This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-1305 Peri od: Worksheet S From 10/01/2020 Parts I-III AND SETTLEMENT SUMMARY 09/30/2021 Date/Time Prepared: 9/19/2022 5: 14 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 9/19/2022 5: 14 pm Manually prepared cost report use only]If this is an amended report enter the number of times the provider resubmitted this cost report]Medicare Utilization. Enter "F" for full or "L" for low. [5] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit (3) Settled with Audit (4) Final Report for this Provider CCN (5) Final Report for this Provider CCN (6) In Indian Report for this Provider CCN (7) In Indi Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

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

(5) Amended

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PULASKI MEMORIAL HOSPITAL (15-1305) for the cost reporting period beginning 10/01/2020 and ending 09/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

		Title XVIII				
Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
	1. 00	2.00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospi tal	0	16, 275	272, 728	0	41, 016	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing Bed - SNF	0	0	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		213, 043		0	10.00
10.01 RURAL HEALTH CLINIC II	0		117, 618		0	10. 01
10.02 RURAL HEALTH CLINIC III	0		19, 357		0	10.02
10.03 RURAL HEALTH CLINIC IV	0		42, 715		0	10.03
200. 00 Total	0	16, 275	665, 461	0	41, 016	200. 00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1305 Peri od: Worksheet S-2 From 10/01/2020 Part I 09/30/2021 Date/Time Prepared: 9/19/2022 5:14 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: 1.00 Street: 616 EAST 13TH PO Box: 1.00 State: IN 2.00 City: WINAMAC Zi p Code: 46996-County: PULASKI 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 PULASKI MEMORIAL 151305 99915 10/01/2000 Ν 0 0 3.00 HOSPI TAI Subprovi der - IPF 4.00 4.00 Subprovi der - IRF 5.00 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF Р PULASKI MEMORIAL 157305 99915 10/01/2000 N 0 7.00 7.00 HOSPI TAI 8.00 Swing Beds - NF 8.00 9.00 Hospital -Based SNF 9.00 Hospital -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospital -Based HHA 12.00 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce 14 00 14 00 15.00 Hospital-Based Health Clinic - RHC PULASKI MEMORIAL RHC -158512 99915 08/21/2014 N 0 Ν 15.00 WI NAMAC PULASKI MEMORIAL RHC -Hospital-Based Health Clinic - RHC 158527 99915 03/14/2018 0 15.01 15.01 NORTH JUDSON Hospital - Based Health Clinic - RHC PULASKI MEMORIAL RHC -158528 99915 03/15/2018 N 15.02 15.02 N 0 1111 FRANCESVILLE Hospital-Based Health Clinic - RHC PULASKI MEMORIAL RHC -158554 99915 07/06/2020 15.03 15.03 0 KNOX MEDICAL 16.00 Hospital-Based Health Clinic - FQHC 16.00 Hospital-Based (CMHC) I 17.00 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 10/01/2020 09/30/2021 20.00 21.00 Type of Control (see instructions) 21.00 2 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for N N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22. 01 Did this hospital receive interim uncompensated care payments for this 22.01 Ν Ν cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care 22. 02 N Ν 22.02 payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas 22.03 Ν Ν Ν adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to Ν Ν Ν 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.

	Financial Systems PULASKI MEM AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		OSPITAL rovider CC	CN: 15-1305	Period: From 10/0 To 09/3	In Lieu 1/2020 0/2021	of For Worksho Part I Date/Ti 9/19/20	et S-2 me Pre	pared:
				1. 00	2.0	00	3. (00	
	Which method is used to determine Medicaid days on lines below? In column 1, enter 1 if date of admission, 2 if c if date of discharge. Is the method of identifying the d reporting period different from the method used in the p reporting period? In column 2, enter "Y" for yes or "N"	ensus da ays in rior cos for no.	ays, or 3 this cost st		2 N				23. 00
	Mec pai d	-State dicaid d days	In-State Medi cai d el i gi bl e unpai d days 2.00	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO day	ys Med	ther li cai d lays	
25. 00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state	0	0	0	0	0.00	0	0	24. 00 25. 00
	Medicaid eligible unpaid days in column 4, Medicaid								
	HMO paid and eligible but unpaid days in column 5.				Urban/R	ural S	Date of	Geogr	
					1. (00	2. (
	Enter your standard geographic classification (not wage) cost reporting period. Enter "1" for urban or "2" for ru		at the be	ginning of	the	2			26.00
27. 00	Enter your standard geographic classification (not wage) reporting period. Enter in column 1, "1" for urban or "2 enter the effective date of the geographic reclassificat	status " for ru ion in o	ural. If a column 2.	ppl i cabl e,		2			27. 00
	If this is a sole community hospital (SCH), enter the nu effect in the cost reporting period.	mber of	peri ods S	CH status i	n	0			35.00
	errect in the cost reporting perrou.				Begi ni	ni ng:	Endi	ng:	
24.00	E			24 6	1. (00	2. (00	27.00
	Enter applicable beginning and ending dates of SCH statu- of periods in excess of one and enter subsequent dates.	s. Subso	cript line	36 TOT NUM	ber				36.00
	If this is a Medicare dependent hospital (MDH), enter the	e numbei	r of perio	ds MDH stat	us	0			37.00
	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the M accordance with FY 2016 OPPS final rule? Enter "Y" for y instructions)								37. 01
	If line 37 is 1, enter the beginning and ending dates of greater than 1, subscript this line for the number of pe enter subsequent dates.								38.00
					1. (Y/ 2. (-
	Does this facility qualify for the inpatient hospital pathospitals in accordance with 42 CFR §412.101(b)(2)(i), (1 "Y" for yes or "N" for no. Does the facility meet the accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? or "N" for no. (see instructions)	ii), or mileage Enter i	(iii)? En requireme in column	ter in colu nts in 2 "Y" for y	ume N mn es		N		39.00
	Is this hospital subject to the HAC program reduction ad "N" for no in column 1, for discharges prior to October no in column 2, for discharges on or after October 1. (s	1. Entei	r "Y" for			V	XVIII		40.00
	Dragonative Dayment Control (DDC) Co. 111					1. 00			
	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment for	or di spi	roporti ona	te share in	accordance	e N	N	N	45.00
46. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L	on for ϵ	extraordi n	ary circums	tances	N	N	N	46. 00
47.00	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS capi Is the facility electing full federal capital payment?					N N	N N	N N	47. 00 48. 00
	Teaching Hospitals Is this a hospital involved in training residents in app "N" for no in column 1. For column 2, if the response to was involved in training residents in approved GME progr- year, and are you are impacted by CR 11642 (or applicable Enter "Y" for yes; otherwise, enter "N" for no in column	column ams in e CRs) M	1 is "Y", the prior	or if this year or pen	hospital ultimate				56.00
57. 00	If line 56 is yes, is this the first cost reporting periods. The strained at this facility? Enter "Y" for ye is "Y" did residents start training in the first month of for yes or "N" for no in column 2. If column 2 is "Y", "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, is	od durin s or "N' f this c complete	" for no i cost repor e Workshee	n column 1. ting period	If column ? Enter "\				57.00

Health Financial Systems PULASKI MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1305 Peri od: Worksheet S-2 From 10/01/2020 Part I 09/30/2021 Date/Time Prepared: 9/19/2022 5: 14 pm XVIII XIX 1.00 2.00 3.00 58.00 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 58.00 Pt. I Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see 60 00 N instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustement? Enter "Y" for yes or "N" for no in column 2 IME Direct GME IME Direct GME 1.00 2.00 3. 00 4. 00 5.00 61.00 Did your hospital receive FTE slots under ACA 0.00 0.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61 02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unwei ghted Unwei ghted IME FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 0.00 61.10 61.10 Of the FTEs in line 61.05, specify each new program 0. 00 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61. 20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 |Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 63.00 "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

Health Financial Systems	PULASKI	MEMORIAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	ATA Provider CC		eriod: com 10/01/2020 o 09/30/2021	Worksheet S-2 Part I Date/Time Pre 9/19/2022 5:1	pared:
			Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 +	
			Nonprovi der Si te	Hospi tal	col . 2))	
			1. 00	2. 00	3. 00	
Section 5504 of the ACA Base Year period that begins on or after J			·Ihis base year	is your cost	reporti ng	
64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to rosettings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 1)	ber of unweighted no tations occurring in number of unweighte ur hospital. Enter i	n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0.00	0. 000000	64. 00
jor (corumn r drvrded by (corumn	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
			FTEs Nonprovi der Si te	FTEs in Hospital	3/ (col. 3 + col. 4))	
	1. 00	2. 00	3. 00	4. 00	5. 00	
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65. 00
			FTEs Nonprovider Site	FTEs in Hospital	1/ (col . 1 + col . 2))	
			1. 00	2. 00	3. 00	
Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Setting	gsEffective f	or cost report	ing periods	
66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	66. 00
	Program Name	Program Code	Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 3 +	
			Nonprovi der	Hospi tal	col . 4))	
	1. 00	2.00	Si te 3. 00	4. 00	5. 00	
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		2. 00	0.00			67. 00

	ibur sed 101% of Tripatrient Services cost; Enter Y Tor yes or N Tor no Tri Corumin 1			
1	title V, and in column 2 for title XIX. s title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of	N	N	98. 04
	patient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and			
	column 2 for title XIX.			
98. 05 Does	s title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on \mid	Υ	Y	98. 05
Wkst	c. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in			
colu	ımn 2 for title XIX.			
98. 06 Does	s title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D,	Υ	Υ	98.06
Pts.	I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in			
	ımn 2 for title XIX.			
Rura	al Providers			
105.00 Does	s this hospital qualify as a CAH?	Υ		105. 00
106.00 lf t	his facility qualifies as a CAH, has it elected the all-inclusive method of payment:	N		106.00
for	outpatient services? (see instructions)			
107. 00 Col u	umn 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R	N		107.00
trai	ning programs? Enter "Y" for yes or "N" for no in column 1. (see instructions)			
	umn 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&Rs in an			
	roved medical education program in the CAH's excluded IPF and/or IRF unit(s)?			
	er "Y" for yes or "N" for no in column 2. (see instructions)			
			f .	1

Health Financial Systems PULASKI MEMORI HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C		eri od:	Worksheet S-	
			rom 10/01/2020 o 09/30/2021	Date/Time Pr	
			V	9/19/2022 5: XIX	14 pm
			1. 00	2.00	
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	e CRNA fee sche	edul e? See 42	N		108.00
	Physi cal	Occupati onal	Speech	Respi ratory	
109.00 f this hospital qualifies as a CAH or a cost provider, are	1.00 N	2. 00 N	3. 00 N	4. 00 N	109. 00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					107.00
			104	1.00	110.00
110.00Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	"Y" for yes or	"N" for no. I	f yes,	N	110.00
			1. 00	2.00	
111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to or integration prong of the FCHIP demo in which this CAH is particled that apply: "A" for Ambulance services; "B" for a for tele-health services.	cost reporting column 1 is Y, articipating ir	period? Enter enter the column 2.	N		111.00
		1.00	2.00	3.00	
112.00 Did this hospital participate in the Pennsylvania Rural Heademonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital content of participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	g period? s "Y", enter the	N	2.30	0.00	112.00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of	or "N" for no	N			0115.00
in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub. 15-1, chapter 22, §2208.1. 116.00 s this facility classified as a referral center? Enter "Y"	'93" percent (includes ers) based on	N			116.00
"N" for no.	,				
117.00 Is this facility legally-required to carry malpractice insu "Y" for yes or "N" for no.	urance? Enter	Y			117. 00
118.00 Is the malpractice insurance a claims-made or occurrence po		1	ı		118. 00
if the policy is claim-made. Enter 2 if the policy is occur	rence.	Premiums	Losses	Insurance	
110 011 :		1.00	2. 00	3.00	0110 01
118.01 List amounts of malpractice premiums and paid losses:		180, 938	3	U	0118.01
110 03		*b *b	1.00	2. 00	110.00
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche and amounts contained therein. 119.00 DO NOT USE THIS LINE			N		118. 02
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that of Hold Harmless provision in ACA §3121 and applicable amendme	n column 1, "Y qualifies for t	/" for yes or the Outpatient	N	N	120. 00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost imples patients? Enter "Y" for yes or "N" for no.		o o	Y		121. 00
122.00 Does the cost report contain healthcare related taxes as de Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included.	1 is "Y", ente		N		122. 00
Transplant Center Information	for ves and "N"	for no. If	N		125. 00
125.00 Does this facility operate a transplant center? Enter "Y" f				1	1
125.00 Does this facility operate a transplant center? Enter "Y" fyes, enter certification date(s) (mm/dd/yyyy) below. 126.00 f this is a Medicare certified kidney transplant center, e	enter the certi	fication date			126. 00
125.00 Does this facility operate a transplant center? Enter "Y" fyes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, ein column 1 and termination date, if applicable, in column 127.00 If this is a Medicare certified heart transplant center, er	enter the certi 2. nter the certif				
125.00 Does this facility operate a transplant center? Enter "Y" fyes, enter certification date(s) (mm/dd/yyyy) below. 126.00 of this is a Medicare certified kidney transplant center, each	enter the certi 2. hter the certif 2. hter the certif	fication date			126. 00 127. 00 128. 00

lealth Financial Systems	PULASKI MEMORI		N. 45 4005			u of Form CMS	
OSPITAL AND HOSPITAL HEALTH CARE COMPLE	EX IDENTIFICATION DATA	Provi der Co	CN: 15-1305	Period:	: 0/01/2020	Worksheet S- Part I	-2
					9/30/2021	Date/Time Pr	
						9/19/2022 5:	14 pm
					1. 00	2. 00	
30.00 If this is a Medicare certified p			ti fi cati on				130.
date in column 1 and termination al. 00 If this is a Medicare certified i	ntestinal transplant cente	er, enter the d	erti fi cati o	n			131. (
date in column 1 and termination at the date in column 1 and termination is 32.00 If this is a Medicare certified i			ication date	_			132.
in column 1 and termination date,			reation date				132.
3.00 Removed and reserved 4.00 If this is an organ procurement o	rganization (OPO), enter 1	the OPO number	in column 1				133. 134.
and termination date, if applicab							
0.00 Are there any related organizatio					N		140.
chapter 10? Enter "Y" for yes or are claimed, enter in column 2 th	<u>e home office chain number</u>	r. (see instruc		ts			
1.00 If this facility is part of a cha	2.0 in organization, enter on		uah 143 the	name ar	3.00 nd address	of the home	+
office and enter the home office	contractor name and contra						
11. 00 Name:	Contractor's Name:		Contrac	tor's Nu	ımber:		141.
12.00 Street: 13.00 Ci ty:	PO Box: State:		Zi p Cod	۵٠			142. 143.
5. 56 51 ty.	State.		21 p 000	<u>. </u>			110.
						1.00	
14.00 Are provider based physicians' co	sts included in Worksheet	A?				Y	144.
					1. 00	2.00	
5.00 If costs for renal services are c							145.
inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N"	clude Medicare utilization for no in column 2.	n for this cost	reporti ng				
6.00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/	n column 1. (See CMS Pub.			lf	N		146.
						1.00	_
17.00Was there a change in the statist	ical basis? Enter "Y" for	yes or "N" for	no.			N N	147.
18.00 Was there a change in the order o	f allocation? Enter "Y" fo	or yes or "N" f	or no.			N	148.
19.00 Was there a change to the simplif	ied cost finding method? E				: +1 - \/	N Title XIX	149.
		Part A 1.00	2. 00	- 1	itle V 3.00	4.00	
Does this facility contain a prov	ider that qualifies for a			cation c			
or charges? Enter "Y" for yes or	"N" for no for each compo			. (See 4		· ·	
55.00Hospi tal 66.00Subprovi der – IPF		N N	N N		N N	N N	155. 156.
57. 00 Subprovider - TRF		N	N N		N	N	157.
58. 00 SUBPROVI DER							158.
99. 00 SNF		N	N		N	N	159.
O. OO HOME HEALTH AGENCY		N	N N		N	N	160.
11. 00 CMHC			l N		N	N	161.
Multicampus						1.00	
o5.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that has or	ne or more camp	uses in dif	ferent C	BSAs?	N	165.
, , , , , , , , , , , , , , ,	Name	County		i p Code	CBSA	FTE/Campus	
6.00 f line 165 is yes, for each	0	1. 00	2.00	3. 00	4. 00	5. 00	00 166.
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)							
122. 4 3 (223 . 11311 4011 6113)					<u> </u>		
	T) !t! . ! . !	D.	al Da'			1. 00	
Health Information Technology (HI 7.00 s this provider a meaningful use	1) Incentive in the Americ	can Recovery ar	nd Reinvestm	ent Act		Υ	 167.
67.00 s this provider a meaningful use 8.00 f this provider is a CAH (line 1				'), ente	r the	Y	167.
reasonable cost incurred for the			13	,, one			
8.01 If this provider is a CAH and is	not a meaningful user, doe	es this provide			dshi p	N	168.
exception under §413.70(a)(6)(ii) 9.00 f this provider is a meaningful					enter tho		00169.
transition factor. (see instruction			(//],

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lie	2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDEN	F				
			To 09/30/2021		
			Begi nni ng	Endi ng	
			1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beginn period respectively (mm/dd/yyyy)			170. 00		
			1. 00	2. 00	
171.00 f ine 167 is "Y", does this provider section 1876 Medicare cost plans report	N	0	171. 00		
"Y" for yes and "N" for no in column 1. 1876 Medicare days in column 2. (see in		nter the number of secti	on		

	Financial Systems PULASKI MEMORIA AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 1E 120E		u of Form CMS-	
HOSPI I	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Peri od: From 10/01/2020 To 09/30/2021	Date/Time Pro	epared:
				Y/N	9/19/2022 5: Date	14 pm
				1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	esponses. Ent	er all dates in	the	
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
1. 00	Has the provider changed ownership immediately prior to the			N		1.00
	reporting period? If yes, enter the date of the change in c	olumn 2. (see	instructions Y/N) Date	V/I	
			1.00	2. 00	3. 00	
2. 00	Has the provider terminated participation in the Medicare P		N			2.00
	yes, enter in column 2 the date of termination and in column	n 3, "V" for				
3. 00	voluntary or "I" for involuntary. Is the provider involved in business transactions, includin	a management	l N			3.00
0.00	contracts, with individuals or entities (e.g., chain home o					0.00
	or medical supply companies) that are related to the provid					
	officers, medical staff, management personnel, or members o of directors through ownership, control, or family and othe					
	relationships? (see instructions)	i Silliiai				
			Y/N	Туре	Date	
			1. 00	2. 00	3. 00	
4. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert	ified Public	Υ	A		4.00
4.00	Accountant? Column 2: If yes, enter "A" for Audited, "C" f		'	^		4.00
	or "R" for Reviewed. Submit complete copy or enter date ava					
- 00	column 3. (see instructions) If no, see instructions.	6				F 00
5. 00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5.00
	<u> </u>			Y/N	Legal Oper.	
				1. 00	2. 00	
6. 00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column	2. If ves in	s the provide	r N		6.00
0. 00	is the legal operator of the program?	2. 11 yes, 1.	s the provide	I IN		0.00
7. 00	Are costs claimed for Allied Health Programs? If "Y" see in			N		7.00
8. 00	Were nursing programs and/or allied health programs approve	d and/or rene	wed during th	e N		8.00
9. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education N					9.00
,, 00	program in the current cost report? If yes, see instruction		oa. oaaoar.o			1 7.00
10. 00	Was an approved Intern and Resident GME program initiated o	r renewed in	the current	N		10.00
11. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I	8. Din an Λn	orovod	N		11.00
11.00	Teaching Program on Worksheet A? If yes, see instructions.	a k ili ali Api	proved	IN.		11.00
					Y/N	
	Bad Debts				1. 00	
12. 00	Is the provider seeking reimbursement for bad debts? If yes	, see instruc	ti ons.		Υ	12.00
13. 00	If line 12 is yes, did the provider's bad debt collection p	olicy change	during this c	ost reporting	N	13.00
14 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme	nts walvada I:	Evec cealn	structions	N	14. 00
14.00	Bed Complement	iits wai veu: i	i yes, see iii	structions.	I N	14.00
15. 00	Did total beds available change from the prior cost reporti				N	15.00
	-		t A		t B	
		1. 00	2. 00	Y/N 3. 00	Date 4. 00	
	PS&R Data		2.00	0.00	11 00	
16. 00	Was the cost report prepared using the PS&R Report only?	Υ	01/18/2022	Y	01/18/2022	16. 00
	If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see					
	instructions)					
17. 00	Was the cost report prepared using the PS&R Report for	N		N		17. 00
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)					
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18.00
	Report data for additional claims that have been billed					1
	but are not included on the PS&R Report used to file this					
	cost report? If yes see instructions					
19.00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19 00
19. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19. 00

HOSPI T	Financial Systems PULASKI MEMORI. AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-1305	Peri od:	worksheet S-2	
				From 10/01/2020 To 09/30/2021	Part II Date/Time Pre	epared:
		Descri	pti on	Y/N	9/19/2022 5: 1 Y/N	14 pm
)	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	20.0
		Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.0
					1. 00	+
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS I	HOSPI TALS)		1.00	
	Capital Related Cost	om Ebileito i	1.001 1 17.20)			
22. 00	Have assets been relifed for Medicare purposes? If yes, see	instructions			N	22.0
3. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	uring the cost	N	23.0		
	Were new leases and/or amendments to existing leases entere If yes, see instructions	· ·			N	24.0
5. 00	Have there been new capitalized leases entered into during instructions.	the cost repo	rting period	f? If yes, see	N	25.0
26. 00	Thistructions. Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	e cost report	ing period?	If yes, see	N	26.0
27. 00	Has the provider's capitalization policy changed during the copy.	cost reporti	ng period? I	f yes, submit	N	27.0
8. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit en	itered into du	ring the cos	st reporting	N	28.0
9. 00	, ,					
0. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu	N	30.0			
	instructions. Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					31.0
	<u>Purchased Services</u> Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		ed through c	contractual	N	32.0
	If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to compet	itive bidding? If	,	33. (
	Provi der-Based Physi ci ans		 			١
	Are services furnished at the provider facility under an ar If yes, see instructions.	· ·	•		Y	34. (
5. 00	If \check{I} ine 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in	sting agreeme structions.	nts with the		N	35.0
				Y/N 1. 00	2. 00	
	Home Office Costs			1.00	2.00	
	Were home office costs claimed on the cost report?			N		36.0
	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.	repared by the	home office			37.0
	If $\check{\text{I}}\text{ine}$ 36 is yes , was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end	of the home	offi ce.			38. (
	If line 36 is yes, did the provider render services to othe see instructions.	•	,			39. (
0. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	9		40.0
		1.	00	2.	00	
	Cost Report Preparer Contact Information					
	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	MI CHAEL		ALESSANDRI NI		41.0
	respectively. Enter the employer/company name of the cost report	BLUE AND CO.,	LLC			42.0
2. 00	preparer.					

Health Fin	ancial Systems	PULASKI MEMOR	I AL HOSPI TA	L	In Lieu	u of Form CMS-	2552-10
HOSPI TAL A	AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi de	r CCN: 15-1305	riod: com 10/01/2020 0 09/30/2021		pared:
				3. 00			
Cost	t Report Preparer Contact Information			3.00			
41.00 Ente	d by the cost report preparer in columpetities of the first name, last name and the first name and the first preparer in columpectively.		DI RECTOR				41.00
42. 00 Ent	er the employer/company name of the co	ost report					42. 00
43. 00 Ent	parer. er the telephone number and email addr ort preparer in columns 1 and 2, respo						43.00

Heal th FinancialSystemsPULASKIHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Peri od: | Worksheet S-3 | From 10/01/2020 | Part I | Date/Time | Prepared: | Provi der CCN: 15-1305

				Т	o 09/30/2021	Date/Time Pre 9/19/2022 5:1	
						I/P Days /	
						0/P Visits /	
						Tri ps	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1. 00	2. 00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	25	9, 125	33, 864. 00	0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO I RF Subprovi der						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0.5	0.405	22 2/4 22	0	6.00
7. 00	Total Adults and Peds. (exclude observation		25	9, 125	33, 864. 00	0	7. 00
0 00	beds) (see instructions)	21 00	0		0.00		0 00
8. 00 9. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	31. 00	U		0.00	0	8. 00 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				o	13.00
14. 00	Total (see instructions)	43.00	25	9, 125	33, 864. 00		14.00
15.00	CAH visits		20	7,120	00,001.00	0	15.00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVIDER - IRF						17. 00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101. 00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE	116. 00	0	C)		24.00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25. 00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88. 00				0	26.00
26. 01	RURAL HEALTH CLINIC II	88. 01				0	26. 01
26. 02	RURAL HEALTH CLINIC III	88. 02				0	26. 02
26. 03	RURAL HEALTH CLINIC IV	88. 03				0	26. 03
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00 28. 00	Total (sum of lines 14-26)		25			0	27. 00
29. 00	Observation Bed Days					U	28. 00 29. 00
30.00	Ambulance Trips Employee discount days (see instruction)						30.00
31.00	Employee discount days (see Histruction)						31.00
32.00	Labor & delivery days (see instructions)		0	(32.00
32. 00	Total ancillary labor & delivery room						32. 00
52.01	outpatient days (see instructions)						52.01
33.00	LTCH non-covered days						33.00
33. 01	LTCH site neutral days and discharges						33. 01

Provider CCN: 15-1305

Peri od: Worksheet S-3 From 10/01/2020 Part I To 09/30/2021 Date/Time Prepared: 9/19/2022 5:14 pm

						9/19/2022 5:1	4 pm
		I/P Days	/ O/P Visits	/ Tri ps	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
		4 00	7.00	Pati ents	& Residents	Payrol I	
1. 00	Harrital Adulta & Dada (asluma E. (7 and	6. 00	7. 00	8.00	9. 00	10. 00	1.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	600	55	1, 411			1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)	234	197				2.00
3. 00	HMO IPF Subprovider	234	137				3.00
4. 00	HMO IRF Subprovider		0				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	401	0	401			5.00
6. 00	Hospital Adults & Peds. Swing Bed NF	401	0	143			6.00
7. 00	Total Adults and Peds. (exclude observation	1, 001	55	1, 955			7.00
7.00	beds) (see instructions)	1,001	55	1, 750			7.00
8. 00	INTENSIVE CARE UNIT	o	o	C	1		8.00
9. 00	CORONARY CARE UNIT	١	o _l				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		o	158	2		13.00
14. 00	Total (see instructions)	1, 001	55	2, 113		181. 69	
15. 00	CAH visits	1,001	0	2, 110		101.07	15.00
16. 00	SUBPROVIDER - IPF		J				16.00
17. 00	SUBPROVIDER - IRF						17.00
18. 00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	ol	0	C	0. 00	0.00	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24. 00	HOSPI CE	ol	0	C	0. 00	0.00	24.00
24. 10	HOSPICE (non-distinct part)		1	Ċ			24. 10
25.00	CMHC - CMHC						25.00
26. 00	RURAL HEALTH CLINIC	5, 044	261	19, 213	0.00	50. 92	26.00
26. 01	RURAL HEALTH CLINIC II	1, 791	27	4, 127		5. 27	
26. 02	RURAL HEALTH CLINIC III	329	12	967		2. 85	
26. 03	RURAL HEALTH CLINIC IV	1, 078	5	3, 197		5. 33	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	ol	o	. C		0.00	
27. 00	Total (sum of lines 14-26)				0.00	246. 06	
28. 00	Observation Bed Days		34	371			28. 00
29.00	Ambul ance Trips	ol					29.00
30.00	Employee discount days (see instruction)			C			30.00
31. 00	Employee discount days - IRF			C			31.00
32.00	Labor & delivery days (see instructions)	l ol	o	9			32.00
32. 01	Total ancillary labor & delivery room]	آ ا	C			32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	o					33.00
33. 01	LTCH site neutral days and discharges	O					33. 01
		. '			•	•	•

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 10/01/2020 | Part | | To 09/30/2021 | Date/Time Prepared: Provi der CCN: 15-1305

				To	09/30/2021	Date/Time Pre 9/19/2022 5:1	
		Full Time		Di sch	arges	77 177 2022 0. 1	T DIII
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
	I	11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	163	18	428	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)			50	78		2. 00
3. 00	HMO IPF Subprovi der			30	0		3.00
4. 00	HMO IRF Subprovider				0		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF				Ŭ		5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	163	18	428	14.00
15. 00	CAH visits						15. 00
16.00	SUBPROVIDER - I PF						16.00
17. 00	SUBPROVIDER - IRF						17. 00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20. 00 21. 00
21.00	OTHER LONG TERM CARE HOME HEALTH AGENCY	0.00					21.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	0.00					23.00
24. 00	HOSPI CE	0.00					24.00
24. 10	HOSPICE (non-distinct part)	0.00					24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	0.00					26. 00
26. 01	RURAL HEALTH CLINIC II	0.00					26. 01
26. 02	RURAL HEALTH CLINIC III	0.00					26. 02
26.03	RURAL HEALTH CLINIC IV	0.00					26. 03
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27.00	Total (sum of lines 14-26)	0.00					27.00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
22 00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days			0			33. 00 33. 01
33. UT	LTCH site neutral days and discharges			ı			33.01

Health Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1305	Peri od:	Worksheet S-8	3
		Component	CCN: 15-8512	From 10/01/2020 To 09/30/2021		
				RHC I	Cost	
		·		1.	00	
Clinic Address and Identification						
1.00 Street		540 H				1.00
			ty	State	ZIP Code	
2.00 City, State, ZIP Code, County		WI NI MAC	00	2.00	3. 00 46996-	2.00
2.00 City, State, Zir code, county		WINIWAC		110	40770-	2.00
					1.00	
3.00 HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rura	al or "U" for			0	3.00
			Grai	nt Award	Date	
Causas of Fadamal Funda				1. 00	2. 00	-
Source of Federal Funds 4.00 Community Health Center (Section 330(d), PHS	Act)		I		T	4.00
5.00 Migrant Health Center (Section 329(d), PHS A						5.00
6.00 Health Services for the Homeless (Section 34)						6.00
7.00 Appalachian Regional Commission						7.00
8. 00 Look-Alikes						8.00
9. 00 OTHER (SPECIFY)						9.00
				1. 00	2. 00	
10.00 Does this facility operate as other than a he	ospi tal -based F	RHC or FQHC? E	nter "Y" for		0	10.00
yes or "N" for no in column 1. If yes, indic. 2. (Enter in subscripts of line 11 the type o hours.)	ate number of d	other operatio	ns in column			
nour 3.)	Sund	day	N	londay	Tuesday	
	from	to	from	to	from	
	1. 00	2. 00	3. 00	4. 00	5. 00	
Facility hours of operations (1) 11.00 CLINIC			08: 00	17: 00	08: 00	11.00
TT. 00 CLINIC			06.00	17.00	06.00	11.00
				1. 00	2. 00	
12.00 Have you received an approval for an exception	on to the produ	uctivity stand	ard?	Y		12.00
13.00 Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	umn 1. If yes,	enter in colu	mn 2 the	N	0	13.00
numbers below.			Drovi	ider name	CCN number	
				1.00	2. 00	
14.00 RHC/FQHC name, CCN number						14.00
	Y/N	V	XVIII	XI X	Total Visits	
15 00 11	1. 00	2. 00	3.00	4.00	5. 00	45.00
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in						15. 00
column 1. If yes, enter in columns 2, 3 and						
4 the number of program visits performed by						
Intern & Residents for titles V, XVIII, and						
XIX, as applicable. Enter in column 5 the						
number of total visits for this provider.						
(see instructions)		Col	l Inty			
			00			
2.00 City, State, ZIP Code, County		PULASKI				2.00
	Tuesday	Wedn	esday	Thur	sday	
	to	from	to	from	to	
Encility hours of counting (1)	6. 00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1) 11.00 CLINIC	17: 30	08: 00	19: 00	08: 00	19: 00	11.00
55 551111 0	اا		1. 7. 00	100.00	1. 7. 00	1

Health Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der (Peri od:	Worksheet S-8	
				From 10/01/2020		
		Component	CCN: 15-8512	To 09/30/2021	Date/Time Pre	pared:
					9/19/2022 5: 1	4 pm
			_	RHC I	Cost	
	Fri	day	Sat	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	16: 30	08: 00	12: 00	-	11.00

Heal th	n Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPI 7	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1305	Peri od:	Worksheet S-8	3
			Component	CCN: 15-8527	From 10/01/2020 To 09/30/2021		
					RHC II	Cost	
	01:-:- Add 1 d+: £:+:				1.	00	
1. 00	Clinic Address and Identification Street				NORTH LANE STR	FET	1.00
1.00	311 66,1		Ci	ty	State	ZIP Code	1.00
				00	2.00	3. 00	
2.00	City, State, ZIP Code, County		NORTH JUDSON		IN	46366-1226	2.00
						1 00	
2 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	or "D" for rure	d or "II" for	urban		1.00	2 00
3. 00	HOSPITAL-BASED FUNCS UNLY: DESIGNATION - ENT	er k for fura	11 01 0 101		nt Award	Date	3.00
					1. 00	2.00	
	Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS						4.00
5. 00	Migrant Health Center (Section 329(d), PHS A						5.00
6. 00	Health Services for the Homeless (Section 34	O(d), PHS Act)					6.00
7. 00 8. 00	Appalachian Regional Commission Look-Alikes						7.00
9. 00	OTHER (SPECIFY)						9.00
7. 00	(or correspond			1			7.00
					1. 00	2. 00	
10.00	j 1					0	10.00
	yes or "N" for no in column 1. If yes, indic						
	2. (Enter in subscripts of line 11 the type of hours.)	or other operati	on(s) and the	operating			
	Tiour S.)	Sund	dav	T N	Monday	Tuesday	
		from	to	from	to	from	
		1. 00	2. 00	3. 00	4. 00	5. 00	
44.00	Facility hours of operations (1)	1		loo oo	47.00	laa aa	44.00
11.00	CLINIC			08: 00	17: 00	08: 00	11.00
					1. 00	2.00	
12. 00	Have you received an approval for an excepti	on to the produ	uctivity stand	ard?	Y	2.00	12.00
13.00					N	0	13.00
	30.8? Enter "Y" for yes or "N" for no in col						
	number of providers included in this report.	List the names	of all provi	ders and			
	numbers below.			Prov	ider name	CCN number	
				1100	1. 00	2. 00	
14. 00	RHC/FQHC name, CCN number						14.00
		Y/N	V	XVIII	XI X	Total Visits	
		1. 00	2. 00	3. 00	4. 00	5. 00	
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in						15.00
	column 1. If yes, enter in columns 2, 3 and						
	4 the number of program visits performed by						
	Intern & Residents for titles V, XVIII, and						
	XIX, as applicable. Enter in column 5 the						
	number of total visits for this provider.						
	(see instructions)		Col	l inty			
				00			
2. 00	City, State, ZIP Code, County		PULASKI				2.00
		Tuesday		esday		sday	
		to	from	to	from	to	
	Facility house of operations (1)	6. 00	7. 00	8. 00	9. 00	10.00	
11 00	Facility hours of operations (1)	17: 00	08: 00	17: 00	08: 00	17: 00	11. 00
11.00	OLIMIO	117.00	00.00	117.00	₁ 00. 00	117.00	1 11.00

Health Financial Systems	PULASKI	MEMORI AL	HOSPI TAL			In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provi der	CCN:		Peri od: From 10/01/2020	Worksheet S-8	}
			Component	CCN:				
						RHC II	Cost	
		Fri da	У		Sa	turday		
	fro	m	to		from	to		
	11. 0	00	12. 00		13.00	14.00		
Facility hours of operations (1)								
11. 00 CLINIC	08: 00	17	: 00					11. 00

Health Financial Systems	PULASKI MEMORI	IAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1305	Peri od:	Worksheet S-8	3
		Component	CCN: 15-8528	From 10/01/2020 To 09/30/2021		
-				RHC III	Cost	1 1 piii
				1.	00	
Clinic Address and Identification				440 E HONTOONE	TDV CTDEET	1 00
1.00 Street		Ci	ty	112 E MONTGOME State	ZIP Code	1.00
			00	2.00	3. 00	
2.00 City, State, ZIP Code, County		FRANCESVI LLE			47946-8087	2.00
				<u>.</u>		
					1.00	
3.00 HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for run	al or "U" for		-+ ^	0	3.00
			Gra	nt Award 1.00	Date 2.00	
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						5.00
6.00 Health Services for the Homeless (Section 34)	O(d), PHS Act)					6.00
7.00 Appalachian Regional Commission						7.00
8.00 Look-Alikes 9.00 OTHER (SPECIFY)						8. 00 9. 00
9.00 OTHER (SPECIFT)						9.00
				1.00	2.00	
10.00 Does this facility operate as other than a h	ospi tal -based	RHC or FQHC? E	nter "Y" for		0	10.00
yes or "N" for no in column 1. If yes, indic. 2. (Enter in subscripts of line 11 the type o hours.)						
mour 3.)	Sun	day	l N	londay	Tuesday	
	from	to	from	to	from	
	1. 00	2.00	3. 00	4. 00	5. 00	
Facility hours of operations (1)		T	loo oo	1.7.00	loo oo	1
11. 00 CLINIC			08: 00	17: 00	09: 00	11.00
				1. 00	2. 00	
12.00 Have you received an approval for an exception	on to the prod	uctivity stand	ard?	1.00 Y	2.00	12.00
13.00 Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the		0	
numbers below.			Prov	ider name	CCN number	
			1100	1. 00	2.00	
14.00 RHC/FQHC name, CCN number						14.00
	Y/N	V	XVIII	XIX	Total Visits	
45 00 11	1. 00	2. 00	3.00	4. 00	5. 00	45.00
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and						15.00
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)		0	l l l l l l l l l l l l l l l l l l l			
			inty 00			
2.00 City, State, ZIP Code, County		PULASKI	00			2.00
	Tuesday		esday	Thur	-sday	
	to	from	to	from	to	
	6. 00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1)	10.00	00.00	4.00	00.00	14, 00	44.55
11. 00 CLINIC	19: 00	08: 00	16: 00	08: 00	16: 00	11.00

Health Financial Systems	PULASKI MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1305	Peri od:	Worksheet S-8	
				From 10/01/2020		
		Component	CCN: 15-8528	To 09/30/2021		pared:
					9/19/2022 5: 1	4 pm
				RHC III	Cost	
	Fri	Fri day Sa		turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC						11. 00

Heal th	n Financial Systems	PULASKI MEMORIA	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
HOSPI 7	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1305	Peri od:	Worksheet S-8	3
			Component	CCN: 15-8554	From 10/01/2020 To 09/30/2021		
					RHC I V	Cost	
							_
	Clinia Address and Identification				1.	00	
1. 00	Clinic Address and Identification Street				2 S. PEARL STR	PEET	1.00
1.00	311 001		Ci	ty	State	ZIP Code	1.00
				00	2. 00	3. 00	
2. 00	City, State, ZIP Code, County	K	NOX		IN	46534	2.00
						1.00	
3. 00	HOSPITAL-BASED FOHCs ONLY: Designation - Ent	er "R" for rura	l or "II" for	urhan		1.00	3.00
0.00	THOSE THE BROCK TENOS ONET. BOST GRACTION EN	ioi it ioi iuiu	1 01 0 101		nt Award	Date	0.00
					1. 00	2. 00	
	Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS						4.00
5. 00 6. 00	Migrant Health Center (Section 329(d), PHS A Health Services for the Homeless (Section 34						5.00
7. 00	Appal achi an Regional Commission	o(a), ino not)		1			7.00
8.00	Look-Alikes						8.00
9. 00	OTHER (SPECIFY)						9. 00
					1 00	2.00	
10. 00	Does this facility operate as other than a h	nosni tal -hased R	HC or FOHC2 F	nter "Y" for	1. 00 N	2. 00	10.00
10.00	yes or "N" for no in column 1. If yes, indic						10.00
	2. (Enter in subscripts of line 11 the type of						
	hours.)						
		Sund			Monday	Tuesday	
		1.00	to 2.00	from 3.00	4. 00	from 5.00	
	Facility hours of operations (1)	1.00	2.00	3.00	4.00	3.00	
11.00	CLINIC			08: 00	19: 00	08: 00	11. 00
12.00	Have you received an approval for an excepti	an to the produ	ativity atand	o.c.d.2	1. 00 Y	2. 00	12.00
12. 00 13. 00						0	
	30. 8? Enter "Y" for yes or "N" for no in col						
	number of providers included in this report.	List the names	of all provi	ders and			
	numbers below.			D	:	CCN	
				Prov	ider name 1.00	CCN number 2.00	
14. 00	RHC/FQHC name, CCN number				1. 00	2.00	14.00
	<u> </u>	Y/N	V	XVIII	XIX	Total Visits	
		1. 00	2.00	3. 00	4. 00	5. 00	
15. 00							15. 00
	GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and						
	4 the number of program visits performed by						
	Intern & Residents for titles V, XVIII, and						
	XIX, as applicable. Enter in column 5 the						
	number of total visits for this provider.						
	(see instructions)		Col	l Inty			
				00			
2. 00	City, State, ZIP Code, County						2.00
		Tuesday		esday		rsday	
		to	from	to	from	to	
	Facility hours of operations (1)	6. 00	7. 00	8. 00	9. 00	10.00	
11. 00	CLINIC	19: 00 C	08: 00	19: 00	08: 00	19: 00	11.00
	1	1 1		1 1 1	1	1 7 7	,

Health Financial Systems	PULASKI MEMOR	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der 0	CCN: 15-1305	Peri od:	Worksheet S-8	
		Component	CCN: 15-8554	From 10/01/2020 To 09/30/2021	Date/Time Pre 9/19/2022 5:1	
				RHC IV	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	16: 00	08: 00	12: 00		11.00

	Financial Systems PULASKI MEMORIAL HC FAL UNCOMPENSATED AND INDIGENT CARE DATA Pr		CN: 15-1305	Peri od:	u of Form CMS-2 Worksheet S-1					
55111	AE GROOMI ENGRIED AND TROUGHT OAKE DATA	TOVI GCT CC	511. 15 1505	From 10/01/2020	Worksheet 5 1	O				
				To 09/30/2021	Date/Time Pre 9/19/2022 5:1					
					1. 00					
	Uncompensated and indigent care cost computation									
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ided by li	ne 202 col ur	nn 8)	0. 518042	1.				
	Medicaid (see instructions for each line)				200 77/					
00	Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid?				899, 776	2.				
00	If line 3 is yes, does line 2 include all DSH and/or supplementa	al navment	ts from Madia	rai d2	Y N	3. 4.				
00	If line 4 is no, then enter DSH and/or supplemental payments from	1 2		zar u :	235, 830	•				
00	Medi cai d charges 10, 666, 898 6									
00	Medicaid cost (line 1 times line 6)				5, 525, 901	7.				
00	Difference between net revenue and costs for Medicaid program (I	line 7 mir	nus sum of li	nes 2 and 5; if	4, 390, 295	8.				
	< zero then enter zero)									
00	Children's Health Insurance Program (CHIP) (see instructions for	r each lir	ne)		0					
00	Net revenue from stand-alone CHIP Stand-alone CHIP charges				0					
. 00	Stand-alone CHIP cost (line 1 times line 10)				0	11.				
2. 00	1 '	line 11 mi	nus line 9:	if < zero then	0					
	enter zero)				_					
	Other state or local government indigent care program (see instr									
3. 00	Net revenue from state or local indigent care program (Not inclu			,		13.				
1. 00	Charges for patients covered under state or local indigent care	program ((Not included	d in lines 6 or	0	14.				
5. 00	10) State or local indigent care program cost (line 1 times line 14))			0	15.				
	Difference between net revenue and costs for state or local indi		e program (Li	ne 15 minus line	-	•				
3. 00	13; if < zero then enter zero)	r gont our c	program (ri	THE TO MITTIGS TITLE		10.				
	Grants, donations and total unreimbursed cost for Medicaid, CHIF instructions for each line)	P and stat	te/Local indi	gent care progra	ms (see					
7. 00	,	ndi ng char	rity care		0	17.				
	Government grants, appropriations or transfers for support of ho				0					
9. 00	Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)	i ndi gent	care program	ns (sum of lines	4, 390, 295	19.				
			Uni nsured	Insured	Total (col. 1					
			pati ents	pati ents	+ col . 2)					
	Uncompensated Care (see instructions for each line)		1. 00	2. 00	3. 00					
0. 00	Charity care charges and uninsured discounts for the entire faci	ility	101, 5	01 0	101, 501	20.				
	(see instructions)									
1. 00	Cost of patients approved for charity care and uninsured discour	nts (see	52, 5	82 0	52, 582	21.				
2. 00	instructions) Payments received from patients for amounts previously written of	off ac	150, 7	91 0	150, 791	22				
2.00	charity care	orr as	150, 7	71	150, 741	22.				
				0 0	0	23.				
3. 00	· · · · · · · · · · · · · · · · · · ·									
3. 00					1. 00					
	Does the amount on line 20 column 2, include charges for patient		yond a Length	n of stay limit	N	24.				
1. 00	imposed on patients covered by Medicaid or other indigent care patient line 24 is yes, enter the charges for patient days beyond the	program? ´	·	,						
4. 00 5. 00	imposed on patients covered by Medicaid or other indigent care plf line 24 is yes, enter the charges for patient days beyond the stay limit	program? e indigent	t care progra	,	0	25.				
4. 00 5. 00 6. 00	imposed on patients covered by Medicaid or other indigent care plf line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see inst	program? e indigent tructions)	t care progra	,	0 1, 039, 738	25. 26.				
4. 00 5. 00 6. 00 7. 00	imposed on patients covered by Medicaid or other indigent care plf line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see instead care reimbursable bad debts for the entire hospital complex	program? e indigent tructions) (see inst	t care progra) tructions)	,	0 1, 039, 738 289, 003	27.				
4. 00 5. 00 6. 00 7. 00 7. 01	imposed on patients covered by Medicaid or other indigent care plf line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see inst	program? e indigent tructions) (see inst	t care progra) tructions)	,	0 1, 039, 738	25. 26. 27. 27.				
4. 00 5. 00 6. 00 7. 00 7. 01 8. 00	imposed on patients covered by Medicaid or other indigent care plf line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see instead care reimbursable bad debts for the entire hospital complex Medicare allowable bad debts for the entire hospital complex (see	program? e indigent tructions) (see inst ee instruc	t care progra	am's length of	0 1, 039, 738 289, 003 444, 620	25. 26. 27. 27. 28.				
6. 00 7. 00 7. 01 8. 00 9. 00 0. 00	imposed on patients covered by Medicaid or other indigent care partial line 24 is yes, enter the charges for patient days beyond the stay limit. Total bad debt expense for the entire hospital complex (see instantial care reimbursable bad debts for the entire hospital complex Medicare allowable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions)	program? e indigent tructions) (see inst ee instruc ense (see	t care progra	am's length of	0 1, 039, 738 289, 003 444, 620 595, 118	25. 26. 27. 27. 28. 29.				

Heal th	Financial Systems	PULASKI MEMORIA	AL HOSPITAL		In Lieu of Form CMS-2552-10			
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der C	CN: 15-1305 F	Peri od:	Worksheet A		
					From 10/01/2020 Fo 09/30/2021			
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	Reclassified	T DIII	
				+ col . 2)	i ons (See	Trial Balance		
				,	A-6)	(col. 3 +-		
					·	col. 4)		
		1. 00	2. 00	3. 00	4. 00	5. 00		
	GENERAL SERVICE COST CENTERS							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1, 538, 350	1, 538, 350	41, 588	1, 579, 938	1.00	
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	6, 314, 311	6, 314, 311	1 0	6, 314, 311	4.00	
5.00	00500 ADMINISTRATIVE & GENERAL	2, 941, 010	3, 325, 904			6, 365, 584	5.00	
7.00	00700 OPERATION OF PLANT	402, 698	547, 897	950, 595	5 0	950, 595	7. 00	
8.00	00800 LAUNDRY & LINEN SERVICE	12, 052	48, 015			60, 067	8. 00	
9. 00	00900 HOUSEKEEPI NG	203, 895	123, 858			327, 753	9. 00	
10.00	01000 DI ETARY	213, 016	169, 597			382, 613	10.00	
13.00	01300 NURSI NG ADMI NI STRATI ON	426, 481	397, 825			824, 306	13.00	
14. 00	01400 CENTRAL SERVICES & SUPPLY	22, 105	38, 433	60, 538	0	60, 538	14. 00	
15. 00	01500 PHARMACY	0	0	(٠	0	15. 00	
16. 00	01600 MEDICAL RECORDS & LIBRARY	334, 050	48, 937			382, 987	16. 00	
17. 00	01700 SOCI AL SERVI CE	36, 402	43	36, 445	5 0	36, 445	17. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS			1				
30.00	03000 ADULTS & PEDIATRICS	2, 065, 383	176, 336			2, 421, 026	30.00	
31.00	03100 INTENSIVE CARE UNIT	0	0	C	-	0	31.00	
43.00	04300 NURSERY	16, 233	3, 848	20, 081	37, 430	57, 511	43.00	
	ANCILLARY SERVICE COST CENTERS			T				
50.00	05000 OPERATING ROOM	600, 453	106, 536				50.00	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	48, 231	20, 117					
53. 00	05300 ANESTHESI OLOGY	0	509, 937			509, 937	53.00	
54.00	05400 RADI OLOGY-DI AGNOSTI C	885, 995	528, 826			1, 414, 821	54.00	
60.00	06000 LABORATORY	719, 536	734, 227	1, 453, 763	0	1, 453, 763	60.00	
60. 01	06001 BLOOD LABORATORY	0	0		0	0	60. 01	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	33, 582			33, 582	63.00	
65.00	06500 RESPI RATORY THERAPY	354, 467	40, 530			394, 997	65.00	
66.00	06600 PHYSI CAL THERAPY	950, 925	64, 684			1, 015, 609		
67.00	06700 OCCUPATI ONAL THERAPY	140, 602	390			140, 992	67.00	
68.00	06800 SPEECH PATHOLOGY	75, 583	3, 202			78, 785		
69.00	06900 ELECTROCARDI OLOGY	0	17, 988			17, 988		
69. 01	06901 CARDI AC REHABI LI TATI ON	71, 200	2, 893			74, 093	•	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	550 (50	٠	0	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	553, 658			337, 134	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	4, 40,	0 070 004	0 400 400	,	l	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	46, 196	2, 073, 994			_,,	73.00	
76. 00	03020 ONCOLOGY	118, 989	38, 880	157, 869	9 0	157, 869	76. 00	
00 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	5, 391, 570	363, 488	5, 755, 058	1 540 000	4 204 040	88. 00	
88. 00 88. 01	08801 RURAL HEALTH CLINIC	710, 136	101, 416				1	
88. 02	08802 RURAL HEALTH CLINIC III	204, 974	29, 876	•			1	
88. 03	08803 RURAL HEALTH CLINIC IV	i i				l '		
90.00	09000 CLINIC	561, 594 51, 813	67, 866 193, 063	•		244, 876		
	09100 EMERGENCY	1, 060, 793				2, 402, 912		
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,000,793	1, 342, 119	2, 402, 912	2	2, 402, 912	92.00	
92.00	OTHER REIMBURSABLE COST CENTERS						92.00	
101 00	10100 HOME HEALTH AGENCY	O	0		0	0	101.00	
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>			<u> </u>	0	101.00	
116 00	11600 HOSPI CE	ol	0		0	0	116. 00	
118.00		18, 666, 382	19, 560, 626					
110.00	NONREI MBURSABLE COST CENTERS	10,000,302	17, 300, 020	30, 227, 000	30, 701	30, 237, 707	1110.00	
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	ما	^				190. 00	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0				190.00	
	1900 HOWECARE	286, 243	E2 7/1	339, 984	1, 441	341, 425		
	19200 PHYSICIANS PRIVATE OFFICES	200, 243	53, 741	337, 784	1, 441		192.00	
	007950 MARKETI NG	84, 687	130, 929	215, 616	-32, 342			
200.00		19, 037, 312	19, 745, 296					
200.00	TOTAL (Som of LINES 110 till bugit 177)	17,007,012	17, 143, 270	1 30, 702, 000	J ₁ 0	1 30, 702, 000	1200.00	

Provi der CCN: 15-1305

Peri od: From 10/01/2020 To 09/30/2021 Date/Ti me Prepared: 9/19/2022 5:14 pm

				9/19/2022 5:1	
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For		
			Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS			T.	
1. 00	00100 NEW CAP REL COSTS-BLDG & FIXT	-17, 033	1, 562, 905		1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	6, 314, 311		4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	-912, 827	5, 452, 757		5.00
7. 00	00700 OPERATION OF PLANT	-278	950, 317	1	7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	60, 067		8.00
9. 00	00900 HOUSEKEEPI NG	0	327, 753		9.00
10.00	01000 DI ETARY	-61, 852	320, 761	l control of the cont	10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0 004	824, 306		13.00
	01400 CENTRAL SERVICES & SUPPLY	-9, 084	51, 454		14.00
15.00	01500 PHARMACY	4 51/	0		15.00
	01600 MEDICAL RECORDS & LIBRARY	-4, 516	378, 471		16.00
17.00	O1700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	36, 445	0	17. 00
30. 00	03000 ADULTS & PEDIATRICS	-512, 167	1, 908, 859		30.00
	1 1	-312, 107 0	1, 900, 039		31.00
	04300 NURSERY	0		l e e e e e e e e e e e e e e e e e e e	43.00
43.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	37,311		45.00
50.00	05000 OPERATING ROOM	-1, 338, 278	430, 334		50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	115, 136		52.00
	05300 ANESTHESI OLOGY	-500, 000	9, 937		53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 414, 821		54.00
	1 1	0	1, 453, 763		60.00
60. 01	06001 BLOOD LABORATORY	0	0		60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	33, 582		63.00
65.00	06500 RESPIRATORY THERAPY	0	394, 997	,	65.00
66.00	06600 PHYSI CAL THERAPY	0	1, 015, 609		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	140, 992		67.00
68.00	06800 SPEECH PATHOLOGY	0	78, 785		68. 00
69. 00	06900 ELECTROCARDI OLOGY	-4, 503	13, 485		69.00
	06901 CARDI AC REHABI LI TATI ON	0	74, 093	3	69. 01
	07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	337, 134		71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	216, 524		72.00
	07300 DRUGS CHARGED TO PATIENTS	-11, 361	2, 108, 829		73.00
76.00	03020 ONCOLOGY	-30, 000	127, 869	/	76. 00
00 00	OUTPATIENT SERVICE COST CENTERS O8800 RURAL HEALTH CLINIC	0	4 204 040		00 00
88. 00 88. 01	08801 RURAL HEALTH CLINIC	0	4, 206, 960 868, 768		88. 00 88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	264, 825		88. 02
	08803 RURAL HEALTH CLINIC IV	0	655, 862		88. 03
	09000 CLINIC	0	244, 876		90.00
	09100 EMERGENCY	0	2, 402, 912		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	Ö	2, 102, 712		92.00
72.00	OTHER REIMBURSABLE COST CENTERS				72.00
101.00	10100 HOME HEALTH AGENCY	0	0		101.00
	SPECIAL PURPOSE COST CENTERS			1	
116.00	11600 HOSPI CE	0	0		116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-3, 401, 899	34, 856, 010		118.00
	NONREI MBURSABLE COST CENTERS				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
	19001 HOMECARE	0	0		190. 01
	19200 PHYSICIANS' PRIVATE OFFICES	0	341, 425		192. 00
	19201 KNOX RHC	0	0)	192. 01
	07950 MARKETI NG	0	183, 274		194.00
200.00	TOTAL (SUM OF LINES 118 through 199)	-3, 401, 899	35, 380, 709	' I	200.00

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

	STITCATIONS			Trovider	JON. 15-1305	From 10/01/2020 To 09/30/2021	Date/Time Prep 9/19/2022 5: 14	
		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	41, 588				1.00
	FIXT							
	0		0	41, 588				
	B - MARKETING RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5. 00	1 <u>2, 7</u> 03	1 <u>9, 6</u> 39				1.00
	0		12, 703	19, 639				
	C - IMPLANATABLE DEVICE							
1.00	IMPL. DEV. CHARGED TO	72. 00	0	216, 524				1.00
	PATI ENTS							
	0		0	216, 524				
	D - PHYSICIAN SALARIES							
1.00	ADULTS & PEDIATRICS	30.00	263, 525	0				1.00
2.00	OPERATING ROOM	50.00	1, 061, 623	0				2.00
3.00	RURAL HEALTH CLINIC II	88. 01	23, 810	0				3.00
4.00	RURAL HEALTH CLINIC III	88. 02	21, 578	0				4.00
5.00	RURAL HEALTH CLINIC IV	88. 03	27, 716	0				5.00
6.00	PHYSICIANS' PRIVATE OFFICES	192. 00	1, 441	0				6.00
	0		1, 399, 693	0				
	G - PATIENT ACCOUNTS RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5. 00	107, 916	0				1.00
	0		107, 916	0				
	H - RHC DEPT 175 RECLASS							
1.00	RURAL HEALTH CLINIC II	88. 01		35, 839				1.00
2.00	RURAL HEALTH CLINIC III	88. 02		8, 397				2.00
3.00	RURAL HEALTH CLINIC IV	88. 03		27, 763				3.00
	0 — — — — —	T		71, 999				
	I - RN SALARIES RECLASS							
1.00	NURSERY	43. 00	37, 430	0				1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	46, 788	0				2.00
	0		84, 218					
500.00	Grand Total: Increases		1, 604, 530	349, 750			[500.00

Peri od: Worksheet A-6
From 10/01/2020
To 09/30/2021 Date/Time Prep

					То	Date/Time 9/19/2022	
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	A - PROPERTY INSURANCE						
1.00	ADMI NI STRATI VE & GENERAL	500	0	4 <u>1, 5</u> 88			1.00
	0		0	41, 588			
	B - MARKETING RECLASS						
1.00	MARKETI NG	1 <u>94.</u> 00	1 <u>2, 7</u> 03	1 <u>9, 6</u> 39			1.00
	0		12, 703	19, 639			
	C - IMPLANATABLE DEVICE						
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	216, 524	0		1. 00
	PATI ENTS						
	0		0	216, 524			
	D - PHYSICIAN SALARIES				T		
1. 00	RURAL HEALTH CLINIC	88. 00	1, 368, 183	0	0		1.00
2.00	RURAL HEALTH CLINIC II	88. 01	2, 433	0	0		2. 00
3. 00	RURAL HEALTH CLINIC IV	88. 03	29, 077	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5. 00
6.00		0.00	0	0			6. 00
	0		1, 399, 693	0			
1 00	G - PATIENT ACCOUNTS RECLASS	00.00	407.047		.l		1 00
1. 00	RURAL HEALTH CLINIC		107, 916	0			1. 00
	0		107, 916	0			
1. 00	H - RHC DEPT 175 RECLASS RURAL HEALTH CLINIC	88. 00	ما	71, 999	0		1.00
2. 00	RURAL HEALTH CLINIC	0.00	0	71, 999			2.00
3. 00		0.00	0	0			3.00
3.00				000	 		3.00
	I - RN SALARIES RECLASS		U	71, 999			
1. 00	ADULTS & PEDIATRICS	30.00	84, 218	0			1.00
2. 00	ADULIS & PEDIATRICS	0.00	84, 218	0			2.00
2.00		<u> </u>		5	 		2.00
500 00	Grand Total: Decreases		1, 604, 530	349, 750			500.00
500.00	poraniu rotar. Decreases	I	1, 004, 530	349, 750	ή Ι		1 300.00

| Period: | Worksheet A-7 | From 10/01/2020 | Part | To 09/30/2021 | Date/Time Prepared: Provider CCN: 15-1305

Acquisitions Acquisitions	2022 5: 1	4 pili
	als and	
	ements	
	. 00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES		
1.00 Land 195, 525 0 0 0	0	1.00
2.00 Land Improvements 432,594 0 0 0	0	2.00
3.00 Buildings and Fixtures 13,253,038 0 0 0	0	3.00
4.00 Building Improvements 187,055 0 0 0	0	4.00
5.00 Fi xed Equipment 7,449,386 2,641,104 0 2,641,104	0	5.00
6.00 Movable Equipment 9,029,066 748,156 0 748,156	0	6.00
7.00 HIT designated Assets 0 0 0 0	0	7.00
8.00 Subtotal (sum of lines 1-7) 30,546,664 3,389,260 0 3,389,260	0	8.00
9.00 Reconciling tems 0 0 0	0	9. 00
10. 00 Total (line 8 minus line 9) 30, 546, 664 3, 389, 260 0 3, 389, 260	0	10.00
Endi ng Fully		
Bal ance Depreciated		
Assets		
6.00 7.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES		
1. 00 Land 195, 525 0		1.00
2.00 Land Improvements 432,594 0		2.00
3.00 Buildings and Fixtures 13,253,038 0		3.00
4.00 Building Improvements 187,055 0		4.00
5.00 Fi xed Equipment 10,090,490 0		5.00
6.00 Movable Equipment 9,777,222 0		6.00
7.00 HIT designated Assets 0 0		7. 00
8.00 Subtotal (sum of lines 1-7) 33,935,924 0		8. 00
9.00 Reconciling Items 0 0		9.00
10.00 Total (line 8 minus line 9) 33, 935, 924 0		10.00

Health Financial Systems	PULASKI MEM	MORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS	CENTERS	Provi der C		Period: From 10/01/2020 To 09/30/2021		pared:
		SI	JMMARY OF CAPI	TAL		
Cost Center Descriț	Depreciation Depreciation	on Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9. 00	10. 00	11. 00	12.00	13.00	
PART II - RECONCILIATION	OF AMOUNTS FROM WORKSHEET A, CO	DLUMN 2, LINES 1	and 2			
1.00 NEW CAP REL COSTS-BLDG &	FI XT 1, 538,	350 C)	0	0	1.00
3.00 Total (sum of lines 1-2)	1, 538,	350 C)	0 0	0	3.00
	SUMMAR	Y OF CAPITAL				
Cost Center Descrip	otion Other	Total (1)				
	Capi tal -Rel	at (sum of cols.				
	ed Costs (s	see 9 through 14)				
	instruction	ns)				
	14. 00	15. 00				
PART II - RECONCILIATION	OF AMOUNTS FROM WORKSHEET A, CO	DLUMN 2, LINES 1	and 2			
1.00 NEW CAP REL COSTS-BLDG &	FIXT	0 1, 538, 350			·	1.00
3.00 Total (sum of lines 1-2)		0 1, 538, 350)			3.00

Health Financial Systems	PULASKI MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od:	Worksheet A-7	
				From 10/01/2020 o 09/30/2021		arod:
			'	0 09/30/2021	9/19/2022 5: 14	
	COM	PUTATION OF RA	TI 0S	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tali zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 -			
	1.00	2.00	col . 2) 3.00	4.00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS (1. 00	2.00	3.00	4.00	5.00	
1.00 NEW CAP REL COSTS-BLDG & FLXT	33, 935, 924	0	33, 935, 924	1. 000000	0	1. 00
3.00 Total (sum of lines 1-2)	33, 935, 924					3.00
3.00 Total (Suill Of Titles 1-2)		TION OF OTHER (DF CAPITAL	3.00
	ALLOCA	ITON OF OTTIER (DALLIAL	JOIWIMART	OALLIAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
	1	Capi tal -Rel at				
		ed Costs	through 7)			
	6. 00	7. 00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS (ENTERS					
1.00 NEW CAP REL COSTS-BLDG & FLXT	0	0	C	1, 537, 617	0	1.00
3.00 Total (sum of lines 1-2)	0		(1, 537, 617	0	3.00
		Sl	JMMARY OF CAPI	ΓAL		
		1 .	1 -			
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
		(see	instructions)	Capi tal -Rel at		
		instructions)		ed Costs (see	9 through 14)	
	11. 00	12. 00	13. 00	instructions)	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS (12.00	13.00	14.00	15.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT	-16, 300	41, 588		0	1, 562, 905	1. 00
3.00 Total (sum of lines 1-2)	-16, 300		•			3. 00
5. 66 Total (Sum of Tries 1-2)	1 -10, 300	1 41, 300	1	,	1, 302, 703	5.00

	(chapter 21)						
9. 00	Parking Lot (chapter 21)		C		0. 00		
10.00	Provi der-based physician	A-8-2	-1, 884, 948			0	10.00
	adj ustment						
11. 00	Sale of scrap, waste, etc.		C		0. 00	0	11.00
	(chapter 23)						
12.00	Related organization	A-8-1	C			0	12.00
	transactions (chapter 10)						
13.00	Laundry and linen service		C		0.00	0	13.00
14.00	Cafeteria-employees and guests		C		0.00	0	14.00
15.00	Rental of quarters to employee		C		0.00	0	15.00
	and others						
16.00	Sale of medical and surgical		C		0.00	0	16.00
	supplies to other than		_			_	
	patients						
17. 00	Sale of drugs to other than		C		0. 00	0	17. 00
17.00	patients				0.00		17.00
18. 00	Sale of medical records and		C		0.00	0	18. 00
10.00	abstracts				0.00		10.00
19. 00	Nursing and allied health		C		0. 00	0	19.00
19.00	education (tuition, fees,		C		0.00		19.00
	,						
20. 00	books, etc.)		C		0.00	0	20.00
	Vending machines				0.00		
21. 00	Income from imposition of		C		0. 00	0	21.00
	interest, finance or penalty						
00.00	charges (chapter 21)				0.00		00.00
22. 00	Interest expense on Medicare		C		0. 00	0	22. 00
	overpayments and borrowings to	1					
	repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	C	RESPI RATORY THERAPY	65. 00		23. 00
	therapy costs in excess of						
	limitation (chapter 14)						
24.00	Adjustment for physical	A-8-3	C	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of						
	limitation (chapter 14)						
25.00	Utilization review -		C	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation						
	(chapter 21)						
26.00	Depreciation - NEW CAP REL		C	NEW CAP REL COSTS-BLDG &	1.00	0	26.00
	COSTS-BLDG & FLXT			FIXT			
27.00	Depreciation - CAP REL		C	*** Cost Center Deleted ***	2.00	0	27.00
	COSTS-MVBLE EQUIP						
28.00	Non-physician Anesthetist		C	*** Cost Center Deleted ***	19. 00		28. 00
29.00	Physicians' assistant		C		0. 00	0	29. 00
30.00	Adjustment for occupational	A-8-3	C	OCCUPATIONAL THERAPY	67.00		30.00
	therapy costs in excess of						
	limitation (chapter 14)						
30. 99	Hospi ce (non-di sti nct) (see		C	ADULTS & PEDIATRICS	30.00		30. 99
	instructions)						
		'	•	1		'	•
MCDL E3	2 17 11 175 0						
WICKI F3	2 - 17. 11. 175. 0						

Heal th	Financial Systems		PULASKI MEMORI	IAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 10/01/2020 To 09/30/2021	Date/Time Pre	narad.
					To 09/30/2021	9/19/2022 5: 1	
				Expense Classification on	Worksheet A	,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
				To/From Which the Amount is			
					-		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	cost center beserretron	(2)	7 tillodi i e		Errio "	Ref.	
		1. 00	2. 00	3.00	4. 00	5. 00	
31.00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
	pathology costs in excess of						
	limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0.00	0	32.00
	Depreciation and Interest	_		L			
33. 00	INVEST INC/UNRESTRIC- INT EXP	В		NEW CAP REL COSTS-BLDG &	1. 00	11	33.00
33. 01	OTHER SERVICES -OTHER REV	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 01
33. 01	CAFETERIA VENDING - OTHER REV	В	· ·	DIETARY	10.00	0	33.01
33. 02	REBATES & REFUNDS - OTHER REV	В		CENTRAL SERVICES & SUPPLY	14. 00	0	33. 02
33. 04	MEDICAL RECORDS FEES -OTHER	В		MEDICAL RECORDS & LIBRARY	16. 00	0	33. 04
00.0.	REV	5	., 0.0	mest one negotibo a erbitini.	10.00	· ·	00.0.
33. 05	EMPLOYEE RX PROGRAM -OTHER REV	В	-11, 361	DRUGS CHARGED TO PATIENTS	73. 00	0	33. 05
33.07	TELEVI SI ON	А	-278	OPERATION OF PLANT	7. 00	0	33. 07
33.08	PHYSICIAN RECRUITMENT- ADMIN	Α	-6, 776	ADMINISTRATIVE & GENERAL	5. 00	0	33. 08
33. 09	LOBBYING EXPENSE	Α		ADMINISTRATIVE & GENERAL	5. 00	0	33. 09
33. 10	CRNA	А		ANESTHESI OLOGY	53. 00	0	33. 10
33. 11	HAF EXPENSE	Α		ADMINISTRATIVE & GENERAL	5. 00	0	33. 11
33. 12	EHR DEPRECIATION ON 2012	Α		NEW CAP REL COSTS-BLDG &	1.00	9	33. 12
EO 00	PAYMENT			FLXT			FO 00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,		-3, 401, 899				50.00
	(II alisiel to worksheet A,				1		

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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

0.00

0.00

0.00

8.00

9.00

10.00

200.00

Provider CCN: 15-1305

Peri od: Worksheet A-8-2 From 10/01/2020

0

0

0 1, 884, 948

0

0

8.00

9.00

10.00

200.00

09/30/2021 Date/Time Prepared: 9/19/2022 5: 14 pm Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov I denti fi er ider Component Remuneration Component Component Hours 1.00 2.00 3. 00 4.00 5. 00 6 00 7 00 30.00 ADULTS & PEDIATRICS 1.00 512, 167 512, 167 0 1.00 2.00 50.00 OPERATING ROOM 1, 338, 278 1, 338, 278 0 0 0 2.00 60. 00 LABORATORY 3.00 660 660 0 0 0 0 3.00 0 4.00 69. 00 ELECTROCARDI OLOGY 4, 503 4,503 4.00 0 76. 00 ONCOLOGY 5.00 30,000 30,000 0 0 5.00 6.00 90. 00 CLI NI C 36, 500 36, 500 6.00 0 91. 00 EMERGENCY 7.00 1, 232, 616 0 1, 232, 616 0 7.00 0.00 8.00 0 8.00 0 0 9.00 0.00 0 9.00 10.00 0.00 0 10.00 3, 154, 724 1, 884, 948 1, 269, 776 200.00 200.00 Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Provi der Physician Cost Cost of I denti fi er Li mi t Unadjusted RCE Memberships & Component of Malpractice Limit Conti nui ng Share of col Insurance Education 12.00 1.00 2.00 8. 00 9.00 13.00 14. 00 30.00 ADULTS & PEDIATRICS 1.00 0 0 1.00 2.00 50.00 OPERATING ROOM 0 0 0 0 2.00 60. 00 LABORATORY 3.00 0 0 0 0 3.00 0 0 69. 00 ELECTROCARDI OLOGY 0 0 4.00 0 4 00 5.00 76. 00 ONCOLOGY 0 0 0 5.00 0 90. 00 CLI NI C 0 6.00 0 0 0 0 6.00 91. 00 EMERGENCY 0 0 7 00 7.00 0 0 0 0 8.00 0.00 0 8.00 9.00 0.00 0 0 9.00 0 10.00 0.00 0 0 0 0 10.00 o 200.00 200.00 Wkst. A Line # Cost Center/Physician Provi der Adjusted RCE RCE Adjustment I denti fi er Component Limit Di sal I owance Share of col. 14 2.00 1.00 16.00 17.00 18.00 15.00 1.00 30. 00 ADULTS & PEDIATRICS 0 0 0 512, 167 1.00 0 50. 00 OPERATING ROOM 0 0 2.00 1, 338, 278 2.00 0 3.00 60. 00 LABORATORY 0 3.00 0 69. 00 ELECTROCARDI OLOGY 0 4.00 4,503 4.00 5.00 76. 00 ONCOLOGY 0 0 0 30,000 5.00 6.00 90. 00 CLI NI C 0 0 0 6.00 91. 00 EMERGENCY 0 0 0 7.00 7 00 0

0

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Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Period: Worksheet B From 10/01/2020 Part I Provi der CCN: 15-1305

				Fr To	om 10/01/2020 09/30/2021	Date/Time Pre	
			CAPI TAL			9/19/2022 5: 1	4 pm
			RELATED COSTS				
	Cost Center Description	Net Expenses for Cost	NEW BLDG & FLXT	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIV E & GENERAL	
		Allocation	FIXI	DEPARTMENT		E α GENERAL	
		(from Wkst A					
		col. 7)	1.00	4.00	4.0	F 00	
	GENERAL SERVICE COST CENTERS	0	1. 00	4. 00	4A	5. 00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	1, 562, 905	1, 562, 905				1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	6, 314, 311	27, 419				4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL	5, 452, 757	303, 902		6, 776, 552		5.00
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE	950, 317 60, 067	136, 548 12, 658		1, 221, 012 76, 740		7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	327, 753	7, 759		403, 434	95, 577	9.00
10.00	01000 DI ETARY	320, 761	62, 933		454, 654	107, 711	10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	824, 306	34, 127		1, 000, 503		13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	51, 454 0	19, 870 16, 296		78, 688 16, 296		14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	378, 471	32, 886		522, 636		16.00
17. 00	01700 SOCIAL SERVICE	36, 445	0		48, 571	11, 507	17. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	4 000 050	100.074	747.750	0.040.57/	/70 055	00.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	1, 908, 859	183, 964 0		2, 840, 576 0	l	30.00 31.00
43. 00	04300 NURSERY	57, 511	3, 385		78, 772	18, 662	43.00
	ANCILLARY SERVICE COST CENTERS		·		•	·	
50.00	05000 OPERATI NG ROOM	430, 334	111, 526		1, 095, 532		
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	115, 136 9, 937	13, 731 652		160, 520 10, 589		1
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 414, 821	101, 265		1, 811, 230	,	
60.00	06000 LABORATORY	1, 453, 763	29, 206		1, 722, 662		60.00
60. 01	06001 BLOOD LABORATORY	0	0	_	0	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	33, 582	1, 283		34, 865	8, 260	63.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	394, 997 1, 015, 609	16, 464 37, 197		529, 541 1, 369, 579	125, 452 324, 464	1
67. 00	06700 OCCUPATI ONAL THERAPY	140, 992	0		187, 829		1
68.00	06800 SPEECH PATHOLOGY	78, 785	0	,	103, 963		1
69. 00 69. 01	06900 ELECTROCARDI OLOGY	13, 485	0 9, 420	0	13, 485		1
70.00	06901 CARDI AC REHABI LI TATI ON 07000 ELECTROENCEPHALOGRAPHY	74, 093 0	9, 420	23, 718	107, 231 0	25, 404 0	69. 01 70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	337, 134	Ö		337, 134	79, 870	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	216, 524	0	0	216, 524		1
73. 00 76. 00	07300 DRUGS CHARGED TO PATIENTS 03020 ONCOLOGY	2, 108, 829	11 050	15, 389	2, 124, 218		1
76.00	OUTPATIENT SERVICE COST CENTERS	127, 869	11, 859	39, 638	179, 366	42, 493	76. 00
88.00	08800 RURAL HEALTH CLINIC	4, 206, 960	215, 315	1, 304, 329	5, 726, 604	1, 356, 677	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	868, 768	0	,	1, 112, 450		
88. 02 88. 03	08802 RURAL HEALTH CLINIC III	264, 825	0	75, 469	340, 294		
	O8803 RURAL HEALTH CLINIC IV O9000 CLINIC	655, 862 244, 876	0 38, 164	,	842, 487 300, 300		1
	09100 EMERGENCY	2, 402, 912			2, 881, 877		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0	l .	92.00
101 00	OTHER REIMBURSABLE COST CENTERS		0				101 00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	101. 00
116. 00	11600 HOSPI CE	0	0	0	0		116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	34, 856, 010	1, 553, 422	6, 221, 917	34, 726, 714	6, 621, 615	118.00
100.00	NONREI MBURSABLE COST CENTERS		0.400	1 2	0.400	0.0:-	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 HOMECARE	0	9, 483 0	1	9, 483		190. 00 190. 01
	19200 PHYSICIANS' PRIVATE OFFICES	341, 425	0	95, 834	437, 259	l e	
192. 01	19201 KNOX RHC	0	0	0	0	0	192. 01
	07950 MARKETI NG	183, 274	0	23, 979	207, 253	49, 100	194.00
200. 00 201. 00			0	o	0		200. 00 201. 00
201.00	1 1 3	35, 380, 709	1, 562, 905		35, 380, 709	l e	
30	, , , , , , , , , , , , , , , , , , ,		,, .00		, , . , ,	, .,,	

Provider CCN: 15-1305

Peri od: Worksheet B From 10/01/2020 Part I To 09/30/2021 Date/Time Prepared:

				10	09/30/2021	9/19/2022 5: 1	
Cost Center Descriptio	n	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	, p
,		PLANT	LINEN SERVICE			ADMI NI STRATI O	
						N	
		7. 00	8. 00	9. 00	10.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00 00100 NEW CAP REL COSTS-BLDG	& FLXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPA	RTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENER	AL						5.00
7.00 00700 OPERATION OF PLANT		1, 510, 280					7. 00
8.00 00800 LAUNDRY & LINEN SERVIC	E	12, 750	107, 670				8.00
9. 00 00900 HOUSEKEEPI NG		7, 815	0	506, 826			9. 00
10. 00 01000 DI ETARY		63, 389	0	22, 214	647, 968		10.00
13.00 01300 NURSING ADMINISTRATION		34, 374	0	12, 046	0	1, 283, 950	13.00
14.00 01400 CENTRAL SERVICES & SUP	PLY	20, 014	0	7, 014	0	0	14.00
15. 00 01500 PHARMACY		16, 414	0	5, 752	0	0	15.00
16.00 01600 MEDICAL RECORDS & LIBR	ARY	33, 124	0	11, 608	0	0	16.00
17. 00 01700 SOCIAL SERVICE		0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE CO	OST CENTERS						
30.00 03000 ADULTS & PEDIATRICS		185, 296	23, 278	64, 936	647, 968	770, 172	30.00
31.00 03100 INTENSIVE CARE UNIT		0	0	0	0	0	31.00
43. 00 04300 NURSERY		3, 410	2, 812	1, 195	0	21, 150	43.00
ANCILLARY SERVICE COST CENTE	ERS						
50.00 05000 OPERATING ROOM		112, 334	24, 369	39, 367	0		50.00
52.00 05200 DELIVERY ROOM & LABOR	ROOM	13, 830	0	4, 847	0	23, 389	52.00
53. 00 05300 ANESTHESI OLOGY		657	0	230	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		101, 998	18, 198		0	0	54.00
60. 00 06000 LABORATORY		29, 418	453	10, 309	0	0	60.00
60. 01 06001 BLOOD LABORATORY		0	0	0	0	0	60. 01
63.00 06300 BLOOD STORING, PROCESS	ING & TRANS.	1, 292	0	453	0	0	63.00
65. 00 06500 RESPIRATORY THERAPY		16, 583	0	5, 812	0	24, 469	65.00
66. 00 06600 PHYSI CAL THERAPY		50, 067	17, 966	17, 546	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, 488	0	3, 325	0	0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARG		0	0	0	0	0	71. 00
72.00 07200 I MPL. DEV. CHARGED TO		0	0	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIE	NTS	0	0	0	0	_	73. 00
76. 00 03020 ONCOLOGY		11, 945	16	4, 186	0	45, 110	76. 00
OUTPATIENT SERVICE COST CENT	ERS						
88.00 08800 RURAL HEALTH CLINIC		216, 874	1, 752	76, 003	0		88. 00
88. 01 08801 RURAL HEALTH CLINIC II		82, 683	300		0	_	88. 01
88. 02 08802 RURAL HEALTH CLINIC II		34, 776	51	12, 187	0	0	88. 02
88. 03 08803 RURAL HEALTH CLINIC IV		45, 556	0	15, 965	0	0	88. 03
90. 00 09000 CLI NI C		38, 440	0	13, 471	0	20, 718	90.00
91. 00 09100 EMERGENCY	DI OTIVOT DADT)	126, 503	18, 149	44, 332	0	228, 606	91.00
92. 00 09200 OBSERVATION BEDS (NON-							92.00
OTHER REIMBURSABLE COST CENT	ERS						
101. 00 10100 HOME HEALTH AGENCY		0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS							
116. 00 11600 HOSPI CE	0 4 11 1 447	0	_	0	0		116.00
118. 00 SUBTOTALS (SUM OF LINE		1, 269, 030	107, 344	437, 519	647, 968	1, 283, 950	118.00
NONREI MBURSABLE COST CENTERS		0.550		0.047			100 00
190. 00 19000 GIFT, FLOWER, COFFEE S	HOP & CANTEEN	9, 552	0	3, 347	0		190.00
190. 01 19001 HOMECARE	EL 0E0	0	0	(5.00	0		190. 01
192. 00 19200 PHYSI CLANS' PRI VATE OF	FICE2	231, 698	326	65, 960	0		192.00
192. 01 19201 KNOX RHC		0	0	0	0		192.01
194. 00 07950 MARKETI NG		0	0	0	0	0	194.00
200.00 Cross Foot Adjustments			_		_		200.00
201.00 Negative Cost Centers	hrough 201)	1 510 222	107 /70	F0/ 00/	(47.000		201.00
202.00 TOTAL (sum lines 118 t	ni ougn 201)	1, 510, 280	107, 670	506, 826	647, 968	1, 283, 950	ZUZ. UU

Health Financial Systems	PULASKI MEMORIA	AL HOSPLTAL		Inlie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	TOLASKI WEWOKIA	Provi der CO	CN: 15-1305	Peri od:	Worksheet B	2332 10
				From 10/01/2020	Part I	
				To 09/30/2021	Date/Time Pre 9/19/2022 5:1	
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	Subtotal	T PIII
·	SERVICES &		RECORDS &	SERVI CE		
	SUPPLY		LI BRARY			
	14. 00	15. 00	16. 00	17. 00	24. 00	
GENERAL SERVICE COST CENTERS	T					1 00
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						1.00 4.00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY						10.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	124, 358					14. 00
15. 00 01500 PHARMACY	0	42, 323				15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0				16.00
17. 00 01700 SOCIAL SERVICE	0	0		0 60, 078		17. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	O	0	21, 42	21 56, 068	5, 282, 670	30.00
31. 00 03100 NTENSI VE CARE UNI T		0		0 0 0	3, 262, 670	31.00
43. 00 04300 NURSERY		0			127, 179	1
ANCI LLARY SERVI CE COST CENTERS	<u> </u>	<u> </u>	1, 1,	, <u>o</u>	127, 177	10.00
50. 00 05000 OPERATING ROOM	0	0	57, 93	32 4, 010	1, 743, 420	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0			245, 650	1
53. 00 05300 ANESTHESI OLOGY	0	0	8, 26	59 0	22, 254	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	148, 56		2, 544, 835	1
60. 00 06000 LABORATORY	0	0	144, 37		2, 315, 332	1
60. 01 06001 BLOOD LABORATORY	0	0		0 0	0	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	2, 20		47, 071	1
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	0	11, 00 30, 51		712, 861 1, 810, 134	1
67. 00 06700 OCCUPATI ONAL THERAPY		0	5, 20		237, 531	1
68. 00 06800 SPEECH PATHOLOGY		Ö	1, 69		130, 291	1
69. 00 06900 ELECTROCARDI OLOGY	o	O	6, 17		22, 857	1
69. 01 06901 CARDI AC REHABI LI TATI ON	0	0	2, 27		147, 727	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	112, 578	0	24, 52		554, 108	1
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	11, 780	0	3, 76		283, 363	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	42, 323			2, 763, 835	1
76. 00 03020 ONCOLOGY	0	0	4, 12	24 0	287, 240	76. 00
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	O	0	48, 85	59 0	7, 426, 769	88. 00
88. 01 08801 RURAL HEALTH CLINIC II		0	7, 74		1, 495, 700	
88. 02 08802 RURAL HEALTH CLINIC III		0	1, 93		469, 860	1
88. 03 08803 RURAL HEALTH CLINIC IV	o	0	5, 43		1, 109, 035	1
90. 00 09000 CLI NI C	0	0		64 0	444, 836	1
91. 00 09100 EMERGENCY	0	0	54, 12	29 0	4, 036, 336	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
101. 00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE		ما			0	11/ 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0 124, 358	0 42, 323		0 35 60, 078		116.00
NONREI MBURSABLE COST CENTERS	124, 330	42, 323	091, 10	55 60,076	34, 200, 694]110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	24 629	190. 00
190. 01 19001 HOMECARE		0		0 0		190. 01
192.00 19200 PHYSICIANS' PRIVATE OFFICES	o	0		0 0	838, 833	
192. 01 19201 KNOX RHC	0	0		0 0	0	192. 01
194. 00 07950 MARKETI NG	0	0		0 0	256, 353	
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	.04 1	0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	124, 358	42, 323	691, 18	35 60, 078	35, 380, 709	1202.00

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

Provider CCN: 15-1305 Worksheet B From 10/01/2020 Part I 09/30/2021 Date/Time Prepared: 9/19/2022 5:14 pm Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 5, 282, 670 30.00 03100 INTENSIVE CARE UNIT 31.00 0 31.00 04300 NURSERY 43.00 43.00 0 127, 179 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 1, 743, 420 50.00 05200 DELIVERY ROOM & LABOR ROOM 0000000000000000 52.00 52.00 245, 650 05300 ANESTHESI OLOGY 53.00 22, 254 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 2, 544, 835 54.00 06000 LABORATORY 60.00 2, 315, 332 60.00 60 01 06001 BLOOD LABORATORY 60 01 Ω 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 47,071 63.00 65.00 06500 RESPIRATORY THERAPY 712, 861 65.00 06600 PHYSI CAL THERAPY 66.00 1,810,134 66.00 06700 OCCUPATI ONAL THERAPY 67 00 237, 531 67 00 06800 SPEECH PATHOLOGY 68.00 130, 291 68.00 06900 ELECTROCARDI OLOGY 22, 857 69.00 69.00 69.01 06901 CARDIAC REHABILITATION 147, 727 69.01 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 554, 108 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 283, 363 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 763, 835 73.00 03020 ONCOLOGY 0 287, 240 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 7, 426, 769 88.00 0 08801 RURAL HEALTH CLINIC II 1, 495, 700 88.01 88.01 08802 RURAL HEALTH CLINIC III 88.02 469, 860 88 02 88.03 08803 RURAL HEALTH CLINIC IV 0 1, 109, 035 88.03 0 09000 CLI NI C 90.00 444.836 90.00 91.00 09100 EMERGENCY 4,036,336 91 00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 0 0 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 116.00 0 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 0 34, 260, 894 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 24, 629 190.00 190. 01 19001 HOMECARE 0 190.01 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 838, 833 192.00 192. 01 19201 KNOX RHC 192.01 194. 00 07950 MARKETI NG 256, 353 194.00 Cross Foot Adjustments 0 200.00 200.00 0 201.00 201.00 Negative Cost Centers C 35, 380, 709 202.00 TOTAL (sum lines 118 through 201) 202.00

| Period: | Worksheet B | From 10/01/2020 | Part | I | To | 09/30/2021 | Date/Time | Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1305

					Ť	09/30/2021	Date/Time Pre 9/19/2022 5:1	
				CAPI TAL			9/19/2022 5: 1	4 piii
				RELATED COSTS				
		Cost Center Description	Di rectly	NEW BLDG &	Subtotal	EMPLOYEE	ADMI NI STRATI V	
			Assigned New	FLXT		BENEFI TS	E & GENERAL	
			Capi tal Related Costs			DEPARTMENT		
			0	1. 00	2A	4. 00	5. 00	
	GENER	AL SERVICE COST CENTERS	Ü	1.00	271	1. 00	0.00	
1.00		NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00		EMPLOYEE BENEFITS DEPARTMENT	0	27, 419		27, 419		4.00
5.00		ADMINISTRATIVE & GENERAL	0	303, 902		4, 409	308, 311	5.00
7. 00		OPERATION OF PLANT	0	136, 548		580	13, 161	7.00
8.00		LAUNDRY & LINEN SERVICE	0	12, 658		17	827	8.00
9. 00 10. 00		HOUSEKEEPI NG DI ETARY	0	7, 759 62, 933		294 307	4, 349 4, 901	9. 00 10. 00
13. 00		NURSING ADMINISTRATION	0	34, 127		614	10, 784	13. 00
14. 00	1	CENTRAL SERVICES & SUPPLY	0	19, 870		32	848	14. 00
15. 00	1	PHARMACY	0	16, 296		0	176	15. 00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	32, 886	32, 886	481	5, 633	16.00
17.00		SOCIAL SERVICE	0	0	0	52	524	17.00
		I ENT ROUTINE SERVICE COST CENTERS	1	100.044	100.011	0.000	00.440	
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	0	183, 964 0		3, 232	30, 619 0	30. 00 31. 00
43. 00		NURSERY	0	3, 385	1	0 77	849	43.00
43.00		LARY SERVICE COST CENTERS		3, 303	3, 303	7.7	047	43.00
50.00		OPERATING ROOM	0	111, 526	111, 526	2, 393	11, 809	50.00
52.00		DELIVERY ROOM & LABOR ROOM	0	13, 731	13, 731	137	1, 730	52.00
53.00		ANESTHESI OLOGY	0	652	•	0	114	53.00
54.00		RADI OLOGY-DI AGNOSTI C	0	101, 265		1, 276	19, 523	54.00
60.00		LABORATORY	0	29, 206		1, 036	18, 569	60.00
60. 01 63. 00		BLOOD LABORATORY BLOOD STORING, PROCESSING & TRANS.	0	0 1, 283	1	0	0 376	60. 01 63. 00
65.00		RESPIRATORY THERAPY	0	16, 464		510	5, 708	65. 00
66. 00		PHYSI CAL THERAPY	0	37, 197		1, 369	14, 763	
67. 00		OCCUPATI ONAL THERAPY	0	0		202	2, 025	67. 00
68.00	06800	SPEECH PATHOLOGY	0	0	0	109	1, 121	68.00
69. 00		ELECTROCARDI OLOGY	0	0	0	0	145	69. 00
69. 01		CARDI AC REHABI LI TATI ON	0	9, 420		103	1, 156	69. 01
70.00		ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3, 634	71. 00 72. 00
73.00		DRUGS CHARGED TO PATTENTS	0	0	0	67	2, 334 22, 897	72.00
76. 00		ONCOLOGY	0	11, 859	11, 859	171	1, 933	76.00
		TIENT SERVICE COST CENTERS		,			,	
88.00		RURAL HEALTH CLINIC	0	215, 315	215, 315	5, 644	61, 713	88.00
88. 01		RURAL HEALTH CLINIC II	0	0		1, 053	11, 991	88. 01
88. 02		RURAL HEALTH CLINIC III	0	0	0	326	3, 668	88. 02
88. 03 90. 00		RURAL HEALTH CLINIC IV CLINIC	0	38, 164	38, 164	807 75	9, 081 3, 237	88. 03 90. 00
91.00		EMERGENCY	0	125, 593			31, 064	
	1	OBSERVATION BEDS (NON-DISTINCT PART)		123, 373	0		31,004	92.00
		REIMBURSABLE COST CENTERS				Į.		
101.00		HOME HEALTH AGENCY	0	0	0	0	0	101.00
		AL PURPOSE COST CENTERS	1 -		1	_		
		HOSPICE	0	1 552 422		0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	0	1, 553, 422	1, 553, 422	26, 901	301, 262	118.00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9, 483	9, 483	0	102	190. 00
190. 01	1 19001	HOMECARE	0	0	0	0		190. 01
		PHYSICIANS' PRIVATE OFFICES	0	0	0	414		192. 00
	1	KNOX RHC	0	0	0	0		192. 01
		MARKETI NG	0	0	0	104		194. 00
200. 00 201. 00		Cross Foot Adjustments Negative Cost Centers		^		0		200. 00 201. 00
201.00		TOTAL (sum lines 118 through 201)	0	1, 562, 905	1, 562, 905	_		
	1	((١	., 332, 700	1, 552, 700			

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1305

				T	09/30/2021		
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	9/19/2022 5: 1 NURSI NG	4 piii
		PLANT	LINEN SERVICE			ADMI NI STRATI O	
						N	
	CENEDAL CEDALCE COCT CENTEDO	7. 00	8. 00	9. 00	10. 00	13. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT		<u> </u>	I			1. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT	150, 289					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 269	14, 771				8.00
9. 00	00900 HOUSEKEEPI NG	778	0	13, 180			9. 00
10.00	01000 DI ETARY	6, 308	0				10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	3, 421	0	313	0		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 992	0	182	0	0	14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	1, 633	0	150 302		0	15. 00 16. 00
	01700 SOCIAL SERVICE	3, 296 0					17. 00
17.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			0	0	0	17.00
30.00	03000 ADULTS & PEDIATRICS	18, 439	3, 193	1, 689	75, 027	29, 547	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0				31.00
43.00	04300 NURSERY	339	386	31	0	811	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	11, 178					50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 376	0		0		52.00
53. 00 54. 00	05300 ANESTHESI OLOGY	65	2, 497	6 930	0	0	53. 00 54. 00
60.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	10, 150 2, 927	62	1		0	60.00
60. 01	06001 BLOOD LABORATORY	2, 727	0	1			60. 01
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	129	ĺ		0	0	63.00
65.00	06500 RESPI RATORY THERAPY	1, 650			0	939	65.00
66.00	06600 PHYSI CAL THERAPY	4, 982	2, 465	456	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	944	0	86	0	0	69. 01
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	70. 00 71. 00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0		71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	_	73.00
76. 00	03020 ONCOLOGY	1, 189	2	109	0		76.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	21, 581	240				88.00
88. 01	08801 RURAL HEALTH CLINIC II	8, 228	41		0		88. 01
88. 02	08802 RURAL HEALTH CLINIC III	3, 461	7	317	0	0	88. 02
88. 03 90. 00	O8803 RURAL HEALTH CLINIC IV O9000 CLINIC	4, 533 3, 825	0		0	0 795	88. 03 90. 00
90.00	09100 EMERGENCY	12, 588	1			8, 771	90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	12, 300	2,470	1, 133	0	0,771	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS		1				
	11600 H0SPI CE	0					116. 00
118.00		126, 281	14, 726	11, 378	75, 027	49, 259	118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	951	0	87	0		190. 00
	19001 HOMECARE	0	ł .				190.00
	19200 PHYSICIANS' PRIVATE OFFICES	23, 057	45				192.00
	19201 KNOX RHC	0	0		0	0	192. 01
	07950 MARKETI NG	0	0	0	0	0	194. 00
200.00							200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	150, 289	14, 771	13, 180	75, 027	49, 259	202. 00

Heal th	Financial Systems	PULASKI MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	ITION OF CAPITAL RELATED COSTS		Provi der CC		Peri od: From 10/01/2020 To 09/30/2021	Worksheet B Part II Date/Time Pre 9/19/2022 5:1	pared: 4 pm
	Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	Subtotal	
		14. 00	15. 00	16.00	17. 00	24.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7. 00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
13.00	01300 NURSING ADMINISTRATION	22.024					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	22, 924	10 255				14. 00 15. 00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	18, 255 0	42, 59	00		16.00
17. 00	01700 SOCI AL SERVI CE	0	0	42, 59	0 576		17.00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	U U	<u> </u>		0 370		17.00
30. 00	03000 ADULTS & PEDIATRICS	0	O	1, 32	20 538	347, 568	30. 00
31. 00	03100 I NTENSI VE CARE UNI T		0	1, 32	0 550	0 347, 300	31.00
43. 00	04300 NURSERY		0	7	73 0	5, 951	43.00
43.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>		,	9 9	3, 731	43.00
50.00	05000 OPERATING ROOM	0	0	3, 57	70 38	150, 649	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		ol	31		18, 307	52.00
53. 00	05300 ANESTHESI OLOGY		ō	51		1, 347	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	o	9, 16	0	144, 802	54.00
60.00	06000 LABORATORY	o	o	8, 89	97 o	60, 965	60.00

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

From 10/01/2020 Part II 09/30/2021 Date/Time Prepared: 9/19/2022 5:14 pm Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 347, 568 30.00 03100 INTENSIVE CARE UNIT 0 31.00 C 31.00 04300 NURSERY 0 5, 951 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 150, 649 50.00 05200 DELIVERY ROOM & LABOR ROOM 0000000000000000 52.00 18, 307 52.00 05300 ANESTHESI OLOGY 1, 347 53.00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 144, 802 54.00 06000 LABORATORY 60.00 60, 965 60.00 60 01 06001 BLOOD LABORATORY Ω 60 01 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 1, 936 63.00 65.00 06500 RESPIRATORY THERAPY 26, 100 65.00 06600 PHYSI CAL THERAPY 66.00 63, 112 66.00 06700 OCCUPATI ONAL THERAPY 67 00 67 00 2.548 06800 SPEECH PATHOLOGY 68.00 1, 335 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 526 69.01 06901 CARDIAC REHABILITATION 11,849 69.01 07000 ELECTROENCEPHALOGRAPHY 70.00 Ω 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 25, 898 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 4, 737 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 47, 014 73.00 03020 ONCOLOGY 76.00 0 17, 248 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 309, 480 88.00 0 08801 RURAL HEALTH CLINIC II 88.01 22.544 88.01 08802 RURAL HEALTH CLINIC III 7, 898 88.02 88 02 88.03 08803 RURAL HEALTH CLINIC IV 0 15, 171 88.03 0 09000 CLI NI C 90.00 46, 493 90.00 09100 EMERGENCY 91.00 91.00 186, 522 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 116.00 0 SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 1, 520, 000 118.00 0 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 10,623 190.00 190. 01 19001 HOMECARE 190.01 00000 192.00 19200 PHYSICIANS' PRIVATE OFFICES 29, 944 192.00 192. 01 19201 KNOX RHC 192.01 C 194. 00 07950 MARKETI NG 2, 338 194.00 200.00 Cross Foot Adjustments 200.00 201.00 201.00 Negative Cost Centers C 202.00 TOTAL (sum lines 118 through 201) 1, 562, 905 202.00

		cial Systems TON - STATISTICAL BASIS	PULASKI MEMORI		CN: 15-1305 P	<u> </u>	u of Form CMS-2 Worksheet B-1	
0031 7	LLOCA	TOW - STATISTICAL BASIS		l l l l l l l l l l l l l l l l l l l	F	rom 10/01/2020 o 09/30/2021		
						0 09/30/2021	Date/Time Pre 9/19/2022 5:1	
		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SOUARE FEET)	
			1.00	SALARI ES) 4. 00	5A	5. 00	7. 00	
	GENER	AL SERVICE COST CENTERS	1.00	4.00	J 3A	3.00	7.00	
1.00		NEW CAP REL COSTS-BLDG & FIXT	74, 329					1.00
4.00		EMPLOYEE BENEFITS DEPARTMENT	1, 304	19, 037, 312	1			4.00
5.00		ADMI NI STRATI VE & GENERAL	14, 453	3, 061, 629	1		74 040	5.00
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE	6, 494 602	402, 698 12, 052	1	., -= :, - :=	71, 310 602	1
9. 00		HOUSEKEEPI NG	369	203, 895	1	403, 434	369	
10.00		DI ETARY	2, 993	213, 016	1		2, 993	
13.00		NURSING ADMINISTRATION	1, 623	426, 481	1	1, 000, 503	1, 623	
14.00		CENTRAL SERVICES & SUPPLY	945	22, 105	1	,	945	
15.00	1	PHARMACY MEDICAL DECORDS & LIBRARY	775	224 050	Ί "	,	775	
16. 00 17. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	1, 564 0	334, 050 36, 402	1	. ,	1, 564 0	
17.00	INPAT	ENT ROUTINE SERVICE COST CENTERS	<u> </u>	30, 402	-1 ~	40, 371	<u> </u>	17.00
30.00	03000	ADULTS & PEDIATRICS	8, 749	2, 244, 690	0	2, 840, 576	8, 749	30.00
31.00		INTENSIVE CARE UNIT	0	0	0		0	
43.00		NURSERY	161	53, 663	B C	78, 772	161	43.00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	5, 304	1, 662, 076) C	1, 095, 532	5, 304	50. OC
52. 00		DELIVERY ROOM & LABOR ROOM	653	95, 019			653	1
53.00	1	ANESTHESI OLOGY	31	0,017	1		31	•
54.00		RADI OLOGY-DI AGNOSTI C	4, 816	885, 995	5 0		4, 816	54.00
60.00	1	LABORATORY	1, 389	719, 536	0	1, 722, 662	1, 389	
60. 01		BLOOD LABORATORY	0	0		0	0	
63. 00 65. 00		BLOOD STORING, PROCESSING & TRANS. RESPIRATORY THERAPY	61 783	354, 467) C	,	61 783	
66.00		PHYSI CAL THERAPY	1, 769	950, 925	1	1, 369, 579	2, 364	•
67. 00		OCCUPATI ONAL THERAPY	0	140, 602	1		0	1
68.00		SPEECH PATHOLOGY	0	75, 583	s c	103, 963	0	68.00
69. 00		ELECTROCARDI OLOGY	0	0	0		0	
69. 01 70. 00		CARDI AC REHABI LI TATI ON	448	71, 200		107, 231	448 0	
70.00		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		337, 134	0	
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	Ö			0	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	46, 196	0		0	73.00
76.00		ONCOLOGY	564	118, 989	0	179, 366	564	76.00
00.00		TIENT SERVICE COST CENTERS	10.240	2 015 471		F 70/ /04	10.240	00.00
88. 00 88. 01		RURAL HEALTH CLINIC RURAL HEALTH CLINIC II	10, 240 0	3, 915, 471 731, 513		., ., .,	10, 240 3, 904	1
		RURAL HEALTH CLINIC III	0	226, 552				
		RURAL HEALTH CLINIC IV	0	560, 233			2, 151	
90.00		CLINIC	1, 815	51, 813	1	,	1, 815	
91.00		EMERGENCY	5, 973	1, 060, 793	8 0	2, 881, 877	5, 973	1
92.00		OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS						92.00
101.00		HOME HEALTH AGENCY	0	0		O	0	101.00
	SPECIA	AL PURPOSE COST CENTERS						
		HOSPI CE	0	0	_			116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	73, 878	18, 677, 644	-6, 776, 552	27, 950, 162	59, 919]118. 00
100 00		MBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	451	0) C	9, 483	AE1] 190. 00
	1	HOMECARE	451	0				190.00
		PHYSICIANS' PRIVATE OFFICES	o	287, 684			10, 940	
192.01	19201	KNOX RHC	0	0	0	0	0	192. 01
		MARKETING	0	71, 984	O	207, 253	0	194.00
200.00		Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
201.00	1	Cost to be allocated (per Wkst. B,	1, 562, 905	6, 341, 730		6, 776, 552	1, 510, 280	
202.00		Part I)	.,002,700	0,011,700		0,770,002	1, 0.10, 200	
203.00	1	Unit cost multiplier (Wkst. B, Part I)	21. 026854	0. 333121		0. 236908	21. 179077	
204.00)	Cost to be allocated (per Wkst. B,		27, 419	7	308, 311	150, 289	204.00
205.00		Part II) Unit cost multiplier (Wkst. B, Part		0. 001440		0. 010779	2. 107545	205 00
200.00	1	II)		0. 001440	1	0.010779	2. 10/345	200.00
206.00)	NAHE adjustment amount to be allocated						206.00
		(per Wkst. B-2)						
207. 00		NAHE unit cost multiplier (Wkst. D,						207.00
	1	Parts III and IV)	1		I	ı l		I

COST ALLOCATION	ON - STATISTICAL BASIS	TOLASKI WEWOK	Provi der Co	CN: 15-1305 P	eri od:	Worksheet B-1	
				F T	rom 10/01/2020 o 09/30/2021	Date/Time Pre	
Co	ost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	9/19/2022 5: 1 CENTRAL	4 pm
	ost center bescription	LINEN SERVICE		(MEALS	ADMI NI STRATI O	SERVICES &	
		(POUNDS OF	FEET)	SERVED)	N (DI DECT	SUPPLY	
		LAUNDRY)			(DI RECT NRSI NG HRS)	(100%)	
		8. 00	9.00	10.00	13. 00	14.00	
	SERVICE COST CENTERS	T	1				1 1 00
	EW CAP REL COSTS-BLDG & FIXT MPLOYEE BENEFITS DEPARTMENT						1.00
1 1	DMINISTRATIVE & GENERAL						5.00
1 1	PERATION OF PLANT						7. 00
	AUNDRY & LINEN SERVICE DUSEKEEPING	117, 392	68, 286				8. 00 9. 00
10. 00 01000 DI			2, 993				10.00
	JRSING ADMINISTRATION	0	1, 623		83, 168	l e	13.00
	ENTRAL SERVICES & SUPPLY	0	945	0	0	_,	
15. 00 01500 PF 16. 00 01600 ME	HARMACY EDICAL RECORDS & LIBRARY		775 1, 564	0	0	0 0	1
	OCIAL SERVICE	0		Ö	0	Ö	
	NT ROUTINE SERVICE COST CENTERS	05.000	0.740		40.000		
	DULTS & PEDIATRICS NTENSIVE CARE UNIT	25, 380	'	100	49, 888	0 0	1
43. 00 04300 NI		3, 066	1		1, 370	l	
ANCI LLA	RY SERVICE COST CENTERS						
	PERATING ROOM ELIVERY ROOM & LABOR ROOM	26, 570 0	1	0	,	l e	
	NESTHEST ROOM & LABOR ROOM		653		1, 515 0	0	
	ADI OLOGY-DI AGNOSTI C	19, 841	l .	Ö	0	ő	
	ABORATORY	494		0	0	0	
1 1	LOOD LABORATORY LOOD STORING, PROCESSING & TRANS.	0	0 61	0	0	0	
	ESPIRATORY THERAPY		l .		1, 585	0	
	HYSI CAL THERAPY	19, 588	2, 364	0	0	0	
	CCUPATI ONAL THERAPY	0	0	0	0	0	
	PEECH PATHOLOGY LECTROCARDI OLOGY		0] 0 0	0	0	
	ARDIAC REHABILITATION	0	448	Ö	0	ő	
	LECTROENCEPHALOGRAPHY	0	0	0	0	0	
	EDICAL SUPPLIES CHARGED TO PATIENTS WPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2, 450, 466 256, 405	
	RUGS CHARGED TO PATIENTS		_	Ö	0	250, 405	
76. 00 03020 01		17	564	0	2, 922	0	76. 00
	ENT SERVICE COST CENTERS JRAL HEALTH CLINIC	1, 910	10, 240		0	0	88. 00
	JRAL HEALTH CLINIC	327			0	0	1
	JRAL HEALTH CLINIC III	56		0	0	0	1
	JRAL HEALTH CLINIC IV	0	, ,	0	0	0	
90. 00 09000 CI 91. 00 09100 EN		19, 788	,		. : / : : :	l	1
92. 00 09200 0	BSERVATION BEDS (NON-DISTINCT PART)	. , , , , ,	0,770		, 555		92.00
	EI MBURSABLE COST CENTERS	1					
	DME HEALTH AGENCY PURPOSE COST CENTERS	0	0	0	0	. 0	101.00
116. 00 11600 H		0	0	0	0	0	116.00
	JBTOTALS (SUM OF LINES 1 through 117)	117, 037	58, 948	100	83, 168	2, 706, 871	118. 00
	BURSABLE COST CENTERS IFT, FLOWER, COFFEE SHOP & CANTEEN	0	451	0	0	0	190.00
190. 01 19001 H			ł	Ö	_		190.00
192. 00 19200 PI	HYSICIANS' PRIVATE OFFICES	355	8, 887	0	0	0	192.00
192. 01 19201 KI		0	0	0	0		192.01
194. 00 07950 MA 200. 00 Cr	ross Foot Adjustments	0	0	0	U		194. 00 200. 00
	egative Cost Centers						201.00
	ost to be allocated (per Wkst. B,	107, 670	506, 826	647, 968	1, 283, 950	124, 358	202. 00
1 1	art I) nit cost multiplier (Wkst. B, Part I)	0. 917183	7. 422107	6, 479. 680000	15. 438029	0. 045942	202 00
	ost to be allocated (per Wkst. B,	14, 771	1			l e	204.00
Pa	art II)				,		
	nit cost multiplier (Wkst. B, Part	0. 125826	0. 193012	750. 270000	0. 592283	0. 008469	205.00
206. 00 NA	l) AHE adjustment amount to be allocated						206. 00
1) (1	per Wkst. B-2)						
	AHE unit cost multiplier (Wkst. D,						207. 00
Pa	arts III and IV)	I	I	I		1	I

Health Financial Systems

PULASKI MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1305 Peri od: Worksheet B-1 From 10/01/2020 09/30/2021 Date/Time Prepared: 9/19/2022 5:14 pm Cost Center Description **PHARMACY** MEDI CAL SOCI AL SERVI CE (100%)RECORDS & LI BRARY (ALLOCATION (GROSS OF TIME) CHARGES) 15. 00 16.00 17.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 100 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 66, 135, 353 16.00 01700 SOCIAL SERVICE 0 17.00 17.00 9.888 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 2,049,683 9, 228 30.00 31.00 03100 INTENSIVE CARE UNIT 0 0 31.00 04300 NURSERY 43.00 0 112, 675 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 5, 543, 183 660 50.00 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 481.883 52.00 0 0 05300 ANESTHESI OLOGY 53.00 791, 208 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 00000000000 14, 215, 265 0 54.00 60.00 06000 LABORATORY 13, 814, 734 0 60.00 0 60 01 06001 BLOOD LABORATORY 60 01 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 210,608 63.00 0 06500 RESPIRATORY THERAPY 1, 052, 910 65.00 65.00 0 66.00 06600 PHYSI CAL THERAPY 2, 919, 569 66.00 0 06700 OCCUPATI ONAL THERAPY 67 00 497, 979 67 00 68.00 06800 SPEECH PATHOLOGY 162, 451 68.00 06900 ELECTROCARDI OLOGY 591, 058 0 69.00 69.00 69.01 06901 CARDIAC REHABILITATION 218,068 0 69.01 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70 00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2, 346, 781 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 360,090 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 100 8, 999, 152 0 73.00 03020 ONCOLOGY 0 76.00 0 394, 605 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 4, 675, 049 0 88.00 08801 RURAL HEALTH CLINIC II 0 0 88.01 740, 872 88.01 08802 RURAL HEALTH CLINIC III 0 88.02 185, 076 88 02 88.03 08803 RURAL HEALTH CLINIC IV 0 520,075 0 88.03 09000 CLI NI C 0 90.00 73. 106 0 90.00 91.00 09100 EMERGENCY 0 5, 179, 273 0 91 00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 116.00 0 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 100 66, 135, 353 9,888 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 0 190. 01 19001 HOMECARE 0 0 0 190.01 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192.00 0 192.01 19201 KNOX RHC 0 C 0 192, 01 194. 00 07950 MARKETI NG 0 0 194.00 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201. 00 201.00 202.00 Cost to be allocated (per Wkst. B, 42, 323 691, 185 60,078 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 423. 230000 0.010451 6.075850 203.00 Cost to be allocated (per Wkst. B, 204.00 18, 255 42.598 204.00 576 Part II) 182. 550000 205.00 205.00 Unit cost multiplier (Wkst. B, Part 0.000644 0.058252 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2)

207.00

NAHE unit cost multiplier (Wkst. D,

Parts III and IV)

207 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 10/01/2020 Part I To 09/30/2021 Date/Time Prepared:

					To 09/30/2021	Date/Time Pre 9/19/2022 5:1	
			Title	XVIII	Hospi tal	Cost	. р
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,	.,				
		col. 26)					
		1. 00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	5, 282, 670		5, 282, 67	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	0			0	0	31.00
43.00	04300 NURSERY	127, 179		127, 17	9 0	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 743, 420		1, 743, 42	0 0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	245, 650		245, 65		0	52.00
53.00	05300 ANESTHESI OLOGY	22, 254		22, 25	4 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 544, 835		2, 544, 83	5 0	0	54.00
60.00	06000 LABORATORY	2, 315, 332		2, 315, 33	2 0	0	60.00
60. 01	06001 BLOOD LABORATORY	0			0	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	47, 071		47, 07	1 0	0	63.00
65.00	06500 RESPI RATORY THERAPY	712, 861	0	712, 86	1 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	1, 810, 134	0	1, 810, 13	4 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	237, 531	0	237, 53	1 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	130, 291	0	130, 29	1 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	22, 857		22, 85	7 0	0	69.00
69. 01	06901 CARDI AC REHABI LI TATI ON	147, 727		147, 72	7 0	0	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0			0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	554, 108		554, 10	8 0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	283, 363		283, 36	3 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 763, 835		2, 763, 83	5 0	0	73.00
76.00	03020 ONCOLOGY	287, 240		287, 24	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	7, 426, 769		7, 426, 76	9 0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	1, 495, 700		1, 495, 70	0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	469, 860		469, 86	0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	1, 109, 035		1, 109, 03	5 0	0	88. 03
90.00	09000 CLI NI C	444, 836		444, 83	6 0	0	90.00
91.00	09100 EMERGENCY	4, 036, 336		4, 036, 33	6 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	892, 515		892, 51	5	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0			0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
	11600 HOSPI CE	0			0		116. 00
200.00		35, 153, 409	0	,,			200. 00
201.00		892, 515		892, 51			201. 00
202.00	Total (see instructions)	34, 260, 894	0	34, 260, 89	4 0	0	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	Peri od: Worksheet C
		From 10/01/2020 Part I

					To 09/30/2021		pared: 4 pm
				XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
			7.00		0.00	Ratio	
	ANDATI ENT. DOUTLINE OFFICE OF COOT OFFITEDO	6. 00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	4 707 045		4 707 045	-I		1 00 00
	03000 ADULTS & PEDIATRICS	1, 707, 945		1, 707, 945			30.00
	03100 INTENSIVE CARE UNIT	0		(140.77	-		31.00
	04300 NURSERY	112, 675		112, 675	<u> </u>		43.00
	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	052 (40	4 500 524	F F40 100	0.21451/	0.000000	
	05200 DELIVERY ROOM & LABOR ROOM	952, 649	4, 590, 534			0. 000000 0. 000000	
	05300 ANESTHESI OLOGY	380, 234	101, 649			0.00000	
	05400 RADI OLOGY-DI AGNOSTI C	123, 564	667, 644			0.00000	
	06000 LABORATORY	986, 917	13, 228, 348			0.00000	
	06001 BLOOD LABORATORY	1, 832, 232	11, 982, 502 0			0.00000	1
	06300 BLOOD STORING, PROCESSING & TRANS.	91, 568	119, 040			0.000000	
	06500 RESPIRATORY THERAPY	1	364, 929			0.000000	
	06600 PHYSI CAL THERAPY	687, 981 359, 317	·			0.00000	
	06700 OCCUPATI ONAL THERAPY	149, 562	2, 560, 252 348, 417			0.000000	
	06800 SPEECH PATHOLOGY	37, 886	124, 565			0.000000	
	06900 ELECTROCARDI OLOGY	24, 983	566, 075			0.000000	1
	06901 CARDI AC REHABI LI TATI ON	24, 703	218, 068				
	07000 ELECTROENCEPHALOGRAPHY		210,000			0.000000	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	825, 049	1, 521, 732			0.000000	
	07200 IMPL. DEV. CHARGED TO PATIENTS	177, 478	182, 612			0.000000	
	07300 DRUGS CHARGED TO PATIENTS	3, 901, 069	5, 098, 083			0.000000	
	03020 ONCOLOGY	0, 701, 007	394, 605				1
	OUTPATIENT SERVICE COST CENTERS	٩	071,000	071,000	0.727710	0.000000	70.00
	08800 RURAL HEALTH CLINIC	0	4, 675, 049	4, 675, 049			88. 00
	08801 RURAL HEALTH CLINIC II	0	740, 872				88. 01
	08802 RURAL HEALTH CLINIC III	0	185, 076				88. 02
	08803 RURAL HEALTH CLINIC IV	0	520, 075				88. 03
	09000 CLI NI C	0	73, 106			0. 000000	90.00
91.00	09100 EMERGENCY	233, 037	4, 946, 236	5, 179, 273	0. 779325	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	341, 738			0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS		•				1
101.00	10100 HOME HEALTH AGENCY	0	0	(101.00
	SPECIAL PURPOSE COST CENTERS				•		1
	11600 HOSPI CE	0	0	(116. 00
200.00	Subtotal (see instructions)	12, 584, 146	53, 551, 207	66, 135, 353	3	l	200.00
201.00	Less Observation Beds					l	201.00
202. 00	Total (see instructions)	12, 584, 146	53, 551, 207	66, 135, 353	3	l	202. 00

Health Financial Systems	PULASKI MEMORIAL	. HOSPI TAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1305	From 10/01/2020	Worksheet C Part I Date/Time Prepared:

			To 09/30/2021	Date/Time Prepared: 9/19/2022 5:14 pm
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 000000			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
60. 00 06000 LABORATORY	0. 000000			60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63. 00
65. 00 06500 RESPI RATORY THERAPY	0. 000000			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
69. 01 06901 CARDI AC REHABI LI TATI ON	0. 000000			69. 01
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
76. 00 03020 ONCOLOGY	0. 000000			76. 00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC				88. 00
88.01 08801 RURAL HEALTH CLINIC II				88. 01
88.02 08802 RURAL HEALTH CLINIC III				88. 02
88.03 08803 RURAL HEALTH CLINIC IV				88. 03
90. 00 09000 CLI NI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202.00

Health Financial Systems	PULASKI MEMORIA	L HOSPITAL		In Lieu	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C	CN: 15-1305	From 10/01/2020	Worksheet C Part I Date/Time Pre 9/19/2022 5:1	
		Ti tl	e XIX	Hospi tal	Cost	
				Costs		

				To 09/30/2021	Date/Time Pre 9/19/2022 5:1	
		Ti tl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst.	Adj .		Di sal I owance		
	B, Part I,					
	col. 26)					
	1. 00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	5, 282, 670		5, 282, 670	0	5, 282, 670	30.00
31.00 03100 INTENSIVE CARE UNIT	0			0		31.00
43. 00 04300 NURSERY	127, 179		127, 179	0	127, 179	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1, 743, 420		1, 743, 420	0	1, 743, 420	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	245, 650		245, 650			52.00
53. 00 05300 ANESTHESI OLOGY	22, 254		22, 25		,	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 544, 835		2, 544, 83	0	2, 544, 835	54.00
60. 00 06000 LABORATORY	2, 315, 332		2, 315, 332	0	2, 315, 332	60.00
60. 01 06001 BLOOD LABORATORY	0		(0	0	60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	47, 071		47, 07°	0	47, 071	63.00
65. 00 06500 RESPIRATORY THERAPY	712, 861	0			712, 861	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 810, 134	0	1, 810, 134	1 0	1, 810, 134	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	237, 531	0	237, 53°	0	237, 531	67.00
68.00 06800 SPEECH PATHOLOGY	130, 291	0	130, 29°	0	130, 291	68. 00
69. 00 06900 ELECTROCARDI OLOGY	22, 857		22, 85	0	22, 857	69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	147, 727		147, 72	0	147, 727	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		(0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	554, 108		554, 108	0	554, 108	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	283, 363		283, 363	0	283, 363	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 763, 835		2, 763, 83	0	2, 763, 835	
76. 00 03020 0NC0L0GY	287, 240		287, 240	0	287, 240	76.00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	7, 426, 769		7, 426, 769	9 0	7, 426, 769	88. 00
88.01 08801 RURAL HEALTH CLINIC II	1, 495, 700		1, 495, 700	0	1, 495, 700	88. 01
88.02 08802 RURAL HEALTH CLINIC III	469, 860		469, 860	0	469, 860	88. 02
88.03 08803 RURAL HEALTH CLINIC IV	1, 109, 035		1, 109, 03	0	1, 109, 035	88. 03
90. 00 09000 CLI NI C	444, 836		444, 836	0	444, 836	90.00
91. 00 09100 EMERGENCY	4, 036, 336		4, 036, 336	0	4, 036, 336	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	892, 515		892, 51	5	892, 515	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0		()	0	101.00
SPECIAL PURPOSE COST CENTERS						
116. 00 11600 HOSPI CE	0		(116.00
200.00 Subtotal (see instructions)	35, 153, 409	0	35, 153, 409	0	,,	
201.00 Less Observation Beds	892, 515		892, 51		892, 515	
202.00 Total (see instructions)	34, 260, 894	0	34, 260, 89	0	34, 260, 894	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 10/01/2020 Part I
		To 09/30/2021 Date/Time Prepared

					Fo 09/30/2021	Date/Time Pre 9/19/2022 5:1	
				e XIX	Hospi tal	Cost	
	Cost Center Description	I npati ent	Charges Outpatient	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	
I	NPATIENT ROUTINE SERVICE COST CENTERS	'					
	D3000 ADULTS & PEDIATRICS	1, 707, 945		1, 707, 94!	5		30.00
	D3100 INTENSIVE CARE UNIT	0					31.00
	04300 NURSERY	112, 675		112, 67	5		43.00
	ANCILLARY SERVICE COST CENTERS				_		
	O5000 OPERATING ROOM	952, 649	4, 590, 534			0. 000000	
	D5200 DELIVERY ROOM & LABOR ROOM	380, 234	101, 649			0. 000000	
	05300 ANESTHESI OLOGY	123, 564	667, 644			0. 000000	1
	05400 RADI OLOGY-DI AGNOSTI C	986, 917	13, 228, 348			0. 000000	
	06000 LABORATORY	1, 832, 232	11, 982, 502			0.000000	1
	06001 BLOOD LABORATORY	01 5(0	110.040		0.00000	0.000000	
	06300 BLOOD STORING, PROCESSING & TRANS.	91, 568	119, 040			0.000000	1
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	687, 981	364, 929			0. 000000 0. 000000	
	06700 OCCUPATIONAL THERAPY	359, 317 149, 562	2, 560, 252 348, 417			0. 000000	1
	06800 SPEECH PATHOLOGY	37, 886	124, 565			0. 000000	
	06900 ELECTROCARDI OLOGY	24, 983	566, 075			0. 000000	
	06901 CARDI AC REHABI LI TATI ON	24, 703	218, 068			0. 000000	
	07000 ELECTROENCEPHALOGRAPHY		210,000			0.000000	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	825, 049	1, 521, 732			0. 000000	
	07200 IMPL. DEV. CHARGED TO PATIENTS	177, 478	182, 612			0. 000000	1
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 901, 069	5, 098, 083	8, 999, 15	0. 307122	0.000000	73.00
76.00	D3020 ONCOLOGY	0	394, 605	394, 60	0. 727918	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS						
	D8800 RURAL HEALTH CLINIC	0	4, 675, 049	4, 675, 04		0.000000	
	08801 RURAL HEALTH CLINIC II	0	740, 872			0. 000000	
	D8802 RURAL HEALTH CLINIC III	0	185, 076			0. 000000	
	D8803 RURAL HEALTH CLINIC IV	0	520, 075			0. 000000	1
	09000 CLI NI C	0	73, 106			0. 000000	
	09100 EMERGENCY	233, 037	4, 946, 236			0. 000000	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	341, 738	341, 73	2. 611694	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	O	0				101 00
	SPECIAL PURPOSE COST CENTERS	l ol	0	')		101. 00
	11600 HOSPI CE	l	0				116. 00
200.00	Subtotal (see instructions)	12, 584, 146	53, 551, 207				200.00
201.00	Less Observation Beds	12, 304, 140	33, 331, 207	00, 100, 30.	1		201.00
202.00	Total (see instructions)	12, 584, 146	53, 551, 207	66, 135, 35	3		202.00
_02.00	1.212. (333 1.131 431 31.3)		55,55.,207	1 23, .23, 00	-1		,

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1305	Peri od: From 10/01/2020 To 09/30/2021	Worksheet C Part I Date/Time Prepared: 9/19/2022 5:14 pm

			10 09/30/2021	9/19/2022 5: 14 pm	
		Title XIX	Hospi tal	Cost	_
Cost Center Description	PPS Inpatient				
	Rati o				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS				30.0	
31.00 03100 INTENSIVE CARE UNIT				31.0	
43. 00 04300 NURSERY				43.0	00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM	0. 000000			50.0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.0	
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.0	
60. 00 06000 LABORATORY	0. 000000			60.0	
60. 01 06001 BL00D LABORATORY	0. 000000			60.0	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.0	
65. 00 06500 RESPI RATORY THERAPY	0. 000000			65.0	
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.0	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.0	
68.00 O6800 SPEECH PATHOLOGY	0. 000000			68.0	
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.0	
69. 01 06901 CARDI AC REHABI LI TATI ON	0. 000000			69.0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.0	
76. 00 03020 ONCOLOGY	0. 000000			76.0	00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0. 000000			88.0	
88.01 08801 RURAL HEALTH CLINIC II	0. 000000			88. 0	
88.02 08802 RURAL HEALTH CLINIC III	0. 000000			88.0	
88.03 08803 RURAL HEALTH CLINIC IV	0. 000000			88. 0	
90. 00 09000 CLINIC	0. 000000			90.0	
91. 00 09100 EMERGENCY	0. 000000			91. 0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.0	00
OTHER REIMBURSABLE COST CENTERS					
101. 00 10100 HOME HEALTH AGENCY				101. 0	00
SPECIAL PURPOSE COST CENTERS					
116. 00 11600 HOSPI CE				116. (
200.00 Subtotal (see instructions)				200. 0	
201.00 Less Observation Beds				201. (
202.00 Total (see instructions)				202.0	00

Health Financial Systems	PULASKI MEMORIAL	_ HOSPI TAL		In Lieu of Form CMS-2552-10
ADDODELONMENT OF INDATIONE	ANCLLIADY SERVICE CARLEAL COSTS	Drovi don CCN, 1E 120E	Donied.	Waskahaat D

Health Financial Systems	PULASKI MEMORI	IAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 15-1305	Peri od:	Worksheet D	
				From 10/01/2020 To 09/30/2021	Part II Date/Time Pre	narod:
				10 09/30/2021	9/19/2022 5: 1	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	150, 649					
52. 00 05200 DELIVERY ROOM & LABOR ROOM	18, 307				Ĭ	52.00
53. 00 05300 ANESTHESI OLOGY	1, 347			· ·		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	144, 802			· ·		54.00
60. 00 06000 LABORATORY	60, 965					
60. 01 06001 BLOOD LABORATORY	0	1				60.01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	1, 936					63.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	26, 100			· ·	· ·	
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	63, 112			· ·	· ·	
68.00 06700 OCCUPATIONAL THERAPY	2, 548 1, 335			· ·		68.00
69. 00 06900 ELECTROCARDI OLOGY	526					69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	11, 849				0	69.01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0				0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	25, 898					
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	4, 737					
73. 00 07300 DRUGS CHARGED TO PATIENTS	47, 014			· ·	· ·	73.00
76. 00 03020 0NCOLOGY	17, 248					76.00
OUTPATIENT SERVICE COST CENTERS	17,210	071,000	0.0107	0		70.00
88. 00 08800 RURAL HEALTH CLINIC	309, 480	4, 675, 049	0. 06619	98	0	88. 00
88. 01 08801 RURAL HEALTH CLINIC II	22, 544				Ō	88. 01
88. 02 08802 RURAL HEALTH CLINIC III	7, 898				Ō	88. 02
88.03 08803 RURAL HEALTH CLINIC IV	15, 171				0	88. 03
90. 00 09000 CLI NI C	46, 493				0	90.00
91. 00 09100 EMERGENCY	186, 522	l '			1, 334	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	58, 722				0	92.00
200.00 Total (lines 50 through 199)	1, 225, 203			2, 322, 017	28, 207	200. 00

Health Financial Systems	PULASKI MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 1	
		F 10 /01 /2020 D+ 11/

Part IV Date/Time Prepared: THROUGH COSTS From 10/01/2020 To 09/30/2021 9/19/2022 5:14 pm Title XVIII Hospi tal Cost Cost Center Description Non Physician Nursi ng Nursi ng Allied Health Allied Health Program Anestheti st Post-Stepdown Program Post-Stepdown Cost Adjustments Adjustments 1. 00 2.00 ЗА 3.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 0 54.00 0 06000 LABORATORY 0 60.00 60.00 0 06001 BLOOD LABORATORY 60.01 0 0 60.01 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 63.00 06500 RESPIRATORY THERAPY 0 0 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 Ω 66.00 0 67.00 06700 OCCUPATI ONAL THERAPY 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 68.00 0 69.00 06900 ELECTROCARDI OLOGY 0 69.00 0 06901 CARDIAC REHABILITATION 0 69.01 69.01 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 0 72.00 0 0 72.00 73.00 0 0 73.00 76.00 03020 ONCOLOGY 0 0 0 0 0 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 0 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 0 0 0 88.01 08801 RURAL HEALTH CLINIC II 0 0 88.01 08802 RURAL HEALTH CLINIC III 88.02 88.02 0 0 0 0 0 0 0 0 08803 RURAL HEALTH CLINIC IV 0 88. 03 Ω 88.03 90. 00 09000 CLI NI C 0 90.00 0 91.00 09100 EMERGENCY 0 0 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 0 0 Total (lines 50 through 199) 0 0 200.00

200.00

Health Financial Systems	PULASKI MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1305	Period: Worksheet D
THROUGH COSTS		From 10/01/2020 Part IV

THROUGH COSTS				o 09/30/2021		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS	1	-				
50.00 05000 OPERATING ROOM	0	0	· ·	5, 543, 183		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	C	481, 883		52.00
53. 00 05300 ANESTHESI OLOGY	0	0	C	791, 208		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	C	, ,		1
60. 00 06000 LABORATORY	0	0	[C	13, 814, 734		1
60. 01 06001 BL00D LABORATORY	0	0	[C	0	0.000000	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	[C	210, 608		63.00
65. 00 06500 RESPI RATORY THERAPY	0	0	[C	1, 052, 910		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	[C	2, 919, 569		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	[C	497, 979		1
68.00 06800 SPEECH PATHOLOGY	0	0	C	162, 451		
69. 00 06900 ELECTROCARDI OLOGY	0	0	C	591, 058	0.000000	69.00
69. 01 06901 CARDI AC REHABI LI TATI ON	0	0	C	218, 068	0.000000	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	C	0	0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	2, 346, 781	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	360, 090		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	C	8, 999, 152		
76. 00 03020 ONCOLOGY	0	0	C	394, 605	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	C	4, 675, 049	0.000000	
88.01 08801 RURAL HEALTH CLINIC II	0	0	C	740, 872	0.000000	88. 01
88.02 08802 RURAL HEALTH CLINIC III	0	0	C	185, 076		
88.03 08803 RURAL HEALTH CLINIC IV	0	0	C	520, 075		1
90. 00 09000 CLI NI C	0	0	C	73, 106	0.000000	90.00
91. 00 09100 EMERGENCY	0	0	[C	5, 179, 273		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	[C	341, 738		l
200.00 Total (lines 50 through 199)	0	0	(64, 314, 733		200. 00

Health Financia	al Systems	PULAS	SKI MEMORIAL I	HOSPI TAL		In Lieu	of Form CMS-2552-10
APPORTI ONMENT THROUGH COSTS	OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE (OTHER PASS	Provi der (CCN: 15-1305	From 10/01/2020	Worksheet D Part IV Date/Time Prepared:

THROUGH COSTS					Date/Time Pre 9/19/2022 5:1		
				XVIII	Hospi tal	Cost	
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷		Costs (col. 8		Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
	T	9. 00	10. 00	11. 00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0. 000000	203, 966		0	0	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	21, 843	•	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	293, 858	l .	0	0	54.00
60.00	06000 LABORATORY	0. 000000	410, 733		0	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0	(0	0	60. 01
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	27, 263		0	0	63.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	329, 312		0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	81, 369		0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	36, 070	(0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	7, 330		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	14, 906		0	0	69. 00
69. 01	06901 CARDI AC REHABI LI TATI ON	0. 000000	0		0	0	69. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	(0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	162, 138		0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	79, 469		0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	616, 710		0	0	73.00
76.00	03020 ONCOLOGY	0. 000000	0	(0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0		0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0.000000	0	(0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0. 000000	0		0	0	88. 02
	08803 RURAL HEALTH CLINIC IV	0. 000000	0		0	0	88. 03
90.00	09000 CLI NI C	0. 000000	0		0	0	90.00
91.00	09100 EMERGENCY	0. 000000	37, 050		0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0	0	92.00
200.00	Total (lines 50 through 199)		2, 322, 017		0	0	200. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1305 Peri od: Worksheet D From 10/01/2020 Part V 09/30/2021 Date/Time Prepared: 9/19/2022 5:14 pm Title XVIII Hospi tal Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 314516 1, 273, 710 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0.509771 52.00 0 52.00 0 0 53.00 05300 ANESTHESI OLOGY 0.028127 0 179, 164 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.179021 3, 981, 138 0 0 0 0 0 0 0 0 54.00 60.00 06000 LABORATORY 0.167599 3, 931, 811 0 60.00 06001 BLOOD LABORATORY 60.01 0.000000 0 0 60.01 0 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0. 223501 54, 155 0 63.00 65.00 06500 RESPIRATORY THERAPY 0.677039 142, 973 0 65.00 06600 PHYSI CAL THERAPY 0.620000 829, 621 0 66.00 66.00 06700 OCCUPATI ONAL THERAPY 0.476990 67.00 133, 895 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.802033 10, 996 0 68.00 06900 ELECTROCARDI OLOGY 0.038671 192, 851 69.00 69.00 0 0 0 06901 CARDIAC REHABILITATION 69.01 69 01 0 677435 87, 757 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 236114 0 390, 573 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0. 786923 0 63, 357 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73 00 0.307122 2, 428, 552 Ω 73 00 1, 648 03020 ONCOLOGY 76.00 0.727918 137, 594 0 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 08801 RURAL HEALTH CLINIC II 88.01 88.01 08802 RURAL HEALTH CLINIC III 88.02 88.02 08803 RURAL HEALTH CLINIC IV 88. 03 88.03 09000 CLI NI C 6.084808 90.00 90.00 58. 975 0 1, 285, 741 91.00 09100 EMERGENCY 0.779325 0 10, 553 91.00 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 2.611694 0 108, 852 0 92.00

0

0

15, 291, 715

15, 291, 715

12, 201

12, 201

0 200. 00

0 202.00

201.00

200.00

201.00

202.00

Subtotal (see instructions)

Only Charges

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1305	Peri od: From 10/01/2020	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	D VACCINE COST		CN: 15-1305	From 10/01/2020 To 09/30/2021	Part V Date/Time Pr 9/19/2022 5:	
		Title	XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS	,					
50.00 05000 OPERATING ROOM	400, 602	0)			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	5, 039	0)			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	712, 707	0				54.00
60. 00 06000 LABORATORY	658, 968	0				60.00
60. 01 06001 BL00D LABORATORY	0	0				60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	12, 104	0				63.00
65. 00 06500 RESPIRATORY THERAPY	96, 798	0	o			65.00
66. 00 06600 PHYSI CAL THERAPY	514, 365	0	o			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	63, 867	0	o			67.00
68.00 06800 SPEECH PATHOLOGY	8, 819	0	o			68. 00
69. 00 06900 ELECTROCARDI OLOGY	7, 458	l o	o l			69. 00
69. 01 06901 CARDI AC REHABI LI TATI ON	59, 450	l o	o l			69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	l o	o l			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	92, 220	l o	o l			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	49, 857	l o	o l			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	745, 862	506	,			73.00
76. 00 03020 ONCOLOGY	100, 157	0				76.00
OUTPATIENT SERVICE COST CENTERS			1			
88. 00 08800 RURAL HEALTH CLINIC						88.00
88. 01 08801 RURAL HEALTH CLINIC II						88. 01
88. 02 08802 RURAL HEALTH CLINIC III						88. 02
88. 03 08803 RURAL HEALTH CLINIC IV						88. 03
90. 00 09000 CLI NI C	358, 852	0				90.00
91. 00 09100 EMERGENCY	1, 002, 010	8, 224				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	284, 288		1			92.00
200.00 Subtotal (see instructions)	5, 173, 423	8, 730				200.00
201.00 Less PBP Clinic Lab. Services-Program	0, 1, 0, 420	0,750				201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	5, 173, 423	8, 730				202. 00
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1 27 27 20	1 27.00	1			1

Health Financial Systems	PULASKI MEMO	ORI AL I	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 15-1305	Peri od: From 10/01/2020	Worksheet D-1	
				To 09/30/2021	Date/Time Prep 9/19/2022 5: 1	oared: 4 pm
			Title XVIII	Hospi tal	Cost	
Cost Center Description						
					1. 00	
PART I - ALL PROVIDER COMPONENTS						
I NPATI ENT DAYS						
1.00 Inpatient days (including private room days	Inpatient days (including private room days and swing-bed days, excluding newborn)					
2 00 Inpatient days (including private room days	excluding s	wi na_h	ed and newhorn days)		1 782	2 00

	Cook Cooking Department of the XVIII Hospital	Cost	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS	1.00	
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2, 326	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	1, 782 0	2. 00 3. 00
3.00	do not complete this line.	U	3.00
4. 00	Semi-private room days (excluding swing-bed and observation bed days)	1, 411	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost		5.00
	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)	311	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	32	7. 00
,, 00	reporting period	02	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	111	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	,,,,	0.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	600	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	401	11.00
12. 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
12.00	through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)	0	15. 00 16. 00
10.00	SWING BED ADJUSTMENT	0	10.00
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17.00
10.00	reporting period		40.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18. 00
19. 00	Medicald rate for swing-bed NF services applicable to services through December 31 of the cost	216. 95	19.00
	reporting period		
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	216. 95	20.00
21. 00	reporting period Total general inpatient routine service cost (see instructions)	5, 282, 670	21.00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		22.00
	5 x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	6, 942	24.00
2 00	7 x line 19)	3, 7.12	2 00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	24, 081	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)	995, 709	26.00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4, 286, 961	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	., 200, 101	
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)	0	29.00
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0.00000	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4, 286, 961	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2, 405. 70	38.00
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35)	1, 443, 420 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39 + line 40)	1, 443, 420	
	1 3 3 4 4 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	, , , , , , , , , , , , , , , , , ,	

Heal th	Financial Systems PULASKI MEMORIAL HOSPITAL In Li	eu of Form CMS-2	2552-10
	FATION OF INPATIENT OPERATING COST Provider CCN: 15-1305 Period:	Worksheet D-1	
	From 10/01/202 To 09/30/202	1 Date/Time Pre	
	Title XVIII Hospital	9/19/2022 5:1 Cost	4 pm
	Cost Center Description Total Total Average Per Program Days		
	Inpatient Inpatient Diem (col. 1	(col. 3 x	
	Cost Days ÷ col . 2) 1.00 2.00 3.00 4.00	col . 4) 5.00	
42.00		0 0	42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT O 0 0.00	0	43.00
44.00	CORONARY CARE UNIT		44. 00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT		45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)		47.00
	Cost Center Description	1.00	
48. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	808, 467	48. 00
49. 00	Total Program inpatient costs (sum of lines 41 through 48) (see instructions)	2, 251, 887	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I ar	nd 0	50.00
51. 00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00		0	53.00
	medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION		
	Program di scharges	0	
55. 00 56. 00		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 0.00	58. 00 59. 00
39.00	market basket	0.00	39.00
60.00		0.00	•
61. 00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target	0	61.00
	amount (line 56), otherwise enter zero (see instructions)	_	
62. 00 63. 00		0 0	
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64. 00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (Secinstructions)(title XVIII only)	0	64. 00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See	964, 686	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For	964, 686	66. 00
00.00	CAH (see instructions)	704, 000	00.00
67. 00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period	0	68. 00
40.00	(line 13 x line 20)		40.00
69. 00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY	0	69. 00
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71. 00 72. 00			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
75.00	26, line 45)		75.00
76.00			76.00
77. 00 78. 00			77. 00 78. 00
79.00			79.00
80. 00 81. 00			80. 00 81. 00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83. 00 84. 00			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)		86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions)	371	87. 00
88. 00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2, 405. 70	88. 00
89. UU	Observation bed cost (line 87 x line 88) (see instructions)	892, 515	89. UU

Health Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 10/01/2020 To 09/30/2021	Date/Time Pre 9/19/2022 5:1	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	347, 568	5, 282, 670	0. 06579	4 892, 515	58, 722	90.00
91.00 Nursing Program cost	0	5, 282, 670	0.00000	0 892, 515	0	91.00
92.00 Allied health cost	0	5, 282, 670	0.00000	0 892, 515	0	92.00
93.00 All other Medical Education	0	5, 282, 670	0.00000	0 892, 515	0	93.00

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 10/01/2020	Worksheet D-1	
			To 09/30/2021	Date/Time Pre 9/19/2022 5:1	pared: 4 pm
		Title XIX	Hospi tal	Cost	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS					
					1

	Cook Contan Description	LOST	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1. 00 2. 00	Inpatient days (including private room days and swing-bed days, excluding newborn) Inpatient days (including private room days, excluding swing-bed and newborn days)	2, 326	1. 00 2. 00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	1, 782 0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1, 411	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
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)	401	6.00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	143	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	55	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13. 00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)	158 0	15. 00 16. 00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0. 00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0. 00	20.00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	5, 282, 670 0	21. 00 22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
	7 x line 19)		
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	970, 384 4, 312, 286	26. 00 27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges)	0	28. 00 29. 00
30.00	Semi -pri vate room charges (excluding swing-bed charges)	0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31.00
32. 00	Average private room per diem charge (line 29 + line 3)	0.00	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	33.00
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4, 312, 286	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2, 419. 91	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	133, 095	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	133, 095	

	reporting period	_	
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	401	6.00
	reporting period (if calendar year, enter 0 on this line)	_	
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	143	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)		0.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	55	9.00
40.00	newborn days) (see instructions)		40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
11. 00	through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	o o	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
14. 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	٠,	15.00
16. 00	Nursery days (title V or XIX only)		16. 00
10.00	SWING BED ADJUSTMENT	Ü	10.00
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17.00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
17.00	reporting period	0.00	19.00
20.00	Medicald rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
	reporting period		
21.00	Total general inpatient routine service cost (see instructions)	5, 282, 670	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22.00
22.00	5 x line 17)	0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	U	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
	7 x line 19)		
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
	x line 20)		
26.00	Total swing-bed cost (see instructions)	970, 384	
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	4, 312, 286	27.00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)	0	29.00
30.00	Semi -pri vate room charges (excluding swing-bed charges)	0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	4, 312, 286	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	0.440.01	20.00
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	2, 419. 91	
39. 00	Program general inpatient routine service cost (line 9 x line 38)	133, 095	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	122 005	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	133, 095	41.00

Heal th	Financial Systems PULASKI MEMORIAL HOSPITAL In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST Provider CCN: 15-1305 Period: From 10/01/2020	Worksheet D-1	
	To 09/30/2021		
	Title XIX Hospital	Cost	
	Cost Center Description Total Total Average Per Program Days Inpatient Inpatient Diem (col. 1	Program Cost (col. 3 x	
	Cost Days ÷ col . 2) 1.00 2.00 3.00 4.00	col . 4) 5.00	
42. 00	NURSERY (title V & XIX only) 127, 179 158 804. 93 0		42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT O 0 0.00 0	0	43.00
44.00	CORONARY CARE UNIT		44.00
46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT		45. 00 46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description		47.00
	·	1. 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)	71, 716 204, 811	1
	PASS THROUGH COST ADJUSTMENTS		
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 and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	
53. 00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
F.4.00	TARGET AMOUNT AND LIMIT COMPUTATION		
54. 00 55. 00	Program discharges Target amount per discharge	0.00	
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	0	58.00
59. 00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	•
61. 00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target	0	61.00
62. 00	amount (line 56), otherwise enter zero (see instructions) Relief payment (see instructions)	0	62.00
63. 00	Allowable Inpatient cost plus incentive payment (see instructions)	0	•
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
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See	0	65. 00
	instructions)(title XVIII only)		
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	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68. 00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71. 00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72. 00 73. 00	Program routine service cost (line 9 x line 71) Medically necessary private room cost applicable to Program (line 14 x line 35)		72. 00 73. 00
74. 00 75. 00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75. 00
76. 00 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 80. 00	Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		79. 00 80. 00
81. 00 82. 00	Inpatient routine service cost per diem limitation		81. 00 82. 00
83. 00	Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions)		83.00
84. 00 85. 00	Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions)		84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions)	371	87. 00
88. 00 89. 00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) Observation bed cost (line 87 x line 88) (see instructions)	2, 419. 91 897, 787	1
57.00	Tobasi varion bed cost (Time of A Time ou) (See That detrois)	J 077, 707	1 07.00

Health Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 10/01/2020 To 09/30/2021	Date/Time Pre 9/19/2022 5:1	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	347, 568	5, 282, 670	0. 06579	4 897, 787	59, 069	90.00
91.00 Nursing Program cost	0	5, 282, 670	0.00000	0 897, 787	0	91.00
92.00 Allied health cost	0	5, 282, 670	0.00000	0 897, 787	0	92.00
93.00 All other Medical Education	l o	5, 282, 670	0. 00000	0 897, 787	0	93.00

Health Financial Systems PULASKI MEMORI INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-1305	Peri od:	u of Form CMS-2 Worksheet D-3	
THE PERIOD ESTATE SERVINGE SOCIETY OF THE PROPERTY OF THE PERIOD SERVINGE SOCIETY OF THE PERIOD SERVINGE SERVING	1.00.00		From 10/01/2020		
			To 09/30/2021	Date/Time Pre 9/19/2022 5:1	
	Title	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS			622, 837		30.00
31. 00 03100 INTENSIVE CARE UNIT			0		31.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM		0. 3145		64, 151	
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0. 5097		0	
53. 00 05300 ANESTHESI OLOGY		0. 0281		614	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1790		52, 607	
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY		0. 1675 0. 0000		68, 838 0	1
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 00000		6, 093	
65. 00 06500 RESPIRATORY THERAPY		0. 2233		222, 957	
66. 00 06600 PHYSI CAL THERAPY		0. 6200		50, 449	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 4769		17, 205	
68. 00 06800 SPEECH PATHOLOGY		0. 8020		5, 879	
69. 00 06900 ELECTROCARDI OLOGY		0. 0386	71 14, 906	576	69.00
69. 01 06901 CARDI AC REHABI LI TATI ON		0. 6774		0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2361		38, 283	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 7869		62, 536	1
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 3071		189, 405	
76. 00 03020 ONCOLOGY OUTPATIENT SERVICE COST CENTERS		0. 7279	18 0	0	76.00
88. 00 08800 RURAL HEALTH CLINIC		0.0000	nnl	0	88. 00
88. 01 08801 RURAL HEALTH CLINIC II		0.0000		0	
88. 02 08802 RURAL HEALTH CLINIC III		0.0000		0	1
88. 03 08803 RURAL HEALTH GETMIN TT		0.0000		0	
90. 00 09000 CLINIC		6. 0848		0	•
91. 00 09100 EMERGENCY		0. 7793	25 37, 050	28, 874	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)		2. 6116		0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)			2, 322, 017	808, 467	200.00
201.00 Less PBP Clinic Laboratory Services-Program only char	ges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			2, 322, 017		202.00

Health Financial Systems PULASKI MEMORIAL	HOSPI TAL		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	
	Component	CCN: 15-Z305	From 10/01/2020 To 09/30/2021	Date/Time Pre 9/19/2022 5:1	
	Title	XVIII	Swing Beds - SNF		т р
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col . 2)	
LADATIENT DOUTLAG CEDALOG COCT OFNITEDO		1. 00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					1 20 00
30. 00 03000 ADULTS & PEDI ATRI CS					30. 00 31. 00
31.00 03100 INTENSI VE CARE UNI T 43.00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					43.00
50, 00 05000 OPERATI NG ROOM		0. 31451	16 2, 146	675	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0. 50977	·	0,70	
53. 00 05300 ANESTHESI OLOGY		0. 02812		Ö	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 17902			
60. 00 06000 LABORATORY		0. 16759		7, 460	
60. 01 06001 BLOOD LABORATORY		0.00000		0	60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 22350	2, 574	575	63.00
65. 00 06500 RESPIRATORY THERAPY		0. 67703	78, 461	53, 121	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 62000	00 121, 792	75, 511	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 47699	90 59, 962	28, 601	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 80203	·	3, 223	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 03867		8	69. 00
69. 01 06901 CARDI AC REHABI LI TATI ON		0. 67743		0	69. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 00000		0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 23611		5, 997	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 78692		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 30712	·	46, 116	•
76. 00 03020 ONCOLOGY OUTPATIENT SERVICE COST CENTERS		0. 7279	18 0	0	76. 00
88. 00 08800 RURAL HEALTH CLINIC		0.00000	20	0	88. 00
88. 01 08801 RURAL HEALTH CLINIC II		0. 00000		0	
88. 02 08802 RURAL HEALTH CLINIC III		0. 00000		Ö	88. 02
88. 03 08803 RURAL HEALTH CLINIC IV		0. 00000		0	88. 03
90. 00 09000 CLI NI C		6. 08480		Ö	90.00
91. 00 09100 EMERGENCY		0. 77932		144	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		2. 61169		0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)			511, 259	225, 344	
201.00 Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)	,		511, 259		202. 00

Health Financial Systems PULASKI MEMORIAL	ΗΛΟΡΙ ΤΔΙ		Inlie	u of Form CMS-2	2552_10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-1305	Peri od:	Worksheet D-3	
			From 10/01/2020	D. I. (T' D	
			To 09/30/2021	Date/Time Pre 9/19/2022 5:1	
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	1 1 1 1 1 1 1 1 1	Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS			32, 374		30.00
31. 00 03100 INTENSIVE CARE UNIT			0		31.00
43. 00 04300 NURSERY			13, 494		43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 3145		10, 215	
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 5097		14, 370	
53. 00 05300 ANESTHESI OLOGY		0. 0281		157	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY		0. 1790: 0. 1675:		2, 185 7, 378	
60. 01 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY		0. 1675		7,378	1
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 2235		402	
65. 00 06500 RESPI RATORY THERAPY		0. 6770		3, 290	
66. 00 06600 PHYSI CAL THERAPY		0. 6200		1, 249	1
67. 00 06700 OCCUPATI ONAL THERAPY		0. 4769		267	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 8020	33 2, 157	1, 730	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 0386	71 194	8	69.00
69. 01 06901 CARDI AC REHABI LI TATI ON		0. 6774		0	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2361			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 7869		0	
73. 00 07300 DRUGS CHARGED TO PATI ENTS 76. 00 03020 ONCOLOGY		0. 3071 0. 7279		16, 840 0	1
OUTPATIENT SERVICE COST CENTERS		0.7279	10 0	0	70.00
88. 00 08800 RURAL HEALTH CLINIC		1. 5885	97 0	0	88. 00
88. 01 08801 RURAL HEALTH CLINIC II		2. 0188		Ö	1
88. 02 08802 RURAL HEALTH CLINIC III		2. 5387	41 0	0	88. 02
88.03 08803 RURAL HEALTH CLINIC IV		2. 1324	52 0	0	88. 03
90. 00 09000 CLI NI C		6. 0848		0	
91. 00 09100 EMERGENCY		0. 7793		6, 955	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		2. 6116		0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)	(1)		226, 070	71, 716	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		224 070		201.00
202.00 Net charges (line 200 minus line 201)		I	226, 070		202.00

Health Financial Systems	PULASKI MEMORIAL HOSPITAL		In Lie	u of Form CMS-2	2552 10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 15-1305	Peri od:	Worksheet D-3	
	'	CCN: 15-Z305	From 10/01/2020 To 09/30/2021	Date/Time Pre 9/19/2022 5:1	
	Ti t		Swing Beds - SNF		
Cost Center Description		Ratio of Cos To Charges	The state of the s	Inpatient Program Costs (col. 1 x	
		1.00	2.00	col . 2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM		0.0000			
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY		0.0000		-	
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C		0.0000		1	
60. 00 06000 LABORATORY		0.0000		-	
60. 01 06001 BLOOD LABORATORY		0.0000		-	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0.0000		1	1
65. 00 06500 RESPIRATORY THERAPY		0.0000		0	65.00
66. 00 06600 PHYSI CAL THERAPY		0.0000	00 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0.0000		-	
68. 00 06800 SPEECH PATHOLOGY		0.0000		-	
69. 00 06900 ELECTROCARDI OLOGY		0.0000			
69. 01 06901 CARDI AC REHABI LI TATI ON		0.0000		-	
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3	0.0000		-	
72. 00 07100 MEDICAL SUPPLIES CHARGED TO PATTENT	3	0.0000		1	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0.0000			
76. 00 03020 ONCOLOGY		0.0000			
OUTPATIENT SERVICE COST CENTERS		•			1
88.00 08800 RURAL HEALTH CLINIC		0.0000			
88.01 08801 RURAL HEALTH CLINIC II		0.0000			
88. 02 08802 RURAL HEALTH CLINIC III		0.0000		1	
88. 03 08803 RURAL HEALTH CLINIC IV		0.0000		1	
90. 00 09000 CLI NI C		0.0000			
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART		0. 0000 0. 0000		1	
200.00 Total (sum of lines 50 through 94 a		0.0000	0		200.00
201.00 Less PBP Clinic Laboratory Services			0		200.00
202.00 Net charges (line 200 minus line 20		1	Ö		202.00
1 1 1 1 1 3 1 3 1 1 1 1 1 1 1 1 1 1 1 1	,	1	1	1	

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-1305	From 10/01/2020	Worksheet E Part B Date/Time Prepared: 9/19/2022 5:14 pm

PART 8. MFDICAL AND OTHER MFAITH SPROPES. 1.00 Vertical and other services (see Instructions) 0.100 0.20 0.00			Title XVIII	Hospi tal	9/19/2022 5: 1 Cost	4 pm
APAT B. WEDICAL AND OTHER HEAT HIS SERVICES 5, 182, 153 1.00			TI CI O XVIII	nospi tui		
		DADT D. MEDICAL AND OTHER HEALTH CERVICES			1. 00	
	1 00				5 192 153	1 00
3.00 OPES payments 0 3.00			ns)			1
0.001 1.00 0.01 1.00 0.00						
Enter the hospit tal specific payment to cost ratio (see instructions)	4.00	Outlier payment (see instructions)			0	4.00
Line 2 times line 5		, , , , , , , , , , , , , , , , , , ,		_		
			ons)			
Transit ional corridor payment (see instructions) 0 8.00 0 0 0 0 0 0 0 0 0						
Ancillary service other pass through costs from Wist. D. Pt. IV. col. 13. line 200						
10.100 Total cost (same of lines 1 and 10) (see instructions) 5.182.153 11.00		, , , , , , , , , , , , , , , , , , , ,	col. 13, line 200		_	
COMPUTATION OF LISSER OF COST OR CHARGES Reasonable Reaso	10.00	Organ acquisitions			0	10.00
Reasonable charges	11. 00				5, 182, 153	11.00
12.00 Ancillary service charges 0 12.00 12.00 10.1						-
13.00 Organ acquisition charges (from Wist, D.4, Pt. III, col. 4, line 69)	12 00				0	12 00
14.00 Total reasonable charges (sum of lines 12 and 13) 14.00 14.00 20.00			: 69)		_	
15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 16.00					0	
16.00 Anicunits that would have been realized from patients Liable for payment for services on a chargebasis 0 16.00 New Note New York						
had such payment been made in accordance with 42 CFR §413.13(e)						
17.00	16.00		ayment for services o	n a chargebasis	0	16.00
18.00 Total customary charges (see instructions) 0 18.00 19.00 20.	17 00				0 000000	17 00
19.00 Excess of customary charges over reasonable cost (complete only if fine 18 exceeds line 11) (see instructions) 20.00 Excess of reasonable cost over customary charges (complete only if fine 11 exceeds line 18) (see 0 20.0						
20. 00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20. 00	19.00	,	if line 18 exceeds li	ne 11) (see	0	19.00
Instructions		,				
1.00 Lesser of cost or charges (see instructions) 5, 233, 975 21.00	20. 00		if line 11 exceeds li	ne 18) (see	0	20.00
22.00 Interns and residents (see instructions) 0 22.00 0 23.00 0 23.00 0 23.00 0 24.00 0 2	21 00				5 233 975	21 00
24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 24.00 24.00 24.00 25.00 24.00 25.00		, , , , , , , , , , , , , , , , , , ,				1
COMPUTATION OF RELIMBURSEMENT SETTLEMENT 5.00	23. 00	Cost of physicians' services in a teaching hospital (see instruc	tions)		0	23. 00
25.00 Deductible sand coinsurance amounts (for CAH, see instructions) 2.705, 872 26.00	24. 00				0	24.00
26.00 Deductible sand Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 2,295,872 26.00 28.00	05.00				/4 705	05.00
27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 2,876,398 27.00			4 (for CAH see instr	ructions)	·	1
Instructions 28 00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28 00 29 00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0 29 00 29 00 20						1
29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 29.00 29.00 28.76.398 30.00 29.00 29.00 28.76.398 30.00 29.00 29.00 28.76.399 30.00 29.00 28.76.399 30.00 29.00 28.76.399 30.00 30.0		I		0] (000	_, _, _, _,	
Subtotal (sum of lines 27 through 29) 30.00 Primary payer payments 1.008 31.00 Subtotal (line 30 minus line 31) 1.008 31.00 32.00 Subtotal (line 30 minus line 31) 2.875, 390 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from West i5, line 11) 0 33.00 34.00 Allowable bad debts (see instructions) 419,581 34.00 35.00 Allowable bad debts (see instructions) 222,348 34.00 37.00 Subtotal (see instructions) 322,238 36.00 37.00 Subtotal (see instructions) 320,348 37.00 38.00 MERCAULTION (SEE INSTRUCTIONS) 39.00 3			50)		0	
31.00 Subtotal (line 30 minus line 31) 2,875,390 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. 1-5, line 11) 0 33.00 33.00 Adjusted reimbursable bad debts (see instructions) 419,581 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 227,728 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 220,348 36.00 37.00 38.0		,			_	
32.00 Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. 1-5, line 11) 0 33.00 34.00 Allowable bad debts (see instructions) 272, 728 35.00 36.00 Allowable bad debts (see instructions) 272, 728 36.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 220, 348 36.00 37.00 Subtotal (see instructions) 31.48, 118 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.00 0 39.00		, ,				1
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 0 0 33.00 Composite rate ESRD (from Wkst. I-5, line 11) 0 34.00 All lowable bad debts (see instructions) 419,581 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 272,728 35.00 220,348 36.00 All lowable bad debts for dual eligible beneficiaries (see instructions) 220,348 36.00 220,348 36.00 37.00 Subtotal (see instructions) 31.48,118 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 MSP-LCC reconciliation amount from PS&R 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.97 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 8ECOVERY OF ACCELERATED DEPRECIATION 0 39.99 8ECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Sequestration adjustment (see instructions) 3,148,118 40.00 40.01 Sequestration adjustment (see instructions) 0 40.01 40.02 Demonstration payment adjustment amount before sequestration 0 40.01 40.02 40.02 40.02 40.03 40.02 40.03 40.03 40.04						
34.00)			1
35.00		· · · · · · · · · · · · · · · · · · ·			-	
36.00					· ·	
37.00 Subtotal (see instructions) 3, 148,118 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 38.00 38.00 39.50 70 70 70 70 70 70 70		· · · · · · · · · · · · · · · · · · ·	tions)			
38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 39.50 39.50 39.50 39.97 Demonstration payment adjustment amount before sequestration 0 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.98 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 3,148.118 40.00 40.01 Sequestration adjustment (see instructions) 0 40.01 40.02 Demonstration payment adjustment amount after sequestration 0 40.01 40.02 Demonstration payment adjustment amount after sequestration 0 40.02 40.03 40.03 40.03 40.03 40.00 40.01 40.02 40.03 4			iti ons)			
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 91.000 39.50 91.000 39.50 91.000 39.50 91.000 39.50 91.000 39.50 91.000 39.50 91.000 39.50 91.000 39.50 91.000 93.00 92.00 93.00						
39.97 Demonstration payment adjustment amount before sequestration 0 39.97		OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 3, 148, 118 40. 00 40. 01 Sequestration adjustment (see instructions) 0 40. 01 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 02 40. 03 Sequestration adjustment-PARHM pass-throughs 40. 03 41. 00 Interim payments 2, 875, 390 41. 00 41. 01 Interim payments-PARHM 41. 01 41. 01 42. 01 Tentative settlement (for contractors use only) 0 42. 01 43. 01 Bal ance due provider/program (see instructions) 272, 728 43. 00 43. 01 Bal ance due provider/program-PARHM (see instructions) 43. 01 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00 41. 02 To BE COMPLETED BY CONTRACTOR 0 90. 00 90. 00 Outlier reconciliation adjustment amount (see instructions) 0 90. 00 92. 00		, , , , , , , , , , , , , , , , , , , ,				39.50
39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 3, 148, 118 40. 00 40. 01 Sequestration adjustment (see instructions) 0 40. 01 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 02 40. 03 Sequestration adjustment-PARHM pass-throughs 40. 03 41. 00 Interim payments 2, 875, 390 41. 00 41. 01 Interim payments 41. 01 Interim payments (for contractors use only) 42. 01 42. 01 Tentative settlement (for contractor use only) 42. 01 43. 00 Bal ance due provider/program (see instructions) 42. 01 43. 01 Bal ance due provider/program-PARHM (see instructions) 43. 01 44. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 91. 00 44. 00 90. 00 Original outlier amount (see instructions) 90. 00 91. 00 Outlier reconciliation adjustment amount (see instructions) 90. 00 92. 00 The rate used to calculate the Time Value of Money (see instructions) 0 93. 00			I dovi cos (sos i set :	etions)		
40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.03 Sequestration adjustment-PARHM pass-throughs 41.00 Interim payments 41.01 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 44.00 Protested amounts (see instructions) 90.00 Orgi inal outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Og 73.00 Time Value of Money (see instructions) 95.00 Time Value of Money (see instructions) 96.00 Time Value of Money (see instructions) 97.00 Time Value of Money (see instructions) 98.00 Time Value of Money (see instructions) 99.00 Time Value of Money (see instructions) 90.00 Time Value of Money (see instructions)		! ·	uevices (see instruc	. (1 0115)	_	
40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration Sequestration adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs 40. 03 Sequestration adjustment-PARHM pass-throughs 41. 00 Interim payments 42. 01 Tentative settlement (for contractors use only) 42. 01 Tentative settlement-PARHM (for contractor use only) 43. 00 Balance due provider/program (see instructions) 43. 01 Balance due provider/program-PARHM (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115. 2 TO BE COMPLETED BY CONTRACTOR 90. 00 Original outlier amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 0 40. 02 40. 03 41. 00 41. 00 41. 00 42. 01 42. 01 42. 01 42. 01 43. 00 43. 01 44. 00 43. 01 44. 00 44. 00 45. 01 46. 02 47. 02 47. 02 48. 00 49. 00 49. 00 90. 00 91. 00 92. 00 93. 00 93. 00					-	1
40. 03 Sequestration adjustment-PARHM pass-throughs 40. 03 1 nterim payments 2,875,390 41. 00 1 nterim payments 1 nterim payments 2,875,390 41. 00 41. 01 1 nterim payments-PARHM 2. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement-PARHM (for contractor use only) 42. 01 43. 00 Balance due provider/program (see instructions) 272,728 43. 00 43. 01 Balance due provider/program-PARHM (see instructions) 43. 01 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00 44. 00 2 nterior may be a contractor on the contractor of the contractor					0	1
41.00 Interim payments 41.01 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 Original outlier amount (see instructions) 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00					0	
1.01 Interim payments-PARHM					2 075 222	
42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Value of Money (see instructions) 95.00 Value of Money (see instructions) 96.00 Value of Money (see instructions) 97.00 Value of Money (see instructions)					2, 8/5, 390	1
42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Time Value of Money (see instructions) 95.00 Time Value of Money (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 98.00 Time Value of Money (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions)					n	
43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordan						
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Time Value of Money (see instructions)					272, 728	1
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 Outlier reconciliation adjustment amount (see instructions) 0 Unitiation adjustment amount (see instructions) 0 91.00 1 The rate used to calculate the Time Value of Money 1 Time Value of Money (see instructions) 0 93.00						
TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)	44. 00		with CMS Pub. 15-2,	chapter 1,	0	44.00
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 90.00 91.00 92.00 93.00						1
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 91.00 0.00 92.00 93.00	90. 00				Ω	90.00
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00					_	1
						1
94.00 Total (sum of lines 91 and 93) 0 94.00						
	94.00	Tiorai (sum of fines 4) and 43)			0	J 94. 00

Health Financial Systems	PULASKI	MEMORI AL	HOSPI TAL	In Lieu	of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			Provider CCN: 15-1305	Peri od:	Worksheet E	
				From 10/01/2020		
				To 09/30/2021		
					9/19/2022 5:	14 pm
			Title XVIII	Hospi tal	Cost	
					1. 00	
MEDICARE PART B ANCILLARY COSTS						
200.00 Part B Combined Billed Days						0 200. 00

Health Financial Systems PULA:
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 10/01/2020 | Part | To 09/30/2021 | Date/Time Prepared: Provi der CCN: 15-1305

				10 09/30/2021	9/19/2022 5: 14	
		Ti tl e	XVIII	Hospi tal	Cost	
		Inpatier	nt Part A		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		1, 635, 28	2	2, 622, 732	1. 00
2.00	Interim payments payable on individual bills, either			0	o	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	06/30/2021	362, 60		446, 300	3. 01
3. 02		02/28/2022	82, 74		0	3. 02
3. 03			l	O	0	3. 03
3. 04			l	0	0	3.04
3. 05				O	0	3. 05
	Provi der to Program			00 (00 (0000	100 (10	
3.50	ADJUSTMENTS TO PROGRAM		1	02/28/2022	193, 642	3. 50
3. 51)	0	3.5
3. 52 3. 53			l	0		3. 5: 3. 5:
3. 54			1)		3. 5.
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		445, 34	~	252, 658	3. 99
3. 77	3. 50-3. 98)		445, 34	5	252, 050	3. 7
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 080, 63)	2, 875, 390	4.00
00	(transfer to Wkst. E or Wkst. E-3, line and column as		2,000,00		2,0,0,0,0	
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR		•			
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		II.	O	0	5.0
5. 02			l	0	0	5. 0
5. 03				O	0	5. 03
F F0	Provi der to Program	I				
5. 50 5. 51	TENTATI VE TO PROGRAM		II.)	0	5. 50
			II.		0	5.5
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		1)		5. 52 5. 99
5. 99	5. 50-5. 98))	ا	5.9
6. 00	Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		16, 27	5	272, 728	6. 0°
6. 02	SETTLEMENT TO PROGRAM		.5,2,	o	0	6. 0
7. 00	Total Medicare program liability (see instructions)		2, 096, 90	5	3, 148, 118	7. 0
	, , , , , , , , , , , , , , , , , , , ,		, , , , , , , , ,	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
			0	1.00	2. 00	
8.00	Name of Contractor					8. 0

		Component	CCN: 15-Z305 1	0 09/30/2021	9/19/2022 5:1	
		Title	XVIII Sv	ving Beds - SNF		ı pııı
		Inpatien	it Part A		t B	
					1	
		mm/dd/yyyy 1.00	Amount 2.00	mm/dd/yyyy 3.00	Amount 4.00	
1. 00	Total interim payments paid to provider	1.00	888, 041	3.00	4.00	1.00
2. 00	Interim payments payable on individual bills, either		000,041		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)					
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER	06/30/2021	201, 300		0	3. 01
3. 02	ADJUSTIMENTS TO FROVIDER	02/28/2022	102, 395		0	
3. 03		02/20/2022	102, 379		0	
3. 04			0		0	
3. 05			0		0	
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	
3. 51			0		0	
3. 52			0		0	
3. 53			0		0	
3. 54 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0 303, 695		0	
3. 99	3. 50-3. 98)		303, 695		0	3.99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 191, 736		0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)]
	TO BE COMPLETED BY CONTRACTOR		ı		ı	
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	TERMINA TO TROTTE EX		0		Ö	
5.03			0		0	5. 03
	Provider to Program		,			
5. 50	TENTATI VE TO PROGRAM		0		0	
5. 51			0		0	
5. 52 5. 99	Subtatal (sum of lines E O1 E 40 minus sum of lines		0		0	
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					6.00
5. 55	the cost report. (1)					5.50
6. 01	SETTLEMENT TO PROVIDER		0		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	
7. 00	Total Medicare program liability (see instructions)		1, 191, 736		0	7.00
				Contractor	NPR Date	
			 O	Number	(Mo/Day/Yr)	
8. 00	Name of Contractor		J	1. 00	2. 00	8. 00
0.00	Inalie of contractor	I		I	I	1 0.0

Heal th	Financial Systems PULASKI MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10	
	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-1305	Peri od:	Worksheet E-1		
	From 10/01/2020					
			To 09/30/2021	Date/Time Pre 9/19/2022 5:1		
		Title XVIII	Hospi tal	Cost	т рііі	
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	₹				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	•			1.00	
2.00	2.00 Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost					
reporting periods beginning on or after 10/01/2013, line 32)					3.00	
	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2					
4. 00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines	1, and 8 through 12, and	d plus for cost		4. 00	
	reporting periods beginning on or after 10/01/2013, line 32)					
5. 00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00	
6. 00	Total hospital charity care charges from Wkst. S-10, col. 3 I				6. 00	
7. 00	CAH only - The reasonable cost incurred for the purchase of c	certified HIT technology	Wkst. S-2, Pt. I		7. 00	
	line 168					
8. 00	Calculation of the HIT incentive payment (see instructions)				8. 00	
9. 00	Sequestration adjustment amount (see instructions)				9. 00 10. 00	
10. 00	10.00 Calculation of the HIT incentive payment after sequestration (see instructions)					
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				30.00	
	30.00 Initial/interim HIT payment adjustment (see instructions)					
	31.00 Other Adjustment (specify)					
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	ns)		32.00	

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	ı of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 15-1305	Peri od: From 10/01/2020	Worksheet E-2
		Component CCN: 15-Z305	To 09/30/2021	Date/Time Prepared:

		Component CCN: 15-Z305	To 09/30/2021	Date/Time Pre 9/19/2022 5:1	
		Title XVIII	Swing Beds - SNF		т рііі
		-	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)		974, 333	0	
2.00	Inpatient routine services - swing bed-NF (see instructions)		007 507		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Par	t A, and sum of Wkst. D,	227, 597	0	3. 00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swi	ng-bed pass-through, see			
3. 01	instructions) Nursing and allied health payment-PARHM (see instructions)				3. 01
4. 00	Per diem cost for interns and residents not in approved teach	ing program (see		0.00	4.00
4.00	instructions)	riig program (see		0.00	7.00
5.00	Program days		401	0	5.00
6.00	Interns and residents not in approved teaching program (see i	nstructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional me	thod only	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1, 201, 930	0	
9. 00	Primary payer payments (see instructions)		0	0	
10.00	Subtotal (line 8 minus line 9)		1, 201, 930	0	
11. 00	Deductibles billed to program patients (exclude amounts appli	cable to physician	2, 574	0	11.00
12. 00	professional services) Subtotal (line 10 minus line 11)		1, 199, 356	0	12.00
13. 00	Coinsurance billed to program patients (from provider records) (evelude coinsurance	7, 620	0	
13.00	for physician professional services)	(exclude collisulance	7,020	O	13.00
14. 00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		1, 191, 736	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)			16. 50
16. 55	Rural community hospital demonstration project (§410A Demonst	ration) payment	0		16. 55
	adjustment (see instructions)				
16. 99	Demonstration payment adjustment amount before sequestration		0	0	
17.00	Allowable bad debts (see instructions)		0	0	
17. 01	Adjusted reimbursable bad debts (see instructions)		0	0	
18.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)	1 101 724	0	
19. 00 19. 01	Total (see instructions) Sequestration adjustment (see instructions)		1, 191, 736	0	
19. 01	Demonstration payment adjustment amount after sequestration)		0	0	
19. 02				O	19. 02
19. 25	Sequestration for non-claims based amounts (see instructions)		0	0	
20.00	Interim payments		1, 191, 736	0	20.00
20. 01	Interim payments-PARHM				20. 01
21.00	Tentative settlement (for contractor use only)		0	0	21.00
21. 01	Tentative settlement-PARHM (for contractor use only)				21. 01
22. 00	Balance due provider/program (line 19 minus lines 19.01, 19.0	2, 19.25, 20, and 21)	0	0	22. 00
22. 01	Balance due provider/program-PARHM (see instructions)				22. 01
23. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	0	0	23. 00
	chapter 1, §115.2	sation) Adiustment			
200 00	Rural Community Hospital Demonstration Project (§410A Demonstration Project (§410A Demonstration pe				200. 00
200.00	Century Cures Act? Enter "Y" for yes or "N" for no.	Trou under the 21st			200.00
	Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from	Wkst. D-1, Pt. II, line			201.00
	66 (title XVIII hospital))				
202.00	Medicare swing-bed SNF inpatient ancillary service costs (fro	m Wkst. D-3, col. 3, line	e		202. 00
	200 (title XVIII swing-bed SNF))				
203.00	Total (sum of lines 201 and 202)				203. 00
204.00	Medicare swing-bed SNF discharges (see instructions)				204. 00
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-year demons	tration	
20E 0	period) Medicare swing-bed SNF target amount				205 00
	Medicare swing-bed SNF target amount Medicare swing-bed SNF inpatient routine cost cap (line 205 t	imos lino 204)			205. 00 206. 00
200.00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				200.00
207 00	Program reimbursement under the §410A Demonstration (see inst	ructions)			207. 00
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-		1		208.00
	and 3)				
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instru	ctions)			209. 00
	Reserved for future use				210.00
	Comparision of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line	209 plus line 210) (see			215. 00
	instructions)		1		I

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provi der CCN: 15-1305	Peri od: From 10/01/2020	Worksheet E-2
		Component CCN: 15-Z305		Date/Time Prepared: 9/19/2022 5:14 pm

		Component CCN: 15-Z305	To 09/30/2021	Date/Time Pro 9/19/2022 5:	
		Title XIX	Swing Beds - SNF		тт рііі
			Part A	Part B	
			1. 00	2. 00	
1 00	COMPUTATION OF NET COST OF COVERED SERVICES				1 00
1. 00 2. 00	Inpatient routine services - swing bed-SNF (see instructions) Inpatient routine services - swing bed-NF (see instructions)		0		1.00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Par	t A and sum of Wkst D	0		3.00
3.00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swi		_		3.00
	instructions)	ing bed pass till odgil, see			
3. 01	Nursing and allied health payment-PARHM (see instructions)				3. 01
4.00	Per diem cost for interns and residents not in approved teach	ing 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 i	•	0		6. 00
7.00	Utilization review - physician compensation - SNF optional me	thod 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 11. 00	Subtotal (line 8 minus line 9) Deductibles billed to program patients (exclude amounts appli	cable to physician	0		10.00
11.00	professional services)	cable to physician			11.00
12. 00	Subtotal (line 10 minus line 11)		0		12.00
13. 00	Coinsurance billed to program patients (from provider records) (exclude coinsurance	0		13. 00
	for physician professional services)	, (
14.00	80% of Part B costs (line 12 x 80%)		0		14.00
15.00	Subtotal (see instructions)		0		15. 00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		16. 00
16. 50	Pioneer ACO demonstration payment adjustment (see instruction				16. 50
16. 55	Rural community hospital demonstration project (§410A Demonst	ration) payment			16. 55
47.00	adjustment (see instructions)				1, 00
16. 99	Demonstration payment adjustment amount before sequestration		0		16. 99 17. 00
17. 00 17. 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)		0		17.00
18. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)	0		18.00
19.00	Total (see instructions)	ructions)	0		19.00
19. 01	Sequestration adjustment (see instructions)		0		19. 01
19. 02	Demonstration payment adjustment amount after sequestration)		0		19. 02
19. 03					19. 03
19. 25	Sequestration for non-claims based amounts (see instructions)		0		19. 25
20.00	Interim payments		0		20.00
20. 01	Interim payments-PARHM				20. 01
21. 00	Tentative settlement (for contractor use only)		0		21.00
21. 01	Tentative settlement-PARHM (for contractor use only)				21. 01
22. 00	Balance due provider/program (line 19 minus lines 19.01, 19.0	2, 19.25, 20, and 21)	0		22. 00
22. 01	Balance due provider/program-PARHM (see instructions)	111 ONC D 1 45 O			22. 01
23. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	0		23. 00
	chapter 1, §115.2 Rural Community Hospital Demonstration Project (§410A Demonst	ration) Adjustment			
200 00	Is this the first year of the current 5-year demonstration pe				200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from	Wkst. D-1, Pt. II, line			201.00
	66 (title XVIII hospital))				
202.00	Medicare swing-bed SNF inpatient ancillary service costs (fro	m Wkst. D-3, col. 3, lin	e		202. 00
	200 (title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	first year of the surre	nt E voor domono	tration	204. 00
	period)	Thist year of the curre	iri b-year deliloris	ti ati on	
205 00	Medicare swing-bed SNF target amount				205. 00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 t	imes Line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbur	sement			1
207.00	Program reimbursement under the §410A Demonstration (see inst	ructions)			207. 00
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-		1		208.00
	and 3)				1
	Adjustment to Medicare swing-bed SNF PPS payments (see instru	ctions)			209. 00
210.00	Reserved for future use				210. 00
045 5	Comparision of PPS versus Cost Reimbursement	000 1 11 210 (1045 05
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line	209 plus line 210) (see			215. 00
	instructions)		T .	l	1

N. I.I. St. I. I. O. I.	10// 1/51/05/ 1/			6.5. 0110.0	
Health Financial Systems PUL	_ASKI MEMORIAL	HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-1305	Peri od: From 10/01/2020 To 09/30/2021	Worksheet E-3 Part V Date/Time Prep 9/19/2022 5:14	pared:
		Title XVIII	Hospi tal	Cost	
				1. 00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT	FOR MEDICARE	PART A SERVICES - COST	T REI MBURSEMENT		
1 00 Innetion complete				2 251 007	1 00

	Title XVIII Hospital	Cost	
		1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1. 00	Inpatient services	2, 251, 887	1. 00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4. 00	Subtotal (sum of lines 1 through 3)	2, 251, 887	
5.00	Primary payer payments	0	5.00
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)	2, 274, 406	6. 00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7. 00	Routine service charges	0	7.00
8. 00	Ancillary service charges	0	8. 00
9. 00	Organ acquisition charges, net of revenue	0	9.00
10.00	J	0	10.00
	Customary charges		44.00
11.00		0	
12.00		0	12.00
40.00	had such payment been made in accordance with 42 CFR 413.13(e)	0.000000	40.00
13.00	,	0.000000	
14.00		0	14.00
15. 00		0	15. 00
16. 00	instructions) Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see	0	16. 00
16.00	instructions)	U	16.00
17. 00	, and the second	0	17. 00
17.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	0	17.00
18. 00		0	18. 00
19. 00		2, 274, 406	
20.00		193, 776	
21. 00	, , ,	0	
22. 00	· ,	2, 080, 630	
23.00	Coinsurance	0	23.00
24.00		2, 080, 630	24.00
25.00		25, 039	25.00
26. 00	Adjusted reimbursable bad debts (see instructions)	16, 275	26. 00
27.00		4, 224	
28.00		2, 096, 905	
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29. 50
29. 98		0	29. 98
29. 99		0	29. 99
30.00	Subtotal (see instructions)	2, 096, 905	30.00
30. 01	Sequestration adjustment (see instructions)	0	30. 01
30.02	Demonstration payment adjustment amount after sequestration	0	30. 02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	2, 080, 630	31.00
31. 01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32. 01
33.00		16, 275	
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33. 01
34.00		0	34.00
	§115. 2		

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1	From 10/01/2020	Worksheet E-3 Part VII Date/Time Prepared: 9/19/2022 5:14 pm

			o 09/30/2021	Date/Time Pre 9/19/2022 5:1	
	Tit	le XIX	Hospi tal	Cost	
			Inpatient	Outpati ent	
			1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR	TITLES V OR XI	X SERVICES		
4 00	COMPUTATION OF NET COST OF COVERED SERVICES		004.044		
1.00	Inpatient hospital/SNF/NF services		204, 811	0	1.00
2.00	Medical and other services		0	0	2.00
3.00	Organ acquisition (certified transplant centers only)		0	0	3.00
4. 00 5. 00	Subtotal (sum of lines 1, 2 and 3) Inpatient primary payer payments		204, 811	U	4. 00 5. 00
6. 00	Outpatient primary payer payments		U	0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		204, 811	Ö	
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		201,011	0	7.00
	Reasonable Charges				
8.00	Routine service charges		45, 868		8.00
9.00	Ancillary service charges		226, 070	0	9. 00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		271, 938	0	12.00
	CUSTOMARY CHARGES				
13. 00	Amount actually collected from patients liable for payment for services	on a charge	0	0	13.00
14 00	basis	for comiless on	0	0	14.00
14. 00	Amounts that would have been realized from patients liable for payment a charge basis had such payment been made in accordance with 42 CFR §41		U	U	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	3. 13(e)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		271, 938	0.000000	16.00
17. 00	Excess of customary charges over reasonable cost (complete only if line	16 exceeds	67, 127	0	17. 00
	line 4) (see instructions)		,		
18.00	Excess of reasonable cost over customary charges (complete only if line	4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)	£ DDC	204, 811	0	21. 00
22. 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed Other than outlier payments	Tor PPS provid	ers.	0	22. 00
23. 00	Outlier payments		0	0	23. 00
	Program capital payments		0	U	24.00
25. 00	Capital exception payments (see instructions)		ő		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		204, 811	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30. 00	Excess of reasonable cost (from line 18)		0	0	
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		204, 811	0	31.00
32.00	Deducti bl es		0	0	32.00
33. 00 34. 00	Coinsurance		0	0	33.00
	Allowable bad debts (see instructions) Utilization review		0	U	34. 00 35. 00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		204, 811	0	36.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		204, 011	Ö	37.00
	Subtotal (line 36 ± line 37)		204, 811	Ö	38.00
	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
	Total amount payable to the provider (sum of lines 38 and 39)		204, 811	0	40.00
41.00	Interim payments		163, 795	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		41, 016	0	42.00
43. 00	Protested amounts (nonallowable cost report items) in accordance with C	MS Pub 15-2,	0	0	43.00
	chapter 1, §115.2		1		

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 10/01/2020 To 09/30/2021 Date/Ti me Prepared: 9/19/2022 5:14 pm

<u>y</u> ,		General Fund	Specific Purpose Fund	Endowment Fund	9/19/2022 5: 1 Plant Fund	4 pm
	T	1.00	2.00	3. 00	4. 00	
1 00	CURRENT ASSETS	1 707 222		ما	0	1.00
1. 00 2. 00	Cash on hand in banks Temporary investments	1, 797, 332	0	0	0	2.00
3. 00	Notes receivable	0	0	0	0	3.00
4. 00	Accounts recei vabl e	11, 565, 908	0	Ö	0	4.00
5.00	Other recei vable	0	0	o	0	5. 00
6. 00	Allowances for uncollectible notes and accounts receivable	-7, 329, 879	0	0	0	6.00
7. 00	Inventory	674, 195	1	0	0	7.00
8. 00	Prepai d expenses	31, 698		0	0	8.00
9. 00 10. 00	Other current assets Due from other funds	3, 750, 238	0	U O	0	9. 00 10. 00
11. 00	Total current assets (sum of lines 1-10)	10, 489, 492	1	0	0	11.00
11.00	FIXED ASSETS	10, 407, 472		<u></u>		11.00
12.00	Land	195, 525	0	0	0	12.00
13.00	Land improvements	432, 594	0	o	0	13.00
14.00	Accumulated depreciation	-420, 317		0	0	14.00
15. 00	Bui I di ngs	13, 253, 038	0	0	0	15.00
16.00	Accumulated depreciation	-8, 763, 421	0	0	0	16.00
17.00	Leasehold improvements	187, 055	1	0	0	17.00
18. 00 19. 00	Accumulated depreciation Fixed equipment	-195, 033 7, 468, 798		U O	0	18. 00 19. 00
20. 00	Accumulated depreciation	-6, 522, 342		0	0	20.00
21. 00	Automobiles and trucks	0,022,012	0	Ö	0	21.00
22. 00	Accumulated depreciation	0	O	Ö	0	22. 00
23.00	Maj or movable equipment	12, 398, 916	0	o	0	23.00
24.00	Accumulated depreciation	-8, 744, 297	0	0	0	24.00
25.00	Mi nor equi pment depreciable	0	0	0	0	25. 00
26. 00	Accumulated depreciation	0	0	0	0	26.00
27. 00	HIT designated Assets	0	0	0	0	27.00
28. 00	Accumulated depreciation	0	0	0	0	28.00
29. 00 30. 00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	9, 290, 516	0	0	0	29. 00 30. 00
30.00	OTHER ASSETS	7, 270, 310	<u> </u>	<u> </u>		30.00
31. 00	Investments	0	0	O	0	31.00
32.00	Deposits on Leases	0	0	o	0	32.00
33.00	Due from owners/officers	0	0	o	0	33.00
34.00	Other assets	11, 011, 742	1	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	11, 011, 742		0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	30, 791, 750	0	0	0	36.00
37. 00	CURRENT LIABILITIES Accounts payable	1, 038, 869	0	ol	0	37.00
38. 00	Salaries, wages, and fees payable	1, 976, 090		Ö	0	38.00
39. 00	Payrol I taxes payable	0	O	Ö	0	39.00
40.00	Notes and Loans payable (short term)	779, 827	0	o	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44. 00 45. 00	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	1, 011, 088 4, 805, 874		0	0	44. 00 45. 00
43.00	LONG TERM LIABILITIES	4,000,074	0	<u> </u>	0	45.00
46. 00	Mortgage payable	0	0	ol	0	46.00
47. 00	Notes payable	3, 142, 428		Ö	0	47. 00
48.00	Unsecured Loans	0	0	o	0	48. 00
49. 00	Other long term liabilities	-182, 913	0	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2, 959, 515	1	0	0	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	7, 765, 389	0	0	0	51.00
E2 00	CAPITAL ACCOUNTS General fund balance	22 024 241				E2 00
52. 00 53. 00	Specific purpose fund	23, 026, 361	0			52. 00 53. 00
54. 00	Donor created - endowment fund balance - restricted			o		54.00
55. 00	Donor created - endowment fund balance - unrestricted			Ö		55.00
56.00	Governing body created - endowment fund balance			o		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
59. 00	replacement, and expansion	23, 026, 361	0	0	0	59.00
60.00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	30, 791, 750	1	ol Ol	0	60.00
50.00	[59]	33, 771, 730		ď	O	55.50
	·	1	. '	'		

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

Peri od: Wo From 10/01/2020

					To 09/30/2021	Date/Time Pre 9/19/2022 5:1	pared: 4 pm
		General	Fund	Special F	Purpose Fund	Endowment Fund	
		1. 00	2.00	3. 00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0 0 0 0	22, 146, 668 879, 693 23, 026, 361		0 0 0 0 0 0	0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0 0 0	0 23, 026, 361 0 23, 026, 361		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0	9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
	Sheet (Time II IIII hus Time 18)	Endowment	PI ant	Fund			
		Fund			_		
		6. 00	7. 00	8. 00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0 0	0 0 0 0 0		0 0 0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

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

			То	09/30/2021	Date/Time Pre 9/19/2022 5: 1	
	Cost Center Description	I npati ent		Outpati ent	Total	трііі
	oust defiter bescription	1.00		2.00	3. 00	
	PART I - PATIENT REVENUES	1.00		2.00	3.00	
	General Inpatient Routine Services					
1. 00	Hospi tal	1, 934, 8	63		1, 934, 863	1.00
2. 00	SUBPROVIDER - IPF	1, 754, 0	03		1, 734, 003	2.00
3.00	SUBPROVIDER - IPF					3.00
4.00	SUBPROVI DER					4.00
5. 00	Swing bed - SNF		0		0	5.00
6.00	Swing bed - NF		0		0	6.00
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9. 00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1, 934, 8	63		1, 934, 863	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	SURGI CAL INTENSIVE CARE UNIT					14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15.00
16. 00	Total intensive care type inpatient hospital services (sum of lines		0		0	16. 00
10.00	11-15)				o o	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	1, 934, 8	63		1, 934, 863	17.00
18. 00	Ancillary services	10, 223, 5		42, 261, 727	52, 485, 301	18. 00
19. 00	Outpatient services	233, 0		5, 361, 080	5, 594, 117	19.00
20. 00	RURAL HEALTH CLINIC	233, 0	0	4, 675, 049	4, 675, 049	20.00
			-			
20. 01	RURAL HEALTH CLINIC II		0	740, 872	740, 872	20. 01
20. 02	RURAL HEALTH CLINIC III		0	185, 076	185, 076	20. 02
20. 03	RURAL HEALTH CLINIC IV		0	520, 075	520, 075	20. 03
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21.00
22. 00	HOME HEALTH AGENCY			0	0	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	0	0	26.00
27.00	NON-PROVI DER BASED		0	120, 447	120, 447	27.00
27. 01	PHYSI CI AN FEES	317, 9	69	1, 243	319, 212	27.01
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst	. 12, 709, 4	43	53, 865, 569	66, 575, 012	28.00
	G-3, line 1)	, , , ,			, , .	
	PART II - OPERATING EXPENSES	<u> </u>		<u> </u>		
29.00	Operating expenses (per Wkst. A, column 3, line 200)			38, 782, 608		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)		O	0		36.00
37. 00	DEDUCT (SPECIFY)		0	٩		37.00
38. 00	DEDUCT (SPECITI)		0			38.00
39. 00			-			39.00
			0			
40.00			0			40.00
41.00			U	_		41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(trans	ter		38, 782, 608		43.00
	to Wkst. G-3, line 4)	1	- 1	l		

Heal th	Financial Systems PULASKI MEMORIAL	HOSDI TAI	In lie	u of Form CMS-2	0552_10
	MENT OF REVENUES AND EXPENSES	Provi der CCN: 15-1305	Peri od:	Worksheet G-3	1332-10
			From 10/01/2020	5	
			To 09/30/2021	Date/Time Pre	
				77 177 2022 0. 1	ı pııı
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin			66, 575, 012	1.00
2.00	Less contractual allowances and discounts on patients' account	nts		33, 341, 565	2.00
3.00	Net patient revenues (line 1 minus line 2)			33, 233, 447	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		38, 782, 608	4.00
5.00	Net income from service to patients (line 3 minus line 4)			-5, 549, 161	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7.00
8. 00	Revenues from telephone and other miscellaneous communication	n services		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00				0	10.00
11. 00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13. 00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14.00
	Revenue from rental of living quarters			0	15.00
16. 00		than patients		0	16.00
17. 00	3			0	17.00
18. 00	Revenue from sale of medical records and abstracts			0	18.00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00				0	20.00
21. 00				0	21.00
22. 00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	OTHER I NCOME			6, 346, 357	24.00
24. 01	RENTAL INCOME			23, 299	
24. 02	NON OPERATING			95, 295	24.02
24. 50				-36, 097	24.50
25. 00	Total other income (sum of lines 6-24)			6, 428, 854	
	Total (line 5 plus line 25)			879, 693	26.00
	OTHER EXPENSES (SPECIFY)			0	27.00
	Total other expenses (sum of line 27 and subscripts)			0	28.00
29. 00	Net income (or loss) for the period (line 26 minus line 28)			879, 693	29.00

NALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C		Peri od: From 10/01/2020	Worksheet M-1	
			Component		To 09/30/2021	Date/Time Pre 9/19/2022 5:1	
					RHC I	Cost	
		Compensation	Other Costs		Reclassi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
		1. 00	2.00	3.00	4. 00	col . 4) 5.00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	3.00	
. 00	Physi ci an	2, 932, 481	22, 214	2, 954, 69	5 -1, 351, 293	1, 603, 402	1.0
2. 00	Physician Assistant	0	0	_,,	0 0	0	2.0
3. 00	Nurse Practitioner	985, 934	41, 070	1, 027, 00	4 -132, 389	894, 615	3.0
1. 00	Visiting Nurse	0	0		0 0	0	4.0
5. 00	Other Nurse	232, 607	0	232, 60	7 0	232, 607	
. 00	Clinical Psychologist	0	0		0	0	
7. 00	Clinical Social Worker	0	0		0 -42, 037	-42, 037	
3. 00	Laboratory Techni ci an	(40.500	0	(40.50	0	(10, 500	
9. 00	Other Facility Health Care Staff Costs Subtotal (sum of lines 1 through 9)	618, 508	0			618, 508	
0.00	Physician Services Under Agreement	4, 769, 530	63, 284	4, 832, 81	4 -1, 525, 719 0 -25, 962	3, 307, 095 -25, 962	
2. 00	Physician Supervision Under Agreement	0	0		0 -25, 962	-25, 962	
3. 00	Other Costs Under Agreement	0	0		0 0	0	
4. 00	Subtotal (sum of lines 11 through 13)	Ö	0		0 -25, 962	-25, 962	
5. 00	Medi cal Supplies	Ö	42, 822	42, 82		34, 542	
6.00	Transportation (Health Care Staff)	0	0		0 0	0	
7.00	Depreciation-Medical Equipment	0	0		0 0	0	17. C
8.00	Professional Liability Insurance	0	0		0	0	
9. 00	Other Health Care Costs	0	0		0	0	
20.00	Allowable GME Costs	_			_		20.0
21.00	Subtotal (sum of lines 15 through 20)	0	42, 822			34, 542	
22. 00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	4, 769, 530	106, 106	4, 875, 63	6 -1, 559, 961	3, 315, 675	22.0
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	0	0		0 0	0	23.0
24. 00	Dental	0	0		o o	Ō	
25. 00	Optometry	0	0		0 0	0	25.0
25. 01	Tel eheal th	0	0		0 157, 536	157, 536	25.0
25. 02		0	0		0	0	
26. 00	All other nonreimbursable costs	0	0		0	0	
27. 00	Nonallowable GME costs						27.0
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 157, 536	157, 536	28.0
	through 27) FACILITY OVERHEAD						
29. 00	Facility Costs	0	104, 151	104, 15	1 -33, 753	70, 398	29.0
30.00	Administrative Costs	622, 040	153, 231			663, 351	30.0
31. 00	Total Facility Overhead (sum of lines 29 and	622, 040	257, 382				
	30)	,]			
32. 00	Total facility costs (sum of lines 22, 28	5, 391, 570	363, 488	5, 755, 05	8 -1, 548, 098	4, 206, 960	32.0
2.00	and 31)	.,				.,	

Health Financial Systems	PULASKI MEM	ORI AL	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FOHC COSTS			Provi der	CCN: 15-1305	Peri od: From 10/01/2020	Worksheet M-1	
			Component	CCN: 15-8512	To 09/30/2021	Date/Time Pre 9/19/2022 5:1	
					RHC I	Cost	
	Adiustment	s Ne	t Evnenses	2			

			Component	CCN. 13-0312	10	09/30/2021	9/19/2022 5: 1	
						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, 603, 402					1.00
2.00	Physician Assistant	o	0					2.00
3.00	Nurse Practitioner	o	894, 615					3.00
4.00	Visiting Nurse	o	0					4.00
5.00	Other Nurse	o	232, 607					5.00
6.00	Clinical Psychologist	o	0					6.00
7. 00	Clinical Social Worker	o	-42, 037					7. 00
8.00	Laboratory Techni ci an	0	0					8.00
9. 00	Other Facility Health Care Staff Costs	0	618, 508					9.00
10.00	Subtotal (sum of lines 1 through 9)	0	3, 307, 095					10.00
11. 00	Physician Services Under Agreement	0	-25, 962					11.00
12. 00	Physician Supervision Under Agreement	0	,	1				12.00
13. 00		0	0					13.00
14. 00	Subtotal (sum of lines 11 through 13)	0	-25, 962					14.00
15. 00	Medical Supplies	0	34, 542					15.00
16. 00	1 ''	0	0					16.00
17. 00	, , ,	0	0	•				17. 00
	Professional Liability Insurance	0	0	•				18.00
	Other Health Care Costs	0	0					19.00
20.00	I I	J	O					20.00
21. 00		0	34, 542					21.00
22. 00	Total Cost of Health Care Services (sum of	0	3, 315, 675	1				22.00
22.00	lines 10, 14, and 21)	٥	3, 313, 073					22.00
	COSTS OTHER THAN RHC/FQHC SERVICES							
23 00	Pharmacy Pharmacy	0	0					23.00
24. 00	1 -	0	0	1				24.00
25. 00	i i	0	0					25.00
25. 01	Tel eheal th	0	157, 536	1				25. 01
25. 02	i i	0	0	1				25. 02
26. 00	All other nonreimbursable costs	ol o	0	•				26.00
27. 00	Nonallowable GME costs	J	O					27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	157, 536					28.00
20.00	through 27)	٥	137, 330					20.00
	FACILITY OVERHEAD							1
29 00	Facility Costs	O	70, 398					29. 00
30.00		0	663, 351	1				30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	733, 749	1				31.00
31.00	30)	٩	133, 149					31.00
32. 00	Total facility costs (sum of lines 22, 28	0	4, 206, 960					32.00
52. 50	and 31)	٩	1, 200, 700					32.00
	1	ı		ı				1

Heal th	Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C		Peri od:	Worksheet M-1	
			Component		From 10/01/2020 To 09/30/2021	Date/Time Pre 9/19/2022 5:1	
					RHC II	Cost	1 p
		Compensation	Other Costs	Total (col.	1 Reclassificat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
						col . 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1. 00	Physi ci an	433, 198	29, 714	462, 91		484, 289	
2.00	Physician Assistant	0	0		0	0	2.00
3. 00	Nurse Practitioner	72, 150	6, 129	78, 27	9 0	78, 279	1
4. 00	Visiting Nurse	0	0	0. 7.	0	0	
5.00	Other Nurse	94, 766	0	, , , , ,		94, 766	
6.00	Clinical Psychologist	0	0	1	0	0	
7.00	Clinical Social Worker	0	0		0	0	
8.00	Laboratory Technician	12,000	0		0 0	12,000	
9.00	Other Facility Health Care Staff Costs Subtotal (sum of lines 1 through 9)	13, 999	35, 843	.0,,,		13, 999	
10. 00 11. 00	Physician Services Under Agreement	614, 113	35, 843	049, 95	6 21, 377 0 12, 923	671, 333 12, 923	
12.00	Physician Supervision Under Agreement	0	0		0 12, 923	12, 923	12.00
13. 00	Other Costs Under Agreement	0	0		0	0	13.00
14. 00	Subtotal (sum of lines 11 through 13)	0	0		0 12, 923	12, 923	
15. 00	Medical Supplies	0	16, 167	16, 16		20, 289	1
16. 00	Transportation (Health Care Staff)	0	10, 107	10, 10	0 4, 122	20, 207	1
17. 00	Depreciation-Medical Equipment	0	0		0 0	Ö	
18. 00	Professional Liability Insurance	0	0		0 0	Ö	
19. 00	Other Health Care Costs	0	Ö	i	0 0	0	
20.00	Allowable GME Costs		·				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	16, 167	16, 16	7 4, 122	20, 289	21.00
22.00	Total Cost of Health Care Services (sum of	614, 113	52, 010	666, 12	3 38, 422	704, 545	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES				_		
23. 00	Pharmacy	0	0	1	0	0	
24. 00	Dental	0	0		0	0	
25. 00	Optometry	0	0		0	0	
25. 01	Tel eheal th	0	0		0	0	
25. 02	Chronic Care Management	0	0		0	0	
26. 00	All other nonreimbursable costs	0	0	1	0	0	
27. 00	Nonallowable GME costs		_			_	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0	1	0	0	28. 00
	through 27)						
20.00	FACILITY OVERHEAD Facility Costs	0	24 242	24.24	14 001	E1 042	20.00
29. 00 30. 00	Administrative Costs	96, 023	34, 242 15, 164	1		51, 043 113, 180	1
30.00	Total Facility Overhead (sum of lines 29 and		49, 406	1		164, 223	
51.00	30)	70, 023	47, 400	173, 42	10, 774	104, 223	31.00

710, 136

101, 416

811, 552

57, 216

868, 768

32.00

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

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	ı of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CCN: 15-1305	Peri od: From 10/01/2020	Worksheet M-1
		Component CCN: 15-8527	To 09/30/2021	Date/Time Prepared: 9/19/2022 5:14 pm
			RHC LT	Cost

			component con.	15-6527	10	04/30/2021	9/19/2022 5: 1	
						RHC II	Cost	
		Adjustments	Net Expenses					
		.,	for					
			Allocation					
			(col. 5 +					
			col. 6)					
		6. 00	7. 00					
	FACILITY HEALTH CARE STAFF COSTS	'						
1.00	Physi ci an	0	484, 289					1.00
2.00	Physician Assistant	o	0					2.00
3.00	Nurse Practitioner	o	78, 279					3.00
4.00	Visiting Nurse	o	0					4.00
5.00	Other Nurse	o	94, 766					5.00
6.00	Clinical Psychologist	o	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	13, 999					9.00
10.00	Subtotal (sum of lines 1 through 9)	0	671, 333					10.00
11. 00	Physician Services Under Agreement	0	12, 923					11.00
12. 00	Physician Supervision Under Agreement	0	0					12.00
13. 00	Other Costs Under Agreement	0	0					13.00
14. 00	Subtotal (sum of lines 11 through 13)	0	12, 923					14.00
15. 00	Medical Supplies	0	20, 289					15.00
16. 00	1 ''	0	0					16.00
17. 00	, , ,	0	o					17. 00
	Professional Liability Insurance	0	o					18.00
	Other Health Care Costs	0	o					19.00
20.00	I I	J	٩					20.00
21. 00		0	20, 289					21.00
22. 00	Total Cost of Health Care Services (sum of	0	704, 545					22.00
22.00	lines 10, 14, and 21)	Ĭ	701,010					22.00
	COSTS OTHER THAN RHC/FQHC SERVICES							
23. 00	Pharmacy	0	0					23.00
24. 00	1 -	0	o					24. 00
25. 00	i i	0	0					25.00
25. 01	Tel eheal th	0	0					25. 01
25. 02	i i	0	0					25. 02
26. 00	All other nonreimbursable costs	0	0					26.00
27. 00	Nonallowable GME costs	Ĭ	٦					27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0					28.00
20.00	through 27)	Ĭ	٦					20.00
	FACILITY OVERHEAD							
29.00	Facility Costs	0	51, 043					29.00
30.00		0	113, 180					30.00
31. 00	Total Facility Overhead (sum of lines 29 and	n	164, 223					31.00
550	30)	٦	, 220					353
32.00	Total facility costs (sum of lines 22, 28	0	868, 768					32.00
	and 31)	٦						
	1	ı	'					•

Heal th	Financial Systems	PULASKI MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 15-1305	Peri od:	Worksheet M-1	
			Component	CCN: 15-8528	From 10/01/2020 To 09/30/2021	Date/Time Pre 9/19/2022 5:1	
					RHC III	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
		1.00	2.00	2.00	4.00	col . 4)	
	FACILITY HEALTH CARE STAFF COSTS	1. 00	2.00	3. 00	4. 00	5. 00	
1. 00	Physician	ol	C	N .	0 21, 578	21, 578	1.00
2. 00	Physician Assistant			•	0 21,378	21, 370	2.00
3.00	Nurse Practitioner	123, 653	10, 214	1	0	112, 759	
4. 00	Visiting Nurse	0	.0,2)	0 0	0	4.00
5. 00	Other Nurse	ol	C		0 0	Ō	
6.00	Clinical Psychologist	o	C		0 0	0	1
7.00	Clinical Social Worker	0	C		0 0	0	7.00
8.00	Laboratory Techni ci an	o	C		0 0	0	8.00
9.00	Other Facility Health Care Staff Costs	52, 979	C	52, 9	79 0	52, 979	9.00
10.00	Subtotal (sum of lines 1 through 9)	176, 632	10, 214	186, 8	46 470	187, 316	10.00
11. 00	Physician Services Under Agreement	0	C)	0 3, 028	3, 028	
12.00	Physician Supervision Under Agreement	0	C)	0	0	12.00
13.00	Other Costs Under Agreement	0	C)	0	0	
14. 00	Subtotal (sum of lines 11 through 13)	0	C	1	0 3, 028	3, 028	1
15. 00	Medical Supplies	0	4, 348	4, 3		5, 314	1
16.00	Transportation (Health Care Staff)	0	C)	0 0	0	
17.00	Depreciation-Medical Equipment	0	C	2	0	0	17.00
18. 00 19. 00	Professional Liability Insurance Other Health Care Costs	0			0 0	0	18. 00 19. 00
20. 00	Allowable GME Costs	۷	C	'	0	0	20.00
21. 00	Subtotal (sum of lines 15 through 20)	٥	4, 348	4, 3	48 966	5, 314	
22. 00	Total Cost of Health Care Services (sum of	176, 632	14, 562			195, 658	
22.00	lines 10, 14, and 21)	170,002	11,002		1, 101	170,000	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES	'		•	•	•	1
23.00	Pharmacy	0	C)	0 0	0	23. 00
24.00	Dental	0	C		0 0	0	24.00
25. 00	Optometry	0	C		0	0	
25. 01	Tel eheal th	0	C)	0 21, 108	21, 108	
25. 02	Chronic Care Management	0	C		0 0	0	
26. 00	All other nonreimbursable costs	0	C		0 0	0	26. 00
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	C)	0 21, 108	21, 108	28. 00
	through 27)						-
20.00	FACILITY OVERHEAD	ما	7.045	7.0	4E 2 027	11 000	29.00
29. 00 30. 00	Facility Costs Administrative Costs	0 28, 342	7, 945 7, 369	1		11, 882 36, 177	30.00
31. 00	Total Facility Overhead (sum of lines 29 and		7, 369 15, 314	1		48, 059	1
31.00	30)	20, 342	15, 514	43, 0.	4, 403	40,039	31.00
32. 00	Total facility costs (sum of lines 22, 28	204, 974	29, 876	234, 8!	50 29, 975	264, 825	32.00

204, 974

29, 876

234, 850

29, 975

264, 825

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

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CCN: 15-1305	Peri od: From 10/01/2020	Worksheet M-1
		Component CCN: 15-8528	To 09/30/2021	Date/Time Prepared: 9/19/2022 5:14 pm
			DUO III	01

Adjustments				Component Co	JN. 13-0320	10 09/30/2021	9/19/2022 5: 1	
Adjustments						RHC III		
FACILITY HEALTH CARE STAFF COSTS			Adiustments	Net Expenses				
Col. 5 + col. 6 C			.,					
Col. 5 + col. 6 C				Allocation				
FACILITY HEALTH CARE STAFF COSTS								
FACILITY HEALTH CARE STAFF COSTS								
FACILITY HEALTH CARE STAFF COSTS			6, 00					
1.00		FACILITY HEALTH CARE STAFF COSTS						
2.00 Physician Assistant 0 0 3.00 4.00 Visiting Nurse 0 0 0 6.00 Visiting Nurse 0 0 0 6.00 Clinical Psychologist 0 0 0 7.00 Clinical Psychologist 0 0 7.00 8.00 Laboratory Technician 0 0 8.00 9.00 Other Facility Heal th Care Staff Costs 0 52.979 9.00 11.00 Other Facility Heal th Care Staff Costs 0 52.979 9.00 11.00 Physician Supervision Under Agreement 0 3.028 11.00 12.00 Physician Supervision Under Agreement 0 0 12.00 13.00 Other Costs Under Agreement 0 0 13.00 14.00 Subtotal (sum of lines 11 through 13) 0 3.028 11.00 15.00 Medical Supplies 0 5.314 15.00 16.00 Trasportation (Heal th Care Staff) 0 0 <	1.00		0	21, 578				1.00
3.00			0					1
4.00			0	112, 759				
5.00			0	0				1
6.00			o o	0				1
7. 00		1	0	٩				1
8. 00			Ŏ	٩				1
9.00 Other Facility Health Care Staff Costs 0 52,979 0 0 187,316 10.00 11.00 Physician Services Under Agreement 0 3,028 11.00 12.00 13.00 14.00 14.00 15.00		1	0	9				
10.00 Subtotal (sum of lines 1 through 9) 0 187, 316 10.00			0	9				
11.00 Physician Services Under Agreement 0 3,028 11.00 12.00 Physician Supervision Under Agreement 0 0 0 12.00 13.00 14.00 14.00 15.00 15.00 16.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00			0					1
12.00			0					1
13.00 Other Costs Under Agreement 0 0 0 0 0 14.00 Subtotal (sum of lines 11 through 13) 0 3,028 14.00 15.00 Medical Supplies 0 5,314 15.00 16.00 Transportation (Heal th Care Staff) 0 0 0 0 17.00 16.00 17.00 16.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 19.00 1			0					
14.00 Subtotal (sum of lines 11 through 13) 0 3,028 14.00 15.00 Medical Supplies 0 0 0 15.00 16.00 17.00 16.00 17.00 16.00 17.00 17.00 18.00 17.00 18.00 19.00 1			0					
15.00 Medical Supplies		j –	0	-1				
16. 00 Transportation (Health Care Staff) 0 0 0 17. 00 Depreciation-Medical Equipment 0 0 0 0 17. 00 18. 00 17. 00 18. 00 17. 00 18. 00 17. 00 18. 00 19. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		,	0					
17. 00 Depreciation-Medical Equipment 0 0 0 0 18. 00 19. 00 18. 00 19. 00 0 0 0 0 0 19. 00 0 0 0 0 0 0 0 0 0		1 ''	0					
18.00 Professional Liability Insurance 0 0 0 18.00 19.00 Other Heal th Care Costs 0 0 0 19.00 20.00 Allowable GME Costs 20.00 20.00 21.00 Subtotal (sum of lines 15 through 20) 0 5,314 21.00 22.00 Total Cost of Heal th Care Services (sum of lines 10, 14, and 21) 0 195,658 22.00 23.00 Pharmacy 0 0 23.00 24.00 25.00 24.00 24.00 25.00 24.00 24.00 25.00 24.00 25.00 26.00 25.00 25.00 25.00 25.00 25.00 25.00 26.00 26.00 26.00 27.00 26.00 27.00 26.00 27.00 27.00 27.00 28.00 27.00 28.00 27.00 28.00 27.00 28.00 27.00 28.00 27.00 28.00 29.00 28.00 29.00 30.00 36.177 30.00 31.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00		, , ,	0					1
19.00 Other Health Care Costs 0 0 0 0 20.00 20		, '	0	- 1				
20.00 Allowable GME Costs 20.00 21.00 22.00			0	- 1				1
21.00 Subtotal (sum of lines 15 through 20) 0 5,314 21.00		1	0	0				
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES 23.00 Pharmacy Dental Denta			_					
Li nes 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES			0					
COSTS OTHER THAN RHC/FOHC SERVICES Pharmacy Dental O	22. 00		0	195, 658				22.00
23.00 Pharmacy								1
24. 00 Dental 0 0 0 0 24. 00 25. 00 Optometry 0 0 0 0 25. 01 Teleheal th 0 21, 108 25. 02 Chronic Care Management 0 0 0 0 26. 00 All other nonreimbursable costs 0 0 0 27. 00 Nonallowable GME costs 0 0 0 28. 00 Total Nonreimbursable Costs (sum of lines 23 0 21, 108 28. 00 Total Voyerhead (sum of lines 23 0 36, 177 30. 00 30. 00 Administrative Costs 0 36, 177 30. 00 31. 00 Total Facility Overhead (sum of lines 29 and 30) 32. 00 Total facility costs (sum of lines 22, 28 0 264, 825 32. 00			اء					
25. 00 Optometry 0 0 0 0 25. 00 25. 01 Tel eheal th 0 21, 108 25. 01 25. 02 Chronic Care Management 0 0 0 0 22, 108 25. 02 26. 00 All other nonreimbursable costs 0 0 0 26. 00 27. 00 Nonallowable GME costs 27 28. 00 Total Nonreimbursable Costs (sum of lines 23 0 21, 108 28. 00 28. 00 Facility Overhead 29. 00 Facility Costs 0 11, 882 29. 00 30. 00 Administrative Costs 0 36, 177 30. 00 31. 00 Total Facility Overhead (sum of lines 29 and 30) 32. 00 Total facility costs (sum of lines 22, 28 0 264, 825 32. 00		1 -	-1					
25. 01 Tel eheal th		1	0	- 1				1
25. 02 Chronic Care Management 0 0 0 0 25. 02 26. 00 All other nonreimbursable costs 0 0 0 27. 00 Nonallowable GME costs 27. 00 28. 00 Total Nonreimbursable Costs (sum of lines 23 through 27) FACILITY OVERHEAD 29. 00 Facility Costs 0 36, 177 31. 00 Total Facility Overhead (sum of lines 29 and 30) 30 Total facility costs (sum of lines 22, 28 0 264, 825 32. 00		1 '	0	- 1				
26. 00		1	0					
27.00 Nonallowable GME costs 27.00 28.00 Total Nonreimbursable Costs (sum of lines 23 0 21,108 28.00			0					
28.00 Total Nonreimbursable Costs (sum of lines 23 through 27) FACILITY OVERHEAD 29.00 Facility Costs 30.00 Administrative Costs Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 0 264, 825 28.00			0	0				
through 27) FACILITY OVERHEAD 29.00 Facility Costs 30.00 Administrative Costs 31.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28) 32.00 Total facility costs (sum of lines 22, 28) 32.00 Total facility costs (sum of lines 22, 28) 32.00 Total facility costs (sum of lines 22, 28)								
FACILITY OVERHEAD 29. 00 Facility Costs	28. 00	,	0	21, 108				28. 00
29.00 Facility Costs								1
30.00 Administrative Costs 0 36,177 31.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 0 264,825 32.00								
31.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 0 264, 825 32.00			T1					
30) 32.00 Total facility costs (sum of lines 22, 28 0 264, 825 32.00		1	0					1
32.00 Total facility costs (sum of lines 22, 28 0 264, 825 32.00	31. 00		0	48, 059				31.00
								l
	32. 00	,	0	264, 825				32.00
and 31)		and 31)						I

	Financial Systems SIS OF HOSPITAL-BASED RHC/FOHC COSTS	PULASKI MEMORI	AL HOSPITAL Provider C	°N: 15_1305	In Lie Period:	u of Form CMS-2 Worksheet M-1	
AIVALIS	NO OF THOSE TIME BROLD KNOT WHO COSTS				From 10/01/2020		
			Component	CCN: 15-8554	To 09/30/2021	Date/Time Pre 9/19/2022 5:1	
					RHC IV	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
		4 00	0.00	2.00	4.00	col . 4)	
	FACILITY HEALTH CARE CTAFE COCTO	1. 00	2. 00	3. 00	4. 00	5. 00	
1 00	FACILITY HEALTH CARE STAFF COSTS	217 210	1F 000	222 21	0 42 012	200 100	1.00
1. 00 2. 00	Physi ci an Physi ci an Assi stant	317, 210 0	15, 000 0		0 -43, 012 0 0	289, 198 0	
3.00	Nurse Practitioner	123, 394	10, 214		-	117, 406	
4. 00	Visiting Nurse	123, 374	10, 214	133,00	0 -10, 202	117, 400	1
5. 00	Other Nurse	0	0		0	0	
6. 00	Clinical Psychologist	0	0		0 0	0	
7. 00	Clinical Social Worker	0	0		0 0	Ö	
8. 00	Laboratory Techni ci an	0	0		0 0	Ö	8.00
9. 00	Other Facility Health Care Staff Costs	70, 384	0	70, 38	4 0	70, 384	1
10.00	Subtotal (sum of lines 1 through 9)	510, 988	25, 214			476, 988	
11. 00	Physician Services Under Agreement	0.0,700	0	000,20	0 10, 011	10, 011	
12. 00	Physician Supervision Under Agreement	0	Ö		0 0	0	12.00
13.00	Other Costs Under Agreement	0	0		0	0	
14.00	Subtotal (sum of lines 11 through 13)	0	0		0 10, 011	10, 011	14.00
15.00	Medical Supplies	0	0		0 3, 193	3, 193	15.00
16.00	Transportation (Health Care Staff)	0	0		0	0	16.00
17.00	Depreciation-Medical Equipment	0	0		0 0	0	17.00
18.00	Professional Liability Insurance	0	0		0	0	18.00
19.00	Other Health Care Costs	0	0		0	0	19.00
20.00	Allowable GME Costs						20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	0		0 3, 193	3, 193	
22. 00	Total Cost of Health Care Services (sum of	510, 988	25, 214	536, 20	2 -46, 010	490, 192	22.00
	lines 10, 14, and 21)						
00.00	COSTS OTHER THAN RHC/FQHC SERVICES		_				00.00
23. 00	Pharmacy	0	0		0	0	
24. 00	Dental	0	0		0	0	24.00
25. 00	Optometry	0	0		0 57 852	0 E7 0E3	
25. 01 25. 02	Telehealth	0	0		0 57, 852	57, 852 0	•
	5	0	0		0	-	1
26. 00 27. 00	All other nonreimbursable costs Nonallowable GME costs	0	0			0	26. 00 27. 00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 57, 852	57, 852	
20.00	through 27)	0			57,652	57,002	20.00
	FACILITY OVERHEAD						1
29. 00	Facility Costs	0	33, 282	33, 28	2 13, 015	46, 297	29.00
	Administrative Costs	50, 606	· ·			61, 521	
	Total Facility Overhead (sum of lines 29 and	·	· ·				

561, 594

42,652

67, 866

93, 258

629, 460

107, 818

655, 862

14, 560

26, 402

31.00

32.00

Total Facility Overhead (sum of lines 29 and

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

Health Financial Systems	PULASKI MEMORIAL HOSPITAL		In Lieu	ı of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der	CCN: 15-1305 Per Fro	riod: om 10/01/2020	Worksheet M-1
	Component	CCN: 15-8554 To		Date/Time Prepared: 9/19/2022 5:14 pm
			RHC I.V	Cost

						9/19/2022 5: 1	4 pm
					RHC IV	Cost	
		Adjustments	Net Expenses				
			for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6. 00	7. 00	1			
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	289, 198				1.00
2.00	Physician Assistant	ام		1			2.00
3. 00	Nurse Practitioner	ol	117, 406	1			3.00
4. 00	Visiting Nurse	ol Ol	(117, 100	1			4.00
5. 00	Other Nurse	0		1			5.00
6. 00	Clinical Psychologist	ol ol					6.00
7. 00		0	(7.00
	Clinical Social Worker	o o	-	1			1
8.00	Laboratory Technician	O O	70.00	1			8.00
9.00	Other Facility Health Care Staff Costs	0	70, 384				9.00
10.00	Subtotal (sum of lines 1 through 9)	O	476, 988				10.00
11. 00	Physician Services Under Agreement	0	10, 011	1			11.00
12. 00	Physician Supervision Under Agreement	0	C	•			12.00
13.00	Other Costs Under Agreement	0	C)			13.00
14.00	Subtotal (sum of lines 11 through 13)	0	10, 011				14.00
15.00	Medical Supplies	0	3, 193	s			15.00
16.00	Transportation (Health Care Staff)	0	C				16.00
17.00	Depreciation-Medical Equipment	o	C				17.00
18.00	Professional Liability Insurance	ol	C				18.00
19.00	Other Health Care Costs	ol	C	oj.			19.00
20.00	Allowable GME Costs						20.00
21. 00	Subtotal (sum of lines 15 through 20)	ol	3, 193				21.00
22. 00	Total Cost of Health Care Services (sum of	ol	490, 192				22. 00
22.00	lines 10, 14, and 21)	Ĭ	170, 172				22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23 00	Pharmacy Pharmacy	O	C				23.00
24. 00	Dental	0	(1			24.00
25. 00	Optometry	0					25.00
25. 00	Tel eheal th	0	57, 852				25. 00
25. 01	Chronic Care Management	o o	37, 632				25. 01
26. 00	All other nonreimbursable costs	ol ol	(()			26.00
	i i	Ч	C	'			
27. 00	Nonallowable GME costs		E7 0E0				27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	57, 852				28. 00
	through 27)						_
00.05	FACILITY OVERHEAD	_1		.1			00.00
	Facility Costs	0	46, 297	•			29. 00
30.00	Administrative Costs	0	61, 521	1			30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	107, 818	3			31.00
	30)						
32. 00	, ,	0	655, 862	!			32. 00
	and 31)						

	Financial Systems	PULASKI MEMORI	I AL HOSPI TAL			u of Form CMS-2	2552-10	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2		
			Component		From 10/01/2020 To 09/30/2021	Date/Time Pre 9/19/2022 5:1		
					RHC I	Cost		
	·	Number of FTE	Total Visits	Producti vi ty	Mi ni mum	Greater of		
		Personnel		Standard (1)	Visits (col.	col. 2 or		
					1 x col. 3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00		
	VISITS AND PRODUCTIVITY							
	Posi ti ons	1						
1.00	Physi ci an	4. 59			1 5		1.00	
2.00	Physician Assistant	0.00			1 0		2.00	
3.00							3. 00 4. 00	
4.00	Subtotal (sum of lines 1 through 3)							
5.00	Visiting Nurse	0.00	0	5. 00 6. 00				
6.00	Clinical Psychologist		0. 00					
7.00	Clinical Social Worker	0.80	l .		518			
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	l .	0	7. 01			
7. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02	
	onl y)							
8.00	Total FTEs and Visits (sum of lines 4	9. 10	19, 213			19, 213	8. 00	
	through 7)		_			_		
9. 00	Physician Services Under Agreements		0			0	9.00	
						1.00		
	DETERMINATION OF ALLOWARIE COOT APPLICABLE T	O HOCDITAL DAG	ED DUO (EQUA CEI	DVII 050		1. 00		
	DETERMINATION OF ALLOWABLE COST APPLICABLE T			RVICES		2 215 /75	10.00	
	Total costs of health care services (from Wk					3, 315, 675		
	Total nonreimbursable costs (from Wkst. M-1,					157, 536	ı	
12.00	Cost of all services (excluding overhead) (s					3, 473, 211		
13.00	Ratio of hospital -based RHC/FQHC services (I			04)		0. 954643		
14.00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		733, 749 3, 219, 809		
15.00								
16.00	Total overhead (sum of lines 14 and 15)					3, 953, 558		
	Allowable GME overhead (see instructions)					0		
	Enter the amount from line 16	NIC	! 10 !	10)		3, 953, 558		
	Overhead applicable to hospital-based RHC/FC					3, 774, 236		
∠∪. ∪∪	Total allowable cost of hospital-based RHC/F	unc services (Sum of Lines I	o and 19)	l	7, 089, 911	J 20.00	

Heal th	Financial Systems	PULASKI MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10	
	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C	CN: 15-1305	Peri od: From 10/01/2020	Worksheet M-2		
			Component	CCN: 15-8527	To 09/30/2021	Date/Time Pre 9/19/2022 5:1		
					RHC II	Cost		
		Number of FTE	Total Visits			Greater of		
		Personnel		Standard (1)	Visits (col.	col. 2 or		
					1 x col. 3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00		
	VISITS AND PRODUCTIVITY							
	Posi ti ons							
1. 00	Physi ci an	0. 79		1	1 1		1.00	
2.00	Physici an Assistant	0.00			1 0		2.00	
3.00	Nurse Practitioner	2. 26			1 2	4, 127	3.00	
4.00	ototal (sum of lines 1 through 3) 3.05 4,127 3						4. 00 5. 00	
5. 00	Visiting Nurse	0.00						
6.00	Clinical Psychologist	1	0. 00				6.00	
7.00	Clinical Social Worker	0.00		0	7. 00			
7. 01	Medical Nutrition Therapist (FQHC only)	0.00		0				
7. 02	Diabetes Self Management Training (FQHC	0.00	0. 00				7. 02	
	onl y)							
8. 00	Total FTEs and Visits (sum of lines 4	3. 05	4, 127	'		4, 127	8. 00	
	through 7)							
9. 00	Physician Services Under Agreements		()		0	9.00	
						4 00		
	DETERMINATION OF ALLOWARIE COCT ADDITIONED F	O HOCDITAL DACI	ED DUC/FOUR CE	DVII CEC		1. 00		
	DETERMINATION OF ALLOWABLE COST APPLICABLE T Total costs of health care services (from Wk			RVICES		704, 545	10.00	
11. 00	Total nonreimbursable costs (from Wkst. M-1,					704, 545	•	
12.00	Cost of all services (excluding overhead) (s					-		
12.00	Ratio of hospital-based RHC/FQHC services (I					704, 545 1. 000000		
14. 00	Total hospital-based RHC/FQHC services (I			ino 21)		1.000000		
15.00				The 31)		626, 932		
16. 00								
17. 00								
	Allowable GME overhead (see instructions) Enter the amount from line 16					0 791, 155		
	Overhead applicable to hospital-based RHC/FC	NAC convices (I	ino 12 v lino	10)		791, 155		
	Total allowable cost of hospital-based RHC/F					1, 495, 700		
20.00	Tiotal allowable cost of hospital-based knc/r	UIIC SELVICES (Sum of TITIES I	o and 19)	ļ	1, 493, 700	20.00	

14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 48,059 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 48,059 15.00	Heal th	Financial Systems	PULASKI MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
Number of FTE Personnel	ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C			Worksheet M-2	
Number of FTE Personnel				Component	CCN: 15-8528		9/19/2022 5: 1	
Personnel Standard (1) Visits (col. col. 2 or col. 4 col. col. 2 or col. 4 col.								
1.00 2.00 3.00 4.00 5.00				Total Visits				
1.00 2.00 3.00 4.00 5.00			Personnel		Standard (1)			
VISITS AND PRODUCTIVITY								
Desirations		I	1. 00	2. 00	3.00	4. 00	5. 00	
1.00								
2. 00 Physician Assistant				T				
3.00 Nurse Practitioner					l .			
4.00 Subtotal (sum of lines 1 through 3)					1	1 0		
5.00 Visiting Nurse								
6.00 Clinical Psychologist 0.00 0 0 0 0 0 0 0 0								
7.00 Clinical Social Worker				_				
7. 01 Medical Nutrition Therapist (FOHC only)			1					
7. 02 Diabetes Self Management Training (FQHC 0.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1		_			
only) 8. 00 Total FTEs and Visits (sum of lines 4 0.63 967 through 7) 9. 00 Physician Services Under Agreements 0 0 0 9. 00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10. 00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 195,658 10. 00 12. 00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 216,766 12. 00 13. 00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 0.902623 13. 00 14. 00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 48,059 14. 00 15. 00 Parent provider overhead allocated to facility (see instructions) 205,035 15. 00 17. 00 Allowable GME overhead (see instructions) 253,094 16. 00 18. 00 Enter the amount from line 16 253,094 18. 00 19. 00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18) 228,448 19. 00								
8.00 Total FTEs and Visits (sum of lines 4 0.63 967 9.00 9.00 9.00 9.00 1.00	7. 02		0.00	C)		0	7. 02
through 7) Physician Services Under Agreements 0 0 9.00			0.40	0.1			0.7	
9. 00 Physician Services Under Agreements 0 1.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 1.00 1.	8.00		0.63	967			967	8.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 1.00	0.00							0.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 195,658 10.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 21,108 11.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 216,766 12.00 13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 0.902623 13.00 14.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 48,059 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 205,035 15.00 16.00 Total overhead (sum of lines 14 and 15) 253,094 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 253,094 18.00 19.00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18) 228,448 19.00	9.00	Physician Services Under Agreements)		0	9.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 195,658 10.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 21,108 11.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 216,766 12.00 13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 0.902623 13.00 14.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 48,059 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 205,035 15.00 16.00 Total overhead (sum of lines 14 and 15) 253,094 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 253,094 18.00 19.00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18) 228,448 19.00							1 00	
10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 195,658 10.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 21,108 11.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 216,766 12.00 13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 0.902623 13.00 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 48,059 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 205,035 15.00 16.00 Total overhead (sum of lines 14 and 15) 253,094 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 253,094 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 228,448 19.00		DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPITAL-BASI	ED RHC/FOHC SE	RVLCES		1.00	
11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 21, 108 11.00 216, 766 12.00 0.902623 13.00 120, 902623 13.00 13.00 148, 059 14.00 225, 035 15.00 253, 094 18.00 253, 094 18.00							195 658	10 00
12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18) 210, 766 12.00								
13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 13.00 0.902623 13.00 48,059 14.00 205,035 15.00 205,035 17.00 207,004 18.00 208,448 19.00								l
14.00Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)48,05914.0015.00Parent provider overhead allocated to facility (see instructions)205,03515.0016.00Total overhead (sum of lines 14 and 15)253,09416.0017.00Allowable GME overhead (see instructions)0 17.0018.00Enter the amount from line 16253,09418.0019.00Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)228,44819.00								
15.00 Parent provider overhead allocated to facility (see instructions) 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 205,035 15.00					ine 31)			
16.00 Total overhead (sum of lines 14 and 15) 253,094 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 253,094 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 228,448 19.00								
17.00Allowable GME overhead (see instructions)017.0018.00Enter the amount from line 16253,09418.0019.00Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)228,44819.00			J (/				
18.00 Enter the amount from line 16253,09418.0019.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)228,44819.00	17. 00							
19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 228,448 19.00	18.00						253, 094	18.00
			MC services (I	ine 13 x line	18)		228, 448	19.00
							424, 106	20.00

Heal th	Financial Systems	PULASKI MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der C		Peri od:	Worksheet M-2		
			Component	CCN: 15-8554	From 10/01/2020 To 09/30/2021	Date/Time Pre		
					RHC IV	9/19/2022 5: 1	4 pm	
		Number of FTE	Total Visits	Producti vi t		Cost Greater of		
		Personnel	TOTAL VISITS	Standard (1)		col. 2 or		
		Personner		Standard (1)	1 x col. 3)	col . 2 or		
		1. 00	2.00	3.00	4. 00	5, 00		
	VISITS AND PRODUCTIVITY	1.00	2.00	3.00	4.00	3.00		
	Posi ti ons						1	
1. 00	Physi ci an	0.77	1, 841		1 1		1.00	
2. 00	Physician Assistant	0.00		1	1 0		2.00	
3. 00	Nurse Practitioner	0. 76	1, 356		1 1		3.00	
4. 00	Subtotal (sum of lines 1 through 3)	1.53	3, 197	4.00				
5.00	Visiting Nurse	0.00	1. 53 0. 00 0					
6.00	Clinical Psychologist	0.00	0		0	6.00		
7.00	Clinical Social Worker	0.00	0		0	7.00		
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7. 01		
7.02	Diabetes Self Management Training (FQHC	0.00	0		0	7. 02		
	onl y)							
8.00	Total FTEs and Visits (sum of lines 4	1. 53	3, 197			3, 197	8. 00	
	through 7)							
9. 00	Physician Services Under Agreements		0			0	9.00	
						4 00		
	DETERMINATION OF ALLOWARIE COCT APPLICABLE T	O HOCDLEAL DAC	ED DUC/FOUR CEI	DVII CEC		1. 00		
	DETERMINATION OF ALLOWABLE COST APPLICABLE T Total costs of health care services (from Wk			RVICES		490, 192	10 00	
11. 00	Total nonreimbursable costs (from Wkst. M-1,					57, 852		
12.00	Cost of all services (excluding overhead) (s					548, 044		
13. 00	Ratio of hospital-based RHC/FQHC services (I					0. 894439		
14. 00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		107, 818		
15. 00	Parent provider overhead allocated to facili			THE ST)		453, 173		
16. 00								
17. 00	Allowable GME overhead (see instructions)					560, 991 0	1	
	Enter the amount from line 16					560, 991		
	Overhead applicable to hospital-based RHC/FC	MC services (I	ine 13 x line	18)		501, 772		
	Total allowable cost of hospital-based RHC/F					991, 964		
	·	,		•	'		•	

Heal th	Financial Systems PULASKI MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		CN: 15-1305	Peri od:	Worksheet M-3	
SERVI C	EES	Component	CCN: 15-8512	From 10/01/2020 To 09/30/2021	Date/Time Pre 9/19/2022 5:1	
		Title	XVIII	RHC I	Cost	, piii
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES				1. 00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst. M-2	, line 20)		7, 089, 911	1.00
2.00	Cost of injections/infusions and their administration (from W	kst. M-4, li	ine 15)		144, 641	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 m	inus line 2)		6, 945, 270	3.00
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)	1: 0)			19, 213	1
5. 00 6. 00	Physicians visits under agreement (from Wkst. M-2, column 5, Total adjusted visits (line 4 plus line 5)	Tine 9)			0 19, 213	5. 00 6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)				361. 49	7.00
			Cal	culation of Limi		
			Data Davisad	1 D-+- D 2	D-+- D!! 2	
			(10/01/2020	1 Rate Period 2 (01/01/2021	(04/01/2021	
			through	through	through	
			12/31/2020)	03/31/2021)	09/30/2021)	
0.00	D	,	1.00	2.00	3. 00	0.00
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20 contractor)	.6 or your	0. (8.00
9. 00	Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT	361. 4		232. 77	9.00	
10.00	Program covered visits excluding mental health services (from records)	1, 25 453, 30				
11. 00	10)	am cost excluding costs for mental health services (line 9 x line			613, 582	
12. 00	Program covered visits for mental health services (from contrrecords)	s for mental health services (from contractor			12 2, 793	
13. 00 14. 00	Limit adjustment for mental health services (see instructions	am covered cost from mental health services (line 9 x line 12) adjustment for mental health services (see instructions)				14.00
15.00	Graduate Medical Education Pass Through Cost (see instruction			1 402 504		15.00
16. 00 16. 01	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 Total program charges (see instructions)(from contractor's re			0 1, 482, 504 667, 284		16. 00 16. 01
16. 01	Total program preventive charges (see instructions) (from prov			34, 443		16. 02
	records)					
16. 03	Total program preventive costs ((line 16.02/line 16.01) times			76, 522		16. 03
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0 times .80) (Titles V and XIX see instructions.)	3 and 18)		1, 058, 967		16. 04
16. 05	Total program cost (see instructions)			0 1, 135, 489		16. 05
17. 00	Pri mary payer amounts			0		17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from		82, 273		18. 00
19. 00		ns) (from		110, 114		19. 00
20 00	contractor records) Net Medicare cost excluding vaccines (see instructions)			1, 135, 489		20.00
	Program cost of vaccines and their administration (from Wkst. 16)	M-4, line		53, 398		21. 00
22. 00	1 '			1, 188, 887		22. 00
23.00	Allowable bad debts (see instructions)			0		23. 00
23. 01	, , , , , , , , , , , , , , , , , , , ,			0		23. 01
	Allowable bad debts for dual eligible beneficiaries (see inst	ructi ons)		0		24.00
25. 00 25. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction		0		25. 00 25. 50	
25. 99			0		25. 99	
26. 00	Net reimbursable amount (see instructions)		1, 188, 887		26. 00	
26. 01	Sequestration adjustment (see instructions)		0		26. 01	
26. 02	, , , , , , , , , , , , , , , , , , , ,			075 044		26. 02
27. 00 28. 00	Interim payments Tentative settlement (for contractor use only)			975, 844 0		27. 00 28. 00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.	02, 27, and		213, 043		29.00
	28)					

30.00

30.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2

Heal th	Financial Systems PULASKI MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provi der C		Peri od:	Worksheet M-3	
SERVI C	EES	Component		From 10/01/2020 To 09/30/2021		
		Title	xVIII	RHC II	Cost	piii
					1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES				1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst. M-2	, line 20)		1, 495, 700	1.00
2.00	Cost of injections/infusions and their administration (from W				65, 157	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 m	inus line 2)		1, 430, 543	3.00
4. 00 5. 00	Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5,	line 0)			4, 127 0	4. 00 5. 00
6. 00	Total adjusted visits (line 4 plus line 5)	11116 7)			4, 127	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)				346. 63	7. 00
			Cal	culation of Limi	t (1)	
			Rate Period	1 Rate Period 2	Rate Period 3	
			(10/01/2020	(01/01/2021	(04/01/2021	
			through	through	through	
			12/31/2020)	03/31/2021)	09/30/2021)	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	. 6 or vour	0.0	2.00	3. 00 188. 36	8. 00
	contractor)					
9. 00	Rate for Program covered visits (see instructions)	346. 6	346. 63	188. 36	9. 00	
10. 00	CALCULATION OF SETTLEMENT Program covered visits excluding mental health services (from	37	5 413	1, 003	10.00	
11. 00	records) Program cost excluding costs for mental health services (line 9 x line			143, 158	188, 925	11.00
12. 00	10)			0 0		12.00
12.00	records)	covered visits for mental health services (from contractor			0	12.00
13.00	Program covered cost from mental health services (line 9 x li			0 0	0	13.00
14. 00	Limit adjustment for mental health services (see instructions			0	0	14.00
15. 00 16. 00	Graduate Medical Education Pass Through Cost (see instruction Total Program cost (sum of lines 11, 14, and 15, columns 1, 2			0 462, 069	,	15. 00 16. 00
16. 01	Total program charges (see instructions)(from contractor's re			215, 954		16. 01
16. 02	Total program preventive charges (see instructions)(from prov	i der' s		16, 014		16. 02
14 02	records)	lino 14)		24 245		16. 03
16. 03 16. 04	Total program preventive costs ((line 16.02/line 16.01) times Total Program non-preventive costs ((line 16 minus lines 16.0			34, 265 317, 026		16. 03
	times .80) (Titles V and XIX see instructions.)	o ana .o,		0177020		10.0.
16. 05	Total program cost (see instructions)			0 351, 291		16. 05
17. 00	Primary payer amounts	(from		0		17.00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) contractor records)	(11 OIII		31, 522		18. 00
19. 00	1	ns) (from		33, 684		19. 00
20.00	Net Medicare cost excluding vaccines (see instructions)			351, 291		20.00
21. 00	Program cost of vaccines and their administration (from Wkst. 16)	M-4, line		23, 665		21.00
22. 00	Total reimbursable Program cost (line 20 plus line 21)			374, 956		22. 00
23. 00	Allowable bad debts (see instructions)			0		23.00
23. 01	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0		23. 01 24. 00
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructions)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instruction		0		25. 50	
25. 99	Demonstration payment adjustment amount before sequestration		0		25. 99	
26.00	Net reimbursable amount (see instructions)		374, 956		26.00	
26. 01 26. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration	· · · · · · · · · · · · · · · · · · ·				26. 01 26. 02
	Interim payments			257, 338		27.00
28. 00	Tentative settlement (for contractor use only)			0		28. 00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.	02, 27, and		117, 618		29. 00
	[28]		1	1		ı

30.00

28)
30.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, \$115.2

Heal th	Financial Systems PULASKI MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provi der Co	CN: 15-1305	Peri od:	Worksheet M-3	
SERVI C	ES	Component (CCN: 15-8528	From 10/01/2020 To 09/30/2021	Date/Time Pre 9/19/2022 5:1	
		Title	XVIII	RHC III	Cost	
	DETERMINATION OF DATE FOR HOSPITAL DASED DUC/FOLIC SERVICES				1. 00	
1. 00	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst M_2	line 20)		424, 106	1.00
2. 00	Cost of injections/infusions and their administration (from W				18, 230	2.00
3. 00	Total allowable cost excluding injections/infusions (line 1 m				405, 876	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)				967	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)				967	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)		Cal	culation of Limi	419. 73 + (1)	7.00
			Car	curation of Limi	(1)	
			Rate Period	1 Rate Period 2	Rate Period 3	
			(10/01/2020	,	(04/01/2021	
			through	through	through	
			12/31/2020)	03/31/2021)	09/30/2021) 3. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	. 6 or vour	0. (306.89	8.00
	contractor)					
9. 00	Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		419. 7			9. 00
10. 00	Program covered visits excluding mental health services (from records)	contractor	}	64	178	10.00
11. 00	Program cost excluding costs for mental health services (line 10)	9 x line	36, 51	7 26, 863	54, 626	11. 00
12. 00	Program covered visits for mental health services (from contrrecords)	actor		0 0	0	12.00
13.00	Program covered cost from mental health services (line 9 x li			0 0	0	13.00
14.00	Limit adjustment for mental health services (see instructions			0 0	0	14.00
15. 00 16. 00	Graduate Medical Education Pass Through Cost (see instruction Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•		0 118, 006		15. 00 16. 00
16. 01	Total program charges (see instructions) (from contractor's re			41, 888		16.00
16. 02	Total program preventive charges (see instructions) (from prov	•		7, 959		16. 02
	records)					
16. 03	Total program preventive costs ((line 16.02/line 16.01) times			22, 422		16.03
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18)		71, 721		16. 04
16. 05	times .80) (Titles V and XIX see instructions.) Total program cost (see instructions)			0 94, 143		16. 05
17. 00	Primary payer amounts			74, 143		17.00
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from		5, 933		18.00
19. 00	contractor records) Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from		5, 599		19. 00
	contractor records)					
	Net Medicare cost excluding vaccines (see instructions) Program cost of vaccines and their administration (from Wkst.	M-4 line		94, 143 12, 210		20.00
21.00	16)	W 4, TITIE		12, 210		21.00
22. 00	Total reimbursable Program cost (line 20 plus line 21)			106, 353		22. 00
23. 00	Allowable bad debts (see instructions)			0		23. 00
23. 01	Adjusted reimbursable bad debts (see instructions)			0		23. 01
24. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0		24.00
25. 00 25. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	s)		0		25. 00 25. 50
25. 99				0		25. 99
26. 00	Net reimbursable amount (see instructions)			106, 353		26.00
26. 01	Sequestration adjustment (see instructions)			0		26. 01
26. 02	, , , , , , , , , , , , , , , , , , , ,			0		26. 02
27. 00	Interim payments			86, 996		27.00
28. 00	,	02 27 and		0 19, 357		28. 00 29. 00
∠7. ∪∪	Balance due component/program (line 26 minus lines 26.01, 26. 28)	υ <u>∠, ∠1, αιΙ</u> Ω		19, 357		27.00

30.00

28)
30.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, \$115.2

Heal th	Financial Systems PULASKI MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provi der C	CN: 15-1305	Peri od:	Worksheet M-3	
SERVIC	EES	Component	CCN: 15-8554	From 10/01/2020 To 09/30/2021	Date/Time Pre 9/19/2022 5: 1	
		Title	XVIII	RHC IV	Cost	, piii
					1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				1. 00	
1. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst. M-2	, line 20)		991, 964	1.00
2.00	Cost of injections/infusions and their administration (from W	kst. M-4, I	ine 15)		9, 813	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 m	inus line 2)		982, 151	3.00
4. 00 5. 00	Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5,	line 0)			3, 197 0	4. 00 5. 00
6. 00	Total adjusted visits (line 4 plus line 5)	11116 7)			3, 197	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)				307. 21	7. 00
			Cal	culation of Limi	t (1)	
			Rate Period	1 Rate Period 2	Rate Period 3	
			(10/01/2020	(01/01/2021	(04/01/2021	
			through	through	through	
			12/31/2020)	03/31/2021)	09/30/2021)	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	6 or your	1.00	2.00	3. 00 203. 35	8. 00
0.00	contractor)	. o or your	0.0	0.00	203. 33	0.00
9. 00	Rate for Program covered visits (see instructions)	307. 2	21 307. 21	203. 35	9. 00	
10.00	CALCULATION OF SETTLEMENT Program covered visits excluding mental health services (from	26	5 244	569	10.00	
11. 00	records) Program cost excluding costs for mental health services (line	81, 41	1 74, 959	115, 706	11.00	
12 00	10)			0 0	0	12.00
12. 00	records)	rogram covered visits for mental health services (from contractor ecords)				12.00
13.00	Program covered cost from mental health services (line 9 x li			0 0	0	13.00
14.00	Limit adjustment for mental health services (see instructions			0	0	14.00
15. 00 16. 00	Graduate Medical Education Pass Through Cost (see instruction Total Program cost (sum of lines 11, 14, and 15, columns 1, 2			0 272, 076		15. 00 16. 00
16. 01	Total program charges (see instructions)(from contractor's re			134, 643		16. 01
16. 02	Total program preventive charges (see instructions) (from prov			5, 276		16. 02
44 00	records)	11		10 //1		47.00
16. 03 16. 04	Total program preventive costs ((line 16.02/line 16.01) times Total Program non-preventive costs ((line 16 minus lines 16.0		•	10, 661 193, 901		16. 03 16. 04
10. 04	times .80) (Titles V and XIX see instructions.)	3 and 16)		173, 701		10.04
16. 05	Total program cost (see instructions)			0 204, 562		16. 05
17. 00	Primary payer amounts			0		17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) contractor records)	(from		19, 039		18. 00
19. 00	1	ns) (from		22, 066		19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)		•	204, 562		20.00
	Program cost of vaccines and their administration (from Wkst. 16)	M-4, line		3, 744		21. 00
22. 00				208, 306		22.00
23.00	Allowable bad debts (see instructions)			0		23. 00
23. 01	, ,			0		23. 01
24.00	Allowable bad debts for dual eligible beneficiaries (see inst OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructions)		0		24. 00 25. 00
25. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)				25. 50
25. 99			0		25. 99	
26.00	Net reimbursable amount (see instructions)		208, 306		26. 00 26. 01	
26. 01	Sequestration adjustment (see instructions)	, , ,				
26. 02 27. 00	Demonstration payment adjustment amount after sequestration Interim payments			165, 591		26. 02 27. 00
28. 00	Tentative settlement (for contractor use only)			0		28.00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.	02, 27, and		42, 715		29. 00
	[28]		I		1	1

30.00

28)
30.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, \$115.2

Heal th	Financial Systems PULASKI MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
СОМРИТ	COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST			Peri od: From 10/01/2020 To 09/30/2021	Worksheet M-4 Date/Time Prepared: 9/19/2022 5:14 pm	
		Title	XVIII	RHC I	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	3, 307, 095	3, 307, 09	3, 307, 095	3, 307, 095	1.00
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 000577	0. 00191	2 0.000239	0. 000000	2. 00
3. 00	<pre>Injection/infusion health care staff cost (line 1 x line 2)</pre>	1, 908	6, 32	790	0	3. 00
4. 00	Injections/infusions and related medical supplies costs (from your records)	30, 128	28, 49	04 0	0	4. 00
5. 00	Direct cost of injections/infusions (line 3 plus line 4)	32, 036	34, 81	7 790	0	5.00

3, 315, 675

3, 774, 236

0.009662

36, 467

68, 503

378.47

18, 545

181

49

3, 315, 675

3, 774, 236

0.010501

39, 633

74, 450

124.08

33, 998

144,641

53, 398

600

274

3, 315, 675

3, 774, 236

0.000238

898

75

24

14

855

1,688

22.51

3, 315, 675

3, 774, 236

0.000000

6.00

7.00

8.00

9.00

10.00

11.00

12.00

13.00

13.01

14.00

15.00

16.00

0.00

0

0

0

6.00

7.00

8.00

9.00

10.00

11.00

12.00

13.00

13.01

14.00

15.00

16.00

Total direct cost of the hospital-based RHC/FQHC (from

Ratio of injection/infusion direct cost to total direct

Total injection/infusion costs and their administration

Total number of injections/infusions (from your records)

administration costs (line 12 times the sum of lines 13

administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)

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

Total Program cost of injections/infusions and their

Overhead cost - injection/infusion (line 7 x line 8)

Number of injection/infusion administered to Program

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

Number of COVID-19 vaccine injections/infusions

Program cost of injections/infusions and their

Total cost of injections/infusions and their

Worksheet M-1, col. 7, line 22)

cost (line 5 divided by line 6)

costs (sum of lines 5 and 9)

administered to MA enrollees

and 13.01, as applicable)

benefi ci ari es

Total overhead (from Wkst. M-2, line 19)

Heal th	Financial Systems	PULASKI	MEMORI A	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUT	TATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST			Provi der C	CN: 15-1305	Peri od: From 10/01/2020	Worksheet M-4	
				Component	CCN: 15-8527	To 09/30/2021	Date/Time Pre 9/19/2022 5:1	pared: 4 pm
				Title	XVIII	RHC II	Cost	
				PNEUMOCOCCAL	INFLUENZA	COVI D-19	MONOCLONAL	
				VACCI NES	VACCI NES	VACCI NES	ANTI BODY	
							PRODUCTS	
				1. 00	2.00	2. 01	2. 02	
1.00	Health care staff cost (from Wkst. M-1, col.	7, line	10)	671, 333	671, 33	671, 333	671, 333	1.00
2.00	Ratio of injection/infusion staff time to total	al healt	th	0. 002032	0. 00668	0. 000584	0. 000000	2. 00

		litle	XVIII	RHC II	Cost	
		PNEUMOCOCCAL	INFLUENZA	COVI D-19	MONOCLONAL	
		VACCI NES	VACCI NES	VACCI NES	ANTI BODY	
					PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	671, 333	671, 333	671, 333	671, 333	1.00
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 002032	0. 006681	0. 000584	0. 000000	2. 00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	1, 364	4, 485	392	0	3. 00
4. 00	Injections/infusions and related medical supplies costs (from your records)	13, 260	11, 191	0	0	4. 00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	14, 624	15, 676	392	0	5.00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	704, 545	704, 545	704, 545	704, 545	6. 00
7.00	Total overhead (from Wkst. M-2, line 19)	791, 155	791, 155	791, 155	791, 155	7.00
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 020757	0. 022250	0. 000556	0. 000000	8. 00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	16, 422	17, 603	440	0	9.00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	31, 046	33, 279	832	0	10.00
11.00	Total number of injections/infusions (from your records)	80	263	23	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	388. 08	126. 54	36. 17	0. 00	12.00
13. 00	Number of injection/infusion administered to Program beneficiaries	28	98	9	0	13.00
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			2	0	13. 01
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	10, 866	12, 401	398	0	14. 00
15. 00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		65, 157			15. 00
16. 00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		23, 665			16.00

Health Financial Systems	PULASKI ME	EMORI AL	HOSPI TAL			In Lieu	of Form CMS-2	2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Γ		Provi der	CCN: 1		Peri od:	Worksheet M-4	
						From 10/01/2020	D . (T) D	
			Component	t CCN:	15-8528	To 09/30/2021	Date/Time Pre 9/19/2022 5:1	
								4 рш
			Ti tl	le XVI	11	RHC III	Cost	
		PN	IEUMOCOCCAL	L II	NFLUENZA	COVI D-19	MONOCLONAL	
			VACCI NES	V	ACCI NES	VACCI NES	ANTI BODY	
							PRODUCTS	
						0 04	0 00	

					9/19/2022 5: 1	4 pm
		Title	XVIII	RHC III	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	187, 316	187, 316	187, 316	187, 316	1.00
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 002650	0. 003886	0. 000088	0. 000000	2.00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	496	728	16	0	3. 00
4. 00	Injections/infusions and related medical supplies costs (from your records)	4, 681	2, 489	0	0	4. 00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	5, 177	3, 217	16	0	5.00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	195, 658	195, 658	195, 658	195, 658	6. 00
7.00	Total overhead (from Wkst. M-2, line 19)	228, 448	228, 448	228, 448	228, 448	7.00
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 026459	0. 016442	0. 000082	0. 000000	8. 00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	6, 045	3, 756	19	0	9.00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	11, 222	6, 973	35	0	10. 00
11.00	Total number of injections/infusions (from your records)	30	44	1	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	374. 07	158. 48	35. 00	0. 00	12.00
13. 00	Number of injection/infusion administered to Program beneficiaries	14	44	0	0	13. 00
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 01
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	5, 237	6, 973	0	0	14. 00
15. 00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		18, 230			15. 00
16. 00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		12, 210			16. 00

Health Financial Systems	PULASKI MEM	MORI AL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Γ		Provi der	CCN: 15-1305	Peri od: From 10/01/2020	Worksheet M-4	
			Component	CCN: 15-8554			
			Ti tl	e XVIII	RHC IV	Cost	
		PNI	EUMOCOCCAL	INFLUENZA	COVI D-19	MONOCLONAL	
		١ ١	VACCI NES	VACCI NES	VACCINES	ANTI BODY	
						PRODUCTS	
			4 00	0 00	0 04	0 00	

					9/19/2022 5: 1	4 pm
		Title	XVIII	RHC IV	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1. 00	2.00	2. 01	2. 02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	476, 988	476, 98	8 476, 988	476, 988	1.00
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 000183	0. 00296	1 0.000000	0. 000000	2.00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	87	1, 41	2 0	0	3.00
4. 00	Injections/infusions and related medical supplies costs (from your records)	1, 168	2, 18	2 0	0	4. 00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	1, 255	3, 59	4 0	0	5. 00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	490, 192	490, 19	2 490, 192	490, 192	6. 00
7.00	Total overhead (from Wkst. M-2, line 19)	501, 772	501, 77	2 501, 772	501, 772	7.00
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 002560	0. 00733	2 0.000000	0. 000000	8. 00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	1, 285	3, 67	9 0	0	9.00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	2, 540	7, 27	3 0	0	10.00
11.00	Total number of injections/infusions (from your records)	6	9		0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	423. 33	74. 9	0.00	0. 00	12.00
13. 00	Number of injection/infusion administered to Program beneficiaries	3	3	3 0	0	13.00
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 01
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	1, 270	2, 47	4 0	0	14. 00
15. 00			9, 81	3		15. 00
16. 00			3, 74	4		16.00

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lieu	ı of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED R SERVICES RENDERED TO PROGRAM BENEFICIARI		Provider CCN: 15-1305	Peri od: From 10/01/2020	Worksheet M-5
SERVICES RENDERED TO TROOKING DENETTOTAKE		Component CCN: 15-8512		Date/Time Prepared: 9/19/2022 5:14 pm
			RHC I	Cost

		Component Con. 13-6312	10 097 307 2021	9/19/2022 5: 14	
			RHC I	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
. 00	Total interim payments paid to hospital-based RHC/FQHC			883, 789	1.
00	Interim payments payable on individual bills, either submit	ted or to be submitted to		0	2.
	the contractor for services rendered in the cost reporting				
	"NONE" or enter a zero	•			
00	List separately each retroactive lump sum adjustment amount	based on subsequent			3.
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
01			02/28/2022	92, 055	3
02				0	3
03				0	3
04				0	3
05				0	3
	Provider to Program				
50				0	3
51				0	3
52				0	3
53				0	3
54				0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			92, 055	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	fer to Worksheet M-3, line)	975, 844	4
	27)				
	TO BE COMPLETED BY CONTRACTOR		_		
00	List separately each tentative settlement payment after des each payment. If none, write "NONE" or enter a zero. (1)	k review. Also show date o	of		5
	Program to Provider				
01	11 ogram to 11 ovrder			0	5
02				0	5
03				0	5
	Provider to Program				~
50				0	5
51				l ol	5
52				o	5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		0	5
00	Determined net settlement amount (balance due) based on the	cost report. (1)			6
01	SETTLEMENT TO PROVIDER			213, 043	6
02	SETTLEMENT TO PROGRAM			0	6
00	Total Medicare program liability (see instructions)			1, 188, 887	7
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1.00	2.00	

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL		In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED F SERVICES RENDERED TO PROGRAM BENEFICIARI		Provider CCN: 1 Component CCN:		From 10/01/2020	Worksheet M-5 Date/Time Prepared:
		Component Con.	10 0027		9/19/2022 5: 14 pm
				DUO LI	0

		Component CCN: 15-8527	10 09/30/2021	9/19/2022 5: 14	
			RHC II	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
. 00	Total interim payments paid to hospital-based RHC/FQHC			246, 063	1. 0
. 00	Interim payments payable on individual bills, either submit the contractor for services rendered in the cost reporting "NONE" or enter a zero	period. If none, write		0	2. 0
00	List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period. payment. If none, write "NONE" or enter a zero. (1) Program to Provider				3. C
01	1 rogi am to 1 rovi dei		02/28/2022	11, 275	3.0
02			02/20/2022	11, 273	3. 0
03				0	3. 0
. 03 . 04				0	3. 0
. 04				0	3. (
	Provider to Program			U	3. (
50	Provider to Program			0	3. !
51				0	3.
52				0	3.
				0	
53				0	3. 3.
54	Cubtatal (aum af lines 2 01 2 40 minus aum af lines 2 50 2 4	00)		-	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.4			11, 275	3. 9
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	rer to worksneet M-3, IIne	9	257, 338	4. (
	27) TO BE COMPLETED BY CONTRACTOR				
		k mayilay Alaa ahay data d	· E		Е.
00	List separately each tentative settlement payment after desleach payment. If none, write "NONE" or enter a zero. (1)	k review. Also show date (OF		5.
	Program to Provider			_	_
01				0	5. (
02				0	5. (
03				0	5.
	Provider to Program				
50				0	5.
51				0	5.
52				0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	5.
00	Determined net settlement amount (balance due) based on the	cost report. (1)			6.
01	SETTLEMENT TO PROVIDER			117, 618	6.
02	SETTLEMENT TO PROGRAM			0	6.
00	Total Medicare program liability (see instructions)			374, 956	7.
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	
			1.00	2.00	

Health Financial Systems	PULASKI MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHO		Provi der CCN: 15-1305	Peri od: From 10/01/2020	Worksheet M-5	
SERVI SES REMERED TO TROSTOM DEREFTOTALLES	,	Component CCN: 15-8528	To 09/30/2021	Date/Time Pre 9/19/2022 5:1	
			RHC III	Cost	
			_		1

				9/19/2022 5: 14	4 pm
			RHC III	Cost	
				rt B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
. 00	Total interim payments paid to hospital-based RHC/FQHC			72, 184	1.
2. 00	Interim payments payable on individual bills, either submitt			0	2.
	the contractor for services rendered in the cost reporting p	period. If none, write			
	"NONE" or enter a zero				
. 00	List separately each retroactive lump sum adjustment amount				3.
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
01			02/28/2022	14, 812	3.
02				0	3.
03				0	3.
04				0	3.
05				0	3.
	Provider to Program				
50				0	3.
51				0	3.
52				0	3.
53				0	3.
54				0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.9			14, 812	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transf	fer to Worksheet M-3, line		86, 996	4.
	27)				
	TO BE COMPLETED BY CONTRACTOR		- T		
. 00	List separately each tentative settlement payment after desk	c review. Also show date of	f		5.
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				_
01				0	5.
02				0	5.
03	Dec. 1 Lea Le Decessor			0	5.
F0	Provider to Program		T	1 0	-
50				1 -1	5. 5.
51				0	
52	Cubtatal (aum af lines F 01 F 40 minus aum af lines F F0 F 0	20)		0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.9			0	5.
00	Determined net settlement amount (balance due) based on the	cost report. (1)		10 257	6.
01	SETTLEMENT TO PROVIDER			19, 357	6.
02	SETTLEMENT TO PROGRAM			104 253	6.
00	Total Medicare program liability (see instructions)		Contract	106, 353	7.
			Contractor	NPR Date	
		0	Number	(Mo/Day/Yr)	
	Name of Contractor	0	1. 00	2. 00	8.
8. 00	Name of Contractor				

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	Peri od: From 10/01/2020	Worksheet M-5
	20	Component CCN: 15-8554	To 09/30/2021	Date/Time Prepared: 9/19/2022 5:14 pm
			DUC IV	C+

		Component Con. 13-0334	10 07/30/2021	9/19/2022 5: 14	
			RHC IV	Cost	
				rt B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
. 00	Total interim payments paid to hospital-based RHC/FQHC			173, 241	1.
2. 00	Interim payments payable on individual bills, either submit			0	2.
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
. 00	List separately each retroactive lump sum adjustment amount				3.
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
. 01				0	3.
. 02				0	3.
. 03				o	3.
. 04				o	3
. 05				o	3
	Provider to Program				
50			02/28/2022	7, 650	3
51				o	3
52				0	3
53				o	3
54				o	3
. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		-7, 650	3
. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans			165, 591	4
	27)				
	TO BE COMPLETED BY CONTRACTOR				
. 00	List separately each tentative settlement payment after des	k review. Also show date o	f		5
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
. 01				0	5
. 02					5
UZ				0	၂ ၁
				0	
	Provider to Program			1	
03	Provider to Program			1	5
03 50	Provider to Program			0	5 5
03 50 51	Provider to Program			0	5 5 5
03 50 51 52	Provider to Program Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		0 0	5 5 5
03 50 51 52 99				0 0 0	5 5 5 5
03 50 51 52 99 00	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0 0 0	5 5 5 5 6
03 50 51 52 99 00 01	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5. Determined net settlement amount (balance due) based on the			0 0 0 0	5 5 5 5 6 6
50 51 52 99 00 01	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.10 Determined net settlement amount (balance due) based on the SETTLEMENT TO PROGRAM			0 0 0 0 0 0 42, 715	5 5 5 5 6 6
. 03 . 50 . 51 . 52 . 99 . 00 . 01	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.00 Determined net settlement amount (balance due) based on the SETTLEMENT TO PROVIDER		Contractor	0 0 0 0 0 0 42, 715	5 5 5 5 6 6 6
5. 03 5. 50 5. 51 5. 52 5. 99 5. 00 6. 01	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.10 Determined net settlement amount (balance due) based on the SETTLEMENT TO PROGRAM			0 0 0 0 0 42,715 0 208,306 NPR Date	5. 5. 5. 5. 6. 6.
i. 02 i. 03 ii. 50 ii. 51 ii. 52 ii. 99 ii. 00 ii. 01 ii. 02 ii. 02	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.10 Determined net settlement amount (balance due) based on the SETTLEMENT TO PROGRAM		Contractor Number 1.00	0 0 0 0 0 42, 715 0 208, 306	5. 5. 5. 5. 6. 6. 7.