PART II - CERTIFICATION

(3) Settled with Audit

(4) Reopened (5) Amended

use only

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 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PULASKI MEMORIAL HOSPITAL (15-1305) for the cost reporting period beginning 10/01/2015 and ending 09/30/2016 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.

> (Si aned) Officer or Administrator of Provider(s) Title

number of times reopened = 0-9.

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
-	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	58, 863	169, 822	0	40, 930	1. 00
2.00	Subprovi der - IPF	0	0	0		0	2. 00
3.00	Subprovi der - IRF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	25, 579	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		47, 515		0	10.00
200.00	Total	0	84, 442	217, 337	0	40, 930	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. 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.

22. 01	Did this hospital receive interim uncompensated care period? Enter in column 1, "Y" for yes or "N" for no reporting period occurring prior to October 1. Enter for no for the portion of the cost reporting period of	for the po	rtion of th 2, "Y" for	ne cost yes or "N"	, r	N	N	22. 01
22. 02	(see instructions) Is this a newly merged hospital that requires final udetermined at cost report settlement? (see instruction "N" for no, for the portion of the cost reporting in column 2, "Y" for yes or "N" for no, for the portion after October 1.	ons) Enter period pri	in column 1 or to Octob	l, "Y" for y per 1. Enter	ves	N	N	22. 02
22. 03	Did this hospital receive a geographic reclassification of the OMB standards for delineating statistical area in column 1, "Y" for yes or "N" for no for the portion of the cotober 1. Enter in column 2, "Y" for yes or cost reporting period occurring on or after October 1 hospital contain at least 100 but not more than 499 to 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N"	as adopted lon of the community of the c	oy CMS in F ost reporti o for the p tructions)	Y2015? Enteng period portion of the Does this	er :he	V	N	22. 03
23. 00	Which method is used to determine Medicaid days on li 1, enter 1 if date of admission, 2 if census days, or method of identifying the days in this cost reporting used in the prior cost reporting period? In column 2	nes 24 and 3 if date 3 period di	of dischar fferent fro ' for yes c	ge. Is the om the metho	od no.	2	N	23. 00
		In-State	In-State	Out-of	Out-of	Medi cai d	1 1 1 1	
		Medicaid paid days	Medicaid eligible	State Medicaid	State Medicaid	HMO days	Medi cai d days	
		para days	unpai d	pai d days	eligible		uays	
			days	para dayo	unpai d			
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	1
24. 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.	0	0		0		0 0	24.00

Heal th	Financial Systems PULASKI	MEMORI AI	L H	OSPI TAL				In Lie	u of	For	n CMS-2	2552-10
	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA			rovider CC	CN: 15-1305		riod: om 10/0			kshe	et S-2	
							To 09/30/2016 Date/Time Pr 4/21/2017 3:					
		In-Stat	е	In-State	Out-of	0ι	ut-of	Medi ca			:her	/ pili
		Medicai paid day		Medicaid eligible	State Medi cai d		tate di cai d	HMO da	ays		i cai d ays	
		para day	,3	unpai d	pai d days	el i	gi bl e			u	ays	
		1.00	_	2. 00	3. 00		npai d 4. 00	5. 00	$\overline{}$		. 00	
25. 00	If this provider is an IRF, enter the in-state	1.00	0	2.00			0		0		. 00	25. 00
	Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2,											
	out-of-state Medicaid days in column 3, out-of-state											
	Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.											
							Urban/F		Dat			
26. 00	Enter your standard geographic classification (not wa	age) stat	us	at the beg	ginning of t	the	1. (	2		2. 0	U	26. 00
27. 00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa		IIS	at the end	1 of the cos	s t		2				27. 00
27.00	reporting period. Enter in column 1, "1" for urban or	~"2" for	rı	ıral. If ap		31		2				27.00
35 00	enter the effective date of the geographic reclassifing this is a sole community hospital (SCH), enter the				CH status in	า		0				35. 00
	effect in the cost reporting period.						ъ.	•		- ··		
						-	Begi n			Endi r 2. 0		
36. 00	Enter applicable beginning and ending dates of SCH stoof periods in excess of one and enter subsequent date		bsc	ript line	36 for numb	oer						36. 00
37. 00	If this is a Medicare dependent hospital (MDH), enter		ber	of period	ds MDH statu	JS		0				37. 00
37. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th	ne MDH tr	ans	sitional na	avment in		N	I				37. 01
07.01	accordance with FY 2016 OPPS final rule? Enter "Y" fo											07.01
38. 00	instructions) If line 37 is 1, enter the beginning and ending dates	s of MDH	sta	ntus. If li	ne 37 is							38. 00
	greater than 1, subscript this line for the number of											
	enter subsequent dates.						Υ/	'N		1\Y	N	
39. 00	Does this facility qualify for the inpatient hospital	navmont	- 20	liustmont f	For Low volu	ımo	1. (			2. 0 N	0	39. 00
34.00	hospitals in accordance with 42 CFR §412.101(b)(2)(ii	)? Enter	ir	column 1	"Y" for yes	s	11	1		IN		39.00
	or "N" for no. Does the facility meet the mileage red CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes											
40. 00	Is this hospital subject to the HAC program reduction	n adjustm	ent	? Enter "Y	" for yes o	or	N	I		N		40. 00
	"N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.			,	es or "N" f	for						
						·		V		/111	XIX	
	Prospective Payment System (PPS)-Capital							1.00	J   Z	. 00	3.00	
45. 00	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions)	nt for di	spr	oporti onat	te share in	acco	ordance	N		N	N	45. 00
46. 00	Is this facility eligible for additional payment exce							N		N	N	46. 00
	pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.	t. L, Pt.	П	I and Wkst	t. L-1, Pt.	l th	hrough					
	Is this a new hospital under 42 CFR §412.300 PPS capi			,			D.	N		N	N	47. 00
48. 00	Is the facility electing full federal capital payment Teaching Hospitals	t? Enter	· · · Y	r ror yes	or "N" Tor	no.		N		N	N	48. 00
56. 00	Is this a hospital involved in training residents in or "N" for no.	approved	GN	ME programs	s? Enter "\	Y" fo	or yes	N				56. 00
57. 00	If line 56 is yes, is this the first cost reporting p											57. 00
	GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont											
	for yes or "N" for no in column 2. If column 2 is "\	/", compl	ete	worksheet								
58. 00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimb				ans' service	es as	S					58. 00
	defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	complete	Wk	st. D-5.				N				59. 00
	Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health					the		N N				60.00
	provider-operated criteria under §413.85? Enter "Y"	for yes	or	"N" for no	o. (see inst Direct GM		tions) IN	IF	Di	rect	GMF	
									DI DI			
61. 00	Did your hospital receive FTE slots under ACA	1.00		2. 00	3. 00		4.	0. 00		5.0		61. 00
00	section 5503? Enter "Y" for yes or "N" for no in							5. 50			5.00	
61. 01	column 1. (see instructions) Enter the average number of unweighted primary care			0. 00		0. 00						61. 01
	FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see											
	instructions)											

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE			AL HOSPITAL Provider CC		eriod: rom 10/01/2015	u of Form CMS-2 Worksheet S-2 Part I Date/Time Pre 4/21/2017 3:3	pared:	
		Y/N	IME	Direct GME	IME	Direct GME	·	
		1. 00	2. 00	3. 00	4. 00	5. 00		
61.02 Enter the current year total unweighted FTE count (excluding OB/GYN, general su and primary care FTEs added under secti ACA). (see instructions)	rgery FTEs, on 5503 of		0.00				61. 02	
61.03 Enter the base line FTE count for prima and/or general surgery residents, which determining compliance with the 75% tes instructions)	is used for		0. 00	0.00			61. 03	
61.04 Enter the number of unweighted primary surgery allopathic and/or osteopathic F current cost reporting period (see inst	TEs in the		0.00	0.00			61. 04	
61.05 Enter the difference between the baseli and/or general surgery FTEs and the cur primary care and/or general surgery FTE	ne primary rent year's counts (line		0.00	0.00			61. 05	
61.04 minus line 61.03). (see instructi 61.06 Enter the amount of ACA §5503 award tha used for cap relief and/or FTEs that ar care or general surgery. (see instructi	0.00			61. 06				
	Program Name Program Code Unweighted IME FTE Count I							
61.10 Of the FTEs in line 61.05, specify each	1.00					4.00	61. 10	
specialty, if any, and the number of FT for each new program. (see instructions column 1, the program name, enter in co program code, enter in column 3, the IM unweighted count and enter in column 4, FTE unweighted count.  61.20 Of the FTEs in line 61.05, specify each program specialty, if any, and the numb residents for each expanded program. (sinstructions) Enter in column 1, the prenter in column 2, the program code, en 3, the IME FTE unweighted count and ent 4, direct GME FTE unweighted count.	) Enter in lumn 2, the E FTE direct GME expanded er of FTE ee ogram name, ter in column				0. 00	0. 00	61. 20	
						1.00		
ACA Provisions Affecting the Health Res 62.00 Enter the number of FTE residents that					od for which	0.00	62. 00	
your hospital received HRSA PCRE fundin 62.01 Enter the number of FTE residents that	your hospital received HRSA PCRE funding (see instructions) 2.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)							
63.00 Has your facility trained residents in "Y" for yes or "N" for no in column 1.	nonprovi der se	ettings	during this co	ost reporting p	oeriod? Enter	N	63. 00	
			,	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
Section 5504 of the ACA Base Year FTE R	esidents in No	nnrovi	der Settinge	1.00	2.00	3.00		
period that begins on or after July 1, 64.00 Enter in column 1, if line 63 is yes, o in the base year period, the number of resident FTEs attributable to rotations settings. Enter in column 2 the number resident FTEs that trained in your hosp	30, 2010.  ned residents ry care nprovider rimary care n 3 the ratio	0. 00			64. 00			
of (column 1 divided by (column 1 + col	umn 2)). (see gram Name	ogram Code	Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 + col.			

1.00

Nonprovi der Si te

3. 00

2.00

Hospi tal

4.00

Ratio (col. 3/ (col. 3 + col. 4))

5.00

From 10/01/2015 Part I Date/Time Prepared: 09/30/2016 4/21/2017 3:37 pm Program Code Unwei ghted Unwei ghted Program Name Ratio (col. 3/ (col. 3 + col FTEs FTEs in Hospi tal 4)) Nonprovi der Si te 1.00 2.00 3.00 4.00 5.00 0. 00 0. 00 0.000000 65.00 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) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 66.00 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ahted Unwei ghted Ratio (col. 3/ Program Code FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 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) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most O 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 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most 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)

Song Torm Care Hospital PRS   1.00	Health Financial Systems PULASKI MEMORIA		ON 45 4005		u of Form CMS	
	HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	CN: 15-1305	From 10/01/2015	Part I Date/Time Pr	epared:
10.00   Si his a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.   N   80.01						57 piii
10.00   S. this a LOng term care hospital (LTCH)? Enter "Y" for yes and "N" for no.   N   80.0	Long Term Care Hospital PPS				1.00	
15.00   Is this a new hospital under 42 CFR Section \$413.40(f)(1)(1) TEFRA? Enter "Y" for yes or "N" for no. No. 18.1.40(0)(1)(1)? Factor "Y" for yes and "N" for no. 18.1.40(f)(1)(1)? Enter "Y" for yes and "N" for no. 19.1.40(1)? Factor "Y" for yes and "N" for no. 19.1.40(1)? Factor "Y" for yes and "N" for no. 19.1.40(1)? Factor "Y" for yes and "N" for no. 19.1.40(1)? Factor "Y" for yes or "N" for no. 19.1.40(1)? Factor "Y" for yes or "N" for no in the applicable column. 19.1.40(1)? Factor "Y" for yes or "N" for no in the applicable column. 19.1.40(1)? Factor "Y" for yes or "N" for no in the applicable column. 19.1.40(1)? Factor "Y" for yes or "N" for no in the applicable column. 19.1.40(1) Factor "Y" for yes or "N" for no in the applicable column. 19.1.40(1) Factor "Y" for yes or "N" for no in the applicable column. 19.1.40(1) Factor "Y" for yes or "N" for no in the applicable column. 19.1.40(1) Factor "Y" for yes or "N" for no in the applicable column. 19.1.40(1) Factor "Y" for yes or "N" for no in the applicable column. 19.1.40(1) Factor "Y" for yes or "N" for no in the applicable column. 19.1.40(1) Factor "Y" for yes or "N" for no in the applicable column. 19.1.40(1) Factor "Y" for yes or "N" for no in the applicable column. 19.1.40(1) Factor "Y" for yes or "N" for no in the applicable column. 19.1.40(1) Factor "Y" for yes or "N" for no in the applicable column. 19.1.40(1) Factor "Y" for yes or "N" for no in the applicable column. 19.1.40(1) Factor "Y" for yes or "N" for no in the applicable column. 19.1.40(1) Factor "Y" for yes or "N" for no in the applicable column. 19.1.40(1) Factor "Y" for yes or "N" for no in the applicable column. 19.1.40(1) Factor "Y" for yes or "N" for no in the applicable column. 19.1.40(1) Factor "Y" for yes or "N" for no in the applicable column. 19.1.40(1) Factor "Y" for yes or "N" for no in the applicable column. 19.1.40(1) Factor "Y" for yes or "N" for no in the applicable column. 19.1.40(1) Factor "Y" for yes or "N" for no in the applicable column. 19.1.40(1) Factor "Y" for	80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes 81.00 Is this a LTCH co-located within another hospital for part o "Y" for yes and "N" for no.			ng period? Enter		80. 00 81. 00
17.00   1s this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(8)(iv)(II)? Enter "Y"   N   V   XIX   X	85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 86.00 Did this facility establish a new Other subprovider (exclude				N	85. 00 86. 00
1.00   2.00	87.00 Is this hospital a "subclause (II)" LTCH classified under se	ction 1886(d)	(1)(B)(iv)(I	)? Enter "Y"	N	87. 00
Title V and XIX Services	Tot yes of W For He.					
00.00   Does this Facility have title V and/or XIX inpatient hospital services? Enter "Y" for v   N   Y   90.0	Title V and VIV Services			1. 00	2. 00	
11.00   Sthis hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.   2.00   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.   3.00   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.   4.00   Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.   5.00   Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.   6.00   Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.   7.00   If I in energy of the XIX reduce operating cost? Enter "Y" for yes or "N" for no in the paplicable column.   7.00   If I in energy of the XIX reduce operating cost? Enter "Y" for yes or "N" for no in the paplicable column.   8.00   Does this hospital qualify as a critical access hospital (CAH)?   8.00   Does this hospital qualify as a critical access hospital (CAH)?   9.10   Does this hospital qualify as a critical access hospital (CAH)?   9.10   Does this hospital qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)   9.10   Does this hospital gualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B. Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.   9.10   Does this hospital qualify in for an exception to the CRNA fee schedule? See 42   N   N   N   N   N   N   N   N   N		I services? E	nter "Y" for	N	Υ	90.00
12.00   Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "" for yes or "NF for no in the applicable column.   13.00   Does this facility operate an ICF/IID facility for purposes of title V and XIX7 Enter "N N N 93. "Y for yes or "NF for no in the applicable column.   14.00   Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the participate column.   15.00   If Iline 94   s "", enter the reduction percentage in the applicable column.   16.00   Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.   17.00   If Iline 94   s "", enter the reduction percentage in the applicable column.   17.00   If Iline 96   s "", enter the reduction percentage in the applicable column.   17.00   If Iline 96   s "", enter the reduction percentage in the applicable column.   18.00   Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.   18.00   Oos this hospital qualify as a critical access hospital (CAH)?   18.00   Oos this hospital qualify as a critical access hospital (CAH)?   18.00   Oos this facility qualifies as a CAH, has it elected the all-inclusive method of payment of providers in the structions of the program is cost preimbursement for I&R   N   Oos training programs? Fenter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the CME elimination is not nade on West. B, Pt. I, col. 25 and the program is cost preimbursed. If yes complete West. D-2, Pt. II.	91.00 Is this hospital reimbursed for title V and/or XIX through t			N	Y	91.00
No.	92.00 Are title XIX NF patients occupying title XVIII SNF beds (du	al certificat			N	92. 00
M.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.  9,00 If I line 94 is "V", enter the reduction percentage in the applicable column.  9,00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.  9,00 If I line 94 is "V", enter the reduction percentage in the applicable column.  9,00 If I line 94 is "V", enter the reduction percentage in the applicable column.  9,00 If I line 94 is "V", enter the reduction percentage in the applicable column.  9,00 If I line 94 is "V", enter the reduction percentage in the applicable column.  9,00 I line 94 is "V", enter the reduction percentage in the applicable column.  9,00 I line 94 is "V", enter the reduction percentage in the applicable column.  9,00 I line 94 is "V", enter the reduction percentage in the applicable column.  9,00 I line 94 is "V", enter the reduction percentage in the applicable column.  9,00 I line 94 is "V", enter the reduction percentage in the applicable column.  9,00 I line 94 is "V", enter the reduction percentage in the applicable column.  9,00 I line 94 is "V", enter the reduction percentage in the applicable column.  9,00 I line 94 is "V", enter the reduction percentage in the applicable column.  9,00 I line 94 is "V", enter the reduction percentage in the applicable column.  9,00 I line 94 is "V", enter the reduction percentage in the applicable column.  9,00 I line 94 is "V", enter the reduction percentage in the applicable column.  9,00 I line 94 is "V", enter the reduction percentage in the applicable column to reduct reductions.  9,00 I line 14 is facility (applications) in the reduction percentage in the applicable column.  9,00 I line 14 is facility lease as a CAH or a cost provider, are the method or payment for law in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.  10,00 I line 14 is a said the reduction percentage in the applicable column.  10,00 I l	93.00 Does this facility operate an ICF/IID facility for purposes		d XIX? Enter	N	N	93. 00
15.00     f	94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes,	and "N" for n	o in the	N	N	94. 00
105.00   If line 96 is "Y", enter the reduction percentage in the applicable column.   0.00	95.00 $ \hat{f} $ line 94 is "Y", enter the reduction percentage in the app 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes					95. 00 96. 00
105.00   Does this hospital qualify as a critical access hospital (CAH)?   V   106.00   If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)   107.00   If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R   N   107.00	97.00 If line 96 is "Y", enter the reduction percentage in the app	licable colum	n.	0.00	0.00	97. 00
For outpatient services? (see instructions)   107.00   If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R   107.00   107.0		H)?		Y		105. 00
training programs? Enter """ for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.  108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 N 108.00 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.  Physical Occupational Speech Respiratory.  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.  109.00 If this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.  110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1.  116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.  117.00 Is the mal practice insurance a claims-made or occurrence policy? Enter 1 if the policy is 1 claim-made. Enter 2 if the policy is occurrence.  Premiums Losses Insurance  118.00 1.00 2.00 3.00	for outpatient services? (see instructions)		. 3			106. 00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.   Physical Occupational Speech Respiratory   1.00   2.00   3.00   4.00   1.00   2.00   3.00   4.00   1.00   2.00   3.00   4.00   1.00   2.00   3.00   4.00   1.00   2.00   3.00   4.00   1.00   2.00   3.00   4.00   1.00   2.00   3.00   4.00   1.00   2.00   3.00   4.00   1.00   2.00   3.00   4.00   1.00   2.00   3.00   1.00   3.00   1.00   3.00   1.00   3.	training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.	1. (see inst 25 and the p	ructions) If rogram is cos	st		107. 00
109.00   f this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.    109.00   Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.    109.00   Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.    109.00   Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.    109.00   Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.    109.00   Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.    109.00   Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the demonstration project (410A Demo) for no.    109.00   Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for no.    109.00   Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for no.    109.00   Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for no.    109.00   Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for no.    109.00   Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for no.    109.00   Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for no.    109.00   Did this hospital participate in the Rural Community Hospital Participate in the Rural Participate in the Rural P						100.00
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.    10.00   Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.    10.00   Interpretation   Inter				-		_
110.00   Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.    1.00   2.00   3.00						109. 00
110.00   Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.    1.00   2.00   3.00					1.00	
Miscellaneous Cost Reporting Information  1. 00 2. 00 3. 00  1. 00 2. 00 3. 00  1. 00 2. 00 3. 00  1. 00 2. 00 3. 00  1. 00 2. 00 3. 00  1. 00 2. 00 3. 00  1. 00 2. 00 3. 00  1. 00 2. 00 3. 00  1. 00 2. 00 3. 00  1. 00 2. 00 3. 00  1. 00 2. 00 3. 00  1. 00 2. 00 3. 00  1. 00 2. 00 3. 00  1. 00 2. 00 3. 00  1. 00 2. 00 3. 00  1. 00 2. 00 3. 00  1. 00 2. 00 3. 00			on project (	410A Demo)for		110. 00
115.00   Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1   N     0   115.00   is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208. 1.   16.00   Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.   N   116.00   In this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.   117.00   In this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.   118.00   In the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is   1   118.00   In this facility legally-required to carry malpractice policy? Enter 1 if the policy is   1   118.00   In this facility legally-required to carry malpractice insurance   Ins				1.00	0 2.00 3.00	
is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208. 1.  116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.  117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.  118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.  Premiums Losses Insurance  1.00 2.00 3.00		II NIII C				
116.00   Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.   N   116.00   Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.   N   117.00   Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is   1   118.00   Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is   1   118.00   Insurance	is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals provider	If column 2 t for long te	is "E", ente rm care (incl	rin column udes		115.00
118.00   Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is   1     118.00     1	l16.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insur					116. 00 117. 00
1.00 2.00 3.00	118.00 s the malpractice insurance a claims-made or occurrence pol	icy? Enter 1				118. 00
			Premi ums	Losses	Insurance	
			1.00	0.00	2.00	
	118.01 List amounts of malpractice premiums and paid losses:					0118.01

Health Financial Systems PULASKI MEMOR				u of Form CN	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CCN	F	eriod: from 10/01/2015 fo 09/30/2016	Worksheet S Part I Date/Time I 4/21/2017 S	Prepared:
			1. 00	2. 00	
118.02 Are mal practice premiums and paid losses reported in a cos- Administrative and General? If yes, submit supporting sche and amounts contained therein.  119.00 DO NOT USE THIS LINE	edule listing cos	st centers	N		118. 02
120.00 s this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	n column 1, "Y" qualifies for the ents? (see instru	for yes or e Outpatient uctions)	N	N	120. 00
121.00 Did this facility incur and report costs for high cost implipatients? Enter "Y" for yes or "N" for no.	antable devices	charged to	Y		121. 00
122.00 Does the cost report contain state health or similar taxes' for no in column 1. If column 1 is "Y", enter in column 2 where these taxes are included.  Transplant Center Information			N		122. 00
125.00 Does this facility operate a transplant center? Enter "Y"	for yes and "N" f	for no. If	N		125. 00
yes, enter certification date(s) (mm/dd/yyyy) below.  126.00  f this is a Medicare certified kidney transplant center, or		cation date			126. 00
in column 1 and termination date, if applicable, in column 127.00 If this is a Medicare certified heart transplant center, e	nter the certific	cation date			127. 00
in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, e		cation date			128. 00
in column 1 and termination date, if applicable, in column 129.00 of this is a Medicare certified lung transplant center, en		ation date in			129. 00
column 1 and termination date, if applicable, in column 2.  130.00 of this is a Medicare certified pancreas transplant center.	enter the certi	fi cati on			130. 00
date in column 1 and termination date, if applicable, in co 131.00 of this is a Medicare certified intestinal transplant cent		rti fi cati on			131. 00
date in column 1 and termination date, if applicable, in co 132.00 of this is a Medicare certified islet transplant center, en		cation date			132. 00
in column 1 and termination date, if applicable, in column 133.00 of this is a Medicare certified other transplant center, e	2.				133. 00
in column 1 and termination date, if applicable, in column 134.00 of this is an organ procurement organization (0PO), enter	2.				134. 00
and termination date, if applicable, in column 2.  All Providers	The of o Humber 11	T COT UNIT 1			134.00
140.00 Are there any related organization or home office costs as			N		140. 00
chapter 10? Enter "Y" for yes or "N" for no in column 1. I are claimed, enter in column 2 the home office chain number	r. (see instructi				
1.00 2.  If this facility is part of a chain organization, enter on	<u>00</u> lines 141 throug	gh 143 the na	3.00 me and address	of the	
home office and enter the home office contractor name and 141.00 Name: Contractor's Name:	contractor number		r's Number:		141. 00
142.00 Street: PO Box: 143.00 City: State:		Zip Code:			142. 00 143. 00
140. Odor ty.		Zip code.		4.00	143.00
144.00 Are provider based physicians' costs included in Worksheet	A?			1. 00 Y	144. 00
			1. 00	2. 00	
145.00 If costs for renal services are claimed on Wkst. A, line 7-inpatient services only? Enter "Y" for yes or "N" for no in no, does the dialysis facility include Medicare utilization period? Enter "Y" for yes or "N" for no in column 2.	n column 1. If co	olumn 1 is	N	2.00	145. 00
146.00 Has the cost allocation methodology changed from the previous Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. yes, enter the approval date (mm/dd/yyyy) in column 2.			N		146. 00
477.00	""			1.00	117.00
147.00 Was there a change in the statistical basis? Enter "Y" for 148.00 Was there a change in the order of allocation? Enter "Y" for	or yes or "N" for	no.		N N	147. 00 148. 00
149.00 Was there a change to the simplified cost finding method?	Part A	Part B	Title V	N Title XI)	149. 00
Does this facility contain a provider that qualifies for a	1.00 n exemption from	2.00 the applicat	3.00 ion of the lowe	4.00 er of costs	
or charges? Enter "Y" for yes or "N" for no for each compo 155.00Hospital	nent for Part A a	and Part B. (	See 42 CFR §413 N	8. 13) N	155. 00
156.00 Subprovi der - IPF 157.00 Subprovi der - IRF	N N	N N	N N	N N	156. 00 157. 00
158. 00 SUBPROVI DER					158. 00
159. 00 SNF 160. 00 HOME HEALTH AGENCY	N N	N N	N N	N N	159. 00 160. 00
161. 00 CMHC		N	N	N	161. 00

Health Financial Systems	PULASKI MEM	ORIAL HOSPITAL			In Lie	u of Form CMS-	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DATA	Provi der CC	N: 15-130!	From 1	0/01/2015 9/30/2016	Worksheet S-Part I Date/Time Pro 4/21/2017 3:	epared:
						1.00	
Multicampus							
165.00 Is this hospital part of a Multion Enter "Y" for yes or "N" for no.	campus hospital that has	one or more campu	ses in di	fferent CE	SAs?	N	165. 00
	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3.00	4. 00	5. 00	
166.00 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)						0.0	0 166. 00
						1.00	-
Health Information Technology (H	IT) incentive in the Amer	rican Recovery and	l Reinves	tment Act		1.00	
167.00 Is this provider a meaningful use						Υ	167. 00
168.00 If this provider is a CAH (line reasonable cost incurred for the	105 is "Y") and is a mear	ingful user (line			the		0168. 00
168.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	)? Enter "Y" for yes or "	N" for no. (see i	nstructio	ons)	•		168. 01
169.00 If this provider is a meaningful transition factor. (see instruction		und is not a CAH (	line 105			0.0	0169. 00
				Ве	gi nni ng	Endi ng	
					1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	beginning date and endir	ig date for the re	porting	10/	′03/2016	12/31/2016	170. 00
					1. 00	2.00	-
171.00 If line 167 is "Y", does this pro	ovider have any days for	individuals enrol	led in		N N		0171.00
section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2.	reported on Wkst. S-3, F umn 1. If column 1 is ye	t. I, line 2, col	. 6? Ente		•		

Heal th	Financial Systems PULASKI MEMOR	LAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			Peri od:	Worksheet S-2	
				From 10/01/2015 To 09/30/2016		anarad:
				10 09/30/2010	4/21/2017 3:3	
	·			Y/N	Date	
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter M	N for all NO re	esponses. Ente	all dates in	the	
	mm/dd/yyyy format.					_
	COMPLETED BY ALL HOSPITALS					_
1. 00	Provider Organization and Operation  Has the provider changed ownership immediately prior to the	a heginning of	the cost	N		1.00
1.00	reporting period? If yes, enter the date of the change in a			IN		1.00
	Troportring portroat it your onter the date of the onange in	00. a 2. (000	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
2. 00	Has the provider terminated participation in the Medicare F	Program? If	N			2. 00
	yes, enter in column 2 the date of termination and in colum	mn 3, "V" for				
	voluntary or "I" for involuntary.					
3. 00	Is the provider involved in business transactions, including		N			3. 0
	contracts, with individuals or entities (e.g., chain home (					
	or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and other					
	relationships? (see instructions)	er simirai				
	Tronder one imper (eee Thetraetrone)		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 Cer-	tified Public	Y	Α		4.00
	Accountant? Column 2: If yes, enter "A" for Audited, "C" i					
	or "R" for Reviewed. Submit complete copy or enter date ava	ailable in				
F 00	column 3. (see instructions) If no, see instructions.					- 0
5. 00	Are the cost report total expenses and total revenues diffe		N			5. 00
	those on the filed financial statements? If yes, submit red	conciliation.		Y/N	Legal Oper.	
				1. 00	2. 00	
	Approved Educational Activities			1.00	2.00	
6. 00	Column 1: Are costs claimed for nursing school? Column 2:	If ves. is th	ne provider is	N		6.00
	the legal operator of the program?	<b>y</b> .	•			
7.00	Are costs claimed for Allied Health Programs? If "Y" see in	nstructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved	and/or renewed	d during the	N		8. 00
	cost reporting period? If yes, see instructions.					
9. 00	Are costs claimed for Interns and Residents in an approved		cal education	N		9.00
10. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of		the europat	N		10.00
10.00	cost reporting period? If yes, see instructions.	or renewed in t	the current	IN		10.00
11. 00	Are GME cost directly assigned to cost centers other than I	I & R in an Apr	proved	N		11.00
	Teaching Program on Worksheet A? If yes, see instructions.	. a app				• (
					Y/N	
					1.00	
	Bad Debts					
12. 00					Y	12.00
13. 00	j ' '	policy change c	during this co	st reporting	N	13.00
44.00	period? If yes, submit copy.					1
14.00	If line 12 is yes, were patient deductibles and/or co-payme	ents walved? IT	yes, see ins	tructions.	N N	14.00
15 00	Bed Complement Did total beds available change from the prior cost reporti	ing period2 lf	vas saa insti	ructi ons	N	15.00
13.00	The total beds available change from the pirol cost reporti		rt A		 `t B	15.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
	PS&R Data	<u>'</u>				
16 00	Was the sest seems as a selection the DCOD December 11.00	Υ	02/09/2017	Υ	02/09/2017	16.00
10. UU	Was the cost report prepared using the PS&R Report only?					1
10.00	If either column 1 or 3 is yes, enter the paid-through					10.00
10.00	If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see					
	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)	, and		N		
	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) Was the cost report prepared using the PS&R Report for	N		N		
	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) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	N		N		
	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) 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	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) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 (see instructions)					17. 0
17. 00	If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 (see instructions)	N N		N N		17.00
16. 00 17. 00 18. 00	If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)  Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)  If line 16 or 17 is yes, were adjustments made to PS&R					17. 00
17. 00	If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)  Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 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					17. 00
17. 00	If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 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 cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R					17. 00 18. 00
17. 00 18. 00	If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 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 cost report? If yes, see instructions.	N		N		17. 00 18. 00

Heal th	Financial Systems PULASKI MEMORI	IAL HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-1305	Peri od: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part II Date/Time Pre 4/21/2017 3:3	pared:
		Descr	pti on	Y/N	Y/N	)   DIII
			)	1. 00	3. 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
		Y/N 1.00	Date 2.00	Y/N 3. 00	Date	
21. 00	Was the cost report prepared only using the provider's	N N	2.00	N N	4. 00	21. 00
	records? If yes, see instructions.					
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	OSPI TALS)			1
22.00	Capital Related Cost	l notructions		I	N	1 22 00
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		als made dur	ing the cost	N N	22. 00 23. 00
24. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	ed into during	N	24. 00		
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	If yes, see	N	25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	ne cost reporti	ng period? I	f yes, see	N	26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reportir	g period? If	yes, submit	N	27. 00
28. 00	Interest Expense Were new loans, mortgage agreements or letters of credit en	ntered into dur	ing the cost	reporti ng	N	28. 00
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		bt Service R	eserve Fund)	N	29. 00
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu		debt? If yes	, see	N	30. 00
31. 00	<pre>instructions. Has debt been recalled before scheduled maturity without is instructions.</pre>	ssuance of new	debt? If yes	, see	N	31.00
32. 00 33. 00	Purchased Services Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instructions of the services instructions are see instructions.	uctions.	-		N	32. 00 33. 00
	no, see instructions. Provider-Based Physicians					-
34. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rangement with	provi der-ba	sed physi ci ans?	Υ	34. 00
35. 00	If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		its with the	provi der-based	N	35. 00
				Y/N	Date	
	Home Offi on Conta			1. 00	2. 00	
36. 00	Home Office Costs Were home office costs claimed on the cost report?			N		36. 00
	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.	repared by the	home office?			37. 00
38. 00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end					38. 00
39. 00	If line 36 is yes, did the provider render services to othe see instructions.			i,		39. 00
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see			40. 00
		1	00	2.	00	
	Cost Report Preparer Contact Information					
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MI CHAEL		ALESSANDRI NI		41. 00
42. 00		BLUE AND CO.,	LLC			42. 00
43. 00		317. 713. 7959		MALESSANDRI NI @E	BLUEANDCO. COM	43. 00

Heal th	Financial Systems	PULASKI MEMORIA	L HOSPITAL			In Lie	u of Form C	MS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QU	JESTI ONNAI RE	Provi der	CCN: 15-1305	Peri Froi To	m 10/01/2015		Prep	pared:
				3. 00					
	Cost Report Preparer Contact Information								
41. 00	Enter the first name, last name and the tit held by the cost report preparer in columns respectively.	'	ENIOR MANAG	ER					41. 00
42. 00	Enter the employer/company name of the cost preparer.	report							42. 00
43. 00	Enter the telephone number and email addres report preparer in columns 1 and 2, respect								43. 00

Provider CCN: 15-1305

| Peri od: | Worksheet S-3 | From 10/01/2015 | Part | To 09/30/2016 | Date/Time Prepared:

					1	0 09/30/2016	4/21/2017 3:3	
							I/P Days / 0/P	, р
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
	35p31.0111	Line Number		o. Bodo	Avai I abl e	57 II 110 G1 5		
		1. 00		2. 00	3. 00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		25	9, 150			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						Ö	6. 00
7. 00	Total Adults and Peds. (exclude observation			25	9, 150	47, 712. 00		7. 00
7.00	beds) (see instructions)			20	,,	17,712.00		7.00
8. 00	INTENSIVE CARE UNIT	31. 00		0	0	0.00	0	8. 00
9. 00	CORONARY CARE UNIT			_	_		_	9. 00
10. 00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13. 00	NURSERY	43. 00					0	13. 00
14. 00	Total (see instructions)	10.00		25	9, 150	47, 712. 00		14. 00
15. 00	CAH visits			20	7, 100	17, 712.00	0	15. 00
16. 00	SUBPROVI DER - I PF						Ĭ	16. 00
17. 00	SUBPROVI DER – I RF							17. 00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY							19. 00
20. 00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY	101, 00					0	22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )	101.00					Ŭ	23. 00
24. 00	HOSPI CE	116. 00		0	0			24.00
24. 10	HOSPICE (non-distinct part)	30. 00		U				24. 10
25. 00	CMHC - CMHC	30.00						25. 00
26. 00	RURAL HEALTH CLINIC	88. 00					0	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)	89.00		25			0	27. 00
28. 00	Observation Bed Days			23			0	28. 00
29. 00	,						0	29.00
	Ambulance Trips							
30. 00 31. 00	Employee discount days (see instruction) Employee discount days - IRF							30. 00 31. 00
				0				
32. 00	Labor & delivery days (see instructions)			0	0			32.00
32. 01	Total ancillary labor & delivery room							32. 01
22 00	outpatient days (see instructions)							22.00
33.00	LTCH non-covered days				I		I	33. 00

Provider CCN: 15-1305

						4/21/2017 3:3	7 pm
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	1, 100	44	1, 988			1. 00
2.00	HMO and other (see instructions)	76	221				2.00
3.00	HMO IPF Subprovider	o	0				3. 00
4.00	HMO IRF Subprovider	o	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	957	0	970			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	162			6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	2, 057	44	3, 120			7. 00
8.00	INTENSIVE CARE UNIT	0	0	0			8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY		12	188			13. 00
14.00	Total (see instructions)	2, 057	56	3, 308	0.00	188. 81	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	2, 880	0	4, 192	0.00	11. 15	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE	0	0	0	0.00	0. 61	
24. 10	HOSPICE (non-distinct part)	0	0	0			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	3, 991	286	18, 977			
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0. 00	26. 25
27. 00	Total (sum of lines 14-26)				0.00	239. 81	
28. 00	Observation Bed Days		0	290			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			0			30. 00
31. 00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32. 00
32. 01	Total ancillary labor & delivery room			18			32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days	0					33. 00

 
 Heal th Financial
 Systems
 PULASKI

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

| Peri od: | Worksheet S-3 | From 10/01/2015 | Part | To 09/30/2016 | Date/Time Prepared:

				To	09/30/2016	Date/Time Pre 4/21/2017 3:3	
		Full Time		Di sch	arges		
		Equi val ents					
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14. 00	15. 00	
1. 00 2. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)		0	293	17	583	2. 00
3. 00 4. 00 5. 00 6. 00 7. 00	HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)			20	0		3. 00 4. 00 5. 00 6. 00 7. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY	0.00		000		500	8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE	0.00	0	293	17	583	14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00
22. 00 23. 00 24. 00 24. 10 25. 00 26. 25 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00	Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0. 00 0. 00 0. 00 0. 00 0. 00					22. 00 23. 00 24. 00 24. 10 25. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 01 33. 00

	Financial Systems HEALTH AGENCY STATISTICAL DATA	PULASKI MEMORI	Provi der C		eriod: rom 10/01/2015	wu of Form CMS-2 Worksheet S-4 Date/Time Pre 4/21/2017 3:3 PPS	pared:
					1.	00	
0.00	County				0.11		0. 00
		Title V 1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	Total 5.00	
	HOME HEALTH AGENCY STATISTICAL DATA	1.00	2.00	0.00	1. 00	0.00	
1.00	Home Health Aide Hours	0			0		1. 00
2. 00	Unduplicated Census Count (see instructions)	0.00	132.00	0.00 Number of Empl	0.00		2. 00
		Enter the numb your normal	er of hours in work week	·	Contract	Total	
			ີ	1.00	2. 00	3. 00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES			1.00	2.00		
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00	Administrator and Assistant Administrator(s) Director(s) and Assistant Director(s) Other Administrative Personnel Direct Nursing Service Nursing Supervisor Physical Therapy Service Physical Therapy Supervisor Occupational Therapy Supervisor Occupational Therapy Supervisor Speech Pathology Service Speech Pathology Service Speech Pathology Supervisor Medical Social Service Medical Social Service Medical Social Service Supervisor Home Health Aide Home Health Aide Supervisor OTHER HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where you provided services during the cost reporting period. List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	Full E	40.00	0. 00 0. 42 0. 02 4. 13 0. 00 0. 60 0. 00 0. 01 0. 05 0. 00 0. 00 0. 00 0. 00 3. 39 0. 00 0. 45 3 23844	0. 00 0. 00	0. 42 0. 02 4. 13 0. 00 0. 60 0. 14 0. 00 0. 05 0. 00 0. 00 0. 00 3. 39 0. 00	14. 00 15. 00 16. 00
		Wi thout		LUPA Epi sodes	PEP Only	Total (cols.	
		Outliers 1.00	2.00	3.00	Epi sodes 4. 00	1-4) 5. 00	
04.05	PPS ACTIVITY DATA						
21. 00 22. 00	Skilled Nursing Visits Skilled Nursing Visit Charges	1, 046 228, 010			4 875	1, 201 261, 899	21. 00 22. 00
23. 00	Physical Therapy Visits	630	21	6	6	663	23. 00
24. 00	Physical Therapy Visit Charges	149, 773			1, 431	157, 644	
25. 00 26. 00	Occupational Therapy Visits Occupational Therapy Visit Charges	131 31, 018	18 4, 293		4 954	155 36, 742	
27. 00	Speech Pathology Visits	55			0	1	27. 00
28. 00	Speech Pathology Visit Charges	13, 118			0	13, 595	
29. 00	Medical Social Service Visits	0	0		0		29. 00
30. 00 31. 00	Medical Social Service Visit Charges Home Health Aide Visits	731	66	_	0	1	30. 00 31. 00
32. 00	Home Health Aide Visit Charges	73, 612			0		32. 00
33. 00	Total visits (sum of lines 21, 23, 25, 27,	2, 593	198	75	14	2, 880	33. 00
24.00	29, and 31)				0		24.00
34. 00 35. 00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	495, 531	0 36, 295		0 3, 260	550, 858	34. 00 35. 00
55.00	30, 32, and 34)	475, 551	30, 240	15,772	3, 200	330, 036	33.00
36. 00	Total Number of Episodes (standard/non outlier)	162		29	1	192	36. 00
37. 00	Total Number of Outlier Episodes	0	4	0.04	0		37. 00
38.00	Total Non-Routine Medical Supply Charges	34, 743	3, 469	2, 310	0	40, 522	J 38. UO

	Financial Systems	PULASKI MEMORI	AL HOSPITAL		In lie	eu of Form CMS-	2552-10
11035111	AL-BASED RHC/FQHC STATISTICAL DATA	T OETIORT INEMOTE	Provider Co	CN: 15-1305	Peri od:	Worksheet S-8	
			Component	CCN: 15-8512	From 10/01/2015 To 09/30/2016		epared:
						4/21/2017 3:3	
					RHC I	Cost	
					1.	. 00	
	Clinic Address and Identification				E 40 LIOCDI TAL. S	NDL VE	1 1 00
1. 00	Street		Ci	ty	540 HOSPITAL D State	ZIP Code	1.00
				00	2. 00	3.00	
2.00	City, State, ZIP Code, County		WINIMAC		IN	46996	2. 00
						1.00	
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rura	I or "U" for u	ırban			3. 00
	-				nt Award	Date	
	Source of Federal Funds				1. 00	2. 00	
4. 00	Community Health Center (Section 330(d), PHS	Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS A	ct)					5. 00
6.00	Health Services for the Homeless (Section 34)	O(d), PHS Act)					6.00
7. 00 8. 00	Appalachian Regional Commission Look-Alikes						7. 00 8. 00
9. 00	OTHER (SPECIFY)						9. 00
					1.00		
10. 00	Does this facility operate as other than a ho	nsnital-hased R	HC or FOHC2 Fr	ter "Y" for	1. 00 N	2.00	10.00
10.00	yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o	ate number of o	ther operation	ns in column			10.00
	hours.)						
		Sund		<del></del>	londay	Tuesday	
		1.00	2. 00	from 3.00	4. 00	from 5.00	
	Facility hours of operations (1)						
11. 00	Clinic			08: 00	17: 00	08: 00	11. 00
					1. 00	2.00	
12. 00	Have you received an approval for an exception				N		12. 00
13. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu		00-04. chapter	· 9, section	N		•
		umn 1 If vac		n 2 the			13. 00
	number of providers included in this report.		enter in colum				•
			enter in colum	lers and			•
	number of providers included in this report.		enter in colum	lers and Provi	der name	CCN number	•
14. 00	number of providers included in this report.		enter in colum	lers and Provi	der name 1.00		•
14. 00	number of providers included in this report. numbers below.	List the names	enter in colum of all provid	Provi	1. 00 XI X	CCN number 2.00  Total Visits	13.00
	number of providers included in this report. numbers below.  RHC/FQHC name, CCN number	List the names	enter in colum of all provid	ders and Provi	1. 00	CCN number 2.00	14.00
	number of providers included in this report. numbers below.  RHC/FOHC name, CCN number  Have you provided all or substantially all	Y/N 1.00	enter in colum of all provid	Provi	1. 00 XI X	CCN number 2.00  Total Visits	13.00
	number of providers included in this report. numbers below.  RHC/FOHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and	Y/N 1.00	enter in colum of all provid	Provi	1. 00 XI X	CCN number 2.00  Total Visits	14.00
	number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by	Y/N 1.00	enter in colum of all provid	Provi	1. 00 XI X	CCN number 2.00  Total Visits	14.00
	number of providers included in this report. numbers below.  RHC/FOHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and	Y/N 1.00	enter in colum of all provid	Provi	1. 00 XI X	CCN number 2.00  Total Visits	14.00
	number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	Y/N 1.00	enter in colum of all provid	Provi	1. 00 XI X	CCN number 2.00  Total Visits	14.00
	number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the	Y/N 1.00	enter in colum of all provid V 2.00	Provi	1. 00 XI X	CCN number 2.00  Total Visits	14.00
	number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	Y/N 1.00	enter in colum of all provid V 2.00	Provi	1. 00 XI X	CCN number 2.00  Total Visits	14.00
15. 00	number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	Y/N 1.00	v 2.00  Cou 4. PULASKI	Provi  XVIII  3.00	1. 00 XIX 4. 00	CCN number 2.00  Total Visits 5.00	14.00
15. 00	number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	Y/N 1.00  Tuesday	v 2.00  Cou 4. PULASKI	Provi  XVIII  3.00  unty 00  esday	1.00 XIX 4.00	CCN number 2.00  Total Visits 5.00	14.00
15. 00	number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	Y/N 1.00	v 2.00  Cou 4. PULASKI	Provi  XVIII  3.00	1. 00 XIX 4. 00	CCN number 2.00  Total Visits 5.00	14.00
2.00	number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	Y/N 1.00  Tuesday to 6.00	enter in column of all provide v v 2.00	Provi  XVIII  3.00  Inty  00  esday  to	1.00  XIX  4.00  Thur from 9.00	CCN number 2.00  Total Visits 5.00	14.00

Health Financial Systems	PULASKI MEMOR	RIAL	HOSPI TAL				In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provi der	CCN:	15-1305	Peri		Worksheet S-8	
					. 45 0540		10/01/2015		
			Componen	t CCN	1: 15-8512	10	09/30/2016	Date/Time Pre 4/21/2017 3:3	
							RHC I	Cost	
	Fri	i day			Sa	turda	У		
	from		to		from		to		
	11. 00		12.00		13.00		14.00		
Facility hours of operations (1)									
11. 00   Cl i ni c	08: 00	16: 3	30						11. 00

∐oal +h	Financial Systems		PULASKI MEMOR	IAI UOSDITAI		In Lio	u of Form CMS-:	2552 10
	TAL-BASED HOSPICE IDENTIFICATION	DATA	PULASKI WEWUR	Provi der C	^N: 15 1205	Peri od:	Worksheet S-9	
позетт	AL-BASED HOSPICE IDENTIFICATION	DATA		Provider C	UN. 13-1303	From 10/01/2015	PARTS I THROU	
				Hospi ce CC	N: 15-1550	To 09/30/2016		
				'			4/21/2017 3:3	7 pm
						Hospi ce I		
		Unduplicated						
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		cols. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS FOR CO	ST REPORTING F	PERI ODS BEGINNI	NG BEFORE OCTO	BER 1, 2015			
1.00	Hospice Continuous Home Care							1. 00
2.00	Hospice Routine Home Care							2. 00
3.00	Hospice Inpatient Respite Care							3. 00
4.00	Hospice General Inpatient Care							4. 00
5.00	Total Hospice Days							5. 00
	Part II - CENSUS DATA FOR COST	REPORTING PERI	ODS BEGINNING	BEFORE OCTOBER	1, 2015			
6.00	Number of patients receiving							6. 00
	hospi ce care							
7.00	Total number of unduplicated							7. 00
	Continuous Care hours billable							
	to Medicare							
8.00	Average Length of Stay (line 5							8. 00
	/ line 6)							
9.00	Unduplicated census count							9. 00
NOTE:	Parts I and II, columns 1 and 2	also include	the days repor	ted in columns	3 and 4.			
				Title XVIII	Title XIX	Other	Total (sum of	
							col s. 1	
							through 3)	
				1.00	2.00	3. 00	4. 00	
	PART III - ENROLLMENT DAYS FOR	COST REPORTING	PERIODS BEGIN	INING ON OR AFT	ER OCTOBER 1,	, 2015		
10.00	Hospice Continuous Home Care			0		0	0	10.00
11.00	Hospice Routine Home Care			7		0	7	11. 00
12.00				0		0	0	12. 00
13.00	Hospice General Inpatient Care			0		0 0	0	
14.00	Total Hospice Days			7		0 0	7	14. 00
	PART IV - CONTRACTED STATISTICA	L DATA FOR COS	ST REPORTING PE	ERIODS BEGINNIN	G ON OR AFTE	R OCTOBER 1, 2015	5	
15.00	Hospice Inpatient Respite Care			0		0 0	0	15. 00
16.00	Hospice General Inpatient Care			0		0 0	0	16.00
	•							

Uool +h	Financial Systems	PULASKI MEMORIAL	HOCDI TAI		In Lie	u of Form CMS-2	DEE2 10	
	Financial Systems  FAL UNCOMPENSATED AND INDIGENT CARE DATA	PULASKI WEWORIAL	Provider CO	ON. 1E 120E	Peri od:	Worksheet S-1		
позетт	AL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CC	JN. 13-1303	From 10/01/2015	WOLKSHEET 3-10	J	
					To 09/30/2016	Date/Time Pre	oared:	
						4/21/2017 3: 3		
						1. 00		
	Uncompensated and indigent care cost comp							
1.00	Cost to charge ratio (Worksheet C, Part I	line 202 column 3 d	ivided by li	ne 202 column	า 8)	0. 436704	1. 00	
	Medicaid (see instructions for each line) Net revenue from Medicaid							
2.00		754, 054	2. 00					
3.00	Did you receive DSH or supplemental payme					Υ	3. 00	
4.00	If line 3 is "yes", does line 2 include a			from Medicaio	<del>1</del> ?	N	4. 00	
5.00	If line 4 is "no", then enter DSH or supp	olemental payments fr	om Medicaid			294, 789	5. 00	
6.00	Medi cai d charges					4, 202, 680	6. 00	
7. 00	Medicaid cost (line 1 times line 6)					1, 835, 327	7. 00	
8. 00	Difference between net revenue and costs	for Medicaid program	(line 7 min	us sum of lir	nes 2 and 5; if	786, 484	8. 00	
	< zero then enter zero)	)	6 1:	- \				
0.00	Children's Health Insurance Program (CHIP	(See Instructions	ror each iin	e)		0	0.00	
9.00	Net revenue from stand-alone CHIP					0	9.00	
10.00	3	10)				_	10. 00 11. 00	
11. 00	Stand-alone CHIP cost (line 1 times line		(lina 11 mi	nua lina O. i	f . zono thon	0		
12. 00	Difference between net revenue and costs enter zero)	TOT Stand-arone CHIP	(Tine II mi	nus i i ne 9; i	i < zero then	U	12. 00	
	Other state or local government indigent	caro program (soo in	structions f	or each line				
13. 00	Net revenue from state or local indigent					0	13. 00	
14. 00	Charges for patients covered under state	. 5			,	0	14. 00	
14.00	10)	or rocar rhargent ca	re program (	NOT THE daca	111 111103 0 01	O	14.00	
15. 00	State or local indigent care program cost	(line 1 times line	14)			0	15. 00	
16. 00	, ,			program (lin	ne 15 minus line	0	16. 00	
	13; if < zero then enter zero)		3	1 3 1				
	Uncompensated care (see instructions for	each line)						
17. 00	Private grants, donations, or endowment i	ncome restricted to	fundi ng char	ity care		0	17.00	
18. 00	Government grants, appropriations or tran	nsfers for support of	hospital op	erati ons		0	18. 00	
19. 00		HIP and state and Loc	al indigent	care programs	s (sum of lines	786, 484	19. 00	
	8, 12 and 16)				1			
				Uni nsured	Insured	Total (col. 1		
				pati ents	pati ents	+ col . 2)		
20. 00	Charity care charges for the entire facil	ity (soo instruction	c)	1. 00 396, 50	2. 00	3. 00 396, 501	20. 00	
21. 00				173, 1		173, 154		
22. 00	1		20)	173, 13	0 0	173, 134		
23. 00	1			173, 1	-	173, 154		
23.00	cost of chartty care (True 21 millios True	22)		173, 1	54 0	173, 134	23.00	
1.00								
24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit N								
	imposed on patients covered by Medicaid of						24. 00	
25. 00	If line 24 is "yes," charges for patient			ogram's Lengt	th of stay limit	0	25. 00	
26.00					,	0	26. 00	
27. 00	· ·		,			308, 380	27. 00	
28. 00	Non-Medicare and non-reimbursable Medicar			s line 27)		-308, 380		
29. 00					e 28)	-134, 671		
30.00	Cost of uncompensated care (line 23 colum	nn 3 plus line 29)	•		:	38, 483	30. 00	
31.00	Total unreimbursed and uncompensated care	e cost (line 19 plus	line 30)			824, 967	31. 00	
		·						

Heal th	Financial Systems	PULASKI MEMORIA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O		Provi der Co		eri od:	Worksheet A	
				F	rom 10/01/2015 o 09/30/2016	Date/Time Pre 4/21/2017 3:3	pared: 7 pm
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)		
		1.00	2.00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1, 301, 907		24, 844	1, 326, 751	1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1 000 (2)	5, 088, 922		0	5, 088, 922	4. 00
5. 00 7. 00	OO5OO  ADMINISTRATIVE & GENERAL   OO7OO  OPERATION OF PLANT	1, 980, 636 252, 510	1, 928, 200 532, 225		327, 347 0	4, 236, 183 784, 735	1
8.00	00800 LAUNDRY & LINEN SERVICE	15, 889	55, 326		0	71, 215	1
9. 00	00900 HOUSEKEEPI NG	149, 929	79, 897		0	229, 826	1
10. 00	01000 DI ETARY	174, 492	176, 943		0	351, 435	1
13. 00	01300 NURSING ADMINISTRATION	416, 080	12, 251		o O	428, 331	
14. 00	01400 CENTRAL SERVICES & SUPPLY	41, 124	44, 945		0	86, 069	
15.00	01500 PHARMACY	0	0		0	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	284, 569	45, 676	330, 245	0	330, 245	16. 00
17. 00	01700 SOCIAL SERVICE	50, 806	127	50, 933	0	50, 933	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	1, 836, 640	138, 688			2, 051, 201	30. 00
31.00	03100   INTENSI VE CARE UNI T	0	0		0	0	
43. 00	04300 NURSERY	65, 488	5, 443	70, 931	0	70, 931	43. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS    O5000   OPERATI NG ROOM	541, 540	109, 533	651, 073	275, 869	926, 942	50. 00
50.00	05200 DELIVERY ROOM & LABOR ROOM	87, 925	6, 353			926, 942 94, 278	1
53. 00	05300 ANESTHESI OLOGY	07, 725	606, 206		0	606, 206	l
54. 00	05400 RADI OLOGY-DI AGNOSTI C	736, 970	861, 822		0	1, 598, 792	l
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	00.,022		0	0	
60.00	06000 LABORATORY	564, 308	710, 954		o O	1, 275, 262	
60. 01	06001 BLOOD LABORATORY	0	0		0	0	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	66, 508	66, 508	0	66, 508	63.00
65.00	06500 RESPI RATORY THERAPY	260, 700	23, 619	284, 319	0	284, 319	65. 00
66. 00	06600 PHYSI CAL THERAPY	689, 140	13, 828		0	702, 968	
67. 00	06700 OCCUPATI ONAL THERAPY	94, 420	957		0	95, 377	1
68. 00	06800 SPEECH PATHOLOGY	97, 157	6, 749		0	103, 906	1
69. 00	06900 ELECTROCARDI OLOGY	12, 634	9, 399			22, 033	1
69. 01 70. 00	06901   CARDI AC REHABI LI TATI ON   07000   ELECTROENCEPHALOGRAPHY	61, 732	1, 950 0		0	63, 682	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		611, 837	1	-182, 423	0 429, 414	
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS		011,037	011,037	182, 423	182, 423	•
73. 00	07300 DRUGS CHARGED TO PATIENTS		1, 973, 436	1, 973, 436	102, 423	1, 973, 436	1
76. 00	03020 ONCOLOGY	104, 396	36, 603		o O	140, 999	1
	OUTPATIENT SERVICE COST CENTERS	,				,	
88.00	08800 RURAL HEALTH CLINIC	3, 419, 654	250, 546	3, 670, 200	-648, 390	3, 021, 810	88. 00
90.00	09000 CLI NI C	85, 223	217, 628	302, 851	0	302, 851	90. 00
91.00	09100 EMERGENCY	892, 790	923, 012	1, 815, 802	0	1, 815, 802	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	OTHER REIMBURSABLE COST CENTERS		00.047		F. 000	/00 001	
101.00	10100 HOME HEALTH AGENCY	567, 696	98, 267	665, 963	-56, 932	609, 031	101.00
11/ 00	SPECIAL PURPOSE COST CENTERS	24 004	1 271	27.467	0	27.447	11/ 00
118.00	11600 HOSPICE   SUBTOTALS (SUM OF LINES 1-117)	26, 096	1, 371 15, 941, 128			27, 467 29, 450, 283	
110.00	NONREI MBURSABLE COST CENTERS	13, 510, 544	13, 941, 120	29, 431, 072	-1, 309	29, 400, 203	1110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	0	0	0	190. 00
	19001 HOMECARE		0		0		190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	1, 094, 399	740, 228		36, 663	1, 871, 290	
	07950 MARKETI NG	89, 201	145, 961			199, 888	
200.00		14, 694, 144	16, 827, 317	31, 521, 461	0	31, 521, 461	200. 00

Provi der CCN: 15-1305

Peri od: From 10/01/2015 To 09/30/2016 Date/Ti me Prepared: 4/21/2017 3:37 pm

				4/21/2017 3: 3	37 pm
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation		
		6.00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-11, 712	1, 315, 039		1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	5, 088, 922		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-339, 420	3, 896, 763		5. 00
7.00	00700 OPERATION OF PLANT	-278			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	1		8. 00
9. 00	00900 HOUSEKEEPI NG	0	l		9. 00
10. 00	01000 DI ETARY	-66, 114	285, 321		10.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	00,114	428, 331		13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	-29, 532	1		14. 00
15. 00	01500 PHARMACY	-27, 332	0 0		15. 00
		, , , , ,		l .	1
16.00	01600 MEDICAL RECORDS & LIBRARY	-6, 667	323, 578		16. 00
17. 00	01700 SOCIAL SERVICE	0	50, 933		17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				4
30. 00	03000 ADULTS & PEDI ATRI CS	-385, 912			30.00
31. 00	03100 INTENSIVE CARE UNIT	0	0		31.00
43.00	04300 NURSERY	0	70, 931		43. 00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-275, 869	651, 073		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	94, 278		52.00
53.00	05300 ANESTHESI OLOGY	-589, 327	16, 879		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 598, 792		54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		59. 00
60.00	06000 LABORATORY	0	1, 275, 262		60.00
60. 01	06001 BLOOD LABORATORY	0	0		60. 01
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	66, 508	•	63. 00
65. 00	06500 RESPIRATORY THERAPY	-1,000	l	l e e e e e e e e e e e e e e e e e e e	65. 00
66. 00	06600 PHYSI CAL THERAPY	-1,000	702, 968	l e e e e e e e e e e e e e e e e e e e	66.00
		0	l		
67. 00	06700 OCCUPATI ONAL THERAPY	0	95, 377		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	103, 906		68. 00
69. 00	06900 ELECTROCARDI OLOGY	-4, 225			69. 00
69. 01	06901 CARDI AC REHABI LI TATI ON	0	63, 682		69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	ı		70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-551	428, 863		71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	182, 423		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	-108, 550	1, 864, 886		73. 00
76.00	03020 ONCOLOGY	0			76. 00
	OUTPATIENT SERVICE COST CENTERS				1
88. 00	08800 RURAL HEALTH CLINIC	0	3, 021, 810		88. 00
90.00	09000 CLI NI C	0			90.00
91. 00	09100 EMERGENCY	0		l control of the cont	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1,013,002		92. 00
92.00	OTHER REIMBURSABLE COST CENTERS				42.00
101 00	10100 HOME HEALTH AGENCY	0	609, 031		101. 00
101.00		U	009, 031		1101.00
11/ 00	SPECIAL PURPOSE COST CENTERS		27.447	,	111, 00
	11600 H0SPI CE	0		1	116. 00
118.00		-1, 819, 157	27, 631, 126		118. 00
	NONREI MBURSABLE COST CENTERS	1			4
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	-		190. 00
	19001 HOMECARE	0	0		190. 01
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	1, 871, 290		192. 00
194.00	07950 MARKETI NG	0	199, 888	3	194. 00
200.00		-1, 819, 157			200. 00
				1	•

Heal th	Financial Systems		PULASKI MEMOR	RIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
RECLASS	SI FI CATI ONS			Provi der (	CCN: 15-1305	Peri od: From 10/01/2015 To 09/30/2016	Worksheet A-6 Date/Time Pro 4/21/2017 3:3	epared:
		Increases						
	Cost Center	Li ne #	Sal ary	Other				

						0 77 307 2010	4/21/2017 3:	: 37 pm
		Increases		·				
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3. 00	4. 00	5. 00				
	A - PROPERTY INSURANCE							
1.00	NEW CAP REL COSTS-BLDG &	1. 00	0	24, 844				1. 00
	FIXT							
	0		0	24, 844				
	B - MARKETING RECLASS							
1. 00	ADMI NI STRATI VE & GENERAL		1 <u>3, 3</u> 80	21, 894				1. 00
	0		13, 380	21, 894				
	C - IMPLANTABLE DEVICES							
1.00	IMPL. DEV. CHARGED TO	72. 00	0	182, 423				1. 00
	PATI ENTS		+					
	0		0	182, 423				
	D - PHYSICIAN SALARIES				T			
1.00	ADULTS & PEDIATRICS	30.00	75, 873	0				1. 00
2.00	OPERATING ROOM	50.00	275, 869	0				2. 00
3.00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	3 <u>6, 6</u> 63	0				3. 00
	0		388, 405	0				
	E - RHC PHYSICIAN COSTS							
1.00	RURAL HEALTH CLINIC		•_	1 <u>5, 5</u> 53				1. 00
	TOTALS		0	15, 553				
	F - BILLER RECLASS							
1.00	ADMI NI STRATI VE & GENERAL	5. 00	5 <u>6, 9</u> 32	0				1. 00
	TOTALS		56, 932	0				
	G - PATIENT ACCOUNTS RECLASS							
1.00	ADMI NI STRATI VE & GENERAL	5. 00	27 <u>5, 5</u> 38	0				1. 00
	TOTALS		275, 538	0				
500.00	Grand Total: Increases		734, 255	244, 714				500.00

Health Financial Systems RECLASSIFICATIONS HOSPITAL In Lieu of Form CMS-2552-10
Provider CCN: 15-1305 Period: Worksheet A-6
From 10/01/2015 PULASKI MEMORIAL HOSPITAL

						From 10/01/2015 To 09/30/2016	epared: 37 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10.00		
	A - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL		0	2 <u>4, 8</u> 44		2	1. 00
	0		0	24, 844			
	B - MARKETING RECLASS						
1.00	MARKETING	194. 00	13, 380	21, 894		<u>D</u>	1. 00
	0		13, 380	21, 894			
	C - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	182, 423	(	0	1. 00
	PATI ENTS	+	+			_	
	0		0	182, 423			
	D - PHYSICIAN SALARIES				1		
1.00	RURAL HEALTH CLINIC	88. 00	388, 405	0	(	0	1.00
2.00		0.00	0	0	(	0	2. 00
3.00			•	0		<u> </u>	3. 00
	0		388, 405	0			
	E - RHC PHYSICIAN COSTS				ı		
1.00	ADMINISTRATIVE & GENERAL			1 <u>5, 5</u> 5 <u>3</u>		<u> </u>	1. 00
	TOTALS		0	15, 553			
	F - BILLER RECLASS				T.		_
1.00	HOME HEALTH AGENCY	1 <u>01.</u> 00	5 <u>6, 9</u> 32	0	<u> </u>	<u> </u>	1. 00
	TOTALS		56, 932	0			
	G - PATIENT ACCOUNTS RECLASS				T		_
1.00	RURAL HEALTH CLINIC	<u>88.</u> 00	27 <u>5, 5</u> 38	0	<u> </u>	<u> </u>	1. 00
	TOTALS		275, 538	0		_	
500.00	Grand Total: Decreases		734, 255	244, 714			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-1305

Peri od: Worksheet A-7 From 10/01/2015 Part I Date/Time Prepared: 09/30/2016

4/21/2017 3:37 pm Acqui si ti ons Begi nni ng Di sposal s and Purchases Donati on Total Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 195, 525 0 1.00 0 2.00 Land Improvements 432, 594 0 2.00 0 3.00 10, 424, 102 3.00 Buildings and Fixtures 324, 363 324, 363 0 0 4.00 Building Improvements 182, 208 4, 847 4, 847 0 4.00 5.00 Fixed Equipment 5, 622, 718 91, 951 0 91, 951 5.00 0 6.00 Movable Equipment 8, 584, 630 1, 093, 474 1, 093, 474 415, 760 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 25, 441, 777 1, 514, 635 1, 514, 635 415, 760 8.00 9.00 Reconciling Items 0 9.00 Total (line 8 minus line 9) 25, 441, 777 415, 760 10.00 1, 514, 635 0 1, 514, 635 10.00 Endi ng Bal ance Fully Depreciated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 195, 525 0 1.00 2.00 Land Improvements 432, 594 0 2.00 Buildings and Fixtures 3.00 10, 748, 465 0 3.00 0 4.00 Building Improvements 187, 055 4.00 5.00 Fi xed Equipment 5, 714, 669 0 5.00 Movable Equipment 0 6.00 9, 262, 344 6.00 7.00 HIT designated Assets 0 7.00 Subtotal (sum of lines 1-7) 8.00 26, 540, 652 0 8.00 9.00 Reconciling Items 9.00 10.00 Total (line 8 minus line 9) 26, 540, 652 0 10.00

Heal th	Financial Systems	PULASKI MEMORI	PULASKI MEMORIAL HOSPITAL			In Lieu of Form CMS-2		
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Peri od: From 10/01/2015			
					To 09/30/2016	Date/Time Pre 4/21/2017 3:3	pared: 7 pm	
			Sl	JMMARY OF CAPI	TAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)		
		9. 00	10.00	11.00	12.00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00	NEW CAP REL COSTS-BLDG & FLXT	1, 123, 514	0	178, 39	3 0	0	1. 00	
3.00	Total (sum of lines 1-2)	1, 123, 514	0	178, 39	3 0	0	3. 00	
		SUMMARY O	F CAPITAL					
	Cost Center Description	0ther	Total (1) (sum					
		Capi tal -Relate	of cols. 9					
		d Costs (see	through 14)					
		instructions)						
		14. 00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1, 301, 907				1. 00	
3.00	Total (sum of lines 1-2)	0	1, 301, 907				3. 00	

Health Financial Systems	PULASKI MEMORI	IAL HOSPITAL		In Lie	eu of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 10/01/2015 Fo 09/30/2016	Date/Time Prep	
					4/21/2017 3: 3	7 pm
	COM	PUTATION OF RAT	1108	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col . 1 - col 2)			
	1.00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT	26, 540, 652	0	26, 540, 65	2 1. 000000	0	1.00
3.00 Total (sum of lines 1-2)	26, 540, 652		26, 540, 65			3.00
	ALLOCA <sup>-</sup>	TION OF OTHER (	CAPITAL	SUMMARY C	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Relate				
		d Costs	through 7)			
	6. 00	7. 00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00 NEW CAP REL COSTS-BLDG & FLXT	0			1, 112, 927	0	1. 00
3.00 Total (sum of lines 1-2)	0			1, 112, 927	0	3. 00
		Sl	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
				d Costs (see	through 14)	
				instructions)		
	11. 00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00 NEW CAP REL COSTS-BLDG & FLXT	177, 268			0	.,	1. 00
3.00  Total (sum of lines 1-2)	177, 268	24, 844		0	1, 315, 039	3. 00

In Lieu of Form CMS-2552-10 ADJUSTMENTS TO EXPENSES Provider CCN: 15-1305 Peri od: Worksheet A-8 From 10/01/2015 09/30/2016 Date/Time Prepared: 4/21/2017 3:37 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 1.00 Investment income - NEW CAP ONEW CAP REL COSTS-BLDG & 1. 00 1.00 REL COSTS-BLDG & FLXT (chapter IFI XT 2.00 Investment income - CAP REL 0 \*\*\* Cost Center Deleted \*\*\* 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) Trade, quantity, and time 0.00 4.00 4.00 discounts (chapter 8) 5.00 Refunds and rebates of 0.00 5.00 expenses (chapter 8) Rental of provider space by suppliers (chapter 8) 6.00 0.00 6.00 7 00 7.00 Tel ephone servi ces (pay 0.00 stations excluded) (chapter 8.00 Television and radio service 0.00 8.00 (chapter 21) 9.00 9.00 Parking lot (chapter 21) 0.00 -664, 947 10.00 Provi der-based physician A-8-2 10.00 adj ustment

Health Financial Systems	PULASKI MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
ADJUSTMENTS TO EXPENSES	Provi der CCN: 15-1305	Period: Worksheet A-8 From 10/01/2015
		To 09/30/2016 Date/Time Prepared: 4/21/2017 3:37 pm
	Expense Classification of To/From Which the Amount i	

						4/21/2017 3: 3	7 pm
				Expense Classification on	Worksheet A		
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	, , , , , , , , , , , , , , , , , , ,	1.00	2.00	3.00	4. 00	5. 00	
34. 00	EMPLOYEE RX PROGRAM -OTHER REV	В	-108, 550	DRUGS CHARGED TO PATIENTS	73. 00		34. 00
35. 00		l B	·	MEDICAL RECORDS & LIBRARY	16. 00	0	35. 00
	RFV		-,				
36. 00	SALE OF SCRAP -OTHER REV	В	-1. 333	CENTRAL SERVICES & SUPPLY	14. 00	0	36. 00
37. 00	REBATES & REFUNDS - OTHER REV	l B	·	CENTRAL SERVICES & SUPPLY	14. 00		37. 00
	BABY PHOTO - OTHER REV	B	·	ADMINISTRATIVE & GENERAL	5. 00		
40. 00		B		MEDICAL SUPPLIES CHARGED TO	71. 00		40. 00
	mes correr order ormer nev		20	PATI ENTS	,	ŭ	10.00
41. 00	NUCLEAR MED- OTHER REV	l B	-523	MEDICAL SUPPLIES CHARGED TO	71. 00	0	41. 00
				PATI ENTS			
43.00	OTHER SERVICES -OTHER REV	В		ADMINISTRATIVE & GENERAL	5. 00	0	43.00
44.00	1	В	·	ADULTS & PEDIATRICS	30.00		44. 00
45. 00	INVEST INC/UNRESTRIC- INT EXP	l B	·	NEW CAP REL COSTS-BLDG &	1. 00	11	45. 00
			·	FIXT		• • •	
45. 02	TELEVI SI ON	l A 1	-278	OPERATION OF PLANT	7. 00	0	45. 02
45. 03	PHYSICIAN RECRUITMENT- ADMIN	l A 1	-16, 644	ADMINISTRATIVE & GENERAL	5. 00	0	45. 03
45. 04	LOBBYING EXPENSE	l A 1	-2, 941	ADMINISTRATIVE & GENERAL	5. 00	0	45. 04
45. 05	1	l A	·	ANESTHESI OLOGY	53.00		
45. 06	HOSPITAL ASSESSMENT FEE	A	·	ADMINISTRATIVE & GENERAL	5. 00		45. 06
	EXPENSE	''	001,001		0.00		
50.00			-1, 819, 157				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

- (1) Description all chapter references in this column pertain to CMS Pub. 15-1. (2) Basis for adjustment (see instructions).

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

  B. Amount Received if cost cannot be determined.

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

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

Peri od: Worksheet A-8-2 From 10/01/2015 To 09/30/2016 Date/Time Prepared:

							4/21/2017 3:3	37 pm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				'	•		Hours	
	1. 00	2.00	3.00	4.00	5. 00	6. 00	7. 00	
1.00	91.00	EMERGENCY	876, 652	(	876, 652	0	0	1. 00
2.00	60.00	LABORATORY	24, 000		24,000	0	0	2. 00
3.00	90.00	CLINIC	36, 000		36, 000	0	0	3. 00
4.00	65. 00	RESPI RATORY THERAPY	1, 000			0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	307, 980		0	0	l 0	5. 00
6.00		ELECTROCARDI OLOGY	4, 225			0	0	6. 00
7.00	30.00	ADULTS & PEDIATRICS	75, 873	75, 87	3 0	l 0	l 0	7. 00
8. 00		OPERATING ROOM	275, 869			0	0	1
9. 00	0.00		0	(	0	0	0	9. 00
10.00	0.00		0		0	0	0	10.00
200.00			1, 601, 599	664, 94	936, 652	_	0	200. 00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE			Provi der	Physician Cost	
		I denti fi er			Memberships &	Component	of Malpractice	
				Limit	Continuing	Share of col.	Insurance	
					Educati on	12		
	1. 00	2.00	8. 00	9. 00	12. 00	13.00	14.00	
1.00	91. 00	EMERGENCY	0	(	0	0	0	1. 00
2.00	60.00	LABORATORY	0		0	0	0	2. 00
3.00		CLINIC	0		0	0	0	3. 00
4.00	65. 00	RESPI RATORY THERAPY	0		0	0	0	4. 00
5.00		ADULTS & PEDIATRICS	0		0	0	0	5. 00
6.00	69. 00	ELECTROCARDI OLOGY	0		0	0	0	6. 00
7.00	30.00	ADULTS & PEDIATRICS	0		0	0	0	7. 00
8.00	50.00	OPERATING ROOM	0	(	0	0	0	8. 00
9.00	0.00		0		0	0	0	9. 00
10.00	0.00		0	(	0	0	0	10. 00
200.00			0		0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1. 00		EMERGENCY	0		0	0		1. 00
2.00		LABORATORY	0	(	0	0		2. 00
3.00		CLINIC	0		0	0		3. 00
4.00		RESPI RATORY THERAPY	0	(	0	1, 000		4. 00
5.00		ADULTS & PEDIATRICS	0		0	307, 980		5. 00
6.00		ELECTROCARDI OLOGY	0		0	4, 225		6. 00
7.00		ADULTS & PEDIATRICS	0	(	0	75, 873		7. 00
8.00		OPERATING ROOM	0		0	275, 869		8. 00
9.00	0.00		0		0	0		9. 00
10.00	0.00		0		0	0		10.00
200.00			0	(	0	664, 947		200. 00

| Period: | Worksheet B | From 10/01/2015 | Part | To 09/30/2016 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1305

					To	09/30/2016	Date/Time Prep 4/21/2017 3:3	
				CAPI TAL			4/21/2017 3.3	/ pili
				RELATED COSTS				
	Cost Center Descri	ption	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
			for Cost	FLXT	BENEFITS		& GENERAL	
			Allocation (from Wkst A		DEPARTMENT			
			col. 7)					
			0	1.00	4. 00	4A	5. 00	
	GENERAL SERVICE COST CE							
1.00	00100 NEW CAP REL COSTS-		1, 315, 039	1, 315, 039				1.00
4.00	00400 EMPLOYEE BENEFITS		5, 088, 922	17, 740		4 000 520	4 000 520	4. 00
5. 00 7. 00	00500 ADMINISTRATIVE & 0		3, 896, 763 784, 457	275, 252 115, 326		4, 980, 539 987, 538	4, 980, 539 198, 953	5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SE		71, 215	10, 075		86, 812	17, 489	8. 00
9. 00	00900 HOUSEKEEPING		229, 826	6, 175		288, 106	58, 043	9. 00
10.00	01000 DI ETARY		285, 321	49, 956		395, 918	79, 763	
13.00	01300 NURSING ADMINISTRA	ATI ON	428, 331	11, 815		584, 746	117, 805	13. 00
14.00	01400 CENTRAL SERVICES 8	& SUPPLY	56, 537	16, 267	14, 292	87, 096	17, 547	14.00
15. 00	01500 PHARMACY		0	12, 970		12, 970	2, 613	15. 00
16. 00	01600 MEDICAL RECORDS &	LI BRARY	323, 578	24, 534		447, 008	90, 056	16. 00
17. 00	01700 SOCIAL SERVICE	OF OOCT OFNITEDS	50, 933	0	17, 657	68, 590	13, 818	17. 00
30. 00	03000 ADULTS & PEDIATRIC		1, 665, 289	146, 086	664, 656	2, 476, 031	498, 831	30. 00
31. 00	03100 I NTENSI VE CARE UNI		1,003,209	140,000		2, 470, 031	470, 031	31. 00
43. 00	04300 NURSERY	•	70, 931	2, 694	· ·	96, 384	19, 418	43. 00
	ANCILLARY SERVICE COST	CENTERS						
50.00	05000 OPERATING ROOM		651, 073	88, 766		1, 023, 913	206, 282	50.00
52. 00	05200 DELIVERY ROOM & LA	ABOR ROOM	94, 278	7, 899		132, 734	26, 741	52. 00
53. 00	05300 ANESTHESI OLOGY	F1.0	16, 879	519		17, 398	3, 505	53. 00
54. 00 59. 00	05400 RADI OLOGY-DI AGNOST 05900 CARDI AC CATHETERI Z		1, 598, 792	60, 098 0		1, 915, 009	385, 805 0	54.00
60.00	06000 LABORATORY	ZATTON	1, 275, 262	23, 263	-	1, 494, 639	301, 116	59. 00 60. 00
60. 01	06001 BLOOD LABORATORY		1, 273, 202	23, 203		1, 474, 037	0	60. 01
63. 00	06300 BLOOD STORING, PRO	OCESSING & TRANS.	66, 508	703	· ·	67, 211	13, 541	63. 00
65.00	06500 RESPIRATORY THERAF		283, 319	13, 104		387, 024	77, 971	65. 00
66.00	06600 PHYSI CAL THERAPY		702, 968	39, 563	239, 497	982, 028	197, 843	66. 00
67. 00	06700 OCCUPATIONAL THERA	APY	95, 377	0	32, 814	128, 191	25, 826	67. 00
68. 00	06800 SPEECH PATHOLOGY		103, 906	0		137, 671	27, 736	68. 00
69. 00	06900 ELECTROCARDI OLOGY		17, 808	0		22, 199	4, 472	69. 00
69. 01	06901 CARDI AC REHABI LI TA		63, 682	7, 498	1	92, 634	18, 662	69. 01
70. 00 71. 00	07000 ELECTROENCEPHALOGE 07100 MEDICAL SUPPLIES (		428, 863	0	1	0 428, 863	0 86, 400	70. 00 71. 00
71.00	07200 I MPL. DEV. CHARGEI		182, 423	0		182, 423	36, 752	71.00
73. 00	07300 DRUGS CHARGED TO F		1, 864, 886	0		1, 864, 886	375, 707	73. 00
76. 00	03020 ONCOLOGY	, 2 0	140, 999	9, 439		186, 719	37, 617	76. 00
	OUTPATIENT SERVICE COST					·		
88. 00	08800 RURAL HEALTH CLINI	C	3, 021, 810	137, 199		4, 116, 705	829, 363	88. 00
90.00	09000 CLI NI C		302, 851	30, 375		362, 844	73, 100	90. 00
91.00	09100 EMERGENCY	(NON DICTINGT DADT)	1, 815, 802	88, 716	310, 271	2, 214, 789	446, 200	91.00
92. 00	09200 OBSERVATION BEDS OTHER REIMBURSABLE COST					0		92. 00
101.00	10100 HOME HEALTH AGENCY		609, 031	8, 769	177, 506	795, 306	160, 226	101. 00
	SPECIAL PURPOSE COST CE		221, 221	97.191	,			
	11600 HOSPI CE		27, 467			39, 733		116. 00
118.00		·	27, 631, 126	1, 207, 998	4, 687, 234	27, 104, 657	4, 457, 206	118. 00
100.00	NONREI MBURSABLE COST CEI			7 540		7 540	1 521	100.00
	19000 GIFT, FLOWER, COFF   19001 HOMECARE	LL SHUP & CANTEEN	0	7, 548 2, 008		7, 548 2, 008		190. 00 190. 01
	19200 PHYSI CLANS' PRI VA	TE OFFICES	1, 871, 290	97, 485		2, 361, 853	475, 828	
	007950 MARKETI NG		199, 888	0		226, 238	45, 579	
200.00	1	ments			==, ===	0		200. 00
201.00	Negative Cost Cent			0	0	0	0	201. 00
202.00	TOTAL (sum lines	118-201)	29, 702, 304	1, 315, 039	5, 106, 662	29, 702, 304	4, 980, 539	202. 00

Provider CCN: 15-1305

				10	09/30/2016	4/21/2017 3:3	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	, piii
	oost content boson per on	PLANT	LINEN SERVICE	HOUSEREEFTING	DIEMMI	ADMI NI STRATI ON	
		7. 00	8. 00	9. 00	10. 00	13. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & 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, 186, 491					7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	12, 796	117, 097				8. 00
9. 00	00900 HOUSEKEEPI NG	7, 843	117,077	353, 992			9. 00
10.00	01000 DI ETARY	63, 447		19, 265	558, 393		10. 00
13. 00	01300 NURSING ADMINISTRATION	15, 006		4, 556	550, 5 <del>7</del> 5	722, 113	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	20, 660		6, 273	0	722, 113	14. 00
15. 00	01500 PHARMACY	16, 473		5, 002	0	0	15. 00
			0	· ·	0	1	
16.00	01600 MEDICAL RECORDS & LIBRARY	31, 160		9, 461	0	0	16.00
17. 00	01700 SOCIAL SERVICE	0	0	l O	0	0	17. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	185, 538	27.075	E4 22E	558, 393	381, 303	20.00
30. 00 31. 00	03100 INTENSIVE CARE UNIT	185, 538		56, 335 0	558, 393	381, 303	30. 00 31. 00
43. 00			-	1	0		
43.00	04300   NURSERY   ANCI LLARY SERVI CE COST CENTERS	3, 422	2, 235	1, 039	0	14, 456	43. 00
50. 00	05000 OPERATING ROOM	111, 208	25, 055	33, 766	0	88, 889	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	10, 032		3, 046	0		52. 00
52.00	05300 ANESTHESI OLOGY	2, 189			0		52.00
54. 00		1		665	0	1	
59.00	05400 RADI OLOGY-DI AGNOSTI C	76, 328 0	14, 861	23, 176	0	17, 966	54. 00 59. 00
	05900 CARDI AC CATHETERI ZATI ON	_	0		0	0	
60.00	06000 LABORATORY	29, 545			0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	893	0	271	0	0	63.00
65. 00	06500 RESPI RATORY THERAPY	16, 643	10.070	5, 053	0	17, 600	65. 00
66.00	06600 PHYSI CAL THERAPY	50, 247	12, 973	· ·	0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
69. 01	06901 CARDI AC REHABI LI TATI ON	9, 522	0	2, 891	0	0	69. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
76. 00	03020 ONCOLOGY	11, 988	138	3, 640	0	30, 217	76. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	174, 251	1, 242		0		88. 00
90.00	09000 CLI NI C	38, 578		11, 714	0		90.00
91. 00	09100 EMERGENCY	112, 674	22, 539	34, 212	0	110, 398	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	OTHER REIMBURSABLE COST CENTERS		1				
101.00	10100 HOME HEALTH AGENCY	11, 138	0	3, 382	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS		1	1			
	11600 H0SPI CE	4, 060		.,	0		116. 00
118.00		1, 015, 641	116, 397	302, 116	558, 393	705, 927	118.00
400.00	NONREI MBURSABLE COST CENTERS	0.50/		0.044			100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	9, 586	ł .	'	0		190.00
	19001 HOMECARE	2, 551	0	774	0		190. 01
	19200 PHYSI CLANS' PRI VATE OFFI CES	158, 713	700	48, 191	0	16, 186	
	07950 MARKETI NG	0	0	0	0	0	194. 00
200.00	,				-		200.00
201.00		0	0	0	0	l e	201. 00
202.00	TOTAL (sum lines 118-201)	1, 186, 491	117, 097	353, 992	558, 393	722, 113	202.00

| Period: | Worksheet B | From 10/01/2015 | Part | To 09/30/2016 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1305

				ř	o 09/30/2016	Date/Time Pre 4/21/2017 3:3	
	Cost Center Description	CENTRAL SERVI CES &	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE		) piii
		SUPPLY 14.00	15. 00	16. 00	17. 00	24. 00	
	GENERAL SERVICE COST CENTERS	11.00	10.00	10.00	17.00	21.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	131, 576					13. 00 14. 00
15. 00	01500 PHARMACY	131, 370	37, 058				15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY		37,030	577, 685			16.00
17. 00	01700 SOCIAL SERVICE		ő	077,000			17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	-	-1		2=1		1
30.00	03000 ADULTS & PEDIATRICS	0	0	21, 224	76, 907	4, 291, 637	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	C	0	0	31.00
43.00	04300 NURSERY	0	0	1, 109	0	138, 063	43. 00
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	56, 598		1, 551, 212	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	2, 970		204, 202	
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C		0	9, 654 124, 901		33, 411 2, 558, 046	1
59. 00	05900 CARDI AC CATHETERI ZATI ON		0	124, 901		2, 556, 046	1
60. 00	06000 LABORATORY		0	107, 664		1, 942, 214	1
60. 01	06001 BLOOD LABORATORY	o	o	(07)		0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	О	2, 277	o o	84, 193	63. 00
65.00	06500 RESPI RATORY THERAPY	0	o	11, 811	0	516, 102	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	25, 409		1, 283, 757	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	3, 674		157, 691	1
68. 00	06800 SPEECH PATHOLOGY	0	0	1, 834		167, 241	1
69. 00	06900 ELECTROCARDI OLOGY	0	0	4, 303		30, 974	1
69. 01	06901 CARDI AC REHABI LI TATI ON 07000 ELECTROENCEPHALOGRAPHY	0	0	1, 329		125, 038	1
70. 00 71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	113, 783	0	23, 893	_	0 652, 939	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	17, 793	0	3, 736		240, 704	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	17,775	37, 058			2, 365, 762	1
76. 00	03020 ONCOLOGY	o	0			272, 897	1
	OUTPATIENT SERVICE COST CENTERS					·	
88. 00	08800 RURAL HEALTH CLINIC	0	0	32, 434	0	5, 206, 903	88. 00
90.00	09000  CLI NI C	0	0	5, 031		507, 686	1
91. 00	09100 EMERGENCY	0	0	39, 573	0	2, 980, 385	1
92. 00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)						92.00
101 00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0	ما	7 500	ار	977, 581	101 00
101.00	SPECIAL PURPOSE COST CENTERS	J U	0	7, 529	0	977, 581	1101.00
116 00	11600 HOSPI CE	l ol	o	43	s o	53 074	116. 00
118.00	1 1	131, 576	37, 058				1
	NONREI MBURSABLE COST CENTERS	121/212	2., 222	2.17.22			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0	21, 566	190. 00
	19001 HOMECARE	0	O	C	o		190. 01
	19200 PHYSICIANS' PRIVATE OFFICES		0	C	0	3, 061, 471	
	07950 MARKETI NG	0	0	C	0	271, 817	
200.00				_			200. 00
201.00		121 574	27 050	E77 40E	0 400		201. 00
202.00	TOTAL (sum lines 118-201)	131, 576	37, 058	577, 685	82, 408	29, 102, 304	12U2. UU

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

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1305 Peri od: Worksheet B From 10/01/2015 To 09/30/2016 Part I Date/Time Prepared: 4/21/2017 3:37 pm Cost Center Description Intern & Total Residents Cost & Post Stepdown Adj ustments 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 00500 ADMINISTRATIVE & GENERAL 5.00 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 01500 PHARMACY 15.00 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, 291, 637 30.00 03100 INTENSIVE CARE UNIT 0 31.00 31.00 04300 NURSERY 0 43.00 43 00 138, 063 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 1, 551, 212 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0000000000000000000 204, 202 52.00 05300 ANESTHESI OLOGY 33, 411 53 00 53 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 2, 558, 046 54.00 05900 CARDI AC CATHETERI ZATI ON 59.00 59.00 60.00 06000 LABORATORY 1, 942, 214 60.00 06001 BLOOD LABORATORY 60 01 60.01 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 84, 193 63.00 06500 RESPIRATORY THERAPY 516, 102 65.00 65.00 06600 PHYSI CAL THERAPY 1, 283, 757 66.00 66.00 06700 OCCUPATIONAL THERAPY 157, 691 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 167, 241 68.00 06900 ELECTROCARDI OLOGY 30, 974 69 00 69.00 69.01 06901 CARDIAC REHABILITATION 125, 038 69.01 07000 ELECTROENCEPHALOGRAPHY 70 00 70 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 652, 939 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 240, 704 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 2, 365, 762 73.00 03020 ONCOLOGY 76.00 272, 897 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 5, 206, 903 88.00 0 90.00 09000 CLI NI C 507, 686 90.00 91.00 09100 EMERGENCY 0 2, 980, 385 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 0 101.00 10100 HOME HEALTH AGENCY 977, 581 101.00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 0 53, 074 116.00 SUBTOTALS (SUM OF LINES 1-117) 0 118.00 26, 341, 712 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190. 00 21, 566 0000000 190. 01 19001 HOMECARE 5, 738 190. 01 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 3, 061, 471 192.00 194. 00 07950 MARKETI NG 271, 817 194. 00 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 201. 00 202.00 TOTAL (sum lines 118-201) 29, 702, 304 202.00

| Peri od: | Worksheet B | From 10/01/2015 | Part II | To 09/30/2016 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1305

				To	09/30/2016	Date/Time Prep 4/21/2017 3:3	
			CAPI TAL			4/21/2017 3.3	7 DIII
			RELATED COSTS				
	Cost Center Description	Di rectly	NEW BLDG &	Subtotal	EMPLOYEE	ADMI NI STRATI VE	
		Assigned New	FIXT		BENEFI TS	& GENERAL	
		Capi tal			DEPARTMENT		
		Related Costs	1.00	2.4	4.00	F 00	
	CENEDAL CEDVICE COCT CENTEDS	0	1.00	2A	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	17, 740	17, 740	17, 740		4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	0	275, 252		2, 808		5. 00
7. 00	00700 OPERATION OF PLANT	0	115, 326		305		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	10, 075		19	976	8. 00
9.00	00900 HOUSEKEEPI NG	0	6, 175	6, 175	181	3, 241	9. 00
10.00	01000 DI ETARY	0	49, 956	49, 956	211	4, 453	10.00
13.00	01300 NURSI NG ADMINI STRATI ON	0	11, 815	11, 815	502	6, 577	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	16, 267		50		14. 00
15. 00	01500 PHARMACY	0	12, 970		0	146	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	24, 534		343		16.00
17. 00	01700 SOCIAL SERVICE	0	0	0	61	772	17. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS   03000   ADULTS & PEDIATRICS	0	146, 086	146, 086	2, 308	27, 850	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	0	140,000	140,080	2, 300		31. 00
43. 00	04300 NURSERY	0	2, 694	-	79		43. 00
101.00	ANCILLARY SERVICE COST CENTERS		2,071	2/07.		., 55.	10.00
50.00	05000 OPERATING ROOM	0	88, 766	88, 766	987	11, 517	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	7, 899	7, 899	106	1, 493	52.00
53.00	05300 ANESTHESI OLOGY	0	519	519	0	196	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	60, 098	60, 098	890	21, 540	54.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	-	0		59. 00
60.00	06000 LABORATORY	0	23, 263		681	16, 812	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	703		0	756	63.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	13, 104 39, 563	· ·	315 832		65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	37, 303	1	114		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		117	1, 549	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	Ö	Ö	15		69. 00
69. 01	06901 CARDI AC REHABI LI TATI ON	0	7, 498	7, 498	75		69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	4, 824	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2, 052	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0		73. 00
76. 00	03020 ONCOLOGY	0	9, 439	9, 439	126	2, 100	76. 00
00.00	OUTPATIENT SERVICE COST CENTERS	1 0	127 100	127 100	2 220	47, 202	00 00
88. 00 90. 00	08800 RURAL HEALTH CLINIC 09000 CLINIC	0	137, 199 30, 375		3, 330 103		88. 00 90. 00
91.00	09100 EMERGENCY	0	88, 716		1, 078		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	00, 710	08, 710	1,076	24, 712	92.00
72.00	OTHER REIMBURSABLE COST CENTERS			١			72.00
101.00	10100 HOME HEALTH AGENCY	0	8, 769	8, 769	616	8, 946	101. 00
	SPECIAL PURPOSE COST CENTERS			,			
116.00	11600 HOSPI CE	0	3, 197	3, 197	31	447	116. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1, 207, 998	1, 207, 998	16, 283	248, 841	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7, 548		0		190. 00
	19001 HOMECARE	0	2, 008		0		190. 01
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	97, 485		1, 365		
	07950 MARKETI NG	0	0	-	92	2, 545	194. 00 200. 00
200. 00 201. 00	1 1		_	0	0		200. 00 201. 00
201.00		0	1, 315, 039	1, 315, 039	17, 740		
202.00	TOTAL (Sum TIMES TID-201)	1	1, 313, 037	1, 313, 037	17, 740	1 270,000	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1305

Peri od: Worksheet B From 10/01/2015 Part II To 09/30/2016 Date/Time Prepared:

4/21/2017 3:37 pm Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY NURSI NG ADMI NI STRATI ON **PLANT** LINEN SERVICE 7. 00 9.00 10.00 8.00 13.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 126, 739 7 00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 1, 367 12, 437 8.00 00900 HOUSEKEEPI NG 838 10, 435 9.00 9.00 61, 965 10.00 01000 DI ETARY 6,777 0 568 10.00 01300 NURSING ADMINISTRATION 13.00 1.603 C 134 20, 631 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 2, 207 185 0 14.00 15 00 01500 PHARMACY 1,760 Ω 147 0 0 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 3, 328 C 279 0 0 17.00 01700 SOCIAL SERVICE 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 10, 895 30.00 19, 818 3, 938 61, 965 1,661 03100 INTENSIVE CARE UNIT 31.00 0 0 31.00 43.00 04300 NURSERY 366 237 31 0 413 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 11.879 2.540 50.00 995 0 2, 661 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 1,072 r 90 819 52 00 05300 ANESTHESI OLOGY 234 20 0 53.00 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 8, 153 1,578 683 0 0 0 0 0 0 0 0 0 513 54.00 05900 CARDI AC CATHETERI ZATI ON 59.00 0 C 0 59.00 60.00 06000 LABORATORY 3, 156 30 264 0 60.00 60.01 06001 BLOOD LABORATORY 0 0 0 0 60.01 06300 BLOOD STORING, PROCESSING & TRANS. 95 63.00 C 0 63.00 8 06500 RESPIRATORY THERAPY 503 65.00 1,778 C 149 65.00 66.00 06600 PHYSI CAL THERAPY 5, 367 1, 378 450 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 C 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 06900 ELECTROCARDI OLOGY 69.00 0 C 0 0 69.00 69. 01 06901 CARDIAC REHABILITATION 1,017 0 85 0 69.01 07000 ELECTROENCEPHALOGRAPHY 70.00 0 0 0 0 70.00 0 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 Ω O 0 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.00 03020 ONCOLOGY 76.00 1, 281 15 107 0 863 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 18,613 132 1,560 0 0 88.00 90.00 09000 CLI NI C 4, 121 345 0 469 90.00 91 00 09100 EMERGENCY 12, 036 2, 394 1,008 o 3, 154 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 1, 190 0 100 0 101. 00 0 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 434 36 0 116, 00 0 SUBTOTALS (SUM OF LINES 1-117) 108<u>, 490</u> 12, 363 8, 905 61, 965 20, 169 118. 00 NONREI MBURSABLE COST CENTERS 0 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1,024 86 0 190. 01 19001 HOMECARE 272 C 23 0 0 190. 01 192.00 19200 PHYSICIANS' PRIVATE OFFICES 16, 953 0 462 192. 00 74 1, 421 194. 00 07950 MARKETI NG 0 0 194.00 C 0 C 200 00 Cross Foot Adjustments 200 00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118-201) 126, 739 12, 437 10, 435 61, 965 20, 631 202. 00

| Peri od: | Worksheet B | From 10/01/2015 | Part II | To 09/30/2016 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1305

				11	0 09/30/2016	Date/lime Pre 4/21/2017 3:3	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	Subtotal	, piii
		SERVICES &		RECORDS &			
		SUPPLY		LI BRARY			
		14. 00	15. 00	16. 00	17. 00	24. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE						8.00
10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
13. 00	01300 NURSING ADMINISTRATION						13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	19, 689					14. 00
15. 00	01500 PHARMACY	17,007	15, 023				15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	o	0				16. 00
17. 00	01700 SOCIAL SERVICE		0		l I		17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	-,	-		1		
30.00	03000 ADULTS & PEDIATRICS	0	0	1, 232	777	276, 530	30. 00
31.00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	31. 00
43.00	04300 NURSERY	0	0	64	0	4, 968	43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	0	0	·	l I	122, 687	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		l .	11, 651	1
53.00	05300 ANESTHESI OLOGY	0	0	560		1, 529	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	7, 228		100, 683	1
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	0	6, 251 0	١	50, 457 0	60. 00 60. 01
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		0	132	· ·	1, 694	
65. 00	06500 RESPI RATORY THERAPY		0	686	l .	20, 888	1
66. 00	06600 PHYSI CAL THERAPY		0	1, 475	·	60, 111	1
67. 00	06700 OCCUPATI ONAL THERAPY		0	213	l .	1, 769	1
68. 00	06800 SPEECH PATHOLOGY		0	106	l .	1, 772	1
69. 00	06900 ELECTROCARDI OLOGY	0	0	250	l .	515	1
69. 01	06901 CARDI AC REHABI LI TATI ON	0	0	77	0	9, 794	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	o	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17, 026	0	1, 387	0	23, 237	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	2, 663	0	217		4, 932	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	15, 023		l I	41, 114	
76. 00	03020  ONCOLOGY	0	0	150	0	14, 081	76. 00
00 00	OUTPATIENT SERVICE COST CENTERS		0	1 002	ا	200, 000	00.00
88. 00 90. 00	08800 RURAL HEALTH CLINIC	0	0	,	l .	209, 009 39, 786	1
91. 00	09100 EMERGENCY		0			135, 595	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		O	2, 271	o o	133, 373	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
101.00	10100 HOME HEALTH AGENCY	0	0	437	0	20. 058	101. 00
	SPECIAL PURPOSE COST CENTERS	·	-		· · · · · · · · · · · · · · · · · · ·	.,	
116.00	11600 H0SPI CE	0	0	2	0		116. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	19, 689	15, 023	33, 512	833	1, 157, 007	118. 00
	NONREI MBURSABLE COST CENTERS						1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		·		190. 00
	19001 HOMECARE	0	0	_	· ·		190. 01
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	· ·	144, 326	
	07950 MARKETI NG	0	O	0	0		194. 00
200. 00 201. 00			0	0	o		200. 00 201. 00
201.00		19, 689	15, 023	_			
202.00	TOTAL (Suil TITIES TTO-201)	17,007	13, 023	33, 512	033	1, 313, 037	1202.00

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

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1305 Peri od: Worksheet B From 10/01/2015 Part II 09/30/2016 Date/Time Prepared: 4/21/2017 3:37 pm Cost Center Description Intern & Total Residents Cost & Post Stepdown Adj ustments 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 00500 ADMINISTRATIVE & GENERAL 5.00 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 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 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 0 276, 530 30.00 03100 INTENSIVE CARE UNIT 0 31.00 31.00 0 04300 NURSERY 43.00 43 00 4,968 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 122, 687 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0000000000000000000 11,651 52.00 05300 ANESTHESI OLOGY 53.00 53 00 1 529 05400 RADI OLOGY-DI AGNOSTI C 54.00 100,683 54.00 59.00 05900 CARDI AC CATHETERI ZATI ON 59.00 60.00 06000 LABORATORY 50, 457 60.00 06001 BLOOD LABORATORY 60 01 60.01 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 1, 694 63.00 06500 RESPIRATORY THERAPY 20, 888 65.00 65.00 06600 PHYSI CAL THERAPY 60, 111 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 67.00 1.769 68.00 06800 SPEECH PATHOLOGY 1, 772 68.00 06900 ELECTROCARDI OLOGY 69 00 515 69.00 69.01 06901 CARDIAC REHABILITATION 9, 794 69.01 07000 ELECTROENCEPHALOGRAPHY 70 00 r 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 23, 237 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 4, 932 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 41.114 73.00 03020 ONCOLOGY 76.00 14, 081 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 209, 009 88.00 0 90.00 09000 CLI NI C 39, 786 90.00 91.00 09100 EMERGENCY 0 135, 595 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 0 101.00 10100 HOME HEALTH AGENCY 20, 058 101.00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 0 4, 147 116.00 SUBTOTALS (SUM OF LINES 1-117) 0 1, 157, 007 118.00 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190. 00 8, 743 000000 190. 01 19001 HOMECARE 2.326 190. 01 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 144, 326 192.00 194. 00 07950 MARKETI NG 2,637 194. 00 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 201. 00 202.00 TOTAL (sum lines 118-201) 1, 315, 039 202.00

Heal th	Financial Systems	PULASKI MEMORI	AL_HOSPITAL		In Lie	eu of Form CMS-:	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					From 10/01/2015 To 09/30/2016	Date/Time Pre	pared.
						4/21/2017 3: 3	
	·	CAPI TAL					
		RELATED COSTS					
	Cost Center Description	NEW BLDG &	EMPLOYEE	Reconciliatio	n ADMI NI STRATI VE		
		FLXT	BENEFITS		& GENERAL	PLANT	
		(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	
		FEET)	(GROSS		COST)	FEET)	
			SALARI ES)				
		1. 00	4. 00	5A	5. 00	7. 00	
	GENERAL SERVICE COST CENTERS	70 577					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	78, 577					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 060	14, 694, 144				4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	16, 447	2, 326, 486	1		l e	5. 00
7.00	00700 OPERATION OF PLANT	6, 891	252, 510	1	0 987, 538		
8.00	00800 LAUNDRY & LINEN SERVICE	602	15, 889	1	0 86, 812	l e	
9.00	00900 HOUSEKEEPI NG	369	149, 929	1	0 288, 106		
10.00	01000 DI ETARY	2, 985	174, 492	1	0 395, 918		1
13.00	01300 NURSI NG ADMI NI STRATI ON	706	416, 080	1	0 584, 746	l .	
14. 00	01400 CENTRAL SERVICES & SUPPLY	972	41, 124	1	0 87, 096	l e	1
15. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	775	204 540	1	0 12, 970	l e	1
16. 00	1	1, 466	284, 569	1	0 447, 008		1
17.00	01700 SOCIAL SERVICE	0	50, 806	)	0 68, 590	0	17. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.720	1, 912, 513	,	0 2, 476, 031	0.720	20.00
30. 00 31. 00	03000   ADULTS & PEDIATRICS   03100   INTENSIVE CARE UNIT	8, 729 0	1, 912, 313	1	0 2, 476, 031 0 0	8, 729 0	1
	04300 NURSERY	161	65, 488		0 96, 384	1	1
43.00	ANCI LLARY SERVI CE COST CENTERS	101	05, 460	9	0 70, 304	101	43.00
50. 00	05000 OPERATING ROOM	5, 304	817, 409		0 1, 023, 913	5, 232	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	472	87, 925		0 132, 734	472	1
53. 00	05300 ANESTHESI OLOGY	31	07, 723	1	0 17, 398	l	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	3, 591	736, 970		0 1, 915, 009		1
59. 00	05900 CARDI AC CATHETERI ZATI ON	3, 371	730, 770		0 1, 713, 007	0, 371	1
60. 00	06000 LABORATORY	1, 390	564, 308	1	0 1, 494, 639		
60. 01	06001 BLOOD LABORATORY	1, 370	304, 300		0 1, 474, 037	1, 370	1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	42	0	1	0 67, 211	42	1
65. 00	06500 RESPIRATORY THERAPY	783	260, 700	1	0 387, 024	783	1
66. 00	06600 PHYSI CAL THERAPY	2, 364	689, 140		0 982, 028	1	1
67. 00	06700 OCCUPATI ONAL THERAPY	2, 304	94, 420	1	0 128, 191	2, 304	1
68. 00	06800 SPEECH PATHOLOGY		97, 157	1	0 137, 671	0	1
69. 00	06900 ELECTROCARDI OLOGY		12, 634	1	0 22, 199		1
69. 01	06901 CARDI AC REHABI LI TATI ON	448	61, 732	1	0 92, 634	l e	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	01, 732	1	0 72,034	0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	1	0 428, 863		1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1	0 182, 423	l e	1
73. 00	07300 DRUGS CHARGED TO PATIENTS		0	1	0 1, 864, 886		1
76. 00	03020 ONCOLOGY	564	104, 396		0 186, 719	l e	1
70.00	OUTPATIENT SERVICE COST CENTERS	55.	1017070	1	100/11/		70.00
88. 00	08800 RURAL HEALTH CLINIC	8, 198	2, 755, 711		0 4, 116, 705	8, 198	88. 00
	09000 CLI NI C	1, 815	85, 223		0 362, 844		90.00
	09100 EMERGENCY	5, 301	892, 790	1	0 2, 214, 789		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		,				92.00
	OTHER REIMBURSABLE COST CENTERS	'			,		1
101.00	10100 HOME HEALTH AGENCY	524	510, 764		0 795, 306	524	101.00
	SPECIAL PURPOSE COST CENTERS			•			1
116.00	11600 HOSPI CE	191	26, 096		0 39, 733	191	116. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	72, 181	13, 487, 261	-4, 980, 53	9 22, 124, 118	47, 783	118. 00
	NONREI MBURSABLE COST CENTERS	·					1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	451	O	)	0 7, 548	451	190. 00
190. 01	19001 HOMECARE	120	0		0 2, 008	120	190. 01
192.00	19200 PHYSICIANS' PRIVATE OFFICES	5, 825	1, 131, 062	2	0 2, 361, 853	7, 467	192. 00
194.00	07950 MARKETI NG	0	75, 821		0 226, 238	0	194. 00
200.00	1 1						200. 00
201.00	Negative Cost Centers						201. 00
202.00		1, 315, 039	5, 106, 662	2	4, 980, 539	1, 186, 491	202. 00
	Part I)						
203.00		16. 735673	0. 347530	1	0. 201464		
204.00			17, 740	η	278, 060	126, 739	204. 00
205 22	Part II)		0.001003	,	0.011010	2 270454	205 00
205. 00			0. 001207		0. 011248	2. 270454	205.00
	1 )	1		1	1	I	I

Heal th	Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der CC	F	Period: From 10/01/2015 Fo 09/30/2016	Worksheet B-1 Date/Time Pre 4/21/2017 3:3	pared:
	Cost Center Description	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HRS)	CENTRAL SERVI CES & SUPPLY (100%)	
		8. 00	9. 00	10.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 13. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01300 NURSING ADMINISTRATION	133, 456 0 0	54, 850 2, 985 706	100	) ) 86, 819		4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 13. 00
	01400 CENTRAL SERVICES & SUPPLY	O	972	(		2, 885, 032	1
15. 00	01500 PHARMACY	O	775	(		0	15. 00
	01600 MEDICAL RECORDS & LIBRARY	0	1, 466	(	o	0	1
	01700 SOCIAL SERVICE	0	0	(	o	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	42, 255	8, 729	100	45, 844	0	
31.00	03100 INTENSIVE CARE UNIT	0	0		0	0	
43.00	04300 NURSERY	2, 547	161	(	1, 738	0	43. 00
FO 00	ANCILLARY SERVICE COST CENTERS	20 555	E 222	,	10 (07		F0 00
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	28, 555 0	5, 232 472		10, 687 3, 448	0	
53. 00	05300 ANESTHESI OLOGY	0	103		0 0	0	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	16, 937	3, 591		2, 160	0	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	(	0	0	59.00
60.00	06000 LABORATORY	318	1, 390	(	o o	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	(	o o	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	42	(	0	0	63. 00
65. 00	06500 RESPI RATORY THERAPY	0	783	(	2, 116	0	65. 00
66.00	06600 PHYSI CAL THERAPY	14, 785	2, 364	(		0	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0			0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	· ·		0	1
69. 01	06901 CARDI AC REHABI LI TATI ON	O	448		ol ol	0	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	(	o o	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(	o o	2, 494, 880	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	· ·	0	390, 152	
	07300 DRUGS CHARGED TO PATIENTS	157	0		0	0	
76. 00	03020 ONCOLOGY OUTPATIENT SERVICE COST CENTERS	157	564	(	3, 633	0	76. 00
88. 00	08800 RURAL HEALTH CLINIC	1, 416	8, 198	(	ol ol	0	88. 00
	09000 CLINIC	1, 410	1, 815		1, 974	0	1
91. 00	09100 EMERGENCY	25, 688	5, 301		13, 273	0	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	·					92. 00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	524	(	0	0	101. 00
444 00	SPECIAL PURPOSE COST CENTERS		404				111 00
116.00	11600 HOSPICE   SUBTOTALS (SUM OF LINES 1-117)	0 132, 658	191 46, 812	100	0 84, 873	2, 885, 032	116.00
116.00	NONREIMBURSABLE COST CENTERS	132, 030	40, 012	100	04, 073	2, 000, 032	]116.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	451	(	ol ol	0	190. 00
	19001 HOMECARE	0	120		o		190. 01
192.00	19200 PHYSICIANS' PRIVATE OFFICES	798	7, 467	(	1, 946		192. 00
	07950 MARKETI NG	0	0	(	이	0	194. 00
200.00	l						200. 00
201.00	1 1 0	117 007	252,002	FF0 201	700 110	101 57/	201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	117, 097	353, 992	558, 393	722, 113	131, 576	202.00
203. 00		0. 877420	6. 453820	5, 583. 930000	8. 317454	0. 045606	203 00
204.00		12, 437	10, 435	61, 965			204. 00
	Part II)	,	.,	. ,		, , , , , ,	
205. 00		0. 093192	0. 190246	619. 650000	0. 237632	0. 006825	205. 00
		1					I

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Period: Worksheet B-1
From 10/01/2015
To 09/30/2016 Date/Time Prepa Provi der CCN: 15-1305

				To	09/30/2016	Date/Time Prepared:
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE		4/21/2017 3:37 pm
	·	(100%)	RECORDS &	(41.1.00471.011		
			LI BRARY (GROSS	(ALLOCATION OF TIME)		
			CHARGES)	01 11 112)		
CENT	EDAL CEDVICE COCT CENTERS	15. 00	16. 00	17. 00		
	ERAL SERVICE COST CENTERS OO NEW CAP REL COSTS-BLDG & FLXT					1.00
4.00 004	OO EMPLOYEE BENEFITS DEPARTMENT					4. 00
-	OO ADMINISTRATIVE & GENERAL OO OPERATION OF PLANT					5.00
	OO LAUNDRY & LINEN SERVICE					7. 00 8. 00
9.00 009	00 HOUSEKEEPI NG					9. 00
	OO DI ETARY OO NURSI NG ADMINI STRATI ON					10.00
	00 CENTRAL SERVICES & SUPPLY					13. 00 14. 00
15. 00 015	OO PHARMACY	100				15. 00
	00 MEDICAL RECORDS & LIBRARY	0	60, 319, 328			16.00
	OO SOCIAL SERVICE ATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	0	9, 888		17. 00
	00 ADULTS & PEDIATRICS	0	2, 216, 137	9, 228		30.00
	00 INTENSIVE CARE UNIT	0	115 047	-		31.00
	OO NURSERY ILLARY SERVICE COST CENTERS	0	115, 847	0		43. 00
50.00 050	OO OPERATING ROOM	0	5, 909, 796	660		50.00
	OO DELIVERY ROOM & LABOR ROOM	0	310, 096			52.00
1	00  ANESTHESI OLOGY 00  RADI OLOGY-DI AGNOSTI C	0	1, 008, 058 13, 041, 089			53. 00 54. 00
	OO CARDI AC CATHETERI ZATI ON	o	0	0		59.00
1	00 LABORATORY	0	11, 241, 925			60.00
	01 BLOOD LABORATORY 00 BLOOD STORING, PROCESSING & TRANS.	0	237, 783	0		60. 01
	00 RESPI RATORY THERAPY	O	1, 233, 272	-		65. 00
1	00 PHYSI CAL THERAPY	0	2, 653, 102			66.00
	00 OCCUPATI ONAL THERAPY 00 SPEECH PATHOLOGY	0	383, 583 191, 470			67. 00 68. 00
	00 ELECTROCARDI OLOGY	O	449, 269			69. 00
	01 CARDI AC REHABI LI TATI ON	0	138, 728 0			69. 01
	00 ELECTROENCEPHALOGRAPHY 00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 494, 880	_		70. 00 71. 00
72. 00 072	00 IMPL. DEV. CHARGED TO PATIENTS	0	390, 152	0		72. 00
	00 DRUGS CHARGED TO PATIENTS 20 ONCOLOGY	100	9, 200, 237			73. 00 76. 00
	PATIENT SERVICE COST CENTERS	J U	269, 186	0		76.00
88. 00 088	00 RURAL HEALTH CLINIC	0	3, 386, 642			88. 00
	00 CLI NI C 00 EMERGENCY	0	525, 301 4, 132, 131			90. 00 91. 00
	OO OBSERVATION BEDS (NON-DISTINCT PART)		4, 132, 131			92. 00
	ER REIMBURSABLE COST CENTERS					
	OO HOME HEALTH AGENCY CLAL PURPOSE COST CENTERS	0	786, 188	0		101. 00
116. 00 116	00 H0SPI CE	0	4, 456	0		116. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	100	60, 319, 328	9, 888		118. 00
	REIMBURSABLE COST CENTERS OO GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	0		190. 00
1	01 HOMECARE	Ö	Ö			190. 01
	OO PHYSICIANS' PRIVATE OFFICES	0	0			192. 00
200. 00	50 MARKETING Cross Foot Adjustments		0	0		194. 00 200. 00
201.00	Negative Cost Centers					201. 00
202. 00	Cost to be allocated (per Wkst. B,	37, 058	577, 685	82, 408		202. 00
203. 00	Part I) Unit cost multiplier (Wkst. B, Part I)	370. 580000	0. 009577	8. 334142		203. 00
204. 00	Cost to be allocated (per Wkst. B,	15, 023	33, 512			204. 00
205. 00	Part II) Unit cost multiplier (Wkst. B, Part	150. 230000	0. 000556	0. 084244		205. 00
203.00	II)	130. 230000	0. 000356	0.004244		203.00
•		·		,		•

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 10/01/2015   Part

				Т	0 09/30/2016	Date/Time Pre 4/21/2017 3:3	pared:
			Title	XVIII	Hospi tal	Cost	<u> </u>
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	'	(from Wkst. B,	Áďj.		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	4, 291, 637		4, 291, 637	0	0	30. 00
31.00	03100 INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300 NURSERY	138, 063		138, 063	0	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 551, 212		1, 551, 212	0	0	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	204, 202		204, 202	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	33, 411		33, 411	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 558, 046		2, 558, 046	0	0	54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0		0	0	0	59. 00
60.00	06000 LABORATORY	1, 942, 214		1, 942, 214	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0		0	0	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	84, 193		84, 193	0	0	63.00
65.00	06500 RESPI RATORY THERAPY	516, 102	0	516, 102	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 283, 757	0	1, 283, 757	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	157, 691	0	157, 691	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	167, 241	0	167, 241	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	30, 974		30, 974	0	0	69. 00
69. 01	06901 CARDI AC REHABI LI TATI ON	125, 038		125, 038	0	0	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	652, 939		652, 939	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	240, 704		240, 704	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 365, 762		2, 365, 762	0	0	73. 00
	03020 ONCOLOGY	272, 897		272, 897		0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	5, 206, 903		5, 206, 903	0	0	88. 00
90.00	09000 CLI NI C	507, 686		507, 686	0	0	90.00
91.00	09100 EMERGENCY	2, 980, 385		2, 980, 385	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	381, 208		381, 208		0	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	977, 581		977, 581		0	101. 00
	SPECIAL PURPOSE COST CENTERS						
116.00	11600 H0SPI CE	53, 074		53, 074			116. 00
200.00	Subtotal (see instructions)	26, 722, 920	0	26, 722, 920	0	0	200. 00
201.00	Less Observation Beds	381, 208		381, 208			201. 00
202. 00	Total (see instructions)	26, 341, 712	0	26, 341, 712	0	0	202. 00

Health Financial Systems	PULASKI MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1305	Period: Worksheet C From 10/01/2015 Part I
		To 09/30/2016 Date/Time Prepared

					To 09/30/2016	Date/Time Pre 4/21/2017 3:3	pared: 7 pm
		_		XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	1, 991, 912		1, 991, 912	2		30. 00
31.00	03100 INTENSIVE CARE UNIT	0		(			31.00
43.00	04300 NURSERY	115, 847		115, 847	7		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	780, 519	5, 129, 277	5, 909, 796		0.000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	201, 405	108, 691	310, 096	0. 658512	0.000000	52. 00
53.00	05300 ANESTHESI OLOGY	113, 145	894, 913	1, 008, 058	0. 033144	0.000000	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 164, 875	11, 876, 214	13, 041, 089	0. 196153	0.000000	54.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	(	0.000000	0.000000	59. 00
60.00	06000 LABORATORY	1, 844, 437	9, 397, 488	11, 241, 925		0.000000	
60. 01	06001 BLOOD LABORATORY	0	0	(	0.000000	0.000000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	121, 796	115, 987	237, 783	0. 354075	0.000000	63.00
65.00	06500 RESPI RATORY THERAPY	944, 603	288, 669	1, 233, 272	0. 418482	0.000000	65. 00
66. 00	06600 PHYSI CAL THERAPY	458, 495	2, 194, 607	2, 653, 102	0. 483870	0.000000	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	180, 173	203, 410	383, 583	0. 411100	0.000000	67. 00
68. 00	06800 SPEECH PATHOLOGY	41, 858	149, 612	191, 470		0.000000	
69. 00	06900 ELECTROCARDI OLOGY	29, 256	420, 013	449, 269		0.000000	69. 00
69. 01	06901 CARDI AC REHABI LI TATI ON	0	138, 728	138, 728	0. 901318	0.000000	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	(		0.000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	884, 690	1, 610, 190	2, 494, 880	0. 261712	0.000000	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	155, 882	234, 270	390, 152	0. 616949	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 695, 122	5, 505, 115	9, 200, 237		0.000000	
76.00	03020 ONCOLOGY	0	269, 186	269, 186	1. 013786	0. 000000	76. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	3, 386, 642	3, 386, 642	2		88. 00
90.00	09000 CLI NI C	0	525, 301	525, 301	0. 966467	0.000000	90.00
91.00	09100 EMERGENCY	166, 845	3, 965, 286	4, 132, 131	0. 721271	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	224, 225	224, 225	1. 700114	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	786, 188	786, 188	3		101. 00
	SPECIAL PURPOSE COST CENTERS						
	11600 H0SPI CE	0	4, 456				116. 00
200.00		12, 890, 860	47, 428, 468	60, 319, 328	3		200. 00
201.00							201. 00
202.00	Total (see instructions)	12, 890, 860	47, 428, 468	60, 319, 328	3		202. 00

Health Financial Systems	PULASKI MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1305	From 10/01/2015	Worksheet C Part I Date/Time Prepared: 4/21/2017 3:37 pm
	Title XVIII	Hospi tal	Cost

			10 07/30/2010	4/21/2017 3: 37 pm
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00   03000   ADULTS & PEDI ATRI CS				30.00
31.00   03100   INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50.00   05000   OPERATI NG ROOM	0. 000000			50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
53. 00   05300   ANESTHESI OLOGY	0. 000000			53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000			54. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0. 000000			59. 00
60. 00  06000 LABORATORY	0. 000000			60.00
60. 01  06001 BL00D LABORATORY	0. 000000			60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.00
65. 00  06500 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00   06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00  06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68.00  06800  SPEECH PATHOLOGY	0. 000000			68. 00
69. 00  06900  ELECTROCARDI OLOGY	0. 000000			69. 00
69. 01  06901 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
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				111.00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00   Total (see instructions)				202. 00

Health Financial Systems	PULASKI MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-1305	From 10/01/2015   Part I
		To 09/30/2016 Date/Time Prepared:

				Т	o 09/30/2016	Date/Time Pre 4/21/2017 3:3	
			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	4, 291, 637		4, 291, 637		4, 291, 637	
31.00	03100 INTENSIVE CARE UNIT	0		0	T -	0	31. 00
43.00	04300 NURSERY	138, 063		138, 063	0	138, 063	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 551, 212		1, 551, 212		1, 551, 212	
52.00	05200 DELIVERY ROOM & LABOR ROOM	204, 202		204, 202		204, 202	
53.00	05300 ANESTHESI OLOGY	33, 411		33, 411	0	33, 411	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 558, 046		2, 558, 046	0	2, 558, 046	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		C	0	0	59. 00
60.00	06000 LABORATORY	1, 942, 214		1, 942, 214	. 0	1, 942, 214	60.00
60. 01	06001 BLOOD LABORATORY	0		C	0	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	84, 193		84, 193	0	84, 193	63. 00
65.00	06500 RESPIRATORY THERAPY	516, 102	0	516, 102	. 0	516, 102	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 283, 757	0	1, 283, 757	0	1, 283, 757	66.00
67.00	06700 OCCUPATI ONAL THERAPY	157, 691	0	157, 691	0	157, 691	67.00
68.00	06800 SPEECH PATHOLOGY	167, 241	0	167, 241	0	167, 241	68. 00
69.00	06900 ELECTROCARDI OLOGY	30, 974		30, 974	. 0	30, 974	69. 00
69. 01	06901 CARDIAC REHABILITATION	125, 038		125, 038	0	125, 038	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0		C	0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	652, 939		652, 939	o	652, 939	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	240, 704		240, 704	. 0	240, 704	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 365, 762		2, 365, 762	o	2, 365, 762	73. 00
76.00	03020 ONCOLOGY	272, 897		272, 897	o	272, 897	
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	5, 206, 903		5, 206, 903	0	5, 206, 903	88. 00
90.00	09000 CLI NI C	507, 686		507, 686	o	507, 686	90.00
91.00	09100 EMERGENCY	2, 980, 385		2, 980, 385	o	2, 980, 385	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	381, 208		381, 208		381, 208	92. 00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	977, 581		977, 581		977, 581	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11600 HOSPI CE	53, 074		53, 074			116. 00
200.00	Subtotal (see instructions)	26, 722, 920	0	26, 722, 920	0	26, 722, 920	200.00
201.00	Less Observation Beds	381, 208		381, 208		381, 208	
202.00	Total (see instructions)	26, 341, 712	0	26, 341, 712	el o	26, 341, 712	202. 00

Health Financial Systems	PULASKI MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1305	Period: Worksheet C From 10/01/2015 Part I To 09/30/2016 Date/Time Prepared:

				Го 09/30/2016	Date/Time Pre 4/21/2017 3:3	pared: 7 pm	
			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Ratio	
	T	6. 00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	1, 991, 912		1, 991, 91:			30.00
31. 00	03100 I NTENSI VE CARE UNI T	0					31. 00
43.00	04300 NURSERY	115, 847		115, 84	7		43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	780, 519	5, 129, 277			0. 000000	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	201, 405	108, 691			0. 000000	
53.00	05300 ANESTHESI OLOGY	113, 145	894, 913			0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 164, 875	11, 876, 214	13, 041, 08		0. 000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0. 000000	0. 000000	
60.00	06000 LABORATORY	1, 844, 437	9, 397, 488	11, 241, 92		0. 000000	
60. 01	06001 BLOOD LABORATORY	0	0	1	0. 000000	0. 000000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	121, 796	115, 987			0. 000000	
65.00	06500 RESPI RATORY THERAPY	944, 603	288, 669			0. 000000	
66. 00	06600 PHYSI CAL THERAPY	458, 495	2, 194, 607			0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	180, 173	203, 410			0. 000000	
68. 00	06800 SPEECH PATHOLOGY	41, 858	149, 612			0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	29, 256	420, 013			0. 000000	
69. 01	06901 CARDI AC REHABI LI TATI ON	0	138, 728	138, 72		0. 000000	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0. 000000	0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	884, 690	1, 610, 190			0. 000000	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	155, 882	234, 270			0.000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 695, 122	5, 505, 115	9, 200, 23		0.000000	
76. 00	03020 ONCOLOGY	0	269, 186	269, 18	1. 013786	0.000000	76. 00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	3, 386, 642			0.000000	
	09000 CLI NI C	0	525, 301	525, 30°	0. 966467	0.000000	90.00
91. 00	09100 EMERGENCY	166, 845	3, 965, 286			0.000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	224, 225	224, 22	1. 700114	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	786, 188	786, 18	3		101. 00
	SPECIAL PURPOSE COST CENTERS						
	11600 H0SPI CE	0	4, 456				116. 00
200.00	1 /	12, 890, 860	47, 428, 468	60, 319, 32	3		200. 00
201.00	1 1						201. 00
202.00	Total (see instructions)	12, 890, 860	47, 428, 468	60, 319, 32	3		202. 00

Health Financial Systems	PULASKI MEMORIA	AL HOSPITAL	In Lieu of Form CMS-2552-10				
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1305	From 10/01/2015	Worksheet C Part I Date/Time Prep 4/21/2017 3:37			
		Title XIX	Hospi tal	Cost			
Cost Center Description	PPS Inpatient						
	Ratio						

INPATIENT ROUTINE SERVICE COST CENTERS   30.00   33000  ADULTS & PEDIATRICS   31.00						4/21/201/ 3:3/ pm
NPATI ENT ROUTINE SERVICE COST CENTERS   30.00   3000  ADDILTS & PEDI ATRI CS   31.00   31.00   31.00   1NTENSI VE CARE UNIT   31.00   30.00				Title XIX	Hospi tal	Cost
NPATI ENT ROUTINE SERVICE COST CENTERS   30.00   3000  ADDILTS & PEDI ATRI CS   31.00   31.00   31.00   1NTENSI VE CARE UNIT   31.00   30.00		Cost Center Description	PPS Inpatient			
NPATI ENT ROUTINE SERVICE COST CENTERS   30.00   30.00   30.00   30.00   ADULTS & PEDI ATRI CS   31.00   31.00   31.00   31.00   NURSERY   43.00   NURSERY   43.00   ANNO   NURSERY   43.00		'				
INPATI ENT ROUTI NE SERVI CE COST CENTERS   30.00						
30. 00   03000   ADULTS & PEDI ATRICS   31. 00   03100   INTENSI VE CARE UNIT   31. 00   03100   INTENSI VE CARE UNIT   31. 00   04300   NURSERY   ANCILLARY SERVICE COST CENTERS	I NE	PATIENT ROUTINE SERVICE COST CENTERS	1			
31.00						30.00
43. 00   04300   NURSERY						•
ANCILLARY SERVICE COST CENTERS						
50. 00         05000   OPERATI NG ROOM         0.0000000         50.00           52. 00         05200   DELI VERY ROOM & LABOR ROOM         0.0000000         52.00           53. 00         05300   ANESTHESI OLOGY         0.000000         53.00           54. 00         05400   RADI OLOGY-DI AGNOSTI C         0.000000         54.00           59. 00         05900   CARDI AC CATHETERI ZATI ON         0.000000         60.00           60. 01   Good   Bood Laboratory         0.000000         60.01           63. 00   Laboratory         0.000000         60.01           63. 00   Good   BLOOD LABORATORY         0.000000         60.01           65. 00   G6500   RESPI RATORY THERAPY         0.000000         63.00           66. 00   O6500   RESPI RATORY THERAPY         0.000000         65.00           67. 00   O6700   OCCUPATI ONAL THERAPY         0.000000         65.00           68. 00   O6800   SPECH PATHOLOGY         0.000000         68.00           69. 01   O6901   CARDI AC REHABI LI TATI ON         0.000000         68.00           69. 01   O6901   CARDI AC REHABI LI TATI ON         0.000000         69.01           70. 00   O7000   ELECTROENCEPHALOGRAPHY         0.000000         70.00           71. 00   O7100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0.000000         71.00						.0.00
52. 00         05200   DELI VERY ROOM & LABOR ROOM         0.000000         52. 00           53. 00         05300   ANESTHESI OLOGY         0.000000         53. 00           54. 00   O5400   RADI OLOGY-DI AGNOSTI C         0.000000         54. 00           59. 00   O5900   CARDI AC CATHETERI ZATI ON         0.000000         59. 00           60. 00   O6000   LABORATORY         0.000000         60. 00           61. 01   O6001   BLOOD LABORATORY         0.000000         60. 01           63. 00   O6300   RESPI RATORY THERAPY         0.000000         65. 00           66. 00   O6600   PHYSI CAL THERAPY         0.000000         66. 00           67. 00   O6700   OCUPATI ONAL THERAPY         0.000000         67. 00           68. 00   O6800   SPECH PATHOLOGY         0.000000         67. 00           69. 01   O6901   CARDI AC REHABI LITATI ON         0.000000         69. 00           69. 01   O6902   CARDI AC REHABI LITATI ON         0.000000         69. 01           70. 00   O7000   ELECTROCARDI OLOGY         0.000000         69. 01           71. 00   O7100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS         0.000000         71. 00           72. 00   O7200   IMPL. DEV. CHARGED TO PATI ENTS         0.000000         72. 00           73. 00   O7300   ORUGS CHARGED TO PATI ENTS         0.000000         72. 00 <td></td> <td></td> <td>0.000000</td> <td></td> <td></td> <td>50.00</td>			0.000000			50.00
53. 00       05300 ANESTHESI OLOGY       0.000000       53. 00         54. 00       05400 RADI OLOGY-DI AGNOSTI C       0.000000       54. 00         59. 00       05900 CARDI AC CATHETERI ZATI ON       0.000000       59. 00         60. 00       06000 LABORATORY       0.000000       60. 01         63. 00       06300 BLOOD STORI NG, PROCESSI NG & TRANS.       0.000000       63. 00         65. 00       06500 RESPI RATORY THERAPY       0.000000       65. 00         66. 00       06600 PHYSI CAL THERAPY       0.000000       66. 00         67. 00       06700 OCCUPATI ONAL THERAPY       0.000000       67. 00         68. 00       06800 SPECH PATHOLOGY       0.000000       68. 00         69. 01       06900 ELECTROCARDI OLOGY       0.000000       69. 01         69. 01       06901 CARDI AC REHABI LI TATI ON       0.000000       69. 01         70. 00       07000 ELECTROENCEPHALOGRAPHY       0.000000       70. 00         71. 00       07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.000000       71. 00         72. 00       07200 IMPL. DEV. CHARGED TO PATI ENTS       0.000000       72. 00         73. 00       07300 DRUGS CHARGED TO PATI ENTS       0.000000       73. 00         76. 00       08800 RURAL HE						
54. 00       05400 RADI OLOGY-DI AGNOSTI C       0.000000       59.00       59.00       59.00       659.00       659.00       59.00       60.00						
59. 00       05900 CARDI AC CATHETERI ZATI ON       0.000000       59. 00         60. 00       06000 LABORATORY       0.000000       60. 00         60. 01       06001 BLOOD LABORATORY       0.000000       60. 01         63. 00       06300 BLOOD STORING, PROCESSING & TRANS.       0.000000       63. 00         65. 00       06500 RESPI RATORY THERAPY       0.000000       65. 00         66. 00       06600 PHYSI CAL THERAPY       0.000000       66. 00         67. 00       06700 OCCUPATI ONAL THERAPY       0.000000       67. 00         68. 00       0800 SPECH PATHOLOGY       0.000000       68. 00         69. 01       06900 ELECTROCARDI OLOGY       0.000000       69. 00         69. 01       06901 CARDI AC REHABI LI TATI ON       0.000000       69. 01         70. 00       07000 ELECTROCEPHALOGRAPHY       0.000000       70. 00         71. 00       07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000       71. 00         72. 00       07200 I MPL. DEV. CHARGED TO PATI ENTS       0.000000       73. 00         76. 00       03020 ONCOLOGY       0.000000       76. 00         88. 00       08800 RURAL HEALTH CLINIC       0.000000       88. 00         90. 00       09000 CLINIC       0.000000 </td <td></td> <td>I</td> <td>I I</td> <td></td> <td></td> <td></td>		I	I I			
60. 00   06000   LABORATORY   0. 000000   60. 01   60. 00   60. 01   60. 01   80.00   LABORATORY   0. 000000   60. 01   63. 00   65. 00   65. 00   65. 00   66. 00			I I			
60. 01       06001       BLOOD LABORATORY       0.000000       60.01         63. 00       06300       BLOOD STORING, PROCESSING & TRANS.       0.000000       63.00         65. 00       06500       RESPI RATORY THERAPY       0.000000       65.00         66. 00       06600       PHYSI CAL THERAPY       0.000000       66.00         67. 00       06700       OCCUPATI ONAL THERAPY       0.000000       67.00         68. 00       06800       SPEECH PATHOLOGY       0.000000       68.00         69. 00       06900       ELECTROCARDI OLOGY       0.000000       69.00         69. 01       06901       CARDI AC REHABI LI TATI ON       0.000000       69.01         70. 00       07000       ELECTROENCEPHALOGRAPHY       0.000000       70.00         71. 00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.000000       71.00         72. 00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000       72.00         76. 00       03020       ONCOLOGY       0.000000       73.00         00 TYPATI ENT SERVICE COST CENTERS       0.000000       88.00         88. 00       09000       CLI NI C       0.000000       90.00		l e e e e e e e e e e e e e e e e e e e	I I			
63. 00 65. 00 65. 00 65. 00 66. 00 68. 00 69		l e e e e e e e e e e e e e e e e e e e	1			
65. 00						
66. 00 06600 PHYSI CAL THERAPY 0. 000000 67. 00 06700 0CCUPATI ONAL THERAPY 0. 000000 67. 00 68. 00 06800 SPECH PATHOLOGY 0. 000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 000000 69. 01 06901 CARDI AC REHABI LI TATI ON 0. 000000 69. 01 07000 ELECTROCEPHALOGRAPHY 0. 000000 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 000000 71. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0. 000000 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0. 000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 75. 00 07400 IMPL. DEV. CHARGED TO PATI ENTS 0. 000000 75. 00 07400 DRUGS CHARGED TO PATI ENTS 0. 000000 0 07500 DRUGS CHARGED TO PATI ENTS 0. 000000 0 07500 DRUGS CHARGED TO PATI ENTS 0. 000000 0 00000 0 00000 0 00000 0 00000 0						
67. 00			1			
68. 00       06800       SPEECH PATHOLOGY       0.000000       68. 00         69. 00       06900       ELECTROCARDI OLOGY       0.000000       69. 00         69. 01       06901       CARDI AC REHABI LI TATI ON       0.000000       69. 01         70. 00       07000       ELECTROENCEPHALOGRAPHY       0.000000       70. 00         71. 00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000       71. 00         72. 00       07200       I MPL. DEV. CHARGED TO PATI ENTS       0.000000       72. 00         73. 00       07300       DRUGS CHARGED TO PATI ENTS       0.000000       73. 00         76. 00       03020       ONCOLOGY       0.000000       76. 00         0UTPATI ENT SERVI CE COST CENTERS       0.000000       88. 00         88. 00       09000       CLI NI C       0.000000       90. 00						
69. 00						
69. 01		l e e e e e e e e e e e e e e e e e e e	1			
70. 00     07000     ELECTROENCEPHALOGRAPHY     0. 0000000     70. 00       71. 00     07100     MEDI CAL SUPPLI ES CHARGED TO PATI ENTS     0. 000000     71. 00       72. 00     07200     I MPL. DEV. CHARGED TO PATI ENTS     0. 000000     72. 00       73. 00     07300     DRUGS CHARGED TO PATI ENTS     0. 000000     73. 00       76. 00     03020     ONCOLOGY     0. 000000     76. 00       0UTPATI ENT SERVI CE COST CENTERS       88. 00     09000     CLI NI C     0. 000000     88. 00       90. 00     09000     CLI NI C     0. 000000     99. 00		1	1			
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0.000000   72.00   72						
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0.000000   73. 00   07300   DRUGS CHARGED TO PATIENTS   0.000000   73. 00   03020   ONCOLOGY   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000		l	1			
73. 00		l	1			
76. 00 03020 0NC0LOGY 0. 000000 76. 00 0UTPATIENT SERVICE COST CENTERS  88. 00 08800 RURAL HEALTH CLINIC 0. 000000 88. 00 09000 CLINIC 0. 000000 90. 00						
OUTPATI ENT SERVI CE COST CENTERS           88. 00         08800 RURAL HEALTH CLINIC         0.000000         88. 00           90. 00         09000 CLINIC         0.000000         90. 00			1			
88. 00 08800 RURAL HEALTH CLINIC 0.000000 88. 00 09000 CLINIC 0.000000 90. 00			0. 000000			76. 00
90. 00   09000   CLI NI C   0. 000000   90. 00						
			1			
			1			
		100 EMERGENCY	0. 000000			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 000000 92. 00			0. 000000			92. 00
OTHER REIMBURSABLE COST CENTERS						
101. 00 10100 HOME HEALTH AGENCY 101. 00						101. 00
SPECIAL PURPOSE COST CENTERS						
116. 00 11600 HOSPI CE 116. 00		I				
200.00 Subtotal (see instructions) 200.00		,				
201.00 Less Observation Beds 201.00	201.00	Less Observation Beds				
202.00   Total (see instructions)   202.00	202.00	Total (see instructions)				202. 00

Health Financial Systems	PULASKI MEMORIA	L HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE	CAPITAL COSTS	Provi der CCN: 15-1305	From 10/01/2015 To 09/30/2016	Worksheet D Part II Date/Time Prepared: 4/21/2017 3:37 pm
		Ti tl a YVIIII	Hosni tal	Cost

				-rom 10/01/2015 Fo 09/30/2016	Date/Time Pre	pared:
					4/21/2017 3:3	
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col.	Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS				.1		
50. 00   05000   OPERATI NG ROOM	122, 687					50. 00
52.00   05200   DELI VERY ROOM & LABOR ROOM	11, 651		•		0	52. 00
53. 00   05300   ANESTHESI OLOGY	1, 529			1		53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	100, 683				· ·	1
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	1	0. 000000		0	59. 00
60. 00   06000   LABORATORY	50, 457	11, 241, 925			2, 970	
60. 01  06001  BL00D   LABORATORY	0	0	0. 000000		0	60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	1, 694				334	63. 00
65. 00 06500 RESPI RATORY THERAPY	20, 888			1		
66. 00 06600 PHYSI CAL THERAPY	60, 111					
67. 00   06700   OCCUPATI ONAL THERAPY	1, 769	383, 583			142	67. 00
68. 00   06800   SPEECH PATHOLOGY	1, 772	191, 470	0. 00925	8, 502	79	68. 00
69. 00   06900   ELECTROCARDI OLOGY	515	449, 269	0. 00114	5 21, 422	25	69. 00
69. 01   06901   CARDI AC   REHABI LI TATI ON	9, 794	138, 728	0. 07059	9 0	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0. 00000	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	23, 237	2, 494, 880	0. 00931	4 295, 127	2, 749	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	4, 932	390, 152	0. 01264	1 88, 570	1, 120	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	41, 114	9, 200, 237	0. 00446	1, 766, 823	7, 896	73. 00
76. 00 03020 ONCOLOGY	14, 081	269, 186	0. 052310	0	0	76. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	209, 009	3, 386, 642	0. 06171	5 0	0	88. 00
90. 00   09000   CLI NI C	39, 786	525, 301	0. 07573	9 0	0	90. 00
91. 00 09100 EMERGENCY	135, 595	4, 132, 131	0. 03281	13, 440	441	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	24, 563			6	0	92. 00
200.00 Total (lines 50-199)	875, 867	57, 420, 925		4, 308, 207	36, 492	200. 00

Health Financial Systems	PULASKI MEMORIAL	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1305	Peri od: From 10/01/2015 To 09/30/2016	Worksheet D Part IV Date/Time Prepared: 4/21/2017 3:37 pm
		Title XVIII	Hospi tal	Cost

			4/21/2017 3:				
				XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician I	Nursing School	Allied Health		Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost	through col.	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0	0	0	0	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00	05400  RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54. 00
59. 00	05900  CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63. 00
65. 00	06500 RESPI RATORY THERAPY	0	0	0	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	0	0	0	66. 00
	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
	06901 CARDI AC REHABI LI TATI ON	0	0	0	0	0	69. 01
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
76.00	03020 ONCOLOGY	0	0	C	0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	C	0	0	88. 00
90.00	09000  CLI NI C	0	0	C	0	0	90. 00
91.00	09100 EMERGENCY	0	0	C	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92. 00
200.00	Total (lines 50-199)	0	0	[	0	0	200. 00

Heal th	Health Financial Systems PULASKI MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10											
APP0R1	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS Provider CCN: 15-1305			Peri od:	Worksheet D						
THROUG	SH COSTS				From 10/01/2015							
					To 09/30/2016							
			Ti tl e	: XVIII	Hospi tal	4/21/2017 3:37 pm Cost						
	Cost Center Description	Total	Total Charges			Inpati ent						
	cost contor boson per on		(from Wkst. C,		Ratio of Cost	Program						
		Cost (sum of				Charges						
		col. 2, 3 and	8)	7)	(col. 6 ÷ col.	3						
		4)	,		7)							
		6.00	7. 00	8.00	9. 00	10.00						
	ANCILLARY SERVICE COST CENTERS											
50.00	05000 OPERATING ROOM	0	5, 909, 796	0.00000	0. 000000	347, 330	50. 00					
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	310, 096	0.00000	0. 000000	0	52. 00					
53.00	05300 ANESTHESI OLOGY	0	1, 008, 058	0.00000	0. 000000	34, 440	53.00					
54.00	05400   RADI OLOGY-DI AGNOSTI C	0	13, 041, 089	0.00000	0. 000000	411, 735	54.00					
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000	0. 000000	0	59. 00					
60.00	06000 LABORATORY	0	11, 241, 925			661, 697	60.00					
60. 01	06001 BLOOD LABORATORY	0	0	0.00000		0	60. 01					
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	237, 783			46, 851	63. 00					
65. 00	06500 RESPI RATORY THERAPY	0	1, 233, 272			503, 983	l					
66. 00	06600 PHYSI CAL THERAPY	0	2, 653, 102			77, 604	66. 00					
67. 00	06700 OCCUPATI ONAL THERAPY	0	383, 583			30, 683						
68. 00	06800 SPEECH PATHOLOGY	0	191, 470			8, 502	68. 00					
69. 00	06900 ELECTROCARDI OLOGY	0	449, 269			21, 422	69. 00					
69. 01	06901 CARDI AC REHABI LI TATI ON	0	138, 728			0	69. 01					
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000		0	70. 00					
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 494, 880			295, 127	71. 00					
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	390, 152			•	l .					
	07300 DRUGS CHARGED TO PATIENTS	0	9, 200, 237			1, 766, 823	73.00					

3, 386, 642 525, 301 4, 132, 131 224, 225 57, 420, 925

269, 186

0.000000

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0.000000

0. 000000 0. 000000

0.000000

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0.000000

0. 000000 0. 000000

76. 00 0

90. 00 91. 00

0

4, 308, 207 200. 00

13, 440 0 92.00

76. 00 03020 0NC0L0GY
0UTPATIENT SERVICE COST CENTERS
88. 00 08800 RURAL HEALTH CLINIC

91.00 | 09100 | EMERGENCY | 92.00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART) | 200.00 | Total (lines 50-199)

90. 00 09000 CLI NI C

Health Financial Systems	PULASKI MEMORIAL	PULASKI MEMORIAL HOSPITAL					
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1305	Peri od: From 10/01/2015 To 09/30/2016	Worksheet D Part IV Date/Time Prepared:			

						10	09/30/2016	Date/IIme Pro   4/21/2017 3::	
				Ti tl e	e XVIII		Hospi tal	Cost	
		Cost Center Description	I npati ent	Outpati ent	Outpati ent				
			Program	Program	Program				
			Pass-Through	Charges	Pass-Through	า			
			Costs (col. 8		Costs (col.	9			
			x col. 10)		x col. 12)				
			11. 00	12.00	13. 00				
		LARY SERVICE COST CENTERS							
50.00		OPERATI NG ROOM	0	C		0			50. 00
		DELIVERY ROOM & LABOR ROOM	0	C		0			52. 00
		ANESTHESI OLOGY	0	C	)	0			53. 00
		RADI OLOGY-DI AGNOSTI C	0	C	)	0			54. 00
59. 00	05900	CARDI AC CATHETERI ZATI ON	0	C		0			59. 00
60.00	06000	LABORATORY	0	C		0			60.00
60. 01	06001	BLOOD LABORATORY	0	C		0			60. 01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	C		0			63.00
65.00	06500	RESPI RATORY THERAPY	0	C		0			65.00
66.00	06600	PHYSI CAL THERAPY	0	C		0			66. 00
67.00	06700	OCCUPATI ONAL THERAPY	0	C		0			67. 00
68. 00	06800	SPEECH PATHOLOGY	0	C		0			68. 00
69.00	06900	ELECTROCARDI OLOGY	0	C		0			69. 00
69. 01	06901	CARDI AC REHABI LI TATI ON	0	C		0			69. 01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	C		0			70. 00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0			71. 00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	C		0			72. 00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	C		0			73. 00
		ONCOLOGY	0	C		0			76. 00
	OUTPA	TIENT SERVICE COST CENTERS	'		1				
88. 00	08800	RURAL HEALTH CLINIC	0	C		0			88. 00
90.00	09000	CLINIC	0	C		0			90. 00
91.00	09100	EMERGENCY	0	C		0			91. 00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	C		0			92. 00
200.00		Total (lines 50-199)	0	C		0			200. 00

Health Financial Systems	PULASKI MEMOR	RLAL HOSPITAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1305	Peri od: From 10/01/2015	Worksheet D Part V

09/30/2016 Date/Time Prepared: 4/21/2017 3:37 pm Title XVIII Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 262481 1, 792, 355 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.658512 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0.033144 302. 942 0 53 00 0 |05400| RADI OLOGY-DI AGNOSTI C 54.00 0. 196153 0 4, 027, 895 0 54.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0 59.00 4, 200, 541 60.00 06000 LABORATORY 0.172765 0 60.00 06001 BLOOD LABORATORY 0.000000 60.01 0 60.01 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.354075 48, 400 0 63.00 06500 RESPIRATORY THERAPY 65.00 0. 418482 124, 745 0 65.00 06600 PHYSI CAL THERAPY 787, 849 0 483870 66.00 66.00 0 67.00 06700 OCCUPATIONAL THERAPY 0.411100 54, 640 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.873458 6, 945 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.068943 177, 173 69.00 0 06901 CARDIAC REHABILITATION 0. 901318 85, 407 69 01 0 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 261712 534, 367 71.00 71.00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.616949 0 121, 622 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 2, 227, 584 73.00 73.00 0.257141 0 76.00 03020 ONCOLOGY 1. 013786 126, 168 0 76.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 0. 000000 88.00 88.00 0 09000 CLI NI C 90.00 0. 966467 Ω 441, 098 0 Ω 90.00 91.00 09100 EMERGENCY 0.721271 0 1, 204, 055 0 91.00 0 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 1. 700114 76, 783 Subtotal (see instructions) 0 0 200. 00 200.00 16, 340, 569 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges 202.00 Net Charges (line 200 +/- line 201) 16, 340, 569 0 202.00

Heal th Financial	Systems			PULASKI	MEMORI AL	HOSPI TAL			In Lieu	of Form C	MS-2552-10
APPORTI ONMENT OF	MEDI CAL,	OTHER HEALTH	SERVICES AND	) VACCINE	COST	Provi der	CCN:	15-1305	10/01/2015 09/30/2016		Prepared:

				To 09/30/2016	Date/Time Pre 4/21/2017 3:3	
		Title	XVIII	Hospi tal	Cost	
	Cos					
Cost Center Description	Cost	Cost	1			
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7. 00	1			
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	470, 459	0				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52. 00
53. 00   05300   ANESTHESI OLOGY	10, 041	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	790, 084	0				54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59. 00
60. 00 06000 LABORATORY	725, 706	0				60.00
60. 01 06001 BLOOD LABORATORY	0	0				60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	17, 137	0				63.00
65. 00 06500 RESPIRATORY THERAPY	52, 204	0				65.00
66. 00   06600 PHYSI CAL THERAPY	381, 216	0				66, 00
67. 00 06700 OCCUPATI ONAL THERAPY	22, 463	0				67. 00
68.00 06800 SPEECH PATHOLOGY	6, 066	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	12, 215	0				69. 00
69. 01   06901 CARDI AC REHABI LI TATI ON	76, 979	0				69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	139, 850	0				71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	75, 035	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	572, 803	0				73. 00
76. 00 03020 ONCOLOGY	127, 907	0	1			76. 00
OUTPATIENT SERVICE COST CENTERS	127,707					70.00
88. 00 08800 RURAL HEALTH CLINIC	0	0				88. 00
90. 00   09000   CLINI C	426, 307	0	•			90.00
91. 00   09100   EMERGENCY	868, 450	0				91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	130, 540	0				92.00
200.00 Subtotal (see instructions)	4, 905, 462	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	1, 700, 402					201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	4, 905, 462	0				202. 00
Just the get ( 201)	1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1		1			

Health Financial Systems		PULASKI	MEMORI AL	HOSPI TAL		In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES	AND VACCINE	COST	Provi der	CCN: 15-1305	Peri od:	Worksheet D
					45 7005	From 10/01/2015	

		Component (		From 10/01/2015 To 09/30/2016	Part V Date/Time Pre	
		T: +1 o	XVIII S	Cui na Dodo CNE	4/21/2017 3: 3 Cost	7 pm
		II ti e	Charges	Swing Beds - SNF	Costs	
Cost Center Description	Cost to Charge	DDS Doimburged		Cost	PPS Services	
cost center bescription		Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	(366 11131.)	
	Part I, col. 9	11131. )	Subject To	Subject To		
	11 1 7 001 7		Ded. & Coins.			
			(see inst.)	(see inst.)		
	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS			•			
50. 00 05000 OPERATI NG ROOM	0. 262481	0		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 658512	0		0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 033144	0		0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 196153	0		0	0	54.00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0. 000000	0		0	0	59. 00
60. 00   06000   LABORATORY	0. 172765	0		0	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0	0	60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 354075	0		0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	0. 418482	0		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 483870	0		0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 411100	0		0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 873458	0		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 068943	0		0	0	69. 00
69. 01   06901   CARDI AC   REHABI LI TATI ON	0. 901318	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. 261712	0		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 616949	0		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 257141	0		0	0	73.00
76. 00 03020 0NCOLOGY	1. 013786	0		0	0	76. 00
OUTPATIENT SERVICE COST CENTERS						
88.00   08800   RURAL HEALTH CLINIC	0. 000000				0	88. 00
90. 00   09000   CLI NI C	0. 966467	0		0	0	90.00
91. 00   09100   EMERGENCY	0. 721271	0		0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 700114	0		0	0	92. 00
200.00 Subtotal (see instructions)		0		0		200. 00
201.00 Less PBP Clinic Lab. Services-Program				0		201. 00
Only Charges						
202.00   Net Charges (line 200 +/- line 201)	1	0	I	0 0	0	202. 00

Health Financial Systems	PULASKI N	MEMORIA	L HOSPITAL		In Lieu	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AI	ND VACCINE (	COST	Provider Component	CN: 15-1305 CCN: 15-Z305	From 10/01/2015	Worksheet D Part V Date/Time Prep 4/21/2017 3:3	pared: 7 pm
			Title	e XVIII	Swing Beds - SNF	Cost	
		Cost	S				
Cost Center Description	Cost		Cost	1			
	Rei mbur:	sed	Rei mbursed				
	Servi c	es S	Services Not				
	Subj ect	То	Subject To				
	Dod o Co	inc D	ed & Coinc				

		11 (16	AVIII Jawriig Beds - Jivi Cos	
		sts		
Cost Center Description	Cost	Cost		
	Rei mbursed	Rei mbursed		
	Servi ces	Services Not		
	Subject To	Subject To		
	Ded. & Coins.			
	(see inst.)	(see inst.)		
	6. 00	7.00		
ANCILLARY SERVICE COST CENTERS			_	
50. 00 05000 OPERATING ROOM	C	0		50. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	C	0		52. 00
53. 00   05300   ANESTHESI OLOGY	C	) 0		53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	C	0		54. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	C	) 0		59. 00
60. 00   06000   LABORATORY	C	0		60. 00
60. 01   06001   BLOOD LABORATORY	C	0		60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	C	0		63. 00
65. 00 06500 RESPI RATORY THERAPY	C	0		65. 00
66. 00 06600 PHYSI CAL THERAPY	C	0		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	C	0		67. 00
68. 00 06800 SPEECH PATHOLOGY	C	0		68. 00
69. 00   06900   ELECTROCARDI OLOGY	C	0		69. 00
69. 01   06901   CARDI AC   REHABI LI TATI ON	C	0		69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	C	0		70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	0		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	C	0		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	C	0		73. 00
76. 00 03020 0NC0L0GY	C	0		76. 00
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC	C	0		88. 00
90. 00   09000   CLI NI C	C	0		90. 00
91. 00 09100 EMERGENCY	C	0		91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	C	0		92. 00
200.00 Subtotal (see instructions)	C	0		200. 00
201.00 Less PBP Clinic Lab. Services-Program	C			201. 00
Only Charges				
202.00   Net Charges (line 200 +/- line 201)	C	0		202. 00

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-1305	Peri od: From 10/01/2015 To 09/30/2016	Worksheet D-1 Date/Time Prep 4/21/2017 3:3	
		Title XVIII	Hospi tal	Cost	

3.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.  4.00 Semi-private room days (excluding swing-bed and observation bed days)  5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period  6.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost 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 (if calendar year, enter 0 on this line)  7.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)  9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after pecember 31 of the cost reporting period (see instructions)  11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after pecember 31 of the cost reporting period (see instructions)					4/21/2017 3:3	7 pm
NATE   FROW IDER COMPONENTS			Title XVIII	Hospi tal	Cost	
NAME		Cost Center Description				
MeATTERT MAYS   1.00   Inpatient days (including private room days and swing-bed days; excluding newborn)   3,110   1.00   Inpatient days (including private mone days, excluding swing-hed and motor and swing swing hed and motor and swing swing hed and motor and swing swing hed and swing swin					1. 00	
Impatient days (including private room days and sain ap-bed days, excluding newborn)   3,410   1,00						
Inpatient days (including private room days)						
Private room days (excluding swing-bed and observation bed days). If you have only private room days, do do not complete this line.  4.00 Semi-private room days (excluding swing-bed and observation bed days).  5.00 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period (if call endary year, enter 0 on this line).  7.00 Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost reporting period (if call endary year, enter 0 on this line).  7.00 Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost reporting period (if call endary year, enter 0 on this line).  8.00 Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost reporting period (in line).  9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and neeborn days).  10.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days).  11.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days).  12.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days).  13.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days).  14.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days).  15.00 Total swing-bed SMF type inpatient days applicable to title XVIII only (including private room days).  16.00 Total swing-bed SMF type inpatient days applicable to title XVIII only (including private room days).  17.00 Modical for the cost reporting period (int XVIII only (including private room days).  18.00 Total swing-bed SMF type inpatient days applicable to title XVIII only (including private room days).  18.00 Total swing-bed SMF type inpatient days applicable to title XVIII only (including private room days).  18.00 Total swing-bed SMF type inpati	1.00				3, 410	
do not complete this line.  4. 05 Sein-private room days (excluding swing-bed and observation bed days)  Total swing-bed SNF type inputient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7. 00 Total swing-bed SNF type inputient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7. 00 Total swing-bed NF type inputient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  8. 00 Total swing-bed NF type inputient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9. 00 Total inputient days including private room days applicable to this line)  10. 00 Swing-bed SNF type inputient days applicable to this line)  10. 00 Swing-bed SNF type inputient days applicable to this line)  10. 00 Swing-bed SNF type inputient days applicable to this swing to this line)  10. 00 Swing-bed SNF type inputient days applicable to this swing to the cost reporting period (see instruction this line)  10. 00 Swing-bed SNF type inputient days applicable to this swing to this swing to the swing to the cost reporting period (see instruction this line)  10. 00 Swing-bed SNF type inputient days applicable to this swing to the swing	2.00	Inpatient days (including private room days, excluding swing-b	ped and newborn days)		2, 278	2. 00
5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost roporting period SNF type inpatient days (including private room days) through December 31 of the cost roporting period SNF type inpatient days (including private room days) through December 31 of the cost roporting 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) through 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 priva	3.00	Private room days (excluding swing-bed and observation bed day	s). If you have only pr	ivate room days,	0	3. 00
1 Total 'swing-bed SNF 'type inpatient days' (including private room days) after December 31 of the cost reporting period (if Calendar year, enter 0 on this line) 7.00 Total 'swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if Calendar year, enter 0 on this line) 9.00 Total 'sing-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 inputient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SNF type inpatient days (and under the cost reporting period (if Calendar year, enter 0 on this line) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII entry (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII entry (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII entry (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 12.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Through becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 15.00 Swing-bed SNF type inpatient days applicable to the Program (excluding an ing-bed days) 16.00 Narray days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (in period in period in period in period (in period SNF services applicable to services after December 31 of the cost reporting period (line SNF type services after December 31 of the cost r		do not complete this line.		•		
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost 770 6.00 reporting period (if calendar year, enter 0 on this line) 9.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost 7.00 for one period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days after December 31 of the cost 7.00 for one 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 neeborn days) 10.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and neeborn days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 13.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 13.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 14.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after 14.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after 14.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after 14.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after 14.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after 14.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after 14.00 Swing-bed Swi	4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		1, 988	4.00
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)   Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period   Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period   Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (including private room days)   Total swing-bed NF type inpatient days applicable to the Program (excluding swing-bed and nexborn days)   Total inpatient days applicable to the Program (excluding private room days)   Total period (including December 31 of the cost reporting period (if calendar year, enter 0 on this line)   Total period (if calendar year, enter 0 on this line)   Total period (if calendar year, enter 0 on this line)   Total period (if calendar year, enter 0 on this line)   Total period (if calendar year, enter 0 on this line)   Total period (if calendar year, enter 0 on this line)   Total period (if calendar year, enter 0 on this line)   Total period (if calendar year, enter 0 on this line)   Total period (if (if calendar year, enter 0 on this line)   Total period (if (if calendar year, enter 0 on this line)   Total period (if (if calendar year, enter 0 on this line)   Total period (if (if calendar year, enter 0 on this line)   Total period (if (if calendar year, enter 0 on this line)   Total period (if calendar year, enter 0 on this line)   Total period (if calendar year, enter 0 on this line)   Total period (if calendar year, enter 0 on this line)   Total period (if calendar year, enter 0 on this line)   Total period (if calendar year, enter 0 on this line)   Total period (if calendar year, enter 0 on this line)   Total period (if calendar year, enter 0 on th	5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	200	5.00
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)   Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period   Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period   Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (including private room days)   Total swing-bed NF type inpatient days applicable to the Program (excluding swing-bed and nexborn days)   Total inpatient days applicable to the Program (excluding private room days)   Total period (including December 31 of the cost reporting period (if calendar year, enter 0 on this line)   Total period (if calendar year, enter 0 on this line)   Total period (if calendar year, enter 0 on this line)   Total period (if calendar year, enter 0 on this line)   Total period (if calendar year, enter 0 on this line)   Total period (if calendar year, enter 0 on this line)   Total period (if calendar year, enter 0 on this line)   Total period (if calendar year, enter 0 on this line)   Total period (if (if calendar year, enter 0 on this line)   Total period (if (if calendar year, enter 0 on this line)   Total period (if (if calendar year, enter 0 on this line)   Total period (if (if calendar year, enter 0 on this line)   Total period (if (if calendar year, enter 0 on this line)   Total period (if calendar year, enter 0 on this line)   Total period (if calendar year, enter 0 on this line)   Total period (if calendar year, enter 0 on this line)   Total period (if calendar year, enter 0 on this line)   Total period (if calendar year, enter 0 on this line)   Total period (if calendar year, enter 0 on this line)   Total period (if calendar year, enter 0 on th		reporting period	3 , 3			
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed Mi Type Inpatient days (including private room days) through December 31 of the cost reporting period (lotal swing-bed Mi Type Inpatient days (including private room days) after December 31 of the cost 123 8.00 Total Inpatient days including private room days) after December 31 of the cost 123 8.00 Responsible to the Program (excluding swing-bed and newborn days) and the private room days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SWF type Inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (isea instructions) 11.00 Swing-bed SWF 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 Total nursery days (title V or XX val) (including private room days) 12.00 Swing-bed SWF year papatient days applicable to title XV or XX val) (including private room days) 13.00 Swing-bed SWF year papatient days applicable to the Program (excluding swing-bed days) 13.00 Swing-bed William (including period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XX val) (including private room days) 16.00 Nursery days (title V or XX val) (including private room days) 17.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 18.00 reporting period (including period (including private room days) 18.00 reporting period (including period (including private room days) 18.00 reporting period (including period (including private room days) 18.00 reporting period (including period (includi	6.00		om davs) after December	31 of the cost	770	6.00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period   Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if catendar year, enter 0 on this line)   Total inpatient days including private room days applicable to the Program (excluding swing-bed and 1,100 9,00 0,00 0,00 0,00 0,00 0,00 0,0			<i>3</i> ,			
Total swing-bed NF type inpatient days (including private room days) arter December 31 of the cost reporting period (ir Calendar year, enter 0 on this line)	7.00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	39	7. 00
reporting period (if calendar year, enter 0 on this line)  10.00 Nating-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  11.00 Sling-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see Instructions)  11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (on this line)  12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (on this line)  13.00 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)  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 the Program (excluding swing-bed days)  16.00 Next or a swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed days)  17.00 Next or a swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed days)  18.00 Next or a swing-bed SNF type services applicable to services through December 31 of the cost reporting period (including private room days)  18.00 Next or a swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days)  18.00 Next or a swing-bed SNF service of the services after December 31 of the cost (a swing-bed SNF services applicable to services after December 31 of the cost (a swing-bed SNF services applicable to services after December 31 of the cost (a swing-bed SNF services applicable to services after December 31 of the cost (a swing-bed SNF services applicable to services after December 31 of the cost reporting period (line 6 sylical days)  18.00 New SNF		reporting period				
10.00   Contain   Inpatient days   Including private room days applicable to the Program (excluding swing-bed and neabtorn days)   0.00   0.00	8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	123	8. 00
newborn days)  newborn days)  10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) on 10.00 through December 31 of the cost reporting period (see instructions)  11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after ps. 11.00 Swing-bed SVIII only (including private room days) on 12.00 Swing-bed SVIII only (including private room days) on 12.00 Swing-bed SVIII only (including private room days) on 12.00 Swing-bed SVIII only (including private room days) on 13.00 Swing-bed SVIII only (including		reporting period (if calendar year, enter 0 on this line)				
1.0.00 Swing-bed SMr type inpatient days applicable to title XVIII only (Including private room days) 1.0.00 Swing-bed SMr type inpatient days applicable to title XVIII only (Including private room days) after pecker by December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1.2.00 Swing-bed SMr type inpatient days applicable to titles V or XIX only (Including private room days) 1.2.00 Swing-bed NR type inpatient days applicable to titles V or XIX only (Including private room days) 1.3.00 Swing-bed NR type inpatient days applicable to titles V or XIX only (Including private room days) 1.4.00 Medically necessary private room days applicable to titles V or XIX only (Including private room days) 1.6.00 Nursery days (title V or XIX only) 1.6.00 Nursery days (title V or XIX only) 1.7.00 Nedicare rate for SWing-bed SNR services applicable to services through December 31 of the cost reporting period 1.8.00 Medicare rate for Swing-bed SNR services applicable to services through December 31 of the cost reporting period 1.9.00 Medicare rate for Swing-bed SNR services applicable to services through December 31 of the cost reporting period 1.9.00 Medicare rate for Swing-bed SNR services applicable to services through December 31 of the cost 134.09 19.00 Medical drate for Swing-bed NR services applicable to services after December 31 of the cost 137.00 2.00 Medical drate for Swing-bed NR services applicable to services after December 31 of the cost 137.00 2.00 Medical drate for Swing-bed NR services applicable to services after December 31 of the cost 137.00 2.00 Medical drate for Swing-bed NR services applicable to services after December 31 of the cost reporting period (line 5 x 11 ine 18) 1.9.00 Name Swing-bed Cost applicable to SNR type services after December 31 of the cost reporting period (line 6 x 11 ine 18) 1.9.00 Name Swing-bed Cost applicable to SNR type services after December 31 of the cost reporting period (line 8 x 11 ine 18) 1.9.00 Name Swing-bed Cost applicable to SNR type services	9.00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	1, 100	9. 00
through December 31 of the cost reporting period (see instructions)  1.00 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 Medical Iv 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 No Nursery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (incare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (incare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (incare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (incare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (incare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (incare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (incare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 0 2 2 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 0 2 2 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 0 2 2 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 0 2 3 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 0 2 3 00 Swing-bed cost applicable to NF type s		newborn days)		-		
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December 31 of the cost reporting period (if calendar year, enter 0 on this line)   0   12.00		through December 31 of the cost reporting period (see instruct	i ons)			
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14.00   Medically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00   15.	13.00				0	13. 00
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reporting period  Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 137.30 20.00 reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 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 19)  25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 5.230 24.00 7 x line 19)  26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 16.888 25.00 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 Semi-private room charges (excluding swing-bed charges)  29.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room per diem charge (line 29 + line 3)  31.00 Average per inprivate room per diem charge (line 29 + line 3)  32.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  38.00 Average per diem private room cost differential (line 34 x line 31)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service looks per diem (see instructions)  38.00 Adjusted general inpatient routine service looks per diem (see instructions)  39.00 Program g						
19.00   Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period   134.09   19.00	18. 00					
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<u>Heal t</u> h	Financial Systems	PULASKI MEMORIA	AL HOSPITAL		<u>In L</u> ie	eu of Form CMS-2	2552-10
COMPUT	TATION OF INPATIENT OPERATING COST		Provi der C	CCN: 15-1305	Peri od: From 10/01/2015	Worksheet D-1	
					To 09/30/2016	Date/Time Pre	pared:
			Ti +l e	e XVIII	Hospi tal	4/21/2017 3:3 Cost	7 pm
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	npatient Days		÷	(col. 3 x col.	
		1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0		0.0			42. 00
	Intensive Care Type Inpatient Hospital Units						
43. 00 44. 00	I NTENSI VE CARE UNI T	0	(	0.0	00	0	43.00
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						45. 00
46. 00	1						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			1, 169, 852	48. 00
	Total Program inpatient costs (sum of lines			ons)		2, 615, 813	
FO 00	PASS THROUGH COST ADJUSTMENTS			WI+ D	-£ D	1 0	 
50. 00	Pass through costs applicable to Program inp.	atient routine s	services (Tro	m wkst. D, Sum	i or Parts i and	0	50.00
51. 00	Pass through costs applicable to Program inp	atient ancillary	y services (f	rom Wkst. D, s	um of Parts II	0	51.00
E2 00	and IV)	EO and E1)				0	52. 00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ated non-phy	vsician anesth	etist and	0	
00.00	medical education costs (line 49 minus line		atea, non pri	ysi ci air anesti	otrot, and		00.00
	TARGET AMOUNT AND LIMIT COMPUTATION					_	
	Program discharges Target amount per discharge					0.00	
56. 00						0.00	1
57. 00	1	ing cost and tar	get amount (	line 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)	norting ported a	anding 1004	undated and a	mnounded by the	0	
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period e	enarng 1996, i	updated and co	illipounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	
61. 00						0	61.00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						
62. 00	Relief payment (see instructions)					0	62. 00
63. 00	63.00 Allowable Inpatient cost plus incentive payment (see instructions)						
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decem	nher 31 of the	e cost renorti	na period (See	T 0	64. 00
	instructions)(title XVIII only)	Ü		•			
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the o	cost reporting	period (See	1, 257, 986	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	64 plus line o	65)(title XVII	LonLy). For	1, 257, 986	66. 00
	CAH (see instructions)					1, 201, 100	
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31	of the cost re	porting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after De	ecember 31 of	the cost repo	rtina period	0	68. 00
	(line 13 x line 20)				3 1.		
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NI					0	69.00
70. 00	Skilled nursing facility/other nursing facil						70. 00
71. 00	Adjusted general inpatient routine service c	-					71. 00
72.00	Program routine service cost (line 9 x line		(line 14 l	: no 3E)			72.00
73. 00 74. 00	Medically necessary private room cost application. Total Program general inpatient routine serv						73.00
75. 00	Capital -related cost allocated to inpatient	•		•	art II, column		75. 00
7/ 00	26, line 45)	0)					7/ 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	. *					76. 00 77. 00
	Inpatient routine service cost (line 74 minus						78. 00
79. 00	Aggregate charges to beneficiaries for exces						79. 00
80. 00 81. 00	Total Program routine service costs for comp. Inpatient routine service cost per diem limi		ost IImitatio	n (line 78 min	us line 79)		80. 00 81. 00
82. 00	Inpatient routine service cost per dreim frim		)				82.00
83. 00	Reasonable inpatient routine service costs (	see instructions					83. 00
84.00	Program inpatient ancillary services (see in		ac)				84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
20.00	PART IV - COMPUTATION OF OBSERVATION BED PASS						]
87. 00	Total observation bed days (see instructions	•	1: 2)			290	1
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	iine 2)			1, 314. 51 381, 208	
57.00	(3e)					1 551, 200	, 57.00

Health Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 10/01/2015 To 09/30/2016		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	276, 530	4, 291, 637	0. 06443	5 381, 208	24, 563	90.00
91.00 Nursing School cost	0	4, 291, 637	0.00000	0 381, 208	0	91.00
92.00 Allied health cost	0	4, 291, 637	0.00000	0 381, 208	0	92.00
93.00 All other Medical Education	0	4, 291, 637	0.00000	0 381, 208	0	93.00

Health Financial Systems	PULASKI MEMORIAL	HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1305	Peri od: From 10/01/2015	Worksheet D-1	
			To 09/30/2016	Date/Time Pre 4/21/2017 3:3	
		Title XIX	Hospi tal	Cost	
Cost Center Description					
				1. 00	
DART I _ ALL PROVIDER COMPONENTS					

		Title XIX	Hospi tal	Cost	, biii
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS			0.110	4 00
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-l			3, 410 2, 278	1. 00 2. 00
3.00	Private room days (excluding swing-bed and observation bed day		vate room days,	0	3. 00
	do not complete this line.			4 000	
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		- 31 of the cost	1, 988	4. 00 5. 00
0.00	reporting period	om dayo) tim odgir booombo.	0. 0. 1 0001		0.00
6.00	Total swing-bed SNF type inpatient days (including private roomsting period (if calendar year enter 0 on this line)	om days) after December :	31 of the cost	970	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	162	7. 00
	reporting period			_	
8. 00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	m days) after December 3°	l of the cost	0	8. 00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	44	9. 00
10.00	newborn days)	-1 /:111		0	10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instruc-		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00
	through December 31 of the cost reporting period	3 ( 3 )	, ,		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ye			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)				15.00
16.00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			12	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost		17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period				19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of t	ne cost	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions			4, 291, 637	
22. 00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ line 17)	er 31 of the cost reporti	ng period (iine	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ ine 19)	r 31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			1, 281, 680	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		3, 009, 957	
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)	1: 20)		0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 ÷ line 3)	÷ 11 ne 28)		0. 000000 0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x lin		- /	0. 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 a	and private room cost di	fferential (line	3, 009, 957	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 321. 32	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			58, 138	
	Medically necessary private room cost applicable to the Progra	,		0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		58, 138	41. 00

Heal th	Financial Systems PULASKI MEMORIAL HOSPITAL In Li	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST Provider CCN: 15-1305 Period: From 10/01/2015	Worksheet D-1	
	To 09/30/2016		
	Title XIX Hospital	Cost	7 piii
	Cost Center Description Total Total Average Per Program Days Inpatient Cost Inpatient Days Diem (col. 1 ÷	Program Cost (col. 3 x col.	
		4)	
42.00	1.00   2.00   3.00   4.00   NURSERY (title V & XIX only)   138,063   188   734.38   13	5.00	42.00
42.00	Intensive Care Type Inpatient Hospital Units		
43. 00 44. 00	INTENSIVE CARE UNIT 0 0 0.00 (CORONARY CARE UNIT	0	43. 00 44. 00
45. 00			45. 00
46.00			46.00
47.00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description		47. 00
40.00	Decares innetient ancillary coming cost (West D.2 col. 2 line 200)	1. 00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	63, 124 130, 075	
	PASS THROUGH COST ADJUSTMENTS		F0 00
50. 00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and	0	50. 00
51. 00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II	0	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines 50 and 51)	0	52. 00
53. 00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and	0	53. 00
	medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION		
	Program di scharges	0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)	0.00	55. 00 56. 00
57. 00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57. 00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the	0 00	58. 00 59. 00
	market basket		
60. 00 61. 00	, , , , , , , , , , , , , , , , , , , ,	0.00	60. 00 61. 00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target		
62. 00	amount (line 56), otherwise enter zero (see instructions) Relief payment (see instructions)	0	62, 00
63. 00	Allowable Inpatient cost plus incentive payment (see instructions)		63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST  Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See	0	64. 00
/F 00	instructions)(title XVIII only)		/F 00
65. 00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66. 00
67. 00		0	67. 00
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	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70. 00
71. 00 72. 00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)   Program routine service cost (line 9 x line 71)		71. 00 72. 00
73. 00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73. 00
74. 00 75. 00	Total Program general inpatient routine service costs (line 72 + line 73)  Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column		74. 00 75. 00
73.00	26, line 45)		
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76)		76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus line 77)		78. 00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		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	Inpatient routine service cost limitation (line 9 x line 81)		82. 00
83. 00 84. 00	Reasonable inpatient routine service costs (see instructions)  Program inpatient ancillary services (see instructions)		83. 00 84. 00
85. 00	Utilization review - physician compensation (see instructions)		85. 00
86. 00	Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		86. 00
87. 00		290	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) Observation bed cost (line 87 x line 88) (see instructions)	1, 321. 32 383, 183	
07.00	Topsel various bed cost (Title of A Title ou) (See Thistractions)	1 303, 103	0 7. 00

Health Financial Systems	PULASKI MEMOR	I AL HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 10/01/2015	Worksheet D-1	·
				To 09/30/2016		
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90. 00 Capital -related cost	276, 530	4, 291, 637	0.06443	5 383, 183	24, 690	90.00
91.00 Nursing School cost	0	4, 291, 637	0.00000	383, 183	0	91.00
92.00 Allied health cost	0	4, 291, 637	0.00000	383, 183	0	92.00
93.00 All other Medical Education	0	4, 291, 637	0.00000	383, 183	0	93.00

	Financial Systems	PULASKI MEMORIAL				u of Form CMS-	
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der C	CN: 15-1305	Peri od: From 10/01/2015	Worksheet D-3	
					To 09/30/2016	Date/Time Pre	nared:
					077 007 2010	4/21/2017 3:3	
			Titl∈	XVIII	Hospi tal	Cost	
	Cost Center Description			Ratio of Cos		I npati ent	
				To Charges	Program	Program Costs	
					Charges	(col. 1 x col.	
				1.00	0.00	2)	
	I NPATIENT ROUTINE SERVICE COST CENTERS			1.00	2. 00	3. 00	
30. 00	03000 ADULTS & PEDIATRICS				921, 846		30. 00
31. 00	03100   NTENSI VE CARE UNIT				921, 840	l	31.00
	04300 NURSERY				0		43.00
43.00	ANCI LLARY SERVI CE COST CENTERS			l		l	1 43.00
50.00	05000 OPERATING ROOM			0. 2624	81 347, 330	91, 168	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM			0. 6585			1
53. 00	05300 ANESTHESI OLOGY			0. 0331		1, 141	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C			0. 1961	53 411, 735		
59.00	05900 CARDI AC CATHETERI ZATI ON			0.0000	00	0	59. 00
60.00	06000 LABORATORY			0. 1727	65 661, 697	114, 318	60.00
60. 01	06001 BLOOD LABORATORY			0.0000	00 0	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.			0. 3540		16, 589	
65.00	06500 RESPI RATORY THERAPY			0. 4184			1
66. 00	06600 PHYSI CAL THERAPY			0. 4838			1
67. 00	06700 OCCUPATI ONAL THERAPY			0. 4111			1
68. 00	06800 SPEECH PATHOLOGY			0. 8734			1
69. 00	06900 ELECTROCARDI OLOGY			0. 0689		1, 477	1
69. 01	06901 CARDI AC REHABI LI TATI ON			0. 9013		0	1
70.00	07000 ELECTROENCEPHALOGRAPHY			0.0000		0	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS			0. 2617		77, 238	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS			0. 6169 0. 2571			
73. 00 76. 00	03020 ONCOLOGY			1. 0137			1
76.00	OUTPATIENT SERVICE COST CENTERS			1.0137	00  0	0	76.00
88. 00	08800 RURAL HEALTH CLINIC			0.0000	nn	0	88. 00
90.00	09000 CLINIC			0. 9664		0	1
91. 00	09100 EMERGENCY			0. 7212			
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			1. 7001		0	
200.00					4, 308, 207	1, 169, 852	
201.00		rogram only charges	(line 61)		0		201.00
202.00		- , ,			4, 308, 207		202. 00
							-

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der C	CN: 15-1305	Peri od:	Worksheet D-3	}
		Component	CCN: 15-Z305	From 10/01/2015 To 09/30/2016		nared.
		Component	0014. 10 2000	077 007 2010	4/21/2017 3: 3	
		Ti tl e	XVIII	Swing Beds - SN		
Cost Center Description			Ratio of Cos		I npati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS			1.00	2. 00	3. 00	
30. 00 03000 ADULTS & PEDIATRICS					N .	30.00
31. 00   03100   NTENSI VE CARE UNIT					1	31.00
43. 00   04300   NURSERY					Ί	43.00
ANCI LLARY SERVI CE COST CENTERS			1		1	1 43.00
50. 00   05000   OPERATING ROOM			0. 2624	81 17, 746	4, 658	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM			0. 6585			1
53. 00   05300   ANESTHESI OLOGY			0. 0331	44	o	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C			0. 1961	53 52, 922	10, 381	54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON			0.0000	00	0	59.00
60. 00   06000   LABORATORY			0. 1727	65 175, 067	30, 245	60.00
60. 01   06001   BLOOD LABORATORY			0.0000	00	1 -	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.			0. 3540			
65. 00 06500 RESPIRATORY THERAPY			0. 4184			
66. 00   06600   PHYSI CAL THERAPY			0. 4838			
67. 00 06700 OCCUPATI ONAL THERAPY			0. 4111			
68. 00 06800 SPEECH PATHOLOGY			0. 8734			
69. 00 06900 ELECTROCARDI OLOGY			0. 0689			
69. 01 06901 CARDI AC REHABI LI TATI ON			0. 9013		1	
70. 00 07000 ELECTROENCEPHALOGRAPHY			0.0000		٠,	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS			0. 2617	·		1
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS			0. 6169		1	
73. 00   07300   DRUGS CHARGED TO PATIENTS 76. 00   03020   ONCOLOGY			0. 2571		1	1
76. 00 03020 ONCOLOGY OUTPATI ENT SERVI CE COST CENTERS			1. 0137	86 (	0	76.00
88. 00 08800 RURAL HEALTH CLINIC			0.0000	00	0	88. 00
90. 00   09000   CLINIC			0.0000		1	
91. 00   09100   EMERGENCY			0. 7004			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			1. 7001			
200.00 Total (sum of lines 50-94 and 96-98)			1.,001	1, 135, 285	1	1
201.00 Less PBP Clinic Laboratory Services-Pr	ogram only charges	(line 61)		., .55, 266	j .33, 128	201.00
202.00 Net Charges (line 200 minus line 201)				1, 135, 285		202. 00

Health Financial Systems PULASKI MEMO	RIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1305	Peri od:	Worksheet D-3	
			From 10/01/2015	D 1 /T' D	
			To 09/30/2016	Date/Time Pre 4/21/2017 3:3	
	Ti +I	e XIX	Hospi tal	Cost	7 рііі
Cost Center Description	11 61	Ratio of Cos		Inpati ent	
555t 55.1ts. 55551 Ft. 5.1		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00   03000   ADULTS & PEDI ATRI CS			28, 612		30. 00
31.00 03100 INTENSIVE CARE UNIT			0		31. 00
43. 00 04300 NURSERY			12, 909		43. 00
ANCILLARY SERVICE COST CENTERS		1			
50. 00   05000   OPERATI NG ROOM		0. 26248		6, 663	50. 00
52. 00   05200   DELI VERY ROOM & LABOR ROOM		0. 6585		12, 384	52.00
53. 00   05300   ANESTHESI OLOGY		0. 03314		155	
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 1961!		3, 625	1
59. 00 O5900 CARDI AC CATHETERI ZATI ON		0.0000		0	59. 00
60. 00   06000   LABORATORY		0. 1727		4, 826	60.00
60. 01   06001   BLOOD LABORATORY 63. 00   06300   BLOOD STORING, PROCESSING & TRANS.		0. 00000 0. 3540		0 687	60. 01 63. 00
65. 00 06500 RESPIRATORY THERAPY		0. 3540		4, 340	
66. 00   06600   PHYSI CAL THERAPY		0. 41848		4, 340	66.00
67. 00   06700   OCCUPATI ONAL THERAPY		0. 41110		155	
68. 00   06800   SPEECH PATHOLOGY		0. 8734		1, 558	
69. 00   06900   ELECTROCARDI OLOGY		0.06894		25	69. 00
69. 01 O6901 CARDI AC REHABI LI TATI ON		0. 9013		0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 00000		0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2617		6, 676	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 6169		0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 2571		17, 030	73. 00
76. 00 03020 0NC0L0GY		1. 01378		0	76. 00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		1. 53748	33 0	0	88. 00
90. 00   09000   CLI NI C		0. 9664	57 0	0	90.00
91. 00   09100   EMERGENCY		0. 7212	71 6, 366	4, 592	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 7001	14 0	0	92. 00
200.00 Total (sum of lines 50-94 and 96-98)			209, 056	63, 124	
201.00 Less PBP Clinic Laboratory Services-Program only cha	rges (line 61)		0		201. 00
202.00 Net Charges (line 200 minus line 201)		[	209, 056		202. 00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der (	CCN: 15-1305	Peri od: From 10/01/2015	Worksheet D-3	
	Component	CCN: 15-Z305	To 09/30/2016		
	Ti t	le XIX	Swing Beds - SNI	PPS	
Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				1	
30. 00   03000   ADULTS & PEDI ATRI CS			C		30. 00
31. 00   03100   INTENSIVE CARE UNIT			C	•	31.00
43. 00   04300   NURSERY			C		43. 00
ANCILLARY SERVICE COST CENTERS		0.04044	24		
50. 00   05000   OPERATING ROOM		0. 26248			
52. 00   05200   DELIVERY ROOM & LABOR ROOM   53. 00   05300   ANESTHESI OLOGY		0. 6585			
		0. 03314		_	
1		0. 1961			1
		0. 00000 0. 1727			
60. 00   06000   LABORATORY 60. 01   06001   BLOOD   LABORATORY		0.17276		_	00.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 3540			1
65. 00 06500 RESPIRATORY THERAPY		0. 41848		_	65. 00
66. 00   06600   PHYSI CAL THERAPY		0. 4838		_	
67. 00 06700 OCCUPATIONAL THERAPY		0. 41110		_	1
68. 00   06800   SPEECH PATHOLOGY		0. 87345		_	68. 00
69. 00   06900   ELECTROCARDI OLOGY		0. 06894		_	1
69. 01   06901   CARDI AC   REHABI LI TATI ON		0. 9013		_	1
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 00000		0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2617			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 61694			1
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 25714		_	
76. 00 03020 0NC0L0GY		1. 01378			
OUTPATIENT SERVICE COST CENTERS		1.0107	30	<u> </u>	70.00
88. 00 08800 RURAL HEALTH CLINIC		1. 53748	33 C	0	88. 00
90. 00   09000   CLI NI C		0. 96646			1
91. 00 09100 EMERGENCY		0. 7212		0	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 7001		ō	
200.00 Total (sum of lines 50-94 and 96-98)			C	0	200.00
201.00 Less PBP Clinic Laboratory Services-Pro	ogram only charges (line 61)		C		201.00

Health Financial Systems	PULASKI MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1305	From 10/01/2015 To 09/30/2016	Worksheet E Part B Date/Time Prepared: 4/21/2017 3:37 pm
	Title XVIII	Hosni tal	Cost

		10 09/30/20	4/21/2017 3:3	
		Title XVIII Hospital	Cost	7 piii
		THE ATTENDED TO		
			1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		4, 905, 462	
2. 00	Medical and other services reimbursed under OPPS (see instruc	tions)	0	
3.00	PPS payments		0	
4.00	Outlier payment (see instructions)		0	
5.00	Enter the hospital specific payment to cost ratio (see instructions 2 times line 5	ctions)	0.000	1
6. 00 7. 00	Line 2 times line 5 Sum of line 3 plus line 4 divided by line 6		0.00	
8.00	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	1
10. 00	Organ acqui si ti ons	. 1, 66.1 16, 11116 266	l o	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)		4, 905, 462	1
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable charges		_	
12. 00	Ancillary service charges		•	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ine 69)	0	
14. 00	Total reasonable charges (sum of lines 12 and 13)		0	14. 00
15 00	Customary charges	nayment for corvices on a charge basis	1 0	15. 00
15. 00 16. 00	Aggregate amount actually collected from patients liable for partients that would have been realized from patients liable for		l e	1
10.00	had such payment been made in accordance with 42 CFR §413.13(			10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	5)	0.000000	17. 00
18.00	Total customary charges (see instructions)		0	18. 00
19.00	Excess of customary charges over reasonable cost (complete only	ly if line 18 exceeds line 11) (see	0	19. 00
	instructions)			
20. 00	Excess of reasonable cost over customary charges (complete only	ly if line 11 exceeds line 18) (see	0	20. 00
21 00	instructions) Lesser of cost or charges (line 11 minus line 20) (for CAH see	o instructions)	4 054 517	21 00
21. 00 22. 00	Interns and residents (see instructions)	e Tristructions)	4, 954, 517 0	ı
23. 00	Cost of physicians' services in a teaching hospital (see insti	ructions)	0	
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)	1 40 (1 6113)	0	
2 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			2 00
25.00	Deductibles and coinsurance (for CAH, see instructions)		37, 748	25. 00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for	r CAH, see instructions)	2, 441, 468	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	plus the sum of lines 22 and 23] (see	2, 475, 301	27. 00
00.00	instructions)	50)		00.00
28. 00 29. 00	Direct graduate medical education payments (from Wkst. E-4, li ESRD direct medical education costs (from Wkst. E-4, line 36)	rne 50)	0 0	
30.00	Subtotal (sum of lines 27 through 29)		2, 475, 301	1
31. 00	Primary payer payments		1, 745	1
32. 00	Subtotal (line 30 minus line 31)		2, 473, 556	1
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	CES)	, , , , , , , , , , , , , , , , , , , ,	
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33. 00
34. 00	Allowable bad debts (see instructions)		423, 512	
35. 00	Adjusted reimbursable bad debts (see instructions)		275, 283	
36. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	402, 827	
37. 00	Subtotal (see instructions)		2, 748, 839	
	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0 0	
39. 00 39. 50	Pioneer ACO demonstration payment adjustment (see instructions	c)		
39. 98	Partial or full credits received from manufacturers for replace	•	Ö	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	004 4011 000 (000 111011 4011 0110)	0	
40. 00	Subtotal (see instructions)		2, 748, 839	1
40. 01	Sequestration adjustment (see instructions)		54, 977	
41.00	Interim payments		2, 524, 040	41. 00
42.00	Tentative settlement (for contractors use only)		0	1
43.00	Balance due provider/program (see instructions)		169, 822	
44. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2, chapter 1,	0	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR			-
90. 00	Original outlier amount (see instructions)		0	90.00
91. 00	Outlier reconciliation adjustment amount (see instructions)		0	1
	The rate used to calculate the Time Value of Money			92. 00
93. 00	Time Value of Money (see instructions)		0	1
94.00	Total (sum of lines 91 and 93)		0	94. 00

Health Financial Systems PULA
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 10/01/2015 Part I
To 09/30/2016 Date/Ti me Prepared: 4/21/2017 3:37 pm Provider CCN: 15-1305

					4/21/2017 3: 3	7 pm
			XVIII	Hospi tal	Cost	
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		2, 183, 57		2, 524, 040	1. 00
2.00	Interim payments payable on individual bills, either		(	)	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	03/22/2016	102, 000	1	0	3. 01
3. 02	ADJUSTIMENTS TO TROVIDER	03/22/2010	102,000			3. 02
3. 03						3. 03
3. 04						3. 04
3. 05			Ò			3. 05
0.00	Provider to Program			1		0.00
3.50	ADJUSTMENTS TO PROGRAM		(		0	3. 50
3. 51			(		l ol	3. 51
3.52			(		0	3. 52
3.53			(		0	3. 53
3.54			(	)	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		102, 000	)	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 285, 57		2, 524, 040	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
5. 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		(		0	5. 01
5. 02			(		0	5. 02
5.03			(		0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		(	)	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
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER		58, 863		169, 822	6. 01
6. 01	SETTLEMENT TO PROGRAM		38, 803		109, 822	6. 02
7. 00	Total Medicare program liability (see instructions)		2, 344, 434	1	2, 693, 862	7. 00
7.00	Tiotal medicale program frability (see histructions)		2, 344, 434	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	•	•		•	. '	

		Component	JCN. 15-2305 1	0 09/30/2010	4/21/2017 3: 3	
		Title	XVIII Sv	ving Beds - SNF		
			t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
4 00	T+ , , , , , , , , , , , , , , , , , , ,	1.00	2.00	3. 00	4. 00	4 00
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either		1, 532, 014 0		0	1. 00 2. 00
2.00	submitted or to be submitted to the contractor for		U		ا ا	2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	03/22/2016	68, 400		0	3. 01
3. 02			0		0	3. 02
3. 03 3. 04			0		0	3. 03 3. 04
3. 04			0		0	3. 04
3.03	Provider to Program				U	3.03
3. 50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			Ö		ol	3. 51
3.52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		68, 400		0	3. 99
4 00	3. 50-3. 98)		4 (00 44 4			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		1, 600, 414		0	4. 00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR	l				
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5. 03	Dravi dan ta Dragnam		0		0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM		0		0	5. 50
5. 51	TENTATIVE TO PROGRAW		0		0	5. 50
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)		_		-	
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		25, 579		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 625, 993		0	7. 00
				Contractor Number	NPR Date	
			 )	1. 00	(Mo/Day/Yr) 2.00	
8.00	Name of Contractor			1.00	2.00	8. 00
		1		1	' '	

Heal th	Financial Systems PULASKI	MEMORI AL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-1305	Peri od: From 10/01/2015 To 09/30/2016		pared: 7 pm
			Title XVIII	Hospi tal	Cost	
					1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST RE					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CAL					
1. 00	Total hospital discharges as defined in AARA §4102 fr			2 14	583	1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of li		12		1, 100	
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line				76	3. 00
4. 00	Total inpatient days from S-3, Pt. I col. 8 sum of li	nes 1, 8-	12		1, 988	4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 lin	ne 200			60, 319, 328	5. 00
6.00	Total hospital charity care charges from Wkst. S-10,	col. 3 li	ne 20		396, 501	6. 00
7. 00	CAH only - The reasonable cost incurred for the purch line 168	nase of ce	rtified HIT technology	Wkst. S-2, Pt. I	0	7. 00
8.00	Calculation of the HIT incentive payment (see instruc	ctions)			0	8. 00
9.00	Sequestration adjustment amount (see instructions)				0	9. 00
10.00	Calculation of the HIT incentive payment after seques	stration (	see instructions)		0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructi	ons)			0	30.00
31.00	Other Adjustment (specify)				0	31.00
22 00	Dalance due provider (line 0 (or line 10) minus line	20 and 1:	no 21) (coo i notruoti on	)		22 00

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

0 30.00 0 31.00 0 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		Worksheet E-2
		Component CCN, 1E 720E	From 10/01/2015	
		Component CCN: 15-Z305	10 09/30/2016	4/21/2017 3:37 pm
		Title XVIII	Swing Reds - SNE	Cost

				4/21/2017 3:3	7 pm
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1, 270, 566	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 Part A,	and sum of Wkst. D,	404, 127	0	3. 00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instruc				
4.00	Per diem cost for interns and residents not in approved teaching p	rogram (see		0.00	4. 00
	instructions)				
5.00	Program days		957	0	5. 00
6.00	Interns and residents not in approved teaching program (see instru	ctions)		0	6. 00
7.00	Utilization review - physician compensation - SNF optional method	onl y	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1, 674, 693	0	8. 00
9.00	Primary payer payments (see instructions)		0	0	9. 00
10.00	Subtotal (line 8 minus line 9)		1, 674, 693	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable	to physician	0	0	11. 00
	professional services)				
12.00	Subtotal (line 10 minus line 11)		1, 674, 693	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (ex	cl ude coi nsurance	15, 516	0	13.00
	for physician professional services)				
	80% of Part B costs (line 12 x 80%)			0	00
	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		1, 659, 177	0	15. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16. 00
	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	16. 50
	410A RURAL DEMONSTRATION PROJECT		0		16. 55
	Allowable bad debts (see instructions)		0	0	
	Adjusted reimbursable bad debts (see instructions)		0	0	17. 01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructi	ons)	0	0	18. 00
19.00	Total (see instructions)		1, 659, 177	0	19. 00
19. 01	Sequestration adjustment (see instructions)		33, 184	0	19. 01
20.00	Interim payments		1, 600, 414	0	20. 00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 2	1)	25, 579	0	22. 00
23.00	Protested amounts (nonallowable cost report items) in accordance w	ith CMS Pub. 15-2,	0	0	23. 00
	chapter 1, §115.2				

Health Financial Systems	PULASKI MEMO	RIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWI NG BEDS	Provider CCN: 15-1305	Peri od:	Worksheet E-2
		Component CCN: 15-Z305		Date/Time Prepared:
		T	0 1 0 1 015	4/21/2017 3: 37 pm

		mporterre 3014. 13 2000	10 077 007 2010	4/21/2017 3:3	
		Title XIX	Swing Beds - SNF	PPS	
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0		1. 00
2.00	Inpatient routine services - swing bed-NF (see instructions)		0		2. 00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A,		0		3. 00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instru				
4.00	Per diem cost for interns and residents not in approved teaching	program (see	0.00		4. 00
	instructions)				
5.00	Program days		0		5. 00
6.00	Interns and residents not in approved teaching program (see instr		0		6. 00
7.00	Utilization review - physician compensation - SNF optional method	l only	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0		8. 00
9.00	Primary payer payments (see instructions)		0		9. 00
10.00	Subtotal (line 8 minus line 9)		0		10. 00
11. 00		e to physician	0		11. 00
	professional services)				
	Subtotal (line 10 minus line 11)		0		12. 00
13.00	3.00 Coinsurance billed to program patients (from provider records) (exclude coinsurance				13. 00
	for physician professional services)				
	80% of Part B costs (line 12 x 80%)		0		14. 00
	5.00 Subtotal (enter the lesser of line 12 minus line 13, or line 14)		0		15. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		16. 00
	Pioneer ACO demonstration payment adjustment (see instructions)		0		16. 50
16. 55	410A RURAL DEMONSTRATION PROJECT		0		16. 55
17. 00	Allowable bad debts (see instructions)		0		17. 00
17. 01	Adjusted reimbursable bad debts (see instructions)		0		17. 01
18. 00	Allowable bad debts for dual eligible beneficiaries (see instruct	i ons)	0		18. 00
19.00	Total (see instructions)				19. 00
19. 01	Sequestration adjustment (see instructions)				19. 01
20.00	Interim payments				20. 00
21.00	Tentative settlement (for contractor use only)				21. 00
22. 00	00 Balance due provider/program (line 19 minus lines 19.01, 20, and 21)				22. 00
23.00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	0		23. 00
	chapter 1, §115.2				

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lie	ս of Form CMS-2	!552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1305	Peri od: From 10/01/2015 To 09/30/2016	Worksheet E-3 Part V Date/Time Prep 4/21/2017 3:37	
		Title XVIII	Hospi tal	Cost	
				1. 00	
PART V - CALCULATION OF REIMBURSEMENT SI	ETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REIMBURSEMENT		
.00 Inpatient services				2, 615, 813	1.00
2.00 Nursing and Allied Health Managed Care payment (see instructions)				0	2. 00
3 00 Organ acquisition	-			اه	3 00

	Title XVIII Hospital	0031	
		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT	1.00	
1.00	Inpatient services	2, 615, 813	1. 00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	2,013,013	2. 00
3.00	Organ acqui si ti on	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2, 615, 813	4.00
5.00	Primary payer payments	2,013,013	5. 00
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)	2, 641, 971	6.00
0.00	COMPUTATION OF LESSER OF COST OR CHARGES	2,041,771	0.00
	Reasonable charges		
7.00	Routi ne servi ce charges	0	7. 00
8.00	Ancillary service charges	l ol	8.00
9. 00	Organ acquisition charges, net of revenue	0	9. 00
10. 00	Total reasonable charges	l ol	10.00
	Customary charges		10.00
11. 00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11. 00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis	o	12.00
	had such payment been made in accordance with 42 CFR 413.13(e)		1
13.00		0. 000000	13.00
14. 00	Total customary charges (see instructions)	0	14.00
15. 00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see	o	15. 00
	instructions)		l
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see	0	16.00
	instructions)		l
17. 00		0	17. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		l
18. 00		0	18. 00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)	2, 641, 971	
20. 00		281, 510	
21. 00	Excess reasonable cost (from line 16)	0	21.00
22. 00	,		
23. 00	Coi nsurance	644	
24. 00		2, 359, 817	
25. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	49, 943	25.00
26. 00	Adjusted reimbursable bad debts (see instructions)	32, 463	
27. 00	5 · · · · · · · · · · · · · · · · · · ·	39, 172	
28. 00		2, 392, 280	28.00
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29. 50
29. 99	Recovery of Accelerated Depreciation	0	29. 99
30.00	Subtotal (see instructions)	2, 392, 280	
30. 01	Sequestration adjustment (see instructions)	47, 846	
31.00		2, 285, 571	
32. 00	Tentative settlement (for contractor use only)	0	32.00
33. 00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	58, 863	
34.00		0	34.00
	§115. 2		I

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-3 Part VII Date/Time Prepared: 4/21/2017 3:37 pm

				4/21/2017 3:3	7 pm
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		130, 075		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)		130, 075	0	4.00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6, 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		130, 075	0	7. 00
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		1007070		7.00
	Reasonable Charges				
8.00	Routi ne servi ce charges		41, 521		8. 00
9. 00	Ancillary service charges		209, 056	0	9. 00
10.00	Organ acquisition charges, net of revenue		207, 030	O	10.00
11. 00	Incentive from target amount computation				11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		250, 577	0	12. 00
12.00	CUSTOMARY CHARGES		230, 377	0	12.00
13. 00	Amount actually collected from patients liable for payment for	s corvi cos en a charge	O	0	13. 00
13.00	basis	services on a charge	١	U	13.00
14. 00	Amounts that would have been realized from patients liable for	r navment for services on	0	0	14. 00
14.00	a charge basis had such payment been made in accordance with		٩	Ü	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	42 CIR 9413. 13(e)	0. 000000	0.000000	15. 00
16. 00	Total customary charges (see instructions)		250, 577	0.000000	16. 00
17. 00	Excess of customary charges over reasonable cost (complete onl	vifling 16 avegads	120, 502	0	17. 00
17.00	line 4) (see instructions)	Ty IT TITLE TO exceeds	120, 302	Ü	17.00
18. 00	Excess of reasonable cost over customary charges (complete onl	v if line 1 exceeds line	o	0	18. 00
10.00	16) (see instructions)	Ty IT TITLE 4 exceeds Title	٩	Ü	10.00
19. 00	Interns and Residents (see instructions)		0	0	19. 00
	Cost of physicians' services in a teaching hospital (see insti	cuctions)		0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line		130, 075	0	
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			0	21.00
22. 00	Other than outlier payments	compreted for 113 provide	0	0	22. 00
	Outlier payments		o o	0	23. 00
	Program capital payments		o o	O	24. 00
	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	26. 00
	Subtotal (sum of lines 22 through 26)			0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)			0	28.00
	Titles V or XIX (sum of lines 21 and 27)		130, 075	0	29. 00
29.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		130, 073	U	29.00
30. 00	Excess of reasonable cost (from line 18)		O	0	30.00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		130, 075	0	31.00
	Deductibles	)	130, 0/5	0	31.00
			0		
33.00			١	0	33.00
	Allowable bad debts (see instructions)		0	0	34.00
35. 00			0		35. 00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		130, 075	0	36. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
	Subtotal (line 36 ± line 37)		130, 075	0	38. 00
			39. 00		
	Total amount payable to the provider (sum of lines 38 and 39)		130, 075	0	40. 00
41. 00	Interim payments		89, 145	0	41. 00
42. 00	Balance due provider/program (line 40 minus line 41)		40, 930	0	42. 00
43.00				43. 00	
	chapter 1, §115.2				l

Health Financial Systems

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

Provider CCN: 15-1305

Peri od: Worksheet G From 10/01/2015 To 09/30/2016 Date/Time Prepared:

onl y)			'	0 09/30/2016	4/21/2017 3:3	
		General Fund	Speci fi c	Endowment Fund		
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS		-	TT	_	
1.00	Cash on hand in banks	2, 889, 797	() C	0	0	1.00
2. 00 3. 00	Temporary i nvestments Notes receivable			_	0	2. 00 3. 00
4. 00	Accounts receivable	8, 759, 938	1	0	0	4.00
5. 00	Other recei vabl e	0,707,700	ol o	Ö	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-4, 372, 635		Ö	0	6. 00
7.00	Inventory	371, 731	c	0	0	7. 00
8.00	Prepai d expenses	65, 511	1	0	0	8. 00
9. 00	Other current assets	3, 092, 256	1	0	0	9. 00
10.00	Due from other funds	0	0		0	10.00
11. 00	Total current assets (sum of lines 1-10)	10, 806, 598	3 <u> </u>	0	0	11. 00
12. 00	FI XED ASSETS Land	195, 525	il c	ol	0	12. 00
13. 00	Land improvements	432, 594		_	0	13.00
14. 00	Accumul ated depreciation	-330, 024	1		0	14. 00
15. 00	Bui I di ngs	10, 748, 465	1	Ö	0	15. 00
16.00	Accumulated depreciation	-6, 532, 227	' C	0	0	16. 00
17. 00	Leasehold improvements	187, 056	1	0	0	17. 00
18. 00	Accumul ated depreciation	-163, 953	1		0	18. 00
19. 00	Fi xed equipment	5, 714, 668		_	0	19.00
20.00	Accumulated depreciation Automobiles and trucks	-3, 887, 105		0	0	20.00
21. 00 22. 00	Accumul ated depreciation			0	0	21. 00 22. 00
23. 00	Major movable equipment	9, 262, 345		0	0	23. 00
24. 00	Accumulated depreciation	-6, 902, 895	1	Ö	Ö	24. 00
25. 00	Mi nor equi pment depreci able	0		Ö	0	25. 00
26.00	Accumulated depreciation	0	) c	0	0	26. 00
27. 00	HIT designated Assets	0	) c	0	0	27. 00
28. 00	Accumulated depreciation	0	) c	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0 704 440			0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)  OTHER ASSETS	8, 724, 449	<u>C</u>	0	0	30. 00
31. 00	Investments	0	) C	ol	0	31.00
32. 00	Deposits on Leases				0	32. 00
33. 00	Due from owners/officers	O		Ö	0	33. 00
34.00	Other assets	2, 637, 586	o c	О	0	34.00
35.00	Total other assets (sum of lines 31-34)	2, 637, 586	1	_	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	22, 168, 633	3 <u> </u> C	0	0	36. 00
27.00	CURRENT LIABILITIES	1 50/ 171			0	1 27 00
37. 00 38. 00	Accounts payable Salaries, wages, and fees payable	1, 586, 171 1, 669, 185	1	0	0	37. 00 38. 00
39. 00	Payroll taxes payable	1,009,100		0	0	39.00
40. 00	Notes and Loans payable (short term)	681, 281		o	0	40.00
41.00	Deferred income	O		O	0	41.00
42.00	Accel erated payments	0				42. 00
43.00	Due to other funds	0	) c	0	0	43. 00
44. 00	Other current liabilities	111, 071			0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	4, 047, 708	3  C	0	0	45. 00
46. 00	LONG TERM LIABILITIES  Mortgage payable	0		ol	0	46. 00
47. 00	Notes payable	5, 399, 191	1	_	0	47. 00
48. 00	Unsecured Loans	0,077,171			Ö	48. 00
49. 00	Other long term liabilities	818, 734		Ö	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	6, 217, 925	5 C	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	10, 265, 633	3 C	0	0	51.00
	CAPI TAL ACCOUNTS					
52. 00	General fund balance	11, 903, 000				52.00
53. 00 54. 00	Specific purpose fund Donor created - endowment fund balance - restricted		C	0		53. 00 54. 00
55. 00	Donor created - endowment fund balance - restricted			0		55.00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant				0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansion					
59.00	Total fund balances (sum of lines 52 thru 58)	11, 903, 000		0	0	59.00
60. 00	Total liabilities and fund balances (sum of lines 51 and	22, 168, 633	S C	0	0	60.00
	[59]	I	I	ı I	l	I

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-1305

					To 09/30/2016	Date/Time Prep 4/21/2017 3:3	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	•
		1.00	2. 00	3.00	4. 00	5. 00	
1.00	Fund balances at beginning of period		9, 579, 423		0		1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		2, 323, 577 11, 903, 000		0		2. 00 3. 00
4. 00	Additions (credit adjustments) (specify)	o	11, 703, 000		0	0	4. 00
5.00	, , , , , , , , , , , , , , , , , , ,	0			0	0	5. 00
6.00		0			0	0	6. 00
7.00		0			0	0	7. 00
8. 00 9. 00					0	0	8. 00 9. 00
10. 00	Total additions (sum of line 4-9)		0		0	ŭ	10. 00
11.00	Subtotal (line 3 plus line 10)		11, 903, 000		0		11. 00
12.00	Deductions (debit adjustments) (specify)	0			0	0	12.00
13.00		0			0	0	13.00
14. 00 15. 00		0			0	0	14. 00 15. 00
16. 00					0	0	16. 00
17. 00		O			Ö	Ö	17. 00
18. 00	Total deductions (sum of lines 12-17)		0		0		18. 00
19. 00	Fund balance at end of period per balance		11, 903, 000		0		19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
1.00	Is a contract to the contract	6.00	7. 00	8. 00			1.00
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	0			0		1. 00 2. 00
3. 00	Total (sum of line 1 and line 2)	o			0		3. 00
4.00	Additions (credit adjustments) (specify)		0				4. 00
5.00			0				5. 00
6.00			0				6. 00
7. 00 8. 00			0				7. 00 8. 00
9. 00			0				9. 00
10.00	Total additions (sum of line 4-9)	O			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 14. 00		1	0				13. 00 14. 00
15. 00			0				15. 00
16.00			0				16. 00
17. 00			0				17. 00
18.00	Total deductions (sum of lines 12-17)	0			0		18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)				U .		19. 00
	12 (	1 1		1	Ti .		

Health Financial Systems FATTEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-1305

			To	09/30/2016	Date/Time Prep 4/21/2017 3:3	
	Cost Center Description	Inpatien	t	Outpati ent	Total	, p
		1.00		2, 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal	2, 107,	759		2, 107, 759	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)	2, 107,	759		2, 107, 759	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 lin	es	0		0	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2, 107,	759		2, 107, 759	17.00
18.00	Ancillary services	10, 616,	256	38, 536, 370	49, 152, 626	18.00
19.00	Outpatient services	166,	845	8, 101, 454	8, 268, 299	19.00
20.00	RURAL HEALTH CLINIC		0	o	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	o	0	21.00
22. 00	HOME HEALTH AGENCY			786, 188	786, 188	22.00
23.00	AMBULANCE SERVICES					23.00
24.00	CMHC					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P. )					25.00
26.00	HOSPI CE		0	4, 456	4, 456	26.00
27.00	HCC SERVICES		0	o	0	27.00
27. 01	PHSYCI SI AN SERVI CES		369	2, 147, 145	2, 147, 514	27. 01
27. 02	PRO FEES	304,	305	455	304, 760	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	Wkst. 13, 195,	534	49, 576, 068	62, 771, 602	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			31, 521, 461		29. 00
30.00	ADD (SPECIFY)		0			30.00
31. 00			0			31. 00
32.00			0			32.00
33.00			0			33.00
34.00			0			34.00
35.00			0			35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECIFY)		0			37.00
38. 00			0			38. 00
39. 00			0			39. 00
40.00			0			40.00
41.00			0			41.00
42.00	Total deductions (sum of lines 37-41)			o		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(t	ransfer		31, 521, 461		43.00
	to Wkst. G-3, line 4)			l		

llool +h	Financial Systems PULASKI MEMORIAL	LIOCOLTAL	la li o	u of Form CMS-2	DEE2 10
	Financial Systems PULASKI MEMORIAL ENT OF REVENUES AND EXPENSES	Provider CCN: 15-1305	Peri od:	Worksheet G-3	2552-10
			From 10/01/2015 To 09/30/2016		
	<u> </u>			1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin			62, 771, 602	1. 00
2.00	Less contractual allowances and discounts on patients' accoun	nts		30, 066, 786	
3.00	Net patient revenues (line 1 minus line 2)			32, 704, 816	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		31, 521, 461	
5.00	Net income from service to patients (line 3 minus line 4)			1, 183, 355	5. 00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	
7.00	Income from investments			0	
8.00	Revenues from telephone and other miscellaneous communication	n servi ces		0	
9.00	Revenue from television and radio service			0	
10. 00	Purchase di scounts			0	
11. 00	Rebates and refunds of expenses			0	11. 00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	
15. 00	Revenue from rental of living quarters				15. 00
16.00	Revenue from sale of medical and surgical supplies to other t	han patients			16. 00
	Revenue from sale of drugs to other than patients				17. 00
18. 00	Revenue from sale of medical records and abstracts				
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
21. 00	Rental of vending machines			0	21. 00
22.00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			0	23.00
24.00	OTHER INCOME			984, 171	24.00
24. 01	NON OP			156, 051	24. 01
25.00	Total other income (sum of lines 6-24)			1, 140, 222	25. 00
26.00	Total (line 5 plus line 25)			2, 323, 577	26. 00
27.00	OTHER EXPENSES (SPECIFY)			0	27. 00
28.00	Total other expenses (sum of line 27 and subscripts)			0	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 28)			2, 323, 577	29. 00

Heal th	Financial Systems		PULASKI MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	LLOCATION - HHA GENERAL SERVICE	COST		Provider Co	CN: 15-1305	Peri od: From 10/01/2015	Worksheet H-1 Part I	
				HHA CCN:	15-7078	To 09/30/2016	Date/Time Pre	
						Home Health	4/21/2017 3: 3 PPS	/ pm
						Agency I		
			Capital Rela	ated Costs				
		Net Expenses	BI dgs &	Movabl e	PI ant	Transportati on	Subtotal	
		for Cost	Fi xtures	Equi pment	Operation 8		(cols. 0-4)	
		Allocation (from Wkst. H,			Mai ntenance			
		col . 10)					_	
	GENERAL SERVICE COST CENTERS	0	1.00	2. 00	3. 00	4. 00	4A. 00	
1.00	Capital Related - Bldg. &	0	0				0	1. 00
2 00	Fixtures	0		0			0	2 00
2. 00	Capital Related - Movable Equipment			U			0	2. 00
3.00	Plant Operation & Maintenance	0	O	0		0	0	3. 00
4. 00 5. 00	Transportation Administrative and General	0 139, 706	0	0		0 0	139, 706	4. 00 5. 00
3.00	HHA REIMBURSABLE SERVICES	137,700	<u> </u>			0 0	137,700	3.00
6.00	Skilled Nursing Care	273, 417	0	0		0 0	273, 417	
7. 00 8. 00	Physical Therapy Occupational Therapy	55, 438 12, 877	0	0	•	0 0	55, 438 12, 877	
9. 00	Speech Pathology	4, 683	0	0		0 0	4, 683	
10.00	Medical Social Services Home Health Aide	122 010	0	0		0 0	0 122, 910	
11. 00 12. 00	Supplies (see instructions)	122, 910	0	0			122, 910	11. 00 12. 00
13.00	Drugs	0	0	0		0	0	13. 00
14. 00	HHA NONREI MBURSABLE SERVI CES	0	0	0		0 0	0	14. 00
15. 00	Home Dialysis Aide Services	0	0	0		0 0	0	15. 00
16.00	Respiratory Therapy	0	0	0	1	0 0	0	
17. 00 18. 00	Private Duty Nursing Clinic	0	0	0		0 0	0   0	17. 00 18. 00
19. 00	Health Promotion Activities	0	o	Ō		0 0	0	19. 00
20.00	1 3	0	0	0		0 0	0	20.00
21. 00 22. 00	Home Delivered Meals Program Homemaker Service	0	0	0		0 0	0 0	21. 00 22. 00
23. 00	All Others (specify)	0	Ō	0		0 0	0	23. 00
23. 50	Telemedicine Total (sum of lines 1-23)	0 609, 031	0	0	•	0 0	0 609, 031	23. 50 24. 00
24.00	Total (Suil of Titles 1-23)	Admi ni strati ve	Total (cols.			0 0	007, 031	24.00
		& General	4A + 5)					
	GENERAL SERVICE COST CENTERS	5. 00	6. 00					
1.00	Capital Related - Bldg. &							1. 00
2. 00	Fixtures Capital Related - Movable							2. 00
2.00	Equi pment							2.00
3. 00 4. 00	Plant Operation & Maintenance Transportation							3. 00 4. 00
5. 00	Administrative and General	139, 706						5. 00
	HHA REIMBURSABLE SERVICES	1						
6. 00 7. 00	Skilled Nursing Care Physical Therapy	81, 390 16, 502	354, 807 71, 940					6. 00 7. 00
8. 00	Occupational Therapy	3, 833	16, 710					8. 00
9.00	Speech Pathology	1, 394	6, 077					9.00
10. 00 11. 00	Medical Social Services Home Health Aide	0 36, 587	0 159, 497					10. 00 11. 00
12. 00	Supplies (see instructions)	0	0					12. 00
13. 00 14. 00	Drugs DME	0 0	0					13. 00 14. 00
14.00	HHA NONREI MBURSABLE SERVI CES	0	U <sub>L</sub>					14.00
15. 00	Home Dialysis Aide Services	0	0					15. 00
16. 00 17. 00	Respiratory Therapy Private Duty Nursing	0	0					16. 00 17. 00
18. 00	Clinic	0	o					18. 00
19.00	Health Promotion Activities	0	0					19. 00
20. 00 21. 00	Day Care Program Home Delivered Meals Program	0	0					20. 00 21. 00
22. 00	Homemaker Service	Ö	0					22. 00
23.00	All Others (specify)	0	0					23.00
	Telemedicine Total (sum of lines 1-23)	0	0 609, 031					23. 50 24. 00
2 00	1.11. (34 3. 11103 1 20)	1	307, 001					00

llool +b	Financial Customs		DIII ACKI MEMODI	I AL LIOCOLTAL		la li a	u of Form CMC (	DEE2 10
	Financial Systems LLOCATION - HHA STATISTICAL BAS	21.0	PULASKI MEMOR	Provider C	^N: 15 12∩5	Peri od:	u of Form CMS-2 Worksheet H-1	2552-10
C031 A	ELUCATION - THIA STATISTICAL DAS	51 3		HHA CCN:	15-7078	From 10/01/2015 To 09/30/2016	Part II	
						Home Health Agency I	PPS	7 рііі
		Canital Rel	ated Costs			Agency I		
		oup tur no	4104 00313					
		BI dgs &	Movabl e	PI ant	Transportati	onReconciliation	Admi ni strati ve	
		Fi xtures	Equi pment	Operation &	(MI LEAGE)		& General	
		(SQUARE FEET)	(DOLLAR VALUE)	Mai ntenance			(ACCUM. COST)	
				(SQUARE FEET)				
		1.00	2. 00	3. 00	4. 00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1		1	1			
1. 00	Capital Related - Bldg. &	0				0		1. 00
2. 00	Fixtures Capital Related - Movable		0			0		2. 00
2.00	Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	1	0	0		0		3. 00
4. 00	Transportation (see		0			0		4. 00
4.00	instructions)			Ĭ				4.00
5.00	Administrative and General	l 0	0	0		0 -139, 706	469, 325	5.00
	HHA REIMBURSABLE SERVICES	•		•	•			
6.00	Skilled Nursing Care	0	0	0		0 0	273, 417	6.00
7.00	Physi cal Therapy	0	0	0		0 0	55, 438	7. 00
8.00	Occupational Therapy	0	0	0		0 0	12, 877	8. 00
9.00	Speech Pathology	0	0	0		0 0	4, 683	9. 00
10.00	Medical Social Services	0	0	0		0 0	0	10. 00
11. 00	Home Health Aide	0	0	0		0 0	122, 910	
12.00	Supplies (see instructions)	0	0	0		0 0	0	
13.00	Drugs	0	0	0		0	0	
14.00	DME	0	0	0		0 0	0	14. 00
	HHA NONREI MBURSABLE SERVI CES	T	T	Г	T	T		
15. 00	Home Dialysis Aide Services	0	0			0 0	0	1 .0.00
16.00	Respiratory Therapy	0	0	0		0 0	0	1
17. 00	Private Duty Nursing	0	0	0		0 0	0	1
18.00	Clinic	0	0	0		0 0	0	
19. 00	Health Promotion Activities	0	0	0		0	0	
20. 00 21. 00	Day Care Program Home Delivered Meals Program	0	0	0		0	0	
21.00	Homemaker Service	0	0	0		0	0	
23. 00	All Others (specify)		0			0 0	0	
23. 50	Telemedicine		0			0 0	0	
24. 00	Total (sum of lines 1-23)		0			0 -139, 706	469, 325	
25. 00	Cost To Be Allocated (per	1 0		١		0 137, 700	139, 706	•
_0.00	Worksheet H-1, Part I)					-	.57,700	=0.00
26. 00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0. 0000	00	0. 297674	26. 00

Peri od: Worksheet H-2
From 10/01/2015 Part I
Date/Time Prepared: 4/21/2017 3: 37 pm HHA CCN: 15-7078 Home Health PPS

						Agency I	PPS	
			CAPITAL			rigency :		
	Cost Center Description	HHA Trial	RELATED COSTS  NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	OPERATION OF	
	·	Bal ance (1)	FLXT	BENEFITS		& GENERAL	PLANT	
		0	1.00	DEPARTMENT 4.00	4A	5. 00	7. 00	
1. 00	Administrative and General	0		177, 506	186, 275		11, 138	1. 00
2.00	Skilled Nursing Care	354, 807		0	354, 807		0	2. 00
3.00	Physi cal Therapy	71, 940	1	0	71, 940		0	3. 00
4.00	Occupational Therapy	16, 710		0	16, 710		0	4. 00
5. 00 6. 00	Speech Pathology Medical Social Services	6, 077	0	0	6, 077	1, 224	0	5. 00 6. 00
7. 00	Home Heal th Aide	159, 497	0	0	159, 497	32, 133	0	7. 00
8. 00	Supplies (see instructions)	0	O	Ö	0	0	Ö	8. 00
9. 00	Drugs	0	0	0	0	0	0	9. 00
10.00	DME	0	0	0	0	0	0	10.00
11. 00 12. 00	Home Dialysis Aide Services Respiratory Therapy	0	0	0	0	0	0	11. 00 12. 00
13. 00	Private Duty Nursing	0		0	0	0	o	13. 00
14.00	Clinic	0	O	0	0	0	0	14. 00
15. 00	Health Promotion Activities	0	0	0	0	0	0	15. 00
16. 00 17. 00	Day Care Program Home Delivered Meals Program	0	0	0	0	0	0	16. 00 17. 00
18. 00	Homemaker Service	0	0	0	0	0	0	18. 00
19. 00	All Others (specify)	0	o	0	0	0	Ō	19. 00
19. 50		0	0	0	0	0	0	19. 50
20. 00 21. 00	Total (sum of lines 1-19) (2)	609, 031	8, 769	177, 506	795, 306		11, 138	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum				0. 000000			21. 00
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.  Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	CENTRAL	PHARMACY	
		LINEN SERVICE			ADMI NI STRATI ON			
		8. 00	9.00	10.00	13. 00	SUPPLY 14. 00	15. 00	
1. 00	Administrative and General	8.00	9. 00 3, 382	10.00	13.00	14. 00	15. 00 0	1. 00
2.00	Skilled Nursing Care		3, 382 0	0 0		14. 00 0	0 0	2. 00
2. 00 3. 00	Skilled Nursing Care Physical Therapy		3, 382	0	0	14. 00 0	0 0 0	2. 00 3. 00
2. 00 3. 00 4. 00	Skilled Nursing Care Physical Therapy Occupational Therapy		3, 382 0	0 0	0	14. 00 0	0 0 0 0	2. 00 3. 00 4. 00
2. 00 3. 00	Skilled Nursing Care Physical Therapy		3, 382 0	0 0	0	14. 00 0	0 0 0	2. 00 3. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide		3, 382 0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0	14. 00 0 0 0 0 0 0	0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)		3, 382 0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0	14. 00 0 0 0 0 0 0 0	0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs		3, 382 0 0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0 0	14. 00 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)		3, 382 0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0	14. 00 0 0 0 0 0 0 0 0	0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy		3, 382 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0 0	14. 00 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing		3, 382 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0 0	14. 00 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	0 0 0 0 0 0 0 0 0 0	3, 382 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	14. 00 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing		3, 382 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	14. 00 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	0 0 0 0 0 0 0 0 0 0	3, 382 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	14. 00 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	0 0 0 0 0 0 0 0 0 0 0	3, 382 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	14. 00 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	0 0 0 0 0 0 0 0 0 0 0	3, 382 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	14. 00 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	0 0 0 0 0 0 0 0 0 0 0	3, 382 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	14. 00 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	0 0 0 0 0 0 0 0 0 0 0	3, 382 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	14. 00 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 19. 50 20. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	0 0 0 0 0 0 0 0 0 0 0	3, 382 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	14. 00 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 19. 50 20. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus	0 0 0 0 0 0 0 0 0 0 0	3, 382 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	14. 00 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 19. 50 20. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	0 0 0 0 0 0 0 0 0 0 0	3, 382 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	14. 00 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00

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

7, 529

	or column 26, line 20 minus				
	column 26, line 1, rounded to				
	6 decimal places.				
	Cost Center Description	Total HHA			
		Costs			
		28. 00			
1.00	Administrative and General				1. 00
2.00	Skilled Nursing Care	569, 518			2. 00
3.00	Physi cal Therapy	115, 473			3. 00
4.00	Occupati onal Therapy	26, 821			4. 00
5.00	Speech Pathology	9, 754			5. 00
6.00	Medical Social Services	0			6. 00
7.00	Home Health Aide	256, 015			7. 00
8.00	Supplies (see instructions)	0			8. 00
9.00	Drugs	0			9. 00
10.00	DME	0			10.00
11.00	Home Dialysis Aide Services	0			11. 00
12.00	Respiratory Therapy	0			12. 00
13.00	Private Duty Nursing	0			13. 00
14.00	Clinic	0			14. 00
15.00	Health Promotion Activities	0			15. 00
16.00	Day Care Program	0			16. 00
17.00	Home Delivered Meals Program	0			17. 00
18.00	Homemaker Service	0			18. 00
19.00	All Others (specify)	0			19. 00
19. 50	Tel emedi ci ne	0			19. 50
20.00	Total (sum of lines 1-19) (2)	977, 581			20.00
21.00	Unit Cost Multiplier: column				21. 00
	26, line 1 divided by the sum				
	of column 26, line 20 minus				
	column 26, line 1, rounded to				
	6 decimal places.				[

977, 581

977, 581

245, 852

0. 335988

20.00

21.00

Total (sum of lines 1-19) (2)

Unit Cost Multiplier: column

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

20.00

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

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS	HHA COST CENTERS STATISTICAL	Provider CCN: 15-1305	Peri od:	Worksheet H-2
BASIS		HHA CCN: 15-7078	From 10/01/2015 To 09/30/2016	Part II   Date/Time Prepared:
		10 7070		4/21/2017 3: 37 pm

Home Health Agency I CAPI TAL RELATED COSTS **EMPLOYEE** Reconciliation ADMINISTRATIVE OPERATION OF LAUNDRY & Cost Center Description NEW BLDG & LINEN SERVICE FIXT **BENEFITS** & GENERAL PI ANT (SQUARE DEPARTMENT (ACCUM. (SQUARE (POUNDS OF FEET) (GROSS COST) FEET) LAUNDRY) SALARI ES) 1.00 5A 5.00 7. 00 8. 00 4.00 524 1.00 Administrative and General 510, 764 C 186, 275 524 1.00 2.00 Skilled Nursing Care 0 354, 807 2.00 3.00 Physical Therapy 0 0 0 71, 940 3.00 0 Occupational Therapy 0 0000000000 4.00 0 16,710 4.00 0 0 6,077 5.00 Speech Pathology 5.00 6.00 Medical Social Services 0 0 0 0 0 0 0 0 6.00 0 7.00 Home Health Aide 159, 497 7.00 0 8.00 8.00 Supplies (see instructions) 0 0 0 9.00 Drugs C 0 9.00 10.00 DMF 10.00 0 11.00 Home Dialysis Aide Services 0 0 11.00 0 0 12.00 Respiratory Therapy 0 12.00 0 13.00 Private Duty Nursing 0 13.00 0 0 14.00 Clinic 0 0 0 0 0 0 14.00 0 15.00 Health Promotion Activities 0 15.00 0 16.00 Day Care Program 16.00 17.00 Home Delivered Meals Program 0 0 0 0 0 0 17.00 0 Homemaker Service 0 18.00 18.00 0 0 19.00 All Others (specify) 19.00 19.50 Tel emedi ci ne 0 0 0 0 19.50 Total (sum of lines 1-19) 795, 306 20.00 524 510, 764 524 20.00 21.00 Total cost to be allocated 8.769 177, 506 160, 226 11, 138 21.00 16. 734733 0. 347530 21. 255725 0.000000 22.00 Unit cost multiplier 0. 201465 22.00 Cost Center Description HOUSEKEEPI NG DI ETARY NURSI NG CENTRAL PHARMACY MEDI CAL (SQUARE (MEALS ADMI NI STRATI ON SERVICES & (100%)RECORDS & FEET) SERVED) SUPPLY LI BRARY (GROSS (DI RECT (100%)NRSING HRS) CHARGES) 14.00 9.00 10.00 13.00 15.00 16.00 1.00 Administrative and General 524 786, 188 1. 00 0 2.00 Skilled Nursing Care 0 000000000000000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 2.00 0 0 Physical Therapy 0 3.00 3 00 O 0 4.00 Occupational Therapy 0 4.00 5.00 Speech Pathology 0 0 5.00 0 6.00 Medical Social Services 0 0 6 00 O 0 7.00 Home Heal th Aide 0 7.00 8.00 Supplies (see instructions) 0 0 8.00 Drugs 0 0 9.00 0 9.00 0 0 DMF Ω 10 00 10.00 Home Dialysis Aide Services 11.00 0 11.00 Respiratory Therapy 0 0 12.00 12.00 13.00 Private Duty Nursing 0 0 0 0 0 13.00 0 14.00 0 14.00 Clinic 0 15.00 Health Promotion Activities 0 15.00 Day Care Program 16.00 16.00 Home Delivered Meals Program 0 0 0 17.00 17.00 0 18.00 Homemaker Service 0 18.00 0 19.00 All Others (specify) 0 0 0 0 19.00 19.50 Tel emedi ci ne 0 0 C 0 0 19.50 Total (sum of lines 1-19) 0 0 0 786, 188 20.00 20.00 524 C 21.00 Total cost to be allocated 3.382 7, 529 21.00 6. 454198 22.00 Unit cost multiplier 0.000000 0.000000 0.000000 0.000000 0.009577 22.00

Heal th	Financial Systems		PULASKI MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	ATION OF GENERAL SERVICE COSTS T	O HHA COST CENT	ERS STATISTICAL	Provider CCN:	: 15-1305	Peri od:	Worksheet H-2	
BASIS				HHA CCN:	15-7078	From 10/01/2015 To 09/30/2016		
							4/21/2017 3:3	7 pm
						Home Health	PPS	
	Cost Center Description	SOCI AL SERVI CE				Agency I		
	cost center bescription	SOCIAL SERVICE						
		(ALLOCATION						
		OF TIME)						
		17. 00						
1.00	Administrative and General	0				•		1. 00
2.00	Skilled Nursing Care	0						2. 00
3.00	Physi cal Therapy	0						3. 00
4.00	Occupational Therapy	0						4. 00
5.00	Speech Pathology	0						5. 00
6.00	Medical Social Services	0						6. 00
7.00	Home Health Aide	0						7. 00
8.00	Supplies (see instructions)	0						8. 00
9.00	Drugs	0						9. 00
10. 00	DME	0						10.00
11. 00	Home Dialysis Aide Services	0						11. 00
12. 00	Respiratory Therapy	0						12.00
13. 00	Private Duty Nursing	0						13. 00
14.00	Clinic	0						14. 00
15. 00	Health Promotion Activities	0						15. 00
	Day Care Program	0						16.00
17. 00	1	0						17. 00
18.00	Homemaker Service	0						18.00
19.00	All Others (specify)							19.00
19. 50	Tel emedi ci ne	0						19. 50
20. 00 21. 00	Total (sum of lines 1-19)							20. 00 21. 00
		0 000000						21.00
22.00	Unit cost multiplier	0. 000000						<sub>1</sub> 22.00

111 41-	Financial Contant		DIII ACKI MEMODI	AL HOCDITAL		1 - 1:-	6 F OMC (	2552 10
	<u>Financial Systems</u> TONMENT OF PATIENT SERVICE COST	-S	PULASKI MEMORI		CN: 15-1305	Period:	wof Form CMS-2 Worksheet H-3	
ALTOKI	TONNENT OF TATTENT SERVICE GOST	3		HHA CCN:	15-7078	From 10/01/2015 To 09/30/2016	Part I	pared:
				Title	e XVIII	Home Health Agency I	PPS	<u>, Бш</u>
	Cost Center Description	From, Wkst.	Facility Costs		Total HHA	Total Visits	Average Cost	
		H-2, Part I,	(from Wkst.	Ancillary	Costs (cols.	1	Per Visit	
		col. 28, line	H-2, Part I)	Costs (from	+ 2)		(col. 3 ÷ col.	
		0	1 00	Part II)	2.00	4.00	4)	
	PART I - COMPUTATION OF LESSER	OF ACCRECATE I	1.00	2.00	3.00	4. 00	5.00	
	BENEFICIARY COST LIMITATION	OF AGGREGATE I	PRUGRAW CUST, A	GGREGATE OF IT	TE PRUGRAW LIW	III IAIT ON COST, OI	<b>.</b>	
4 00	Cost Per Visit Computation		F ( 0 F 4 0		F/0 F/	1 05/	450.44	1 00
1.00	Skilled Nursing Care	2.00			569, 51		l e	
2. 00 3. 00	Physical Therapy Occupational Therapy	3. 00 4. 00		(			l e	
4.00	Speech Pathology	5. 00		-			l e	
5.00	Medical Social Services	6. 00	1		9, 73	0 0	ł	
6.00	Home Heal th Aide	7. 00			256, 01	-		
7. 00	Total (sum of lines 1-6)	7.00	977, 581	(	1		124. 10	7.00
7.00	Total (suil of Titles 1-0)		977, 301		Program Visit			7.00
						art B		-
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject t			
	oost deliter bescription	0031 211111 13	OBSIT NO. (1)	rai t A	Deducti bl es			
					Coi nsurance			
		0	1.00	2.00	3.00	4. 00	5. 00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		23844	(	•	5		8. 00
8. 01	Skilled Nursing Care		50031	(	•			8. 01
8. 02	Skilled Nursing Care		99915	(	94			8. 02
9.00	Physi cal Therapy		23844	(	•	23		9. 00
9. 01	Physical Therapy		50031	(	) 10	)6		9. 01
9.02	Physical Therapy		99915	(	53	34		9. 02
10.00	Occupational Therapy		23844	(		0		10.00
10. 01	Occupational Therapy		50031	(	) 3	34		10. 01
10.02	Occupational Therapy		99915	(	) 12	21		10. 02
11.00	Speech Pathology		23844	(		0		11. 00
11. 01	Speech Pathology		50031	(		0		11. 01
11. 02	Speech Pathology		99915	(	) 5	57		11. 02
12.00	Medical Social Services		23844	(		0		12. 00
12.01	Medical Social Services		50031	(		0		12. 01
12.02	Medical Social Services		99915	(		0		12. 02
13.00	Home Health Aide		23844	(	) 1	3		13. 00
13.01	Home Health Aide		50031	(	11	4		13. 01
13. 02	Home Health Aide		99915	(	67	77		13. 02
14.00	Total (sum of lines 8-13)			(	2, 88	30		14. 00
	Cost Center Description		Facility Costs		Total HHA		Ratio (col. 3	
		Part I, col.	(from Wkst.	Ancillary	Costs (cols.		÷ col. 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Records)		
		0	1.00	Part II)	2.00	4.00	Г 00	
	Cupplies and Dayes Cost Comput	0	1.00	2. 00	3.00	4. 00	5. 00	
15. 00	Supplies and Drugs Cost Computation Cost of Medical Supplies	8. 00	0	(	1	0 0	0. 000000	15. 00
16. 00	Cost of Drugs	9. 00			•	0 0	i e	
10.00	Cost of brugs	7.00	Program Visits		Cost of	0 0	0.000000	10.00
			riogiam visits		Servi ces			
			Par	t B	OCI VI CCS	Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to	Subject to	
			Deductibles &			Deductibles &		
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
		6. 00	7. 00	8. 00	9.00	10.00	11. 00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE I	PROGRAM COST, A	GGREGATE OF TH	HE PROGRAM LIN	IITATION COST, OF	?	
	BENEFICIARY COST LIMITATION							1
	Cost Per Visit Computation	ı	1			al =		
1.00	Skilled Nursing Care	0	.,			0 544, 581	l e	1. 00
2.00	Physi cal Therapy	0				0 115, 475		2. 00
3.00	Occupational Therapy	0	155			0 26, 995		3. 00
4.00	Speech Pathology	0	57			0 9, 928		4.00
5.00	Medical Social Services	0	0			0 0		5. 00
6.00	Home Heal th Aide	0	804			0 99, 776		6.00
7. 00	Total (sum of lines 1-6)	0	2, 880		1	0 796, 755	l	7. 00

_	Financial Systems TONMENT OF PATIENT SERVICE COST  Cost Center Description	rs .	PULASKI MEMORI	Provider CC	CN: 15-1305 15-7078 XVIII	Peri od: From 10/01/2015 To 09/30/2016 Home Heal th Agency I	wof Form CMS- Worksheet H-3 Part I Date/Time Pre 4/21/2017 3:3 PPS	pared:
	oost conten bescriptron	6.00	7.00	8. 00	9. 00	10.00	11.00	
	Limitation Cost Computation	<b>.</b>						
8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 11. 00 11. 01 11. 02 12. 00 12. 01 12. 02 13. 00 13. 01 13. 02 14. 00	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Medical Social Services Home Health Aide Home Health Aide Total (sum of lines 8-13)							8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 11. 01 11. 02 12. 00 12. 01 12. 02 13. 00 13. 01 13. 02 14. 00
		Prog	ram Covered Cha	rges	Cost of			
					Servi ces			
	Cost Center Description	Part A	Part Not Subject to Deductibles & Coinsurance 7.00	Subject to	Part A	Part B Not Subject to Deductibles & Coinsurance 10.00	Subject to Deductibles & Coinsurance 11.00	
	Supplies and Drugs Cost Computa		7.00	0.00	7.00	10.00	11.00	
15.00	Cost of Medical Supplies	0	1 -1	0		0 0	0	
16. 00		T D	0	0		0	0	16. 00
	Cost Center Description	Total Program						
		Cost (sum of cols. 9-10)						
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation	col s. 9-10) 12.00	PROGRAM COST, AG	GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	3	
1. 00		col s. 9-10) 12.00	PROGRAM COST, AC	GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	3	1. 00
2.00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy	col s. 9-10) 12. 00 0F AGGREGATE F 544, 581 115, 475		GREGATE OF TH	E PROGRAM LI	MITATION COST, OF	2	2. 00
2. 00 3. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy	col s. 9-10) 12.00 0F AGGREGATE F 544, 581 115, 475 26, 995		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	2	2. 00 3. 00
2.00 3.00 4.00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	col s. 9-10) 12. 00 0F AGGREGATE F 544, 581 115, 475		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	2	2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00 6. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	col s. 9-10) 12.00 0F AGGREGATE F  544, 581 115, 475 26, 995 9, 928 0 99, 776		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	3	2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6)	col s. 9-10) 12.00 0F AGGREGATE F  544, 581 115, 475 26, 995 9, 928 0		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	2	2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00 6. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	544, 581 115, 475 26, 995 9, 928 0 99, 776 796, 755		SGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	3	2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6)	col s. 9-10) 12.00 0F AGGREGATE F  544, 581 115, 475 26, 995 9, 928 0 99, 776		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	3	2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00	BENEFICIARY COST LIMITATION  Cost Per Visit Computation  Skilled Nursing Care  Physical Therapy  Occupational Therapy  Speech Pathology  Medical Social Services  Home Health Aide  Total (sum of lines 1-6)  Cost Center Description	544, 581 115, 475 26, 995 9, 928 0 99, 776 796, 755		SGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	3	2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 8. 01	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description  Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care	544, 581 115, 475 26, 995 9, 928 0 99, 776 796, 755		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	}	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 8. 01
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 8. 01 8. 02	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description  Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care	544, 581 115, 475 26, 995 9, 928 0 99, 776 796, 755		SGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	3	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 01 8. 02
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 8. 01 8. 02 9. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description  Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy	544, 581 115, 475 26, 995 9, 928 0 99, 776 796, 755		SGREGATE OF TH	E PROGRAM LI	MITATION COST, OF		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 01 8. 02 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 8. 01 8. 02	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description  Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care	544, 581 115, 475 26, 995 9, 928 0 99, 776 796, 755		SGREGATE OF TH	E PROGRAM LI	MITATION COST, OF		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 01 8. 02
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description  Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy	544, 581 115, 475 26, 995 9, 928 0 99, 776 796, 755		GREGATE OF TH	E PROGRAM LI	MITATION COST, OF	3	8. 00 8. 01 9. 00 9. 01 9. 02 10. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description  Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy	544, 581 115, 475 26, 995 9, 928 0 99, 776 796, 755		GREGATE OF TH	E PROGRAM LI	MITATION COST, OF		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description  Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy	544, 581 115, 475 26, 995 9, 928 0 99, 776 796, 755		GREGATE OF TH	E PROGRAM LI	MITATION COST, OF	2	8. 00 8. 01 9. 00 9. 01 9. 02 10. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 10. 02 11. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description  Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology	544, 581 115, 475 26, 995 9, 928 0 99, 776 796, 755		GREGATE OF TH	E PROGRAM LI	MITATION COST, OF	2	8. 00 8. 01 9. 00 9. 01 9. 02 10. 00 11. 01
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 11. 00 11. 01	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description  Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology	544, 581 115, 475 26, 995 9, 928 0 99, 776 796, 755		GREGATE OF TH	E PROGRAM LI	MITATION COST, OF	2	8. 00 8. 01 8. 02 9. 00 10. 01 10. 02 11. 00 11. 01 11. 02
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 11. 00 11. 00 11. 01 11. 02 12. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description  Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Medical Social Services	544, 581 115, 475 26, 995 9, 928 0 99, 776 796, 755		GREGATE OF TH	E PROGRAM LI	MITATION COST, OF	2	8. 00 8. 01 9. 01 10. 02 11. 00 11. 02 12. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 11. 00 11. 01 11. 02 12. 00 12. 01	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description  Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services	544, 581 115, 475 26, 995 9, 928 0 99, 776 796, 755		GREGATE OF TH	E PROGRAM LI	MITATION COST, OF		8. 00 8. 01 8. 02 9. 00 10. 01 11. 02 11. 00 12. 00 12. 01
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 11. 00 11. 01 11. 02 12. 00 12. 01	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description  Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services	544, 581 115, 475 26, 995 9, 928 0 99, 776 796, 755		GREGATE OF TH	E PROGRAM LI	MITATION COST, OF	2	8. 00 8. 01 9. 01 10. 02 11. 00 11. 02 12. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 8. 01 9. 01 9. 02 10. 00 11. 01 11. 02 12. 00 12. 01 12. 02 13. 00 13. 01	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description  Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Home Health Aide Home Health Aide	544, 581 115, 475 26, 995 9, 928 0 99, 776 796, 755		GREGATE OF TH	E PROGRAM LI	MITATION COST, OF	2	8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 11. 01 11. 02 12. 00 12. 01 12. 02 13. 00 13. 01
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 8. 01 8. 02 9. 01 9. 02 10. 00 11. 01 11. 02 12. 00 12. 01 12. 02 13. 00 13. 01	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description  Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Medical Social Services Home Health Aide	544, 581 115, 475 26, 995 9, 928 0 99, 776 796, 755		SGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	2	8. 00 8. 01 8. 02 9. 00 10. 01 11. 02 11. 02 12. 00 12. 01 12. 02 13. 00

Heal th	Financial Systems		PULASKI MEMORI	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORT	TIONMENT OF PATIENT SERVICE COST	S		Provi der C	CN: 15-1305	Peri od:	Worksheet H-3	
				HHA CCN:	15-7078	From 10/01/2015 To 09/30/2016		
				Ti tl	e XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to		
Part I, col. Ratio			Charge (from	Ancillary	Part I as			
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1.00	2.00	3. 00	4. 00		
	PART II - APPORTIONMENT OF COST	T OF HHA SERVIO	CES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	NTS		
1.00	Physi cal Therapy	66. 00	0. 483870	(		0 col. 2, line 2	. 00	1. 00
2.00	Occupational Therapy	67. 00	0. 411100	(		0 col. 2, line 3	. 00	2.00
3.00	Speech Pathology	68. 00	0. 873458	(	D	Ocol. 2, line 4	. 00	3. 00
4.00	Cost of Medical Supplies	71. 00	0. 261712	(		0 col. 2, line 1	5. 00	4. 00
5.00	Cost of Drugs	73. 00	0. 257141	(		0 col. 2, line 1	6. 00	5. 00

th Financial Systems PULASKI MEMORIA CULATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CO	N: 15-1305	Period:	wof Form CMS-2 Worksheet H-4	
SOLATION OF THIS RETIREDUCATION SETTLEMENT	HHA CCN:	15-7078	From 10/01/2015 To 09/30/2016	Part I-II	
				4/21/2017 3:3	
	Title	XVIII	Home Health Agency I	PPS	
		D 1 A		t B	
		Part A	Not Subject to Deductibles &		
			Coi nsurance	Coi nsurance	
		1. 00	2. 00	3. 00	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUS	TOMARY CHARGES	<u>`</u>			4
Reasonable Cost of Part A & Part B Services  Reasonable cost of services (see instructions)	1		0 0	0	1
0 Total charges			0 0	<b>l</b>	
Customary Charges			<u> </u>		1
O Amount actually collected from patients liable for payment f	or services		0 0	0	5 3
on a charge basis (from your records)					
Amount that would have been realized from patients liable for for services on a charge basis had such payment been made in with 42 CFR §413.13(b)			0 0	0	) 4
0 Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	0. 000000	0. 000000	) 5
O Total customary charges (see instructions)	ļ		0 0	0	
0 Excess of total customary charges over total reasonable cost	(complete		0 0	0	) -
only if line 6 exceeds line 1)  Excess of reasonable cost over customary charges (complete of 1 exceeds line 6)	only if line		0 0	0	) {
O Primary payer amounts			0 0	0	) (
			Part A	Part B	
			Servi ces	Servi ces	-
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			1. 00	2. 00	+
OO Total reasonable cost (see instructions)			0	0	10
OO Total PPS Reimbursement - Full Episodes without Outliers			0	1	
00 Total PPS Reimbursement - Full Episodes with Outliers			0	13, 404	
00 Total PPS Reimbursement - LUPA Episodes			0	10, 196	
00  Total PPS Reimbursement - PEP Episodes			0	1, 136	
· ·					1 13
00 Total PPS Outlier Reimbursement - Full Episodes with Outlier	'S		0	1, 361	۱ 1 م
Total PPS Outlier Reimbursement - Full Episodes with Outlier Total PPS Outlier Reimbursement - PEP Episodes	'S		0	0	
Total PPS Outlier Reimbursement - Full Episodes with Outlier Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments	rs		0 0	0	1
Total PPS Outlier Reimbursement - Full Episodes with Outlier Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments	rs		0 0 0	0	1 1 1 1 1
Total PPS Outlier Reimbursement - Full Episodes with Outlier Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments			0 0 0 0	0 0 0 0	) 1: ) 1: ) 1: ) 2:
Total PPS Outlier Reimbursement - Full Episodes with Outlier Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments  DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coin				0 0 0 0 0	) 1: ) 1: ) 1: ) 2: ) 2:
Total PPS Outlier Reimbursement - Full Episodes with Outlier Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments  DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coin Subtotal (sum of lines 10 thru 20 minus line 21)			0	0 0 0 0 0 0 417, 019	) 1: ) 1: ) 2: ) 2:
Total PPS Outlier Reimbursement - Full Episodes with Outlier Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments  DME Payments  Oxygen Payments  Prosthetic and Orthotic Payments  Part B deductibles billed to Medicare patients (exclude coin Subtotal (sum of lines 10 thru 20 minus line 21)  Excess reasonable cost (from line 8)			0	0 0 0 0 0 0 417,019	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Total PPS Outlier Reimbursement - Full Episodes with Outlier Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coin Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23)			0	0 0 0 0 0 0 417,019	150 180 190 190 190 190 190 190 190 190 190 19
Total PPS Outlier Reimbursement - Full Episodes with Outlier Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments  DME Payments  Oxygen Payments  Prosthetic and Orthotic Payments  Part B deductibles billed to Medicare patients (exclude coin Subtotal (sum of lines 10 thru 20 minus line 21)  Excess reasonable cost (from line 8)			0	0 0 0 0 0 0 417,019 0 417,019	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Total PPS Outlier Reimbursement - Full Episodes with Outlier Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments  DME Payments  Oxygen Payments  Prosthetic and Orthotic Payments  Part B deductibles billed to Medicare patients (exclude coin Subtotal (sum of lines 10 thru 20 minus line 21)  Excess reasonable cost (from line 8)  Subtotal (line 22 minus line 23)  Coinsurance billed to program patients (from your records)  Net cost (line 24 minus line 25)  Reimbursable bad debts (from your records)	isurance)		0 0 0	0 0 0 0 0 0 417,019 0 417,019	1 18 19 19 20 20 22 20 20
Total PPS Outlier Reimbursement - Full Episodes with Outlier Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments  DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coin Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see	isurance) i nstructi ons)		0 0 0	0 0 0 0 0 417, 019 0 417, 019	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Total PPS Outlier Reimbursement - Full Episodes with Outlier Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments  DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coin Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see Total costs - current cost reporting period (line 26 plus li	isurance) i nstructi ons)		0 0 0	0 0 0 0 0 417,019 0 417,019	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Total PPS Outlier Reimbursement - Full Episodes with Outlier Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments  DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coin Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see Total costs - current cost reporting period (line 26 plus li OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	instructions)		0 0 0	0 0 0 0 0 417,019 0 417,019 417,019	110 180 180 180 180 180 180 180 180 180
Total PPS Outlier Reimbursement - Full Episodes with Outlier Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Owygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coin Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see Total costs - current cost reporting period (line 26 plus li OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction)	instructions)		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 417,019 0 417,019 417,019	17. 17. 17. 17. 17. 17. 17. 17. 17. 17.
Total PPS Outlier Reimbursement - Full Episodes with Outlier Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments  DME Payments  Oxygen Payments  Prosthetic and Orthotic Payments  Part B deductibles billed to Medicare patients (exclude coin Subtotal (sum of lines 10 thru 20 minus line 21)  Excess reasonable cost (from line 8)  Subtotal (line 22 minus line 23)  Coinsurance billed to program patients (from your records)  Net cost (line 24 minus line 25)  Reimbursable bad debts (from your records)  Reimbursable bad debts for dual eligible beneficiaries (see Total costs - current cost reporting period (line 26 plus li OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  Pioneer ACO demonstration payment adjustment (see instruction Subtotal (see instructions)	instructions)		0 0 0	0 0 0 0 0 417,019 0 417,019 417,019 0 417,019	100 17 18 18 19 19 19 19 19 19 19 19 19 19 19 19 19
Total PPS Outlier Reimbursement - Full Episodes with Outlier Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Owygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coin Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see Total costs - current cost reporting period (line 26 plus li OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction)	instructions)		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 417,019 0 417,019 417,019 0 417,019	188 199 199 199 199 199 199 199 199 199
Total PPS Outlier Reimbursement - Full Episodes with Outlier Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments  DME Payments  Oxygen Payments  Prosthetic and Orthotic Payments  Part B deductibles billed to Medicare patients (exclude coin Subtotal (sum of lines 10 thru 20 minus line 21)  Excess reasonable cost (from line 8)  Subtotal (line 22 minus line 23)  Coinsurance billed to program patients (from your records)  Net cost (line 24 minus line 25)  Reimbursable bad debts (from your records)  Reimbursable bad debts for dual eligible beneficiaries (see Total costs - current cost reporting period (line 26 plus li OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  Pioneer ACO demonstration payment adjustment (see instruction Subtotal (see instructions)	instructions)		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 417, 019 0 417, 019 417, 019 0 417, 019 8, 340	100 100 100 100 100 100 100 100 100 100
Total PPS Outlier Reimbursement - Full Episodes with Outlier Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments  DME Payments  Oxygen Payments  Prosthetic and Orthotic Payments  Part B deductibles billed to Medicare patients (exclude coin Subtotal (sum of lines 10 thru 20 minus line 21)  Excess reasonable cost (from line 8)  Subtotal (line 22 minus line 23)  Coinsurance billed to program patients (from your records)  Net cost (line 24 minus line 25)  Reimbursable bad debts (from your records)  Reimbursable bad debts for dual eligible beneficiaries (see Total costs - current cost reporting period (line 26 plus li OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  Pioneer ACO demonstration payment adjustment (see instructions)  Sequestration adjustment (see instructions)  Interim payments (see instructions)	instructions) ne 27) ons) and 33)		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 417, 019 0 417, 019 417, 019 417, 019 0 417, 019 8, 340 408, 679	100 170 170 170 170 170 170 170 170 170

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

Health Financial Systems PULASKI MEMORI ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES Provider CCN: 15-1305 HHA CCN: 15-7078

				Home Health Agency I	PPS	рііі
		Inpatien	t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	408, 679 0	1. 00 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)  Program to Provider					3. 00
3. 01				0	0	3. 01
3.02				0	0	3. 02
3.03				0	0	3. 03
3.04				0	0	3. 04
3. 05				0	0	3. 05
3. 50	Provider to Program			ol	1 0	3. 50
3. 51				0		3. 51
3. 52				Ö		3. 52
3. 53				0	0	3. 53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0	408, 679	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider					
5. 01				0	0	5. 01
5. 02				0	0	5. 02
5. 03	Provider to Program			0	0	5. 03
5. 50	Provider to Program			ol	0	5. 50
5. 51				Ö	l ő	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM			0	0	6. 01
6. 02 7. 00	Total Medicare program liability (see instructions)			0	408, 679	6. 02 7. 00
7.00	notal medical e program i ability (see ilistructions)			Contractor Number	NPR Date (Mo/Day/Yr)	7.00
		(	)	1. 00	2.00	
8. 00	Name of Contractor					8. 00

Peri od: From 10/01/2015 To 09/30/2016 Worksheet 0 Date/Time Prepared: 4/21/2017 3:37 pm Hospi ce CCN: 15-1550

SALARIES						Heeni ee I	4/21/2017 3.3	, biii
1,00   2,00   3,00   4,00   5,00			CALADIEC	OTUED	CUDTOTAL (SOL		CURTOTAL	
CAP REL COSTS-BUDG & FIXT*			SALARIES	UTHER	,		SUBTUTAL	
GENERAL SERVICE COST CENTERS			1 00	2.00			F 00	
1.00   CAP REL COSTS-BLOG & FIXT*   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		CENEDAL CEDALCE COCT CENTEDO	1.00	2.00	3.00	4.00	5.00	
2.00   CAP REL COSTS-WRELE EQUIP*   0 0 0 0 0 0 0 2.00   4.00   ADMINISTRATIVE & CENERAL*   5,637   1.335   6,972   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1 00				J o	0		1 00
3.00   ADDITION   SEMPLICATE BENEFITS DEPARTMENT*   0				0		-		
4.00 AMM INSTRATIVE & GENERAL* 5.00 PLANDRY & LINEN SERVICE* 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	_	0	-	
PLANT OPERATION & MAINTENANCE*			0	0	_	0	-	
AUMDRY & LINEN SERVICE"			5, 637	1, 335		0		
0.00   0.00			0	0	0	0	-	
B. 00   O   CTARY*   O   O   O   O   O   O   O   O   O			0	0	0	0	-	
9.00   NURSING ADMINISTRATION*   0   0   0   0   0   0   0   0   10   0	7. 00	HOUSEKEEPI NG*	0	0	0	0	0	7. 00
10. 00   ROUTI NE MEDICAL SUPPLIES*   0   0   0   0   0   0   10   00	8.00	DI ETARY*	0	0	0	0	0	8. 00
11.00   MEDI CAL RECORDS*   0   0   0   0   11.00   13.00   13.00   0   0   0   0   13.00   13.00   0   0   0   0   0   0   0   0   0	9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9. 00
12.00   STAFF TRANSPORTATION*   0   36   36   0   33   12.00   14.00   14.00   0   0   0   0   0   0   13.00   14.00   0   0   0   0   0   0   0   0   0	10.00	ROUTINE MEDICAL SUPPLIES*	O	0	0	0	0	10.00
13.00   VOLUNTEER SERVICE COORDINATION*	11. 00	MEDI CAL RECORDS*	O	0	0	0	0	11. 00
13.00   VOLUNTEER SERVICE COORDINATION*   0   0   0   0   13.00     14.00   PHASHAMCY*   0   0   0   0   0   14.00     15.00   PHYSICIAN ADMINISTRATIVE SERVICES*   0   0   0   0   0   15.00     17.00   DIRECT GENERAL SERVICE (CELETED)*   16.00     17.00   DIRECT PATIENT CARE SERVICE COST CENTERS   0   0   0   0   0   0   0   0     25.00   INPATIENT CARE-CONTRACTED**   0   0   0   0   0   0   0   25.00     27.00   NURSE PRACTITIONER**   0   0   0   0   0   0   0   26.00     29.00   LPM/LNN**   0   0   0   0   0   0   0   27.00     29.00   LPM/LNN**   0   0   0   0   0   0   0   0   0	12.00	STAFF TRANSPORTATION*	o	36	36	0	36	12.00
14. 00   PHARMACY*			o	0	0	0		
15. 00   PHYSI CIAN ADMINI STRATI VE SERVI CES   0   0   0   0   0   15. 00		4	0	0	0	0	0	
16. 00   OTHER GENERAL SERVICE (DELETED)*   17. 00   17				0	Ō	0		
17. 00   PATI ENT.RES DENTI AL CARE SERVI CES		4	1	· ·		ŭ		
DIRECT PATIENT CARE SERVICE COST CENTERS								
25.00   INPATIENT CARE-CONTRACTED**	17.00							17.00
26. 00	25 00		0	0		0	0	25 00
27.00   NURSE PRACTITIONER*		4	1	0		-		
28. 00				0		0		
29.00   PHYLVN**		4	0 ((3)	0	0 ((2	0	·	
30. 00   DHYSI CAL THERAPY**   11,706   0   11,706   0   0   0   0   0   0   0   0   0		4	8, 663	0	8, 663	0		
31.00   OCCUPATIONAL THERAPY**   0   0   0   0   31.00   32.00   SPEECH/LANGUAGE PATHOLOGY**   0   0   0   0   32.00   33.00   MEDICAL SOCIAL SERVICES**   0   0   0   0   0   33.00   34.00   SPIRITUAL COUNSELING**   0   0   0   0   0   0   34.00   35.00   OSPIRITUAL COUNSELING**   0   0   0   0   0   0   35.00   36.00   COLINSELING -*   0   0   0   0   0   0   0   37.00   HOSPICE AIDE & HOMEMAKER SERVICES**   90   0   0   0   0   0   0   37.00   HOSPICE AIDE & HOMEMAKER SERVICES**   90   0   90   0   0   0   38.00   DURABLE MEDICAL EQUIPMENT/OXYGEN**   0   0   0   0   0   0   39.00   PATI ENT TRANSPORTATION**   0   0   0   0   0   0   41.00   LABS & DIAGNOSTICS**   0   0   0   0   0   0   41.00   LABS & DIAGNOSTICS**   0   0   0   0   0   0   42.00   MEDICAL SUPPLIES-NON-ROUTINE**   0   0   0   0   0   0   43.00   OUTPATIENT SERVICES**   0   0   0   0   0   0   44.00   PALLIATIVE RADIATION THERAPY**   0   0   0   0   0   0   45.00   PALLIATIVE CHEMOTHERAPY**   0   0   0   0   0   0   45.00   PALLIATIVE CHEMOTHERAPY**   0   0   0   0   0   45.00   OTHER PATIENT CARE SERVICES (SPECIFY)**   0   0   0   0   0   61.00   OTHER PATIENT CARE SERVICES (SPECIFY)**   0   0   0   0   0   62.00   FERRAWEMENT PROGRAM *   0   0   0   0   0   63.00   OSPICE/PALLIATIVE MEDICINE FELLOWS*   0   0   0   0   64.00   OTHER PHYSICIAN SERVICES*   0   0   0   0   65.00   OTHER PHYSICIAN SERVICES*   0   0   0   0   66.00   RESIDENTIAL CARE ** 66.00   OTHER PHYSICIAN SERVICES*   0   0   0   0   67.00   OTHER PHYSICIAN SERVICES*   0   0   0   0   68.00   THEIR FINTELELEMONITORING*   0   0   0   0   67.00   OTHER PHYSICIAN SERVICES*   0   0   0   0   67.00   OTHER NONREIMBURSABLE (SPECIFY)*   0   0   0   67.00   OTHER NONREIMBURSABLE (SPECIFY)*   0   0   0   67.00   OTHER NONREIMBURSABLE (SPECIFY)*   0   0   0   67.00   OTHER NONREIMBU			14 70	0	44 70/	0		
32. 00   SPEECH/LANGUAGE PATHOLOGY**   0 0 0 0 0 0 0 32. 00   33. 00   MEDI CAL SOCI AL SERVI CES**   0 0 0 0 0 0 0 33. 00   33. 00   MEDI CAL SOCI AL SERVI CES**   0 0 0 0 0 0 0 0 33. 00   34. 00   SPIRI TUAL COUNSELI NG**   0 0 0 0 0 0 0 0 34. 00   35. 00   DI ETARY COUNSELI NG**   0 0 0 0 0 0 0 0 35. 00   36. 00   COUNSELI NG - OTHER**   0 0 0 0 0 0 0 0 36. 00   37. 00   HOSPI CE AI DE & HOMEMAKER SERVI CES**   90 0 90 0 90 0 90 37. 00   38. 00   DURABLE MEDI CAL EQUI PMENT/OXYGEN**   0 0 0 0 0 0 0 38. 00   39. 00   PATI LENT TRANSPORTATI ON**   0 0 0 0 0 0 0 38. 00   40. 00   IMAGI NG SERVI CES**   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	1	ŭ		· ·		
33.00 MEDICAL SOCIAL SERVICES** 0 0 0 0 0 0 0 33.00 34.00 SPIR ITUAL COUNSELING** 0 0 0 0 0 0 0 33.00 35.00 DI ETARY COUNSELING** 0 0 0 0 0 0 0 35.00 36.00 COUNSELING - OTHER** 0 0 0 0 0 0 0 0 36.00 37.00 HOSPICE AIDE & HOMEMAKER SERVICES** 90 0 0 90 0 0 0 36.00 38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN** 0 0 0 0 0 0 0 0 38.00 39.00 PATI ENT TRANSPORTATI ON** 0 0 0 0 0 0 0 0 38.00 41.00 LABS & DI AGNOSTICS** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			١	0	1	0		
34. 00 SPIRITUAL COUNSELING** 0 0 0 0 0 0 34. 00 35. 00 DIETARY COUNSELING** 0 0 0 0 0 0 35. 00 36. 00 COUNSELING - OTHER** 0 0 0 0 0 0 0 35. 00 37. 00 HOSPICE AIDE & HOMEMAKER SERVICES** 90 0 0 90 0 90 0 97. 37. 00 38. 00 DURABLE MEDICAL EQUI PMENT/OXYGEN** 0 0 0 0 0 0 0 0 39. 00 40. 00 IMAGING SERVICES** 0 0 0 0 0 0 0 0 39. 00 40. 00 IMAGING SERVICES** 0 0 0 0 0 0 0 0 0 0 40. 00 41. 00 LABS & DIAGNOSTICS** 0 0 0 0 0 0 0 0 0 0 41. 00 42. 00 MEDICAL SUPPLIES-MON-ROUTINE** 0 0 0 0 0 0 0 0 42. 00 43. 00 OUTPATIENT SERVICES** 0 0 0 0 0 0 0 0 0 43. 00 44. 00 PALLIATIVE RADIATION THERAPY** 0 0 0 0 0 0 0 0 0 44. 00 45. 00 PALLIATIVE CHEMOTHERAPY** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1	0	1	0	-	
35. 00 DI ETARY COUNSELING - "THER"*			١	0	1	0	-	
36. 00 COUNSELING - OTHER**			1	0		0	-	
37. 00 HOSPICE AIDE & HOMEMAKER SERVICES** 90 0 90 0 90 0 37. 00 38. 00 DURABLE MEDICAL EQUI PMENT/OXYGEN** 0 0 0 0 0 0 38. 00 39. 00 PATI ENT TRANSPORTATION** 0 0 0 0 0 0 39. 00 40. 00 IMAGING SERVICES** 0 0 0 0 0 0 0 0 0 40. 00 41. 00 LABS & DI AGROSTICS** 0 0 0 0 0 0 0 0 41. 00 42. 00 MEDICAL SUPPLIES-NON-ROUTINE** 0 0 0 0 0 0 0 0 43. 00 43. 00 OUTPATIENT SERVICES** 0 0 0 0 0 0 0 0 44. 00 44. 00 PALLIATIVE RADIATION THERAPY** 0 0 0 0 0 0 0 44. 00 45. 00 PALLIATIVE RADIATION THERAPY** 0 0 0 0 0 0 0 0 44. 00 46. 00 OTHER PATIENT CARE SERVICES (SPECIFY)** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1	0		0	-	
38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN** 0 0 0 0 0 0 38. 00 39. 00 PATIENT TRANSPORTATION** 0 0 0 0 0 0 39. 00 40. 00 IMAGING SERVICES** 0 0 0 0 0 0 0 0 40. 00 41. 00 LABS & DIAGNOSTICS** 0 0 0 0 0 0 0 41. 00 42. 00 MEDICAL SUPPLIES-NON-ROUTINE** 0 0 0 0 0 0 0 42. 00 43. 00 OUTPATIENT SERVICES** 0 0 0 0 0 0 0 43. 00 44. 00 PALLIATIVE RADIATION THERAPY** 0 0 0 0 0 0 0 45. 00 45. 00 PALLIATIVE CHEMOTHERAPY** 0 0 0 0 0 0 0 45. 00 46. 00 OTHER PATIENT CARE SERVICES (SPECIFY)** 0 0 0 0 0 0 0 46. 00 NONREI MBURSABLE COST CENTERS  60. 00 BEREAVEMENT PROGRAM * 0 0 0 0 0 0 0 61. 00 61. 00 VOLUNTEER PROGRAM * 0 0 0 0 0 0 0 62. 00 64. 00 PALLIATIVE CARE PROGRAM* 0 0 0 0 0 0 0 64. 00 65. 00 FUNDRAI SI NG* 0 0 0 0 0 0 0 64. 00 66. 00 PALLIATIVE CARE PROGRAM* 0 0 0 0 0 0 0 64. 00 66. 00 OTHER PHYSI CIAN SERVICES* 0 0 0 0 0 0 0 0 66. 00 66. 00 THER PHYSI CIAN SERVICES* 0 0 0 0 0 0 0 0 66. 00 67. 00 ADVERTI SI NG* 0 0 0 0 0 0 0 0 66. 00 68. 00 TELEHEALTH/TELEMONI TORING* 0 0 0 0 0 0 0 0 68. 00 69. 00 THIRIFT STORE* 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1	0	_	0		
39. 00 PATIENT TRANSPORTATION** 0 0 0 0 0 0 0 39. 00 40. 00 1 MAGI NG SERVI CES** 0 0 0 0 0 0 0 0 0 40. 00 41. 00 LABS & DI AGNOSTI CS** 0 0 0 0 0 0 0 0 0 41. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE** 0 0 0 0 0 0 0 0 0 42. 00 43. 00 OUTPATIENT SERVI CES** 0 0 0 0 0 0 0 0 0 43. 00 44. 00 PALLI ATI VE RADI ATI ON THERAPY** 0 0 0 0 0 0 0 0 44. 00 45. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 0 0 0 0 0 45. 00 46. 00 OTHER PATIENT CARE SERVI CES (SPECI FY) ** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			90	0	90	0		
1			0	0	0	0	-	
41.00 LABS & DI AGNOSTI CS** 0 0 0 0 0 0 0 0 41.00 42.00 42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE** 0 0 0 0 0 0 0 0 42.00 43.00 UTPATI ENT SERVI CES** 0 0 0 0 0 0 0 0 0 43.00 44.00 PALLI ATI VE RADI ATI ON THERAPY** 0 0 0 0 0 0 0 0 0 45.00 46.00 OTHER PATI ENT CARE SERVI CES (SPECI FY)** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	39. 00		0	0	0	0	0	39. 00
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE** 0 0 0 0 0 0 0 42. 00 43. 00 OUTPATI ENT SERVI CES** 0 0 0 0 0 0 0 43. 00 44. 00 PALLI ATI VE RADI ATI ON THERAPY** 0 0 0 0 0 0 0 0 45. 00 46. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	40.00	I MAGI NG SERVI CES**	0	0	0	0	0	40. 00
43. 00   OUTPATIENT SERVICES**   0   0   0   0   0   0   43. 00   44. 00   PALLIATIVE RADIATION THERAPY**   0   0   0   0   0   0   45. 00   PALLIATIVE CHEMOTHERAPY**   0   0   0   0   0   46. 00   OTHER PATIENT CARE SERVICES (SPECIFY)**   0   0   0   0   NONREIMBURSABLE COST CENTERS    60. 00   BEREAVEMENT PROGRAM *   0   0   0   0   0   61. 00   VOLUNTEER PROGRAM *   0   0   0   0   0   62. 00   FUNDRAI SI NG*   0   0   0   0   0   63. 00   HOSPI CE/PALLIATIVE MEDICINE FELLOWS*   0   0   0   0   64. 00   PALLIATIVE CARE PROGRAM*   0   0   0   0   65. 00   OTHER PHYSI CIAN SERVICES*   0   0   0   0   66. 00   RESI DENTIAL CARE*   0   0   0   0   67. 00   ADVERTI SI NG*   0   0   0   0   68. 00   TELEHEALTH/TELEMONI TORI NG*   0   0   0   69. 00   TRIR IFT STORE*   0   0   0   70. 00   NURSI NG FACILITY ROOM & BOARD*   0   0   0   71. 00   OTHER NONREIMBURSABLE (SPECIFY)*	41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
44. 00 PALLI ATI VE RADI ATI ON THERAPY** 0 0 0 0 0 0 0 0 44. 00 45. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 0 0 0 0 45. 00  46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY) ** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00
45. 00 PALLIATI VE CHEMOTHERAPY** 0 0 0 0 0 0 0 45. 00 46. 00 OTHER PATIENT CARE SERVICES (SPECIFY)** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	43.00	OUTPATIENT SERVICES**	O	0	0	0	0	43.00
46. 00 OTHER PATIENT CARE SERVICES (SPECIFY)** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	44.00	PALLIATIVE RADIATION THERAPY**	o	0	0	0	0	44. 00
NONREIMBURSABLE COST CENTERS   O O O O O O O O O O O O O O O O O O	45.00	PALLIATIVE CHEMOTHERAPY**	O	0	0	0	0	45. 00
NONREIMBURSABLE COST CENTERS   O O O O O O O O O O O O O O O O O O	46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	o	0	o	0	0	46.00
60. 00 BEREAVEMENT PROGRAM * 0 0 0 0 0 0 0 0 61. 00 61. 00 61. 00 VOLUNTEER PROGRAM * 0 0 0 0 0 0 0 0 61. 00 62. 00 FUNDRAI SI NG* 0 0 0 0 0 0 0 0 62. 00 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS* 0 0 0 0 0 0 0 0 63. 00 64. 00 PALLI ATI VE CARE PROGRAM* 0 0 0 0 0 0 0 64. 00 65. 00 OTHER PHYSI CI AN SERVI CES* 0 0 0 0 0 0 0 65. 00 66. 00 RESI DENTI AL CARE* 0 0 0 0 0 0 0 0 66. 00 67. 00 ADVERTI SI NG* 0 0 0 0 0 0 0 0 66. 00 67. 00 ADVERTI SI NG* 0 0 0 0 0 0 0 68. 00 69. 00 THRI FT STORE* 0 0 0 0 0 0 0 68. 00 69. 00 THRI FT STORE* 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
61. 00 VOLUNTEER PROGRAM * 0 0 0 0 0 0 0 61. 00 62. 00 63. 00 FUNDRAI SI NG* 0 0 0 0 0 0 0 0 62. 00 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS* 0 0 0 0 0 0 0 63. 00 64. 00 PALLI ATI VE CARE PROGRAM* 0 0 0 0 0 0 0 64. 00 65. 00 0 0 0 0 665. 00 0 0 0 0 665. 00 0 0 0 0 0 0 65. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	60 00		0	0	0	0	0	60 00
62. 00 FUNDRAI SI NG* 0 0 0 0 0 0 62. 00 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS* 0 0 0 0 0 0 63. 00 64. 00 PALLI ATI VE CARE PROGRAM* 0 0 0 0 0 0 64. 00 65. 00 OTHER PHYSI CI AN SERVI CES* 0 0 0 0 0 0 65. 00 66. 00 RESI DENTI AL CARE* 0 0 0 0 0 0 66. 00 67. 00 ADVERTI SI NG* 0 0 0 0 0 0 66. 00 68. 00 TELEHEALTH/TELEMONI TORI NG* 0 0 0 0 0 68. 00 69. 00 THRI FT STORE* 0 0 0 0 0 0 69. 00 70. 00 NURSI NG FACI LI TY ROOM & BOARD* 0 0 0 0 0 0 71. 00 71. 00 OTHER NONREI MBURSABLE (SPECI FY)*			1			-		
63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS* 0 0 0 0 0 0 63. 00 64. 00 PALLI ATI VE CARE PROGRAM* 0 0 0 0 0 0 0 64. 00 65. 00 OTHER PHYSI CI AN SERVI CES* 0 0 0 0 0 0 0 65. 00 66. 00 67. 00 ADVERTI SI NG* 0 0 0 0 0 0 66. 00 67. 00 68. 00 TELEHEALTH/TELEMONI TORI NG* 0 0 0 0 0 0 68. 00 69. 00 THRI FT STORE* 0 0 0 0 0 0 0 69. 00 70. 00 NURSI NG FACILITY ROOM & BOARD* 0 0 0 0 0 0 0 70. 00 71. 00 OTHER NONREI MBURSABLE (SPECI FY)* 0 0 0 0 0 0 0 0 71. 00		4	1	0		-		
64. 00 PALLI ATI VE CARE PROGRAM* 0 0 0 0 0 0 0 64. 00 65. 00 OTHER PHYSI CI AN SERVI CES* 0 0 0 0 0 0 0 65. 00 66. 00 RESI DENTI AL CARE* 0 0 0 0 0 0 0 66. 00 67. 00 ADVERTI SI NG* 0 0 0 0 0 0 68. 00 68. 00 THEI FT STORE* 0 0 0 0 0 0 0 0 68. 00 70. 00 NURSI NG FACI LI TY ROOM & BOARD* 0 0 0 0 0 0 0 0 71. 00				0		0		
65. 00 OTHER PHYSICIAN SERVICES* 0 0 0 0 0 0 65. 00 66. 00 66. 00 66. 00 0 0 0 0 0 66. 00 66. 00 67. 00 0 0 0 0 0 67. 00 68. 00 THRIFT STORE* 0 0 0 0 0 0 0 68. 00 69. 00 0 0 0 0 69. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0		0		
66. 00 RESI DENTI AL CARE*  0 0 0 0 0 0 0 66. 00  67. 00 ADVERTI SI NG*  0 0 0 0 0 0 67. 00  68. 00 TELEHEALTH/TELEMONI TORI NG*  0 0 0 0 0 0 68. 00  69. 00 THRI FT STORE*  0 0 0 0 0 0 0 69. 00  70. 00 NURSI NG FACI LI TY ROOM & BOARD*  71. 00 OTHER NONREI MBURSABLE (SPECI FY)*  0 0 0 0 0 0 71. 00				0		0		
67. 00   ADVERTI SI NG*   0 0 0 0 0 0 67. 00 68. 00 68. 00   TELEHEALTH/TELEMONI TORI NG*   0 0 0 0 0 0 68. 00 69. 00   69. 00   0 0 0 0 0 0 69. 00   70. 00   NURSI NG FACILITY ROOM & BOARD*   0 0 0 0 0 0 0 0 70. 00   71. 00   OTHER NONREI MBURSABLE (SPECI FY)*   0 0 0 0 0 0 0 71. 00   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		4		0		0		
68. 00 TELEHEALTH/TELEMONI TORI NG* 0 0 0 0 0 68. 00 69. 00 70. 00 NURSI NG FACILITY ROOM & BOARD* 0 0 0 0 0 0 71. 00 0 0 0 71. 00 0 0 0 0 0 71. 00				0		0		
69. 00 THRIFT STORE* 0 0 0 0 0 69. 00 70. 00 NURSING FACILITY ROOM & BOARD* 0 0 0 0 0 71. 00 OTHER NONREIMBURSABLE (SPECIFY)* 0 0 0 0 0 71. 00				0		0		
70. 00   NURSING FACILITY ROOM & BOARD* 0 0 0 70. 00 71. 00   OTHER NONREIMBURSABLE (SPECIFY)* 0 0 0 0 71. 00			0	0		0		
71. 00 OTHER NONREIMBURSABLE (SPECIFY)* 0 0 0 71. 00			0	0		0		
			0	0	1 0	0	-	
100. 00  101AL   26, 096  1, 371  27, 467  0  27, 467   100. 00			0	0	]0	0	-	
	100.00	IUIAL	26, 096	1, 371	27, 467	0	27, 467	100.00

<sup>\*</sup> Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate. \*\* See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

				Hospi ce I	
	·	ADJUSTMENTS	TOTAL (col. 5		
			± col. 6)		
	T	6. 00	7.00		
	GENERAL SERVICE COST CENTERS	_			
1.00	CAP REL COSTS-BLDG & FIXT*	0	1		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0			3.00
4.00	ADMI NI STRATI VE & GENERAL*	0	6, 972		4.00
5. 00 6. 00	PLANT OPERATION & MAINTENANCE* LAUNDRY & LINEN SERVICE*	0 0	0 0		5. 00 6. 00
7. 00	HOUSEKEEPING*		1		7.00
7. 00 8. 00	DI ETARY*				8.00
9. 00	NURSING ADMINISTRATION*	0			9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0			
11. 00	MEDICAL RECORDS*	0	1		10.00
12.00	STAFF TRANSPORTATION*	0			12. 00
13. 00	VOLUNTEER SERVICE COORDINATION*	0	36		13. 00
14. 00	PHARMACY*	0			14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES*	0			15. 00
16. 00	OTHER GENERAL SERVICE (DELETED)*	0			16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES				17. 00
17.00	DIRECT PATIENT CARE SERVICE COST CENTERS				17:00
25. 00	INPATIENT CARE-CONTRACTED**	0	0		25. 00
26. 00	PHYSI CI AN SERVI CES**	0			26. 00
27. 00	NURSE PRACTITIONER**	0	o		27. 00
28. 00	REGI STERED NURSE**	0	8, 663		28. 00
29. 00	LPN/LVN**	0	0		29.00
30.00	PHYSI CAL THERAPY**	0	11, 706		30.00
31.00	OCCUPATI ONAL THERAPY**	0	o		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	O		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0		33.00
34.00	SPIRITUAL COUNSELING**	0	0		34.00
35.00	DIETARY COUNSELING**	0	0		35. 00
36.00	COUNSELING - OTHER**	0	0		36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	90		37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		38. 00
39. 00	PATI ENT TRANSPORTATION**	0	0		39. 00
40.00	I MAGING SERVI CES**	0	0		40. 00
41.00	LABS & DI AGNOSTI CS**	0	0		41. 00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	0		42. 00
43.00	OUTPATIENT SERVICES**	0			43. 00
44. 00	PALLIATIVE RADIATION THERAPY**	0			44. 00
45. 00	PALLI ATI VE CHEMOTHERAPY**	0			45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		46. 00
	NONREI MBURSABLE COST CENTERS				(0.00
60.00	BEREAVEMENT PROGRAM *	0	1		60.00
61.00	VOLUNTEER PROGRAM *	0			61.00
62.00	FUNDRAL SI NG*	0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0			63.00
64. 00	PALLIATIVE CARE PROGRAM*	0			64.00
65. 00 66. 00	OTHER PHYSICIAN SERVICES* RESIDENTIAL CARE*	0	0 0		65.00
67. 00	ADVERTI SI NG*	0 0			66.00
68.00	TELEHEALTH/TELEMONI TORI NG*				67. 00 68. 00
69. 00	THRIFT STORE*				69.00
70.00	NURSING FACILITY ROOM & BOARD*				70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)*		1		71. 00
	TOTAL	0			100.00
. 55. 50	1		2,, 107		1100.00

<sup>\*</sup> Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate. \*\* See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

Hospi ce CCN: 15-1550

Peri od: Peri od: From 10/01/2015 To 09/30/2016 Date/Time Prepared: 4/21/2017 3:37 pm

						4/21/201/ 3:3	/ pm
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
				1 + col . 2)	CATI ONS		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	I NPATIENT CARE-CONTRACTED						25. 00
26.00	PHYSI CI AN SERVI CES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27. 00
28.00	REGI STERED NURSE	8, 663	0	8, 663	0	8, 663	28. 00
29. 00	LPN/LVN	0	0	0	0	0	29. 00
30.00	PHYSI CAL THERAPY	11, 706	0	11, 706	0	11, 706	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPI RI TUAL COUNSELI NG	o	0	0	0	0	34.00
35.00	DI ETARY COUNSELI NG	o	0	0	0	0	35.00
36.00	COUNSELING - OTHER	o	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	90	0	90	0	90	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38. 00
39.00	PATI ENT TRANSPORTATION	0	0	0	0	0	39. 00
40.00	I MAGI NG SERVI CES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	o	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	o	0	0	0	0	46.00
100.00	TOTAL *	20, 459	0	20, 459	0	20, 459	100.00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5	
		ADJUSTNIENTS	± col. 6)	
		6. 00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS	0.00	7.00	
25. 00	I NPATI ENT CARE-CONTRACTED			25. 00
26. 00	PHYSI CI AN SERVI CES	0	ol	26. 00
27. 00	NURSE PRACTITIONER	0	l ol	27. 00
28. 00	REGI STERED NURSE	0	8, 663	28. 00
29. 00	LPN/LVN	0	o	29. 00
30. 00	PHYSI CAL THERAPY	0	11, 706	30.00
31.00	OCCUPATI ONAL THERAPY	0	ol	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	ol	32. 00
33.00	MEDICAL SOCIAL SERVICES	0	o	33.00
34.00	SPIRITUAL COUNSELING	0	o	34.00
35.00	DI ETARY COUNSELING	0	o	35. 00
36.00	COUNSELING - OTHER	0	ol	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	90	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	o	38. 00
39.00	PATIENT TRANSPORTATION	0	o	39. 00
40.00	I MAGI NG SERVI CES	0	o	40.00
41.00	LABS & DIAGNOSTICS	0	o	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	o	42. 00
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	o	44. 00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46. 00
100.00	TOTAL *	0	20, 459	100. 00

 $<sup>^{\</sup>star}$  Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

Heal th	Financial Systems PULASKI MEMORIAL	HOSPI TAI		In lie	u of Form CMS-2	2552-10
	LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provi der Co	CN: 15-1305	Peri od:	Worksheet 0-5	
	ES FOR ALLOCATION		10 1000	From 10/01/2015		
		Hospi ce CCI	N: 15-1550	To 09/30/2016		
				Heeni ee I	4/21/2017 3:3	/ pm
	Descriptions		HOSPICE DIREC	Hospice I GENERAL	TOTAL EXPENSES	
	Descriptions		EXPENSES (se		(sum of cols.	
				) EXPENSES FROM	1 + 2)	
			Instructions	WKST B PART I	1 + 2)	
				(see		
				instructions)		
			1.00	2. 00	3. 00	
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT			0 3, 197	3, 197	1.00
2.00	CAP REL COSTS-MVBLE EQUIP			0 0	0	2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT			0 9, 069	9, 069	3. 00
4.00	ADMINISTRATIVE & GENERAL		6, 9	72 8, 005	14, 977	4. 00
5.00	PLANT OPERATION & MAINTENANCE			0 4, 060	4, 060	5. 00
6.00	LAUNDRY & LINEN SERVICE			0 0	0	6. 00
7.00	HOUSEKEEPI NG			0 1, 233	1, 233	7. 00
8.00	DI ETARY			0 0	0	8. 00
9.00	NURSI NG ADMI NI STRATI ON			0 0	0	9. 00
10.00	ROUTINE MEDICAL SUPPLIES			0 0	0	10.00
11.00	MEDI CAL RECORDS			0 43	43	11. 00
12.00	STAFF TRANSPORTATION		[	36	36	12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0	13. 00
14.00	PHARMACY			0	0	14. 00
15. 00	PHYSI CI AN ADMINISTRATI VE SERVI CES			0	0	15. 00
16.00	OTHER GENERAL SERVICE (DELETED)					16. 00
17. 00	PATI ENT/RESI DENTI AL CARE SERVI CES			0	0	17. 00
	LEVEL OF CARE					
50. 00	HOSPICE CONTINUOUS HOME CARE			0	0	50.00
51. 00	HOSPICE ROUTINE HOME CARE		20, 45		20, 459	1
52. 00	HOSPICE INPATIENT RESPITE CARE			0	0	52.00
53. 00	HOSPICE GENERAL INPATIENT CARE			0	0	53. 00
(0.00	NONREI MBURSABLE COST CENTERS		I	o	0	40.00
60. 00 61. 00	BEREAVEMENT PROGRAM			0	0	
62. 00	VOLUNTEER PROGRAM FUNDRAI SI NG			0	0	61. 00 62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS				0	63.00
64. 00	PALLIATIVE CARE PROGRAM				0	64. 00
65. 00	OTHER PHYSICIAN SERVICES				0	65. 00
66. 00	RESI DENTI AL CARE			0	0	66.00
	ADVERTI SI NG			o o	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG			0	o o	68. 00
69. 00	THRIFT STORE			o o	0	69.00
70. 00	NURSING FACILITY ROOM & BOARD			0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			Ö	0	71.00
	NEGATIVE COST CENTER			0	0	
100.00			27, 40	25, 607	-	100.00

53, 074 100. 00

25, 607

100. 00 TOTAL

Heal th Financial	Systems		PULASKI	MEMORI AL	HOSPI TAL			In Lieu of Form CMS-2552-10
COST ALLOCATION	- HOSPI TAL-BASED	HOSPI CE GENERAL	SERVICE CO	STS	Provi der CCI	N: 15-1305	Peri od:	Worksheet 0-6

From 10/01/2015 Part I
To 09/30/2016 Date/Time Prepared: Hospi ce CCN: 15-1550 4/21/2017 3:37 pm Hospi ce I TOTAL EXPENSES CAP REL BLDG & CAP REL MVBLE EMPLOYEE SUBTOTAL Descriptions FIX EQUI P **BENEFITS** DEPARTMENT 1.00 2.00 0 ЗА 3.00 GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FLXT 1.00 3, 197 3, 197 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 0 3.00 EMPLOYEE BENEFITS DEPARTMENT 9,069 9,069 3.00 4.00 ADMINISTRATIVE & GENERAL 14, 977 3, 197 18, 174 4.00 0 5.00 PLANT OPERATION & MAINTENANCE 4,060 0 4, 060 5.00 LAUNDRY & LINEN SERVICE 0 0 6.00 0 0 6.00 7.00 HOUSEKEEPI NG 1, 233 0 1, 233 7.00 8.00 DI ETARY 0 0 0 0 0 0 0 0 0 8.00 NURSING ADMINISTRATION 0 9.00 0 0 9.00 0 ROUTINE MEDICAL SUPPLIES 0 0 10.00 0 10.00 0 11.00 MEDICAL RECORDS 43 11.00 12.00 STAFF TRANSPORTATION 36 36 12.00 VOLUNTEER SERVICE COORDINATION 0 13.00 0 0 0 13.00 14.00 PHARMACY C 0 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 15.00 OTHER GENERAL SERVICE (DELETED) 0 16.00 0 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 0 17.00 0 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 50.00 HOSPICE ROUTINE HOME CARE 51.00 20, 459 9,069 29, 528 51.00 HOSPICE INPATIENT RESPITE CARE 52.00 0 C 0 0 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 0 0 0 0 0 53.00 NONREI MBURSABLE COST CENTERS BEREAVEMENT PROGRAM 60.00 0 n 0 0 n 60.00 0 VOLUNTEER PROGRAM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 61.00 0 61.00 62.00 FUNDRAI SI NG 0 0 62.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 0 63.00 0 63.00 PALLIATIVE CARE PROGRAM 0 0 64.00 0 64.00 65.00 OTHER PHYSICIAN SERVICES 0 0 65.00 RESIDENTIAL CARE 0 0 66.00 0 66.00 0 67 00 ADVERTI SI NG Ω 0 67.00 TELEHEALTH/TELEMONI TORI NG 68.00 0 0 68.00 69.00 THRIFT STORE 0 0 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 0 70.00 OTHER NONREIMBURSABLE (SPECIFY) 0 71 00 0 71.00 C 0 0

0

53,074

C

3, 197

0

9,069

99.00

53, 074 100. 00

99.00 NEGATIVE COST CENTER

100.00 TOTAL

Heal th FinancialSystemsPULASKI MEMCOST ALLOCATION- HOSPITAL-BASED HOSPICE GENERALSERVICE COSTS

			· ·			4/21/2017 3:3	7 pm
					Hospi ce I		
	Descriptions	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	OPERATION &	LINEN SERVICE			
			MAI NTENANCE				
		4. 00	5. 00	6. 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL	18, 174					4. 00
5.00	PLANT OPERATION & MAINTENANCE	2, 114	6, 174				5. 00
6.00	LAUNDRY & LINEN SERVICE	0	0	C	)		6. 00
7.00	HOUSEKEEPING	642	0		1, 875		7. 00
8.00	DI ETARY	0	0		0	0	8. 00
9.00	NURSI NG ADMI NI STRATI ON	o	0		O		9.00
10.00	ROUTINE MEDICAL SUPPLIES	o	0		O		10.00
11. 00	MEDI CAL RECORDS	22	0		0		11.00
12.00	STAFF TRANSPORTATION	19	6, 174		1, 875		12.00
13. 00	VOLUNTEER SERVICE COORDINATION	0	0		0		13. 00
14. 00	PHARMACY	0	0		0		14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15. 00
16. 00	OTHER GENERAL SERVICE (DELETED)	0	0		0		16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17. 00
	LEVEL OF CARE		-	I.	-		1
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51. 00	HOSPICE ROUTINE HOME CARE	15, 377					51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	0	0		o	0	
53. 00	HOSPICE GENERAL INPATIENT CARE	0	0		1	0	
	NONREI MBURSABLE COST CENTERS	-1	-		-		1
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61. 00	VOLUNTEER PROGRAM	0	0		0		61. 00
62. 00	FUNDRAI SI NG	0	0		0		62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63. 00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64. 00
65. 00	OTHER PHYSI CI AN SERVI CES	0	0		0		65. 00
66. 00	RESI DENTI AL CARE	0	0	0	o o	0	1
67. 00	ADVERTI SI NG	0	0	Ĭ	0	Ŭ	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	0	0		0		68. 00
69. 00	THRI FT STORE	0	0		0		69. 00
70. 00	NURSING FACILITY ROOM & BOARD		O				70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)		0	0	n	0	
99. 00	NEGATIVE COST CENTER		0		n n	0	1
	TOTAL	18, 174	6, 174	ĺ	1, 875		100.00
	1		-, . , .	,	., 0, 0		

Heal th Financial	Systems		EMORIAL HOSP	. HOSPITAL In Lie			n Lieu of F	Form CMS-2552-10	
COST ALLOCATION	- HOSPI TAL-BASED	HOSPI CE GENERAL	SERVICE COST	S Prov	vider CCN:	15-1305	Peri od:	Works	sheet 0-6

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS				CN: 15-1305	Peri od:	Worksheet 0-6	
				N 45 4550	From 10/01/2015	Part I	
			Hospi ce CCI	N: 15-1550	To 09/30/2016	Date/Time Pre 4/21/2017 3:3	parea:
					Hospi ce I	4/21/2017 3.3	7 рііі
	Descriptions	NURSI NG	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	
	26361 1 p t 1 6/13	ADMI NI STRATI ON	MEDI CAL	RECORDS	TRANSPORTATION	SERVI CE	
		ADMIT INTO THE CITY	SUPPLI ES	KEOOKBO	THURST OILTHIN OIL	COORDI NATI ON	
		9.00	10.00	11. 00	12.00	13. 00	
	GENERAL SERVICE COST CENTERS	1 1122					
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4. 00	ADMINISTRATIVE & GENERAL						4. 00
5. 00	PLANT OPERATION & MAINTENANCE						5. 00
6. 00	LAUNDRY & LINEN SERVICE						6. 00
7. 00	HOUSEKEEPI NG						7. 00
8. 00	DI ETARY						8. 00
9.00	NURSING ADMINISTRATION	0					9.00
10. 00	ROUTINE MEDICAL SUPPLIES		0				10.00
11. 00	MEDICAL RECORDS		O		65		11.00
12. 00	STAFF TRANSPORTATION				8, 104		12.00
13. 00	VOLUNTEER SERVICE COORDINATION	0			0, 104	0	13. 00
14. 00	PHARMACY	0			0	0	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15. 00
16. 00	OTHER GENERAL SERVICE (DELETED)				0	0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	٧			0	U	17. 00
17.00	LEVEL OF CARE						17.00
50. 00	HOSPICE CONTINUOUS HOME CARE	0			0 0	0	50.00
51. 00	HOSPICE CONTINUOUS HOME CARE		0		65 8, 104	0	51.00
52. 00	HOSPICE INPATIENT RESPITE CARE		0	1	0 0, 104	0	52.00
53. 00	HOSPICE GENERAL INPATIENT CARE		0	1	0 0	0	53.00
33.00	NONREI MBURSABLE COST CENTERS	U U	0		0 0	0	33.00
60. 00	BEREAVEMENT PROGRAM	T ol		I	0	0	60.00
61. 00	VOLUNTEER PROGRAM				0	0	61.00
62. 00	FUNDRAI SI NG	0			0	0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
	PALLIATIVE CARE PROGRAM				0	0	64. 00
64. 00		0			0		1
65. 00	OTHER PHYSICIAN SERVICES	0			0	0	65. 00
66.00	RESI DENTI AL CARE	0			0	0	66.00
67. 00	ADVERTI SI NG	0			0	0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68. 00
69. 00	THRIFT STORE	O				0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	_		0	0	71.00
99. 00	NEGATIVE COST CENTER	0	0		U 0	0	99. 00
100.00	TOTAL	0	0	1	65 8, 104	0	100. 00

			nospi ce coi	13-1330	10 07/30/2010	4/21/2017 3:	
					Hospi ce I		
	Descriptions	PHARMACY	PHYSI CI AN	OTHER GENERAL	PATI ENT/	TOTAL	
	'	A	DMI NI STRATI VE	SERVI CE	RESI DENTI AL		
			SERVI CES	(DELETED)	CARE SERVICES		
		14. 00	15. 00	16.00	17.00	18. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT						1. 00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5. 00
6.00	LAUNDRY & LINEN SERVICE						6. 00
7.00	HOUSEKEEPING						7. 00
8.00	DI ETARY						8. 00
9.00	NURSI NG ADMI NI STRATI ON						9. 00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDI CAL RECORDS						11. 00
12.00	STAFF TRANSPORTATION						12. 00
13. 00	VOLUNTEER SERVICE COORDINATION						13. 00
14. 00	PHARMACY	o					14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	o	0				15. 00
16. 00	OTHER GENERAL SERVICE (DELETED)	o					16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES				0		17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	(			0 50.00
51.00	HOSPICE ROUTINE HOME CARE	o	0			53, 07	4 51.00
52.00	HOSPICE INPATIENT RESPITE CARE	o	0		ol ol		0 52.00
53.00	HOSPICE GENERAL INPATIENT CARE	o	0		ol ol		0 53.00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		(			0 60.00
61.00	VOLUNTEER PROGRAM	0					0 61.00
62.00	FUNDRAI SI NG	O					0 62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	O					0 63.00
64.00	PALLIATIVE CARE PROGRAM	O					0 64.00
65.00	OTHER PHYSICIAN SERVICES	O					0 65.00
66.00	RESI DENTI AL CARE	O	0		ol ol		0 66.00
67.00	ADVERTI SI NG	o					0 67.00
68.00	TELEHEALTH/TELEMONI TORI NG	o					0 68.00
69.00	THRI FT STORE	О					0 69.00
70.00	NURSING FACILITY ROOM & BOARD						0 70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	О	0	(	o		0 71.00
99. 00	NEGATIVE COST CENTER	О	0	(	o		0 99.00
100.00	TOTAL	О	0	(	o	53, 07	4 100. 00
	•			•			•

Health Financial Systems	PULASKI MEMORIAL HOS	SPITAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE STATISTICAL BASIS		ovider CCN: 15-1305 spice CCN: 15-1550	Peri od: From 10/01/2015 To 09/30/2016	Worksheet 0-6 Part II Date/Time Prepared: 4/21/2017 3:37 pm

CAP REL BLDG & CAP REL MYBLE   EQUIP   COLLAR VALUE)   COST CENTERS   CAP REL BLDG & CAP REL MYBLE   EQUIP   COLLAR VALUE)   COSTS)   COSTS)	3171112	THORE BIGHT		Hospi ce CCN	l: 15-1550 T	o 09/30/2016	Date/Time Pre 4/21/2017 3:3	
FIX   SQUARE FEET   DOLLAR VALUE   DEPARTMENT (ACCUMPLATED COSTS)						Hospi ce I	.,	<u> </u>
COUARE FEET   COULAR VALUE   CROSS   CACCUMULATED COSTS)		Cost Center Descriptions	CAP REL BLDG & (	CAP REL MVBLE	EMPLOYEE	RECONCI LI ATI ON	ADMI NI STRATI VE	
CEMERAL SERVICE COST CENTERS							& GENERAL	
1.00			(SQUARE FEET) (	(DOLLAR VALUE)			•	
1.00   2.00   3.00   4A   4.00							COSTS)	
SENERAL SERVICE COST CENTERS								
1.00		I	1.00	2. 00	3. 00	4A	4. 00	
2.00			104			T T		
3. 00   EMPLOYEE BENEFITS DEPARTMENT		1	191					
4. 00   ADMIN ISTRATIVE & CENERAL   191   0   0   -18, 174   34, 900   4, 00   6. 00   1.00		4		0	0.010			
S. DO				0	9, 069			
6. 00 LAUNDRY & LINEN SERVICE		•		0	0	-18, 1/4		
7. 00   HOUSEKEEPING			0	0	0	0		
8. 00   DIETARY   0			0	0	0	0	_	
9. 00 NURSI NG ADMI NI STRATI ON 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 11. 00 MEDI CAL RECORDS 0 0 0 0 0 0 0 43 11. 00 12. 00 STAFF TRANSPORTATI ON 0 0 0 0 0 0 36 12. 00 0 13. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 14. 00 15. 00 0 0 0 0 0 0 0 0 14. 00 15. 00 16. 00 17. 00 16. 00 17			0	0	0	0		1
10.00   ROUTI NE MEDI CAL SUPPLIES   0   0   0   0   0   0   10.00     11.00   MEDI CAL RECORDS   0   0   0   0   0   43   11.00     12.00   STAFF TRANSPORTATI ON   0   0   0   0   36   12.00     13.00   VOLUNTEER SERVI CE COORDINATI ON   0   0   0   0   0   0   13.00     14.00   PHARMACY   0   0   0   0   0   0   0   14.00     15.00   PHYSI CI AN ADMI NI STRATI VE SERVI CES   0   0   0   0   0   0   15.00     16.00   OTHER GENERAL SERVI CE (DELETED)   0   0   0   0   0   0   16.00     17.00   DTHER GENERAL SERVI CE (DELETED)   0   0   0   0   0   0   0     15.00   HOSPI CE CONTI NUOUS HOME CARE   0   0   0   0   0   0   0     15.00   HOSPI CE CONTI NUOUS HOME CARE   9,069   0   29,528   51.00     15.00   HOSPI CE CONTI NUOUS HOME CARE   9,069   0   29,528   51.00     15.00   HOSPI CE GENERAL INPATI ENT CARE   0   0   0   0   0   53.00     15.00   HOSPI CE GENERAL INPATI ENT CARE   0   0   0   0   0   0     15.00   HOSPI CE ROTINE HOME CARE   0   0   0   0   0   0   53.00     16.00   HOSPI CE ROTINE HOME CARE   0   0   0   0   0   0   0     16.00   ONDER IMBURSABLE COST CENTERS   0   0   0   0   0   0   0     16.00   ONDER IMBURSABLE COST CENTERS   0   0   0   0   0   0   0   0     16.00   ONDER IMBURSABLE COST CENTERS   0   0   0   0   0   0   0   0     16.00   ONDER IMBURSABLE COST CENTERS   0   0   0   0   0   0   0   0     16.00   ONDER IMBURSABLE COST CENTERS   0   0   0   0   0   0   0   0   0     16.00   ONDER IMBURSABLE COST CENTERS   0   0   0   0   0   0   0   0   0     16.00   ONDER IMBURSABLE COST CENTERS   0   0   0   0   0   0   0   0   0			0	0	0	0	_	
11. 00   MEDICAL RECORDS   0   0   0   0   43   11. 00     12. 00   STAFF TRANSPORTATION   0   0   0   0   0   36   12. 00     13. 00   VOLUNTEER SERVI CE COORDI NATI ON   0   0   0   0   0   0     14. 00   PHARMACY   0   0   0   0   0   0   0     15. 00   PHYSI CI AN ADMI NI STRATI VE SERVI CES   0   0   0   0   0   0     16. 00   OTHER GENERAL SERVI CE (DELETED)   0   0   0   0   0   0     17. 00   PATI ENT/RESI DENTI AL CARE SERVI CES   0   0   0   0   0     16. 00   OTHER GENERAL SERVI CE (DELETED)   0   0   0   0   0     17. 00   PATI ENT/RESI DENTI AL CARE SERVI CES   0   0   0   0   0     18. 00   OTHER GENERAL SERVI CE (DELETED)   0   0   0   0   0     19. 00   0   0   0   0   0   0     19. 00   0   0   0   0   0   0    10. 00   HOSPI CE CONTI NUOUS HOME CARE   0   0   0   0   0   0     19. 00   OSTAFE HOME CARE   0   0   0   0   0   0     19. 00   0   0   0   0   0   0     19. 00   OSTAFE HOME CARE   0   0   0   0   0   0     19. 00   OSTAFE HOME CARE   0   0   0   0   0   0     19. 00   OSTAFE HOME CARE   0   0   0   0   0     19. 00   OSTAFE HOME CARE   0   0   0   0   0     19. 00   OSTAFE HOME CARE   0   0   0   0   0   0     19. 00   OSTAFE HOME CARE   0   0   0   0   0     19. 00   OSTAFE HOME CARE   0   0   0   0   0     19. 00   OSTAFE HOME CARE   0   0   0   0   0     19. 00   OSTAFE HOME CARE   0   0   0   0   0     19. 00   OSTAFE HOME CARE   0   0   0   0   0     19. 00   OSTAFE HOME CARE   0   0   0   0   0     19. 00   OSTAFE HOME CARE   0   0   0   0   0     19. 00   OSTAFE HOME CARE   0   0   0   0   0     19. 00   OSTAFE HOME HOME CARE   0   0   0   0   0     19. 00   OSTAFE HOME HOME CARE   0   0   0   0   0     19. 00   OSTAFE HOME HOME CARE   0   0   0   0   0     19. 00   OSTAFE HOME HOME CARE   0   0   0   0   0     19. 00   OSTAFE HOME HOME CARE   0   0   0   0   0     19. 00   OSTAFE HOME HOME CARE   0   0   0   0   0     19. 00   OSTAFE HOME HOME CARE   0   0   0   0   0     19. 00   OSTAFE HOME HOME CARE   0   0   0   0   0     19. 00   OSTAFE HOME HOME CARE   0   0   0   0			0	0	0	0		
12. 00 STAFF TRANSPORTATION 0 0 0 0 0 36 12. 00 13. 00 VOLUNTEER SERVICE COORDINATION 0 0 0 0 0 0 13. 00 14. 00 PHARMACY 0 0 0 0 0 0 0 13. 00 15. 00 PHARMACY 0 0 0 0 0 0 0 14. 00 15. 00 PHASILCI AN ADMINISTRATIVE SERVICES 0 0 0 0 0 0 0 15. 00 16. 00 OTHER GENERAL SERVICE (DELETED) 0 0 0 0 0 0 0 16. 00 17. 00 PATIENT/RESIDENTIAL CARE SERVICES 0 0 0 0 0 0 16. 00 18. 00 HOSPICE CONTINUOUS HOME CARE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0	0		
13. 00   OLUNTEER SERVICE COORDINATION   0   0   0   0   0   13. 00     14. 00   PHARMACY   0   0   0   0   0   0   0     15. 00   PHYSICIAN ADMINISTRATIVE SERVICES   0   0   0   0   0   0     16. 00   OTHER GENERAL SERVICE (DELETED)   0   0   0   0   0   0     17. 00   DETENTANCES DENTIAL CARE SERVICES   0   0   0   0   0     18. 00   PATIENT/RESIDENTIAL CARE SERVICES   0   0   0   0   0     19. 00   HOSPICE CONTINUOUS HOME CARE   0   0   0   0   0     19. 00   HOSPICE ROUTINE HOME CARE   0   0   0   0   0     19. 00   HOSPICE GENERAL INPATIENT CARE   0   0   0   0   0     19. 00   HOSPICE GENERAL INPATIENT CARE   0   0   0   0   0     10. 00   OLUNTEER PROGRAM   0   0   0   0   0   0     10. 00   OUUNITEER PROGRAM   0   0   0   0   0   0     10. 00   OUUNITEER PROGRAM   0   0   0   0   0   0     10. 00   OUUNITEER PROGRAM   0   0   0   0   0   0     10. 00   OUUNITEER PROGRAM   0   0   0   0   0     10. 00   OUUNITEER PROGRAM   0   0   0   0   0   0     10. 00   OUUNITEER PROGRAM   0   0   0   0   0   0     10. 00   OUUNITEER PROGRAM   0   0   0   0   0   0     10. 00   OUUNITEER PROGRAM   0   0   0   0   0   0     10. 00   OUUNITEER PROGRAM   0   0   0   0   0   0     10. 00   OUUNITEER PROGRAM   0   0   0   0   0     10. 00   OUUNITEER PROGRAM   0   0   0   0   0     10. 00   OUUNITEER PROGRAM   0   0   0   0   0     10. 00   OUUNITEER PROGRAM   0   0   0   0   0     10. 00   OUNITEER PROGRAM   0   0   0   0   0     10. 00   OUNITEER PROGRAM   0   0   0   0   0     10. 00   OUNITEER PROGRAM   0   0   0   0   0     10. 00   OUNITEER PROGRAM   0   0   0   0   0     10. 00   OUNITEER PROGRAM   0   0   0   0   0     10. 00   OUNITEER PROGRAM   0   0   0   0   0     10. 00   OUNITEER PROGRAM   0   0   0   0   0     10. 00   OUNITEER PROGRAM   0   0   0   0   0     10. 00   OUNITEER PROGRAM   0   0   0   0   0     10. 00   OUNITEER PROGRAM   0   0   0   0   0     10. 00   OUNITEER PROGRAM   0   0   0   0   0     10. 00   OUNITEER PROGRAM   0   0   0   0   0   0     10. 00   OUNITEER PROGRAM   0   0   0   0   0			0	0	0	0		
14. 00 PHARMACY 0 PHYSI CI AN ADMINISTRATI VE SERVI CES 0 0 0 0 0 0 0 0 0 15. 00 17. 00 PHYSI CI AN ADMINISTRATI VE SERVI CES 0 0 0 0 0 0 0 0 0 15. 00 17. 00 PATI ENTLYRESI DENTI AL CARE SERVI CES 0 0 0 0 0 0 0 0 0 17. 00  LEVEL DF CARE    0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0	0		
15. 00   PHYSICIAN ADMINISTRATIVE SERVICES   0   0   0   0   0   0   15. 00   16. 00   OTHER GENERAL SERVICE (DELETED)   0   0   0   0   0   0   16. 00   17. 00   PATIENT/RESIDENTIAL CARE SERVICES   0   0   0   0   0   17. 00      EVEL OF CARE			0	0	0	0	_	•
16. 00 OTHER GENERAL SERVICE (DELETED) 0 0 0 0 0 0 16. 00 17. 00 PATI ENT/RESI DENTI AL CARE SERVICES 0 0 0 0 0 17. 00  LEVEL OF CARE  50. 00 HOSPI CE CONTI NUOUS HOME CARE 51. 00 HOSPI CE CONTI NUOUS HOME CARE 0 0 0 0 0 50. 00 51. 00 HOSPI CE ROUTI NE HOME CARE 0 0 0 0 0 0 29, 528 51. 00 52. 00 HOSPI CE INPATI ENT RESPITE CARE 0 0 0 0 0 0 52. 00 53. 00 HOSPI CE GENERAL INPATI ENT CARE 0 0 0 0 0 0 53. 00  NONREI MBURSABLE COST CENTERS  60. 00 BEREAVEMENT PROGRAM 0 0 0 0 0 0 0 60. 00 61. 00 VOLUNTEER PROGRAM 0 0 0 0 0 0 0 60. 00 62. 00 FUNDRAI SI NG 0 0 0 0 0 0 63. 00 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 0 0 0 0 0 0 63. 00 64. 00 PALLI ATI VE CARE PROGRAM 0 0 0 0 0 0 0 64. 00 65. 00 OTHER PHYSI CI AN SERVI CES 0 0 0 0 0 0 0 66. 00 66. 00 RESI DENTI AL CARE 0 0 0 0 0 0 0 66. 00 67. 00 ADVERTI SI NG 0 0 0 0 0 0 66. 00 68. 00 TELEHEALTH/TELEMONI TORI NG 0 0 0 0 0 0 66. 00 69. 00 THRIF FT STORE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0	0		
17. 00   PATIENT/RESIDENTIAL CARE SERVICES   0   0   0   0   0   0   0   0   0			0	0	0	0	_	•
LEVEL OF CARE				0	0	0		
50. 00   HOSPI CE CONTINUOUS HOME CARE   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	17.00		O O	0		0	0	17.00
51.00   HOSPI CE ROUTI NE HOME CARE   0 0 0 0 0 0 0 0 52.00     52.00   HOSPI CE INPATI ENT RESPITE CARE   0 0 0 0 0 0 0 0 52.00     53.00   HOSPI CE GENERAL INPATI ENT CARE   0 0 0 0 0 0 0 0 0 52.00     53.00   NONREI MBURSABLE COST CENTERS	EO 00						0	FO 00
Description   Section					•	۱	_	
HOSPICE GENERAL INPATIENT CARE   0   0   0   0   0   0   0   0   0		4		0			-	
NONREI MBURSABLE COST CENTERS   SEREAVEMENT PROGRAM   O					-	-		
60. 00 BEREAVEMENT PROGRAM 61. 00 VOLUNTEER PROGRAM 60. 00 0 0 0 0 0 0 0 61. 00 62. 00 FUNDRAI SI NG 62. 00 FUNDRAI SI NG 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 64. 00 PALLI ATI VE CARE PROGRAM 65. 00 0 0 0 0 0 0 0 0 64. 00 65. 00 OTHER PHYSI CI AN SERVI CES 66. 00 RESI DENTI AL CARE 66. 00 RESI DENTI AL CARE 67. 00 ADVERTI SI NG 68. 00 TELEHEALTH/TELEMONI TORI NG 69. 00 THIEF T STORE 70. 00 NURSI NG FACI LI TY ROOM & BOARD 71. 00 OTHER NONREI MBURSABLE (SPECI FY) 79. 00 NEGATI VE COST CENTER 79. 00 NEGATI VE COST CENTER 79. 00 OO	53.00		<u> </u>	U		U U	U	53.00
61. 00 VOLUNTEER PROGRAM 62. 00 FUNDRAI SI NG 62. 00 FUNDRAI SI NG 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 64. 00 PALLI ATI VE CARE PROGRAM 65. 00 OTHER PHYSI CI AN SERVI CES 66. 00 RESI DENTI AL CARE 66. 00 RESI DENTI AL CARE 67. 00 ADVERTI SI NG 68. 00 TELEHEALTH/TELEMONI TORI NG 69. 00 THAI FT STORE 70. 00 NURSI NG FACILI TY ROOM & BOARD 71. 00 OTHER NONREI MBURSABLE (SPECI FY) 99. 00 NEGATI VE COST CENTER 99. 00 100. 00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 99. 00 100. 00 O O O O O O O O O O O O O O O O O	60.00		n	0	0	0	0	60 00
62. 00 FUNDRAISING 0 0 0 0 0 0 62. 00 63. 00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 0 0 0 0 0 0 63. 00 64. 00 PALLIATIVE CARE PROGRAM 0 0 0 0 0 0 0 64. 00 65. 00 OTHER PHYSICIAN SERVICES 0 0 0 0 0 0 0 65. 00 66. 00 RESIDENTIAL CARE 0 0 0 0 0 0 0 65. 00 67. 00 ADVERTISING 0 0 0 0 0 0 0 67. 00 68. 00 TELEHEALTH/TELEMONITORING 0 0 0 0 0 0 68. 00 69. 00 THRIFT STORE 0 0 0 0 0 0 69. 00 70. 00 NURSING FACILITY ROOM & BOARD 70. 00 71. 00 OTHER NONREI MBURSABLE (SPECIFY) 0 0 0 0 0 0 71. 00 99. 00 NEGATIVE COST CENTER 99. 00 100. 00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 3, 197 0 9, 069		4		0	· ·	0		1
63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS 64. 00 PALLI ATI VE CARE PROGRAM 0 0 0 0 0 0 0 0 64. 00 65. 00 OTHER PHYSI CI AN SERVI CES 0 0 0 0 0 0 0 0 65. 00 66. 00 RESI DENTI AL CARE 0 0 0 0 0 0 0 0 66. 00 67. 00 ADVERTI SI NG 0 0 0 0 0 0 0 67. 00 68. 00 TELEHEALTH/TELEMONI TORI NG 0 0 0 0 0 0 0 68. 00 69. 00 THRI FT STORE 0 0 0 0 0 0 0 69. 00 71. 00 ONURSI NG FACILI TY ROOM & BOARD 71. 00 OTHER NONREI MBURSABLE (SPECI FY) 99. 00 NEGATI VE COST CENTER 100. 00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 3, 197 0 9 9, 069		4		0	0	0	_	
64. 00 PALLIATIVE CARE PROGRAM  65. 00 OTHER PHYSICIAN SERVICES  60 O O O O O O O O O O O O O O O O O O O		1	o o	0	0	0		
65. 00 OTHER PHYSICIAN SERVICES 0 0 0 0 0 0 0 65. 00 66. 00 66. 00 67. 00 ADVERTI SI NG 0 0 0 0 0 0 0 67. 00 68. 00 TELEHEALTH/TELEMONI TORI NG 0 0 0 0 0 0 0 68. 00 69. 00 THIR FT STORE 0 0 0 0 0 0 0 0 0 69. 00 71. 00 THER NONREI MBURSABLE (SPECI FY) 0 NEGATI VE COST CENTER 99. 00 0 0 9, 069 18, 174 100. 00		4	0	0	0	0	_	1
66. 00 RESI DENTI AL CARE 0 0 0 0 0 0 0 66. 00 67. 00 68. 00 0 0 0 0 0 0 67. 00 68. 00 TELEHEALTH/TELEMONI TORI NG 0 0 0 0 0 68. 00 69. 00 THI FT STORE 0 0 0 0 0 0 0 68. 00 70. 00 NURSI NG FACILI TY ROOM & BOARD 0 71. 00 OTHER NONREI MBURSABLE (SPECI FY) 0 0 0 0 0 0 71. 00 99. 00 NEGATI VE COST CENTER 99. 00 100. 00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 3, 197 0 99. 00 99. 069		1	0	0	0	0		1
67. 00   ADVERTISING   0 0 0 0 0 0 67. 00 68. 00   TELEHEALTH/TELEMONITORING   0 0 0 0 0 0 68. 00 69. 00   THIFFT STORE   0 0 0 0 0 0 0 69. 00   69. 00   70. 00   NURSING FACILITY ROOM & BOARD   0 0 0 0 0 0 0   70. 00   71. 00   OTHER NONREIMBURSABLE (SPECIFY)   0 0 0 0 0 0 0   71. 00   99. 00   NEGATIVE COST CENTER   99. 00   100. 00   COST TO BE ALLOCATED (per Wkst. 0-6, Part I)   3, 197   0   9, 069   18, 174   100. 00			o o	0	0	0		
68. 00 TELEHEALTH/TELEMONITORING 0 0 0 0 0 68. 00 69. 00 THRI FT STORE 0 0 0 0 0 0 69. 00 70. 00 NURSI NG FACILITY ROOM & BOARD 0 0 0 0 0 70. 00 71. 00 OTHER NONREI MBURSABLE (SPECI FY) 0 0 0 0 0 71. 00 99. 00 NEGATI VE COST CENTER 99. 00 100. 00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 3, 197 0 9, 069 18, 174 100. 00			0	0	0	0		1
69. 00 THRIFT STORE 0 0 0 0 0 69. 00 70. 00 NURSING FACILITY ROOM & BOARD 0 0 0 0 0 70. 00 71. 00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 0 0 0 71. 00 99. 00 NEGATIVE COST CENTER 99. 00 100. 00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 3, 197 0 9, 069 18, 174 100. 00			0	0	0	0		1
70. 00   NURSING FACILITY ROOM & BOARD   0   70. 00   71. 00   0   71. 00   0   0   71. 00   0   0   71. 00   0   0   0   0   0   0   0   0   0			0	0	0	0		•
71. 00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 0 0 71. 00 99. 00 NEGATIVE COST CENTER 99. 00 100. 00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 3, 197 0 9, 069 18, 174 100. 00				, i	· ·	0	, , ,	
99.00   NEGATIVE COST CENTER   99.00   100.00   COST TO BE ALLOCATED (per Wkst. 0-6, Part I)   3,197   0   9,069   18,174   100.00			0	O	n	n	n	
100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 3,197 0 9,069 18,174 100.00				ا	· ·			
			3, 197	o	9, 069		18, 174	
			16. 738220	0. 000000	1. 000000			

Health Financial Systems	PULASKI MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-1
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENE STATISTICAL BASIS		Fr		Peri od: From 10/01/2015 To 09/30/2016	Worksheet 0-6 Part II	pared
				Hospi ce I		•
Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI NO	G DI ETARY	NURSI NG	
	OPERATION &	LINEN SERVICE	(SQUARE FEET	(IN-FACILITY	ADMI NI STRATI ON	
	MAI NTENANCE	(IN-FACILITY		DAYS)		
	(SQUARE FEET)	DAYS)			(DIRECT NURS.	
		ŕ			HRS. )	
	5. 00	6.00	7.00	8. 00	9. 00	
GENERAL SERVICE COST CENTERS		•	•			
1.00 CAP REL COSTS-BLDG & FLXT						1. (
2.00 CAP REL COSTS-MVBLE FOULP						2. (

	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI NG	DIETARY	NURSI NG	
		OPERATION &	LINEN SERVICE	(SQUARE FEET)		ADMI NI STRATI ON	
		MAI NTENANCE	(IN-FACILITY		DAYS)	(51.5507.11150	
		(SQUARE FEET)	DAYS)			(DI RECT NURS.	
				7.00	0.00	HRS. )	
		5. 00	6.00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS		T	ı			
1. 00	CAP REL COSTS-BLDG & FIXT						1. 00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4. 00	ADMINISTRATIVE & GENERAL						4. 00
5.00	PLANT OPERATION & MAINTENANCE	6, 134					5.00
6. 00	LAUNDRY & LINEN SERVICE	0	0	)			6.00
7.00	HOUSEKEEPI NG	0		6, 134			7.00
8.00	DI ETARY	0		0	C		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11. 00	MEDI CAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	6, 134		6, 134		0	12.00
13. 00	VOLUNTEER SERVICE COORDINATION	0		0		0	13. 00
14. 00	PHARMACY			0		0	14. 00
	PHYSICIAN ADMINISTRATIVE SERVICES			١		0	15. 00
16. 00	OTHER GENERAL SERVICE (DELETED)						16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
17.00	LEVEL OF CARE			0			17.00
50.00	HOSPI CE CONTI NUOUS HOME CARE					0	50. 00
51. 00	HOSPICE ROUTINE HOME CARE					0	51. 00
52. 00		0	0	0	C	-	52. 00
53. 00	HOSPICE GENERAL INPATIENT CARE		Ö		C	1	53. 00
00.00	NONREI MBURSABLE COST CENTERS			1		,	00.00
60.00		0		0		0	60.00
61. 00	VOLUNTEER PROGRAM			0		0	61. 00
62. 00				0		0	62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0		0	63. 00
64. 00	PALLIATIVE CARE PROGRAM			0		0	64. 00
65. 00	OTHER PHYSICIAN SERVICES			ا م		0	65. 00
66. 00	RESI DENTI AL CARE		0	j ,	0	ام	66. 00
67. 00	ADVERTI SI NG			l o			67. 00
68. 00				l ő		0	68. 00
69. 00	THRI FT STORE			١			69. 00
70. 00	NURSING FACILITY ROOM & BOARD						70. 00
	OTHER NONREIMBURSABLE (SPECIFY)		_	_	^		71.00
	NEGATIVE COST CENTER			T o		ή "	99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part	I) 6, 174		1, 875	_		100.00
	UNIT COST MULTIPLIER	1. 006521	l .		0. 000000	1	
101.00	PIONI 1 0001 MOLITICIEN	1. 000521	0.00000	0.303073	0.000000	0.00000	101.00

Health Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SEISTATISTICAL BASIS	RVICE COSTS	Provider CC Hospice CCN		Peri od: From 10/01/2015 To 09/30/2016		pared:
				Hospi ce I		
C+ C+ Di-+i	DOUTLNE	MEDICAL	CTAFF	VOLUNTEED	DUADMACV	

			Hospi ce cc	N: 15-1550   I	0 09/30/2016	4/21/2017 3:3	
					Hospi ce I	., _ ,, _ , , , , , , ,	
	Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
	'	MEDI CAL	RECORDS	TRANSPORTATION	SERVI CE	(CHARGES)	
		SUPPLI ES	(PATIENT DAYS)		COORDINATION	· ´	
		(PATIENT DAYS)	(	(MI LEAGE)	(HOURS OF		
		(		( ==,	SERVICE)		
		10.00	11.00	12.00	13. 00	14. 00	
	GENERAL SERVICE COST CENTERS	•					
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5. 00	PLANT OPERATION & MAINTENANCE						5. 00
6. 00	LAUNDRY & LINEN SERVICE						6.00
7. 00	HOUSEKEEPI NG						7. 00
8. 00	DI ETARY						8.00
9. 00	NURSING ADMINISTRATION						9. 00
10. 00	ROUTINE MEDICAL SUPPLIES	7					10.00
11. 00	MEDICAL RECORDS	′	7	,			11.00
12. 00	STAFF TRANSPORTATION		/	55			12.00
13. 00	VOLUNTEER SERVICE COORDINATION			33			13.00
						0	1
14.00	PHARMACY				0	0	
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES			C	١	0	
16.00	OTHER GENERAL SERVICE (DELETED)			C	U	0	
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	LEVEL OF CARE						
50. 00	HOSPICE CONTINUOUS HOME CARE	0	0	1	-	0	
51. 00	HOSPICE ROUTINE HOME CARE	7	7	55		0	
52. 00	HOSPICE INPATIENT RESPITE CARE	0		1		0	
53. 00	HOSPICE GENERAL INPATIENT CARE	0	0	) <u> </u>	0	0	53. 00
	NONREI MBURSABLE COST CENTERS	T	T				
60. 00	BEREAVEMENT PROGRAM			C		0	
61. 00	VOLUNTEER PROGRAM			C	-	0	1
62. 00	FUNDRAI SI NG			0	0	0	
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	1
64.00	PALLIATIVE CARE PROGRAM			0	0	0	
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65. 00
66.00	RESI DENTI AL CARE			0	0	0	66. 00
67.00	ADVERTI SI NG			0	0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG			C	0	0	68. 00
69. 00	THRI FT STORE			0	0	0	69. 00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	1			o	0	71. 00
99. 00	NEGATIVE COST CENTER	1					99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	65	8, 104	o	0	100.00
	UNIT COST MULTIPLIER	0. 000000			l l	0. 000000	

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE STATISTICAL BASIS	GENERAL SERVICE COSTS	Provider CCN: Hospice CCN:	15-1305 15-1550	Peri od: From 10/01/2015 To 09/30/2016	Worksheet 0-6 Part II Date/Time Prepared: 4/21/2017 3:37 pm

			nospi ce coi	10. 13-1330	10 07/30/2010	4/21/2017 3: 3	
					Hospi ce I		
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/		1	
		ADMI NI STRATI VE		RESI DENTI AL			
		SERVI CES	(DELETED)	CARE SERVICE	S		
		(PATIENT DAYS)	, ,	(IN-FACILITY			
		( )	BASIS)	DAYS)			
		15. 00	16.00	17. 00			
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS BEDG & TTAT						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6. 00
7.00	HOUSEKEEPI NG						7. 00
8.00	DI ETARY						8. 00
9.00	NURSING ADMINISTRATION						9. 00
10. 00	ROUTINE MEDICAL SUPPLIES						10. 00
11. 00	MEDI CAL RECORDS						11. 00
12. 00	STAFF TRANSPORTATION						12. 00
13. 00	VOLUNTEER SERVICE COORDINATION						13. 00
14.00	PHARMACY						14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	7					15. 00
16.00	OTHER GENERAL SERVICE (DELETED)		0				16. 00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17. 00
	LEVEL OF CARE	•					1
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	)			50.00
51.00	HOSPICE ROUTINE HOME CARE	7					51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	0	0		0		52.00
53. 00	HOSPICE GENERAL INPATIENT CARE	0			0		53. 00
	NONREI MBURSABLE COST CENTERS		-				1
60.00	BEREAVEMENT PROGRAM		0	ol .			60.00
61. 00	VOLUNTEER PROGRAM		ĺ	•			61.00
62. 00	FUNDRAI SI NG		0				62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS						63.00
64. 00	PALLIATIVE CARE PROGRAM						64. 00
	OTHER PHYSICIAN SERVICES						65.00
66. 00	RESIDENTIAL CARE	0			0		66.00
				()	U		1
67. 00	ADVERTI SI NG		0	<u>'</u>			67.00
68. 00	TELEHEALTH/TELEMONI TORI NG		0	<u>'</u>			68.00
69. 00	THRIFT STORE		0	ľ			69. 00
	NURSING FACILITY ROOM & BOARD						70. 00
	OTHER NONREIMBURSABLE (SPECIFY)	0	0	)	0		71. 00
	NEGATIVE COST CENTER						99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		0	)	0		100. 00
101.00	UNIT COST MULTIPLIER	0. 000000	0. 000000	0.00000	00		101. 00

Heal th	Financial Systems	PULASKI MEMORIA	I HOSPITAI		Inlie	u of Form CMS-2	2552_10
	TONMENT OF HOSPITAL-BASED HOSPICE SHARED SER		Provi der CO	CN: 15-1305	Peri od:	Worksheet 0-7	
LEVEL	OF CARE		Hospice CCN	N: 15-1550	From 10/01/2015 To 09/30/2016	Date/Time Pre 4/21/2017 3:3	pared: 7 pm
					Hospi ce I		
				Charges by	LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C, Co Part I, Col. 9 line	Ratio		HRHC	HI RC	
		0	1. 00	2. 00	3. 00	4. 00	
1 00	ANCILLARY SERVICE COST CENTERS	// 00	0.402070				1 00
1. 00 2. 00 3. 00 4. 00	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPEECH PATHOLOGY DRUGS CHARGED TO PATI ENTS	66. 00 67. 00 68. 00 73. 00	0. 483870 0. 411100 0. 873458 0. 257141		0 0 0 0 0 0 0 0	0 0 0	2. 00
5. 00 6. 00	DURABLE MEDICAL EQUIP-RENTED LABORATORY	96. 00 60. 00	0. 172765			0	5. 00 6. 00
6. 01	BLOOD LABORATORY	60, 01	0. 000000			0	
7. 00 8. 00 9. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS OTHER OUTPATIENT SERVICE COST CENTER RADIOLOGY-THERAPEUTIC	71. 00 93. 00 55. 00	0. 261712		0 0	0	
10.00	ONCOLOGY Totals (sum of lines 1-11)	76. 00	1. 013786		0 0	0	10. 00 11. 00
		Charges by LOC (from Provider Records)					
	Cost Center Descriptions	HGI P HC	col . 2)	col. 3)	xHIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5. 00	6. 00	7. 00	8. 00	9. 00	
4 00	ANCILLARY SERVICE COST CENTERS			I			1 4 00
1. 00 2. 00	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	0	0		0 0	0	
3. 00	SPEECH PATHOLOGY		0			0	
4. 00	DRUGS CHARGED TO PATIENTS	o	0			0	
5.00	DURABLE MEDICAL EQUIP-RENTED						5. 00
6.00	LABORATORY	0	0		0 0	0	
6. 01	BLOOD LABORATORY	0	0		0 0	0	
7. 00 8. 00 9. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS OTHER OUTPATIENT SERVICE COST CENTER RADIOLOGY-THERAPEUTIC	0	0		0 0	0	7. 00 8. 00 9. 00
10. 00 11. 00	ONCOLOGY Totals (sum of lines 1-11)	0	0		0 0	0	10. 00 11. 00

Health Financial Systems	PULASKI	MEMORI AL	HOSPI TAL		In Lie	u of Form CMS-2552-10
CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM C	OST		Provi der CCN:	15-1305	Peri od: From 10/01/2015	Worksheet 0-8
			Hospi ce CCN:	15-1550		Date/Time Prepared:

		nospi ce con	1. 13-1330 1	0 077 307 2010	4/21/2017 3:3	
				Hospi ce I		
			TITLE XVIII	TITLE XIX	TOTAL	
		_	MEDI CARE	MEDI CAI D		
			1. 00	2. 00	3. 00	
	HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7	7, col. 6,			0	1. 00
	line 11)					
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2. 00
3.00	Total average cost per diem (line 1 divided by line 2)				0.00	
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line	10)	0	-		4. 00
5.00	Program cost (line 3 times line 4)		0	0		5. 00
	HOSPICE ROUTINE HOME CARE			1		
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7	7, col. 7,			53, 074	6. 00
	line 11)				_	
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				7 500 00	7. 00
8.00	Total average cost per diem (line 6 divided by line 7)	4.43	_		7, 582. 00	8. 00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, lir	ne 11)		0		9. 00
10. 00	Program cost (line 8 times line 9)		53, 074	. 0		10. 00
44.00	HOSPICE INPATIENT RESPITE CARE				0	44.00
11. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7 line 11)	, coi. 8,			0	11. 00
12 00	Total unduplicated days (Wkst. S-9, col. 4, line 12)				0	12. 00
	Total average cost per diem (line 11 divided by line 12)				0 00	13. 00
14. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, lir	no 12)	0	o	0.00	14. 00
	Program cost (line 13 times line 14)	12)	0			15. 00
13.00	HOSPICE GENERAL INPATIENT CARE			ı o		15.00
16 00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7	7 col 0			0	16. 00
10.00	lline 11)	, сог. ,			O	10.00
17. 00	Total unduplicated days (Wkst. S-9, col. 4, line 13)				0	17. 00
	Total average cost per diem (line 16 divided by line 17)				0.00	
19. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, lir	ne 13)	0	o	0.00	19. 00
	Program cost (line 18 times line 19)	,	0	o		20.00
	TOTAL HOSPICE CARE			-1		
21. 00	Total cost (sum of line 1 + line 6 + line 11 + line 16)				53, 074	21. 00
	Total unduplicated days (Wkst. S-9, col. 4, line 14)	j			7	22. 00
	Average cost per diem (line 21 divided by line 22)	j			7, 582. 00	
		'		'		

	Financial Systems	PULASKI MEMORI		ON 15 1205		u of Form CMS-2	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der CO		Peri od: From 10/01/2015	Worksheet M-1	
			Component (		To 09/30/2016	Date/Time Pre 4/21/2017 3:3	
					RHC I	Cost	
		Compensation	Other Costs	`	Reclassi fi cati	Reclassified	
				+ col . 2)	ons	Trial Balance (col. 3 + col.	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	0.00	11.00	0.00	
1.00	Physi ci an	2, 148, 857	23, 913	2, 172, 77	0 -377, 948	1, 794, 822	1.00
2.00	Physici an Assistant	0	0		0 0	0	2. 00
3.00	Nurse Practitioner	240, 058	0	240, 05	8 -10, 457	229, 601	3. 00
4.00	Visiting Nurse	0	0		0	0	4. 00
5.00	Other Nurse	100, 946	0	100, 94	6 0	100, 946	
6. 00	Clinical Psychologist	0	0		0 0	0	
7.00	Clinical Social Worker	0	0		0	0	
8.00	Laboratory Technician	201 702	0	201 70	0	0	
9. 00 10. 00	Other Facility Health Care Staff Costs Subtotal (sum of lines 1 through 9)	391, 703	0 23. 913	391, 70			1
11. 00	Physician Services Under Agreement	2, 881, 564 1, 401	23, 913	2, 905, 47 1, 52		2, 241, 534 1, 526	1
12. 00	Physician Supervision Under Agreement	1, 401	0		0 0	1, 526	1
13. 00	Other Costs Under Agreement	0	0		0 0	0	
14. 00	Subtotal (sum of lines 11 through 13)	1, 401	125	1, 52	6 0	1, 526	
15. 00	Medical Supplies	0	22, 796			22, 796	
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	22, 796			22, 796	
22. 00	Total Cost of Health Care Services (sum of	2, 882, 965	46, 834	2, 929, 79	9 -663, 943	2, 265, 856	22. 00
	lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	0	0		0 0	0	23. 00
24. 00	Dental	0	0		0 0	0	
25. 00	Optometry	Ö	Ö		0 0	o o	
25. 01	Tel eheal th	O	0		o o	0	
25. 02	Chronic Care Management	0	0		0 0	0	25. 02
26.00	All other nonreimbursable costs	0	0		0 0	0	26. 00
27.00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	28. 00
	through 27)						
	FACILITY OVERHEAD	1	70		-I -		
29. 00	Facility Costs	0	79, 524			79, 524	
30.00	Administrative Costs	536, 689	124, 188			676, 430	
31. 00	Total Facility Overhead (sum of lines 29 and 30)	536, 689	203, 712	740, 40	1 15, 553	755, 954	31.00

3, 419, 654

250, 546

3, 670, 200

3, 021, 810

32.00

-648, 390

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

Health Financial Systems	PULASKI MEMORIAL HOSPITAL	In Lieu of Form CMS-255	2-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 15-1305	Period: Worksheet M-1 From 10/01/2015	
	Component CCN: 15-8512	2 To 09/30/2016 Date/Time Prepar 4/21/2017 3:37 p	

			Component	CCN. 13-031	12   10	077 307 2010	4/21/2017 3: 3	
						RHC I	Cost	
	·	Adjustments	Net Expenses					
		•	for Allocation					
			(col. 5 + col.					
			6)					
		6. 00	7. 00					
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	0	1, 794, 822					1.00
2.00	Physician Assistant	0	0	1				2. 00
3.00	Nurse Practitioner	0	229, 601					3. 00
4.00	Visiting Nurse	0	0	1				4. 00
5.00	Other Nurse	0	100, 946	·				5. 00
6.00	Clinical Psychologist	0	0	)				6. 00
7.00	Clinical Social Worker	0	0					7. 00
8.00	Laboratory Techni ci an	0	0					8. 00
9.00	Other Facility Health Care Staff Costs	0	116, 165					9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	2, 241, 534					10. 00
11. 00	Physician Services Under Agreement	0	1, 526					11. 00
12.00	Physician Supervision Under Agreement	0	0	1				12. 00
13.00	Other Costs Under Agreement	0	0	1				13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	1, 526					14. 00
15. 00	Medical Supplies	0	22, 796					15. 00
16. 00	Transportation (Health Care Staff)	0	0	1				16. 00
17. 00	Depreciation-Medical Equipment	0	0					17. 00
18. 00	Professional Liability Insurance	0	0	1				18. 00
19. 00	Other Health Care Costs	0	0	1				19. 00
20. 00	Allowable GME Costs							20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	22, 796	1				21. 00
22. 00	Total Cost of Health Care Services (sum of	0	2, 265, 856	1				22. 00
	lines 10, 14, and 21)							1
	COSTS OTHER THAN RHC/FQHC SERVICES							
23. 00	Pharmacy	0	0	1				23. 00
24. 00	Dental	0	0	1				24. 00
25. 00	Optometry	0	0	1				25. 00
25. 01	Tel eheal th	0	0	1				25. 01
25. 02	Chronic Care Management	0	0	1				25. 02
26. 00	All other nonreimbursable costs	0	0	1				26. 00
27. 00	Nonallowable GME costs	_	_					27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0	1				28. 00
	through 27)			L				_
20.00	FACILITY OVERHEAD	0	70 504	I				20.00
29. 00	Facility Costs	0	79, 524					29. 00
30.00	Administrative Costs	0	676, 430					30.00
31. 00	Total Facility Overhead (sum of lines 29 and	U	755, 954	1				31.00
32. 00	30) Total facility costs (sum of lines 22, 29	0	2 021 010	J				32. 00
32.00	Total facility costs (sum of lines 22, 28 and 31)	U	3, 021, 810	Ί				32.00
	Jana 51)			1				1

Heal th	Financial Systems	PULASKI MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	ERVI CES	Provi der Co		Peri od:	Worksheet M-2	
			Component		From 10/01/2015 To 09/30/2016	Date/Time Pre 4/21/2017 3:3	
					RHC I	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col.		
		1.00			3)	4	
	MICLIES AND DECEMBER OF	1.00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
1 00	Posi ti ons	4 42	14 714	4.20	10 (0)		1 00
1.00	Physi ci an	4. 43					1.00
2.00	Physician Assistant	0.00					2.00
3. 00 4. 00	Nurse Practitioner	2. 01			·	22 027	3. 00 4. 00
4. 00 5. 00	Subtotal (sum of lines 1 through 3)	6. 44 0. 00			22, 827	22, 827 0	
6.00	Visiting Nurse Clinical Psychologist	0.00	l e			0	•
7. 00	Clinical Social Worker	0.00	l e			0	•
7. 00 7. 01	Medical Nutrition Therapist (FQHC only)	0.00	l e			0	7.00
7. 01	Diabetes Self Management Training (FQHC	0.00				0	7. 01
7.02	only)	0.00	0			U	7.02
8. 00	Total FTEs and Visits (sum of lines 4	6. 44	18, 966			22, 827	8.00
0.00	through 7)	0	10,700			22,02,	0.00
9.00	Physician Services Under Agreements	•	11			11	9. 00
		1	l		<u>'</u>		
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	) HOSPI TAL-BASE	D RHC/FQHC SER	VI CES			
10.00	Total costs of health care services (from Wk	st. M-1, col. 7	7, line 22)			2, 265, 856	10.00
11. 00	Total nonreimbursable costs (from Wkst. M-1,					0	11. 00
12.00	Cost of all services (excluding overhead) (s					2, 265, 856	12. 00
13.00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	
14.00	Total hospital-based RHC/FQHC overhead - (fr			ne 31)		755, 954	
15.00	Parent provider overhead allocated to facili	ty (see instruc	ctions)			2, 185, 093	
16. 00	Total overhead (sum of lines 14 and 15)					2, 941, 047	
	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16					2, 941, 047	
	Overhead applicable to hospital-based RHC/FQ					2, 941, 047	
20.00	Total allowable cost of hospital-based RHC/F	UHC services (s	sum of lines 10	and 19)		5, 206, 903	20.00

	Financial Systems PULASKI MEMORIAL			u of Form CMS-2	2552-10
SERVI (	FS	Provider CCN: 15-1305 Component CCN: 15-8512	Period: From 10/01/2015 To 09/30/2016	Worksheet M-3 Date/Time Pre	nared:
		component con. 15 0512	07/30/2010	4/21/2017 3: 3	
		Title XVIII	RHC I	Cost	
	DETERMINATION OF DATE FOR HOODITAL BACER BUG (FOUR CERVILORS			1. 00	
1. 00	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES  Total Allowable Cost of hospital-based RHC/FQHC Services (from	Wkst M 2 Line 20)	1	5, 206, 903	1. 00
2. 00	Cost of vaccines and their administration (from Wkst. M-4, line			100, 955	2. 00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)	5 13)		5, 105, 948	3. 00
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)			22, 827	4. 00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, li	ne 9)		11	5. 00
6.00	Total adjusted visits (line 4 plus line 5)			22, 838	6. 00
7.00	Adjusted cost per visit (line 3 divided by line 6)			223. 57	7. 00
			Cal cul ati on	of Limit (1)	
			Prior to	On or After	
			January 1	January 1	
			1. 00	2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6	or your contractor)	80. 44	81. 32	8. 00
9.00	Rate for Program covered visits (see instructions)	,	223. 57	223. 57	9. 00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from o		0	3, 986	10.00
11. 00	Program cost excluding costs for mental health services (line 9	,	0	891, 150	11. 00
12.00	Program covered visits for mental health services (from contract		0	5	12.00
13. 00 14. 00	Program covered cost from mental health services (line 9 x line	e 12)	0	1, 118	
15. 00	Limit adjustment for mental health services (see instructions) Graduate Medical Education Pass Through Cost (see instructions)		٩	1, 118	15. 00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 a		0	892, 268	
16. 01	Total program charges (see instructions) (from contractor's reco		Ĭ	454, 853	
16. 02	Total program preventive charges (see instructions)(from provide			6, 845	16. 02
16. 03	Total program preventive costs ((line 16.02/line 16.01) times I	ine 16)		13, 428	16. 03
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.03	and 18) times .80)		663, 392	16. 04
44.05	(Titles V and XIX see instructions.)			474 000	47.05
16. 05	Total program cost (see instructions)		0	676, 820	16. 05 17. 00
17. 00 18. 00	Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		0 49, 600	17. 00
10.00	records)	(11 om contractor		47, 000	10.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instructions records)	s) (from contractor		79, 682	19. 00
20.00	Net Medicare cost excluding vaccines (see instructions)			676, 820	20. 00
21. 00	Program cost of vaccines and their administration (from Wkst. M	M-4, line 16)		41, 644	21. 00
22. 00	Total reimbursable Program cost (line 20 plus line 21)			718, 464	22. 00
23. 00	Allowable bad debts (see instructions)			975	
23. 01	Adjusted reimbursable bad debts (see instructions)			634	23. 01
24. 00	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)		159	24. 00
25. 00 25. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)			0 159	25. 00 25. 50
26. 00	Net reimbursable amount (see instructions)	)		718, 939	
26. 00	Sequestration adjustment (see instructions)			14, 379	26. 00
27. 00	Interim payments			657, 045	
28. 00	Tentative settlement (for contractor use only)			0	28. 00
29. 00	Balance due component/program (line 26 minus lines 26.01, 27, a			47, 515	
30. 00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub. 15-II,		0	30. 00
	chapter I, §115.2				

Health Financial Systems Pl	ULASKI MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FOHC PNEUMOCOCCAL AI VACCINE COST	ND INFLUENZA	Provider CCN: 15-1305	Peri od: From 10/01/2015	Worksheet M-4	
VACCINE COST		Component CCN: 15-8512			
		Title XVIII	RHC I	Cost	
			Pneumococcal	Infl uenza	

				4/21/201/ 3.3	<i>,</i> biii
		Title XVIII	RHC I	Cost	
			Pneumococcal	I nfl uenza	
			1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		2, 241, 534	2, 241, 534	1. 00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total	al health care staff time	0.000780	0. 002262	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (li	ne 1 x line 2)	1, 748	5, 070	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (fi	rom your records)	25, 820	11, 293	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	s line 4)	27, 568	16, 363	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksho	eet M-1, col. 7, line 22)	2, 265, 856	2, 265, 856	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		2, 941, 047	2, 941, 047	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0. 012167	0. 007222	8.00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x l	ine 8)	35, 784	21, 240	9. 00
10.00	Total pneumococcal and influenza vaccine cost and its (their)	administration (sum of	63, 352	37, 603	10.00
	lines 5 and 9)				
11. 00	Total number of pneumococcal and influenza vaccine injections		225		11. 00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10		281. 56	57. 67	12.00
13.00	Number of pneumococcal and influenza vaccine injections admini	stered to Program	84	312	13.00
	benefi ci ari es				
14. 00	Program cost of pneumococcal and influenza vaccine and its (t	neir) administration	23, 651	17, 993	14.00
	(line 12 x line 13)				
15. 00				100, 955	15. 00
	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3,				
16. 00	Total Program cost of pneumococcal and influenza vaccine and i	` ,		41, 644	16. 00
	administration (sum of cols. 1 and 2, line 14) (transfer this	amount to Wkst. M-3,			
	line 21)				

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED R SERVICES RENDERED TO PROGRAM BENEFICIARI		Provider CCN: 15-1305 Component CCN: 15-8512		
				_

		Component Con. 13-8312	077 307 2010	4/21/2017 3: 3	
			RHC I	Cost	
			Par	rt B	
			mm/dd/yyyy	Amount	
			1, 00	2, 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC	-		560, 945	1. 00
2.00	Interim payments payable on individual bills, either submit	ted or to be submitted to		0	2. 00
	the contractor for services rendered in the cost reporting				
	"NONE" or enter a zero	•			
3.00	List separately each retroactive lump sum adjustment amount	based on subsequent			3.00
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3. 01			03/22/2016	96, 100	3.0
3. 02				0	3. 02
3.03				0	3. 03
3.04				0	3.04
3. 05				0	3. 0!
	Provider to Program				
3.50				0	3. 50
3. 51				0	3. 5
3. 52				0	3. 5
3. 53				0	3. 5
3.54				0	3. 5
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			96, 100	3. 9
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line		657, 045	4.0
	27)				
	TO BE COMPLETED BY CONTRACTOR				
5. 00	List separately each tentative settlement payment after des	sk review. Also show date o	f		5.0
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
5. 01				0	5.0
5. 02				0	5. 02
5. 03				0	5. 0
o	Provider to Program			1 0	
5. 50 5. 51					5. 5 5. 5
5. 52					5. 5
5. 99	Subtatal (sum of lines E 01 E 40 minus sum of lines E E0 E	00)			5. 9
5. 99 6. 00	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5. Determined net settlement amount (balance due) based on the			١	6.0
	,	e cost report. (1)		47 515	
5. 01	SETTLEMENT TO PROVIDER			47, 515 0	6.0
6. 02	SETTLEMENT TO PROGRAM  Total Medicara program Lightlity (see instructions)				6.0
7. 00	Total Medicare program liability (see instructions)		Contine	704, 560	7. 0
			Contractor	NPR Date	
		0	Number	(Mo/Day/Yr)	
8. 00	Name of Contractor	U	1. 00	2. 00	8. 00
0.00	Invalle of Contractor	l	I	1	J 8.00