  2, 421.60 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 930, 254)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 35.00  37.00 37.00  37.00 37.00  38.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			nus line 33)(see instruc	ctions)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37.00 2, 930, 254 37.00		Average per diem private room cost differential (line 34 x li				35.00
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)  2, 421.60 38.00  Program general inpatient routine service cost (line 9 x line 38)  1, 174, 476 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00				66		
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)  2, 421.60 38.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	37. 00		and private room cost di	rrerential (line	3, 930, 254	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  2, 421.60 38.00  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  2,421.60 39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  2,421.60 39.00 40.00			USTMENTS			
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	38. 00	Adjusted general inpatient routine service cost per diem (see	instructions)		2, 421. 60	38. 00
			*			
41.00   Total Program general inpatient routine service cost (line 39 + line 40)   1,174,476   41.00		, , , , , , , , , , , , , , , , , , , ,				
	41.00	protar Frogram general impatrent routine service cost (fine 39	+ IIIIe 40)	ı	1, 1/4, 4/6	41.00

45.00   SURCIAL INTENSIVE CARE UNIT		Financial Systems	PULASKI MEMORIA		ON: 1E 120E		u of Form CMS-2	
Dost Center Description	COMPUT	ATION OF INPATIENT OPERATING COST		Provider C		From 10/01/2021	Date/Time Pre	pared:
Cost Center Description				Ti +I a	2 V/III	Hospi tal		8 pm
1.00   NURSERY (Little V. 8.XIX cert)   1.00   2.00   3.00   4.00   5.00   0.		Cost Center Description	I npati ent	Total Inpatient	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
Interestive Care Type Inpatient Hospital Units   Interestive Care Type Inpatient Hospital   Interestive Care Type Inpatient   Interestive Care Type Interestive Care Type Interestive Care Type Interestive Care Interes						4.00		
	42.00		0	C	0.0	0	0	42.00
44.00   COROMARY CARE UNIT	43 00				0.0	0	0	43.00
44.00 OTHER SPECIAL CARE (DNIT 17.00 OTHER DNIT 17.00 OTHER	44.00	CORONARY CARE UNIT			0.0		0	44. 00 45. 00
Cost Center Description								46.00
100   Program inpatient ancillary service cost (Wisst. D-3, col. 3, line 200)   124,625 #8 00   124,045 #8 0	47. 00							47. 00
48.00   Program Inpatt ent ancillary service cost (wist. D-3, col. 3, line 200)   Program Inpatt ent costs (sum of lines 41 through 48) (see Instructions)   1,799, 128   49.00   Program Inpattent costs (sum of lines 41 through 48) (see Instructions)   1,799, 128   49.00   Program Inpattent costs (sum of lines 41 through 48) (see Instructions)   1,799, 128   49.00   Program Inpattent costs (sum of lines 50 and 51)   1,799, 128		cost center bescription					1. 00	
PASS THROUGH COST ADJUSTMENTS							624, 652	
5.00 Pass through costs applicable to Program Inpatient routine services (from West. D. sum of Parts I and III) 5.00 Pass through costs applicable to Program Inpatient ancillary services (from West. D. sum of Parts II on 51.00 and IV) 5.00 Total Program excludable cost (sum of lines 50 and 51) 6.00 Program inpatient operating cost excluding capital related, non-physician anesthetist, and 0.52.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 0.53.00 Program discharges 6.00 Program discharges 7.00 Program anount (line 54 x line 55) 7.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 8.00 Program amount (line 54 x line 55) 8.00 Program amount (line 55 x line 55) 8.00 Program amount (line 56 minus line 53) 9.00 Program amount (line 56 minus line 53 minus line 53) 9.00 Program (line 53/54 is less than the lower of lines 55, 50 or 60 minus line basket 9.00 Program (line 15 x line 51 minus line 57 m	49. 00		41 through 48)(s	ee instructi	ons)		1, 799, 128	49.00
111   111	50 00		atient routine s	ervices (fro	nm Wkst D sui	m of Parts I and	0	50.00
Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 muss line 52)  53.00 Program discharges  54.00 Program discharges  55.00 Target amount per discharge  55.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  56.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  58.00 Bonus payment (see instructions)  59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket to compare the basket should be supported to the same than the lower of lines 55.50 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)  50.00 Relief payment (see instructions)  50.00 Relief payment (see instructions)  60.00 Relief payment (see instruc		and IV)	,	•				
TARCET ANDUNT AND LIMIT COMPUTATION   54.00   FORT and Ischarge   0.54.00   55.00   Target amount per discharge   0.00   55.00   55.00   Target amount per discharge   0.00   55.00   56.00		Total Program inpatient operating cost exclu	ding capital rel	ated, non-ph	ysician anest	hetist, and	1	
54.00   Program discharges   0.0   54.00   55.00   1   1   1   1   1   1   1   1   1			52)					
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73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 80.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost limitation 82.00 Inpatient routine service cost limitation 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions) 86.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  73.00 74.00 74.00 75.00 76.00 77.00				ne 70 ÷ line	2)			71.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 77.00 Program capital-related costs (line 74 minus line 77) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient operating costs (sum of lines 28 through 85) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2)		,	,	(line 14 v l	ine 35)			
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)  76.00 Per diem capital-related costs (line 75 ÷ line 2)  77.00 Program capital-related costs (line 9 x line 76)  1npatient routine service cost (line 74 minus line 77)  80.00 Aggregate charges to beneficiaries for excess costs (from provider records)  79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79)  81.00 Inpatient routine service cost per diem limitation  81.00 Reasonable inpatient routine service costs (see instructions)  82.00 Utilization review - physician compensation (see instructions)  83.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  83.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  75.00  76.00  76.00  77.00  78.00  79.00  80.00  80.00  80.00  81.00  82.00  83.00  84.00  85.00  86.00  87.00  87.00  88.00  88.00  88.00								74.00
77. 00 Program capital-related costs (line 9 x line 76)  78. 00 Inpatient routine service cost (line 74 minus line 77)  79. 00 Aggregate charges to beneficiaries for excess costs (from provider records)  79. 00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)  80. 00 Inpatient routine service cost per diem limitation  81. 00 Inpatient routine service cost limitation (line 9 x line 81)  82. 00 Reasonable inpatient routine service costs (see instructions)  83. 00 Program inpatient ancillary services (see instructions)  84. 00 Utilization review - physician compensation (see instructions)  85. 00 Utilization review - physician compensation (see instructions)  86. 00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88. 00 Read of the following service of the fol	75. 00		routine service	costs (from	Worksheet B,	Part II, column		75. 00
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 RAT IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine service costs (see instructions) 89.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 89.00 Reasonable inpatient routine service costs (see instructions) 80.00 Reasonable inpatient routine service costs (see instructions) 80.00 Reasonable inpatient routine service costs (see instructions) 80.00 Reasonable inpatient routine service costs (see instructions) 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Reasonable inpatient routine service cost per diem (line 27 ÷ line 2) 83.00 Reasonable inpatient routine service cost per diem (line 27 ÷ line 2) 84.00 Reasonable inpatient routine service cost per diem (line 27 ÷ line 2) 85.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 80.00 Reasonable inpatient 79 80.00 Reasonable inpatient 79 80.00 Reasonable inpatient 79 81.00 Reasonable inpatient 79 82.00 Reasonable inpatient 79 83.00 Reasonable inpatient 79 84.00 Reasonable inpatient 79 85.00 Reasonable inpatient 79 86.00 Reasonable inpatient 79 87.00 Reasonable inpatient 79 88.00 Reasonable inpatient 79 88.00 Reasonable inpatient 79 88.00 Reasonable inpatient 79 89.00 Reasonable inpatient 79 89.00 R								76.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)  79.00 Reasonable inpatient routine service cost (see instructions)  82.00 Inpatient routine service cost limitation (line 9 x line 81)  82.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Reasonable inpatient routine service costs (see instructions)  80.00 Reasonable inpatient routine service costs (see instructions)  81.00 Reasonable inpatient ancillary services (see instructions)  82.00 Reasonable inpatient operation (line 9 x line 81)  83.00 Reasonable inpatient routine service costs (see instructions)  84.00 Reasonable inpatient routine service costs (see instructions)  85.00 Reasonable inpatient routine service costs (see instructions)  86.00 Reasonable inpatient routine service cost (see instructions)  87.00 Reasonable inpatient routine service cost (see instructions)  88.00 Reasonable inpatient routine service cost per diem (line 27 ÷ line 2)  89.00 Reasonable inpatient routine service cost per diem (line 27 ÷ line 2)  80.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79)  80.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79)  80.00 Reasonable inpatient routine service cost limitation (line 9 x line 81)  81.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79)  81.00 Reasonable inpatient 700 Reasonable inpati								
81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Reasonable inpatient routine service cost (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine service cost limitation 89.00 Reasonable inpatient routine service cost (see instructions) 89.00 Reasonable inpatient routine service cost (see instructions) 89.00 Reasonable inpatient routine service cost (see instructions) 89.00 Reasonable inpatient routine service cost limitation 89.00 Reasonable inpatient routine service cost (see instructions) 89.00 Reasonable inpatient routine service cost limitation 89.00 Reasonable inpatient routine service cost (see instructions) 89.00 Reasonable inpatient routine service cost (se		,	,	ovi der recor	ds)			79.00
82.00   Inpatient routine service cost limitation (line 9 x line 81)   82.00   83.00   Reasonable inpatient routine service costs (see instructions)   83.00   84.00   Program inpatient ancillary services (see instructions)   84.00   Utilization review - physician compensation (see instructions)   85.00   Total Program inpatient operating costs (sum of lines 83 through 85)   86.00   PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST   87.00   Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)   2,421.60   88.00		Total Program routine service costs for comp	arison to the co			nus line 79)		80.00
83.00 Reasonable inpatient routine service costs (see instructions)  84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Reasonable inpatient routine service costs (see instructions)  86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Reasonable inpatient routine service costs (see instructions)  87.00 Reasonable inpatient routine service costs (see instructions)  88.00 Reasonable inpatient routine service costs (see instructions)  87.00 Reasonable inpatient routine service costs (see instructions)  88.00 Reasonable inpatient routine service costs (see instructions)  87.00 Reasonable inpatient routine service costs (see instructions)  88.00 Reasonable inpatient routine service costs (see instructions)  87.00 Reasonable inpatient routine service costs (see instructions)  88.00 Reasonable inpatient routine service costs (see instructions)  87.00 Reasonable inpatient routine services (see instructions)  88.00 Reasonable inpatient routine services (see in								81.00
84.00 Program inpatient ancillary services (see instructions)  85.00 Utilization review - physician compensation (see instructions)  86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  87.00 Ratio observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Ratio observation bed days (see instructions)				)				83.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)  PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	84.00	Program inpatient ancillary services (see in	structions)					84.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST  Total observation bed days (see instructions)  87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  2,421.60 88.00			•					85.00
87.00 Total observation bed days (see instructions)  88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)  536 87.00 2, 421.60 88.00	86.00			ough 85)				J 86.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 2,421.60 88.00	87. 00						536	87. 00
89.00   Ubservation bed cost (line 87 x line 88) (see instructions)   1,297,978   89.00		Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			2, 421. 60	88. 00
	89. 00	Ubservation bed cost (line 87 x line 88) (se	e instructions)				1, 297, 978	89. 00

Health Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 10/01/2021 To 09/30/2022	Date/Time Pre 2/23/2023 4:2	
		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	390, 730	4, 702, 210	0. 08309	5 1, 297, 978	107, 855	90.00
91.00 Nursing Program cost	0	4, 702, 210	0.00000	0 1, 297, 978	0	91.00
92.00 Allied health cost	0	4, 702, 210	0.00000	0 1, 297, 978	0	92.00
93.00 All other Medical Education	l o	4, 702, 210	0.00000	0 1, 297, 978	0	93.00

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	ı of Form CMS-2	552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1305	Peri od: From 10/01/2021	Worksheet D-1	
			To 09/30/2022	Date/Time Prep 2/23/2023 4:28	
		Title XIX	Hospi tal	Cost	

		Title XIX	Hospi tal	2/23/2023 4: 2 Cost	8 pm
	Cost Center Description	THE XIX	1103pi tai	0031	
	DADT I ALL DROWNER COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day	rs, excluding newborn)		2, 243	1.00
2.00	Inpatient days (including private room days, excluding swing-			1, 623	
3. 00	Private room days (excluding swing-bed and observation bed da	0	3. 00		
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	(ave)		1, 087	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	· ·	5.00
	reporting period	3 ,			
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	287	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)	m daya) thrayah Dagambar	21 of the cost	25	7 00
7. 00	Total swing-bed NF type inpatient days (including private rooreporting period	ill days) through beceiliber	31 Of the Cost	35	7. 00
8.00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	31 of the cost	298	8. 00
	reporting period (if calendar year, enter 0 on this line)	-			
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	g swing-bed and	7	9. 00
10.00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	nlv (including private m	room days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instruc		days)	G	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11.00
40.00	December 31 of the cost reporting period (if calendar year, e			0	40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	x only (including privat	te room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	te room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar y				
14.00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	14.00
15.00	Total nursery days (title V or XIX only)			23	15. 00 16. 00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			U	16.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 d	of the cost		17. 00
	reporting period	-			
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	231. 10	19 00
17.00	reporting period	3 through beechber 31 of	the cost	231. 10	17.00
20.00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	the cost	231. 10	20.00
04 00	reporting period			4 700 040	04 00
21. 00 22. 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ting period (line	4, 702, 210 • 0	21.00
22.00	5 x line 17)	iei 31 01 the cost report	ing perrou (inte	. 0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23. 00
	x line 18)			0.000	
24. 00	Swing-bed cost applicable to NF type services through Decembe $7 \times 1$ ine 19)	r 31 of the cost reporti	ng period (line	8, 089	24. 00
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	68, 868	25. 00
	x line 20)		, ,		
26.00	Total swing-bed cost (see instructions)	(1)		771, 956	
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Tine 21 minus Tine 26)		3, 930, 254	27. 00
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	28. 00
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 33. 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	
34. 00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	ctions)	0. 00	
35.00	Average per diem private room cost differential (line 34 x li		,	0. 00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		66	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	rrerential (line	3, 930, 254	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see	instructions)		2, 421. 60	
39.00	Program general inpatient routine service cost (line 9 x line			16, 951	
40. 00 41. 00	Medically necessary private room cost applicable to the Progr Total Program general inpatient routine service cost (line 39			0 16, 951	
00	1		1	.0, 701	

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: From 10/01/2021	Worksheet D-1	
	To 09/30/2022	Date/Time Pre 2/23/2023 4:2	
	Title XIX Hospital	Cost	
	Cost Center Description Total Total Average Per Program Days  Inpatient Inpatient Diem (col. 1	Program Cost (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) 37, 329 23 1, 623.00 0		42.00
43.00	Intensive Care Type Inpatient Hospital Units   O O O O O O O	0	43. 00
44.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT		44. 00 45. 00
46.00	SURGICAL INTENSIVE CARE UNIT		46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description		47.00
49.00		1.00	49.00
48. 00 49. 00	Total Program inpatient costs (sum of lines 41 through 48) (see instructions)	11, 456 28, 407	
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
	111)		
51. 00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52. 00 53. 00	Total Program excludable cost (sum of lines 50 and 51) Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and	0	52. 00 53. 00
55.00	medical education costs (line 49 minus line 52)	0	33.00
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges	0	54.00
55.00	Target amount per discharge	0. 00	55.00
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 market basket		
60. 00 61. 00		0.00	60. 00 61. 00
01.00	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target	o l	01.00
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) PROGRAM INPATIENT ROUTINE SWING BED COST	0	63. 00
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See	0	64. 00
65.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period	0	67.00
68 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
	(line 13 x line 20)		
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 71. 00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		70. 00 71. 00
72.00	Program routine service cost (line 9 x line 71)		72.00
73. 00 74. 00	Medically necessary private room cost applicable to Program (line 14 x line 35)  Total Program general inpatient routine service costs (line 72 + line 73)		73. 00 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 78. 00	Program capital-related costs (line 9 x line 76) Inpatient routine service cost (line 74 minus line 77)		77. 00 78. 00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79. 00
80. 00 81. 00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) Inpatient routine service cost per diem limitation		80. 00 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 83. 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
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	F.C.	
87. 00 88. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	536 2, 421. 60	87. 00 88. 00
89. 00	Observation bed cost (line 87 x line 88) (see instructions)	1, 297, 978	89. 00

Health Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 10/01/2021 To 09/30/2022	Date/Time Pre 2/23/2023 4:2	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capi tal -related cost	390, 730	4, 702, 210	0. 08309	5 1, 297, 978	107, 855	90.00
91.00 Nursing Program cost	0	4, 702, 210	0.00000	0 1, 297, 978	0	91.00
92.00 Allied health cost	0	4, 702, 210	0.00000	0 1, 297, 978	0	92.00
93.00 All other Medical Education	0	4, 702, 210	0.00000	0 1, 297, 978	0	93.00

I NPATI ENT	ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1305	Peri od:	Worksheet D-3	3
				From 10/01/2021 To 09/30/2022	D-+- /T: D	
				To 09/30/2022	Date/Time Pre 2/23/2023 4:2	
		Titl∈	XVIII	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges		Program Costs	
				Charges	(col . 1 x	
			1.00	2.00	col . 2) 3.00	
I NPA	ATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	00 ADULTS & PEDI ATRI CS			496, 687		30.00
31.00 0310	DO INTENSIVE CARE UNIT			0		31.00
43.00 0430	DO NURSERY					43.00
	LLARY SERVICE COST CENTERS					
	OO OPERATING ROOM		0. 2827		68, 258	
	DO DELIVERY ROOM & LABOR ROOM		0. 6879		0	52.00
	DO ANESTHESI OLOGY		0. 0280		660	
	DO RADI OLOGY-DI AGNOSTI C		0. 1692		34, 151	54.00
	DO LABORATORY		0. 1670		54, 673	
	D1 BLOOD LABORATORY D0 BLOOD STORING, PROCESSING & TRANS.		0. 00000 0. 3540		0	
	DO RESPIRATORY THERAPY		1. 09070		4, 868 98, 946	
	00 PHYSI CAL THERAPY		0. 5905		38, 450	1
	OO OCCUPATI ONAL THERAPY		0. 49690		16, 710	1
	OO SPEECH PATHOLOGY		0. 0531		0	
	DO ELECTROCARDI OLOGY		0. 0270		367	69.00
69. 01 0690	O1 CARDI AC REHABI LI TATI ON		0. 5382	58 0	0	69. 0°
70. 00   0700	DO ELECTROENCEPHALOGRAPHY		0.00000	00 0	0	70.00
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2524		92, 267	
	DO IMPL. DEV. CHARGED TO PATIENTS		0. 3778		23, 519	
	DO DRUGS CHARGED TO PATIENTS		0. 3303		161, 040	
	20 ONCOLOGY		0. 8026	91 0	0	76.00
	PATIENT SERVICE COST CENTERS DO RURAL HEALTH CLINIC		0.0000	00	0	88. 00
	DI RURAL HEALTH CLINIC		0.0000			
	22 RURAL HEALTH CLINIC III		0.0000		0	
	33 RURAL HEALTH CLINIC IV		0. 00000		Ö	
	OO CLINIC		1. 4312		Ö	
	DO EMERGENCY		0. 7193		20, 280	
	OO OBSERVATION BEDS (NON-DISTINCT PART)		2. 8361			
200. 00	Total (sum of lines 50 through 94 and 96 through 98)			1, 957, 877	624, 652	
201. 00	Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		0		201.00
202. 00	Net charges (line 200 minus line 201)			1, 957, 877		202.00

Health Financial Systems PULASKI MEMORIA	I HOSDITAL		ln lio	u of Form CMS-2	DEE2 10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1305	Peri od:	Worksheet D-3	
		CCN: 15-Z305	From 10/01/2021 To 09/30/2022		pared:
	Title		Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program Charges	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					30.00
31. 00   03100   INTENSIVE CARE UNIT					31.00
43. 00   04300   NURSERY					43.00
ANCILLARY SERVICE COST CENTERS		0.00075	- D - D - D - D - D - D - D - D - D - D	1 405	F0 00
50.00   05000   OPERATING ROOM 52.00   05200   DELIVERY ROOM & LABOR ROOM		0. 28275 0. 6879		1	50. 00 52. 00
53. 00   05300   ANESTHESI OLOGY		0. 0280		0	53.00
54. 00   05400   RADI OLOGY - DI AGNOSTI C		0. 16928		1	
60. 00   06000   LABORATORY		0. 16702			
60. 01   06001   BLOOD LABORATORY		0. 00000		1	60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 35403		<b>l</b>	1
65. 00 06500 RESPI RATORY THERAPY		1. 09070		29, 304	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 59052	92, 197	54, 445	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 49690		28, 542	67.00
68. 00 O6800 SPEECH PATHOLOGY		0. 05311		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 02703		l .	69.00
69. 01 06901 CARDI AC REHABI LI TATI ON		0. 53825			69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000		0	70.00
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS		0. 2524 <sup>2</sup> 0. 37783		12, 183 0	71.00 72.00
73. 00   07300   DRUGS CHARGED TO PATTENTS		0. 37763			
76. 00 03020 0NC0L0GY		0. 80269		27, 703	76.00
OUTPATIENT SERVICE COST CENTERS		0.0020	- 1		70.00
88. 00 08800 RURAL HEALTH CLINIC		0.00000	00	0	88. 00
88. 01   08801 RURAL HEALTH CLINIC II		0. 00000	00	0	88. 01
88. 02 08802 RURAL HEALTH CLINIC III		0.00000	00	0	88. 02
88. 03   08803   RURAL HEALTH CLINIC IV		0. 00000		0	88. 03
90. 00   09000   CLI NI C		1. 43129		0	90.00
91. 00 09100 EMERGENCY		0. 71931			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		2. 83617		0	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)	(1)		378, 240	167, 375	
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		270 240		201.00
202.00   Net charges (line 200 minus line 201)		I	378, 240	l	202. 00

Health Financial Systems PULASKI MEMORIA		ON 15 1005		u of Form CMS-1	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1305	Peri od: From 10/01/2021	Worksheet D-3	5
			To 09/30/2022	Date/Time Pre 2/23/2023 4:2	pared: 28 pm
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col . 1 x	
		1.00	2. 00	col . 2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00   03000   ADULTS & PEDI ATRI CS			3, 436		30.00
31. 00   03100   NTENSI VE CARE UNI T			0		31.00
43. 00   04300   NURSERY			0		43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM		0. 2827	50 3, 927	1, 110	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 6879	·		1
53. 00   05300   ANESTHESI OLOGY		0. 0280			
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 1692	·		
60. 00   06000   LABORATORY		0. 1670			
60. 01   06001   BLOOD LABORATORY 63. 00   06300   BLOOD STORING, PROCESSING & TRANS.		0.0000		-	
65. 00 06500 RESPIRATORY THERAPY		0. 3540 1. 0907			
66. 00   06600   PHYSI CAL THERAPY		0. 5905			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 4969			67.00
68. 00 06800 SPEECH PATHOLOGY		0. 0531			
69. 00 06900 ELECTROCARDI OLOGY		0. 0270			69.00
69. 01 06901 CARDI AC REHABI LI TATI ON		0. 5382	58 0	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2524	·		71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 3778			
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 3303			
76. 00 03020 0NCOLOGY		0. 8026	91 0	0	76.00
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC		1. 5819	39 0	0	88. 00
88. 01   08801 RURAL HEALTH CLINIC II		2. 1733			
88. 02   08802 RURAL HEALTH CLINIC III		2. 9768		0	
88. 03   08803 RURAL HEALTH CLINIC IV		2. 0961		1	
90. 00   09000   CLI NI C		1. 4312			
91. 00   09100   EMERGENCY		0. 7193		1, 071	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		2. 8361	74 0	0	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			33, 254	11, 456	
201.00 Less PBP Clinic Laboratory Services-Program only charg	es (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			33, 254		202.00

Health Financial Systems	PULASKI MEMORIAL HOSPITAL		In lie	u of Form CMS-2	2552-10
I NPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 15-1305	Peri od:	Worksheet D-3	
	Component	CCN: 15-Z305	From 10/01/2021 To 09/30/2022	2/23/2023 4: 2	pared: 8 pm
	Ti -		Swing Beds - SNF	PPS	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program Charges	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					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS		0.0000	20		
50. 00   05000   OPERATING ROOM		0.00000			
52.00   05200   DELIVERY ROOM & LABOR ROOM		0.0000			
54. 00   05300   ANESTHEST OLOGY 54. 00   05400   RADI OLOGY-DI AGNOSTI C		0.0000		1	
60. 00   06000   LABORATORY		0.0000		1	
60. 01   06001   BLOOD LABORATORY		0. 00000		-	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 00000		l .	1
65. 00 06500 RESPIRATORY THERAPY		0. 00000	00	0	65.00
66. 00 06600 PHYSI CAL THERAPY		0.0000	00	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0.00000		-	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 00000			
69. 00 06900 ELECTROCARDI OLOGY		0. 00000			
69. 01   06901   CARDI AC REHABI LI TATI ON		0. 00000		1	
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 00000 0. 00000		1	
72.00 07700 MEDICAL SUPPLIES CHARGED TO PATTENTS		0.0000		1	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0.0000			
76. 00 03020 0NC0L0GY		0. 00000			
OUTPATIENT SERVICE COST CENTERS		1			1
88. 00 08800 RURAL HEALTH CLINIC		0.00000	00 00	0	88. 00
88.01 08801 RURAL HEALTH CLINIC II		0.0000	00	0	88. 01
88. 02 08802 RURAL HEALTH CLINIC III		0. 00000		1	
88. 03   08803   RURAL HEALTH CLINIC IV		0. 00000			
90. 00   09000   CLI NI C		0. 00000			
91. 00   09100   EMERGENCY		0.00000		1	
92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART) 200.00   Total (sum of lines 50 through 94 and 9	4 through 00)	0. 00000	00		92. 00 200. 00
200.00 Total (sum of lines 50 through 94 and 9 201.00 Less PBP Clinic Laboratory Services-Pro			0		200.00
202.00 Net charges (line 200 minus line 201)	gram only charges (fille 61)	'	0		201.00
202. 00    Met charges (Trite 200 minus Trite 201)		1	1	I	1202.00

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-1305		Worksheet E Part B Date/Time Prepared: 2/23/2023 4:28 pm

		Title XVIII	Hospi tal	2/23/2023 4: 2 Cost	8 pm
			110001 141		
	DADT D. MEDICAL AND OTHER HEALTH CERVICES			1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES  Medical and other services (see instructions)			5, 723, 845	1.00
2. 00	Medical and other services reimbursed under OPPS (see instructi	ons)		0,723,043	1
3. 00	OPPS payments	,		0	1
4.00	Outlier payment (see instructions)			0	4.00
4. 01	Outlier reconciliation amount (see instructions)			0	
5. 00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		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 Transitional corridor payment (see instructions)			0.00	1
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV	col 13 line 200		0	ı
10.00	Organ acquisitions	, cor. 13, 11116 200		0	1
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			5, 723, 845	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
12.00	Ancillary service charges	(0)		0	
13. 00 14. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin Total reasonable charges (sum of lines 12 and 13)	e 69)		0	
14.00	Customary charges			0	14.00
15. 00	Aggregate amount actually collected from patients liable for pa	vment for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for			0	
	had such payment been made in accordance with 42 CFR §413.13(e)		-		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	1
18.00	Total customary charges (see instructions)	. : 6   : 10	11) (	0	
19. 00	Excess of customary charges over reasonable cost (complete only instructions)	TIT TIME 18 exceeds II	ne II) (See	0	19. 00
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20.00
20.00	instructions)	e execute			20.00
21.00	Lesser of cost or charges (see instructions)			5, 781, 083	21.00
	Interns and residents (see instructions)			0	
	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24.00
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			74 202	25.00
25. 00 26. 00	Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line		ructions)	74, 383 2, 617, 138	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl			3, 089, 562	1
	instructions)		(	0, 221, 222	
28.00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	28. 00
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30.00	Subtotal (sum of lines 27 through 29)			3, 089, 562	1
31.00	Primary payer payments Subtotal (line 30 minus line 31)			2, 441 3, 087, 121	1
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	S)		3,007,121	32.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	<u> </u>		0	33.00
34.00	Allowable bad debts (see instructions)			196, 795	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			127, 917	35.00
	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		187, 270	
37.00	Subtotal (see instructions)			3, 215, 038	
	MSP-LCC reconciliation amount from PS&R			0	1
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)			U	39. 00 39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	ı
	Partial or full credits received from manufacturers for replace	d devices (see instruc	ctions)	Ö	ı
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	( )	,	0	1
	Subtotal (see instructions)			3, 215, 038	1
40. 01	Sequestration adjustment (see instructions)			24, 113	1
40. 02	Demonstration payment adjustment amount after sequestration			0	
	Sequestration adjustment-PARHM pass-throughs			0 404 440	40.03
	Interim payments			3, 121, 440	1
41.01	Interim payments-PARHM			0	41. 01 42. 00
	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)				42.00
43. 00	Balance due provider/program (see instructions)			69, 485	1
43. 01	Balance due provider/program-PARHM (see instructions)				43. 01
44.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	0	1
	§115. 2				]
00.00	TO BE COMPLETED BY CONTRACTOR			-	00.00
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)			0.00	1
	Total (sum of lines 91 and 93)				94.00
				•	•

Health Financial Systems	PULASKI	MEMORI AL	HOSPI TAL	In Lie	of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			Provider CCN: 15-1305		Worksheet E	
				From 10/01/2021		
				To 09/30/2022	Date/Time Pre	epared:
					2/23/2023 4: 2	28 pm
			Title XVIII	Hospi tal	Cost	
					1. 00	
MEDICARE PART B ANCILLARY COSTS						
200.00 Part B Combined Billed Days					C	200.00

Health Financial Systems PULA:
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provi der CCN: 15-1305

			1	0 09/30/2022	2/23/2023 4: 2	
		Title	: XVIII	Hospi tal	Cost	•
		Inpatient Part A Part B		t B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4. 00	
1. 00	Total interim payments paid to provider		1, 669, 901		3, 067, 840	1. 00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3. 01 3. 02 3. 03 3. 04 3. 05	ADJUSTMENTS TO PROVIDER		0 0 0 0		53, 600 0 0 0	3. 01 3. 02 3. 03 3. 04 3. 05
0 50	Provi der to Program	l	1			0.50
3. 50 3. 51 3. 52 3. 53 3. 54	ADJUSTMENTS TO PROGRAM		0 0 0 0 0		0 0 0	3. 50 3. 51 3. 52 3. 53 3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		53, 600	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		1, 669, 901		3, 121, 440	4.00
5. 00	List separately each tentative settlement payment after					5. 00
3.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider	<u> </u>				
5. 01 5. 02 5. 03	TENTATI VE TO PROVI DER		0 0		0 0	5. 01 5. 02 5. 03
	Provider to Program					
5. 50 5. 51	TENTATI VE TO PROGRAM		0		0	5. 50 5. 51
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5. 52 5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		0		69, 485	6. 01
6. 02	SETTLEMENT TO PROGRAM		81		0	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 669, 820	Contractor	3, 190, 925	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
0.00	lu co i		)	1. 00	2. 00	0.55
8.00	Name of Contractor					8.00

Provi der CCN: 15-1305 Provider CCN: 15-1305 | Period: | Worksheet E-1 | From 10/01/2021 | Part | To 09/30/2022 | Date/Time Prepared: | 2/2/2023 4: 28 pm

		'			2/23/2023 4: 2	28 pm
				wing Beds - SNF		
		I npati en	nt Part A	Par	⁻t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		838, 038	3	0	1.00
2.00	Interim payments payable on individual bills, either			O	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		1	- 1	1	
3. 01	ADJUSTMENTS TO PROVIDER				0	
3. 02			1	O	0	
3. 03				D	0	
3. 04					0	
3.05			(	)	0	3. 05
	Provider to Program		1	. 1	1	
3. 50	ADJUSTMENTS TO PROGRAM				0	
3. 51			1		0	
3. 52			l .	0	0	
3. 53			1	0	0	0.00
3. 54			l .	0	0	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		(	O	0	3. 99
4 00	3.50-3.98)		020 020		0	4 00
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		838, 038	5	0	4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after		I			5.00
3.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER				0	5.01
5. 02					0	
5. 03					0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		(	D	0	5. 50
5. 51				)	0	5. 51
5. 52			(	)	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			)	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		22, 16		0	
6. 02	SETTLEMENT TO PROGRAM		1	O	0	
7. 00	Total Medicare program liability (see instructions)		860, 203		0	7. 00
				Contractor	NPR Date	
			0	Number	(Mo/Day/Yr)	
9 00	Name of Contractor		0	1.00	2.00	8.00
8. 00	Name of Contractor			1	I	J 8.00

Heal th	Financial Systems PULASKI MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2	2552-10	
	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-1305	Peri od:	Worksheet E-1		
			From 10/01/2021	Part II		
			To 09/30/2022	Date/Time Pre 2/23/2023 4: 2		
		Title XVIII	Hospi tal	Cost	.o p	
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATI					
1. 00	Total hospital discharges as defined in AARA §4102 from Wks			I	1. 00 2. 00	
2. 00	2.00   Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost					
	reporting periods beginning on or after 10/01/2013, line 32)					
	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2					
4. 00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of line		d plus for cost	I	4. 00	
	reporting periods beginning on or after 10/01/2013, line 32	2)		I		
5. 00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			I	5. 00	
6. 00	Total hospital charity care charges from Wkst. S-10, col. 3			I	6.00	
7. 00	CAH only - The reasonable cost incurred for the purchase of	certified HII technology	Wkst. S-2, Pt. I	I	7. 00	
0.00	line 168			I	0.00	
8. 00	Calculation of the HIT incentive payment (see instructions)			I	8.00	
9. 00	Sequestration adjustment amount (see instructions)			I	9.00	
10. 00	· · · · · · · · · · · · · · · · · · ·	n (see instructions)			10.00	
	I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH					
	Initial/interim HIT payment adjustment (see instructions)			I	30.00	
	Other Adjustment (specify)		`	I	31.00	
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instructio	ns)	ı	32.00	

Health Financial Systems	PULASKI MEMORIAL	. HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 15-1305	Peri od:	Worksheet E-2
			From 10/01/2021	
		Component CCN: 15-Z305	To 09/30/2022	Date/Time Prepared:
				2/23/2023 4:28 pm

		Component CCN: 15-2305	10 09/30/2022	2/23/2023 4: 2	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
	COMPUTATION OF NET COST OF COVERED SERVICES		1. 00	2. 00	
1. 00	Inpatient routine services - swing bed-SNF (see instructions)		701, 949	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)		·		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Par		169, 049	0	3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swi	ng-bed pass-through, see	:		
3. 01	instructions) Nursing and allied health payment-PARHM (see instructions)				3. 01
4. 00	Per diem cost for interns and residents not in approved teachi	ng program (see		0.00	
00	instructions)	rig program (see		0.00	
5.00	Program days		287	0	5.00
6. 00	Interns and residents not in approved teaching program (see in			0	
7.00	Utilization review - physician compensation - SNF optional me	thod only	070.000	0	7.00
8. 00 9. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7) Primary payer payments (see instructions)		870, 998	0	
10.00	Subtotal (line 8 minus line 9)		870, 998	0	
11. 00	Deductibles billed to program patients (exclude amounts applic	cable to physician	910	0	1
	professional services)	. ,			
12.00	Subtotal (line 10 minus line 11)		870, 088	0	
13. 00	Coinsurance billed to program patients (from provider records)	) (exclude coinsurance	3, 384	0	13.00
14. 00	for physician professional services) 80% of Part B costs (line 12 x 80%)			0	14.00
	Subtotal (see instructions)		866, 704	0	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions	•			16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstr	ration) payment	0		16. 55
16. 99	adjustment (see instructions)			0	16. 99
	Demonstration payment adjustment amount before sequestration Allowable bad debts (see instructions)		0	0	
	Adjusted reimbursable bad debts (see instructions)		ő	0	1
	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	0	0	18.00
	Total (see instructions)		866, 704	0	
19. 01	Sequestration adjustment (see instructions)		6, 501	0	
19. 02 19. 03	Demonstration payment adjustment amount after sequestration)		0	0	19. 02 19. 03
	Sequestration adjustment-PARHM pass-throughs Sequestration for non-claims based amounts (see instructions)		0	0	
	Interim payments		838, 038	0	1
	Interim payments-PARHM				20. 01
	Tentative settlement (for contractor use only)		0	0	
	Tentative settlement-PARHM (for contractor use only)		00.445		21.01
22. 00 22. 01	Balance due provider/program (line 19 minus lines 19.01, 19.02	2, 19.25, 20, and 21)	22, 165	0	22. 00
23. 00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance	nce with CMS Pub 15-2	0	0	1
20.00	chapter 1, §115. 2			· ·	20.00
	Rural Community Hospital Demonstration Project (§410A Demonstr	ration) Adjustment			1
200. 00	Is this the first year of the current 5-year demonstration per	riod under the 21st			200.00
	Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement				-
201 00	Medicare swing-bed SNF inpatient routine service costs (from N	Wkst D-1 Pt II line			201.00
201.00	66 (title XVIII hospital))				201.00
202. 00	Medicare swing-bed SNF inpatient ancillary service costs (from	m Wkst. D-3, col. 3, lin	e		202.00
	200 (title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-year demons		204.00
	period)	Tirst year of the curre	iit 3-year deliloris	ti ati on	
205. 00	Medicare swing-bed SNF target amount				205.00
206. 00	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti	mes line 204)			206. 00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				ļ
	Program reimbursement under the §410A Demonstration (see insti	*			207.00
∠∪ช. UU	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2 and 3)	z, cor. r, sum of lines	'		208.00
209. 00	Adjustment to Medicare swing-bed SNF PPS payments (see instru	ctions)			209.00
	Reserved for future use	/			210.00
	Comparision of PPS versus Cost Reimbursement				1
215. 00	Total adjustment to Medicare swing-bed SNF PPS payment (line 2	209 plus line 210) (see			215. 00
	instructions)				I

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provi der CCN: 15-1305	Peri od: From 10/01/2021	Worksheet E-2
		Component CCN: 15-Z305		

		Component CCN: 15-Z305	To 09/30/2022	Date/Time Pro 2/23/2023 4:2	
		Title XIX	Swing Beds - SNF		
			Part A	Part B	
	COMPUTATION OF NET COST OF COVERED SERVICES		1. 00	2. 00	
1. 00	Inpatient routine services - swing bed-SNF (see instructions)		0		1.00
2. 00	Inpatient routine services - swing bed-NF (see instructions)		o		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Par	t A, and sum of Wkst. D,	0		3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swi	ng-bed pass-through, see	9		
2 01	instructions)				2 01
3. 01 4. 00	Nursing and allied health payment-PARHM (see instructions) Per diem cost for interns and residents not in approved teach	ing program (see	0.00		3. 01 4. 00
4.00	instructions)	The program (see	0.00		7.00
5.00	Program days		0		5.00
6.00	Interns and residents not in approved teaching program (see i		0		6.00
7. 00	Utilization review - physician compensation - SNF optional me	thod only	0		7.00
8. 00 9. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7) Primary payer payments (see instructions)		0		8. 00 9. 00
10.00	Subtotal (line 8 minus line 9)		0		10.00
11. 00	Deductibles billed to program patients (exclude amounts applied	cable to physician	0		11.00
	professional services)	. 3			
12.00	Subtotal (line 10 minus line 11)		0		12.00
13. 00	Coinsurance billed to program patients (from provider records)	) (exclude coinsurance	0		13.00
14. 00	for physician professional services) 80% of Part B costs (line 12 x 80%)		0		14.00
	Subtotal (see instructions)		0		15.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		16.00
16. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)			16. 50
16. 55	Rural community hospital demonstration project (§410A Demonst	ration) payment			16. 55
14 00	adjustment (see instructions)				14 00
	Demonstration payment adjustment amount before sequestration Allowable bad debts (see instructions)		0		16. 99 17. 00
	Adjusted reimbursable bad debts (see instructions)		0		17. 01
	Allowable bad debts for dual eligible beneficiaries (see inst	ructi ons)	0		18.00
19.00	Total (see instructions)		0		19.00
	Sequestration adjustment (see instructions)		0		19. 01
	Demonstration payment adjustment amount after sequestration)		0		19. 02
	Sequestration adjustment-PARHM pass-throughs Sequestration for non-claims based amounts (see instructions)		0		19. 03 19. 25
	Interim payments		0		20.00
	Interim payments-PARHM				20. 01
	Tentative settlement (for contractor use only)		0		21.00
	Tentative settlement-PARHM (for contractor use only)	0 40 05 00   04)			21. 01
22. 00 22. 01	Balance due provider/program (line 19 minus lines 19.01, 19.0). Balance due provider/program-PARHM (see instructions)	2, 19.25, 20, and 21)	0		22. 00 22. 01
23. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2	0		23. 00
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonst				
200.00	Is this the first year of the current 5-year demonstration per	riod under the 21st			200.00
	Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from )	Wkst. D-1, Pt. II, line			201.00
	66 (title XVIII hospital))	,			
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from	m Wkst. D-3, col. 3, lir	ne		202.00
	200 (title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202) Medicare swing-bed SNF discharges (see instructions)				203. 00 204. 00
204.00	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	ent 5-vear demons	tration	1204.00
	peri od)	or you. or the our.	one o your domono		
205.00	Medicare swing-bed SNF target amount				205. 00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 t				206. 00
207.00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				207.00
	Program reimbursement under the §410A Demonstration (see inst	•	1		207. 00 208. 00
200.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-: and 3)	z, cor. r, sum or rilles	'		200.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instru	ctions)			209.00
	Reserved for future use				210. 00
045 65	Comparision of PPS versus Cost Reimbursement	200 1 211 212 4			045 05
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line instructions)	209 plus line 210) (see			215. 00
	r nati dati ona)				1

Health Financial Systems	PULASKI MEMORIAL HOSPITA	\L	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi d	er CCN: 15-1305	Peri od: From 10/01/2021	Worksheet E-3 Part V Date/Time Prepared:
			10 077 307 2022	2/23/2023 4: 28 pm
	1	itle XVIII	Hospi tal	Cost

				2/23/2023 4: 2	8 pm
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	T REIMBURSEMENT		
1.00	Inpatient services			1, 799, 128	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructi	ons)		0	
	Organ acquisition	,		0	3.00
	Subtotal (sum of lines 1 through 3)			1, 799, 128	4.00
	Primary payer payments			0	5.00
	Total cost (line 4 less line 5). For CAH (see instructions)			1, 817, 119	
	COMPUTATION OF LESSER OF COST OR CHARGES			1,017,117	0.00
H	Reasonable charges				i
-	Routine service charges			0	7.00
	Ancillary service charges			0	
	Organ acquisition charges, net of revenue			0	
	Total reasonable charges			0	
	Customary charges			0	10.00
	Aggregate amount actually collected from patients liable for	navment for services on	a charge basis	0	11.00
	Amounts that would have been realized from patients liable fo			0	
	had such payment been made in accordance with 42 CFR 413.13(e		on a charge basis	0	12.00
1	Ratio of line 11 to line 12 (not to exceed 1.000000)	-)		0. 000000	13.00
	Total customary charges (see instructions)			0.000000	
	Excess of customary charges over reasonable cost (complete or	alv if line 14 evceeds li	ina 6) (saa	0	
	instructions)	illy II IIIle 14 exceeds II	ine o) (see	U	13.00
	Excess of reasonable cost over customary charges (complete or	alvifling 6 avegade li	no 14) (soo	0	16.00
	instructions)	ily il lille o exceeds ill	116 14) (366	U	10.00
	Cost of physicians' services in a teaching hospital (see inst	tructions)		0	17. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	ir de trons)		0	17.00
	Direct graduate medical education payments (from Worksheet E-	4 line 49)		0	18.00
	Cost of covered services (sum of lines 6, 17 and 18)	1, 11116 17)		1, 817, 119	
	Deductibles (exclude professional component)			144, 263	
	Excess reasonable cost (from line 16)			0	
	Subtotal (line 19 minus line 20 and 21)			1, 672, 856	
	Coinsurance			1, 072, 030	23.00
	Subtotal (line 22 minus line 23)			1, 672, 856	
	Allowable bad debts (exclude bad debts for professional servi	cos) (soo instructions)		1, 672, 636	
		ces) (see Histructions)		9, 582	
	Adjusted reimbursable bad debts (see instructions)	h			
	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		9, 374	
	Subtotal (sum of lines 24 and 25, or line 26)			1, 682, 438	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	>		0	
1	Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	
1	Recovery of accelerated depreciation.			0	
	Demonstration payment adjustment amount before sequestration			0	
	Subtotal (see instructions)			1, 682, 438	
1	Sequestration adjustment (see instructions)			12, 618	
	Demonstration payment adjustment amount after sequestration			0	
	Sequestration adjustment-PARHM				30.03
1	Interim payments			1, 669, 901	
	Interim payments-PARHM				31.01
	Tentative settlement (for contractor use only)			0	
	Tentative settlement-PARHM (for contractor use only)				32. 01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.0	02, 31, and 32)		-81	33.00
	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, m	ninus lines 30 03 31 01	. and 32.01)		33. 01
34. 00	Protested amounts (nonallowable cost report items) in accorda §115.2			0	34.00

Health Financial Systems	PULASKI MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1305	Peri od: Worksheet E-3 From 10/01/2021 Part VII To 09/30/2022 Date/Time Prepared: 2/23/2023 4:28 pm

			0 09/30/2022	2/23/2023 4: 2	
		Title XIX	Hospi tal	Cost	, p
			Inpatient	Outpati ent	
			1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		28, 407		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		o		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		28, 407	0	4.00
5.00	Inpatient primary payer payments		O		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		28, 407	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonable Charges				1
8.00	Routine service charges		3, 436		8.00
9.00	Ancillary service charges		33, 254	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)		36, 690	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
	basis				
14.00	Amounts that would have been realized from patients liable for	1 3	0	0	14.00
45 00	a charge basis had such payment been made in accordance with 4	2 CFR §413.13(e)			45.00
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)	1611 47	36, 690	0	
17. 00	Excess of customary charges over reasonable cost (complete onl	y IT line 16 exceeds	8, 283	0	17. 00
18. 00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete onl	wifling 4 avecade line		0	18.00
16.00	16) (see instructions)	y IT TITLE 4 exceeds TITLE	٩	U	10.00
19. 00	Interns and Residents (see instructions)		0	0	19.00
	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		28, 407	0	
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be				21.00
22.00	Other than outlier payments		T 0	0	22.00
	Outlier payments		o	0	
	Program capital payments		o		24.00
	Capital exception payments (see instructions)		o		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		o	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		28, 407	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
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)		28, 407	0	31.00
32.00	Deducti bl es		0	0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
	Utilization review		0		35.00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	I 33)	28, 407	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Subtotal (line 36 ± line 37)		28, 407	0	
	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
	Total amount payable to the provider (sum of lines 38 and 39)		28, 407	0	
41.00	Interim payments		11, 755	0	
42.00	Balance due provider/program (line 40 minus line 41)	111 ONG 5 1 15 3	16, 652	0	
43.00	Protested amounts (nonallowable cost report items) in accordan	ice with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2		1		1

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

Provider CCN: 15-1305 Period: From 10

Peri od: Worksheet G From 10/01/2021 To 09/30/2022 Date/Time Prepared:

2/23/2023 4:28 pm General Fund Speci fi c Endowment Plant Fund Purpose Fund Fund 1.00 2.00 4.00 3.00 CURRENT ASSETS 1.00 Cash on hand in banks 1,091,224 0 0 0 1.00 0 0 2.00 Temporary investments 0 2.00 0 3 00 Notes receivable 0 0 3 00 0 4.00 Accounts receivable 12, 114, 659 0 4.00 5.00 11, 127 0 0 0 5.00 Other receivable ol 6.00 Allowances for uncollectible notes and accounts receivable -7, 505, 948 0 0 6.00 o 691, 039 0 7 00 7 00 0 Inventory 0 8.00 Prepaid expenses 52, 059 0 0 8.00 0 9.00 Other current assets 3, 650, 341 0 9.00 10.00 Due from other funds 0 ol 0 10.00 Total current assets (sum of lines 1-10) 10, 104, 501 11.00 0 0 0 11.00 FIXED ASSETS 12.00 Land 195, 525 0 0 0 12.00 Land improvements 0 0 13.00 432.594 0 13.00 οĺ 14.00 Accumulated depreciation -438, 869 0 14.00 Bui I di ngs o 15.00 13, 253, 038 0 0 15.00 -9, 212, 240 16.00 Accumulated depreciation 0 0 0 0 0 16.00 0 Leasehold improvements 17.00 17.00 187, 055 0 0 18 00 Accumulated depreciation -201, 069 0 18 00 Fixed equipment 7, 548, 063 19.00 19.00 0 0 20.00 Accumulated depreciation -7, 074, 063 0 0 0 20.00 0 21.00 Automobiles and trucks 0 21.00 22.00 Accumulated depreciation 0 22.00 23.00 Major movable equipment 15, 552, 260 0 0 0 0 23.00 Accumulated depreciation 0 24.00 -9, 108, 874 0 24.00 0 25.00 Minor equipment depreciable 0 25.00 Accumulated depreciation 0 0 26.00 26.00 C 0 0 27.00 HIT designated Assets 0 0 0 27.00 0 28.00 Accumulated depreciation 0 0 28.00 0 0 29.00 Mi nor equi pment-nondepreci abl e 0 29.00 Total fixed assets (sum of lines 12-29) 30.00 11, 133, 420 0 0 0 30.00 OTHER ASSETS 31 00 31.00 Investments 0 0 0 0 32.00 Deposits on Leases C 0 0 32.00 0 0 33.00 Due from owners/officers 0 33.00 ol 34.00 Other assets 14, 191, 949 0 34.00 0 Total other assets (sum of lines 31-34) 0 0 35.00 14, 191, 949 0 35.00 36.00 Total assets (sum of lines 11, 30, and 35) 35, 429, 870 0 0 0 36.00 CURRENT LIABILITIES 37 00 863 247 0 0 n 37 00 Accounts payable 0 0 38.00 Salaries, wages, and fees payable 2, 249, 783 0 38.00 Payroll taxes payable 0 0 0 39.00 39.00 40.00 Notes and Loans payable (short term) 866, 952 0 0 0 40.00 o Deferred income 0 41 00 41 00 C 0 42.00 Accelerated payments C 42.00 43.00 Due to other funds 0 0 0 43.00 Other current liabilities 892, 921 ol 44.00 0 0 44.00 0 Total current liabilities (sum of lines 37 thru 44) 45.00 4, 872, 903 0 0 45.00 ONG TERM LIABILITIES 0 0 0 46.00 46,00 Mortgage payable 0 6, 374, 997 0 Notes payable 0 47.00 47.00 48.00 Unsecured Loans 0 0 0 48.00 Other long term liabilities 0 0 49.00 49.00 -375, 782 0 Total long term liabilities (sum of lines 46 thru 49) 5, 999, 215 0 ol 0 50.00 50.00 51.00 Total liabilities (sum of lines 45 and 50) 10, 872, 118 0 0 0 51.00 CAPITAL ACCOUNTS 24, 557, 752 52.00 General fund balance 52.00 0 Specific purpose fund 53.00 53.00 54.00 Donor created - endowment fund balance - restricted 0 54 00 Donor created - endowment fund balance - unrestricted 0 55.00 56.00 Governing body created - endowment fund balance 0 56.00 Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, 57.00 57.00 0 58.00 0 58.00 replacement, and expansion Total fund balances (sum of lines 52 thru 58) 24, 557, 752 0 0 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 35, 429, 870 0 0 0 60.00

Provider CCN: 15-1305

| Peri od: | Worksheet G-1 | From 10/01/2021 | To 09/30/2022 | Date/Time Prepared:

					To	09/30/2022	Date/Time Pre 2/23/2023 4: 2	
		General	Fund	Speci al	Pui	rpose Fund	Endowment	
							Fund	
		4 00	0.00	0.00		4.00	F 00	
1 00	Fund balances at beginning of period	1. 00	2. 00 22, 193, 346	3. 00		4. 00	5. 00	1.00
1. 00 2. 00	Net income (loss) (from Wkst. G-3, line 29)		2, 364, 406			U		2.00
3. 00	Total (sum of line 1 and line 2)		24, 557, 752			0		3.00
4. 00	Additions (credit adjustments) (specify)	0	24, 337, 132		0	Ŭ	0	4.00
5. 00	Constant and astimonites, (speeding)	o			0		Ő	5. 00
6.00		0			0		0	6.00
7.00		0			0		0	7. 00
8.00		0			0		0	8. 00
9. 00		0			0		0	9. 00
10.00	Total additions (sum of line 4-9)		0			0		10.00
11.00	Subtotal (line 3 plus line 10)		24, 557, 752			0		11.00
12. 00 13. 00	Deductions (debit adjustments) (specify)	0			0		0	12. 00 13. 00
14. 00		0			0		0	14.00
15. 00		0			0		0	15.00
16. 00		o			0		Ö	16.00
17. 00		0			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		24, 557, 752			0		19.00
	sheet (line 11 minus line 18)							
		Endowment Fund	PI ant	Fund				
		runa						
		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 4. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	U	0		0			3. 00 4. 00
5. 00	Additions (credit adjustments) (specify)		0					5.00
6. 00			0					6.00
7. 00			0					7. 00
8.00			0					8. 00
9.00			0					9. 00
10.00	Total additions (sum of line 4-9)	0			0			10.00
11. 00	Subtotal (line 3 plus line 10)	0			0			11.00
12. 00	Deductions (debit adjustments) (specify)		0					12.00
13.00			0					13.00
14. 00 15. 00			0					14. 00 15. 00
16.00			0					16.00
17. 00			0					17.00
18. 00	Total deductions (sum of lines 12-17)	0	0		0			18.00
19. 00	Fund balance at end of period per balance	Ö			0			19.00
	sheet (line 11 minus line 18)							

| Peri od: | Worksheet G-2 | From 10/01/2021 | Parts | & II | To | 09/30/2022 | Date/Time | Prepared: Health Financial Systems PRISTATEMENT OF PATLENT REVENUES AND OPERATING EXPENSES Provi der CCN: 15-1305

		To	09/30/2022	Date/Time Pre 2/23/2023 4: 2	
	Cost Center Description	I npati ent	Outpati ent	Total	о рііі
	oost oontor boson per on	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	1100	2.00	0.00	
	General Inpatient Routine Services				
1.00	Hospi tal	1, 537, 945		1, 537, 945	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	NURSING FACILITY				8.00
9. 00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1, 537, 945		1, 537, 945	10.00
	Intensive Care Type Inpatient Hospital Services	,			
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)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines	0		0	16.00
	11-15)			_	
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1, 537, 945		1, 537, 945	17.00
18. 00	Ancillary services	10, 174, 316	43, 933, 540	54, 107, 856	
19. 00	Outpati ent services	262, 626	6, 457, 750	6, 720, 376	
20. 00	RURAL HEALTH CLINIC	0	4, 649, 023	4, 649, 023	
20. 01	RURAL HEALTH CLINIC II	0	697, 170	697, 170	
	RURAL HEALTH CLINIC III	0	168, 149	168, 149	
20. 03		0	555, 385	555, 385	
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22. 00	HOME HEALTH AGENCY		ol	0	22.00
23. 00			٩	Ü	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	NON-PROVI DER BASED	0	117, 917	117, 917	27.00
27. 01	PHYSI CI AN FEES	316, 141	328	316, 469	27. 01
28. 00		12, 291, 028	56, 579, 262	68, 870, 290	
20.00	G-3, line 1)	12/2/1/020	00,077,202	00/0/0/2/0	20.00
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		38, 643, 942		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)		ol		36.00
37. 00	DEDUCT (SPECIFY)	0			37.00
38. 00		0			38. 00
39. 00		0			39.00
40. 00		0			40.00
41. 00		0			41.00
42. 00	Total deductions (sum of lines 37-41)		o		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transf	er	38, 643, 942		43.00
	to Wkst. G-3, line 4)		,,,		
		,	ı		•

	Financial Systems	PULASKI MEMORIAL		In Lie	u of Form CMS-2	2552-10
STATEM	IENT OF REVENUES AND EXPENSES		Provider CCN: 15-1305	Peri od:	Worksheet G-3	
				From 10/01/2021 To 09/30/2022	Date/Time Pre	pared.
				10 077 007 2022	2/23/2023 4: 2	
1 00	T-1-1 (C WI1 - C C D1	1 2 1 2 2 1 2	20)		1.00	1.00
1. 00 2. 00	Total patient revenues (from Wkst. G-2, Part Less contractual allowances and discounts on				68, 870, 290	
3.00	Net patient revenues (line 1 minus line 2)	patrents accoun	ıs		35, 258, 724	1
4. 00	Less total operating expenses (from Wkst. G-	O Dont II lino	42)		33, 611, 566	
5. 00	Net income from service to patients (line 3)		43)		38, 643, 942 -5, 032, 376	
5.00	OTHER INCOME	IIII IIus IIIIe 4)			-5, 032, 370	3.00
6. 00	Contributions, donations, bequests, etc				0	6.00
7. 00	Income from investments				0	1
8. 00	Revenues from telephone and other miscellane	ous communication	servi ces		Ö	1
9. 00	Revenue from television and radio service	ous communication	301 VI 003		Ö	
10.00	Purchase di scounts				0	
	Rebates and refunds of expenses				0	
	Parking lot receipts				0	ı
	Revenue from Laundry and Linen service				0	1
	Revenue from meals sold to employees and gue	sts			0	14.00
	Revenue from rental of living quarters				0	15.00
	Revenue from sale of medical and surgical su	pplies to other t	han patients		0	16.00
17.00	Revenue from sale of drugs to other than pat	ients	•		0	17. 00
18.00	Revenue from sale of medical records and abs	tracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms,	etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, a	nd 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 INCOME				6, 368, 851	24.00
24. 01	RENTAL INCOME				15, 709	24. 01
24. 02	NON OPERATING				103, 193	
24. 50	COVI D-19 PHE Fundi ng				909, 029	24. 50
	Total other income (sum of lines 6-24)				7, 396, 782	
	Total (line 5 plus line 25)				2, 364, 406	
	OTHER EXPENSES (SPECIFY)				0	
28. 00	Total other expenses (sum of line 27 and sub	scripts)			0	28.00

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

0 28.00 2, 364, 406 29.00

Heal th	Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	IS OF HOSPITAL-BASED RHC/FOHC COSTS	TOLINOTTI IIILIIIOTTI	Provi der C	CN: 15-1305	Peri od:	Worksheet M-1	
			Component	CCN: 15-8512	From 10/01/2021 To 09/30/2022	Date/Time Pre 2/23/2023 4:2	
					RHC I	Cost	
		Compensation	Other Costs		1 Reclassi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
		1.00	2.22		4.00	col . 4)	
	FACILITY HEALTH CARE CTAFE COCTO	1. 00	2. 00	3. 00	4. 00	5. 00	
1 00	FACILITY HEALTH CARE STAFF COSTS	2 710 72/	24.000	2 742 7	1 170 400	1 5/5 220	1 00
1.00	Physician	2, 719, 726	24, 000		26 -1, 178, 488	1, 565, 238	
2. 00 3. 00	Physician Assistant Nurse Practitioner	1 074 003	48, 000		93 -40, 091		
4. 00	Visiting Nurse	1, 074, 993	48, 000	1, 122, 99	-40,091	1, 082, 902 0	1
5. 00	Other Nurse	206, 708	0	206, 70	0 0	206, 708	
6. 00	Clinical Psychologist	200, 708	0	200, 70	0	200, 708	
7. 00	Clinical Social Worker	15, 360	0	15, 30	50 -7, 932		
8. 00	Laboratory Techni ci an	13, 300	0		0 -7, 732	7,420	
9. 00	Other Facility Health Care Staff Costs	709, 713	0	l .	13 0	709, 713	
10.00	Subtotal (sum of lines 1 through 9)	4, 726, 500	72, 000			3, 571, 989	
11. 00	Physician Services Under Agreement	4, 720, 300	72,000	4, 770, 30	0 -26, 660		1
12. 00	Physician Supervision Under Agreement	0	0		0 20,000	0	
13. 00	Other Costs Under Agreement	0	0		0 0	0	
14. 00	Subtotal (sum of lines 11 through 13)	0	0		0 -26, 660	-	
15. 00	Medical Supplies	0	44, 034	44, 03			
16. 00	Transportation (Health Care Staff)	0	0	,	0 0	0	1
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	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	44, 034	44, 03	-10, 761	33, 273	21.00
22.00	Total Cost of Health Care Services (sum of	4, 726, 500	116, 034	4, 842, 53	-1, 263, 932	3, 578, 602	22.00
	lines 10, 14, and 21)						]
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	l .	0		
24. 00	Dental	0	0		0	0	
25. 00	Optometry	0	0		0 0	0	
25. 01	Tel eheal th	0	0		0 32, 776		
25. 02	9	0	0		0	0	
26. 00	All other nonreimbursable costs	0	0		0	0	
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 32, 776	32, 776	28. 00
	through 27)						
20.00	FACILITY OVERHEAD	ما	140 700	1/0 7/	20 52 424	117 //4	20.00
29.00	Facility Costs	0 E34 091	169, 790				
30. 00 31. 00	Administrative Costs Total Facility Overhead (sum of lines 29 and	536, 081 536, 081	152, 087 321, 877				
31.00	30)	330, U81	3∠1,8//	007, 9	- 144, 082	/13,2/0	31.00
32. 00	Total facility costs (sum of lines 22, 28	5, 262, 581	437, 911	5, 700, 49	-1, 375, 838	4, 324, 654	32.00
32.00	and 31)	5, 202, 301	437,711	3, 700, 4	-1,373,030	4, 324, 034	32.00
	·/	'		1	T.	I .	1

Health Financial Systems	PULASKI MEMORIAL I	HOSPI TAL	In Lieu	of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CCN: 15-1305	Peri od: From 10/01/2021	Worksheet M-1
		Component CCN: 15-8512	To 09/30/2022	Date/Time Prepared: 2/23/2023 4:28 pm

			Component Co	JN. 13-0312	10 0	9/30/2022	2/23/2023 4:2	
					R	HC I	Cost	_0 piii
		Adjustments	Net Expenses					
		,	for					
			Allocation					
			(col. 5 +					
			col. 6)					
		6. 00	7. 00					
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	0	1, 565, 238					1.00
2.00	Physician Assistant	0	0					2.00
3.00	Nurse Practitioner	0	1, 082, 902					3.00
4.00	Visiting Nurse	0	0					4.00
5.00	Other Nurse	0	206, 708					5.00
6.00	Clinical Psychologist	0	0					6.00
7.00	Clinical Social Worker	0	7, 428					7. 00
8.00	Laboratory Techni ci an	0	0					8. 00
9.00	Other Facility Health Care Staff Costs	0	709, 713					9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	3, 571, 989					10.00
11. 00	9	0	-26, 660					11.00
12.00		0	0					12.00
13.00	Other Costs Under Agreement	0	0					13.00
14.00	Subtotal (sum of lines 11 through 13)	0	-26, 660					14.00
15.00	Medi cal Supplies	0	33, 273					15.00
16.00	Transportation (Health Care Staff)	0	0					16.00
17.00	Depreciation-Medical Equipment	0	0					17.00
18.00	Professional Liability Insurance	0	0					18. 00
19.00	Other Health Care Costs	0	0					19.00
20.00								20.00
21. 00		0	33, 273					21.00
22. 00		0	3, 578, 602					22. 00
	lines 10, 14, and 21)							
	COSTS OTHER THAN RHC/FQHC SERVICES							4
23. 00		0	0					23. 00
24. 00	· ·	0	0					24. 00
25.00		0	0					25. 00
25. 01	Tel eheal th	0	32, 776					25. 01
25. 02	9	0	0					25. 02
26. 00	All other nonreimbursable costs	0	0					26.00
27. 00	Nonallowable GME costs	_						27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	32, 776					28. 00
	through 27)							4
00.66	FACILITY OVERHEAD	51	447 (14					1 00 00
	Facility Costs	0	117, 664					29.00
30.00		0	595, 612					30.00
31. 00	Total Facility Overhead (sum of lines 29 and	o	713, 276					31.00
22.00	30)		4 224 (54					22.00
32. 00	Total facility costs (sum of lines 22, 28 and 31)	Ч	4, 324, 654					32.00
	Tana 31)	ı	I					1

	Financial Systems SIS OF HOSPITAL-BASED RHC/FQHC COSTS	PULASKI MEMORI	AL HOSPITAL  Provider C	CN: 1E 120E	<u> </u>	u of Form CMS-2 Worksheet M-1	
ANALTS	SIS OF HOSPITAL-BASED KHC/FUHC COSTS		Provider C	CN. 15-1305	From 10/01/2021	WOLKSHEET M-1	
			Component	CCN: 15-8527	To 09/30/2022	Date/Time Pre	
					RHC II	2/23/2023 4: 2 Cost	28 pm
		Compensation	Other Costs	Total (col 1	Reclassificat	Recl assi fi ed	
		00por.out. 0	011101 00010	+ col . 2)	i ons	Tri al Balance	
				<u> </u>		(col. 3 +	
						col . 4)	
		1. 00	2.00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1. 00	Physi ci an	447, 048	36, 000	483, 04	8 69, 874	552, 922	1
2. 00	Physician Assistant	0	0		0	0	
3. 00	Nurse Practitioner	22, 694	7, 200	29, 89	4 -2, 033	27, 861	3.00
4.00	Visiting Nurse	0	0	404.00	0	0	
5.00	Other Nurse	104, 906	0	104, 90	6 0	104, 906	1
6.00	Clinical Psychologist	0	0		0 1 705	0	1 0.00
7.00	Clinical Social Worker	0	0		0 1, 725	1, 725	1
8. 00 9. 00	Laboratory Technician Other Facility Health Care Staff Costs	24, 691	0	24, 69	0	0 24, 691	8. 00 9. 00
10.00	Subtotal (sum of lines 1 through 9)	599, 339	43, 200	•		712, 105	1
11. 00	Physician Services Under Agreement	399, 339 0	43, 200		0 13, 231	13, 231	1
12. 00	Physician Supervision Under Agreement	0	0		0 13, 231	13, 231	1
13. 00	Other Costs Under Agreement	0	0		0 0	0	
14. 00	Subtotal (sum of lines 11 through 13)	0	0		0 13, 231	13, 231	
15. 00	Medical Supplies	0	12, 960	1		18, 301	15.00
16. 00	Transportation (Health Care Staff)	0	0	,	0 0	0	1
17. 00	Depreciation-Medical Equipment	0	0		0 0	0	
18.00	Professional Liability Insurance	0	0		0 0	0	18.00
19.00	Other Health Care Costs	0	0		0 0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	12, 960	12, 96	0 5, 341	18, 301	21.00
22. 00	Total Cost of Health Care Services (sum of	599, 339	56, 160	655, 49	9 88, 138	743, 637	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES			T			
23.00	Pharmacy	0	0		0	0	
24.00	Dental	0	0		0	0	24.00
25. 00	Optometry	0	0		0 0 856	0	
25. 01 25. 02	Telehealth	0	0		0 856	856 0	
	Chronic Care Management	0	0		0	0	26.00
26. 00 27. 00	All other nonreimbursable costs Nonallowable GME costs	0				0	26.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	n	0		0 856	856	
20.00	through 27)	U		]	050	030	20.00
	FACILITY OVERHEAD			·	1		1
29. 00		0	33, 680	33, 68	0 25, 871	59, 551	29. 00
30.00	Administrative Costs	85, 389	•	1	·	108, 804	1
	Total Facility Overhead (sum of lines 20 and	·					

684, 728

139, 588

795, 087

54, 199

110, 359

28, 767

117, 761

31.00

32.00

168, 355

912, 848

Total Facility Overhead (sum of lines 29 and

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

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CCN: 15-1305	Peri od: From 10/01/2021	Worksheet M-1
		Component CCN: 15-8527	To 09/30/2022	Date/Time Prepared: 2/23/2023 4:28 pm

			Component CC	N: 15-8527	10	09/30/2022	2/23/2023 4:2	
						RHC II	Cost	о рііі
		Adjustments	Net Expenses			1410 11	3001	
		riaj ao timorito	for					
			Allocation					
			(col. 5 +					
			col. 6)					
		6. 00	7. 00					
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	0	552, 922					1.00
2.00	Physici an Assistant	ol	o					2.00
3.00	Nurse Practitioner	ol	27, 861					3.00
4.00	Visiting Nurse	ol	o					4.00
5.00	Other Nurse	ol	104, 906					5.00
6.00	Clinical Psychologist	ol	o					6.00
7.00	Clinical Social Worker	o	1, 725					7. 00
8.00	Laboratory Techni ci an	o	o					8. 00
9.00	Other Facility Health Care Staff Costs	o	24, 691					9. 00
10.00	Subtotal (sum of lines 1 through 9)	ol	712, 105					10.00
11. 00	Physician Services Under Agreement	ol	13, 231					11.00
12.00	Physician Supervision Under Agreement	ol	0					12.00
	Other Costs Under Agreement	ol	o					13.00
14. 00	Subtotal (sum of lines 11 through 13)	0	13, 231					14.00
15. 00	Medical Supplies	ol	18, 301					15.00
16. 00	Transportation (Health Care Staff)	ol	0					16.00
	Depreciation-Medical Equipment	ol	o					17. 00
18. 00		ol	0					18.00
	Other Health Care Costs	ol	0					19.00
20.00	Allowable GME Costs							20.00
21. 00	Subtotal (sum of lines 15 through 20)	ol	18, 301					21.00
22. 00	Total Cost of Health Care Services (sum of	ol	743, 637					22.00
	lines 10, 14, and 21)		,					
	COSTS OTHER THAN RHC/FQHC SERVICES	<u> </u>	<u> </u>					1
23.00	Pharmacy	0	0					23. 00
24.00	Dental	o	o					24.00
25.00	Optometry	o	o					25. 00
25. 01	Tel eheal th	o	856					25. 01
25. 02	Chronic Care Management	o	o					25. 02
26.00	All other nonreimbursable costs	o	o					26. 00
27.00	Nonallowable GME costs							27. 00
28.00	Total Nonreimbursable Costs (sum of lines 23	ol	856					28. 00
	through 27)							
	FACILITY OVERHEAD							
29.00	Facility Costs	0	59, 551					29. 00
30.00	Administrative Costs	o	108, 804					30.00
31.00	Total Facility Overhead (sum of lines 29 and	ol	168, 355					31.00
	30)							
32.00	Total facility costs (sum of lines 22, 28	0	912, 848					32. 00
	and 31)							

	Financial Systems	PULASKI MEMORI		ov. 45 4005 T		u of Form CMS-	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	UN: 15-1305	Peri od: From 10/01/2021	Worksheet M-1	
			Component	CCN: 15-8528	To 09/30/2022	Date/Time Pre 2/23/2023 4:2	
				_	RHC III	Cost	
		Compensation	Other Costs	Total (col.	1 Recl assi fi cat	Recl assi fi ed	
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
						col . 4)	
	FACILITY HEALTH CARE CTAFE COCTO	1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	0		0 42, 777	42, 777	1.00
2.00	Physician Assistant	0	0		0 0	0	
3.00	Nurse Practitioner	122, 620	12, 000	134, 62	-13, 461	121, 159	
4.00	Visiting Nurse	0	0		0	0	1
5.00	Other Nurse	0	0		0	0	
6.00	Clinical Psychologist	0	0		0	0	
7.00	Clinical Social Worker	0	0		0	0	
8.00	Laboratory Technician	74 400	0	74.46	0	0	8.00
9.00	Other Facility Health Care Staff Costs	71, 480		71, 48		71, 480	1
10.00	Subtotal (sum of lines 1 through 9)	194, 100	12, 000	206, 10			
11.00	Physician Services Under Agreement	0	0		0 3, 402	3, 402	
12.00	Physician Supervision Under Agreement	0	0		0	0	12. 00 13. 00
13.00	Other Costs Under Agreement	0	0		0 3 402	0	
14.00	Subtotal (sum of lines 11 through 13)	0	4, 220	4 22	0, 102	3, 402	
15.00	Medical Supplies	0	4, 220	4, 22	1, 373	5, 593	16.00
16. 00 17. 00	Transportation (Health Care Staff)	0	0			0	17.00
18.00	Depreciation-Medical Equipment Professional Liability Insurance	0	0			0	18.00
19.00		0	0			0	19.00
20.00	Allowable GME Costs	U	0		9	l o	20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	4. 220	4, 22	1, 373	5, 593	
22. 00	Total Cost of Health Care Services (sum of	194, 100	16, 220			244, 411	1
22.00	lines 10, 14, and 21)	174, 100	10, 220	210, 32	.0 34,071	244, 411	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						1
23. 00	Pharmacy	0	0		0 0	0	23.00
24. 00	Dental	0	0		0 0	0	
25. 00	Optometry	0	0		0 0	l o	
25. 01	Tel eheal th	0	0		0 14, 972	14, 972	1
25. 02	l I	0	Ö		0 0	0	
26. 00	All other nonreimbursable costs	0	0		0 0	0	26.00
27. 00	Nonallowable GME costs	, and the second se					27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 14, 972	14, 972	
	through 27)		_		1		
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	5, 855	5, 85	6, 652	12, 507	29. 00
30.00	Administrative Costs	12, 140	7, 714	19, 85		20, 599	30.00
31 00	Total Facility Overhead (sum of lines 29 and	12 140	13 569	25.70	9 7 397	l 33 106	31 00

206, 240

13, 569

29, 789

25, 709

236, 029

7, 397

56, 460

33, 106

292, 489

31.00

32.00

Total Facility Overhead (sum of lines 29 and

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

Health Financial Systems	PULASKI MEMORIAL HOSPITAL		In Lieu	of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der C		Period: From 10/01/2021	Worksheet M-1
	Component	CCN: 15-8528   1		Date/Time Prepared: 2/23/2023 4:28 pm

Adjustments	1. 00 2. 00 3. 00
Adjustments Net Expenses for Allocation (col. 5 + col. 6)	2. 00 3. 00
for Allocation (col. 5 + col. 6)	2. 00 3. 00
Allocation (col. 5 + col. 6)	2. 00 3. 00
(col. 5 + col. 6)	2. 00 3. 00
	2. 00 3. 00
	2. 00 3. 00
6.00   7.00	2. 00 3. 00
FACILITY HEALTH CARE STAFF COSTS	2. 00 3. 00
1. 00 Physi ci an 0 42, 777	3.00
2.00 Physician Assistant 0 0	
3.00 Nurse Practitioner 0 121, 159	
4.00   Visiting Nurse   0   0	4.00
5.00 Other Nurse 0 0	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 71,480	9.00
10.00   Subtotal (sum of lines 1 through 9) 0   235,416   1	10.00
11.00 Physician Services Under Agreement 0 3,402	11. 00
12.00 Physician Supervision Under Agreement 0 0 0	12.00
13.00 Other Costs Under Agreement 0 0 0	13.00
14.00   Subtotal (sum of lines 11 through 13) 0   3,402	14.00
15.00 Medical Supplies 0 5,593	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 0	19. 00
20.00 Allowable GME Costs	20. 00
21.00   Subtotal (sum of lines 15 through 20) 0 5,593 2	21. 00
22.00 Total Cost of Health Care Services (sum of 0 244,411 244,411	22. 00
lines 10, 14, and 21)	
COSTS OTHER THAN RHC/FQHC SERVICES	
	23. 00
	24. 00
	25. 00
	25. 01
	25. 02
	26. 00
	27. 00
	28. 00
through 27)	
FACILITY OVERHEAD	00.00
	29. 00
	30.00
	31. 00
30) 32.00 Total facility costs (sum of lines 22, 28	32. 00
32.00 Total facility costs (sum of lines 22, 28 0 292, 489 31)	3∠. UU
land 517	

	Financial Systems	PULASKI MEMORI		ON 45 4005		u of Form CMS-2	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 15-1305	Peri od: From 10/01/2021	Worksheet M-1	
			Component	CCN: 15-8554	To 09/30/2022		
					DUO 11/	2/23/2023 4: 2	!8 pm
		C	0+1	Tabal (aal	RHC IV	Cost	
		Compensation	Other Costs	+ col . 2)	1 Reclassi fi cat i ons	Reclassified Trial Balance	
				+ (01. 2)	1 0115	(col. 3 +	
						col . 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	326, 320	15, 000	341, 32	29, 198	370, 518	1.00
2.00	Physici an Assistant	0	0		0 0	0	2.00
3.00	Nurse Practitioner	123, 395	11, 000	134, 39	-13, 549	120, 846	3.00
4.00	Visiting Nurse	0	0		0	0	4.00
5.00	Other Nurse	0	0		0	0	5.00
6.00	Clinical Psychologist	0	0		0	0	6.00
7.00	Clinical Social Worker	0	0		0	0	7.00
8.00	Laboratory Techni ci an	0	0		0	0	8.00
9.00	Other Facility Health Care Staff Costs	73, 822	0			73, 822	1
10.00	Subtotal (sum of lines 1 through 9)	523, 537	26, 000	549, 53			
11.00	Physician Services Under Agreement	0	0		0 10, 026		
12.00	Physician Supervision Under Agreement	0	0		0	0	12.00
13.00	Other Costs Under Agreement	0	0		0 0	0	
14.00	Subtotal (sum of lines 11 through 13)	0	0		0 10, 026	l .	
15.00	Medical Supplies	0	0		0 4, 047	4, 047	
16.00	Transportation (Health Care Staff)	0	0		0	0	
17. 00 18. 00	Depreciation-Medical Equipment Professional Liability Insurance	0	0		0	0	
19.00	Other Health Care Costs	0	0		0	0	
20.00	Allowable GME Costs	U	U		٥	0	20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	0		0 4, 047	4, 047	
22. 00	Total Cost of Health Care Services (sum of	523, 537	26, 000	549, 53			
22.00	lines 10, 14, and 21)	323, 337	20,000	347, 30	27, 122	377, 237	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			I.			1
23. 00	Pharmacy	0	0		0 0	0	23.00
24.00	Dental	0	0		0 0	0	24.00
25.00	Optometry	0	0		0 0	0	25.00
25. 01	Tel eheal th	0	0		0 32, 573	32, 573	25. 01
25. 02	Chronic Care Management	0	0		0	0	25. 02
26.00	All other nonreimbursable costs	0	0		0 0	0	26.00
27.00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 32, 573	32, 573	28. 00
	through 27)						1
	FACILITY OVERHEAD	.1					
	Facility Costs	22 201	33, 574 19, 726				29.00
אט טס	I/Administrative Costs	1 27 2011	10 726	l 51 10	171 2 10/	i 52 201	20 00

32, 381

555, 918

18, 726

52, 300

78, 300

51, 107

84, 681

634, 218

2, 194

21, 797

84, 092

53, 301

106, 478

718, 310

30.00

31.00

32.00

30.00 Administrative Costs

Total Facility Overhead (sum of lines 29 and

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

Health Financial Systems	PULASKI MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1	305   Peri od:   Worksheet M-1   From 10/01/2021
	Component CCN: 15-8	8554 To 09/30/2022 Date/Time Prepared: 2/23/2023 4:28 pm

Adjustments				Component CCN: 15-855	4 10	09/30/2022	Date/IIMe Pre   2/23/2023 4:2	
Adjustments						RHC IV		.o piii
FACILITY HEALTH CARE STAFF COSTS			Adiustments	Net Expenses		1	0001	
All Coartion								
FACILITY HEALTH CARE STAFF COSTS								
FACILITY HEALTH CARE STAFF COSTS								
FACILITY HEALTH CARE STAFF COSTS				`				
1.00			6. 00					
2.00		FACILITY HEALTH CARE STAFF COSTS	<u> </u>					
3.00	1.00	Physi ci an	0	370, 518				1.00
4.00	2.00	Physician Assistant	o	o				2.00
5.00	3.00	Nurse Practitioner	o	120, 846				3.00
6.00	4.00	Visiting Nurse	o	o				4.00
7.00	5.00	Other Nurse	o	o				5. 00
8.00   Aboratory Technician   0   0   0   0   0   0   0   0   0	6.00	Clinical Psychologist	o	o				6. 00
9.00   Other Facility Health Care Staff Costs   0   73,822   9.00   10.00   Subtotal (sum of lines 1 through 9)   0   565,186   10.00   10.00   10.00   10.002   11.00   12.00   13.00   14.	7.00	Clinical Social Worker	0	0				7. 00
10. 00	8.00	Laboratory Techni ci an	0	0				8. 00
11. 00   Physician Services Under Agreement   0   10,026   11.00	9.00	Other Facility Health Care Staff Costs	0	73, 822				9. 00
12.00   Physician Supervision Under Agreement   0   0   0   13.00   14.00   14.00   14.00   15.00   16.00   16.00   16.00   16.00   17.00   16.00   17.00   17.00   18.00   17.00   18.00	10.00	Subtotal (sum of lines 1 through 9)	0	565, 186				10.00
13.00   Other Costs Under Agreement	11.00	Physician Services Under Agreement	0	10, 026				11.00
14.00   Subtotal (sum of lines 11 through 13)   0   10,026   10,	12.00	Physician Supervision Under Agreement	O	О				12.00
15.00   Medical Supplies   0   4,047   15.00   16.00   Transportation (Heal th Care Staff)   0   0   0   17.00   Depreciation-Medical Equipment   0   0   0   0   17.00   18.00   17.00   Depreciation-Medical Equipment   0   0   0   0   18.00   19.00   0   0   0   0   0   0   0   19.00   0   0   0   0   0   0   0   0   0	13.00	Other Costs Under Agreement	o	О				13.00
16.00	14.00	Subtotal (sum of lines 11 through 13)	o	10, 026				14.00
17. 00	15.00	Medical Supplies	o	4, 047				15. 00
18. 00	16.00	Transportation (Health Care Staff)	o	О				16.00
19.00   Other Heal th Care Costs   0   0   0   0   0   0   0   0   0	17.00	Depreciation-Medical Equipment	0	0				17.00
20.00   Allowable GME Costs   20.00   21.00   22.00	18.00	Professional Liability Insurance	0	0				18.00
21.00   Subtotal (sum of lines 15 through 20)   0   4,047     21.00	19.00	Other Health Care Costs	0	0				19.00
22.00   Total Cost of Health Care Services (sum of lines 10, 14, and 21)   COSTS OTHER THAN RHC/FOHC SERVICES     23.00   Pharmacy   0 0 0     24.00   Dental   0 0 0     25.00   Optometry   0 0 0     25.00   25.01   Tel eheal th   0   32,573     25.02   Chronic Care Management   0 0 0     26.00   All other nonreimbursable costs   0 0 0     26.00   All other nonreimbursable costs   0 0 0     26.00   Nonallowable GME costs   0 0 0     26.00   26.00     27.00   Total Nonreimbursable Costs (sum of lines 23     28.00   Total Nonreimbursable Costs   0     29.00   Facility Overhead   0     30.00   Administrative Costs   0     31.00   Total Facility Overhead (sum of lines 29 and 30)     31.00   Total Facility Overhead (sum of lines 29 and 30)     31.00   Total Facility Overhead (sum of lines 29 and 30)     30.00   Total	20.00	Allowable GME Costs						20.00
Li nes 10, 14, and 21)   COSTS OTHER THAN RHC/FOHC SERVICES	21.00	Subtotal (sum of lines 15 through 20)	0	4, 047				21.00
COSTS OTHER THAN RHC/FOHC SERVICES   Pharmacy	22.00	Total Cost of Health Care Services (sum of	0	579, 259				22.00
Pharmacy		lines 10, 14, and 21)						
24.00   Dental   0   0   0   24.00   25.00   Optometry   0   0   0   25.01   Tel eheal th   0   32,573   25.01   26.02   Chronic Care Management   0   0   0   26.00   All other nonreimbursable costs   0   0   27.00   Nonal lowable GME costs   0   32,573   28.00   Total Nonreimbursable Costs (sum of lines 23   0   32,573   28.00   Total Nonreimbursable Costs (sum of lines 23   0   32,573   29.00   FACILITY OVERHEAD   29.00   Administrative Costs   0   53,177   30.00   Administrative Costs   0   53,301   31.00   Total Facility Overhead (sum of lines 29 and 30)   30   On the static of t		COSTS OTHER THAN RHC/FQHC SERVICES						
25. 00   Optometry   Tell eheal th   O   32,573   25. 01   25. 02   26. 00   Chronic Care Management   O   O   O   O   O   O   O   O   O		1 1	0	0				
Tel eheal th   0   32,573   25.01   25.02   26.00   Chronic Care Management   0   0   0   0   25.02   26.00   All other nonreimbursable costs   0   0   0   0   27.00   28.00   Total Nonreimbursable Costs (sum of lines 23   0   32,573   28.00   28.00   27.00   28.00   Eacility Costs   0   53,177   29.00   30.00   Administrative Costs   0   53,301   30.00   31.00   30.00   30.00   31.00   30.00   30.00   31.00   30.00		Dental	0	0				
25. 02 Chronic Care Management 0 0 0 0 25. 02 26. 00 All other nonreimbursable costs 0 0 0 0 27. 00 28. 00 Nonallowable GME costs 27. 00 28. 00 through 27)  FACILITY OVERHEAD  29. 00 Administrative Costs 0 53, 301 31. 00 Total Facility Overhead (sum of lines 29 and 30)  Total Facility Overhead (sum of lines 29 and 30)			0	-1				
26. 00		i i	0	32, 573				
27.00   Nonallowable GME costs   27.00   28.00   Total Nonreimbursable Costs (sum of lines 23   0   32,573   28.00			0					
28.00 Total Nonreimbursable Costs (sum of lines 23 through 27) FACILITY OVERHEAD  29.00 Facility Costs		i i	0	0				
through 27) FACILITY OVERHEAD  29.00 30.00 Administrative Costs Total Facility Overhead (sum of lines 29 and 30)  Total Facility Overhead (sum of lines 29 and 30)		1						
FACILITY OVERHEAD  29. 00 30. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00	28. 00	· ·	0	32, 573				28. 00
29.00   Facility Costs   0   53,177   29.00   30.00   31.00   Total Facility Overhead (sum of lines 29 and 30)   106,478   31.00   31.								
30.00   Administrative Costs   0   53,301   30.00   31.00   Total Facility Overhead (sum of lines 29 and 30)   106,478   31.00			.1					
31.00 Total Facility Overhead (sum of lines 29 and 31.00 106, 478 31.00		1 1	0					
30)			0	-				
	31.00		이	106, 478				31.00
32.00 Hotal Facility costs (sum of lines 22, 28 1 - 01 /18,310) - 132.00	00.00	1 /		710 010				00.00
	32.00	,	0	/18, 310				32.00
and 31)		lana si)	I	I				I

	Financial Systems	PULASKI MEMORI		ON 45 4005		u of Form CMS-2	
ALLUCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVICES	Provi der C	CN: 15-1305	Peri od: From 10/01/2021	Worksheet M-2	
			Component	CCN: 15-8512	To 09/30/2022	Date/Time Pre 2/23/2023 4:2	
					RHC I	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1. 00	Physi ci an	4. 83			1 5		1.00
2.00	Physician Assistant	0.00		1	1 0		2.00
3.00	Nurse Practitioner	3. 62			1 4		3.00
4.00	Subtotal (sum of lines 1 through 3)	8. 45			9	20, 295	
5.00	Visiting Nurse	0.00	l e			0	5.00
6.00	Clinical Psychologist	0.00				0	6.00
7.00	Clinical Social Worker	1. 05	1, 545			1, 545	
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
	onl y)						
8.00	Total FTEs and Visits (sum of lines 4	9. 50	21, 840			21, 840	8. 00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9. 00
	I					1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T			RVI CES			
	Total costs of health care services (from Wk					3, 578, 602	
11. 00						32, 776	
12.00	Cost of all services (excluding overhead) (s					3, 611, 378	
13.00	Ratio of hospital-based RHC/FQHC services (I					0. 990924	
14.00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		713, 276	
15.00	Parent provider overhead allocated to facili	ty (see instru	ctions)			3, 029, 816	
16. 00	Total overhead (sum of lines 14 and 15)					3, 743, 092	
17. 00	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16					3, 743, 092	
	Overhead applicable to hospital-based RHC/FQ					3, 709, 120	
20.00	Total allowable cost of hospital-based RHC/F	QHC services (	sum of lines 1	0 and 19)		7, 287, 722	20.00

Heal th	Financial Systems	PULASKI MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 10/01/2021 To 09/30/2022	Date/Time Pre 2/23/2023 4:2	
					RHC II	Cost	
		Number of FTE	Total Visits	Producti vi ty		Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1. 00	Physi ci an	0. 81		1	1 1		1.00
2.00	Physician Assistant	0.00			1 0		2.00
3.00	Nurse Practitioner	1. 69			1 2		3.00
4.00	Subtotal (sum of lines 1 through 3)	2. 50		1	3	4, 852	
5.00	Visiting Nurse	0.00		•		0	
6.00	Clinical Psychologist	0.00				0	6.00
7.00	Clinical Social Worker	0. 03				52	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
	onl y)						
8. 00	Total FTEs and Visits (sum of lines 4	2. 53	4, 904			4, 904	8. 00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9.00
						4 00	
	DETERMINATION OF ALLOWARIE COCT ADDITIONED F	O HOCDLEAL DAC	ED DUC/FOUR CEI	DVII CEC		1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T Total costs of health care services (from Wk			RVICES		743, 637	10 00
11. 00	Total nonreimbursable costs (from Wkst. M-1,					743, 637 856	
12. 00	Cost of all services (excluding overhead) (s					744, 493	
12.00	Ratio of hospital-based RHC/FQHC services (I					0. 998850	
14. 00	Total hospital-based RHC/FQHC services (i Total hospital-based RHC/FQHC overhead - (fr			ino 21)		168, 355	
15. 00				THE 31)		602, 371	
16. 00	Parent provider overhead allocated to facili Total overhead (sum of lines 14 and 15)	ty (see mstru	Ctrons)			770, 726	
17. 00	Allowable GME overhead (see instructions)					770,728	
	Enter the amount from line 16					770, 726	
	Overhead applicable to hospital-based RHC/FC	NUC convices (1	ino 12 v lino	10\		769, 840	
	Total allowable cost of hospital-based RHC/F					1, 513, 477	
20.00	Tiotal allowable cost of hospital-based knc/r	WILL SELVICES (	Jun UI IIIICS I	0 anu 17)	ļ	1,515,477	20.00

Heal th	Financial Systems	PULASKI MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 10/01/2021 To 09/30/2022	Date/Time Pre 2/23/2023 4:2	
					RHC III	Cost	•
	·	Number of FTE	Total Visits	Producti vi ty	/ Minimum	Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1.00	Physi ci an	0. 05			1 0		1.00
2.00	Physician Assistant	0.00			1 0		2.00
3.00	Nurse Practitioner	0. 57		l .	1		3.00
4.00	Subtotal (sum of lines 1 through 3)	0. 62			1	1, 261	
5.00	Visiting Nurse	0.00				0	
6.00	Clinical Psychologist	0.00				0	0.00
7.00	Clinical Social Worker	0.00				0	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
	onl y)						
8.00	Total FTEs and Visits (sum of lines 4	0. 62	1, 261			1, 261	8. 00
	through 7)		_			_	
9. 00	Physician Services Under Agreements		0			0	9.00
						4 00	
	DETERMINATION OF ALLOWARIE COST APPLICABLE T	O HOCDITAL DAG	ED DUO (EQUID CEI	DVII 050		1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T			RVICES		244 411	10 00
10.00	Total costs of health care services (from Wk					244, 411 14, 972	
	Total nonreimbursable costs (from Wkst. M-1,						
12.00	Cost of all services (excluding overhead) (s					259, 383	
13.00	Ratio of hospital -based RHC/FQHC services (I			: 21)		0. 942278	
14.00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		33, 106	
15. 00 16. 00	Parent provider overhead allocated to facili	ty (see Instru	Ctions)			208, 068	
17. 00	Total overhead (sum of lines 14 and 15)					241, 174 0	
	Allowable GME overhead (see instructions) Enter the amount from line 16					241, 174	
	Overhead applicable to hospital-based RHC/FC	NAC convices (I	ino 12 v lino	10\		241, 174	
	Total allowable cost of hospital-based RHC/F					471, 664	
∠∪. ∪∪	Tiotal allowable cost of Hospital-Dased RHC/F	unc services (	Sum Of FITTES I	o anu 19)		4/1,004	<sub>1</sub> 20.00

	Financial Systems	PULASKI MEMORI	I AL_HOSPI TAL		In Lie	u of Form CMS-2	<u> 2552-10</u>
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od: From 10/01/2021	Worksheet M-2	
			Component	CCN: 15-8554	To 09/30/2022	Date/Time Pre 2/23/2023 4:2	
					RHC IV	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)	,	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons			ı	al al		
1.00	Physi ci an	0. 90			1		1.00
2.00	Physician Assistant	0.00	l e		0		2.00
3.00	Nurse Practitioner	0. 81		l .		2 714	3. 00 4. 00
4. 00 5. 00	Subtotal (sum of lines 1 through 3) Visiting Nurse	1. 71 0. 00	•		2	3, 716 0	•
6. 00	Clinical Psychologist	0.00				0	
7. 00	Clinical Social Worker	0.00				0	7.00
7. 00	Medical Nutrition Therapist (FQHC only)	0.00				0	7.00
7. 02	Diabetes Self Management Training (FQHC	0.00				0	7.02
7.02	only)	0.00	Ĭ				7.02
8. 00	Total FTEs and Visits (sum of lines 4	1. 71	3, 716			3, 716	8.00
	through 7)						
9.00	Physician Services Under Agreements		0			0	9.00
	•						
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T			RVI CES			
	Total costs of health care services (from Wk					579, 259	1
	Total nonreimbursable costs (from Wkst. M-1,					32, 573	•
12.00	Cost of all services (excluding overhead) (s					611, 832	1
13.00	Ratio of hospital-based RHC/FQHC services (I					0. 946762	
14.00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		106, 478	
15.00	Parent provider overhead allocated to facili	ty (see instru	ctions)			445, 871	1
16.00	Total overhead (sum of lines 14 and 15)					552, 349	1
	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16	IIC comilect (1)	ino 12 v li	10)		552, 349	1
	Overhead applicable to hospital-based RHC/FQ Total allowable cost of hospital-based RHC/F					522, 943	1
20.00	Tiotal allowable cost of hospital-based knc/F	unc services (:	Suiii Oi TTHES I	u anu 19)	ļ	1, 102, 202	<sub>1</sub> 20.00

(01/2021 (30/2022 : I		ppared: 28 pm 1.00 2.00 3.00 4.00	
230/2022 E. I.	2 Date/Time Pre 2/23/2023 4:2 Cost 1.00 7,287,722 96,013 7,191,709 21,840 0 21,840	1. 00 2. 00 3. 00 4. 00	
ul ati on	7, 287, 722 96, 013 7, 191, 709 21, 840 21, 840	1.00 2.00 3.00 4.00	
	7, 287, 722 96, 013 7, 191, 709 21, 840 0 21, 840	2. 00 3. 00 4. 00	
	7, 287, 722 96, 013 7, 191, 709 21, 840 0 21, 840	2. 00 3. 00 4. 00	
	96, 013 7, 191, 709 21, 840 0 21, 840	2. 00 3. 00 4. 00	
	7, 191, 709 21, 840 0 21, 840	3. 00 4. 00	
	21, 840 0 21, 840	4.00	
	0 21, 840		
	21, 840		
	J 27		
eriod 1	of Limit (1)		
	Rate Period 2		
1/2021	(01/01/2022		
ough /2021)	through 09/30/2022)		
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232. 77	237. 66	9. 00	
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0	1, 124, 504 628, 562	1	
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2 Demonstration payment adjustment amount after sequestration 0 Interim payments			
j	0		
	37, 894		
	0	1	
	0	788, 544  0 830, 514	

Hoal +h	Financial Systems PULASKI MEMORIAL	HOSDI TAI	In Lio	u of Form CMS 1	DEE2 10
	Financial Systems PULASKI MEMORIAL ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI C		Component CCN: 15-8527	From 10/01/2021 To 09/30/2022		pared:
		Title XVIII	RHC II	Cost	<u> </u>
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES			1. 00	
1. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst. M-2. line 20)		1, 513, 477	1.00
2. 00	Cost of injections/infusions and their administration (from W	37, 800	2.00		
3.00	Total allowable cost excluding injections/infusions (line 1 m	inus line 2)		1, 475, 677	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4, 904	4.00
5. 00 6. 00	Physicians visits under agreement (from Wkst. M-2, column 5, Total adjusted visits (line 4 plus line 5)	line 9)		0 4, 904	5. 00 6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			300. 91	7.00
7.00	This does not be with a contract by this of		Cal cul ati on		7100
				Rate Period 2	
			(10/01/2021 through	(01/01/2022 through	
			12/31/2021)	09/30/2022)	
			1.00	2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	188. 36		8.00
9. 00	Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT	188. 36	192. 32	9. 00	
10.00	Program covered visits excluding mental health services (from	533	1, 237	10.00	
11. 00	Program cost excluding costs for mental health services (line		100, 396	237, 900	
12.00	Program covered visits for mental health services (from contr		0	14	12.00
13.00	Program covered cost from mental health services (line 9 x li	,	0	2, 692	13.00
14. 00 15. 00	Limit adjustment for mental health services (see instructions Graduate Medical Education Pass Through Cost (see instruction	•	0	2, 692	14. 00 15. 00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	340, 988	
16. 01	Total program charges (see instructions) (from contractor's re	,		215, 671	16. 01
16. 02	Total program preventive charges (see instructions)(from prov	•		10, 265	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	*		16, 230	•
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0 (Titles V and XIX see instructions.)	3 and 18) times .80)		230, 230	16. 04
16. 05	Total program cost (see instructions)		0	246, 460	16. 05
17. 00	Pri mary payer amounts			0	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		36, 971	18. 00
19. 00	records) Beneficiary coinsurance for RHC/FQHC services (see instruction	unc) (from contractor		22 407	19. 00
17.00	records)	ins) (IT oill contractor		33, 687	17.00
20.00	Net Medicare cost excluding vaccines (see instructions)			246, 460	20.00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		15, 738	
22. 00	, , ,			262, 198	•
23. 00 23. 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	23. 00 23. 01
24. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,		0	
	Pioneer ACO demonstration payment adjustment (see instruction	is)		0	
25. 99	Demonstration payment adjustment amount before sequestration			0	
26. 00 26. 01	Net reimbursable amount (see instructions)  Sequestration adjustment (see instructions)			262, 198 1, 966	
26. 02	1 '			0	26. 02
27. 00	Interim payments			244, 414	27. 00
	Tentative settlement (for contractor use only)	00 07 1 00		0	28.00
29. 00 30. 00	Balance due component/program (line 26 minus lines 26.01, 26. Protested amounts (nonallowable cost report items) in accorda			15, 818 0	•
30.00	chapter I, §115. 2	mee with own run. 10-11	'	U	30.00
			1	'	•

Heal th	Financial Systems PULASKI MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Peri od:	Worksheet M-3	
SERVI (	CES	Component CCN: 15-8528	From 10/01/2021 To 09/30/2022	Date/Time Pre	nared:
		Component Con. 15-6528	10 09/30/2022	2/23/2023 4: 2	
		Title XVIII	RHC III	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)		471, 664	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)				2.00
3.00	Total allowable cost excluding injections/infusions (line 1 m	inus line 2)		457, 920	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1, 261	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			1, 261	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	363.14	7. 00
			Carcuration	OI LIMIT (I)	
			Rate Period 1		
			(10/01/2021	(01/01/2022	
			through	through	
			12/31/2021)	09/30/2022) 2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	306. 89	313. 33	8. 00
9. 00	Rate for Program covered visits (see instructions)	. e e. yeu. eentraeter,	306. 89	313. 33	1
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from		72	232	
11. 00	Program cost excluding costs for mental health services (line		22, 096	72, 693	ł
12.00	Program covered visits for mental health services (from contr	•	0	0	
13. 00 14. 00	Program covered cost from mental health services (line 9 x li	•	0	0	13. 00 14. 00
15. 00	Limit adjustment for mental health services (see instructions Graduate Medical Education Pass Through Cost (see instruction		U U	U	15.00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	94, 789	
16. 01	Total program charges (see instructions) (from contractor's re	•		37, 875	ł
16. 02	Total program preventive charges (see instructions) (from prov	•			16. 02
16. 03	Total program preventive costs ((line 16.02/line 16.01) times			12, 944	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		60, 968	16. 04
14 05	(Titles V and XIX see instructions.)			72 012	14 05
16. 05 17. 00	Total program cost (see instructions) Primary payer amounts		0	73, 912 0	l
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		-	18.00
	records)	(1.10 00111. 00101		0,000	
19.00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		5, 414	19. 00
	records)				
20.00	Net Medicare cost excluding vaccines (see instructions)	M 4 11		73, 912	
21. 00 22. 00	Program cost of vaccines and their administration (from Wkst. Total reimbursable Program cost (line 20 plus line 21)	M-4, TINE 16)		8, 822 82, 734	
23. 00	Allowable bad debts (see instructions)			02, 734	1
23. 01	Adjusted reimbursable bad debts (see instructions)			0	23. 01
24.00		ructions)		0	1
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
	Pioneer ACO demonstration payment adjustment (see instruction	is)		0	•
25. 99	Demonstration payment adjustment amount before sequestration			02.724	
26.00	, , ,			82, 734	1
26. 01 26. 02	Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration				26. 01 26. 02
27. 00	, , , ,			72, 760	•
28. 00	1 3			0	28.00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.	02, 27, and 28)		9, 353	29. 00
30.00		nce with CMS Pub. 15-II	.	0	30.00
	chapter I, §115.2		1		

Heal th	Financial Systems PULASKI MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Peri od:	Worksheet M-3	
SERVI (	EES	Component CCN: 15-8554	From 10/01/2021 To 09/30/2022	Date/Time Pre	
		Title XVIII	RHC IV	2/23/2023 4: 2 Cost	8 pm_
		11 (10 /////		3331	
				1. 00	
1 00	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES	W+ M 2 1: 20)		1 102 202	1 00
1. 00 2. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Most of injections (infusions and their administration (from Most of injections)			1, 102, 202 6, 323	1. 00 2. 00
3. 00					3.00
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)	irius irric 2)		1, 095, 879 3, 716	1
5.00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)	•		3, 716	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			294. 91	7. 00
			Cal cul ati on	of Limit (1)	
			Rate Period 1	Rate Period 2	
			(10/01/2021	(01/01/2022	
			through	through	
			12/31/2021)	09/30/2022)	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	1 6 or your contractor)	1. 00	2. 00	8. 00
9. 00	Rate for Program covered visits (see instructions)	. o or your contractor)	203. 35	207. 62	1
7. 00	CALCULATION OF SETTLEMENT		200.00	207.02	7.00
10.00	Program covered visits excluding mental health services (from	contractor records)	255	815	10.00
11.00	Program cost excluding costs for mental health services (line	9 x line 10)	51, 854	169, 210	11.00
12.00	Program covered visits for mental health services (from contr	•	0	0	
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	
15. 00 16. 00	Graduate Medical Education Pass Through Cost (see instruction Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	221, 064	15.00
16. 00	Total program charges (see instructions) (from contractor's re	•		136, 971	
16. 02	Total program preventive charges (see instructions) (from prov	•			16. 02
16.03	Total program preventive costs ((line 16.02/line 16.01) times	•		16, 133	16. 03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		148, 919	16. 04
	(Titles V and XIX see instructions.)				
16. 05	Total program cost (see instructions)		0	165, 052	
17. 00 18. 00	Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		0 18, 782	
10.00	records)	(Troil contractor		10, 702	10.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		21, 639	19. 00
20.00	records)			1/5 050	20.00
20. 00 21. 00	Net Medicare cost excluding vaccines (see instructions) Program cost of vaccines and their administration (from Wkst.	M 4 lino 16)		165, 052 1, 715	1
22. 00	,	W-4, TTHE 10)		166, 767	
23. 00	Allowable bad debts (see instructions)			0	
23. 01	Adjusted reimbursable bad debts (see instructions)			0	23. 01
24.00		ructi ons)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25. 00
	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	•
25. 99	Demonstration payment adjustment amount before sequestration			144 747	
26. 00 26. 01				166, 767 1 251	26.00
26. 02	1 '			1, 231	
27. 00	, , , , , , , , , , , , , , , , , , , ,			163, 052	
28. 00	1			0	
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.	02, 27, and 28)		2, 464	29. 00
30.00		nce with CMS Pub. 15-II	,	0	30.00
	chapter I, §115.2				I

	Financial Systems PULASKI MEMOR			Period:	ieu of Form CMS-2552-10		
COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der Co			Worksheet M-4		
		Component	CCN: 15-8512	From 10/01/2021 To 09/30/2022			
		Title	XVIII	RHC I	Cost		
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS		
		1.00	2. 00	2. 01	2. 02		
1. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	3, 571, 989	3, 571, 98	3, 571, 989	3, 571, 989	1.00	
2.00	Ratio of injection/infusion staff time to total health	0. 000365	0. 00152	0. 001832	0.000000	2. 00	
3. 00	care staff time Injection/infusion health care staff cost (line 1 x line 2)	1, 304	5, 45	58 6, 544	0	3.00	
4. 00	Injections/infusions and related medical supplies costs (from your records)	18, 313	15, 52	27 C	0	4. 00	
5.00	Direct cost of injections/infusions (line 3 plus line 4)	19, 617	20, 98	6, 544	0	5.00	
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3, 578, 602	3, 578, 60	3, 578, 602	3, 578, 602	6. 00	
7.00	Total overhead (from Wkst. M-2, line 19)	3, 709, 120	3, 709, 12	20 3, 709, 120	3, 709, 120	7.00	
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 005482	0. 00586	0. 001829	0.000000	8. 00	
9.00	Overhead cost - injection/infusion (line 7 x line 8)	20, 333	21, 7!	50 6, 784	0	9.00	
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	39, 950		1	1		

95. 39

18, 887

96,013

36, 363

198

24. 82

206

107

7, 769

373.36

9, 707

26

0.00 12.00

0

13.00

0 13.01

14.00

15.00

16.00

12.00 Cost per injection/infusion (line 10/line 11)

benefi ci ari es

and 13.01, as applicable)

13.01

14.00

15.00

Number of injection/infusion administered to Program

administration costs (line 12 times the sum of lines 13

Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02,

administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)

line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of injections/infusions and their

Number of COVID-19 vaccine injections/infusions administered to MA enrollees

Program cost of injections/infusions and their

Health Financial Systems	PULASKI	MEMORI AL	HOSPI TAL				In Lieu	u of Form C	MS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	T		Provi der	CCN:	15-1305	Perio		Worksheet	M-4
			Component	CCN:	: 15-8527		10/01/2021 09/30/2022		

		Component (	CCN: 15-8527   To	09/30/2022	Date/Time Pre 2/23/2023 4:2	
		Title	XVIII	RHC II	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1. 00	2.00	2. 01	2. 02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	712, 105	712, 105	712, 105	712, 105	1.00
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 000938	0. 006864	0. 004102	0. 000000	2.00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	668	4, 888	2, 921	0	3. 00
4. 00	Injections/infusions and related medical supplies costs (from your records)	5, 644	4, 452	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	6, 312	9, 340	2, 921	0	5.00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	743, 637	743, 637	743, 637	743, 637	6. 00
7.00	Total overhead (from Wkst. M-2, line 19)	769, 840	769, 840	769, 840	769, 840	7.00
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 008488	0. 012560	0. 003928	0. 000000	8. 00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	6, 534	9, 669	3, 024	0	9.00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	12, 846	19, 009	5, 945	0	10.00
11.00	Total number of injections/infusions (from your records)	35	256	153	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	367. 03	74. 25	38. 86	0.00	12.00
13. 00	Number of injection/infusion administered to Program beneficiaries	10	106	58	0	13.00
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			50	0	13. 01
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	3, 670	7, 871	4, 197	0	14.00
15. 00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		37, 800			15. 00
16. 00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		15, 738			16. 00

Health Financial Systems	PULASKI	MEMORIAL HOSPITAL		In Lieu	of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC VA	CCINE COST	Provi der	CCN: 15-1305	Peri od: From 10/01/2021	Worksheet M-4
		Component	CCN: 15-8528		Date/Time Prepared: 2/23/2023 4:28 pm
		Ti ti	le XVIII	RHC III	Cost

		Component (	CCN: 15-8528 T	o 09/30/2022	Date/Time Pre 2/23/2023 4: 2	
		Title	XVIII	RHC III	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	235, 416	235, 416			1.00
2.00	Ratio of injection/infusion staff time to total health	0. 001656	0. 004388	0. 000000	0.000000	2.00
	care staff time					
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	390	1, 033	0	0	3. 00
4. 00	Injections/infusions and related medical supplies costs (from your records)	3, 137	2, 562	0	0	4. 00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	3, 527	3, 595	0	0	5.00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	244, 411	244, 411	244, 411	244, 411	6. 00
7.00	Total overhead (from Wkst. M-2, line 19)	227, 253	227, 253	227, 253	227, 253	7.00
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 014431	0. 014709	0. 000000	0. 000000	8. 00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	3, 279	3, 343	0	0	9. 00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	6, 806	6, 938	0	0	10.00
11.00	Total number of injections/infusions (from your records)	20	53	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	340. 30	130. 91	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program	14	31	0	0	13.00
	benefi ci ari es					
13. 01	Number of COVID-19 vaccine injections/infusions			0	0	13. 01
44.00	administered to MA enrollees					44.00
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13	4, 764	4, 058	0	0	14. 00
15. 00	and 13.01, as applicable)		12 744			15. 00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02,		13, 744			15.00
	line 10) (transfer this amount to Wkst. M-3, line 2)					
16, 00	Total Program cost of injections/infusions and their		8, 822			16. 00
	administration costs (sum of columns 1, 2, 2.01, and 2.02,		0,022			
	line 14) (transfer this amount to Wkst. M-3, line 21)					

Health Financial Systems	PULASKI MEMORIAL	_ HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC VA	ACCINE COST	Provi der CCN: 15-1305	Peri od:	Worksheet M-4
			From 10/01/2021	

COMPUT	ATTON OF HOSPITAL-BASED KHC/FUHC VACCINE COST	Provider Co		From 10/01/2021	worksneet M-4	
		Component (	CCN: 15-8554	To 09/30/2022	Date/Time Pre 2/23/2023 4:2	
			XVIII	RHC IV	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	565, 186	565, 18	565, 186	565, 186	1.00
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 000031	0. 00217	0.000000	0. 000000	2.00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	18	1, 23	0	0	3.00
4. 00	Injections/infusions and related medical supplies costs (from your records)	105	1, 96	0 8	0	4. 00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	123	3, 20	0 0	0	5.00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	579, 259	579, 25	579, 259	579, 259	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	522, 943	522, 94	522, 943	522, 943	7. 00
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 000212	0. 00552	0. 000000	0. 000000	8. 00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	111	2, 88	0	0	9.00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	234	6, 08	0	0	10.00
	Total number of injections/infusions (from your records)	1		71 0	0	
12.00	Cost per injection/infusion (line 10/line 11)	234. 00			0. 00	
13. 00	Number of injection/infusion administered to Program beneficiaries	0	2	0.0	0	
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 01
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	1, 71	5 0	0	14.00
15. 00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02,		6, 32	23		15. 00
16. 00	line 10) (transfer this amount to Wkst. M-3, line 2) Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		1, 71	5		16. 00

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/ SERVICES RENDERED TO PROGRAM BENEFICIARIES	FQHC PROVIDER FOR	Provider CCN: 15-1305 Component CCN: 15-8512	From 10/01/2021	
			DUC I	0+

				2/23/2023 4: 28	8 pm
			RHC I	Cost	
			Par	rt B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
00	Total interim payments paid to hospital-based RHC/FQHC			822, 482	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	•			
00	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				
21				0	3.
02				0	3.
23				0	3.
04				0	3
)5				0	3
	Provider to Program				
0				0	3
51				0	3
52				0	3
53				0	3
54				0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line		822, 482	4
	27)				
	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after des	sk review. Also show date o	f		5
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
)1				0	5
)2				0	5
)3				0	5
	Provider to Program				
50				0	5
51				0	5
52				0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	5
00	Determined net settlement amount (balance due) based on the	e cost report. (1)			6
)1	SETTLEMENT TO PROVIDER			37, 894	6
)2	SETTLEMENT TO PROGRAM			0	6
0	Total Medicare program liability (see instructions)			860, 376	7
			Contractor	NPR Date	
				(11 /0 // )	
			Number	(Mo/Day/Yr)	
00	Name of Contractor	0	Number 1.00	(Mo/Day/Yr) 2.00	8.

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED F SERVICES RENDERED TO PROGRAM BENEFICIARI		Provider CCN: 15-1305 Component CCN: 15-8527	Peri od: From 10/01/2021 To 09/30/2022	Date/Time Prepared:
			DUO 11	2/23/2023 4: 28 pm

		Component CCN. 13-0327	10 077 307 2022	2/23/2023 4: 2	
			RHC II	Cost	
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
	Total interim payments paid to hospital-based RHC/FQHC			244, 414	1.
	Interim payments payable on individual bills, either submit			0	2.
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
	List separately each retroactive lump sum adjustment amount				3.
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
. 01				0	3.
. 02				0	3.
. 03				0	3.
. 04				0	3.
. 05				0	3.
	Provider to Program				
50				0	3
51				0	3
52				0	3.
. 53				0	3.
. 54				0	3.
. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	. 98)		0	3.
. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line	:	244, 414	4.
	27)				
	TO BE COMPLETED BY CONTRACTOR				
	List separately each tentative settlement payment after des	sk review. Also show date o	f		5.
	each payment. If none, write "NONE" or enter a zero. (1)				1
	Program to Provider				
. 01				0	5.
. 02				0	
.03				0	5.
	Provider to Program				
50				0	
51				0	
52				0	5.
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	5
	Determined net settlement amount (balance due) based on the	e cost report. (1)			6
-	SETTLEMENT TO PROVIDER			15, 818	6.
-	SETTLEMENT TO PROGRAM			0	6.
. 00	Total Medicare program liability (see instructions)			260, 232	7.
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
	Name of Contractor	0	1. 00	2. 00	8.
3. 00					

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 15-1305 Component CCN: 15-8528	From 10/01/2021	
		Component Con: 15-8528	10 09/30/2022	2/23/2023 4: 28 pm

				2/23/2023 4: 28	8 pm
			RHC III	Cost	
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			72, 760	1.00
2.00	Interim payments payable on individual bills, either submit			0	2.00
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
3.00	List separately each retroactive lump sum adjustment amount				3.00
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider			_	
3. 01				0	3. 01
3. 02				0	3. 02
3. 03				0	3. 03
3. 04				0	3. 04
3. 05				0	3.05
	Provider to Program		_		
3.50				0	3. 50
3. 51				0	3. 5
3. 52				0	3. 52
3. 53				0	3. 5
3. 54		22)		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	ster to Worksheet M-3, line		72, 760	4.00
	27)				
E 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after des	ak roui ou. Al oo obou data of	-		E 00
5. 00	each payment. If none, write "NONE" or enter a zero. (1)	sk review. Also show date of			5.00
	Program to Provider				
5. 01	11 ogi alli to 11 ovi dei			0	5. 0°
5. 02					5. 02
5. 02				0	5. 02
5. 05	Provider to Program		-		5. 0.
5. 50	11 ovi dei 16 11 ogi dili			0	5. 50
5. 51				l ol	5. 5
5. 52				l ol	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		0	5. 99
6. 00	Determined net settlement amount (balance due) based on the				6. 00
6. 01	SETTLEMENT TO PROVIDER	. 3331 . opor t. (1)		9, 353	6.0
6. 02	SETTLEMENT TO PROGRAM			7, 333	6. 02
7. 00	Total Medicare program liability (see instructions)			82, 113	7. 00
55			Contractor	NPR Date	,
			Number	(Mo/Day/Yr)	
		0	1.00		
		U	1.00	2.00	

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAR		Provider CCN: 15-1305 Component CCN: 15-8554	Peri od: From 10/01/2021	Worksheet M-5 Date/Time Prepared:
		Component con. 10 ccc 1	077 007 2022	2/23/2023 4: 28 pm
			DUIG 11/	0

		Component Con. 13-8334	10 077 307 2022	2/23/2023 4: 28	
			RHC IV	Cost	
				rt B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			163, 052	1. (
2. 00	Interim payments payable on individual bills, either submit			0	2. (
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
3. 00	List separately each retroactive lump sum adjustment amount				3.
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3. 01				0	3.
3. 02				0	3.
. 03				0	3.
3. 04				0	3.
3. 05				0	3.
	Provider to Program		<u>'</u>		
. 50	-			0	3.
. 51				0	3.
. 52				0	3.
. 53				0	3.
. 54				0	3.
. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		0	3.
1. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans		,	163, 052	4.
	27)	·		•	
	TO BE COMPLETED BY CONTRACTOR			•	
5. 00	List separately each tentative settlement payment after desl	k review. Also show date c	f		5.
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
. 01				0	5.
. 02				0	5.
. 03				0	5.
	Provider to Program				
. 50				0	5.
. 51				0	5.
. 52				0	5.
. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.49	98)		0	5.
	Determined net settlement amount (balance due) based on the	cost report. (1)			6.
. 00	OFFICE FACILITY TO DECLAR DEED	, , ,		2, 464	6.
	SETTLEMENT TO PROVIDER				
. 01	SETTLEMENT TO PROGRAM			0	6.
. 01	SETTLEMENT TO PROGRAM			ı "	
. 01			Contractor	0 165,516 NPR Date	
5. 01 5. 02	SETTLEMENT TO PROGRAM			165,516 NPR Date	
5. 00 5. 01 5. 02 7. 00	SETTLEMENT TO PROGRAM	0	Contractor Number 1.00	165, 516	6. 7.